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STATE OF MICHIGAN
IN THE SUPREME COURT

ANTONIO SELLIMAN,

Plaintiff-Appellant,

vs.

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

Defendants-Appellees.

Supreme Court Case No. _____
Court of Appeals Case No. 352781
Lower Court Case No. 18-167068-NH
Hon. Jeffrey S. Matis
Oakland County Circuit Court

NOTICE OF FILING APPLICATION

PLAINTIFF-APPELLANT ANTONIO SELLIMAN'S

APPLICATION FOR LEAVE TO APPEAL

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CERTIFICATE OF SERVICE

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

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STATEMENT REGARDING BASIS FOR JURISDICTION, ORDERS BEING APPEALED, ALLEGATIONS OF ERROR, AND GROUNDS FOR SUPREME COURT REVIEW

I. STATEMENT REGARDING BASIS FOR JURISDICTION

Antonio Selliman seeks leave to appeal the Court of Appeals opinion in *Selliman v Jeffrey J. Colton, MD, Jeffrey J. Colton, PLLC, and the Colton Center,* unpublished per curiam opinion of the Court of Appeals, issued May 20, 2021, Docket No. 352781. ***Exhibit 1*** This Application for Leave to Appeal is being filed within 42 days of issuance of the Court of Appeals opinion, pursuant to MCR 7.305(C)(2)(a).

II. TRIAL COURT ORDER APPEALED

Defendants-Appellees sought interlocutory appellate review of the Oakland County Circuit Court's denial of their Motion to Strike Michael J. Armstrong, MD and for Summary Disposition. A panel of the Court of Appeals granted leave in an Order issued May 27, 2020 (O'Brien, P.J. and Jansen, J.). Judge Gleicher would have denied the application for leave to appeal. ***Exhibit 2***

Dr. Michael J. Armstrong, Plaintiff-Appellant's expert, and Defendant-Appellee Dr. Jeffrey Colton are board certified in the same specialties, those being Otolaryngology-Head and Neck Surgery and Facial, Plastic, and Reconstructive Surgery, as required by MCL 600.2169(1)(a). At issue in this case is the active clinical practice requirement of MCL 600.2169(1)(b), which requires a proposed expert to have:

> during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
> (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

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> licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

In his Affidavit of Merit attached to Plaintiff-Appellant's Complaint, Dr. Armstrong asserts:

> 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. ***Attachment to Exhibit 3 at 1***

> 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. ***Attachment to Exhibit 3 at 2***

In their Affidavit of Meritorious Defense, Defendants-Appellees' expert Michael A. Carron, MD, who, like Dr. Armstrong and Dr. Colton, is board certified by the American Board of Otolaryngology-Head and Neck Surgery and the American Board of Facial, Plastic, and Reconstructive Surgery, asserts:

> During the time period at issue in this case and the year preceding, I devoted the majority of my professional time to the active clinical practice of otolaryngology-head and neck surgery and facial, plastic, and reconstructive surgery. ***Exhibit 4 at 1***

> I understand the standard of care applicable to Jeffrey Colton, MD in this matter to be that which a physician specializing in otolaryngology-head and neck surgery and facial, plastic and reconstructive surgery of ordinary learning, skill, and judgment would do or would not do under the same or similar circumstances as existed in treating Plaintiff Anthony Selliman. ***Exhibit 4 at 2***

After Dr. Armstrong's deposition, excerpted in part below, Defendants-Appellees filed their Motion to Strike and for Summary Disposition, arguing, for the first time in this litigation, that Dr. Armstrong failed to meet the requirements of MCL 600.2169(1)(b), specifically that he did not spend the majority of his professional time in the practice of the one most relevant specialty, which Defendants- Appellees, again for the first time and in conflict with their own Affidavit of Meritorious Defense, contend is facial plastic and reconstructive surgery. ***Exhibit 6*** In Response, Plaintiff-Appellant disputed both the characterization of Dr. Armstrong's deposition testimony and

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the unilateral assertion that the one most relevant specialty is facial plastic and reconstructive surgery. ***Exhibit 7*** Defendants-Appellees then filed their Reply Brief, attaching an Affidavit from Defendant Colton, dated three days prior to the filing, which states:

> Since 1983, including throughout my treatment of Plaintiff Anthony Selliman from 2012 through 2017, 100% of my professional time has been devoted to the active clinical practice of Facial, Plastic and Reconstructive Surgery.
>
> 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. ***Attachment to Exhibit 8 at 2***

Because the Affidavit was attached to the Reply Brief, rather than the principle Motion, Plaintiff-Appellant had no opportunity to respond to same other than at oral argument, where counsel continued to dispute facial plastic and reconstructive surgery was the one most relevant specialty. Nevertheless, the trial court ruled that Plaintiff-Appellant had failed to present "any documentary evidence to contest Doctor Colton's affidavit that the procedures at issue in this litigation were cosmetic in nature and fell with the specialty of facial, plastic, and reconstructive surgery". ***Exhibit 9 at 28*** As discussed in Section III, the Court of Appeals appears to have interpreted this statement to mean the trial court determined facial, plastic, and reconstructive surgery to be the most relevant specialty. On the issue of Dr. Armstrong's active clinical practice, the trial court concluded the deposition testimony was unclear as to whether he devoted 90 percent of his practice to otolaryngology and 10 percent to facial plastic and reconstructive surgery or whether 10 percent of his facial plastic and reconstructive surgery practice was cosmetic in nature and 90 percent was functional in nature. Opining that portions of Dr. Armstrong's testimony were "seemingly contradictory," the trial court denied the motion without prejudice. ***Exhibit 9 at 29***

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III. COURT OF APPEALS DECISION BEING APPEALED

In *Selliman v Jeffrey J. Colton, MD, Jeffrey J. Colton, PLLC, and the Colton Center*, unpublished per curiam opinion of the Court of Appeals, issued May 20, 2021, Docket No. 352781, attached at ***Exhibit 1***, the Court of Appeals found the trial court abused its discretion in denying the motion to strike Dr. Armstrong's testimony. In so finding, the panel concluded "it is clear that Dr. Armstrong unequivocally testified that 10 percent of his practice consists of facial plastic and reconstructive surgery procedures and 90 percent of his practice consists of ENT procedures." *Selliman* at *5 The panel further concluded the trial court "correctly determined that facial plastic and reconstructive surgery is the most relevant specialty" and that Plaintiff-Appellant "presented no evidence rebutting Dr. Colton's affidavit". *Id.* at *6 On that basis, the Court of Appeals held:

> 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. *Id.*

IV. ALLEGATIONS OF ERROR AND GROUNDS FOR SUPREME COURT REVIEW

The issues presented by this appeal are jurisprudentially significant to the development of the law in this state, and this Court's review is warranted on the following grounds: under MCR 7.305(B)(3), because the issues involve legal principles of major significance to the state's jurisprudence; under MCR 7.305(B)(5)(a), because the Court of Appeals decision is clearly erroneous and will cause material injustice; and under MCR 7.305(B)(5)(b), because the Court of Appeals decision conflicts with other published and unpublished decisions of the Court of Appeals and this Court.

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A. MCR 7.305(B)(3)

This case demonstrates the absurdity that results from the current jurisprudence surrounding expert qualification under MCL 600.2169(1)(b), beginning with this Court's holding in *Woodard v Custer*, 476 Mich 545; 719 NW2d 842 (2006), which articulated the "one most relevant specialty" standard. *Woodard* at 567-568. Pursuant to MCL 600.2169(1)(a), the specialty engaged in by the defendant doctor during the course of the alleged malpractice constitutes the one most relevant specialty. *Woodard* at 560. A proposed expert must have devoted a majority of his or her professional time to the relevant specialty in order to be qualified to testify as an expert witness. In *Kiefer v Markley*, 283 Mich App 555; 769 NW2d 271 (2009), the Court of Appeals determined the use of the word "majority" in 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 the year before the alleged malpractice. *Kiefer* at 559.

Despite their holding, the *Kiefer* majority noted "this is not a result we think the Legislature intended." *Id*. at 560. The Court believed the similarity in certification between the defendant and plaintiff's expert, coupled with the fact that, when combined, plaintiff's expert spent more than 50 percent of his time in the area of hand surgery and the closely related area of reconstructive surgery of other extremities, should qualify him as an expert, yet they were compelled to affirm the disqualification by existing caselaw. *Id.* This would become a familiar refrain in the Court of Appeals on this issue, as further discussed in Arguments II and III.

In the 15 years since *Woodard* was decided by this Court, the jurisprudence surrounding MCL 600.2169(1) has grown increasingly clouded. The legislative concern addressed by MCL 600.2169(1) is ensuring 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

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they are testifying. This concern has been lost amidst subsequent appellate decisions which, when applied in the manner argued here by Defendants-Appellees and employed by the Court of Appeals, would require a proposed expert who mirrors the board certifications and practice experience of the defendant to be disqualified by a judicially created mathematical calculation. The issue of expert qualification under MCL 600.2169(1) is clearly a legal principle of major significance to the state's jurisprudence, and requires re-examination by this Court. MCR 7.305(B)(3). Plaintiff-Appellant respectfully suggests this case presents the ideal set of circumstances under which to do so.

B. MCR 7.305(B)(5)(a) and (b)

Supreme Court review is also requested because the Court of Appeals decision is clearly erroneous and will cause material injustice. 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". *Selliman* at *2, *6. Respectfully, the trial court did not explicitly rule facial plastic and reconstructive surgery was the one most relevant specialty, and to the extent it implicitly did so, the determination was based on Defendant-Appellee's self-serving Affidavit, which was attached not to the principle Motion, to which Plaintiff-Appellant could respond, but the Reply, to which Plaintiff-Appellant could not, other than at oral argument. MCR 2.116(G)(1)(a)(iv).

The Court of Appeals stated in Footnote 4 of its opinion that "although Selliman disputes Defendants-Appellees' contention that facial plastic and reconstructive surgery is the one most relevant specialty, he provides no substantive argument in support of that assertion." This is clearly error, as Plaintiff-Appellant provided substantive argument in support of its assertion in his

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Response to the motion, in his Motion to Amend Witness List, filed after receipt of Defendants-Appellees' Reply, and at oral argument on both motions. ***Exhibits 9, 10*** At every opportunity, Plaintiff-Appellant has disputed facial plastic and reconstructive surgery is the one most relevant specialty. While it is true Plaintiff-Appellant did not present any documentary evidence to specifically rebut Dr. Colton's Affidavit, he had no opportunity to do so, as the non-moving party is not entitled to a sur-reply. MCR 2.116(G)(1)(a)(iv). Because it is based, at least in part, on the false premises that the trial court properly determined the one most relevant specialty to be facial plastic and reconstructive surgery and that Plaintiff-Appellant failed to challenge that determination, the Court of Appeals decision is clearly erroneous and will cause material injustice. Therefore, Plaintiff-Appellant respectfully requests review by this Court pursuant to MCR 7.305(B)(5)(a).

Further, the Court of Appeals erred in determining the trial court abused its discretion by denying the motion to strike Dr. Armstrong's testimony. The panel opined

> it is clear that Dr. Armstrong unequivocally testified that 10 percent of his practice consists of facial plastic and reconstructive surgery procedures and 90 percent of his practice consists of ENT procedures. Notwithstanding Plaintiff-Appellant'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-Appellees sought answers related to the proportionality of the whole of Dr. Armstrong's practice—ENT versus facial plastic and reconstructive surgery. And, though Dr. Armstrong responded to Defendants-Appellees' questions about the proportionality of his practice by using the terms "functional" and "cosmetic," Dr. Armstrong understood and used the term "functional" to equate with his ENT practice, while his facial plastic and reconstructive surgery practice was for cosmetic services. *Selliman* at *5

In *Maldonado v Ford Motor Co,* 476 Mich 372; 719 NW2d 809 (2006), this Court updated the standard for determining whether a trial court's discretion has been abused, stating that the "standard acknowledges that there will be circumstances in which there will be no single correct outcome; rather, there will be more than one reasonable and principled outcome" and "[w]hen the

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trial court selects one of these principled outcomes, the trial court has not abused its discretion and, thus, it is proper for the reviewing court to defer to the trial court's judgment." *Id.* at 388, citing *People v Babcock*, 469 Mich 247; 666 NW2d 231 (2003). The Court of Appeals gave no deference to the trial court's decision below. 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". ***Exhibit 9 at* 5, 21, 29** The trial court's ruling reflects a reasonable and principled outcome under the circumstances. Thus, the Court of Appeals clearly erred in ruling the trial court abused its discretion in denying the motion to strike Dr. Armstrong's testimony.

Finally, the Court of Appeals decision conflicts with other published and unpublished decisions of the Court of Appeals and this Court. The decision is completely contrary to the spirit of *Woodard* and *Kiefer*, which are chiefly concerned with ensuring experts have firsthand practical expertise in the subject matter about which they are testifying. Although the unpublished decisions discussed in Arguments II and III, attached at ***Exhibit 11***, are not binding under the rule of stare decisis pursuant to MCR 7.215(C)(1), they illustrate 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. Therefore, Plaintiff-Appellant respectfully requests review by this Court pursuant to MCR 7.305(B)(5)(b).

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STATEMENT OF THE QUESTIONS PRESENTED

ARGUMENT I

Is the one most relevant specialty test articulated in *Woodard* and subsequent jurisprudence logically inapplicable to this case, where the defendant and proposed expert are identically board certified and routinely perform rhinoplasty, the procedure at issue, in their clinical practice?

The Court of Appeals would say "NO"

The Trial Court did not address this question.

Plaintiff-Appellant says "YES"

Defendants-Appellees will say "NO"

In light of *Woodard* and subsequent jurisprudence, should this Court re-examine the proper interpretation and application of MCL 600.2169(1) to this and other medical malpractice actions?

The Court of Appeals would say "NO" *See Footnote 1*

The Trial Court did not address this question.

Plaintiff-Appellant says "YES"

Defendants-Appellees will say "NO"

ARGUMENT II

Did the Court of Appeals err in concluding that the trial court correctly determined that facial plastic and reconstructive surgery is the most relevant specialty, where the trial court did not explicitly rule facial plastic and reconstructive surgery was the one most relevant

1 While the panel assigned to this appeal would say "NO", multiple judges of the Court of Appeals would say "YES", as illustrated by the opinions discussed in the unpublished decisions attached at ***Exhibit 11***

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specialty, and to the extent it implicitly did so, the determination was based on Defendant-Appellee's self-serving Affidavit, to which Plaintiff-Appellant had no opportunity to respond, other than at oral argument?

The Court of Appeals would say "NO"

The Trial Court did not address this question.

Plaintiff-Appellant says "YES"

Defendants-Appellees will say "NO"

Did the Court of Appeals err in holding that the Trial Court abused its discretion in denying without prejudice Defendants-Appellees' Motion to Strike and for Summary Disposition based on the deposition testimony of Plaintiff-Appellant's expert Dr. Michael J. Armstrong?

The Court of Appeals would say "NO"

The Trial Court would say "YES"

Plaintiff-Appellant says "YES"

Defendants-Appellees will say "NO"

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STATEMENT OF MATERIAL FACTS AND PROCEEDINGS

This is a medical malpractice action arising of the Defendants-Appellees' medical treatment of Plaintiff-Appellant Antonio Selliman from August 2014 through November 2017. While under the care of Defendants-Appellees, Plaintiff-Appellant underwent a total of seven rhinoplasty procedures: August 25, 2014, March 25, 2015, September 9, 20115, January 12, 2016, June 23, 2016, April 19, 2017, and November 9, 2017. The repeated negligent performance of these rhinoplasty procedures resulted in severe and permanent damage and disfigurement. ***Exhibit 3 at ¶20***

Following the November 9, 2017 surgery, Plaintiff-Appellant ceased treatment with Defendants-Appellees Jeffrey Colton, MD, Jeffrey J. Colton, PLLC, and the Colton Center. On July 16, 2018, Plaintiff-Appellant filed his Complaint alleging medical malpractice committed by the Defendants-Appellees in the course of the multiple rhinoplasty procedures, resulting in facial scarring and functional deformity. ***Exhibit 3 at ¶¶19-20*** In his Complaint, Plaintiff-Appellant alleges 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-Appellees' negligent performance of repeated rhinoplasty surgeries. *Id.* The nasal tip has been deconstructed so that it is round and amorphous. The radix of the nose has become progressively thicker and wider through multiple fractures and inappropriate osteotomies. The appearance of this thickness has been aggravated by the inappropriate removal of tissue in the middle third of the nose. The lining of the nose is poorly functional due to complete obstruction of the nasal valve area and upper half of the nose from the osteotomies and deconstruction of the upper lateral cartilages, making breathing difficult. ***Exhibit 7 at 4-5***

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As required by MCL 600.2912d, Plaintiff-Appellant's Complaint was accompanied by an Affidavit of Merit from Dr. Michael J. Armstrong, Jr., MD, a physician board certified by the American Board of Otolaryngology and by the American Board of Facial Plastic and Reconstructive Surgery. ***Attachment to Exhibit 3*** 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. ***Attachment to Exhibit 3 at 1***
>
> 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. ***Attachment to Exhibit 3 at 2***

On October 11, 2018, Defendants-Appellees filed their Affidavit of Meritorious Defense of Michael A. Carron, MD, a physician, identical to Defendant Dr. Colton and Plaintiff-Appellant's expert Armstrong, board certified by the American Board of Otolaryngology-Head and Neck Surgery and the American Board of Facial, Plastic, and Reconstructive Surgery. ***Exhibit 4*** Defendants-Appellees' Affidavit of Meritorious Defense employs nearly identical language to Plaintiff-Appellant's Affidavit of Merit. Like Dr. Armstrong, Dr. Carron asserts the following:

> During the time period at issue in this case and the year preceding, I devoted the majority of my professional time to the active clinical practice of otolaryngology-head and neck surgery and facial, plastic, and reconstructive surgery. ***Exhibit 4 at 1***
>
> I understand the standard of care applicable to Jeffrey Colton, MD in this matter to be that which a physician specializing in otolaryngology-head and neck surgery and facial, plastic and reconstructive surgery of ordinary learning, skill, and judgment would do or would not do under the same or similar circumstances as existed in treating Plaintiff Anthony Selliman. ***Exhibit 4 at 2***

Litigation commenced and Dr. Armstrong was deposed on September 24, 2019. ***Exhibit 5*** At the deposition, Dr. Armstrong testified he was board certified, like Dr. Colton, in both otolaryngology and facial plastic and reconstructive surgery. As the deposition progressed, Dr. Armstrong gave

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unclear and confusing testimony when questioned about the division of his clinical practice between otolaryngology and facial plastic and reconstructive surgery, instead seeming to classify rhinoplasty as either cosmetic or functional:

> 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.

Exhibit 5 at 32-33

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 testifies that "the practice", that being facial plastics as referenced in the preceding sentence, "might be 10 percent cosmetic, 90 percent functional". Dr. Armstrong

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was not attributing these percentages to the division of his practice between otolaryngology and 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". ***Exhibit 5 at 29***

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. ***Exhibit 5 at 34***

> 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. ***Exhibit 5 at 34-35***

> 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?

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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. ***Exhibit 5 at 36***

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?

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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. ***Exhibit 5 at 114-115***

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 active clinical practice 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.

On October 16, 2019, Defendants-Appellees filed their Motion to Strike Michael J. Armstrong, Jr., MD and for Summary Disposition. In this Motion, filed approximately 15 months after Plaintiff-Appellant's initial disclosure of their expert and his qualifications, Defendants-Appellees 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-Appellees, again for the first time in this litigation and in conflict with their own Affidavit of Meritorious Defense, contend is facial plastic and reconstructive surgery. ***Exhibit 6*** In Response, Plaintiff-Appellant disputed both the Defendants-Appellees' characterization of Dr. Armstrong's testimony and the Defendants-Appellees' unilateral assertion that the one most relevant specialty is facial plastic and reconstructive surgery. ***Exhibit 7*** Plaintiff-Appellant pointed to Defendants-Appellees' own

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Affidavit of Meritorious Defense, which mirrors Plaintiff-Appellant's Affidavit of Merit in stating the applicable standard of care to be that of a physician specializing in otolaryngology-head and neck surgery *and* facial, plastic and reconstructive surgery, in support of his argument. ***Exhibit 7***

On November 25, 2019, Defendants-Appellees filed their Reply Brief, attaching an Affidavit from Defendant Dr. Jeffrey J. Colton, MD, dated November 22, 2019, three days prior**.** ***Exhibit 8*** In his Affidavit, Defendant Colton unequivocally states:

> Since 1983, including throughout my treatment of Plaintiff Anthony Selliman from 2012 through 2017, 100% of my professional time has been devoted to the active clinical practice of Facial, Plastic and Reconstructive Surgery. ***Exhibit 8 at 2***
>
> Plaintiff Anthony Selliman presented to me for aesthetic rhinoplasty revision procedures, which falls within the medical specialty of Facial, Plastic and Reconstructive Surgery. My treatment of Mr. Selliman involved only Facial, Plastic and Reconstructive Surgery. Mr. Selliman never presented to me with general otolaryngology issues and none of my treatment of Mr. Selliman involved general Otolaryngology. ***Exhibit 8 at 2***

Following receipt of Defendants-Appellees' self-serving Affidavit, Plaintiff-Appellant moved for leave to amend his witness list on December 4, 2019. ***Exhibit 10*** While Plaintiff-Appellant objected to Defendants-Appellees' attempt to unilaterally decide the applicable standard of care, Plaintiff-Appellant sought this amendment to avoid further delay or confusion to the jury. An Order Denying Plaintiff-Appellant's Motion was entered on December 12, 2019, approximately six weeks before oral argument on Defendants-Appellees' 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-Appellant's expert's practice. ***Exhibit 9 at 5, 21*** Ultimately, the trial court agreed with Plaintiff-Appellant'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

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> 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).

Exhibit 9 at 29 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. *See Footnote* 2

Defendants-Appellees sought interlocutory appellate review of the trial court's denial of the Motion to Strike and for Summary Disposition. In response, Plaintiff-Appellant disputed Defendants-Appellees 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 and other documentary evidence. A panel of this Court granted Defendants-Appellees application through 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." ***Exhibit 2***

ARGUMENT

I. STANDARD OF REVIEW

The interpretation of MCL 600.2169(1) is reviewed de novo. *Woodard*, 476 Mich at 557. This Court reviews a trial court's ruling concerning the qualifications of a proposed expert witness

2 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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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,* 476 Mich at 388.

II. THE ONE MOST RELEVANT SPECIALTY TEST ARTICULATED IN *WOODARD* AND SUBSEQUENT JURISPRUDENCE IS LOGICALLY INAPPLICABLE TO THIS CASE AND LEAVE TO APPEAL SHOULD BE GRANTED TO RE-EXAMINE THE PROPER INTERPRETATION AND APPLICATION OF MCL 600.2169(1) IN THIS AND OTHER MEDICAL MALPRACTICE ACTIONS

Defendants-Appellees argue that Plaintiff-Appellant has failed to establish his expert, Dr. Michael J. Armstrong, Jr. is qualified to provide standard of care testimony as required by MCL 600.2169, and the trial court therefore erred in denying their Motion to Strike and for Summary Disposition. MCL 600.2169 provides as follows:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

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It is undisputed that Defendant Dr. Colton and Plaintiff-Appellant's expert Dr. Armstrong are board certified in the same specialties, those being Otolaryngology-Head and Neck Surgery and Facial, Plastic, and Reconstructive Surgery, as required by MCL 600.2169(1)(a). At issue in this case is the active clinical practice requirement of MCL 600.2169(1)(b).

While both Dr. Armstrong and Defendants-Appellees' expert Dr. Carron stated in their respective Affidavits that the applicable standard of care is that of a "physician specializing in otolaryngology-head and neck surgery and facial, plastic and reconstructive surgery", Defendants-Appellees' Motion to Strike and for Summary Disposition announces the one most relevant specialty to be facial plastic and reconstructive surgery. An Affidavit from Dr. Colton attached to Defendants-Appellees' Reply Brief contains the self-serving statement that the alleged negligent treatment "involved only Facial, Plastic and Reconstructive Surgery", again in contradiction of his own expert Dr. Carron's Affidavit. Defendants-Appellees' claim is premised on the classification of the alleged malpractice as arising out of the performance of a "cosmetic" rather than "functional" rhinoplasty.

Irrespective of the descriptors Defendants-Appellees wish to affix to the treatment, Plaintiff-Appellant's theory in this case is that the malpractice occurred during the negligent performance of repeated rhinoplasty procedures. Plaintiff-Appellant's expert opined the applicable standard of care is otolaryngology and facial plastic and reconstructive surgery. Defendants-Appellee's expert opined the applicable standard of care is otolaryngology and facial plastic and reconstructive surgery. Defendants-Appellees did not attempt to amend Dr. Carron's Affidavit to 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

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on the opinion of their expert, Defendants-Appellees sought to unilaterally declare the applicable standard of care.

MCL 600.2169(1) does not exist to allow defendants in medical malpractice cases the opportunity to dictate a plaintiff's theory of the alleged malpractice, as Defendants-Appellees attempt to here. *Tate v Detroit Receiving Hospital*, 249 Mich App 212, 220; 642 NW2d 346 (2002). To the contrary, as pointed out by this Court in *McDougall v Schanz*, 461 Mich. 15, 25; 597 NW2d 148 (1999), quoting *McDougall v Eliuk*, 218 Mich App 501, 509, n.1, 554 NW2d 56 (1996) (Taylor, P.J., dissenting), and the Report of the Senate Select Committee on Civil Justice Reform, the statute exists 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 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)

Plaintiff-Appellant's theory of malpractice in this case relates to the negligent performance of repeated rhinoplasty procedures. The standard of care for performing the procedure is the same regardless of whether the rhinoplasty is performed for cosmetic or functional reasons. A physician may perform the procedure as part of an active clinical practice in either otolaryngology or facial plastics and reconstructive surgery. Therefore, to the extent current jurisprudence requires a determination of a singular most relevant specialty, such a standard is logically inapplicable to this case.

The "one most relevant specialty" standard was articulated by this Court in *Woodard v Custer*, 476 Mich 545; 719 NW2d 842 (2006). The *Woodard* defendant was board certified in pediatrics with certificates of special qualifications in pediatric critical care medicine and neonatal-

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perinatal medicine. *Id.* at 554. Plaintiff's proposed expert witness was also board certified in pediatrics, but lacked any certificates of added certification. *Id.* at 554-55. The alleged malpractice arose from defendant's placement of an arterial line in an infant patient's leg while the infant was in a pediatric intensive care unit. *Id.* at 554, 557. The trial court found the defendant physician was practicing pediatric critical care medicine at the time of the alleged malpractice, determining pediatric critical care medicine to be the one most relevant specialty. *Id.* at 576. The facts of *Woodard,* that being an infant whose condition required hospitalization in a Pediatric Intensive Care Unit and the placement of an arterial line for hemodynamic monitoring, necessarily required the most relevant specialty to be pediatric critical care medicine, rather than pediatrics. The facts of the instant case do not necessarily require the one most relevant specialty to be facial plastic and reconstructive surgery. 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. Nothing about Defendants-Appellees' negligent treatment of Plaintiff-Appellant here implicates one specialty over the other, unlike the circumstances of *Woodard.* Accordingly, the "one most relevant specialty" formulation upon which Defendants-Appellees rely in seeking to disqualify Plaintiff-Appellant's expert is logically inapplicable to this case.

The one most relevant specialty test was similarly applied in *Hamilton v. Kuligowski*, the companion case to *Woodard*. In *Hamilton,* the defendant physician was board-certified in general internal medicine and was practicing general internal medicine at the time of the alleged malpractice. *Id.* at 556. The proposed expert witness was also board-certified in general internal medicine. *Id.* However, the proposed expert devoted a majority of his professional time treating infectious diseases, a subspecialty of internal medicine, and explicitly testified that he is "not sure what the average internist sees day in and day out." *Id.* at 578. Thus, the Court held that the

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proposed expert did not satisfy the practice requirement of MCL 600.2169(1)(b) because the defendant physician specialized in general internal medicine and was practicing general internal medicine at the time of the alleged malpractice, and the proposed expert did not. *Id.* at 577-578. Rather, the proposed expert spent a majority of his professional time treating infectious diseases and was unfamiliar with the day-to-day practice of a general internist. *Id.* Such is not the case here. Dr. Armstrong testified during his deposition that he has performed hundreds of rhinoplasty procedures over the course of his career. He testified that he can, and does, regularly perform the procedure Defendant Dr. Colton performed on Plaintiff-Appellant; it is one of the more common procedures he performs.

Defendants-Appellees argue *Woodard/Hamilton* presents a "clear mandate" upon which this Court has consistently relied when determining the qualifications of an expert witness. Plaintiff-Appellant submits the instant litigation presents the ideal set of circumstances which demonstrate the absurdity that results from too strict an adherence to the language of *Woodard/Hamilton* and its progeny, a sentiment suggested by multiple dissenting opinions and dicta of the Court of Appeals, sampled below and attached at ***Exhibit 11***

In *Kiefer v Markley*, 283 Mich App 555; 769 NW2d 271 (2009), the Court of Appeals affirmed the trial court's disqualification of plaintiff's expert based on testimony that he spent a plurality, rather than a majority (30 to 40 percent as opposed to 50 percent) of his time in the practice of hand surgery. *Id.* at 557, 559. Despite their holding, the *Kiefer* majority noted "this is not a result we think the Legislature intended." *Id.* at 560. The Court believed the similarity in certification between the defendant and plaintiff's expert, coupled with the fact that plaintiff's expert spent more than 50 percent of his time in the area of hand surgery and the closely related area of reconstructive surgery of other extremities, should qualify him as an expert, yet they were

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compelled to affirm the disqualification by existing caselaw. *Id.* at 559. A similar result is not required under the facts of the instant case. Where the *Kiefer* majority considered only the time spent performing hand surgery, the procedure giving rise to the malpractice, as opposed to other extremities, the panel considered distinct, albeit closely related, procedures. The procedure considered in this litigation is one and the same – rhinoplasty. Defendants-Appellees, like Dr. Armstrong in his deposition testimony, may describe the procedure as either "cosmetic" or "functional", but the procedure being performed remains the same.

In *Johnson v Bhimani,* Docket No. 292327, rel'd February 10, 2011 (unpublished), the Court of Appeals, applying *Woodard, Hamilton,* and *Kiefer,* rejected plaintiff's argument that a neuroradiologist expert was qualified to testify against a defendant practicing diagnostic radiology at the time of the alleged malpractice. ***Exhibit 11a*** The *Johnson* majority described the characterization of diagnostic radiology as undisputed, yet plaintiff argued the significant overlap between the specialties rendered his expert qualified, as either discipline was implicated. In a dissenting opinion, Judge Gleicher explained the absurdity that results from too close an adherence to the traditional understanding of *Woodard, Hamilton,* and *Kiefer*:

> I strongly disagree that any *meaningful* distinction between the two specialties exists in this case. In my view, Bhimani [defendant] practiced both diagnostic radiology and neuroradiology, or either specialty, when he interpreted Johnson's films. Irrespective whether Bhimani claims to have worn the hat of a neuroradiologist or a diagnostic radiologist at the moment he interpreted Johnson's films, the standard of care governing his interpretation had no relationship to the label he attached to his specialty.
>
> In my view, it simply defies logic to conclude that two radiologists sharing identical board certifications and certificates of added qualifications, whose practices involve substantial time commitments to precisely the same specialty and subspecialty, would observe different standards of care when interpreting films of an anatomic area falling within the realm of their mutual expertise.

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Just as the practice at issue in *Johnson* – interpreting films – fell within the realm of mutual expertise for both a neuroradiologist and a diagnostic radiologist, the practice at issue in this case – performance of a rhinoplasty procedure – falls within the realm of mutual expertise for both an otolaryngologist and a facial plastic surgeon. This dissent illustrates that the "one most relevant specialty" test of *Woodard* is logically inapplicable in some cases.

In *Stevens v Lansing Anesthesiologists,* Docket No. 328971, rel'd November 17, 2016 (unpublished), the Court of Appeals upheld the trial court's finding that plaintiff's expert, who was board certified in both anesthesiology and pain management, was not qualified to testify against a defendant practicing anesthesiology at the time of the alleged malpractice. ***Exhibit 11b*** Despite conceding the one most relevant specialty was anesthesiology, plaintiff's expert testified he had not acted as an anesthesiologist in a hospital procedure such as the one giving rise to the malpractice in years. As previously discussed in the analysis of *Hamilton,* such is not the case here. Dr. Armstrong testified during his deposition that he has performed hundreds of rhinoplasty procedures over the course of his career. He testified that he can, and does, regularly perform the procedure Defendant Dr. Colton performed on Plaintiff-Appellant.

In *Estate of Patricia E. LeBlanc v Agnone,* Docket Nos. 330330 and 330416, rel'd July 6, 2017, (unpublished), the Court of Appeals affirmed the trial court's ruling that plaintiff failed to establish their proposed expert satisfied the active clinical practice requirement of MCL 600.2169. ***Exhibit 11c*** The defendant in *LeBlanc* was board certified in internal medicine and medical oncology. Plaintiff's proposed expert was also board certified in internal medicine and medical oncology, with additional certifications in numerous other specialties. While the parties agreed defendant was practicing medical oncology at the time of the alleged malpractice, plaintiff's expert expressed difficulty dividing the time he spent practicing his various specialties during confusing

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and at times contentious deposition testimony. The Court of Appeals thus concluded it would be improper to combine the proposed expert's time spent in medical oncology with the time spent practicing other overlapping specialties. In an opinion concurring in part and dissenting in part, Judge Ronayne Krause found the "lack of clarity or coherence [in plaintiff's expert's testimony] is obviously the result of a cultural clash between a formality and reality." Essentially, the "one most relevant specialty" formulation is a legal formality at odds with the realities of the practice of medicine, as evidenced in both *LeBlanc* and the instant case.

Finally, in *Perez v Henry Ford Health System*, Docket No. 340082, rel'd December 4, 2018 (unpublished), the Court of Appeals found plaintiff's expert, who was board certified in neurology, as well as neurocritical care and vascular neurology, unqualified to testify against a defendant who was a board-certified neurologist practicing as a general neurologist at the time of the alleged malpractice. ***Exhibit 11d*** *Perez,* where a proposed expert testified to spending the majority of her time in the practice of neurocritical care, rather than the most relevant specialty of general neurology, is essentially the inverse of *Woodard*, in which the proposed expert testified to spending the majority of his time in the practice of pediatrics, rather than the one most relevant specialty of pediatric critical care medicine. Judge Shapiro dissented, concluding that because plaintiff's proposed expert "made it clear that her practice as a consulting neurologist, whether with the general medical unit or the intensive care unit, involves caring for all of a patient's neurological needs" the requirements of MCL 600.2169(1)(b) are satisfied. The dissent in *Perez,* like *Johnson*, makes it clear that a blind adherence to the "one most relevant specialty" formulation of *Woodard, Hamilton,* and *Kiefer* overlooks both common sense and the intent of the Legislature in enacting the statute, as articulated in *McDougall*. In some cases, including the instant case, no meaningful

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or practical distinction can be found which renders one specialty more relevant than the other for purposes of qualifying an expert witness.

III. THE TRIAL COURT PROPERLY EXERCISED ITS DISCRETION IN DENYING DEFENDANTS-APPELLEES' MOTIONS BASED ON THE DEPOSITION TESTIMONY OF PLAINTIFF-APPELLANT'S EXPERT AND LEAVE TO APPEAL SHOULD BE GRANTED TO ADDRESS THE COURT OF APPEALS' FAILURE TO GIVE DEFERENCE TO THIS RULING

The qualification or competency of expert witnesses is a matter for the discretion of the trial judge. *Gay v Select Specialty Hospital,* 295 Mich App 284; 813 NW2d 354 (2012). An abuse of this discretion occurs when the judge's decision falls outside the range of principled outcomes. 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. ***Exhibit 11e*** The Court of Appeals found the trial court did not abuse its discretion in finding the proposed expert was qualified, in part based on his testimony that even with respect to persons certified in a subspecialty such as sports medicine, they are still practicing the specialty, due to the potential overlapping medical conditions and treatment options. This Court subsequently denied leave to appeal. *Turkish v William Beaumont Hospital,* 504 Mich 963; 932 NW2d 783 (2019).

Similarly, in *In Re Estate of Linda 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

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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. ***Exhibit 11f*** 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." 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. *In re Estate of Linda Roberdeaux*, 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. For purposes of MCL 600.2169(1), 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". The trial court's ruling reflects a reasonable and principled outcome under the circumstances. Thus, the Court of Appeals clearly erred in ruling the trial court abused its discretion in denying the motion to strike Dr. Armstrong's testimony.

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CONCLUSION AND RELIEF REQUESTED

Respectfully, this Court should grant leave to consider all of the issues discussed above. The one most relevant specialty test articulated in *Woodard* and subsequent jurisprudence is logically inapplicable to this case, where Dr. Armstrong and Dr. Colton spent the majority of their professional time in the same active clinical practice, practicing the same medicine, performing the same rhinoplasty procedures. Leave to appeal should be granted to re-examine the proper interpretation and application of MCL 600.2169(1) in this and other medical malpractice actions. Further, the trial court did not abuse its discretion in denying Defendants-Appellees' motion, because trial courts are afforded wide discretion to determine the qualifications of an expert witness, and the trial court's ruling was within the range of principled outcomes. In finding to the contrary, the Court of Appeals clearly erred.

WHEREFORE, Plaintiff-Appellant Antonio Selliman respectfully requests this Court summarily reverse the Court of Appeals May 20, 2021 Opinion, or in the alternative, requests this Court schedule oral argument on this application, grant leave to appeal, and any such other and further relief as this Court deems appropriate.

July 1, 2021

Respectfully submitted,

RATTON LAW GROUP, PC

/s/ Rachel M. Ratton

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on July 1, 2021, she caused to be served a copy of Plaintiff-Appellant's Notice of Filing Application, Application for Leave to Appeal, Index of Exhibits, Exhibits 1-11, and this Certificate of Service as follows:

Robert Kamenec (P35283) Counsel for Defendants-Appellees rkamenec@plunkettcooney.com	Counsel was electronically served via MiFile
Paul J. Dwaihy (P66074) Counsel for Defendants-Appellees paul.dwaihy@tnmglaw.com	Counsel was electronically served via MiFile

The undersigned further states that the Notice of Filing Application was served upon the following courts:

Court of Appeals	The Court was electronically served via MiFile
Oakland County Circuit Court	The Court was electronically served via MiFile

/s/ Rachel M. Ratton
RACHEL M. RATTON
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