Introduction to Special Issue on NeuroLaw

Neurolaw attorneys face formidable challenges when representing persons with acquired mild traumatic brain injury. By almost anyone's definition of mild traumatic brain injury, there are very few, if any, objective findings that the clinician can point to to document mild traumatic brain injury. The most widely accepted definition of mild traumatic brain injury was developed by the American College of Rehabilitation Medicine. It defines mild traumatic brain injury as loss of consciousness, if any, for thirty minutes or less; no focal deficits on neurological or clinical examination; and an absence of abnormal or positive findings on diagnostic testing, such as MRI or CT scans. Most commonly, the person with acquired mild traumatic brain injury has vague and poorly defined emotional, behavioral and physical complaints.

As a result of the dearth of objective findings and other associated difficulties, claims to compensate people with acquired mild traumatic injury are hotly contested battlegrounds in the legal arena. Plaintiff attorneys struggle to prove that their clients actually have a brain injury, while defense attorneys point to the lack of objective findings to argue that no brain injury actually exists. For these reasons, attorneys who represent the injured continue to search for objective diagnostic tools that will definitively prove to a judge, a jury and the insurance companies the true presence of a brain injury and the corresponding right to fair and adequate compensation.

Concurrently, a revolution is taking place in our civil court system where all attorneys face new challenges to the admissibility of expert opinion evidence – novel, scientific, or otherwise. Under the Federal Rules of Evidence as interpreted by the United States Supreme Court, all proposed expert opinion testimony must undergo a rigorous evaluation by a "gatekeeping" trial judge. *Daubert v. Merrell Dow Pharmaceuticals* and *Carmichael v. Kuhmo Tire* have heightened the level of judicial scrutiny applied to expert opinion testimony by requiring the trial judge to serve as a gatekeeper to make the initial evaluation regarding the validity of the scientific testimony before it may be presented to a jury. Previously, almost all of this testimony would have been admissible and it would have had been left solely to the jury's discretion to accept or reject its validity. Unfortunately, the admissibility of scientific diagnostic testing to objectively prove the presence or absence of brain injury lags far behind in our court system's understanding of the usefulness and reliability of such testing.

It is not surprising that the topics voluntarily chosen by the authors, as opposed to the editor, unanimously addressed this problem of objectively proving or disproving the presence of traumatic brain injury.

J. Sherrod Taylor, Esq., who coined the term "Neurolaw", provides an expansive discussion and explanation of the field of neurolaw and provides an excellent starting point for the reader to appreciate the difficulties and hurdles faced by the neurolaw attorney. His article is followed by one of two articles written by Howard Friedman, Ph.D. and Catherine Klee, Ph.D. discussing the impact of *Daubert* and *Kumho Tire* on neurolaw cases.

How *Daubert* and *Kumho Tire* are applied in specific instances is addressed in the following two articles. Samuel Mehr, M.D. and Steven Gerdes, Esq. address the contribution of PET Scan to objectively document brain injury, while at the same time discussing the limitations in this new technology.

Guest Editor, Bruce H. Stern, Esq. similarly addresses the admissibility of neuropsychological testing and the requirements that the neurolaw attorney and neuropsychologist must satisfy in order to admit the testing under the *Daubert* and *Kumho Tire* analysis.

A common residual of brain injury is post traumatic headaches. Like traumatic injury, there presently exists no objective diagnostic criteria for proving, within a reasonable degree of medical certainty, the existence of headaches. Harvey Hyman, Esq. provides advice on how to prove to a jury's satisfaction the existence of this common brain injury residual.

From the opposite standpoint, however, there are times when a patient's treating physician or forensic experts, due to a failure to obtain an adequate pre and post morbid history, improperly or incorrectly diagnoses a traumatic brain injury and more importantly causally relates it to the specific trauma in the litigation. Catherine Klee, Ph.D. and Howard Friedman, Ph.D. address this critical issue, delineating the proper requirements and criteria to establish a premorbid baseline in order to properly diagnosis and determine whether a traumatic injury has occurred.

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Finally, Laurence Miller, Ph.D. takes an in-depth look at the important issue of malingering. Most often, the defense to mild traumatic brain injury claims is the argument that the injured person is not only not brain injured, but is in fact faking or exaggerating the claim. Dr. Miller takes an in-depth look at this critical issue.

Today, objective proof of mild traumatic injury remains elusive. Until such time that doctors and neuropsychologists are able to objectively and conclusively document the existence of mild traumatic brain injury, neurolaw attorneys will continue to battle over whether or not a specific person does or does not have a mild traumatic brain injury. As time goes on, hopefully the legal arena will catch up with science so that tests which are presently being utilized by physicians and neuropsychologists will be acceptable and admissible in our trial courts.

Bruce H. Stern