Techniques for Dealing with an Adversarial Medical Expert

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The involvement of medical experts (MEs) in Social Security Disability hearings is often seen as unwelcome news for many practitioners. First, an ME, by nature, is (or should be) a tremendously knowledgeable witness in matters of medicine, and medicine is an area where the representative simply cannot evenly compete with the ME. Second, ALJs are known to rely heavily on ME testimony when determining a claimant’s residual functional capacity (RFC). As a result, it is not surprising that the task of cross-examining an ME makes some practitioners uneasy; perhaps even a bit nervous. The task becomes even harder when the ME takes a clearly adversarial position towards the claimant’s case during his/her testimony. But what exactly is an “adversarial position” in a Social Security Disability hearing? After all, the hearing is designed to be a non-adversarial proceeding, meaning that all expert witnesses are supposed to be neutral.

It is important to point out that unfavorable testimony, in and of itself, is not necessarily adversarial. On the other hand, in order for testimony to be adversarial, it does not have to be confrontational or combative. Simply stated, in an SSD/SSI hearing, an adversarial position is taken when a witness gives testimony designed to advance or defend a position for the purpose of creating a prevailing side. In regards to an ME (or any expert, for that matter), an adversarial position towards the claimant materializes when it becomes clear during the direct or cross-examination of the doctor that he/she does not believe that the claimant is disabled.

Below, I have included a cross-examination scenario involving ME testimony. The scenario only addresses the testimony of an ME in regards to physical, not mental impairments. However, the questions can be used in all cases involving MEs. Many of the questions that I’ve included in the cross are questions that I consistently use. Obviously, they are examples and have been edited, so they should not be taken as a “be all, end all” of an ME’s cross-examination, but they have proven to be quite useful.

In any case, the most important principle to remember when cross-examining an ME is to always try to argue your case through the cross-examination.

Scenario

The claimant is a 43 year old male with past relevant work (PRW) as a waiter and a bartender. He claims disability as a result of severe pain and weakness due to a back impairment and carpal tunnel syndrome. To be specific, an MRI of the claimant’s lumbar spine revealed degenerative disc disease, with bulges at the L3-L4 and L4-L5 levels and a large right paracentral herniated disc at the L5-S1 level with mild foraminal encroachment. No frank nerve compromise, impingement or any other abnormalities were shown. EMG testing of the claimant’s lower extremities was negative. The claimant underwent a series of epidural-block injections as part of his pain management treatment, which was recommended by his treating orthopedist of 4 years, as a result of his
complaints of radiating pain to his legs (mostly the right leg). No surgical recommendation was made by his treating orthopedist. The claimant takes prescription pain medications as indicated by his primary care physician, who (at the time of the hearing) had treated the claimant for over 6 years. In addition, the claimant has been diagnosed with severe carpal tunnel syndrome of his right hand (the claimant is right hand dominant). The diagnosis was confirmed by a positive NCV/EMG of the claimant's right wrist. The claimant alleges that his right hand is not only painful but weak when he has to hold objects weighing “2 or 3 pounds.” The claimant’s orthopedist did recommend surgery for his carpal tunnel but the claimant could not afford the cost of the surgery due to his insurance plan’s deductible and co-pay responsibility.

The claimant’s treating orthopedist did not provide a physical residual functional capacity (RFC) form on behalf of the claimant. However, he did write a narrative letter stating that the claimant should refrain from lifting more than 10 to 15 pounds repeatedly and should also avoid any repetitive use of his right hand due to pain and weakness caused by carpal tunnel syndrome. The orthopedist also stated that the claimant should be allowed to sit, stand and walk “as tolerated” in order to avoid increasing symptoms of back pain.

The claimant’s primary care physician provided an RFC form which stated that (among other things) the claimant would be limited to lifting or carrying no more than 10 pounds occasionally, he could sit as tolerated in an 8 hour day but would need a change in position to alleviate pain or discomfort for 5 minutes every 30 minutes; he could stand or walk at least 2 hours in an 8 hour day but would need a change in position to alleviate pain or discomfort for 5 minutes every 30 minutes; the claimant would need to avoid pushing or pulling. Finally, the primary care physician stated that the claimant would be expected to miss 3 or more days of work every month due to his back pain symptomatology and related medical treatment.

ME Testimony

At the hearing, the ALJ called Dr. X, a board certified Family Medicine and Physical Medicine and Rehabilitation (PM&R) physician with over 39 years of experience. The doctor agreed that the claimant’s alleged impairments, which he identified as degenerative disc disease, lumbar disc herniation and carpal tunnel syndrome of the right hand, were severe as defined by Social Security regulations. He stated that none of the claimant’s impairments met or equaled a listing. He testified that based on his review of the medical records, his opinion was that the claimant could lift and carry 20 pounds occasionally and 10 pounds frequently; the claimant would be able to sit for 6 hours in an 8 hour day with an option to change his position for 2 minutes every 30 minutes; the claimant would be able to walk and stand for at least 2 hours in an 8 hour day with a 2 minute break every 30 minutes; the claimant would be able to use his upper extremities to push or pull objects as long as they do not exceed 20 pounds but would not be able to safely use his lower extremities to push or pull due to his back impairment. When it comes to the claimant’s postural abilities, the ME opined that the claimant could occasionally climb ramps and stairs but never ladders, ropes or scaffolds. The claimant could engage in occasional balancing, stooping, kneeling, crouching and crawling. As for manipulative abilities, the claimant had an unlimited ability to reach, he could frequently handle objects with his right hand, constantly
handle object with his left hand, and he had unlimited fingering and feeling capacity. The claimant had no visual limitations but should avoid concentrated exposure to extreme cold, heat, wetness, humidity and fumes, and avoid all exposure to hazards such as machinery and heights.

Cross-Examination of the ME

I. Assessing the ME's Qualifications, Specialization and Treatment History (or Lack Thereof) of the Claimant. C.F.R. 404.1520c, 404.1527 & 416.920c, 416.927

EXAMINATION

ATT: Good Morning Doctor X.

ME: Good Morning.

ATT: Doctor, just to be clear, you’ve never provided medical treatment to the claimant, correct?

ME: That’s correct.

ATT: You’ve never examined the claimant, correct?

ME: Correct.

ATT: I mean, you wouldn’t be able to pick the claimant out of a lineup because you have never even seen him, right?

ME: You’re right.

ATT: So all of your opinions in this case are based on the medical records that you reviewed, isn’t that right?

ME: My review of medical records and my experience treating patients for almost 40 years.

ATT: Ok. Now, doctor, would you categorize the claimant's impairments as orthopedic or neurological in nature?

ME: Well, they are musculoskeletal impairments that involve nerves. Carpal tunnel occurs when the median nerve is pinched in the wrist. The wrist is a joint and the tunnel through which the nerve passes is surrounded by ligaments, bones and muscle tissue. When the nerve is compressed, the person will get symptoms. As for the degenerative disc disease, obviously the disc material housing the nucleolus pulposus, the paste-like substance in the center of the disc, is innervated.
ATT: Understood. But within the musculoskeletal system, do you agree that the specific impairments presented by the claimant fall within the area of orthopedics? I’m not saying that the impairments can only be treated by orthopedic physicians. I’m simply asking whether the impairments themselves, which I understand are musculoskeletal in nature, can be specifically characterized as orthopedic.

ME: Well, orthopedic medicine is the study of the musculoskeletal system. So one can call this gentleman’s conditions orthopedic conditions.

ATT: Thank you. Now, as I understand it, you have two areas of specialization: One is family medicine and the other is PM&R (physical medicine and rehabilitation), correct?

ME: Right.

ATT: But you’re not an orthopedist, right?

ME: Well, I do have training in orthopedics and, in fact, I have a subspecialty in orthopedics.

ATT: Oh, I’m sorry, are you an orthopedic doctor?

ME: No, sir. I’m not. But I have significant training in orthopedics.

ATT: Let me ask this way: Are you a specialist in orthopedic medicine, and by that I mean whether you are board certified in the field of orthopedic medicine or you have been recognized as a specialist in orthopedic medicine by an accredited medical board in the United States?

ME: No.

ATT: Ok. So, no as to both? In other words, you are not board certified in orthopedics and you have not been recognized as a specialist in orthopedics?

ME: Correct.

ATT: Ok. So you’re not an orthopedic specialist. Thank you for clarifying that, doctor.

Tip: Polarize This line of questioning accomplished two specific goals: First, it confirmed that that opinion evidence of this ME should be at the bottom of the pile when it comes to weight due to the fact that he was neither a treating nor examining source. Second, the ME’s specialization was not in the area of orthopedics, which covered the entirety of the claimant’s physical impairment allegations and complaints. See C.F.R. 404.1527 & 416.927, for claims filed before March 27, 2017, stating that SSA will generally give more weight “to the opinion of a specialist about medical issues related to his area of specialty than to the opinion of a source who is not a specialist.” See also C.F.R. 404.1520c & 416.920c, for claims filed after March 27, 2017, stating
that “[t]he medical opinion or prior administrative medical finding of a medical source who has received advanced education and training to become a specialist may be more persuasive about medical issues related to his or her area of specialty than the medical opinion or prior administrative medical finding of a medical source who is not a specialist in the relevant area of specialty.” In this regard, keep an eye out for MEs that haven't practiced in a while or haven’t treated patients with conditions such as the claimant’s.

II. Proving That the Claimant’s Symptoms and Complaints Are Consistent with the Evidence.

**ATT:** Doctor, you already stated that the claimant’s back and wrist conditions were severe impairments, correct?

**ME:** Correct.

**ATT:** And both conditions have been objectively shown by diagnostic testing right? The back issues were shown by the MRI and the carpal tunnel problem by the NCV/EMG? Correct?

**ME:** That’s right.

**ATT:** And, can those conditions, or impairments rather, be reasonably expected to cause pain and discomfort?

**ME:** They could, yes.

**ATT:** And in fact, the claimant underwent a course of pain management, did he not?

**ME:** Yes, he did.

**ATT:** Doctor, are you familiar with epidural-block injections?

**ME:** Yes, I am. Very much, actually.

**ATT:** Have you ever recommended that sort of treatment for your own patients?

**ME:** Many times.

**ATT:** Do you recommend epidural block injections to all of your patients?

**ME:** No. When I make a recommendation for interventional pain management, which is the category where epidural-blocks fall under, I normally do it as an alternative to narcotic pain medications or as step to perhaps avoid surgery . . .
ATT: Doctor, have you prescribed either the same or similar pain medications that the claimant is taking?

ME: Yes.

ATT: So, doctor, is the treatment that the claimant has received for over 6 years objectively consistent with someone who is having continuing pain?

ME: Well, yes. I've already stated that this gentleman's back condition and his carpal tunnel condition may cause pain.

ATT: And could the pain associated with those conditions cause other issues such as lack of range of motion and weakness?

ME: It could, sure. Although I noticed that in most the records his range of motion is either normal or only mildly limited.

ATT: But did the range of motion exams elicit pain? Did you notice that?

ME: Yes, sometimes they did.

ATT: And the range of motion was reduced at least mildly due to his (the claimant’s) complaints of pain? Isn’t that correct?

ME: Some records do state that, yes.

Notice that the ME just proved that the claimant's impairments were demonstrated by medical findings contained in the record and that they are reasonably expected to produce the symptoms that the claimant alleged. See SSR 16-3p.

After the above line of questioning, the representative should ask the following question:

"Doctor, I would like to ask you about the impact of the claimant's exertional and non-exertional impairments on his/her activities of daily living. Based on your review of the evidence and the symptoms that you discussed, would it be inconsistent with the record to state that as a result of the claimant’s impairment(s) and symptoms that you described, the claimant would be completely asymptomatic (i.e., totally fine) for 50 minutes during an hour but for a very limited period of only 10 minutes he/she would have to be off-task in activities like cooking, working, cleaning, etc.?"
If the ME agrees that claimant being off-task for 10 minutes every hour is not inconsistent with the record, your cross-examination should conclude. If he/she does not, you should ask why not? In my experience, and by way of anecdotal evidence, MEs are now testifying that they cannot state the percentage of time that a claimant would be off-task because such an opinion would be “too speculative.” The representative should address this type of testimony as follows:

“So, doctor, your testimony under oath is that even though you have never treated, examined or even seen the claimant, just by reading his records you are able to specifically determine his RFC, which essentially limits him/her to (insert exertional or skill category), but you somehow cannot determine his ability to remain on task? Is that what you are testifying under oath?”

By asking the question in such a manner, the representative makes the point that the ME’s testimony makes little sense, or worse, he/she may be biased.

III. Addressing the ME’s RFC Testimony.

ATT: Doctor, can you state the basis that you relied on to give an opinion regarding the claimant’s residual functional capacity?

ME: I based those opinions on my review of the records as well as my experience treating patients with conditions like the claimant has.

ATT: Did those records include the letter from the claimant’s orthopedic doctor and the RFC form from the primary care physician?

ME: Yes.

ATT: Ok. I ask because, as you may recall, the orthopedist said that the claimant should refrain from lifting more than 10 to 15 pounds repeatedly and should also avoid any repetitive use of his right hand due carpal tunnel. Also, he said that he (the claimant) should be allowed to sit, stand and walk as tolerated in order to avoid pain. So, first of all, are those recommendations consistent with the condition of the claimant?

ME: I don’t understand what you mean by consistent with his condition. To the extent that those recommendations differ from my RFC assessment, I see no reason why someone with degenerative disc disease with no nerve root involvement or objectively diagnosed radiculopathy, couldn’t lift anything heavier than 20 pounds. I mean, I agree that the claimant should avoid activities that cause pain. No doubt. But I would expect him to be able to tolerate sitting, standing and walking for 30 minutes taking a break for a few minutes. I do not see anything in the record that would indicate more significant restrictions.
ATT: I’m sorry, doctor. Are you saying that, to a reasonable degree of medical certainty, someone that has degenerative disc disease with a large paracentral herniated disc and carpal tunnel of his dominant hand will automatically be able to lift as much as 20 pounds and sit, stand and walk for a whole hour with a couple of two minutes breaks simply because they have no nerve root involvement in the lumbar spine? Is that what you’re saying?

ME: What I’m saying is that I am very familiar with this gentleman’s condition. In almost 40 years of treating patients I’ve seen conditions like his a thousand times. Patients that I’ve personally treated are able to lift 20 pounds with either the same or similar diagnostic findings. They can also sit and walk with very short breaks.

ATT: I see. So, are you saying, to a reasonably degree of medical certainty, that because your patients that have similar conditions to those of the claimant are able to lift 20 pounds and sit and stand with very short breaks, this claimant must also be able lift 20 pounds and sit, walk and stand for an hour with a couple of short breaks?

ME: I’m not saying that because my patients can do certain things everyone else can. I’m saying that in my experience this gentleman’s condition would not preclude the restrictions I spoke about.

ATT: Ok. So let me clarify this. You’re not saying that every person that has the conditions that the claimant has, also necessarily experiences the same type of symptoms and has the same type of limitations that he is experiencing, correct?

ME: Correct.

ATT: Ok. So would you agree that people suffering from the same medical condition or impairment can certainly experience different symptoms and limitations; some more severe and intense than others?

ME: Sure.

ATT: Pain is a subjective symptom, right?

ME: Correct.

ATT: And subjective, that means it cannot be objectively measured and people have different levels of tolerance for it because it can feel more intense for one person than another, correct?

ME: Yes.
ATT: So with that in mind, what specific medical evidence have you relied on to state to a reasonably degree of medical certainty that someone with degenerative disc disease of the lumbar spine, a large paracentral herniated disc and carpal tunnel syndrome of his dominant hand will have the residual functional capacity that you testified to?

ME: As I stated before, my experience treating patients with these types of conditions.

ATT: But being that you have agreed that just because your patients can do certain things while suffering from the same condition as the claimant doesn’t mean that everyone suffering from the those conditions can do the same things, are you aware of any studies, articles or medical research that show that someone with the claimant’s actual medical impairments will have or be expected to have the actual residual functional capacity that you testified the claimant should be expected to have?

ME: I’m not aware of any studies or research that deal with the correlation between someone's specific condition and a specific individual's residual functional capacity. It seems to me that for that someone would need to observe and study only the patient in an environment like a functional capacity evaluation (FCE), which I do not believe was done in this case. At least I didn’t see one done.

ATT: So the answer to my question is no, correct?

ME: I’m not aware of any studies of the type you mentioned.

ATT: I see. So with that in mind, what about your experience allows you to be able to state that this claimant can lift 20 pounds for up to two and a half hours during a workday? Tip: ME testimony should address THE claimant not simply A claimant.

ME: I didn’t say that. I said that he could lift 20 pound occasionally. Tip: Make sure the ME realizes what the SSD strength definitions actually mean!

ATT: Doctor, are you aware that occasionally is defined by Social Security regulations as an activity that can occur up to one-third of a work day?

ALJ: Excuse me counsel, but that’s not an accurate definition of occasional. You know better than that. Occasional means occurring from very little up to one-third of the time.

ATT: Yeah, but he didn’t say that the claimant could lift 20 pounds for very little time. That means that according to his RFC the claimant can lift 20 pounds up to one-third of the time according to the definition. How’s that inaccurate judge?

ALJ: Well, it seems that the doctor did not understand your question.

ATT: Really? Well, let me try again. Doctor, how often can this claimant lift or carry 20 pounds?
ME: To be safe, it would be on a limited basis. Most likely once or twice every 30 minutes to an hour.

ATT: I see. So you’re not saying that the claimant can lift 20 pounds whenever someone wants him to lift 20 pounds, correct?

ME: Correct.

ATT: Doctor, is it your testimony that the claimant would be able to carry 20 pounds twice an hour for a total of one-third of an hour, which is 20 minutes?

ME: No, that would not be advisable. I’m not necessarily saying that he would not be able to do it, but it would not be ideal.

ATT: And it wouldn’t be ideal because is not as medically safe as to have him carry less weight, correct?

ME: True. Or the same weight for a lesser period of time.

ATT: Well, tell me for how long would the claimant be able to lift or carry 20 pounds in a continuous basis? In other words, from the moment he starts lifting or carrying the 20 pound object, how long can he continue to lift it or carry it?

ME: The type of lifting and carrying that I’m referring to is specific and episodic, not repetitive. Basically, taking an object and moving it from one place to another place; a short distance.

ATT: Would a repetitive use of the claimant’s right hand be expected to increase pain in his wrist, the one with carpal tunnel syndrome?

ME: Depending on the length of the use, it can.

ATT: Would you be able to say exactly how many repetitions the claimant would have to make with his right hand for the pain to increase?

ME: Exactly? No. It would depend on the state of his wrist at that specific time.

ATT: Doctor, do you agree that 10 pounds is less stressful on an impaired joint than 20 pounds?

ME: Well, by its very nature 20 pounds is a heavier weight than 10 pounds. But that doesn’t mean that someone with a condition such as carpal tunnel syndrome is unable to lift 20 pounds.
ATT: Well, my question is not whether someone with carpal tunnel can lift 20 pounds. The question is whether 10 pounds puts less stress on an impaired joint than 20 pounds.

ME: When it comes to weight pressure, yes, obviously 10 pounds will be less pressure than 20 pounds.

ATT: So would you say it is inconsistent with the medical evidence in this case for the claimant’s PCP to recommend for the claimant a lifting and carrying restriction of 10 pounds instead of 20 pounds?

ME: I don’t understand. What do you mean by inconsistent with the medical evidence?

ATT: The evidence shows that the claimant has carpal tunnel syndrome in his right wrist and he has been recommended surgery. Correct?

ME: Yes.

ATT: The medical records show that he’s having pain; actually, some records state severe pain, in his right wrist, correct?

ME: Yes.

ATT: So, would you say that the PCP’s recommendation that the claimant lift or carry 10 pounds instead of 20 is inconsistent with the finding of the claimant’s carpal tunnel syndrome in his right dominant hand?

ME: I don’t know what you mean by inconsistent.

ATT: Ok. Let me explain. I’m assuming that if the claimant had only complained of carpal tunnel syndrome and his doctor had told him that as a result of the carpal tunnel he should avoid sitting for more than 30 minutes at a time, that recommendation would not logically correlate with the impairment? Correct?

ME: Probably not.

ATT: But in this case the recommendation is that he should lift no more than 10 pounds. Is that recommendation reasonable and consistent with the finding of severe carpal tunnel syndrome?

ME: Is a more conservative recommendation.

ATT: But is it unreasonable? Tip: Make doctor state weather recommendation is reasonable and consistent with the evidence in the record. If not, why SPECIFICALLY not?
ME: I would not say that, no.

ATT: Doctor, do you believe that the claimant’s treating orthopedist is being unreasonable in his statement regarding the claimant’s ability to lift and carry?

ME: I never said he was.

ATT: Do you believe that an opinion that this claimant can lift 10 to 15 pounds instead of 20 is unreasonable or inconsistent with the medical evidence that you’ve reviewed?

ME: No, I don’t. I simply believe that based on this gentleman’s records and my experience dealing with patients, he should be expected to lift 20 pounds at least twice in an hour.

ATT: You said that the claimant would be able to sit for 30 minutes with two breaks of two minutes each, right?

ME: Yes. I would expect him to be able to do that.

ATT: The claimant’s primary care physician has an assessment similar to yours but instead of two breaks of two minutes each, he believes that the claimant would benefit from two breaks of 5 minutes. Do you recall that?

ME: Yes, I read the form he filled out.

ATT: Do you believe that assessment is unreasonable or inconsistent with the evidence?

ME: I don’t see why he would have to take a 5 minute break every 30 minutes.

ATT: Understood. But my question is whether the assessment is inconsistent with the medical evidence in the record, not with your opinion as to what the assessment should be.

ME: If the individual is in pain, depending on the degree of pain, 5 minutes may be a necessary amount of time. It could be less.

ATT: Or more.

ME: Of course. It would depend on the intensity and duration of the pain.

ATT: When you testified as to the claimant’s RFC, did you consider the claimant’s pain to make your opinions?

ME: I did.
ATT: So, based on your testimony, do all of your patients that have a condition like the claimant have the same RFC that you testified to?

ME: I feel that we’ve already covered this, but to answer the question, no.

ATT: Well, doctor, you’re going to have to help me out on this. So let me lay the predicate for my question. You gave this claimant an RFC of lifting no more than 20 pounds occasionally with the sitting, standing and walking restrictions that you mentioned and you based that RFC on the records and your experience treating thousands of patients that have the condition or a similar condition that the claimant has, right?

ME: Yes.

ATT: And you testified that people that have the same medical condition can experience different symptoms and limitations and just because one person can do something doesn’t mean that the other can do the same, right?

ME: Right.

ATT: You also said that pain is subjective so that it affects people differently, right?

ME: Right.

ATT: So my question is this: If the claimant has medical conditions that are expected to produce pain and the basis for your RFC is your review of the records and your extensive treatment of patients with the claimant’s condition, and based on your experience in the treatment of patients you’d expect the claimant to have the RFC you testified to, even taking into account his subjective complaints of pain, then all of your patients that have the same condition of the claimant should be expected to have the same RFC of the claimant, right?

ME: Not necessarily. Many of my patients are of advanced age. Others have had surgery which failed to improve their condition.

ATT: Have you ever treated patients of a similar age of the claimant that didn’t have surgery but had the same conditions of the claimant?

ME: I’ve treated patients of all ages with or without surgeries.

ATT: So is the answer yes?

ME: Yes.
ATT: Would you say that all of those patients that were of a similar age of the claimant and didn’t have surgery have the exact same RFC that you testified about the claimant?

ME: Not necessarily. Someone’s RFC is by definition particular to that person.

ATT: Thank you, sir. I completely agree. So, with that mind, is it inconsistent with the medical evidence in this case for someone with the medical conditions that the claimant has to occasionally lift 20 pounds and sit for 30 minutes but to experience bouts of pain that would decrease his ability to lift and carry and to sit, stand and walk?

ME: It is certainly possible. I do not see that as a restriction in this case though.

ATT: Well, I know it’s possible, but is it inconsistent?

ME: I would not necessarily call it inconsistent. Someone with increased episodes of pain will obviously be less able to carry out exertional functions than someone with no or very little pain.

ATT: Doctor, you agree that the true measure of someone’s residual functional capacity is not what the person can potentially do but what the person can actually safely do. Is that correct?

ME: Obviously . . .

The purpose of this cross was two-fold. First, make sure to confront the ME with the questions addressing the consistency of the claimant’s complaints with the evidence of record. Remember; the opinions of the claimant’s treating physician(s) do not have to be a 100% consistent with all of the medical evidence. They simply cannot be inconsistent with the evidence. Second, always ask the ME on what basis did he/she rely upon to come up with the RFC that he/she did. Notice that the ME gave inconsistent testimony. He testified that the claimant had a particular RFC based on his review of records and experience but when confronted on how did his treatment to his patients correlated to the claimant’s RFC, he did not have a concrete (or coherent) answer. To the extent he answered, he actually made the claimant’s point under 96-7p. Also, remember that someone’s RFC, whether physical or mental, is not measured in a vacuum. The real measure of someone’s RFC is whether the individual can engage in specific mental or exertional activities safely. The regulations, however, do not mention the word “safely” when addressing an individual’s RFC. See 404.1545 and 416.945 Definition of RFC: Residual functional capacity is the most you can still do despite your limitations. TOTAL LIMITING EFFECTS: Pain or other symptoms may cause a limitation of function beyond that which can be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone; e.g., someone with a low back disorder may be fully capable of the physical demands consistent with those of sustained medium work activity, but another person with the same disorder, because of pain, may not be capable of more than the physical demands consistent with those of light work activity on a sustained basis.
However, although the ME’s testimony has to comply with Social Security regulations, the substantive portion of his/her testimony is medical in nature. The most important principle behind the practice of medicine is “never do harm.” A physician, therefore, has a duty to make sure that his opinions are not contrary to that principle. This is true even when the physician is testifying as an expert. Therefore, an ME cannot give testimony stating opinions that are harmful to an individual (harmful is not equivalent to unfavorable) and contrary to the available medical evidence provided to him/her, regardless of the setting in which the doctor is giving that testimony. To do so goes contrary to the physician’s code of ethics. **Tip: See AMA Code of Medical Ethics.**

**IV. Polarize the ME’s Testimony When He/She Is Critical of a Treating Physician’s Medical Care or Treatment Plan.**

**ME:** The records do show that the claimant was prescribed pain medications and that he received two sets of epidural injections. I frankly do not see the reason why the second set of epidural injections was recommended.

**ATT:** Doctor, are you saying that the claimant’s treating physician went below the accepted standard of care when he made the recommendation? I mean, did he commit medical malpractice?

**ME:** No, sir. I’m not saying that. I do question the actual necessity of the second set of injections but if he felt that that was warranted, I would not say that he deviated from the standard of care.

**ATT:** So what you’re saying is that your personal choice would not have been to order the second set of injections but that the treating doctor complied with the accepted stand of care when he ordered the injections?

**ME:** Correct.

Don’t be afraid of polarizing the ME testimony, i.e., making the ME choose one position or another. As an example, either the claimant’s treating physician committed malpractice (i.e., his treatment went below the accepted standard of care) or he did not. If he did not, the treatment complied with the accepted standard of care and is reasonable. Personally, I do not know of a case where the ME said that a treating doctor committed malpractice. If the treatment prescribed complied with the standard of care, the opinion of the treating doctor should still carry more weight than that of the ME.

I also utilize this line of questions in order to differentiate the non-treating/non-examining status of the ME vis-à-vis my client’s treating physician(s).

- The claimant’s treating physician(s) actually provided medical treatment to the claimant, correct? You did not, correct?
- The claimant’s treating physician(s) performed multiple examinations of the claimant, correct? You did not, correct?
• **If applicable**: The claimant’s treating physician(s) reviewed the actual MRI scan, (or whatever diagnostic test was performed) not just a report, correct? You did not, correct?
• The claimant’s treating physician(s) designed a plan of treatment for the patient, which is the claimant, correct? You did not, correct?
• You agree, don’t you, that the claimant’s treating physician(s) is (are) much more familiar than you with the claimant and how his/her specific impairment(s) is/are actually affecting him/her?

V. The ME Relies on an Unfavorable FCE Report or CE Report

ATT: Doctor, do you agree that in this case there was only a single FCE performed?

ATT: Doctor, do you agree that the FCE report states that it was conducted for only 41/2 hours (or whatever time the FCE took to be completed), correct?

ATT: Isn’t it true that at the beginning of the FCE, the claimant was told that he was allowed to suspend any activity due to pain or any other symptom and take multiple breaks?

ATT: Doctor, do you believe that a single evaluation conducted for only 41/2 hours (or for whatever time the FCE took to be completed) where the claimant is allowed to take multiple breaks is an accurate and valid measure of what a claimant can physically do for a whole work day of 8 hours, 5 days a week?

ATT: Doctor, did you find any reports following up or documenting the condition of the claimant subsequent to the FCE?

ATT: Did you see any reports documenting that the claimant was in significant pain for two days (or whatever time) after the FCE?

ATT: Assuming that the claimant experienced a significant increase in pain (or whatever symptom) after the FCE, would you agree that such is an important fact to be considered?

The same line of questioning can be used if the ME relies on an unfavorable CE. By undermining the validity or reliability of the CE’s findings, the ME’s testimony will suffer from the same deficiencies.

VI. The ME Fails or Refuses to Consider the Claimant’s Subjective Complaints.

It is not uncommon for an ME to testify about the claimant’s RFC without considering his/her subjective complaints even after medical signs and/or laboratory findings prove that an impairment is present (e.g. MRI shows a herniated disc). For this type of testimony, it is advisable to confirm the ME’s failure to consider the claimant’s complaints and the object to the testimony during closing arguments. Below, you can find a sample cross-examination and argument.
ATT: Doctor, did you consider the claimant’s complaints of pain and numbness when you came up with his RFC? (Tip: Use the term “came up”. It re-enforces the arbitrary nature of the ME’s RFC testimony).

ME: No, I didn’t. I based his RFC solely on the objective evidence in the record.

ATT: And by objective you mean what specific evidence?

ME: The MRI reports in exhibit 14F and the examinations and impressions of [claimant’s primary care physician, orthopedic doctor, and pain management doctor] in exhibits 2F, 3F, 4F, 7F, 8F, 9F, 10F, 11F and 16F.

ATT: And the MRI report describes the claimant’s herniated discs in his neck and back, right?

ME: It does. But it doesn’t show any frank impingement on nerve roots.

ATT: But one can have discogenic pain even if a disc doesn’t impinge on a nerve, right?

ME: Yes.

ATT: Well, [the claimant] complained of pain and numbness to his doctors in all of those visits and they planned his treatment accordingly, correct?

ME: Yes, subjective complaints.

ATT: But you did not consider his complaints at all, right?

ME: Not to determine his RFC. I only considered objective evidence, as I already stated.

At this point, the best plan is to allow the ME’s testimony to stand. However, look at a relevant portion of CFR §§404.1545 & 416.945.

(3) Evidence we use to assess your residual functional capacity.

We will also consider descriptions and observations of your limitations from your impairment(s), including limitations that result from your symptoms, such as pain, provided by you, your family, neighbors, friends, or other persons.

Further, SSR 16-3p states as follows:

Once the existence of a medically determinable impairment that could reasonably be expected to produce pain or other symptoms is established, we recognize that some individuals may experience symptoms differently and may be limited by symptoms to a greater or lesser extent than other individuals with the same
medical impairments, the same objective medical evidence, and the same non-medical evidence. *In considering the intensity, persistence, and limiting effects of an individual’s symptoms, we examine the entire case record, including the objective medical evidence; an individual’s statements about the intensity, persistence, and limiting effects of symptoms; statements and other information provided by medical sources and other persons; and any other relevant evidence in the individual’s case record.*

The ME’s opinion goes contrary to plain language of the CFR and the rule. Still, to continue to question the ME as to why he/she rejected, dismissed or overlooked the claimant’s subjective complaints would simply invite the ME so explain his testimony. Therefore, the representative should simply point out during a closing argument that the ME’s testimony regarding the claimant’s RFC is deficient as it goes contrary to SS regulations. By doing this during the closing argument, the ME has no opportunity to cure his/her flawed RFC testimony and opinions.

**Endnotes:**

1. Part of these materials were also included in a presentation titled “How to Cross-Examine Experts”: August of 2015, WCI (Worker’s Compensation Institute) Annual Conference, Orlando, Florida.

2. Off-task means that the claimant will not be able to complete tasks in a satisfactorily manner or period of time.

3. I have turned this answer into a question: Doctor, isn’t it true that someone with increased episodes of pain will be less able to carry out exertional functions than someone with little or no pain?