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Affidavit of Merit Law Still Mysterious After 15 Years

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The Affidavit of Merit Statute has been on the books since 1995, yet the flood of cases interpreting it is unabated. There have been at least 28 appellate decisions on the topic during the last two years, exceeding all other medical malpractice opinions combined. Two recent cases are particularly troublesome, because they leave plaintiffs' lawyers guessing on what type of affidavit will suffice when a defendant physician is certified in one specialty but is sued for acting in a different capacity.

If one were to Google the phrase "bad facts make bad law," the first result should say, "See *Buck v. Henry*," A-0362-09, decided by the Appellate Division on March 25, 2010. Robert Buck had trouble sleeping and sought treatment from Dr. James Henry, who diagnosed mild depression and insomnia. Henry prescribed Zoloft for the former and Ambien for the latter. Buck took his Ambien and, as described by the appellate court, "began inspecting his .38 caliber Colt revolver, and fell asleep" in a chair. The telephone rang, and as the

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plaintiff reached for it with his left hand, he caused the gun, still in his right hand, to discharge into his mouth. The bullet fractured his skull and multiple facial bones, and destroyed his left eye. Buck sued Henry for negligently prescribing the Ambien.

Henry had identified himself pursuant to N.J.S.A. 45:9-22 as being certified in emergency medicine. Buck's attorney, in his efforts to comply with the Affidavit of Merit Statute, N.J.S.A. 2A:53A-27, served two affidavits: one from a psychiatrist who treats depression and insomnia and one from a physician who was board-certified in emergency medicine. However, Henry claimed that he specialized in family medicine, and moved to dismiss. Buck argued that affidavits from a doctor who actually treats the condition and from a doctor with the same board certification were sufficient. Alternatively, since Henry was not board-certified in family medicine, he was merely a general practitioner treating mild depression and insomnia, and the psychiatrist's affidavit was therefore sufficient, Buck argued.

The motion judge dismissed the case, holding that since neither of the affiants practiced or were board-certified in family medicine, their affidavits were inadequate. The Appellate Division affirmed, first observing that

N.J.S.A. 2A:53A-41(a) provides that if the defendant is a specialist recognized by the American Board of Medical Specialties or the American Osteopathic Association, and the care involved that specialty, the expert must have the same specialty.

Additionally, if the defendant is board-certified and the care involved that board specialty, the expert witness must be either credentialed by a hospital to the medical condition or to perform the procedure, or be board-certified in the same specialty. The appeals court then observed that the ABMS listed Family Medicine as a specialty, and accepted Henry's certification that he is a family medicine specialist. The court therefore concluded that Buck was obligated to serve an affidavit from a physician who specialized in family medicine.

The court explained: "Although Dr. Henry diagnosed plaintiff as suffering from depression and insomnia, two maladies with clear psychiatric overtones, Dr. Henry's conduct cannot be evaluated through the standard of care applicable to a psychiatrist. Only a board-certified family medicine physician" was qualified to submit an affidavit of merit. There was no discussion of whether the psychiatrist was qualified to render the affidavit because he was "credentialed by a hospital to treat patients for the medical condition" in issue.

The court also rejected the argument that Henry was a general practitioner subject to the provisions of N.J.S.A. 2A:53A-41(b), which provides that if the defendant is a "general practitioner," the expert must have devoted a major-

ity of his practice to the “active clinical practice as a general practitioner; or active clinical practice that encompasses the medical condition.” Thus, a plaintiff who secured an affidavit from both a physician who had an “active clinical practice that encompasses the medical condition” and one who shares the same board certification as the defendant was denied his day in court.

Although these bad facts no doubt motivated the result, the decision leaves the malpractice bar wondering what to do. For example, what does one do in a claim against a doctor who is board-certified in internal medicine but who claims to be a family practitioner and who negligently manages a pregnancy by failing to obtain an ultrasound? Must a careful lawyer now obtain three affidavits in order to be able to sleep at night?

The state Supreme Court granted Buck leave to appeal, 203 N. J. 432 (2010), and the case was argued to the Court on Jan. 19.

To add to the confusion, another unreported case, *Harbeson v. Underwood Memorial Hospital*, A-2215-08, decided June 24, 2009, reached an opposite conclusion. Clifford Harbeson was scheduled to have a surgery, and the surgeon ordered that an antibiotic be given prior to the surgery by the anesthesia staff. The antibiotic was not given until the surgery started, and the plaintiffs’ expert opined that it was administered too late. Harbeson suffered from a severe infection, leaving him disabled. He and his wife sued Dr. Gregg Saldutti, a board-certified anesthesiologist, Ben Wright, a certified nurse anesthetist, and others.

However, the plaintiffs served an affidavit of merit only from a physician board-certified in internal medicine and infectious diseases. The medical defendants argued that N.J.S.A. 2A:53A-41

required an affidavit from an anesthesiologist. The plaintiffs responded that the case was not about anesthesiology but rather about precautions to prevent infection. The motion judge dismissed the case as to these defendants, and the plaintiffs’ motion for leave to appeal was granted.

The Appellate Division first explained that N.J.S.A. 2A:53A-41(a) “created two classes of defendant health care providers: (1) specialists and subspecialists recognized by the ABMS or AOA; and (2) board-certified specialists and subspecialists recognized by the ABMS or AOA.” As to the first category, if the treatment involves the defendant’s speciality, the expert must be so specialized. As to the second category, if the defendant is board-certified and the care involves that specialty, the expert must also similarly board-certified.

However, the appellate court concluded that Saldutti failed to demonstrate that the presurgical administration of antibiotics is within the specialty of anesthesiology. Instead, the court accepted the plaintiffs’ contention that the duty to prevent infection is a general medical duty and therefore rejected Saldutti’s claim that he was entitled to an affidavit from a board-certified anesthesiologist.

The court concluded that Saldutti should be classified under N.J.S.A. 2A:53A-41(b), dealing with a “general practitioner,” despite the fact that Saldutti was a board-certified anesthesiologist, explaining: “[H]e was providing care and treatment that could have been provided by any physician or nurse, including general practitioners. Because the role he was fulfilling required no specialty expertise, the sufficiency of [plaintiffs’ experts’] credentials should be measured against the criteria applicable where the defendant health care provider is a gen-

eral practitioner.”

The court remanded for a determination whether the plaintiffs’ expert was qualified as to Saldutti, given the guidance provided. As to Wright, the court observed that the nurse’s certification in anesthesia is not recognized by either the ABMS or the AOA. The court deemed Wright a general practitioner under N.J.S.A. 2A:53A-41(b), and similarly remanded for a determination as to whether the plaintiffs’ expert was qualified.

So what is a malpractice attorney to do? No one actually knows anymore. These recent interpretations of the Affidavit of Merit Statute have spun far away from the Supreme Court’s early and oft-quoted statement that the purpose of the statute is “to require plaintiffs in malpractice cases to make a threshold showing that their claim is meritorious, in order that meritless lawsuits readily could be identified at an early stage of litigation.” See *In Re Hall*, 147 N.J. 379, 391 (1997), and *Cornblatt v. Barow*, 153 N.J. 218, 242 (1998). Clearly, this purpose is satisfied by service of an affidavit from someone who is trained to or actually treats the medical condition.

Yet, drawing a bright line for the requirements of the statute remains a frustrating pursuit, and a casual perusal of the unpublished opinions reveals that meritorious cases are still being dismissed because of affidavit-of-merit miseries. Imposing additional requirements, above and beyond the “threshold showing that their claim is meritorious,” demonstrates that courts have come to disregard another early and oft-quoted piece of advice from the Court: that the Affidavit of Merit Statute should be construed “to avoid the risk that even a few meritorious cases may be dismissed for noncompliance with the Statute.” *Hall*, at 392-393. ■