NICHOLAS V. MYNSTER: EXPERT WITNESS REQUIREMENTS FOR MEDICAL MALPRACTICE CASES ARE HEIGHTENED AS SUPREME COURT ENFORCES THE *PATIENTS FIRST ACT'S* SAME-SPECIALTY REQUIREMENTS

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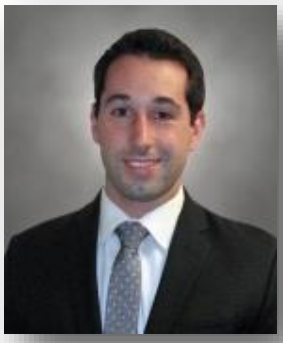

There are a few overly simple yet staggeringly consistent explanations that pop up whenever the issue of increased costs of healthcare in the United States is debated. A certainly non-exhaustive list could include: our general unhealthiness as a nation; medical instrument manufacturers and pharmaceutical companies overcharging hospitals which causes a hike in the costs of treatment; the insured are footing the bill for the uninsured's hospital visits; the insured are demanding excessive testing simply because they can; doctors are ordering unnecessary tests in order to cover themselves against potential lawsuits; and, last but certainly not least, the rise in lawsuits and verdict awards increases the cost of medical malpractice insurance.

While healthcare legislation has most recently featured on a national stage, individual states have also attempted to address the problem by enacting laws to curb the costs of healthcare. In 2004, the New Jersey state legislature cited several of the issues above as specific concerns that must be remedied in order for the state to face the fiscal and medical dilemmas brought on by a rampant healthcare system. In part, the legislature surmised that high medical malpractice insurance premiums and an influx in civil suits were causing good doctors to leave the state for cheaper pastures, drop high-risk patients, and engage in "defensive medicine" in an effort to avoid being sued.

The goal of the "Patients First Act" then was to decrease the number of frivolous, costly suits by heightening the threshold requirements for proving a medical malpractice case, and was accomplished in part by creating the same-specialty standard. This new requirement was finally implemented and enforced in the April 2013 decision, Nicholas v. Mynster, 213 N.J. 463 (2013). As is discussed below, there has been an immediate response from the courts and law offices statewide.

The Patients First Act

On July 7, 2004, in a sweeping piece of legislation that affected insurance companies, medical providers, and malpractice attorneys alike, the state lawmakers enacted the "New Jersey Medical Care Access and Responsibility and Patients First Act," better known as the Patients First Act. What the Patients First Act (hereinafter PFA) meant for malpractice attorneys was the introduction of a more defined set of rules outlining the parameters for expert testimony in malpractice cases. The previous set of guidelines for expert qualifications was the incredibly broad language of New Jersey Rule of Evidence 702 and several interpreting New Jersey opinions, which held in effect that an expert was qualified to

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testify if he or she had "sufficient knowledge of professional standards applicable to the situation under investigation to justify his expression of an opinion relative thereto." See Sanzari v. Rosenfeld, 34 N.J. 128, 136 (1961). This standard allowed for considerable latitude in the threshold qualifications for expert witnesses.

The legislature attempted to tighten up those parameters in the "expert testimony requirements" section of the PFA, codified as N.J.S.A. § 2A:53A-41. In an early draft of the new law, the legislature conveyed that an expert would now need to maintain "the same type of practice and possess the same credentials, as applicable, as the defendant health care provider, unless waived by the court." See Assembly Health & Human Services Committee, Statement to Assembly Bill No. 50 at 20 (March 4, 2004). Or, as a later influential Supreme Court opinion put it: when a physician is a specialist and the basis of the malpractice action *involves* the physician's specialty, the challenging expert must practice in the same specialty. See Buck v. Henry, 207 N.J. 311 (2011) (emphasis added).

Despite the statute's attempt at concise parameters for qualifying an expert, questions remained: in the complex and overlapping world of medicine, what exactly qualifies as practicing "in the same specialty" as the defendant? Two of the most significant cases to first interpret the PFA were Ryan v. Renny and Buck v. Henry, and were not decided until 2010 and 2011, respectively. See 203 N.J. 37 (2010) , 207 N.J. 311 (2011). While both opinions serve as influential precedent, neither scrutinized the same-specialty provisions espoused in § 2A:53A-41 (a), that had the potential to alter expert discovery in malpractice cases.

The Nicholas Opinion

Then came the New Jersey Supreme Court 's April 2013 decision in Nicholas v. Mynster. At issue in Nicholas was that same-specialty provision of § 2A:53A-41(a) which states that a plaintiff's medical expert must "have specialized at the time of the occurrence that is the basis for the action in the same specialty or subspecialty" as the defendant. Nicholas, 213 N.J. at 467. This would be the first appellate level decision to - if it so chose - interpret the PFA's limiting language on very similar, albeit technically different, medical specialties. The Court seemingly took the opportunity to draw a line in the sand, and reversed the lower court's decision to allow expert testimony from a witness who did not "specialize" in the same field of medicine as the defendant-physicians, as set forth by the PFA.

Nicholas involved a malpractice claim against two physicians (among other medical providers) for the alleged negligent treatment of a carbon monoxide patient in a hospital setting. The Supreme Court ruled that under the PFA, an expert who is board-certified in internal medicine and preventative medicine, with subspecialty certifications in critical care medicine, pulmonary disease, and hyperbaric medicine, was *not qualified* to establish the standard of care for either of the two defendant-physicians who were boarded in emergency medicine and family medicine.

Justice Albin explained in his majority opinion that now, under the PFA, if the alleged negligence occurs in the course of a defendant's practice in his or her specialty, the challenging expert must specialize in that same field - not have knowledge of the field, but actively practice in that very specialty. If the defendant is actually *board-certified* in that specialty, and the alleged negligence occurred within that area or specialty, an additional layer is added: the challenging expert must be either credentialed by

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a hospital to perform the procedure or treat the condition, **or** be board-certified in that specialty in the year preceding the occurrence that is the basis of the action. Extremely important is the following proviso: "the hospital-credentialing is not an alternative to the same-specialty requirement . . . only a specialist can testify against a specialist about the treatment of a condition within the specialty area." Id. at 482. So, the hospital-credentialing provision is only a substitute for board certification, not the same-specialty requirement. Id. Additionally, a board-certified expert must have devoted a majority of his professional time in the year preceding the occurrence to either clinical practice in the specialty or teaching the specialty at an accredited medical school.

To recap, assuming the alleged negligence occurred within the defendant's specialty, the challenging expert will *always* have to specialize in that same area. "When a physician is a specialist and the basis of the malpractice action 'involves' the physician's specialty, the challenging expert must practice in the same specialty." Id. at 481-82. Only if the defendant is board-certified will the court need to move on to the next step of determining whether the expert is similarly certified in the specialty, or credentialed by a hospital to specialize in that specific area.

The Nicholas opinion shook up many attorneys' understanding of what qualified as sufficient testimony against a specialist. Justice Albin - along with a unanimous panel - distinguished the specialties at issue in Nicholas, writing that "emergency, family, internal, and preventative medicine are distinct specialty areas recognized by the American Board of Medical Specialties." Id. at 484. It did not matter that the plaintiff's expert, Dr. Weaver, had a certification in internal medicine, which is often understood as overlapping with family medicine. It neither mattered that Dr. Weaver was credentialed by a hospital to treat patients with the illness at issue, carbon monoxide poisoning, because the benefit of that credentialing only comes into play once it has *already* been determined that the expert specializes in the same field as the defendant. The justices weren't required to reach that step in their analysis. The specialties at play were family medicine and emergency medicine, and under Nicholas' interpretation of the PFA, an internal medicine expert was out of his element.

This was a clear departure from the standard-bearer case on expert qualifications, Khan v. Singh, which had been relied upon by the lower court. See 200 N.J. 82 (2009). The lower court ruled that expertise in the treatment of the condition was sufficient even if the expert did not share the same medical specialty as the defendant physicians. To reach that end, the court cited Khan, the then-prevailing precedent on expert witness qualifications, which permitted "an expert to testify despite the fact that the expert had a different specialty than the defendant doctor." Nicholas, 213 N.J. at 474. The trial court went so far as to extrapolate that "Khan could stand for the proposition that an expert who has a different specialty than the alleged negligent doctor but practices similar medicine is sufficient to allow the expert to testify so long as the similar medicine is reasonably related to the patient's treatment." Id. But, the reviewing Court was clear: the Khan analysis was no longer sufficient post-enactment of the PFA. If the events that served as the basis for the action occurred after July 2004, Nicholas and the PFA were to guide.

The evolution from the broader parameters of Khan to the much narrower constraints of the PFA, as interpreted by Nicholas, had a very immediate im-

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pact. Now, medical malpractice attorneys would have to take a look at the experts retained in their own active cases and evaluate whether they would survive under the new PFA scrutiny as endorsed by Nicholas. Similarly, courts would be faced with whether to immediately apply the same-specialty requirement despite the fact that they would be faced mostly with cases where experts had been retained well before the Nicholas opinion was decided, but after the PFA had been enacted.

Quick Impact

There is little doubt of the impact of the Nicholas decision. In the 6 months since the opinion was handed down by New Jersey's highest court, Nicholas has already been cited in at least 5 written opinions, been the subject of law alerts and malpractice blogs alike, and currently features as an annotated case on the Lexis page for N.J.S.A. § 2A:53A-41.

On June 16, 2013, less than 2 months after Nicholas, an Essex County trial court relied heavily on the Nicholas Court's interpretation of the PFA in the matter of Austin v. Deitch, 2013 N.J. Super. Unpub. LEXIS 1524. Judge Vena held that a board-certified internist and cardiologist did not have the requisite credentials under the PFA to testify against a board-certified general surgeon, even when the treatment at issue was post-operative care and monitoring well within the expert's own specialty. The opinion heavily-cited Nicholas and referred specifically to the Supreme Court's differentiation between an expert who was qualified to testify on the subject matter, and an expert who shares the same specialty qualifications as the defendant. Once Judge Vena found that the defendant's post-operative care was within his specialty as a general surgeon, he held that plaintiff was "obligated to find an equivalently-qualified expert." Austin, 2013 N.J. Super. Unpub. LEXIS at 10.

A week later, in Parker v. Batarseh, the Appellate Division used the newly minted Nicholas precedent to support an expert witness who was board certified in internal medicine and infectious disease as qualified to opine against doctors board-certified in internal medicine and infectious disease and practicing within that specialty. See 2013 N.J. Super. Unpub. LEXIS 1551. Here, the plaintiff's expert intelligently identified himself as a specialist in both internal medicine and infectious diseases, and was therefore permitted under the PFA to provide testimony against both the internist-defendant and infectious disease specialist-defendant. The Appellate Division also ruled that the additional qualification of § 2A:53A-41(a)(2)(b) , which permits an expert who is similarly certified and has taught the specialty within the past year, is met when the proposed expert "educates students . . . in both a clinical setting as well as a research environment," even if the instruction is not given in the traditional didactic classroom setting. Parker, 2013 N.J. Super. Unpub. LEXIS at 27.

The publicity tour continued on August 2, 2013 in the Appellate Division's decision in Kim v. Ahn, 2013 N.J. Super. Unpub. LEXIS 1944. Although the court chastised the defendants for waiting five years to object to the plaintiff's expert's credentials - and so invoked the doctrine of equitable estoppel to bar defendant's otherwise credible motion to dismiss the complaint - it precluded the expert report of an internal medicine physician who was attempting to opine against a family practice doctor. Despite the patient having been seen in the defendant's family practice, and the expert having maintained his own clinical internal medicine practice, the Appellate Division ruled that the difference in board-

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certifications amounted to a difference in specialties and the expert was hence precluded pursuant to the PFA and Nicholas. Kim, 2013 N.J. Super. Unpub. LEXIS at 22. The court opined "because Ahn is board-certified in family medicine, only a physician similarly credentialed in family medicine can provide the necessary testimony to establish the standard of care." Id.

Of course, the sweeping Nicholas opinion, like the PFA, applies only to those malpractice cases that involve negligence occurring after July 7, 2004. In Zinn v. Chalom, the Essex County trial court implicitly accepted the tenets of the Nicholas decision, but withheld its application under the particular circumstances as the Zinn defendants' alleged malpractice occurred prior to the enactment of the PFA. See 2013 N.J. Super. Unpub. LEXIS 2065. Because the alleged malpractice in Zinn occurred in February 2004, 5 months prior to the appearance of the PFA, plaintiff was permitted to proceed with his chosen experts as the court deemed them acceptable under N.J.R.E. 702 and the accompanying pre-Nicholas precedent of Khan.

However, the court made it a point to notify prospective readers that the ruling could have gone the defendants' way had the negligence occurred after the enactment of the PFA: "*[w]ithout having to take into account the heightened 'same-specialty' requirements of the Patients First Act and Nicholas v. Mynster* . . . the court is satisfied there is sufficient overlap between the subspecialties at issue that Dr. Silver, a pediatrician with a certification in the subspecialty of pediatric critical care is suitably qualified . . . to express an expert opinion . . . as to the standard of care [for a] pediatrician with a certification in the subspecialty of pediatric emergency medicine . . . ." Id. at 8-9 (emphasis added).

And finally, as recently as September 19, 2013, the Hudson County Superior Court invoked Nicholas to bar plaintiff's expert in Camacho-Gardner v. Rubenstein, 2013 N.J. Super. Unpub. LEXIS 2313. Camacho-Gardner involved specifically the specialty of neonatology, and saw an expert witness board-certified in Neonatal-Perinatal Medicine pitted against two defendants certified in Pediatrics with sub-specialty qualifications in neonatology. Since the case involved board-certified defendants practicing within their sub-specialties, the provisions of § 2A:53A-41(a)(1) and (2) applied.

Plaintiff's expert was ruled unqualified under § 2A:53A-41(a)(1) as he was no longer credentialed by St. Johns hospital to practice in neonatology at the time of the incident; in fact, St. Johns was no longer open. Therefore, "[the expert] is not credentialed, was not at the time of the occurrence, and cannot satisfy this requirement." Camacho-Gardner, 2013 N.J. Super. Unpub. LEXIS at 16. Plaintiffs also found no luck under § 2A:53A-41(a)(2). Despite their expert being board-certified in neonatal medicine, he ceased practicing almost 11 months before the date of the occurrence, and was only teaching physician-assistants around the time of the occurrence, which "does not satisfy the requirement that the expert be instructing students 'in the same health care *profession* in which the defendant is licensed.'" Id. at 17 (citing N.J.S.A. § 2A:53A-41(a)(2)(b)).

Similar to Ahn, however, the court decided that outright dismissal would be prejudicial to the plaintiffs, and extended the discovery deadline and gave them the opportunity to move to vacate and find new a new expert who would qualify under the PFA.

Moving Forward & Effect on The AOM Statute

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Exceptions like the ones made in Ahn and Camacho-Gardner should not be expected for newer litigation, especially those claims that were filed after April 2013, when Nicholas gave definition and clarity to the PFA. For cases that have already exceeded the *Ferreira* stage and are coming up on expert reports and depositions, courts may opt to dole out Nicholas justice on a case-by-case basis, potentially opting for the "preclusion and discovery extension" method so as to not prejudice plaintiffs in the short-term.

Nevertheless, the threshold requirement for expert testimony in medical malpractice cases has been unquestionably heightened. While the cases of the last 6 months dealt mostly with challenges to expert reports and trial testimony, courts will soon be flooded with Nicholas/PFA challenges to a plaintiff's Affidavit of Merit (AOM). As the above cases acknowledged, the AOM Statute, N.J.S.A. § 2A:53A -27 defers to the PFA for AOM requirements in medical malpractice cases. While the AOM Statute was enacted to "weed out frivolous claims" and therefore require only a threshold showing of negligence, plaintiff attorneys will certainly feel a greater burden by having to retain an affiant who can pass Nicholas/PFA muster just to get past a *Ferreira* Conference.

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