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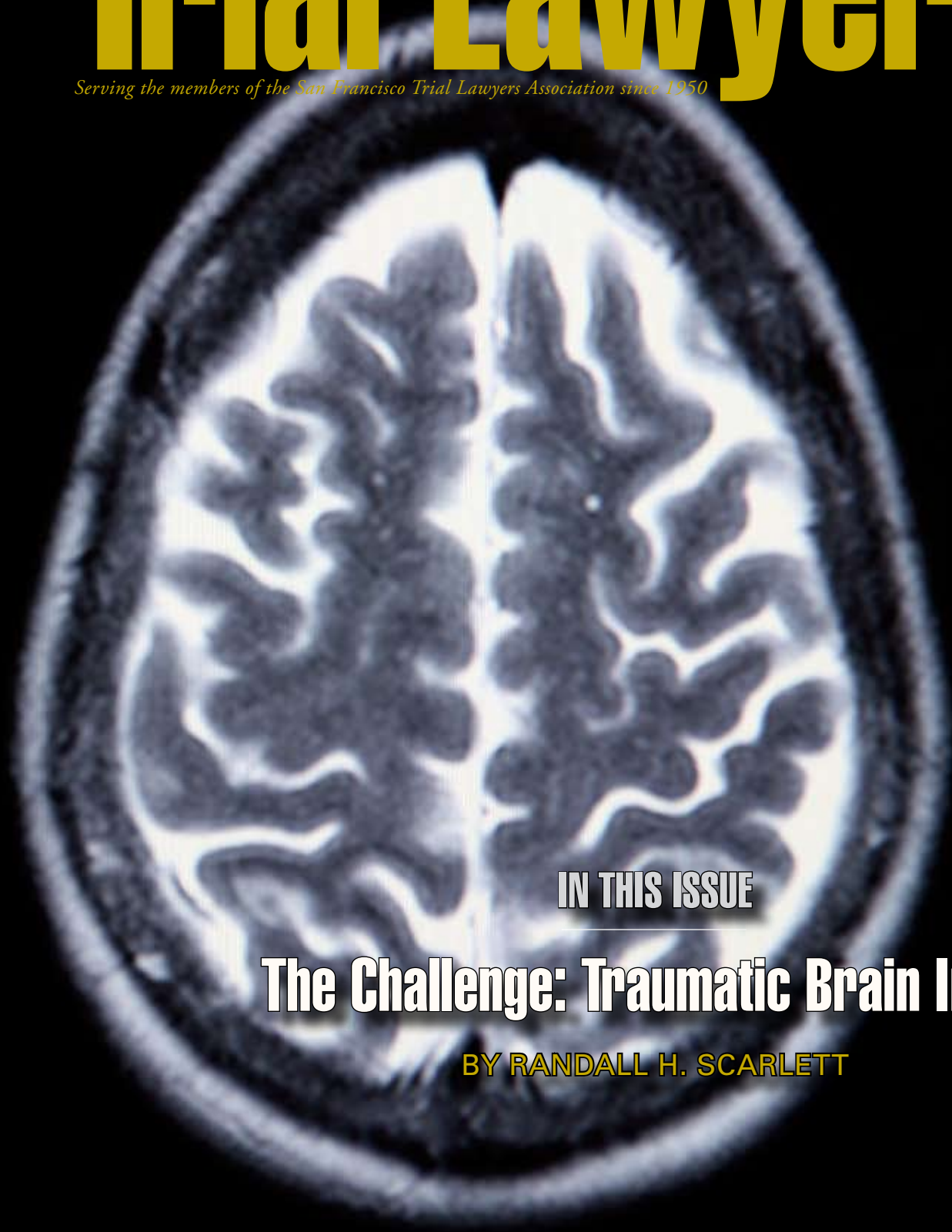

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BY RANDALL H. SCARLETT

THE CHALLENGE: TRAUMATIC BRAIN INJURY

by Randall H. Scarlett

If there is no greater reward than making a difference in the quality of another person's life, then the challenge of representing survivors of traumatic brain injury provides us with the opportunity to achieve our highest potential.

While the recent tragic death of actress Natasha Richardson has again served to put a face on traumatic brain injury (TBI), it remains that head injury is unlike any other injury. When the headlines shift to other topics, and the fleeting public interest in TBI subsides, there will remain a pressing need for competent legal advocacy on behalf of TBI survivors. Regardless of the cause of TBI, at least three distinct hurdles must be overcome by all trial lawyers.

First, the injury is misunderstood. While traumatic brain injury is the signature injury of both the Iraq and Afghanistan wars, most people (including judges and juries) cling to misconceptions about the injury. I cannot begin to recount the times I have appeared before the court, especially in settlement conference, only to hear a judge say, "Mr. Scarlett, your client only sustained a concussion . . ." To all those understanding the depth and tragedy of traumatic brain injury, the naivety of such a statement is readily apparent. For trial lawyers, such statements, whether by court, opposing counsel, or others, mean only that the gauntlet has been thrown down. Our challenge is firmly to educate!

Second, traumatic brain injury is "invisible." This fact only adds to misconceptions regarding the injury. Victims of traumatic brain injury are not necessarily wheelchair-bound, do not always walk with an abnormal gait, do not bear casts, braces, or other external assistive devices. If their cognitive deficits are extremely focal, the deficits might not become apparent, even after a short conversation with the victim. In fact, not only do many of our clients appear outwardly "normal" but, with respect to certain concussion injuries, (injuries involving traumatic axonal shearing -commonly diffuse), the failure to have abnormal neuro-radiological findings leads to the common misperception that the victim is also inwardly "normal." This may be a very difficult prejudice to overcome.

Lastly, no other type of injury lends itself to such a wide array of defenses. These defenses are possible as a result of the nature of the injury itself, (organic injury plus psychiatric overlay), as opposed to the facts of a given case. In other words, it is much easier for the defense to accuse a plaintiff of malingering when the injury cannot be seen, as opposed to when the injury is readily apparent. Counsel must be prepared to meet these frivolous defenses swiftly and effectively. Most juries will become absolutely outraged if plaintiff's counsel effectively deals with these unmeritorious defenses in plaintiff's case-in-chief.

The good news is that each of these hurdles can be overcome by a well-prepared lawyer. Misconceptions are, after all, misconceptions. In fact, the more one learns about the profound deficits suffered by survivors of TBI, the easier it is to educate court and counsel, and become a forceful advocate for the client.

FREQUENCY OF TBI

So, let's start with an understanding of the frequency of TBI. Worldwide, every 23 seconds there is a traumatic brain injury. Of the 1.4 million individuals sustaining TBI each year in the United States, 50,000 die, 235,000 are hospitalized, and 1.1 million are treated and released from an emergency department.

If trauma-caused brain injury were instead disease-resulting, it would be labeled a plague of epidemic proportions. Correlation comes from the most recent data from the Center for Disease Control and Injury Prevention (CDC): Nearly 2% of the population lives with the consequences of TBI.

TBI does not discriminate. It can happen to a child or adult of any age, gender, race, religion, or socio-economic status. The risk of TBI is highest among adolescents and persons over the age of 75. In comparing the national prevalence rate for TBI with other more commonly cited and discussed disabilities, it is easily understood why TBI is often referred to as the "silent epidemic." Examples of other prevalence rates (from CDC) follow:

400,000 with Spinal Cord Injuries;
500,000 with Cerebral Palsy;
2.3 million with Epilepsy;
3.0 million with Stroke Disabilities;
4.0 million with Alzheimer's Disease; and
5.3 million with TBI

All right, the statistics establish the frequency of the injury, but what, really, is traumatic brain injury?

Historically, words such as "mild," "moderate," and "severe" were utilized to define brain injury. For many years, these

terms were utilized based on duration of loss of consciousness. Today, it is universally accepted that brain injury can occur without loss of consciousness, without direct external trauma to the head, and without positive neuro-radiological findings.

MILD TRAUMATIC BRAIN INJURY

The Mild Traumatic Brain Injury Committee of the Head Injury Interdisciplinary Special Interest Group of the American Congress of Rehabilitative Medicine has authoritatively defined "mild traumatic brain injury." This Group's definition is universally accepted.

The definition includes individuals sustaining a traumatically induced physiological disruption of brain function with any period of loss of consciousness, or, any retrograde or antigrade amnesia of the accident, or, any significant alteration in mental state at the time of the accident. The definition specifically allows for a Glasgow Coma Scale of between 13 to 15.

Biomechanically, the definition provides for the head being struck, the head striking an object, or the brain undergoing an acceleration/deceleration movement (whiplash) without direct external trauma to the head.

Significantly, the definition notes that symptomatology falls into three non-exclusive categories - physical, behavioral, and cognitive. Physical symptoms of brain injury include nausea, vomiting, dizziness, headache, blurred vision, lethargy, sleep disturbance, or other sensory loss. Behavioral changes and/or alterations in degree of emotional response include irritability, quickness to anger, disinhibition, and emotional lability. Cognitive deficits include difficulties involving attention, speech/language, perception, concentration, and difficulties with "executive functions." All symptomatology may be transient. Often, they are synergistic. Not all symptoms need be present, and in fact, depending on location of the brain injury (frontal lobe, parietal lobe, temporal lobe, occipital lobe, brainstem, etc.), certain symptomatology may not be expected at all.

Trying a case involving mild traumatic brain injury can be a difficult ordeal. Often the events giving rise to the injury involve low impact automobile crashes, or seemingly every day falls or blows to the head. Indeed, concussions are brain injuries by definition. (Post concussion syndrome defines the cluster of symptoms resulting from that brain injury). Yet since concussions are frequently sustained by athletes, the injury is often downplayed by opposing counsel and misunderstood by jury. While many concussions are transient, leaving no residual damage, certain concussions are profoundly disabling, necessitating a lifetime of care.

I am often reminded that we injure the brain we already had. Simply put, many individuals have pre-existing susceptibilities which make them absolutely at risk for poor outcome after a seemingly mild insult. Statistically, after one head

injury, an individual is exponentially at risk for poor outcome following a second insult.

Fortunately, 80% to 85% of those sustaining so-called mild traumatic brain injury return to full pre-morbid levels of functionality within about one year. Unfortunately, this means that 15% to 20% of those sustaining such injury do not. These statistics caused a prominent San Francisco neuropsychologist to name this profoundly impaired group of individuals the "miserable minority."

MODERATE TRAUMATIC BRAIN INJURY

Approximately 10% to 28% of all TBI's are "moderate traumatic brain injuries." Various tests can be utilized in order to determine and rate traumatic brain injury severity. Each of the tests has its own limitations, and no one test is absolutely authoritative. However, most physicians will agree that when certain factors exist, such as posttraumatic amnesia (PTA) documented between 1 and 24 hours, Glasgow Coma Scale documented between 9 to 12, and the presence of transient subdural or epidural bleeds on neuroimaging, at least a "moderate traumatic brain injury" has occurred.

The length of a coma or unconsciousness is yet another indicator of injury severity. Length of unconsciousness greater than 20 minutes, though no longer than six hours, indicates a moderate traumatic brain injury. Remember, however, that one need not ever lose consciousness to sustain a brain injury, irrespective of its so-called classification, mild, moderate or severe.

In a recent case handled by my office, a woman was struck in a crosswalk by a tour bus. There was absolutely no documented loss of consciousness. At the scene of the crash, the woman was reported to have been conversant and conscious. After transport to the hospital, however, it was found that she had sustained skull fracture together with massive intracranial bleeding causing extremely elevated intracranial pressures. When therapeutic administration of drugs did not dissipate, my client was forced to undergo two craniotomy's involving decompression and evacuation. Clearly this was a severe traumatic brain injury. Yet there was absolutely no loss of consciousness at the scene, whatsoever.

As with the trial of all cases involving TBI, residual damages sustained by those surviving moderate TBI are a primary dividing point. While the existence of a moderate TBI is much easier to establish, the predictive residual outcome is usually hotly contested. More will be discussed on the damage issue relative this injury later in this article.

SEVERE TRAUMATC BRAIN INJURY

At least 10% of all TBI's are classified as "severe." Using the same tests discussed above, where a patient sustains a post-traumatic amnesia (PTA) with duration from one day or longer, their injury is thought to be severe. Where the Glasgow Coma Scale score is found to be equal to, or less than 8, or where a coma duration or loss of consciousness is found to be greater than 6 hours, a rating of "severe traumatic brain injury" is clearly indicated. Hematomas or other bleeds seen on MRI, CT and other neuroimaging, are other indicators of severe traumatic brain injury.

There is usually little debate over classification or rating, medically or otherwise, when an individual has sustained a severe traumatic brain injury. Rather, the battlegrounds are usually drawn over life expectancy and other issues.

ESTABLISHING DAMAGES IN TBI

Okay, now that we understand the tragic frequency of TBI, and the manner through which the medical profession rates or classifies TBI, I submit the medical profession has it absolutely dead wrong! There is simply nothing mild or moderate about a permanent brain injury.

I start with a rather simple premise: there is no prosthetic device for the brain. We can lose an arm or a leg, and the medical sciences have been ingenious enough to build us workable replacements. I certainly do not contend that a prosthesis is an acceptable consequence of an individual's tortious conduct, but I do note that something exists to assist with the extremity loss. Absolutely not so with brain injury.

Space prohibits adequate discussion of the damages sustained by survivors of TBI. However, given the frequency of injury to the frontal lobes (largest lobes of the brain), and the debilitating consequences of such injury, I herein place emphasis on injury to the frontal lobes, though obviously for case preparation, all aspects of TBI must be explored.

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The cortex and underlying white matter of the frontal lobes is the site of interconnections and feedback loops between motor systems and major sensory systems, linking and integrating behavior at the highest level. Simply put, the frontal lobes are the control center of our brain. Deficits associated with injury to the frontal lobes are often the most debilitating as they interfere with the ability to use knowledge and skills fluently, appropriately, or adaptively. Independent function is absolutely impaired, while highly structured tasks may be easily accomplished.

Executive functions consist of those capacities that enable a person to engage successfully in independent, self-motivated, behavior. Executive functions are centered in the frontal lobes, and when impaired, an individual may no longer be capable of satisfactory self-care, of performing independently, and of interacting vocationally, professionally, or socially. Disorders with executive function can directly affect cognitive functioning, especially in areas involving planning, self-monitoring, coordinating, and sequencing.

Many behavioral problems arising from executive dysfunction are apparent even to casual observers. These would include, for example, irritability, excitability, impulsivity, rigidity, lack of self control, and emotional lability or flattening. However, other deficits in executive function are not so obvious. In the litigation setting, these deficits are often thrown at the inexperienced trial lawyer as examples of malingering or lack of "best effort" as opposed to what they really are - pathology of the injury itself. Examples of these deficits include impaired capacity to initiate, decreased motivation (anergia), and perseveration.

Damage to the frontal lobes often impairs memory, particularly involving new learning. Concentration and attention are also negatively impacted. Distractibility is all too common. With executive dysfunction, meta-cognition, the concept of how we view who we are, can be extremely altered. I challenge you to name anything more important than losing your sense of who you are. Without comparing tragedies, I submit that there can be no greater injury than loss of self. Combine the loss of self with problems involving memory, concentration, attention, judgment, and the profound impacts of frontal lobe dysfunction emerge.

Sometimes a simple example is most illustrative. What would happen if you left an 11-year-old at home alone while at a conference? I think the child could get up on his or her own. I think the child could make breakfast. Certainly the child could get dressed. Likely, the child could make his way to school, assuming a short walking distance. Certainly the child could get home from school, and fix a snack. If the child were motivated, the child could get to sleep at a decent hour, though that prospect is questionable. But what would happen, legally, if you did leave your child at home, alone? The answer is simple: you would be arrested. Why? Because the law recognizes that 11-year-olds do not have frontal lobes.

The fact is that many individuals sustaining damage to their frontal lobes are physically capable of accomplishing many tasks. Perhaps they have even been doing it, alone, without assistance for some time since the injury. However, with damage to the frontal lobes, the question is not whether lack of judgment will be demonstrated, but when.

Far more complex, are other common deficits resulting from frontal lobe dysfunction, such as pathological inertia. A prominent Bay area neuropsychologist often relates a story involving one of his patients. The patient was absolutely capable of recognizing when she had the need to utilize the restroom. She was also physically capable of physically walking to the restroom and voiding. However, the patient was so inert that she would literally sit on the couch and void. Without someone actively prompting her to get up, and in spite of her awareness, the pathology of her injury was such that she would literally void wherever she sat, without regard to consequence.

Unless your clients are able to exist simply due to their physical prowess, TBI is the most debilitating injury they could sustain. In order to fully express the magnitude of profound injury sustained by survivors of TBI, you must expend considerable time learning the consequence of the deficits themselves. Often times this means placing yourself in your client's position.

CONCLUSION

Cases involving TBI are fraught with misunderstanding, due in large part to the invisible nature of the injury itself. A plethora of defenses, most without merit, await the trial lawyer prosecuting such damage claims. However, with education regarding the injury, come empathy, passion, and spirit emboldening and empowering the advocate in each of us. The challenge of representing survivors of TBI provides a wonderful opportunity to have a meaningful impact on the quality of another's life. As trial lawyers, we could strive for no greater accomplishment.

Randall H. Scarlett is the principal of San Francisco's Scarlett Law Group. He predominately handles catastrophic injury cases involving traumatic brain injury and has numerous record settlements and verdicts. Mr. Scarlett is a current Board Member of San Francisco Trial Lawyers Association, is a Board Member of The California Brain Injury Association, and is a past Chair and current Executive Board Member of American Association for Justice's Traumatic Brain Injury Litigation Group.
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