

MEDICAL MALPRACTICE UPDATE

September 2006

WOODARD V CUSTER – THE SUPREME COURT SETS FORTH MORE STRINGENT STANDARDS FOR MATCHING SPECIALTIES IN MEDICAL MALPRACTICE CASES

By Richard Kraus and Cindy Boer

In *Woodard v Custer*, the Michigan Supreme Court interpreted key provisions of the 1993 statute establishing the necessary qualifications for expert witnesses who give opinions on the standard of care in malpractice actions. The statute states that an expert on the standard of care must “match” the defendant physician’s specialty and board certification. In order to “match,” the proposed expert must spend the majority of his or her professional time practicing or teaching in the “same specialty” as the defendant physician. If the defendant physician is board-certified, the expert also has to be “board certified in that specialty.”

Richard Kraus, of Smith Haughey Rice & Roegge, successfully represented the defendant physician and the University of Michigan Health System in the *Woodard* case.

In several prior decisions, the Court of Appeals held that the statute only required matching at the general specialty and board certification level and did not extend to “subspecialties.” Under this interpretation of the statute, for example, under the hierarchy used by the American Board of Medical Specialties, cardiology is classified as a subspecialty of internal medicine. According to this interpretation of the statute, a physician engaged in general internal medicine could give an opinion about the standard of care for cardiologists, because both were internal medicine specialists.

On July 31, 2006, the Supreme Court issued a 98-page opinion holding that the matching requirement extends to subspecialty practices and certification in subspecialties. The Court concluded that the term “specialty” includes subspecialties in which a physician can be certified by an official group that directs or

supervises the practice of medicine and provides evidence of one’s medical qualifications.

The *Woodard* decision involved the consolidation of two cases – *Woodard v Custer* and *Hamilton v Kuligowski*. In *Woodard*, the defendant was a board-certified pediatrician who held certificates of special qualification in both pediatric critical care medicine and neonatal-perinatal medicine. The proposed expert in that case was a board-certified pediatrician who did not practice critical care medicine or hold any certificates of special qualification. In the companion case, *Hamilton*, the defendant was an internal medicine physician practicing general internal medicine. The proposed expert was an internal medicine physician specializing in infectious disease, a subspecialty of internal medicine.

In *Woodard*, the Supreme Court held that the defendant was practicing pediatric critical care medicine at the time of the alleged malpractice and, therefore, this was the “relevant” specialty that had to be matched by plaintiff’s proposed expert witness. Because plaintiff’s expert did not practice pediatric critical care and was not board-certified in that subspecialty, he was not qualified to testify to the applicable standard of care and was properly excluded by the trial court. The case against Smith Haughey Rice & Roegge’s clients was dismissed.

In *Hamilton*, although the proposed expert had the same board certification in internal medicine as the defendant physician, he spent the majority of his professional time in the subspecialty of infectious disease rather than practicing general internal medicine. Therefore, the Supreme Court held that he was not qualified to testify to the applicable standard of care for a general internal medicine practitioner.

While the Supreme Court was unanimous in its holding that the statute required subspecialty matching, the decision was sharply divided as to what specialty or subspecialty must be matched. The statute governs opinion testimony regarding the “appropriate standard of practice or care.” If a defendant physician “specializes at the time of the occurrence that is the basis for the action,” the expert’s specialty must match the defendant’s. In today’s highly specialized health care practice, many physicians are board certified in more than one specialty or subspecialty. In a case involving such a physician, the question is whether the expert must match *all* of the defendant’s multiple certifications.

In the majority opinion authored by Justice Markman, the Court held that the statute only requires matching one specialty, *i.e.* “the one most relevant standard of practice or care – the specialty engaged in by the defendant physician during the course of the alleged malpractice.” In the minority opinion, Chief Justice Taylor maintained that a plaintiff may be forced to retain multiple experts to “match” the qualifications of a defendant who has more than one specialty. None of the Justices advocated a requirement that a single expert must have the exact match of multiple specialties and certifications as the defendant.

In an unusual procedural twist, Justice Markman wrote a separate concurring opinion to the majority opinion that he authored. To address the case where more than one specialty may be relevant, *i.e.* where “the defendant’s actions were informed by both specialties at the time of the alleged malpractice,” Justice Markman’s concurrence stated that other statutory and evidentiary requirements for expert witnesses may require matching of other relevant specialties, and not simply the one “most” relevant specialty. He noted that an expert may be qualified under the statute because he or she specialized in the most relevant specialty, but may not be qualified due to lack of specialization or certification in the other relevant specialties. The dissenting opinion agreed with this conclusion, but would have followed different reasoning.

Because the requirements of the statute, as interpreted by the *Woodard* court, apply equally to plaintiff and defense experts, the decision has important implications for both sides. Essentially, the decision means that litigants will have to pay closer attention to the qualifications of proposed experts and in doing so, adhere to the following principles set forth in *Woodard*:

In most cases, Woodard simply means that the expert must have the same specialization and board certification, whether at the general specialty level or at more particular subspecialties.

- Specialties and board-certifications have to match – but not *all* specialties and board-certifications. If the defendant physician has specialties or board-certifications that were irrelevant to the care at issue, the expert does not have to have those same specialties or board-certifications.
- Find the one-most-relevant specialty – this is the one the expert has to match. And if the defendant is board-certified in that specialty, the expert must also be board-certified in that specialty.
- A physician can be a specialist, yet not be board certified in that specialty. If a physician practices a particular branch of medicine or surgery – whether he is board-certified or not – the expert has to practice or teach in that same branch of medicine or surgery.
- Subspecialties matter. If the defendant specializes in a subspecialty, and was practicing that subspecialty during the incident at issue, the expert must specialize in the same subspecialty. This rule applies to any subspecialty for which certification can be obtained through certificates of added qualification or specialization.
- Timing matters. In the year preceding the date of the malpractice, the expert must have spent a majority of her or his professional time practicing, teaching, or practicing and teaching, in the same specialty that the defendant physician was practicing at the time of the malpractice.

In most cases, *Woodard* simply means that the expert must have the same specialization and board certification, whether at the general specialty level or at more particular subspecialties. Numerous variations on a theme can be envisioned,

however. For example, consider the case where an ob-gyn with a subspecialty in maternal fetal medicine is sued for care rendered during a routine delivery. Would a general ob-gyn be qualified to comment on the standard of care? The answer to this question will depend on the facts of the particular case and whether the delivery involved any issues that maternal-fetal medicine specialists are uniquely equipped to deal with.

Another scenario that arises somewhat frequently is the physician who is trained and board-certified in one specialty, but who chooses to practice as a generalist or in a different specialty altogether. For example, a physician with board certification in family medicine decides instead to practice emergency medicine and works solely in the emergency room. If a lawsuit arises involving care given in the ER, what kind of expert should be retained to evaluate the standard of care: a

board-certified emergency medicine physician or a board-certified family medicine physician? Under a *Woodard* analysis, it could be argued that the “one most relevant” specialty would be emergency medicine – the specialty practiced by the physician, but without board-certification. Under that argument, the proposed expert would have to specialize in emergency medicine, and would not have to be board-certified in either emergency medicine or family medicine. These issues will have to be resolved in future cases.

When the legislature enacted the current statute, it probably envisioned it as a “black and white” rule of thumb that would be quite simple to follow. What the legislature likely did not consider was the increasing importance of subspecialties and added certificates of special qualification in the practice of medicine.

Currently, the American Board of Medical Specialties has approved 24 specialty boards, 37 “general” certificates, and more than 90 “subspecialty” certificates. *Woodard* certainly fortifies the legislature’s requirement that expert witnesses should have the training and experience necessary to provide reliable opinion testimony in medical malpractice actions by applying the statute to subspecialties. Ironically, the holding that matching is only required for the “one most relevant” specialty harkens back to the 1986 version of that statute, which provided that the expert must specialize “in the same or related, relevant area of medicine.” The reliance on other factors to determine expert qualifications as set forth in MCL 600.2169(2), MCL 600.2955, and MRE 702, also presents substantial issues that may operate to preclude an expert from testifying.

CASE LAW UPDATE

Edited by: Brian Molde

SUPREME COURT DECISIONS:

Costa v Community Emergency Medical Services, Inc (June 28, 2006) A co-worker brawl results in one employee lying unconscious on the pavement. EMS and fire department units from the City of Taylor arrive, revive the unconscious plaintiff, and despite his inability to recall the events leading to his head injury, conclude that he is competent to refuse further medical treatment. The next morning, another coworker is unable to awaken the plaintiff, and the plaintiff is found to have suffered an epidural hematoma. The resulting lawsuit asserts that the care at the scene was negligent.

The fire department defendants assert governmental immunity as a complete defense, and do not file an affidavit of meritorious defense with their Answer to the Complaint. On appeal to the Supreme Court, the court holds that defendants asserting governmental immunity as an immunity to tort claims are not required to file an affidavit of meritorious defense because allowing the defense, “while simultaneously requiring that they disrupt their duties and expend time and taxpayer resources to prepare an unnecessary affidavit of meritorious defense would render illusory the immunity afforded by [law].” Thus, defendants who have the defense of governmental immunity available to them are only required to file an affidavit of merit after a court has concluded that the governmental immunity defense does not apply to them.

COURT OF APPEALS – Unpublished Decisions Affidavits of Merit

Slaggert v Michigan Cardiovascular Institute (July 6, 2006) The defendants in this matter included a board-certified cardio-thoracic surgeon and two physician assistants specializing in cardio-thoracic procedures. Plaintiff filed an affidavit from a board-certified cardiologist. The Court of Appeals, relying upon precedent interpreting MCL 600.2169, affirmed the trial court’s dismissal finding no evidence that plaintiff’s attorney had a reasonable belief that the physician defendant was board-certified in cardiology, or that an affidavit from a cardiologist could properly commence a claim against the physician assistants.

Yaunke v Mercy General Health Partners (June 15, 2006) The plaintiff in this case asserted claims of nursing negligence arising out of IV drug administration. With her complaint, plaintiff filed two affidavits from physicians, together with a nurse’s affidavit; however, the Court of Appeals found numerous defects in the nursing affidavit and further found that the physician affidavits could not properly commence a malpractice claim against a nurse. For these reasons, the Court of Appeals reversed the trial court and remanded the case, directing the trial court to enter a dismissal in defendants’ favor.

Kapp v Colony (May 9, 2006) The plaintiff sought removal of her chest tattoo from the defendant, a board-certified plastic surgeon. When the removal went awry, she filed suit and served a complaint with an affidavit from a board-certified dermatologist. Defendants moved

for dismissal based on the failure to match the board-certification of the defendant, and the trial court agreed and dismissed the case. On appeal, the Court of Appeals held that the failure to match board-certifications was fatal to plaintiff's claim and plaintiff's counsel had no reason to believe that the dermatologist was competent to testify against a plastic surgeon.

Dube v St. John Hosp. & Med Center (May 16, 2006)

A misapplied ground plate for an electrocautery machine left the plaintiff with a painful reminder of her gynecologic surgery. She filed a complaint with an affidavit of merit by an OB-Gyn. Midway through discovery, the parties discovered that a nurse was responsible for placement of the ground plate, not the OB-Gyn defendant. Plaintiff made several arguments regarding why it was reasonable for her to believe that an affidavit from an OB-Gyn was sufficient, but the Court of Appeals rejected them all, including the contention that an affidavit of merit is not required in a *res ipsa loquitur* claim. As a result, plaintiff's claim was dismissed with prejudice.

Notice of Intent

Young v Spectrum Health (May 18, 2006) In her Notice of Intent, the plaintiff stated simply that if the defendant had "recognized and reported the significant cardiac changes in their patient, provided continuing monitoring and observations of their patient, and communicated [her] symptoms to the physicians, she would not have experienced the cardiac arrest and died." The trial court and the Court of Appeals agreed that this statement was too conclusory and failed to specify the manner in which more monitoring and reporting would have prevented the plaintiff's decedent's death. The Court of Appeals also rejected application of equitable tolling to this case, finding no external reason for plaintiff's failure to comply with the statutory requirements.

Newton v Medina (April 18, 2006) Plaintiff was involved in a car accident that fractured his right fibula and ankle. Defendant repaired the fractures on May 5, 2002, and treated plaintiff from May until August 2002. On May 7, 2004 (more than two years after the procedure), plaintiff filed a Notice of Intent, alleging negligence in performance of the surgical repair. In November 2004, plaintiff filed a complaint that included allegations of surgical and post-surgery negligence. Defendants moved to dismiss the claims arising out of the surgery based on plaintiff's failure to commence those claims within two years of the date of the alleged negligence, and then moved to dismiss the remaining claims based on plaintiff's failure to include them in the NOI. The Court of Appeals agreed and affirmed on both counts, concluding that there were no statements in the

NOI sufficient to place the defendants on notice of the post-surgery claims.

Statutes of Limitation

Long v Children's Hosp. of Michigan (August 1, 2006) Plaintiff was the next friend of a twelve year-old. The Complaint alleged malpractice in December 1999, but no claim was filed until December 2002. In response to a motion for summary disposition based on the statute of limitations, the plaintiff claimed that the minor child was insane at the time the claim accrued and therefore the period of limitations was expanded by operation of MCL 600.5851(1). Defendants replied that pursuant to case law, this statutory provision does not apply to medical malpractice plaintiffs, and the claim was untimely. The trial court agreed, but found that the case law upon which defendants relied should only be applied to cases filed after that decision was published, not to cases like this one, which was filed before. The Court of Appeals agreed that the child's mental status was immaterial given the statutory language, but held that the case law interpreting the statute did not announce a new rule of law and should therefore be applied retroactively.

Lost Opportunity

Bevis v Bartholomew (June 20, 2006) The Court of Appeals reversed a trial court's dismissal of this action based on the plaintiff's failure to show a lost opportunity to achieve a better result. In the lower court the defendant asserted that plaintiff's expert's conclusion that the plaintiff had a "zero" chance of a better life after the alleged negligence was a "retrospective conclusion" and not sufficient to establish the actual chance of cure, as required by Fulton v William Beaumont Hosp., 253 Mich App 70; 665 NW2d 569 (2002). The Court of Appeals disagreed, stating that because the plaintiff's condition was chronic when diagnosed, but not when the alleged negligence occurred, the expert's opinion that the condition was incurable was appropriate. Using this reasoning, the Court of Appeals distinguished this case from another unpublished opinion, Kuper v Metropolitan Hosp.

Causation

Cochrane v W A Foote Hosp (July 18, 2006) If a drunk man falls in the radiology department, can he sue? The Court of Appeals said, "No," concluding that the plaintiff failed to establish any duty on the part of the hospital's radiology technician to prevent the fall. Plaintiff filed his claim beyond the statute of limitations for medical malpractice actions, and alleged premises liability and ordinary negligence. When defendant filed a motion to dismiss the premises liability claim, the plaintiff asserted only ordinary negligence claims. When the defendant filed a motion to dismiss based on the plaintiff's voluntary intoxication, plaintiff filed an

affidavit stating he was not drunk at the time. Contorting its reasoning to avoid applying a professional standard of care (in light of the expiration of the medical malpractice statute of limitations), the Court of Appeals concluded that plaintiff had failed to prove and support any duty of care owed by the radiology technician to the plaintiff. The Court of Appeals also found that even if there was a duty to prevent the fall, plaintiff presented no evidence that failure to fulfill that duty caused the alleged injuries.

Nudell v Oakwood Healthcare (August 3, 2006) The court held that plaintiff's expert, pediatric neurologist

Dr. Ronald Gabriel, failed to support causation in a birth trauma matter. The Court stated that "because Dr. Gabriel could not say when the damaging processes began or whether complying with the standard of care (i.e. delivery by 11:45 a.m.) would have prevented [the child's] injuries, plaintiff has not set forth facts that support a reasonable inference of a logical sequence of cause and effect." Thus, Dr. Gabriel's testimony failed to establish an element of this claim and summary disposition was granted.

NEWS AND SUCCESS

The Grand Rapids Bar Association has presented **L. Roland "Bud" Roegge** with the "Donald R. Worsfold Distinguished Service Award" for his service to the Grand Rapids Bar Association, the legal profession, and the community. Congratulations Bud!

Welcome to **Mary Rich, RN**, who joins our Medical Malpractice Department team of legal nurse consultants. Mary worked as a labor and delivery nurse for a local hospital for more than 10 years and as a travel Ob-Gyn nurse.

In August, **Bill Jewell** presented a seminar to a local hospital entitled "Drug Seeking Patients." In September, he will be giving a seminar regarding disclosure issues.

In September 2006, **Cindy Boer** will co-present at the Pediatric Grand Rounds Risk Management and Litigation Update for Michigan Professional Insurance Exchange. This session will be attended by local pediatricians, family practice physicians, residents, and medical students. The topics will include the medical-legal climate for pediatricians; an overview of medical malpractice law in Michigan; tips for documentation and risk management; and a hypothetical case illustration highlighting the importance of coordinating patient care.

Also in September, **Jack O'Loughlin** will present an informational seminar for physicians involved in litigation entitled "Litigation Journey," through MPIE.

Bill Jewell and **Cara Nieboer** recently defended and successfully preserved the attorney-client privilege with respect to communications between a medical malpractice defendant and their malpractice insurer.

In May, **Paul Oleniczak** and **Carol Carlson** obtained a no-cause verdict in Kalamazoo County Circuit Court for a group of ophthalmologists accused of failing to detect

a small wafer-like sponge left in the cul-de-sac of a patient's eye after surgery. The ophthalmologist who performed the surgery personally settled prior to trial. At the trial against the remaining ophthalmologist and the professional corporation, plaintiff claimed that the defendants should have further investigated her complaints of recurrent eye infections, wateriness, blurry vision and general discomfort in her right eye, which she had for four and a half years before the wafer was found by another physician. Expert testified that the defendants should have suspected a foreign body in the eye within several months of the surgery. The ophthalmologist who settled testified at trial and provided several plausible explanations for plaintiff's eye complaints. Two treating ophthalmologist also testified that the plaintiff's eye complaints continued even after the wafer was removed and that plaintiff suffered no permanent damage from the wafer. The jury returned a unanimous no-cause verdict for the defendants, including the settling physician.

John Kruis and **Cindy Boer** obtained a no-cause on behalf of an Ob-Gyn physician in Ottawa County Circuit Court in a case involving gynecologic surgery. The plaintiff suffered an injury to her ureter during laparoscopic surgery to remove a fallopian tube and ovary. Plaintiff's expert criticized the physician for not identifying the ureter during surgery. The defendant physician testified how the injury can occur without negligence. His surgical technique was supported by two Ob-Gyns who had performed this procedure in the past and who testified that in the absence of obviously distorted anatomy (such as the presence of cancer, scarring or adhesions), the Ob-Gyn can assume the ureter is in its correct anatomical position, and is not required by the standard of care to ensure the ureter is visualized in every case before proceeding with the surgery. The jury returned a defense verdict.

Bill Jewell, assisted by **Cara Neiboer**, received a no-cause verdict in a case tried in Southwest Michigan on behalf of a hospital defendant. The plaintiff alleged she developed Asherman's Syndrome (scar tissue) following a postpartum dilation and curettage (D&C) performed by the co-defendant, a general surgeon with staff privileges at the hospital. The plaintiff, who already had two children, alleged she was not able to conceive a child because of the scarring in her uterus. In defense of the surgeon, for which the hospital was alleged to be vicariously liable, the hospital called its own experts who testified that the procedure was not only indicated and performed within the standard of care, but that infertility can result from a D&C in the absence of any negligence.

Bill Jack obtained a voluntary dismissal with prejudice without indemnity payment. The case, brought by Geoffrey Feiger's firm, involved the death of a nursing home patient after she received an alleged overdose of narcotic medication at another hospital. After receiving the medication, she was sent back to the nursing home, which refused to accept her because of her condition. She was then transferred to our client hospital. Upon her arrival, she was comatose and in congestive heart failure, and her advanced directives classified her as DNR. Following extensive discussions with the family, she was treated with comfort measures only until she expired. Plaintiff's expert contended that the physicians were negligent in not taking more aggressive measures to save her life. Plaintiff also argued that the DNR order applied to nursing home care only, but not hospital care. A motion in Limine was pending on this issue when plaintiff agreed to dismiss the claim against the hospital.

In August, **Ed Stein** and **Kevin Lesperance** obtained a no-cause verdict on behalf of a family practice physician in Washtenaw County Circuit Court. The plaintiff claimed that the defendant had failed to diagnose his wife's ovarian cancer leading to her untimely death. She was 28 years old and left behind a two year old daughter. Before she died, the decedent testified in a videotaped deposition that she had told all of her healthcare providers, including the defendant, about her abdominal pain prior to her diagnosis. Those complaints were not contained in the pertinent medical records. Moreover, defendant's expert pathologist from Harvard testified that the decedent had a rare and virulent form of ovarian cancer and that more likely than not she did not lose the opportunity to survive or achieve a better result in excess of 50%. The jury found no malpractice.

Joe Engel and **Cindy Boer** obtained summary disposition on behalf of five physicians and a hospital defendant. The plaintiff alleged that when she called the clinic with a complaint of "cramping," the triage nurse should have sent her to the hospital to rule out preterm labor. Instead, the patient was advised to take a stool softener for a documented complaint of "constipation." The patient went on to deliver later that evening, and the child had significant visual deficits as a result of being born prematurely at 26 weeks. The Court ruled that plaintiff was unable to meet her burden of proof on causation, noting that even if she had been sent to the hospital per the alleged standard of care, her expert witnesses could only speculate as to whether administration of tocolytics would have delayed the delivery long enough to avoid the visual deficits.

**SMITH HAUGHEY RICE & ROEGGE'S
MEDICAL MALPRACTICE DEPARTMENT**

Paul M. Oleniczak, Chair 616.458.5461	L. R. Roegge 616.458.7425	Edward R. Stein 734.913.5387	John C. O'Loughlin 616.458.9370
John M. Kruis 616.458.8304	Paul Van Oostenburg 616.458.9462	Mark P. Bickel 231.486.4506	William R. Jewell 616.458.8203
Brian J. Kilbane 616.458.0296	Robert W. Tubbs 231.486.4535	Albert J. Engel, III 616.458.6247	Carol D. Carlson 616.458.9289
Christopher R. Genther 616.458.0222	Kevin M. Lesperance 616.458.3443	Stephanie A. Neal 616.458.9481	Mark A. Gilchrist 517.318.5654
Brian A Molde 616.458.1499	Cindy C. Boer 616.458.1331	Cara L. Nieboer 616.458.0437	Jason R. Sebolt 616.458.3628
We invite you to call any of these attorneys directly for more information.			