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OMEGA LAW GROUP



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TBI roundtable

VETERAN PLAINTIFF AND DEFENSE ATTORNEYS DISCUSS WHAT TO LOOK FOR IN A POTENTIAL TBI CASE, WHAT YOU NEED TO SETTLE THE CASE AND WHAT WILL DRIVE THAT CASE TO TRIAL OR LEAD YOU INTO A MALPRACTICE SUIT

Traumatic brain-injury cases are uniquely complex and challenging. There are a multitude of things that an attorney must do from the inception of the case in order to achieve success at trial. Getting justice for your client in a brain-injury case requires thorough preparation and exceptional advocacy starting from day one.

While there are no cheat sheets, Diana Diskin and Lourdes De Armas, your issue editors, decided to give you an advantage. brought together and moderated a discussion with a super-star panel from both sides of the aisle. Masters in TBI from the plaintiffs and defense bars, in the same room for a three-hour discussion to give you tips and insight into the complex world of traumatic brain-injury cases.

For the Plaintiff: *Deborah Chang of Chang Klein, Erica Chavez and Joey Low of Trauma Law, Taylor Ernst of Ernst Law Group, Boris Treyzon of ACTS Law and Dorothy Clay Sims of the Law Offices of Dorothy Clay Sims.*

For the Defense: *Christopher Faenza of Yoka & Smith LLP, Erin Hallissy of Schonbuch Hallissy LLP, and Nicole Whyte of Bremer, Whyte, Brown & O'Meara, LLP/*

Professional responsibility and ethics: *Marshall Cole of Nemcek & Cole.*

(Editor's note: The transcript has been edited lightly for clarity.)

First impressions in TBI cases: What plaintiff attorneys need to look out for

MS. DISKIN (M): Let's start with first impressions: What are you looking

for when a TBI case comes in, so that you can properly work it up? Boris, can you start us off?

MR. TREYZON (Pltf): Well, first of all, every person out there has TBI. I mean, it's just that simple. We all have lived our lives, we all have hit our heads, we all have suffered some sort of trauma. That doesn't mean it's a TBI that's actionable. It doesn't mean that it's a TBI that's part of your damages.

So, the first part of diagnosing TBI is really simple: You talk to your client. More importantly, you talk to their family members. The family members are actually significantly more important than the client, because clients who suffer a traumatic brain injury rarely know it. They don't realize that they have short-term memory lapses, don't realize they have behavior changes. They don't understand that their executive function, their ability to process information and filter appropriately, has been affected. To them, everything is proper because otherwise, they would not do it.

So, you start by having that conversation, and if you see a marked difference, you get a specialist involved.... [E]verybody thinks...that they are referring a traumatic brain injury case. They very well may be, but I have cases that the physical damage absolutely almost guarantees traumatic brain injury and there is none. And I have cases where the forces of impact don't support an obvious diagnosis of traumatic brain injury, and then you go into it and the injury can be absolutely profound.

So, the first thing you do is just have a simple conversation. Then...you start

eliminating other effects: prior instances, military service, sports activities, soccer, football....[T]hey can all contribute to a brain-injury diagnosis. Once you know you have a brain injury, now you start going in and you're trying to put a time limitation on it. When did it happen? When did you notice the change? And, finally, if you've been able to identify that there is a traumatic brain injury suspicion, you send them off to a specialist. And the specialist in this case is not necessarily [a] neurologist. You could be better off sending that person off to a neuropsychologist for a cognitive deficiency as opposed to necessarily a non-cognitive problem.

MS. DISKIN (M): A quick follow-up: Do you treat every case as a potential TBI case?

MR. TREYZON (Pltf): Absolutely not. We treat every case [as one] that deserves a conversation. And as a part of every conversation, we ask: Have you noticed changes? How has this person's life changed? And part of the questions we ask goes to the person's daily functions and activities. And then, if you have gone through that and they've answered certain critical questions, then you go deeper into it. There are protocols for really, really weeding [it] out. Also keep in mind, you have to be able to pick out people who are malingerers who are coming in hoping for a payday, and you really talk to them and you talk to their family members and you should be able to filter [those] out. We all know that there is a lot of value to a significant traumatic brain injury case. But that also brings a lot of fakes.

MS. DISKIN (M): Debbie, what's your intake process like for a potential TBI case?

MS. CHANG (Pltf): First and foremost, before anything else, you have to look at the nature of the injury. And I mean that in a couple different ways. One is the location of the injuries. For example, there are some injuries that occur – like facial injuries or a significant whiplash coup-contrecoup situation – where it would almost be impossible to not have a TBI.

The other way I look at it is, many times there are multiple injuries going on. And the most critical – like if there is a broken bone, if there is something that needs setting, if they need surgery, if it's a life-threatening condition, hospitals and doctors will tend to go to that emergent condition. And a TBI is often overlooked. You have to be on the lookout for multi-trauma.

MR. TREYZON (Pltf): Debbie brings up a really important point. Emergency rooms are not treating facilities. They are stabilizing facilities. Their job is to make sure the person survives the next 24 hours, get them out, and get them to a professional. CT scans very often will miss traumatic brain injury. MRI will also miss traumatic brain injury. Emergency rooms are not diagnostic. If it's obvious, they will bring in a consulting neurologist, but if it's not, it's definitely not a method for ruling out a TBI.

MR. ERNST (Pltf): I'm really glad that Debbie brought up ERs. There are white papers that say ERs miss over 50% of TBIs. When I'm in trial, I talk about the ER as this initial snapshot of the person's injury. TBI is way low on the list of stabilizing injuries unless emergency brain surgery is needed. If the person's arm is significantly injured, the ER is focusing on the arm, not so much on a potential TBI. And by the time experts get involved in litigation, they're going to have a much more comprehensive picture about the TBI than an ER would.

MS. SIMS (Pltf): This is a great point. Emergency rooms are in the business of saving lives. Frankly, it's just their job to see if your client has a brain injury that could kill them – imminently, there in the ER. Beyond that, it's not their responsibility. And that's why they use CT scans; those are cheaper and faster than MRIs.

And it's why you may want to demand the audit trail for electronic medical records – you may be able to determine how long the ER doctor and, if it's an issue in your case, that may help you demonstrate why the ER is not the setting in most TBIs are going to be found.

MS. CHANG (Pltf): And see, it's up to us to look for it, because the defense will jump on the lack of TBI noted in the emergency room. Many times, TBI doesn't come until there is an attorney who can set up a specialist evaluation. That's just a fact of life.

MS. DISKIN (M): Taylor, can you tell us a little about your intake process?

MR. ERNST (Pltf): One of the most valuable lessons is: You don't want to use medical terminology in the client interview, because the client won't know what you're talking about. It's very easy for lawyers to talk in medical jargon. What we teach other firms is to ask "curiosity questions": Have you noticed anything strange? Tell us how your head feels.

You don't want to ask about headaches; you want to ask about their head. And you don't want to ask about memory; you want to ask, "Have you noticed any significant changes in your husband since the incident?" You want *them* to volunteer the information. The more you ask leading questions, the more difficult it is to discern what's really going on. They don't mean to, but clients are answering based on what they think the right answer is, where you want them to go. So, you start by asking them, "Hey, what's been odd since the incident?" And all of a sudden the floodgates open and

they're telling you that they've got sticky notes all over the fridge and in their car, or they're eating Doritos while they're walking down the hall, and the walls are covered in Dorito dust because their balance is messed up.

So that's our process: I do an initial interview where I ask a bunch of curiosity questions, non-leading, about different subject areas – physical, cognitive, emotional – and then we do family interviews. You have to be careful about attorney-client privilege there. And then we set up "deep dive" meetings where we have a specific person in our office meet with the client three or four sessions in the first two weeks and we go through the alphabet of criteria. You need detailed information so that you get the right experts, because every TBI case is different. If you've got a case that involves dizziness, vestibular problems, that's one set of experts. If you have a case with memory-encoding problems, you've got another set, and so on.

Also, when we're doing initial intake, everybody should be using the 2003 American Congress of Rehabilitation Standards. And there are new standards that make it really easy to go through and see whether some of these diagnostic criteria are being hit in your case.

MS. SIMS (Pltf): In addition to everything that everyone else has said, I would just say: It's often best to speak to the family without your client present. A TBI patient may suffer from *anosognosia*, meaning a lack of awareness of their own deficits. They may think they're just fine, but the family can see that they're not. And the family is usually more comfortable telling you things that they've observed about the client's injuries without the client right there to hear about all that.

Also, for intake, I would find a way – whether through the client or their family – to see whether the client is using more salt or hot sauce on their food. It's usually a sign of damage to the first cranial

nerve, and it's very common in brain injuries. Most doctors don't check for it.

First impressions: What the defense is looking for?

MS. DE ARMAS (M): Let's kick it over to our defense friends. Chris, let's start with you. Defense attorneys obviously don't have an intake process like we do, but what do you look for right away to determine whether this is a legitimate, credible TBI case that merits your serious consideration?

MR. FAENZA (Def): I'm very passionate about this. I think if you – a plaintiff attorney – pick up a case and pursue a mild TBI that's not there, you can wipe out your other claims. The way I look at it, there's three categories: severe, moderate (defined as a 13 on the Glasgow Coma Scale or worse), and mild. What we look for is very simple – it's whether there's a Glasgow Coma Scale of 15; was there a loss of consciousness that was observed and not just self-reported, was there any imaging? The gold standard for a TBI in the ER is a CT scan; they're looking for fractures or a brain bleed. So, if we have a case with a normal GCS of 15, no loss of consciousness, normal CT, normal MRI, I'll take that case to trial every day, and I don't care what the doctors say.

I've been there for seminars on functional MRI and DTI. Those experts are telling a jury, "Look, the gold standard can't find anything. But I'm sitting here in my office and I can tell you something is wrong with this person's brain." It just doesn't click. I've had probably four or five trials in the last three years with TBI – and the gold standard was clear, but they all had DTI-type findings. The juries haven't gone for it.

The other thing that's helpful on mild TBI cases is that you really can't fake it since the pandemic. Because of COVID, we used to go to trial in a year or so; now it's years before we go to trial. So, if you can fake it for four years and you have your Post-Its for four years

and you keep it together, you're probably going to win. But if you're back to work, your coworkers say you're fine, and our surveillance cameras see you doing stuff, then you've got a problem with your case.

My unicorn thought for mild TBI cases, is that there is good news for plaintiffs because the definition just changed. The definition for a concussion is now a hit on the head, followed by headache or nausea. You don't need a loss of consciousness. So basically, every defense doctor is going to say, "Did they have a concussion? Of course, they got hit on the head. And they have dizziness or they have headache and, boom, you have a concussion. But the vast majority of people heal within six to eight weeks." So why is your client the unicorn? If most people resolve, why is this plaintiff not one of them?

From our perspective, if you have a GCS of 15, normal imaging studies, we'll fight those all day long. But if you have a brain bleed, that's not a mild TBI case. That case will never go to trial, because it will settle.

MS. DE ARMAS (M): Nicole, how about you?

MS. WHYTE (Def): I would agree with everything that Chris just said. The big issue for us is, of course, the GCS. And then we're looking for objective findings. Objective findings are important. Going back to the discussion about ERs: What the ER determines, the findings of the paramedics and initial treating physicians is relevant, because that's before anyone has a stake in the outcome and before any lawyers are involved. The treatment in the ER is very relevant. We're looking for evidence of any type of head trauma – bleeding, bumps, bruises, physical evidence is there. And we're looking at the imaging.

Like you, we also look at the mechanics of injury and the nature of the impact: Was the head hit, was there severe whiplash, was there some sort of mechanism that could cause a TBI injury?

Sometimes we'll get a biomechanical expert involved early on, as part of a rapid response protocol on our cases. When there's a bad injury, we'll get a call right away and we may even be called to the scene, talking to witnesses, getting a bio-mech involved immediately.

Along with objective findings, the initial recorded symptoms are super important, as is the diagnosis in the ER. What is there to support a potential actual TBI?

So, we look at the ambulance records, we look at the ER records, we look at the GCS. If the GCS is 15, I'll take that case to trial every day.

And I'll just add another point. When we're getting the case, one of the other factors that has got nothing to do with the medicine or the mechanism of injury is: Who is the plaintiff attorney who has this case? Because, quite honestly, as you all know, when it's any of the esteemed plaintiff lawyers, you've got great credibility – because we know you carefully evaluate your cases. We report that to the carrier; mark my words.

MS. DE ARMAS (M): Erin?

MS. HALLISSY (Def): Ditto everything that Nicole and Chris just said. I would also add that if I have a case with a plaintiff who has gone to a trauma center, and that trauma center didn't do a CT scan because they're following the Canadian rule and they didn't feel it was even worthy to do a CT scan, that's obviously a problem for the plaintiff because those places are used to evaluating people that have been injured in accidents. And if they don't think it's serious enough to even CT the patient – and I understand the point about needing to triage serious injuries – but if they haven't even done a CT, that's problematic for you guys.

I absolutely agree with Nicole about the quality of the plaintiff lawyers. You guys get a large amount of credibility just based on who you are. But there's a lot of people out there that are making your jobs harder because they're making us

have to question everything – I’m seeing some ridiculous stuff lately.

Also: I look at prior medical records. For example, in these subsets of TBI – vision, vestibular, speech, hearing, etc. – we need to determine whether it’s a reaction to this accident or is it something else? So, I always look at the prior medical records.

And then the other thing that I evaluate – and it’s very important to me – are the people who don’t have an interest in the outcome. Like the housekeeper who’s at the home regularly, the employer’s records, school records – outside third parties that are dealing with the plaintiff day in and day out and really seeing how they act when they’re not in a litigation setting.

Contending with the Glasgow Coma Scale

MS. DISKIN (M): Since this has come up a lot now, let’s talk about the Glasgow Coma Scale. Erica, just to start, can you explain what it is, when it’s supposed to be performed, and its significance – or lack of significance.

MS. CHAVEZ (Pltf): The Glasgow Coma Scale was meant to be a quick and dirty test to figure out the extent of a person’s consciousness. It measures awakeness, alertness, and orientation. It’s given right at the scene.

The GCS looks at eye response, motor response, and verbal response. Eye response goes with how awake and alert the patient is: Does the patient open their eyes? When you call the patient’s name, do they look at you? When you pinch them, do they look at you? Motor response shows how well your brain controls muscle movement or if there’s some issue with the connection between your brain and body. So, if I tell you to squeeze my hand, are you able to do it? If I press on some part of your body, do you move away intentionally, or by reflex, or in some lesser way, or at all? And then the verbal response goes to thinking, memory, attention, awareness of surroundings. Do you know who you are,

where you are, what day it is, or is there some confusion, or some impaired level of response?

Each of these categories gets its own score, and then those scores are added up for a total out of 15 points. It’s just a quick and dirty test. It’s not going to tell me whether your brain is bleeding. I had a case just recently where the GCS was perfect, the client went to two trauma centers, went home, no CT, but their brain was actually bleeding.

I think if you don’t understand it, you might put too much or too little value on it. It’s important to know where the GCS was administered, what was the score, and what specifically was asked. If it’s a little kid and you ask them to show you their pinky, they might not be able to. So, it’s important to know what was asked. And it’s also important to talk about how GCS changes over time. You need to know when it was administered.

MR. ERNST (Pltf): It’s supposed to be every 15 to 30 minutes, because it’s used to make medical decisions about whether someone has a deteriorating mental condition that means they need emergency brain surgery. So, if they’re at a 13 or 14 and suddenly they’re at an 11, they’re probably going under the knife.

I want to say that the last three or four trials and arbitrations I’ve done, there’s been a GCS of 15 and they’ve all been big results.

MS. CHANG (Pltf): I had a case where there was video footage that showed our client totally unconscious, like a dead body, for several minutes. But by the time the paramedics came in, they assessed her at 15 because she was conscious and talking and her eyes were moving and she was responsive. But she had this long period of unconsciousness.

MR. ERNST (Pltf): Yeah, GCS is not something to be afraid of. It’s something you’ve got to make the jury understand what it was for, what’s the point of the GCS, and why it can be significant afterwards. Basically, what we end up

talking about the most – if there’s a very normal GCS or a mild GCS – is the difference between a primary brain injury and a secondary brain injury.

Primary brain injury comes from the initial insult or impact. The secondary brain injury happens over days, a week, or the first couple of weeks that they [end] up having all these symptoms show up from a biochemical reaction in the brain that will not be apparent in the first ER records – because it hasn’t happened yet. That’s why MRIs are most effective after a couple weeks or a month – because the brain injury hasn’t finished occurring throughout the brain.

Dealing with delays in treatment

MS. DE ARMAS (M): I want to ask the defense – and I’ll start with you, Nicole: Does a delay in diagnosis or treatment affect your evaluation as a defense attorney?

MS. WHYTE (Def): Yes, because that’s definitely an argument we can make to the jury, right? We’re looking at the timeline of treatment, the timeline of diagnosis. For us, the first critical questions are always: When was plaintiff counsel hired, was their treatment after plaintiff’s counsel was hired, and what was the treatment? I think a lot of that just goes to credibility; it gives us something to argue. A key part of the defense is whether there was a delay in treatment or whether there was a buildup of treatment only after counsel was hired.

MS. HALLISSY (Def): I’m always looking for inconsistencies. So, if I’ve got something in the records before new counsel comes in and raises it that supports your position, that’s one thing. When I don’t see anything in the records – headaches, memory loss, confusion, any TBI-type symptoms prior to what is now being claimed in litigation – I don’t give a lot of credence to that claim.

And I know the argument back from plaintiff’s counsel is always, “Well, their back injury was so bad, they were in so much pain, they didn’t realize they had a

TBI.” But I think when you have a legit TBI, it doesn’t take years to come to fruition. I understand you may not know it in 24 hours, 48 hours. But in those situations where you might have an early GCS of 15, something’s happened immediately after where you’re getting a brain bleed, you’re seeing MRIs with some deficits. Rarely, if ever, do you see a situation where you’ve got 12 months, 9 months go by with treatment just for – only for – the back, neck, whatever, and now we’ve got someone that’s going to have dementia for the rest of their life.

MS. DE ARMAS (M): Debbie, if you get a case where the plaintiff hasn’t been quickly diagnosed and there’s been a delay of, let’s say, a year, how do you deal with it?

MS. CHANG (Pltf): That is a common scenario, and it’s an interesting one. I dive into the records and I look for things like GCS – and if you have a hospital stay, there will be multiple GCS scores throughout the medical records. I do a comparison of the GCS scores. I look for persistent complaints in the medical records like headaches, fatigue, memory issues, not functioning at work or at school. I had a client who was a Ph.D. candidate – he was a superstar before and then he plummeted after his incident. He had perfect testing on all things medical, but his performance in school became bad after his injury. So, you’re looking at all of these things.

Let’s face it, if you have a mild TBI case and there’s no objective evidence, that describes a lot of our cases. But I’m going to say that some of our largest verdicts have been with perfect GCS scores where the TBI wasn’t diagnosed until experts were retained. But I want to caution: if it’s not a TBI, it’s not a TBI. It’s either there or it’s not; accept it.

MR. FAENZA (Def): I support what Debbie says, because that’s the thing: It’s either there or it’s not. We’re not going to go into court and say this person is faking a brain injury if we think the person is telling the truth. It’s all common sense.

You can send your clients to any experts you want, but if your client goes to their own doctor or they go to UCLA or USC on their own, and these independent doctors say there’s a TBI, we’re kind of boxed in.

On that point, if you have a neuropsychologist who says the plaintiff is nuts, tell your client. I’ve seen more cases lost by plaintiffs because I cross-examined their neuropsychologist and said, “You’re telling me that you told all these other people – plaintiff’s counsel, plaintiff’s other experts, whoever – but you didn’t tell the plaintiff how bad they are when you examined them? Are you kidding me? You don’t care about the plaintiff. All you care about is making money, because if you cared, you would have conveyed that.” So, you should always keep your client in the loop if it’s a legitimate thing. Get them help.

It’s not just the GCS score of 15. It’s the normal films, the lack of reporting. It’s a smell test. You can’t have five experts come in and say how messed up the plaintiff is and then I come in and show a photo of the plaintiff on the podium winning the state championship when he says his TBI is so bad he can’t even function. Look at your client’s real life separate and apart from the lawsuit. But those are the cases we fight – the ones that don’t pass the smell test.

MS. CHANG (Pltf): Let me say one thing in response to that. We turn down so many more cases than we take. Intake can almost be looked at as a de-screening, almost like you’re screening out the bad cases. Because when you put your name and your money and your time away from other clients into a new case, you want to make sure it’s a real TBI. Everything that the defense attorneys have said here, you can see what the value of your reputation is on these cases. You don’t want it to start going down.

MS. HALLISSY (Def): I want to follow up on Deb. She raises an excellent point. I was brought in recently at the eleventh hour to try a

TBI case. When I looked at it on paper, my gut reaction was it was a legit case, but it wasn’t clear how serious it was. And then I saw body-worn camera footage. The case was like five years old; how no one had seen this before me, I don’t know. But it showed the plaintiff slumped over like a dead body covered in blood and unconscious. I made the call immediately. I said, “We’re not going to keep this out of evidence. It’s coming in. It’s bad. I’m going to try the case, because that’s what you’ve hired me to do, but any doubt you had about this case? A picture speaks a thousand words and a video is even better, so....”

MS. DE ARMAS (M): Curious, what was the GCS in that case?

MS. HALLISSY (Def): It wasn’t a significant deficit, but there was a deficit. I want to say 13 or 14.

Experts in TBI cases

MS. DISKIN (M): Let’s talk experts. On the defense side, what experts are you bringing in immediately to evaluate these cases?

MS. WHYTE (Def): When we get involved on Day 1 of a catastrophic injury, we’re immediately getting liability experts involved as well as biomechanical. In terms of medical experts, if we’re getting the case within the regular course, once the complaint has been filed or there’s a demand in prelit, right off the bat we’re hiring the neuro expert. That’s an obvious go-to to take a look at everything. Then, from there, we would hire the neuropsychologist and neuroradiologist once we’ve had a full work-up by the neuro.

MS. DISKIN (M): I want to ask all of you: How important is it to you to have a neuropsychologist on your TBI cases? On the defense side, it often seems to be an absolute must. On the plaintiff side, there’s an emerging trend to forgo retaining a neuropsychologist and to challenge the science.

MR. ERNST (Pltf): That's a great question. We have cases where we sometimes do not have neuropsychs, which I know is surprising to some people. Neuropsychologists are Ph.D.s that deal with cognitive deficits, so it really depends on your client's symptoms. If the client's TBI symptoms are not as strongly related to cognitive deficits as they are to something else – vision, spasticity, tremors, etc. – then we'll go after experts to deal with those symptoms more than the cognitive deficits. Most of the time, if we're not going to be using a neuropsych, it's because there's a more significant brain injury like a skull fracture or brain bleed. We're not going to be fighting so much about whether there was a brain injury; we'll be fighting about the severity of it. Every expert you call is time taken away from the jury's lives, so you want to be hyper-specific about what case you're putting on. I don't want to just put on experts to put on experts.

MS. CHANG (Pltf): I agree with Taylor. I do want to say that there is one category of client that I love to do neuropsychological testing on: children with TBI.

This is because we have a set system of pre-incident testing in the schools. You have a basis of comparison that is so valuable. But in order to make all this data mean something to the jury – because it can be very dry – you need to display, in chart-like form, the comparison to the norm. And then your client before and after.

MS. SIMS (Pltf): I generally don't recommend using neuropsychologists, except – like Debbie just said – in cases involving children. I really find that neuropsychology tests are often misused by the defense. I can't attack the underlying science if my own experts are relying on it too. And I think neuropsychologists tend to drive up the costs on many cases. If you use a neuropsychologist, then the defense is going to hire one to say your client is malingering.

MS. CHAVEZ (Pltf): I once asked Debbie whether neuropsychologists are always necessary and she gave the best answer I think I've heard on this issue: What are your money issues? Meaning, what are the big issues in your case. Is your money issue a major vestibular dysfunction? Is it a sleep issue? Identify your major issues first. If cognitive issues are not your major issue, then a neuropsych is probably not appropriate.

But, even before that, is your client the right client for a neuropsych? Do they have a history of drug or alcohol abuse? Do they have suicidal ideation in their past? There might be things that are going to make your client not appropriate for a cognitive claim.

Let's assume your client has a cognitive deficit. Is a neuropsych the right way to go? There are other things to do, other tests we can do, and other experts we can use that don't leave your client exposed on the issues where the defense can attack them through neuropsych testing.

Not every case has a money issue aside from cognitive deficits. So, you want to step back and look objectively at your client first. Are they appropriate for neuropsych? What testing is appropriate for them?

When neuropsych testing is done well and it's used appropriately, it's helpful. But there are times when it's abused and it needs to be called out. And don't forget about the power in limiting or defining the test environment. Talk about the climate, the size of the room, and so on.

MS. CHANG (Pltf): Yes, and you must make sure that your client understands that you want them to perform to the best of their abilities. They may think they need to perform badly, but you need to explain that the neuropsych testing is designed to find malingering. So, you need them to give maximum effort and do their best.

If you've got a non-English-speaking client, make sure that the tester speaks the client's language. The neuropsychologist needs to adapt to

whatever your client is. Make sure that language is never a barrier. Also, lack of sleep and pain can impact testing results, so do what you can to make sure your client is comfortable so they can get through the testing.

MR. TREYZON (Pltf): Yes – for example, if you have a client whose injuries include an optical component so that they're light sensitive or something, the lighting in the room is important. Ambient noise is important.

Keep in mind that these tests have been administered on hundreds of thousands of subjects. The conditions in which the tests are given are very important. For example, between Part I and Part II of the MMPI, if the subject asks how they did in Part I, the tester is supposed to give a response telling them. But the tester is not supposed to volunteer that information unless the subject specifically asks. These are the sorts of little nuances that are so important for the scoring – and it's hard to overemphasize their importance.

MS. CHAVEZ (Pltf): Always get yourself a good psychometrician.

MS. CHANG (Pltf): Boris is absolutely correct. One of the most “aha” moments for me is getting all the data and the test manuals and the test scores. I also asked a neuropsychologist if I could have my whole office tested because I just think if we could go through the neuropsych testing, we would understand so much about what to ask in depositions. Seeing what the questions are, what the answers are, that was life changing to me.

MR. FAENZA (Def): I think one of the mistakes that people make on both sides is that they bring the plaintiff in and the neuropsychologist says, “I did eight hours of testing and administered such-and-such tests.” The jury has no idea what that means. This is upper-level stuff. It's not like putting on an X-ray and pointing at the fracture. The

neuropsychologist needs to do a good enough job of giving a history of the science, what they're looking for, what the science can do and what it can't do. But often they just go right to "I find this person disabled" or "I find this person isn't disabled" and it really doesn't move the needle that much. I don't think you're going to win your case if your neuropsychologist is the lead witness. Neuropsychology is more helpful when there is complementary imaging.

Going back to the other point I made before: Don't bring a neuropsychologist on to tell the jury how bad your client is if that neuropsych has never had a discussion with the plaintiff. I just had one testify that the plaintiff shouldn't be driving a car, shouldn't be handling a gun. I asked him, "Did you ever tell the plaintiff?" His answer: "No, I relied on the plaintiff's lawyer to tell him that." All credibility is lost there.

If the point is to get the person better, then have a conversation. If it's just to get money, then your position is that the plaintiff is on their own, on an island.

MR. LOW (Pltf): I want to add some context about trial and neuropsychological testing. At trial, the story of the client is not the neuropsych testing. The jury is not going to tune in for the enormous amount of words that one has to generate to even describe the testing.

The test itself has a story that should be delivered in a meaningful and emotional way to a jury so that they understand what the testing is like: At the end of the day, it's some paper testing that's kind of like what you got in school when you were tested to see what aptitude you may have or where you should go to college. This testing is developed in a way so they can see if your brain doesn't work as well in some areas that maybe others do. They call this cognitive testing.

[But] the jury is not going to listen to a six-hour presentation that you and the defense put on about what a neuropsych exam is. Their attention span ain't going

to last that long. They see two people fighting and don't know what to make of it. So, you've got to find a succinct, powerful way to deliver the story of what a neuropsych exam is.

The aftermath of *Randy's Trucking*

MS. DISKIN (M): Let's talk about *Randy's Trucking* [*Randy's Trucking, Inc. v. Superior Court (Buttram)* (2023) 91 Cal.App.5th 818 [holding that trial court had discretion, when granting defense request for a mental examination, to order the defense to provide plaintiff's counsel with all raw data and test information after the exam]. I think everyone on both sides is having some issues now. On the defense side, what kind of problems are you encountering trying to get experts to go along with a stipulated protective order?

MS. HALLISSY (Def): It's a legitimate problem on the defense. We are literally going expert to expert to expert to see if anyone will do testing under the *Randy's Trucking* scenario, and they all declined. So, we're somewhat hampered, and are trying to do work-arounds – for example, the plaintiff's neuropsych expert does the testing, shares the data with us, and then we're able to show that to our expert to figure where there's weaknesses, strengths, problems.

I'm always trying to work with plaintiff's counsel to meet a particular expert's requirements, but a lot of the neuropsychologists do feel that there's an ethical problem on their end in terms of producing this. So, I sympathize with their point.

But I'm going to flip the question back to plaintiff's counsel – I want to ask all of you about something I truly do not understand. As long as the data is going to your experts, what's the downside for letting your experts funnel that information to you in a way that you can use at trial or in deposition?

MS. CHANG (Pltf): Having briefed this issue multiple times, let's start with

the premise of what *Randy's Trucking* is all about. The manufacturer or owner of these tests feels that they have a strong reason why they want to keep the test manuals and tests private. They're afraid that it will diminish them or that it will get out to the public on YouTube or whatever and could affect patients' results. That's the reason why, for years, the rule has been to just have the professionals exchange it. They know how to keep it safe and not to disclose it. If they're board certified, there are rules of ethics that they have to follow.

But times have changed. And, over the years, plaintiff's attorneys have repeatedly raised, "How can I properly cross-examine when I don't even understand what question was asked and what answer was given or what criteria are being applied? Yes, you can give it to my expert, but my expert isn't deposing this witness, I am. I need to understand it to cross-examine."

As time has passed, the ethical rules of the American Psychological Association (the "Ethical Principles of Psychologists" and the "Code of Conduct") have changed – to the point where we are now: It's okay to send this material to the plaintiff's counsel if there is a protective order. There is a whole section now on the release of test data, and this very issue is contemplated.

So, when you put a protective order into place, it shows that the lawyers and everybody associated with the case will not divulge the test materials or the data. But it does allow us to understand the testing like we never could before. It allows us to see time restrictions, what our client did, where they went wrong or right. And it's invaluable.

Your depositions will be so much better when you're armed with all of this. An expert will never be able to tell you what to ask because they don't think like a lawyer and they don't understand what you don't know. You're the one who has to go through it all. That's the whole logic.

Also, and this has always been true, a plaintiff always has the right to get their own data. And even before *Randy's*

Trucking, there was *Carpenter* [*Carpenter v. Superior Court* (2006) 141 Cal.App.4th 249], which basically said that the judge had the power to order the release of the data.

There are experts who use tests in ways that they were never meant to be used, with no research on the method by which they interpret data. It's especially important to make use of *Randy's Trucking* with experts like that.

MS. HALLISSY (Def): I think now, in light of this current dynamic going on, it behooves all of us to meet and confer before we even select experts to find out what the fight is going to be. When you have a legit TBI, the neuropsychs are in agreement, so there's not usually this big of a fight. When I'm dealing with quality, credible neuropsychs, they are very close. They may have some slight nuances, but they are usually fairly close together.

Would you all agree with that?

MR. FAENZA (Def): I find this interesting. We just dealt with this the other day. The plaintiffs were whooping and hollering during the neuropsych's deposition that they didn't have all the raw data, and said they were going to go to court. So we said, we're going to make the same motion for your experts. All of a sudden, it became a moot point.

Turnabout is fair play. We all have the same issues. And that's why I think it'll work out. I do think there was a fear – like what Deb was saying – that if this material is out in the open market, if you can take a practice test, then the testing is worthless.

MR. TREYZON (Pltf): It is out there on the open market and in all their books written about these tests and how to interpret them. I've never understood the copyright argument. I think that argument has come and gone. And if we're dealing with stuff like the MMPI, that's a 5 1/2-hour test. What kind of practice can you take for that?

MS. CHAVEZ (Pltf): I agree with Boris. There is a lot of data out there. There is no protecting the tests. They are commercially available. There are tons of books out there. I don't buy into this argument that we have to protect the test.

MS. DISKIN (M): How do you all feel about videotaping the clinical interview and the written testing? That's starting to happen in some states.

MS. CHANG (Pltf): It's a double-edged sword, and I'm anxious to see what defense counsel says too. It could go horribly for the plaintiff. We audiotape the interview portion and transcribe it – so that you know if the defense expert is listing only the positive and eliminating the negative things that the plaintiff reported.

What we have to understand is that this is testing that goes on for a long period of time. I think jurors sometimes have this perception that a brain-injured person should be drooling or something. So, when they see someone looking perfectly normal, sitting and taking a test and acting like a completely normal person, it takes a lot of education to explain that. It's like another form of surveillance.

MR. TREYZON (Pltf): I agree with Debbie. The last thing I want is a videotape of my client taking that test because very often, you can cut five minutes of it and the client is perfectly fine. I want the audiotape, so that I can ensure the quality of the testing. We listen to each and every minute of that tape to look for something that was done inappropriately. It doesn't invalidate the test, but it can certainly explain a result. Because these tests are really intricate. They are so intricate that surgeons can sometimes detect which areas to operate on based on your psychological testing because it affects a particular region of the brain.

These are highly calibrated, highly specific tests. They don't rule in or out a brain injury, but they rule in and out

cognitive deficits. That's really important to understand. You can have a cognitive deficiency without an anatomical finding. 77% of mild traumatic brain injuries have no positive anatomical finding on imaging, but you can have a cognitive effect.

MS. CHANG (Pltf): I want to follow up on something Erica said because I think it's so important. First, there are some doctors who don't follow what is published and they do their own testing. When you see the scores for the first time, there are discrepancies in what they find. Because, with all these tests, there's research on what is normal, what isn't, what is deficient. You could research each test and get a great explanation. You could see the manual. You could see your client's handwriting. You could see a picture drawing. But without the data, you can't do what I can now do, which is look at that raw data and see what everybody else would score as abnormal and impaired, but this defense witness is saying it's absolutely normal. This gives you great fodder for cross-examination. You can't do that without that data. So, I think filing the motions is important. The law is on our side and so is the experts' own code of ethics.

The plaintiff's deposition – Perspectives on preparation and presentation

MS. DE ARMAS (M): For our defense colleagues, what factors do you take into consideration about the timing of plaintiff's deposition?

MS. HALLISSY (Def): It depends on what the allegations are. Personally, I want to have all medical records in before I depose the plaintiff, and that includes past and current treatment, because a lot of times, we're taking plaintiff's depo too early. They're continuing to treat. And I get called in to try the case and am finding out that they had more treatment or developed a new condition. So, I like to have all medical records in, all written discovery done.

The first depositions that I like to take are the first responders. First, because their memories fade over time. Second, because they'll give you a very clean response as to what they've seen. A lot of times we get these cases years after the event, and they don't remember anything – it's just whatever is on paper, whatever is on the report. That's a waste of time. But if I have a case where someone's filed very quickly, those are the first depositions I take.

MS. DISKIN (M): What about educational or employment records? Do you want those before the plaintiff's depo?

MS. HALLISSY (Def): I wait until after the depo for those, because I want a better understanding of what records I'm going to order. So, after the deposition, that's when I'll order employment and educational records. Once you meet the plaintiff and you get a sense of what their issues are that they're claiming, that's where I'm going to point my focus.

MR. FAENZA (Def): It's really a game of Battleship – where I'm asking a question and the plaintiff has to give the right answer so I know where to go next. Sometimes you don't know if you need the records, but you know where to get them. Many times, I have records that the plaintiff wouldn't be aware of. Most of the time, their lawyer has the records, but hasn't read them.

We just had a trial last week where the first question to plaintiff's mother was, "You said she couldn't go boating." "Yeah, terrible thing, she can't boat." "Who is this picture of four days after the accident, in the boat? Is this your daughter?" "Oh yeah, yeah, she had a good day."

I love this line: The plaintiff's lawyer will say, "That was a surprise; that statement was surprise!" Well, gee, it wasn't a surprise to your client – it was just a surprise that *we* knew.

On legitimate TBI cases, I don't think it matters when we take the

deposition. We probably take it earlier because our client wants to price it to get rid of it and not keep the file open. So, if you get a deposition notice earlier, we're probably considering your case legitimate more so than if we wait and try to gather as much information as we can to kind of go in for the kill.

MS. WHYTE (Def): Timing is critical, because I think you want to make sure you've got enough information – medical records, employment records, educational records, so that we're able to read all of that and craft our questions. A lot of the deposition is about the plaintiff's credibility and testing the believability and credibility of the plaintiff's story. So, when we have the records, we can take a great deposition. The flip side is that you want to take the deposition well enough in advance of trial so that there is fully enough time to do follow-up discovery if there are other witnesses who need to be deposed.

MS. DISKIN (M): For our plaintiff attorneys: How do you prepare your TBI clients for depositions? For example, if your client is claiming memory loss because of their TBI, how do you prepare them to testify about their medical history?

MS. CHANG (Pltf): An expert once told me that TBI patients are the hardest to prep for a depo or trial. And I've found that generally to be true. I have literally talked to my client and told them the importance of something. "Please don't say X, Y, Z," and then it pops up in depo as the first thing the client says. If you have a client with a true TBI, it's very difficult to prep. I think prepping a plaintiff for a deposition takes multiple sessions. It has to be done simply and clearly. And you just have to enjoy the ride at depo or at trial. By the time a plaintiff gets on the stand at trial, you can explain what a brain injury is and how some things will appear perfectly normal so that their memory is not affected on certain things but is affected on others.

I also think it's very much up to us to control the setting of the deposition, especially if there's polytrauma. So, constant breaks, giving reassurance, make the environment as comfortable for them as possible. It can get very emotional. Sometimes there'll be tears for no reason or inappropriate laughter.

MR. ERNST (Pltf): I kind of lean into a science perspective for some of the prep work – meaning, if your client has memory issues, you want to get the prep work out of their short-term memory and into their longer-term memory. We won't do one prep; we'll do four. Or we'll make them way shorter and do 15 prep sessions on a single issue over the course of a week. And then we'll do a really longer session on another section.

So, when that's the level of difficulty, it's hard. And you do have to set the right conditions. Erin deposed one of my clients and graciously agreed at the start of the depo to lower the shades and turn off the lights and reduce stimulus as much as possible. You need to think about that before depo so that you can make sure you're giving your client an environment where they can answer questions as best they can.

I think if you talk to defense counsel beforehand, they're more agreeable to that than not, because they want to find out what the issues are with your client too. I think, more than anything, the prep work for a brain-injured client needs to be fundamentally different than any other type of case you're prepping – you need to know and prep your client on each of the issues: vision, sound, memory, whatever your client has.

MS. DISKIN (M): For our defense counsel, what are you looking for in terms of the plaintiff's presentation? What are you looking for to evaluate whether the plaintiff is or isn't credible?

MS. HALLISSY (Def): One of the strongest factors for me in the evaluation of any case is: who is the plaintiff? How

likable are they? How do they get their story across? Do they seem credible? Do they have inconsistencies? Are they lying? Are they truthful?

It's difficult to evaluate that with TBI plaintiffs – like, when I try to get a history from them and they're incapable of doing that. So, then I need to find out if this is a show or is there some legitimacy to how they're presenting. And so, I always say to younger defense attorneys, put your script away, talk to them, get to know them. Really try to hear their story, because it's going to come out one way or another.

If you sit there and try to go through their medical history, most of the non-TBI plaintiffs can't even do that. If you've got a TBI plaintiff, why are you expecting them to remember who their treaters were or what procedures they had? You have the medical records; you know that. That's not as important to me as really seeing how they present.

MS. WHYTE (Def): For the defense, the deposition is where the insurance adjuster is looking to us to evaluate a big chunk of the case: the believability, sincerity, likeability, credibility of the plaintiff. That's a huge piece in our evaluation. How sympathetic is this plaintiff going to be in front of a jury? And the carrier is looking to us, the defense counsel, to give that evaluation.

I always say that one of the most dangerous plaintiffs, in my view, is the stoic plaintiff – the one who comes and is making that effort to do it all and isn't complaining and is trying to put on that brave face. And then the real clincher is when there's been a change in functionality – because that, to me, is the true value in a TBI. That testimony is coming from other witnesses, people who don't have a stake in this. You talk about the changes that they've seen at work or in the social setting or wherever.

So, for all you plaintiff lawyers, when you're preparing your client for this, please keep that critical piece in mind. I've done plaintiff work and have

prepared plaintiffs for depositions. I think you can't do enough preparation in getting them ready, in helping them understand the process. Even doing a mock examination and putting them through all that.

One other point I want to make: It's no secret that we on the defense side love our surveillance videos. We're often getting that surveillance before the deposition so that can clue us into what questions to ask. Can you do this? Can you do that? And maybe it's all already on surveillance. And we can also do follow-up surveillance afterwards, if need be, to challenge what's been said.

Framing the case for different types of plaintiffs

MS. DISKIN (M): We've all had difficult cases where the plaintiff was high achieving before their injury and they're high achieving afterward, but there's been some sort of change. And the difficulty lies in quantifying the change in the before and after. How do you frame cases like that so that it is properly valued – even if that change isn't reflected to any great degree in the neuropsychological testing?

MR. TREYZON (Pltf): It becomes very much a game of universes. We had a client who was the CFO of a larger company. She had an MBA and, I think, another degree. And afterwards, she couldn't balance her checkbook – which most people can't do, frankly. But she couldn't be the CFO. So, the baseline becomes the most important thing.

Everybody knows there's a huge difference in individual abilities. What the loss of that ability means is a separate issue. You have to use examples and you have to describe it. You have to get examples of what your client was able to do before and what they're able to do now. It's not going to be quite as telling on a neuropsych test because those are large model tests. There are very few neuropsych tests that are narrow in issue. You cannot necessarily say, oh, the client's IQ dropped from this point to this point. First, IQs are usually determined by the

client's levels of education across the baseline and, second, you're going to have very few clients who had an IQ test done a month before the incident and then again, like, five months after. So, I'm not aware of any other way that you can demonstrate it except by giving examples: This is what the person did before, this is what the person is able to do now.

MS. DE ARMAS (M): Let's reverse that example: what if you have a client who was low performing beforehand – like they had an IEP in school and now they need more accommodations. How do you deal with someone that was low performing before and low performing afterward?

MR. TREYZON (Pltf): I actually had defense counsel tell me once in a recorded statement – it was so good that this was recorded – “Your client was stupid before and is stupid now.” None of the defense attorneys on this panel!

But, once again, it's going to be all about examples. You just show what activities of daily living and what things that we're so used to do doing and that the client can't do anymore or has more difficulty doing. I had a brain-injured client who was undocumented, barely had rudimentary reading abilities. But he functioned – he'd go to the store, he'd shop for himself. After the incident, the only thing he could do is walk out of his house and turn right. He couldn't turn left, he'd get lost. So, the way not to get lost, was to turn only right. He could go around one block; that was it. We described that as his entire universe. That's what he could do, he could turn right. We estimated his pre-incident IQ to be about 85. He was below 65 afterwards with significant cognitive injuries.

So, you have to use examples. I'm literally not aware of any other way to demonstrate any difference other than by using examples.

MS. CHAVEZ (Pltf): You know, there's no substitute for spending time with your client. There just isn't. Because

the things that are different for the client can be really, really subtle – and they can be the doorway to something so much bigger. Like the client who’s quick to anger. You dig and dig and you find out that they’ve lost their family and now they’re separated.

Or maybe it’s something that just takes them longer to do – a job or activity. Maybe it’s all of these things. But you’re not going to find out if you don’t constantly build that trust with them, that rapport with them, and talk to them. I want to talk to everybody. Sometimes the client doesn’t want me to talk to certain people, so I ask for letters.

And when you find those things, those deficits that they have, that’s where your therapies and providers that they have really come into play. If they have a balance issue, maybe it’s minor, but you can use the therapy that they do to build out that issue and that story. Or a vision issue: now they’ve got floaters, for example. Maybe it’s minor, but it comes out in everyday life. And you got back to all the things that you’ve learned from spending time with them.

MS. DISKIN (M): How about eggshell plaintiffs – like a plaintiff who has had prior TBI?

MR. LOW (Pltf): I don’t use the label “eggshell.” When a lawyer hears another lawyer use that word, it creates a negative energy. It comes between you and your ability to connect with the client and their story.

When you spend a lot of time with the client, you start to take on their energy. But that’s why you need to spend a lot of time in a lot of different environments – because the client will be on their best behavior at the beginning. So, you’re not going to be talking with them from behind your desk, or in your office, or in a conference room, or in a doctor’s office. And what you’re really looking for is what it feels like when you see that client and they don’t think anybody is looking. How do they do things? What are they doing?

So, that energy you take on from your client in different settings, it comes out at trial as nonverbal communication. Studies show that less than 8% of what you learn comes from audible input – meaning that, even though lawyers love to do nothing but talk, talk, talk, the jury is not absorbing much of what is being said. So, that nonverbal communication between you and your client is really telling the story.

So, about “eggshell” – you have to ask yourself the question: What is it about this person? Don’t use the word “client” anymore. What is it about this person that I love? Change that energy. Go into learning and absorption mode, just like you want the jury to do.

MS. CHANG (Pltf): I embrace “eggshell.” I love it. And the reason why is because of two jury instructions I know I’m always going to ask for: CACI 3928, unusually susceptible plaintiff, and 3927, aggravation of a preexisting injury or condition.

I even make slides with eggs. I have an egg on the left side, an egg on the right side, and I put down all their problems from before in white. Then on the left, I put down: He was working, thriving, energetic, happy, had a job. On the right, I have post-incident. I put all those things at the bottom in white, plus all the new things from this incident. Now he can’t work. He’s fatigued. He has cognitive difficulties, and so on.

And I use this with defense experts. I ask, “Well, he had all this before, and you would agree he still has that, but now he also has TBI, and that makes it worse, doesn’t it?” There’s never been a doctor who’s said, “Oh yeah, that TBI made him better.” And at closing, I say, “Sometimes you go through life and you’re a robust, healthy egg. You’re a hard-boiled egg. But there are some people have little cracks, because he had this or that. Now he has a TBI, and it’s so much worse than it would be for the hard-boiled egg.” I love it.

MR. ERNST (Pltf): I lean into it. For clients with prior brain injuries, they are significantly more susceptible to another brain injury. And it makes for cognitive leak. You can really teach the jury that, where your client has had prior TBI, why this individual, new brain injury is statistically significant. This is the unicorn – this is the TBI that usually gets better in 3 to 6 months, but that prior TBI is why it didn’t get better within that time frame. This is why it’s a statistical anomaly, and why it’s so much worse.

When you’re deposing the defense expert and they say that the injury should have gotten better at this many weeks or months. How many of the statistics upon which they base that opinion are patients with prior brain injury. How many of those statistics had a brain injury that got better – what are the actual numbers? “I don’t know,” the defense expert will say. And you keep going: “Well, isn’t it important that your research matches up to what you’re testifying to in this case?” And you can see where that whole line of question goes pretty quickly.

MR. TREYZON (Pltf): I love Debbie’s slides. She’s the best slide presenter I’ve ever seen. And for eggshell plaintiffs – well, people are people, and you present them the way they are. If they had prior TBI, you talk about the prior TBI.

There’s a great saying: “It’s not what you lose, it’s what you’re left with that matters.” What was the client like before? What did they become? Taylor is right, if the client had prior TBI, they’re infinitely more susceptible to the new injury. If the client was just making his way in life and that was enough and now he can’t, well, they took the one level of dignity that he had. We all have prior issues, just to a different level. I don’t hide the ball. I provide it in discovery. Your client is a human being, and human beings are never the same, and they’re never perfect. Neither are jurors.

MR. LOW (Pltf): I agree with Boris, and will just add: It's not just what you're left with. It's what was taken from you without your permission, and what value did that have? That has to resonate with the jurors. You have to warm them up and help them to discover in voir dire what value they place on their health, what is it about them that's priceless and irreplaceable to the degree that they are willing to extend that same commitment to a complete stranger, your client.

Communication and building the groundwork for resolution

MS. DE ARMAS (M): For our defense attorneys, what do you find is the biggest roadblock that you have with your carriers on TBI cases? How can we help you educate them?

MS. HALLISSY (Def): It all goes back to credibility. So, when I have a plaintiff or a plaintiff attorney who has lied, overstated, it really creates a huge impediment for us to try to get money. Once the carrier determines that what has been claimed is not what is being portrayed, it's difficult for us to get money from them.

I had a case with a plaintiff who saw all the usual suspects and then made a representation at deposition and was very adamant that he did not get to those providers through lawyers. He testified that he self-selected. I was, like, what are the odds of that? And we go through everything and get the records, and he's lied. There is not a lot of willingness to go out of the way to fund those. Those are the cases that get tried.

Own your bad facts. We have to do the same on this side. We might have some very bad facts, and that's the first thing I bring up to the jury. I want to tell the jury from the start in voir dire what the problems are so I can see their reaction to it. When you're not open and honest about it, it harms you.

So, I think the cases that get settled the most are the ones that say, here's

everything. Here's our medical records, here's our experts' reports. I know a lot of people are giving me life care plans subject to mediation privilege. I think that's great. It's better for me to know earlier rather than later. If you're saying this person is going to need attendant care for life, what's the basis? Who's going to support it? Tell me so that we can figure out a value.

MS. WHYTE (Def): I think the biggest roadblock in getting the carrier to pay on these TBI cases is skepticism, because there are cases that are not true TBI, but lawyers will try to make them into TBI cases. Debbie made the point earlier: It's either a TBI or it's not. And if it is a TBI, then what you can do to help us is give us the information. Give the info to us so that we're not having to ferret it out and then make it seem like it's a nefarious claim.

To the extent that there are objective findings, those are always valued by the carrier. And yes, just because there are no objective findings and a GCS of 15, you can still get a multi-million-dollar verdict. But it helps if you can get us the information that's going to help us explain the case to the carrier and help us objectively, fairly evaluate the claim.

MR. TREYZON (Pltf): People forget that until we're actually in trial, defense counsel and us are on the same side if we want to resolve the case. I mean, Nicole and I have discussed doing a mock trial and having a carrier watch it.

MS. CHANG (Pltf): I love that idea.

MR. ERNEST (Pltf): Boris, we've done it. We've done it twice now to see what case value comes up. And it settled the case both times.

MR. TREYZON (Pltf): If your case is worth \$5 million, and defense comes to you with a \$500,000 offer, that case is going to get tried. That means there's a failure of information. There is somebody

who is not getting something one way or another. Good defense counsel, good carriers, they will settle every case every time if you have provided them with the information.

I view it as an obligation to educate the other side. They don't have the burden of proof. Educate them, and if you have educated them and are smart about what you do, then the case will settle. If you have failed to do that, the case won't settle.

Resources and education

MS. DISKIN (M): On that point, what are your go-to reading materials and resources for TBI education?

MS. HALLISSY (Def): It's usually on a case-by-case basis for me. A lot of times I will ask plaintiff's experts what materials and resources they are basing their opinions on, and I read every page. We're never going to be as smart as the neurologists or the neuropsychs who deal with this day to day. But I can ask what they're reading and then I read it.

MS. WHYTE (Def): It's a multi-level approach: talking to other attorneys, reading Daily Journal articles and these kinds of roundtables, and articles recommended by experts. I think these types of roundtables are invaluable.

MR. TREYZON (Pltf): You have to have the DSM-5-TR. You can't do a TBI case without that. Look for the "TR" – it's the most recent edition, and it has extremely significant changes to it. We also have a subscription to Academia, which is a scientific journal aggregator site, so we constantly get updates on the most recent studies. There's also all the major health agencies: FDA, Veterans Affairs, National Institute of Health. They regularly put out publications that are more digestible.

Definitely talk to your experts; they're a great source of education and they will tell you what they use. Talk to

the folks on this panel, and talk to the defense counsel. Nicole and I have had great conversations about the most recent developments in TBI.

This field is changing so rapidly. Ten years ago, the NFL denied chronic traumatic encephalopathy until they did a multi-billion-dollar settlement. This area is changing rapidly and if you have an expert against you who is using information from 10 years ago, you can really destroy them.

MR. ERNST (Pltf): I have a tiered approach. You've got to understand the standards of the experts who are rendering opinions – the basis for their opinions, like DSM-5 or DOD or Congress of Rehab. You need to understand those basic levels to be able to say, "What are the bases of your opinions and why?"

The second tier is the tests themselves. What are the bases of the tests? Why did they do those tests? What tests should have been done that they didn't do? And if you really want to get in the weeds, you can look at the board-certification tests for the specific field. If you have a defense neuropsych who is not board certified and you have a book on how to become board certified, it is some very powerful cross-examination.

Over time, you will have read so much information about neuropsychs and neurologists and different testing that it's much easier to stay up to date when new papers come out or there's a change, because you know all the references that are being cited. It's building up a war chest of information.

MS. CHANG (Pltf): In addition to what everybody else has said, I always pull every single article, book, slide presentation, or seminar that the defense expert has ever spoken about. You would be shocked at how many times they've talked on video in a speech or teaching students and they say exactly what you want them to say.

I also really like material that comes from governmental entities like the Department of Health & Human Services or the Center for Disease Control. They tend to put out publications that recognize the difficulty of concussions and mild TBI, especially in children or in specific groups that are more susceptible. They tend to be very current. And they have the American flag on the cover! So, I'd add those to the list.

Don't turn your TBI case into a legal-malpractice case

MS. DE ARMAS (M): Marshall, what are the most common scenarios that you see in legal-malpractice cases arising out of a TBI case? What can we plaintiff attorneys do to keep a TBI case from turning into a legal-malpractice case?

MR. COLE (Legal Mal): As you can see, TBI cases raise a whole host of unique issues that can cause problems for lawyers on both sides of the "v" if you are not familiar with this type of work. The most important thing I see that gets lawyers into trouble on these claims is a lack of education and understanding of what a TBI is and how to handle a TBI case. Lawyers need to be familiar with the science. In order to properly handle these claims, you are going to be deposing and cross-examining very experienced physicians on complicated and nuanced issues. If you go in blind, or think you can wing it, you are going to end up in trouble. If you treat the case the same as any other personal-injury matter, you're going to overlook issues based upon ignorance. This will lead to a claim.

As you can see from the lawyers on this panel, all of them have an intimate knowledge of the science and issues that come up in these types of cases. They continue to learn and develop skills to deal with experts, medical records and trials. What many lawyers forget is that a malpractice claim does not have to be a single cut-and-dry error that's black

and white. It can be a combination of factors that are overlooked or missed throughout a case that resulted in a bad outcome.

For plaintiffs' attorneys, it's important to manage expectations from the outset. TBI claims seem to be extremely popular now, but if your client doesn't really have a TBI, don't create one. The great defense lawyers on this panel, and in the community, will poke holes in the case and ultimately the result will not be that great for the client. If you have oversold your case to your client, when the bad outcome arrives, your client is going to look to you and claim that had you not oversold the case, the client would have prevailed. This happens not just with TBI cases, but with many types of catastrophic-injury cases.

Client communication is also key – you may have a client with diminished capacity as a result of the TBI. Your obligation to communicate is essential and in fact is elevated due to the circumstances.

You also may need to get a guardian ad litem or conservator appointed so that informed decisions are being made by someone who can give informed consent.

You also need to be cautious about communicating with family members. Don't do it unless you have express consent from your client. Family members can often turn on one another, especially when money comes into the picture. If you inadvertently share confidential information with the wrong family member, you could find yourself in hot water.

This Roundtable was made possible thanks to the efforts and generosity of STENO (including Armando Medina and Richard Kim) and JUSTICE HQ. STENO provided excellent and speedy transcription services and JUSTICE HQ hosted us in their beautiful downtown Los Angeles office.

See participant bios on next page

Erica Chavez has devoted her legal career to representing victims of catastrophic injury, particularly TBI. Erica single-handedly built the largest brain injury conference in the world, TBI Med-Legal, and is a co-founder of the firm Trauma Law with Joseph H. Low IV. Erica is the Chair of the Board of the Brain Injury Association of California, a member of the Board of Consumer Attorneys of California, and a frequent speaker on the lecture circuit, mentoring young attorneys and educating the legal community on TBI litigation.



Chavez

Joseph H. Low IV is a co-founder of the firm Trauma Law with Erica Chavez. He helps develop and lead programming for the Gerry Spence Method at Thunderhead Ranch, training the nation's best trial lawyers. Among his victories, Mr. Low has argued before the United States Supreme Court, successfully ensuring the right to hire a lawyer of one's own choosing. He was the first to introduce PTSD and TBI as defenses for capital murder in military war crime trials.



Low

Marshall Cole is a trial attorney at Nemecek & Cole. He specializes in complex and high-profile professional liability and other civil litigation matters, representing many of the most successful licensed professionals in the U.S. through all aspects of litigation. The Daily Journal has recognized Marshall as one of the top Professional Liability attorneys in California (2022-2024). He has also been named a "Rising Star" (2014-2022), "Super Lawyer" (2023-2024), and an "Up and



Cole

Coming Top 100" attorneys (2019-2022). In 2024, he was awarded with the Association of Southern California Defense Counsel Patrick A. Long President's Award for his exemplary service.

Erin Hallissy is a managing partner at Schonbuch Hallissy LLP, where she handles a wide variety of cases: from catastrophic automobile accidents with alleged TBI and spinal injuries to bad faith and insurance coverage. She has argued appeals before the California Supreme Court and the Ninth Circuit Court of Appeal. Erin's focus as a civil defense attorney is on taking care of her clients and putting their interests first. She develops clients' trust by listening, frequent communication, and top-quality work product. She believes preparation is key and that aggressive advocacy includes a good working relationship with opposing counsel.



Hallissy

Nicole Whyte is the founder and CEO of Bremer, Whyte, Brown and O'Meara, LLP. Specializing in family law, complex civil litigation, and appeals, she has been named by the Daily Journal as one of California's Top 100 Women Attorneys and is rated AV by Martindale-Hubbell. Nicole is consistently named in lists of Best Lawyers in America and top Super Lawyers in Orange County. Nicole is also dedicated to educating other attorneys and to giving back to the community: she speaks at legal conferences throughout the United States and around the world, is a published author on family law and trial advocacy, and is also long-standing board member and past president of the Public Law Center, where she has donated hundreds of hours of service to the board and pro bono clients.



Whyte

Boris Treyzon is a founding partner and lead trial attorney at ACTS Law. An active member of CAALA, CAOC, AAJ and ABOTA, Boris has been recognized as a Trial Lawyer of the Year by CAALA and a Top 100 Attorney and Top 100 Plaintiff's Attorney in California by the Los Angeles Daily Journal. He is deeply involved in every case, handling motions, hearings, and advocating vigorously for his clients both in the boardroom and the courtroom. Boris tries approximately 8-12 cases per year, focusing on catastrophic injuries, insurance bad faith and complex business disputes.



Treyzon

Deborah Chang is an attorney and founder of Chang Klein LLP and Athea Trial Lawyers LLP. She is the former president of the Consumer Attorneys of California (CAOC) and the Los Angeles chapter of the American Board of Trial Advocates (ABOTA). She is the 2023 recipient of the CAOC Consumer Attorney of the Year and the Marvin E. Lewis Award. Previously, she was recognized by Best Lawyers as a "Lawyer of the Year" for Personal Injury Litigation Plaintiffs for the Los Angeles area, and she received the California Lawyer Attorneys of the Year (CLAY) Award.



Chang

Taylor Ernst is a lawyer at the Ernst Law Group. He won the Daily Journal's California Lawyer Attorney of the Year (CLAY Award) for his landmark 2023 verdict against Chevron in Wright v. Union Oil Company of California. Taylor specializes in



Ernst

TBI and other complex matters. He frequently roundtables cases with other firms, teaching other firms how to evaluate TBI cases, reviewing at least a few TBI cases a week for other firms, and providing guidance for the proper handling of TBI matters.

Dorothy Clay Sims is the founder of Law Offices of Dorothy Clay Sims, Esq. For three decades, she headed one of the largest workers' compensation practices in Florida – but after years of watching her clients suffer at the hands of defense medical examiners, Dorothy decided to focus her practice on acting as a consultant for other attorneys, helping them to uncover how dishonest doctors spin the science for the defense. In this capacity, Dorothy guides



Sims

*plaintiff lawyers in researching defense expert witnesses, deciphering their reports, understanding the science, and crafting cross-examinations. She is the author of the acclaimed book *Exposing the Deceptive Defense Doctor*, and a highly sought-after speaker and writer throughout the world.*

Chris Faenza is a civil defense trial attorney and partner at Yoka | Smith, focusing on catastrophic injury cases. Chris has tried over 80 cases to verdict throughout California.



Faenza

His clients include excess insurance carriers as well as corporate clients in a range of industries, including trucking, business, and products. Chris was the President of the Association of Southern California Defense Counsel in 2019, President of the California Defense Counsel in 2021, and President of the Los Angeles chapter of the American Board of Trial Advocates in 2023. He is also a Fellow of the American College of Trial Lawyers.

