

To obtain a comprehensive understanding of your client's medical case, it is essential that you create a narrative time line of your client's treatment records. By organizing relevant physician notes, orders, consults, nurses findings, and the results of diagnostic and laboratory tests in chronological order before filing the suit, you will get a far better understanding of your client's course of treatment than by simply reviewing a hospital or other medical record, in the fortuitous manner it is presented.

Attorneys must insist on timely service of defendant's interrogatory answers. It is common practice to receive incomplete answers from the defendant to uniform interrogatories mandated by the court rules. A demand for more specific answers to interrogatories will invariably be required, followed by a formal motion addressed to the court. Even the most diligent attorney will find it takes a minimum of four to six months before responsive answers are provided.

It is common for defense counsel to interpose objections to uniform interrogatory questions required by the court rules, to assert objections such as the need for clarification of the interrogatory, an assertion that the interrogatory calls for a legal conclusion, or a claim that the interrogatory is unduly broad and overly burdensome. None of these objections have any merit in view of the fact that R. 4:17-1(b)4 requires that "every question propounded by a uniform interrogatory must be answered unless the court has otherwise ordered."

Uniform Interrogatory Form C(3), question 1, seeks the identity of every person in the vicinity of the alleged occurrence. Defense counsel routinely attempts to avoid giving an answer to this question by taking the position that it is unclear what the "alleged occurrence" is. While such an answer is improper under any circumstances, it can be even further avoided by plaintiff's counsel providing detailed allegations in response to uniform interrogatory form A(1), question number 7, which seeks plaintiff's contentions as to the negligence of the defendants.

Uniform Interrogatory Form C(3), questions 2 and 3, seek detailed narratives from the defendant physician regarding the care provided to the plaintiff. Interrogatory 9 seeks a description of defendant's informed consent interview, and interrogatory 15 requires an explanation from the physician defendant as to why consultations were ordered and requests the reports received by the defendant from such consults. Since it is common for physicians to recall details about the care provided to a plaintiff that goes well beyond what has been written in the defendant's medical chart, or to claim that what has been written in the medical chart is merely a summary, plaintiff's counsel must reject a defense response which generically references the medical records. R. 4:17-4(a) requires interrogatory answers to be furnished "separately, fully and responsively." Id. It is the defendant's obligation to collect information and supply it in the form required by the rule, and defense counsel should not be permitted to allow their clients to cleverly avoid the rule. Seiden v. Allen, 135 N.J. Super. 253, 256 (Ch. Div. 1975).

Uniform Interrogatory Form C(3), question 4 requires the defendant to attach a complete curriculum vitae. In the first instance, having this information will avoid wasting valuable deposition time and costs to learn the details of a defendant's professional background and education. Moreover, and more importantly, the professional boards and societies to which a defendant belongs often publish standards and practice publications that will serve to corroborate

your expert's opinions about such standards and eliminate much of the debate on these issues at trial.

Uniform Interrogatory number 6 seeks complete information about past malpractice suits. Since R. 4:17-4 requires that responses be furnished by supplying all information available to the party, the party's agents, employees and attorneys, a defendant may not simply avoid providing a responsive answer by claiming a failure to have such details committed to memory. This information is clearly available to the doctor and his counsel. Uniform Interrogatory number 11 seeks information about peer review materials. The ancillary information concerning peer review meetings mandated by this interrogatory is not subject to a claim of privilege. Whether a particular document resulting from a peer review investigation is privileged depends on its substance and the availability of the information contained in the document from other sources. See Christy v. Salem, 366 N.J. Super. 535 (App. Div. 2004). Defendants should not be permitted to block all inquiry into this area of evidence by asserting a blanket objection to a question which has been mandated by the court rules.

Demands for documents pursuant to R. 4:18-1 serve as an excellent tool to buttress your expert's position regarding the standard of care from which the defendant deviated. If a defendant physician is employed by a group or organization, employment contracts or shareholder agreements executed by members of such organizations often require the physician to practice medicine in accordance with the standards of a particular professional society. Such contracts and agreements may also delineate the defendant's responsibilities with respect to rounding, being on call, supervising physician assistants and residents, and interacting with other members of the group. While some of this information may be confidential in nature, case law clearly establishes that the information must be disclosed if relevant. Lakewood Trust Co. of Lakewood v. Fidelity & Deposit Co. of Maryland, 81 N.J. Super. 529 (Law Div. 1963); Gureghian v. Hackensack Hospital, 109 N.J. Super. 143, 148 (Law Div. 1970).

It is also not uncommon for physician groups to generate triage protocols regarding communications between patients and the office relevant to potential emergencies by telephone or otherwise. If a hospital is a defendant in a case, resident codes of conduct, resident/hospital employment contracts, medical staff bylaws, medical staff rules and regulations, coding booklets and hospital protocols, are all extremely useful in supporting plaintiff's expert testimony on applicable standards. These materials become extremely useful where there are multiple defendants in the case, all of whom are disclaiming responsibility for patient monitoring, yet, nevertheless, fail to implicate one another.