CROSS-EXAMINE THAT DOCTOR WITHOUT A DEPOSITION

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I. Introduction

Conventional wisdom dictates that the deposition of a treating or examining physician should be taken prior to trial in order to lock in his or her testimony, and to help develop cross-examination. The purpose of this article is to suggest that the conventional wisdom be reconsidered. In many, if not most, cases, an effective cross-examination can be developed without taking the deposition, working only from the physician's records, or narrative report. The principles discussed here are equally applicable for defense lawyers where the physician has treated the plaintiff, or plaintiff's lawyers where the physician has only examined the plaintiff pursuant to a Rule 35 examination.

The primary reason an attorney should not take the doctor's deposition is to force the opposing party to require the doctor to actually attend trial. If a pre-trial discovery deposition is taken, that testimony can be used at trial in place of live testimony, and the cross-examination will be significantly less effective since a discovery deposition customarily is used to gather information rather than to establish cross-examination points.[1] However, if the doctor is compelled to testify at trial, neither opposing counsel nor the doctor will have an advance preview of the precise points you want to make. Additionally, many doctors, while comfortably familiar with the deposition process, may be less experienced in the foreign environment of a courtroom, resulting in some apprehension, increased candor, and perhaps even a degree of malleability.

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An effective cross-examination can be created from the doctor's records or report, and an understanding of the injury at issue, obtained with the assistance of your own medical witness or consultant. A doctor's records are the bible for his or her treatment of the patient. They must be accurate and timely recorded. The doctor will not be able to deny what is written in the records any more than he or she could deny sworn deposition testimony. The primary purpose for accurate records is to provide subsequent caregivers with important information relevant to the patient's condition and treatment. Thus, they are a contemporary record of what care was or was not rendered, and the basis for such care. The narrative report of a Rule 35 examination, likewise, is a record of what the doctor is told, sees, detects and believes. In either case, the physician will not be able to back away from or diminish what has been recorded. There is virtually universal agreement to the adage "If it is not documented, it was not done."

II. The first visit

The records of a treating physician will permit you to establish whether there is a causal relationship between the accident, and the first visit to the doctor's office. If more than a week has elapsed between the accident and the first visit, you can cast doubt on the claim that the injury was caused by the accident. A person who has been injured and is in pain goes to a doctor as soon as practicable. A soft tissue injury such as a sprain or strain may not reach maximum pain intensity for 2 or 3 days, but even in such a case, the onset of pain is rarely delayed more than 4 days after the incident. Thus, if the records reveal an unusual lapse of time between the accident and the first visit for treatment, the cross-examiner can question the causal relationship by establishing that the injury would have resulted in immediate pain.

The initial history taken from the patient is critically important to both the doctor and the cross-examiner. The doctor relies on the history to diagnose and treat the injury. The cross-examiner relies on the history to establish what the patient said, or did not say. Whether the history is taken by the doctor or the doctor's assistant, it can only be a record of what the patient has told the writer. If there is a fact in the history, the patient said it. Conversely if it is not in the history, the patient did not say it. Thus, if a previously undocumented injury appears at a later time, the doctor should be asked specifically about the history taken at the first visit. All doctors will agree that when taking a history they ask the question "What is the matter?" or

1 In several states, including the author's state of Florida, the deposition of an expert witness may be used at trial without any showing of necessity or unavailability. Federal Rule 32 does not have this provision, but requires a motion and a showing of "exceptional circumstances" in order to use the doctor's deposition in lieu of an appearance. In either event, if a deposition is not taken, the doctor will have to testify live in order for the jury to consider the evidence.

"Where does it hurt?" or something very similar. If the injury is not recorded in the history, the patient did not complain of the condition. The logical conclusion is that the injury did not exist at the time of the first visit. The same holds true for subsequent visits. The patient is always asked "How are you doing [or feeling]?" so if the pain or injury is not recorded, it was not present. Also, all patients complete an initial intake sheet when first visiting a doctor. The information on the intake sheet is completed in the patients own handwriting, and includes a space for the chief complaint. The information in this sheet can be used in much the same way as the initial history to discredit injuries claimed at a later time.

III. Continuing treatment

Many private practitioners use a form history sheet listing the various systems and areas of the body (cardiovascular, neurological, orthopedic, etc.), in detail. Customarily, only abnormal findings are recorded. This allows the cross-examiner to inquire about the related areas that were not noted to establish they were within normal limits, or that there were no complaints. For example, the form for a patient who complains of an injury to the shoulder or knee that impairs normal motion may not indicate a reduction in the range of motion, or any atrophy of the affected muscle. The Rule 35 examiner's narrative report may reveal that the physician did not perform appropriate tests. Even if the tests were performed, it is highly unlikely that the total time spent with the claimant was more than 30 minutes, with most of it being used to take the history. This brief personal contact can be contrasted with the treating physician's numerous examinations and treatment sessions over a period of months or years.

It is often useful to take some time to establish the difference between subjective complaints and objective signs. This is an area of questioning which holds no danger for the cross-examiner, so make sure the jury understands that when a doctor relies on subjective complaints, he or she is relying on the veracity of the claimant, and there is no way to scientifically determine whether the patient is telling the truth. If a Rule 35 examiner doubts the truthfulness of the complaints of pain, it can easily be established that doctors treat patients every day solely on the basis of subjective complaints.

Where the records show that the doctor treated the patient over a period of time, look carefully at the descriptive terms and language used in the records. You can often see that healing and improvement in the patient's condition is clearly documented. For example, the description of pain may begin with "severe" or "intense" and progress over time to "mild" or "minimal." Likewise, a Rule 35 examiner may be expected to use the terms mild or minimal, in which case, the cross-examiner can explore the subjective nature of the words themselves. How is it possible for an observer, no matter how skilled, to accurately describe the sensations felt by another?

IV. Final visit or discharge

Where there is a significant lapse of time between visits, a doctor customarily will agree with your suggestion that he or she told the patient to return "as needed." Therefore, if the records show a period of time with no visits, it is reasonable to argue that the patient did not feel pain and there was no need to see the doctor. The Rule 35 examiner, on the other hand, will agree that many types of injuries will feel better, and then be exacerbated by the normal activities of daily living. The same is true when a patient is discharged from the doctor's care. "Discharge" means there is no further need for medical treatment. This isn't the same as saying the patient is healed, nevertheless, if the patient does not return, the argument can be made that the patient is the best one to decide whether treatment is necessary. Conversely, an injury may become asymptomatic following treatment, but due to scar tissue or weakness, may once again become painful and need additional treatment.

V. Final thoughts about techniques

It is not necessary to take the deposition of a treating or examining physician if you are in possession of complete and thorough records, or narrative report. It should go without saying that when cross-examining a physician in trial, you should always treat the witness with respect and as a professional, not as an adversary. Not only because jurors dislike it when a questioning lawyer takes unfair advantage of his or her superior position in a courtroom, but also because the physician is more likely to agree with your suggestions and leading questions. If you feel it is necessary to become antagonistic, or challenging, it is best to leave those subjects to the end of the examination, after you have obtained the physicians agreement to as much as possible.