The Qualification of Experts in Medical Malpractice Cases after Nicholas v. Mynster

by Abbott Brown and Jonathan Lomurro

The affidavit of merit statute (AOM), at N.J.S.A. 2A:53A-27 et seq., was enacted in 1995, and requires the plaintiff in a malpractice case “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.”¹ This statement has been often quoted.² The AOM statute no doubt caused the reduction of filed medical malpractice complaints, from more than 2,500 in 1994 to 1,249 in 2008.³

The affidavit of merit statute initially defined the qualifications for the affiant in simple and practical terms. The statute required the person executing the affidavit shall:

[B]e licensed in this or any other state; [and] have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. ⁴

However, the Medical Care Access and Responsibility and Patients First Act, (PFA), at N.J.S.A. 2A:53A-38, et seq., which was enacted in 2004, created a new standard for qualification of expert witnesses in medical malpractice cases. If a medical malpractice defendant claims to be a specialist and that the treatment of the plaintiff involved the specialty, the expert must also claim to be a specialist in the same specialty as the defendant.

Critically, the reader should take note any doctor may claim to be an expert in any specialty. There is nothing that prevents a doctor certified in one specialty, such as emergency medicine, from opening an office and simply claiming to be a specialist in family medicine, as was the case in Buck v. Henry.⁵ The person claiming to be a specialist need not be board certified or even credentialed by a hospital to treat the condition or perform the procedure.⁶

Additionally, if the defendant is actually board certified, then the affiant or expert must not only be a specialist in the same field, but also must be board certified in the same specialty or sub-specialty, or credentialed by a hospital to perform the procedure or treat the condition. This is the only circumstance in which credentialing can substitute for board certification.

Although simple enough on its face, the PFA, and the interpretation of the statute by the Supreme Court in Nicholas v. Mynster,⁷ has caused much confusion and dismay in the medical malpractice bar for several reasons. First, as noted above, neither the PFA nor Nicholas establishes a standard for how one is determined to be ‘a specialist.’ Almost every defendant, board certified or not, now self-declares he or she is a specialist in something. This is critical because the PFA requirements only apply when the defendant is a specialist.

Second, neither the PFA nor Nicholas adequately addresses the common practice of doctors who treat conditions and perform procedures that are well outside their specialty. This is also important, as the PFA requirements only apply when the treatment ‘involves’ the physician’s specialty.

Third, by focusing on the claimed specialties, and not the condition being treated or the procedure being performed, the Nicholas decision has dramatically increased the number of experts required in malpractice cases.

Finally, the Nicholas decision appears to be a reversal of the longstanding policy of the Court, beginning with In re Hall, that the affidavit of merit statute should be construed “to avoid the risk that even a few meritorious cases may be dismissed for non-compliance with the Statute.”⁸

Although it appears the Supreme Court intended to clarify this area of law by reaching out to take a denial of a motion to dismiss by a trial court, this decision has already resulted in the unintended consequences of the dismissal of many meri-
torious claims, cross-claims and defenses. The problem was compounded by the fact that the Court did not make the Nicholas decision prospective, as was the case in every previous affidavit of merit or PFA case.

This article will review the development of the AOM and PFA statutes, and attempt to provide practice tips to make certain practitioners remain counsel for and not parties to malpractice litigation.

**Background**

The affidavit of merit statute requires the plaintiff in a malpractice action provide a preliminary expert opinion that the case has merit. Several aspects of this statute are worth noting.

In any action for damages for personal injuries, wrongful death or property damage resulting from an alleged act of malpractice or negligence by a licensed person in his profession or occupation, the plaintiff shall, within 60 days following the date of filing of the answer to the complaint by the defendant, provide each defendant with an affidavit of an appropriate licensed person that there exists a reasonable probability that the care, skill or knowledge exercised or exhibited in the treatment, practice or work that is the subject of the complaint, fell outside acceptable professional or occupational standards or treatment practices. The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit pursuant to this section, upon a finding of good cause.

Thus, the statute only applies to claims for: 1) personal injuries, wrongful death, or property damage resulting from 2) malpractice or negligence by a 3) licensed person in his 4) profession or occupation. Claims for injuries sustained as the result of a fall in a doctor’s office, or an assault, are not within the statute.

In 2004, the PFA added the following language:

In the case of an action for medical malpractice, the person executing the affidavit shall meet the requirements of a person who provides expert testimony or executes an affidavit as set forth in section 7 of P.L.2004, c.17 (C.2A:53A-41).

In all other cases, the person executing the affidavit shall be licensed in this or any other state; have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person’s practice substantially to the general area or specialty involved in the action for a period of at least five years. The person shall have no financial interest in the outcome of the case under review, but this prohibition shall not exclude the person from being an expert witness in the case.

The PFA amended the affidavit of merit statute to provide, in relevant part, that if a party offering or opposing the expert testimony:

1. Does the defendant claim to be a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association?

   As noted above, the defendant does not actually have to be board certified to claim to be a specialist. The Court’s interpretation of the PFA allows a doctor or expert to simply self-declare their specialty, hence the use of the word ‘claim.’ Since this will almost always be the case, the affiant or expert must also claim to be a specialist in the same specialty.

2. Does the defendant claim the treatment involved the defendant’s specialty?

   Assuming the defendant does claim to be a specialist, and also claims the treatment involves the specialty, then and only then must the expert be either:

3. Board certified in the same specialty or credentialed by a hospital to perform the procedure or treat the condition.

   Critically, practitioners should note that neither board certification nor being credentialed to treat the condition is a substitute for the expert claiming to be a specialist in the same specialty or subspecialty as the defendant.

   Practitioners should also note that since only physicians are recognized by the American Board of Medical Specialties or the American Osteo-
The PFA statute provides that a court may determine the 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. Therefore, the trial court dismissed the case with prejudice. The Appellate Division affirmed, but the Supreme Court reversed and remanded the case for a Ferrreira conference.

The Buck Court started the analysis by explaining that “The basic principle behind N.J.S.A. 2A:53A-41 is that ‘the challenging expert’ who executes an affidavit of merit in a medical malpractice case, generally, should ‘be equiva-

pathic Association, N.J.S.A. 2A:53A-41 only applies to physicians. Obviously, the statute could not be deemed to apply to:

1. medical practitioners other than physicians;
2. experts who are called to testify about proximate causation;
3. experts testifying about damages.

Theoretically, if the defendant is a ‘general practitioner,’ the expert witness must have spent the majority of his or her professional time in “active clinical practice as a general practitioner; or active clinical practice that encompasses the medical condition, or that includes performance of the procedure, that is the basis of the claim” or to teaching “in an accredited medical school, health professional school, or accredited residency or clinical research program in the same health care profession” as the defendant. However, since every doctor can now declare he or she is a specialist, this part of the statute has been rendered obsolete, except perhaps for interns and residents.

Practitioners may also want to note the PFA statute provides that a court “may waive the same specialty or subspecialty...requirements of this section, upon motion by the party seeking a waiver, if, after the moving party has demonstrated to the satisfaction of the court that a good faith effort has been made to identify an expert in the same specialty or subspecialty, the court determines the 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 list of recognized specialties can be found at the websites for the American Board of Medical Specialties (ABMS) for medical doctors (MD) and the American Osteopathic Association (AOA) for osteopaths (DO).

The many problems that arise with the PFA begin with the fact that the statute and cases have not recognized there is substantial overlap between the recognized medical specialties. For example, “hand surgery” is listed as a sub-specialty of the ABMS boards of orthopaedic surgery, plastic surgery, and surgery, and the AOA board of orthopedic surgery. Similarly, “sports medicine” is listed by 10 different boards as a sub-specialty (i.e., the American boards of emergency medicine, family medicine, internal medicine, orthopaedic surgery, pediatrics and the AOA boards of emergency medicine, internal medicine, neuromusculoskeletal medicine, pediatrics, and physical medicine and rehabilitation.) Indeed, there are four boards that list “Undersea and Hyperbaric Medicine” as a specialty.

This has major implications for the qualification of expert witnesses, because many specialties and subspecialties treat the same condition. For example, does the standard of care for treatment of chest pain differ between an internist and a family doctor? Does the standard of care for treatment of post-operative infection differ for an orthopedic surgeon, a neurosurgeon, or an internist sub-certified in infectious disease?

The Doctrine of Equivalent Qualifications

The qualification of an expert to testify against a doctor who is a specialist in another field of medicine was most recently considered in Buck v. Henry and Nicholas, supra. In Buck, the plaintiff sued a doctor who was board certified in emergency medicine but who was maintaining a family medicine practice. The defendant diagnosed the plaintiff as suffering from depression and insomnia, and prescribed an anti-depressant and a sleep aid. Several weeks after the defendant prescribed the medication, the plaintiff fell asleep while inspecting a hand gun. The plaintiff was awakened by a phone ringing. The plaintiff reached for the phone, but placed the gun in his mouth and it discharged, resulting in severe injuries.

The plaintiff alleged the defendant was negligent, and served an affidavit of merit signed by a psychiatrist. The defendant asserted the psychiatrist was not qualified to render the affidavit because the defendant was a family practitioner. The plaintiff then served a second affidavit of merit signed by a physician specializing in emergency medicine, because the website of the New Jersey Division of Consumer Affairs, njdoctorlist.com, indicated the defendant was board certified in emergency medicine. The defendant moved for summary judgment, contending he specialized in family medicine, that the care he provided to the plaintiff involved family medicine, and that the case should be dismissed because the plaintiff did not submit an affidavit of merit from a specialist in family medicine. The plaintiff replied that he served an affidavit from a psychiatrist who treated patients such as the plaintiff, and from a physician who was board certified in emergency medicine because the defendant was boarded in that specialty. The plaintiff also argued that a physician cannot be a ‘specialist’ without board certification.

The trial court found the defendant was a specialist in family medicine, and that the plaintiff was required to serve an affidavit from a specialist in family medicine. Therefore, the trial court dismissed the case with prejudice. The Appellate Division affirmed, but the Supreme Court reversed and remanded the case for a Ferrreira conference.

The Buck Court started the analysis by explaining that “The basic principle behind N.J.S.A. 2A:53A-41 is that ‘the challenging expert’ who executes an affidavit of merit in a medical malpractice case, generally, should ‘be equiva-
lently-qualified to the defendant’s physician.” The Court then observed that:

The statute sets forth three distinct categories embodying this kind-for-kind rule:

(1) those who are specialists in a field recognized by the American Board of Medical Specialties (ABMS) but who are not board certified in that specialty; (2) those who are specialists in a field recognized by the ABMS and who are board certified in that specialty; and (3) those who are ‘general practitioners.’ See N.J.S.A. 2A:53A-41(a), (b).16

The Court explained that pursuant to the plain language of N.J.S.A. 2A:53A-41a, if the defendant is “a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association and the care or treatment at issue involves that specialty or subspecialty,” the expert must be a specialist in the same specialty or subspecialty. Furthermore, if the defendant is board certified and the care or treatment at issue involves that board specialty or subspecialty, the expert witness must either be “credited or otherwise qualified to the defendant’s physician.” The Court then observed that:

Significantly, the Court added:

A physician may practice in more than one specialty, and the treatment involved may fall within that physician’s multiple specialty areas. In that case, an affidavit of merit from a physician specializing in either area will suffice.19

This comment suggested that experts in one specialty could testify in cases involving other specialties. However, the issue was revisited less than a year later by the Supreme Court in Nicholas.20 The plaintiff in Nicholas was brought to the hospital suffering from carbon monoxide poisoning. The plaintiff came under the care of the defendants, Dr. Mynster, who was board certified in emergency medicine, and Dr. Sehgal, who was board certified in the practice of family medicine. Dr. Sehgal was described as the “attending physician” and admitted the plaintiff to the intensive care unit of the hospital. However, there is nothing in the opinion to suggest Dr. Sehgal had ever treated the plaintiff before the events that gave rise to the case. Additionally, there is nothing in the record to suggest Dr. Sehgal was practicing ‘family medicine’ as opposed to ‘critical care medicine’ or working as a hospitalist.21

The defendants moved to bar the testimony of the plaintiff’s expert and for summary judgment, asserting the plaintiff’s expert could not establish the standard of care “because he did not practice in the same medical specialty as defendants.”22 The trial court denied the motion, concluding 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.”23 The Appellate Division denied the defendants’ motion for leave to appeal.

In an extraordinarily rare decision, the Supreme Court granted an interlocutory motion for leave to appeal a trial court decision, and reversed, holding that “N.J.S.A. 2A:53A-41 of the Patients First Act requires that plaintiffs’ medical expert must ‘have specialized at the time of the occurrence that is the basis for the [malpractice] action in the same specialty or subspecialty’ as defendant physicians.”24 Justice Barry Albin acknowledged:

In both Ryan v. Renny, 203 N.J. 37, 999
A.2d 427 (2010), and Buck v. Henry, 207 N.J. 377, 25 A.3d 240 (2011), we held 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.29

However, after quoting the statute, the Nicholas Court explained:

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, supra, 207 N.J. at 391. A medical expert must be a specialist in the same field in which the defendant physician specializes; there are no exceptions to that requirement other than the waiver provision of N.J.S.A. 2A:53A-41(c), which is inapplicable in this case.30

The Nicholas Court explicitly rejected the argument that a physician credentialed by a hospital to treat patients for the same medical condition “need neither practice in the same medical specialty nor be board certified in that specialty.”31

Emergency medicine, family medicine, internal medicine, and preventive medicine are all distinct specialty areas recognized by the American Board of Medical Specialties. No one disputes that physicians practicing in all four of these specialty areas may treat carbon monoxide poisoning. However, there is no statutory exception—other than the waiver provision of N.J.S.A. 2A:53A-41(c)—that permits a physician specializing in internal and preventive medicine to serve as an expert witness against a physician specializing in emergency or family medicine, even though each is qualified to treat a patient for carbon monoxide poisoning.32

The Court then concluded that, therefore, the “plaintiffs’ medical expert is barred from testifying to the standard of care governing defendants. Because plaintiffs cannot establish the applicable standard of care, summary judgment must be granted in favor of defendants.”33

This argument disregards the similarities between, for example, internal medicine and family medicine. The ABMS and AOA websites also define the scope of practice for each specialty. For example the ABMS member board the American Board of Family Medicine, defines family medicine as follows:

Family physicians deliver a range of acute, chronic and preventive medical care services. In addition to diagnosing and treating illness, they also provide preventive care, including routine checkups, health risk assessments, immunization and screening tests, and personalized counseling on maintaining a healthy lifestyle. Family physicians also manage chronic illness, often coordinating care provided by other subspecialists.34

For comparison, ABMS member board the American Board of Internal Medicine defines the internal medicine specialty as follows:

An internist is a personal physician who provides long-term, comprehensive care in the office and in the hospital, managing both common and complex illnesses of adolescents, adults and the elderly. Internists are trained in the diagnosis and treatment of cancer, infections and diseases affecting the heart, blood, kidneys, joints and the digestive, respiratory and vascular systems. They are also trained in the essentials of primary care internal medicine, which incorporates an understanding of disease prevention, wellness, substance abuse, mental health and effective treatment of common problems of the eyes, ears, skin, nervous system and reproductive organs.35

There is no distinction between these two closely related specialties in the context of the Nicholas case, and there was no discussion in the opinion of how it was determined that Dr. Sehgal was practicing ‘family medicine’ as opposed to ‘critical care medicine’ or working as a hospitalist.

Nevertheless, the Nicholas Court concluded that because the defendants rendered treatment within their specialties, and since the plaintiff’s expert was only board certified in internal medicine, pulmonary diseases, critical care, and undersea & hyperbaric medicine (with subspecialties in pulmonary diseases and critical care, and preventive medicine with a subspecialty in undersea and hyperbaric medicine) the expert could not be permitted to establish the standard of care for either emergency medicine or family medicine.36

Dr. Weaver unquestionably is an expert in the treatment of carbon monoxide poisoning and the use of hyperbaric oxygen as a treatment modality. But in addition to the expert-witness qualifications required by N.J.R.E. 702, the Legislature has imposed the requirements set forth in N.J.S.A. 2A:53A-41. Dr. Weaver and Drs. Mynster and Sehgal practice in different ABMS specialties. The statute does not permit Dr. Weaver to testify about the standard of care exercised by a physician practicing in a different specialty. That Dr. Weaver is credentialed by a hospital to treat carbon monoxide poisoning is a substitute for board certification in emergency and family medicine; it is not a substitute for specializing in those practice areas. Plaintiffs never presented an
expert in family medicine and never filed an affidavit of merit from a physician specializing in family medicine. Accordingly, at the summary-judgment stage, plaintiffs had no statutorily qualified expert who could render an opinion regarding the standard of care applicable to Drs. Mynster and Sehgal. … For these reasons, we reverse the trial court, enter summary judgment in favor of defendants, Drs. Mynster and Sehgal, and remand to the trial court for proceedings consistent with this opinion.37

Perhaps the result would have been different if the plaintiff’s expert, who as noted above was board certified in internal medicine, pulmonary diseases, critical care, and hyperbaric medicine, had simply declared that internal medicine encompassed family medicine, and that critical care encompassed emergency medicine, and thus self-declared he was also a specialist in both family medicine and emergency medicine, albeit not board certified in those specialties. In such a case, the fact that the plaintiff’s expert was credentialed by a hospital to treat the condition at issue would have permitted him to testify against the defendants. Indeed, the Nicholas Court explained:

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.38

Of course, the prudent malpractice lawyer will strive to avoid such artificial manipulations, and rely upon experts whose credentials match those of the defendants.

Constitutional Issues

The Patients First Act is contrary to long-settled law in New Jersey regarding the qualification of the expert witness. Additionally, it has been suggested that similar requirements relating to the affidavit of merit statute may be unconstitutional.39 This was an argument first advanced by the various bar associations that appeared as amicus in Cornblatt v. Barow,40 although the Cornblatt Court declined to decide the issue at that time.41 If anything, the changes to the affidavit of merit statute and the changes in the requirements for expert testimony trespass much deeper upon the exclusive obligation of the Supreme Court to make the rules governing the administration of the courts and the practice and procedure in all such courts.42

In Nicholas, the Supreme Court briefly addressed the constitutionality of the statute, and declined to address the issue:


109, 123 n.6 (App. Div. 1976)). We did not grant certification on the additional issues raised by NJAJ. We decline to address these issues because they were not argued by the parties or considered by the trial court and are therefore not properly before this Court.43

Conclusion

As stated in the introduction, the Nicholas decision has raised many serious concerns among the medical malpractice bar. First, it is unclear how one is determined to be a specialist. Virtually all doctors now claim they are specialists in something, and every defendant does so. Indeed, the determination of who is a specialist remains arbitrary. Is a doctor a specialist simply by declaring he or she is?

Second, it remains unclear how the statute will be applied to the common practice of doctors who treat conditions and perform procedures that traditionally were well outside of their specialty. Who provides the affidavit in a case involving an anesthesiologist who performs complex spinal fusions, or the family medicine doctor who is sub-certified in sports medicine and responds to serious fractures in the emergency room as the on-call orthopedist? Where does one locate an anesthesiologist who performs complex spinal fusions, or a family doctor who treats fractures to serve as an expert witness?

Indeed, in Nicholas, the defendant family medicine doctor was actually practicing as a critical care physician in the intensive care unit (ICU), or as a hospitalist. The Nicholas decision simply accepted the claim that the defendant was practicing family medicine without any critical analysis of the claim. In fact, it is difficult to comprehend how, pursuant to N.J.S.A. 2A:53A-41, it was determined the treatment of the plaintiff in the ICU by the defendant involves the physician’s specialty of family medicine. This is, of course, critical to the analysis
because the equivalency requirements only apply “when the treatment ‘involves’ the physician’s specialty.”

Additionally, the *Buck* and *Nicholas* decisions have eliminated the portion of N.J.S.A. 2A:53A-41 that refers to general practitioners. The authors of this article have never had a defendant designate in the answer that he or she was a general practitioner. This is because every defendant, board certified or not, now self-declares that he or she is a specialist. This was obviously not the intent of the Legislature.

Third, by focusing on the specialty, and not the condition being treated or the procedure being performed, the *Nicholas* decision has dramatically increased the number of experts required in malpractice cases. As a proximate result of this decision, the cost to all parties for what is already an extraordinarily expensive type of personal injury litigation has increased. It is common to have doctors from two or more disparate specialties treat the same condition. In such cases, the parties must now engage multiple experts. This has already shut the door to the courthouse for many victims of medical errors.

Finally, the *Nicholas* decision appears to be a reversal of the longstanding policy of the Court, beginning with *In re Hall*, that the affidavit of merit statute should be construed “to avoid the risk that even a few meritorious cases may be dismissed for non-compliance with the Statute.” The *Nicholas* Court also did not recall its statement in *Ferreira*, that “there is no legislative interest in barring meritorious claims brought in good faith.” As recently as *Buck*, the Supreme Court reiterated that the “Legislature did not intend ‘to create a minefield of hyper-technicalities in order to doom innocent litigants possessing meritorious claims.’” *Nicholas* can be viewed as an implicit reversal of *Buck*, where the Court remanded to determine the “adequacy of plaintiff’s affidavits of merit,” in a case where psychiatry and emergency medicine experts had rendered the affidavits of merit in a case against a self-declared specialist in family medicine.

Although it appears the Supreme Court intended to clarify this area of law by reaching out to take a denial of a motion to dismiss by a trial court, this decision has already resulted in the unintended consequences of the dismissal of meritorious claims and defenses. The problem was compounded by the fact that the Court did not make the *Nicholas* decision prospective, as was the case in every previous affidavit of merit case. While the intent of these statutes was to promptly rid the system of frivolous suits and lower costs, the authors believe the present interpretation has had the opposite impact and the litigation over the affidavit of merit and the qualifications of experts has taken on a life of its own. The authors believe, unless the statute is declared unconstitutional, amended, or reinterpreted, an enormous amount of time and resources will continue to be wasted on the process, instead of determining the merits of cases.

### Endnotes

6. “Credentialing” is defined by The Joint Commission as “[t]he process of granting authorization by the governing body to provide specific patient care and treatment services in the hospital.” The Joint Commission, Accreditation Manual for Hospitals 222 (1993).

11. *Id.*
12. The list of recognized specialties can be found at the websites for the American Board of Medical Specialties for medical doctors (MD) and the American Osteopathic Association for osteopaths (DO). See, e.g., abms.org and osteopathic.org. The websites also define the scope of practice for each specialty.
14. *Id.* at 383-389.
15. *Id.* at 383, 387-89.
16. *Id.* at 389.
17. *Id.*
18. *Id.* at 391.
19. *Id.*
21. The aforementioned websites also define the scope of each specialty.
22. *Nicholas*. *Id.* at 213 N.J. 471.
23. *Id.* at 473.
24. *Id.*
25. *Id.*
26. *Id.* at 468-474.
27. *Id.*
28. *Id.*
29. *Id.* at 467.
31. *Id.* at 468.
32. *Id.* at 484.
33. *Id.*
34. American Board of Medical Specialties, certificationmatters.org/abmsmember-boards/family-medicine.aspx.
35. American Board of Medical Specialties, certificationmatters.org/abms member-boards/internal-medicine.aspx.
36. Nicholas, Id. at 487-488.
37. Id.
38. Id. at 483.
41. Id. at 248.
42. See N.J. Const. art. VI, § 2, ¶3.
44. Buck, Id. at 389.
45. In re Hall, Id. at 392-93.
47. Buck, Id. at 393-94 (2011) (quoting Ryan v. Renny, 203 N.J. 37 (2010)).

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