Have You Noticed the Increase in Mild Traumatic Brain Injury?

Authored by ALFA International Attorneys:

Warner Fox
HAWKINS PARNELL & YOUNG, LLP
Atlanta, GA
wfox@hpylaw.com

Lance Eberhart
HALL & EVANS, L.L.C.
Denver, Colorado
eberhartl@hallevans.com
We all know a true traumatic brain injury (TBI) case when we see one. It usually involves significant trauma to the victim's head, an immediate hospitalization, positive findings on CT scans and MRIs and long-term consequences to the victim. This paper is not really designed to discuss those types of matters. Rather, the focus here is on mild traumatic brain injuries (mTBI) which, while a real injury, is quite often turned into a manufactured damages case in a litigation setting. The cases can be complex, troublesome, and difficult to defend. They have also been known to result in seven-figure verdicts.

Traumatic brain injuries are usually delineated into three types. The first is what this paper will deal with, a mTBI, second is a moderate TBI and the third is a severe TBI. Generally, an mTBI is defined by several criteria that are evident almost immediately after the alleged injury. The first is a normal Glasgow Coma Scale finding of 13 to 15 (The Glasgow Coma Scale (GCS) is a neurological scale (15 points total) which aims to give a reliable and objective way of recording the conscious state of a person for initial as well as subsequent assessment). While an actual loss of consciousness is not required for a diagnosis of a mTBI, a period of 30 minutes or less of loss of consciousness will certainly result in an mTBI diagnosis. An mTBI is sometimes also occasioned by posttraumatic amnesia of an hour or less.

It is certainly arguable that TBIs are an epidemic in the United States. They account for 40% of all acute injury deaths in this country. Approximately 1.74 million people a year sustain a TBI requiring medical assessment. And there may be many more instances of mTBI that never get medically assessed. For instance, anyone that hits their head and is dazed as a result of it would, if seen by a physician, receive a diagnosis of mTBI. Out of 100,000 TBI cases only about 30 of them will be moderate or severe. The
remainder are mTBI which demonstrates the immense number of these that occur every year.

From an epidemiology standpoint the greatest risk for any type of TBI is in the male population, with the peak years of age between 15 and 24. There is also a far higher incidence of TBI in low income, ethnic minority, and inner-city-dweller populations. Motor vehicle accidents are the leading cause with over 50% of TBI's arising from them. Falls account for 20% to 30% and firearms 12%. Alcohol is also a major contributing factor.

It is important to understand that from a medical standpoint anyone sustaining a mTBI has also sustained a concussion. A concussion is defined as a “clinical syndrome characterized by immediate and transient alteration in brain function, including alteration of mental status and level of consciousness, resulting from mechanical force or trauma.” A knock on the head that causes a very brief moment of confusion equals the diagnosis of concussion/mTBI. Therefore, anytime a medical records review on a plaintiff shows a diagnosis of concussion, you are automatically looking at a potential mTBI case. And you may also be dealing with a case where post-concussion syndrome (PCS) may be asserted. There is a great deal of similarity between the symptoms of a mTBI and PCS.

From a diagnostic standpoint, mTBI is generally considered as an injury that will not reveal itself on imaging such a CT scan or MRI. There are certainly plaintiffs'-oriented neurologists and radiologists that are contending that more advanced forms of MRIs can show indicia of a mTBI. This is still hotly contested within the medical field and, if you are confronted with such an assertion, it should be examined closely for potential challenges to its use in a court of law.
A key point that needs to be understood with respect to mTBI is related to the expected outcome. There are many widely accepted peer-reviewed studies in the field of neuropsychology over the last 20 years that indisputably prove that the outcome from a mTBI should be universal recovery, such that an individual is back to performing at his baseline within about 90 days. This fact should really no longer be in dispute. Unfortunately, however, there are plaintiffs'-oriented neuropsychologists and neurologists that continue to contend that there is a certain percentage (usually 5 to 10%) of victims of mTBI that will continue to have long-term sequela from their injury. This group is referred to in research as “the miserable minority.” The truth, however, is that this miserable minority's claims of long enduring symptoms cannot be explained by a mTBI.

This 5 to 10% subset, however, can lead to very expensive verdicts. There are plenty of plaintiffs'-oriented neuropsychologists and neurologists that will steadily and vigorously promote this concept. The research simply does not support it, particularly within the field of neuropsychology. Unfortunately, especially in the field of medicine, physicians have been and are being taught that this minority population exists. In the meantime, the great weight of research in the field of neuropsychology demonstrates that while there may be a “miserable minority,” their symptoms are not caused by a mTBI. The medical providers for these plaintiffs often fail to consider other likely causes of the alleged symptoms. Not only that, their treatment and sympathy for these “victims” result in plaintiffs being convinced that they are still having symptoms related to a mTBI. These providers should instead be telling their patients that they are going to improve and return to normal.
There are numerous papers in the field of neuropsychology that clearly demonstrate a close connection between this “miserable minority” and litigation. There is also significant research that shows a 40% base rate of malingering in mTBI cases involving plaintiffs. Secondary gain can play a role even outside of litigation. Finally, many of this subset of “miserable minority” plaintiffs will be found to have a variety of comorbid and pre-existing conditions, such as substance abuse, depression, and somatizations that clearly can explain the alleged symptoms. And not only can those conditions explain the symptoms but on neuropsychological testing, they can result in significant scoring deviations.

Almost every litigated mTBI case will involve at some point a neuropsychological evaluation. Plaintiffs’ lawyers have become very adept at handpicking neuropsychologists that will support the assertion of a “miserable minority” plaintiff. These neuropsychologists will generate lengthy and detailed reports based upon neuropsychological testing. They will then contend that the report and testing supports their diagnosis and the claims that the plaintiff suffers from innumerable symptoms and will continue to do so. Generally, the only way to combat this is by the retention of a defense neuropsychologist, who actually understands the medicine and the research behind mTBI and recovery rates. This expert will be called upon to do an in-depth evaluation of the plaintiff’s neuropsychologist’s work product. Many times this will be followed by a neuropsychological evaluation done by the defendant’s neuropsychologist. This, of course, makes it imperative that a neuropsychologist selected by the defendant be eminently qualified in the field of mTBI research and treatment. And there are many neuropsychologists that will not meet these requirements.
The field of neuropsychological testing is complex. For the most part, it is certainly beyond the ken of a defense lawyer to understand all the nuances and issues that arise in neuropsychological testing. For one thing, there are literally hundreds of neuropsychological tests that can be utilized by a neuropsychologist. Mistakes can be made by neuropsychologists on both sides, in the manner in which these tests are administered and then subsequently scored and interpreted. The selection of which test battery to administer to a plaintiff can become incredibly important. Perhaps as important is the selection of either standalone tests or tests that have embedded within them what are known as validity measures. The purpose of these tests is to look at effort and to look for deceit and/or malingering. These types of validity measures have strong research support behind them. This is also an issue that many times will be conveniently overlooked by the plaintiff’s neuropsychologist.