

Think like a doctor

Tips on understanding medical jargon, appreciating the roles of different medical specialties and the use of analogies in medical testimony

By Michael E. Gatto

As personal-injury attorneys, we are responsible for effectively communicating complex medical terminology and anatomy to multiple audiences: adjusters, defense attorneys, mediators, judges and jurors. Understanding how doctors think, formulate differential diagnoses, speak, and the role they play in our healthcare system facilitates better communication regardless of audience. Introducing complex medical evidence in a memorable way for unsophisticated and disinterested jurors is essential to our roles as advocates.

For 20+ years, I have handled catastrophic personal injury, medical malpractice and elder abuse claims. There are few injuries, diseases, laboratory or diagnostic tests, critical values or treatments I have not encountered.

There are many parallels between the practice of law and the practice of medicine. Both are highly specialized; filled with rules and defaults to handle various situations; and, requiring mastery of a new language with prefixes, suffixes and root words. Each physician plays a particular role in our healthcare delivery system. A physician's specialty defines their role and the "tools" they have to offer.

In this article, I provide tips for handling complex medical issues that will improve your presentation and your audience's comprehension of medical testimony.

Medical jargon/anatomy/analogies

Like all languages, medicine utilizes root words, prefixes and suffixes. In quick order, you can quickly develop a solid base to then facilitate comprehension of a large segment of medical language. Resources abound to aid in this process. The same is true of anatomy.

Cervical is neck. Radicular means to radiate. Pathy means disease/bad/dysfunction. So, cervical radiculopathy means arm dysfunction from neck injury. Cephalo is head. So, traumatic encephalopathy is brain damage from trauma.

Hyper/tachy is high. Hypo/brady is low. Poly is multiple. A/an is not or absence. Neuro is nerve. Genic is suffix for genesis or cause. So, neurogenic bladder is bladder dysfunction due to nerve lesion.

Acute in medical parlance is temporal, not gradation. So, typically this will mean a short period of time. Not a severe episode. Infrequent events are episodic, transient or paroxysmal.

Jurors and anatomy

Anatomy has specific terms. Jurors don't typically use correct anatomic terms. So, patella becomes kneecap; scapula becomes shoulder blade; femur becomes thigh bone and on and on.

Jurors range from brilliant and interested to intellectually challenged and bored. We have to communicate with all jurors. The sophisticated, interested juror will likely want to know both the actual term and receive much more detailed explanation. Less sophisticated jurors may struggle with complex terminology. I suggest toggling between the specific term and an analogy or generic term to engage all jurors.

Possible analogies

An intervertebral disc composed of an annulus and nucleus pulposus becomes a jelly donut or a radial tire.

Foraminal narrowing causing nerve root compression becomes an extension cord with the outside coating damaged and the wires inside compromised. Thus, an electrical signal may still get through, but function is impaired. When trying cases involving these issues, consider keeping jurors with electrical training or other basis to understand these arguments and become an advocate in deliberations.

Diffuse axonal shearing at the gray-white matter junction becomes a tennis ball where the green fuzz is attached. The propensity for shearing during coup-contrecoup becomes tearing of the green fuzz.

A bacterial infection is not about bands and a left shift. The body is fighting a war, the infection. Wars require troops. White blood cells are the body's troops.

The possibilities here go on and on. Focus-group or run your proposed analogies by non-medical individuals to see what resonates. Presenting medical evidence in this fashion allows jurors to use existing mental constructs to understand, absorb and remember the evidence.

Our healthcare delivery system

We deliver medical care through a complex hyperspecialized system of providers. Each provider has a "tool box." A surgeon has a scalpel; a pain doc has meds and interventional procedures; physiatrists are primary care docs for patients with complex disabilities; emergency-medicine physicians triage acutely injured patients; radiologists interpret images but often have little, if any, role in treatment plans. The list goes

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on. Recognizing the role each physician fills facilitates communication and allows you to expose defense fallacies.

Treating physicians, which are becoming harder to get access to, often express gratitude when I meet with them and demonstrate an understanding of my clients' injuries. I find these physicians want their patients to receive legal representation from medically astute attorneys or at least ones that will put in the time to learn the pertinent issues. I load imaging studies on to my computer to discuss with physicians when pertinent. It is not difficult to develop a working familiarity with this type of evidence. Treating physicians seem to appreciate these efforts. Thereafter, they seem more inclined to teach the nuanced aspects of injuries, causation and future care needs.

Common scenario

To illustrate the above points, we will discuss a hypothetical patient, a driver T-boned with severe neck pain and a knot to left temporal region with altered consciousness from MVA, with cervical disc and mild traumatic brain injuries.

In the typical severe-injury case, plaintiff will receive treatment on scene from an Emergency Medicine Technician. Do no harm, as always, is the mantra. Get the patient to a hospital for appropriate care without causing further injury. So, c-collars are applied. Fractures will be stabilized with air casts. Pain meds may be administered. If there is blood loss, efforts to stem the bleeding will be implemented and fluids for hemostasis will be provided.

Upon arrival at the hospital, triage and assessment begin. Depending on the level of acuity, this may be a nurse and an emergency medicine physician all the way up to a multi-disciplinary trauma team. Now, the focus becomes first whether there are life-threatening issues and then whether the patient will be admitted. A host of tests and diagnostic imaging may be performed. Within this setting, mild traumatic brain injury or occult disc injury are not treated meaningfully. This is because neither is life threatening nor require admission. Rather, you see a diagnosis of concussion, if they even list that, and cervical sprain/strain.

Emergency department workup for the neck would focus on possible fracture/subluxation. Workup for the blow to head would focus on possible acute brain bleed which might require neurosurgical intervention.

X-rays of the cervical spine will show possible compression or other fracture as well as alignment to rule out subluxation. Head CT can identify acute brain bleed. So, someone with a mild traumatic brain injury without frank hemorrhage, and cervical disc herniation without fracture or subluxation or loss of neurologic function, will likely get diagnosed with concussion and cervical sprain/strain.

Does this mean they were not injured severely? The defense will certainly tell the jury so. The doctors at the hospital did not diagnose disc herniation or brain injury. Only plaintiff's hired experts say that. We will address how to combat this when we explore the role of physicians later.

Outpatient follow-up

Patients will often be instructed to follow with their primary care physician, orthopedics, etc. at discharge from the emergency department. Conservative treatment and the passage of time to see if symptoms resolve are the default. Conservative treatment may be as little as time off from work with rest. Physical therapy may be ordered. Generally, only if plaintiff "fails" physical therapy will an MRI be ordered that might diagnose disc herniation. If symptoms are severe enough and pathology warrants, a referral to an orthopedic surgeon and/or pain management is usually the next step.

With regard to post-concussion syndrome, while it is true 80-85% of patients' symptoms resolve within a short period of time, roughly one in five or six will have lingering and sometimes permanent symptomatology and disability. Referral to neurology will then follow.

Neurologists have advanced training and skills identifying subtle symptoms of TBI. Medical advancements to include 3T MRI with DTI sequencing, VNG testing, functional capacity evaluations and others are available to establish persistent and somewhat subtle TBI symptoms.

Neuropsychological referral and testing should be obtained. Neuropsychological testing can identify cognitive deficits. Neurologists, neuroradiologists and neuropsychologists can interface to provide foundation for the area of trauma shown on 3T MRI; respective functions of the region of the brain injured; clinical symptoms seen neurologically; and, to impaired cognitive function on neuropsych testing.

With regard to nerve root compression, symptoms will likely evolve absent severe injury. So, initially, there will be pain, spasm and loss of lordosis secondary to trauma. Rest, ice, anti-inflammatories, pain meds will often be ordered and beneficial in the short term. Over time, the nerve root irritation may worsen. The inflammatory response and/or injured disc may further collapse, causing greater impingement; the pain leads to disuse and atrophy. Sensory symptoms – pain, tingling, burning, etc., may evolve to motor symptoms – dropping things; lack of dexterity; weakness. Generally, pain is a poor indication for surgery and correlates to bad outcomes. More often, motor involvement will be the point when surgery is considered.

Working with treating physicians

Increasingly, treating physicians are unwilling or at least reluctant to treat MVA victims or work with their lawyers. If you are able to speak with them, do your homework. Study the records; imaging studies; and anatomy. Demonstrate your efforts to learn and enlist their help.

Explain the medical-legal process. Have jury instructions available and offer, if needed, to demonstrate the legal standards. The medical community typically operates on a higher degree of certainty than preponderance before

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making changes in treatment protocols. So, you have to overcome some of this inertia.

Be prepared to provide prior records; TCR; damage photos and any other evidence probative of forces involved. Also, consider providing subsequent records to show outcome.

Identify your goals. Do you need to provide context; buttress foundation; neutralize the respective physician? Thereafter, you can refine your approach.

For the treaters in the ER, seek to get them to agree concussion is TBI. See how far you can get them to go regarding CDC guidelines on TBI. The more evidence you can get from a treater, the better. Most will agree concussion is TBI and/or they didn't rule out TBI by that diagnosis. Have them explain the medical delivery system and need for TBI to be worked up as outpatient. Have them admit the symptoms your client is currently having are symptoms of TBI; significance of temporal relation to traumatic event; and, probability of permanence at one year out.

For treaters in the ER regarding sprain/strain, have them admit focus was fractures/paralysis, not mild to moderate disc herniation. Again, they will have requisite training to diagnose and know about treatment for and limitations stemming from cervical radiculopathy. So, have them run through it. Again, you are buttressing your expert and likely undercutting things defense experts will try to assert and/or argue.

As to outpatient treaters, it is crucial they have prior and subsequent records. These records will provide foundation for opinions. If you do not provide this, the defense will certainly use it to try to claim the defense expert has superior foundation. Do not allow that to happen.

Test-run your analogies with the treaters to see if they will adopt them. If not, ask how they communicate these concepts to their patients. They may be more comfortable using their own verbiage. Ask them about demonstratives they use to discuss with their patients. Incorporating these in your exam can be powerful.

Consider videotaping and doing a direct examination. Trials are evolving to fewer and fewer live witnesses. This saves time and money and provides flexibility. You can edit a video and know exact length, making trial presentation/scheduling much simpler. If it turns out the witness is extremely powerful or something comes up, you can still call the witness live.

Again, do your homework. Cull the records to identify issues that can demonstrate extent of injury or general damages. Ask the doctor to bring anatomic diagrams or hardware to use as exhibits. For surgery, point out what surgeon could observe grossly versus imaging studies. Often, they will observe additional pathology. This can be critical to overcome bogus defense arguments.

Medical expert witnesses

While truly the subject of a separate full article, many of the ideas discussed above apply to experts. Consider your goals and how to best present the evidence in verbiage jurors will understand and recall. Ask them how they communicate these concepts to their patients. Identify analogies these physicians are comfortable using and consider incorporation.

In the battle of the experts, the defense jurors face difficult decisions. The regular defense witnesses are commonly well qualified and glib. Getting them to agree with your analogies and simplified medical concepts undermines their effectiveness and enhances your credibility.

Having plaintiff's experts armed with compelling analogies or effectively testifying to all jurors in a straightforward manner will aid in the battle of the experts.

Conclusion

Do not shy away from complex medical evidence. Put in the time to learn the anatomy and language. Work with your consultants and treaters, if able. Identify and use compelling analogies to allow your audience to use their mental constructs to understand and retain this evidence. By use of these ideas, your settlements and verdicts should increase.



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