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STATE OF MICHIGAN

IN THE SUPREME COURT

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

Plaintiff-Appellee,

vs.

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

Defendants-Appellants,

Supreme Court No. 162302

Court of Appeals No. 349522

Mecosta County Circuit Court No. 2018- 164148-NH

ANTONIO SELLIMAN,

Plaintiff-Appellant,

vs.

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

Defendants-Appellees.

Supreme Court No. 163226

Court of Appeals No. 352781

Oakland County Circuit Court No. 18-167068-NH

SUPPLEMENTAL BRIEF AS AMICUS CURIAE SUBMITTED ON BEHALF OF THE NEGLIGENCE SECTION OF THE STATE BAR OF MICHIGAN

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RECEIVED by MSC 9/29/2023 12:40:54 PM

TABLE OF CONTENTS

Page

INDEX OF AUTHORITIES ii

STATEMENT OF QUESTIONS PRESENTED iv

STATEMENT OF INTEREST v

INTRODUCTION 1

ARGUMENT 2

I. *WOODARD* WAS NOT CORRECTLY DECIDED AND THAT DECISION IS NOT CONSISTENT WITH THE LANGUAGE OF MCL 600.2169(1) 2

II. THE TEST THAT SHOULD BE APPLIED IN THESE CASES IF *WOODARD* IS REEXAMINED AND OVERRULED 3

III. UNDER THE APPROPRIATE READING OF §2169(1), THE COURT OF APPEALS REACHED AN INCORRECT RESULT IN BOTH OF THESE CASES 6

RELIEF REQUESTED 10

CERTIFICATION PURSUANT TO MCR 7.312(A) 11

RECEIVED by MSC 9/29/2023 12:40:54 PM

INDEX OF AUTHORITIES

Cases **Page**

Robinson v City of Detroit,
462 Mich 439 (2000) 2

Selliman v Colton,
___ Mich ___; 982 NW2d 396 (2022) 2

Selliman v Colton,
505 Mich 960; 972 NW2d 843 (2022) 1

Stokes v Swofford,
___ Mich ___; 982 NW2d 397 (2022) 1

Stokes v Swofford,
334 Mich App 281; 964 NW2d 904 (2020) 1

Stokes v Swofford,
508 Mich 959; 965 NW2d 210 (2021) 1

Woodard v Custer,
476 Mich 544; 719 NW2d 842 (2006) . . . . . iv, 1

Woodard v Custer,
476 Mich 545 (2006) 2

Statutes

MCL 333.2701(a) 4

MCL 600.2169 . . . . . v, 1

MCL 600.2169(1) . . . . . iv, 2

MCL 600.2169(1)(a) 3

MCL 600.2169(1)(b) 3

MCL 600.2169(1)(b)(i) 4

MCL 600.2169(3) 5

RECEIVED by MSC 9/29/2023 12:40:54 PM

Court Rules

MCR 7.212(B)(1) 11

MCR 7.312(H)(4) 1

Other Authorities

MRE 702 5

RECEIVED by MSC 9/29/2023 12:40:54 PM

STATEMENT OF QUESTIONS PRESENTED

I. SHOULD THIS COURT CONCLUDE THAT ITS DECISION IN *WOODARD V CUSTER*, 476 Mich 544; 719 NW2d 842 (2006), MISCONSTRUED MCL 600.2169(1) IN SEVERAL RESPECTS?

Amicus curiae says, "Yes."

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STATEMENT OF INTEREST

The State Bar of Michigan Negligence Law Section ("the Section") is comprised of attorneys who represent both plaintiffs and defendants in personal injury litigation. The mission of the Section includes:

> the study of the procedures, rules, and statutes which embody the law of negligence to promote scholarship among its members and to unwaveringly promote the fair, equitable, and speedy administration of negligence litigation in the Michigan trial and appellate courts.

Because of its composition, the Section has a significant role in the jurisprudence of the State of Michigan. Notably, the Section is regularly requested to provide its consensus opinions on pending appellate matters or proposed legislation. By virtue of its mission, the Section has an overriding interest in those issues which impact and ultimately govern negligence law, civil justice, and the right to trial by jury.

The issues raised in this case are of importance to the jurisprudence in this State and to the members of the Section. The statute that is at the center of this case, MCL 600.2169, is one that governs the qualifications of expert witnesses in every medical malpractice action, both for plaintiffs and defendants. And since that statute has created a significant degree of confusion for all medical malpractice practitioners, the Section has a substantial interest in this case.

RECEIVED by MSC 9/29/2023 12:40:54 PM

INTRODUCTION[1]

These two cases come before this Court following Court of Appeals decisions interpreting and applying the Michigan statute that governs the qualifications of expert witnesses providing standard of care testimony in medical malpractice cases, MCL 600.2169.

In orders entered in October 2021 and April 2022, the Court granted oral argument on the applications for leave filed in these two cases. *Stokes v Swofford*, 508 Mich 959; 965 NW2d 210 (2021); *Selliman v Colton*, 505 Mich 960; 972 NW2d 843 (2022). Oral argument was held on the two cases in December 2022.

In advance of that argument, the Negligence Section of the State Bar filed an amicus curiae brief in the *Stokes* case in which it urged the Court to take up an issue raised by Judge Mark T. Boonstra in his Court of Appeals concurring opinion in *Stokes*: whether this Court should step in "to provide much-needed clarity in this complex area of law." *Stokes v Swofford*, 334 Mich App 281, 299; 964 NW2d 904 (2020) (Boonstra, J., concurring). In its amicus brief, the Negligence Section argued that the precedents of this Court on the subject of §2169(1) were inconsistent and confusing and that the Court's principal case analyzing this statute, *Woodard v Custer*, 476 Mich 544; 719 NW2d 842 (2006), was incorrectly decided in several important respects.

Following the oral argument on the parties' applications for leave, this Court granted leave to appeal in both cases in orders entered on December 22, 2022. *Stokes v Swofford*, ___ Mich ___;

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[1]Pursuant to MCR 7.312(H)(4), the undersigned represents that no counsel for any of the parties was involved in the preparing of this brief. The undersigned further represents that none of the parties to the case made a financial contribution toward the preparation of this brief. The position taken herein was achieved by a unanimous vote of the voting members of the Negligence Section Council. This brief and the positions taken are submitted on behalf of the Negligence Section of the State Bar of Michigan, and not the State Bar of Michigan itself.

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982 NW2d 397 (2022); *Selliman v Colton*, ___ Mich ___; 982 NW2d 396 (2022). The Court's orders granting leave requested further briefing on five issues:

> (1) whether *Woodard v Custer*, 476 Mich 545 (2006), was correctly decided and is consistent with the requirements of MCL 600.2169(1); (2) if not, whether it should nonetheless be retained under principles of stare decisis, *Robinson v City of Detroit*, 462 Mich 439, 463-468 (2000); (2) if *Woodard* should be retained, whether a defendant's practice of only a single medical specialty affects the application of *Woodard*'s "one most relevant specialty" requirement, 476 Mich at 560; (4) if *Woodard* was not correctly decided and should not be retained, the test that should be applied under MCL 600.2169(1); and (5) whether the Court of Appeals reached the right result under the proper application of the requirements of MCL 600.2169 in this case.

The December 22, 2022 orders entered by this Court further indicated that amici curiae who appeared at the application stage could file supplemental briefing. Pursuant to that invitation, the Negligence Section submits this supplemental brief.

ARGUMENT

I. *WOODARD* WAS NOT CORRECTLY DECIDED AND THAT DECISION IS NOT CONSISTENT WITH THE LANGUAGE OF MCL 600.2169(1).

The first and most important question that the Court has posed in its December 22, 2022 orders is whether its decision in *Woodard* was correctly decided. In the amicus brief that it filed in November 2022, the Negligence Section went into some detail explaining how the *Woodard* case misconstrued the language of §2169(1) and, as the Court of Appeals rulings in these two cases display, how that misconstruction has resulted in applications of §2169(1) that could never have been intended by the Michigan Legislature when it passed this statute.[2]

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[2]Both *Stokes* and *Selliman* present a situation in which adherence to *Woodard*'s holding renders results that could not have been intended by the Michigan Legislature. In *Stokes*, the *Woodard* holding results in the conclusion that the defendant, Dr. Michael Swofford, was not qualified under §2169(1)(b) to provide standard of care testimony as to his own alleged breaches

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The arguments previously made in the Negligence Section's amicus brief will not be repeated, but they can be summarized:

1. The words "specialist" and "specialty" as used in both 2169(1)(a) and (b) should be interpreted as the Legislature wrote them – "specialist" and "specialty." These two words should not encompass what the medical field has defined as subspecialties nor should they include certificates of added qualifications.

2. Since the words "specialist" and "specialty" should be interpreted as they are written, the term "specialist who is board certified," as used in §2169(1)(a) should be confined to board certifications in what the medical profession defines as a specialty, not any subspecialties.

3. The *Woodard* Court seriously erred when it added to §2169(1)(b) the qualification that "one cannot devote a 'majority' of ones professional time to more than one specialty." 476 Mich at 566. In engrafting this requirement to §2169(1)(b), the *Woodard* decision reached a result that is not to be found in the text of this statute and it is also reached a result that is oblivious to the real world practice of medicine in which, as both of these cases demonstrate, there is a substantial overlap between various specialties and subspecialties of medicine.

II. THE TEST THAT SHOULD BE APPLIED IN THESE CASES IF *WOODARD* IS REEXAMINED AND OVERRULED.

As the Negligence Section urged in its initial brief submitted in the *Stokes* case, the Court should reject *Woodard*'s determination that the words "specialist" and "specialty" include what the medical profession classifies as subspecialties. Amicus curiae submitted with its initial brief two exhibits showing the American Board of Medical Specialties (ABMS) list of 24 specialties in which it allows board certification and the 27 primary specialties recognized by the American Osteopathic

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of the standard of care. In *Selliman*, plaintiff's expert, Dr. Michael Armstrong, has certifications from both the American Board of Otolaryngology and the American Board of Facial Plastic and Reconstructive Surgery, the same two certifications that the defendant, Dr. Jeffrey Colton, possesses. Yet, Dr. Armstrong is, under *Woodard*'s analysis, unqualified to provide standard of care testimony. Neither of these results could have been intended by the Legislature.

RECEIVED by MSC 9/29/2023 12:40:54 PM

Association (AOA). The Court should, consistent with MCL 333.2701(a), conclude that the words "specialist" or "specialties" as used in §2169(1) are confined to these 24 or 27 specialties.

What such a holding would mean is that the "matching" of specialties called for by §2169(1)(a) would only have to be at the level of these board certified specialities, not at the subspecialty levels that *Woodard* called for.

The same would be true of the term "specialist" in §2169(1)(b)(i), the practice requirement in the statute. That subsection should be read as requiring that, in a malpractice action against a specialist, any standard of care expert must devote a majority of her professional time to one of the same 24 ABMS specialties or one of the 27 primary specialties identified by the AOA, as the defendant.

The facts of the *Woodard* case itself provide an example as to how the words "specialist" and "specialty" should be interpreted as the Legislature wrote them. The defendant in *Woodard*, Dr. Joseph Custer, was board certified in pediatrics, one of the 24 ABMS specialties. He also possessed certificates of special qualifications in two of the subspecialties of pediatric medicine that the ABMS recognizes, pediatric critical care medicine and neonatal-perinatal medicine. The plaintiff's expert in the case was, like Dr. Custer, board certified in pediatrics, but he lacked the additional certifications that Dr. Custer had.

Because the *Woodard* Court read the word "specialty" in §2169(1) as including subspecialties, it had to determine whether, at the time of the alleged malpractice, Dr. Custer was practicing pediatric medicine, pediatric critical care medicine, or neonatal-perinatal medicine. The Court's majority in *Woodard* concluded that Dr. Custer was, at the time of the alleged malpractice, engaged in the practice of pediatric critical care medicine. As a result of that finding, the Court

RECEIVED by MSC 9/29/2023 12:40:54 PM

concluded that plaintiff's standard of care expert was not qualified to testify under §2169(1)(a) because that expert did not "match" Dr. Custer's special certification in what the Court deemed the one most relevant subspecialty, pediatric critical care.

This analysis was not correct. It was incorrect because the Legislature used the word "specialty," not "subspecialty" when it drafted §2169(1). All that should have been required in *Woodard* for purposes of the "matching" component of §2169(1)(a) is that the plaintiff's expert be a specialist in the one ABMS specialty (not subspecialty) that mattered – pediatrics. And since Dr. Custer was board certified in that specialty, plaintiff's expert had to be similarly board certified in that specialty.[3]

The facts of *Woodard* also serve to expose the second major error in the *Woodard* Court's analysis. This second error has created significant problems in the application of §2169(1)(b), which requires that, where the defendant is a specialist, to be qualified an expert must spend a majority of his/her professional time practicing in that same specialty. The Court further ruled in *Woodard* that a physician "can only devote a *majority* of his professional time to *one* specialty." 476 Mich at 560.

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[3]The facts of *Woodard* demonstrate that reading the words "specialty" and "specialist" as amicus curiae has proposed, not as "subspecialty" and "subspecialist," may render situations in which an expert who "matches" at the ABMS or the AOA primary specialty level may still not be qualified to testify to the standard of care in a particular case. It may be in a case such as *Woodard* that Dr. Custer's additional training and experience in pediatric critical care medicine or neonatal-perinatal medicine might render any proposed expert who is only board certified in pediatrics, but lacks any additional training or experience in pediatric critical care or neonatal-perinatal medicine, unqualified to testify to the malpractice alleged. But such additional qualifications for an expert would not be dictated by §2169(1)(a) or (b). Such an additional qualification would, instead, fall under §2169(3), the subsection of the statute that provides the trial court with the authority "to disqualify an expert witness on grounds other than the qualifications set forth above." Thus, there would be cases in which an expert is qualified to provide standard of care testimony under §2169(1)(a) and (b), but is precluded from testifying under MRE 702 or some other rule governing the admission of expert testimony.

RECEIVED by MSC 9/29/2023 12:40:54 PM

This interpretation of §2169(1)(b), which finds no support in the text of that subsection, when combined with the *Woodard* Court's erroneous conclusion that the word "specialty" in §2169(1) includes subspecialties, has led to the balkanization of the practice of medicine in the application of §2169(1)(b) that is completely at odds with the real world of medicine.

Once again, the facts of *Woodard* highlight the error in this statement. Dr. Custer, according to *Woodard*, had to divide the entirety of his professional life into one of three slots, pediatrics, pediatric critical care medicine, and neonatal-perinatal medicine, and the *Woodard* holding dictates that, in assessing the practice requirement of §2169(1)(b), there can be no overlap between these three areas.

Yet, what should be obvious is that, when Dr. Custer is practicing pediatric critical care medicine, one of the recognized subspecialties of pediatric medicine, *he is practicing pediatrics*. Similarly, when he is practicing neonatal-perinatal medicine, *he is practicing in a branch of pediatrics*. Thus, while Dr. Custer might, hypothetically, spend 40% of his professional time practicing pediatric critical care and 30% of his time practicing neonatal-perinatal medicine, the fact is that he spends 100% of his professional time in the field of pediatrics.[4]

III. UNDER THE APPROPRIATE READING OF §2169(1), THE COURT OF APPEALS REACHED AN INCORRECT RESULT IN BOTH OF THESE CASES.

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[4]These hypothetical percentages of practice demonstrate yet another strange quirk in the analysis employed in *Woodard.* If Dr. Custer spent 40% of his professional time in pediatric critical care, 30% of his time practicing neonatal-perinatal medicine, and the remaining 30% of his professional time practicing general pediatrics, he could never serve as a standard of care expert in *any* malpractice case. It would not matter if the malpractice involved a doctor engaged in general pediatric medicine or pediatric critical care or neonatal-perinatal medicine, our hypothetical Dr. Custer would be completely foreclosed from offering standard of care testimony under the holding in *Woodard*. This is yet another result that the Legislature could never have intended when it enacted §2169(1).

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The final question on which the Court has requested supplemental briefing is whether the Court of Appeals correctly decided these two cases. Amicus curiae would urge the Court to reverse both decisions under an appropriate interpretation of §2169(1).

In *Stokes*, the Court of Appeals was compelled by *Woodard* to determine whether the defendant, Dr. Swofford, was, at the time of the malpractice alleged in this case, practicing in the specialty of diagnostic radiology or in the subspecialty or neuroradiology. The Court of Appeals, forced to make that determination, concluded that Dr. Swofford was practicing neuroradiology and, on that basis, it concluded that plaintiff's expert, Dr. Scott Berger, would be allowed to testify to the standard of care because he was both board certified in that subspecialty and he devoted a majority of his professional time to that subspecialty. *Stokes*, 334 Mich App at 295-297.

The correct analysis of *Stokes* under the text of §2169(1) as it was written, should have been that Dr. Swofford, whether reading x-rays of broken bones, or examining CT scans of the kidneys, or interpreting the neuroimaging that was involved in this case, is practicing within the *specialty* of diagnostic radiology. Diagnostic radiology is the ABMS "specialty" that matters in this case for purposes of *both* §2169(1)(a) and (b).

Since Dr. Swofford is board certified in diagnostic radiology, plaintiff's expert, Dr. Berger, to satisfy the requirements of §2169(1)(a), must be board certified in that specialty, which he is. Moreover, since both Dr. Swofford and Dr. Berger are engaged in diagnostic radiology whenever they read any imaging study, including neuroimaging, Dr. Berger spends 100% of his professional time practicing in the one relevant specialty, diagnostic radiology. Dr. Berger, therefore, meets the requirements of §2169(1) and may testify to the standard of care in this case.

This happens to be the same result that the Court of Appeals arrived at in this case in

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applying *Woodard*'s holdings – Dr. Berger is qualified to testify as a standard of care expert under §2169(1). But, the difference in the approach to this issue suggested here is substantial in one important respect. Under the Court of Appeals analysis of what *Woodard* requires, Dr. Berger can testify to the standard of care in this case, *but Dr. Swofford, the defendant, cannot*.

This is, in the view of amicus curiae, a completely inappropriate result, one that could never have been contemplated by the Legislature when it passed §2169(1). Dr. Swofford is board certified in the ABMS specialty that matters in this case, diagnostic radiology. Moreover, since Dr. Swofford is unquestionably performing in the field of diagnostic radiology when he reviews *any* imaging study – including neuroimaging – he spends 100% of his professional life practicing in that one relevant specialty. On that basis, Dr. Swofford is, contrary to the result by the Court of Appeals in following *Woodard*, qualified to testify to the standard of care in this case.

In the *Selliman* case, the defendant and plaintiff's expert have certifications in an ABMS specialty, otolaryngology, and both have an additional certification issued by another body, the American Board of Facial Plastic and Reconstructive Surgery. The Court of Appeals, compelled by *Woodard* to determine in which of these two areas Dr. Colton was practicing when he committed the malpractice that is alleged in this case, determined that Dr. Colton was practicing facial plastic and reconstructive surgery. On that basis, the Court of Appeals came to the conclusion that Dr. Armstrong, plaintiff's expert, was not qualified under §2169(1)(b) because he spent a majority of his professional time in otolaryngology; he did not devote a majority of his practice to facial plastic and reconstructive surgery.

Upon a reexamination of the *Woodard* ruling, the Court of Appeals decision should be reversed. The ABMS specialty involved in this case is otolaryngology. That should be the "specialty"

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for purposes of §2169(1).

The defendant in *Selliman* suggests that this case is somehow different from *Stokes* for purposes of §2169(1)(b) in that this case does not involve a specialty and a subspecialty, but rather two different specialties. This argument, however, overlooks the fact that only one of these two is an ABMS specialty. More importantly, this argument overlooks the fact that the certification in facial plastic and reconstructive surgery, that both Dr. Colton and Dr. Armstrong have, is only available to physicians who have first obtained board certifications in otolaryngology or plastic surgery. This means that Dr. Armstrong (and Dr. Colton) when performing any professional services that might be within the realm of facial plastic and reconstructive surgery are practicing medicine that is within the specialty of otolaryngology. And, because 100% of Dr. Armstrong's professional time is spent in the practice of the relevant specialty, otolaryngology, the practice requirement of §2169(1)(b) is satisfied. He meets the qualifications of §2169(1)(a) and (b) and can testify to the standard of care in this case.

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RELIEF REQUESTED

Based on the foregoing, amicus curiae, the State Bar of Michigan Negligence Section requests that the Court revisit its decision in *Woodard,* clarify the meaning of MCL 600.2169(1), and modify the October 22, 2020 decision of the Court of Appeals in *Stokes* and reverse the Court of Appeals May 20, 2021 decision in *Selliman*.

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CERTIFICATION PURSUANT TO MCR 7.312(A)

Mark Granzotto, attorney for amicus curiae, the Negligence Section of the State Bar of Michigan, hereby certifies pursuant to MCR 7.212(B)(1) that this brief was typed using the Corel Word Perfect word processing program. That program has a function which can calculate the total number of words contained in a document. According to that program function, there are 2,911 words in this brief.

/s/ Mark Granzotto
Counsel for Amicus Curiae