STATE OF MICHIGAN

COURT OF APPEALS

ESTATE OF JASON A. BLACKWELL, by PENNY COLE, Personal Representative,

Plaintiff-Appellant/Cross-Appellee,

v

ST. MARY'S OF MICHIGAN, doing business as ST. MARY'S OF MICHIGAN HOSPITAL,

Defendant-Appellee/Cross-Appellant.

UNPUBLISHED
August 13, 2020

No. 346652
Saginaw Circuit Court
LC No. 15-028060-NH

Before: FORT HOOD, P.J., and JANSEN and TUKEL, JJ.

PER CURIAM.

In this medical malpractice action, plaintiff Penny Cole, as personal representative of the Estate of Jason A. Blackwell, appeals as of right the trial court's order granting the motion of defendant, St. Mary's of Michigan, doing business as St. Mary's of Michigan Hospital, to strike the testimony of plaintiff's expert, Timothy Hawkins, and granting summary disposition in favor of defendant. The trial court found that Hawkins was qualified under MCL 600.2169 to provide expert testimony on the standard of care for defendant's hospital administrators in developing and implementing a Code Blue policy,[1] but that Hawkins's expert opinion was not admissible because it was not rationally derived from a solid foundation. Earlier, the trial court found that plaintiff's anesthesiology expert, Dr. Dennis Doblar, M.D., was not qualified under MCL 600.2169 to testify as an expert in support of plaintiff's hospital-administration claims. The trial court also dismissed plaintiff's nursing-malpractice claims for lack of evidence that any malpractice caused Blackwell's death. Plaintiff appeals these decisions. On cross-appeal, defendant appeals the trial court's decision that Hawkins was qualified under MCL 600.2169 to testify regarding the standard of care for defendant's hospital administrators. This appeal is being decided without oral argument pursuant to MCR 7.214(E)(1). We affirm in part, reverse in part, and remand for further proceedings.

[1] A Code Blue is the name given at defendant hospital to the response when a patient experiences respiratory distress.

I. UNDERLYING FACTS

This case arises from the death of plaintiff's decedent, 30-year-old Jason A. Blackwell, on March 17, 2012, in the Intensive Care Unit (ICU) of defendant hospital after his tracheostomy tube became dislodged and several members of defendant's staff were not able to secure an airway.[2] Blackwell arrived at the hospital approximately a week earlier for treatment of multiple gunshot wounds. On March 15, 2012, Blackwell underwent surgery to repair a fracture of his mandible, which required that his jaw be wired shut. Before the surgery, Dr. Timothy Hackett, M.D., placed an open tracheostomy tube in Blackwell's trachea. At approximately 6:20 a.m. on March 17, 2012, Blackwell suffered respiratory distress. When the attending nurse, Sara Enser, R.N., was unable to rectify the situation by herself, a Code Blue was called, but multiple intervention efforts by defendant's medical and nursing staff were unsuccessful in securing an airway. Blackwell died at 6:44 a.m.

Plaintiff alleged malpractice against defendant hospital based on its development and implementation of its Code Blue policy, and additionally for nursing malpractice. Following discovery, defendant filed several motions for summary disposition challenging the qualifications of plaintiff's expert witnesses and the causation element of plaintiff's nursing-malpractice claims. The trial court's rulings on these motions form the basis for this appeal.

II. EXPERT TESTIMONY OF TIMOTHY HAWKINS

Plaintiff argues that the trial court erred by ruling that the proposed trial testimony of Timothy Hawkins, plaintiff's hospital-administration expert, was not admissible because it was not reliable. On cross-appeal, defendant challenges the trial court's preliminary determination that Hawkins was qualified under MCL 600.2169 to provide testimony with regard to the standard of care for a hospital administrator. We conclude that Hawkins was not qualified to testify as an expert witness in this case, because in his deposition taken during discovery, Hawkins failed to establish his qualifications regarding the applicable local standard of care for hospital administrators. Consequently, we need not reach the issue of whether Hawkins's testimony would have been reliable.

A. STANDARD OF REVIEW

"The trial court's decision regarding whether an expert witness is qualified is reviewed for an abuse of discretion." *Turbin v Graesser*, 214 Mich App 215, 217-218; 542 NW2d 607 (1995). "An abuse of discretion occurs when the decision resulted in an outcome falling outside the range of principled outcomes." *Hayford v Hayford*, 279 Mich App 324, 325-326; 760 NW2d 503 (2008). A decision on a close evidentiary question ordinarily cannot constitute an abuse of discretion, *Barr v Farm Bureau Gen Ins Co*, 292 Mich App 456, 458; 806 NW2d 531 (2011), but an erroneous

[2] Defendant hospital is a level II trauma center in Saginaw, Michigan. Defendant hospital is also a teaching hospital that is partially staffed by residents.

application of the law is by definition an abuse of discretion, *Gay v Select Specialty Hosp*, 295 Mich App 284, 292; 813 NW2d 354 (2012).

A motion for summary disposition under MCR 2.116(C)(10) tests the factual sufficiency of the complaint and is reviewed de novo. *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 205-206; 815 NW2d 412 (2012). This Court reviews a motion brought under MCR 2.116(C)(10) "by considering the pleadings, admissions, and other evidence submitted by the parties in the light most favorable to the nonmoving party." *Patrick v Turkelson*, 322 Mich App 595, 605; 913 NW2d 369 (2018). Summary disposition "is appropriate if there is no genuine issue regarding any material fact and the moving party is entitled to judgment as a matter of law." *Id.* "There is a genuine issue of material fact when reasonable minds could differ on an issue after viewing the record in the light most favorable to the nonmoving party." *Allison v AEW Capital Mgt, LLP*, 481 Mich 419, 425; 751 NW2d 8 (2008). "Only the substantively admissible evidence actually proffered may be considered." *1300 LaFayette East Coop, Inc v Savoy*, 284 Mich App 522, 525; 773 NW2d 57 (2009) (quotation marks and citation omitted). "Circumstantial evidence can be sufficient to establish a genuine issue of material fact, but mere conjecture or speculation is insufficient." *McNeill-Marks v Midmichigan Med Ctr-Gratiot*, 316 Mich App 1, 16; 891 NW2d 528 (2016).

B. WHETHER HAWKINS IS QUALIFIED TO TESTIFY REGARDING THE STANDARD OF CARE FOR HOSPITAL ADMINISTRATORS

"A plaintiff in a medical malpractice action must establish (1) the applicable standard of care, (2) breach of that standard of care by the defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury." *Elher v Misra*, 499 Mich 11, 21; 878 NW2d 790 (2016) (citation and quotation marks omitted). In general, "expert testimony is required in a malpractice case in order to establish the applicable standard of care and to demonstrate that the professional breached that standard." *Id*. (citation and quotation marks omitted). But an expert witness is not required "when the professional's breach of the standard of care is so obvious that it is within the common knowledge and experience of an ordinary layperson." *Id*. at 21-22 (citation omitted). Finally, "[t]he proponent of the evidence has the burden of establishing its relevance and admissibility." *Id*. at 22 (citation omitted).

"The proponent of expert testimony in a medical malpractice case must satisfy the court that the expert is qualified under MRE 702, MCL 600.2955 and MCL 600.2169." *Elher*, 499 Mich at 22 (citation and quotation marks omitted). MRE 702 and MCL 600.2955 address the reliability of a proposed expert's testimony, but MCL 600.2169 addresses the qualifications of the proposed expert witness. See MCL 600.2169; MCL 600.2955; MRE 702.

Before we can turn to the question of whether a witness meets the requirements to testify regarding the standard of care under MCL 600.2169 (which is based on his or her licensure and work experience), we must first determine the applicable standard of care and the expert's knowledge of it. In MCL 600.2912a, the Legislature codified the standard of care applicable to medical practitioners, meaning those individuals who engage in the practice of medicine for their profession. *Cox v Flint Bd of Hosp Managers*, 467 Mich 1, 18-19; 651 NW2d 356 (2002). For purposes of MCL 600.2912a, "the practice of medicine" is defined as

> the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition, by attendance, advice, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts. [*Id*. at 20, quoting MCL 333.17001(1)(d).]

But when a medical malpractice case is brought based on the actions of someone other than a medical practitioner, like a nurse, then the common law standard of care applies instead. *Id*. at 20.[3] Hospital administrators engage in administrative activities such as reviewing staffing at hospitals and writing and implementing procedures for specific events, such as the Code Blue in this case. As such, they are not engaged in the practice of medicine and thus the common law standard of care applies to them. See *id*. For medical malpractice cases, when the common law standard of care applies, "the applicable standard of care is the skill and care ordinarily possessed and exercised by practitioners of the profession in the same or similar localities." *Id*. at 21-22. Thus, an expert in hospital administration must be knowledgeable of the standard of care in the relevant locality to be qualified as an expert in a medical malpractice case. See *id*. at 20-22.

In his deposition, Hawkins testified about a national standard of care, not the local standard of care for a level II trauma center in Saginaw, Michigan, such as defendant. Specifically, Hawkins based his standard of care testimony on the national standards set by the Joint Commission.[4] Hawkins had never worked in a hospital in Michigan and he also conceded that he did not contact any local hospital administrators in the Saginaw area, or any other health system in Michigan, when preparing his opinion in this case. Additionally, Hawkins also conceded that he never had primary responsibility for drafting a policy or procedure for ICU management. Furthermore, Hawkins had never worked in a level II trauma center or in a teaching hospital staffed with residents, as is defendant. As such, Hawkins failed to establish that he was knowledgeable of the local standard of care for a level II trauma center in Saginaw, Michigan. Because Hawkins was not knowledgeable about the applicable standard of care, he was not qualified to offer standard of care testimony in this case. Consequently, the trial court erred by finding that Hawkins was

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[3] As explained in *Cox*, the practice of nursing is different from the practice of medicine because the practice of nursing consists of

> the systematic application of substantial specialized knowledge and skill, derived from the biological, physical, and behavioral sciences, to the care, treatment, counsel, and health teaching of individuals who are experiencing changes in the normal health processes or who require assistance in the maintenance of health and the prevention or management of illness, injury, or disability. [*Cox*, 467 Mich at 19, quoting MCL 333.17201(1)(a).]

[4] The Joint Commission was founded in 1951 and accredits and certifies more than 22,000 hospitals around the United States. The Joint Commission also develops standards that focus on patient safety and quality of care.

qualified to offer standard of care testimony, and thus it is unnecessary for us to consider the additional question of whether his standard of care testimony would have been reliable.

III. QUALIFICATIONS OF DRS. DOBLAR AND ALLEN AS HOSPITAL ADMINISTRATION EXPERTS

Plaintiff argues that the trial court also erred by concluding that Dr. Dennis Doblar, M.D., and Dr. Paul Allen, M.D., were not qualified to offer testimony on the standard of care in support of plaintiff's hospital-administration claims. We disagree.

As stated earlier, "[t]he trial court's decision regarding whether an expert witness is qualified is reviewed for an abuse of discretion." *Turbin*, 214 Mich App at 217-218. Additionally, a motion for summary disposition under MCR 2.116(C)(10) tests the factual sufficiency of the complaint and is reviewed de novo. *Joseph*, 491 Mich at 205-206.

As an initial matter, we note that the issue of whether Dr. Allen can testify regarding the standard of care for hospital administrators was not actually decided by the trial court. Nevertheless, to the extent defendant raises the issue here, we choose to address it and conclude that the issue is waived. "It is well established that a party who waives a right is precluded from seeking appellate review based on a denial of that right because waiver eliminates any error. A waiver is a voluntary and intentional abandonment of a known right." *Braverman v Granger*, 303 Mich App 587, 608; 844 NW2d 485 (2014) (citations, quotation marks, and brackets omitted). Plaintiff conceded in her November 16, 2017 response to defendant's interrogatories that Dr. Allen was not qualified to testify about the standard of care for hospital administrators. Thus, the issue is waived. Consequently, only the qualifications of one of plaintiff's anesthesiology experts, Dr. Doblar, to testify about the standard of care for hospital administrators remains at issue.

Plaintiff argues that Dr. Doblar is qualified to testify about hospital administration under MCL 600.2169, which is entitled "Qualifications of expert witness in action alleging medical malpractice." But we need not address this issue because Dr. Doblar failed to demonstrate that he knows the applicable local standard of care for a hospital administrator at a level II trauma center in Saginaw, Michigan and, therefore, whether Dr. Doblar fulfills the requirements of MCL 600.2169 is irrelevant to whether he can testify as an expert about hospital administration in this case. To the extent Dr. Doblar testified about the standard of care applicable to hospital administrators, he only discussed the national standard of care. As such, Dr. Doblar failed to testify about the local standard of care in Saginaw, Michigan, which, as already noted, is the relevant standard regarding a witness's qualifications to testify as an expert regarding hospital administration. See *Cox*, 467 Mich at 20-22. Thus, Dr. Doblar is precluded from testifying about hospital administration in this case because he failed to establish knowledge of the applicable standard of care. See MRE 702.

IV. NURSING-MALPRACTICE CLAIM

Plaintiff argues that in concluding that plaintiff had failed to present evidence of causation and accordingly dismissing her claims for nursing malpractice, the trial court erred. We agree.

As stated earlier, a motion for summary disposition under MCR 2.116(C)(10) tests the factual sufficiency of the complaint and is reviewed de novo. *Joseph*, 491 Mich at 205-206.

At issue here is whether, for summary disposition purposes, plaintiff presented sufficient evidence that the alleged breaches of the standard of care by defendant's nursing staff were causally linked to Blackwell's death. In *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004), in the context of deciding whether the evidence at trial supported the jury's verdict that the defendants' breach of the applicable standard of care caused the plaintiff's cerebral palsy, the Supreme Court held that under MCL 600.2912a(2), a plaintiff in a malpractice action is required to prove causation by a preponderance of the evidence standard. Describing proximate cause as a legal term of art, the Court explained that the term includes both cause in fact and legal, or proximate cause. *Craig*, 471 Mich at 86. The Court explained:

> The cause in fact element generally requires showing 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. [*Id*. at 86-87 (citation omitted).]

Accordingly, "[a]s a matter of logic, a court must find that the defendant's negligence was a cause in fact of the plaintiff's injuries before it can hold that the defendant's negligence was the proximate or legal cause of those injuries." *Id*. at 87. With regard to causation in fact, the plaintiff must present evidence that demonstrates that the injury would not have occurred "but for" the alleged act or omission. *Id*. Therefore, while a plaintiff is not required to prove that the alleged act or omission "was the *sole* catalyst" for the injuries at issue, evidence must be presented that would allow the jury to determine that the alleged act or omission was a cause. *Id*.

> It is important to bear in mind that a plaintiff cannot satisfy this burden by showing only that the defendant *may have* caused his injuries. Our case law requires more than a mere possibility or a plausible explanation. Rather, a plaintiff establishes that the defendant's conduct was a cause in fact of his injuries only if he "set[s] forth specific facts that would support a reasonable inference of a logical sequence of cause and effect." *A valid theory of causation, therefore, must be based on facts in evidence*. And while " '[t]he evidence need not negate all other possible causes,' " this Court has consistently required that the evidence " 'exclude other reasonable hypotheses with a fair amount of certainty.' " [*Id*. at 87-88 (citations omitted; emphasis added).]

Consequently, a plaintiff in a malpractice action must put forth evidence that draws a causal link between the alleged breach in the standard of care and the plaintiff's injuries. *Id*. at 90. Accordingly, to withstand summary disposition under MCR 2.116(C)(10) here, plaintiff was required to present evidence that causally linked the alleged breaches of the standard of care by defendant's nursing staff to the conditions that caused Blackwell's death.

During her deposition, plaintiff's expert witness on the nursing standard of care, Kaisa Ring, R.N., testified that defendant's nursing staff breached the standard of care by not removing Blackwell's entire tracheostomy tube to allow access to the stoma. In pertinent part, Ring testified:

> *Q.* So you believe as soon as a Code Blue is called, the first reaction should be to remove the entire [tracheostomy tube?]
>
> *A.* Yes. I would have removed it, yes.
>
> *Q.* And does the standard of care for a nurse require that they remove the [tracheostomy tube]?
>
> *A.* Me, as an [Intensive Care Nurse], would I have done that? Absolutely. I wouldn't have hesitated.
>
> *Q.* But excluding your own personal standard of care.
>
> *A.* Well, it's not even really my personal standard of care. If you don't take [the tracheostomy tube] out, your patient still doesn't have an airway, so you could do nothing and your patient dies, or you could take it out and have at least a chance.
>
> *Q.* So you believe it's within the standard of care of a nurse to remove the [tracheostomy tube]?
>
> *A.* Yes.
>
> *Q.* You have no criticisms from 6:15 to 6:20 for nurses, but you believe as soon as the Code Blue was called, it was indicated right then and there that the tracheostomy tube should have been removed?
>
> *A.* Yes, because at that point, [Blackwell's] [saturation levels] were in the 50s.

Ring further testified that after the tracheostomy tube was removed, the stoma should have been ventilated with an Ambu bag in an attempt to get air into Blackwell's lungs, and Blackwell should have been ventilated. According to Ring, if these steps did not help, and defendant's nursing staff was not seeing that Blackwell was immediately responding, "then call somebody, do something else." In Ring's words, "[t]he standard of care is really getting an airway as fast as possible, so whatever steps you need to take to do that." Ring testified that defendant's nursing staff breached the standard of care by waiting until 6:30 a.m., 12 minutes, until deciding to change out the tracheostomy tube. Ring explained that "[a]nything that delays that is just making your patient hypoxic for that much longer, and he'll lose brain function." Ring further testified as follows:

> *Q.* So you believe that from 6:20 to 6:26 for a nurse to continue to bag the patient in an attempt to oxygenate by bagging, that that's a breach of the standard of care?

A. Yes, because you're still not in an airway.

Q. Was it Nurse Enser's responsibility within the standard of care to remove the tracheostomy tube?

A. I wouldn't just fault her, but yes, it was her responsibility.

Q. Once she removed the tracheostomy tube what could she do to oxygenate the patient?

A. Put a mask over his face, put a mask over his stoma. She could do both at the same time. Technically the patient could have had a mask on his face the entire time that they were trying to bag the stoma.

When reminded that Nurse Enser, the attending nurse who was present when Blackwell first lost his airway, testified that she had never removed a tracheostomy tube before, Ring responded: "Nurses do trach care all the time. In fact, they're the ones responsible for that. I don't think that I've ever seen a physician do trach care." Ring also testified that Blackwell could have been nasally intubated to provide him with oxygen because his jaw was wired shut. When asked if Blackwell's prognosis would have been different if the steps she believed should have been taken were done, Ring responded, "Yes. It's hard to imagine trying to hold your breath for 20 minutes and then come out alive."

Ring clarified that all of the steps within the standard of care, including removing the tracheostomy tube, bagging the stoma, bagging Blackwell's mouth and nasally intubating him, were all steps that preceded Blackwell getting a "formal secured airway." In Ring's opinion, "[y]ou keep going until you exhaust all your possibilities." Ring believed that if all of these steps had been taken, an airway for Blackwell would have been secured. In Ring's words, "it's a priority to have an airway; because if you don't have an airway, none of the rest of the [steps that were taken] really matters."

At the outset of his deposition testimony, Dr. Allen acknowledged that he was not a nurse, and during the balance of his testimony he did not offer evidence concerning the standard of care for defendant's nursing staff. Dr. Allen did testify that in his work as an anesthesiologist, he has had to replace a tracheostomy tube in a patient. This could occur under circumstances in which the tracheostomy tube is not properly secured, and when the patient is moved, the tracheostomy tube can fall out. According to Dr. Allen, it is "not probable" for a tracheostomy tube to become dislodged merely from a patient coughing. Dr. Allen agreed that a tracheostomy tube can become dislodged if a patient is moved while attached to a ventilator and the person moving the patient is not being careful. When asked what opinion he intended to offer at trial, Dr. Allen responded:

> The opinion I intend to offer is that this patient expired as a result of having his trach tube dislodged, and that it was nobody present who could, who was able to first understand the situation, and second to fix the situation, that there were several options, none of which were taken.

Dr. Allen also testified that "someone who is capable of fixing the problem" should have been on staff at defendant's hospital where fresh tracheostomies were performed "to manage them should something go awry."

In our opinion, Ring's testimony regarding how defendant's nursing staff breached the standard of care, taken together with Dr. Allen's testimony regarding how the failure of defendant's staff to appropriately intervene to secure an airway for Blackwell, and the reasonable inferences drawn from this evidence, all viewed in the light most favorable to plaintiff, demonstrate that genuine issues of material fact exist with regard to the causation element of plaintiff's claim of nursing malpractice. See *Allison*, 481 Mich at 425. Specifically, Dr. Allen testified that a tracheostomy tube is more likely to become dislodged when a patient is moved rather than simply as a result of a patient coughing. Viewed in the light most favorable to plaintiff, Dr. Allen's testimony can be seen as establishing that Nurse Enser may have dislodged Blackwell's tracheostomy tube when she moved him. Nurse Enser, as well as other nurses, were present after Blackwell's tracheostomy tube became dislodged. Dr. Allen testified that there was "nobody present who could" understand and "fix the situation," which he opined led to Blackwell's death. Consequently, based on Dr. Allen's testimony, if Nurse Enser or another person present at the Code Blue had been able to understand and fix the situation then Blackwell would not have died. Thus, viewed in the light most favorable to plaintiff, there is a dispute of material fact regarding whether Blackwell died as a result of nursing malpractice, because the evidence established a causal link between the alleged breaches of the standard of care by the nursing staff and Blackwell's death. In other words, factual disputes remain concerning whether, but for the nursing staff's failure to perform the interventions Ring testified were required by the standard of care, an airway would have been secured for Blackwell, thereby enabling him to survive the Code Blue. See *Craig*, 471 Mich at 86-87. Accordingly, the trial court erred by granting summary disposition as to plaintiff's claim for nursing malpractice.

Defendant also argues that plaintiff failed to present evidence that if defendant's nursing staff had performed the interventions that Ring testified were necessary to save Blackwell's life, Blackwell would not have died. Defendant claims that its nursing and medical physician staff did perform the interventions that Ring alleged were lacking, such as removing Blackwell's tracheostomy tube, and performing additional ventilation and suction measures as well as a cricothyrotomy, but these measures did not save Blackwell's life. Contrary to defendant's assertion, Dr. Shah testified that he did not remove Blackwell's tracheostomy tube. Rather, he attempted to use a tube exchanger to ensure that Blackwell's tracheostomy tube was not blocked while the nursing staff continued to ventilate Blackwell. Dr. Shah, along with defendant's nursing team, also performed a needle decompression to remove subcutaneous air from Blackwell's body. Nurse Patricia Longoria, R.N., also explained the steps she took to provide additional ventilation for Blackwell. Nurse Longoria further testified that defendant's nursing staff performed a cricothyrotomy and a needle decompression to remove subcutaneous air from Blackwell's body.

According to defendant, because Dr. Shah's actions were not successful in providing the needed ventilation and oxygen for Blackwell, the other interventions that Ring suggested should have been done, including "bagging the stoma, placing a mask over the stoma, or nasally intubating" Blackwell, would not have been successful either. Defendant contends that the alleged interventions identified by Ring "were essentially performed" and thus, "[m]ore likely than not,

the 'required' interventions could not have saved [Blackwell] because in reality he did not survive when these interventions were performed."

Defendant is correct that the evidence showed that defendant's nursing and medical staff undertook several interventions that were aimed at providing additional ventilation and oxygenation for Blackwell in order to save his life. The record also demonstrates that Ring has criticized defendant's nursing staff for not undertaking the appropriate measures to secure an airway for Blackwell and to provide oxygen for him. In our opinion, the divergence in the evidence creates genuine issues of material fact to be resolved by the trier of fact, not only with regard to determining what measures were in fact undertaken, but whether the measures were undertaken correctly, in a timely fashion, in the correct sequence from a medical standpoint, and whether the interventions reasonably likely would have saved Blackwell's life. Accordingly, defendant was not entitled to summary disposition of the nursing-malpractice claims under MCR 2.116(C)(10).

V. CONCLUSION

We reverse the trial court's April 30, 2018 opinion and order granting defendant's motion for summary disposition as to plaintiff's nursing-malpractice claims; we affirm the trial court's May 3, 2018 supplemental opinion and order concluding that Dr. Doblar was not qualified to testify in support of plaintiff's hospital-administration claims; and we affirm the trial court's September 27, 2018 opinion and order to the extent that it dismissed plaintiff's hospital-administration claims on the basis of its conclusion that Hawkins's expert witness testimony was not reliable; however, we reverse the September 27, 2018, order to the extent that it dismissed plaintiff's entire cause of action, including her nursing-malpractice claims. We remand for further proceedings consistent with this opinion.

Affirmed in part, reversed in part, and remanded for further proceedings. We do not retain jurisdiction.

/s/ Karen M. Fort Hood
/s/ Jonathan Tukel

STATE OF MICHIGAN

COURT OF APPEALS

ESTATE OF JASON A. BLACKWELL, by PENNY COLE, Personal Representative, Plaintiff-Appellant/Cross-Appellee, v ST. MARY'S OF MICHIGAN doing business as ST. MARY'S OF MICHIGAN HOSPITAL, Defendant-Appellee/Cross-Appellant.	UNPUBLISHED August 13, 2020 No. 346652 Saginaw Circuit Court LC No. 15-028060-NH

Before: FORT HOOD, P.J., and JANSEN and TUKEL, JJ.

JANSEN, J. (*concurring in part, dissenting in part*).

I concur with the majority's ultimate conclusion that the trial court did not abuse its discretion by excluding Timothy F. Hawkins' expert opinion. I write separately because I agree with the trial court's reasoning that although Hawkins was qualified under MCL 600.2169 to provide expert testimony on the standard of care for defendant's hospital administrators in developing and implementing a Code Blue policy, Hawkins' expert opinion was nevertheless inadmissible under MRE 702. In my view, Hawkins' expert opinion was not rationally derived from a solid foundation. I also agree with the majority that Dr. Dennis Doblar and Dr. Paul Allen were unqualified to offer standard of care testimony in relation to plaintiff's hospital administration claims.

However, I disagree with the majority that plaintiff had presented sufficient evidence of causation to support her nursing malpractice claims. Because I would affirm the trial court's order granting summary disposition in favor of defendants on plaintiff's nursing malpractice claims, I respectfully dissent.

I. HAWKINS' EXPERT TESTIMONY

Plaintiff argues that the trial court abused its discretion by concluding Hawkins' expert testimony was inadmissible. Like the majority, I disagree.

This Court reviews for an abuse of discretion a trial court's ruling regarding the qualifications of an expert witness. *Crego v Edward W Sparrow Hosp Ass'n*, 327 Mich App 525, 531; 937 NW2d 380 (2019). A court abuses its discretion when its decision falls outside the range of reasonable and principled outcomes. *Id.* We review de novo a trial court's decision on a motion for summary disposition. *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152, 159; 934 NW2d 665 (2019). In challenging Hawkins's qualifications, defendant moved for summary disposition under MCR 2.116(C)(10). In *El-Khalil*, our Supreme Court explained:

> A motion under MCR 2.116(C)(10), . . . , tests the factual sufficiency of a claim. *Johnson v VanderKooi*, 502 Mich 751, 761; 918 NW2d 785 (2018). When considering such a motion, a trial court must consider all evidence submitted by the parties in the light most favorable to the party opposing the motion. *Id.* A motion under MCR 2.116(C)(10) may only be granted when there is no genuine issue of material fact. *Lowrey v LMPS & LMPJ, Inc*, 500 Mich 1, 5; 890 NW2d 344 (2016). "A genuine issue of material fact exists when the record leaves open an issue upon which reasonable minds might differ." *Johnson*, 502 Mich at 761 (quotation marks, citation, and brackets omitted in original).

A. WHETHER HAWKINS IS QUALIFIED TO TESTIFY REGARDING THE STANDARD OF CARE FOR HOSPITAL ADMINISTRATORS

To succeed on a claim of malpractice, a plaintiff is required to demonstrate (1) the standard of care, (2) a breach of that standard of care, (4) injury, and (4) proximate causation between the injuries and the alleged breach of the standard of care. *Lanigan v Huron Valley Hosp, Inc*, 282 Mich App 558, 565; 766 NW2d 896 (2009). When a party offers expert testimony, it is the trial court's obligation to act as a gatekeeper to ensure that the expert's qualifications, as well as the testimony itself, meets the threshold standards under the law. *Gay v Select Specialty Hosp*, 295 Mich App 284, 813 NW2d 354 (2012).

Count I of plaintiff's first amended complaint alleged that defendant's hospital administrators failed to adopt internal policies and procedures for responding to a Code Blue within any area of the hospital. Plaintiff specifically alleged that defendant's administrators did not adopt an appropriate plan and procedure to ensure that the ICU was properly staffed to respond to a Code Blue in a timely manner. According to plaintiff, administrators should have ensured that the ICU was staffed with an in-house physician, or that a physician was immediately available for consult, particularly with respect to issues involving a patient's airway or respiratory issues. Plaintiff alleged that as a result of these breaches of the standard of care, Jason Blackwell did not receive appropriate care and treatment because (1) he was not treated by an anesthesiologist, trauma surgeon, emergency room physician, or other qualified physician, and (2) he did not receive adequate airway management at the necessary time, which ultimately led to his death. Plaintiff offered Hawkins' testimony to bolster her claims. At issue here is whether Hawkins was qualified to testify concerning the standard of care for a hospital administrator.

MCL 600.2169 provides, in pertinent part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is

licensed as a health professional in this state or another state and meets the following criteria:

(a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

(b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:

(*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.

(*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

(c) 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, devoted a majority of his or her professional time to either or both of the following:

(*i*) Active clinical practice as a general practitioner.

(*ii*) Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed.

(2) In determining the qualifications of an expert witness in an action alleging medical malpractice, the court shall, at a minimum, evaluate all of the following:

(a) The educational and professional training of the expert witness.

(b) The area of specialization of the expert witness.

(c) The length of time the expert witness has been engaged in the active clinical practice or instruction of the health profession or the specialty.

(d) The relevancy of the expert witness's testimony.

The record before us indicates that Hawkins is board-certified in hospital administration and holds the designation of a Fellow of the American College of Healthcare Executives. Hawkins also has a bachelor's degree and a master's degree in business administration from the University of Akron. At the time he was deposed in this case, Hawkins worked part time in hospital administration expert witness consulting, and from 2009 until 2012, he served as the executive vice president and chief operating officer of the Villages Regional Hospital, which is part of the Central Florida Health Alliance. Previously, Hawkins served as the senior vice president of clinical services for Central Florida Health Alliance from 2008 to 2009, he was the senior vice president and chief administrative officer of Thompson Cancer Survival Centers from 2007 to 2008, and he was the vice president of clinical services for Baptist Hospital of Miami from 1999 to 2007. Hawkins also worked at Mercy Hospital as the vice president of support services, the administrative director of support services, and the director of materials management. Additionally, Hawkins worked as the assistant director of materials management, and as director and assistant director of purchasing for Akron City Hospital. Hawkins also sat on the Board of Directors for the University of Miami Masters in Healthcare Administration Advisory Board during an unspecified period.

In my view, the trial court did not abuse its discretion in concluding that Hawkins's qualifications satisfy the requirements of MCL 600.2169 because he is board-certified in hospital administration, having worked in that capacity for more than 10 years before testifying in this case, he was a hospital safety manager, and in the year preceding the alleged malpractice he devoted a majority of his professional time to the active clinical practice of hospital administration. MCL 600.2169(1)(b)(*i*). The trial court also considered Hawkins's "educational and professional training," that hospital administration was his area of specialization, and the length of time that Hawkins had devoted his professional career to hospital administration, as required by MCL 600.2169(2)(a), (b), and (c). The trial court's decision that Hawkins was qualified under MCL 600.2169 to testify regarding the standard of care for hospital administration is within the range of reasonable and principled outcomes.

B. WHETHER HAWKINS'S OPINION IS THE PRODUCT OF RELIABLE PRINCIPLES AND METHODS

Although I believe Hawkins was qualified under MCL 600.2169, I do not believe his opinion was the product of reliable principles and methods, and that his testimony was properly excluded on that basis.

In his deposition, Hawkins described that the Joint Commission[1] and other regulatory bodies require that hospitals put in place policies to deal with "cardiac and respiratory and other critical issues." He added:

> Then the hospitals, themselves, will administratively put together a code blue policy and procedure in conjunction with the clinical staff, the nursing staff, and the

[1] The Joint Commission was founded in 1951 and accredits and certifies more than 22,000 hospitals around the United States. The Joint Commission also develops standards that focus on patient safety and quality of care.

> medical staff of the hospital on how we're going to deal with cardiac arrests, respiratory arrests, other critical natures of that – or things of that nature. And it may not be called code blue. It could be code red. It could be code rescue. It could have any number of names.

Such a policy is developed not only for regulatory purposes, but also to address the patient-care needs of the hospital. Hawkins also explained that a small community hospital may have a different policy and procedure for a Code Blue than a major teaching hospital, such as defendant's hospital. This is because larger hospitals that are trauma centers may perform surgeries and provide services that a smaller hospital does not. Because the needs of a hospital may vary, the Joint Commission "is not prescriptive in its policy and procedure standards" and will allow each hospital to develop its own policies and procedures.

Hawkins opined that Dr. Vinay Shah, M.D., a second-year resident who responded to the Code Blue, did not have the proper training to attend to Blackwell when he coded on the morning of March 17, 2012, because Dr. Shah had never revised a tracheotomy tube. While Hawkins described defendant's Code Blue policy as "comprehensive," the one thing he believed was missing was "adequate implementation." Hawkins expressed his concern that Dr. Shah had testified that he was not aware that a Code Blue policy existed for the hospital, and particularly that he had not been trained with regard to it and was not familiar with its requirements. After acknowledging that Dr. Shah had contacted the anesthesiology department, the emergency department, and Dr. Hackett, Hawkins elaborated with respect to how implementation of the Code Blue policy was not handled effectively by defendant:

> Yes, [Dr. Shah] called the – or he instructed the unit clerk or somebody, the clerical individual that was attending the code, to call those individuals. He neglected to call the . . . intensivist that was on call for the surgical ICU. When he realized that he needed additional help, he called those other specialties.
>
> Part of the policy and procedure, in order for it to be effective, is the administration of the hospital, which my counterparts at St. Mary's are responsible for providing the proper trained individuals to provide service under that policy. . . .
>
> Since this was a surgical ICU, the hospital administration has a responsibility for some arrangement with someone that can deal with surgical ICU cases. In my past experience, we used the emergency room physicians. As part of their emergency room contract, they would attend all code blues, or intensivists.
>
> We had a contract for 24-7 to have intensive care physicians in our facilities. The intensivists would then deal with a patient like Patient Blackwell. So they would arrive on scene at the same time as Dr. Shah. Dr. Shah, being a student, a resident physician, would be there to perform the procedures under the guidance of a fellowship-trained ER physician or a fellowship-trained intensivist or a surgeon.
>
> * * *

> The – on a nursing unit outside of the intensive care setting, you would expect to find respiratory arrests and cardiac arrests. In those areas, the internal medicine resident and physicians are trained to deal with those using [Advanced Cardiovascular Life Support (ACLS)][2] protocols, which are nationally-publicized published protocols. And they'll follow those protocols and treat the patient.
>
> In the surgical ICU, there are no nationally publicized protocols for a surgical code. It depends upon what that particular patient needs, which is why there's a higher standard in the intensive care unit, which is why you have the intensive care unit to begin with.
>
> And these codes should be attended by somebody that's fellowship trained in either emergency medicine or as a surgical intensivist.

Hawkins also observed that defendant's hospital essentially provided two standards of care, one during the dayshift hours during the week when an intensivist would be on staff and ready to assist with a Code Blue, and another after the dayshift was over, when the Code Blue was turned over to a second-year medical resident and there was no fellowship-trained physician on site to treat the patients in the surgical ICU. When asked how defendant could have complied with the standard of care, Hawkins explained:

> The stand—the national standards of care with the Joint Commission require the hospital, if they're going to provide a service, then they have to have qualified staff to – to take care of those patients that – that are in the hospital. So if you're going to perform surgery and have a surgical ICU, you have to have qualified individuals, not just on the dayshift, Monday through Friday, but 24-7. the Joint Commission will not allow us to provide physical therapy services just Monday through Friday. It's you know, as simple as that.
>
> When you get to critical care services, they expect them 24-7. So the patient that codes at noon receives the same level of care that -- of the patient that codes at midnight. Those are standards that the Joint Commission sets, that you cannot have two standards of care unless that standard of care – unless the treatment of that patient would not result in a negative outcome.
>
> Well, when you're dealing with code blues, if you've got the expert fellowship physicians that are treating the patient during the daytime and a second-year resident treating them at night, and it's only a matter of time before one of those patients that are coding at night has an out—a bad outcome because the expert wasn't there with them.

[2] Hawkins described that ACLS protocols are published by the American Heart Association for patients who have cardiac or respiratory arrest and there are "specific steps that are medications and steps that take place during the code that are followed nationwide."

Hawkins clarified that to satisfy the standard of care, defendant must not only develop an appropriate Code Blue policy, but implement it as well.

Hawkins stated that he stepped down from his position as Chief Executive Officer (CEO) of the Villages Hospital in 2012 after a new CEO was selected and chose to bring his own administrative team. Hawkins had not held an executive position in a hospital since that time, and he had never worked in a hospital in Michigan. Hawkins also conceded that he did not contact any local hospital administrators in the Saginaw area, or any other health system in Michigan, when preparing his opinion in this case. Hawkins also agreed that he had not had primary responsibility for drafting a policy or procedure for ICU management. Hawkins agreed that while the Joint Commission standards do not list specific individual disciplines that are required to be on a Code Blue team, the standards "specifically state that the members of the code team who are providing the clinical services have the training to perform whatever it is you're requesting them to perform." However, the Joint Commission does not list a specific set of skills that must be held by a member of a Code Blue team. Those standards also do not require that an intensivist, critical care medicine specialist, or an anesthesiologist be in-house in a hospital around-the-clock. Additionally, the hospital at which Hawkins served as CEO, the Villages Hospital, was not a teaching hospital or trauma center, and it did not have a residency program.

In his first deposition in June 2017, Hawkins stated that he was relying on the Joint Commission standards in formulating his opinion, the first being LD-03.606.01, which requires that hospitals provide "for a sufficient number and mix of individuals to support safe, quality care, treatment and services." The standard further required that "[t]he number and mix of individuals [be] appropriate to the scope and complexity of the services offered," but it did not list specific disciplines that are required. The next standard that Hawkins relied on, LD-04.0307, provides that patients with comparable needs receive the same standard of care and treatment throughout the hospital. Hawkins offered this opinion regarding how defendant breached this standard of care:

> The primary opinions that I have regarding the code coverage is that the two standard of care standards from the Joint Commission [were] violated because during the day the codes – the patients are attended to and codes attended to by the intensive care physician who's a fellowship trained physician capable of dealing with endotracheal tubes and tracheotomies and the care and maintenance of those. After hours, according to deposition testimony, a second-year resident who admitted that he had no experience with tracheotomy tubes, and Mr. Blackwell was the first tracheotomy tube that he had dealt with, is the physician that attended to him during the code.
>
> So there's two standards of care taking place. We've got a fellowship trained physician if you have an arrest or a medical emergency during the day, and you have a second-year resident treating you medically after hours.

Hawkins also stated that he would "expand" his criticism to defendant's hospital administration because it did not compel an emergency room physician to attend the Code Blue, unless that physician was already involved with a Code Blue in the emergency room. According to Hawkins, defendant's staff ought to have contacted an intensivist to come to Blackwell's bedside to rectify the problem with his airway and the proper chain in command to allow that to happen was not in

place. Hawkins also elaborated that an emergency room physician ought to have been summoned to the ICU to deal with Blackwell, who at that point was *in extremis*. While acknowledging that the Joint Commission standards do not require that a hospital have an intensivist in-house around-the-clock, Hawkins emphasized that whatever services are provided during the day shift must also be provided to patients during the night shift.

MRE 702 provides:

> If the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand 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 if (1) the testimony is based on sufficient facts or data, (2) *the testimony is the product of reliable principles and methods*, and (3) *the witness has applied the principles and methods reliably to the facts of the case*. [Emphasis added.]

In *Daubert v Merrell Dow Pharmaceuticals, Inc*, 509 US 579; 113 S Ct 2786; 125 L Ed 2d 469 (1993), the United States Supreme Court referred to a dictionary definition in interpreting the word "knowledge" in FRE 702,[3] the federal counterpart to MRE 702. The Court observed that "the word 'knowledge' connotes more than subjective belief or unsupported speculation. The term 'applies to any body of known facts or to any body of ideas inferred from such facts or accepted as truths on good grounds.' " *Daubert*, 509 US at 590, quoting Webster's Third New International Dictionary 1252 (1986). The Court stated: "In short, the requirement that an expert's testimony pertain to 'scientific knowledge' [as set forth in FRE 702] establishes a standard of evidentiary reliability." *Daubert*, 509 US at 590.

Similarly, in *Gilbert v DaimlerChrysler Corp*, 470 Mich 749, 782; 685 NW2d 391 (2004), our Supreme Court emphasized that the trial court's important role as a gatekeeper applies at all stages of the analysis concerning an expert witness, and that MRE 702 requires a "searching inquiry" not only of the data underlying the expert's opinion, "*but also of the manner in which the expert interprets and extrapolates from those data*." (Emphasis added.) The Court stated:

> Thus, it is insufficient for the proponent of expert opinion merely to show that the opinion rests on data viewed as legitimate in the context of a particular area of expertise (such as medicine). The proponent must also show that any opinion based on those data expresses conclusions reached through reliable principles and methodology. [*Id*.]

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[3] In *Daubert*, 509 US at 588, the Court quoted FRE 702 as follows:

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand 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.

The Court in *Gilbert* further cautioned that *how* an expert interprets and applies the data that the expert relies on in formulating an opinion is a pivotal consideration for the trial court in assessing the reliability of that testimony. The Court explained:

> When a court focuses its MRE 702 inquiry on the data underlying expert opinion and neglects to evaluate the extent to which an expert extrapolates from those data in a manner consistent with *Davis–Frye* (or now *Daubert*), it runs the risk of overlooking a yawning "analytical gap" between that data and the opinion expressed by an expert. As a result, ostensibly legitimate data may serve as a Trojan horse that facilitates the surreptitious advance of junk science and spurious, unreliable opinions.
>
> * * *
>
> As shown, MRE 702 establishes preconditions for the admission of expert opinion. Such testimony must be rooted in "recognized *scientific*, technical, or other specialized *knowledge*" and must assist the trier of fact. The burden is on the party *offering* the expert to satisfy the preconditions established by MRE 702.
>
> Where the subject of the proffered testimony is far beyond the scope of an individual's expertise—for example, where a party offers an expert in economics to testify about biochemistry—that testimony is inadmissible under MRE 702. In such cases, it would be inaccurate to say that the expert's lack of expertise or experience merely relates to the weight of her testimony. An expert who lacks "knowledge" in the field at issue cannot "assist the trier of fact." [*Id*. at 783, 789 (emphasis in original).]

In the instant case, the trial court observed that while the Joint Commission standards that Hawkins relied on were not themselves reliable, Hawkins, without training as a physician or intensivist, used his professional experience as a hospital administrator and surgical technician to generate a more specific standard of care applicable to defendant in the implementation and development of the Code Blue policy. The trial court also correctly observed that Hawkins had not worked (1) in hospital administration in a Michigan hospital, (2) in a teaching hospital with residents, (3) and notably, had not carried primary responsibility for drafting a Code Blue policy for the ICU or a teaching hospital that is staffed with residents. Also persuasive in the trial court's analysis is that Hawkins's medical experience was limited to working as a surgical technician in the 1970s, and he did not work with medical practitioners in determining what he thought should be the standard of care applicable to defendant in its development and implementation of the Code Blue policy.

While relying on the Joint Commission standards to formulate his opinion concerning the standard of care, Hawkins expanded, beyond the four corners of the Joint Commission standards, on what he believed defendant was required to do to comply with the standard of care. Hawkins also conceded that the requirements of a Code Blue policy will vary depending on the size, needs, resources, and functionality of a hospital, and that such policies are drafted with the input and oversight of the physicians and nurses working in the departments to which the policies are applicable. However, Hawkins was not trained as a physician, had not worked in a Level II trauma

center or a teaching hospital staffed by residents, and his clinical experience was limited. In my view, without knowledge of a specific hospital's resources and staffing needs, Hawkins simply did not have the requisite knowledge to provide a reliable opinion regarding the implementation of a Code Blue policy at defendant's hospital. The trial court concluded that Hawkins's opinion was not reliable because of the significant gap between the Joint Commission standards and the opinion Hawkins expressed regarding the standard of care. Under these circumstances, the trial court's decision does not fall outside the range of reasonable and principled outcomes, and therefore, it did not constitute an abuse of discretion.

II. NURSING MALPRACTICE CLAIM

I disagree with the majority that the trial court erred in dismissing plaintiff's nursing malpractice claim. Because I do not believe plaintiff has established the requisite element of causation, I would affirm.

The issue with plaintiff's nursing malpractice claim, as noted, is that plaintiff fails to present any evidence that the alleged breaches of the standard of cause were causally linked to Blackwell's death. In a medical malpractice action, a plaintiff is required to prove causation by a preponderance of the evidence. *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004). Proximate cause is a legal term of art that includes both cause-in-fact and proximate causation. *Id*. See also MCL 600.2912a(2). The plaintiff is required to put forth evidence that causally links the alleged breach in the standard of care to plaintiff's injuries in order to be successful. *Id*. at 90.

The issue, as I see it, with plaintiff's nursing malpractice claim is that plaintiff has failed to present any evidence that any breach in the standard of care by attending nurse Sara Enser, RN, was the proximate cause of Blackwell's death. In granting summary disposition in favor of defendant, the trial court examined the testimony of plaintiff's only two causation experts: Dr. Allen and Dr. Doblar. Dr. Allen offered the opinion that Blackwell's death occurred as "a result of having his trach tube dislodged, and . . . nobody [was] present who could, who was able to first understand the situation, and second to fix the situation." It was Dr. Allen's opinion that someone capable of adequately recognizing and addressing the situation, as well as someone capable of monitoring a freshly placed trach tube that could become dislodged, should have been available at all times. Similarly, Dr. Doblar further opined that the proximate cause of Blackwell's death was that the proper staff failed to response after Code Blue was called.

Neither of plaintiff's causation experts opined that defendant's nursing staff breached the standard of care, and that breach proximately caused Blackwell's death. Where plaintiff has failed to present any evidence that Blackwell's death was proximately caused by Ensor or any other nursing staff, plaintiff cannot establish the requisite element of causation to sustain a nursing malpractice claim, and summary disposition in favor of defendant was appropriate.

In reaching the contrary conclusion, the majority accepts the testimony of Kaisa Ring, RN, as expert witness testimony on the relevant standard of care for nurses, and further relies on King's testimony in concluding that a question of fact remained regarding causation. However, nowhere in Michigan jurisprudence has a court concluded that a nurse is permitted to testify concerning proximate causation in a nursing malpractice action. Additionally, the CJS Evidence, § 868, states:

> Generally, while a registered nurse may possess the education and skill necessary to testify as to the standard of care of a patient's treating nurses, a nurse is not competent to testify as to the patient's cause of death; consequently, a medical doctor must still generally connect the patient's death to the alleged nursing deficiencies.

The majority fails to engage in any analysis on this issue, specifically whether nurses should be permitted to offer expert testimony to establish causation before relying on Ring's testimony to do just that. I would conclude that given Ring's education, training, and time spent as a registered nurse, and the language of MCL 333.17201(1)(c), which limits the scope of the practice of nursing, Ring was *not* qualified to provide a medical opinion concerning wehtehr the failure of defendant's nursing staff to engage in particular interventions were in the cause-in-fact and proximate cause of Blackwell's death. See MCL 333.17201(1)(c), which defines the practice of nursing as

> the systematic application of substantial specialized knowledge and skill, derived from the biological, physical, and behavioral sciences, to the care, treatment, counsel, and health teaching of individuals who are experiencing changes in the normal health processes or who require assistance in the maintenance of health and the prevention or management of illness, injury, or disability.

Additionally, MCL 333.17201(1)(e) further defines a registered professional nurse or "r.n." as

> an individual who is licensed under this part to engage in the practice of nursing which scope of practice includes the teaching, direction, and supervision of less skilled personnel in the performance of delegated nursing activities.

Compare with MCL 333.17001(1)(f), which defines a "physician" as "an individual who is licensed or authorized under this article to engage in the practice of medicine." Likewise, the practice of medicine is defined by MCL 333.17001(1)(j) as

> the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition, by attendance, advice, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts.

III. CONCLUSION

On the basis of the foregoing, I would affirm the trial court's April 30, 2018 opinion and order, the trial court's May 3, 2018 supplemental opinion and order, and the trial court's September 27, 2018 opinion and order.

/s/ Kathleen Jansen