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ROGERS, C. J., with whom NORCOTT and ZARELLA, Js., join, dissenting. General Statutes § 52-190a (a) requires a party filing a medical malpractice action to conduct a reasonable inquiry to ensure that there are grounds for a good faith belief that the party has received negligent care or treatment, to append to his or her complaint "a certificate of the attorney or party filing the action . . . that such reasonable inquiry gave rise to [that] good faith belief," and finally, to "obtain a written and signed opinion of a similar health care provider . . . that there appears to be evidence of medical negligence *and includes a detailed basis for the formation of such opinion*. . . ." (Emphasis added.) Failure to obtain and file the written opinion required by this provision "shall be grounds for the dismissal of the action." General Statutes § 52-190a (c). I disagree with the majority that a bare statement that the named defendant, Daniel S. Schwartz, "failed to prevent injury to [the] . . . biliary structures [of the named plaintiff, Kristy Wilcox][1] during laparoscopic [gallbladder] surgery" satisfies the "detailed basis" requirement of the statute.

After examining the legislative history and purpose of § 52-190a (a), the majority explains that the "detailed basis" requirement of the statute may be satisfied by a written opinion that "sets forth the basis of the similar health care provider's opinion that there appears to be evidence of medical negligence by express reference to what the defendant did or failed to do to breach the applicable standard of care. In other words, the written opinion must state the similar health care provider's opinion as to the applicable standard of care, the fact that the standard of care was breached, and the factual basis of the similar health care provider's conclusion concerning the breach of the standard of care." That is a reasonable explanation of what the statute requires, with which I have no quarrel. The majority concludes, however, that the written opinion provided in this case, which is little more than an unadorned statement that Schwartz failed to prevent injury to Wilcox, satisfies the foregoing standard. Because I am unconvinced by the majority's analysis and find its conclusion to be contrary to the legislative intent underlying the "detailed basis" requirement of § 52-190a (a), I respectfully dissent.

I begin with the key statutory phrase, "detailed basis," by considering the plain meaning of the terms that comprise it.[2] "Basis" is defined, most pertinently, as "something on which something else [here, the similar health care provider's opinion that there appears to be evidence of medical negligence] is established or based . . . ." Webster's Ninth New Collegiate Dictionary

(1983), p. 134. "Detail" means "extended treatment of or attention to particular items," while something "detailed" is "marked by abundant detail or by thoroughness in treating small items or parts . . . ." Id., p. 345. Reading these terms together in the context of the statute suggests that the author of the written opinion must explain, in thorough fashion and with particularity, the foundation for his or her assessment of apparent negligence. More specifically, the author should elaborate on the particular standard of care involved in the medical treatment at issue, the manner in which he or she believes it likely was breached and the facts that led to his or her conclusion.

To the extent that ambiguity remains as to the degree of detail required, the legislative history of § 52-190a (a) indicates that our lawmakers intended that the written opinion provide a clear and complete explanation of the standard of care and its apparent breach, rather than a conclusory statement that the defendant was negligent. As we have explained, when § 52-190a originally was enacted as part of the Tort Reform Act of 1986; see Public Acts 1986, No. 86-338, § 12; it required a medical malpractice plaintiff to conduct a reasonable inquiry into his or her allegations of negligence and to file a certificate attesting to his or her good faith belief that there were grounds for the action, but did not require the plaintiff to obtain and file a supporting, written opinion of a similar health care provider. *Dias* v. *Grady*, 292 Conn. 350, 357, 972 A.2d 715 (2009). "[T]he purpose of the original version of § 52-190a was to prevent frivolous medical malpractice actions" by mandating an adequate investigation prior to the filing of an action. Id.

In 2005, the requirement of filing the written opinion of a similar health care provider was added to § 52-190a (a) as part of Public Acts 2005, No. 05-275 (P.A. 05-275), which included a comprehensive array of measures aimed at the overall goal of lowering medical malpractice insurance premiums. See id., 358–59 n.7. As the majority explains in the present case, one purpose of the written opinion requirement was to reinforce the statute's original purpose of dissuading frivolous malpractice actions by " 'address[ing] the problem that [had developed whereby] some attorneys, either intentionally or innocently, were misrepresenting in the certificate of good faith the information that they had obtained from experts.' [Id., 358]." Requiring a similar healthcare provider to vouch directly for the allegations of negligence would provide a check against such misrepresentations.

Closer examination of the legislative history underlying P.A. 05-275 reveals that the amendment to § 52-190a (a) had a secondary purpose that further would help lower malpractice insurance premiums, namely, to promote the more efficient resolution of potentially *merito-*

rious claims by requiring a plaintiff to disclose as much as possible about the nature of his or her claim at the very outset of the action.[3] To that end, when introducing the legislation, Representative Michael P. Lawlor explained that a similar healthcare provider "would have to state, *in explicit detail*, his or her opinion that this is a meritorious claim"; (emphasis added) 48 H.R. Proc., Pt. 31, 2005 Sess., p. 9446; and that "the *entire opinion* would be there attached to the complaint." (Emphasis added.) Id., p. 9501. Senator Andrew J. McDonald used language suggesting that the opinion should have real substance, referring to it repeatedly as a "report," and explaining that it was required to be "presented in a detailed fashion . . . ." 48 S. Proc., Pt. 14, 2005 Sess., p. 4411. Senator John A. Kissel, who had worked on the legislation, stated that appending the written opinion to the complaint would "help . . . defense counsel and their clients right into the ballpark, right at the inception of the medical malpractice case," and address the preexisting problem that "months could go by, even over a year, until defense counsel and their clients could really narrow down exactly what was the basis for . . . the plaintiff's claim that there was medical malpractice and why they had brought that case." Id., pp. 4428–29. By requiring the inclusion of the written opinion with the complaint, Senator Kissel explained, "We're trying to speed it up. We're trying to expedite it." Id., p. 4429. At the judiciary committee hearing on the amendments, Senator Kissel stated that having "the substance of the report appended to the complaint" would enable defense counsel to "review the nuts and bolts of what's in there and make a reasonable determination" regarding the claim. Conn. Joint Standing Committee Hearings, Judiciary, Pt. 18, 2005 Sess., p. 5545. Michael D. Neubert, an attorney testifying on behalf of the Connecticut State Medical Society at the committee hearing, agreed with Senator Kissel that appending the "doctor's written statement . . . just makes good sense. Clearly that's going to help defendants accept cases earlier . . . [and] perhaps lead to a quicker resolution in many cases." Id., p. 5548.

The wording of § 52-190a (a), as amended by P.A. 05-275, is consistent with the legislature's dual purpose of eliminating frivolous lawsuits and hastening potentially meritorious ones. The relevant portion of § 52-190a (a) begins by stating that, "[t]o show the existence of . . . good faith, the claimant or the claimant's attorney . . . shall obtain a written and signed opinion of a similar health care provider . . . that there appears to be evidence of medical negligence . . . ." If that were all the statute required, it would be sufficient to accomplish the purpose of deterring frivolous actions by mandating that a medical professional vouch for the certification by the claimant or the claimant's attorney that there is a good faith basis for bringing the action. Section 52-190a (a) was amended further, however, to require that

the opinion include "a detailed basis for [its] formation . . . ." P.A. 05-275, § 2 (a). Unless this language is to be regarded as superfluous,[4] the legislature must have had a reason for including it. I believe that reason was articulated clearly by the sponsors of the legislation as quoted in this dissent, namely, to provide defendants with specific information about the claim at the outset of the litigation so as to reduce the time necessary to resolve it.[5]

In light of the foregoing, I am unable to conclude, as does the majority, that a bare statement that Schwartz "failed to prevent injury to . . . Wilcox's biliary structures during laparoscopic [gallbladder] surgery" satisfies the "detailed basis" requirement of § 52-190a (a). The written opinion does not explain with any particularity the standard of care, namely, what precautions normally are taken by physicians skilled in laparoscopic gallbladder surgery to prevent injuries to nearby anatomical structures. Nor does the written opinion purport to assess how the standard was breached by specifying which, if any, precautions Schwartz apparently failed to take,[6] and what, in the available information, led the author to reach this conclusion.[7]

"[T]o prevail in a medical malpractice action, the plaintiff must prove (1) the requisite standard of care for treatment, (2) a deviation from that standard of care, and (3) a causal connection between the deviation and the claimed injury." (Internal quotation marks omitted.) *Carrano* v. *Yale-New Haven Hospital*, 279 Conn. 622, 656, 904 A.2d 149 (2006). We have made clear that a § 52-190a (a) written opinion must address the first two elements only, and is not required to speak to the third. *Dias* v. *Grady*, supra, 292 Conn. 359. Here, the written opinion, in essence, has identified an injury and suggested that Schwartz caused it by failing to do some unarticulated thing. In short, the written opinion omits entirely the required information, and includes only information that we have deemed to be unnecessary. It is axiomatic that the fact of a bad result, standing alone, does not prove wrongdoing by a physician; *Boone* v. *William W. Backus Hospital*, 272 Conn. 551, 576, 864 A.2d 1 (2005); and that inadvertent injury to a patient during surgery may, or may not, constitute negligence. See generally annot., 37 A.L.R.3d 464 (1971). It may be the case that the injury at issue is a necessary risk accompanying the surgical procedure during which the injury occurred, in which case there is no malpractice. Id., § 3 [b], p. 472.

For the reasons explained herein, I respectfully dissent.

[1] See footnote 1 of the majority opinion.

[2] In the absence of statutory guidance regarding the definition of a word used in a statute, we "may appropriately look to the meaning of the . . . [word] as commonly expressed in the law and in dictionaries." (Internal quotation marks omitted.) *State* v. *Silas S.*, 301 Conn. 684, 693, 22 A.3d 622 (2011).

[3] This requirement complemented §§ 3 and 4 of P.A. 05-275, which also

were aimed at promoting speedier resolution of medical malpractice claims by, respectively, providing a mechanism to have certain claims transferred in timely fashion to the complex litigation docket and adding provisions to foster early settlement of cases.

[4] When interpreting statutes, we presume that "the legislature did not intend to enact meaningless provisions. . . . [S]tatutes must be construed, if possible, such that no clause, sentence or word shall be superfluous, void or insignificant . . . ." (Internal quotation marks omitted.) *Housatonic Railroad Co.* v. *Commissioner of Revenue Services*, 301 Conn. 268, 303, 21 A.3d 759 (2011).

[5] I recognize that the information available to a similar health care provider who provides a written opinion pursuant to § 52-190a (a) necessarily is limited in comparison to the information that becomes available once discovery is completed. It is important to recognize, however, that § 52-190 (a) requires the author to opine only that there "*appears* to be evidence of medical negligence"; (emphasis added); and, in so doing, seems to allow for some measure of speculation given the timing of the requirement. Thus, an opinion need not include every detail that later might emerge via discovery or establish negligence definitively, but at the same time, it should be adequate to put a defendant on notice of the nature of the plaintiff's claims and, thereby, facilitate discovery or settlement. If a similar health care provider is unable to articulate the foundation for his or her theory that there *apparently* was negligent treatment or care, the existence of a good faith basis for the action is questionable, and the action begins to resemble a fishing expedition. Notably, without a showing of malice, § 52-190a (a) exempts the author of a written opinion from personal liability for damages to a defendant by reason of having provided an opinion that later proves to be incorrect.

[6] Compare, e.g., *Landi* v. *Wertheim*, Superior Court, judicial district of Stamford-Norwalk, Docket No. CV-06-5001608-S (October 2, 2006). In *Landi*, the trial court held the following written opinion to be sufficiently detailed under § 52-190a (a): "On [June 16, 2004] [the plaintiff] underwent a total abdominal hysterectomy plus bilateral [salpingo-oophorectomy]. On review of the notes associated with this procedure, I find that the injury suffered by [the plaintiff] is directly related to the lack of appropriate caution practiced by the operating surgeon. *The absence of uteral stents being placed prior* [*to*] *the surgery*, as well as the inadequate evaluation once an injury was suspected, *resulted in the unfortunate outcome.*" (Emphasis added; internal quotation marks omitted.)

[7] It appears that the majority is attempting to rehabilitate the inadequate written opinion supplied by the plaintiffs by paraphrasing it, speculating as to what is implied and supplying additional explanation that the opinion simply does not contain. For instance, the majority changes "failed to prevent injury" to "failed to protect," and avers that a similar health care provider in the present case "opine[d] that, in essence, the injury would not have occurred in the absence of medical negligence . . . ." As I have explained, our legislators when mandating attachment of a written opinion envisioned that it be "explicit"; 48 H.R. Proc., supra, p. 9446; and "presented in a detailed fashion"; 48 S. Proc., supra, p. 4411; and that it would enable a defendant to "narrow down exactly what was the basis for the determination of . . . the plaintiff's claim that there was medical malpractice and why they had brought that case." Id., pp. 4428–29. If the written opinion in the present case complied with these requirements, it would obviate the need for any judicial reconstruction.