STATE OF MICHIGAN

COURT OF APPEALS

JOHN H CASTLE, Personal Representative of the Estate of ALVIN F PROVOT, THERESE PROVOT, HELYN CASTLE, JOHN H CASTLE, MARIE LIPPINCOTT, KEITH LIPPINCOTT, and LISA GWISDALLA,

Plaintiffs-Appellants,

v

BATTLE CREEK AREA AMBULANCE, d/b/a LIFECARE AMBULANCE SERVICE, SHANDY M PARTEE, and KEVIN L BROCKWAY,

Defendants-Appellees.

UNPUBLISHED
March 19, 2009

No. 277068
Branch Circuit Court
LC No. 05-012800-NI

Before: Murphy, P.J., and Bandstra and Beckering, JJ.

PER CURIAM.

In this wrongful death action, plaintiffs appeal as of right the trial court order granting defendants' motion for summary disposition under MCR 2.116(C)(7) and (10). We affirm.

I. Basic Facts and Procedural History

On July 18, 2004, 74-year old Alvin Provot was admitted to the Intensive Care Unit at Community Health Center of Branch County (CHC) for treatment of acute bilateral pneumonia with respiratory failure. Provot's other health complications included a history of non-Hodgkin's lymphoma with treatment and subsequent recurrence, hypothyroidism, heart rhythm disorder, and anemia. Provot was intubated and placed on a mechanical ventilator. A lung biopsy revealed scar tissue and advanced lung disease. Provot remained ventilator dependant, and on July 26, 2004, he underwent a tracheostomy and received a feeding tube.

On July 27, 2004, Provot's physicians arranged to transfer him to Select Care in Battle Creek, Michigan, a facility that cares for chronic ventilator and critically ill patients. The goal of the rehabilitation was to wean Provot from the ventilator and eventually send him home. An "Authorization for Acute Hospital to Hospital Transfer" form for emergency transfers was signed by Provot's physician. It indicated Provot was stable enough such that, "within

reasonable medical probability, no material deterioration of the patient's condition is likely to result from the transfer."

CHC hospital staff arranged for Provot to be transferred to Select Care by ambulance through defendant Battle Creek Area Ambulance (d/b/a "LifeCare"). CHC staff advised LifeCare to bring a ventilator, insulin drip, and cardiac monitor. LifeCare dispatched defendants Kevin L. Brockway and Shandy M. Partee, licensed paramedics, to transport Provot. Brockway and Partee inspected the ambulance's equipment, including the ventilator, and concluded that everything was operating properly.

Upon arriving at the hospital, Brockway and Partee discussed Provot's respiratory status with a CHC registered nurse. Brockway indicated that LifeCare could not complete the transport because Provot had spontaneous respirations, and LifeCare's ventilator could not accommodate a patient with spontaneous respirations. The registered nurse then left to contact the receiving physician to discuss their options. When she returned, she informed the paramedics that, by order of the receiving physician, to facilitate transport Provot would be sedated and paralyzed to temporarily discontinue his spontaneous respirations.

CHC staff prepared Provot for transport by administering a sedative and Pavulon, a medication designed to paralyze him. Provot was then removed from the hospital ventilator and connected to the LifeCare ventilator. Partee "hear[d] [the ventilator] cycling to know it was working there [and] [b]reath sounds were taken and you could see the [patient's] chest rise." Brockway also indicated that Provot was evaluated before being taken to the ambulance. He testified:

> The ventilator settings were verified by either an RN or respiratory tech, I do not recall which one, with my partner to verify the vent settings. The patient was hooked up to an EKG monitor, pulse oximetry, lung sounds were auscultated, and we left for the ambulance . . . .
>
> The settings were dictated by the physician. There's three knobs on an Auto-Vent; one adult/pediatric setting, verify it was adult, verify the respiratory rate was appropriate, and verify that the title volume was set correctly.

The paramedics left CHC at approximately 3:20 p.m. They had a one-hour window from the time the Pavulon was administered until it would no longer be effective. Several members of Provot's family followed behind the ambulance in two vehicles. Brockway drove the ambulance while Partee attended to Provot in the passenger compartment.

Partee testified in his deposition that en route to Select Care, the ventilator was working properly because he assessed Provot's lung sounds and observed his chest rise and fall. However, at some point, Partee told Brockway to pull the ambulance over. Provot was without a pulse and unresponsive.[1] Brockway pulled the vehicle over to the side of the road at

[1] Dr. Ginger Williams, who treated Provot upon his arrival to Oaklawn Hospital, testified at her (continued…)

approximately 3:46 p.m. and turned on the emergency lights. He exited the ambulance and joined Partee in the passenger compartment. In the passenger compartment, Brockway observed Partee performing chest compressions on Provot. Partee told Brockway to look at the "Lifepak 12 monitor" while he ceased compressions, and Brockway observed that the patient had flat lined. Brockway gave the patient's "drug bag" to Partee because he believed that Provot might be in need of his cardiac medication. Brockway decided to divert his destination to Oaklawn Hospital, located nearby in Marshall, Michigan. The Oaklawn Hospital emergency room received notice that the paramedics were on their way at 3:51 p.m.

The Provot family-member vehicles had pulled over to the side of the road behind the ambulance. Provot's daughter, plaintiff Helyn Castle, approached Brockway as he left the passenger compartment and was returning to the driver's seat. Brockway told Castle that the patient had "coded" or "was in full arrest," and that they were now en route to Oaklawn Hospital. Castle told Brockway that she was a registered nurse and asked if she could get into the passenger compartment. Brockway testified at his deposition that he declined Castle's request and returned to the driver's seat, but Castle testified at her deposition that Brockway had consented. Brockway claims he did not realize Castle had entered the passenger compartment until after he turned off the exit ramp of Interstate 69. The other family members followed behind the ambulance en route to Oaklawn Hospital.

Castle testified that when she entered the passenger compartment of the ambulance and asked what happened, Partee informed her that Provot's "trach is dislodged, we can't ventilate him," which he surmised had occurred due to jarring from the ambulance.[2] He told her that he noticed Provot's heart rate going down, and that it flat lined after they pulled over. Castle never saw whether the trach was dislodged. Partee testified that he asked Castle about Provot's "do not resuscitate" ("DNR") status, and Castle equivocated.[3] She told Partee that she wanted her father to be treated if the paramedic could guarantee a good outcome; however, she changed her mind and stated that she "want[ed] everything done." Castle testified that she responded to the DNR inquiry by saying it "depends on what it is," but then she told him to do everything.

Partee contends that he started to perform CPR on Provot, but that Castle disrupted him and took over compressions, obstructing his access to the patient and instruments. Castle contends that Partee performed "two chest compressions" before reaching for medication, and then she started to perform compressions. She maintains that she was trying to assist Partee without interfering with his treatment. Castle also contends that at some point en route to the

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(…continued)

deposition that after reviewing the EKG reports, she learned that "[a]t [3:45 p.m.] [Provot] had a tremendously bradycardic rhythm and there was nothing that transpired that would have caused that other than the ineffective ventilation given the fact that effective ventilation reversed it." Dr. Williams noted, however, that Provot was probably properly ventilated when the transport began.

[2] The ventilator was connected to the tracheostomy tube.

[3] At her deposition, Castle testified that Provot "really didn't have a DNR order," but "he had a living will . . . if something were to happen so that we could have judgment in the thing."

hospital she told Partee, "it doesn't do any good to do these compressions if he's not being ventilated." Partee testified that he does not recall this comment.

Brockway estimated that it took three to five minutes to reach Oaklawn Hospital, and they arrived at 3:55 p.m. Dr. Ginger Williams was the attending physician. At the emergency room, Partee provided a brief report to the emergency room staff. Dr. Williams testified that she recalls a paramedic telling her the tracheostomy tube must be dislodged because the transport ventilator was not ventilating Provot. Dr. Williams recalls that Provot had no pulse, no chest wall movement, and he was not breathing.

Oaklawn Hospital emergency room staff successfully resuscitated Provot by disconnecting the mechanical ventilator and manually ventilating him through the use of an ambu bag. At her deposition, Dr. Williams described her recollection of the incident:

> [Provot] arrived in [full] arrest [with no pulse and no respirations], and standard practice in an arrest is ABC [airway, breathing, circulation]. You assess the airway. He had a tracheostomy tube. You assess the breathing, he was hooked up to a transport ventilator which we disconnect and we hooked him to an ambu bag and he ventilated easily. And then we assessed the circulation, and he didn't have any, so we started chest compressions which would be standard.
>
> I remember that shortly after starting to ventilate him, he started to get a rhythm back. I would have to refer to the record to see exactly what it was. We gave him [Epinephrine], I don't remember if we gave him anything else without referring to the record, and he did get pulses back after we ventilated him, did the chest compressions, and gave him the [Epinephrine].

Brockway recalls Dr. Williams returning the LifeCare ventilator and telling him, "[t]his does not work." Dr. Williams admitted at her deposition, however, that she did not actually test the ventilator. Partee maintains that Provot was "ventilated the entire time with a functioning ventilator," and that "[t]here was chest wall movement while the patient was with me." Castle indicated that she did not see Provot's chest rise and fall, and she believes the ventilator was not working.

Dr. Williams concluded that Provot had suffered anoxic encephalopathy (brain damage due to lack of oxygen to the brain) before arriving at the emergency room. A CT scan performed on July 28, 2004, revealed the following:

> Large right posterior cerebral artery distribution infarct. Since this is not within a watershed distribution, it is not typical for a post cardiac arrest infarct. Consider possibility that the posterior cerebral artery stroke contributed to arrest rather than resulting from arrest.

A second CT scan performed on July 30, 2004 confirmed the above results.

At some point, Oaklawn Hospital staff discussed Provot's condition with his family, and "they opted for comfort measures." Provot was taken off of the ventilator and died on July 31, 2004. Dr. Alcides Gil-Acosta prepared the Oaklawn Hospital discharge summary and provided

the following final diagnosis: "severe posterior cerebral stroke, anoxic brain injury, acute respiratory distress syndrome, and status post cardiopulmonary arrest." The discharge summary further states:

> Mr. Provot was admitted under conditions dictated in the admission history and physical. As stated he had a cardiopulmonary arrest en route between Coldwater and Select Specialty Hospital in Battle Creek. The ambulance brought him to Oaklawn Hospital, which was the closest hospital. By the time they arrived, they had been able to resuscitate him with reinstitution of pulse and blood pressure and ventilation. He was admitted to the Intensive Care Unit. Throughout his hospital stay his mental status did not improve, in fact it was consistent with extreme neurological deficits. A head CT scan was done which surprisingly showed presence of a posterior cerebral stroke, which probably cannot be accounted for by simple anoxic brain injury. More than likely, the patient had suffered a stroke prior to transfer or during transfer, as the prime etiology was cardiopulmonary arrest.

On December 27, 2005, plaintiffs filed a seven-count complaint against defendants, alleging the following: negligence against all defendants; gross negligence against all defendants; negligence against LifeCare; and four individual claims of negligent infliction of emotional distress filed by several of Provot's family members who followed behind the ambulance at the time of the transport, including Castle.

Defendants moved for summary disposition pursuant to MCR 2.116(C)(7), (8), and (10). Defendants argued that they were entitled to immunity pursuant to MCL 333.20965(1) of the Emergency Medical Services Act ("EMSA"), and that plaintiffs had failed to establish proximate cause or that Provot had a greater than 50 percent opportunity to survive as required by MCL 600.2912a(2). Defendants also claimed that plaintiffs failed to demonstrate the elements of negligent infliction of emotional distress.

Plaintiffs responded that qualified immunity under MCL 333.20965(1) did not apply to the transportation of Provot. Further, even if the statute did apply, the paramedics' conduct rose to the level of gross negligence. Plaintiffs further asserted that they had established proximate cause and the elements of negligent infliction of emotional distress.

The trial court denied defendants' motion with respect to MCR 2.116(C)(8), but granted the motion pursuant to MCR 2.116(C)(7) and (10). The trial court ruled:

> First, that brought under [MCR 2.116](C)(8), the court finds no merit in the suggestion that the plaintiffs have failed to state a claim upon which relief can be granted. Looking at the pleadings on their face and in the light most favorable to the plaintiffs, clearly the court would find that under [MCR 2.116](C)(8), that motion must fail.
>
> Turning to the question of immunity as is heard under [MCR] 2.116(C)(7), as I suggested in trying to save [defendants' counsel] some breath, the fact is that the language within [MCR 2.116](C)(7) itself does not require simply governmental immunity as often as we might presume. But again the language of

the court rule simply indicates it may be brought—or one of the grounds under [MCR 2.116](C)(7) is that it may be barred by immunity granted by law and I'm sure that's what we're referring to. Here the law in question is MCL 333.20965(1)(d). The question is whether the circumstances of this case are such that immunity can apply. The assertion by the plaintiffs is that . . . if it applies at all, it only applies in emergency circumstances.

In this case, the fact is that while the representation had been made that this was, in essence, a transfer for rehabilitation, as I read the supporting documentation, this by no means was the sort of transportation intended for some sort of rehabilitation after knee surgery or the like. Indeed the transfer of Mr. Provot was in great part because the care he needed was not available here and he had to be transferred to a facility where such care could be provided. Whether we view it as emergency or urgent, clearly it was not a routine rehabilitation. And if that care were not of an emergency nature when he left the hospital here, it certainly became such when his circumstances changed dramatically during the transport and the court can find no case citations that suggest that such a designation is improper or impermissible when it may have been due to the alleged negligent acts of the defendants that may have caused the later emergency.

Therefore the court would determine that the standard that must be applied would be that of gross negligence. And the court would determine in looking at that standard and the allegations made by the plaintiffs that there was a failure to act and, in this case, that the court would determine was, in fact, a deviation of a standard of care and in all of the pertinent citations, the court has found that would rise at most to a standard of ordinary negligence, not gross negligence.

The court would further parenthetically indicate that, as I reviewed the plaintiffs' expert deposition testimony, that it fails to establish a breach of the standard of care. There was some argument that perhaps there may have been an equipment failure. That would not rise to the level of gross negligence either. As a consequence, the court would determine that whether it be under [MCR 2.116](C)(7) or (C)(10), there is no genuine issue of material fact.

As far as the claims of the bystanders, the court would indicate inasmuch as they are derivative of the underlying claim, they would require a standard of gross negligence as well. If that were not the . . . standard, the court would determine that while each of them was a close family relative, only one of them immediately saw the deceased at the time of distress and the court would determine that even that relative did not establish, and could not before reasonable prior effect, the standard necessary to make a bystander claim.

The trial court affected its oral ruling in a subsequent written order, and this appeal followed.

II. Applicability of the EMSA Immunity Provision

This Court reviews de novo a trial court's grant of summary disposition. *Amburgey v Sauder*, 238 Mich App 228, 231; 605 NW2d 84 (1999). "'MCR 2.116(C)(7) tests whether a claim is barred because of immunity granted by law, and requires consideration of all documentary evidence filed or submitted by the parties.'" *Grahovac v Munising Twp*, 263 Mich App 589, 591; 689 NW2d 498 (2004), quoting *Wade v Dep't of Corrections*, 439 Mich 158, 162; 483 NW2d 26 (1992). In ruling on a motion under MCR 2.116(C)(7), this Court considers all well-pleaded allegations as true, construing them in favor of the nonmoving party. *Id.* "If the facts are not in dispute and reasonable minds could not differ concerning the legal effect of those facts, whether a claim is barred by immunity is a question for the court to decide as a matter of law." *Poppen v Tovey*, 256 Mich App 351, 354; 664 NW2d 269 (2003). This Court reviews de novo questions of statutory interpretation. *Ford Motor Co v Woodhaven*, 475 Mich 425, 438; 716 NW2d 247 (2006).

We first address whether defendants are entitled to qualified immunity under MCL 333.20965(1). MCL 333.20965(1) states in pertinent part:

> (1) Unless an act or omission is the result of gross negligence or willful misconduct, the acts or omissions of a medical first responder, emergency medical technician, emergency medical technician specialist, paramedic, medical director of a medical control authority or his or her designee, or, subject to subsection (5), an individual acting as a clinical preceptor of a department-approved education program sponsor while providing services to a patient outside a hospital, in a hospital before transferring patient care to hospital personnel, or in a clinical setting that are consistent with the individual's licensure or additional training required by the medical control authority including, but not limited to, services described in subsection (2), or consistent with an approved procedure for that particular education program do not impose liability in the treatment of a patient on those individuals or any of the following persons:
>
> * * *
>
> (d) The life support agency or an officer, member of the staff, or other employee of the life support agency.

"Life support agency" is defined as "an ambulance operation, nontransport prehospital life support operation, aircraft transport operation, or medical first response service." MCL 333.20906(1).

The parties do not dispute that MCL 333.20965(1) provides qualified immunity to ambulance companies and paramedics during emergency transport situations. While the parties contest whether the statute applies in non-emergency transport situations, our first task is to ascertain whether Provot's July 27, 2004 transfer was an emergency or a non-emergency situation.

MCL 333.20904(2) defines "[e]mergency" as, "a condition or situation in which an individual declares a need for immediate medical attention for any individual, or where that need

is declared by emergency medical services personnel or a public safety official." MCL 333.20904(9) defines an "[e]mergency patient" as:

> (9) "Emergency patient" means an individual with a physical or mental condition that manifests itself by acute symptoms of sufficient severity, including, but not limited to, pain such that a prudent layperson, possessing average knowledge of health and medicine, could reasonably expect to result in 1 or all of the following:
>
> (a) Placing the health of the individual or, in the case of a pregnant woman, the health of the patient or the unborn child, or both, in serious jeopardy.
>
> (b) Serious impairment of bodily function.
>
> (c) Serious dysfunction of a body organ or part.

MCL 333.20908(1) defines a "[N]onemergency patient" as:

> "Nonemergency patient" means an individual who is transported by stretcher, isolette, cot, or litter but whose physical or mental condition is such that the individual may reasonably be suspected of not being in imminent danger of loss of life or of significant health impairment.

In the instant case, we agree with the trial court that, in taking the facts in a light most favorable to the plaintiffs, reasonable minds could not dispute that Provot's transfer involved an emergency situation. At the time of his transfer Provot was stabilized, but he remained ventilator dependent in the Intensive Care Unit. His diagnosis included bilateral pneumonia, acute respiratory failure, lymphoma, hypothyroidism, heart rhythm disorder, and anemia. He had a tracheostomy tube in his throat, to which the ventilator was attached, and a feeding tube for nutritional sustenance. Prior to boarding the ambulance, CHC staff paralyzed Provot with Pavulon, which rendered him completely unable to breath on his own. The Pavulon was expected to last one hour, whereafter Provot might recommence occasional spontaneous respirations, a situation that was not compatible with the transport ventilator. As such, defendants were acting under a strict time deadline. Given Provot's own respiratory compromise, compounded by a medically induced total paralysis of his breathing capacity at the time of transfer, we find that he had a serious impairment of a bodily function under MCL 333.20904(9)(b), and alternatively, a serious dysfunction of a body organ or part under MCL 333.20904(9)(c). He was, therefore, an emergency patient as defined by the EMSA. Further, Provot was in need of immediate medical attention to ensure that he was receiving adequate ventilation at the time of transport from one hospital to the other. Under the particular circumstances of this case, Provot's transfer satisfied the EMSA's definition of an emergency under MCL 333.20904(2).

As the trial court pointed out, "this by no means was the sort of transportation intended for some sort of rehabilitation after knee surgery or the like. Indeed the transfer of Mr. Provot was in great part because the care he needed was not available here and he had to be transferred to a facility where such care could be provided. Whether we view it as emergency or urgent, clearly it was not a routine rehabilitation." Because we find defendants were engaged in an

emergency transport situation, we hold that MCL 333.20965(1) applies, entitling defendants to qualified immunity. Given our finding in this regard, we need not address whether MCL 333.20965(1) applies in non-emergency situations.

III. Gross Negligence

We next address plaintiffs' contention that the trial court improperly found that defendants' conduct did not constitute gross negligence. Under MCL 333.20965(1), defendants are immune from liability so long as their conduct did not amount to "gross negligence or willful misconduct." Plaintiffs admit that defendants did not engage in willful misconduct, but allege that they were grossly negligent. The trial court concluded that defendants' conduct "[rose] at most to a standard of ordinary negligence, not gross negligence," and granted summary disposition.

This Court reviews de novo a trial court's grant of summary disposition. *Amburgey*, *supra* at 231. Our Supreme Court provided the following standard for motions pursuant to MCR 2.116(C)(10):

> A motion under MCR 2.116(C)(10) tests the factual sufficiency of the complaint. In evaluating a motion for summary disposition brought under this subsection, a trial court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties, MCR 2.116(G)(5), in the light most favorable to the party opposing the motion. Where the proffered evidence fails to establish a genuine issue regarding any material fact, the moving party is entitled to judgment as a matter of law. MCR 2.116(C)(10), (G)(4). [*Maiden v Rozwood*, 461 Mich 109, 119-120; 597 NW2d 817 (1999).]

For claims implicating gross negligence, "[s]ummary disposition is appropriate only where reasonable minds could not have reached different conclusions with regard to whether the defendant's conduct amounted to gross negligence." *Haberl v Rose*, 225 Mich App 254, 265; 570 NW2d 664 (1997). Generally, once a standard of conduct is established, the reasonableness of conduct under that standard is a question for the factfinder. *Jackson v Saginaw Co*, 458 Mich 141, 146; 580 NW2d 870 (1998) (quotation omitted). "However, if, on the basis of the evidence presented, reasonable minds could not differ, then the motion for summary disposition should be granted." *Id.* (quotation marks and citation omitted).

In *Jennings v Southwood*, 446 Mich 125, 128; 521 NW2d 230 (1994), superseded in part on other grounds by MCL 333.20965(2), our Supreme Court addressed "whether the common-law definitions of gross negligence and willful and wanton misconduct remain viable against the backdrop of the [EMSA]." The Court concluded that the EMSA's "gross negligence" language required evidence of "conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results." *Id.* at 136-137. Essentially, our Supreme Court borrowed the gross negligence standard from the Government Tort Liability Act ("GTLA"), MCL 691.1401 *et seq*. In doing so, the Court recognized that "the GTLA and the EMSA share the common purpose of immunizing certain agents from ordinary negligence and permitting liability for gross negligence." *Id*. at 136. The Court concluded that "[b]ecause the provisions have a common purpose, the terms of the provisions should be read *in pari materia*." *Id*. (emphasis added). Additionally, "evidence of ordinary negligence does not create a material question of fact

concerning gross negligence." *Maiden*, *supra* at 122. "[A] plaintiff must adduce proof of conduct 'so reckless as to demonstrate a substantial lack of concern for whether an injury results.'" *Id*. Significantly, "the content or substance of the evidence proffered must be admissible in evidence." *Id.* at 123.

In the instant case, plaintiffs allege that the paramedics' conduct constituted gross negligence, or at least a question of fact remains on the matter, based on defendants' "[a]ccepting the transfer from CHC to Battle Creek without being properly trained to transport a ventilator patient"; "[a]ccepting the transfer of Provot from CHC to Battle Creek without having the proper equipment in the LifeCare ambulance"; "[f]ailing to make any attempt to manually ventilate Provot after determining that he was not being properly ventilated by the portable ventilator located within the LifeCare ambulance"; and "[m]istakenly determining that the tracheotomy tube of Provot had become dislodged and could not be utilized for ventilation."

Plaintiffs seek to prove that defendants' conduct amounted to gross negligence based on the medical evidence, applicable protocols, and deposition testimony, including medical experts. Plaintiffs' expert witness Bruce Wheeler, a Michigan licensed emergency medical service provider, provided an affidavit purportedly stating the applicable standard of care for transferring a ventilator patient. Wheeler averred that defendants breached the applicable standard of care by failing to do the following:

> (a) Test and utilize an appropriate ventilator for the transfer from Coldwater to Battle Creek.
>
> (b) Recognize and appreciate the effect of lack of oxygen being experienced by Mr. Provot during the transfer and respond accordingly.
>
> (c) Proceed directly to the closest emergency care hospital upon an apparent malfunction of the ventilator.
>
> (d) Properly ventilate Mr. Provot manually with an ambu bag after determination that the ventilator had malfunctioned and Mr. Provot was not being ventilated mechanically.
>
> (e) Properly administer CPR to Mr. Provot.
>
> (f) Comply with Medical Control Authority protocol General Control Procedures #1-Airway/Oxygenation, with respect to the transfer of Mr. Provot and managing his airway and ventilation during the transfer.

Wheeler further averred that "the failure of [defendants] to attempt any manual ventilation of Mr. Provot after determining that the ventilator had malfunctioned was so reckless as to demonstrate a substantial lack of concern for the care and well-being of Mr. Provot."

At his deposition, Wheeler testified regarding his qualification as an expert witness:

> My training . . . I know that critical care paramedic goes into . . . more in-depth patient care . . . I feel that there is a lot of basics to EMS . . . . There is not a lot of variation in the way you can treat someone that is . . . ventilation dependent.

With respect to defendants' alleged failure to use an appropriate ventilator, Wheeler indicated that he had no training in the use of ventilators, and he had never managed the transfer of a patient on a ventilator. He had no basic knowledge of how a ventilator works, the operation of a ventilator, how one turns it on, or how it is hooked up. Additionally, Wheeler admitted that he had no experience with paralytic medications. Wheeler also admitted that he did not know if the portable ventilator used in this case was tested, or if that ventilator was appropriate to transfer Provot. Further, he admitted that the CHC was responsible for selecting and verifying the ventilator settings, not the paramedics. He was also unfamiliar with the Auto Vent 3000.

With respect to Provot's oxygenation status, although Wheeler indicated that defendants should have recognized something was wrong with Provot based on his skin colorization, he acknowledged that there was no evidence indicating that defendants did not recognize and appreciate the effect of any lack of oxygen to the patient.

With respect to the need to proceed to the closest emergency care hospital upon the occurrence of an apparent ventilator malfunction, Wheeler admitted that it was appropriate to divert to the nearest emergency facility under the circumstances of this case, and defendants did so.

With respect to how to properly ventilate Provot, Wheeler acknowledged that conditions dictate whether a patient should be removed from a mechanical ventilator. He noted that it would be difficult to assess breath sounds in a moving ambulance, and that under such circumstances, the only way to determine if the ventilator was working was if the patient's chest was rising. He indicated that if the ventilator is working, then there would be no need for manual ventilation.

Wheeler contended that "the ABC's of patient care were neglected" in that airway and breathing were neglected. He indicated that Partee breached the ABC protocol by failing to assess the patient's airway, which was evidenced by Partee's report that stated he was unable to assess the airway. He opined that Partee was "neglectful" because the patient developed problems en route, and that Partee was not breathing for the patient. Wheeler explained that a paramedic can "breath for a patient" by ventilating, intubating, or "criching" the patient.

In the instant case, Provot was attached to a ventilator, although we will accept as true plaintiffs' contention that it was not working. With respect to intubation, Wheeler stated that a patient with a tracheostomy would not have been intubated. Further, he admitted that a crichothyrotomy was an extraordinary procedure, and that he had not performed one in more than ten years as a paramedic.

Finally, Wheeler claimed that Provot should have been manually ventilated in the ambulance through the use of a hand-held ambu bag. This contention is corroborated by the fact that the emergency room staff at Oaklawn Hospital was able to successfully "bag" Provot without resistance and restore his vital signs. Without engaging in expert witness qualifications analyses, Dr. Williams and Castle also agree on this point, as does defendants' expert if indeed

the mechanical ventilation was not working. Although such failure to attempt manual ventilation on Provot may have constituted medical negligence, neither Wheeler nor anyone else was able to point out any conduct by defendants that was so reckless as to demonstrate a substantial lack of concern for whether an injury results. The following colloquy ensued on this point during Wheeler's deposition:

> *Defendants' counsel:* Do you know of any reckless conduct on the part of the paramedics in this case? As opposed to neglectful conduct?
>
> *Wheeler:* I don't know that it would be—I don't know that it would be reckless versus neglectful.

The admissible medical evidence and testimony in this case demonstrates that the ventilator used on Provot was tested and operable when the transport commenced. Although the exact time is unclear, approximately twenty-five minutes into the transport Provot became bradycardic and then astystolic, and Partee asked Brockway to pull over. Apparently, this was done to better assess the patient's situation, and thereafter the paramedics decided to divert to the nearest medical facility. Provot remained on a mechanical ventilator during transport, which may not have been working, and Castle took over chest compression from Partee. The ambulance arrived at the emergency room three to five minutes later. For purposes of this motion, we accept as true plaintiffs' contention that had Provot been manually ventilated, he would not have arrested. Although defendants may have been negligent in failing to detach Provot from the mechanical ventilator and to manually ventilate him with an ambu bag, plaintiffs' allegations essentially amount to second guessing defendants' judgment when deciding how to treat the complication that arose during transport. Viewing the evidence in a light most favorable to plaintiffs, we find that reasonable minds could not differ as to whether defendants engaged in conduct "so reckless as to demonstrate a substantial lack of concern for whether injury resulted." *Jennings*, *supra* at 136-137. Evidence of ordinary negligence does not create a question of fact regarding gross negligence. *Maiden*, *supra* at 122. Summary disposition was properly granted to defendants.

IV. Bystander Claims

The final issue we must address is whether plaintiffs' "bystander" claims survive despite dismissal of the wrongful death action. The trial court granted defendants' motion for summary disposition with respect to plaintiffs' bystander claims without expressly specifying the grounds:

> As far as the claims of the bystanders, the court would indicate inasmuch as they are derivative of the underlying claim, they would require a standard of gross negligence as well. If that were not the . . . standard, the court would determine that while each of them was a close family relative, only one of them immediately saw the deceased at the time of distress and the court would determine that even that relative did not establish, and could not before reasonable prior effect, the standard necessary to make a bystander claim.

This Court reviews de novo a trial court's grant of summary disposition. *Amburgey*, *supra* at 231. This Court also reviews de novo the proper interpretation and application of a statute. *Ford Motor Co, supra* at 438.

We hold that because defendants' conduct did not amount to gross negligence, they are immune from liability pursuant to MCL 333.20965(1) and entitled to summary disposition under MCR 2.116(C)(7) with respect to plaintiffs' claims for negligent infliction of emotional distress. MCL 333.20965(1) provides that the acts or omissions of paramedics, while providing services consistent with their licensure to a patient outside a hospital, do not impose liability on those individuals in the treatment of the patient unless such acts or omissions are the result of gross negligence or willful misconduct. "Liability" means "the state or quality of being liable," and "liable" means "legally responsible." *Bailey v Oakwood Hosp & Medical Ctr*, 472 Mich 685, 696; 698 NW2d 374 (2005), quoting *Random House Webster's College Dictionary* (2001). The statute limits liability in this case for defendants' conduct absent the presence of gross negligence or willful misconduct.

Plaintiffs have not cited any authority to support their implicit argument that the EMSA immunity provision does not bar their claims of negligent infliction of emotional distress. Moreover, plaintiffs also fail to cite any authority to support their assertion that they "only need to prove 'simple negligence'" to support those claims. An appellant may not merely announce a position and leave it to this Court to discover and rationalize the basis for the claim; nor may an appellant give issues cursory treatment with little or no citation to supporting authority. *Peterson Novelties, Inc v City of Berkley*, 259 Mich App 1, 14; 672 NW2d 351 (2003).

Plaintiffs' unsupported assertion that they only need to prove "simple negligence" to sustain their claims arising out of the treatment of a patient by paramedics lacks merit. Given that plaintiffs are unable to demonstrate that defendants' conduct constituted gross negligence or willful misconduct, all of plaintiffs' claims are barred, including the claims for negligent infliction of emotional distress.

Affirmed.

/s/ William B. Murphy
/s/ Richard A. Bandstra
/s/ Jane M. Beckering