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The defense spine expert

HOW TO DISMANTLE THE DEFENSE PLAYBOOK IN FRONT OF A JURY

In almost every significant spine-injury case, the defense will hire a spine expert. Sometimes it is a neurosurgeon. Sometimes it is an orthopedic spine surgeon. Sometimes it is an orthopedic surgeon who wants the jury to believe they are a spine specialist. But the message is usually the same: Your client did not suffer a serious injury. They suffered, at most, a soft tissue sprain or strain that should have resolved within three to six months. Any ongoing symptoms are attributed to degeneration, poor conditioning, noncompliance, exaggeration, or some undefined “other cause” that conveniently appears after the defense’s preferred cutoff date.

Surgery is framed as aggressive, unnecessary, or unrelated. Treating doctors are portrayed as mistaken or financially motivated, while the defense expert presents as the calm voice of reason. If that testimony lands, it can devastate your case.

The good news is that these experts are predictable. Their playbook is known. Their opinions follow patterns. Their reports often recycle the same language from case to case. And their conclusions frequently depend on three things that are vulnerable to cross-examination: financial incentives, incomplete analysis, and arbitrary lines that do not match the medical records or real life.

The strategies in this article are drawn from repeated experience that I have had cross-examining defense spine experts in jury trials. While the names and venues change, the tactics do not. With preparation and a disciplined approach to cross-examination, you can expose the incentives, force concessions, and turn the defense expert into a source of admissions that strengthen your causation argument and reinforce your client’s credibility in closing.

The deposition

If you wait until trial to learn who the defense expert really is, you are already behind. The work begins before deposi-

tion. Do not accept the CV at face value. Write down what the expert wants the jury to remember: academic titles, board certifications, hospital affiliations, publications, claimed specialties. Then verify what they actually do today.

Check the employer’s website. Compare the courtroom identity to the public description of their practice. Look for prior testimony patterns. Confirm whether they actually perform the surgeries they criticize. Many defense spine experts build opinions around surgical necessity while being far removed from current surgical practice. That gap matters, and it is discoverable if you do the homework.

The deposition is not about winning an argument. It is about creating leverage. Your goal is to lock the expert into a clean, complete record on five things: what they reviewed, what they did not review, the background and experience they claim supports their opinions, and the full scope of opinions they intend to offer at trial, and bias. Commit them to the specific records and films relied upon. Commit them that the opinions disclosed are all the opinions they plan to give. When that record is tight *Kenmemur* kicks in, and trial becomes controlled.

The money paid to the expert

Do the same with money. Capture hourly rates, testimony rates, minimum charges, preparation time, cancellation policies, and the total billed through deposition. By the time you stand up at trial, you should already have the math done. Walk the witness through their own invoices. Add up the deposition time, the preparation time between deposition and trial, and the trial testimony itself. Lock them into a total number. Do not argue whether it is excessive. Just make it clear.

Jurors may not understand the mechanics of a DME, but they understand paid relationships. After the total is established, move to volume. What percentage of their litigation work is for the defense? How often do they testify for plaintiffs? The most damaging concession of bias is not the hourly rate. It is the admission

that the overwhelming majority of their litigation income comes from one side. You do not have to label the witness a hired gun. The witness does that for you.

If the expert talks about “secondary gain” as a motive for plaintiffs, the concept applies to everyone. A physician paid tens of thousands of dollars to testify also has incentives. You do not need to argue it. The numbers speak.

Once the financial relationship and defense-heavy litigation practice are established, the jury’s lens shifts. The witness is no longer simply “a doctor.” The witness is a paid litigation expert. From there, you are positioned to challenge claimed spine authority and expose gaps in current hands-on practice.

Attacking qualifications and outdated practice

Once you establish that the defense spine expert is a paid litigation witness, the next step is to test whether the courtroom image matches real-world practice. Do not assume the titles and credentials carry the day. Your job is to determine whether this doctor actually does what they are criticizing.

One of the most effective and underused questions in spine cases is simple: When was the last time you performed the surgery you are telling this jury was unnecessary? If the expert is criticizing a spinal fusion, decompression, or discectomy, you need to know whether they actively perform that procedure or whether they stopped years ago.

In one of my trials, the defense orthopedic surgeon had not performed spine surgery since 1991. That fact alone reframes everything. Medicine evolves. Surgical techniques evolve. Hardware evolves. Imaging evolves. Recovery protocols evolve. Jurors understand that instinctively. You do not need to argue it. You establish the timeline and let common sense do the rest.

It is equally important to compare courtroom claims with public-facing

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reality. If the expert presents as a spine specialist, verify whether their own practice identifies them that way. Employer websites are candid. They list actual specialties and areas of focus. In one case, the defense expert portrayed himself as a spine authority, yet his own practice website listed sports medicine, shoulder, elbow, and knee as specialties. Spine was not listed. He was not identified among the group's spine surgeons. That disconnect matters. It shows the jury that the expert's litigation identity may be broader than their actual day-to-day practice.

Follow that with a practical question: When patients in your office need spine surgery, do you perform it, or do you refer them out? If the answer is that they refer surgical spine cases to someone else, the contrast becomes powerful. The expert is willing to criticize a treating surgeon's decision under oath, but in their own practice, they defer those same decisions to other doctors. Jurors understand the difference between theory and practice. A surgeon who actually evaluates patients, recommends surgery, and performs it lives with those decisions. A litigation expert reviewing records does not.

Defense experts often lean heavily on training completed decades ago. Residency. Fellowship. Board certification. Those are important credentials, but jurors care about what the doctor does today. How much of their current practice is devoted to spine? How many spine surgeries have they performed in the last five years? How many fusions? How many decompressions? If the answer is few or none, that fact reshapes how the jury hears every later disagreement about radiculopathy, stenosis, surgical necessity, or chronic pain.

This portion of cross-examination is not about attacking the witness. It is about establishing a hierarchy of credibility. The treating physicians examined the patient multiple times. They followed the course of symptoms. They perform these surgeries regularly. The defense expert either examined the patient once, never examined them at all, or has not performed the procedure in years. Once that contrast is clear, the jury begins to view the minimization testimony differently. And that perspective carries forward into every other theme you develop.

Incomplete examinations and missing evidence

After qualifications, the next vulnerability is foundation. Defense spine experts routinely render sweeping opinions based on incomplete examinations and incomplete records. When you expose those gaps, the credibility erosion accelerates.

In cases where the defense expert on the stand has not performed a defense medical exam, address that immediately when attacking their foundation. For whatever reason, we have those cases where the defense fails to timely serve a request for DME and their expert is forced to limit their work to a record review. They never touch the patient. They never test reflexes. They never assess strength, sensation, or gait. Yet they testify confidently about what the plaintiff "should" be feeling or whether symptoms are consistent with objective findings.

When that is the posture, the contrast is powerful. The defense expert is offering opinions about function, pain behavior, neurological findings, and physical limitations without ever placing hands on the patient. Jurors understand the difference between reading about someone and examining them.

Even when the expert does conduct an examination, timing matters. In several trials, the defense examination occurred after surgery. By that point, the anatomy has changed. Pain patterns may have shifted. Surgical intervention itself affects range of motion and neurological findings. When the expert admits they evaluated the plaintiff months after surgery, you establish that they never assessed the true pre-surgical condition. They are necessarily relying on records from other physicians for that period. That admission narrows the weight of their testimony.

Equally important is what the expert did not review. This is where your deposition work pays off. Did they review the plaintiff's deposition testimony? Did they review all imaging studies or only selected films? Did they review the actual MRI films or just the radiology reports? Did they review all prior medical records, or only what was sent to them?

In one trial, the defense expert criticized the plaintiff for failing to perform home exercises properly, suggesting

compliance would have resolved the symptoms. But he had not reviewed the plaintiff's deposition testimony describing efforts to exercise and ongoing limitations. When confronted, he admitted he did not know what the plaintiff had actually done. That is not a technical gap. That is an opinion built on assumption.

In another case, the expert finalized opinions before reviewing the actual MRI films, relying solely on written reports. Once that admission was made clear, it reframed the entire testimony. Jurors expect that a physician minimizing a spinal injury has personally reviewed the images.

The admission you are looking for is not merely that incomplete information can be problematic. It is that this defense expert did less. They did not review everything. They did not examine the patient. They did not evaluate the case with the same depth as the plaintiff's retained experts who reviewed the records, reviewed the films, and performed a hands-on examination. That distinction matters. It undermines the reliability of the defense opinion by exposing the gaps it rests on, and at the same time strengthens the credibility of your experts without you having to argue it. When jurors see one side did the full work and the other did not, the comparison forms naturally.

And once the jury begins to question the foundation of the defense opinion, you are ready to move into one of the most predictable themes in spine litigation, the "sprain or strain" that supposedly resolves in a defined window, even when the pain does not.

The sprain/strain timeline trap

One of the most predictable themes in defense spine testimony is the "sprain or strain" diagnosis. No matter the venue, no matter the expert, the narrative is familiar. The collision may have caused a minor soft-tissue injury, but sprains and strains resolve within a defined period. The window varies slightly, but it is usually framed as three to six months. After that, anything ongoing is no longer attributable to the accident. So many attorneys call me, frustrated when the defense doctor says "sprain or strain." I always tell them to step back and realize it is a gift. The expert has just checked the

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box for substantial factor on your verdict form.

Securing the admission that the collision did cause an injury, irrespective of how minor the defense expert labels it, is critical. This is where discipline in cross-examination pays dividends.

The first step is to lock the expert into their healing timeline. Do not rush it. Make them commit. Ask how long soft-tissue injuries typically take to resolve. Clarify whether that applies to cervical strains. Lumbar strains. Muscle injuries. Get them to agree that the vast majority of these injuries resolve within three to six months. Most will use words like “typically,” “generally,” or “in the majority of cases.” That is enough. Once the timeline is fixed, shift to the plaintiff’s actual course.

Establish that your client continued to report pain well beyond that three-to-six-month window. Confirm that medical records document ongoing complaints. Confirm that treatment continued. Confirm that imaging was obtained after that time period. Often, the expert will admit that the plaintiff’s pain persisted past the timeframe they just described. Now the contradiction begins to form.

Ask the doctor directly: You agree my client continued to experience pain past three to six months, correct? Yes. And you testified at your deposition that he suffers from chronic pain, correct? Yes. Then the follow-up becomes unavoidable: By your own definition of a sprain or strain – which you told this jury resolves within three to six months – if he is still experiencing pain beyond that timeframe, you must agree that by your own definition this is not simply a sprain or strain.

That is the moment where the expert begins to struggle. They have committed to the timeline. They have admitted ongoing pain. They have defined chronic pain as pain lasting beyond the expected healing window.

Defense experts often attempt to resolve this tension by labeling the ongoing condition “chronic pain” while still insisting the underlying injury was minor. But once they concede chronic pain, the jury hears something very different from “temporary strain.” The condition has extended beyond what the expert defined as normal healing. At that point, the cross becomes surgical.

You have established that sprains and strains typically resolve within three to six months. You have established that this plaintiff had pain beyond that period. You have established that the plaintiff meets the definition of chronic pain. Now force the expert to identify the alternative cause.

This is when I begin to physically move closer to the jury box. I quickly walk back through the admissions. Then I ask: You believe that at some point within the first three to six months, the pain stopped being related to the collision and started being related to something else, correct? And then I stop.

Doctor, what date and time did it stop being related to the subject collision?

The witness usually looks perplexed.

Doctor, you are telling this jury that my client’s pain is now related to something else. They are going to want to know when that happened and what happened. So, tell them what event occurred that made the pain stop being related to the collision and start being related to something else?

They cannot answer it.

There is no identified event. There is no new trauma. There is no specific date when the pain became unrelated. Instead, the expert retreats to generalities about degeneration or “natural history,” without tying those concepts to a concrete change in the plaintiff’s condition. That vagueness is powerful.

If the expert cannot identify when the accident-related pain ended, cannot identify what replaced it, and cannot point to an alternative cause, then their timeline becomes arbitrary. It is not based on a medical event. It is based on a generalized expectation that strains “should” heal by a certain time.

Once the admission of an injury caused by the collision is in the record, and once they cannot identify a new intervening event, the jury is left with a straightforward question: Why would symptoms that began with the collision suddenly become unrelated without anything else happening?

The sprain/strain timeline trap works because it exposes circular reasoning. The expert says the injury healed because it should have healed. The patient still has pain. The expert cannot explain the pain but insists it is no longer related. When

you lay those concessions next to each other, the logic collapses under its own weight.

Strategically, this section of cross gives you closing argument gold. You do not have to prove complex biomechanics. You simply remind the jury of the admissions: The injury happened, the pain continued, no other cause was identified, and the defense timeline was based on generalities rather than this patient’s actual medical course.

When done properly, the defense expert’s own testimony becomes the bridge that carries causation from the day of the collision through the date of trial.

Attacking the degeneration defense

If the sprain-or-strain theme is predictable, the degeneration argument is inevitable. In nearly every spine case, the defense expert points to MRI findings and labels them “degenerative.” Disc protrusions become “age-related changes.” Stenosis is described as “normal wear and tear.” The implication is consistent: Whatever ongoing symptoms exist are not the result of trauma, but the natural aging process. Do not run from that word. Use it.

The first step is to normalize degeneration in the courtroom. Doctor, degeneration is common, correct? Many people have degenerative findings on MRI and no symptoms at all, correct? Everyone in this courtroom likely has some level of degeneration, correct?

Then I point to myself. Including me? I can do jumping jacks. (I actually do jumping jacks in court.) I can do push-ups. I have never treated for spine pain. The jury understands the point immediately. Degeneration without symptoms proves nothing. Now the focus shifts to what changed.

So, Doctor, a person can have degeneration and be asymptomatic correct? No pain? Correct.

Trauma like a motor-vehicle collision can make an asymptomatic degenerative condition symptomatic, correct? “It can.”

That “It can” is the opening you need. From there, the issue becomes timing and history. Then I turn to the review of all the records defense went through to try to establish they were thorough

and I say: In the thousands of pages you reviewed, you saw no documented complaints of neck or back pain before this collision, correct? Correct. In cases where there are older complaints, but there is a significant gap before the subject collision, I focus on those symptom-free years. The point remains the same: The condition was not actively symptomatic.

The collision occurs. You agree he was injured in the collision, correct? After the collision, complaints begin at the same levels where the MRI shows degenerative findings, correct? Correct.

Now the theory narrows. Either there was no meaningful degeneration before the collision and the trauma caused the problem. Or there was degeneration that was asymptomatic, and the collision aggravated or activated it. Both paths lead to causation.

Handled correctly, degeneration does not sever causation. It reinforces it. Degeneration describes a condition. Aggravation explains why that condition became symptomatic when it did.

Narrowing the battlefield: Separating reasonableness from causation

Another powerful way to narrow a spine case is to separate medical reasonableness from causation. Defense experts often blur those two concepts together. I do the opposite. I separate them immediately.

In one trial, I began by saying, “Let’s move the collision aside and let’s talk about the treatment he received after that initial six-month period. Forget causation and what caused it.” Then I focused the expert on what mattered: “You reviewed the treatment he had. The treatment itself was reasonable based on his symptoms and what you saw on the MRI; correct?”

The expert tried to condition the answer but ultimately conceded that if the patient had the correct symptoms and understanding of why surgery was being performed, the treatment would be appropriate. I made it concrete. “So, if this was meant to prevent him from paralysis, it would be okay?” Yes. “If it was meant to prevent further spinal cord damage or symptoms related to spinal cord damage, that would be okay?” Again, yes.

Then I closed the loop: “What you’re

telling this jury is you don’t believe it was related to the collision; correct?” “That is what I’m saying.”

“You are not telling this jury that the treatment was unreasonable?” For the right reasons, the treatment was reasonable, yes.

In another case, the concession was even cleaner. I asked, “You agree that the fusion surgery that was performed was reasonable; you just don’t believe it was related to the collision; correct?” The answer was yes.

Once that admission is secured, the battlefield shrinks. The defense is no longer arguing that the surgeon acted outside the standard of care or that the care itself was improper medicine. The dispute becomes purely about causation. That distinction is powerful in closing. You can tell the jury that even the defense expert agreed the treatment was medically reasonable. Their only disagreement was about what caused the condition.

When an expert refuses to concede that the treatment was reasonable and instead claims it fell outside the standard of care, the cross shifts. If you truly believe this surgery was unwarranted, did you report the surgeon to the Medical Board of California? Have you ever?

If a doctor is performing operations that should not be performed, there is an ethical mechanism to address it. Jurors understand that. When no report was made, the “unreasonable treatment” opinion begins to look less like a professional obligation and more like a litigation position. I then test consistency: Have you ever performed this type of surgery under similar imaging findings? Under what circumstances would you recommend it?

If the expert has done similar procedures, their criticism becomes selective. If they have not performed spine surgery in decades, their authority to condemn current surgical decisions weakens. Either way, the credibility balance shifts.

Conclusion: Control the narrative

Defense spine experts are not unpredictable. Their structure is familiar. Temporary sprain or strain. Degeneration. Alternative explanations. Criticism

of surgery. Minimization of chronic pain. The language changes slightly, but the framework does not.

The mistake is to treat their testimony as overwhelming medical complexity. It is not. It is a series of positions that depend on assumptions, generalities, and financial alignment. Your job is not to out-lecture them on anatomy. Your job is to control the narrative.

Establish the paid relationship. Test whether the claimed expertise matches current practice. Expose incomplete examinations and selective record review. Lock them into their own healing timelines. Use degeneration to reinforce aggravation. Separate reasonableness from causation. Force them to identify an alternative cause they cannot name.

When done properly, the defense expert becomes a source of admissions rather than a threat. Their concessions form the spine of your closing argument: The collision caused an injury, the pain persisted, degeneration can be asymptomatic, the treatment was reasonable, and no other cause was identified.

Jurors do not decide these cases on medical jargon. They decide them on credibility, logic, and common sense. If you stay disciplined, prepare thoroughly, and force clean admissions, the defense spine expert will often give you everything you need.



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