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STATE OF MICHIGAN

IN THE SUPREME COURT

APPEAL FROM THE MICHIGAN 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 BRIEF ON APPEAL

CERTIFICATE OF COMPLIANCE

CERTIFICATE OF SERVICE

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

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JURISDICTIONAL STATEMENT

On January 29, 2020, the Oakland County Circuit Court entered an Order denying Defendants-Appellees' Motion to Strike and for Summary Disposition. **Appendix 286a** Defendants sought interlocutory appellate review, and a panel of the Court of Appeals granted leave in an Order issued May 27, 2020 (O'Brien, P.J. and Jansen, J.). **Appendix 288a** Judge Gleicher would have denied the application for leave to appeal. After briefing and oral argument, the Court of Appeals issued an unpublished opinion reversing the trial court on May 20, 2021. **Appendix 290a** The ruling was premised on a belief that "because Dr. Colton averred in his affidavit that the procedures at issue were cosmetic in nature, the [trial] court opined that the most relevant specialty was facial plastic and reconstructive surgery" and "the trial court correctly determined that facial plastic and reconstructive surgery is the most relevant specialty". **Appendix 291a, Appendix 295a**

Plaintiff-Appellant Antonio Selliman sought leave to appeal the May 20, 2021 opinion of the Court of Appeals. **Appendix 290a** An application for leave to appeal is timely if it is filed within 42 days of the issuance of an opinion of the Court of Appeals. MCR 7.305(C)(2)(a). Plaintiff-Appellant timely filed his application on July 1, 2021. Pursuant to MCL 600.215, MCR 7.303(B)(1), and MCR 7.305(H)(1), this Court has the authority to grant leave to appeal or order other relief after a decision of the Court of Appeals. On April 27, 2022, this Court directed the Clerk to schedule oral argument on the application and directed the parties to file supplemental briefs. **Appendix 298a** Following mini oral argument on the application, this Court granted leave on December 22, 2022. **Appendix 300a**

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STATEMENT OF THE QUESTIONS PRESENTED

ARGUMENT I

1. Was *Woodard v Custer,* 476 Mich 545 (2006), correctly decided?

Plaintiff says "NO"

Defendants will say "YES"

2. Should *Woodard* be retained under principles of stare decisis?

Plaintiff says "NO"

Defendants will say "YES"

ARGUMENT II

3. Is *Woodard*'s "one most relevant specialty" test consistent with MCL 600.2169(1) and should it be retained?

Plaintiff says "NO"

Defendants will say "YES"

4. Is *Woodard*'s interpretation of the "majority of . . . professional time" consistent with MCL 600.2169(1) and should it be retained?

Plaintiff says "NO"

Defendants will say "YES"

ARGUMENT III

5. Did the Court of Appeals reach the right result under the proper application of the requirements of MCL 600.2169 in this case?

Plaintiff says "NO"

Defendants will say "YES"

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STATEMENT OF FACTS

This is a medical malpractice action arising of Defendants-Appellees Jeffrey Colton, MD, Jeffrey J. Colton, PLLC, and the Colton Center ("Defendants")' medical treatment of Plaintiff-Appellant ("Plaintiff") Antonio Selliman from August 2014 through November 2017. While under the care of Defendants, Plaintiff underwent a total of seven rhinoplasty procedures: August 25, 2014, March 25, 2015, September 9, 2015, January 12, 2016, June 23, 2016, April 19, 2017, and November 9, 2017. The repeated negligent performance of these rhinoplasty procedures resulted in severe and permanent damage and disfigurement. **Appendix 12a, ¶20**

I. FACTUAL BACKGROUND

Defendants performed the first of seven rhinoplasty procedures on August 25, 2014, approximately two years after Plaintiff first presented for treatment. This case specifically concerns the 2016 and 2017 surgeries. On January 12, 2016, Dr. Colton performed a rhinoplasty procedure intending to reshape Plaintiff's nose by narrowing the bridge and reshaping the tip of the nose. **Appendix 11a, ¶11** During a post-operative visit, Dr. Colton administered approximately seven (7) steroid injections into the area surrounding Plaintiff's nose, in an attempt to minimize the nasal deformity which resulted from the January rhinoplasty. **Appendix 11a, ¶11** Plaintiff was instructed to return to The Colton Center in thirty (30) days for additional treatment. **Appendix 11a, ¶11** When Plaintiff returned as instructed, Dr. Colton administered an additional six (6) steroid injections into Plaintiff's nose and surrounding tissue, again in an attempt to correct the damage caused by the prior rhinoplasty. **Appendix 11a, ¶12** During this visit in March 2016, Dr. Colton promised Plaintiff he could narrow and lower Plaintiff's nose and remove tissue on the bridge of the nose by performing another surgery. **Appendix 11a, ¶13**

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In June 2016, Plaintiff underwent another rhinoplasty with Defendants in an attempt to narrow and reshape his nose. **Appendix 12a, ¶14** Following this procedure, Dr. Colton again promised he could and would accomplish his goal of reshaping and narrowing Plaintiff's nose with another surgery. **Appendix 12a, ¶14** Dr. Colton further assured Plaintiff that his nasal deformity he was afflicted with was correctable **Appendix 12a, ¶14** On April 19, 2017, Dr. Colton performed a sixth rhinoplasty in an attempt to lower and narrow Plaintiff's nose. **Appendix 12a, ¶15** On November 9, 2017, Plaintiff underwent a seventh rhinoplasty performed by Dr. Colton. **Appendix 12a, ¶16** During a post-operative visit, Dr. Colton recommended additional steroid injections in an attempt to correct the damage to Plaintiff's nose and facial tissue. **Appendix 12a, ¶17** Dr. Colton stated he would correct the damage caused to Plaintiff's nose and facial tissue by performing another surgery, in conjunction with the additional steroid injections. **Appendix 12a, ¶17** Rather than undergo yet another rhinoplasty, Plaintiff ceased treatment with Jeffrey Colton, MD, Jeffrey J. Colton, PLLC, and The Colton Center in December 2017.

II. PROCEDURAL HISTORY

On July 16, 2018, Plaintiff filed his Complaint alleging medical malpractice committed by Defendants in the course of the multiple rhinoplasty procedures, resulting in scarring and disfigurement, among other damages. **Appendix 12a, ¶¶19-20** In his Complaint, Plaintiff alleged he is left with severe and permanent damage to his nose and surrounding tissue, including scarring and a highly visible saddle deformity, as a result of Defendants' negligent performance of repeated rhinoplasty surgeries. **Appendix 12a, ¶20; Appendix 211a** The nasal tip has been deconstructed so that it is round and amorphous. **Appendix 211a** The radix of the nose has become progressively thicker and wider through multiple fractures and inappropriate osteotomies. **Appendix 211a** The appearance of this thickness has been aggravated by the inappropriate removal of tissue in the

middle third of the nose. **Appendix 211a** 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. **Appendix 211a-212a**

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, like Dr. Colton, board certified by the American Board of Otolaryngology and by the American Board of Facial Plastic and Reconstructive Surgery. **Appendix 19a** In the Affidavit of Merit, Dr. Armstrong states the following:

> 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. **Appendix 19a**
>
> I am of the opinion that the standard of care applicable to Jeffrey Colton, MD was that of his peers in the professional community in the medical specialty of on [sic] Otolaryngology and Facial Plastic and Reconstructive Plastic Surgery. **Appendix 20a**

On October 11, 2018, Defendants filed their Affidavit of Meritorious Defense of Michael A. Carron, MD, a physician, identical to Defendant Dr. Colton and Plaintiff's expert Dr. Armstrong, board certified by the American Board of Otolaryngology-Head and Neck Surgery and the American Board of Facial Plastic and Reconstructive Surgery. **Appendix 24a** 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. **Appendix 24a**
>
> 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. **Appendix 24a**

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Litigation commenced and Dr. Armstrong was deposed on September 24, 2019. **Appendix 29a** At his deposition, Dr. Armstrong testified he was board certified, like Dr. Colton, in both otolaryngology and facial plastic and reconstructive surgery. **Appendix 58a-59a** As the deposition progressed, Dr. Armstrong gave arguably unclear and confusing testimony when questioned about the division of his clinical practice between otolaryngology and facial plastic and reconstructive surgery, instead seeming to offer a division of his practice of rhinoplasty:

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 more medically ENT. (emphasis added) **Appendix 60a-61a**

Although defense counsel's apparent objective was to determine the percentage of professional time "devoted to ENT…as opposed to facial plastic and reconstructive surgery", Dr. Armstrong's testimony was not responsive to that inquest. Rather, the syntax of his response illustrates he was offering percentages as to the division of his professional time within "the category of facial plastics". He testified that "the practice", that being facial plastics as referenced in the preceding sentence, "might be 10 percent cosmetic, 90 percent functional". Dr. Armstrong was not attributing these percentages to the division of his practice between otolaryngology and

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facial plastic and reconstructive surgery. This clear disconnect between the information defense counsel sought in the question and the response Dr. Armstrong gave permeated through the remainder of the deposition, producing what the trial court deemed "seemingly contradictory statements…regarding Doctor Armstrong's practice". **Appendix 278a**

The evidence of this false equivalence can be seen in further deposition testimony, where the percentages and classification of rhinoplasties as either cosmetic or functional/reconstructive, are repeated:

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.
Q: Okay, and the facial plastic and reconstructive surgery would include cosmetic rhinoplasties?
A: Yes. **Appendix 62a**

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. **Appendix 62a-63a**

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. **Appendix 64a**

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Plaintiff's counsel sought to clarify this confusion during his examination of Dr. Armstrong:

Q: 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.

OBJECTION BY COUNSEL FOR DEFENDANTS.

A: Rhinoplasty is part of the required training for an otolaryngologist, and 25 percent of the otolaryngology board 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.
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. **Appendix 142a-143a**

A reading of the complete deposition transcript evidences that Dr. Armstrong was speaking of the division of his facial plastics practice between the performance of cosmetic and functional/reconstructive rhinoplasties, rather than the division of his professional time between the specialties of otolaryngology and facial plastic and reconstructive surgery. While the apparent objective was to determine the clinical composition of Dr. Armstrong's practice for purposes of the "one most relevant specialty" requirement, defense counsel did not explicitly ask Dr. Armstrong what specialty he spends the majority of his professional time practicing, or what specialty he practices when performing rhinoplasty procedures. That Dr. Armstrong was not

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classifying the treatment at issue as being within the specialty of facial plastic and reconstructive surgery, but rather attempting to explain the division of rhinoplasty procedures as either "cosmetic" or "functional/reconstructive" is further evidenced by his repeated reference to what a "reasonably prudent otolaryngologist" would know when discussing Defendants' negligence. **Appendix 105a; Appendix 149a; Appendix 160a**

A. IN THE TRIAL COURT

On October 16, 2019, Defendants filed their Motion to Strike Michael J. Armstrong, Jr., MD and for Summary Disposition. **Appendix 187a** In this Motion, filed approximately 15 months after Plaintiff's initial disclosure of their expert and his qualifications, Defendants alleged for the first time that Dr. Armstrong failed to meet the requirements of MCL 600.2169(1), 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 and in conflict with their own Affidavit of Meritorious Defense executed by Dr. Carron, contend is facial plastic and reconstructive surgery. **Appendix 191a; Appendix 195a-196a** Importantly, Defendants failed to retract or amend Dr. Carron's Affidavit and failed to provide any alternative affidavit from a different expert supporting their new position that facial plastic and reconstructive surgery was the singular relevant specialty. In Response, Plaintiff disputed both Defendants' characterization of Dr. Armstrong's testimony and Defendants' unilateral assertion that the one most relevant specialty is facial plastic and reconstructive surgery. **Appendix 206a** Plaintiff pointed to Defendants' own Affidavit of Meritorious Defense, which mirrors Plaintiff's Affidavit of Merit in stating the applicable standard of care is that of a physician specializing in otolaryngology-head and neck surgery ***and*** facial plastic and reconstructive surgery, in support of his argument. **Appendix 217a; Appendix 24a**

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On November 25, 2019, Defendants filed their Reply Brief, attaching an Affidavit from Defendant Dr. Jeffrey Colton, MD, dated November 22, 2019, three days prior**. Appendix 221a; Appendix 228a** In his Affidavit, Defendant Colton announced:

> 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. **Appendix 229a**
>
> 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. **Appendix 229a**

Following receipt of Defendants' self-serving Affidavit, Plaintiff moved for leave to amend his witness list on December 4, 2019. **Appendix 231a** While Plaintiff objected to Defendants' attempt to unilaterally decide the applicable standard of care, Plaintiff sought this amendment to avoid further delay or confusion to the jury. Plaintiff's Motion was denied approximately six weeks before oral argument on Defendants' Motion to Strike and for Summary Disposition was held.

During oral argument on January 29, 2020, the trial court stated that "there were multiple questions with multiple answers" on the subject Plaintiff's expert's practice. **Appendix 254a; Appendix 270a** Ultimately, the trial court agreed with Plaintiff's contention, ruling that

> it is unclear whether Doctor Armstrong's testimony reflects that 90 percent of his practice was devoted to [otolaryngology], and 10 percent to facial, plastic, and reconstructive surgery or whether within his facial, plastic, and reconstructive practice, 10 percent of his procedures may be for cosmetic purposes with 90 percent being more functional." Upon the basis of "seemingly contradictory statements…made regarding Doctor Armstrong's practice, the Court cannot determine at this time whether Doctor Armstrong is qualified or not pursuant to MCR [MCL] 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). **Appendix 278a**

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An Order Denying Defendants' Motion to Strike Without Prejudice and for Summary Disposition [MCR 2.116 (C)(10)] and Granting in Part and Denying in Part Defendants' Motion for Summary Disposition [MCR 2.116(C)(7)] was subsequently entered .[1] **Appendix 286a**

B. IN THE COURT OF APPEALS

Defendants sought interlocutory appellate review of the trial court's denial of the Motion to Strike and for Summary Disposition. In response, Plaintiff disputed Defendants would suffer any substantial harm by awaiting final judgment, and further argued the trial court correctly denied the motion after careful review of the deposition testimony. A panel of this Court granted Defendants' Application in an Order issued May 27, 2020. Judge Gleicher would have denied the Application, finding "the standard of care for performing a rhinoplasty is the same regardless of whether the rhinoplasty is performed for cosmetic or medical reasons." **Appendix 288a**

On May 20, 2021, the Court of Appeals released an unpublished opinion concluding that the trial court abused its discretion in denying the motion to strike Dr. Armstrong's testimony. In so finding, the panel stated that "because Dr. Colton averred in his affidavit that the procedures at issue were cosmetic in nature, the [trial] court opined that the most relevant specialty was facial plastic and reconstructive surgery" and "the trial court correctly determined that facial plastic and reconstructive surgery is the most relevant specialty". **Appendix 291a, Appendix 295a** On this basis, the Court of Appeals reversed the trial court's ruling, holding:

> 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

1 Defendants-Appellees moved for summary disposition on the basis of the expiration of the statute of limitations. The trial court granted that motion in part with respect to dates of treatment predating January 12, 2016. The "denial in part" portion of that motion is not part of these appellate proceedings.

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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. **Appendix 295a**

C. IN THE SUPREME COURT

Plaintiff sought leave to appeal in this Court arguing the Court of Appeals clearly erred in concluding the trial court determined the one most relative specialty to be facial plastic and reconstructive surgery, when the trial court did not explicitly rule as such. To the extent the trial court implicitly ruled that facial plastic and reconstructive surgery was the one most relevant specialty, the determination was based on Defendants' self-serving Affidavit, which was attached not to the principle motion giving rise to these proceedings, to which Plaintiff could respond, but to Defendants' Reply, to which Plaintiff could not, other than at oral argument. MCR 2.116(G)(1)(a)(iv). Plaintiff further argued the Court of Appeals erred in determining the trial court abused its discretion by denying the motion to strike Dr. Armstrong's testimony, when the trial court's ruling reflected a reasonable and principled outcome. Finally, Plaintiff encouraged this Court to re-examine the proper interpretation and application of MCL 600.2169(1), arguing the issue of expert qualification in medical malpractice actions had become increasingly clouded by a line of cases beginning with is *Woodard v Custer,* 476 Mich 545; 719 NW2d 842 (2006).

On April 27, 2022, this Court directed the Clerk to schedule oral argument on the application. **Appendix 298a** This Court further directed the parties to file supplemental briefs 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

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discretion standard of review. **Appendix 298a** Following mini oral argument on the application, this Court granted leave on December 22, 2022. **Appendix 300a**

STANDARD OF REVIEW

As a question of law, the interpretation of MCL 600.2169(1) is reviewed de novo. *Woodard*, 476 Mich at 557; *Crego v Edward W. Sparrow Hosp Ass'n*, 327 Mich App 525, 931; 937 NW2d 380 (2019) ("[t]he construction of MCL 600.2169 presents a question of law subject to de novo review.") This Court reviews a trial court's ruling concerning the qualifications of a proposed expert witness 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. *Maldonado v Ford Motor Co,* 476 Mich 372, 388; 719 NW2d 809 (2006).

ARGUMENT

MCL 600.2169(1) was first enacted in 1986, before being amended in 1993 to impose more stringent requirements. As plainly stated in the Report of the Senate Select Committee on Civil Justice Reform, the statute was designed to combat a perceived problem with expert witness qualification in medical malpractice cases:

> As a practical matter, in many courts merely a license to practice medicine is needed to become a medical expert on an issue.
>
> This has given rise to a group of national professional witnesses who travel the country routinely testifying for plaintiffs in malpractice actions. These 'hired guns' advertise extensively in professional journals and compete fiercely with each other for the expert witness business. For many, testifying is a full-time occupation and they rarely actually engage in the practice of medicine. There is a perception that these so-called expert witnesses will testify to whatever someone pays them to testify about.
>
> 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. In particular, with the malpractice crisis facing high risk specialists, such as

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> neurosurgeons, orthopedic surgeons and ob/gyns, this reform is necessary to insure that in malpractice suits against specialists the expert witnesses actually practice in the same specialty. This will protect the integrity of our judicial system by requiring real experts instead of "hired guns." (Internal citations omitted) *McDougall v Schanz*, 461 Mich 15, 25 n 9; 597 NW2d 148 (1999), quoting *McDougall v Eliuk*, 218 Mich App 501, 509, n.1, 554 NW2d 56 (1996) (Taylor, P.J., dissenting)

The intent behind the enactment of MCL 600.2169(1) is clear and reasonable. It is reasonable for the Legislature to takes steps to ensure the testimony presented to Michigan juries is reliable and grounded in the expert's experience, rather than in the expert's pecuniary interest. Unfortunately, in the three decades since MCL 600.2169(1) was amended to its current form, judicial interpretation of the statute has produced a body of law wholly inconsistent with its original intent.

There is no dispute that MCL 600.2169(1) was enacted to ensure all medical malpractice experts "will have firsthand practical expertise in the subject matter about which they are testifying". *McDougall v Schanz*, 461 Mich. 15, 25; 597 NW2d 148 (1999). To that end, the statute sets forth requirements intended to act as guardrails to expert qualification:

> (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.

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> (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.
>
> (c) If the party against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness, 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) Active clinical practice as a general practitioner.
>
> (ii) 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.
>
> (2) In determining the qualifications of an expert witness in an action alleging medical malpractice, 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 practice or instruction of the health profession or the specialty.
>
> (d) The relevancy of the expert witness's testimony.
>
> (3) This section does not limit the power of the trial court to disqualify an expert witness on grounds other than the qualifications set forth in this section.

The Michigan Legislature perceived a problem and responded to it; Plaintiff takes no issue with this appropriate exercise of legislative authority. The problem arises from the central holdings first announced in *Woodard v Custer*, 476 Mich 545 (2006), which are untethered to the text of the statute.

Beginning with *Woodard,* the language of MCL 600.2169(1) has been bastardized by judicially created tests which would require disqualification of an expert who holds the same board

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certifications, practices the same medicine, and performs the same procedures as the defendant, as is the case here. While an expert such as Dr. Armstrong, who testified that he has performed over 400 rhinoplasties, may be disqualified, another physician similarly board certified in facial plastic and reconstructive surgery who does not perform rhinoplasty but instead administers Botox injections and chemical peels would not be disqualified. Such a ridiculous result could not have been the intention of the Michigan Legislature in enacting MCL 600.2169(1). This Court should take this opportunity to clarify the proper interpretation and application of MCL 600.2169(1) so that such absurdities do not continue.

I. *WOODARD* IS NOT CONSISTENT WITH THE REQUIREMENTS OF MCL 600.2169(1) AND SHOULD BE OVERRULED

The infirmity of the central holdings in *Woodard* is the result of this Court, as composed in 2006, alternatively adding to and ignoring the words selected by the Legislature when drafting MCL 600.2169(1). This practice is evident in the key principles introduced in *Woodard*: (1) that there can only be "one most relevant" specialty; (2) that a subspecialty is the same as a specialty; (3) that a certificate of added qualification constitutes a board certification; and (4) a physician cannot devote a majority of their professional time to more than one specialty. *Id.* at 559-566. Each of these principles employs extratextual definitions inconsistent with the plain language of MCL 600.2169(1). Because *Woodard* misunderstands and misconstrues a plainly worded statute, it is wrongly decided, poorly reasoned, and should be overruled. *Robinson v City of Detroit*, 462 Mich 439, 464-465; 613 NW2d 307 (2000).

A. *WOODARD'S* INTERPRETATION OF MCL 600.2169(1)(a) IS INCONSISTENT WITH ITS TEXT

The first significant judicial contortion of MCL 600.2169(1) came with the *Woodard* Court's announcement of the "one most relevant specialty" test. *Id.* at 560, 566. This test is

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premised, in part, on the mistaken belief that a physician can only be practicing one branch of medicine at a time. Citing the Court of Appeals in *Tate v Detroit Receiving Hosp,* 249 Mich. App. 212, 218; 642 NW2d 346 (2002) (explaining that "the statute expressly uses the word 'specialty,' as opposed to 'specialties,' thereby implying that the specialty requirement is tied to the occurrence of the alleged malpractice and not unrelated specialties that a defendant physician may hold"), the *Woodard* Court concluded that there can be only a singular relevant specialty. But this conclusion is a step too far beyond the text of the statute. It is true that the statute does not require matching of irrelevant specialties, but it is not true that the statute contemplates only one specialty may itself be relevant – there is no language to this effect. This is not to say that such a test is always untenable; there are certainly cases where the applicable specialty is easily and singularly determined. The problem arises in cases such as this, where no meaningful or practical distinction can be found which renders one specialty more relevant than another for purposes of qualifying an expert witness to testify as to the standard of care. *Woodard*'s one most relevant specialty test is also premised on the erroneous belief that the standard of care changes based on the specialty of the physician performing the procedure. As has been repeatedly acknowledged by the Court of Appeals, the reality of modern medicine is that multiple different specialties may perform the same procedures; this does not change the standard of care. [2]

Specific to this case, the standard of care is the same regardless of whether the rhinoplasty is performed for cosmetic or medical reasons or performed by an otolaryngologist or a facial plastic

2 See e.g. *Johnson v Sultan,* unpublished per curiam opinion of the Michigan Court of Appeals, issued February 10, 2011 (Docket No. 292327) **Appendix 17** at *15-16; *Higgins v Trail,* unpublished per curiam opinion of the Michigan Court of Appeals, issued July 30, 2019 (Docket No. 343664) **Appendix 23** at *27-28; *Strasser v Oakwood Heritage Hospital,* unpublished per curiam opinion of the Michigan Court of Appeals, issued November 4, 2021 (Docket No. 355496) **Appendix 25** at *35-36

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and reconstructive surgeon.[3] There is obvious and unignorable overlap between these two disciplines, and a physician brings all of his training and experience to bear when practicing medicine. Dr. Colton and Dr. Armstrong practice both otolaryngology and facial plastic and reconstructive surgery, or either specialty, when performing rhinoplasty. Irrespective of whether Dr. Colton claims to have worn the hat of an otolaryngologist or a facial plastics surgeon (or both hats at once) when performing rhinoplasty, the standard of care is unmoored from the label he attaches to his practice.

The *Woodard* Court further contorted MCL 600.2169(1) by conflating subspecialties with specialties and certificates of added qualification with board certification. According to *Woodard*, "[a] subspecialty, although a more particularized specialty, is nevertheless a specialty." 476 Mich at 562. This pronouncement plainly defies the text of the statute. The two terms are simply not synonymous, and there is no reason to believe the Legislature thought they were. [4] This Court's jurisprudence requires that when a statute's language is clear and unambiguous, it will

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3 Plaintiff's expert has opined that the applicable standard of care is otolaryngology and facial plastic and reconstructive surgery. **Appendix 19a** Defendants' expert has identically opined that the applicable standard of care is otolaryngology and facial plastic and reconstructive surgery. **Appendix 24a** Defendants have presented nothing, by way of testimony or medical treatise, that suggests the standard of care for rhinoplasty changes depending on whether it is performed for cosmetic or medical reasons. Defendants never challenged Plaintiff's Affidavit of Merit or Dr. Armstrong's qualifications pursuant to MCR 2.112(L)(2)(b). Defendants did not attempt to amend Dr. Carron's Affidavit or in any way retract his previous opinion that the applicable standard of care is both otolaryngology and facial plastic and reconstructive surgery following Dr. Armstrong's deposition. Instead, rather than rely on the opinion of their retained expert, Defendants sought to unilaterally declare the applicable standard of care by attaching an Affidavit from Dr. Colton to a trial court reply brief. **Appendix 229a**

4 According to the American Board of Medical Specialties, there are 24 certifying medical specialty boards. Spread across these boards are 40 *specialty* and 88 *subspecialty* areas. See "About the American Board of Medical Specialties" available at https://www.abms.org/member-boards/ (last accessed February 16, 2023); see also *ABMS Guide to Medical Specialties,* available at https://www.abms.org/wp-content/uploads/2021/12/ABMS-Guide-to-Medical-Specialties-2022.pdf (last accessed February 16, 2023).

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> [A]ssume that the Legislature intended its plain meaning and the statute is enforced as written. Stated differently, a court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statute itself. Only where the statutory language is ambiguous may a court properly go beyond the words of the statute to ascertain legislative intent. *People v Phillips*, 469 Mich 390, 395; 666 NW2d 657 (2003) (citations and quotation marks omitted).

Because a subspecialty is plainly not a specialty, the *Woodard* Court erred in when concluding to the contrary.

The Court similarly erred in equating certificates of added qualification with board certification. MCL 600.2169(1) states that an expert's qualification rises or falls on their "board certification." Just as it does not mention subspecialities, the statute never mentions certificates of added qualification. This is no reason to believe the Legislature mistakenly overlooked the existence of certificates of added qualification when drafting MCL 600.2169(1). "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 second-guess 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). Nor can this Court assume the Legislature considered certificates of added qualification synonymous with board certification when it chose to exclude the former and include the latter. This Court "may not assume that the Legislature inadvertently made use of one word or phrase instead of another." *Robinson,* 462 Mich at 459. Rather, the Legislature made an intentional choice when it decided that board certification, and board certification alone, establishes the first indicator of expert qualification. By equating certificates of added qualification with board certification, *Woodard* plainly ignored this choice and impermissibly expanded the scope of the statute.

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Interesting in light of its holding in *Woodard,* this Court once recognized the difference between board certification and certificates of added qualification. 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*. This 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, which was consistent with its plain meaning, concluding that "because plaintiff's expert witness did not share the same board certification as the defendant doctor", the witness was unqualified to testify under MCL 600.2169(1). *Id*. at 574-575. Merely two years later in *Woodard,* the Court reversed course and began equating certificates of added qualification with board certification.

B. *WOODARD*'S INTERPRETATION OF MCL 600.2169(1)(b) IS INCONSISTENT WITH ITS TEXT

By its plain language, MCL 600.2169(1)(b) requires that an expert devote a majority of his or her professional time to either or both the active clinical practice or instruction of the specialty that the defendant physician was practicing at the time of the alleged malpractice. *Woodard* decreed that "obviously, a specialist can only devote a *majority* of his professional time to *one* specialty." *Id.* at 560 (italics original). Following this "obvious" instruction, the Court of Appeals in *Kiefer v Markley,* 283 Mich App 555; 769 NW2d 271 (2009), concluded that MCL 600.2169(1)(b), as interpreted by *Woodard,* requires a physician to devote more than 50 percent of his or her professional time to the relevant specialty in order to be qualified to testify as an expert witness. With this, *Woodard* and its progeny have adopted a zero-sum proposition divorced from the statutory text and realities of the practice of medicine.

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That this artificial division in the practice of medicine is not supported by the text of MCL 600.2169(1) is obvious. There is nothing in the statute that suggests "a majority" equates to a particular percentage, let alone declares how a percentage is to be calculated. While "majority" can mean more than half, it can also mean the greater part of a whole. *Webster's New World Dictionary*, 2d College Ed (1980). *Kiefer* acknowledged this alternative definition, before concluding without any reasoning that MCL 600.2169(1)(b) "requires a proposed expert physician to spend greater than 50 percent of his or her professional time practicing the relevant specialty". *Kiefer,* 283 Mich App at 559. *Woodard* further compounded its error in declaring that "one cannot devote a 'majority' of one's professional time to more than one specialty." *Woodard,* 476 at 566. No language in the statute suggests that a doctor may only be engaged in the practice of one specialty or subspecialty at any given time. To the contrary, the statute itself recognizes one can devote "a majority" of one's professional time to more than one profession – "either or both" the active clinical practice of medicine or the instruction of students. Just as the plain language of the statute permits a proposed expert devote a majority of his time to more than one profession – either or both active clinical practice and instruction – it permits a physician to devote a majority of his time to more than one specialty.

As demonstrated *supra, Woodard* employs extratextual definitions inconsistent with the plain language of MCL 600.2169(1). Its central holdings are unsound and highly questionable, so much so that disagreement exists over which of the four opinions is actually the majority opinion. *Id.* at 591-592 (TAYLOR, CJ, concurring). Because it is poorly reasoned and misconstrues a plainly worded statute, *Woodard* is wrongly decided.

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II. STARE DECISIS DOES NOT JUSTIFY RETAINING *WOODARD* OR ITS CENTRAL HOLDINGS

While generally the preferred course, stare decisis is not to be applied mechanically to forever prevent this Court from overruling earlier erroneous decisions determining the meaning of statutes. *Robinson v City of Detroit*, 462 Mich 439, 463; 613 NW2d 307 (2000). This Court has recognized that stare decisis is "a 'principle of policy' rather than 'an inexorable command,' and that the Court is not constrained to follow precedent when governing decisions are unworkable or are badly reasoned." *Id.* at 464. Once it has determined an earlier case was wrongly decided, the Court must proceed on to examine the effects of overruling that case, including "whether the decision at issue defies 'practical workability,' whether reliance interests would work an undue hardship, and whether changes in the law or facts no longer justify the questioned decision.'" *Id.* No principle of stare decisis favors continued adherence to *Woodard.* This Court should find additional justification for overruling *Woodard* in the inequity that results from adherence to its judicially created tests, as demonstrated by this case.

With regard to reliance interests, "the Court must ask whether the previous decision has become so embedded, so accepted, so fundamental, to everyone's expectations that to change it would produce not just readjustments, but practical real-world dislocations." *Robinson,* 462 Mich at 466. While *Woodard* is routinely cited in medical malpractice litigation, it has also been repeatedly questioned.[5] Given the nature of the rules announced in *Woodard,* it is unclear in what

5 See, e.g. *Johnson v Sultan,* unpublished per curiam opinion of the Michigan Court of Appeals, issued February 10, 2011 (Docket No. 292327) **Appendix 17**; *Stevens v Lansing Anesthesiologists,* unpublished per curiam opinion of the Michigan Court of Appeals, issued November 17, 2016 (Docket No. 328971); *Estate of LeBlanc v Agnone,* unpublished per curiam opinion of the Michigan Court of Appeals, issued July 6, 2017 (Docket Nos. 330330 and 330416) **Appendix 20**, leave denied 501 Mich 1031; 908 NW2d 544 (2018); *Estate of Perez v Henry Ford Health System,* unpublished per curiam opinion of the Michigan Court of Appeals, issued December 4, 2018

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form reliance could manifest. Certainly, a medical malpractice defendant has an interest in ensuring that any expert who may be called to testify on the appropriate standard of care has firsthand, practical expertise in the subject matter about which they are testifying. Even if *Woodard* is overruled, this interest is protected, and in fact guaranteed, by the statute. Thus, the reliance interest in retaining *Woodard* is nonexistent. Further, when assessing reliance, this Court in *Robinson* directed:

> [W]hen dealing with an area of the law that is statutory,... that it is to the words of the statute itself that a citizen first looks for guidance in directing his actions...Thus, if the words of the statute are clear, the actor should be able to expect, that is, rely, that they will be carried out by all in society, including the courts. In fact, should a court confound those legitimate citizen expectations by misreading or misconstruing a statute, it is that court itself that has disrupted the reliance interest. When that happens, a subsequent court, rather than holding to the distorted reading because of the doctrine of stare decisis, should overrule the earlier court's misconstruction. The reason for this is that the court in distorting the statute was engaged in a form of judicial usurpation that runs counter to the bedrock principle of American constitutionalism, i.e., that the lawmaking power is reposed in the people as reflected in the work of the Legislature, and, absent a constitutional violation, the courts have no legitimacy in overruling or nullifying the people's representatives. 462 Mich. At 467-468

Because the Court in *Woodard* strayed considerably from the statutory language of MCL 600.2169(1), as explained in Section I above, it undermines the reliance interest that litigants have with regard to that language. As a result, it is this Court's duty to restore such reliance interests by restoring the law to mean what its language plainly states. See *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 220; 815 NW2d 412 (2012).

(Docket No. 340082) **Appendix 21**, leave denied 504 Mich 963; 932 NW2d 782 (2019); *Higgins v Trail,* unpublished per curiam opinion of the Michigan Court of Appeals, issued July 30, 2019 (Docket No. 343664) **Appendix 23**; *Estate of Horn v Swofford*, 334 Mich App 281; 964 NW2d 904 (2020); *Mallory v Beaumont Health Sys,* unpublished per curiam opinion of the Michigan Court of Appeals, issued December 22, 2020 (Docket No. 350263) **Appendix 24**, leave denied 508 Mich 939; *Strasser v Oakwood Heritage Hospital,* unpublished per curiam opinion of the Michigan Court of Appeals, issued November 4, 2021 (Docket No. 355496) **Appendix 25**.

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While Defendants are likely to claim that overruling *Woodard* would result in a reproliferation of circuit-riding, unqualified experts who are in the active practice of litigation rather than medicine, such fears are unfounded. Whether or not *Woodard* is retained, MCL 600.2169, which was enacted to address this problem, endures. The guardrails to expert qualification established by the statute remain firmly in place; Plaintiff is only requesting those guardrails be enforced as written, rather than as interpreted by this Court as composed in 2006.

Neither does practical workability weigh in favor of retaining *Woodard*, as is demonstrated by this case. Here, Defendant Dr. Colton and Plaintiff's proposed expert Dr. Armstrong are mirror images of one another, identically board certified in Otolaryngology-Head and Neck Surgery (by the American Board of Otolaryngology-Head and Neck Surgery) and Facial Plastic and Reconstructive Surgery (by the American Board of Facial Plastic and Reconstructive Surgery). Dr. Armstrong also mirrors Defendant's retained expert, Dr. Carron, who is similarly board certified in both Otolaryngology-Head and Neck Surgery and Facial Plastic and Reconstructive Surgery. In short, Defendant, his expert, and Plaintiff's proposed expert hold all of the same board certifications, practice the same medicine, and perform the same procedures, including the procedure giving rise to the alleged malpractice. Yet, based solely on Defendant Dr. Colton's description of the procedure as being "cosmetic" rather than "functional", Dr. Armstrong was determined to be unqualified by the Court of Appeals pursuant to *Woodard.* Equally absurd, as demonstrated by both *Estate of Horn v Swofford*, 334 Mich App 281 and *Higgins v Trail,* Docket No. 343664, issued July 30, 2019 (unpublished), *Woodard*'s interpretation of MCL 600.2169(1) can also operate to preclude a defendant physician from testifying as to the standard of care

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governing his own alleged malpractice. [6] There is no practical workability to a decision which requires such absurd results.

Each factor to be considered before overruling precedent as laid out in *Robinson* weighs in favor of overruling *Woodard* – it was wrongly decided, poorly reasoned, and holds no reliance interest or practical workability. Its central holdings, namely the "one most relevant specialty" test of MCL 600.2169(1)(a) and the "majority of professional time" test of MCL 600.2169(1)(b), contravene the Legislature's intent as demonstrated by the plain language of the statute. Thus, this Court has a duty to re-examine, and Plaintiff submits to overrule, *Woodard.*

III. THE CERTIFICATION AND SPECIALTY TEST UNDER MCL 600.2169(1)(a)

Because they are inconsistent with the requirements of MCL 600.2169(1) and no principle of stare decisis weighs in favor of retention, neither *Woodard* nor any of its central holdings should be retained. This Court should do away with the erroneous interpretation of board certification as

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6 See also *Reeves v Carson City Hosp (On Remand),* 274 Mich App 622, 629-630; 736 NW2d 284 (2007) (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).

Contributing to the dubiety of *Woodard*'s interpretation of MCL 600.2169(1), and as pointed out by Judge Boonstra in *Estate of Horn,* there remains disagreement about whether this Court's order in *Estate of Jilek v Stockson*, 490 Mich 961 (2011), implicitly overruled *Reeves.* In *Jilek,* this Court concluded that the trial court had correctly determined the appropriate standard of care was family practice because the defendant physician was board-certified solely in family medicine. This Court further held that "the trial court did not abuse its discretion in ruling that defendants' two experts were qualified to provide 'standard of care' testimony under MCL 600.2169 because they satisfied the specific qualifications of MCL 600.2912(a)-(b)." 490 Mich at 961.

The manner in which the *Jilek* Court resolved the question of expert qualification does not appear to be completely consistent with *Woodard* or with *Reeves*, which tied the most relevant specialty to the actual specialty that the defendant was engaged in at the time of the malpractice, even when the defendant was not himself certified in that specialty.

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encompassing subspecialties and certificates of added qualifications. These false equivalencies have no basis in the plain language of MCL 600.2169(1). Rather, this Court should enforce the text of the statute as written and hold that board certification means exactly and singularly that. Plaintiff submits that this Court should adopt the definition of "board certified" found in the Public Health Code, MCL 333.2701(a), defining "board certified" as "certified to practice in a particular medical specialty by a national board recognized by the American Board of Medical Specialties or the American Osteopathic Association". The *Woodard* Court considered this definition, along with the slightly broader definition of "board certified" found in the Insurance Code (then at MCL 500.2212a(4), now at MCL 500.2212a(5)) before eschewing both in favor of its own, far more expansive definition.[7] *Woodard,* 475 Mich at 563-565. Plaintiff advocates for the adoption of a definition actually endorsed by the Legislature, albeit in different statutes, rather than one created by the judicial branch.

The "one most relevant specialty" test, which also has no basis in the text of the statute, should be replaced with a test that acknowledges there may be more than one relevant specialty for purposes of testifying on the appropriate standard of care. Restricting the meaning of "specialty" to its plain meaning and excluding subspecialties and certificates of added qualification will go far toward remedying the problems of *Woodard*'s "one most relevant specialty" test. Nevertheless, there will be situations where there is such significant overlap in the practice of medicine that a defendant's negligence may equally implicate multiple specialties. In those cases,

7 The Insurance Code's definition of board certified remains slightly broader than the Public Health Codes. MCL 500.2212a(5) defines "board certified" as "certified to practice in a particular medical or other health professional specialty by the American Board of Medical Specialties, the American Osteopathic Association Bureau of Osteopathic Specialists, *or another appropriate national health professional organization*." (emphasis added)

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it may be necessary for the trial court to make further assessment of an expert's qualifications pursuant to MCL 600.2169(2) and (3) or MRE 702. That a proposed expert may be disqualified under some other provision of the statute or other evidentiary mechanism does not militate his disqualification under MCL 600.2169(1).

IV. THE PROFESSIONAL TIME TEST UNDER MCL 600.2169(1)(b)

Just as *Woodard*'s "one most relevant" test should not be retained, neither should its interpretation of "majority of...professional time". The word "specialty" as used in MCL 600.2169(1) should be interpreted to exclude subspecialties, with the acknowledgment that when a physician is practicing a subspecialty, he is necessarily practicing the overarching specialty. By conflating subspecialties with specialties and then decreeing that a physician can only practice one discipline at a time, *Woodard* and *Kiefer* force potential experts to quantify their professional time as percentages that are simply incompatible with the actual practice of medicine. This requirement is also incompatible with the plain text of the statute, which recognizes that one can devote "a majority" of one's professional time to more than one profession – "either or both" the active clinical practice of medicine or the instruction of students. If the statute permits a proposed expert to devote a majority of his time to more than one profession – either or both active clinical practice and instruction – it permits a physician to devote a majority of his time to more than one specialty.

Because they are inconsistent with the requirements of MCL 600.2169(1), *Woodard* and its central holdings, namely the "one most relevant specialty" and the "majority of professional time" tests, should not be retained. Instead, they should be replaced with tests that are faithful to the text of MCL 600.2169(1).

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V. UNDER THE PROPER APPLICATION OF MCL 600.2169, THE COURT OF APPEALS DID NOT REACH THE RIGHT RESULT IN THIS CASE

When MCL 600.2169(1) is properly applied, the Court of Appeals clearly did not reach the right result in this case. Dr. Colton and Plaintiff's expert Dr. Armstrong are mirror images of one another – identically board certified in Otolaryngology-Head and Neck Surgery (by the American Board of Otolaryngology-Head and Neck Surgery) and Facial Plastic and Reconstructive Surgery (by the American Board of Facial Plastic and Reconstructive Surgery).[8] The Court of Appeals correctly noted "it is undisputed that, as required by MCL 600.2169(1)(a), Dr. Armstrong's qualifications 'match' Dr. Coltron's (sic) qualifications." **Appendix 292a** Where the Court of Appeals erred was in its analysis of "the one most relevant specialty" and "the majority of professional time" requirements. The panel's analysis was grounded not in the text of MCL 600.2169(1), but in the flawed *Woodard* interpretation of the statute.

The panel concluded "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" and "the trial court correctly determined that facial plastic and reconstructive surgery is the most relevant specialty".[9] **Appendix 291a, Appendix 295a** The Court of Appeals further stated in Footnote 4 of its opinion that "although Selliman disputes

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8 Unlike many of the cases germane to these discussions, which concern specialties and subspecialties of ABMS boards, this case concerns two distinct board certifications from different entities. The American Board of Otolaryngology-Head and Neck Surgery is an ABMS board; The American Board of Facial Plastic and Reconstructive Surgery is not.

9 Plaintiff maintains that the trial court did not explicitly rule facial plastic and reconstructive surgery was the one most relevant specialty. See **Appendix 278a** To the extent it implicitly did so, the determination was based on Defendants' self-serving Affidavit, which was attached not to the principle Motion, to which Plaintiff could respond, but the Reply, to which Plaintiff could not, other than at oral argument. MCR 2.116(G)(1)(a)(iv).

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Defendants' contention that facial plastic and reconstructive surgery is the one most relevant specialty, he provides no substantive argument in support of that assertion." **Appendix 295a** This is clearly error, as Plaintiff provided substantive argument in support of his assertion in his Response to the motion, in his Motion to Amend Witness List, filed after receipt of Defendants' Reply, and at oral argument on both motions. At every opportunity, Plaintiff has disputed facial plastic and reconstructive surgery is the "one most relevant" specialty.

In finding that facial plastic and reconstructive surgery is the "one most relevant" specialty, the Court of Appeals accepted Defendants' argument, made without any actual support, that the determinant of the relevant specialty is whether the rhinoplasty is for "cosmetic" or "functional" reasons. Such a subjective determination is not addressed, let alone required, by *Woodard* (and certainly not by the statute). The conclusion reached by the Court of Appeals is based solely on Dr. Colton's self-serving Affidavit, wherein he announces his treatment of Plaintiff involved only facial plastic and reconstructive surgery, a position directly contradicted by Defendants' own expert's Affidavit of Meritorious Defense. **Appendix 24a; Appendix 228a**

Simply stated, under the plain language of MCL 600.2169(1) and without the edict of the "one most relevant" specialty test announced in *Woodard,* either or both otolaryngology and facial plastic and reconstructive surgery are the relevant specialty for purposes of standard of care testimony in this case. The alleged malpractice of Dr. Colton arose from his performance of repeated rhinoplasties, procedures which can be performed by either facial plastic surgeons or otolaryngologists and for either cosmetic or functional reasons. Because either or both specialties are relevant, and because Dr. Colton and Dr. Armstrong are identically board certified in both specialties, the relevant specialty and board certification requirements of MCL 600.2169(1)(a) are satisfied.

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Concerning the "majority of professional time" requirement, the Court of Appeals concluded that "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." **Appendix 294a** When measured against other, albeit unpublished rulings, the Court of Appeals gave no deference to the trial court's decision in this case, as it was required to do. "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 & 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*.

In recent years, the Court of Appeals and this Court have reaffirmed the wide discretion afforded to trial courts in interpreting a proposed expert's deposition testimony regarding the active clinical practice requirement, even where the trial court's interpretation appears to directly contradict the expert's actual testimony. In *Turkish v William Beaumont Hospital,* Docket No. 339522, rel'd December 13, 2018 (unpublished), the Court of Appeals affirmed a trial court's decision to allow standard-of-care testimony against an orthopedic surgeon practicing orthopedic surgery at the time of the malpractice by a board-certified orthopedic surgeon with fellowship training in sports medicine who testified to practicing the subspecialty of sports medicine. **Appendix 22** 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

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potential overlapping medical conditions and treatment options. *14-15 This Court subsequently denied leave to appeal. 504 Mich 963; 932 NW2d 783 (2019).

Previously, in *In Re Estate of Roberdeaux,* Docket No. 323802, rel'd October 18, 2016 (unpublished), 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. **Appendix 18** 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 Court of Appeals found that "the trial court could have found that [the expert] spent the majority of his time practicing internal medicine in the year preceding the alleged malpractice." *25 This Court subsequently denied leave to appeal, over the dissenting opinion of Justice Markman, who opined that the expert's testimony that he practiced geriatrics, and not internal medicine, plainly disqualified him from testifying against a general internist. 500 Mich 1025; 897 NW2d 164 (2017).

When measured against these rulings, it is clear the Court of Appeals gave no deference to the trial court's decision in this case. Dr. Armstrong's testimony was far less problematic than that at issue in *Turkish* and *Roberdeaux.* When ruling on the Motion to Strike Dr. Armstrong and for Summary Disposition, the trial court stated that "there were multiple questions with multiple answers" and "seemingly contradictory statements" on the subject of Dr. Armstrong's practice such that "the Court cannot determine at this time whether Dr. Armstrong is qualified or not". **Appendix 21a; Appendix 277a** The trial court's ruling reflects a reasonable and principled

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outcome under the circumstances. Thus, the Court of Appeals erred in ruling that the trial court abused its discretion in denying the motion to strike Dr. Armstrong's testimony.

At his deposition, Dr. Armstrong gave arguably unclear and confusing testimony when questioned about the division of his clinical practice between otolaryngology and facial plastic and reconstructive surgery, instead seeming to offer a division of his practice of rhinoplasty amongst the two disciplines. **Appendix 60a-61a** What is clear, however, from both his testimony and his Affidavit of Merit, is that during the one year prior to the malpractice alleged in this case, Dr. Armstrong devoted the majority of his professional time to the active clinical practice of Otolaryngology and Facial Plastic and Reconstructive Surgery. **Appendix 19a** Because there is significant overlap between the specialties and it is within the purview of both to perform the procedure giving rise to the malpractice, Dr. Colton and Dr. Armstrong practice as both otolaryngologists and facial plastic and reconstructive surgeons when performing rhinoplasty. Therefore, regardless of whether 90 percent of Dr. Armstrong's practice is devoted to otolaryngology and 10 percent to facial plastic and reconstructive surgery or whether within his facial plastic and reconstructive practice, 90 percent of his procedures are for functional purposes and 10 percent are cosmetic, 100 percent of Dr. Armstrong's practice is devoted to the relevant specialties of otolaryngology and facial plastic and reconstructive surgery. Thus, Dr. Armstrong clearly satisfies the majority of professional time requirement of MCL 600.2169(1)(b).

Applying only the plain language of MCL 600.2169(1), rather than the flawed, judicially created precepts of *Woodard,* the Court of Appeals clearly did not reach the right result in this case. Plaintiff's proposed expert is a mirror image of both Defendant and his retained expert. These three identically board certified physicians practice the same medicine and perform the same procedures, including the procedure giving rise to the alleged malpractice. The only difference, if

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one exists, is how they divide their professional time amongst two equally relevant and interrelated specialties – an arbitrary, illogical, and legal exercise divorced from the actual practice of medicine. Under the edicts of *Woodard,* Plaintiff's proposed expert has been determined by the Court of Appeals to be unqualified to give expert testimony on the standard of care required for a procedure he has performed over 400 times in the course of his career. Such a ridiculous result cannot possibly have been the intention of the Michigan Legislature in enacting MCL 600.2169(1).

CONCLUSION AND RELIEF REQUESTED

Beginning with *Woodard,* MCL 600.2169(1) has been so bastardized by judicially created precepts that the current state of the law permits disqualification of an expert who holds the same board certifications, practices the same medicine, and performs the same procedure as the defendant, as is the case here. Such an absurd result is at odds with the express intentions of the Michigan Legislature in enacting the statute. This Court should take this opportunity to overrule *Woodard*, which is poorly reasoned and wrongly decided. In doing so, this Court should clarify the proper interpretation and application of MCL 600.2169(1), remaining faithful to the text of the statute as written.

For all of the reasons contained in this Brief on Appeal, Plaintiff respectfully requests that this Court overrule *Woodard,* reverse the May 20, 2021 opinion of the Court of Appeals, which is clearly erroneous under the proper application of MCL 600.2169(1), and remand this matter to the Oakland County Circuit Court for further proceedings.

Dated: February 16, 2023

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies that Plaintiff-Appellant's Brief on Appeal complies with the type-volume limitations set forth in MCR 7.212(B). This brief uses a 12-point proportional font (Times New Roman), has at least one-inch page margins, and its text is double-spaced, except for quotations and footnotes, which are single-spaced. The number of countable words 10, 826. I am relying on the word count of Microsoft Word, the word-processing system used to produce this document.

Dated: February 16, 2023

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on February 16, 2023, she served a copy of Plaintiff-Appellant's Brief on Appeal, Plaintiff-Appellant's Appendix, and this Certificate of Service upon counsel of record as disclosed below:

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