SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A—001934-24

KATHERINE KEIM	:	CIVIL ACTION
Plaintiff-Appellant	:	ON APPEAL FROM A FINAL JUDGMENT OF THE SUPERIOR
v.	:	COURT LAW DIVISION PASSAIC COUNTY
BRAD HOLMBERG, *et al.*	:	
Defendants-Appellees	:	SAT BELOW: HON BRUNO MONGIARDO, J.S.C.

BRIEF OF APPELLANT

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STATEMENT OF PROCEDURAL HISTORY[1]

This is a veterinary malpractice case involving the alleged negligent treatment of plaintiff Katherine Keim's pet dog ultimately leading to the need to euthanize the animal. Plaintiff alleges a pattern of mistreatment over an extended period of time between May 2018 and September 2019 when her pet was euthanized due to complications of necrotizing pancreatitis.

The Complaint in this matter was filed by plaintiff Katherine Keim acting *pro se* on 5/10/21 naming Brad Holmberg, a veterinarian specializing in veterinary ophthalmology as well as his practice Animal Eye Center of New Jersey and

[1] Pursuant to *R.* 2:6-8, the pertinent transcripts in this matter are designated as follows:

Volume Designation	Hearing Date	Description of Proceeding
1T	1/20/23	Motion to Dismiss Emotional Distress Claims
2T	2/3/23	Continuation of Motion to Dismiss Emotional Distress Claims
3T	4/28/23	Motion for Reconsideration of Motion to Dismiss Emotional Distress Claims
4T	9/13/24	Motion to Bar Plaintiff's Expert Witness
5T	11/4/24	Continuation of Motion to Bar Plaintiff's Expert Witness

Deborah Hall and John Lucy, general veterinarians affiliated with Oradell Animal Hospital. (Pa1). On 6/8/21 defendants Hall, Lucy and Oradell filed an Answer to the Complaint, (Pa8), followed a month later by defendants Holmberg and Animal Eye Center on 7/8/21. (Pa16). Plaintiff proceeded *pro se* through the remainder of 2021 and all of 2022.

On 12/21/22 defendants filed a motion to dismiss plaintiff's emotional distress claims asserting that it is not a "recognized cause of action" in cases involving injuries to pets. Defendants also sought dismissal of plaintiff's economic loss claims or to limit any such claims to the "lost value of the pet." On 2/6/23 the court entered an Order granting in part and denying in part defendants' motion. (Pa41). The court dismissed plaintiff's emotional distress claims with prejudice citing *McDougall v. Lamm*, 211 N.J. 203 (2012) where the Supreme Court "declined to extend recovery for emotional distress for the loss of a pet." (Pa27). The court distinguished *Quesada v. Compassion First Pet Hospitals,* 2021 WL 1235136 (App Div. 2021), an unpublished Appellate Division opinion in which the appeals court held that claims of direct infliction of emotional distress, as distinct from bystander liability, are sustainable where the emotional distress is associated with a breach of a duty owed directly to the pet owner. (Pa51). As to the claim for economic loss, the court denied the motion to dismiss, also citing *McDougall* for the proposition that "our courts have permitted pet owners to be

awarded costs in excess of the animal's value that represent pecuiniary losses associated with with medical treatment, damages based on the intrinsic value of the pet, or specific performance of an agreement between the pet owners." (Pa51). Accordingly, the court concluded that plaintiff was "entitled to recovery greater than the replacement value of [her dog]; recoverable economic damages such as veterinary expenses, treatment costs, and other costs of restoring [her pet] to her pre-incident state." (Pa51).

On 3/23/23, Morgan Browning, Esq. entered an appearance on behalf of plaintiff and took over the management of the case. (Pa26). Shortly after Browning's appearance, plaintiff produced the report of Bart Sutherland, D.V.M. who, based on the limited discovery provided by defendants by way of medical records and without the depositions of the defendants, nevertheless set out what he described as "failure[s] of the standard of veterinary care" on the part of Holmberg, Hall and Lucy. (Pa136-37). On 3/23/23 Plaintiff moved for reconsideration of the court's Order of 2/6/23 dismissing her emotional distress claims. Oral argument was heard on 4/28/23, (3T), and on 5/1/23 the court entered an Order, accompanied by a Memorandum Decision denying the motion. (Pa33; Pa34). On 11/14/23, a Stipulation of Dismissal was filed dismissing Holmberg and Animal Eye Center with prejudice leaving Hall, Lucy and Oradell Animal Hospital as defendants.

A little more than a year later, on 6/25/24 Browning filed a Substitution of Attorney attempting to withdraw and have plaintiff proceed again *pro se*. Then on 7/16/24, defendants filed a Motion to Bar plaintiff's expert as unqualified under the Patient First Act, *N.J.S.A.* 2A:53A-41 because, despite the fact that he is a duly-licensed Doctor of Veterinary Medicine, he was not board-certified by the American Board of Veterinary Specialties (ABVS) as the defendants were. Defendants also asserted that Dr. Sutherland's opinion constituted an inadmissible "net opinion." That same day the Clerk entered a "Deficiency Notice" regarding the purported substitution of counsel advising plaintiff that she was "still represented by counsel" who would have to move to withdraw as counsel rather than substitute out. On 7/17/24 Browning then moved to withdraw citing, among other things, defendants' alleged failure to cooperate in discovery as well as an agreement with the plaintiff that it would be best if they parted ways. That motion, which was opposed by defendants, was granted on 8/6/24. (Pa27).

On 9/13/24 the court heard argument on defendants' motion to bar plaintiffs' expert. At argument the judge inquired as to whether the issue of the expert's qualifications had been addressed in a *Ferreira* conference early on and thus whether defendants' motion was more properly addressed to the weight of the expert's opinion rather than his qualifications to offer such opinion. The court observed that

> I am shocked that – I am really shocked that there was no objection to the affidavit of merit here. I am shocked. Because that's where – and had that happened, then you would have had the opportunity to get another expert. And that's the only reason at this point that I would be inclined not to grant the motion at this time.
>
> * * * * *
>
> My only problem, and as I said, the problem that I have with the defense motion is, is that no one ever complained about or objected to the affidavit of merit. I don't understand why. Because I, you know, we get these all the time where . . . if there are objections, then the other side gets the opportunity to cure that.

(4T at 21-11 to 22-4).

The court reserved a decision pending further elucidation of the issue of the *Ferreira* conference saying

> [H]ere is the thing. If there was [a *Ferreira* conference], if there was no objection to the content of the affidavit, then my inclination . . . would be to deny the motion. However, if that was something that was never addressed one way or the other, and there was never an affirmative representation by the defense that the affidavit of merit is okay, as far as its contents are concerned, then I might be inclined to rule differently. But before I can do that, I need to know what happened here.

(4T at 31-23 to 32-7).

One week later, on 9/20/24 counsel for defendants filed a Certification in which she acknowledged that no *Ferreira* conference was held but asserted that was irrelevant since the issue was not plaintiff's expert's qualifications to execute

an Affidavit of Merit that was at issue but rather his qualifications to *testify* at trial as expert. Defendants argued that the Patient First Act, *N.J.S.A.* 2A:53A-41 governed and that because Dr. Sutherland was not board-certified by the American Board of Veterinary Services (ABVS) as the defendants were, the PFA barred him from testifying; nothwithstanding the fact that nowhere in the PFA does it mention the ABVS.

Thereafter, on 11/4/24 Judge Mongiardo issued an Order barring plaintiff's expert from testifying. (Pa31). In his oral opinion explaining the decision the judge distinguished the Affidavit of Merit statute from the Patient First Act and, citing *Nicholas v. Mynster*, 213 N.J. 463 (2013), noted that the PFA "requires that 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 *physicians*." (5T at 11-20 to 24 (emphasis supplied)). To reach its conclusion that the PFA applied to bar plaintiff's expert the court took judicial notice of the fact that

> [T]he American Veterinary Medical Association . . . is an organization similar to the American Medical Association. And like the AMA and the AMA's American Board of Medical Specialties maintains the American Board of Veterinary Specialties which recognizes veterinary specialties. As the AVMA/ABVS website indicates currently, there are 22 AVMA recognized veterinary specialty organizations representing 46 distinct specialties, such as behavior, ophthalmology, internal medicine, surgery, dentistry and

> as is relevant to this matter, small animal internal medicine.

(5T at 15-9 to 22).

Notwithstanding that the ABVS is nowhere mentioned in the PFA, the court found that because the defendants were board-certified by the ABVS in small-animal internal medicine "any expert produced to testify regarding their care and to opine on any deviation from the standard of care must also be board certified small animal internal medicine specialists practicing or teaching in that specialty." (5T at 14-21 to 25). While acknowledging that plaintiff's expert is, like the defendants, a doctor of veterinary medicine, the court held that he was unqualified to testify because he is not board-certified in small animal internal medicine. (5T at 17-1 to 25). And, while the court had initially offered that in looking at Dr. Sutherland's report he was "not so sure that it would come under the category of net opinion," (4T at 5-13 to 16), by the time of the 11/4/24 hearing he concluded that it was a net opinion and should be barred for that reason as well. (5T at 23-11 to 13).

On 11/24/24, now again proceeding *pro se*, plaintiff filed a motion for reconsideration of the order barring her expert arguing that the court had misapplied the PFA in this case because "[t]he specific statutes and laws that have been enacted with the intention to protect the rights of human patients, such as the 'Patient First Act' were not written with the legislative intent to include professionals who do not treat human patients." Plaintiff also asserted that Dr.

Sutherland's report was not an inadmissible net opinion and if there was a defect in that opinion it was due to the failure of defendants to provide requested discovery. In support of the motion plaintiff also attached a Supplemental Certification of Dr. Sutherland in which he stated that he was active in the practice of veterinary medicine in 2018 and 2019 as well as the time he wrote his report and he was still actively practicing veterinary medicine at the time of making the Certification. (Pa138). He also renewed his request for additional documentation. (Pa139).

While the motion for reconsideration was pending, defendants filed a motion for summary judgment based on the fact that plaintiff could not produce any expert testimony at trial bearing on the standard of care. That motion was returnable on 1/17/25. In the meantime Judge Mongiardo granted oral argument on the motion for reconsideration and set it down for 1/15/24. On 1/3/25 Kevin Haverty, Esq. substituted in for the plaintiff, (Pa28), and on 1/7/25 withdrew the motion for reconsideration. (Pa29). No opposition was filed to the motion for summary judgment and on 1/24/25 the court entered an Order granting summary judgment and dismissing the case as "plaintiff does not have an expert to testify at the time of trial as to the alleged deviations from veterinary care." (Pa30). Notice of Appeal was then filed on 3/5/25. (Pa53).

STATEMENT OF FACTS

This veterinary malpractice case arises initially out an admission to Oradell Animal Hospital ("Oradell" or "OAH") on May 7, 2018. Plaintiff's pet Minature Schnauzer "Olive" was presented to Oradell with a reported history "restlessness" for the past month and "drinking more" as well as back pain. (Pa140). It was noted that "full bloodwork" performed 5 weeks earlier was "normal" with the exception of "high triglycerides." *Id.* At urine strip collected by the owner the morning of admission was significant for the presence of ketones and glucose. *Id.* Physical examination was unremarkable noting her eyes were clear bilaterally and no murmurs or arrhythmias appreciated. (Pa141). The assessment "pancreatitis and suspect diabetic ketoacidosis (DKA)" in a "new diabetic." *Id.* Prognosis was regarded as "fair" and the plan was "hospitalization for pancreatitis." It appears that the admitting veterinarian already concluded that Olive was diabetic as she noted in her plan that Olive "will require daily insulin injections for life." (Pa142).

An ultrasound performed the following day by John Lucy, DVM was significant only for liver changes "consistent with an endocrine/vacuolar hepatopathy" with no evidence of pancreatitis or adrenomegaly. (Pa146). Olive was discharged on the morning of May 8, 2018 by Deborah Hall, DVM with an apparent diagnosis of new onset diabetes with instructions to plaintiff to "give w units of insulin under the skin twice a day roughly 12 hours apart." (Pa147).

According to plaintiff she called Oradell the next day due to what she perceived as an abnormal reaction to the insulin

> I called and explained about the reaction that Olive was having. And she was shaking. She looked like she couldn't catch her breath. It was the same thing. The bloodshot eyes. It was not good. She didn't want to – they put her on a different food she had to eat, and give her the insulin. And before that, she was a free feeder. She would not gooble food down. That's not the kind of dog she was. She didn't overeat, she kind of grazed. So, it uprooted her whole schedule. I was giving her the canned food, everything they told me to give her. And it just her reaction to the insulin was very bad.

(Pa118-19 at 73-17 to 74-13).

The response she got was "it takes a while to get adjusted, and . . . give her the recommended dosage." (Pa119 at 75-9 to 12).

After continuing on "for a little bit listening to what they told me to do," (Pa119 at 76-1 to 76-3), she made another appointment with Dr. Hall to discuss the difficulties Olive was having on the prescribed insulin regime, telling the veterinarian

> Her blood sugar was rising, I was saying to [Dr Hall] she is shaking, she's not acting normal. And instead of even being the as . . . why I brought her in, it seemed like she was experiencing . . . stomach pain and vomiting and stuff. It turned into . . . her life, she was different, she was shaking, she was weak.
>
> * * * * *

> [And after getting a glucose meter] I noticed that her blood sugar was extremely high and extremenly low. It was not normal.

(Pa119 at T76-15 to 77-11).

According to Keim Dr. Hall told her that

> [Olive] is getting used to insulin. I think I did say could it be something else, is there a reason for this. She never spoke to me about pancreatitis. She stayed with the diabetes. She said [Olive] is a Schnauzer. She really pushed that she had diabetes, and that was the end of it. And you just have to adjust the insulin, and it takes a while to get it adjusted right.

(Pa119 at T77-15 to 23).

Two months after Olive was diagnosed, she was seen by a veterinary ophthalmologist, Michael Brown, D.V.M. with a presenting complaint of "red eyes." (Pa149). Dr. Brown's examination was significant for a finding of "incipient cataracts" which he described as "small" but "tear film is reduced in both eyes." *Id*. He prescribed a number of medications to improve lubrication as well as tear stimulation and anti-inflammatory medication noting that "long term therapy is necessary for this condition." *Id.* Dr. Brown recommended re-check in 2 months. *Id*.

Twelve days later, on 7/17/18, Olive presented to University of Pennsylvania Veterinary Hospital with a chief complaint of "restlessness and discomfort during the evenings," (Pa297), and for "evaluation of diabetes

mellitus." (Pa295). At Penn it was noted that Olive's diabetes "has been difficult to regulate and that she has not acted normally since . . . her diagnosis." *Id.* Physical examination was significant for new finding of a heart murmur, described as having a "slightly more abnormal sound than a more classic murmur." *Id.* Echocardiogram was recommended for further evaluation of the murmur but was deferred as "not possible to be done today." *Id.* As to the diabetes, the attending clinician explained that

> [w]hen a patient has unregulated diabetes, we think about a few potential causes for that. It is possible that Olive simply needs more insulin. She is not on an incredibly high does, so we may have to increase her amount to control her condition. However, it could be that there is an underlying reason for her being difficult to regulate. It is also possible that her not acting like herself is unrelated to her diabetes and could represent an unrelated condition.

Id.

Olive returned to Penn on 9/14/18 for a cardiology evaluation. At that visit it was noted that Olive had "been evaluated for intermittent shaking (that seems to coincide with a certain time before or after she receives insulin) and restlessness at night." (Pa302). It was also noted that "[i]nitially when first beginning insulin, it was reported that one hour post-administration, Olive's respiratory effort would increase. Olive shakes occasionally and has developed black flakes on both ears." *Id.* On physical examination a grade II-III/VI left sided systolic, apical murmur

was appreciated along with a "musical right sided murmur" described as "intermittent." *Id.* Echocardiogram was signficant for "mild thickening of [the] mitral valve and a mild to moderate amount of mitral regurgitation . . . [along with a] trace tricuspid regurgitation. *Id.* The assessment was "degenerative valve disease."

On 12/20/18 Olive re-presented to Dr. Brown, the veterinary ophthalmologist, for re-evaluation of her cataracts first seen in July. The eye exam was signficant for a finding of "mature diabetic cataracts" in both eyes. (Pa150). Dr. Brown instructed that "[a]nimals with cataracts are at increased risk of developing glaucoma and/or retinal detachment," the risk of which is not eliminated by cataract surgery. (Pa151). If cataract surgery was desired Brown recommended an ocular ultrasound and electroretinogram to assess retinal health before surgery as well a establishing that diabetes is well-regulated through a fructosamine level. *Id.* If surgery was not desired, periodic re-checks every 1 to 4 months was recommended "depending upon the degree of cataract formation." *Id.*

Two weeks later, on 1/3/19, Olive was evaluated by Bradford Holmberg, D.V.M. a veterinary ophthalmologist and partner of Dr. Brown, for cataract surgery. Dr. Bradford peformed a gonioscopy (a test to evaluate the drain angle of the eye and assess glaucoma risk) as well as an electroretinogram (ERG) and ocluar ultrasound. Gonioscopy was sigificant for a "narrowed drain in both eyes"

which suggested that "Olive may be predisposed to glaucoma with or without cataract surgery." (Pa238). The electroretinogram was unremarkable but the ocular ultrasound, while normal in the left eye revealed "mild vitreous degeneration in the right eye." *Id.* Nevertheless, Dr. Holmberg assessed Olive as a "reasonable candidate" for cataract surgery in both eyes and estimated an 80% chance of success in both eyes. *Id.* He recommended pre-surgical bloodwork, including fructosamine "to verify systemic health and relative control of the diabetes" as he could not perform surgery "[i]f Olive is not systemically stable." *Id.*

10 Surgery was intially scheduled for 1/31/19 but on 1/18/19 Olive represented to Oradell with complaints of inappetence and shaking for several days as well as arching her back. (Pa152). On the morning of the 18th she reportedly vomited bile and had a "slight soft bowel movement." *Id*. Keim was concered about Addison's disease and the differential diagnosis included "pancreatitis versus gastroenteritis versus secondary to Carprofen versus other." (Pa153). Olive was also noted to be hypercholestrolemic and hypetrigyleridemic with a differential diagnosis of "diabetes mellitus versus Cushing's disease versus Addison's disease versus other." (Pa154). Abdominal ultrasound was signifcant for an "enlarged, visible, prominent" pancreas demonstrating "changes consistent with chronic or acute on

chronic pancreatitis." (Pa155). The plan was to admit overnight for supportive care and monitoring. (Pa154).

Early in the morning of 1/19/19 Margaret Winter, D.V.M. called Keim to report that "Olive ate her food voraciously . . . [was] still panting, but had stopped trembling." (Pa159). Dr. Winter noted that she was "very happy with how [Olive was] doing so far." *Id.* Later that day, Dr. Lucy noted a phone call with Keim in which he reported that "Olive is eating well and seems comfortable on gabapentin" and he

> [d]iscused that [Olive] clearly has both pancreatitis and disc disease and these are probably amplifying pain. Pancreatitis [is] likely a manifestation of the chronic lipidemia and diabetes mellitus. We will need to make sure that Olive does not continue to somogyi[2] and may also need to intervene with her lipid levels. [The] Owner is frustrated that we don't have a simple or easy fix and I explained that unfortunately dogs with diabetes mellitus and hyperlipidemia (which unfortunately is a lot of Schnauzers) often get pancreatitis and the treatment for this is purely supportive. Owner asked about taking [Olive] home today and I said given the good appetite and overally comfort level on oral meds I thought that would be fine.

(Pa162).

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[2] As described by the Cleveland Clinic "[t]he Somogyi (so-MOH-gyee) effect happens when a low blood sugar (hypoglycemia) episode overnight leads to high blood sugar(hyperglycemia in the morning due to a surge of hormones. It can affect people with diabetes who take insulin." *See* Somogyi Effect: What It Is, Causes, Symptoms & Treatment (last visited 6/9/25).

Olive was discharged on the afternoon of the 19th but re-presented to Emergency Room at Oradell the next day with Keim reporting that Olive had not eaten since going home and "she seems to be getting worse /more painful over [the] past 24 hours." (Pa201). On physical exam it was noted that the patient's abdomen [was] far more painful than she had been and her serum was even more lipemic that she had been." (Pa203). The assessment was worsening pancreatitis and the plan was to admit Olive for supportive care. *Id.*

Olive was admitted to Oradell from 1/20/19 to 1/29/19 for what was deemed to be "acute-on-chronic pancreatitis." (Pa163). During her admission her symptoms waxed and waned but she was deemed stable for discharge on admission day 10, 1/29/19. The Discharge Summary noted that

> Olive has been hospitalized at Oradell for the past week after she failed outpatient management for pancreatitis. She has been treated with de-escalating opioid pain management, gastroprotectants and insulin therapy based on monitoring of blood glucose levels. She is no longer painful and has a great energy level. She continues to have a finicky appetite but will eat when hand-fed Royal Canin low fat gruel. She has had no recent vomiting or diarrhea. We are sending her home with some dietary strategies and gemfibrozil to try and decrease her circulating triglyceride and cholesterol levels. As hyperlipidemia is a risk factor for pancreatitis and can make diabtetic management quite challenging, I feel that it is paramount to do what we can to get Olive's lipid levels better controlled. This will also make her a safer candidate for cataract surgery moving forward.

(Pa164).

A little more than a week later Olive re-presented to OAH with a noted episode of a "black pasty formed stool" the previous evening. (Pa208). Keim reported that Olive had been "slowly improving since her recent hospitalization for pancreatitis however she believes Olive has not been the same since initial diagnosis of diabetes and [is] concerned there is other underlying disease causing her to be lethargic." *Id*. Abdominal ultrasound on 2/8/19 was significant for mild acute colitis, chronic liver changes secondary to diabetes and chronic renal disease, none of which were deemed diagnostic. (Pa207). Treatment was symptomatic and Olive was discharged the same day. (Pa204).

Keim's next contact with Dr. Holmberg was at the end of February 2019 where he noted a phone call with her in which she reported that "Olive is doing better[,] [p]ancreatitis is not active and her regular vet is working on getting her DM better regulated." (Pa272). Holmberg noted that Olive's insulin had been adjusted down to 2 units twice a day but "this is still causing too low BG values." *Id.* Keim reported to him that Olive's eyes "have been looking good" and she (Keim) still wanted to pursue surgery on Olive's systemic health is more stable." *Id.* Holmberg encouraged Keim to have Olive seen at Animal Eye Center for a recheck within the next month "to make sure everything is stable." *Id*.

On March 22, 2019 Olive was re-evaluated by Holmberg who determined that "Olive is doing well and both eyes [and] [s]urgery to remove the cataracts is

indicated." (Pa273). He instructed Keim to call to schedule a repeat electroretinogram "to verify retinal health" after which surgery could be scheduled. He also instructed her to "make sure the diabetes is relatively controlled prior to the repeat testing and surgery." *Id*. Of note, Olive's intraocular pressures at this visit were measured as 14 in the right eye (OD) and 16 in the left eye (OS). *Id.*

ERG and ocular ultrasound were repeated on 5/1/19 and Olive was "approved for surgery." (Pa274). There is no indication in the AEC records that Olive's diabetes control was established before clearing her for surgery. On 5/2/19 Olive underwent phacoemulsification of bilateral cataracts with the implantation of artificial intraocular lenses in the anterior chamber of each eye. (Pa275). According to Holmberg the procedure "went very well" and he planned to start Olive on "our routine, aggressive, post-op medical therapy." *Id*. She was seen in immediate post-operative the day after surgery at which time Holmberg noted that following surgery "[b]oth eyes are comfortable and visual with normal pressure and less than expected amount of intraocular inflammation." (Pa277). Intraocular pressures were OD-10 and OS-11. *Id.* The next visit was on 5/8/19 where Holmberg recorded normal IOP's of OD-10/OS-12, (Pa279), but "mild inflammation" in both eyes. (Pa278). He injected the eyes with tissue plasminogen activator (tPA) to reduce the inflammation and planned to "alter therapy slightly." *Id.* While the plan was to recheck the eyes in 7 days, Keim

brought Olive back two days later on 5/10/19 reporting that Olive's eyes were "red." (Pa281). Holmberg's exam was normal"with no flare, good vision" and normal IOP in both eyes of 8. *Id*.

Following the visit on 5/10/19, Olive's condition began to deteriorate slowly but measurably. On 5/14/19 Keim called Holmberg to report that "Olive has had eyes shut since last night. BG is high and she is not acting like herself." (Pa280-81). Olive was then seen in followup by Holmberg the next day at which time he noted that Olive was "squinting a lot [with both eyes] yesterday." (Pa239). It was reported that Olive had no appetite and had ketones in her urine and her regular vet increased her insulin to 2.5 units twice a day. *Id.* On examination, Olive's IOPs were signficantly elevated above those measured at the prior visit with the right eye at 18 and the left eye measured at 20. *Id.* Holmberg's plan was to recheck her in 2 days and to withdraw topical steroid therapy as they were suspected to be affecting her diabetes. (Pa240).

On 5/17/19 Olive returned for post-op visit #5 at which time it was reported that she was "still very lethargic" and "not eating on her own." (Pa241). The pressure in the right eye had decreased substantially from 18 to 9 but the pressure in the left eye was only slightly lower at 19. *Id.* Holmberg characterized the pressure OD as "low-normal" while the pressure OS was "high-normal." (Pa242). He also noted a concern for Olive's "systemic health" and that the oral medication

she was on may be causing nausea. *Id.* His plan was discontinue oral medications and "only treat topically." *Id.* A re-check was recommended in 3 days.

At the next visit, on 5/20/19, Olive was "about the same" and "still not eating." (Pa243). She reportedly had two days of diarrhea as well. *Id.* IOPs were OD-13/OS-21. *Id.* While Holmberg noted that "[b]oth eyes are visual and comfortable with no active inflammation," he was concerned that the pressure in the left eye "remains at the high end of normal even with ongoing glaucoma therapy." (Pa244). The plan was to recheck in 5 days. *Id.*

Later that same day Olive was brought to the Emergency Department at OAH by the pet sitter who reported that Olive had a poor appetite and was lethargic. She was not drinking and was being hydrated by syringe. (Pa235). The provider spoke with Keim by phone and noted that

> [Olive] went to animal general last week – lethargic. Had pre-op blood work prior to cataract surgery. This was the most recent blood work performed. Owner feels she has not been the same since cataract surgery. Had trace ketones last week, went away when owner increased dose to 3 units twice a day, previous to this was on 2 units twice a day. Per owner blood glucose has never been controlled since diagnosed with diabetes a year ago - sometimes go[es] down to 60, sometimes in the 500[s]. Prior to surgery was on 2 unites twice a day [in] March and April. BGs were good. Had erratic BSs since discharge from OAH after pancreatitis, owner slowly decreased does of insulin and finally improved and was stable in March/April.

Id.

The plan was to admit for diagnostic testing including bloodwork and abdominal ultrasound. (Pa237).

She was seen the following day by Dr. Lucy who noted that overnight Olive had "no interest in food" and that he blood glucose was "quite variable on a very low dose regular insulin scale." (Pa229). Labs were significant for "mild hyperlipidemia" and "mild thrombocytosis" as well as "moderate hyperglycemia" and the plan was continue IV fluids and insulin every six hours. (Pa231). Later that day Dr. Lucy spoke with Keim and told her that the Olive had mild hyperlipidemia but the abdominal ultrasound was negative for pancreatitis. *Id.* Keim requested that they recheck the IOP pressues which Lucy said he would and that he would "reach out to Dr. Holmberg if the values are inappropriate." *Id.* The IOPs obtained that day showed a marked increase in pressure in the left eye of 29 (up from 21 the prior day) as well as significant increase in the right eye from a normal 13 on 5/20/19 to 21. *Id*.

On 5/22/19 Dr. Lucy noted that Olive was "eating great and bright, alert and responsive this morning!" (Pa225). She had no episodes of vomiting or diarrhea overnight and the plan was to restart her long-acting insulin and place a Freestyle Libre glucose monitor. *Id*. Lucy also planned to recheck the eye pressures and "contact Dr. Holmberg with [an] update. (Pa227). IOPs on 5/22/19 were OD-20/OS-30. (Pa224). There is no notation in either the OAH records or Holmberg's

records that either of the IOP measurements taken at OAH were reported to Dr. Holmberg.

The next day Olive was again seen by Dr. Lucy who noted that "Olive is eating great and will go home today." (Pa222). He also noted that he would be "rechecking with Dr. Brown prior to release to decide if ophthalmic protocol needs to be adjusted given the mildly increased intraocular pressure in the left eye." *Id.* Sometime later that day Dr. Brown measured the IOPs which were found to be markedly elevated in both eyes with the right eye at 33 and left at 45. (Pa214). He prescribed Mannitol "to treat the eyes aggressvily to lower the IOP," which succeded in lowering the pressure in the right eye down to 8 but only reduced the pressure in the left eye to 38. *Id.* Then in the evening he performed a centesis (a surgical puncture of the eye) in the left eye to reduce the pressure which brought the pressure down to 8. *Id.* His plan was to reevaluate the pressures the next day and repeat Mannitol if still elevated and "try to send Olive to see Dr. Holmberg at AEC for possible repeat tPA and/or centesis." *Id*.

Olive was apparently evaluated by Dr. Holmberg on the morning of 5/24/19 at which time the IOPs were OD-45/OS-47. (Pa245). It is not clear from the records but it appears that a centesis was performed that day on both eyes after which the pressures were reduced to 10 and 13 respectively. *Id*.

On 5/25/19 Dr. Holmberg performed cyclophoto coagulation (CPC) with placement of an anterior shunt in both eyes. (Pa284). He described it as "surgery to laser the ciliary body (faucet part of the eye) and to place an anterior chamber shunt (make a new drain) to try and better control the glaucoma long-term." *Id*.

Holmberg examined Olive the following day at which time he noted mild edema with moderate conjunctival hyperemia. Her IOPs on intial exam were OD-4/OS-7 and he injected tPA in both eyes after which the IOPs increased to 10 and 13 respectively. (Pa286). Olive was then seen on 5/27/19, post-op day 2, with Holmberg finding that she was "sighted" in both eyes and with a superficial corneal ulcer in the left eye. (Pa287). At the next visit on 5/28/19 Olive was noted to be "doing much better" but the left eye appeared "cloudy" and she seemed "painful [and] anxious." (Pa249). The supericial corneal ulcer is again noted. (Pa247). Holmberg noted that "the glaucoma is controlled in both eyes and the inflammation is as expected," and he planned to "continue aggressive therapy" and recheck Olive in 2 days. (Pa248).

Olive was seen the next day, however, reportedly in pain overnight and a still "cloudy" left eye. (Pa250). On examination Holmberg noted a "trace" flare in the right eye and 2+ flare in the left. (Pa288). He also noted a focus of fibrin in the tip of the shunt in the left eye. *Id*. The corneal ulcer in the left eye was again appreciated and Holmberg debrided it and placed a contact lens bandage. IOPs

were noted to be OD-4/OS-8 and he injected the left eye with tPA. *Id.* On the next visit, 5/31/19, the IOPs were unchanged but Holmberg now noted that the flare in the right eye had gone from "trace" to 1+; the left eye was unchanged and the ulcer in the left eye was still present. (Pa288). Significantly, he noted that the menace response was present on the right but said nothing about the left eye. *Id.*

The next visit was on 6/3/19 at which time there is a notation of "vision unsure." (Pa251). The IOPs were OD-4/OS-10 and the shunt appeared patent. (Pa289). The menace response was noted to be positive in both eyes but was described as "minimal" in the left eye. *Id.* The corneal ulcer in the left eye was again noted. *Id.* On 6/7/19 she was noted to be "doing better" but the pressure in the left eye had dropped to 6; right eye pressure was unchanged at 4. (Pa252). The left corneal ulcer was again appreciated and Holmberg noted that "Olive continues to improve slowly. Both eyes are comfortable and visual (although impaired) with no (right eye) to minimal (left eye) inflammation and low pressure." (Pa253). The plan was to taper therapy and recheck the eyes in 7 days. *Id.* At the next visit on 6/14/19 it was noted that Olive was "holding eyes shut" and IOP in the right eye was noted to be "soft." Pressure on the left was 9. (Pa254). Signficantly, a corneal ulcer on the right was seen and Holmberg peformed a debridement of the edges of the ulcer. (Pa255). His plan was recheck the eyes in 10 days and perform a grid keratotomy on the right eye ulcer if not healed by then. *Id*.

Olive returned on 6/24/19 for follow up of the corneal ulcers. In the meantime Olive was diagnosed with Addison's Disease and had been started on oral prednisone which reportedly resulted in an improvement with appetite and alertness. (Pa290). IOPs were 5 on the right and 4 on the left. (Pa291). Again appreciated was the "healing" corneal ulcer on the left and "superficial" corneal ulcer on the right. (Pa290). Holmberg noted that the ulcer on the right has healed and on left was "just about healed." *Id.* The plan was to recheck in 3 weeks. *Id.*

On 7/2/19, however, Olive returned with a complaint that the right eye "looked swollen" and she was squinting. (Pa257). Physical examination was significant for "corneal degeneration," *id,* which Holmberg described as "healing ulcers" and abnormal "tear film" which was thought to be the likely cause of the discharge and irritation. (Pa257-58). IOPs were OD-6/OS-4. (Pa257).

Nearly 4 weeks later Olive was again seen at AEC after her left eye reportedly "turned white," and was described as "puffy." (Pa259). On physical exam, Dr. Holmberg noted that the shunts were in place in both eyes but a suture on the left was exposed adjancent to the nose. *Id.* He also noted "mild degeneration" of the vitreous and was unable to visualize the retina on the left. *Id.* In the right eye he appreciated "mild vascular attenuation" of the retina and described the optic nerve on the right as "pale." *Id.* The IOPs were OD-5/OS-soft. While Holmberg concluded that "both eyes are comfortable and visual (although

impaired . . . the cloudiness in the left eye has progressed and this represents scar tissue." (Pa260). He mused that "[t]here could have been a previous corneal ulcer or other," and he planned to "monitor" it. *Id.*

On 8/6/19 Holmberg reexamined Olive at which time he appreciated a "large superficial corneal ulcer" in the left eye, the edges of which he debrided before performing a grid keratotomy to "promote healing." (Pa261). He also placed a contact lens bandage. *Id.*

Keim left for Italy that same day and took Olive with her. Upon her arrival in Italy she perceived that Olive's condition had worsened and called Dr. Holmberg. From Dr. Holmberg's note of the exchange it appears that he had a Facetime call with Keim on Friday 8/9/19 during which he noticed that the shunt in the left eye had extruded and he talked her through removing it. (Pa263). He recommended continuing all medications and placing a hot compress over the eye. (Pa262). According to Holmberg while Olive initially did well, by the next day she appeared painful and not eating. *Id.* Keim called an Italian veterinarian who noted a fever of 102.5 and gave an antibiotic and anti-inflammatory injections. *Id.* The next day he received a text that Keim and Olive were returning to the U.S. and he recommended that Olive be seen at Animal Medical Center (AMC) in New York City upon arrival. *Id*.

At AMC on 8/11/16 her left eye was described as “not visual and appears painful.” (Pa267). The IOP in her left eye was signficantly elevated at 42, (Pa266), and it was recommended that she consult with a veterinary ophthalmologist as soon as possible as "it is likely the left eye will need to be removed.” (Pa268). The next day she was seen by Corey Schmidt, D.V.M. of Veterinary Eye Specialists for a second opinion. Dr. Schmidt noted the corneal ulcere in the left eye which “appears infected." (Pa269). She recommended additional antibotics which “should help clear the infection.” *Id*. Olive was then seen by Dr. Brown at AEC on 8/13/19 who noted a “melting corneal ulcer in the left eye.” (Pa270). He described the eye as “painful [and] enlarged [with] an infected corneal ulcer,” and he recommended surgical removal. (Pa271). Given Keim’s desire to save the eye if possible, Dr. Brown continued her antibiotic therapy and arranged to recheck the eye in one week. *Id*.

On 8/16/19 Olive returned to Dr. Schmidt who peformed a surgical removal of Olive’s left eye, which had ruptured. (Pa292). Three weeks later she was admitted to Blue Pearl Veterinary Clinical with a 2-day history or lethargy, lack of appetite and appearing painful. (Pa305). She was cared for at Blue Pearl from 9/5/19 to 9/7/19 during which she decompensated with increased respiratory effort, decreasing pulse oxygenation and persistent hypotension. (Pa304). She was euthanized on 9/7/19. *Id.* An necropsy was performed at Penn Vet Diagnostic

Laboratories with a final diagnosis including "severe necrotizing chronic-active pancreatitis with peripancreatic and multicentric abdominal fat necrosis [and] moderate pulmonary edema." (Pa294).

PLAINTIFF'S EXPERT

In March 2018 Plaintiff produced the report of Bart Sutherland, D.V.M. (Pa128). Dr. Sutherland is veterinarian licensed in Mississippi who was been in practice since 1990. From 1990 to 1994 he was in practice at the Nelson Animal Hospital after which he practiced at Savannah Veterinary Clinic from 1995 to 1996 before starting his own practice in 1996. *Id.* From 2010 to 2018 he was a veterniary medical officer for the U.S. Department of Agriculture's Animal Care and Horse Protection Programs after which he returned to private practice and consulting. *Id.* At the time of the events at issue in this case, Dr. Sutherland was "an actively practicing veterinarian, providing medical, surgical, and dental care for small, large, and exotic animals." (Pa138).

After reviewing Olive's extensive medical records Dr. Sutherland concluded that Dr. Holmberg of Animal Eye Center and Drs. Hall and Lacy of OAH deviated from the accepted standard of veterinary care in the diagnosis and treatment of Olive. As an intial proposition he expressed "concern" about the lack of diagnostic data leading to the original diagnosis of diabetes in May 2018 which, if the problems associated with the management of her condition "had . . . been solved

first" the problems associated with the cataract surgery "would probably not have occurred." (Pa136). Dr. Sutherland explained that

> The fact that initial diagnosis and treatment of diabetes in May of 2018 was made in the absence of a complete blood count, chemistry and further diagnostics concerns me. Also establishing insulin treatment in such a relatively short time period with a very limited number of glucose checks are concerning as well. I am concerned a CBC could have revealed a potential infection such as pancreatitis. Also chemistry could have provided information on potential liver and/or kidney involvement. It appears that Olive's glucose was checked 3 or maybe 4 times after her first ever dose of insulin was given. My concern is that most of the literature I have reviewed state anywhere from 6 to 12 or possibly 24 glucose checks after being given insulin intiaally over a 12-24-hour period prior to establishing a treatment plan [citing to Merck website for vetsulin]. It seems that rather than try to identify the reason for the lack of stabilizing the up and down onslaught waves of he blood glucose and lack of remedying treatment with insulin, the problem was ignored. Unfortunately this isn't just the clinicians at Oradell Animal Hospital but also the Animal Eye Center of New Jersey.

Id.

Dr. Sutherland went on to explain how this initial failure to understand and effectively treat Olive's condition led to the cascade of complications resulting from the cataract surgery. As to Dr. Holmberg, he noted that

> On July 5, 2018 Dr. Brown of the Animal Eye Center of New Jersey diagnosed Olive with cataracts. ***On December 12, 2018*** Dr. Brown diagnosed her with mature cataracts and recommended that her diabetes be stabilized using the laboratory test of ***fructosamine to***

> ***confirm the stability. On January 3, 2019*** Dr. Brad Holmberg of Animal Eye Center of New Jersey ***also recommended that she have her diabetes stabilized prior to surgery and recommended a fructosamine test.*** He also said surgery ***would not be performed unless she was stabilized.*** On February 17, 2019 Dr. Holmberg noted that the referring veterinarian was working to stabilize the diabetes. ***On March 22, 2019*** Dr. Holmberg again ***warned to make sure that the diabetes was under control prior to surgery.*** On the day of her cataract surgery (May 2, 2019) Dr. Holmberg notes that her glucose prior to surgery was 416 and it ranged from **348-400** during surgery. It was also noted in the record that her diabetes was described as **fair to poorly controlled *immediately prior* to the surgery.** On this day and prior there are no records showing the fructosamine values. There are ***four notes*** in the records of Animal Eye Center of New Jersey regarding Olive's issue of controlling the diabetes prior to surgery. ***Three times*** the record clearly notes the concern for getting it under control. Unfortunately, Dr. Holmberg goes against his own advice and performs the surgey anyway. In my opinion this was a ***failure of the standard of veterinary care.***

(Pa136-37) (emphasis in original).

Dr. Sutherland criticizes OAH for its failure to timely and appropriately deal with Olive's elevated IOPs during her admission on May 20, 2019 which lead to the loss of a chance for a more favorable outcome

> On May 20, 2019 a caretaker for Katherine Keim presented Olive to Oradell Animal Hospital with a history of a poor appetite, lethargic and trouble breathing. Olive was seen by Dr. Erica Swanke and the owner talked by phone with Dr. Swanke. The owner explained concerns having just had surgery recently for cataracts and ***the need to check Olive's intraocular pressure.*** Olive was hospitalized and this information was passed

> along to Dr. John Lucy. In addition. In addition [I was advised by the owner that] on May 21, 2019 her friend and veterinarian Amanda Rogers related the concern regarding the recent eye surgery and intraocular pressures with Dr. Deborah Hall. On 5/21/19 and 5/22/19 Olive's intraoculare pressures were recorded and both times they were elevated. The record shows that there ***was not any action taken regarding the elevated intraocular pressures until 5/23/19.*** In my opinion this delay in treatment from the time the intraoculare pressures were noted until eventual treatment caused the irreversible damage to Olive's eye. Had treatment been instituted on [] 5/21/19 the opportunity for response to treatment would have been significantly improved. From my review of the medical records and interview with Ms. Keim, it appears that it was happenstance that Dr. Brown noticed Olive's condition since he was alos working at the Oradell Animal Hospital and was likely the reason action was taken then. This lack of action in the treatment by the primary veterinarians Drs. Deborah Hall and John Lucy or Oradell Animal Hospital directly affected the well-being and health of Olive. It is my opinion that this delay is a ***failure of the standard of veterinary care.***

(Pa137) (emphasis in original).

He concluded that

> Had Dr. Holmberg not performed the eye surgery until Olive's diabetes was stabilized, Olive would have not likely needed to return to Oradell on 5/20/19 with issues of poor appetite, lethargic and diarrhea. Had Drs. Hall and Lucy treated the increase eye pressures found on 5/21/19 in a timely matter, Olive would have had a much better chance of a favorable response to treatment.
>
> In my opinion, Olive's fate seems to be sealed after these two series of unfortunate mistakes. By August Ms. Keim is advised by other ophthalmologists to have Olive's left

> eye removed. In September Ms. Keim is strongly urged and does so by a team of veterinarians at Blue Pearl Specialty and Emergency Pet Hospital to have Olive euthanized due to the severe chronic-active pancreatitis.

Id.

LEGAL ARGUMENT

I. THE TRIAL COURT ERRED IN BARRING PLAINTIFF'S EXPERT FROM TESTIFYING. SUMMARY JUDGMENT ON THE BASIS OF LACK OF EXPERT TESTIMONY IMPROPERLY BARRED WAS THEREFORE ERRONEOUS AND SHOULD BE REVERSED (Pa30; Pa31; 5T)

The trial court erroneously barred plaintiff's expert for two reasons, neither of which were correct.

First, despite the plain and unambiguous language of the Patient First Act, *N.J.S.A.* 2A:53A-41, which applies to physicians only, the court extended the Act to veterinarians and applied the like-qualifications for specialists in veterinary medicine who are board-certified by the American Board of Veterinary Specialties (ABVS) as those applied to phycians. There is nothing in the text or history of the statute or in the case law interpreting the Act supporting that extension.

Second, the court erroneously concluded that plaintiff's expert's opinion was an inadmissible net opinion because "[h]e seems to be concluding in [his] report that the [defendants] delayed in taking action regarding Olive's increased eye pressures in May of 2019 and 'had treatment been instituted on May 21, the opportunity for a responsive treatment would have been improved.'" (5T at 22-10

to 16). But by that very statement the court implicitly acknowledged that this case involves an increased risk of harm and that plaintiff only bears the burden of demonstrating an increased risk with the burden then shifting to the defense to prove that the outcome would have been the same. The court placed too high a burden on the plaintiff's expert and commited error requiring reversal.

A. The Trial Court's Extension of the Patient First Act's Requirements to Board-Certified Veterinarians was Unsupported by the Plain Language of the Act, Its History and the Caselaw Interpreting It (Pa31; 5T)

Statutory interpretation logically "begins with the plain language of the statute." *DiProspero v. Penn*, 183 N.J. 477, 493 (2005). "If the language is plain and clearly reveals the statute's meaning, the Court's sole function is to enforce the statute according to its terms." *Frugis v. Bracigliano*, 177 N.J. 250, 280 (2003). On the other hand, "if the statute suggests more than one interpretation, the broader legislative schemee, its history, and relevant sponsor statements may also inform the Court's interpretation in light of the statute's overall policy and purpose." *Id.* Whatever the starting point, the court's "overriding goal must be to determine the legislative intent." *Id.* In the case of the Patient First Act, *N.J.S.A.* 2A:53A-41, both the language of the statute and the legislative intent behind its passage are clear and unambiguous that it applies only to *phyisicians* and not *verterinarians.* The trial court's conclusion that there is "no reason and logic as to why it should not," apply to veterinarians, (5T at 18-23 to 19-1), is plainly erroneous.

The New Jersey Medical Care Access and Responsibility and Patients First Act, *L.* 2004, *c.* 17 was passed in 2004 with the legislature noting that

> One of the vital interests of the State is to ensure that high-quality health care continues to be available in this State and that residents of this State continue to have access to a full spectrum of health care providers, including highly trained *physicians* in all specialties.

New Jersey State Bar Ass'n v. State, 387 N.J. Super. 24, 36 (App. Div. 2006)

The legislature took particular notice of an "alarming result of rising premiums" reportedly leading to

> doctors retiring or moving to other states where insurance premiums are lower, dropping high-risk patients and procedures and practicing defensive medicine in a manner that may significantly increase the cost of health care for all our citizens.

Id.

Thus it concluded that

> this act provides for a comprehensive set of reforms affecting the State's tort liability system, health care system, and medical malpractice liability insurance carriers to ensure that health care services continue to be available and accessible to residents of the State and to enhance patient safety at health care facilities.

Id.

Part of that enactment is codified in *N.J.S.A.* 2A:53A-41 which addresses qualifications of expert witnessess offering testimony concerning the standard of

care for *physicians* and in particular *physician specialists*. In this vein the statute provides that

> In an action alleging *medical malpractice*, a person shall not give expert testimony or execute an affidavit pursuant to the provisions of [*N.J.S.A.* 2A:53A-*26 et seq*.] *on* the appropriate standard of practice or care unless the person is licensed as a physician or other health care professional in the United States and meets the following criteria:
>
> a. If the party against whom or on whose behalf the testimony is offered 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 recognized by the American Board of Medical Specialties or the American Osteopathic Association*, *the person providing the testimony shall have specialized at the time of the occurrence that is the basis for the action in the same specialty or subspecialty, recognized by the American Board of Medical Specialties or the American Osteopathic Association, as the party against whom or on whose behalf the testimony is offered, and if the person against whom or on whose behalf the testimony is being offered is board certified and the care or treatment at issue involves that board specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association, the expert witness shall be:*
>
> (1) a physician credentialed by a hospital to treat patients for the medical condition, or to perform the procedure, that is the basis for the claim or action; or
> (2) a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association who is board certified in the same specialty or subspecialty, recognized by the American Board of Medical Specialties or the American

Osteopathic Association, and during the year immediately preceding the date of the occurrence that is the basis for the claim or action, shall have devoted a majority of his professional time to either:

(a) the active clinical practice of the same health care profession in which the defendant is licensed, and, if the defendant is a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association, the active clinical practice of that specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association; or

(b) the instruction of students in an accredited medical school, other accredited health professional school or accredited residency or clinical research program in the same health care profession in which the defendant is licensed, and, if that party is a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association, an accredited medical school, health professional school or accredited residency or clinical research program in the same specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association; or

(c) both.

b. If the party against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, shall have devoted a majority of his professional time to:
(1) 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 action; or

> (2) the instruction of students in an accredited medical school, health professional school, or accredited residency or clinical research program in the same health care profession in which the party against whom or on whose behalf the testimony is licensed; or
>
> (3) both.

Id. (emphasis supplied).

The statute's clear reference to specialty certifications recognized by the American Board of Medical Specialties and the American Osteopathic Association unambiguously conveys the legislative intent that it applies only to *physicians* and not other "licensed professionals" entitled to an Affidavit of Merit pursuant to *N.J.S.A.* 2A:53A-26, *et seq.* Indeed the Supreme Court has expressly determined that with regard to the enhanced qualification requirement of Section 41. *See Meehan v. Antonellis*, 226 N.J. 216 (2016). In *Meehan* the Court directly addressed the question of whether Section 41 applied to dentists (and by extension other non-physician health care providers) in the context of the affidavit of merit provisions. The court concluded it did not:

> The plain language of section 41 states that the like-qualified standards apply only to physicians.[3] And it does so repeatedly. For example [section a] governs parties to a medical malpractice action who are

[3] Of note, "physician" is a distinct designation of licensed professional under the Affidavit of Merit statute, *see N.J.S.A.* 2A:53A-26c, as are a number of other human health care providers. Veterinarians are also a distinct designation of licensed professional under the AoM statute who were added in 2002 pursuant to *L.* 2002 c. 372 § 1.

> specialists or subspecialists recognized by the American Board of Medical Specialties or the American Osteopathic Association. Those organizations recognize and establish the criteria for board certification only for physicians.
>
> * * * * *
>
> Similarly, only a physician falls within the bounds of *N.J.S.A.* 2A:53A-41b. That subsection addresses general practitioners and limits the expert or affiant to a physician (1) actively engaged in "clinical practice as a general practitioner" or active in clinical practice involving the medical condition or procedure that is the basis of the claim or (2) who instructs students at an accredited medical school, health professional school, or residency or research program or both.
>
> Interpreting section 41's like-qualified credential requirements as applying only to physicians who are defendants in medical malpractice actions is also supported by and consistent with the stated purpose and of the Patients First Act and its legislative history.
>
> * * * * *
>
> In sum, we conclude that the plain language of sections 27 and 41 lead to the inexorable conclusion that the enhanced credential requirements established under section 41 for those submitting affidavits of merit and expert testimony apply only to physicians in medical malpractice actions.

226 N.J. at 233-34.

See also Lomando v. U.S., 667 F.3d 363 (3rd Cir. 2011) (predicting that the New Jersey Supreme Court would apply the PFA to physicians only and holding it inapplicable to a physician's assistant engaged in the practice of emergency care).

And see Szemple v. Univ. of Med. & Dentistry of NJ, 162 F.Supp.3d 423, 433-34 (D.N.J. 2016) (decided 6 months before *Meehan*) ("[t]he state legislature could rationally have decided to confine Section 41 to the field of medicine. Every other profession is relegated to the general standard of Section 27; it is not anomalous that dentistry should take its place among them.")

If the PFA does not apply to board-certified dentists, as in *Meehan*, and its express purpose was to address a perceived looming crisis involving medical malpractice insurance premiums driving physicians to retire, restrict their practices or move out of state, it cannot by any stretch apply to veterinarians who, like dentists are "relegated to the general standard of Section 27." The trial court's conclusion that "there is no reason [or] logic as to why [Section 41] should not [apply]" was manifestly erroneous and should be reversed.

B. The Trial Court Erroneously Excluded Plaintiff's Expert's Opinion as an Inadmissible Net Opinion (Pa31; 5T)

Though the decision to admit or exclude expert testimony is left to the sound discretion of the trial court, *State v. Berry,* 140 N.J. 280 (1995); *State v. Moore,* 122 N.J. 420 (1991), that decision is subject to review for abuse of that discretion. *Hisenaj v. Kuehner*, 194 N.J. 6 (2008). "While an 'abuse of discretion defies precise definition' [it may lie where a] judge's decision 'rested on an impermissble basis,' considered 'irrelevant or inappropriate factors, failed to consider controlling legal principles or made findings inconsistent with or unsupported by competent

evidence'" *Elrom v. Elrom*, 439 N.J. Super. 424, 434 (App. Div. 2015) (citations omitted). *See also Flagg v. Essex County Prosecutor*, 171 N.J. 561, 571 (2002) ("a functional approach to abuse of discretion examines whether there are good reasons for an appellate court to defer to the particular decision at issue. It may be 'an arbitrary, capricious, whimsical or manifestly unreasonable judgment.'") (citations omitted)); *Moraes v. Wesler*, 439 N.J. Super. 375, 378 (App. Div. 2015) ("[a]n abuse of discretion also arises when 'the discretionary act was not premised upon consideration of all relevant factors, was based upon consideration or irrelevant factors, was based upon consideration of irrelevant or inappropriate factors, or amounts to a clear error of judgment." In the instant case, without the expert having been deposed regarding his opinions and the bases thereof as well as without conducting a hearing, the trial court abused its discretion in determining that plaintiff's expert opinion was an inadmissible net opinion despite that fact that his report facially did not set forth a bare net opinion.[4] This court should reverse.

[4] At the initial hearing on defendants' motion to bar, the trial court mused that "[i]n looking at this, and again, I understand the arguments that are being made by the defense, but one of the problems that the Court has is that it seems that these are the types of arguments that would necessarily go to the weight to be given Dr. Sutherland's report, rather than to its admissibility . . .The court is well aware, of course, of our evidence rules that deal with that particular factor [net opinion]. Looking at the report itself, I am not so sure that it would come under the category of net opinion. And as I said , it seems to me that this is a matter that can best be addressed by the trial court at the time of trial and that this really goes to the the question of weight rather than admissibility. (4T at 5-6 to 23).

N.J.R.E. 703 provides the foundation for expert testimony and requires the expert's opinion be based upon "facts or data, or other expert's opinion perceived or made known to the expert at or before trial." *See Buckelew v. Grossbard*, 87 N.J. 512 (1981). The rule provides that the facts and data relied upon in forming the opinions need not themselves be admissible as long as they are "of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject." *N.J.R.E.* 703; *Rubanick v. Witco Chemical Corp.*. 125 N.J. 421 (1991). Opinions which are not supported by factual evidence or data or where the expert fails to provide the "why or wherefore" supporting the opinion as opposed to a bare conclusion unsupported by factual evidence constitute inadmissible net opinion. *Buckelew, supra* at 524 ("the net opinion rule appears to be a mere restatement of the established rule that an expert's bare conclusions, unsupported by factual evidence, is inadmissible. It frequently focuses . . . on the expert to explain a causal connection between the act or incident complained of and the injury or damage allegedly resulting therefrom.") Measured by this standard, Dr. Sutherland's opinion is not, on its face, a net opinion as he does point to the specific facts supporting his opinion as well as to the why and wherefore those facts support the conclusions that the defendants were negligent and their negligence led to the injuries at issue in the case.

In the first instance, the trial court mischaracterizes Dr. Sutherland's "conclusions" as mere "concerns." (5T at 22-8 to 9). A fair reading of his report, however, shows that Dr. Sutherland is calling into question the initial diagnosis of diabetes as unsupported by appropriate diagnostic testing or clinical data (i.e. inadequate glucose testing to establish a dosing curve). (Pa136). But, because the diagnosis was made, insulin therapy was initiated. The problem, and Dr. Sutherland's central criticism, is that Olive's blood glucose was never adequately controlled and that cataract surgery was not indicated—by Dr. Holmberg's own admission—in the absence of evidence of stable glucose values. (Pa136-37). And it was the surgery which appeared to have triggered the cascading complications Olive suffered. Indeed, the trial court appears to have completely misunderstood Dr. Sutherland's opinion first incorrectly asserting that he is does not have any "experience or expertise in the care of a small dog with diabetes, pancreatitis, glaucoma and/or cataracts . . . [and] does not define the standard of care to a dog under these circumstances." (5T at 22-18 to 23). Even assuming that to be true (which it is not), Dr. Sutherland—who the court recognized was a duly licensed veterinarian, (5T at 17-1 to 3)—derives the standard of care not just from his education, training and experience but from Dr. Holmberg himself who said that he would not perform surgery unless Olive's blood glucose was stabilized but did it anyway "go[ing] against his own advice." (Pa137). And Dr. Sutherland points out

that on the day of surgery Olive's blood glucose was markedly elevated at 416 and remained elevated throughout the surgery despite the administration of insulin pre-surgically. (Pa131). And contrary to the court's characterization of Dr. Sutherland's qualifications, he was at the time of these events, in active clinical practice treating small, large and exotic animals. (Pa138).

As to Hall, Lucy and OAH, Dr. Sutherland points out that they were aware of increased intraocular pressures when Olive was admitted on 5/20/19 with a history of poor appetite, lethargy and trouble breathing and that the IOPs remained elevated over the next two days, but did nothing. (Pa137). As Dr. Sutherland put it "it appears that it was only happenstance that Dr. Brown noticed Olive's condition [on 5/23/19] since he was also working at OAH [that day] and was likely the reason action was taken." *Id*. Dr. Sutherland specifically notes that had earlier intervention occurred "the opportunity for response to treatment would have been significantly improved." *Id.* That is, the failure to timely act increased the risk of harm, which actually ensued, and resulted in the loss of chance to avoid that harm. *See Scafidi v. Seiler*, 119 N.J. 93 (1990).

As to the "why and wherefore" Dr. Sutherland concluded that

> Had Dr. Holmberg not performed the eye surgery until Olive's diabetes was stabilized, Olive would have not likely needed to return to Oradell on 5/20/19 with the issues of poor appetite, lethargic and diarrhea. Had Drs. Hall and Lucy treated the increased eye pressure in a

> timely manner, Olive would have had a much better chance of a favorable response to treatment.

(Pa137).

Instead, she suffered a cascade of complications resulting in the removal of her left eye with deteriorating health leading to her being euthanized a month later.

II. THIS COURT SHOULD VACATE THE TRIAL COURT'S ORDER DISMISSING PLAINTIFF'S EMOTIONAL DISTRESS CLAIMS WITH PREJUCIDE AND REMAND FOR RECONSIDERATION (Pa41; Pa43; Pa33; Pa34)

Should this court reverse the lower court's Order barring plaintiff's expert from testifying and return the case for trial, it should also vacate the trial court's Order dismissing plaintiff's emotional distress claim.

Plaintiff filed this case on 5/10/21 *pro se*, (Pa1), and represented herself for nearly two years until the spring of 2023. In that Complaint plaintiff did not expressly plead a claim for emotional distress but did raise a claim in her Answers to Interrogatories served in August 2022. (Pa83 (defendants "ignor[ed] patient/caregiver's concerns"); Pa92 ("Dr. Lucy would not acknowledge owners' concern about Olive's poor regulation or abnormal reactions to insulin.")) Thereafter, in early 2023 defendants moved to dismiss plaintiff's emotional distress claim with prejudice as "not a recognized cause of action." At the time of filing plaintiff had not been deposed[5] and the only articulation of the nature and

[5] Plaintiff was first deposed on 7/20/23. *See* (Pa100).

basis of her emotional distress claim was in her interrogatory answers which she had prepared herself. The trial court heard oral argument on 2/3/23 and thereafter entered an Order dismissing plaintiff's emotional distress claims pursuant to *McDougall v. Lamm*, 211 N.J. 203 (2012) in which the New Jersey Supreme Court declined to extend liability for negligent infliction of emotional distress of bystanders to pet owners under *Portee v. Jaffee*, 84 N.J. 88 (1988). (Pa41-2). The court distinguished *Quesada v. Compassion First Pet Hospitals*, 2021 WL 1235136 (App. Div. 2021)[6] in which this court, relying on *Decker v. Princeton Packet, Inc.*, 116 N.J. 418 (1989), held that a claim for negligent infliction of emotional distress relating to a pet can arise from the breach of a duty owed to *pet owner* directly; i.e. a "direct" rather than "bystander" claim. (Pa51).

In *Quesada*, the owner claimed severe emotional distress after his deceased cat was returned to him decapitated without his knowledge that would be done. The cat was euthanized and during the process reportedly bit a techician as a result of which the clinic informed the owner that they would have to send a sample of brain tissue to the State Department of Health for rabies testing. They did not, however, tell the owner how they planned to obtain the sample and he did not discover it until he held a viewing for the cat. After he was directed to the New

[6] Pursuant to *R.* 2:6-1(a)(1), a copy of the *Quesada* opinion is included in plaintiff's Appendix at Pa73.

Jersey DOH he was told that the cat's head was disposed of as "medical waste." Plaintiff claimed he suffered severe emotional distress over this.

This court in *Quesada* distinguished claims of "bystander" emotional distress claims for injuries to pets barred under *McDougall* from "direct" claims arising out a duty of care owed to the owner

> In contrast [to a *Portee/McDougall* bystander claim], a direct claim of negligent infliction of emotional distress "can be understood as negligent conduct that is the proximate cause of emotional distress in a person to whom the actor owes a duty to exercise reasonable care. To establish a direct claim of negligent infliction of emotional distress, a plaintiff must establish "(a) defendant owed a duty of reasonable care to plaintiff; (b) defendant breached that duty; (c) plaintiff suffered severe emotional distress; and (d) defendant's breach of duty was the proximate cause of the injury." "Whether the defendant has a duty of care depends on whether it was foreseeable that the plaintiff would be seriously mentally distressed."

Id. at *5 (*quoting Russo v. Nagel*, 358 N.J. Super. 254, 269-70 (App. Div. 2003)).

The *Quesada* court held that

> RBVH owed plaintiff a duty to return his cat's body in an acceptable condition for the viewing at the Hamilton Pet Meadow. It was foreseeable that plaintiff would have a serious mental reaction to seeing his cat's decapitated body upon arrival at the viewing. After the veterinarian euthanized Amor, plaintiff was given the opportunity to say goodbye, where he was "loudly crying and exclaiming to staff how Amor had saved his family when his sister died." Plaintiff also held Amor's body, "spoke

> to him and sang to him" before the veterinarian had to take the cat's body away. This emotional reaction combined with the fact that RBVH was twice on notice that plaintiff wanted to have a viewing of his cat's body prior to cremation establishes that defendants owed plaintiff a duty.
>
> Defendants breached their duty to plaintiff, disregarding this foreseeable serious mental distress, by decapitating plaintiff's cat without fully informing him of possible alternative testing procedures or requesting that the decapitated head be returned intact, which is an available procedure.

Id. at *6.

In the instant case, plaintiff's emotional distress claims were dismissed *with prejudice* before she had the opportunity to establish the elements of direct claim of negligent infliction of emotional distress.[7] As noted, plaintiff was only first deposed in July 2023 followed by two more days of testimony in which she testified about Olive's diabetes diagnosis, how the defendants left it to her to manage by injecting insulin without adequate instruction, the difficulties she had in stabilizing Olive's blood sugars as well as the numerous conversations she had with defendants about these problems as well as whether Olive did in fact have diabetes or some other condition. She also testified at length about the toll it took

[7] Plaintiff, through her newly-entered counsel filed a motion for reconsideration on 3/23/23 which was heard on 4/28/23. On 5/1/23 the court entered an Order denying reconsideration, (Pa33), which was accompanied by a Memoradum Decision explaining why reconsderation was denied. (Pa34). Plaintiff then filed a Motion for Leave to Appeal, AM-000497-22, which was denied.

on her—particularly the role she was playing which she was concerned may be harming her pet. None of this was considered by the trial court because the evidence didn't come out until *after* the court dismissed the emotional distress claims with prejudice. Should this court reverse the trial court's Orders barring plaintiff's expert and entering summary judgment, the court should also vacate the trial court's Order dismissing plaintiff's emotional distress claims and remand for further consideration by the lower court.

CONCLUSION

For the foregoing reasons, this court should vacate the trial court's Orders barring plaintiff's expert from testiying and dismissing plaintiff's emotional distress claims and reverse the Order entering summary judgment for lack of expert testimony.

Respectfully submitted

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In the Superior Court of New Jersey
Appellate Division

DOCKET NO: A-001934-24

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KATHERINE KEIM *Plaintiff-Appellant,* *v.* BRAD HOLMBERG, ANIMAL EYE CENTER OF NEW JERSEY, ORADELL ANIMAL HOSPITAL, DEBORAH HALL, JOHN LUCY *Defendants-Respondents.*	On appeal from: SUPERIOR COURT OF NEW JERSEY LAW DIVISION PASSAIC COUNTY DOCKET NO.: PAS-L-1549-21 Sat Below: Hon. Darren J. Del Sardo, J.S.C. Hon. Bruno Mongiardo, J.S.C.

BRIEF OF RESPONDENTS, ORADELL ANIMAL HOSPITAL, DEBORAH HALL, AND JOHN LUCY

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Preliminary Statement

This appeal stems from the grant of summary judgment in a veterinary malpractice action in which Plaintiff asserted claims stemming from the treatment of her dog, who was later euthanized as a consequence of the dog's significant medical difficulties, which included diabetes, glaucoma, and pancreatitis.

Defendants—two veterinarians and the practice which employed them—were granted summary judgment because Plaintiff's expert was barred and the Plaintiff's theory of recovery required expert opinion to establish the action. The expert was barred for two separate reasons: First, he was deemed not qualified to offer an opinion in opposition to the Defendants because the Defendants were small-animal specialist veterinarians, but Plaintiff's expert's practice and expertise did not address such matters.

Second, the expert was also barred from testifying because his opinion was a net opinion which failed to properly demonstrate the applicable standard of care, how that standard was allegedly breached in this case, and a causal connection between that alleged breach and the claimed damages.

The appeal also addresses the dismissal of Plaintiff's claim for emotional distress damages under a negligent infliction theory, which had been dismissed early in the litigation as New Jersey law holds that no such damages are

recoverable under a bystander theory with regard to the death of a pet. Further, Plaintiff's argument to proceed under a theory that Defendants owed her a direct duty was not supported in this case by the pleadings or any evidence of record. As such, the dismissal of the claim for emotional damages was proper.

Because Plaintiff failed to demonstrate a viable cause of action, the grant of summary judgment should be affirmed.

Procedural History

On May 10, 2021, Plaintiff filed her *pro se* complaint alleging that Defendants committed professional malpractice in the treatment of her dog, Olive. (Pa1-7) On June 8, 2021, Defendants, Oradell Animal Hospital, Deborah Hall, DVM, and John Lucy, DVM, filed an Answer to Plaintiff's Complaint. (Pa8-15)

On December 21, 2022, Defendants filed a motion to dismiss which, among other things, sought to bar any claim for the emotional distress that Plaintiff alleged she suffered as a consequence of the alleged malpractice. (Da1-2) The motion was heard before the Honorable Darren J. Del Sardo, J.S.C. (1T,

2T)[1] On February 6, 2023, the motion was decided by Judge Del Sardo, who barred any claim for emotional distress damages stemming from the death of Plaintiff's dog. (Pa41-42) He explained his decision in the accompanying memorandum detailing that the claim could only be an claim for bystander liability under a negligent infliction of emotional distress claim, however, such a claim may not be awarded as a result of injuries to a pet. (Pa43-52)

On March 23, 2023, counsel entered an appearance in behalf of Plaintiff and filed a motion for reconsideration. (See, 3T20:18-35:11) In that motion, Plaintiff argued that her alleged emotional distress damages did not stem from an indirect, bystander claim but rather a "direct" claim based on an alleged duty owed to her. (Id.) However, the underlying basis for this alleged cause of action—that the dog was misdiagnosed and did not have diabetes and that therefore the daily injections of insulin given to the dog by Plaintiff at Defendants' direction was a cause of harm to the dog, which led to additional medical problems, leading to her ultimate euthanasia—were not based on any facts alleged in the complaint nor supported by any medical opinion evidence at

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[1] 1T= January 20, 2023 Transcript of Motion
2T= February 3, 2023 Transcript of Motion
3T= April 28, 2023 Transcript of Motion
4T= September 13, 2024 Transcript of Motion
5T= November 4, 2024 Transcript of Motion

any time. (Cf. Pa1-7; Pa128-137) That reconsideration motion was denied by Judge Del Sarto on May 1, 2023. (Pa33-40)

On July 16, 2024, Defendants Oradell Animal Hospital and Drs. Hall and Lucy filed their motion to bar the Plaintiff's expert, Dr. Bart Sutherland. (Da3-4) The motion asserted two independent bases. (Id.) First, the motion argued that Dr. Sutherland was not qualified to offer an opinion as against Drs. Hall and Lucy as they were board certified by the American Veterinary Medical Association as specialists in small animal internal medicine. (Id.) Dr. Sutherland, by contrast, had no such certification and practiced in the area of large-animal veterinary medicine. (Id.)

Second, the motion argued that Dr. Sutherland's opinion was a net opinion, as it failed to detail the "whys and wherefores" concerning the applicable standard of veterinary care, the supposed violation of that standard, and a causative link between that alleged violation and the injuries claimed by Plaintiff. (Id.)

The matter was heard before the Hon. Bruno Mongiardo, J.S.C. (4T4:18-36:19) The motion was granted on November 4, 2024. (Pa31-32) Judge Mongiardo explained his reasoning on the record. (5T5:9-25:19) In that decision, Judge Mongiardo found that summary judgment was warranted on both grounds argued by the Defendants. (Id.) Specifically, he found that Dr.

Sutherland was not qualified to offer an opinion in support of the professional negligence claims. (5T8:15-20:18) He further found that Dr. Sutherland's opinion was a net opinion. (5T20:19-25:10)

On December 19, 2024, Defendants filed their motion for summary judgment arguing that the veterinary malpractice claim asserted by Plaintiff required the support of an expert and the order barring Dr. Sutherland precluded Plaintiff from establishing a cause of action as a matter of law. (Da15-16) Judge Mongiardo granted that motion on January 24, 2025 after Plaintiff withdrew opposition to the motion. (Pa30)

This appeal follows. (Pa53-58)

Counterstatement of Facts

Plaintiff Katherine Keim first brought her dog, Olive, to Oradell Animal Hospital to be seen by the internal medicine specialists on May 7, 2018. (Pa140-148) She had been referred to Oradell Animal Hospital by Animal General, the primary clinic used by Plaintiff for the animal's care. (Id.) Earlier that day, the dog was diagnosed with diabetes at Animal General but Plaintiff had refused to allow her to be started on insulin at that facility. (Id.) At Oradell, Plaintiff also reported that she was not happy with the care given at another facility, Blue Pearl, where Olive had been treated for pancreatitis. (Id.)

At Oradell, the dog was initially seen and assessed by Dr. Elizabeth

Lennon. (Id.) Dr. Lennon reviewed the testing that had been done at Animal General, including a CBC [i.e., complete blood count] panel and urine studies, which had led to the diabetes diagnosis. (Id.) Dr. Lennon advised Plaintiff that the dog would need daily insulin injections for the rest of her life. (Id.) Dr. Lennon initially placed Olive on a short acting insulin. (Id.) Dr. Debra Hall, a board-certified, internal-medicine, small-animal specialist veterinarian, took over the case and prescribed Vestulin-a, a long acting insulin. (Id.) Dr. John Lucy performed an ultrasound, which found that the pancreas was unremarkable but that the liver showed signs of diabetes. (Id.) The dog was later discharged on insulin therapy. (Id.)

On July 5, 2018, Plaintiff brought Olive to Dr. Michael Brown, a consulting ophthalmologist at Oradell Animal Hospital.[2] (Pa148-149) Dr. Brown advised Plaintiff that the dog had cataracts and reduced tear film in both eyes. (Id.) She was given eye drops and advised that the cataracts could be removed if they matured. (Id.)

In December 2018, Dr. Brown examined the dog again and found the cataracts had matured and recommended pre-surgical testing, which Plaintiff had done by Dr. Brad Holmberg at the Animal Eye Center of New Jersey.

[2] Dr. Michael Brown is veterinary specialist in ophthalmology who is not an employee of Oradell Animal Hospital but sees patients at the facility as well as other facilities.

(Pa150-151) His ultrasound determined that Olive had congenitally narrow drains in both eyes, putting her at increased risk for glaucoma. (Id.)

On January 18, 2019, Olive was brought emergently to Oradell Animal Hospital where she was diagnosed and treated for pancreatitis. (Pa152-163) She was initially seen and discharged but, because she continued to struggle, she returned the following day and was admitted for several days for supportive treatment. (Id.) Dr. Lucy recommended that Plaintiff should work to achieve better control of the dog's diabetes and her glucose levels before undergoing cataract surgery. (Pa163-164) Dr. Amanda Rogers of Complete Animal Care in Ohio cleared Olive for cataract surgery despite a blood glucose of 681 (normal range 63-114) and triglycerides of 843 (normal range 20-150).

On May 2, 2019, Dr. Holmberg performed the cataract surgery at the Animal Eye Center. (Pa239-240) In a May 15, 2019 referral letter, Dr. Holmberg set forth his findings of the dog's post-surgery condition and noted that Olive's intraocular pressures were 18 mm Hg in the right eye and 20 mm Hg in the left eye. (Id.) Thereafter, Olive continued to have persistent surgical uveitis (inflammation inside of the eye). Dr. Holmberg noted that the left eye pressure was at the high end of normal and suspected that topical steroids were affecting her diabetes, and he therefore altered the topical therapy to try and reduce the systemic affects. (Pa239-240) By May 17, 2019 the intraocular pressures had

lowered to 9 mm Hg in the right eye and 19 mm Hg in the left. Dr. Holmberg noted that he was more concerned with her systemic health and wondered if the oral medication may be causing nausea. (Pa241-242) Therefore, he stopped the oral medication and opted to treat her topically. (Id.)

At a visit to Animal Eye Center on May 20, 2019, Olive's right eye pressure was 13 mm Hg and the left eye pressure was 21 mm Hg. (Pa243-244) Dr. Holmberg believed that the dog's medical condition, including lack of appetite and diarrhea, were associated with her preexisting diabetes or pancreatitis. (Id.) He noted that her left eye pressure remained at the high end of normal despite glaucoma therapy and that her underlying conditions of pancreatitis and diabetes may be a factor in her feeling unwell. (Id.)

Later that night, Olive was brought by a pet sitter to Oradell's Emergency Room as she had not been doing well since the cataract surgery. (Pa209-237) She was admitted and seen by Dr. Lucy and, over the next few days, Olive's eye pressures increased. (Id.) On May 23, Olive was seen by Dr. Brown at Oradell and he adjusted her medications. (Pa214-215) Dr. Brown consulted with Dr. Holmberg on May 24 to discuss the findings of his previous examinations. (Id.) Dr. Brown diagnosed Olive with glaucoma in both eyes and started therapy which included centesis, a procedure to remove fluid to reduce intraocular pressure for patients with acute glaucoma. (Id.) Dr. Brown also prescribed

topical and intravenous therapy. (Id.) Dr. Brown recommended that Dr. Holmberg check Olive on May 24, 2019, but she did not return to the eye center. (Id.)

Olive was kept overnight at Oradell and transferred the next day to Animal Eye Center. (Pa212) On May 25, 2019, Dr. Holmberg performed emergency glaucoma surgery, which included laser therapy for glaucoma and a placement of an anterior chamber shunt to increase Olive's congenitally narrow eye drains. (Pa284-286) Olive's eye pressures then returned to normal. (Pa287)

At a follow up visit on May 28, 2019, Dr. Holmberg identified a superficial corneal ulcer in the animal's left eye. (Pa288) The pressure in both eyes were low, with the right eye at 6 mm Hg and the left eye at 8 mm Hg. (Id.) Olive returned to the Animal Eye Center on June 7, 2019, at which time Olive was improving slowly. (Pa252-253)

On June 14, 2019, the dog's left eye was doing well, as it had normal pressure and the ulcer was healing. (Pa254-255) However, the right eye presented with a superficial corneal ulcer, which was debrided. (Id.) In the week of June 24, 2019, a different provider at another facility that was treating Olive began oral steroids to treat Addison's disease, although previous testing had been negative for that condition. (Pa290)

On July 2, 2019, both eyes were stable with no corneal ulceration or

inflammation. (Pa257-258) On July 10, 2019, Olive presented to the Animal Medical Center ("AMC") in New York City to determine if she had Addison's or Cushing's disease. (Da17-21) Olive had been taking Prednisone for the past three weeks. (Id.) Dr. Jennifer Slovak recommended that the Prednisone be tapered to gain better control of her diabetes, which would also be better for Olive's heart. (Id.) They also discussed placing a Libre Freestyle Continuous Glucose monitor in place of the Alpha Track Glucose monitoring. (Id.)

In July 2019, Dr. Holmberg saw Olive, who was still doing well and who had no active inflammation and low eye pressures. (Pa259-260) By August 6, 2019, Olive had developed a large corneal superficial ulcer. Dr. Holmberg debrided the edges and placed grid keratotomy to help with healing. (Pa261-263)

On August 8, 2019, Plaintiff traveled with Olive to Italy and in the following days she contacted Dr. Holmberg via video conferencing, who determined that the previously placed shunt to treat the dog's congenitally small eye drains had extruded, and instructed Plaintiff on its removal. (Pa262) Upon Plaintiff's return to the United States, Plaintiff took Olive to AMC to be treated for pain, dehydration and high glucose. (Pa262) AMC's emergency staff recommended enucleating—that is, the surgical removal—of the dog's left eye. (Pa262)

Plaintiff eventually sought treatment at Veterinary Eye Specialist in Thornwood, New York. (Pa269) On August 12, 2019, Olive was seen at Veterinary Eye Specialists by Dr. Corey Schmidt, who determined that Olive's eye pressures were high but returned to normal with glaucoma medication and that her left eye ulcer was infected. (Id.) A stronger medication was prescribed in an attempt to save the eye. (Id.)

On August 16, 2019, Olive's left eye was removed after it ruptured as a result of the infection; pathology showed that the eye had a severe bacterial infection and corneal perforation. (See, Pa292) On September 3, 2019 Olive was seen at Tribeca Wellness, who found a significant amount of bacteria in her stool. (Pa293) On September 5, 2019, Plaintiff took the dog to Blue Pearl where she was admitted with a two day history of lethargy, lack of appetite and diarrhea. (Pa293) She was diagnosed with severe pancreatitis, gastritis, severe duodenitis, chronic nephropathy, uncontrolled diabetic, and heart murmur. (Pa305-310) Euthanasia was recommended and, on September 7, 2019, Olive was euthanized. (Pa304)

A necropsy was performed and showed that Olive died of severe pancreatitis and arteriosclerosis. (Pa293-294)

On March 10, 2021, Plaintiff filed her *pro se* professional negligence complaint against Oradell, Eye Center of New Jersey, and Drs. Hall, Lucy and

Holmberg. (Pa1-7) The matter proceeded to discovery. In her answers to interrogatories, Plaintiff discussed claims of economic and emotional distress damages she supposedly suffered, leading to the Defendants to file a motion to, *inter alia*, dismiss Plaintiff's emotional distress damages claim, as they are not cognizable as for bystander liability in a negligence claim alleging harm to a pet. (Pa80-99) On February 6, 2023, Judge Del Sardo filed his order grating the motion to dismiss Plaintiff's emotional distress claims. (Pa41-42; 43-52)

After obtaining counsel, Plaintiff sought reconsideration of that order and argued that the emotional distress damages were based on a direct theory and that the Defendants breached a duty owed to her. (3T20:18-35:11) Her argument was premised on the claim that Olive was misdiagnosed with diabetes and that, therefore, the daily insulin injections by Plaintiff were harming the dog. (3T21:20-22:9) However, that argument had not been made in opposition to the original motion, and her claim for a direct duty was never supported by any expert veterinary medical opinion. (Cf. Pa1-7; Pa128-137)

Plaintiff presented the expert opinion of Dr. Bart Sutherland in support of her claims. (Pa128-139) However, unlike Drs. Hall and Lucy, Dr. Sutherland did not specialize and was not certified in small-animal internal veterinary medicine. (Da12-14) Drs. Hall and Lucy are not only doctors of veterinary medicine, but also board-certified specialists in small-animal internal medicine

by the American College of Veterinary Internal Medicine. (Da5-11)

This required them to each complete an internship and a residency and, thereafter, pass an examination. (Id.) The Board Certification identifies each as being a Diplomat of the American College of Veterinary Internal Medicine (Small Animal Internal Medicine). (Id.) Both Dr. Lucy and Dr. Hall are in a clinical practice entirely devoted to the care of animals within that specialty. (Id.)

By contrast, Dr. Sutherland, while a doctor of veterinary medicine, has little to no experience in small-animal practice, nor any experience in treating the medical problems at issue here. (Da12-14) Further, he is not board certified in small-animal internal medicine, nor any other specialty recognized by the American Board of Veterinary Specialties, a committee of the American Veterinary Medical Association. (Id.) In the year immediately preceding the date of the occurrences of the alleged malpractice, Dr. Sutherland was not in clinical practice as a small-animal internal-medicine veterinarian, nor was he involved in teaching students in the field of small-animal internal medicine. (Id.)

At the time of the decision, Dr. Sutherland was an "experienced veterinary consultant." (Da13-14) From 2010 to 2018 Dr. Sutherland worked for the United States Department of Agriculture as a Veterinary Medical Officer-USDA/Animal Plant Health Inspector/Horse Protection Program & Animal

Care, and prior to that, in private practice. (Id.) In his CV, he listed a number of activities associated with that practice, none of which involved small-animal internal-medical care. (Id.) Finally, Dr. Sutherland has never published and on any subject related to small-animal internal-medical care. (Id.)

In his report, Dr. Sutherland summarizes his background, noting that he worked at a number of animal clinics between 1994 and 1996 when he opened his own practice. (Pa128) These practices were, at the time, treating both small and large animals such as cows and horses. (Id.)

Moreover, Dr. Sutherland's April 17, 2023 report was a net opinion, as it failed to detail the applicable standard of care, how that standard was allegedly breached, and a causal connection between that alleged breach and the claimed damages. (Pa128-137)

On November 4, 2024, the Hon. Bruno Mongiardo, J.S.C., issued his order barring Dr. Sutherland from testifying. (Pa31-32) Judge Mongiardo provided two independent bases for barring Dr. Sutherland's testimony. (5T5:9-25:19) First, he found that Dr. Sutherland was not qualified to offer an opinion against Drs. Hall and Lucy in light of their certification and specialization which Dr. Sutherland did not share. (5T8:15-20:18) Second, he found that the opinion was a net opinion and therefore inadmissible. (5T20:19-25:10)

Under either reasoning, Dr. Sutherland's opinion be presented to the jury

and was therefore barred. (Pa31-32) Because that decision precluded plaintiff professional negligence in this case, as it is not a common-knowledge case, defendants then moved for summary judgment, which was granted. (Pa30)

This appeal followed. (Pa53-58)

Legal Argument

POINT I: STANDARDS FOR APPELLATE REVIEW.

The standard for the appellate review of an order deciding a motion for summary judgment is plenary, and this court applies the same standard as the trial court. See Ben Elazar v. Macrietta Cleaners, Inc., 230 N.J. 123, 135-36 (2017); Turner v. Wong, 363 N.J. Super. 186, 199 (App. Div. 2003) (holding that the standard of review on appeal is de novo.)

Pursuant to Rule 4:46-2(c), summary judgment shall be granted when "the pleadings, depositions, answers to interrogatories and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact challenged and that the moving party is entitled to a judgment or order as a matter of law." R. 4:46-2(c). Our Supreme Court has encouraged trial courts to use summary judgment to "eliminate from crowded court calendars cases in which a trial would serve no useful purpose" and has advised courts "not to refrain from granting summary judgment when the proper circumstances present themselves," Brill v. Guardian Life Ins. Co. of Am., 142 N.J. 520, 541

(1995).

In Brill, the Supreme Court re-examined the standard for summary judgment and adopted the approach used by the United States Supreme Court in Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986), among others. Under that standard, trial courts are to determine "whether the evidence presents a sufficient disagreement to require a submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." Brill, 142 N.J. at 533 (citations omitted). The court is to consider whether the competent evidence presented, when viewed in the light most favorable to the non-moving party, is sufficient to permit a rational fact-finder to resolve the alleged disputed issue in favor of the non-moving party. Id. at 540.

For a dispute to constitute a genuine issue of material fact, it must be "genuine" as well as "substantial"; it must be "true, solid [or] real," rather than "imaginary, unreal, or apparent only." Id., at 529. "[I]f the opposing party offers... only facts which are immaterial or of an insubstantial nature, a mere scintilla, fanciful, frivolous, gauzy or merely suspicious," summary judgment should be granted. Ibid. (quotation omitted). Accordingly, summary judgment "is designed to provide a prompt, businesslike, and inexpensive method of disposing of cases not warranting a trial. Id., at 530 (quoting Ledley v. William Penn Life Ins. Co., 138 N.J. 627, 641-42 (1995)).

In opposition to a motion for summary judgment, the non-moving party "must do more than simply show that there is some metaphysical doubt as to the material facts." Triffin v. American Int'l Group, Inc., 372 N.J. Super. 517, 523-24 (App. Div. 2004) (citations omitted). Even in cases where the evidence is "likely to be within the possession of the defendant, the plaintiff is still required to present affirmative evidence in order to defeat a properly supported motion for summary judgment." Anderson, 477 U.S. at 257.

Furthermore, the admission or preclusion of an expert is a matter left to the discretion of the trial judge. Review of that determination on appeal proceeds under an abuse of discretion standard. Pomerantz Paper Corp. v. New Cmty. Corp., 207 N.J. 344, 371–72 (2011).

In this case, because Judge Mongiardo barred Plaintiff's expert, Plaintiff did not have expert testimony on the issues of deviation from the accepted standard of veterinary care or proximate cause as against the Oradell Defendants. Without expert testimony on these subjects, Plaintiff could not prove a prima facie case of negligence against the Oradell Defendants as a matter of law and the dismissal of the complaint against them was proper and should be affirmed.

POINT I: THE TRIAL COURT'S DECISION FINDING PLAINTIFF'S EXPERT TO BE UNQUALIFIED IS NOT ERROR.

Plaintiff first argues that Judge Mongiardo committed reversible error when he found that Bart Sutherland, DVM was unqualified to offer an opinion on the standard of care of Drs. Hall and Lucy.

Plaintiffs asserting claims for professional negligence have the burden of demonstrating a deviation from the appropriate standard of care, generally through expert testimony, and that the departure from the standard of care was causally connected with the alleged injuries. Verdicchio v. Ricca, 179 N.J. 1, 23 (2004); Vizzoni v. B.M.D., 459 N.J. Super. 554, 568 (App. Div. 2019); Butler v. Acme Mkts., Inc., 89 N.J. 270, 283 (1982). Except in rare circumstances not applicable here[3], proof of the deviation from the appropriate standard of care and of causation requires expert testimony, as it "would otherwise lie beyond the competence of a technically unschooled jury." Lanzet v. Greenberg, 243 N.J. Super. 218, 224 (App. Div. 1990), rev'd on other grounds, 126 N.J. 168 (1991).

New Jersey Rules of Evidence 702 recognizes, that when "scientific, technical or other specialized knowledge will assist the trier of fact to understand

[3] Such as a common knowledge case in which the jurors' common knowledge permits them to determine a defendant's negligence using ordinary understanding and experience and without the benefit of an expert. Hubbard v. Reed, 168 N.J. 387, 394 (2001) That doctrine does not apply here.

the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise." N.J.R.E. 702.

The three requirements for the admission of expert testimony are that (1) the testimony must concern a subject that is beyond the ken of the average juror; (2) the subject matter must be at such state of the art that such expert's testimony could be sufficiently reliable; and (3) the witness must have proficient expertise to offer the intended testimony. Dehanes v. Rothman, 158 N.J. 90 (1999).

In his decision, Judge Mongiardo concluded that Dr. Sutherland was not qualified to provide an expert opinion as to the care and treatment of Keim's dog, because Drs. Hall and Lucy are not only doctors of veterinary medicine, but also board-certified specialists in small-animal internal medicine. There was no error in this conclusion.

Based on the fact that Drs. Hall and Lucy are board-certified specialists and Dr. Sutherland has neither the credentials nor the experience applicable to opine on the condition and treatment of Olive in this case, Judge Mongiardo drew an analogy to the same-specialty requirements of N.J.S.A. 2A:53A-41 used in medical cases. He analogized that statute as it applies in medical negligence claims, to the veterinary-medicine claim presented in this case, to determine if Dr. Sutherland was an appropriately qualified expert who could provide

testimony to establish the requisite proofs.

Under N.J.R.E. 201, a trial judge may take judicial notice of " specific facts and propositions of generalized knowledge which are capable of immediate determination by resort to sources whose accuracy cannot reasonably be questioned…" N.J.R.E. 201(a). Thus, Judge Mongiardo properly took judicial notice of the fact that the American Veterinary Medical Association ("AVMA") is an organization similar to the American Medical Association and maintains a board of veterinary specialties, recognizing the varied veterinary medical specialties.

The stated purpose of these organizations is:

> The American Board of Veterinary Specialties (ABVS) of the AVMA recognizes and encourages the development of recognized veterinary specialty organizations (RVSOs) promoting advanced levels of competency in well-defined areas of study or practice categories to provide the public with exceptional veterinary service. [4]

As the American Veterinary Medical Association website indicates, currently, there are twenty-two AVMA-recognized veterinary specialty organizations representing forty-six distinct specialties such as behavior, ophthalmology, internal medicine, surgery, dentistry and, as is relevant to this

[4] AVMA, https://www.avma.org/education/veterinary-specialties (last visited: Aug. 27, 2025)

matter, small animal internal medicine. Like their counterparts in the American Medical Association, a board-certified veterinary specialist is a veterinarian who has completed additional training, generally through a residency program, in a specific area of veterinary medicine and has then passed an examination that evaluates their knowledge and skills in that area of specialty.

Dr. Lucy and Dr. Hall are doctors of veterinary medicine and further are board certified specialists in small animal internal medicine

Therefore, considering the provisions of N.J.S.A. 2A:53A-27 and N.J.S.A. 2A:53A-41 by analogy, Judge Mongiardo properly determined that Dr. Sutherland was not properly qualified to offer an opinion against Drs. Hall and Lucy, in light of their specialization in small-animal internal medicine.

Accordingly, Dr. Sutherland was not qualified to offer expert testimony on the subject the standard of care for a veterinarian who is a board certified specialist in small animal internal medicine, such as Drs. Lucy and Hall, and was not qualified to opine as to any deviation from the accepted standards of care applicable to Drs. Lucy and Hall. Further, Dr. Sutherland was not qualified to opine that the care rendered to Olive by defendant caused her any injury because he is not board certified in small animal ophthalmology nor does his report or CV demonstrate any expertize in this specialized field of veterinary medicine.

Consequently, Dr. Sutherland was properly barred and this decision by Judge Mongiardo should be affirmed.

POINT II: THE TRIAL COURT'S DETERMINATION THAT THE EXPERT'S OPINION WAS AN INADMISSIBLE NET OPINION IS NOT ERROR.

However, even if this Court should find that Judge Mongiardo erred by finding that Dr. Sutherland was not qualified to offer an expert opinion, the order barring Dr. Sutherland should be affirmed under the second reason given by Judge Mongiardo. In addition to finding that Dr. Sutherland was not qualified to offer an opinion in this matter, Judge Mongiardo also determined that Dr. Sutherland offered a net opinion and therefore properly excluded it. Given that a jury would not be capable, based on its own knowledge, of determining the appropriate veterinary standard of care and whether either Defendant breached that standard, because Dr. Sutherland is an improper net opinion, once it was properly barred, summary judgment was warranted.

"The admission or exclusion of expert testimony is committed to the sound discretion of the trial court." Townsend v. Pierre, 221 N.J. 36, 52 (2015). Well-established New Jersey law holds that an expert witness may not provide a "net opinion." Pomerantz, 207 N.J. at 372. The "Net Opinion Rule is a 'corollary of [N.J.R.E. 703] … which forbids the admission into evidence of an expert's conclusions that are not supported by factual evidence or other data.'"

Townsend, 221 N.J. at 54 (quoting Polzo v. Cty. of Essex, 196 N.J. 569, 583 (2008)). See, also, Davis v. Brickman Landscaping, Ltd., 219 N.J. 395, 401, 410 (2014) (when expert's opinion is not founded on objective support and represents expert's personal views, it is an inadmissible net opinion.)

The Rule requires an expert to '"give the why and wherefore' that supports the opinion, 'rather than a mere conclusion."' Townsend, 221 N.J. at 54 (quoting Borough of Saddle River v. 66 E. Allendale, LLC, 216 N.J. 115, 144 (2013)). "A party's burden of proof on an element of a claim may not be satisfied by an expert opinion that is unsupported by the factual record or by an expert's speculation that contradicts that record." Id., at 55.

The rule "mandates that experts be able to identify the factual bases for their conclusions, explain their methodology, and demonstrate that both the factual bases and the methodology are reliable." Matter of P.D., 243 N.J. 553, 572 (2020)(internal citation omitted.) See, also, Townsend, 221 N.J. at 55. '"[O]pinion testimony 'must relate to generally accepted… standards, not merely standards personal to the witness.'" Taylor v. DeLosso, 319 N.J. Super. 174, 180 (App. Div. 1999) (quoting Fernandez v. Brauch, 52 N.J. 127, 131 (1968)). That is, the opinion must demonstrate the standard of care in the industry as a whole and not merely the witnesses personal preference. Satec, Inc. v. Hanover Ins. Grp., Inc., 450 N.J. Super. 319, 332 (App. Div. 2017) (expert

opinion must be based on industry standards or practice.)

Further, a proper, non-net opinion would be informed by the facts of the case. "Expert opinion is valueless unless it is rested upon the facts which are admitted or are proved." Stanley Co. of Am. v. Hercules Powder Co., 16 N.J. 295, 305 (1954). See, also, C.W. v. Cooper Health Sys., 388 N.J. Super. 42, 64-65 (App. Div. 2006) (finding impermissible net opinion where expert failed to explain why his announced standard of care was the "accepted practice.")

Judge Mongiardo did not commit an abuse of discretion in barring Dr. Sutherland's opinion. Dr. Sutherland's April 17, 2023 report purports to criticize the care rendered by Dr. Lucy and Dr. Hall. He first reviewed the veterinary records in the case and then, in a section entitled "Conclusions," described matters he characterized as "concern[s]" regarding the initial diagnosis and treatment of the dog's diabetes. Specifically, his "concern" centers on the formulation of a treatment plan "in the absence of a CBC, chemistry and further diagnostics" and the fact that three of four glucose checks were made prior to establishing a treatment plan. (Pb136)

However, nowhere does Dr. Sutherland identify the standard of care applicable to Drs. Lucy and Hall, nor what that standard requires in their formulation of the treatment plan. Further, he does not identify the basis for his "concern" over the lack of a CBC, chemistry and further diagnostic, and whether

the standard of care requires those things or whether it is his own personal belief. Additionally, he makes no attempt to causally relate the "concern" to the damages alleged in this case.

He does note that "most of the literature" he reviewed "state anywhere from 6 to 12 or possibly 24 glucose checks after being given insulin initially over a 12-24 hour period of time prior to establishing a treatment plan." (Pa136) However, Sutherland does not demonstrate that these "6 or 12 or possibly 24 glucose checks" is an applicable standard of care, rather than being merely a suggestion, preference, or one of many acceptable options.

Additionally, he fails to causally link these issues with the damages alleged. He first asserts that the problem is the "up and down onslaught waves of the blood glucose" and then Sutherland states, "I tend to think had this problem been solved first, the issues that I discuss below would probably not have occurred." (Id.) However, Sutherland failed to demonstrate that the "up and down onslaught wave" was a product of the failure of either Dr. Lucy or Dr. Hall to abide by the applicable standard of care. Further, neither "tend to think" nor "would probably not have occurred" is the applicable standard required of an expert when expressing the required causal link.

Next, in his report, in a section entitled "Medical Opinions," in the subsection addressing "concerns" related to Oradell, Sutherland discusses the

presentation of the dog on May 20-22, 2019, and noted two conversations, one between Plaintiff and Dr. Erica Swanke of Oradell Animal Hospital, and the other between Plaintiff's friend[5] and Dr. Lucy. In both conversations "concerns" regarding the dog's recent surgery and intraocular pressure were allegedly raised. (Pa137) He further notes that on May 21 and 22, the intraocular pressure was noted as being elevated, but that no action was taken regarding the intraocular pressure until May 23, 2019. (Id.) He further states, in summary fashion, that this "caused irreversible damage" to the dog's eyes, "directly affected the well-being and health" of the animal, and was a "failure of the standard of veterinary care." (Id.)

However, nowhere in the report does Dr. Sutherland detail or demonstrate the "whys and wherefores" concerning the standard of care concerning the alleged breach and concerning causation. He notes that "concerns" about the intraocular pressure were allegedly raised in the two conversations, one involving Plaintiff and the other involving her friend, but he does not detail whether such conversations alter or affect the standard of care, and, if it does, how it changes the steps a veterinarian is obligated to take in response.

The report notes that the dog had a left eye pressure of 29 mm Hg on May

[5] The friend, Amanda Rogers, is also a veterinarian in Ohio who cleared the dog for her cataract surgery.

21, 2019 and 30 mm Hg on May 22, 2019, and a right eye pressure of 21 mm Hg on May 21, 2019 and 20 mm Hg on May 22, 2019. (Pa133) In his report, he also claims that "the normal intraocular pressure for a canine is about 10-25mm Hg" and citing an article on the veterinary website "DVM360." (Pa129)[6] Thus, on both days, the right eye pressure was in the normal range and the left eye pressure was elevated. However, Dr. Sutherland does not define the standard of care, does not detail what the standard of care requires when the left eye intraocular pressure exceeds the normal range by 4-5 mm Hg, given the specifics of all of this dog's medical conditions and various diagnoses. He did not detail what pressure intervention was required, what that intervention would entail, nor why continued monitoring in that situation is not an acceptable practice.

Finally, he stated, in conclusory fashion, that the supposed delay in treatment caused "irreversible damage" to the dog, that the supposed failures to treat the increased eye pressure "directly affected" the dog and that it "would have had a much better response to treatment" had treatment begun on May 21, 2019. However, nowhere in his report does Dr. Sutherland substantiate these

[6] In fact, the article actually states that that is the normal range for "dogs and cats" but also cautions that "the normal IOP range will vary according to the instrument and technique used, the examiner, the degree of restraint, any surface disease, and the time of day." (https://www.dvm360.com/view/6-eye-errors-you-re-probably-overlooking (last visited July 30, 2025)) Sutherland did not address any of those caveats in his report, nor analyze whether and to what extent they played a part in the readings on May 21 and 22, 2019.

statements. He does not demonstrate how this earlier care would have improved the dog's outcome, what treatment would have been required by the standard of care, and he failed to adequately link this supposed failure to any injury to the animal.

Thus, Dr. Sutherland's opinion was a net opinion and was properly barred by Judge Mongiardo. (5T24:23-25:10) There was no error in this conclusion nor an abuse of discretion. Further, the law holds that a cause of action must be dismissed when a party is required to provide an expert's opinion, but only provides a net opinion. Townsend, 221 N.J. at 43.

As such, the dismissal of Plaintiff's complaint should be affirmed.

POINT III: PLAINTIFF IS NOT ENTITLED TO RECOVER EMOTIONAL DISTRESS DAMAGES FOR THE LOSS OF A PET

Finally, Plaintiff argues that if this matter is remanded, that she be permitted to assert emotional distress damages. In her brief, Plaintiff assets that Judge Del Sardo erred by citing to McDougall v. Lamm, 211 N.J. 203 (2012) for the proposition that emotional distress damages are not recoverable for the death of a pet. Rather, Plaintiffs' argue, the unpublished decision in Quesada v. Compassion First Pet Hosps., A-1226-19, 2021 WL 1235136 (N.J. Super. Ct. App. Div. Apr. 1, 2021) should apply. There is no merit to this argument.

First, Quesada is an unpublished, and therefore non-binding, decision. R.

1:36-3 ("No unpublished decision shall constitute precedent or be binding upon any court.")

Further, in McDougall, the Supreme Court held that compensatory damages for the loss of a pet are limited to the value of the lost pet. McDougall, 211 N.J. at 227. A plaintiff cannot recover emotional damages for the loss of a pet because a pet is considered chattel. Id., at 223-225. The McDougall Court recognized that a pet may carry more sentimental value than an inanimate object, but held that public policy precludes permitting a plaintiff to recover more than the replacement value of the pet. Id., at 210.

In this case, Plaintiff's complaint sought economic and emotional damages as a result of Defendants' alleged negligence in the care and treatment of plaintiff's pet. In her answers to interrogatories, Plaintiff asserted that she suffered panic, trauma, stress, and mental and emotional damage from May 2019 forward, supposedly as consequence of that alleged negligence. Judge Del Sardo properly analyzed Plaintiff's claims and held that Plaintiff cannot recover emotional damages.

In her brief in this Court, Plaintiff argued that Quesada applies and that she can assert a valid "direct" claim against Defendants. Her primary argument on appeal in this Court is that Judge Del Sardo's determination was made before Plaintiff's deposition was taken, and before she was able to "establish the

elements of a direct claim of negligent infliction of emotional distress" which she describes as including the animal's diagnosis of diabetes, how she was "left" to inject insulin in the dog "without adequate instruction", her difficulty in stabilizing the dog's blood sugar levels, the conversations she had about these problems, and the question of whether the dog in fact had diabetes or some other condition. (Pb47)

However, nothing precluded Plaintiff from submitting a certification detailing these issues in response to the motion to dismiss the claim for emotional distress damages. Nor was Plaintiff precluded from filing a motion for reconsideration to reinstate the claim after her deposition was taken and the expert discovery was completed, if those facts supported a claim under Quesada as she believes.

It should be noted that Plaintiff filed a reconsideration motion after she obtained counsel. The motion was premised on the argument that Plaintiff suffered distress because the dog was not actually a diabetic but was misdiagnosed with the condition, and the insulin injections given by Plaintiff harmed the dog and ultimately led the dog's eye to burst or explode. (3T21:20-22:9)

However, this argument does not demonstrate that the dismissal of this claim was reversible error, as there is simply no medical expert opinion

whatsoever substantiating the allegations that the dog was misdiagnosed, that there was any breach of the standard of care in the manner Plaintiff was instructed to inject the animal with insulin, that the difficulty in stabilizing the dog's blood sugar level was the result of any negligence by the Defendants, or that the dog, in fact, had some other condition such that Plaintiff's insulin injections were perpetrating harm.

Even in the absence of a negligent infliction of emotional distress claims, those allegations—had they been true and supported by veterinary science—would have been relevant to Plaintiff's malpractice claims. Consequently, the fact that Dr. Sutherland does not assert any claim based on an alleged misdiagnosis of the diabetes, inadequate instruction regarding the insulin injection, or any of the other matters upon which Plaintiff bases this claim is telling. Had any of them been supportable based on the veterinary records and the facts of the case, they could have—and no doubt would have—been cited by Dr. Sutherland as a basis for his opinion alleging malpractice.

The fact that Dr. Sutherland does not mention them means that Plaintiff's citation to Quesada is unavailing, as there was no factual basis for the kind of "direct duty" case in Quesada to be cognizable here.

As such, this Court should affirm Judge Del Sardo's determination.

Conclusion

For all the foregoing reasons, Oradell Animal Hospital, Deborah Hall, and John Lucy ask this court to affirm the trial court orders, and the grant of summary judgment.

Respectfully Submitted,
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SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A—001934-24

KATHERINE KEIM	:	CIVIL ACTION
Plaintiff-Appellant	:	ON APPEAL FROM A FINAL JUDGMENT OF THE SUPERIOR
v.	:	COURT LAW DIVISION PASSAIC COUNTY
BRAD HOLMBERG, *et al.*	:	
		SAT BELOW:
Defendants-Appellees	:	HON BRUNO MONGIARDO, J.S.C.

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LEGAL ARGUMENT

I. IT WAS AN ABUSE OF DISCRETION EITHER TO APPLY OR ANALOGIZE TO THE PATIENT FIRST ACT TO DISQUALIFY PLAINTIF'S EXPERT WITNESS, A LICENSED VETERINARIAN WITH OVER 20 YEARS OF EXPERIENCE, IN A VETERINARY MALPRACTICE CASE

Because the Patient First Act (PFA), *N.J.S.A.* 2A:53A-41 by its very terms only applies to physicians in medical malpractice actions, the trial court abused its discretion by grounding its decision to disqualify plaintiff's veterinary medicine expert as in this veterinary malpractice case. This court should reverse.

While the admission of expert testimony is commited to the sound discretion of the trial court, it is equally true that "our trial courts take a liberal approach when assessing a person's qualifications." *State v. Jenewicz*, 193 N.J. 440, 454 (2008). As the Court in *Jenewicz* noted, "[o]ur case law is replete with examples of the generous appproach taken by our courts when qualifying experts based on training and experience," citing, as an example, *State v. Krivacksa*, 341 N.J. Super. 1 (App. Div. 2001) in which this court affirmed the admission of psychologist's opinion regarding a mentally handicapped individual despite the fact the expert did not specialize in the evaluation of mentally handicapped patients and had no experience with the victim's specific cognitive impairment. 193 N.J. at 454 *See also Rodriguez v. Wal-Mart Stores, Inc.* 237 N.J. 36, 68 (2019) (reversing a determination that a neurologist was not qualified to offer an opinion about a

patient's somatic disorder and symptom magnification because he was not a pyschiatrist, psychologist or other mental-health specialist noting the "significant overlap between the fields of neurology and psychiatry" as well as the fact that the disorders at issue "are commonly encountered in primary care and other medical settings.")

As the Court in *Jenewicz* explained:

> [C]ourts allow the thinness and other vulnerabilities in an expert's background to be explored in cross-examination and avoid using such weaknesses as a reason to exclude a party's choice of expert witness to advance a claim or defense. That the strength of an individual's qualifications may be undermined through cross-examination is not a sound basis for precluding an expert from testifying as part of a defendant's defense, even if it will likely affect the weight that the jury will give the opinion. Rather, a court should simply be satisfied that the expert has a basis in knowledge, skill, education, training, or experience to be able to form an opinion that can aid the jury on a subject that is beyond it ken.

193 N.J. at 455 (citation omitted). *See also Rodriguez, supra* 237 N.J. at 68 (qualifying an expert based on training and experience is subject to a generous approach "primarily because the jury is 'to determine the credibility, weight and probative value of the expert's testimony.'" (*quoting Lanzet v, Greenberg*, 126 N.J. 168 (1991)); *Rosenberg v. Tavorath*, 352 N.J. Super. 385, 400-01 (App. Div. 2002) ("[a]ny perceived deficiencies in [an expert's] qualifications should . . . be[] left to the consideration of a jury 'to determine the credibility, weight and probative value

of the expert's testimony.'" (*quoting James v. City of East Orange*, 246 N.J. Super. 554 (App. Div. 1991)).

The PFA, however, represents an explicit and deliberate yet sharply circumscribed limitation to this liberal approach toward the qualification of expert witnesses. In enacting the PFA, the legislature—addressing what it perceived as a crisis involving medical malpractice cases—expressly confined the trial courts' discretion in qualifying expert witnesses in cases involving *physicians only*. *See Meehan v. Antonellis*, 226 N.J. 216, 233-34 (2016) ("[t]he plain language of section 41 states that the like-qualified standards [for testifying experts] apply only to phyicians. And it does so repeatedly . . . In sum, we conclude that the plain language of sections 27 [relating to Affidavits of Merit] and 41 lead to the inexorable conclusion that the enhanced credential requirements established under section 41 . . . apply only to physicians in medical malpractice actions.") There was thus no basis for the trial court "analogize" to, let alone apply, the PFA in assessing the qualifications of plaintiff's veterinary expert in a veterinary malpractice case. Rather, the ordinary "liberal" approach in qualifying Dr. Sutherland as an expert was warranted leaving to the jury the determination of the weight to be accorded to his opinion based upon its assessment of his qualifications.

There is no dispute that Dr. Sutherland is a licensed veterinarian who, at the time of the occurences forming the basis of the claim in this case had been in practice for nearly 30 years and was "an actively practicing veterinarian, providing medical, surgical, and dental care for small, large, and exotic animals." (Pa138). The fact that he is not board-certified in veterinary internal medicine as are the defendants goes not to the admissibility of his opinions but rather the weight a jury might afford them given his qualifications. *See Carbone v.* Warburton, 11 N.J. 418, 426 (1953) (deficiencies in an expert's qualificatioons "go to the weight to be given to his opinion and not to his competency to testify." Where the expert demonstrates sufficient qualifications to offer an opinion, it is left "to the jury the determination of its worth."); *Espinal v. Arias*, 391 N.J. Super. 49 (App. Div. 2007) ('"[d]eficiencies in the qualification of an expert is a matter to be weighed by the jury.' An 'expert's skill or knowledge go to the weight to be accorded the expert testimony.'" (*quoting Waldorf v. Shuta*, 142 F.3d 601 (3rd Cir. 1998)).

Here the trial court imposed too high a burden for qualifying plaintiff's expert based on an erroneous analogy to a statute which by its own terms was inapplicable under the circumstances. At trial defendants certainly would be free to cross-examine Dr. Sutherland not just on his opinions but on his qualifications to offer the opinions, leaving it to the jury to weigh those opinions accordingly. It

was error and an abuse of discretion to disqualify Dr. Sutherland by application of or analogy to the PFA and this court should reverse.

II. IT WAS ERROR TO CONCLUDE THAT PLAINTIFF'S EXPERT'S OPINIONS WERE INADMISSIBLE, PARTICULARLY IN THE ABSENCE OF A *RULE* 104 HEARING

In concluding that Dr. Sutherland's report constituted an inadmissible net opinion, the trial judge not only incorrectly assessed Sutherland's qualifications but also misstated and mischaracterized his opinions and the factual bases thereof. When read in its entirety the report lays out, admittedly not in the most polished way, what the standard of care was under the circumstances, how that standard was breached and how that breach caused or substantially contributed to the injuries at issue in this case.

The trial court started off its analysis by incorrectly noting that "Dr. Sutherland . . . has never engaged in the clinical care focused on small animal internal medical care and . . . has not practiced clinical care of any kind since 2010." (5T at T22-2 to 22-5). To the contrary, Dr. Sutherland submitted a Certification in opposition to the motion to bar his testimony in which he averred, under oath, that he was "an actively practicing veterinarian, providing medical, dental, and surgical care for small, large, and exotic animals," having returned to private practice in 2018. (Pa138). Even more significantly, the court incorrectly

labeled Dr. Sutherland's "conclusions" as mere "concerns" without ever analyzing the actual conclusions Dr. Sutherland expressed based upon the facts of the case.

Indeed the court, again pivoting off its conclusion that Dr. Sutherland was not qualified to opine on the standard of care under the PFA, incorrectly stated that "[n]owhere in his report does he define the standard of care to a dog under these circumstances. The doctor does not define, nor is he qualified to do so, the standard of care for a small animal internal medical specialist or for a veterinary ophthalmologist specialist either in general or under these circumstances." (5T at T22-22 to 23-3). Again, this is a distortion of Dr. Sutherland's opinion which is belied by a careful reading of his report.

In his report Dr. Sutherland sets out two specific deviations from the standard of care, *viz.* the decision to go ahead with the cataract surgery without evidence that Olive's glucose was stable and was in fact markedly elevated on the day of surgery, and the failure to address Olive's elevated intraocular pressures over the course of 3 days when she was admitted to OAH and the admitting vets were aware of the issue. In Dr. Sutherland's opinion, the first deviation led to the problems with elevated intraocular pressures while the second led to delay in recognition that the IOPs had become markedly elevated and required intervention which finally occurred 5 days after admission when Holmsberg implanted shunts in both eyes.

As to the decision to do the surgery in the first instance, Dr. Sutherland sets out the standard of care *as expressed by Dr. Holmberg himself* that surgery was not indicated in the face of unstable glucose. Indeed, Holmberg noted that he *would not* perform surgery absent testing demonstrating stable glucose but he did just that. (Pa136).

Similarly, the standard of care was likewise expressed by defendant Dr. Lucy himself that Olive's elevated intraoperative pressures should have been reported to Dr. Holmberg on both the 21st or the 22nd but weren't. Lucy noted a call with Keim on 5/21/19 in which she requested that Olive's IOPs be rechecked. Lucy said he would and that he "would reach out to Dr. Holmberg if the values were inappropriate." (Pa231). The pressure in the left eye had increased from 21 the day before to 29 while the pressure in the right eye had increased from 13 to 21; Holmberg was not informed. The following day, Lucy noted that he planned to recheck the pressures and "contact Dr. Holmberg with an update." (Pa227). The pressure in the left eye had increased from 29 to 30 and the left eye pressure had decreased from 21 to 20; no update was provided to Dr. Holmberg. On the 23rd Lucy noted that prior to discharging Olive that day he would be "rechecking with Dr. Brown . . . to decide if ophthalmic protocol needs to be adjusted given the mildly increased intraocular pressure in the left eye." (Pa222). When Dr. Brown measured the pressure later that day they were found to be markedly elevated with

OD at 33 and OS at 45, necessitating an emergency centesis in the left eye after medication only succeeding in bringing down the left eye pressure to 38. (Pa214).

Lucy was aware that the eye pressures—particularly in the left eye were increasing but never communicated that to the treating phyisician despite his stated intent to do so. And as Dr. Sutherland points out "it appears that it was only happenstance that Dr. Brown noticed Olive's condition [on 5/23/19] and was likely the reason action was taken then." (Pa137). Dr. Sutherland opined that "[t]his lack of action in the treatment by the primary veterinarians Drs. Deborah Hall and John Lucy or Oradell Animal Hospital directly affected the well being and health of Olive . . . [and was] a ***failure of the standard of veterinary care.***" (Pa137) (emphasis in original).

As to causation Dr. Sutherland offered that

> [h]ad Dr. Holmberg not performed the eye surgery until Olive's diabetes was stabilized, Olive would have not likely needed to return to Oradell on 5/20/19 with issues of poor appetite, letharg[y] and diarrhea. Had Drs. Hall and Lucy treated the increased eye pressures for on 5/21/19 in a timely manner, Olive would have had a much better chance of a favorable response to treatment.

Id.

While Dr. Sutherland's report is, admittedly, not a model of precision or refinement, it nevertheless constitutes a fairly exhaustive review of the operative

facts and explains how those facts demonstrate negligence as well as how that negligence led to the outcome.

It is important to note that defendants did not depose Dr. Sutherland nor did the court hold a *Rule* 104 hearing to further flesh out the basis of his opinions before simply declaring them inadmissible. While the decision to conduct a *Rule* 104 hearing is committed to the sound discretion of the trial court, *Kemp v. State*, 174 N.J. 412 (2002),

> in cases in which the scientific reliability of an expert's opinion is challenged and the court's ruling on admissibility may be dispositive of the merits, the sounder practice is to afford the proponent of the expert's opinion an opportunity to prove its admissibility at a Rule 104 hearing.

Id. at 432-33.

In *Kemp*, the defendants challenged the scientific reliability of plaintiff's expert witness that a rubella vaccination administered to a pregnamt woman caused Cogential Rubella Syndrome (CRS) to her unborn fetus who was found to have CRS at birth. The expert produced two reports and was deposed. Central to the attacks on his opinion was the acknowledgement by the witness that there were no prior reported cases of CRS in which the inoculation of a pregnant woman led to a child developing CRS. *Id.* at 423. Defendants moved for summary judgment following the expert's deposition arguing that his opinion was not scientifically

reliable and therefore inadmissible. *Id.* at 417. The trial court entered summary judgment without conducting a *Rule* 104 hearing and this court affirmed saying

> [i]t can be said that [Dr. Huggins] applied no methodology at all in reaching his conclusion. He acknowledges that no study, report, medical journal, treatise, epidemiological or toxicology data, or other recognized authority has demonstrated a correlation between attenuated rubella vaccines and congenital rubella syndrome in a child born with congenital rubella syndrome. His opinion has not been the subject of peer review or adopted by any recognized scientific disciplines. Because he could identify no such data or scientific study, it cannot be said that his opinion is founded on a scientifically tested and accepted methodology recognized by the medical community.

Id.

The Supreme Court reversed primarily on the basis of the failure of the trial court to conduct a *Rule* 104 hearing even though the witness had been deposed noting that

> we are persuaded that the lack of a Rule 104 hearing may adversely have affected plaintiffs' ability to present their expert's testimony in its best light. Because Dr. Huggins' testimony was taken only at defendants' deposition, the trial court did not have the benefit of an orderly and comprehensive presentation of his expert testimony elicited by plaintiffs' counsel. Rather, Dr. Huggins' deposition afforded defense counsel the opportunity to challenge and cast doubt on the reliability of his opinion. We are not satisfied that the record of that deposition fairly reflects the more balanced and complete presentation of his opinion that a Rule 104 hearing would have afforded.

* * * *

> We fully agree with the Third Circuit's observation [that] "[t]he adversarial process upon which our legal system is based assumes that a fact finder will give the parties an adequate opportunity to be heard; if it does not, it cannot find facts reliably. Thus, the detailed factual record requirement, firmly entrenched in our jurisprudence, requires adequate process at the evidentiary stage, particularly when a summary judgment may flow from it."

Id. at 432 (*quoting In re Paoli Railroad Yard PCB Litigation*, 916 F.2d 829 (3rd Cir. 1990).

While not on all fours with *Kemp* procedurally, the concerns which suggested the need for a *Rule* 104 hearing in that case arise here, albeit in a different context. It is important to note that at the time of the motion to bar Dr. Sutherland's opinion, the plaintiff was proceeding *pro se* without the benefit of experienced counsel. That combined with the fact that Dr. Sutherland was never deposed (despite the fact that his report had been produced a year-and-a-half earlier) meant that the legally unsophisticated *pro se* plaintiff never had notice of any claimed deficiencies in his report until the motion to strike was filed. As a result, she never had the chance to cure any such deficiencies which might have been revealed in a deposition. Under the circumstances, the trial court should not have ruled on the report alone without probing more deeply by way of a *Rule* 104 hearing. Indeed, the court itself implicitly suggested the need for such a hearing initially with the judge observing that

> Looking at the report itself, I am not so sure that it would come under the category of net opinion. And as I said, it seems to me that this is a matter that can best be addressed by the trial court at the time of trial and that this really goes to the question of weight rather than admissibility.

(4T at 5-6 to 23).

In a case involving a *pro se* plaintiff whose expert was not deposed but whose report is challenged as an inadmissible "net opinion," the "better practice" under the circumstances would have been to conduct a *Rule* 104 hearing before declaring it inadmissble. While not conceding that Dr. Sutherland's report constitutes an inadmissible net opinion, if this court considers it to be a close call, the case should be remanded for a *Rule* 104 hearing.

III. PLAINTIFF'S EMOTIONAL DISTRESS IN THIS CASE ARISES NOT AS A BYSTANDER BUT AS A PARTICIPANT IN DEFENDANTS' MISTREATMENT OF HER PET. THE CLAIM IS THEREFORE NOT BARRED UNDER *McDOUGALL*

While this court is not bound its unpublished decision in *Quesada v. Compassion First Pet Hospitals*, 2021 WL 1235136 (App. Div. 2021), the logic underlying that decision is compelling. In *Quesada* the court held that an emotional distress of a pet owner may arise when distress is caused by the breach of a duty owed to the pet owner directly rather than from the owner merely witnessing injury to a pet as a bystander. In that case this court held that the defendant animal hospital owed a duty to the pet owner to return his cat's

euthanized body to him in an "acceptable condition" for a planned viewing and breached that duty by returning the cat's body without the head, causing severe emotional distress. The existence of that duty distinguished the case from *McDougall v. Lamm*, 211 N.J. 203 (2012) in which the Supreme Court declined to extend liability for negligent infliction of emotional distress of bystanders under *Portee v. Jaffee*, 84 N.J. 88 (1988) to pet owners.

This case implicates similar issues of breach of duty owed directly to the pet owner particularly when defendants involved the owner in the alleged mistreatment of the pet. Here plaintiff testified that as early as the day after Olive was released with a diagnosis of diabetes she noticed the dog having abnormal reactions when she administered the insulin, (Pa118-19 at 73-17 to 74-13), but was told that "it takes a while to get adjusted, and . . . give her the recommended dosage." (Pa 119 at 75-9 to 12). She then made an appointment with defendant Hall to discuss Olive's wildly fluctuating blood glucose and her shaking and weakness, (Pa119 at T76-15 to 77-11), but was told by Hall that "[Olive] is getting used to the insulin . . . She [Hall] really pushed that [Olive] had diabetes, and that was the end of it. And you just have to adjust the insulin, and it takes a while to get it adjusted right." (Pa119 at T77-15 to 23). And Keim continued to have problems regulating Olive's blood glucose when administering insulin as directed by the defendants for the presumptive diagnosis of diabetes resulting in multiple

hospitalizations for pancreatitis. Throughout this time Keim continually questioned the defendants about the diagnosis of diabetes and whether Olive's symptoms were related to some other condition, but was repeatedly told that this was a problem common to Schnauzers in particular. Indeed in the first post-diagnosis admission for pancreatitis on 1/18/19, Dr. Lucy noted a conversation with Keim in which he described her as "frustrated that we don't have a simple and easy fix" and he "explained to her that unfortunately dogs with diabetes mellitus and hyperlipidemia (which unfortunately is a lot of Schnauzers) often get pancreatitis and the treatment is purely supportive." (Pa162).

10 At the heart of this case is the initial diagnosis of diabetes and everything that flowed from it. Plaintiff's expert has questioned that diagnosis as based upon inadequate glucose monitoring initially as well as a lack of other diagnostic testing to rule out other conditions. (Pa136). Without adequate diagnostic workup it could never be known whether Olive truly had diabetes or something else was causing her symptoms. Nevertheless, the diagnosis was made and insulin was prescribed, to be administered by Keim. And despite her continued reports of Olive's abnormal reactions to the insulin and wide swings in her glucose, defendants held to the diagnosis and continued to instruct Keim to administer insulin,

Here plaintiff's emotional distress arises not simply from witnessing her dog's suffering but from the fact that she was a participant in inflicting that suffering at the direction of the defendants. Plaintiff is no mere bystander but an active, if unwitting, participant. Defendants repeatedly brushed off her concerns and instructed her to administer insulin to the dog even though Olive was plainly suffering from the treatment.

Keim testified about this over three days of depositions conducted months *after* the trial court dismissed her emotional distress claims *with prejudice*. To the extent that testimony supports a claim for direct liability rather than bystander liability under *McDougall*, this court should vacate the dismissal of the emotional distress claim and return it to the trial court for reconsideration in the setting of plaintiff's testimony.

CONCLUSION

For the foregoing reasons, this court should vacate the trial court's Orders barring plaintiff's expert from testifying and dismissing plaintiff's emotional distress claims and reverse the Order entering summary judgment for lack of expert testimony.

Respectfully submitted

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