



# Lessons I've learned in TBI litigation

## PLUS A PRIMER ON THE NEW DIAGNOSTIC STANDARDS FOR MILD TRAUMATIC BRAIN INJURY

I specialize in traumatic brain injury cases. I regularly review and consult on TBI cases for other law firms – and, when I'm looking at a case, I won't take it if I don't think I can add the value of the referral fee. But I always give my advice about what I would do if it was my case: the tests I'd want run, how I'd do the client interview, the experts I would consider, and where the strength of the case should be focused.

When I first started working on TBI cases, I – like many others – believed that a TBI diagnosis required evidence from a scan. My father – also a lawyer – disabused me of that notion and told me something that I've carried with me ever since: If you believe the client, the evidence will be there. So, I went searching.

I vividly remember my first major TBI case, representing a young woman I will call Sarah. Sarah presented with classic post-concussion symptoms: severe headaches, dizziness, memory loss, and an inability to concentrate. Despite these debilitating symptoms, her MRI and CT scans came back clear. Defense counsel seized on the lack of scan evidence to downplay her injuries. "No acute abnormality, no injury," they argued. For a while, I felt cornered.

But then I started researching – delving deep into TBI medical literature, talking to experts, and educating myself. And I learned to recognize "mild" TBI as one of the most devastating and complex diagnoses that a patient – a client – can receive.

The more I've consulted with other law firms on their cases, the more I've realized how important it is to help each other, to share information, and to educate one another. And that's what I love doing most. I want all lawyers to have the tools to take care of their clients. This article strives to address the most common questions and misconceptions that I answer on a week-in/week-out basis

– these are the topics that I want every plaintiff's lawyer to understand.

### **Traumatic brain injury is a clinical diagnosis, not a scan result**

A TBI medical diagnosis is easier to make with a positive scan, but all TBI diagnoses are clinical diagnoses. A clinical diagnosis is determined based on a comprehensive clinical evaluation, not just neuroimaging. This involves assessing the patient's symptoms, history of the injury, neurological examinations, and cognitive tests.

The absence of a positive neuroimaging finding does not rule out TBI; it simply indicates that further evidence is needed to make the clinical diagnosis. The real damage, especially in mild TBIs, often occurs at the cellular level – a level at which MRI and CT scans are not capable of imaging.

At trial, I have my expert explain that this is like looking out of the window of a plane. You're high above a city and you look down: you see streets and buildings, but you're too high up to see people on those streets or in those buildings. That doesn't mean they're not there. Similarly, a negative MRI does not rule out the existence of TBI. The damage is just too small to be seen on the MRI.

Understanding this – and the medicine – helped me resolve Sarah's case so that she would be taken care of for life.

### **TBI severity is a snapshot, not a comprehensive result**

Defense counsel love to fight about mild, moderate, and severe grades of TBI. At trial, juries don't care. Experts do, but they do not decide the damages of a case. Juries just want to know if there is a brain injury or not, and how significant the injury is.

When experts agree our client has a mild TBI, this is the language that I use

in opening is as follows: "Plaintiff and defense agree there is a traumatic brain injury. The dispute is over how significant the brain damage is."

Then I go further and educate the jury why this is.

We have to teach the juries why doctors call TBIs mild, moderate, and severe. I explain it this way: These grades are a snapshot, not the complete picture. The grades are often just the first impression captured during the initial evaluation at the hospital following the incident. But that grade does not fully capture the extent of the injury or its impact on the individual's life.

If you cross-examine the defense experts well, they will have to concede that the medical decisions made in the immediate aftermath of the injury are simply used to determine the surgical and trauma level needed. The term "mild" is misleading, usually causing defense lawyers and adjustors to undervalue a case. They don't understand that the initial grade is just a start point, not a definitive measure of the injury's impact.

So remember, initial symptoms and classification correlate to a long-term statistic, but they don't necessarily demonstrate the full range of damages that the individual – your client – is actually suffering or will suffer in the future. Statistics are a snapshot. By the time a case goes to trial, you will have more witnesses, more tests, and more quantification of the long-term and lasting significance of the TBI than the ER doctors did in the initial evaluation.

### **The location of a brain lesion is crucial**

Most often, it's not the size of the lesion, but rather its location that is most critical. When a lesion is closer to the brainstem, the injury is usually more significant. The number of cases I look at

where there is a brain bleed, but there is no testimony or search for evidence related to what part of the brain is affected is close to 90%. Meaning out of 10 brain injury bleed cases that I will look at, only one will have been worked up the way I'd recommend. There is often a lack of clinical correlation in the case file. It's important to raise awareness about this issue so that lawyers can better prepare their cases.

### **A majority of TBI injuries are not diagnosed in the ER**

Just because there is no TBI diagnosis in the ER does not mean you don't have a case. I took on a case where the client had significant TBI symptoms, but was never worked up for TBI and did not get diagnosed with TBI until two years after the incident. Once the case got properly worked up, the result was a large verdict – the largest in the county. No ER diagnosis of a TBI makes it more difficult to prove a TBI, but it doesn't make it impossible. If the evidence is there, go for it.

Emergency rooms miss about 56% of TBIs. (Powell, *Accuracy of mild traumatic brain injury diagnosis* (2008) 89 Archives of Physical Medicine and Rehabilitation 8, pp. 1550-1555.) This means more people with TBIs leave the ER without a correct diagnosis than those who get a correct diagnosis. (Thurman, *Traumatic brain injury in the United States: A public health perspective* (1999) 14 J Head Trauma Rehabil. 6, pp. 602-15.)

### **Understanding the Glasgow Coma Scale, its purpose and its limitations in TBI litigation**

We've all heard this from defense attorneys: "The plaintiff's Glasgow Coma Scale was 15 – normal. They don't have a brain injury." Early in my career, I misunderstood the true purpose of the Glasgow Coma Scale (GCS) in TBI cases. I've since learned that understanding what the GCS was actually intended to do is crucial for effective TBI litigation.

The Glasgow Coma Scale was developed by Graham Teasdale and

Bryan J. Jennett in 1974. It was designed for a very specific clinical purpose: to provide a quick, objective way of evaluating the consciousness level of patients with acute brain injury. Its primary aim is to help healthcare providers determine how urgently a patient may need *neurosurgical* intervention.

While GCS is invaluable for emergency medical treatment decisions, it is not intended to be – and never was intended to be – predictive of long-term TBI effects. An emergency room tool should not be the sole determinant of brain injury in a legal context. And remember, the first MRI was performed in 1977, years after the GCS was invented and put into use. MRIs help us see into the brain, but the GCS was created because there was literally no way to do that in 1974. Doctors needed *something* to determine whether surgery was immediately necessary – and, in extremely rough fashion, that's what the GCS does. It is an acute assessment tool, not an end-all, be-all final determination of the long-term effects of TBI. A normal GCS score never rules out TBI. That score is one factor to consider, but not the only one.

### **The invisible progression: Primary versus secondary TBI**

Some TBI symptoms don't show up right away. This fact hit home for me during a particularly challenging case that went to trial. My client's most severe symptoms didn't begin until 10 days after the initial incident. At first, I was stumped. How could I explain this delay to a jury? How could I deal with an ER doctor who said "left leg pain" only?

I pored over the medical records, trying to find a way to connect the dots. It wasn't until I was deep into the medicine that I stumbled upon the concepts of primary and secondary TBI injuries. I had not seen many experts or lawyers talk about this. This was my lightbulb moment.

Primary brain injuries, I learned, happen right when the trauma occurs.

They're caused directly by the impact or force of the injury. These are the injuries we typically think of when we hear "brain injury" – the immediate damage that often shows up on CT scans or MRIs. They're the bruises, the tears, the shearing of delicate brain tissue that happens in that split second of impact.

Secondary brain injuries are different. They develop over time, sometimes days or even weeks after the initial trauma. They're not caused directly by the impact, but by *the body's response* to that initial injury. The medical term for it is "physiological response."

Think of it like this: the primary injury is like a rock thrown into a pond. The secondary injury is the ripple effect that follows. These secondary injuries can include swelling in the brain, changes in blood flow, inflammation, and a whole host of chemical changes. And here's the kicker: They can often be more severe and have longer-lasting effects than the primary injury. But because they develop slowly, they're easy to miss or dismiss. It is why so many mild TBIs do not – and cannot – get diagnosed in the ER.

This is exactly what happened to my client. The initial impact caused some damage, sure. But it was the secondary injuries - the swelling, the changes in his brain chemistry - that really turned his life upside down. And it took days for these effects to fully manifest.

Once I understood this, everything clicked. I could now tell a story that made sense - a story of how brain injuries can evolve and worsen over time, even when the initial impact is in the past. I explained how the brain injury my client suffered wasn't a single event, but an ongoing process. I showed the jury how those late-appearing symptoms weren't disconnected from the original incident, but a direct result of it – just on a delayed timeline.

By clarifying the distinction between primary and secondary injuries, the story made sense. The jury could see the clear line from the initial trauma to my client's current struggles, even with the time gap. The result? A significant verdict that truly

accounted for the full scope of my client's injuries.

This case drove home for me the importance of understanding the full timeline of TBI progression. Now, when I approach TBI cases, I'm always on the lookout for those secondary injuries. I know that the story of a brain injury doesn't end in the ER; it's often just beginning.

### The new ACRM standards for mild TBI

From years of battling misconceptions and navigating the intricate landscape of TBI litigation, one truth stands clear: Understanding the full scope of traumatic brain injuries is non-negotiable.

The truth that took me years to fully grasp is that mild TBIs can be every bit as devastating as those with visible bleeds and skull fractures. I've stood in hospital rooms with clients whose CT scans result in doctors telling patients' families the client may not survive, yet they've gone on to lead semi-normal lives, holding down regular jobs. Then I've sat across from those with so-called "mild" TBIs, watching as they struggle to remember their kids' names or hold a simple conversation.

Here's a fact that'll make any jury sit up and take notice: Over 50% of the homeless population has suffered a TBI. (Stubbs, *Traumatic Brain Injury in Homeless and Marginally Housed Individuals: A Systematic Review and Meta-Analysis* (2020) 5 *Lancet Public Health* 1, pp. e19-e32.) Let that sink in. We're not just talking about personal injury here; we're looking at a silent epidemic with staggering social and economic ramifications.

For years, I fought the battle of the experts about mild TBI, with no clear standards. It was messy and caused low insurance evaluations that, in turn, caused more cases to have to go to trial.

In 2023, the American Congress of Rehabilitation Medicine (ACRM) created new standards for diagnosis of mild TBI. They are the most widely accepted criteria for diagnosing mild TBI, but many lawyers – and even some medical professionals – don't even know they exist.

At their core, the ACRM standards consist of six key criteria:

- 1. Mechanism of injury.** This establishes a plausible cause of brain injury through force transfer to the head, body, or rotational forces. It's not just about direct hits – whiplash or blast exposure can qualify. (See, for example, Phillips, *Pattern of Brain Damage is Pervasive in Navy Seals Who Died by Suicide*, *N.Y. Times* (June 30, 2024).)
- 2. Clinical signs.** These are the immediate physical manifestations of brain dysfunction. We're talking loss of consciousness, confusion, or amnesia. But here's the kicker: These signs can be established through witness reports or the client's own recollection, not just medical records.
- 3. Acute symptoms.** The ACRM requires two or more new or worsening symptoms within the early presentation. This could be anything from headaches and dizziness to memory problems or mood changes.
- 4. Clinical examination and laboratory findings.** This is where we get into the nitty-gritty of cognitive, balance, and eye movement tests – hard evidence of impairment.
- 5. Neuroimaging.** Here's a surprising one: Neuroimaging isn't necessary for diagnosis of mild TBI. In fact, most mild TBI cases have normal scans. This factor is actually pointed more at ruling out other issues.
- 6. Not better accounted for by other conditions.** The final hurdle. We need to show that the symptoms aren't due to something else – e.g., a pre-existing condition, medication, or psychological factors.

Now, here's what makes these standards so powerful: They recognize that mild TBI often goes undiagnosed in the emergency room. As I've already explained above, a normal Glasgow Coma Scale score or a lack of immediate TBI diagnosis doesn't rule out a mild TBI, and these standards demonstrate that those concepts are accepted by the medical and scientific community. So, when the defense argues "no TBI" based

on initial ER records or "clear" CT scans? Educate yourself on the ACRM standards and use them as the foundation for you – and your experts – to explain to the jury why those initial ER records and clear CT scans don't show the true picture of what's happened to your client.

But knowing the standards isn't enough. You need to apply them strategically throughout your case. Use them to guide your initial client interviews, ensuring you gather information relevant to each criterion. (And if you do not have a good "standard" approach for evaluating TBI cases, call me and I'll give you mine. Sharing information is the best way to change the landscape of TBI litigation.)

Structure your discovery requests around these standards, seeking records and witness statements that speak to each point. When working with expert witnesses, have them explicitly address how your client meets each criterion in their reports and testimony.

These standards are also a powerful tool in depositions. Use them to cross-examine defense experts. I've seen opposing experts crumble when forced to concede that a client meets multiple ACRM criteria, despite their initial opinion of "no TBI."

One of the most valuable applications of these standards is in educating the court. Many judges aren't familiar with the ACRM criteria. Use motions in limine or force an evidentiary hearing to explain their significance. This can set the stage for how TBI evidence is viewed throughout the trial.

However, a word of caution: These standards are nuanced and require careful application. Pay particular attention to the sixth criterion – "not better accounted for by other conditions." This requires a thorough consideration of pre-existing conditions or concurrent injuries. Don't gloss over this; addressing it head-on strengthens your case and preempts defense arguments.

Remember, understanding and utilizing these standards isn't just about

winning cases; it's about serving justice. Mild TBIs are often invisible injuries with profound impacts. They are expensive and crucial cases we need to litigate. This is the new weapon. You need to deploy it to get your client's injuries properly recognized and compensated.

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