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STATE OF MICHIGAN
IN THE SUPREME COURT
APPEAL FROM THE COURT OF APPEALS

ANTONIO SELLIMAN,

Plaintiff-Appellant,

vs.

JEFFREY J. COLTON, MD,
JEFFREY J. COLTON, PLLC, and
THE COLTON CENTER,

Defendants-Appellees.

Supreme Court Case No. 163226
Court of Appeals Case No. 352781
Lower Court Case No. 2018-167068-NH
Hon. Jeffrey S. Matis
Oakland County Circuit Court

PLAINTIFF-APPELLANT'S APPENDIX

*****ORAL ARGUMENT REQUESTED*****

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PLAINTIFF-APPELLANT'S APPENDIX
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24	*Mallory v Beaumont Health Sys.,* Docket No. 350263, rel'd December 22, 2020 (unpublished decision of the Court of Appeals)	378a-389a
25	*Strasser v Oakwood Heritage Hospital,* Docket No. 355496, rel'd November 4, 2021 (unpublished decision of the Court of Appeals)	390a-401a

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APPENDIX 1

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Court Explorer

Register of Actions

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Case Number
2018-167068-NH
Entitlement
SELLIMAN ANTONIO vs. COLTON JEFFREY J
Judge Name
JEFFERY S. MATIS
Case E-Filed
YES
Case Filed
07/16/2018
Case Disposed
10/20/2020

Date	Code	Desc
05/06/2022	CPL	CONTINUED PENDING OTHER LITIGATION
05/06/2022	APC	ADJ-COUNSEL 05122022 TO 07252022
05/06/2022	APR	DATE SET FOR STAT CONF ON 07252022 09 00 AM Y 04
05/06/2022		PROCEEDING TO BE HELD REMOTELY BY ZOOM
03/08/2022	AID	ADJOURN FOR INVESTIGATION/DISCOVERY
03/08/2022	APC	ADJ-COUNSEL 03102022 TO 05122022
03/08/2022	APR	DATE SET FOR STAT CONF ON 05122022 09 00 AM Y 04
01/21/2022	CPL	CONTINUED PENDING OTHER LITIGATION
01/21/2022	APC	ADJ-COUNSEL 01242022 TO 03102022
01/21/2022	APR	DATE SET FOR STAT CONF ON 03102022 09 00 AM Y 04
01/13/2022	JNA	JUDGE NOT AVAILABLE
01/13/2022	APJ	ADJ-JUDGE 01212022 TO 01242022
01/13/2022	APR	DATE SET FOR STAT CONF ON 01242022 09 00 AM Y 04
10/04/2021	CPL	CONTINUED PENDING OTHER LITIGATION
10/04/2021	APC	ADJ-COUNSEL 10082021 TO 01212022

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Date	Code	Desc
10/04/2021	APR	DATE SET FOR STAT CONF ON 01212022 08 30 AM Y 04
08/19/2021	CPL	CONTINUED PENDING OTHER LITIGATION
08/19/2021	APC	ADJ-COUNSEL 08202021 TO 10082021
08/19/2021	APR	DATE SET FOR STAT CONF ON 10082021 08 30 AM Y 04
07/15/2021	AID	ADJOURN FOR INVESTIGATION/DISCOVERY
07/15/2021	APC	ADJ-COUNSEL 07162021 TO 08202021
07/15/2021	APR	DATE SET FOR STAT CONF ON 08202021 08 30 AM Y 04
07/01/2021	CA	CLAIM OF APPEAL FILED COA/SELLIMAN
07/01/2021	MPS	MIFILE PROOF OF SERVICE FILED
06/22/2021	AID	ADJOURN FOR INVESTIGATION/DISCOVERY
06/22/2021	APC	ADJ-COUNSEL 06212021 TO 07162021
06/22/2021	APR	DATE SET FOR STAT CONF ON 07162021 08 30 AM Y 04
05/20/2021	ORD	ORDER FILED COA
05/17/2021	CPL	CONTINUED PENDING OTHER LITIGATION
05/17/2021	APC	ADJ-COUNSEL 05242021 TO 06212021
05/17/2021	APR	DATE SET FOR STAT CONF ON 06212021 09 00 AM Y 04
03/16/2021	CPL	CONTINUED PENDING OTHER LITIGATION
03/16/2021	APC	ADJ-COUNSEL 03232021 TO 05242021
03/16/2021	APR	DATE SET FOR STAT CONF ON 05242021 08 30 AM Y 04
02/04/2021	MPS	MIFILE PROOF OF SERVICE FILED
02/04/2021	ORD	ORDER FILED SUB ATTY/DFTS
11/19/2020	SEN	SENT TO COA/FTP/JM
11/12/2020	NTC	NOTICE FILED REQ FOR FILE COA
10/20/2020	FD	FINAL DISPOSITION
10/20/2020	SY	STAY COA GRANTED LEAVE
10/20/2020	STO	STIP/ORD FILED STAY PROCEEDINGS
10/19/2020	MPS	MIFILE PROOF OF SERVICE FILED
09/28/2020	JNA	JUDGE NOT AVAILABLE
09/28/2020	APJ	ADJ-JUDGE 10192020 TO 10202020
09/28/2020	APR	DATE SET FOR PRETRIAL ON 10202020 10 00 AM Y 04

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Date	Code	Desc
06/30/2020	AID	ADJOURN FOR INVESTIGATION/DISCOVERY COVID 19 EMRGY OPS
06/30/2020	APC	ADJ-COUNSEL 07062020 TO 10192020
06/30/2020	APR	DATE SET FOR PRETRIAL ON 10192020 08 30 AM Y 04
05/27/2020	ORD	ORDER FILED COA
05/22/2020	JNA	JUDGE NOT AVAILABLE COVID 19 EMRGY OPS
05/22/2020	APJ	ADJ-JUDGE 08032020 TO 11022020
05/22/2020	APR	DATE SET FOR TRIAL ON 11022020 08 30 AM Y 04
03/30/2020	TRN	TRANSCRIPT FILED 03/04/2020 MTN HRNG
03/27/2020	JNA	JUDGE NOT AVAILABLE COVID19 EMERG OPS
03/27/2020	APJ	ADJ-JUDGE 04062020 TO 07062020
03/27/2020	APR	DATE SET FOR PRETRIAL ON 07062020 08 30 AM Y 04
03/27/2020	JNA	JUDGE NOT AVAILABLE COVID19 EMERG OPS
03/27/2020	APJ	ADJ-JUDGE 05262020 TO 08032020
03/27/2020	APR	DATE SET FOR TRIAL ON 08032020 08 30 AM Y 04
03/04/2020	DM	DEFENSE MOTION STAY PROCEED & ADJ TRIAL -G- & -D- IN PART
03/04/2020	AID	ADJOURN FOR INVESTIGATION/DISCOVERY
03/04/2020	APC	ADJ-COUNSEL 04062020
03/04/2020	APR	DATE SET FOR PRETRIAL ON 04062020 08 30 AM Y 04
03/04/2020	APR	DATE SET FOR TRIAL ON 05262020 08 30 AM Y 04
03/04/2020	ADJ	ORDER OF ADJOURNMENT FILED TRIAL/DENY MTN STAY PROCEED
03/02/2020	RES	RESPONSE FILED TO MTN LIMINE PRECLUDE REFERENCE/PLF
03/02/2020	RES	RESPONSE FILED TO MNT LIMINE LIMINT PROOFS/BRF/PLF
03/02/2020	RES	RESPONSE FILED TO MTN LIMINE PRECLUDE QUESTION/BRF/PLF
03/02/2020	RES	RESPONSE FILED TO MTN LIMINE PRECUDE CRITICISM/BRF/PLF
03/02/2020	RES	RESPONSE FILED TO MTN LIMINE PRECLUDE QUESTION/BRF/PLF
03/02/2020	MPS	MIFILE PROOF OF SERVICE FILED

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Date	Code	Desc
02/26/2020	MPR	MOTION PRAECIPE FILED FOR 03042020 JUDGE 04
02/26/2020	MTN	MOTION FILED LIMINE PRECLUDE REF TO PRO LIABILITY/DFT
02/26/2020	MTN	MOTION FILED LIMINE PRECLUDE PLF QUESTIONING DFT/NOH
02/26/2020	MTN	MOTION FILED LIMINE LIMIT PLFS PROOFS TO CLAIM/NOH/DFT
02/26/2020	MTN	MOTION FILED LIMINE PRECLUDE EXPERT WITNESSES/DFT
02/26/2020	MTN	MOTION FILED LIMINE PRECLUDE CRITICISMS OF DFTS/NOH
02/26/2020	MPS	MIFILE PROOF OF SERVICE FILED
02/21/2020	NTC	NOTICE FILED FILING TRANSCRIPT
02/21/2020	MPS	MIFILE PROOF OF SERVICE FILED
02/21/2020	TRN	TRANSCRIPT FILED MTN SUM DISP 01/29/20
02/20/2020	MPR	MOTION PRAECIPE FILED FOR 03042020 JUDGE 04
02/20/2020	MTN	MOTION FILED FOR STAY PROCEEDINGS/BRF/NOH/POS/DFT
02/20/2020	MPS	MIFILE PROOF OF SERVICE FILED
02/19/2020	CA	CLAIM OF APPEAL FILED /POS/DFT
02/07/2020	MSR	MEDIATION STATUS REPORT FILED
02/03/2020	MSR	MEDIATION STATUS REPORT FILED
01/29/2020	DM	DEFENSE MOTION STRIKE DR. ARMSTRONG-DENIED
01/29/2020	DM	DEFENSE MOTION SUMMARY DISPOSITION-GRANTED/DENIED IN PART
01/29/2020	ORD	ORDER FILED MTN STRIKE DENIED/SUM DISP GRTD/DENIED
01/02/2020	TRN	TRANSCRIPT FILED MTN AMD WITNESS LIST 12/11/19
12/18/2019	OMA	CASE EVALUATION OUTCOME 11072019 REJECTED
12/13/2019	ORD	ORDER FILED RE FACILITATION
12/12/2019	ORD	ORDER FILED DENY PLF MTN AMD WITNESS LIST
12/12/2019	MPS	MIFILE PROOF OF SERVICE FILED
12/11/2019	MPS	MIFILE PROOF OF SERVICE FILED
12/11/2019	M	MOTION TO AMEND WITNESS LIST DENIED
12/10/2019	PTH	PRE-TRIAL HELD HELD OFF THE RECORD
12/10/2019	AID	ADJOURN FOR INVESTIGATION/DISCOVERY

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Date	Code	Desc
12/10/2019	APC	ADJ-COUNSEL 01272020 TO 04062020
12/10/2019	APR	DATE SET FOR TRIAL ON 04062020 08 30 AM Y 04
12/10/2019	ORD	ORDER FILED FOLLOW PRETRIAL CONFERNCE
12/06/2019	MPS	MIFILE PROOF OF SERVICE FILED
12/06/2019	RES	RESPONSE FILED MTN AMD WLT/POS/DFTS
12/04/2019	MPR	MOTION PRAECIPE FILED FOR 12112019 JUDGE 04
12/04/2019	MTN	MOTION FILED AMD WIT/BRF/NOH/POS/PLF
12/04/2019	MPS	MIFILE PROOF OF SERVICE FILED
12/02/2019	STO	STIP/ORD FILED AMD CASE CAPTION
11/27/2019	MPS	MIFILE PROOF OF SERVICE FILED
11/25/2019	MPS	MIFILE PROOF OF SERVICE FILED
11/25/2019	BRF	BRIEF FILED REPLY IN SUPT MTN STRIKE/SUM DISP/DFT
11/18/2019	MPS	MIFILE PROOF OF SERVICE FILED
11/18/2019	RES	RESPONSE FILED MTN TO STRIKE SUM DISP/BRF/POS/PLF
10/22/2019	MPS	MIFILE PROOF OF SERVICE FILED
10/22/2019	NOH	NOTICE OF HEARING FILED /POS
10/22/2019	MPR	MOTION PRAECIPE FILED FOR 01292020 JUDGE 04
10/21/2019	ORD	ORDER FILED RE SUM DISP
10/16/2019	MPS	MIFILE PROOF OF SERVICE FILED
10/16/2019	MTN	MOTION FILED SUM DISP/BRF/NOH/POS/DFT
09/06/2019	APR	DATE SET FOR CASE EVAL ON 11072019 11:00 AM
09/05/2019	MPS	MIFILE PROOF OF SERVICE FILED
09/05/2019	WLT	WITNESS LIST FILED SUPPLEMENTAL/EXH/POS/DFT
08/01/2019	SE	SCHEDULING ERROR
08/01/2019	APJ	ADJ-JUDGE 09092019 TO 12102019
08/01/2019	APR	DATE SET FOR PRETRIAL ON 12102019 08 30 AM Y 04
07/01/2019	APM	ADJOURNED PER CASE EVALUATION CLERK FROM 08082019
07/01/2019	APR	DATE SET FOR CASE EVAL ON 11072019 NO TIME SET
06/28/2019	AID	ADJOURN FOR INVESTIGATION/DISCOVERY
06/28/2019	APC	ADJ-COUNSEL 12102019 TO 09092019

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Date	Code	Desc
06/28/2019	APR	DATE SET FOR PRETRIAL ON 09092019 08 30 AM Y 04
06/28/2019	AID	ADJOURN FOR INVESTIGATION/DISCOVERY
06/28/2019	APC	ADJ-COUNSEL 10282019 TO 01272020
06/28/2019	APR	DATE SET FOR TRIAL ON 01272020 08 30 AM Y 04
06/28/2019	ADJ	ORDER OF ADJOURNMENT FILED SCHED ORD/STP
06/27/2019	MPS	MIFILE PROOF OF SERVICE FILED
06/19/2019	MTN	MOTION FILED ADJ SO DATES/BRF/POS/PLF
06/19/2019	NOH	NOTICE OF HEARING FILED /POS
06/19/2019	MPS	MIFILE PROOF OF SERVICE FILED
06/19/2019	OTH	DFT CONCUR TO MTN ADJ SO DATES FILED
06/19/2019	MPS	MIFILE PROOF OF SERVICE FILED
06/19/2019	MPR	MOTION PRAECIPE FILED FOR 07032019 JUDGE 04
06/18/2019	INT	INTERROGATORIES FILED /POS
06/18/2019	MPS	MIFILE PROOF OF SERVICE FILED
06/11/2019	WLT	WITNESS LIST FILED 1ST/POS/PLF
06/11/2019	MPS	MIFILE PROOF OF SERVICE FILED
06/07/2019	APR	DATE SET FOR CASE EVAL ON 08082019 10:15 AM
06/05/2019	NTC	NOTICE FILED TAKING DEP/POS
06/05/2019	MPS	MIFILE PROOF OF SERVICE FILED
06/03/2019	WLT	WITNESS LIST FILED /EXH/POS/DFT
06/03/2019	MPS	MIFILE PROOF OF SERVICE FILED
12/29/2018	OJR	CASE REASSIGNED FROM JUDGE ANDERSON TO JUDGE MATIS
10/11/2018	AFF	AFFIDAVIT FILED MERIT DEFENSE MICHAEL CARRON
10/11/2018	POS	AFFIDAVIT/PROOF OF SERVICE FILED
10/04/2018	STO	STIP/ORD FILED PROT ORD
10/02/2018	POS	AFFIDAVIT/PROOF OF SERVICE FILED
09/26/2018	ORD	ORDER FILED PRETRIAL
09/24/2018	SO	SCHEDULING ORDER FILED
09/22/2018	SOP	SCHEDULING ORDER WRITTEN
09/22/2018		06/07/2019 EXPERT DATE.

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Date	Code	Desc
09/22/2018		08/08/2019 CASE EVALUATION DATE.
09/22/2018		06/11/2019 WITNESS DATE.
09/22/2018		08/09/2019 MOTION DATE.
09/22/2018		07/11/2019 DISCOVERY DATE.
09/22/2018		09/09/2019 SETTLEMENT CONFERENCE.
09/22/2018		10/28/2019 TRIAL DATE.
09/22/2018	APR	DATE SET FOR PRETRIAL ON 09092019 09 00 AM
09/22/2018	APR	DATE SET FOR TRIAL ON 10282019 09 00 AM
09/07/2018	ANS	ANSWER FILED TO DFT AFM/POS/PLF
09/07/2018	POS	AFFIDAVIT/PROOF OF SERVICE FILED
08/29/2018	MPR	MOTION PRAECIPE FILED FOR 10032018 JUDGE 04
08/29/2018	MTN	MOTION FILED PROTECT ORD/BRF/NOH/POS/DFT
08/29/2018	POS	AFFIDAVIT/PROOF OF SERVICE FILED
08/16/2018	APP	APPEARANCE FILED /POS/DFTS
08/16/2018	ATC	ANSWER TO COMPLAINT FILED /AFM/JD/POS/DFTS
08/16/2018	POS	AFFIDAVIT/PROOF OF SERVICE FILED
07/31/2018	SUM	P/S ON SUMMONS FILED 07/26/18
07/31/2018	SUM	P/S ON SUMMONS FILED 07/26/18
07/31/2018	SUM	P/S ON SUMMONS FILED 07/26/18
07/31/2018	POS	AFFIDAVIT/PROOF OF SERVICE FILED
07/16/2018	C	COMPLAINT FILED /JURY DEMAND
07/16/2018	SI	SUMMONS ISSUED
07/16/2018	SI	SUMMONS ISSUED
07/16/2018	SI	SUMMONS ISSUED

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APPENDIX 2

This case has been designated as an eFiling case. To review a copy of the Notice of Mandatory eFiling visit www.oakgov.com/clerkrod/Pages/efiling.

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

2018-167068-NH

JUDGE MARTHA D. ANDERSON

ANTHONY SELLIMAN,

Plaintiff,

Hon. _____

Case No: 2018- -NH

vs.

JEFFREY J. COLTON, MD,

JEFFREY J. COLTON, PLLC,

and THE COLTON CENTER,

Defendants.

MICHAEL T. RATTON (P42399)
RATTON LAW GROUP, PC
Attorneys for Plaintiff
201 E. Fourth Street
Royal Oak, Michigan 48067
P| (248) 291-6776
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PLAINTIFF'S COMPLAINT AND JURY DEMAND

There is no other civil action between these parties arising out of the same transaction or occurrence as alleged in this Complaint pending in this Court, nor has any such action been previously filed and dismissed or transferred after having been assigned to a judge, nor do I know of any other civil action, not between these parties, arising out of the same transaction or occurrence as alleged in this Complaint that is either pending or was previously filed and dismissed, transferred or otherwise disposed of.

/s/ Michael T. Ratton
MICHAEL T. RATTON (P42399)

NOW COMES Plaintiff, ANTHONY SELLIMAN, by and through his attorneys, MICHAEL T. RATTON and RATTON LAW GROUP, PC, and for his Complaint against the above named Defendants states as follows:

COMMON AND JURISDICTIONAL ALLEGATIONS

1. This is a medical malpractice action brought before the Court.

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2. At all times relevant hereto, Plaintiff, Anthony Selliman, lived in Rochester, Michigan.

3. At all times relevant hereto Jeffrey J. Colton, MD, Jeffrey J. Colton, PLLC, and The Colton Center were medical practitioners and/or facilities located in the City of Novi, County of Oakland, State of Michigan.

4. The acts, transactions and occurrences complained of herein occurred in the County of Oakland, State of Michigan.

5. The amount in controversy greatly exceeds this Court's jurisdictional limit, exclusive of costs, interest and attorney's fees.

FACTUAL ALLEGATIONS

6. Plaintiff re-alleges and incorporates by reference the preceding paragraphs as if fully set forth, line for line, and word for word.

7. Defendants were given notice of intent to file malpractice suit within the applicable statute of limitations, pursuant to MCL 600.2912b.

8. The Affidavit of Merit is attached hereto as required by MCL 600.2912(d). (Attachment A).

9. This case arises out of the treatment of Anthony Selliman ("Plaintiff") which began in 2012 by the named Defendants above.

10. Mr. Selliman is a 55-year old male patient who presented to The Colton Center in 2012 and underwent multiple procedures by Dr. Colton between 2012 and 2017.

11. Specifically on January 12, 2016, Defendant, Dr. Colton performed his 4th surgery on the Plaintiff. The procedure was a scheduled rhinoplasty surgery. This routine surgery was meant to reshape Mr. Selliman's nose, including narrowing the bridge of the nose and reshaping the tip of the nose.

11. On or about February 5, 2016, Mr. Selliman saw Dr. Colton in his office for a post-operative visit. During this visit, Dr. Colton administer approximately seven (7) steroid injections into the area surrounding Mr. Selliman's nose, in an attempt to minimize the nasal deformity which resulted from the January rhinoplasty. Mr. Selliman was instructed to return to The Colton Center in thirty (30) days for additional treatment.

12. On or about March 1, 2016, Mr. Selliman returned to The Colton Center for additional treatment with Dr. Colton. On this visit, Dr. Colton administered an additional six (6) steroid injections into Mr. Selliman's nose and surrounding tissue, again in an attempt to correct the damage caused by the prior rhinoplasty.

13. Further, during the March visit, Dr. Colton promised Mr. Selliman he could narrow and lower Mr. Selliman's nose and remove tissue on the bridge of the nose by performing another surgery.

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14. On or about June 16, 2016, in reliance on the aforementioned promises, Mr. Selliman underwent another surgical procedure by Dr. Colton in an attempt to narrow and reshape his nose. Following this procedure, Dr. Colton again promised he could and would accomplish his goal of reshaping and narrowing Mr. Selliman's nose with another surgery. Dr. Colton further assured Mr. Selliman that the nasal deformity he was afflicted with was correctable.

15. In April 2017, Dr. Colton performed a 6th plastic surgery procedure in an attempt to lower and narrow Mr. Selliman's nose.

16. In November 2017, Mr. Selliman underwent a 7th surgical procedure in an attempt to narrow and lower his nose.

17. In November 2017, Mr. Selliman presented to The Colton Center for treatment with Dr. Colton. During this visit, Dr. Colton recommended additional steroid injections in an attempt to correct the damage to Mr. Selliman's nose and facial tissue. Further, Dr. Colton stated he would correct the damage caused to Mr. Sellimans nose and facial tissue by performing another surgery, in conjunction with the additional steroid injections.

18. To date, no further surgery has been performed and Mr. Selliman remains with a nasal deformity.

19. The above mentioned nasal deformity was the result of Dr. Colton's negligent performance of the initial rhinoplasty, and the subsequent negligence in performing multiple and identical operative procedures without variation leading to a worsening undesirable result.

20. As a result of Defendants' negligence, Plaintiff suffered grave injuries, including, but not limited to:

A) Severe and permanent damage to his nose and surrounding tissues;

B) Facial asymmetry;

C) Scarring and disfigurement;

D) Constant pain;

E) Conscious pain and suffering;

F) Mental anguish;

G) Mortification and humiliation;

H) Embarrassment;

I) Economic Loss;

J) All other damages allowed by law.

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COUNT I

NEGLIGENCE AND MEDICAL MALPRACTICE

AS TO JEFFREY J. COLTON, MD

21. Plaintiff re-alleges and incorporates by reference the preceding paragraphs as if fully set forth, line for line, and word for word.

22. At all times relevant to this lawsuit, Defendant Jeffrey J. Colton, MD was a medical professional employed by and/or otherwise an agent of Jeffrey J. Colton, PLLC and/or The Colton Center.

23. At no time prior to his treatment of Mr. Selliman did Defendant have an independent, physician-patient relationship with Mr. Selliman.

24. At the time of Mr. Selliman's care and treatment, Defendant Jeffrey J. Colton, MD, was a medical professional employed by and/or otherwise an agent of Jeffrey J. Colton, PLLC and/or The Colton Center, which are thus vicariously liable for Defendant's acts of medical malpractice.

25. At all times pertinent hereto, the Defendant undertook and had a duty to provide Mr. Selliman with competent medical care and treatment which would at all times be in accordance with the following acceptable standards of care:

A) Perform an appropriate history and physical examination of the patient;

B) Document history, physical examination, follow-up medical visits, and interactions with the patient;

C) Provide a safe environment for surgical intervention including, but not limited to appropriate documentation of the surgical procedure including patient medical status, vital signs, and response to anesthesia;

D) Obtain and document appropriate informed consent;

E) Refrain from performing an unnecessary surgical procedure;

F) Refrain from performing the same operative procedure without variation, leading to a worsening undesirable result;

G) Refer to or consult with a colleague after several failed operations and before proceeding with additional surgeries;

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H) Use Radiesse, an injectable filler, in an appropriate fashion to achieve compliance with patient wishes; and

I) Do no harm to the patient.

26. Defendant breached the standards of care named above.

27. These breaches of the standard of care resulted in a severe nasal deformity.

28. As a direct and proximate cause of the negligence and breach of the standard of care complained of herein by the Defendant, Plaintiff sustained severe pain and suffering, resulting from the negligent performance of the initial rhinoplasty, and the subsequent negligence in performing multiple and identical operative procedures without variation leading to a worsening undesirable result. Defendant is liable therefore.

WHEREFORE, Plaintiff requests that this Honorable Court enter judgment in his favor against the Defendant, in an amount determined to be fair and just together with all interest, attorneys' fees and costs allowable by law.

COUNT II

NEGLIGENCE, GROSS NEGLIGENCE AND/OR MEDICAL MALPRACTICE AS TO JEFFREY J. COLTON, PLLC & THE COLTON CENTER

29. At the time that Plaintiff, Anthony Selliman, went to Jeffrey J. Colton PLLC and/or The Colton Center seeking medical care and treatment, he looked to the Center to provide him with physicians, nurses and health care providers and reasonably believed that they were all acting as agents and/or employees of the Center due to affirmative acts and/or omissions of the Center.

30. Mr. Selliman's reasonable belief that the above physician(s), nurse(s), and health care provider(s) were agents or employees of the hospital was created by words, conduct and/or omissions of Defendants Jeffrey J. Colton, PLLC and The Colton Center.

31. Defendants Jeffrey J. Colton, PLLC and The Colton Center are responsible for all phases of operation of their health facility, the selection of medical staff and health care, and quality of care rendered in the health facility pursuant to MCL §333.20141 and MCL §333.20151.

32. Defendants Jeffrey J. Colton, PLLC and The Colton Center are liable for the acts of medical malpractice committed by the above referenced doctors, nurses, and other health care providers, including, but not limited to, Defendant Jeffrey J. Colton, MD, pursuant to the doctrine of Respondeat Superior and/or ostensible agency.

33. At the time of the above treatment, Defendants Jeffrey J. Colton, PLLC and The Colton Center owed duties to the general public, but especially to Anthony Selliman, to act reasonably, prudently and to comply with the pertinent standards of care by way of its care and treatment of Rochelle Ruhl.

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34. Defendants Jeffrey J. Colton, PLLC and The Colton Center and/or their authorized agents, servants and/or employees breached the above duties and obligations owed to Anthony Selliman by acting contrary to the acceptable standards of care, and therefore committed medical malpractice and are professionally negligent in the following particulars, which include, but are not limited to:

A) Perform an appropriate history and physical examination of the patient;

B) Document history, physical examination, follow-up medical visits, and interactions with the patient;

C) Provide a safe environment for surgical intervention including, but not limited to appropriate documentation of the surgical procedure including patient medical status, vital signs, and response to anesthesia;

D) Obtain and document appropriate informed consent;

E) Refrain from performing an unnecessary surgical procedure;

F) Refrain from performing the same operative procedure without variation, leading to a worsening undesirable result;

G) Refer to or consult with a colleague after several failed operations and before proceeding with additional surgeries;

H) Use Radiesse, an injectable filler, in an appropriate fashion to achieve compliance with patient wishes; and

I) Do no harm to the patient.

35. The liability of Defendants Jeffrey J. Colton, PLLC and The Colton Center is also based on the theory of respondeat superior. The above-described physician(s), resident(s), nurse(s) and other health care providers were the actual or ostensible agents of the health care providers and are liable for their negligence.

36. As a direct and proximate cause of the negligence and breach of the standard of care complained of herein by the Defendants Jeffrey J. Colton, PLLC and The Colton Center, Plaintiff sustained severe pain and suffering, resulting from the negligent performance of the initial rhinoplasty, and the subsequent negligence in performing multiple and identical operative procedures without variation leading to a worsening undesirable result. Defendants are liable therefore.

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WHEREFORE, Plaintiff requests that this Honorable Court enter judgment in his favor against the Defendants, jointly and severally, in an amount determined to be fair and just together with all interest, attorneys' fees and costs allowable by law.

37. Affidavit of Merit pursuant to MCL 600.2912(d) is attached and incorporated herein.

Respectfully submitted,

/s/Michael T. Ratton

Michael T. Ratton (P42399)

Attorney for Defendant

201 E. Fourth Street

Royal Oak, MI 48067

Dated: July 13, 2018

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DEMAND FOR JURY TRIAL

NOW COMES Plaintiff, ANTHONY SELLIMAN, by and through his attorneys, MICHAEL T. RATTON and RATTON LAW GROUP, PC, and hereby requests trial by jury in the above-captioned matter.

Respectfully submitted,

/s/Michael T. Ratton

Michael T. Ratton (P42399)

Attorney for Defendant

201 E. Fourth Street

Royal Oak, MI 48067

Dated: July 13, 2018

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APPENDIX 3

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COMMONWEALTH OF VIRGINIA)
) ss.
CITY OF RICHMOND)

AFFIDAVIT OF MERIT – MICHAEL ARMSTRONG, M.D.

I Michael Armstrong, Jr., M.D. being first duly sworn, deposes and says:

1. I attended Duke University, Durham North Carolina, graduating with a M.D. in 1989.
2. Between 1989 and 1995, I completed my postdoctoral training consisting of an Internship and Residency at John Hopkins Hospital in Baltimore, Maryland.
3. I am currently licensed to practice medicine in the Commonwealth of Virginia.
4. I became certified by the American Board of Otolaryngology in 1995 and by the American Board of Facial Plastic and Reconstructive Surgery in 2001.
5. During the one year prior to the treatment involved in this case I devoted the majority of my professional time to the active clinical practice of Otolaryngology and Facial Plastic and Reconstructive Surgery.
6. At the request of attorney Michael Ratton, I have reviewed medical records of Anthony Selliman as produced by Dr. Theodore Golden and Dr. Jeffrey Colton.
7. I have also reviewed the Notice of Intent to File Claim pursuant to MCL 600.2912(B) served on behalf of the estate of Anthony Selliman.
8. I affirm that I have personal knowledge of the facts stated in this affidavit.

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9. If sworn as a witness, I can testify competently to the facts stated in this affidavit.

10. I have advised attorney Michael Ratton that I believe reasonable cause exists for the filing of the lawsuit concerning the medical treatment rendered to Anthony Selliman. This opinion and the opinions stated below are based upon the information currently available to me. I reserve the right to modify my opinions as additional information becomes available subsequent to the lawsuit of this matter being filed.

11. I am of the opinion that the standard of care applicable to Jeffrey Colton, M.D. was that of his peers in the professional community in the medical specialty of on Otolaryngology and Facial Plastic and Reconstructive Plastic Surgery.

12. It is my opinion that the requirements of the standard of care included but were not limited to the following:

a. Perform appropriate history and physical examination;

b. Document history, physical examination, follow-up medical visits and interactions with the patient;

c. Provide a safe environment for surgical intervention including but not limited to appropriate documentation of the surgical procedure including patient medical status, vital signs and response to anesthesia;

d. Obtain and document appropriate informed consent;

e. Refrain from performing an unnecessary surgical procedure;

f. Refrain from performing the same operative procedure without variation leading to a worsening undesirable result;

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g. Refer to or consult with a colleague after several failed operations and before proceeding with additional surgeries;

h. Use Radiesse in an appropriate fashion to achieve compliance with patient wishes;

13. It is my opinion that Dr. Colton violated the standard of care when he failed to:

a. Perform appropriate history and physical examination;

b. Document history, physical examination, follow-up medical visits and interactions with the client;

c. Provide a safe environment for surgical intervention including but not limited to appropriate documentation of the surgical procedure including patient medical status, vital signs and response to anesthesia;

d. Obtain and document appropriate informed consent;

e. Refrain from performing an unnecessary surgical procedure;

f. Refrain from performing the same operative procedure without variation leading to a worsening undesirable result;

g. Refer to or consult with a colleague after several failed operations and before proceeding with additional surgeries;

h. Use Radiesse in an appropriate fashion to achieve compliance with patient wishes;

14. In order to comply with the standard of care, Dr. Colton should have performed the following acts:

a. Perform appropriate history and physical examination;

b. Document history, physical examination, follow-up medical visits and interactions with the client;

c. Provide a safe environment for surgical intervention including but not limited to appropriate documentation of the surgical procedure

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including patient medical status, vital signs and response to anesthesia;

d. Obtain and document appropriate informed consent;

e. Refrain from performing an unnecessary surgical procedure;

f. Refrain from performing the same operative procedure without variation leading to a worsening undesirable result;

g. Refer to or consult with a colleague after several failed operations and before proceeding with additional surgeries;

h. Use Radiesse in an appropriate fashion to achieve compliance with patient wishes;

15. It is further my opinion that as a result of the violations of the standard of care as outlined above, Anthony Selliman suffered severe and permanent damage to his nose and surrounding tissues including pain, suffering, facial asymmetry, scarring, disfigurement, emotional distress and other injuries. These sequelae occurred as a consequence of a breach of the standards of care in properly performing a history and physical assessment, obtaining informed consent, performing skillful rhinoplasty, performing multiple repeated surgeries, and failing to properly diagnose and treat damages and complications.

16. Further the affiant sayeth naught.

M. Armstrong

Michael Armstrong, M.D.

Subscribed and sworn to before me

this 11 day of July, 2018

Debra V. Larkin

Personally known ✓ or Produced Identification ___

Type of Identification Produced _____

Debra V. Larkin
Notary for the Commonwealth of Virginia
#220644
Commission expires: April 30, 2019

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APPENDIX 4

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

ANTHONY SELLIMAN,

Plaintiff,

v

Case No. 18-167068-NH
Hon. Martha D. Anderson

JEFFREY J. COLTON, M.D., JEFFREY J. COLTON, PLLC, and THE COLTON CENTER,

Defendants.

MICHAEL T. RATTON (P42399)
RATTON LAW GROUP, PC
Attorney for Plaintiff
201 E. Fourth St.
Royal Oak, MI 48067
(248)291-6776
mratton@rattonlaw.com

PAUL J. DWAIHY (P66074)
ERIC T. RAMAR (P77713)
PLUNKETT COONEY
Attorney for Defendants
150 West Jefferson, Suite 800
Detroit, MI 48226
(586) 783-7621
pdwaihy@plunkettcooney.com

AFFIDAVIT OF MERITORIOUS DEFENSE OF MICHAEL A. CARRON, M.D. ON BEHALF OF JEFFREY J. COLTON, M.D., JEFFREY J. COLTON, PLLC AND THE COLTON CENTER

STATE OF MICHIGAN)
)ss.
COUNTY OF WAYNE)

MICHAEL A. CARRON, M.D., being first duly sworn, deposes and state as follows:

1. I am familiar with the facts herein and I can competently testify to their truth.

2. I am a medical doctor, I am licensed to practice medicine in Michigan, and I am board certified by the American Board of Otolaryngology-Head and Neck Surgery and the American Board of Facial, Plastic and Reconstructive Surgery.

3. During the time period at issue in this case and the year preceding, I devoted the majority of my professional time to the active clinical practice of otolaryngology-head and neck surgery and facial, plastic and reconstructive surgery.

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4. I have reviewed the Notice of Intent, Complaint, Affidavit of Merit signed by Michael Armstrong, M.D. and the medical records of Anthony Selliman, including those of Dr. Jeffrey Colton.

5. The facts upon which I rely and base my opinions are contained within the above noted pleadings and medical records, which I have reviewed. In forming my opinions, I further rely on my medical education, training and experience.

6. I understand the standard of care applicable to Jeffrey Colton, M.D. in this matter to be that which a physician specializing in otolaryngology-head and neck surgery and facial, plastic and reconstructive surgery of ordinary learning, skill and judgment would do or would not do under the same or similar circumstances as existed in treating Plaintiff Anthony Selliman.

7. I believe that Jeffrey Colton, M.D. complied with the applicable standard of care in all respects in his care and treatment of Anthony Selliman, including in performing the multiple rhinoplasty procedures on Mr. Selliman.

8. The standard of care required Dr. Colton to obtain an appropriate history from Mr. Selliman; obtain informed consent; and perform the rhinoplasty procedures in a reasonable manner. I believe Dr. Colton complied with the standard of care by doing all of the above.

9. The standard of care did not require, as alleged in Plaintiff's Notice of Intent, Complaint and Affidavit of Merit, Dr. Colton to refrain from performing any of the procedures which he performed, obtaining any consultations, or using Radiesse.

10. I do not believe that any act or alleged failure to act by Dr. Colton proximately caused Mr. Selliman to sustain injury or damage.

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11. To the extent Dr. Colton is an agent, servant and/or employee of Jeffrey J. Colton, PLLC and/or The Colton Center, those corporate entities also complied with the standard of care in the treatment of Mr. Selliman and therefore did not proximately cause injury or damage.

12. I reserve the right to amend and/or supplement my opinions as additional information becomes available during the course of discovery.

MICHAEL A. CARRON, M.D.

Subscribed and sworn to before me this
10 day of October, 2018.

Natalia Apolyn
Notary Public

Wayne County, State of Michigan
Acting in Wayne County, MI
My Commission Expires: 08/17/2020

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PROOF OF SERVICE

The undersigned certifies that on the 11th day of October, 2018, a copy of the foregoing document was served upon the attorney(s) of record in this matter at their stated business address as disclosed by the records herein via:

☐ Hand delivery	☐ Overnight mail
☐ U.S. Mail	☐ Facsimile
☐ Email	☒ Electronic E-File

I declare under the penalty of perjury that the foregoing statement is true to the best of my information, knowledge and belief.

/s/Marjorie E. Renaud
Marjorie E. Renaud

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APPENDIX 5

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE

COUNTY OF OAKLAND

ANTHONY SELLIMAN, Plaintiff,	:	
v.	:	CASE NO.:
JEFFREY J. COLTON, M.D.,	:	18-167068-NH
JEFFREY J. COLTON, PLLC,	:	
and	:	
THE COLTON CENTER, Defendants.	:	

Deposition of MICHAEL ARMSTRONG, JR., M.D.

Richmond, Virginia

Tuesday, September 24, 2019

11:08 a.m.

Job No.: 837939

Pages 1 - 135

Reported by: Helen B. Yarbrough, RPR, CCR

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Deposition of MICHAEL ARMSTRONG, JR., M.D., held at the offices of:

ADVANCED OTOLARYNGOLOGY, P.C.
8700 Stony Point Parkway, Suite 110
Richmond, Virginia 23235

Pursuant to agreement, before Helen B. Yarbrough, RPR, CCR, Notary Public in and for the Commonwealth of Virginia.

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A P P E A R A N C E S

ON BEHALF OF PLAINTIFF ANTHONY SELLIMAN:

MICHAEL T. RATTON, ESQUIRE
RATTON LAW GROUP
1300 Broadway, Seventh Floor
Detroit, Michigan 48226
248-291-6776

ON BEHALF OF DEFENDANTS JEFFREY J. COLTON, M.D., JEFFREY J. COLTON, PLLC, AND THE COLTON CENTER:

PAUL J. DWAIHY, ESQUIRE
PLUNKETT COONEY
150 West Jefferson, Suite 800
Detroit, Michigan 48226
586-783-7621

ALSO PRESENT:
Anthony Selliman

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P R O C E E D I N G S

(Dr. Armstrong Deposition Exhibit 1, Exhibit 2, Exhibit 3, Exhibit 4, and Exhibit 5 were marked for identification and are attached.)

Whereupon,

MICHAEL ARMSTRONG, JR., M.D.,

being first duly sworn or affirmed to testify to the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR THE DEFENDANTS

BY MR. DWAIHY:

Q Good morning, Doctor. Would you please state your full name for the record.

A Yes. My name is Michael Armstrong, Jr.

Q And your date of birth, please.

A October 9th, 1962.

Q And your professional address, please.

A 8700 Stony Point Parkway, Suite 110, Richmond, Virginia 23235.

Q Thank you. That's where we are today?

A We are near my office in the same building.

Q Thank you for that. Before we started the deposition, I marked for the record certain exhibits that I want to discuss with you.

Before we do that, I will put on the record

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that this is the discovery-only deposition of Dr. Michael Armstrong, taken pursuant to notice and agreement of the parties.

Doctor, you've had your deposition taken many times before, correct?

A Yes, I have.

Q If I ask you a question that does not make sense, would you please tell me that.

A Yes, I will.

Q Thanks. If you do, I'll try to rephrase it so we're understanding one another. Similarly, if I ask you a question that you do not have an opinion on or to which you simply don't know the answer, please tell me that. Okay?

A Yes.

Q If you do tell me that, I'll move on to another topic.

Finally, if I ask you a question that falls outside your area of expertise, let me know that as well. Okay?

A Yes.

Q I don't want you to answer any of those questions either.

If I ask you a question and you answer it, I'll assume that we are understanding one another, and

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I'll move on to the next question or topic. Is that fair?

A Fair enough.

Q We have marked with your help -- and thank you again -- as Exhibit Number 1 a binder of materials, and that binder contains an Affidavit of Merit that you signed in this case, correct?

A Correct.

Q Did Mr. Ratton or someone from his office prepare this affidavit for your review and signature?

A We have prepared it together, so I stand by, you, know what I wrote at the time.

Q Okay. Did Mr. Ratton or someone from his office actually prepare it in terms of typing it for you to review and then sign?

A I don't recall.

Q Do you know whether there was a rough draft of this affidavit prepared?

A I am sure that they would have gone through preparation stages and corrections until it was finalized, but I don't have the other drafts of that.

Q Okay. Do you recall being provided with an affidavit and you making changes to it and sending it back to Mr. Ratton?

A I don't specifically recall in this case.

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Q Okay. There was also an e-mail correspondence, I think, between you and Mr. Ratton that was originally included in Exhibit Number 1 that was removed. Can you just tell me generally what that was, please.

A It was a summary time line and administrative correspondence back and forth as we were communicating about scheduling and whatever arrangements. I haven't actually looked at it to observe the contents. I've not looked at it in detail to determine the entirety of the contents.

Q Are any of your opinions included in that e-mail correspondence?

A I don't know if there are opinions in there, and I don't know if they are current, because the e-mail correspondence was prior to receiving the documents before me, and so I know that my opinion has evolved over the course of discovery.

Q Did that e-mail correspondence contain information upon which you relied to come to your opinions in this case?

A I have no reason to believe there would be any unique information on which I relied that's not in these other documents.

Q Okay.

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A It would have only been a summary.

MR. DWAIHY: Okay. And Michael, whatever we're talking about, e-mail correspondence or whatever it is, you're saying it's work product, right?

MR. RATTON: Right.

Q Okay. Also included in Exhibit Number 1 is your understanding of what is Dr. Colton's complete chart, correct?

A That is the complete chart as best I've received it, yes.

Q Including photographs of Mr. Selliman throughout the years?

A That is my understanding.

Q And finally, included in Number 1 is the records of Dr. Any Lai -- I think it's L-A-I -- is that correct?

A Correct.

Q And then Exhibit Number 2 seems to be a short time line that you prepared?

A Correct.

Q Okay. And this just outlines the various procedures that Mr. Selliman's undergone; is that correct?

A Correct.

Q And Exhibit Number 3 is a sketch that you

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prepared?

A Yes.

Q Could you please briefly explain to me what that represents.

A It is a tracing that I took of his -- Mr. Selliman's profile from photographs dated August 21, 2014, and I performed some geometric analysis to better explain my rationale for how I might have handled the consultation if I were seeing Mr. Selliman on that date of service.

Q So could you start by reading for me what you wrote --

A Certainly.

Q -- in the upper left-hand corner, please.

A So my notes say, "8/21/2014, slightly feminized nose 'scoop' as requested of Dr. Golden in 2010."

Q That's what the plaintiff in this case asked another surgeon, Dr. Golden, to perform on him back in 2010; he wanted a rhinoplasty that resulted in a slightly feminized nose with a scoop on; is that --

A That is my understanding, yes.

The next line incorrectly says "Convex dorsum." I'm going to change that to "concave," which was my intent.

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Q What does that mean?
A Basically that if you draw a line from the top of the nose, which we sometimes will call the nasion, N-A-S-I-O-N, or radix, R-A-D-I-X --
Q That's the area between the eyes?
A That is the area where the nose attaches to the forehead. It is typically at the upper crease, the crease of the upper eyelid. And if you draw a line from the nasion to the tip of the nose, you see that there is a curvature where the nose curves beneath the straight line. Therefore, there is somewhat of a concavity on profile view, or scoop, as Mr. Selliman called it, with Dr. Golden.
Q So this is all obviously pre-Dr. Colton?
A Correct.
Q Okay. Next line, please.
A The next line says, "Upper tip rotation," and that's an assessment based on the position of the nasal tip, which I am defining here as the most forward-projecting point of the nose. And typically that can range from 90 to 110 degrees, closer to 90 degrees in men, a little bit more upwardly rotated in women. And he does have an upward tip rotation, which is also what he requested of Dr. Golden in 2010, according to my understanding of the records.

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Q Okay. Please continue.
A The next line says, "Requested thinner, decreased projection, and rotate down."
Q Is that what he was requesting of Dr. Colton?
A That's what I understand he was requesting of Dr. Colton; and that was based on an illustration in Dr. Colton's notes, which was dated either from those photographs or from the photographs two years earlier, which were dated November 16th, 2012. There's a composite image in which it's drawn a circle around the nasal tip. There is a line as if to slice off the nasal tip on the left profile view and an arrow suggesting downward rotation.
Q Okay. By the way, included in Exhibit 1, you did not make any notes of your own; is that correct?
A I -- not in -- there are maybe a few notes in the margins. I've numbered some pages.
Q Okay.
A But --
Q I know you told me you made a couple highlights --
A A few highlights.
Q -- randomly.

A Uh-huh.
Q Yes?
A Yes.
Q Okay. There's no substantive notes in terms of your opinion or --
A I'm not aware that there are any opinions written.
Q So can we get back to Exhibit Number 3? When did you prepare Exhibit Number 3?
A Over the weekend, within the past three days.
Q And that's a sketch based on a photograph you saw from August 21st, 2014?
A Correct.
Q And what are your geometric calculations? What do those mean, please?
A So, one of the common criteria used for defining an aesthetic nose geometrically -- and this is based on U.S./Western European aesthetics and doesn't necessarily apply to all ethnicities -- is that the nose on profile view should fit approximately into a 3:4:5 right triangle, and so that the length of the dorsum of the nose from the nasion to the tip should be about five parts, compared to four parts from the nasion down to a line drawn through the tip

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and a line drawn through the alar crease -- alar -- A-L-A-R -- alar crease, which is where the nose attaches to the cheek. A line drawn from the alar crease to the tip should be about three parts.

And if you -- if you measure those distances on Mr. Selliman's nose, you find that I got on this drawing, which is not necessarily to scale, I measured 3.2 centimeters in projection, 4.3 centimeters in height, and 5.4 centimeters in length, which is approximately a 3:4:5 right triangle.

So I would conclude, based on those calculations, that his nasal projection is considered aesthetically ideal by most aesthetic rhinoplasty surgeons.

Q Well, let me ask you a couple of follow-up questions. Those measurements, you did not take from his actual nose, correct?

A I did not take them from the nose. I took them from photographs, which is the way that it would typically be done.

Q You actually took them from your sketch of photographs, correct?

A I traced the photograph as precisely as possible and then measured because I didn't want to deface the original photograph.

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Q This 3:4:5 idea, is that something that you, as a surgeon, does in real life practice when you're performing a rhinoplasty on a patient?

A I don't typically make this measurement on every patient unless I have a question about whether there is congruity about my goals with the patient versus the patient's expectations. Sometimes it's helpful to educate a patient.

I would say that in common practice, it is -- the appearance of beauty is an art that is understood by practicing surgeons and doesn't always require geometric measurements.

Q Typically, you would not actually take geometric measurements of a patient's nose when performing a rhinoplasty; is that correct?

A I would not routinely.

Q That's not standard of care?

A I'm not saying that it is standard of care to make these measurements, no.

Q Fair enough. It's not standard of care?

A I'm saying -- I would say that these numbers are well-established in the literature, well-accepted in the community, but I am not saying that the standard of care requires that these calculations be performed.

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Q Okay. Have you discussed this case in particular of Mr. Selliman with any of your colleagues?

A I have not sought any advice from colleagues, no.

Q In what literature would I find this 3:4:5 concept?

A It would be -- in most standard textbooks of rhinoplasty, I believe that you would be able to find it in -- Ira Papel's Textbook of Facial Plastic Surgery. I can certainly produce references if necessary.

Q Is that a textbook, the one you just referenced, is that one you reference from time to time in your practice?

A I have in the past. It's -- the textbook is from when I was a resident, but it was the primary textbook for facial plastic surgery at the time.

Q Is it a generally reliable source of information in terms of facial plastic surgery, including rhinoplasty?

A Technology's changed. Techniques change over the years, but -- you know, certainly, different surgeons have opinions. Rhinoplasty is a very complex area where people do have opinions. But I would say

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that, yes, it is considered a well-respected textbook.
Q Is it generally reliable?
A I would like you to define that as you understand it.
Q Is it something that you rely on from time to time in your practice with specific respect to rhinoplasty?
A Yes, I will refer to it for -- yes.
Q Is it considered an authority in the ENT world, the facial plastics world?
A That's where I hesitate to agree. I don't want to say that any textbook is authoritative to the point of being infallible, but I would say that it is -- it is a well-respected and well-known textbook.
Q You wouldn't call any textbook authoritative?
A I wouldn't say that anything is perfect, no.
Q Did you do any specific research in this case?
A Yes, I did.
Q Okay. What did you research?
A I did some review of some of my textbooks in facial plastic and plastic surgery, specifically reviewing concepts of rhinoplasty to see if there

would be illustrations that might be helpful. And I also looked at some literature regarding appropriate protocols and procedures for conscious sedation in the office setting.

Q Okay. Let me back up and ask you a couple questions. Which textbooks did you research in particular here? For this case, I mean.

A I don't have that listed, but I could -- I can produce it.

Q I mean, you are going to be relying on textbooks to support your opinions in this case?

A I'm not relying on them. They may be useful for illustration.

Q Okay. You just looked at a textbook that you can't recall as you sit here today, just to look at illustrations of rhinoplasty?

A Ask the question again.

Q I'm just wondering why did you look at a textbook or textbooks with reference to this case.

A Looking to see if I needed to provide illustrations or exhibits to describe what we're seeing, and I haven't brought them in today.

Q Did you find any illustrations that you thought would be applicable to this case?

A There are lots of illustrations in these

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textbooks that could be useful, depending on the questions that you ask.

Q Okay. First of all, do you remember how many textbooks you looked at?

A I don't mean to be evasive. I would be happy just to walk, to go get them. I will be back in 30 seconds.

Q I don't necessarily need them if you're not going to rely on them in this case. But the main point of me asking you these questions is, if you're going to rely on some portion of the textbook, whether it be a photograph or some part of the literature included in the textbook, I need to know about it.

A Right.

Q If you looked at them in general but you're going to tell me, "I'm not relying on anything," then that's fine too. You can tell me that.

A I would say that at the moment, I've looked at the textbooks in general to -- and that I'm relying on my professional experience and training and that I have textbooks that are supportive of my opinions. I'm not personally relying on those textbooks, but I can provide documentation, if necessary, that others would have similar opinions.

Q Okay. Which textbooks are those, please?

A I would -- I can -- I can get them.
Q You can't remember them as you sit here today?
A I can tell you that -- specifically to reference in detail, I can't state the exact title.
Q Okay.
A I can picture them, and I can get -- and I'm happy to show them to you.
Q I'm going to ask you to do that in a minute.
A Okay.
Q Let me finish a couple other things if that's okay.
You also made reference to literature or maybe policies about conscious sedation in the office.
A Yes.
Q What did you look at in that regard?
A I looked at guidelines from the American Society of Anesthesiology, an opinion paper published for emergency physicians. I looked at a Michigan Quality Insurance -- Quality Improvement Guideline for office sedation. I looked at a training policy from a nearby hospital in Michigan, and I looked at a -- those are the first four that come to mind.
Q Why did you look at all these references in

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terms of office sedation?

A I was horrified to see that Mr. Selliman was subjected to moderate conscious sedation in the office without a history and physical examination, without vital signs, and without proper monitoring; and I'm very concerned that there is a fundamentally dangerous practice that is going on in that office.

Q So you were horrified to see that he was subjected to what? Moderate conscious sedation?

A Correct.

Q With no history and physical?

A Correct.

Q No vital signs?

A Correct.

Q And what else?

A No proper monitoring.

Q In terms of what?

A Monitoring vital signs during the procedure, monitoring oxygenation during the procedure, a determination that Mr. Selliman was back to normal baseline at the end of the procedure.

Q Okay. And how did you glean all this information? From reviewing Dr. Colton's chart?

A The -- except for the operative report, the chart was only about four pages, and none of that

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information was there.

Q But I'm talking about -- you're saying you looked at Dr. Colton's chart and saw that he used moderate conscious sedation for these procedures, correct?

A Yes.

Q What does that mean?

A So, he was receiving a mixture of benzodiazepines intravenously. Typically, 2 to 3 milligrams of Versed, V-E-R-S-E-D, which is also known as midazolam, M-I-D-A-Z-O-L-A-M, and 5 milligrams of Valium.

The operative reports described -- and some of the operative reports didn't even say how much drug was given, and it described that these were given in IV push, which is not consistent with the recommended standard of care. These drugs should be given one at a time and slow -- slowly over several minutes. And one of the references suggested that midazolam should never be given more than 2.5 milligrams at one time. And Mr. Selliman on one occasion received 3 milligrams, along with Valium, which is a similar drug, potentiating it. And there is a serious risk of respiratory suppression that could bring harm to a patient.

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Q Okay. So tell me exactly what you think Dr. Colton did not do and should have done in terms of sedating Mr. Selliman at his office, please.

A Okay. He should have taken a comprehensive medical history less than a month before each surgery, and he did not. He should have performed a physical examination, including, at the minimum, examination of the heart and the lungs and the airway, within a month of the surgeries; and he did not. He should have obtained vital signs on the initial consultation and certainly the day of the procedures, before beginning the procedure; and he did not.

He should have had monitoring of some sort, preferably electrocardiographic monitoring and oxygen monitoring. Current guidelines are now recommending CO-2 monitoring, although I'm not sure that that was required at the time of these surgeries. But certainly pulse oximetry and EKG monitoring was appropriate or at least some level of assessment of the level of alertness and airway, and there is no documentation that any of this is done.

As I said, he should have given the midazolam and Valium slowly and titrated in, and he said that it was a bolus. He should have documented the exact dose of medication given. And on at least

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one occasion he simply said "after induction of intravenous sedation," without even specifying what drugs were given.

He should have recorded that the patient was adequately recovered from surgery before discharge, and there's no record of that. He should have advised Mr. Selliman not to have anything to eat or drink for six hours before intravenous sedation, and there's no record that that occurred.

Q Okay. There's no evidence in this case that Mr. Selliman ever suffered from respiratory suppression. True?

A There is not.

Q What I said was true?

A True.

Q There's no evidence in this case that he ever suffered from a heart complication as a result of any of the procedures Dr. Colton performed. True?

A True.

Q There's no evidence in this case that he aspirated on any food or liquid that he'd ingested?

A True.

Q I think we can agree there's no evidence in this case that Mr. Selliman suffered any medical complication as a result of any of Dr. Colton's

surgeries. Correct?
A Except for the nose, agreed.
Q And when you say "Except for the nose," you're talking about he wasn't happy with the appearance of his nose?
A Right.
Q Which we'll talk about more.
A His nose is damaged. But I agree despite -- despite what I consider to be gross negligence with the administration of anesthesia, Mr. Selliman was fortunate enough that he did not suffer from it.
Q Despite your opinions, there was no damage whatsoever with respect to the administration of anesthesia, sedation, and how Dr. Colton performed the surgery in his office setting. True?
A True.
Q Do you perform rhinoplasties or rhinoplasty revisions in your office?
A Very rarely. And not with intravenous sedation.
Q Okay. All right. So all the references, like the policies, the -- I think you referenced, Doctor, some literature from a Michigan hospital -- everything other than the textbooks you told me about

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a few moments ago, those all relate to the sedation issue, correct?

A Correct.

Q Okay. You also told me about a couple textbooks. You said you could picture them, but you couldn't name them for me, but you'd be willing to walk into your office and get them for me so I know which ones they are.

A Yes.

Q Would you please do that if you don't mind?

A I'll be happy to.

MR. DWAIHY: Thanks. Can we take a short break?

(A recess was taken.)

BY MR. DWAIHY: (Continuing)

Q So, Doctor, you kindly just walked into your office, and it looks like you brought back five textbooks. Did you review portions of all those textbooks relative to your work in this case?

A Yes.

Q Okay. Can you tell me what they are briefly -- the name, the author, the publication date, and just briefly why you looked at that particular textbook?

A Well, I would say that I looked at all of

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the textbooks for the same reason, which was to determine if there was -- if there were useful illustrations that might be necessary for explaining my opinions and -- but not necessarily as a basis for forming my opinions, if my distinction is clear.

Q Okay.

A One of the textbooks is Rhinoplasty Problems and Controversies, by Thomas Rees, R-E-E-S, published in 1988 by C.V. Mosby.

Q Did you find any useful information?

A That was not -- that was not the most useful.

Q Okay.

A A more useful textbook, I thought, was Aesthetic Rhinoplasty by Jack Sheen, published by Quality Medical Publishing in 1998. And one particular concept that I do think is useful in this case is a discussion on page 70 about the idea that the nose should curve smoothly off of the eyebrow and that the width of the radix, which is the top of the nose, is somewhat uncontrollable, that that is something that you're basically born with, that you can't change, and that you need to keep a straight line from that area, curving smoothly down into the nose. Okay? So I thought that that was useful. And

this book also had some -- lots of technique photographs, none of which that I have particularly highlighted for discussion today but, if necessary, can refer to or use for illustration.

Q I said five books, but it looks like one book is two.

A This is two volumes, correct.

Q So you're really only talking about four books?

A Four things. I also have a Volume 2 of Reconstructive Plastic Surgery by Converse, and there is a chapter on nasal surgery within here. Chapter 29 is Corrective and Reconstructive Surgery of the Nose, and it has some very nice illustrations if we need them, showing the anatomy of the nose and the techniques for rhinoplasty. So, again, we have that for reference, but I have not selected any for use.

And probably the most useful is Facial Plastic and Reconstructive Surgery by Ira Papel and Nathan Nachlas. This was published by Mosby Yearbook. This was an older edition from 1992. But there is a Chapter 30 analysis in rhinoplasty that talks about the nasal proportions that I was speaking of earlier. And so that discussion is on pages 274 and 275, primarily, and it talks about how the physical

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examination is done for a rhinoplasty.

Q All of the textbooks that you referenced, generally speaking, are they reliable in the field of facial plastic surgery, including rhinoplasty?

A Yes, I would say they are generally reliable.

Q I have to back up and ask you a question I may have neglected to a couple moments ago, just to clear the record. I think we agree on this, but I want to make sure the record's clear for future purposes.

None of the opinions you gave me regarding the sedation method Dr. Colton used and the monitoring of Mr. Selliman in terms of his sedation, et cetera, none of those criticisms of yours resulted -- or alleged breaches of standard of care resulted in any damages to Mr. Selliman, including damage to the appearance of his nose. Is that fair?

A Not quite.

Q Okay.

A The relationship is that -- my opinion is without a proper physical examination, I don't feel that Dr. Colton was able to properly design and deliver the proper nasal surgery. And so the failure to do a proper history and physical examination still

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applies to the planning of the rhinoplasty and the failure to adequately consider the effect of the rhinoplasty on Mr. Selliman and understanding what was feasible, what was not feasible, what was appropriate.

Q In all fairness, you're talking about examining his nose, correct?

A Correct.

Q I'm talking about the opinions you gave me about the history and physical exam including examining his heart and his lungs and monitoring his vital signs. I think I'm asking an obvious question. But none of those criticisms of yours obviously resulted in any damage to Mr. Selliman medically or in terms of the appearance of his nose? That's all I'm trying to establish.

A Correct.

Q All right. And we'll get more into your opinions about the actual rhinoplasty and provisions as we go. Thank you for that.

You are board certified by the American Board of American Otolaryngology, correct?

A Correct.

Q 1995?

A Correct.

Q Continuously board certified?

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A Yes.
Q Are you also board certified by the American Board of Facial Plastic Reconstructive Surgery?
A Yes.
Q 2001?
A Yes.
Q Continuously board certified?
A Yes.
Q Do you hold any other board certifications?
A No.
Q Have you ever?
A No.
Q And as far as I could tell, you are involved in three medical corporations. One is Richmond ENT; is that correct?
A Correct.
Q Another is Richmond Hearing Aids?
A Correct.
Q And the third that I'm aware of is Richmond Facial and Plastics?
A That's just another trade name. So, the practice name is officially Advanced Otolaryngology, PC, but we have also used -- we have registered -- I don't think it's quite a trademark -- but, essentially

registered names, including Facial Plastics in Richmond -- Richmond Facial Plastics and Richmond ENT.

Q Your ENT work, your general ENT work, would include hearing aids, obviously?

A Yes.

Q Do you have any subspecialty interests within your practice?

A Primarily nasal conditions, sinusitis, allergies, rhinoplasty.

Q Everything, I guess except for rhinoplasty -- sinusitis, allergies, those types of treatments -- would be included in your general ENT practice. True?

A Correct.

Q Can you give me an approximation of the percentage of your professional time that's devoted to ENT, general ENT, as opposed to --

A Excluding what?

Q As opposed to facial plastic and reconstructive surgery.

A There are certainly medical conditions that overlap quite a bit. A lot of my nasal functional surgeries would fall into the category of facial plastics. You know, I would say that the practice might be 10 percent cosmetic, 90 percent functional;

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but rhinoplasty is one of the more common procedures that I do.

Q Within your cosmetic practice?

A Or within my functional nasal practice. They're not all cosmetic.

Q Okay. So can you give me an approximation of currently the breakdown of your practice, general otolaryngology versus facial plastic and reproductive surgery?

A Reconstructive.

Q Reconstructive surgery; sorry. That didn't make sense.

A I've not looked at it recently; but as I said, 10 percent, maybe, in the facial plastic realm and 90 percent would be considered more medically ENT.

Q Do you have any administrative responsibilities?

A I'm the owner of the practice.

Q Can you give me an estimation in terms of how much of your professional time is devoted to administrative duties?

A Less than an hour a day.

Q Okay. So less than 1 percent of your practice, probably?

A It's probably 5 percent of the practice.

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Q How about medical-legal work?
A That, in -- I would have said much less, but this year it's been about 20 percent in the last six months.
Q Okay. Same set of questions, 2015 to 2017: Was your practice then approximately 90 percent otolaryngology and 10 percent facial plastic and reconstructive surgery?
A Yes.
Q Okay. And the facial plastic and reconstructive surgery would include cosmetic rhinoplasties?
A Yes.
Q What other types of cosmetic procedures do you do?
A Facelifts; eyelids; Botox; Radiesse, R-A-D-I-E-S-S-E; laser treatment; and skin cancer repairs.
Q Can you give me an approximation as to the percentage of your facial plastic and reconstructive surgery that is composed of rhinoplasties?
A No. I can tell you that -- I see where you're headed. I would say that I perform upwards of 30 cases a year of some type of rhinoplasty.
Q Okay. Do you have any estimation as to

how -- when we're talking about rhinoplasty, some of those are cosmetic, and some of those are, what, reconstructive?

A Some are reconstructive, and some are cosmetic, and I can't give you a breakdown off the top of my head.

Q How many rhinoplasties do you think you've performed in total over your career?

A Four to five hundred.

Q And how many revisions do you think you've performed? Do you perform rhinoplasty revision procedures?

A Yes.

Q How many revisions do you think you've performed throughout your entire career?

A Forty to fifty.

Q Is that included in the four to five hundred?

A Yes.

Q So about 10 percent of all your rhinoplasties are revisions, roughly?

A Yes. These are broad guesses, and so, again --

Q I'm not going to hold you to a precise number. I'm just asking for your best estimation.

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Fair enough?

A Yes, fair enough.

Q So I understand your testimony, your entire career, approximately four to five hundred rhinoplasties, about 10 percent of which, 40 to 50, would be revisions. Fair enough?

A That's my best guess, yes.

Q And those included in that four to five hundred number would be cosmetic rhinoplasties and reconstructive rhinoplasties?

A Correct.

Q You told me you couldn't differentiate between the two.

A Correct.

Q Do you know which one's more common in your practice, purely cosmetic versus reconstructive?

A No.

Q And when we're talking about -- I understand what cosmetic is. That's what we're talking about in this case. What's an example of a reconstructive rhinoplasty? Someone who has an injury to their nose and you fix --

A Severely broken nose or a pinched nose, an overresected nose, cancer.

Q Thank you for that. Have you had a patient

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where you've performed multiple revisions of rhinoplasty on the same patient?

A I have -- I would say that of the -- of the 50 revision rhinoplasties, I would guess that half of them were revising my own work. I cannot think of a patient that I operated on three times.

Q Okay. So as you sit here today, you can only recall a patient upon whom you've done a cosmetic rhinoplasty and revised it once?

A I can -- I can -- again, not thinking of specific patients, but I know there are instances where I've done a minor revision in the office following a rhinoplasty or taken a patient back to the OR; but it would be very unusual, if ever, that I have done it three times, three surgeries on the same patient.

Q And if you're doing a revision for cosmetic purposes, you're doing so because the patient's unhappy with the result of your original surgery?

A Well, usually because the patient and I are both unhappy. I would have to agree with the complaint.

Q Have you had occasion to have a patient complain about the result of a cosmetic rhinoplasty where you were actually satisfied with it, you just

had a difference of opinion with your patient?
A Yes.
Q That doesn't mean you breached the standard of care; would you agree? It just means that the patient wanted a different result than what occurred?
A I would agree.
Q When did you start doing rhinoplasties?
A When I was a resident at Johns Hopkins.
Q Outside of residency?
A When I started practice in 1995.
Q Okay. I neglected to ask you earlier, Doctor, when we went through all the exhibits, you also reviewed the two depositions that were taken in this case, one of Mr. Selliman and one of Dr. Colton, correct?
A Yes.
Q Have we discussed everything you reviewed in this case?
A No. We haven't discussed the visit that he had earlier in the summer. We've mentioned it and labeled it, that he had with -- was it Lai?
Q You told me you reviewed Dr. Lai's --
A Right.
Q -- records.
A We haven't discussed it.

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Q But did you --
A Maybe I didn't understand the question.
Q I'm sorry; I'm interrupting you. I apologize.
You've told me all the records you reviewed, correct?
A Correct.
Q You've told me all the depositions you've reviewed, the only two that have been taken?
A Correct. The only thing I haven't told you is that I have personally taken a history this morning with Mr. Selliman, and I personally examined him.
Q Okay. Let's talk about that for a second.
A And so we have these pictures, as you see.
Q Before I do so, the breakdown of your practice, generally, that you gave me earlier, 90 percent ENT, 10 percent facial plastic and reconstructive surgery, is that generally consistent dating back to 2013, 2014?
A Yes.
Q Okay. Please tell me what you did this morning.
Well, let me ask a better question. You met Mr. Selliman in person for the first time this morning?

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A Correct.
Q Okay. And how much time did you spend with him?
A Just over an hour.
Q Okay. And was his attorney present?
A Yes.
Q Okay. Mr. Ratton?
A Yes.
Q You, Mr. Selliman, Mr. Ratton. Anyone else present?
A I had a nurse assisting, as well, at portions of the visit.
Q What's the nurse's name?
A Dana Christian. And she took vital signs.
Q She works for you?
A She does.
Q Why did you have her take vital signs?
A Because that is my standard practice.
Q Were you planning on performing a procedure on Mr. Selliman?
A I was offering him a complete examination and wanted to know whether there were other medical conditions, and I was also trying to be thorough.
Q Were his vitals normal?
A Yes.

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Q Okay. Was a record made of them?
A It's not complete yet.
Q Okay. So you're going to be preparing some type of expert report based on today's meeting?
A Just a -- just a medical visit.
Q Is he your patient?
A He is not. I think of it -- I looked at this as an IME, sort of, although I guess I'm not entirely independent since I have been retained by the plaintiff.
Q Right.
A But that was the approach that I took.
Q Okay.
A I wanted to understand what was going on with his nose, primarily; but I also performed a comprehensive ear, nose, and throat examination at the same time.
Q Okay. And you took some photographs?
A I did.
MR. DWAIHY: We'll talk about those in a moment.
So I guess, Michael, I really hope I don't have to do this, but I have to reserve the right to continue his deposition to the extent he's going to issue some type of expert report.

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Q But maybe you can tell me today, as best you can, all of your conclusions and opinions and findings based on what happened this morning.

A Absolutely.

Q So you spent about an hour with Mr. Ratton and Mr. Selliman today. A nurse was also in the room to take vital signs. They were all normal, correct?

A Yes.

Q And what did you do in terms of examining Mr. Selliman?

A So after we spoke, I examined his external face, his external nose and ears. You want me to pause and describe results or just tell you what I did?

Q Just tell me what you did. Thanks.

A Looked at his external and internal ears and nose and throat. I did not examine his voice box because he was gagging. I examined his neck and listened to his heart and lungs, observed his voice, his speech, his gait, mannerisms.

Q Was everything normal as far as you could tell?

A Except for the nose and ears, yes.

Q What was wrong with his ears?

A He had two cotton balls stuck in his right

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ear.

Q Why is that?

A I think -- he acknowledged that he sometimes cleans his ears and sometimes puts cotton in his ears, and apparently he must have lost them.

Q Okay. So he had two cotton balls in his right ear, and he told you those were there because . . .

A He was not aware that they were there.

Q Oh. How deep in the ear canal were they?

A All the way in.

Q Did you remove them?

A With his permission, I did.

Q Okay. Were there any complications?

A No. He was complaining of fullness in his ears before I examined him, and I discovered the cotton balls and offered to take care of it for him.

Q Okay. So you accomplished something. What was wrong with -- anything wrong with the other ear, left ear?

A No.

Q Okay. And what was wrong with his nose, in your opinion?

A Okay. So, the nose is underprojected, and severely deflated. As you can see in recent

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photographs and from looking at Mr. Selliman, there's a ridge line that he has been complaining about the dorsum of his nose, and that is actually a fold of skin that is mobile, and it is not a cartilage or an implant of any kind. It is basically just a shrunken cover over his nose.

And the bony cartilage dorsum, which is the ridge of the -- bony ridge of his nose, has been dramatically reduced. It's also been repeatedly infractured so that you can feel a step-off along the junction where his nose attaches to the face, and there's a deep groove on both sides of the nose where it's been repeatedly narrowed. And you can --

Q Where's the fold of skin that you're talking about exactly?

A The fold of skin is right on top of his nose, and you can see it here, and it's just like a pinch of loose skin.

Q And you took some photographs from today, correct?

A Yes.

Q Those are marked as Exhibit 1?

A Correct.

Q Exhibit Number 1; I'm sorry.

A I think it's 4.

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Q Four? How many photographs did you take for the record, please, in Exhibit Number 4?
A Eight.
Q Okay. Any other abnormalities of the nose that you observed that we haven't discussed yet?
A So the internal nose was --
Q Can we stop there for a second?
A Sure.
Q Do you know the cause of -- well, strike that.
You told me the nose is underprojected, number one, correct?
A Let me clarify that. The tip is -- I haven't taken similar measurements yet, as I did the other day. I think the tip is somewhat underprojected. The dorsum is dramatically underprojected, so I want to clarify, and the dorsum meaning the middle of the bony cartilage part as opposed to the most projecting tip.
Q So you believe the dorsum is underprojected?
A Yes.
Q And that's just based on you looking at his nose?
A And feeling his nose.

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Q You did not measure his nose, right?
A I have not performed measurements yet, no.
Q Okay. Do you think the nose is severely deflated?
A Correct.
Q Let me back up. I'm sorry I'm skipping around. You said you have not performed measurements yet. Do you have another appointment scheduled with him?
A No. What I'm saying is I haven't done a geometric analysis of the photographs, as I did on his 2014 photograph.
Q Is that something you might do?
A It's something I might do. I haven't -- I haven't decided if it's necessary.
Q Has someone asked you to do that?
A Nobody's asked me to do that yet.
Q Have you asked for any materials to review that you haven't been provided in this case?
A No. No.
Q So you told me about the dorsum being underprojected. That's just based on you looking at his nose and feeling his nose?
A Feeling it, yes.
Q And then you also made the comment that his

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nose is severely deflated.

A Correct.

Q And what do you mean by that?

A So, one of the principles of rhinoplasty is that the skin soft tissue envelope of the nose has a limited ability to contract, and so it's incumbent upon a rhinoplasty surgeon to recognize the ability to change a nose and not to overpromise or to take off too much of the nose because then it's just going to shrivel up like a raisin. The skin can shrink a little bit if you take a hump off; but if you take too much off of the dorsum of the nose, then it's just going to -- the skin won't lay down nicely, and it will wrinkle.

Q I'm sorry. What part of his nose is deflated?

A The dorsum, the edge along the -- the leading edge of his nose.

Q The same part -- when you say his dorsum is severely deflated you also said it was underprojected. Is that the same as --

A The cartilage and bone have been removed, leaving an empty bag of skin that's shriveled up and created what appears to be a ridge along the line -- along the top of his nose. But it's not a bony or

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cartilage ridge. It's actually an empty fold of skin.

Q And you also told me there's a fold of skin at the top of his nose; is that correct?

A That's what I'm talking about.

Q Okay. So the cause of his dorsum being underprojected, creating a deflated effect, in your words, and causing a fold of skin on the top of his dorsum is what? Removal of --

A Removal of too much bone and cartilage.

Q From the dorsum?

A Correct.

Q Okay. And that's one of the things, as I understand it, that Mr. Selliman requested of Dr. Colton. He wanted to have a lower profile nose, correct?

A Correct.

Q Okay. Any other abnormalities of the nose that we have not already talked about that you observed today?

A There is also some soft tissue fullness on the left side where the cartilage -- excuse me -- where the sidewall of the nose joins the cheek. There's a fullness that overlies the defect, the step-off, bony deformity that I previously described.

Q And what's that caused by?

A I don't know exactly. It could be scar tissue. It feels -- it could be -- I don't know. But there -- but there's a fullness that shows on photographs -- where the left side of his nose attaches to the cheek, there's sort of a rounded fullness that's soft and kind of a fatty consistency, and underneath that is a depression in the bone.

Q Okay. And you observed all these things by looking at his nose and feeling his nose?

A Correct.

Q Any other abnormalities of his nose that we have not already discussed?

A The nasal tip from base view, which is looking up with his head thrown back and looking up his nostrils, is relatively underprojected. I have not geometrically measured this. But in 2014, the nose looked like it fit into an equilateral triangle, which is considered aesthetically ideal, and at this time it looks like it's somewhat lower. The left nostril is somewhat more pinched, but I'm not certain that that -- whether that is a dramatic change or not.

Q Do you know what caused that?

A It -- yes. Dr. Colton described taking out cartilage grafts in the columna, C-O-L-U-M-N-A, which is the portion of the nose between the nostrils that

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you could grab with your fingers if you put a finger in each nostril. So that had grafts in there that Dr. Golden had placed, and Dr. Colton had removed those grafts so that the nose would be deprojected and the tip would be less pronounced.

Q Which is one of the things Mr. Selliman requested, correct?

A Correct.

Q He wanted those grafts removed, correct?

A He said he wanted it deprojected and less upwardly rotated, correct.

Q And removing the grafts was --

A Consistent with that, yes.

Q All these abnormalities of his nose that you've described for me are all aesthetic abnormalities, in your opinion, correct?

A What I've described so far, yes.

Q Doesn't have any functional abnormalities of his nose, does he?

A He complains that his left nose is periodically obstructed.

Q Obstructed by what?

A He doesn't know. He just says that sometimes it's hard to breathe on the left and that he's started snoring.

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Q He does have a left-deviated septum, correct?
A Not on my examination today, no.
Q Did you review any records from his medical history that observed a left-deviating septum?
A I did.
Q Okay. Did he ever have that corrected?
A He did not.
Q Okay. Would that be one explanation for obstruction of the left nostril?
A No.
Q Okay.
A Because I disagree with that diagnosis.
Q That wasn't Dr. Colton's diagnosis?
A Dr. Colton, to my knowledge, never documented looking inside the nose at all.
Q Okay. So you don't think he has a deviated septum -- Mr. Selliman?
A No, I think he has a straight septum.
Q Do you have any explanation for the periodic obstruction he's been describing in his left nostril?
A Yes.
Q What is that?
A The nasal bones have been repeatedly

fractured and pushed inward and squeezed narrowly. And when you look inside his nose, you can see them falling into his nostrils and closing the upper half of his nasal airway.

Q So you took some pictures of the inside of his nose?

A I did.

Q That's Exhibit number what?

A That is Exhibit Number 5.

Q How did you obtain these pictures?

A So, these pictures were taken with an endoscope. It was a 4-millimeter telescope. I sprayed his nose with a topical decongestant, Neo-Synephrine, and lidocaine, which is a topical anesthetic, and then I examined his nose with the endoscope and a camera, and I did -- actually did a video recording of that and can produce it if you wish.

Q Yes, I would like that.

A Certainly.

Q How long is the video recording?

A Less than two minutes.

Q You can give that to Mr. Ratton?

A Yeah, we can take care of that later.

The -- but, also, we snapped off some still

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photos, and so this is Exhibit Number 5. And in the upper left photograph, the first one, what you see is this angled white thing coming down, which is his bone and cartilage, and it's sitting on the septum. The nasal septum is maybe just 20 percent on the left of the picture, and the sidewall of the nose should go diagonally up to, say, five o'clock to eleven o'clock on this picture, but there's this chunk or piece of bone and cartilage that's pushed down, blocking the upper half of his nose on the left side.

Then in the lower right picture on the first page of this exhibit is the top of the left nose, showing a similar appearance where the external bones of the nose have been displaced into the nasal airway.

Q Do you know if he ever injured his nose?

A Yes.

Q After he treated with Dr. Colton?

A Since Dr. Colton?

Q Right.

A I'm not aware of an injury since the 1980s when he had his first injury.

Q Okay. What was the injury in the 1980s that you're aware of?

A He broke his nose, I believe he said,

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playing football and had a septoplasty and a reduction of the nasal fracture.

Q Okay. Has he sought any medical treatment for the occasional obstruction in his left nostril?

A I'm not aware that he has.

Q Did you ask him?

A He -- I asked him if he was taking any medication for it -- no, I did not ask the question.

Q Did not. Did you ask him whether he was taking any medication for it?

A I did. And he's not taking any medication for it.

Q Is he seeing any physicians or health care providers for it?

A I did not ask that question.

Q Has he undergone any surgery since treating with Dr. Colton?

A Not that I'm aware of.

Q Did you ask him?

A I asked him about his surgeries, and he did not offer any others. I'm not aware of anything else.

Q Okay. Did he tell you whether or not he has had surgeries since treating with Dr. Colton?

A I did not specifically ask that question.

Q Okay. That might be relevant, correct?

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A It might be.
Q Does he have any surgery planned?
A I did not specifically ask that. I have read his deposition. My understanding is that he had a consultation this summer, that she recommended that he go to the University of Michigan, and that at the moment he was not proceeding with that until this case was resolved. And that's what I picked up from the deposition. We didn't discuss it beyond -- we didn't discuss that today.
Q Did you offer to perform surgery on his nose?
A No.
Q Would you?
A I would not like to perform surgery on his nose.
Q Why not?
A Because I don't think that I can meet his expectations in a satisfactory way.
Q Why not?
A Because what he needs to have done is he needs to have his nose dramatically rebuilt with introduction of bone or cartilage to refill the dorsum and bring it back up to a normal height and restore the contour. I think it's going to be extremely

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difficult, and I also think it's incongruous with what he has been requesting.

Q To whom would you refer him for such a procedure?

A I -- I'm not sure who's going to want to operate on him in this circumstance.

Q You do -- I'm sorry to interrupt you. But you do, obviously, as we've discussed, reconstructive surgeries --

A Yes.

Q -- of the nose, right?

A Yes.

Q So why can't you fix his nose?

A The problem is being able to meet the patient's expectations and do what's reasonable and safe. I -- he's had 12 rhinoplasties, and his -- it's not something that I want to tackle.

Q Do you think he has unrealistic expectations?

A Yes.

Q In what ways?

A In that he has been repeatedly asking for the nose to be reduced after, I think, most otolaryngologists would agree that it had already been reduced; and he is consistently concerned about the

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width of the upper portion of the nose and asking for it to be narrowed in a way that I don't believe can be delivered.

Q Did he ask you to perform surgery on him?

A No.

Q Did he tell you what he wanted done with his nose currently?

A No.

Q Did you ask him?

A No. We talked about -- I did not ask him what he wanted done now, no. That was not -- we did not discuss that.

Q He doesn't have any pain in his nose. True?

A I did not ask him.

Q Did you feel his nose with your hands?

A I did.

Q Did it elicit any pain so far as you could tell?

A He did not tell me that he had any pain in his nose.

Q You took a history of him, right?

A I did.

Q Did he tell you he had any pain in his nose?

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A He did not volunteer that information.
Q Did he tell you that he has any other problems besides occasional obstruction of the left nostril and/or snoring?
A He did not.
Q Did he tell you when that started?
A Gradually over recent years.
Q Did you ask him whether he had snoring before he treated with Dr. Colton?
A I did not.
Q Did you ask him whether he had any nasal obstruction before he treated with Dr. Colton?
A I did not.
Q Did he pay you for today's visit?
A This was -- there was a schedule -- this hour was originally scheduled as deposition preparation with Mr. Ratton, and so to that extent it was -- the hour was paid for.
Q Okay. Who pays for it?
A My contract is with Mr. Ratton. How he handles that, I don't know.
Q What will you charge for today's hour visit?
A I believe my fees were quoted at $800 an hour, and -- it's either 750 or 800. It went up a

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little bit in the last year. Do you remember, Michael?

Q That's okay. You charge --

A I charged him for an hour of legal consulting, and the --

Q Your hourly rate is either $750 or $800 an hour?

A Yes. Same thing I'm charging you.

Q And your deposition rate is either $750 or $800 an hour?

A Correct.

Q With what minimum?

A I normally have a minimum of four hours because I set aside a half a day for this. We had negotiated.

Q I think we challenged that.

A You did. And we agreed to two hours.

Q Okay. What about trial testimony; how much do you charge for that?

A Same thing. If it was -- that same hourly rate, which, if I have to come to Michigan -- and then I'll cap it at 12 hours per day.

Q Okay. So up until the start of today's deposition, can you give me an approximation as to how much time you have spent on this case, please.

A Between 10 and 15 hours.
Q Did that include your one-hour visit with Mr. Selliman?
A Yes.
Q So, between 10 and 15 hours at either $750 or $800 an hour?
A Yes.
Q Plus a minimum of two hours at that rate today for the deposition, correct?
A I believe that was probably included in that 10 to 15 hours, I think.
Q Okay. So including an approximate time of two hours at your deposition today and the meeting with Mr. Selliman, you think in total you spent between 10 and 15 hours on this?
A Probably counting it, adding it all up, about 15 hours.
Q And then after today if we go to trial, you will continue to charge, obviously, your rate of either $750 or $800 an hour to prepare for trial, correct?
A Correct.
Q And the same rate plus expenses to travel to Michigan, if you do that, to testify at trial?
A Correct.

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Q Back to your visit with Mr. Selliman this morning, you spent about an hour with him. You told me a nurse was there to take vital signs. Mr. Ratton was there. You observed and you felt with your hands Mr. Selliman's nose. You examined his ears. You were able to remove some cotton from his right ear. You told me a little bit about what you discussed. Is there anything else you discussed with him that we haven't -- that you haven't shared with me so far?

A We also took a CT scan of his nose in the office.

Q Why did you do that?

A I wanted to have a better understanding of what -- what was done in terms of bony modifications in the nose, and what that showed was very consistent with the medical record, that -- and with my examination, that the nasal bones had been severely infractured, narrowed; that they were -- that the nasal bones were narrower than the nasal opening, as we saw endoscopically; that the nasal dorsum was straight but very low.

It looked like there was a little bit of bony growth on the top -- at the top of the nose between the eyes, which is the one area that Mr. Selliman has been most frustrated with that

repeated surgeries did not make smaller. It looked like there was a bit of a callus forming, sort of like a heaped-up scar or bone tissue that may have made that area slightly worse than it was five years ago.

Q Worse: You mean larger?

A Larger. Again, I don't have a comparison from five years ago. It may have been that way from the broken nose in 1985; I don't know -- or 1980-something.

Q You don't know what caused it?

A I don't know what caused it or how long it's been there.

Q Did you discover anything from the CT scan other than this callus formation at the top of the dorsum above his eyes? Did you discover anything other than that from the CT scan that you didn't know from examining him in the office?

A Well, we were also -- there were questions about the Radiesse. The Radiesse was not visible on the CT scan. So I don't know where that was applied, whether it was applied to the cheek or applied to the nose.

He does have some mild chronic sinusitis. There's some swelling in his maxillary or cheek sinuses on both sides, a little bit of swelling in the

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ethmoid cavity on the left, as I recall. The nasal septum was perfectly straight. The inferior turbinates have been dramatically removed, and that's visible also on nasal examination, intranasal examination.

Q What is that?

A The inferior turbinates are the baffles on the outer edge of the nose on each side, and that's the part of the nose that swells when you get a stuffy nose, and they sort of parallel the septum. And when it's cold and dry, they swell up to secrete moisture; and when it's warm and moist, they shrink to let more air flow.

Q Let me ask you some follow-up questions because you just told me a lot of information.

A Yes.

Q First of all, you took a CT scan of his nose, correct?

A Correct.

Q Did you interpret it, or did a radiologist?

A I interpreted it, as I routinely do with my patients, yes.

Q Do you ever have radiologists interpret CT scans?

A If I find something in my office that I

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don't understand, I will occasionally; but most of the time I do not.

Q Are you having a radiologist interpret the CT scan that you performed on Mr. Selliman today?

A I have not made any such decision.

Q Have you been asked to do that?

A No.

Q Is there anything that you feel is outside your area of expertise to interpret on that CT scan?

A No.

Q Okay. You're not a board certified radiologist, correct?

A I'm not.

Q Have you ever practiced as a radiologist?

A Not as a radiologist.

Q Have you completed a residency in radiology?

A I have not completed residency in radiology.

Q Do you hold yourself out as an expert in radiology?

A In radiology of the nose and sinuses, yes, and I do have an accredited radiology center just for looking at the nose and the ears and the sinuses because that's something I do several times a day.

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Q Have you ever been asked to give expert opinions on the standard of care for a radiologist?
A No.
Q The sinusitis that you observed from the CT scan, you're not of the opinion that anything Dr. Colton did caused that, are you?
A No.
Q Okay. Are you charging Mr. Selliman or Mr. Ratton for performing the CT scan today?
A No. This was all worked into my one hour of time.
Q Okay. Are you charging separately for the endoscopy that you performed?
A No.
Q Are you recommending any follow-up medical treatment to Mr. Selliman based on the endoscopy you performed?
A That was not the purpose. My purpose was to understand the injuries to his nose, and so it was -- all of these procedures were done in preparation for better understanding the medical record and what's been done. I'm not offering advice. I'm considering him a claimant, not a patient.
Q Okay. So you don't have a patient-doctor relationship with him?

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A Correct.
Q So you're not offering any follow-up -- strike that.
You're not recommending any follow-up medical care and treatment or surgical care and treatment as a result of your examination, the endoscopy, or the CT scan?
A Correct.
Q And you're not charging for them separately?
A Correct.
Q Are you preparing a report, a CT scan report?
A Yes, I will.
Q Okay. And you'll provide that to Mr. Ratton when it's done?
A Absolutely.
Q Okay. Have you ever performed a CT scan on a patient for medical-legal purposes before?
A I believe so.
Q How many times have you done that?
A Once or twice. I do -- I don't remember specifically, but I do independent medical examinations, for example. And so whether they come in with hearing loss, we do an audiogram; if they come

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in with sinus complaints, we do endoscopy and CT depending on the situation. I can't recall the specific cases.

Q How many times have you done a CT scan for medical-legal purposes in your career?

A I don't recall.

Q Did Mr. Selliman sign anything?

A He did not. We talked about -- he gave permission for each step of the examination. He came here -- we discussed this before, or at least I discussed it with Mr. Ratton. We invited him to come to Richmond. He made the effort to come here, expecting that I was going to examine him.

Q Did you get an informed consent for the endoscopy?

A Yes. I told him exactly what we were going to do.

Q Did you tell him -- describe for him any of the risks associated with the endoscopy?

A I told him -- yes.

Q Which would include what?

A Which would include feeling numb in the throat for about 15 minutes and maybe momentary discomfort.

Q What about the CT scan; did you get an

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informed consent?

A I told him the CT scan involved a very low dose of radiation because it's a specialized CT scan that does that and that the radiation is comparable to a cross-country airline flight or a chest x-ray and that it does have some radiation but that it's very little.

Q I mean, I know you told me you don't have a patient-doctor relationship with him. But what if you had discovered something on the CT scan or by doing an endoscopy of him that required medical follow-up?

A If I found something that was dangerous and required medical follow-up, I would certainly advise him of that.

Q I mean, is it ethical to perform a CT scan on a person who's not a patient of yours solely for purposes of litigation?

MR. RATTON: Objection. Argumentative. You can answer.

Q I'm truly asking. I'm not trying to argue with you. I know it sounded argumentative.

A Yes, because I feel that this is a very complicated case, and it's difficult to tell from the medical records and the depositions exactly what's occurred and exactly what the problems are with his

nose, and I didn't feel that I could fully understand and advise the court on what's going on with his nose without -- without taking an x-ray.

I felt -- so I feel that the -- that the risk is negligible. I think he takes greater risks driving in an automobile around Detroit or wherever he lives and that this has given me additional information that helps me to understand what's going on.

Q But it's solely for purposes of litigation, correct?

A It may be -- it may be useful if he decides to consult with a surgeon for medical reasons. It could be very useful. I would not have operated on him -- if I were going to operate on him or offer surgery, I would not do it without a CT.

Q But you're not going to operate on him, right?

A I'm not.

Q You are not going to refer him to another medical care provider for treatment, correct?

A Well, he has referrals, and I assume that he has local care available and the referrals that have already been made, potentially, to the University of Michigan. I would not presume that he would want

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to get his care here.

Q What I'm saying is you told me as far as you know he has no plans for future surgery, correct?

A My understanding is that it is not planned yet. I do think that he wants -- wants it fixed, still.

Q What did he tell you he wants? Did you ask him?

A He wants -- he wants his nose to look normal again.

Q Is that what he told you?

A I think his words were something like "the way it used to look," may have been one of the phrases that he used.

Q Used to look when?

A When he was younger, before he had all this surgery.

Q Is that what he told you, or are you just surmising that?

A There was a phrase he used. You know, "I want my nose back. When I was a young man, I didn't have a wide nose like this, and I want that back. I never had a big nose before."

Q Okay.

A That's what I recall him saying.

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Q Back to my original question, obviously you performed this CT scan on him not because you were going to perform surgery on him or render any follow-up medical care to him. True?

A Right.

Q You performed it on him so you could possibly elaborate on your opinions in the medical-legal context for purposes of this litigation. True?

A True.

Q Okay. And in doing so, you did expose him to some radiation. True?

A Yeah, a little. Not much more radiation than you experience by flying to Richmond and back.

Q Okay. And back to an earlier question, is that medically ethical to do for solely purposes of litigation?

MR. RATTON: Same objection. Argumentative.

A I feel that it is ethical yes, because I think the risk was comparable to the risk of traveling to Richmond for the examination and that that was a negligible risk.

Q Anything else you discussed with Mr. Selliman during this visit that we have -- that

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you have not already shared with me?
A Not that I recall.
Q And have you shared with me all of your findings as a result of the visit this morning?
A Yes. And I will -- I will produce for you the CT scan, of course, and reports for the visit. I will produce all of that.
Q What percentage of rhinoplasties have you performed on males versus females?
A I've never looked at that. But I would say that it's probably -- I have no reason to think that it's different than half and half.
Q All right. Of the types of cosmetic procedures you perform, what are the most common in your practice?
A Rhinoplasty, laser surgery; and then facelift, eyelids, chin implants would be less common.
Q Rhinoplasty is the most --
A Absolutely.
Q Of the cosmetic procedures you perform?
A Correct.
Q You reviewed Dr. Colton's deposition, correct?
A Correct.
Q Is there anything that you disagreed with?

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A I'm not sure I understand that question. I'm not sure how I disagree with his testimony.

Q I mean, is there anything you recall him testifying about that you read and you said, "I don't agree with that"?

MR. RATTON: Other than the number of procedures performed?

MR. DWAIHY: I don't know if he'll disagree with that.

A Yeah, I certainly disagree with his decision to perform these seven operations, and it -- I mean, in terms of what he stated in terms of disagreeing with his testimony, I'm not sure how to answer that question.

Q Is there some limit on the number of rhinoplasty revisions a surgeon is permitted to perform on a patient, or does it depend on the circumstances?

A I don't know that there is an absolute limit, but I think that -- but I've never seen a case that I can recall where somebody had had more than four or five rhinoplasties. So at some point, 12 strikes me as a very large number. Where I would draw it -- but I can't draw the line in the absence of a specific patient.

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Q Fair enough. So it depends on the circumstances? True?
A Yes.
Q There's no authority in your medical community or literature that says a surgeon cannot perform more than X number of rhinoplasty revisions?
A Agreed.
Q When performing a rhinoplasty or a revision of a rhinoplasty for cosmetic purposes, can we agree that a patient is never guaranteed a perfect result?
A Agreed.
Q And I think you told me earlier you have had certain patients who were not satisfied with the result of a cosmetic rhinoplasty that you have performed. Is that true?
A Agreed.
Q Simply because a patient is not satisfied with the result of a cosmetic procedure does not mean that the surgeon breached the standard of care or committed malpractice. Is that fair?
A Agreed.
Q It's not uncommon or unusual for a patient to be dissatisfied with the result of a cosmetic procedure. Is that true?
MR. RATTON: Object to the form. Vague.

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A I would say that it is -- depends on your definition of "uncommon." I would say -- I will acknowledge that it occurs, it occasionally occurs.

Q That patients are not satisfied with a cosmetic result?

A It occasionally occurs that patients are not satisfied with a cosmetic result, yes.

Q That doesn't mean the surgeon committed malpractice, obviously?

A Not by itself, no.

Q When you do rhinoplasty revision procedures, do you charge for the revisions, typically?

A If it is somebody else's work, yes. If I'm touching up my own work, no.

Q What do you charge for a rhinoplasty, cosmetic?

A Between 3,000 and 4,500. 4,500 if it's a full rhinoplasty, 3,000 if it's just an add-on to another nasal surgery.

Q And what would you charge for a revision?

A If it were -- if someone came in with a complex nose and revision rhinoplasty, then typically it would be at least 4,500.

Q So, the same charge as the original

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rhinoplasty?

A Might be 5,000, but I don't think more than that, unless there were additional grafts or complexities above and beyond the types of rhinoplasties that we are reading about in this case.

Q But you've never charged one of your patients to revise one of your original rhinoplasties?

A I don't like to use the word "never" in testimony, but I don't recall it.

Q Fair enough.

A I would say my policy is generally to touch up my own work.

Q Which is what Dr. Colton did in this case?

A Correct.

Q He only charged for his original procedure. True?

A That's my understanding.

Q None of Dr. Colton's procedures on Mr. Selliman were medically contraindicated. True?

A This is where it's hard to know, because there was no medical history or internal nasal examination performed to determine that.

Q Are you aware of any medical reason Mr. Selliman could not undergo a rhinoplasty or a rhinoplasty revision based on what you know today?

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A One. I believe that many of my colleagues would have proposed a diagnosis of body dysmorphic syndrome, and I do not know Mr. Selliman well enough to make that diagnosis. But on the basis of my review of the record, I would say that many colleagues would propose to him that he, at the time in 2012-2014, had excessive preoccupation with his nose when, at the time, it looked fairly normal. And a reasonably prudent otolaryngologist would have refused to operate on his nose, as Dr. Golden did following the fourth surgery of Dr. Golden, when he told Mr. Selliman, "That's all I'm going to do; I'm not going to touch it again; it's not the right thing to do."

Q What's body dysmorphic syndrome?

A It's an excessive preoccupation with an aesthetic feature that, in the judgment of the physician, is disproportionate to the reality.

Q Okay. And you have not discussed Mr. Selliman with any of your colleagues, correct?

A No.

Q What I said was correct?

A Correct.

Q So you don't -- you do not know what any of your colleagues would say about whether or not they think he has body dysmorphic syndrome. True?

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A Specifically in this case, I would say "true"; yes.
Q And you are not diagnosing him with body dysmorphic syndrome. True?
A I'm not at this time because I sit here today, he has a real deformity of his nose that's very obvious, and his concerns with his nose are understandable. Since I did not see him at the time in 2014 -- at this time I can't say that, no. I --
Q And you can't say whether or not he had body dysmorphic syndrome when he was treating with Dr. Colton. Is that fair?
A I can't say that for sure.
Q You are not going to give that opinion in this case. True?
A Not in terms of labeling it as a psychiatric diagnosis.
Q You are not a psychologist, correct?
A No.
Q You are not a psychiatrist?
A No.
Q You've never practiced as such, correct?
A Correct.
Q You are not board certified in psychiatry?
A Right.

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Q You are not a mental health professional?
A Correct.
Q You didn't render any type of mental health screening or psychological testing to Mr. Selliman this morning when you met him?
A I did not.
Q Is that correct?
A Correct.
Q And you are not qualified to give any opinion on whether or not Mr. Selliman has some type of psychiatric, psychological, or mental health problem. Is that true?
A That's true.
Q Okay. And you are not going to take the stand at trial and try to give opinions about whether or not when he treated with Dr. Colton he had body dysmorphic syndrome. True?
A True.
Q Now, my original question was whether or not you believe Mr. Selliman had a medical contraindication to any of the procedures performed by Dr. Colton, and I understood your answer, and I appreciate it. But body dysmorphic syndrome, I would think of more of a psychiatric or psychological issue. So specifically, my question is, he did not have any

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medical contraindication to Dr. Colton's procedures. Is that fair?

A Based on my examination and history that I obtained today, I'm not aware of any medical reason that Mr. Selliman could not have cosmetic surgery on his nose.

Q Okay. The same when he was treating with Dr. Colton. True?

A I have no reason to believe otherwise. It wasn't recorded in the record.

Q Okay. And he did not suffer from any medical complications as a result of Dr. Colton's procedures. True?

A True.

Q Have you ever had a patient who has suffered from a medical complication as a result of a rhinoplasty?

A I am sure that I have.

Q What are the most common complications?

A Most common complication would be a nosebleed, certainly soreness and swelling, and disappointing aesthetic result.

Q Have you had patients who have suffered from all of those complications?

A Certainly all of those.

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Q A disappointing aesthetic result wouldn't really be a medical complication. True?
A It's different.
Q Now, Dr. Colton performed six procedures on Mr. Selliman, correct?
A I thought it was seven.
Q I'm sorry. Seven. You are correct. I said six. He performed seven procedures on Mr. Selliman. True?
A True.
Q Six of the seven were revision procedures, correct?
A Correct.
Q Okay. And --
A All of them were really revisions because the first one was a revision of Dr. Golden's work.
Q Fair enough. That is true. So he really performed seven revisions. True?
A True.
Q Plaintiff did request all of them. True?
A True.
Q And Dr. Colton did obtain informed consent for all of them. True?
A True.
Q And --

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A To the extent that he had a generic -- I don't know that he -- I don't know what risks he discussed in detail because there was no documentation of conversations. He did obtain his signature on an informed consent document.

Q All right. And we know that he did not -- Mr. Selliman did not realize any complications of risks, correct?

MR. RATTON: Object to the form.

Q That was a bad question. We already talked about this a moment ago. We know that he didn't have any medical complications, right?

A Right.

Q Okay. Dr. Colton did document -- and I'm sure you saw it in his record -- that he had extensive conversations with Mr. Selliman about his expectations and about the results that Dr. Colton thought he could achieve for him aesthetically?

A Yes.

Q That was proper to do?

A There were statements to that effect in his operative reports, yes.

Q And that was appropriate, and he should have done it, correct?

A Correct.

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Q Okay. And what is your understanding as to what each of these seven revision procedures involved? Just in layman's terms, what was Dr. Colton doing each time?

A He was trying to reduce the height of the nose and narrow the width of the nose.

Q And that's exactly what Mr. Selliman requested of him. True?

A True.

Q Wanted a narrower nose and a flatter nose, correct?

A Yes.

Q Okay. And Dr. Colton tried to achieve that by removing bone or tissue from the nose?

A Yes.

Q Okay. Have you performed the type of revision procedures that Dr. Colton performed on Mr. Selliman? Have you performed those in your practice, ever?

A Yes.

Q Okay. The type of revision that Dr. Colton performed in this case, do you routinely perform that type of revision in the same way?

A No, not in the same way. These were aggressive revisions. And, again, it's a matter of

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degree in terms of have I done osteotomies? Have I taken off a hump? Yes, I've done that.

Q Why do you say they were aggressive?

A Well, he talks about -- June 23rd, this is already the fifth operation. The first thing he did in 2014, the very first operation, he removed the tip grafts, the columellar struts and the spreaders. I've never done that in my career, and I can't imagine why anybody would want to do that.

Q Didn't he do that because Mr. Selliman told him he wanted a narrower nose, a smaller nose?

A That's exactly the problem. You can't just let the patient ask you for something. This is not like a retail business where if you want to buy a book, I'll sell you the book. You know, this is a profession.

If you had a client that came to you and asked you to represent him in a certain way that you thought was wrong or unethical or bad legal strategy and he said, "No, I want you to do such-and-such," and you knew that it was not proper, you know, legal care, that you would have to say to your client, "No, that's not going to work," or, "No, that's not legal," or, "No, the judge won't allow it."

Q What, in your opinion, was improper, if

anything, about --

A Taking out the spreader grafts, trying to narrow -- thinking that he could narrow and reduce the tip -- the dorsum of the nose at the same time, because those are confounding principles.

Q So, hold on. You think -- did the standard -- strike that. You think he should not have removed the spreader grafts.

A I agree. Yes.

Q Have you ever done that?

A I've never removed spreader grafts. I only put them in.

Q Why, in your opinion, should he have not removed the spreader grafts?

A Because that's what's holding the nose up and holding it together and keeping it straight and keeping the airway open in a proper way.

Q How do you make the nose narrower and flatter with those?

A Well, that's the problem. First of all, let's talk about narrower and flatter. Okay? So flatness is a perception of width.

We're talking about an essentially triangular structure; so if you lop the top off of a triangle, the top of the triangle looks wider. And so

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if you -- reducing it, you have to be very careful about reducing it; and if you continue to reduce and crunch and reduce and crunch and reduce and crunch, it becomes absurdly narrow, absurdly underdeveloped to the point where he is now, that there's not enough bony cartilage to fill the skin of his nose, and the skin is all rolled up in a wrinkle.

Q How long did Dr. Colton's revision procedures last, approximately, each of them?

A I would have to look back at the record. I think the first one was a bit longer. I think some of the latter ones probably took about 30 minutes, if that's what you're asking. Are you asking about duration?

Q Yes.

A Duration of surgery or duration of benefit?

Q No, duration of surgery.

A I'd have to look at each one and tell you.

Q If they lasted 20 minutes or 30 minutes each, would you characterize those revisions as minor procedures?

A Well --

Q You don't have to go through the record. It'll speak for itself.

A I'm not sure that even that much detail was

in the record.

Q If they lasted 20 to 30 minutes each, Doctor, would those be fairly characterized as minor procedures?

MR. RATTON: Objection to form. I think it's vague as to what's being done in the procedures and basing it only on the time.

A First of all, I don't see that he documented time in any of these, and time doesn't necessarily mean minor. Time might also mean rushed.

Q Let me ask, do you have any evidence to suggest that Dr. Colton rushed the procedures?

A I don't. You're asking me about time, so I didn't bring it up.

Q Okay. Do you know how long the revision procedures lasted, each of them?

A I don't recall reading that in the record.

Q Okay.

A But, so, no, I don't know at the moment.

Q On each revision procedure, he was trying to make the nose narrower and flatter, for lack of a better term. True?

A Yeah, lower, I believe.

Q Lower?

A Tony's words.

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Q Lower. Okay. On each revision procedure, Dr. Colton was attempting to make the nose narrower and lower. True?

A Yes. Yes.

Q Would it be fair to characterize each revision procedure as a minor procedure?

A No.

Q Why not?

A Because he was doing osteotomies. He was taking a hammer and chisel to Tony's face. I think that's fairly invasive.

Q When you're trying to achieve the result that Mr. Selliman requested, is it better to be conservative and remove less bone and less tissue?

MR. RATTON: Are we talking about Tony Selliman or --

MR. DWAIHY: Right; Mr. Selliman.

A There's two components to that question. First of all, it's trying to achieve what he requested; and then the second is, is it better to remove less.

If we speak in generalities about that patient -- because the first thing is I don't think Dr. Colton should have ever tried to achieve what Tony was requesting. And so having laid -- acknowledged

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that --

Q You don't think he should have ever done any procedure on him at all?

A Correct.

Q You think he should have turned him away?

A He should have said the same thing Dr. Golden did. "You've had enough nose jobs. You've got a good-looking nose, and you're only going to cause harm if you do more."

Q But Mr. Selliman wasn't happy with the way his nose looked, correct?

A Correct.

Q So he was trying to help Mr. Selliman achieve the result that he wanted. True?

A Well, that was the mistake.

Q But that's what he was trying to do. True?

A That's what he was trying to do, yes.

Q Okay. So back to my original question, which is, is it, generally speaking, a good idea to be more conservative and remove less bone or less tissue as opposed to more?

A I would rather take too little than take too much, yes.

Q Because you can always take more off later?

A Agreed.

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Q Okay. If you take more off to begin with, that may, however, result in less revision procedures. True?

A Or it could work -- unless it resulted in a greater revision because you took too much.

Q Okay. What I'm saying is if you take more bone off to begin with and the patient wants a smaller nose, that could result in less procedures in total. Do you understand what I'm asking?

A Yeah, but you twisted it a little bit. The goal is to take off the right amount the first time and not do revisions. If you're going to err, I would definitely err on the conservative side, and I would say that where I have done revisions, it's been to take a sliver more because I will definitely prefer to err on the conservative side, taking out less.

Q Fair enough. Does Mr. Selliman have any physical characteristics that would have made his procedures more challenging?

A I would say that -- I didn't see the inside of his nose in 2014. Clearly, it's a challenge now, and I didn't see -- I haven't seen Dr. Golden's office notes or analysis. I've only seen his operative reports that were in Colton's office. So I'm not aware of any physical characteristics that would make

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his more challenging.

Q What about his skin type?

A His skin type is a little on the thick side. Bones were strong.

Q You said his skin type was a little on the thicker side?

A Yes.

Q How is that relevant?

A Well, that is going to camouflage small imperfections. It can also blunt some of the design features.

And one of the things about thicker skin in a heavier nose is it greatly limits your ability to reduce the size of the nose, and so we're taught in training to recognize this and not to try to create a nose that's too small for the patient's face or a nose that's too small for the patient's ethnicity and body type, skin type, because the thicker skin is not going to contract well, and so it's very important that the cartilages be strong and that you maintain structure, as Dr. Golden did when he put the grafts in.

Q Does thicker skin produce more scarring?

A I wouldn't necessarily say more scarring. But if there's dead space between the cartilage that's been removed and the skin, regardless of the type of

skin, there can be space in between. I'm not really claiming that he has any unattractive scars.

Q Okay. Did Dr. Colton make his nose thinner?

A Yes.

Q Did he make it lower?

A Yes.

Q We discussed this a little bit early on. I think you mentioned it, but I think we can agree that cosmetic surgery is more of an art than a science. True?

A It's -- I'm not going to say one more than the other, but it's very much both.

Q You mentioned that there are differing opinions within the field of cosmetic surgeons. True?

A True.

Q One surgeon can hold one opinion; another surgeon can hold a differing opinion; they can be both acting within the standard of care. True?

A I'm not going to say every opinion is within the standard of care. I would say there are differing opinions within the standard of care.

Q Right. That's what I'm asking. You can have two surgeons who perform rhinoplasties hold two different opinions, disagree with each other, and

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still be acting within the standard of care. True?
A That can occur, yes.
Q And obviously, an acceptable result in the realm of cosmetic surgery is somewhat subjective. True?
A Yes.
Q So you started to tell me, Doctor, some of your criticisms of Dr. Colton in this case. In your personal opinion, you said you wouldn't have even operated on Mr. Selliman to begin with.
A Correct.
Q If he came to you, you would have turned him away?
A Yes.
Q Okay. And I understand that's your opinion. Would it have been at least reasonable for Dr. Colton to attempt a revision of Dr. Golden's work?
A In the absence of performing a proper history and physical examination and documenting it, I think it was a deviation from the standard of care to attempt a revision surgery.
Q Let's say he performed a history and physical, there were no medical contraindications to revising the nose. Would it have been reasonable -- I know you wouldn't have done it in your practice. But

would it have been reasonable to attempt at least one revision procedure of Dr. Golden's work?

MR. RATTON: Asked and answered.

A There's also analysis. I'm not just talking about the heart/lung examination. I'm talking about the analysis of the nose, understanding what was done, understanding why the grafts were there, and so forth.

And so -- so it's hard to say, you know, what was appropriate, because the information is not there. And, again, you're asking me now to speculate on if something had been done and certain answers had been given. I don't want to speculate on a situation that didn't occur.

Q Could it have been within the standard of care to perform one revision of Dr. Golden's surgery?

MR. RATTON: Objection. Asked and answered twice now, but you can answer it again.

A To do a subtle reduction of the nasal tip projection and rotation would have been reasonable and within the standard of care, but that would not have included disarticulating all of the grafts and the excessive, you know, destruction that was done in that first operation -- deconstruction, I should say.

Q Would it have been acceptable and within

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the standard of care to shave some of the bone off the dorsum?

A In my opinion, the dorsum was already underprojected because Dr. Golden had already shaved off 80 percent of the graft that he put there. And again, without -- without understanding the anatomy, without understanding the structure of the nose, it was -- in my opinion, it was inappropriate.

At some point you've got to -- you know, a surgeon tells a patient that what you're asking for is not something that we can deliver --

Q All right.

A -- safely.

Q Why don't you tell me exactly when you think, in your opinion, Dr. Colton breached the standard of care?

A I think he breached the standard of care on the first surgery when he performed a major deconstructive rhinoplasty without a proper history and physical examination.

Q Okay.

A And he took apart things that were appropriately placed and artfully done by Dr. Golden.

Q What history and physical was not performed that should have been performed?

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A All of it. We talked about this before. The medical history --

Q Besides the medical history.

A Well, in terms of the nose, allergies, sinusitis, nasal congestion, snoring, palpation of the nose and understanding where the cartilage is, where are the strong parts, where are the weak parts, what is creating the width of the nose.

My opinion is that what Tony really wanted was this nasion or radix area between his eyes to be narrower, and everything that was being done was in the middle bulbs in the middle third of the nose and in the tip of the nose. And by continually reducing time after time after time, repeating the osteotomies, repeating the dorsal reduction another quarter inch, another several millimeters, all that did was accentuate the size of bony radix, which is determined by the distance between his eyes, and that's a solid piece of bone right here, which is not that amenable to narrowing.

Q Have you ever narrowed that part of the nose on any of your patients?

A No, I don't think I have effectively narrowed the nasion or -- no.

Q Okay. Let me go back and I'll ask you some

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follow-up questions. Do you think Dr. Colton breached the standard of care because prior to the first surgery he did not take a proper history and physical? Part of that was medical, and we talked about that earlier, correct?

A Uh-huh.

Q Yes?

A Uh-huh.

Q You have to say --

A Yes.

Q And the other part of that was specific to the nose. True?

A True.

Q Do you think he should have asked him questions about allergies, correct?

A Correct.

Q Okay. Can we agree that not asking him about his history of allergies did not result in any harm in this case?

A Agreed.

Q Okay. Same with sinusitis?

A Agreed.

Q Same with snoring?

A Agreed.

Q You also say he should have palpated the

nose, correct?
A Correct.
Q Okay. And you don't think he palpated the nose, why? You didn't see it documented?
A I don't see any documentation.
Q Okay. Is there anything about not documenting his history and physical that you are describing that you can say likely caused damage to Mr. Selliman in this case?
A Well, I know you want me to draw a line in the sand, you know, where did he breach the standard of care? And, you know, this is a three-year -- two-and-a-half-year process of -- so -- so it -- and at some point --
Q Can I interrupt you? I'm sorry.
A Yes.
Q When we are talking about the first surgery, we are talking about the first surgery of Dr. Colton on or about August 25th, 2014, correct?
A Right. Right. And, again, I'm not going to -- you know, I've told you that I would not have operated on him the first time. I think that that was the -- that was the first mistake and the biggest -- that was the biggest surgery and the biggest mistake.
But it's important to understand that this

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was compounded; you know, every three to six months, more and more taken off. And not just small amounts. You talked, you know, about minor revisions. I mean, he's had several millimeters on June 23rd, 2016. He's had a quarter of an inch more on April 19th, 2017; 2 to 3-millimeters on November 9, 2017.

So these are -- these are big reductions. And the deviation from the standard of care is not so much the first decision for surgery as it is this cumulative injury as he's going lower and lower and lower, trying to achieve a concept of narrowness. But when you take the top of a triangle, it makes the top look wider, not narrower.

Q So you're saying, if I can understand you, that his entire plan of care of trying to narrow his nose and make his nose lower, given the patient's requests and the patient's history, was inappropriate and a breach of the standard of care?

A Yes. The plaintiff care over 2014 to 2017.

Q Starting with the August 25th, 2014, surgery?

A Yeah. Yeah.

Q And essentially, as we discussed before, Dr. Colton was attempting to achieve the same result with each successive revision?

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A Uh-huh.
Q Yes?
A Yes.
Q Okay. So you are saying he breached the standard of care by adhering to his original plan of care and trying to do the same thing each revision?
A He -- yes, by pursuing a plan of care at the request of the patient and by not recognizing that he was headed down a path that was destructive, that was going to end up with the nose that Mr. Selliman has today.
Q By trying to do the same thing over and over again?
A Doing the same thing over and over again.
Q Each revision procedure was for the same purpose?
A Each revision was for the same purpose and made the same thing worse.
Q Okay. And he was doing essentially the same thing at each procedure; he was trying to take more bone off the dorsum?
A Correct.
Q And remove tissue from the sides of the nose?
A Not so much remove tissue from the sides of

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the nose but crack -- cut the sides of the nose away from the face and squeeze them together into the nose, into the airway.

Q That's basically what he did with each revision procedure?

A Yes.

Q And you're saying adhering to that plan of care, he should have known better, and that was a breach of the care?

A Correct.

Q And it was a breach of the standard of care to even take him in for the first surgery, in your opinion -- for the first revision, I guess?

MR. RATTON: Objection. Asked and answered.

A Break it down a little bit just to be clear, that to agree to do the first surgery was poor judgment. I'll grant you that. And then there's room for judgment. We discussed that. To do so without proper documentation, proper history and physical exam, thinking of the consequences is a deviation from the standard of care, and we discussed that a lot of that may not have led directly into the complications.

But to completely disassemble what Dr. Golden had done intraoperatively, to aggressively

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reduce -- you asked me earlier would it be better to underdo than to overdo. Well, he overdid on the first operation.

And then -- and if there was any room for judgment there, that was -- you know, I think that that was the wrong thing to do. But certainly to persist in it and do it again, and again and again and again, maybe even one more time again -- the same thing, making it worse and worse, at some point deviated from the standard of care.

And it's -- you know, I can't absolutely testify that, you know -- a certain period. But in that period, that whole plan during that two-and-a-half-year period he was perseverating and trying to, you know, cut and squeeze and cut and squeeze and making it worse and not realizing that he was actually making it worse in the process.

Q Well, the second procedure was performed on March 25th, 2015. This is after he had removed the hardware that was placed by Dr. Golden. Do you believe that was a breach of the standard of care, March 25th, 2015? This would have been Dr. Colton's second procedure.

A Yeah. I'm going to say -- from that point forward, I will say he crossed the line.

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Q And he kept trying to achieve the same result by doing the same thing from that point forward?

A Right.

Q Have we discussed all your opinions, Doctor?

A I think we've covered most of it. You know, I'm just looking back at the Affidavit of Merit, and I had -- there was a comment, letter (g), that an alternative to the surgery would have been to refer or consult with a colleague before proceeding with additional surgeries. I think that that's, you know, consistent with what we've been discussing, that -- and not to do it; you could seek advice before doing that.

And then the last one, number (h), use of Radiesse in an appropriate fashion, my understanding is, based on the deposition, the Radiesse was not used in the nose, so I withdraw that criticism regarding the rhinoplasty.

Q Did Mr. Selliman himself ever do anything to alter the appearance of the nose?

A To my knowledge, not in the time that he was seeing Dr. Colton.

Q When did he place a clothespin on it?

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A I believe that was after Dr. Golden's first procedure.

Q Do you think that damaged his nose in any way? Is that possible?

A Didn't -- I don't think it's likely, and I didn't see any documentation in Dr. Golden's notes to suggest that it had. I'd be happy to -- if it's necessary, I'd be happy to look back at those notes.

Q I may have asked you this earlier. You have no plans to see Mr. Selliman again. True?

A True.

Q Are you required to renew your board certifications?

A Facial plastics, I renew every ten years. Otolaryngology is a lifetime certificate.

Q Okay. When's the last time you renewed your facial plastic certificate?

A 2011.

Q When do you have to renew that again?

A 2021.

Q So we've discussed all your criticisms of Dr. Colton?

A I believe so.

Q How long have you been doing medical-legal reviews?

A All of my career but exponentially more within the last three to five years.
Q Why is that?
A Lawyers are calling me, and I believe that my name is becoming known. I've also placed my name on some registries so I can be located.
Q So what types of lawyers call you the most -- plaintiff lawyers or defense lawyers?
A Plaintiff lawyers have more cases than defense lawyers because some complaints never get to the -- never get to lawsuit. So sometimes I get plaintiff lawyers calling. I would say they call often, but I certainly --
Q What percentage of your reviews are on behalf of plaintiffs versus defendants?
A I would say by the time, you know, we get into a case it's probably half and half.
Q So do you do 50 percent reviews for defendants, roughly, and 50 percent for plaintiffs?
A I've never calculated it, at least not in the last year. But, yeah, approximately so. That's my impression.
Q How many cases have you reviewed in total?
A About 135.
Q And how many depositions have you given?

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A I know that I've had at least 22 depositions and courtroom testimonies, total.
Q Any of those for defendants?
A Yes.
Q What percentage?
A About half.
Q How many times have you testified at trial?
A Six or seven times as an expert.
Q Any for defendants?
A Yeah.
Q Approximately how many?
A About half.
Q Have you ever testified at trial in Michigan?
A I have not. I've had some cases, but I have not traveled to testify in court.
Q Have you ever reviewed any other cases pending in Michigan?
A Yes.
Q How many?
A Haven't counted. I know that I've got one active case in Michigan right now and possibly have reviewed one or two more; I'm not sure.
Q What firms?
A I don't have my phone. I think I told you

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who the lawyer was the other day.

Q Plaintiff firm or defense firm?

MR. RATTON: Plaintiff firm. I forgot who you told me. Who's a plaintiff in --

THE WITNESS: Chocron.

MR. RATTON: That name I didn't know, but I knew the firm.

THE WITNESS: Chocron, C-H-O-C-R-O-N. I'm reviewing a case for her.

Q Okay. Have you ever reviewed any other cases for Mr. Ratton?

A No.

Q Have you ever reviewed any cases involving rhinoplasty other than this one?

A Yes.

Q How many?

A Probably one or two.

Q Do you know what states they were in?

A No.

Q Were they for the plaintiff or the defendant?

A Don't remember.

Q Do you remember what they were?

A I remember -- I know one is in Texas and is for the plaintiff.

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Q What's the name of the plaintiff's firm?
A Don't recollect offhand.
Q Is it pending?
A It's pending.
Q Would you know the name of the patient?
A I don't remember at this moment. I have it written down and don't want to discuss opinion cases.
Q I just want to know the name of the case.
A I can tell you, you know, the general -- I mean, it's not related to this -- the general premise is a plaintiff was at the V.A. and went in for what he thought was a rhinoplasty, and he got a septoplasty and felt that -- and the surgeon didn't do the cosmetic hump reduction that he was expecting.
Q What's the name of the case?
A I don't remember. I would have to look at my notes.
Q Do you know the lawyer?
A No, not at the moment.
Q Name of the defendant?
A United States.
Q Oh. It was a V.A. hospital?
A Yes.
Q Okay. What about the other rhinoplasty case you reviewed?

A The other one was a case against Bally's at Las Vegas. A woman was hit in the nose by a pool chair that was lifted up by a gust of wind and had a nasal fracture and needed a rhinoplasty.

Q So that wasn't a medical malpractice case?

A Most of my cases aren't medical malpractice. Most of them are personal injury or on-the-job injuries.

Q What percentage of your cases are medical malpractice cases?

A I never looked. Probably 15, 20 percent.

Q Of the medical malpractice cases that you review, how many of those cases do you review for defendants versus plaintiffs?

A Again, I -- it could be -- it could be half-and-half. I don't know which is more. I -- I talk to the attorney, and I decide if my opinion is likely to be supportive of the case, and they either retain me or they don't retain me based on my opinions.

Q How many cases have you reviewed in total -- all cases?

A At least 135.

Q And you said what percentage of those were medical malpractice cases?

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A Maybe 20 percent.
Q So maybe 25 cases are medical malpractice cases?
A Again, I'm speculating, estimating.
Q That's fine. Just your best estimate is fine. Of those 25 cases, roughly, how many do you think you've been hired by the plaintiff attorney versus the defense attorney?
A I would say probably hired, two-thirds --
Q Plaintiff?
A -- of the time by the plaintiff. I mean, in terms of testimony, I think I've only testified twice on medical malpractice, once for the plaintiff and once for the defendant.
Q Depositions?
A Depositions, probably two or three for each.
Q Okay. In the Texas case, the rhinoplasty case in Texas that's pending, did you give a deposition in that case?
A No.
Q Are you scheduled to?
A No.
Q Where do you advertise your medical-legal services?

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A The primary source is SEAK, seakexperts.com.
Q Do you pay to be listed on that service?
A Yes.
Q How much do you pay?
A I think it's less than -- maybe $2,000 a year. Might be a little bit more.
Q How many years have you paid that to be listed on SEAK?
A I'm paying more that year than I paid in previous years, but I've been listed on SEAK maybe for three years.
Q How much are you paying this year?
A Somewhere around $2,000, I believe.
Q Okay. And what other services are you listed in?
A I believe ALM, ALM Experts.
Q Do you pay for that?
A I do. That's a lower fee. I think that's $600 or so. I haven't looked at this recently.
Q How long have you paid $600 or so per year to be listed on ALM?
A Probably two years.
Q Any other services?
A And I get referrals from TASA.

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Q What's that?
A TASA is Technical Advisory Service for Attorneys, I believe, and they are sort of a middleman. They contract with the -- with attorneys and then with me, and then I actually -- they actually pay me. I'm not -- I don't pay for advertising with them.
And there are a few others I've recently -- I have had with the plaintiff's attorney. I think it's American Justice League. It changed names recently.
Q You are listed on the American Justice League expert site?
A Yeah.
Q That's a group of attorneys who represent plaintiffs?
A Plaintiff attorney website, yes.
Q How much do you pay to be listed on that?
A I think it's 600 a year.
Q How long have you paid that?
A Two months.
Q How did you get in touch with that organization?
A The salesperson called me.
Q Are you affiliated with any other plaintiff

attorney organizations?

A That's the only one that I'm aware of that specifically caters to plaintiff attorneys.

Q Are you affiliated with any defense attorney associations?

A No. I haven't -- I would like to be but I don't know -- don't know which one to -- don't know about that yet.

Q Have you published on the topic of rhinoplasty or rhinoplasty revision?

A No.

Q What percentage of your professional time is devoted to medical-legal work?

A This year, it's been about 20 percent.

Q Has that been true for the last five years or so?

A No. It's doubling each year for the last five years.

MR. DWAIHY: Are you going to ask him questions, Michael?

(Defense counsel nods head in the affirmative.)

MR. DWAIHY: I'll let you do that. I think I'm done.

MR. RATTON: I wasn't going to, but you

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made me.

EXAMINATION BY COUNSEL FOR THE PLAINTIFF

BY MR. RATTON:

Q Good afternoon, Doctor. I have just a few follow-ups for you.

You, like Dr. Colton, are double-boarded?

A Yes.

Q And I'm assuming there's some overlap between those two boards?

A Yes.

Q Is it hard to distinguish the extent of the overlap? When I think of otolaryngology, I think of procedures that also involve rhinoplasties and things like Mr. Selliman had done.

MR. DWAIHY: Form objection.

A Rhinoplasty is part of the required training for an otolaryngologist, and 25 percent of the otolaryngology examination is on facial plastic and reconstructive surgery. So facial plastic surgery is considered an integral part of otolaryngology, or ear, nose, and throat; and facial plastics is an additional credential for about 10 percent or so of otolaryngologists who have performed additional training, had peer review of their cases, and taken an additional examination to show expertise in facial

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plastic surgery, just as others might do a fellowship or take an examination in neuro-otology or in the voice or various other subspecialties within the broad scope of otolaryngology.

Q And although your practices may differ somewhat, do you feel that you're qualified to give opinion testimony against Dr. Colton?

A Yes.

Q Could you do the type of procedures that Dr. Colton does?

A Yes, I do.

Q You do the type of procedures that Dr. Colton did on Mr. Selliman?

A Yes.

Q And, Doctor, based on conversations you and I had, an Affidavit of Merit was authored, which you signed, correct?

A Correct.

Q Today, you did retract or withdraw one of your criticisms with regard to the Radiesse?

A Radiesse, correct.

Q Other than that, do you stand by your Affidavit of Merit as signed?

A Yes.

Q Doctor, I want to go back all the way to

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the beginning of your deposition. There was a comment made that I wrote down where you indicated, looking at some of the photographs you took of Mr. Selliman today, that there was a fullness on the left side of his nose, and you weren't sure of the cause. Do you recall that statement?

A Yes.

Q Although you're not certain of the cause, was it caused by the repetitive surgeries?

A Regarding that specific fullness on the left side of the nose, I can't say.

Q What are possibilities?

A It could be fatty tissue, scar tissue, muscle tissue because there are muscles in the nose which had been detached through all these surgeries.

What I can say is that it is soft tissue because there's actually a bony depression underneath that swelling. And swelling, again, also implies a momentary change, so maybe that's not the best word. Beneath that mound or convexity in the skin of his nose, the tissue is very soft. And so although I don't know what that tissue is made of, I can only describe how it feels.

Q And, Doctor, today you described Mr. Selliman's nose as having a deformity?

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A Yes.
Q And when you say that, are you talking about a visual deformity?
A Yes.
Q And having looked up into his nose, is there a structural deformity?
A Yes.
Q And are both of those deformities that you're referring to the result of multiple surgical procedures by Dr. Colton?
A Yes.
Q And is it the multiple surgical procedures by Dr. Colton that you believe to be a violation of the standard of care?
A Yes.
Q And I believe you said near the end of testimony with opposing counsel that -- I'm not going to say "give him a pass," but although you are critical of the first surgery, you can see how there might be some judgment involved in that procedure?
A Correct.
Q And, however, you did say that in doing that procedure, it should have been a very subtle procedure?
A Correct.

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Q As opposed to one where the physician goes in and removes prior grafts and does an extensive procedure?

A Yes.

Q And, Doctor, there were questions asked of you with regard to when Dr. Colton was trying to thin the nose, that was what Mr. Selliman wanted. Do you recall those questions?

A Yes.

Q And making it more narrow, that was what Mr. Selliman wanted?

A Yes.

Q Is it a violation of the standard of care to allow a patient to dictate the course of your medical treatment?

A If -- if in your training and experience you know that that treatment plan or that the request of the patient is likely to cause harm, then it is. One of the first principles of medicine and surgery, primum non nocere, do no harm; and that is often repeated at rhinoplasty, facial plastics, ENT conferences. You always have to think about avoiding harm and consider -- consider possible complications. And so, you know, if you feel that it would be harmful, then, yes, that would be a deviation of the

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standard of care.

Q And in this case -- I don't think there's a doubt that Dr. Colton was trying to help Mr. Selliman.

A I agree.

Q However, if you cannot achieve the result Mr. Selliman wants, is it a violation of the standard of care to continue to do the procedures only because Mr. Selliman wants them done?

A It is a violation, because the obligation is to tell the patient what is reasonably expected and to know what the limits are and to know what they can possibly do.

Q And in formulating the plan and knowing what the limitations are, is that where you talk about that it's a violation of the standard of care not to obtain a proper history and physical?

A The history and physical is important for determining what's feasible, what's -- and -- and developing proper expectations and setting reasonable goals.

Q And when talking about the history and physical, we are not really just talking about blood pressures and temperatures; we are talking about really investigating with an internal exam or other testing of the structure of the nose, the procedures

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that have been done before, correct?

A Correct.

Q You were asked that a patient being disappointed in the result does not mean it's medical malpractice, correct?

A Correct.

Q But by the same token, the other side of that coin is a patient's disappointment in the result could be the result of medical malpractice?

A Correct.

Q Doctor, if you know that a specific desired result cannot be achieved, is it a violation of the standard of care to perform that procedure anyway?

A Yes.

Q And I believe you stated clearly that in your opinion, Dr. Colton should have done what Dr. Golden did and just turned him away and said, "I can't give you what you're looking for."

A Yes.

Q And I just want to make a distinction. You said you personally would not have performed all these procedures. We're not really talking about your personal opinion as much as we're talking about what an average doctor would do under the same or similar circumstances. And although I think you're very clear

about what your opinion would be, is it your testimony that it's a violation of the standard of care for all these procedures to have been done?

A Looking at the entire constellation of seven procedures and the continued repetitive nature of those procedures, I do think that that is a violation of the standard of care based on what a reasonably prudent otolaryngologist or facial plastic surgeon would do.

Q I believe you -- although you didn't want to draw a line in the sand, you did kind of draw a line about that March 2015 procedure. You said everything moving forward from that was a violation. Do you recall that testimony?

A I do.

Q And these are separate and distinct acts of negligence, correct? I get it's part of the bigger plan.

MR. DWAIHY: Form and foundation.

Q It's part of the bigger plan, but they are all separate and distinct acts. Am I correct?

A Yes.

MR. RATTON: I have nothing else. Thank you.

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EXAMINATION BY COUNSEL FOR THE DEFENDANTS

BY MR. DWAIHY:

Q Doctor, all cosmetic procedures by definition are elective procedures, correct?

A Correct.

Q Dr. Colton's not performing a surgery on Mr. Selliman's nose to fix some medical condition; he's doing it because Mr. Selliman is telling him he wants his nose to look a certain way, right?

A Right.

Q He wants it narrower, and he wants it lower, right?

A Right.

Q So he has to take some input from the patient. True?

A True.

Q And it's not appropriate simply because a physician may not agree with the aesthetic outcome, a patient's desires, to turn him away from surgery. You wouldn't agree with that. True?

A I disagree with you there. One of the principles that is consistently taught in our academies is that if you do not have congruency between what the surgeon thinks is attractive, what the patient desires, and what the surgeon thinks he

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can accomplish, that he should not do the surgery.

Q Right. But if Mr. Selliman wants his nose to look narrower than Dr. Colton or Dr. Armstrong may personally prefer, that's not a reason not to do surgery on him. True?

A To the extent that there is -- you know, again, there are degrees of preference. I will acknowledge that.

Q You don't turn a patient away simply because in your mind you think his nose would look better if it's a little wider and the patient wants it a little narrower, as long as you can reasonably believe you can achieve the result the patient wants. True?

A No. I absolutely would turn the patient away.

Q Because your personal opinion about the patient's aesthetics is different than the patient's and what the patient wants?

A Yes. Yes.

Q Okay. And that's the standard of care?

MR. RATTON: Objection. I would object that it mischaracterizes his testimony.

A I haven't said that it was the standard of care.

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Q That's your personal practice?
A I have said that the teaching is that you don't -- is not to -- I would say -- I would say that it is poor judgment in that case to operate in a situation that you disagree with the goal of the surgery.
Now -- but the surgery that was done on the 25th of August 2014 was far more than what was illustrated in the photograph where it just said, you know, tip down and a little shave on the right side and derotate, you know. All I've got is little pictures, but you know, it's -- so, you know, what we're talking about is, you know, there are -- there are gray zones; I would acknowledge that. And there's room for judgment, and there's room for art in rhinoplasty. But at some point you've got to say, "No, this isn't possible," or, "No, this is too much," and this is one case where I think it's crossed the line.
Q He had how many prior surgeries with Dr. Golden?
A Four.
Q Did he have any other prior surgeries besides Dr. Golden? Strike that.
Did he have any surgeries other than with

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Dr. Golden or with Dr. Colton?

A Yes. And actually, maybe it was only three with Golden. Three with Golden. He also had one, I believe, with Dr. Arden in 2005. That was December 9th, 2005. I don't have those records. And he also had a repair of the nasal fracture and septoplasty sometime in the eighties.

Q He had an accident in the eighties and then the corrective surgery, correct?

A That's my understanding.

Q And he had at least three procedures with Dr. Golden, correct?

A Yes.

Q And then he had a procedure with Dr. Arden, correct?

A Yes.

Q And he had seven revisions with Dr. Colton?

A Yes.

Q All right. It would be impossible to say what caused the deformities that you're describing in Mr. Selliman's nose. True? Is that a fair statement?

A No.

Q How could you possibly distinguish which surgeries resulted in which deformities as you describe them?

A Because I have photographs from 2012 and 2014.

You're saying which surgeries by Dr. Colton?

Q By anyone.

A Because I have pictures from 2012 and 2014, which were after Golden and before Colton, so I know what his nose looked like in between those two surgeries.

Q You didn't examine him in 2012.

A Didn't examine him, but I've got the photographs, and it's as much as --

Q You didn't do a CT scan of his nose in 2012?

A No, I did not.

Q You did not obviously do an endoscopy of the inside of his nose in 2012?

A I did not.

Q Okay. You certainly can't distinguish between which of Dr. Colton's surgeries allegedly caused the deformities in his nose today. True?

A Which of -- it was a cumulation. Again, I'm not going to draw a line and say that this one operation did it. It was the repeated banging his head against the wall and getting the same result.

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Q When did the profile of his nose become too low? When did the dorsum become underprojected?
A I have -- I don't have a clear documentation of intervening photographs each step of the way because we haven't had consistent photographs. So, again, I can't -- I can't say that -- I think that his nose was -- the profile was low to normal before Dr. Colton started, and it got progressively lower over time.
Q You can't say when his dorsum became underprojected. True?
A I can't say what day, no.
Q Can you say what year?
A Between 2014 and 2017.
Q Okay. You can only narrow it down to a three-year time frame?
A I can narrow it down to the time Dr. Colton was managing it.
Q Those three years?
A Yes.
Q Same with the severe deflation of his nose?
A That's when that occurred.
Q Same with the fold of skin on the top of his nose?
A Yes.

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Q Same with the left side of soft tissue fullness?
A Yes.
Q Is there any difference in the appearance of his nose now from when the time he left Dr. Colton's care?
A I don't have pictures from November -- from December 2017.
Q What are the last pictures you have?
A Maybe this one. These pictures aren't dated, so I don't know when they were taken.
Q So you can't say whether there was any difference in the appearance of his nose now versus when he left Dr. Colton's care?
A It was not at the last visit with Dr. Colton. I would say that compared to the pictures in -- I can say that -- you were asking me also about breaking things down. I can say that the fold on -- the fold of skin, the deflationary fold of skin and the underprojection was clearly visible on April 19th, 2017, before the last two operations. And that was -- so you can see this fold already forming, and I can tell that he's already overresected as of April 19th. And then Dr. Colton did two more surgeries, removing first a quarter of an inch and then removing another 2

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to 3 millimeters, and so continuing to do the same thing after he'd already caused the problem as early as April 19th.

Q So can you tell me whether his nose looks different now than when he left Dr. Colton's care? Yes or no.

A I believe he left Dr. Colton's care sometime in December or so, 2017. I don't know -- I don't know what he looked -- I don't have a dated picture, I don't think, from that date.

Q So you can't tell me whether it looks different?

A I can't tell you whether it looks different than it did in December 2017.

Q Do you know whether he had any accidents or injuries to his nose in the intervening time frame?

A No, I don't.

Q Do you know whether he has personally done anything to manipulate the appearance of his nose during the intervening time frame?

A No. I don't.

MR. DWAIHY: Okay. Thank you, Doctor. Those are all the questions I have.

MR. RATTON: I may have one more. One second.

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EXAMINATION BY COUNSEL FOR THE PLAINTIFF

BY MR. RATTON:

Q Doctor, my question's really only one of clarification. There were a list of things that originally you were trying to pin down, and then you ran across the April photos of '17, and timing could be an issue with regard to damages. Can you tell me -- and I believe you talked about the fold and the low projection was present in the April photo, and he continued to do more surgery.

A Yes.

Q Is there anything else that you equate to that time period or that we can relate to that time period other than, I believe the other things you mentioned were the fullness on the right side of the nose, and I think that appeared earlier. I'm just trying to do a little better on the time line as to when some of these things appeared.

A Yeah, so -- so, in 2012, there was an illustration that implied that there was a distinct fullness on the right side of the nose and that the tip was overprojected and overrotated. And that seemed to be the plan for -- that was in 2012, but that also seemed to be the plan for the 2014 operation.

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Then -- then there was the March 2015, further resection and osteotomies. And then September 9th, 2015, there was a further resection, upwardly rotated back, deprojected and then rotated back up, the upper lateral cartilages were separated, the radix was rasped, and Radiesse was injected.

Now, again, a lot of these photographs, especially the cell phone photographs that the plaintiff took himself, were not dated as presented to me. But my understanding is that a lot of the swelling between the eyes was identified after the December -- the September 2015, because my understanding is that Mr. Selliman had the impression that the Radiesse was the cause of this initially, which -- which we subsequently resolved.

Now -- but then he has another reduction. And by June 23rd, 2016, there's this discussion of a scar and reduction of a scar. And I think that this is a missed diagnosis, where the scar that we're talking about is actually the fold of deflated tissue that he's trying to reduce, and you can see that in those April 2017 photographs. You can see it forming. But then he took another quarter of an inch off, which would only be expected to make it worse.

And then -- and then again on November 9th,

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2019, which would again be expected to make it worse compared to the photographs in April, which are the ones that he has the Detroit Tigers hat on.

And then we have some other photos that I think were dated a bit later. I'll welcome anybody to guide me to them, but there were some photographs that showed this fold a little bit more discretely. Well, here's one from 2016. So now we've got 7/5/2016, which is after the fifth operation, and we're seeing that fold is starting to build up on the 7/5/2016 photographs.

And so, again, certainly by the time -- by the time we get to January 12, 2016, undoubtedly the nose has already been overresected, and Dr. Colton is incorrectly diagnosing this as scar tissue or feeling like it's going to retract with -- trying to get it to retract with steroids and taping and re-excision, but it's just taking the volume out, and it's just not going to contract. And he should have known better. A reasonably prudent otolaryngologist would know better than to keep taking tissue out when all of this is contracting down.

And so that's where I really see the progression. It becomes abnormal between January 12th, 2016, November 9th, 2017. And, you

know -- and I don't know what, if anything, has transpired in the last two years since then.

MR. RATTON: Thank you very much. I don't have anything else.

EXAMINATION BY COUNSEL FOR THE DEFENDANTS

BY MR. DWAIHY:

Q Dr. Golden performed three revisions, correct?

A Correct.

Q So Dr. Arden performed the initial rhinoplasty, and then Dr. Golden performed revisions on January 15, '09; January 15, 2010; January 14, 2011, correct?

A Uh-huh.

Q Yes?

A Yes.

Q So he performed multiple revisions of this patient, correct?

A Yes. He performed three revisions.

Q I think you commented earlier that after his revisions, in your opinion, his nose looked aesthetically pleasing?

A Yes. It was --

Q So you don't have any criticisms that Dr. Golden, after performing three revisions, breached

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the standard of care?

A No.

MR. DWAIHY: I don't have any further questions.

MR. RATTON: I have nothing else. Thank you, Doctor.

THE COURT REPORTER: Are you ordering?

MR. DWAIHY: Yes, please. Can I have an E-transcript, with all the exhibits attached? Some of the exhibits are color photos. I would like those in color if that's possible.

THE COURT REPORTER: Do you want paper, or do you want them scanned?

MR. DWAIHY: Scanning is fine with me.

MR. RATTON: Same with me. E-trans, everything just scanned and attached is fine.

AND FURTHER THIS WITNESS SAITH NOT

(Off the record at 2:04 p.m.)

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CERTIFICATE OF SHORTHAND REPORTER - NOTARY PUBLIC

I, Helen B. Yarbrough, Registered Professional Reporter, Certified Court Reporter, and Notary Public, the officer before whom the foregoing deposition was taken, do hereby certify that the foregoing transcript is a true and correct record of the testimony given, to the best of my ability; that said testimony was taken by me stenographically and thereafter reduced to typewriting under my supervision; that reading and signing was not requested; and that I am neither counsel for, nor related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 28th day of September 2019.

Helen B. Yarbrough, RPR, CCR
VCRA Certification #0313016

My Commission Expires:
July 31, 2021
Notary Registration Number: 158897

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APPENDIX 6

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

ANTHONY SELLIMAN,

Plaintiff,

v

Case No. 18-167068-NH
Hon. Martha D. Anderson

JEFFREY J. COLTON, M.D., JEFFREY J. COLTON, PLLC, and THE COLTON CENTER,

Defendants.

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NOTICE OF HEARING

TO: CLERK OF THE COURT
ALL COUNSEL OF RECORD

PLEASE TAKE NOTICE that the attached Motion to Strike Michael J. Armstrong, Jr., M.D. and for Summary Disposition will be brought on for hearing before the **Honorable Martha D. Anderson** on **a date and time to be determined by the Court.**

Respectfully Submitted,

PLUNKETT COONEY

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FEE

Dated: October 16, 2019

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

ANTHONY SELLIMAN,

Plaintiff,

v

Case No. 18-167068-NH
Hon. Martha D. Anderson

JEFFREY J. COLTON, M.D., JEFFREY J. COLTON, PLLC, and THE COLTON CENTER,

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DEFENDANTS' MOTION TO STRIKE MICHAEL J. ARMSTRONG, JR., M.D. AND FOR SUMMARY DISPOSITION PURSUANT TO MCR 2.116(C)(7)

NOW COME Defendants, Jeffrey J. Colton, M.D., Jeffrey J. Colton, PLLC, and The Colton Center, by and through their attorneys, Plunkett Cooney, and for their Motion to Strike Michael J. Armstrong, Jr., M.D. and for Summary Disposition Pursuant to MCR 2.116(C)(7), state as follows:

1. This is a medical malpractice action wherein Plaintiff alleges Defendant Dr. Jeffrey Colton negligently performed cosmetic rhinoplasty/rhinoplasty revisions from August 25, 2014 through November 9, 2017. (**Exhibit A**, Plaintiff's Complaint filed July 16, 2018).

2. For the reasons stated in Defendants' Brief in Support, Plaintiff's sole liability expert Dr. Armstrong, Jr. must be stricken as he fails to meet the expert witness qualifications set forth in MCL 600.2169. Additionally, Plaintiff's action is time-barred as

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this action arises out of the August 25, 2014 cosmetic rhinoplasty and treatment plan. All revision procedures were performed in accordance with the original treatment plan. Provided that there is no "continuing wrongs" doctrine for medical malpractice actions in Michigan, the entire action is time-barred.

WHEREFORE, Defendants respectfully request this Honorable Court grant its motion and enter an order striking Dr. Armstrong and/or dismissing this action.

Respectfully Submitted,

PLUNKETT COONEY

By: /s/Paul J. Dwaihy

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Dated: October 16, 2019

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

ANTHONY SELLIMAN,

Plaintiff,

v

Case No. 18-167068-NH
Hon. Martha D. Anderson

JEFFREY J. COLTON, M.D., JEFFREY J. COLTON, PLLC, and THE COLTON CENTER,

Defendants.

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BRIEF IN SUPPORT OF DEFENDANTS' MOTION TO STRIKE MICHAEL J. ARMSTRONG, JR., M.D. AND FOR SUMMARY DISPOSITION PURSUANT TO MCR 2.116(C)(7)

I. Introduction

Plaintiff Anthony Selliman ("Plaintiff") filed the current Complaint alleging Defendant Dr. Colton negligently performed cosmetic rhinoplasty/rhinoplasty revisions from August 25, 2014 through November 9, 2017. On August 25, 2017, Plaintiff presented for a cosmetic rhinoplasty with Dr. Colton. The goal of the procedure was make the tip of plaintiff's nose narrower, drop the projection of plaintiff's nose, and to thin the mid-portion and bony area of the nose. Plaintiff alleges that Dr. Colton breached the standard of care in his original rhinoplasty procedure and further breached the standard of care by continuing to adhere to the original treatment plan during his subsequent revision procedures.

Defendant Dr. Jeffrey Colton possesses two separate Board Certifications—one by the American Board of Otolaryngology and the second by the American Board of Facial

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Plastic and Reconstructive Surgery. Otolaryngology and Facial Plastic and Reconstructive Surgery are separate specialties recognized by the American Board of Preventative Medicine. The procedure at-issue in this case, a cosmetic rhinoplasty, is plastic surgery on the nose with the goal of enhancing the appearance of the individual's nose. Plaintiff's sole liability expert, Dr. Michael Armstrong, Jr., testified that from 2013-2017 he devoted approximately 90% of his practice to otolaryngology whereas only 10% was devoted to facial plastic and reconstructive surgery. (**Exhibit B**, p 34). Dr. Armstrong further testified that his facial plastic and reconstructive surgery practice included cosmetic rhinoplasties. *Id.* For the reasons provided more fully *infra*, Plaintiff's expert fails to satisfy the requirements of MCL 600.2169 which requires an expert witness offering standard of care testimony to have devoted a majority of his/her professional time to either or both the active clinical practice of the specialty at issue or the instruction of students in the specialty at issue. Here, the specialty at issue is facial plastic and reconstructive surgery.

Plaintiff's expert further testified that Dr. Colton breached the standard of care by adhering to an improper treatment plan created in August 2014 and negligently performed revision procedures in accordance with that treatment plan. (**Exhibit B**, p 99-100). In Michigan, there is no "continuing violations" doctrine in medical malpractice actions. *McKiney v Clayman*, 237 Mich App 198 (1999); *Garg v Macomb Co Community Mental Health Services*, 472 Mich 263 (2005). Plaintiff's cause of action arose on August 25, 2014. The statute of limitations for malpractice actions required Plaintiff to file his Complaint on or before August 25, 2016[1]. The Notice of Intent sent on January 11, 2018 was not timely and

[1] The Notice of Intent tolling provision under MCL 600.2912b is not applicable to the August 25, 2014 procedure due to the fact that the Notice of Intent was not sent until January 11, 2018. At a very minimum, treatment dates occurring on or before January 12, 2016 are time-barred.

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did not toll plaintiff's original cause of action. As such, Plaintiff's Complaint filed on July 16, 2018 is time-barred and this action must be dismissed.

II. Material Facts

Prior to his treatment with Dr. Colton, Plaintiff Anthony Selliman underwent three cosmetic rhinoplasties with Dr. Theodore Golden. The rhinoplasties with Dr. Golden occurred in 2009, 2010, and 2011. Still unhappy with the appearance of his nose, Mr. Selliman presented to Dr. Colton on August 25, 2014 for a cosmetic rhinoplasty. The treatment plan created for Mr. Selliman was intended to thin the nose and decrease the projection of the tip. Much like his treatment with Dr. Golden, Mr. Selliman expressed continuing displeasure with the results and wanted to pursue revisions following each procedure.

Following the original cosmetic rhinoplasty, Dr. Colton performed six rhinoplasty revisions in total—March 25, 2015, September 9, 2015, January 12, 2016, June 23, 2016, April 19, 2017, and November 9, 2017. Each revision was done in order to achieve the result contemplated in the original treatment plan. Following the November 9, 2017 revision procedure, Plaintiff ceased treatment with Dr. Colton once it was determined that his desired result could not be realistically achieved.

III. Standard of Review

Defendants bring this Motion pursuant to MCR 2.116(C)(7), (C)(8), and (C)(10). Whether a plaintiff's action is statutorily barred is a question of law for the court to decide. *Moll v Abbott Laboratories*, 444 Mich 1, 28 (1993). A motion pursuant to MCR 2.116(C)(7) does not test the merits of a claim but rather tests certain defenses that may make a trial on the merits unnecessary. *DMI Design and Manufacturing Inc v Adac Plastics, Inc*, 165 Mich

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App 205 (1987). MCR 2.116(C)(7) allows summary disposition when the "claim is barred because of release, payment, prior judgment, immunity granted by law, *statute of limitations*, statute of frauds, an agreement to arbitrate, infancy or other disability of the moving party, or assignment or other disposition of the claim before commencement of the action."

A motion brought pursuant to MCR 2.116(C)(8) tests the legal sufficiency of a complaint and requires the Court to determine whether or not an opposing party's pleadings allege a prima facie case. This court rule allows the Court to grant summary disposition where "[t]he opposing party has failed to state a claim on which relief can be granted." MCR 2.116(C)(8). No findings of fact are made; instead, all well-pled facts are accepted as true. *Radtke v Everett*, 442 Mich 368, 373; 501 NW2d 155 (1993). Summary disposition under MCR 2.116(C)(8) is warranted where allegations fail to state a legal claim. (*Id.*). Summary disposition must be granted under this rule when the claim is legally unenforceable and no factual development would justify recovery. *Simko v Blake*, 448 Mich 648, 654; 532 NW2d 842 (1985).

A motion for summary disposition filed pursuant to MCR 2.116(C)(10) tests the factual sufficiency of a complaint. *Maiden v Rozwood*, 461 Mich 109; 597 NW2d 817 (1999); *Smith v Globe Life Insurance Co*, 460 Mich 446; 597 NW2d 28 (1999). In evaluating a motion brought under (C)(10), a court must consider the affidavits, pleadings, depositions, admissions and other evidence submitted by the movant in a light most favorable to the opposing party. *Maiden, supra* at 120.

IV. Law and Argument

1. Plaintiff's Expert Dr. Michael Armstrong, Jr. must be stricken as he fails to meet the requirements of MCL 600.2169

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A. Governing Law – Expert Testimony

"Proof of a medical malpractice claim requires the demonstration of the following four factors: (1) the applicable standard of care, (2) breach of that standard of care by the defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury." *Locke v Pachtman*, 446 Mich 216, 222; 521 NW2d 786 (1994). "These common-law elements have been codified in MCL 600.2912a." *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004). Expert testimony is required to establish the applicable standard of conduct, the breach of that standard, and causation. *Thomas v McPherson Community Health Center*, 155 Mich App 700, 705; 400 NW2d 629 (1986).

The proponent of expert testimony in a medical malpractice case must satisfy the court that the expert witness is qualified under MRE 702, MCL 600.2955, and MCL 600.2169. *Clerc v Chippewa County War Memorial Hospital,* 477 Mich 1067; 729 NW2d 221 (2007); *Edry v Adelman,* 486 Mich 634, 639; 786 NW2d 567 (2010). The Court's "gatekeeper" function is vitally important because there is the real risk that "expert" opinion in an area outside of a witness's expertise could unduly sway a jury to accept that opinion rather than reach their own conclusion on the facts. *Franzel v Kerr Mfg Co*, 234 Mich App 600, 622-623; 600 NW2d 66 (1999).

In order to provide expert testimony on the relevant standard of care, an expert witness in a medical malpractice action must meet the requirements under MCL 600.2169 which provides as follows:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:

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> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

MCL 600.2169(1)(a) requires an expert offering standard of care testimony to match the one most relevant standard of practice—the specialty engaged in by the defendant physician during the course of the alleged malpractice. If the defendant is board certified, the expert must also be board certified in that same specialty. *Woodard v Custer*, 476 Mich 545 (2006). Additionally, the expert must have been a specialist in the same specialty as the defendant at the time of the occurrence at issue. MCL 600.2169(1)(a); *Rock v Crocker*, 499 Mich 247 (2016).

B. Dr. Armstrong did not spend the majority of his professional time in the active clinical practice of Facial Plastic and Reconstructive Surgery during the year immediately preceding the date of the occurrence that is the basis for Plaintiff's claim.

Defendant Dr. Jeffrey Colton is Board Certified in both Otolaryngology and Facial Plastic and Reconstructive Surgery. The treatment at-issue in this action arises out of Dr. Colton's performance of a cosmetic rhinoplasty—a plastic surgery procedure for correcting

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the appearance of an individual's nose. In other words, the "one most relevant specialty" is Facial Plastic and Reconstructive Surgery.

Dr. Armstrong testified that approximately 90% of his current practice is devoted to otolaryngology whereas 10% is devoted to facial plastic and reconstructive surgery. (**Exhibit B**, p 33). This breakdown of Dr. Armstrong's practice holds true for the years 2013-2017.

Q Before I do so, the breakdown of your practice, generally, that you gave me earlier, 90 percent ENT, 10 percent facial plastic and reconstructive surgery, is that generally consistent dating back to 2013, 2014?
A Yes.

Q Okay. Same set of questions, 2015 to 2017: Was your practice then approximately 90 percent otolaryngology and 10 percent facial plastic and reconstructive surgery?
A Yes.
Q Okay. And the facial plastic and reconstructive surgery would include cosmetic rhinoplasties?
A Yes.

(**Exhibit B**, p 34, 39).

Dr. Armstrong's testimony demonstrates that cosmetic rhinoplasties fall within the "facial plastic and reconstructive surgery" portion of his practice, of which he devotes only 10% of his professional time during the relevant time period. From his testimony it is clear that he did not devote the majority of his professional time engaged in the active clinical practice of the specialty at-issue or "the one most relevant specialty".

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C. Overlapping areas of practice do not count towards the requisite "majority" of professional time.

Dr. Armstrong's belief that there exists a significant "overlap" between the two specialties does not render his testimony admissible under MCL 600.2169. The question under the law is what percentage of your professional time is devoted to the one most relevant specialty in the year prior to the alleged malpractice. Dr. Armstrong answered that question unequivocally.

The Supreme Court in *Woodard* held that an expert can only devote a majority of his or her professional time to *one* specialty, finding that it would be "improper to combine [the expert's] time spent in medical oncology with his time spent practicing internal medicine when considering whether he is qualified as an expert under MCL 600.2169(1)(b).

See Woodward v Custard appeal, *Hamilton v Kuligowski. Hamilton v. Kuligowski,* 261 Mich App 608, 611–612; 684 NW2d 366 (2004), *rev'd sub nom Woodard v. Custer,* 476 Mich 545, 566; 719 NW2d 842 (2006) (holding that where the expert spent the majority of his time practicing infectious disease, he did not qualify as an internal medicine expert because ID and internal medicine are distinct, despite the former being a subspecialty of the latter). *See also Johnson v Bhimani,* No. 292327, 2011 WL 476443, at *2 (Mich Ct App, February 10, 2011) (attached as **Exhibit D**) (despite the argument that "neuroradiology is a subspecialty of diagnostic radiology and there is considerable overlap of the fields," the expert testified he spent 50-80% of his time on neuroradiology and was accordingly not qualified to testify to the standard of care in diagnostic radiology).

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Plaintiff's counsel attempted to clean up Dr. Armstrong's testimony by asking him about "overlap" between his two board certifications—Otolaryngology and Facial Plastic and Reconstructive Surgery.

You, like Dr. Colton, are double-boarded?
A Yes.
Q And I'm assuming there's some overlap between those two boards?
A Yes.
Q Is it hard to distinguish the extent of the overlap? When I think of otolaryngology, I think of procedures that also involve rhinoplasties and things like Mr. Sellman had done.
MR. DWAIHY: Form objection.
A Rhinoplasty is part of the required training for an otolaryngologist, and 25 percent of the otolaryngology examination is on facial plastic and reconstructive surgery. So facial plastic surgery is considered an integral part of otolaryngology, or ear, nose, and throat; and facial plastics is an additional credential for about 10 percent or so of otolaryngologists who have performed additional training, had peer review of their cases, and taken an additional examination to show expertise in facial plastic surgery, just as others might do a fellowship or take an examination in neuro-otology or in the voice or various other subspecialties within the broad scope of otolaryngology.
Q And although your practices may differ somewhat, do you feel that you're qualified to give opinion testimony against Dr. Colton?
A Yes.

(Exhibit B, pp 114-115).

Dr. Armstrong's opinion on whether he deems himself qualified to give standard of care testimony against Dr. Colton is not of any legal significance. Dr. Armstrong himself testified as to the breakdown of his professional time from 2013-2017. Dr. Armstrong further confirmed that cosmetic rhinoplasties fell under his facial plastic and

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reconstructive surgery practice. Because he only devoted 10% of his professional time to the active clinical practice of facial plastic and reconstructive surgery during the relevant time period, he must be precluded from testifying in this matter.

D. It is Plaintiff's burden to demonstrate the qualifications of Dr. Armstrong.

It is Plaintiffs' burden at all times to show that their expert witness meets the statutory qualifications. *Gay v Select Specialty Hospital*, 295 Mich App 284, 293; 813 NW2d 354 (2012). In addition to his deposition testimony, Dr. Armstrong's own Affidavit of Merit fails to demonstrate that he spent the majority of his time practicing the most relevant specialty in this matter.

> 5. During the one year prior to the treatment involved in this case I devoted the majority of my professional time to the active clinical practice of Otolaryngology and Facial Plastic and Reconstructive Surgery.

(**Exhibit C**, Affidavit of Merit Dr. Armstrong).

Dr. Armstrong's affidavit is contrary to the holding in *Woodard* which provides that an expert can only devote a majority of his or her professional time to *one* specialty. Clearly, Dr. Armstrong did not spend the majority of his professional time practice the one most relevant specialty and as such does not satisfy the requirements for an expert witness under MCL 600.2169.

2. Plaintiff's claims are statutorily time barred.

A. Governing Law – Limitations Period

Absent tolling, the statute of limitations for a medical malpractice action is two years. MCL 600.5805(8). The limitations period runs from the date the claim first accrued.

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The claim first accrues "at the time the wrong upon which the claim is based was done regardless of the time when damage results." MCL 600.5838a. There is no continuing wrongs doctrine in Michigan. *Garg v Macomb Co Community Mental Health Services*, 472 Mich 263; 696 NW2d 646 (2005). The statute of limitations can be tolled for up to 182 days pursuant to MCL 600.2912b(1), which requires a plaintiff to provide a Notice of Intent to file a medical malpractice action and then wait up to 182 days before filing suit. *See* MCL 600.5856. MCL 600.2912b provides, in pertinent part, as follows:

> (1) Except as otherwise provided in this section, a person shall not commence an action alleging medical malpractice against a health professional or health facility unless the person has given the health professional or health facility written notice under this section not less than 182 days before the action is commenced.

Thus, under the statute, after providing the written Notice of Intent, the plaintiff is required to wait for the applicable period to pass before filing suit. Generally, the plaintiff must wait 182 days after providing the Notice of Intent before commencing a malpractice action. MCL 600.2912b(1). If a Notice of Intent is timely filed, it can serve to toll the running of the statute of limitations. MCL 600.5856(c) provides that the statute of limitations is tolled "[a]t the time notice is given in compliance with the applicable notice period under section 2912b, if during that period a claim would be barred by the statute of limitations or repose; but in this case, the statute is tolled not longer than the number of days equal to the number of days remaining in the applicable notice period after the date notice is given."

B. Plaintiff's allegations arising out of the August 25, 2014 treatment are time barred as there is no "continuing wrong" theory of liability in Michigan malpractice actions.

As stated *supra*, Plaintiff's Complaint alleges negligent treatment arising out of the cosmetic rhinoplasty/rhinoplasty revisions starting on August 25, 2014. Plaintiff further

alleges that the six revision procedures performed thereafter constitute separate and distinct acts of negligence. Plaintiff's expert testified that an original treatment plan was created between Dr. Colton and Mr. Selliman, and Dr. Colton performed each revision procedure in adherence to the original treatment plan.

Q So you're saying, if I can understand you, that his entire plan of care of trying to narrow his nose and make his nose lower, given the patient's requests and the patient's history, was inappropriate and a breach of the standard of care?
A Yes. The plaintiff care over 2014 to 2017.
Q Starting with the August 25th, 2014, surgery?
A Yeah. Yeah.
Q And essentially, as we discussed before, Dr. Colton was attempting to achieve the same result with each successive revision?

A Uh-huh.
Q Yes?
A Yes.
Q Okay. So you are saying he breached the standard of care by adhering to his original plan of care and trying to do the same thing each revision?
A He -- yes, by pursuing a plan of care at the request of the patient and by not recognizing that he was headed down a path that was destructive, that was going to end up with the nose that Mr. Selliman has today.
Q By trying to do the same thing over and over again?
A Doing the same thing over and over again.
Q Each revision procedure was for the same purpose?
A Each revision was for the same purpose and made the same thing worse.
Q Okay. And he was doing essentially the same thing at each procedure; he was trying to take more bone off the dorsum?
A Correct.

(Exhibit B, pp 99-100).

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In Michigan, there is no "continuing violations" doctrine in medical malpractice actions. *McKiney v Clayman*, 237 Mich App 198 (1999); *Garg v Macomb Co Community Mental Health Services*, 472 Mich 263 (2005). Dr. Colton's adherence to the original treatment plan during his six revision procedures does not create a new cause of action with each subsequent revision. In other words, there are no new or distinct negligent acts or omissions, but merely adherence to the doctor's original treatment determination.

Given the pertinent dates in this case, Plaintiff's action must be dismissed. Plaintiff's cause of action arose on August 25, 2014. The two year limitations period expired on August 25, 2016. Plaintiff filed the Notice of Intent on January 11, 2018, after the expiration of the limitations period for the August 25, 2014 procedure. Through Plaintiff's expert's testimony it is clear that Dr. Colton's purported negligence is premised on an improper adherence to an original treatment plan. As such, Plaintiff's entire case arose on August 25, 2014. The July 16, 2018 filing of Plaintiff's Complaint was untimely and now requires dismissal with prejudice.

In the event that the Court was to assess each treatment independently, all treatment dates occurring on or before January 12, 2016 must be dismissed. Plaintiff's Notice of Intent was sent on January 11, 2018, with 1 day remaining in the limitations period for the January 12, 2016 revision procedure. In order for Plaintiff's Complaint to be timely with respect to the January 12, 2016 procedure, the action needed to be filed on July 13, 2018 (January 11th + 182 days + 1 day left in SOL period). Plaintiff filed his Complaint on July 16, 2018. At the very minimum, the treatment dates occurring on or before January 12, 2016 must be dismissed as untimely.

C. Dismissal on the basis that an action is untimely filed is an adjudication on the merits.

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In *Washington v Sinai Hospital of Greater Detroit,* 478 Mich 412; 733 NW2d 755 (2007), the Michigan Supreme Court held that a subsequent complaint filed by a plaintiff is barred by *res judicata* if an initial action was filed outside the applicable statute of limitations or savings provision (in *Washington*, the Court analyzed the wrongful death savings provision). See also *Al-Shimmari v The Detroit Medical Center,* 477 Mich 280; 731 NW2d 29 (2007), in which the Supreme Court held that dismissal of a claim on the statute of limitations is "an adjudication on the merits" under MCR 2.504(B)(3) barring all future claims that were, or could have been, raised in the action. *Al-Shimmari v Detroit Medical Ctr*, 477 Mich 280, 284, 295 (2007). Accordingly, Plaintiff's allegations arising out of the August 25, 2014 treatment must be dismissed with prejudice.

IV. Conclusion

Plaintiff's sole liability expert Dr. Armstrong fails to satisfy the requirements for expert witness testimony under MCL 600.2169. As such, Dr. Armstrong must be stricken from this matter. Further, Plaintiff's claims arose on August 25, 2014. The late-filed Complaint should be dismissed as statutorily time-barred.

Respectfully Submitted,

PLUNKETT COONEY

By: /s/Paul Dwaihy

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Dated: October 16, 2019

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PROOF OF SERVICE

The undersigned certifies that on the 16th day of October, 2019, a copy of the foregoing document was served upon the attorney(s) of record in this matter at their stated business address as disclosed by the records herein via:

- ☐ Hand delivery
- ☐ U.S. Mail
- ☐ Email
- ☐ Overnight mail
- ☐ Facsimile
- ☒ Electronic E-File

I declare under the penalty of perjury that the foregoing statement is true to the best of my information, knowledge and belief.

/s/Deanna Nagy
Deanna Nagy

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APPENDIX 7

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STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

ANTHONY SELLIMAN,
Plaintiff,
v.
JEFFREY J. COLTON, MD,
JEFFREY J. COLTON, PLLC, and
THE COLTON CENTER,
Defendants.

Case No. 18-167068-NH
Hon. Jeffrey Mattis

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PLAINTIFF'S RESPONSE TO DEFENDANTS' MOTION TO STRIKE MICHAEL J. ARMSTRONG, JR., MD & FOR SUMMARY DISPOSITION

NOW COMES Plaintiff, Anthony Selliman, by his attorneys, Ratton Law Group, PC and Michael T. Ratton, and for his Response to Defendants' Motion to Strike Michael J. Armstrong, Jr., MD and for Summary Disposition states as follows:

1. Admitted that this is a medical malpractice action wherein Plaintiff alleges Defendant Dr. Jeffrey Colton negligently performed rhinoplasty/rhinoplasty revisions from August 25, 2014 through November 9, 2017. Denied to the extent such surgeries be classified as solely cosmetic.

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2. Denied that Plaintiff's expert Dr. Armstrong must be stricken for failure to meet the expert witness qualifications set forth in MCL 600.2169, as further discussed in the accompanying Brief in Support.

Further denied that Plaintiff's action is time-barred, as further discussed in the accompanying Brief in Support.

WHEREFORE, for the above-mentioned reasons, further explained in the accompanying Brief in Support, Plaintiff respectfully requests this Honorable Court **deny** Defendants' Motion to Strike Michael J. Armstrong, Jr., MD and for Summary Disposition.

Dated: November 15, 2019

Respectfully submitted,

/s/ Michael T. Ratton

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STATE OF MICHIGAN
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ANTHONY SELLIMAN,
Plaintiff,
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BRIEF IN SUPPORT OF PLAINTIFF'S RESPONSE TO DEFENDANTS' MOTION TO STRIKE MICHAEL J. ARMSTRONG, JR., MD & FOR SUMMARY DISPOSITION

I. INTRODUCTION & FACTUAL BACKGROUND

This is a medical malpractice action arising out of Defendant Dr. Colton's repeated performance of rhinoplasty procedures, which resulted in facial scarring and deformity to Plaintiff, Tony Selliman. ***Exhibit 1 – Plaintiff's Complaint & Jury Demand.*** As a result of the repeated surgeries, Tony Selliman is left with facial scarring and functional deformity that no physician (except the Defendant) is willing to correct.

A. THE GOLDEN SURGERIES

Plaintiff sustained a broken nose in the 1980s which warranted surgical repair by Dr. Juan Beekus (his first rhinoplasty). In 2005, his nose was broken again and a second rhinoplasty was

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performed by Dr. Richard Arden. Over the course of the next few years, Tony began to experience sinus problems and felt the nose appeared "too thick". As such, he initially consulted with Dr. Theodore Golden.

Dr. Golden noted the presence of a "wide asymmetric nose with a thick nasal tip". On January 15, 2009, Dr. Golden performed Plaintiff's third rhinoplasty in an effort to thin the nose. On January 15, 2010, Dr. Golden performed a fourth rhinoplasty to provide a more feminine "scoop" nose. Plaintiff was unhappy with the results of this surgery, believing his nose was still asymmetric with the left side appearing larger. On January 14, 2011, Dr. Golden performed yet another rhinoplasty (Plaintiff's fifth) in an effort to thin the left side of the nose and provide symmetry. Plaintiff was again unhappy with the results of the surgery and the appearance of his nose. At that time, after performing three surgeries, Dr. Golden indicated he would do no further surgeries on Plaintiff because he could not achieve the desired results.

B. THE COLTON SURGERIES

In 2012, after Dr. Golden terminated his treatment, Plaintiff found Defendants Jeffrey Colton, MD, Jeffrey J. Colton, PLLC, and the Colton Center. Plaintiff explained to Dr. Colton that he was unhappy with his appearance and desired a thinner nose. Following consultation, Dr. Colton performed Plaintiff's sixth rhinoplasty on August 25, 2014. Multiple grafts which had been placed previously and were providing support to the nose were removed by Dr. Colton. Post-operative visits occurred through the end of 2014, with documented complaints from Plaintiff and reassurances from Defendant.

On March 25, 2015, Defendant Dr. Colton performed what would be Plaintiff's seventh rhinoplasty. It appears at this time that Dr. Colton performed a reduction of the nasal dorsum, but ignored Plaintiff's request for refining fullness in the nasal tip. Dr. Colton failed to recognize that

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the fullness in the nasal tip was due to the removal of the previous cartilage grafts, causing the tip to soften and appear widened. Dr. Colton failed to advise Plaintiff that further removal of cartilage would make the nose look softer and wider and that further resection of tissue was contraindicated. Plaintiff again expressed displeasure with the results of the rhinoplasty and his appearance.

On September 9, 2015, Dr. Colton performed Plaintiff's eighth nasal surgery. The written plan was to lower the dorsum and rasp and thin the left lateral and raise the tip. Had Dr. Colton properly examined Plaintiff preoperatively, including examination of the internal nose and palpation of the nasal dorsum, he would have realized that the nasal dorsum was already over resected. If acting as a reasonably prudent physician, Defendant would have determined that further resection of the nasal dorsum was contraindicated and would lead to greater distortion Instead, Defendant resected the caudal portion of the septum to encourage the tip to rotate upward and shorten the apparent length of the nose. He lowered the cartilaginous dorsum slightly and tried to rasp the bony dorsum at the root of the nose where it connects to the forehead.

Again, Plaintiff expressed dissatisfaction with the results of the rhinoplasty, in both appearance and function. On January 12, 2016, Dr. Colton performed Plaintiff's ninth rhinoplasty. Dr. Colton's records note that within days of the surgery, Plaintiff was complaining about failure to remove the "cartilage in the center of the front of the septum" and the line of "material" which has formed from the bridge of the nose to the tip. Dr. Colton assured Plaintiff the appearance and function would improve with the healing process and encouraged patience. Despite these assurances, Plaintiff continued to complain about the appearance and function of his nose, including his difficulty breathing. On June 23, 2016, Dr. Colton performed Plaintiff's tenth rhinoplasty. Defendant noted Plaintiff's request that he remove the line of "material" at the bridge of the nose, which Defendant believed was scar tissue resulting from surgery. As much scar tissue

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as possible was identified and removed. In emails sent to Defendants on August 5 and August 8, 2016, Plaintiff explained that removing this line of "material" was his number one priority and non-negotiable. Plaintiff indicated in these emails that he did not wish to continue with surgical intervention unless his goals were achievable. ***Exhibit 2 – Emails from August 5 and August 8, 2016.***

On April 19, 2017, Dr. Colton performed Plaintiff's eleventh surgery, again lowering the cartilaginous and bony nasal dorsum by a full quarter inch. Tissue was inexplicably removed from the "lower upper lateral cartilages." What Dr. Colton failed to recognize was that the complained of "material" was actually a fold of skin created by having so much tissue removed from the nose throughout prior surgeries. Dr. Colton failed to recognize that the solution was not to remove the tented up skin and soft tissue, but to replace the cartilage. In violation of the principles of reconstructive rhinoplasty, Dr. Colton documented that he took off another ¼ inch. Photographs taken after surgery demonstrate a severe depression on the left side of the nose. On November 9, 2017 Dr. Colton inexplicably performed a twelfth surgery, further reducing the middle third of the nose, where there was already a pre-existing saddle deformity.

Following the November 9, 2017 surgery, Plaintiff ceased treatment with Defendants Jeffrey Colton, MD, Jeffrey J. Colton, PLLC, and the Colton Center. Plaintiff filed this medical malpractice action on July 16, 2018. After a total of twelve rhinoplasties, the majority (7) performed by Defendant Dr. Colton, Plaintiff is left with a severe and highly visible saddle deformity. The nasal tip has been deconstructed so that it is round and amorphous. The radix of the nose has become progressively thicker and wider through multiple fractures and inappropriate osteotomies. The appearance of this thickness has been aggravated by the inappropriate removal of tissue in the middle third of the nose. The lining of the nose is poorly functional due to complete

obstruction of the nasal valve area and upper half of the nose from the osteotomies and deconstruction of the upper lateral cartilages, making breathing difficult.

II. STANDARDS OF REVIEW

Defendants brings this motion pursuant to MCR 2.116 (C)(7), (C)(8), and (C)(10). A motion under MCR 2.116(C)(7) may be brought based on certain specified affirmative defenses, including the statute of limitations. Whether a claim is barred by a statute of limitations is a question of law to be decided by the trial court. When deciding a motion under MCR 2.116(C)(8), the court must accept as true all factual allegations in the complaint. *Spiek v. Dep't of Transportation*, 456 Mich. 331, 336; 572 NW 2d 201 (1998). Factual allegations contained in the complaint are taken as true, along with inferences or conclusions which may be fairly drawn from the facts alleged." *McCallister v Sun Valley Pools, Inc,* 100 Mich App 131, 135; 298 NW2d 687 (1980), 411 Mich. 905 (1981).

A trial court may grant a motion for summary disposition under MCR 2.116(C)(10) only when there is no genuine issue regarding any material fact and the moving party is entitled to judgment as a matter of law. *Quinto v Cross & Peters Co.*, 451 Mich 358, 362; 547 N.W.2d 314 (1996). "A genuine issue of material fact exists when the record, giving the benefit of reasonable doubt to the opposing party, leaves open an issue upon which reasonable minds might differ." *West v General Motors Corp.,* 469 Mich 177, 183; 665 NW2d 468 (2003). When reviewing a motion for summary disposition brought under MCR 2.116(C)(10), a court must examine the pleadings, affidavits, depositions, admissions, and any other documentary evidence submitted by the parties and, drawing all reasonable inferences in favor of the nonmoving party, determine whether a genuine issue of material fact exists. MCR 2.116(G)(5); *Quinto*, 451 Mich at 361-362. The trial court is not permitted to assess credibility, to weigh the evidence, or to determine the

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facts, and if material evidence conflicts, it is not appropriate to grant a motion for summary disposition under MCR 2.116(C)(10). *Hines v Volkswagen of America, Inc*, 265 Mich App 432, 437; 695 NW2d 84 (2005).

III. LAW & ARGUMENT

A. GRANTING DEFENDANTS' MOTION WOULD BE INAPPROPRIATE BECAUSE PLAINTIFF'S EXPERT IS QUALIFIED UNDER MCL 600.2169.

In an action alleging medical malpractice, MCL 600.2912a requires a Plaintiff to demonstrate the following factors: (1) the applicable standard of care, (2) a breach of that standard of care by the defendant, (3) an injury suffered, and (4) proximate causation between the injury sustained and defendant's breach of the standard of care. To establish the applicable standard of care, a breach thereof, and causation, a plaintiff must offer testimony from an expert witness so qualified under MRE 702, MCL 600.2955, and MCL 600.2169. Whether an expert witness has the requisite qualifications to offer expert testimony is left to the trial court's sound discretion. *Albro v Drayer,* 303 Mich App 758, 760; 846 NW2d 70 (2014) (citing *Woodard v Custer,* 476 Mich 545, 557; 719 NW2d 842 (2006)).

MRE 702 allows for expert testimony when (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; and (d) the expert has reliably applied the principles and methods to the facts of the case. MCL 600.2955 holds that "in an action for the death of a person or for injury to a person or property, a scientific opinion rendered by an otherwise qualified expert is not admissible unless the court determines that the opinion is reliable and will assist the trier of fact. In making that determination, the court shall examine the opinion and the basis for the opinion,

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which basis includes the facts, technique, methodology, and reasoning relied on by the expert, and shall consider all of the following factors…"

Defendants allege Plaintiff's expert, Dr. Michael J. Armstrong, Jr., should be stricken for failure to meet the requirements of MCL 600.2169, specifically that he "did not spend the majority of his professional time practice the one most relevant specialty." ***See Def's Brief at 7-8***. Defendants base this argument on testimony given by Dr. Armstrong at his September 24, 2019 deposition and in the Affidavit of Merit filed with Plaintiff's Complaint on July 16, 2018.

1. ARMSTRONG'S DEPOSITION TESTIMONY

Defendant Dr. Jeffrey Colton is board certified in both Otolaryngology and Facial Plastic and Reconstructive Surgery; Dr. Michael J. Armstrong, Jr. is board certified in both Otolaryngology and Facial Plastic and Reconstructive Surgery. It is undisputed that Dr. Colton and Dr. Armstrong are board certified in the same specialties, as required for expert testimony by the Michigan Supreme Court in *Woodard v Custer,* 476 Mich 545, 557. Defendants contend "the treatment at issue in this action arises out of Dr. Colton's performance of a cosmetic rhinoplasty – a plastic surgery procedure for correcting the appearance of an individual's nose. In other words, the 'one most relevant' specialty' is Facial Plastic and Reconstructive Surgery." ***See Def's Brief at 9-10.*** Plaintiff disputes the rhinoplasty procedures performed by Dr. Colton were solely for cosmetic purposes, as Plaintiff's condition resulted in functional issues and difficulty breathing. Plaintiff further disputes that Facial Plastic and Reconstructive Surgery is the one most relevant specialty, as discussed *infra.* For purposes of addressing Defendants' instant motion **only,** Plaintiff argues that even if Facial Plastic and Reconstructive Surgery is the one most relevant specialty, Dr. Armstrong's deposition testimony does not require he be stricken.

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Defendants selectively included excerpts from Dr. Armstrong's testimony to support their contention that approximately 90% of his current practice is devoted to otolaryngology and 10% is devoted to facial plastic and reconstructive surgery. ***See Def's Brief at 10.*** The quoted excerpt ignores testimony previously offered by Dr. Armstrong about the division of his practice:

Q: Can you give me an approximation of the percentage of your professional time that's devoted to ENT, general ENT, as opposed to--

A: Excluding what?

Q: As opposed to facial plastic and reconstructive surgery.

A: There are certainly medical conditions that overlap quite a bit. A lot of my nasal functional surgeries would fall into the category of facial plastics. You know, I would say that the practice might be 10 percent cosmetic, 90 percent functional; but rhinoplasty is one of the more common procedures that I do.

Q: Within your cosmetic practice?

A: Or within my functional nasal practice. They're not all cosmetic.

Exhibit 3 – Deposition of Dr. Michael J. Armstrong, pp. 32-33.

As evidenced by this exchange, Dr. Armstrong testified that **within** his facial plastic and reconstructive surgery practice, 10 percent of his procedures may be for cosmetic purposes, with 90 percent being more functional. Dr. Armstrong was not attributing these percentages to the division of his practice between otolaryngology and facial plastic and reconstructive surgery, although that was defense counsel's apparent objective in asking the question. Having not received an adequate response, defense counsel posits the question again:

Q: Okay. So can you give me an approximation of currently the breakdown of your practice, general otolaryngology versus facial plastic and reproductive [reconstructive] surgery?

A: I've not looked at it recently; but as I said, 10 percent, maybe in the facial plastic realm and 90 percent would be considered more medically ENT.

Exhibit 3 – Deposition of Dr. Michael J. Armstrong, p. 33.

Dr. Armstrong was clearly referring to his earlier testimony ("as I said") when he again assigned the percentages at issue. It is clear he was discussing the division **within** his facial plastic

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and reconstructive surgery practice between cosmetic/facial plastic realm and functional/more medically ENT, not assigning percentages between his practice of Otolaryngology and Facial Plastic and Reconstructive Surgery.

Only after these previous exchanges is the testimony cited in Defendants' Brief given, when defense counsel again posits the question of the division of Dr. Armstrong's practice:

> Q: Before I do so, the breakdown of your practice, generally, that you gave me earlier, 90 percent ENT, 10 percent facial plastic and reconstructive surgery, is that generally consistent dating back to 2013, 2014?
>
> A: Yes.
>
> Q: Okay. Same set of question, 2015 to 2017: was your practice then approximately 90 percent otolaryngology and 10 percent facial plastic and reconstructive surgery?
>
> A: Yes.

Exhibit 3 – Deposition of Dr. Michael J. Armstrong, p. 39.

Again, a reading of the complete deposition transcript evidences that Dr. Armstrong was speaking of the division of his facial plastic and reconstructive surgery practice between cosmetic and functional/medically ENT procedures, not the division of his practice between Otolaryngology and Facial Plastic and Reconstructive Surgery. While Dr. Armstrong's testimony could certainly have been more precise, the facts tend more towards potential impeachment at trial than disqualification under MCL 600.2169.

2. ARMSTRONG'S AFFIDAVIT OF MERIT

Defendants rely on *Woodard*'s holding that an expert can only devote a majority of his professional time to one specialty, finding that it would be "improper to combine the expert's time spent in medical oncology with his time spent practicing internal medicine when considering whether he is qualified as an expert under MCL 600.2169(1)(b)." As previously discussed, Dr. Armstrong did not clearly testify as to the division of his practice between Otolaryngology and Facial Plastic and Reconstructive Surgery. Further, this action is distinguishable from *Woodard*

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because Defendant Colton and Dr. Armstrong share identical board certifications. In *Woodard*, the defendant was board certified and specialized in pediatric critical care medicine. *Id.* at 575, 719 NW2d 842. The plaintiffs' expert was board certified in pediatrics but did not specialize in pediatric critical care medicine. *Id.* at 554-555, 719 NW2d 842.

Defendants further allege that Dr. Armstrong's Affidavit of Merit fails to demonstrate that he spent the majority of his time practicing the most relevant specialty because he states that "during the one year prior to the treatment involved in this case I devoted the majority of my professional time to the active clinical practice of Otolaryngology and Facial Plastic and Reconstructive Surgery." ***See Def's Brief at 13.*** However, the Court of Appeals held in *Jones v Botsford Continuing Care Corp.* that plaintiff's expert not be stricken when counsel held a reasonable belief that his expert matched the necessary qualifications to render testimony on the standard of care. *Jones v Botsford Continuing Care Corp.,* 310 Mich App. 192, 206-207, 871 NW2d 15. Under this ruling, issued after *Woodard*, it would be inappropriate to somehow hold Dr. Armstrong's Affidavit of Merit against him in determining whether or not he was qualified to render expert testimony, especially when the issue of the "most relevant specialty" has not been determined.

It would further be inappropriate to suggest Dr. Armstrong is unqualified based on the language of his Affidavit of Merit when Defendants' own expert, Dr. Michael A. Carron, MD used nearly identical language to that of Dr. Armstrong in his own Affidavit of Meritorious Defense. In his Affidavit on behalf of Defendants, Dr. Carron states that "during the time period at issue in this case and the year preceding, I devoted the majority of my professional time to the active clinical practice of otolaryngology-head and neck surgery and facial, plastic, and reconstructive surgery." ***Exhibit 4 – Affidavit of Meritorious Defense of Dr. Michael Carron, p. 1.*** Dr. Carron further

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states that "I understand the standard of care applicable to Jeffrey Colton, MD in this matter to be that which a physician specializing in otolaryngology-head and neck surgery and facial, plastic, and reconstructive surgery of ordinary learning, skill and judgment would do or would not do under the same or similar circumstances as existed in treating Plaintiff Anthony Selliman." ***Exhibit 4, p. 2.*** Because Defendants' own expert witness holds the same opinion as Dr. Armstrong as to the standard of care, it would be inappropriate to consider Plaintiff's expert witness unqualified without determining Defendants' witness to be unqualified as well.

B. PLAINTIFF'S ACTION IS NOT TIME BARRED, AS DEFENDANTS COMMITTED ACTS OF MEDICAL MALPRACTICE AFTER JANUARY 12, 2016.

Defendant Dr. Colton performed a total of seven rhinoplasty procedures: August 25, 2014, March 25 2015, September 9, 20115, January 12, 2016, June 23, 2016, April 19, 2017, and November 9, 2017. Defendants suggest Plaintiff relies upon a "continuing wrong" theory of liability. ***See Def's Brief at 14-16.*** To the contrary, Plaintiff alleges each and every surgery performed by Defendant Dr. Colton was a separate and distinct incident of medical malpractice. Plaintiff has never predicated this action upon a "continuing wrong" doctrine, as such is inapplicable to medical malpractice actions in Michigan. *Blazer Foods, Inc v Restaurant Properties, Inc,* 259 Mich App 241, 247; 673 NW2d 805 (2003).

Pursuant to MCL 600.5805 (8), the statute of limitations for a medical malpractice action is two years, absent tolling. The statute of limitations in a medical malpractice action can be tolled for up to 182 days through the filing of a Notice of Intent, which is statutorily required by MCL 600.2912b(1). The plaintiff must wait until the expiration of this notice period before filing a complaint to commence the action. Upon expiration of the notice period, the time remaining to

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commence an action for medical malpractice is equal to the number of days remaining in the applicable period after the date notice was given.

Plaintiff would now agree that dates prior to January 12, 2016 be considered untimely. However, this action should not be dismissed as subsequent surgery dates of June 23, 2016, April 19, 2017, and November 9, 2017 were timely preserved by the filing of the Notice of Intent and filing of the Complaint, and are thus not time barred.

IV. CONCLUSION & RELIEF REQUESTED

Defendants' argument that Plaintiff's expert, Dr. Michael J. Armstrong, Jr., should be stricken for failure to comply with MCL 600.2169 is unsupported by the deposition testimony, as well as Defendants' own Affidavit of Meritorious Defense, and the instant motion should therefore be denied. Further, Defendants' motion should be denied because independent acts of malpractice were committed by Defendants after January 12, 2016, and Plaintiff's claims are thus not time barred.

WHEREFORE, for all of the foregoing reasons, Plaintiff respectfully requests that this Honorable Court **deny** Defendants' Motion to Strike Michael J. Armstrong, Jr., and for Summary Disposition and allow the case to proceed on the merits.

Dated: November 15, 2019

Respectfully submitted,

CERTIFICATE OF SERVICE
The undersigned certifies that the foregoing instrument was served upon all parties to the above cause to each of the attorneys of record herein at their respective addresses disclosed on the pleadings on November 20 19
By: ☐ Overnight Courier ☐ FAX ☐ E mailed
☐ Hand Delivered ☐ U.S. Mail ☒ Other Court's efile
☐ Certified Mail ☐ Scanned
Signature Tracy Hughes Service

/s/ Michael T. Ratton
MICHAEL T. RATTON (P42399)
RATTON LAW GROUP, PC
Attorneys for Plaintiff
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Detroit, MI 48226

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APPENDIX 8

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

ANTHONY SELLIMAN,

Plaintiff,
v

Case No. 18-167068-NH
Hon. Jeffery S. Matis

JEFFREY J. COLTON, M.D., JEFFREY J . COLTON, PLLC, and THE COLTON CENTER,

Defendants.

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REPLY BRIEF IN SUPPORT OF DEFENDANTS' MOTION TO STRIKE MICHAEL J. ARMSTRONG, JR., M.D. AND FOR SUMMARY DISPOSITION PURSUANT TO MCR 2.116(C)(7)

A. Plaintiff's sole liability expert, Dr. Armstrong, is not qualified to testify as an expert witness, which in turn requires the grant of summary disposition.

First, Plaintiff contends that Facial Plastic and Reconstructive Surgery is not the one most relevant specialty because Plaintiff's procedures did not fall within this practice of medicine. This position is unsupported and contrary to the medicine as practiced by Dr. Colton. (**Exhibit A**, Affidavit of Jeffrey J. Colton, M.D.). Dr. Colton testifies that the aesthetic rhinoplasty revision procedures which he provided to Plaintiff fall within the medical specialty of Facial, Plastic and Reconstructive Surgery. *Id*. at para. 6. In support, Dr. Colton explains that "*Mr. Selliman never presented to me with the otolaryngology issues and none of my treatment of Mr. Solomon involved general otolaryngology*. *Id*. Plaintiff's only retort is that Defendants' affiant, Dr. Michael A.Carron, M.D., stated at the beginning of the case in his Affidavit of Meritorious Defense that the standard of care applicable to Dr. Colton in this matter is a physician

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practicing in both otolaryngology and facial, plastic, and reconstructive surgery. An Affidavit of Merit/Meritorious Defense filed at the beginning of the case is meant only to demonstrate an *initial* showing of merit the litigants to allow the case to proceed on the merits. Plaintiff presents no authority for the proposition that a statement made in an Affidavit of Meritorious Defense establishes the standard of care, and more precisely, the relevant area of medicine and required qualification for the expert witnesses.

Second, Plaintiff contends that Defendants have misconstrued Dr. Armstrong's deposition testimony, and that he only testified that "within" his facial plastic and reconstructive surgery practice, 10% of those procedures are for a cosmetic purposes and 90% are for more functional procedures. Plaintiff' brief in support, page 8. This is not a plausible reading of Dr. Armstrong's deposition, which is clear and unequivocal that, during the relevant time periods, 90% of his practice was devoted to otolaryngology, and only 10% devoted to facial plastic and reconstructive surgery. (Dr. Armstrong's deposition testimony, pages 34, 39, previously submitted as **Exhibit B**). To avoid summary disposition, Plaintiff seeks to subdivide the type of procedures performed by Dr. Armstrong in his active clinical practice into different categories, and then argues that because certain procedures are in one area versus the other, this suggests Dr. Armstrong was only testifying about the percentage of his work with in the one most relevant specialty, facial plastic and reconstructive surgery. It is the majority of active clinical practice, not the majority of the type of procedure, which governs the active clinical practice requirement of section 2169. Additionally, in reading into Dr. Armstrong's deposition testimony contrary to his very words, Plaintiff seeks to establish that certain procedures may overlap in the respective areas, and therefore a procedure in otolaryngology would count towards a majority of practice in facial plastic and reconstructive surgery. Dr. Armstrong did not go so far in his testimony. And, as addressed next, even if this was a reasonable reading of his deposition, using procedures to overlap two separate areas of specialty is prohibited under the law.

Third, Plaintiff contends that Dr. Armstrong's active clinical practice in otolaryngology counts towards the "majority" requirement of section 2169 because there was considerable overlap between his

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practice in otolaryngology and facial plastic and reconstructive surgery, and that considering such overlap he spent the majority of his professional time practicing in the same area of medicine as Dr. Colton. Michigan law does not allow an expert to rely on a claimed overlapping practice in dual specialties to satisfy the active clinical practice requirement of MCL 600.2169, which may have been allowed under the prior version of the statute, but not under the present version which governs in this matter. Prior to 1993, MCL 600.2169 provided that in order to offer standard of care testimony, an expert must spend a *substantial* portion of his time in the active clinical practice of the same or a related relevant area of health care. Under the pre-1993 version of MCL 600.2169, Michigan Court's considered overlap between specialties in determining an expert's qualifications. See e.g., *McClellan v Collar*, 240 Mich App 403; 613NW2d 729 (2000).

However, in 1993, the Michigan Legislature amended MCL 600.2169, that qualify to offer standard of care testimony, an expert must spend the *majority* of his/her professional time in the year preceding the date of the occurrence in the active clinical practice of the same specialty as the defendant. MCL 600.2169(1). The purpose of this amendment was to limit the court's discretion in qualifying experts and to "insure that in malpractice suits against specialists the expert witnesses actually practice in the same specialty." *McDougal v Schanz*, 461 Mich 15, 25, n 9; 597 NW2d 148 (1999) citing the *Report of the Senate Select Committee on Civil Justice Reform.* In *Woodard v Custer*, 476 Mich 545; 719 NW2d 842 (2006), the Michigan Supreme Court held:

- As used in the current version of MCL 600.2169(1)(a) "a specialty is a particular branch of medicine in which one can potentially become board certified." 476 Mich at 561.
- "[A] 'subspecialty' is a particular branch of medicine or surgery in which one can potentially become board certified that falls under a specialty or within the hierarchy of that specialty. A subspecialty, although a more particularized specialty, is nevertheless a specialty." *Id.* at 562.

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- An expert can only devote the majority of his professional time to one specialty. *Id*. at 560, 566.[1]

Relying on the clear mandate in *Woodard/Hamilton*, the Michigan Court of Appeals has consistently rejected the claimed overlap between specialties when determining the qualifications of an expert witness:

- *Kiefer v Markley*, 283 Mich App 555; 769 NW2d 271 (2009) (in striking plaintiff's expert, the Court of Appeals considered only time the expert spent in hand surgery and not the closely related area of reconstructive surgery of other extremities).

- *Johnson v Bhimani,*[3] unpublished decision of the Court of Appeals, February 10, 2011 (Docket No. 292327) (applying *Woodard, Hamilton,* and *Kiefer*, the Court rejected plaintiff's argument that an expert in general diagnostic radiology was qualified to testify against a neuroradiologist because of overlap between the specialties) (**Exhibit B**).

- *Stevens v Lansing Anesthesiologists*, unpublished decision of the Court of Appeals, November 17, 2016 (Docket No. 328971) (applying *Woodard* and *Hamilton*, the Court rejected plaintiff's argument that the practice of the subspecialty of pain management was part and parcel of anesthesiology and struck plaintiff's expert) (**Exhibit C**).

- *Estate of Patricia E. Leblanc v Agnone*, unpublished decision of the Court of Appeals, July 6, 2017 (Docket Nos. 330330, 330416) (applying *Woodard* and *Kiefer*, the Court ruled that it was improper to combine time an expert spent in other overlapping specialties when determining an experts qualifications under MCL 600.2169(1)(b) and struck plaintiff's expert) (**Exhibit D**).

---

[1] The *Woodward* court struck the standard of care testimony of the plaintiff's expert in the companion case of *Hamilton v Kuligowski.* 476 Mich at 553-554. In *Hamilton,* the defendant physician was board certified in internal medicine and practiced general internal medicine. *Woodard*, *Id*. at 577. Plaintiff's expert, Dr. Markowitz, was also board certified in internal medicine, but testified at trial that he had additional subspecialty training in the area of infectious disease. *Hamilton v Kuligowski,* 261 Mich App 608, 609; 684 NW2d 366 (2004), *rev'd Woodard v Custer*, 476 Mich 545 (2006). Dr. Markowitz further testified that, although not board certified in infectious disease, he devoted the majority of his practice to that subspecialty, explaining that the subspecialty of infectious disease was a more focused application of internal medicine, and that his practice in infectious disease was entirely within the ambit or rubric of internal medicine. 261 Mich App at 611. He testified that his patient's saw him because he was an internal medicine specialist, and that his interest in infectious disease simply allowed him to do more for his patients. *Id*.

The defendants moved to preclude the testimony of plaintiff's expert because he did not devote the majority of his professional time to the active clinical practice of general internal medicine. *Woodard*, 476 Mich at 555. The trial court agreed, granting directed verdict. *Id.* The Court of Appeals reversed the trial court, finding that the treatment of infectious diseases is a subspecialty within the area of internal medicine. *Id*. at 557. The Supreme Court disagreed, reasoning that the relevant specialty that must be matched pursuant to MCL 600.2169(1)(a) and (b) was internal medicine. While plaintiff's expert may have been a specialist in both internal medicine and infectious disease, he spent the majority of his professional time in the practice of the subspecialty of infectious disease and not general internal medicine. *Id.* at 577-578.

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- *Perez v Henry Ford Health System,* unpublished decision of the Court of Appeals, issued December 4, 2018 (Docket No. 340082), lv denied __ Mich __; 932 NW2d 782 (2019) (applying *Woodard* and *Kiefer*, the Court of Appeals rejected Dr. Venkatasubramanian's testimony that she was practicing neurology even when practicing as a neurointensivist, because the two titles of general neurology and neuro-critical care flow together, and struck plaintiff's expert) (**Exhibit E**).

B. Plaintiff's action is time-barred by expiration of the statute of limitations.

At page 12 of his Brief in Support, Plaintiff concedes that the statute of limitations has expired on "dates prior to January 12, 2016," and that claims relating to surgeries before that time may be "considered untimely." Accordingly, at a minimum partial summary disposition is required.[2] However, plaintiff contends that the "continuing wrong" statute of limitations' rule is inapplicable because here there were separate procedures on separate dates. Plaintiff's focus is misplaced. He complains of Dr. Colton's adherence to the original treatment plan during revision procedures, which is adherence to the original treatment determination, admittedly time-barred.

Respectfully Submitted,

PLUNKETT COONEY

By: /s/Paul J. Dwaihy

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Dated: November 25, 2019

[2] March 25, 2015 and September 9, 2015 procedures.

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PROOF OF SERVICE

The undersigned certifies that on the 25th day of November, 2019, a copy of the foregoing document was served upon the attorney(s) of record in this matter at their stated business address as disclosed by the records herein via:

☐ Hand delivery	☐ Overnight mail
☐ U.S. Mail	☐ Facsimile
☐ Email	☒ Electronic E-File

I declare under the penalty of perjury that the foregoing statement is true to the best of my information, knowledge and belief.

/s/Marjorie E. Renaud
Marjorie E. Renaud

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APPENDIX 9

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

ANTHONY SELLIMAN,

Plaintiff,

v

Case No. 18-167068-NH
Hon. Jeffrey Mattis

JEFFREY J. COLTON, M.D., JEFFREY J. COLTON, PLLC, and THE COLTON CENTER,

Defendants.

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AFFIDAVIT OF JEFFREY J. COLTON, M.D.

STATE OF MICHIGAN)
)ss.
COUNTY OF OAKLAND)

JEFFREY J. COLTON, M.D., being first duly sworn, deposes and state as follows:

1. I have personal knowledge of the facts herein and I can competently testify to their truth.

2. I am a medical doctor and I am licensed to practice medicine in the State of Michigan.

3. I am board certified in Otolaryngology by the American Board of Otolaryngology.

4. I am also board certified in Facial, Plastic and Reconstructive Surgery by the American Board of Facial, Plastic and Reconstructive Surgery.

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5. Since 1983, including throughout my treatment of Plaintiff Anthony Selliman from 2012 through 2017, 100% of my professional time has been devoted to the active clinical practice of Facial, Plastic and Reconstructive Surgery.

6. Plaintiff Anthony Selliman presented to me for aesthetic rhinoplasty revision procedures, which falls within the medical specialty of Facial, Plastic and Reconstructive Surgery. My treatment of Mr. Selliman involved only Facial, Plastic and Reconstructive Surgery. Mr. Selliman never presented to me with general otolaryngology issues and none of my treatment of Mr. Selliman involved general Otolaryngology.

JEFFREY J. COLTON, M.D.

Subscribed and sworn to before me this
22nd day of November, 2019.

Emmerson E. Ash, Jr, Notary Public
Oakland County, State of Michigan
Acting in Washtenaw County, MI
My Commission Expires: 06/18/2023

EMMERSON E. ASH JR
NOTARY PUBLIC, STATE OF MI
COUNTY OF OAKLAND
MY COMMISSION EXPIRES Jun 18, 2023
ACTING IN COUNTY OF Washtenaw

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APPENDIX 10

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STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

ANTONIO SELLIMAN,
Plaintiff,
v.
JEFFREY J. COLTON, MD,
JEFFREY J. COLTON, PLLC, and
THE COLTON CENTER,
Defendants.

Case No. 18-167068-NH
Hon. Jeffery Matis

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NOTICE OF HEARING

TO: CLERK OF THE COURT
ALL COUNSEL OF RECORD

PLEASE TAKE NOTICE that Plaintiff's Motion to Amend Witness List will be brought for hearing before the Honorable Jeffery Matis, in the Oakland County Circuit Court, 1200 Telegraph Rd, Pontiac, MI 48340 on Wednesday, December 11, 2019 at 8:30 AM, or as soon thereafter as it may be heard by the Court.

Respectfully submitted,

/s/ Michael T. Ratton
MICHAEL T. RATTON (P42399)
RATTON LAW GROUP, PC
Attorneys for Plaintiff
1300 Broadway | Seventh Floor
Detroit, MI 48226

Dated: December 4, 2019

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STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

ANTONIO SELLIMAN,
Plaintiff,
v.
JEFFREY J. COLTON, MD,
JEFFREY J. COLTON, PLLC, and
THE COLTON CENTER,
Defendants.

Case No. 18-167068-NH
Hon. Jeffery Matis

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PLAINTIFF'S MOTION TO AMEND WITNESS LIST

NOW COMES Plaintiff, ANTONIO SELLIMAN, by his attorneys RATTON LAW GROUP, PC and MICHAEL T. RATTON, and for his Motion to Amend Witness List, states as follows:

1. On July 16, 2018, Plaintiff filed his Complaint for this medical malpractice action against Defendants Jeffrey J. Colton, MD, Jeffrey J. Colton, PLLC, and the Colton Center, alleging negligent medical treatment over the course of multiple rhinoplasty procedures, resulting in facial scarring and functional deformity to Plaintiff. ***Exhibit 1 – Plaintiff's Complaint.***

2. As required by MCL 600.2912d, Plaintiff's Complaint was accompanied by an Affidavit of Merit from Dr. Michael J. Armstrong, Jr., MD, a physician board certified by the

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American Board of Otolaryngology and by the American Board of Facial Plastic and Reconstructive Surgery. ***Exhibit 2 – Affidavit of Merit of Michael J. Armstrong, Jr., MD.***

3. On October 11, 2018, Defendants filed their Affidavit of Meritorious Defense of Michael A. Carron, MD, a physician board certified by the American Board of Otolaryngology-Head and Neck Surgery and the American Board of Facial, Plastic, and Reconstructive Surgery. ***Exhibit 4 – Affidavit of Meritorious Defense of Michael A. Carron, MD.***

   Defendants' Affidavit of Meritorious Defense employs nearly identical language to Plaintiff's Affidavit of Merit. Like Dr. Armstrong, Dr. Carron asserts the following:

   - During the time period at issue in this case and the year preceding, I devoted the majority of my professional time to the active clinical practice of otolaryngology-head and neck surgery and facial, plastic, and reconstructive surgery. ***Exhibit 4, p. 1.***
   - I understand the standard of care applicable to Jeffrey Colton, MD in this matter to be that which a physician specializing in otolaryngology-head and neck surgery and facial, plastic and reconstructive surgery of ordinary learning, skill, and judgment would do or would not do under the same or similar circumstances as existed in treating Plaintiff Anthony Selliman. ***Exhibit 4, p. 2.***

4. Pursuant to this Court's initial scheduling order, counsel for Defendants filed a witness list naming Michael A Carron, MD as Defendants' expert witness and Shan Baker, MD as Defendants' potential expert witness on June 3, 2019. Plaintiff filed a witness list naming Michael J. Armstrong, MD, as Plaintiff's expert witness on June 11, 2019.

5. Upon stipulation of the parties, an Order adjourning all Scheduling Order dates for 90 days was entered on June 28, 2019. Pursuant to the new Scheduling Order, Defendants filed a Supplemental Witness List on September 5, 2019, naming among others, Dr. Giancarlo Zuliani and Dr. George Miguel as two additional potential expert witnesses in the field of Plastic Surgery.

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6. A search of the American Medical Association's online "DoctorFinder" for Drs. Colton, Armstrong, Carron, Baker, and Zuliani returns results listing the designation of American Board of Medical Specialties Certification: Otolaryngology – Head and Neck Surgery. An inquiry for Dr. Miguel using the same search tool provides no information. ***Attachment A – DoctorFinder Search Results Dated November 27, 2019.***

7. The deposition of Plaintiff's expert, Dr. Michael J. Armstrong, was taken on September 24, 2019.

8. On October 16, 2019, Defendants filed a Motion to Strike Michael J. Armstrong, Jr., MD and for Summary Disposition, alleging for the first time that Dr. Armstrong failed to meet the requirements of MCL 600.2169, specifically that he did not spend the majority of his professional time in the practice of the one most relevant specialty, which Defendants contend was Facial Plastic and Reconstructive Surgery. ***Exhibit 5 – Brief in Support of Defendants' Motion to Strike and for Summary Disposition, pp. 9-10***

9. On November 18, 2019, Plaintiff filed his Response to Defendants' Motion to Strike Michael J. Armstrong, Jr., MD and for Summary Disposition. In his Response, Plaintiff disputes the "one most relevant specialty" is Facial Plastic and Reconstructive Surgery. ***Exhibit 6 – Brief in Support of Plaintiff's Response to Defendants' Motion to Strike and for Summary Disposition, pp. 7, 10***

10. On November 25, 2019, Defendants filed a Reply to Plaintiff's Response, attaching an Affidavit of Jeffrey J. Colton, MD, dated November 2, 2019. ***Exhibit 7 – Defendants' Reply Brief, Attachment A***

In his Affidavit, Defendant Colton unequivocally states:

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- Since 1983, including throughout my treatment of Plaintiff Anthony Selliman from 2012 through 2017, 100% of my professional time has been devoted to the active clinical practice of Facial, Plastic and Reconstructive Surgery ***Exhibit 7, Exhibit A, p. 2.***
- Plaintiff Anthony Selliman presented to me for aesthetic rhinoplasty revision procedures, which falls within the medical specialty of Facial, Plastic and Reconstructive Surgery. My treatment of Mr. Selliman involved only Facial, Plastic and Reconstructive Surgery. Mr. Selliman never presented to me with general otolaryngology issues and none of my treatment of Mr. Selliman involved general Otolaryngoloy ***Exhibit 7, Exhibit A, p. 2.***

11. The Colton Affidavit is contrary to Defendants' Affidavit of Meritorious Defense, which states the applicable standard of care is that of a physician specializing in otolaryngology-head and neck surgery and facial, plastic and reconstructive surgery.

12. While Plaintiff continues to dispute that Facial Plastic and Reconstructive Surgery is the one most relevant specialty, in light of the unclear deposition testimony of Dr. Armstrong regarding the significant overlap between Otolaryngology and Facial, Plastic and Reconstructive Surgery, as well as Defendant Dr. Colton's recently sworn Affidavit, Plaintiff requests leave of the Court to file an Amended Witness List naming a similarly board-certified expert witness who devotes the majority of their professional time to the active clinical practice of Facial, Plastic and Reconstructive Surgery, rather than Otolaryngology, as Defendant Dr. Colton now avers.

13. MCR 2.401(I) requires that no later than the time directed by the court under subrule (B)(2)(a) [the Scheduling Order], the parties shall file and serve witness lists. MCR 2.118(A) allows for the amendment of pleadings by leave of the court or by written consent of the adverse party. Leave shall be freely given when justice so requires.

14. Pursuant to the Scheduling Order, trial of this matter is scheduled to begin on January 27, 2020. Defendants' Motion to Strike Michael J. Armstrong, Jr., MD and for Summary

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Disposition is scheduled to be heard on January 29, 2020. Assuming the current trial date will be adjourned to a date after Defendants' Motion is heard, trial is unlikely to commence any earlier than January 29, 2020.

15. Allowing Plaintiff to amend his Witness List would not delay trial, as s/he will be made available to the Defendants for deposition forthwith upon the Court's granting of this Motion to Amend Witness List. Thus, there is no prejudice to any party or to the Court in permitting this requested amendment.

16. Allowing Plaintiff to amend his Witness List would similarly not affect Defendants' pending Motion to Strike Michael J. Armstrong, Jr., MD and for Summary Disposition, as Plaintiff continues to dispute that Facial, Plastic and Reconstructive Surgery is the one most relevant specialty. Rather, allowing Plaintiff to amend his Witness List provides Plaintiff the opportunity to defend against the eleventh-hour affidavit filed by Defendants, and allows this case to proceed on its obvious merits.

WHEREFORE, for the above-mentioned reasons, further explained in the accompanying Brief in Support, Plaintiff respectfully requests this Honorable Court **grant** Plaintiff's Motion to Amend Witness List.

Dated: November 27, 2019

Respectfully submitted,

/s/ Michael T. Ratton

MICHAEL T. RATTON (P42399)
RATTON LAW GROUP, PC
Attorneys for Plaintiff
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Detroit, MI 48226

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STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

ANTONIO SELLIMAN,
Plaintiff,
v.
JEFFREY J. COLTON, MD,
JEFFREY J. COLTON, PLLC, and
THE COLTON CENTER,
Defendants.

Case No. 18-167068-NH
Hon. Jeffery Matis

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BRIEF IN SUPPORT
OF PLAINTIFF'S MOTION TO AMEND WITNESS LIST

I. INTRODUCTION & FACTUAL BACKGROUND

On July 16, 2018, Plaintiff filed his Complaint for this medical malpractice action against Defendants Jeffrey J. Colton, MD, Jeffrey J. Colton, PLLC, and the Colton Center, alleging negligent medical treatment over the course of multiple rhinoplasty procedures, resulting in facial scarring and functional deformity to Plaintiff. ***Exhibit 1 – Plaintiff's Complaint; see also Exhibit 5 – Brief in Support of Plaintiff's Response to Defendants' Motion to Strike and for Summary Disposition, pp.1-5.*** As required by MCL 600.2912d, Plaintiff's Complaint was accompanied by an Affidavit of Merit from Dr. Michael J. Armstrong, Jr., MD, a physician board certified by the

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American Board of Otolaryngology and by the American Board of Facial Plastic and Reconstructive Surgery. ***Exhibit 2 – Affidavit of Merit of Michael J. Armstrong, Jr., MD***.

Defendants were timely served with Plaintiff's Complaint, and filed their Answer and Affirmative/Special Defenses on August 16, 2018. Included in their Affirmative/Special Defenses, Defendants allege:

> Plaintiffs' failed to commence a lawsuit by failing to file an Affidavit of Merit signed by an expert with the proper qualifications. Plaintiffs' Affidavit of Merit also asserts the incorrect standard of care. Plaintiffs' Affidavit of Merit also does not comply with the provisions of *Simonelli v. Cassidy*, 336 Mich 635 (1953) and its progeny, and may also have failed to conform to the mandates of MCL 600.2912d(1), MCL 600.2169 and MCL 600.2102;… ***Exhibit 3 – Defendants' Answer and Affirmative/Special Defenses, pp.10-11.***

On October 11, 2018, Defendants filed their Affidavit of Meritorious Defense of Michael A. Carron, MD, a physician board certified by the American Board of Otolaryngology-Head and Neck Surgery and the American Board of Facial, Plastic, and Reconstructive Surgery. ***Exhibit 4 – Affidavit of Meritorious Defense of Michael A. Carron, MD***. Despite the defense asserted in their Affirmative/Special Defenses, which Defendants completely abandon or at minimum contradict in this subsequent filing, the Affidavit of Meritorious Defense employs nearly identical language to Plaintiff's Affidavit of Merit. Like Dr. Armstrong, Dr. Carron asserts the following:

- During the time period at issue in this case and the year preceding, I devoted the majority of my professional time to the active clinical practice of otolaryngology-head and neck surgery and facial, plastic, and reconstructive surgery. ***Exhibit 4, p. 1.***

- I understand the standard of care applicable to Jeffrey Colton, MD in this matter to be that which a physician specializing in otolaryngology-head and neck surgery and facial, plastic and reconstructive surgery of ordinary learning, skill, and judgment would do or would not do under the same or similar circumstances as existed in treating Plaintiff Anthony Selliman. ***Exhibit 4, p. 2.***

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On June 3, 2019, Defendants filed a Witness and Exhibit List naming Michael A. Carron, MD as Defendants' expert witness, and Shan Baker, MD as Defendants' potential expert witness. Plaintiff filed his Witness List naming Michael J. Armstrong, MD as his expert witness on June 11, 2019. On September 5, 2019, consistent with the Scheduling Order issued in June 2019, Defendants filed a Supplemental Witness and Exhibit List naming, among others, Giancarlo Zuliani, MD and George S. Miguel, DO, designated as "potential expert - plastic surgery"[1].

The deposition of Plaintiff's expert, Dr. Armstrong was taken on September 24, 2019. Based on the admittedly imprecise testimony offered by Dr. Armstrong during his deposition, Defendants filed a Motion to Strike Michael J. Armstrong, Jr., MD and for Summary Disposition on October 16, 2019. In this Motion, filed approximately 15 months after Plaintiff's initial disclosure of their expert and his qualifications, Defendants allege for the first time that Dr. Armstrong failed to meet the requirements of MCL 600.2169, specifically that he did not spend the majority of his professional time in the practice of the one most relevant specialty, which Defendants, again for the first time in this litigation, contend was Facial Plastic and Reconstructive Surgery. ***Exhibit 5 – Brief in Support of Defendants' Motion to Strike and for Summary Disposition, pp. 9-10.***

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[1] A search of the American Medical Association's online "DoctorFinder" for Drs. Colton, Armstrong, Carron, Baker, Zuliani, and Miguel returns the following results:
Dr. Colton – American Board of Medical Specialties Certification: Otolaryngology – Head and Neck Surgery
Dr. Armstrong – American Board of Medical Specialties Certification: Otolaryngology – Head and Neck Surgery
Dr. Carron – American Board of Medical Specialties Certification: Otolaryngology – Head and Neck Surgery
Dr. Baker – American Board of Medical Specialties Certification: Otolaryngology – Head and Neck Surgery
Dr. Zuliani – American Board of Medical Specialties Certification: Otolaryngology – Head and Neck Surgery
Dr. Miguel – No information listed
Search Results Dated November 27, 2019 are included as Attachment A

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On November 18, 2019, Plaintiff filed his Response to Defendants' Motion to Strike Michael J. Armstrong, Jr., MD and for Summary Disposition. In his Response, Plaintiff disputes the "one most relevant specialty" is Facial Plastic and Reconstructive Surgery. ***Exhibit 6 – Brief in Support of Plaintiff's Response to Defendants' Motion to Strike and for Summary Disposition, pp. 7, 10.*** Plaintiff has never and does not now believe the one most relevant specialty to be Facial Plastic and Reconstructive Surgery. Plaintiff further disputes Defendants' characterization of Dr. Armstrong's deposition testimony. Contrary to Defendants' assertion, Dr. Armstrong did not testify as to the division of his professional time between otolaryngology and facial, plastic and reconstructive surgery, but to the division of his time performing procedures he considered cosmetic or functional within his the facial, plastic and reconstructive surgery practice. ***Exhibit 6, pp. 8-9.*** Even if parts of Dr. Armstrong's testimony regarding his practice of otolaryngology and facial, plastic and reconstructive surgery were a bit equivocal in isolation, a complete reading of the transcript would allow the trial court to find that he satisfied the requirements of MCL 600.2169.

On November 25, 2019, Defendants filed their Reply Brief, attaching an Affidavit from Defendant Dr. Jeffrey J. Colton, MD, dated November 2, 2019. ***Exhibit 7 – Defendants' Reply Brief, Exhibit A.*** In his Affidavit, Defendant Colton unequivocally states:

- Since 1983, including throughout my treatment of Plaintiff Anthony Selliman from 2012 through 2017, 100% of my professional time has been devoted to the active clinical practice of Facial, Plastic and Reconstructive Surgery. ***Exhibit 7, Exhibit A, p. 2.***

- Plaintiff Anthony Selliman presented to me for aesthetic rhinoplasty revision procedures, which falls within the medical specialty of Facial, Plastic and Reconstructive Surgery. My treatment of Mr. Selliman involved only Facial, Plastic and Reconstructive Surgery. Mr. Selliman never presented to me with general otolaryngology issues and none of my treatment of Mr. Selliman involved general Otolaryngoloy. ***Exhibit 7, Exhibit A, p. 2.***

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While Plaintiff continues to dispute that Facial Plastic and Reconstructive Surgery is the one most relevant specialty, in light of the unclear deposition testimony of Dr. Armstrong and Defendant Dr. Colton's recently sworn Affidavit, Plaintiff requests leave of the Court to file an Amended Witness List naming a similarly board-certified expert witness who devotes their professional time to the active clinical practice of Facial, Plastic and Reconstructive Surgery, rather than Otolaryngology, as Defendant Dr. Colton now avers.

II. LAW & ARGUMENT

Plaintiff brings this Motion pursuant to MCR 2.401(I) and MCR 2.118(A). MCR 2.401(I)(1) requires that no later than the time directed by the court under subrule (B)(2)(a) [the Scheduling Order], the parties shall file and serve witness lists. Pursuant to MCR 2.401(I)(2), the court "may order that any witness not listed in accordance with this rule will be prohibited from testifying at trial except upon good cause shown." See also *Cox v Hartman,* 322 Mich App 292, 315; 911 NW2d 219 (2017). Plaintiff brings the instant motion approximately three months after the date for filing and serving witness lists. It is thus Plaintiff's burden to demonstrate good cause for the late addition of a new expert witness. MCR 2.118(A) allows for the amendment of pleadings by leave of the court or by written consent of the adverse party. Leave shall be freely given when justice so requires. The Michigan Supreme Court has held that a motion to amend should ordinarily be granted, with exceptions for instances where the need for an amendment was the result of undue delay, bad faith on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, futility, or such instances where undue prejudice to the opposing party would result. *Weymers v Khera*, 454 Mich 639, 658; 563 NW2d 647 (1997).

The decision whether to allow a party to add an expert witness is within the sound discretion of the trial court. *Tisbury v Armstrong,* 194 Mich App 19, 20; 486 NW2d 51 (1991); *Butt*

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v Giammariner, 173 Mich App 319, 321; 433 NW2d 360 (1988). In making such a determination, the court considers whether the party seeking to add an expert has adequately explained the reason for delay, and whether the opposing party would be prejudiced. *Tisbury* at 21.

A. ALLOWING PLAINTIFF TO AMEND HIS WITNESS LIST WOULD CAUSE NO PREJUDICE TO EITHER PARTY OR TO THE COURT.

When considering a motion such as this, a court should consider whether prejudice would result from granting a motion to add an expert witness. *Tisbury* at 21; *Levinson v Sklar*, 181 Mich App 693, 698–699, 449 NW2d 682 (1989). In determining whether prejudice may result from allowing an amendment, some factors to be considered include: (1) whether the original expert witness has already been deposed, (2) whether the addition of an expert would affect any mediation evaluation, (3) whether the party seeking to add the expert has caused repeated delays because of a lack of diligence, and (4) whether the failure to allow the addition of an expert will deny a party a determination on the merits of their claim. *Tisbury* at 21; *Levinson* at 699.

While Dr. Armstrong has been deposed and this matter was submitted to Case Evaluation on November 7, 2019, allowing Plaintiff to amend his witness list would not prejudice Defendants. No new or additional theories of liability which would affect the case evaluation award will be offered by the additional expert witness. Plaintiff has caused no delay due to a lack of diligence, and brings this motion promptly upon receipt of Defendant Dr. Colton's Affidavit. Further, the need to add the expert was not created by Plaintiff, but by the eleventh-hour filing of Defendants' Affidavit. With their Affidavit, Defendants have taken an unchangeable position on the applicable standard of care, one that is contrary to Defendants' Affidavit of Meritorious Defense, which states the applicable standard of care is that of a physician specializing in otolaryngology-head and neck surgery **and** facial, plastic and reconstructive surgery. Given this newly asserted position, denial of leave to amend may ultimately deny Plaintiff a determination on the merits of his claim. Plaintiff

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continues to dispute that Facial Plastic and Reconstructive Surgery is the one most relevant specialty, an issue central to Defendants' Motion to Strike Michael J. Armstrong, Jr., MD and for Summary Disposition presently pending before the Court. Plaintiff would likely be unable to carry his burden without the assistance of Dr. Armstrong, his expert witness. Allowing Plaintiff to amend his witness list to add a new expert not only affords Plaintiff the opportunity to defend against Defendants' self-serving affidavit, but would allow this case to move forward on its merits. In this way, allowing Plaintiff's proposed amendment furthers Michigan's policy favoring the meritorious determination of issues. *Tisbury, supra* at 21, (citing *Wood v. Detroit Automobile Inter–Ins. Exchange*, 413 Mich 573, 321 NW2d 653 (1982)).

Allowing Plaintiff to amend his Witness List would not delay trial, as s/he will be made available to the Defendants for deposition forthwith upon the Court's granting of this Motion to Amend Witness List. Pursuant to the current Scheduling Order, trial of this matter is scheduled to begin on January 27, 2020. Defendants' Motion to Strike Michael J. Armstrong, Jr., MD and for Summary Disposition is scheduled to be heard on January 29, 2020. Assuming the current trial date will be adjourned to a date after Defendants' Motion is heard, trial is unlikely to commence any earlier than January 29, 2020, approximately seven weeks from the date the instant motion is scheduled to be heard. Plaintiff will immediately produce the additional expert witness for deposition, thus preventing any prejudice to Defendants. Further, this requested amendment is unlikely to inconvenience the Court, as the trial date will remain unaffected.

Similarly, allowing Plaintiff to amend his Witness List would not affect Defendants' pending Motion to Strike Michael J. Armstrong, Jr., MD and for Summary Disposition, as Plaintiff continues to dispute that Facial, Plastic and Reconstructive Surgery is the one most relevant specialty. Rather, allowing Plaintiff to amend his Witness List provides Plaintiff the opportunity

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to defend against the eleventh-hour affidavit filed by Defendants, and allows this case to proceed on its obvious merits.

B. ALLOWING PLAINTIFF TO AMEND HIS WITNESS LIST SERVES TO CLARIFY THE APPLICABLE STANDARD OF CARE & IS IN THE INTEREST OF JUSTICE.

Plaintiff does not seek to belabor his position opposing Defendants' Motion for Summary Disposition in this Motion to Amend Witness List. This instant motion should in no way be understood to alter Plaintiff's position with respect to the Summary Disposition Motion, nor taken to be a concession that Facial Plastic and Reconstructive Surgery is the one most relevant specialty. As stated in Plaintiff's Response, a complete reading of the deposition testimony reveals that Dr. Armstrong was not attributing percentages to the division of his practice **between** otolaryngology and facial plastic and reconstructive surgery, although eliciting such a response was defense counsel's objective. ***Exhibit 6, pp. 8-9.*** Taken in context, Dr. Armstrong was classifying procedures he performs as either cosmetic or functional in nature, and assigning percentages to the frequency with which he performs those procedures.

For purposes of addressing Defendants' Motion to Strike Michael J. Armstrong and for Summary Disposition only, Plaintiff further argued, and maintains now, that even if Facial Plastic and Reconstructive Surgery was determined to be the most relevant specialty, Dr. Armstrong need not be stricken. The Michigan Court of Appeals has held that plaintiff's expert need not be stricken when counsel held a reasonable belief that his expert matched the necessary qualifications to render testimony on the standard of care. *Jones v Botsford Continuing Care Corp.,* 310 Mich App 192, 206-207; 871 NW2d 15 (2015). Additionally, Dr. Armstrong testified that certain medical conditions "overlap quite a bit" and that "a lot of my nasal functional surgeries would fall into the category of facial plastics". ***Exhibit 6, p. 8.*** Defendants argue that the current version of MCL

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600.2169 does not allow Plaintiff to rely on a claimed overlapping practice in dual specialties to satisfy the active clinical practice requirement. However, the Court of Appeals and Michigan Supreme Court have reaffirmed the wide discretion afforded to trial courts in interpreting a proposed expert's deposition regarding the active clinical practice requirement, even when the trial court's interpretation appears to directly contradict the expert's actual testimony[2]. *In Re Roberdeaux,* rel'd October 18, 2016; WL 9245786 (unpublished). More recently, the Court of Appeals affirmed a ruling of the Oakland County Circuit Court which allowed standard-of-care testimony against a board certified orthopedic surgeon practicing orthopedic surgery at the time of the alleged malpractice by an orthopedic surgeon who testified (in a similarly unclear fashion) that he spent the majority of his professional time during the relevant period in the practice of sports medicine, a subspecialty of orthopedic surgery. *Turkish v William Beaumont Hospital,* rel'd December 13, 2018; 2018 WL 6578922 (unpublished)[3].

Defendant Dr. Jeffrey Colton is board certified in both otolaryngology and facial plastic and reconstructive surgery; Dr. Michael J. Armstrong, Jr. is identically board certified in both otolaryngology and facial plastic and reconstructive surgery. It is undisputed that Dr. Colton and Dr. Armstrong are board certified in the same specialties, as required for expert testimony by MCL 600.2169(1)(b) and the Michigan Supreme Court in *Woodard v Custer,* 476 Mich 545, 719 NW2d

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[2] In *In Re Roberdeaux,* the Court of Appeals affirmed a trial court's decision to allow standard-of-care testimony against a board certified internist who was practicing internal medicine at the time of the alleged malpractice by a board certified internist who testified unequivocally that he spent the majority of his practice in geriatrics, a subspecialty of internal medicine, during the relevant time period. The Court of Appeals found the trial court did not abuse its discretion in so finding because the expert's testimony that he predominantly practiced "geriatrics" was not conclusive of what he was actually practicing during the relevant time period. The Michigan Supreme Court subsequently denied leave to appeal.

[3] In *Turkish*, the Court of Appeals found the trial court did not abuse its discretion in finding the proposed expert was qualified, in part based on his testimony that even with respect to persons certified in a subspecialty such as sports medicine, they are still practicing the specialty, due to the potential overlapping medical conditions and treatment options.

842 (2006). With the exception of potential expert witness Dr. Miguel, Dr. Armstrong is listed with an American Board of Medical Specialties Certification identical to Defendant Dr. Colton and each of his expected and potential expert witnesses; that certification is in Otolaryngology – Head and Neck Surgery. ***Attachment A – DoctorFinder Search Results Dated November 27, 2019.***

Defendants' Affidavit suggests a belief that they may unilaterally decide the applicable standard of care. As discussion *supra,* Plaintiff continues to dispute the applicable standard of care is that of Facial, Plastic and Reconstructive Surgery. As reflected in Attachment A, Drs. Colton, Armstrong, Carron, Baker, and Zuliani each hold certifications in Otolaryngology – Head and Neck Surgery from the American Board of Medical Specialties (ABMS). The ABMS offers board certification in 24 specialized areas of medicine, one of which is Otolaryngology – Head and Neck Surgery. ***Attachment B – ABMS Guide to Medical Specialties, 2019 Edition, pp. 42-43.*** Once a physician becomes board certified in Otolaryngology – Head and Neck Surgery, he or she may apply for additional subspecialty certifications from the ABMS within Otolaryngology – Head and Neck Surgery, one of which is Plastic Surgery Within the Head and Neck. There is no Facial, Plastic and Reconstructive Surgery certification within the ABMS. There is an ABMS certification in Plastic Surgery by the American Board of Plastic Surgery, which includes a subspecialty in Plastic Surgery Within the Head and Neck. Dr. Colton does not hold ABMS certification by the American Board of Plastic Surgery. Rather, he is board certified in Facial, Plastic and Reconstructive Surgery by the American Board of Facial, Plastic and Reconstructive Surgery. ***Exhibit 7, Exhibit A.***

Despite his continued assertion that Facial Plastic and Reconstructive Surgery is not the one most relevant specialty, in light of Defendants' eleventh-hour Affidavit of Dr. Colton, who

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now explicitly swears his "treatment of Mr. Selliman involved only Facial, Plastic and Reconstructive Surgery" and that "none of my treatment of Mr. Selliman involved general Otolaryngology", Plaintiff respectfully requests leave to amend his witness list to add an expert who unequivocally devotes the majority of their professional time to the active clinical practice of Facial, Plastic and Reconstructive Surgery, rather than Otolaryngology. Allowing this amendment serves to clarify the triable issues of this case, by essentially functioning as a stipulation to the applicable standard of care, and results not in prejudice to Defendants, but rather in fairness to Plaintiff. Leave to amend should thus be freely granted, as it is in the interest of justice.

IV. CONCLUSION & RELIEF REQUESTED

For all of the foregoing reasons, Plaintiff respectfully requests this Honorable Court **grant** this Motion to Amend Witness List and allow Plaintiff to add another expert witness.

Dated: November 27, 2019

Respectfully submitted,

/s/ Michael T. Ratton

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STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

ANTONIO SELLIMAN,
Plaintiff,
v.
JEFFREY J. COLTON, MD,
JEFFREY J. COLTON, PLLC, and
THE COLTON CENTER,
Defendants.

Case No. 18-167068-NH
Hon. Jeffery Matis

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PROOF OF SERVICE

I hereby certify that on December 4, 2019, I electronically filed and served the foregoing Notice of Hearing, Plaintiff's Motion to Amend Witness List and Brief in Support, with all attached Exhibits, and this Proof of Service, with the Clerk of the Court using the electronic filing/MiFile system, which will send notification of such filing to all electronic filing participants and counsel of record.

I declare the above statement to be true to the best of my knowledge, information, and belief.

Respectfully submitted,

Dated: December 4, 2019

/s/ Rachel M. Ratton
RACHEL M. RATTON
RATTON LAW GROUP, PC

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APPENDIX 11

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

ANTONIO SELLIMAN,

Plaintiff,

v Case No. 2018-167068-NH

JEFFREY J. COLTON, MD,
JEFFREY J. COLTON, PLLC,
THE COLTON CENTER,

Defendants./

MOTION FOR SUMMARY DISPOSITION

BEFORE THE HONORABLE JEFFERY S. MATIS, CIRCUIT JUDGE

Pontiac, Michigan - Wednesday, January 29, 2020

APPEARANCES:

For the Plaintiff:	MR. MICHAEL T. RATTON (P42399) Ratton Law Group, P.C. 1300 Broadway, Seventh Floor Detroit, Michigan 48226 (313) 771-0074
For the Defendants:	MR. ROBERT KAMENEC (P35283) Plunkett Cooney 38505 Woodward Avenue, Suite 100 Bloomfield Hills, Michigan 48304 (248) 901-4000
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WITNESSES

None

EXHIBITS RECEIVED

None offered.

Pontiac, Michigan

Wednesday, January 29, 2020 - 1:28 p.m.

* * * * * *

THE CLERK: Your Honor, calling from the docket number 5. Case number 2018-167068-NH, Anthony Selliman versus Jeffrey Colton.

MR. RATTON: Good morning, Your Honor. Michael Ratton appearing on behalf of the Plaintiff.

THE COURT: Yes.

MR. KAMENEC: Good afternoon, Your Honor. Robert Kamenec. I represent the Defendants.

THE COURT: Yeah. You've been here all day like me.

MR. KAMENEC: I admire --

THE COURT: You had an earlier motion --

MR. KAMENEC: -- your patience and your -- your energy, Your Honor.

THE COURT: All right.

MR. KAMENEC: On both counts --

THE COURT: Well, thank you. All right. It is good afternoon. Uh, this is before the Court on Defendant's motion to strike Michael J. Armstrong, Jr., M.D. and for summary disposition.

Uh, I have read the motion. I have read Plaintiff's response and I have read the reply brief so

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you don't need to repeat anything but what would you like to say?

MR. KAMENEC: I will, uh -- famous last words, right? But I'll -- I'll be very brief.

THE COURT: Okay.

MR. KAMENEC: Uh, on the qualification issue, it -- it comes down to whether Plaintiff can satisfy under the statute the act of clinical practice requirement. It's -- it's that straightforward. And the Court knows from med mal cases that, you know, that is a requirement that's separate and distinct from matching board qualifications or certifications. So it's separate and distinct.

Uh, we have a case here where I believe that the expert's testimony is unequivocal and, uh, he said that he spent 90 percent of his time with, uh, with otolaryngology and for purposes of this, I'll just call it ENT, Your Honor. Uh --

THE COURT: Yeah. I always --

MR. KAMENEC: -- ears, nose, and throat.

THE COURT: -- mispronounce that word, too.

MR. KAMENEC: I -- and I --

THE COURT: I'm -- I'm with you on that one.

MR. KAMENEC: I apologize.

THE COURT: Yeah. Yeah.

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MR. KAMENEC: And 10 percent of it was in the specialty that we contend that Doctor Colton was practicing and that's facial plastic and reconstructive surgery. If you're wondering, Your Honor, and I -- it's in the brief. Those are separate specialties. I don't think there's any debate on that. And, uh -- and so, I'll just -- I'll -- you know, I think if you just left it at that, we win. But I'll just really briefly talk about the Plaintiff's responses if you wish --

THE COURT: Yeah. I -- I guess, let me just --

MR. KAMENEC: Or answer any --

THE COURT: -- address one --

MR. KAMENEC: -- questions you have.

THE COURT: Yeah. The, uh -- Doctor Armstrong's deposition testimony, do you think it was clear as to, uh, what percentage of his practice he devoted to the one area of specialty as opposed to the other? There was a number -- there were a number of different places within his dep testimony where he was asked questions about it and, uh --

MR. KAMENEC: Uh huh. I --

THE COURT: It wasn't just one question with one answer. There were a number of areas there where he -- he addressed that. Uh, and there were different answers given. What -- what -- what do you -- what do you --

MR. KAMENEC: Well --

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THE COURT: Do you think his testimony was -- was truly clear on his area of pra -- amount of practice in each area?

MR. KAMENEC: I -- I -- yes, I do. Because I do think --

THE COURT: Hold -- hold -- I'm sorry.

MR. KAMENEC: Sure.

THE COURT: Hold one moment, please.

(From 1:31 p.m. to 1:32 p.m., bench conference held with non-party)

THE COURT: Counsels, thank you.

MR. KAMENEC: Thank you, Your Honor.

THE COURT: Please continue.

MR. KAMENEC: I do think his testimony was such that he verified that, uh, 90 percent of his time was in ENT. I think where the confusion, if you wanna call it, goes back and forth about what constitutes ENT and what constitutes facial, plastic, reconstructive surgery. I think -- I think really that's more the question before the Court, in my view, than anything else. And -- and, uh, if the Court -- I'm -- I'm -- I'm trying to answer your question but I'm also --

THE COURT: Right.

MR. KAMENEC: -- trying to key in on the -- what I believe is the main point. And -- and that is --

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THE COURT: Sure.

MR. KAMENEC: -- that, you know, what was this procedure? We know our -- we know Doctor Colton practices 100 percent, based on his affidavit, of facial, plastic, and reconstructive surgery.

THE COURT: Uh huh.

MR. KAMENEC: The question is with -- with respect to the rhinoplasty. It -- does it fall within one category or the other? Or as the Plaintiff contends, if I read it properly, whether or not it overlaps and that's part of the confusion. That's a legal question for Your Honor because the Michigan med mal law is pretty clear. It's the one most relevant specialty and we gave you a plethora of cases -- sorry about that --

THE COURT: Uh huh. That's okay.

MR. KAMENEC: -- and with -- with respect to the reply brief saying that overlaps don't count. And so we -- if -- when -- when you go -- this is an aesthetic procedure, Your Honor. There's no debate about that. This is not a situation where --

THE COURT: Well, it -- I guess, let me stop you on that. The --

MR. KAMENEC: Sure.

THE COURT: -- wasn't -- didn't Plaintiff (indiscernible) make an argument that there was a, uh --

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that -- that there was a breathing issue? That there were other aspects --

MR. KAMENEC: Uh huh.

THE COURT: It was not simply a cosmetic issue. That there was something more to it than that.

MR. KAMENEC: He -- he did but that still goes back to the primary purp -- I mean, the Court's gotta make a decision at some point about which one it is. And if -- if the law says it's the one most relevant specialty, in my view it's an either or. Because if -- if the procedure arguably -- and I'm not conceding this -- but arguably, uh, is such that it has a touch in one area and a touch in the other, the -- the Court has to make that decision. Uh, I -- I was trying to figure out a good analogy for Your Honor.

THE COURT: Okay.

MR. KAMENEC: And the best -- the best I could think about and maybe this goes a little too far but I'll give it anyways. If you've got a surgical oncologist -- and you're familiar with what surgical oncologists do -- if -- if the -- that surgical oncologist removes a cancerous tumor, well, you -- you know what? The other thing that may happen is that the client may get, uh, orthopedic relief. Let's assume it's around the spine. So there may be relief in a different area that would be a

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different specialty. But it's still, at the end of the day when you're looking at the qualifications, you're still talking about oncology -- uh, surgical oncology.

THE COURT: Uh huh.

MR. KAMENEC: That's the best I can kind of give you on relatively short notice --

THE COURT: Uh huh.

MR. KAMENEC: -- on this.

THE COURT: Okay.

MR. KAMENEC: And, uh, I do think that -- more than anything else -- addresses the question. Uh, qualification issues are for the Court. They're not for the jury as the Court well knows. So this is -- I think the parties agree on that. It's not a matter to go to the jury at some point in time. Uh, respectfully, the Court has to make a decision on this.

Uh, and I -- otherwise on -- on -- at least on this issue, I'll defer to the brief. I do have some comments on the statute of limitations if you wanna take it issue by issue. That's fine with me --

THE COURT: Yeah. No. Yeah.

MR. KAMENEC: Or --

THE COURT: I'd like to hear your full argument on all the --

MR. KAMENEC: Oh, sure.

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THE COURT: -- issues and then --

MR. KAMENEC: Okay.

THE COURT: -- I'll jump over here --

MR. KAMENEC: All right.

THE COURT: -- to Plaintiff.

MR. KAMENEC: And statute of limitations, uh, is a pretty short argument. Uh, one, the Plaintiff concedes as you probably --

THE COURT: Right.

MR. KAMENEC: -- read.

THE COURT: Yes.

MR. KAMENEC: That for anything before January 12th, 2016 is time barred.

THE COURT: It -- and I -- I guess that's a good point. Does Plaintiff -- is it on or before --

MR. RATTON: It says before.

MR. KAMENEC: Before.

THE COURT: Or just before? In other words, we have -- we have a -- a date of 1-12-16.

MR. RATTON: Correct.

THE COURT: So is Plaintiff conceding that that day is time barred?

MR. RATTON: No. No, Your Honor.

THE COURT: Okay. I didn't think so but I wanted to make sure. It's --

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MR. RATTON: And --

THE COURT: -- not on or before. It's just prior to.

MR. RATTON: Correct.

MR. KAMENEC: Yes. And I -- I -- that was my understanding as well. Uh, but nonetheless, 1-12-16 is time barred. Uh --

THE COURT: 1-12-16?

MR. KAMENEC: The -- I'm -- I'm sorry --

THE COURT: Yeah.

MR. KAMENEC: -- the -- the treatment that was provided --

THE COURT: Yeah?

MR. KAMENEC: -- on January 12th, 2016, uh, is -- is time barred and I can give you that --

THE COURT: Go ahead.

MR. KAMENEC: -- in real short order.

THE COURT: Yep.

MR. KAMENEC: So, uh, as the Court knows, there is, uh, is there a 2-year statute of limitations.

THE COURT: Right.

MR. KAMENEC: Okay. And that would expire -- uh, but for a notice of intent, that would expire on January 12th, 2018. Two years later. Even I could do that math with -- as a English major.

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THE COURT: Right.

MR. KAMENEC: All right?

THE COURT: Yep.

MR. KAMENEC: All right. Uh, but there was also a notice of intent tolling. The Court is probably fairly familiar --

THE COURT: Right. Yep.

MR. KAMENEC: -- with that --

THE COURT: Yep. Yeah. Very much so.

MR. KAMENEC: And the notice --

THE COURT: Yeah. Yep.

MR. KAMENEC: My understanding of the notice of intent is it was filed the day before the statute was going to run. January --

THE COURT: Okay.

MR. KAMENEC: -- 11th --

THE COURT: Yep.

MR. KAMENEC: -- 2018. So when the notice of intent period is done, uh, which -- which was July 12th, Plaintiff had one day left. That's all that was on the statute when the notice of intent was filed. Plaintiff had one day left to file a timely action, i.e., Plaintiff had to file the action the day after the notice of intent expired. That would be July 13th, 2018. The complaint was filed on July 16th.

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THE COURT: Uh huh.

MR. KAMENEC: It's -- it'll -- three days late.

THE COURT: Uh huh.

MR. KAMENEC: Uh, I don't -- and I -- I went through my math again to make sure that the 182 days was counted properly. That's what I come up with. I'm pretty sure that's what we had in the motion but for whatever it's worth, Your Honor, I went through it again last night.

So, uh, at a minimum on the statute of limitations question, if this math is correct -- and I suggest it is -- it's everything before, uh, January 12th, 2016 and January 12th, 2016. The only remaining question if the Court were to agree with that math, uh, is what happens to the remaining procedures. I've got that briefed. I know you've read it. We -- we contend --

THE COURT: Uh huh.

MR. KAMENEC: -- it's basically a continuing course of treatment. Revisions kind of are the tip off here. And it all kind of relates back to the original surgery. Uh, I've cited to Your Honor the, uh -- the -- the Clayton (sic) case. Uh, which, uh, McKiney versus Clayton (sic) that deals with this. Uh, at, uh, 237 Mich App.

THE COURT: All right. Yes?

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MR. KAMENEC: Uh, and I -- I'm not trying to be rude, Your Honor. I'm just -- I'm trying to be polite.

THE COURT: Yeah. Yeah.

MR. KAMENEC: Okay?

THE COURT: I can tell. That's --

MR. KAMENEC: Okay. Uh --

THE COURT: -- okay. I -- I've -- I pull the file up and -- and documents up on my screen that I'm reviewing while you're talking.

MR. KAMENEC: Thank you, Your Honor.

THE COURT: So, go right ahead.

MR. KAMENEC: Uh, but under the -- the McKiney versus Clayton case, it's 237 Mich App 198, 1998. It's case I argued in the Court of Appeals. Uh, you know, the -- there's no continuing wro -- wrong doctrine in Michigan. And if the subsequent procedures relate back to the original procedure, then they are time barred as well. And as that's the importance, Your Honor, of finding that the January 12th, uh, 2016 procedure is time barred. Because from that flows the whole notion that the revisions thereafter are tied to that. (indiscernible) by -- by being as clear as I can on that point.

THE COURT: Understand.

MR. KAMENEC: Uh --

THE COURT: Understand.

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MR. KAMENEC: -- if you -- if there's a opportunity for a short rebuttal, god bless.

THE COURT: Uh, yep.

MR. KAMENEC: And the Court can, uh --

THE COURT: It's your motion. I will give you that.

MR. KAMENEC: Thank you, Your Honor.

THE COURT: I promise.

Uh, I guess let's start with the -- Plaintiff's counsel, the 1-12-16 visit. Do you -- do you -- you -- first of all, you agree that the 2015 dates are barred?

MR. RATTON: Yes, sir.

THE COURT: 3-25-15 and 9-9-15.

MR. RATTON: Yes, sir.

THE COURT: Okay. As to the 1-12-16, Defense Counsel just made an argument why that should be barred as well. Do you agree with that?

MR. RATTON: Yeah. Actually I calculated a different way but I -- I do agree with that because --

THE COURT: So you think the 1-12-16 visit is also barred?

MR. RATTON: I -- I do because --

THE COURT: Okay.

MR. RATTON: -- even though the -- I think the date when they get the January 11th date, that's on the

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notice of intent. It's my understanding -- I didn't do the notice of intent; the client did but it was mailed on the 12th. But I don't think that really changes our date. I think it takes it from being filed on the last day, uh, 182 days out puts us on a Thursday, the next day's Friday and it wasn't filed till Monday.

THE COURT: Okay.

MR. RATTON: I think the 12th --

THE COURT: So --

MR. RATTON: -- is out.

THE COURT: So the bottom line, your position is the only dates of service that are in play, right, are the 6-23-16, 4-19-17, and 11-9 of '17?

MR. RATTON: That's correct.

THE COURT: The -- the last three.

MR. RATTON: That's correct.

THE COURT: Okay.

MR. RATTON: And it's our belief and with regard to those, it -- it's not like he's coming in for a checkup and he doesn't make a change which is more along this continuing thing.

THE COURT: Okay.

MR. RATTON: Those are all surgical --

THE COURT: Because that's --

MR. RATTON: -- events.

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THE COURT: -- Defense's argument. It's -- you have this initial plan. Right? You put this initial plan together and everything that flows is in accordance with the plan and flows from the plan. So therefore you look at the plan, date, and inception as really the trigger date here.

MR. RATTON: We disagree because every single time he comes in on these three subsequent visits, he's performing a separate and distinct surgical procedure. Uh, he -- he's taking him. He's anesthetizing him and he's doing another rhinoplasty. And -- and each individual procedure could be done correctly or incorrectly. And it's the opinion of my expert that they're done incorrectly 'cause he's continuing to remove tissue. So it's not this continuation doctrine. It's a separate and distinct procedure every time he subjects him to a surgery that should not be done. That's our belief on that.

THE COURT: Okay.

MR. RATTON: Now, there's an argument about this is just merely cosmetic. One, it's not. As the Court pointed out, there is indications in Doctor Colton's medical records where our client complains and there's an email where he specifically complains about breathing at night. It's horrible. And he's having difficulties.

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There's a functional component to what's going on here. So, when we look at it, we've really gotta look at what the board specialties are. And there -- there's obviously confusion in the dep and there's confusion in the courts about this issue because the procedure that's being done here, this rhinoplasty, it can be done by a facial plastics guy. It can be done by an ENT. It can be done by someone boarded under the American Board of Facial, Plastic, and Reconstructive Surgery.

We have to look -- take a harder look at what their board certifications are. Now, the gold standard in board certification that we've all -- that I've been looking at for 30 years of doing this and I know Mr. Kamenec does 'cause I've seen it cited in other appellate briefs of his -- is ABMS which is the Aberic -- American Board of Medical Specialties. The American Board of Medical Specialties is the go-to where we all look for people's board certification. It consists of 24 member boards, 40 specialties, and 87 subspecialties. And one of the specialties or the mem -- member boards is otolaryngology and this is a procedure that could be done under the board of otolaryngology.

There is also, recognized by the ABMS, a plastic surgery board. That does not apply here. There is also a subspecialty American Board of Medical Specialties board

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under otolaryngology which deals with plastic surgery of the -- the head and neck. That doesn't apply here. We have this second board certification out there, this American Board of Facial, Plastic, and Reconstructive Surgery, that it's somewhat of an obscure board. It's not this recognized ABMS. It's just another board that's out there.

But what's amazing about what Defense is trying to do here by disqualifying Doctor Armstrong, you're taking Doctor Armstrong who is double boarded in identical fields to Doctor Colton. This isn't a case where we're talking about specialties and subspecialties. These two doctors mirror each other. And by disqualifying him, you're saying, well, yeah. They have exactly the same boards. They have exactly the same training; yet, he's not qualified to give an opinion because since the Plaintiff thinks this is more otolaryngology, Doctor Colton's gonna sign an affidavit which was produced in December attached to a motion to add a witness list where he's now saying, hey, all I do is cosmetics.

He can't dictate what the standard of care is in his self-serving affidavit just to disqualify my expert. The expert and Doctor Colton are identical in what their board certifications are. And it would lead us to an absurd result to say that he -- that Doctor Armstrong

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can't comment on the practice of Doctor Colton when their credentials are exactly the same. It's also interesting if you look at the affidavit of merit that was signed by Doctor Armstrong. Because of the confusion in those specialties, he says the applicable -- and this was attached to my brief -- the applicable standard of care is otolaryngology and facial plastics. The affidavit of meritorious defense by their expert who shares this exact same board certification with Armstrong and Colton says ex -- excuse me -- exactly the same thing that the applicable standard of care is otolaryngology and this American Board of Facial and Plastic Surgery. It reads exactly like my expert's affidavit of merit.

And to now come in and say, oh, this is just a cosmetic surgery case when it's not because of the functional component leads to a ridiculous result. Because if -- I'm assuming if I would have had a plastic surgeon sign an affidavit, they would be saying, no. This is otolaryngology. But it -- it just seems ludicrous to me to disqualify a doctor who mirror images the qualifications of the Defendant.

THE COURT: All right.

MR. RATTON: And if the Court has any questions, I'm happy --

THE COURT: Yeah.

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MR. RATTON: -- to answer.

THE COURT: I -- I'm -- I guess I'm gonna ask you the same question I just -- I asked Defense Counsel and that is in Doctor Armstrong's deposition testimony he was -- deposition, he was asked about how much time he spends in his area of practice in the two areas. Uh, and, uh, he gave the -- there wasn't just one question and one answer. There were multiple questions with multiple answers. Uh, so I guess I'd like to hear from you the same question I just asked a minute ago and that is, uh, what do you believe Doctor Armstrong's testimony was in that regard? Do you think it was clear and consistent and ultimately, uh, how do you think that impacts my decision?

MR. RATTON: Did I think it's cl -- I -- I don't think it's clear. I -- I think there's a lot of confusion. I think what Armstrong says in there that is clear is he's taking the question of, in your facial plastic surgery practice, what percentage of that is cosmetic versus general ENT type things.

THE COURT: Uh huh.

MR. RATTON: And I think in that is where we get that statement it's 90-10. That's where I think that comes in. But I think it is confusion. But what I think the board is and we admitted it when we were in front of Your Honor back in December on another motion, I think the

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applicable standard of care in this case is the American Board of Medical Specialties recognized specialty of otolaryngology.

THE COURT: Hm.

MR. RATTON: It's not this obscure board. They can be doing cosmetic surgery under the specialty of otolaryngology but that is the board. The arguments being made are more of an impeachment argument to discredit him in front of a jury. Not --

THE COURT: So -- so you --

MR. RATTON: -- to disqualify him.

THE COURT: So your statement that his, uh, testimony was confusing or unclear whatever you just said a minute ago, uh, how do you believe that im -- should impact the decision that I have to make regarding Defendant's motion?

MR. RATTON: I think Defendant's motion should be denied because it's a -- based on their board certifications which mirror each other and they both -- there's no dispute they both do the procedure. They do exactly the same procedure whether you call it cosmetic or oto -- uh, or a general ENT procedure. It's a procedure both of these doctors do under boards legitimately that are -- they're both board certified in. I -- I think it is a -- a difficult and confusing question but I think

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they're both qualified to do it and if -- if the goal here is to have an expert who knows the procedure, who's qualified to do the procedure and comment on the procedure, I -- I -- whether you call it, you know, this or that --

THE COURT: Okay.

MR. RATTON: -- I think they're both qualified.

THE COURT: All right. Thank you.

Last word? The moving party.

MR. KAMENEC: Thank you, Your Honor. A couple points. I'll try to limit it to rebuttal.

THE COURT: Yeah.

MR. KAMENEC: Uh, while you had asked the original question about the deposition and whether it was confusing and while, uh, Opposing Counsel was, uh, arguing this, I -- I don't think it is. We -- we quoted it in our brief, uh, and -- and I've been thinking about whether or not there's something here I'm missing and you know that's -- believe me, uh, as I hear at home, that's always possible. But, uh, if you go to page 10 of our brief, I -- I know there's some context that's always surrounding a question. I've got -- I got that.

But I went back and -- and, you know, the dep is attached and I went and looked at pages 34 and 39 wh -- and I did find out we quoted it right. And I -- I think

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regardless of context, it's pretty straightforward. The questions are pretty straightforward. The percentages are pretty straightforward. Uh, there -- the answers are certainly not equivocal. They're clear as a bell. So, I -- I'm suggesting to the Court that there is more than enough based on the deposition testimony to at least decide the percentages on active clinical practice. That's the first question you had asked me. So that -- I wanted to clarify as best I could and took a little --

THE COURT: Okay.

MR. KAMENEC: -- time to take a look at that while we were listening --

THE COURT: Okay.

MR. KAMENEC: -- to the argument. So, that's --

THE COURT: All right.

MR. KAMENEC: -- that's one thing. Uh --

THE COURT: All right.

MR. KAMENEC: -- the -- the second thing is in these cases that deal with experts that have dual qualifications and then the Defendant has dual qualifications, I can just tell you, uh, the mirror image procedure argument's made all the time. Uh, I've probably had 20 of those on appeal. I've had 450 appeals in my career.

THE COURT: Uh huh.

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MR. KAMENEC: It happens all the time. It's a good argument. I understand the practicality of it. And -- and -- and, uh, Opposing Counsel's an excellent attorney. Now, obviously based on the -- the, uh -- the documents you have. But the -- the difficulty with it is the law doesn't allow it. The law does not allow that. The law says that the Court has to figure out the one, uh, most relevant specialty. And that's, uh -- and with active clinical practice, you've got to be able to show and -- and I know it was in the reply brief, I don't want to get too redundant here.

The old law used to say that if you spent a substantial portion of your time in one area, that was enough. They changed the law, the statute, 600.2169 in 1993. And they said it's gotta be a majority of your time. So now, it has to be quantified. The Court has to, uh -- with respect, the Court has to have the ability and has to at some point in time, uh, quantify that. And the mere fact that somebody in one specialty may be able to do the procedure with respect to somebody else who spends the majority of their time in a different specialty, that's not the law. It's -- it's a -- it's an enticing argument. I understand it. And it's got -- in some ways, it's got some degree of practicality. But the law doesn't allow that. And the statute is -- it -- the statute is clear as

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a bell and a lot of the cases are.

So, it -- in that regard, uh, I don't think there's any question about where Doctor Colton was practicing. Uh, he was practicing in his area. You've got an affidavit to that effect. I think the def -- deposition testimony is clear about where Doctor Armstrong's divisions are. Between the like. The law says -- and we've given you four cases including Lablant (ph) -- overlapping doesn't count when you're counting to the majority or over the 50 percent. And you throw all that together, so to speak if I may, Your Honor, and it says, well, okay. I've gotta follow the law. The law says that you've gotta satisfy the active clinical practice requirement. It has to be more than 50 percent and it doesn't work here.

THE COURT: All right

MR. KAMENEC: Thank you.

THE COURT: Thank you.

MR. RATTON: Judge, can I make one statement? Only one?

THE COURT: Go ahead.

MR. RATTON: This isn't a cosmetic rhinoplasty. It's a -- when we're talking about what it is. That's it.

THE COURT: Okay. Anything else, Counsel? I said I'd give you the last word.

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MR. RATTON: I --

MR. KAMENEC: I -- yeah. Here it is. Thank you.

THE COURT: All right. All right. This matter is before the Court on Defendant's motion to strike Michael J. Armstrong, Jr, M.D. and for summary disposition pursuant to MCR 2.116(C)(7), statute of limitations; (C)(8), failure to state a claim; (C)(10), genuine issue of material fact.

This is a medical malpractice action wherein Plaintiff alleges that Doctor Colton, the Defendant, negligently performed a rhinoplasty and -- and/or rhinoplasty revisions from August 25, 2014 through November 9, 2017. The Court adopts the standard of review and the party's corresponding burden of proof for a motion brought pursuant to MCR 2.116(C)(7), (C)(8), and (C)(10) as stated in both party's briefs.

Defense first assert that summary disposition is warranted because Plaintiff's sole liability expert, Doctor Armstrong must be stricken arguing that Doctor Armstrong fails to meet the expert witness qualifications set forth in MCL 600.2169. Court's require expert testimony to establish the standard of care and a breach of that standard. Decker versus Rochowiak, R-o-c-h-o-w-i-a-k, 287 Mich App 666, 2010 case. The parties do not

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dispute that Doctor Colton and Doctor Armstrong are both board certified in -- this is the word I always mispronounce -- old (sic), uh -- Counsel, you said it a minute ago?

MR. RATTON: Otolaryngology.

THE COURT: Otolaryngology. Yes. And I'll spell it for the record -- o-t-o-l-a-r-y-n-g-o-l-o-g-y -- and facial plastic and reconstructive surgery. At issue here is whether Doctor Armstrong meets the qualifications set forth under MCL 600.2169(1)(B).

Defendant has attached the affidavit of Doctor Colton which states that Plaintiff presented to him for aesthetic rhinoplasty revision procedures which fall within the medical specialty of facial, plastic, and reconstructive surgery and that none of his treatment rendered involved general otonology (sic). Although Plaintiff makes unsupported statements in his brief that the procedures at issue in this case were done to address both cosmetic and functional concerns, the Court has not been presented with or directed to any documentary evidence to contest Doctor Colton's affidavit that the procedures at issue in this litigation were cosmetic in nature and fell within the specialty of facial, plastic, and reconstructive surgery.

Nonetheless, the Court has reviewed Doctor

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Armstrong's deposition testimony which both parties rely upon in sup -- to support their respective positions. And the Court agrees with Plaintiff that it is unclear whether Doctor Armstrong's testimony reflects that 90 percent of his practice was devoted to otono -- ot -- otonology, o-t-o-l-a-r-y-n-g-o-l-o-g-y, and 10 percent to facial, plastic, and reconstructive surgery or whether within his facial, plastic, and reconstructive surgery practice, 10 percent of his procedures may be for cosmetic purposes with 90 percent being more functional.

Therefore, based on seemingly contradictory statements re -- made regarding Doctor Armstrong's practice, the Court cannot determine at this time whether Doctor Armstrong is qualified or not pursuant to MCR 600.2169(1)(B). Consequently, the Court denies the motion to strike without prejudice and accordingly summary disposition is not warranted on this basis pursuant to MCR 2.116(C)(10).

Next, Defendant argues it is entitled to dismissal of Plaintiff's claims as they are barred by the statute of limitations. Defendant argues that the limitations period runs from the date the claims first accrued. And that all of Plaintiff's claims arise out of the August 25, 2014 treatment and are time barred as there is no continuing wrong theory of liability in Michigan

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malpractice actions.

Plaintiff concedes that any action based on the dates prior to January 12th, 2016 are time barred. I'll note as well, uh, that, Plaintiff conceded during this proceeding that the -- the service on January 12th, 2016 is also barred as well. Uh, the Plaintiff disputes the statute of limitations bars claims arising from subsequent treatment dates after January 12th, 2016.

Construing the allegations in Plaintiff's complaint in the light most favorable to Plaintiff, the Court finds Plaintiff's -- Plaintiff alleged a new distinct action or omission within the limitation period. Under MCL 600.5838. -- I'm gonna do that again -- 600.5838 paran little A, for the remaining disputed dates. A physician must act within the standard of care on each visit and a physician's continued adherence to a particular diagnosis or treatment plan at a later appointment might constitute a breach of the standard of care if there are facts that show that continued adherence was unreasonable. Kincaid versus Cardwell, 300 Mich App 513, 2013 case. As an example of an unreasonable adherence, the panel in Kincaid cited a hypothetic (sic) scenario where a Plaintiff's condition or symptoms worsened.

Here, Plaintiff alleged a change to his

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condition -- uh, in his condition. In the complaint, Plaintiff alleged that the February 5, 2016 visit was done to minimize a deformity which resulted from the January 2016 procedure. That the March procedure was done to correct the damage of a prior February surgery and that multiple subsequent procedures were then done to lower and narrow Plaintiff's nose. Plaintiff alleged that Doctor Colton negligently performed the initial rhinoplasty and negligently performed multiple and identical operative procedures without variation leading to a worsening and undesirable result.

Moreover, in determining a motion under (C)(7), the Court may consider documenting (sic) evid -- documentary evidence submitted. MCR 2.116(G)(5). While Doctor Armstrong testified that each revision performed by Doctor Colton was done for the same original purpose, he also stated that each revision performed made the condition worse and that Doctor Colton breached the standard of care by pursuing, uh, the plan of care at the request of the patient and not recognizing that he was heading down a destructive path resulting in the patient's current state. That he did not recognize he was making the condition worse and Doctor Colton, uh -- that he should have known to -- not to adhere to that initial care plan.

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Therefore, the Court finds that Plaintiff's claims withstand a motion for summary disposition under MCR 2.116(C)(7) and Plaintiff may pursue his malpractice claims against Doctor Colton for all dates after January 12, 2016. So the motion is, I guess, granted in part as it pertains to the dates of service that the parties agree are barred, uh, by. And denied as to the other claims would be subsequent to 1-12-16.

With that said, that's -- that's my call. That's my ruling. It's -- I made the record. It's there. Uh, I'll just need an order entered consistent with that. Just write out, you know, motion is granted in part, denied in part for the reasons stated on the record.

MR. KAMENEC: And Your Honor, I just -- just for the order. That's the only --

THE COURT: Yeah.

MR. KAMENEC: -- reason I'm gonna take 20 seconds.

THE COURT: Yeah. Yeah.

MR. KAMENEC: So, uh --

THE COURT: Go ahead.

MR. KAMENEC: -- the qualification is denied without prejudice, right? I heard --

THE COURT: Without prejudice.

MR. KAMENEC: -- that. (indiscernible) --

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THE COURT: Yeah. I did -- I said that. Yes.

MR. KAMENEC: And then -- I -- I got you. I just wanna make sure we got the order right.

THE COURT: That is correct.

MR. KAMENEC: And then the statute of limitations is granted in part and denied in part.

THE COURT: Correct.

MR. KAMENEC: Done. Thank you, Your Honor.

THE COURT: Absolutely. Just present an order consistent with that and you can just say for the reasons stated on the record.

MR. KAMENEC: Okay.

THE COURT: And it's there.

MR. RATTON: All right.

THE COURT: All right.

MR. KAMENEC: Thank you, Your Honor.

THE COURT: Thank you both.

MR. RATTON: Thank you, Judge.

THE COURT: Have a good day.

MR. RATOON: Nice to see you.

MR. KAMENEC: Thank you.

THE COURT: Good to see you.

MR. KAMENEC: Have a good day.

THE COURT: All right. Thank you. Thank you for your patience, Counsel.

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MR. KAMENEC: Uh huh.

(At 2:00 p.m., proceeding concluded)

* * * * * *

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STATE OF MICHIGAN)

COUNTY OF OAKLAND)ss.

I certify that this transcript is a true and accurate transcription to the best of my ability of the proceeding in this case before the Honorable Jeffery S. Matis, as recorded by the clerk.

Proceedings were recorded and provided to this transcriptionist by the Circuit Court and this certified reporter accepts no responsibility for any events that occurred during the above proceedings, for any inaudible and/or indiscernible responses by any person or party involved in the proceeding or for the content of the recording provided.

Dated: February 21S, 2020

/s/ Alison Joersz

Alison Joersz, CER #9320

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APPENDIX 12

FILED Received for Filing Oakland County Clerk 1/29/2020 5:01 PM

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STATE OF MICHIGAN OAKLAND COUNTY 6TH JUDICIAL CIRCUIT	ORDER	Case No. 18-167068 NH

Court Address:
1200 N. Telegraph Road, Dept. 404, Pontiac, MI 48341

Telephone: (248) 858-0368

Plaintiff: Anthony Selliman

v

Defendant: Jeffrey Colton, MD et al

Upon Defendants' Motion to Strike Michael J. Armstrong, MD, and for Summary Disposition,

The Motion to Strike Dr Armstrong is DENIED WITHOUT PREJUDICE for the reasons stated on the record of January 29, 2020.

The Motion for Summary Disposition [statute of limitations] is GRANTED IN PART and DENIED IN PART. The Motion is GRANTED with respect to date of treatment prior to and including January 12, 2016. The Motion is otherwise DENIED, for the reasons stated on the record of January 29, 2020.

Plaintiff Michael T. Rotten P42399

Defendant Robert G. Kamenec P35283

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DATE

HON. JEFFERY S. MATIS, P51284

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APPENDIX 13

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Court of Appeals, State of Michigan

ORDER

Antonio Selliman v Jeffrey J Colton MD

Docket No. 352781

LC No. 2018-167068-NH

Colleen A. O'Brien
Presiding Judge

Kathleen Jansen

Elizabeth L. Gleicher
Judges

The application for leave to appeal is GRANTED. The time for taking further steps in this appeal runs from the date of the Clerk's certification of this order. MCR 7.205(E)(3). This appeal is limited to the issues raised in the application and supporting brief. MCR 7.205(E)(4).

Colleen A. O'Brien
Presiding Judge

Gleicher, J., would deny the application for leave to appeal. The board certifications of the experts match in this case. The standard of care for performing a rhinoplasty is the same regardless of whether the rhinoplasty is performed for cosmetic or medical reasons. Accordingly, the "one most relevant specialty" formulation is logically inapplicable to this case.

A true copy entered and certified by Jerome W. Zimmer Jr., Chief Clerk, on

MAY 27 2020
Date

Jerome W. Zimmer Jr.
Chief Clerk

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APPENDIX 14

If this opinion indicates that it is "FOR PUBLICATION," it is subject to revision until final publication in the Michigan Appeals Reports.

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STATE OF MICHIGAN

COURT OF APPEALS

ANTONIO SELLIMAN,

Plaintiff-Appellee,

v

JEFFREY J. COLTON, M.D., JEFFREY J. COLTON, PLLC, and COLTON CENTER,

Defendants-Appellants.

UNPUBLISHED
May 20, 2021

No. 352781
Oakland Circuit Court
LC No. 2018-167068-NH

Before: MARKEY, P.J., and M. J. KELLY and SWARTZLE, JJ.

PER CURIAM.

In this interlocutory appeal, defendants appeal by leave granted[1] the order denying their motion to strike plaintiff, Antonio Selliman's, expert witness and partially denying their motion for summary disposition. For the reasons stated in this opinion, we reverse and remand for further proceedings.

I. BASIC FACTS

This case stems from Selliman's rhinoplasty surgical procedures that defendant Dr. Jeffrey J. Colton, M.D., performed from 2012 through 2017. Selliman alleges that the surgeries caused a nasal deformity to develop, which additional surgical procedures failed to correct. He filed this action against Dr. Colton, his corporation, and his medical facility. Dr. Colton is board-certified in otolaryngology, or "ear, nose, throat" (ENT), which involves surgery and treatment of conditions related to the head and neck. He is also board-certified in facial plastic and reconstructive surgery. Selliman's proposed standard-of-care expert, Dr. Michael J. Armstrong, holds the same certifications.

[1] *Selliman v Colton*, unpublished order of the Court of Appeals, entered May 27, 2020 (Docket No. 352781).

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Defendants filed a motion to strike Dr. Armstrong's testimony and for summary disposition. They argued that the specialty at issue is facial plastic and reconstructive surgery and that Dr. Armstrong did not spend the majority of his professional time practicing facial plastic and reconstructive surgery in the year immediately preceding the alleged malpractice as required under MCL 600.2169(1)(b). Defendants relied on Dr. Armstrong's deposition testimony stating that he devoted 90 percent of his practice to ENT and 10 percent of his practice to facial plastic and reconstructive surgery. They argued that the fact that there may be some overlap between ENT and facial plastic and reconstructive surgery was irrelevant because an expert is statutorily required to have spent the majority of his or her professional time practicing the one most relevant specialty.

Selliman opposed defendants' motion, arguing that Dr. Armstrong was qualified under MCL 600.2169. Selliman also disputed that his treatment had been solely cosmetic because his condition had resulted in functional issues and difficulty breathing. He disputed that facial plastic and reconstructive surgery was the one most relevant specialty, but he argued that, even if it were, Dr. Armstrong's testimony should not be stricken. Selliman argued that defendants had misconstrued Dr. Armstrong's testimony and that Dr. Armstrong had actually testified that within his facial plastic and reconstructive surgery practice 10 percent of his surgeries were for cosmetic purposes and 90 percent were for functional or medical purposes. Selliman maintained that, reading Dr. Armstrong's deposition testimony as a whole, Dr. Armstrong was qualified to testify under MCL 600.2169(1).

The trial court denied defendants' motion. Because Dr. Colton averred in his affidavit that the procedures at issue were cosmetic in nature, the court opined that the most relevant specialty was facial plastic and reconstructive surgery.[2] The court also determined, however, that Dr. Armstrong's testimony was unclear as to whether he devoted 90 percent of his practice to ENT and 10 percent to facial plastic and reconstructive surgery or whether 10 percent of his facial plastic and reconstructive surgery practice was cosmetic in nature and 90 percent was functional or medical in nature. The court opined that portions of Dr. Armstrong's testimony were "seemingly contradictory," so it denied defendants' motion to strike Dr. Armstrong as an expert witness.

II. EXPERT WITNESS QUALIFICATIONS

A. STANDARD OF REVIEW

Defendants argue the trial court erred when it denied defendants' motion to strike. This Court's interpretation of MCL 600.2169(1) is reviewed de novo. *Woodard v Custer*, 476 Mich 545, 557; 719 NW2d 842 (2006). We review for an abuse of discretion "a trial court's rulings concerning the qualifications of a proposed expert witness to testify." *Id*. "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." *Id*.

[2] Although Selliman challenged the accuracy of Dr. Colton's averment that the procedures were solely cosmetic, he did not present any documentary evidence to rebut it.

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B. ANALYSIS

In a medical malpractice action, the plaintiff must prove: "(1) the applicable standard of care, (2) breach of that standard by defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury." *Cox v Hartman*, 322 Mich App 292, 299; 911 NW2d 219 (2017) (quotation marks and citation omitted). "Failure to prove any one of these elements is fatal." *Id.* (quotation marks and citation omitted). Generally, "expert testimony is necessary in a malpractice action to establish the applicable standard of care and the defendant's breach of that standard." *Id.* at 300. "The proponent of the evidence has the burden of establishing its relevance and admissibility." *Elher v Misra*, 499 Mich 11, 22; 878 NW2d 790 (2016).

An expert testifying regarding the standard of care must meet the requirements of MCL 600.2169(1). *Rock v Crocker*, 499 Mich 247, 260; 884 NW2d 227 (2016). MCL 600.2169(1) provides:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.

In *Woodard*, 476 Mich at 560, our Supreme Court held that an expert "must match the one most relevant standard of practice or care—the specialty engaged in by the defendant physician during the course of the alleged malpractice . . . ." "That is, if a defendant physician is a specialist, the . . . expert witness must have specialized in the same specialty as the defendant physician at the time of the alleged malpractice." *Id.* at 560-561. Here, it is undisputed that, as required by MCL 600.2169(1)(a), Dr. Armstrong's qualifications "match" Dr. Coltron's qualifications.

As it relates to the requirement that the expert devote the majority of his or her professional time to practicing or teaching a specialty, our Supreme Court has stated:

> [O]ne cannot devote a "majority" of one's professional time to more than one specialty. Therefore, in order to be qualified to testify under § 2169(1)(b), the plaintiff's expert witness must have devoted a majority of his professional time

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> during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty. [*Woodard*, 476 Mich at 566.]

The term "majority" in MCL 600.2169(1)(b) requires that an expert "spend greater than 50 percent of his or her professional time practicing the relevant specialty the year before the alleged malpractice." *Kiefer v Markley*, 283 Mich App 555, 559; 769 NW2d 271 (2009).

In this case, Dr. Armstrong averred in an affidavit that "[d]uring the one year period prior to the treatment involved in this case I devoted the majority of my professional time to the active clinical practice" of ENT and facial plastic and reconstructive surgery. At that time, he did not offer a breakdown to indicate whether the majority of his professional time was spent on ENT or on facial plastic reconstructive surgery. Subsequently, during his deposition, Dr. Armstrong testified as follows:

> *Q*. Can you give me an approximation of the percentage of your professional time that's devoted to ENT, general ENT, as opposed to --
>
> *A*. Excluding what?
>
> *Q*. As opposed to facial plastic and reconstructive surgery.
>
> *A*. There are certainly medical conditions that overlap quite a bit. A lot of my nasal functional surgeries would fall into the category of facial plastics. You know, I would say that the practice might be 10 percent cosmetic, 90 percent functional; but rhinoplasty is one of the more common procedures that I do.
>
> *Q*. Within your cosmetic practice?
>
> *A*. Or within my functional nasal practice. They're not all cosmetic.
>
> *Q*. Okay. So can you give me an approximation of currently the breakdown of your practice, general otolaryngology versus facial plastic and reproductive surgery?
>
> *A*. Reconstructive.
>
> *Q*. Reconstructive surgery; sorry. That didn't make sense.
>
> *A*. I've not looked at it recently; but as I said, 10 percent maybe, in the facial plastic realm and 90 percent would be considered more medically ENT.
>
> * * *
>
> *Q*. Okay. Same set of questions, 2015 to 2017: Was your practice then approximately 90 percent otolaryngology and 10 percent facial plastic and reconstructive surgery?

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A. Yes.

Q. Okay. And the facial plastic and reconstructive surgery would include cosmetic rhinoplasties?

A. Yes.

Based upon the above testimony, it is clear that Dr. Armstrong unequivocally testified that 10 percent of his practice consists of facial plastic and reconstructive surgery procedures and 90 percent of his practice consists of ENT procedures. Notwithstanding plaintiff's argument that Dr. Armstrong's testimony on this point related to the proportionality of functional versus cosmetic rhinoplasties, from the context of the questions, it appears that defendants sought answers related to the proportionality of the whole of Dr. Armstrong's practice—ENT versus facial plastic and reconstructive surgery. And, though Dr. Armstrong responded to defendants' questions about the proportionality of his practice by using the terms "functional" and "cosmetic," Dr. Armstrong understood and used the term "functional" to equate with his ENT practice, while his facial plastic and reconstructive surgery practice was for cosmetic services.[3] Thus, Dr. Armstrong's testimony unequivocally shows he did not spend a majority of his time in facial plastic and reconstructive surgery, the relevant specialty. As a result, the trial court abused its discretion by denying the motion to strike his testimony.

Moreover, although Dr. Armstrong testified that there is some overlap regarding rhinoplasty procedures, the unrefuted evidence shows that Selliman's procedures were cosmetic, so facial plastic reconstructive surgery is the most relevant specialty. As the trial court recognized, defendants presented Dr. Colton's affidavit stating that Selliman presented to him for aesthetic rhinoplasty revision procedures and that Selliman's treatment did not involve general ENT

---

[3] Throughout his testimony, Dr. Armstrong understood that the procedure at issue, a cosmetic rhinoplasty, fell under the practice of FPRS. For example:

Q. Okay. Same set of questions, 2015 to 2017: Was your practice then approximately 90 percent [ENT] and 10 percent facial plastic and reconstructive surgery?

A. Yes.

Q. Okay. And the facial plastic and reconstructive surgery would include cosmetic rhinoplasties?

A. Yes.

Q. What other types of cosmetic procedures do you do?

A. Facelifts; eyelids; Botox; Radiesse, . . . laser treatment; and skin cancer repairs.

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procedures. Selliman presented no evidence rebutting Dr. Colton's affidavit. In addition, Dr. Armstrong testified that Selliman suffered no medical complications as a result of Dr. Colton's surgeries, and that his only complaint was the appearance of his nose. He also testified as follows:

> *Q*. Dr. Colton's not performing a surgery on [Selliman's] nose to fix some medical condition; he's doing it because [Selliman] is telling him he wants his nose to look a certain way, right?
>
> *A*. Right.
>
> *Q*. He wants it narrower, and he wants it lower, right?
>
> *A*. Right.

Therefore, the trial court correctly determined that facial plastic and reconstructive surgery is the most relevant specialty.[4] Consequently, while Selliman directs this Court to the overlap between rhinoplasty procedures performed for medical or functional reasons and procedures performed for cosmetic reasons, and although he cites caselaw pertaining to overlapping specialties, the issue is not relevant in this case because Selliman's procedures were cosmetic, thereby making the one most relevant specialty facial plastic and reconstructive surgery, not ENT.

III. MOTION TO AMEND WITNESS LIST

In his brief on appeal, Selliman argues that if this Court reverses the trial court's order denying the motion to strike, we should find that the trial court also erred by denying his motion to amend the witness list. Selliman did not file a cross-appeal under MCR 7.207. Although an appellee need not file a cross-appeal to advance alternative reasons rejected by a trial court in support of the court's judgment, an appellee cannot obtain greater relief or a decision more favorable than rendered by the lower court without taking a cross-appeal. *Middlebrooks v Wayne Co*, 446 Mich 151, 166 n 41; 521 NW2d 774 (1994). Because Selliman seeks to expand the scope of relief awarded by the trial court and he did not file a cross-appeal, he is not entitled to this requested relief. In any event, our grant of leave was limited to the issues raised in the application, none of which involved the propriety of the trial court's decision to not permit Selliman to amend his witness list.

[4] Although Selliman disputes defendants' contention that facial plastic and reconstructive surgery is the one most relevant specialty, he provides no substantive argument in support of that assertion. "A party cannot simply assert an error or announce a position and then leave it to this Court to discover and rationalize the basis for his claims, or unravel and elaborate for him his arguments, and then search for authority either to sustain or reject his position." *Mitchell v Mitchell*, 296 Mich App 513, 524; 823 NW2d 153 (2012) (quotation marks and citation omitted).

Reversed and remanded for further proceedings consistent with this opinion. Defendants may tax costs. MCR 7.219(A). We do not retain jurisdiction.

/s/ Jane E. Markey
/s/ Michael J. Kelly
/s/ Brock A. Swartzle

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APPENDIX 15

Order

Michigan Supreme Court
Lansing, Michigan

April 27, 2022

Bridget M. McCormack,
Chief Justice

Brian K. Zahra
David F. Viviano
Richard H. Bernstein
Elizabeth T. Clement
Megan K. Cavanagh
Elizabeth M. Welch,
Justices

163226

ANTONIO SELLIMAN,
Plaintiff-Appellant,

v

SC: 163226
COA: 352781
Oakland CC: 2018-167068-NH

JEFFREY J. COLTON, M.D., JEFFREY J. COLTON, PLLC, and COLTON CENTER,
Defendants-Appellees.

_____/

On order of the Court, the application for leave to appeal the May 20, 2021 judgment of the Court of Appeals is considered. We direct the Clerk to schedule oral argument on the application. MCR 7.305(H)(1).

The appellant shall file a supplemental brief within 42 days of the date of this order addressing: (1) whether the one most relevant specialty test as articulated in *Woodard v Custer*, 476 Mich 545 (2006), and as applied in this case, is consistent with the requirements of MCL 600.2169(1); (2) whether the Court of Appeals properly applied the requirements of MCL 600.2169(1) in this case; and (3) whether the Court of Appeals properly applied the abuse of discretion standard of review. In the brief, citations to the record must provide the appendix page numbers as required by MCR 7.312(B)(1). The appellees shall file a supplemental brief within 21 days of being served with the appellant's brief. A reply, if any, must be filed by the appellant within 14 days of being served with the appellees' brief. The parties should not submit mere restatements of their application papers.

We further direct the Clerk to schedule the oral argument in this case for the same future session of the Court when it will hear oral argument in *Stokes v Swofford* (Docket No. 162302).

I, Larry S. Royster, Clerk of the Michigan Supreme Court, certify that the foregoing is a true and complete copy of the order entered at the direction of the Court.

April 27, 2022

Clerk

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APPENDIX 16

Order

Michigan Supreme Court
Lansing, Michigan

December 22, 2022

Elizabeth T. Clement
Chief Justice

Brian K. Zahra
Bridget M. McCormack
David F. Viviano
Richard H. Bernstein
Megan K. Cavanagh
Elizabeth M. Welch
Justices

163226

ANTONIO SELLIMAN,
Plaintiff-Appellant,

v

SC: 163226
COA: 352781
Oakland CC: 2018-167068-NH

JEFFREY J. COLTON, M.D., JEFFREY J. COLTON, PLLC, and COLTON CENTER,
Defendants-Appellees.

_____/

On December 8, 2022, the Court heard oral argument on the application for leave to appeal the May 20, 2021 judgment of the Court of Appeals. On order of the Court, the application is again considered, and it is GRANTED. The parties shall include among the issues to be briefed: (1) whether *Woodard v Custer*, 476 Mich 545 (2006), was correctly decided and is consistent with the requirements of MCL 600.2169(1); (2) if not, whether it should nonetheless be retained under principles of stare decisis, *Robinson v City of Detroit*, 462 Mich 439, 463-468 (2000); (3) if the "one most relevant specialty" test as set forth in *Woodard* is not consistent with MCL 600.2169(1) and should not be retained, the test that should be applied; (4) if *Woodard*'s interpretation of "majority of . . . professional time" is not consistent with MCL 600.2169(1) and should not be retained, the correct interpretation; and (5) whether the Court of Appeals reached the right result under the proper application of the requirements of MCL 600.2169 in this case. The time allowed for oral argument shall be 20 minutes for each side. MCR 7.314(B)(1).

We further direct the Clerk to schedule the oral argument in this case for the same future session of the Court when it will hear oral argument in *Stokes v Swofford, DO* (Docket No. 162302).

Amici who appeared at the application stage are invited to file supplemental briefs amicus curiae. The Michigan Association for Justice, Michigan Defense Trial Counsel, Inc., and the Negligence Law Section of the State Bar of Michigan are invited to file briefs amicus curiae. Other persons or groups interested in the determination of the issues presented in this case may move the Court for permission to file briefs amicus curiae.

I, Larry S. Royster, Clerk of the Michigan Supreme Court, certify that the foregoing is a true and complete copy of the order entered at the direction of the Court.

December 22, 2022

Clerk

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APPENDIX 17

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Johnson v. Sultan

Court of Appeals of Michigan

February 10, 2011, Decided

No. 292327

Reporter
2011 Mich. App. LEXIS 272 *; 2011 WL 476443

SCOTT JOHNSON and KATHLEEN JOHNSON, Plaintiffs-Appellants, v SULTAN BHIMANI, M.D. and ADVANCED DIAGNOSTIC IMAGING, P.C., Defendants-Appellees, and COVENANT HEALTHCARE SYSTEM, Defendant.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Prior History: **[*1]** Saginaw Circuit Court. LC No. 04-054130-NH.

Core Terms

specialty, radiology, diagnostic, practicing, neuroradiology, spine, films, alleged malpractice, subspecialty, devoted, percent, proposed expert, qualifications, certificates, expert witness, malpractice, falls, internal medicine, board certified, neuroradiologist, occurrence, realm, radiologist, clinical, medicine, spent, hip, standard of care, pediatric, images

Judges: Before: CAVANAGH, P.J., and HOEKSTRA and GLEICHER, JJ. GLEICHER, J. (dissenting).

Opinion

PER CURIAM.

Plaintiffs appeal as of right from the trial court's order that granted defendants' motion to strike plaintiffs' expert radiology witness, Harold Parnes, M.D., and dismissed plaintiffs' lawsuit with prejudice. We affirm.

Plaintiff Scott Johnson [1] suffered pelvic injuries that eventually required surgery as a result of falling off a ladder. Plaintiffs alleged that defendant Sultan Bhimani, M.D., a radiologist at the hospital, initially failed to diagnose plaintiff's injury causing complications and a worsening of his condition.

Plaintiffs argue that the trial court incorrectly determined that Parnes was not qualified as an expert witness under MCL 600.2169. We disagree.

A trial court's ruling regarding a proposed expert's qualifications to testify is reviewed for an abuse of discretion. *Kiefer v Markley, 283 Mich App 555, 556; 769 NW2d 271 (2009)*. An abuse **[*2]** of discretion occurs when the decision results in an outcome falling outside the range of principled outcomes. *Id*.

In malpractice actions, parties are obligated to provide an expert witness to articulate the applicable standard of care involved. MCL 600.2912d(1)(a); *Tate ex rel Estate of Hall v Detroit Receiving Hosp, 249 Mich App 212, 216; 642 NW2d 346 (2002)*. A person cannot give expert testimony in a malpractice suit unless the person meets the list of qualifications of MCL 600.2169. MCL 600.2169(1); *Grossman v Brown, 470 Mich 593, 599; 685 NW2d 198 (2004)*. MCL 600.2169(1)(a) specifically states that an expert witness must "specialize[ ] at the time of the occurrence that is the basis for the action" in the same specialty as the defendant physician. The specialty requirement is tied to the specialty engaged in during the occurrence of the alleged malpractice and not unrelated specialties that a defendant physician may hold. *Halloran v Bhan, 470 Mich 572, 577 n 5; 683 NW2d 129 (2004)*. The specialty or subspecialty that the defendant physician was practicing at the time of the alleged malpractice is the one most relevant specialty or subspecialty that must be matched by the proposed **[*3]** expert. *Woodard v Custer, 476 Mich 545, 566; 719*

[1] References to "plaintiff" in the singular throughout this opinion are to Scott Johnson because Kathleen Johnson's claim for loss of consortium is derivative to his primary claim of medical malpractice.

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NW2d 842 (2006). It is not disputed that diagnostic radiology is the one most relevant specialty involved here, and that both defendant Bhimani and Parnes were board certified in general diagnostic radiology. Thus, the requirements of MCL 600.2169(1)(a) were met.

However, whether Parnes satisfied MCL 600.2169(1)(b) is the dispute. The trial court granted defendants' motion to strike Parnes as an expert because it found he had not devoted the majority of his professional time during the year preceding the alleged malpractice practicing diagnostic radiology. According to MCL 600.2169(1)(b), the proposed expert must have devoted a majority of his or her professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the one most relevant specialty the defendant physician was practicing at the time of the alleged malpractice. In Kiefer, 283 Mich App at 559, this Court held that "majority" of professional time meant that a proposed expert physician was required to "spend greater than 50 percent of his or her professional time practicing the relevant specialty the year before **[*4]** the alleged malpractice."

Here, Parnes was questioned extensively regarding how he spent his professional time. Parnes stated that, although the specialty he engaged in was determined by the needs of his patients, he spent the majority of his professional time in neuroradiology. Parnes estimated that he spent 50 to 80 percent of his professional time in neuroradiology. Therefore, Parnes was not able to meet the requirements of MCR 600.2169(1)(b) because he did not spend more than 50 percent of his professional time practicing the one relevant specialty of general diagnostic radiology.

Plaintiffs argue that, because neuroradiology is a subspecialty of diagnostic radiology and there is considerable overlap of the fields, the trial court should have found that Parnes spent the majority of his time practicing diagnostic radiology. Parnes explained that neuroradiology was a subspecialty of general radiology that involved imaging of the brain, spine, and nerves, with different modalities. Defendant Bhimani also stated that neuroradiology was a branch of radiology that deals with the brain, spinal cord, and central nervous system, and that general radiology is the branch dealing with imaging **[*5]** the rest of the body, including the lumbar region and pelvis at issue here. Parnes indicated that muscular skeletal films and diagnostic films would be within the realm of neuroradiology if they were related to the spine or even sacroiliac joint, but that they were also in the realm of diagnostic radiology. Parnes also asserted that components of neuroradiology were muscular skeletal because all systems worked together as one, meaning that muscular skeletal was related to the nervous system.

However, general diagnostic radiology and neuroradiology are two distinct specialties, and practicing neuroradiology is not the same as practicing general diagnostic radiology. A "specialty" is a particular branch of medicine or surgery in which one can potentially become board certified. Woodard, 476 Mich at 561. A "subspecialty" is a particular branch of medicine or surgery in which one can potentially become board certified that falls under a specialty or within the hierarchy of that specialty. Id. at 562. "A subspecialty, although a more particularized specialty, is nevertheless a specialty." *Id*. For the purposes of MCL 600.2169(1)(b), a subspecialty is a specialty. Id. at 566 n 12. Therefore, **[*6]** the specialties of diagnostic radiology and neuroradiology are distinct from each other.

The case of Hamilton v Kuligowski, 261 Mich App 608, 611-612; 684 NW2d 366 (2004), rev'd sub nom Woodard v Custer, 476 Mich 545, 566; 719 NW2d 842 (2006), is factually similar to the instant case because the defendant's one relevant specialty was internal medicine and the proposed expert also specialized in internal medicine, but spent the majority of his professional time practicing a subspecialty of internal medicine, infectious diseases. This Court held that the proposed expert was qualified as a witness because, by practicing the infectious diseases subspecialty, "he devoted the majority of his professional time to the 'active clinical practice' of defendant's 'internal medicine specialty.'" Hamilton, 261 Mich App at 611-612. However, the Supreme Court reversed, finding that the proposed expert witness was not qualified under MCL 600.2169(1)(b) because he did not devote a majority of his professional time to practicing the one most relevant specialty or subspecialty that the defendant physician was practicing at the time of the alleged malpractice. Woodard, 476 Mich at 578-579. [2] Even though **[*7]** the proposed expert practiced a subspecialty of the defendant's one most relevant specialty, the Supreme Court specifically found that the "plaintiff's proposed expert witness did not devote a majority of his time to practicing or teaching general internal medicine. Instead, he devoted a majority of his professional time

[2] *Hamilton v Kuligowski* was decided as a companion case to *Woodard v Custer*.

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to treating infectious diseases." *Id. at 577-578*. Similarly, here, Parnes did not devote a majority of his time practicing the one most relevant specialty of defendant Bhimani, i.e., diagnostic radiology. Rather, Parnes testified that he devoted the majority of his professional time to neuroradiology. Therefore, the trial court did not abuse its discretion in finding that Parnes was not qualified as an expert witness under *MCL 600.2169(1)(b)*.

Affirmed.

/s/ Mark J. Cavanagh

/s/ Joel P. Hoekstra

Dissent by: Elizabeth L. Gleicher

Dissent

GLEICHER, J. (*dissenting*).

Plaintiffs' expert witness in this medical malpractice case, Dr. Harold Parnes, is board-certified in diagnostic radiology. Defendant Sultan Bhimani, M.D., is board-certified in diagnostic radiology. Both physicians possess certificates of added qualification **[*8]** in neuroradiology. The radiologic images at issue depict the lumbosacral spine and sacroiliac joint, closely related anatomical areas falling within the purview of both specialties. The majority concludes that Parnes lacked the requisite qualifications under *MCL 600.2169(1)(b)* because he "did not spend more than 50 percent of his professional time practicing the one relevant specialty of general diagnostic radiology." *Ante* at 3. I respectfully disagree with the majority, and would find Parnes fully qualified to testify in this case.

Plaintiff Scott Johnson fell from a ladder, and presented at defendant Covenant Healthcare System complaining of pain in his abdomen, groin and hips. An emergency room physician ordered an x-ray of Johnson's lumbosacral spine. A short time later, the physician ordered a CT scan of Johnson's abdomen and pelvis. Bhimani interpreted all the radiologic studies as negative for fractures or other abnormalities. Bhimani described as follows at his deposition the "possible fractures" that a CT scan of the pelvis and abdomen may reveal: "Well, the CT study is involved from the upper part of the thoracic spine all the way to the pubic symphysis, so [that] includes **[*9]** the thoracic spine, the lumbar spine, the iliac bone, and the sacrum." The sacrum is "the triangular bone just below the lumbar vertebrae, formed usually by five fused vertebrae (sacral vertebrae) that are wedged dorsally between the two hip bones." Dorland's Illustrated Medical Dictionary, 1373 (25th ed, 1974). The term sacroiliac pertains "to the sacrum and ilium; denoting the joint or articulation between the sacrum and ilium and the ligaments associated therewith." *Id*. The ilium is "the expansive superior portion of the hip bone." *Id*. at 763. Indisputably, the lumbar vertebrae and sacrum are structures of the spine.

Parnes opined that Bhimani failed to detect on the lumbosacral spine x-rays "separation of the left SI [sacroiliac] joint compared to the right[,] asymmetric." Regarding the CT scan, Parnes observed:

> If you look at the CT scan ... you can see that there is a widening of the pubic symphysis on the scalp image which is basically the image that's used to sort of coordinate where all the image slices are going to be. So the scalp image shows the widening of the pubic symphysis. Additionally, on the individual images themselves, there is a fracture of the anterior left sacrum **[*10]** and a widening of the left SI joint as compared to the right side. Asymmetric.

According to Parnes, films like those at issue in this case are read by diagnostic radiologists and neuroradiologists:

> *Q*. Muscular skeletal films, diagnostic films, that doesn't fall within the realm of neuroradiology, correct?
>
> *A*. It falls within the realm of it as far as whether there was something related to the spine, or even sacroiliac joint, which we image, but it also falls in the realm of diagnostic radiology.

The American Board of Radiology agrees with Parnes's description of neuroradiology practice. The board defines neuroradiology as "a subspecialty of diagnostic radiology that utilizes diagnostic and interventional techniques, including computed tomography, magnetic resonance imaging, angiography, myelography, and radiographs to evaluate and treat conditions of the central nervous system, *spine*, and head and neck." *http://www.theabr.org/moc/moc_neuro_landing.html*, accessed January 16, 2011 (emphasis added).

In addition to their precisely matching specialties and subspecialties, Barnes and Bhimani share remarkably

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similar practice histories. After they achieved board certification in diagnostic radiology, **[*11]** both successfully completed fellowship training in neuroradiology. At his 2005 deposition, Bhimani testified that he "currently practice[s]" both "general radiology" and neuroradiology, and holds himself out as a neuroradiologist. Bhimani acknowledged that he held himself out as a neuroradiologist at the time the alleged medical malpractice occurred:

> *Q*. Did you hold yourself out to be a neuroradiologist in April 2002?
>
> *A*. I was a neuroradiologist during that time, too.

Bhimani estimated that in April 2002, when he reviewed Johnson's radiographs, "about 50 percent [of my practice] was neuro and 50 percent was general." During part of the year preceding the asserted malpractice, April 2001 through January 2002, Bhimani worked at McLaren Hospital. He recalled that "[d]uring the time, the job changed, and I was roughly figuring out to working about 25 percent neuro and 75 percent general diagnostic radiology." From 1985 to 2000, Bhimani practiced with Associated Radiologists of Flint. Throughout that time, his practice "was . . . close to about 70 percent neuro and 30 percent general."

Parnes estimated that he spent "somewhere between maybe 50 percent, 60 percent" of his professional time practicing **[*12]** neuroradiology. [1] He continued, "It is hard to say because if you consider lumbar spine, cervical spine, you know, head and neck, it depends also on a daily basis." Later in the deposition, he clarified that "50 to 80 percent" of his time "is neuroradiology."

The relevant statute, MCL 600.2169(1), delineates as follows the criteria necessary for qualification of an expert witness in a medical malpractice action:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. *However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert* ***[*13]*** *witness must be a specialist who is board certified in that specialty*.
>
> (b) *Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following*:
>
> *(i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty*.
>
> (*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the Tsame specialty. [Emphasis added.] [2]

The majority correctly observes that Parnes met the conditions in MCL 600.2169(1)(a), given that both he and Bhimani are board-certified radiologists. *Ante* at 2. But the majority **[*14]** finds that Parnes cannot fulfill the requirements of § 2169(1)(b)(*i*) "because he did not spend more than 50 percent of his professional time practicing the one relevant specialty of general diagnostic radiology." *Ante* at 3. The majority's focus on "the one relevant specialty" derives from Woodard v Custer, 476 Mich 545, 566; 719 NW2d 842 (2006), in which our Supreme Court held that

> in order to be qualified to testify under § 2169(1)(b), the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty.

Although the majority acknowledges the "overlap"

[1] Neither counsel requested that Parnes provide a statistical breakdown of his practice over the course of the year before the occurrence at issue.

[2] Subsection (c) concerns general practitioners and has no relevance here.

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present in this case between anatomical structures within the purview of both diagnostic radiology and neuroradiology, the majority rules that "the specialties of diagnostic radiology and neuroradiology are distinct from each other," and "practicing neuroradiology is not the same as practicing general diagnostic radiology." *Ante* at 3-4. While I agree that the two disciplines **[*15]** are "distinct from each other," *ante* at 4, I strongly disagree that any *meaningful* distinction between the two specialties exists in this case. In my view, Bhimani practiced both diagnostic radiology and neuroradiology, or either specialty, when he interpreted Johnson's films. Irrespective whether Bhimani claims to have worn the hat of a neuroradiologist or a diagnostic radiologist at the moment he interpreted Johnson's films, the standard of care governing his interpretation had no relationship to the label he attached to his specialty. Therefore, I would hold that Parnes possesses the requisite qualifications to give expert testimony under MCL 600.2169. In reaching this conclusion, I rely on the text of § 2169, relevant case law and common sense.

"We need not leave our common sense at the doorstep when we interpret a statute." *Price Waterhouse v Hopkins, 490 U.S. 228, 241; 109 S Ct 1775; 104 L Ed 2d 268 (1989)*, superseded in part by statute on other grounds as noted in *Landgraf v USI Film Products, 511 U.S. 244, 251; 114 S Ct 1483; 128 L Ed 2d 229 (1994)*. When endeavoring to interpret a statute in a manner faithful to the Legislature's intent, "a court should not abandon the canons **[*16]** of common sense." *Marquis v Hartford Accident & Indemnity, 444 Mich 638, 644; 513 NW2d 799 (1994)*. The majority presumes that because Bhimani claims to have been practicing diagnostic radiology at the time he interpreted films depicting Johnson's spine and pelvis, he could not have been practicing neuroradiology. Alternatively stated, the majority concludes that while interpreting films of Johnson's spine and pelvis, Bhimani somehow avoided drawing on his knowledge, training and extensive experience as a neuroradiologist, even though at the same time he held himself out to the public as a neuroradiologist. According to the majority's reasoning, Bhimani somehow isolated his neuroradiology training and experience from his diagnostic radiologic consideration of Johnson's films, and reviewed the x-rays while utilizing only those neurons dedicated to diagnostic radiology methods. In my view, it simply defies logic to conclude that two radiologists sharing identical board certifications and certificates of added qualifications, whose practices involve substantial time commitments to precisely the same specialty and subspecialty, would observe different standards of care when interpreting **[*17]** films of an anatomic area falling within the realm of their mutual expertise.

Aside from common sense, case law does not support the disqualification of an expert whose qualifications and relevant practice mirror those of the defendant. In *Woodard, 476 Mich at 560*, our Supreme Court emphasized the role of relevance in interpreting MCL 600.2169:

> Because the plaintiff's expert will be providing expert testimony on the appropriate or relevant standard of practice or care, not an inappropriate or irrelevant standard of practice or care, it follows that the plaintiff's expert witness must match the one most relevant standard of practice or care—the specialty engaged in by the defendant physician during the course of the alleged malpractice, and, if the defendant physician is board certified in that specialty, the plaintiff's expert must also be board certified in that specialty.

The Court in *Woodard* applied the relevant specialty test in two different cases. The first, *Woodard v Custer*, involved a defendant physician who possessed board certification in pediatrics and certificates of special qualifications in pediatric critical care medicine and neonatal-perinatal medicine. *Id. at 554*. The **[*18]** plaintiff's proposed expert witness had board certification in pediatrics, but lacked any certificates of added qualifications. *Id. at 554-555*. The alleged malpractice arose from the defendant's placement of an arterial line in an infant patient's leg while the infant was a patient in a pediatric intensive care unit. *Id. at 554, 575*. The Supreme Court held "that the trial court did not abuse its discretion in finding that the defendant physician was practicing pediatric critical care medicine at the time of the alleged malpractice, and, thus, pediatric critical care medicine is the one most relevant specialty." *Id. at 576*.

In the second case discussed in *Woodard, Hamilton v Kuligowski*, the defendant physician specialized in general internal medicine and practiced that specialty at the time of the alleged malpractice. *Id. at 577-578*. The plaintiff's proposed expert witness was also board certified in general internal medicine, but devoted the majority of his professional time to the practice of infectious diseases, a subspecialty of internal medicine. *Id. at 556, 578*. The plaintiff averred that the defendant "failed to properly diagnose and treat the decedent while she exhibited prestroke **[*19]** symptoms." *Id. at 556*. The plaintiff's expert admitted that he was "not sure what the average internist sees day in and day out." *Id.*

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at 578. The malpractice asserted in *Hamilton* had no connection to infection or the subspecialty of infectious diseases. The Supreme Court affirmed the trial court's finding that the plaintiff's proposed expert lacked the requisite qualification under MCL 600.2169(1)(b) because he failed to "satisfy the same practice/instruction requirement." *Id*.

Because § 2169(1) uses the word "specialty" rather than "specialties," the Supreme Court determined that the statute "requires the matching of a singular specialty, not multiple specialties." Woodard, 476 Mich at 559. The Supreme Court further explained that "the specialty requirement is tied to the occurrence of the alleged malpractice and not unrelated specialties that a defendant physician may hold." *Id*. The Supreme Court then addressed § 2169(1)(b), which requires that the plaintiff's expert have "'devoted a *majority* of his or her professional time to either' the 'active clinical practice' or the 'instruction of students' in 'the same specialty' as the defendant." Id. at 559-560 (emphasis in original). The **[*20]** Supreme Court added, "Obviously, a specialist can only devote a *majority* of his professional time to *one* specialty." Id. at 560 (emphasis in original).

Here, the purported malpractice arises from the interpretation of spine and hip films, which falls within the realm of two radiology specialties. The specialty requirement "tied to the . . . occurrence of the alleged malpractice" could include either diagnostic radiology or neuroradiology, depending on the qualifications of the physician who read the films. *Ante* at 2. Under the circumstances presented in this case, the two specialties qualify as closely related; indeed, they implicate interchangeable professional skills. Because the interpretation of spine and hip films fell within the intersection of diagnostic and radiology and neuroradiology, either constituted a relevant specialty.

Although Parnes and Bhimani share matching board certifications and virtually identical practice experience, the majority concludes that a mathematical calculation disqualifies Parnes from offering testimony in this case. In the majority's estimation, because Parnes "did not spend more than 50 percent of his professional time practicing the one relevant **[*21]** specialty of general diagnostic radiology," he cannot meet the statutory condition that a specialist has "devoted a majority of his or her professional time to ... [t]he active clinical practice" of the specialty practiced by the defendant "at the time of the occurrence that is the basis for the action." *Ante* at 3; MCL 600.2169(1)(a) and (b). The Legislature incorporated in MCL 600.2169(b) a 50-percent practice requirement as a second indicator of a proposed expert's familiarity with the standard of care. In addition to sharing the same board certification, the proposed expert must also have regular, hands-on experience in the medical field practiced by the defendant *at the time of the alleged malpractice*. As a simple measure of experience within a medical discipline, the Legislature established a 50-percent rule; the proposed expert must devote at least half his or her professional efforts to the specialty engaged in by the defendant at the time of the "occurrence" giving rise to the case. § 2169(a), (b)(*i*). A physician who spends half his time in a particular specialty likely has familiarity with the standard of care governing professional conduct in that field.

With respect to the **[*22]** majority's statement, "It is not disputed that diagnostic radiology is the one most relevant specialty involve here," I respectfully submit that the majority has mischaracterized plaintiff's position in this case. *Ante* at 2. At the hearing on Bhimani's motion for summary disposition, plaintiffs' counsel insisted that "there's a lot of overlapping" between the two fields, and explained that "when a radiologist is looking, say, at a spine film, there's a merging there because, you know, you've got nerves in the spine, you've got bones in the spine." Because the professional conduct at issue here falls within the realms of both neuroradiology and diagnostic radiology, the 50-percent calculus reasonably applies to *either* discipline. Stated differently, when interpreting images of the spine and immediately surrounding structures, a physician certified in both diagnostic radiology and neuroradiology engages in professional conduct implicating equally two professional disciplines. Under the circumstances presented here, the specialties are intimately related, and both are relevant. [3] Because Parnes devotes at least half his professional efforts to neuroradiology, I would hold that the text **[*23]** of MCL 600.2169(1)(b) sanctions Parnes's eligibility to testify in this case.

My analysis also comports with the Legislature's intent. In McDougall v Schanz, 461 Mich 15, 24-25; 597 NW2d 148 (1999), the Supreme Court explained that MCL 600.2169(1) "operates to preclude certain witnesses from testifying solely on the basis of the witness' lack of practice or teaching experience in the relevant

[3] In contrast, the plaintiff's expert in Hamilton, 476 Mich at 556, devoted the majority of his professional time to the practice of an unrelated and irrelevant specialty.

specialty." In a footnote, the Supreme Court quoted the legislative history: "'This proposal is designed to make sure that expert witnesses actually practice or teach medicine. In other words, to make sure that experts will have firsthand practical expertise in the subject matter about which they are testifying.'" *Id. at 25 n 9*. Parnes lacked neither training nor recent practice experience in interpreting spine and hip films. Regardless whether the mathematical calculation applies to time spent in diagnostic radiology or neuroradiology, Parnes's board certifications and regular practice experience equip him with firsthand knowledge **[*24]** of the standard of care applicable to Bhimani's interpretation of Johnson's spine and hip films. Consequently, I would reverse the circuit court's grant of summary disposition to Bhimani.

/s/ Elizabeth L. Gleicher

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APPENDIX 18

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Roberdeaux v. Evangelical Homes of Mich.

Court of Appeals of Michigan

October 18, 2016, Decided

No. 323802

Reporter
2016 Mich. App. LEXIS 2492 *; 2016 WL 9245786

DENNIS ROBERDEAUX, SR., Personal Representative, Plaintiff-Appellant, v EVANGELICAL HOMES OF MICHIGAN, doing business as EVANGELICAL HOME-SALINE, and MICHIGAN SPORTS MEDICINE & ORTHOPEDIC CENTER, Defendants, and WASHTENAW MEDICINE, P.C., doing business as WASHTENAW INTERNAL MEDICINE ASSOCIATES, CHERYL A. HUCKINS, M.D., and MARK A. KELLEY, M.D., Defendants-Appellees.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Subsequent History: Motion granted by *Estate of Roberdeaux v. Evangelical Homes of Mich., 890 N.W.2d 673, 2017 Mich. LEXIS 434 (Mich., Mar. 10, 2017)*

Leave to appeal denied by *Roberdeaux v. Evangelical Homes of Mich. (In re Estate of Roberdeaux), 500 Mich. 1025, 897 N.W.2d 164, 2017 Mich. LEXIS 1334 (June 30, 2017)*

Leave to appeal denied by *Roberdeaux v. Evangelical Homes of Mich. (In re Estate of Roberdeaux), 500 Mich. 1025, 897 N.W.2d 167, 2017 Mich. LEXIS 1337 (June 30, 2017)*

Prior History: **[*1]** Washtenaw Circuit Court. LC No. 13-000675-NH.

Core Terms

internal medicine, geriatric, medicine, specialty, practicing, trial court, alleged malpractice, hearsay, patients, board certified, clinical, blood clot, devoted, legs, board-certified, subspecialty, surgery, expert witness, nursing home, abuse of discretion, conversation, diseases, swelling, older, pain, proposed expert, testifying, questions, immediately preceding, emergency medicine

Judges: Before: SERVITTO, P.J., and WILDER and BOONSTRA, JJ. SERVITTO, P.J. (concurring in part and dissenting in part).

Opinion

PER CURIAM.

In this medical malpractice matter, plaintiff, as personal representative of the Estate of Linda Roberdeaux (hereinafter Linda or Linda Roberdeaux), appeals as of right the trial court's order dismissing with prejudice defendant, Evangelical Homes of Michigan, d/b/a Evangelical Home-Saline (hereinafter "Evangelical Saline"). Plaintiff also appeals from the judgment of no cause for action entered in favor of defendants, Washtenaw Medicine, P.C., d/b/a Washtenaw Internal Medicine Associates, P.C. (hereinafter "Washtenaw"), Cheryl Huckins, M.D., and Mark A. Kelley, M.D. We affirm in part, reverse in part, vacate in part, and remand for further proceedings consistent with this opinion.

I

This case arises from Linda Roberdeaux's death on October 14, 2009, from a pulmonary embolism. Linda underwent a total left knee replacement surgery on August 28, 2009, which was performed by Dr. Kelley. On August 31, 2009, Dr. Kelley ordered a venous Doppler study of Linda's leg based on her complaints of pain in her left calf and swelling. **[*2]** The Doppler did not reveal any sign of a blood clot.

Linda was discharged from the hospital on August 31, 2009, and moved to Evangelical Saline, a nursing facility, where she was treated by Dr. Huckins, an internal medicine physician. Dr. Huckins ordered another Doppler for Linda on September 8, 2009, because she had increased pain and swelling in her left

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calf.

Dr. Huckins's note in the records from September 9, 2009, indicated "Doppler left negative." She did not recall when and if she reviewed the report from the Doppler, although she testified that it would have been her practice to do so. The Doppler report indicated that there was no clot in the veins in the thigh, several veins were incompletely visualized, the exam was incomplete, and "isolated tibial vein thrombosis" could not be ruled out. Dr. Huckins believed this meant that even though certain veins were not well-visualized, "the physician reading the report did not feel that there was a question about those veins." Dr. Huckins testified that the Doppler was negative for the vessels that she was most concerned about. After reviewing the results of the Doppler, the contents did not cause her to change her care of Linda because **[*3]** it was her practice to follow up clinically with patients in similar situations and order a Doppler if there was any change in the patient's condition. There was no medical reason to place Linda on therapeutic anticoagulation medication. There is a risk-benefit analysis that must be conducted in deciding whether to administer anticoagulation therapy because of the risk of bleeding.

Linda traveled from Evangelical Saline to her first follow-up visit with Dr. Kelley on September 10, 2009. The purpose of the appointment was, in part, to check the wound and remove staples. Linda did not tell Dr. Kelley that she had a Doppler or had pain or swelling in her leg. Dr. Kelley also did not know that a Doppler had been performed, but he testified that he would not expect to be informed every time a doctor at Evangelical Saline ordered a Doppler. Moreover, Linda did not have any of the symptoms that she had complained of on September 8, 2009, her calves were soft, and she did not complain of pain or swelling.

Linda was discharged from Evangelical Saline and returned home on September 18, 2009. She visited Dr. Kelley again on September 28, 2009, October 8, 2009, and October 13, 2009. Dr. Kelley observed **[*4]** no signs of blood clots on September 28, 2009, and Linda did not complain of any pain, tenderness, or redness. The October 8, 2009 visit was unscheduled, and Linda had pain and redness around the scar, but she did not have swelling or tenderness in her calf.

According to Linda's mother, Theresa Collins, Linda visited Collins at least every other day after she returned home. Theresa Jackson, a licensed practical nurse (LPN) who assisted Collins daily, testified that she saw Linda at Collins's home on October 12, 2009, two days before her death. When Linda arrived, she was grimacing and indicated that she was in pain. Jackson observed Linda's legs and saw swelling on the left knee, calf, and ankle. Jackson encouraged Linda to discuss these issues with her doctor the next day. Linda's records from physical therapy on October 12, 2009, however, did not indicate that she had complaints of pain or swelling on that date.

At Linda's visit with Dr. Kelley on October 13, 2009, Linda had stiffness in the knee joint, but the redness was going away. Her leg was not warm or swollen. Dr. Kelley and Linda discussed Linda's plans to go to Florida and Dr. Kelley told Linda that she could travel to Florida. **[*5]** However, he did not clear her for Florida at that appointment and she was scheduled to see him again the next week. According to Dr. Kelley, if at any time Linda had exhibited any clinical signs or symptoms of a clot, or she had complained of pain or swelling, he would have ordered a Doppler. Linda visited Collins after her appointment on October 13, 2009.

Plaintiff, Linda's husband, testified that, at 11:00 p.m. on the night before her death, Linda "seemed okay." On the morning of October 14, 2009, Linda was nonresponsive when plaintiff tried to wake her up. Plaintiff called 911 and began performing CPR, but he believed she had already passed away. Plaintiff testified that he called Dr. Kelley that day and had a brief conversation with him in which plaintiff asked Dr. Kelley some questions. Dr. Kelley recalled plaintiff calling his office, but he did not recall plaintiff asking him questions, only informing him that Linda had passed away. According to plaintiff, the swelling in Linda's leg never went down after the surgery.

On July 3, 2013, plaintiff filed this medical malpractice action against defendants,[1] alleging that, despite Linda having experienced deep vein thrombosis (DVT) and/or **[*6]** pulmonary embolism before her death, her condition was not properly or timely diagnosed and treated. He further alleged that both Dr. Kelley and Dr. Huckins knew or should have known about Linda's risk factors, signs, and symptoms for DVT or pulmonary embolism. Plaintiff asserted that both doctors were negligent in failing to take further action after the Doppler study performed on September 9, 2009, which did not adequately rule out DVT. He claimed that, on

[1] The trial court granted defendant Michigan Sports Medicine & Orthopedic Center's motion for summary disposition and dismissed the complaint against it.

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October 13, 2009, Dr. Kelley told Linda that she had blood clots, but she did not need to worry because the clots would not travel to her lungs. Plaintiff claimed also that Dr. Kelley admitted, in the telephone conversation with plaintiff on October 14, 2009, that he had told Linda during the last visit that she had blood clots in her leg. Plaintiff alleged that defendants breached the standard of care resulting in Linda's death of a pulmonary embolism and that appropriate treatment and care would have prevented her death. Plaintiff sought economic and noneconomic damages.

Before trial, Dr. Kelley filed a motion to exclude hearsay. Specifically, Dr. Kelley sought to preclude plaintiff's testimony that Linda told him, after her visit **[*7]** with Dr. Kelley on October 13, 2009, that Dr. Kelley had said she had clots in her legs, but she should not worry about them because they would not move. Dr. Kelley denied making such statement and argued that the testimony was double hearsay that was not admissible under any exception to the hearsay rule. Plaintiff responded that the motion was premature and that he did not intend to offer any hearsay statements at trial.

Also before trial, plaintiff filed a motion to strike or disqualify Dr. Huckins's expert, Dr. John Voytas, from testifying at trial. Plaintiff argued that Dr. Huckins was board-certified in internal medicine and, at the time of the alleged malpractice, was practicing in the specialty area of internal medicine. He argued that Dr. Voytas did not meet the requirement of *MCL 600.2169(1)(b)* that, during the year before the alleged malpractice, the expert must have devoted a majority of his professional time to the active clinical practice of the specialty at issue. Plaintiff claimed that, during the relevant time, Dr. Voytas was board-certified in geriatric medicine and devoted a majority of his professional time to the clinical practice of geriatric medicine. Plaintiff argued that, while **[*8]** Dr. Huckins may claim that Dr. Voytas's geriatric practice overlaps with the field of internal medicine, geriatrics and internal medicine are two distinct specialties, or branches of medicine in which one can potentially become board-certified. Plaintiff cited and attached portions of deposition testimony of Dr. Voytas from 2009 in an unrelated case, as well as portions of Dr. Voytas's deposition testimony in this case.

In the unrelated case, Dr. Voytas testified that from 1984 to 1993 he was employed as an internal medicine physician. In 1994, he left the internal medicine practice, completed a mid-career geriatrics fellowship, and accepted a position in the Division of Geriatrics at Beaumont Hospital. He testified that internal medicine "involves the evaluation and management of medical conditions primarily in the adult," but internists "may also see some older patients either in their offices or in the hospital." Dr. Voytas also testified that "most geriatricians are internal medicine [doctors] by training." In 2009, Dr. Voytas spent two-thirds of his time as a medical director in the nursing home business and one-third of his time as a program director at Beaumont Hospital, training **[*9]** other physicians how to care for elderly patients.

In his deposition in this case, Dr. Voytas testified as follows:

> *Q*. Now, you have been listed as a geriatric physician; is that right?
>
> *A*. An internist and geriatrician, yes.
>
> *Q*. A geriatrician, is that something that has its own -- you had a fellowship in that particular area, didn't you?
>
> *A*. Yes, I took a fellowship.
>
> *Q*. If I understand it, sir, from your prior testimony that I have read, that in 1994 you left the internal medicine practice and completed a mid-career geriatrics fellowship at the Medical College of Pennsylvania; is that correct?
>
> *A*. Correct.
>
> *Q*. And since 1994 you have been doing geriatric medicine since?
>
> *A*. Predominantly. I mean I have ages that are under 65, if you consider 65 the beginning of geriatrics, but the predominance has been people 65 and older.
>
> *Q*. But your testimony has been that since that time, after taking your fellowship and being board certified as a geriatrician, greater than 50 percent of your practice has been regarding geriatric medicine?
>
> *A*. Correct, 65 and older.
> * * *
>
> *Q*. Okay. In prior testimony, sir, you have indicated that the majority of your practice is as a geriatric physician. Is that still true?
>
> *A*. Taking **[*10]** care of people over 65, if you call

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that geriatrics, yes.

Q. In your prior testimony you have indicated that the majority of your practice is geriatrics; is that correct?

A. Correct.

Q. And that was true in the years we are talking about, 2009.

A. Correct.

Q. And also in 2008, right?

A. Correct.

Dr. Voytas also testified that he is board-certified in geriatric medicine and most of his clinical work is in a nursing home environment, where the average age is approximately 82. He testified that, in 2008 and 2009, he had a full-time practice of geriatric medicine. During that time, he saw patients who were at risk for DVT. From 1994 to 2012, Dr. Voytas was on the medical staff in the geriatric division at Beaumont Hospital and was also an attending physician and medical director at Woodward Hills Nursing Home.

Dr. Huckins and Washtenaw filed a response to plaintiff's motion in which they argued that Dr. Huckins's and Dr. Voytas's active clinical practices were the same because they both devoted 100% of their time to the care and treatment of elderly patients. They argued that Dr. Huckins described her practice as "a skilled nursing facility specialist" under the broad umbrella of internal medicine. **[*11]** Dr. Voytas used the term geriatrics to describe his practice of taking care of patients 65 or older, which is a sub-specialty under the broad umbrella of internal medicine. Dr. Huckins and Washtenaw argued that it was undisputed that the majority of Dr. Voytas's clinical practice is exactly the same as Dr. Huckins's clinical practice. They further argued that either Dr. Huckins's and Dr. Voytas's practices were both 100% nursing home/subacute rehab under the umbrella of internal medicine, or, alternatively, considering what Dr. Huckins was actually doing at the time of the alleged malpractice, she was practicing geriatrics. They further argued that a physician does not have to be board-certified in a specialty to practice it. The purpose of the practice requirement is to prevent professional witnesses from testifying, but Dr. Voytas had a full-time practice at the time of the alleged malpractice. Dr. Huckins testified that she was a "skilled nursing facility specialist," and Dr. Voytas testified that the majority of his practice was the same as what Dr. Huckins did. The relevant area of inquiry regarding the practice requirement is what the physician was doing at the time of the alleged **[*12]** malpractice.

Dr. Huckins and Washtenaw attached Dr. Huckins's deposition testimony, in which she testified that, in 2008, she joined Washtenaw Medicine, a primary care practice. Before that time, she was a skilled nursing facility specialist with St. Joseph Mercy Medical Group. Dr. Huckins is board-certified in internal medicine. She testified that, in 2009, she "was doing a full-time practice in several different nursing homes." She saw patients, including Linda, as an internal medicine physician. Her role was as the "doctor of record," which was similar to an attending physician. Dr. Huckins and Washtenaw also attached Dr. Huckins's affidavit, in which she averred that, in 2009, the average age of her patients was 80 and 88% of her patients were 65 years of age or older.

At a hearing on various pretrial motions, Dr. Kelley argued that he denied making the alleged statement to Linda and nothing in his records or the physical therapy records from the day before the October 13, 2009 appointment would support the presence of clots. Dr. Kelley further argued that plaintiff testified that Linda's brother drove her to the visit when the alleged statements were made and then drove Linda to **[*13]** Collins's house where she repeated the statement; however, Linda's brother denied taking her to the visit, Collins said that only Jackson was also present during the conversation (not plaintiff), and Jackson testified that she was not at Collins' home on that date. Dr. Kelley argued that the inconsistent testimony regarding the alleged statements showed that the testimony was inherently unreliable and should not be admitted. He also argued that the trial court did not have to wait until trial to make a ruling. Plaintiff responded that he should able to reference the conversation regarding Linda's ability to go to Florida without admitting hearsay. The trial court granted Dr. Kelley's motion and excluded any testimony about purported statements made by Dr. Kelley to Linda on October 13, 2009, regarding clots in her legs. The trial court found that it was not premature to make a ruling on what clearly constituted hearsay, but would rule on any other related evidentiary issues as they arose at trial. The trial court's order provided that "neither counsel nor any witness shall comment upon/refer to/or testify regarding alleged discussions as occurred between [Linda] and Dr. Kelley at the **[*14]** office visit of October 13, 2009 with respect to blood clots being in [Linda's] leg but that such clots would not move."

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Regarding the motion to strike Dr. Voytas as an expert witness, the parties argued consistently with their briefs. Plaintiff also argued in rebuttal that there was no board specialty in nursing home practice. The trial court found that Dr. Huckins and Dr. Voytas practiced "the exact same medicine." The trial court stated:

> [T]he fact of matter is that they were each practicing more than 50 percent of their time practicing medicine on elderly patients. We all know that Geriatrics is fundamentally Internal Medicine for older patients. So there is no question that Dr. Voitus [sic] is qualified. They were both internists--Internal Medicine Board-certified and they're both doing the exact same kind of work, so motion is denied.[2]

At trial, plaintiff called three expert witnesses. Before Jackson's testimony, Dr. Kelley's counsel objected to Jackson giving diagnosis testimony, which he argued was not permissible. Plaintiff's counsel responded that Jackson would only testify to what she saw and did. Dr. Kelley's counsel requested that Jackson be prohibited from testifying about her **[*15]** discussion with Linda regarding Coumadin, which she argued was "expert testimony." Plaintiff's counsel responded that Jackson's statement to Linda that "you must be on Coumadin" was not hearsay and merely led to Jackson looking at Linda's legs. The trial court ruled that it would allow Jackson to testify regarding what she saw, but that her statement implied that Linda should be on Coumadin, which was "sort of [a] medical judgment." The trial court also ruled that Jackson could not testify that she told Linda that she could go and have a Doppler because such testimony was also a medical judgment and was not relevant.

Outside the presence of the jury, Jackson testified that she made a statement to Linda that she suspected she was on blood thinner after her surgery. When Linda said that she was not, Jackson was stunned because she works with numerous individuals who have had hip or knee replacements and 90% of the time they are on Coumadin or a blood thinner. After examining Linda's legs, Jackson encouraged Linda to go to the emergency room for testing. When Linda said she was going to see her doctor the next day, Jackson told her to show her doctor where it hurts. Jackson told Linda **[*16]** that the worst case scenario was a pulmonary embolism.

After plaintiff rested his case, plaintiff's counsel indicated that she had honored the trial court's ruling regarding conversations with Dr. Kelley about blood clots, but that she wanted to make a record of testimony that she would have elicited from plaintiff. She read plaintiff's deposition testimony in which he testified that he called Dr. Kelley on October 14, 2009, and Dr. Kelley confirmed that he told Linda that she had blood clots in her legs, but they would not move. Plaintiff's counsel also read Collins's deposition testimony in which she testified that Linda told her that Dr. Kelley said she had a blood clot, but he did not think it would not move. Plaintiff's counsel argued that his statement was not hearsay because he was the declarant, Dr. Kelley's statement was admissible as a party admission, and Collins's statement was admissible under *MRE 803(24)* (the "catch-all" hearsay exception). Dr. Kelley's counsel responded that the trial court properly ruled that such statements were hearsay and reiterated her argument that there was inconsistent testimony from the depositions regarding who was present when Linda's statements were **[*17]** made. The trial court stood by its rulings, finding that the statements were hearsay without an exception and there was no "inherent reliability factor in this instance."

Defendants presented the testimony of three experts at trial—Dr. Voytas testified regarding the standard of care applicable to Dr. Huckins, Dr. Casey Bartman testified regarding the standard of care applicable to Dr. Kelley, and Dr. Thomas Gravelyn testified regarding causation. The jury returned a verdict finding that neither Dr. Huckins nor Dr. Kelley was professionally negligent and the trial court entered a judgment of no cause for action in favor of Washtenaw, Dr. Huckins, and Dr. Kelley.

Following entry of the judgment, Dr. Huckins and Washtenaw filed a motion for case evaluation sanctions and taxable costs in the amount of $84,212.22. The trial court entered an order finding that plaintiff's counsel had first priority to any settlement proceeds and assets of the estate, Dr. Huckins and Washtenaw had second priority, the amount of taxed costs was $7,840, and the amount of case evaluations sanctions was $78,811.82.

After stipulation of the parties, the trial court entered an order dismissing Evangelical Saline ***[*18]*** *nunc pro tunc*, as of September 10, 2014. This appeal ensued.

II

Plaintiff first contends that the trial court erred by allowing Dr. Voytas to provide standard-of-care testimony because he was not qualified to do so under

[2] The trial court denied a similar motion filed by Dr. Huckins and Washtenaw to exclude plaintiff's expert, stating that "both sides are making way too much of an artificial distinction between--between nursing home medicine and medicine."

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MCL 600.2169(1)(b). We disagree.

"This Court reviews for an abuse of discretion a trial court's determination of the qualifications of a proposed expert witness." Chapin v A & L Parts, Inc, 274 Mich App 122, 126; 732 NW2d 578 (2007). "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." Woodard v Custer, 476 Mich 545, 557; 719 NW2d 842 (2006). "Questions of statutory interpretation are reviewed de novo. *Id.*

MCL 600.2169(1) provides, in relevant part:

> In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, **[*19]** the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.

In Woodard, 476 Mich at 560, the Michigan Supreme Court held that, under MCL 600.2169(1), "the plaintiff's expert witness must match the one most relevant standard of practice or care—the specialty engaged in by the defendant physician during the course of the alleged malpractice, and, if the defendant physician is board certified in that specialty, the plaintiff's expert must also be board certified in that specialty." The Court further held that "a 'specialty' is a particular branch of medicine or surgery in which one can potentially become board certified." Id. at 561. Therefore, "if the defendant physician practices a particular branch of medicine or surgery in which one can potentially become board **[*20]** certified, the plaintiff's expert must practice or teach the same particular branch of medicine or surgery." Id. at 561-562. Moreover, "a 'subspecialty' is a particular branch of medicine or surgery in which one can potentially become board certified that falls under a specialty or within the hierarchy of that specialty," and is also considered a specialty. Id. at 562. The Court also stated that, under MCL 600.2169(1)(a), "the proposed expert witness must have the same board certification as the party against whom or on whose behalf the testimony is offered." Id. at 562-563 (citation and quotation marks omitted). The Court held that

> in order to be qualified to testify under § 2169(1)(b), the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty. [Id. at 566.]

In the companion case to *Woodard, Hamilton v Kuligowski*, the Court held that the proposed expert did not satisfy the practice requirement of MCL 600.2169(1)(b) where the defendant physician specialized in general internal medicine and was **[*21]** practicing general internal medicine at the time of the alleged malpractice, but the proposed expert did not devote a majority of his professional time to practicing or teaching general internal medicine in the year immediately preceding the alleged malpractice. Woodard, 476 Mich at 577-578. Rather, the proposed expert spent a majority of his professional time treating infectious diseases, a subspecialty of internal medicine. Id. at 556, 578.

A defendant doctor may, however, be practicing outside his or her area of board-certification at the time the alleged malpractice occurs. In Reeves v Carson City Hosp (On Remand), 274 Mich App 622, 623, 628; 736 NW2d 284 (2007), the defendant doctor was board-certified in family medicine, but was working in the emergency room at the time of the alleged malpractice. The Court concluded that because the defendant doctor was practicing emergency medicine at the time of the alleged malpractice and could potentially become board-certified in emergency medicine, she was a specialist in emergency medicine. Id. at 628-630. Therefore, the Court held that the plaintiff needed a specialist in emergency medicine to satisfy MCL

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600.2169. Id. at 630. The proposed expert was board-certified in emergency medicine, but the Court remanded for the trial court to determine whether the proposed expert devoted a majority of his **[*22]** professional time during the year preceding the alleged malpractice to the active clinical practice of emergency medicine or the instruction of students. *Id.*

There is no dispute that Dr. Voytas satisfied the requirement of MCL 600.2169(1)(a). Dr. Huckins was board-certified in internal medicine and Dr. Voytas was board-certified in internal medicine as well as geriatric medicine. At issue in this case is the practice requirement of MCL 600.2169(1)(b). Plaintiff contends that because Dr. Huckins testified that she was practicing internal medicine when she treated Linda and, because Dr. Voytas testified that he spent the majority of his time during the relevant period practicing geriatric medicine, Dr. Voytas was not qualified under MCL 600.2169(1)(b).

Geriatric medicine and internal medicine are distinct specialties, as one can become board-certified in either and geriatric medicine is also a subspecialty of internal medicine. Woodard, 476 Mich at 561-562. "Internal medicine" is "the branch of medicine concerned with nonsurgical diseases in adults, but not including diseases limited to the skin or to the nervous system." *Stedman's Medical Dictionary* (28th ed). "Geriatric medicine" is "a specialty of medicine that is concerned with the disease and health problems of **[*23]** older people, usually those over 65 year of age. Considered a subspecialty of internal medicine." *Id.* Accordingly, if Dr. Huckins was practicing internal medicine at the time of the alleged malpractice and Dr. Voytas devoted the majority of his professional time during the year preceding the alleged malpractice to geriatric medicine, a subspecialty of internal medicine, then Dr. Voytas did not satisfy the practice requirement. See Woodard, 476 Mich at 577-578. However, Dr. Huckins and Washtenaw argue that, considering what Dr. Huckins and Dr. Voytas were actually doing at the relevant times, then either (1) Dr. Huckins was actually practicing geriatric medicine at the time of the alleged malpractice, or (2) Dr. Voytas was actually practicing internal medicine in the year preceding the alleged malpractice.

The trial court did not clearly identify the relevant specialty, but instructed the jury that the standard of care applicable to Dr. Huckins was that of an internal medicine doctor. We agree with the trial court and reject Dr. Huckins and Washtenaw's argument that Dr. Huckins was actually practicing geriatric medicine at the time of the alleged malpractice. As the above definitions show, geriatrics is not merely **[*24]** about the age of the patients—it relates to problems and diseases related to old age. Moreover, internal medicine is broad and may include the treatment of elderly patients. Accordingly, this case is unlike *Reeves*, in which the defendant doctor working in the emergency room was clearly practicing emergency medicine and not family medicine. See Reeves, 274 Mich App at 628. Rather, a doctor treating elderly patients in a nursing home could be practicing internal medicine or geriatric medicine. And in this case, there was no evidence that Dr. Huckins was dealing with problems related to old age, rather than practicing internal medicine with patients who were predominantly elderly. Accordingly, the trial court properly found that the applicable standard of care was that of an internal medicine physician at the time of the alleged malpractice.

Nonetheless, the trial court could have found that Dr. Voytas spent the majority of his time practicing internal medicine in the year preceding the alleged malpractice. Dr. Voytas's testimony that he predominantly practiced "geriatrics" is not conclusive of what he was actually practicing during the relevant period, particularly where he described his "geriatric" practice merely **[*25]** as "[t]aking care of people over 65." Again, the definitions show that geriatrics is about more than the age of the patient and Dr. Voytas testified that internists may also treat elderly patients. It is necessary to consider what Dr. Voytas actually did in his practice. In this case, Dr. Voytas predominantly treated patients 65 or older as a medical director and attending physician in a nursing home. Similarly, at the time of the alleged malpractice, Dr. Huckins was treating Linda, who was 65 years old, in a nursing home as the "doctor of record," similar to an attending physician. Both saw patients who were at risk for DVT. Although there was no further testimony regarding the particular issues, problems, or diseases that either doctor treated, the trial court did not abuse its discretion in finding that Dr. Voytas did the same thing as Dr. Huckins, internal medicine, based on the record before it. Because Dr. Voytas spent a majority of his professional time practicing in the specialty of internal medicine in the year preceding the alleged malpractice, Dr. Voytas was qualified under MCL 600.2169(1)(b). Because Dr. Voytas was qualified, the trial court did not abuse its discretion in allowing him to testify **[*26]** at trial.

III

Next, plaintiff contends that the trial court committed

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error requiring reversal by refusing to admit the substance of his telephone conversation with Dr. Kelley on the day of Linda's death. According to plaintiff, he asked Dr. Kelley whether Dr. Kelley told Linda that she had blood clots, and Dr. Kelley said that he did. Plaintiff argues that his questions to Dr. Kelley did not constitute hearsay because they were not assertions. Plaintiff further argues that Dr. Kelley's response was exempt from the hearsay rule as a statement of a party opponent under MRE 801(d)(2)(A). We agree in both respects.[3]

"A trial court's decision whether to admit evidence is reviewed for an abuse of discretion, but preliminary legal determinations of admissibility are reviewed de novo." *Albro v Drayer, 303 Mich App 758, 760; 846 NW2d 70 (2014)*. "An abuse of discretion occurs when the trial court's decision results in an outcome falling outside the range of principled outcomes." *Dep't of Transp v Gilling, 289 Mich App 219, 243; 796 NW2d 476 (2010)*.

"'Hearsay' is a statement, other than the one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted." MRE 801(c). "A 'statement' is (1) an oral or written *assertion* or (2) nonverbal conduct of a person, if it is intended by the person **[*27]** as an *assertion*." MRE 801(a) (emphasis added). We agree with plaintiff that his questions to Dr. Kelley were not assertions and, therefore, did not constitute hearsay. However, the questions alone, without Dr. Kelley's response, would not have been helpful to plaintiff's case, and the trial court's failure to admit plaintiff's testimony regarding the questions alone is harmless. See MCR 2.613(A). The determinative issue is whether plaintiff's testimony regarding Dr. Kelley's response, which was an assertion, was admissible as non-hearsay.

MRE 801(d)(2) provides that "[a] statement is not hearsay if--"

> The statement is offered against a party and is (A) the party's own statement, in either an individual or a representative capacity, except statements made in connection with a guilty plea to a misdemeanor motor vehicle violation or an admission of responsibility for a civil infraction under laws pertaining to motor vehicles, or (B) a statement of which the party has manifested an adoption or belief in its truth, or (C) a statement by a person authorized by the party to make a statement concerning the subject, or (D) a statement by the party's agent or servant concerning a matter within the scope of the agency or employment, **[*28]** made during the existence of the relationship, or (E) a statement by a coconspirator of a party during the course and in furtherance of the conspiracy on independent proof of the conspiracy.

The above rule "allows admission of a statement offered against a party when it is the party's own statement, in either an individual or a representative capacity." *Merrow v Bofferding, 458 Mich 617, 633; 581 NW2d 696 (1998)*. The party seeking to introduce the statement has the burden of proving, by a preponderance of the evidence, that the alleged proponent actually said it. *Id. at 633 n 14*. But the fact that the alleged proponent denies making the statement "does not render the statement inadmissible[.]" *Bradbury v Ford Motor Co, 123 Mich App 179, 188; 333 NW2d 214 (1983)*, judgment mod by *419 Mich 550; 358 N.W.2d 550 (1984)*. Rather, "if he denies it, a jury question of credibility is raised." *Id.*

Here, plaintiff laid a proper foundation regarding the source of the statement in question. Specifically, plaintiff testified unequivocally that the source of the statement was Dr. Kelley, who is a named defendant and therefore plaintiff's party opponent. It is true that Dr. Kelley did not recall plaintiff asking him any questions during the telephone conversation. Additionally, in his motion to exclude hearsay, Dr. Kelley denied having told plaintiff that he told Linda that **[*29]** she had blood clots. But Dr. Kelley's denial in that regard did not make plaintiff's proffered testimony inadmissible. Instead, the denial created a credibility issue that should have been submitted to the jury. Thus, the trial court erred by concluding that the testimony at issue was inadmissible. Such error resulted in an abuse of discretion. See *Kidder v Ptacin, 284 Mich App 166, 170; 771 NW2d 806 (2009)* ("A court by definition abuses its discretion when it makes an error of law.") (quotation marks and citation omitted).

Moreover, we cannot conclude that the trial court's error

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[3] Because plaintiff did not raise this issue at trial until after he rested his case, it is arguably unpreserved. See *Hines v Volkswagen of America, Inc, 265 Mich App 432, 443; 695 NW2d 84 (2005)*. Nevertheless, we exercise our discretion to review this issue because doing so is necessary to properly decide this matter and because the record is sufficient to permit our consideration of the legal questions involved. See *Smith v Foerster-Bolser Constr, Inc, 269 Mich App 424, 427; 711 NW2d 421 (2006)*.

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was harmless. In pertinent part, MRE 103(a) provides, "Error may not be predicated upon a ruling which admits or excludes evidence unless a substantial right of the party is affected[.]" Similarly, MCR 2.613(A) provides, in pertinent part, "An error in the admission or the exclusion of evidence . . . is not ground for granting a new trial, for setting aside a verdict, or for vacating, modifying, or otherwise disturbing a judgment or order, unless refusal to take this action appears to the court inconsistent with substantial justice." The testimony at issue here is directly material and presents an issue of witness credibility. As established by an offer of proof at trial, plaintiff would **[*30]** have testified that he called Dr. Kelley on October 14, 2009—the day the decedent died—and during that telephone conversation Dr. Kelley admitted that, during his appointment with the decedent the day prior, he told her that she had blood clots in her legs, but they would not move. If believed by the jury, plaintiff's testimony was evidence that just a day before the decedent suffered her fatal pulmonary embolism, Dr. Kelley was aware that she had blood clots in her legs but took no measures to treat the condition. Thus, we cannot conclude that the trial court's failure to admit the evidence was harmless. Consequently, we reverse the trial court's evidentiary ruling and remand for a new trial as to Dr. Kelley only.

IV

Plaintiff also argues that the trial court erred by refusing to allow Jackson to testify regarding her reaction to what she saw or her conversation with Linda regarding Coumadin on October 12, 2009. We disagree.

"We review for an abuse of discretion a trial court's decision to admit or exclude evidence. An abuse of discretion occurs when the trial court's decision results in an outcome falling outside the range of principled outcomes." Gilling, 289 Mich App at 243 (citations omitted).

Because Jackson **[*31]** was not qualified as an expert, the admissibility of her testimony is governed by MRE 701, which provides:

> If the witness is not testifying as an expert, the witness' testimony in the form of opinions or inferences is limited to those opinions or inferences which are (a) rationally based on the perception of the witness and (b) helpful to a clear understanding of the witness' testimony or the determination of a fact in issue.

Plaintiff argues that Jackson's testimony was not relevant as a diagnosis, but was relevant because "even a person with her level of training and experience had serious concerns based on [Linda's] condition and the symptoms she was reporting." However, whether Linda should have been on a blood thinner, whether Linda should have gone to the emergency room to have a Doppler performed, and whether Linda was at risk for a pulmonary embolism are beyond the scope of lay knowledge. Jackson's excluded testimony itself showed that her statements about blood thinners were based on her specialized knowledge as a nurse, not merely her observations. Cf. Mitchell v Steward Oldford & Sons, Inc, 163 Mich App 622, 630; 415 NW2d 224 (1987) (concluding that the police officer's testimony "was not overly dependent on scientific, technical or other specialized knowledge"). **[*32]** Jackson's opinion was not helpful to the jury in determining whether Linda should have been on a blood thinner. Therefore, the trial court did not abuse its discretion in excluding Jackson's testimony. See Gilling, 289 Mich App at 243.

V

Next, plaintiff contends that the trial court erred by refusing to allow plaintiff and Collins to testify that Linda stated that Dr. Kelley told her, during the October 13, 2009 appointment, that she had blood clots, but they would not move. Plaintiff argues that such testimony was admissible under *MRE 803(24)*. We disagree.

We note that plaintiff only argued below that Collins's testimony was admissible under *MRE 803(24)*. Nonetheless, because the content of Collins's testimony regarding Linda's statement was the same as plaintiff's testimony, we are considering such testimony together, and the result would be the same under the plain error standard of review, we will consider this issue as preserved. "We review for an abuse of discretion a trial court's decision to admit or exclude evidence. An abuse of discretion occurs when the trial court's decision results in an outcome falling outside the range of principled outcomes." Gilling, 289 Mich App at 243 (citations omitted).

MRE 803(24) provides:

> A statement not specifically covered by any of **[*33]** the foregoing exceptions but having equivalent circumstantial guarantees of trustworthiness, if the court determines that (A) the statement is offered as evidence of a material fact, (B) the statement is more probative on the point for which it is offered than any other evidence that the proponent can procure through reasonable efforts, and (C) the general purposes of these rules and the

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> interests of justice will best be served by admission of the statement into evidence. However, a statement may not be admitted under this exception unless the proponent of the statement makes known to the adverse party, sufficiently in advance of the trial or hearing to provide the adverse party with a fair opportunity to prepare to meet it, the proponent's intention to offer the statement and the particulars of it, including the name and address of the declarant.

This Court has stated:

> *MRE 803(24)* is the "catch-all" exception to the hearsay rule. Evidence admitted under *MRE 803(24)* must satisfy four elements: "(1) it must have circumstantial guarantees of trustworthiness equal to the categorical exceptions, (2) it must tend to establish a material fact, (3) it must be the most probative evidence on the fact that the offering **[*34]** party could produce through reasonable efforts, and (4) its admission must serve the interests of justice." [*Detroit/Wayne Co Stadium Auth v Drinkwater, Taylor, and Merrill, Inc, 267 Mich App 625, 651; 705 NW2d 549 (2005)* (citation omitted).]

In considering "double hearsay," such as Linda's statement regarding what Dr. Kelley said at the October 13, 2009 appointment, each statement must fall within a hearsay exception. See *Solomon v Shuell, 435 Mich 104, 129, 457 NW2d 669 (1990)* ("Under *MRE 805*, hearsay within hearsay is excluded where no foundation has been established to bring each independent hearsay statement within a hearsay exception."). Therefore, in order for plaintiff's and Collins's testimony to be admissible, both Linda's statement and Dr. Kelley's statement must have satisfied the requirements of *MRE 803(24)*.

Even assuming that the statements had circumstantial guarantees of trustworthiness and tended to establish a material fact, i.e., that Dr. Kelley was aware that Linda had blood clots on October 13, 2009, the statements were not the most probative evidence on that fact that plaintiff could produce through reasonable efforts. See *Detroit/Wayne Co Stadium Auth, 267 Mich App at 651*. Rather, Dr. Kelley's testimony and the medical records were the most probative evidence of whether Dr. Kelley knew that Linda had blood clots on October 13, 2009, both of which were produced at trial.[4] Moreover, given Dr. Kelley's **[*35]** argument regarding the inconsistencies in the testimony that she would have elicited, the admission of such statements would not have served the interests of justice. Accordingly, the trial court did not abuse its discretion in excluding the testimony of plaintiff and Collins.

VI

Finally, plaintiff argues that because the trial court's judgment must be reversed, the trial court's award of case evaluation sanctions must also be reversed. Having concluded that remand for a new trial is necessary, we vacate the trial court's order granting defendants case evaluation sanctions.

Affirmed in part, reversed in part, vacated in part, and remanded for further proceedings consistent with this opinion. No party having prevailed in full, no costs may be taxed under *MCR 7.219*. We do not retain jurisdiction.

/s/ Kurtis T. Wilder

/s/ Mark T. Boonstra

Concur by: Deborah A. Servitto (In Part)

Dissent by: Deborah A. Servitto (In Part)

Dissent

SERVITTO, P.J. (*concurring in part and dissenting in part*).

I agree with most of the majority's conclusions in this case. I would have found, however, that the trial court abused its discretion in allowing Dr. Voytas to provide standard-of-care testimony in this case. Thus, on that issue, I respectfully dissent. **[*36]**

MCL 600.2169 governs expert testimony on the appropriate standard of care and provides, in part, as follows:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the

[4] This Court may not, however, consider whether the evidence produced at trial corroborates the statement. *People v Lee, 243 Mich App 163, 178; 622 NW2d 71 (2000)*.

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person is licensed as a health professional in this state or another state and meets the following criteria:
(a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

(b) Subject to *subdivision (c)*, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:

(*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party **[*37]** is a specialist, the active clinical practice of that specialty.

(*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

Interpreting *MCL 600.2169*, our Supreme Court explained, "Although specialties and board certificates must match, not *all* specialties and board certificates must match." *Woodard v Custer, 476 Mich 545, 558; 719 NW2d 842 (2006)*. ". . . *§ 2169(1)* should not be understood to require such witness to specialize in specialties and possess board certificates that are not relevant to the standard of medical practice or care about which the witness is to testify . . . [it] operates to preclude certain witnesses from testifying solely on the basis of the witness' lack of practice or teaching experience in the *relevant* specialty." *Id. at 559* (internal citation omitted). "A 'specialty' is a particular branch of medicine or surgery in which one can potentially become board certified. Accordingly, if the defendant physician **[*38]** practices a particular branch of medicine or surgery in which one can potentially become board certified, the [] expert must practice or teach the same particular branch of medicine or surgery." *Id. at 561-562*.

Prior to trial, plaintiff moved to strike and/or disqualify Dr. Voytas from testifying as an expert at trial. Plaintiff pointed out that defendant Dr. Cheryl Huckins was board certified in internal medicine and testified at deposition that she saw the decedent as an internal medical physician. She is not, according to her deposition testimony, board certified in any other specialty. Thus, an expert witness testifying on behalf of Dr. Huckins must, in order to comply with *MCL 600.2169*, *(1)* be board certified in internal medicine, (2) during the year immediately preceding the date of the occurrence that is the basis for the claim or action, have devoted a majority of his or her professional time to the active clinical practice of internal medicine.

Dr. Voytas, the proposed expert on behalf of Dr. Huckins is board certified in internal medicine and geriatric medicine. Dr. Voytas testified at deposition in this case that since 1994, he has predominantly worked in geriatric medicine, devoting greater than 50% **[*39]** of his time since then to the practice of geriatric medicine. At a deposition in an unrelated 2009 case, Dr. Voytas testified that he worked as an internal medicine physician from 1984 to 1994, at which point he left internal medicine practice, completed a geriatrics fellowship, and accepted a position in the geriatrics division at Beaumont Hospital, where he has been since. Dr. Voytas testified that the practice of internal medicine involves the evaluation and management of medical conditions (including the most common conditions) primarily in adults.

Stedman's Medical Dictionary (26th ed.) defines "internal medicine" as "the branch of medicine concerned with nonsurgical diseases in adults, but not including diseases limited to the skin or to the nervous system." "Geriatric medicine" is defined as "a subspecialty of medicine that is concerned with the disease and health problems of older people, usually those over 65 years of age. Considered a subspecialty of internal medicine." *Id.* According to *Woodward, 476 Mich at 562*:

> [A] "subspecialty" is a particular branch of medicine or surgery in which one can potentially become board certified that falls under a specialty or within the hierarchy of that specialty. A subspecialty, **[*40]** although a more particularized specialty, is nevertheless a specialty. Therefore, if a defendant physician specializes in a subspecialty, the plaintiff's expert witness must have specialized

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> in the same subspecialty as the defendant physician at the time of the occurrence that is the basis for the action.

As the majority notes, the trial court instructed the jury that the standard of care applicable to Dr. Huckins was that of an internal medicine doctor. The majority also agrees that Dr. Huckins was not practicing geriatric medicine at the time of the alleged malpractice. Given the above, and Dr. Voytas's testimony, I cannot agree that a logical conclusion would be that Dr. Voytas could testify on behalf of Dr. Huckins as an expert in internal medicine.

At his deposition in this case, Dr. Voytas unequivocally testified that since 1994 greater than 50% of his practice has been in geriatric medicine. He further testified that from 1994 through 2012 he had two responsibilities: one as being "on the medical staff of Beaumont Hospital in the division of geriatric medicine—the last six of those years being the actual program director" and the second responsibility as "an attending physician **[*41]** as well as the medical director of the Woodward Hills Nursing Home . . . ." Dr. Voytas thus *did not*, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devote a majority of his or her professional time to the active clinical practice of internal medicine and thus did not qualify as an expert witness under *MCL 600.2169*. As stated in *Woodward, 476 Mich at 566*, "one cannot devote a 'majority' of one's professional time to more than one specialty. Therefore, in order to be qualified to testify under *§ 2169(1)(b)*, the [] expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty." Where the medical community and our Supreme Court have found it appropriate to determine that internal medicine and geriatric medicine are two different specialties (or one being a subspecialty of the other, and thus a specialty of its own), I would find that the trial court abused its discretion in allowing Dr. Voytas to provide standard-of-care **[*42]** testimony in this case. Because Dr. Voytas was the only expert providing expert testimony on Dr. Huckins's behalf regarding the standard of care, reversal and remand for a new trial are warranted on the claims against Dr. Huckins and Washtenaw.

Because I find reversal and remand for a new trial appropriate with respect to defendants Dr. Huckins, Washtenaw, and Dr. Kelley, I would also necessarily reverse the award of attorney fees and costs in favor of these defendants.

/s/ Deborah A. Servitto

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APPENDIX 19

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Stevens v. Lansing Anesthesiologists, P.C.

Court of Appeals of Michigan

November 17, 2016, Decided

No. 328971

Reporter
2016 Mich. App. LEXIS 2120 *

CINDY STEVENS and STEVE STEVENS, Plaintiffs-Appellants, v LANSING ANESTHESIOLOGISTS, P.C., INGHAM REGIONAL MEDICAL CENTER, and MCLAREN HEALTH CARE CORP, Defendants, and DOUGLAS BEZ, D.O., Defendant-Appellee.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Prior History: [*1] Ingham Circuit Court. LC. No. 13-000056-NH.

Core Terms

trial court, specialty, plaintiffs', practicing, witness list, anesthesiology, expert witness, qualifications, alleged malpractice, devoted, directed verdict, board certified, pain management, anesthesiologist, surgery, standard of care, malpractice, discovery, clinical, proposed expert, preceding, trial court's finding, abuse of discretion, internal medicine, motion to amend, subspecialty, notice

Judges: Before: Owens, P.J., and HOEKSTRA and BECKERING, JJ.

Opinion

PER CURIAM.

In this medical malpractice action, plaintiffs Cindy Stevens and Steve Stevens appeal as of right the trial court's order granting a directed verdict to defendant Douglas Bez, D.O. based on plaintiffs' failure to proffer a qualified expert on the standard of care under *MCL 600.2169(1)(b)(i)*.[1] Because the trial court did not abuse its discretion by excluding the opinion of plaintiffs' expert, the trial court's grant of a directed verdict was not erroneous given the absence of expert testimony supporting plaintiffs' medical malpractice claim, and the trial court did not abuse its discretion by denying plaintiffs' request to add an unidentified replacement expert to their witness list mid-trial, we affirm.

I. FACTS & PROCEDURAL HISTORY

In October 2011, plaintiff underwent coronary arterial bypass graft (CABG) surgery. The CABG surgery was successful, but plaintiff experienced complications related to the injection of sodium bicarbonate through a peripheral intravenous ("IV") **[*2]** line placed in her right hand, which caused the tissue to become necrotic and required multiple surgeries. As a result, plaintiff has significant scarring and she continues to suffer pain as well as loss of function in her hand.

In 2012, plaintiffs provided defendant, the anesthesiologist in charge of plaintiff's medications during the surgery, with a notice of intent to file suit.[2] Plaintiffs later filed a three-count complaint, alleging medical malpractice, ordinary and gross negligence, and loss of consortium. Plaintiffs' theory was that defendant breached the standard of care by administering sodium bicarbonate, the caustic substance that caused plaintiff's injury, through the IV in plaintiff's hand rather than through the central IV line.

Plaintiffs attached an affidavit of merit (AOM) to their complaint, provided by Jason Brajer, M.D. With respect

[1] Throughout this opinion, "plaintiff" refers to Cindy Stevens individually, whereas "plaintiffs" refers to both Cindy and Steve Stevens.

[2] Plaintiffs also filed suit against Lansing Anesthesiologists, P.C., Ingham Regional Medical Center, and McClaren Health Care Corporation. These parties were dismissed from the action by stipulation.

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to Dr. Brajer's qualifications, the AOM provided:

> 2. I graduated from Johns Hopkins University in 1976 with a Bachelor of Arts, and received **[*3]** my Doctor of Medicine degree from Hahnemann Medical College in 1980. I completed an internship at Albert Einstein Medical Center in 1981, and an Anesthesiology Residency at Thomas Jefferson University in 1984. I completed a fellowship in Cardiovascular Anesthesia and Obstetrical Anesthesia at Thomas Jefferson University in 1985;
> 3. During the year preceding the alleged malpractice I practiced on a full time basis as an anesthesiologist with 100% of my time devoted to clinical practice. I currently practice as a full time anesthesiologist with 100% of my time devoted to clinical practice at Grossinger NeuroPain Specialists in Ridley Park, Pennsylvania[.]

During discovery, Dr. Brajer testified at his deposition that the last time he performed anesthesia in a CABG procedure was in 1988. He indicated that he left the hospital system altogether in 2008, after which he did some "part-time anesthesia" through early 2009, but "basically, effective[], as of September of 2008," he had been practicing "office-based pain management." He explained that his pain management practice entailed x-ray guided interventional spine and large joint injections for the treatment of semi-acute and chronic pain. **[*4]**

Trial ensued during which plaintiffs, after presenting eight of their witnesses, sought to introduce Dr. Brajer as an expert in the "field of anesthesiology" in order to establish the applicable standard of care. Dr. Brajer testified that he currently practiced in "pain management," but that he had participated in "at least a thousand" cardiac surgeries as an anesthesiologist. During voir dire, he clarified that he had not participated as an anesthesiologist in a hospital procedure for "[a] little less than three years" before plaintiff's CABG procedure. He further admitted that he had not participated in a CABG procedure since 1988, 23 years earlier. Upon further questioning, he confirmed that he was board certified in pain management, which he admitted does not require one to be an anesthesiologist.

Defendant then moved to strike Dr. Brajer as an expert witness under MCL 600.2169(1). The trial court granted defendant's request, concluding that defendant's specialty was anesthesiology and that, although Dr. Brajer was a board certified anesthesiologist, Dr. Brajer was not qualified as an expert witness "based on the *Woodard*[3] case" because he "was not practicing anesthesiology in the year prior to the **[*5]** incident in this matter [as required by MCL 600.2169(1)(b)(i)]. He was practicing pain management." The trial court then granted defendant's related motion for a directed verdict and denied plaintiffs' motion to amend their witness list to add a new, yet to be identified, expert. Plaintiffs appeal as of right.

II. MOTION TO STRIKE & DIRECTED VERDICT

Plaintiffs first argue that the trial court erred by granting defendant's motion for a directed verdict because, according to plaintiffs, Dr. Brajer qualified as an expert. Specifically, plaintiffs assert that the trial court, in considering Dr. Brajer's qualifications, was only permitted to consider the evidence presented before or up to the point when defendant moved for a directed verdict. Plaintiffs maintain that the trial record at the time of defendant's motion was insufficient to support the trial court's findings regarding Dr. Brajer's qualifications, or lack thereof, to testify as an expert. Thus, plaintiffs argue that the trial court abused its discretion by excluding Dr. Brajer's testimony and that the directed verdict was premature. We disagree.

"A trial court's rulings concerning the qualifications of proposed expert witnesses are reviewed for **[*6]** an abuse of discretion." Rock v Crocker, 499 Mich 247, 260; 884 NW2d 227 (2016). "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." Woodard, 476 Mich at 557. We review de novo a trial court's decision to grant a directed verdict motion. Aroma Wines & Equip, Inc v Columbian Distribution Servs, Inc, 497 Mich 337, 345; 871 NW2d 136 (2015). "A party is entitled to a directed verdict if the evidence, when viewed in the light most favorable to the nonmoving party, fails to establish a claim as a matter of law." *Id.*

In a medical malpractice action, it is the plaintiff's burden to prove: "(1) the applicable standard of care, (2) breach of that standard by defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury." Wischmeyer v Schanz, 449 Mich 469, 484; 536 NW2d 760 (1995). "Failure to prove any one of these elements is fatal." Wiley v Henry Ford Cottage Hosp, 257 Mich App 488, 492; 668 NW2d 402 (2003). With respect to the standard of care, a plaintiff must show "that the medical care provided by the defendant fell below the standard of medical care applicable at the

[3] Woodard v Custer, 476 Mich 545; 719 NW2d 842 (2006).

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time the care was provided." Rock, 499 Mich at 260. The relevant standard of care must be established through expert testimony. Gonzalez v St John Hosp & Med Ctr, 275 Mich App 290, 294; 739 NW2d 392 (2007).

To testify as an expert in a medical malpractice action, an individual must satisfy the requirements of MCL 600.2169, which provides, in part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the **[*7]** appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c) [not relevant], *during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to* either or both of the following:
>
> (*i*) *The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty*.
>
> *(ii)* The instruction of students in an accredited health professional school or accredited residency or clinical **[*8]** research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty. [Emphasis added.]

Briefly stated, MCL 600.2169(1) requires "that the qualifications of a purported expert match the qualifications of the defendant against whom that expert intends to testify." Decker v Flood, 248 Mich App 75, 85; 638 NW2d 163 (2001).

More specifically, at issue in this case is MCL 600.2169(1)(b)(i). Under this provision, if, as in this case, a defendant physician is a specialist, in order to qualify as an expert, "the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty." Woodard, 476 Mich at 566. A "specialty" is "a particular branch of medicine or surgery in which one can potentially become board certified." Woodard, 476 Mich at 561. Moreover, a "subspecialty is a specialty" for purposes of MCL 600.2169(1), meaning that "if the defendant physician specializes **[*9]** in a subspecialty and was doing so at the time of the alleged malpractice, the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching that subspecialty." Woodard, 476 Mich at 562, 566 n 12. Conversely, a physician devoting a majority of his or her time to a subspecialty would not qualify as an expert relative to a defendant physician who practiced the more general specialty. See id. at 577-578. For example, in *Hamilton v Kuligowski*, a companion case to *Woodard*, the defendant physician was board certified in internal medicine and practicing general internal medicine while the proposed expert was also board certified in internal medicine but primarily worked as an infectious disease specialist, which was a subspecialty of internal medicine. See id. at 556, 577-578. The Court held:

> [P]laintiff's proposed expert witness did not devote a majority of his time to practicing or teaching general internal medicine. Instead, he devoted a majority of his professional time to treating infectious diseases. As he himself acknowledged, he is "not sure what the average internist sees day in and day out." Therefore, plaintiff's proposed expert **[*10]** witness does not satisfy the same practice/instruction requirement[.] [Id. at 578.]

In the instant matter, defendant was engaged in the practice of anesthesiology at the time of the alleged malpractice, making anesthesiology the one most relevant specialty. See id. at 560, 566. Dr. Brajer was board certified in anesthesiology and board certified in pain management.[4] It is undisputed that he did not

[4] On appeal, plaintiffs suggest that pain management is not

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devote a majority of his time to anesthesiology in the year preceding the alleged malpractice. Indeed, Dr. Brajer conceded that he had not acted as an anesthesiologist for a hospital surgical procedure for years before the procedure in question and he had not participated in a CABG surgery since 1988. Cf. *id. at 577 n 21* (criticizing proposed expert who had not performed "the specific medical procedure that was allegedly performed negligently in this case, since his residency in the early 1980's"). Instead, he was engaged in clinical pain management. Because he did not, in the year preceding the alleged malpractice, devote a majority of his professional time to the same specialty as that practiced by defendant, and there is no indication that Dr. Brajer instructed students in this field, we conclude that the trial court did not **[*11]** abuse its discretion by finding that Dr. Brajer did not qualify as an expert witness under *MCL 600.2169(1)(b)*. Consequently, the trial court properly excluded Dr. Brajer's proposed testimony.

In contrast to our conclusion that the trial court did not abuse its discretion by determining that Dr. Brajer was not qualified to testify, plaintiffs assert that the evidence was insufficient to support the trial court's findings and that this ruling was "premature."[5] Specifically, **[*12]** plaintiffs take issue with the trial court's finding that "[defendant was] not practicing pain management in any fashion whereas Doctor Brajer is[,]" suggesting that this finding is without support because defendant had not yet testified with regard to the specialty he practiced at the time of the alleged malpractice. Absent sufficient evidence of defendant's specialty and what that specialty entailed, plaintiffs maintain the trial court could not reasonably conclude that defendant's and Dr. Brajer's specialties did not match for purposes of *MCL 600.2169(1)*.

However, witnesses at trial, including, for example, a resident physician present in the operating room, identified defendant as the attending anesthesiologist for the surgery in question. Given this evidence, the trial court did not abuse its discretion by determining that anesthesiology was the relevant specialty. See *Woodard, 476 Mich at 569 n 15* & 576 n 19. Indeed, while plaintiffs now contest defendant's relevant specialty for purposes of comparison to Dr. Brajer's area of practice, in the trial court, plaintiffs attempted to offer Dr. Brajer as an expert in anesthesiology. Further, during argument concerning Dr. Brajer's qualifications, plaintiffs' counsel stated that the relevant specialty "is anesthesiology" and counsel argued that Dr. Brajer was a qualified expert in this area because pain management is "part and parcel of anesthesiology." In other words, plaintiffs' counsel conceded that defendant was practicing anesthesiology **[*14]** at the time of the alleged malpractice. In conceding these facts, plaintiffs have waived any argument on appeal that the trial court's finding regarding the relevant specialty was erroneous. See *Bates Assoc, LLC v 132 Assoc, LLC, 290 Mich. App. 52, 64; 799 N.W.2d 177 (2010)* ("A party may not claim as error on appeal an issue that the party deemed proper in the trial court because doing so would permit the party to harbor error as an appellate parachute.").

In sum, the trial court's finding that Dr. Brajer was not qualified as an expert witness and its decision to grant defendant's motion to strike was not an abuse of discretion. See *Rock, 499 Mich at 260*. Because

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necessarily a distinct specialty from anesthesiology. However, this assertion is plainly belied by Dr. Brajer's own testimony. In addition to his board certification in anesthesiology, Dr. Brajer indicated that he was certified in "pain management" by the American Academy of Pain Management. He further testified that "pain management" was a recognized subspecialty by the American Board of Medical Specialties and that, while Dr. Brajer was an anesthesiologist, one did not need to be an anesthesiologist in particular to specialize in "pain management." Under *Woodward*, this type of subspecialty for which certification is available constitutes a "specialty" for purposes of *MCL 600.2169(1)*. See *Woodard, 476 Mich at 561-562, 565*; *Jones v Botsford Continuing Care Corp, 310 Mich App 192, 210; 871 NW2d 15 (2015)*.

[5] In making this argument, plaintiffs contend that the trial court was only permitted to consider evidence offered at trial up to the time of defendant's directed verdict motion. This argument confuses the standards applicable to motions for a directed verdict and the qualification of expert witnesses. While a motion for a directed verdict involves consideration of all the evidence presented up to the point of the motion to determine whether a fact question exists, *Heaton v Benton Const Co, 286 Mich. App. 528, 532; 780 N.W.2d 618 (2009)*, consideration of a proposed expert's qualifications is a preliminary question entrusted to the discretion of the trial court, *Woodard, 476 Mich at 571 n 16*; *Gilbert v DaimlerChrysler Corp, 470 Mich 749, 780-781; 685 NW2d 391 (2004)*. When determining a preliminary question, a trial court **[*13]** is not bound by the rules of evidence and may consider evidence presented by the proponent and, if applicable, the opponent of the expert witness. See *MRE 104(a)*; *Gay v Select Specialty Hosp, 295 Mich App 284, 293; 813 NW2d 354 (2012)*. Ultimately, there was nothing improper in the evidence relied on by the trial court or premature in the timing of the trial court's decision.

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plaintiffs had no expert witness to testify to the standard of care applicable at the time of the surgery, plaintiffs failed to meet their burden of proving the elements of their medical malpractice claim. See *Gonzalez, 275 Mich App at 294*. In the absence of evidence establishing the standard of care, the trial court did not err by granting a directed verdict for defendant. Cf. *Woodard, 476 Mich at 578*.

III. MOTION TO AMEND WITNESS LIST

Finally, plaintiffs argue that the trial court erred by denying their request to amend their witness list to add a new expert witness in place of Dr. Brajer. According to plaintiffs, good cause for the amendment existed because plaintiffs were **[*15]** surprised by defendant's motion to strike and plaintiffs had diligently pursued their case causing no delays in the litigation.

A trial court's decision on a motion to amend a witness list and to adjourn the proceedings is reviewed for an abuse of discretion. *Tisbury v Armstrong, 194 Mich App 19, 20; 486 NW2d 51 (1991)*. As part of the discovery process, the trial court, under *MCR 2.401(I)(1)*, sets the time period for submitting witness lists and disclosing whether any witness is an expert. In the event that a witness is "not listed in accordance with this rule[,]" the trial court "may order that" the witness "will be prohibited from testifying at trial except upon good cause shown." *MCR 2.401(I)(2)*. In considering whether a witness not properly named on a witness list should be allowed to testify, the trial court may consider the following non-exhaustive list of factors:

> (1) whether the violation was wilful or accidental; (2) the party's history of refusing to comply with discovery requests (or refusal to disclose witnesses); (3) the prejudice to the defendant; (4) actual notice to the defendant of the witness and the length of time prior to trial that the defendant received such actual notice; (5) whether there exists a history of [the movant] engaging in deliberate delay; **[*16]** (6) the degree of compliance by the [movant] with other provisions of the court's order; (7) an attempt by the [movant] to timely cure the defect[;] and (8) whether a lesser sanction would better serve the interests of justice. [*Duray Development, LLC v Perrin, 288 Mich App 143, 165; 792 NW2d 749 (2010)* (footnote omitted).]

In this matter, the trial court's scheduling order required disclosure of plaintiffs' expert witnesses by October 1, 2013. Plaintiffs listed Dr. Brajer in their witness list and did not move to amend their list until the third day of trial. Notably, at the time plaintiffs sought to amend their witness list, they did not have another expert available. Before ruling on plaintiffs' motion, the trial court questioned plaintiffs whether any other witness on their list could testify to their proposed standard of care and considered the qualifications of each proposed witness, but concluded that each would not qualify. The trial court queried what it was to do with the jury that had already been sworn during a period when plaintiffs must look for another expert witness and the court also noted that defendant was ready to proceed with trial. In the context of an ongoing jury trial, the court concluded that it simply could not suspend trial for **[*17]** "however long it would take, 90 days or 120 days," to allow the plaintiffs to obtain a new expert and permit depositions. Ultimately, there being no lesser sanctions available, the trial court denied plaintiffs' motion to amend their witness list and struck Dr. Brajer.

We acknowledge that Michigan courts prefer disposition of litigation on the merits, *Tisbury, 194 Mich App at 21*, but we cannot conclude under the present circumstances that the trial court's denial of plaintiffs' motion to amend their witness list was an abuse of discretion. While plaintiffs' failure to name a qualified expert on their witness list does not appear to have been a willful omission, the factual aspects of this case do not otherwise demonstrate good cause. Despite plaintiffs' claim of surprise, there is nothing new about the requirements of *MCL 600.2169(1)* and indeed the *Woodward* decision outlining these requirements in detail was decided more than a decade ago. Given the existing state of the law and the substance of Dr. Brajer's deposition testimony, plaintiffs knew, or should have known, that Dr. Brajer's qualifications were problematic well before trial. See generally *Rock, 499 Mich at 267* (noting that the requirements of *MCL 600.2169* allow "a plaintiff to ensure that an expert **[*18]** is qualified well in advance of the time of the testimony"); *Sturgis Bank & Trust Co v Hillsdale Community Health Ctr, 268 Mich App 484, 494; 708 NW2d 453 (2005)* (describing a plaintiff attorney's obligation to use the benefit of discovery to better ascertain the qualifications of the defendant physician to confirm that a proposed expert is qualified under *MCL 600.2169*). Indeed, plaintiffs admit on appeal that the issue of Dr. Brajer's qualifications was "foreseeable," and they offer no reason why they did not exercise reasonable diligence to cure the defect before trial.[6] In

[6] While ostensibly conceding in their brief that defendant did not have to challenge Dr. Brajer's qualifications before trial,

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the face of plaintiffs' inadequate preparation and apparent lack of foresight, given the age of the case, the trial court did not abuse its discretion by denying plaintiffs additional time to search for an unidentified expert to add to their witness list mid-trial, well after the close of discovery. See *Grubor Enterprises, Inc v Kortidis, 201 Mich App 625, 630; 506 NW2d 614 (1993)*; *Bates v Detroit, 66 Mich App 701, 706; 239 NW2d 716 (1976)*.

This is particularly true given that defendant had no notice of who the unidentified expert witness might be or how the unknown expert might testify, and defendant would have had to expend more resources litigating this matter, perhaps requiring retention of a counter-expert and development of a new strategy mid-trial. Cf. *Kalamazoo Oil Co v Boerman, 242 Mich App 75, 90-91; 618 NW2d 66 (2000)* (disallowing late expert testimony when the opposing party had "no chance to conduct any discovery of the expert and that it would be unfair to require [the opposing party] to prepare on such short notice"). Moreover, despite plaintiffs' assertion that defendant was the only party to cause delay in this case, the record reflects that plaintiffs repeatedly refused to comply with discovery deadlines, causing defendant to file numerous **[*20]** motions to compel. Overall, plaintiffs did not demonstrate good cause to support amendment of their witness list. We therefore conclude that the trial court did not abuse its discretion by denying plaintiffs' leave to amend.

Affirmed.

/s/ Donald S. Owens

/s/ Joel P. Hoekstra

/s/ Jane M. Beckering

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much of plaintiffs' argument nonetheless focuses on the assertion that plaintiffs' failure to timely identify a qualified witness should be excused because defendant engaged in gamesmanship by waiting until trial to challenge the admissibility of Dr. Brajer's testimony. To be clear, there is no rule **[*19]** that an opposing party must challenge a medical malpractice expert before trial or within a reasonable time of learning the expert's identity. See *Cox v Bd of Hosp Managers for Flint, 467 Mich 1, 17 n 18; 651 NW2d 356 (2002)*; *Greathouse v Rhodes, 465 Mich 885; 636 NW2d 138 (2001)*. Instead, it is ultimately the *proponent* of expert testimony in a medical malpractice case who "must satisfy the court that the expert is qualified." *Elher v Misra, 499 Mich 11, 22; 878 NW2d 790 (2016)* (citation omitted). Quite simply, it was plaintiffs' obligation, not defendant's, to ensure that plaintiffs had a qualified expert for trial.

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APPENDIX 20

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Neutral
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Estate of Leblanc v. Agnone

Court of Appeals of Michigan

July 6, 2017, Decided

No. 330330, No. 330416

Reporter
2017 Mich. App. LEXIS 1091 *; 2017 WL 2882552

ESTATE OF PATRICIA E. LEBLANC, by SUZANNE RUBBA and DANIEL LEBLANC, Personal Representatives, Plaintiff-Appellant, v EUGENE J. AGNONE, M.D., and MICHIGAN CANCER SPECIALISTS, PLC, Defendants-Appellees, and CHAKRPANI RANGANATHAN, M.D., MICHAEL F. ROMANELLI, M.D., MACOMB NEUROLOGY ASSOCIATES, PC, and WOODS CARDIOVASCULAR INTERNAL MEDICINE ASSOCIATES, PC, Defendants.ESTATE OF PATRICIA E. LEBLANC, by SUZANNE RUBBA and DANIEL LEBLANC, Personal Representatives, Plaintiff-Appellee, v EUGENE J. AGNONE, M.D., CHAKRPANI RANGANATHAN, M.D., MICHIGAN CANCER SPECIALISTS, PLC, and MACOMB NEUROLOGY ASSOCIATES, PC, Defendants, and MICHAEL F. ROMANELLI, M.D., and WOODS CARDIOVASCULAR INTERNAL MEDICINE ASSOCIATES, PC, Defendants-Appellants.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Subsequent History: Leave to appeal denied by *Rubba v. Agnone, 501 Mich. 1031, 908 N.W.2d 544, 2018 Mich. LEXIS 452 (Mar. 28, 2018)*

Leave to appeal denied by *Rubba v. Agnone, 501 Mich. 1031, 908 N.W.2d 544, 2018 Mich. LEXIS 449 (Mar. 28, 2018)*

Motion granted by *Rubba v. Agnone, 2019 Mich. LEXIS 1012 (Mich., June 7, 2019)*

Prior History: [*1] Macomb Circuit Court. LC No. 2013-002255-NH.

Core Terms

oncology, fraction, specialty, ejection, patient, devoted, proposed expert, cardiotoxic, standard of care, practicing, doses, trial court, percent, internal medicine, cardiac, alleged malpractice, expert witness, clinical, teaching, radiation, reliable, cardiologist, deposition, board certified, recommendation, discontinued, medicine, cardiomyopathy, subspecialty, defendants'

Judges: Before: FORT HOOD, P.J., and CAVANAGH and RONAYNE KRAUSE, JJ. RONAYNE KRAUSE, J. (concurring in part and dissenting in part).

Opinion

PER CURIAM.

These two interlocutory consolidated appeals arise from the same medical malpractice case. In Docket No. 330330, plaintiff appeals by leave granted[1] an order granting the motion of defendants Eugene J. Agnone, M.D., and Michigan Cancer Specialists, PLC (MCS), to disqualify plaintiff's proposed expert in medical oncology, Gerald Sokol, M.D., from testifying regarding the standard of practice applicable to Dr. Agnone. In Docket No. ***330416***, defendants Michael F. Romanelli, M.D., and Woods Cardiovascular Internal Medicine Associates, PC (Woods), appeal by delayed leave granted[2] four orders: (1) an order denying the motion of Dr. Romanelli and Woods to strike plaintiff's proposed cardiology expert, Arthur Meltzer, M.D., or to preclude his testimony; (2) an order denying the motion of Dr. Romanelli and Woods to strike Dr. Meltzer's testimony regarding his standard of care criticism that the chemotherapeutic agent Novantrone must be discontinued when a patient has a 10% decrease in

[1] *LeBlanc Estate v Agnone*, unpublished order of the Court of Appeals, entered May 31, 2016 (Docket No. 330330).

[2] *LeBlanc Estate v Agnone*, unpublished order of the Court of Appeals, entered May 31, 2016 (Docket No. ***330416***).

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ejection fraction; (3) an order denying **[*2]** the motion of Dr. Romanelli and Woods to strike Dr. Meltzer's allegedly new standard of care criticisms; and (4) an order denying the motion of Dr. Romanelli and Woods to strike the testimony of Dr. Meltzer and Dr. Sokol regarding proximate causation. We affirm in both appeals.

Plaintiff commenced this medical malpractice action alleging that plaintiff's decedent, Patricia E. LeBlanc (Patricia) (date of birth 07/27/1940), died on July 12, 2010, as a result of cardiogenic shock caused by the purportedly excessive and inappropriate administration of a chemotherapeutic drug called Novantrone between August 2008 and November 2009. In May 2008, defendant Chakrpani Ranganathan, M.D., a neurologist employed by defendant Macomb Neurology Associates, PC, diagnosed Patricia with progressing relapsing multiple sclerosis (MS). Dr. Ranganathan referred Patricia to Dr. Agnone, a medical oncologist employed by MCS, for the intravenous administration of Novantrone, a chemotherapeutic drug, as a form of treatment for Patricia's MS. Patricia was also referred to a cardiologist, Dr. Romanelli, who was employed by Woods, for a cardiac evaluation in connection **[*3]** with the administration of Novantrone. In July 2008, Dr. Romanelli's office determined that Patricia's ejection fraction, i.e.., the percentage of blood pumped out of a filled ventricle with each heartbeat, was 76%. In August 2008, Patricia began receiving 20 milligram doses of Novantrone administered by Dr. Agnone every four to six weeks, eventually receiving a total of 16 doses. According to plaintiff, the appropriate dosage for Patricia given her body surface area was 24.72 milligrams every three months, and her appropriate lifetime dosage was 288.4 milligrams. On the date of Patricia's sixth treatment, in January 2009, Dr. Agnone noted that Patricia had recent dyspnea (difficult or labored breathing) and that her ejection fraction was 62% according to Dr. Romanelli. By the time Patricia received her final dose in November 2009, she had received a lifetime total of 300 milligrams of Novantrone. The Novantrone was then discontinued after an echocardiogram showed that her ejection fraction was between 50% and 55%. In January 2010, Patricia was found to be suffering from cardiac toxicity as a result of taking Novantrone; she suffered congestive heart failure and cardiomyopathy (heart **[*4]** disease leading to decreased function). In February 2010, Patricia underwent a mitral valve repair. She later suffered respiratory failure, cardiogenic shock, and failure of multiple organs, ultimately dying in July 2010 of cardiogenic shock. Plaintiff alleged medical malpractice on the part of each defendant physician regarding the purportedly excessive doses of Novantrone administered to Patricia and negligence in the failure to ensure the appropriate assessment of Patricia for cardiac signs and symptoms before the administration of each dose of Novantrone; plaintiff also asserted vicarious liability of the respective entity defendants employing each defendant physician. The trial court decided several motions in limine, five of which are the subject of these appeals.

In Docket No. 330330, plaintiff argues that the trial court abused its discretion in concluding that Dr. Sokol lacked the requisite qualification under MCL 600.2169(1)(b) to testify as an expert in medical oncology concerning the standard of care applicable to Dr. Agnone. We disagree.

A trial court's ruling regarding the qualification of a proposed expert witness to testify at trial is reviewed for an abuse of discretion. Woodard v Custer, 476 Mich 545, 557; 719 NW2d 842 (2006). A trial court's **[*5]** decision whether to admit evidence is also reviewed for an abuse of discretion. Edry v Adelman, 486 Mich 634, 639; 786 NW2d 567 (2010). An abuse of discretion occurs when the trial court's decision falls outside the range of principled outcomes. *Id.*; Woodard, 476 Mich at 557. This Court reviews de novo questions of law underlying evidentiary rulings, such as the interpretation of court rules and statutes. Elher v Misra, 499 Mich 11, 21; 878 NW2d 790 (2016).

As our Supreme Court explained in Elher, 499 Mich at 21-22:

> A plaintiff in a medical malpractice action must establish (1) the applicable standard of care, (2) breach of that standard of care by the defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury. Generally, expert testimony is required in a malpractice case in order to establish the applicable standard of care and to demonstrate that the professional breached that standard. An exception exists when the professional's breach of the standard of care is so obvious that it is within the common knowledge and experience of an ordinary layperson. The proponent of the evidence has the burden of establishing its relevance and admissibility. [Quotation marks, footnotes and citations omitted.]

MCL 600.2169 provides, in relevant part:

> (1) In an action alleging medical malpractice, a

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> person shall not give expert **[*6]** testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c) [pertaining to general practitioners and which is not applicable here], during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (*ii*) The instruction of students **[*7]** in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

"The proponent of expert testimony in a medical malpractice case must satisfy the court that the expert is qualified under . . . MCL 600.2169." Elher, 499 Mich at 22 (footnote and citation omitted).

In Woodard, 476 Mich at 559, our Supreme Court explained that MCL 600.2169(1) "requires the matching of a singular specialty, not multiple specialties." After taking note of the requirement in MCL 600.2169(1)(b) that the plaintiff's expert must have devoted a majority of his or her professional time to practicing or teaching the same specialty as the defendant physician in the year immediately preceding the alleged malpractice, the *Woodard* Court stated:

> Obviously, a specialist can only devote a *majority* of his professional time to *one* specialty. Therefore, it is clear that §2169(1) only requires the plaintiff's expert to match one of the defendant physician's specialties. Because the plaintiff's expert will be providing **[*8]** expert testimony on the appropriate or relevant standard of practice or care, not an inappropriate or irrelevant standard of practice or care, it follows that the plaintiff's expert witness must match the one most relevant standard of practice or care — the specialty engaged in by the defendant physician during the course of the alleged malpractice, and, if the defendant physician is board certified in that specialty, the plaintiff's expert must also be board certified in that specialty. [Woodard, 476 Mich at 560.]

"[A] 'specialty' is a particular branch of medicine or surgery in which one can potentially become board certified." Id. at 561.

> [A] 'subspecialty' is a particular branch of medicine or surgery in which one can potentially become board certified that falls under a specialty or within the hierarchy of that specialty. A subspecialty, although a more particularized specialty, is nevertheless a specialty. Therefore, if a defendant physician specializes in a subspecialty, the plaintiff's expert witness must have specialized in the same subspecialty as the defendant physician at the time of the occurrence that is the basis for the action. [Id. at 562 (footnote omitted).]

Also, "the proposed expert witness must have the same **[*9]** board certification as the party against whom or on whose behalf the testimony is offered." Id. at 562-563 (quotation marks and citation omitted). A certificate of special or added qualifications constitutes a board certificate. Id. at 565. Hence, "if a defendant physician has received a certificate of special qualifications, the plaintiff's expert witness must have obtained the same certificate of special qualifications in order to be qualified to testify under §2169(1)(a)." *Id.* (footnote omitted).

The *Woodard* Court also provided the following explanation concerning the requirement in MCL 600.2169(1)(b) that an expert witness must have devoted a majority of his or professional time in the year immediately preceding the date of the alleged malpractice to practicing or teaching the same specialty as the defendant physician:

> As we explained above, one cannot devote a

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> "majority" of one's professional time to more than one specialty. Therefore, in order to be qualified to testify under §2169(1)(b), the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the same specialty that the defendant **[*10]** physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty. [Woodard, 476 Mich at 566 (footnote omitted).]

The *Woodard* Court further explained:

> Just as a subspecialty is a specialty within the meaning of §2169(1)(a), a subspecialty is a specialty within the meaning of §2169(1)(b). Therefore, if the defendant physician specializes in a subspecialty and was doing so at the time of the alleged malpractice, the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching that subspecialty. [Id. at 566 n 12.]

For these reasons, "the plaintiff's expert does not have to match all of the defendant physician's specialties; rather, the plaintiff's expert only has to match the one most relevant specialty." Id. at 567-568.

In Woodard, 476 Mich at 554-555, the defendant physician was board certified in pediatrics with certificates of special qualifications in pediatric critical care medicine and neonatal-perinatal medicine, whereas the plaintiff's proposed expert was board certified in pediatrics without any certificates of special qualifications. The defendant physician was practicing pediatric critical **[*11]** care medicine at the time of the alleged malpractice, and pediatric critical care medicine thus constituted "the one most relevant specialty." Id. at 576. Because the plaintiff's proposed expert did not specialize in pediatric critical care medicine at the time of the alleged malpractice, the proposed expert did not satisfy the same specialty requirement of MCL 600.2169(1)(a). Id. at 576-577. The plaintiff's proposed expert also did not satisfy the same practice or instruction requirement of MCL 600.2169(1)(b) because the proposed expert did not practice or teach pediatric critical care medicine during the year immediately preceding the alleged malpractice. Id. at 577. The trial court in *Woodard* therefore did not abuse its discretion in concluding that the plaintiff's proposed expert was not qualified to testify regarding the appropriate standard of practice or care under MCL 600.2169(1). *Id.*

The *Woodard* Court also applied its holdings to the companion case of Hamilton v Kuligowski, 2005 Mich. LEXIS 1104, which was consolidated with *Woodard*. Woodard, 476 Mich at 577-578. In *Hamilton*, the defendant physician was board certified in general internal medicine and specialized in general internal medicine. Id. at 556. The plaintiff's proposed expert was board certified in general internal medicine but devoted a majority of his professional **[*12]** time to the treatment of infectious diseases, which is a subspecialty of internal medicine. *Id.* The trial court granted a directed verdict in favor of the defendant physician, reasoning that the plaintiff's proposed expert was not qualified given that he specialized in infectious diseases and did not spend a majority of his professional time practicing or teaching general internal medicine. *Id.* This Court reversed, stating that the proposed expert and the defendant physician both specialized in internal medicine and that the proposed expert devoted "a majority of his professional time to the practice of internal medicine given that the treatment of infectious diseases is a subspecialty of internal medicine." Id. at 556-557 (summarizing this Court's reasoning). Our Supreme Court reversed this Court's decision and held that the trial court had properly granted a directed verdict to the defendant physician. Id. at 579. Our Supreme Court explained:

> The defendant physician specializes in general internal medicine and was practicing general internal medicine at the time of the alleged malpractice. During the year immediately preceding the alleged malpractice, plaintiff's proposed expert witness did not devote a **[*13]** majority of his time to practicing or teaching general internal medicine. Instead, he devoted a majority of his professional time to treating infectious diseases. As he himself acknowledged, he is "not sure what the average internist sees day in and day out." Therefore, plaintiff's proposed expert witness does not satisfy the same practice/instruction requirement of §2169(1)(b).
>
> For this reason, the trial court did not abuse its discretion in concluding that plaintiff's proposed expert witness is not qualified to testify regarding the appropriate standard of practice or care under §2169(1). Because plaintiff failed to present an expert qualified under §2169(1) to testify with regard to the appropriate standard of practice or

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> care, the trial court properly granted a directed verdict in favor of defendant. [*Id. at 577-578*.]

In *Kiefer v Markley, 283 Mich App 555, 559; 769 NW2d 271 (2009)*, this Court applied the holding in *Woodard* and noted that the word "majority" means "the greater part or larger number; more than half of a total." (Quotation marks and citation omitted.) "*MCL 600.2169(1)(b)*, therefore, requires a proposed expert physician to spend greater than 50 percent of his or her professional time practicing the relevant specialty the year before the alleged malpractice." **[*14]** *Kiefer, 283 Mich App at 559*. Because the plaintiffs' proposed expert devoted only 30 to 40 percent of his time to the practice of hand surgery, which was the one most relevant specialty in that case, the proposed expert was not qualified under *MCL 600.2169(1)(b)*. *Kiefer, 283 Mich App at 559*. The majority of the panel in *Kiefer* expressed respectful disagreement with Judge O'Connell's dissenting view that the term "majority" means "an amount that represents the largest percentage of the whole, even if this amount is less than 50 percent." *Id. at 558 n 1* (quotation marks omitted). The *Kiefer* majority explained:

> Let us consider a situation where a doctor spends 40 percent of his time in one area, 40 percent in a second area, and 20 percent in a third. Under our colleague's definition, this hypothetical doctor would then be in the position of devoting the "majority" of his time to two different specialties. Because the *Woodard* Court maintained that this is impossible, it is clear that the *Woodard* Court relied on a definition of "majority" as "an amount that exceeds 50 percent of the total." [*Id.*]

Despite concluding that the plaintiffs' proposed expert was not qualified to testify at trial under *MCL 600.2169(1)(b)*, the *Kiefer* majority made the following observation:

> Given the unambiguous language **[*15]** of the statute and the caselaw on this issue, this panel is constrained to affirm the trial court's decision [striking the plaintiffs' proposed expert witness]. However, we note that this is not a result we think the Legislature intended. Defendant Dr. John M. Markley was board-certified in plastic surgery with an added qualification in hand surgery, as was [the plaintiffs' proposed expert witness,] Dr. [Frederick A.] Valauri. We believe that this similarity, coupled with the fact that Dr. Valauri spent more than 50 percent of his time in the area of hand surgery and the closely related area of reconstructive surgery of other extremities, should qualify him as an expert in this situation. Nonetheless, we reluctantly hold that the trial court did not abuse its discretion by granting defendants' motion in limine to strike plaintiffs' expert witness. [*Kiefer, 283 Mich App at 559-560* (citations omitted).]

In this case, the parties are in agreement that the one most relevant specialty, i.e., the specialty that defendant-physician Dr. Agnone was practicing at the time of the alleged malpractice, was medical oncology. It is undisputed that Dr. Agnone is board certified in internal medicine and medical oncology, which is **[*16]** a subspecialty of internal medicine. Plaintiff's proposed expert witness in medical oncology, Dr. Sokol, is, like Dr. Agnone, board certified in internal medicine and medical oncology. But unlike Dr. Agnone, Dr. Sokol is board certified in numerous other specialties, including radiation oncology (also known as therapeutic radiology),[3] clinical pharmacology, skin cancer medicine, and quality assurance and utilization review.[4] The issue is therefore whether Dr. Sokol devoted a majority of his professional time to practicing or teaching medical oncology during the year immediately preceding the date of the alleged malpractice.

In his affidavit of merit filed with the complaint, Dr. Sokol made the following assertion: "I further certify that during the year immediately preceding the date of the occurrence that is the basis for this claim, I devoted a majority of my professional time to the active clinical practice of Medical Oncology and/or the instruction of students in an accredited health professional school or clinical research program in Medical Oncology." Despite this conclusory claim in the affidavit of merit, Dr. Sokol's testimony regarding this issue at his trial deposition was decidedly **[*17]** less clear or coherent. Early in the direct examination of Dr. Sokol, plaintiff's counsel asked whether Dr. Sokol devoted a majority of his professional time to the clinical practice of "oncology" during the relevant time period, without specifying whether the question pertained to medical oncology, radiation oncology, or both. Dr. Sokol responded, "Well, at least 30 hours, maybe more, a week. In addition to that, teaching in that area and, of course, the Center for Drug Research, which is kind of a supervisory overview of a

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[3] Dr. Sokol acknowledged that radiation oncology is a different certification from medical oncology.

[4] The skin cancer medicine certification is from Australia rather than the United States.

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lot of — lot of medicine."

On cross-examination, Dr. Sokol's testimony failed to establish that he devoted a majority of his professional time to practicing or teaching medical oncology during the relevant time period. For example, he testified:

> *Q*. When we took your deposition in July of last year, you could not state what percentage of your time was in medical oncology versus only radiation oncology. Isn't that true?
>
> *A*. Well, because obviously I draw upon all my specialties and trainings every time I see a given patient.
> * * *
>
> *Q*. Therefore, you cannot as you could not back in 19 - or 2014, you cannot state — state what percentage of your day-to-day practice is in medical **[*18]** oncology. Right?
>
> *A*. Not exactly. I told you that — that there is a special benefit of having practiced medical oncology or radiation oncology drawing upon all of those experience[s]. I hope you're not — I hope you're not criticizing me for being overtrained to do it.
> * * *
>
> *Q*. . . . What percentage of your day-to-day practice is in radiation oncology, for example?
>
> *A*. What percentage is in radiation oncology? I don't know how to answer that question when I draw upon every specialty when I see a patient. And — and this patient would be a perfect example — a perfect example of why it's important to do so.
>
> *Q*. Just answer my question now. Okay.
>
> *A*. I just told you that I can't answer it because I draw upon all those specialties. And I will add that it's in a patient like this probably critically important that I do.

Later, Dr. Sokol testified that he spends 20 hours a week in medical oncology at the Center for Drug Research. Dr. Sokol stated that "whatever standard you want to meet, I believe that I spent enough time in medical oncology and pharmacology and internal medicine to qualify for that [standard]." Dr. Sokol further testified:

> *Q*. Okay. And you have given opinions over the years that you cannot in your **[*19]** mind state what percentage of your practice is in either therapeutic radiation oncology or medical oncology. Correct?
>
> *A*. When I see a patient, I draw opinion [sic: upon] all of those specialties.
>
> *Q*. I didn't ask you that.
>
> *A*. Well -
>
> *Q*. Can you give me a percentage of your professional time in medical oncology? Yes or no?
>
> *A*. . . . Well, I think you asked that question three times and I told you that I have no way of separating them when I utilize all of my training when I see a patient.
> * * *
>
> *Q*. In the year immediately preceding [the alleged malpractice], you cannot state that you devoted a majority of your professional time to the active clinical practice of medical oncology. Yes or no?
>
> *A*. Well, I think I already answered that. And it's — it stays the same. I told you what I did in medical oncology working at the FDA in medical oncology for over 20 hours practicing medical oncology for several hours more, however you want to define it.

When again asked whether he devoted a majority of his professional time to medical oncology, Dr. Sokol stated that he did not know how to answer the question and that "I've got five boards and I use them to the best of my abilities to take care of patients." Dr. **[*20]** Sokol also stated, in response to questioning by defense counsel concerning the amount of time he spent in the "active clinical practice of pharmacology[,]" "I can't practice medical oncology doing the best job I possibly can without knowing clinical pharmacology and utilizing it every time I practice medical oncology." Dr. Sokol indicated that he makes more money practicing radiation oncology than medical oncology but claimed that he thinks more about medical oncology. On further questioning, Dr. Sokol testified:

> *Q*. Of the two — I'm not counting the other several — do you do more radiation oncology than medical oncology now at the facilities you're at?
>
> *A*. Let's see. Being on call once a month about 20 hours that week, just being on call, two, four hours a day covering medical oncology, about another 20 hours a week, so that would be about — I don't know - 25 hours a week where I have a total

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medical oncology responsibility. And then seeing additional patients where I kind of have to balance and sort out -

Q. Doctor -

A. Well, I'm trying to give you some time.

Q. My question is you want -

A. You want — you want me to quantitate it. I'm trying to do it.

Q. No. Give me the answer. Do you spend **[*21]** more time on radiation oncology than you do in medical oncology? Yes or no? Now in the past four or five years. Isn't that true, sir?

A. The answer is maybe except for the fact that when I spend time in radiation oncology, I'm doing it as a medical oncologist in evaluating it for that purpose.

Q. But you bill as a radiation oncologist when you do that. Correct?

A. Oh, well, I just told you I make more money doing radiation oncology than doing medical oncology. I already told you that.

On redirect examination, Dr. Sokol indicated that it was difficult to separate out the time he spent as an internist from the time he spent as a medical oncologist. He then testified as follows:

Q. Understanding that when you are practicing medical oncology, you're also practicing internal medicine?

A. Yes.

Q. Are you able to state that a majority of your professional time is spent in medical oncology with that overlap in internal medicine?

A. Well, yes.

On recross examination, Dr. Sokol testified:

Q. When I asked you yes or no whether you can state that you spend a majority of your professional time in medical oncology, you couldn't answer, could you?

A. Well, you're asking me — you were asking me to divvy it up. **[*22]** And I don't know how to divvy it up.

* * *

Q. By the way — what percentage of your time presently is medical radiation oncology? Can you give us that?

A. What percentage?

Q. Yeah. What percentage of your professional time?

A. I just told you that I combined them. It's very difficult.

Q. I'm asking this because we have laws in Michigan we have to follow. Can you tell me, yes or no, what percentage of your professional time is in medical radiation oncology?

A. Well, let's see. About the 80 hours that I work, I'd say maybe — let's see — hard to say. Let's see. Eighty hours. Maybe — and I'm just guessing because I -

Q. I don't want you to guess, Doctor.

A. Well, I'm just guessing because of the overlap and what I told you. The multiple specialties that I combine to be what I hope to be a good doctor. I would speculate that it would be 30 hours maybe out of the 80 that I work, maybe — maybe more, a little less. Hard to say for all of the reasons that I told you.

Q. Many times it's more than your medical oncology. Correct?

A. Well, I think I — we talked to you about, well, medical oncology when I was doing the FDA, that was 20 hours of pretty academic oncology -

Q. No. I mean -

A. Taking call[s] 20 hours every **[*23]** month in medical oncology, seeing patients at least three hours a day in medical oncology, being the only medical oncologist in the facility, another 15 hours a week. I mean it's -

MR. SIEMION: Okay. That's your answer. That's fine. Thank you very much. I have nothing further.

BY MS. MACKENZIE:

Q. I didn't hear the end of your answer. Another 15 hours of -

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A. Well, research and teaching and writing papers and -

Q. In medical oncology?

A. Medical oncology and clinical pharmacology associated with the things we do in the practice of oncology.

We conclude that the trial court did not abuse its discretion in determining that plaintiff failed to establish that Dr. Sokol devoted a majority of his professional time to the practice or teaching of medical oncology in the year immediately preceding the alleged malpractice. It is true that Dr. Sokol's affidavit of merit filed with the complaint contained a conclusory assertion that he devoted a majority of his professional time to the practice or teaching of medical oncology during that time period. But Dr. Sokol's trial deposition testimony indicates that the conclusory assertion in his affidavit of merit lacks factual support. Upon repeated questioning **[*24]** on cross-examination, Dr. Sokol expressed that he had difficulty separating or divvying up the time he spent in his various specialties because he purportedly draws upon all of his specialties when seeing a patient. Although Dr. Sokol at various points did attempt to quantify the hours devoted to his various specialties, it is far from clear from his confusing testimony that he devoted a majority of his professional time to the practice or teaching of medical oncology during the relevant time period. Dr. Sokol did agree with plaintiff's counsel during redirect examination that he devoted a majority of his professional time to medical oncology "with that overlap in internal medicine[,]" but our Supreme Court's decision in *Woodard, 476 Mich at 560, 566*, indicates that an expert can only devote a majority of his professional time to one specialty. It is thus improper to combine Dr. Sokol's time spent in medical oncology with his time spent practicing internal medicine when considering whether he is qualified as an expert under *MCL 600.2169(1)(b)*. See *Woodard, 476 Mich at 577-578* (concluding that the proposed expert in *Hamilton* did not satisfy the same practice or instruction requirement of *MCL 600.2169(1)(b)* where the expert devoted a majority of his professional time to the **[*25]** subspecialty of treating infectious diseases rather than to practicing or teaching general internal medicine). Overall, the trial court's decision fell within the range of principled outcomes.[5]

Plaintiff asserts that the language in *Woodard* providing that an expert can only devote a majority of his or her professional time to one specialty constitutes mere obiter dictum.[6] Obiter dictum is an incidental remark or opinion that is not essential to the case. *Allison v AEW Capital Mgt, LLP, 481 Mich. 419, 437; 751 N.W.2d 8 (2008)*. That is, language in a judicial opinion may be deemed obiter dictum if it is "in the nature of a gratuitous and irrelevant remark with no bearing on the case." *Detroit Free Press, Inc v Univ of Mich Regents, 315 Mich App 294, 298; 889 NW2d 717 (2016)* (citation omitted). The language in *Woodard* stating that a specialist can only devote a majority of his or her professional time to one specialty was not a mere gratuitous or irrelevant remark. Rather, it was central to the Supreme Court's reasoning for concluding that, in order to be qualified under *MCL 600.2169(1)*, a plaintiff's expert is required to match only one of the defendant physician's specialties, i.e., the specialty engaged in by the defendant during the alleged malpractice, and to devote a majority of his or her professional time to that one most relevant specialty. See *Woodard, 476 Mich at 560, 566-568*. Further, **[*26]** this Court in *Kiefer, 283 Mich App at 558 n 1*, relied on the pertinent language in

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[5] The parties present competing arguments regarding whether Dr. Sokol's affidavit of merit constitutes hearsay and whether it may be considered in assessing his qualification to testify under *MCL 600.2169(1)*. But it makes no difference whether the affidavit of merit is considered. As explained, the affidavit of merit contained merely a conclusory assertion that Dr. Sokol devoted a majority of his professional time to practicing or teaching medical oncology; this assertion fell apart at his deposition when he failed to provide sufficient supporting facts. See *Hamade v Sunoco, Inc (R & M), 271 Mich App 145, 163; 721 NW2d 233 (2006)* (in the analogous context of summary disposition, "mere conclusory allegations within an affidavit that are devoid of detail are insufficient to create a question of fact.").

[6] Plaintiff's counsel arguably waived this issue at the motion hearing by stating, "I do agree that *Woodard* is the test. I agree that you can only spend a majority of your professional time in the active clinical practice of one specialty; that in this case it's medical oncology." "[A] waiver is a voluntary and intentional abandonment of a known right." *Quality Prod & Concepts Co v Nagel Precision, Inc, 469 Mich. 362, 374; 666 N.W.2d 251 (2003)*. "A party who waives a right is precluded from seeking appellate review based on a denial of that right because waiver eliminates any error." *Cadle Co v Kentwood, 285 Mich App 240, 255; 776 NW2d 145 (2009)* (citations omitted). By agreeing that an expert could only spend a majority of his or her professional time in the active clinical practice of one specialty as set forth in *Woodard*, plaintiff arguably abandoned the right to claim that this aspect of *Woodard* is merely obiter dictum rather than the governing test. We will nonetheless address plaintiff's argument.

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Woodard to conclude that the word "majority" means more than 50 percent of the proposed expert's professional time, given that the *Woodard* Court said that it is impossible for a physician to devote the majority of his or her professional time to more than one specialty. Because the language at issue in *Woodard* was not an incidental or gratuitous remark, it is not obiter dictum.

Plaintiff suggests that there is confusion regarding which opinion in *Woodard* was the majority opinion. We disagree. Justice Markman's lead opinion in *Woodard*, which is the opinion that we have been citing throughout this opinion, is unquestionably the majority opinion because it was supported by four of the seven justices of our Supreme Court. Indeed, Justice Markman's lead opinion in *Woodard* removed any doubt that it was the majority opinion:

> Contrary to Chief Justice Taylor's concurrence's assertion, *this* opinion is the *majority* opinion in this case given that it has four supporters — Justices Cavanagh, Weaver, and Kelly, and myself. Chief Justice Taylor's concurrence sows confusion in an area of the law that is desperately in need of **[*27]** clarity. [*Woodard, 476 Mich at 554 n 1*.]

Plaintiff contends that the language in *Woodard* that a physician can only devote a majority of his or her professional time to one specialty is unrealistic because a physician may draw on more than one specialty in treating a patient. This argument should be directed to our Supreme Court. This Court is obligated to follow a decision of our Supreme Court until it has been overruled or modified by our Supreme Court. See *Paige v Sterling Hts, 476 Mich 495, 524; 720 NW2d 219 (2006)* (only our Supreme "Court has the authority to overrule one of its prior decisions. Until [our Supreme] Court does so, all lower courts and tribunals are bound by that prior decision and must follow it even if they believe that it was wrongly decided or has become obsolete.").

Plaintiff argues that it should be permitted to produce a substitute expert witness if this Court affirms the trial court's order striking Dr. Sokol. This argument is not preserved because it was not raised in the trial court. *Polkton Charter Twp v Pellegrom, 265 Mich App 88, 95; 693 NW2d 170 (2005)*. "Although this Court need not address an unpreserved issue, it may overlook preservation requirements when the failure to consider an issue would result in manifest injustice, if consideration is necessary for a proper determination of the case, or if the issue **[*28]** involves a question of law and the facts necessary for its resolution have been presented." *Gen Motors Corp v Dep't of Treasury, 290 Mich App 355, 387; 803 NW2d 698 (2010)* (citation omitted). Plaintiff fails to acknowledge that this aspect of the issue is unpreserved and offers no argument for the applicability of any ground for addressing the unpreserved issue. The trial court's order did not dismiss plaintiff's claim against Dr. Agnone and MCS, and the trial court has not yet been presented with any request to allow a substitute expert witness. It is thus premature for this Court to address plaintiff's unpreserved argument. We note, however, that the failure to present an expert witness who is qualified under *MCL 600.2169(1)* to testify regarding the appropriate standard of practice or care has been held to warrant dismissal with prejudice. See *Woodard, 476 Mich at 577-579*.

We now address the issues raised by Dr. Romanelli and Woods in Docket No. ***330416***. In these remaining issues, we will refer to Dr. Romanelli and Woods as "defendants" because they are the only defendants appealing with respect to these issues.

Defendants argue that the trial court abused its discretion in denying defendants' motions seeking to strike plaintiff's proposed expert in cardiology, Dr. Meltzer, or to preclude his standard **[*29]** of care testimony. We disagree.

MRE 702 provides:

> If the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

Under *MRE 702*, then, "the proposed expert witness must be 'qualified' to render the proposed testimony. Generally, the expert may be qualified by virtue of 'knowledge, skill, experience, training, or education.'" *Craig ex rel Craig v Oakwood Hosp, 471 Mich 67, 78; 684 NW2d 296 (2004)* (footnotes and citations omitted). Also, *MCL 600.2169(2)* provides:

> In determining the qualifications of an expert witness in an action alleging medical malpractice,

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the court shall, at a minimum, evaluate all of the following:
(a) The educational and professional training of the expert witness.
(b) The area of specialization of the expert witness.

(c) The length of time the expert witness has been engaged in the active clinical **[*30]** practice or instruction of the health profession or the specialty.
(d) The relevancy of the expert witness's testimony.

MRE 702 "requires the circuit court to ensure that each aspect of an expert witness's testimony, including the underlying data and methodology, is reliable." Elher, 499 Mich at 22.

MRE 702 incorporates the standards of reliability that the United States Supreme Court articulated in Daubert v Merrell Dow Pharm, Inc, [509 U.S. 579; 113 S. Ct. 2786; 125 L. Ed. 2d 469 (1993)], in order to interpret the equivalent federal rule of evidence. Under *Daubert*, the trial judge must ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable. A lack of supporting literature, while not dispositive, is an important factor in determining the admissibility of expert testimony. Under MRE 702, it is generally not sufficient to simply point to an expert's experience and background to argue that the expert's opinion is reliable and, therefore, admissible. [Elher, 499 Mich at 22 23 (footnotes, quotation marks and citations omitted).]

In addition, MCL 600.2955(1) provides:

In an action for the death of a person or for injury to a person or property, a scientific opinion rendered by an otherwise qualified expert is not admissible unless the court determines that the opinion is reliable and will assist the trier of fact. **[*31]** In making that determination, the court shall examine the opinion and the basis for the opinion, which basis includes the facts, technique, methodology, and reasoning relied on by the expert, and shall consider all of the following factors:
(a) Whether the opinion and its basis have been subjected to scientific testing and replication.
(b) Whether the opinion and its basis have been subjected to peer review publication.
(c) The existence and maintenance of generally accepted standards governing the application and interpretation of a methodology or technique and whether the opinion and its basis are consistent with those standards.
(d) The known or potential error rate of the opinion and its basis.
(e) The degree to which the opinion and its basis are generally accepted within the relevant expert community. As used in this subdivision, "relevant expert community" means individuals who are knowledgeable in the field of study and are gainfully employed applying that knowledge on the free market.

(f) Whether the basis for the opinion is reliable and whether experts in that field would rely on the same basis to reach the type of opinion being proffered.

(g) Whether the opinion or methodology **[*32]** is relied upon by experts outside of the context of litigation.

In short, "MCL 600.2955(1) requires the court to determine whether the expert's opinion is reliable and will assist the trier of fact by examining the opinion and its basis, including the facts, technique, methodology, and reasoning relied on by the expert, and by considering seven factors[.]" Elher, 499 Mich at 23. "[A]ll the factors in MCL 600.2955 may not be relevant in every case." Id. at 27; see also Chapin v A & L Parts, Inc, 274 Mich App 122, 137; 732 NW2d 578 (2007) (opinion by DAVIS, J.) ("[A]lthough MCL 600.2955(1) explicitly requires the trial court to *consider* all seven of the factors it enumerates, the statute does not require that each and every one of those seven factors must favor the proffered testimony."). "[I]t is within a trial court's discretion how to determine reliability." Elher, 499 Mich at 25. The proponent of expert testimony in a medical malpractice case has the burden of establishing that the expert is qualified under MRE 702 and MCL 600.2955, and that the evidence is relevant and admissible. Id. at 22.

"The inquiry is not into whether an expert's opinion is necessarily correct or universally accepted. The inquiry is into whether the opinion is rationally derived from a sound foundation." People v Unger, 278 Mich App 210, 217; 749 NW2d 272 (2008), quoting Chapin, 274 Mich App at 139 (opinion by DAVIS, J.). "Pursuant to *Daubert* and MRE 702, 'the trial court's role as gatekeeper does not require **[*33]** it to search for absolute truth, to admit only uncontested evidence, or to resolve genuine scientific disputes.'" Unger, 278 Mich App at 217, quoting Chapin, 274 Mich App at 127 (opinion by DAVIS, J.).

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> The standard focuses on the scientific validity of the expert's methods rather than on the correctness or soundness of the expert's particular proposed testimony. An expert's opinion is admissible if it is based on the "methods and procedures of science" rather than "subjective belief or unsupported speculation." [*Unger, 278 Mich App at 217-218* (citation omitted), quoting *Daubert, 509 U.S. at 590*.]

In medical malpractice cases, the standard of care for a specialist is defined by "the recognized standard of practice or care within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances . . . ." *MCL 600.2912a(1)(b)*. "[T]he standard of care is not based on how a particular health care professional would act." *Wiley v Henry Ford Cottage Hosp, 257 Mich App 488, 493; 668 NW2d 402 (2003)* (citation omitted).

Defendants initially contend that Dr. Meltzer is not qualified to testify as an expert because he lacks specialized knowledge regarding the medical issues he purports to address. Defendants emphasize Dr. Meltzer's testimony that he is not an expert in the use of Novantrone, that he has never seen **[*34]** a patient who was taking Novantrone, and that he had no experience with Novantrone aside from the research he conducted in this case. Defendants also note Dr. Meltzer's testimony that he conducted research on the Internet to learn about Novantrone in preparation for his expert testimony in this case. Moreover, defendants argue that Dr. Meltzer therefore lacks the requisite knowledge and experience to qualify as an expert regarding the cardiotoxic effects of Novantrone and the information that a cardiologist should provide to other physicians. According to defendants, Dr. Meltzer is merely "parroting" information that he learned on the Internet.

We find defendants' argument unpersuasive. Dr. Meltzer is not holding himself out as an expert in Novantrone. Rather, Dr. Meltzer is testifying as an expert in cardiology. Dr. Meltzer has been a practicing cardiologist for 27 years. His knowledge in cardiology comes from attending medical school and continuing education that includes reviewing new studies that come out, reviewing clinical trials, reviewing peer-reviewed literature, and his 27 years of experience as a practicing cardiologist. Although Dr. Meltzer had no prior experience with Novantrone **[*35]** before his research in this case, Dr. Meltzer testified that he does have "experience with assessing patients on other cardiotoxic chemotherapeutic drugs. That gives you a foundation and an understanding of how to evaluate the changes you may see in a patient and relate that to whether or not the patient is suffering a cardiotoxic effect of the drug." Dr. Meltzer explained that he possesses a "general understanding of cardiotoxic chemotherapeutic drugs" in addition to the information he obtained in this case from researching articles concerning Novantrone. Dr. Meltzer further explained:

> I know from my training and experience how to evaluate patients on cardiotoxic chemotherapeutic agents. I've done it many times. I had to learn about Novantrone to see the details of Novantrone, and what the parameters were to form a fair and reasonable educated opinion as to how the drug is assessed, and how the cardiotoxic effects are assessed because it's different for every drug. . . . It's different for every drug and you have to be familiar with how to compile the information and make a reasonable and correct decision and recommendation.

Dr. Meltzer emphasized that he did not use the medical literature **[*36]** he obtained from the Internet to determine the standard of care; rather, he used the literature to determine the parameters by which a cardiologist would evaluate a patient who is taking Novantrone. Defendants' suggestion that Dr. Meltzer was merely "parroting" information he obtained from the Internet is therefore not supported by the record.

Moreover, Dr. Meltzer's standard of care criticisms of Dr. Romanelli were limited to the role of a cardiologist in determining whether and how to assess a patient who was taking Novantrone; Dr. Meltzer was not purporting to possess expertise more generally in Novantrone itself. Dr. Meltzer explained his first standard of care criticism of Dr. Romanelli as follows:

> The first criticism is based on Dr. Romanelli's testimony that at the time he evaluated [Patricia] he had no understanding whatsoever of the drug Novantrone, no understanding of how it worked or no understanding of the parameters by which a patient taking the drug is to be evaluated. And in my opinion he violated the standard of care by offering a recommendation in light of the fact that he did not have any knowledge about the drug.

Dr. Meltzer noted that Dr. Romanelli had testified that **[*37]** he lacked any knowledge about Novantrone when Dr. Romanelli was asked by Patricia's treating physicians to perform a cardiac assessment of Patricia to determine the risks of using Novantrone. Following

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his cardiac evaluation, Dr. Romanelli wrote to the treating physician in January 2009 that Patricia was an acceptable risk for the medication. In Dr. Meltzer's view, "no reasonable or prudent board-certified cardiologist would make a recommendation concerning a drug when he has absolutely no knowledge of the drug, how the drug works, how you assess the drug or how to evaluate a patient for risks associated with the drug." When asked what Dr. Romanelli should have done, Dr. Meltzer testified:

> Well, in my opinion he had to choose between one of two choices. One choice would be to research the drug and educate himself about the drug. And if that research left him satisfied that he was sufficiently knowledgeable to make a recommendation about the drug, then make a recommendation about the drug.
>
> The second thing he could have done was to tell [the treating physician] I'm not qualified to evaluate this patient. I don't know anything at all about this drug. And you need to send her to a cardiologist **[*38]** who knows how to do a proper evaluation concerning a patient taking Novantrone.

Dr. Meltzer's second standard of care criticism was that Dr. Romanelli failed to recognize that Patricia was suffering a cardiotoxic effect of Novantrone:

> When Dr. Romanelli evaluated [Patricia] he failed to recognize that she was demonstrating toxic effects, potentially toxicity effects of Novantrone therapy. And this included a fall in ejection fraction from 76 percent to 62 percent. She had an echocardiogram in July of 2008 that had an ejection fraction of 76 percent and in January of 2009 her ejection fraction was 62 percent.
>
> In addition, the echo from July of 2008 demonstrated hyperdynamic left ventricular wall motion. And the echocardiogram performed in January of 2009 demonstrated wall motion. Both of these — I'm sorry, normal wall motion. Both of these findings, the fall in ejection fraction and the change in the character of the wall motion, are consistent with and suggestive of a cardiotoxic effect of the drug.
>
> And third of all, in January of 2009 she was noted to have a new right bundle branch block on her electrocardiogram. And a right bundle branch block could be a sign of a cardiotoxic effect **[*39]** of the Novantrone.

The echocardiogram in January 2009 indicated that Patricia's ejection fraction was 62%, which was an 18% decrease from her ejection fraction in July 2008. Also, a stress test performed in January 2009 indicated that Patricia's ejection fraction was 50%, which was more than a 30% drop from the July 2008 ejection fraction. Dr. Meltzer explained why the decreases in ejection fraction were significant: "In all of the literature that I reviewed it recommends that a fall in ejection fraction of greater than 10 percent and some of the literature says even 5 percent, indicates a cardiotoxic effect of Novantrone and the drug should be stopped." Dr. Meltzer further explained that

> those are very big changes in ejection fraction and when you look at a patient who is taking a chemotherapeutic — a cardiotoxic chemotherapeutic agent a fall in ejection fraction from 76 to 62, or 76 to 50 indicates a significant decrease in ejection fraction in cardiac function.

In short, the significant decrease in ejection fraction "suggests that the patient is suffering a cardiotoxic effect of the drug."

We conclude that Dr. Meltzer was properly qualified to testify as an expert in cardiology. His **[*40]** extensive knowledge and experience in practicing cardiology, including in performing cardiac evaluations of patients who are taking cardiotoxic chemotherapeutic drugs, supports the conclusion that he was qualified to testify concerning the appropriate standard of care for a cardiologist who is asked to perform a cardiac evaluation of a patient who is taking a chemotherapeutic drug such as Novantrone. Cf. *Elher, 499 Mich at 24* ("There is no doubt that . . . plaintiff's sole expert regarding the standard of care[] was qualified to testify as an expert based on his extensive experience. . . . The question is whether [the expert's] opinion was sufficiently reliable under the principles articulated in *MRE 702* and by the Legislature in *MCL 600.2955*."). Dr. Meltzer's lack of prior experience with the particular chemotherapeutic drug used in this case, Novantrone, does not disqualify him to testify concerning the standard of care for a cardiologist. There is no requirement in case law that an expert possess prior experience with exactly the same drug at issue in the case. Dr. Meltzer's standard of care criticisms were limited to areas that fell within his expertise as a practicing cardiologist. We are thus not persuaded by defendants' **[*41]** argument that Dr. Meltzer lacked the qualification to testify as an expert in this case.

Defendants next argue that Dr. Meltzer's standard of care testimony was unreliable. In particular, defendants focus on Dr. Meltzer's opinion that a decrease of the ejection fraction by 10% or more indicates that a

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cardiotoxic effect of the drug exists such that Dr. Romanelli should have recommended the discontinuation of the Novantrone therapy. Defendants contend that there is no peer-reviewed literature establishing that the standard of care requires a cardiologist to recommend ending the administration of Novantrone upon a 10% drop in ejection fraction. Defendants state that the FDA packaging for Novantrone does not refer to a 10% decrease in ejection fraction as a reason to discontinue the medication. Defendants characterize the medical articles cited by Dr. Meltzer as merely describing clinical trials and case studies of patients in which the authors and treating physicians chose to discontinue the medication upon a 10% decrease in ejection fraction. Defendants claim that these articles do not establish the standard of care for a cardiologist who is performing a cardiac evaluation of a patient **[*42]** taking Novantrone.

We find defendants' argument unconvincing. There was adequate support for Dr. Meltzer's standard of care testimony to conclude that it was reliable. The FDA-approved label for Novantrone warns, in relevant part: "Additional doses of NOVANTRONE should not be administered to multiple sclerosis patients who have experienced either a drop in [ejection fraction] to below the lower limit of normal *or a clinically significant reduction in [ejection fraction] during NOVANTRONE therapy*." (Emphasis added.) Dr. Meltzer identified medical articles that supported his view that a 10% drop in ejection fraction was significant and warranted discontinuation of the medicine. Of particular note is Avasarala et al., *Rapid onset Mitroxantrone-induced cardiotoxicity in secondary progressive multiple sclerosis*, Multiple Sclerosis Journal (2003), in which the physician-authors studied 28 MS patients who were treated with Mitroxantrone[7] every three months. Five of the 28 patients displayed what the authors described as a "significant" decrease in ejection fraction of 10% or more, and the Mitroxantrone treatment was thus discontinued for those patients. *Id.* The authors stated that "[a] decline **[*43]** in [ejection fraction] of 10 percentage points or more should be viewed with concern." *Id.*

Defendants claim that none of the medical literature on which Dr. Meltzer relied was peer-reviewed,[8] but defendants fail to address the article summarized above or to explain why defendants believe it was not peer-reviewed. "A party cannot simply assert an error or announce a position and then leave it to this Court to discover and rationalize the basis for his claims, or unravel and elaborate for him his arguments, and then search for authority either to sustain or reject his position." *Mitchell v Mitchell, 296 Mich App 513, 524; 823 NW2d 153 (2012)* (quotation marks and citation omitted). Given defendants' inadequate briefing, this aspect of their argument may be deemed abandoned. *Prince v MacDonald, 237 Mich App 186, 197; 602 NW2d 834 (1999)*. The above article was authored by multiple medical professionals. It was written in a formal, scholarly manner using technical medical terms and included citations to numerous other medical studies in endnotes. The article indicated that it was "accepted" more than two months after it was "received." This strongly suggests that there was a peer-review process before publication. We find nothing to support defendants' conclusory assertion that the article was not peer-reviewed. **[*44]** Also, the article was written outside of the context of litigation, and defendants articulate no basis for disagreement with the substantive content of the article. Overall, Dr. Meltzer's opinion was based not only on his experience and background but found general support in the FDA packaging information and additional support in the medical literature. Regardless of whether Dr. Meltzer's conclusion was necessarily correct, his opinion was "rationally derived from a sound foundation[ ]" and did not comprise mere speculation. See *Unger, 278 Mich App at 217*, quoting *Chapin, 274 Mich App at 139* (opinion by DAVIS, J.). The trial court did not abuse its discretion in finding that Dr. Meltzer's standard of care testimony was reliable.

Next, we disagree with defendants' contention that Dr. Meltzer improperly used the medical literature in contravention of *MRE 707*. *MRE 707* provides:

> To the extent called to the attention of expert witnesses upon cross-examination, statements contained in published treatises, periodicals, or pamphlets on a subject of history, medicine, or other science or art, established as a reliable authority by the testimony or admission of the witness or by other expert testimony or by judicial notice, are admissible for impeachment purposes **[*45]** only. If admitted, the statements may be read into evidence but may not be received as exhibits.

MRE 707 has been interpreted to bar the use of learned treatises as substantive evidence on direct examination,

[7] Novantrone is the trade name for Mitroxantrone.

[8] Again, peer-reviewed literature is not always necessary to satisfy the requirements of *MRE 702*. *Elher, 499 Mich at 28*.

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but the rule "does not absolutely forbid using learned treatises at other stages of a trial or for other reasons." *Hilgendorf v St John Hosp & Med Ctr Corp, 245 Mich App 670, 702; 630 NW2d 356 (2001)*. Defendants assert that Dr. Meltzer was repeatedly questioned about the literature he reviewed and that this essentially constitutes the use of the literature as direct evidence. Defendants fail to provide any record citations to support this assertion in the argument section of their brief on appeal for this issue (although defendants quote testimony concerning the literature earlier in their brief). "This Court will not search the record for factual support for a party's claim." *McIntosh v McIntosh, 282 Mich App 471, 485; 768 NW2d 325 (2009)* (citation omitted); see also *MCR 7.212(C)(7)* ("Facts stated must be supported by specific page references to the transcript, the pleadings, or other document or paper filed with the trial court."). In any event, although Dr. Meltzer referred to medical literature as supporting his opinion, he did not read into evidence any statements contained in the medical literature.[9] Defendants have failed to establish that **[*46]** the admission of Dr. Meltzer's testimony is a violation of *MRE 707*.

Next, defendants argue that the trial court erred in denying their motion to exclude Dr. Meltzer's allegedly new standard of care criticisms. Defendants contend that Dr. Meltzer offered new standard of care criticisms at his trial deposition, i.e., that (1) Dr. Romanelli should have informed Patricia's other medical providers that her computer-generated ejection fraction had fallen to 50% in a January 2009 stress test, and (2) Dr. Romanelli should have ordered a multigated acquisition (MUGA) scan to determine Patricia's correct ejection fraction. Therefore, defendants argue, Dr. Meltzer's new standard of care criticisms should be excluded. We disagree.

MCR 2.302(E)(1) provides, in relevant part:

> *Duty to supplement*. A party who has responded to a request for discovery with a response that was complete when made is under no duty to supplement the response to include information acquired later, except as follows:
> (a) A party is under a duty seasonably to supplement the response with respect to a question directly addressed to
>
> (*i*) the identity and location of persons having knowledge of discoverable matters; and
>
> (*ii*) the identity of each person expected **[*47]** to be called as an expert witness at trial, the subject matter on which the expert is expected to testify, *and the substance of the expert's testimony*. [Emphasis added.]

At his trial deposition, Dr. Meltzer testified that Dr. Romanelli should have informed Patricia's treating physicians that, according to a stress test performed in January 2009, her ejection fraction had fallen to 50%. Dr. Meltzer noted that, although the body of Dr. Romanelli's report reflected that the computer-generated ejection fraction was 50%, Dr. Romanelli changed the ejection fraction to greater than 60% in the conclusion of his report, on the basis of Dr. Romanelli's subjective assessment. Defendants contend that Dr. Meltzer had not disclosed during his discovery deposition that he was making a standard of care criticism related to Dr. Romanelli's failure to report the 50% ejection fraction to the other medical providers. We disagree. In his discovery deposition, Dr. Meltzer testified:

> The next violation of the standard of care is that he arbitrarily changed the value of the ejection fraction on the Persantine stress test from sixty to fifty [sic: 50 to 60] based on his subjective evaluation that the left ventricular **[*48]** contraction looked normal to him so he gave it a normal number of sixty.
> The next violation of the standard of care is that he

[9] That is, Dr. Meltzer did not read into evidence any statements from a specific article by directly quoting it. In explaining his understanding of the literature, Dr. Meltzer arguably paraphrased it by stating, "In the medical literature that I reviewed it consistently says that the risk of cardiotoxicity increases with the risk, with the increasing doses of the drug." Dr. Meltzer also stated, "In all of the literature that I reviewed it recommends that a fall in ejection fraction of greater than 10 percent and some of the literature says even 5 percent, indicates a cardiotoxic effect of Novantrone and the drug should be stopped." Again, however, defendants' brief fails to include record citations to indicate the specific portions of Dr. Meltzer's testimony that they are challenging in this issue. Defendants also fail to address whether a general statement paraphrasing medical literature, as opposed to a direct quotation of a specific article, amounts to a violation of *MRE 707*, nor do defendants cite case law addressing that issue. "A party cannot simply assert an error or announce a position and then leave it to this Court to discover and rationalize the basis for his claims, or unravel and elaborate for him his arguments, and then search for authority either to sustain or reject his position." *Mitchell, 296 Mich App at 524* (quotation marks and citation omitted). Given defendants' inadequate briefing, this aspect of their argument may be deemed abandoned. *Prince, 237 Mich App at 197*.

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> failed to recognize, likely due to his ignorance of Novantrone, that the patient's change in ejection fraction, change in wall motion, new right bundle branch block were all suggestive of Novantrone-induced cardiotoxicity and that a more thorough workup was indicated.
>
> A consequence of his changing the ejection fraction from fifty to sixty on the stress test and ignoring or not being aware of the ejection fraction of seventy-six and sixty-two percent, in my mind, prevented him from thinking about getting a different kind of estimation of her stress test, namely a MUGA, which is more accurate, so that he could ascertain, get a better idea of what her ejection fraction truly is.
>
> * * *
>
> [Dr. Romanelli] violated the standard of care. What he did was not consistent with what a reasonable and prudent cardiologist would do. You have an eighteen percent fall in ejection fraction and then you have a fall to fifty percent, which is a thirty-six percent fall in ejection fraction, and you don't make a recommendation to stop the drug, that's a violation of the standard of care. **[*49]**

In his discovery deposition, then, Dr. Meltzer stated that it was a violation of the standard of care for Dr. Romanelli not to recommend discontinuation of Novantrone therapy in light of the fall in the ejection fraction to 50%. Recommending the discontinuation of Novantrone due to the ejection fraction of 50% implies informing the medical providers of the 50% ejection fraction. Dr. Meltzer also indicated in his discovery deposition that it was a violation of the standard of care for Dr. Romanelli to change the ejection fraction of 50% that was generated by the computer during the stress test to 60% on the basis of Dr. Romanelli's subjective assessment, which again suggests that the 50% ejection fraction finding should have been communicated to the other medical providers. Although not phrased identically to his trial deposition testimony, it was sufficiently clear from Dr. Meltzer's discovery deposition that he was critical of Dr. Romanelli for failing to inform the other medical providers of the 50% ejection fraction finding.

Defendants also claim that Dr. Meltzer first testified during his trial deposition that it was a violation of the standard of care for Dr. Romanelli to fail to **[*50]** order a MUGA scan in order to determine Patricia's true ejection fraction. According to defendants, Dr. Meltzer did not state during his discovery deposition that the failure to order a MUGA scan violated the standard of care. Again, we conclude that, while not stated in precisely the same manner as in Dr. Meltzer's trial deposition testimony, Dr. Meltzer's discovery deposition testimony adequately informed defendants of Dr. Meltzer's view on this point. In his discovery deposition, Dr. Meltzer testified that a MUGA scan is the most accurate way to measure ejection fraction and that Patricia did not undergo a MUGA scan. And, as quoted above, Dr. Meltzer also testified in his discovery deposition that, as a result of Dr. Romanelli's changing the ejection fraction from 50% to 60% and being unaware of the earlier ejection fraction findings, Dr. Romanelli did not consider ordering a MUGA scan, which is a more accurate way of determining a patient's ejection fraction. It is thus clear from Dr. Meltzer's discovery deposition testimony that a MUGA scan is the most accurate way to determine ejection fraction and that a MUGA scan was warranted given the change in Patricia's ejection fraction **[*51]** from earlier findings. While not explicitly phrased in terms of being a violation of the standard of care, the discovery deposition testimony concerning the MUGA scan, considered in its entirety, sufficed to apprise defendants of Dr. Meltzer's opinion on the matter.

Defendants further argue that the complaint failed to apprise defendants of Dr. Meltzer's two allegedly new standard of care criticisms discussed above. Defendants note that, before deciding the motion at issue here, the trial court had entered a consent order limiting plaintiff to theories pleaded in the complaint unless the trial court permitted an amendment pursuant to *MCR 2.118*. We disagree with defendants' argument. "[T]he primary function of a pleading in Michigan is to give notice of the nature of the claim or defense sufficient to permit the opposite party to take a responsive position." *Stanke v State Farm Mut Auto Ins Co, 200 Mich App 307, 317; 503 NW2d 758 (1993)*. A complaint must contain "[a] statement of the facts, without repetition, on which the pleader relies in stating the cause of action, with the specific allegations necessary reasonably to inform the adverse party of the nature of the claims the adverse party is called on to defend[.]" *MCR 2.111(B)(1)*. Plaintiff's allegations were sufficient to provide defendants **[*52]** with notice of the nature of the claims. The complaint included allegations that Dr. Romanelli failed to communicate pertinent information to the other specialists and to appropriately collaborate and coordinate with the other specialists; these allegations encompass Dr. Meltzer's theory that Dr. Romanelli should have informed the other medical providers of the 10% decrease in ejection fraction. The failure to order a MUGA scan was encompassed by allegations of a failure to ensure that Patricia is

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assessed for cardiac signs and symptoms. Overall, the allegations in the complaint sufficed to reasonably inform defendants of the nature of the claims.

Finally, defendants argue that the trial court abused its discretion in denying their motion to exclude the proximate causation testimony of Dr. Meltzer and Dr. Sokol, which defendants characterize as speculative and unsupported. We disagree.[10]

"[A] plaintiff's prima facie case of medical malpractice must draw a causal connection between the defendant's breach of the applicable standard of care and the plaintiff's injuries." *Craig, 471 Mich at 90*. Expert testimony is required to establish causation in a medical malpractice action. *Teal v Prasad, 283 Mich App 384, 394; 772 NW2d 57 (2009)*. "'Proximate cause' is a legal **[*53]** term of art that incorporates both cause in fact and legal (or 'proximate') cause." *Craig, 471 Mich at 86* (footnote and citation omitted).

> As a matter of logic, a court must find that the defendant's negligence was a cause in fact of the plaintiff's injuries before it can hold that the defendant's negligence was the proximate or legal cause of those injuries.
>
> Generally, an act or omission is a cause in fact of an injury only if the injury could not have occurred without (or "but for") that act or omission. While a plaintiff need not prove that an act or omission was the *sole* catalyst for his injuries, he must introduce evidence permitting the jury to conclude that the act or omission was *a* cause. [*Id. at 87* (footnotes and citations omitted).]

There must be proof of "more than a mere possibility or a plausible explanation." *Id.* (footnote and citation omitted).

> [A] plaintiff establishes that the defendant's conduct was a cause in fact of his injuries only if he sets forth specific facts that would support a reasonable inference of a logical sequence of cause and effect. A valid theory of causation, therefore, must be based on facts in evidence. And while the evidence need not negate all other possible causes, this Court **[*54]** has consistently required that the evidence exclude other reasonable hypotheses with a fair amount of certainty. [*Id. at 87-88* (quotation marks, brackets, footnotes and citations omitted).]

"It is axiomatic in logic and in science that correlation is not causation. This adage counsels that it is error to infer that A causes B from the mere fact that A and B occur together." *Id. at 93* (footnote and citation omitted). "Where the connection between the defendant's negligent conduct and the plaintiff's injuries is entirely speculative, the plaintiff cannot establish a prima facie case of negligence." *Id.* (footnote and citation omitted).

In this case, Dr. Meltzer testified that as a result of receiving 16 doses of Novantrone for 16 consecutive months, Patricia developed a severe cardiomyopathy, meaning that her heart did not work or pump correctly. Dr. Meltzer noted that this conclusion was supported by the diagnosis of Dr. Romanelli's partner, Dr. David Graham, who examined Patricia in the hospital in January 2010 and concluded that she was suffering from "dilated cardiomyopathy likely nonischemic in nature related to the cardiac toxicity of her chemotherapy that she was receiving for multiple sclerosis." Dr. **[*55]** Meltzer opined that the cardiomyopathy was caused by the cardiotoxic effects of Novantrone. Dr. Meltzer explained that Patricia "didn't have any reason to develop a cardiomyopathy. So there's no other causative factor and Novantrone is known to cause a cardio, to have the potential to cause a cardiomyopathy." In Dr. Meltzer's view, Patricia would not have developed a dilated cardiomyopathy if the Novantrone had been discontinued in January 2009. He explained:

> She had evidence of cardiomyopathy in January of 2009. But what is known about Novantrone is when you stop the drug the patient has the potential to have the cardiotoxic effect slowly go away.
>
> So that, in my opinion, more likely than not, she would not have gone on to develop a dilated cardiomyopathy and severe mitral regurgitation had the Novantrone been stopped in January of 2009.

According to Dr. Meltzer, if Dr. Romanelli had recognized the significant decrease in ejection fraction and recommended the discontinuation of Novantrone therapy in January 2009, Patricia "would not have developed cardiotoxicity to the extent that she did and

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[10] We earlier determined that the trial court did not abuse its discretion in concluding that Dr. Sokol lacked the requisite qualification under *MCL 600.2169(1)(b)* to testify as an expert in medical oncology about the standard of care applicable to Dr. Agnone. This does not preclude Dr. Sokol from testifying regarding causation. See *Woodard, 476 Mich at 558 n 4* ("*MCL 600.2169(1)* only applies to expert testimony on the appropriate standard of practice or care; it does not apply to other kinds of expert testimony, such as expert testimony on causation.").

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more likely than not she would not have developed the severe cardiac dysfunction and valvular **[*56]** — mitral valvular regurgitation that required her to be operated on." Dr. Meltzer noted that Patricia "was already suffering cardiotoxic effects of the drug in January of 2009. And she was receiving subsequent, relatively close to monthly treatments with the drug, and that would have only added to the cardiotoxic effects of the drug and it would have been manifested as a consistent decline in her ejection fraction." Dr. Meltzer further explained: "The combination of the drug induced cardiomyopathy and the mitral regurgitation basically placed her in the state where she deteriorated into a condition called cardiogenic shock. And she, therefore, required surgery on her mitral valve in order to try to improve her cardiac performance to the point that she could survive." Patricia underwent surgery for this cardiac condition and then developed complications following the surgery that led to her death.

Dr. Sokol provided similar testimony. Dr. Sokol opined that the doses of Novantrone administered to Patricia were more concentrated and dense and given at more frequent intervals than were recommended for safe usage, which added significantly to the toxicity of the drug. Dr. Sokol stated that **[*57]** the frequency with which Novantrone was administered added "significantly to the inability of the drug to be metabolized and it adds to the concentration of a toxin that exists for a much longer period of time. There is no time for a washout. And, of course, the concentration of the drug is much higher for a period of time." In Dr. Sokol's view, Patricia would not have suffered the same degree of cardiotoxicity that she did if the drug had been stopped after six doses in January 2009, which was when the significant decline in ejection fraction was measured. Dr. Sokol explained that if the Novantrone administration had ended in January 2009, Patricia "would have gotten only, what, 30 to 40 percent of the dose that she [ultimately] got. So if you're saying that, gee, she was a dead duck at six months, well, I hate to see her shot 10 more times with additional [sic] to make sure the deed was done." Dr. Sokol noted that it was "[n]ot just my opinion that she sustained cardiotoxic death, to a large extent contributed to [sic] the dose of Novantrone and the way it was given, but apparently it was the opinion of the people that took care of her as well." Dr. Sokol expressed agreement with Dr. **[*58]** Graham's consultation notes in the hospital records concluding that Patricia had suffered a dilated cardiomyopathy "related to the cardiac toxicity of her chemotherapy that she was receiving for multiple sclerosis."

Dr. Sokol also indicated that the cardiotoxicity of Novantrone increases with each dose:

> *Q*. And — okay. Moving on. Novantrone can lead to cardio toxicity with the first dose. Correct?
>
> *A*. To a very small extent, that's true.
>
> *Q*. But you cannot state at any point in time what dose could have tipped this patient over into the area where you claim — the area you claimed occurred? You can't isolate one dose, can you?
>
> *A*. If that's an accusation, I deny it because that would be an inaccurate accusation when you say I can't do that.
>
> *Q*. Okay.
>
> *A*. Because there is a clear cut statistical association between the early doses, the low doses, and the increasing incidents of cardio toxicity as the dose increases particularly above the limits that have been defined.
>
> *Q*. Doctor, you indicated that the numbers — the risk percentage is small with cardio toxicity for Novantrone, two or three percent, correct?
>
> *A*. Oh, you're talking about Novantrone when it's given every three months. And that's drawn from **[*59]** the studies that have utilized it every three months. But if you draw appropriately from the studies that were done every month, you will find a significantly higher incidents [sic] of cardio toxicity.
>
> *Q*. Is it dose-related, Doctor, not frequency-related?
>
> *A*. It's both.
>
> *Q*. If it's dose-related, don't we know what the percentage risks are at certain levels or do you?
>
> *A*. I just told you it's both.

In short, then, Dr. Meltzer opined that, more likely than not, Patricia would not have developed the severe cardiac condition that ultimately led to her death if the Novantrone therapy had been discontinued in January 2009, and Dr. Sokol testified that Patricia would not have suffered the degree of cardiotoxicity that she did if the Novantrone had been stopped after six doses in January 2009. Notably, defendants do *not* challenge the reliability of the experts' testimony that Patricia died as a result of Novantrone-induced cardiogenic shock. As

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discussed, medical literature and FDA packaging information reflect the risk of cardiac complications arising from the use of Novantrone, and Dr. Romanelli's own partner who treated Patricia concluded that she suffered a dilated cardiomyopathy related to the **[*60]** cardiac toxicity of her chemotherapy drug. Rather than challenging the theory that Patricia died from cardiac complications arising from the use of Novantrone, defendants claim that there is no support for the opinion that Patricia would not have suffered the degree of cardiotoxicity that she suffered if the Novantrone administration had ended in January 2009. Defendants take note of testimony from plaintiff's neurology expert, Dr. Douglas Jeffery, that one dose of Novantrone could cause what occurred in this case, that a patient could suffer a delayed reaction to Novantrone months or years later, and that the same injury could have occurred even if the appropriate dosage had been given. Defendants also note that Dr. Sokol, when asked whether the first dose of Novantrone can lead to cardiotoxicity, stated, "To a very small extent, that's true."

The flaw in defendants' argument is that it fails to take into account the increased risk of cardiotoxicity with each dose of Novantrone and the fact that, in January 2009, Patricia had only received six of the 16 doses that she ultimately received. Defendant-oncologist Dr. Agnone acknowledged in his deposition that the risk from taking Novantrone **[*61]** increases with each milligram. Most of the doses of Novantrone were administered to Patricia after January 2009. The frequent and dense doses after January 2009 therefore may reasonably be determined to have not only infused more of this drug into Patricia's body but also, as Dr. Sokol explained, prevented her body from having an opportunity to metabolize the drug and wash out the toxins. The risk of complications with only the first dose of Novantrone, on which defendants focus, was very small, according to Dr. Sokol. Defendants seem to suggest that there must be medical literature explicitly addressing the precise question of whether a patient would suffer complications if the Novantrone administration had been discontinued after six doses. Such a fact-specific medical article conclusively addressing the exact situation presented here is not required. See *Unger, 278 Mich App at 220* ("Indeed, it is obvious that not every particular factual circumstance can be the subject of peer-reviewed writing."). Utilizing the knowledge and experience they have obtained in their respective fields, Dr. Meltzer and Dr. Sokol posited a

causation theory that was reasonably extrapolated from an established scientific foundation **[*62]** as reflected in the medical literature and FDA packaging information regarding the cardiac risks of this drug. Their testimony was sufficiently reliable to be admitted for a jury to consider. See *Unger, 278 Mich App at 220* ("When expert witnesses offer conflicting opinions, it is solely for the jury to determine which expert is more credible."). The trial court properly denied defendants' motion to exclude the proximate causation testimony of plaintiffs' experts.

Affirmed in both appeals. In Docket No. 330330 defendants Dr. Agnone and MCS, as the prevailing parties, may tax costs pursuant to *MCR 7.219*. In Docket No. ***330416***, plaintiff, as the prevailing party, may tax costs pursuant to *MCR 7.219*.

/s/ Karen M. Fort Hood

/s/ Mark J. Cavanagh

Concur by: Amy Ronayne Krause (In Part)

Dissent by: Amy Ronayne Krause (In Part)

Dissent

RONAYNE KRAUSE, J. *(concurring in part and dissenting in part)*.

I respectfully dissent from the majority's conclusion that Dr. Gerald Sokol was appropriately disqualified from rendering an expert opinion of the standard of practice applicable to defendant Dr. Eugene Agnone. The purpose of *MCL 600.2169* is to preclude expert testimony from an underqualified expert, not from an arguably overqualified expert. Furthermore, this case serves to demonstrate how **[*63]** the interpretation given to the statute is not only incompatible with its plain language, in that it treats "a majority" as synonymous with "the majority," but it is also incompatible with the reality of how medicine is practiced. In all other respects, I concur.

The instant issue turns on a single phrase used by our Supreme Court in discussing the implications of *MCL 600.2169(1)(b)*, which, *inter alia*, requires a proposed expert doctor intending to render an opinion on a medical malpractice defendant's standard of care to have "devoted a majority of his or her professional time to" the active clinical practice of the same specialty the defendant was practicing relevant to the alleged

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malpractice. Our Supreme Court stated, without any discernable basis whatsoever, that "[o]bviously, a specialist can only devote a *majority* of his professional time to *one* specialty." Woodard v Custer, 476 Mich 545, 560; 719 NW2d 842 (2006) (emphasis in original). Dr. Sokal's testimony in this matter made it clear that no such conclusion is either obvious or warranted, even assuming that there is only one possible definition of "majority": he dedicated a considerable amount of his testimony to attempting to explain how his various specialties intertwine and overlap. Furthermore, as Judge **[*64]** O'CONNELL eloquently explained, in an opinion unfortunately disregarded by the majority on that panel, the blithe assumption that "majority" necessarily means "more than half" instead of "the largest percentage" seems to have passed unnoticed and has little bearing on reality. Kiefer v Markley, 283 Mich App 555, 560-566; 769 NW2d 271 (2009) (O'CONNELL, J., dissenting). I think it highly significant that the statute requires "*a* majority," strongly suggesting that "majority" refers to the largest percentage as Judge O'CONNELL opined; it does not specify "*the* majority," which is how *Woodard* nevertheless treated it.

I further conclude that our Supreme Court's statement that "a specialist can only devote a *majority* of his professional time to *one* specialty" was also obiter dicta and not binding. The proposed expert doctors discussed in *Woodard* simply did not share the relevant subspecializations with the defendant doctors. Consequently, neither the question of whether "a majority" can encompass multiple simultaneous overlapping specializations nor which possible definition of "majority" should apply were properly before the Court, and they had no bearing on the Court's holding.[1] See SBC Health Midwest, Inc v City of Kentwood, 500 Mich. 65, ; 894 NW2d 535 (2017). Notwithstanding my conclusion that the statement in *Woodard* is mere **[*65]** dicta, I recognize that the *Kiefer* majority is binding on this panel pursuant to MCR 7.215(J)(1), and the majority in *Kiefer*, despite opining that the Legislature had actually intended a different result, a conclusion with which I agree, nevertheless held that "majority" necessarily meant "more than 50 percent." Kiefer, 283 Mich App at 557-560. Were I at liberty to do so, I would declare a conflict with *Kiefer* pursuant to MCR 7.215(J)(2). However, such is not necessary.

In any event, I believe the majority in this case and the trial court improperly relied on Dr. Sokal's reluctance to employ talismanic legal terms of art. It has long been established that courts look to the substance of matters, not superficial descriptors or labels given by any particular person. Hurtford v Holmes, 3 Mich. 460, 463 (1855); In re Traub Estate, 354 Mich 263, 278-279; 92 NW2d 480 (1958); Wilcox v Moore, 354 Mich 499, 504; 93 NW2d 288 (1958); Norris v Lincoln Park Police Officers, 292 Mich App 574, 582; 808 NW2d 578 (2011). Indeed, parties are entitled to the benefit of the evidence even if they express an opinion to the contrary in open court. Ortega v Lenderink, 382 Mich 218, 222-223; 169 NW2d 470 (1969). See also Zantop Int'l Airlines, Inc v Eastern Airlines, 200 Mich App 344, 364; 503 NW2d 915 (1993) (noting that arguments of counsel are neither evidence nor stipulations of fact). The fact that Dr. Sokal refused to engage in what he clearly reasonably believed to be a legal absurdity[2] does not establish anything, especially where a review of his testimony as a whole *does* indicate that a majority, no matter how it is defined, of his professional **[*66]** time entailed the practice or teaching of medical oncology.

I agree with the majority to the extent that they describe Dr. Sokal's testimony regarding the percentage of time he spent in any particular kind of practice as "less clear or coherent" than might be hoped for under the circumstance. Nonetheless, that lack of clarity or coherence is obviously the result of a cultural clash between a formality and reality.[3] In practice, Dr. Sokal *was* able to quantify at least some portions of his time. He stated that he worked at least 20 hours a week exclusively in medical oncology at the Center for Drug Research, saw patients for "at least three hours a day in medical oncology," "[t]aking call 20 hours every month in medical oncology," 15 hours a week teaching and writing in a combination of medical oncology and clinical pharmacology, and that a majority of the time he billed for radiation oncology[4] was actually performed "as a medical oncologist in evaluating it for that purpose."

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[1] Indeed, I doubt they would have even been argued by the parties.

[2] Even from a bare written transcript, it is readily apparent that the doctor and the lawyers were all mutually frustrated with each others' perceived obstinance and incomprehension.

[3] Additionally, at one point counsel for defendant asked Dr. Sokal how much time he spent in "medical radiation oncology," which is of course a nonsensical contradiction in terms pursuant to defendant's own position in this matter.

[4] Dr. Sokal specifically pointed out, in response to questioning from defendant's counsel, that although he made more money from billing for radiation oncology, that did not mean he spent more time practicing radiation oncology.

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Although Dr. Sokal did not clearly articulate how many total hours a week he worked, I believe we are forced to presume that he does in fact sleep occasionally even in the absence of specific testimony to that effect. Even **[*67]** disregarding the teaching and writing, the remaining hours exceed half of a typical work-week for most people employed full-time.

I therefore conclude that the statement from *Woodard* dictating that "a majority" necessarily means that there can be only one majority is dicta, contrary to the plain language of the statute. This Court's decision in *Kiefer* was wrong in concluding that "a majority" as used in the statute meant more than half, and that conclusion should be challenged by convening a conflict panel at some point. Finally, I find adequate support in Dr. Sokal's testimony to find that he spent more than half of his time practicing medical oncology, thus even satisfying the *Woodard* requirement made binding on us by *Kiefer*. I would reverse the trial court to the extent it excluded Dr. Sokal as an expert witness for being overqualified. In all other respects, I concur with the majority.

/s/ Amy Ronayne Krause

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APPENDIX 21

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Estate of Aura Arg. v. Henry Ford Health Sys.

Court of Appeals of Michigan

December 4, 2018, Decided

No. 340082

Reporter
2018 Mich. App. LEXIS 3624 *

ESTATE OF AURA ARGENTINA PEREZ, by JENNY NASYELLY PEREZ, Personal Representative, and RUBEN PEREZ, Plaintiffs-Appellees/Cross-Appellants, v HENRY FORD HEALTH SYSTEM, Defendant-Appellant/Cross-Appellee, and DANIEL MORRIS,M.D., DR. FRANK MCGEORGE, DR. OLESYA KRIVOSPITSKAYA, DR. TAREK TOUBIA, DR. MICHELLE SLEZAK, DR. GREGORY HAYS, DR. HEATHER EVANSON, DR. E. JENKINS BROWN, DR. DENISE LEUNG, DR. LAURIE ROLLAND, VIVEK RAI, M.D., DR. ANDREW RUSSMAN, DR. SATHYAVANI RAMANUJAM, and DR. ASHA SHAJAHAN, Defendants.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Subsequent History: Leave to appeal denied by *Perez v. Henry Ford Health Sys., 2019 Mich. LEXIS 1674 (Mich., Sept. 18, 2019)*

Prior History: **[*1]** Wayne Circuit Court. LC No. 15-014697-NH.

Core Terms

neurology, plaintiffs', expert witness, witness list, clinical, specialty, trial court, standard of care, practicing, devoted, subspecialty, defense motion, spent, board certified, teaching, summary disposition, vascular, neurologist, deposition, percent, qualified to testify, alleged malpractice, stipulated order, accredited, internal medicine, neurointensivist, parties, spend, health professional, motion for leave

Judges: Before: SHAPIRO, P.J., and CAVANAGH and K. F. KELLY, JJ. SHAPIRO, J. (concurring in part and dissenting in part).

Opinion

PER CURIAM.

Defendant appeals by leave granted an order denying its motion to strike plaintiffs' expert witness, Dr. Chitra Venkatasubramanian, and for summary disposition under *MCR 2.116(C)(10)*. We reverse in part and affirm in part. On cross-appeal, plaintiffs challenge an order denying their motion for leave to file a second amended witness list. We reverse.

On November 13, 2010, plaintiff's decedent Aura Perez went to defendant's emergency room with complaints that included hand numbness, difficulty walking, headache, and shortness of breath. She died on November 18, 2010. In this medical malpractice action, plaintiffs contend that Dr. Howard Feit, a board-certified general neurologist, failed to diagnose an acute peripheral or neuropathic disease process, likely botulism, which led to paralysis of breathing muscles, respiratory failure, and death. Plaintiffs' complaint was filed on November 11, 2015, with an affidavit of merit by Dr. Venkatasubramanian. On February 27, 2017, a stipulated order was entered naming the parties' expert witnesses and **[*2]** striking extraneous experts from their witness lists. On March 7, 2017, the deposition of Dr. Venkatasubramanian was taken.

On May 1, 2017, defendant filed a motion to strike plaintiffs' expert witness, Dr. Venkatasubramanian, under *MCL 600.2169(1)*, and for summary disposition under *MCR 2.116(C)(10)*. Defendant argued that Dr. Venkatasubramanian is not qualified to testify regarding whether general neurologist Dr. Feit met the standard of care. Relying on *MCL 600.2169(1)*, defendant argued that Dr. Venkatasubramanian's testimony showed that she did not spend a majority of her professional time practicing in the area of general neurology. In particular,

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defendant noted that Dr. Venkatasubramanian testified that she is board certified in neurology, neurocritical care, and vascular neurology; neurocritical care and vascular neurology are subspecialty board certifications of neurology. Dr. Venkatasubramanian also testified that she is a clinical associate professor of neurology. In the relevant time period, November 2009 through November 2010, about 20-25% of her professional time was spent in education and research, while 75-80% of her time was spent in clinical practice. Of her clinical practice, 60-65% was spent as a "neurointensivist," **[*3]** with the rest of her time split between general neurology and vascular neurology.[1] As a neurointensivist, she saw patients in the emergency room and in the neurointensive care unit. More specifically, Dr. Venkatasubramanian testified:

> *Q*. . . . So 60 to 65 percent of your time was devoted to work as a neurointensivist, and we're talking 2009-2010; is that accurate?
>
> *A*. So of my clinical time, 60 to 65 percent was as a neurointensivist. The rest of my clinical time was split between vascular neurology and general neurology.
>
> *Q*. Okay, so 20 percent vascular neurology, 20 percent neurology; is that accurate?
>
> *A*. Give or take.

Later in her deposition, Dr. Venkatasubramanian agreed with the description that "approximately 20 percent general, 20 percent vascular, and 60 percent of your work was devoted to neurointensivist work," and then she added, "I don't know where to throw clinic in there, but clinic also gets mixed in." Thus, defendant argued, because Dr. Feit is only board certified in general neurology, and his entire clinical practice is devoted to the treatment of general neurology patients, Dr. Venkatasubramanian, who devoted a majority of her professional practice to neurocritical care—and **[*4]** not general neurology—at the time of the alleged occurrence, is not qualified under *MCL 600.2169(1)* to provide standard of care testimony against Dr. Feit. Further, because she is not qualified to offer testimony against Dr. Feit, plaintiffs are unable to satisfy their burden of proof that he was professionally negligent and, thus, defendant was entitled to summary disposition under *MCR 2.116(C)(10)*.

Plaintiffs responded to defendant's motion, arguing that the majority of Dr. Venkatasubramanian's time was spent practicing neurology even as a neurointensivist and she considered herself a neurologist first. That is, "the two titles 'general neurology' and 'neurocritical care' flow together." Further, her additional knowledge made her more qualified to offer opinion testimony, not less qualified. Thus, defendant's motion to strike plaintiffs' expert witness and for summary disposition should be denied.

Defendant replied to plaintiffs' response, arguing that general neurology is the relevant specialty in this case and plaintiffs' expert only devoted about 20% of her clinical practice to general neurology. Thus, she is not qualified under *MCL 600.2169(1)* to provide standard of care testimony in this case and defendant is entitled to **[*5]** summary disposition.

Plaintiffs then filed a supplemental response which consisted of an affidavit from Dr. Venkatasubramanian. In the affidavit, she averred that 100% of her professional time as an associate professor is spent teaching in the specialty of general neurology. "This teaching takes place primarily in a clinical setting, but also in a didactic setting." The affidavit is written in the present tense and does not refer to the 2009-2010 time period. She stated:

> Between my work on the general neurology floor, my continued treatment of patients in the ICU and Vascular Neurologic service for what includes their general neurologic needs and my teaching/academic work which is 100% devoted to general neurology, I am confident that I can accurately state under oath by way of this sworn affidavit, that well over 50% of my professional time involves practice in the field of general neurology.

Defendant filed a supplemental reply to plaintiffs' supplemental response, arguing that the affidavit was an attempt to create a genuine issue of fact in contrast to her harmful, but clear and unequivocal deposition testimony; thus, it may not be considered.

Following oral arguments on defendant's **[*6]** motion, the court ruled:

> The Court is going to deny the Motion to Strike. I do believe that, and I'll make this clear, that the Affidavit does come in. I know, you are objecting. You can appeal me on that one. I think that Mr. Sanfield [plaintiffs' counsel] is correct. I think that his [sic] just saying, "That's only the deposition testimony and nothing else" could be considered. I

[1] It appears from the evidence that work as a "neurointensivist" relates to the board certification in neurocritical care.

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> think, that is not — not only is not fair, I don't think that's the law. She did sign an Affidavit indicating that her practice is 100% in General Neurology. She teaches. This is her field. I don't — I don't see a problem with her. I think that she is qualified to testify as an expert.
>
> The Court will respectfully deny your motion.

On June 28, 2017, the court entered an order denying defendant's motion.

Defendant then moved for reconsideration. Defendant argued that even considering Dr. Venkatasubramanian's time spent teaching she only spent 45% of her professional time in the clinical practice and instruction of general neurology. More specifically, she testified that she devoted 20% of her professional practice to general neurology and that she devoted 20-25% of her professional time to teaching and research; **[*7]** thus, she was not qualified under MCL 600.2169(1) to provide standard of care testimony against Dr. Feit, a board-certified general neurologist.

Plaintiffs then filed a motion seeking relief from the previously entered stipulated order specifically naming the parties' expert witnesses, and for leave to file a second amended witness list. Plaintiffs argued that, although Dr. Venkatasubramanian was extremely qualified to give standard of care expert testimony in this case, to avoid further delay plaintiffs retained another expert in general neurology, Dr. Michael Gold. Thus, plaintiffs sought leave to file an amended witness list naming Dr. Gold as their expert in general neurology. Plaintiffs averred that adding this expert witness would not cause undue delay or alter the theories and issues in this case because the substance of Dr. Gold's testimony was to be similar to Dr. Venkatasubramanian's testimony, and thus, defendant would not be prejudiced by the amendment. Defendant opposed this motion to amend plaintiffs' witness list, arguing that the issue was moot since the court agreed that Dr. Venkatasubramanian was qualified to testify. Further, plaintiffs are bound by the stipulated order naming their **[*8]** expert witnesses and to permit the naming of a different witness, who was not on their witness list, would prejudice defendant and delay the proceedings.

On August 18, 2017, the court heard oral argument on plaintiffs' motion.[2] Plaintiffs argued that the parties had agreed to limit their experts in the interest of reducing costs and streamlining the issues but, after they agreed to do so, defendant filed a motion to strike plaintiffs' sole standard of care expert. And although the trial court denied the motion, defendant was seeking leave to appeal on the matter. In the interest of expediting this case so that it could be heard on its merits, plaintiffs sought leave to add a different standard of care expert to their witness list, Dr. Gold. Plaintiffs argued that trial was months away, Dr. Gold's opinions were substantially the same as Dr. Venkatasubramanian's, and that defendant could depose Dr. Gold without objection; thus, there was no prejudice to defendant. Defendant argued that plaintiffs entered into a stipulated order to limit their expert witness to Dr. Venkatasubramanian and they are bound by that order. The trial court denied plaintiffs' motion to amend their witness list, **[*9]** apparently relying on its prior ruling that Dr. Venkatasubramanian is qualified to testify as a standard of care expert in this case. On August 23, 2017, orders denying defendant's motion for reconsideration and denying plaintiffs' motion were entered by the trial court.

On September 11, 2017, defendant filed an application for leave to appeal the order denying its motion to strike plaintiffs' expert witness, Dr. Venkatasubramanian, and for summary disposition under MCR 2.116(C)(10), as well as a motion to stay pending appeal.

On November 2, 2017, this Court entered an order granting defendant's application for leave to appeal, limited to the issues raised in the application and supporting brief, and granting the motion to stay pending appeal. *Estate of Aura Argentina Perez v Henry Ford Hosp*, unpublished order of the Court of Appeals, entered November 2, 2017 (Docket No. ***340082***).

On November 15, 2017, plaintiffs filed a claim of cross-appeal, challenging the trial court's order denying plaintiffs' motion to amend their witness list to add a different standard of care expert. On November 20, 2017, the trial court entered an order for stay of proceedings pending appeal.

On appeal, defendant first argues **[*10]** that the trial court erred in denying its motion to strike plaintiffs' expert witness, Dr. Venkatasubramanian, as unqualified under MCL 600.2169(1). We agree.

The interpretation of MCL 600.2169(1) is reviewed de

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[2] Because the court had not ordered oral argument on defendant's motion for reconsideration, arguments were not made in its regard but the court denied the motion on the record.

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novo. Woodard v Custer, 476 Mich 545, 557; 719 NW2d 842 (2006). The trial court's decision whether Dr. Venkatasubramanian is qualified to render an expert opinion under MCL 600.2169(1) is reviewed for an abuse of discretion. *Id.* "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." *Id.* When a court's ruling is premised on an incorrect interpretation of the law, the ruling is necessarily an abuse of discretion. Gay v Select Specialty Hosp, 295 Mich App 284, 292; 813 NW2d 354 (2012).

MCL 600.2169(1) sets forth the criteria a proposed expert must satisfy in order to testify regarding the appropriate standard of practice or care, Rock v Crocker, 499 Mich 247, 260; 884 NW2d 227 (2016), and states in pertinent part:

> In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the **[*11]** party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

In *Woodard*, the Court explained that a "specialty" is "a particular branch of medicine or surgery **[*12]** in which one can potentially become board certified." Woodard, 476 Mich at 561. A "subspecialty" is "a particular branch of medicine or surgery in which one can potentially become board certified that falls under a specialty or within the hierarchy of that specialty." 476 Mich at 562. A subspecialty is itself a "specialty" within the meaning of the statute. *Id.*

In this case, there is no dispute that Dr. Feit is a board-certified neurologist who was practicing as a general neurologist at the time of the alleged malpractice. At issue here is whether Dr. Venkatasubramanian meets the qualifications set forth under § 2169(1)(b). While she is board certified in neurology, she was also board certified in neurocritical care and vascular neurology which are subspecialty board certifications of neurology. As our Supreme Court explained in *Woodard*:

> [I]n order to be qualified to testify under § 2169(1)(b), the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty. [Woodard, 476 Mich at 566 (footnote omitted).] **[*13]**

In Kiefer v Markley, 283 Mich App 555, 559; 769 NW2d 271 (2009), this Court clarified that the word "majority" in the statute means that a proposed expert physician must have spent "greater than 50 percent of his or her professional time practicing the relevant specialty the year before the alleged malpractice."

In this case, because the specialty Dr. Feit was practicing at the time of the alleged malpractice was general neurology, a proposed standard of care expert testifying against Dr. Feit must have spent greater than 50% of her time practicing or instructing students in general neurology the year before the alleged malpractice. Dr. Venkatasubramanian testified in her deposition that during the relevant time, she spent about 75-80% of her professional time in clinical practice, and 20-25% in research and education. With regard to her clinical practice, she spent 60-65% of her professional time practicing as a neurointensivist, about 20% of her time practicing general neurology, and 20% of her time practicing vascular neurology. Clearly, then, Dr. Venkatasubramanian did not spend a majority of her

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professional time *practicing* general neurology during the relevant time.

In *Hamilton v Kuligowski*, the companion case to *Woodard*, our Supreme Court **[*14]** was faced with a similar factual scenario as presents in this case, i.e., a plaintiff's proposed expert witness who devoted a majority of time to a subspecialty rather than the general specialty at issue. *476 Mich at 556*. In that case, the defendant physician was board certified in general internal medicine, specialized in general internal medicine, and was practicing general internal medicine at the time of the alleged malpractice. *Woodard, 476 Mich at 556, 577-578*. The plaintiff's proposed expert was also board certified in general internal medicine; however, he spent the majority of his professional time treating infectious diseases, a subspecialty of internal medicine. *476 Mich at 556, 578*. Our Supreme Court concluded that because the plaintiff's expert devoted a majority of his professional time to treating infectious diseases, the subspecialty, and not general internal medicine, he did "not satisfy the same practice/instruction requirement of *§ 2169(1)(b)*." *Woodard, 476 Mich at 578*. Similarly, in this case, Dr. Venkatasubramanian was not qualified under *§ 2169(1)(b)* because she did not spend the majority of her time practicing general neurology.

In a supplemental response to defendant's motion, plaintiff filed an affidavit from Dr. Venkatasubramanian which attempted to clarify her deposition **[*15]** testimony. Although defendant argued that the trial court was not permitted to consider this affidavit because it was an attempt to essentially rehabilitate damaging testimony, the trial court correctly rejected this argument. The affidavit did not contradict the deposition testimony as much as it clarified a point that was not explored—the subject area of Dr. Venkatasubramanian's research and teaching. But even considering the affidavit, the conclusion remains the same—she did not spend a majority of her professional time during the year immediately preceding the alleged malpractice practicing or teaching general neurology. According to her affidavit, 100% of her teaching/academic work was devoted to general neurology. But, again, she testified that only 20-25% of her professional time was devoted to teaching/academic work. The other 75-80% of her time was devoted to clinical practice, but only 20% of her clinical practice was devoted to general neurology which, combined, still amounts to less than a majority of her time, i.e., less than 50 percent (20% of 80% = .2 x .80 = .16 or 16% plus teaching/academics at most 25% = 41%).

In summary, Dr. Venkatasubramanian did not meet the requirements **[*16]** set forth under *MCL 600.2169(1)* because she did not spend a majority of her professional time practicing or instructing students in general neurology; thus, she was not qualified to render standard of practice or care testimony against Dr. Feit. Accordingly, the trial court abused its discretion in concluding that she was qualified to render such testimony and erred when it denied defendant's motion to strike this expert witness.

Next, defendant argues that, because plaintiff does not have an expert qualified under *MCL 600.2169(1)* to testify to the standard of care, defendant is entitled to summary disposition under *MCR 2.116(C)(10)*. The trial court denied defendant's motion for summary disposition after concluding that Dr. Venkatasubramanian was a qualified expert witness. Generally, a decision on a motion for summary disposition is reviewed de novo. *Maiden v Rozwood, 461 Mich 109, 118; 597 NW2d 817 (1999)*.

There are two issues relevant to defendant's argument: plaintiffs' cross-appeal and the stipulated order entered on February 27, 2017 naming the parties' expert witnesses. We first address these matters.

Plaintiffs argue on cross-appeal that if Dr. Venkatasubramanian is determined to be unqualified, they should be allowed to amend their witness list to add a substitute expert witness, **[*17]** Dr. Michael Gold. In fact, the only reason the trial court denied their motion to amend their witness list was because the court also believed Dr. Venkatasubramanian to be a qualified expert in this case. A trial court's decision on a motion to amend a witness list is reviewed for an abuse of discretion. *Tisbury v Armstrong, 194 Mich App 19, 20; 486 NW2d 51 (1991)*. We agree that plaintiffs' motion for leave to file an amended witness list to add Dr. Gold as a standard of care expert should have been granted.

MCR 2.401(I)(1) mandates that parties file and serve witness lists in the time directed by the trial court's scheduling order. And if a witness is not listed in such a witness list, the court may prohibit that witness from testifying at trial except upon good cause shown. *MCR 2.401(I)(2)*. However, before such a sanction is imposed—which may be equivalent to a dismissal—the trial court should consider a number of relevant factors, including but not limited to: "(1) whether the violation was wilful or accidental; (2) the party's history of refusing to comply with discovery requests (or refusal to disclose witnesses); (3) the prejudice to the defendant;

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(4) actual notice to the defendant of the witness and the length of time prior to trial that the defendant received such **[*18]** actual notice; (5) whether there exists a history of plaintiff's engaging in deliberate delay; (6) the degree of compliance by the plaintiff with other provisions of the court's order; (7) an attempt by the plaintiff to timely cure the defect[;] and (8) whether a lesser sanction would better serve the interests of justice." *Dean v Tucker, 182 Mich App 27, 32-33; 451 NW2d 571 (1990)* (footnotes omitted); see also *Duray Dev, LLC v Perrin, 288 Mich App 143, 165; 792 NW2d 749 (2010)*. Further, the trial court should be mindful that the policy of this state favors the meritorious determination of issues. *Tisbury, 194 Mich App at 21*.

In this case, plaintiffs moved for leave to file a second amended witness list after defendant's motion to strike plaintiffs' expert was denied by the trial court. Plaintiffs offered that, to avoid further delay, they retained another expert in general neurology, Dr. Gold, who they would call as an expert in the place of Dr. Venkatasubramanian. Plaintiffs averred that the substance of Dr. Gold's testimony was the same or similar to Dr. Venkatasubramanian's testimony, and thus, would not alter the theories or issues in this case and would not cause undue delay or prejudice. However, the trial court denied the motion because it deemed the substitution unnecessary—Dr. Venkatasubramanian was sufficiently qualified **[*19]** to testify. There was no evidence that plaintiffs' negligently or wilfully retained an unqualified expert witness and, in fact, even the trial court believed the witness was qualified. See *Dean, 182 Mich App at 32*. Further, because of defendant's challenge, plaintiffs almost immediately retained another expert witness who they identified by name and offered for deposition. Defendant did not argue that plaintiffs had a history of discovery violations or engaged in deliberate delay. Defendant did claim that it would be prejudiced because discovery was closed and trial was scheduled for a few months later. However, the delay that resulted from the pursuit of this appeal was far greater than would have been occasioned by an amendment to plaintiffs' witness list and the taking of Dr. Gold's deposition. Further, any prejudice to defendant would be minimal considering that, as argued by plaintiffs, Dr. Gold shared the same or similar opinions as Dr. Venkatasubramanian. Moreover, review of the lower court record shows that this case had been timely litigated up through the time that plaintiffs sought leave to amend their witness list. And the consequence of striking plaintiffs' sole standard of care expert is that **[*20]** this case will be dismissed rather than decided on its merits, contrary to this state's policy. See *Tisbury, 194 Mich App at 21*.

Defendant argues, however, that the parties had stipulated to a reciprocal order limiting their experts and striking extraneous experts from their witness lists; thus, the trial court was prevented from granting plaintiffs' motion for leave to file an amended witness list. It is true that stipulated orders that are entered by the trial court are generally construed under the same rules that apply to contracts, as an agreement reached by and between the parties. See *Eaton Co Bd of Co Rd Comm'rs v Schultz, 205 Mich App 371, 378-379; 521 NW2d 847 (1994)*. And in contract interpretation, the goal is to determine and then enforce the intent of the parties based on the plain language of the contract. *St Clair Med, PC v Borgiel, 270 Mich App 260, 264; 715 NW2d 914 (2006)*. That is, the plain and unambiguous contract language must be enforced as written unless the contract is contrary to law or public policy. *Rory v Continental Ins Co, 473 Mich 457, 468-470; 703 NW2d 23 (2005)*.

The provision of the stipulated order at issue provides: "IT IS HEREBY STIPULATED, by and between counsel for the parties hereto, that Plaintiffs shall only utilize, at the time of trial, independent experts Dr. Chitra Venkatasubramanian (neurology), Dr. Daniel Spitz (forensic pathology), and Dr. Michael Thomson (economics)[.]" According the **[*21]** words their ordinary and plain meaning as we must, in relevant part, this provision states that the parties agreed that Dr. Venkatasubramanian was plaintiffs' neurology expert who would testify at trial. The only way to "utilize" an expert witness "at the time of trial" is through the provision of testimony. But contrary to the parties' agreement, this doctor may not testify at trial because she is not qualified as an expert witness. Because the parties' contract in this regard is contrary to the law, it will not be enforced. See *473 MIch at 470*. Further, this stipulated order in no way impaired the trial court's discretion regarding plaintiffs' motion for leave to file a second amended witness list.

We conclude that, under all of the circumstances of this case, the trial court should have found that good cause existed to support plaintiffs' motion for leave to file a second amended witness list to add Dr. Gold as an expert witness in general neurology. Therefore, the trial court abused its discretion by denying plaintiffs' motion. In light of this holding, we also conclude that the trial court properly denied defendant's motion for summary disposition under *MCR 2.116(C)(10)*, premised on the claim that plaintiffs **[*22]** had no expert qualified to

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testify to the standard of care. At minimum, defendant's motion is premature in light of our holding.

In summary, the trial court's order denying defendant's motion to strike plaintiffs' expert witness Dr. Venkatasubramanian is reversed, but we affirm the denial of defendant's motion for summary disposition. We also reverse the trial court's order denying plaintiffs' motion for leave to file a second amended witness list.

Affirmed in part, reversed in part, and remanded for further proceedings. We do not retain jurisdiction.

/s/ Mark J. Cavanagh

/s/ Kirsten Frank Kelly

Concur by: Douglas B. Shapiro (In Part)

Dissent by: Douglas B. Shapiro (In Part)

Dissent

SHAPIRO, J. (*concurring in part and dissenting in part*).

I concur with the majority's conclusion that plaintiff should be permitted to amend her witness list to add a new expert given the reversal of the trial court's ruling as to Dr. Chitra Venkatasubramanian's qualifications. However, under the circumstances of this case, I do not agree that Dr. Venkatasubramanian's subspecialty certifications in neurological critical care and vascular neurology and her practice in those subspecialties disqualifies her as an expert witness.

Plaintiffs' medical **[*23]** malpractice action concerns Dr. Howard Feit, a board-certified neurologist. Dr. Venkatasubramanian is also a board-certified neurologist and therefore satisfies MCL 600.2169(1)(a), which provides:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

The issue in this case is whether Dr. Venkatasubramanian satisfies MCL 600.2169(1)(b), which requires that the expert witness must have

> during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following: **[*24]**
>
> (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

The majority determines that the key question is whether more than 50% of Dr. Venkatasubramanian's time was spent in the practice of "general neurology" as opposed to neurocritical care or vascular neurology and arithmetically concludes that it was less than 50%. Even assuming that the majority's calculation is correct, I would conclude that Dr. Venkatasubramanian's is qualified to testify as an expert witness in this case.

It is clear that a general specialist may not testify against a subspecialist regarding performance of that subspecialty. However, the inverse **[*25]** is not necessarily the case. Depending on the nature of the subspecialty and the expert's particular practice, a subspecialist may testify as to the standard of care in his or her general specialty. The only published decision in which a specialist was disqualified on the basis of spending more than 50% of his or her time performing a subspecialty is *Hamilton v Kuligowski*, the companion case to Woodard v Custer, 476 Mich 545; 719 NW2d 842 (2006). In *Hamilton*, the Supreme Court held that an internist with a subspecialty in infectious diseases could not testify to the standard of care of an internist with no subspecialty, but the Court did not set out a bright-line rule barring any subspecialist from testifying as to the standard of care for the more general specialty. 476

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Mich at 577-578. Instead, the Court concluded that the proposed expert did not spend a majority of his time practicing general internal medicine because his practice was completely focused on infectious diseases and he agreed that he was "not sure what the average internist sees day in and day out." *476 Mich at 578* (quotation marks omitted). By contrast, in this case Dr. Venkatasubramanian made it clear that her practice as a consulting neurologist, whether with the general medical unit or the intensive **[*26]** care unit, involves caring for all of a patient's neurological needs.[1] Thus, I would conclude that Dr. Venkatasubramanian satisfies *MCL 600.2169(1)(b)*'s practice requirement and is able to testify to whether Dr. Feit's actions met the applicable standard of care.

/s/ Douglas B. Shapiro

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[1] Notably, the subspecialties within internal medicine are unusual in that internal medicine is an extraordinarily broad specialty. Subspecialties within internal medicine represent widely divergent areas of practice including nephrology, cardiology, infectious diseases, hepatology, gastroenterology, and endocrinology. A gastroenterologist may recognize that his or her patient should be referred to a cardiologist, but is extraordinarily unlikely to diagnose or treat a patient's heart, while a neurologist with a subspecialty can (and often does) treat all of a patient's neurological conditions.

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APPENDIX 22

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Turkish v. William Beaumont Hosp.

Court of Appeals of Michigan

December 13, 2018, Decided

No. 339522

Reporter
2018 Mich. App. LEXIS 3693 *; 2018 WL 6578922

JASON TURKISH, Plaintiff-Appellant, v WILLIAM BEAUMONT HOSPITAL, Defendant-Appellee.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Subsequent History: Leave to appeal denied by, Motion granted by, Motion denied by *Turkish v. William Beaumont Hosp., 2019 Mich. LEXIS 1678 (Mich., Sept. 18, 2019)*

Prior History: **[*1]** Oakland Circuit Court. LC No. 2015-147273-NH.

Core Terms

sports medicine, board-certified, specialty, orthopedic surgery, devoted, practicing, proposed expert, surgery, orthopedic surgeon, internal medicine, subspecialty, alleged malpractice, expert witness, board certified, standard-of-care, motion in limine, orthopedics, medicine, immediately preceding, medical specialty, trial court, take care, certification, deposition, fellowship, knee, infectious disease, questioned, internist, clinical

Judges: Before: O'BRIEN, P.J., and TUKEL and LETICA, JJ. LETICA, J. (dissenting).

Opinion

PER CURIAM.

Plaintiff appeals by leave granted[1] the trial court's order denying his motion in limine to preclude defendant's expert witness from giving standard-of-care testimony in this medical malpractice action. We affirm.

On August 7, 2011, plaintiff fell and fractured his right knee. He went to defendant hospital and was released with crutches and a knee immobilizer. He returned the following day because of increased pain and was admitted under the care of Dr. Gregory Nowinski, M.D., an orthopedic surgeon. Plaintiff was taking Coumadin because of a suspected right lower leg deep vein thrombosis (DVT), commonly known as a blood clot. Dr. Nowinski discontinued plaintiff's Coumadin while he considered whether to perform surgery on plaintiff's knee. Dr. Nowinski chose not to perform surgery, and resumed plaintiff's Coumadin 22 hours after it had been discontinued. Plaintiff was thereafter diagnosed with DVT, and he filed this action alleging that the 22-hour Coumadin "hold" caused the DVT.

Plaintiff filed a motion in limine to preclude Dr. **[*2]** Laith Farjo, M.D., defendant's orthopedic expert, from offering standard-of-care testimony. Plaintiff argued that, according to Dr. Farjo's testimony, he spent the majority of his professional time practicing sports medicine—a subspecialty of general orthopedics—and therefore, Dr. Farjo was not qualified to offer standard-of-care testimony pertaining to orthopedic surgery.

In his deposition, Dr. Farjo testified that he is board-certified in orthopedic surgery and fellowship trained in sports medicine. He completed his sports medicine fellowship in 1999 but never became board certified. When questioned by plaintiff's counsel, Dr. Farjo further testified:

> *A*. I have a full-time practice in orthopedic surgery. I take care of patients of all ages, from one to 101, but primarily sports medicine, which is usually ligamentous injuries of the shoulder and knee and

[1] *Turkish v William Beaumont Hosp*, unpublished order of the Court of Appeals, entered September 20, 2017 (Docket No. ***339522***).

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then also the hip. I do deal with fractures as well.

Q. I saw somewhere in the materials that I reviewed that about 70 percent of your practice is laparoscopic sports medicine surgeries and the balance would be more general open procedures?

A. It's probably even more so arthroscopic at this point.

Q. Has that been the case for the past **[*3]** ten years or so?

A. Yes.
* * *

Q. Doctor, on direct examination you testified that the majority of your practice is sports medicine?

A. Sports medicine encompasses a pretty wide variety of treatment. I said, I take care of people from 1 to 101. So, yes, sports medicine in that I take care of ligaments that are damaged and tendons that are torn, so I would say more than 50[%] is that.

Q. And do you hold yourself out as a sports medicine specialist?

A. I do.

Q. And you [have] done that for a number of years?

A. Yes.

Q. You were doing that since receiving your board certification in orthopedics?

A. Yes, it's common in orthopedics to have a specialty interest and so I do hold myself out to that.

Q. And sports medicine is now a board-recognized subspecialty of orthopedics?

A. Correct.

When questioned by defense counsel, Dr. Farjo clarified that his practice included more general orthopedic surgery. He testified as follows:

Q. So back in the time frame at issue, August of 2011, did you devote the majority of your professional time to the active clinical practice as a board-certified orthopedic surgeon?

A. Yes.

Q. The same specialty as Dr. Nowinski?

A. Yes.

Q. And you were asked questions by plaintiff's counsel **[*4]** at the beginning of your deposition about your fellowship that you had previously performed. You performed that fellowship from 1998 to 1999, a fellowship in sports medicine and arthroscopy at — in Virginia with Drs. Caspari J. Meyers, et al; is that right?

A. Yes.

Q. But your practice over the years has been as a board-certified orthopedic surgeon; is that right?

A. Yes.

Q. And, in fact, your CV indicates the various types of work that you perform which includes a great deal of arthroscopic; is that right?

A. Yes.

Q. And if surgery had actually been performed on [plaintiff] back in August of 2011 or even the subsequent surgery that was performed later that year, is that the type of surgery that you performed on many occasions?

A. Yes.
* * *

Q. Doctor, you're not subspecialty certified in sports medicine, correct?

A. Correct.

Q. And you never have been, correct?

A. Correct.

Q. What you have is a special interest in sports medicine within the rubric of a board-certified orthopedic surgeon; is that correct?

A. Correct. I'd say probably a majority of orthopedic surgeons would say they have an interest in sports medicine.

Q. So plaintiff's counsel is trying to suggest that you're not really and were **[*5]** not really practicing and devoting the majority of your professional time

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as a board-certified orthopedic surgeon back in this time frame that would be relevant, August 2010 to August 2011. Back in that time frame what type of patients were you seeing, what type of practice did you have as a board-certified orthopedic surgeon?

A. So — well, I would see people with knee ligament injuries and shoulder rotator cuff tears which is considered part of the purvey of general orthopedics as well as sports medicine. I took care of 90-year-old ladies with a broken hip surgically, people who had broken their ankles surgically, I did and I still do hand surgery, so people with carpal tunnel syndrome, people with trigger fingers, people with tendinitis. I take care of people with dislocated kneecaps which this patient had, so it's a pretty wide variety. . . .

Q. And the statue [sic] in Michigan requires that the year immediately preceding the treatment at issue that an expert be board-certified in actively devoting the majority of his or her professional time to the same practice of medicine as the defendant in this case or the doctor whose treatment is being alleged, which would be Dr. Nowinski, **[*6]** is that something you did? Did you devote the majority of your professional time to that same practice of board-certified orthopedic surgery during that period of time?

[Objection by plaintiff's counsel omitted]

A. The answer to your question is absolutely. So, in orthopedic surgery, we all take care of these problems. It's — you know, I don't have a — I don't hold myself out as only a sports specialist and I haven't opted to take that special certification exam. You have the option to take that exam. My understanding is even if you took the exam most people who do that still practice general orthopedic surgery.

Q. And that's what you do and have done since you become [sic] a board-certified orthopedic surgeon; is that right?

A. Yes.

Following oral argument during which the trial court took the matter under advisement, the court entered a written order denying plaintiff's motion. The order stated as follows:

> After reviewing the Briefs and Exhibits and having considered the merits and being fully advised in the premises, the Court finds that Dr. Farjo is qualified to testify as to the standard of care. Based upon the evidence submitted there is no valid basis under MCL 600.2169 to preclude him from offering **[*7]** the testimony because Dr. Farjo is a Board-certified Orthopedic Surgeon who has devoted the majority of his professional time to the active clinical practice as such.

On appeal, plaintiff argues that the trial court abused its discretion in denying its motion in limine to preclude Dr. Farjo from giving standard-of-care testimony. We disagree.

This Court reviews a trial court's decision on a motion in limine for an abuse of discretion. *Bellevue Ventures, Inc v Morang-Kelly Investment, Inc, 302 Mich App 59, 63; 836 NW2d 898 (2013)*. This Court also reviews a trial court's ruling regarding the qualifications of a proposed expert witness for an abuse of discretion. *Woodard v Custer, 476 Mich 545, 557; 719 NW2d 842 (2006)*. "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." *Id.* Questions of statutory interpretation are reviewed de novo. *476 Mich at 557*.

In a medical malpractice action, the plaintiff must prove: "(1) the applicable standard of care, (2) breach of that standard by defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury." *Cox v Hartman, 322 Mich App 292, 299; 911 NW2d 219 (2017)*. Generally, expert testimony is necessary to establish the applicable standard of care as well as the defendant's breach of that standard. *322 Mich App at 300*. *MCL 600.2169*, which governs the criteria for an expert witness in a medical malpractice **[*8]** action, provides, in relevant part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board-certified, the expert witness must be a

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specialist who is board-certified in that specialty.

(b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:

(*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.

In *Woodard, 476 Mich at 560*, the **[*9]** Michigan Supreme Court held that, under *MCL 600.2169(1)*, "the plaintiff's expert witness must match the one most relevant standard of practice or care—the specialty engaged in by the defendant physician during the course of the alleged malpractice, and, if the defendant physician is board-certified in that specialty, the plaintiff's expert must also be board-certified in that specialty." The Court further held that "a 'specialty' is a particular branch of medicine or surgery in which one can potentially become board-certified." *476 Mich at 561*. Therefore, "if the defendant physician practices a particular branch of medicine or surgery in which one can potentially become board-certified, the plaintiff's expert must practice or teach the same particular branch of medicine or surgery." *476 Mich at 561-562*. Moreover, "a 'subspecialty' is a particular branch of medicine or surgery in which one can potentially become board-certified that falls under a specialty or within the hierarchy of that specialty," and is also considered a specialty. *476 Mich at 562*. The Court also stated that, under *MCL 600.2169(1)(a)*, "the proposed expert witness must have the same board certification as the party against whom or on whose behalf the testimony is offered." *476 Mich at 562-563* (citation and quotation **[*10]** marks omitted). The Court held the following:

> in order to be qualified to testify under *§ 2169(1)(b)*, the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty. [*476 Mich at 566*.]

In *Hamilton v Kuligowski*, the companion case to *Woodard*, the defendant physician was board-certified in general internal medicine and was practicing general internal medicine at the time of the alleged malpractice. *476 Mich at 556*. The proposed expert witness was also board-certified in general internal medicine. *Id.* However, the proposed expert devoted a majority of his professional time treating infectious diseases, a subspecialty of internal medicine, and explicitly testified that he is "not sure what the average internist sees day in and day out." *476 Mich at 578*. Thus, the Court held that the proposed expert did not satisfy the practice requirement of *MCL 600.2169(1)(b)* because the defendant physician specialized in general internal medicine and was practicing general internal medicine at the time of the **[*11]** alleged malpractice, and the proposed expert did not. *476 Mich at 577-578*. Rather, the proposed expert spent a majority of his professional time treating infectious diseases and was unfamiliar with the day-to-day practice of a general internist. *Id.*

In this case, there is no dispute that Dr. Farjo satisfied the requirement of *MCL 600.2169(1)(a)*. During the relevant period, Dr. Nowinski was a board-certified orthopedic surgeon, and Dr. Farjo was also a board-certified orthopedic surgeon as well as fellowship trained in sports medicine. At issue in this case is the practice requirement of *MCL 600.2169(1)(b)*. Plaintiff contends that because Dr. Nowinski testified that he was practicing general orthopedic surgery when he treated plaintiff and Dr. Farjo testified that he practiced the subspecialty of sports medicine, Dr. Farjo was not qualified to give standard-of-care testimony under *MCL 600.2169(1)*.

Orthopedic surgery is a "medical specialty concerned with the preservation, restoration, and development of form and function of the musculoskeletal system, extremities, spine, and associated structures by medical, surgical, and physical methods." *Stedman's Medical Dictionary* (26th ed). Once a physician becomes board-certified in orthopedic surgery, he or she **[*12]** may apply for additional subspecialty certifications from the American Board of Medical Specialties, one of which is sports medicine. See American Board of Medical Specialties, *Specialty and Subspecialty Certificates* https://www.abms.org/member-boards/specialty-subspecialty-certificates/ (accessed November 5, 2018). The American Board of Medical Specialties defines sports medicine as "[t]he surgical and medical care for all structures of the musculoskeletal system directly affected by participation in sporting activity." *Id.* It is undisputed that Dr. Nowinski was practicing orthopedic

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surgery at the time of the alleged malpractice. Thus, if Dr. Farjo devoted a majority of his professional time during the year preceding the alleged malpractice to sports medicine, a subspecialty of orthopedic surgery, Dr. Farjo did not satisfy the practice requirement under MCL 600.2169(1)(b). See Woodard, 476 Mich at 577-578.

Based on the evidence before it, the trial court found that Dr. Farjo met the practice requirement and was qualified to give standard-of-care testimony under MCL 600.2169(1)(b). Several times throughout his deposition, Dr. Farjo testified that the majority of his practice was dedicated to general orthopedic surgery. Early in the deposition, **[*13]** when asked if he "devote[d] the majority of [his] professional time . . . to the active clinical practice as a board-certified orthopedic surgeon . . . the same specialty as Dr. Nowinski," Dr. Farjo unequivocally answered "yes." He also testified that he has performed the surgery at issue in this case several times and was able to describe, in detail, the practice of an orthopedic surgeon. Accordingly, this case is unlike *Hamilton*, in which the proposed expert, who testified that he was "not sure what an average internist sees," was clearly not practicing internal medicine. Woodard, 476 Mich at 558.

Plaintiff's argument focuses almost entirely on Dr. Farjo's testimony on direct-examination where he stated he spent a majority of his time practicing sports medicine. Plaintiff contends that Dr. Frajo's subsequent testimony on cross-examination should not be considered because it was just an effort by defense counsel to "rehabilitate Dr. Farjo and qualify him as an expert." However, Dr. Farjo's testimony that he spent the majority of his practice in sports medicine is not conclusive of what he was actually practicing during the relevant period, particularly where he described sports medicine, both on direct and **[*14]** cross-examination, as encompassing "a pretty wide variety of treatment" including treating "knee ligament injuries and shoulder rotator cuff tears," which as Dr. Farjo stated, "is considered part of the purvey of general orthopedics as well as sports medicine." While Dr. Farjo's testimony regarding his practice of sports medicine versus general orthopedic surgery seemed to be contradictory or unclear at times, he sufficiently clarified his testimony at the end of his deposition when he testified that he "absolutely" devoted a majority of his professional time to the practice of board-certified orthopedic surgery during the relevant time period. He also explained that he did not opt to take the special certification examination in sports medicine and that even with respect to those persons who are certified in sports medicine, they still practice general orthopedic surgery. Moreover, as the above definitions show, both sports medicine and orthopedic surgery deal with problems related to the "musculoskeletal system." Indeed, defense counsel's questioning on cross-examination could have been merely an attempt to clarify Dr. Farjo's qualifications due to the significant overlap of sports **[*15]** medicine and orthopedic surgery.

In conclusion, the trial court had sufficient evidence before it to conclude that Dr. Farjo practiced the same specialty as Dr. Nowinski—orthopedic surgery—and so its finding that Dr. Farjo spent a majority of his professional time practicing in the specialty of orthopedic surgery in the year preceding the alleged malpractice was within the range of reasonable and principled outcomes. Woodard, 476 Mich at 560.[2] Accordingly, the trial court did not abuse its discretion by finding that Dr. Farjo was qualified to give standard-of-care testimony under MCL 600.2169(1).

Affirmed. Defendant, as the prevailing party, may tax costs pursuant to MCR 7.219.

/s/ Colleen A. O'Brien

/s/ Jonathan Tukel

Dissent by: Anica Letica

Dissent

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[2] The dissent is concerned that this case is analogous to *Hamilton*, namely because it would conclude that Dr. Farjo "devoted a majority of his professional time to a subspeciality regardless of any overlap" with the more general practice. While we understand the dissent's concern, we disagree that the evidence necessitates concluding that Dr. Farjo devoted a majority of his professional time to sports medicine. To the contrary, Dr. Farjo's testimony conflicted on that point; he said that he spent a majority of his professional time practicing orthopedic surgery, and contradicted himself by saying that he spent a majority of his time practicing sports medicine. Both statements could not be true, and so the trial court had to credit one. It decided that that Dr. Farjo spent the majority of his time practicing orthopedic surgery. This was a close question, as Dr. Farjo's testimony supported both that he did—and that he did not—spend a majority of his professional time practicing orthopedic surgery. "A decision on a close evidentiary question ordinarily cannot be an abuse of discretion." See Morales v State Farm Mut Auto Ins Co, 279 Mich App 720, 729; 761 NW2d 454 (2008).

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LETICA, J. (*dissenting*).

While the majority has correctly outlined the facts, in my opinion, our binding caselaw requires the opposite result. Accordingly, I would reverse and remand for entry of an order granting plaintiff's motion in limine and remand for further proceedings.

Under MCL 600.2169(1)(b), a proposed "expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant **[*16]** physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty." Woodard v Custer, 476 Mich 545, 566; 719 NW2d 842 (2006). Obviously, "one cannot devote a 'majority' of one's professional time to more than one specialty." *Id.*

In *Hamilton v Kuligowski*, the companion case to *Woodard*, "[t]he defendant physician [was] board certified in general internal medicine and specialize[d] in general internal medicine." 476 Michat 556. The "[p]laintiff's proposed expert witness [was] board certified in general internal medicine and devote[d] a majority of his professional time to treating infectious diseases, a subspeciality of internal medicine." *Id.* Although this Court concluded that the "plaintiff's expert [was] qualified to testify against the defendant physician because both plaintiff's proposed expert witness and the defendant physician specialize[d] in internal medicine and because plaintiff's proposed expert . . . devote[d] a majority of his professional time to the practice of internal medicine given that the treatment of infectious diseases is a subspecialty of internal medicine[,]" our Supreme Court reversed. 476 Mich at 554, 556-557. In doing so, it explained:

> During the year immediately preceding the alleged malpractice, plaintiff's proposed **[*17]** expert witness did not devote a majority of his time to practicing or teaching general internal medicine. Instead, he devoted a majority of his professional time to treating infectious diseases. As he himself acknowledged, he is "not sure what the average internist sees day in and day out." Therefore, plaintiff's proposed expert witness does not satisfy the same practice/instruction requirement of § 2169(1)(b). [476 Mich at 578.]

Following the plain statutory language and this caselaw, our Court held that the proposed expert must devote more than 50% of his or her professional time to the practice of "the relevant specialty the year before the alleged malpractice." Kiefer v Markley, 283 Mich App 555, 559; 769 NW2d 271 (2009). In *Kiefer*, both the plaintiffs' expert witness and the defendant physician were board certified in plastic surgery with an added qualification in hand surgery. 283 Mich App at 560. The trial court granted the defendants' motion in limine to strike the plaintiffs' expert witness pursuant to MCL 600.2169(1)(b) because the plaintiffs' expert witness dedicated, at most, 40% of his professional time to hand surgery, which was the relevant medical specialty at issue. 283 Mich App at 557. This Court upheld the trial court's decision because the plaintiffs' expert did not devote more than 50% of his time to the **[*18]** same specialty as the defendants' expert witness. 283 Mich App at 560.

Here, based on Dr. Farjo's deposition testimony, he is *not* qualified to give standard-of-care testimony under MCL 600.2169(1)(b). Dr. Nowinski is a board-certified orthopedic surgeon who was actively practicing as an orthopedic surgeon when the alleged malpractice and negligence occurred. Dr. Farjo is also board certified in orthopedic surgery but he dedicated most of his professional time to sports medicine in the relevant time period. In fact, Dr. Farjo testified that he devoted as much as 70% of his professional time in the last 10 years to either laparoscopic or arthroscopic sports medicine.[1] Sports medicine is a subspecialty of orthopedic surgery because it is a more particularized branch of orthopedic surgery. See Woodard, 476 Mich at 562, 577-578. The fact that Dr. Farjo considers himself a specialist in both sports medicine and orthopedic surgery is irrelevant because *Hamilton* and *Kiefer* make clear that the proposed expert witness must spend a majority of his or her professional time in the relevant specialty or subspecialty. Woodard, 476 Mich at 566 n 12; Kiefer, 283 Mich App at 559. Likewise, the fact that Dr. Farjo has not opted to become board certified in sports medicine is irrelevant. Woodard, 476 Mich at 561 ("Both the dictionary definition of 'specialist' **[*19]** and the plain language of § 2169(1)(a) make it clear that a physician can be a specialist who is not board certified. They also make it clear that a 'specialist' is somebody who can potentially become

[1] Dr. Farjo certainly attempted to reverse course regarding his subspeciality before again admitting it was "more than 50 percent" of his practice and that he held himself out as a sports medicine specialist.

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board certified. Therefore, a 'specialty' is a particular branch of medicine or surgery in which one can potentially become board certified.") And, finally, that Dr. Farjo previously made the particular medical decision at issue—discontinuing Coumadin therapy—is also immaterial because *MCL 600.2169* focuses on the particular medical specialty or subspecialty of the proposed expert witness and the defendant physician. Therefore, Dr. Farjo does not qualify as an expert witness under *MCL 600.2169(1)(b)* because he did not spend a majority of his professional time in the practice of orthopedic surgery during the year immediately preceding August 2011. See *476 Mich at 565-566* & n 12.

Thus, in my opinion, the circuit court abused its discretion by admitting Dr. Farjo's testimony because it misapplied the relevant law. *Craig v Oakwood Hosp, 471 Mich 67, 76; 684 NW2d 296 (2004)* ("A court necessarily abuses its discretion when it 'admits evidence that is inadmissible as a matter of law.'"), quoting *People v Katt, 468 Mich 272, 278; 662 NW2d 12 (2003)*. And, while my colleagues seek to distinguish *Hamilton* on the basis that the proposed expert there acknowledged that **[*20]** he was unsure about "'what the average internist sees day in and day out,'" the problem there is the problem here: the proposed expert devoted a majority of his professional time to a subspecialty regardless of any overlap. *Woodard, 476 Mich. 545, 719 N.W.2d 842*.

For these reasons, I would reverse and remand for entry of an order granting plaintiff's motion in limine and for further proceedings.

/s/ Anica Letica

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APPENDIX 23

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Higgins v. Traill

Court of Appeals of Michigan

July 30, 2019, Decided

No. 343664

Reporter
2019 Mich. App. LEXIS 4295 *; 2019 WL 3433085

JOAN HIGGINS and RICHARD HIGGINS, Plaintiffs-Appellees, v LARISA TRAILL, M.D., EMERGENCY MEDICAL SPECIALISTS, PC, and ST. JOHN PROVIDENCE HEALTH SYSTEM, Defendants, and DAVID FRY, M.D., DIAGNOSTIC RADIOLOGY CONSULTANTS, PC, and ST. JOHN MACOMB-OAKLAND HOSPITAL, Defendants-Appellants.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Subsequent History: Leave to appeal denied by *Higgins v. Larisa, 2020 Mich. LEXIS 873 (Mich., May 1, 2020)*

Prior History: [*1] Macomb Circuit Court. LC No. 2016-001382-NH.

Higgins v. Traill, 2019 Mich. App. LEXIS 4121 (Mich. Ct. App., July 23, 2019)

Core Terms

specialty, radiology, diagnostic, neuroradiology, board certification, certificate, qualification, practicing, board certified, subspecialty, angiogram, brain, radiologist, devote, expert witness, medicine, alleged malpractice, trial court, clinical, terms, standard of care, board-certified, malpractice, appropriate standard, qualified to testify, neuroradiologists, subspecialists, match, medical specialty, family practice

Judges: Before: M. J. KELLY, P.J., and MARKEY and GLEICHER, JJ. GLEICHER, J. (concurring).

Opinion

PER CURIAM.

In this medical malpractice action, defendants-appellants David Fry, M.D., Diagnostic Radiology Consultants, PC, and St. John Macomb-Oakland Hospital appeal by leave granted[1] the trial court order denying their motion for summary disposition.[2] Defendants moved for summary disposition, arguing that plaintiffs' expert witnesses, Dr. Joel Meyer and Dr. Gregg Zoarski, were unqualified to render an expert opinion on the applicable standard of care. Because the trial court did not abuse its discretion by determining the expert witnesses qualified to render an expert opinion on the applicable standard of care, we affirm.[3]

I. BASIC FACTS

In October 2013, plaintiff, Joan Higgins, collapsed in her home. When Emergency Medical Services (EMS) arrived, Higgins could not speak, had right-sided weakness, and was experiencing facial droop. Higgins was transported to St. John Macomb-Oakland Hospital. Relevant to this appeal, plaintiffs argue that Dr. Fry read a CT angiogram of Higgins's head as normal when it actually showed an occlusion in the middle cerebral **[*2]** artery. Plaintiffs contend that Dr. Fry's failure to properly read the CT angiogram delayed Higgins's treatment, which caused her to experience the full effect of an

[1] *Higgins v Traill*, unpublished order of the Court of Appeals, entered June 28, 2018 (Docket No. ***343664***).

[2] Defendants Dr. Traill, Emergency Medical Specialists, PC, and St. John Providence Health System did not apply for leave to appeal the trial court's order and are not participating in this appeal.

[3] Defendants also sought summary disposition on the basis that plaintiffs could not establish proximate cause. That issue, however, is not before this Court as it was not decided by the trial court and is not raised as an issue on appeal.

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ischemic stroke and resulted in her sustaining permanent neurological deficits.

Following discovery, defendants moved for summary disposition under MCR 2.116(C)(10), arguing that plaintiffs' experts, Dr. Meyer and Dr. Zoarski, were not qualified to provide standard-of-care testimony under MCL 600.2169. Specifically, defendants asserted that the specialty that Dr. Meyer and Dr. Zoarski spent the majority of their time practicing — neuroradiology — did not match Dr. Fry's specialty — diagnostic radiology — so they were not qualified to testify against Dr. Fry. Plaintiffs, however, maintained that the specialty matched because at the time of the alleged malpractice Dr. Fry was practicing neuroradiology, not diagnostic radiology. The trial court agreed with plaintiffs, holding that Dr. Meyer and Dr. Zoarski were qualified to testify as experts against Dr. Fry under MCL 600.2169 and MRE 702, and denying defendants' motion for summary disposition.

II. QUALIFICATION OF EXPERT UNDER MCL 600.2169

A. STANDARD OF REVIEW

Defendants argue that the trial court abused its discretion by ruling that Dr. Fry **[*3]** was practicing neuroradiology when he read the CT angiogram of Higgins's head. "This Court reviews questions of statutory interpretation de novo." Woodard v Custer, 476 Mich 545, 557; 719 NW2d 842 (2006). We review for an abuse of discretion "a trial court's rulings concerning the qualifications of proposed expert witnesses to testify . . . ." *Id.* "The abuse of discretion standard recognizes that there may be no single correct outcome in certain situations; instead, there may be more than one reasonable and principled outcome." *Gonzalez v St John Hosp (On reconsideration)*, 275 Mich App 290, 294; 739 NW2d 392 (2007). "When the trial court selects one of these principled outcomes, it has not abused its discretion, and the reviewing court should defer to the trial court's judgment." *Id.* "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." Woodard, 476 Mich at 557. The determination of the relevant standard of care is a question of law that is reviewed de novo by this Court. Cox v Flint Bd of Hosp Managers, 467 Mich 1, 16 n 16; 651 NW2d 356 (2002).

B. ANALYSIS

Generally, in a medical malpractice action a plaintiff must establish the following elements: "(1) the appropriate standard of care governing the defendant's conduct at the time of the purported negligence, (2) that the defendant breached that standard of **[*4]** care, (3) that the plaintiff was injured, and (4) that the plaintiff's injuries were the proximate result of the defendant's breach of the applicable standard of care." Craig v Oakwood Hosp, 471 Mich 67, 86; 684 NW2d 296 (2004). "Expert testimony is required to establish the standard of care and a breach of that standard[.]" Kalaj v Khan, 295 Mich App 420, 429; 820 NW2d 223 (2012).

In order to provide expert testimony on the relevant standard of care, an expert witness in a medical malpractice case must meet the requirements under MCL 600.2169, which provides in pertinent part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), during the year **[*5]** immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

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Under MCL 600.2169(1), "the plaintiff's expert witness must match the one most relevant standard of practice or care—the specialty *engaged in* by the defendant physician during the course of the alleged malpractice, and, if the defendant physician is board certified in that specialty, the plaintiff's expert must also be board certified in that specialty." Woodard, 476 Mich at 560 (emphasis added). Further, if the defendant is **[*6]** practicing outside his or her area of specialty at the time of the alleged malpractice, the relevant specialty is the specialty that the defendant was practicing regardless of whether the defendant is or is not certified in the area of medicine that was being practiced so long as the defendant could *potentially* become certified in that specialty. Reeves v Carson City Hosp (On Remand), 274 Mich App 622, 630; 736 NW2d 284 (2007). See also Gonzalez, 275 Mich App at 297 (holding that a resident is held to the standard of the specialty he or she is practicing in even though the resident is not yet a specialist in any field).

In this case, defendants contend that the specialty Dr. Fry was engaged in, i.e., practicing, during the course of the alleged malpractice was diagnostic radiology. Plaintiffs, however, contend that the specialty Dr. Fry was engaged in during the course of the alleged malpractice was neuroradiology. Recognizing that there was a factual dispute on this point, the trial court evaluated the evidence before it and the parties arguments, and the court determined that the relevant specialty was neuroradiology because that was the specialty that Dr. Fry was practicing when he read the CT angiogram of Higgins's head.

In determining that Dr. Fry was engaged in neuroradiology, the trial **[*7]** court first considered that Dr. Fry was in a practice group consisting of 12 radiologists, only one of whom was certified in neuroradiology. Despite the fact that one of the radiologists had a subspecialty, the group did not divide the tests based on whether someone was a radiologist or a neuroradiologist. In addition, the court considered that Dr. Fry read a CT angiogram of Higgins's head, which was a function performed by a neuroradiologist according to the American Board of Radiology's website.[4] The American Board of Radiology states that a "diagnostic radiologist" is someone who " . . . uses x-rays, radiolnuclides, ultrasound, and electromagnetic radiation to diagnose and treat disease." The American Board of Radiology further provides that a specialist in neuroradiology does the following:

> diagnoses and treats disorders of the brain, sinuses, spine, spinal cord, neck, and the central nervous system, such as aging and degenerative diseases, seizure disorders, cancer, stroke, cerebrovascular diseases, and trauma. Imaging commonly used in neuroradiology includes angiography, myelography, interventional techniques, and magnetic resonance imaging (MRI). . . .

Based on this definition, **[*8]** the trial court concluded that because Dr. Fry was reading an angiogram of Higgins's brain in order to diagnose and treat her stroke, he was engaged in the practice of neuroradiology. Although defendants argue on appeal that there is substantial overlap between diagnostic radiology and neuroradiology, given that there is evidence to support each view, we discern no error in the court's determination that the relevant specialty was neuroradiology because that was what Dr. Fry was practicing when he read the CT angiogram. See Reeves, 274 Mich App at 629-630 (stating that the relevant specialty is the one that the defendant was practicing at the time of the alleged malpractice notwithstanding that the defendant may not be certified in the specialty he was practicing in); see also Estate of Norczyk v Danek, 326 Mich App 113, 123; NW2d (2018) (stating that the one most relevant specialty was cardiology, not interventional cardiology, because the allegations of medical malpractice pertained the defendant's actions as a cardiologist, not an interventional cardiologist).[5]

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[4] See https://www.theabr.org/diagnostic-radiology/subspecialties#neuro , last access June 20, 2019. A printout of the webpage containing the definition is included in the court record.

[5] Having determined that the trial court did not err by determining that the one most relevant specialty was neuroradiology, we likewise discern no abuse of discretion in the court's determination that plaintiffs' experts were, therefore, qualified to provide standard-of-care testimony against Dr. Fry.

In order to satisfy the first requirement of MCL 600.2169(1)(a), plaintiffs' experts must have the same specialty as Dr. Fry had "at the time of the occurrence that is the basis for the action . . ." See Woodard, 476 Mich at 560. In *Woodard*, our Supreme Court defined "specialty" as "a particular branch of medicine or surgery in which one can potentially become board certified." Woodard, 476 Mich at 561. Relatedly, a "'subspecialty' is a particular branch of medicine or surgery in which one can potentially become board certified that falls under a specialty or within the hierarchy of that specialty." Id. at 562. Thus, for

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Defendants assert that *Reeves* was overruled by our Supreme Court. We disagree. In Jilek v Stockson, 289 Mich App 291, 302-303; 796 NW2d 267 (2010) (*Jilek I*), rev'd sub nom Estate of Jilek v Stockson, 490 Mich 961; 805 NW2d 852 (2011) (*Jilek II*), recon den *491 Mich. 870, 809 N.W.2d 566 (2012)* (*Jilek III*), this Court, relying in part on *Reeves*, held that the **[*9]** trial court erred when it ruled that the one most relevant specialty was "family practice" where the defendant physician, who only possessed a family medicine board certification, allegedly committed malpractice while working at an urgent care facility. This Court held that "the proper standard of care was that for emergency-medicine specialists" because the terms "urgent" and "care" were "more consistent with the scope of emergency medicine than they [were] with the scope of family practice." Jilek I, 289 Mich App at 302-303. In *Jilek II*, the Michigan Supreme Court reversed this Court's holding in *Jilek I* because it held that the trial court "correctly determined as a matter of law that the appropriate standard of care was 'family practice' because the defendant physician [was] board-certified solely in family medicine." Jilek II, 490 Mich at 961.

In *Jilek III*, the Michigan Supreme Court denied a motion for reconsideration. *Jilek III, 491 Mich at 870*. Justice MARKMAN authored a concurrence to the order denying the motion for reconsideration, wherein he explained that he believed "the 'one-most-relevant-specialty' test is only applicable if the defendant has more than one specialty," and although the defendant "was practicing family medicine at the time of the alleged **[*10]** malpractice," that was "irrelevant because [the] defendant has only one specialty, and the 'one-most-relevant-specialty' test [was] inapplicable." *Jilek III, 491 Mich at 872* (MARKMAN, J., concurring). Therefore, Justice MARKMAN explained, that "[t]o the extent that" *Reeves* was "inconsistent with this conclusion, [it was], in [his] judgment, necessarily overruled by" *Jilek II*. *Jilek III, 491 Mich at 872* (MARKMAN, J., concurring).

Notably, the Michigan Supreme Court's holding in *Jilek II* explained that "the appropriate standard of care was 'family practice' because the defendant physician [was] board-certified *solely in family medicine*." Jilek II, 490 Mich at 961 (emphasis added). The Michigan Supreme Court provided no further guidance regarding its rationale in *Jilek II*. Therefore, it is unclear if the holding of *Jilek II* was based in part on a determination that the defendant physician in *Jilek* was not practicing outside her board certification of "family practice" when she provided medical services at an urgent care facility, which rendered only her actual board certification relevant. As the Michigan Supreme Court provided no further explanation, and it did not explicitly question the rationale of *Reeves* in *Jilek II*, there is no reason to assume that the Michigan Supreme **[*11]** Court

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purposes of MCL 600.2169(1), although more particularized, a subspecialty "is nevertheless a specialty." *Id.* Here, it is undisputed that neuroradiology is a subspecialty of diagnostic radiology. Accordingly, as Dr. Fry was practicing neuroradiology, plaintiffs' experts were also required to practice neuroradiology. See *id. at 561-562* ("[I]f the defendant physician practices a particular branch of medicine or surgery in which one can potentially become board certified, the plaintiff's expert must practice or teach the same particular branch of medicine or surgery."). Thus, because the trial court determined that Dr. Fry was practicing neuroradiology during the alleged malpractice, and because neuroradiology is a subspecialty, plaintiffs' experts were required to share that same specialty. The evidence submitted to the trial court established that both plaintiffs' experts were board-certified in diagnostic radiology and had CAQs in neuroradiology, so they have the same specialty as Dr. Fry did at the time that he allegedly committed malpractice.

MCL 600.2169(1)(a) also requires that if the defendant physician is board-certified, the expert witness must be a specialist who is board-certified in the same specialty. See Woodard, 476 Mich at 562. In *Woodard*, our Supreme Court explained that "if a defendant physician has received a certificate of special qualifications, the plaintiff's expert witness must have obtained the same certification of special qualifications in order to be qualified to testify under § 2169(1)(a)." *Id. at 565*. In this case, as Dr. Fry did not have a certification of added qualification in neuroradiology, it is not relevant whether plaintiffs' experts held such a certificate.

Next, "MCL 600.2169(1)(b) provides that if the defendant physician is a specialist, the expert witness must have 'during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either . . . the active clinical practice of that specialty . . . .'" Woodard, 476 Mich at 565, quoting MCL 600.2169(1)(b). Here, Dr. Meyer testified that he spent the majority of his time practicing neuroradiology in the year immediately preceding the date of Dr. Fry's alleged malpractice, so he satisfies he practice requirement in MCL 600.2169(1)(b). Further, Dr. Zoarski testified that he spent the majority his time conducting "interventional procedures," but he clarified that his interventional training was part of his neuroradiology fellowship. Accordingly, Dr. Zoarski satisfies the practice requirement in MCL 600.2169(1)(b).

In sum, with neuroradiology as the one most relevant specialty, the plaintiffs' experts satisfy the requirements in MCL 600.2169(1), so they are qualified under that statute to offer opinion testimony on the appropriate standard of care.

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intended for *Jilek II* to implicitly reverse *Reeves*. We, therefore, remain bound to follow *Reeves*. See *Straman v Lewis, 220 Mich App 448, 451; 559 NW2d 405 (1996)*.

Affirmed.

/s/ Michael J. Kelly

/s/ Jane E. Markey

Concur by: Elizabeth L. Gleicher

Concur

GLEICHER, J. (*concurring*).

Plaintiffs Joan and Richard Higgins contend that defendant David Fry, M.D., negligently misread a CT angiogram of Joan Higgins' brain. Two expert witnesses provided deposition testimony supporting their claim: Drs. Joel Meyer and Gregg Zoarski. Drs. Meyer and Zoarski are board certified in diagnostic radiology, and so is Dr. Fry. Drs. Meyer and Zoarski also have certificates of added qualification in neuroradiology. Dr. Fry does not.

Relying on *Woodard v Custer, 476 Mich 545; 719 NW2d 842 (2006)*, Dr. Fry asserts that the relevant specialty in this case is diagnostic radiology. Because the two experts have certificates of added qualification in neuroradiology and devote a majority of their professional time to practicing neuroradiology, they may not testify to the appropriate standard of care, Dr. Fry insists.

Guided by this Court's decision in *Reeves v Carson City Hosp (On Remand), 274 Mich App 622, 629-630; 736 NW2d 284 (2007)*, the majority holds that the relevant specialty is neuroradiology and not diagnostic radiology. Since Dr. Fry was practicing neuroradiology when he interpreted the CT angiogram, the majority finds **[*12]** the experts qualified under *MCL 600.2169(1)(b)*.

I concur that Drs. Zoarski and Meyer qualify as standard of care experts. Drs. Fry, Meyer and Zoarski are all board certified in diagnostic radiology. If Dr. Fry is correct and diagnostic radiology is the relevant specialty under *MCL 600.2169*, a textual reading of the statute dictates that Drs. Meyer and Zoarski must be permitted to testify regarding the standard of care. I acknowledge that my analysis collides with the Supreme Court's opinion in *Woodard*. I respectfully suggest that reconsideration of *Woodard* is in order.

I. AN OVERVIEW OF *WOODARD*'S TEXTUAL ERRORS

Dr. Fry's argument rests on the following three principles introduced in *Woodard*: (1) a medical subspecialty is the same thing as a specialty under *MCL 600.2169(1)(a)*; (2) a certificate of added qualification is the same thing as board certification in a specialty, and (3) a specialist can devote the majority of his or her professional time only to a single specialty. The words of the statute, combined with a small dose of logic, refute all three of these judge-created precepts.

The Legislature enacted *MCL 600.2169(1)* to limit the discretion of trial courts in determining whether a medical malpractice expert is qualified to testify. *McDougall v Schanz, 461 Mich 15, 25; 597 NW2d 148 (1999)*. The portion **[*13]** of the statute relevant to this case provides:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to *subdivision (c)*, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty. **[*14]**

The plain language of *subsection (1)(a)* links an expert's qualification to his or her professional credentials. For specialists, board certification is the focal point of the statute's credentialing prong. *Subsection (1)(b)* centers on actual clinical practice. In a case involving a

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specialist, an expert must have devoted a majority of his or her professional time to the active clinical practice of the same specialty during a relevant time period. MCL 600.2169(1)(b)(i). Like the credential prong, the practice prong hinges on an expert's "specialty."

The terms "board certified" and "specialty" figure prominently in the statute. I believe that *Woodard* created definitions for these terms out of thin air, and that the definitions are inconsistent with the words used by the Legislature. In my view, board certification means board certification, and specialty means specialty. Board certification is not the same thing as certification with additional qualifications. A specialty is not a subspecialty. Respectfully, the *Woodard* majority abandoned a textual approach when it conflated board certification with attainment of a certificate of added qualification. It committed the same error by announcing that specialties and subspecialties are identical **[*15]** concepts. These mistakes paved the way for *Woodard*'s central error: that a physician can practice only one specialty at a time.

II. *WOODARD* VERSUS THE TEXT OF MCL 600.2169(1)(a)

Subsection (1)(a), the statute's credentialing prong, provides: "[I]f the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty." MCL 600.2169(1)(a). This sentence references "a specialist," "that specialty," and "board certification." Alternatively stated, it provides that when a defendant is a "board certified" "specialist," the plaintiff's expert must be a "specialist" "board certified" in the same "specialty."

None of these terms were defined by the Legislature, but they are not difficult to parse. *Woodard* defined the word "specialty" by combining the *Dorland's Illustrated Medical Dictionary* definition of "specialist," which incorporates board certification in the concept, with the portion of MCL 600.2961(1)(a) referencing defendant physicians who are "specialists" and "board certified." "[A] 'specialty,' " the Court adduced, "is a particular branch of medicine or surgery in which one can potentially become board certified." *Woodard, 476 Mich at 561*.

So far, so good. The Legislature **[*16]** paired the terms "specialist" and "board certified," so thinking about board certification (or potential board certification) as an essential attribute of being a specialist makes sense. And when it comes to specialists, the Legislature tied expert qualification to matching board certification. It logically follows that in a case involving the standard of care expected of a board-certified specialist, a standard-of-care expert must be board certified in the same specialty.

The *Woodard* majority fell off the textual rails, however, by fashioning its own definition of the term "board certification," and then deciding that the words "specialty" and subspecialty" mean exactly the same thing. I submit that the term "board certified" is unambiguous and well understood, and so is the term "specialty." The meanings assigned those terms by the *Woodard* majority, however, are the majority's own creations. They are untethered to the text, do not derive from a dictionary, and do not even relate to any rule of statutory construction. I suggest that the plain meanings of the terms should control the statute's interpretation and application.

A. Board Certification Means Board Certification

In *Woodard, 476 Mich at 564-565*, the majority **[*17]** decided that "board certification" encompasses both certification by a board recognized by the American Board of Medical Specialties, *and* the possession of a "certificate of added qualification." According to *Woodard*, board certification and a possession of a certificate of added qualification are identical concepts. *Id. at 565*.

But having a board certification is *not* the same thing as having a certificate of special qualification. Attaining board certification is a process separate and distinct from obtaining a certificate of added qualification. Those who earn certificates of added qualification have training above and beyond that required for board certification. That is why Dr. Fry objects so strenuously to plaintiffs' experts; in Dr. Fry's view, plaintiffs' experts are overqualified. *Woodard* supports Dr. Fry. It holds that if a defendant physician has received *any* official certification of professional competence from a medical organization, "the plaintiff's expert witness must also have obtained the same certification in order to be qualified to testify concerning the appropriate standard of practice or care." *Id. at 564*. Conversely, as defendants argue here, if a defendant lacks a certificate of **[*18]** added qualification, an expert possessing such a certificate may not testify.

This approach to qualifying an expert might make sense. But the Legislature did not embrace it when it enacted MCL 600.2169. Instead, MCL 600.2169(1)

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states that an expert's qualification rises or falls on the expert's "board certification." The statute never mentions certificates of added qualification. Certificates of added qualification were not new in 1986, when the statute took effect. They had been earned by specialists for decades before that date, and no doubt the Legislature was aware that they existed. *Woodard* assumes that when drafting MCL 600.2169, the Legislature overlooked this highly relevant, discrete professional achievement. I submit that fidelity to the text requires that we avoid changing the meaning of an ambiguous term. "The words of the statute provide the best evidence of legislative intent and the policy choices made by the Legislature. Our role as members of the judiciary is not to secondguess those policy decisions or to change the words of a statute in order to reach a different result." People v Harris, 499 Mich 332, 345; 885 NW2d 832 (2016). The Legislature did not inadvertently overlook the existence of certificates of added qualification: "The Court may not assume that **[*19]** the Legislature inadvertently made use of one word or phrase instead of another." Robinson v Detroit, 462 Mich 439, 459; 613 NW2d 307 (2000). Rather, it decided that board certification, and board certification alone, establishes the first indicator of expert qualification.

According to the American Board of Medical Specialties, there are 24 medical specialty boards. American Board of Medical Specialties, ABMS Guide to Medical Specialties (2019), p 5, available at <https://www.abms.org/media/194925/abms-guide-to-medical-specialties-2019.pdf > (accessed July 22, 2019). Radiology is one such board. Neuroradiology is not. A board-certified radiologist can obtain a certificate of added qualification in neuroradiology. But the radiologist with a certificate of added qualification remains board certified in one discipline—radiology. In *Woodard*, the Supreme Court conflated these two different terms. Just as a Master's degree in History reflects a different level of achievement than does a Ph.D. in the same "specialty," a board-certified physician has different training than one who has earned a certificate of added qualification. The physicians involved in this case know the difference. As stated by Dr. Meyer:

> *Q*. I believe you testified there is no **[*20]** separate Board certification for neuroradiologists relative to diagnostic radiology; correct?
>
> *A*. There is only the certificate of added qualifications, but it's not a separate Board certification. That's correct.

The Supreme Court once knew the difference, too. A mere two years before deciding *Woodard*, the Supreme Court relied on the *difference* between board certification and a certificate of added qualification to decide that a plaintiff's expert was unqualified to testify under § 2169(1). In Halloran v Bhan, 470 Mich 572, 575; 683 NW2d 129 (2004), the defendant was board certified in internal medicine and had a certificate of added qualification in critical care medicine. The plaintiff's proposed expert was board certified in anesthesiology and had a certificate of added qualification in critical care medicine. *Id.* The Supreme Court observed that the parties in that case did not "dispute that the subspecialty certification is not a 'board certification' for the purpose of the statute." *Id.* The Court's holding was consistent with the parties' understanding of the term — "Because plaintiff's expert witness did not share the same board certification as the defendant doctor, we reverse the decision of the Court of Appeals that held to the contrary and **[*21]** reinstate the circuit court's order granting defendants' motion to strike." Id. at 574-575.

Woodard implicitly overruled Halloran, serving as a "reminder that activism comes in all guises, including so-called textualism." McCormick v Carrier, 487 Mich 180, 209; 795 NW2d 517 (2010) (quotation marks and citation omitted). Why was *Halloran* so easily overlooked in *Woodard*? Part of the reason is that the *Woodard* majority became entangled in two additional parts of the statute: the definition of specialty and the meaning of subsection 2169(1)(b).

B. Specialist and Subspecialists: Different Words, Different Definitions

According to Woodard, 476 Mich at 562, "[a] subspecialty, although a more particularized specialty, is nevertheless a specialty." Calling something by another name does not transform its true meaning. The two terms are not synonymous. All doctors know that a "specialty" is *not* a subspecialty, and I am certain that the Legislature knew it, too. Physicians who wish to be known as subspecialists must devote extra time and effort to earning that description. Generally, a certificate of added qualification transforms a specialist into a subspecialist. In medicine, a subspecialty is a narrower field within a specialty. Dr. Meyer explained:

> *Q*. I understand you are a neuroradiologist; **[*22]** is that true?

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A. Yes.

Q. You are Board certified in diagnostic radiology?

A. Yes.

Q. And then you obtained a CAQ in neuroradiology?

A. Yes.

Q. And I understand that you did your - - well, neuroradiology is a subspecialty of diagnostic radiology; correct?

A. Yes.

Q. And it's a subspecialty in which you can obtain a CAQ or Board certification; correct?

A. It's not a separate Board at this stage in neuroradiology. It's just a certificate of added qualifications to the primary Board.

Q. You had - - what did you have to do to get your CAQ?

A. I needed to qualify to take the exam. I qualified by having done a fellowship in neuroradiology, and then by practicing greater than 50 percent of the time in neuroradiology for the three years prior to a CAQ being instituted after I finished my training.

The American Board of Radiology also knows the difference between a specialist and a subspecialist. On its website, the Board declares: "Subspecialty initial certification in the areas below is available for candidates who are initially certified in diagnostic radiology. Specialty certification is required to earn and maintain subspecialty certification." Neuroradiology is one of the "areas below." American Board **[*23]** of Radiology, Subspecialties, available at <https://www.theabr.org/diagnostic-radiology/subspecialties#neuro > (accessed July 22, 2019).

The inaccurate and nontextual blending of the terms specialty and subspecialty blights the balance of *Woodard*'s analysis.

III. *WOODARD* VERSUS THE TEXT OF *MCL 600.2169(1)(b)*

I now turn to the section of the statute at the center of defendant's argument, *§ 2169(1)(b)*. Here, too, *Woodard* has engrafted language into the statute going well beyond and, in my view, contradicting the Legislature's choices.

"[T]he specialty requirement is tied to the occurrence of the alleged malpractice," *Woodard* decreed. *Woodard, 476 Mich at 559* (quotation marks and citation omitted). *Subsection 2169(1)(b)* requires that an expert devote "the *majority*" of his or her professional time to the practice of "the same specialty," the Court reasoned. *Woodard, 476 Mich at 559-560*. *Woodard* holds:

> [T]he plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty. [*Id. at 566*.]

And "one cannot devote a 'majority' **[*24]** of one's professional time to more than one specialty," *Woodard* declares. *Id.*

With this, *Woodard* adopted a zero-sum proposition: a physician can practice only one specialty for the majority of his or her time, and the expert must match that specialty. The singular-specialty-practice construct is at odds with the text, not to mention the realities of modern medicine. This case illustrates the flaws inherent in *Woodard*'s approach.

Dr. Fry argues that when he interpreted the CT angiogram of Joan Higgins' brain, he was practicing diagnostic radiology. The interpretation of CT angiograms of the brain falls well within the competence of a diagnostic radiologist, Dr. Fry claims. In Dr. Fry's estimation, diagnostic radiology is *the* relevant specialty.

If Dr. Fry was practicing diagnostic radiology when he interpreted the CT angiogram of Joan Higgins' brain, it inescapably follows that Drs. Zoarski and Meyer practice diagnostic radiology when *they* interpret CT angiograms of the brain. If the interpretation of a CT angiogram is within the purview of a diagnostic radiologist, as Dr. Fry contends, and Drs. Zoarski and Meyer are both board certified in diagnostic radiology, they, too, practice diagnostic **[*25]** radiology when they interpret CT angiograms of the brain.

Woodard holds that only one specialty may be practiced at a time, and only one specialty may be matched. *Id.* This case demonstrates that the "one specialty" concept

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is incompatible with real life. Obviously, Drs. Meyer and Zoarski bring all of their training and experience to bear when they interpret CT angiograms, including their training and experience as subspecialists in neuroradiology. Nevertheless, I submit that under § 2169(1)(b), they are qualified to testify against Dr. Fry.[1]

MCL 600.2169(1)(b) instructs that to be qualified as a standard-of-care expert, a physician must devote a majority of his or her professional time to the active clinical practice of the "specialty" practiced by a board-certified defendant. If Dr. Fry is correct, that specialty is diagnostic radiology. Diagnostic radiology is the only "*specialty*" that Drs. Zoarski and Meyer practice. In addition to diagnostic radiology, both also practice neuroradiology. But that is a subspecialty, and the statute does not mention subspecialties. Instead, the plain language tells us that only "specialties" count.

If reading CT angiograms of the brain is part of the practice of diagnostic radiology, **[*26]** Drs. Meyer and Zoarski practice diagnostic radiology when they interpret CT angiograms of the brain. Under *Woodard*, a recalculation of their professional time division is in order. This recalculation must be accomplished because *Woodard* dictates that subspecialists like Drs. Meyer and Zoarski can only practice one specialty at a time.

By conflating specialties and subspecialties, *Woodard* forces potential experts to carve their professional time into separate pieces so they can settle on what constitutes a "majority." As this case so aptly demonstrates, this is fool's errand. It makes no sense to balkanize an expert's practice in the manner that *Woodard* dictates, because in reality there is a substantial overlap between the work of specialists and subspecialists. *Woodard* demands bright lines and impenetrable borders based on definitions unsupported by the words of the statute or the realities of life. A return to the text would go far toward remedying this problem.

Woodard compels a contorted calculation of which specialty or subspecialty consumes the majority of an expert's time based on the notion that it is possible to practice only one thing at a time. This case undercuts *Woodard* **[*27]** 's central thesis. Both diagnostic radiologists and neuroradiologists interpret CT angiograms of the brain. The content of their practices overlap in this regard, and likely many others.

I join the majority opinion because the result it reaches is consistent with the zero-sum reading of § 2169 advanced in *Woodard*. That approach leads to several absurd propositions, including that a "specialist" can devote a majority of his or her time to practicing only one "specialty." This case involves a radiologic examination of the brain, typical fodder for neuroradiologsts, who routinely review studies of the brain and spinal cord. Neuroradiology, a "specialty" according to *Woodard*, is stripped of its meaning and importance as a medical discipline by a judicial holding that reading a CT angiogram of the brain is actually not neuroradiology, but instead diagnostic radiology. Faced with the obvious overlap between the two "specialties," I agree with the conclusion that Dr. Fry was practicing neuroradiology when he read the study involved in this case.

This *Woodard*-dictated result remains mystifying. Applied here, one consequence is that the universe of expert witnesses qualified to testify does not include **[*28]** Dr. Fry. This result must obtain, *Woodard* tells us, because Dr. Fry does not devote a majority of his professional time to the practice of the most relevant specialty, neuroradiology. This incongruity can be avoided by reexamining *Woodard*. The word "specialty" should be construed to include specialties (more than one specialty), and to exclude subspecialties. In real life, diagnostic radiologists and neuroradiologists review CT angiograms of the brain. Therefore, they are engaged in the same "specialty." Second, because there is obvious overlap in the practices of the two disciplines, it makes sense to conclude that a radiologist practices *both* diagnostic radiology and neuroradiology when he or she interprets a brain or spinal cord study.

As board-certified radiologists, both general (diagnostic) radiologists and neuroradiologists are qualified to interpret CT angiograms. The Legislature understood this when it enacted MCL 600.2169, because it tied qualification to board certification rather than to subspecialization. MCL 600.2169(1)(a) provides that because Dr. Fry is a board-certified specialist in radiology, an expert who is board certified in the same specialty is qualified to testify to the standard of care. **[*29]** Under subsection (1)(b), the expert must have devoted his professional time during the relevant timeframe to "the active clinical practice of" the defendant's *specialty*. Drs. Meyer and Zoarski practice

[1] Of course, an attorney may always argue that an expert's additional training, or lack thereof, renders his or her opinions less credible. In my view, the Legislature anticipated exactly this when it decided against including certificates of added qualification in any definition of board certification.

the *specialty* of diagnostic radiology and the subspecialty of neuroradiology. Guided by the words selected by the Legislature rather than extratextual, judicially created definitions, I would hold that they qualify as experts in this case.

/s/ Elizabeth L. Gleicher

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APPENDIX 24

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Mallory v. Beaumont Health Sys.

Court of Appeals of Michigan

December 22, 2020, Decided

No. 350263

Reporter
2020 Mich. App. LEXIS 8634 *; 2020 WL 7636560

CATHERINE MALLORY and LABARON MALLORY, Plaintiffs-Appellants, v BEAUMONT HEALTH SYSTEM, doing business as BEAUMONT ROYAL OAK HOSPITAL, DR. ARTIN BASTANI, M.D., LINDSEY SARNOVSKY, CRNA, and JANICE E. WOLFF, CRNA, Defendants-Appellees.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Subsequent History: Motion granted by *Mallory v. Beaumont Health Sys., 955 N.W.2d 480, 2021 Mich. LEXIS 383, 2021 WL 1035388 (Mich., Mar. 17, 2021)*

Leave to appeal denied by *Mallory v. Beaumont Health Sys., 2021 Mich. LEXIS 1610 (Mich., Sept. 22, 2021)*

Prior History: **[*1]** Oakland Circuit Court. LC No. 2018-164572-NH.

Core Terms

trial court, plaintiffs', intubation, standard of care, expert witness, vocal cord, pain management, practicing, anesthesiology, discovery, specialty, witness list, reliable, malpractice, spent, expert testimony, motion to strike, witnesses, affidavit of merit, subspecialty, anesthesia, deposition, motions, amend, grant a motion, factors, overlap, surgery, national standard, motion for leave

Counsel: For CATHERINE MALLORY, Plaintiff-Appellee: DAVID R. PARKER.

For BEAUMONT HEALTH SYSTEM, LINDSEY SARNOVSKY CRNA, Defendant-Appellant: ROBERT G. KAMENEC.

For DR ARTIN BASTANI MD, Defendant-Appellee: JOANNE GEHA SWANSON.

Judges: Before: CAVANAGH, P.J., and JANSEN and SHAPIRO, JJ. SHAPIRO, J. (concurring in part and dissenting in part).

Opinion

PER CURIAM.

In this medical malpractice action, plaintiffs appeal as of right following the trial court's order granting a motion for a directed verdict in favor of defendants,[1] Beaumont Health System, Lindsey Sarnovsky,[2] and Dr. Artin Bastani. We affirm.

I. FACTS

In November 2015, plaintiff Catherine Mallory[3] was admitted to defendant Beaumont Hospital as an outpatient to undergo a medical procedure. Before this procedure, Mallory was evaluated by an anesthesiologist, defendant Bastani, and it was decided that the "anesthesia plan" for the procedure would be "general anesthesia with endotracheal intubation." Mallory signed a consent form that warned the anesthesia procedure came with risks to her "vocal cords" and also with the risk of "hoarseness."

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[1] The trial court entered a stipulated order dismissing plaintiffs' claims against defendant Janice E. Wolff, CRNA, a nurse employed by Beaumont Health System.

[2] For convenience, we collectively refer to Beaumont Health System and Sarnovsky as "Beaumont" in light of their substantial identity of interest and common representation below and on appeal.

[3] Because Catherine Mallory is the patient alleging medical malpractice, and plaintiff LaBaron Mallory has only a derivative claim, references to "Mallory" in this opinion will refer to Catherine.

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Dr. Bastani was present during the induction of anesthesia for Mallory. After "induction of anesthesia," Mallory's intubation was performed **[*2]** by Sarnovsky, a certified registered nurse anesthetist (CRNA). Dr. Bastani supervised Mallory's intubation, and he testified during his deposition that there "was only one attempt" at the procedure and that he did not recall any trauma or difficulty during that single attempt."

After the procedure, Mallory woke up in the recovery room experiencing soreness in her throat beyond what she expected. The soreness did not subside after the procedure, and eventually Mallory was diagnosed by Dr. Glendon Gardner with "left vocal cord scarring."

Subsequently, plaintiffs commenced this cause action. Ultimately, the trial court granted defendants' motions to strike the testimony of plaintiffs' standard-of-care witnesses, denied plaintiffs' motion for leave to amend their witness list before trial, and granted defendants' motion for a directed verdict. This appeal followed.

II. DR. WEINGARTEN

Plaintiffs first argue on appeal that the trial court erred when it granted Bastani's motion to strike the testimony of their physician expert witness Dr. Alexander Weingarten. We disagree.

"We review a trial court's decision on a motion in limine for an abuse of discretion." *Bellevue Ventures, Inc v Morang-Kelly Investment, Inc, 302 Mich App 59, 63; 836 NW2d 898 (2013)* "A trial court's rulings concerning **[*3]** the qualifications of proposed expert witnesses are reviewed for an abuse of discretion." *Rock v Crocker, 499 Mich 247, 260; 884 NW2d 227 (2016)*. "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." *Woodard v Custer, 476 Mich 545, 557; 719 NW2d 842 (2006)*. Questions of law "underlying evidentiary rulings, including the interpretation of statutes and court rules," are reviewed de novo. *Elher v Misra, 499 Mich. 11, 21; 878 N.W.2d 790 (2016)*.

"In a medical malpractice case, plaintiff bears the burden of proving: (1) the applicable standard of care, (2) breach of that standard by defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury." *Wischmeyer v Schanz, 449 Mich. 469, 484; 536 N.W.2d 760 (1995)*. "Failure to prove any one of these elements is fatal." *Wiley v Henry Ford Cottage Hosp, 257 Mich. App. 488, 492; 668 N.W.2d 402 (2003)*. "Expert testimony is required to establish the applicable standard of care and to demonstrate that the defendant breached that standard." *Gonzalez v St John Hosp & Med Ctr, 275 Mich. App. 290, 294; 739 N.W.2d 392 (2007)*.

MCL 600.2169(1) provides, in relevant part, as follows:

> In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence **[*4]** that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to *subdivision (c)*,[4] during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

In *Woodard*, the Michigan Supreme **[*5]** Court explained that a "'specialty' is a particular branch of medicine or surgery in which one can potentially become board certified.'" *Woodard, 476 Mich at 561*. Relatedly, a "'subspecialty' is a particular branch of medicine or surgery in which one can potentially become board certified that falls under a specialty or

[4] *Subdivision (c)* comes into play "[i]f the party against whom or on whose behalf the testimony is offered is a general practitioner . . . ."

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within the hierarchy of that specialty." *Id. at 562*. "A subspecialty, although a more particularized specialty, is nevertheless a specialty," and therefore, "if a defendant physician specializes in a subspecialty, the plaintiff's expert witness must have specialized in the same subspecialty as the defendant physician at the time of the occurrence that is the basis for the action." *Id.*

Plaintiffs retained Dr. Weingarten as an expert witness to offer standard-of-care testimony in support of their claim of medical malpractice against Dr. Bastani. Dr. Weingarten authored an affidavit of merit that was attached to plaintiffs' complaint, in which he stated that he "devoted more than 50% of [his] professional time to either or both of . . . [t]he active clinical practice of Anesthesiology," or instructing "students in an accredited health professional school or accredited residency or clinical research program **[*6]** in Anesthesiology."

Dr. Bastani testified that he was a board-certified anesthesiologist, and that the medical specialty he spent the majority of his time practicing was anesthesiology. While Bastani also testified that he was board certified in the subspecialty of critical care, he only practiced critical care "six weeks a year," and there was no evidence that Bastani was practicing critical care when he treated Mallory.

Dr. Weingarten testified that he was board certified in the practice of anesthesiology and the medical subspecialty of pain management. He estimated that he generally worked between 80 to 100 hours each week. When he was asked how many of his weekly work hours were devoted to his practice of pain management, Dr. Weingarten explained, "Well, right now, I guess probably around 80 to 85 percent when I am not doing—you know, basically I am doing a majority of my pain management. And I do some office space anesthesia . . . ." According to Dr. Weingarten, he had spent approximately 80 percent of his professional time practicing pain management since "about 2007, 2008."

According to Dr. Weingarten, the common procedures he performed during his pain management practice included **[*7]** "lumbar epidural injections, whether interlaminar or transforaminal," which constituted the majority of the procedures, and he also performed "trigger point injections," "facet blocks," "radio frequency ablation," "sympathetic blocks," "spinal cord simulator trials," "percutaneous diskectomies," and "some plate rich plasma, occasional stem cell injections." He last practiced as a member of an anesthesia group providing anesthesia to hospital patients in 2017, and this practice occupied between "5 to 8 percent" of his weekly professional time. When he was asked if his scope of work as an expert witness reached beyond standard-of-care issues, Dr. Weingarten replied, "I don't believe so."

Dr. Weingarten testified that as of the date of the deposition he had "medical students and residents . . . fairly frequently come through [his] office," and he taught "them about pain management." He previously trained anesthesiology residents at the Nassau University Medical Center, but that program disbanded in 2010.

Dr. Bastani filed a motion to strike Dr. Weingarten's testimony on the ground that he was unqualified to offer expert testimony under *MCL 600.2169* in light of his deposition testimony that he spent **[*8]** the majority of his professional time practicing pain management, where the medical specialty relevant to plaintiffs' malpractice claim against Dr. Bastani was anesthesiology. In their response, plaintiffs argued that Dr. Weingarten was qualified to offer expert testimony because he taught medical students anesthesiology even though he also testified that he spent a significant amount of his professional time practicing the subspecialty of pain management. Plaintiffs also argued that there was conflicting evidence regarding the extent of time Dr. Weingarten spent practicing, respectively, pain management and anesthesiology, given the contents of Dr. Weingarten's affidavit of merit, and therefore the trial court should weigh the evidence and consider the substantial overlap between the practice of pain management and anesthesiology. Plaintiffs alternatively contended that even if Weingarten was not qualified to offer standard of care testimony, he was nonetheless qualified to offer causation testimony.

During the hearing on the motion to strike Dr. Weingarten's testimony, the trial court acknowledged that there was a conflict between the affidavit of merit and Dr. Weingarten's deposition **[*9]** testimony. But the court noted that Dr. Weingarten's testimony came after the affidavit of merit, and that he "clearly admit[ted] and concede[d] that 80 to 85 percent of his time" was spent on a specialty other than anesthesiology. And the trial court stated that even when viewing the "vague reference to teaching" in the light most favorable to plaintiffs, that reference did not "overcome the fact there [was] an insufficient amount of time" to "meet the majority of time threshold" given Dr. Weingarten's other testimony.

The trial court also rejected plaintiffs' contention

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regarding overlap between specialties, on the ground that "the authority cited very plainly reveals that subspecialties do not permit the determination of an overlap to eviscerate the timing requirements." Ultimately, the trial court noted that Dr. Weingarten testified that he was only providing an opinion on standard of care, and therefore allowing Dr. Weingarten to testify regarding causation "would be trial by ambush" and otherwise "dubious in light of the fact he would not be able to testify as a standard of care expert." The trial court subsequently entered an order granting the motion to strike.

Plaintiffs argue **[*10]** that the trial court erred because Bastani contended that Weingarten spent the majority of his professional time practicing pain management, but that Bastani's motion failed to address Dr. Weingarten's testimony that he taught medical students anesthesiology. Curiously, plaintiffs' appellate argument does not directly address the trial court's rejection of this argument. Indeed, as discussed above, the trial court ruled that "the vague reference to teaching" failed to overcome Dr. Weingarten's unequivocal testimony that he spent the majority of his time practicing pain management.

Regardless, closer examination of Dr. Weingarten's testimony reveals that he had "medical students and residents come through [his] office," and that he "teach[es] them about pain management." Therefore, that portion of Dr. Weingarten's testimony only reinforces that he spent the majority of his time involved in the practice of pain management and not anesthesiology. Dr. Weingarten also explained that as of April 2018 he had a "current appointment at New York Medical College through the Department of Pharmacology," and that he previously was an instructor for an anesthesiology residency program that disbanded **[*11]** in 2010. Given that the relevant time period is the year preceding Mallory's intubation, these teaching activities are irrelevant because they fall outside of that time range.

Plaintiffs contend that even if Dr. Weingarten's testimony established that he spent the majority of his time practicing pain management, such testimony conflicted with his affidavit of merit in which he indicated he spent the majority of his time practicing anesthesiology. Plaintiffs offer no explanation why Dr. Weingarten's affidavit of merit should be afforded the same weight as his unequivocal and more detailed deposition testimony.

This Court has rejected attempts by a party "to contrive factual issues by relying on an affidavit when unfavorable deposition testimony shows that the assertion in the affidavit is unfounded," even when the affidavit in question was an affidavit of merit authored before the unfavorable deposition. *Dykes v William Beaumont Hosp, 246 Mich App 471, 481-482; 633 NW2d 440 (2001)* (quotation marks and citation omitted). Therefore, plaintiffs have not demonstrated that the trial court erred in how it dealt with the conflict between Dr. Weingarten's testimony and affidavit of merit.

Plaintiffs nonetheless argue that the conflict between Dr. Weingarten's testimony **[*12]** and the affidavit of merit provided the trial court an opportunity to consider the overlap between pain management and anesthesiology. Plaintiffs explain that their "overlap" analysis is based on an unpublished, per curiam opinion of this Court.

We have reviewed the decision relied upon by plaintiffs[5] and note that it does not create or endorse an "overlap" analysis when considering conflicting evidence regarding which medical specialty an expert witness spent the majority of his or her professional time practicing. Rather, in that decision this Court merely noted indications that the defendant's expert witness practiced orthopedic surgery largely in the context of sports medicine. Thus, plaintiffs' reliance on that decision is wholly misplaced.

Regardless, Dr. Weingarten did not offer any contradictory testimony regarding which specialty he spent the majority of his professional time practicing. And despite plaintiffs' contention regarding the overlap between pain medicine and anesthesiology, Dr. Weingarten listed the common procedures he performed as a pain management physician, and his list did not include intubations.

Plaintiffs contended in their statement **[*13]** of questions presented that that trial court erred when it disqualified Dr. Weingarten from offering causation testimony, but plaintiffs' brief on appeal contains no

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[5] *Turkish v William Beaumont Hosp, unpublished per curiam opinion of the Court of Appeals, issued December 13, 2018 (Docket No. 339522), 2018 Mich. App. LEXIS 3693*. "An unpublished opinion is not precedentially binding under the rule of stare decisis." *MCR 7.215(C)(1)*. However, such opinions may be consulted as persuasive authority. See *Hicks v EPI Printers, Inc, 267 Mich. App. 79, 87 n 1; 702 N.W.2d 883 (2005)*.

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further developed argument or any legal authorities in support of their contention. Similarly, plaintiffs' reply brief contains no discussion of plaintiffs' contention regarding the barring of Dr. Weingarten as a causation witness. "A party may not simply announce a position and leave it to this Court to make the party's arguments and search for authority to support the party's position." *Seifeddine v Jaber, 327 Mich. App. 514, 519-520; 934 N.W.2d 64 (2019)*. "Failure to adequately brief an issue constitutes abandonment." *Id. at 520*. Plaintiffs have abandoned this contention by failing to brief it.

Plaintiffs assert that *Woodard* was wrongly decided, with the result that "overqualified" expert witnesses are prevented from offering testimony. However, plaintiffs also correctly concede that "this Court does not have the power to overrule or modify *Woodard* in any meaningful way." Therefore, this Court need not address plaintiffs' assertions further.

III. NURSE BUETTNER

Plaintiffs argue that the trial court erred when it granted Beaumont's motion to strike the testimony of their CRNA expert witness, Neil **[*14]** Buettner. We disagree.

"The proponent of expert testimony in a medical malpractice case must satisfy the court that the expert is qualified under *MRE 702*, *MCL 600.2955* and *MCL 600.2169*." *Clerc v Chippewa Co War Mem Hosp, 477 Mich. 1067, 1067; 729 N.W.2d 221 (2007)*. *MRE 702* states as follows:

> If the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

MRE 702 "incorporates the standards of reliability that the United States Supreme Court articulated in *Daubert v Merrell Dow Pharm, Inc, [509 U.S. 579; 113 S. Ct. 2786; 125 L. Ed. 2d 469 (1993)]*, in order to interpret the equivalent federal rule of evidence," and, under *Daubert*, "the trial judge must ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable . . . ." *Elher, 499 Mich at 22* (quotation marks and citation omitted). Thus, *MRE 702* "requires the circuit court to ensure that each aspect of an expert witness's testimony, including the underlying data and **[*15]** methodology, is reliable." *Id.* Or, in other words, "*MRE 702* requires trial judges to act as gatekeepers who must exclude unreliable expert testimony." *Lenawee Co v Wagley, 301 Mich. App. 134, 162; 836 N.W.2d 193 (2013)* (quotation marks omitted).

"Under *MRE 702*, it is generally not sufficient to simply point to an expert's experience and background to argue that the expert's opinion is reliable and, therefore, admissible." *Edry v Adelman, 486 Mich. 634, 642; 786 N.W.2d 567 (2010)*. "A lack of supporting literature, while not dispositive, is an important factor in determining the admissibility of expert witness testimony." *Elher, 499 Mich at 23*.

"*MCL 600.2955(1)* requires the court to determine whether the expert's opinion is reliable and will assist the trier of fact by examining the opinion and its basis, including the facts, technique, methodology, and reasoning relied on by the expert[.]" *Elher v Misra, 499 Mich. 11, 23; 878 N.W.2d 790 (2016)*. *MCL 600.2955(1)* provides that a trial court "shall consider" the following factors when it makes this determination:

> (a) Whether the opinion and its basis have been subjected to scientific testing and replication.
> (b) Whether the opinion and its basis have been subjected to peer review publication.
>
> (c) The existence and maintenance of generally accepted standards governing the application and interpretation of a methodology or technique and whether the opinion and its basis are consistent **[*16]** with those standards.
> (d) The known or potential error rate of the opinion and its basis.
> (e) The degree to which the opinion and its basis are generally accepted within the relevant expert community. As used in this subdivision, "relevant expert community" means individuals who are knowledgeable in the field of study and are gainfully employed applying that knowledge on the free market.
> (f) Whether the basis for the opinion is reliable and whether experts in that field would rely on the same basis to reach the type of opinion being proffered.
> (g) Whether the opinion or methodology is relied upon by experts outside of the context of litigation.

However, not every factor may be relevant to the determination in every case. *Elher, 499 Mich at 27*. And, ultimately, "it is within a trial court's discretion how to determine reliability." *Id. at 25*.

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"Expert testimony is necessary to establish the standard of care because the ordinary layperson is not equipped by common knowledge and experience to judge the skill and competence of the service and determine whether it meets the standard of practice in the community." *Wiley, 257 Mich App at 492*. "Although nurses are licensed healthcare professionals, they do not engage in the practice of medicine." *Decker v Rochowiak, 287 Mich. App. 666, 686; 791 N.W.2d 507 (2010)*. Thus, **[*17]** "the standards of care for general practitioners and specialists do not apply to nurses," and instead "the common-law standard of care applies to malpractice actions against nurses." *Id.*

"'[T]he applicable standard of care is the skill and care ordinarily possessed and exercised by practitioners of the profession in the same or similar localities.'" *Id.*, quoting *Cox ex rel Cox v Bd of Hosp Managers, 467 Mich 1, 21-22; 651 NW2d 356 (2002)* (alteration in the original). "A nonlocal expert may be qualified to testify if he or she demonstrates a familiarity with the standard of care in an area similar to the community in which the defendant practiced." *Decker, 287 Mich App at 686*.

Plaintiffs retained Buettner to offer expert testimony in support of their malpractice claims against Beaumont relating to defendant Sarnovsky's intubation of Mallory. Buettner testified that he was first certified as a CRNA in 1987, and had approximately 33 years of experience. Asked if the standard of care for a CRNA was a local or national one, he replied that, "generally speaking, it's probably a national standard," that he "testified in some jurisdictions in which they had a local standard," but that he could not "tell the difference in terms of things that [he] was opining on." Buettner had no opinion whether **[*18]** plaintiffs' claims implicated a local or national standard of care.

Buettner did not agree that an injury to the vocal cords could occur when a CRNA complied with the standard of care for intubating and extubating a patient. Asked if a patient could sustain an injury from intubation in the absence of malpractice, he replied, "No."

Buettner stated that "if you injure the vocal cords, that is a breach of the standard of care," and agreed that it was "impossible to use proper technique during intubation or extubation, comply with the standard of care and still get a vocal cord injury." Buettner stated that he did not have any literature that supported his opinion, but also that he was not aware of any literature stating that an injury during intubation or extubation could occur absent malpractice. Buettner did not do any research or speak with any of his colleagues relating to his opinion, and could offer no support for his position other than his "personal practice," including his understanding that "hoarseness" was usually "a short-term issue" because only "one percent or two percent of patients" experienced hoarseness following intubation that lasts longer than a week. He believed that **[*19]** malpractice occurred when there was "visual evidence" of an "injury or scarring to the vocal cord."

When asked "[w]hy is it not possible to have a vocal cord injury and have the CRNA comply with the standard of care," Buettner replied that "based on [his] training, education, and experience, [he] can sit here and opine, and [he] just know[s] it's a breach of the standard of care to injure the vocal cords and that it should be a never event."

Beaumont filed a motion to strike Buettner's testimony on the grounds that he did not satisfy the requirements imposed by *MRE 702* and *MCL 600.2955*, because the only support he offered for his opinion was his personal experience, and because he did not know if his opinion that vocal cord injury caused by intubation would only occur during a breach of the standard of care was accepted among CRNAs generally. Beaumont also contended that Buettner's opinion was unreliable because his testimony showed that he was unfamiliar with the local standard of care, and because his testimony that the intubation at issue was traumatic lacked evidentiary support and contradicted Dr. Bastani's testimony that Mallory's intubation occurred without incident.

Plaintiffs answered that Buettner's **[*20]** expert opinion was reliable given his extensive education, training, and experience working in cities similar to Royal Oak. Plaintiffs also argued that Buettner's testimony regarding the traumatic intubation was consistent with the other evidence that showed that Mallory's scar occurred when she was intubated in 2015.

The trial court held that Buettner's opinion fell "well short of the standards that are required [by] *MRE 701 through 703*" and that Buettner's opinion was "not well-grounded" or "reliable." The court explained that there was no need for an evidentiary hearing because of "the very thorough analysis both in the motion, but also in the testimony" where Buettner made several "very vivid, clear, unequivocal admissions with regard to the source of his opinion, which reveal[ed] the unreliability of it." Therefore, the trial court granted the motion to strike on the basis of Buettner's testimony "and for the other

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reasons articulated in the motion."

Plaintiffs contend that the trial court erred because Buettner's opinion was reliable in light of his education, training, and experience. Yet it is generally insufficient to rely on a proposed expert's experience and background to establish the reliability **[*21]** of his or her opinion. *Edry, 486 Mich at 642*. Plaintiffs do not identify any other basis for Buettner's opinion. Our Supreme Court has explained that the concern in relying on an expert witness's personal opinion is that the expert witness "may have held himself to a higher, or different standard than that practiced by the medical community at large." *Elher, 499 Mich at 28*. Plaintiffs' reiteration that Buettner's opinion was supported solely by his education and experience does not show that the trial court erred when it ruled that Buettner's opinion was unreliable.

Plaintiffs also argue that Beaumont improperly argued that Buettner's description of Mallory's intubation as traumatic contradicted record evidence on the ground that some of Mallory's medical records indicated that the intubation was indeed traumatic. We note that plaintiffs' argument is based on records of an assessment of Mallory performed by Dr. Glendon Gardner, but that those records were not attached to plaintiffs' response to Beaumont's motion to strike Buettner or otherwise presented to the trial court at that time, and, therefore, those records were not part of the lower court record when the trial court granted the motion to strike.

"This Court's review **[*22]** is limited to the record established by the trial court, and a party may not expand the record on appeal." *Sherman v Sea Ray Boats, Inc, 251 Mich. App. 41, 56; 649 N.W.2d 783 (2002)*. Accordingly, plaintiffs' reliance on Dr. Gardner's assessment for any purpose on appeal is unavailing.

Plaintiffs assert that Buettner was qualified to offer standard-of-care testimony regardless of whether it pertained to a local or national standard. In *Decker*, this Court held that an expert witness was qualified to offer such testimony despite having testified that a national standard of care governed the defendant's actions, because the expert explained how the same standard applied locally and nationally given the commonplace nature of the procedures at issue. *Decker, 287 Mich App at 686-687*.

As noted, Buettner admitted that he did not know if plaintiffs' claims involved a local or national standard of care, but supposed generally that it was a national standard, and added that when he "testified in some jurisdictions in which they had a local standard" he could not "tell the difference in terms of things that [he] was opining on." Thus, Buettner did not testify to any similarities between national and local standards of care regarding intubations, but merely reported that he personally could not tell **[*23]** the difference when he testified in jurisdictions that recognized local standards. Therefore, plaintiffs have not shown that the trial court erred when it accepted Beaumont's argument that Buettner was unfamiliar with the relevant standard of care.

IV. LEAVE TO AMEND WITNESS LIST

Finally, plaintiffs argue that the trial court erred when it denied their motion for leave to amend their witness list before trial. We disagree.

"This Court reviews for an abuse of discretion a trial court's decision whether to allow a party to add an expert witness." *Cox v Hartman, 322 Mich. App. 292, 312; 911 N.W.2d 219 (2017)*.

"Witness lists are an element of discovery." *Grubor Enterprises, Inc v Kortidis, 201 Mich. App. 625, 628; 506 N.W.2d 614 (1993)*. "The ultimate objective of pretrial discovery is to make available to all parties, in advance of trial, all relevant facts which might be admitted into evidence at trial." *Id.* "The purpose of witness lists is to avoid trial by surprise." *Id.* (quotation marks and citation omitted).

MCR 2.401(I) provides as follows:

> (1) No later than the time directed by the court . . ., the parties shall file and serve witness lists. The witness list must include:
>
> > (a) the name of each witness, and the witness' address, if known; however, records custodians whose testimony would be limited to providing the foundation for the admission **[*24]** of records may be identified generally;
> >
> > (b) whether the witness is an expert, and the field of expertise.
>
> (2) The court may order that any witness not listed in accordance with this rule will be prohibited from testifying at trial except upon good cause shown.
>
> (3) This subrule does not prevent a party from obtaining an earlier disclosure of witness information by other discovery means as provided in these rules.

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"Once a party has failed to file a witness list in accordance with the scheduling order, it is within the trial court's discretion to impose sanctions against that party." *Duray Dev, LLC v Perrin, 288 Mich. App. 143, 164; 792 N.W.2d 749 (2010)*. "These sanctions may preclude the party from calling witnesses." *Id.* "Disallowing a party to call witnesses can be a severe punishment, equivalent to a dismissal." *Id.* However, "'[t]he mere fact that a witness list was not timely filed does not, in and of itself, justify the imposition of such a sanction.'" *Id. at 166 n 53*, quoting *Dean v Tucker, 182 Mich. App. 27, 32; 451 N.W.2d 571 (1990)*. Additionally, Michigan policy favors "the meritorious determination of issues." *Tisbury v Armstrong, 194 Mich. App. 19, 21; 486 N.W.2d 51 (1991)*.

Thus, the "'record should reflect that the trial court gave careful consideration to the factors involved and considered all of its options in determining what sanction was just and proper in the context of the case **[*25]** before it.'" *Duray Dev, 288 Mich App at 165*, quoting *Dean, 182 Mich App at 32*. In *Duray Dev*, this Court reiterated the nonexhaustive *Dean* factors, which trial courts should consider before sanctioning a party:

> "(1) whether the violation was wilful or accidental; (2) the party's history of refusing to comply with discovery requests (or refusal to disclose witnesses); (3) the prejudice to the defendant; (4) actual notice to the defendant of the witness and the length of time prior to trial that the defendant received such actual notice; (5) whether there exists a history of plaintiff's engaging in deliberate delay; (6) the degree of compliance by the plaintiff with other provisions of the court's order; (7) an attempt by the plaintiff to timely cure the defect[;] and (8) whether a lesser sanction would better serve the interests of justice. This list should not be considered exhaustive." [*Duray Dev, 288 Mich App at 165*, quoting *Dean, 182 Mich App at 32-33* (alteration in the original).]

"The court should also evaluate other options before concluding that a drastic sanction is warranted." *Mink v Masters, 204 Mich. App. 242, 244; 514 N.W.2d 235 (1994)*. This Court has held that a trial court's failure to consider other sanctions "on the record before concluding that dismissal of the complaint was warranted constituted error." *Thorne v Bell, 206 Mich. App. 625, 635; 522 N.W.2d 711 (1994)*.

"Where the sanction is the barring **[*26]** of an expert witness resulting in the dismissal of the plaintiff's action, the sanction should be exercised cautiously." *Dean, 182 Mich App at 32*. In *Thorne*, this Court held that the plaintiffs' violation of the trial court's scheduling order by failing to timely file witness and exhibit lists did not justify dismissal of the action, in part because the record did not indicate "a history of recalcitrance or deliberate noncompliance with discovery orders, which typically precedes the imposition of such a harsh sanction." *Thorne, 206 Mich App at 633-634*. Yet, where the lateness of the disclosure of a witness prevents pertinent discovery from being conducted, barring the witness may be proper. See *Kalamazoo Oil Co v Boerman, 242 Mich. App. 75, 90-91; 618 N.W.2d 66 (2000)* (disallowing expert testimony from a late-disclosed expert because the opposing party "had no chance to conduct any discovery of the expert and . . . it would be unfair to require [the party] to prepare on such short notice").

After the trial court granted the motions striking Dr. Weingarten and Buettner, plaintiffs filed a motion for leave to amend their witness list to add two experts to replace the stricken ones, arguing that plaintiffs' claims would fail without expert testimony, that because denying their motion would be tantamount to a dismissal **[*27]** of their claims this required consideration of the *Dean* factors, and that public policy supported resolution of their claims on their merits.

The trial court denied the motion on the grounds that they filed it approximately six weeks before trial, where discovery had "long since closed," case evaluation was conducted, the filing deadline for dispositive motions had passed, and "trial preparation [was] underway." The court observed that plaintiffs essentially wanted a "redo" after their expert witnesses were stricken even though plaintiffs' "case was built around" those witnesses, and that such a redo would result in palpable prejudice to defendants because defendants would be unable to properly investigate, depose, and evaluate the new experts before trial.

The trial court also considered the *Dean* factors, and found that they weighed in favor of denying plaintiffs' motion. The court found that plaintiffs' failure to disclose their new expert witnesses was "the result of the culpable negligence" of plaintiffs, there would be significant prejudice to defendants, plaintiffs provided actual notice of the new witnesses "just weeks before trial," plaintiffs "squandered approximately 7 weeks **[*28]** between the initial rulings striking the experts" before they filed their motion, plaintiffs "obstructed discovery in the past and [were] ordered to

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allow" defendants "to conduct discovery on [their] fact witnesses,"[6] and that granting the motion would result in either substantial delay or prejudice to defendants.

Plaintiffs assert that the trial court was responsible for their need to file an amended witness list because the court granted defendants' motions to strike plaintiffs' experts, which were de facto motions for summary disposition filed past the deadline for dispositive motions. "Courts are not bound by a party's choice of labels because this would effectively elevate form over substance." *Jawad A Shah, MD, PC v State Farm Mut Auto Ins Co, 324 Mich App 182, 204; 920 NW2d 148, 161 (2018)* (quotation marks and citation omitted).

The trial court's scheduling order required that all dispositive motions be filed no later than April 5, 2019, and that all motions in limine be filed no later than July 31, 2019, and it set the trial date as September 3, 2019. Defendants filed their respective motions to strike plaintiffs' experts in May 2019. When plaintiffs argued that Bastani's motion to strike was nothing more than an untimely de facto motion for summary disposition, the trial **[*29]** court held that the motion was a timely motion in limine that contained no reference to *MCR 2.116* or prayers for dismissal.

Plaintiffs argue on appeal that, because the effect of the trial court's granting of the motions to strike was dismissal of their claims, those motions were necessarily untimely motions for summary disposition. Plaintiffs' thus base their argument on the effect of the motions, rather than their substance, which pertained to only the qualifications and reliability of the proposed experts. Because both motions were properly filed within the terms of the scheduling order, we are not persuaded by plaintiffs' characterization of them as untimely dispositive motions. "There is no statutory or case law basis for ruling that a medical malpractice expert must be challenged within a 'reasonable time.'" *Greathouse v Rhodes, 465 Mich. 885, 885; 636 N.W.2d 138 (2001)*. It was plaintiffs' responsibility to ensure their expert witnesses were qualified. *Clerc, 477 Mich at 1067*. Moreover, plaintiffs' problems with establishing their experts' qualifications should have been foreseeable to plaintiffs. See *Rock, 499 Mich at 267* (*MCL 600.2169(1)(a)* "allows a plaintiff to ensure that an expert is qualified well in advance of the time of the testimony"). Plaintiffs' attempt to place the blame for their expert witness **[*30]** woes on the trial court is thus misplaced.

Plaintiffs additionally urge this Court to independently apply the *Dean* factors, even though the trial court actually fulfilled its obligation to do so, and explained its findings in a written opinion and order. Regardless, plaintiffs argue on appeal that the *Dean* factors weighed in favor of granting their motion to amend.

First, plaintiffs do not address whether their violation was willful or accidental, but they do assert that the trial court's "tardy rulings" created plaintiffs' "emergency." But, as discussed above, the trial court's rulings on defendants' timely motions to strike were proper under the trial court's scheduling order. And the trial court itself found that plaintiffs' motion for leave to file an amended witness list was "the result of the culpable negligence" of plaintiffs.

Second, plaintiffs argue that they fully complied with discovery in the trial court, yet the court found that plaintiffs "obstructed discovery in the past and [were] ordered to allow" defendants "to conduct discovery on [plaintiffs'] fact witnesses." Plaintiffs do not address the trial court's finding in their brief on appeal, and the trial court's finding **[*31]** was supported by the record.

Third, plaintiffs assert that defendants would not have been prejudiced if the trial court granted plaintiffs' motion because the court could have allowed defendants time to perform discovery on plaintiffs' new experts. Plaintiffs once again do not address the trial court's finding that defendants would be significantly prejudiced where plaintiffs' disclosure of their new witnesses would occur months after the close of discovery and "a few weeks before trial," and where defendants "would be required to swallow whole the testimony" of the new experts as the result of the lack of time investigate the veracity of the positions of the new witnesses. The trial court also astutely observed that plaintiffs essentially requested a "redo" of the proceedings in response to plaintiffs' "self-inflicted wounds."

And fourth, plaintiffs contend that they provided notice to defendants on the day before case evaluation that they might offer additional expert witnesses, and that they took prompt steps to do so after Dr. Weingarten and Buettner were disqualified. The trial court entered orders

[6] Dr. Bastani filed a motion to strike plaintiffs' fact witnesses on the ground that plaintiffs failed to provide them for deposition before the close of discovery. The trial court responded by denying Bastani's motion, but also ordering plaintiffs to answer interrogatories within seven days, and that the "outstanding depositions" of plaintiffs' fact witnesses be completed by the end of May 2019.

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granting the motions to strike on May 22, 2019, and May 29, 2019, but plaintiffs **[*32]** waited until July 9, 2019, to file their motion for leave to amend their witness list. Thus, the record supports the trial court's finding that plaintiffs "did not attempt to cure the defect" caused by the loss of their expert witnesses "until the eve of trial," having "squandered approximately 7 weeks between the initial rulings" and their filing of the motion to amend.

While not addressed by plaintiffs on appeal, the trial court also contemplated the lesser sanction of reopening discovery and adjourning the trial, but it found that would "lead to the dilatory and uneconomical determination of the action because it, in essence, would add months of delay and expense to the case without necessarily any corresponding improvement of the substantial rights of the parties," and it would "encourage parties to flaunt the scheduling orders of the court with no concomitant sanction." Given the foregoing, plaintiffs have not shown that the trial court erred by denying their motion for leave to amend their witness list.

Affirmed.

/s/ Mark J. Cavanagh

/s/ Kathleen Jansen

Concur by: Douglas B. Shapiro (In Part)

Dissent by: Douglas B. Shapiro (In Part)

Dissent

SHAPIRO, J. (*concurring in part and dissenting in part*).

I concur as to the **[*33]** dismissal of defendant Dr. Bastani and respectfully dissent as to the dismissal of defendant Certified Registered Nurse Anesthetist (CRNA) Sarnovsky.

I concur as to Dr. Bastani because the caselaw requires me to do so. However, for the same reasons stated in Judge GLEICHER's dissent in *Higgins v Traill, unpublished per curiam opinion of the Court of Appeals, issued July 30, 2019 (Docket No. 343664), 2019 Mich. App. LEXIS 4295*, I urge the Supreme Court to reconsider and clarify the rule governing medical expert matching. It has been 25 years since the medical malpractice statute was adopted and it is time we had a rule that can be readily understood and applied, particularly given the evolving nature of medical subspecialties. See e.g., *Jilek v Stockson, 289 Mich App 291, 296-305; 796 NW2d 267 (2010)*, rev'd *490 Mich 961; 805 N.W.2d 852 (2011)*.

As to the case against the CRNA, certain facts are not disputed, at least for purposes of her motion for summary disposition. Plaintiff Catherine Mallory had a normal voice before undergoing surgery in which the CRNA performed the intubation. It is uncontested that following the surgery the plaintiff awoke with a substantial loss of her voice and has never recovered. Post-operative tests have revealed that the voice loss was the result of an injury to plaintiff's vocal chords and such an injury could only have occurred during the surgery given her normal voice before and the immediate **[*34]** post-operative damage.

As part of the anesthesia procedure, the CRNA intubated plaintiff at the outset of surgery. She did so using a "glidescope," which contains a camera that allows the anesthetist to view the intubation on a screen in real time and so perform the procedure with a full view of the relevant anatomy. The glidescope is a rigid instrument. Plaintiffs' CRNA expert testified that it violates the standard of care for the anesthetist to strike the vocal cords with the glidescope while performing the intubation. When asked how the CRNA violated the standard of care in this case, the expert testified: "[S]he failed to properly direct the tip of the endotracheal tube between the cords. She didn't use proper care with this rigid stylette and endotracheal tube and ended up injuring the left vocal cord. . . . You're supposed to put it . . . between the cords . . . [and] she had it offline."

In her deposition defendant CRNA stated that the standard of care is "to perform intubation . . . as gently and deliberately as possible as to minimize any risk of injury." However, when asked how the instrument could have caused damage to the vocal cords if the intubation was performed properly, **[*35]** she stated that she did not want to speculate.

The trial court concluded that the expert's testimony did not meet the relevant evidentiary standard because he failed to cite supporting medical literature and instead relied on his 33 years of practice as a CRNA and his experience in performing about 200 intubations each year. However, it does not require medical literature to conclude that normal anatomical structures should not be permanently damaged during intubation absent unusual circumstances or a necessary trade-off in treatment. The CRNA defendant has not asserted that

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the injury to plaintiff's vocal cords occurred because of an unforeseen anatomical variation or a need to perform the intubation in an emergency setting or some other reason that explains why the structure was damaged. Further, it is highly unlikely that studies of this question have been or could be done since (a) it would be unethical to conduct a study in which a physician purposely strikes the vocal chords of operative patients; and (b) there is no central repository of information concerning when and why vocal cords are struck during intubation.[1] Perhaps what is more significant is the lack of any medical literature **[*36]** in the record suggesting that the vocal cords can be scarred as a result of an atraumatic intubation. As plaintiff's M.D. expert, Dr. Weingarten, noted in his deposition: "I have not seen any study that supports scarring on the vocal cord resulting from . . . a known atraumatic intubation." On the other hand, Dr. Weingarten stated that he is aware of "plenty of reports of trauma to the vocal cords when it is known that the trauma caused the vocal cord injury leading to scarring."

For these reasons, I would reverse the dismissal of the suit against the CRNA defendant.

/s/ Douglas B. Shapiro

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[1] Indeed, in *Daubert v Merrell Dow Pharms., Inc., 509 US 579, 593; 113 S Ct 2786; 125 L Ed 2d 469 (1993)*, the Supreme Court acknowledged that "[s]ome propositions . . . are too particular . . . or of too limited interest to be published."

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APPENDIX 25

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Strasser v. Oakwood Heritage Hosp.

Court of Appeals of Michigan

November 4, 2021, Decided

No. 355496

Reporter
2021 Mich. App. LEXIS 6287 *

TRAVIS STRASSER, Plaintiff-Appellee, v OAKWOOD HERITAGE HOSPITAL, OAKWOOD HEALTHCARE, INC., BEAUMONT HOSPITAL-TAYLOR, BEAUMONT HEALTH, and BEAUMONT HEALTH SYSTEM, Defendants, and GOKUL RAGHUNATH TOSHNIWAL, M.D., and ANESTHESIA ASSOCIATES OF ANN ARBOR PLLC, Defendants-Appellants

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Prior History: **[*1]** Wayne Circuit Court. LC No. 18-014954-NH.

Strasser v. Oakwood Heritage Hosp., 2021 Mich. App. LEXIS 577 (Mich. Ct. App., Jan. 27, 2021)

Core Terms

pain, specialty, medicine, anesthesiology, block, surgery, nerve block, trial court, expert witness, board-certified, subspecialty, practicing, board certified, standard of care, postoperative, adductor, informed consent, anesthesiologist, specialized, anesthesia, alleged malpractice, medical malpractice, pain management, clinical, nerve, defendants', regional, devoted, motion to strike, reconsideration

Counsel: For STRASSER TRAVIS, Plaintiff - Appellee: GREGORY T YOUNG.

For OAKWOOD HERITAGE HOSPITAL, Defendant: CLYDE M METZGER.

For TOSHNIWAL GOKUL RAGHUNATH MD, Defendant - Appellant: JOANNE GEHA SWANSON.

For BEAUMONT HOSPITAL-TAYLOR, Defendant: CLYDE M METZGER.

For ANESTHESIA ASSOCIATES OF ANN ARBOR PLLC, Defendant - Appellant: JOANNE GEHA SWANSON.

For BEAUMONT HEALTH SYSTEM, Defendant: CLYDE M METZGER.

Judges: Before: MARKEY, P.J., and BECKERING and BOONSTRA, JJ.

Opinion

PER CURIAM.

Defendants Gokul Toshniwal, M.D., and Anesthesia Associates of Ann Arbor PLLC appeal by leave granted[1] the trial court's order denying their motion to strike plaintiff Travis Strasser's expert witness. We reverse and remand for entry of an order striking plaintiff's expert witness.

I. BACKGROUND AND PROCEDURAL HISTORY

In his complaint, plaintiff alleged that on June 8, 2016, he went to defendant hospital[2] "for the purpose of care and treatment, more particularly an open reduction and internal fixation of his fractured left patella." Plaintiff contended that he "clearly and specifically informed all Defendants that he did not want any spinal or regional blocks for post-operative **[*2]** pain control." (Emphasis omitted.) The anesthesiologist for the surgery was Dr.

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[1] *Strasser v Oakwood Heritage Hosp, unpublished order of the Court of Appeals, entered January 27, 2021 (Docket No. **355496**), 2021 Mich. App. LEXIS 577*.

[2] Our reference to "defendant hospital" pertains collectively to defendants Oakwood Heritage Hospital, Oakwood Healthcare, Inc., Beaumont Hospital-Taylor, Beaumont Health, and Beaumont Health System, which entities are not involved in this appeal.

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Toshniwal. Plaintiff alleged that despite his directive that no nerve block be used, Dr. Toshniwal, shortly after the surgery was completed, performed "a post-operative regional block of the left adductor canal" absent properly-obtained informed consent.[3] Plaintiff maintained that Dr. Toshniwal subverted plaintiff's wishes by obtaining purported informed consent from other persons or plaintiff's family members. Plaintiff further alleged that the adductor canal block directly caused severe "left femoral neuropathy," resulting in the loss of "motor activities in the left leg, atrophy, pain, decreased sensation distribution, and numerous other problems."

In support of his medical malpractice complaint, plaintiff attached an affidavit of merit executed by Robert A. Savala, M.D. Mirroring language in the complaint, Dr. Savala averred that Dr. Toshniwal breached the applicable standard of care by failing to obtain informed consent from plaintiff, ignoring plaintiff's stated desire for no spinal or regional nerve blocks, supplanting plaintiff's wishes by obtaining consent from **[*3]** others, failing to explain the risks of doing a nerve block, including femoral neuropathy, and by not offering alternatives for pain control other than the adductor canal block. Neither in the complaint nor the affidavit of merit was it asserted that Dr. Toshniwal committed medical malpractice with respect to the actual performance of the adductor canal block. Dr. Savala and Dr. Toshniwal are both board-certified in anesthesiology and in the subspecialty of pain medicine.

According to defendants, plaintiff was treated with three narcotics, but he screamed and shouted about continued pain while he was in the post-anesthesia care unit (PACU). Dr. Toshniwal informed plaintiff that the opioid pain medications that he was receiving could not be given in higher doses, and the two then discussed the possibility of an adductor canal block being performed. Plaintiff allegedly told Dr. Toshniwal to do whatever he needed to manage the pain. Dr. Toshniwal obtained written consent from plaintiff's fiancée and administered the nerve block. Defendants claimed that a postoperative nerve block is commonly administered by an anesthesiologist to relieve pain related to the surgery.

In a motion to strike **[*4]** Dr. Savala as an expert witness, defendants argued that Dr. Savala was not qualified to testify against Dr. Toshniwal. In his deposition, Dr. Toshniwal testified that 30 to 40 percent of his practice concerned pain medicine, while 60 to 70 percent was devoted to anesthesiology. He performed three or four hundred nerve blocks every year. In answers to interrogatories, Dr. Toshniwal indicated that he provided "anesthesiology care and treatment [for plaintiff] during surgery and post-surgery on June 8, 2016." When asked at his deposition whether someone else could have provided different relief to plaintiff at the time, Dr. Toshniwal responded, "I'm the anesthesiologist." Dr. Toshniwal testified that he was present throughout the entire surgical process, including the period that plaintiff was in the PACU. Dr. Toshniwal observed that "[p]ostoperatively the opioids administered were not effectively managing Plaintiff's pain safely[;] [t]herefore, alternatives such as an adductor canal block were discussed with Plaintiff, his significant other, and the surgeon."

In his deposition, Dr. Savala testified that for many years 100 percent of his time was devoted to managing acute and chronic pain. **[*5]** According to Dr. Savala, some of his work takes place at an outpatient surgery center where various types of surgeries are performed. He indicated that he performs nerve blocks three days per week in his practice. Dr. Savala noted, however, that he had not performed a femoral nerve block, which would encompass the adductor canal block, in a dozen years. When asked why he had not done so, Dr. Savala explained:

> Well, because when it comes to those procedures, the operating room anesthesiologists are typically the ones that are providing those services. I'm providing, you know, nerve block procedures for the diagnosis and treatment of acute chronic pain problems; whereas, these femoral nerve blocks are most commonly used in preparation for perioperative treatment.

Dr. Savala further testified as follows:

> *Q*. I said I'm describing femoral blocks as being used to treat acute pain. You're calling it perioperative pain, but it's not chronic pain, correct?

---

[3] An "adductor canal block . . . is an interfascial plane block performed in the thigh. It anesthetizes multiple distal branches of the femoral nerve including the saphenous nerve and branches of the mixed sensory and motor nerves to the quadricep, as well as branches of the obturator nerve." Adam W. Amundson, M.D., and Rebecca L. Johnson, M.D., *Adductor Canal Block Procedure Guide* <http://www.uptodate.com/contents/adductor-canal-block-procedure-guide> (accessed August 30, 2021). In this opinion, we shall occasionally refer to the "adductor canal block" performed on plaintiff as a "nerve block."

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A. Well, what we typically do is that you are putting in these regional blocks, we call them peripheral nerve blocks, you know, whether that was femoral or . . . .

Q. Right.

A. [T]hose will typically be done preoperatively and in anticipation that **[*6]** you're going to use the pain relief, the analgesia and the anesthesia that you get from it, to aid in the performance of surgery and then to help treat postoperative pain. So we usually put them in before the case begins, but in some cases we use them afterwards, like in the case of [plaintiff].

Q. Right. I've got it. Can we call the block that was done here a regional block?

A. Yes, you can.

Q. When is the last time that you performed a regional block to assist with the perioperative pain and postoperative pain?

A. Oh, boy, that was probably — oh, I'd say the last time I was in the operating room, so that was about a dozen years ago.

Dr. Savala asserted that the adductor canal block in this case was done for pain management. Dr. Savala testified about what "an experienced and professional anesthesiologist understands [regarding] possible scenarios . . . in controlling postoperative pain . . . ." He noted that "in anesthesia, more than any other field of medicine, [you must] really make sure that you understand the course of what's happening, because many times patients are incapacitated or unable to answer . . . questions." Dr. Savala opined that Dr. Toshniwal could have handled things **[*7]** differently in the operating room, such as administering longer-lasting opiates. Dr. Savala was of the view that Dr. Toshniwal had not communicated well with plaintiff before the surgery.

In the motion to strike, defendants argued that Dr. Toshniwal is a board-certified anesthesiologist who, although board-certified in the subspecialty of pain medicine, spends the majority of his time practicing anesthesiology. Therefore, according to defendants, anesthesiology and not pain medicine is the one most relevant specialty applicable to the instant case. Because Dr. Savala spent nearly 100 percent of his time in the practice of the subspecialty of pain medicine in the preceding 12 years, defendants maintained that he was not qualified to offer his testimony regarding the standard of care in this action.

Plaintiff responded that the case involved a pain-medicine procedure, not general anesthesia. Plaintiff pointed out that Dr. Toshniwal was the Pain Consultant Chairperson at Beaumont Taylor Hospital. Plaintiff argued that Drs. Toshniwal and Savala shared the same qualifications and that defendants were attempting to disqualify Dr. Savala merely because he spent the majority of his time in pain **[*8]** medicine. According to plaintiff, Dr. Toshniwal was performing postoperative pain medicine as indicated in his deposition. Plaintiff maintained that the pertinent conduct at the time of the alleged malpractice involved the management of pain, not anesthesiology in general. Plaintiff further noted that the action concerned informed consent rather than the surgery itself. In the alternative, plaintiff requested that the trial court allow him to amend his witness list if the court found merit in defendants' position. In challenging the motion to strike, plaintiff included an affidavit from Dr. Savala, which was separate and distinct from his affidavit of merit, averring that because the nerve block was performed after plaintiff's surgery, it was not related to the anesthesia given plaintiff by Dr. Toshniwal.

Defendants replied that the lawsuit involved anesthesiology, not pain medicine, and that anesthesia services entail postoperative nerve blocks. Defendants argued that management of a patient immediately before, during, and right after surgery is within the realm of an anesthesiologist, whereas pain medicine involves the management of chronic pain. Defendants emphasized that Dr. Savala **[*9]** had not performed the type of postoperative adductor canal block used in this case in over ten years because he had not been practicing anesthesiology.

At the hearing on the motion to strike Dr. Savala, the trial court ruled, in relevant part, as follows:

> I think it, it was a pain management procedure, the, the nerve block. [B]ased on the evidence, the documents that both sides presented, and then Woodard v Custer says that it's the relevant specialty that was being performed. And it is pain management. But this seems, to me, and maybe I just got lost in my head, it seems to be much ado about nothing, because, Plaintiff, I don't think, is alleging that the pain, pain management was done wrong. Or that the nerve block was done incorrectly. But it was done without consent. [Quotation format restructured.]

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Defense counsel then voiced disagreement with the trial court that informed consent was the only issue. The court, however, renewed its belief that informed consent was the issue, not whether the actual procedure was "performed incorrectly." Plaintiff's counsel stated that the trial court was exactly correct—the case concerned informed consent, not negligence in the performance of the **[*10]** adductor canal block. The trial court reiterated that it was denying the motion to strike because it was clear that a pain-medicine procedure was at the heart of plaintiff's action, and, consequently, pain medicine was the one most relevant specialty.

An order was entered denying defendants' motion to strike Dr. Savala's testimony for the reasons stated on the record at the hearing. Defendants moved for reconsideration, submitting new affidavits from two expert witnesses, Paul Jaklitsch, M.D., a board-certified anesthesiologist who was not a pain-medicine doctor, and Dennis Dobrit, D.O., who was board-certified in both pain medicine and anesthesiology. Both opined that the one most relevant specialty for purposes of the instant lawsuit was anesthesiology. The trial court denied the motion for reconsideration, ruling, in pertinent part:

> Defendants reiterate their position that the one most relevant specialty . . . is . . . anesthesiology rather than pain medicine. This Court notes that Defendants have made an effort to bolster their position via submission of additional documentary evidence in the form of affidavits from alleged expert witnesses. However, Defendants' further development **[*11]** of the evidence is something that could have, and should have, been done the first time this issue was raised during the proceedings on the underlying motion to exclude the testimony of and strike expert Robert Savala, M.D. . . . [T]his Court's focus when reviewing a motion for reconsideration is limited to the initial, underlying motion, the evidence that was presented at time, and the arguments that were made in support thereof. As such, defendants' argument on this issue, as presented in the instant motion for reconsideration, remains unpersuasive.

Defendants appeal by leave granted.

II. ANALYSIS

A. APPELLATE ARGUMENTS

On appeal, defendants argue that the trial court erred by concluding that Dr. Savala was qualified to testify against Dr. Toshniwal. Defendants contend that although both doctors were board-certified in anesthesiology and pain medicine, Dr. Toshniwal was practicing anesthesiology at the time of the alleged malpractice, but Dr. Savala had been devoting 100 percent of his time to the practice of pain medicine, which is why it had been at least 12 years since Dr. Savala last performed a comparable nerve block. Defendants further maintain that the trial court erred by considering **[*12]** Dr. Savala's affidavit because it contradicted his deposition testimony.[4] Defendants additionally assert that the trial court should have taken into consideration the affidavits that they had offered on reconsideration in an effort to counter Dr. Savala's affidavit.

Plaintiff argues that the trial court properly ruled that the one most relevant specialty was pain medicine. And there is no dispute that Dr. Savala was board-certified in pain medicine and had been practicing pain medicine. Plaintiff notes that defendants relied in part on an expert in pain medicine for their affidavit of meritorious defense. Plaintiff also contends that defendants did not raise any issue below regarding the propriety of Dr. Savala's affidavit; therefore, that issue is unpreserved for appeal.

Defendants reply that it is illogical to conclude that Dr. Toshniwal was practicing anesthesiology before and during the surgery but immediately began practicing the specialty of pain medicine directly after the operation. As framed by defendants, Dr. Toshniwal did not suddenly change hats after the surgery.

B. STANDARDS OF REVIEW

In *Estate of Horn v Swofford, DO, 334 Mich App 281, 287-88; NW2d (2020)*, **[*13]** this Court, addressing whether the one most relevant specialty was radiology or neuroradiology, set forth the pertinent standards of review:

> This case turns on the interpretation of *MCL 600.2169*, and "[t]he construction of *MCL 600.2169* presents a question of law subject to de novo review." *Crego v Edward W Sparrow Hosp Ass'n, 327 Mich App 525, 531; 937 NW2d 380 (2019)*; see also *Woodard v Custer, 476 Mich 545, 557; 719 NW2d 842 (2006)*. We review for an abuse of discretion a trial court's decision concerning the qualifications of a proposed expert witness to

[4] Again, we are not speaking of Dr. Savala's affidavit of merit; we are referencing the affidavit that was prepared and submitted as part of the motion for summary disposition.

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testify. Crego, 327 Mich App at 531. When a trial court's decision falls outside the range of principled and reasonable outcomes, the court abuses its discretion. *Id.* A court necessarily abuses its discretion when a particular ruling constitutes an error of law. *Id.*

C. STATUTORY CONSTRUCTION

When construing a statute, the primary rule of interpretation is to discern and give effect to the intent of the Legislature, and the most reliable indicator of that intent is the plain language of the statute. Crego, 327 Mich App at 531. "Such language must be enforced as written, giving effect to every word, phrase, and clause." *Id.* (quotation marks and citation omitted). Additional judicial construction is only permitted if the statutory language is ambiguous. *Id.* "When determining the Legislature's intent, statutory provisions are not to be read **[*14]** in isolation; rather, they must be read in context and as a whole." *Id.* (citation omitted).

D. MEDICAL MALPRACTICE FRAMEWORK AND MCL 600.2169

"The plaintiff in a medical malpractice action bears the burden of proving: (1) the applicable standard of care, (2) breach of that standard by defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury." Cox v Flint Bd of Hosp Managers, 467 Mich 1, 10; 651 NW2d 356 (2002) (quotation marks and citation omitted); see also Estate of Horn, 334 Mich App at ; slip op at 4. "Failure to establish any one of these four elements is fatal to a plaintiff's medical malpractice suit." Estate of Horn, 334 Mich App at 288 (citation omitted). In Cudnik v William Beaumont Hosp, 207 Mich App 378, 382; 525 NW2d 891 (1994), this Court noted that the "standard of care is founded upon how other doctors in that field of medicine would act and not how any particular doctor would act." (Quotation marks and citation omitted.)

MCL 600.2912d(1) requires a medical malpractice plaintiff to "file with the complaint an affidavit of merit signed by a health professional who the plaintiff's attorney reasonably believes meets the requirements for an expert witness under section 2169." MCL 600.2169 provides, in pertinent part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate **[*15]** standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c)[inapplicable], during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the **[*16]** same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

When a defendant doctor is a specialist, the expert witness for the plaintiff must have specialized in the same specialty as the defendant doctor at the time of the purported malpractice. Woodard, 476 Mich at 560-561; Estate of Horn, 334 Mich App at ; slip op at 5; Estate of Norczyk v Danek, 326 Mich App 113, 118; 931 NW2d 59 (2018). The plaintiff's expert must have the same board-certification as the defendant physician if in fact the defendant is board-certified in the relevant specialty. Woodard, 476 Mich at 560; Estate of Horn, 334 Mich App at ; slip op at 5; Estate of Norczyk, 326 Mich App at 118. Although specialties and board certificates must match, not all of them are required to match. Woodard, 476 Mich at 558; Estate of Horn, 334 Mich App at ; slip op at 5; Estate of Norczyk, 326 Mich App at 118. "Because an expert witness is not required to testify regarding an inappropriate or irrelevant standard of medical practice or care, § 2169(1) should not be understood to require such witness to specialize in specialties and possess board certificates that are not

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relevant to the standard of medical practice or care about which the witness **[*17]** is to testify." *Woodard, 476 Mich at 559*. The language of *MCL 600.2169(1)(a)* only requires one specialty to match, not multiple specialties. *Woodard, 476 Mich at 559*; *Estate of Horn, 334 Mich App at ; slip op at 5*. Stated otherwise, "the plaintiff's expert does not have to match all of the defendant physician's specialties; rather, the plaintiff's expert only has to match the *one most relevant specialty*." *Woodard, 476 Mich at 567-568* (emphasis added); see also *Estate of Horn, 334 Mich App at ; slip op at 5*; *Estate of Norczyk, 326 Mich App at 118*. The specialty that a defendant physician is engaged in during the course of the alleged medical malpractice constitutes the one most relevant specialty. *Woodard, 476 Mich at 560*; *Estate of Horn, 334 Mich App at ; slip op at 5*; *Estate of Norczyk, 326 Mich App at 118*.

In *Woodard*, the Michigan Supreme Court discussed the meaning of the terms "specialty" and "specialist" as used in *MCL 600.2169(1)(a)*, along with touching on the subject of subspecialties:

> Both the dictionary definition of "specialist" and the plain language of *§ 2169(1)(a)* make it clear that a physician can be a specialist who is not board certified. They also make it clear that a "specialist" is somebody who can potentially become board certified. Therefore, a "specialty" is a particular branch of medicine or surgery in which one can potentially become board certified. Accordingly, if the defendant **[*18]** physician practices a particular branch of medicine or surgery in which one can potentially become board certified, the plaintiff's expert must practice or teach the same particular branch of medicine or surgery.
>
> Plaintiffs argue that *§ 2169(1)(a)* only requires their expert witnesses to have specialized in the same specialty as the defendant physician, not the same subspecialty. We respectfully disagree. . . . [A] "subspecialty" is a particular branch of medicine or surgery in which one can potentially become board certified that falls under a specialty or within the hierarchy of that specialty. A subspecialty, although a more particularized specialty, is nevertheless a specialty. Therefore, if a defendant physician specializes in a subspecialty, the plaintiff's expert witness must have specialized in the same subspecialty as the defendant physician at the time of the occurrence that is the basis for the action. [*Woodard, 476 Mich at 561-562*.]

E. CASELAW FACTUAL SCENARIOS

We shall now examine some of the particular circumstances addressed by this Court and our Supreme Court in the caselaw. In *Woodard*, a fifteen-day-old child suffered leg fractures, allegedly caused by negligent medical care while the child was being treated in a pediatric **[*19]** critical or intensive care unit. *Woodard, 476 Mich at 554*. The defendant physician was board-certified in pediatrics and additionally held certificates of special qualifications in pediatric critical care medicine and neonatal-perinatal medicine, which certificates were considered the equivalent of board-certification. *Id. at 554, 565*. The plaintiff's proposed expert, however, was only board-certified in pediatrics and had no certificates of special qualifications. *Id. at 554-555*. The *Woodard* Court held that the one most relevant specialty in the suit was pediatric critical care medicine; consequently, the plaintiff's expert did not satisfy the same specialty requirement of *MCL 600.2169(1)(a)*. *Id. at 576*.

In *Hamilton v Kuligowski*, the companion case to *Woodard*, the underlying facts were presented as follows:

> Plaintiff alleges that the defendant physician failed to properly diagnose and treat the decedent while she exhibited prestroke symptoms. The defendant physician is board certified in general internal medicine and specializes in general internal medicine. Plaintiff's proposed expert witness is board certified in general internal medicine and devotes a majority of his professional time to treating infectious diseases, a subspecialty of internal medicine. [*Woodard, 476 Mich at 556*.]

The Michigan Supreme **[*20]** Court ruled that the plaintiff's proposed expert did not qualify to give testimony with respect to the standard of care under *MCL 600.2169*, commenting that the expert himself conceded that he was "not sure what the average internist sees day in and day out." *Id. at 577-578*.

Estate of Horn concerned "a medical malpractice action involving the death of Linda Horn allegedly caused by the negligence of defendant Michael J. Swofford, D.O., with respect to his interpretation of a cranial computerized tomography (CT) scan . . . ." *Estate of Horn, 334 Mich App at 284*. Dr. Swofford was a board-certified diagnostic radiologist, whose additional board-certification in the subspecialty of neuroradiology had lapsed by the time of the alleged negligence, and the

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plaintiff's expert was board-certified in both diagnostic radiology and neuroradiology, the latter in which he spent the vast majority of his time. *Id. at 292*. The panel noted that the "difficulty that arises . . . is that while no longer a board-certified, or its equivalent, neuroradiologist, Dr. Swofford was undoubtedly engaged in interpreting a neuroimage when he examined Horn's CT scan"—"Horn's CT scan could have been interpreted **[*21]** by a neuroradiologist or a diagnostic radiologist." *Id. at 293*. This Court held as follows:

> In this case, Dr. Swofford was, in fact, practicing neuroradiology when he examined and interpreted neuroimages—the CT scan of Horn's skull—and he potentially could obtain, as he had done in the past, board certification in neuroradiology. And therefore Dr. Swofford was acting or practicing as a "specialist" or "subspecialist" in neuroradiology, at least for purposes of *MCL 600.2169(1)* as interpreted by *Woodard*. Although Dr. Swofford was also practicing diagnostic radiology when he interpreted Horn's CT scan considering that diagnostic radiologists are credentialed to interpret neuroimages, neuroradiology was the one most relevant specialty. [*Id. at 295*.]

In *Reeves v Carson City Hosp (On Remand), 274 Mich App 622, 623; 736 NW2d 284 (2007)*, this Court addressed the following set of circumstances:

> Catherine R. and Anthony L. Reeves filed this medical malpractice action against several defendants, including Lynn Squanda, D.O., who is board-certified in family medicine, but was working in the emergency room at the time of the alleged malpractice. The Reeveses claimed that Dr. Squanda and others were negligent in failing to timely diagnose and treat Catherine Reeves's ectopic **[*22]** pregnancy. The Reeveses filed an affidavit of merit signed by Eric Davis, M.D., who is board-certified in emergency medicine, but not board-certified in family medicine.

The trial court in *Reeves* ruled that Dr. Davis was not qualified to give expert testimony against Dr. Squanda; however, the *Reeves* panel vacated the trial court's order. *Id. at 624*. The Court reasoned and held:

> In sum, because Dr. Squanda was practicing emergency medicine at the time of the alleged malpractice and potentially could obtain a board certification in emergency medicine, she was a "specialist" in emergency medicine under the holding in *Woodard*. Thus, plaintiffs would need a specialist in emergency medicine to satisfy *MCL 600.2169*; Dr. Davis, as a board-certified emergency medicine physician, would satisfy this requirement. However, the specialist must have also devoted the majority of his professional time during the preceding year to the active clinical practice of emergency medicine or the instruction of students. Because there is no information in the record regarding what comprised the majority of the expert's professional time, a remand for a determination on this issue is necessary. [*Id. at 630*.]

In *Estate of Norczyk*, the plaintiff alleged medical malpractice by the **[*23]** defendant physician for failure to properly assess the decedent's need for a heart catherization. The defendant doctor was board-certified in cardiology and the subspecialty of interventional cardiology, the former of which entails assessing, evaluating, and diagnosing cardiac problems and the latter of which involves the performance of invasive heart procedures. *Estate of Norczyk, 326 Mich App at 115- 116, 122*. The plaintiff's expert witness was board-certified solely in cardiology, not interventional cardiology. *Id. at 116*. This Court held "that the one most relevant specialty here is cardiology, not interventional cardiology, because the allegations of medical malpractice do not pertain to negligence in the performance of invasive procedures but instead concern failures by [the defendant doctor] to act relative to [the decedent's] care and treatment, falling outside of and not encompassed by the performance of invasive procedures." *Id. at 122-123*.

F. DISCUSSION AND RESOLUTION

We begin our discussion with a couple of issues that are procedurally problematic from defendants' perspective. With respect to Dr. Savala's affidavit, which defendants challenge on appeal, the issue was not preserved for review by an objection in the trial court and thus need not **[*24]** be reviewed. *Toaz v Dep't of Treasury, 280 Mich App 457, 463; 760 NW2d 325 (2008)*. Moreover, the record does not reflect that the trial court placed any reliance on Dr. Savala's affidavit. We note that affidavits that are contrary to or conflict with deposition testimony may not be considered. *Casey v Auto Owners Ins Co, 273 Mich App 388, 396; 729 NW2d 277 (2006)*. Regardless of the preservation failure and whether the affidavit conflicted with Dr. Savala's deposition testimony, substantive consideration of the affidavit

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does not alter our conclusion that Dr. Savala is not qualified to testify in regard to the standard of care in relation to Dr. Toshniwal.

Next, to the extent that defendants object that the trial court did not consider the affidavits that they provided on reconsideration, a trial court "has discretion on a motion for reconsideration to decline to consider new legal theories or evidence that could have been presented when the motion was initially decided." *Yoost v Caspari, 295 Mich App 209, 220; 813 NW2d 783 (2012)*. We need not explore this issue because, for the reasons discussed below, we rule in defendants' favor absent consideration of the affidavits supplied by defendants in their motion for reconsideration.

There can be no reasonable dispute that the only reason Dr. Toshniwal placed or performed the adductor canal block was to control plaintiff's pain and **[*25]** that plaintiff's lawsuit concerned whether legally-sound informed consent was obtained with respect to that particular medical procedure. Therefore, at first glance, it would appear that the one most relevant specialty was pain medicine, which was essentially the exclusive focus of Dr. Savala's practice. But this case requires closer and deeper inspection. Although a pain-medicine procedure was used, the particular nerve block Dr. Toshniwal employed is most commonly used by anesthesiologists in connection with surgeries. Indeed, pain-medicine specialist Dr. Savala acknowledged that he had not performed a femoral nerve block in at least 12 years because "operating room anesthesiologists are typically the ones that are providing those services." While such regional nerve blocks are typically placed preoperatively, anesthesiologists occasionally perform them postoperatively. When the procedure to control plaintiff's pain is viewed within the context of the underlying surgery, it becomes evident that the one most relevant specialty is anesthesiology and not pain medicine. Moreover, during the year immediately preceding the date of the alleged medical malpractice, Dr. Savala had not devoted **[*26]** the majority of his professional time to either the active clinical practice of anesthesiology or to the instruction of students in anesthesiology. *MCL 600.2169(1)*; *Woodard, 476 Mich at 561-562*.

Furthermore, plaintiff's medical malpractice action encompassed not only the events that took place after the surgery on his fractured patella and immediately before the nerve block was performed, but also events that occurred before the surgery when plaintiff allegedly stated his desire for no regional nerve blocks. The postoperative nerve block cannot be viewed in isolation or in a vacuum given the nature of plaintiff's lawsuit; rather, all of the circumstances surrounding the surgery must be considered, and it was the practice of anesthesiology and not pain medicine that was the relevant specialty when the circumstances are viewed more broadly, as is appropriate in this case.

In sum, the trial court erred by failing to strike plaintiff's expert witness, Dr. Savala, as he was not qualified to give standard-of-care testimony against Dr. Toshniwal. On remand, plaintiff may file a motion for permission to amend his witness list.

We reverse and remand for proceedings consistent with this opinion. We do not retain jurisdiction. Having fully **[*27]** prevailed on appeal, defendants may tax costs under *MCR 7.219*.

/s/ Jane E. Markey

/s/ Mark T. Boonstra

Dissent by: Jane M. Beckering

Dissent

BECKERING, J., (*dissenting*).

In this medical malpractice action, defendants Gokul Toshniwal, M.D. and Anesthesia Associates of Ann Arbor PLLC ask this Court to overturn the trial court's order denying their motion to strike plaintiff Travis Strasser's expert witness. Defendant Dr. Toshniwal is board certified in anesthesiology as well as the subspecialty of pain medicine. Likewise, plaintiff's expert, Robert Savala, M.D., is board certified in anesthesiology as well as the subspecialty of pain medicine. The parties debate which of those two specialties Dr. Toshniwal was performing at the time of the alleged malpractice for purposes of assessing whether Dr. Savala meets the requirements of *MCL 600.2169(1)*. Under the presenting facts, I would conclude that the trial court did not abuse its discretion in denying defendants' motion. Thus, I respectfully dissent.

This Court reviews for an abuse of discretion a trial court's decision regarding whether an expert witness is qualified. *Tate v Detroit Receiving Hosp, 249 Mich App 212, 215; 642 NW2d 346 (2002)*. "The abuse of discretion standard recognizes that there may be no

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single correct outcome in certain situations; instead, **[*28]** there may be more than one reasonable and principled outcome." *Gonzalez v St. John Hosp & Med Ctr, 275 Mich App 290, 294; 739 NW2d 392 (2007)*. Moreover, "[w]hen the trial court selects one of these principled outcomes, it has not abused its discretion, and the reviewing court should defer to the trial court's judgment." *Id.* Also, a trial court's decision regarding a motion to strike is discretionary. *Kalaj v Khan, 295 Mich App 420, 425; 820 NW2d 223 (2012)*. The relevant standard of care in a medical malpractice action is a question of law that this Court reviews de novo. *Cox v Board of Hosp Managers for Flint, 467 Mich 1, 16 n 16; 651 NW2d 356 (2002)*. To the extent that the resolution of this appeal requires interpretation of *MCL 600.2169*, questions of statutory interpretation are also reviewed de novo. *Id. at 16*.

> To establish a cause of action for medical malpractice, a plaintiff must establish four elements: (1) the appropriate standard of care governing the defendant's conduct at the time of the purported negligence[1], (2) that the defendant breached that standard of care, (3) that the plaintiff was injured, and (4) that the plaintiff's injuries were the proximate result of the defendant's breach of the applicable standard of care. [*Kalaj, 295 Mich App at 429*.]

"Expert testimony is required to establish the standard of care and a breach of that standard, as well as causation." *Id.* (citations omitted). The party offering the expert must show **[*29]** that the witness is knowledgeable regarding the applicable standard of care. *Decker v Rochowiak, 287 Mich App 666, 685; 791 NW2d 507 (2010)*.

MCL 600.2169(1) establishes the requirements for a standard of care expert in a medical malpractice action, and provides in pertinent part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to *subdivision (c)*, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (*i*) The active clinical practice of the same health profession in which the **[*30]** party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

In *Woodard v Custer, 476 Mich 545, 560; 719 NW2d 842 (2006)*, the Supreme Court concluded that *MCL 600.2169(1)(a)* requires a plaintiff's expert to specialize in the defendant's relevant specialty. "That is, if a defendant physician is a specialist, the plaintiff's expert witness must have specialized in the same specialty." *Id. at 560-561*. "If a defendant physician specializes in a subspecialty[2], the plaintiff's expert witness must have specialized in the same subspecialty as the defendant physician at the time of the occurrence that is the basis for the action." *Id. at 562*.

Here, there is no dispute that Drs. Toshniwal and Savala have the same two specialties. At the time of the incident at issue, they were each board certified by the **[*31]** American Board of Anesthesiology in the specialty of anesthesiology as well as the subspecialty

[1] Plaintiff alleges that Dr. Toshniwal performed a medical procedure without his consent. "The doctrine of informed consent requires a physician to warn a patient of the risks and consequences of a medical procedure." *Wlosinski v Cohn, 269 Mich App 303, 308; 713 NW2d 16 (2005)*.

[2] The *Woodard* court determined that a specialty, for purposes of *MCL 600.2169(1)(a)*, is a particular branch of medicine or surgery in which one can potentially become board certified, and that includes subspecialties. *Id. at 561-562*.

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of pain medicine. Thus, MCL 600.2169(1)(a) is clearly met, regardless of which of these specialties Dr. Toshniwal was practicing at the time of the alleged malpractice.[3]

With respect to MCL 600.2169(1)(b), the *Woodard Court* explained that

> [I]n order to be qualified to testify under [MCL 600.2169(1)(b)], the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty. [Id. at 566 (footnote omitted.)]

Dr. Savala testified at his deposition that in the year preceding the date of the alleged malpractice, he spent nearly all of his time in pain medicine.[4] Dr. Toshniwal testified that he spent roughly 30 to 40 percent of his time in pain medicine and 60 to 70 percent in anesthesiology. The parties dispute which specialty Dr. Toshniwal was practicing at the time of the alleged malpractice. According to defendants, if it was anesthesiology, Dr. Savala would not be qualified under MCL 600.2169(1)(b), but if it was **[*32]** pain medicine, he would be.

In this case, plaintiff had just undergone knee surgery, which was performed under general anesthesia. After the operation, the opioids given to plaintiff were not effectively managing his pain. Dr. Toshniwal testified that he discussed with plaintiff, his significant other, and the surgeon various alternatives to help plaintiff manage the pain, and then performed an adductor canal block procedure, which is an analgesic sensory nerve block injected into the adductor canal of the thigh.[5] Plaintiff does not claim that Dr. Toshniwal performed the procedure improperly. Rather, he claims that Dr. Toshniwal should not have performed the procedure at all. He alleges in his complaint that he "clearly and specifically informed all Defendants that he did **not** want any spinal or regional blocks for post-operative pain control."[6] He feared the potential side effects experienced by one of his friends. After Dr. Toshniwal performed the procedure, plaintiff experienced severe left femoral neuropathy, resulting in this lawsuit alleging a lack of informed consent.[7]

Defendants claim that because Dr. Toshniwal performed the nerve block during the perioperative period in order to **[*33]** treat acute pain, it falls under the domain of anesthesiology. Pain medicine, according to defendants, focuses on acute chronic pain, not acute perioperative pain. In contrast, plaintiff argues that the treatment at issue involved a pain management procedure; it did not entail the use of anesthesia, so it falls under the umbrella of pain medicine, not anesthesiology. Moreover, plaintiff points out that the case involves a dispute over informed consent, not the performance of the procedure itself, so under either specialty, the standard of care is the same.

At the motion hearing, the trial court ruled, in relevant part:

> I think it, it was a pain management procedure, the, the nerve block. [B]ased on the evidence, the documents that both sides presented, and then Woodard v Custer [476 Mich 545; 719 NW2d 842 (2006)] says that it's the relevant specialty that was being performed. And it is pain management.
> But this seems, to me, and maybe I just got lost in my head, it seems to be much ado about nothing, because, Plaintiff, I don't think, is alleging that the pain, pain management was done wrong.
> Or that the nerve block was done incorrectly.
> But it was done without consent.

In my view, the trial court did not abuse its discretion in denying defendants' **[*34]** motion. See Gonzalez, 275

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[3] Even though Dr. Savala is board certified in both specialties, a plaintiff's expert's specialties need not match all of the defendant physician's specialties, just the one that the defendant was practicing at the time of the alleged malpractice. Id. at 567-68.

[4] Dr. Savala testified that he spends the majority of his time managing acute and chronic pain, both in an office and in a hospital outpatient surgery center, and he regularly performs nerve blocks 15 to 20 times per week. He agreed that nerve blocks are a pain control procedure.

[5] Whether Dr. Toshniwal properly obtained informed consent for the procedure is a disputed question of fact that is not before this Court.

[6] Plaintiff's medical records indicate that plaintiff "refused spinal or any regional block for postop pain control."

[7] Plaintiff alleged in his complaint that he "has no active motor activities in the left leg, atrophy, pain, decreased sensation distribution, and numerous other problems." Whether plaintiff suffered injury due to the procedure is a disputed question of fact that is not before this Court.

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Mich App at 294. First, the trial court's conclusion that Dr. Toshniwal was practicing pain medicine at the time he performed the nerve block is reasonable. Dr. Toshniwal was treating plaintiff's pain. Second, the materials before this Court illustrate that the specialties of anesthesiology and pain medicine, when it comes to pain treatment, appear to greatly overlap. Essentially, defendants are asking this Court to split hairs where Dr. Savala's credentials exactly match those of Dr. Toshniwal, and Dr. Savala's practice includes the regular performance of nerve blocks.[8] Given that Dr. Toshniwal testified that he was considering which of various pain medications to administer to alleviate plaintiff's pain, that supports a finding that he was practicing pain medicine. The parties debate whether a nerve block given after surgery can credibly be argued to fall under the sole umbrella of anesthesiology, as a nerve block does not include general anesthesia, and its focus is on pain management, not sedation. Plaintiff points out that the medical records and billing records distinguish between general anesthesia and pain management, referring to post-operative pain control as a separate item. **[*35]** Defendants state that is irrelevant, where the procedures are not the same, and thus, are not billed the same, but the fact that they are different does not make one pain medicine and the other not. Weighing against the argument that the most relevant specialty is anesthesiology is the fact that defendants themselves formally relied on a pain medicine doctor's affidavit of meritorious defense at the outset of this case.[9]

Based on the record evidence, the question of "which hat" Dr. Toshniwal was wearing when tasked with obtaining informed consent for the performance of a nerve block to manage plaintiff's pain after surgery could reasonably be answered either way. Both anesthesiologists and pain medicine physicians perform nerve blocks to treat pain. And because there is no dispute that the standard of care with respect to obtaining informed consent is the same under either specialty, the splitting of hairs in this case makes no sense, other than for purposes of legal strategy. Because Dr. Toshniwal was undertaking to treat plaintiff's pain, and because Dr. Savala possess the exact same board certifications as Dr. Toshniwal, I do not believe the trial court abused its discretion by denying **[*36]** defendants' motion. See Tate, 249 Mich App at 215; Gonzalez, 275 Mich App at 294. As such, I would affirm.

/s/ Jane M. Beckering

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[8] While Dr. Savala testified that he routinely performs a different type of nerve block and he had not performed the type of nerve block at issue in several years, that this fact goes to the weight and credibility of his testimony, not its admissibility. See Ykimoff v Foote Mem Hosp, 285 Mich App 80, 101; 776 NW2d 114 (2009) ("Gaps or weaknesses in the witness' expertise are a fit subject for cross-examination, and go to the weight of his testimony, not its admissibility") (quotation marks and citation omitted). Again, this case is about informed consent, not the way he performed the particular nerve block.

[9] Codefendants Oakwood Heritage Hospital, Beaumont Hospital-Taylor, Oakwood Healthcare, Inc., and Beaumont Health System submitted an affidavit of meritorious defense from Nabil Sibai, M.D., a physician who is board certified in both anesthesiology and the subspecialty of pain medicine and who, like Dr. Savala, devoted the majority of his professional time in the year preceding the subject incident in the active clinical practice of the medical subspecialty of pain medicine. His affidavit indicated that "[t]he applicable standard of care is what a board-certified anesthesiologist with a subspecialty in pain medicine of ordinary learning, judgment, or skill would or would not do under the same or similar circumstances then and there existing." In addition to filing his own affidavit, Dr. Toshniwal filed a pleading formally relying on Dr. Sibai's affidavit of meritorious defense.