

# HOW TO PREPARE FOR AND TAKE A DOCTOR'S DEPOSITION

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"Discovering anatomy" is really the key to understanding the language of medicine. My view may be biased. Since I have some anatomy training, I tend to emphasize the importance of such knowledge. However, if you observe the most skilled medical cross-examiners, you will note their knowledge of the relevant anatomy of the case. The anatomy may be the only thing you need to know in an orthopedic injury case involving bones, muscles, nerves, and vessels. In other cases, the anatomy is the first step to fully understanding the physiology of the injury or disease. In every case, anatomy is the key to understanding the language of medicine.

Understanding the language of medicine enables you to function effectively on the many levels needed in tort cases:

- First, in conferences with your doctor, understanding the anatomy from the beginning will enable you to move to the substantive issues more quickly;
- Second, a prior understanding of the anatomy will enable you to talk more effectively with your doctor or cross-examine the opposing doctor;
- Third, demonstrating some knowledge gives your doctor confidence in your professionalism and establishes your authority with the opposing doctor; and
- Fourth, understanding the anatomy enables you to simplify the medical terminology for the

jury—especially if your doctor is not a very good communicator.

## PREPARING FOR THE DEPOSITION: "DISCOVERING ANATOMY"

Gaining knowledge of anatomy is simple and cost-effective. It is simple because independent study is possible without an extensive scientific background. It is cost-effective because once you learn it, it doesn't change! Although medicine as a science changes as new diseases, treatments, and theories arise, the anatomical basis (on a gross level) does not. Once learned, anatomy is a body of knowledge that is reusable. So if there is one place to spend your independent time as a trial lawyer, it is the study of anatomy. How do you get such knowledge? There are quite a few sources.

### Reference Books

The starting point is a dictionary. There are several good ones, but I use Dorland's Illustrated Medical Dictionary (Elsevier, 32nd ed. 2011). It contains sections on medical pronunciation, etymology, and illustrations of muscles, nerves, and vessels. When encountering a medical record or doctor's report, the medical dictionary is the first resource in understanding the language.

If a record contains unfamiliar abbreviations, there are sources which provide the answer. Most hospitals have their own glossaries of acceptable symbols and abbreviations. These may be difficult to get.

A good resource is *Medical Abbreviations: 30,000 Conveniences at the Expense of Communication and Safety*, by Neil M. Davis (Neil M. Davis Associates, 14th Edition 2008). Misunderstanding abbreviations can lead to malpractice claims. Missing the meaning of an abbreviation in a record can lead to leaving the key facts of the case undiscovered. Look up every abbreviation you do not know.

Basic anatomy texts are readily available. The best known is *Gray's Anatomy*. I use *Hollinshead's Textbook of Anatomy* (Philadelphia: Lippincott, Williams and Wilkins, 5th ed. 1997). Almost any standard anatomy text at a health science library is sufficient. A call to a medical school will get you a list of currently recommended texts. Such a call put me on the track of the following texts:

- *Atlas of Human Anatomy*, Frank H. Netter (Elsevier, 7th ed. 2018);
- *Anatomy: A Regional Atlas of the Human Body*, Carmine D. Clemente, (LWW, 6th ed. 2010);
- *Abraham's and McMinn's Functional and Clinical Anatomy* (Elsevier, 8th ed. 2019).

There are also anatomy and physiology texts written for lawyers and tremendous online internet resources. These can serve as a useful starting point. But for cross-examining doctors, the best thing to do is to familiarize yourself with the texts that the doctors use. And as a practical matter, it is much easier to cross-examine a doctor based on one of the common medical texts than it is to do it based on a book written for lawyers. The doctor will be familiar with the former, not the latter.

### **Medical Texts, Journals**

In every specialty, there is a standard medical text (although usually more than one):

- In orthopedics, most orthopedic surgeons acknowledge the authority of *Campbell's Operative Orthopedics* (Elsevier, 13th ed. 2018);
- In internal medicine, most doctors acknowledge *Goldman-Cecil Textbook of Medicine* (Elsevier,

25th ed. 2015) or *Harrison's Principles of Internal Medicine* (McGraw-Hill, 20th ed. 2018);

- In pediatrics, it is *Nelson Textbook of Pediatrics* (Elsevier, 21st ed. 2019).

Standard medical texts and journals are listed in *Print Books and Journals in Allied Health*, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC141184/>.

These texts and journals enable you to understand the medicine of the case. Plowing through the technical language is daunting but rewarding. Begin by looking at the same topics in lawyers' medical treatises to get a feel for the area and the language. Then try the medical text. If the area cannot be understood without further background, try to get it from your expert or further basic study. Being somewhat conversant in the relevant medical area enables you to understand the doctor's testimony in depth, test the doctor's assumptions against that knowledge, and establish your own competence. How that knowledge is used or disclosed during discovery and cross-examination is part of the art of cross-examination discussed later in this book.

The one book that is crucial in cross-examining a psychiatrist or psychologist is the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association. The fifth edition is commonly referred to as the *DSM-V*. Since the practice of psychiatry and psychology is arguably the most subjective of the medical subspecialties, the *DSM-V's* listing of diagnostic criteria for all psychiatric conditions is indispensable. Because the *DSM* has been used effectively to cross-examine, there are now disclaimers in the introduction, but the actual criteria list for diagnoses is still useful.

Further, many psychologists and psychiatrists use the *DSM-V* and cite the diagnostic criteria numbers when making a diagnosis. Whether the history and criteria really do match is a useful area for cross-examination.

### **Journal Articles**

Journal articles are useful on several levels. Once the medical area is identified, a current journal article is

more current than the most current text—an important point in a medical area that is evolving rapidly. A journal article provides potential experts. A journal article provides, in addition to information, material for cross-examination. Finally, some review articles can be used in many cases. For example, an article by Richard A. Deyo, et al., entitled *How Many Days of Bed Rest for Acute Low Back Pain*, appeared in the October 23, 1986, issue of the *New England Journal of Medicine*, and concluded that a shorter period of bed rest (two days) is just as effective as a longer period. Excluded from the study were “those seeking compensation.” Well-recognized, refereed journals such as the *Journal of the American Medical Association (JAMA)* and the *New England Journal of Medicine (NEJM)* containing such review articles can be part of a journal bank used to support your doctor and cross-examine the opposing doctor. Particularly useful are position papers by the relevant specialty societies such as the American College of Obstetrics and Gynecology.

Having obtained sufficient general and specific medical background for the case, and conducted preliminary non-deposition discovery of the doctor, it is time to prepare and take the discovery deposition of the opposing doctor to further arm yourself for cross-examination.

### **Doctors Who Are Friends**

As you practice in the area of torts, you become friends with some doctors. They will often take the time to give you anatomical information. However, this is of limited utility since it is not an organized effort. Such doctors are excellent resources, however, for answers to specific anatomical or medical questions.

### **Private Lessons—Anatomy Teacher**

If your schedule does not permit class attendance, try private tutoring. A Ph.D. anatomy professor at a medical school is a good resource and is sometimes willing to tutor. Often, Ph.D. candidates are anxious to tutor.

### **Courses at University**

There are several sources of anatomic training. Auditing a first-year medical school anatomy course may be difficult both in time commitment and attitude of the doctors at the medical school about lawyers. However, there are anatomy courses in the allied health services that are essentially the same. Try the nursing school, dental school, optometry school, and physical therapy school. Evening courses are available at most local colleges and universities. Finally, try the art school. Most offer a drawing course that teaches basic anatomy. All of these courses offer a complete exposure to general anatomy and will not leave gaps in your knowledge. Computer programs that teach gross anatomy may also be available at the university.

### **Anatomy Seminars—Taught By Anatomists and Doctors**

Although law schools have recognized the importance of trial practice courses, very few have devoted attention to courses in anatomy or dealing with doctors—a substantive skill much needed in practice. Therefore, bar associations have tried to fill that gap with medical seminars, usually trying to teach basic anatomy. These are useful, particularly if taught by a Ph.D. anatomist or doctor. They are, however, usually limited to one day and do not cover enough ground to give you a sufficient foundation in anatomy.

### **Basic Terms**

Many anatomical terms are Greek or Latin derivatives. There are helpful medical etymology outlines in such books as *Dorland's*. Learning parts becomes easier if the derivatives are appreciated. For example, “cervic” means “neck.” Thus, “cervical” refers to the neck. “Cervix” is the “neck” of the uterus. “Cervix” is also used to indicate the constructed part of an organ. This interplay of meaning and terms leads to acquiring a large body of knowledge by learning suffixes and prefixes.

## Joint Movements

Doctors' reports contain, particularly in orthopedic cases, the range of motion of the joints. The lack of normal range of motion (expressed in a percentage) equates to increased disability. The following terms (with meanings) are often used:

**Flexion** – bending toward the body;

**Extension** – bending away from the body or straightening the limb;

**Hyperextension** – moving beyond normal straight position; can be normal range of motion in the elbow and abnormal in a neck injury;

**Dorsiflexion** – describes raising the part beyond the straight position; it usually refers to raising the foot up;

**Plantar flexion** – moving the foot down;

**Pronation** – turning the palm down;

**Supination** – turning the palm up;

**Eversion** – turning the foot outward;

**Inversion** – turning the foot inward;

**Abduction** – away from the body;

**Adduction** – toward the body.

Sometimes reports describe joint movements in describing injury (“hyperextension injury,” “flexion-extension injury”). These injuries occur when the body part is moved beyond the normal range of joint movement due to trauma. Hyperextension of the elbow occurs if the elbow is bent back too far; flexion-extension injury (commonly called whip-lash) occurs when the neck is flexed and extended beyond its normal range of motion.

## Anatomical Terms

The normal anatomical position is a person standing, facing forward, feet flat, palms up (toward the viewer). Given that position, the following terms are used by anatomists to describe directions:

**Lateral** – away from the midline of the body;

**Medial** – toward the midline of the body;

**Proximal** – near or nearer a structure;

**Distal** – farther away from a structure;

**Anterior** or **ventral** – front;

**Posterior** or **dorsal** – back;

**Cranial** or **superior** – toward the head;

**Caudal** or **inferior** – toward the tail (tailbone) or toward the feet.

There are other terms and variations to learn. Once you learn them, however, you will be able to make sense of reports, records, and transcripts of medical testimony.

## Goal of Discovering Anatomy And a Warning

In their enthusiasm, doctors may give you more than you need, both in the sense of giving you too much information and in giving it to you in terms too technical for the jury to absorb. Breaking down information and tailoring it to the needs of the case is a job for both the lawyer and the consulting doctor. If you have a basic understanding of general anatomy, you will be better able to communicate with the consulting doctor and narrow the focus of the discussion to the medical issues that are directly relevant to the case.

## Need Only Enough To Talk to Doctor

It is not necessary to become an expert in the specialty. It is only necessary to be knowledgeable of a small portion of that field. This is attainable with study and consultation. Focusing in on the basic relevant anatomy is easier today. In the past, attending surgery was an accepted way to understand relevant anatomy and surgical procedure. Today, videotapes of most surgical procedures are available for review. The goal is to be able to understand the doctor you are cross-examining — and to make it clear that you understand the testimony and cannot be overwhelmed, misled, or otherwise fooled by jargon.

## Need Only Enough To Simplify For Jury

The unalterable goal is to get the jury to understand the medicine. Even if you understand the medicine, this knowledge won't help the case unless you can get the jury to understand it, too. Simplifying the medicine is the job of both your doctor and you.

## Never Use Your Knowledge Solely To Demonstrate Your Knowledge To The Jury

Jurors generally believe lawyers are egotistical. Don't feed this negative stereotype by showing off your new knowledge. Jurors should look to you as an interpreter and explainer of technical medical information. If you can do this, you will have increased your credibility—the goal of every trial lawyer. The education of jurors begins in voir dire and opening and continues throughout the trial. Assuming the role of an effective educator is valued in the courtroom.

## Discovering the Doctor and the Doctor's Opinions

An initial reaction to the idea of discovering the doctor and his or her opinion might be, "Why not discover the doctor and the opinion during a discovery deposition? This looks like a lot of unnecessary work before the discovery deposition." Not true. If the only discovery of the doctor you undertake is during the deposition, you miss the opportunity to set up your cross-examination during the discovery deposition for use at trial. You will be able to determine during the discovery deposition if the doctor is exaggerating qualifications, minimizing the amount of expert testimony, or contradicting a prior opinion. If you wait to do this discovery until *after* the deposition, you lose the opportunity to "close the circle" on your questions so the doctor cannot weasel out at trial because your questions were not precisely phrased and focused. Some investigation of the doctor (or any witness) always occurs after the deposition due to information discovered during the deposition. However, for formidable witnesses such as doctors, investigation before the discovery deposition is essential.

## Websites and Online Directories

Sometimes the most obvious source is the best. Who is the doctor? Is the doctor an allopath (M.D.) or an osteopath (D.O.)? Where does the doctor practice? What hospitals are near the doctor's office? Is the doctor on that hospital's staff? If not, why not? What was the reason? Who are the doctor's partners? Who are his competitors? Do you know any of them? Is the doctor listed in the phone book? Why not? Some highly professional physician-professors associated with universities have no listing; this may also be true of some highly questionable practitioners who only treat patients who are involved in litigation. The simplest starting point generates potential questions and potential sources to answer those questions before the deposition; it provides questions to ask and cross-check after the deposition.

## Medical Board Inquiry and National Practitioner Databank

Many states maintain a roster of registered physicians in that state. It lists all licensed M.D.s and D.O.s practicing in the state. Sometimes those rosters are not available to the general public. There are two sources for uncovering the "bad" doctor: state medical boards and the National Practitioner Databank:

- The state medical board can be a source of information. Try the national website for medical boards at [www.fsmb.org](http://www.fsmb.org). Is the doctor presently licensed in the state of residence? This is a threshold criterion for testimony in most courts. Have any licensing actions been taken against the doctor? Often, medical boards will disclose final actions on the internet and much of the file becomes public record. This can be a treasure trove of material for cross-examination. The failure to investigate leaves this available material undiscovered;
- The National Practitioner Databank was created as part of the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§11101–11152 (Pub. L. No. 99-660, 100 Stat. 3784). It requires insurers to report malpractice judgments and settlements, and requires hospitals to report certain

disciplinary actions against physicians. Attorneys and individuals can only access the Data-bank under limited circumstances, so its utility is limited.

### **The ABMS Directory Of Board Certified Medical Specialists**

The most useful source of preliminary information is the American Board of Medical Specialists' Directory of Board Certified Medical Specialists, published by Marquis Who's Who. Their website is [www.ambms.org](http://www.ambms.org). All the board certified specialists who have obtained the requisite training and experience and have successfully completed examinations in a medical specialty are listed in this publication. It also lists subspecialties within a general specialty. Early examination of these volumes, available at health science libraries, can disclose two vital pieces of information: Whether the doctor is board certified and whether the doctor is board certified in the relevant specialty. Check the general index for the doctor's name. If it is missing, the doctor is not board certified. This raises a series of interesting questions. Was the doctor not qualified to take the exam? Is the doctor too new to the practice to be qualified to take the exam?

Examining the table of contents discloses subspecialties available for certification. If the issue is diabetes, you may find the doctor is certified in internal medicine, a relevant specialty. But is the doctor certified in "endocrinology, diabetes, and metabolism," the relevant subspecialty? If your doctor expert is so certified in the relevant subspecialty, you have created an argument regarding the weight of the opposing doctor's testimony. Similarly, is the board certified neurologist a board certified child neurologist? Is the board certified orthopedic or plastic surgeon a board certified hand surgeon? Is the board certified radiologist a board certified neuroradiologist?

If the doctor is board certified, the book will contain brief biographical sketches of credentials. Is the doctor a member of the relevant medical society? Are the doctor's credentials better or worse than your doctor's? Was the doctor trained at recognized training centers? All this information and more is helpful in constructing discovery and cross-examination as

noted in later discussions in this book. It is also helpful in selecting your testifying doctor if you have a choice.

### **Prior Depositions and Activities: Expert Deposition Bank**

Organizations that were created by the plaintiff's bar, such as the American Association for Justice (AAJ) (formerly the Association of Trial Lawyers in America (ATLA)), or the defense bar, such as Defense Research Institute (DRI), have deposition banks for experts who regularly testify. These banks include doctor experts. They are most useful in cases with "national" experts. Often in malpractice litigation, a certain expert will appear frequently in a certain specialty area for one side or the other. Obtaining these depositions can be crucial in making sure that the expert takes a position consistent with earlier helpful opinion testimony. A doctor contradicting a prior opinion is a powerful piece of cross-examination. Such a deposition is a sworn prior inconsistent statement that can be used at trial. Asbestos cases also involve national experts. There are often multiple depositions of the same experts testifying on the same medical issue, such as diagnosis of asbestos-related disease or proximate cause of disability. These experts have a narrow area of opinion limited by their prior deposition testimony. These depositions are readily obtainable by either side from other plaintiffs' and defense attorneys. Much of the work of the local courts does involve local experts, particularly in workers' compensation and auto accident cases. For these doctors, there are other methods of discovery.

### **Prior Depositions and Activities: Deposition Bank—Your Own**

Every time you depose a doctor, keep a copy of the deposition. If you are active in this type of practice, you will build a deposition bank on local doctors. If you have partners, have them do the same. Index such a deposition bank by doctor, by specialty (orthopedic surgery, neurosurgery), and by medical condition (burns, scars, low back and neck, and so on). Soon you will have information not only about

specific doctors and their opinions, but also about general medical wisdom and opinion in certain areas. You will have efficiently grown your knowledge base in areas most relevant to your practice.

An added benefit is the accumulation of material for cross-examination. For example, does the doctor have the same opinion on permanency in all cases? Does the doctor always find permanency or never find permanency—no matter what the medical condition? If you have 30 depositions to show the jury, it can be an interesting evidentiary presentation.

Deposition banks are particularly useful with psychologists and psychiatrists, the most difficult of medical witnesses. Categorizing the conditions such a doctor has found associated with psychological diagnoses can be interesting: broken fingers, small scars, strained back, and so on.

### **Files of Activities—Newspaper Articles, Internet Sources**

Occasionally, information on local doctors appears in newspapers, magazines, or other print media. Save such potential material for cross-examination at a future date. File it in your deposition bank. Advertising for expert testimony by a doctor can be useful, particularly when such advertisements appear in lawyer publications. A name search on the Internet is also interesting. Does the doctor have some activity or business that seems strange for a professional? This will be discussed further below.

### **Local Lawyer Information**

One of the more pleasant interactions between lawyers in some, but not all, communities is trading information and assisting each other for mutual benefit. Effectively dealing with the less-than-honest expert is a benefit to the client and the legal system. Conversations with codefendants' or co-plaintiffs' lawyers expand your experience and insight into a certain doctor. Similarly, conversations with colleagues not involved in the case are helpful. Discuss the lawyer's experience with the doctor, evaluation of the doctor, and approach and success in cross-examination. Such discussions are surprising because

fellow lawyers really can be helpful and are mostly willing to be helpful. Such discussions improve collegiality, particularly when you can reciprocate.

### **Fellow Doctors**

The medical community, like the legal community, knows the reputations and incredible amounts of gossip about practitioners. Some is confidential and cannot be disclosed—for example, hospital staff discipline if the doctor was on the disciplinary committee. (Such questions, however, can be asked directly to the involved doctor in deposition.) Other information is fair game. Who did this doctor train under? Is it, perhaps, your expert doctor? Does the doctor have excessive malpractice claims? Has the doctor changed practice patterns and is now doing more testifying and less surgery? These questions are, of course, proper to ask in discovery depositions, but the leads you may receive from fellow doctors may prevent shading testimony in a way that is unfair to your client. Fellow doctors may save you time in discovery. If the doctor has an excellent reputation and is a straight shooter, your efforts need to be directed elsewhere.

### **STANDARD WITNESS INVESTIGATION**

An assault conviction, a divorce case, a telephone harassment charge, or a tax evasion indictment all can damage the doctor's credibility. Running criminal checks on doctors may seem unnecessary, but occasionally they bear fruit. With computerization, a name search on the Internet, online court records, and other online resources may produce interesting material. Does the doctor litigate against others, suing for antitrust or defamation? Are there public lawsuits involving removal from hospital medical staffs, containing information that may be otherwise confidential? Is a Freedom of Information Act inquiry justified? Although such searches may not produce useable information, the effort may stimulate your thinking to discover other sources of useful information. Further information that may not appear useful when first discovered may be crucial as the case develops.

## PubMed

PubMed is an online database website comprising 29 million citations from sources including Medline and is an excellent starting point for research. <https://www.ncbi.nlm.nih.gov/pubmed/>. A search by the doctor's name will produce all articles published by the doctor. If the doctor's list of publications is not found, you may find the doctor "forgot" to list some articles, claiming they are awaiting acceptance for publication. If there are publications on the relevant or marginally relevant topic, get them. They are always a fertile source for cross-examination. Compare your doctor's relevant publications with the opposing doctor's publications to determine real expertise in the relevant area.

## Refereed Journals

Certain publications are more stringent in accepting articles. These publications are more prestigious and authoritative. They are called "refereed journals." An article must be reviewed by a panel of well-recognized experts in the specialty and be found to be scientifically sound before it is accepted by such publications. Often, doctors' "theories" are not accepted in the medical community and are rejected by refereed journals. However, if the doctor is published in non-refereed journals, he or she may appear authoritative. As a matter of weight, however, refereed journals can be used to show the acceptance of your doctor's opinions as authoritative and the opposing doctor's opinions as not authoritative, even though that opposing doctor has "published."

## Local Medical Society Journals

Local medical societies publish journals in which doctors often offer personal opinions on healthcare issues, some relevant to personal injury litigation. A doctor testifying for a plaintiff may have editorialized on negligence, or exaggerated symptoms and the evaluation of pain when litigation is pending. One doctor who regularly testified for plaintiffs wrote that he did not believe in "pain" and that most people should get on with their lives rather than focusing on their lawsuits! Accessing such journals may be difficult, but can be worthwhile.

## Medical Records—Office Records

Hospital and office records can be obtained through written discovery. All records need to be discovered, even seemingly unrelated prior treatment and hospital records. Reviewing those records in detail and understanding them is an important process in the case.

Chronology is often important. In office records, the chronology may be easy to follow since most events are grouped in dated written notes. Hospital records analysis requires more experience. Grouping progress notes, X-rays, consultations, and laboratory reports by date can give you a clearer picture of treatment. For both plaintiff and defendant, prior history is crucial. In a medical record, "PMH" means "prior medical history." It is usually found in the first entry in a doctor's office chart and the first physical exam or exams. If an office chart contains a long prior history of treatment, review it. It is not only the prior history the doctor comments on, but also the prior history of treatment with that doctor which may disclose a defense for the defendant or increase the damage for the plaintiff. In the hospital record, the emergency admission, progress notes, consultation reports, or discharge summary all may contain prior history.

Awareness of prior injuries, diseases, and other medical facts is often the linchpin of a case. Doctors' opinions are often found in progress notes or consultation reports in the hospital records, and less often in office records. Inconsistency in opinions offered before litigation, after litigation commences, and later at deposition will provide fodder for the cross-examiner. The most interesting post-litigation document is the doctor's opinion letter written at the request of the patient's lawyer.

## Opinion Letter—Key Tool in Cross-Examination

In most auto accident personal injury claims, medical reports from treating doctors are requested by the defendant's insurer or the plaintiff's attorney to facilitate settlement. When those efforts stall, the report becomes a tool for cross-examination. Defense attorneys schedule "independent" medical

examinations (IMEs) with specialists. Such examinations also produce reports. Such reports are likewise tools for cross-examination.

**Understand Technical Language** The first task is to understand the report using a medical dictionary and other sources to translate the report. The doctor may impressively list “epidermophytosis coupled with unguis incarnatus, hypermetrophia, and singultus.” Using your medical dictionary, you find that this only means “athlete’s foot with ingrown toenail, farsightedness, and hiccups.” On a deeper level, you must appreciate the difference between a strain (overstretching or overextension of a muscle) and a sprain (a joint injury where some of the ligaments are ruptured but the continuity of the ligament remains intact); hypoxia (low amount of oxygen) and anoxia (absence or lack of oxygen); hypesthesia or hypoesthesia (abnormally decreased sensitivity of skin or a sense organ) and anesthesia (loss of feeling or sensation).

### **Understand Content**

Doctors sometimes write in code. The code may not only be the technical language but a more subtle form of comment. For example, a range of motion test on the lower limb may be performed two ways—sitting and lying down. The hip joint goes through the same degrees of motion during both sitting and lying down, but the patient complains of pain during one maneuver and not the other. The doctor is screening for malingering. The doctor’s report may only list the two maneuvers without comment or simply note, “However, the second maneuver was performed without a complaint of pain.” At deposition or trial you may be unprepared to deal with the impact of the doctor’s opinion testimony resulting from these tests.

When a doctor uses the words “may have,” “could have,” “probably,” or “possibly,” the strength and legal sufficiency of the opinion is in play. These words coming at the end of an opinion letter are the essence of the proximate cause or damages (present and future) issues. Know your state law in regard to these issues of expert testimony. Most states require medical

opinion based on a “reasonable medical probability,” not possibilities. Words like “may” or “could” are usually not sufficient. Future damages often require testimony based on “reasonable medical certainty,” a higher standard than “probability.” So, in addition to understanding content, understanding the legal implications of that content is necessary.

In recent years, opinion letters have become less prevalent on both sides of litigation. This is particularly true in medical malpractice claims. It is precisely because these letters are tools for cross-examination and, in some cases, evidentiary, that lawyers are “requesting” their experts give oral rather than written opinions. The opposing lawyer is left with a tougher task to produce useable information for cross-examination. Other sources, particularly the discovery deposition, have become more significant in preparing for cross-examination.

### **Opinions in Other Cases**

The absence of an opinion letter in a particular case does not mean you are left with only your discovery deposition. Opinion letters in other cases and depositions from your deposition bank or fellow practitioners are keys to preparation for discovery absent (or even having) an opinion letter.

### **DISCOVERY DEPOSITIONS**

It is a rare case in which a discovery deposition of a doctor is not essential. If the case is too small from the plaintiff’s perspective to justify the discovery deposition of the defense expert, examine the economics of your decision to take the case in the first place. Taking cases that are not justifiable on a time and expense basis, in the hope of just settling them, usually leads to loss leaders for plaintiffs. The defense usually does not have the same cost equation for discovery of a doctor because the insurer is funding that expense. Economics aside, the assumption here is that a discovery deposition of a doctor is always necessary to craft an effective cross-examination at trial, particularly in the era of absent opinion letters.

## **Preliminary Procedural Matters**

The overall goal of the discovery deposition of a doctor is to develop material for cross-examination. It must be done in a way that does not disclose the likely course of that cross-examination. This requires reaching a point of equilibrium among three goals: collecting information, discovering the doctor's opinion and the underlying basis of that opinion, and committing the doctor to helpful admissions or positions that can be successfully attacked. You can pursue all three simultaneously. If you follow the outline provided, it is easier than it sounds.

### **Scheduling**

The key is to accommodate the doctor's schedule, if possible. Agreement of time and place is the usual method for arranging depositions, given scheduling issues. Evening and early morning depositions are the rule. Courtesy and comity are important elements in relations between lawyers and doctors. Many bar associations and medical societies have written standards governing those relationships. Check with knowledgeable practitioners in this area to see if your jurisdiction has a current set of standards.

### **Subpoena Duces Tecum**

The usual course in most jurisdictions is to set a discovery deposition by agreement. However, if you have no assurance the doctor will comply with a request to bring all records, files, working notes, references searched, and the like, issue a subpoena duces tecum with a notice of deposition after an agreed time, date, and place have been set.

### **Fees**

As noted, the doctor is entitled to compensation for time spent during the discovery deposition. Some doctors require advance payment. Unless you have some familiarity with the doctor's fee, ask the hourly fee in advance. Some medical specialists have astronomical hourly fees, and you may have to seek the court's assistance in setting a reasonable fee. Be careful, though; your expert may charge the same

fee and end up being similarly limited by the court. Pay promptly. It makes a difference.

### **Court Reporters—Care and Feeding**

Do not forget to schedule a court reporter—a rookie mistake when you do. Ask for a reporter familiar with medical terms. There is nothing so distracting as constant interruption by a reporter to clarify a word. Writing key medical terms on a sheet of paper for the court reporter before the deposition begins can help to solve the problem. It also establishes your authority and grasp of the case. Often, more seasoned testifying doctors will spell difficult terms during the deposition. Pay the reporter promptly. It makes a difference.

### **Method—Live, Telephone, Video Conference, Videotaping**

The recommended method for taking discovery depositions is in person. Seeing and evaluating a witness face-to-face is one of the most important functions a lawyer performs. The visual clues are often more significant than the actual words. How a person reads on paper (deposition) versus in person can be significant. Many depositions are taken by telephone, particularly if the doctor is out-of-state. The anomalous situation develops where the lawyer may be sitting with the deponent doctor and the court reporter at the other end of the line. You cannot see the interchange between the lawyer and witness. You cannot review files on the telephone, and obtaining documents is much harder. Video conferencing may solve some of these objections.

Some lawyers videotape all depositions as a matter of course. This is a good idea in a malpractice case in which the doctor deponent is the defendant. Long experience has taught some lawyers that the doctor's bad performance at a discovery deposition is considerably improved at trial. Anger, surprise, or confusion at the discovery deposition is easily corrected at trial. The contrast can be useful in cross-examining the doctor using that videotape. For other personal injury cases, videotaping discovery depositions is probably not necessary.

## Preliminary Deposition Statements

Begin in a friendly way. Shake the doctor's hand. This is more difficult if you are the plaintiff's lawyer suing the deponent doctor—but try anyway. Your attitude of openness and friendliness will get you more information than postured hostility in most cases. After the doctor is sworn, introduce yourself again for the record and state for the record the purpose of the deposition (to discuss the doctor's treatment and opinions in this case). Many lawyers like to do a preliminary statement over and above the standard witness instruction (audible answers, don't talk at the same time so the court reporter can take down our words, and so on). This may include the following:

- "Doctor, is there any reason you cannot testify fully and completely today?"
- "Doctor, do you understand this discovery deposition can be used for cross-examination at trial?"
- Or, more friendly:
- "Doctor, are you able to give us complete answers to the best of your ability today?"
- "Is there any reason that you are aware of that would make it difficult for you to answer my questions fully and completely today? For example, have you been working all day or all night?"
- "Doctor, if there are any questions you do not understand, I will rephrase the question, but I will assume you understood the question if you don't ask me to rephrase it. Is that fair?"

These questions are obviously used to prevent the doctor from making excuses when cross-examined at trial. Depending on the situation, you may prefer the aggressive or friendlier approach. I prefer the latter.

## Get the File and Records

The primary and most significant event in a discovery deposition is to get the doctor's file. This file contains the most useful information for cross-examination. The first substantive question in every doctor's deposition is, "May I examine your file?"

It is interesting the number of lawyers who fail to do this or do it after the deposition is concluded. They miss the opportunity to get and use truly useful information. Either fear of invading privilege or some other reason seems to intervene. The privilege issue is non-existent for a testifying doctor and usually for a treating doctor by the time the discovery deposition is taken. Depending on the case, these files may be extensive. Before you begin the deposition and while the court reporter is setting up, ask to review the file. It will give you more time and speed the deposition along.

"Getting the file" means different things in different contexts. A treating physician's office file may be complete, or records (particularly billing records) may be scattered in different locations. An independent medical examiner may have a complete file plus X-rays all in one place. A university physician may have incorporated parts of the file in current research. The following are suggestions for determining and obtaining a complete file.

## Take Possession and Review the File

Get the file in your hands and go through it page by page. If the file has been previously produced and copied, compare the original and the copies. Was material not copied such as Social Security or insurance examination reports? Do these materials create conflicts with present testimony?

## Make Sure the File Is Complete

"Doctor, is this your complete office chart?" "Are there any records (excluding hospital records) relating to Mr. Smith not in this file?" Answers to both of these questions should be tested.

## Testing Answers—Removed Anything?

Sometimes lawyers and doctors in preparation for deposition may remove (can you believe it?!) documents the lawyers believe are marginally relevant. You may find these documents are relevant. Test that with a simple question: "Doctor, has anything been removed from this file?"

## Get Correspondence with Lawyer

Sometimes the most interesting documents are items of correspondence between the doctor and the lawyer. Is the doctor's opinion based on the lawyer's view of the facts? Specifically ask for such correspondence if it is missing and determine why it is missing and where it went. Subpoena it and follow up. Such correspondence is not privileged or work product and should be discoverable. Able lawyers will seldom be too detailed in such correspondence or fail to be scrupulously fair on the facts. If not—or if facts were honestly mistaken—such correspondence becomes ammunition for cross-examination. In some cases, vigorous discovery in this area will disclose actual unethical behavior, such as contingent fee contracts between lawyers and doctors. This arrangement is unethical for the lawyer (see American Bar Association, Model Rules of Professional Conduct, Rule 3.4(b) Comment [3] and Model Code of Professional Responsibility DR 7-109(C)) and for the doctor. Discovering such an arrangement will be challenging indeed. But if discovered, the bias implications are devastating to the parties involved. The assumption is that this is, at best, an unusual occurrence.

## Get Opinion Letters to Lawyers

As mentioned earlier, many lawyers who recognize the danger of subsequent cross-examination specifically instruct experts not to write reports (particularly in malpractice cases). Nevertheless, a doctor may produce one simply out of habit. You may miss it because you failed to request it in discovery or it is not in the doctor's office file. Therefore, always ask if a report was produced. If there is one, it will probably be helpful to cross-examination. If not, and the answer is that the lawyer instructed the doctor not to produce a report, the information is of limited utility. After all, you will probably be instructing your doctor not to produce a report either.

## Reviewing Handwritten Notes: What To Look for

Office records and hospital progress notes are often handwritten and may be difficult to read. If you can't make out what you are looking at, have the doctor

decipher it. And then have the doctor read this into the record.

Look for conflicts, particularly in the prior history of a treating physician. Prior headaches, injuries, or other problems may be long forgotten by the patient and doctor but helpful in defending the claim. On the plaintiff's side, conflicts between the history obtained by the doctor from the patient/plaintiff and that provided by the defense lawyer may differ; understand and exploit that conflict.

Both at trial and in the discovery deposition note the following: Has the doctor testified to all examinations and treatments? Has the doctor left out information favorable to you? Check changes of complaints during treatment. Is the first complaint to the right shoulder, and the next complaint to the left shoulder with the right shoulder never being mentioned again? Bring out the absence of the left shoulder complaint. Check unrelated treatment. Use days of unrelated treatment to negate major complaints at trial. For example, suppose that the patient complains of low back pain on December 12 and gets treatment for a cold on January 3, with no complaint of low back pain. Careful phrasing of a question will make a favorable point: "Doctor, on January 3 when you treated the plaintiff for the flu, apparently you made no note or mention of plaintiff's back hurting at that time; isn't that correct?" The phrasing of questions tying the doctor to the records will be discussed later.

Check whether the patient returned to work by the date the doctor recommended. Often, the office records will reveal an earlier recommended return date than the patient recalls. Also check to see if the doctor is still treating the plaintiff. Note the last treatment. If "return prn" is noted, this means plaintiff is to return "as needed." If the plaintiff has not returned, bring that out. Note the length of time from the last treatment. All of this information is helpful on the defense side for liability and limitation of damage issues.

## Consultation Reports

Examine all referrals to consultants for either conflict or support of the doctor's opinion. Sometimes specialists agree with the opinion of the treating doctors; often, they do not. Note the conflict. The doctor has recommended this specialist to the plaintiff. Bring that fact out. If favorable, have the doctor agree with such specialists.

## X-rays, Imaging, Reports, and Photographs

One advantage of conducting live discovery depositions at the doctor's office is that X-rays and other imaging taken by the treating doctor are available either as film or, more likely today, digitally stored at his or her office. If the doctor does not bring these X-rays to the deposition, go get them. Old X-rays can be instructive, particularly in lung cases. If the plaintiff claims that his or her emphysema was caused by exposure in the workplace, an old chest X-ray taken before the plaintiff began working for the defendant can be extremely valuable—or destructive, depending on which side you represent.

Sometimes other records guide you to valuable evidence. Here's a war story, though it isn't strictly about cross-examination. An ear/nose/throat (ENT) surgeon treated an auto accident plaintiff for significant facial fractures within a few hours of the accident. During discovery, a written release was found. It wasn't in the office records; it was in the hospital records. The release permitted the treating ENT to take photographs of the plaintiff's facial fractures on the day of the accident. Although a prior conference was held, nobody mentioned any photos—including the doctor. In preparing the doctor for the discovery deposition, he was asked about the photographic release. He said he had forgotten he had taken some photos because "this was the worst facial fracture" he had ever seen (a statement he had neglected to mention before). These were photos taken before any lawyers entered the case. With this motivation, a half-hour search of his office disclosed three Polaroids under the coffee maker. His staff had put them there because they had a hard time looking at them.

Unlike a criminal case, such photos of the actual injuries are admissible. And they were the key to the damages award in the case. Without querying the doctor about the photographic release, crucial evidence and testimony might have remained undiscovered. Plastic surgeons often take photographs before and after surgeries. The pictures may or may not be in the office chart. Investigation of those pictures may aid the defense, particularly if the "after" pictures demonstrate a good result. In any event, they may be less staged and lighted than the plaintiff's photographs taken at the direction of the lawyer. On the plaintiff's side, those photographs may demonstrate the stages of healing and are additional evidence of what the plaintiff "went through."

## Laboratory Data

Do not neglect laboratory data. It may disclose underlying diseases with which both plaintiff and defendant must deal. Plaintiff may have an aggravation argument; defendant may have an alternative causation argument. The laboratory data can assist, with the help of a doctor consultation, in determining the strength of each argument.

## Slides and Tissue Blocks

Pathologists examine tissue under a microscope by fixing samples in chemicals, putting them in paraffin blocks, cutting them, and preserving the slices on a slide. When deposing a pathologist, obtain copies of the slides or even uncut paraffin blocks so your expert can cut his or her own slides and use special stains which may be useful in analysis of the medical issue. Reviewing the slides with the pathologist under a double-headed microscope can be revealing. You will find that diagnoses are often less certain than they appear in a consultation or autopsy report.

## Qualifications

Discovering the doctor's qualifications is an important effort. Is the doctor qualified to testify on the subject matter? Is your expert more qualified? A detailed review of qualifications will begin to answer those questions. Most courts allow any licensed doctor to testify concerning any medical matter. Under

this rule and in defiance of logic, a general practitioner can testify about neurosurgery or a complex orthopedic injury. Courts hold that such testimony goes to weight, not admissibility. As is true in many areas of physician cross-examination, the information does not have to be fatal to be useful. Information that casts doubt on the doctor's testimony will diminish its weight. And the best area to wage a "weight" battle is the doctor's qualifications.

### **Get Curriculum Vitae—Areas of Inquiry**

Most doctors, and all specialists, have a curriculum vitae (resumé for most of us) listing personal information, educational experience, awards and honors, specialty training, board certifications, teaching appointments, medical society memberships, hospital staff appointments, and publications. All these areas need to be compared against your doctor's credentials.

Sometimes a curriculum vitae is produced before the deposition, sometimes at the deposition. In either event, exploring the curriculum vitae is a productive exercise in a discovery deposition. But there is a danger: You might give the doctor a chance to amplify and strengthen his or her credentials beyond what is stated on paper. To avoid this danger, you have to know what key information to look for in a curriculum vitae.

But before we discuss what weakness to look for, a word or two about qualifications generally. Many lawyers believe qualifications are not as important as how the jury perceives the witness's candor, appearance, and presentation. This is sometimes true. However, if the jury appreciates that there is a difference in the qualifications of the doctors testifying, even a subtle one, it can make a difference. Consider the typical bread-and-butter auto accident case. The plaintiff's expert is likely to be the general practitioner who has been treating the plaintiff. The defense expert will probably be an orthopedic specialist. The jurors will note this difference, and may give the testimony of the defense expert greater weight. This is even more likely if the difference is emphasized in closing argument by arguing to the

jury that the orthopedic specialist treats *only* these types of injuries. But qualifications can serve as a shield as well as a sword. In the same auto accident case, careful attention to qualifications might lead to an admission from the orthopedist that general practitioners are competent to evaluate and treat soft tissue injuries like the plaintiff's. The point is that qualifications not only make a better-qualified expert stronger. They can make a less-qualified expert stronger, too.

### **Professional Training**

After four years of premed courses in college, doctors usually attend four years of medical school. The first two years involve course work in, among other subjects, anatomy, physiology, biochemistry, pharmacology, microbiology, and pathology. The next two years involve clinical exposure in hospital settings and elective courses. Doctors rotate through the various specialty services, which include internal medicine, surgery, obstetrics and gynecology, pediatrics, and psychiatry. Why is such information important to the lawyer? There are several issues you can explore in this connection. Many jurors will initially believe that all doctors are more or less equal. They often believe this because they know that the training is rigorous and demanding. Your job is to demonstrate that there are differences in the ways that doctors are trained, and that these differences really should affect how much weight the jurors accord a particular doctor's testimony.

When examining a curriculum vitae or questioning a doctor about qualifications, note the following:

- Are there any gaps between college, medical school, or specialty training? If so, as noted, there may be an issue of admission to medical school, specialty training, or other problems;
- What medical school was attended? Jurors recognize Johns Hopkins, Harvard, Columbia, and University of Chicago as superior institutions;
- If an opposing doctor is less qualified than your doctor, you may determine the only exposure to the medical issue or area in question is in medical school and nothing since.

## Specialty Training

During the two clinical years in medical school, doctors often choose a specialty. They enter graduate medical education in that specialty, called a residency, and in recent years it has been combined with an internship year following medical school graduation. Depending on the specialty, a residency program may take an additional three years to six years. Note the following:

- Did the doctor enter and not complete any residency training? Why? Are there gaps in training? Why?
- Is the length of specialty training the same? Some allopathic (M.D.) programs have longer time requirements than osteopathic (D.O.) programs;
- Where did the doctor train? Is the doctor a heart surgeon trained at the Cleveland Clinic (an institution with a known reputation in the area) or is his training at a smaller, community, non-university-affiliated hospital? Was the residency program accredited by the Accreditation Council on Graduate Medical Education (“ACGME”) or comparable body?
- Most importantly, is the doctor practicing in the relevant specialty? This is a complicated question. Some specialties overlap, and specialists in neurosurgery, orthopedic surgery, or neurology may all be able to render appropriate opinions on certain neck and back conditions. The neurologist may not be appropriate or the best witness to testify on the surgical procedures. All three specialists may have much more training in back and neck problems than an internist or general practitioner. A doctor may be a neonatologist (newborn care in an intensive care unit) but not also specially trained and certified in pediatric critical care. A doctor trained in both may be the better expert in a malpractice case.

## Board Certification

After specialty training in a residency and, depending on the specialty, some further experience or training, a doctor becomes qualified to become certified as a specialist and be called a diplomate of that

Board. There are presently 24 specialty boards of the American Board of Medical Specialties (ABMS):

- Allergists and immunologists;
- Anesthesiologists;
- Colon and rectal surgeons;
- Dermatologists;
- Emergency medicine physicians;
- Family physicians;
- Internists;
- Medical geneticists;
- Neurological surgeons;
- Nuclear medicine specialists;
- Obstetricians and gynecologists;
- Ophthalmologists;
- Orthopaedic surgeons;
- Otolaryngologists;
- Pathologists;
- Pediatricians;
- Physical medicine & rehabilitation specialists;
- Plastic surgeons;
- Preventive medicine specialists;
- Psychiatrists;
- Radiological and radiological physicists;
- Surgeons;
- Thoracic surgeons;
- Urologists.

There are subspecialties within these specialties that may have separate board certification exams. For example, a plastic surgeon can be also board certified in hand surgery; an orthopedic surgeon can also be certified in hand surgery.

The Official ABMS Directory contains a list of the area of medicine each specialty covers. It helps you determine not only whether the certification of a

doctor is appropriate to the case, but also which certification is appropriate.

Board certification is an important credential for a testifying doctor. It confirms that the doctor has the requisite knowledge, training, and experience, and has passed the appropriate tests to become board certified. Note the following when examining curriculum vitae or questioning a doctor on discovery:

- When was the doctor board certified? Usually certification is available two to five years after completion of training. If longer, why?
- Did the doctor pass the certification exam on the first try? When were the exams taken? When passed? How many times were they taken? Always ask these questions in discovery. The answers will surprise you. Failing the exam is damaging to a doctor's credibility. You may choose not to argue the point too vigorously depending on the doctor's overall presentation. Older doctors took oral and written exams and had to pass both parts. Younger doctors are less likely to have been required to take oral exams;
- Does the specialty have a recertification requirement? Some are voluntary, some mandatory. In either event, has the doctor recertified?
- Does the doctor claim "board eligibility" or "board eligible status"? "Board eligible" as a term is tricky. If the doctor is just out of training (two to five years) and claims he or she is board eligible, that is appropriate. If, however, the doctor has been out of training for 10 years and claims "board eligibility," red flags should be raised. Either there was a failure on taking the exam or a failure to qualify to take the exam. The ABMS Directory discourages the use of this term.

### **Professional Societies and Organizations**

Whether the doctor is a member of a professional society or organization leads to other information. Many physicians are not members of the American Medical Association and have opinions on that issue (usually politically or economically based) that may be interesting comments for cross-examination.

More significant, however, is membership in the relevant specialty society. Some societies are open to anyone to join, others are by invitation. Find out which societies the doctor is a member of and which the doctor is not. Compare those with your testifying doctor expert. In a few cases (and usually based on information from your doctor), you may inquire when the doctor applied to the society and when the doctor was accepted, if ever.

### **HOSPITAL STAFFS**

Review hospital staff membership and ask about the following:

#### **Teaching**

The presence or absence of teaching may be interesting in contrasting your testifying doctor with the opposing doctor. You should go beneath the surface on this issue. Many doctors hold the title of "clinical professor" or "instructor" at a university hospital. You may find that this involves little or no teaching responsibility and is primarily a method of obtaining faculty football tickets! A full professorship at a university hospital is a significant position carrying substantial teaching and research responsibilities.

#### **Publications**

Note whether the doctor has any published scientific writing. Note the dates. Does the doctor currently publish, or have the only publications occurred during or immediately after residency? Ask the doctor if any publications are relevant to the involved medical issue. Examine those publications. Examine all marginally relevant publications. Such publications may contain helpful general language, particularly text chapters. Determine if the publications are in refereed or throwaway journals. In particular cases, speeches and presentations at grand rounds in hospitals or seminars may also disclose helpful material. Usually the doctor claims that he or she cannot locate presentations but persistence may pay off.

If you have obtained the curriculum vitae before the deposition, examine the publications. You may come across something that the doctor has written

that contradicts his or her opinion in the current case. In some instances, you may want to keep this under wraps until cross-examination at trial. It is safer, however, to use the contradiction as a basis to discover admissions that will help you to structure that cross-examination. For example, you might be able to get admissions that the doctor was the lead author, approved the language in the article, wrote the article, and so on. These admissions will make it difficult for the witness to explain away the contradiction during trial.

### **Nature of Practice—Practice Profile**

Inquiring about the nature of the doctor's present practice is useful. A doctor can present impressive credentials and actually have little practice left. The doctor may be devoting substantial time to examining or testifying in litigation. Many states have witness competency evidence rules in malpractice claims, requiring doctors testifying about the standard of care to devote at least 50 percent of their time to "active clinical practice of medicine."

How many surgeries similar to the one involved in the case does the doctor do? Does the doctor perform such surgeries or regularly treat such conditions? Inquiry into a "practice profile" can be revealing. How many days of surgery does this doctor perform? What are the office hours? What types of medical problems are most often treated? All of these questions disclose areas of possible attack and comparison with your doctor.

### **Experience as a Witness**

You will find that areas of questioning overlap. When asking about a practice profile you may get information about a doctor's experience as a witness. Such information may lead to further questions or cause you not to pursue further questions. Again, not every element of this outline is appropriate in every case, but it is a guide to areas that, from time to time, arise in particular cases. The following are questions used to discover the "professional witness" doctor.

### **Number of Depositions and Trials**

Ask about the number of depositions and trial appearances. If you believe the doctor is not completely candid about the number, a deposition bank and/or inquiry of fellow lawyers to get depositions is appropriate. A professional witness has less credibility than a treating doctor, even if the treating doctor is a less experienced witness.

### **Number of Exams, Reports for Non-Treatment**

The defense doctor is not a treating doctor. The plaintiff's lawyer needs to highlight this at trial. In a malpractice case, the defendant may be the only treating doctor testifying to the standard of the care. Again, either side may highlight this. In personal injury or malpractice claims, the fact that an expert is examining and not treating the plaintiff can be highlighted in a number of ways. Discovering the number of medicolegal exams per week or month can be a start. Is there a day or half-day set aside for such exams? How many are done in a week? In personal injury cases, experts still generate written reports. Find out the number of reports issued per week. Compare these numbers in appropriate cases with the number of surgeries.

### **Usual Charges—Examinations, Hourly, Deposition, Court**

How much does the doctor charge for medicolegal examinations? How much does the doctor charge for non-medicolegal examinations and treatment? You may find a difference. How much does the doctor charge for hourly review of records and giving depositions? Is the charge reasonable? When multiplied by the number of medicolegal exams, will it appear exorbitant? (Check your jurisdiction's case law to determine the availability of arguments on this issue.) Again, apparently exorbitant charges may be the going rate, so put such matters in context, comparing charges with your own expert's rate.

### **Relationship with Lawyer**

Lawyers tend to settle in with a doctor witness and, if they have experienced success with that witness, use the witness again. Ask how the doctor was

retained—who contacted him or her? How many times has the doctor reviewed cases for this lawyer, or the lawyer’s law firm? How many examinations has the doctor conducted at the request of this lawyer or the lawyer’s law firm? What types of cases? A deposition bank on this doctor may keep those figures accurate.

### **Advertising**

In personal injury cases, few doctors advertise. In malpractice and products liability cases, it is more common. Advertising offends some jurors because they perceive a lack of impartiality. Ask the doctor, “Do you advertise in legal journals? Do you send mailings about your testimony?” Check the Internet with a word search of the expert’s name to determine if the doctor advertises on the Internet, or simply to locate other information. Get the advertisement; it sometimes contains useful puffery or inartful statements (“We shape our opinions to your specific needs.”) These can be used to cross-examine.

### **Contact with Patient**

If an examination of a party has occurred, explore the amount of time taken, tests done, and discussions with the doctor.

### **Other Knowledge**

Once you have obtained the complete file and investigated the doctor’s background, experience, and relationship with the lawyer, a follow-up inquiry concerning any other sources of information is useful before the inquiry into the medical opinion.

### **Conference with Lawyer**

Explore any pre-deposition conferences with lawyers, particularly any facts supplied in those conferences.

### **Re-Explore Any Notes or Writings**

In some cases, testifying doctors will review other depositions of parties or other doctors. Notes are made in the margins or on yellow tablets. Questions are often posed in those notes. They are often made

while the doctor is forming his or her opinion. Copy them. They may become relevant.

### **Ask Whether Records or Reports Were Expected But Not Received—Additional Research**

After reviewing records and other materials, you might ask if there are any materials that were expected and not received. Also, ask if there was any further material the doctor needs to form an opinion and if there is anything further the doctor needs to do to give an opinion. Finally, is there anything further the doctor expects to do in connection with this case? All these questions can close the door for changing an opinion based on information you may have that the doctor does not.

### **Other Materials Reviewed**

Did the doctor review policies, standards, charts, or other materials perhaps not considered research or medical literature? Explore this possibility and how it was obtained. You may find it being supplied by the opposing lawyer.

### **Establishing Authority**

If a witness perceives a weakness in the examiner, it will go badly for the examiner. Although you cannot be an equal with the doctor, you have the advantage of preparation on the facts and issues involved. If you demonstrate knowledge about medical training, are conversant about the medicine of the case, and demonstrate knowledge of the facts—in short, if you have prepared for the discovery deposition—you will establish authority and gain a subtle measure of control over the witness. This is important because although you will not be using many leading questions (although some are necessary), you will be in the trial cross-examination. If the doctor knows you are knowledgeable and prepared, there is less likelihood of deviation from the discovery deposition at trial.

### **Opinions And Bases**

The central purpose of the discovery deposition is to get the doctor’s opinions and the bases of those

opinions. Tactically, some lawyers dispense with qualifications, witness experience, and materials received and go directly to the opinions and bases of them. Sometimes tactically saving credentials or other damaging information to the end of the deposition is appropriate. Each case presents a challenge of discovery organization.

Basically, a lawyer is trying to determine how the doctor formed an opinion in the case. In other words, what did the doctor review? What was significant in the review in forming the opinion? Why was that information significant? How does that significant information relate to the opinion? The basis of the opinion is even more important than the opinion itself, because you will not change the doctor's opinion. The best a competent cross-examiner can hope to accomplish is to show the jury that the basis of that opinion is flawed, inaccurate, or just plain wrong. There is an old saying that if you accept a ridiculous premise, a ridiculous conclusion will follow logically. So it is with discovering opinions—if the opinion is not sound, it is based on one or two unsupportable assumptions about the facts or medicine.

The simplest approach to beginning the discussion of opinions with the doctor is as follows:

- “Doctor, do you have an opinion in this case?”
- “What is that opinion?”
- “What is the basis of that opinion?”

In malpractice cases, lawyers often ask, “Doctor, what are your criticisms of Dr. X?” I believe this simply opens the floodgates of “criticism” that the lawyer then has to sort through, many unrelated to the issues of standard of care or proximate cause. It gives the doctor permission to “criticize.” One word can set a tone. A better approach is simply to ask whether, in the doctor's opinion, there are deviations from the standard of care, and if so, which ones proximately caused the alleged injury.

Doctors will sometimes feign ignorance concerning the meaning of “basis” or may simply respond generically that the basis was “my training, experience, and examination.” This is not acceptable. Be prepared to

discuss specific medical and factual issues in the case. Which findings did the doctor find significant? Which did he not find significant? In selected cases, which findings supported the doctor's conclusion, and which did not? If the doctor is still recalcitrant, try this question: “Doctor, what is the medical subject matter in this case?” This question will disclose the doctor's mindset and can shape further inquiry. Another way to get to the basis is to ask the doctor what assumptions were made in coming to the opinion. What medical facts, historical information, or other information, including literature, was used (or not) in forming the opinion?

In a particular case, you may want to list assumptions or facts and determine what contribution these made to the opinion. Or you may want to follow up later with specific factual questions to determine if particular assumptions were or were not significant in forming the opinion. The bases of an opinion must be legally sufficient. Does the doctor hold the opinion to a possibility, probability, or a reasonable medical certainty? In a malpractice case, what is the doctor's definition of “standard of care?” Finally, in most cases, opinions concerning present and future medical conditions are crucial in the damages calculation. Does the doctor have an opinion to a probability (for present conditions) or a reasonable medical certainty (for future conditions)?

Here is a sample road map to discovering an opinion in a personal injury case, malpractice case, or any case where the doctor is opining concerning liability (malpractice) and/or damages (malpractice, personal injury, products liability, or any case involving injury).

Lay out the opinions:

- Have the witness list each medical opinion reached or category of opinion;
- Read the opinions back to be sure you have them right;
- Get the witness to agree you have them all, and that your list is accurate.

Establish the basis of the opinion:

- Get testimony of the significant facts upon which the opinion is based (e.g., history or tests);
- Get testimony on the source of each fact;
- Get testimony on assumptions made (e.g., history as reported was accurate, test results were accurate);
- Get testimony on the bases of these assumptions;
- Get agreement that you have explored all relevant facts for each opinion.

Set forth the doctor's reasoning:

- For each opinion, get an explanation of the reasoning process from facts to conclusion;
- In the Daubert environment, ask whether any research or published literature supports the opinion. A negative answer can be a basis of a motion to exclude testimony or used to decrease the weight of the argument. ("The doctor can cite no research or literature to support this opinion. In fact, there is none.")

Proximate cause:

- For each opinion, get an explanation of its causal relationship to the case;
- Be sure proper legal tests are met (e.g., reasonable medical probability, certainty, substantial aggravation);

If there are multiple causation opinions, get apportionment, if possible.

Finally, in some cases you may want to explore two further issues. First, the task the doctor was asked to undertake; namely, what was the doctor told to do or what did the doctor understand about the task? Second, how did the doctor go about forming his opinion? Did the doctor use a computer, programs, or an assistant in forming the opinion?

Determining the opinion can be a rather open-ended process, and a complete roadmap for every case is impossible. Although the elements are simple, the permutations are not. How much material you choose to directly confront the doctor and

how much you passively receive from the doctor depends on a series of changing judgments before and during the discovery deposition. One thing is clear: Once you receive favorable information for later cross-examination, you must decide how you seal those answers so they are useful at trial.

### Admissions on Discovery Depositions— Preserving Good Answers

I would suggest these approaches to sealing answers to prevent the doctor from successfully disavowing them at trial:

- First, leave the answer alone, if it is clear in the record and complete. Repeating or rephrasing the question may only give the doctor an opportunity to avoid the statement because its significance is suspected.
- Second, restate or clarify the answer. This approach is useful if it is not clear in the record or part of a long, rambling discourse containing digressions and interrupted questions and answers.
- Third, use either a complete or modified hypothetical question.

If you have admissible evidence which contradicts the doctor's assumptions of the facts and the doctor has identified that piece or pieces of evidence as significant or determinative in forming the opinion, then a hypothetical may be in order at the discovery deposition. This would include the following generic approach:

**Q:** "Doctor, I want you to assume the following facts. . . . Based on those facts, would your opinion be different?"

**A:** "Yes."

**Q:** "And that opinion would be . . ." (Here you state the favorable opinion.)

A less cumbersome and appropriate approach would be simply to ask, "Doctor, would your opinion change if . . . were true?" A more subtle approach would be to ask, "Doctor, would it be significant

that. . . ?” And then follow up using leading questions concerning the significance. Finally, using the phrase “consistent with” is useful. “Doctor, is regularly lifting 150 pounds consistent with your opinion that Mr. Smith cannot perform any type of work?” Assuming there is admissible evidence that Mr. Smith is regularly lifting 150 pounds (an actual case), the doctor is hard pressed to answer in the affirmative. In obtaining admissions useful at trial, you will more frequently use leading questions, primarily because the answers are shorter (yes or no) and will have a greater impact on the jury.

### Qualifications

In most areas of qualifications, you will be comparing and contrasting credentials. Usually, the recitation of selected credentials is sufficient. For example:

**Q:** “Doctor, did you receive any awards or honors during medical school, residency, or practice?”

**A:** “No.”

Direct questioning of your doctor at trial will establish the contrast:

**Q:** “Doctor, have you received any awards or honors during medical school, residency, or practice?”

**A:** “Yes, I was a member of the AOA fraternity limited to the top academic 10 percent in the medical school, was elected chief resident in my residency, and received five teaching awards from the medical school where I teach.”

Of course, you may want to separate that question into three parts for greater effect and expand on each of these honors. If your doctor is well known and highly qualified, you might consider asking the opposing doctor if he or she knows your doctor and if your doctor has a reputation as a competent and highly qualified doctor. Occasionally, you will get a flip answer, but that may only motivate your doctor. Most often, the doctor will acknowledge his fellow professional.

### Authoritative Texts

A separate and challenging area is obtaining admissions about authoritative texts. Cross-examining using authoritative texts is a powerful tool. Many jurisdictions, however, require that a doctor acknowledge that a text or journal is generally authoritative before a lawyer can cross-examine on statements in those texts or journals. Lawyers often suggest to their experts that texts and journals are not “generally authoritative.” Additionally, the doctor may interpret the word “authoritative” as the “final word” on the subject and reasonably believe there is no such literature. In either event, doctors will resist this admission in a number of ways. The doctor may respond as follows:

- No text is “generally” authoritative because medicine deals in specifics;
- No text is authoritative because medicine changes so rapidly that doctors consider even current texts to be out-of-date;
- The text or journal is out-of-date; and
- The question cannot be answered in the abstract because some items may be authoritative and some not.

Because doctors are told to avoid acknowledging something as “authoritative,” the answers may stretch the doctor’s credibility. After all, the doctor has to rely on some resource besides current practice and former training. If the doctor will not admit texts are “generally authoritative,” try to get the doctor to acknowledge “some texts are more authoritative or reliable than others.” Find out which ones. If the answer then becomes authoritative or reliable information is in the “periodical literature” (i.e., medical journals), find out which ones. If the doctor continues to be resistant, get an admission that the doctor was trained by competent practitioners who were authoritative in their fields. (A negative answer will help you and test how bound the doctor is to avoiding the word “authoritative.”) Get their names; they may have written texts and probably write journal articles, some of which may contradict the testifying doctor. Find out which texts the doctor owns.

Find out to which journals the doctor subscribes. Find out which texts and journals are kept in the doctor's office or hospital. Find out which texts the doctor uses to teach. Find out which text the doctor recommends to residents and students. Even if the doctor will not acknowledge the magic legal word of "authoritative," this information is useful in presenting your doctor. He or she can cite these texts, which the other side's doctor owns or teaches from, but will not acknowledge as "authoritative."

If the doctor wants to pick and choose, claiming some statements may be authoritative or reliable and others not, you can proceed to ask if the doctor agrees or disagrees with the statement found in the particular text or journal in question. If you perceive through earlier questioning that there is simply resistance to acknowledging "authoritative" material which you cannot overcome, consider going directly to the medical statement without attribution and ask the doctor to agree or disagree with the statement. You will, in essence, be treating the text or journal as a helpful medical fact.

### **Helpful Medical Facts**

As you review medical texts in preparation for a doctor's discovery deposition, you will find helpful general statements about medicine and the mechanics of injury or disease that the doctor will have to acknowledge. For example, a personal injury plaintiff might want to present testimony that aging worsens traumatic arthritis, scars are permanent, and brain injuries involving loss of neurons are likewise permanent (neurons do not regenerate). The defense would want to counter that soft tissue injuries generally resolve in several months or a few years, scars fade and become less noticeable, and brain-injured patients adapt over time to losses and use other parts of the brain to compensate. Many helpful medical facts may recur in orthopedic, cardiac, neurologic, and other cases. Keeping a list may be helpful in cases involving these specialties.

Later in this discussion, helpful medical facts will be useful in cross-examining at trial. Confirming these facts at discovery deposition is the safest course to

get confirmation at trial, although it may disclose some of your strategy. If you feel it discloses too much, you can go about it less directly. If a statement of a helpful medical fact is in literature written by the doctor being examined, simply confirm that he or she wrote or authorized the language in the article. If the helpful medical fact is in a prior deposition, confirm the fact that a deposition, under oath, was given in the prior case.

This discussion of alternative approaches applies to all opinions a doctor may have when you have literature or prior depositions. This would include opinions on future medical treatment and permanency as discussed below. If the doctor's position on a helpful medical fact is unknown, you are probably better off testing the information at the discovery deposition. Often the doctor will not recognize the significance of the medical fact and readily agree. Even if the doctor disagrees or (more likely) distinguishes the fact from the issues in the case, you will be prepared to respond at trial after talking to your doctor and further research.

### **Confirming the Opinion**

Once an opinion and the basis for it has been explored, confirming that opinion or locking the doctor into that opinion becomes the next task. Although many expert depositions are taken close to trial when theoretically all facts are "known," in reality, this is seldom true. Facts are continually being uncovered before and during trial. The significance of known facts often changes just before and during trial. Opinions are strengthened or weakened by new facts or a different emphasis. This is the great advantage of the defense in "going second" and of the plaintiff in having rebuttal.

Given changing facts and changing emphasis, it is important to get an admission that the opinion is complete, no further facts are needed, and the testimony will not vary at trial. The following is one lawyer's approach. It is the discovery deposition of the plaintiff's expert doctor in a malpractice case. Although the lawyer uses the word "criticism," which I discourage, the colloquy demonstrates efforts by

the doctor to avoid being locked in and efforts by the lawyer to lock him in:

**Q:** "Have you told us everything that you have in the way of criticism of the conduct of any of the defendants here?"

**A:** "Yes."

**Q:** "And I take it you contemplate testifying live . . . in this case?"

**A:** "If that's necessary, yes."

**Q:** "And at that time or as of now your testimony will be as substantially as you have now given it here, is that correct?"

**A:** "Presuming the situation doesn't change, the same kind of questions are asked."

**Q:** "Well, in response to the questions that were asked, you have told us all that you have in mind?"

**A:** "The only thing I can say is unless I get some new information, that would be the only thing that would change my testimony in the future."

**Q:** "What new information —"

**A:** "I haven't got any."

**MR. SHAWN:** "I think you are asking for speculation and I have to object to that."

**Q:** "Well, let's see if we can nail it down a little better."

**MR. SHAWN:** "O.K."

**Q:** "It's my understanding that you considered all of this material which you felt was necessary to for you to form an opinion?"

**A:** "I considered all of the material that was available to me."

**Q:** "Well, did you feel that you should have additional information in order to arrive at an opinion?"

**A:** "I don't need additional information to arrive at the opinions that I have arrived at."

**Q:** "So that you are perfectly satisfied to give an opinion on the basis of what you had?"

**A:** "Yes."

**Q:** "And you didn't ask for more material?"

**A:** "No, I did not."

**Q:** "I take it that this is the same situation with which you would approach your testimony in court?"

**A:** "Oh, yes."

**MR. FLAHITE:** "I don't think I have anything else at this time. Thank you, Doctor."

Note the use of leading questions to lock in testimony. Although not perfect (it never is), the lawyer's effort to preserve the opinion on the facts the doctor understands is worthwhile.

### Confirming Sufficiency or Insufficiency of the Opinion

Opinions containing "magic" words such as "probability" and "reasonable medical certainty" are less important under today's expert rules and in some courts. However, if the doctor's opinion is not legally sufficient, the best advice is usually to leave it alone. If the doctor writes in an opinion letter or medical record that something is a "possibility" (not legally sufficient), let the other side worry about it. Confirm it in the record once or leave it alone altogether and use the documentary evidence of the letter or record. Usually, a colloquy on the meanings of "possible" and "probable" leads to a change in the testimony in the discovery deposition that gives the doctor an argument at trial. Namely, "As I told you in deposition, I meant 'probable' now that I understand these legal requirements—I am not a lawyer." Sometimes that works and it makes you appear you are trying to cover up the deposition testimony (which you are). So leave it alone.

### CONCLUSION

You have now, hopefully, accomplished the three overarching goals of the discovery deposition of a

doctor: getting the records, getting the opinions, and preserving good answers. You can now prepare for cross-examination at trial. In most cases, you will now share the discovery deposition with your doctor and discuss it, follow up on cited literature, and follow up on other records or sources of information not apparent before the deposition. From this point on, the effort switches from the discovery mode to the trial mode. Planning your attack on cross-examination, carefully phrasing your questions, and considering the various techniques of cross-examination continues your preparation for cross-examination. 🔥

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