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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.

Supreme Court Case No. 163226

Court of Appeals Case No. 352781

Oakland County Circuit Court
Case No. 18-167068-NH
Hon. Jeffrey S. Matis

SUPPLEMENTAL AMICI CURIAE BRIEF OF MICHIGAN STATE MEDICAL SOCIETY AND THE AMERICAN MEDICAL ASSOCIATION

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STATEMENT OF INTEREST OF AMICI CURIAE MICHIGAN STATE MEDICAL SOCIETY AND AMERICAN MEDICAL ASSOCIATION[1]

Amicus Curiae Michigan State Medical Society (MSMS) is a professional association which represents the interests of over 14,000 physicians in the State of Michigan. Organized to promote and protect the public health and to preserve the interests of its members, MSMS is frequently called upon to express its views with respect to legal issues of significance to the medical profession.

Amicus Curiae American Medical Association (AMA) is the largest professional association of physicians, residents, and medical students in the United States. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice and reside in all states, including Michigan. Through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents and medical students in the United States are represented in the AMA's policy-making process.

MSMS and the AMA join this brief on their own and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

Amici Curiae have a compelling interest in the law applicable to the qualification of experts who provide standard of care testimony in medical malpractice actions, which is in large part

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[1] Pursuant to MCR 7.312(H)(4), amici curiae Michigan State Medical Society and American Medical Association state that neither appellant's counsel nor appellee's counsel authored this brief in whole or in part, or contributed money that was intended to fund the preparation or submission of the brief. Further, no person other than the amici curiae have contributed money intended to fund the preparation and submission of this brief.

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governed by MCL 600.2169. MSMS and the AMA are simultaneously filing a supplemental amici brief in *Joelynn T Stokes, Personal Representative of the Estate of Linda Horn, v Michael J Swofford, DO*, Supreme Court Case No. 162302, in which this Court issued an order directing the parties to address a number of issues that overlap with the Court's order in this case, including whether *Woodard v Custer*, 476 Mich 545 (2006), was correctly decided and is consistent with the requirements of MCL 600.2169(1); if not, whether it should nonetheless be retained under principles of stare decisis; and if *Woodard* was not correctly decided, the test that should be applied.

MSMS and the AMA believe that *Woodard's* "one most relevant specialty test" is consistent with MCL 600.2169(1) and gives effect to the statutory requirement that the expert practice the *same* specialty as the defendant during the time of the alleged malpractice and have devoted a majority of his or her professional time to the practice of *that* specialty in the year preceding the alleged malpractice. It would contravene the statutory language to find, as Plaintiff asks here, that an expert practicing a *different* specialty nonetheless satisfies the majority practice requirement as long as the expert alleges that he has performed the at-issue procedure in the course of practicing the expert's specialty and further alleges that the standard of care is the same in the expert's specialty. This is clearly insufficient under the statute.

Here, Plaintiff's expert testified that the procedure performed on Mr. Selliman was cosmetic and not performed for a medical purpose. Thus, facial plastic and reconstructive surgery was the specialty being practiced at the time of the alleged malpractice. However, in the year preceding the alleged malpractice, the *Selliman* expert devoted only 10 percent of his professional time to that specialty; 90 percent of his practice was devoted to the specialty of otolaryngology.

Therefore, the *Selliman* expert is not qualified to testify under the plain language of MCL 600.2169(1)(b).

The qualification requirements for expert testimony have been prescribed by the Legislature and cannot be disregarded. Amici Curiae appreciate this opportunity to submit this amicus brief to more fully express the views of their members.

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STATEMENT OF QUESTIONS ADDRESSED BY AMICI CURIAE

Question One:

Was *Woodard v Custer*, 476 Mich 545 (2006) correctly decided, and does it effectuate the plain language of MCL 600.2169(1)?

The Trial Court did not address this issue.

The Court of Appeals did not address this issue.

Plaintiff-Appellant says "no."

Defendants-Appellees say "yes."

Amici Curiae Michigan State Medical Society and
American Medical Association say "yes."

Question Two:

If this Court determines that *Woodard* was not correctly decided, should it nonetheless be retained under the principles of stare decisis?

The Trial Court did not address this issue.

The Court of Appeals did not address this issue.

Plaintiff-Appellant says "no."

Defendants-Appellees say "yes."

Amici Curiae Michigan State Medical Society and
American Medical Association say "yes."

Question Three:

Did *Woodard* correctly interpret the "one most relevant specialty" requirement set forth in MCL 600.2169(1)?

The Trial Court did not address this issue.

The Court of Appeals did not address this issue.

Plaintiff-Appellant says "no."

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Defendants-Appellees say "yes."

Amici Curiae Michigan State Medical Society and
American Medical Association say "yes."

Question Four:

Did *Woodard* correctly interpret the "majority of . . . professional time" requirements set forth in MCL 600.2169(1)?

The Trial Court did not address this issue.

The Court of Appeals did not address this issue.

Plaintiff-Appellant says "no."

Defendants-Appellees say "yes."

Amici Curiae Michigan State Medical Society and
American Medical Association say "yes."

Question Five:

Did the Court of Appeals reach the right result in its application of the requirements of MCL 600.2169 where it held that an otolaryngologist who devotes the majority of his professional time to otolaryngology could not provide standard of care testimony against a practicing facial plastic and reconstructive surgeon?

The Trial Court would say "no."

The Court of Appeals would say "yes."

Plaintiff-Appellant says "no."

Defendants-Appellees say "yes."

Amici Curiae Michigan State Medical Society and
American Medical Association say "yes."

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INTRODUCTION

The "one most relevant specialty" rule set forth in *Woodard v Custer*, 476 Mich 545; 719 NW2d 842 (2006), is consistent with MCL 600.2169, and the statute was properly applied in this case. Plaintiff's expert, Dr. Armstrong, does not satisfy the expert qualification requirement of MCL 600.2169(1)(b) because: (1) Defendant Dr. Colton was practicing facial plastic and reconstructive surgery at the time of the alleged malpractice; (2) Dr. Armstrong devotes the majority of his professional time to otolaryngology; and (3) facial plastic and reconstructive surgery is a different specialty from otolaryngology.

Plaintiff spends a significant portion of his brief criticizing holdings in *Woodard* that are not applicable to the circumstances here, and therefore, not before this Court in this case. For example, whether a subspecialty is a specialty is not relevant here because neither of the specialties at issue are considered subspecialties.[2] In addition, whether a certificate of added qualification constitutes board certification is not an issue in this case, where neither of the specialties involves a certificate of added qualification. The two holdings in *Woodard* applicable to this case are the "one most relevant specialty" rule and the requirement that the proffered expert devotes a majority of his professional time to that one most relevant specialty. Both of these holdings are required to effectuate the plain meaning of the statutory language, and any change in their application would rewrite the statute.

Woodard articulated the rule for determining which of Dr. Colton's specialties (otolaryngology or facial plastic and reconstructive surgery) sets the standard of care under MCL 600.2192a and governs the expert's majority practice requirement (MCL 600.2169(1)(b)). In *Woodard*, the defendant argued that the expert must match all of the defendant's specialties and

[2] Amici address subspecialties in detail in their supplemental brief filed in *Stokes* (attached as Exhibit A) at pp 16-24.

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board certifications. The *Woodard* majority rejected this assertion, holding that when the defendant has multiple specialties, only the one most relevant specialty – the specialty being practiced at the time of the alleged malpractice – must match. This rule effectuates the statute, which looks to the specialty being practiced "at the time of the occurrence that is the basis for the action." MCL 600.2169(1).

There is nothing erroneous or inappropriate about this rule. It does not conflict with the statute; nor is it illogical. Rather, the rule effectuates the Legislature's intent to require a standard of care expert to practice the *same* specialty as the defendant at the time of the alleged malpractice and to devote *the majority* of his or her professional time in the preceding year to *that* specialty. If *Woodard* allowed the qualification of an expert who devoted the majority of his practice to a different but related specialty, as would have been permitted under the prior (but superseded) 1986 version of the statute, this Court might well conclude that *Woodard* contravened the plain language of MCL 600.2169(1)(b). That is what Plaintiff is asking of this Court, but it is a misdirected request. This Court cannot rewrite the statute. If Plaintiff wishes the law to return to former days, where an expert could be qualified if he or she devoted only a *substantial* portion of his or her professional time in the year preceding the alleged malpractice to a *related relevant* specialty, it must direct its argument to the Legislature.

CONCISE STATEMENT OF MATERIAL PROCEEDINGS AND FACTS

Amici Curiae refer this Court to the Statement of Material Proceedings and Facts provided in Defendants' Application for Leave to Appeal, Supplemental Brief, and Brief on Appeal.

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ARGUMENT

I. *Woodard v Custer* was Correctly Decided and Effectuates the Plain Language of MCL 600.2169(1).

MSMS and the AMA respect the Court's interest in assuring that MCL 600.2169 is properly applied in accordance with its statutory language. That is obviously a different issue than whether this Court agrees with the Legislature's policy choice. But the policy question is the focus of Plaintiff's argument, which disregards the typical tools of legal analysis. Plaintiff struggles to explain how the "one most relevant specialty" rule conflicts with the plain language of the statute or what a more appropriate rule would be. Plaintiff's constant reprise simply argues the illogic of the statute, seeking an expedient result untethered to jurisprudence. This alone should tell us that Plaintiff is in the wrong forum.

A. The Standard of Care is That Applicable to Defendant's Specialty.

In Michigan, the standard of care applicable to a medical malpractice action is the standard of care that governs the defendant's specialty. This has been codified in MCL 600.2912a(1), which provides in pertinent part:

> [I]n an action alleging malpractice, the plaintiff has the burden of proving that in light of the state of the art existing at the time of the alleged malpractice:
>
> * * *
>
> (b) The defendant, if a *specialist*, failed to provide the recognized standard of practice or care *within that specialty* as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances, and as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury. [*Id*. (emphasis added)]

B. A Standard of Care Expert Must Devote the Majority of His/Her Professional Time to the Practice of Defendant's Specialty.

An expert witness must meet an established qualification threshold before he or she will be permitted to give standard of care testimony for or against a defendant. To testify regarding the

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standard of care within the defendant's specialty, the expert must specialize at the time of the alleged occurrence *in the same specialty* as the defendant and devote the majority of his professional time to *that specialty* in the year preceding the alleged malpractice. This is required by the plain language of MCL 600.2169(1):

> (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*. . . [*Id.* (emphasis added)]

These are unequivocal requirements. The expert must practice the same specialty as the defendant at the time of the occurrence and have devoted the majority of his or her professional time to that specialty in the year preceding the alleged malpractice.

C. *Woodard's* One Most Relevant Specialty Rule Effectuates the Requirements of MCL 600.2169(1).

Plaintiff claims that the "one most relevant specialty" rule is premised on the "mistaken belief that a physician can only be practicing one branch of medicine at a time." Plaintiff asserts

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that the language of the statute does not contemplate that only one specialty may be relevant. However, the language of the statute requires the determination of the area of medicine that the alleged negligence falls under and that the plaintiff's expert both specialize in that area and devote a majority of his time to it. Plaintiff's issue is with the statute itself, not *Woodard*.

1. When the Defendant Has Multiple Specialties, the Specialty Referred to in MCL 600.2169 is the Specialty Being Practiced at the Time of the Alleged Malpractice.

In *Woodard*, this Court determined how MCL 600.2169 is applied when the defendant has multiple specialties. This Court held that when the defendant physician has multiple specialties, the standard of care expert is not required to match *all* of the specialties and board certifications of the defendant, but, rather, only the "one most relevant" specialty "engaged in by the defendant physician during the course of the alleged malpractice." *Woodard,* 476 Mich at 559-560. Thus, where a defendant has additional specialties unrelated to the plaintiff's claim, the expert is not required to match those irrelevant specialties. *Id*. at 559. Only a single specialty must be matched.

Further, because the statute refers to "specialty" not "specialties" and because a health professional cannot devote a "majority" of his or her time to more than one specialty, the majority of the expert's professional time under MCL 600.2169(1)(b) must have been devoted to the specialty the defendant was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty. This effectuates the language and intent of the statute, which looks to the specialty being practiced "at the time of the occurrence that is the basis for the action." MCL 600.2169(1). In *Woodard*, this Court explained:

> MCL 600.2169(1)(b) provides that if the defendant physician is a specialist, the expert witness must have "during the year immediately preceding the date *of the occurrence* that is the basis for the claim or action, devoted a majority of his or her professional time to either . . . the active clinical practice of *that specialty* [or][t]he instruction of students in an . . . accredited health professional school or accredited residency or clinical research program in the *same specialty*." Once again the statute refers to "the same specialty" and "that specialty," *implying that only a single*

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> *specialty must be matched.* In addition, § 2169(1)(b) requires the plaintiff's expert to have "devoted a majority of his or her professional time" to practicing or teaching the specialty in which the defendant physician specializes. *As we explained above, one cannot devote a "majority" of one's professional time to more than one specialty. Therefore, in order to be qualified to testify under § 2169(1)(b), the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty.* [*Id*. at 567-568 (emphasis added).]

The underlying *Woodard* facts involved an infant's fractured legs that allegedly resulted from the improper placement of an arterial line in the femoral vein of the infant's right leg and the improper placement of a venous catheter in the infant's left leg. *Woodard,* 476 Mich at 554, 575. The placements were made when the infant was critically ill and a patient in the hospital's pediatric intensive care unit. *Id*. at 575. The defendant physician was board certified in pediatrics, pediatric critical care medicine, and neonatal-perinatal medicine. *Id*. at 554. This Court concluded that the defendant was practicing pediatric critical care medicine at the time of the alleged malpractice. *Id*. at 575-576. The plaintiff's proposed expert was board certified in pediatrics and had never specialized in pediatric critical care medicine. *Id*. at 554-555, 576-577. Because the plaintiff's proposed expert witness did not practice or teach pediatric critical care medicine during the year immediately preceding the alleged malpractice, the proposed expert did not satisfy the majority practice/instruction requirement of MCL 600.2169(1)(b). *Id*. at 577.

In its companion case, *Hamilton v Kuligowski*, the defendant physician was board certified in general internal medicine, specialized in general internal medicine, and was practicing general internal medicine at the time of the alleged malpractice. *Woodard*, 476 Mich at 556, 577-578. The plaintiff's proposed expert was also board certified in general internal medicine but "devote[d] a majority of his professional time to treating infectious diseases, a subspecialty of internal medicine." *Id*. at 556, 578. This Court concluded that the proposed expert did "not satisfy the

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same practice/instruction requirement of § 2169(1)(b)" and was "not qualified to testify regarding the appropriate standard of practice or care under § 2169(1)." *Id*. at 578.

2. MCL 600.2169(1)(b) Refers to a Single Specialty.

MCL 600.2169(1) has multiple references to "the occurrence that is the basis for the action" in conjunction with the word "specialty" in singular form. Subpart (a) requires the plaintiff's expert to specialize in the defendant's same specialty at the time of the occurrence, and subpart (b) requires the expert to devote a majority of his or her professional time to the active clinical practice or instruction of that specialty during the year preceding the occurrence. *Woodard* is consistent with MCL 600.2169(1)(b) and effectuates the Legislature's intent to require that a standard of care expert practice the same specialty the defendant was engaged in at the time of the alleged occurrence and to have devoted the majority of his or her professional time to that particular specialty. This requirement means that an expert "spend greater than 50 percent of his or her professional time practicing the relevant specialty the year before the alleged malpractice." *Kiefer v Markley*, 283 Mich App 555, 559; 769 NW2d 271 (2009). The statute does not refer to multiple specialties and simply does not contemplate the practice of multiple specialties during a single occurrence of alleged malpractice.

a. The Expert Need Only Match One Specialty.

Consistent with MCL 600.2169(1), *Woodard* holds that when a defendant has multiple specialties, the standard of care expert is not required to match *all* of the specialties and board certifications of the defendant, but, rather, only the specialty "engaged in by the defendant physician during the course of the alleged malpractice." *Woodard,* 476 Mich at 559-560. As this Court explained, the statute "refers to 'the same specialty' and 'that specialty,'" not "the same specialties" or "those specialties," and implies that only a single specialty must be matched. *Id*. at 559. Certainly, requiring only one specialty to match is consistent with this statutory language.

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Plaintiff disregards the language of the statute in asserting that "the standard of care is the same whether the rhinoplasty is performed for cosmetic or medical reasons or performed by an otolaryngologist or a facial plastic and reconstructive surgeon." Pls' Br at 17-18. The qualification of an expert is not determined by the procedure being performed nor satisfied if an expert who devotes the majority of his practice to another specialty is familiar with the standard of care. MCL 600.2169 is specific; it requires that the proposed expert have devoted the majority of his professional time in the year preceding the alleged malpractice to the specialty the defendant was practicing at the time of the alleged malpractice. Nothing less will suffice; indeed, the Legislature rejected the notion that an expert could be qualified by practicing a specialty that performs overlapping procedures when it amended the statute in 1993.[3] This Court should reject Plaintiff's effort to give the 1993 statute the same meaning that the Legislature rejected when it amended the 1986 version.

b. The Matching Specialty Must be the Specialty Practiced at the Time of the Alleged Malpractice.

Woodard properly defines the relevant specialty as the specialty being practiced at the time of the alleged malpractice. *Id.* at 560-561. This definition is not inconsistent with MCL 600.2169(1). To the contrary, it is required by the statute, which requires that the expert "specialize[] *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," MCL 600.2169(1)(a) (emphasis added), and "during the year immediately *preceding the date of the occurrence that is*

[3] As set forth in more detail below, the 1986 version of the statute required that the expert practice in a relevant, related specialty rather than the same specialty required in the current version. In addition, the expert was only required to devote a substantial amount of his or her professional time to that specialty rather than a majority. Plaintiff essentially seeks a reinstatement of the 1986 statute via an inappropriate use of the courts.

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the basis for the claim or action, devoted a majority of his or her professional time to" that specialty. MCL 600.2169(1)(b) (emphasis added).

Plaintiff's appeal evidences a disagreement with this statutory matching specialty requirement, arguing that a physician practicing facial plastic and reconstructive surgery "who does not perform rhinoplasty but instead administers Botox injections and chemical peels would not be disqualified." Pls Br at 16. But as this Court well knows, MCL 600.2169 is not the only qualification requirement. In *Woodard*, this Court explained that an expert who satisfies the requirements of MCL 600.2169(1) might still be disqualified for other reasons under MCL 600.2169(2) and MCL 600.2169(3):

> Further, we note that just because an expert is qualified under § 2169(1) does not mean that the trial court cannot disqualify the expert on other grounds. MCL 600.2169(2) provides:
>
> > In determining the qualifications of an expert witness in an action alleging medical malpractice, the court shall, at a minimum, evaluate all of the following:
> >
> > (a) The educational and professional training of the expert witness.
> >
> > (b) The area of specialization of the expert witness.
> >
> > (c) The length of time the expert witness has been engaged in the active clinical practice or instruction of the health profession or the specialty.
> >
> > (d) The relevancy of the expert witness's testimony.
>
> In addition, MCL 600.2169(3) specifically states, "[t]his section does not limit the power of the trial court to disqualify an expert witness on grounds other than the qualifications set forth in this section." [*Woodard*, 476 Mich at 572]

This Court also referred to MCL 600.2955 ("a scientific opinion rendered by an otherwise qualified expert is not admissible unless the court determines that the opinion is reliable and will assist the

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trier of fact") and MRE 702."[4] But more to the point, the "illogic" Plaintiff complains of is not a function of *Woodard*; it is compelled by the statute. Plaintiff simply disagrees with the singularity of "same specialty" and "that specialty" – the words chosen by the Legislature.

c. An Expert Can Devote a Majority of His or Her Time to Only One Specialty.

"Majority" means and always has meant more than half. See, e.g., *Merriam-Webster's Online Dictionary*, https://www.merriam-webster.com/dictionary/majority (defining majority as "a number or percentage equaling more than half of a total"); *Cambridge Online Dictionary*, https://dictionary.cambridge.org/us/dictionary/english/majority (defining majority as "more than half a total number or amount; the larger part of something"). Plaintiff seeks to change the meaning of "majority" to a "plurality" or "substantial part." Once again, this would constitute a return to the pre-amended statute. Furthermore, it would not help Plaintiff in this case, where his expert only devoted 10 percent of his professional time to the specialty at issue. Even if this Court were empowered to adopt a standard that is less than 50 percent but still a plurality or substantial amount of time, 10 percent would not meet those lesser standards.

Plaintiff claims that the statute recognizes that a person can devote a majority of one's time to more than one profession because it uses the phrase "either or both" in Subsection (b). However, this language allows an expert to aggregate time spent in both active clinical practice of a specialty and instruction in that specialty to count toward the majority requirement. It does not mean that an expert can somehow spend more than the majority of his time in each one.

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[4] MRE 702 states: "If the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by *knowledge, skill, experience, training, or education* may testify thereto in the form of an opinion or otherwise if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case" (emphasis added).

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Woodard is faithful to the statutory language in applying the singularity requirement, reasoning that because a health professional "cannot devote a 'majority' of his or her time to more than one specialty, the majority of the expert's professional time must have been devoted to the specialty the defendant was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty." *Id*. at 567-568 This is a proper interpretation and application of the majority practice requirement, which expressly refers to "same specialty" and "that specialty" in their singular form.

Nothing in the statute suggests that the majority practice requirement can be achieved by combining multiple specialties, by contending that multiple specialties are being practiced at the same time, or by asserting that the procedure at issue cuts across multiple specialties. Such assertions do not effectuate the plain language of the statute but seek to thwart it. As *Woodard* explains, "In addition, § 2169(1)(b) requires the plaintiff's expert to have 'devoted a majority of his or her professional time' to practicing or teaching the specialty in which the defendant physician specializes. *As we explained above, one cannot devote a 'majority' of one's professional time to more than one specialty.*" *Id*. at 566 (emphasis added).[5]

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[5] "Majority" is not a judicial requirement; it is the word used by the Legislature. The Court explained:

> MCL 600.2169(1)(b) provides that if the defendant physician is a specialist, the expert witness must have "during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either ... the active clinical practice of that specialty [or][t]he instruction of students in an ... accredited health professional school or accredited residency or clinical research program in the same specialty." Once again the statute refers to "the same specialty" and "that specialty," implying that only a single specialty must be matched. In addition, § 2169(1)(b) *requires the plaintiff's expert to have "devoted a majority of his or her professional time*" to practicing or teaching the specialty in which the defendant physician specializes. As we explained above, *one cannot devote a "majority" of one's professional time to more*

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There is no ambiguity in the meaning of majority. It denotes more than half -- greater than 50 percent. One can devote more than half of his or her time, or greater than 50 percent of his or her time, to only one specialty. There can be only one "majority."

D. Related Relevant Fields of Practice are not Sufficient Under the Statute.

Woodard concludes, "[t]herefore, in order to be qualified to testify under § 2169(1)(b), the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty." *Id*. at 566. This is a proper interpretation of the statute. Related relevant specialties do not satisfy the statute's same specialty majority practice requirement. That would have been allowed under the earlier 1986 statute but not under the statute as amended in 1993.

1. The 1986 Statute Allowed Experts with Related Relevant Specialties to Testify as Long as They Devoted a Substantial Portion of Their Practice to Those Specialties.

The circumstances leading to the enactment of MCL 600.2169 are described in the MSMS/AMA amicus brief in *Stokes*. See *Stokes* supplemental brief (attached as Exhibit A) at pp 9-14. In short, prior to 1986, MRE 702 was the sole determinant regarding the admissibility of expert testimony. At that time, the rule allowed a witness to give expert testimony if the witness was "qualified as an expert by knowledge, skill, experience, training, or education …" This

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> *than one specialty*. Therefore, in order to be qualified to testify under § 2169(1)(b), the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty. [*Id*. at 565-566 (emphasis added) (footnotes omitted)]

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standard gave Michigan courts free rein to determine whether a proffered expert had the requisite familiarity with the standard of care to pass evidentiary muster. Indeed, familiarity with the standard of care was frequently articulated as the qualifying test, allowing experts to testify even absent credentials in the defendant's specialty and despite an expert's absence from the practice of medicine for decades. This led to the proliferation of circuit-riding "experts" who "practiced" only in the litigation arena, providing "pay for what you want testimony" and compromising the integrity of the judicial process.

The resulting "perfect storm" contributed to the high cost of malpractice insurance, the reluctance of physicians to practice in high exposure specialties, and consequent deficiencies in the availability of health care. To address this problem, the 1986 enactment of MCL 600.2169 required that an expert testifying for or against a specialist, specialize in the same specialty *or a related relevant area of medicine* as the defendant in the action, and devote or have devoted at the time of the occurrence involved in the action, a *substantial portion* of his or her professional time to practice or teaching in that area.[6] This meant that a specialist in one field could testify against a

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[6] The statute provided in relevant 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 is or was a physician licensed to practice medicine or osteopathic medicine and surgery or a dentist licensed to practice dentistry in this or another state and meets both of the following criteria:
>
> (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 or dentistry as the specialist who is the 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*

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specialist in another field "as long as the two fields were connected to each other and had practical value to one another and as long as the proposed expert practiced or taught in the associated, pertinent area of health care." *McClellan v Collar,* 240 Mich App 403, 410; 613 NW2d 729 (2000). This is the "logic" Plaintiff Selliman advocates in this case. But his analysis is behind the times. The 1986 statute no longer controls.[7]

2. The 1993 Statute Requires the Expert to Practice the Same Specialty as Defendant and Devote the Majority of His/Her Professional Time to That Specialty.

In 1993, the Legislature amended the statute to require that the proffered expert practice in the *same specialty* as the defendant, be board certified in that *specialty* if the defendant was board certified, and *devote the majority* of his or her professional time to practice or instruction in that *specialty*. These are specific requirements set forth in very plain language. Relevant, related, and substantial portion were eliminated and are no longer operative. "Same specialty" and "majority"

> *professional time* to the active clinical practice of medicine or osteopathic medicine and surgery or the active clinical practice of dentistry, or to the instruction of students in an accredited medical school, osteopathic medical school, or dental school in the same specialty *or a related, relevant area of health care* as the specialist who is the defendant in the medical malpractice action. [(emphasis added).]

This statute was part of the Michigan Tort Reform Act of 1986, P.A. 1986, No. 178.

[7] See e.g., Pl's Brief at 18, where Plaintiff argues that Dr. Colton and Dr. Armstrong both practice otolaryngology and facial plastic and reconstructive surgery, and therefore, "[i]rrespective of whether Dr. Colton claims to have worn the hat of an otolaryngologist or a facial plastics surgeon (or both hats at once) when performing rhinoplasty, the standard of care in unmoored from the label he attaches to his practice." That may have worked under the 1986 statute but under the plain language of the statute, it *absolutely does matter* which specialty "they are deemed to be practicing." The defendant and the expert must be practicing the "same" specialty and the defendant must devote the majority of his professional time to the specialty being practiced at the time of the alleged malpractice. Plaintiff's expert described what defendant was practicing at the time of the alleged malpractice (cosmetic non-medical surgery) and admitted that he does not devote the majority of his practice to that specialty.

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now control the expert qualification requirement. This is the version of the statute that is presently before this Court. It has remained intact for 29 years without further amendment.[8]

"Same" quite clearly does not mean "related relevant." "Same" means identical. *See e.g., Oxford English Reference Dictionary* (Rev 2d ed, 2002) (defining same to mean "… identical; not different; unchanged …"); *Webster's Universal College Dictionary* (2001) (defining "same" as "identical with what is about to be or has just been mentioned …"). Further, substantial is not the same as majority. Substantial means "large in size, value, or importance," https://dictionary.cambridge.org/us/dictionary/english/substantial, and "considerable in quantity: significantly great." https://www.merriam-webster.com/dictionary/substantial. Majority, on the other hand, means "a number or percentage equaling more than half of a total," https://www.merriam-webster.com/dictionary/majority, and "more than half of a total number or amount; the larger part of something." https://dictionary.cambridge.org/us/dictionary/english/majority.

Plaintiff argues that Dr. Armstrong is a knowledgeable expert, has performed "hundreds of" rhinoplasty procedures, and is familiar with the standard of care which, he argues, applies to both specialties. This argument harkens back to the earlier version of MCL 600.2169 which allowed an expert to testify if he or she practiced in a related relevant specialty and devoted a

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[8] As this Supreme Court explained in *McDougall v Schanz*, 461 Mich 15, 25, n 9; 596 NW2d 148 (1999), the statute was designed to ensure that experts had firsthand practical experience in the subject matter about which they are testifying, citing the *Report of the Senate Select Committee on Civil Justice Reform*, issued September 26, 1995. *Woodard* gives effect to this statutory purpose, as expressed in the meaning of the words used. As the *Select Committee Report* states, "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.'" [*Id*. at 29 (emphasis added).]

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substantial portion of his/her practice to that specialty. The 1993 amendment to MCL 600.2169 changed that formula by prescribing the specific requirements for standard of care experts that have been discussed herein. Whether the standard of care is "the same" across different specialties (as Plaintiff argues here) is irrelevant.

II. Even if this Court Disagrees with the Decision in *Woodard*, it Should Nonetheless be Retained under the Principles of Stare Decisis.

"Under the doctrine of stare decisis, principles of law deliberately examined and decided by a court of competent jurisdiction become precedent which should not be lightly departed." *People v Jamieson*, 436 Mich 61, 79 n 8; 461 NW2d 884 (1990), citing *Kirby v Larson*, 400 Mich 585, 618, 256 NW2d 400 (1977) ("Alterations are not usually made in a doctrine which is serving well, and with which the bench, bar and public are satisfied."). As Justice McCormack expressed in an order implicitly reflecting this Court's refusal to overturn precedent established by *Opdyke Investment Co v Norris Grain Co*, 413 Mich 354; 320 NW2d 836 (1982), "There are times when courts must overturn precedent. But, in my view, those occasions should be rare and the case for doing so compelling. This is plainly not one of those cases." *N Am Brokers, LLC v Howell Pub Sch*, 502 Mich 882; 913 NW2d 638, 641 (2018) (McCormack, C.J. concurring).

This Court has recognized the importance of stare decisis**,** the purpose of which is to establish "uniformity, certainty and stability in the law." *Parker v Port Huron Hosp*, 361 Mich 1, 10; 105 NW2d 1 (1960). *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 (1998). A compelling justification must exist to overrule precedent. *Peterson v Magna Corp*, 484 Mich 300, 317; 773 NW2d 564 (2009).

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In *Robinson,* this Court held that the first question is to ask whether the decision was wrongly decided. *Robinson*, 462 Mich at 464. A decision is wrongly decided if it misunderstood or misconstrued a plainly worded statute, or if a decision "has fallen victim to a subsequent change in the law." *Id*. at 465. However, the Court will not overrule a decision solely because the decision was wrongly decided. *McEvoy v City of Sault Ste Marie*, 136 Mich 172, 178; 98 NW 1006 (1904); *People v Tanner*, 496 Mich 199, 250; 853 NW2d 653 (2014). Instead, the Court will only overrule an erroneous decision if overruling the case results in less injury than leaving it in place. *Id. Robinson* acknowledges that "the mere fact that an earlier case was wrongly decided does not mean overruling it is invariably appropriate." *Robinson*, 462 Mich at 465.

As a result, the *Robinson* analysis requires a second inquiry which requires the Court to examine the effects of overruling the decision. *Id.* at 466. This second step invokes a three-part test: (i) whether the questioned decision defies practical workability; (ii) whether changes in the law or facts no longer justify the decision; and (iii) whether reliance interests would work an undue hardship if the decision were overturned. *Id*. at 464. In weighing this last factor, *Robinson* instructs the Court to ask whether the questioned decision "has become so embedded, so accepted, so fundamental, to expectations that to change it would produce not only readjustments but practical real-world dislocations." *Id*. at 466. Simply put, "the longer a rule has continued, the more thoroughly has it inevitably become interwoven with the business and property interests of the community at large; and, therefore, the more disastrous must be a change, especially a sudden change." *N Am Brokers*, 502 Mich 882 at 913 (McCormack, C.J. concurring) (quoting Wells, A Treatise on the Doctrines of Res Judicata and Stare Decisis (1878), pp. 544–545).

The factors required to overrule precedent are not satisfied here. *Woodard* was not wrongly decided, did not misconstrue the plain language of MCL 600.2169, and there has been no

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subsequent change in the law. Further, this Court is not empowered to adopt the rule Plaintiff requests. To do so, it would have to rewrite the statute. The requirements for overturning *Woodard* cannot be satisfied.

A. *Woodard* Was Correctly Decided and Gives Effect to the Plain Language of the Statute.

As addressed above, *Woodard* was correctly decided. Plaintiff's criticisms of *Woodard* that are actually relevant to the circumstances in this case are nothing more than criticisms of the 1993 amendments to the statute. Plaintiff argues that its expert is qualified because he has the same board certifications regardless of his percentage of practice in each and regardless of which specialty Defendant was practicing when he performed the rhinoplasty at issue in this action. This is simply an argument that his expert is qualified in a related, relevant field of medicine. In *Robinson*, this Court stated that a decision is wrongly decided if it misunderstood or misconstrued a plainly worded statute, or if a decision "has fallen victim to a subsequent change in the law." 462 Mich at 465. None of these circumstances apply to *Woodard*.

B. The Other *Robinson* Criteria Cannot be Satisfied.

Woodard does not defy practical workability, and there are no changes in the law or facts that de-justify the decision. Quite the contrary, *Woodard* "has become so embedded, so accepted, so fundamental to expectations that to change it would produce not only readjustments but practical real-world dislocations." *Robinson*, 462 Mich at 466. For over 16 years, *Woodard*'s one most relevant specialty rule has been accepted law. Plaintiff cites a few Court of Appeals opinions that ostensibly support his request for review. But numerous other opinions express no reservations about *Woodard*. This Court has acknowledged and/or relied upon *Woodard* with seeming approval. In *Rock v Crocker*, 499 Mich 247, 263; 884 NW2d 227 (2016), an opinion authored by Justice Bernstein in which Chief Justice McCormack and Justices Zahra and Viviano and all other

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justices concurred, this Court held that the specialty and board certification requirements in MCL 600.2169 *applied to the time of the occurrence* rather than to the time of trial and cited *Woodard*'s approach as supportive of its conclusion. This Court explained:

> Construing the board-certification requirement as applying at the time of the occurrence is also consistent with *Woodard*. In *Woodard*, this Court commented on the requirement that the proposed expert witness be qualified to testify about what the relevant standard of care was when the alleged malpractice occurred:
>
> > 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. [*Woodard*, 476 Mich. at 560, 719 N.W.2d 842.]
>
> This suggests that the board-certification requirement also applies at the time of the alleged malpractice. Despite the fact that the central issue in *Woodard* did not involve the present issue, this Court's approach in *Woodard* lends support to our rejection of defendant's interpretation. [499 Mich at 263, n 11.]

Respectfully, *Woodard* properly adheres to and effectuates the language of the statute.

Further, it is the statute, not *Woodard*, that imposes the requirement that the expert devote a majority of his or her professional practice time to the *same* specialty as the defendant. It is the statute that Plaintiff is asking this Court to overrule under the guise of overruling *Woodard*. The danger of allowing an expert to testify regarding a specialty practice and procedure that he does not devote a majority of his professional time to is the very circumstance the Legislature sought to avoid in enacting MCL 600.2169. One need only hark back a few decades to recall with dismay the haphazard manner in which medical malpractice experts were deemed qualified to testify without credentials or experience in the defendant's specialty, and despite years of absence from medical practice. Professional experts proliferated, jeopardizing the integrity of the judicial process and prompting the enactment of the expert witness qualification statute which governs

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today. As the Supreme Court explained in *McDougall*, 461 Mich at 25, n 9, the statute was designed to ensure that experts had firsthand practical experience in the subject matter about which they are testifying. *Woodard* gives effect to this statutory purpose, as expressed in the meaning of the words used.

That purpose is just as necessary today as it was when the statute was enacted. But for *Woodard*'s application of the statute to different specialties, the proposed experts in *Woodard* and *Hamilton* might have been qualified to testify despite their lack of recent and relevant experience in the defendant's specialty. This would have wholly defeated the purpose of the statute. Indeed, the intent of the statute would have been quickly derailed if the only required match was to any of the defendant's specialties without regard to the particularized field of medicine he or she was actually practicing.

Woodard was based upon the plain meaning of MCL 600.2169(1). The pertinent language of thar statute has not changed, nor has Plaintiff identified any change in the law that requires the reversal of *Woodard.* Under the rules of stare decisis, *Woodard* should not be overruled.

III. The "One Most Relevant Specialty" Standard is the Only Workable Test under MCL 600.2169(1).

Under the plain language of MCL 600.2169, if the defendant is a specialist, the proffered expert must specialize in that same specialty; if the defendant is board certified, the expert must also be board certified in the same specialty; and in the year preceding the occurrence, the expert must have devoted a majority of his or her professional time to the practice or instruction of that same specialty. The test set forth in *Woodard* is the only workable test that gives effect to the language of the statute. The Legislature made it clear that only physicians specializing, board certified, and practicing in the same specialty should testify to the standard of care of a defendant physician.

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Here, there is no dispute that Defendant has two specialties and is board-certified in both. Thus, Plaintiff's criticisms of *Woodward's* holdings regarding subspecialties and certificates of added qualifications are inapposite. These arguments show Plaintiff's struggle to come up with a different test that would both effectuate the intent of the Legislature and result in a different outcome in this case.

Plaintiff also argues that there may be more than one relevant specialty. But that assertion is belied by the majority practice requirement -- one can only devote a majority of his or her practice to one specialty. One can only imagine the problems that would otherwise result. If the procedure being performed arguably falls under multiple specialties, is the plaintiff then required to have an expert in every one of those specialties? What if each of those experts testifies that the standard of care is somewhat different depending on the purpose of the procedure, *i.e.*, aesthetics versus functionality? Would the defendant have to meet different standards of care? If only one expert is necessary, could the parties shop around for one in any relevant specialty to find someone who will say whatever helps their case? This would set the standard back decades to the pre-statute era. The only workable standard is to determine the specialty the defendant is practicing at the time of the procedure and follow the statutory requirements for the expert to be qualified in that specialty.

IV. The "Majority of Professional Time" Requirement is Set Forth in the Statute and Cannot be Modified by this Court.

MCL 600.2169(1)(b) requires that for the year preceding the occurrence that is the basis for the action, the proffered expert have spent a majority of his or her professional time in either or both the active clinical practice or instruction of the applicable specialty. The fact that the Legislature allowed the expert to aggregate time in active clinical practice with instructing does

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not somehow write into the statute that the expert can aggregate time in different specialties, as Plaintiff suggests.

There is no language in the statute that would allow the majority practice requirement to be achieved by combining specialties or by asserting that the procedure that is the basis of the action falls into multiple specialties. Majority means more than half. It does not mean plurality or a substantial amount. The Legislature chose to replace "substantial" with "majority" to ensure that the expert spent more than half his or her time in the relevant specialty. There simply is no workable alternative that would give meaning to the change in the statute. Of note, the 10 percent that Plaintiff's expert spent practicing in the relevant specialty in this case would not meet any of the proposed alternative standards.

V. The Court of Appeals Properly Applied the Requirements of MCL 600.2169(1) in this Case.

As plainly understood, facial plastic and reconstructive surgery and otolaryngology are not the *same specialty*. Likewise, an expert who devotes 90 percent of his professional time to otolaryngology and 10 percent to facial plastic and reconstructive surgery does not devote the *majority* of his professional time to facial plastic and reconstructive surgery. This is why Dr. Armstrong was not qualified to render standard of care testimony against Dr. Colton; he could not satisfy the unambiguous statutory requirements.

The trial court did not have discretion to disregard the statute. Once it determined that facial plastic and reconstructive surgery was the specialty being practiced at the time of the alleged malpractice, it did not have the discretion to disregard Dr. Armstrong's unequivocal testimony regarding the nature of his practice, which showed that he could not satisfy the statutory requirements. Nor did the Court of Appeals. There was nothing else for the trial court and Court

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of Appeals to do but apply the statute to Dr. Armstrong's unequivocal testimony. The Court of Appeals understood and properly executed its duty.

CONCLUSION AND RELIEF REQUESTED

The "one most relevant specialty" and "majority of professional time" requirements applied in *Woodard v Custer* are necessary to effectuate the language and intent of MCL 600.2169(1) and were properly applied in this case. Amici respectfully request that this Court uphold *Woodard* and affirm the Court of Appeals decision in this case.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on August 3, 2023, I electronically filed the foregoing Amici Curiae Brief with the Clerk of the Court using the Court's electronic filing system which will electronically serve all parties of record.

Cynthia J. Villeneuve
Cynthia J. Villeneuve

Exhibit A

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STATE OF MICHIGAN

IN THE SUPREME COURT

JOELYNN T. STOKES, Successor Personal Representative of the Estate of LINDA HORN, deceased,

Plaintiff-Appellee,

v.

MICHAEL J. SWOFFORD, D.O. and SOUTHFIELD RADIOLOGY ASSOCIATES, PLLC,

Defendants-Appellants.

Supreme Court Case No. 162302

Court of Appeals Case No. 349522

Mecosta County Circuit Court
Case No. 18-164148-NH
Hon. Cheryl A. Matthews

SUPPLEMENTAL AMICI CURIAE BRIEF OF MICHIGAN STATE MEDICAL SOCIETY AND THE AMERICAN MEDICAL ASSOCIATION

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STATEMENT OF INTEREST OF AMICI CURIAE MICHIGAN STATE MEDICAL SOCIETY AND AMERICAN MEDICAL ASSOCIATION[1]

Amicus curiae Michigan State Medical Society (MSMS) is a professional association which represents the interests of over 14,000 physicians in the State of Michigan. Organized to promote and protect the public health and to preserve the interests of its members, MSMS is frequently called upon to express its views with respect to legal issues of significance to the medical profession.

Amicus curiae American Medical Association (AMA) is the largest professional association of physicians, residents, and medical students in the United States. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice and reside in all states, including Michigan. Through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents and medical students in the United States are represented in the AMA's policy-making process.

MSMS and the AMA join this brief on their own and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

Amici curiae have a compelling interest in the state of the law governing medical malpractice actions. In this appeal, Defendants Michael J. Swofford, D.O. and Southfield

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[1] Pursuant to MCR 7.312(H)(4), amici curiae Michigan State Medical Society and American Medical Association state that neither appellant's counsel nor appellee's counsel authored this brief in whole or in part, or contributed money that was intended to fund the preparation or submission of the brief. Further, no person other than the amici curiae have contributed money intended to fund the preparation and submission of this brief.

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Radiology Associates, PLLC, have been granted leave to appeal from the Michigan Court of Appeals' decision in *Horn v Swofford*, 334 Mich App 281; 964 NW2d 904 (2020), which held that a physician who devoted the majority of his professional time practicing neuroradiology in the applicable time period was qualified to render standard of care testimony against a physician who specializes solely in diagnostic radiology. Amici curiae support Defendants' request for reversal of the Court of Appeals decision in *Horn*. Amici also supported Defendants' appeal at the MOAA stage and pursuant to this Court's December 22, 2022 order, now file an amicus brief for consideration with the grant of leave.

Horn involves the application of two important statutory provisions to allegations of malpractice against a board certified diagnostic radiologist arising from his interpretation of a cranial CT scan: MCL 600.2912a(1)(b), which governs the standard of care in a medical malpractice case, and MCL 600.2169(1), which prescribes requirements that an expert witness must satisfy to render standard of care testimony for or against a medical malpractice defendant.

It is undisputed that the interpretation of a cranial CT scan falls within the realm of diagnostic radiology. Nonetheless, the Court of Appeals concluded that Dr. Swofford was practicing neuroradiology when he interpreted the cranial CT scan, which, according to the Court of Appeals, made Dr. Swofford a specialist in neuroradiology, and neuroradiology the "one most relevant" standard of practice or care applicable to the asserted claims.[2] This erroneous conclusion disregards the plain requirements of the standard of care statute (MCL 600.2912a) and the expert witness qualification statute (MCL 600.2169). As discussed in more detail below, the clear and

[2] The Court of Appeals acknowledged that Dr. Swofford was a board-certified diagnostic radiologist and that diagnostic radiologists are qualified to interpret neuroimages even if they do not obtain a certification in neuroradiology. Thus, Dr. Swofford was not practicing outside of his specialty of diagnostic radiology when he interpreted Plaintiff's decedent's cranial CT scan.

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collective intent of these statutes is (1) to ensure that a physician is held to the standard of care that governs his or her specialty practice, and (2) to require that the credentials and current experience of a standard of care expert *match* the credentials and specialty practice of the physician against whom, or on whose behalf, the expert will testify.

The court in *Horn* purported to rely upon this Court's decision in *Woodard v Custer*, 476 Mich 545; 719 NW2d 842 (2006), and its companion case, *Hamilton v Kuligowski*, but reached a contrary result. The "one most relevant specialty" standard from *Woodard* is not applicable to this case because Defendant did not practice multiple specialties. Defendant was board certified in and practiced only diagnostic radiology at the time of the alleged malpractice. Plaintiff's proposed expert is board certified in both diagnostic radiology and the subspecialty of neuroradiology but spends the majority of his professional time practicing neuroradiology. *Woodard* properly held that a subspecialty is a specialty for purposes of the statute, a determination which effectuates the intent of the statutes. Thus, under the clear language of MCL 600.2912a(1)(b) and MCL 600.2169(1)(b), Plaintiff's proposed expert cannot give expert testimony on the appropriate standard of care applicable to Dr. Swofford's practice.

MSMS and AMA respectfully urge this Court to dispel the confusion created by the result in *Horn*, to adhere to the express language of the governing statutes, and to ultimately reverse the *Horn* decision. Further, there is no need to revisit *Woodard*, which properly interprets and applies MCL 600.2169(1)(b).

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STATEMENT OF QUESTIONS ADDRESSED BY AMICI CURIAE

Question One:

Was *Woodard v Custer*, 476 Mich 545 (2006) correctly decided and consistent with the requirements of MCL 600.2169(1)?

The Trial Court did not address this issue.

The Court of Appeals did not address this issue.

Plaintiff-Appellee says "no."

Defendants-Appellants say "yes."

Amici Curiae Michigan State Medical Society and
American Medical Association say "yes."

Question Two:

If this Court determines that *Woodard* was not correctly decided, should it nonetheless be retained under the principles of stare decisis?

The Trial Court did not address this issue.

The Court of Appeals did not address this issue.

Plaintiff-Appellee says "no."

Defendants-Appellants say "yes."

Amici Curiae Michigan State Medical Society and
American Medical Association say "yes."

Question Three:

Is the "one most relevant specialty" standard inapplicable in a case where a defendant practices a single medical specialty?

The Trial Court would say "yes."

The Court of Appeals would say "no."

Plaintiff-Appellee says "no."

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Defendants-Appellants say "yes."

Amici Curiae Michigan State Medical Society and
American Medical Association say "yes."

Question Four:

Is the test set forth in *Woodard* the only workable test under MCL 600.2169?

The Trial Court did not address this issue.

The Court of Appeals did not address this issue.

Plaintiff-Appellee says "no."

Defendants-Appellants say "yes."

Amici Curiae Michigan State Medical Society and
American Medical Association say "yes."

Question Five:

Did the Court of Appeals err in its application of the requirements of MCL 600.2169 where it held that a board certified neuroradiologist who devotes the majority of his professional time to neuroradiology could provide standard of care testimony against a board certified diagnostic radiologist who specializes solely in diagnostic radiology and is not board certified in neuroradiology?

The Trial Court would say "yes."

The Court of Appeals would say "no."

Plaintiff-Appellee says "no."

Defendants-Appellants say "yes."

Amici Curiae Michigan State Medical Society and
American Medical Association say "yes."

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INTRODUCTION

In 1986, the Michigan Legislature enacted MCL 600.2169 to address the lack of standards for expert witnesses in medical malpractice actions. The absence of such standards led to inconsistent decisions and compromised the integrity of the judicial process. The first version of the statute required the proffered expert to specialize and practice in an area of medicine that was *related* and *relevant* to the defendant's specialty. The resulting case law made it clear that the statute required further restrictions, and in 1993, the Legislature amended the statute to its present version, which requires the expert to practice in the *same* specialty as the defendant, to be board certified in that specialty if the defendant is board certified, and to devote the majority of his or her professional time to practice or instruction in that *same* specialty. This Court's interpretation of the statute in *Woodard v Custer*, 476 Mich 545; 719 NW2d 842 (2006), is consistent with the language of the amended statute. Further, this decision has been published for over 16 years, and the Legislature has not felt compelled to amend the statute during that time, apparently content with this Court's interpretation.

This case does not involve the "one most relevant specialty" holding from *Woodard*, 476 Mich at 560. Defendant Michael J. Swofford, D.O., has one specialty, diagnostic radiology, in which he is board certified and to which he devotes his medical practice. Dr. Swofford was practicing within that specialty at the time of the alleged malpractice. Accordingly, under MCL 600.2912a(1)(b), diagnostic radiology provides the standard of care that governs Plaintiff's claim and under MCL 600.2169(1)(b), Plaintiff's standard of care expert against Dr. Swofford must also specialize in diagnostic radiology and have devoted the majority of his professional time in the year preceding the occurrence to the practice of diagnostic radiology. Plaintiff's standard of care expert, Scott Berger, M.D., specializes in neuroradiology and testified that he devoted the majority of his professional time during the preceding year to neuroradiology. Under *Woodard*'s proper

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definition of specialty, neuroradiology and diagnostic radiology are different specialties. Therefore, Dr. Berger is not qualified to give standard of care testimony against Dr. Swofford.

CONCISE STATEMENT OF MATERIAL PROCEEDINGS AND FACTS

Amici Curiae refer this Court to the Statement of Material Proceedings and Facts provided in Defendants' Application for Leave to Appeal, Supplemental Brief, and Brief on Appeal.

ARGUMENT

I. *Woodard* was Correctly Decided and is Consistent with the Requirements of MCL 600.2169, Which Requires That a Standard of Care Expert Practice the Same Specialty as the Defendant Physician.

To sustain a claim for medical malpractice, the plaintiff must plead and prove: (1) the applicable standard of care, (2) the defendant's breach of that standard, (3) injury, and (4) proximate causation between the alleged breach and the injury. *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004), quoting *Weymers v Khera*, 454 Mich 639, 655; 563 NW2d 647 (1997). The standard of care is a key element to the prosecution and defense of a medical malpractice case. In Michigan, the standard of care applicable to medical malpractice actions has been codified in MCL 600.2912a(1), which provides, in pertinent part:

> [I]n an action alleging malpractice, the plaintiff has the burden of proving that in light of the state of the art existing at the time of the alleged malpractice:
>
> * * *
>
> (b) The defendant, if a *specialist*, failed to provide the recognized standard of practice or care *within that specialty* as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances, and as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury. [*Id*. (emphasis added)]

Expert testimony is required to establish the applicable standard of care in a medical malpractice case. *In re Jankowksi*, 507 Mich 1013; 961 NW2d 208, 209 (2021). "This Court has long recognized the importance of expert testimony in establishing a medical malpractice claim,

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and the need to educate the jury and the court regarding matters not within their common purview." *Locke v Pachtman*, 446 Mich 216, 223; 521 NW2d 786 (1994). "[T]he benefit of expert testimony, particularly in demonstrating the applicable standard of care, cannot be overstated." *Id*. at 224.

An expert witness must meet an established qualification threshold before he or she will be permitted to give standard of care testimony for or against a defendant. MCL 600.2169(1)(a) requires that the expert specialize at the time of the occurrence that is the basis for the claim in the same specialty as the health professional against whom or on whose behalf the testimony is to be given, and if the health professional is board certified, the expert must be board certified in that same specialty. Further, pursuant to MCL 600.2169(1)(b), during the year immediately preceding the occurrence that is the basis for the claim, the expert must have devoted a majority of his or her professional time to the practice of the health professional's specialty or to the instruction of students at an accredited health professional school, residency, or clinical research program in the same specialty. The statute provides, in pertinent part:

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

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> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty. . . .

As this Court recognized in *McDougall v Schanz*, 461 Mich 15, 36; 597 NW2d 148 (1999), the expert witness statute essentially modifies the standard of care element "to require that proof of malpractice 'emanate from sources of reliable character as defined by the Legislature,'" quoting then Judge Taylor's dissenting Court of Appeals opinion in *McDougall*, 218 Mich App at 518. The language of MCL 600.2169 is mandatory: "a person *shall not* give expert testimony on the appropriate standard of care" if that person does not meet the requirements of the statute. See also *Woodard*, 476 Mich 545 at 607 n 36 (discussing the "statute's mandate," which in turn reflects "the Legislature's mandate").

A. The Pre-Amendment Language of the Statute Evidences the Legislature's Intent to Require the Expert's Specialty to Match the Defendant Physician's Specialty.

"When interpreting a statute, the primary rule of construction is to discern and give effect to the Legislature's intent, the most reliable indicator of which is the clear and unambiguous language of the statute." *Perkovic v Zurich Am Ins Co*, 500 Mich 44, 49; 893 NW2d 322 (2017) (citation omitted). Courts must "enforce such language as written, giving effect to every word, phrase, and clause." *Id*. "[T]o discern the Legislature's intent, statutory provisions are *not* to be read in isolation; rather, context matters, and thus statutory provisions are to be read as a whole." *Robinson v City of Lansing*, 486 Mich 1, 15; 782 NW2d 171 (2010) (emphasis in original).

The judicial role "precludes imposing different policy choices than those selected by the Legislature." *The Herald Co v City of Bay City,* 463 Mich 111, 117; 614 NW2d 873 (2000). As this Court explained in *Hanson v Board of County Road Commissioners of the County of Mecosta,* 465 Mich 492, 504; 638 NW2d 396 (2002): "[O]ur function is not to redetermine the Legislature's

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choice or to independently assess what would be most fair or just or best public policy." "In construing an amendment to a statute, it is presumed that a change in phraseology reflects a legislative intent to change the meaning of the statute." *Harder v Harder*, 176 Mich App 589, 592; 440 NW2d 53 (1989).

Prior to 1986, MRE 702 was the sole determinant regarding the admissibility of expert testimony. At that time, the rule allowed a witness to give expert testimony if the witness was "qualified as an expert by knowledge, skill, experience, training, or education …"[3] This standard gave Michigan courts fairly free rein to determine whether a proffered expert had the requisite familiarity with the standard of care to pass evidentiary muster. Indeed, familiarity with the standard of care was frequently articulated as the qualifying test.[4]

While courts traditionally examined the specialty of the defendant when determining whether the proffered expert was qualified to testify under MRE 702, the absence of specific guidelines led to an obvious lack of uniformity. Some courts found that an expert who did not specialize in the same field as the defendant was not sufficiently familiar with the applicable

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[3] Amended effective January 1, 2004 to bring the admissibility of expert testimony in line with the federal standard established by the United States Supreme Court in *Daubert v Merrell Dow Pharmaceuticals, Inc*, 509 US 579 (1993), MRE 702 now provides:

> If the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

[4] *See e.g., Dybata v Kistler,* 140 Mich App 65, 69; 362 NW2d 891 (1985); *Bahr v Harper-Grace Hospitals,* 198 Mich App 31, 34-35; 497 NW2d 526 (1993) *rev'd in part on other grounds* 448 Mich 135 (1995); *Siirila v Barrios,* 398 Mich 576, 593; 248 NW2d 171 (1976); *Francisco v Parchment Medical Clinic, P.C.,* 407 Mich 325, 327; 285 NW2d 39 (1979); *Callahan v William Beaumont Hospital,* 400 Mich 177, 180; 254 NW2d 31 (1977).

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standard of care to testify. See e.g., *Dunn v Nundkumar,* 186 Mich App 51, 54; 463 NW2d 435 (1990) (even though expert need not specialize in the field he is asked to testify about, general surgeon and family practitioner was unqualified to testify regarding the standard of care governing an obstetrician-gynecologist); *Carlton v St John Hospital,* 182 Mich App 166, 171-172; 451 NW2d 543 (1989) (even though witness need not specialize in the field he is asked to testify about, cardiologist was not qualified to opine whether performance of surgery violated the standard of care applicable to a surgeon); *Dybata*, 140 Mich App at 69, n 10 (obstetrician-gynecologist is not sufficiently familiar with the standard of care governing a general practitioner); *Dengler v State Farm Mutual Ins Co,* 135 Mich App 645, 649; 354 NW2d 294 (1984) (proffered expert who was not a specialist in neurology was not qualified to testify regarding a subarachnoid hemorrhage); *Swantek v Hutzel Hospital,* 115 Mich App 254, 259; 320 NW2d 234 (1982) (pediatric neurologist could not testify as to the standard of care of an obstetrician-gynecologist).

However, other courts allowed expert witnesses to testify *even absent credentials or experience in the defendant's specialty*. See e.g., *Mazey v Adams,* 191 Mich App 328, 331; 477 NW2d 698 (1991) (internist with specialty in cardiology permitted to testify to standard of care of general practitioner); *Strach v St John Hospital Corp,* 160 Mich App 251, 273; 408 NW2d 441 (1987) (board certified general surgeon permitted to testify against a thoracic surgeon); *Wolak v Walczak,* 125 Mich App 271, 276; 335 NW2d 908 (1983) (obstetrician-gynecologist may testify about the effect of bilirubin in newborns); *Berwald v Kasal,* 102 Mich App 269, 276; 301 NW2d 499 (1980) (specialist may testify as to standard of care applicable to a general practitioner); *Wilson v W A Foote Memorial Hospital,* 91 Mich App 90, 101-102; 284 NW2d 126 (1979) (orthopedic surgeon permitted to testify regarding the standard of care of a hospital relative to the emergency nature of a breech presentation at birth); *Banks v Wittenberg,* 82 Mich App 274, 277;

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266 NW2d 788 (1978) (urologist can testify regarding the standard of care applicable to a general practitioner).

There was also a discrepancy in the requisite timeliness of the expert's knowledge. Some courts allowed experts to testify *despite their absence from the practice of medicine for years*. See e.g., *Pietrzyk v Detroit,* 123 Mich App 244, 247-248; 333 NW2d 236 (1983) (medical doctor's 20-year absence from the emergency room setting did not preclude him from testifying about the standard of care in an emergency room); *Haisenleder v Reeder,* 114 Mich App 258, 265; 318 NW2d 634 (1982) (physician who had not practiced for 13 years in an emergency room setting was permitted to testify regarding the standard of care applicable to an emergency room physician). Other experts were disqualified because of their absence from practice. *Gilmore v O'Sullivan,* 106 Mich App 35, 39; 307 NW2d 695 (1981) (an expert who had not delivered a baby since 1959 nor performed surgery since 1967 could not testify regarding the standard of care applicable to an obstetrician-gynecologist).

Not surprisingly, these amorphous requirements for standard of care testimony led to a proliferation of circuit-riding "experts" who "practiced" only in the litigation arena. Their "pay-for-what-you-want testimony" compromised the integrity of the judicial process and contributed to the malpractice crisis that prompted the need for tort reform.[5]

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[5] As the *Report of the Senate Select Committee on Civil Justice Reform* viewed the problem in Michigan:

> Testimony of expert witnesses is normally required to establish a cause of action for malpractice. Expert testimony is necessary to establish both the appropriate standard of care and the breach of that standard. There is currently no specific requirement for an expert witness to devote a specific percentage of time to the actual practice of medicine or teaching, or when testifying against a specialist that the expert actually practices or teaches in *that specialty*. Instead, a physician-witness is qualified to testify as an expert in Michigan, even though he/she does not

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To address this problem, the 1986 enactment of MCL 600.2169 required that expert witnesses "actually practice" or "teach medicine" and have "firsthand practical expertise in the subject matter about which they are testifying." *Id*.[6] The 1986 version of the statute sought to do this by requiring that an expert testifying for or against a specialist, specialize in the same specialty *or a related relevant area of medicine* as the defendant in the action, and devote or have devoted at the time of the occurrence involved in the action, a substantial portion of his or her professional time to practice or teaching in that area.[7] The statute provided in relevant 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 is or was a physician licensed to practice medicine or osteopathic medicine and surgery or a dentist licensed to practice dentistry in this or another state and meets both of the following criteria:
>
> (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

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practice in Michigan and is not of the same specialty, based on a mere showing of an acceptable background and a familiarity with the nature of the medical condition involved in the case. As a practical matter, in many courts merely a license to practice medicine is needed to become a medical expert on an issue.

This has given rise to a group of national professional witnesses who travel the country routinely testifying for plaintiffs in malpractice actions. These "hired guns" advertise extensively in professional journals and compete fiercely with each other for the expert witness business. For many, testifying is a full-time occupation and they rarely actually engage in the practice of medicine. There is a perception that these so-called expert witnesses will testify to whatever someone pays the [sic] to testify about. [*Id*. at 28-29 (emphasis added).]

[6] The *Senate Report* explained:

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 that same specialty*. This will protect the integrity of our judicial system by requiring real experts instead of "hired guns." [*Id*. at 29 (emphasis added).]

[7] This statute was part of the Michigan Tort Reform Act of 1986, P.A. 1986, No. 178.

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> and surgery or dentistry as the specialist who is the 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 osteopathic medicine and surgery or the active clinical practice of dentistry, or to the instruction of students in an accredited medical school, osteopathic medical school, or dental school in the same specialty *or a related, relevant area of health care* as the specialist who is the defendant in the medical malpractice action. [(emphasis added).]

Thus, the first enacted version of MCL 600.2169 permitted the proffered expert to specialize and practice in an area of medicine that was "related" and "relevant" to the defendant's specialty. This meant that a specialist in one field could testify against a specialist in another field "as long as the two fields were connected to each other and had practical value to one another and as long as the proposed expert practiced or taught in the associated, pertinent area of health care." *McClellan v Collar,* 240 Mich App 403, 410; 613 NW2d 729 (2000).

Although the 1986 statute tightened up the requirements for the qualification of experts, it became apparent that the statute had not gone far enough and that more restrictive reforms were necessary. Therefore, in 1993, the Legislature amended the statute to require that the proffered expert practice in the *same specialty* as the defendant, be board certified in that *specialty* if the defendant was board certified, and devote the majority of his or her professional time to practice or instruction in that *specialty*. This is the version of the statute that is presently before this Court. It has not been amended since 1993, 29 years ago, and this Court's interpretation in *Woodard* has been published for 16 years without triggering any change on the part of the Legislature.

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B. *Woodard* Correctly Held that Under the Present Version of MCL 600.2169, the Expert Must Specialize in the Same Specialty as the Defendant Physician, and if the Defendant has Multiple Specialties, in the One Most Relevant Specialty Engaged in by the Defendant During the Course of the Alleged Malpractice.

In *Woodard*, 476 Mich at 561-562, this Court considered the meaning of "specialist" and emphasized that for the purposes of MCL 600.2169, a "specialty" includes a "subspecialty" in which board certification may be obtained. This Court explained:

> *Dorland's Illustrated Medical Dictionary* (28th ed) defines a "specialist" as "a physician whose practice is limited to a particular branch of medicine or surgery, especially one who, by virtue of advanced training, is certified by a specialty board as being qualified to so limit his practice." MCL 600.2169(1)(a) requires the plaintiff's expert to specialize in the same specialty as the defendant physician, and, if the defendant physician is "a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty." (Emphasis added.) Both the dictionary definition of "specialist" and the plain language of § 2169(1)(a) make it clear that a physician can be a specialist who is not board certified. Therefore, a "specialty" is a particular branch of medicine or surgery in which one can potentially become board certified. Accordingly, if the defendant physician practices a particular branch of medicine or surgery in which one can potentially become board certified, the plaintiff's expert must practice or teach the same particular branch of medicine or surgery. [*Id*.]

Because subspecialties fall within this definition, the majority concluded that "if a defendant physician specializes in a subspecialty, the plaintiff's expert must have specialized in the same subspecialty as the defendant physician at the time of the occurrence that is the basis for the action." *Id*. at 562.

In *Woodard*, this Court also determined how MCL 600.2169 is applied when the defendant health professional has multiple specialties. This Court held that when the defendant physician has multiple specialties, the standard of care expert is not required to match *all* of the specialties and board certifications[8] of the defendant, but, rather, only the "one most relevant" specialty "engaged

[8] "[T]o be 'board certified' within the meaning of § 2169(1)(a) means to have received certification from an official group of persons who direct or supervise the practice of medicine that provides evidence of one's medical qualifications." *Woodard*, 476 Mich at 564. A certificate of special qualifications constitutes a board certification. *Id*. at 565.

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in by the defendant physician during the course of the alleged malpractice." *Woodard,* 476 Mich at 559-560. Thus, where a defendant has additional specialties unrelated to the plaintiff's claim, the expert is not required to match those irrelevant specialties. *Id*. at 559.

The underlying *Woodard* facts involved an infant's fractured legs that allegedly resulted from the improper placement of an arterial line in the femoral vein of the infant's right leg and the improper placement of a venous catheter in the infant's left leg. *Woodard,* 476 Mich at 554, 575. The placements were made when the infant was critically ill and a patient in the hospital's pediatric intensive care unit. *Id*. at 575. The defendant physician was board certified in pediatrics, pediatric critical care medicine, and neonatal-perinatal medicine. *Id*. at 554. The Supreme Court concluded that the defendant was practicing pediatric critical care medicine at the time of the alleged malpractice. *Id*. at 575-576. The plaintiff's proposed expert was board certified in pediatrics and had never specialized in pediatric critical care medicine. *Id*. at 554-555, 576-577. Because the plaintiff's proposed expert witness did not practice or teach pediatric critical care medicine during the year immediately preceding the alleged malpractice, the proposed expert did not satisfy the same practice/instruction requirement of MCL 600.2169(1)(b). *Id*. at 577. It would have been inappropriate and contrary to the intent of the statute for a pediatrician who had never practiced pediatric critical care medicine (or performed the procedures to which his opinion was directed) to testify against a pediatric critical care specialist who was attempting to save the life of a critically ill infant. A determination of the particular specialty engaged in by the defendant was only required because the defendant had more than one specialty. Because Dr. Swofford does not have multiple specialties or board-certifications, the present case does not require this Court to determine the "one most relevant specialty."

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C. *Woodard* Correctly Held that a Subspecialty is a Specialty.

The Legislature's determination that the reliability of expert testimony requires a precise match between the specialties, board certifications, and devotion to practice specialties of the expert and the defendant reflects the stringency of real world practice. The rapid advancement of medical science has necessitated increasing efforts by the medical profession to ensure that physicians are properly trained in their practice areas. This frequently requires multiple levels of specialized training and certification within a particular area of medicine. While some may refer to these increasingly particularized medical fields as "subspecialties," the nomenclature is merely a matter of semantics. Subspecialties are, in fact, specialties.

Medicine has extensively evolved into specialty practice. The American Board of Medical Specialties ("ABMS") consists of 24 member boards which develop and utilize professional and educational standards for the training, evaluation and credentialing of physicians in their respective specialty areas.[9] The American Osteopathic Association has 18 approved specialty boards.[10] Hospitals rely upon the credentialing and certification procedures of these boards, as well as numerous other certifying boards, such as the American Board of Oral and Maxillofacial Surgery, the American Board of Clinical Neurophysiology, and the American Society of Echocardiography, to screen, select, appoint and award hospital privileges to physicians. These boards certify subspecialty practice areas in the same way as specialty certifications are awarded.

A physician who lacks the training, experience and certification required to be credentialed by a hospital to perform a certain procedure or to practice a particular specialty is certainly not

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[9] American Board of Medical Specialties, <http:/www.abms.org/about-abms/member-boards/> (accessed June 20, 2023).

[10] American Osteopathic Association, <https://certification.osteopathic.org/> (accessed June 20, 2023).

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qualified to articulate the standard which governs that procedure or specialty in a court of law, and MCL 600.2169 recognizes the reliability need for matching board certifications. But matching board certifications do not end the inquiry. The statute goes further. The expert must also *specialize* in the *same* field as the defendant and devote a majority of his professional time to *active clinical practice* or instruction in that *specialty*. These later requirements reflect the Legislature's recognition that matching board certifications in an umbrella specialty may not reflect the real world practice experience of the defendant and the expert. This case is illustrative. Dr. Swofford and Plaintiff's expert, Dr. Berger, are both board certified in diagnostic radiology. However, Dr. Berger possesses a certificate of added qualification in neuroradiology and devotes the majority of his professional time to the practice of neuroradiology, while Dr. Swofford devotes all of his professional time to the practice of diagnostic radiology. Their real world practice experiences are not the same; indeed, they differ significantly.

The American Board of Radiology certifies four specialty areas: diagnostic radiology, interventional radiology and diagnostic radiology, radiation oncology, and medical physics.[11] Neuroradiology is among several other subspecialties that are certifiable under the first two radiology specialties after first receiving certifications for the applicable specialty. These subspecialties are not identical to the diagnostic radiology specialty or to the other subspecialties under the same umbrella. Having gone beyond the generality of a specialty in diagnostic radiology, these additionally certified individuals have in fact become specialists in another field subject to different standards of care.

[11] American Board of Radiology, <https://www.abms.org/board/american-board-of-radiology/> (accessed June 20, 2023).

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The first enacted version of MCL 600.2169 permitted the proffered expert to specialize and practice in an area of medicine that was "related" and "relevant" to the defendant's specialty. This meant that a specialist in one field could testify against a specialist in another field "as long as the two fields were connected to each other and had practical value to one another and as long as the proposed expert practiced or taught in the associated, pertinent area of health care." *McClellan,* 240 Mich App at 410. Therefore, under the 1986 version of the statute, a neuroradiologist may have been permitted to testify against a diagnostic radiologist.

The 1993 amendment eliminated this leeway by requiring that the expert specialize in the same specialty as the defendant.[12] "Same" quite clearly does not mean related or relevant. "Same" means identical. *See e.g., Oxford English Reference Dictionary* (Rev 2d ed, 2002) (defining same to mean "… identical; not different; unchanged …"); *Webster's Universal College Dictionary* (2001) (defining "same" as "identical with what is about to be or has just been mentioned …") As plainly understood, a defendant who specializes in diagnostic radiology and an expert who specializes in neuroradiology do not specialize or devote a majority of their professional time to the "same" specialty. A contrary conclusion would turn the definition of "same" on its head.

Further, nothing in the commonly accepted meanings of "specialty" or "specialist" precludes attention to the more particularized fields within a designated practice area. Indeed, particularity is the hallmark of specialization. In *Cox v Board of Hospital Managers for the City of Flint,* 467 Mich 1, 18-19 n 8; 651 NW2d 356 (2002), this Court quoted the *Random House Webster's College Dictionary* (1997), which defined specialist as "a medical practitioner who

[12] A change in the language used in a statute is presumed to reflect a change in its meaning. *Harder*, 176 Mich App at 592. This Court and the Court of Appeals have characterized the 1993 statute as "more restrictive" than the 1986 version. *McDougall v Schanz,* 461 Mich at 21, n 2; *McClellan,* 240 Mich App at 408 n 2 ("The 1993 amendments are more restrictive than the requirements set out in the version of § 2169 that applies to this case").

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deals only with a particular class of diseases, conditions, patients, etc." *See also, Decker v Flood,* 248 Mich App 75, 83; 638 NW2d 163 (2001) (quoting same *Random House Webster's College Dictionary* (1997) definition, as well as the *Stedman's Medical Dictionary* (26th ed) definition which defines specialist as "one who devotes professional attention to a particular specialty or subject area.") A similar definition was employed in *Jalaba v Borovoy,* 206 Mich App 17, 22; 520 NW2d 349 (1994*),* where the Court of Appeals observed that a doctor is a specialist "on the basis of advanced training and expertise in a particular field of general medicine." In *Woodard*, this Court looked to the definition in *Dorland's Illustrated Medical Dictionary* (28th ed), which defined "specialist" as "a physician whose practice is limited to a particular branch of medicine or surgery, especially one who, by virtue of advanced training, is certified by a specialty board as being qualified to so limit his practice." *Woodard*, 476 Mich at 561.[13]

These well-accepted definitions of "specialty," "specialist," and "specialize" are certainly broad enough to encompass the more particularized training, qualifications, and practice areas which, although sometimes referred to as subspecialties, are in fact only narrower specialties. The statute does not expressly limit its scope to *primary* or *general* specialties or expressly exclude *narrower or more focused* specialties. This Court would have to read words into the statute to impose such a restriction, but doing so would defeat the express purpose of the statute. If, for example, "specialty" is to be given no greater meaning in this context than "pediatrics," a pediatric

[13] *See also, Webster's New World College Dictionary* (4th ed, 2002) ("specialize" means "to make special, specific, or particular; specify … to direct toward or concentrate on a specific end … to make a special study of something or work only in one part or branch of a subject, profession, *etc* …"); *Oxford English Reference Dictionary* (Rev. 2d ed, 2002)("specialist" means "… a person who specially or exclusively studies a subject or a particular branch of a subject …"); *Merriam-Webster's Collegiate Dictionary* (11th ed 2004) ("specialize" means "to apply or direct to a specific end or use … to concentrate one's efforts in a special activity, field, or practice …"); *Webster's Universal College Dictionary* (2001) ("specialist" includes " … a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc. … ").

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nephrologist would be qualified to testify against a pediatric oncologist, and a pediatric rheumatologist could testify against a pediatric neonatologist, solely because they share an umbrella board certification in pediatrics. However, such an interpretation would fail to give any meaning to the statute's use of the word "same" because no one could veritably insist that one pediatric specialty is the "same' as another, e.g., pediatric oncology and pediatric rheumatology or endocrinology, even though each practitioner has first been certified in pediatrics by the American Board of Pediatrics.

Giving "specialty" a meaning that includes subspecialties is consistent with other legislative uses of the word. Section 16105(3) of Part 161 of the Public Health Code, which contains "General Provisions," defines a "health profession specialty field" as "an area of practice established under this article which is within the scope of activities, functions, and duties of a licensed health profession and which requires advanced education and training beyond that required for initial licensure." MCL 333.16105(3). Nothing in this definition of "specialty field" distinguishes between specialties or subspecialties or excludes subspecialties from the intended meaning. In fact, subspecialties fit neatly within the definition.

Part 27 of the Public Health Code pertains to "Michigan Essential Health Provider Recruitment Strategy." Sections 2705 and 2707 establish the terms upon which the health department may provide minority grants and tuition loan repayments for health professionals who agree to engage in the full-time practice in a health resource shortage area. MCL 333.2705, MCL 333.2707. Section 2711 requires the department to recruit "physicians qualified or students training to become qualified" in designated physician "specialty" areas and requires that the physicians be "board certified, or eligible for board certification" in those areas. MCL 333.2711. Section 2701(a) defines "board certified" to mean "certified to practice in a particular medical

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specialty by a national board recognized by the American Board of Medical Specialties or the American Osteopathic Association." MCL 333.2701(a). Although not expressly stated, the context implicitly encompasses subspecialties because the American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA) recognize boards that "certify to practice in a particular medical specialty" that might otherwise be considered a subspecialty, such as cardiology, nephrology, gastroenterology, and neuroradiology.

In related sections of Part 27, the department is authorized to develop criteria regarding the "[a]verage time the resident population must travel to obtain physician services from physicians in a designated physician specialty area" and to make recommendations concerning "physician specialty areas or other health professions for inclusion in the Michigan essential health provider recruitment strategy." MCL 333.2717(1)(i) and MCL 333.2723(2)(b). Only by artificial distinction could one logically conclude that these statutes do not allow recommendations and travel time criteria for sub-specialists, whose services may be as critically needed (and in even shorter supply) than more generalized specialists.

Section 5815(a) of Part 58 of the Public Health Code requires the health department to establish and administer a program of services for children with special health care needs and to "[p]rovide for the monitoring of the availability and quality of facilities, treatment centers, *medical and surgical specialists*, and other providers for children or youth with special health care needs." MCL 333.5815(a) (emphasis added). Similarly, Section 5826 allows the department to approve *medical and surgical specialists* to render services. MCL 333.5826 (emphasis added). Because surgery is itself a specialty, "surgical specialists" can only mean subspecialists within the practice of surgery such as pediatric surgeons, orthopedic surgeons, neurosurgeons, and cardiac surgeons. Further, it would be illogical to allow the department to prescribe requirements for "medical and

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surgical specialists" – such as pediatricians and general surgeons - but to have no requirements for subspecialists, such as orthopedic surgeons or neurosurgeons.

Section 2617 of Part 26 (Data, Information, and Research) of the Public Health Code requires that a comprehensive health information system include statewide statistics relating to a variety of subjects including "[t]he utilization of health care, which may include the utilization of ambulatory health services by *specialties* and types of practices of the health professionals providing the services …" MCL 333.2617(f) (emphasis added). Only a contorted interpretation of the word "specialty" would exclude from the survey the utilization statistics of subspecialty fields like cardiology, nephrology, oncology, gastroenterology, and the like.

Subspecialties are also implicit in the Legislature's use of the word "specialist" in statutes outside the Public and Mental Health Codes. For example, MCL 791.244, which sets forth procedures for gubernatorial reprieves, commutation of sentences and pardons, provides that the office of health care shall evaluate the condition of a prisoner in all cases where a commutation application is based on physical or mental incapacity and if the office of health care confirms that a physical or mental incapacity exists, it "shall appoint a *specialist in the appropriate field of medicine* … to evaluate the condition of the prisoner." MCL 791.244(2)(d) (emphasis added). In this context, "the appropriate field of medicine" could well be cardiology if the prisoner suffers from heart disease, oncology if the physical incapacitation is cancer, nephrology if the prisoner suffers from kidney disease, or endocrinology if diabetes is the disabling cause. Nothing in the statute limits the specialist to be appointed under such circumstances to the umbrella specialties.

The same is true of uses of the word "specialist" and "specializes" in the Revised Judicature Act, of which MCL 600.2912a and MCL 600.2169 are a part. Enacted in 1986 along with the earlier version of the expert witness qualification statute, MCL 600.4905(1) requires that the health

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care provider members of medical malpractice mediation panels "specialize in the same or a related, relevant area of health care as the defendant" if the defendant is a "specialist." Similarly, Section 401d of the Nonprofit Health Care Corporation Reform Act, MCL 550.1401d, provides reimbursement for services performed by a physician's assistant who works for a physician or facility that *specializes* in a particular area of medicine if the "physician that *specializes* in that area is physically present on the premises when the physician's assistant's services are performed." MCL 550.1401d(1)(a) (emphasis added). It would be illogical to exclude subspecialty practice areas from the definition of "specializes" or "specialist" in either of these contexts simply because the statute does not say "sub-specializes in that area." For example, it would be every bit as urgent – if not more so – to ensure that a "nephrologist" is present when a physician's assistant performs nephrology services as it is to ensure that an internal medicine specialist is present when the physician's assistant is performing services in the field of internal medicine. Similarly, the policy reasons that suggest the need for health care provider members of medical malpractice mediation panels to specialize in the same or a related, relevant field as the defendant, apply equally to defendants who are subspecialists.

These statutes are compelling. Only a contorted, illogical interpretation would exclude subspecialists from the meaning of "specialize" or "specialty" in any of these provisions. The same should be true in the expert witness context. Within the meaning of MCL 600.2169(1)(a) and (1)(b)(i), "specialize" and "that specialty" must include subspecialties or the intent of the statute cannot be fulfilled. A neuroradiologist who devotes the majority of his professional time to neuroradiology is not qualified under the statute to testify against a defendant who specializes – and was specializing at the time of the alleged malpractice – in diagnostic radiology. The

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Woodard Court correctly held that a subspecialty is its own specialty, and there is no reason to revisit this holding.

D. This Court Overruled the Anomalous Holding in *Reeves*, the Reason for any Confusion in the Law.

Woodard provides a workable standard that honors the intent of the Legislature. It requires the expert to practice in the same specialty that the defendant physician was practicing at the time of the alleged malpractice. It is not prohibitive or opaque, and there is no need for this Court to revisit the holding. Per MCL 600.2912a, a defendant physician is to be held to the standard of care of the specialty he or she is practicing, and pursuant to MCL 600.2169, an expert testifying against that physician must be credentialed in and practice that same exact specialty.

If there is any confusion in the case law, it was caused by the Court of Appeals' anomalous decision in *Reeves v Carson City Hosp*, 274 Mich App 622; 736 NW2d 284 (2007). In *Reeves*, 274 Mich App at 623, the defendant physician was board certified in family medicine and working in the emergency room at the time of the alleged malpractice, which was an alleged failure to timely diagnose and treat the plaintiff's ectopic pregnancy. The court held that the defendant was practicing outside of her board certification, and the "one most relevant specialty" was emergency medicine. *Id*. at 628. The court held that because the defendant was practicing emergency medicine at the time of the alleged malpractice and potentially could obtain board certification in emergency medicine, she was a specialist in emergency medicine and the plaintiff's expert, a board certified emergency physician, could testify against her if he met the practice requirements in MCL 600.2169(1)(b) on remand. *Id*. at 630.

Shortly thereafter, in *Gonzalez v St John Hosp & Med Ctr*, 275 Mich App 290, 298-299, 300-304; 739 NW2d 392 (2007), the court followed the holding in *Reeves* to find that a third-year surgical resident was a specialist because he could someday become board certified, and that an

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expert who was board certified in general surgery could testify against him. The Court of Appeals misconstrued *Woodard* in *Reeves* and *Gonzalez* to achieve results beyond the Legislature's intent to match the credentials and practice experience of defendant physicians and experts.

This Court essentially disavowed the course of *Reeves* and *Gonzalez* in *Estate of Jilek ex rel Jilek v Stockson*, 490 Mich 961; 805 NW2d 852 (2011). The Court of Appeals had ruled that the defendant physician who was board certified in family medicine but practicing at an urgent care facility at the time of the alleged malpractice should be held to the standard of care for emergency medicine based on the holding in *Reeves*. *Jilek v Stockson*, 289 Mich App 291, 301-302; 796 NW2d 267 (2010). This Court reversed, stating that "the appropriate standard of care was 'family practice' because the defendant physician is board-certified solely in family medicine." *Jilek*, 490 Mich at 961. "Further, pursuant to MCL 600.2912a, the trial court properly allowed the jury to consider that standard of care in light of the facilities available to the defendant physician—an urgent care center, not an emergency medical facility." *Id*.

The plaintiff filed a motion for reconsideration which this Court denied, and Justice Markman wrote a concurring opinion to address the plaintiff's claims that this Court's order would create confusion. *Estate of Jilek ex rel Jilek v Stockson*, 491 Mich 870, 870; 809 NW2d 566 (2012). Justice Markman clarified that this Court's conclusion was the result of the following application of the law:

> (1) As we stated in *Locke v Pachtman*, 446 Mich 216, 222 (1994):
>
> > Proof of a medical malpractice claim requires the demonstration of the following four factors: (1) the applicable standard of care, (2) breach of that standard of care by the defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury. MCL 600.2912a. . . .
>
> (2) As our citation in *Locke* indicates, MCL 600.2912a establishes the basis for determining the applicable "standard of care" in medical malpractice cases. It provides, in relevant part:

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> (1) ... [I]n an action alleging malpractice, the plaintiff has the burden of proving that in light of the state of the art existing at the time of the alleged malpractice:
>
> * * *
>
> (b) The defendant, if a specialist, failed to provide the recognized standard of practice or care within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances, and as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.

(3) In *Woodard v Custer*, 476 Mich 545, 561 (2006), we then defined a "specialist" as "'a physician whose practice is limited to a particular branch of medicine or surgery, especially one who, by virtue of advanced training, is certified by a specialty board as being qualified to so limit his practice.'" (Citation omitted.)

(4) Defendant here is board-certified in family medicine. Thus, she is properly characterized as a "specialist" in family medicine.

(5) Therefore, pursuant to MCL 600.2912a(1)(b), the applicable standard of care is "that specialty as reasonably applied in light of the facilities available. . . ."

(6) In this case, "that specialty" was family medicine, and the "facilities available" consisted of an urgent care center. Accordingly, "the appropriate standard of care was 'family practice' because the defendant-physician is board-certified solely in family medicine" and "the trial court properly allowed the jury to consider that standard of care in light of the facilities available [to] . . . an urgent care center. . . ." *Jilek*, 490 Mich at 961.

(7) Contrary to the holding of the Court of Appeals, and as I believe is clear from *Woodard*, *the "one-most-relevant-specialty" test is only applicable if the defendant has more than one specialty. Woodard*, 476 Mich at 590 (Markman, J., concurring). Here, defendant has only one specialty, family medicine. Pursuant to MCL 600.2912a(1)(b), that specialty determines defendant's standard of care. Thus, although defendant was practicing family medicine at the time of the alleged malpractice, this is irrelevant because defendant has only one specialty, and the "one-most-relevant-specialty" test is inapplicable. *To the extent that Reeves v Carson City Hosp (On Remand), 274 Mich App 622 (2007), and Gonzalez v St John Hosp & Med Ctr (On Reconsideration), 275 Mich App 290 (2007), are inconsistent with this conclusion, they were, in my judgment, necessarily overruled by this Court's previous order.* [*Id*. at 871-872 (emphasis added).]

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Thus, if it is not clear from the overwhelming similarity in the facts between *Reeves* and *Jilek*, followed by a different holding from this Court, it should be clear from Justice Markman's concurrence that *Jilek* overruled *Reeves*, and likewise, *Gonzalez*. *Reeves* was an anomaly that created confusion in an otherwise clear and workable area of law. There is no reason to revisit the holdings in *Woodard*. If any clarity is needed, it would only be to confirm that *Jilek* effectively overruled *Reeves* and *Gonzalez*.

II. Even if this Court Disagrees with the Decision in *Woodard*, it Should Nonetheless be Retained under the Principles of Stare Decisis.

"Under the doctrine of stare decisis, principles of law deliberately examined and decided by a court of competent jurisdiction become precedent which should not be lightly departed." *People v Jamieson*, 436 Mich 61, 79 n 8; 461 NW2d 884 (1990), citing *Kirby v Larson*, 400 Mich 585, 618, 256 NW2d 400 (1977) ("Alterations are not usually made in a doctrine which is serving well, and with which the bench, bar and public are satisfied."). As Justice McCormack expressed in an order implicitly reflecting this Court's refusal to overturn precedent established by *Opdyke Investment Co v Norris Grain Co*, 413 Mich 354; 320 NW2d 836 (1982), "There are times when courts must overturn precedent. But, in my view, those occasions should be rare and the case for doing so compelling. This is plainly not one of those cases." *N Am Brokers, LLC v Howell Pub Sch*, 502 Mich 882; 913 NW2d 638, 641 (2018) (McCormack, C.J. concurring).

This Court has recognized the importance of stare decisis**,** the purpose of which is to establish "uniformity, certainty and stability in the law." *Parker v Port Huron Hosp*, 361 Mich 1, 10; 105 NW2d 1 (1960). *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 *Hahn v United*

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States, 524 US 236, 251; 118 S Ct 1969 (1998). A compelling justification must exist to overrule precedent. *Peterson v Magna Corp*, 484 Mich 300, 317; 773 NW2d 564 (2009).

In *Robinson,* this Court held that the first question is to ask whether the decision was wrongly decided. *Robinson*, 462 Mich at 464. A decision is wrongly decided if it misunderstood or misconstrued a plainly worded statute, or if a decision "has fallen victim to a subsequent change in the law." *Id*. at 465. However, the Court will not overrule a decision solely because the decision was wrongly decided. *McEvoy v City of Sault Ste Marie*, 136 Mich 172, 178; 98 NW 1006 (1904); *People v Tanner*, 496 Mich 199, 250; 853 NW2d 653 (2014). Instead, the Court will only overrule an erroneous decision if overruling the case results in less injury than leaving it in place. *Id. Robinson* acknowledges that "the mere fact that an earlier case was wrongly decided does not mean overruling it is invariably appropriate." *Robinson*, 462 Mich at 465.

As a result, the *Robinson* analysis requires a second inquiry which requires the Court to examine the effects of overruling the decision. *Id.* at 466. This second step invokes a three-part test: (i) whether the questioned decision defies practical workability; (ii) whether changes in the law or facts no longer justify the decision; and (iii) whether reliance interests would work an undue hardship if the decision were overturned. *Id*. at 464. In weighing this last factor, *Robinson* instructs the Court to ask whether the questioned decision "has become so embedded, so accepted, so fundamental, to expectations that to change it would produce not only readjustments but practical real-world dislocations." *Id*. at 466. Simply put, "the longer a rule has continued, the more thoroughly has it inevitably become interwoven with the business and property interests of the community at large; and, therefore, the more disastrous must be a change, especially a sudden change." *N Am Brokers*, 502 Mich 882 at 913 (McCormack, C.J. concurring) (quoting Wells, A Treatise on the Doctrines of Res Judicata and Stare Decisis (1878), pp. 544–545).

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The factors required to overrule precedent are not satisfied here. *Woodard* was not wrongly decided, did not misconstrue the plain language of MCL 600.2169, and there has been no subsequent change in the law. Further, this Court is not empowered to adopt the rule Plaintiff requests. To do so, it would have to rewrite the statute. The requirements for overturning *Woodard* cannot be satisfied.

A. *Woodard* Was Correctly Decided and Gives Effect to the Plain Language of the Statute.

As addressed above, *Woodard* was correctly decided. While Plaintiff asks this Court to reconsider *Woodard*, the more obvious goal is to judicially rewrite the expert qualification statute to the pre-1993 statute or even the pre-1986 standard. Plaintiff argues that only the overriding specialty of the defendant and expert has to match, and subspecialties should not be considered. The principles Plaintiff takes issue with are consistent with the statutory language. The principle that a subspecialty is a specialty within the meaning of the statute if one can become board certified in the subspecialty relies upon the plain meaning of the word "specialty." The Court in *Woodard* noted that MCL 600.2169(1) does not define the term "specialty" and deemed it appropriate to consult medical dictionaries to ascertain the meaning of the term. 476 Mich at 561. In so doing, the Court concluded that a specialty is "a particular branch of medicine or surgery in which one can potentially become board certified," and "[a]ccordingly, f the defendant physician practices a particular branch of medicine or surgery in which one can potentially become board certified, the plaintiff's expert must practice or teach the same particular branch of medicine or surgery." *Id.* at 561-562.

This Court rejected the argument that the statute only requires an expert to have specialized in the same specialty as the defendant physician, not the same subspecialty. This Court said:

> We respectfully disagree. As explained above, "specialty" is defined as a particular branch of medicine or surgery in which one can potentially become board certified.

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> Moreover, "sub" is defined as "a prefix ... with the meanings 'under,' 'below,' 'beneath' ... 'secondary,' 'at a lower point in a hierarchy[.]' " *Random House Webster's College Dictionary* (1997). Therefore, a "subspecialty" is a particular branch of medicine or surgery in which one can potentially become board certified that falls under a specialty or within the hierarchy of that specialty. A subspecialty, although a more particularized specialty, is nevertheless a specialty. Therefore, if a defendant physician specializes in a subspecialty, the plaintiff's expert witness must have specialized in the same subspecialty as the defendant physician at the time of the occurrence that is the basis for the action. [*Id*. 562.]

To eliminate the holding that a subspecialty is a specialty would revert back to the standards before the statute was amended or even enacted and allow cardiologists to testify to the standard of care of a general practitioner (*Mazey v Adams*), general surgeons to the standard of care of thoracic surgeons (*Strach v St John Hospital Corp*), and orthopedic surgeons to the standard of care regarding the emergency nature of breech presentation at birth (*Wilson v W A Foote*), as some examples. Plaintiff's request would undo the last 37 years of legislation.

Plaintiff also asserts that *Woodard* wrongly held that a physician can only practice one specialty at a time. However, that was not the holding. Rather, the Court held that one could only devote a *majority* of his or her professional time to one specialty for purposes of the active practice section of the statute. *Id*. at 565-566. Any other holding is a mathematical impossibility. In *Robinson*, this Court stated that a decision is wrongly decided if it misunderstood or misconstrued a plainly worded statute, or if a decision "has fallen victim to a subsequent change in the law." 462 Mich at 465. None of these circumstances apply to *Woodard*.

B. The Other *Robinson* Criteria Cannot be Satisfied.

Woodard does not defy practical workability, and there are no changes in the law or facts that de-justify the decision. Quite the contrary, *Woodard* "has become so embedded, so accepted, so fundamental, to expectations that to change it would produce not only readjustments but practical real-world dislocations." *Robinson*, 462 Mich at 466. As the past 16 years have shown, *Woodard* has provided valuable direction to the bench and bar of this state. The principles Plaintiff

takes issue with apply to defendants and plaintiffs alike. Specialty and subspecialty practice have been part and parcel of medicine since long before *Woodard,* and it is not a reason to overrule *Woodard*. If anything, it underscores the importance of adhering to *Woodard.*

Further, it is the statute, not *Woodard*, that imposes the requirement that the expert devote a majority of his or her professional practice time to the *same* specialty as the defendant. It is the statute that Plaintiff is asking this Court to overrule under the guise of overruling *Woodard*. The danger of allowing an expert to testify regarding a specialty practice and procedure that he does not devote a majority of his professional time to is the very circumstance the Legislature sought to avoid in enacting MCL 600.2169. One need only hark back a few decades to recall with dismay the haphazard manner in which medical malpractice experts were deemed qualified to testify without credentials or experience in the defendant's specialty, and despite years of absence from medical practice. Professional experts proliferated, jeopardizing the integrity of the judicial process and prompting the enactment of the expert witness qualification statute, MCL 600.2169, which governs today. As the Supreme Court explained in *McDougall*, 461 Mich at 25, n 9, the statute was designed to ensure that experts had firsthand practical experience in the subject matter about which they are testifying. *Woodard* gives effect to this statutory purpose, as expressed in the meaning of the words used.

That purpose is just as necessary today as it was when the statute was enacted, and is particularly relevant in the context of specialty/subspecialty distinctions. But for *Woodard*'s application of the statute to subspecialty distinctions, the proposed experts in *Woodard* and *Hamilton* might have been qualified to testify despite their lack of recent and relevant experience in the defendant's specialty. This would have wholly defeated the purpose of the statute. Indeed, the intent of the statute would have been quickly derailed if the only required match was to the

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defendant's broader, more generalized specialty without regard to the particularized field of medicine he or she [or the testifying expert] was actually practicing. Imagine, for example, nephrologists testifying against internists, and internists testifying against cardiologists; gastroenterologists testifying against cardiologists and cardiologists testifying against neurologists – merely because they all began with the same general specialty certification in internal medicine.

Woodard was based upon the plain meaning of MCL 600.2169(1). The pertinent language of that statute has not changed, nor has Plaintiff identified any change in the law that requires the reversal of *Woodard.* Under the rules of stare decisis, *Woodard* should not be overruled.

Furthermore, courts are not to substitute their judgment for that of the Legislature. In *Ferguson v Skrupa,* 372 US 726, 730-731 (1963), the United States Supreme Court stated:

> [C]ourts do not substitute their social and economic beliefs for the judgment of legislative bodies, who are elected to pass laws. As this Court stated in a unanimous opinion in 1941, "We are not concerned … with the wisdom, need, or appropriateness of the legislation." Legislative bodies have broad scope to experiment with economic problems, and this Court does not sit to "subject the State to an intolerable supervision hostile to the basic principles of our Government and wholly beyond the protection which the general clause of the Fourteenth Amendment was intended to secure." … We refuse to sit as a "superlegislature to weigh the wisdom of legislation."

Observing that "it is not the province of the court to make policy judgments or to protect against anomalous results," this Court has explained that its "function is not to redetermine the Legislature's choice or to independently assess what would be most fair or just or best public policy," but rather "to discern the intent of the Legislature from the language of the statute it enacts. " *Hanson v Bd of Co Rd Comm'rs*, 465 Mich 492, 501-502, 504; 638 NW2d 396 (2002). Thus, the judiciary does not have the authority to judge the wisdom of a statute or to impose its own policy preferences under the guise of construction.

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III. The "One Most Relevant Specialty" Standard is Not Applicable Where a Defendant Practices a Single Medical Specialty, as in This Case.

Under the plain language of MCL 600.2169, if the defendant is a specialist, the proffered expert must specialize in that same specialty; if the defendant is board certified, the expert must also be board certified in the same specialty; and in the year preceding the occurrence, the expert must have devoted a majority of his or her professional time to the practice or instruction of that same specialty. The application of this language is straightforward where the defendant practices only a single specialty.

This case does not require application of the "one most relevant specialty" test. Rather, it is more analogous to *Hamilton v Kuligowski*, the companion case to *Woodard*, because it involves a defendant physician with a single specialty. In *Hamilton*, the defendant physician was board certified in general internal medicine, specialized in general internal medicine, and was practicing general internal medicine at the time of the alleged malpractice. *Woodard*, 476 Mich 556, 577-578. The plaintiff's proposed expert was also board certified in general internal medicine but "devote[d] a majority of his professional time to treating infectious diseases, a subspecialty of internal medicine." *Id*. at 556, 578. The Court concluded that the proposed expert did "not satisfy the same practice/instruction requirement of § 2169(1)(b)" and was "not qualified to testify regarding the appropriate standard of practice or care under § 2169(1)." *Id*. at 578.

Similarly, in this case, Dr. Swofford is board certified in diagnostic radiology, specializes in diagnostic radiology, and was practicing diagnostic radiology at the time of the alleged malpractice. Dr. Berger is also board certified in diagnostic radiology, but he devotes a majority of his professional time to neuroradiology, a subspecialty of diagnostic radiology. Therefore, as in *Hamilton*, Dr. Berger does not meet the requirements of MCL 600.2169(1)(b) and is not qualified to give standard of care testimony. Under MCL 600.2912a and MCL 600.2169, the only

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relevant specialty is diagnostic radiology and that is the standard to which Dr. Swofford should be held.

IV. The Only Workable Test Under MCL 600.2169 is the Test Set Forth in *Woodard*.

The test set forth in Woodard is the only workable test that gives effect to the language in the statute. The Legislature made it clear that only physicians specializing, board certified, and practicing in the same specialty should testify to the standard of care of a defendant physician. The test in *Woodard* accomplishes that in the context of the complexities of the medical field with its varying specialties and subspecialties. All proposed alternatives ignore the legislative intent, rewrite the statute, and create worse problems than the existing test.

Plaintiff proposes a test in which the specialty matching requirement under MCL 600.2169(1) only requires a matching of the defendant physician's primary specialty and not any subspecialties. Time spent practicing a subspecialty would count toward the primary specialty. The "one most relevant specialty" test would remain if a defendant has more than one primary specialty. Plaintiff then acknowledges the problems this test would bring based on the differences between specialties and subspecialties. Plaintiff claims these issues could be addressed under MCL 600.2169(3), which allows the trial court to disqualify an expert "on grounds other than the qualifications set forth in this section."

There are any number of examples that can demonstrate the problems with Plaintiff's proposal. The specialty of internal medicine has 21 subspecialties.[14] Under Plaintiff's test, a sleep medicine specialist could testify to the standard of care of a cardiologist specializing in advanced heart failure and transplant. A rheumatologist could testify against an endocrinologist. A sports medicine specialist could testify against a hematologist. All of these specialists would fall under

[14] American Board of Medical Specialties, < https://www.abms.org/board/american-board-of-internal-medicine/> (accessed June 20, 2023).

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the umbrella of internal medicine and according to Plaintiff, would be specializing not in their particularized medical specialty but in the general practice of internal medicine and would thus satisfy the statute's majority practice requirement. But this scenario is exactly what the Legislature sought to remedy with the 1993 amendment.

Furthermore, Plaintiff's MCL 600.2169(3) proffer would not ameliorate the problem created by Plaintiff's interpretation. The word "section" refers to the entire Section 2169 of the statute. If MCL 600.2169(1) is interpreted in the manner Plaintiff proposes, the problematic scenarios envisioned above would not be precluded by application of MCL 600.2169(3) because they would not be grounds "other than the qualifications set forth in this section." Subsection 2169(3) simply makes clear that other challenges to an expert can still be made, such as lack of foundation, failure to establish reliability, and other factors listed in MCL 600.2955. Plaintiff's solution would rewrite the statute to the 1986 version requiring expertise merely in a related area, or even reinstate the standards of the pre-statute era.

V. The Court of Appeals Erred in its Application of the Requirements of MCL 600.2169 Where it Held that a Board Certified Neuroradiologist who Devotes the Majority of his Professional Time to Neuroradiology Could Provide Standard of Care Testimony Against a Board Certified Diagnostic Radiologist who Specializes Solely in Diagnostic Radiology and is Not Board Certified in Neuroradiology.

A. Under MCL 600.2912a, Diagnostic Radiology Provides the Standard of Care to Which Defendant Must be Held.

MCL 600.2912a provides the basis for determining the applicable standard of practice or care in a medical malpractice case. *Locke v Pachtman*, 446 Mich at 222 n 6. The plaintiff bears the burden of proving the applicable standard of care. MCL 600.2912a(1). With respect to a defendant that is a specialist, the plaintiff must show that "in light of the state of the art existing at the time of the alleged malpractice," that specialist "failed to provide the recognized *standard of practice or care within that specialty* as reasonably applied in light of the facilities available in the

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community or other facilities reasonably available under the circumstances." MCL 600.2912a(1)(b) (emphasis added). Thus, it is the defendant's specialty that governs the applicable standard of care. There is no mention in the statute of the service provided. Dr. Swofford is board certified in and practices the specialty of diagnostic radiology. Therefore, Dr. Swofford is a specialist in diagnostic radiology. Under MCL 600.2912a, the only relevant specialty is diagnostic radiology, and the standard of care applicable to Dr. Swofford is that of a diagnostic radiologist as reasonably applied in light of the facilities available in the community or other facilities reasonably available.

B. Under the Plain Language of MCL 600.2169(1), Dr. Berger Cannot Provide Expert Testimony on the Standard of Care Applicable to Dr. Swofford's Practice Because He does not Practice Diagnostic Radiology.

In prescribing the requirements for expert testimony, as in MCL 600.2912a, the language of MCL 600.2169 focuses on the physician and the physician's specialty, not on the particular task being performed at the time of the alleged malpractice. Here, the party against whom the testimony is offered is Dr. Swofford. Dr. Swofford is board certified in and practices the specialty of diagnostic radiology. He is thus a specialist in diagnostic radiology. Therefore, at the time of the occurrence that is the basis for this action, Plaintiff's proposed expert, Dr. Berger, must have specialized in the same specialty of diagnostic radiology. Although board certified in diagnostic radiology, Dr. Berger testified that he spends approximately 70 to 75 percent of his practice in the area of neuroradiology and 20 percent doing various general forms of radiology. Joint Appx, pp 102-103.

Although neuroradiology is a subspecialty of diagnostic radiology, it is considered a separate specialty under the statute. Thus, on the date of the occurrence, Dr. Berger did not practice diagnostic radiology and he did not devote a majority of his professional time to the active clinical practice or teaching of diagnostic radiology in the year immediately preceding the date of the

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occurrence. Under the clear language of MCL 600.2169(1)(b), Dr. Berger cannot give expert testimony on the appropriate standard of care applicable to Dr. Swofford's practice.

C. The Court of Appeals' Holding Reverts the Statute Back to its Pre-Amendment Language.

Despite the Legislature's apparent satisfaction with this Court's interpretation of MCL 600.2169 in *Woodard*, the Court of Appeals' holding reverts the statute back to the 1986 version by allowing an expert in a *related area of medicine* to testify to the standard of care applicable to Dr. Swofford. Neuroradiology, as a subspecialty of diagnostic radiology, is a related area of medicine. Dr. Berger is board certified in and spends the majority of his professional time practicing neuroradiology. Thus, under the former language of MCL 600.2169(1)(b), Dr. Berger might have been qualified to give expert testimony on the appropriate standard of care applicable to Dr. Swofford's practice because he specialized in a related field. But under the present version of MCL 600.2169(1)(b)*, Dr. Berger is not qualified*.

The Court of Appeals acknowledged that Dr. Swofford was a board certified diagnostic radiologist at the time of the occurrence at issue in this case.[15] The court also acknowledged that the parties agree that diagnostic radiologists are qualified to interpret neuroimages even if they do not obtain a certification in neuroradiology. Thus, Dr. Swofford was not practicing outside of his specialty of diagnostic radiology when he interpreted Plaintiff's decedent's cranial CT scan. The court even noted Dr. Berger's testimony that although every diagnostic radiologist is trained to

[15] Plaintiff wants to characterize Dr. Swofford as a neuroradiologist because he was board certified and practiced as a neuroradiologist seven years earlier. Under the statute, what the defendant physician was practicing seven years earlier is not relevant. MCL 600.2169 looks to the defendant's specialty at the time of the occurrence, as does MCL 600.2912a. Beyond this pivotal point, it seems Plaintiff is asking this Court to disregard the statutory language and hold that once a neuroradiologist always a neuroradiologist despite the physician's own apparent decision to move his or her practice in another direction. This Court cannot accept that invitation.

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interpret cranial CT scans, neuroradiologists have more expertise on the matter, must obtain and maintain a certificate of added qualification in neuroradiology, must have a certain number of neuroimage reads per year, and must pass an examination. Finally, the court conceded that the decedent's CT scan could have been interpreted by a neuroradiologist or a diagnostic radiologist. Yet, inexplicably, the court held that Dr. Swofford, a diagnostic radiologist, was practicing neuroradiology when he interpreted the CT scan and should be held to the same standard of care as a neuroradiologist. The court offers no rationale for this holding, which violates MCL 600.2912a and impermissibly reverts back to the 1986 statutory language of MCL 600.2169(1)(b). It also conflicts with *Jilek*.

The Court of Appeals relied on *Higgins v Traill*, unpublished opinion per curiam of the Court of Appeals, issued July 30, 2019 (Docket No. 343664), because it was a similar case which held that the defendant radiologist was practicing neuroradiology when he read a CT scan. However, *Johnson v Bhimani*, unpublished opinion per curiam of the Court of Appeals, issued February 10, 2011 (Docket No. 292327), is just as similar.[16] In *Johnson*, the defendant and the plaintiff's proposed expert were both board certified in diagnostic radiology, but the expert testified that he spent the majority of his time practicing neuroradiology. *Id*. at 2. The proposed expert testified that the muscular skeletal films and diagnostic films at issue in the case were within the realm of both neuroradiology and diagnostic radiology. *Id*. at 2-3. The Court of Appeals held that diagnostic radiology and neuroradiology were two distinct specialties, and because the expert did not devote a majority of his time practicing diagnostic radiology, he was not qualified to testify to the standard of care applicable to the defendant. *Id*. at 3. Here, the Court of Appeals relied on

[16] A copy of this unpublished opinion is attached as Exhibit A. Amici cite to this opinion because it is similar to *Higgins* and the facts in this case but resulted in the opposite holding as *Higgins* and the Court of Appeals' ruling in this case.

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Higgins as a similar case without giving equal credence to *Johnson* or even attempting to reconcile the inconsistent holdings.

The current language of MCL 600.2169(1) requires the Court to assess the defendant physician's specialty in determining whether a proffered expert is qualified to testify to the standard of care applicable to that specialty. The statute does not have any language requiring the Court to assess whether the defendant was practicing in a related field, nor does it (or MCL 600.2912a) allow the Court to assign a different standard of care to the defendant outside of his specialty based upon the specific task he was performing. MCL 600.2169(1) requires that the proffered expert practice in the *same specialty* as the defendant, be board certified in *that specialty* if the defendant was board certified and devote the majority of his or her professional time to practice or instruction in *that specialty*. MCL 600.2912a likewise requires that a defendant who is a specialist be held to "the recognized standard of practice or care within that specialty." The standard of care applicable to Dr. Swofford is that of a diagnostic radiologist, not neuroradiology. *Horn* should be reversed.

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CONCLUSION AND RELIEF REQUESTED

Amici Curiae MSMS and AMA respectfully urge this Court to dispel the confusion created by the result in *Horn*, to ultimately reverse it, and to hold that Plaintiff's neuroradiology expert is not qualified to testify against Dr. Swofford.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on August 3, 2023, I electronically filed the foregoing Supplemental Amici Curiae Brief with the Clerk of the Court using the Court's electronic filing system which will electronically serve all parties of record.

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