

THE IMPACT OF RECENT APPELLATE DECISIONS ON MEDICAL LITIGATION:

A review of recent significant cases and their impact on
medical litigation from the perspective of the Plaintiff and
Defense Bars.

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SUMMARY OF PERTINENT MEDICAL MALPRACTICE DECISIONS IN 2006-2007

I. Introduction

- Medical malpractice tort reform continues to create many Michigan appellate decisions. Most of the 2006/2007 appellate decisions involve one or more of the following topics:
 - ⇒ Affidavit of merit;
 - ⇒ Notice of intent;
 - ⇒ Statute of limitations/tolling;
 - ⇒ Expert witness qualifications;
 - ⇒ Ordinary negligence versus medical malpractice;
 - ⇒ Reliability of expert witness opinions (*Daubert*);
 - ⇒ Lost opportunity;
 - ⇒ Comparative fault;
 - ⇒ Informed consent;
 - ⇒ Joint and several liability.

II. Important Michigan appellate decisions in 2006-2007 (to date)

A. Affidavit of Merit (MCL 600.2912d and 2912e)

1. *Saffian v Simmons, DDS*, 477 Mich 8; 727 NW2d 132 (February 6, 2007).

A defendant may be defaulted for failing to respond to a summons and complaint when that defendant believed complaint was accompanied by a technically deficient affidavit of merit under MCL 600.2912d(1).

The Supreme Court explained the “more orderly process” of having the complaint presumed valid, and then allowing the defendant to challenge the affidavit. There is nothing in the affidavit of meritorious defense statute, MCL 600.2912e, which authorizes a defendant to determine unilaterally whether the plaintiff’s affidavit of merit is sufficient. The Supreme Court distinguished a technically deficient affidavit of merit from an absent affidavit of merit (which renders the complaint a nullity under *Scarsella v Pollak*, 461 Mich 547, 550; 607 NW2d 611 (2000)). In turn, the Supreme Court rejected the defense argument that the default entered against him, for failing to respond to the complaint, was void *ab initio*.

Saffian stands for the proposition that it is the court’s province, not that of the defendant, to determine the sufficiency of the pleadings.

2. *Costa v Community Emergency Medical Services, Inc*, 475 Mich 403; 716 NW2d 236 (June 28, 2006).

The Supreme Court held that the requirement of an affidavit of meritorious defense, MCL 600.2912e, does not apply to City Emergency Medical personnel who are entitled to governmental immunity. Notwithstanding the use of the word “shall” in the affidavit of meritorious defense statute, the Supreme Court reasoned that the central purpose of governmental immunity is to prevent a drain on state financial resources by avoiding even the expense of having to contest the merits of any claim barred by governmental immunity. “It would be incongruous to conclude that the failure to comply with a pleading requirement of this nature would subject a defendant to tort liability, where such a defendant is already immune from tort liability by virtue of his or her status as a governmental employee.”

3. *Brown v Hayes*, 270 Mich App 491; 716 NW2d 13 (June 12, 2006).

A physical therapist is not a qualified affiant against the defendant occupational therapist because the physical therapist was not engaged in the same “health profession.” The Court of Appeals held that defense counsel had a reasonable belief that physical therapist was qualified because *registered* occupational therapists and *licensed* physical therapists are engaged in the same “vocation, calling, occupation, or employment.” (In *Brown*, work-hardening therapy.)

4. *McElhaney v Harper Hutzell Hospital*, 269 Mich App 488; 711 NW2d 795 (2006).

The Court of Appeals held that an obstetrician cannot testify against a nurse midwife because each holds a different certification. The appellate court found as reasonable the attorney’s belief that an obstetrician/gynecologist was a qualified affiant because the affidavit of merit did not offer an opinion regarding the specific standard of care applicable to or breached by the nurse midwife.

5. *Robins v Garg*, 270 Mich App 519; 716 NW2d 318 (2006).

The Court of Appeals held that an affidavit of merit signed by a family practitioner could be used against a general practitioner because of the overlap between the two practices. “Family practitioner” is defined as “medical specialization in general practice that requires additional training and leads to board certification.” “General practitioner” is defined as “a medical practitioner whose practice is not limited to any specific brand of medicine.” These two practices are overlapping. The *Garg* court also found that these two practices are similarly alike because neither is limited to a specific branch of medicine.

6. *Potter v McLeary*, ___ Mich App ___; ___ NW2d ___ (2007).

A properly-submitted affidavit of merit does not have retroactive effect under MCL 600.2301 (which gives the trial court power to amend any “process, pleading, or proceeding”). The Court of Appeals reasoned that the plaintiff’s interpretation would subvert the affidavit requirement and render superfluous the remedy in MCL 600.2912d(2) for circumstances where a conforming affidavit cannot accompany the complaint. The Court also reasoned that MCL 600.2301 applies generally to pending actions or proceedings, whereas MCL 600.2912d(2) applies only to medical malpractice actions. Where two statutes conflict, the Court applies the more specific statute, here, the affidavit of merit statute.

7. *Wood v Bediako, MD*, 272 Mich App 558; ___ NW2d ___ (2006).

In *Wood*, the plaintiff prepared three original affidavits of merit, one devoid of notarization. The plaintiff mistakenly submitted the complaint with the unnotarized affidavit of merit. Defendant moved for summary disposition and the plaintiff’s response contained a copy of one of the two original notarized affidavits as an exhibit.

The trial court granted summary disposition because the affidavit attached to the complaint was unnotarized. The trial court did not address the effect of plaintiff’s subsequent filing of a notarized affidavit within the limitations period.

The Court of Appeals reversed, remanding for the trial court to consider the effect of the subsequent filing of a notarized affidavit within the limitations period.

8. *Gawlik v Rengachary, MD*, 270 Mich App 1; 714 NW2d 386 (2006).

In *Gawlik*, the Court of Appeals held that dismissal with prejudice, like a default, is only appropriate when a flaw in a plaintiff’s affidavit of merit in a medical malpractice action is accompanied by a statute of limitations’ problem.

9. *James v WA Foote Memorial Hosp*, (No. 262622, rel’d 01/19/06) (unpublished).

The Michigan Court of Appeals held that a “bare bones” affidavit of merit, which contained very minimal information, was sufficient under MCL 600.2912d. The practical effect of this case allows plaintiffs to be very vague in their affidavits of merit, thus giving their experts more room to change their opinions as the case develops.

10. *Apsey v Memorial Hospital*, 266 Mich App 666; 702 NW2d 870 (2005).

Plaintiff filed a complaint, alleging defendants misdiagnosed her and failed to report her symptoms, causing sepsis and several follow-up surgeries. Plaintiff's affidavit of merit had a normal notarial seal and was prepared in Pennsylvania, using a notary public of that state. At the time of filing, the plaintiff failed to provide special certification to authenticate the out-of-state notary's credentials. Plaintiff later provided the special certification but after the statute of limitations had run.

Defendants moved for summary disposition, arguing that the affidavit of merit was required to have the special certification at the time of filing for it to be deemed proper under MCL 600.2912d and 600.2102. The trial court granted defendants' motion, reasoning that the failure to provide the special certification was fatal to the notarization and the affidavit itself was a nullity rendering plaintiff's complaint invalid. Accordingly, the trial court dismissed plaintiff's complaint with prejudice.

The Court of Appeals affirmed, holding that without the special certification, the affidavit of merit was defective and the belatedly filed certification did not toll the statute of limitations, nor did it cure the defect.

In so doing, the Court of Appeals held MCL 600.2102, which requires the special certification, was the controlling statute.

Because of the injustice and inequity that the opinion would create, the Court of Appeals reversed the trial court's order granting defendant's motion for summary disposition and allowed plaintiff to proceed with the claim. With regard to all currently pending medical malpractice cases, the court required plaintiffs to come into compliance by filing the proper certification. Further, the court held justice and equity dictated a strict application from the date of the opinion.

Both parties filed applications for leave to appeal in August 2005. Nine amicus briefs have also been filed as of February 2006.

B. Notice of Intent (MCL 600.2912b)

1. *Burton v Reed City Hosp Corp*, 471 Mich 745; 691 NW2d 424 (2005).

On February 10, 2000, plaintiff filed his complaint, alleging that his common bile duct and pancreatic duct were negligently transected during surgery and that corrective surgery was required. The malpractice allegedly occurred on January 26, 1998. Absent a tolling provision, the plaintiff's claim expired on January 26, 2000.

Plaintiff's counsel sent defendants a notice of intent on October 18, 1999, which left the statute of limitations period unaffected. On February 10, 2000, only 115 days after the filing of the notice of intent, plaintiff filed a complaint and affidavit of merit. After receiving two extensions from plaintiff's counsel, defendants filed an answer to the complaint on May 8, 2000 and included affirmative defenses as to the statute of limitations and failure to comply with the provisions of MCL 600.2912b and MCL 600.2912d.

On August 24, 2000, defendants moved for summary disposition under MCL 600.2912b because plaintiff's complaint was filed 115 days after the date the notice of intent was sent. Defendants further argued that the prematurely filed complaint did not toll the limitations period, which expired on July 26, 2000. Plaintiff acknowledged that the complaint was filed before the expiration of the notice period, but argued that the filing of the complaint tolled the limitations period, such that the proper remedy was dismissal without prejudice.

The trial court initially denied the defendants' motion concluding the defendants' failure to bring their motion for summary disposition before the expiration of the limitations period resulted in waiver. However, upon motion for reconsideration, the trial court reversed its prior ruling and concluded that the affirmative defenses were sufficiently pled so as to place the plaintiff on notice of a problem before the expiration of the limitations period.

The Court of Appeals reversed the trial court's ruling. The court determined that because the affidavit of merit was filed with the complaint, it tolled the statute of limitations. Further, the court concluded that tolling is permissible when a complaint is prematurely filed because it does not result in unfair prejudice to the defendant.

The Supreme Court reversed the judgement of the appellate court and reinstated the trial court's grant of summary disposition to defendants. The Supreme Court held that defendants did not waive the defense by waiting to move for summary disposition until the limitations period had run. The Supreme Court further held under MCL 600.2912b a plaintiff must wait until the statutory notice period expires before filing the complaint.

2. *Mayberry v General Orthopedics, PC*, 474 Mich 1; 704 NW2d 69 (2005).

On November 22, 1999, defendant physician performed plaintiff's wrist surgery. Plaintiff alleged that defendant negligently cut a nerve in his wrist, causing loss of use. Plaintiff mailed a notice of intent on June 21, 2000. On October 12, 2001, one month before the statute of limitations expired, plaintiff mailed another notice of intent, naming the physician and his professional corporation, and setting forth additional allegations. On March 19, 2002, 158 days after plaintiff mailed the second notice of intent plaintiff filed a complaint.

Defendants moved for summary disposition, arguing that the complaint was filed after the statute of limitations expired. The plaintiffs argued the second notice of intent served to toll the statute of limitations period and therefore the complaint was timely. Relying on the holding in *Ashby v*

Byrnes, 251 Mich App 537 (2002), the Court of Appeals held that only the plaintiffs' first notice of intent was eligible for tolling and, therefore, granted defendants' motion. In *Ashby*, the Court of Appeals held that only the initial notice tolls the limitation period, regardless of how many additional notices are subsequently filed. Thus, the Court of Appeals held that plaintiff's second notice of intent did not toll the statute of limitations.

The *Mayberry* Court disagreed and overruled *Ashby*. The Supreme Court held that tacking "generally refers to adding time periods together to affect the running of a limitations period." Furthermore, because tacking is a legal term of art, the reference to tacking in MCL 600.2912b(6) must be "interpreted in a manner that is consistent with its acquired meaning." The Supreme Court concluded that tacking, as referred to in MCL 600.2912b(6), applied only to limitation periods that had been initiated under MCL 600.5856(d), and accordingly, only multiple tolling periods were precluded.

Because plaintiff's first notice of intent did not toll the statute of limitations, there were no successive 182-day periods as prohibited by MCL 600.2912b(6). Instead, only a single 182-day tolling period was initiated as a result of the second notice of intent and plaintiff timely filed his complaint.

3. *Gawlik v Rengachary, MD*, 270 Mich App 1; 714 NW2d 386 (2006).

A notice of intent is insufficient when it does not contain a standard of care particularly tailored to the allegations brought against the defendant. Incorporation by reference of an earlier, defective part of the notice of intent is insufficient to satisfy the statutory requirements. Plaintiff's notice of intent is insufficient which contained a one-sentence standard of care statement that generally encompassed all caretakers. Court rejects entry of default against defendant who relied on insufficiency of the notice of intent.

4. *Newton v Medina, MD*, (No. 266232, rel'd 04/18/06).

A notice of intent is insufficient when it does not address claims with respect to the defendant's post-surgical treatment of the plaintiff, otherwise identified in the complaint. Mere reference to "defendant's follow-up treatment of plaintiff" is insufficient. The only remaining claim adequately addressed in notice of intent, alleged malpractice at the time of surgery, was time-barred under statute of limitations.

5. *Young v Spectrum Health – Reed City Campus*, (No. 259644, rel'd 05/18/06), lv den.

The doctrine of judicial/equitable tolling does not excuse deficiency in affidavit of merit through which plaintiff failed to specify *the manner* in which better medical treatment would have

averted the decedent's cardiac arrest and death. Equitable tolling requires plaintiff's noncompliance as a result of some *external* influence.

6. *Korpal v Shaheen, MD* (No. 266418, rel'd 12/28/06).

Plaintiff did not make a good-faith effort to provide notice of a claim regarding chest x-rays that proved inadequate. The notice of intent failed to provide any statement about chest x-rays. A broad statement of the standard of care cannot compensate for the total lack of any statement regarding the particular malpractice alleged, here the interpretation of chest x-rays. The mere fact that there was an opportunity to resolve the case - - consistent with the purpose behind the notice of intent statute - - does not excuse this deficiency.

C. Statute of Limitations; Tolling

1. *Vance v Henry Ford Health System*, 272 Mich App 426; 726 NW2d 78 (January 17, 2007).

The two-year wrongful death savings provision, MCL 600.5852, rather than the minor disability time provisions, apply in a case involving a minor who died before his eighth birthday. In *Vance*, the seven-year-old decedent died in the defendant hospital after overdosing on morphine. The plaintiff (personal representative) sued the defendant, which moved for summary disposition under the statute of limitations. The defendant argued that under MCL 600.5852, the plaintiff had to commence her action within two years from the date she received letters of authority appointing her as personal representative. The plaintiff argued that her suit was timely commenced because she was entitled to the extended minor disability time provision under MCL 600.5851(7), which allows suits up to the minor's tenth birthday. The trial court agreed.

The Court of Appeals reversed and held that MCL 600.5851(7) does not apply to a cause of action by a personal representative on behalf of a minor who died before reaching the age of majority. The Court reasoned that a deceased minor does not continue to age after death, and thus he is incapable of having a tenth birthday, as the statute requires.

2. *Mullins v St. Joseph Mercy Hospital*, 271 Mich App 503; 722 NW2d 666 (October 2, 2006) (conflict panel).

The Court of Appeals held that full retroactivity governs the application of *Waltz v Wyse*, 469 Mich 642; 677 NW2d 813 (2004). In *Waltz*, the Michigan Supreme Court held that the savings statute, MCL 600.5852, is not tolled by a qualifying notice of intent, MCL 600.5856. The *Mullins* court cited to three Supreme Court orders in which that Court remanded matters to the Michigan Court of Appeals with instructions that *Waltz* apply retroactively.

Mullins is presently pending on application in the Michigan Supreme Court.

3. *Ward v Siano*, 272 Mich App 715; ____ NW2d ____ (November 14, 2006) (published conflict decision).

The Court of Appeals held that the doctrine of equitable tolling is unavailable to save a plaintiff from the retroactive application of *Waltz v Wyse*. The Court reasoned that equitable tolling applies to specific extraordinary situations. Application of equitable tolling would constitute a “wholesale disregard” of the retroactivity of *Waltz*, as required by other cases. In addition, equitable tolling is unavailable because plaintiff’s claim for such equity is not based on any intervening, external circumstance. Plaintiff failed to demonstrate any inequity independent of the “unknowing failure” to comply with the retroactive time limits delineated in *Waltz*.

4. *Hollins v Sinai-Grace Hospital* (No. 257682, rel’d 03/16/06), lv den.

The Court of Appeals held that the statute of limitations relative to a minor, MCL 600.5851(7) (requiring a claim brought on or before the minor’s 15th birthday), trumps a claim of tolling under the insanity provision, MCL 600.5851(1).

5. *Dewan v Khoury, MD*, (No. 265020, rel’d 03/28/06), lv den.

The Court of Appeals held that the 182 day tolling period, measured in days, is calculated under MCR 1.108(1), and does not allow for an argument that the notice of intent, sent before midnight on a certain date, left part of that day remaining, and accordingly left a portion of the statute of limitations unexpired.

6. *Bonucchi v Michigan State University Board of Trustees*, (Nos. 256233, 257966, rel’d 03/28/06).

The Court of Appeals rejected the argument that plaintiff neither discovered nor should be charged with discovering a possible cause of action for an allegedly negligent prescription of Tavist-D for treatment of a sinus infection. A “reasonable person,” who experienced these problems earlier, and was treated for a sinus infection therefrom, should have known earlier of a possible connection between the medication and the symptoms.

7. *Hughes v Patel*, (No. 259174, rel’d 04/11/06).

Plaintiff fails to establish a case of fraudulent concealment necessary to extend the statute of limitations when allegedly altered records concealed information which was already known to plaintiff, and that information provided the basis for the cause of action against the defendants.

8. *Allen v Estate of Treusch*, (No. 259737, rel'd 04/20/06).

The Court of Appeals rejected plaintiff's claim that consecutive office visits constitute new instances of medical malpractice, and thus resurrect the six month discovery period, when the symptoms presented were the same symptoms observed and considered from the beginning of her treatment years earlier. The Court rejected application of the "continuing-wrong or continuing-treatment" rule to extend the period of limitations as being inconsistent with the accrual statute.

9. *Long v Children's Hospital of Michigan*, (No. 266948, rel'd 08/01/06).

The Court of Appeals held that there is retroactive application of the rule that a minor's claim is not extended by the general savings provision contained in MCL 600.5851(1), as held in *Vega v Lakeland Hospital*, 267 Mich App 565, 572; 702 NW2d 389 (2005), *lv gtd* 477 Mich 957 (2006).

D. Expert Witness Qualifications

1. *Woodard v Custer, MD*, 476 Mich 545; 719 NW2d 842 (July 31, 2006).

In *Woodard*, the Supreme Court interpreted the phrase "the same specialty" in MCL 600.2169(1) to mean only a single specialty must be matched. From this, the Supreme Court noted that with specialists, the statute requires the expert devote a majority of his or her time to practicing or teaching the specialty in which the defendant specializes. The Court held that the expert witness must have devoted a majority of his professional time during the previous year to practicing or teaching the specialty that the defendant was practicing at the time of the alleged malpractice, "i.e., the one most relevant specialty," because one cannot devote a majority of time to more than one specialty.

2. *Pennington v Longbaugh, MD*, 271 Mich App 101; 719 NW2d 616 (2006).

In *Pennington*, the defendant performed a transesophageal echocardiogram on the plaintiff's decedent. After the defendant discharged the decedent, she learned she suffered a perforated esophagus. The decedent underwent surgery to repair the perforation, suffered a stroke, and died.

The plaintiff sued, alleging the defendant improperly performed the echocardiogram, did not obtain informed consent, and improperly diagnosed and negligently repaired the perforation. To support these claims, the plaintiff presented an expert, Dr. Gubernikoff, who could not state the medical probability of the cause of her stroke nor whether earlier diagnosis of the perforation

would have altered her outcome. The trial court dismissed the plaintiff's claims because the expert did not establish the requisite causation.

The Court of Appeals affirmed, noting Dr. Gubernikoff's testimony did not establish the necessary causal link between the alleged negligence and the ultimate death.

The Court of Appeals also rejected the plaintiff's attempt to rely on the death certificate and affidavit of merit to establish causation because that evidence, without expert testimony, was insufficient to establish a fact issue on causation.

3. *Sessoms v Bay Regional Medical Center*, (No. 260516, rel'd 08/22/06).

The Court of Appeals held that neither an internist specializing in infectious disease nor a board certified general surgeon is qualified to testify against the defendant who is board certified in orthopedic surgery. The Court of Appeals rejected the assertion that the "most relevant standard or practice of care" in *Woodard* was post-operative care when, in fact, there was no evidence that the complained-of infection occurred during the post-operative period.

4. *Trevino v Turfah, MD*, (No. 263999, rel'd 09/19/06).

The Court of Appeals held that plaintiff's proffered expert, a board certified general surgeon, was not qualified to render expert testimony against the defendant, a board certified general surgeon who was also board certified in colon and rectal surgery, as well as general surgery. The Court rejected an argument that complications arising post-operatively from surgery equate with a finding that the defendant was not engaged in colorectal surgery at the time of the asserted malpractice.

5. *Robins v Garg*, 270 Mich App 519; 716 NW2d 318 (2006).

In this pre-*Woodard* case, Court of Appeals held that plaintiff's expert, who was a family practitioner in Florida, was qualified to testify as a standard of care expert against a general practitioner who was operating a walk-in clinic.

6. *Gonzales v St. John Hospital and Medical Center*, (No. 272093, rel'd 02/06/07).

The Court of Appeals held that a physician can be a specialist without being board certified and that a resident is a non-specialist against whom plaintiff also must present a qualified non-specialist, rather than a board certified general surgeon.

E. Ordinary Negligence versus Medical Malpractice

1. *David v Sternberg DPM*, 272 Mich App 377; 726 NW2d 89 (2007).

In *David*, the defendant performed a bunionectomy on plaintiff. The plaintiff suffered eurythmia to her heel and sued the defendant. The plaintiff alleged that the defendant failed to properly treat her pain and treat her circulation. The trial court dismissed her claim for failing to comply with the medical malpractice tort reform statutes and the Court of Appeals affirmed. The Court reasoned that proper pain management and treatment of circulation are not in the realm of common knowledge and require the exercise of medical judgment.

2. *Kuznar v Raksha Corp*, 272 Mich App 130; 724 NW2d 493 (2006).

In *Kuznar*, the plaintiff sued the defendant pharmacy for negligent disbursement of medication. The defendant moved for summary disposition, arguing plaintiff failed to comply with the medical malpractice tort reform statutes and that the statute of limitations had expired. The trial court agreed and plaintiff appealed.

The Court of Appeals affirmed, concluding that a pharmacy is not a licensed health facility subject to malpractice under the requisite licensing statutes. As a result, there was no “professional relationship” and this removed plaintiff’s claim from the realm of medical malpractice.

3. *Tipton v William Beaumont Hospital*, 266 Mich App 27; 697 NW2d 552 (2005).

Plaintiff became pregnant and contacted defendant hospital’s physician referral and information service. She received a list of several doctors along with a brief curriculum vitae for each physician. Plaintiff selected the defendant doctor to provide prenatal care during her pregnancy and delivered a full-term baby boy who died two months after delivery.

Plaintiff sued defendants under the Michigan Consumer Protection Act (MCPA), alleging that the hospital and doctor failed to inform her that the doctor had been involved in five birth trauma medical malpractice lawsuits. Plaintiff also alleged her decision to treat with the doctor was based upon inadequate information.

Defendants moved for summary disposition on the basis that the practice of medicine is not subject to the MCPA, that failure to disclose prior lawsuits does not violate the MCPA, and prior lawsuits that did not result in settlement or verdict are not material to the transaction under the MCPA. The trial court held that although plaintiff’s claims were properly pled under the MCPA, summary disposition was proper.

The Court of Appeals affirmed, ruling that if a plaintiff's claim encompasses a professional relationship that raises questions involving medical judgment, the gravamen of the case is medical malpractice. A medical malpractice action is proper under the MCPA only if it relates to the entrepreneurial, commercial or business aspect of the practice of medicine, such as allegations of unfair or deceptive methods, acts, or practices on behalf of the physician or hospital. Because plaintiff's allegations focused on defendants' failure to inform her of the doctor's prior involvement in birth trauma medical malpractice lawsuits, the Court of Appeals held that plaintiff was attacking the defendant doctor's ability to provide medical care, which raised questions involving medical judgment and must be addressed in a medical malpractice claim. Accordingly, the Court of Appeals held that plaintiff did not state a claim under the MCPA.

No application to Supreme Court filed.

4. Summary of other cases:

Ordinary Negligence:

- Alleged disclosure of confidential information. *Stratton v Krywko, MD*, (No. 248669, rel'd 01/06/05);
- Allegations for failure to bathe, clean, and change. *Davis v Botsford General Hospital*, (No. 250880, rel'd 05/24/05);
- Allegations that security guards used improper restraints when restraining a patient in the emergency room. *Lewis v St John Hospital*, (No. 252712, rel'd 06/23/05);
- Alleged failure to properly position the patient on the MRI table by an MRI technician. *Howell v Macomb MRI*, (No. 260774, rel'd 10/11/05).

Medical Malpractice:

- Allegations involving selection of personnel, including claims of negligent supervision and training, and negligent entrustment of hospital employees. *Lindsey v St John Health System, Inc*, (No. 251898, rel'd 03/22/05);
- An allegation stating the medical staff was inexperienced or was caring for too many patients. *DeZacks v Tendercare, Inc, et al*, (No. 254468, rel'd 07/28/05) (P&C case);
- Allegations involving failure to timely triage. *Krueger v Spectrum Health*, (No. 262035, rel'd 08/25/05);

- Alleged failure to adequately inform a patient about the risks and benefits of treatment. *Dixon v Ambani, MD*, (No. 256292, rel'd 11/22/05);
- Alleged failure to properly administer medication. *Dennis v Specialty Select Hospital-Flint*, (No. 262649, rel'd 9/29/05).

F. Reliability of Expert Testimony (*Daubert*)

1. *Sands v Providence Hospital and Medical Center*, (No. 268401, rel'd 12/28/06).

The Court of Appeals held as unreliable the expert testimony of Dr. Ronald Gabriel, a pediatric neurologist, who opined that abnormal uterine pressures amounted to mechanical trauma resulting in subdural bleeding and resultant brain injury. The Court rejected the argument that the expert's background, medical data, and depositions were sufficient to render the causation testimony scientifically reliable. Plaintiff failed to establish that the causation theory had been tested, had been subjected to peer review and publication, or was generally accepted within the relevant scientific community.

In addition, the necessary foundation for the opinion was missing: the record was void of evidence of hyper-stimulation or abnormal uterine pressures.

2. *Williams v Chelsea Community Hospital*, (No. 261946, rel'd 12/28/06).

The Court of Appeals rejected the proposition that the trial court's gatekeeping responsibility relieves a defendant from challenging the scientific reliability of the plaintiff's evidence until after trial. If a party does not challenge the expert testimony under the Michigan Rules of Evidence, the court has no duty to *sua sponte* conduct a hearing and determine whether the expert testimony is admissible. Rather, the issue is waived absent the raising of the issue by the defendant.

3. *Dukes v Harper-Hutzel Hospital*, (No. 255824, rel'd 01/30/07).

The Court of Appeals affirmed a lower court finding that Dr. Gabriel's deposition of a "hyper-acute event" a few minutes before birth, resulting from an infection of the plaintiff mother's amniotic membranes, was unreliable. Defendants presented medical arguments that tended to disprove the specific medical mechanism underlying the plaintiff's expert's theory. Plaintiff failed to present any scientific evidence or authority to the contrary.

4. *Clerc v Chippewa County War Memorial Hospital*, 267 Mich App 597; 705 NW2d 703 (2005), *lv pending*.

In July 1997, the decedent sought medical treatment for pneumonia-like symptoms. The radiologist found no abnormalities in her x-rays. In February 1998, the decedent was diagnosed with lung cancer and died in March of 1999. Plaintiff filed a medical malpractice wrongful death action against the radiologist and hospital, alleging that the negligent x-ray misreading delayed the decedent's treatment, causing her death.

Defendants filed separate motions to strike the plaintiff's experts' testimony. Plaintiff's experts were board certified medical oncologists who opined that the decedent's cancer was probably at Stage II or I in July of 1997. One expert concluded that the decedent, if properly diagnosed at the time of the 1997 x-ray, would have had a sixty percent chance to live another five years. However, because their opinions were based on "general experience" and not specific medical research, neither could state with a reasonable degree of certainty what stage the cancer was when the 1997 x-rays were taken.

The defendant hospital asked the trial court to conduct a *Davis-Frye* hearing and both defendants moved for summary disposition. Without conducting a *Davis-Frye* hearing, the trial court granted defendants' motions for summary disposition, finding that plaintiff could not prove that the decedent would have had a greater than fifty percent chance of survival even if properly diagnosed in 1997.

The Court of Appeals reversed, holding that the trial court's inquiry into the expert testimony concerning "backwards cancer staging" was inadequate for the purposes of MRE 702 and *People v Beckley*, 434 Mich 691, 456 NW2d 391 (1990). The Court of Appeals remanded the case back to the trial court, ordering the trial court to determine if "backwards cancer staging" is a novel scientific principle, and if so, to conduct a *Davis-Frye* hearing.

If the trial court determines that it is not a novel scientific principle, then the trial court must conduct a "more searching inquiry" under MRE 702 to determine if the expert testimony satisfies the conditions for admissibility set forth in *Beckley*, by giving the plaintiff the opportunity to offer testimony from impartial experts that "backwards cancer staging" is accepted in the medical community.

In September 2005, application for leave to appeal to the Supreme Court filed.

G. Lost Opportunity

1. *Compton v Pass*, (No. 260362, rel'd 08/22/06).

In this loss of an opportunity for better result case, the Court of Appeals rejected plaintiff's argument that individual lost opportunities per morbidity can be totaled to establish the "greater than 50%" threshold of *Fulton v William Beaumont Hospital*. In *Compton*, each morbidity carried a less than 50% lost opportunity to obtain a better result. Yet, when added together, the

aggregate exceeded the 50% lost opportunity threshold established in *Fulton v William Beaumont Hospital* (the difference between the lost opportunity before and after the asserted malpractice must be greater than 50%). The Court of Appeals reasoned that plaintiff's interpretation would allow a plaintiff who alleged specific injuries to be relieved from proving that her chances of avoiding the specifically alleged injuries exceeded 50%. Rather, plaintiff would simply have to prove that her chance of avoiding any injury, even one not sustained, exceeded 50%.

H. Comparative Fault

1. *Yax v Knapp*, (No. 260007, rel'd 09/19/06).

In *Yax*, the plaintiff told the defendant doctor of pain and swelling in his leg. The defendant diagnosed the plaintiff with deep vein thrombosis and advised plaintiff that he would require hospital treatment. The plaintiff delayed hospital treatment for about two months. Due to that delay, the plaintiff suffered post-phlebotic syndrome.

The plaintiff sued the defendant for malpractice. The jury found that the defendant was negligent but also apportioned fault to the plaintiff. The plaintiff requested judgment notwithstanding the verdict because there was insufficient evidence to support the jury's finding. The trial court agreed.

The Court of Appeals reversed and remanded the case for consideration consistent with the holding in *Shinholster v Annapolis Hospital*, 471 Mich 540; 685 NW2d 275 (2004) and MCL 600.6304(1)(b), which provides that a jury must determine the percentage of the total fault of all persons who contributed to plaintiff's injuries, including the plaintiff.

I. Informed consent

1. *Wlosinski v Cohn, MD*, 269 Mich App 303; 713 NW2d 16 (2006).

The Court of Appeals held that, as a matter of law, defendants have no duty to disclose a surgeon's statistical history of transplant failures to obtain informed consent. Notably, Robert G. Kamenec, a Plunkett & Cooney, P.C. appellate attorney, successfully argued this case.

In May 1998, the decedent was diagnosed with kidney failure. After his kidney transplant surgery in July 1999, the decedent suffered post-operative complications and the transfer failed. The decedent elected to withdraw from dialysis and died in September 2000.

Plaintiff filed a medical malpractice wrongful death lawsuit against the surgeon and hospital, alleging they committed errors regarding a blood clot that appeared after the operation. Plaintiff amended the complaint, adding an informed consent count based on an alleged discrepancy between the hospital's reported success rates for kidney transplants and its actual success rate.

Defendants moved for summary disposition. Defendants argued that plaintiff's informed consent claims had no factual support because plaintiff testified that she had been informed of the risks associated with the surgery. The trial court denied the motion because defendants failed to counter plaintiff's expert's statements about withheld statistical information related to the standard of care.

The jury awarded plaintiff \$1.4 million in damages.

On appeal, defendants argued that a doctor has no duty to disclose to a patient his or her success rates for a medical procedure, thus, the doctor's failure to do so in this case did not taint the patient's consent.

The Court of Appeals agreed, relying on *Lincoln v Gupta*, 142 Mich App 615; 370 NW2d 312 (1985), which held that "the doctrine of informed consent requires a physician to warn of patient of the risks and consequences of a medical procedure." The Court of Appeals reasoned that by itself, the doctor's success rate was not a risk associated with the medical procedure. Further, the court explained that none of plaintiff's affidavits of merit indicated that disclosing the doctor's success rate was necessary to obtain informed consent.

The Court of Appeals also held that the doctor did not misrepresent his transplant history and that there was no hint of relationship between the doctor's previous failed transplants and the decedent's.

The Court also rejected plaintiff's use of statistical evidence as a link between a doctor's negligence and the treatment's failure. The court reasoned that bare numerical success rates are not evidence that a doctor did anything wrong. Thus, the court concluded the trial court erred in allowing the limited inclusion of these statistics, which encouraged the jury to conclude that the doctor had a proclivity to fail.

In conclusion, the *Wlosinski* court held that, as a matter of law, a physician's raw success rates do not constitute risk information reasonably related to a patient's medical procedure. Therefore, a physician does not have a duty to disclose statistical history of medical successes or failures to obtain informed consent. The court vacated the trial court's judgment and remanded for a new trial.

J. Joint and several liability

1. *Bell v Ren-Pharm, Inc*, 269 Mich App 464; 713 NW2d 285 (2006), *lv den* 477 Mich 866; 721 NW2d 184 (2006).

A minor child suffered burns on his legs after his grandmother applied an ointment supplied by the defendant pharmacy. The plaintiffs, the co-guardians of the minor child, sued the pharmacy and its co-owner pharmacist. The plaintiffs did not sue the minor's grandmother because they were unsure if the contribution statute, MCL 600.2925a, survived the tort reform legislation. The grandmother was named, however, as a non-party at fault.

The jury returned a special verdict, which found that the negligence of the grandmother and the defendants was the proximate cause of the minor child's injuries. The jury determined that the grandmother was 80 percent at fault, while the defendants were 20 percent at fault. The trial court held that the defendants were jointly and severally liable for the damages resulting from the grandmother's negligence.

On appeal, the defendants argued that their joint and several liability should not extend to non-parties. The defendants maintained that the plain language of MCL 600.6304(6)(a) extends joint and several liability only to "each defendant" and that if the Legislature intended to extend this liability to at-fault non-parties, the statute would have specified "each defendant and non-party." The plaintiffs argued that the statute clearly made each defendant, including non-parties, jointly and severally liable. The Court of Appeals rejected both parties' arguments, stating the statute was silent on the issue of the extension of joint and several liability to non-parties.

The Court began its analysis by stating that there was no Michigan precedent on the question of the extension of joint and several liability to at fault non-parties under MCL 600.6304(6)(a). Therefore, because the statute was silent on this issue, the Court resolved the question by turning to generally accepted principles of joint and several liability. The Court cited the Third Restatement of Torts, which states that if, the "independent tortious conduct of two or more persons is the legal cause of an injury, each person is jointly and severally liable". The Court noted that the Restatement refers to the conduct of "persons", and not just to parties to the litigation. The Court further notes that the Restatement's commentary states that a plaintiff may recover all damages from any defendant found liable and the burden of joining "other potentially responsible persons" as parties to the litigation is on the defendant. Therefore, the Court concluded that under the general principles of joint and several liability, a defendant is liable for all damages, including those resulting from the acts of non-parties.

Relying on the opinion in *Johnson v Billot*, 109 Mich App 578; 311 NW2d 808 (1981), the *Bell* Court reasoned that the purpose of joint liability is to place the burden of injustice on the wrongdoer, not the innocent plaintiff. Therefore, under both the Restatement of Torts and *Johnson*, joint and several liability extends to non-parties at fault in medical malpractice actions under MCL 600.6304(6)(a).