

A Primer for In-House Counsel and Claims Professionals

In 2009, a six-year-old fell before class. She sustained minor scrapes to her knees, and may have hit her head.

Over the next several months, the child began exhibiting aggressive and bizarre behaviors. She pulled her hair out, started to harm the family pets, and inexplicably forgot her family members' names. She even had episodes where she forgot how to speak the English language. Most doctors were dumbfounded. However, there seemed to be a growing consensus that the problems were psychiatrically based, or functional in nature. Once an attorney became involved, the child was referred to a psychiatrist, who diagnosed a brain injury. Her parents sued the school district and the school bus company, with a demand in excess of eight figures.

That same year, a tow truck rear-ended a family in a Saturn coupe at a slow speed. One of the children was transported to the hospital for back pain. The parents and their other son complained of soreness, but had no other major complaints. The family underwent limited treatment in the following weeks. However, after retaining an attorney, the wife treated with a local doctor who performed "brain mapping" and diagnosed her with a traumatic brain injury. When the husband and one of

the children visited the same doctor, both were also diagnosed with brain injuries. They were told they would suffer a lifetime of disability. In their lawsuit, the family demanded millions of dollars for an expensive life care plan and years of future medical follow-up.

These examples illustrate how a relatively minor incident with minimal injuries can escalate quickly into a high-risk scenario for companies and their insurers if claimants, their attorneys, and their doctors piece together a traumatic brain injury claim. Both of these cases involve minor incidents with minor soft tissue injuries. The cases initially went relatively unnoticed by the insurance companies because of the apparently minimal injuries. However, after retaining attorneys, the individuals in both cases treated with doctors who attributed all of the symptoms to traumatic brain injuries (TBIs). Capitalizing on the recent media coverage on sports concussion, settlement demands exceeded eight figures. These demands accompanied allegations that the claimants were at increased risk for Alzheimer's disease, the need for institutionalization, and lifetime disability.

The Rise of Concussion Claims

Although the media has focused on TBIs in sports, brain injuries are not limited to professional athletes. Brain injury litigation spawns from car accidents, falls at work and school, and hypoxic brain dam-

age in the medical setting. A search of civil cases on Lexis shows that, over the last 20 years, the phrases "traumatic brain injury," "concussion," and "head injury" have tripled. The trend is unmistakable.

Not only are TBI claims being litigated more frequently, but claimants are also demanding more money for them. Perhaps because of increasing public awareness of concussions in the media, seven- and eight-figure demands in cases involving minor head trauma are quickly becoming the norm. Several factors may be influencing this increase in the number and size of TBI claims.

First, the recent litigation involving brain injuries among professional athletes in the NFL and NHL has publicized the potential long-term effects of multiple TBIs. Media coverage sensationalizing the professional sports litigation has failed to educate the public on the fundamental differences between an isolated concussion and the types of brain injuries sustained by career athletes. Many members of the public now erroneously believe that a single minor concussion can result in a catastrophic neurological outcome.

Second, it is very easy for plaintiffs to "tack on" a concussion claim to any personal injury claim. Unlike many physical injuries such as broken bones, which can be proven or disproven simply by looking at an X-ray, concussions are more difficult to objectively prove or disprove. Based on the current diagnostic criteria used by



■ Brandon A. Woodard is an attorney at Montgomery, Rennie & Jonson, in Cincinnati, Ohio, where he devotes his practices to litigating traumatic brain injuries and complex psychological injuries full-time. He graduated from the University of Cincinnati College of Law, where he completed a fellowship in Law and Psychiatry. Gregory A. Kendall is an attorney at Montgomery, Rennie & Jonson and a member of the firm's Brain Injury Practice Group. He dedicates his practice to litigating traumatic brain injuries and complex medical issues. He is a graduate of the University of Cincinnati College of Law, where he served as executive editor of the *Law Review*.

major health organizations around the world, all that is required to support a concussion diagnosis is an “alteration of consciousness”—a poorly defined symptom that may manifest in a variety of ways. *Practice Parameter: The Management of Concussion in Sports (Summary Statement)*. Report of the Quality Standards Subcommittee. 48 *Neurology* 581 (1997). For instance, an individual may feel “dazed and confused,” or appear agitated, combative, drowsy, or in any other state deviating from the “normal” level of cognitive alertness and arousal. Kathy Boutis *et al.*, *The Diagnosis of Concussion in a Pediatric Emergency Department*, 166 *J of Peds* 1214, 1216 (2015); Victor F. Coronado *et al.*, *Traumatic Brain Injury Epidemiology and Public Health Issues*, 8 *Brain Injury Medicine* 84, 85 (2013). Occasionally, cases that appear to involve only orthopedic injuries are transformed into TBI cases when the plaintiff testifies in a deposition that she experienced altered consciousness at the time of the accident. And, because altered consciousness is a subjective complaint, it can be difficult to rebut the plaintiff’s statements on this issue.

Third, because TBIs are often more technical than other types of injuries, the plaintiffs’ bar has benefited from aggressively pursuing novel methods of identifying TBIs. Plaintiffs’ attorneys expect that use of neuropsychological testing, advanced neuroimaging, and other methods will intimidate defense counsel and insurance adjusters into larger settlements. Unfortunately, many defense attorneys tend to underestimate these claims and continue to handle them as they would any run-of-the-mill orthopedic injury claim. To succeed in defending against these claims, defense counsel must become familiar with the science behind TBI, the types of proof the plaintiffs’ bar uses, and the defenses to TBI claims.

This article provides a general overview of traumatic brain injuries—concussions in particular—and why these injuries present unique challenges in personal injury litigation. After introducing TBI generally, we discuss how plaintiffs’ attorneys and experts seek to maximize the damages recoverable from a concussion—the most commonly litigated type of TBI, and

the one that is arguably the most unpredictable in terms of risk. Because moderate and severe traumatic brain injuries (TBIs) are easier to identify (given the severity of the symptoms and have a greater likelihood of resulting in some degree of permanent impairment) these claims tend to present a more predictable level of risk. The

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biggest controversies in TBI litigation surround the proof of the existence and scope of mild TBI, more commonly referred to as concussion. Therefore, this article will focus on the litigation of concussions.

Next, we describe the types of medical and testimonial proof defense counsel can expect to encounter in a typical concussion case and identify particular areas of controversy where defense counsel can mitigate risk through effective preparation and cross-examination of plaintiffs’ experts. Finally, we suggest a conceptual framework for defending a concussion claim using a proactive approach.

What Is a Traumatic Brain Injury?

Broadly speaking, a traumatic brain injury is any disruption in normal brain function caused by forces acting on the head or brain. Centers for Disease Control and Prevention, *Traumatic Brain Injury in the United States: Fact Sheet*, available at http://www.cdc.gov/traumaticbraininjury/get_the_facts.html (accessed July 10, 2015).

These forces may be a blunt force impact to the head, or the rotational forces experienced by the head and neck in a whiplash

situation. Victor F. Coronado *et al.*, *Traumatic Brain Injury Epidemiology and Public Health Issues*, 8 *Brain Injury Medicine* 84, 85 (2013).

TBIs are typically classified as mild, moderate, or severe. Mild TBIs are commonly called “concussions.”

Although several major medical organizations have promulgated slightly different definitions of concussion, the diagnostic criteria usually include (1) loss of consciousness, (2) alteration of consciousness, (3) posttraumatic amnesia, (4) positive findings on diagnostic imaging studies, and (5) focal neurological abnormalities such as seizures, visual or hearing disturbances, dizziness, and others. Victor F. Coronado *et al.*, *Traumatic Brain Injury Epidemiology and Public Health Issues*, 8 *Brain Injury Medicine* 84, 85 (2013).

Concussion is generally diagnosed where loss of consciousness is less than 30 minutes, alteration of consciousness less than 24 hours, and posttraumatic amnesia is less than 24 hours. Carroll *et al.*, *Methodological Issues and Research Recommendations for Mild Traumatic Brain Injury: The WHO Collaborating Centre Task Force on Mild Traumatic Brain Injury*, 43 *Suppl. J. Rehabil. Med.* 113–125 (2004). When a particular plaintiff’s symptoms approach the upper ends of these ranges, a plaintiff’s TBI may be classified as “moderate” or “severe”—especially where there are positive findings on CT scans or MRIs showing an abnormality in the brain or skull.

Contrary to popular belief, a TBI does not always result in a loss of consciousness. In fact, loss of consciousness may be the exception to the rule in cases involving concussions. Only one of the above criteria needs to be present in order to support a TBI diagnosis. Victor F. Coronado *et al.*, *Traumatic Brain Injury Epidemiology and Public Health Issues*, 8 *Brain Injury Medicine* 84, 84 (2013).

A subjective complaint of unwitnessed altered consciousness (*i.e.*, feeling “dazed and confused”), in some cases, can be sufficient by itself to support a plaintiff’s TBI claim.

In addition, several other factors often attendant to an accident can complicate the analysis of neurological symptoms at the time of the injury. For example, if the

plaintiff was intoxicated at the time of the injury, or was immediately sedated and intubated by emergency medical personnel at the scene of the accident, it may be very difficult or impossible to determine whether the unconsciousness, drowsiness, combativeness, agitation, or memory loss observed by medical personnel was due to a brain injury, or instead due to the plaintiff's intoxication or subsequent medical treatment. Victor F. Coronado *et al.*, *Traumatic Brain Injury Epidemiology and Public Health Issues*, 8 *Brain Injury Medicine* 84, 85 (2013).

After sustaining a TBI, a person may go on to have additional symptoms ("sequelae"). Common complaints include headaches, nausea, fatigue, short-term memory problems, concentration deficits, irritability, anxiety, depression, drowsiness, insomnia, mood swings ("emotional lability"), and sensory changes. Concussion sequelae are generally *nonspecific*. Veterans Health Initiative, *A Conceptual Framework for TBI Assessment and Management*, in *Traumatic Brain Injury* (2010). That is, none of the commonplace concussion symptoms can be used to diagnose a concussion to the exclusion of all other medical conditions. Therefore, a critical issue is whether a doctor has ruled out other plausible explanations for the plaintiff's symptoms through a process called differential diagnosis.

The nonspecific nature of TBI sequelae also leads to a critical issue that defense counsel must keep in mind throughout the TBI case: *the TBI diagnostic criteria described above must be present at or near the time of the trauma*. Often, plaintiffs will not complain of *any* of the diagnostic signs of TBI to ambulance personnel or emergency room doctors, but complain only weeks or months later of headaches or cognitive impairment. This issue becomes extremely important when the time comes to depose the plaintiff's experts. Doctors should not diagnose a TBI based on symptoms that first arise weeks or months after an accident. Douglas I. Katz, *et al.*, *Mild Traumatic Brain Injury*, 9 *Traumatic Brain Injury*, Part 1: *Handbook of Clinical Neurology* 131, 135 (2015).

Where an expert omits a review of date-of-accident medical records from his or her

analysis, defense counsel should strongly consider an evidentiary motion to preclude that expert from opining as to whether a brain injury occurred. A TBI diagnosis rendered without a foundation of diagnostic criteria contemporaneous with the injury is not based on a scientifically reliable method.

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Temporary Dysfunction Versus Permanent Brain Damage: How Plaintiffs Maximize Damages

The physiological processes of concussion versus moderate and severe TBI are a key distinction for the defense. Moderate and severe TBI are more likely to involve structural brain damage that will appear on CT scans or MRIs after the accident. This structural damage may be permanent. The symptoms that follow moderate and severe TBI are more easily correlated with findings on MRI scans or other diagnostic tests. As such, moderate and severe TBI claims can be easier to prove or disprove than concussions.

The general consensus in the medical literature is that concussion symptoms are caused by a complex sequence of chemical and metabolic changes that occur in neurons when subjected to mechanical stress. Grant L. Iverson, *Outcome from Mild Traumatic Brain Injury*, 18 *Current Opinion Psychiatry* 301, 302–03 (2005).

This process, known as the neurometabolic cascade, results in dysfunction of neurons that lead to classic concussion symptoms like headaches, cognitive disruption, drowsiness, dizziness, insomnia, emotional dysregulation, and others. Depending on the severity of the impact, these chemical changes can last longer or result in more serious damage to neurons. However, years of research have demonstrated that the vast majority of patients fully recover from their symptoms as the chemical processes in their brains return to their pre-injury state. Matthew T. McCarthy & Barry E. Kosofsky, *Clinical Features and Biomarkers of Concussion and Mild Traumatic Brain Injury in Pediatric Patients*, 1345 *Ann. N. Y. Acad. Sci.* 89, 91 (2015).

By way of illustration, many readers of this article may have sustained a concussion at some point in their lives, made complete recoveries, and enjoy successful professional careers. However, a minority of individuals—often referred to in the medical literature as the "miserable minority"—do not recover fully after an extended period following an accident. Michael A. McCrae, *Functional Outcome after MTBI*, 13 *Mild Traumatic Brain Injury and Postconcussion Syndrome* 129, 130 (2008).

Why most people recover fully from concussions, while others remain symptomatic, is a key issue to both the plaintiff and the defense in any concussion lawsuit. Plaintiffs and their experts argue that an individual plaintiff's protracted post-concussion symptoms are due to microscopic damage in the brain. In contrast, defense experts try to explain persistent post-concussion symptoms by emphasizing the role that pre-injury personality traits, psychological processing, pre-existing medical or psychological problems, and psychosocial stress play in determining outcomes following concussions. Michael A. McCrae, *Functional Outcome after MTBI*, 13 *Mild Traumatic Brain Injury and Postconcussion Syndrome* 129, 132 (2008).

Literature demonstrates that 95–97 percent of individuals who sustain a concussion fully recover. Grant L. Iverson *et al.*, *Conceptualizing Outcome from Mild Traumatic Brain Injury*, in *Brain Injury Medicine: Principle and Practices* 470 (Nathan

D. Zasler *et al.* eds., 2d ed. 2013) (noting that the percentage of all MTBI patients with symptoms after one year is “clearly less than 5 percent”); Michael A. McCrea, *Mild Traumatic Brain Injury and Postconcussion Syndrome* 165 (2008) (concluding that “the true incidence of PCS would appear to be far less than 5 percent of all MTBI patients” and “could be lower than 1 percent of all MTBI patients”). Grant L. Iverson, *Outcome from Mild Traumatic Brain Injury*, 18 *Current Opinion Psychiatry* 301 (2005) (noting that the 15 percent statistic is “frankly wrong.”). Plaintiffs use outdated figures to suggest a larger non-recovery minority, then argue that they are among the minority with “permanent” concussion symptoms. Their experts often include opinions that concussion patients are at increased risk for a variety of neurodegenerative diseases such as Alzheimer’s disease (or other types of dementia). In addition, experts in pediatric cases may opine that children with concussions are at increased risk of dropping out of school, unemployment, and criminal activity, all because of cognitive, emotional, and behavioral problems allegedly stemming from a single concussion. Epidemiological research does not support a causal link between a single concussion and these catastrophic life outcomes.

How Are Plaintiffs “Proving” TBI Claims, and What Can Defense Counsel Do About It?

A plaintiff’s initial hurdle is proving that she sustained a TBI in the first place. However, rather than resolving this issue by pointing to acute neurological signs present on the date of the accident, plaintiffs often attempt to prove that a brain injury occurred by relying on evidence from months or years after the initial trauma. This evidence can include neuropsychological testing, neuroimaging, and damages witnesses.

Neuropsychological Evaluations

In most TBI cases, the plaintiff’s attorney will refer her client to a neuropsychologist. Neuropsychology is a subfield of psychology that seeks to understand the relationships between the brain and human behavior and learning. Eric A. Zillmer,

Mary V. Spiers, *et al.*, *A History of Neuropsychology* in *Principles of Neuropsychology* 5 (2d Ed. 2008). Although most states do not regulate who may hold themselves out as neuropsychologists, neuropsychology is a specialty that requires specific training and experience. Neuropsychologists are not medical doctors; they usually possess a Ph.D. or a psychological doctorate (Psy.D.) instead.

Neuropsychological testing involves a battery of tests lasting between several hours and a few days. Often, the neuropsychologist administers test of cognitive skills thought to be relatively unaffected by brain injury in order to estimate the person’s pre-accident level of cognitive functioning (sometimes referred to as a “baseline”). Patients are then administered tests of general intelligence, auditory and visual processing, memory, problem solving, and fine motor skills like manual dexterity and grip strength. These evaluations attempt to (1) diagnose the plaintiff with brain dysfunction, (2) determine the type and severity of dysfunction, and (3) link that dysfunction to a TBI sustained in a traumatic accident. A patient’s test scores are then compared against scores achieved by other demographically similar individuals, taking into account age, gender, education, and race—a process called “norming.”

Beyond qualifications, the key areas for cross-examination of a neuropsychologist are their test selection, assessment of effort, consideration of other factors that could have affected test performance, and the neuropsychologist’s method of test interpretation.

Neuropsychologists have wide discretion to determine the specific neuropsychological tests administered to a particular individual. Defense counsel should inquire as to the neuropsychologist’s reasoning for test selection. The neuropsychological community conducts extensive research on neuropsychological tests to ensure that they are scientifically reliable and determine what conclusions about the brain and behavior can reasonably be drawn from the results of the tests. Over decades of research, some tests have demonstrated greater sensitivity to TBI.

In addition to test selection, a key component of neuropsychological test-

ing is evaluating the patient’s effort and test-taking attitudes. In order for neuropsychological testing to be an accurate picture of an individual’s cognitive ability, the individual must give full effort. Ideally, several effort tests will be administered to the patient over the course of neuropsychological testing. These tests are designed to identify patients who purposely underperform or who over-report symptoms in order to appear more injured than they actually are. For example, the person may have consciously failed a cognitive test that even severely brain-injured patients are capable of passing, in order to appear more impaired than he or she actually is. Plaintiffs’ neuropsychologists tend to explain away failed effort tests in a variety of ways. They may argue that the plaintiff failed the effort test because she is far more brain-injured than was originally expected. Or, the plaintiff endorsed symptoms that even severely psychopathic patients do not even endorse, because the plaintiff is attempting to “cry for help” about her condition. The failure of the plaintiff’s neuropsychologist to administer effort testing, or to interpret correctly the significance of failed effort tests, is a critical methodological issue that defense counsel should address.

Finally, scientifically reliable conclusions about neuropsychological test results must take into account other medical, psychological, or environmental factors that could explain why a particular plaintiff scored the way she did on neuropsychological testing. For example, a neuropsychologist should know whether the plaintiff took opioid pain medication or prescription anxiety medication on the date of the neuropsychological evaluation, as these medications commonly seen in TBI cases have well-known cognitive side effects. The neuropsychologist should also assess the plaintiff’s personality and degree of psychosocial stress through the administration of tests designed to test personality and emotional functioning, such as the Minnesota Multiphasic Personality Inventory. However, defense counsel should be on the lookout for “self-report” measures of emotional functioning, which may allow the plaintiff to appear as emotionally impaired as he or she wants to, based on how many symptoms he or she endorses.

Once the neuropsychological testing is complete, the data is evaluated for qualitative and quantitative clinical findings. This is an area where the plaintiff's neuropsychologist may take significant liberties to support or refute certain diagnoses. Confirming that the neuropsychologist used appropriate normative data is key. Individuals with higher education or within a certain age group may score better on testing than those with less education or older or much younger individuals, and neuropsychologists must adequately control for these variables that can affect test results. Therefore, defense counsel should confirm that the plaintiff's neuropsychologist compared the plaintiff's test scores against demographically similar individuals.

Neuroimaging

A comprehensive review of the new and emerging forms of neuroimaging is beyond the scope of this article. Still, a working understanding of neuroimaging, especially its limitations, is essential when defending a concussion claim. There are two broad categories of neuroimaging: structural and functional. Plaintiffs generally use structural neuroimaging to support a claim that there has been actual tissue damage in the brain. Plaintiffs use functional imaging to argue that the functioning of the brain has been disrupted somehow due to a TBI. Defense counsel should be aware of the differences between the various modes of imaging plaintiffs are using to prove their cases, and potential issues that may arise when plaintiffs seek to introduce this evidence into court.

Structural imaging examines the physical characteristics of the skull and brain. Structural imaging methods include X-Ray, computed tomography (CT or CAT scans), and magnetic resonance imaging (MRI). CT, which is a more detailed form of X-ray, is often encountered in the emergency room setting, where it is used to quickly scan a patient's skull and brain to rule out skull fractures or bleeding inside the skull. However, CT has relatively low sensitivity to changes in the soft tissue of the brain. Doctors may follow up with a MRI days or weeks after the accident. MRI creates more detailed images of the soft brain tissue, and doctors can use several differ-

ent MRI settings to identify different types of abnormalities—for example, structural abnormalities, areas of abnormal fluid collection, or leftover byproducts of past bleeding in the brain.

A recent advance in MRI technology, called diffusion tensor imaging (DTI), is quickly gaining traction among the plain-

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tiffs' bar. Plaintiffs' attorneys claim that a DTI scan (which results in a three-dimensional, colorful, visually appealing image that makes for great demonstrative evidence) can show permanent structural damage after even a minor concussion. Although this technology is arguably promising, DTI is not widely used by doctors to diagnose patients with concussions in non-litigation settings. Additionally, DTI has some major methodological flaws that may undermine the conclusions that some plaintiffs' experts often try to derive from interpreting a DTI scan. Should DTI appear in a TBI case, defense counsel should be aware of the potential value this technology has to mislead jurors through its visually appealing imagery, and should consult closely with defense experts to determine whether an evidentiary challenge is appropriate based on the methodology utilized by the plaintiff's expert to administer and interpret the scan.

In contrast to structural imaging, functional imaging examines the actual physiological processes that take place in brain tissue. This includes modalities such as positron emission tomograph (PET), single photon emission computed tomography (SPECT), and functional MRI (fMRI) to examine several parameters, such as metabolism of glucose or uptake of oxygen. Broadly speaking, functional imaging seeks to determine differences in the

uptake or metabolism of certain molecules in the brain and uses those differences to draw conclusions about whether the brain is functioning normally. For example, a PET scan may show reduced metabolism in certain areas of the brain, which a plaintiff's expert may argue is evidence of brain dysfunction following a concussion.

Although functional imaging such as PET has a wide range of applications in medicine, its use in TBI cases should be carefully scrutinized. There are an extraordinary number of variables that may explain why a person's brain is functioning in a certain way at any given moment. Where functional imaging appears in a TBI case, defense counsel should be prepared to address and attack the plaintiff's expert's methodology and the scientific validity of the conclusions derived from functional imaging.

The "Before and After" Lay Witness

The "before and after lay witness" in brain injury cases is no different from a similar witness in other physical injury cases. Generally, a friend or family member testifies that prior to the accident the plaintiff was a totally different person—more active, more mentally sharp, and more emotionally and intellectually stable. Although these allegations may sometimes be true, in whole or part, these witnesses may be influenced by what psychologists refer to as the "good old days" bias. This scientifically demonstrated phenomenon can lead injured individuals, as well as their friends and family, to emphasize the positive aspects of their pre-accident life while downplaying the negative aspects. In short, individuals tend to remember the good times and selectively forget the bad times. This is another example of why, as discussed below, it is critical to develop a comprehensive profile of a TBI plaintiff's pre-accident medical history, as well as the pre-accident lifestyle, family life, career functioning, and other environmental circumstances.

The Defense Approach to Evaluating TBI Claims

In deciding whether to settle or try TBI claims, the key issue is whether the plaintiff's complaints make sense from a medical standpoint. If not, what is the most logical explanation for the symptoms? From the

plaintiff's perspective, proving a TBI claim to a jury is about portraying to jurors a logical connection between the negligence, accident, injuries, and plaintiff's current condition. For defense attorneys, the goal is to identify for jurors the weak point in this logical chain, to pinpoint the gaps between expectations and reality, and to explain to jurors a reason *why* the plaintiff's alleged permanent symptoms (or their causal link to the accident) do not make sense based on the nature of the trauma. It is not sufficient for defense counsel to simply point out to jurors that the accident was minor and that the claimed injuries are therefore disproportionate. Instead, defense counsel must develop a theory of the case that explains *why* the plaintiff has turned out the way she is.

To develop an alternative theory of the case, defense counsel *must* investigate the plaintiff's pre-accident medical history thoroughly. The purpose of this investigation is to understand all the medical or psychological conditions that could explain the symptoms and problems the plaintiff is coming into court with—that is, to answer the question: are this plaintiff's symptoms actually because of a TBI, or because of something else like psychiatric disorder or other chronic medical conditions? Consultation with defense experts can be helpful in determining the significance of unique features of a plaintiff's medical history. The process is simply one of issue spotting. Failing to investigate a plaintiff's pre-accident medical history deprives defense experts of critical information needed to evaluate the causation component of the plaintiff's claim.

The classic defense approach to TBI claims is to build a case that the plaintiff is malingering for purposes of secondary gain. While this is certainly a possibility that should, in the exercise of due diligence, be considered, we suggest that pure malingering is in play only in an extreme minority of cases. Based on the definition of malingering as "intentional reporting of symptoms for personal gain" (*i.e.*, seeking external rewards), Am. Psychiatric Ass'n, *The Diagnostic and Statistical Manual of Mental Disorders*, 326 (5th ed. 2013), attorneys should be cautioned that "malingering" is only one of several labels or

diagnoses that can be applied to scenarios involving medically unexplained symptoms. For example, a variety of psychological conditions exist wherein people may experience actual motor or sensory symptoms that have no clear correlation with any neurological injury or known neurological condition. In these cases, the fact

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Rather, each plaintiff's expert must be deposed with an eye towards setting up the expert for an evidentiary challenge under the forum's rules of evidence regarding the admissibility of expert witness testimony in court (a "Daubert" or "Frye" challenge).

that doctors cannot explain the patient's symptoms by referencing a known neurological diagnosis does not mean that the plaintiff's symptoms are fake or illegitimate. Symptoms can be both unexplained and real at the same time. To compulsively label all TBI plaintiffs as malingerers is to disregard the nuanced explanations for why a particular person's complaints in litigation do not make sense based on the nature of the injury. In TBI litigation, when the claimed injuries are disproportionate to the trauma, defense counsel must use *all* of the available evidence to explain to jurors: *what is actually going on with this plaintiff?*

Defense counsel must also be fully engaged in the scientific issues surrounding the processes and conclusions being used by the plaintiff's experts to support their conclusions about the causes of the plaintiff's symptoms and the effects of

the plaintiff's alleged brain injury. It is not enough for defense counsel to simply take a discovery deposition of a plaintiff's expert. Rather, each plaintiff's expert must be deposed with an eye towards setting up the expert for an evidentiary challenge under the forum's rules of evidence regarding the admissibility of expert witness testimony in court (a "Daubert" or "Frye" challenge). The methodology used by the expert, and the scientific validity of the conclusions derived from that methodology, must be fully researched and understood prior to the deposition, including by consultation with defense doctors, if possible. Then, during the deposition, defense counsel's questioning should focus on the expert's sources of information, method of evaluating the plaintiff, ruling in or ruling out other explanations for the plaintiff's condition, and the scientific or technical support for the expert's conclusions derived from such processes. Failure to challenge the plaintiff's experts from a scientific standpoint is giving the plaintiff and her experts a free pass to say whatever they want about whether a TBI occurred and how it has affected the plaintiff.

In addition to presenting the case that a TBI does not fully explain the plaintiff's outcome, defense counsel should use the medical records (both pre- and post-accident), educational records, defense medical examinations, and other information obtained through surveillance, witness interviews, or other methods, to develop a compelling, comprehensive theory of the case that can actually explain the plaintiff's outcome. Again, "malingering" is not the answer in the vast majority of cases. Therefore, giving jurors a viable alternative explanation for the plaintiff's outcome following the accident can prevent them from defaulting to oversimplified analyses of the case—such as, "look what happened to all those NFL players—that must be what's going on here!" Or, "this person wasn't like this before the accident, and now look at them!" Defense counsel must help the jurors connect the dots between the accident and the plaintiff's outcome in a way that results in a favorable result for the defendant. Consulting defense doctors can be helpful to understand how a person's

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pre-accident personality, medical history, psychological profile, and other environmental circumstances explain how a particular concussion plaintiff ended up in the “miserable minority” following a minor accident.

Conclusion

From our work litigating TBI claims nationally, it has become apparent that some defense attorneys, insurance adjusters, risk management officers, and others may not fully appreciate the risks presented by a TBI claim. The plaintiffs’ bar has become more aggressive and sophisticated by presenting emerging science and novel neuroimaging techniques; the defense bar has unfortunately not always kept up. As a result, “malingering” remains the go-to defense for many attorneys, insurance adjusters, and in-house counsel. However, as the public becomes more informed about the nature and effects of brain injuries, it is unlikely that the defense can continue to persuade jurors that everyone is “just faking it.” The malingering defense is tired and unsophisticated, and defense attorneys can do better.

The fact remains that a large number of individuals sustain concussions at some point in their lives and yet go on to lead full and productive lives. These claims are defensible, but only with a full, nuanced understanding of the science behind TBI and the methods plaintiffs use to prove them. Most importantly, defense attorneys have an important role to play to ensure that jurors are not misled or confused by junk science, overreaching expert opinions, and appeals to media sensationalism about concussions in professional sports. Through thoughtful litigation practices and preparation, defense attorneys can make sure that jurors get the full picture about what is really going on with a particular plaintiff. This should help encourage jurors to issue reasonable verdicts consistent with the true nature of the injury. In-house counsel’s role in TBI litigation can help prevent runaway TBI verdicts as well, by recognizing the risks of these claims when accidents occur, and by working proactively with trial counsel to collect the appropriate records early and retain the appropriate experts. 