



Lior Behdadnia

SASOONESS LAW GROUP, APC

The expert you didn't know you had

WHEN A TREATING PHYSICIAN BECOMES AN EXPERT WITNESS

Your client is a 52-year-old woman who was involved in a rear-end motor-vehicle collision. Six months before the collision, an incidental finding on an unrelated cervical-spine imaging scan showed mild disc-space narrowing at levels C5-6 and C6-7, which is the kind of age-related degeneration radiologists note almost reflexively in half the population over 40.

Before the collision, she had no complaints of neck pain, no treatment, and no missed work. Then a car rear-ends her vehicle at a moderate speed. Within days, she has radiating pain down her right arm, numbness in two fingers, and a positive Spurling's test. A cervical spine MRI performed six weeks after the accident shows a disc protrusion at C6-7 with new nerve root compression. Conservative treatment fails and her treating spine surgeon subsequently performs an anterior cervical spine discectomy and spine fusion. Thereafter, defense counsel disputes the causal link between your client's injuries related to the subject collision and the subsequent surgery.

A common defense theory is that your client's injuries were the result of a pre-existing medical condition, the collision was minor and lacking the mechanism of injury to cause the injury in question, and that the surgery would have happened regardless of the crash.

The best rebuttal to the defense's argument is the opinion and testimony of your client's surgeon, not a retained biomechanical expert or a hired spine surgeon who has never treated

your client. The surgeon who reviewed the pre-collision diagnostic imaging, examined her post-collision injuries, witnessed the new radicular symptoms develop, and recommended and performed the surgery is the most important testimony. The issue becomes how to get the doctor's opinion in front of a jury cleanly, without being subject to objections and without turning the doctor into an undisclosed retained expert.

The difference between non-retained experts and retained experts

California's expert witness disclosure requirements draw a sharp line between two categories of experts: non-retained experts and retained experts. The correct strategy depends on knowing exactly where that line sits and how to navigate the requirements. California Code of Civil Procedure section 2034.210, subdivision (b), defines a retained expert as one retained "by a party for the purpose of forming and expressing an opinion in anticipation of the litigation or in preparation for the trial of the action." Everyone else who may offer "expert" opinion testimony falls outside that definition as a non-retained expert.

A party who intends to call a retained expert must serve an expert witness declaration under California Code of Civil Procedure section 2034.260, subdivision (c), setting out the expert's qualifications, the expert's hourly rate, and a fair, good-faith summary of the substance of the anticipated testimony. Those declaration requirements do not apply to non-retained experts.

The party need only identify the treating physician as a witness expected to offer expert testimony. This efficiency is exactly why defense counsel will try to argue that a treating physician's testimony has, in substance, crossed into retained-expert territory.

The Schreiber rule

The California Supreme Court settled the core question in *Schreiber v. Estate of Kiser* (1999) 22 Cal.4th 31. The Court held that a treating physician may testify to opinions formed in the course of treatment, including the cause of the patient's condition, without being disclosed as a retained expert. The Court's reasoning turned on the physician's role as a percipient witness:

A treating physician is a percipient expert, but that does not mean that his testimony is limited only to personal observations. Rather, like any other expert, he may provide both fact and opinion testimony. As the legislative history clarifies, what distinguishes the treating physician from a retained expert is not the content of the testimony, but the context in which he became familiar with the plaintiff's injuries that were ultimately the subject of litigation, and which form the factual basis for the medical opinion ... [a] treating physician is not consulted for litigation purposes, but rather learns of the plaintiff's injuries and medical history because of the underlying physician-patient relationship.

(*Id.* at pp. 35-36.)

Schreiber sets the foundation for using non-retained expert testimony and is the reason a treating surgeon can testify to causation and aggravation, without separately retaining the physician to formulate that opinion for litigation.

The Kalaba boundary

Schreiber establishes that a treating physician does not require a separate expert-witness declaration. The Court of Appeal confronted the question of whether a treating physician needed to be identified before being called at trial in *Kalaba v. Gray* (2002) 95 Cal.App.4th 1416, and framed the rule at the very outset of the opinion:

Although a designation of retained experts must be accom-

panied by the "expert witness declaration" described in Code of Civil Procedure section 2034, subdivision (f), no expert declaration is required for a treating physician who will be called to testify at trial as an expert witness. ... But the transformation from treating physician to expert does not occur unless the treating physician is identified by name and address in the proponent's designation, and it is not enough that a plaintiff has "designated" as experts "all past or present examining and/or treating physicians."

(*Id.* at 1418.)

That is precisely what the plaintiff in *Kalaba* had done. Her expert-witness designation named two retained experts specifically, but in regard to her treating physicians, it stated only that she "reserve[d] the right to call as potential experts any and all [of her] past or present examining and/or treating physicians." (*Ibid.*) When she later attempted to call treating physicians at trial who had never been named, the defendant moved to exclude them, and the trial court agreed. The Court of Appeal affirmed, explaining:

[T]reating physicians are not 'retained experts' within the meaning of section 2034, and no expert declaration is required when a party intends to call a treating physician for the purpose of eliciting expert testimony; it is sufficient if a treating physician is identified by name and address in the proponent's designation of expert witnesses. Where, as here, the treating physicians are not listed or identified by name but simply referred to in the designation as 'all past or present examining and/or treating physicians,' there has been no compliance with the letter or the spirit of section 2034, and the trial court acts within its discretion when it excludes expert testimony by the non-designated doctors.

(*Id.* at pp. 1422-1423.)

Kalaba does not narrow what *Schreiber* allows a treating physician to testify. It narrows how that physician gets into the case in the first place. Naming a category of witnesses is not naming a witness. If

the treating physician who will testify to causation at trial is not identified by name and address in the expert-witness designation itself, *Schreiber*'s protection never comes into play, no matter how squarely the opinion falls within the physician-patient relationship.

Why the treating physician's testimony carries more weight than testimony of a retained expert

There is a reason defense counsel fights so hard to categorize a treating physician as a retained expert, instead of simply conceding and cross-examining the treating physician on the merits. A treating physician who testifies to causation carries a kind of credibility that a retained expert at times does not.

Consider the spine surgeon from the scenario outlined at the start of this article. That physician did not treat your client in anticipation of trial. That physician examined the client before any lawyers were involved, objectively ordered and interpreted her diagnostic imaging, witnessed her radicular symptoms develop over the following weeks, and ultimately made the decision to operate after conservative treatment had failed. When the surgeon testifies in front of a jury that the collision caused a previously silent degenerative condition to progress into an injury requiring surgery, it carries weight because the opinion was formed during treatment rather than developed for purposes of litigation. The surgeon is simply describing the reasoning behind the need for the surgery and why it was necessary to perform.

In contrast, a retained expert, however well credentialed, is always vulnerable to the suggestion that the opinion was purchased in preparation for litigation. A treating physician, who is a non-retained expert, is less vulnerable to this suggestion because the opinion was formed in the course of treatment rather than at the request of litigation counsel.

The treating physician is the one who lays the foundation. A retained expert is typically brought in long after the injury and does not examine the patient at the moment of injury or witness the condition unfold over months of treatment. What that retained expert relies on, more often than not, is the treating physician's own medical records, the visit notes, the imaging, the diagnosis, and the course of treatment the treating physician

documented in real time. The retained expert's opinion is built with the treating physician's records. There is no gap between the witness and the foundation, because the treating physician witness created the foundation that the retained experts rely upon.

Notably, the treating physician's credibility comes with the added benefit of lower cost. A retained expert's opinion comes with significant fees. Retained experts charge an hourly fee for medical record review, records summary, an independent examination, and deposition preparation, among other trial preparations. This cost often runs into the thousands of dollars before trial even begins.

Depose the treating physician before you ever need a retained expert

Discovery statutes do not require waiting for the section 2034 expert designation exchange before deposing a treating physician. Unlike a retained expert, a treating physician acquires the factual basis for his or her opinions independently through the physician-patient relationship. Because that knowledge comes from treatment rather than from litigation, the physician's deposition can be noticed months or even years before the case is anywhere near expert designation.

The California Supreme Court in *Schreiber* recognized exactly this, observing that "defendants have a strong incentive to depose treating physicians well prior to the exchange of expert information to ascertain whether their observations and conclusions support the plaintiff's allegations." (*Schreiber, supra.*, 22 Cal.4th at p. 38.) That incentive runs in both directions. Plaintiff's counsel who waits until the eve of the expert exchange to depose a treating physician is leaving one of the most valuable and least expensive tools in the case sitting unused.

Taking the deposition early allows you to determine whether the treating physician's opinions support your causation and aggravation theories before incurring the expense of retained experts. It also provides the defense with sworn testimony from a medical professional regarding the patient's complaints, injuries, medical treatment, findings, and recommendations.

Defense counsel routinely responds to a section 998 offer served during litigation by objecting that they lack sufficient information to evaluate it, pointing to

the absence of necessary information as the reason. That objection loses its force once treating physician depositions have been taken. The same is true at mediation. Quotes from the treating physician's deposition pack a punch far greater than a summary of medical records.

Structuring the treating physician deposition

An early deposition is only useful if it is built correctly. Even though no expert-witness declaration is required for a treating physician, it is still worth laying foundation on the record at the deposition itself. This includes the nature and dates of the treatment relationship, every record and diagnostic imaging the physician ordered and reviewed, and the physician's training and experience relevant to the opinion. None of this is required by statute. All of the above information will matter later, whether at a hearing on a motion in limine, in the video edited for trial, or simply in front of a jury who will be hearing testimony from several different medical providers.

Every substantive opinion should be anchored to something specific in the chart: the medical-exam notes, diagnostic imaging, and treatment recommendations. More importantly, counsel should establish the basis for the treating physician's observations and opinions by asking why the patient became a surgical candidate, what surgery was required, and what future treatment is medically probable.

Why the treating physician deposition should be video recorded

A transcript proves what a witness said, not the way it was said. When the treating surgeon explains why a previously silent degenerative condition progressed into an injury requiring necessary surgery six weeks after a collision, the jury needs to see them say it, not just hear the words read at trial.

Video recording the deposition also solves the scheduling problems which are common at trial with treating physicians. Subpoenaing and scheduling a non-retained treating physician to testify live is never simple. Surgeons are busy with patients and clearing their schedules to sit in a courtroom waiting to be called as a witness is difficult.

Of course, having the treating physician testify live in court, especially if they operated on the plaintiff, is always preferred. Jurors lose interest in watching video clips faster than they lose interest

in live question and answer. However, many courts will force your case to rest if there are time gaps between witnesses, and trial is fluid enough that something will eventually go sideways. A video deposition in reserve can save your case when a surgeon gets called into emergency surgery, is out of town, or refuses to comply with a subpoena. To ensure the video is available to you later, your deposition notice must properly notice the deposition as being recorded by video, not just stenographically.

The takeaway

Handled correctly, the treating physician is often the strongest witness the case will ever have, because their opinion existed before the lawsuit did, was formed for the patient rather than for litigation, and rests on a foundation, the medical record itself, that no amount of money spent on a retained expert can replicate after the fact.

Effectively using a treating physician as a non-retained expert depends on knowing exactly where *Schreiber* ends and *Kalaba* begins, properly identifying the physician in the expert witness designation, and anchoring each opinion to the physician's treatment of the patient. Important strategies include taking that deposition early on video to ensure the testimony is preserved and ready to use when needed, whether for mediation, a section 998 offer, or at trial.

Causation cases are not won by the expert with the most credentials. They are won by the neutral and objective witness whose opinions were formed in the course of treatment rather than for litigation. That witness is already treating the patient, and the only real question is whether counsel gets to those records and that deposition early enough to use them. Do not wait for the expert designation exchange to find out what the treating physician's medical records already prove. Depose the physician early and let their opinion do the work.



Lior Behdadnia is a personal-injury attorney at Sasooness Law Group, APC, in Woodland Hills. He has tried multiple cases to verdict and is admitted to practice in California, Arizona, Texas, Nevada, and Washington.