STATE OF MICHIGAN

COURT OF APPEALS

JEFFREY CULLUM,

Plaintiff-Appellant,

v

FREDERICK L. LOPATIN, D.O.,

Defendant-Appellee,

and

DEARBORN EAR, NOSE, AND THROAT CLINIC, P.C.,

Defendant.

UNPUBLISHED
July 10, 2014

No. 313739
Wayne Circuit Court
LC No. 10-007013-NH

Before: CAVANAGH, P.J., and OWENS and M. J. KELLY, JJ.

PER CURIAM.

Plaintiff appeals as of right the trial court's order granting summary disposition in favor of defendant, Frederick Lopatin, D.O.,[1] in this medical malpractice action. We reverse and remand for further proceedings consistent with this opinion.

In June 2010, plaintiff filed this action against defendant, an otolaryngologist, after he developed avascular necrosis (AVN) of his right hip bone in 2008 allegedly following defendant's treatment of sinusitis with a series of three Medrol Dosepaks, which is the brand name of the corticosteroid methylprednisolone. Plaintiff alleged that AVN is a well-known potential side effect of corticosteroid therapy. Plaintiff attached two affidavits of merit to his complaint: one from Dr. Clifton Hood, an otolaryngologist, who opined that defendant breached the standard of care relative to his treatment of plaintiff, and one from Dr. Michael McKee, an orthopedic surgeon, who opined that the steroid "was the probable cause of the avascular

[1] Plaintiff's claim against defendant Dearborn Ear, Nose, and Throat Clinic, P.C. was dismissed by stipulated order dated March 10, 2011; thus, we refer to Dr. Lopatin as "defendant."

necrosis . . . or, at the least, materially aggravated and/or precipitated the presence of that condition."

In December 2011, defendant filed a motion for summary disposition under MCR 2.116(C)(10). Defendant argued that plaintiff could not establish a causal link between the alleged negligence and plaintiff's injury. First, defendant argued that plaintiff's standard of care expert, Dr. Hood, testified that he could not state within a reasonable degree of medical probability that plaintiff's AVN was caused by the Medrol Dosepaks as opposed to plaintiff's excessive alcohol consumption. Dr. Hood also agreed that it is a rare occurrence for a person to develop AVN of the hip upon being administered steroids. Second, defendant argued that plaintiff's causation expert, Dr. McKee, testified that there is a causal connection between the prescribed steroids and plaintiff's AVN, but his opinion was not supported by authoritative literature. Rather, Dr. McKee's opinion on causation was based in large part on a case study that he performed with fifteen patients between 1986 and 1996 which resulted in a "research letter" that he authored. However, even that research letter acknowledged that there may be unknown causes or other causes, including alcohol, that cause AVN. Consequently, the testimony of plaintiff's experts failed to create a question of fact as to causation. See MCL 600.2912a(2). In particular, defendant argued, Dr. McKee's opinion on causation was speculative and without sufficient scientific basis; thus, his testimony was inadmissible under MRE 702 and MCL 600.2955. Accordingly, defendant argued that he was entitled to summary disposition of plaintiff's claims.

Plaintiff responded to defendant's motion, arguing that Dr. Hood was his standard of care expert and clearly testified that defendant breached the standard of care; however, his testimony was not being offered for causation purposes. Plaintiff's causation expert was Dr. McKee, who testified that defendant's negligence was both the cause in fact and legal cause of plaintiff's injuries. Plaintiff argued that Dr. McKee's testimony was admissible under MRE 702 and MCL 600.2955 because it was reliable and supported by a substantial scientific foundation. Dr. McKee's own research letter published in 2001 was part of the large and growing body of scientific research that identified a causal link between corticosteroids and AVN. This research letter had been submitted for peer review before and after it was published, and was referred to in at least 44 related articles. Further, a court in Delaware found this research letter reliable and persuasive in a worker's compensation case. Moreover, Dr. McKee identified and relied upon at least three other studies on the link between short-term corticosteroid administration and AVN. Consequently, plaintiff argued, there was a sufficient and reliable scientific basis for Dr. McKee's testimony as to causation and is therefore admissible under MRE 702 and MCL 600.2955. Thus, a genuine issue of material fact as to causation existed, and defendant was not entitled to the summary dismissal of plaintiff's claims.

Following these oral arguments, the trial court denied defendant's motion for summary disposition, holding that defendant's challenge to Dr. McKee's opinion goes to "the weight that anybody wants to give to his opinion as to it's [sic] validity." After noting that another court had accepted Dr. McKee's study, the court concluded that it was "not in a position to grant this motion based on your arguments."

In May 2012, defendant filed a second motion for summary disposition under MCR 2.116(C)(10). Defendant argued that plaintiff could not establish that his AVN was a

foreseeable, natural, and probable consequence of defendant's steroid prescriptions. And because plaintiff could not establish an element of his medical malpractice claim, i.e., proximate cause, defendant was entitled to summary disposition. In particular, plaintiff's treating orthopedic physician, Dr. David Mayo, testified that the development of AVN is a very rare occurrence. Dr. McKee also testified that the development of AVN with steroid use was a rare occurrence. Thus, even if plaintiff could establish a jury question regarding cause in fact, which defendant disputed, plaintiff could not establish that a question of fact existed on the issue of legal cause, i.e., whether AVN was a foreseeable, natural, and probable cause of low dose steroid administration.

Plaintiff responded to defendant's motion for summary disposition, arguing that the motion was essentially "a retread of the failed *Daubert*[2] motion" previously considered by the trial court. Further, plaintiff argued, whether plaintiff's AVN condition was foreseeable was an issue to be determined by the jury. See *Lockridge v Oakwood Hosp*, 285 Mich App 678, 684-685; 777 NW2d 511 (2009), quoting *Davis v Thornton*, 384 Mich 138, 147; 180 NW2d 11 (1970). And, in this case, Dr. McKee's testimony was clear: in his experience and in light of the facts of this case, it was more likely than not that the corticosteroids played a material role in plaintiff developing AVN. That is, if plaintiff had not received the steroids, he would not have developed the AVN condition. Dr. McKee's deposition testimony pointed to a specific sequence of events that occurred in this case, which followed a pattern he had witnessed previously, and which he believed was a typical presentation of AVN resulting from short-course steroid therapy. Thus, plaintiff argued, defendant's motion for summary disposition should be denied.

Defendant replied to plaintiff's response to his motion for summary disposition, arguing that the substantively admissible evidence on the issue of foreseeability did not create an issue of fact that AVN would develop as a result of steroid administration in the low doses at issue in this case. That is, defendant argued, plaintiff could not establish that AVN was a foreseeable, natural, and probable cause of the low dose steroid administration at issue in this case, which was 315 milligrams of the corticosteroid.

In November 2012, the trial court issued a written opinion and order granting defendant's motion for summary disposition. The trial court began by noting that defendant was requesting summary disposition on the ground that plaintiff "failed to establish proximate cause of his injuries. Plaintiff's expert failed to establish thru reliable scientific evidence the cause and effect relationship between short-course steroid therapy and AVN." The trial court then noted that plaintiff offered the expert testimony of Dr. McKee "to support the theory that Defendant's prescription of the steroids caused Plaintiff's AVN." The trial court then stated: "Defendant argues that there is no reliable evidence to support the expert's testimony as required by MRE 702 and MCL 600.2955." In review of the evidence, the court noted that Dr. McKee relied on his own study of fifteen patients, and his article stated that the study did not "provide conclusive

[2] *Daubert v Merrell Dow Pharmaceuticals, Inc*, 509 US 579, 590; 113 S Ct 2786; 125 L Ed 2d 469 (1993). See also *Gilbert v DaimlerChrysler Corp*, 470 Mich 749, 780 n 46; 685 NW2d 391 (2004).

proof that there is a cause effect relationship between short course therapy and osteonecrosis." The court also noted that plaintiff's treating orthopedic surgeon had testified that he believed the primary cause of plaintiff's AVN was that he was drinking a lot of alcohol which increased his risk for AVN. The court further noted that plaintiff's standard of care expert, Dr. Hood, testified that he was unaware of a study or evidence that recognized a causal relationship between alcohol or steroids and AVN, and actually agreed with defendant's expert witness, Dr. John Jacob, that AVN is a disease of unknown etiology. Accordingly, the trial court concluded: "it is clear that Plaintiff's expert's opinion on causation is speculative and unsupported." Thus, the motion for summary disposition was granted. This appeal followed.

On appeal, plaintiff first argues that the trial court improperly reconsidered its earlier denial of defendant's "*Daubert* motion" without giving plaintiff notice or an opportunity to be heard on those issues. We disagree.

As plaintiff notes, defendant had previously filed a motion for summary disposition premised on the argument that plaintiff could not establish a causal link between the alleged negligence and plaintiff's injury. In that motion, defendant argued that Dr. McKee's opinion on causation was speculative and without sufficient scientific basis; thus, his testimony was inadmissible under MRE 702 and MCL 600.2955. Plaintiff opposed the motion, and the trial court eventually denied the motion. Defendant's second motion for summary disposition was also premised on the argument that plaintiff could not establish causation. In particular, though, defendant argued that plaintiff could not establish legal cause—that his AVN was a foreseeable, natural, and probable consequence of defendant's prescriptions of steroids. Thus, both motions challenged plaintiff's ability to establish the necessary element of proximate causation in support of his medical malpractice action. While it appears that the trial court may have confused the two motions when it granted defendant's second motion for summary disposition, the trial court did not introduce new theories or questions and then premise its dismissal on an issue that had not been previously raised or argued by the parties. Plaintiff was given the opportunity, through both briefing and oral argument, to oppose defendant's motions challenging causation, including the precise grounds on which the court's dismissal decision was based. And on appeal plaintiff does not set forth any additional argument or evidence that he was denied the opportunity to present as a consequence of the court's decision.

Further, we note that because there "is always the concern that jurors will disregard their own common sense and give inordinate or dispositive weight to an expert's testimony. . . . trial courts must—at every stage of the litigation—serve as the gatekeepers who ensure that the expert and his or her proposed testimony meet the threshold requirements." *Gay v Select Specialty Hosp*, 295 Mich App 284, 291; 813 NW2d 354 (2012). And, in the interests of correcting mistakes, preserving judicial economy, and minimizing costs to the parties, trial courts are not precluded from giving a "second chance" to a motion that it previously denied. *Bers v Bers*, 161 Mich App 457, 462; 411 NW2d 732 (1987); *Smith v Sinai Hosp of Detroit*, 152 Mich App 716, 723; 394 NW2d 82 (1986); see also *Kokx v Bylenga*, 241 Mich App 655, 659; 617 NW2d 368 (2000). In this case, it appears the trial court may have reconsidered its previous decision regarding defendant's challenge to the proposed testimony of Dr. McKee, plaintiff's causation expert—a challenge that would have been preserved for subsequent review even if this case had proceeded to trial and plaintiff had secured a verdict in his favor. Accordingly, to the extent that plaintiff argues that he was denied procedural due process by the trial court's "reconsideration"

of defendant's first motion for summary disposition, no appellate relief is warranted. See *Al-Maliki v LaGrant*, 286 Mich App 483, 485; 781 NW2d 853 (2009).

Next, plaintiff argues that the trial court abused its discretion when it concluded that Dr. McKee's expert opinion testimony on the issue of causation was inadmissible; thus, the decision to summarily dismiss this action must be reversed. We agree.

We review de novo a trial court's decision on a motion for summary disposition. *Spiek v Dep't of Transp*, 456 Mich 331, 337; 572 NW2d 201 (1998). A trial court's decision to admit or exclude evidence, including the testimony of an expert witness, is reviewed for an abuse of discretion. *Edry v Adelman*, 486 Mich 634, 639; 786 NW2d 567 (2010). "An abuse of discretion occurs when the trial court chooses an outcome falling outside the range of principled outcomes." *Id.*

In a medical malpractice claim, a plaintiff must establish the following 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).]

At issue in this case is the element of causation. To prove that an injury was the proximate result of a defendant's breach of the applicable standard of care, both causation in fact and legal, also known as "proximate," cause must be established. *Id.*; *Skinner v Square D Co*, 445 Mich 153, 162-163; 516 NW2d 475 (1994). The *Craig* Court further explained:

> Generally, an act or omission is a cause in fact of an injury only if the injury could not have occurred without (or "but for") that act or omission. While a plaintiff need not prove that an act or omission was the *sole* catalyst for his injuries, he must introduce evidence permitting the jury to conclude that the act or omission was *a* cause.
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> 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.'" [*Craig*, 471 Mich at 87-88 (citations omitted).]

The *Craig* Court also noted: "[i]t is axiomatic in logic and in science that correlation is not causation." *Id.* at 93. Thus, causation is not established if the connection between the defendant's negligent conduct and the plaintiff's injuries is tenuous, speculative, or merely possible. *Id.*; *Teal v Prasad*, 283 Mich App 384, 392-393; 772 NW2d 57 (2009).

In this case, it appears that the trial court concluded that plaintiff failed to establish a question of material fact regarding whether, but for defendant's allegedly negligent conduct of prescribing steroids to plaintiff, plaintiff would not have developed AVN. And because plaintiff could not establish causation in fact, the trial court did not consider the issue of legal cause.[3] In reaching that conclusion, the trial court must have considered and rejected Dr. McKee's testimony that, if plaintiff had not been prescribed the steroids by defendant, he would not have developed AVN. The trial court rejected Dr. McKee's causation testimony on the ground that it was "speculative and unsupported." Thus, although unclear from its opinion, the trial court must also have concluded that Dr. McKee's testimony constituted evidence that failed to meet the requirements of reliability set forth in either or both MRE 702 and MCL 600.2955 and, therefore, was inadmissible. See *Edry*, 486 Mich at 642 n 7.

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.

"MRE 702 has imposed an obligation on the trial court to ensure that any expert testimony admitted at trial is reliable." *Gilbert v DaimlerChrysler Corp*, 470 Mich 749, 780; 685 NW2d 391 (2004). "Careful vetting of all aspects of expert testimony is especially important when an expert provides testimony about causation." *Id*. at 782.

Here, the trial court held that Dr. McKee's 2001 study, which the court described as forming the sole basis for his opinion regarding causation, was insufficient to form an adequate basis for Dr. McKee's opinion on causation. The trial court stated that, other than this 2001 study, "[n]o other literature or studies were presented to support [Dr. McKee's] conclusions." However, Dr. McKee testified that his opinion was based on more than just this single study. Dr. McKee stated that, in the years since his 2001 study, his practical experience "tended to strengthen [his] conviction that in certain individuals the administration of short courses of steroid medication can precipitate the clinical outcome of osteonecrosis of the hip." While discussing his 2001 study, Dr. McKee testified that he had "seen a number of patients since that time with similar dosages in the low—between 200 and 300 milligrams of Prednisone—which have then subsequently developed avascular necrosis in the same time sequence of events. It's just that at this point it's fairly well accepted, so no one's that interested in publishing anything more like this." Dr. McKee further testified that he was personally aware of other literature

[3] "As 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." *Craig*, 471 Mich at 87.

indicating that short-course steroid therapy could cause AVN, and cited to three such studies. In describing his opinion, Dr. McKee testified:

> I've reviewed the chart and the possible factors involved in the etiology of the cause of his avascular necrosis. And I think that his case is consistent with many other similar cases I've seen, where a short course of oral corticosteroids eventually causes the development of avascular necrosis in young individuals such as [plaintiff].
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> It seems likely to me based on his presentation. So, he was given the steroids, he developed a brief period of hip pain, and then six months or eight months later, he developed severe hip pain and the classic features of avascular necrosis. Based on that, I believe that it's likely with the steroid medication that precipitated this condition in what may be considered a susceptible individual.
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> And it's thought that what happens in that situation is the pain, the transient pain he experiences early, is the pain from the death of the osteocytes in the hip, or the avascular or the necrosis part. So the cells in the hip die. That's the initial pain someone experiences.
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> Then that pain diminishes or goes away. It's only months later when the mechanical effects of that are felt that the hip pain returns in a more sustained fashion.
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> That is a typical history for someone who has this type of condition induced by a steroid medication.
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> And I think [corticosteroids are] a probable cause. I would firmly believe that if he had never received the steroids, he would not have developed avascular necrosis of the hip when he did.

Thus, Dr. McKee testified that his opinion was based primarily upon his own clinical experience with similar cases and his examination of how plaintiff's symptoms developed; his 2001 study was only one portion of the basis for his opinion. However, the trial court did not take this testimony into account, and instead concluded that Dr. McKee had no support for his causation theory other than his 2001 study. By failing to consider substantial evidence forming the basis for Dr. McKee's opinion, the trial court inadequately performed its gatekeeper role under MRE 702, and thus, abused its discretion, assuming the trial court intended to exclude Dr. McKee's testimony under MRE 702. See *Gilbert*, 470 Mich at 782.

MCL 600.2955(1) provides:

> In an action for the death of a person or for injury to a person or property, a scientific opinion rendered by an otherwise qualified expert is not admissible unless the court determines that the opinion is reliable and will assist the trier of fact. In making that determination, the court shall examine the opinion and the basis for the opinion, which basis includes the facts, technique, methodology, and reasoning relied on by the expert, and shall consider all of the following factors:
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> (a) Whether the opinion and its basis have been subjected to scientific testing and replication.
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> (b) Whether the opinion and its basis have been subjected to peer review publication.
>
> (c) The existence and maintenance of generally accepted standards governing the application and interpretation of a methodology or technique and whether the opinion and its basis are consistent with those standards.
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> (d) The known or potential error rate of the opinion and its basis.
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> (e) The degree to which the opinion and its basis are generally accepted within the relevant expert community. As used in this subdivision, "relevant expert community" means individuals who are knowledgeable in the field of study and are gainfully employed applying that knowledge on the free market.
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> (f) Whether the basis for the opinion is reliable and whether experts in that field would rely on the same basis to reach the type of opinion being proffered.
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> (g) Whether the opinion or methodology is relied upon by experts outside of the context of litigation.

In *Clerc v Chippewa Co War Mem Hosp*, 477 Mich 1067; 729 NW2d 221 (2007), our Supreme Court held that, before excluding testimony under MCL 600.2955, the trial court must "consider all of the factors listed in MCL 600.2955(1)." *Id*. at 1068. The trial court in *Clerc* "did not fulfill its gatekeeping role" because it focused only on a single factor, rather than considering each factor enumerated in the statute. See *id*. Here, despite quoting the language of MCL 600.2955(1), the trial court did not specifically discuss any one factor, and instead found only that Dr. McKee's "opinion on causation is speculative and unsupported." Thus, if the trial court intended to exclude Dr. McKee's testimony under MCL 600.2955(1), the trial court abused its discretion by failing to consider each factor before finding Dr. McKee's opinion inadmissible under that rule. See *Clerc*, 477 Mich at 1068. In summary, the trial court abused its discretion when it concluded that Dr. McKee's expert opinion testimony on the issue of causation was inadmissible.

Further, it appears that the trial court improperly weighed the relative value of testimonial evidence provided by each party and inappropriately made credibility determinations in reaching its decision to exclude Dr. McKee's causation testimony. Courts "may not resolve factual

disputes or determine credibility in ruling on a summary disposition motion." *Burkhardt v Bailey*, 260 Mich App 636, 646-647; 680 NW2d 453 (2004). Indeed, "'[t]he granting of a motion for summary disposition is especially suspect . . . where a witness or deponent's credibility is crucial. Accordingly, where the truth of a material factual assertion of a moving party depends upon a deponent's credibility, there exists a genuine issue for the trier of fact and a motion for summary disposition should not be granted.'" *White v Taylor Distributing Co, Inc*, 275 Mich App 615, 625; 739 NW2d 132 (2007) (citation omitted). "[A] court may not weigh the evidence before it or make findings of fact; *if the evidence before it is conflicting*, summary disposition is improper." *Lysogorski v Bridgeport Charter Twp*, 256 Mich App 297, 299; 662 NW2d 108 (2003) (emphasis in original) (quotation marks and citation omitted). Simply put, the trial court was not at liberty to decide which expert or experts to believe. *Burkhardt*, 260 Mich App at 646-647; *Lysogorski*, 256 Mich App at 299.

We also reject defendant's argument on appeal that the trial court's summary dismissal decision should be affirmed on the alternate ground that plaintiff's evidence failed to create a question of fact regarding both factual and legal causation. Defendant argues that plaintiff's causation theory is speculative, and that plaintiff's AVN was more likely caused by his alcohol use or by a steroid injection plaintiff received shortly before being diagnosed with AVN. However, Dr. McKee testified that, in his opinion, plaintiff's AVN was caused by his use of steroids administered by defendant. As discussed above, Dr. McKee's opinion was based on his own study, other prior studies, and his clinical experience. His opinion was also based on his analysis of the progression of plaintiff's symptoms and his comparison of that progression to similar instances he had encountered in his own practice. In this regard, Dr. McKee's opinion was not speculative.

Dr. McKee also provided his opinion regarding whether alcohol could have caused plaintiff's injury, and concluded that plaintiff's alcohol use was not a likely source of his AVN:

> I would state that [plaintiff's] alcohol use may have predisposed him to develop osteonecrosis with a lower dose of corticosteroid than typically would be seen since as far as we understand it, it can be a multifactorial condition. I think it's possible that alcohol abuse would have been the cause of his avascular necrosis, but I think on the balance of probabilities that it's unlikely and that the more probable cause would be the steroid administration.
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> . . . I believe [plaintiff] was an individual who may have been susceptible to this kind of complication because of his alcohol intake, but that the precipitant or the most important factor contributing to his development of osteonecrosis was the short course of corticosteroid medication that he received.
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> Again, as I stated before, it's my firm belief that had he not taken those corticosteroids, he would not have developed osteonecrosis of the hip.

Regarding the steroid injection, defendant's argument lacks merit. Dr. Hood did not opine that this injection caused plaintiff's AVN. Dr. McKee was asked whether a steroid

injection could have caused plaintiff's AVN and he responded that it "would depend highly on the route of the administration and the amount of medication administered." Dr. McKee also testified that he was unaware of whether plaintiff actually received such an injection. And defendant has not referred us to any expert opinion that this injection was a cause, let alone the more likely cause, of plaintiff's AVN.

We conclude that plaintiff presented sufficient evidence to establish that a genuine issue of material fact exists on the issue of factual causation. Plaintiff was not required to rule out other potential causes of his AVN; rather, he was only required to "'exclude other reasonable hypotheses with a fair amount of certainty.'" *Craig*, 471 Mich at 88 (citation omitted). Dr. McKee's testimony rules out alcohol as a possible cause with reasonable certainty, and identifies defendant's steroid prescriptions as the most likely source of plaintiff's AVN. Defendant has pointed to no evidence tending to show that a steroid injection was the likely cause of plaintiff's AVN. Accordingly, defendant's claim that he was entitled to summary disposition because plaintiff failed to present evidence creating a question of fact regarding factual causation is without merit.

We also reject defendant's claim that he was entitled to summary disposition because plaintiff failed to present evidence creating a question of fact regarding legal causation. As he did in the trial court, defendant argues that plaintiff's evidence demonstrates that the incidence of AVN after short-course steroid use was too remote to be a foreseeable consequence of defendant's actions. Defendant again relies primarily upon his mathematical analysis. Notwithstanding the flaws in his analysis,[4] defendant's argument has no merit. "'The determination of remoteness . . . should seldom, if ever, be summarily determined.'" *Lockridge*, 285 Mich App at 685 (citation omitted). Further, "the legal issue is not whether the patient's actual ailment is foreseeable, but whether the patient's injuries and damages . . . qualify as a 'natural and probable result of' the defendant's negligent conduct." *Id*. at 689 (citation omitted). Here, Dr. McKee testified that, based on his own research and experience, AVN results from short-course steroid therapy with some regularity. Dr. McKee also testified it was generally accepted in the medical community that short-course steroid therapy was a known cause of AVN. "Proximate cause is usually a factual issue to be decided by the trier of fact, but if the

[4] Defendant argues that, as only 15,000 cases of AVN are reported annually in the United States, which has a total population of slightly over 300 million people, the average incidence rate of AVN is only 0.0049 percent. Defendant then cites Dr. Mayo's deposition for the conclusion that, if one were to ingest three grams of steroids in a span of three months, the expected incidence of AVN is only 0.6 percent. Defendant errs, however, by multiplying these numbers together to reach what he describes as an expected incidence of steroid-induced AVN of only 0.000029 percent. This final number actually represents the percentage of the entire population that is diagnosed each year with AVN caused by ingesting three grams of steroids in three months, an understandably small group of approximately 90 individuals, assuming a population of 308,745,538, as defendant stated in his brief in support of his second motion for summary disposition. This percentage would be relevant here only if it were also true that, in any given year, every person in the United States ingested three grams of steroids in a three-month period.

facts bearing on proximate cause are not disputed and if reasonable minds could not differ, the issue is one of law for the court." *Dawe v Bar-Levav & Assoc (On Remand)*, 289 Mich App 380, 393; 808 NW2d 240 (2010). In this case, plaintiff produced sufficient evidence to create a question of fact regarding whether developing AVN was a natural and probable result of defendant's allegedly negligent conduct. Accordingly, defendant's claim that he was entitled to summary disposition because plaintiff failed to present evidence creating a question of fact regarding legal causation is without merit.

Reversed and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Mark J. Cavanagh
/s/ Donald S. Owens
/s/ Michael J. Kelly