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A new playbook for traumatic brain injury

THE SCIENCE HAS CHANGED. HAS YOUR CASE STRATEGY?

An estimated 2.87 million Americans visit emergency rooms for traumatic brain injury (TBI) each year, yet research shows that nearly half will never receive a formal TBI diagnosis during that visit – and of those who do, roughly 43% experience long-term disabilities. For personal-injury attorneys, these figures represent cases that are being mishandled and undervalued.

The school of thought behind diagnosing and treating TBI has undergone a fundamental shift in recent years, and attorneys who understand what that shift means for their clients will be better positioned to secure the outcomes they deserve. As a physician who has spent decades treating TBI patients and serving as an expert witness in catastrophic-injury cases and an attorney who has litigated catastrophic-injury cases and worked with plaintiff firms nationwide on TBI cases, we have seen firsthand how outdated assumptions about brain injury can undermine otherwise strong claims.

We know this because at Ernst Law Group we reviewed roughly 300 TBI cases for plaintiffs' firms across the country. We saw the same pattern repeatedly across cases worth significantly more than they settled for, not due to better defense lawyers, but to outdated case-building assumptions. What follows is what the science says, and what to do about it.

The science has changed. Has your case strategy?

No two brain injuries are the same. Each TBI presents a unique combination of symptoms, severity, and recovery trajectory, shaped by both the mechanics of the impact and the patient's biology. Two clients with similar accidents may experience entirely different cognitive, emotional, and physical consequences, and their cases must be built accordingly.

At the same time, the long-held assumption that a concussion is a minor temporary disruption has been dismantled. What was once dismissed as short-lived is now understood to involve complex and sometimes lasting changes in brain function. Symptoms can evolve, and recovery is not always linear.

Attorneys who rely on outdated framework risk undervaluing both the injury and the claim. When the full scope of a brain injury is not recognized early, it becomes far more difficult to secure the long-term care and compensation a client may need.

Every brain-injury case reviewed shared the same flaw: The defense persuaded the jury that the client appeared fine. Defense firms are willing to take multimillion-dollar TBI cases to trial because it is often cheaper to challenge an injured person's credibility in front of a jury than to pay for the full extent of what was lost.

Most undervalued TBI cases were not undervalued because the injury was impossible to prove. They were lost because the case was built around the wrong question: How badly was my client hurt? That framing plays directly into the defense strategy. They rely on a familiar script of experts, talking points, and well-rehearsed narratives designed to make jurors focus on appearances rather than impairment.

The more powerful question is: What was taken from this person, and what will it cost to restore it? A Glasgow Coma Scale (GCS) score from the day of the accident cannot answer that. Neither can a normal MRI. The answer comes from showing what a traumatic brain injury changes in a person's life: the work they can no longer do, the relationships strained, the independence lost, and the future altered.

Modern science supports that framework. The question is whether your case strategy does.

"Mild" TBI is a misleading label, and the defense knows it

The terms "mild," "moderate," and "severe" are deeply ingrained in both medicine and litigation, but they are increasingly viewed as scientifically imprecise. These labels do not reliably predict outcomes and do not reflect meaningful biological thresholds. A so-called "mild" injury can produce profound and lasting impairment, while a "severe" classification does not always correlate with long-term disability.

Similarly, a perfect score on the GCS, often cited to suggest that a patient is neurologically intact, does not rule out intracranial injury. Peer-reviewed studies have shown that a notable percentage of patients with a "perfect" score still demonstrate clinically significant findings on CT imaging. Treating these scores as definitive evidence of a lack of injury can be a costly mistake in litigation.

The defense understands exactly how to use the label "mild." Here is what to do about it: "Mild" is not a defense. It is a concession.

The medical basis for the term is narrow: Was there a brain injury? Yes. Was the client in a coma? No. Were they unconscious for more than 30 minutes? No. That is the distinction. Yet the defense asks jurors to treat that classification as if it defines the entire injury.

Do not avoid the label. Lead with it. Yes, this is a mild TBI.

Then reframe what "mild" actually means. A mild heart attack is still a heart attack. A mild stroke is still a stroke. Mild does not mean imaginary or insignificant. It means the injury occurred without prolonged unconsciousness or coma.

Once you define the term, the cross-examination changes. Is a mild TBI still a brain injury? Yes. Can it cause cognitive impairment? Yes. Emotional changes? Yes. Sleep disruption, chronic pain, and personality shifts that last for years? Yes.

The defense uses "mild" to minimize the case. Your job is to show that the label describes the initial presentation, not the lasting consequences. A mild TBI is still a traumatic brain injury, and the impact on

a person's life can be anything but mild.

The invisible injury problem: Why your client may look fine but isn't

TBI is often called the "invisible injury" because it frequently lacks outward signs. A client may appear composed and physically uninjured while experiencing significant neurological disruption, creating skepticism among adjusters, defense counsel, and juries.

Brain structure and function are inseparable. Even microscopic injury can produce meaningful changes in memory, attention, emotional regulation, and executive functioning. These deficits may not be immediately visible, but can significantly disrupt daily life.

Standard imaging such as CT scans and MRIs often fail to detect nerve fiber damage that characterizes many TBIs. More advanced techniques, such as Diffusion Tensor Imaging, can identify these injuries when conventional scans appear normal. Ensuring appropriate evaluation when symptoms persist is critical to both treatment and case development.

The long-term implications are equally important. Research has identified TBI as a significant environmental risk factor for Alzheimer's disease, meaning an injury that appears manageable today may carry serious consequences decades later. That reality should be reflected in how damages are evaluated.

The problem of invisible injury is not just a medical phenomenon. It is a litigation challenge that begins with how attorneys understand the injury itself.

Too often, brain injuries are treated like car accidents: a single event with a clear before and after. The case is built around the incident, symptoms are documented, and the file moves forward as though the injury ended when the collision did. That model no longer reflects the science.

TBI: A chronic health condition, not an acute event

In 2024, the Centers for Medicare and Medicaid Services designated traumatic brain injury as a chronic health condition rather than an acute event, effective January 2025. That distinction matters. Emergency rooms are designed to stabilize immediate crises, not identify conditions that develop over time. It helps explain why a study published in the *Archives of Physical Medicine and Rehabilitation* found that 56% of patients who met CDC criteria for mild TBI had no documented diagnosis in their emergency room records. The injury was not absent. The system was not designed to recognize it in its earliest stages.

A brain injury does not end at impact. The brain continues to change in the days, weeks, and months that follow. Inflammation, chemical cascades, and structural disruption can continue long after a client walks away from the crash. Early medical records that appear unremarkable are not proof the injury was minor. In many cases, they show only that the injury was still unfolding.

Every TBI has a symptom profile, and that shapes the claim

Modern TBI medicine focuses on identifying distinct symptom patterns that commonly emerge after injury, including headaches, cognitive dysfunction and fatigue, emotional and mood changes, visual and balance issues, and sleep disruption. Most patients present a combination, but the profile varies.

Identifying a client's symptom profile early allows for more targeted treatment and creates a consistent medical record that strengthens the claim. Each profile carries its own recovery timeline and long-term implications, which should directly inform how damages are characterized and valued.

Identifying the symptom profile is only the starting point. How those symptoms are translated into a case a jury can understand is what matters most. Not every symptom has a definitive test. But every symptom has a human consequence. Too often, attorneys document what a client reports and stop there. That creates a symptom list, not a compelling case narrative. Instead, use a three-part framework: Gather, Focus, Reveal.

First, gather every symptom, including the ones that are easy to overlook or never asked about directly. Then focus those symptoms through objective findings whenever possible, so the case does not rely solely on the client's account. A complaint about memory problems may begin in intake, but it gains weight through neuropsychological testing such as the Trail Making Test for processing speed, Digit Span for working memory, or the Rey Auditory Verbal Learning Test for delayed recall.

The final step is reveal. This is where the symptoms become real. At trial, a memory deficit is not just a score on a test. It becomes a moment the jury can recognize and understand.

Thanksgiving. Her son walks outside to bring in the groceries because his mother forgot them in the car. On the dashboard, he finds a note in her handwriting: Remember to turn off the car.

That moment changes how a jury understands memory loss. A symptom list describes the problem. Testing validates it. The story reveals what the injury actually took from the family, and why it matters.

How to build a stronger TBI case from day one

A well-supported TBI diagnosis rests on three core elements: a plausible mechanism of injury, symptoms that emerge within a medically consistent timeframe, and the absence of a more likely alternative explanation. Establishing these early creates a strong foundation.

A patient's own account of their experience is also clinically valid evidence. Reports of feeling dazed, confused, or disoriented are meaningful indicators of brain injury. The absence of immediate treatment does not negate the diagnosis.

Not only that, but building a stronger TBI case starts with getting the first conversation right. Most attorneys lose momentum before the intake interview is even finished. You do not build a TBI case. You reveal one.

When you try to construct a brain-injury narrative in a case where invisibility and skepticism already shape how the injury is perceived, you are working against the facts from the start. The only thing that holds up under a defense Independent Medical Examination (IME),

a skeptical adjuster, and three weeks of cross-examination is what is real. Your job is to uncover it and bring it forward.

That process begins with the first interview. One rule matters most: Do not lead the client with TBI symptoms. The moment you ask about headaches, dizziness, or memory loss, you stop getting their experience and start getting their interpretation of what you want to hear.

Instead, ask two questions. What has changed? What can you not figure out? Then stop talking.

What comes back is often unexpected, not because clients are withholding information, but because no one has ever asked in a way that makes sense to them. Seizure-like episodes they assumed were normal. Vision changes they expected would resolve. Speech that does not come out the way they intend. Hormonal disruption that quietly ended relationships long before anyone connected it to the crash. These are objective, testable findings that often sit in plain sight while the intake form focuses narrowly on headaches.

The attorney who asks about symptoms gets a list. The attorney who asks what has changed gets the truth. And the truth is almost always more valuable than the initial case valuation suggests.

Most plaintiffs' attorneys are strong advocates. The issue is not skill. It is a framework. A TBI case is not just another injury case. It is a neuroscience case that requires a different intake, a different workup, a different approach to damages, and a different theory of what happened to the person after the crash.

The standard of care in TBI litigation is evolving. Attorneys who align themselves with current science and specialized medical expertise will be better positioned to advocate effectively for their clients and to secure outcomes that reflect the true scope of these often misunderstood injuries.

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Taylor Ernst is the 2024 California Lawyer Attorney of the Year (Daily Journal) and author of The Ernst Way: The Definitive Guide to TBI Litigation. Ernst Law Group works with plaintiff firms across the country to help them build stronger TBI cases.