

# A case for the physician defendant at plaintiff's expert witness deposition

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One of the most crucial points in a medical liability civil action is the discovery deposition of plaintiff's medical expert. In most instances, a plaintiff cannot establish a *prima facie* case of medical negligence without a qualified medical expert to establish that the defendant physician deviated from acceptable standards of care and in so doing caused injury or death to the plaintiff (*Bruni v. Tatsumi*, 46 Ohio St. 2d 127 [1976]). The pretrial discovery process allows the attorney for the defendant physician to take what is known as a discovery deposition of the plaintiff's medical expert to learn his or her opinions and their foundation in medical fact, as well as to determine the credibility of that individual. Customarily, the defendant physician does not attend that deposition to confront the plaintiff's most important witness. Rather, the defendant physician's attorney will fly off to some distant city to confront the physician's accuser in a medical arena often unfamiliar to the attorney. In some cases, the discovery deposition will be followed by a videotape deposition of that same medical expert to be introduced later at the time of trial.

We submit, and even encourage, that under certain circumstances it is advisable and helpful for the defendant physician to be present at this most crucial part of the medical negligence claim. The presence of the defendant physician may be valuable for several reasons. A professional medical witness may be more hesitant to criticize a colleague in his or her own presence, the defendant physician may assist his or her lawyer in understanding complex medical issues, and the defendant physician may be more prepared at the time of trial or in the consideration of a settlement for the criticisms that are being proffered.

### **Case summary**

A surgeon (Dr. Reiling, co-author of this article) was sued for "wrongful death" following uncontrollable bleeding during a planned pancreaticoduodenal resection. The case involved a middle-aged man with a history of significant intake of alcohol, a mass in the head of the pancreas, and a significant weight loss prior to resection. A workup included an ERCP and a hepatic angiogram, which led to a diagnosis of probable pancreatic cancer. The surgeon discussed the findings with the patient, as well as the risks and potential complica-

tions of exploratory surgery. The patient was informed that there was a concern that the disease process was not cancer and that it is not always possible to confirm a diagnosis until resection of the pancreas and the possibility that a resection might occur in the face of benign disease.

At the time of the exploratory surgery, the surgeon and fifth-year surgical resident noted a large mass in the head of the pancreas with a considerable surrounding of inflammation, especially in the head and neck of the pancreas. Initial exploratory steps were relatively standard. A decision was made to attempt a tissue diagnosis with a transduodenal biopsy because the patient was relatively young for cancer and had a history of substance abuse. Two intraoperative biopsies were taken and did not confirm malignancy. The surgeons therefore were faced with the facts that the preoperative radiographic studies clearly showed the probability of pancreatic cancer, and a mass in the head of the pancreas was clearly palpable at the time of exploration. The surgeons were then faced with the alternatives of "backing-out" in circumstances where the tissue biopsies may have missed a resectable pancreatic tumor or a decision to proceed with a major Whipple procedure only to have a final diagnosis of pancreatitis.

Awaiting a final biopsy result, the surgeon and the resident attempted to ascertain the resectability of the pancreatic head. A decision to proceed with the Whipple procedure or not would have been made for them had they found that a mass extended beyond the back of the pancreas to the mesenteric or portal vein. An effort was made to identify the superior mesenteric vein, inferior to the neck of the pancreas, to determine the extent of any potential mass and resectability. Unfortunately, the vein was found to be encased in considerable inflammatory tissue, and even the gentle exploration resulted in an injury to the mesenteric or portal vein behind the neck of the pancreas. Injury to the portal vein is a well-recognized but tragic complication in this procedure. Unfortunately, control of the hemorrhage was extremely difficult, and the blood loss became excessive. The pancreas was divided over the approximate area of the mesenteric-portal vein but blood control still could not be obtained. Because of the excessive bleeding and inability to gain control, the patient went

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into irreversible shock and subsequently expired. Upon autopsy it was found that the patient had acute pancreatitis and no malignancy.

### **Legal action**

The estate of the patient filed suit against the surgeon and the hospital. Original counsel for the plaintiffs enlisted a vascular surgeon as an expert witness. After the deposition of the defendant surgeon, they elected to recommend a dismissal of the case. The family, however, elected to enlist new legal counsel. Plaintiffs' new legal team identified two surgeons from California, retained through a professional witness service. The defense team also enlisted two recognized surgeons in the field of pancreatic cancer. Extensive medical research and a re-deposition of the defendant followed. Still, the most crucial part in the discovery process leading to trial were the depositions of the plaintiff's medical experts. The surgeon and his legal counsel (Mr. Gibson, co-author of this article) took considerable time to understand the medical concepts of establishing a diagnosis for pancreatic cancer, doing the procedure with or without a positive tissue diagnosis, exposing the head of the pancreas in preparation for resection, and the resection itself. The attorney viewed films prepared by the American College of Surgeons on this subject matter. He also met with defendant's medical experts and read extensively on the subject matter. All of these steps are what a surgeon should traditionally expect in the preparation of the defense of such a medical case.

As the time approached for discovery deposition of the plaintiff's medical experts in California, the

issue was raised as to the advisability of the defendant physician accompanying his attorney to those depositions. The attorney not only agreed, but encouraged his participation, due to his familiarity with the complex medical issues, his own credibility as a highly regarded academic surgeon, and the advisability of having the defendant appreciate the strengths and weaknesses in the plaintiffs' case. The attorney had utilized this method numerous times in the past in circumstances where the presence of the defendant physician was thought to be an advantage. A request was made to the liability insurance carrier for the defendant physician to reimburse defendant for his travel expenses; however, at that juncture the insurance carrier refused such an expense, and the surgeon elected to pay his own expenses and accompany his attorney.

### **Presence of the defendant**

The physician and his attorney arrived at the deposition of plaintiffs' first medical expert apparently somewhat to the surprise of the medical expert and plaintiffs' counsel. While sitting in the waiting room of the surgeon to be deposed, the authors met another legal team from Florida leaving after a deposition of the same expert on another case. After introductions, the deposition was commenced, and it was quickly discovered that the deponent was new to the business of medical testimony. It is certainly difficult to ascertain to what degree his opinions were affected by the presence of the defendant physician; however, it was clear that he was not an "advocate" but most humble and modest in his opinions. His criticisms were hardly beyond a difference of judgment and certainly were not clear deviations from acceptable standards of medical practice. Both the deponent and the surgeon discussed their acquaintances with mutual medical colleagues, and the deposition was relatively benign. Again, one will never know whether the deponent's opinions would have been any different or more critical had the defendant physician not been present; however, it certainly appeared that the presence of the defendant mitigated any adverse nature of the testimony.

### **Confrontation**

The defense team returned to California for the deposition of plaintiffs' second medical surgical oncologist. Of course, the presence of the defen-



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dant surgeon was no surprise at that deposition; however, it probably would have made no difference. This medical expert was a much more legally sophisticated advocate. The presence of the defendant physician at that deposition was not nearly as helpful in confronting the witness but in confronting the medical facts. The defendant's medical expert ventured into detailed discussion of the anatomy of the back of the pancreas and why the portal vein should not have been explored in circumstances where he believed there was portal hypertension and a lack of tissue diagnosis. The presence of the defendant physician at the time of the deposition, and even immediately afterwards in discussion with his attorney, helped formulate defense strategy and the rationale for such an exploration—for example, determining the resectability of the pancreas and determining the extent of any potential tumor behind the pancreas in the decision-making process of backing-out or going forward with the surgery. The surgeon provided guidance and assistance to his legal team throughout difficult discussion of the nature of the surgery around the head of the pancreas.

### **Outcome**

Plaintiffs' attorneys proceeded with discovery depositions of three prominent surgical experts on behalf of the defendant physician and the hospital. As trial approached it became apparent that the plaintiff "would get to the jury" with weak medical testimony from one expert and somewhat embellished medical testimony from another in the face of defense experts whom plaintiffs' own experts recognized as authorities and highly recognized surgeons in the field of pancreatic cancer. Certainly there was a risk of a very sympathetic jury in the circumstances of a death of a 38-year-old husband in circumstances where a surgical death had occurred and where there was an ultimate diagnosis at autopsy of pancreatitis. A settlement was reached one week before the actual trial date for a very minimal amount.

In conclusion, it was felt that the attendance of the defendant physician at the discovery depositions of the plaintiffs' medical experts was helpful in minimizing the criticism of one expert and fully appreciating and defining the criticisms of the other. That understanding helped lead the defendant surgeon to prepare his attorney for the de-

fense of the case and to prepare himself for areas of potential exposure for liability.

### **Discussion**

The discovery deposition of plaintiffs' medical experts is probably the most important aspect in the preparation of the defense of a medical liability claim prior to trial. At that point, the defendant is able to "test the waters" of the case against him or her. It is at that point that the defendant learns the potential criticisms and the credibility of plaintiff's expert. At times it will be of great advantage to the defendant and his legal team for the defendant/physician to be present at that encounter with professional medical witnesses. The defendant may be able to assist his legal counsel in understanding the medical issues to a degree that legal counsel may not have been fully prepared, especially in complex medical or surgical cases. While defense counsel are usually quite well-versed on the medical topics, at times there may be no adequate substitute for the presence of the physician. A professional medical witness may overstate or misstate medical facts, which an attorney might not fully appreciate without the assistance of a physician. Furthermore, a medical expert may be more hesitant to criticize the medical colleague when directly confronted by a peer.

The presence of the defendant physician may also prepare that person for the trial. A written summary of a deposition by an attorney cannot fully prepare a physician for the criticisms that he or she will face by that expert at the time of trial. The defendant physician will more adequately under-

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stand the nature of the critical opinions as well as the credibility and forcefulness of opinions by actually seeing that expert testify.

However, there are times when the defendant physician should not be present at the deposition of the plaintiff's medical expert, and their presence may work to their own disadvantage. The personality of the defendant physician may be such that he or she is unable to look at the case objectively and be so emotionally involved that such a presence becomes distracting to his or her attorney. If a professional witness believes that the presence of the physician is intended to intimidate the witness, he or she may only become more of an advocate. Likewise, any emotional display might educate plaintiff's counsel of weaknesses of the defendant physician to be played upon at the time of trial. It is incumbent upon the attorney for the defendant physician to judge whether the presence of the physician works to the advantage or disadvantage for the defense of the case. The medical complexities in the case, the personalities of the defendant physician and the medical experts, as well as those of legal counsel, and the value of educating the defendant physician on plaintiff's theories are all factors to be considered in arriving at the decision to have the defendant physician present at the plaintiff's medical expert discovery deposition.

Finally, one last caution: There is little or no room for the presence of the defendant physician at the deposition of experts enlisted by the defendant's legal team. The defendant physician should not have contacted those experts prior to their enlistment by the defendant's lawyers. It certainly would not behoove the defendant for the plaintiff's counsel to inquire of such experts as to whether they have had any discussions with the defendant, and for those experts to have to admit that the defendant had contacted them to ask them to testify on his or her own behalf and that they had been old friends or professional colleagues. The presence of the defendant physician at the deposition of his or her own experts only implies an apparent fraternization of experts and defendant. □

committee believe that this and other articles published in the *Bulletin* should stimulate thought and possible action on a wider spectrum of issues related to professional liability.

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This article on professional liability was generated through the efforts of the Committee on Professional Liability of the ACS Board of Regents. Members of the