NOT DESIGNATED FOR PUBLICATION

MELISSA LEBOEUF	*	**NO. 2008-CA-1351**
VERSUS	*	
		COURT OF APPEAL
B & K CONTRACTORS, INC., GEMINI INSURANCE COMPANY AND DELGADO COMMUNITY COLLEGE	*	**FOURTH CIRCUIT**
		STATE OF LOUISIANA

*** * * * * * ***

CONSOLIDATED WITH:	**CONSOLIDATED WITH:**
DAVID K. BROOME	**NO. 2008-CA-1352**
VERSUS	
EDWARD PORTE, B & K CONTRACTORS, INC. AND GEMINI INSURANCE COMPANY	

APPEAL FROM
CIVIL DISTRICT COURT, ORLEANS PARISH
NOS. 2004-12740 C/W 2004-12746, DIVISION "B-15"
Honorable Rosemary Ledet, Judge
* * * * * *

Judge Patricia Rivet Murray
* * * * * *

(Court composed of Judge Patricia Rivet Murray, Judge James F. McKay, III, Judge Edwin A. Lombard)

MCKAY, J., CONCURS IN THE RESULT

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AFFIRMED

This is a personal injury suit. The plaintiffs, David Broome and Melissa LeBoeuf, filed this suit seeking to recover for the personal injuries they sustained as a result of being struck by a ladder that an employee of the defendant, B & K Contractors, Inc. ("B&K"), hurled over a fence. The trial court granted partial summary judgment on the issue of the liability of the defendants, B&K and its insurer, Gemini Insurance Company ("Gemini"). Following a trial on the issue of damages, the trial court rendered judgment awarding damages of $761,860.94 to Mr. Broome and $133,027.74 to Ms. LeBoeuf. From that judgment, B&K and Gemini appeal. For the reasons that follow, we affirm.

FACTUAL AND PROCEDURAL BACKGROUND

On September 4, 2003, Mr. Broome and Ms. LeBoeuf, who were classmates, were working together on a project in an herb garden at Delgado Community College, City Park Campus. Without warning, Edward Porte, an employee of B&K, tossed a large aluminum ladder over the brick fence located adjacent to the herb garden in which they were working. The ladder struck Mr. Broome on the head and Ms. LeBoeuf in the neck area. As a result of the impact, both of them fell to the ground and sustained injuries. Mr. Broome had a cut on the head and was

bleeding. Ms. LeBoeuf instructed him not to move and went to get help. When she returned in about two or three minutes, Mr. Broome had not moved. Ms. LeBoeuf, a teacher, and another student assisted Mr. Broome from the ground into a classroom. After reporting the accident to the campus police, Ms. LeBoeuf drove Mr. Broome to the Ochsner emergency room. Both Mr. Broome and Ms. Leboeuf were treated for their injuries and released that day.

On September 2, 2004, Ms. LeBoeuf filed suit against B&K, Gemini, and Delgado Community College ("Delgado"). On that same date, Mr. Broome filed suit against Mr. Porte, B&K, and Gemini. On May 9, 2007, the trial court consolidated the two suits. Following a hearing, the trial court in January 2008 rendered a partial summary judgment in favor of Mr. Broome and Ms. LeBoeuf as to liability.

In June 2008, a two-day bench trial was held on the issue of damages—the nature and degree of the injuries sustained by Mr. Broome and Ms. LeBoeuf. On the morning of trial, Ms. LeBoeuf dismissed her claims against Delgado.

In July 2008, the trial court rendered judgment in favor of Mr. Broome and Ms. LeBoeuf and against B&K and Gemini.[1] As to Mr. Broome, the trial court awarded total damages of $761,860.94, which it itemized as follows: $400,000 general damages, $100,000 loss of enjoyment of life, $20,160.94 past medical expenses, and $241,700 future medical expenses. As to Ms. Leboeuf, the trial court awarded total damages of $133,027.74, which it itemized as $125,000 general damages and $8,027.74 past medical expenses. The trial court denied the motion for new trial filed by B&K and Gemini. From this judgment, B&K and

[1]Although Mr. Broome's petition names Mr. Porte (B&K's employee who threw the ladder) as a defendant, the trial court's judgment does not impose liability on Mr. Porte. Mr. Porte is not a party to this appeal.

Gemini appeal contending that the damage awards are excessive. Mr. Broome answered the appeal contending that the damage awards were inadequate and that the trial court erred in failing to award him future loss wages and dimunition of wage-earning capacity.

DISCUSSION

A plaintiff in a personal injury case has the burden of proving by a preponderance of the evidence that the accident more probably than not caused the claimed disabling condition. *Jones v. Peyton Place, Inc.*, 95-0574, pp. 12-13 (La. App. 4 Cir. 5/22/96), 675 So.2d 754, 763. The plaintiff satisfies this burden if expert medical and lay testimony is presented establishing that it was more probable than not that the claimed condition was caused by the accident. *Id.* Whether the accident caused the plaintiff's injuries is a factual question, which should not be reversed on appeal absent manifest error. *See American Motorist Ins. Co. v. American Rent-All, Inc.*, 579 So.2d 429, 433 (La. 1991). Credibility determinations, including evaluating expert witness testimony, are for the trier of fact. *Sportsman Store of Lake Charles, Inc. v. Sonitrol Security Systems of Calcasieu, Inc*., 99-0201, p. 6 (La. 10/19/99), 748 So.2d 417, 421. Such credibility determinations are factual findings governed by the well-settled manifest error standard of review. Under the manifest error rule, a "reviewing court must give great weight to factual conclusions of the trier of fact; where there is conflict in the testimony, reasonable evaluations of credibility and reasonable inferences of fact should not be disturbed upon review, even though the appellate court may feel that its own evaluations and inferences are as reasonable." *Canter v. Koehring Co.*, 283 So.2d 716, 724 (La. 1973).

When, as here, the trier of fact (in this case, the judge) has made a general damage award and the parties are contending that award is excessive (B&K and Gemini) or inadequate (Mr. Broome), the "much discretion" standard applies. *Youn v. Maritime Overseas Corp*., 623 So.2d 1257 (La. 1993). The rationale behind the application of the much discretion standard is that "awards of general damages, at least as to the amount awarded for injuries proved to have been caused by the tort, cannot be calculated with mathematical certainty." *Guillory v. Insurance Co. of North America*, 96-1084, p. 1 (La. 4/8/97), 692 So.2d 1029, 1036 (Lemmon, J., concurring)(citing *Viator v. Gilbert*, 253 La. 81, 216 So.2d 821 (1968)). This rationale is codified in both La. C.C. art. 1999, which provides that "[w]hen damages are insusceptible of precise measurement, much discretion shall be left to the court for the reasonable assessment of these damages," and La.C.C. art. 2324.1, which provides that "[i]n the assessment of damages in cases of offenses, quasi offenses, and quasi contracts, much discretion must be left to the judge or jury."

A reviewing court's initial inquiry is whether the particular effects of the particular injuries on the particular plaintiff are such that there has been an abuse of the "much discretion" vested in the trier of fact. *Youn*, 623 So.2d at 1260; *Cone v. National Emergency Services, Inc.*, 99-0934, p. 8 (La. 10/29/99), 747 So.2d 1085, 1089 (citing *Youn, supra,* and noting that the abuse of discretion standard is difficult to express and necessarily is "non-specific"). Because "[r]easonable persons frequently disagree about the measure of general damages in a particular case," a reviewing court may disturb a general damage award on appeal only when "the award is, in either direction, beyond that which a reasonable trier of fact could assess for the effects of the particular injury to the particular plaintiff under the

particular circumstances." *Youn*, 623 So.2d at 1261. In sum, the jurisprudential theme that has emerged is that "the discretion vested in the trier of fact is 'great,' and even vast, so that an appellate court should rarely disturb an award of general damages." *Id.*

Although the parties invite us to resort to a consideration of awards for generically similar injuries and contend that the awards in this case are disproportionate to such prior awards, the jurisprudence is settled that a "resort to prior awards is only appropriate after an appellate court has concluded that an 'abuse of discretion' has occurred." *Cone*, *supra*; *Reck v. Stevens*, 373 So.2d 498, 501 (La. 1979). Because we find no abuse of discretion, a comparison of prior awards is inappropriate. Instead, we focus our analysis of the effects of the particular injuries on the particular plaintiffs under the particular circumstances of this case. We divide our analysis into the following three sections: (1) Defendants' Appeal: Mr. Broome's Damages; (2) Mr. Broome's Appeal: His Damages; and (3) Defendants' Appeal: Ms. LeBoeuf's Damages.

(1) Defendants' Appeal: Mr. Broome's Damages

At trial, Mr. Broome called the following seven witnesses: (i) Dr. Morteza Shamsnia, a neurologist; (ii) Dr. Gerard Gianoli, a neurotologist; (iii) Dr. Susan Andrews, a neuropsychologist; (iv) Shael Wolfson, an economist; (v) Ms. LeBoeuf; (vi) Jessica Guntner, Mr. Broome's girlfriend; and (vii) Mr. Broome. B&K and Gemini called the following two witnesses: Dr. Donald Adams, the independent medical examiner ("IME") and a neurologist; and Dr. Kevin Bianchini, a clinical psychologist and neuropsychologist. The testimony of these witnesses is summarized below.

Dr. Morteza Shamsnia

On September 9, 2003, Dr. Shamsnia, who was qualified by the trial court as an expert in neurology, first saw Mr. Broome. Mr. Broome provided a history of a head trauma five days earlier as a result of being struck on the head by a ladder while at a local college. Mr. Broome reported that he lost consciousness and fell to the ground. Mr. Broome further reported that he did not recall what happened to him until he was in the car on his way to the hospital. Mr. Broome complained of headaches in the temporal area, which occurred every day since the accident with some nausea. He also complained of difficulty sleeping and focusing in his classes since the accident. He reported that his school performance had dropped. Mr. Broome denied any other significant associated symptoms. Dr. Shamsnia found that Mr. Broome had a head trauma in that he had a cut of more than an inch, which required three or four stitches.

Dr. Shamsnia's initial impressions were post-concussion syndrome with post-traumatic headaches and sleep dysfunction or central sleep disorder. Dr. Shamsnia restricted Mr. Broome by instructing him to stay off of school for two weeks. (Dr. Shamsnia acknowledged that this was the only restriction that his records reflected he ever placed on Mr. Broome.) Based on Mr. Broome's complaints, Dr. Shamsia ordered diagnostic testing: a MRI of the brain, an EEG or brain wave, and sleep studies. He also instructed Mr. Broome to return for a follow-up evaluation in two weeks.

On September 15, 2003, the MRI was done; it was normal. On October 9, 2003, the EEG was done; it was normal. On October 18, 2003, the sleep study (polysomnogram) was done; as noted below, it was abnormal.

On November 17, 2003, Dr. Shamsnia saw Mr. Broome for a second time. On this visit, Dr. Shamsnia reviewed the abnormal results of the sleep study, which

reflected that Mr. Broome had periodic limb movements and early rapid eye movement (REM), which indicated that his sleep structures were impaired. Dr. Shamsnia testified that these sleep abnormalities probably were related to Mr. Broome being struck in the head with the ladder. He also noted that Mr. Broome continued to have difficulty sleeping and that his other symptoms were essentially unchanged. Dr. Shamsnia prescribed Klonopin, a sleep medication, and instructed Mr. Broome to return for a follow-up evaluation in eight weeks.

On March 22, 2004, Dr. Shamsnia saw Mr. Broome a third time. Mr. Broome reported that his headaches had decreased in frequency, but he complained of dizziness and vertigo with head movements and intermittent ringing in his ears. Dr. Shamsnia testified that it was not unusual for Mr. Broome to complain for the first time six months post-head trauma of vertigo. He noted that Mr. Broome had signs of ear problems on the initial visit at which he complained of dizziness and that subsequently Mr. Broome had dizziness plus other symptoms—vertigo or ringing in his ears. Dr. Shamsnia testified that "whatever happened in his ear was getting worse." For this reason, Dr. Shamsnia referred Mr. Broome to Dr. Gianoli for a neuropathology evaluation after his head trauma. Dr. Shamsnia prescribed Tylenol No. 3 for the headaches and instructed Mr. Broome to see him for a follow up evaluation after he had completed his consultation with Dr. Gianoli.

On September 8, 2004, six months later, Dr. Shamsnia saw Mr. Broome for a fourth time. On this visit, Mr. Broome's symptoms had improved, and Dr. Shamsnia characterized him as "essentially neurologically asymptomatic." By "neurologically asymptomatic," Dr. Shamsnia explained he meant that Mr. Broome did not have "much symptoms." He noted, however, that symptoms fluctuate. Dr. Shamsnia also noted that Mr. Broome had seen Dr. Gianoli for his

ringing in the ear.[2] On that visit, Dr. Shamsnia discharged Mr. Broome from his clinic and instructed him to return as needed.

Two months later, on November 24, 2004, Mr. Broome returned to Dr. Shamsnia. On this fifth visit, Mr. Broome complained of increased headaches, which were occurring about three times per week, and ringing in his ears. After reviewing Mr. Broome's diagnostic testing, Dr. Shamsnia referred Mr. Broome back to his regular work and instructed him to return for a follow up evaluation in eight weeks.

On July 26, 2006, almost two years later, Dr. Shamsnia saw Mr. Broome for a sixth time.[3] On this visit, Mr. Broome complained of increased headaches, which were occurring about two days per week. Mr. Broome's other symptoms were unchanged. Mr. Broome reported that he had been taking Ibuprofen and Tylenol #3. Dr. Shamsnia prescribed Topamax (a seizure medication that the FDA has approved for use in treating migraine headaches) and provided Mr. Broome with samples of other medicines (Imitrex and Zomig). Mr. Broome was instructed to return for a follow up evaluation in eight weeks.

On June 6, 2007, Dr. Shamsnia, without actually seeing Mr. Broome, prepared a narrative report in which he stated that "[i]n the last few years, the patient has been asymptomatic with medications." Continuing, he stated:

> The patient's diagnosis is first concussion syndrome with posttraumatic headaches, as well as abnormal sleep including periodic limb movement disorders and abnormal sleep deficiencies since the head trauma.

[2] As discussed elsewhere, Dr. Gianoli saw Mr. Broome on two occasions: June 10, 2004, and February 27, 2008.

[3] As noted elsewhere in this opinion, this two year gap in treatment can be attributed, at least in part, to Hurricane Katrina, which struck the New Orleans area on August 29, 2005.

> Based on the patient's history of the head trauma, his symptoms and his findings are causally related to his accident of 09/04/2003. I am not aware of the other workup that this patient had. He will be required to be under the care of a physician for treatment of his symptoms especially in regard to his headaches, and if he continues to have intermittent ringing in his ears and vertigo, he will need to have a neurootology [(sic)] evaluation. He has not reached maximum medical improvement. His condition has become chronic, and will require treatment on a regular basis. He will need approximately an every two or three month follow-up visit with medication treatment including prevention, as well as pain medications for treatment of his headaches. It is difficult to assess the future medical bills, but his treatment for chronic headaches and the medications that he needs will be approximately $2,000.00 to $3,000.00 a year, and he may require further diagnostic workup including a new high-resolution MRI of the brain with 3.0 tesla resolution for a better evaluation of his head injury.

Dr. Shamsnia explained that he characterized Mr. Broome's condition as chronic because "on and off when [he] had seen him, [Mr. Broome] was symptomatic. That is what chronic condition means."

On July 16, 2007, Dr. Shamsnia saw Mr. Broome for the seventh time. On this visit, Mr. Broome reported that the migraine headaches were well-controlled with the current medical therapy, including Topamax. He further reported that he was having episodes of headaches about three times per week; however, the episodes were not severe and were of a shorter duration. He still further reported that he was continuing to have episodes of vertigo with intermittent buzzing sensation in the left ear. The vertigo episodes were about sixty seconds each and were occurring about three times per week. At this time, Dr. Shamsnia continued the current medication therapy. Dr. Shamsnia also scheduled a repeat MRI of the brain and instructed Mr. Broome to follow up in three months or when the studies had been completed.

On August 16, 2007, Mr. Broome had a high resolution 3.0 Telsa MRI of the brain at the Nevada Imaging Centers in Las Vegas, Nevada.[4] According to the report by Dr. William Orrison of Nevada Imaging Centers, Mr. Broome's MRI reflected three findings consistent with post-traumatic changes: (i) moderate bilateral hippocampal atrophy, (ii) dilated perivascular (Virchow-Robin) spaces, and (iii) decrease in corpus callosum fiber tracks. Dr. Shamsnia characterized this MRI as objective evidence of traumatic brain injury. Dr. Shamsnia pointed out that the hippocampus is located in the temporal lobe of the brain and is responsible for regulating emotional response. He testified that atrophy of the hippocampus will affect Mr. Broome's ability to retain and process information as he ages. He further testified that due to the head trauma Mr. Broome will be more susceptible to memory and emotional problems as he ages. His ability to deal with the daily stress of life and to adapt into his environment will diminish faster than others his same age that do not have this problem.

On December 3, 2007, Dr. Shamsnia saw Mr. Broome for the eighth time. On this visit, Mr. Broome complained of migraine headaches, tinnitus, and vertigo. His migraine headaches were occurring at least three times per week. Dr. Shamsnia noted that Mr. Broome indicated that "things are improving." He further noted that the neuropsychological tests had been completed by Dr. Andrews in October 2007. The neuropsychologist's findings, which are discussed elsewhere, indicated that Mr. Broome should be encouraged to continue to be mentally active and should be able to continue in his present occupation. On this visit, Dr.

[4] Dr. Shamsnia explained that the reason he referred Mr. Broome to the Nevada Imaging Centers for the MRI was because "Nevada is in the forefront of the head injuries because of the boxing . . . and Nevada apparently is one of the centers that has been a pioneer in this area." Dr. Shamsnia further noted that he had been using Nevada Imaging Centers for years because he gets a comprehensive, detailed report from them.

Shamsnia continued Mr. Broome on Topamax and added Axert as a "rescue medication." Mr. Broome was instructed to follow up in three months.

On March 12, 2008, Dr. Shamsnia saw Mr. Broome for the last time before trial. At this time, Mr. Broome reported that his symptoms were improving and that his migraine headaches were well-controlled with Topamax. Mr. Broome further reported that "he has not had any migraines as long as he takes his medications, although if he happens to forget, the Axert medication is helping as a rescue medication." Dr. Shamsnia refilled Mr. Broome's medication and instructed him to follow up in three months.

Although Dr. Shamsnia hesitated to testify that Mr. Broome would be required to take medication for life, he testified that Mr. Broome would be required to take it for "an indefinite period of time." Dr. Shamsnia testified that the particular medication he was prescribing for Mr. Broome's headaches was expensive: the Topamax cost between $297.99 and $345.95 for a month supply, and the Axert cost between $133.96 to $163.95 for a supply of six pills ($22.32 to $27.32 per pill).

Dr. Shamsnia testified that the symptoms Mr. Broome periodically reported to him were consistent with the diagnosis of traumatic brain injury. According to Dr. Shamsnia, the most probable cause of Mr. Broome's traumatic brain injury was being struck in the head with the ladder in 2003. Characterizing Mr. Broome's conditions as permanent, Dr. Shamsnia testified:

> I think it's permanent because he had the MRI done four years after his brain injury. We give now a year or two for him to recover. And people do recover. Clinically, he has recovered. He has improved. Treated with medications, he improved. But, these new technologies allow us to look at the brain that we couldn't do it before and say what it is now. . . . So he has brain damage because of this. And I think he has reached what we call MMI, maximum medical improvement.

Dr. Shamsnia further added that Mr. Broome's symptoms may "wax and wane, but they just don't go away."

Dr. Shamsnia testified that he saw no evidence of any exaggerating or malingering on Mr. Broome's part. He further testified that he never had the feeling that Mr. Broome was lying or exaggerating or having symptoms that were inconsistent with what happened to him. Finally, he testified that Mr. Broome's symptoms and the fact he had a brain injury were verified by, among other things, the 2007 MRI and the neuropsychological testing.

Dr. Gerald Gianoli

Dr. Gianoli was qualified by the trial court as an expert in neurotology, a subspecialty of the ear, nose, and throat that deals specifically with the ear and the inner ear and skull-based disorders. On June 10, 2004, Dr. Gianoli first saw Mr. Broome, who was referred to him by Dr. Shamsnia. Dr. Gianoli testified that Mr. Broome related to him that he had suffered a head injury after a ladder fell on his head resulting in a loss of consciousness for a couple of minutes and a laceration of his scalp. Mr. Broome's complaints were dizziness, tinnitus, and headaches. Mr. Broome indicated that the dizziness was much more severe during the first two months after the accident and had improved considerably since then, but he still had symptoms of dizziness.[5] At that time, Mr. Broome's dizzy spells were lasting about ten seconds per episode and were occurring about once per week. These episodes were sometimes associated with nausea and tylism, which is that sort of excess salivation one gets before throwing up.

[5] Dr. Gianoli explained that dizziness is a nonspecific term that can mean many different things ranging from lightheadedness to headaches. In contrast, he explained that vertigo is a medical term with a specific meaning: "it's hallucination of motion. More specifically, it usually means a rotary type motion, feel like things are spinning or

Mr. Broome related that the activities that exacerbated his symptoms were fast head movements, coughing, straining, using inversion boots, and running. He also related that especially during the first two months after the accident almost any head movement would bring on the symptoms. Mr. Broome reported some fluctuation of hearing and a fullness or pressure feeling in his ears. Dr. Gianoli testified that he did not make any specific recommendations to Mr. Broome with regard to physical activities; however, he generally tells patients who present with vertigo or dizziness to use extreme caution when engaging in certain activities. He also testified that he probably told Mr. Broome to stop using inversion boots.

Based on a series of diagnostic tests that he conducted, Dr. Gianoli's initial impressions were as follows: "[Mr. Broome] had a mild vestibular disturbance that was perhaps on the left side with associated benign positional vertigo that is for the most part compensated and resolved. He also has a suggestion of cochlear dysfunction on the left side as noted by the Otoacoustic emissions. This could objectively corroborate the symptom of tinnitus." Dr. Gianoli noted that the treatment for benign positional vertigo is generally canalith repositioning—a non-invasive office procedure that is highly effective (90-95% of patients). For patients who do not respond to this procedure, a surgical procedure was noted to be an option, but required four to six weeks of postoperative rehabilitation. As to the tinnitus, Dr. Gianoli noted that "the tinnitus is likely a permanent sequelae of this injury and treatment for this is often unsuccessful." He noted that treatment options that were available for tinnitus include pharmacologic therapy, tinnitus retraining therapy, and masking devices.

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moving or you're moving or spinning."

On March 6, 2008, Dr. Gianoli saw Mr. Broome for a repeat evaluation.[6] At that time, Mr. Broome related that he still had tinnitus and dizziness, but that it "waxes and wanes, at times it is more severe and other times less noticeable." He described the tinnitus as intermittent, high-pitched, and non-pulsatile, but varying in intensity. As to the dizziness, he described a rotary type sensation that occurs for seconds per episode. He stated that the episodes were occurring multiple times per day. These episodes were associated with nausea and exacerbated by lying down and movement, especially fast movement. He also reported a constant unsteadiness. He indicated that he was having one to two migraines per month and that he was taking Topamax which seemed to help the headaches.

Summarizing his findings from the second evaluation, Dr. Gianoli stated:

> Mr. Broome has findings of an inner ear abnormality consistent with left labyrinthine fistula and benign paroxysmal positional vertigo. This is more probable than not caused by the accident in which the ladder struck his head. The patient's subjective symptoms correlate very well with the objective findings on testing and the patient showed no evidence of symptom magnification or non-physiologic responses on testing.

Dr. Gianoli noted that treatment options include medical therapy and surgery.[7] However, he acknowledged that he had neither provided any treatment nor recommended surgery for Mr. Broome.

Dr. Gianoli testified that Mr. Broome passed all the malingering tests and opined that the blow to Mr. Broome's head was the cause of the ear-related symptoms he was experiencing. Insofar as the several other head injuries in the

[6] Although scheduled for a follow-up visit with Dr. Gianoli in September 2005, Mr. Broome was not available for this appointment because had had moved out of state in late August 2005 due to Hurricane Katrina.

[7] At this time, Dr. Gianoli recommended a CT scan of the temporal bones to rule out superior semicircular canal dehiscense. That CT scan was normal.

past noted in Dr. Gianoli's report,[8] Dr. Gianoli testified that those incidents were in the far distant past and that Mr. Broome was completely asymptomatic from that point until the ladder incident. Dr. Gianoli testified that the fact Mr. Broome had no problems until years later when he was hit by the ladder made it unlikely that any of the prior head traumas had any relevance to his current condition.

Dr. Susan Andrews

Dr. Andrews, who the trial court qualified as an expert in clinical neuropsychology, testified that she saw Mr. Broome on referral from Dr. Shamsnia to conduct a neuropsychological evaluation. On October 16 and 18, 2007, Dr. Andrews' office performed the evaluation. Dr. Andrews noted that Mr. Broome's complaints at the time of the evaluation included migraine headaches (about twice per week), difficulty sleeping since the accident, and vertigo and tinnitus in his left ear. He also reported memory difficulties at school. He elaborated that when the accident occurred he was enrolled at Delgado taking horticulture. Since the accident, he reported that he had significant difficulty memorizing and recalling new information in the more difficult classes and that he had quit school.

Dr. Andrews testified that her neuropsychological evaluation showed evidence of a traumatic brain injury. Of the twenty-three tests she administered, Mr. Broome's test results were abnormal on thirteen. Mr. Broome scored lower than predicted on five measures: (i) general intellectual functioning, (ii) measures of attention and executive functioning, (iii) motor functions, (iv) language functions, and (v) perceptual functions. Mr. Broome had some difficulties with his

[8] These incidents involved being struck by a bat at age eight, by a bottle at age twenty, by a brick, and running into a car. None of these prior incidents involved loss of consciousness. Dr. Bianchini also noted in his report that Mr. Broome gave a history of head injury as a child with no loss of consciousness: "He was hit in the head a few times while paying with his brothers. One time he was on a bicycle and his brother pushed him and his head hit the back

ability to learn new information and with his executive functioning in certain areas. He had right hand motor weakness related to his left side of his brain. He had difficulties with attention and concentration. His naming was mildly impaired on the Boston naming test.

Dr. Andrews testified that in her opinion it was more probable than not that Mr. Broome's performance on the tests was related to the 2003 head trauma he suffered as a result of being struck in the head with a ladder. She stated that she had not seen any indication that before being struck with the ladder Mr. Broome had any brain injury. She indicated that the test results reflected residual difficulties related to the 2003 head trauma. Dr. Andrews commented that "[b]asically, they were mild findings that demonstrated four years later that the left side of the brain primarily had been damaged."

As to the Minnesota Multiphasic Personality Inventory ("MMPI")(a social-emotional functioning test), Dr. Andrews testified that it reflected Mr. Broome had a large number of physical complaints, which included headaches that had continued for a number of years and inner ear dysfunction. He was not particularly depressed. Dr. Andrew testified that her clinical impression was that Mr. Broome had a cognitive disorder, not otherwise specified, which is a general diagnosis that is used for cognitive deficits that are secondary to some kind of brain dysfunction, but not necessarily related to drugs or related to other physical kinds of problems. Dr. Andrews found no basis to support Dr. Bianchini's diagnosis of an adjustment disorder. She testified that Mr. Broome had made a good adjustment to his injuries

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of a vehicle; he got a knot on his head."

and to the residual deficits that he had. She found it significant that he was working and going on with his life.

Dr. Andrews stated in her report that Mr. Broome "appears excessively preoccupied with bodily concerns and may be inclined to somatization, e.g., expressing physical health problems as a result of psychological difficulties." She explained that Mr. Broome had a high score on the somatization scale because he tends to focus on the large number of physical complaints that he has. Nonetheless, Dr. Andrews testified that a diagnosis of somatization was not appropriate given that Mr. Broome actually had physical injuries.

Dr. Andrews reported that Mr. Broome's test results were consistent with the results of the 2007 MRI and the location of Mr. Broome's scalp laceration. She noted that one of the results of the 2007 MRI was a decrease in corpus callosum fiber tracks connecting the two sides of the brain consistent with post-traumatic change. She explained that this referred to a decrease in fiber tracks anteriorly and posteriorly on the left in a coupe-contre-coup pattern. Dr. Andrews further explained that coupe-contre-coup is French for a strike and against the strike or a hit against the hit. It refers to the mechanism of the injury. "[T]he brain is hit on one side and it bounces against the opposite side causing, from a variety of different sources, injury on both sides of the brain." Dr. Andrews testified that her findings based on neuropsychological test results were consistent with the coupe-contre-coup type of injury that Mr. Broome sustained in that the testing revealed some deficits on both sides of the brain.

In terms of memory difficulties, Dr. Andrews testified that Mr. Broome tested in the normal range. She noted in her report that "[c]ontrary to subjective complaints of memory difficulties, Mr. Broome's current memory abilities are

average and consistent with current intellectual functioning." Explaining this statement, Dr. Andrews testified that "[p]eople who have cognitive difficulties of various types, because they are not schooled in neuropsychology, often just kind of lump them together as memory complaints." Insofar as Mr. Broome's report that he was having more difficulty in school, Dr. Andrews testified that based on Mr. Broome's Delgado records it would be hard to document any decline.

On cross-examination, Dr. Andrews testified that she agreed there was no way for a "brain injury" to become neurologically asymptomatic and then symptomatic again several years later, but she added that "headaches are a different issue."

On all of the testing for exaggerating or malingering, Dr. Andrews testified that Mr. Broome scored one hundred percent. She agreed that this indicated that he was being truthful and candid in communicating his symptoms. Dr. Andrews testified that from a brain injury standpoint she would consider Mr. Broome's condition to be mild. She noted in her report that Mr. Broome had significantly improved in function since the accident, which was over four years before this evaluation. She opined that from a neuropsychological standpoint, Mr. Broome was capable of continuing in his present occupation. She further opined that Mr. Broome did not need any type of rehabilitation given that he has continued to work, which she characterized as a "very solid form of rehabilitation." Indeed, she found it to his credit that he is working. She did not recommend any restrictions on him in terms of work. Nonetheless, she testified that as Mr. Broome gets older, he will have a greater risk for developing dementia-type syndromes earlier.

Shael Wolfson

Mr. Wolfson, who was qualified as an expert economist, testified that he was provided with a letter from Dr. Gianoli outlining certain future medical and prescription costs and asked to prepare present value estimates for these costs over Mr. Broome's life expectancy. Based on Mr. Broome's life expectancy of 44.4 years and a 4.5% annual increase in the cost of prescription drugs, Mr. Wolfson calculated the present value of future prescription medication costs for the two medications Mr. Broome was taking to be $5,651 per year and $223,736 total.[9] Mr. Wolfson also calculated Dr. Gianoli's follow up costs for office visits and audio testing to be $225 a year and $8,041 for his life expectancy in present value terms assuming a four percent increase in the fees associated with providing these services.

Melissa LeBoeuf

Ms. LeBoeuf, the other plaintiff in this matter, testified that at the time of the accident she and her classmate, Mr. Broome, were bent over in the herb garden at Delgado observing a honey bee when an object hit them and knocked them to the ground. She described it as a shock. She testified that they initially did not know what the object was or where it came from. Ms. LeBoeuf described Mr. Broome immediately after the accident as lying on the ground with a large cut on his head that was bleeding; he was glassy eyed, and dazed. She testified that "[i]t was obvious – he was not all there." He had no recollection of what had happened. On cross-examination, Ms. LeBoeuf acknowledged that she could not say for sure that Mr. Broome lost consciousness; nor, assuming he lost consciousness could she give an estimate of how long it lasted.

[9] As noted earlier, Dr. Shamsnia testified that at the time of trial Topamax cost between $297.99 and $345.95 for a month supply, and Axert costs between $133.96 to $163.95 for a supply of six Axert ($22.32 to $27.32 per pill).

At trial, Ms. LeBoeuf identified pictures of the large aluminum ladder that was thrown over the fence and the laceration on Mr. Broome's head. Ms. LeBoeuf testified that before the accident Mr. Broome was in good physical shape, very active, and enjoyed being outside. He liked physical activities such as skateboarding. She further testified that before the accident she never heard Mr. Broome complain of headaches or ringing in his ears. She stated that when Mr. Broome returned to school after the accident he complained about headaches, and due to the headaches he would have to get up and leave class.

Jessica Guntner

Ms. Guntner, Mr. Broome's girlfriend, testified that she lived with Mr. Broome and their two children, ages two and one. (The children bear Mr. Broome's name.) She knew Mr. Broome for about one year before the accident; they started living together shortly before the accident occurred. Ms. Guntner was working when the accident occurred, and Mr. Broome called her to inform her that he had been hurt. She first saw him when she arrived home from work that night. She described him as having a big gash on his head with stitches and a patch over it. He was not moving around much, and he was nauseous and sleepy. She testified that she was afraid to let him go to sleep that night because of his head injury. According to Ms. Guntner, Mr. Broome was unable to return to school or to work for the next couple of weeks, and she had to drive him to his doctor's appointments.

Ms. Guntner testified that Mr. Broome has been taking Topamax on a daily basis since it was prescribed to him and that he also takes Axert, which is for bad headaches, about three times per week. She testified that she has picked up his

prescription medications several times, and she identified a receipt for Axert for $1,339.59.

Ms. Guntner testified that she has noted the following changes in Mr. Broome's behavior since the accident: He often complains of headaches. He gets dizzy and nauseous when he overexerts himself such as when he plays with their little boy. (The dizziness is followed by a headache.) He forgets things that she has just told him and that he is definitely a "lot more flighty." He kicks in his sleep as if he is fighting in his dreams.

Ms. Guntner characterized Mr. Broome as a very active person before the accident. The hobbies he previously engaged in included working out at the gym, jujitsu, wrestling, and landscaping. As to landscaping, she elaborated that he enjoyed putting koi ponds together, building retention walls, and working in the yard. Before the accident, Mr. Broome never sat around and watched television. Since the accident, when Mr. Broome comes home from work he wants to sit around. She stated that he has tried to go back to the gym, but he comes home sick with a migraine and has to miss work. Before the accident he did not miss work on a regular basis. She noted that Mr. Broome has gained weight (about four pants sizes) since the accident, which depresses him.

Ms. Guntner testified that when they moved to North Carolina after Hurricane Katrina Mr. Broome did not seek medical attention because they had a baby and ran out of money. Although she acknowledged that Mr. Broome was tasered by the police on May 17, 2007, Ms. Guntner testified that Mr. Broome's

complaints did not change after the taser incident.[10] Rather, she testified that his condition consistently has stayed the same since the 2003 accident.

David Broome

Mr. Broome, who was thirty-two at the time of trial and twenty-seven at the time of the accident, confirmed Ms. Guntner's testimony that they live together with their two young children. At the time of trial, Mr. Broome was employed full time as a lead greensman for a union; his job consists of supervising the building of sets for movies. He characterized himself as an average student. He obtained a General Equivalency Diploma ("GED"). When the accident occurred, in September 2003, he was enrolled at Delgado in horticulture. He testified that he subsequently quit school without obtaining a degree from Delgado.

Mr. Broome corroborated Ms. LeBouef's testimony that at the time of the accident they were working together in an herb garden at Delgado. The next thing he recalled was being driven by Ms. LeBouef to the hospital and asking her what happened. He recalled neither the accident nor the visit to the Ochsner emergency room. On cross examination, Mr. Broome disputed the accuracy of the Ochsner emergency room records insofar as those records indicated that he denied a loss of consciousness. He testified when he got home that night he felt dizzy and that Ms. Guntner took care of him after the accident.

Mr. Broome indicated that his primary problem following the accident was painful headaches. Dr. Shamsnia was the first doctor he saw following the emergency room visit. Dr. Shamsnia told him that he had migraine headaches. A

[10] Mr. Broome testified that the taser incident occurred when he and Ms. Guntner were having a domestic dispute, and Ms. Guntner called the police. Ms. Gunter acknowledged that Mr. Broome was charged with disturbing the peace, battery of a police officer, and resisting arrest. Mr. Broome testified that he has never been convicted of a felony.

few months later, he also developed ringing in the ear, tinnitus. Mr. Broome described the tinnitus as a hit and miss symptom, which occurred sometimes once per week, but then it stopped for a few weeks. Mr. Broome also indicated that he had a short-term memory problem. Ms. Guntner would catch him slipping and forgetting things that she just told him five minute earlier. He testified that the doctor's testimony that the testing revealed he has a traumatic brain injury made him scared for his family.

At the time of trial, Mr. Broome testified he was still being treated by Dr. Shamsnia and Dr. Gianoli. Mr. Broome testified that he was taking two medications for his headaches: Topamax and Axert. Mr. Broome estimated that he has to take an Axert about once or twice a week. Mr. Broome identified his medical expenses, which totaled $20,160.94.

Mr. Broome denied having any prior medical problems. He testified that the prior head injuries that he reported to Dr. Gianoli were incidents in which he was "just rough housing with his older brother." On those prior occasions, he was not knocked out, did not receive medical treatment, and did not experience any subsequent headaches or ringing in the ears. Mr. Broome also denied any head injury as a result of the taser incident; rather, he testified that when he was tasered he landed on his butt.

Addressing the gaps in treatment, Mr. Broome attributed a large gap to Hurricane Katrina. During that period, he had no medical insurance, and his priority was getting a job and paying his bills not reconnecting with his doctors. He acknowledged that the gap from September 2004 to August 2005 was not related to Hurricane Katrina.

Before this accident, Mr. Broome testified that he rarely missed work. Since the accident, he has missed work multiple times due to migraine headaches. He estimated that he has missed up to two months of work. Mr. Broome testified that before the accident he was in great health. He described his prior hobbies as including martial arts, landscaping, working out at the gym, skateboarding, jogging, and participating in biathlons. Mr. Broome testified that since the accident he has gained about fifty pounds (from 180 to 230 pounds). He attributed this weight gain to his inability to engage in physical activities since the accident. He explained that he gets very sickly when he moves around a lot. When he plays with his children, he readily becomes tired and has to rest. Mr. Broome testified that his physical appearance has changed since the accident. Not only has he gained weight, but also he still has a scar on his head from the ladder striking him.

Dr. Donald Adams

Testifying for the defendants, Dr. Adams, who was qualified as an expert in neurosurgery, stated that he was retained to perform an IME on Mr. Broome. Dr. Adams testified that according to the medical literature an assessment immediately or very shortly after a head injury is crucial.[11] Dr. Adams thus focused on the Ochsner emergency room records regarding Mr. Broome's treatment immediately following the accident. The emergency room records reflect that Mr. Broome complained of a laceration to the head, which Dr. Adams characterized as a "small scalp laceration." Mr. Broome told both the triage nurse and emergency room

[11] Dr. Adams identified several well accepted categories in the medical literature for measuring the severity of sports injuries or brain injuries. One category widely used by emergency personnel is the Glasgow Coma Scale, which ranges from 3 to 15, with 15 being normal. Another category is based on the length of altered consciousness; less than thirty minutes is characterized as a mild traumatic brain injury. All of these categories depend on an assessment immediately or shortly after the injury occurring, such as in the emergency room. Dr. Adams noted that in sports, if a player has a mild brain injury that clears within fifteen minutes, the player is sent back into the game.

physician that he had not been knocked out; he specifically denied loss of consciousness, headache, vomiting, and neck pain. Dr. Adams noted that the emergency room staff did not note Mr. Broome to be confused and did not note any other complaints referable to a head injury. Dr. Adams further noted that the emergency room staff neither made a concussion diagnosis, nor ordered a MRI, which is part of the standard workup on an acute basis for someone who has been unconscious. Rather, the emergency room staff sutured Mr. Broome's head laceration and discharged him. Dr. Adams still further noted that on September 15, 2007, when Mr. Broome returned to Ochsner to have his sutures removed he made no mention of headache, confusion, or vertigo. Although the Ochsner records show that he was discharged that day with a notation "improved with symptoms resolved," he complained on that same date when he went to have an MRI of constant migraines, nausea, dizziness, and balance offset.

Dr. Adams indicated that even assuming that the emergency room staff simply overlooked Mr. Broome's head injury, Mr. Broome had no worse than a mild traumatic brain injury (a mild concussion). Dr. Adams thus concluded in his report that "[s]ince it is generally agreed in the medical literature that the after effects of a concussion produce symptoms that are maximum at or shortly after the injury, it is very difficult to relate his subsequent complaints to this particular injury."

Dr. Adams disputed Dr. Shamsnia's opinion that Ms. Broome's current problems are related to the 2003 accident; he stated:

> The natural history of problems that follow a concussion is that they get better and generally resolve. The symptoms of what has been termed the persistent post concussive syndrome are thought in the medical literature to be primarily related to medication overuse or

> psychological issues. In Mr. Broome's case, the records document that his symptoms went away as would be expected.

Dr. Adams further stated that "[a]lthough it took longer than usual for the symptoms following a blow to the head to resolve in this case, they are clearly documented as having gone away." In support of the position that the symptoms went away Dr. Adams cited Dr. Shamsnia's September 8, 2004 office note, which stated that Mr. Broome was "essentially neurologically asymptomatic" and discharged him. Dr. Adams thus concluded that there was "no possible biological mechanism to relate the current problems to the accident in question."

Dr. Adams emphasized that the neuropsychological testing failed to show any difficulties in the areas generally known to be affected by mild traumatic brain injuries. "The anticipated difficulties would most prominently affect attention and concentration and speed of information processing" and possibly short term memory. Although problems with language were noted in the testing, Dr. Adams pointed out that this is not an area of brain function affected by this type of injury and that one would have to review Mr. Broome's prior school records to determine if he had prior problems in this area. Regardless, Dr. Adams pointed out that Mr. Broome acknowledged that his perceived cognitive difficulties had resolved. Insofar as the sleep abnormalities, Dr. Adams stated that injuries of the type Mr. Broome sustained are not associated with permanent changes in brain architecture or sleep function.

As to the 2007 MRI, Dr. Adams disputed the need for Mr. Broome to go to Las Vegas for a MRI. He opined that the local MRI facilities were acceptable and that "[h]igh field strength magnets are necessary to do diffusion tensor imaging studies, but the changes seen with this methodology do not, to date, have any

accepted meaning in the evaluation of brain injury and no consistent correlation with observed changes in function or on psychometric testing." Dr. Adams testified that he did not observe atrophy of the hippocampus on the 2007 MRI film. Although the hippocampus is exquisitely involved in memory functioning, the neuropsychological testing did not show Mr. Broome to have problems with his memory. Dr. Adams noted that when hippocampal atrophy is seen in the general population, the most common causes are alcohol and marijuana use. Dr. Adams also noted that the medical literature supports a finding of hippocampal atrophy in cases involving severe brain injury, not mild head injuries such as the type Mr. Broome sustained.

Dr. Adams also testified that he was unable to observe dilated perivascular spaces on the MRI. He noted that about fifteen to twenty percent of the normal population has some sort of minor white matter abnormality on high resolution MRI scanning. Dr. Adams testified that he thus would not call this an abnormality. He pointed out that this is the reason why it is important to focus on how the brain works and on the neuropsychological tests. He still further noted that in severe brain injury cases where there is atrophy there also is an increased size of the Virchow-Robin spaces.

As to the vertigo, Dr. Adams emphasized that Dr. Shamsnia's records did not reflect a complaint or diagnosis of vertigo until March 2004, six months after the accident. Describing vertigo as a "noxious symptom," Dr. Adams stated that it was unlikely it would have been overlooked. He further noted that "[s]ince vertigo has many potential causes, this delay in onset makes it very difficult to relate the current complaints to the accident of 09/03/2003 in which he was struck in the head by the ladder." Dr. Adams also disputed the notion that Mr. Broome's vertigo

could have improved and then reoccurred and worsened. Dr. Adams noted that when Mr. Broome returned to Dr. Gianoli in 2008 after a four year gap the testing results changed and were consistent with vertigo related to a fistula. According to Dr. Adams, "[v]ertigo related to a fistula would not have latency of onset and would have begun at or very shortly after the accident of September 2003 if it were related to it." He further noted it was unlikely that someone with the symptoms vertigo produces would have gone years without having it evaluated. Dr. Adams also acknowledged that a fistula could develop from any form of direct blow to the ear or from an electrical charge or a taser.

In sum, Dr. Adams' conclusions were as follows:

- The records do not document that Mr. Broome suffered a concussion at the time he was hit in the head in September 2003. Assuming that he was briefly unconscious, or perhaps simply stunned, he was clearly alert, oriented, and coherent with an unremarkable cognitive evaluation within a brief period of time. If one applied the current guidelines for management of concussion in sports, he would have been felt to have a grade 1 or the most minimal concussion, and once the post concussive symptoms had cleared (which they appear to have done by the time he left the emergency department), if an athlete he would have been allowed to return to the football game or whatever contest had been in progress when he was injured.

- Lasting sequellae from an injury of this degree are not expected and probably do not occur in younger individuals. We also know from the medical records that this man's symptoms had resolved by 2004. There is, therefore, no reason to relate the current complaints to the accident in question. By Mr. Broome's own description he no longer has any problems with cognitive processing.

- Given the significant delay in onset of his complaint of vertigo, the significant change in the character of that vertigo, and the new findings on evaluation in 2008, I do not see a basis for relating the current problem with vertigo to the accident involving the ladder.

Although Dr. Adams testified that he did not see any indication that Mr. Broome was not giving a valid effort or malingering, he also testified that he did not see any evidence that Mr. Broome was impaired.

Dr. Kevin Bianchini

The defendants' other expert who testified was Dr. Bianchini, a clinical psychologist and neuropsychologist. Dr. Bianchini testified that he was retained by B&K and Gemini to evaluate Mr. Broome. Dr. Bianchini tested Mr. Broome over the course of a three day period in March 2009. At that time, Mr. Broome attributed the following three symptoms to the accident involving the ladder: (i) dizziness—several things triggered these symptoms, including heights and moving quickly from back to front and anything that jars his head, and he becomes nauseous; (ii) tinnitus—he had constant ringing in his ears; and (iii) headaches—he had migraines and also smaller headaches once or twice a week that lasted for two to three hours.

Dr. Bianchini, like Dr. Adams, testified regarding the importance with brain injuries to focus on the symptoms at the time of the injury. For this reason, he characterized the emergency room report as the most important document. Dr. Bianchini noted that considering the emergency room report from Ochsner, there was no indication that Mr. Broome experienced even the mildest form of traumatic brain injury. Even assuming a brief loss of consciousness, Dr. Bianchini opined that the record does not support a finding of anything more than a mild traumatic brain injury, also known as a concussion. Based on the studies that have been conducted, he noted out that most people (85 to 90%) recover from such injury within a period of months. As to the subset of people who have persistent symptoms, the studies have shown that this group has motivational factors, such as litigation, that are believed to explain their persistent symptoms.

Overall, Dr. Bianchini's opinion was that Mr. Broome did not have residual neurocognitive problems that were attributable to being struck in the head by the

ladder. Dr. Bianchini noted Mr. Broome indicated that he had no problems with concentration, memory, speech, or processing speed; that he was helped from hearing the positive results from Dr. Andrews' testing, presumably meaning that he was not impaired; and that "he has improved and does not have meaningful cognitive impairments at this time." Like Dr. Adams, Dr. Bianchini disputed Dr. Shamshia's conclusion that Mr. Broome had hippocampal atrophy given that Mr. Broome did not have any short term memory deficit. Dr. Bianchini also disagreed with Dr. Andrews insofar as she suggested that the results of her neurological testing were consistent with the location of Mr. Broome's scalp laceration and the 2007 MRI findings. He noted that "Dr. Andrews reports some findings that she indicates are consistent with the mechanism of injury, including consideration of the MRI. Some of these are problems that are not typically impaired as a result of concussion, including motor and language function." Disagreeing, he stated that "the idea of relating a set of neuropsych findings to a scalp laceration is not supported by the literature."

In response to the trial court's question regarding what he would attribute the problems in Mr. Broome's testing results, Dr. Bianchini testified that:

> The naming, the lowered verbal I.Q. score, which really doesn't come even with more severe forms of traumatic brain injury seems to suggest and is somewhat consistent with Mr. Broome's history of himself in academics. He was not real, you know, wasn't knocking the lights out as a student. Those things could be related to that, the language problem.

Dr. Bianchini noted the formal symptom validity and symptom evaluation measures that were included in the testing were entirely negative. He thus noted that during the evaluation there was no indication of Mr. Broome's intentional exaggeration of symptoms or intentional poor performance on the testing.

Returning to the issue of whether the general damage award was excessive (or inadequate), we note that general damages may be established in three ways: (i) the circumstances of the case, (ii) expert medical testimony, and (iii) the tort victim's testimony. Frank L. Maraist & Thomas C. Galligan, Jr., *Louisiana Tort Law*, §7-2 (c)(1996). In this case, the circumstances of the 2003 ladder accident were virtually undisputed. Mr. Broome's complaints regarding his symptoms were noted by all the experts to be truthful. The experts also were in agreement that he was not a malingerer. The expert medical testimony regarding the nature and degree of injuries Mr. Broome sustained, however, was conflicting. Resolving that conflict in Mr. Broome's favor, the trial court concluded that:

> David Broome suffered a mild brain injury with residual symptomatology of chronic headaches, decreased verbal and motor skills, and a likelihood of early dementia. Mr. Broome also suffers from a traumatically induced inner ear injury with chronic symptoms of vertigo and tinnitus.
>
> Mr. Broome also suffered a severe head laceration and nausea following the accident which has resolved, as well as depression, worry and anxiety regarding his medical condition and his injuries would prevent him from taking [care] of his two young children. The court finds these injuries were causally related to the accident of September 4, 2003 when he was struck in the head by a ladder.

Based on its finding that the evidence established Mr. Broome sustained a mild brain injury, inner ear damage, and a deep scalp laceration as a result of this accident, the trial court awarded Mr. Broome general damages in the amount of $400,000. Under the particular circumstances of this case, in light of the pain and suffering that Mr. Broome experienced shortly after the accident and the migraine headaches and other physical problems he continues to experience we cannot say that the trial court clearly abused its discretion or that the award is so high that it

shocks the conscience. Accordingly, we decline to disturb the trial court's award of general damages.

The trial court also awarded Mr. Broome $100,000 for his loss of enjoyment of life. In so doing, the trial court reasoned that "Mr. Broome's ongoing problems with headaches, dizziness, and ringing in the ears have resulted in his inability to participate in the activities and pleasures of life that he formerly enjoyed." The court thus found Mr. Broome suffered a "detrimental alteration of his lifestyle as a result of his physical injuries."

Although a form of general damages, loss of enjoyment of life is conceptually distinct from pain and suffering. It "refers to detrimental alterations of the person's life or lifestyle or the person's inability to participate in the activities or pleasures of life that were formerly enjoyed prior to the injury." *McGee v. AC and S, Inc*., 05-1036, pp. 3-4 (La. 7/10/06), 933 So.2d 770, 773-75. The record supports the trial court's finding that Mr. Broome can no longer pursue many of the physical activities and hobbies he once enjoyed due to the accident. Mr. Broome, corroborated by his girlfriend (Ms. Guntner), testified regarding his inability to engage in certain activities since the accident. Given his young age, the loss of enjoyment of life he has sustained will span most of his lifetime and result in the curtailment of many activities that he otherwise would have been expected to enjoy. As with the general damage award, we cannot say that the trial court clearly abused this discretion or that this award is so high that it shocks the conscience. Accordingly, we decline to disturb the trial court's award of loss enjoyment of life damages.

The trial court awarded Mr. Broome past medical expenses of $20,160.94, which are documented in the record. At trial, Mr. Broome identified these expenses. We find no error in this award.

The trial court also awarded Mr. Broome future medical expenses in the amount of $241,700, which included $233,700 in future prescription medication expenses and $8,000 in future medical treatment. The trial court explained this award as follows:

> Mr. Broome testified his migraines are sometimes as often as once a week or it may be a few weeks between episodes. Mr. Shael Wolfson, plaintiff's expert economist, totaled Mr. Broome's annual prescription costs at $5,651.00. This figure is based on an average combined cost of six Axerts Mr. Broome is prescribed for headaches a monthly supply of plaintiff's seizure medicine, Topamax. Based on Mr. Broome's life expectancy of 44 years, an inflation rate of 4.5% for the cost of the medication, and a present day discount value, Mr. Wolfson calculated the cost of plaintiff's future prescription medications at $233,700.00.
>
> Also, Mr. Wolfson averaged expenses associated with Mr. Broome's future medial care with Dr. Gianoli to have a present day value of approximately $8,000.00.

Future medical expenses are a form of special damages. The Louisiana Supreme Court has held that "[f]uture medical expenses must be established with some degree of certainty and will not be awarded in the absence of medical testimony that they are indicated and sets out their probable cost." *Hanks v. Seale*, 04-1485, p. 16 (La. 6/17/05), 904 So.2d 662, 672 (citing *Duncan v. Kansas City So. Railway Co.*, 00-0066, p. 17 (La. 10/30/00), 773 So.2d 670, 685). The proper standard for determining whether a plaintiff is entitled to an award of future medical expenses is "proof by a preponderance of the evidence that the future medical expenses will be medically necessary." *Hall v. Folger Coffee Co.*, 02-0920, p. 23 (La. App. 4 Cir. 10/1/03), 857 So.2d 1234, 1250 (quoting *Hoskin v.*

Plaquemines Parish Government, 97-0061, pp. 4-6 (La. App. 4 Cir. 12/1/97), 703 So.2d 207, 210-11). When the record sufficiently establishes the need for future medical care, but not the exact cost of such care, "the factfinder may make a reasonable award." *Lacy v. ABC Ins. Co.*, 97-1182, p. 13 (La. App. 4 Cir. 4/1/98), 712 So.2d 189, 196. The record in this case supports the trial court's finding that Mr. Broome met his burden of proving an entitlement to future medical expenses. Dr. Shamshia testified that Mr. Broome will need to take the prescribed medication for the indefinite future. We thus find that the record supports the future medical expenses award.

(2) Mr. Broome's Appeal: His Damages

Mr. Broome's appeal seeks an increase in general damages and loss of enjoyment of life damages. For the reasons set forth above, we find no basis to disturb these awards. Mr. Broome's appeal further seeks review of the trial court's failure to award damages for lost wages and impairment of earning capacity. We find no evidence in the record to support such awards. We therefore find the trial court did not err in failing to award such damages.

(3) Defendants' Appeal: Ms. LeBouef's Damages

Ms. LeBoeuf introduced into evidence the deposition testimony of her three physicians: Dr. Bradley Bartholomew, a neurosurgeon; Dr. Fred DeFrancesch, an expert in the fields of physical medicine and rehabilitation; and Dr. Thomas Lyons, an orthopedic surgeon. Ms. LeBoeuf testified as a witness on her own behalf. B&K and Gemini called in opposition Dr. John Steck, the IME and a neurologist.

Melissa LeBoeuf

Describing her injuries and course of treatment, Ms. LeBoeuf testified that at the time of the accident at Delgado she had an immediate onset of pain in her neck

and arms. She was treated that day at the Ochsner emergency room. At the emergency room, her complaints were soreness in her neck and pain in her arms. On September 10, 2003, Ms. LeBoeuf went to Dr. Dominic Arcuri, her primary care physician, with complaints of pain in her arm, and a sore neck. She also indicated that she had begun to feel a bit of tingling in her fingers. He recommended that she rest, apply ice, and "keep an eye on it."

From October 2003 through May 2004, Ms. LeBoeuf treated with Dr. Marshall Book, an orthopedic surgeon. Her complaint during this time was soreness and pain in her neck that would radiate down her arms. She had tingling in her third and fourth finger and "[i]t would eventually start to go numb." Based on Dr. Book's recommendation, she attended physical therapy for about one month, which provided some short term relief. She did not dispute a reference in Dr. Book's records of her complaining of hurting her neck when moving a couple of Christmas trees.

In November 2004, Ms. LeBoeuf changed doctors and went to Dr. Bartholomew because she was continuing to have pain and physical therapy was not helping. Again, in August 2005, she changed doctors and went to Dr. DeFrancesch because Dr. Bartholomew wanted her to undergo another round of Vertis,[12] which she testified was painful, and because she was not getting any better.

On August 1, 2006, Ms. LeBoeuf was in a subsequent automobile accident. According to Ms. LeBoeuf, she experienced an increase in pain after the

[12] Vertis is also called percutaneous neuromodulation therapy ("PNT").

automobile accident. For that reason, she saw Dr. Lyons on one occasion in August 2006.

Ms. LeBoeuf testified that she has radiating pain in her left shoulder, which goes through her arm; numbness and tingling in her third and fourth fingers of her left hand; and headaches. All the conservative treatment she has received has provided only short term relief. Ms. LeBoeuf testified that before the 2003 ladder accident she had no prior accidents or injuries to her neck and that since the 2006 automobile accident she has had no subsequent accidents. She testified that following the 2006 automobile accident her neck and arm pain were worse for about three months and then returned to the same level of pain that she had been experiencing since the 2003 ladder accident.

Ms. LeBoeuf described herself as very active and in good physical condition before the 2003 accident. She testified that before the 2003 accident she enjoyed exercising, playing golf, playing basketball, and running. She noted that in high school she played golf in the Junior PGA and that she was an avid golfer. She testified that she is no longer able to play golf because it is uncomfortable for her to swing a golf club. She testified that she also no longer exercises, jogs, plays tennis or lift weights.

At the time of trial, Ms. LeBoeuf was twenty-five years old and working as a project manager for a landscaping company. She testified that her job has drastically changed since the accident. Her present job responsibilities require her to oversee landscaping and maintenance crews. She indicated that she would prefer to work outside with plants as she did before the 2003 accident, but because of her neck injury she has assumed more administrative duties. Ms. LeBoeuf

acknowledged that the injury from the 2003 accident did not interfere with her academic performance and that she obtained her decree.

Dr. Bradley Bartholomew

On November 16, 2004, Ms. LeBoeuf first saw Dr. Bartholomew, a neurosurgeon. She gave a history of being injured on September 4, 2003, when she was hit in the neck by a ladder, and she denied a loss of consciousness. She reported that she had immediate neck pain and that she was treated in the emergency room where she was x-rayed and released. She also reported having seen two other physicians for this injury: Dr. Arcuri, her primary care physician; and Dr. Book, an orthopedic surgeon.

On her first visit to Dr. Bartholomew, Ms. LeBoeuf's complaints were continuing neck pain, pressure, pinching, and a painful sensation going to the left shoulder. She reported that the pain in the neck was not constant and not every day and that the pain was brought on by things that put stress on the neck. She also reported pain going to the left upper extremity to approximately the forearm, which also was not constant and not every day. She still further reported occasional left hand numbness and weakness and tingling in the left hand digits three and four. She denied any previous history of neck pain. Dr. Bartholomew noted that a MRI of the spine dated April 26, 2004 was normal. He concluded Ms. LeBoeuf was not a surgical candidate given the continuing spasm she was experiencing despite conservative measures. Dr. Bartholomew prescribed a muscle stimulator to use at home and medication (Skelaxin and Naprosyn). He instructed her to return in one month.

On January 25, 2005, Dr. Bartholomew saw Ms. LeBoeuf for a second time. On this visit, she reported that her neck was better. She stated that she was using

the stimulator every day. She indicated that she had pain every other day for three to four hours and that the pain was worse at night and in the afternoon. She stated that when the weather changed she experienced a picking type or pulsating sensation into the left upper extremity. Overall, Ms. LeBouef estimated that she was about "50% better." Dr. Bartholomew continued her on the muscle stimulator and instructed her to return in two months.

On March 22, 2005, Dr. Bartholomew saw Ms. LeBoeuf a third time. On this visit, she stated that her neck had been fine for about six weeks, but about three weeks earlier without any trauma she woke with a stiff, sore neck. Given Ms. LeBoeuf's MRI was normal, Dr. Bartholomew recommended a home exercise program along with a muscle relaxant (Robaxin) and continued the home stimulator. He instructed her to return in about one month.

On March 26, 2005, Dr. Bartholomew saw Ms. LeBoeuf a fourth time. She reported some pulsating pain that became worse about three weeks earlier. She indicated that the pain was in the left neck area and trapezius. She also reported pain in the left elbow to the wrist and numbness in the third and fourth fingers. On this visit, he gave her a trigger point injection in the left trapezius area, which he noted provided her with some immediate decrease in pain in the area.

On May 17, 2005, Dr. Bartholomew saw Ms. LeBoeuf a fifth time. She reported that for a week and a half following the trigger point injection 80% of the pain was gone, but it gradually returned. She reported pain in the neck going to the left upper extremity. She indicated that the left upper extremity pain was not constant, but that the neck pain was constant. She described the pain as sometimes sharp. Dr. Bartholomew opined that most likely the radicular symptoms were a

result of the spasm. He noted that she agreed with his recommendation to try Vertis, which he noted is called percutaneous neuromodulation therapy ("PNT").

On August 9, 2005, Dr. Bartholomew saw Ms. LeBoeuf for the last time. On this visit, Ms. LeBoeuf had her first PNT. Dr. Bartholomew noted that the PNT was painful at the insertion of the needles on the left side where she was having the spasm. He further noted that Ms. LeBouef tolerated the treatment and that she was going to consider whether she wanted to have another PNT. He discussed other treatment options including message therapy and a chiropractor. He again opined that she was not a surgical candidate.

Dr. Fred DeFrancesch

On January 17, 2006, Dr. DeFrancesch, an expert in the fields of physical medicine and rehabilitation (a pain management doctor), first saw Ms. LeBoeuf. At this time, Ms. LeBoeuf's complaints were paresthesias in the left third and fourth fingers and occasional weakness throughout her hand. Dr. DeFrancesch found that she had cervicalgia, possibly left C6-C7 radiculitis/radiculopathy, and myofascial pain. He prescribed medication and suggested that she have an EMG (electromyogram) and nerve conduction study to determine if neurological issues were present. On February 14, 2006, the tests were done, which showed nerve abnormalities. On February 27, 2006, Ms. LeBouef had a second MRI of the cervical spine, which was compared to the prior one of April 2004. The MRI was normal; it showed no evidence of disc herniation.

On June 20, 2006, Dr. DeFrancesch last saw Ms. LeBoeuf. On this visit, Ms. LeBoeuf related that "[s]he was doing okay." She rated her pain as 4 out of 10 (10 being the most intense) in intensity, but noted that a week earlier she had one episode of exacerbation at 8 out of 10 when she extended her neck and had

"pinching in the neck." Dr. DeFrancesch's diagnosis was cervicalgia, facet disorder, myofascial pain, cervical strain, and soft tissue injury. He continued her on medication (Celebrex and Robaxin) and a home exercise plan. Although he also continued her on physical therapy (which she went to in March and May 2006), Dr. DeFrancesch noted that "it has not provided significant relief."

Dr. DeFrancesch testified that Ms. LeBoeuf appeared to be truthful in her complaints and that she was not malingering. In response to whether he would expect her to still be experiencing pain when he saw her, Dr. DeFrancesch replied that some patients who have similar symptoms have pain that never resolves.

Dr. Thomas Lyons

Dr. Lyons, an orthopedic surgeon, testified that he saw Ms. LeBoeuf on one occasion, August 2, 2006. On this visit, Ms. LeBoeuf's complaints were pain in her neck, upper back, headaches, and pain involving the left arms and extending into the hand. Dr. Lyons testified that these complaints for which Ms. LeBoeuf sought treatment arose from a motor vehicle accident that had occurred the prior day, August 1, 2006. Ms. LeBoeuf never mentioned to Dr. Lyons the September 2003 ladder accident; however, she related to him that she had prior neck pain and upper extremity symptoms.

Dr. John Steck

Testifying for the defendants, Dr. Steck, a neurosurgeon, stated that he saw Ms. LeBoeuf on one occasion, on July 31, 2006, for an IME. According to Dr. Steck, Ms. LeBoeuf provided a history of being struck by a ladder in the lower cervical spine at the junction of the spine and the trapezius. She was knocked to the ground. Her primary symptoms were neck pains and numbness and panesthesias into the third and fourth fingers of the left hand. Based on the history,

physical exam, and review of the medical records from Dr. Bartholomew's office, Dr. Steck concluded that Ms. LeBoeuf had a soft tissue injury to the muscles of the neck and the supporting structure of the left shoulder. Dr. Steck testified that "[h]er examination was normal other than a slight decrease in pin prick or a sensitivity to pin sensation in the fourth finger of the left hand." He testified that this generally was not something that would cause pain or disability. He concluded that more than likely her injuries could be managed conservatively and would not require surgery. In response to the trial court's questions, Dr. Steck testified that the existence of a pending lawsuit is something that is put in a patient's medical records because it "may be a motivating factor for them to either compain more, complain longer, or not to respond to therapy."

As noted, the trial court awarded Ms. LeBoeuf $125,000 in general damages and $8,027.74 in past medical expenses. In its reasons for judgment, the trial court stated that it agreed with the defendants' expert neurosurgeon, Dr. Steck, that Ms. LeBoeuf sustained a soft tissue cervical injury. The court noted that Dr. Steck testified "the EMG ordered by Dr. Fred DeFrancesh, plaintiff's treating physician, showed abnormalities in the C-6, C-7 nerve distribution. This objective finding supports plaintiff's complaints of chronic pain." The jurisprudential doctrine that a treating physician's opinion should be accorded greater weight than the opinion of a doctor who examines a patient only once for purposes of litigation (or for purposes of rendering an expert opinion concerning the party's condition) is not irrebuttable. Rather, "the inquiry is whether, based on the totality of the record, the jury was manifestly erroneous in accepting the expert testimony presented by defendants over that presented by plaintiff." *Miller v. Clout*, 03-0091, p. 6, n. 3 (La. 10/21/03), 857 So.2d 458, 462. Given the particular circumstances of this

case, we cannot say that the trial court abused its vast discretion. Accordingly, we decline to disturb the trial court's award of general damages. We further find the award of past medical expenses supported by the record.

DECREE

For the foregoing reasons, the judgment of the trial court is affirmed.

AFFIRMED