WHAT TO THINK? INVESTIGATING AND DEFENDING A MILD TRAUMATIC BRAIN INJURY

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INTRODUCTION

Continued media coverage of traumatic brain injuries ("TBIs") has increased public awareness of this often "invisible" injury. Accompanying this increased awareness is a rise in claims of mild TBIs in even the lowest-speed motor vehicle accidents. TBI claims cost more to defend than the standard soft tissue or orthopedic injury: TBI claims often require several experts, extensive written discovery, before-and-after witness depositions, and motions in limine. Plaintiffs tack on mild TBI claims generally without impunity, knowing that some potential future jury could believe their subjective complaints. Unfortunately, verdicts for mild TBIs vary from case to case. However, the common denominator on high settlements, awards, and verdicts is a credible, likeable, and sympathetic plaintiff. Any evidence impeaching the plaintiff will chip away at these positive character traits. Merely presenting medical testimony contradicting the plaintiff's opinions of the treating doctors may be insufficient to persuade a charmed jury.

Most mild TBIs are not visible on diagnostic tests either in the form of a brain bleed or swelling immediately after, or brain atrophy long after the accident. Often, mild TBIs do not involve any true loss of consciousness. In these circumstances, whether a mild TBI exists often turns on the existence, or non-existence, of relatively subjective complaints such as headaches, nausea, dizziness, lightheadedness, blurred vision, convergence, vertigo, sensitivity to light, sensitivity to sound, depression, anxiety, difficulty concentrating, language loss, confusion, emotional instability, reduced motivation, and impaired reasoning. A thorough investigation by the defense can shed light on the legitimacy of the mild TBI. Although subjective complaints depend mainly on a plaintiff's credibility, TBIs are still subject to specific medical principles and follow general standard patterns. Nonetheless, the mild TBI presents a more unpredictable risk scenario vis-a-vis moderate to severe TBIs. A defense attorney needs at least a working understanding of the anatomy of a mild TBI claim. This article will provide guidance on how to evaluate the existence of a legitimate mild TBI, and provide strategy considerations in defending the mild TBI claim.

CAUSE OF A MILD TBI

TBIs fall into one of three classifications: mild, moderate, or severe, depending on whether the patient loses

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consciousness, the length of unconsciousness, and severity of other symptoms. Most TBIs are classified as mild and are commonly coined "concussions." Typically, mild TBIs are not life threatening and resolve without treatment.

Before a TBI can occur, some force must be exerted on the brain either by an object penetrating the brain, an impact to the head, or an external force strong enough to move the brain within the skull. Not all blows or movements of the brain cause brain injuries. In fact, most do not. There is no agreed upon threshold for the amount of force necessary to cause a mild TBI. Additional factors also come into play including, for example, whether the plaintiff had prior TBIs. Repeat mild TBIs over an extended period of time may cause cumulative neurological and cognitive deficits, increase the risk of brain disorders such as Alzheimer's and Parkinson's disease, or cause chronic traumatic encephalopathy. Repeat mild TBIs within hours, days, or weeks can be catastrophic or fatal.

In motor vehicle accidents, plaintiffs typically claim mild TBIs from whiplash, bumping the headrest, being hit by an airbag, hitting the window, or being struck by an unsecure object. The lack of mechanism of injury, i.e., the plaintiff testifies that their body made no movement on impact, is normally fatal to a TBI claim. The defense must therefore pinpoint the specific mechanism of injury and extent of the impact upon the plaintiff.

Ideally, in any recorded statement taken after an accident, the plaintiff should be asked about movement of or trauma to the head. Follow-up into the severity of the force should include a detailed description of the movements, whether any lacerations, bruises, bumps, or tender spots developed, whether any items were displaced in the vehicle on impact (e.g., coffee mugs, glasses, or bags), and whether whatever the plaintiff's head hit (e.g. the window, steering wheel, or window) broke or cracked. Whether the plaintiff participated in other activities that would cause whiplash movements before after the accident (e.g., amusement park rides, contact or high impact sports, assault, accident, or fall) may assist to compare the force of the accident with the force of other activities in which the plaintiff participates, especially voluntary activities.

Data contained within the vehicles involved in an accident may reveal the force, and hence severity, of impact. Most modern vehicles contain an event data recorder ("EDR") that enables precise calculations of speeds upon impact. In a non-airbag deployment accident, the data is saved for only a certain number of ignition cycles, which is about three to four weeks of normal driving activities. It is therefore imperative to download EDR information from all vehicles involved before overwriting occurs. A biomechanical engineer may then use that precise information to evaluate whether the force applied to a plaintiff in an accident was sufficient to cause injury.

Photographs of the damage to the involved vehicles may also support a mild TBI denial if the damage is minimal. Photographs exist as a matter of course if a vehicle is submitted for repairs. However, low impact accidents cause minimal to no property damage and thus photographs may not exist. In those cases, photographing the lack of damage would be a best practice. A picture is worth a thousand words and will go a long way to persuading a trier of fact that a plaintiff did not sustain a mild TBI.

DOCUMENTATION AND PROGRESSION OF A MILD TBI

Defense of a mild TBI requires focusing on when TBI symptoms manifest, the nature of those symptoms, and the evolution of the symptoms. The defense should pay close attention to the onset date of symptoms, consistency of symptoms, and progression or resolution of symptoms in evaluating the legitimacy of the mild TBI.

Generally, mild TBI symptoms fall into four categories: (1) physical, (2) cognitive, (3) emotional, and (4) sleep. Within these categories are numerous symptoms including: dizziness, loss of balance, poor coordination, headaches, appetite change, nausea, vomiting, visual disturbances, light sensitivity, noise sensitivity, hearing difficulty, tinnitus, poor concentration, language impairment, forgetfulness, difficulty making decisions, slowed thinking, anxiety, depression, attention deficit, irritability, lack of motivation, inability to moderate emotions, fatigue, and insomnia. Generally, a person with a legitimate mild TBI will manifest some, but not all, potential symptoms. Plaintiffs falsely claiming a mild TBI tend to report most, if not all, potential subjective symptoms and will not report these symptoms consistently from visit to visit or doctor to doctor. A plaintiff who starts using technical medical terms to describe symptoms indicates the plaintiff is likely researching brain injuries and may be overstating their actual symptoms, if any. Importantly, symptoms do not evolve or escalate over time, and most mild TBIs resolve with no permanency.

A. Sources of Documentation

Law Enforcement Reports. The accident report may contain evidence relevant to evaluating the existence of a mild TBI. However, especially in lower impact accidents, accident reports tend to be lackluster. As soon as practicable, the defense should talk to all law enforcement who were present at the scene of the accident to obtain all details regarding the physical and mental condition of the

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plaintiff. The longer the delay in this investigation, the higher probability that the law enforcement will fail to recall details not contained in the frequently minimalist accident reports.

911 recordings may also contain evidence of the plaintiff's behavior at the scene. If the plaintiff called 911, a jury would listen for slurring and disorientation. If the plaintiff did not call, the caller may have provided information regarding the plaintiff's state. 911 recording retention policies vary and requests should be made as soon as practicable to the police jurisdiction where the 911 call occurred.

Medical Records. Medical records for visits within the first few hours, days, and weeks after an accident are crucial to evaluating a mild TBI claim. If these medical records fail to properly document the initial symptoms of a TBI or counter-indicate a TBI, the subsequent development of subjective symptoms of a TBI are likely from attorney suggestion, monetary motivation, or some other non-organic source.

Notably, the ambulance or emergency records will contain a Glasgow Coma Scale ("GCS"). The GCS can generally rule out a moderate to severe TBI. The GCS is a 3 to 15 point scale measured soon after the time of injury and consists of three scored sections: (1) motor response; (2) verbal response; and (3) eye opening. A plaintiff with a GCS score from 3 to 8 is classified as having a severe TBI; 9 to 13 is classified as a moderate TBI; and 14 to 15 may have a mild TBI. In most mild TBI cases, a plaintiff has a GCS of 15. However, nearly all people with mild TBIs will have some amount of disorientation or amnesia within hours of the accident, but GCS is not designed to detect these lesser symptoms.

If the plaintiff went to the emergency room, which a person with even a mild TBI would, look for the exact neurological, emotional, and cognitive complaints reported. The key indicator of a fabricated TBI is a subsequent development of amnesia. If the emergency records, or any subsequent records, document a plaintiff recalling the events of the accident, no amnesia exists. A plaintiff who later claims amnesia is likely fabricating, either consciously or unconsciously.

A plaintiff in a low-speed accident often relies solely on an emergency room diagnosis of concussion or closed TBI for their case-in-chief. If a patient reports subjective complaints of a TBI, the emergency room will order diagnostic testing (i.e. brain CT or head MRI) as a matter of course to rule out a significant injury. This protocol, however, is based almost entirely on the subjective complaints of the plaintiff and not necessarily the true diagnosis of the treating doctor. When the diagnostic tests eliminate a moderate or severe TBI, then the standard protocol is to diagnose a plaintiff presenting with only subjective complaints of headache, confusion, amnesia, dizziness, blurred vision, and/or nausea with no loss of consciousness with a concussion or mild TBI. If a plaintiff relies solely on the emergency room record and no other qualified expert, a motion in limine to exclude the mild TBI or Rule 50 judgment as a matter of law upon close of a plaintiff's case at trial is warranted.

Another commonly reported symptom with mild TBIs is headache. A headache from a mild TBI will manifest itself rather immediately, given the cause is the force put on the brain itself. Distinction needs to be made, however, between tension headaches from the stress of a collision or musculoskeletal whiplash injury, and headaches from a mild TBI. Headaches caused by the mild TBI will not drastically change in nature over time. For example, mild TBI headaches will not move around in location, will have consistent triggers, and will generally decrease in frequency over time. Most quality treating providers will instruct a patient reporting headaches to keep a headache journal, which should be requested in discovery.

Another TBI trend is to seek an opinion of convergence disorder, which is a condition in which eyes are unable to work together when looking at nearby objects. Obtaining all prior eye exam records is necessary to evaluate whether the condition was pre-existing. If the plaintiff has not had a legitimate eye exam within years of the accident, they may have had undiagnosed convergence problems improperly attributed to a mild TBI. If a plaintiff does not follow through on the recommended treatment plan, they have likely been living with the convergence problems long before the alleged mild TBI. If a plaintiff claims he or she has convergence problems, the defense should always obtain a Rule 35 examination with a neuro-ophthalmologist. A judge may find that a general neurologist or neuropsychologist lacks foundation to render an opinion on the convergence claim.

In some cases, a plaintiff with a mild TBI may not manifest symptoms until days or weeks after the accident. Such a delay, however, directly relates to the severity of the mild TBI. By the one-month mark, most, if not all, the mild TBI symptoms normally would have manifested.

Nonetheless, in a small minority of patients with mild TBIs, symptoms may persist long after the injury, such as a year or more. These outliers are often diagnosed as "persistent post-concussion syndrome," a diagnosis and term the medical community disputes. The cause of persisting symptoms and prolonged disability after a mild TBI is much less likely a direct consequence of the injury to the brain and more likely multidimensional, resulting from a mix of intertwined psychological, social, and tissue injury factors. These factors comprise the nature and extent of the brain injury, interplay with other injuries and comorbidities, genetics, pre-existing mental health problems, stress, litigation, bias in belief, and attitude. Thus, closely review a plaintiff's pre-accident mental and physical health records

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to identify other medical explanations for a plaintiff's lingering symptoms.

B. The Plaintiff Outside the Courtroom

Nearly all defense attorneys have been forced to watch a plaintiff act stiff in court, barely able to turn their head to one side, and then witnessed that same plaintiff skip unabashedly to their vehicle after trial. Unfortunately, a jury does not see the plaintiff skip merrily away, pleased with the day's proceedings. It is therefore extremely important to make reasonable attempts to obtain incriminating evidence depicting the plaintiff acting drastically different in the real world versus legal proceedings or litigation-related medical visits. The pandemic has placed a significant damper on defense attorneys' best evidence contradicting a mild TBI: surveillance. As the world opens up again, hopefully in the next year, surveillance will return to center stage.

A super majority in the United States have at least one social media account. Often, a plaintiff shuts down or tightens privacy settings on social media accounts upon retaining an attorney. Pre-litigation social media searches are thus crucial to setting up a potential motion to compel. More courts are permitting production of social media accounts, but typically only if the public portion contains some relevant information. Clarifying a plaintiff's social media use via written discovery and depositions may give additional grounds for a motion to compel. A best practice is to send a litigation hold on social media accounts upon receipt of a referral and serve Rule 35 Request for the Production of Documents, Electronically Stored Information, and Things 21 days after service of the complaint. If the plaintiff subsequently changes privacy settings or removes items from social media accounts, a spoliation sanction may be available.

In some cases, deposing before-and-after witnesses assists in gathering contrasting information for a jury. A cardinal rule at trial is not to ask any questions on cross-examination where the answer is unknown. A discovery deposition is a prime opportunity to dig deeper into what the witness actually knows and obtain impeachment material for trial. A request for documents should accompany every subpoena for a before-and-after witness and request, at minimum, all photographs, social media posts, and communications the witness has had with the plaintiff since the accident.

Deposing a direct supervisor or manager would also provide insight into whether the plaintiff is exaggerating a mild TBI. In cases where a mild TBI is just a throw-in or is otherwise illegitimate, a plaintiff will not want an employer to be deposed and thus informed of the alleged mild TBI. An alleged permanent mild TBI may disqualify a plaintiff from performing certain jobs, i.e. truck driver, bus driver, handling heavy machinery. Merely noting the employer's deposition for after mediation may be incentive enough for the plaintiff to accept a reasonable and appropriate settlement.

Pre-TBI medical and psychological records, employment records, social media posts, hunting and fishing licenses, gym use, and health monitoring data can lead to the discovery of evidence that the plaintiff is malingering. The data also help medical and other experts to understand who the plaintiff was emotionally, psychologically, intellectually, and physically before the example. For example, a pre-existing psychological history or physical condition could explain why a plaintiff is experiencing physical symptoms that lack correlation with a TBI.

C. Typical Progression of a Mild TBI

Most people with mild TBIs do not require treatment other than over-the-counter pain relievers and temporary brain rest. Brain rest is a reduction in cognitive activity including, but not limited to, avoiding work, social gatherings, complicated tasks, screen time, and physical activity. The medical rationale is that the brain needs to refocus its energy on healing versus cognitive tasks.

What a plaintiff does in the weeks after an alleged TBI will shed light into the existence and severity of the mild TBI. Discovery requests should include inquiries into social media activity, social activity, phone records, employment records, hunting and fishing licenses, gym use, and health monitoring devices. The more active a plaintiff, the less likely they sustained a mild TBI.

Generally, the fastest improvement occurs within six months of a mild TBI. A person with a mild TBI may continue to improve after six months, but most neurologists agree that maximum medical improvement will likely occur around two years after the accident. Any dramatic improvement in subjective complaints after the two-year mark should raise a red flag.

DAMAGES EXPERTS IN A MILD TBI CASE

When preparing for trial, pay close attention to whether the plaintiff's experts have foundation to issue each and every opinion. Likewise, the defense must retain experts with sufficient foundation to refute all the plaintiff's treating doctors or independent examiners. Depending on the severity of the plaintiff's complaints, one or more of the following experts may be necessary:

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A. Neurologist

If a referral occurs following a concussion or mild TBI diagnosis, the referral is typically to a neurologist. A neurologist is a physician skilled in the diagnosis and treatment of disease of the nervous system, including the brain, spinal cord, cranial nerves, peripheral nerves, nerve roots, autonomic nervous system, neuromuscular junction, and muscles. If the plaintiff has not and is not recommended to treat with a neuropsychologist, then a neurologist is generally a sufficient defense expert.

B. Neuropsychologist

Arguably one of the most helpful resources to assist the evaluation and defense of a mild TBI case is a neuropsychologist ("neuropsych"). Neuropsychology is concerned with relationships between the brain and behavior, i.e. how well the brain is working. Neuropsychs conduct evaluations, known as the neuropsychological examinations, to assess a patient's brain function. A neuropsych is not a licensed medical doctor; they usually possess a Ph.D. or a psychological doctorate (Psy.D).

The examination involves an interview and a battery of tests over a two- to eight-hour period, depending on the complexity of the case. The tests are mainly administered by the neuropsychs, but some are self-reporting tests. The tests include baseline cognitive testing (estimating pre-accident level of cognitive functioning), general intelligence, auditory processing, visual processing, memory, problem solving, fine motor skills like dexterity and grip, personality, and emotional functioning. A patient's score is evaluated by comparison to the score of healthy individuals of similar demographic backgrounds. The neuropsych will analyze the data for patterns of strengths and weaknesses of the patient's brain function, provide a diagnosis and prognosis, and recommend treatment.

Unlike "bedside" cognitive and behavioral screenings, the neuropsychological tests are standardized. If serial exams occur too close in time, the results in the subsequent test could be unreliable because the patient recalled the actual test items and recalled how to take the test. Generally, most neuropsychs require at least six months between exams.

Early in a claim, a neuropsych can provide advice to assist in guiding investigation, preliminary thoughts on the merits of the plaintiff's mild TBI, and an unbiased review of the plaintiff's expert disclosures. If a plaintiff has undergone neuropsychological testing that revealed brain function deficits, anticipate needing an independent neuropsych examination. Recall that the independent exam cannot occur until at least six months after the treating doctor administers the exam. Set scheduling order deadlines reflecting the six months. A best practice is to execute a stipulation to attend the independent neuropsychological exam containing language whereby the plaintiff agrees to attend the independent exam as scheduled and further agrees not to schedule or undergo any other neuropsych testing in that six-month period. If the plaintiff then fails to attend or undergoes more neuropsychological testing within six months of the independent exam, grounds exist to request sanctions (i.e. the no-show fee, cancellation fee, and motion costs and fees) under Rule 37.02 of the Minnesota Rules of Civil Procedure.

A neuropsych will evaluate the plaintiff for malingering or incomplete effort by incorporating performance validity tests. There is minimal research into the effectiveness of these validity tests, but the neuropsych community generally accepts them as sufficient. The neuropsych will also compare individual test results to the big picture. A plaintiff exhibiting severe cognitive deficits in testing but who can complete most or all activities of daily living is likely malingering.

Provide the independent neuropsych all evidence about the plaintiff (e.g. deposition transcripts, surveillance, photographs, social media posts, medical records, employment records, and school records). Obtain an authorization from the plaintiff to release their treating doctor's raw test data to the independent neuropsych. Often the independent neuropsych knows more about the plaintiff than the treating neuropsych.

At trial, the neuropsych should provide straightforward, understandable testimony. Focus on only those specific tests and opinions that refute the claims of the plaintiff or their experts. Avoid boring the jury.

C. Vocational Rehabilitation

The majority of mild TBIs resolve without residuals. This alone should cast doubt on claims for future loss of earnings from a mild TBI. A plaintiff seeking loss of future earnings will undergo a vocational rehabilitation evaluation with a licensed evaluator, which appraises the plaintiff's current and future employability and wages. The evaluation will take one to four days and includes an interview, vocational testing, market research, and predictions.

D. Other Experts

The neurologist and/or neuropsych typically provides the essential expert testimony in most mild TBI cases. However, the need for additional experts turns on the facts of the

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case, and the specific disabilities the plaintiff asserts. When assessing the need for additional experts, ask whether the neurologist and/or neuropsych has the foundation to offer an opinion on the specific residual symptom.

In cases where the parties agree the plaintiff had a mild TBI but dispute the nature and extent of said TBI, symptom-specific experts should be considered. For example, if the plaintiff is calling a neuro audiologist to testify to hearing loss or tinnitus, the defense should, at minimum, consult with an independent neuro audiologist about the legitimacy of the treating neuro audiologist's opinions. Other examples include a psychologist and/or psychiatrist for anxiety or depression, a neuro optometrist for visual deficits, a speech therapy pathologist for speech problems, a physical therapist for muscle atrophy, a vestibular physical therapist for dizziness and loss of balance, and a neuroradiologist for diagnostic test interpretation.

Give your expert all relevant evidence, the good and bad, to avoid the risk of the expert changing opinions or expressing surprise during trial testimony upon being presented with the undisclosed evidence. Reach out to the expert long before the independent examination to see if additional information is needed or otherwise requested.

IV. CONCLUSION

Mild TBI claims continue to be on the rise even in low-impact accidents. In general, most mild TBIs heal without residuals. A disproportionately high number of plaintiffs involved in motor vehicle accidents claim to be the exception and attempt to convince a jury that they have the rare mild TBI with permanent physical, cognitive, and emotional changes. Investigating and defending a mild TBI claim is costly, and the scope should be proportionate to the severity of the claim. Given the subjective nature of a mild TBI claim, focus on gathering any and all impeaching material and identifying medical impossibilities. The goal is to collect sufficient impeachment evidence to erode a plaintiff's credibility and likeability, and give a jury a picture of the plaintiff outside the courtroom. Further and importantly, the pièce de résistance is a solid independent examiner who can plainly articulate the medical inconsistencies and defend his or her opinions.

The authors relied on their breadth of experience deposing medical experts, reading medical reports, speaking with medical providers in mild TBI cases, and attending CLEs. In addition, the authors consulted several credible websites including but not limited to the following:

- https://www.cdc.gov
- https://www.health.state.mn.us
- https://www.mayoclinic.org
- http://pnl.bwh.harvard.edu

The authors also obtained information from the following medical publications:

- Douglas I. Katz, *et al., Mild Traumatic Brain Injury, 9* Traumatic Brain Injury, Part 1: Handbook of Clinical Neurology 131 (2015).
- Victor F. Coronado, *et al., Traumatic Brain Injury Epidemiology and Public Health Issues*, 8 Brain Injury Medicine, 84 (2013).
- Grant L. Iverson, *et. al., Conceptualizing Outcome from Mild Traumatic Brain Injury*, in Brain Injury Medicine: Principle and Practices 470 (2005).