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Cross Examination: Exploring the Process That Leads to the Choice

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It is indisputable that life is full of choices. It is also indisputable that each choice has consequences. Reduced to its most basic terms, a choice can either be helpful or harmful, positive or negative, good or bad, ethical or unethical or, simply put, right or wrong. Whether the choice results in an affirmative act or an omission, the choice one makes has the potential to have far reaching consequences on others. In every case, someone makes a choice that gives rise to the claim. For the attorney conducting a cross examination of the person or persons who made the choice, dissecting the thought process that led to that choice will provide fodder for cross examination and lead to success in the courtroom.

Consider first the example of a driver who made a choice to text while driving. As a result of her texting, the driver struck a young boy who was terribly injured. Although the choice to text was made in a split second, the potential consequences surrounding the choice were well known to the driver before the life changing event ever took place. It is the underlying knowledge of those potential consequences that must be explored during cross examination to fully unlock the severity of that choice. In this example the trial lawyer could jump right to the improper conduct:

Q: You picked up your phone while you were driving, true?

Q: And you struck the child while texting, correct?

A: The child ran out from between cars.

Q: You looked away from the road?

A: Only for a split second. The child darted out.

The problem with this approach is that the trial lawyer rushed in for the kill and in doing so lost control of the witness, failed to explore the underlying choice and allowed the witness to create a defense by offering non-responsive answers. The better approach is to focus on all of the risks and benefits that were appreciated but ignored by the witness before making that choice. To begin, the trial lawyer should focus on "voice of reason questions" —questions that are so reasonable that if the witness dares to disagree he will be made to look foolish. The set up should begin as follows:

Q: As a driver you understood the importance of keeping your eyes on the road, true?

Q: You fully understood the importance of keeping a proper look out, correct?

Q: We can agree that by keeping your eyes on the road you would better be able to see what is there in front of you, true?

Q: So that you can avoid accidents, correct?

Q: So that you can avoid injuring others, true?

Knowledge of the consequences of the underlying conduct for which the claim is based must be explored in detail.

Q: Well before this accident ever took place you had heard the phrase: "Don't Text While Driving," true?

Q: You understood why drivers are told not to text while driving, am I right?

Q: You understood the dangers of driving while distracted, correct?

Q: In fact, you knew that texting while driving could lead to a crash, true?

A: I only looked for a split second.

Q: Who taught you that it is safe to look at your phone for a split second? A: No one.

Q: Did the instructor in your driver's ed class teach you it is okay to text so long as it is only a split second?

A: No.

Q: That was your decision, true?

Q: So returning to the question I asked you: You knew that texting while driving could lead to a crash, true?

Q: You knew that texting while driving could cause harm, correct?

Q: You understood that texting while driving could kill someone, am I right?

Q: And you knew that before the day of this incident, true?

It is at this point that the choice itself must be brought out to fully capture the thought process behind the conduct. That choice must be slowly and carefully dissected to prove the point:

Q: You were driving on a residential road at the time of the incident, correct?

Q: It was 4:00 p.m. in the afternoon, true?

Q: You knew that children would be in the area, correct?

Q: Knowing you were on a residential road at 4pm and that children may be in the area you nevertheless made a decision to reach for your phone, didn't you?

Q: But before you reached for your phone you had a choice, correct?

Q: You had the choice to pick up that phone or to wait, correct?

Q: You had the choice to keep your eyes on the road or to look at your phone, true?

Q: You had the choice to focus on the road ahead of you or to focus on the wording of your text, correct?

Q: You also had the choice to simply pull over and stop, correct?

Here, the decision, based on that choice, must be brought out in detail to drive the point home.

One of the most effective ways to do this is to first focus on the negatives – that which was not done:

- Q: You made a series of choices, didn't you?
- Q: You chose not to stop, true?
- Q: You chose not to pull over, correct?
- Q: You chose not to wait, true?
- Q: Instead, you chose to continue driving, didn't you?
- Q: You chose to take your eyes off the road, correct?
- A: Just for a split second.
- Q: And for what you claim was a "split second," you took your eyes off the road, true?
- Q: You chose to put your eyes on the phone, didn't you?
- Q: Would you agree that was completely contrary to what you were taught in driver's education?
- Q: We can agree it was your choice and yours alone to take your eyes off the road, true?
- Q: And now we know that a child was injured while you were texting, correct?
- A: It was only a split second.
- Q: And in that split second a child's head was split open, correct?
- Q: And we can certainly agree this child has suffered for far longer than a split second, true?

While this technique works well with an affirmative decision or act as in the above example, it also works just as well with an omission—the failure to do something that should have been done at a specific point in time. Take, for example, a medical malpractice case in which a patient was scheduled for knee replacement surgery. As part of the surgical clearance a radiologist read the patient's chest x-ray, a requirement for surgical approval. The chest x-ray

was read as normal and the patient was approved for surgery, but the radiologist noted an incidental finding: "There is a spiculated nodule in the upper right lung. Suggest further work up with CT." The radiologist sent the report to the surgeon but did nothing further. The knee surgery went well, but unfortunately the patient died 18 months later from lung cancer. In this example, the radiologist was concerned about cancer but did nothing more than note an incidental finding in her report. At no point in time did the radiologist call the surgeon or her patient with her concerns.

Clearly, the cross of the radiologist could ignore the underlying choice and instead jump to the conduct in not calling the surgeon:

Q: You were concerned about cancer, true?

A: Yes.

Q: Despite your concerns you never notified the surgeon of those concerns, did you?

A: I sure did. I notified him of my concerns in my report.

Q: But you never called the surgeon, true?

A: It was not necessary. I followed standard operating procedure in our hospital which was to note the findings in my report.

Once again, by not taking the time to properly set up the witness, the cross examiner has lost control of the witness and allowed non-responsive answers to rule the day. In rushing in for the kill, the attorney missed the opportunity to focus on the choices made in failing to do something that should have been done. Again, begin with the "voice of reason" questions which work equally well when working with omissions:

Q: Can we agree that your most important concern as a radiologist is the health, safety and well-being of your patient?

Q: Certainly, you would never do anything to injure your patient, true?

Q: That would go completely against your training as a physician, correct?

- Q: Because you understand the findings you make may be a matter of life and death for your patient, true?
- Q: The hospital where you work is a teaching hospital, true?
- Q: In addition to treating patients, you also have responsibilities that involve teaching medical residents, true?
- Q: Can we agree that you train and instruct your residents to do everything they reasonably can to promote the health, safety and well-being of their patients?
- Q: Would it be fair to say you do not encourage your residents to do the "bare minimum" when it comes to treating a patient, true?
- Q: To the extent you saw one of your residents doing the "bare minimum" for a patient, can we agree that would not be in keeping with appropriate standards of medical care?
- Q: Can we agree that is something you would not tolerate?

Here, the choices that were available to the radiologist must be brought out in detail and explored. More than this, the attorney must carefully spell out the negatives or the omissions – the choices the radiologist did not make, but could reasonably have made:

- Q: In your report you wrote the words "spiculated nodule," true?
- Q: You were concerned about cancer, correct?
- Q: You understood that cancer could be a life-threatening event, right?
- Q: That is why you suggested a CT scan in your report, correct?
- Q: To rule out cancer, true?
- Q: In suggesting the CT scan, you were trying to help the patient, true?
- Q: Because you know that early detection may allow for a better outcome in someone diagnosed with cancer, correct?
- Q: Now, after you wrote your findings, you had a choice to make at that point in time, didn't you?

At this point, the choices that were not made and the actions that the radiologist chose not to take must be explored.

Q: Knowing that you were concerned about cancer, you could have picked up the phone and called the surgeon, true?

A: I wrote it in the report.

Q: My question was specific. You had the choice to pick up the phone and call the surgeon, correct?

Q: You had the choice to tell her your concerns, true?

Q: Did anybody say: "Don't call the surgeon?"

Q: That was your choice not to call her, true?

Q: You could have texted the surgeon and let her know: "I am concerned about cancer," correct?

Q: But you chose not to text, true?

Q: You also had the ability to call the patient, true?

Q: You had the choice to convey your concerns and findings directly to the patient, correct?

Q: You made a choice with respect to your patient, true?

Q: The choice you made was to say nothing to your patient about your fears and concerns?

Q: You made a choice not to mention the very thing you were concerned about — cancer?

Here, a low risk open ended question, one where the answer could not possibly hurt the case, can be effective:

Q: Tell us how it helped your patient by choosing not to tell her about your concerns of cancer?

Q: Tell us how it helped your patient to not tell her your suggestion about getting a CT scan?

Q: Tell us how your decision not to tell your patient about your findings was helpful for early detection?

Q: Can we agree that your choice not to tell your patient about your findings allowed the cancer to progress?

A: No. It was in the report.

Q: Is it your testimony that your choice not to say something helped the patient?

Q: Did anyone in the department of radiology say: "Don't tell the patient"?

Q: The choice to keep quiet was yours and yours alone, true?

Q: The better choice would have been to tell your patient: "I saw something that is concerning for cancer - go get a CT scan"?

Q: And wouldn't you agree that had you made that choice it may have allowed patient to live longer?

When cross-examining a witness, it is essential that the attorney take the time to set the witness up before going in for the kill. The best set up will focus on, and dissect, the risks and benefits the witness did and did not consider before making his or her choice. By carefully exploring those risks and benefits that led to the ultimate act or omission you will be well on your way to creating a compelling and winning argument on summation.

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