Table of Contents

Volume 1

PAI	RT I. BRAIN INJURY LITIGATI FROM A PERSONAL INJURY LAWYER'S	ON
	PERSPECTIVE	1
CHA	APTER 1. INTRODUCTION	1
§ 1:1	Scope	-
§ 1:2	Epidemiology of brain injury	
§ 1:3	Traumatic brain injury: Is it time we stop using the terms moderate and severe?	mild,
§ 1:4	Biases in the civil justice system towards traumatic	
	brain injury cases	
CHA	APTER 2. MYTHS OF TBI	13
§ 2:1	The myths of traumatic brain injury	10
§ 2:2	Myth 1: mild traumatic brain injury is not serious	
§ 2:3	Myth 2: loss of consciousness is necessary to sustain a traumatic brain injury	
§ 2:4	Myth 3: one must strike one's head in order to suffer a traumatic brain injury	
§ 2:5	Myth 4: negative MRIs, CT scans and EEGs rule out brain injury	
§ 2:6	Myth 5: the effects of TBI are immediate	
§ 2:7	Myth 6: neuropsychological testing is subjective	
§ 2:8	Myth 7: cognitive impairments on neuropsychological testing must fit a predictable pattern	
§ 2:9	Myth 8: children with traumatic brain injury all get better	
§ 2:10	Pediatric traumatic brain injury and behavior	
§ 2:11	Myth 9: mild traumatic brain injury is not permanent	
§ 2:12	Myth 10: mild traumatic brain injury is not disabling	
CHA	APTER 3. CASE SELECTION AND	
	EPARATION	47
§ 3:1	Special considerations in identifying and litigating brain injury cases	41

§ 3:2	The interview
§ 3:3	Representing the professional with traumatic brain
	injury
§ 3:4	Case examples
§ 3:5	Initial work to be done
§ 3:6	Assessing liability
§ 3:7	—Sample HIPPA authorization cover letter and form
§ 3:8	What to look for in the medical records
§ 3:9	The trial consultant
§ 3:10	Before and after witnesses
§ 3:11	Focus groups
§ 3:12	Voir dire—Special problems with a brain injury case
3 0.12	von die Special prostonis with a stain injuly case
CHA	PTER 4. THE EXPERT
	MEGOEG
	00
§ 4:1	The biomechanical engineer
§ 4:2	The neurologist
§ 4:3	The neuropsychologist
§ 4:4	—Choosing a neuropsychologist
§ 4:5	The neuro-otologist
§ 4:6	The physiatrist
§ 4:7	The neuropsychiatrist
§ 4:8	The behavioral psychologist
§ 4:9	Annuity specialist
§ 4:10	The vocational rehabilitation expert
§ 4:11	Plaintiff's answer to defence motion to bar vocational expert
§ 4:12	Life care planner
§ 4:13	—Hiring the life care planner
$\S 4:14$	The economist
§ 4:15	—Methods used: discount to total offset
§ 4:16	—Value of household services
§ 4:17	The rebuttal expert
~	
CHA	PTER 5. DEFENSE TACTICS AND HOW
TO C	COUNTER THEM 143
§ 5:1	General defense themes: no injury or pre-existing
Ü	injury
§ 5:2	Expensive discovery
§ 5:3	Surveillance videotaping the client
§ 5:4	Outspending the plaintiff
§ 5:5	Delaying the case
§ 5:6	Rushing the trial date
§ 5:7	Focusing on pre-incident problems of the plaintiff
§ 5:8	Emphasizing lack of clinical symptoms
§ 5.8 § 5:9	Focusing on the client's normal aspect
_	The low-impact accident defense
§ 5:10	The low-impact accident defense

r	L'VDI E	OF	CONTENTS

IABLE (OF CONTENTS	
\$ 5:11	Emphasizing plaintiff's low medical costs	
\$ 5:12	Claiming plaintiff's return to work or school is proof of low damages	
§ 5:13	Defense medical examination and third-party observers	
§ 5:14	Third-party observers during neuropsychological testing	
\$ 5:15	Raw data from neuropsychological examination	
\$ 5:16	Plaintiff's motion: neuropsychological testing	
\$ 5:17	Plaintiff's motion to exclude evidence of plaintiff's prior psychological treatment	
\$ 5:18	Barring testimony of symptom magnification	
\$ 5:19	Increased risk of future consequences after TBI: Are future consequences recoverable?	
§ 5:20	Plaintiff's motion to strike net opinions of defense expert and compel production of neuropsychological raw data	
§ 5:21	Brief in support of plaintiff's motion to bar neuropsychological examination, or to require defendants to produce raw test data and allow plaintiff to video record neuropsychogical examination	
CHA	APTER 6. ADMISSIBILITY OF TESTIN	I G
RES	ULTS	229
	SULTS	
I. IN	N GENERAL General rule: admissibility of neuropsychological	
I. IN § 6:1 § 6:2 § 6:3	GENERAL General rule: admissibility of neuropsychological testimony on diagnosis, causation, and prognosis Minority position: limited admissibility of neuropsychological testimony on causation and/or	
I. IN § 6:1 § 6:2 § 6:3 § 6:4	General rule: admissibility of neuropsychological testimony on diagnosis, causation, and prognosis Minority position: limited admissibility of neuropsychological testimony on causation and/or prognosis General medical acceptance of neuropsychological testing Method skeptics: eliminating or limiting neuropsychological expert testimony	
I. IN § 6:1 § 6:2 § 6:3 § 6:4 § 6:5	General rule: admissibility of neuropsychological testimony on diagnosis, causation, and prognosis Minority position: limited admissibility of neuropsychological testimony on causation and/or prognosis General medical acceptance of neuropsychological testing Method skeptics: eliminating or limiting neuropsychological expert testimony Fixed vs. flexible neuropsychological test batteries	
I. IN § 6:1 § 6:2 § 6:3 § 6:4 § 6:5 § 6:6	General rule: admissibility of neuropsychological testimony on diagnosis, causation, and prognosis Minority position: limited admissibility of neuropsychological testimony on causation and/or prognosis General medical acceptance of neuropsychological testing Method skeptics: eliminating or limiting neuropsychological expert testimony Fixed vs. flexible neuropsychological test batteries Importance of a pre-morbid baseline	
I. IN § 6:1 § 6:2 § 6:3	General rule: admissibility of neuropsychological testimony on diagnosis, causation, and prognosis Minority position: limited admissibility of neuropsychological testimony on causation and/or prognosis General medical acceptance of neuropsychological testing Method skeptics: eliminating or limiting neuropsychological expert testimony Fixed vs. flexible neuropsychological test batteries	
6:1 \$ 6:2 \$ 6:3 \$ 6:4 \$ 6:5 \$ 6:6 \$ 6:7	General rule: admissibility of neuropsychological testimony on diagnosis, causation, and prognosis Minority position: limited admissibility of neuropsychological testimony on causation and/or prognosis General medical acceptance of neuropsychological testing Method skeptics: eliminating or limiting neuropsychological expert testimony Fixed vs. flexible neuropsychological test batteries Importance of a pre-morbid baseline	
I. IN § 6:1 § 6:2 § 6:3 § 6:4 § 6:5 § 6:6 § 6:7 II. H	General rule: admissibility of neuropsychological testimony on diagnosis, causation, and prognosis Minority position: limited admissibility of neuropsychological testimony on causation and/or prognosis General medical acceptance of neuropsychological testing Method skeptics: eliminating or limiting neuropsychological expert testimony Fixed vs. flexible neuropsychological test batteries Importance of a pre-morbid baseline Issue of ecological validity	
I. IN § 6:1 § 6:2 § 6:3 § 6:4 § 6:5 § 6:6 § 6:7 II. II § 6:8	General rule: admissibility of neuropsychological testimony on diagnosis, causation, and prognosis Minority position: limited admissibility of neuropsychological testimony on causation and/or prognosis General medical acceptance of neuropsychological testing Method skeptics: eliminating or limiting neuropsychological expert testimony Fixed vs. flexible neuropsychological test batteries Importance of a pre-morbid baseline Issue of ecological validity	
6:1 \$ 6:2 \$ 6:3 \$ 6:4 \$ 6:5 \$ 6:6 \$ 6:7	General rule: admissibility of neuropsychological testimony on diagnosis, causation, and prognosis Minority position: limited admissibility of neuropsychological testimony on causation and/or prognosis General medical acceptance of neuropsychological testing Method skeptics: eliminating or limiting neuropsychological expert testimony Fixed vs. flexible neuropsychological test batteries Importance of a pre-morbid baseline Issue of ecological validity EFFECT OF DAUBERT Daubert and its progeny Admissibility of neuropsychological testimony after	

0.010		
§ 6:12	—Admissibility under <i>Daubert</i>	
§ 6:13	Role of SPECT scans in diagnosing and treating brain	
0.0.1.	injuries	
§ 6:14	—Admissibility under Daubert	
§ 6:15	Admissibility of SPECT scans under Daubert	
§ 6:16	Brief in support of the admissibility of SPECT	
§ 6:17	Direct examination of Expert using SPECT	
§ 6:18	Role of diffusion tensor imaging in diagnosing and	
e c.10	treating brain injuries	
§ 6:19	—Admissibility under Daubert	
§ 6:20		
§ 6:21		
§ 6:22	Planner (LCP) testimony	
§ 6:23	e	
§ 6:24	—Counterattack by questioning the methodology and reliability of defendant's experts	
$\S~6{:}25$	—Direct offensive challenge: barring the defendant's	
	experts' testimony	
§ 6:26		
§ 6:27	1 0	
	requires	
CHA	PTER 7. OPENING STATEMENTS A	ND
CIL	FIER 7. OF ENING STATEMENTS A	עוו
OT O		
CLO	SING STATEMENTS	349
		349
I. O	PENING STATEMENTS	349
I. O § 7:1	PENING STATEMENTS Opening statement	349
I. O § 7:1 § 7:2	PENING STATEMENTS Opening statement —Building a story	349
I. O § 7:1 § 7:2 § 7:3	PENING STATEMENTS Opening statement —Building a story Structuring your opening statement	349
I. O § 7:1 § 7:2 § 7:3 § 7:4	PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one	349
I. O § 7:1 § 7:2 § 7:3 § 7:4 § 7:5	PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one Plaintiff's opening statement: example two	349
\$ 7:1 § 7:2 § 7:3 § 7:4 § 7:5 § 7:6	PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one Plaintiff's opening statement: example two Plaintiff's opening statement: example three	349
I. O § 7:1 § 7:2 § 7:3 § 7:4 § 7:5	PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one Plaintiff's opening statement: example two	349
\$ 7:1 \$ 7:2 \$ 7:3 \$ 7:4 \$ 7:5 \$ 7:6 \$ 7:7	PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one Plaintiff's opening statement: example two Plaintiff's opening statement: example three	349
\$ 7:1 \$ 7:2 \$ 7:3 \$ 7:4 \$ 7:5 \$ 7:6 \$ 7:7	PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one Plaintiff's opening statement: example two Plaintiff's opening statement: example three Plaintiff's opening statement: Example 4 CLOSING STATEMENTS	349
I. O \$ 7:1 \$ 7:2 \$ 7:3 \$ 7:4 \$ 7:5 \$ 7:6 \$ 7:7 II. (PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one Plaintiff's opening statement: example two Plaintiff's opening statement: example three Plaintiff's opening statement: Example 4 CLOSING STATEMENTS Summation in brain injury cases	349
\$ 7:1 \$ 7:2 \$ 7:3 \$ 7:4 \$ 7:5 \$ 7:6 \$ 7:7	PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one Plaintiff's opening statement: example two Plaintiff's opening statement: example three Plaintiff's opening statement: Example 4 CLOSING STATEMENTS Summation in brain injury cases —Providing favorable jurors with answers; techniques	349
I. O \$ 7:1 \$ 7:2 \$ 7:3 \$ 7:4 \$ 7:5 \$ 7:6 \$ 7:7 II. (PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one Plaintiff's opening statement: example two Plaintiff's opening statement: example three Plaintiff's opening statement: Example 4 CLOSING STATEMENTS Summation in brain injury cases	349
\$ 7:1 \$ 7:2 \$ 7:3 \$ 7:4 \$ 7:5 \$ 7:6 \$ 7:7 II. (\$ 7:8 \$ 7:9	PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one Plaintiff's opening statement: example two Plaintiff's opening statement: example three Plaintiff's opening statement: Example 4 CLOSING STATEMENTS Summation in brain injury cases —Providing favorable jurors with answers; techniques	349
I. O \$ 7:1 \$ 7:2 \$ 7:3 \$ 7:4 \$ 7:5 \$ 7:6 \$ 7:7 II. O \$ 7:8 \$ 7:9	PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one Plaintiff's opening statement: example two Plaintiff's opening statement: example three Plaintiff's opening statement: Example 4 CLOSING STATEMENTS Summation in brain injury cases —Providing favorable jurors with answers; techniques to arm your allies	349
I. O \$ 7:1 \$ 7:2 \$ 7:3 \$ 7:4 \$ 7:5 \$ 7:6 \$ 7:7 II. (\$ 7:8 \$ 7:9 CHA EVI	PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one Plaintiff's opening statement: example two Plaintiff's opening statement: example three Plaintiff's opening statement: Example 4 CLOSING STATEMENTS Summation in brain injury cases —Providing favorable jurors with answers; techniques to arm your allies APTER 8. INTRODUCING DENCE	
I. O \$ 7:1 \$ 7:2 \$ 7:3 \$ 7:4 \$ 7:5 \$ 7:6 \$ 7:7 II. O \$ 7:8 \$ 7:9	PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one Plaintiff's opening statement: example two Plaintiff's opening statement: example three Plaintiff's opening statement: Example 4 CLOSING STATEMENTS Summation in brain injury cases —Providing favorable jurors with answers; techniques to arm your allies PTER 8. INTRODUCING DENCE Sequence of evidence and witnesses in a traumatic	
I. O \$ 7:1 \$ 7:2 \$ 7:3 \$ 7:4 \$ 7:5 \$ 7:6 \$ 7:7 II. (\$ 7:8 \$ 7:9 CHA EVI	PENING STATEMENTS Opening statement —Building a story Structuring your opening statement Plaintiff's opening statement: example one Plaintiff's opening statement: example two Plaintiff's opening statement: example three Plaintiff's opening statement: Example 4 CLOSING STATEMENTS Summation in brain injury cases —Providing favorable jurors with answers; techniques to arm your allies APTER 8. INTRODUCING DENCE	

Table of Contents

\$ 8:3 \$ 8:4 \$ 8:5 \$ 8:6 \$ 8:7 \$ 8:8 \$ 8:9 \$ 8:10 \$ 8:11	Calling the investigating police officer Calling all treating physicians Calling neurologists and neuropsychologists Calling a physiatrists as an alternative to neurologist Calling a neuropsychiatrist Calling accident reconstruction/biomechanical engineers Calling medical witnesses to attest to injuries other than brain injury Calling the plaintiff and his or her family Economic testimony	
§ 8:12	Presenting the life care planner in court	
§ 8:13	The Affordable Care Act and life care planning	
§ 8:14	Finale; presenting the concluding witness	
§ 8:15	The best laid plans flexible guidelines	
	PTER 9. DIRECT AND CROSS- MINATION OF EXPERTS	413
§ 9:1	Establishing the experts' qualifications	410
§ 9:2	Presenting the expert's opinions	
§ 9:3	—Explaining brain anatomy	
§ 9:4	Presenting details of the case	
§ 9:5	Sample direct of a neurologist	
§ 9:6	Sample direct of a neuropsychologist	
§ 9:7	Sample direct examination of neuro-otologist	
§ 9:8	Sample direct examination of a vocational economist	
§ 9:9	Deposition of an emergency room physician	
§ 9:10	Cross-examination of the defendant's experts	
§ 9:11	—Obtaining concessions	
§ 9:12	—Discrediting expert opinions	
§ 9:13	—Making the witness your own	
	PTER 10. MALINGERING AND	451
I. IN	GENERAL	
	Introduction; other references	
-	·	
§ 10:2	Why attorneys seek testimony about malingering; the worthiness factor	
§ 10:3	Proving that the client is not malingering	
§ 10.5 § 10:4	—Using lay testimony	
§ 10.4	Clinicians' opinions and court responses	
§ 10.6	How neurolawyers should deal with malingering	
II. SI	PECIFIC MEASURES	
§ 10:7	Paul Lees-Haley Fake Bad Scale (FBS)	

§ 10:8	Green's word memory test	
§ 10:9	Axis V—The global assessment of functioning scale	
§ 10:10	—Sample cross-examination; GAF	
§ 10:11	American Congress of Rehabilitation Medicine's	
	definition of mild traumatic brain injury	
§ 10:12	New diagnostic criteria for mild traumatic brain	
	injury (MTBI) from the American Congress of Rehabilitation Medicine	
§ 10:13	American Congress of Rehabilitation Medicine's	
8 10.19	definition of mild traumatic brain injury—Sample	
	cross-examination using definition	
§ 10:14	Lack of effort by normal undergraduate students in	
	neuropsychological test performance	
III. FO	ORMS	
\$ 10.15	Mation to much de defense amout from animin and	
§ 10:15	Motion to preclude defense expert from opining on malingering or symptom magnification by plaintiff	
	maningering or symptom magnification by plantin	
D 4 D 0		
PAK'I	Γ II. BRAIN INJURY	
_	TOTATION EDOM A	
	ALLICTALICAN PRODUCE A	
	LITIGATION FROM A	
N	NEUROPSYCHIATRIST'S	
N		505
N H	NEUROPSYCHIATRIST'S PERSPECTIVE	505
N F CHAP	NEUROPSYCHIATRIST'S PERSPECTIVE TER 11. AVOIDING PREDICTABLE	505
N F CHAP	NEUROPSYCHIATRIST'S PERSPECTIVE	505 505
N F CHAP	NEUROPSYCHIATRIST'S PERSPECTIVE TER 11. AVOIDING PREDICTABLE	
N H CHAP CASE	NEUROPSYCHIATRIST'S PERSPECTIVE PERSPECTIVE PERSPECTIVE	
CHAP CASE § 11:1	NEUROPSYCHIATRIST'S PERSPECTIVE TER 11. AVOIDING PREDICTABLE BLUNDERS Introduction	
CHAP CASE § 11:1 § 11:2	NEUROPSYCHIATRIST'S PERSPECTIVE	
CHAP CASE § 11:1 § 11:2 § 11:3	NEUROPSYCHIATRIST'S PERSPECTIVE TER 11. AVOIDING PREDICTABLE BLUNDERS Introduction Case selection —Example	
CHAP CASE § 11:1 § 11:2 § 11:3 § 11:4	NEUROPSYCHIATRIST'S PERSPECTIVE	
CHAP CASE § 11:1 § 11:2 § 11:3 § 11:4 § 11:5	PERSPECTIVE	
CHAP CASE § 11:1 § 11:2 § 11:3 § 11:4 § 11:5 § 11:6	PERSPECTIVE	
CHAP CASE § 11:1 § 11:2 § 11:3 § 11:4 § 11:5 § 11:6 § 11:7	PERSPECTIVE	
CHAP CASE § 11:1 § 11:2 § 11:3 § 11:4 § 11:5 § 11:6 § 11:7 § 11:8	PERSPECTIVE	
CHAP CASE § 11:1 § 11:2 § 11:3 § 11:4 § 11:5 § 11:6 § 11:7	PERSPECTIVE TER 11. AVOIDING PREDICTABLE BLUNDERS Introduction Case selection —Example Defense resource allocation The difference between medical and legal reasoning —Nature of legal reasoning —Nature of medical reasoning —Inductive reasoning; speculations about possibilities; diagnosis with reasonable medical probability Practical consequences of physician clinical-decision	
CHAP CASE § 11:1 § 11:2 § 11:3 § 11:4 § 11:5 § 11:6 § 11:7 § 11:8	PERSPECTIVE	
CHAP CASE § 11:1 § 11:2 § 11:3 § 11:4 § 11:5 § 11:6 § 11:7 § 11:8	PERSPECTIVE TER 11. AVOIDING PREDICTABLE BLUNDERS Introduction Case selection —Example Defense resource allocation The difference between medical and legal reasoning —Nature of legal reasoning —Nature of medical reasoning —Inductive reasoning; speculations about possibilities; diagnosis with reasonable medical probability Practical consequences of physician clinical-decision making; Daubert challenges; evidence based medicine (EBM) Overview of eight litigation process myths; the	
CHAP CASE § 11:1 § 11:2 § 11:3 § 11:4 § 11:5 § 11:6 § 11:7 § 11:8 § 11:9 § 11:10	PERSPECTIVE TER 11. AVOIDING PREDICTABLE BLUNDERS Introduction Case selection —Example Defense resource allocation The difference between medical and legal reasoning —Nature of legal reasoning —Nature of medical reasoning —Inductive reasoning; speculations about possibilities; diagnosis with reasonable medical probability Practical consequences of physician clinical-decision making; Daubert challenges; evidence based medicine (EBM) Overview of eight litigation process myths; the Emperor's New Clothes	
CHAP CASE § 11:1 § 11:2 § 11:3 § 11:4 § 11:5 § 11:6 § 11:7 § 11:8 § 11:9 § 11:10 § 11:11	PERSPECTIVE TER 11. AVOIDING PREDICTABLE BLUNDERS Introduction Case selection —Example Defense resource allocation The difference between medical and legal reasoning —Nature of legal reasoning —Nature of medical reasoning —Inductive reasoning; speculations about possibilities; diagnosis with reasonable medical probability Practical consequences of physician clinical-decision making; Daubert challenges; evidence based medicine (EBM) Overview of eight litigation process myths; the Emperor's New Clothes —Myth 1: truth doesn't matter	
CHAP CASE § 11:1 § 11:2 § 11:3 § 11:4 § 11:5 § 11:6 § 11:7 § 11:8 § 11:9 § 11:10	PERSPECTIVE TER 11. AVOIDING PREDICTABLE BLUNDERS Introduction Case selection —Example Defense resource allocation The difference between medical and legal reasoning —Nature of legal reasoning —Nature of medical reasoning —Inductive reasoning; speculations about possibilities; diagnosis with reasonable medical probability Practical consequences of physician clinical-decision making; Daubert challenges; evidence based medicine (EBM) Overview of eight litigation process myths; the Emperor's New Clothes —Myth 1: truth doesn't matter —Myth 2: money doesn't matter	
CHAP CASE § 11:1 § 11:2 § 11:3 § 11:4 § 11:5 § 11:6 § 11:7 § 11:8 § 11:9 § 11:10 § 11:11 § 11:12	PERSPECTIVE TER 11. AVOIDING PREDICTABLE BLUNDERS Introduction Case selection —Example Defense resource allocation The difference between medical and legal reasoning —Nature of legal reasoning —Nature of medical reasoning —Inductive reasoning; speculations about possibilities; diagnosis with reasonable medical probability Practical consequences of physician clinical-decision making; Daubert challenges; evidence based medicine (EBM) Overview of eight litigation process myths; the Emperor's New Clothes —Myth 1: truth doesn't matter —Myth 2: money doesn't matter Unintended consequences of not dealing directly with the money	
CHAP CASE § 11:1 § 11:2 § 11:3 § 11:4 § 11:5 § 11:6 § 11:7 § 11:8 § 11:9 § 11:10 § 11:11 § 11:12	PERSPECTIVE TER 11. AVOIDING PREDICTABLE BLUNDERS Introduction Case selection —Example Defense resource allocation The difference between medical and legal reasoning —Nature of legal reasoning —Nature of medical reasoning —Inductive reasoning; speculations about possibilities; diagnosis with reasonable medical probability Practical consequences of physician clinical-decision making; Daubert challenges; evidence based medicine (EBM) Overview of eight litigation process myths; the Emperor's New Clothes —Myth 1: truth doesn't matter —Myth 2: money doesn't matter Unintended consequences of not dealing directly with the	

Table of Contents

	Emperor's New Clothes—Myth 3: specificity doesn't matter
§ 11:15	Myth 3: Specificity doesn't matter; the risk of relying on brain function imaging studies to "prove" the presence of traumatic brain injury
§ 11:16	New myth: Misperceiving history means malingering
§ 11:17	Myth 3: Specificity doesn't matter
§ 11:18	Myths: Self-Deception: the 800 pound gorilla in the room
§ 11:19	Overview of eight litigation process myths; the
	Emperor's New Clothes—Myth 4: effort doesn't matter
§ 11:20	Catastrophic reliance on "mind/body dualism"
§ 11:21	Critical "mind/psyche/body" issues regarding the accuracy, validity, and reliability of retroactive recollection of the traumatic event
§ 11:22	Intended and unintended consequences of "mind/body" dualism on admissibility of psychotherapeutic records
§ 11:23	Overview of eight litigation process myths; the Emperor's New Clothes—Myth 5: brain injured patients always are reliable factual historians
§ 11:24	—Myth 6: cases don't get settled
§ 11:25	—Myth 7: partial recovery should be ignored
§ 11:26	—Myth 8: TBI patients always are likeable
_	TER 12. APPROACHING THE CASE: A
NEUR	OPSYCHIATRIC PERSPECTIVE 587
§ 12:1	Introduction
§ 12:2	The medical knowledge experts expect attorneys to have
§ 12:3	Understanding why the attorney picked the client
§ 12:4	Deciding to work with the attorney
§ 12:5	Deciding to work with the attorney: Three of the most humiliating mistakes any expert can make—and which one of the editors repeatedly has (!)
§ 12:6	Understanding the uses and limitations of DSM-5
§ 12:7	DSM-5 and malingering
§ 12:8	DSM-5 and "neurocognitive disorders": New DSM-5 approaches and new limitations
§ 12:9	The other 800 pound gorilla in the room that DSM-5 also leaves out: the "unused" brain
§ 12:10	Deciding to work with the attorney: The necessity of making clear policies regarding finances and "on call" rules for depositions, trials, and cases that get settled
§ 12:11	Deciding to work with the attorney: failure to anticipate plaintiffs fleeing treatment after the case is resolved
§ 12:12	New neuroscientific tools that should be used as early as
	possible during the client selection process

§ 12:13	Deciding to work with the attorney: making sure that any referring attorney has up-to-date knowledge about the uses and limitations of clinical history—And making sure they do not bully their own experts into ignoring/"dumbing down" facts that weaken the case
§ 12:14	The increasing importance—And pitfalls of using—Diffusion tensor imaging
§ 12:15	Painful lessons from 50 years of being an expert witness for plaintiff attorneys, defense counsel, and judges: Let the buyer of expert services beware
	Volume 2
_	PTER 13. PRETRIAL
PREI	PARATIONS
I. PI	CKING THE EXPERT TEAM
§ 13:1 § 13:2	Overview; choosing a captain for the expert team Types of expert credentialing; board certifications; trends in the use of neurobehavioral experts
§ 13:3	—American Academy of Neurology guidelines for treating testifiers
§ 13:4 § 13:5	Compensation and fees Daubert challenges to the admissibility of clinical opinions not based on evidence-based medicine
§ 13:6	The treating expert as advocate; bias
II. M	EMBERS OF THE EXPERT TEAM
§ 13:7 § 13:8 § 13:9 § 13:10 § 13:11	In general Neurologists; cross-examination questions Neuropsychologists —Bigler and Brooks review of forensic neuropsychology Neuropsychologists and the terrifying possibility of "real life"
	invalidity of in-office neuropsychological tests in proving or disproving the presence of true traumatic brain injury consequences
§ 13:12	Neuropsychologists—Sample cross examination questions
§ 13:13	Neuropsychiatrists
§ 13:14	Neuro-otologists
§ 13:15	Physiatrists and neuropsychiatrists
§ 13:16 § 13:17	Vocational rehabilitation experts Life care planners
III. (COLLECTING DOCUMENTATION
§ 13:18	Determining what records to collect

§ 13:19 Emergency room records

§ 13:20	Other relevant records
	REPARING FOR THE NEUROPSYCHIATRIC KAMINATION
A.	IN GENERAL
§ 13:21	History taking
В.	FIRST CUT: IDENTIFYING CLINICAL ISSUES AND THE FACTS NEEDED FROM EXAM
§ 13:22 § 13:23 § 13:24 § 13:25	Clinical issue spotting —Skull fractures and lesions to the scalp and dura —Intracranial hematoma —Brain damage caused by increased intracranial pressure
§ 13:26 § 13:27 § 13:28	 Other types of focal damage Diffuse axonal damage Hypoxic-ischemic brain damage; carbon monoxide poisoning
§ 13:29	—Brain swelling
C.	SECOND CUT: LOBE-BY-LOBE POINTS OF INTEREST
§ 13:30 § 13:31 § 13:32 § 13:33 § 13:34 § 13:35 § 13:36 § 13:37 § 13:38 § 13:39 § 13:40 § 13:41 § 13:42 § 13:43	Locations of injury, generally Localization of injury, specifically Frontal lobes —Frontal operculum —Superior mesial region —Inferior mesial regions —Dorsolateral frontal region Temporal lobes —Mesial temporal region — The hippocampal examples — The amygdala The amygdala and posttraumatic stress Temporal lobes—Mesial temporal region—Other temporal regions
\$ 13:44 \$ 13:45 \$ 13:46 \$ 13:47 \$ 13:48	Parietal lobes —Temporoparietal junction —Inferior parietal lobule; anosgnosia Occipital lobes; dorsal portion Occipital lobes; ventral part

D. THIRD CUT: UNDERSTANDING THE PURPOSE AND LIMITATIONS OF DSM-IV

- § 13:49 Issue of ecological validity of the diagnostic manual DSM-IV
- § 13:50 Suggested screening questions for clinical practice

V. THE NEUROPSYCHIATRIC EXAMINATION ITSELF

- § 13:51 Clinical TBI scale scores; Glasgow Coma Scale
- § 13:52 —Rancho Los Amigos Scale and other assessments
- § 13:53 Treatment interventions known to improve symptoms in traumatic brain injury survivors
- § 13:54 Reviewing and confirming important history
- § 13:55 Reviewing and confirming important history: Interviewing collaterals
- § 13:56 The clinical interview and mental status examination
- § 13:57 Psychological tests and neuropsychological screening

VI. PREPARING THE REPORT

- § 13:58 Length of the report
- § 13:59 Effect of preparing a draft report
- § 13:60 Differential diagnosis, comorbidity and causation: being aware of medical conditions that can result in symptoms that mimic mild traumatic brain injury
- § 13:61 —Multiple sclerosis
- § 13:62 —Diabetes
- § 13:63 —Alzheimer's disease
- § 13:64 —Cardiovascular disease
- § 13:65 —Stroke
- § 13:66 —Systemic Lupus Erythematosis
- § 13:67 —HIV Infection
- § 13:68 —Tuberculosis
- § 13:69 —Hypertension

VII. AFTER THE REPORT BUT BEFORE TRIAL: ANTICIPATING DEFENSE RESPONSES—AND DEFENSE BLUNDERS

- § 13:70 Scope of the expert's advice
- § 13:71 Counting on malingering
- § 13:72 Countering by turning malingering on its head
- § 13:73 Ignoring insurance company treatment denials
- § 13:74 Exaggerating the degree of recovery
- § 13:75 Not recommending or doing follow-up tests that are capable of detecting consequences of brain injury

§ 13:76	Exaggerating pre-morbid history and ignoring pre- accident fragility
§ 13:77	Ignoring lack of treatment response
VIII.	ANTICIPATING ERRORS MADE BY FELLOW EXPERTS, PLAINTIFFS AND EVEN PLAINTIFF ATTORNEYS
§ 13:78	Common plaintiff expert team member miscalculations
§ 13:79	Common plaintiff blunders
§ 13:79 § 13:80	-
§ 13:80 § 13:81	Common plaintiff attorney blunders Common plaintiff experts blunders
§ 13:82	Common plaintiff experts' blunders: Ignoring the specificity problem
§ 13:83	Common plaintiff and defense expert blunders: Ignoring the long-term consequences of traumatic brain injury
§ 13:84	Avoiding short-term tactical and long-term strategic blunders
§ 13:85	Seizing the initiative and understanding the impending dominance of the "substantial factor" test in traumatic brain injury litigation
§ 13:86	Understanding, using and defending against the concept of "thresholds"
§ 13:87	The increasing importance the resilience defense
§ 13:88	Increasing importance of the resilience defense: Posttraumatic stress disorder with implications for traumatic brain injury
§ 13:89	The critical importance of understanding the uses and limits of "localization" dogma
§ 13:90	One of the most serious pretrial blunders of all: ignoring the sensitivity and specificity traps
§ 13:91	Understanding and presenting the need for comprehensive—sometimes expensive but financially efficient—clinical interventions for traumatic brain injury victims
§ 13:92	Ignoring necessary treatment for post brain injury alcoholism
§ 13:93	Voir dire considerations and possible questions related to "moral hazard" and litigation "awards"
§ 13:94	Common defense expert blunders
§ 13:95	The uses and misuses of video depositions and video testimony
SCIE	PTER 14. AT TRIAL: CUTTING EDGE NCE ON KEY CLINICAL DITIONS
	OSTTRAUMATIC STRESS DISORDER
§ 14:1	Issue of plaintiff's pre-accident condition

§ 14:2	Using posttraumatic stress disorder to explain TBI- caused injury
§ 14:3	Life care planning, functional independence and comorbidity
§ 14:4	Effect of hippocampal atrophy and white matter lesions
§ 14:5	Plaintiff's strategies using building blocks of pre- incident fragilities and conditions
§ 14:6	—Building a paper trail
§ 14:7	Other aspects; substance abuse; depression; neuroimaging fingerprint for posttraumatic stress disorder; hippocampal size
§ 14:8	Co-causality: explaining catastrophic emotional responses to "only mild" traumatic brain injury
§ 14:9	Co-causality: explaining catastrophic emotional responses to "only mild" traumatic brain injury: posttraumatic stress disorder
§ 14:10	Co-Causality: explaining catastrophic emotional responses to only mild traumatic brain injury: posttraumatic stress disorder
§ 14:11	Co-causality: Combination of injuries, stress of treatment. and post-traumatic stress
§ 14:12	Co-causality: explaining catastrophic emotional responses to only "mild" traumatic brain injury in comparison to data in patients having severe traumatic brain injury
§ 14:13	The importance of understanding co-morbid conditions
§ 14:14	The importance of understanding co-morbid conditions: attention deficit disorder
§ 14:15 § 14:16	The importance of understanding co-morbid conditions: HIV Hearing loss and dementia
II. M	AJOR DEPRESSIVE DISORDER
§ 14:17 § 14:18	Correlation between depression and hippocampal size Depression as a complication of TBI
§ 14:19	—Neuroanatomical and biochemical markers of depression
§ 14:13 § 14:20	Depression as a complication of TBI-executive function disorders
§ 14:21	The integration of clinical, neuropsychological, neurophysiological, neuroimaging, and genetic measures of depression when present as a complication of TBI
§ 14:22	The interactions amongst genetics, major depression, brain structure and traumatic brain injury
§ 14:23	The interactions amongst genetics, major depression, brain structure and traumatic brain injury: recent findings regarding the hippocampus
§ 14:24	The interactions amongst genetics, major depression, brain structure and traumatic brain injury: factors likely to lead to recurrent depression

- § 14:25 Brain lesions manifesting themselves as psychiatric disorders
- § 14:26 Family history and depression vulnerability "markers"

III. BIPOLAR AFFECTIVE DISORDER

- § 14:27 Understanding the interaction between bipolar disorder and traumatic brain injury
- § 14:28 —recent studies

IV. THE IMPACT OF TRAUMA ON PRE-INCIDENT PERSONALITY DISORDERS

§ 14:29 Defense strategy: establish plaintiff's personality disorder

V. MALINGERING, SOMATOFORM, AND OTHER SYMPTOM EXAGGERATION DISORDERS

- § 14:30 Defining and identifing malingering
- § 14:31 Defining and identifying malingering—Symptom validity tests
- § 14:32 Effect on jury of accusation of malingering
- § 14:33 Research regarding malingering
- § 14:34 Research regarding malingering: Self deception: malingering or not?
- § 14:35 Somatoform disorders and other secondary gain syndromes
- § 14:36 DSM-IV categories of symptom exaggeration disorders
- § 14:37 Effect of finding new onset seizures; distinguishing organic and psychogenic seizures
- § 14:38 Plaintiff's strategies when faced with malingering defense

VI. NONCOMPLIANCE WITH TREATMENT

- § 14:39 Understanding noncompliance with treatment regimen
- § 14:40 Behavioral, neurocognitive, and affective side effects of medications used to treat TBI

VII. CEREBROVASCULAR DISORDERS AND TREATABLE CONCOMITANTS OF TRAUMATIC BRAIN INJURY

- § 14:41 Cerebrovascular disorders
- § 14:42 Treatable concomitants of traumatic brain injury
- § 14:43 Treatable concomitants of traumatic brain injury: seizures
- § 14:44 Seizures
- § 14:45 Diabetes

VIII. ALCOHOL AND SUBSTANCE ABUSE

- § 14:46 Traumatic brain injury, attention deficit disorder and/or substance abuse
- § 14:47 The future: the relentless search for specific traumatic brain injury "footprints": cellular level "biomarkers"
- § 14:48 Traumatic brain injuries and pain related complaints: dealing with the elderly
- § 14:49 Consequences of intoxication at the time of traumatic brain injury
- § 14:50 Recognized neurobehavioral syndromes for alcoholinduced disorders
- § 14:51 Plaintiff's strategies for dealing with alcohol use before or at the time of a traumatic event; teenagers and alcohol use

IX. NON-ANALGESIC STREET DRUGS

- § 14:52 Neuropsychiatric and neurobehavioral syndromes secondary to the use of street drug abuse
- § 14:53 Issue of base rate prevalence of conditions in the plaintiff's population

X. USE AND ABUSE OF PRESCRIPTION MEDICATIONS

- § 14:54 Neurocognitive, affective, and neurobehavioral disturbances from pain medications
- § 14:55 Over-medication and self-medication issues

XI. ATTENTION-DEFICIT DISORDERS

- § 14:56 Symptoms of Attention-Deficit-Hyperactivity Disorder and the sequelae of traumatic brain injury
- § 14:57 —Plaintiff's strategies

XII. LISTS OF CONDITIONS AND MEDICATIONS

- § 14:58 List of psychiatric disorders which can cause neurobehavioral and/or cognitive dysfunction
- § 14:59 List of psychiatric disorders which can cause neurobehavioral and/or cognitive disruption/functional impairment
- § 14:60 List of medical conditions and procedures which can cause neurobehavioral and/or cognitive dysfunction
- § 14:61 List of medications which can cause neurobehavioral and/or cognitive dysfunction
- § 14:62 List of conditions other than TBI which can cause functional imaging study abnormalities
- § 14:63 List of conditions associated with hippocampal changes

XIII. DISORDERS OF IMPULSE CONTROL AND DISINHIBITION

§ 14:64 Below the neurocognitive "tip of the iceberg"

XIV	CHRONIC	PAIN	SVNDR	OMES
AIV.	CHRUNIC	PAIN	SINDU	

§ 14:65	Traumatic brain injuries and pain related complaints
§ 14:66	Violence and TBI
§ 14:67	Personality disorders and the brain
§ 14:68	Recasting current twenty-first century neuroscience into
	cross-examination questions for experts on both sides
§ 14:69	Specific possible cross-examination questions for plaintiff
	experts in emotional and brain injury litigation
§ 14:70	Specific possible cross-examination questions for defense
	experts in emotional and brain injury litigation

CHAPTER 15. STRATEGIC PLANNING FOR FUTURE LITIGATION

FUTU	RE LITIGATION	44
§ 15:1	Organic injuries mimicking neuropsychiatric illness	
§ 15:2	—Non-convulsive status epilepticus; DNA scarring	
§ 15:3	Neuroplasticity and adaptive changes	
§ 15:4	—Resilience in TBI cases	
§ 15:5	—Resilience in TBI cases: treatability of cognitive impairment in TBI survivors	
§ 15:6	Implications of resilience and dedifferentiation; kindling and supersensitization	
§ 15:7	—Extent of functional recovery capacity	
§ 15:8	—Posttraumatic stress disorder	
§ 15:9	—Neurochemicals and hormonal mediators of the psychobiological response to extreme stress; Ritalin (methylphenidate) and other psychostimulants; deep brain stimulation	
§ 15:10	Defendants' use of neuroplasticity, dedifferentiation; functional collateral circulation	
§ 15:11	Kindling and supersensitization	
§ 15:12	Demonstrating the presence of neuroplasticity using Diffusion Tensor Imaging	
§ 15:13	Life care planning and the provision of an artificial brain: the new damages frontier	
§ 15:14	—Costs of care and rehabilitation	
§ 15:15	Early settlement-oriented independent medical mediation, clinical coordination and joint case conferences	
§ 15:16	Lessons from current research	
§ 15:17	The great coming convergence between neuropsychiatry the law	and
§ 15:18	The great coming convergence between neuropsychiatry	and

	the law: the continuing search for objective traumatic brain injury causes and consequences: neuroendocrinology
§ 15:19	The coming era of biomarkers for traumatic brain injury
§ 15:20	More on uses and limitations of biomarkers in diagnosing traumatic brain injury and other conditions
§ 15:21	Defending defense claims of "fraud on the court"
§ 15:22	Fraud, traumatic brain injury and the functional
	neuroanatomy of memory
§ 15:23	Fraud, traumatic brain injury, and the functional neuroanatomy of memory: dissociative disorders
§ 15:24	The coming legal revolution
§ 15:25	Myth 5: Brain injured patients always are reliable factual historians Litigants
§ 15:26	Twenty-first century neuroscience from the top down: getting ahead of the curve
§ 15:27	The coming critical importance of understanding interactions in presenting causation and damages in brain injury litigation
§ 15:28	The coming "duty to mitigate" by <i>Defense</i> counsel to pay for early intervention in TBI cases
§ 15:29	Defending against future malingering defenses
§ 15:30	Lifecare planning and suicide risks
§ 15:31	Caregiver burden: the new clinical and legal frontier
§ 15:32	The coming duty to mitigate by plaintiff litigants and plaintiff counsel in all future pain and brain cases
§ 15:33	Testing the limits of expert knowledge: awareness of "cutting
	edge" clinical research or not
§ 15:34	Anticipating the increasing use of neuroimaging studies and biomarkers to detect the presence of co-morbid traumatic brain injury and posttraumatic stress disorder
§ 15:35	Update on brain injury biomarker explosion
§ 15:36	The coming need to integrate the findings of neuroimaging studies and biomarker tests with the clinical concepts of resilience and treatability
§ 15:37	The coming neuropsychiatric revolution and its legal consequences: prions
§ 15:38	More on the looming battles regarding subjective perceptions and misperceptions of valid indicators nonetheless of brain injury-caused psychological damage and "real world" functional limitations
§ 15:39	Dealing with brain injury-caused changes in sexual functioning
§ 15:40	Diffusion tensor imaging: The new battleground for admissibility and clinical credibility

Table of Laws and Rules

Table of Cases

Index