WORKING WITH EXPERTS IN A BRAIN INJURY CASE

ACTLA March 2019 Seminar:

Traumatic Brain Injury

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INTRODUCTION

Providing legal assistance to brain injured individuals is one of the most challenging aspects of a personal injury practice. These clients can be extremely difficult to work with; diagnosis can be complex and varied; and each case has its own separate identity. However, the proper analysis and organization at the outset and throughout these cases can mean the difference between a $30,000 claim and a $3 million claim, and more importantly, to maximize your client's health and recovery.

KNOW THE BASICS

Unfortunately, there is a great deal of heterogeneity in the medical literature regarding the definition of Traumatic Brain Injury ("TBI"), especially mild TBI.[1] As a starting point, however, the WHO Collaborating Centre for Neurotrauma Task Force on MTBI defines a mild TBI as follows:

> MTBI is an acute brain injury resulting from mechanical energy to the head from external physical forces. Operational criteria for clinical identification include: (i) 1 or more of the following: confusion or disorientation, loss of consciousness for 30 minutes or less, post-traumatic amnesia for less than 24 hours, and/or other transient neurological abnormalities such as focal signs, seizure, and intracranial lesion not requiring surgery; (ii) Glasgow Coma Scale score of 13–15 after 30 minutes post-injury or later upon presentation for healthcare. These manifestations of MTBI must not be due to drugs, alcohol, medications, caused by other injuries or treatment for other injuries (e.g. systemic injuries, facial injuries or intubation), caused by other problems (e.g. psychological trauma, language barrier or coexisting medical conditions) or caused by penetrating craniocerebral injury.[2]

Some of the diagnostic and clinical indicators of a mild TBI are found in its definition. However, if a loss of consciousness or altered Glasgow Coma Scale ("GCS") are not documented, other indicators of a TBI may include:

> The suspected diagnosis of SRC [Sport Related Concussion] can include one or more of the following clinical domains:
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> 1. Symptoms: somatic (eg, headache), cognitive (eg, feeling like in a fog) and/or emotional symptoms (eg, lability)
> 2. Physical signs (eg, loss of consciousness, amnesia, neurological deficit)
> 3. Balance impairment (eg, gait unsteadiness)
> 4. Behavioural changes (eg, irritability)
> 5. Cognitive impairment (eg, slowed reaction times)

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[1] Linda Carroll et al, "Methodological Issues and Research Recommendations for Mild Traumatic Brain Injury: The WHO Collaborating Centre Task Force on Mild Traumatic Brain Injury" (2004) Suppl 43 Journal of Rehabilitation Medicine, DOI 10.1080/16501960410023877.

[2] *Ibid*.

6. Sleep/wake disturbance (eg, somnolence, drowsiness)[3]

It is also important to understand the difference in nomenclature between a concussion and a mild TBI. Unfortunately, there also remains a great deal of confusion and debate in the medical community with respect to what, if anything, differentiates a concussion from a mild TBI. Historically, it was accepted that all concussions were mild TBI's, but not all mild TBI's were concussions. The recent Consensus Statement on Concussion in Sport summarized this debate as follows:

> In the broadest clinical sense, SRC is often defined as representing the immediate and transient symptoms of traumatic brain injury (TBI). Such operational definitions, however, do not give any insights into the underlying processes through which the brain is impaired, nor do they distinguish different grades of severity, nor reflect newer insights into the persistence of symptoms and/or abnormalities on specific investigational modalities. This issue is clouded not only by the lack of data, but also by confusion in definition and terminology. Often the term mild traumatic brain injury (mTBI) is used interchangeably with concussion; however, this term is similarly vague and not based on validated criteria in this context.
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> One key unresolved issue is whether concussion is part of a TBI spectrum associated with lesser degrees of diffuse structural change than are seen in severe TBI, or whether the concussive injury is the result of reversible physiological changes. The term concussion, while useful, is imprecise, and because disparate author groups define the term differently, comparison between studies is problematic.[4]

Regardless of the nomenclature, it is important for a lawyer practicing in this area to know enough to recognize when a client may have suffered a head injury of any kind and to take appropriate action.

DO THE LEG WORK

<u>Do Not Always Trust the Initial Records</u>

Understand the GCS, look for it within EMT and hospital records, and recognize appropriate and/or inappropriate diagnosis at the outset. Take time to read comments as GCS doesn't always follow observations. Far too often, initial treatment providers record a GCS as 15, but it is noted that the client may not be oriented to time, place, or recall the impact. These are critical points, particularly in mild TBI cases, the diagnosis of which often fall through the cracks.

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[3] Paul McCrory et al, "Consensus statement on concussion in sport—the 5th international conference on concussion in sport held in Berlin, October 2016" (2016) 51(11) British Journal of Sports Medicine, online: <http://dx.doi.org/10.1136/bjsports-2017-097699>.

[4] *Ibid*.

In your initial client interview, particularly in motor vehicle and pedestrian claims, ALWAYS ask a client if they remember the impact, the immediate moments leading up to the impact, and the moments following the impact. These questions are often overlooked by emergency responders, triage nurses and doctors in hospital (if that even occurs), and/or by GPs in follow-up. Again, this is particularly true in mild TBI cases.

In cases involving clients with a moderate TBI, ensure that you investigate whether your client has experienced any changes in hearing, smell, taste, memory, concentration, focus, anxiety, mood swings, sleep problems, etc. Determine the timing, severity, and impact of each of these symptoms. Checklists are often redundant, but use them in these cases.

While cases of severe TBI claims may be more obvious, they are often accompanied by polytrauma and orthopedic injuries, which will take precedence during the course of hospital treatments. Unless there are obvious signs of TBI on CT or MRI scans, neuropsychological assessments often will not be completed in hospital in cases of significant polytrauma. Therefore, do not treat these initial records as gospel.

Obtain and Utilize Witness Statements

In the event that your client is alleging to suffer from mild, moderate, or severe TBI symptoms, obtain eye witness statements from those who were at the injury scene and can be located. Quite often these witnesses will arrive while the client is still discombobulated, or even unconscious. Again, do not trust the EMT reports or the initial hospital reports, as errors may be made by either underdiagnosing or failing to follow-up on symptoms present at the scene.

Further along in a case, especially in those cases involving moderate to severe TBI's, collateral witness statements can be useful. These statements can come from the client's family, work colleagues, long-term friends, spouses, etc. Collateral witness statements can help you properly assess the case, inform your experts, and prepare for trial. In many cases, these reports will be far more significant and reliable than the Plaintiff's self-reporting of his or her abilities and situation.

Take Control and Build the Case

If you are of the opinion that your client may have suffered a brain injury, instruct your client to ensure that his or her family physician, physiotherapist, chiropractor, and all other health care providers are fully aware of the symptomatology. Again, particularly in mild TBI cases, family practitioners will either gloss over head injury symptoms, or diagnose a concussion, and tell the client to wait on their recovery. Obviously this can lead to very poor results.

Obtain a referral from your client's physician for a preliminary Independent Medical Examination. Suggest to your client that referrals be made through their family physician for specialized brain injury care and rehabilitation. Examples of these types of facilities in Calgary include: the Brain Injury Clinic; the Calgary Brain Injury Program; Community Accessible Rehabilitation – Neurological Rehabilitation; and the Association for the Rehabilitation of the Brain Injured. It is

often helpful to retain the services of an occupational therapist who specializes in TBI's to assess and support your client through their rehabilitation and to provide a report if necessary.

We recently had a file transferred to our office involving a client had 25 staples in his head who, 18 months post-injury, had not had a neuropsychological evaluation nor any follow-up with respect to a brain injury. This individual had been represented by another firm, and the Section B insurer sent this unfortunate man to an orthopedic IME, who deemed him orthopedically able to work, specifically denied commentary on the head injury as it was "out of their expertise," and ceased his benefits entirely. There are many stories like this within our system, and it is up to us to prevent this from ever occurring.

In sum, a severe TBI claim should be treated with similar magnitude to that of a spinal cord injury or other catastrophic event. A moderate traumatic brain injury should be analyzed, thorough investigation should be done, and all future care and economic loss analyses should be assessed at the highest level. For mild traumatic brain injury claims, ensure that these do not fall through the cracks by ensuring proper diagnosis is made.

KNOW AND RETAIN THE CORRECT EXPERTS

Brain injuries can be properly diagnosed by physiatrists, psychiatrists, neuropsychologists, and/or neurologists. Understand your client, their pre-existing conditions, the etiology of their injury, and choose the best expert(s) for your client.

When choosing an expert, it is important to understand your client's injuries and the value added by a given specialist for a given clinical presentation:

- Physiatrists: "Physiatrists are physicians who specialize in physical medicine and rehabilitation, a medical specialty that deals with the evaluation and treatment of patients whose functional abilities have been impaired."[5] From our firm's perspective, physiatrists who specialize in TBI's are particularly useful in diagnosing and evaluating clinical outcomes.
- Psychiatrists: "Psychiatry is the medical specialty that deals with diseases of the mind."[6] Psychiatrists can be invaluable in cases in which a TBI has had a profound effect on a client's personality and/or long-term mental health.
- Neuropsychologists: "Clinical Neuropsychology is a specialty in professional psychology that applies principles of assessment and intervention based upon the scientific study of human behavior as it relates to normal and abnormal functioning of the central nervous system."[7] We utilize neuropsychologists to provide initial baseline reports and to establish the diagnosis. We typically leave prognosis to a later report.

[5] Canadian Association of Physical Medicine & Rehabilitation: https://www.capmr.ca/about-capmr/what-is-a-physiatrist/
[6] Canadian Medical Association: https://www.cma.ca/sites/default/files/2019-01/psychiatry-e.pdf
[7] American Psychological Association: https://www.apa.org/ed/graduate/specialize/neuro.aspx

- Neurologists: "Neurology is the branch of medicine concerned with the study of the nervous system in health and disease."[8] From our perspective, locating neurologists in Alberta is somewhat difficult, and as such, the availability and accessibility of independent physiatrists, neuropsychologists, and psychiatrists is usually better.

Meet with your client prior to testing by any of these experts. Ensure that maximum effort is provided and advise them that there are tests to determine if maximum effort is provided. Failing these tests means failing their case.

Obtain and label reports as "DRAFT".[9] Follow-up with a phone call with the expert to get both their thoughts on paper, and off, regarding your client's presentation, difficulties encountered through testing, and confirm their defensible opinion with respect to their diagnosis.

UTILIZE REBUTTAL REPORTS

Far too often we see only one Plaintiff and one Defence report. Rebut their position.

Share the Defence report with the client to identify any factual errors – these errors are almost always there to be found. Review the Defence report to see what reports were (or were not) reviewed by the Defendant's expert. Far too often they are not provided with pertinent Plaintiff reports. Finally, review any witness statements to determine whether the Defence report was based upon unreliable information.

Review and discuss the Defence opinions with your expert and obtain a draft rebuttal report. In many cases we see the Plaintiff expert is far more qualified to diagnose TBI than a Defence expert. If you have got a physiatrist, psychiatrist or neurologist versus a neuropsychologist, you are better positioned for success.

We recently resolved a file involving a catastrophic pedestrian versus motor vehicle collision. Our client suffered a permanent frontal lobe brain injury, in addition to severe polytrauma. One of the consequences of his frontal lobe injury was anosognosia, an impairment of a person's ability to recognize their own limitations and deficits – a complete lack of insight. The Defence produced a neuropsychological vocational report, which concluded that our client was employable as a cook. However, it was based entirely on our client's self-reporting of his abilities, which were wildly inaccurate when compared to the collateral witness statements from his family and employers. Our experts, a neuropsychologist and psychiatrist, were able to provide rebuttal reports, which explained this fatal flaw and undermined the Defence's theory on income loss.

Finally, do not feel like you are alone in these claims. Generally speaking, senior counsel in Alberta are more than willing to share their thoughts on experts for various claims, and provide support.

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[8] Canadian Medical Association: https://www.cma.ca/sites/default/files/2019-01/neurology-e.pdf

[9] For more on the producibility of draft expert reports and notes, see: *Moore v Getahun*, 2015 ONCA 55, leave to appeal to the SCC denied, 2015 CarswellOnt 14066.

CONCLUSION

The proper analysis in cases involving TBI can mean a difference between a $30,000 claim and a $3 million claim. Take control of these cases from beginning to end. You must learn to recognize the symptoms and clinical presentation of a TBI – this may not be obvious when relying only on the initial medical reports or even from your own client without specific relevant questions being posed to them. Choose the appropriate expert(s) and prepare your client to meet with them. Work with your chosen expert(s) to ensure you have properly crafted primary and rebuttal reports. If you put in the work and spend the money on these cases to properly prove the injury and future losses of functional and earning capacity, you will obtain adequate, if not superior, compensation for your client.