# Expert Witness Standards in a Medical Malpractice Action

By Cheryl A. Cardelli and Erik J. Warsow

## Introduction

In a medical malpractice action, the standard of care (and the compliance or lack thereof) of a medical care professional who is board certified in a specialty must be established by an expert witness who is board certified in that specialty and spends a majority of his or her professional time in that specialty by way of active clinical practice or instruction of students in an accredited health professional school, residency, or clinical research program.[1]

In a series of cases, the Michigan appellate courts have addressed the required qualifications of an expert in three scenarios: (1) when the defendant board-certified physician practices in a *sub*specialty of his or her board certification, (2) when the alleged negligence occurs when the defendant physician is practicing *outside* his or her board specialty, and (3) when the care at issue has been provided by a *non-board*-certified physician who is a resident in a specialty training program. The courts have held that the focus in such cases should be on the "most relevant specialty" instead of, or in addition to, the board certification of the defendant physician.

## "Most Relevant Specialty" May Be the Subspecialty of the Defendant Physician

In the companion cases of *Woodard v Custer* and *Hamilton v Kuligowski,*[2] the Court considered the statutory meaning of "specialty" and "board certification" in the context of challenges to qualifications of expert witnesses.

*Woodard* involved an infant admitted to a pediatric intensive care unit. The defendant physician was board certified in pediatrics and also held certifications of special qualification in pediatric critical care medicine and neonatal-perinatal medicine. The plaintiffs' expert was board certified in pediatrics, but had not obtained any specialty certification.

*Hamilton* concerned an alleged failure to diagnose the plaintiff's pre-stroke symptoms. The defendant physician was board certified in and practiced general internal medicine. The plaintiff's expert was also board certified in general internal medicine, but devoted a majority of his professional time to treating infectious diseases, a subspecialty of internal medicine.

MCL 600.2189 does not define "specialty." The *Woodard* Court noted that the statute does not require a specialist to be board certified and used a dictionary definition for "specialist" ("a physician whose practice is limited to a particular branch of medicine or surgery, especially one who, by virtue of advanced training, is certified by a specialty board as being qualified to so limit his practice").[3] The Court also noted that "a 'specialist' is somebody who can potentially become board certified" and then ruled that a "specialty" is a "particular branch of medicine or surgery in which one can potentially become board certified," and found that "[a] subspecialty, although a more particularized specialty, is nevertheless a specialty."[4]

Noting conflicting statutory definitions of "board certification," the *Woodard* Court defined the term, again relying on dictionary definitions, as "to have received certification from an official group of persons who direct or supervise the practice of medicine that provides evidence of one's medical qualifications."[5] The Court then held that a *certification* of special qualifications constitutes a "board certification."[6]

The *Woodard* Court found that although the specialties and board certificates of the expert must match with the defendant physician, not *all* specialties and board certificates must match. The Court held that the expert "must match the one most relevant standard of practice or care—the specialty engaged in by the defendant physician during the course of the alleged malpractice, and, if the defendant physician is board certified in that specialty, the plaintiff's expert must also be board certified in that specialty."[7] To meet the statutory requirements, the expert must have devoted a majority of his or her professional time in the year preceding the alleged malpractice to practicing or teaching "the one most relevant specialty."[8]

Accordingly, the Court in *Woodard* held that since the defendant physician was practicing pediatric critical care medicine at the time of the alleged malpractice, pediatric critical care medicine was the one most relevant specialty. Since the plaintiffs' expert was not board certified in that specialty and did not specialize in, practice, or teach pediatric critical care, he did not satisfy the same specialty requirement of MCL 600.2169.

In *Hamilton,* the Court determined that general internal medicine was the one most relevant specialty. Noting that the plaintiff's expert did not devote a majority of his time to practicing or teaching general internal medicine (even though he was board certified in that specialty), the court held that plaintiff's expert did not meet the statutory requirements.[9]

## "Most Relevant Specialty" is the Specialty in which the Defendant Physician was Practicing at the Time of the Alleged Malpractice

In *Reeves v Carson City Hospital,*[10] the Court of Appeals applied *Woodard* to a case in which the defendant was practicing outside his specialty. The defendant physician was board certified in family medicine but practicing emergency medicine. The plaintiffs' expert was board certified in emergency medicine but not in family medicine. The Court held that, since the specialty in which the defendant engaged during the alleged malpractice was emergency medicine, that specialty was the one most relevant standard of practice or care. Further, although the defendant physician was not board certified in emergency medicine, she could potentially become board certified in emergency medicine, and therefore, under *Woodard,* she was a specialist in emergency medicine. Accordingly, the Court held that the plaintiffs' expert must be a specialist in emergency medicine and must have devoted a majority of his practice during the preceding year to the active clinical practice of emergency medicine or the instruction of students.[11]

## "Most Relevant Specialty" for a Resident Physician

In *Gonzalez v St John Hospital,*[12] plaintiff alleged that a general surgery resident improperly diagnosed and treated decedent's post-operative complications. The plaintiff's expert was a board-certified general surgeon. The trial court granted defendant's motion for summary disposition on the basis of *Bahr v Harper-Grace Hospital.*[13] *Bahr* held that interns and residents are not "specialists" and that the applicable standard of care for these physicians is that applicable to general practitioners in "the local community or similar communities."[14] However, a specialist could testify as to the standard of care of residents if the specialist has knowledge of the applicable standard of care.[15]

On appeal, the *Gonzalez* Court determined that the resident was practicing within the specialty of general surgery at the time of the alleged malpractice. Applying *Woodard,* the Court found that the resident was a physician who had limited his training to general surgery, and who could *potentially become* board certified in that specialty. The Court held that the "one most relevant standard of practice or care" under the facts of the case was general surgery.[16] The *Gonzalez* Court stated that "there is no difference between a defendant physician who is board certified in a specialty but is practicing outside that specialty at the time of the

### Fast Facts

The expert's qualifications must match "the most relevant specialty" instead of, or in addition to, the board certification of the defendant physician.

"The most relevant specialty" is the specialty in which the defendant physician was practicing at the time of the alleged malpractice.

"The most relevant specialty" may be one of the defendant physician's subspecialties.

To qualify as an expert for or against a resident physician, the expert must demonstrate knowledge of the resident's expected capabilities in the "most relevant specialty."

alleged malpractice and a physician, like [the resident], 'who can potentially become board certified' and is practicing in a specialty but is not board certified in that specialty."[17]

Importantly, the *Gonzalez* Court also held that, *in addition to* satisfying the requirements of MCL 600.2169(1)(a) and (b), a plaintiff must affirmatively establish that his or her proffered expert is qualified under MRE 702, MRE 703, and MCL 600.2955. Specifically, the *Gonzalez* Court reasoned that, because the doctor involved was a resident, "such an inquiry must include sufficient knowledge, skill, experience, training, or education in, and familiarity with, the practice of the discrete specialty by residents."[18]

## Issues for Future Consideration

While *Woodard* and its progeny provide guidance to legal counsel in matching the most relevant specialty of defendant physicians and experts, its holding has in effect negated the distinction set forth in MCL 600.2169 between a "specialist" and "general practitioner." Under *Woodard,* a "general practitioner" will be held to the same standard as a specialist because he or she can *potentially* become board certified in any specialty.

The *Woodard* definition of "specialist" is potentially troublesome when applied to a resident physician. Residents—regardless of their specialty program—rotate through many specialty areas of their hospitals. The knowledge base of residents varies depending on their level of training. It is rational to believe that most physicians would acknowledge that the standard of care is not the same for a first-year resident, a physician participating in a fellowship program, and a board-certified physician in the same specialty. The courts must recognize that there is a distinction between an expert's qualification to testify and the standard of care applicable to the resident physician.

*Kwasniewski v Harrington*[19] provides an example of the failure to recognize the difference between the most relevant specialty of an expert and the applicable standard of care of the defendant resident physician. There, in an unpublished opinion, a panel of the Court of Appeals held that a second-year general surgery resident was practicing thoracic surgery, and accordingly, the plaintiff's expert, who was board certified in both surgery and thoracic surgery but spent the majority of his practice in cardio-thoracic surgery, qualified to testify against the general surgery resident.

In that case, massive bleeding was observed from the patient's chest tube after coronary artery bypass graft surgery, and the general surgery resident, among others, was paged to the intensive care unit. The cardio-thoracic surgeon who performed the initial coronary artery bypass graft surgery was contacted on his cell phone, and gave the resident instructions as he returned to the hospital. Following the surgeon's instructions, the resident opened the chest and attempted to stanch the bleeding, but did not locate the source of the bleeding.

Applying *Woodard* and *Gonzalez,* the panel in *Kwasniewski* determined that since the general surgery resident could potentially become board certified in general surgery, she was therefore a "specialist" in general surgery. However, the Court went on to focus on the care provided by the general surgery resident (opening the decedent's chest and attempting to stop the bleeding in his chest) and determined that this was care typically provided by a thoracic surgeon. The Court then determined that the resident was acting as a *thoracic surgeon* (outside of her area of specialty) at the time of the alleged malpractice. Applying *Reeves,* the Court determined that since certification in thoracic surgery is available, the resident was a "specialist" in thoracic surgery at the time of the alleged malpractice. The Court implied that the standard of care to which she should be held was that of a thoracic surgeon as she could also potentially become board certified in that specialty. This clearly was a misapplication of the *Woodard* and *Gonzalez* decisions.

Resident physicians do not easily fit within the "specialist" or "general practitioner" dichotomy set forth in MCL 600.2169. When the defendant physician is a resident, *Woodard*'s arguably overbroad definition of "specialist" and the focus on the "most relevant specialty" must be tempered with the requirement in *Gonzalez* that, inter alia, the expert must exhibit "sufficient knowledge, skill, experience, training, or education in, and familiarity with, *the practice of the discrete specialty by residents.*"[20] Accordingly, any proposed expert must, in addition to meeting the "most relevant specialty" tests, be required to demonstrate knowledge of a resident physician's expected capabilities in the "most relevant specialty." ■

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### FOOTNOTES

1. MCL 600.2169.
2. *Woodard v Custer,* 476 Mich 545; 719 NW2d 842 (2006).
3. *Id.* at 561.
4. *Id.* at 561–562.
5. *Id.* at 564.
6. *Id.* at 564–565.
7. *Id.* at 560.
8. *Id.* at 561, 566.
9. *Id.* at 576–578.
10. *Reeves v Carson City Hosp (On Remand),* 274 Mich App 622; 736 NW2d 284 (2007).
11. *Id.* at 628, 630.
12. *Gonzalez v St John Hospital & Medical Ctr (On Remand),* 275 Mich App 290; 739 NW2d 392 (2007).
13. *Bahr v Harper-Grace Hospital,* 198 Mich App 31; 497 NW2d 526 (1993), rev'd on other grounds, 448 Mich 135; 528 NW2d 170 (1995).
14. *Id.* at 34.
15. *Id.* at 35.
16. *Gonzalez, supra* at 301.
17. *Id.* at 303.
18. *Id.* at 305.
19. *Kwasniewski v Harrington (On Reconsideration),* unpublished opinion per curiam of the Court of Appeals, issued July 3, 2007 (Docket No. 268774).
20. *Gonzalez, supra* at 305 (emphasis added).