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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. 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

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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
specialty, the statute
requires a testifying expert to be of
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. Merrell-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.

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.

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Mr. Jackson was counsel for the Medical Society of New Jersey and the American Medical Association in the Nicholas v. Mynster and Ryan v. Renny appeals to the New Jersey Supreme Court and other matters.