

STATE OF MICHIGAN
IN THE SUPREME COURT

SHERRI MARTIN,
Plaintiff–Appellant,

v

Supreme Court
No. 138636

DAVID LEDINGHAM, M.D., DAVID
RYNBRANDT, M.D., ANDRIS KAZMERS,
M.D., AND PETOSKEY SURGEONS, P.C.
Defendants,

Court of Appeals
No. 280267

and

Emmet County Circuit Court
No. 05-009021-NH

NORTHERN MICHIGAN HOSPITAL,
Defendant–Appellee.

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**APPELLEE’S ANSWER IN OPPOSITION TO APPELLANT’S
APPLICATION FOR LEAVE TO APPEAL**

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FILED
MAY 13 2009
CORBIN R. DAVIS
CLERK
MICHIGAN SUPREME COURT

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COUNTER-STATEMENT OF QUESTION INVOLVED

- I. DID THE TRIAL COURT ERR IN GRANTING DEFENDANT HOSPITAL'S MOTION FOR SUMMARY DISPOSITION PURSUANT TO MCR 2.116(C)(10) IN THIS CASE, WHERE PLAINTIFF FAILED TO PRESENT ANY LEGALLY SUFFICIENT EVIDENCE OF PROXIMATE CAUSATION IN RESPONSE TO DEFENDANT'S MOTION?**

The trial court would answer this question "No."

The Court of Appeals has answered this question "No."

The Plaintiff–Appellant contends the answer should be "Yes."

The Defendant–Appellee contends the answer is "No."

INTRODUCTION

Having settled her claim against the attending physician and dismissed her claims against the other physicians involved without payment, Plaintiff Sherri Martin has sought additional compensation for her alleged injuries from Defendant Northern Michigan Hospital, based upon her theory that the nurses responsible for her care failed to make proper reports of her worsening condition. Her theory of liability against the Hospital has two components: 1) That the nurses failed to inform the attending physician, Dr. David Rynbrandt, of post-surgical complications in a timely manner; and 2) That the nurses failed to make reports of these complications, and Dr. Rynbrandt's failure to address them, up the Hospital's chain of command.

Plaintiff's claim against the Hospital based upon these alleged omissions on the part of its nurses depends upon the essential premise that Dr. Rynbrandt, or another physician called upon to review his treatment decisions, would have taken appropriate corrective action based upon the omitted reports had they been made, and that this action would have prevented the injuries in question. That premise has been solidly refuted, however, by two affidavits submitted in support of Defendant's motion for summary disposition. As Plaintiff has noted, Dr. Rynbrandt's lengthy and detailed affidavit has asserted that he was fully informed with regard to Plaintiff's condition during the period in question, and that his care of Plaintiff would not have been altered if the nurses had made additional reports to him as Plaintiff has alleged they should have done. Defendant also presented an affidavit of Dr. Jeffrey Beaudoin, the Chief of Surgery to whom the nurses would have reported under Hospital policy if further reporting had been deemed necessary. Dr. Beaudoin's affidavit reflects his review of Plaintiff's Complaint and the Hospital's medical records relating to the treatment at issue, and

states his belief that he would not have suggested or requested any change in the care provided to the Plaintiff if he had been contacted for review of her treatment under the Hospital's policy.

Although Plaintiff has presented an expert opinion as to what the standard of care applicable to Dr. Rynbrandt and Dr. Beaudoin would have required them to do in response to the additional reports that she claims the nurses should have made, she has presented no evidence whatsoever as to what Dr. Rynbrandt and Dr. Beaudoin would actually have done in response those reports, had they been made, and thus, she has presented nothing to refute the assertions, made in their respective affidavits, that they would not have altered the care or treatment provided based upon any such reports.

Plaintiff's present application for leave to appeal is based upon her claims that the trial court and the Court of Appeals have improperly adjudicated questions of fact and resolved questions of credibility. But a review of their decisions will quickly reveal that this was not the case at all. The trial court and the Court of Appeals have merely recognized, and properly so, that the Plaintiff has failed to sustain her burden of establishing a genuine issue of material fact as to the essential element of proximate causation – a failure which properly warranted a grant of summary disposition under MCR 2.116(C)(10) in this case. Plaintiff's application does not present any question of significance to the jurisprudence of the state or reveal any manifest injustice. The trial court and the Court of Appeals have properly applied the well-established law of this state, and thus, further review by this Court is unwarranted. Plaintiff's application for leave to appeal should therefore be denied.

COUNTER-STATEMENT OF FACTS

The facts pertinent to the challenged disposition of Defendant's motion for summary disposition are undisputed and relatively uncomplicated. In this medical malpractice action, Plaintiff has claimed that the nurses at Northern Michigan Hospital violated the standard of care applicable to their profession by their failure to make timely reports of post-surgical complications to her attending physician and/or the Hospital's Chief of Surgery during the week-long hospitalization following the surgery performed for the removal of a duodenal diverticulum from her small intestine. Plaintiff has alleged that her injuries were proximately caused by these failures because the omitted reports would have prompted appropriate corrective action if made in the manner that Plaintiff claims was required, and that this corrective action would have prevented those injuries.

Dr. Rynbrandt performed this very serious surgery on May 1, 2003, assisted by Dr. David Ledingham. He removed the section of Plaintiff's small intestine where the diverticulum ballooned out and then re-attached the two remaining ends of the intestine. The area where the two ends are sutured together is called the "anastomosis" site. The anastomosis is where the healing takes place and is the prime spot where leaks occur because of the sutures. Dr. Rynbrandt ordered that Plaintiff not eat or drink anything for several days after the surgery so that the anastomosis had a chance to heal. But despite a "nothing by mouth" order like this, some fluids, namely saliva and other bodily fluids, do pass through the intestine, so infections and leaks can occur. If the anastomosis gets infected, it does not heal, the tissues break down, and a leak can occur.

The surgeons were aware of the possibility of an infection or leak, as these are the primary problems that can arise in the days following this type of surgery. They (and the

nurses) watch the patient closely and do blood tests to check for any signs of a problem. It is in this area that Plaintiff alleges that the nurses failed to keep the physicians informed of test results and significant changes in her condition, and that this failure contributed to Dr. Rynbrandt's alleged failure to timely diagnose the infection and leak at the anastomosis site.

The surgery went well, with no significant complications. During the next week, Plaintiff's condition improved and her activity level increased. The medical records show that she was alert, awake, and doing well. Two days after surgery, Plaintiff was allowed to increase her activity level and her pain was controlled. The following day, May 4th, discharge was already being discussed. Plaintiff had some slight confusion on May 5th, but this was gone the next day.

Three days later, on May 8th, Plaintiff's condition suddenly worsened and she appeared confused. Dr. Rynbrandt saw her in the morning and was now unsure about discharging her. That afternoon, Plaintiff began having shortness of breath and her abdominal pain increased. The nurses called Dr. Rynbrandt to come see Plaintiff. When he checked in on her again at 5:00 p.m., she had started to look weak and tired, and her white blood cell count was increased – a sign of a possible infection. In light of these developments, Dr. Rynbrandt decided that Plaintiff should not be discharged. Post-operative infection is always a concern, but with intestinal surgery, this also raises the possibility of a leak. Dr. Rynbrandt ordered X-rays to see if there was any evidence of a leak. That evening, soon after the X-rays were taken, Plaintiff had increased pain and confusion. Because it was after hours, the nurses notified the on-call surgeon, Dr. Jeffrey Beaudoin, who came in, examined Plaintiff, and ordered a CT scan which showed a leak in the area of the surgery. Dr. Beaudoin performed emergency surgery and repaired the leak in the early morning hours of May 9th.

Plaintiff's recitation of the facts creates an inaccurate impression that the doctors did not have regular contact with Plaintiff during her hospitalization, did not look at the nursing notes, and did not speak with the nurses. This, however, was clearly not the case. In any hospital setting, the doctors rely upon the nurses to be their "eyes and ears" when they cannot be there – they speak with them constantly. In this case, the medical records show that the physicians saw Plaintiff every day, usually several times, and conferred with the nurses concerning her progress.

On page 2 of her Statement of Facts, Plaintiff has acknowledged that she was seen by associates of Dr. Rynbrandt during her post-surgical hospitalization: "[d]uring this 7-day period, the medical records show associates of Dr. Rynbrandt intermittently seeing Plaintiff, but the medical records are unclear as to whether some of the symptomology – the decreased urine output, the patient's confusion, and the elevated white blood count – were communicated by the nurses to Dr. Rynbrandt."¹ The Court should note, however, that the record reflects that Plaintiff was also seen by Dr. Rynbrandt himself on a regular basis during this period. Plaintiff's Complaint² alleged that Plaintiff was seen by Dr. Rynbrandt on May 2, 5 and 7, 2003. (Complaint, ¶¶ 22, 30, 35) The Complaint alleged that Plaintiff was also seen by Dr. Rynbrandt's partner, Dr. Kazmers, on May 2, 3 and 4, 2003. (Complaint, ¶¶ 24, 25, 28) Although the Complaint does not allege any facts concerning Dr. Rynbrandt's evaluation of the Plaintiff on May 8, 2003, the circumstances of those visits were noted in the medical records, as shown by the deposition testimony of Lawrence Boyd, Plaintiff's nursing standard

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¹ Noticeably absent from this discussion, is any claim that any of this symptomology was not duly noted in the chart.

² A copy of Plaintiff's Complaint is submitted herewith as Appendix "A."

of care expert. (Boyd Deposition, pp. 21-24)³ Mr. Boyd's deposition testimony also reflects that the nurses consulted with Dr. Rynbrandt concerning Plaintiff's condition on May 6, 2003. (Boyd Deposition, pp. 21-24)

In the trial court proceedings, Plaintiff's counsel candidly acknowledged that Plaintiff had been seen by multiple doctors during the week after her surgery:

"THE COURT: Do the records show that Dr. Rynbrandt was rounding on this patient and seeing the patient on each of the days post-surgery, or was the patient being seen by other doctors during that time frame?

"MR. BREWER: The patient was seen by various physicians.

"THE COURT: Other general surgeons, I should say?

"MR. BREWER: Various physicians, residents, partners of Dr. Rynbrandt,

"THE COURT: Where do I have that in the record before me for purposes of this motion?

"MR. BREWER: Well, that – that was covered in the depositions of Dr. Rynbrandt and Badoine, and it is extant in the medical record that will be introduced into evidence at trial.

"This is simply not a situation where they only had one person to go to and that person would have committed malpractice, too.

"THE COURT: Let me be specific with my questions so I can get a specific response. I understand the patient in the hospital may well have been seen by a variety of doctors. I'm focusing in on general surgery care. Were there other general surgeons that saw this patient during the relevant time frame, or was it just Dr. Rynbrandt?

"MR. BREWER: No, your Honor. There were multiple general surgeons.

"THE COURT: Who else?

"MR. BREWER: Dr. Badoine is one of them. There was another physician who is in doctor with Dr. Rynbrandt who saw her. There were

³ Mr. Boyd's deposition has been submitted to the Court as Exhibit 7 of Plaintiff's application for leave to appeal.

various physicians who were on staff at the hospital who saw her. They were all involved in her care.

“THE COURT: Again, I’m asking about general surgeons. Not physicians, generically.

“MR. BREWER: And that’s what I’m responding to. There were multiple general surgeons and general surgery residents who –

“THE COURT: Residents?

“MR. BREWER: Or, I’m sorry – I’m sorry.

“THE COURT: They don’t have residents at this hospital, I don’t believe.

“MR. BREWER: My mistake. There were multiple general surgeons who were involved in her care other than Dr. Rynbrandt.

“THE COURT: Who?

“MR. BREWER: And that’s a fact. Dr. Badoine, and there was a third gentleman whose deposition we took whose name is escaping me at the moment.”

(Motion Hearing Transcript, 6-28-07, pp. 9-11)

As noted previously, Plaintiff’s theory of liability against the Hospital has two components: 1) That the nurses failed to inform Plaintiff’s attending physician, Dr. Rynbrandt, of post-surgical complications in a timely manner; and 2) That the nurses failed to make reports of these complications, and Dr. Rynbrandt’s failure to address them, up the Hospital’s chain of command. With regard to the second claim, Plaintiff has contended that the nurses should have realized that Dr. Rynbrandt was not ordering the correct tests and was ignoring signs of an intestinal leak, and that they should therefore have “gone over his head,

up the chain of command,” pursuant to the Hospital’s policy entitled, “Responsibilities For Patient Care: Lines Of Authority.”⁴

Under the terms of this policy, if a nurse has a concern or disagreement regarding a patient’s care, the nurse first discusses the issues with the attending physician, and if there is no resolution, the nurse then contacts the team leader or the House Manager/Care Center Manager (*i.e.*, the nursing supervisor), who then discusses the matter with the attending physician. If there is still no resolution, the House Manager contacts the appropriate Medical Staff Section Chair to discuss the matter. Thus, when a nurse has an issue with the physician’s care, the policy provides the nurse with an avenue to resolve the issue by going up the hierarchical chain of command to the nurse’s supervisor, and then to the attending physician’s section head, and then to Administration, if necessary.⁵

Plaintiff was being treated by a general surgeon, Dr. Rynbrandt, and therefore, in terms of this policy, the applicable Section Chair of General Surgery was Dr. Jeffrey Beaudoin. *See*, Affidavit of Jeffrey F. Beaudoin, M.D., ¶¶ 5-6).⁶ Thus, if the nurses had raised concerns regarding Plaintiff’s treatment with Dr. Rynbrandt and wished to further pursue the matter “up the chain of command,” the policy would have required them to raise their concerns with Dr. Beaudoin.

⁴ A copy of this Policy, provided to the trial court as Exhibit F of Defendant’s Second Motion For Summary Disposition Regarding Proximate Cause, is submitted herewith as Appendix “B.”

⁵ Paragraph 1(g) of the Policy allows an additional step beyond the Section Chair. It provides that the Administrator on call will be contacted if a resolution is not reached after referral to the Section Chair.

⁶ A copy of Dr. Beaudoin’s affidavit, provided to the trial court as Exhibit H of Defendant’s Second Motion For Summary Disposition Regarding Proximate Cause, has been submitted to this Court as Exhibit 9 of Plaintiff’s application for leave to appeal.

As noted previously, Plaintiff's claim against the Hospital based upon the allegedly deficient reporting by its nurses has been built upon the essential premise that Dr. Rynbrandt, or another physician called upon to review his treatment decisions, would have taken appropriate corrective action based upon the omitted reports, had they been made, and that this action would have prevented the injuries in question. That premise has been solidly refuted, however, by two affidavits submitted in support of Defendant's motion for summary disposition. Dr. Rynbrandt's lengthy and detailed affidavit⁷ has asserted that Dr. Rynbrandt had been fully informed with regard to Plaintiff's condition during the period in question, and that his care of Plaintiff would not have been altered if the nurses had made additional reports to him as Plaintiff has alleged they should have done. Dr. Rynbrandt testified, in his affidavit, that he had reviewed Plaintiff's medical records in detail. (Rynbrandt Affidavit, ¶ 4) He stated that he had reviewed and evaluated all of the various laboratory results and conditions in question every day that he had seen Plaintiff, and on the days that she had been seen by another physician, he had either agreed with the care provided or changed the care ordered by the other physician. With regard to each of the criticisms of the nurses listed in Plaintiff's Complaint, Dr. Rynbrandt stated there was nothing that the nurses could have done differently which would have led him to alter Plaintiff's treatment. (Rynbrandt Affidavit, ¶¶ 18, 19, 21, 23, 25, 28, 29, 31, 32, 34, 41, 42, 46, 48, 51, 53, 57, 61, 67, 73, 74, 75, 76)

In Paragraph 7 of his affidavit, Dr. Rynbrandt expressed his opinion that the nurses had fully informed him of Plaintiff's condition and progress through telephone conversations and other discussions, and through their entries in Plaintiff's medical record. In Paragraph 8

⁷ A copy of Dr. Rynbrandt's affidavit, provided to the trial court as Exhibit E of Defendant's Second Motion For Summary Disposition Regarding Proximate Cause, has been submitted to this Court as Exhibit 8 of Plaintiff's application for leave to appeal.

of his affidavit, Dr. Rynbrandt stated that “I do not believe that any of the actions alleged by Plaintiff in Paragraph 61, had the nurses performed them as Plaintiff alleges they should have been performed, would have led me to alter the care that I provided to Mrs. Martin.”

Defendant also presented an affidavit of Dr. Jeffrey Beaudoin, the Chief of Surgery to whom the nurses would have reported under Hospital policy if further reporting had been deemed necessary. In his affidavit, Dr. Beaudoin stated that he had reviewed Plaintiff’s Complaint and the allegations made against Dr. Rynbrandt therein, and that he had also reviewed, in detail, Plaintiff’s medical records from Northern Michigan Hospital pertaining to the treatment at issue. (Beaudoin Affidavit, ¶ 4) Dr. Beaudoin stated that if he had been contacted pursuant to the Hospital’s policy for review of Plaintiff’s treatment, he would have reviewed Plaintiff’s medical record, including nursing notes and laboratory test results; discussed Plaintiff’s care and treatment with Dr. Rynbrandt; and might also have spoken with and examined Plaintiff. (Beaudoin Affidavit, ¶ 8) Based upon his detailed review of the matter, Dr. Beaudoin expressed his belief that, more likely than not, he would not have suggested or requested any change in the care provided to the Plaintiff by the surgeons attending to her care, including Dr. Rynbrandt, if he had been contacted for review of her treatment under the Hospital’s Responsibilities For Patient Care: Lines of Authority policy. (Beaudoin Affidavit, ¶ 10)

Plaintiff’s counsel presented deposition testimony of two experts in opposition to Defendant’s motion for summary disposition. As noted previously, Lawrence Boyd, Plaintiff’s nursing standard of care expert, provided testimony describing his findings that the Hospital’s nurses had beached the standard of care by their failure to provide timely reports of certain post- surgical complications to Dr. Rynbrandt, and by their failure to make further

reports up the Hospital's chain of command when Dr. Rynbrandt failed to provide appropriate treatments. Plaintiff attempted to establish the required element of proximate causation through the deposition testimony of Dr. Eduardo Phillips.⁸ Although Dr. Phillips has given testimony as to what he believed the standard of care applicable to Dr. Rynbrandt and Dr. Beaudoin would have required them to do in response to the additional reports that Plaintiff claims the nurses should have made, that testimony made no showing whatsoever as to what Dr. Rynbrandt and Dr. Beaudoin would actually have done in response those reports, had they been made, and thus, Plaintiff presented nothing to refute the assertions, made in their respective affidavits, that they would not have altered the care or treatment provided based upon any such reports.

By its Opinion of August 9, 2007 and subsequent Order of August 21, 2007,⁹ the trial court granted Defendant's motion for summary disposition pursuant to MCR 2.116(C)(10), based upon its finding that Plaintiff had failed to establish a genuine issue of material fact as to the essential element of proximate causation. The trial court held, and the Court of Appeals later agreed,¹⁰ that the deposition testimony of Dr. Phillips did not create a friable issue of fact as to what Dr. Rynbrandt and Dr. Beaudoin would have done if the nurses had made the additional reports that Plaintiff has claimed were required by the nursing standard of care, and did not provide any basis, beyond impermissible speculation, for a finding that additional reporting would have prevented Plaintiff's injuries.

⁸ A copy of the transcript of Dr. Phillips' deposition testimony has been provided to the Court as Exhibit 6 of Plaintiff's application for leave to appeal.

⁹ Exhibits 3 and 4 of Plaintiff's application for leave to appeal.

¹⁰ Exhibits 1 and 2 of Plaintiff's application for leave to appeal.

Plaintiff now seeks leave to appeal the decisions of the lower courts to this Honorable Court pursuant to MCR 7.302. This response is respectfully submitted by Defendant Northern Michigan Hospital in opposition to Plaintiff's application. Additional pertinent facts will be discussed in the body of the Legal Argument, *infra*, to the extent that such discussion may be required to fully inform the Court with regard to the issues raised in Plaintiff's application.

LEGAL ARGUMENT

I. THE TRIAL COURT PROPERLY GRANTED DEFENDANT HOSPITAL'S MOTION FOR SUMMARY DISPOSITION PURSUANT TO MCR 2.116(C)(10) IN THIS CASE, WHERE PLAINTIFF FAILED TO PRESENT ANY LEGALLY SUFFICIENT EVIDENCE OF PROXIMATE CAUSATION IN RESPONSE TO DEFENDANT'S MOTION.

Plaintiff's theory of liability against Northern Michigan Hospital requires proof that Dr. Rynbrandt, or another duly authorized physician reviewing his treatment decisions, would have taken corrective action preventing Plaintiff's injuries if the nurses had made additional or more timely reports of her condition. This theory has been refuted by the affidavits of Dr. Rynbrandt and Dr. Beaudoin, which have shown, more probably than not, that this would not have occurred, and thus, Plaintiff's injuries would not have been prevented by better reporting. Plaintiff has presented no evidence of what these physicians would or would not have actually done in response to such reporting, and thus, Plaintiff's proposed proofs provide nothing to refute their specific testimony that it would not have changed the treatment provided. Plaintiff has merely offered evidence of what the standard of care, as defined by Dr. Phillips, would have required, but that is not a legally relevant question with respect to establishment of proximate causation in this case.

The trial court and the Court of Appeals have not made findings of fact or judged credibility, as Plaintiff has suggested. They have merely found, correctly, that Plaintiff has not satisfied her burden of showing a genuine question of material fact as to the required element of proximate causation in this case. The lower courts have properly determined that the deposition testimony offered in opposition to Defendant's motion did not refute the specific

evidence provided in the affidavits of Dr. Rynbrandt and Dr. Beaudoin. They have also correctly determined that Plaintiff's proposed proofs did not provide any basis, beyond impermissible speculation, for a finding that additional reporting would have prevented Plaintiff's injuries. It is well established in this state that a finding of proximate cause cannot be based upon speculation, and thus, summary disposition was properly granted in Defendant's favor. The trial court's well-reasoned decision was properly affirmed. Plaintiff's application for leave to appeal should therefore be denied.

A. THE STANDARDS OF REVIEW

A trial court's decision granting or denying a motion for summary disposition is reviewed *de novo*. *Spiek v Michigan Department of Transportation*, 456 Mich 331, 337; 572 NW2d 201 (1998); *Lindsey v Harper Hospital*, 213 Mich App 422; 540 NW2d 477 (1995)

In this case, Defendant Northern Michigan Hospital sought summary disposition under MCR 2.116(C)(10). A motion under MCR 2.116(C)(10) tests the factual support for a claim. *Spiek, supra*, 456 Mich at 337 (1996). When considering a motion under MCR 2.116(C)(10), a trial court considers affidavits, pleadings, depositions, admissions, and documentary evidence filed in the action or submitted by the parties in the light most favorable to the non-moving party. *Quinto v Cross and Peters Co.*, 451 Mich 358, 362; 547 NW2d 314 (1996). Summary disposition may be granted under subrule (C)(10) when the affidavits or other documentary evidence show that there is no genuine issue in respect to any material fact, and the moving party is entitled to judgment as a matter of law. *Id.* The initial evidentiary burden is on the moving party, who is required to support the motion by affidavits, pleadings, depositions, admissions, and other documentary evidence. *Id.* When the moving party has done so, the burden shifts to the non-moving party, who must establish the existence of a

genuine issue of material fact. *Id.* If the non-moving fails to satisfy its burden of showing facts establishing a genuine issue of material fact, summary disposition is appropriately granted. *McCormick v Auto Club Insurance Association*, 202 Mich App 233, 237; 507 NW2d 741 (1993).

A mere restatement of allegations and denials contained in the pleadings will not suffice to carry the non-moving party's burden. MCR 2.116(G)(4). The non-moving party must present actual evidence, for "it is no longer sufficient for plaintiffs to *promise to offer* factual support for their claims at trial." *Smith v Globe Life Ins Co.*, 460 Mich 446, 455 n 2; 597 NW 2d 28 (1999) (emphasis in Opinion). Conclusory allegations are insufficient, *Quinto, supra*, 451 Mich at 371, and courts may consider evidence only insofar as it would be substantively admissible at trial. *Veenstra v Washtenaw Country Club*, 466 Mich 155, 163-164; 645 NW2d 643 (2002); MCR 2.116(G)(6).

B. PLAINTIFF'S BURDEN OF PROVING CAUSE-IN-FACT.

In medical malpractice actions, the plaintiff's burden of proof is defined by statute. With respect to the necessary element of proximate causation, MCL 600.2912a(2) provides that a malpractice 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." This is consistent with the reported case law which has long held that, to prevail in any tort action, a plaintiff must prove damages proximately caused by the defendant's acts or omissions. This requires proof of two separate elements: (1) cause-in-fact, and (2) legal cause. *Weymers v Khera*, 454 Mich 639, 647-648; 563 NW2d 647 (1997); *Skinner v Square D Co.*, 445 Mich 153, 162-163; 516 NW2d 475 (1994). To establish cause-in-fact, the plaintiff must present **substantial evidence** from which the trier of fact may conclude that,

“more likely than not, but for the defendant’s conduct, the plaintiff’s injuries would not have occurred.” *Skinner, supra*, 445 Mich at 164-165. Thus, as this Court explained in *Weymers*, a mere possibility of causation cannot suffice:

“The Plaintiff must introduce evidence which affords a reasonable basis for the conclusion that it is more likely than not that the conduct of the defendant was a cause in fact of the result. A mere possibility of such causation is not enough; and when the matter remains one of pure speculation or conjecture, or the probabilities are at best evenly balanced, it becomes the duty of the court to direct a verdict for the defendant.”

454 Mich at 647-648 (quoting *Skinner v Square D Co., supra*; and Prosser & Keaton, Torts (5th ed), § 41, p. 269)

Accordingly, causation theories based upon mere speculation are insufficient to create a question of fact for a jury. *Skinner v Square D Co., supra*, 445 Mich at 164-165.

These well established principles were recently reaffirmed by this Court in the case of *Craig v Oakwood Hospital, et al.*, 471 Mich 67; 684 NW2d 296 (2004). Again, the Court emphasized that a plaintiff cannot satisfy his burden of proof as to causation by showing only that the defendant *may* have caused his injuries; the Plaintiff’s theory of causation must be supported by specific facts in evidence – facts sufficient to exclude other reasonable hypotheses with “a fair amount of certainty”:

“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.

“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.

“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.’ ”

(471 Mich at 87-88 – Emphasis in Opinion– footnotes omitted)

In this case, Plaintiff has not alleged that her injuries were directly caused by any negligent act or omission on the part of the Hospital’s nurses. In such cases – cases where a nurse has negligently administered an overdose of prescribed medication, for example – questions of causation are much simpler. But in this case, establishment of the necessary cause-in-fact is more complicated because it requires a showing that the actions of third parties would have been influenced by a more appropriate performance of the nurses’ duties. Nurses do not have authority to prescribe medication or write orders regarding a patient’s course of treatment – that is the sole province of the physician. If the patient’s condition changes, the nurse must communicate that to the physician, who then decides whether to change the course of treatment or not. Thus, Plaintiff’s claim against the Hospital based upon the allegedly deficient reporting of its nurses depends upon the essential premise that Dr. Rynbrandt, or another physician called upon to review his treatment decisions, would have taken appropriate corrective action based upon the omitted reports, had they been made, and that this action would have prevented the injuries in question. Proof of this premise necessarily requires a showing of what Dr. Rynbrandt, or another physician having authority to review his treatment decisions in this case, would have done in response to the reports that should allegedly have been made.

C. PLAINTIFF'S RESPONSE TO DEFENDANT'S MOTION FOR SUMMARY DISPOSITION DID NOT ESTABLISH A GENUINE QUESTION OF MATERIAL FACT REGARDING THE REQUIRED ELEMENT OF PROXIMATE CAUSATION.

The opinions expressed by Dr. Phillips in his deposition testimony did not shed any light upon the pertinent question of how Dr. Rynbrandt and Dr. Beaudoin would have responded to additional or more timely reports of Plaintiff's condition. As the trial court correctly noted on page 4 of its opinion, Dr. Phillips freely admitted that he had no knowledge of whether the Chief of Surgery would have agreed or disagreed with Dr. Rynbrandt's course of treatment. (Phillips Deposition, p. 32) Dr. Phillips' deposition is also devoid of any testimony establishing a foundation for any opinion as to what Dr. Rynbrandt would have done, or failed to do, if the nurses had made the additional reports concerning Plaintiff's condition. Dr. Phillips' testimony merely provided his opinion of what the applicable standard of care would have required Dr. Rynbrandt and Dr. Beaudoin to do in response to such reports, if made. It did not constitute any evidence of what these specific doctors would have done. A clear answer to that question has been provided by the affidavits of Dr. Rynbrandt and Dr. Beaudoin, and Dr. Phillips' opinion as to what a hypothetical doctor should have done has not refuted their very specific testimony that the care provided in this case would not have been changed.

1. THE TRIAL COURT'S RULING WAS NOT BASED UPON FINDINGS OF FACT OR WEIGHING OF CREDIBILITY.

Much of Plaintiff's application has been devoted to discussion of the uncontroversial proposition that a trial court should not weigh issues of credibility or make findings on contested issues of fact when deciding a motion for summary disposition under MCR

2.116(C)(10). This discussion is superfluous because the trial court and the Court of Appeals have not made findings of fact or resolved questions of credibility, as Plaintiff has so vigorously suggested. It is not necessary to quote the lower court opinions at length; a review of their decisions will quickly reveal that they have done nothing more than to properly determine whether Plaintiff's proposed proofs cannot satisfy her burden of establishing a genuine issue of material fact in this case.

Neither the trial court nor the Court of Appeals, have made any judgments regarding the credibility of Dr. Rynbrandt or Dr. Beaudoin. They have simply made accurate note of what the submission of their affidavits has proposed to prove by way of testimony at trial. Nor has either of the lower courts made any findings that the facts are as stated in these affidavits. They have merely performed their proper function of deciding, as a matter of law, whether Defendant's proposed proofs can be refuted by Plaintiff's proposed proofs so as to create a triable question of fact on the essential issue of proximate causation. Thus, it may be seen that there is no basis whatsoever for the exaggerated suggestion, on page 28 of Plaintiff's application, that the Court of Appeals' decision in this case will now stand as authority for the proposition that trial courts "will hereafter be empowered to decide questions of weight and credibility in summary disposition proceedings." The Court of Appeals has suggested nothing of the sort. Its decision simply reiterates the well-established principle that a Plaintiff must present competent, admissible evidence to support his or her claim when a motion for summary disposition is filed under MCR 2.116(C)(10). Plaintiff has failed to do so in this case, and thus, her claims against the Hospital were properly subject to dismissal under Subrule (C)(10).

2. THE DEPOSITION TESTIMONY OF PLAINTIFF'S EXPERTS DID NOT REFUTE THE TESTIMONY PROVIDED IN DEFENDANT'S AFFIDAVITS, AND THUS, DID NOT CREATE A QUESTION OF MATERIAL FACT AS TO THE REQUIRED ELEMENT OF PROXIMATE CAUSATION.

This is not a case where competent, admissible evidence conflicts and a determination of credibility is key to resolution of the conflict. The essential question is, instead, a matter of whether the Plaintiff can present any competent, admissible evidence in support of her theory of liability – a theory which she must prove by a preponderance of the evidence to prevail.

The affidavits of Dr. Rynbrandt and Dr. Beaudoin have satisfied Defendant's burden, as the moving party, to present evidence that the essential element of proximate causation cannot be established in this case. The sworn testimony provided therein has shown that, whatever Dr. Phillips' opinions might be, the real doctors who had the responsibility for managing Plaintiff's care during the time in question would not have altered the care provided based upon anything that the nurses could have done, or any additional information that they might have provided. Thus, Plaintiff is unable to make the essential showing of cause-in-fact required for establishment of proximate causation in this case even if it is assumed, for the sake of discussion, that a breach of the standard of care can be found. Having satisfied its burden of going forward with proof that proximate causation cannot be established in this case, Defendant has shifted the burden of refuting this showing to the Plaintiff. But Plaintiff has not presented any competent evidence to refute Defendant's proofs, and thus, has failed to show that there is a genuine issue of material fact as to this issue.

The deposition testimony of Dr. Phillips is not relevant, and is therefore inadmissible to prove causation in this case, because it is not probative of the specific factual question presented here, *i.e.*, whether Dr. Rynbrandt and/or Dr. Beaudoin would have taken corrective

action preventing the injuries in question if the nurses had reported changes in Plaintiff's condition as Plaintiff has claimed the standard of care required. Michigan Rule of Evidence 401 defines "relevant evidence" as "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." The pertinent portion of MRE 402 is concise and definite: "**Evidence which is not relevant is not admissible.**"

Dr. Phillips' testimony does not provide any insight as to what Dr. Rynbrandt or Dr. Beaudoin would have done – his testimony merely sets forth what the standard of practice was, and what some hypothetical physician following the standard of practice would have done. But Plaintiff was not treated by hypothetical doctors; she was treated by Dr. Rynbrandt, and Dr. Beaudoin was the Chief of Surgery who would have reviewed his treatment decisions if the matter had been referred to his attention under the Hospital's policy. Because Dr. Rynbrandt and Dr. Beaudoin were free to either follow or not follow the standard of practice as Dr. Phillips described it, Dr. Phillips' opinion provides no insight as to how they would have reacted to any additional reports made by the nurses on duty and whether their response would have changed the outcome. Thus, because Dr. Phillips' testimony cannot serve to make the existence of the facts necessary for proof of Plaintiff's theory any more or less probable, it is irrelevant, and therefore inadmissible for purposes of establishing proximate causation in this case under MRE 401 and 402.

Because Dr. Phillips' opinion testimony cannot satisfy the basic requirement of relevance imposed under MRE 401 and 402, that opinion cannot be properly presented as an expert opinion under MRE 702. But even if Dr. Phillips' opinion could clear the hurdle of relevancy under MRE 401 and 402, it still would not qualify for admission as an expert

opinion under MRE 702 because it's presentation could not meaningfully assist the trier of fact in understanding the evidence or determining the facts at issue.

MRE 702 provides, in relevant part, that:

“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 . . .”

Whether Dr. Rynbrandt would have changed the treatment course or Dr. Beaudoin would have agreed or disagreed with Dr. Rynbrandt's treatment course are not matters for an expert witness – these issues are solely a matter of what their mindset was, and their own opinions of what Plaintiff needed.

As the Court of Appeals noted in *Davis v Link, Inc*, 195 Mich App 70; 489 NW2d 103 (1992), there are three prerequisites to the admission of expert testimony:

“There are three prerequisites to the admission of expert testimony: (1) the witness must be an expert, (2) there must be facts in evidence that require or are subject to examination and analysis by a competent expert, and (3) there must be knowledge in a particular area that belongs more to an expert than the common man.”

195 Mich App at 73.

These requirements are not satisfied here. The only relevant issue with respect to proximate causation was what Dr. Rynbrandt and Dr. Beaudoin would have done in a given situation. But Dr. Phillips has no personal knowledge of what Dr. Rynbrandt or Dr. Beaudoin would or would not have done, and Plaintiff has not identified any evidence, admissible or otherwise, which can contradict their specific sworn testimony that the course of treatment would not have been altered by any action that the nurses could have taken. An expert may offer opinion testimony under MRE 702 without the personal knowledge normally required under MRE 602, but the expert opinion must be “based on sufficient facts or data.”

Accordingly, it has become well settled that expert opinion is objectionable and should be excluded if based upon assumptions that are not in accord with the established facts. *Badalamenti v Beaumont Hospital*, 237 Mich App 278; 602 NW2d 854 (1999); *Green v Jerome Duncan Ford*, 195 Mich App 493, 598-499; 491 NW2d 243 (1992); *Thornhill v City of Detroit*, 142 Mich App 656, 658; 369 NW2d 871 (1985).

In this case, there are no facts or data to support Dr. Phillips' opinion, and Dr. Phillips is no better qualified than any ordinary juror to speculate as to what these physicians would actually have done in response to further reporting by the nurses. Thus, his opinion testimony is not admissible for establishment of causation under MRE 702.

For all of these reasons, it is clear that Dr. Phillips' opinion cannot provide any competent evidence as to what Dr. Rynbrandt and Dr. Beaudoin would have done in this case if additional reports of Plaintiff's condition had been made. At best, Dr. Phillips' testimony might raise questions about the credibility of Dr. Rynbrandt and Dr. Beaudoin, but as the trial court has aptly noted, creating a triable issue as to credibility does not create a triable issue as to proximate causation.¹¹ Michigan law has always recognized an important distinction between substantive evidence and evidence which serves only as a basis for impeachment, and it has always been well known that a finding of fact must be based upon admissible

¹¹ Plaintiff has complained that it would be impossible to refute the testimony of Dr. Rynbrandt and Dr. Beaudoin without Dr. Phillips' opinion as to what a hypothetical doctor would have done. Although this appears to be true in this case, the result might be different in other cases where the plaintiff is able to present admissible evidence to refute the treating physician's testimony. The result in this case might have been different, for example, if these physicians had been agents of the Hospital and Plaintiff was able to present a prior inconsistent statement admissible under MRE 801(d)(2)(D). But in any event, difficulty of obtaining admissible evidence, or the inability to do so, cannot serve as a basis for admission of evidence that does not satisfy the requirements for admissibility under the rules of evidence.

substantive evidence. Evidence which merely erodes the credibility of a witness's testimony does not constitute substantive evidence of facts to the contrary. Thus, even if the trier of fact were to determine that the testimony of these witnesses was totally incredible, this would not provide any evidentiary basis for a finding of facts contrary to their sworn testimony.

This was made clear by this Court's decision in *Mazur v Blendea*, 413 Mich 540; 321 NW2d 376 (1982), in which the Court noted that:

"The two principal matters on which the trial judge relies are insufficient to do so. The finding that Mr. Mazur is not worthy of belief might justify rejecting all of his testimony. However, even a finding of the total incredibility of a witness does not provide *affirmative evidence* of the contrary of his testimony."

413 Mich at 547 (Emphasis in Opinion)

Accord: Lytle v Malady (On Rehearing), 458 Mich 153, 182; 579 NW2d 906 (1998) ("mere disproof of an employer's 'nondiscriminatory' reason is insufficient to survive summary disposition, unless such disproof also raises a triable question of discriminatory motive, not mere falsity.")

Although there are no reported Michigan decisions addressing the admissibility of expert opinion testimony in the specific circumstances of this case, the decisions of the trial court and the Court of Appeals are well supported by the general principles of Michigan law previously discussed. And, as the Court of Appeals has aptly noted, "courts in other states have similarly concluded that liability can be imposed for a failure to adequately report to a physician only if the physician would have, in fact, altered a diagnosis or treatment had a better or earlier report been received." (Court of Appeals Opinion, p. 3)

In the case of *Albain v Flower Hospital*, 50 Ohio St 3d 251; 553 NE2d 1038 (1990), overruled on other grounds by *Clark v Southview Hospital and Family Health Center*, 68 Ohio St 3d 7 (1994), the Ohio Supreme Court held that the only relevant proof of causation in

this type of case is proof of what the actual physician would have done. There, the plaintiff alleged that a nurse, while attending to a patient in active labor, failed to fully apprise the on-call physician of the extent of the patient's distress such that the on-call physician did not treat the matter as emergent and did not come in to examine the patient as soon as she would have if fully informed by the nurse. After first reiterating that a nurse does have a duty to keep the physician informed of the patient's condition, the Court set forth the next required step in the plaintiff's proofs:

“Even assuming that a nurse breached this duty to inform the attending physician of a patient's condition, it must further be shown that such breach was the proximate cause of the patient's injury before the hospital will be held vicariously liable therefor. **Thus, a plaintiff must prove that, had the nurse informed the attending physician of the patient's condition at the proper time, the physician would have altered his diagnosis or treatment and prevented the injury to the patient.**”

553 NE2d at 1051(Emphasis added)

The Court then set out the testimony of Dr. Abbo, the physician whom the nurses allegedly failed to fully inform of the patient's emergent condition, who testified that, even with this information, she would not have changed her course of treatment:

“Dr. Abbo testified that had she been told about this bleeding she would have come to the hospital sooner. However, Dr. Abbo clearly testified that “sooner” did not mean immediately – it simply meant she would not have gone home to eat dinner, but would have come at 5:30 p.m. as she had originally promised. **Moreover, Dr. Abbo testified that even if she had gone to the hospital earlier, she would not have done anything differently.**”

553 NE2d at 1051 (Emphasis added – footnote omitted)

Based on this lack of proximate cause testimony, the *Albain* Court reinstated the summary disposition granted by the trial court.

Illinois appellate courts, including its Supreme Court, have reached the same result as the Ohio Supreme Court in its *Albain* decision, and have expressly rejected Plaintiff's

argument that a genuine issue of material fact can be created with expert testimony about what a hypothetical physician following the standard of practice would have done.

In *Seef v Ingalls Memorial Hospital*, 311 Ill App 3d 7, 724 NE 2d 115 (1999), another case cited with approval by the lower courts in this case, a mother was in labor and there were allegations that the nurse failed to keep the physician fully informed of the mother's condition. However, the physician, Dr. Sutkus, testified that he would not have done anything differently if the nurses had provided the additional information.

“Dr. Sutkus testified that he would have done nothing differently even had he seen the monitor strips earlier, thereby negating any argument for notifying him earlier. If the nurses had notified Dr. Sutkus earlier, his interpretation of those earlier monitor strips would not have indicated a problem requiring immediate intervention prior to 3:05 a.m.

* * *

“This evidence of what Dr. Sutkus would or would not have done cannot be negated by Dr. Lilling’s [Plaintiff’s expert] testimony. Dr. Lilling cannot testify regarding what Dr. Sutkus’ mental state was nor contradict what Dr. Sutkus thought at the time. Further, Dr. Lilling’s testimony that any reasonably qualified obstetrician would have delivered the baby sooner goes to Dr. Sutkus’ liability, not to the nurses’ or the hospital’s. Dr. Sutkus already admitted that, apparently contrary to what any other reasonably qualified obstetrician within Dr. Lilling’s ken would have done, he would have done nothing differently if the nurses had notified him earlier to show him the monitor strips. Assuming arguendo that the nurses had notified Dr. Sutkus several hours earlier, Dr. Sutkus admitted that he would have misinterpreted the data on the monitor strips in the same way. . . . By his own admission, the nurses’ failure to notify Dr. Sutkus earlier made no difference in this case.

724 NE 2d at 122-123 (Emphasis added).

The above-emphasized portions of the *Seef* Court’s opinion make two important points relevant to the issues presented here: first, that the only relevant question is what the actual doctor would have done; and second, that expert testimony as to the standard of practice is irrelevant unless it provides information concerning the actual physician’s mindset. Thus, the

Illinois Court of Appeals' decision in *Seef* provides a persuasive example of how Plaintiff's arguments have failed in that state.

The Illinois Court of Appeals' decision in *Seef* echoed what the Illinois Supreme Court had decided six years earlier, in the case of *Gill v Foster*, 157 Ill 2d 304; 626 NE 2d 190 (1993). In that case, the Court held that where it was claimed that the nurse had failed to notify the doctor of a fact of which the doctor was already aware, there was no causation, and dismissal was required:

“In short, when plaintiff was discharged from St. John’s Hospital, he was experiencing pain in his chest for which he was taking no medication, which was similar to that which he had been experiencing for several days prior to discharge, and which he had reported to his attending physician on the morning of discharge. In light of these facts, we must agree with the appellate court and find that **even assuming the nurse had breached a duty to inform the treating physician of the patient’s complaint, this breach did not proximately cause the delay in the correct diagnosis of the plaintiff’s condition.**”

626 NE2d at 193 (Emphasis added).

As the *Gill* opinion shows, if the physician is already aware of the information the nurses supposedly failed to convey to him, there can be no causation – the result would be the same regardless of what the nurses did or did not tell the physician. In the present case, Dr. Rynbrandt has testified that he had all of the information he needed and would not have changed his course of treatment. This testimony presents a scenario identical to the situation in *Gill*, and the result should be the same – if the failure to inform did not make a difference, the claim fails.

Similarly, in the case of *Sunderman v Agarwal*, 322 Ill App 3d 900; 750 NE 2d 1280 (2001), the allegations revolved around whether a pathology lab had failed to report a biopsy

as malignant. The patient's physician, Dr. Agarwal, testified that, regardless of what the report stated, he believed that the biopsy was malignant and managed the patient accordingly:

“Similarly, in the case at bar, the testimony of Dr. Agarwal established that, regardless of whether the pathology report definitively stated that the biopsy specimen was malignant, he believed that the mass was malignant and recommended treatment accordingly. Thus, no question of fact exists as to whether Dr. Agarwal would have done anything differently if the report had been different.”

750 NE 2d at 1284.

The plaintiff in *Sunderman* argued that the challenged summary disposition had been premature because she had not had an opportunity to disclose who her expert witness would be. The Illinois Court of Appeals, citing to *Seef*, rejected that argument, ruling that expert testimony would be irrelevant:

“Plaintiff further contends that it was error for the trial court to grant summary judgment to the pathology defendants before plaintiff had disclosed and presented medical experts. This argument fails because no expert can testify regarding what Dr. Agarwal's mental state was or contradict Dr. Agarwal's testimony regarding what he thought after reading the biopsy report. See *Seef*, 311 Ill.App.3d at 16, 243 Ill. Dec. 806, 724 N.E.2d 115. Consequently, no expert testimony could negate the evidence that the treatment options Dr. Agarwal presented were based on his belief that the mass in Janet's lung was cancerous.”

50 NE 2d at 1284.

Plaintiff has correctly noted that in *Snelson v Kamm*, 204 Ill 2d 1; 787 NE 2d 796 (2003), the Illinois Supreme Court cited the dissenting opinion in *Seef* as support for its statement that “a plaintiff would always be free to present expert testimony as to what a reasonably qualified physician would do with the undisclosed information and whether the failure to disclose the information was a proximate cause of the plaintiff's injury in order to discredit a doctor's assertion that the nurse's omission did not affect his decision making.” 787 NE 2d at 821. This citation of *Seef* is puzzling for two reasons. First, the Court's holding

in *Snelson* was based upon its finding that the plaintiff had presented no expert testimony establishing the necessary breach of the standard of care on the part of the Hospital's nurses. 787 NE2d at 819. The Court's discussion concerning sufficiency of the evidence of proximate cause was unnecessary to the Court's holding, and therefore *obiter dictum*. Thus, the majority decision in *Seef* has not been specifically overruled, or even directly disapproved, by *Snelson*.

Second, the *Snelson* Court did find the Plaintiff's evidence of proximate causation deficient based upon its prior decision in *Gill*, noting that "[s]imilar to *Gill*, there was no indication that Kamm would have taken a different course of action had he been informed that *Snelson* had some pain after Kamm left at 6 p.m." 787 NE2d at 820. In so ruling, the Court distinguished the Illinois Court of Appeals' holding in *Suttle v Lake Forest Hospital*, 315 Ill App 3d 96; 733 NE2d 726 (2000), noting that in that case, the treating physician had testified that the Hospital's breach had resulted in a delay in his taking appropriate action. Obviously, there has been no such testimony in this case. Dr. Rynbrandt has testified, to the contrary, that his treatment would not have been changed by a more effective performance of the nurses' duty to report.

Plaintiff's reliance upon the Alabama Supreme Court's decision in *Davison v Mobile Infirmary*, 456 So 2d 14 (1984), is also misplaced because its pertinent facts are very different. In *Davison*, the radiologist who negligently failed to report the dangerous accumulation of un-dissolved pills had testified that in cases that he deemed to be an emergent situation, the policy of the hospital was to call the attending physician, whether the physician requested such notification or not, and that when such notification was given, the attending physicians generally came to the hospital themselves immediately to determine the appropriate course of treatment. 456 So 2d at 23. Thus, in *Davison*, there was independent

admissible evidence to suggest that, in the specific hospital setting and the specific circumstances at issue, more appropriate reporting would probably have led to more prompt attention and corrective action preventing the plaintiff's injuries. The existence of this independent evidence appears to have influenced the Court's finding that there was a triable question of fact as to causation despite the treating physician's testimony that he would not have done anything differently if he had received the radiology report sooner. No such testimony appears in this case.

The decision in *Davison* also appears to have been strongly influenced by the Court's belief that the attending physician's testimony was motivated by self-interest. The Court noted, in this regard, that the jury "could have concluded that it was in the treating doctor's self-interest to say he would have done nothing sooner, for to have said otherwise would have been an admission of guilt, where, as here, he did nothing sooner or later to alleviate the toxic condition." 456 So 2d at 24. In *Davison*, the potential self-interest was real because the attending physician remained as a defendant throughout the trial proceedings. Here, Plaintiff's claim against Dr. Rynbrandt was settled prior to the filing of Defendant's motion for summary disposition, leaving only the Hospital as a Defendant in this case, and thus, his testimony could not have been influenced by the potential for any further liability for Plaintiff's injuries.

Dr. Rynbrandt's affidavit has clearly shown that he would not have altered the course of care and treatment that he had devised for Plaintiff Martin if the Hospital's nurses had made additional or more timely reports of her condition. Having reviewed the medical records in detail, Dr. Beaudoin expressed a similar conclusion. He has testified that if he had been contacted pursuant to the Hospital's policy for review of Plaintiff's treatment, he would

have reviewed Plaintiff's medical record, including nursing notes and laboratory test results; discussed Plaintiff's care and treatment with Dr. Rynbrandt; and might also have spoken with and examined Plaintiff. (Beaudoin Affidavit, ¶ 8) Based upon his detailed review of the matter, Dr. Beaudoin has expressed his belief that, more likely than not, he would not have suggested or requested any change in the care provided to the Plaintiff by the surgeons attending to her care, including Dr. Rynbrandt, if he had been contacted for review of her treatment under the Hospital's Responsibilities For Patient Care: Lines of Authority policy. (Beaudoin Affidavit, ¶ 10)

Thus, the affidavits of Dr. Rynbrandt and Dr. Beaudoin have successfully demonstrated that the required element of proximate causation cannot be established in this case, and Plaintiff has not presented any competent, admissible evidence to the contrary. Plaintiff has also claimed, however, that the testimony of Dr. Rynbrandt and Dr. Beaudoin does not settle the matter because the nurses had a duty to go farther up the Hospital's "chain of command" in the event that her needs were not sufficiently addressed after Dr. Beaudoin's review as Chief of Surgery. This claim lacks merit for two reasons.

First, Plaintiff has not established that the nursing standard of care required any reporting beyond the Chief of Surgery. Although it may be acknowledged that Paragraph 1(g) of the Hospital's policy (Appendix "B") appears to require a report to the Administrator-on-call if resolution of a "question" of patient condition or management is not reached after referral of the matter to the Chief of Surgery, Plaintiff's standard of care expert, Lawrence Boyd, did not provide any testimony, in his Affidavit of Merit¹² or his deposition, that the nurses were required by the standard of care to take any such questions or concerns any

¹² A copy of Mr. Boyd's Affidavit of Merit is submitted herewith as Appendix "C."

further than the Chief of Surgery. In his deposition testimony, Mr. Boyd stated that the nurses would have an obligation to report to, and discuss their concerns with, the attending physician, and if no favorable response was obtained, to their nursing manager or supervisor, or even the Chief of Surgery, if necessary. (Boyd Deposition, pp. 25, 34, 38-40) Mr. Boyd did not provide any testimony that the standard of care would require any reporting to anyone beyond the Chief of Surgery.

Dr. Phillips opined that the nurses would have been required to go higher up the Hospital's chain of command to the Chief of Staff or other Hospital Administration. (Phillips Deposition, pp. 13-14) However, Dr. Phillips did not provide any information as to who, specifically, the nurses might have reported to if dissatisfied with Dr. Beaudoin's response, or how any such persons might have responded, and thus, his testimony provides no basis for establishment of proximate causation in this case. But more importantly, Dr. Phillips was not qualified to present expert testimony as to the standard of care applicable to the Hospital's nurses. *McElhaney v Harper-Hutzel Hospital*, 269 Mich App 488; 711 NW2d 795 (2006). Thus, Dr. Phillips' opinions cannot establish a breach of the standard of care with respect to any failure to report matters beyond the Chief of Surgery.

Second, and perhaps most importantly, the effect that any further reporting might have had in this case cannot be established beyond raw speculation. Again, Dr. Phillips did not provide any information as to who, specifically, the nurses might have reported to if dissatisfied with Dr. Beaudoin's response, or how any such persons might have responded if such a report had been made. Nor is there any basis, beyond sheer speculation, to suppose that the nurses could have been faulted at all for a failure to report their concerns farther up the chain of command if their concerns had been discussed with the attending physician and the

Chief of Surgery, and both had agreed that no modification of treatment was warranted. How far up the chain of command must nurses go to second-guess the professional judgment of physicians? Plaintiff has not provided, and cannot provide, a meaningful answer.

Finally, viewing the matter from the standpoint of the Illinois Supreme Court's decision in *Gill*, Plaintiff's effort to establish proximate causation in this case also fails because Plaintiff has not presented any proof that Dr. Rynbrandt was not aware of the information she alleges the nurses failed to communicate to him. Where the physician already knew the information the nurses allegedly had failed to inform him of, there can be no proximate causation. *Gill v Foster, supra*, 626 NE2d at 193. As the trial court aptly observed on Pages 3 and 4 of its opinion:

“It is significant that all of the things Plaintiff's nursing expert says are observations or test results that should have been verbally communicated to the physicians, are things that are documented in the medical record. . .

“Accordingly, these findings were all available in the chart for review by the physicians, and they may well have been fully aware of these things without verbal notification.”

Plaintiff has not shown that Dr. Rynbrandt did not already know the information that she claims the nurses failed to provide him. If he did already know it, Plaintiff's proof of the requisite cause-in-fact fails. Plaintiff has produced no evidence in this regard, and thus, summary disposition was appropriate for this reason as well.

3. THE TRIAL COURT AND THE COURT OF APPEALS HAVE PROPERLY DETERMINED THAT PLAINTIFF'S THEORY OF PROXIMATE CAUSATION WAS NOT SUPPORTED BY LEGALLY SUFFICIENT PROOFS, BECAUSE PLAINTIFF'S PROPOSED PROOFS DID NOT PROVIDE ANY BASIS, BEYOND IMPERMISSIBLE SPECULATION, FOR A FINDING THAT ADDITIONAL REPORTING WOULD HAVE PREVENTED PLAINTIFF'S INJURIES.

The trial court and the Court of Appeals have also appropriately concluded that Plaintiff's proposed proofs are simply insufficient to present a triable question of fact as a matter of law, regardless of admissibility, because Plaintiff's proofs cannot provide a basis for establishment of proximate causation beyond impermissible speculation. Even if Dr. Phillips' opinion as to what a reasonable surgeon would have done under the supposed circumstances could properly be considered competent evidence of what Dr. Rynbrandt and Dr. Beaudoin would actually have done (contrary to their own sworn testimony), that evidence could hardly suffice to show, more probably than not, that they would have performed according to Dr. Phillips' expectations if the nurses had provided better or more timely reporting. To make that assumption, contrary to their sworn testimony, would be pure speculation, and this cannot support a verdict for the Plaintiff under the well established law of this state.

As the trial court correctly observed, on page 6 of its opinion, there are simply too many uncertainties involved, and these uncertainties reduce Plaintiff's theory of causation to conjecture:

“While Plaintiff maybe able to raise a triable question as to Dr. Rynbrandt's veracity, this does not mean there is a triable question of causation. In this case, the testimony from Plaintiff's experts does not establish, more likely than not, the care by Dr. Rynbrandt, Dr. Beaudoin, or any other physician would have been altered by verbal communication from NMH's nurses.”

“The doctors may have timely known the findings in question, without verbal notification. The record does not establish otherwise. Even if verbally informed, the doctors may not have agreed with Plaintiff’s surgical expert about what the standard of care required, or may have simply negligently failed to provide the standard of care which Plaintiff’s expert says was required by the standard. Among the plausible explanations, Plaintiff’s theory of causation is no more likely than alternative theories. Plaintiff’s theory remains conjecture, only.”

As the trial court has noted, there is a distinct likelihood that all of the information which could have been reported was already known to Dr. Rynbrandt and the other physicians involved in monitoring Plaintiff’s condition through their many visitations and their review of the test results and Hospital chart. It is also very possible that Dr. Rynbrandt and Dr. Beaudoin might have had a different opinion as to what the standard of care required under the circumstances, or that their performance might have been deficient, by Dr. Phillips’ standards, even if they had been better informed.¹³ And if the real-life physicians responsible for Plaintiff’s care would have performed deficiently in spite of additional or more timely reporting by the nurses, their negligence would clearly constitute an intervening superseding cause, relieving the nurses of any liability for their alleged failure to report.¹⁴

¹³ Plaintiff’s presumption that Dr. Rynbrandt would have performed according to the standard of care defined by Dr. Phillips if he had been better informed by the nurses is obviously inconsistent with the allegations made in Plaintiff’s Complaint, which asserted that he had violated the standard of care by his negligent failure to diagnose and treat the infection causing Plaintiff’s injuries. Dr. Rynbrandt settled with Plaintiff, presumably because he did not wish to continue disputing her claims. This suggests that Dr. Rynbrandt may have felt that he was responsible, at least in part, for the injury suffered. And to the extent that this settlement reflects an acceptance of responsibility for professional negligence, this would seem to undermine Plaintiff’s assumption that Dr. Rynbrandt’s affidavit was untruthful.

¹⁴ An intervening cause breaks the chain of causation and constitutes a superseding cause which relieves the original actor of liability unless the intervening factor was reasonably foreseeable. *McMillian v Vliet*, 422 Mich 570; 374 NW2d 679 (1985) Thus, an intervening superseding cause relieves a defendant of liability, irrespective of whether his antecedent negligence was or was not a substantial factor in bringing about the injury. *Coy v Richards Industries Inc*, 170 Mich App 665, 670; 428 NW2d 734 (1988).

Additionally, as noted previously, there is no way at all to predict whether the nurses would have found it necessary to report farther up the chain of command if the matter had been referred to Dr. Beaudoin, as Chief of Surgery, after initial consultation with Dr. Rynbrandt, or what the result of such a report might have been, if made.

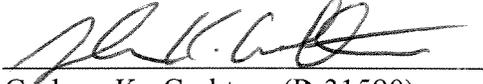
Again, it must be kept firmly in mind that it is the Plaintiff who bears the burden of proof by a preponderance of the evidence. It is the Plaintiff who must prove that the injury in question was caused, more probably than not, by some negligent act or omission of the Defendant. As this Court noted in *Skinner*, and confirmed in *Craig*, the plaintiff must show probability, not mere possibility. It does not suffice to rely upon speculation, and that is all that can be presented in this case. The trial court and the Court of Appeals have properly determined that Plaintiff's proposed proofs cannot establish a genuine issue of material fact as to proximate causation in this case. The trial court's order of summary disposition was properly affirmed by the Court of Appeals, and Plaintiff's arguments to the contrary do not warrant further consideration by this Court. Plaintiff's application for leave to appeal should therefore be denied.

RELIEF REQUESTED

WHEREFORE, Defendant–Appellee Northern Michigan Hospital respectfully requests that Appellant’s Application for Leave to Appeal be denied.

Respectfully submitted,

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Dated: May 13, 2009

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