NICHOLAS V. MYNSTER: The Same Specialty Witness Requirement for Malpractice Cases is Enforced

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In an opinion issued on April 25, 2013, the New Jersey Supreme Court clarified the standards for expert witnesses in medical malpractice cases with full-throated acceptance of a frequently misunderstood if not ignored statutory provision.

The Court ruled that expert witnesses testifying about the standard of care in a medical malpractice case must practice in the same specialty and have comparable credentials to the defendant physician or physicians. The decision of *Nicholas v. Mynster* was reached unanimously based on a "plain textual reading" of N.J.S.A. 2A:53A-41.

This statute had been part of the tort reform package enacted by the Legislature and signed by the Governor in 2004 and for which MSNJ along with other organizations had worked for many years. The 2004 amendments enhanced the preliminary showing to be made in the affidavit of merit that had to be submitted in medical malpractice claims that had originally been established in 1995.

SOME HISTORICAL PERSPECTIVE

It is long-standing legal doctrine that except in the unusual circumstance of an event that was within the "common knowledge" of lay jurors, a plaintiff presenting a medical malpractice claim needed to have expert opinion identifying the applicable standard of care and the alleged breach that caused the injury at issue. However, the legal requirements to qualify as a medical expert witness were rather marginal. Not much more than having a medical degree and a medical license was required.

The proposed expert would essentially just recite having knowledge of the standard of care with such familiarity being derived from training, association with other physicians, and general reading of medical literature. As a consequence, general practitioners could testify against specialists and sub-specialists. Even where a witness had not seen let alone performed a procedure since a rotating internship decades before, cases were submitted to the juries for decision.

Defense counsel might thoroughly and vigorously cross-examine the lack of expertise and substance of the opinion but all of this went to the "weight" of believability to be given by the jury in its consideration of the testimony and not to its threshold adequacy to support the case. While jurors often rejected such gossamer proofs, some juries in emotion-laden cases with profoundly bad outcomes after being told by the trial judge in accordance with the prevailing law that the witness was "qualified" to be an expert returned substantial damage awards.

The burgeoning litigation in the professional liability area led to legislative initiatives found in the so-called Affidavit of Merit Statute in 1995. That statute encompassed a variety of professions and was not limited to medical defendants. As originally enacted in 1995, the statute only addressed early screening by requiring that the affidavit be submitted by "an appropriate licensed person" who has "particular expertise in the general area or specialty involved." N.J.S.A. 2A:53A-27.

In contrast, the purpose of the 2004 amendments to the Affidavit

of Merit Statute concerning medical liability actions found in N.J.S.A. 2A:53A-41 was to tighten up the requirements for expert witness testimony in medical malpractice cases. There had been earlier cases that suggested a looser standard in areas of overlapping practice between different specialties. The new 2004 statutory provisions required that experts practice the "same specialty" and be Board-certified in the same specialty as the defendant if the defendant had such certification.

The effect of the statute in the context of the screening affidavit was diluted by a series of cases that identified various rationales for lax enforcement.[1] In the *Nicholas* case, counsel for the defendants acted in a manner that protected against procedural deficiencies that might be said to have "lulled" the plaintiff into inaction or reliance on a defective or inadequate affidavit of merit.

But the facts of the case squarely presented the Court with the application of the statute to a trial witness rather than simply the preliminary screening affidavit. In addition, it presented the question not of an under-qualified expert but rather what might seem to be an over-qualified expert.

THE FACTS OF THE CASE

The claim of alleged malpractice arose out of the April 2005 treatment given to a man who had been doing construction work using a gas-powered cutting machine in the basement of a customer's house. He collapsed at the work site after inhaling noxious fumes and vapors that had built up in the work space. He was brought to the Emergency Department facilities where the presenting problem was suspected carbon monoxide poisoning.

The patient was evaluated by a Board-certified Emergency Medicine physician Dr. Mynster. After his initial evaluation of the patient, Dr. Mynster contacted another physician who came to the Emergency Room and admitted the patient for further care in the Intensive Care Unit. That physician, Dr. Sehgal, was certified by the American Board of Family Practice. The treatment started in the ED and continued in the ICU combined medication for the patient's agitation and muscle cramps with 100% oxygen administration by mask.

Plaintiff's counsel provided an affidavit of merit from Lindell Weaver, M.D. Dr. Weaver did not practice either Emergency Medicine or Family Practice and was not certified in either field. His credentials, however, include certification by the American Board of Internal Medicine and subspecialty certification in Critical Care and Pulmonary Disease by the same American Board of Internal Medicine as well as certification from the American Board of Preventative Medicine.

He was a well-published and well-regarded proponent of hyperbaric oxygen therapy for carbon monoxide poisoning. As reflected in a written report, it was Dr. Weaver's opinion that the standard of care required that Dr. Mynster and/or Dr. Sehgal refer the patient for hyperbaric oxygen treatment immediately following his presentation to the hospital and that had Mr. Nicholas received hyperbaric oxygen his problems would have been prevented or mitigated.

The adequacy of this affidavit was challenged and plaintiff provided an additional affidavit from an Emergency Medicine practitioner in at least facial satisfaction of the statutory requirements.

This designated Emergency Medicine provider, however, did not prepare a written report and for purposes of trial the only identified expert witness on behalf of plaintiff addressing the issue of standard of care as to the medical providers was authored by Dr. Weaver. Although he was certified in several specialty areas and well-published, a pretrial

[1] For example in *Ferreira v. Rancocas Orthopedic Associates,* 178 N.J. 144 (2003), the Court ruled that the failure to move promptly for dismissal based on lack of an affidavit of merit would prevent the defendant from advancing that defense and it injected the need for the trial judge to conduct a case management conference to remind counsel of the need for plaintiff to have an affidavit of merit within the statutory time period of 120 days after the filing of defendant's responsive pleading. Then in *Ryan v. Renny*, 203 N.J. 37 (2010), a general surgeon had provided an affidavit of merit in a case against a board-certified gastroenterologist arising out of a bowel perforation during a colonoscopy. The Court ruled that there would be a waiver of the statutory specialty requirement for the physician providing the affidavit of merit where there had been a good-faith effort to obtain such an affidavit but could not do so but had obtained an affidavit from a physician with sufficient training and knowledge of the condition or procedure in issue.

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deposition clearly established Dr. Weaver's lack of credentials or experience in Family Practice or Emergency Medicine.

Indeed, in 2008 the American College of Emergency Physicians had issued a Clinical Policy on the management of adults presenting to the Emergency Department with carbon monoxide poisoning. One of the points under consideration was whether hyperbaric oxygen therapy should be used. Based on its review of available evidence, it made only Level C recommendations and these noted that hyperbaric oxygen was a therapeutic option; "however, its use cannot be mandated."

With the close of the time for identifying expert witnesses to testify at trial, the defendants moved for summary judgment of dismissal on the ground that plaintiff did not have an appropriate witness to establish the necessary predicate of the applicable standard of care and deviation from or breach of that standard of care as it related to the conduct of the defendants. The trial court rejected the motion, finding that there was enough "similarity" between what Dr. Weaver did and the condition being evaluated and treated by the defendants.

The Supreme Court agreed to review the case in advance of a final decision at the trial level.

THE SUPREME COURT RULING

In addition to the briefs on behalf of the parties, the Court received amicus briefs from the Medical Society of New Jersey and the American Medical Association and from the New Jersey Association for Justice (NJAJ), a representative of the organized plaintiff's bar.

The Court began its analysis with the postulate voiced (but not actually enforced) in earlier decisions that generally a plaintiff's medical expert testifying to the standard of care allegedly breached by a defendant physician must be equivalently credentialed in the same specialty or subspecialty as the defendant physician.

It concluded that in denying summary judgment the trial court had erroneously relied upon case law that predated the 2004 Patients First Act amendments that went into effect in April 2005 that had allowed medical professionals may express opinions in overlapping fields provided they have sufficient knowledge of professional standards applicable to the situation under investigation.

It accepted the defense argument in a medical malpractice action where a defendant physician is specialist and board certified in a specialty and the care and treatment involves that specialty, the Patients First Act triggered two requirements.

First, the plaintiff's expert must have specialized in the same specialty as the defendant physician who treated the patient. Second, if the defendant physician was board certified, the plaintiff's expert must either meet the hospital-credentialing requirement of N.J.S.A. 2A:53A-41(a)(1) to treat patients for the medical condition or perform the procedure at issue or be board certified and meet the additional requirements of N.J.S.A. 2A:53A-41(a)(2) with regard to the time of active practice of the specialty or instruction of medical students or residents concerning the specialty. But the threshold was being of the same specialty.

It rejected the position advanced by plaintiffs that under the statute there was an alternative to the requirement of equivalent specialty and the next requirement of equivalent of board-certification so that someone like Dr. Weaver could offer an expert opinion on the standard of care for treating carbon monoxide poisoning because he was "credentialed by a hospital to treat" the condition of carbon monoxide poisoning.

Plaintiffs had contended that *"any doctor who is credentialed by a hospital to treat the same condition . . . is a 'specialist' in the treatment of that condition . . . and should be deemed qualified to testify to the standard of care for treatment."* Instead, the Court looked to the statutory language which defined the scope of "specialty" by the categories recognized as specialties and subspecialties by the American Board of Medical Specialties and the American Osteopathic Association.

The core of the Court's decision is found in the following two paragraphs:

If a defendant physician not only practices in an ABMS specialty, but also is board certified in that specialty, then the challenging expert must have additional credentials. Thus, if the defendant physician specializes in a practice area "and . . . is board certified and the care or treatment at issue involves that board specialty . . ., the expert witness" then must either be credentialed by a hospital to treat the condition at issue, N.J.S.A. 2A:53A-41(a)(1) (emphasis added), or be board certified in the same specialty in the year preceding "the

occurrence that is the basis for the claim or action," N.J.S.A. 2A:53A-41(a)(2).

The hospital-credentialing provision is not an alternative to the same-specialty requirement; it only comes into play if a physician is board certified in a specialty. Again, only a specialist can testify against a specialist about the treatment of a condition that falls within the specialty area. The hospital-credentialing provision is only a substitute for board certification.

In reaching its decision, the Court concluded that the specific statutory scheme regarding standard of care experts in medical malpractice actions trumped the more general provisions regarding qualifications of experts found in the Rules of Evidence.

IMPACT OF THE DECISION

Emphasizing its role as not being to judge the merits or wisdom of the statute "but only to construe its meaning and to enforce it as intended by the Legislature," the Court found that the "plain textual reading" of this statute meant that the plaintiff could not establish the standard of care through a medical expert who does not practice in the same medical specialties as the defendant physicians and any such expert would be barred from testifying to the standard of care governing defendants.

This is a very positive outcome for at least the short term. Indeed, the report and commentary on the decision that appeared in the New Jersey Law Journal on April 29, 2013 had the headline of "No Wiggle Room for Specialties of Medical Malpractice Experts." While the Supreme Court did not explicitly address the application of its decision to cases not yet tried but awaiting disposition, the usual paradigm for judicial decisions is to have retroactive application at least to other cases "in the pipeline." That remains to be seen.

Another issue that remains open is the basis for invoking a statutory waiver of the same specialty as well as the board-certification requirement. The statute explicitly provides that "a court may waive" these requirements on motion by a party seeking a waiver if there is a demonstration of "a good faith effort … to identify an expert in the same specialty or subspecialty" and a basis for the court's determination that the proposed alternative expert "possesses sufficient training, experience and knowledge to provide the testimony as a result of active involvement in, or full-time teaching of, medicine in the applicable area of practice or a related field of medicine." The Supreme Court in *Nicholas* remarked that the plaintiffs had not sought to invoke the waiver provision. Its full scope has yet to be tested.

There is the likely effect of a diminution in cases with multiple defendants having differing specialties since it will require the investment and expense of multiple specialty experts be incurred for purposes of trial. In cases of non-catastrophic magnitude, that may have a dampening effect since plaintiff's counsel look for a return on investment.

The interplay between the more relaxed approach to the initial affidavit of merit and the trial witness standard should be the subject of new litigation challenges to bring the requirements of "same specialty" for the AOM itself in line with the trial witness standard enforced in Nicholas. It is a tautology to suggest that the Nicholas decision does not advance the touted purpose of the statute to block frivolous claims. This contention is built upon a very well qualified expert having identified problematic care. However, the law in New Jersey reflected in many court opinions and embodied in the Model Jury Charge – similar to that in other jurisdictions – is that the conduct of a physician defendant who is a specialist is measured against the knowledge and skill normally possessed and used "by the average specialist in that field" to determine if there has been a breach.

The circumstance of where a patient's condition could properly be treated by more than one specialty does not change the conclusion that where the defendant is a certified specialist in one field treating a condition properly treated by that particular specialty, the statute requires a testifying expert to be of that specialty, even if physicians in other specialties might also have competently provided the treatment. The legislative intent to have physicians with comparable training and experience as the defendant would control.

The statute's use of the ABMS and AOS categorizations of particular specialty areas results in a workable approach because these areas are objectively identifiable and reflect recognition by certifying bodies that certain practice areas involve distinct training and experience. Those categorizations by ABMS and AOS provide a meaningful definition to the concept of "specialist" or "subspecialist."

An unintended and potentially

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undesirable consequence of the *Nicholas* case may be that the cases of lesser magnitude with multiple potential defendants may be narrowly focused on the key player, leaving out the somewhat tangential physicians who are still involved in the chain of events. Since a plaintiff is not required to sue all potential tortfeasors, it may fall upon a sole defendant to totally embrace the case or choose the unpalatable path of pointing fingers at absent parties and even affirmatively bringing them into the case in order to claim the protective benefit of joint tortfeasor contribution and allocation laws.

In a footnote, the Supreme Court noted that the amicus NJAJ had raised a challenge to the constitutionality of the statute as violating the separation of powers doctrine and intruding on the authority of the Supreme Court (and not the Legislature) over the rules of procedure and the establishment of rules of evidence.

The amicus submission on behalf of MSNJ and AMA had responded to that assertion both procedurally pointing out that it was an issue that had not been raised by any of the actual litigants in the case and on the merits. Commenting that amicus curiae must generally accept the case as presented by the parties and cannot raise issues not raised by the parties, the Supreme Court declined to address the issue. In some future case, however, the issue may in fact be raised as an explicit challenge.[2]

Well-qualified specialty physicians have become increasingly involved in litigation. The original specter of the virtual total unavailability of qualified and competent physicians to participate in litigation has no substance anymore. Indeed, many specialty societies recognize an obligation to be available as a source of information and support. However, that undertaking is accompanied by the duty to provide ethical, honest, and reliable testimony in the formulation of the medical opinions. The role of specialty societies in monitoring the conduct of its members should be encouraged by the Nicholas decision.

A related issue to the matter of qualifications and equivalent credentials is the basis for the medical opinion. New Jersey uses a multi-factorial test and has not explicitly adopted the federal standard in the *Daubert v. Merrill-Dow* decision. MSNJ has been a participant in recent hearings before the New Jersey Supreme Court supporting proposal for strengthening the reliability test for expert opinion in civil litigation generally and in medical malpractice actions in particular.

The Court's language also signals reason to be hopeful as to a change in the judicial stance on the interpretation of legislative reform efforts. That remains to be seen and may well be a function not only of political will but also the clarity of expression necessary to compel a "plain textual reading" of the enacted legislation. The opportunity for action may also find support in Protection of Patients and Affordable Care Act.

There is little said in the Obamacare law about malpractice reform; however, in Section 6801 the "sense of the Senate" was articulated. This statement recognized that health care reform presented an opportunity to address issues related to medical malpractice and "encouraged" States to develop and test alternatives to the existing civil litigation system to improve patient safety, reduce medical errors, and stimulate efficiency in the resolution of disputes while preserving an individual's right to seek redress through the courts. Moreover, Section 10607 provides the potential of federal grant money to support demonstration or pilot programs to develop alternatives.

There is still much to do. But the *Nicholas* decision is an important step in the journey.

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[2] Such a case with this issue is now in the court system. On June 4, 2013, a motion was filed in *Carter v. Riverview Medical Center et al.*, Docket No. MON-L-387-13 seeking a declaration that the Affidavit of Merit Statute is unconstitutional and invalid.