STATE OF MICHIGAN

COURT OF APPEALS

ESTATE OF BETTY SIMMS-NORMAN, by its Personal Representative, MARCIA BUTTS, Plaintiff-Appellee, v ST. JOHN MACOMB-OAKLAND HOSPITAL, ST. JOHN PROVIDENCE HEALTH SYSTEM, SETH B. PARKER, M.D., and GREAT LAKES MEDICINE, PLC, Defendants-Appellants.	UNPUBLISHED June 19, 2018 No. 334892 Macomb Circuit Court LC No. 2015-000135-NH

Before: JANSEN, P.J., and SERVITTO and SHAPIRO, JJ.

PER CURIAM.

In this medical malpractice action, defendants appeal by leave granted an order denying their motion for summary disposition under MCR 2.116(C)(10). We affirm.

Plaintiff filed a complaint alleging that defendant, Dr. Seth Parker, was liable for "ordinary negligence, professional negligence and/or medical malpractice" because he included a prescription for Protonix, a proton pump inhibitor (PPI) medication, in the discharge instructions for Betty Simms-Norman, an 81-year-old woman, when she was discharged from St. John Macomb-Oakland Hospital to a nursing home after being treated at the hospital for renal failure.[1] Upon Simms-Norman's placement at the nursing home, the nursing home doctor did not give Simms-Norman Protonix but "exchanged" Prilosec, another PPI medication, for Protonix. After several days at the nursing home, Simms-Norman was readmitted to the hospital with acute renal failure, which required approximately two months of dialysis. Plaintiff alleged that the PPI medication caused Simms-Norman's renal failure. Plaintiff further alleged that Dr. Parker was negligent in failing to prescribe a non-PPI medication, such as Pepcid, and in failing to inform the nursing home that Simms-Norman should not take a PPI, where the nephrologist saw Simms-Norman at the hospital and had recommended that Simms-Norman be given Pepcid rather than a

[1] The complaint alleged that Great Lakes Medicine, PLC, which employed Dr. Parker and St. John Macomb-Oakland Hospital, were vicariously liable for Dr. Parker's negligence.

PPI, due to a possibility that PPI medications were causing her renal failure. Plaintiff does not allege that Dr. Parker's conduct caused Simms-Norman's eventual death in March 2015 but alleges that the dialysis caused pain, suffering, an overall deterioration of her condition, and other damages.

Defendants moved for summary disposition under MCR 2.116(C)(10), arguing that plaintiff was unable to demonstrate that Dr. Parker's conduct was a proximate cause of Simms-Norman's injuries. The trial court denied defendants' motion after concluding that genuine issues of fact existed with respect to whether Dr. Parker's conduct was a proximate cause of the alleged injuries. Defendants now argue that the trial court erred in denying their motion for summary disposition. We disagree.

This Court reviews a trial court's grant or denial of summary disposition de novo. *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999). A motion under MCR 2.116(C)(10) tests the factual sufficiency of a claim. *Id.* at 120. When considering the motion, the court considers the affidavits, pleadings, depositions, admissions, and other evidence in the light most favorable to the nonmoving party. *Id.* If the proffered evidence fails to establish a genuine issue of material fact for trial, then the moving party is entitled to judgment as a matter of law. MCR 2.116(G)(4); *Maiden*, 461 Mich at 120.

In order to be a proximate cause in a negligence action, "the negligent conduct must have been a cause of the plaintiff's injury and the plaintiff's injury must have been a natural and probable result of the negligent conduct. These two prongs are respectively described as 'cause-in-fact' and 'legal causation.' " *O'Neal v St John Hosp and Med Ctr*, 487 Mich 485, 496-497; 791 NW2d 853 (2010). To establish that a defendant's conduct was a cause-in-fact of the plaintiff's injury, the plaintiff must "present substantial evidence from which a jury may conclude that more likely than not, but for the defendant's conduct, the plaintiff's injuries would not have occurred." *Weymers v Khera*, 454 Mich 639, 647-648; 563 NW2d 647 (1997). Legal causation relates to the foreseeability of the consequences of the defendant's conduct. *O'Neal*, 487 Mich at 496. There can be more than one proximate cause contributing to an injury. *Id.* at 496-497.

Defendants first argue that plaintiff cannot establish proximate cause where the evidence showed that the nursing home physician exercised her independent authority to exchange the Protonix prescribed by Dr. Parker for Prilosec. There was undisputed evidence from plaintiff's expert, Dr. Winston, however, that Prilosec and Protonix are both PPI drugs and that it was the effect of the PPI class of drugs that was relevant to plaintiff's kidney condition. Essentially, the distinction between Prilosec and Protonix was irrelevant because both medications were PPI medications. Dr. Winston testified that Prilosec is far more often prescribed than Protonix so that the greater number of cases that they have detailing AIN as a result of PPI's comes from Prilosec. Dr. Winston further testified that the decedent more likely than not developed AIN and that it was a cofactor in her recurrent kidney injury. He testified that the PPI was a cofactor in causing the decedent's acute kidney problems and that either Prilosec or Protonix would have caused the AIN because it was a class effect, not drug specific. Thus, where the evidence showed that Dr. Parker prescribed a PPI and that the nursing home doctor gave Simms-Norman a PPI, the fact that the nursing home doctor gave a different PPI does not defeat plaintiff's claim of proximate cause.

Defendants next argue that Dr. Parker's prescription of Protonix was not a proximate cause of Simms-Norman's injuries because there was expert testimony from Dr. Winston that the nursing home doctor, rather than Dr. Parker, was responsible for Simms-Norman's care upon her return to the nursing home. While Dr. Winston testified that the nursing home doctor was responsible for continuing Dr. Parker's orders, he also testified that it was "usual and customary" for a nursing home doctor to rely on the discharge medications of the discharging doctor and that there was no way for the nursing home doctor to have known that PPIs were an issue. In fact, it appears that the nursing home doctor did not receive the decedent's medical records upon her discharge from the hospital; rather she only received the discharge orders, which contained the prescription for Protonix. It is unclear why the nursing home doctor, the decedent's primary care physician, would be expected to ignore a medication that was ordered by the doctor and hospital that had just treated the decedent for a serious illness. When read in context, we are not convinced that Dr. Winston's testimony that the nursing home doctor was responsible for continuing Dr. Parker's orders defeats plaintiff's claim that Dr. Parker's conduct contributed to the alleged injuries.

Defendants next argue that plaintiff cannot establish causation where her expert's opinion was based on assumptions that were not in accord with the objective facts. We disagree. "[A]n expert's opinion is objectionable where it is based on assumptions that are not in accord with the established facts." *Badalamenti v William Beaumont Hosp-Troy*, 237 Mich App 278, 286; 602 NW2d 854 (1999). Defendants argue that plaintiff should not be permitted to rely on Dr. Winston's testimony to establish causation because Dr. Winston's opinions ignored six relevant facts. Our review of the record shows, however, that Dr. Winston's opinion considered the six facts to which defendants refer. We specifically note that nephrologist, Dr. Brar, who consulted with the decedent while she was in the hospital on several occasions, testified that she ultimately believed that ATN rather than AIN was the cause of the decedent's renal failure but that a biopsy, which was not done, is the only way to get a definitive diagnosis. She repeated that a definitive diagnosis can only be obtained through a biopsy several times throughout her testimony. When specifically asked if she ruled out AIN for the decedent, Dr. Brar testified, "The only definitive thing to do is a biopsy." We thus find no merit in defendants' argument.

Defendants next argue that plaintiff's causation theory is not supported by Michigan law regarding legal causation. Defendants rely on *Singerman v Muni Serv Bureau*, 455 Mich 135; 565 NW2d 383 (1997), to support their argument that plaintiff cannot establish legal causation. In *Singerman*, the plaintiff hockey coach was hit in the eye with a puck while on the ice hockey rink at a sports arena. *Id.* at 136-137. The plaintiff alleged, in part, that his injury resulted from the defendants' failure to enforce rink safety rules requiring participating coaches to wear helmets while on the ice. *Id.* at 144. The plaintiff did not argue that a helmet would have prevented his eye injury but argued that, had the rink enforced the rule requiring coaches to wear helmets while on the ice, he would not have entered the ice and would not have been injured. *Id.* After noting that "the allegedly negligent failure to enforce the helmet rule would create liability in defendants only for injuries that would have been prevented by use of the helmet," the Court explained:

> An event may be one without which a particular injury would not have occurred, but if it merely provided the condition or occasion affording opportunity for the other event to produce the injury, it is not the proximate cause thereof.

> Negligence which merely makes possible the infliction of injuries by another, but does not put in motion the agency by which the injuries are inflicted, is not the proximate cause thereof. Causes of injury which are mere incidents of the operating cause, while in a sense factors, are so insignificant that the law cannot fasten responsibility upon one who may have set them in motion. [*Id.* at 145, citing 57A Am Jur 2d, Negligence, § 473, pp 454–455.]

The court concluded that, because a helmet would not have prevented the plaintiff's injury, the plaintiff had failed to demonstrate proximate cause. *Id.* at 145.

Relying on *Singerman*, defendants argue that, given the nursing home doctor's responsibility to exercise independent judgment with respect to her care of Simms-Norman, Dr. Parker's prescription of a PPI was too remote for the law to allow recovery. *Singerman*, however, is distinguishable from the instant case. While enforcement of the ice rink's helmet rule would not have prevented the plaintiff's injury in *Singerman*, there exists a question of fact with respect to whether Dr. Parker's prescription of a PPI caused the nursing home doctor to give Simms-Norman a PPI, which plaintiff alleges resulted in her injuries. Accordingly, *Singerman* does not support defendants' argument that Dr. Parker's conduct was not a proximate cause of Simms-Norman's injuries.

Finally, defendants argue that plaintiff's theory of causation is impermissibly based on speculation and conjecture. We disagree. "Cause in fact may be established by circumstantial evidence, but such proof 'must facilitate reasonable inferences of causation, not mere speculation.' " *Genna v Jackson*, 286 Mich App 413, 417-418; 781 NW2d 124 (2009), quoting *Skinner v Square D Co*, 445 Mich 153, 164; 516 NW2d 475 (1994). While plaintiff did not present direct factual evidence that the nursing home doctor relied on Dr. Parker's discharge prescription, the evidence that Dr. Parker prescribed a PPI in the discharge instructions, that the nursing home doctor would not have had sufficient evidence to determine independently that Simms-Norman should not be given a PPI, that it was "usual and customary" for a nursing home doctor to rely on the discharge medications, and that Simms-Norman was given a PPI at the nursing home is circumstantial evidence sufficient to demonstrate a genuine issue of material fact with respect to whether, but for Dr. Parker's conduct, Simms-Norman would not have been given a PPI at the nursing home.

Therefore, we affirm the trial court's order denying defendants' motion for summary disposition under MCR 2.116(C)(10).

Affirmed.

/s/ Deborah A. Servitto
/s/ Douglas B. Shapiro

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Before: JANSEN, P.J., and SERVITTO and SHAPIRO, JJ.

JANSEN, P.J. (*dissenting*)

Because I believe defendants were entitled to summary disposition, I dissent.

In a medical malpractice case, it is plaintiff's burden to prove that defendant's breach of the standard of care was the proximate cause of his or her injuries. *Lockridge v Oakwood Hosp*, 285 Mich App 678, 684 (2009), citing *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004). "Proximate cause is a term of art that encompasses both cause in fact and legal cause." *Craig*, 471 Mich at 86. Plaintiff must prove that " 'but for' the defendant's actions, the plaintiff's injury would not have occurred. On the other hand, legal cause or 'proximate cause' normally involves examining the foreseeability of consequences, and whether a defendant should be held legally responsible for such consequences." *Skinner v Square D Co.,* 445 Mich 153, 163; 516 NW2d 475 (1994) (citations omitted). A plaintiff need not prove that the defendant's actions were the *sole* cause of his or her injuries, however plaintiff must "introduce evidence permitting the jury to conclude that the act or omission was *a* cause." *Craig*, 471 Mich at 87.

Michigan law is clear that causation cannot be established by "mere speculation." *Genna v Jackson*, 286 Mich App 413, 417-418; 781 NW2d 124 (2009). "A mere possibility of . . . causation is not sufficient; and when the matter remains one of pure speculation and conjecture, or the probabilities are at best evenly balanced, it becomes the duty of the court to direct a verdict in favor of the defendant." *Id*. Additionally, an act that occurs after the actor's negligent act was committed, " 'which actively operates in producing harm to another[,]' " may break the causal chain. *McMillian v Vliet*, 422 Mich 570, 576; 374 NW2d 679 (1985) (citations omitted).

Such an act will constitute a superseding cause that relieves the original actor from liability. *Id*. Generally, proximate cause is a question for the jury; however, "if reasonable minds could not differ regarding the proximate cause of plaintiff's injury, the court should decide the issue as a matter of law." *Nichols v Dobler*, 253 Mich App 530, 532; 655 NW2d 787 (2002).

As an initial matter, it appears as though my colleagues ignore the testimony of plaintiff's treating nephrologist Dr. Navkiranjot Brar, who is also a board certified nephrologist. Dr. Brar was clear in her opinion that plaintiff's eventual dialysis treatment was the result of acute tubular necrosis (ATN), and not acute interstitial nephritis (AIN) caused by plaintiff's use of a proton pump inhibitor (PPI) medication. Specifically, Dr. Brar testified that if the PPI medications administered to plaintiff were causing her acute kidney failure, when plaintiff was taken off of the PPI drugs, her kidney function would have improved, and she would not have "ended up with renal failure." However, that did not happen in this case. During plaintiff's second hospitalization, plaintiff showed no signs of AIN. She did not have a fever, she did not exhibit a rash, and there was no presence of eosinophil in her urine. Dr. Brar testified:

> Yes, she has renal failure. You're trying to find out why she's in renal failure. Could it be [the PPI medication]? I stopped [the PPI medication]. I expect the kidney numbers to be better. Didn't happen. Okay. I give IV fluids. The patient was dehydrated, but it's still not happening. So what's going on? So then we check the urine sediment, and this time she had just tons of granular cast sitting there which tells, okay, yes, this is ATN.

Dr. Brar further explained that when PPI drugs cause

> damage to the kidney, it's a different form, and I wasn't see[ing] any of those results on the lab tests. When the other things your heart failure, prerenal causing and leading to ATN, there is a different component of the kidney being affected. And all the data was suggestive it is more ATN. ***We didn't have any data to support that it's AIN.*** [Emphasis added.]

Plaintiff has failed to present evidence suggesting that PPI medications can, or did in this case, cause ATN. Accordingly, in my view, plaintiff has failed to establish cause-in-fact, and on that basis alone defendants were entitled to summary disposition in their favor.

Further, I disagree with my colleagues that plaintiff has established legal causation. The record here is clear that before plaintiff was admitted to the emergency room, Dr. Yalala, plaintiff's nursing home physician, had been treating plaintiff with Prilosec, a PPI medication, and when plaintiff returned to the nursing home, Dr. Yalala continued to administer Prilosec.[1] Accordingly, Protonix, the PPI medication listed, but not proscribed, by Dr. Seth Parker in the discharge instructions was never administered to plaintiff. This is significant because despite being members of the same class of drugs, Prilosec and Protonix are not the same medication. Prilosec and Protonix have different chemical compositions, and one is not the generic for the

[1] Dr. Yalala's first name does not appear in the record.

other. Indeed, plaintiff's expert witness, Dr. David Winston, testified that most of the medical literature that attributes PPI medication to AIN focuses on a patient's use of Prilosec, not Protonix. Dr. Winston specifically testified that "[b]ecause of the prevalence of omeprazole or Prilosec use being far greater than Protonix, the greater number of cases have been omeprazole; however the authors would speculate that its due to the ratio of overall prescribing and use." However, such speculation is insufficient to establish causation. *Genna*, 286 Mich App at 417-418. Additionally, there is no testimony that Dr. Yalala, or any other medical professional at the nursing home, ever relied on the discharge instructions written by Dr. Parker. Although Dr. Winston testified that it was "usual and customary" for a nursing home doctor to rely on the discharge instructions, it is speculative to assume that Dr. Yalala did so here. Again, plaintiff cannot prove proximate causation based on speculation or conjecture. *Id.*

Assuming *arguendo* that plaintiff had established proximate causation, my colleagues also ignore the fact that Dr. Yalala used her independent medical judgment and continued to treat plaintiff with a PPI medication upon plaintiff's return to the nursing home, despite the discharge instructions being clear that plaintiff was suffering from kidney failure. Specifically, the discharge instructions state in large, bold, and capital letters that plaintiff was suffering from renal failure. Dr. Yalala's judgment is particularly questionable in light of Dr. Winston's expert opinion that the medical community widely accepted that PPI drugs can be linked to AIN, and possible subsequent kidney failure. I would conclude that Dr. Yalala's equally negligent medical treatment was a superseding cause of plaintiff's injuries, which breaks the causal chain and relieves Dr. Parker of all liability. Regardless, in my view, plaintiff has presented only speculative evidence regarding legal causation. Reasonable minds could not differ that Dr. Parker was not the proximate cause of plaintiff's injuries, and for that reason, defendants were entitled to summary disposition as a matter of law.

/s/ Kathleen Jansen

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Before: JANSEN, P.J., and SERVITTO and SHAPIRO, JJ.

SHAPIRO, J. (*concurring*).

I concur in the majority opinion and write only to note several errors in the dissenting opinion.

The dissent begins by stating that plaintiff must show that "defendant's breach of the standard of care was the proximate cause of his or her injuries." The use of the phrase "the proximate cause" is misplaced in the setting of a medical malpractice case, or indeed, in any case not involving governmental immunity governed specifically by MCL 691.1407(2). The statute defining the elements of a medical malpractice action does not contain the phrase "the proximate cause." MCL 600.2912a. The dissent cites to *Lockridge v Oakwood Hosp*, 285 Mich App 678, 684; 777 NW2d 511 (2009), as authority for its statement, but that case never used the phrase "the proximate cause," and there is *no* case that has held that a breach of the standard of care must be the sole proximate cause in a medical malpractice case, or in any case other than one involving governmental immunity. Indeed, the dissent later goes on to say, citing *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004), that "[a] plaintiff need not prove that the defendant's actions were the *sole* cause of his or her injuries." Perhaps the dissent's use of the phrase "the proximate cause" was merely inadvertent, but the use of that phrase in this case has no basis in law or fact and if read out-of-context could distort well-settled law.

Second, the dissent has lost sight of the basic principle that in the context of a motion for summary disposition, a court must consider the pleadings, affidavits, depositions, admissions, and other documentary evidence submitted in the light most favorable to the nonmoving party,

MCR 2.116(G)(5); *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 206; 815 NW2d 412 (2012), and all reasonable inferences are to be drawn in favor of the nonmovant, *Dextrom v Wexford Co*, 287 Mich App 406, 415; 789 NW2d 211 (2010). Rather than adhering to this basic axiom, the dissent does the opposite. The dissent scours the record for any evidence that could support the *moving* party, and interprets the entire record in the light most favorable to that party. Oddly, the dissent seems to take the position that in order to survive a motion for summary disposition the non-movant must show that there is no evidence that supports the moving party's position, rather than that there is evidence that support's the non-movant's case.

Third, the dissent fails to fully understand the facts of this case. While in the hospital, the PPI that plaintiff had been receiving at the nursing home was *discontinued* because the hospital doctors discovered its causal link to the plaintiff's malady.[1] Thus, the critical decision was the initial resumption of that medication and it is, at least for this motion, uncontested that this decision was made by defendant.[2] That a second doctor does not discontinue a medication negligently prescribed by a prior doctor does not immunize the prior doctor.

/s/ Douglas B. Shapiro

[1] The kidney specialist treating decedent in the hospital noted in her consult note, written on the day of discharge, that she recommended switching the patient's medication to "Pepcid rather than PPI" because of possible "AIN complications related to that." Pepcid and PPI's both treat heartburn and stomach ulcers, but they have different biochemical mechanisms and side-effects.

[2] The discharge orders signed by defendant directed that as an outpatient decedent should be taking a PPI. The discharge document further stated: "This is a complete list of medication(s) that you should be taking based on information you provided us as well as treatment provided during this hospital visit." When asked about this in deposition, defendant stated, "these are the medications I chose to put the patient on at discharge."