DEPOSING DOCTORS IN MEDICAL MALPRACTICE ACTIONS

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INTRODUCTION

Proper case selection is arguably the most critical skill necessary for success in a medical malpractice action. However, without good deposition skills, even meritorious cases will likely be lost. With only a small percentage of cases actually going to trial, the real battleground for most litigation is the deposition room. An effective deposition is the best opportunity to directly influence the ultimate outcome of the case. If you do not win the case at the depositions, it is likely that you will meet the same fate at trial.

Medical malpractice depositions are unique, unlike other personal injury matters, in that "opinion questions" are permitted,. As has often been stated, it is well settled that a plaintiff in a medical malpractice action may inquire during a deposition as to a defendant physician's expert opinion (*see* *McDermott v. Manhattan Eye, Ear & Throat Hosp.*, 15 N.Y.2d 20 (1964); *Orner v. Mount Sinai Hosp.*, 305 A.D.2d 307 (1st Dept. 2003); *Johnson v. New York City Health & Hosps. Corp.*, 49 A.D.2d 234, 236 (2nd Dept. 1975).

Medical depositions are challenging because of the technical nature of the subject matter, the skill of the adversary representing the doctor, and the degree to which the doctor-witness will go to avoid disclosing anything that can be helpful to the plaintiff's case. A medical deposition is not only about discovery of what the other side has to say, it is also an effort to create evidence that supports

your case. The effective questioner uses techniques to bring out and document everything the medical witness knew and thought about the case at the time it was unfolding, but also uses strategies to control the witness by leading, summarizing and careful choice of specific words and concepts that support his case. The deposition is the testing ground for all of your theories of the case.

CASE LAW BEFORE THE "NEW RULES"

There is little guidance from the Appellate Courts concerning depositions in medical malpractice cases because, for the most part, such issues are not appealable as of right. See, Lacerenza *v. Rich*, 39 AD2d 716 (2ND Dept. 1972).

McDermott-Where it all started:

The first significant change in the law with respect to medical malpractice actions occurred more than 40 years ago, in a major break from the Common Law. For the first time, attorneys were given their most powerful tool for prevailing in medical malpractice cases: the right to ask "opinion questions" of doctors at trial. Up to that point, only questions of fact were permitted to be asked at trial or depositions. In *McDermott v. Manhattan Eye, Ear & Throat Hosp*, 15 N.Y.2d 20 (1964), the Court of Appeals held that a plaintiff in a medical malpractice action was entitled to call the defendant doctor to the stand and question him both as to his factual knowledge of the case and as an *expert for the purpose of establishing the standard of care.*

In *McDermott*, plaintiff's attorney, Max Toberoff, sued a number of doctors involved in a failed corneal transplant procedure. At the end of the plaintiff's case, the trial court dismissed the complaint against all the defendants. The case was

appealed all the way to the Court of Appeals. At trial, plaintiff called only two of the defendants as witnesses, and no expert on her behalf. One of the defendants had written a book on the subject of corneal transplants, and Toberoff attempted to examine both defendants on the risks of the procedure, the favorable conditions which must be present before the procedure would be deemed suitable, the significance of the plaintiff's pre-existing condition of "Fuch's dystrophy," and its impact on a successful implant. In short, Toberoff attempted to establish the standard of care out of the mouths of the defendants. All such questions were objected to and sustained by the trial judge; therefore, no deviations were established, leading to the dismissal at the end of plaintiff's case.

The question on appeal was stated as follows: "Whether the plaintiff should have been given the opportunity of establishing her claim of malpractice by showing, through the testimony of the defendant doctors, that proper medical practice contraindicated the performance of a corneal transplant on a patient such as the plaintiff." Heretofore, doctors had been required to testify to facts within their knowledge, that is, "what he actually saw and did"-but not as to whether his actions deviated from the accepted standard of medical practice. In now permitting questioning concerning proper medical practice, the Court reasoned that the *doctor's knowledge of the standards of care are as much matters of "fact" as are the diagnosis and examination he made or the treatment upon which he settled.* The issue of deviation from the standard of care, so reasoned the Court, is "assuredly pertinent and relevant" to a malpractice action. (The wording of this sentinel case has significance to the "Carvalho Rule,"

discussed below, equating knowledge of the standards of care to matters of fact, supporting the argument that if a medical witness has knowledge of the standard of care as it applies to co-defendant, it is as if he knows a "fact" that is "assuredly pertinent and relevant."

A significant point made by the Court of Appeals, still relevant to date, was that once on the stand, the defendant has no inherent right to remain silent or, answer only those inquires which will have no adverse effect on his case. Rather, "he must, if called as a witness, respond to virtually all questions aimed at eliciting information he may possess relevant to the issues, even though his testimony on such matters might further the plaintiff's case. This language is particularly significant and appears to have been ignored by the Appellate Division, Second Department in *Carvalho v. New Rochelle Hospital*, 53 A.D.2d 635 (2nd Dept. 1976).

Johnson: (Onto Depositions)

Eleven years later, the Second Department, in *Johnson v. New York City Health & Hospitals* Corp., 49 A.D.2d 234 (2ndDept.1975), extended the *McDermott* holding to depositions. At the deposition, questions were not permitted of the doctor produced by the defendant on the grounds that it called for an expression of an opinion and the doctor was not a party defendant in the lawsuit. The Court framed the question as follows: "The issue is whether the rule of *McDermott v. Manhattan Eye, Ear & Throat* should be extended to examinations before trial. Finding that every evidentiary expansion touching the trial touches the pretrial deposition as well, and that the scope is even greater at

a deposition, *McDermott* must be held to affect both, citing as well CPLR 3113.

Carvalho: But Hold On, There Are Limits

Two years later, however, the same Court, in *Carvalho v. New Rochelle Hosp.*, 53 A.D.2d 635 (2nd Dept 1976) qualified the rule somewhat, by holding that one defendant physician may not be examined before trial about the professional quality of care by another defendant physician if the questions "*bear solely on the alleged negligence of the co-defendant and not on the practice of the witness.*"

In *Carvalho*, the plaintiff underwent an appendectomy performed by a Dr. Mannix; the pathology report revealed purulent exudate on the specimen. Dr. Cappelletti, who performed subsequent surgeries on the defendant, was questioned concerning the significance of this finding with respect to developing a post operative abscess and whether a doctor (i.e. Mannix) should have gotten a culture and sensitivity on the material. (Had I been the examiner, I would first have established the general standard of care by asking: Does the standard of care require a surgeon (witness was a surgeon) to submit for pathological evaluation surgical specimens removed at the time of surgery? If there is an observable exudate [I would have asked questions about what is an exudate and its significance to patient safety, and whether it is a finding that required documentation in the operative and whether, again for patient safety, cultures were required to be performed to identify the organism so that appropriate treatment could be started in a timely fashion.)

Citing both *McDermott* and *Johnson* for the proposition that a defendant

may not be questioned about the professional quality of the services rendered by a co-defendant if the questions bear solely on the alleged negligence of the codefendant and not on the practice of the witness, the Court went on to hold that it is proper, however, if the opinion sought refers to the treatment rendered by the witness, even if it also refers to the treatment by the co-defendant. (Having read, and re-read both *McDermott* and *Johnson*, I have been unable to find anything in the language in these decisions supporting the main holding of the case, or even the sentiment above expressed.)

Harley v Catholic Medical Center, 57 A.D.827 (2nd Dept., 1977), the following year, clearly stated that where "the opinion sought refers to the treatment rendered by the witness, the fact that it may also refer to the services of the codefendant does not excuse the defendant witness from being deposed as an expert." In *Harley*, questions concerning medication given to the mother during her pregnancy by the co-defendant and the effect that it might have on the infant were permitted to be asked of the pediatrician. The Court reasoned: "The appellant was aware of the effects of those medications on the child may be relevant in the determination of whether he reasonably diagnosed the child's condition and properly treated him. Certainly, it does not appear that the questions are based solely on the alleged negligence of the codefendant physician. The appellant should therefore be required to answer those questions." The holding in this case suggests the proper method for questioning one physician concerning what was done by another physician, since invariably they both will be treating the same patient who likely has one common medical

problem.

Carvalho Is Dead

The misuse of *Carvalho* has become a significant source of obstruction during depositions for the past forty years. Second only to objections to the form of the question, Carvalho objections are still being made in a majority of medical depositions. The only case reported since the New Rules, *infra,* which discussed the issues raised above in Carvalho, is Bubar *v. Brodman,* 908 NYS 2d 864 (Sup. Ct Erie Co., Neymoyer, J, 2010). The case involved a cardiac bypass and aortic valve replacement, where there was a bleeding complication requiring re-exploration; the operative report did not include the re-exploration surgery. The subsequent treating cardiologist was not otherwise made aware of the complication. The patient later developed sepsis leading to a stroke. During the cardiologist's deposition, he was instructed not to answer, on the grounds that it was a hypothetical question, a number of questions concerning the significance of the post-operative bleeding complication. Justice Neymoyer wrote that he had "serious doubts that the decision in *Carvalho* would be rendered today, in the era of 22 NYCRR part 221, and noted further that he had serious misgivings about the provenance, let alone the sense, of the rule set out in *Carvalho*. The Court held the doctor had to answer the questions. A close analysis of McDermott and *Johnson*, so reasoned the Judge, in light of the current law, suggests that the holding in *Carvalho* is no longer valid, and the questions and answers should be permitted. ***If the deponent knows the standard of care, whether or not it bears on the treatment of another doctor, he should be required to state it.***

Does this case, while merely a lower court decision, mark the death of *Carvalho*? This is a very reasoned decision, which is totally consistent with the letter and spirit of the New Rules and existing case law, *Carvalho* not withstanding. Reason suggests that *Carvalho* is indeed dead. If the doctor knows the standard of care, then he must answer the question at a deposition.

Carvalho must be placed into the 1976 historical perspective of medical malpractice litigation; a time when there were very few doctors willing to testify for plaintiffs, and the practice was to sue just about everyone whose name appeared in the hospital record. I was around at this time, and can bear witness that it was not uncommon to have ten to twenty defendant doctors named in a lawsuit. Carvalho was decided before the enactment of Article 16, which provides that a defendant's liability can be reduced by the culpable conduct of another physician, even one not named in the lawsuit. Because a defendant could wait until trial to point the finger at a treating physician not named in the lawsuit, it only seems fair that defendant doctors should be compelled at their deposition to state their opinions regarding all medical providers who treated the plaintiff, whether a party or not. A plaintiff needs to know during the depositions whether a defendant will blame another medical provider at trial because of the significant impact upon the plaintiff's potential recovery.

Moreover, in a majority of cases where doctors of different specialties are parties to the litigation, there is only one patient being treated by everyone. All specialist work in conjunction with other specialist when treating patients, and are

expected to be generally familiar with the standards of care prevailing in related specialties. Specialist are required to know what effect, if any, treatment given by others may have upon their own management of the patient, and to what extent the treatment of others might affect the witness' differential diagnosis.

At least one lower court has ruled that *Carvalho* is a rule governing discovery, and should not be applied to trial testimony. See, Giventer v Rementria, 184 Misc.2d 744 (Sup 2000). In *Orner v Mount Sinai Hospital*, 305 AD2d 307 (1st Dept. 2003), plaintiff appealed from an order denying his motion for further depositions of the defendant doctors. The Court reversed and noted the evidentiary scope of a deposition is at least as broad as that of the trial itself. To the same effect see *Parker v Ollivierre*, 60 AD 3d 1023 (2nd Dept 2009; *O'Neill v Ho* 28 AD3d 626 (2d Dept 2006); *Mora v Saint Vincent's Catholic Medical Center of New York*, 8 Misc. 3d 868 (Sup 2005).

***Ithier*: Authoritative text:**

It would seem logical, relevant and informative if a professional witness would have to support his medical opinions with reliable medical literature. Clearly, if the doctor expresses an opinion concerning the standard of care, one would hope that there would be somewhere in the available medical literature corroboration or support for the opinion, rather than the mere *ipsi* dixit opinion of the witness. Alas, in what appears to be another late 1970's misguided attempt to shield doctors from being challenged at trial by the use of authoritative literature, the Court has made it the plaintiff's job to guess what specific articles to inquire about at the deposition, rather than merely asking the witness whether there is

any literature supporting his position. In *Ithier v. Solomon*, 59 AD2d 935 (2nd Dept 1977)-one year after *Carvalho,* the ability to inquire of the defendant-doctor concerning what text books he considered "authoritative" was all but eliminated by this Appellate Court. In that case, where plaintiff alleged the doctor misdiagnosed the plaintiff's ailment as tuberculosis, the defendant was asked whether he recognized any books as authoritative in the field of tuberculosis, as well as what text books he had studied in medical school or subsequent thereto dealing with tuberculosis. The Court, without citing any authority, declared these questions "altogether too broad."

In a similar situation, defendants in medical malpractice action were not required to disclose to the patient the medical literature that the defendant doctor referenced, but was allegedly unable to specifically recall, during his deposition; it could not be determined whether the failure to identify the medical literature was either willful or in bad faith, and the doctor was not appearing as defendants' expert, the alternative theory of causation the doctor proffered was not posited with a reasonable degree of medical certainty, and defendants could not be compelled to produce information which they did not possess. *Sagiv v. Gamache*, 26 A.D.3d 368, 810 N.Y.S.2d 481 (2d Dep't 2006). (See, also *Forgays v. Merola*, 222 A.D.2d 1088, 636 N.Y.S.2d 509 (1995).

PREPARING FOR THE DEPOSITION

The more you know going into the deposition, the more you will learn when you conduct the deposition. Medical depositions can be daunting, even for

the experienced litigator, because so much depends on a successful deposition. The deposition will be the first opportunity to sit across the table from the defendant, and for you to size him or her up, as well as being seized up. You will be examining a professional in his or her field, using documents created by him, and who has been prepared to make your job as difficult as possible. While this may, at first glance, appear to be an unfair contest, in reality it is not. A well prepared and confident litigator is more than an even match for most physician witnesses. As the examiner, it is you who controls the questions and the subject matter under discussion. Do not expect the witness to educate you voluntarily, but the witness must answer your well thought out questions, which gives you the upper hand. You get to pick the words used in your questions, and with so many witnesses trained to answer only yes or no, your words can become the vocabulary of the case.

I always approach a medical deposition with the notion of making the witness assist me in telling my story. I keep in mind the notion that if I only had this one witness at the time of trial, could I present my complete case to the jury. Every case has agreed upon core medical concepts and a set of facts, many of them contemporaneously documented. Most experienced trial lawyers know, however, that complicated medical debates rarely move jurors to a verdict. Often, it is the secondary or peripheral issues that determine case outcomes, such as credibility, caring for the patient, honesty and other non-technical matters. These issues must be looked for and developed in every case, and the depositions are where your theories are tried out, face to face.

Deposition preparation begins with a complete review of all medical records in the case. Every medical condition in the records, regardless of whether it is actually involved with the merits of the case, must be researched, studied and mastered (so much easier now in the digital age). Every medical term, wherever found, must be looked up and learned. Only after having mastered the medicine, can you really begin to understand the significance of the facts as they relate to the medicine.

A master chronology must be developed and documented. I have always attempted to do things once, and do it thoroughly the first time, which is why I begin working on a detailed chronology when I first begin investigating the case, adding to the medical history as new records become available. Currently, I use Factbox (CaseMap is also good for PC users) for my chronologies, discussed later in this article.

It is always important to know going into a deposition which facts are agreed upon and which ones are in dispute. When formulating questions, always attempt to use sentences containing one fact. All facts that are important to resolving critical issues in the case must be specifically identified and questions formulated to commit the witness's testimony concerning the significance of these critical facts. Often the fact is not so much in controversy as is the significance of the fact in the context of the case.

List the necessary documents and whether this witness can provide the legal foundation for its introduction at trial. You should develop a standard line of

questions when the witness testifies that he does not know if a particular document exists, such as billing records or some other document other than the clinical record. Ask if he or she ever knew where the document was kept and has he ever seen it, who usually keeps such documents, where in the office the record would be found, and other general questions that might be necessary when creating a discovery demand.

Knowing that every medical malpractice case has similar elements (PJI 2:150), think about how this witness can help establish these basic elements, even if he or she will not give you a departure from accepted standards of car. For instance, always look to close off any causation issues, and think about how the witness can help you with free testimony about damages, based not only on his treatment of your client, but his experience treating other patients who have had similar medical problems, like living without a kidney or loss of a substantial portion of their bowel.

Write out your “goals” for the deposition (always have at least one thing that you must have the answer to by the end of the deposition). Prepare an outline of topics to be covered. It is generally better to not have pages and pages of questions written out in advance. The true art of taking a doctor’s deposition is taking the answer given by the witness and using it to explore further by proper follow up questions. To do this effectively, listening must be your most active sense. In order to actively listen, you can not be tied to your notes. If you have properly prepared, you will not need copious notes; you do need, howerver, the confidence to know that the knowledge will be there to be used whenever the

situation calls for it, so trust yourself. Topics and specific areas should be outlined in advance. For some additional thoughts about eliminating too much paper at depositions, which can be difficult to manage distracting, see the section on using iPads at depositions.

Organize in advance the documents that will be used during the deposition. It usually saves time to make copies of any documents that are going to be used during the deposition for the attorneys and witness. Pre-mark them to save time. Bates stamp (number) pages of the chart and make a clear record when used during the deposition by stating that the witness is now referring to bates stamped page number six. Use the same exhibits for all subsequent depositions to eliminate any confusion concerning documents. I make a working copy for the deposition so that I can write directly on the document if an explanation is provided by the witness that embellishes what is recorded. I usually ask the attorney for the defendant in advance of the deposition how many entries the witness has made in the chart to make certain I did not miss something in my preparation, and I always encourage the defense attorney to put tabs on the entries to save time.

Review the case law and Pattern Jury Instructions. It is just as important to know the law that is favorable to the defense as it is to know the law necessary for your case. Mastering the dozen or so legal issues that reoccur in medical malpractice cases is critical, such as “loss of a chance” and vicarious responsibility. Probably the best source to get a general overview is the PJI section on medical malpractice. Know the elements necessary to establish a

case or hold in a co-defendant, and be familiar with the terminology used by the appellate courts when deciding cases, and attempt to incorporate the language into your questions.

Learn something about the witness in advance, if possible. Web sites are fertile ground for information proclaiming how good a hospital or doctor is, and why the patient is in better hands with them. It is always good to have something on the doctor's website that can be used to establish a general rule concerning patient safety. A great deal of information can be found in advance, such as whether a hospital is a designated stroke center, and therefore required to comply with the State standards. Scrutinize transcripts of prior depositions conducted by others after doing a search to identify other cases the witness has been involved with.

Standards of Care and Medical Rules

The appropriate standard of care is always at issue in a medical malpractice case. Formulate questions that require the witness to answer questions that establish rules of conduct or standards of care. Whether helpful or not, having clear rules or standards agreed to by the defense is the beginning of trial preparation. Research professional literature for generally agreed upon principles and have the witness commit to them at the deposition. Formulate common sense rules, such as the importance of proper chart documentation or listening to the patient. The rules should be easy to understand, and case specific. The rules should be prescriptive rather than just a general principle. You

will know in advance of the deposition what your expert's opinion is concerning the standard of care. The witness should be confronted with your expert's opinion at the deposition, since the witness certainly will have an opinion concerning the opinion at the time of trial. I think it is a mistake to hold back too much during the deposition. I would rather know what the witness is going to say at trial and be prepared in advance. Have the witness acknowledge that the standards of care are formulated to protect the patient.

Attempt to formulate medical rules that will put real definition into otherwise ambiguous concepts, such as what a reasonable prudent doctor would do. As PJI 2:150 states, medical malpractice is the failure to use "reasonable care" under the circumstances. The law requires that all medical treatment be based upon reason and care taken for the patient. Questions, such as, how does not seeing a patient for three days who has a bowel obstruction help the patient? Have the witness commit to concepts such as the "greater the danger, the greater the degree of care required" or the sooner the diagnosis is made, the sooner the treatment can be started, and the sooner the treatment is started the better the prognosis for the patient. The purpose of medicine is to intercede in the disease process to affect a more favorable outcome. Formulate questions in the context of how the treatment helped the patient obtain the best medical outcome under the circumstances, which is always the goal of medical practice.

For instance, in a failure to diagnose cancer case, there will always be some factual support for the doctor's decision, and the defense will surely argue hindsight at the trial. It is far better to question a doctor about the differential

diagnosis method and the rule requiring a doctor to rule out the most serious conditions first, and establish all the specifics that should have been on the differential list, as will be discussed in more detail to follow.

It bears repeating; prepare an outline of topics, rather than writing out questions. Listening to an answer is as important as asking the question, particularly with doctors. The real gold is in the follow up questions, often in response to the witness' prior answer. You should know the medical subject matter so well going into the deposition that detailed technical notes will be un-necessary. You have to trust your preparation skills and feel confident that you can explore any answer given by the witness and relate it to your theory of the case. Remember, a deposition is different than cross-examining a witness at trial. In a deposition you are going in without a transcript of the doctor's testimony, whereas at trial, thanks to a good deposition, you are in a much better position. Your goal: get it all out on the record.

General Medical or Surgical Concepts In the Beginning:

In the beginning before any facts of the case are discussed, it is best to ask general medical or surgical questions, as general concepts, including anatomy, surgical procedures, risks, signs and symptoms of a disease. Standard of care statements are more easily obtained as a general concept rather than case-fact specific. It is critical to outline all areas of contention where the standard of care is at issue. If the doctor testifies that there is no standards of care with respect to a certain issue or procedure, follow up and find out if that

means everyone is free to do what they please. Find out where or when the doctor first learned about the standard of care or manner of dealing with the condition. Whether he continued to follow that standard, and if not, why he changed. If there are variables, ask what they are. Always establish if there are differing opinions in the medical profession concerning this standard of care.

Whatever the doctor's position, you must know where he stands on the standards applicable to your case. Once the witness has testified, in response to an open ended question, I will then ask direct, closed questions to determine if he agrees or disagrees with my expert's opinions on the subject. Ask specific direct questions as to whether the doctor's acts departed from the accepted standards of care, and if not, why not or the basis of his opinion (it is always better to know in advance of trial so you can plan accordingly). It is always enlightening to ask, once you have established a general standard of care, whether the failure to act accordingly would be a departure from the standard of care. Doctors are so programed to respond in the negative to any departure questions that you often end up with logically inconsistent responses.

iPad Apps For Depositions

Technology is slowly but surely finding its way into the way medical malpractice attorneys handle their cases. The iPad, first introduced in 2010, has changed many of the old habits. The iPad has become a frequent tool used during trials to present evidence, and now is being used in new ways at depositions. The iPad is easy to use, reliable and permits fast access to large

amounts of information, eliminating the need to lug into depositions huge files containing lots of paper that is difficult to quickly access when needed. When all important documents are scanned as PDF files, word searches can find just about anything within seconds. Eliminating paper clutter on the table when taking a deposition permits better focus on questioning and listening.

To be safe, it is advisable to have all of the important files residing on your iPad for the deposition, with other less important files in the cloud, in programs such as DropBox. Files can easily be download directly to your iPad using a popular program such as iAnnotate PDF, which is a robust PDF annotator.

My practice is to have a copy of all of my documents in DropBox for use at any time and any where. Moreover, most iPad software programs access the documents through programs like DropBox. The majority of depositions are conducted in locations with Wi-Fi access, and for those that are not, it is easy to bring your own hot spot, either a dedicated piece of small hardware or your iPhone.

One of the most useful apps for depositions is iAnnotate PDF, which has many advanced features that can be useful when taking a medical deposition. Question outlines, originally made in Word, can be brought into iAnnotate from a cloud based program such as DropBox. Even if the outline was originally prepared as a Word document, iAnnotate PDF will easily convert it to a PDF file, which can then be edited and annotated. Your finger can be used to make notes, or you can type in additional notes, or, as I prefer, use a stylus pen to make

additional notations. The program permits multiple documents to be open at the same time, facilitating moving between your question outline and notes on the medicine in the case. If needed, pictures can be added directly to your outline notes, for instance, showing the anatomy of the shoulder or some other structure.

Dedicated deposition transcript software has been around for a number of years, and I have used many different ones during my career. Because I am a Mac user and bring my iPad to depositions, my current favorite is TranscriptPad, which is the same company that makes TrialPad, my favorite courtroom presentation software for the iPad. All reporting agencies provide transcripts in multiple formats, including PDF (good for Adobe) as well as ASCII (.txt), which is used by TranscriptPad because it retains the formatting from the original transcript. The transcript is uploaded to the cloud, and in my case DropBox, and from there easily imported into TranscriptPad and assigned to a case. While reading the transcript, I can annotate it with a number of tools, including multiple color highlighters and under-liners, and flag answers of significance. More importantly, custom issues can be created, permitting the responses of multiple witnesses on a given point to be assigned to an issue, which can then be filtered, viewed or printed as a report. This tool can be very helpful, particularly in a case with multiple witnesses. You can quickly see the exact responses of other witnesses on a given issue while examining a different witness at a deposition. The program also indexes every word, thereby permitting rapid and advanced word searches of other witness' depositions for key words.

Factbox, another program recently released, can be used during the

deposition of a doctor. This program is designed as a tool to organize the facts of your medical malpractice case, which usually means all the medical data in your case organized into a chronology. But the program does so much more. Each fact can be linked to a custom issue in the case, and filtered to see only just those entries. Each fact can also be linked to a particular individual, permitting you to filter all the progress notes authored by a particular person, which can be very helpful when preparing for a deposition of that witness. During the deposition, if a question arises concerning the entry of another doctor, a search can quickly bring up those entries. For me, however, the best feature of Factbox is the ability to create a fact in the main content section using my own entry, and then link that note to the actual entry in the hospital record. There have been other programs that permit linking to the entire hospital chart or medical record, but Factbox permits a link to the actual page in the chart with the note. Additionally, the deposition transcript of the witness who authored the note can be linked to the fact, and the specific pages easily and quickly brought up for review of the doctor's actual testimony concerning the entry.

There are a number of good note taking apps for iPad, including Noteshelf, Penultimate and GoodNotes. All use a stylus and come with a multitude of tools, making note taking easy at a deposition. The important feature is that the notes will reside on your iPad or computer for future use, and will not be lost in the pages of legal pads that clog up files. The iPad Air 2 supports a "split view", permitting two apps to run side-by-side. You can have your outline notes on one side and the actual progress note on the other side. In older iPads,

double clicking the home button brings up all of the open apps, which can be switched to very quickly. By having two apps open, you can have all of the medical records in TrialPad and then immediately switch to a 3-D anatomy program to demonstrate an anatomical structure. Similar, although not identical, is the ability for an updated iPad to use “slide over”, which reveals a list of other apps very quickly. One use of this feature would be to have your outline in one program, and then quickly bring up iAnnotate PDF with the medical records, of TranscriptPad with a deposition page. To engage this function all that is required is to sweep from the right edge with your finger, and all of the programs on your iPad are displayed as icons in a scroll down menu.

I also have several scanner software programs on my iPad, such as Scannable, and Scanner Pro. These program operate like a camera and save the image as a PDF file. If a document is produced at the deposition, I am always able to scan it immediately, with the exhibit label. Rather then collecting business cards and then loosing them in the file, it is easy to scan them for your permanent records.

CONDUCTING THE DEPOSITION: TECHNIQUES

The goal of the deposition is to get information from the doctor, who often is hostile at the outset, feeling that he is being unjustly persecuted. Setting the

proper tone is important to facilitate getting more information from the witness. Be polite, civil and even-tempered. Even in the face of a difficult, non-responsive witness, persevere politely, and let it be known that you have enough endurance and patience to get a responsive answer; as the British say: “Be calm and carry on.” Always stay in control, and never loss your cool; it will always affect your ability to think clearly and appropriately respond to the situation.

I always arrive early and ask if the witness is already here. Most medical witnesses are prepared days in advance of the deposition, but I like to see what the witness brings into the office and compare it with what comes into the deposition room. I have witnessed, and questioned, concerning observed textbooks and journals brought to the office on the day of the deposition but not brought into the deposition room.

Take notes only to remind you to ask a question, not to preserve the testimony. Encourage the witness to open up and testify. Always look at the witness when questioning, and always remain in control of the situation. Be polite: you want the witness to be relaxed so that they will open up and volunteer information. Get the witness to tell his story completely. A talkative witness is usually better than one who is not. Avoid surprises at the time of trial; lock the witness in at the deposition so that the story, for better or worse, does not change at the time of trial.

Think of a deposition as the opposite of cross-examination, although cross-examination techniques are frequently used as well during the deposition,

particularly when closing off an answer from the witness, such as, should you have also considered this condition as a potential cause of the patient's problem. Ask open-ended questions as often as possible. Ask the witness to explain frequently. Remember, the more terms you get agreement on at the deposition, the less there is to be concerned about at the time of trial. Always hear every response with the ears of a potential juror. If you do not completely understand the response, there is a better than even chance the jury will not either. Ask why questions concerning every significant action taken by the doctor. Doctors are trained to explain cases to residents on rounds, and their scientific method (the basis of western medicine) is based on logical thinking, a lawyer's strong suit. Think in paragraphs (announce a new topic before beginning questioning). Identify a topic when moving to a new area. Make it clear when asking "general medical questions" and when the question if case specific.

Going into a deposition of a doctor, you should have a good idea where the critical fork in the road is; that point in the treatment where the witness did one thing and your expert advises you that something else should have been done. Every malpractice case has at least one such issue, and most cases have many more than one, but it is crucial to identify that point, if possible, before the deposition. Every medical case involves many facts, the majority of which are not in dispute. Often the facts are not so much in dispute, as is the doctor's cognitive process. The witness will be using the same documented medical record that everyone else has access to, but often the witness is the creator of the record. It is therefore important to have the witness identify every fact that was relied on to

formulate a diagnosis, plan of treatment, or why he or she did something.

Most medical cases involve competing expert opinions as to what the appropriate standard of care was at the time of treatment. Have the witness define what is meant by the standard of care so that at the time of trial there is no debate as to what the term means. Cement the underlying theme that all standards of care are designed first and foremost to promote patient safety and well being. Inquire whether there is a consensus in the profession concerning the standard of care, or whether there are differing schools of thought. Also be aware that there may be a difference between the appropriate “standard of care” and the “standard of practice” that existed in the hospital.

Equally important, identify every subjective judgment made by the witness. Identify the basis of all opinions and decisions concerning the management of the patient, and what was the thought process. Establish the standard of care that was followed in the case. Explore why it was the standard, when and where did doctor become aware of this standard, and who else considers it the appropriate standard, and whether any literature supports this standard. If something is the standard of care, then it is the standard for others as well, so it must be published somewhere. Ask it the witness has read any medical literature that supports his opinion with respect to this case. After all, the medical profession is constantly publishing literature for the profession that is designed to educate the doctor and promote the general welfare of patients. If the witness is board certified, ask if the organization has an official journal and whether the appropriate standards of care were the subject matter of any articles.

To avoid any surprises at trial, ask the doctor if any algorithms were used when treating the plaintiff. In *Hinlicky v Dreyfuss*, 6 NY3d 636 (2006), during the trial (apparently not asked at the deposition), the defendant/anesthesiologist testified that a flow chart or algorithm, published by the American Heart Association, was used in deciding to allow surgery without a cardiac evaluation, which was the main issue in the case. Although clearly hearsay and an improper use of medical literature, the Court of Appeals concluded that the algorithm was correctly admitted as demonstrative evidence demonstrating the steps the anesthesiologist followed in clearing the plaintiff for surgery. There was an issue about whether the plaintiff's attorney properly objected, but the point is that all medical witnesses should be asked at the deposition if an algorithm was used at the time of treating the plaintiff.

Think of broad questions first, followed by directed questions, followed by narrow questions to nail down specific facts. I have always found that asking general medical questions first, not specific to the case, yields more honest answers and sets up later, fact specific questions. Even the most difficult medical witness will admit to knowing basic anatomy, physiology and principals of disease. In a clinical, failure to diagnose case, I usually get affirmative answers when I pose the question this way: Q: Is loss of consciousness *consistent with*, among other things, a decrease in blood flow to the brain? If you get a response such as "not usually" you must follow up with, "but it does occur, does it not?

Doctors frequently will answer many questions by testifying that it is "not necessarily" the case. Follow-up questions must always be asked, such as: Q:

when you say “not necessarily” does that mean that it usually is the case, but that there are some exceptions? Is it more likely than not the case, or can you quantify how often it occurs, are good follow up questions. What specifically do you mean when you say not necessarily?

Be on guard for conclusions and opinions, and always request details; doctors are masters at giving non responsive, but correct sounding, answers. Be sensitive to non-responsive answers, and repeat the question as often as necessary to get an answer to “your question.”

When you get a bad answer, that is the time to ask more, not less, follow up questions. I have read countless transcripts where the doctor gives a harmful answer and the questioner, unhappy with the response, moves on without challenging the witness. The bad answers require the most detail. It is much easier to give a conclusion than it is to back it up with detail. The bad answers require as much detailed questioning as possible.

Always inquire as to what the doctor reviewed in preparation for the deposition and how much time was spent doing so. As if prepared by the same universal malpractice defense attorney, the witness will invariably testify that he or she only reviewed his or her own notes; did not review the complete hospital or medical records, other deposition transcripts and certainly did not consult any literature in preparation for the deposition. While I understand the logic behind this approach, I am not certain that jurors do. I will certainly parade this out in front of the jury at the time of trial, so I usually explore this area in a little more

detail. I ask if the witness met with his attorney before giving testimony, and whether he had available to him or her the complete medical record. I ask a series of questions to explore whether the witness intentionally chose to skip all of the other entries in the chart and only read his or her own entries. From there I go into a general discussion concerning the importance of medical records and proper documentation, all designed for patient safety, before asking the witness whether he read the patient's chart when he was actually treating the plaintiff. Even if the witness did not review the hospital notes of others in preparation for the deposition, you still have the right to make the witness review any note that was in the chart. If this was at trial, the witness could be asked about entries in the medical record, which would be in evidence. Because you have greater latitude at a deposition than at trial, the witness should be required to answer. Personally, I do not have the witness read every note, but I do question about specific notes that I have segregated, either as separate hard copies or on my iPad.

In *Crawford v Lahiri*, 250 AD2d 722 (2nd Dept 1998), the Court held that if the defendant doctor reviewed any records regarding the plaintiff's treatment in preparation for his testimony, he was required to divulge that fact and turn them over whether or not his review was expressly done to refresh his recollection or was the material was supplied to him by his attorney. This holding is certainly broad enough to include any medical literature reviewed prior to the deposition.

Most depositions involve some attempt to find out if there is any medical literature supporting the witnesses' position. Because of the holding in *Ithier*,

supra, is difficult to get an answer to the question what literature does the doctor consider authoritative. Under the new rules for depositions, such a question certainly is relevant, but whether it is "plainly improper" and would cause "significant prejudice" is debatable. Where the defendant doctor testified that there were books that he considered to be authoritative during his deposition, he was properly ordered to provide the names of these books. *Bryant ex rel. Bryant v Bui*, 265 AD2d 848 (4th Dept 1999). The witness should be asked whether or not he had any medical text books in his office and whether they are standard reference textbooks and whether he refers to them on occasion when he has a specific issue to be resolved. Ask whether he used any textbooks in medical school school or residency and whether these books were standard reference books. Acceptance of a medical textbook is a standard reference book should be deemed authoritative, but it really depends on judge's ruling at the time of trial. What journals he subscribes to or are published by any of the organizations he belongs to may be helpful. The medical profession publishes on everything. It is a critical method for keeping abreast of current trends in medicine.

Depositions are a good time to get agreement on any medical illustrations that you might want to use during the trial, and thereby avoid the controversy that the witness might not agree that it is fair and accurate at the time of trial. If there is an objection, remind the defense attorney of the law that the evidentiary scope of a deposition is at least as broad as that of the trial itself. *Orner v Mount Sinai Hospital*, 305 AD2d 307 (1st Dept 2003); to the same effect see *Parker v*

Ollivierre, 60 AD3d 1023 (2nd Dept 2009); *O'Neill v Ho* 28 AD3d 626 (2d Dept 2006).

Boxing:

Exhaust the subject so that the witness cannot improve the answer at trial. This requires listening first, then asking as many follow up questions as are necessary in order to completely exhaust the subject. If you are uncertain about what the doctor said, it is likely the jury will be also: never leave any ambiguity, even if you have to show your ignorance by asking what may be a simple question; better now than at trial.

Ask short questions containing only one fact. Always ask simple, clear questions, avoiding compound and complicated questions and language. It is important to convert the medical terminology to simple lay language. Using medical terminology is fine, but then go back and reframe it in more easily understandable terms. Use nouns and verbs when possible. Avoid adjectives and adverbs. This is the best way to avoid objections as well. To improve, go back and read your old transcripts and then edit out all of the unnecessary language; it is eye opening. Also be patient. If there is a term used during the answer, make sure to explore every term of medical art in the answer.

Recapitulating and Summarizing (Laundering):

Often, important facts are buried in the middle of an otherwise useless

answer, filled with rationalizations and excuses, which is very common in medical depositions. To use the information at trial, the usable portion must be recapitulated, pulled out of otherwise harmful or useless testimony. Always think about how the answer will sound if read at trial. If the important part is buried in explanation, recapitulate it only using the important part. Again, this involves first having a sensitive ear and actually hearing exactly what was said by the doctor.

Ask lots of follow-up questions. Clearly, the greatest deficiency of most examiners is not asking follow up questions. Many of my best deposition questions and answers came on the third follow question to the witnesses' prior answer. A question elicits a good response, a bad answer, or an ambiguous response, and the questioner moves on to the next question without getting to the next level; this is usually not helpful. "Tell me about that" is one of my favorite follow-up questions, or what is the basis for that opinion.

Establish facts necessary for your case. Lawyers suffer from the "curse of knowledge." We have lived with our cases for so long, and know them so well, we assume the jury will as well. Use the witness to tell as much of the story as possible with an eye towards saving time when your expert testifies at trial, as well as giving you more details that you can count on when preparing your opening statement.

Many important predicate facts are overlooked when proper foundation questions are not thought through in advance. Have the witness read every entry into the record, ask and then go back and have him explain every term, even if

you know the meaning; you want to be able to use his terms at trial.

Where are the documents that are not there at the deposition, such as the billing records, or the super bill? What are the documents called (when looking for printed rules and regulations), or how can they be identified, and where are they kept? If someone needed to find the answer to this question, where would they look? Establish the foundation at the deposition for the ultimate admission as a business record at trial. Was it kept in the regular course of the business? Was it the regular course of the business to keep such documents?

Eliminate defenses or claims, which requires review of the pleadings. If the witness verified the pleadings, then the witness can be examined concerning the contents. If the doctor is blaming the patient, such as lack of compliance, make the doctor be very explicit on the record so you can prepare for trial.

Identify potential witnesses. Cases often go in different directions than originally conceived, so it is important to identify people, documents and items in the event they are needed in the future. Even after many years of reading hospital records, it is still often difficult to identify everyone who was involved in treating the patient during critical periods, so ask the witness to identify every name in the record that he can. Make certain that you have a clear picture of how the unit (hospital cases) was set up and run, and who was in charge.

Evaluate the witness.

Will the witness favorably impress the jury? How credible was the witness? Will he hold up under cross-examination? Is he professional appearing, so that you will have to deal with this at the time of trial and particularly in jury selection: even good doctors make mistakes some times.

Bad techniques:

Asking long, complicated questions and arguing with witnesses is always a mistake. As an exercise, sit in on a trial and listen to most lawyers ask questions of a witness; lawyers cannot help but ask long, complicated, and compound questions. Not resolving ambiguous answers is probably the greatest omission in medical depositions, due in part because the examiner does not appreciate they have just been given an ambiguous answer and medicine, inherently, can almost always be made to sound ambiguous. Not asking follow-up questions, which is similar, but more pervasive in medical depositions. Follow-up questions to answers are usually more important than the original question. You must listen carefully to the witnesses' response for clues to the next follow-up question. Always try to find out from where the witness got the information. It is not enough to find out "what happened," always try to find out "why" it happened. (Even though lawyers may not be interested in motive, jurors almost always are)

Types of questions:

Information gathering questions are the principal type of question used at a medical deposition. The form is usually: open ended questions; clarifying questions and closing off questions (Is there anything else? Have you now told me everything you know about the incident?).

Questions seeking admissions are important. Hypothetical questions are permitted. In *Bubar v. Brodman*, supra, the court specially found hypothetical questions proper. Obviously, the hypothetical must be accurate, and, hopefully, contain facts about which there is no real dispute. Asking a witness if the facts were otherwise, that is different than what he stated they were (and were as the plaintiff testified they were) would that change his opinion, can be very effective in many cases.

Chronological Questioning Versus Skipping Around:

The leapfrog method may keep the witness off guard, but may cause the witness to close down. You still need to follow up with questions, so the advantage of surprise may be lost after the first question. This method is also difficult to keep track of topics. Starting off a deposition with the "ultimate question of the case" can sometimes be effective before the doctor has settled into his comfort zone. In a failure to timely diagnose cancer case, I might ask early on whether the cancer was "present" during the time the doctor was treating the patient. There is a difference between whether a cancer was present (i.e. on a cellular level) and whether it was clinically detectable at the time. I want to at least eliminate or know the doctor's opinion on that critical issue.

Other Techniques:

Do not ask questions in the negative; a yes or no response is almost always ambiguous. Pause after important questions; it encourages the witness to keep talking. Look at the witness as if to suggest: “Is there anything else?”

Always ask questions that the witness can answer clearly. Many questions are phrased so poorly that the answer can be ambiguous. Separate facts from opinions. If a doctor renders an opinion, always ask the basis of the opinion and whether there is any support in the medical literature for the proposition (a work around the *Ithier* case rule). If an admission is obtained, move on, do not give the witness an opportunity to clarify (care must be taken not to loose a fragile admission).

When the attorney representing the doctor makes an objection, I always keep in mind that the lawyer is representing a professional client and must never be made to look bad in front the client, unless really necessary. It is usually best to consider that maybe there is something wrong with the form of the question, which is more often than not easily fixable. When in doubt, go back several steps and build up to the question, using simple, non-controversial questions, to get you back to where you want to be.

General Questions:

Education and credentials, such as Board Certification and re-certification, are good warm up questions, but this information is readily available before the

deposition. I often ask about subjects covered on the certification examination, particularly where there is an issue of a different area of medicine involved, such as an internist being able to do a basic neurological examination. It may be important when the doctor claims to not know what the current literature is saying about a subject, such as the significance of “age adjusted” PSA where the value was normal for a 70-year-old male, but abnormal for a 50-year-old male.

Hospital affiliations and positions held, including any Boards responsible for formulating rules of conduct and standards of care should be explored. Have the witness describe staff privileges and the responsibility to follow the rules of the hospital. Any contracts between the witness, his group and the hospital (particularly important in emergency room cases and imaging cases, where the doctor may actually work for a sub contractor) should be questioned. Any published rules and regulations of the hospital, and whether he has ever bothered to read them. Although doctors will concede that there are hospital rules and regulations concerning physician conduct, very few of them have ever read them, which can be significant to some jurors. Any licensing suspensions should also be inquired about. Publications should always be explored for topic matter.

Whether the doctor has an “independent” recollection of the case, or is merely testifying from the records, is always essential to know. This often leads to many responses based upon the doctor’s “custom and practice” which is usually permitted at trial with the barest of foundation testimony. If the witness has no recollection of the events, however, it certainly gives the patient the upper

hand in any disputes involving conversations or events not in the records.

Differential Diagnosis Method:

The best tool available to plaintiffs in a clinical case is the proper use of the differential diagnosis method line of questioning. The method has been the foundation of clinical medicine for over 100 years, and has been taught to every medical student, PA and nurse, usually during the first year of his or her schooling.

Every witness will agree with the fundamentals:

1. Collect data or information (history, labs, imaging, etc.)

2. List the most likely causes of the patient's condition.

3. Prioritize those potential causes, which pose the greatest potential of harm to the patient.

4. Rule out or rule in all of these causes, giving first priority to those conditions that pose the greatest risk of harm to the patient.

Doctors are never permitted to guess or assume that the problem is caused by one condition without first ruling out all other potential causes. If the condition which ultimately turned out to be the case should have been on the

doctor's differential diagnosis list, but was not at the time of treatment, the questioning must establish that it should have been, and why it was not. I always ask first about the method, then about the symptoms and whether a particular "cause, i.e. disease" should be in the differential. Or, is something, like loss of consciousness, "consistent with" stroke or TIA, as a general proposition. At trial, I will have a blow up, or computer slide, of all the agreed upon symptoms either testified to by plaintiff or charted, and why the differential diagnosis should have included the condition I claim was over looked.

Opinion questions are the essence of a proper medical malpractice deposition. Ask as many opinion questions as you can think up. Always be sensitive to opinion versus fact answers. Ask how certain are you of this opinion. Ask what is the basis of your opinion and who else supports your opinion. If it is common practice, then it must be in the literature somewhere. Doctors are prepped to give as few opinion answers as possible so they can stay flexible for trial, so ask away at the deposition.

Complications

Many surgical malpractice cases involve "complications" of the procedure. Often found in the medical literature as a complication, more often than not there is no discussion or distinction between "avoidable and non-avoidable" complications. Always attempt to "quantify" the complication rate, such as it occurs in one percent of the cases, and why is this case one of those. Always ask if the "complication" was discussed with the patient before the procedure,

and if not, why not. Ask what could have been done to “predict” the complication or avoid it. Also ask if this complication has ever occurred with the doctor’s other patients.

Cognitive Errors

Most mistakes made by doctors are not technical errors, but mistakes in thinking. Having taken over a thousand medical depositions, I have seen first hand just how often doctors use heuristics, medical short cuts, when treating patients. Pattern recognition is critically influenced by the physician’s visual appraisal. If the patient does not look that sick, the doctor thinks that he probably isn’t, and an error in diagnosis occurs. Relying too heavily on intuition, as many doctors do, puts patients at risk. Why doctors make mistakes in diagnosis has been studied by the medical profession, and is often the subject at continuing medical education seminars. Cognitive bias, present in all of us, often is the cause of errors in diagnosis.

There are many common biases that occur frequently in the practice of medicine that put patients at risk. Confirmation bias occurs often. Doctors confirm what they expect to find by selectively accepting or ignoring information. The doctor’s initial diagnosis is often reinforced by his selective survey of diagnostic data. Anchoring, where a doctor arrives at a diagnosis, throws down his anchor, and fails to consider other reasonable possibilities. Availability bias, where a doctor has seen multiple patients that week with the flue, it is only reasonable to assume that the next patient who doesn’t feel well also has the flue, without

exploring other possibilities. There are many more biases that contribute to doctors overlooking clues about other problems. Diagnosis momentum is a common bias seen in malpractice cases. Once a particular diagnosis is fixed on a patient, it is passed on to next doctor who often fails to evaluate the patient completely. The symptoms of a disease can change from day to day, and if a physician fails to evaluate the patient daily with unbiased eyes, patients can be hurt.

When I conduct depositions, where appropriate, I ask questions concerning biases. This always elicits an objection; I suspect because most defense attorneys reflexively object to any line of questioning that they are unaccustomed to hearing. Where I have had to get rulings, most judges have permitted me to ask the questions, particularly when I explain the basis for asking the line of questions. The medical profession knows that cognitive bias causes many errors in diagnosis. It is time that this subject be explored in depositions as a valid reason, although flawed, why a correct diagnosis was not made.

Causation

Rule out as many other causes as possible, leaving only a few to deal with. Always determine the basis for the causation opinion. Ask about alternative causation after the witness has volunteered his opinion. Push as far as possible to use the witness to establish damages, such as what medical care the patient will need in the future, what the future holds, such as an organ transplant, etc.

Medical Records and Proper Documentation

Proper documentation is always required by the rules of the hospital, as well as custom and practice. Other health care professions rely on proper records to treat patients (a good question). And most important, the rule is designed for the safety of the patient more than for the benefit of the author. What should be documented, such as all positive findings, should always be established at the deposition. If not documented, how can the witness be certain that it was done?

Have the witness read and interpret all medical records: always ask what something means, even if you know what it means. It is critical to know exactly what is in the chart, even at the expense of looking unprepared (in this day and age, there is very little excuse for not being able to interpret the various medical abbreviations used in charts; the handwriting, on the other hand, is another story.)

Relationship to and Role in the Management of the Patient:

Establish the witness's role in the management of the patient and how inter-related all the various specialist's treatments were to the overall management of the patient. Establish who was responsible for the patient's care at particular times during the hospitalization. Now that we live in an era of more and more medical specialization, where doctors know more and more about less and less, the roles of various specialists treating the patient often becomes blurred when there is a complication. Responsibility is particularly important when it comes to follow-up of indicated imaging studies or other evaluations. Where

there are numerous specialists involved in managing a patient, as is often the case during a complicated hospitalization, most communication between the treating physicians about the patient's care takes place through the notes in the hospital record. It is important, where one specialist is relying on the notes of another specialist to formulate a treatment plan for the patient, that the witness be questioned concerning not only the content of the other notes, but the substance of the other notes. Specialists must have some knowledge of other specialties in order to properly treat the patient.

Patient Noncompliance:

Doctor's are trained, and know from personal experience, that many patients do not always follow their directions. It is the responsibility of the doctor to insure that the patient is sufficiently well informed of the importance of, say, a study, consult, or medication, and what is at risk if the patient does not wish to proceed as requested. Equally, it is the doctor's responsibility to continue to reinforce the importance of the request, even though it is the patient's decision as to whether to comply or not. The doctor should be questioned as to why he sent the patient for a consult, whether it was important for patient safety, and what procedures were in place to insure the consultant's report was received. This is an ongoing responsibility, which obviously requires reading prior chart entries, a habit not often employed in modern medicine. If it was important enough to send a patient for an indicated study, it is important enough to follow up to see if the patient went for the study. The medical profession, at least a large percentage of the, do not follow up on such things.

Motive:

Although not legally necessary, most jurors find motive critical in deciding close medical cases. Always attempt to develop facts to permit your version of the motive to be argued to the jury, since it is the rare case when the defendant will honestly testify to the real story. Question about the number of patients seen the day in question, activities before and after the event or any other area to demonstrate the lack of attention to the problem. I have had a number of cases involving a doctor leaving to go home before the patient is taken care of or the results of a study available: always an important jury issue.

Imaging Studies:

Always have the doctor actually review the imaging study at the deposition; do not rely strictly on the report in the chart. In the old days you generally had to bring a shadow box with you. Now, all imaging studies are digitized, come on disc and can be displayed on a computer. Determine if the impression is still the same today as it was back then, or whether the witness's opinion has changed; if so, why? The differential diagnosis method applies, even in the field of radiology. Radiologist, however, frequently do not document the "cause" of the finding, only that something is present, and then it is up to the clinician to make that decision. In radiology, observation and perception are critical skills: first, did the radiologist see anything abnormal, and secondly, could he determine what it was?

Billing Records:

Billing records can be a valuable source of information. “Super bills” used for billing purposes frequently are at variance to the office records in terms of what is charted and how they billed. Jurors are often shocked by what doctors bill for and claim they have done to justify such billing. Doctors have developed methods of billing to overcome managed care, which sometimes creates issues as to how extensive the examinations actually were.

Electronic Records:

Most hospital and many office records are now electronic. If there is an issue concerning when an imaging study report was in the computer or chart, it is good to serve a Notice for D & I to obtain the audit log for the medical record. This log is federally mandated, and contains a great deal of information, including when a doctor entered the computer to look at the patient’s chart. Many medical records also use electronic templates, where if the doctor does not affirmatively make a selection, the test is recorded as within normal limits, even when the doctor did not test for it. Make certain to identify the program used and how the default settings function.

Post EBT:

Always dictate a memo as to what kind of impression the witness will make at trial. When the deposition transcript arrives in about a month, review it as soon as possible, while things are still relatively fresh in your mind; think of additional questions that you should have asked (this is the only way to really learn and improve). Start developing your cross examination for trial. Review you

wording and try to simplify, not only your vocabulary but the technical issues in the case.

Non-Party Depositions of Doctors:

Generally, depositions of a treating physician are not permitted by the defendant (*Patterson v. St. Francis Center*, 249 AD2d 457 (2nd Dept. 1998), while the plaintiff can always depose his own treating doctor. There are a few exceptions: special circumstances or exclusive knowledge of the fact (*220-52 Associates v. Edelman*, 241 AD2d 365 (1st Dept. 1997). If plaintiff's version of the accident differs from the history in a treating doctor's office records, a factual deposition may be permitted (*Schroder v. Consolidated Edison Co.*, 249 AD2d 69 (1st Dept. 1998). There are no expert opinions permitted at such depositions. In *People ex rel. Kraushaar Broos. & Co. v. Thorpe*, 296 NY 223 (1947) it was noted: "the rule in England holding that an expert witness cannot be compelled to give expert testimony but may contract to do so for an adequate consideration, "was also the rule in New York; it is still the rule. An examiner cannot compel a non-party expert to answer questions, which seek expert opinion; he may only ask "fact" questions (*Fristrom v. Peekskill Cnty. Hosp*., 239 AD2d 315 (2d Dept. 1997); *Piervinanzi v Bronx Cross County Medical Group,* 244 A.D.2d 396 (2nd Dept. 1997); *Jones v. Cummings,* 55 A.D.3d 677 (2nd Dept. 2008).

In practice, however, the line between permissible factual testimony and impermissible expert opinion testimony is not always clear. In *Horowitz v Upjohn Co.*, 149 AD2d 467 (2nd Dept 1989) the trial judge had made a prospective ruling

concerning the scope of the deposition of the non-party, partner, and physician. There the Court held: Moreover, the witness, in his capacity as a physician, may possess knowledge of discoverable facts which goes beyond that which is derived from his direct contact with the infant plaintiff's mother. The Supreme Court therefore improvidently exercised its discretion when it, in effect, prospectively limited the scope of examination to the witness's treatment of the infant plaintiff's mother.

Silent No More: CPLR 3113(c)

In an interesting case, which changed things up for a number of years, held that counsel for a non-party physicians-witness was precluded from objecting during or otherwise participating in his client's videotaped deposition. (*Thompson v. Mather*, 70 A.D.3d 1436 (4th Dept. 2010). The court reasoned that CPLR 3113(c) provides that the examination and cross-examination of deposition witnesses "shall proceed as permitted in the trial of actions in open court." Clearly, the witness's attorney would not be permitted to object to questions posed at the time of trial. This twist has been straightened out by a recent amendment to CPLR 313(c), which now reads:

> "Examination and cross-examination of deponents shall proceed as permitted in the trial of actions in open court, except that a non-party deponent's counsel may participate in the deposition and make objections on behalf of his or her client in the same manner as counsel for a party. When the deposition of a party is taken at the instance of an adverse party, the deponent may be cross-

examined by his or her own attorney. Cross-examination need not be limited to the subject matter of the examination in chief."

An interesting issue arises when a nonparty witness subpoena is served on a former employee of one of the parties. In *Rivera v. Lutheran Medical Center*, 73 A.D.3d 891 (2nd Dept 2010), the attorneys for defendant contacted former employee witnesses and advised them that they would represent them, without fee, in pending nonparty depositions. Most of the witnesses were not in a position to bind Lutheran (see*, Neisig v. Team I*, 76 N.Y.2d 363 (1990). There, the Court disapproved of the attorneys "soliciting" the clients, in violation of Rules of Professional Conduct, 22 NYCRR 1200, Rule 7.3, and disqualified the firm from representing the witnesses. The Court held that the law firm was attempting to get a tactical advantage to prevent informal interviews of the employees by representing them, without fee.

The New Rules (2006)

After years of abusive deposition practice, the Courts finally stepped in to make the basic deposition rules clear. Many of the cases cited for abuse by the Courts through the years involved medical depositions. By Administrative Order of the Chief Administrative Judge of the Courts, a new Part 221 of the Uniform Rules for the Trial Courts relating to the conduct of depositions became effective October 1, 2006. Although most issues that arise during a deposition are not appealable as a matter of right, the scarcity of reported cases since the enactment of the new rules may actually be an indication that the rules are

working.

There are three rules, which apply in all courts. Objections at depositions (221.1); Refusal to answer when objections made (221.2); Communication with the deponent (221.3). The new rules merely codify the prior law on the subject, except that it inverts the CPLR rule and directs lawyers and their clients to answer all of the questions they are asked, so that beyond the protection that the CPLR provides (objections are not waived), objections cannot be raised at all in the depositions, except in certain, circumscribed situations. Unfortunately, there are no specific sanctions set forth in the new rules, although there have been a limited number of cases where sanctions were imposed by the trial courts.

221.1 Objections at Depositions:

Objections in General: no objections shall be made at a deposition except those which, pursuant to subdivision (b), (c), (d) all of Rule 3115 of the CPLR would be waived if not interposed, and except in compliance with subdivision (a) of such rule. All objections made at a deposition shall be noted by the officer before whom the deposition is taken, and the answer shall be given at the deposition shall proceed subject to the objections and to the right of a person to apply for appropriate relief pursuant to Article 31 of the CPLR.

Speaking objections restricted: every objection raised during a deposition shall be stated **succinctly** and framed so as not to suggest an answer to the deponent and, at the **request** of the questioning attorney, shall include a **clear statement** as to any defect in form or other basis of error or a regularity. Except

to the extent permitted by CPLR §3115 or by this rule, during the course of the examination, persons in attendance shall not make statements or comments that interfere with the questioning.

221.2 Refusal to answer when objection is made:

A deponent shall answer all questions at a deposition, except (I) to preserve a privilege or right of confidentiality, (ii) to enforce a limitation set forth in an order by the court, or (iii) when the question is ***plainly improper*** and would, if answered, cause ***significant prejudice*** to any person. An attorney shall not direct a deponent not to answer except as provided in CPLR Rule 3115 or this subdivision. Any refusal to answer or direction not to answer shall be accompanied by a succinct and clear statement of the basis therefor. If the deponent does not answer a question, examining party shall have the right to complete the remainder of the deposition. This section has not been interpreted by the Courts yet, and its import is less than clear. Plainly improper is certainly subject to perspective. In a false arrest case, the police officer was not permitted to be questioned concerning his marital status was deemed to be “palpably improper.” Significant prejudice: what does that mean? There are few, if any cases giving any clear direction to attorneys on this point. Remember, all questions that may be irrelevant must be answered and the objection is preserved for trial.

221.3 Communication with the deponent.

An attorney shall not interrupt the deposition for the purpose of

communicating with deponent unless all parties consent or the communication is made for the purpose of determining whether the question should not be answered on the grounds set forth in section 221.2 of these rules and, in such event, the reason for the communication shall be stated for the record succinctly and clearly.

Improper Questions, Objections and Directions Not To Answer

Interposing and responding to objections are skills that take time and practice to master. There is a fair amount of disagreement over what constitutes a proper objection under particular circumstances, and what effect interposing an objection has on the witness's obligation to answer the question. Many of the old cases, which pre-date the new Uniform Rules, are arguably no longer good law.

Questions may be improper as to the form of the question itself or as to the substance of the testimony the question seeks to elicit. Misleading, argumentative, ambiguous or multiple questions are improper as to form. Objections as to form are generally waived unless made when the question is asked.

CPLR §3115: allows objections to be raised at trial to the use of any part of a deposition just "as if the witness were then present and testifying. Preserves the right to make general, substantive objections, even where the court has previously ruled that the question must be answered at the deposition. Objection may be raised even though not made at the deposition. Hearsay is probably the best example.

"Unless a question is clearly violative of the witness' constitutional rights, or some privilege recognized in law, or is palpably irrelevant, questions should be freely permitted and answered, since all objections other than as to form are preserved for the trial and may be raised at that time." (*Freedo Prods. v. New York Tel. Co.*, 47 AD2d 654 (2nd Dept 1975)-so you see, the "New Rules" really are not so new). Under the old law, there was no need to answer palpably or grossly irrelevant questions (*Ferraro v. New York Telephone Co.*, 94 AD2d 784, 785 (2nd Dept. 1983)-probably still good law, but where do you draw the line? Is there a distinction between "plainly improper" and "palpably or grossly irrelevant?"

There are many easily recognizable improper objections: Improper speaking objections, such as: "If you know"-suggests to the witness to respond: "I don't know". This happens all the time in medical depositions, even with the new rules. Objections designed to coach the witness. Objections to impede or break up the questioning. Objections designed to harass or embarrass the questioning attorney. *Simmons v. Minerly*, NYLJ, Sept. 25, 2007, p. 29, col. 1 (Sup. Ct. Dutchess Co.) Imposed a $2,500 fine on attorney who repeatedly directed his witness not to testify at a deposition.

Raising Objections that must be made at Deposition:

CPLR § 3115(b) provides that errors in the form of questions or answers, and other errors that might be obviated if objections were promptly made, are

waived. These objections should be made promptly, before the answer. The questioner then has a choice: reformulating the question or standing by the question and demanding an answer. It is crystal clear, however, if the questioner stands on his question, it must be answered. There are several other grounds that must be raised at the time of the taking of the deposition: Qualifications of person before whom deposition taken, and competency of witness. Failure to object to unresponsive answers at the deposition, which would have permitted the objection to be cured with a proper answer, may result in the admission of the otherwise objectionable testimony (*Saturno v. Yanow,* 58 AD2d 968 (4th Dept 1977).

Objections to the "form" of the question usually involve one of these situations: compound questions, ambiguous or vague questions, confusing or unintelligible questions, argumentative, repetitive or asked and answered questions, assumes facts not in evidence, misstates facts, excessive broad.

Privileged communication is waived unless objection is timely made during the deposition (*Riccardi v. Tampax, Inc.*, 113 AD2d 880 (2nd Dept. 1985). The same is true of attorney work product.

Examples of Questions Permitted and Improper Direction to Not Answer

These questions were permitted of a doctor at deposition (*Palmeri v. Island Medical Care, P.C.*, 2002 WL 1677701 (Sup. Ct. Suffolk Co., 2002)

concerning testimony in prior malpractice cases as an expert, deposition testimony in the past, and courtroom testimony in the past.

In *Lewis v. Brunswick Hospital*, 2001 N.Y. Slip Op. 30021 (Sup. Ct. Queens County, 2001) the following exchange was deemed to be obstructive of the questioning of the defendant-radiologist. The case involved an alleged mis-diagnosis of a cerebral aneurysm. The witness was being questioned about his reading and interpretation of a cerebral arteriogram. The following are some of the sampled objections (there were many more, I have only selected a few.)

Q: "Doctor, if an arteriogram is misread would you agree that is a departure of accepted standards of radiology practice?

Attorney: I direct the witness not to answer the question.

Q: "what did you review before coming here today?"

A: "I was coached by Maddie Hirschhorn on how to answer questions; not to give you too much information."

Q: Did you see an aneurysm present?"

Attorney: "Objection"

Q: "Doctor, did it indicate to you, what I just read, "angio to be done today and pending same patient would be a candidate for craniotomy the patient has accessible aneurysm," did I read that correctly from the record?"

A: "Yes"

Q: “What does that mean?”

Objection: “I am going to object. He is a radiologist. He would not be one that would make the decision based on the aneurysm and any— based on the study and in the other information that a neurosurgeon would take into consideration. He is not able to answer that question based on his specialty and under Carvalho I am certainly not going to let him postulate as to what he thinks a physician in another field would have done with the information available to that physician at the time he made a decision.”

Q: “Doctor, do you have an opinion whether or not cerebral aneurysm can be cured in patients?”

Objection: “That is over broad”

Q: “Was there any type of urgency on 4/10/92 to evaluate these arterial studies of the surgeons who might be waiting to perform surgery on the patient?’

Objection: “Again, I’m going to object to this broad, speculative situation where you are asking him to answer for any and all situations. I am directing him not to answer. It calls for speculation.”

Q: “Will you allow him to look at any of the films with the assistance of a shadow box to see if this is still his opinion today?”

Attorney: “I will not.”

Difficult Witnesses:

Keep asking the question until you get an appropriate response. Do not accept half answers, evasive answers or answers to a different question. Always be sensitive to ambiguous answers. Be a “critical listener.”

If witness does not know or cannot remember, ask: “Did you once know the answer?” “Did you tell anyone?” “Are there any documents that might help you remember?” “Do you understand that if you find the answer that you are under an obligation to bring it to our attention?”

Challenge conclusions and inferences. Ask for the basis or source of the information. Do not accept “I do not know” answers unless it helps your case. A series of “I don’t know” answers is certainly better than a direct contradiction, particularly if there are other favorable witnesses who do know. Attempt to string a series of “I don’t know answers together.” When read, one after another at trial, it can have a significant impact. Is there someone who does know the answer to this question? Are there any documents that you could review that would help you to answer the question? Where would you look to find the answer?

Conclusion:

Medical malpractice depositions are clearly challenging, but at the same time much more comprehensive than other personal injury depositions. Now that the New Rules have leveled the playing field and the examining attorney has greater latitude to seek answers to the relevant issues in the case, medical malpractice depositions are the single most important discovery device available to insure a proper and just result. There are very few experiences more satisfying

to a medical malpractice attorney than saying, “No further questions,” and meaning it, knowing that you have done a good job.