PREPARATION AND DEFENSE OF THE MEDICAL PROVIDER AT DEPOSITION

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Introduction:

This article will provide information that will assist in understanding the complexities of the defendant medical provider deposition and provide helpful guidelines for the attorney to prepare for the deposition, as well as how to prepare the client to successfully survive the deposition relatively unscathed.

From the plaintiff's perspective, the deposition of the defendant medical provider may be the single most important event in the medical malpractice lawsuit. The defendants' deposition provides plaintiff's counsel the opportunity to assess the credibility of the defendant. Not only is the medical provider's appearance important but as well his or her responsiveness to questions and overall demeanor. In addition, plaintiff's counsel will attempt to uncover all relevant facts, identify potentially other admissible evidence and perhaps most importantly, pin the medical provider down to a position he cannot later squirm out of at trial. Indeed, a medical malpractice trial can be won or lost at the deposition.

Preparation:

The defendant deposition must be considered a critical moment in the life of a lawsuit. The defendant's performance at that deposition will go a long way towards counsel and ultimately the insurer deciding whether this is a case best settled or taken to trial.

Statistically speaking a medical provider, depending on specialty, can expect to be sued at least once in his or her career. [1] Notwithstanding that, a deposition for the average medical provider is a frightening affair. The medical provider will rely upon counsel to prepare him/her in such a way that the actual deposition proceeds less rigorously than does the prep. In my experience, clients often tell me after the deposition that they expected worse. Preparation therefore goes a

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[1] New England Journal of Medicine – **Malpractice Risk According to Physician Specialty – 2011**

Method: We analyzed malpractice data from 1991 through 2005 for all physicians who were covered by a large professional liability insurer with a nationwide client base (40,916 physicians and 233,738 physician-years of coverage). For 25 specialties, we reported the proportion of physicians who had malpractice claims in a year, the proportion of claims leading to an indemnity payment (compensation paid to a plaintiff), and the size of indemnity payments. We estimated the cumulative risk of ever being sued among physicians in high- and low-risk specialties.

Results: Each year during the study period, 7.4% of all physicians had a malpractice claim, with 1.6% having a claim leading to a payment (i.e., 78% of all claims did not result in payments to claimants). The proportion of physicians facing a claim each year ranged from 19.1% in neurosurgery, 18.9% in thoracic–cardiovascular surgery, and 15.3% in general surgery to 5.2% in family medicine, 3.1% in pediatrics, and 2.6% in psychiatry. The mean indemnity payment was $274,887, and the median was $111,749. Mean payments ranged from $117,832 for dermatology to $520,923 for pediatrics. It was estimated that by the age of 65 years, 75% of physicians in low-risk specialties had faced a malpractice claim, as compared with 99% of physicians in high-risk specialties.

long way to reducing the medical provider's anxiety about the process in the first place and should ultimately expose the medical provider to the potential weaknesses and pitfalls of his/her defense.

In order to best accomplish this, counsel must be well prepared prior to undertaking to prepare the medical provider to give testimony. It is strongly advised that every available medical record and other relevant documents be obtained via the discovery process well in advance of a medical provider's deposition. Counsel is mandated to have read every line on every page of every medical record. With the advent of electronic medical records, these are becoming easier to decipher but virtually all hospitals in the Metropolitan area still maintain a hybrid record, which is a combination of electronic and handwritten entries. Every note on every page that has been handwritten must be deciphered. In addition, if your client's notes are poorly written or indecipherable, it is incumbent upon counsel to obtain a typed written transcription of same to insure that you have an accurate and clear understanding of the medical provider's documentation.

It goes without saying that most attorneys who practice in the medical malpractice arena have a wealth of medical knowledge, the science of medicine is constantly evolving and changing. Thus, it is incumbent upon counsel to not only be familiar with what the state of science was at the time the care was rendered but as well what the present state of medicine is. I strongly recommend utilizing search engines such as mdconsult.com, Lexis Medical Malpractice Navigator or Google Scholar. The carrier paying your bill should not hesitate to reimburse you for your time spent reviewing all of the relevant medical literature. I do caution that the results of your research should not be shared with your medical provider except in the most general terms. (This topic will be covered in the Refreshed Recollection section below).

Once counsel has fully familiarized himself/herself with the medical records, the patient's history and relevant medical research, counsel is half way there to being ready to actually meet with the client.

Next, you must acquaint yourself with your client. Begin by reviewing any interviews that the insurance company may have conducted at the onset of the litigation. I strongly recommend a social media search, as well as Google search utilizing your client's full name and variations to ascertain what is out there on the worldwide web. Additionally, each medical provider in New York is mandated to maintain a "doctor profile" www.nydoctorprofile.com, which is supposed to be updated by a licensee no later than six months prior to renewing the license. In New York, this occurs every two years. That profile should provide an up to date list of education, board certifications, publications and most importantly, any disciplinary proceedings. Do not rely on your client to advise you as to whether or not they have ever had a license or privilege problem prior to meeting you. It is incumbent on you to know that. You can be sure that plaintiff's counsel will have undertaken that search and will be loaded for bear at the deposition if there is any such relevant information.

If your client has published literature, undertake to obtain everything he/she has written. I recommend uncovering not only peer reviewed journal articles but any chapter texts or even articles written for the popular media. It goes without saying that anything that the medical provider himself/herself has written begins to encroach into the realm of "authoritative texts". (That phrase will be explored in the Refreshed Recollection section below.)

Importantly, in this day and age virtually every medical provider or medical practice has its own website. Familiarize yourself with that website. It is rare but not unheard of that there may be a website that your client may not even know he or she has. Services such as Health Grades will create at least a cursory or rudimentary type information page for patients searching for medical providers. Anything in writing on that website that speaks to healthcare in general or heaven forbid more specifically the facts at issue in the instant lawsuit, is potentially fair game for questioning.

Preparation of the Medical provider:

An important factor to consider when preparing the medical provider is the timing and location of the pre-deposition conference or meeting. Medical providers are very busy people and generally don't like to leave their office for extended periods of time. It is strongly recommended that the pre-deposition conference occur in the medical provider's office only as a last resort. Generally, a medical malpractice case generates a voluminous amount of paper records which are difficult to transport to a medical provider's office. Have you seen a medical provider's office lately? It is usually cramped and jammed packed with records and the like, leaving very little work space available to spread out the medical record. Additionally, the medical provider will be interrupted repeatedly by support staff and phone calls. These are distractions which ultimately take away from an effective pre-deposition conference.

Thus, insist that the medical provider travel to your office where a conference can take place in the quiet and comfort of a conference room with a large table. Similarly, preparing the medical provider in the same room the deposition will take place may reduce the anxiety associated with it as you can point out where each party will sit as well as where the court reporter will be located as your client acclimates himself/herself to the room.

It is generally recommended that the pre-deposition meeting take place on a separate day than the actual deposition. Sometimes medical providers' schedules are such that this cannot be accomplished but it should be avoided.

How often to meet with the medical provider depends on a number of factors. In a simple and straightforward case, one pre-deposition conference of several hours duration may be sufficient. The complexity of the case, the medical provider's level of anxiety, the medical provider's ability to communicate and the medical provider's understanding of the relevant issues all militate towards more than one pre-deposition conference.

The structure of the pre-deposition conference can be free form but various goals must be accomplished. Counsel and the medical provider must discuss in general terms the relevant medicine and science and more specifically how the state of knowledge at the time of the malpractice affected the patient's care and treatment and ultimate outcome. The medical provider should review with you all of his/her notes to insure that they can read them without undue anxiety. If he or she cared for the patient in the hospital, each page of that hospital record, including laboratory values, medical provider's orders, medication administration records and the like should be reviewed. The purpose for that review is not only to locate the medical provider's handwriting in various places but as well to identify potential pitfalls that these records might create. For instance, an order may have been entered electronically and attributed to your client without his knowledge. This is typically the case in a teaching hospital where

medical providers in training are authorized to enter orders on behalf of the supervising attending medical provider.

Counsel should review with the medical provider his training, education and experience. That review should be guided by whatever your Google search uncovered in your preparation for the process and as well include a review of the medical provider's most current curriculum vitae. Obviously, gaps or a checkered past must be explored and explained.

The medical provider's independent recollection should be thoroughly probed as well as any refreshed recollection that might have occurred by virtue of the preparation process. Then a general discussion about the usual outline of the deposition should take place before more specifically focusing in on the problem areas, including hypothetical questions, expert opinion questions and causation questions.

Usual Admonitions:

Invariably counsel should instruct a client to never guess or speculate. Some medical providers have a tendency to want to help the questioner and hence may volunteer more information than the question actually required. The witness should be admonished not to go beyond the question asked. I generally compare the question and answer process to a key and lock metaphor. If the proper key is not placed into the lock the door won't open. Thus, my witnesses are strongly cautioned to listen very carefully to the question and insure that they understand it fully before answering it. If the witnesses first reaction to the question is to ask a clarifying question such as: Are you saying…? Do you mean….?, then that is a question that is not completely understood. The medical provider should not answer that question but should instead respond that he/she does not understand the question and thus cannot answer it.

Although the deposition is a wonderful opportunity for the defendant medical provider to showcase his medical knowledge and superior intellect, sometimes the best answers are "yes", "no", "I don't know" or "I don't recall". The witness should be encouraged to not consider the deposition a memory test where they are obligated to know the answer. The witness should only respond based on his/her independent recollection, documentation or recollection of relevant custom and practice. The witness should also be cautioned not to fall for the estimating traps of time and distance.

An "I don't recall" answer is perfectly appropriate but I do spend significant time talking about recollection in the pre-deposition conference. I remind the medical provider that the patient recalls every detail of what may have been a life altering event, such as a botched surgery or a misdiagnosis of cancer. At trial, the patient's recollection of crucial facts is frequently contrasted with the medical provider's utter lack of any recollection whatsoever. When a medical provider cannot recall anything it allows plaintiff's counsel to portray that medical provider as either uncaring or mercenary as "he/she has cared for perhaps thousands of patients since he destroyed the plaintiff's life." Thus, much time should be spent probing the medical provider's recollection about the patient or the care rendered. Perhaps the medical provider can remember the plaintiff as a nice person, or the wife as being friendly and concerned. Anything to humanize the medical provider goes a long way towards succeeding at trial. Of course, the medical provider must be admonished in every instance to testify truthfully, whether it hurts or helps.

Objections:

The Uniform Court Rules pertaining to depositions will be discussed below. However, it is important to warn the medical provider that there may be objections stated after the question and before the medical provider answers. To that extent, the medical provider is instructed to wait to answer the question until counsel has clearly stated his objection and stated a succinct reason before undertaking to answer the question. The medical provider is also advised that the deposition itself might become heated and contentious. The medical provider should not be distracted by the behavior of counsel.

Likewise, the medical provider is instructed that he should not be uncomfortable in the deposition. Thus, if a bathroom break is needed it should be taken. If liquid refreshment is required, it should be obtained.

Recollection:

As previously touched upon, ideally if a medical provider has an independent recollection of his/her care and treatment of the patient he/she is in a good position to properly defend the care and treatment. Besides humanizing the experience by recollecting facts or even the plaintiff's physical appearance, being able to testify from a position of independent recall provides an indicia of reliability a jury can appreciate. Indeed, on more than one occasion, jurors have commented after a trial that they felt the medical provider was lying when he could only answer "I don't recall". Apparently, in common everyday experience, the lay public considers someone who does not recall as someone who is intentionally lying or attempting to cover up. Not only is the medical provider's testimony more reliable if he/she can recall some specifics about the care, his/her overall credibility is enhanced. As so much of the trial process turns more on nonverbal communication and inferences rather than direct evidence, a medical provider who can specifically testify as to recollection may well carry the day. Thus, in the pre-deposition conference counsel needs to spend significant time discussing the import of an independent recollection and as well attempting as best as possible to refresh the practitioner's recollections.

Recollection Refreshed:

While a failure to independently recall the patient or circumstances surrounding the care is not necessarily fatal to a successful defense, being able to articulate a practitioner's custom and practice at the time is the next best equivalent. The law is well settled in New York that evidence of habit is admissible to prove conformity on a specific occasion because "one who has demonstrated consistent response under given circumstances is more likely to repeat that response when the circumstances arise again." However, the applicability of the doctrine is generally limited to cases where proof demonstrates "a deliberate and repetitive practice by a person in complete control of the circumstances as opposed to conduct however frequent yet likely to vary from time to time depending upon the surrounding circumstances." Custom and practice testimony is generally applicable to cases involving routine procedures, including surgery, dentistry and other invasive procedures, as well as informed consent.

In Rivera v. Anilesh, 8 N.Y.3d 627 (2007 N.Y. Slip. Op 5134), the patient sued her dentist for a jaw infection related to an allegedly negligent anesthetic injection. The patient was to have a tooth removed. According to her, the dentist had to give a second injection of anesthesia which

caused extreme pain. After the extraction, the patient developed a fever, had pain in her mouth and experienced increased swelling in her face. She was eventually diagnosed with a severe infection in her jaw.

Plaintiff's expert testified that the second injection was wrongly administered. The Court of Appeals ultimately held that the record supported the admissibility of the dentist's routine procedure for administering injections of anesthesia in light of the frequency that she utilized the technique and the nature of the routine conduct. At her deposition, the defendant testified that the administration of the type of injection used in the case was a routine procedure that was performed every day on at least three to five patients. The dentist testified that she had been practicing since 1982. The care at issue was in 2000. She further testified that a second injection of anesthesia was required in 15% to 20% of her cases. At her deposition, she testified in detail about a step by step description of the injection procedure.

The trial court granted the defendant's summary judgment motion predicated on the defendant's deposition testimony and an expert who established that she had acted in accordance with generally accepted dental practices. Although the Appellate Division reversed, the Court of Appeals reinstated the dismissal. The Court of Appeals relied upon Halloran v. Virginia Chemicals, 41 N.Y.2d 386, 391, 361 N.E.2d 991, 393 N.Y.S.2d 341 (1977) which held that "evidence of habit has, since the days of the common law reports, generally been admissible to prove conformity on a specified occasion" because "one who was demonstrated a consistent response under given circumstances is more likely to repeat that response when the circumstances arise again." The Court of Appeals noted that the Appellate Division had generally adopted the proposition that normal documentation and notification protocols, routine warnings to patients and the process of undertaking certain non-invasive medical procedures can qualify as habit evidence. In contrast, the Appellate Division had generally deemed inadmissible evidence concerning a medical provider's surgical practices under the theory that every patient and surgery are necessarily unique and thus vary depending on the nature of the patient's medical condition and the actions of the medical provider. In the instant matter, the Court of Appeals was impressed that the defendant dentist had performed the same procedure in the same manner thousands of times.

Admissibility of custom and practice is generally well accepted in the informed consent realm. Informed consent is a transaction between the patient and medical provider where the medical provider advises the patient of the nature of the illness or injury, discusses reasonable options, discusses the risks, benefits and alternatives to those options and obtains the patient's written consent on a pre-printed consent form. Although the trend in the past decade has been for medical providers to be more detailed in their documentation of the actual transaction and specifically what risks and benefits were disclosed, inevitably it seems that the very injury which gives rise to the lawsuit was the only injury not enunciated in the written documentation confirming the transaction. Generally speaking, at the pre-deposition conference much time must be spent addressing informed consent. This should start with a brief review of what the Public Health Law Section 2805(d) requires with a focus on whether or not informed consent would be applicable to the instant facts. A separate cause of action alleging a lack of informed consent may have been interposed as well. Certainly, if the case involves surgery, an invasive procedure, chemo or radiation therapy, amongst other things, one can reasonably conclude that an informed consent should have been obtained. The medical provider defendant should be

drilled on his/her habit as to informing the patient as to all risks, benefits, and procedures and should further be prepared to testify that his note documenting the informed consent was never intended to be a verbatim recitation of the informed consent transaction but merely documents that the event took place. This permits the medical provider defendant to testify based on custom and practice that in fact the very risk that occurred herein was one discussed with the patient and family.

Opinion Questions:

In New York, plaintiff attorneys often ask the medical provider defendant opinion questions. The medical provider defendant is required to answer expert opinion questions and give answers about his/her medical opinions. See as illustrative Sagiv v. Gamache, 26 A.D.3d 368, 810 N.Y.S.2d 481 (2nd Dept. 2006). This interesting case did not specifically deal with opinion testimony but instead whether a plaintiff could serve a notice to admit as to the "ultimate question". Plaintiff's notice demanded that the defendant admit that the surgery performed by the defendant was a proximate cause of the plaintiff's injury. The Second Department affirmed the Supreme Court decision denying plaintiff's motion to compel an answer to that notice to admit. In a well-reasoned decision, the Second Department held that it is well settled that a plaintiff in a medical malpractice action may inquire during a deposition as to a defendant medical provider's expert opinion, citing McDermott v. Manhattan Eye, Ear & Throat Hospital, 15 N.Y.2d 20, 203 N.E.2d 469, 255 N.Y.S.2d 65 (1964). However, opinions could not be sought via a notice to admit.

Thus, a medical provider defendant should be prepared to answer causation questions at deposition as well as questions concerning generally accepted medical practice in the community. In Johnson v. New York City Health and Hospitals Corp., 49 A.D.2d 234; 374 N.Y.S.2d 343 (2nd Dept. 1975) the Second Department reversed the trial court's order denying plaintiff's motion to compel a medical provider to answer questions concerning the generally accepted medical practice in the community. In that case, the medical provider defendant was asked a series of questions relating to the procedures used in a surgical procedure. One of the questions was "Is it the usual custom and practice in the performance of a right hemicolectomy, to leave a twelve inch retractor in the abdomen?" The defense attorney objected to those questions and did not permit the medical provider to answer. Plaintiff moved for an order directing that the questions be answered. The Second Department considered whether the rule stated in McDermott v. Manhattan Eye, Ear & Throat Hospital, supra applied. McDermott was the first case to permit a plaintiff in a malpractice action to call a defendant medical provider to the stand at trial and to question him for the purpose of establishing the generally accepted medical practice in the community. In Johnson, the Second Department was invited to extend that rule to examinations before trial. The Second Department reasoned that McDermott established in effect a basic rule of evidence that would permit such questioning. The Second Department noted that since the evidentiary scope of an examination before trial is at least as broad as that applicable to the trial itself, it is obvious that every evidentiary expansion touching the trial touches the pre-trial deposition as well. In that light, the Second Department held that the McDermott rule would apply equally to trial testimony and deposition testimony.

Further, the Court noted that CPLR 3115 statutorily assures every deponent that any objections not raised at deposition are not waived and that even when the question is read, notwithstanding that it might have been answered without objection, the deposition is still subject to the test of its

admissibility at trial. This is designed to permit deposition questioning to roam "wide and far without constant punctilio exercised to exclude questions objectionable under the rules of evidence."

The Second Department did not stop its analysis there, noting that McDermott permits the plaintiff to question a defendant medical provider at trial and at deposition as to his factual knowledge of the case. The court concluded that he, if he is so qualified, is an expert for the purpose of establishing the generally accepted medical practice in the community.

Indeed, when preparing a witness for either deposition or trial, I emphasize that everything said under oath at deposition is admissible at trial absent some properly placed objection, and that a lay jury expects the defendant medical provider to be an expert in his own right. Thus, my pre-deposition conference always focuses on insuring that the defendant is fully conversant with the contents of his medical records, and any applicable hospital records, and conversant with the applicable medical science. I am sure the reader has experienced the sensation of the air being sucked out of the courtroom, when a medical provider is made to look foolhardy on the stand simply because he might not be able to define a medical term, or worse, read his/her own handwriting. Thus, knowing that your client can and will likely be questioned as an expert as to the medical facts and applicable standard of care, the pre-deposition conference focus must be precise when it comes to preparing for these issues.

Refreshing Recollection:

Anything that a defendant medical provider reviews in preparation for trial is discoverable by the plaintiff's attorney. Thus, as the attorney prepares for the pre-deposition conference, thought must be given to what the defendant medical provider will actually be permitted to review.

It is generally well accepted that the medical provider defendant should comprehensively review his/her office record, as well as all applicable medical records. I am always cautious when considering whether to permit the defendant to review the records of prior or subsequent treaters.

However, where a defendant medical provider testifies at pre-trial examination and used some writing to refresh his memory and bases his/her deposition testimony on that writing, any claim that the writing is privileged as having been prepared for litigation has been waived. See Rouse v. County of Greene, 115 A.D.2d 162; 495 N.Y.S.2d 496 (3rd Dept. 1985). In that case, plaintiff testified at her deposition that she had recently refreshed her recollection of the events surrounding the medical malpractice action by reviewing a diary her mother had kept at the direction of plaintiff's attorneys. The defendant medical provider moved to compel production of that diary. While the trial court denied the motion on the ground that the diary had been prepared for litigation, the Appellate Court compelled disclosure since any claim that it was privileged had been waived when the plaintiff used it to refresh her recollection. That rule applies not only to privileged material reviewed for a deposition, it has been extended to any situation where a defendant reviews any record regarding the decedent's treatment in preparation for his deposition. In Crawford v. Lahiri, 250 A.D.2d 722; 633 N.Y.S.2d 189 (2nd Dept. 1998), the defendant reviewed records expressly for the purposes of refreshing his recollection. These had been supplied to him by his attorney. The court held that neither the fact that the records were reviewed simply to refresh his recollection nor that they had been supplied to him by his

attorney was dispositive. The long standing rule that any writing used to refresh recollection waives the privilege that might otherwise attach.

The above rule also applies in a situation where the defendant in a malpractice action might have made private and personal notes after the incident in question which she later reviews to refresh her recollection prior to a deposition. In Doxtator v. Swarthout, 328 N.Y.S.2d 150; 38 A.D.2d 782 (4th Dept. 1972), the Court endorsed what it called a "sound rule" that writings used to refresh the memory of a witness prior to deposition, be made available to the adversary whether at trial or at the deposition phase of a lawsuit. When material prepared in anticipation of litigation is later used to refresh recollection, that material becomes material affirmatively used in litigation as opposed to in preparation or the defense of litigation and thus any privilege protections must be removed.

It must, however, be emphasized, that anything counsel speaks to his client about is privileged. Thus, if a strategic decision has been made not to have a medical provider review certain records or medical literature, certainly counsel may safely paraphrase this information to enlighten his client. Medical literature poses a particularly sticky issue. It is well settled in New York that unless a medical provider recognizes a chapter, a text or article as "authoritative", a properly placed hearsay objection is always sustained. The defendant must be warned about the pit falls in recognizing authoritative treatises and the like and be prepared accordingly. Some attorneys, knowing the bar the authoritative text rule places on this topic, peck at the issue in a more indirect way. Thus, your client should be prepared to handle questions that ask what literature is reliable, what journals the medical provider presently subscribes to, what texts and the like might be in the medical providers library and even what on-line research subscriptions the medical provider has.

The practitioner can be sure that if plaintiff's counsel is questioning the medical provider about a particular article, then something in that article supports plaintiff's case and weakens the defense. The medical provider should be apprised accordingly.

Objections at Deposition:

Uniform Rules for N.Y.S. Trial Courts

PART 221. UNIFORM RULES FOR THE CONDUCT OF DEPOSITIONS

§221.1 Objections at Depositions

(a) Objections in general. No objections shall be made at a deposition except those which, pursuant to subdivision (b), (c) or (d) of Rule 3115 of the Civil Practice Law and Rules, would be waived if not interposed, and except in compliance with subdivision (e) 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 and 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.

(b) 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 irregularity. Except to the extent permitted by CPLR Rule 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.

Added Part 221 Oct. 1, 2006

§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 of a 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, the examining party shall have the right to complete the remainder of the deposition.

§221.3 Communication with the deponent

An attorney shall not interrupt the deposition for the purpose of communicating with the 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.

As mentioned above, the defendant medical provider should be prepared at the pre-deposition conference to anticipate objections being made and even the potential for rancor between counsel. The medical provider should be instructed to simply wait until he is directed to answer a question after an objection has been placed on the record. It goes without saying that if the question is answered over objection or before an objection can be properly interposed, the objection has been waived. Notwithstanding the above referenced uniform court rule, objections are still routinely made at defendant medical provider depositions. In my experience, the rules have limited the quantum of objections and fostered a more civil and collegial atmosphere, but objections still have their place.

However, inappropriate objections, directions not to answer and incivility between counsel continues to be a problem. The courts do not tolerate this behavior and even when it would seem logical and within the bounds of zealous advocacy to object and block questions, the courts have nonetheless sided with plaintiffs. Lunt v. Mt. Sinai Hospital, 2010 N.Y.Slip.Op. 32468 is a perfect example of my point.

Plaintiff sued Mt. Sinai Hospital alleging medical malpractice and negligence for failure to properly prevent and treat decubitus ulcers that plaintiff acquired while hospitalized. The deponent was a unlicensed, first year general surgery intern participating in a one month rotation

with the plastic surgery team when she was involved in the care of the patient. She had no independent recollection of the plaintiff. She testified that her job was to observe the senior residents' examinations of patients and to write notes in the medical record.

In this case, plaintiff's wife took several photographs of the plaintiff's decubitus ulcer. Plaintiff's counsel attempted to question the medical provider about these photos. Plaintiff's wife had attempted to authenticate these photos at deposition by testifying that these had been taken of Mr. Lunt's body after he was discharged from the defendant hospital while a patient at a nursing home. Plaintiff's counsel presented one of these photos to the witness and asked her whether she could describe what stage the ulcer was. I think the hospital attorney appropriately blocked the question on the grounds that the photo had not been properly authenticated.

Plaintiff's counsel then attempted to ask a general question about the photo and what stage it might depict. This question was also blocked for similar reasons. The witness was then asked whether during the time she cared for the plaintiff he had a decubitus at or near the location which was shown in the photo. Counsel again blocked the question but the witness answered over objection that she could not tell if the picture was that of the plaintiff or not. Counsel then asked the witness whether the photo revealed subcutaneous and muscular tissue. These were also blocked. The last question required the witness to read the note authored by another medical provider written at the time of an examination where the witness was not present for. The basis for that objection was that the witness was being asked to speculate as to what the author of the note meant.

The trial court refused to sustain the objections and directed the witness to return for a further deposition limited to the challenged questions. The trial court endorsed the new Uniform Court Rules as to conduct at depositions, noting that the only questions which can be blocked are those which invade a privilege or right of confidentiality; invade a prior order limiting testimony; or are plainly improper and the answer would cause significant prejudice to any person. The court found no such elements to exist in this matter in granting plaintiff's motion. To the court's credit, the court held that the objections were not so frivolous as to warrant sanctions.

The rules as to the conduct of depositions apply equally to plaintiffs and defendants. In Watkins v. Hospital for Special Surgery, 2001 N.Y.Misc.Lexis 6199, 2011 N.Y.Slip.Op. 33414, plaintiff's counsel refused to allow plaintiff to answer questions as to whether she participated in physical activity; whether she was a member of a country club; whether she had taken any vacations after the indexed negligent procedure and whether anyone other than her attorney had criticized care. Counsel objected to these questions and refused to permit the witness to answer.

The court held that plaintiff's counsel failed to articulate that the questions either sought answers that were privileged or would cause his client significant prejudice. Weakening the case on damages was not considered significant prejudice so as to justify blocking the questions.

Trial courts will indeed sanction counsel when their behavior at deposition is unprofessional. In Cioffi v. Habberstad, 22 Misc.3d 839; 869 N.Y.S.2d 321; 2008 N.Y.Misc.Lexis 6952; 2008 N.Y.Slip.Op. 28483, Justice Thomas Feinman determined that counsel for defendant's behavior was offensive and unprofessional. Counsel's comments were made during objections to questions and during general comments made about the quality of the questioning. Counsel was ultimately ordered to pay $1,000 in sanctions to the Lawyer's Fund for Client Protection. The

court specifically found that counsel's statements "You're obviously in over your head" and to "stop whining" to be particularly unprofessional, condescending, rude, insulting and obstructive.

Special Circumstances – Altered Records:

It is incumbent upon defense counsel to obtain from plaintiff's counsel whatever records were obtained prior to the initiation of the lawsuit. This is good defense practice as there are those rare occasions where the records exchanged prior to the medical provider's knowledge that he might be sued differ from those produced once the lawsuit has been commenced. If plaintiff's counsel refuses, it certainly is sound practice when meeting the client and reviewing his original records to ask for any correspondence associated with disclosure of the records. This might give you a clue as to the potential for a second set of records.

If there is a suspicion that the records have been altered, it is generally the better course to attempt to quietly settle the matter prior to the medical provider's deposition. Certainly a medical provider's intentional alteration, falsification or destruction of his/her records violates the Public Health Law and is professional misconduct if not outright criminal behavior. This situation could put the medical provider's insurance coverage at risk. There are occasions however where a record may appear to have been altered, but the medical provider's handwriting practices or office practices are simply sloppy and careless. If the original record reflects the use of two different color inks, and/or darker and lighter notes, specific inquiry as to why needs to take place in the pre-deposition conference so that an appropriate answer to the inevitable questions can be formulated at deposition.

With the advent of the electronic medical record, the opportunity to alter, falsify or destroy is minimized. However, many electronic medical record products permit copious cutting and pasting of history and physical examination data. If the electronic medical record does reflect what appears to have been simply a cut and paste from day to day, the defendant medical provider needs to be prepared to assert that that fact does not mean that he/she hadn't been at the patient's bedside and conducted a physical examination on a particular date. If the patient's condition is unchanged from day to day, it is certainly within accepted practice to cut and paste. However, from a risk management stand point, it is always better that a medical provider generate at least some unique data on a particular patient interaction so as to avoid the appearance that the medical provider simply cut and pasted the record rather than rendered specific and appropriate medical treatment. The pre-deposition conference should focus on those issues and the witness should be prepared to withstand an attack along those lines.

Many hospital electronic medical records have automatic discontinuance orders and automatic stop parameters, as well as requirements that orders for diagnostics, medications and laboratory studies be attributed to the attending medical provider but ordered by the resident medical provider in training. Thus, a review of medical provider orders generated by the electronic medical record may frequently reflect that an order was entered by a resident but that the attending is documented as having requesting the order. Frequently, the client is completely unaware that residents are entering orders attributed to him/her. The attending must be prepared to assert that the resident staff was authorized to enter orders on his behalf. His/her actual presence or even knowledge of same is not necessarily required. Of course, if there is a malpractice action brought, there is generally an instance or instances during the course of the patient's treatment whereby the residents might have ordered something in a crisis and failed to

notify the attending medical provider. When counsel represents both the hospital and the attending this could pose the potential for a conflict of interest. Counsel needs to have considered this before meeting with the attending medical provider to prepare him/her for deposition. To the extent possible, the defense of the hospital and the attending must be harmonized. Thus, the attending medical provider should be prepared not to needlessly criticize the resident staff. He ultimately will be deemed primarily responsible for the acts of the resident being supervised in his/her absence from the hospital.

Billing and Coding – Attestation Sheets:

At the conclusion of a patient's in-patient admission, the medical record is transported to the medical records department and ultimately made complete by a medical records clerk. Once the record is complete, it is painstakingly reviewed by medical billers whose sole purpose is to identify all potential diagnoses, treatments and procedures. This is necessary to ensure that an accurate hospital bill is generated which captures the maximum appropriate reimbursement for the facility.

In most facilities, the attending medical provider is obligated to sign the attestation sheet which is generated by the efforts of the medical biller.

In my experience, many attending medical providers simply sign the document without reviewing it. Often times there are diagnoses listed on the sheet that the medical provider was completely unaware of or disagrees with in the first place. Experienced plaintiff's counsel will question the practitioner about the attestation sheet and attempt to create a conflict between what the medical provider believes, testifies and documented and what the hospital ultimately said happened. Thus, the attestation sheet should be abundantly reviewed in the pre-deposition conference so as to avoid this.

Differential Diagnosis:

The differential diagnosis method of questioning is frequently the bane of defense counsel's existence. While it is true that medical providers do engage in a process of differential diagnosis, they rarely if ever thoroughly document each and every potential diagnosis they considered in the moments spent evaluating the patient. The process of differential diagnosis essentially follows a standard format of assessment, identification of potential causes of the patient's condition, and then a plan to rule in or rule out the most likely cause and implement treatment for same.

In the practice of medicine, this is a fluid process and occurs almost unconsciously in the experience practitioner's mind. The process itself is rarely neatly and tidily documented in the medical record. Notwithstanding, plaintiff's counsel will endeavor to have the medical provider agree that differential diagnosis process is a proper method for ascertaining the true cause of the patient's condition and requires a prioritization of the potential causes with the focus on the most lethal or serious condition first.

Essentially, the plaintiff's bar wishes medicine to be practiced in cookbook fashion when in fact medicine is as much an art as it is a science even in this day and age of medical guidelines and the electronic medical record.

The medical provider must be alerted to the possibility of this line of questioning.

Next the pre-deposition conference should focus on having the medical provider defendant manifest what his/her thinking was at the time. Certainly comprehending all of the relevant assessment data must be part of the demonstration of the exercise of the medical provider's best judgment under the circumstances. The medical provider should be prepared to expand on what may be mere shorthand in his progress notes. Thus, the medical provider defendant should be prepared to testify that while he may have considered "certain conditions", he more likely than not concluded that the patient's condition was due to something more specific in his best judgment. The word "consider" means different things to attorneys then it means to medical providers. It is a potent word in medical litigation and the medical provider needs to be made aware of its legal import in advance of the deposition.

Likewise, the words "significant" and "important" frequently mean different things to counsel than the medical provider. Again, the medical provider should be prepared to handle questions as to what was important and what was significant. I prefer an answer which sounds like "of course everything about the patient is significant, the patient is important, but specifically in this instance what was most likely or most probably to be the problems was _____."

Aphorisms:

The plaintiff's bar would like all cases to turn on the following aphorism: "The earlier the diagnosis, the sooner treatment can be implemented and the better the outcome." That phrase has a certain attraction and seems intuitively correct, but it is certainly not true in all medical situations. The question itself usually goes to the heart of causation in cancer and rheumatology malpractice cases and the medical provider must be prepared to assert that in some instances the timing of the diagnosis is ultimately irrelevant to the outcome. There are cancers which are ultra-aggressive or particularly slow growing and not responsive to earlier treatment and each host responds differently to the time that treatment is instituted.

The medical provider defendant should be prepared to assert that it is not necessarily true that earlier diagnosis and treatment means a better outcome. The medical provider should be prepared to state something like: "While that may be true generally, in this instance it is not the case." Plaintiff's counsel would then be forced to explore the medical providers' rationale for same. The defendant should be prepared to explain.

Hypothetical Questions:

Defense counsel is faced with two choices as it relates to hypothetical questions which seek opinions as to the ultimate questions of departure and causation. While the case law permits the defendant medical provider to be questioned as to his/her opinions he/she does not necessarily have to be possessed of an opinion. This may be easier to assert if the medical provider's knowledge of the case is limited strictly to plaintiff's bill of particulars and his/her records. Thus, it may be appropriate to state that he/she does not have an opinion at present as to the standard of care or causation. If he/she does commit to a position on either, he/she is locked in at the time of trial. Likewise, if he/she does not hedge his/her bets enough by giving a cautious "I don't know at this point" answer, he might as well be foreclosed at the time of trial from asserting any opinion as to the ultimate issues.

Counsel has to decide whether it is more helpful to the credibility of the defense for the medical provider to have an opinion at the time of deposition. If he/she does not have an opinion, counsel may have to rely solely on expert testimony at trial. If the medical provider does formulate an opinion, counsel better be sure that that opinion is in line with what the expert will opine to at trial to avoid inconsistencies between the two. Otherwise, the jury may be confused. This would provide a fertile opportunity for the plaintiff's counsel to exploit in summation.

Conclusion:

Counsel must be at least as knowledgeable about the medicine and the substance of the relevant records exchanged in discovery as the practitioner. Preparation for the pre-deposition conference is paramount. Counsel is obligated to protect the medical provider from himself by insisting that enough time is spent to adequately review the relevant medicine, science and records. This may require multiple meetings with the medical provider in order to have him/her properly prepared to give testimony. As the deposition goes so will the trial. A case can in fact be lost at deposition. Adequate preparation on the part of the attorney and the medical provider will go a long way to preventing this.