Credibility is Crucial

By Stephanie Walkley, JD, BSN

Pearl McGuire[1], a 70-year-old retired nursing assistant with chronic back pain, scheduled an appointment to see orthopedic surgeon, Dr. Howard Glover, for evaluation of ongoing back issues. During her initial visit, Mrs. McGuire reported significant back pain, bilateral leg numbness, and difficulty walking. She also reported a history of three prior lumbar disc surgeries. In order to evaluate Mrs. McGuire's back, Dr. Howard ordered an MRI.

The MRI showed degenerative changes in the lumbar spine and evidence of postoperative changes, particularly at L4-5. Based on the MRI, Dr. Glover diagnosed Mrs. McGuire with post-laminectomy syndrome. Dr. Glover recommended conservative treatment and ordered physical therapy. He discussed with Mrs. McGuire that if her symptoms persisted despite physical therapy, then she might be a candidate for surgery.

Mrs. McGuire began a course of physical therapy that lasted approximately two months. After her completion of physical therapy, Mrs. McGuire returned to see Dr. Glover. She told Dr. Glover that she felt the physical therapy improved her overall pain level. Dr. Glover

instructed her to continue exercises at home and to return for another office visit in three months.

At her return visit, Mrs. McGuire complained of increased back pain due to a recent motor vehicle accident. Dr. Glover prescribed pain medication, steroid pack, and physical therapy. He instructed Mrs. McGuire to follow up in one month.

When Mrs. McGuire came back to see Dr. Glover one month later, she complained that her pain had continued to get worse. Given the circumstances, Dr. Glover ordered another MRI, which showed severe stenosis at L3 due to disc bulge and severe stenosis at L4. Mrs. McGuire underwent epidural steroid injections at L3 and L4. The injections provided relief at first, but the pain and leg numbness returned within days.

Dr. Glover ordered an EMG of the lower extremities to further evaluate Mrs. McGuire's condition. The EMG results indicated that there was denervation in multiple L4 and L5 myotomes in both lower extremities. Dr. Glover recommended decompression at L3-4 and L4-5, which he performed soon after.

Postoperatively Mrs. McGuire had initial improvement, but it did not last. Over the course of several months, Mrs. McGuire's pain increased, and her mobility and gait worsened despite medication and physical therapy. Additional imaging studies revealed a spondylolisthesis at L3-4 that was not present on earlier films. Since Mrs. McGuire's symptoms were more pronounced on the right side, Dr. Glover recommended right L3-4 fusion with transforaminal lumbar interbody infusion. After receiving medical and cardiac clearance, Mrs. McGuire scheduled the surgery with Dr. Glover at a local hospital.

The day of surgery arrived. After the informed consent process and signing of the operative permit, Mrs. McGuire was prepped for surgery. Dr. Glover began the procedure with a midline incision to expose L2-4. He detached scar tissue which was particularly extensive at L3-4. Dr. Glover used pituitary rongeurs to prepare the disc space and remove disc material.

Near the end of the disc preparation, Dr. Glover introduced a pituitary rongeur into the disc space to check the lateral view. After a few additional passes, Dr. Glover noted significant, brisk bleeding. He immediately notified anesthesia and blood was administered. The OR staff urgently called general and vascular surgeons for assistance. Dr. Glover, anesthesia, and the OR staff worked to stabilize Mrs. McGuire until the other surgeons arrived.

A cardiovascular surgeon identified a tear in the aorta and made a surgical repair. Mrs. McGuire developed severe coagulopathy and was admitted to ICU. Her condition remained unstable, and she passed away later that day.

Less than one year after her death, Mrs. McGuire's husband filed suit against Dr. Glover. Lengthy, extensive litigation followed. The case went through the discovery process which included the deposition of Dr. Glover.

During his deposition, Dr. Glover made a strong witness on his own behalf. He testified consistent with the medical records and was able to explain the complex medical issues and procedures at issue very well. He provided testimony on the standard of care and causation. With respect to causation, he stated that it was likely he went outside the disc space with the rongeur resulting in the injury. Once the parties completed discovery, they proceeded with a jury trial.

At trial, plaintiff's counsel called Dr. Glover to testify. Once again, he did a good job of explaining the facts and the medicine in this case. Unfortunately, at the end of the direct examination, Dr. Glover surprised everyone, including defense counsel, when he opined that he likely stayed within the disc space and pulled disc material attached to the vessel causing the injury. This was a material change from his deposition testimony, and the plaintiff's attorney seized the opportunity to impeach him. And just like that, Dr. Glover's credibility went down the drain.

The trial proceeded with the testimony of other providers, Mrs. McGuire's family members, and experts for both sides. During his closing statement, the plaintiff's counsel highlighted Dr. Glover's change in testimony. At the conclusion of the proof the case went to the jury. It took the jury one hour to return a verdict in favor of the plaintiff. Post-trial interviews with some of the jurors revealed that their decision was heavily influenced by Dr. Glover's change in testimony. They simply did not believe or trust him.

Although this was a sympathetic case, throughout the course of litigation, it appeared defensible on the medicine. The defense team for Dr. Glover had obtained strong expert support. The well-qualified defense experts testified that the injury was a known risk of the procedure and not the result of negligence. Nonetheless, the expert proof for Dr. Glover at trial could not overcome the impact made by his change in testimony.

This case demonstrates the importance of a defendant physician's credibility at trial. It cannot be overstated how crucial credibility is to a jury. Any changes in testimony between deposition and trial can have a devasting effect on the outcome of the trial unless there is a reasonable and honest explanation.

It should go without saying, whether at deposition or at trial, the physician testifying should be truthful in their testimony. However, there may be times when a physician who has been deposed realizes later that they have explained something poorly or that there was something wrong or incomplete with their testimony. In those instances, the physician should consult with their defense attorney. The defense attorney will have to evaluate what, if anything, may be done procedurally to rehabilitate or explain that testimony.

By the time a case makes it to trial, all the facts and anticipated proof should be known to all parties. If there is an extenuating circumstance that may compel a change in the proof, then the defense attorney should be notified immediately and in advance of trial. This information could impact trial strategy or even prompt settlement negotiations. Contradictory testimony at trial, without an explanation, may lead to a loss of and

potentially an adverse verdict. The defendant physician does not have to carry the burden of a lawsuit alone. He or she should contact their defense counsel any time a concern arises, no matter how small it may seem.

[1] Names of all parties involved have been changed.
