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Many Potential Pitfalls In Brain Injury Cases

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Traumatic brain injuries (commonly referred to as TBIs) are unique: No two are the same.

Unlike demonstrable orthopedic injuries, a TBI is unseen, misunderstood and overlooked. Yet, it is described by the Brain Injury Association as "The Silent Epidemic." The unique presentation of a TBI can present many potential pitfalls in litigation from statute of limitations to proving damages.

Not Clear Cut

TBIs are not clear-cut. They are not often seen on diagnostic tests (EEGs, X-rays, CT scans, MRIs, PET Scans), and normal diagnostic film studies do not rule out the presence of a TBI. Unlike fractures, which are demonstrated on such films, brain damage can occur that current film studies are insensitive to.

Manifestation of a TBI varies both in quality, extent and duration. Many factors affect the nature and consequences of a TBI: the premorbid personality of the injured person; the amount (g force) and direction (acceleration/deceleration and/or rotational) of the forces causing the TBI; and the areas of the brain affected.

Some people recover from severe brain injuries while others are permanently impaired from minor TBIs. Some areas of the brain (frontal) are susceptible to injury but brain injury can be diffuse and opposite the area of impact (coup, contre-coup). No two TBIs are alike; no two TBI cases are the same.

A few words about nomenclature: TBIs that are the result of trauma may differ qualitatively from traumatic brain injuries (e.g. those caused by oxygen deprivation or toxic poisoning).

Regardless of etiology, brain injuries are described as minor, moderate or severe. These adjectives describe the duration of unconsciousness (or alteration of mental awareness), not the severity of the resulting impairment.

Ratings scales - such as the Glasgow Coma Scale or Los Ranchos Amigos Scale - are used by medical personnel to record a person's duration of unconsciousness and subsequent responsiveness to emergency, acute and rehabilitative treatments.

Because TBIs vary, the ultimate case damages are not necessarily obvious from the first interview. Sometimes the presenting symptoms or complaints are attributed to pre-existing and/or co-existing medical issues. Making the differential diagnosis and the causal connection may take time.

When a TBI is diagnosed (and many minor TBIs are not diagnosed until months after the traumatic event), time will reveal whether the injury will be permanent or not. This uncertainty will cause plaintiffs' attorneys consternation in deciding whether or not to pursue a TBI claim (while the statute of limitations, infra, is running).

When pursuing a TBI claim, attorneys confront the ambiguity of whether and when a person with a TBI has reached -or will reach - a medical end result, and whether that person is at increased risk for additional neurological consequences (i.e., damages), see Gore, infra.

Though, generally, most recovery occurs within 18 to 24 months post-incident, attorneys may not have the luxury of time to file suit. Given the often-late diagnosis of a TBI, the uncertainty of outcome and the statute of limitations, *infra,* attorneys are faced with a difficult choice whether or not to pursue the claim.

The statute of limitations, with respect to brain injury, may be unforgiving. In a 1984 Massachusetts case, a construction worker had sustained a head injury, but his claim was not brought until four-and¬a-half years after the incident, when the family claims it first became aware that the plaintiffs depression and organic brain injury were likely caused by the construction accident. (The plaintiffs "discovered" the relationship of the plaintiffs injuries to the incident through a later diagnosis by a physician, Dr. Neal Borenstein.) See Gore v. Daniel O'Connell Sons, Inc., 17 Mass. App. Ct. 645 (1984).

Dr. Borenstein diagnosed the plaintiff as having "depression" and "organic brain syndrome." The plaintiffs argued that the three-year statute of limitations was tolled because the plaintiff's condition was inherently unknowable. (Id. at p. 646)

The Gore facts illustrates that TBI litigation may have traps for the unwary:

"On August 16, 1976, Gore, while working as a mason on a construction job, was hit in the head by a 4" x 4" x 8' timber. Although he was wearing hardhat, the blow must have been considerable because Gore was told at the Holyoke Hospital, to which he had been taken for examination, that 'he had apparently received a bad concussion.' (The quoted phrase is from a report by the psychiatrist who examined Gore on May 31, 1979, and who made the diagnosis on which the plaintiffs rest their action.) Gore displayed no outward physical manifestations of injury, but twenty-four hours after the accident he felt helpless and listless. From that time on Gore was depressed. He consulted a series of physicians. Dr. Smith, the physician who originally examined Gore at the hospital, sent Gore for a neurological work-up which turned up no neurological symptoms. A Dr. Reiss was similarly unable to find a neurological basis for Gore's difficulties. There

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followed a trip to the Lahey Clinic. Doctors there, following a medical and psychiatric work-up, diagnosed Gore's difficulty as anxiety with depression. Psychotherapy with a Dr. Williams followed. He wrote on February 28, 1978, that it was his 'impression that the symptoms are related to [Gore's] accident.' [fn3] Dr. Williams posited 'residual symptomatology from the blow to the head' and 'a compensation neurosis' arising from the accident. On June 6, 1978, Gore underwent a battery of tests at the Neuro-Psychological Testing Laboratory at the Baystate Medical Center. An examining psychologist, Dr. Klepper, gave his diagnostic impression that: 'Gerald Gore appears to have a chronic, mild, organic syndrome, associated with brain trauma, affecting the frontal and temporal lobes.' Still another psychiatric examination of Gore was conducted May 31, 1979, by Dr. Borenstein, who made a written report and diagnosis on June 19, 1979. Dr. Borenstein addressed his report to the plaintiffs' lawyer, and we may safely infer that it was prepared in anticipation of litigation. The Borenstein diagnosis is the one which the plaintiffs say informed them for the first time of the nature of Gore's medical condition. (Id., pgs. 646-47)."

'Inherently Unknowable'?

Though TBI is not easily or quickly diagnosed, it may not be "inherently unknowable."

When undertaking a TBI claim, all of the damages may not be "knowable" when settlement or trial comes. The late occurrence of seizures exemplifies the attorney's quandary.

Whether by settlement of jury verdict, the resolution of a TBI case should take in to account all of the plaintiffs damages, but the consequences of TBI are not always readily manifest, as the VanAlstyne case proved.

The plaintiff in that case, a 15-year-old, sustained a TBI in a motor vehicle accident and was awarded $50,000 by a jury (less a percentage for comparative negligence). But about two months after the verdict and nearly three years after the subject incident, the plaintiff sustained his first seizure.

The court granted the plaintiffs motion for relief from the judgment and a new trial on the issue of damages, pursuant to Mass. R. Civ. P. 60(b)(2), 365 Mass. 828 (1974), on the basis of newly discovered evidence (the 10-day period for a motion for new trial prescribed in Mass. R. Civ. P. 59[b], 365 Mass. 827 [1974], having by then expired). See VanAlstyne v. Whalen, 15 Mass. App. Ct. 340, 345 (1983).

According to an affidavit filed by a physician on behalf of the plaintiff, this permanent condition could not have been diagnosed earlier. (Id.) The court allowed the plaintiffs motion and remanded the case for a new trial on damages only.

What would have been the result had the case settled and the undiagnosable seizures occurred three months later? What if the settlement had been approved by a court (because it involved a minor (as in the Gore case) or an incompetent and seizures occurred post-court approval?

With medical literature and research reporting an association between Alzheimer's and TBI, and depression and TBI, these questions may no longer be academic.

As seen, the sequelae from a TBI are sometimes (1) undiagnosable at a given moment, (see VanAlstyne); and (2) unpredictable (there was no early onset of seizures in the Gore case. The sequelae do not occur in isolation; often, the person sustains other injuries. Sometimes the TBI is overlooked or minimized in the context of other serious, easier to prove orthopedic and/or neurological injuries. Psychological injuries can coexist with TBI.

Persons with TBI can have a range of symptoms from problems in attention, concentration, short-term memory, spatial relations, time concepts and speech to loss of smell, disturbances in gait, balance and sometimes paralysis.

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The cognitive changes are subtler than the physical injuries and present the attorney with the greatest challenges because the person with TBI may be his or her own worst witness. Persons with TBI may have amnesia for events immediately before and after the subject incident, leaving the liability evidence to other witnesses including the defendant(s).

Cognitive symptoms will impact other aspects of the litigation. Persons with TBI who have ongoing short-term memory problems make the person a less effective client in the litigation process.

When a Rule 35 defense medical exam occurs, the person with TBI may be at a disadvantage. (TBI cases often involve a neuropsychological (defense) examination under Rule 35. But note that Rule 35 may expressly provide for examination by a "physician" only, not a neuropsychologist, who is a licensed psychologist with specialized training in the field of neuropsychology. "When the mental or physical condition (including the blood group) of a party, or of a person in the custody or under the legal control of a party, is in controversy, the court in which the action is pending may order the party to submit to a physical or mental examination by a physician or to produce for examination the person in his custody or legal control." See Mass. R. Civ. P 35.)

If a person with TBI undergoes a Rule 35 examination, the person may be unable to recall what occurs during the defense examination. A motion to have the examination recorded (audio and/or video) or monitored in some fashion may be warranted. Such motions are met with varied success.

The Alaska Supreme Court, in allowing plaintiff's counsel to attend the defense medical exam, cited cases from California, New York, Florida and Washington. See Langfeldt-Haaland v. Saupe Enterprises, Inc., 768 P.2d 1144, 1145 (1989).

The Alaska court reversed the lower court's decision requiring the petitioner to submit to an unrecorded medical examination without the presence of counsel. Id. at 1147.

A Rule 35 DME is an adversarial discovery tool. The DME is analogous to a deposition where the examiner asks the plaintiff questions, but, unlike a deposition, only the defendant's expert notes (and remembers) what is discussed and happens. The results of the DME can then be used adversely against the plaintiff.

A plaintiff with short-term memory problems would be incapable of assisting his counsel in challenging what occurred during the Rule 35 examination. Audio-taping, video-recording and stenographic records may provide the needed safeguards to a plaintiff with TBI.

A person with TBI may also have psychiatric injuries: TBI and psychiatric conditions are not mutually exclusive. For example, as the person with TBI becomes aware of cognitive difficulties, while remembering how they functioned pre-accident, they may become depressed. Is such a process organic or non-organic in origin? Does it make a difference in the litigation context?

Still others are traumatized by the horrible event and develop Post-Traumatic Stress Disorder (PTSD), which complicates their clinical and legal presentation. Query as whether or not the psychiatric condition obscures or exacerbates the cognitive deficits.

Neuropsychological testing may become a focal point in sorting out the multitude of symptoms after TBI. Performed by a well-credentialed and experienced neuropsychologist, the testing results may provide objective data of the profound cognitive and emotional effects of a TBI. Challenges, however, are made to the methodology, raw data, interpretation and validity of the scores, findings and interpretation, whether the neuropsychologist is a treater, plaintiffs or defendant's expert.

TBI litigation presents our clients and our profession with significant challenges; and it is for good reason:

"What we are today comes from our thoughts of yesterday, and our present thoughts build our life of tomorrow: our life is the creation of our mind."

- Dhammapada v. I, circa, 2nd Century B.C.

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