



## mTBI – The seven deadly sins

MILD TBI PRESENTS DIFFERENTLY THAN MODERATE AND SEVERE TBI;  
IT REQUIRES MORE WORK TO IDENTIFY

Unlike their more famous siblings – the moderate TBI and severe TBI, who come to you with a cracked skull or bleeding brain, the mild TBI (“mTBI”) case is more mysterious and requires more work to identify. The mTBI also requires much more work to present to a jury without committing one of the mTBI 7 Deadly Sins.

The mTBI case presents in your office as a “normal” high policy-limit case, but over time, the case manager becomes annoyed by the one client who calls just a little too much, misses a few too many appointments, flies off the handle one too many times, or just flat out “lies,” saying they have not heard from your office in weeks or months even though you and your case manager talked to them last week. (They’re not lying – they just don’t remember.)

Let’s talk about a few threshold issues before starting to talk about how to maximize these cases and avoid the mTBI 7 Deadly Sins.

First, mTBI cases are expensive, so you need a high or open policy before you go down this road.

Next, know your client. Know where their skeletons are buried and at a minimum, know their history of drug use/abuse, alcohol use/abuse and psychological history and history of suicide or suicide attempts.

Finally, you will get paid more for dysfunction than you will for damage, so let this question guide you as you work on your client’s case: What can your client no longer do that they used to be able to do before the injury-causing event?

### **Deadly Sin #1: Over-reliance on ER medical records**

Hands down, the most common mistake I hear is an overreliance on emergency room records. Remember: if the ER physician ordered a CT scan, the physician did so to identify an injury that *may* require immediate surgery or immediate medical treatment. The emergency department physician thought there were enough 1) signs and symptoms

and/or 2) relevant history to support a CT exam. So, if the CT is without findings, keep in mind that a doctor thought that there could be something very wrong and ordered a CT scan.

Further, if there is no TBI/mTBI diagnosis or no TBI symptom(s) in the records, recall that the purpose of the emergency room is to identify immediate and life-threatening symptoms. The ER does not exist to identify all the potential working diagnoses. It takes time for TBI/mTBI injuries and symptoms to develop. If there is a CT study in your TBI/mTBI emergency room records, that is a big statement. If there is no TBI/mTBI diagnosis, that is okay, it is not the job of the emergency room physician to give a working diagnosis based on limited facts, time and findings.

One last thing, please look at which medications were administered by which ambulance or emergency room worker and what time each was administered versus what time your client’s drug test specimen was collected. Several times, I’ve had clients labeled as drug addicts when it was the hospital who gave them the pain medication detected in the drug test.

### **Deadly Sin #2: Failure to “give it time”**

Brent Masel’s article “Traumatic Brain Injury: A Disease Process, Not an Event” reminds us to give TBI/mTBI clients/survivors time for their symptoms to arise (Masel, *Traumatic Brain Injury: A Disease Process, Not an Event* (August 2010) *Journal of Neurotrauma* 27: 1529-1540). It takes time for a client to recognize that they are forgetting things (having trouble with short-term memory), that their vision has declined or now they see floaters (specifically since the crash), or how irregular their sleep has become. Each of these things seem like they should be so easy to recognize, but even when faced with a checklist, it takes time to recognize each of these symptoms in your own life, and harder yet to place them in time to specifically after the

injury-causing event. Further, this becomes more difficult when symptoms are constantly changing and sometimes just fade away.

The take-away here is that TBI/mTBI is a disease process and symptoms will change from time to time, so create a system to protect your clients. Choose a list, use that same list over and over. I give the same list to our clients every month. Sometimes we call them and ask the questions, sometimes we text the questions/symptoms to our clients, sometimes we email a short questionnaire. Either way, it is the same checklist, we just feed it to them differently each month. Give that same list to the client’s family members or people they live with (obviously ask your client who it is okay to talk to) and keep pointing your client back to their neurologist to document the symptoms and possibly refer to a subspecialty. Remember, it takes time for a client to recognize what they can no longer do that they used to be able to do before the injury-causing event.

### **Deadly Sin #3: Under or incomplete treatment**

Let’s pretend your client has vestibular dysfunction (disturbance of the body’s balance system). Most times, the law firm will direct the client back to their neurologist to document the deficit. Most times the documentation and treatment ends there. This is not where the process should end.

After the neurologist documents the chart, the neurologist should send the client to at least one subspecialty to help further document the deficit and hopefully get some therapy ordered so we can find out how this deficit affects our client’s everyday life. Here, the neurologist could send the client to an Ear Nose and Throat doctor (ENT) for further documentation, testing, and therapy. The ENT could do a series of balance testing, document the client’s chart, prescribe therapy, and if the findings support it, send the client out for additional subspecialty referrals (common

treaters for vestibular disturbance include neuro optometry, neuro ophthalmology, audiology, etc.) for further documentation, treatment and even more therapy. The key in all these subspecialties and the subspecialty referrals is the therapy.

The therapy is here to identify and document each deficit and figure out how the deficit encroaches upon your client's life. Remember, the big question in mTBI is: What can your client no longer do that they used to be able to do before their injury-causing event? Therapy will answer this question for you.

I take at least one call a week where a referring lawyer calls to say, "My client has vestibular dysfunction, I sent him to your doctors and got your same report but the insurance company will not tender. I don't get it." I have to explain to the attorney that he or she is missing the biggest part – what the client can no longer do that they used to be able to do. Your mTBI identification, documentation and treatment is incomplete until therapy answers the key question for you. The defendant did not steal something from your client, without your client's permission, until you answer this question.

Sticking with the same scenario, a client cannot walk without vestibular disturbance. A young man is in the prime of his life, but he has vestibular disturbance. He cannot walk straight, runs a little funny, and cannot walk downstairs. He wants to go ask his girlfriend's family for her hand in marriage but worries about how to get her family's blessing without having to tell them he is now "handicapped." This client was in my office just last week – and one thing he can no longer do that he used to be able to do before the injury-causing event is walk normally. A little limp does not seem so bad until it keeps you from being able to confidently ask for your girlfriend's hand in marriage.

#### **Deadly Sin #4: Lean into PTSD**

Here is the question: If the treatment and long-term effect is the same, does it matter what we call it? I have taken so

many lawyer phone calls where, in their most defeated voice, they say, "You won't believe it. My TBI case is done, I got a PTSD diagnosis." My response is always the same, "Okay, so what?"

Maybe it is my own naivete, but genuinely, I do not understand, if the symptoms and treatments and damages are the same (client has vestibular dysfunction, vision issues, anxiety, sleep issues, etc.), what does it matter if we call it TBI vs. mTBI vs. PTSD? Again, the question is, what can your client no longer do that they used to be able to do before the injury-causing event? If the sound of dishes clanking or any loud sound causes the client to dash under the kitchen table because it reminds our client of his crash, what does it matter if we call it PTSD vs. mTBI? Either way, there is a chemical reaction in the brain that is not working the way it should because a part of the brain is damaged after the injury-causing event.

Here is the game plan: Lean into that PTSD diagnosis. Go get that diagnosis before opposing counsel does. Go identify each and every one of those symptoms. Go get therapy for each symptom. Identify how each symptom affects your client's life and answer the money question – what can your client no longer do that they used to be able to do because of this new symptom? Then, when opposing counsel says PTSD, you say, absolutely!

#### **Deadly Sin #5: Not understanding TBI headaches**

No one loves a good headache case more than me. The key to headache cases is understanding that not all headaches are TBI/mTBI headaches. Find a good pain-management doctor with a headache subspecialty and a good neurologist who understands headaches and make those two doctors your headache team. Using a process of elimination, your team will be able to tell you whether your client's headaches are due to the TBI – or due to something else entirely.

The pain-management doctor will get a detailed history of the client's

headaches – and their family history of headaches. They will have to eliminate causes other than the TBI that could be causing your client's headaches.

You will send the client to a neurologist to get a headache protocol going. Your neurologist will have an 8-12-month plan where they use a combination of muscle relaxers, occipital nerve blocks, Botox, and some neuro-imaging.

Done right, mTBI headache cases are very simple and quick for your client. The key here, again, is what can your client no longer do that they used to be able to do before the injury-causing event?

#### **Deadly Sin #6: Stacking it all on a neurologist**

While neurologists and physiatrists are both doctors that deal with conditions that affect the patient's brain, neurologists are more concerned with the disease process in the brain and nervous system – while physiatrists are more concerned with the effects of the disease process on other body systems.

A neurologist will often send the patient to a neuroradiologist to see an image of the brain using MRI, fMRI, DTI, SWI, PET, MEG, SPEC, etc., or send them to a neuropsychologist to verify the brain-injury disease process and progress. A physiatrist's primary goal is to treat the patient as a whole and not focus on just treating the brain problem area.

Physiatrists generally work collaboratively with other providers such as physical, occupational, speech therapists, rheumatologists, neuroendocrinologists, pain management, orthopedic surgeons, and neurologists. They are usually affiliated with hospitals and part of an inpatient brain-injury program. Physiatry is more of a whole-body systematic approach to TBI versus a neurologist's monocular approach.

Go back to your core question: What can your client no longer do that they used to be able to do?

When it comes to answering that question, using a physiatrist as your

quarterback makes a lot of sense. A neurologist is a great starting point, but ultimately, for the purposes of your case, a physiatrist may be the best specialty to connect the dots and help you see the whole answer.

So, make sure your client's brain structure is safe and in place with a neurologist, but then let the physiatrist send your client out to the subspecialties that your client requires. Once you know the brain structure is safe and in place, now your physiatrist can treat your client as an individual, looking at each of their systems, understanding each of their deficits, and following each of their providers and therapists. Psychiatrists are used to regular team meetings between all the different providers so that the entire team is constantly communicating to best serve your client. Psychiatrists are used to identifying deficits and using physical therapy, occupational therapy, speech therapy, vestibular therapy, and other therapies to rehabilitate brain injury survivors.

### **Deadly Sin #7: mTBI forgotten symptoms**

When we think of TBI/mTBI, there are a few symptoms that we hear most often (headaches, dizziness, irritability and nervousness, etc.), but what about the forgotten symptoms? Many of these "forgotten" symptoms carry major damages.

First, let's talk about sleep. This is an easy one to identify. Sleep dysfunction usually manifests in any or a combination of three different ways: your client can have trouble falling asleep, trouble

staying asleep, or feeling restored after a night of sleep.

Sleep studies are expensive, so I ask my clients if they have an Apple Watch or Fitbit. If they don't, I send them one. I ask them to wear it non-stop for four to six weeks. If you determine, after four to six weeks of data gathering, that your client in fact is having sleep issues, this is when you can suggest that they may want to go see their neurologist or physiatrist and ask for some direction. After that visit, most neurologists or psychiatrists will order a sleep study.

Lack of sleep can lead to an early onset of dementia, can make it harder to concentrate, and can cause stress and anxiety.

Hormone dysfunction is another forgotten symptom. This is another easier one to identify. When a client has gained or lost more than 10-15 pounds in the last six months, is struggling with fatigue, has stunted or unusual growth spurts, or has either a noticeable increase or decrease in hair growth (e.g., hirsutism or alopecia), I ask the client to go see their physiatrist or neurologist for a hormone panel.

A human growth hormone (HGH) shot is approximately \$1,300 per week (\$67,600 per year). Generally, people who need HGH will need it for the rest of their life (\$67,600 per year X life expectancy).

A few others that I see forgotten are brain fog/lack of focus, loss of sense of smell, loss of sense of taste, photophobia (sensitivity to light), phonophobia (sensitivity to sound), fatigue, mood disruption, lack of focus, memory difficulties, inability to regulate body

temperature, inability to regulate heart rate, sexual dysfunction, word blindness and other vision issues, and impaired motor coordination. All of these need to be sussed out through careful and consistent communication with your client.

### **Conclusion**

All brain-injury cases come back to that one question: What can your client no longer do that they used to be able to do before the injury-causing event? That is the thing that the defendant took from your client. What happened to your client is rarely found on the police report – rather, it comes from months of talking to your client and finding out what things they miss, what things they lost, what things they mourn and what they are working to keep. It is in that story of loss that you will find something redeeming and heroic about your TBI/mTBI survivor – and it will make you want to fight harder for them and their recovery than you have fought for any client before them. These seven Deadly Sins outlined above are just a few things that I have learned along the way, and I hope they will help you as you fight for your clients.

*Erica Chavez has devoted her legal career to representing victims of catastrophic injury, particularly TBI. Erica built the largest brain-injury conference in the world, TBI Med-Legal, and is a co-founder of the firm Trauma Law with Joseph H. Low IV. Erica is the chair of the Board of the Brain Injury Association of California, and a member of the board for the Consumer Attorneys of California. ☒*