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STATE OF MICHIGAN

IN THE SUPREME COURT

ANTONIO SELLIMAN,

Plaintiff-Appellant,

v

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

Defendants-Appellees.

SC No. 163226
COA No. 352781
LC No. 18-167068-NH
(Oakland Circuit Court)

DEFENDANTS-APPELLEES' BRIEF ON APPEAL

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

APPELLEES' APPENDIX

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COUNTER-STATEMENT OF APPELLATE JURISDICTION

Plaintiff-Appellant Antonio Selliman ("Plaintiff") correctly states that this Court has jurisdiction over his appeal by virtue of the Court's December 22, 2022, Order granting Plaintiff's application for leave to appeal.

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COUNTER-STATEMENT OF QUESTIONS PRESENTED

I.

WHETHER *WOODARD V CUSTER,* 476 MICH 545 (2006), WAS CORRECTLY DECIDED AND IS CONSISTENT WITH THE REQUIREMENTS OF MCL 600.2169(1)?

Plaintiff-Appellant answers "no."

Defendants-Appellees answer "yes."

II.

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, WHAT TEST SHOULD BE APPLIED?

Plaintiff-Appellant proposes that "specialty" as used in MCL 600.2169(1) should be interpreted to exclude subspecialties and certificates of added qualification.

Defendants-Appellees answer: a test that requires the expert to possess the one most relevant specialty the party possesses.

III.

IF *WOODARD'S* INTERPRETATION OF "MAJORITY OF . . . PROFESSIONAL TIME" IS NOT CONSISTENT WITH MCL 600.2169(1) AND SHOULD NOT BE RETAINED, WHAT IS THE CORRECT INTERPRETATION?

Plaintiff-Appellant suggests that a proposed expert can "devote a majority of his time to more than one specialty." (P's brief, p 27)

Defendants-Appellees answer: to interpret "majority" to include plurality.

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IV.

ASSUMING *WOODARD* WAS NOT CORRECTLY DECIDED, WHETHER IT SHOULD NONETHELESS BE RETAINED UNDER PRINCIPLES OF STARE DECISIS?

Plaintiff-Appellant answers "no."

Defendants-Appellees answer "yes."

V.

WHETHER THE COURT OF APPEALS REACHED THE RIGHT RESULT UNDER THE PROPER APPLICATION OF THE REQUIREMENTS OF MCL 600.2169 IN THIS CASE?

Plaintiff-Appellant answers "no."

Defendants-Appellees answer "yes."

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COUNTER-STATEMENT OF MATERIAL FACTS AND PROCEEDINGS

A. Introduction

This action alleges malpractice by Defendant Jeffrey J. Colton ("Dr. Colton") in conjunction with his decision to perform, and performance of, a series of rhinoplasty procedures on plaintiff for cosmetic purposes. The trial court refused to strike Plaintiff's standard-of-care expert, Dr. Armstrong, despite his concession that during the relevant timeframe he devoted only 10% of his active clinical practice to facial plastic and reconstructive surgery; he devoted 90% of his practice to the undisputedly different specialty of otolaryngology (also referred to as "ENT"). The Court of Appeals correctly recognized that the trial court reversibly erred, that because of the undisputed fact that Dr. Armstrong did not devote a majority of his time to facial plastic and reconstructive surgery—the specialty in which Dr. Colton was engaged when the alleged malpractice occurred—he is not permitted to provide expert standard-of-care testimony under MCL 600.2169(1)(b).

Despite conceding that facial plastic and reconstructive surgery and ENT are two distinct specialties, each of which has its own independent board certification, Plaintiff argues that Dr. Armstrong should have been permitted to testify. Plaintiff argues that because the two specialties are related and can involve similar activity, including performance of rhinoplasties, the Court's interpretation of MCL 600.2169(1) in *Woodard v Custer,* 476 Mich 545; 719 NW2d 842 (2006) is incorrect insofar as it precludes Dr. Armstrong from testifying in this case.

Plaintiff's argument is a criticism, not of *Woodard*, but of MCL 600.2169(1). More specifically, Plaintiff's argument is essentially that the Michigan Legislature should not have

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amended MCL 600.2169 to require an expert to devote a "majority" of his or her professional time to "that specialty" in which the defendant was engaged at the time of the malpractice. Instead, Plaintiff essentially argues that the Legislature should have left in place the previous version, which allowed an expert to testify so long as he or she devotes "a substantial portion of his or her professional time" to the practice or the instruction "in the same specialty or a related, relevant area" as the defendant.

This Court's decision in *Woodard* correctly interpreted the statute as amended. Indeed, the correctness of *Woodard* is shown by Plaintiff's inability to proffer a better interpretation of the statute, whether the focus is on the "one most relevant specialty" test or on the "majority of . . . professional time" test.

Furthermore, Plaintiff's criticisms of MCL 600.2169(1) as amended, couched as criticisms of *Woodard,* suggest modifications that would make no difference in this case. For example, Plaintiff argues vigorously that *Woodard* erred in concluding that a subspecialty is not a "specialty," and in its interpretation of the phrase "board certified." But even if the Court were to accept Plaintiff's arguments on both fronts, it would make no difference in this case. That is because Dr. Colton and Dr. Armstrong specialize in two different specialties—not a specialty and a subspecialty within it—regardless of how "board certified" is interpreted.

Woodard's interpretation of the statute not only is correct, it has represented entrenched Michigan law for nearly two decades. *Woodard* has been cited more than a thousand times, including in more than 400 decisions. To say that *Woodard* has become embedded Michigan law that has engendered reliance interests would be an understatement. Thus, even if *Woodard* had been incorrectly decided and there were

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better tests for applying the statute than those adopted in *Woodard,* stare decisis considerations counsel heavily against changing the law.

Finally, the Court of Appeals correctly applied *Woodard* and MCL 600.2169 in this case. Consequently, and for the reasons that follow, this Court should affirm the Court of Appeals decision or withdraw its grant of leave as improvidently granted in this case.

B. Material facts

1. Plaintiff's allegations.

According to the complaint, this case arises out of treatment designed to re-shape Plaintiff's nose by Dr. Colton, which began in 2012. (Complaint at **Appellant's Apx 0011a**, ¶ 9). The complaint alleges that Dr. Colton performed a fourth surgery on Plaintiff on January 12, 2016, after another doctor had performed three earlier surgeries that left Plaintiff displeased with his appearance. (*Id.,* ¶ 11). The goal of the procedure was to 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. (*Id.*).

Plaintiff alleges that, on or about February 5, 2015, Dr. Colton administered seven steroid injections into the area surrounding Plaintiff's nose in an attempt to minimize the nasal deformity that resulted from the January rhinoplasty. (Complaint, **Appellant's Apx 0011a**, second ¶ 11 (sic)). He also alleges that, on or about March 1, 2016, Dr. Colton administered an additional six steroid injections, again in an attempt to minimize the nasal deformity from the January rhinoplasty. (*Id.,* ¶ 12). During that visit, Dr. Colton also allegedly promised that another surgery would be appropriate to narrow and lower Plaintiff's nose. (*Id.,* ¶ 13).

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Plaintiff alleges that he underwent a fifth, then a sixth, then a seventh rhinoplasty between June 16, 2016, and November 2017 in an attempt to narrow and lower his nose. (Complaint, **Appellant's Apx. 0012a**, ¶¶ 14-16). Also in November, Dr. Colton allegedly recommended an eighth surgery in conjunction with additional steroid injunctions to remedy the deformity, but that was not done. (*Id.,* ¶¶ 17-18).

Plaintiff alleges that "[t]he 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." (*Id.,* ¶ 19).

2. Qualifications of Dr. Colton and Dr. Armstrong

Dr. Colton possesses board certifications in both otolaryngology and facial plastic and reconstructive surgery. (**Appellant's Apx 0228a**, ¶¶ 3-4). Dr. Armstrong is also board certified in both specialties. (**Appellant's Apx 0058a-0059a**, dep. of Michael Armstrong, Jr., 9/24/2019, pp. 30-31). As Dr. Armstrong acknowledged, the board certifications are issued by different organizations: otolaryngology by the American Board of American Otolaryngology; facial plastic and reconstructive surgery by the American Board of Facial Plastic Reconstructive Surgery. (*Id.*).

3. Dr. Armstrong's deposition testimony

Dr. Armstrong's deposition was taken on September 24, 2019. (**Appellant's Apx 0029a**, p. 1). Dr. Armstrong acknowledged that his deposition had been taken "many times before" and agreed to advise counsel if he did not understand a question during his deposition. (*Id.* at 6). Discussing the measurements taken of Plaintiff's nose, Dr. Armstrong acknowledged that "the appearance of beauty is an art that is understood by practicing

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surgeons and doesn't always require geometric measures." (*Id.* at 15, **Appellant's Apx 0043a**). He acknowledged literature supporting his opinion, including Textbook of Facial Plastic Surgery[1] (*Id.* at 16, **Appellant's Apx 0044a**) and reviewed textbooks in facial plastic and plastic surgery for purposes of providing illustrations that could be helpful. (*Id.* at 17-18, **Appellant's Apx 0045a-0046a**).

Dr. Armstrong acknowledged no evidence that Mr. Selliman ever suffered from respiratory suppression, heart complication, aspiration of any foods or liquids, and acknowledged that the only medical complication allegedly resulting from Dr. Colton's surgery was Mr. Selliman's nose. (*Id.* at 24-25, **Appellant's Apx 0052a-0053a**).

After being asked of his board certifications and the certifying organizations (*id.* at 30-31, **Appellant's Apx 0058a-0059a**), Dr. Armstrong was asked to give an approximation of the percentage of his professional time devoted to ENT (general ENT), "[a]s opposed to facial plastic and reconstructive surgery." (*Id.* at 32, **Appellant's Apx 0060a**). He responded:

> 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 the practice might be 10 percent cosmetic, 90 percent functional; but rhinoplasty is one of the more common procedures that I do.

(*Id.* at 32-33, **Appellant's Apx 0060a-0061a**).

[1] Dr. Armstrong also acknowledged consulting other textbooks in the area of facial plastic and reconstructive surgery, including Rees, *Rhinoplasty Problems and Controversies* (*Id.* p. 27, **Appellant's Apx 0055a**), Sheen, *Anesthetic Rhinoplasty* (*id.* at 27, **Appellant's Apx 0055a**), Volume II, Chapter 29, *Reconstructive Plastic Surgery and Corrective and Reconstructive Surgery of the Nose* (*id.* at 27, **Appellant's Apx 0055a**), and Papel and Nachlas, *Facial Plastic and Reconstructive Surgery* (*id.* at 28, **Appellant's Apx 0056a**).

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Dr. Armstrong then stated that rhinoplasty falls within either his cosmetic practice or as functional nasal practice ("They're not all cosmetic") (*Id.* at 32-33, **Appellant's Apx 0060a-0061a**), which lead to his more detailed testimony regarding the breakdown of his practices between the specialties of otolaryngology and facial plastic and reconstructive surgery:

> 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.

(*Id.* at 33, **Appellant's Apx 0061a** (emphasis added)). After confirming that less than one hour a day (5% of his practice) of his professional time is devoted to administrative duties, Dr. Armstrong again confirmed the 90% vs. 10% division of his professional time between otolaryngology versus facial plastic and reconstructive surgery:

> 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.

(*Id.* at 34, **Appellant's Apx 0062a** (emphasis added)).

Dr. Armstrong was then asked about the number of rhinoplasties he performed, of which he was unable to give a breakdown between cosmetic and reconstructive

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rhinoplasties. (*Id.* at 34-35, **Appellant's Apx 0062a-0063a**). Then, *for the third time*, Dr. Armstrong confirmed the 90% vs 10% breakdown previously discussed, this time dating back to 2013-2014:

> 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.

(*Id.* at 39, **Appellant's Apx 0067a** (emphasis added)).

Dr. Armstrong also confirmed that Mr. Selliman's surgery was not to "fix some medical condition" but rather to have it "look a certain way." Specifically, Dr. Armstrong acknowledged expressly that the purpose of Plaintiff's procedure was cosmetic in nature, rather than to correct some "medical condition:"

> 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.

(*Id.* at 122, **Appellant's Apx 0150a**).

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C. Material proceedings

Plaintiff's complaint is dated July 16, 2018. (Complaint, p. 1, **Appellant's Apx 0010a**). Dr. Armstrong's deposition was taken more than a year later, on September 24, 2019. (Deposition, p. 1, **Appellant's Apx 0029a**). Discovery closed on October 9, 2019.

1. The trial court's ruling on the motion to strike

On October 16, 2019, Defendants filed their Motion to Strike Michael J. Armstrong, M.D. and for Summary Disposition Pursuant to MCR 2.116(C)(7). (**Appellant's Apx 0187a-0204a**). On November 15, 2019, Plaintiff filed his response. (**Appellant's Apx 0206a-0219a**). On November 25, 2019, Defendants filed their reply brief. (**Appellant's Apx 0221a-0226a**). The trial court heard oral argument on January 29, 2020, at which time it rejected Defendants' argument, reflected in the January 29, 2020, Order Denying Without Prejudice Defendants' Motion to Strike Dr. Armstrong. (**Appellant's Apx 0286a**).[2]

The trial court found that Dr. Armstrong's testimony was "seemingly contradictory" on whether 90% of his practice was devoted to otolaryngology and 10% of his practice devoted to facial, plastic, and reconstructive surgery, or whether, within his facial, plastic, and reconstructive surgery practice, 10% of the procedures or for cosmetic purposes with 90% of the procedures "being more functional." (Tr. 1/29/2020, pages 28-29, **Appellant's Apx 0277a-0278a**). Finding the deposition testimony to be ambiguous, the trial court denied without prejudice the motion to strike Dr. Armstrong.

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[2] Defendants also moved for summary disposition on the basis of expiration of the statute of limitations. The trial court granted in part that motion with respect to dates of treatment prior to and including January 12, 2016. (**Appellant's Apx 0286a**). The "denial in part" portion of that motion was not part of Defendants' application, but rather is preserved for appellate review at the end of all trial court proceedings.

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2. The grant of leave to appeal and the Court of Appeals Opinion

Defendants applied for leave to appeal, Plaintiff opposed, and the Court of Appeals granted leave through an order dated May 27, 2020 (**Appellant's Apx 0288a**). In its May 20, 2021, per curium opinion, the Court of Appeals reversed and remanded for further proceedings upon determining that Dr. Armstrong's deposition testimony established the lack of the requisite active clinical practice majority requirement of § 2169(1)(b)(ii).

Citing to the three times that Dr. Armstrong testified regarding the percentage of his professional time between facial plastic and reconstructive surgery and ENT, Opinion, pp 4-6 (**Appellant's Apx 0293a-0295a**), the Court of Appeals determined that the trial court erred by categorizing the testimony as equivocal and limited to the proportionality of functional versus cosmetic rhinoplasties. "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 relating to the proportionality of the whole of Dr. Armstrong's practice – ENT versus facial plastic and reconstructive surgery." Opinion, p 5 (**Appellant's Apx 0294a**). The Court of Appeals further opined that Dr. Armstrong "understood and used the term 'functional' to equate his ENT practice, while his facial plastic and reconstructive surgery practice was for cosmetic services." *Id*. at 5 (footnote omitted) (**Appellant's Apx 0294a**).

The Court of Appeals also rejected Plaintiff's position that Dr. Armstrong's testimony established that the rhinoplasties were performed for both cosmetic reasons (falling within facial plastic and reconstructive surgery) and to address a medical condition (ENT). In fact, the very first question asked on re cross-examination of Dr. Armstrong established that the purpose of the surgery was cosmetic, thus defeating the factual

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predicate for Plaintiff's argument that overlapping specialties count toward the active clinical practice majority requirement. (Armstrong deposition transcript, p 122, **Appellant's Apx 0150a**).

Upon finding that Plaintiff did not contest that the one most relevant specialty was facial plastic and reconstructive surgery, but only argued that professional time in yet another specialty counts towards the majority requirement, the Court of Appeals found the "majority" requirement unsatisfied:

> [T]he trial court correctly determined that facial plastic and reconstructive surgery is the most relevant specialty. 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.

Opinion, p 6 (footnote omitted), **Appellant's Apx 0295a**.

Having determined that all the procedures here were cosmetic in nature, and that the one most relevant specialty was facial plastic and reconstructive surgery, not ENT, the Court of Appeals found immaterial Plaintiff's overlapping specialties argument.

3. Plaintiff's application and proceedings in this Court

Plaintiff's Application to this Court followed. On April 27, 2022, this Court issued an Order directing the clerk to schedule oral argument on Plaintiff's application. The Court also ordered the parties to file supplemental briefs, which they did.

The Court heard oral argument on the application on December 8, 2022. On December 22, 2022, the Court issued its Order granting Plaintiff's application and directing the parties to include certain issues in their briefing.

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ARGUMENT I

WOODARD V CUSTER, 476 MICH 545 (2006), WAS CORRECTLY DECIDED AND IS CONSISTENT WITH THE REQUIREMENTS OF MCL 600.2169(1)

The Court's *Woodard* decision correctly interpreted MCL 600.2169(1), whether the focus is on the "one most relevant specialty" test or on the Court's interpretation of "majority of . . . professional time." The correctness of *Woodard* is especially apparent when comparing the version of the statute considered in *Woodard* with the version as it existed prior to the Legislature's amendments in 1993. Plaintiff's attacks on *Woodard* in this case are more properly characterized as attacks on the Legislature's decision to amend the statute than on *Woodard*'s interpretation of the statute. As such, they should be rejected, since it is not this Court's role to re-write legislation even if it believes a statute does not strike the right balance.

A. The "one most relevant specialty" test as articulated in *Woodard* is consistent with MCL 600.2169(1).

Woodard correctly interpreted MCL 600.2169(1). The one most relevant specialty test does nothing more than apply the plain, unambiguous language of the statute. That test is based on MCL 600.2169(1)(a), which provides in pertinent 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 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.

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MCL 600.2169(1).[3]

The statute unambiguously states that if the defendant is a specialist, an expert must specialize in the "same specialty" as the defendant. It does not say "same or similar specialty" or words to that effect. And it does not use the plural term "specialties." The use of the singular "specialty" makes it absolutely clear that the expert must specialize in the same *one* "specialt***y***" as the defendant.

Where the statute gives room for a difference of opinion is on whether the expert must match more than the one most relevant specialty—the specialty in which the defendant was engaged at the time of the alleged malpractice. That was the main source of disagreement between the lead opinion and Justice Taylor's concurring opinion in *Woodard*. The two main opinions in *Woodard* differed on whether *all* relevant specialties possessed by the defendant doctor must be matched by expert testimony. The concurring opinion expressed the view that when more than one specialty is deemed relevant by either party, the statute requires an expert to match all specialties put at issue. *Woodard,* 476 Mich at 614-617 (J. Taylor's concurring opinion). The concurring opinion recognized that the defendant doctor's specialties and board certifications could be addressed by different plaintiffs experts, but opined that *all* relevant specialties and certifications must be covered by plaintiff's experts. *Id.* at 617 (J. Taylor, concurring).[4]

---

[3] MCL 600.2169(1)(b), which sets forth the "majority of . . . time" requirement, also refers to time devoted to "that specialty" or the "same specialty" in which the party specialized. MCL 600.2169(1)(b)(*i*), (*ii*).

[4] The majority opinion opined that the concurring opinion, if adopted, would lead to substantial burden and inefficiency. As the lead opinion put it,

> Under the concurrence's approach, if the defendant physician specializes in five specialties, for example, and refuses to concede that not all of these

(cont'd next page)

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Plaintiff certainly does not suggest that Justice Taylor's concurring opinion in *Woodard* correctly interpreted § 2169(1). That concurring opinion, joined by Justices Young and Corrigan, did not take issue with the lead opinion's recognition of the one most relevant specialty test—at least not in the way that Plaintiff complains about in this case. That concurring opinion agreed that "the practice and teaching requirements in MCL 1600.2169(1)(b) preclude any expert providing testimony regarding more than one specialty area." *Woodard,* 476 Mich at 592 (J. Taylor, concurring).

Indeed, not one of the Court's seven Justices disagreed that the statute as amended requires a plaintiff's expert, at a minimum, to specialize in the one most relevant specialty, namely the specialty in which the defendant doctor was engaged at the time of the alleged malpractice.

Plaintiff's criticism of the "one most relevant specialty" test appears to be grounded in the fact that there can be more than one relevant specialty because different types of specialists can share similar, or even the same, areas of expertise. Plaintiff argues that "the reality of modern medicine is that multiple different specialties may perform the same procedures; this does not change the standard of care." (Plaintiff's Brief, p 17). This argument reveals that the real target of Plaintiff's criticism is not *Woodard,* but the statute. It was the Legislature, not this Court, that amended the statute to require an expert to specialize in the "same specialty" as the defendant. Plaintiff's, or even a court's, perception

---

> specialties are relevant to the alleged malpractice, the plaintiff would be required to present five expert witnesses to testify. Not only would this be extraordinarily burdensome for the plaintiff, it would also be extraordinarily burdensome for the trier of fact by infecting the entirety of the trial process with irrelevant, distracting, and confusing arguments.

Woodard, 476 Mich at 568.

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of what the "reality of modern medicine" should allow by way of an expert's qualifications is not a basis for this Court to interpret a statute to say something other than what it says.

Plaintiff also criticizes *Woodard* for "conclud[ing] that there can be only a singular relevant specialty." (Plaintiff's Brief, p 17). *Woodard* did *not* conclude that there can be only a singular relevant specialty; it concluded that there can be only a single *most* relevant specialty, which is axiomatic. And that conclusion is required by the statute's use of the singular "that specialty" in MCL 600.2169(1)(a) and (b)(i) and (ii). Plaintiff's brief also states, "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." (Plaintiff's Brief, p 17). That is just plain wrong. The statute absolutely, unequivocally does "contemplate" only one specialty may be relevant. Indeed, it does not merely "contemplate" that; it says it in black and white. The only viable alternative in terms of interpreting the statute is to opine that all relevant specialties must be matched by experts, as Justice Taylor's concurring opinion did.

That Plaintiff's argument is a criticism not of *Woodard* but of the Legislature's decision to amend the statute is laid bare by comparing the amended version with the pre-amendment version of the statute. Indeed, the correctness of the one most relevant specialty test as pronounced in *Woodard* is particularly apparent when comparing the then (and still) current version of MCL 600.2169 with the pre-amended version of the statute. Prior to the Legislature's amendment of the statute in 1993, MCL 600.2169 stated in pertinent part:

> (1) In an action alleging medical malpractice, if the defendant is a specialist, a person shall not give expert testimony on the appropriate standard of care unless the person . . .

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> (a) Specializes, or specialized at the time of the occurrence which is the basis for the action, in the same specialty ***or a related, relevant area of medicine*** or osteopathic medicine and surgery . . . as the specialist who is a defendant in the medical malpractice action.
>
> (b) Devotes, or devoted at the time of the occurrence which is the basis for the action, a substantial portion of his or her professional time to the active clinical practice of medicine . . . or to the instruction of students in an accredited medical school . . . in the same specialty ***or a related, relevant area of healthcare*** as the specialist who is the defendant in the medical malpractice action.

MCL 600.2169 (pre-1993 amendment) (emphasis added).

Thus, the Legislature amended the statute in 1993 specifically to replace the phrase "the same specialty or a related, relevant area of healthcare" with the requirement that the expert be a specialist in "that specialty"—meaning the specialty pertaining to "the appropriate standard of practice or care," i.e., the specialty in which the defendant doctor was engaged when the alleged malpractice was committed.[5]

It is hard to imagine how the Legislature could have been clearer in requiring that the expert specialize in the *same exact* specialty (as opposed to "the same specialty or a related, relevant area of healthcare") as the defendant. It is as if the Legislature specifically envisioned and rejected the very criticisms that are being lodged in this case.

B. *Woodard*'s interpretation of "majority of . . . professional time" is consistent with MCL 600.2169(1).

1. *Woodard* correctly interpreted the statutory text.

Woodard correctly interpreted the "majority of . . . professional time" provision in MCL 600.2169(1)(b). In particular, *Woodard* correctly construed the requirement that the

[5] Another aspect of the amendment pertains to the "majority . . . of professional time" issue and is discussed below.

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expert must have devoted a "majority"—meaning most—of his or her professional time within the relevant timeframe to the same "specialty" in which the defendant doctor was licensed and engaged when the alleged malpractice was committed. This is especially apparent when the current version of the statute is contrasted with the pre-amended version, which allowed an expert to qualify so long as the expert devoted a "*substantial portion* of his or her professional time" (as opposed to a "majority") to "the same specialty or a related, relevant area" (as opposed to the same "specialty").

MCL 600.2169(1) provides in pertinent 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 person is licensed as a health professional in this state or another state and meets the following criteria:
>
> * * *
>
> (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) (emphasis added).

The Court in *Woodard* correctly recognized that the use of the word "majority," as well as the phrases "that specialty" in subsection (i) and "the same specialty" in subsection

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(ii), combine to mean that a specialist can only devote a majority of his or her professional time to one specialty. *Woodard*, 476 Mich at 559-560.

The Court also correctly recognized that the reference to "the *appropriate* standard of care" requires that the relevant standard of care in the context of a specialist must be the standard for the specialty in which the defendant doctor was engaged when the alleged malpractice was committed. *Id.* at 560. Combining these observations the Court explained, correctly:

> 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 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.

Id., at 560 (emphasis in original).

Notably, nothing in any of the concurring opinions in *Woodard* reflects disagreement by any Justice with the majority on the issue of the meaning of the "majority of his or her professional time" requirement. As noted earlier, Justice Taylor's main concurring opinion would have required a plaintiff's expert or experts to match all specialties placed at issue by either party. Not one Justice interpreted "majority" to mean half or less, as Plaintiff seems to urge this Court to do.

The correct interpretation of the word "majority" reached by *Woodard* was also discussed in *Kiefer v Markley*, 283 Mich App 555, 559; 769 NW2d 271 (2009), in which the plaintiff's expert devoted professional time to three different areas. The plaintiff argued

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that because the expert devoted 30% to 40% of his time in the relevant specialty, hand surgery, that constituted a "majority." The Court of Appeals disagreed. The court correctly recognized that the Legislature's use of the phrase "devoted a majority of his or her professional time" reflects a requirement that the expert spend more than 50% of his or her time in the most relevant specialty. The court did say that its holding was "not a result we think the Legislature intended." *Kiefer,* 283 Mich App at 560. But there is no suggestion in *Kiefer* that the court believed *Woodard* misinterpreted the statute. Quite to the contrary, *Kiefer* recognized that the language in § 2169(1)(b) "is unambiguous, and judicial construction is neither required nor permitted." *Id.* at 559. The court also added, "[t]o the extent the word 'majority' needs explanation, it is defined as, 'the greater part of larger number; more than half of a total.'" *Id.*, quoting Webster's New World Dictionary, 2d College ed (1980).

The correctness of *Woodard*'s interpretation of "majority of . . . professional time" is particularly apparent when comparing the then (and still) current version of MCL 600.2169 with the pre-amended version of the statute. Prior to the Legislature's amendment of the statute in 1993, MCL 600.2169 stated in pertinent part:

> (1) In an action alleging medical malpractice, if the defendant is a specialist, a person shall not give expert testimony on the appropriate standard of care unless the person . . .
>
> (b) Devotes, or devoted at the time of the occurrence which is the basis for the action, ***a substantial portion of his or her professional time*** to the active clinical practice of medicine . . . or to the instruction of students in an accredited medical school . . . in the same specialty or a related, relevant area of healthcare as the specialist who is the defendant in the medical malpractice action.

MCL 600.2169 (pre-1993 amendment) (emphasis added).

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Thus, the Legislature amended the statute in 1993 specifically to replace the requirement that an expert devote "a substantial portion of his or her professional time" with a requirement that the expert devote "a majority of his or her professional time" to "that specialty," meaning the specialty in which the defendant doctor was engaged when the alleged malpractice was committed.

As with the changes pertaining to the one most relevant specialty test, it is hard to imagine how the Legislature could have been clearer in requiring that the expert devote *most*, i.e., "a majority" (as opposed to a "substantial portion") of his or her professional time to the *same exact* specialty (as opposed to "the same specialty or a related, relevant area of healthcare") as the defendant. Again, it is as if the Legislature specifically envisioned and rejected the very criticisms that are being lodged in this case.

2. Plaintiff's criticisms of *Woodard*'s interpretation of the "majority of . . . professional time" language all lack merit.

Plaintiff's brief harshly criticizes *Woodard*'s interpretation of the phrase "a majority of his or her professional time," as "divorced from the statutory text . . . ." (Plaintiff's Brief, p 20). Plaintiff even claims *Woodard*'s interpretation of "majority" to mean more than 50% creates an "artificial division" that "obvious[ly]" "is not supported by the text of MCL 600.2169(1)." (Plaintiff's Brief, p 21). But the notion that the word "majority" "obviously" does *not* mean more than 50% is simply absurd. That is the common, ordinary meaning of that word. Indeed, what is "obvious" is that the Legislature intended that common, ordinary meaning, particularly given the nature of the amendments it made.

First, and without regard to the nature of the statutory amendments, Defendants respectfully submit that the notion that there can be multiple "majorities" in the context of the requirement that an expert "devoted a majority of his or her professional time to . . .

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that specialty" is wrong on its face. The term "majority" means more than 50% of the expert's professional time. Respectfully, to say that an expert can spend two or more majorities of his or her time engaging in different specialties is nonsensical.

Simply put, the seven Justices in *Woodard* and the majority in *Kiefer* correctly recognized that "majority" means more than half. They also correctly recognized that, under MCL 600.2169(1)(b), an expert cannot testify unless he or she devotes more than 50% of his or her professional time to the specialty at issue.

Plaintiff also argues that "[n]o language in the statute suggests that a doctor may only be engaged in the practice of one specialty or subspecialty at any given time." (Plaintiff's Brief, p 21). That may be true, but it is beside the point. Assuming arguendo a defendant doctor is engaged in multiple specialties at the time of the alleged malpractice, the statute still requires an expert to specialize in, and to have devoted a majority of his or her professional time to, the most relevant specialty. That, again, is required by the use of the singular "specialty" throughout the statute, and by the reference to "the appropriate standard of practice or care" in the first sentence of subsection (1).

Plaintiff also notes that the statute "recognizes one can devote a 'majority' of one's professional time to more than one profession," citing the provision that qualifies an expert who devotes a majority of professional time "to either or both" clinical practice or/and instruction. (Plaintiff's Brief, p 21). But that provision *undermines* Plaintiff's argument. It was of course possible for the Legislature to allow aggregation of either specialties or professions (practice versus instruction) for purposes of calculating how an expert must devote his or her professional time. The Legislature chose to allow aggregation only of the

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latter, not the former. The Legislature allowed aggregation of time spent either practicing or instruction. It did *not* allow aggregation of time devoted to multiple specialties.

Plaintiff summarizes his argument thusly:

> Just as the plain language of 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.

(Plaintiff's Brief, p 21). This argument has it exactly backward. The plain language of the statute permits a proposed expert to aggregate time spent both in practice and instruction. But it does *not* allow aggregation of time devoted to multiple specialties, even if they are related. If anything, the Legislature's decision to allow aggregation of professions while not allowing aggregation of specialties confirms the Legislature's intent *not* to permit what Plaintiff claims the Legislature implicitly permitted.

The Legislature's decision not to allow aggregation of specialties is also perfectly consistent with its amending the statute to substitute "same specialty" for "same specialty or a related, relevant area of medicine." If the Legislature had intended to allow an expert to aggregate related specialties for purposes of the "majority of . . . professional time" requirement, it could have done so very easily *by not making that change to the statute*.

Once again, as with so much of Plaintiff's argument, it is abundantly clear that Plaintiff's attack is aimed at the Legislature's decision to amend the statute, not *Woodard*'s interpretation of those amendments.

Plaintiff also cites a number of Court of Appeals decisions that included opinions criticizing *Woodard,* although Plaintiff makes no real argument that any of those opinions is correct. (Plaintiff's Brief, pp. 22 n 5, 25, n 6). In the event the Court nevertheless is inclined

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to search those opinions for grounds to pull back from *Woodard,* Defendants will address them.

For example, Plaintiff cites *Estate of LeBlanc v Agnone,* Docket No. 330330, 2017 WL 2908790 (July 6, 2017, Mich App), in which Judge Krause, dissenting, agreed with Judge O'Connell's dissent in *Kiefer* that "majority" does not necessarily mean more than 50%.[6] Judge Krause found significant the distinction between the phrase "a majority" and "the majority," and ultimately concluded "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." *LeBlanc* at *20 (J. Krause dissenting).

Plaintiff also cites *Johnson v Sultan,* Docket No. 292327, 2011 WL 476443 (Feb 10, 2011, Mich App). There, Judge Gleicher dissented from the court's holding that a neuroradiologist expert was not qualified to testify against a defendant practicing diagnostic radiology. Judge Gleicher acknowledged that the two disciplines are distinct

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[6] Judge O'Connell's dissenting opinion in *Kiefer* argued that "majority" could refer to "plurality," i.e., the largest percentage among multiple portions less than 50%. *Id.* at 564 (J. O'Connell, Dissenting). The majority in *Kiefer* correctly rejected that argument, reasoning as follows:

> [W]e do not agree with the dissent's rationale. Using the definition of "majority" advocated by our colleague, an expert could engage in 11 different areas of practice, but because the expert spent ten percent of his or her time in one area (greater than the amount of time spent in any other) he or she would qualify as an expert in that area. Although admittedly unlikely, this scenario demonstrates that defining "majority" as "an amount that represents the largest percentage of the whole, even if this amount is less than 50%," could result in expert opinions being rendered by underqualified individuals.

Kiefer, 283 Mich App at 560. This reasoning is correct, which likely explains why even Plaintiff has not seriously argued that "majority" actually means "plurality."

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from each other, but said, "I strongly disagree that any *meaningful* distinction between the two specialties exists in this case." *Johnson,* at *5 (emphasis in original). Judge Gleicher conceded that "[t]he Legislature incorporated in MCL 600.2169(b) [sic: (1)(b)] a 50% percent practice requirement as a second indicator of a proposed expert's familiarity with the standard of care." *Id.*, *8.[7] She opined that "[r]egardless whether the mathematical calculation applies to time spent in diagnostic radiology or neuroradiology, [the expert] board certifications and regular practice experience equip him with firsthand knowledge of the standard of care applicable to [the case]." *Id.* *8. Thus, Judge Gleicher criticized MCL 600.2169(1)(b), not *Woodard's* interpretation of it.

Plaintiff also cites *Strasser v Oakwood Heritage Hosp,* Docket No. 355496, 2021 WL 5145401 (November 4, 2021, Mich App). There, Judge Beckering, dissenting, argued that the difference between anesthesiologists and pain medicine physicians is one that involved "splitting of hairs" that "makes no sense" as applied to that case. *Id.* *13 (J. Beckering, dissenting). Again, that is not a criticism of the *Woodard* holding. It is a criticism of the legislation.

It is also important to point out that several criticisms of *Woodard* lodged by Court of Appeals Judges are simply inapplicable to this case. In her concurring opinion in *Higgins v Traill,* Docket No. 343664, 2019 WL 3433085 (July 30, 2019, Mich App), which Plaintiff also cites, Judge Gleicher identified three principles introduced in *Woodard* that she argued were incorrect. They are as follows:

> (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

[7] Actually, the Legislature incorporated a *more than* 50% requirement, as *Kiefer* recognized.

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> devote the majority of his or her professional time only to a single specialty.

Higgins *5 (J. Gleicher concurring). Judge Gleicher opined that all three propositions are incorrect. But the first two propositions are irrelevant in this case.

This case does not involve the context of a subspecialty versus a specialty. Plaintiff concedes that there are two specialties in this case. And, while Plaintiff argues that *Woodard* erred in concluding that a subspecialty is a specialty, he makes no suggestion that a contrary holding would make a difference in this case. It would not.[8]

The second criticism also is not relevant. This case does not involve the issue of whether "board certification" is satisfied by a certificate of added qualification or by a certification by some entity other than a leading organization. As Plaintiff concedes,

> Unlike many of the cases discussed herein, which concern specialties and subspecialties of the [American Board of Medical Specialties] boards, this case concerns two distinct board certifications from different entities.

(Plaintiff's Brief, p. 28, n 9).

In other words, if and to the extent this Court is critical of *Woodard's* holding that a subspecialty is a specialty, or its holding that "board certified" is not limited to certification by specific organizations, that is not a basis for reversal in this case.[9]

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[8] Plaintiff's citation to Judge Shapiro's dissenting opinion in *Estate of Perez v Henry Ford Health System,* Docket No. 340082, 2018 WL 6331343 (December 4, 2018, Mich App), is misplaced for the same reason. Judge Shapiro's dissent was based on his view that a subspecialist should be allowed to testify against a specialist, and that *Woodard*'s holding to the contrary is wrong.

[9] It should be noted that *Woodard* was unanimous on both of these (non)issues as well. Both the lead opinion and the concurring opinion agreed that a subspecialty is a specialty and that "board certified" is not limited to certification by specific organizations. See *Woodard*, 476 Mich at 611-613 (J. Taylor, concurring).

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The only one of Judge Gleicher's three criticisms of *Woodard* that has relevance to the instant case is the third one, namely her disagreement that a specialist can devote the majority of his or her professional time only to a single specialty. As set forth above, however, that is a criticism of the Legislation, not of *Woodard's* (unanimous) interpretation of it. And, indeed, analysis of Judge Gleicher's opinion in *Higgins* demonstrates that her argument on that point was simply a repackaging of her argument that a medical subspecialty is not a specialty. As Judge Gleicher put it, "The word 'specialty' should be construed to include specialties (more than one specialty), and to exclude subspecialties." *Higgins* *10 (J. Gleicher concurring). That statement fundamentally misreads the statute by arguing that "specialty" should include "specialties." And the argument that "specialty" should exclude subspecialties, whether correct or not, is irrelevant in this case, which does not involve subspecialties.

None of the other concurring opinions in which Court of Appeals Judges have expressed misgivings about *Woodard* or asked this Court to revisit it raises any issue that is materially different from the issues raised by Judges Gleicher and Shapiro (and Judges O'Connell and Krause, regarding the meaning of "majority," which is addressed above). Neither Plaintiff nor any appellate judge has set forth a persuasive argument why *Woodard* is inconsistent with the requirements of MCL 600.2169(1)—because it is not. That likely explains Plaintiff's desperate request that this Court find the test "logically inapplicable" to this case—a conclusion that, respectfully, this Court is not at liberty to draw given the Legislature's statement that MCL 600.2169(1) applies in any action alleging medical malpractice.

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The circumstances in which MCL 600.2169(1) is "applicable" are set forth in the clearest possible terms in the first sentence of the statute. It says "(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 . . . ." Contrary to Plaintiff's argument and that of some Court of Appeals judges, MCL 600.2169(1) *is* applicable in this case and cases like it because it is one alleging medical malpractice. Plaintiff's argument urging the Court not to apply a statute that quite clearly does apply is an argument that should be aimed at the Michigan Legislature, not this Court. In construing a statute, this Court has stressed that it "need not be sure of the precise reasons for a statutory judgment or be convinced of the wisdom of the legislation." *People v Harris*, 499 Mich 332, 357 n 55; 885 NW2d 832 (2016), *citing People v McIntire*, 461 Mich 147, 159; 599 NW2d 102 (1999).

Defendants nevertheless hasten to add that there ***are sound reasons*** for the amendments to § 2169(1) and the one most relevant specialty test required by that statute as amended. In fact, the Court need look no further than Plaintiff's quote from the Report of the Senate Select Committee on Civil Justice Reform (Plaintiff's Brief, p 13). As Plaintiff acknowledges, the goal of the reform was to make sure that experts will have "firsthand practical expertise" based on actually practicing in the practice area of the doctor about whom they will testify. (*Id.*).

Plaintiff simply trumpets his opinion that a doctor who devotes most of his time to ENT has a sufficiently similar background to a doctor who focuses on facial plastic and reconstructive surgery. But the Legislature thought differently, and the suggestion that the Legislature had no basis for its position is itself baseless.

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Furthermore, there is an eminently sound basis for the Legislature's judgment as applied in this case. Plaintiff's argument is essentially that there is no appreciable difference between an ENT and a facial plastic and reconstructive surgery specialist because both perform rhinoplasties. But Plaintiff's own theory of the case belies that argument. Plaintiff complaints not merely that a rhinoplasty was incorrectly performed. Plaintiff argues that the alleged malpractice encompassed several instances of heavy steroid injections and decisions to continue to perform additional rhinoplasties—a sixth, then a seventh, then an eighth—all designed to improve Plaintiff's appearance. (Complaint, ¶¶ 11-18). The propriety of this alleged course of treatment falls within the specialty of a facial plastic and reconstructive surgeon and does *not* fall within the specialty of an ENT. The mere fact that both specialists perform rhinoplasties is hardly grounds for declaring that a specialist of either type would be equally familiar with the standard of care as applied in this case.

Finally, even if there are circumstances in which the amended statute appears to work an inequity, surely there were such circumstances under the pre-amended version—which presumably is why the statute was amended, as Plaintiff concedes. The 1993 amendments to MCL 600.2169 reflect the Legislature's judgment call on an issue with competing arguments on both sides as to whether the pre- or post-amendment version strikes a better balance. There undoubtedly are circumstances in which the pre-amendment version could have been thought "logically inapplicable." That would not be a basis for a court, even this Court, to refuse to enforce the language of the statute. And it is not a basis to refuse to enforce the current version.

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C. Plaintiff's criticisms of *Woodard's* interpretation of "specialist" and "board certified" are both without merit and are irrelevant.

Plaintiff's criticisms of *Woodard*, as noted, are more properly characterized as criticisms of the Legislature's decision to amend MCL 600.2169 to tighten its requirements. But Plaintiff also lodges more specific criticisms that are both without merit and irrelevant, as discussed below.

1. A subspecialty is a specialty, and, regardless, Dr. Colton and Dr. Armstrong focused on different specialties.

Plaintiff criticizes the conclusion in *Woodard* that "a subspecialty, although a more particularized specialty, is nevertheless a specialty." (Plaintiff's Brief, p. 18, quoting *Woodard*, 476 Mich at 562). According to Plaintiff, this conclusion "plainly defies the text of the statute" and fails to effectuate the Legislature's intent. *Id.* But Plaintiff presents no real argument to support that bold assertion. He does nothing more than cite the American Board of Medical Specialties (ABMS), pointing out that, according to ABMS, there are 24 certifying medical specialty boards across which are 40 specialty and 88 subspecialty areas. (Plaintiff's Brief, p. 18, fn. 4).

Plaintiff's heavy reliance on the perspective of the ABMS only undermines his argument and underscores the correctness of *Woodard*. ABMS has spoken on this very issue; it filed an amicus brief in *Woodard* in which it emphasized that subspecialties *are* specialties. (ABMS's Amicus Brief at 2005 WL 3465389, filed herewith at **Appellees' Apx. 01b-07b**). As the ABMS put it, "The term 'board certified' applies equally to those physicians certified in a primary specialty and those who attain certification in one of the ABMS recognized subspecialties, because the requirements to obtain subspecialty recognition are as rigorous as the requirements for a primary certificate." (*Id.*, p. 3,

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Appellees' Apx. 03b). The ABMS also recognized, correctly, that "[w]hen the Legislature enacted the requirement that experts be 'board certified', it used a term that is synonymous with certification by an ABMS Member Board." (*Id.,* p. 5, **Appellees' Apx. 05b**). ABMS stressed that both "ABMS and its Member Boards recognize the importance and validity of both general certification and subspecialty certification because both general specialties and subspecialties represent a distinct body of knowledge, and certification for both requires extensive training and rigorous testing." (*Id.*, p. 5, **Appellees' Apx. 05b**).[10]

So important is this issue to ABMS that it adopted a Policy Statement on it, which it included in its amicus brief in *Woodard* and which states:

> Specialty certification in a subspecialty field is of significance for physicians preparing for careers in teaching, research, or practice restricted to that field. Such special certification is a recognition of exceptional expertise and experience . . . .

(*Id.*, p. 6, **Appellees' Apx. 06b**, quoting The Significance of Certification in Medical Specialties: A Policy Statement, Adopted by the AMS Assembly 9/18/75; Revised 9/23/93). In stark contrast to Plaintiff's assertion that "there is no reason to believe the Legislature thought" subspecialties constituted specialties, ABMS asserted that "[t]here is no justification for excluding subspecialties from this requirement." (*Id.*, p. 7, **Appellees' Apx. 07b**).

In fact, this Court, in concluding that a subspeciality is a specialty, cited ABMS's position in that regard. *Woodard,* 476 Mich at 562, n 6. The Court also recognized that ABMS is "the national certifying board by which 90% of all physicians are certified . . . " *Id.*.

[10] ABMS also included "certificates of special qualifications" among board certificates that it believed must be matched. *Id.*, p. 3, **Appellees' Apx. 03b.**

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This Court also recognized, correctly, that because the statute does not define the term "specialty," the Court was permitted to consult dictionary definitions—which it did and which supported the Court's conclusion that a subspecialty is a specialty. *Id.* at 561-562.

The main concurring opinion in *Woodard* did not disagree with the lead opinion's conclusion that a subspecialty is a specialty. As the main concurring opinion put it,

> [B]ecause the broader, more generalized areas and the narrower, more limited areas within them (subspecialties) both constitute specialties under the accepted technical meaning of the word "specialty," a plaintiff's proposed expert must match the defendant doctor's qualifications at both levels.

Woodard, 476 Mich at 609 (J. Taylor's concurring opinion). There is no indication that any of the seven Justices disagreed with the conclusion that a subspecialty is a specialty under the statute.

The Court's thorough analysis—in marked contrast to Plaintiff's rather shallow analysis—led to the correct conclusion that "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. Consequently, "[a] subspeciality, although a more particularized specialty, is nevertheless a specialty." *Id.* Nothing in Plaintiff's brief or in the statute itself exposes any flaw in this Court's logic on this point, even setting aside the fact that agreement with Plaintiff on this point would do nothing to support reversing the Court of Appeals decision in this case.

2. Woodard correctly interpreted "board certified."

Plaintiff also makes a passing reference to another supposed error in *Woodard*: its interpretation of "board certified" as used in MCL 600.2169(1). (Plaintiff's Brief, p 26). Plaintiff does not develop an argument on this front, but simply declares that the Court

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should have adopted the definition of "board certified" found in the Public Health Code, MCL 333.2701(a). But, as Plaintiff concedes, that statute does not apply in this case. Nor does the Insurance Code, which, as Plaintiff acknowledges, also contains a different definition of "board certified." Plaintiff proffers no argument as to why the Court erred in declining to adopt a statutory definition from a different, inapplicable statutory scheme—or even why it would make more sense to adopt one of two inapplicable statutory definition rather than the other one.

Finally, even if the Court were to adopt a different definition of "board certified" than what was adopted in *Woodard,* it would make no difference in this case. As Plaintiff concedes, both specialties, ENT and facial plastic and reconstructive surgery, are subject to board certifications by different boards. Plaintiff does not explain how changing the law in this area would make any difference.

* * *

Ultimately, none of Plaintiff's challenges to *Woodard*'s holdings has any merit. And none supports Plaintiff's request that the Court reverse the Court of Appeals decision in this case.

ARGUMENT II

THE "ONE MOST RELEVANT SPECIALTY" COULD BE DEEMED THE SPECIALTY THE PARTY POSSESSES IF IT IS NOT THE ONE IN WHICH THE PARTY WAS ENGAGED AT THE TIME OF THE ALLEGED MALPRACTICE

Because the "one most relevant specialty" test as set forth in *Woodard* is consistent with MCL 600.2169(1), it is the test that should continue to be applied. Nevertheless, and *only* in order to comply with this Court's directive in its December 22, 2022, Order that the

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parties do so, Defendants will set forth a possible alternative to the "one most relevant specialty" test. Defendants will also address the alternative test proposed by Plaintiff.

Woodard's adoption of the "one most relevant specialty" test was tethered to the requirement in the statute that the expert be a specialist in the "same specialty" "as the party against whom or on whose behalf the testimony is offered." The use of the singular "specialty" reflects the Legislature's requirement that the expert possess one particular specialty. When a defendant, at the time of the alleged malpractice, is engaged in a specialty that is different than the specialty he or she possesses, it raises the question which of the two specialties the expert must possess. Focusing on what constitutes "the appropriate standard of practice or care," MCL 600.2169(1), *Woodard* held that that specialty must be "the specialty engaged in by the defendant physician during the course of the alleged malpractice," i.e., not the specialty the defendant possessed but was not practicing at the time of the allege malpractice. *Woodard,* 476 Mich at 560. [11]

A potential alternative to that holding would be to interpret MCL 600.2169(1)(a) to mean that an expert in this scenario must possess the specialty that the defendant *possessed*, not the specialty in which the defendant was engaged at the time of the allege malpractice. Arguably, the first clause in subsection (1)(a) supports this interpretation. It says, "If the party against whom or on whose behalf the testimony is offered is a specialist,"

[11] *Reeves v Carson City Hosp (On Remand),* 274 Mich App 622; 736 NW2d 284 (2007), involved this situation. In *Reeves,* the defendant specialized in family practice but, at the time of the alleged malpractice, was engaged in emergency medicine. The Court of Appeals applied *Woodard* to hold that the one most relevant specialty was emergency medicine. While Plaintiff suggests that that ruling is anomalous (Plaintiff's Brief, pp 24-25), Defendants submit there is nothing wrong with disallowing a doctor from opining on an area in which he does not specialize.

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which could be read to suggest that it is the specialty the party possesses that matters, not the specialty in which the party was engaged at the time of the alleged malpractice.

Defendants hasten to add that adoption of this alternative test would not render erroneous the Court of Appeals' decision. Indeed, it would make no difference in this case, since Dr. Colton was a specialist in the area in which he was practicing at the time of the alleged malpractice—facial plastic and reconstructive surgery.

Plaintiff's only argument as to what test should be adopted in lieu of the "one most relevant specialty" test is that the Court should hold that a subspecialty is not a specialty. (Plaintiff's Brief, p 26). That does not really answer the Court's question, and it also does not advance the ball for Plaintiff in this case. Again, Dr. Colton and Dr. Armstrong were specialists in two distinct specialties—not a specialty and a subspecialty. Thus, even if the Court agrees with Plaintiff and modifies the "one most relevant specialty" test to omit subspecialities, that would not be a basis for reversal in this case.

Plaintiff's inability to come up with an alternative to the "one most relevant specialty" test that would change the outcome of this case speaks volumes, particularly given his strident criticism of *Woodard*. It only underscores the correctness of *Woodard* and the absence of any need to revisit the correct holding in that case on this issue.

ARGUMENT III

IF *WOODARD'S* INTERPRETATION OF "MAJORITY OF . . . PROFESSIONAL TIME" MUST BE REPLACED, CONSTRUING "MAJORITY" TO INCLUDE "PLURALITY" IS PROBABLY THE LEAST BAD OPTION

As noted, Defendant submits *Woodard* correctly construed the phrase "a majority of his or her professional time" to mean more than half of his or her professional time. This is especially clear when the amended version of the statute is compared with the pre-

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amendment version, which required only that the expert devote "a substantial portion of his or her professional time" to a particular practice or specialty. Nevertheless, and *only* in order to comply with the Court's directive that the parties come up with an alternative test, Defendant will attempt to do so.

The only viable alternative that appears to present itself is that reached by Judge O'Connell in his dissenting opinion in *Kiefer* and by Judge Krause in her dissenting opinion in *Estate of LeBlanc.* Under that approach, "majority" would be deemed satisfied so long as an expert devoted a plurality of his or her time to a particular specialty, i.e., the largest portion of time among multiple portions none of which totals more than 50%. Defendants merely add that such a holding in this case would not warrant reversal, since Dr. Fitzgerald did not devote even a plurality to the specialty of ENT, the specialty in which Dr. Colton was engaged at the time of the alleged malpractice.

Plaintiff's proposed replacement of the "majority of . . . professional time" test adopted in *Woodard* is merely to suggest that the Court should interpret "specialty" to include subspecialties—the same proposal she makes with respect to the "one most relevant specialty" test. (See Plaintiff's Brief, p. 27). But that proposal, even if adopted, would not logically supplant the "majority of . . . professional time" test correctly adopted in *Woodard*. Nor would it make a difference in this case.

Plaintiff also suggests that "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." *Id.* As discussed above, that is simply not true. The mere fact that the Legislature allows an expert to aggregate time spent on both practicing and teaching within

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a particular specialty does *not* mean the expert can devote "a majority" of his or her time to more than one specialty. Nothing prevented the Legislature from allowing aggregation of time spent both practicing and teaching within a particular specialty, which the Legislature did. Nothing prevented the Legislature from allowing an expert to aggregate time spent on different specialties, either—but the Legislature did *not* allow that type of aggregation.

Regardless, Plaintiff does not actually provide an answer as to what the test ought to be even if the statute did "permit [] a physician to devote a majority of his time to more than one specialty." (Plaintiff's Brief, p. 27). Like his inability to proffer an alternative to the "one most relevant specialty" test, Plaintiff's inability to articulate a better interpretation of "majority of . . . professional time" than that adopted in *Woodard* speaks volumes—and it underscores that *Woodard* was correctly decided.

ARGUMENT IV

WOODARD SHOULD BE RETAINED UNDER PRINCIPLES OF STARE DECISIS EVEN IF THE COURT BELIEVES IT WAS INCORRECTLY DECIDED

Woodard's holding should not be overturned even if the Court is of the view that it was incorrectly decided. That is because important stare decisis principles counsel strongly in favor of retaining it.

"Stare decisis is generally 'the preferred course because it promotes the evenhanded, predictable, and consistent development of legal principles, fosters reliance on judicial decisions, and contributes to the actual and perceived integrity of the judicial process.'" *Robinson v City of Detroit,* 462 Mich 439, 463; 613 NW2d 307 (2000) quoting *Hohn v United States,* 524 US 236, 251; 118 S Ct 1969, 141 L Ed 2d 242 (1998). Even if a decision is deemed to have been decided incorrectly, courts should also review whether the decision at issue (1) defies "practical workability," (2) whether reliance interests would

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work an undue hardship, and (3) whether changes in the law or facts no longer justify the questioned decision. *Robinson,* 462 Mich at 464 (citation omitted). As this Court recognized in *Robinson,* "The mere fact that an earlier case was wrongly decided does not mean overruling it is invariably appropriate." *Id.* at 465. "Rather, the Court must proceed on to examine the effects of overruling, including most importantly the effect on reliance interests and whether overruling would work an undue hardship because of that reliance." *Id.* at 466.

Here, none of the three above-mentioned stare decisis considerations warrants overturning *Woodard*.

First, *Woodard* does not defy practical workability. Quite to the contrary, *Woodard* has been effectuated in thousands, probably tens of thousands, of medical malpractice cases. Plaintiff identifies nothing that could be considered defiance of practical workability by *Woodard's* holding. (See Plaintiff's Brief, pp. 22-25). While Plaintiff notes that *Woodard* has been criticized from time to time, none of the criticisms levied at *Woodard's* holdings suggests workability problems. The criticisms of *Woodard* present *policy* issues, i.e., they argue that the policy purportedly adopted in *Woodard* is bad policy because it makes it too difficult to name a proper expert. Those criticisms are criticisms of the Legislature's decision to amend MCL 600.2169 more than they are criticisms of *Woodard's* interpretation of that statute as amended. Regardless, policy criticisms are not criticisms of practical workability. Nothing about *Woodard's* holdings has proven to be unworkable in practice. Consequently, this factor mitigates in favor of retaining *Woodard*.[12]

[12] Should the Legislature wish to amend the statute at any point, it is free to do so. But it is notable that the Legislature thus far has declined to do so despite the judicial criticisms of
(cont'd next page)

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Second, *Woodard* has engendered substantial reliance interests that would work undue hardship were *Woodward* to be overturned. *Robinson,* 462 Mich at 464. Indeed, *Woodard* has been heavily relied upon by the bench and bar alike. *Woodard* has been cited more than a thousand times, including by more than four hundred decisions. And *Woodard* has been heavily relied upon by plaintiffs and defendants in the context of naming and challenging expert witnesses in medical malpractice cases for the more than 15 years *Woodard* has been on the books.

The reliance interests that *Woodard* has spawned are particularly acute given the subject matter of the statute *Woodard* interpreted, namely the qualifications of an expert witness. This is not a context in which reliance is found only in determining whether potential litigants have shaped their conduct in reliance on a judicial decision. This context presents a stark contrast with the absence of reliance interests as described in *Robinson*. The Court described the absence of reliance interests in that case as follows:

> It is apparent that the fleeting drivers, as they saw to evade the police, were undoubtedly not aware of our previous case law, nor is it likely that they drove as they did in reliance on the theory that they or the person injured as a result of their fleeing might have recourse against the municipality or individual police officers.

Robinson, 462 Mich at 466.

Unlike *Robinson,* which interpreted a statute that addressed immunity for certain conduct, *Woodard* interpreted a statute that addresses expert witness qualifications. Unlike fleeing drivers who were unaware of previous case law, parties and counsel required to name expert witnesses most definitely are familiar with *Woodard* and the

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Woodard that date back at least to 2011 according to Plaintiff. See Plaintiff's Brief, p. 22, n 5, citing *Johnson v Sultan,* Docket No. 292327, Mich App February 10, 2011.

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statute *Woodard* interpreted. Case law interpreting a statute setting out requirements for an expert witness to qualify presents a very different context when it comes to reliance interests.

Indeed, Plaintiff does not—and cannot—deny that *Woodard* has engendered strong reliance interests. Plaintiff argues only that "[w]hile *Woodard* is routinely cited in medical malpractice litigation, it has also been repeatedly questioned." (Plaintiff's Brief, p. 22). The fact *Woodard* has been questioned by various Court of Appeals panels hardly suggests it has not engendered substantial reliance interests. Quite clearly it has, and, therefore, this factor counsels strongly against overturning it.

Finally, there have been no "changes in the law or facts [that] no longer justify the questioned decision." *Robinson*, 462 Mich at 464. Plaintiff identifies no changes in any law or fact that "no longer" justifies adherence to *Woodard*. Quite to the contrary, Plaintiff's argument seems to be that *Woodard* was wrong from its inception, i.e., that there has been no change in the facts or law that support overturning *Woodard* now that did not exist 17 years ago when *Woodard* was decided.

In short, none of the three considerations that support adherence to stare decisis supports overturning *Woodard*.

Finally, even if the Court were persuaded by the policy-based criticisms of *Woodard* identified by Plaintiff, those criticisms do not warrant overturning *Woodard*. The basic upshot of the policy criticisms of *Woodard* are that *Woodard* made it more difficult to match an expert to a defendant doctor's qualifications. But the changes Plaintiff proposes are relatively minor, as discussed in Arguments II and III. As noted, Plaintiff does not really even suggest a different test to replace either *Woodard's* interpretation of "majority of. . .

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professional time." And Plaintiff's only criticism of the "one most relevant specialty" test is that specialty should not encompass subspecialities—a criticism that, as noted, is not shared by very entity Plaintiff cites to support his view.

At bottom, no aspect of the stare decisis factors supports overturning *Woodard* to make changes in the case law of the type Plaintiff proposes. This Court should decline to overturn *Woodard* even if it is of the view that *Woodard* was incorrectly decided.

ARGUMENT V

THE COURT OF APPEALS REACHED THE RIGHT RESULT UNDER THE PROPER APPLICATION OF THE REQUIREMENTS OF MCL 600.2169 IN THIS CASE

The Court of Appeals properly applied the requirements of MCL 600.2169(1) in this case, not only because *Woodard* is correct and the Court of Appeals properly followed *Woodard*, but because those requirements simply are not met even setting aside *Woodard*'s interpretation.

A. Dr. Armstrong does not satisfy the active clinical practice requirements of MCL 600.2169(1).

Dr. Armstrong clearly and unequivocally testified that during the relevant time periods, 90% of his practice was devoted to otolaryngology, and only 10% devoted to facial plastic and reconstructive surgery. (Armstrong deposition pp. 34, 39, **Appellant's Apx 0062a, 0067a**). Dr. Armstrong answered repeatedly to the same percentage breakdown of his professional time between otolaryngology and facial plastic and reconstructive surgery.

Deposition testimony that is clear, intelligent, and unequivocal in nature is to be considered conclusively binding. *Kaufman & Payton, PC v Nikkila,* 200 Mich App 250; 503 NW2d 728 (1993); *Gamet v Jenks*, 38 Mich App 719; 197 NW2d 160 (1972) (applied in the

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summary disposition context). As explained in the context of summary disposition, when creating a genuine issue of material fact, the *Gamet* court reasoned:

> If a party who has been examined at length on deposition could raise an issue of fact simply by submitting an affidavit contradicting his own prior testimony, this would greatly diminish the utility of summary judgment as a procedure for screening out sham issues of fact.

Gamet, 38 Mich App at 164, quoting *Perma Research and Development Co v Singer Co*, 410 F2d 572, 578 (CA 2, 1969). The *Gamet v Jenks* prohibition has been extended to circumstances beyond deposition testimony. *Atkinson v City of Detroit*, 222 Mich App 7, 11-12; 564 NW2d 573 (1997) (the "no-contradiction" rule applies to affidavits that contradict prior interrogatory answers).

Also, Michigan law requires that the deposition testimony of a witness be read fairly and in context. *Mate v Wolverine Mutual Insurance Co,* 233 Mich App 14, 21; 592 NW2d 379 (1998) (A witnesses' deposition testimony read in context did not raise a genuine issue of material fact); *Young v Oakland Gen Hosp*, 175 Mich App 132, 138-139; 437 NW2d 321 (1989) (The deposition testimony of a witness read in context failed to raise a genuine issue of material fact).

Dr. Armstrong acknowledged that rhinoplasty falls within either his cosmetic practice (facial plastic and reconstructive surgery) or his functional practice (otolaryngology). (Armstrong deposition, pages 32-33, **Appellant's Apx 0060a-0061a**). He then confirmed that there was a 90% versus a 10% division of his professional time between otolaryngology and facial plastic reconstructive surgery. (*Id.* at 34). Finally, Dr. Armstrong confirmed that the 90% versus 10% breakdown related back to 2013-2014, the relevant time period for measuring the active clinical practice requirement under § 2169.

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(*Id.* at 39, **Appellant's Apx 0067a**). Confirming that Mr. Selliman's surgery was not to "fix some medical condition" but rather have it "look a certain way," (*Id.* at 122, **Appellant's Apx 0150a**), Dr. Armstrong stated in the clearest of terms that "90 percent ENT, 10 percent facial plastic and reconstructive surgery" was the breakdown of his practice in 2013-2014. (*Id.* at 39, **Appellant's Apx 0067a**).

Only one conclusion can be drawn from this testimony: During the year preceding the date of the occurrence, Dr. Armstrong devoted the majority of his professional time to ENT/otolaryngology—not to facial plastic and reconstructive surgery.

Dr. Armstrong was even asked to define the breakdown of "your practice, generally." (*Id.* at 39, **Appellant's Apx 0067a**). The question was not defined with respect to the type of procedure at issue, and for that matter the earlier questions were not limited or defined within the context of a particular medical procedure, namely rhinoplasty. The trial court's reasoning that Dr. Armstrong confused his general practice with percentages within one of his specialties for the specific procedure might hold water if the questions were asked in the context of the particular procedure. They were not, and it is only through ignoring clear and unequivocal answers that the trial court could find "seemingly contradictory statements." (Transcript, p. 29, **Appellant's Apx 0278a**).

It is important to note that Dr. Armstrong never stated what the trial court found to be an alternative interpretation of his testimony: 10% of his procedures were for cosmetic purposes with 90% being more functional. In this sense, Dr. Armstrong's testimony is not internally contradictory, but only contrary to the proposition presented by Plaintiff and accepted by the trial court: the 90/10 percentages dealt with the division of procedures within the relevant specialty. In fact, this case never reaches the point of internal

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contradiction within and between Dr. Armstrong's deposition testimony, and even if so his unequivocal statements on the general percentages of his practice would govern.[13]

Plaintiff also contends that Dr. Armstrong's active clinical practice in otolaryngology counts towards the "majority" requirement of § 2169 because there was considerable overlap between his 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. But this argument runs directly afoul of MCL 600.2169(1). The statute simply does not allow an expert to rely on a claimed overlapping practice in dual specialties to satisfy the active clinical practice requirement. That may have been allowed under the prior version of the statute, but not under the present version which governs in this matter.

B. The specialty in which Dr. Colton was engaged was facial plastic and reconstructive surgery, not ENT.

Plaintiff also argues that the Court of Appeals erred in concluding that the one most relevant specialty was facial plastic and reconstructive surgery. The Court of Appeals did not err on that point.

As Plaintiff acknowledges, the Court of Appeals stated that "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." (Plaintiff's Brief, pp 28-29, quoting Ct App Opinion, fn 4) (**Appellant's Appendix 0295a**). Plaintiff then declares that "Plaintiff provided substantive argument in support of his

[13] See *Kucharczyk v State*, 2001 A2d 683, 685 (Md 1964) ("When a witness says in one breath that a thing is so, and in the next breath that it is not so, his testimony is too inconclusive, contradictory, and uncertain to be the basis of a legal conclusion.").

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assertion in Response to" Defendants' summary disposition motion. (*Id.* p 29). But the Court will search in vain for any such "substantive argument," which is likely why Plaintiff cited no page in the appendix to support it.

Dr. Armstrong himself confirmed that the nature of the procedures was cosmetic, rather than addressing a medical necessity, thereby circumscribing the medical treatment to facial plastic and reconstructive surgery for cosmetic services:

> 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.

(Armstrong deposition transcript, p 122, **Appellant's Apx 0150a**).[14]

At a minimum, the most relevant specialty, i.e., "that specialty" in which Dr. Colton was engaged, § 2169(1)(b), was facial plastic and reconstructive surgery. That is undisputed. Accordingly, and because nothing in § 2169(1)(b) allows an expert to aggregate multiple specialties for purposes of the "specialty" in which he or she devoted the majority of his professional time, the Court of Appeals properly applied the requirements of § 2169(1)(b).

[14] Plaintiff's curiously heavy reliance on the fact that Dr. Colton's affidavit was submitted with Defendants' reply brief is entirely misplaced given Dr. Armstrong's concession that the surgery was done for cosmetic reasons, not to fix a medical condition.

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C. Plaintiff's claim in this case implicates facial plastic and reconstructive surgery, not ENT.

The fundamental predicate of Plaintiff's entire theory as to why *Woodard* (really MCL 600.2169(1)) should not apply in this case is that rhinoplasties are performed by both ENTs and facial plastic and reconstructive surgeons and, therefore, a specialist in either field is equally qualified to provide expert testimony. Even if there were some merit to that argument in the context of a case that involved nothing more than an allegedly improperly performed rhinoplasty procedure, that is not what this case involves. According to Plaintiff's own complaint, this case involves a lengthy history of treatment and decision-making unique to facial plastic and reconstructive surgery.

As discussed earlier, Plaintiff's complaint alleges the malpractice included decisions to inject multiple steroids on several occasions in an attempt to improve Plaintiff's appearance. It also involved decisions to perform a 6th, then a 7th, then an 8th rhinoplasty, all aimed at trying to improve Plaintiff's appearance.

The notion that there is no basis for drawing a distinction between an ENT and a facial plastic and reconstructive surgeon in the context of this case simply because both are capable of performing rhinoplasties misses the bigger picture. There is, without question, a genuinely substantive basis for the distinction in this case. The Court of Appeals correctly recognized that Dr. Armstrong simply is not qualified to provide expert testimony on the standard of care applicable in this case. Accordingly, this Court should affirm or should deny leave as improvidently granted.

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RELIEF

For the reasons set forth herein, Defendants requests that this Court either affirm the judgment of the Court of Appeals or deny Plaintiff's application for leave to appeal as improvidently granted. Defendants further request any and all other relief to which they are entitled.

Respectfully submitted,

PLUNKETT COONEY

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Dated: April 13, 2023

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WORD COUNT CERTIFICATE

JEFFREY C. GERISH, being first duly sworn, certifies and states the following:

1. He is a shareholder with the firm Plunkett Cooney, and is in principal charge of the above-captioned cause for the purpose of preparing the attached brief on appeal;

2. The brief prepared by his office complies with the type-volume limitation;

3. Plunkett Cooney relies on the word count of their word processing system used to prepare the brief, using Cambria size 12 font; and

4. The word processing system counts the number of words in the brief as 12,938.

s/Jeffrey C. Gerish
JEFFREY C. GERISH

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STATE OF MICHIGAN

IN THE SUPREME COURT

ANTONIO SELLIMAN,

Plaintiff-Appellant,
v

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

Defendants-Appellees.

SC No. 163226
COA No. 352781
LC No. 18-167068-NH
(Oakland Circuit Court)

PROOF OF SERVICE/STATEMENT REGARDING E-SERVICE

Robin M. Larson, being duly sworn, deposes and says that she is an employee of the law firm of Plunkett Cooney, and that on April 13, 2023, she caused to be served a copy of Defendants-Appellees' Brief on Appeal, Oral Argument Requested, Appellees' Appendix, and Proof of Service/Statement Regarding E-Service as follows:

Rachel M. Ratton (P83860) Michael T. Ratton (P42399) Attorneys for Plaintiff-Appellant rachel@rattonlaw.com	**Counsel was served via MiFile**

/s/Robin M. Larson
ROBIN M. LARSON

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