SMITH FREED & EBERHARD P.C.
Your Litigation Partner

Case Study

Instructing on a "Previous Infirm Condition"

— *by* **Jeffrey D. Eberhard**

Claims Pointer: The Oregon Court of Appeals holds that failure to give a jury instruction on a plaintiff's previous infirm condition is reversible error. Further, the Court held that the distinction between a "Previous Infirm Condition" instruction (which explains that the defendant is liable for the plaintiff's damages notwithstanding the plaintiff's prior condition which makes her more susceptible to injury), and an "Aggravation of Preexisting Injury" instruction, is significant.

The right to a trial by a jury of your peers is every American citizen's fundamental right, guaranteed by the Constitution. The result? Two teams of legal professionals gather in a courtroom, arguing their cases in front of a group of decision-makers that represent a cross-section of citizens of different ages, races and ethnic origins, educational levels, life experiences, and religious beliefs. One challenge to this otherwise desirable process is that the jury members are frequently asked to make sense of some very complex legal issues, often beyond their areas of expertise. Thus, the trial judge will frequently give members of the jury instructions to help clarify the law and guide them on how to apply that law properly to the evidence in a particular case. In a recent case, Crismon v. Parks, (No. 06C19006, October 27, 2010), the Oregon Court of Appeals considered the appropriate instruction to give a jury where a plaintiff was injured in a car accident, but had a prior condition which made her more susceptible to injury and, ultimately, led to her damages.

Plaintiff was injured in a rear-end automobile collision and brought an action to recover damages. The medical evidence presented at trial established that, as a result of a genetic condition, Plaintiff had spondylolisthesis (a condition in which a vertebra in the lower part of the spine slips forward and onto a bone below it.) At trial, physicians for both the Plaintiff and Defendant testified that Plaintiff likely had spondylolisthesis for some time prior to the accident, but never experienced any symptoms of the condition until the accident occurred and caused the condition to be painful.

Therefore, Plaintiff's theory of the case was that the collision caused her asymptomatic spondylolisthesis condition to become symptomatic. She requested that the following "Previous Infirm Condition" instruction be given to the jury:

> "If you find that the plaintiff had a bodily condition that predisposed her to be more subject to injury than a normal person in normal health, nevertheless the defendant would be liable for any and all injuries and damage that may have been suffered by the plaintiff as the result of the negligence of the defendant, even though those injuries, due to the prior condition, may have been greater than those that would have been suffered by another person under the same circumstances."

The trial court decided that there was not sufficient evidence to support Plaintiff's claim that her spondylolisthesis made her more susceptible to injury, and refused to give the requested instruction. The court instead offered to give the jury the "Aggravation of Preexisting Injury or Disability" instruction. Plaintiff declined, arguing that the Aggravation of Preexisting Injury instruction is only appropriate when a plaintiff suffers from a *previous* injury or disability, and the condition is symptomatic *before* the accident. After the jury returned a verdict that was less than Plaintiff had hoped for, she appealed.

On appeal, Plaintiff argued that the trial court erred in declining to give the jury the Previous Infirm Condition instruction as requested. She contended that the Previous Infirm Condition instruction would help the jury understand that Defendant was responsible for the full extent of the Plaintiff's damages, *notwithstanding* the preexisting condition. Further, she explained that the Aggravation of Preexisting Injury instruction ("not to include damages for the earlier injury but only those that are due to its enhancement") would have been insufficient because it could have misled the jury to believe that Plaintiff's current condition would not have been Defendant's responsibility.

The Oregon Court of Appeals ultimately agreed with Plaintiff, noting that there was enough evidence offered at trial for the jury to infer that Plaintiff had a condition that predisposed her to be more susceptible to injury than a person in normal health, and that was sufficient to warrant the instruction. The Court also recognized that it was important for the jury to understand that Defendant should "take the Plaintiff as he finds her," that is, they should have been instructed not to discount Plaintiff's damages because a "normal" person would not have suffered the same extent of damages as she did. Thus, since the trial court declined to give the requested instruction, and Plaintiff was likely prejudiced by that decision, the Court reversed and remanded the trial court's award. ❖

— If you would like to be notified of new cases and legal updates, please send an email to caseupdate@smithfreed.com.

ExamWorks

Medical Notes

Visual Consequences of Mild Traumatic Brain Injury

By Richard London, OD, MA, FAAO, Diplomat,
Binocular Vision, Perception & Pediatric Optometry
Professor, Pacific University College of Optometry

Mild traumatic brain injury (mTBI) is defined as head trauma in which there is either loss of consciousness for less than 30 minutes or an altered state of consciousness, a score of 13 or greater on the Glasgow coma scale and posttraumatic amnesia lasting less than 24 hours. Mild TBI is a major epidemiologic concern, thought to account for 70-80% of the TBI in the United States.

The visual system is uniquely susceptible to damage following traumatic brain injury (TBI). The eyes, placed in the front of the brain, send afferent neurons to the rear of the brain, the occipital cortex. That information is distributed for further processing: to the inferior temporal lobe (ventral stream) to process detailed visual information such as color, fine visual acuity, naming objects, and towards the parietal lobe (dorsal stream) for motion detection and visual spatial relationships. Additionally, the efferent system, which controls eye movements and pupil size, incorporates the area from the brain stem to the frontal lobe. It is, therefore, very probable that any insult to the brain will affect some portion of the visual system. The brain trauma need not be the result of the head making direct impact against a rigid surface; the action of acceleration and deceleration may cause damage to gray matter due to contusion and hemorrhage resulting from coup-countercoup contact of the brain against the skull internally, and, because of the different densities of the white and gray matter, rotational effects of whipping the head may cause a shearing effect on the axons. These combined traumas result in many of the problems of mild TBI. Unfortunately, the diffuse axonal injury is not well imaged on CT or MRI, leading to questions of the validity of complaints. However, development of diffuse tensor imaging and SPECT scans show promise in providing an improvement in the ability to detect mTBI in the future.

The visual system can be divided into two separate aspects. The first is the more familiar, visual information gathering. This includes visual acuity, visual field, ocular motility, accommodation, binocular cooperation between the eyes and ocular health. The goal of this portion of the system is to capture information visually in the environment by properly detecting an object of interest, aiming the eyes, focusing on the target and resolving the visual information. Defects in this area may result in visual scotomas, reduced visual acuity, diplopia, inability to easily change focus from distance to near or near to distance and over-or undershoots as the eyes move from one target to another.

The second aspect of the visual system is the processing of the visual information required to make sense of the captured sensory data. This includes properly identifying objects and naming them, understanding the function of the seen object and determining the visual spatial relationships between objects. Defects in this area may result in agnosias, inability to sequence visual information and getting lost attempting to navigate well-known areas.

Providers typically monitor survivors of major TBI and request specialty referrals as needed for the many problems the patient experiences. However, patients who have experienced mTBI often experience symptoms that are either overlooked or devalued by many clinicians. Three commonly encountered visual problems resulting from mild TBI are convergence insufficiency, accommodative dysfunction and dry eye. These problems greatly impact the patient's quality of life, especially if they enjoy or are required by their job to perform near tasks. Fortunately, they are problems that are relatively easily treated with excellent results. It should be noted that optometrists will often describe accommodative and convergence insufficiency problems as "functional." Their intention is that the components look intact, but the system does not function properly. These problems can be very disruptive in activities of daily living. This use of the term "functional" is often misinterpreted by the rest of the medical community who use the term "functional" to denote a non-organic (psychogenic or malingering) condition. Hopefully, as communication among providers improves, a more standardized language will clarify the intended meaning.

Convergence insufficiency (CI) and accommodative dysfunction cause symptoms during tasks like reading, working on a computer monitor, knitting and other near activities. In a series of 160 patients aged 8 – 91 years with mTBI and vision symptoms, 42.5% showed CI, 41.1% demonstrated accommodative dysfunction. CI refers to a lack of ability to converge both eyes comfortably in a coordinated manner to aim at a visual target of regard near the patient. The result is that the patient may find that they are no longer able to do near tasks for as long as a period of time as they would like – often giving up in minutes. Frequently reported complaints include diplopia at near, words running together, having to close one eye when reading and frontal headaches following near tasks. Interestingly, there is no evidence of a correlation between the severity of the TBI (mild/moderate/severe) and the severity of the vergence disorder.

Basic testing for CI consists of testing for near point of convergence, fusional vergence reserves, and assessment of the alignment of the eyes at distance and near under dissociative conditions looking for exophoria or exotropia. While a near point of convergence can be conducted in most practices, the assessment of alignment and fusional vergence ranges require special training, the use of prism and are typically performed by eye care specialists.

Accommodation is the ability to change the shape of the crystalline lens in the eye to focus properly at a given distance. Following even mild TBI pre-presbyopic patients may experience difficulty in clearly seeing their reading material (accommodative insufficiency) or have difficulty in changing focus through different viewing distances (accommodative

(Continued on next page)

Medical Notes… *(Continued from previous page)*

infacility). Patients often present like presbyopes despite being of a much younger age. Testing for accommodative insufficiency may be done in office by monocularly moving a detailed, accommodatively demanding target slowly towards the patient's eye until it becomes blurry and comparing the result between eyes to a normative scale. Testing for accommodative facility is best accomplished by challenging the patient's ability to accommodate and relax accommodation through use of minus (stimulating) and plus (relaxing) lenses. Testing is done both monocularly and binocularly and compared to norms. This facility testing is most commonly performed by optometrists.

While both CI and accommodative dysfunction may limit or preclude patients from enjoying near work, they respond well to proper management. CI is usually treated by prism placed in the spectacle prescription or vision exercises, or frequently a combination of the two. Prism may provide more immediate relief, but requires the patient to wear spectacles, while vision exercises take a bit longer to provide relief, but frequently controls the problem long term by building up convergence ability. Likewise, accommodative difficulties may be treated by giving the patient "reading lenses" just as would be done for presbyopic patients. However, many patients may respond well to controlled vision exercises that emphasize using the ciliary muscle to rapidly change the shape of the crystalline lens. Vision exercises for either condition are normally completed within 6 -12 weeks, most of which is home-based therapy. There is evidence to suggest that improved binocular coordination and visual perceptual skills can hasten progress in other rehabilitative programs. However, it should be noted that concurrent patient problems such as easy fatigability, visual field loss, sensory fusion disruption and cognitive impairment could negatively impact prognosis for successful vision therapy.

Spectacles provide a passive solution for both of these problems, an option that is very valuable in patients who have multiple dysfunctions following TBI since not all providers have the benefit of passive options for their therapy. Glasses can provide rapid relief while the patient concentrates on spending time working with physical, occupational or speech therapists for problems necessitating active therapy. Moreover, prism may usually be incorporated into the same lenses that provide relief for the accommodative problem.

The third frequently encountered symptom is dry eye. Patients may be surprised at this diagnosis, pointing out that their eyes frequently tear – so how could they be dry? The conflict here is due to a misunderstanding of what eye doctors mean by "dry eye." The eye as an optical system requires the front portion (the cornea) to be lubricated to function optimally. Normally there are three layers to this lubrication: the tears, a mucin layer and an oily layer. The latter two keep the tear layer from evaporating. Blinking greatly helps to distribute these layers. However, when something happens to disrupt the protective layers the tears rapidly evaporate. \In response, the body produces reflex tears in an attempt to maintain lubrication. Unfortunately, without the viscous protective layers, the evaporation process continues. The problem is compounded because people blink less during tasks requiring concentration such as reading. This is known as "evaporative" dry eye. There also may be a reduction of the tear layer known as "aqueous deficient" dry eye. Patients with dry eye may report symptoms ranging from viewed objects going in and out of focus (sounding like accommodative dysfunction), itching, burning or "sandy/gritty" feeling, to actual soreness or pain.

Treatment for dry eye has traditionally been aimed at replenishing the moisture in the eye and delaying evaporation. This is accomplished by use of artificial tears of varying viscosity. These should be used frequently and regularly during early therapy; as the condition is controlled and the corneal epithelium healed, the lubricants can be used as needed. Very low dose topical steroids coupled with Restasis may hasten recovery. When the problem appears due to meibomian gland dysfunction, oral doxycycline is helpful as are Omega 3 fatty acid supplements. Finally, the placement of punctual plugs, a very quick in-office procedure, reduces the drainage of tear film and allows for longer contact with the corneal surface. These plugs have the additional advantage of freeing the patient from regular compliance with eye drops and are particularly useful for patients with poor hand coordination who have difficulty installing drops.

These three conditions, frequently overlooked by clinicians, negatively impact the mTBI patient's quality of life. However, the symptoms can be greatly reduced or eliminated by treatment from the appropriate eye care practitioner. ❖

Legislative Update

HB 2494 (recently filed) creates a private right of action, (and authorize class actions), for "any person who suffers an ascertainable loss of money or property, real or personal, as a result of any act or omission prohibited by this chapter (Chapter 746 – Insurance Code)….".

Recoverable damages would be actual damages or $200 – whichever is greater. So even a nominal loss of money (postage, etc.) would mean a minimum recovery of $200 could be pursued. Statutory damages ($200) are recoverable in class actions.

This bill would create a private right of action for any alleged violation of the Unfair Claims Settlement Practices statute (essentially creating First and Third Party Bad Faith).

To view the text of HB2494 go to:
www.leg.state.or.us/11reg/measpdf/hb2400.dir/hb2494.intro.pdf

Actual summary from the bill:
Permits person to bring action against insurer or other person that commits unlawful insurance practices. Directs court to award attorney fees in certain circumstances. Allows class actions against persons committing unlawful insurance practices. Establishes one-year statute of limitations for actions against unlawful insurance practices. ❖