The Adverse Direct Examination of a Defendant Doctor in a Medical Malpractice Case

By Ben Rubinowitz and Evan Torgan

There is no better way to prove medical malpractice than through the mouths of the defendant physicians themselves. Although they may never specifically admit that they departed from accepted standards of medical practice, a skillfully pointed adverse direct examination can leave no doubt as to their culpability.

Although it does take some courage to begin a case with an adverse witness, it is almost always the best way to proceed for any number of reasons. First, it is very dramatic. Second, because you can lead the doctor as an adverse party, you are controlling precisely the content and tempo of his testimony[1]. Next, you can teach the jury the anatomy, medicine and standards of care through the very person who injured your client and violated those very standards. Finally, by having the defendants testify prior to your expert, the defense cannot put a spin on the defendants' testimony to rebut your expert's opinion on the facts, issues and medical departures.

Because you are going to make your case through a witness who wants to do nothing less than destroy it, you must be in total control of the examination, from beginning to end. Needless to say, to exercise total control, every question has to be a leading question. A leading question, of course, is one which suggests the answer, contains within it the answer, or calls for a "yes or no" answer. When dealing with an

1The right to ask leading questions of an adverse witness on direct examination is well established: "An adverse witness may be cross-examined, and leading questions may be put to him by the party calling him, for the very sensible and sufficient reason that he is adverse and that the danger arising from such a mode of examination by a party calling a friendly or unbiased witness does not exist" Becker v. Koch, 104 N.Y. 394 (1887).

adverse physician, however, it is best to always suggest the answer, and ask for the witness' assent.

Let's take a simple fact pattern where a young woman gets paralyzed during an epidural steroid injection in her neck. The case is brought against the neuroradiologist for wrongly diagnosing a herniated disc rather than a discitis or infection of the disc or spine, the treating neurosurgeon for missing the signs of the infection and misreading the MRI studies as well, and the pain management physician who paralyzed the client with his injection:

Q: Dr. McCann, in the past, you have actually treated Valerie Smith, correct?

Q: You were her neurosurgeon, true?

Q: You treated her long before March 29th of 2006, true?

Q: But on March 29th, 2006, you had to operate on her, correct?

Q: And that was because, after an epidural injection in her neck, she couldn't move her arms or legs, true?

Q: And you came to an opinion, first of all, that she was paralyzed, true?

Q: And that she was now a quadriplegic, right?

Q: And you also came to the opinion, at that very time of the surgery, that it was the epidural injection administered an hour before your surgery that caused her paralysis, true?

If the witness is inconsistent or uncooperative, use your impeachment materials: medical reports, office charts and deposition transcripts. So, assuming the doctor is inconsistent with his prior testimony, impeach him with his deposition transcript:

Q. Prior to surgery, you came to an opinion that it was the epidural steroid injection that caused the quadriplegia in Valerie Smith, true?

A: True.

Q: No question about that, correct?

A: Correct.

Q: And that opinion, before the surgery, was based upon looking at the MRI's of her cervical spine, true?

A: True.

Q: And nothing that you saw in surgery changed your opinion that it was the epidural steroid injection that caused her paralysis, true?

A: Not true. And it is not that simple.

Q: But, Sir, you thought it was that simple on June 21, 2007, correct?

Q: That is when you previously testified in this case, right?

Q: At what is known as a deposition, true?

Q: At that time, you were with your lawyer, true?

Q: You raised your right hand, and swore that the testimony you were about to give was the truth, the whole truth, and nothing but the truth, true?

Q: And your testimony was truthful, wasn't it?

Q: And you were asked the following questions, and gave the following answers, page 29, line 2:

> "Question, Prior to the surgery, did you have an opinion as to the cause of the paralysis? Answer, Yes, the epidural steroid injection. Question, After the surgery, did your opinion change? Answer, no. Next question, Question So your opinion was, both before and after surgery that the cause of the paralysis was the epidural steroid injection? Answer, Yes."

Q: You were asked those questions sir, under oath?

Q: You gave those answers, true?

Q: You'd agree that they were different than your answers today?

Q: Correct me if I'm wrong sir, but prior to testifying – and I'm not going to ask you what you spoke about – but you did speak to your lawyer, true?

Q: And it was after that time, that your answers changed?.

Be careful when using a deposition to impeach the adverse physician. Do not impeach on an unimportant point; do not impeach unless the inconsistency is clear; and do not impeach without specific reference to the page numbers, line numbers, date and place of the deposition, by reading the transcript verbatim beginning each question by actually saying "Question," and each answer by actually saying "Answer." Otherwise, you will draw a valid objection from your adversary (or interruption from the court reporter) which will interfere with the flow of your examination.

Even when defendants share a unified defense, when the medicine is on your side, you can use leading questions to enhance the claim against a co-defendant. For example, if you want the operating surgeon who reviewed the pre-surgical MRI's to implicate the doctor who performed the injection, you can go after him this way:[2]

Q: Sir, prior to the surgery, you reviewed the MRI films, true?

Q: You did that with the radiologist in real time, sitting at the computer?

Q: Not only that, the radiologist rendered a report of his reading of the MRI, true?

2Carvalho v. New Rochelle Hosp., 53 A.D.2d 635 (2d Dept. 1976) and its progeny, which stand for the proposition that defendants may not be required to opine about the care rendered by a co-defendant at deposition, have been held inapplicable at trial (see Giventer v. Rementeria, 181 Misc.2d 582). The rationale is clear: the purpose of Carvalho is to prevent plaintiffs from suing doctors merely to obtain a free expert opinion against a co-defendant at deposition. This danger disappears at trial, and should not serve to impair the rules of evidence which permit broad and probing cross-examination of a defendant.

Q: And that MRI, which is part of the hospital record in evidence said as follows: ‘There is subarachnoid air consistent with air piercing the cord”, true?

Q: And that means air from the needle got into the meninges, or one of the three layers of the outside of the spinal cord, true?

Q: No question about that, right?

Q: So that the needle wielded by Dr. Riser - your co-defendant, put air right into the subarachnoid space, true?

Q: And it was at that very time, Valerie became paralyzed, right?

Needless to say, surgeons try to avoid opining on MRI’s and CT scans in court as being outside of their expertise. However, this position is a silly one in light of the fact that they constantly read these films in practice before, during and after surgery. Instead of letting the clinician say he is not a board certified radiologist and therefore uncomfortable giving an expert opinion on them in court, make him first admit that he is, in fact, qualified to read them.

Here, the set-up becomes just as important is the substantive cross-examination. Establish that there is not a spinal surgeon in the world who would perform surgery on a patient without looking at the actual scans. And lay a foundation for the clinician’s expertise in reviewing films:

Q: Sir, you are a board certified neurosurgeon, true?

Q: You were boarded over ten years ago, right?

Q: And you have been operating on spines for many years, haven’t you?

Q: And certainly prior to deciding whether a patient needs spinal surgery, you refer the patient for an MRI, true?

Q: In the old days, the radiologist would write a report and send it back to you with the actual films, correct?

Q: Films that you would personally review, right?

Q: You would read the report and look at the actual films, true?

Q: Now you can access your radiologist's pac system and review the films and the report remotely, correct?

Q: Because before you open up a patient's spine, you want to see the pathology for yourself, correct?

Q: And even though you are not a neuroradiologist, or even a radiologist, you review the actual films before operating, don't you?

Q: As a matter of fact, that is the standard of care for a spinal surgeon, true?

Q: In fact, you would never operate – or even decide to operate – without looking at the films first, true?

Q: It would be wrong to do that, wouldn't it?

Q: It would be below the standard of care for a clinician to do surgery of the spine without first looking at the actual MRI films, right?

Q: Sir, you've done thousand of surgeries, true?

Q: And it would be safe to say that before each of those surgeries you looked at the actual films, true?

Q: Not only that, you put the films up on your light box and showed my client specifically where you believed the pathology was, didn't you?

Q: When you did that you didn't offer the patient a disclaimer, did you?

Q: And you didn't say to her, "I'm not a board certified radiologist, so disregard what I'm telling you is on these films," did you?

Now confront him with the actual films and establish that he misread them and therefore directed the wrong treatment for the patient:

Q: Doctor, I'm showing you what are known as sagittal images of the cervical spine, correct?

Q: By sagittal, we mean lateral or side images, true?

Q: With cuts starting on the outer edge of the body coming into the midline of the spinal column, then back out to the outer edge of the body, right?

Q: And you diagnosed an acute herniated disc at C5-C6, true?

Q: But you'd agree sir that Valerie was 60 years old at the time of this scan, right?

Q: And these are T2 weighted images, aren't they?

Q: Which means that things with high-water content like cerebrospinal fluid and healthy disc material should be bright in color, or white, or high in signal or hyper-intense, true?

Q: Yet her discs at C3-C4, C4-C5 and C6-C7 are hypo-intense, true?

Q: Meaning low in signal, right?

Q: Or dark in color right?

Q Which is not surprising in a 60-year-old woman, true?

Q: That darkness is from what is known as dessication, or dehydration or loss of water, correct?

Q: Because as we age, our discs dehydrate or lose water, don't they?

Q: Yet the disc that is causing her pain is bright in signal true?

Q: It is white in color, correct?

Q: It lights up, doesn't it?

Q: Doctor, you would expect someone with a long history of degenerative disc disease like Valerie has to have a dark, degenerated, dessicated, dehydrated disc, wouldn't you?

Q: Yet this disc is white, bright and hyper-intense, isn't it?

Q: Because it does have fluid content, right?

Q: But not water, true?

Q: Because every other disc is dessicated due to drying up from aging, right?

Q: That fluid is pus, isn't it?

Q: From an infected disc, true?

Q: And you now know that because you operated on her, removed the disc, sent it to pathology and determined it was, in fact, pus, true?

Q: And you would agree with me that an epidural steroid injection is contraindicated in the face of an infection, isn't it?

Q: Yet you sent my client for that steroid injection, didn't you?

Q: The injection that rendered her paralyzed, true?

To make a prima facie case of medical malpractice, you need expert testimony outlining the departures from accepted standards of medical practice with causation of injury. To win the case, however, you have to beat the defendant doctors on their own turf. Rather than waiting for your adversary's case to confront the defendant doctors on cross-examination – where your adversary can put forward his client in the best light and then tailor the testimony to fall outside of your expert's opinion – it is far better to call the defendants and prove your case through them. Then, by the time your expert testifies, the jury already knows the medicine, the standard of care and the departures. With a thorough knowledge of the medicine and radiological studies, and total control of the witnesses through the use of leading questions and impeachment materials, a decisive victory awaits.

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