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Identifying mild traumatic brain injuries

Your job is to determine if your client may have suffered an undiagnosed brain injury

Your client comes into your office having been involved in an automobile collision, slip/trip and fall, explosion, or falling object, etc. He or she has suffered some physical injuries for which treatment was received and the physical injuries appear to be resolving. However, the client just doesn't "feel right." Memory problems, outbursts of anger, inability to concentrate and/or retain information, and trouble learning new materials have appeared recently since the incident and are persisting and/or getting worse. Co-workers, family members, and even casual acquaintances will ask, "Are you alright? You don't seem to be yourself." Your job is to determine if your client has suffered a brain injury. Did he or she have some form of concussion?

Over the years, these types of mild traumatic brain injuries have gone undetected and untreated. Recently, new diagnostic techniques and more probing clinical evaluations have allowed these mental, emotional, and psychological abnormalities to be recognized.

In every case where there is a potential for trauma, either direct or indirect, contact between the brain and the skull in a violent or reverberating manner, you must look for a traumatic brain injury. Obviously the severe and/or moderate brain injuries are more easily detected at an early period after a traumatic event. Most brain injuries, however, are mild traumatic brain injuries or "MTBI." These types of injuries must be teased out by you if you are to adequately represent your client and obtain full, fair, and complete compensation for him or her.

Many more mild traumatic brain injuries occur from a minor direct blow to the head, coup-contrecoup or introduction of a toxic substance than were often recognized in the past. The much maligned concept of "whiplash," in which the neck is snapped back and forth causing the brain to collide with the solid protuberances of the interior of the skull, is a reality which can and does cause defuse axonal sheering.

The initial interview

Your initial interview should be one that is time consuming in order to make it complete. Often, the client will not recognize that there has been some trauma to the brain and will not associate mental deficiencies to that trauma. I have included a questionnaire (see pages 3-5 of this document) that is provided to a client, family members and friends which seeks information about a variety of physical and behavioral changes that have occurred since the trauma. These behavioral changes are only a gross evaluation of the client's potential brain injury but can be very telling in the information they provide. In comparing the before and after signs, symptoms, and anecdotal information you can gain much information that will be helpful in how you prosecute your case. Additionally, once a head injury is suspected and the questionnaires have been completed, interviewing family members or friends who have completed the questionnaires is important.

It must be emphasized that the questionnaires be completed solely by the individual responding and that there not be any influence by other respondents in completing the forms. You want the individual's personal responses without any collaboration of others. It is amazing the difference in responses others will express regarding the client's behavioral changes since the incident that are not recognized or complained about by the injured individual.

Using medical records

Medical records including first responder reports, emergency room materials and initial primary care evaluations will be of great assistance to you. You must have a knowledge of the basic preparation of these records to properly evaluate them. Such items as the Glasgow Coma Scale ("GCS") being reported as normal is not of much value because it is a very limited and gross evaluation. If there is any abnormality in the scale, however, that is significant because the recognition of a variant in eye opening, motor responses or verbal responses, would indicate that there was an initial problem identified. Also a report of no "loss of consciousness" (LOC) is often placed in a report and may be useful because an individual may not recognize the fact that he or she had some "alteration of consciousness" even if there was "no LOC." Comments such as "dazed," "bell is rung," "confused," or "in shock" in a report are of value because that is one of the signs that a head trauma or concussion has occurred. Additionally, any indication of an amnesic episode such as not remembering the incident itself or for a period thereafter is, again, a classic sign of some potential organic brain injury.

The classic history for a head injury includes a trauma to the head/brain, an alteration of consciousness at or near the time of the event, and an amnesic episode (an inability to recall facts) immediately before, during or after the incident. These elements can be teased out if a sufficiently extensive and complete initial interview is undertaken. Often, repeated questions regarding a description of the incident and events immediately before and after will cause a client to remember things that a cursory interview would not. Because of the time that has passed between the event and your interview with the client, superficial memory may be depleted and it is only by more probing and repeated questions that these facts come to the client's mind.

Medical evaluation

Once you are satisfied that there appears to be some injury to the brain, it

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is important to have a proper medical evaluation accomplished by a medical provider. At a minimum, a neurological evaluation, psychological evaluation and neuroradiological evaluation are necessary. Normally, medical insurance will require that the client's primary care physician be the "gate keeper" of this information and going through proper channels is the most effective and appropriate way of having a proper evidencing of the nature and extent of the client's injury.

The emergency room may have ordered a CT scan of the brain if there are complaints of headaches, nausea, vomiting, etc., at that initial visit. A normal CT scan is the usual finding in a mild traumatic brain injury because the stretching and sheering of axons in the white and gray matter are not usually found in this type of test. An MRI, preferably with a 3.0 Tesla machine, will give you information regarding the nature and extent of axonal injury. Additionally, a PET scan, DTI, or a SPECT test will provide greater information regarding the extent of axonal sheering or stretching. These tests can pick up such medical evidence as white matter changes as well as hemorrhagic deposits.

The reports of the specialists will go directly to the primary-care physicians and be made part of the client's medical file. You can obtain copies of these records to establish the actual location of the brain injury. Signs, symptoms and the results of diagnostic studies must correlate in order to evidence this location. This approach is necessary to present at trial, arbitration or mediation because no single test will allow for a diagnosis of the mild brain injury. It is only the synergistic effects of these factors that allow for a proper opinion that within reasonable medical probability the incident was responsible for the organic injury.

Post-traumatic stress disorder

Post-traumatic stress disorder is another condition that can relate to the traumatic event and is separate from an organic brain injury. The two maladies, however, can coexist and complement each other in having a debilitating effect on the client. Additionally, depression and anxiety are related to the traumatic brain injury and often coexist with it. In other words, a person whose cognitive, emotional and intellectual capacities have been diminished will feel these conditions and are really expected to suffer same. Do not be discouraged or frustrated by findings of depression or anxiety to which the defense will often attribute the plaintiff's symptoms, but be prepared to have your medical witnesses explain how there is an interaction between depression and anxiety, post-traumatic stress and the organic brain injury.

Repeated use of the questionnaires over a period of time is also important. Most head injuries will resolve within a period of 18 months to 2 years. Statistically, 15 percent of these brain injuries do not resolve. This is often referred to as the "miserable minority." The timing on the various tests and evaluations can, therefore, become critical as far as garnering and obtaining the evidence necessary to present your case. It is also important to periodically sit with your client and go over his or her most recent history. Having the client record in some fashion his or her progress, or lack thereof, also is a valuable way of maintaining the most current information regarding your client's condition.

The client's deposition and the timing of same is something that you should control to the best of your ability. Often, because of the nature of this injury, the client will not be in the best position to provide the necessary information about the incident or its aftereffects. The client must be encouraged not to fill in the gaps in this information by what she or he has heard. This is a psychologically-recognized concept that can often occur. By definition, this means the client will incorporate into what he perceives as his memory that which has been told to him by others who either witnessed the event or the effects thereof; the injured party then believes this is his own recollection. That is why, in your pre-deposition conference, you must emphasize that all you are seeking is the client's own memory and not what they have been told by others.

Conclusion

Taking the time, effort, and money to establish brain injuries is an important part of every practitioner's desire to obtain full, fair, and adequate compensation for their client. The sooner the recognition of this injury is made, the better position you are in to achieve this result.

Thomas M. Dempsey is a sole practitioner in Brentwood, where he specializes in personal injury and complex litigation, with emphasis on spinal cord and traumatic brain injuries resulting from medical negligence, products liability and premises liability. He is a past president of Consumer Attorneys Association of Los Angeles. CAALA honored him in 1994 with the Ted Horn Memorial award, and he has twice been its Trial Lawyer of the Year nominee. He is a member of ABOTA, the United States Supreme Court Bar, and the Board of Governors for Consumer Attorneysof California.

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INJURY INFORMATION SHEET FOR THE INJURED PARTY

Injured Party: _____ Date of Accident:_____
Address. _____
Phone: _____
DATE: _____

Instructions: After reviewing the symptoms listed below, please check the appropriate response if you have experienced any of these since the date of the accident. Please complete and return this form to _____ as soon as possible.

Frequently	Occasionally	Never	
_____	_____	_____	Reduced attention and concentration
_____	_____	_____	Memory problems
_____	_____	_____	Easily angered
_____	_____	_____	Anxiety
_____	_____	_____	Overreaction to events
_____	_____	_____	Depression
_____	_____	_____	Decreased emotional responsiveness
_____	_____	_____	Reduced reasoning and problem solving
_____	_____	_____	Difficulty following directions
_____	_____	_____	Misunderstanding what is said by others
_____	_____	_____	Difficulty expressing thoughts verbally
_____	_____	_____	Impulsive or inappropriate social behavior
_____	_____	_____	Impaired judgment
_____	_____	_____	Difficulty establishing / maintaining relationships
_____	_____	_____	Difficulty following through with responsibilities at work or home
_____	_____	_____	Headaches
_____	_____	_____	Nausea
_____	_____	_____	Dizziness or Balance Problems
_____	_____	_____	Muscle weakness
_____	_____	_____	Numbness and tingling
_____	_____	_____	Fatigue or difficulty sleeping
_____	_____	_____	Blurred vision
_____	_____	_____	Ringing in ears

LIST NAME, ADDRESS AND TELEPHONE NUMBER OF ALL MEDICAL PROVIDERS FOR THE PAST 5 YEARS:

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INFORMATION SHEET FOR FAMILY MEMBER/SUPPORT PERSON

Injured Party: _____ Relationship: _____
Your Name: _____ Phone: _____
Address: _____
DATE: _____

Instructions: Fili out as completely as possible. Do not have the injured party help you. Where you have no knowledge, leave blank. COMPARE THE PROBLEMS OF THE INJURED PARTY BEFORE AND AFTER THE ACCIDENT. Please complete and return this form to_____ as soon as possible.

Physical

BEFORE THE ACCIDENT Yes	BEFORE THE ACCIDENT No		AFTER THE ACCIDENT Yes	AFTER THE ACCIDENT No
_____	_____	Headaches	_____	_____
_____	_____	Nausea	_____	_____
_____	_____	Dizziness	_____	_____
_____	_____	Balance Problems	_____	_____
_____	_____	Muscle Weakness	_____	_____
_____	_____	Numbness & Tingling	_____	_____
_____	_____	Fatigue	_____	_____
_____	_____	Difficulty Sleeping	_____	_____
_____	_____	Ringing in Ears	_____	_____
_____	_____	Hearing Problems	_____	_____
_____	_____	Reduced Taste and Smell	_____	_____

Cognitive / Mental

Yes	No		Yes	No
_____	_____	Attention Problems	_____	_____
_____	_____	Concentration Problems	_____	_____
_____	_____	Reduced Reasoning	_____	_____
_____	_____	Problem Solving Skills Impaired	_____	_____
_____	_____	Problems Doing Math	_____	_____
_____	_____	Difficulty Following Directions	_____	_____
_____	_____	Difficulty Reading	_____	_____
_____	_____	Word Finding Difficulty	_____	_____
_____	_____	Doesn't Seem as Smart	_____	_____
_____	_____	Sensitive to Noise or Confusion	_____	_____
_____	_____	Difficulty Expressing Thoughts Verbally	_____	_____

Emotional

Yes	No		Yes	No
_____	_____	Increased Frustration	_____	_____
_____	_____	Decreased Tolerance	_____	_____
_____	_____	Easily Angered / Short Temper	_____	_____
_____	_____	Anxiety	_____	_____
_____	_____	Overreaction to Events	_____	_____
_____	_____	Depression	_____	_____
_____	_____	Cries Easily	_____	_____
_____	_____	Irritable	_____	_____

Personality Yes	No		Yes	No
_____	_____	Significant Personality Changes	_____	_____
_____	_____	Poor Insight into Problems	_____	_____
_____	_____	Difficulty Following Through with	_____	_____
_____	_____	Responsibilities at Work or Home	_____	_____
_____	_____	Loss of interest in Hobbies, etc.	_____	_____
_____	_____	Problems Getting Going in the Morning	_____	_____
_____	_____	Problems Getting Organized	_____	_____
_____	_____	Problems with Planning	_____	_____

Social Yes	No		Yes	No
_____	_____	Misunderstanding What Others Say	_____	_____
_____	_____	Inappropriate Social Behavior	_____	_____
_____	_____	Reduced Judgment	_____	_____
_____	_____	Difficulty Getting along with Others	_____	_____
_____	_____	Difficulty Establishing and Maintaining	_____	_____
		Relationships		

ADDITIONAL COMMENTS AND EXPLANATIONS
(Use additional paper if necessary)