Head Games: Coming Out On Top In Your Brain Injury Cases

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I. INTRODUCTION

“A head injury is not a brain injury.” So writes Dr. Albert M. Drukteinis, a forensic psychiatrist specializing in evaluation of neuropsychiatric disability (available at http://www.psychlaw.com/LibraryFiles/HeadInjury.html). Dr. Drukteinis says the primary question to be resolved any time there is traumatic head impact is whether the impact caused injury to the head or to the brain, a separate and distinct entity. Head injury is not synonymous with brain injury even though the terms are frequently used interchangeably. But the determination whether there has been a brain injury as a result of head trauma, often referred to as Traumatic Brain Injury (TBI), is often difficult. This is especially true in “mild cases” which "comprise 85 percent of the total." Id. "[T]here may be few reliable diagnostic methods to confirm mild TBI." Id.

One of the key differences between Mild TBI and brain trauma like a fractured skull, an object penetrating into the brain parenchyma, intracerebral hemorrhage, or a subdural hematoma, is that Mild TBI cannot necessarily be seen in x-rays, MRIs, or the operating room. Because of this, mild brain injuries more often involve causation questions. In cases where the connection between the trauma and the resulting parenchymal injury is obvious, the case usually boils down to defending liability (hopefully you have a liability defense) and possibly challenging the extent and location of the brain tissue injured, along with the extent of the resulting disability and its effect on the claimant’s social, economic, and family life. Mild TBI, on the other hand, is most often an invisible injury. The usual diagnostic modalities – CT, MRI, EEG – are all normal. Thus, the existence of the injury itself, and its causation, may also be in dispute.

It is this invisible injury that is the primary subject of this paper. All brain injury cases are difficult to defend. They involve the body’s most complex organ, and true brain injuries can and do result in truly devastating, life-altering, lifelong neurologic deficits. Mild traumatic brain injuries have the added difficulty of trying to prove a negative, i.e. that the plaintiff is not disabled or affected in the way he or she claims. This makes them the most difficult of all difficult brain injury cases to defend. Mild TBI is also particularly difficult because there are hundreds of “experts” willing to make a diagnosis based primarily on subjective symptoms verified by equally subjective “tests.” Effective handling of these “experts” and these “tests” is key to successfully defending a mild TBI case.

So much has been published about TBI, in the medical and legal literature, that it is not possible to cover the full scope of defending a mild TBI case here. Further, while generalizations can be made, each case is individually and factually dependent, so that oftentimes the exception ends up proving the rule. Nevertheless, certain general principles can be articulated and trouble spots highlighted. This paper gives overviews of both the medical issues raised by a mild TBI claim, and some key considerations and resources for a lawyer defending such claims.
II. UNDERSTANDING THE BRAIN

Often, defense-oriented articles suggest that understanding the brain is a necessary step to effectively defending TBI. See, e.g., C.B. Montgomery & B.C. Nahrstadt, Advanced Strategies For Defending Complex Brain and Spinal Cord Cases, 56 Fed’n Def. & Corp. Counsel Q. 121 (2006) (hereinafter, Montgomery, Brain Injuries) at 127; D.T. Patterson, A Defense Lawyer’s Perspective: Mild Traumatic Brain Injury, 45 For The Defense, 12-13 (2003) (hereinafter Patterson, Mild TBI). The thought is that an understanding of brain anatomy is essential to effectively cross-examine plaintiff experts.

While this is a laudable suggestion and may be within reach of many practitioners, neuroanatomy is complicated and excruciatingly difficult to learn. Unless a lawyer has a truly thorough grasp of neuroanatomy, which usually comes only with decades of experience, cross-examination based on brain anatomy is akin to swatting flies with a sledgehammer. A lot of effort will be expended but it is doubtful that there will be any useful results. Unless the witness is a complete novice or has made a gross error that can be exposed in cross-examination, cross-examination on complex issues of brain anatomy is unlikely to be effective and will likely put most jurors to sleep. Instead, the best cross-examination of a plaintiff’s expert is through the testimony of your own expert, who can point out the fallacies of the plaintiff’s expert’s testimony and do so succinctly and authoritatively. Select good experts who can help you understand the anatomy, and help them understand how best to explain those concepts to a jury.

Your experts are the best and most reliable source of information. If you rely solely on books and articles you will find that the medical terminology and concepts are confusing because of a variance in anatomical terminology and descriptions between authors and between publications. Descriptions vary greatly depending on the date of publication and the particular specialty describing the brain anatomy or function. Thus, it is far easier to rely upon your own expert for an understanding of the anatomy and functions involved in your particular case to ensure that the language and concepts remain consistent.

That said, some knowledge of brain anatomy and function is necessary in order to communicate and be effective with your own experts. If you are so inclined, there are a number of resources available to the practitioner who wishes to gain more of an understanding of the anatomical issues involved in a claim of TBI. These books range from books for the medical profession to books for medical students and laymen. There are also websites with varying levels of sophistication. The books that break down concepts the best can be found in medical bookstores and online at websites like Majors (www.majors.com). For more generalized information, look for books written for medical students or for family practitioners. Some examples include: Stephen Goldberg, Clinical Neuroanatomy Made Ridiculously Simple (1995); William J. Weiner & Christopher G. Goetz, Neurology For The Non-Neurologist (1994); Richard S. Snell, Clinical Neuroanatomy For Medical Students (5th ed. 2001); J. Nolte & J.D. Angevine, The Human Brain In Photographs And Diagrams (2nd ed. 2000).

The real difficulty is not so much in the lawyer understanding brain anatomy and function as it is breaking down anatomy and function into understandable concepts and pictures that a lay jury will understand. Not surprisingly, some of the better websites that can assist in this endeavor are websites for children. The best example is: Neuroscience for Kids,
This website is maintained by Dr. Eric H. Chudler and was supported by a science education partnership award from the National Center for Research Resources. While visiting a kids’ site may seem silly to some, the site breaks down complex concepts into understandable packets that the average juror will be able to grasp. The average juror, after all, is the ultimate audience for any direct or cross-examination.

III. HOW DOES THE BRAIN GET INJURED?

A. DIRECT INJURY

Injury to the brain can be direct or indirect. The direct injury can be by handlebars or some other object penetrating the skull and entering the brain tissue, or by blunt trauma. Blunt trauma to the head can result in a skull fracture with bony fragments entering the brain. Even in the absence of fracture, however, blunt trauma can cause brain contusion or bruising, or the brain can move within the skull, striking the wall of the skull and recoiling in the opposite direction. This is a classic coup-contrecoup injury. See Textbook Of Traumatic Brain Injury, (J.M. Silver, T.W. McAllister & S.C. Yudofsky, eds.) (2005) (hereinafter Yudofsky, et al., TBI Textbook) at Ch. 2; Raymond D. Adams, et al., Principles of Neurology (6th ed. 1997). All of these are considered direct injuries because they are caused by the impact between the head and a foreign object, which may or may not intrude into the brain.

Depending upon the type of direct trauma, the injury to the brain can be focal or diffuse, and the resulting damage can range from temporary deficits to death. Usually, the direct brain injury does not present much of a diagnostic problem or cause-and-effect controversy. Thus, direct brain injury is not the controversial issue in TBI. It is the indirect head injury that produces most of the difficult litigation.

B. INDIRECT BRAIN INJURY

A brain injury can occur in the absence of any contact between the head and a foreign object or surface. Linear head acceleration and/or rotational forces subject the malleable brain to stresses that cause contusions and bleeding and can result in significant or even fatal brain damage. Yudofsky, et al., TBI Textbook; Adams, Principles Of Neurology. Even these indirect injuries can typically be visualized with the usual medical diagnostic modalities, however, and are known to result in symptoms documented in many studies. Id. It is the invisible injury, the so-called Mild Traumatic Brain Injury (Mild TBI) – with a plethora of symptoms or claimed symptoms but an absence of diagnostic confirmation – that causes a defense lawyer the most difficulty.

C. THE INVISIBLE INJURY

Injury to the brain without a contusion is a concussion, also called Mild Traumatic Brain Injury (MTBI). The hallmark of concussion is loss of consciousness (LOC) or at least some dazed state like “I saw stars.” A concussion is also usually coupled with post-traumatic amnesia (PTA). The amnesia can be for events prior to the injury as well as after. There have been many efforts to define concussions (Mild TBI), beginning with
neurosurgeons in 1966. The exact criteria, however, has varied over time, with arguments for extending various criteria occupying considerable space in medical journals. Yudofsky, et al., *TBI Textbook*, supra at 464.

Currently, a Mild TBI is usually defined as loss of consciousness for less than twenty minutes and PTA for less than 24 hours. R.D. Adams, et al., *Principles of Neurology* Chap. 35 (6th ed. 1998); Drukteinis, *supra*. A good many Mild TBI claims seen in litigation, however, involve individuals with little or no LOC and no PTA.

A concussive injury to the brain often results in mental, physical, and behavioral symptoms which, in a varied combination, are collectively called post-concussive syndrome (PCS). About half of the individuals experiencing a concussion will develop some degree of PCS. Adams, et al., *Principles of Neurology*. The complaints described in PCS are described in virtually every textbook, brochure, paper, seminar and magazine ever written about Mild TBI. Without detailing all of them here, they generally involve mental disturbance, physical symptoms and behavior changes. The mental disturbances can relate to attention, memory processing, and executive functions. Physical symptoms can include headache, nausea, dizziness, and lack of energy. Behavioral changes can include irritability, poor social judgment, anxiety and depression. Adams, et al., *Principles of Neurology*, *supra*.

The difficulty in defending these claims is that PCS complaints are generally subjective and include complaints that are also common among the general population, most of whom never had a head injury. Drukteinis, *supra*. In fact, Drukteinis cites papers that reveal that people who did not have personal experience with or knowledge of head injuries, when asked to select from a list of symptoms they would expect to have, chose a cluster virtually identical to PCS. In another study of personal injury claimants who did not have head injury, there were high rates of complaints which were commonly associated with PCS or Mild TBI. Drukteinis, *supra*. Both results suggest that the symptoms of PCS are those a malingering claimant might select to complain of in seeking recovery. Separating the malingering from the truly injured can be difficult.

Plaintiffs' attorneys like to look to the old medical adage “absence of proof is not proof of absence.” In other words, just because a plaintiff cannot produce direct proof of a brain injury does not mean that there is not a brain injury. This approach might be used as a cross-examination question to defense experts who, if not properly prepared, would concede that in medicine “anything is possible.” While anything may be possible in medicine, in a lawsuit a plaintiff has the burden of proof and has to prove an injury by a preponderance of evidence, not by speculation as to what is or is not possible. Thus, the problem for the plaintiffs' attorneys has been how to prove an invisible injury where there was no documented physical head injury, no loss of consciousness, and no amnesia, and where the only symptoms are subjective symptoms of which many Americans complain to their doctors every day, despite having never experienced a head injury.

The task of proving Mild TBI became immeasurably easier for the plaintiffs' attorneys, however, with the use of neuropsychological tests and advances in EEG, CT, and MRI.
technology. Although, as we will see, these “advances” are still highly questionable with respect to confirming Mild TBI, they now present a significant challenge to a defense lawyer defending a Mild TBI case.

IV. “PROVING” BRAIN DAMAGE

A. NEUROPSYCHOLOGICAL TESTS

Today, virtually every plaintiff claiming brain injury will have undergone neuropsychological testing. The goal of such testing is to determine whether the abnormal behavior being exhibited by the plaintiff is due to an organic injury, i.e., brain damage, or some other cause such as an emotional or mental problem. Montgomery, et al., Defending Brain Cases, supra at 134. There are dozens of neuropsychological tests and many different subdivisions of these tests, all of which, broadly speaking, divide into testing the following functions: general intellectual functioning; attention and concentration; learning and memory; executive function and problem solving skills; language; visual-spatial/visuoconstructional tasks; sensory-perceptual and motor functioning; and emotional/psychological functioning. Montgomery, Brain Injury, supra at 134-137; Drukteinis, supra.

Despite the super-sophisticated names and seemingly sophisticated nature of neuropsychological testing, these tests are actually quite basic. They consist of a number of physical tasks, i.e., connecting circles with numbers in sequence, copying a figure, repeating a string of numbers. The results are a measurement based on accuracy and speed in completing the assigned task. Test results are then compared to “normal” people who completed the same tasks.

A great many neuropsychologists understand that neuropsychological testing is only one tool and that those tests do not measure the source of the behavior. In other words, test results do not make a Mild TBI diagnosis. The most that can be said is how well or poorly a person did (or chose to do) at that particular test time. Drukteinis, supra. Put simply, poor performance simply means that the person did not do well − it does not mean that person could not do well. Drukteinis, supra.

But there are also neuropsychologists who put total reliance on test results and assert that a brain injury diagnosis can indeed be made from the tests. And, when a plaintiff comes to these professionals with a history of traumatic brain injury, it is not difficult for a plaintiff’s attorney to put the history together with the test results and wind up with testimony that the poor test performance was due to a brain injury sustained during the accident or event being litigated.

There are so many thousands of published studies and articles regarding neuropsychological testing that a plaintiff’s neuropsychologist can usually point to dozens of articles “validating” a particular test and its relationship to brain injury. Thus, it is likely that a neuropsychiatrist will survive a Daubert challenge on these issues. The counter to such testimony is sometimes cross-examination, but for the most part, unless one is a neuropsychologist, cross-examination will be of limited value. As discussed
above, the best way to counter neuropsychological testing effectively is with your own neuropsychologist and/or psychiatrist.

B. X-RAYS, CT’S, MRIS, AND EEGS

Following the rise of neuropsychological testing came the claim that new and more sophisticated medical machines could make the diagnosis when all else had failed. These diagnostic tools include computerized axial tomography (CAT), magnetic resonance imaging (MRI), electroencephalogram (EEG), cerebral arteriography (CT), positron emission tomography (PET), single photon emission computerized tomography (SPECT), and quantitative electroencephalogram (QEEG). As advanced and high-tech as all of these procedures sound and as much intellectual and creative energy as has gone into the development of these modalities, they still have not been able to focus into the brain in such a way as to demonstrate microscopic brain injury with reliability. There are, of course, thousands of articles dealing with these modalities and hundreds of opinions about how much and what they demonstrate. Nevertheless, clinical correlation for an individual patient is still lacking. A brief summary of these tests and the results yielded by each is contained in Montgomery, Defending Brain Injury, supra at 129-133. See also, Yudofsky, et al., TBI Textbook, supra ch. 6.

The latest imaging technique is Diffusion Tensor Imaging (DTI). DTI uses magnetic resonance imaging technology to examine white matter. It is said that this modality allows quantification of structural changes in white matter which some people believe is the area of injury in chronic Mild TBI patients. See, M.F. Kraus, et al., White Matter Integrity And Cognition In Chronic Traumatic Brain Injury: A Diffusion Tensor Imaging Study, 130 Brain 2508-2519 (2007). However, DTI is still in its infancy and clinical research is still lacking. It should not yet be allowed in a courtroom to confirm Mild TBI. Of course, that judgment often depends on the jurisdiction and the judge before which you find yourself on this issue.

V. DEFENDING THE INVISIBLE INJURY

Obviously, Daubert challenges can be made to any or all of the diagnostic “tests” that a plaintiff may offer in support of the TBI diagnosis. While much can be made about the variability of these modalities and their lack of clinical correlation, as well as the subjective interpretation needed to connect a result with a particular patient, it is again unlikely that much headway will be made on cross-examination. It is imperative, therefore, that the attack on the use of these modalities be made through a defense expert such as a neuroradiologist, neurosurgeon, or neurologist. The expert can explain the tests and drive home the basic proposition that these modalities are not used in clinical practice to make the type of diagnosis that the plaintiff’s expert is making.

A. GENERAL PRINCIPLES

In just about any personal injury suit a defendant should be thinking in terms of defending three broad categories: liability, causation and damages. Liability is, of course, dependent upon the particular facts. Oftentimes, when there is a strong liability defense
the emphasis is on defending liability to the neglect of the other two categories. Each category should be aggressively defended.

In the past, it was somewhat controversial whether a defendant should attempt to refute a plaintiff’s injury claims with experts directed at causation and money damages. The argument was that by doing so a defendant conceded negligence and acknowledged the plaintiff’s entitlement to damages. That argument should by now be thoroughly discredited. In a brain injury case the defendant must address causation and damages to some extent, no matter how strong the liability defense. While the emphasis on causation and damages may vary depending upon the strength of the liability defense, neither should be neglected. Thus, in virtually every case a defendant should be considering the use of experts in life care planning, economics, and annuities, in addition to a neurologist, neurosurgeon, neuropsychologist, radiologist, physical medicine and rehabilitation, psychiatry, and other applicable medical specialties that may fit a particular case. Depending on the jurisdiction, use of an annuitist to discuss the amount of money, in present value dollars, needed to fund the Life Care Plan may or may not be allowed. If allowed, such testimony can be a powerful tool in getting the jury to consider smaller numbers even in a “high damages” case.

One important element of a brain injury case that a defense lawyer should never forget, whether the injury is thought to be legitimate or exaggerated, is that lay people have an inherent belief that a head injury is in fact a brain injury. And they believe any brain injury is likely serious and life-changing. It is this common sense “knowledge” amongst lay people that can prove to be a defendant’s biggest challenge. There is some empirical research suggesting that jurors make up their minds early in a trial, often before the experts testify. Neil Vidmar, Empirical Evidence On The Deep Pockets Hypothesis: Jury Awards For Pain And Suffering In Medical Malpractice Cases, 43 Duke Law L. J. 217 (1993). Thus, a defendant must give considerable emphasis to dispelling this myth as early as voir dire and opening statement.

B. MOUNTING THE DEFENSE

1. Strong Defense Experts

As emphasized repeatedly herein, the vast majority of Mild TBI lawsuits will not be won on cross-examination. Unless the plaintiff has hired particularly incompetent experts, most neuropsychologists, neurologists, neurosurgeons, etc., that appear for the plaintiff will be capable of holding their own on cross-examination. This is not to say that they should not be cross-examined, but rather the cross-examination should be coordinated with the direct testimony from the defendant’s experts. In other words, the cross-examination should be like the set-up pitcher in baseball with the defendants’ experts coming into the game as the closer.
2. Pre-Morbid I.Q. Level

A plaintiff’s neuropsychologist almost always has one area of significant vulnerability: pre-morbid I.Q. level. In order to make the brain damage claim worthy of significant damages, the plaintiff’s neuropsychologist must demonstrate that the accident damaged so much of the brain that the plaintiff has lost I.Q. points. In other words, the plaintiff must not simply be low functioning, but must be lower functioning than before the accident. Determining the plaintiff’s pre-accident I.Q. level is often the weakest link in the neuropsychologist’s causation chain.

Neuropsychologists frequently estimate a plaintiff’s pre-accident level of functioning by using various complicated calculations connected to the I.Q. testing. In essence, this methodology is nothing but pure guess despite the claims to authenticity. When no earlier I.Q. test has been administered, there is simply no well-validated, accurate method of estimating pre-morbid intelligence or capacity. Drukein, supra.

If there is no prior I.Q. test then the best method for the defense lawyer to estimate a plaintiff’s pre-morbid I.Q. level and function is to gather all records that deal with evaluating a person’s abilities. These include past school records, employment records, military records, and every other similar record that can be obtained for that plaintiff. Frequently these records reveal that the plaintiff displayed many of the same functional disabilities he/she now claims are due to brain damage. The same holds true with respect to post-accident functioning. Current employment records, school records, etc., can be used to demonstrate that a plaintiff is functioning quite well in the real world post-accident, and has conveniently forgotten to let the neuropsychologist know that he/she made straight A’s in the eight college courses taken after the accident.

3. Malingering

There may have been more articles written regarding malingering in neuropsychological testing than virtually any other subject in personal injury trial law.

Malingering refers to a continuum of behaviors ranging from subconscious or conscious exaggeration of actual symptoms all the way to outright fabrication of symptoms. Motivation in nearly all cases, however, is secondary gain, i.e., the symptoms will allow the person to get something they want or to get out of something that they don’t want. A.G. Harrison, Adult’s Faking ADHD: You Must Be Kidding!, ADHD Report (2006), available at Regional Assessment & Resource Center, Queens University, http://www:queens-hcds.org/rarc/blacations.html.

Malingering is perhaps neuropsychology’s biggest stumbling block, and there are dozens of tests and scales within tests devoted to detecting malingering.

The bottom line on malingering is that you will need to establish its existence in a particular plaintiff through examinations and testings done by your neuropsychologist and psychiatrist and other experts. Your own expert will also be able to explain the phenomenon of malingering generally to the jury. It would be a rare case where you could make a malingering charge stick just by cross-examination. Such cases do exist certainly, but one must be extremely careful in choosing to rely on cross-examination alone to support that allegation.

**4. Independent Medical Examination**

In virtually every case the defendant will want experts to examine the plaintiff and likely administer neuropsychological testing. Occasionally there may be reason not to do an examination but those situations will be rare.

An independent medical examination (IME) can be as cursory as a 15-minute examination or as extensive as a multi-examiner one- or two-day, full-scale physical examination with an MRI, CT, lab studies, genetic testing, and neuropsychological testing, in addition to day-long or more observation and videotaping of activities at school and home. A defendant must always be aware that experts who have never touched the plaintiff will be compared unfavorably to the plaintiff’s experts who have had unlimited access to physical interactions and examinations. Overall, the pendulum almost always comes down on the side of examining the plaintiff in some form or fashion. See, J.R. Gass, *Defending Against Catastrophic Damages: Challenges And Choices*, 39 For The Defense 10 (June 1997).

**VI. Traumatic Brain Injury Resources**

There is so much information on Traumatic Brain Injury available that it becomes impossible to absorb it all. Lawyers are interested in TBIs because they generate large verdicts. Thus, the techniques for trying and defending TBI lawsuits generate high numbers of books, articles, websites, and blogs. Medical and ancillary personnel who treat TBIs and those that testify on medical issues also generate huge numbers of articles and books on all sorts of associated medical issues. TBI patients and their families write books and blogs and have formed dozens if not hundreds of advocacy groups, all of whom have web sites, research conferences, and meetings. Sifting through this information explosion to separate truth from advocacy is difficult.
A. The Internet

Type the words “litigating brain injuries” into Google. In 0.07 seconds you are presented with 189,000 results, the vast majority of which are lawyer web sites. The words “brain injury” return 26,400,000 Google results in 0.08 seconds. Despite the overwhelming volume of Internet information, there are good TBI resources to be found on the Internet including web sites, books, articles, how-to papers, expert witnesses and even blogs.

Naturally, as with anything to do with the Internet, the information must be vetted with a huge salt shaker, not just taken with a grain of salt.

One new Internet resource for TBI is the blog. While this may sound counterintuitive to a defense lawyer, plaintiff lawyers' blogs and plaintiff law firm web sites have a remarkable amount of information regarding the latest trial techniques, books, meetings, seminars, speeches, experts, regulations, court decisions and verdicts. It is worthwhile to go through the blogs and web sites to find one that addresses your particular issues or your state’s law and verdicts and periodically monitor that site for new information. This is the absolute best way to keep up with plaintiff lawyers’ changing strategies and determine the techniques they will be using to cross-examine your witnesses. Forewarned is forearmed. Here are three blog examples:

- Mike Kaplan blogging at http://www.braininjury.blogs.com;
- Bruce Stern blogging at http://www.braininjurylawblog.com; and
- NeuroNotes at http://www.traumaticbraininjury.net/neuronotes.html

There are some other web sites offering information useful to defending TBI, but these are rather sparse compared to plaintiff-oriented sites. Find Law and other such search engines will turn up articles, as will a survey of some defense law firm web sites. Information can also be found at the DRI web site and other defense-oriented organizations. One excellent, comprehensive paper on defense of brain and spinal cord injuries can be found at The Federation of Defense & Corporate Counsel site: http://www.thefederation.org C.B. Montgomery & B.C. Nahrstadt, Advanced Strategies For Defending Complex Brain and Spinal Cord Cases, 56 Fed’n Def. & Corp. Counsel Q. 121 (2006) (hereinafter, Montgomery, Brain Injuries).

B. Books and Articles

Books and articles can be found on virtually every subject related to TBI. Type TBI in Amazon's book search and you receive 7,833 results. One assumes these results must represent every TBI book ever written. The book titles run from first person accounts to family memoirs to medical textbooks.

One of the best medical textbooks is Textbook Of Traumatic Brain Injury (J.M. Silver, T.W. McAllister & S.C. Yudofsky, eds.) (2005). Those conceptionalizing TBI as purely a physical injury may be surprised to learn that Dr. Yudofsky, Chairman of the Department of Psychiatry at Baylor College of Medicine in Houston, his co-editors and many contributors are psychiatrists. Psychiatry ends up with a good many TBI patients. Psychiatrists become involved in a patient’s care because of significant behavioral changes that can follow TBI. Psychiatry also becomes involved in TBI as a result of
associated “malingering” issues (in which a patient fabricates or exaggerates symptoms). It is natural, therefore, that brain injury has become a psychiatric subspecialty.

TBI is also a subspecialty area for many other medical specialties including neurology, neurosurgery, physical medicine and rehabilitation, as well as the psychology profession, particularly including neuropsychology. All of these specialties have published literally hundreds of TBI books and articles on every subject involved in TBI diagnosis and treatment.

C. Brain Injury Associations and Foundations

There are dozens of brain injury associations, advocacy groups, and foundations. Each has a website, annual meetings and seminars touching on just about every conceivable issue involved in TBI. Most are advocacy groups formed by people with TBI or their families, and the information is often oriented to a particular world view, colored by their own experiences. Nevertheless, there is valuable information available. Three examples of such sources that may provide helpful information include:

- Brain Trauma Foundation (http://www.braintrauma.org)
- North American Brain Injury Society (http://www.nabis.org)

D. Professional Societies


The defense lawyer will want to check the various professional websites for potential cross-examination materials and to make certain that the defense experts are aware of the latest pronouncements, edicts, and guidelines from their own professional societies.

From time to time medical journals and professional societies also publish information directed to patients on head injury topics. These publications can be a source of easily digestible information concerning concepts involved in TBI. The Journal of the American Medical Association (JAMA), for example, publishes a patient page in its weekly journal. One recent topic was head injuries. See Janet M. Torpy, JAMA Patient Page, Head Injury, 294 J.Am.Med.Ass’n 1580 (2005). The JAMA website has a Patient Page link allowing access to the published Patient Pages: http://www.Jama.com.
VII. CONCLUSION

Cases involving brain damage are among the most difficult to defend. Mild TBI cases are perhaps even more difficult than frank brain injuries merely because one is trying to prove a negative. It should go without saying that a defense lawyer’s luck in securing favorable verdicts will inevitably correlate with the amount of preparation and quality of defense experts.
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