Disability-insurance claims: The deposition of the defense medical examiner

Strategic and substantive approaches to deposing the defense's hired guns

By Rebecca Grey

Many plaintiffs' injuries are subject to review or examination by a medical professional hired by an insurance company. On good days, the medical reviewer issues an honest and forthright opinion, objectively summarizing the injuries, regardless of who is paying their bill. Sometimes it's the reviewing doctor. Sometimes, insurance companies retain dishonest reviewing doctors who simply reap the financial benefits of doing favorable forensic medical reviews for defendants. This can lead to biased and misleading medical reports which undermine our clients' claims.

This soul-selling conduct does tremendous harm, not just to our cases, but it literally and figuratively recapitulates our clients' injuries. It's hard enough to get up the nerve to see a doctor when you're his or her patient. The poking, weighing, and "hurry it up" rapid-fire questions, and that gigantic paper napkin they call a "robe," can make the toughest among us feel pretty vulnerable.

Now imagine that doctor is an adversary. He or she is paid not just to prod and poke your client, but to poke holes in his or her damages claims. We've all seen it before: after a cursory examination, or a dry review of medical records selected by the insurance company, the deceitful doctor formulates a report dozens of pages long which invariably boils down to a simple, but deceptively implicit narrative that the plaintiff is not telling the truth.

This is what faces many disability insurance claimants who have been forced by injury or illness to stop working and make a claim for disability benefits. For 13 years, I've represented people who had worked and schooled hard to get where they were. Although they love their jobs, they become injured or sick and are forced to stop working. These clients are grieving the loss that comes with having to stop work. They have little financial incentive to falsely claim disability as disability policies generally pay only a portion of their former salary. This makes it exquisitely unjust when an unethical medical professional who has taken an oath to "do no harm" writes a willfully inaccurate report, effectively cutting their safety net out from under your plaintiff.

In this article, I suggest some strategic and substantive approaches to deposing medical professionals bought and paid for by insurance companies. In doing so, I acknowledge two required texts which provide outstanding practical tips and techniques: Dorothy Clay Sims' Deposing Deceptive Defense Doctors, and Rick Friedman's Polarizing the Case, from which I have benefited tremendously.

Strategic themes

•Exploit physician arrogance

As the child of a doctor, I can say this: some physicians are arrogant, know-it-all jerks. (News flash!) Savvy plaintiff's attorneys can use this to their advantage. Many physicians are constitutionally unable to answer a question with, "I don't know." And yet if you do your job right, you will eventually ask a question that the physician does not know the answer to. When a physician does not know, several fun things happen.

One, they make stuff up. Two, they look bad. Three, and this is my favorite, they feel very uncomfortable and you gain control of the deposition. You can use this very effectively by testifying for them, making them your educator and expert and then disciplining them with their own ignorance.

•Testify for the doctor

"You know," "you remember," and "you're aware" are magic prefatory words in the doctor deposition. "You are aware that the 2010 MRI is different than the 2005 MRI, aren't you doctor?" "You recall seeing in the file dozens of references to the fact that my client's back surgery was a failure, don't you?" "You're aware that repetitive use of the hands and arms can exacerbate the symptoms of thoracic outlet syndrome, aren't you?"

These are polarizing questions, to use Rick Friedman's wonderful nomenclature. The doctor can't win – he either has to admit the fact, plead ignorance or dispute a proven fact.

• The defense doctor as your expert

Use your doctor deponent to educate you (or your judge or your jury) about your client's condition. Get granular to

the most basic anatomic level: how does the necrotic bone translate pain to the nerves? What happens in the brain with central pain syndrome? What causes the synovitis seen on imaging?

You will often encounter testimonial reluctance when you ask about your client's specific situation. Instead, genericize the questions, and ask about the condition, symptoms or syndrome in general terms. For example, rather than asking if your client's MRI results are consistent with her complaints of pain, ask how a disc bulge anatomically causes pain. What is failed back syndrome? How? The doctor has no escape and will be forced to help you.

• **Capitalize on an area of ignorance**

We are sometimes intimidated by doctors; they know so much more than we do and can snow us with medical mumbo jumbo. Seize the opportunity to have the doctor walk you through her terms. Drill down to the medical nitty-gritty, forcing the defense doctor to give you a medical education.

Know this: at some level of detail or some area outside the doctor's niche, you will almost always find an area where the doctor is not confident. You can exhaust the doctor's expertise, and they will be at a delicious loss.

Here's an excerpt from an actual deposition of a neurologist I took in a disability case involving Thoracic Outlet Syndrome. In finding that my client could do "heavy work," the doctor had disregarded a sonogram finding which demonstrated unequivocally the existence and relative severity of the condition which results in restricted blood flow and oxygenation of the upper limbs, resulting in pain.

Q: What does the sonogram measure?
A: Well, the ones I do mostly are the carotid and when I do that I look for decreased blood flow in the carotid artery or significant narrowing in the carotid and sometimes I look for dissection. So you are looking for blood flow, dissection, collateral narrowing.
Q: And the blood flow means the flow rate? Does it measure the flow rate?
A: Yes.
Q: What is the significance of the flow rate in a sonogram?
A: That's where I defer to the radiologist. But according to their findings, if there is an obstruction or a problem, the rate changes. I forgot if it gets faster or slower. They're numbers. I don't remember their numbers. But you can tell. Like they say 60 percent stenosed or 70 percent stenosed. Things like that. So they are measuring reduction – the flow rate – okay.
(All right. Never mind. Ask the question.)
Q: What is the medical significance of these results?
(Long pause)
Q: Let me ask this question, what does that mean in English?
(Longer pause, flipping pages)
Q: Let me ask this question, do you know what that means?
A: I know what this means. Just trying to think.
Q: Okay. Can you explain in lay terms what that means?
A: Just trying to – I'm looking for the year. Wait – this is written weird. (Long pause) It means there is a decrease in blood flow in the – with the arm's positioning. The arm positioning – with and without the brace. So there is some change in the blood flow.
Q: So that would corroborate thoracic outlet syndrome; wouldn't it?
A: Not necessarily. Not necessarily because some – not necessarily.
Q: You keep saying not necessarily. Does this sonogram finding corroborate a diagnosis of thoracic outlet syndrome?
A: Not necessarily. By that I meant thoracic outlet syndrome is more than just one finding of one thing. It's a conglomeration of stuff. It could support thoracic outlet syndrome.

Substantive themes

• **The definition of disability**

One dirty trick disability insurers employ is the use of pseudo-technical jargon in their communications with defense doctors rather than the actual policy terms. This is particularly true for the definition of *disability*. In California the definition of disability is a creature of court decisions and must be imported into a disability insurance policy regardless of the actual language of the ensuring contract.

Under California law, a person is disabled from "any occupation" if she cannot perform the important and material duties of any occupation for which she is reasonably suited in the usual and customary way with reasonable continuity which maintains the person's station in life. Disability insurance companies almost never provide any definition of disability to their reviewing physicians. Instead, they ask reviewing doctors about claimant's "restrictions and limitations," which are also usually undefined, widely open to interpretation, and import extra-contractual conditions not contained in the policy.

Depose the dishonest defense doctor on the standards he or she applied to your client. Many doctors mistakenly believe that "total disability" means total incapacity, the inability even to take care of oneself. Many doctors import a requirement that a disability be permanent. Force the doctor to commit to the most extreme definition possible.

Then you have two winning follow-ups. You can establish how the doctor is a directionless rogue who came up with inapplicable interpretations on his own, without any responsible guidance by the insurance company. Or you can establish that the doctor's conduct was entirely consistent with and at the instruction of the insurance company. You win either way.

Here's another excerpt from a deposition in which the physician said that the "restrictions and limitations" demonstrated by my client with debilitating failed back syndrome "would not preclude sedentary work." Her policy entitled her to total disability benefits if she was precluded from working full time in an actual occupation "in the usual and customary manner with reasonable continuity." The occupation would have to be one she was actually qualified for and which paid her wages similar to her former work as a police officer.

I asked this defense doctor about the question the insurance company asked him to answer:

Q: And you see where [the referral from the insurance company] says, "Please include your opinion on the possibility of returning to working any type position and when." Do you see that?
A: Yes.
Q: What was your understanding of what was meant by that sentence?
A: Beyond simply a customary work, whether she could perform any other type of work and at what time she could do so.
Q: And when it says "any type position," what was your understanding of what that meant?
A: I don't see how I could add any more words to that.
Q: Part time, full time, volunteer, a dollar an hour, a hundred dollars an hour, any type?
A: Well, any – it would include all of those.
Q: And is the definition you applied when you did your IME of Ms. Client?
A: Yes.
Q: If Ms. Client could work five hours a week selling pencils on the street, you would conclude she would be able to work in any type of position; is that a fair statement?
A: Well, I didn't answer that specific type of work.
Q: Would that satisfy the call of her question, which is whether Ms. Client could work in "any type" of position?
A: I don't really understand the question. I never considered whether she could sell pencils on the street. I was generally considering what type of basic category of work she could do, such as heavy work or sedentary work, but not any specific job.
Q: Were you considering full time, part time, or all of those?
A: All of those.
Q: So she could work five hours a week as a – in a sedentary job, she would not be disabled under your analysis?
A: Not totally disabled.
Q: Okay. And did anyone [at the insurance company] communicate any standards to you?
A: No.
Q: What types of positions were appropriate?
A: No one [at the insurance company] gave me any such instructions.
Q: Were you given any instructions regarding any income she would have to make in order to be disqualified from total disability?
A: No.
Q: If she earned $5 a week working a few hours in a sedentary position, that would satisfy their question of whether she was not disabled?
A: Well, again, not only didn't I consider specific job descriptions like selling pencils, but I didn't consider that dollar or hourly wage issue.

- **Winning with pain**

Many disability claimants have pain of one sort or another. Pain can cause or exacerbate the inability to continue working. Dishonest insurance companies have capitalized on pain's inherent subjectivity. Dishonest doctors will frequently conclude that the level of pain is not substantiated by some sort of objective measure or physical finding.

We can use this to our own advantage in a couple of ways. First, you can get the doctor to admit that under no circumstances could your client prove the existence and severity of her pain. This demonstrates that the insurance company is willfully requiring evidence that it knows does not exist.

Here is an excerpt from a deposition in which my client had severe foot pain in which the insurance doctor testified that she could return to her own occupation as an anesthesiologist. This demonstrates the earlier point about how physicians invariably misapply the definition of disability as well as applying inappropriate requirements to prove the existence and severity of pain.

The insurance medical director testified that my anesthesiologist client was not disabled from her own occupation despite foot pain so severe she often could not bear weight. He admitted he did not know the level of her pain and could not tell me how much pain would be disabling.

Q: So is it a common occurrence for you to opine that a person is not disabled by pain without knowing how much pain they're in and without knowing how much pain they would need to be in, in order to be disabled?
A: That is not correct by itself. It would depend upon the relationship between the pain and the clinical findings.
Q: Is it your testimony that there needs to be objective clinical findings justifying the pain in order to find somebody disabled by pain?
A: It would depend upon the amount of disability. There is total disability and there's partial.
Q: What's the difference?
A: Partial disability – a person may – when we talk about disability, it may be in part and there's certain activities from which the patient would be restricted or it may be total and the patient is totally incapacitated. That is the difference.
Q: Is it your testimony that in order to be totally disabled, a person has to be totally incapacitated? I believe that was the word you used. Is that correct?
A: Total disability means total incapacity. Many doctors will testify that pain itself cannot be disabling.
Q: Given her reports of pain, given that she and her medical providers all indicated that pain precluded practice as an anesthesiologist, how is it that you determined that she could perform the duties of an anesthesiologist?
A: Because pain all by itself from a psychiatric perspective is not sufficient as an entity to be limiting without more.
Q: So simply the existence of pain for an anesthesiologist is necessarily insufficient in order to establish restrictions and limitations from her own occupation?
A: Essentially yes, that the existence of pain standing by itself would not be sufficient.

• Medication side effects

Doctors are generally desensitized to the potentially troubling side effects of medication. Many laypeople, however, are aware and wary of the side effects of different types of medication, particularly narcotic pain medication.

In deposition, make your doctor testify for you about the laundry list of medications' side effects. Have the Physicians Desk Reference right there with you and let the string cite parade of horribles begin.

Q: What are the side effects of Vicodin?
A: Vicodin is a pain medication which has a potential side effect of affecting the mental status of a person, meaning the concentration, cognitive ability, memory.
Q: The authority that you would refer to for side effects would be the Physicians Desk Reference; is that correct?
A: If I were to look it up, yes.
Q: Did you look it up in this case?
A: I did not.
Q: You understand that lightheadedness, dizziness, sedation, nausea and vomiting, constipation, and respiratory depression are potential adverse reactions to Vicodin, correct?
A: I know that those side effects that you just listed are possible and they occur in some patients.
Q: And what are the side effects of morphine?
A: They're more or less the same.
Q: You understood that Dr. Client was taking morphine at the time you did your review, correct?
A: Yes.
Q: And you understand that the side effects of morphine include respiratory depression, lightheadedness, dizziness, constipation, somnolence, nausea, vomiting, and sweating, correct?
A: Those are potential side effects, yes.
Q: What are the side effects of amitriptyline?
A: The side effects are more or less the same as the ones previously mentioned.
Q: And those include stroke, seizure, blurred vision, and dry mouth, correct?
A: That is possibly the case.
Q: And you understood that she was taking fentanyl, correct?
A: She was given prescriptions for fentanyl.
Q: And the adverse reactions to fentanyl include hypoventilation, headache, fever, nausea, vomiting, constipation, dry mouth, somnolence, confusion, asthenia, sweating, nervousness, apnea, and dyspnea, correct?
A: Those may be the side – potential – side effects of fentanyl, yes.
Q: Is it appropriate for an anesthesiologist to be practicing anesthesiology on those narcotic drugs, doctor?
A: I don't believe I can answer that question.
Q: You made a determination that she could, didn't you?
A: That is a legal question and I'm not going to answer it.
Q: You are not able to answer the question, sitting here today, whether or not she can practice anesthesia on the narcotic drugs we discussed earlier; is that correct?
A: I'm not going to answer that question.

• Make them call your disabled client a liar

Disability claimants aren't the only victims of the dangerous and offensive insinuation that they are somehow gaming the system; personal injury plaintiffs suffer the same fate. You know the drill, the physician examines your client or reviews the foot-high stack of medical records, cherry-picks the record for any reference to improvement, stability, activity, recuperation or normal physical findings. Then the physician concludes, in regurgitated template language, that the complaints of pain or severity of symptoms are not supported by the medical findings.

Let's be clear, the doctor is calling your client a liar, a faker and a malingerer. Indeed, the doctor is accusing your injured client of a crime. In deposition, make the dishonest doctor commit to that narrative. Shame them by forcing them to confront what they are really saying.

Q: You doubt Ms. Client's complaints of pain?
A: I don't. No, she does complain of pain. Is that what your question was?
Q: Do you doubt that the pain exists that she complains of?
A: Yes, I doubt that the pain she complains of exists.
Q: Is it your opinion that Ms. Client is lying?
A: I don't like to call people liars.
Q: It appears, based on your testimony, that's exactly what you are doing. Is there any explanation in your mind, other than Ms. Client is a liar, for Ms. Client's complaints of pain in light of your doubts of the existence of that pain?
A: I don't know what Ms. Client is thinking or if she's lying.
Q: Is there any other possibility other than she is lying?
A: I don't know.
Q: What possible explanation could you provide, other than Ms. Client has been untruthful, for Ms. Client's complaints of pain in light of your doubt of the existence of that pain?
A: I don't know.

It can be demoralizing when you receive a medical report from a seemingly legitimate physician that dishonestly undermines your client's claimed medical conditions or injuries through cherry-picking, junk science or rhetorical gobbledygook. Fear not! You can and must use the defense doctor to educate you, to expose the insurance company's bias, to commit to or abandon the bogus malingering narrative.


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