Think Like a Doctor:

Tips for introduction of Medical Evidence

Law Office of Michael E. Gatto

www.gattopc.com

Learn the Language

Medicine

- **Suffixes**
- **Prefixes**

Anatomy

- **Nomenclature**

Anatomical/Medical Resources

- Models
- Animations
- Client's Imaging Studies
  - Load to your laptop
  - Learn how to manipulate the images/What they depict

Common ER Presentation Resulting in mTBI and Cervical Spine surgery

- Prehospital Care
- Nursing Notes
- Trauma Work Up
  - CT Scans
- Likely Diagnoses
  - Cervical sprain/strain
  - Closed Head Injury or Concussion, if you are lucky

Every Doctor has a Role/Toolbox

- Emergency Medicine Physician
- General Practitioner
- Neurologist
- Pain Management Physician
- Surgeon

Analogies

- Intervertebral disc – Jelly Donut/Radial Tire
- Infection: Elevated White Count; Bands/Left Shift – War: White Blood Cells are the Body's Troops
- Diffuse Axonal Injury: Tearing at the Gray White Junction – Green Fuzzy Tennis Ball

Examination of Medical Witnesses

- Diffusing what the Defense wants to do with:
  - Emergency Medicine Physician
  - Treating Physician
  - Defense Neuroradiologist

Introduction

Videotaped Depositions Provide Opportunities to have the Defendant:

1. Establish your Rules of the Road;
2. Overcome Juror Bias against Plaintiff's Counsel;
3. Establish Crucial Evidentiary Issues; and
4. Enhance your Examinations of Defendants and Their Experts

Video Testimony

Different times you can use it:

- Opening
- Direct Testimony
- Cross-examination
- Expert Testimony
- Closing and Rebuttal

Video Testimony

Different ways you can use it:

- **Support** a witness's testimony
- **Contradict** a witness's testimony
- **Foundation** for a witness's testimony
- **Impeach** a witness's testimony
- **Critique** an expert's opinion

Brian C. v. Contra Costa Health Systems

Use of Videotaped Deposition in Opening Statement

- Validate Rules of the Road
- Establish your Credibility
- Damage Defendant's Credibility

Use of Videotaped Depositions During Trial

- Party – CCP Section 2025.620(b)
  - While the witness is on the stand
  - Between witnesses to set up contradictions
  - During examination of experts
- Percipient witness may be impeached with their own deposition
  - CCP Section 2025.620(a)
- Expert – Impeachment regarding foundation

Examples of Use of Videotaped Deposition in Opening

- Birth Plan:
  - Date (in weeks/days) and mode (vaginal v. cesarean section of delivery)
  - Avoid emergencies/foreseeable injuries through proper plan
  - Goal – minimize risks to mom and baby(ies) through **Risk-Benefit Analysis**
  - Plan made when **Risk-Benefit Analysis** is known
  - Plan must be changed if **Risk-Benefit Analysis** changes

Dr. Madrigal Testimony re Birth Plan Formulation

Monochorionic Diamniotic ("Mo-Di") Pregnancy

- One placenta; two amniotic sacs
- Very rare: approximately 1 in 240 pregnancies
- The womb is one "vascular system"
- If one baby dies, it is an **Obstetrical Emergency**
- The survivor can "bleed across" to the dead baby, leading to brain damage

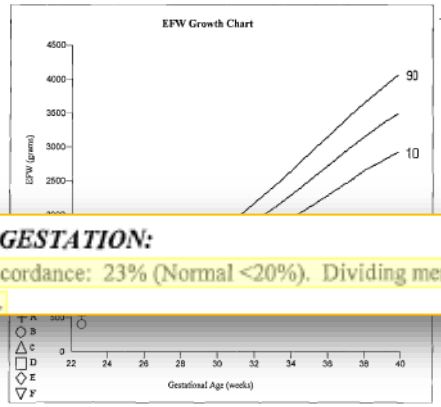
Mo-Di Pregnancy (continued)

- Risk of “preferential” blood flow to one fetus
- Referred to as **“Twin to Twin Transfusion Syndrome”**
- Extremely rare: approximately 1 in 2,500 pregnancies
- Results in variation in the developing babies’ weight: referred to as **“Discordance”**

EBPMA – Ultrasound Report 3/11/08

SUMMARY PAGE

Patient: Evelia Ontiveros **Medical Record #: 900013178** **Exam Date:** 3/11/2008



EFW Summary Table

Exam Date	Fetus #	EFW	Percentile
3/11/2008	1	523	44 %
	2	400	20 %
2/12/2008	1	224	
	2	261	

MULTIPLE GESTATION:

Weight discordance: 23% (Normal <20%). Dividing membrane was seen. Placentation is monochorionic, diamniotic.

AMNIOTIC FLUID VOLUME:

Fetus A

POLYHYDRAMNIOS — Moderately Increased. Maximum Vertical Pocket: 10 cm

Fetus B

NORMAL — Mildly Decreased. Maximum Vertical Pocket: 3 cm

COMMENTS:

Note: This is a monochorionic-diamniotic twin gestation. Twins are discordant with A greater in size than B. Amniotic fluid volume is greater around the larger twin and less around the smaller twin. This suggests twin-twin transfusion.

The patient has been referred to the UCSF Fetal Treatment Center for evaluation and possible laser photocoagulation. They will call the patient to schedule her initial appointment.

We recommend a follow-up scan in 3-4 weeks to check fetal growth. This exam has been scheduled. Thank you for your kind referral.

Susan Fong, MD
Perinatologist

Plaintiff's
Exhibit 23.003

Cuevas Rec 2
East Bay Perinatal Medical Associates 27

Dr. Madrigal's Testimony re Familiarity with Mo-Di Pregnancies

Dr. Madrigal's Testimony re Knowledge of TTTS Risks

UCSF Ultrasound Report 3/18/08

UCSF MEDICAL CENTER

PT NAME: ONTIVEROS, EVELIA
UNIT # 4904854-8
DOB: 04/09/1970 SEX: F
VISIT # 14263118 REPORT STATUS: FINALIZED

PROCEDURES: US FETAL SURVEY MULTI GESTATIN (3-18-08 09:30)

COMPLETE OBSTETRICAL SONOGRAM: 3/18/200

CLINICAL HISTORY: 37-year-old female, p
gestation. Evaluate for twin-twin trans

COMPARISON EXAMS AND/OR REPORTS: No pri

IMPRESSION:

Twin fetuses are identified. Twin A is in cephalic presentation on the maternal left. Twin B is in breech presentation on the maternal right.

GENDER TWIN A: MALE TWIN B: MALE
AMNIOTIC FLUID SAC A: 6.3cm SAC B: 7.8cm
MEMBRANE PRESENT: Yes THICKNESS: thin
PLACENTA POSITION: Anterior CHORIONICITY: Monochorionic
CERVIX: 3.2cm transabdominal, closed

The following biometric data were obtained.

TWIN A TWIN B
MEASUREMENTS

Biparietal diameter 23 wks 0 days 23 wks 4 days
Head circumference 23 wks 4 days 24 wks 5 days
Abdominal circumference 22 wks 6 days 25 wks 2 days
Femur length 21 wks 1 day 22 wks 6 days
Humeral length 22 wks 4 days

FETAL WEIGHT ESTIMATE 515 grams 699 grams
Percentile by LMP 27% 55%

COMPOSITE AGE 22 wks 1 day 23 wks 4 days
ULTRASOUND EDD: 7/21/2008 7/11/2008

LMP AGE 23 wks 4 days 23 wks 4 days
LMP EDD: 7/11/2008 7/11/2008

This examination includes a general survey of the fetuses. The survey is comprised of (but not limited to) the following views of where technically possible and clinically appropriate: cerebral ventricles, cerebellum, choroid plexus, cisterna magna, midline falx, cavum septi pellucidi, four-chamber image of the heart, great vessels (and/or outflow tracts), spine, stomach, kidneys, urinary bladder, umbilical cord insertion, umbilical cord vessel number, and extremities.

2. A single anterior placenta is identified. The cord insertion of Twin B is central, whereas the cord insertion for Twin A is along the margin of the placenta along the left lateral aspect. A vessel is identified on the placental surface coursing between the two areas of cord insertion, with a to-and-fro waveform consistent with an artery-to-artery anastomosis.

Plaintiff's
Exhibit 31.038

0019
Cuevas Rec 38
UCSF Medical Center

COMMENT:

1. Twin fetal survey performed by Dr. Seerat Aziz.

2. A single anterior placenta is identified. The cord insertion of Twin B is central, whereas the cord insertion for Twin A is along the margin of the placenta along the left lateral aspect. A vessel is identified on the placental surface coursing between the
nd-fro waveform consistent

s by 10 days, is at the
cal pocket of 6.3cm.

s at 54th percentile,
m.

5 grams, that for Twin B
discordance.

6. All of the above findings are consistent with unequal placental sharing and continued surveillance of both twins is recommended.

The above findings were discussed at fetal treatment conference the same day by Dr. Aziz.

RADIOLOGIST: Aziz,Seerat
ORDERING MD: Lee,Hanmin

Plaintiff's
Exhibit 31.039

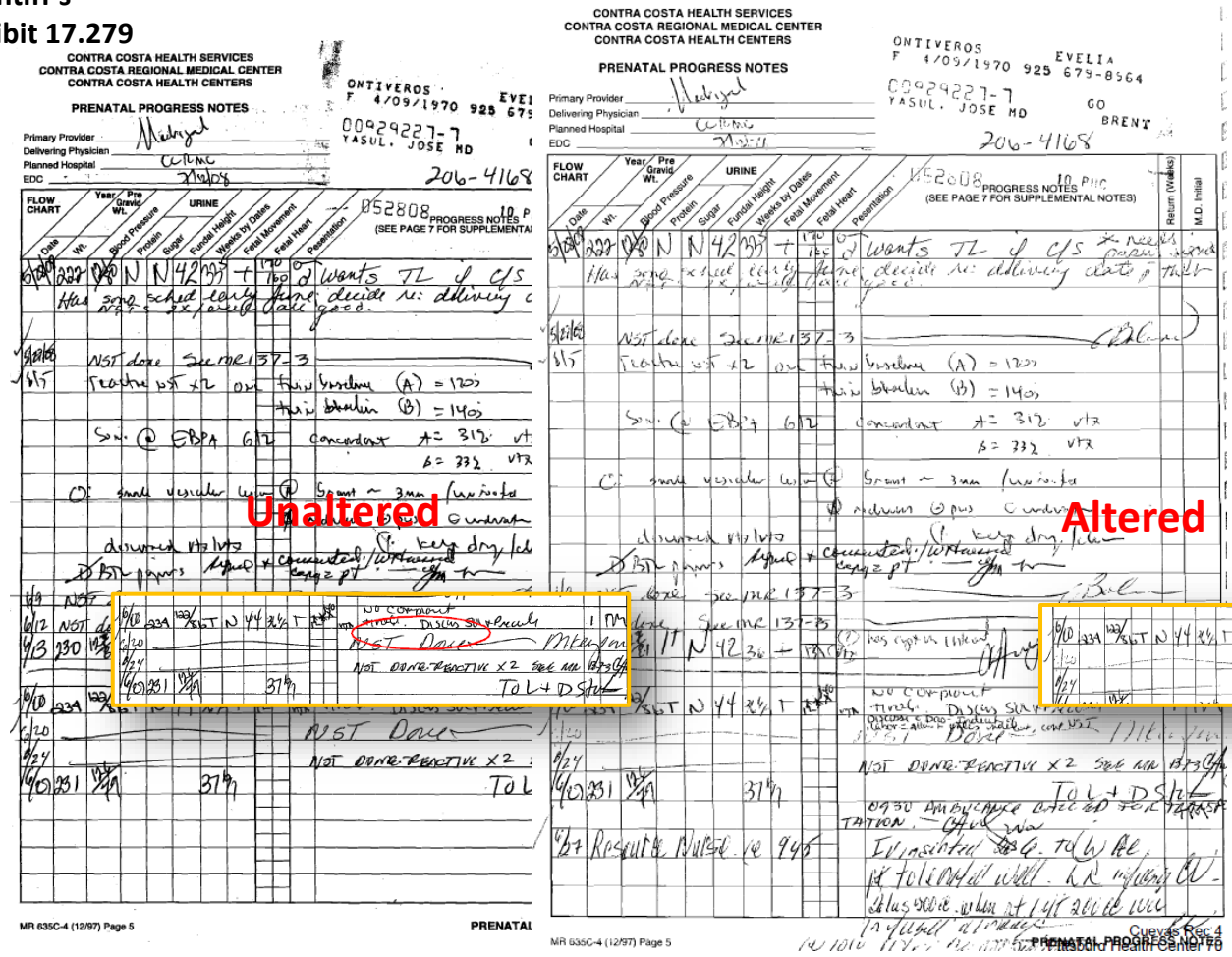
002
Cuevas Rec 38
UCSF Medical Center

Dr. Madrigal Admits Not Qualified to Manage Pregnancies with Marginal Cord Insertion

Dr. Madrigal's Testimony re Requirements for Charting

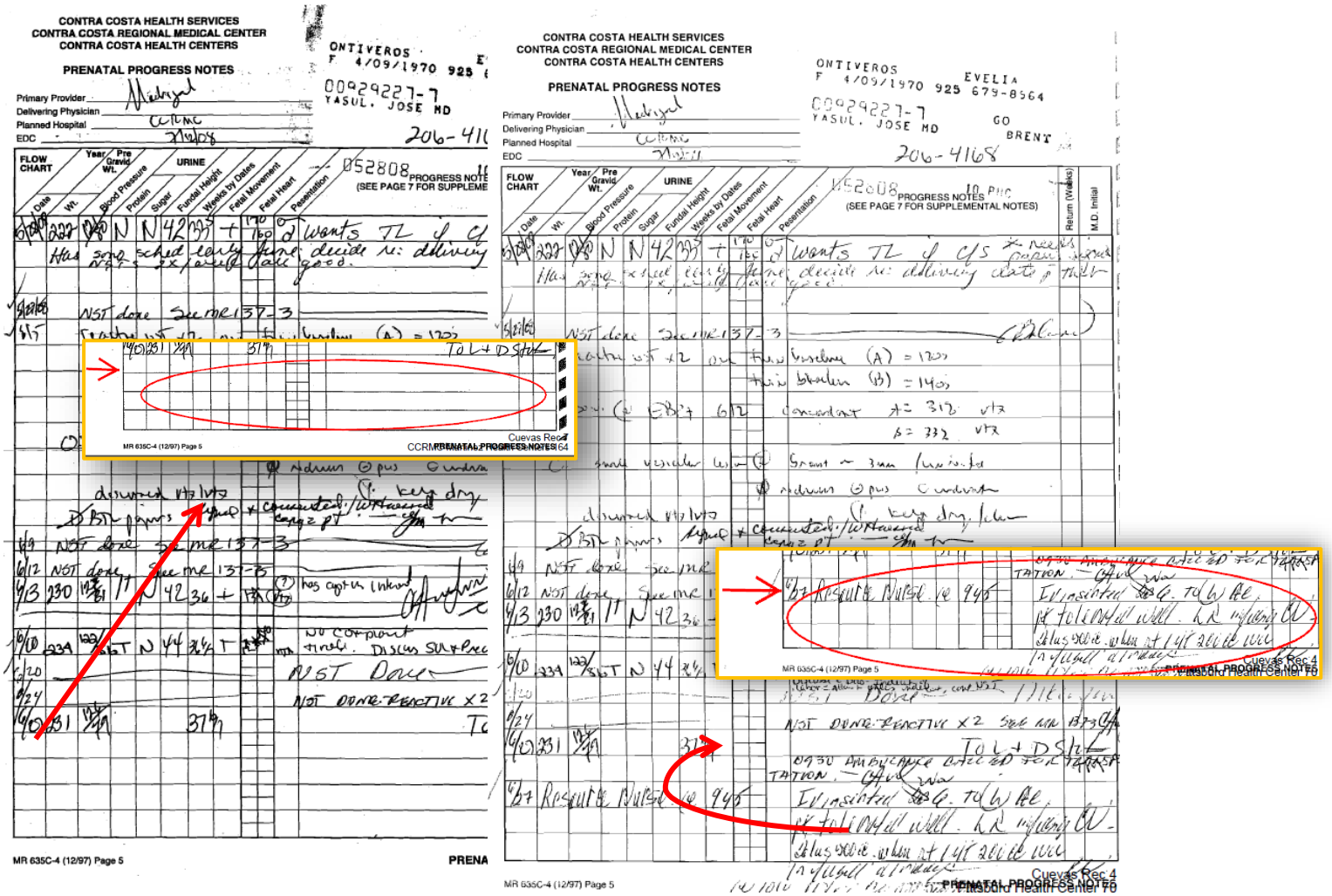
Prenatal Progress Notes – 6/20/08

Hospital Chart
Plaintiff's
Exhibit 17.279



Clinic Chart
Plaintiff's
Exhibit 15.138

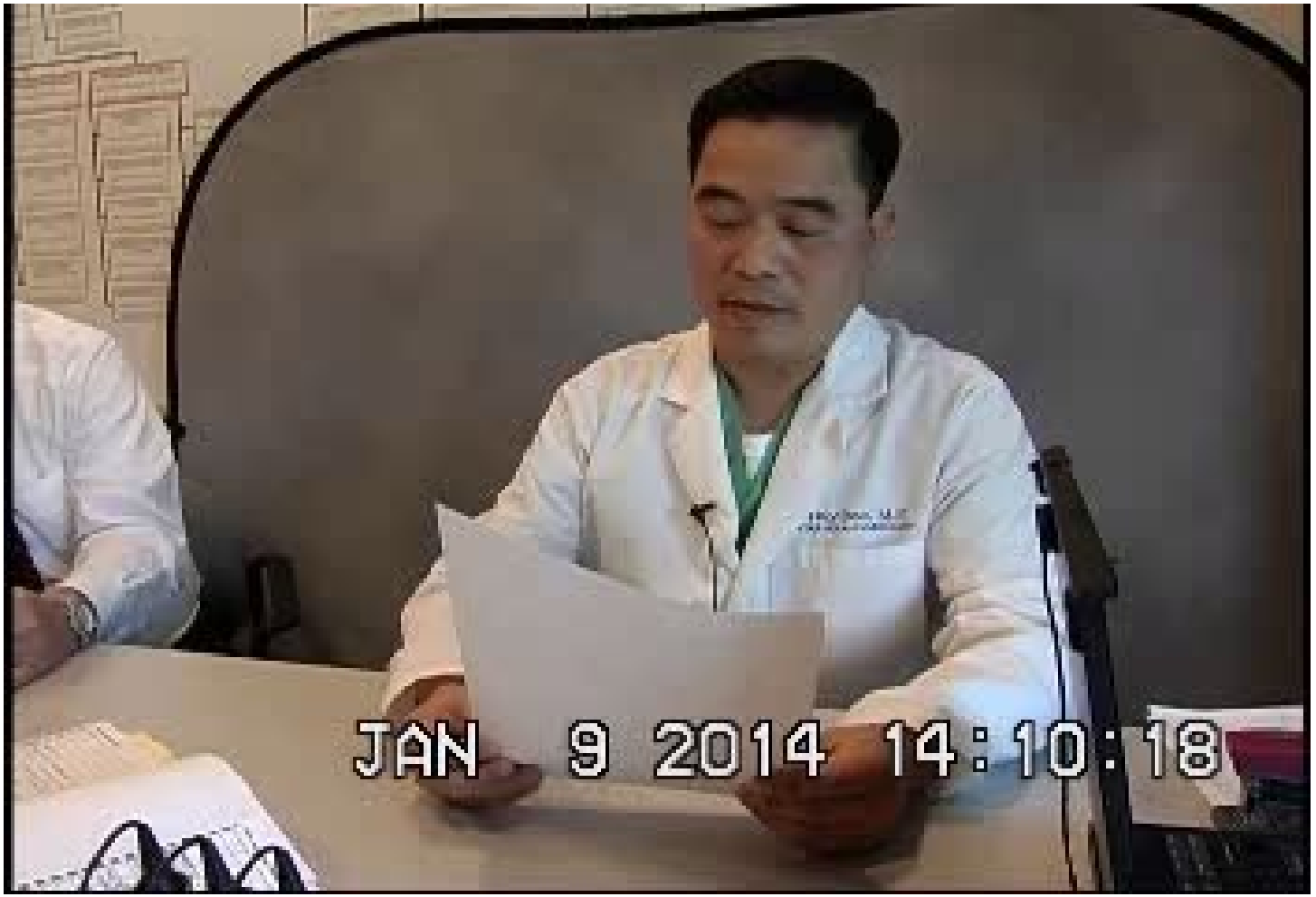
Prenatal Progress Notes - Clinic



Dr. Madrigal's Testimony re Late Entries

Dr. Madrigal Testified She Consulted with Drs. Fong, Dao, Hay re Due Date

Dr. Dao's Testimony re Consult – 6/20/08



Dr. Fong's Testimony re Consult with Dr. Madrigal

Dr. Hay's Testimony re Consult with Dr. Madrigal

Win the Opening, Win the Trial:

A Paradigm for Prosecution of Institutional Cases

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- 2/3 of Jurors Make Up Their Mind Based Upon Opening Statement

- Only 20% of Jurors Have the Intellectual Capacity to Change Their Mind if Appropriate Based Upon the Evidence

Anonymous

How and Why Do We Win Cases Generally?

- Foreseeable
- Preventable

How and Why Do We Win Cases Against Institutions?

- Demonstrate the institution knows these incidents/injuries can occur
- Demonstrate the institution is supposed to prevent these incidents
- Institutional make up/hierarchy
- Goals:
  - Make money
  - Efficiently - to include lack of claims/injuries

Labor & Delivery

- Goal – Deliver Without Injury to Mother or Fetus(es)
- Process - Team Effort:
  - Doctors
  - Nurses
  - Ancillary Personnel/Services
- Division of Labor/Specialization

Resources

- Fetal Heart Monitor
- Ultrasound
- Identify Situations when Fetus is at Risk of Injury

BY MR. GATTO:

Q. In your career, how many times have you had a situation occur where a fetus is born, it has a heart rate, and it dies without leaving the OR?

A. Just this one.

Q. Okay. Talk a little bit conceptually about labor and delivery right now. Labor and delivery department in hospital -- your training and experience is that this is a team effort, correct?

A. That's correct.

Q. To include the delivering doctor, yes?

A. Yes.

Q. The labor and delivery nurses, yes?

A. Yes.

Q. And what other disciplines, personnel, etcetera do you conceptualize as this team in this context?

A. Anesthesiologist and pediatrician and to some extent, nursery nurses.

Q. Each person on this team has a particular role, correct?

A. Correct.

Q. So there's division of labor, yes?

A. Yes.

Q. Each person is trained up, yes?

A. Yes.

Q. And there are resources available that identify situations where a fetus may be at risk of neurologic injury, true?

Damages from Institutional Error

- Hypoxic Ischemic Encephalopathy
- Mutli-system Organ Failure/Seizures
- Not Competitively Employable
- Requires Protected Living Environment