[Cite as *Johnson v. Abdullah*, 2019-Ohio-4861.]

IN THE COURT OF APPEALS
FIRST APPELLATE DISTRICT OF OHIO
HAMILTON COUNTY, OHIO

MARK JOHNSON, Individually, and as Guardian of David Johnson, an incompetent,	:	APPEAL NO. C-180309 TRIAL NO. A-1501878
	:	*O P I N I O N.*
	:	
GLENDA JOHNSON,	:	
and	:	
GARY JOHNSON,	:	
Plaintiffs-Appellants,	:	
vs.	:	
ANTHONY ABDULLAH, M.D.,	:	
Defendant-Appellee.	:	

Civil Appeal From: Hamilton County Court of Common Pleas

Judgment Appealed From Is: Reversed and Cause Remanded

Date of Judgment Entry on Appeal: November 27, 2019

Brannon & Associates, Dwight D. Brannon, Kevin A. Bowman and *Matthew C. Schultz*, for Plaintiffs-Appellants,

Arnold Todaro Welch & Foliano Co., LPA, Gregory B. Foliano and *John B. Welch*, for Defendant-Appellant.

BERGERON, Judge.

{¶1} Evid.R. 601(D) stems from a salutary purpose—preventing "hired gun" professional witnesses who do not actually treat patients from pontificating on how treating doctors should have performed their jobs in medical malpractice cases. But the square peg of this purpose does not always fit in the round hole of the language the rule employs. As a result, since its inception, Ohio courts have sometimes struggled trying to imbue the rule with sensible meaning. This case-by-case analysis has generated some confusion, and we endeavor to clarify today the standard required for an expert to engage in the "active clinical practice" of medicine.

{¶2} We hold that an accomplished doctor should not have testified at trial because he did not engage in the "active clinical practice" of medicine as the rule commands. As chief operating officer ("COO") of a hospital system, his job was almost entirely administrative, and while he insisted that everything he did impacted patient care in some fashion, that is a bridge too far for us to cross. By that logic, a nonphysician COO would also be engaged in the active clinical practice of medicine. We decline to equate administrative work far removed from patient care with "active clinical practice," regardless of how noble the work or how qualified the doctor.

{¶3} Because the rule's plain language should have prevented this doctor from testifying, we reverse the judgment entered by the trial court and remand for a new trial.

I.

{¶4} In September of 2011, David Johnson underwent an invasive surgery, the procedure requiring his surgeon, Dr. Farooq Mirza, to remove a section of his diseased colon and then sew the ends back together (i.e., anastomosis). Despite Mr. Johnson's deteriorating condition during his recovery, he was discharged from The Christ Hospital on

the afternoon of October 1, just a few days after his surgery. Within hours of his discharge, Mr. Johnson returned to the hospital with complaints of shortness of breath, this time seeing defendant-appellee Dr. Anthony Abdullah in the emergency room. In an attempt to identify the problem, Dr. Abdullah, between the hours of 9:45 p.m. and 2:50 a.m., ordered and performed a battery of tests. Unfortunately, during one of these tests, Mr. Johnson suffered a cardiac arrest, which necessitated resuscitation before a pulse returned. As a result of the cardiac arrest, Mr. Johnson suffered an anoxic brain injury, requiring him to live in the care of a long-term nursing facility where he remains in a vegetative state.

{¶5} In the aftermath of Mr. Johnson's tragedy, his brother and appointed guardian (and one of the named plaintiffs-appellants here[1]) commenced a medical malpractice claim against numerous defendants, including The Christ Hospital, Dr. Mirza, Dr. Daugherty (Mr. Johnson's primary care physician), and Dr. Abdullah. As to Dr. Mirza and Dr. Daugherty, Mr. Johnson specifically alleged the doctors were negligent during Mr. Johnson's first hospitalization, including prematurely discharging him when he suffered from an anastomotic leak (a common risk associated with his surgery). With respect to Dr. Abdullah, Mr. Johnson accused him of negligence in his care and treatment during Mr. Johnson's stay in the emergency department. Prior to trial, Dr. Mirza, Dr. Daugherty, and The Christ Hospital all settled with Mr. Johnson, leaving Dr. Abdullah the lone defendant during the three-week trial.

{¶6} At trial, Mr. Johnson's negligence claim against Dr. Abdullah focused on a narrow issue: whether the standard of care required Dr. Abdullah to recognize his deteriorating respiratory status and thus intubate him in the emergency department prior to his cardiac arrest. Predictably, this devolved into a battle of the experts. To support his

[1] For simplicity's sake, we use "Mr. Johnson" to refer to David as well as his brother, Mark, and the other two named plaintiffs, unless context necessitates a distinction.

case, Mr. Johnson presented expert testimony that, based on his symptoms and signs (i.e., belabored breathing, audible wheezing, and portable x-ray picture of his "abnormal" lung), the standard of care required Dr. Abdullah to intubate Mr. Johnson earlier, instead of after his cardiac arrest. Such measures, according to Mr. Johnson's expert, would have protected his airways and prevented him from entering into arrest, thereby avoiding the anoxic brain injury that precipitated his vegetative state.

{¶7} To rebut this evidence, Dr. Abdullah provided his own expert testimony, the centerpiece of which involved Dr. Ron Walls, the COO of Brigham Health (a hospital system affiliated with Harvard) and a professor of emergency medicine at Harvard Medical School, regarding why the standard of care did not require intubation. Dr. Walls emphasized the dangers of intubation and indications of when to do it—none of which, he believed, manifested themselves in this case. Coupled with his opinion, the jury also heard a litany of Dr. Walls's impressive accomplishments and experiences, including performing over 1,000 intubations himself, creating a course on intubations and airway management and training between 8,000 and 10,000 physicians through this course, collecting numerous honors from emergency medicine societies, authoring myriad peer reviewed publications and chapters in textbooks on intubation, and currently editing the most recent edition of *Rosen's Emergency Medicine, Concepts and Clinical Practice* (himself authoring the chapter on airway management)—to name just a few. Although Dr. Walls's renowned credentials would seem to make him an ideal witness on this point, Mr. Johnson objected to his testimony, maintaining that Dr. Walls failed to satisfy the requirements of Evid.R. 601(D) because he was not involved in the active clinical practice of medicine. Faced with this objection, the trial court conducted a short voir dire at trial, ultimately deeming Dr. Walls competent to testify.

{¶8} Given our disposition of this appeal, and in the interests of brevity, we will not dwell on the other details of the trial germane to other assignments of error that we find moot. Suffice it to say, after hearing all the evidence at trial, the jury returned a unanimous defense verdict, finding Dr. Abdullah not negligent.

{¶9} Mr. Johnson now appeals, asserting six assignments of error. He challenges the trial court's decision to admit expert testimony, the weight of the evidence of the verdict in favor of Dr. Abdullah, the jury instructions provided, the trial court's failure to exclude testimony concerning the settling defendants, defense counsel's misuse of the learned treatise exception to hearsay, and the trial court's decision to allow Dr. Abdullah to present his case against the settling nonparties without requiring the jury to apportion fault.

II.

{¶10} In Mr. Johnson's first assignment of error, he raises two separate issues regarding expert testimony offered at trial. We turn first to his assertion that the trial court erred in admitting Dr. Walls's expert testimony at trial because, at the time of trial, Dr. Walls did not devote at least one-half of his professional time to the active clinical practice of medicine, rendering him incompetent to testify under Evid.R. 601(D). Because a trial court enjoys discretion in evaluating a witness's competency to testify as an expert, we will not reverse a trial court's decision absent a showing that the court abused its discretion. *See Celmer v. Rodgers*, 114 Ohio St.3d 221, 2007-Ohio-3697, 871 N.E.2d 557, ¶ 19.

A.

{¶11} When providing expert testimony regarding liability in a medical malpractice action, Evid.R. 601(D) requires:

> (1) The person testifying is licensed to practice medicine and surgery * * * by the state medical board or by the licensing authority of any state; (2) [t]he

> person devotes at least one-half of his or her professional time to the active clinical practice in his or her field of licensure, or to its instruction in an accredited school and (3) [t]he person practices in the same or a substantially similar specialty as the defendant.

Because the only issue as to Dr. Walls's competency concerns whether he devoted at least one-half of his professional time to the active clinical practice of medicine, we concentrate our analysis on this aspect of the rule, attempting to crystalize the standard for "active clinical practice" along the way.

{¶12} Notably, Evid.R. 601(D) fails to define "active clinical practice," leaving courts to struggle with this somewhat elusive requirement when evaluating the competency of medical experts. Several decades ago, in offering guidance, the Ohio Supreme Court in *McCrory v. State*, 67 Ohio St.2d 99, 423 N.E.2d 156 (1981), encouraged courts to interpret "active clinical practice" broadly in light of the purpose behind Evid.R. 601(D): "to preclude testimony by the physician who earns his living or spends much of his time testifying against his fellows as a professional witness[.]" *McCrory* at 103; *see Celmer* at ¶ 23 ("[T]o prohibit a physician who makes his living as a professional witness from testifying on the liability of physicians who devote their professional time to the treatment of patients.").

{¶13} With this purpose in mind, the court in *McCrory* interpreted "active clinical practice" to include not only the physician who directly treats patients, but also a physician whose work is "so related or adjunctive to patient care as to be necessarily included in" the active clinical practice definition. *McCrory* at 104. Wary about excluding from the rule's reach medical experts who "work daily in and for our hospitals often assisting, directing, or advising the attending physician in his care of the sick," the Supreme Court invited more flexibility. *Id*. at 103. The rule must therefore encompass physicians whose "ministrations

form inseparable parts of [a] patient's care," for they too are "directly involved in the care of the patient and are usually aware of the progress of the treatment of [the patient's] health problems and of that treatment's ultimate result." *Id*. Applying this newfound standard, the court in *McCrory* held that a physician's work, as a director of clinical research at a pharmaceutical company where he performed (and supervised other physicians') medical research concerning new drugs and detailed the drugs' usage and dosage to other physicians, was so adjunctive to patient care that he engaged in the active clinical practice of medicine. *Id*. at 104-105.

{¶14} Building on *McCrory*, Ohio courts have recognized that "active clinical practice" at its essence requires courts to evaluate "how closely the purported expert's work is related to patient care." *Aldridge v. Garner*, 159 Ohio App.3d 688, 2005-Ohio-829, 825 N.E.2d 201, ¶ 12 (4th Dist), quoting *Nicholson v. Landis*, 4th Dist. Athens No. 1404, 1990 WL 34276, *9 (Feb. 27, 1990). In doing so, courts must find, at the very least, the expert's professional work be "the type that forms an essential link in the chain of services and activities which comprise the comprehensive treatment of patients." *Goldstein v. Kean*, 10 Ohio App.3d 255, 257, 461 N.E.2d 1350 (10th Dist.1983). In other words, the expert's work cannot simply encompass patient care from an abstract level but must include activities, so entwined with patient care, that the physician is essentially involved or engaged in treating patients him or herself (even if not standing by the patient's bedside). Courts appropriately insist that an expert's work entail more than a mere relation to the healthcare industry (because virtually every doctor could check that box). *See Goldstein* at 257 (finding that a physician who spends 75 percent of his professional time evaluating workers' compensation claims but who does not personally examine, treat, or diagnose patients failed to meet the active clinical practice requirement); *Aldridge* at ¶ 15 (devoting 80 percent of his

professional time at insurance companies reviewing casework, talking to doctors, and consulting with medical insureds concerning claims was not "so adjunctive to patient care as to render his current practice within the realm of 'active clinical practice' as intended by the rule.").

{¶15} Divining where on this continuum a particular doctor's practice sits necessarily constitutes a fact-specific inquiry, which has yielded some inconsistent results in the caselaw. For instance, while performing medical research or working in an administrative position generally, on its own, may not closely relate to patient care, if interrelated with other activities—consulting with or evaluating patients, reviewing patient records, or supervising other physicians—then the expert's work may suffice to satisfy active clinical practice. *See Witzmann v. Adam*, 2d Dist. Montgomery No. 23352, 2011-Ohio-379, ¶ 26 (finding because his administrative role as Executive Medical Director for Johns Hopkins International included seeing patients, performing weekly surgeries, and publishing numerous medical articles, his activities met the active clinical practice requirement); *Siuda v. Howard*, 1st Dist. Hamilton Nos. C-000656 and C-000687, 2002 WL 946188, *9 (May 10, 2002) (holding that because the expert's position, as the medical director for the Cincinnati Eye Institute, included consulting with patients, reviewing patient records, and researching and publishing pieces relating to ophthalmology he satisfied "active clinical practice"); *Williams v. Reynolds Road Surgical Ctr., LTD*, 6th Dist. Lucas No. L-02-1144, 2004 WL 628972, *5 (Mar. 31, 2004) ("[C]onsulting activities deal directly with patient care and satisfy 'the active clinical practice' definition as set forth in *McCrory*."); *but see Hunt v. Crossroads Psych. & Psychological Ctr.*, 8th Dist. Cuyahoga No. 79120, 2001 WL 1558574, *6-7 (Dec. 6, 2001) ("[Expert] does not meet the fifty percent rule for the active practice or teaching of medicine since the majority of his time is spent as

an administrator and he sees only a few patients, if any."); *Nicholson* at *9 (holding the medical expert who, as assistant dean and professor of surgery, interviewed prospective residents, but no longer made rounds with residents, and only taught a couple of two-hour lectures every 12 weeks did not satisfy active clinical practice); *Cunningham v. St. Alexis Hosp. Med. Ctr.*, 143 Ohio App.3d 353, 368, 758 N.E.2d 188 (8th Dist.2001) (spending "seventy-five percent of his time doing research, with the balance spent in patient care" did not satisfy the active clinical care requirement.).

{¶16} Other states with similar statutes or rules have likewise struggled to define "active clinical practice," and the results help shed some light on the term, but they also do not proceed in a straight path. *See Moore v. Proper*, 366 N.C. 25, 33, 726 S.E.2d 812 (2012) ("*[C]linical* means 'actual experience in the observation and treatment of patients'—not activities simply relating to the health profession, such as administration or continuing education.") (Emphasis sic.); *Id.* at 40 (Newby, J., concurring in part and concurring in the result) ("[A]n individual who observes or diagnoses patients but who does not regularly perform the various treatments done by other members of that health profession likely would not qualify as an expert under this rule."); *Hinkley v. Koehler*, 269 Va. 82, 90, 606 S.E.2d 803 (2005) (finding doctor not engaged in "active clinical practice" when he "did not evaluate, manage, or treat problems in pregnancies in the context of direct patient care[.]"); *Gay v. Select Specialty Hosp.*, 295 Mich.App. 284, 813 N.W.2d 354 (2012), fn.2 ("[A] nurse who supervises other nurses in a hospital *is* practicing nursing in a clinical setting even though he or she does not directly treat specific patients."); *Id.* at 306 (Whitebeck, J., dissenting) ("[W]orking in a clinical setting merely overseeing employees who actually treat the patients is too removed from the type of experience contemplated by the statutory requirement.").

{¶17} Distilling all of this, a doctor does not have to sit by a patient's bedside to engage in the "active clinical practice" of medicine, but she must be sufficiently engaged in the practice to have some role in patient treatment,[2] even if that role is supervisory. But at some point, the doctor gets so far removed from actual patient care that to qualify the physician as an expert would be to write that restriction out of the rule. Needless to say, the line between the two is not always clear, and must be evaluated on a case-by-case basis, but the words of the Supreme Court in *McCrory* continue to ring true in terms of guiding us where to draw the line in that inquiry—"assisting, directing, or advising the attending physician in his care of the sick." With this backdrop in mind, we turn to the case at hand, evaluating whether Dr. Walls, as COO of Brigham Health, devoted at least one-half of his time to the active clinical practice of medicine at the time he testified. This involves an analysis of how "administrative" work should be treated for purposes of attempting to satisfy the active clinical practice requirement.

B.

{¶18} The problem in this case is that Dr. Walls is not a "hired gun" professional witness—he occasionally does testify as an expert, but this represents a small fraction of his practice. He is also, as we have noted above, eminently qualified in his field. If we thus confined our view to the purpose of Evid.R. 601(D), Dr. Walls would seem to pass the test. But this is where the purpose collides with the language. Even though it would be consistent with the purpose of the rule to allow Dr. Walls to testify, we cannot disregard the requirements embodied in its language. As we describe below, the "administrative" work performed by Dr. Walls does not satisfy the "active clinical practice" requirement.

[2] The rule also permits academic instruction to qualify, but Dr. Walls does not engage in sufficient teaching endeavors to satisfy this aspect of the rule.

{¶19} As Mr. Johnson properly notes, generally, administrative or executive work falls outside of the purview of active clinical practice. *See Hunt*, 8th Dist. Cuyahoga No. 79120, 2001 WL 1558574, at *6-7 (finding that the medical expert's position as chair of the department of psychiatry, which included overseeing the educational effort for medical students, recruiting and maintaining faculty, and performing research, did not meet the active clinical practice requirement); *Nicholson*, 4th Dist. Athens No. 1404, 1990 WL 34276, at *9 (holding the medical expert did not devote the required time to active clinical practice as the assistant dean or as a professor of surgery, since he spent much of his time interviewing prospective residents, no longer making rounds with residents, and only teaching a couple of two-hour lectures every 12 weeks).

{¶20} However, as touched on above, administrative work may satisfy the active clinical practice requirement when coupled with activities closely intertwined with patient care—engaging in patient visits, supervising other physicians' treatment, or reviewing patient records. *See Witzmann*, 2d Dist. Montgomery No. 23352, 2011-Ohio-379, at ¶ 26 (finding the medical expert who, as the Executive Medical Director for Johns Hopkins International, routinely saw patients and performed weekly surgeries satisfied active clinical practice); *Siuda*, 1st Dist. Hamilton Nos. C-000656 and C-000687, 2002 WL 946188, at *9 (finding the expert satisfied the active clinical practice requirement as medical director for the Cincinnati Eye Institute because his professional activities included consulting with patients, reviewing patient records, and researching and publishing pieces relating to ophthalmology); *Williams*, 6th Dist. Lucas No. L-02-1144, 2004 WL 628972, at *5 (holding that despite devoting much of his time to developing programs, the medical expert fulfilled the active clinical practice requirement because he consulted with other doctors and supervised operations). In other words, saying that one is engaged in "administrative" work

is not much more illuminating than the phrase "active clinical practice"—but that means that the proponent of the witness bears the burden of demonstrating that this doctor's "administrative" work was really patient-centric in nature.

{¶21} In this case, holding the same position at the time of his deposition as he did at trial, Dr. Walls admitted during his deposition that, as the COO of Brigham Health, he no longer sees patients and "probably 90 percent of [his] work would be characterized as purely executive or administrative." Needless to say, that answer seems to be all but fatal in terms of qualifying him under Evid.R. 601(D). By the time of trial, therefore, he sought to portray his experience in a slightly different light (perhaps anticipating the standard we just articulated). When asked to elaborate upon his responsibilities during voir dire, Dr. Walls explained his duties as including developing the teaching and training programs for the residents and students in medicine, mentoring and guiding department chairs and clinical nurse leaders, and overseeing the quality, safety, and clinical operations related to patient care (i.e., operating rooms, inpatient units, the emergency department, and post-operative recovery areas). After hearing his responsibilities (and in an attempt to speed up the process), the court asked Dr. Walls point blank whether he devoted at least one-half of his professional time to the active clinical practice of medicine, to which Dr. Walls responded "everything that happens related to patient care in our hospital is my direct responsibility." Satisfied with this response, the court found Dr. Walls competent to testify.

{¶22} While we have no doubt that Dr. Walls's work as a COO has an impact on all facets of patient care at Brigham Health, based on the work activities that he described, we cannot help but view his COO duties as too attenuated from patient care to satisfy Evid.R. 601(D). As COO of Brigham Health, Dr. Walls essentially runs the whole hospital system, acknowledging himself that much of his responsibilities involve evaluating the needs of

departments, calculating the number of clinicians essential for the hospital, and assessing any new technology or expertise required. Under the standard set forth by Evid.R. 601(D), it is not enough for Dr. Walls's work to simply relate to the healthcare industry, but must include other activities that are so intertwined with patient care that Dr. Walls is, to paraphrase *McCrory*, assisting, directing, or advising the attending physician. The record before us fails to substantiate that point; to the contrary, it suggests a doctor who sits several levels removed from the doctors on the ground providing direct patient care.

{¶23} In fact, much of Dr. Walls's activities strike us as quintessentially administrative (i.e., nonclinical). Similar to the medical expert's duties the Eighth District deemed administrative in *Hunt*, Dr. Walls's responsibilities involve developing education programs for residents and students and engaging with faculty through mentorship and oversight of departments. *Hunt*, 8th Dist. Cuyahoga No. 79120, 2001 WL 1558574, at *6-7. And while Dr. Walls serves as a professor of Emergency Medicine at Harvard Medical School, like the medical expert in *Nicholson*, he only spends a de minimis amount of time actually teaching (about six hours a year) and no longer makes rounds with residents (only making rounds once a week for about an hour with clinical nurses). *Nicholson*, 4th Dist. Athens No. 1404, 1990 WL 34276, at *9. Moreover, unlike the medical experts in *Witzmann*, *Siuda*, and *Williams*, Dr. Walls's position as COO of Brigham does not include time consulting with patients, reviewing patient records, supervising other physicians' direct treatment, or treating patients himself. *See Witzmann*, 2d Dist. Montgomery No. 23352, 2011-Ohio-379, at ¶ 26; *Siuda*, 1st Dist. Hamilton Nos. C-000656 and C-000687, 2002 WL 946188, at *9; *Williams*, 6th Dist. Lucas No. L-02-1144, 2004 WL 628972, at *5. Stated differently, Dr. Walls's testimony fails to illuminate any activities closely related to patient care (i.e., observing patients, performing rounds with residents, reviewing patient

records) that form a link from his more managerial/administrative COO pursuits to the direct patient care performed at the hospital.

{¶24} Accordingly, while we are mindful that "active clinical practice" does not require direct treatment of patients, based on the analysis above, we cannot say that Dr. Walls's work is so "adjunctive to patient care" as to fall within the definition of active clinical practice. We understand the frustration that the defense must surely feel at the exclusion of a witness who, on paper, seems ideally situated to testify in this case. But no manner of "broad" construction of "active clinical practice" can justify allowing Dr. Walls's testimony lest we write that clause out of the rule. Unwilling to do that, we conclude that Dr. Walls was not competent to testify under Evid.R. 601(D), since he did not devote at least one-half of his professional time to the active clinical practice of medicine at the time he testified.

C.

{¶25} Perhaps anticipating this result, as a fallback, Dr. Abdullah urges us not to evaluate Dr. Walls's competency at the time of trial, but instead at the time the cause of action accrued, pointing to *Celmer* and other Ohio caselaw for support. In *Celmer*, after reiterating the purposes behind Evid.R. 601(D) discussed in *McCrory*, the Ohio Supreme Court considered a different aspect of the "active clinical practice" analysis—the timing. Emphasizing the rule's use of present tense, the court pronounced that, in general, "an expert witness in a medical malpractice action must meet the requirements of Evid.R. 601(D) at the time the testimony is offered at trial." *Celmer*, 114 Ohio St.3d 221, 2007-Ohio-3697, 871 N.E.2d 557, at ¶ 25, 27. However, the court carved out an exception to this general rule—when the other party requests multiple trial continuances, causing the expert who initially met the active clinical practice standard to no longer satisfy it. *Id*. at ¶ 27 ("[W]here trial continuances requested by the defense and the insolvency of a defendant's

carrier delay trial for such time as the plaintiff's medical expert no longer devotes one-half of his professional time to the active clinical practice of medicine, and where the medical expert is not a professional witness, a trial court has discretion to permit that witness to testify as an expert at trial.").

{¶26} In applying this limited exception, the court held that, despite the plaintiff's medical expert no longer devoting at least one-half of his professional time to active clinical practice at the time of trial, he could testify because he met the requirements of Evid.R. 601(D) at the time the cause of action accrued, at the time of filing suit, and during the first three years of litigation. *Id.* at ¶ 26. In justifying its decision, the court emphasized the trial continuances requested by the defense, noting that if the trial had commenced when originally scheduled, the competency issue would never have arisen, and thus the expert's "hiatus from the practice of medicine should not render him incompetent to testify[.]" *Id*. In other words, the court exhibited concern about strategic delay that would embolden intentionally foot-dragging by parties who thought they might be able to disqualify experts by running out the clock. But at the same time, concerned about throwing open the door to routine retroactive assessments of an expert's qualifications, the court went out of its way to emphasize the narrowness (and fact-dependent nature) of its holding. *See id.* at ¶ 27 ("But the facts here are an exception to that general rule.").

{¶27} We recognize that some Ohio appellate courts choose to read *Celmer* and Evid.R. 601(D) broadly, which risks allowing the exception to swallow the general rule that the expert devote one-half of his professional time to active clinical practice at the time of testifying. *See O'Malley v. Forum Health*, 11th Dist. Trumbull No. 2012-T-0090, 2013-Ohio-2621, ¶ 36 (finding the medical expert satisfied the active clinical practice requirement despite his retirement from the practice of medicine prior to trial, because of his length of

practice, extensive experiential background, and the fact that he was engaged in active clinical practice at the time the cause of action accrued); *Aldridge*, 159 Ohio App.3d 688, 2005-Ohio-829, 825 N.E.2d 201, at ¶ 18 (holding that despite the medical expert's failure to satisfy "active clinical practice" at the time of trial, based upon the expert's length of practice and his engagement in the active clinical practice of medicine during the time of the defendant's alleged malpractice, the expert "satisfie[d] the purpose intended by the active-clinical-practice rule."); *Crosswhite v. Desai*, 64 Ohio App.3d 170, 179, 580 N.E.2d 1119 (2d Dist.1989) (finding that despite the physician's retirement from practicing medicine at the time of his testimony, he satisfied the active clinical practice requirement—citing *McCrory* for support). However, we take the Supreme Court at its word, and its fact-dependent emphasis on the nature of the exception convinces us that the court did not endorse allowing an expert to testify just because at some point in his career he engaged in the active clinical practice of medicine. *Celmer* at ¶ 27; *see Berlin v. Thompson*, 5th Dist. Stark No. 2007CA00115, 2007-Ohio-5700, ¶ 18, 20 (declining to extend *Celmer* to appellant's case since the "[a]ppellant does not assert delay caused by appellees."). The policy reasons giving rise to *Celmer* are self-evident, and the case limited itself to that context.

{¶28} Because Dr. Abdullah fails to present any such justification here, we decline to extend *Celmer*'s limited exception to his case. And even if we were inclined to go down that path, we are not convinced Dr. Walls satisfied Evid.R. 601(D) at the time the cause of action accrued. In October 2011, when Dr. Abdullah treated Mr. Johnson, Dr. Walls served as chair of the Department of Emergency Medicine at Brigham and Women's Hospital and professor of medicine at Harvard Medical School. During his deposition, when asked to apportion time in this role between his administrative functions and his teaching and clinical care roles, he equivocated: "probably 50-50 roughly, between the administrative

components of my job and the teaching and clinical care parts, maybe a little more on the teaching/clinical care than 50-50." The defense bears the burden in establishing the competency of its witness, and we need more than this to evaluate whether Dr. Walls devoted more than one-half of his professional time to active clinical practice at the time the cause accrued (particularly in light of his voir dire testimony that evinced an overly broad conceptualization of "active clinical practice"). It remains incumbent upon the proponent of an expert to establish in the record sufficient evidence from which the court can draw a conclusion as to whether the "active clinical practice" standard was satisfied.

{¶29} In light of our analysis above, the trial court did not properly apply the "active clinical practice" standard and abused its discretion in allowing Dr. Walls's testimony on this record.

D.

{¶30} With error established, we must next ask whether we can dismiss the improper evidentiary ruling here as harmless. *See* Civ.R. 61. ("The court at every stage of the proceeding must disregard any error or defect in the proceeding which does not affect the substantial rights of the parties."); *Beard v. Meridia Huron Hosp.*, 106 Ohio St.3d 237, 2005-Ohio-4787, 834 N.E.2d 323, ¶ 35 ("An improper evidentiary ruling constitutes reversible error only when the error affects the substantial rights of the adverse party or the ruling is inconsistent with substantial justice.") Evaluating whether the error affected Mr. Johnson's substantial rights requires us to "not only weigh the prejudicial effect of th[e] error[] but also determine that, if th[e] error[] had not occurred, the jury * * * would probably have made the same decision." *Beard*, quoting *Hallworth v. Republic Steel Corp.*, 153 Ohio St. 349, 91 N.E.2d 690 (1950), paragraph three of the syllabus.

{¶31} Dr. Abdullah does not seriously argue harmless error, and for good reason. Dr. Walls formed the centerpiece of the defense case (on the issue the jury had to decide), he was imminently qualified, and his testimony consumed an entire day. *See Guarino-Wong v. Hosler*, 1st Dist. Hamilton No. C-120453, 2013-Ohio-1625, ¶ 19 (finding that "[g]iven the nature of this testimony, we cannot say that it did not affect [the plaintiff's] substantial rights or the outcome of the trial," when the trial court improperly admitted a doctor's report that largely supported the defendant's expert). The countless references to Dr. Wall throughout the trial only magnify the prejudicial effect of admitting his testimony. *See Rasalan v. TJX Operating Cos., Inc.*, 129 Ohio App.3d 364, 370, 717 N.E.2d 1123 (9th Dist.1998) ("[A] trial court's admission of an expert's opinion, over an objection, * * * becomes prejudicial error when substantial emphasis was placed upon that opinion in establishing the plaintiff's case."). Underscoring the point, during one of the many references to Dr. Walls during closing arguments, defense counsel stressed the weight of Dr. Walls's testimony in comparison to all other experts on the issue of intubation: "If there is a physician who knows more about airway management, all right, who knows more about whether or not to intubate a patient in the emergency department or not, is Dr. Walls." And to hammer home the importance of Dr. Walls's opinion, defense counsel in closing encouraged the jury during plaintiff counsel's surrebuttal to think "how Dr. Walls would" respond.

{¶32} Therefore, we cannot dismiss the error as harmless, and we accordingly sustain Mr. Johnson's first assignment of error as described above.

III.

{¶33} For all of the foregoing reasons, we sustain Mr. Johnson's first assignment of error only insofar as it relates to the trial court's decision to admit Dr. Walls's expert

testimony, and we remand this cause for retrial. Based on our disposition, we find that the remaining assignments of error (most of which address trial-related issues that may change based on the record upon retrial) are moot and may be reevaluated, as appropriate, by the trial judge at the retrial. *See* App.R. 12(A)(1)(c).

Judgment reversed and cause remanded.

MYERS, P. J., and **CROUSE, J.,** concur.

Please note:

The court has recorded its own entry this date.