STATE OF MICHIGAN

COURT OF APPEALS

MELISSA McCONIHA, Plaintiff-Appellee,	UNPUBLISHED November 29, 2011
v	No. 299556 Ingham Circuit Court
RICK SMITH, M.D., and RICK SMITH, M.D., P.C., d/b/a MICHIGAN PLASTIC SURGERY, Defendants-Appellants.	LC No. 07-001289-NH

Before: SHAPIRO, P.J., and SAAD and BECKERING, JJ.

PER CURIAM.

In this medical malpractice action, brought by plaintiff Melissa McConiha against defendant Rick Smith, M.D. and his professional corporation, defendant Rick Smith, M.D., P.C., doing business as Michigan Plastic Surgery, defendants appeal by leave granted the trial court's July 20, 2010, order denying their motion for partial summary disposition under MCR 2.116(C)(10). We affirm in part, reverse in part, and remand for further proceedings.

I. FACTUAL BACKGROUND AND PROCEDURAL HISTORY

McConiha began treating with Dr. Smith, a plastic and reconstructive surgeon, on May 26, 2004.[1] According to McConiha's complaint, Dr. Smith diagnosed her with mammary hypoplasia and recommended bilateral augmentation mammoplasty. He performed the surgery on July 26, 2004. At a follow-up visit, he noted that there was a displacement of the right infra-mammary crease and applied Elastoplast tape to the area. McConiha underwent a second surgery on March 4, 2005. Dr. Smith repositioned the right implant and increased the volume bilaterally. Thereafter, "additional complications arose including the appearance of the right implant being higher than the left implant and the development of some abnormality, described variously in the records." An abscess also developed. On April 12, 2005, Dr. Smith performed

[1] We note that while Dr. Smith's medical records are attached to the parties' briefs on appeal and are heavily referenced in their briefs, none of the records were presented to the trial court. They are not included in the lower court record. Therefore, we will not rely on the records in reaching our decision in this matter.

an incision and debridement in his office and prescribed Augmentin for an infection of the breast. Because McConiha's infection persisted, however, Dr. Smith conducted surgery on May 9, 2005, removing the right implant.

After several follow-up visits and various "post operative difficulties," McConiha underwent another surgery. Dr. Smith placed a Becker implant in the right breast on September 16, 2005. After the surgery, McConiha again "developed complications including what appeared to be a discoloration on an area of the breast, erythema, and infection." On September 22, 2005, she was admitted to the hospital for treatment with IV antibiotics.[2] Thereafter, Dr. Smith attempted to treat McConiha's infection "by opening an incision site near or about the Becker port, and by attempting to aspirate through the body of the breast." The parties agree that on October 11, 2005, Dr. Smith exteriorized the Becker port to allow for drainage. On November 28, 2005, however, Dr. Smith conducted surgery, removing the right implant.

When asked why he removed the Becker implant from the right breast, Dr. Smith testified:

> *Q.* On the 28th of November the Becker came out. Why did the Becker come out?
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> * * *
>
> *A.* As she followed up on [the] 15th and then [the] 22nd of November, I felt that she had some thinning of the tissues. Otherwise, everything looked well. I noted that she was feeling and looking better.
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> * * *
>
> *Q.* . . . Thinning of what tissue?
>
> *A.* The lower portion of her breast.
>
> * * *

[2] The parties point out that on September 30, 2005, McConiha presented to William E. Thompson, Jr., M.D., a plastic and reconstructive surgeon. In Dr. Thompson's record of the visit, he noted that McConiha had recently required hospitalization for swelling, tenderness, and redness in the right breast. She was on antibiotics, and there was no open wound or drainage. The area of redness was "somewhat raised but not thinned." The doctor informed McConiha "that generally antibiotics alone do not alleviate infection and more often than not implants need removal to allow the infection to heal." He noted that it was "quite possible opening the area locally with some drainage may be helpful." We note, however, that like Dr. Smith's medical records, Dr. Thompson's records were not presented to the trial court, and, therefore, cannot be considered in our decision.

A. The problem that we had before.

* * *

Q. What causes the tissue to be thin?

A. It could be infection. It could be pressure. It could be—those would—the aging process thins tissue, too.

* * *

Q. All right. So you must have been satisfied at some point that there was some type of infection going on, which is why you took the Becker out; is that a fair statement?

A. Right, I just didn't feel that—I didn't want to risk a worsening infection. And I felt that it wasn't doing us any good.

McConiha also testified about the removal of the Becker implant:

Q. And how did that decision [the decision to remove the implant] come about?

A. I had gone to Dr. Smith after being hospitalized and antibiotics and all of that. That's when he had aspirated—made a little needle hole. And within a short time that needle hole was like the size of a quarter or a 50 cent piece again.

* * *

A. . . . And we made the decision, once the hole was good sized, that it needed to come out.

* * *

A. . . . I just knew that the skin integrity had been broken. I wasn't sure why it was getting big . . .

Both Dr. Smith and McConiha testified that she recovered well after the removal of the Becker implant. They agreed to wait several months before attempting to place another implant. Dr. Smith informed McConiha at a follow-up visit on May 5, 2006, that he believed she was ready for an implant. The firmness, redness, and infection had cleared. However, on May 19, 2006, the morning scheduled for surgery, Dr. Smith determined that it would be better to conduct a "fat injection" before moving forward with placing a new implant. Dr. Smith testified about his decision:

A. On May 19, 2006, I felt that our problem all along was really soft tissue coverage resulting from initial mastitis, as well as the right breast just had less soft tissue than the left.

* * *

A. I think there was enough breast tissue that covered the implant. But to have a stable environment for the implant, it wasn't sufficient.

Q. What does that mean?

A. I mean that she developed an irritation, inflammation, infection of the lower portion of her breast on two previous occasions and that it could happen again.

Q. But you felt that was due to the quantity of soft tissue?

A. I felt that the reason that we had the problem on the right compared to the left was that there was less soft tissue coverage of the foreign body, or foreign bodies that had been placed.

Q. Is that another way of saying that you felt that there was compression?

A. No. I—you keep going back to compression. I'm not sure what you mean by that. I just mean, I don't think that her tissues were doing well with having a foreign body below them. It could be compression. It could be pressure. But I just don't—I didn't really feel that there was a sufficient amount of coverage of the implant. That we needed to try to recruit tissue to help cover the implant.

* * *

A. My previous experience with her in [sic] that she looked good for a month, six weeks, but that progressively that tissues thinned and that we had problems with the implant.

In looking at her tissues and pre-op in the examining room, I felt the same. I felt that there was a deficiency of tissue initially, but that with the subsequent problems that we had, that there was even less tissue, albeit improved from when I had seen her previous. So, I felt that we should attempt to achieve better coverage of her chest and breast with the fat injection.

Q. Now, is this a procedure that you have done before?

A. Frequently.

Q. Have you performed fat injections for the same reason on prior occasions?

A. For areas of scarring, areas of radiation, yes.

Q. Okay. Well, she didn't have scarring and she didn't have radiation. That wasn't the—

A. She had significant scarring.

Q. But that wasn't the reason why you're doing the fat injection, was it—

A. Oh, yeah.

Q. —because of the scarring?

A. Oh, yeah.

Q. So in this particular case, the reason for the fat injection was because of the scarring?

A. And to try to give more soft tissue coverage of the—[3]

McConiha signed a consent form authorizing Dr. Smith to inject fat into the right breast, and he performed the procedure that day.

McConiha underwent another surgery on July 14, 2006, at which time Dr. Smith placed a new implant in her right breast. She had a follow-up visit with Dr. Smith on July 18, 2006. That was her last appointment with him. Thereafter, the right breast continued to be "characterized by asymmetry and irregularities." Photographs of McConiha's bare chest after the final surgery conducted by Dr. Smith reveal significant "migration" of the implant in the right breast.[4]

The parties claim in their briefs on appeal that after her final visit with Dr. Smith, McConiha presented to Dr. David Brown and possibly other plastic surgeons. She did not, however, undergo any surgeries until 2009. On March 18, 2009, McConiha was examined and evaluated by Paul H. Izenberg, M.D., a plastic and reconstructive surgeon. He performed corrective surgery on April 14, 2009.[5] According to the testimony of Dr. Hubert Weinberg, McConiha's expert witness, the surgery was "partially successful," meaning that the appearance of the right breast is much improved and McConiha is much happier with the appearance since the surgery, but that there is still a depression and some unevenness on the breast. Dr. Weinberg made some recommendations for further correcting the appearance of the breast.

McConiha filed suit on September 18, 2007, approximately 14 months after her last surgery with Dr. Smith, alleging medical negligence. Defendants initially took the deposition of Dr. Weinberg on August 12, 2008. The trial court granted defendants' motion to redepose Dr.

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[3] The portion of Dr. Smith's deposition included in the lower court record ends there.

[4] Although the photographs are not included in the lower court record, it is apparent from the record that photographs were presented to the trial court to be reviewed.

[5] Dr. Izenberg's medical records were not presented to the trial court.

Weinberg after Dr. Izenberg's surgery. Defendants filed a motion in limine regarding damages, requesting that McConiha be precluded from presenting evidence of economic damages predating October 11, 2005, as she had presented no evidence of alleged malpractice occurring before that date. After redeposing Dr. Weinberg on October 22, 2009, defendants moved for partial summary disposition under MCR 2.116(C)(10), asserting that there was no expert support for any of the allegations of malpractice in McConiha's complaint, other than the allegation that Dr. Smith improperly placed the implant at the time of the July 2006 surgery. In response, McConiha argued that the motion was premature, that genuine issues of material fact existed regarding, at a minimum, Dr. Smith's conduct between October 11, 2005, and July 2006, and that additional testimony in support of her allegations might be elicited at trial.

On June 30, 2010, the trial court heard oral argument on defendants' motion in limine to limit damages and motion for partial summary disposition. The court granted defendants' motion in limine, finding that McConiha could not present any evidence of economic damages that occurred prior to October 11, 2005.[6] It denied defendants' motion for partial summary disposition, finding that there were questions of fact for the jury.

Defendants filed an application for leave to appeal the trial court's order denying their motion for partial summary disposition, and this Court granted the application.

II. DEFENDANTS' MOTION FOR PARTIAL SUMMARY DISPOSITION

Defendants argue on appeal that the trial court erred in denying their motion for partial summary disposition. For the reasons indicated, we hold that the trial court should have granted the motion in part and denied it in part.

A. STANDARD OF REVIEW AND APPLICABLE RULES

McConiha incorrectly asserts that a clearly erroneous standard of review should be applied to a trial court's decision on a motion for summary disposition. We review a trial court's decision on such a motion de novo. *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999). A motion for summary disposition under MCR 2.116(C)(10) tests the factual sufficiency of the complaint. *Maiden*, 461 Mich at 119. "In evaluating a motion for summary disposition brought under this subsection, a trial court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties, MCR 2.116(G)(5), in the light most favorable to the party opposing the motion." *Maiden*, 461 Mich at 119-120. If the evidence fails to establish a genuine issue of material fact, the moving party is entitled to judgment as a matter of law. *Id*. at 120. The "court should evaluate a motion for summary disposition under MCR 2.116(C)(10) by considering the substantively admissible evidence actually proffered in opposition to the motion." *Maiden*, 461 Mich at 121. It "may not employ a standard citing the mere possibility that the claim might be supported by evidence produced at trial. A mere promise is insufficient under our court rules." *Id*.

[6] McConiha has not appealed the trial court's ruling limiting damages.

To establish medical malpractice, "a plaintiff must establish four elements: (1) the appropriate standard of care governing the defendant's conduct at the time of the purported negligence, (2) that the defendant breached that standard of care, (3) that the plaintiff was injured, and (4) that the plaintiff's injuries were the proximate result of the defendant's breach of the applicable standard of care." *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004). Regarding the fourth prong, "the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants." MCL 600.2912a(2). Expert testimony is required to establish the standard of care and a breach of that standard, *Decker v Rochowiak*, 287 Mich App 666, 685; 791 NW2d 507 (2010), as well as causation, *Teal v Prasad*, 283 Mich App 384, 394; 772 NW2d 57 (2009).

> However, an expert opinion based upon only hypothetical situations is not enough to demonstrate a legitimate causal connection between a defect and injury. Instead, plaintiffs must set forth specific facts that would support a reasonable inference of a logical sequence of cause and effect. [T]here must be facts in evidence to support the opinion testimony of an expert. The evidence need not negate all other possible causes, but the evidence of causation must exclude other reasonable hypotheses with a fair amount of certainty. [*Id*. at 394-395 (internal quotation marks and citations omitted).]

B. ANALYSIS

1. PRE-OCTOBER 11, 2005, CLAIMS AND OTHER CLAIMS LACKING EXPERT SUPPORT

In their motion for partial summary disposition, defendants argued that McConiha should be precluded from presenting evidence of alleged malpractice occurring before October 11, 2005, because there was no expert testimony establishing that there was any breach of the standard care before that date. We agree. Expert testimony is required to establish a breach of the standard of care, *Decker*, 287 Mich App at 685, and McConiha's expert witness, Dr. Weinberg, testified multiple times that he found no such breach before October 11, 2005. Defendants further argued that any other allegation of malpractice in McConiha's complaint that lacked expert support should be dismissed. In their brief in support of their motion for partial summary disposition and now in their brief on appeal, defendants point out 23 specific allegations listed in McConiha's complaint that lack expert support. We agree with defendants that McConiha should be precluded from presenting evidence regarding this "laundry list" of overly broad allegations of malpractice, which are lacking in expert support.[7]

[7] We note that the final allegation identified by defendants, which is paragraph 38 of McConiha's complaint, is supported, in part, by expert testimony. But the allegation is, in essence, a broad summary of several allegations already listed in the complaint, some of which have expert support and some of which do not. Paragraph 38 is an unnecessary summary of allegations.

On appeal, McConiha concedes that there is currently no expert testimony establishing a breach of the standard of care before October 11, 2005, and that there may be a lack of expert support for some of the other allegations of malpractice in her complaint. Nonetheless, she asserts that both Dr. Weinberg and Dr. Smith will be called to testify at trial, and that she anticipates one or both of them, or possibly other witnesses, providing testimony that will support her pre-October 11 allegations and any other allegations that currently lack sufficient support. We are not persuaded by such an argument. As noted, a trial "court should evaluate a motion for summary disposition under MCR 2.116(C)(10) by considering the substantively admissible evidence *actually proffered* in opposition to the motion." *Maiden*, 461 Mich at 121 (emphasis added). The court may not rely on a mere promise or "the mere possibility that the claim might be supported by evidence produced at trial." *Id*.

McConiha asserts that granting defendants' motion for partial summary disposition would have a "chilling" effect on the proofs at trial. But precluding McConiha from bringing certain allegations of malpractice does not necessarily prevent her from presenting evidence of Dr. Smith's conduct and her treatment, if necessary for other purposes such as providing factual context for her claims. As McConiha herself notes, under the Michigan Model Civil Jury Instructions, the jury may be instructed to consider evidence for a limited purpose. See M Civ JI 3.07.

The trial court should have granted defendants' motion with respect to McConiha's pre-October 11, 2005, claims and the 23 claims raised in her complaint that lack expert support.

2. CLAIMS REGARDING THE EXTERIORIZATION OF THE BECKER PORT AND FAILURE TO MORE QUICKLY REMOVE THE BECKER IMPLANT

Defendants next argued in their motion for partial summary disposition that while there was expert testimony that Dr. Smith breached the standard of care on October 11, 2005, by exteriorizing the Becker port and failing to remove the Becker implant at that time, there is no evidence of a causal link between the alleged breach and injury to McConiha. We disagree.

In September 2005, Dr. Smith placed a Becker implant in McConiha's right breast. Thereafter, she developed various complications, including an infection in the breast, and was hospitalized for treatment with IV antibiotics. On October 11, 2005, Dr. Smith evaluated McConiha's condition and exteriorized the port attached to the Becker implant to allow for drainage. On November 28, 2005, however, Dr. Smith conducted surgery, removing the right implant. Dr. Weinberg testified that it was a breach of the standard of care to exteriorize the port and place McConiha on antibiotics, rather than removing the implant altogether or, as a secondary option, removing the implant, washing out the "pocket" with an antibiotic solution, and immediately placing a new implant.

According to defendants, Dr. Weinberg's testimony does not establish that Dr. Smith's alleged breach of the standard of care proximately caused any injury to McConiha. As noted, expert testimony is required to establish not only the standard of care and breach of that standard, but also causation. *Teal*, 283 Mich App at 394. Defendants point to Dr. Weinberg's testimony that even if Dr. Smith had not exteriorized the port, McConiha's infection still would have persisted. Dr. Weinberg testified:

Q. In your opinion, more likely than not, if he had not exteriorized the port, would the infection have cleared sooner?

A. No. I think the infection was present, would not have cleared up, and the only way of treating the infection would be to have removed the implant.

Dr. Weinberg additionally testified that had Dr. Smith simply removed the implant altogether on October 11, 2005, rather than exteriorizing the port, the infection would have cleared up much sooner, and that Dr. Smith's conduct in exposing McConiha's implant to the environment by exteriorizing the port "permitted the infection to persist, to worsen, and cause further damage to the breast." When asked to explain the basis for this conclusion, Dr. Weinberg testified:

A. Well, we can just read the next several records.

(Perusing document.) On November 1[, 2005,] it says patient states concern of purple spot developing on the right breast. She states that she has been draining continuously for the past three weeks, but no change in odor.

Again, on that date—that was the nursing note. On that date, Dr. Smith writes: Smaller area that was pointing . . . was opened. Clearly something is happening; that it is worsening, that now there is an area or a fistula developing, basically is what he's describing that had to be opened and drained.

He also describes that she has a thin area on the inferior pole. He never describes that before. That thin area in the inferior pole is the ongoing necrosis that is occurring in the tissue, and that's what is draining, is this ongoing process of an infection, low grade infection causing necrosis of tissue, causing thinning of breast tissue. He's trying to reinforce it with the Blastoplast.

And not only is the port remaining in place, by the way, but he's even putting in more fluid inside. . . .

Q. . . . So your evidence that by exteriorizing the port that this infection was persisting or worsening is—you pointed to an 11/1/05 note—

A. Right.

Q. —which you think describes a fistula?

A. That's correct.

Q. And also the fact that there is a description of a thinning area on the inferior pole?

A. That's correct.

Thus, there is expert testimony supporting McConiha's allegation that the exteriorization of the Becker port and failure to more quickly remove the Becker implant proximately caused her

injury, particularly the increase in the severity of the infection that she had been suffering from, the development of a fistula, and the thinning of the breast tissue around the inferior pole due to the persisting and worsening infection. Defendants argue that because Dr. Weinberg attributed the thinning of the tissue to the infection McConiha developed after the placement of the Becker implant, and Dr. Weinberg did not criticize Dr. Smith for the original development of the infection, there can be no causal connection between the alleged breach of the standard of care and the thinning of the tissue. But, again, Dr. Weinberg attributed the thinning of the tissue around the inferior pole to the infection persisting and worsening, which was a result of Dr. Smith's decision to exteriorize the port and not remove the implant on October 11, 2005.

Defendants further argue that the thinning of McConiha's breast tissue cannot be considered an injury because the thinning did not, more probably than not, proximately cause the migration of the implant Dr. Smith placed in July 2006. See MCL 600.2912a(2). Dr. Weinberg initially testified that there were two possible causes for the migration of the implant: (1) "weak" tissue, meaning that the breast tissue was so weak that the sutures failed; or (2) placement of the implant too low relative to the infra-mammary crease. Dr. Weinberg explained that the infra-mammary crease or fold is an anatomical structure that keeps the implant in place, that although McConiha had "thinning of the tissue," she had a crease, and that Dr. Smith could have placed the implant too low relative to the crease, which would have allowed the implant to drop. Dr. Weinberg later clarified that the implant migrated, more likely than not, because of misplacement of the implant and not weak tissue. In her brief on appeal, McConiha concedes this point.

McConiha argues, however, that the thinning of the tissue around the inferior pole, which was due to the infection that persisted and worsened in October and November 2005 when Dr. Smith decided to exteriorize the Becker port and not remove the implant, led to Dr. Smith conducting the fat injection on May 19, 2006. In other words, according to McConiha, the fat injection was an additional procedure proximately caused by the exteriorization of the port and failure to more quickly remove the implant. McConiha attempts to distinguish the thinning of the tissue around the inferior pole from the "weak" tissue described by Dr. Weinberg in relation to the infra-mammary crease. As indicated, when asked to explain his reasons for removing the Becker implant, Dr. Smith testified that on November 15 and 22, 2005, he observed thinning of the tissue in the lower portion of McConiha's breast, which could have been caused by infection. Dr. Smith further testified that he decided to conduct the fat injection on May 19, 2006, because of a lack of soft tissue coverage resulting from mastitis. He explained that there was an insufficient amount of tissue coverage to create a stable environment for an implant. Dr. Weinberg testified that Dr. Smith's medical notes in November 2005 evidenced thinning of the breast tissue around the inferior pole. Dr. Weinberg explained that the area under the breast does not have muscle coverage and that when the tissue in that area is thinned, an implant is easily palpable, the tissue cannot resist extrusion, and the edges of the implant can be felt on the outside of the breast. While Dr. Weinberg expressed disagreement with Dr. Smith's decision to conduct the fat injection under the circumstances, he acknowledged that Dr. Smith conducted the procedure "to improve the thinning of the tissue." Dr. Weinberg did not describe the specific tissue to which he referred, nor did he specifically address whether there was any material distinction between the thinning of the tissue around the inferior pole and the infra-mammary crease.

Considering Dr. Smith's and Dr. Weinberg's testimonies together in the light most favorable to McConiha, see *Maiden*, 461 Mich at 119-120, there is at least a material question of fact in regard to this issue. The trial court properly denied defendants' motion as to McConiha's claims regarding the exteriorization of the Becker port and failure to more quickly remove the Becker implant.

3. CLAIM REGARDING LACK OF INFORMED CONSENT FOR THE FAT INJECTION PROCEDURE

Defendants finally argued in their motion for partial summary disposition that McConiha's allegation that Dr. Smith committed malpractice by conducting the fat injection procedure should be dismissed because she suffered no injury as a result of the procedure. At his first deposition, Dr. Weinberg testified that McConiha likely suffered fat necrosis from the fat injection. But at his second deposition, the doctor testified that there was no evidence that McConiha had experienced calcification, fat necrosis, or any other complications as a result of the fat injection. McConiha acknowledges this testimony on appeal. Nonetheless, she asserts that Dr. Smith breached the standard of care by conducting the fat injection procedure without informed consent; the procedure was, therefore, an unauthorized medical touching that in and of itself constitutes damages.

Dr. Weinberg testified about the alleged lack of informed consent:

> *A.* . . . On May 19th a decision was made by Dr. Smith on that date to do a fat grafting, and the patient was informed about this on that same day.
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> I don't think she was given any literature or any time to really consider the consequence of fat grafting.
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> So I certainly think that certainly fat grafting under these circumstances was certainly below accepted standards of care. And, you know, I've looked at literature all over to see—you know, we have it here. No one has done it under these circumstances with an infection several months previously and an implant to be placed subsequently to the fat injection. . . .
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> * * *
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> *Q.* In order to have given her appropriate informed consent, what would Dr. Smith have needed to do in addition to what was done?[8]

[8] As indicated, McConiha signed a consent form before Dr. Smith conducted the procedure. She testified that on May 19, 2006, the morning she had been scheduled to have a new implant placed, Dr. Smith informed her that he was not comfortable placing a new implant and that he believed injecting fat to build up her tissue was a better course of action. McConiha asked him questions about the procedure, and he answered them. She recalled him saying that he had either

A. He would have had to have spoken to her about the nature of this procedure; that it has not been a procedure that has been within the standard armamentarium of plastic surgeons . . . .

* * *

But that in her particular circumstances . . . this would be a new novel procedure; that he could not guarantee her results . . . .

And that this should all be documented on the record, and that she should have been given several days to think about it. . . .

Q. Now, if you assume that he had given her that kind of an informed concept [sic] that she had been given adequate time to consider her options, in your opinion would it have been within the standard of care to use fat grafting in this manner?

* * *

A. If Dr. Smith had performed fat grafting of the breast prior to this, if he felt that he was an expert in the technique . . . and he had explained the novel procedure that was done and the patient accepted all of this, then, yes, I think it would have been within the standard of care if all of these circumstances are met.

* * *

So, I mean, is there something inherently wrong and below the standard of care? No. But it has never really been done, as well. So, I'm not sure that I can say that it's below or within the standard of care if it has never been tried.

Considering this evidence in the light most favorable to McConiha, Dr. Weinberg did not testify that the fat injection procedure was, in and of itself, a breach of the standard of care; rather, Dr. Weinberg testified that Dr. Smith breached the standard of care by failing to obtain informed consent.

We note, as do defendants, that McConiha failed to raise a claim of negligence based on the failure to adequately obtain informed consent in her complaint. Consequently, this issue has not been properly presented for review. See MCR 2.111(B)(1). Moreover, even if she had raised such a claim, McConiha has not presented any legal authority in support of her assertion that a lack of informed consent under the circumstances presented here would automatically give rise to an injury. "A party may not leave it to this Court to search for authority to sustain or reject its position." *In re Keifer*, 159 Mich App 288, 294; 406 NW2d 217 (1987). Accordingly,

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done such a procedure before or that he had researched it. After their conversation, she felt comfortable enough with the procedure to consent.

McConiha's claim regarding a lack of informed consent for the fat injection procedure should have been dismissed.

In sum, we hold that the trial court erred by denying defendants' motion for partial summary disposition with regard to McConiha's allegations of malpractice occurring before October 11, 2005, the 23 broadly-stated allegations of malpractice in her complaint that lack expert support, and her allegations related to a lack of informed consent for the fat injection procedure. Genuine issues of material fact exist with regard to McConiha's claims concerning the exteriorization of the Becker port and failure to more quickly remove the Becker implant, and the trial court properly denied defendants' motion with regard to those claims. Plaintiff's claim that Dr. Smith improperly placed the implant at the time of the July 2006 surgery also remains a matter for jury determination.

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

/s/ Douglas B. Shapiro
/s/ Henry William Saad
/s/ Jane M. Beckering