

STATE OF MICHIGAN
IN THE SUPREME COURT

MAKENZIE GREER, Minor,
KENNETH GREER, Individually and
as Conservator, and ELIZABETH
GREER

Plaintiffs-Appellees,

vs.

ADVANTAGE HEALTH and
ANITA R. AVERY,

Defendants-Appellants,

and

TRINITY HEALTH MICHIGAN d/b/a
ST. MARY'S HOSPITAL and
KRISTINA MIXER, M.D.

Defendants.

Supreme Court No. 149494

Court of Appeals No. 312655

Kent County Circuit Court
No. 10-009033-NH

BRIEF OF AMICUS CURIAE
MICHIGAN STATE MEDICAL SOCIETY

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STATEMENT OF QUESTIONS PRESENTED FOR REVIEW

Whether the Court of Appeals misapplied the collateral source setoff rule of MCL 600.6303 and erroneously held that Makenzie Greer was entitled to recover the full amount of her invoiced medical expenses even though her health care insurers paid a lesser amount to Makenzie's health care providers pursuant to a negotiated discount, and could not assert a lien for the discounted amount?

The Court of Appeals would say "no."

The Trial Court said "no."

Plaintiff-Appellee says "no."

Defendants-Appellants say "yes."

Amicus Curiae MSMS says "yes."

Whether the Court of Appeals properly held that the entire proceeds received in the settlement of claims asserted against Defendants St. Mary's Hospital and Dr. Kristina Mixer were properly set off against the recovery of Makenzie Greer?

The Court of Appeals would say "yes."

The Trial Court said "no."

Plaintiff-Appellee says "no."

Defendants-Appellants say "yes."

Amicus Curiae MSMS says "yes."

STATEMENT OF INTEREST OF AMICUS CURIAE
MICHIGAN STATE MEDICAL SOCIETY

Amicus Curiae Michigan State Medical Society (“MSMS”) is a professional association which represents the interests of over 14,000 physicians in the State of Michigan. Organized to promote and protect the public health and to preserve the interests of its members, MSMS is frequently called upon to express its views with respect to legal issues of significance to the medical profession.

The focus of this appeal is MCL 600.6303, a collateral source setoff statute that was enacted as part of Michigan’s 1986 tort reform legislation. The statute abrogates the common law collateral source rule and prevents personal injury plaintiffs from obtaining double recovery. This Court is being asked to decide whether the Court of Appeals incorrectly held that Makenzie Greer was entitled to recover the *full amount* of her invoiced medical expenses even though Makenzie’s health care insurers paid Makenzie’s health care providers (and asserted a lien for) a *lesser discounted amount*. *Greer v Advantage Health*, 305 Mich App 192; 852 NW2d 198 (2014).

In *Greer*, the invoiced medical expenses totaled \$425,533.75 but the health care providers accepted \$212,714.75 as full payment pursuant to a previously agreed upon discount they negotiated with the health insurers. The health insurers asserted a lien for the lesser amount. While the Court of Appeals properly concluded that both the medical expense payment of \$212,714 and the unpaid discount of \$212,819 were “benefits received or receivable from an insurance policy” and therefore collateral sources within the meaning of MCL 600.6303(4), the Court of Appeals erroneously held that both amounts were also “benefits paid or payable” and subject to a lien, and thus excepted from the setoff reduction requirement. 305 Mich App at 206-

207. Thus Makenzie was permitted to recover the full amount of the invoiced medical expenses, even the amount that – because of the discount – was not required to be paid.

A second issue, raised on cross-appeal, is whether the Court of Appeals correctly held that the entire proceeds received in the settlement of claims asserted against Defendants St. Mary's Hospital and Dr. Kristina Mixer were properly set off against the recovery of Makenzie Greer. The proper application of the common law setoff rule in medical malpractice cases is an issue of immense importance to MSMS. The setoff doctrine has been embedded in the law of joint and several liability for many years. Although tort reform eliminated joint and several liability in other contexts, it remains the rule in medical malpractice cases. Thus the common law setoff rule applies to ensure that a plaintiff does not recover twice for a single injury.

The statutory collateral source setoff rule and the common law setoff rule are important aspects of medical malpractice litigation and are matters of significance to MSMS and its members. In accordance with MCR 7.306(D), and pursuant to this Court's December 16, 2014 order granting MSMS leave to file an amicus brief, MSMS now presents its views.

STATEMENT OF FACTS

MSMS relies upon the Statement of Facts contained within Defendants-Appellants' Brief on Appeal.

ARGUMENT

I. The Court of Appeals Erroneously Held That the Insurance Discount Qualifies As an Exception to the Collateral Source Setoff Rule.¹

The status of collateral source payments in personal injury litigation is governed by statute in Michigan, specifically MCL 600.6303. Before MCL 600.6303 was enacted in 1986, the common law collateral source rule “provided that compensation from a source other than another tortfeasor ... did not operate to reduce the damages recoverable from the wrongdoer.” *Heinz v Chicago Rd Investment Co*, 216 Mich App 289, 294; 549 NW2d 47 (1996). MCL 600.6303 reverses the common law rule by (1) allowing the admission of evidence in post-verdict proceedings to establish that medical expenses, rehabilitation services, loss of earnings/earnings capacity, and other forms of economic loss have been paid or are payable by a collateral source, and (2) requiring the trial court to reduce the verdict by the amount of collateral source payments it finds to have been “paid or payable.” MCL 600.6303(1) provides in pertinent part:

In a personal injury action in which the plaintiff seeks to recover for the expense of medical care, rehabilitation services, loss of earnings, loss of earning capacity, or other economic loss, *evidence to establish that the expense or loss was paid or is payable, in whole or in part, by a collateral source shall be admissible to the court in which the action was brought* after a verdict for the plaintiff and before a judgment is entered on the verdict. Subject to subsection (5), *if the court determines that all or part of the plaintiff’s expense or loss has been paid or is payable by a collateral source, the court shall reduce that portion of the judgment which represents damages paid or payable by a collateral source by an amount equal to the sum determined pursuant to subsection (2)*. This reduction shall not exceed the amount of the judgment for economic loss or that portion of the verdict which represents damages paid or payable by a collateral source.

¹ Questions of statutory construction are reviewed de novo. *Feyz v Mercy Mem Hosp*, 475 Mich 663, 672; 719 NW2d 1 (2006). The Court’s role “is to give effect to the intent of the Legislature, as expressed by the language of the statute” and to “apply clear and unambiguous statutes as written, under the assumption that the Legislature intended the meaning of the words it has used ...” *Id.* (footnotes omitted).

Id. (emphasis added). See also MCL 600.6306a(1)(a) (requiring the trial court to make the post-verdict deduction for collateral source payments in medical malpractice cases); MCL 600.6306(1)(a) (same as to personal injury actions not involving medical malpractice); and MCL 600.6304(3) (directing the court to “determine the award of damages ... subject to any reduction under ... 6303”).²

MCL 600.6303(4) defines “collateral source” and includes within that definition “benefits received or receivable from an insurance policy” and “benefits payable pursuant to a contract with a health care corporation ... or health maintenance organization,” as well as “medicare benefits.” However, benefits “paid or payable” and subject to a contractual lien that “has been exercised” are excluded from the definition of collateral source. MCL 600.6303(4) provides in part:

Collateral source does not include life insurance benefits or benefits *paid* by a person, partnership, association, corporation, or other legal entity *entitled by law to a lien against the proceeds of a recovery by a plaintiff in a civil action for damages*. Collateral source does not include benefits *paid or payable* by a person, partnership, association, corporation, or other legal entity *entitled by contract to a lien against the proceeds of a recovery by a plaintiff in a civil action for damages, if the contractual lien has been exercised pursuant to subsection (3)*.

Id. (emphasis added).³

The obvious effect of the collateral source setoff statute is to allow a plaintiff to recover for paid medical expenses only in those instances where the benefits must be repaid to the provider pursuant to a properly exercised lien. If the plaintiff enjoys full value of the benefit

² The amount of the expense or loss which has been paid or which is payable by a collateral source (except for insurance premiums required by law) shall be reduced by the premiums paid for the collateral source benefit. MCL 600.6303(2).

³ Also excluded are life insurance benefits or benefits paid by a person or entity entitled by law to a lien against the proceeds of recovery. Subsection (3) imposes notice and time limitations upon the assertion of the lien.

because no lien has been exercised, the benefit remains a collateral source which reduces the medical expense component of the verdict. This avoids double recovery. In *Heinz*, the Court explained:

[I]t is just as reasonable to presume from the enactment of MCL 600.6303; MSA 27A.6303 that the Legislature’s intent was to promote fairness, i.e., to prevent personal injury plaintiffs from being compensated twice for the same injury.

216 Mich App at 301. See also *id.* at 306 (referring to “the statutory purpose of preventing ‘double recovery’”).

Justice Young confirmed this purpose in *State Auto Mut Ins Co v Fieger*, 477 Mich 1068, 1072; 730 NW2d 212 (2007) (Young, J, concurring), and likewise explained that payments subject to a lien are not eligible for deduction because the amount due to the lien holder “must still be paid.” Justice Young explained:

The collateral source rule is designed to prevent double recovery by plaintiffs. After a trier of fact reaches a verdict for a plaintiff, the court must enter an order of judgment. MCL 600.6306(1). The judgment must contain a number of elements of damages, including “[a]ll past economic damages, less collateral source payments as provided for in section 6303.” MCL 600.6306(1)(a). Section 6303 allows for “evidence to establish that [an] expense or loss was paid or is payable, in whole or in part, by a collateral source” MCL 600.6303(1). If the court determines that a portion of the past economic damages was paid by a collateral source, then the court must reduce the judgment by that amount. *Id.* However, payments subject to a statutory or contractual lien are not eligible for deduction as “collateral sources” under the statute. MCL 600.6303(4). This is because the amount due to the lien holder must still be paid.

Id. (emphasis added).

In *Greer*, the jury awarded plaintiff the full amount of the invoiced medical expenses in the amount of \$425,533. 305 Mich App at 196-197. But plaintiff’s health care providers accepted a discounted payment of \$212,714.75 in full satisfaction of the invoices rendered to plaintiff’s health care insurers. Hence, the health care insurers asserted a lien only in the amount of the discounted payment. The remainder of the amount invoiced for health care services – the

actual discount of \$212,819 – was not “paid or payable” and could not be recovered by lien. *Id.* at 212-213. Thus, the discount should not have been excluded from the collateral source benefits deducted from the verdict. *Id.* at 213.

To get around the plain meaning of the statute, *Greer* concluded that when a lien is exercised the benefits payable pursuant to the lien *are not limited to the amount of the lien but include the full amount of the invoiced benefits, including the discount.* *Greer* explained:

Because insurance discounts are “benefits received or receivable from an insurance policy” within the plain meaning of the first sentence of § 6303(4), we must conclude that the insurance discounts are also “benefits paid or payable” within the plain and ordinary meaning of the last sentence of § 6303(4). The words “paid” and “payable” are both derived from the word “pay,” which is defined as “to discharge or settle (a debt, obligation, etc.), as by transferring money or goods, or by doing something.” Random House Webster’s College Dictionary (1996). There appears to be no dispute that the insurance discounts here, along with cash payments, discharged or settled plaintiffs’ debt or obligation to their healthcare providers. So, assuming that an insurance discount is a “benefit[] paid or payable” within the meaning of § 6303(4), then the last sentence of subsection (4) would read: “Collateral source does not include [an insurance discount used to settle or discharge a debt of the plaintiff for medical expenses provided] by [an insurance company] entitled by contract to a lien against the proceeds of a recovery by a plaintiff in a civil action for damages, if the contractual lien has been exercised pursuant to subsection (3).”

Id. at 211-212. See also *id.* at 212-213 (“the plain terms of the exclusion from the statutory collateral source rule of § 6303(4) when a contractual lien is exercised is not limited to the amount of the lien; it applies to all benefits that were paid or payable by a ‘legal entity entitled by contract to a lien’”).

The conclusion that the use of the term “lien” in the statute refers to something other than a properly asserted lien for benefits actually paid, violates the intent of the statute. *Greer* overlooks the absence of any lien – and the inability of the insurers to ever assert a lien - on the unpaid discounted amount. *Greer* also overlooks significant statutory language differentiating between liens allowed by law and those allowed by contract. Under MCL 600.6303(4),

collateral source does not include life insurance benefits or benefits paid by a person “entitled by law to a lien against the proceeds.” However, the statute qualifies the collateral source exception for benefits paid by contract. To be removed from the definition of collateral source, benefits paid or payable by a person entitled by contract to a lien against the proceeds must be subject to a lien that has “been exercised.” *Greer* gives no effect to this distinction.

Indeed, the *Greer* court contradicted itself in finding its holding to be consistent with the holding in *Zdrojewski v Murphy*, 254 Mich App 50; 657 NW2d 721 (2002), particularly given the *Greer* court’s recognition that *Zdrojewski* supports the position that a lien can only be asserted (and the collateral source exclusion can only apply) *to amounts actually paid*. *Id.* at 212. Addressing *Zdrojewski*, the *Greer* court explained:

The Court concluded that “[b]ecause the statute clearly states that benefits subject to an exercised lien do not qualify as a collateral source, and [Blue Cross Blue Shield of Michigan (BCBSM)] and Medicare exercised their liens, health insurance benefits provided by BCBSM and Medicare to plaintiff do not constitute a collateral source under MCL 600.6303(4).” *Id.* While this ruling supports plaintiffs’ position that the insurance payments were not collateral sources because the insurers asserted a lien with respect to the payments, *it also supports defendants’ position that only payments an entity actually makes and asserts a lien for—and no lien may be asserted for insurance discounts—are excluded under § 6303(4).*

305 Mich App at 209 (emphasis added).

In *Zdrojewski*, the insurers paid *more* in medical expenses than the liens asserted, and the Court of Appeals noted that the record was unclear as to whether the insurers would exercise their additional lien rights in the future. 254 Mich App at 70. “Regardless of those considerations,” however, the Court noted that “the statute does not make any provision for a situation where a lien has been exercised, but for an amount less than the lienholder would be legally entitled to recover.” *Id.* Hence, unlike here (where the amount of the lien equals the amount actually paid), the touchstone in *Zdrojewski* was the existence of payments which

exceeded the amount of the asserted liens. This discrepancy was noted in *Wilson v Keim*, unpublished opinion per curiam of the Court of Appeals, issued July 24, 2008 (Docket Nos. 275997, 276022, and 276446), 2008 Mich App LEXIS 1535, at *37, where the Court explained, “Here, defendant admits that HAP exercised a lien. This *lien was arguably for a lesser amount than it was entitled to recover*. *Zdrojewski* instructs that in *this situation*, the health insurance benefits do not constitute a collateral source under the law”) (emphasis added). See also *Rocha v Better Built Mfg, Inc*, unpublished opinion per curiam decision of the Court of Appeals, issued June 21, 2011 (Docket No. 297090), 2011 Mich App LEXIS 1111, at *4 (“As a collateral source, worker’s compensation benefits should be offset from a damages award *unless the recovery is subject to a valid lien* held by the worker’s compensation insurance carrier”).⁴

Unlike *Zdrojewski*, the health insurers in *Greer* exercised the full amount of the liens to which they were entitled. They could not exercise additional lien rights for the discount they were never required to pay. See *Howell v Hamilton Meats & Provisions, Inc*, 52 Cal 4th 541, 558; 257 P3d 1130 (2011) (“Having agreed to accept the negotiated amount as full payment, a provider may not recover any difference between that and the billed amount through a lien on the tort recovery”).⁵

⁴ The Court of Appeals erroneously failed to appreciate this distinction in *Hall v Bartlett*, unpublished opinion per curiam of the Court of Appeals, issued March 29, 2011 (Docket No. 290147), 2011 Mich App LEXIS 596 at 52, when it concluded that “[n]othing meaningfully distinguishes this case from *Zdrojewski*.” In *Hall*, as in the present case, the health insurer paid less than the amount awarded for past medical expenses. The case does not disclose whether a lien was exercised for the entire amount.

⁵ *Detary v Advantage Health Physicians, PC*, unpublished opinion per curiam of the Court of Appeals, issued November 29, 2012 (Docket No. 308179), 2012 Mich App LEXIS 2409, is to the contrary. In *Detary*, the Court of Appeals refused to deduct the medical expenses “written off” by the health care providers (and as to which no lien could be asserted), finding that the write off was not a collateral source benefit. See *id.* at *23-24 (finding that “[a]n amount that has
(footnote continued . . .)

Thus in *Greer*, the collateral source benefits deducted from the verdict should have only been reduced by the amount paid or payable by lien – \$212,714. In other words, because Makenzie was awarded the full amount of the invoiced medical expenses and no lien could be claimed for the discounted amount of \$212,819, the verdict should have been reduced by that amount.⁶

Elementary damages principles support this interpretation of the collateral source setoff statute. In Michigan, the purpose of tort damages is to compensate the injured party and make him whole. *Murray v Ferris*, 74 Mich App 91, 95; 253 NW2d 365 (1977). Thus, a tort plaintiff can only recover for the reasonable damages actually sustained due to the defendant’s acts or omissions. *Id.* Where medical expenses are discounted pursuant to a negotiated fee for service agreement between the health insurer and the medical care providers, the discounted portion of the medical expenses will never be paid by the plaintiff, the insurer, or anyone else. Therefore, the discounted medical expenses are not damages which can be recovered in a tort action. To hold otherwise improperly permits a plaintiff to profit from litigation by obtaining a greater

been written off has not been paid, nor is it payable, such that it is not a collateral source” and “[a]ny benefit plaintiff received from the write offs” was “not a benefit received or receivable from an insurance policy, nor is it a benefit payable pursuant to a contract with a health care corporation” and “does not fall within the statutory definition of ‘collateral source.’”). The Court rejected the assertion that this would result in a windfall to plaintiff stating, “Because plaintiff’s medical care providers elected to absorb some of the cost of her care does not make defendant any less negligent, nor does the fact that she was insured. Should a windfall arise due to the action of an outside party (here, the “write off” by a medical provider), that would be a function of the statute, and we do not venture into that area of public policy.” *Id.* at *25. MSMS believes that this is faulty thinking and contrary to the intent of the statute, which was to prevent windfalls and double recovery.

⁶ In addition to disregarding the absence of a valid lien for the amount of the discount, *Greer* erroneously interpreted benefits “received or receivable” (within the definition of collateral source) to mean the same thing as benefits “paid or payable” (for the purpose of the exception). It is incongruent to equate a discount with a payment. Indeed, the very purpose of a discount is to negate the need for a payment in the discounted amount.

reimbursement for medical expenses than were actually paid. As the Court of Appeals explained in *Bombalski v Auto Club Ins Assoc*, 247 Mich App 536, 543; 637 NW2d 251 (2001):

Plaintiff submits that he likewise became liable for the amounts charged by his health care providers when he accepted their services and that consequently he incurred the full amounts charged. Plaintiff's claim does not persuade us, however, because plaintiff overlooks the significance of "liable," which means "responsible or answerable in law; legally obligated." Black's Law Dictionary, *supra* at 927. The satisfaction of plaintiff's medical bills by BCBSM through payment of less than the amounts charged by the providers relieved plaintiff of any responsibility or legal obligation to pay the providers further amounts exceeding those proffered by BCBSM and accepted by plaintiff's health care providers. Because plaintiff bears no liability for the full medical service amounts initially charged by his health care providers, he has not incurred these full charges...

See also Howell, 52 Cal 4th at 555; ("if the plaintiff negotiates a discount and thereby receives services for less than might reasonably be charged, the plaintiff has not suffered a pecuniary loss or other detriment in the greater amount and therefore cannot recover damages for that amount...The same rule applies when a collateral source, such as the plaintiff's health insurer, has obtained a discount for its payments on the plaintiff's behalf"); *Coop Leasing Inc. v Johnson*, 872 So 2d 956, 958 (Fla App 2004) ("Johnson was not entitled to recover for medical expenses beyond those paid by Medicare because she never had any liability for those expenses and would have been made whole by an award limited to the amount that Medicare paid to her medical providers"); *Moorhead v Crozer Chester Med Ctr*, 564 Pa 156, 162; 765 A2d 786 (2001) ("We find that the amount paid and accepted by Appellee as payment in full for the medical services is the amount Appellant is entitled to recover as compensatory damages").

In *Dyett v McKinley*, 139 Idaho 526; 81 P3d 1236 (2003), the issue was whether Medicare write-offs are a collateral source under the Idaho statute. Idaho Code §6-1606, entitled *Prohibiting Double Recoveries from Collateral Sources*, states in part:

In any action for personal injury or property damage, a judgment may be entered for the claimant only for damages which exceed amounts received by the claimant

from collateral sources as compensation for the personal injury or property damage, whether from private, group or governmental sources, and whether contributory or noncontributory. For purposes of this section, collateral sources shall not include benefits paid under federal programs which by law must seek subrogation ... Evidence of payment by collateral sources is admissible to the court after the finder of fact has rendered an award. Such award shall be reduced by the court to the extent the award includes compensation for damages, which have been compensated independently from collateral sources.

The Court concluded that plaintiff could not recover the written-off amounts under this statute, stating:

Although the write-off is not technically a collateral source, it is the type of windfall that I.C. §6-1606 was designed to prevent. As reasoned by the New York court in *Kastick [v. U-Haul]*, 740 NYS 2d 167, 292 AD2d 797 (2002), “Although the write-off technically is not a payment from a collateral source within the meaning of [the collateral source statute], it is not an item of damages for which plaintiff may recover because plaintiff has incurred no liability therefore.” *Id.* 740 N.Y.S. 2d at 169, 292 A.D.2d at 798.

139 Idaho at 529. *Kastik* involved medical expenses arising from an automobile accident. In refusing recovery for the unpaid amounts, the Court explained:

Plaintiff contends that the court’s determinations concerning the reductions for collateral sources are erroneous. After receiving payments from no-fault and Medicare, University Hospital “wrote off” the remaining balance of \$ 138,613.88. Plaintiff contends that defendants were not entitled to a credit for that amount because the “write-off” did not constitute payment from a collateral source. Defendants contend that plaintiff may not recover from them an amount for which she never became obligated. We agree with defendants. Although the write-off technically is not a payment from a collateral source within the meaning of CPLR 4545, it is not an item of damages for which plaintiff may recover because plaintiff has incurred no liability therefor (*see, Coyne v Campbell*, 11 N.Y.2d 372, 374-375, 230 N.Y.S.2d 1, 183 N.E.2d 891 *Hartman v Dermont*, 89 A.D.2d 807, 808, 453 N.Y.S.2d 464; *see also, McAmis v Wallace*, 980 F. Supp. 181, 183-184; *Moorhead v Crozer Chester Med. Ctr.*, 564 Pa 156, 162-163, 765 A.2d 786, 789-790; *Bates v Hogg*, 22 Kan App 2d 702, 705-706, 921 P.2d 249, 252-253).

740 NYS 2d at 169.

By allowing recovery for amounts not paid, *Greer* has seriously undermined the intended purpose and effect of MCL 600.6303, and has expanded the meaning of “damages.”

Respectfully, as to that issue, the Court of Appeals decision should be reversed.

II. The Court of Appeals Correctly Applied The Common Law Setoff Rule to Reduce Recovery By the Amount of the Settlement.

For nearly a century, setoff has been properly embedded in the principles of joint and several liability, which renders “each tortfeasor ... liable for the full amount of damages.” *Markley v Oak Health Care Investors of Coldwater, Inc*, 255 Mich App 245, 253; 660 NW2d 344 (2003). Because a plaintiff can elect to fully recover from multiple potentially liable defendants, plaintiff could conceivably recover many times over by settling her claim with one or more defendants and/or proceeding to judgment in different actions against others. Setoff exists to ensure that despite such machinations, the plaintiff can only recover once for a single injury.

In 1995, the Michigan Legislature abolished joint and several liability in most instances and replaced it with an allocation of fault system by which each defendant pays that portion of the judgment which correlates to the defendant’s percentage of fault (as determined by the jury). See MCL 600.2956 and MCL 600.6304. However, allocation of fault only applies where “liability ... is several only and not joint,” MCL 600.6304(4), and the Legislature *expressly preserved joint and several liability* in medical malpractice cases where the plaintiff is without fault. MCL 600.6304(6). Further, medical malpractice actions are expressly carved out of the allocation of fault provisions. See MCL 600.6304(4), which states in pertinent part that “[e]xcept as otherwise provided in subsection (6) [the provision which preserves joint and several liability in medical malpractice cases], a person shall not be required to pay damages in an amount greater than his or her percentage of fault as found under subsection (1).”

Prior to its amendment in 1995, MCL 600.2925d provided, in part, that a settlement and release “reduces the claim against the other tortfeasors to the extent of any amount stipulated by the release or the covenant or to the extent of the amount of the consideration paid for it,

whichever amount is the greater.” *Markley* held that where joint and several liability continued to exist, the common law setoff rule survived the elimination of the statutory setoff provision.⁷ 255 Mich App at 257. *Markley* recognized that the common law setoff rule effectuates the principle that “a plaintiff is entitled to only one recovery for his injury.” *Id.* at 250, citing *Great Northern Packaging, Inc v Gen Tire & Rubber Co*, 154 Mich App 777, 781; 399 NW2d 408 (1986). *Markley* noted that the rule is rooted in this Court’s opinion in *Verhoeks v Gillivan*, 244 Mich 367, 371; 221 NW 287 (1928), which explained that an injured party may elect to pursue joint tortfeasors jointly or severally “but, the injury being single, he may recover but one compensation.” *Id.* at 251, quoting *Verhoeks*, 244 Mich at 371. See also *Thick v Lapeer Metal Products Co*, 419 Mich 342, 348 n 1; 353 NW2d 464 (1984) (reciting the common law rule “that where a negligence action is brought against joint tortfeasors, and one alleged tortfeasor agrees to settle his potential liability by paying a lump sum in exchange for a release, and a judgment is subsequently entered against the non-settling tortfeasor, the judgment is reduced *pro tanto* by the settlement amount”). See also *Salter v Patton*, 261 Mich App 559, 566; 682 NW2d 537 (2004) (relying on *Markley* and stating that “plaintiffs are not entitled to double recovery from settling and nonsettling defendants ...”)

In *Velez v Tuma*, 492 Mich 1, 6; 821 NW2d 432 (2012), this Court confirmed that “where the Legislature has retained principles of joint and several liability, the common-law setoff rule

⁷ *Markley* noted that the setoff language in MCL 600.2925d represented a codification of the common-law rule of setoff and “was apparently deleted because the tort reform legislation, for the most part, abolished joint and several liability in favor of allocation of fault or several liability.” 255 Mich App at 253.

applies.” *Id.* at 6.⁸ This was in keeping with this Court’s decision in *Kaiser v Allen*, 480 Mich 31; 746 NW2d 92 (2008), and with long-standing jurisprudential principles that are bedrock law. These principles counsel that, in cases of joint and several liability, set off must be applied to ensure that a plaintiff will only recover once.⁹ In *Velez*, this Court explained:

Inherent in the meaning of joint and several liability is the concept that a plaintiff’s recovery is limited to one compensation for the single injury. Because in some instances a jointly and severally liable tortfeasor settles before trial, the common-law setoff rule is necessary to ensure that the plaintiff does not recover more than a single recovery for the single injury. The common-law setoff rule entitles the remaining tortfeasors, who are still liable for the *entire* injury, to set off the amount of the cotortfeasor’s settlement from any verdict rendered against them.

492 Mich at 13-14.

In advance of trial in this case, defendant St. Mary’s Hospital paid \$600,000 to settle the personal injury claims asserted by Makenzie Greer and her mother, along with the medical expenses and loss of consortium claims asserted by Makenzie’s father. The settlement did not assign a particular portion of the settlement amount to a particular claim or legal theory. Rather, “the settlement payment was for ‘any and all claims’ that all plaintiffs may have arising from the incident that ‘occurred on or about September 28, 2008’ and included ‘the subsequent medical treatment’ of Makenzie.” *Greer*, 305 Mich App at 202. As the Court explained, “the settlement was a lump sum payment by an alleged jointly and severally liable tortfeasor to settle all claims of all plaintiffs arising out of the malpractice incident described in plaintiffs’ complaint.” *Id.*

⁸ The Court further held that a joint tortfeasor’s settlement must be setoff from the final judgment after application of the noneconomic damages cap of MCL 600.1483 and the collateral source rule.

⁹ See also *Mayhew v Berrien Co Rd Comm*, 414 Mich 399; 326 NW2d 366 (1982), where this Court concluded that the verdict should be reduced by the amount of a jointly liable defendant’s settlement, not the percentage of fault, because it was consistent “with the ever-important policies of (1) encouraging settlements and (2) assuring that a plaintiff is fully compensated for injuries sustained.” *Id.* at 411-412.

Before the entry of judgment, the defendants moved to set off the entire \$600,000 against the jury verdict. Declining to deduct the settlement *in toto*, the trial court reasoned that the settlement was payment for all claims but the verdict applied only to Makenzie (a no cause verdict having been returned for Mr. Greer and Mrs. Greer). Thus, the trial court thought it fair to allocate 1/3 of the settlement to Makenzie's claim and to set off that amount. The Court of Appeals properly concluded that this was error.

Finding "no basis in the release and settlement agreement ... or the jury's verdict to allocate any portion of the St. Mary's payment to injuries other than those of Makenzie Greer," and recognizing that it could not "alter the settlement, which is, of course, a contract," the Court of Appeals held that the entire amount of the settlement should have been set off against Makenzie Greer's recovery. 305 Mich App at 200. The Court of Appeals concluded that by assigning one-third of the settlement to each plaintiff's claims, the trial court "***failed to fully apply the principle of setoff that for one injury there may be a single recovery.***" *Id.* at 203 (emphasis added). The Court explained:

Plaintiffs collectively settled all their claims against a jointly liable tortfeasor arising out of a single instance of malpractice involving Makenzie's birth for a single undifferentiated lump sum of \$600,000 ... To ensure that plaintiffs are fully but not overly compensated for all their claims, the entire St. Mary's settlement must be offset against the amount the jury determined represented plaintiffs' collective damages. *Markley*, 255 Mich App at 250-251. When there is a recovery "for an injury identical in nature, time and place, that recovery must be deducted from [the plaintiffs'] other award." *Great Northern Packaging, Inc. v. General Tire & Rubber Co.*, 154 Mich App 777, 781; 399 NW2d 408 (1986).

Id.

The Court of Appeals' conclusion that the entire amount of the settlement be set off against the verdict is fully supported by *Velez*. See *Velez*, 492 Mich at 24, n 45 ("our holding requires a court to subtract the entire amount of the settlement from *whatever* damages remain after applying the relevant statutory adjustments.") That a plaintiff's recovery is limited to one

compensation for a single injury is inherent in the meaning of joint and several liability. *Id.* at 13. Thus, to insure that Makenzie did not receive more than a single recovery for her single injury, the Court of Appeals properly directed that the full amount of the settlement – which provided partial compensation already received for her single injury - be deducted. See *Id.* at 23 (“application of the common-law setoff rule requires that codefendants’ settlement be subtracted from the final judgment so that [she] does not receive more than a single recovery for her single injury.”).

Further, *Velez* discouraged the apportionment of an indivisible lump sum settlement into divisible portions. The Court explained that “in instances like the present, in which the composition of the settlement is unknown, circuit courts would be left to guess at how a settlement should be allocated.” The Court explained:

Requiring circuit courts to engage in this guesswork, from which a range of potential outcomes could result, unreasonably burdens them with a determination that they are, in the absence of any statutory guidance, ill-prepared to make.

492 Mich at 26. Given *Velez*, the Court of Appeals properly concluded “that to avoid speculative apportionment of an undifferentiated lump sum settlement paid by a jointly liable codefendant to settle all of the plaintiffs’ claims arising from a single incident of malpractice, the entire settlement must be offset.” *Greer*, 305 Mich App at 205.

The correct result and analysis inheres in *Greer*. This Court must continue to reject assaults on the longstanding one injury-one recovery rule. Absent application of setoff, nothing would prevent a plaintiff from obtaining duplicative recovery against jointly liable defendants through judgment and settlement. For these reasons, MSMS respectfully requests that this Court affirm *Greer* with respect to the common law setoff issue.

RELIEF REQUESTED

For these reasons, Amicus Curiae Michigan State Medical Society respectfully requests that this Court reverse that portion of the Court of Appeals decision which addresses the collateral source setoff issue and affirm that portion of the Court of Appeals decision which addresses common law setoff based on the settlement with St. Mary's Hospital.

Respectfully submitted,

KERR, RUSSELL AND WEBER, PLC

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Dated: March 6, 2015

Unpublished Cases

A Neutral

As of: March 6, 2015 10:24 AM EST

Detary v. Advantage Health Physicians

Court of Appeals of Michigan

November 29, 2012, Decided

No. 308179

Reporter

2012 Mich. App. LEXIS 2409; 2012 WL 6035024

LINDA DETARY and JERRY DETARY, Plaintiffs-Appellees, v ADVANTAGE HEALTH PHYSICIANS, PC, Defendant-Appellant, and STEVEN A. CRANE, MD, PAUL O. FARR, MD, GRAND RIVER GASTROENTEROLOGY, PC, MUMNOON HAIDER, MD, JODY LYN HEILMAN, MD, BAO THIEN HUYHN, MD, NASIR ABBAS KHAN, and TRINITY HEALTH-MICHIGAN, Defendants.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Subsequent History: Leave to appeal denied by *Detary v. Advantage Health Physicians, PC, 2013 Mich. LEXIS 620 (Mich., Apr. 29, 2013)*

Prior History: [*1] Kent Circuit Court. LC No. 2008-010179-NH.

Core Terms

collateral source, band, lap, prolapse, stomach, damages, necrosis, benefits, medical expenses, trial court, surgery, pain, complications, contends, insurer, blood, medical bills, healthcare, ischemia, services, respiratory distress, directed verdict, hospitalization, malpractice, injuries, syndrome, vomiting, severe, adult, x-ray

Judges: Before: SERVITTO, P.J., and MARKEY and MURRAY, JJ.

Opinion

PER CURIAM.

Defendant, Advantage Health Physicians, PC, appeals as of right the judgment entered in favor of plaintiffs on the jury verdict and the trial court's denial of defendant's motions for directed verdict, judgment notwithstanding the verdict ("JNOV") and remittitur in this medical malpractice action. We affirm.

Plaintiff, Linda Detary, presented at St. Mary's Health Care Emergency Department on April 1, 2006, due to vomiting and severe abdominal pain. Plaintiff¹ described a sharp, burning pain that increased when she ate, and advised that she had a surgical history of a lap band procedure.² While in the emergency room, plaintiff vomited blood and blood clots. As a result, she was admitted as a patient. Plaintiff was evaluated by various doctors employed by Advantage Health Physicians, PC, over the next few days, and the doctors came up with several potential diagnoses, none of which included potential complication of her lap band. Eventually, one of plaintiff's family members contacted the doctor who performed her lap band surgery, Dr. Bhesania, and he requested that plaintiff be transferred [*2] to Port Huron Hospital so that he could assume her care. Upon her arrival, Dr. Bhesania performed an abdominal x-ray, which showed a prolapse³ of her stomach and a change in orientation of the lap band. It was discovered that part of her stomach had actually suffered from necrosis due to the prolapse and lack of blood flow to the area. Plaintiff underwent surgery to remove a portion of her stomach and, post operatively, developed septic shock, adult respiratory distress syndrome, and hypotension. She remained hospitalized for 48 days and continues to suffer from adult respiratory distress syndrome.

Plaintiff initiated this lawsuit against all of the above named defendants, alleging [*3] that their negligence in, among other things, failing to properly and timely diagnose and treat her prolapsed stomach, led to ischemia and necrosis. Plaintiff further alleged that as a natural and probable consequence of the defendants' breach of the applicable standards of care and the ensuing necrosis and complications, plaintiff suffered physical and monetary damages.

During the course of litigation the parties stipulated to the dismissal of all defendants except Advantage Health Physicians, PC. A jury trial proceeded against Advantage Health Physicians, PC (hereafter "defendant"), at the conclusion of which the jury found that defendant was professionally negligent through its physicians. A judgment on the jury verdict was entered on September 29, 2011, in favor of both plaintiffs in the amount of \$174,000.00 for medical expenses and \$8,000.00⁴ in favor of plaintiff for pain and suffering. Defendant thereafter moved for a judgment notwithstanding the verdict,

¹ "Plaintiff" shall be used throughout this opinion in reference to Linda Detary, as plaintiff Jerry Detary's claims are derivative in nature.

² A lap band procedure is a weight loss procedure wherein an adjustable gastric banding device is surgically implanted around the upper part of the stomach to reduce the amount of food the stomach can hold. <http://www.lapband.com/>

³ "Prolapse" is defined as "the falling down or slipping of a body part from its usual position or relations." <http://www.merriam-webster.com/medline>

⁴ The jury found that plaintiff's medical expenses were \$213,000.00 and awarded her \$10,000.00 for pain and suffering, but [*4] also found plaintiff 20% at fault. The judgment was thus adjusted to account for plaintiff's 20% comparative fault.

reduction in the verdict, or for reconsideration, which the trial court denied. This appeal followed.

On appeal, defendant first contends that plaintiff presented insufficient evidence at trial to casually connect her medical expenses to the negligence of defendant. Defendant thus contends that the trial court erred in denying its motions for directed verdict and JNOV. We disagree.

We review a trial court's decision on a motion for a directed verdict de novo. Genna v Jackson, 286 Mich App 413, 416; 781 NW2d 124 (2009). In reviewing the trial court's decision, we view the evidence presented up to the time of the motion in the light most favorable to the nonmoving party. Smith v Foerster-Bolser Constr. Inc. 269 Mich App 424, 428; 711 NW2d 421 (2006). We additionally grant the non-moving party every reasonable inference and resolve conflicts in the evidence in that party's favor to determine whether a question of fact existed. *Id.* Directed verdicts are generally viewed with disfavor and it is only where reasonable persons, after reviewing the evidence in the light most favorable to the nonmoving party, could honestly not reach different conclusions about whether the nonmoving [*5] party established his or her claim, that a directed verdict should be entered. Taylor v Kent Radiology, PC, 286 Mich App 490, 499-500; 780 NW2d 900 (2009).

We also review de novo a trial court's decision on a motion for JNOV. Prime Financial Services LLC v Vinton, 279 Mich App 245, 255; 761 NW2d 694 (2008). When deciding a motion for JNOV, the trial court views the evidence and all reasonable inferences in the light most favorable to the nonmoving party and determines whether the facts presented preclude judgment for the nonmoving party. Merkur Steel Supply, Inc v Detroit, 261 Mich App 116, 123124; 680 NW2d 485 (2004). A motion for JNOV should be granted only if the evidence viewed in this light fails to establish a claim as a matter of law. Sniecinski v Blue Cross & Blue Shield of Michigan, 469 Mich 124, 131; 666 NW2d 186 (2003).

In an action alleging medical malpractice, the plaintiff must prove that the defendant failed to provide the recognized standard of care and that "he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants." MCL 600.2912a(2). "Proximate cause" is a legal term of art that incorporates both [*6] cause in fact and legal (or "proximate") cause. Skinner v Square D Co, 445 Mich 153, 162-163; 516 NW2d 475 (1994). As explained in Craig ex rel Craig v Oakwood Hosp, 471 Mich 67, 86-88; 684 NW2d 296 (2004):

The cause in fact element generally requires showing that "but for" the defendant's actions, the plaintiff's injury would not have occurred. On the other

hand, legal cause or "proximate cause" normally involves examining the foreseeability of consequences, and whether a defendant should be held legally responsible for such consequences.

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 [*7] 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 sets 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 the 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. (internal quotation marks omitted).

In a medical malpractice action, damages are divided into categories of economic and noneconomic, both past and future. *Taylor v Kent Radiology*, 286 Mich App 490, 519; 780 NW2d 900 (2009). This Court has turned to the definition provided in MCL 600.2945(c) to determine whether a claim for damages in a medical malpractice action should be characterized as one for economic or noneconomic losses. *Thorn v Mercy Mem Hosp Corp*, 281 Mich App 644, 664-665; 761 NW2d 414 (2008). Under MCL 600.2945(c), economic losses are defined as:

objectively verifiable pecuniary [*8] damages arising from medical expenses or medical care, rehabilitation services, custodial care, loss of wages, loss of future earnings, burial costs, loss of use of property, costs of repair or replacement of property, costs of obtaining substitute domestic services, loss of employment, or other objectively verifiable monetary losses.

At issue in the instant matter are plaintiff's medical expenses from her hospitalization at Port Huron Hospital, which are recognized economic losses under MCL 600.2945(c). The parties stipulated that the medical expenses associated with plaintiff's hospitalization

were \$213,000.00. Defendant, did not, however, stipulate that these expenses were the result of its negligence and the medical bills were not entered as exhibits at trial. According to defendant, plaintiff simply submitted a blanket statement that her medical expenses amounted to \$213,000.00 without establishing that the amount related in any way to the injuries that she claimed she suffered as a result of defendant's negligence. However, the evidence at trial was sufficient to connect defendant's negligence to her hospitalization at Port Huron Hospital and, subsequently, her medical expenses [*9] from the same.

At trial, plaintiff testified that when she went to St. Mary's Hospital on April 1, 2006, she told staff at the hospital several times that she had undergone lap band surgery several years prior. Plaintiff testified that she was told she was experiencing acid reflux and was going to be sent home, until she threw up blood. Plaintiff and her husband both testified that St. Mary's hospital performed an x-ray of her stomach on April 1, 2006, but told them that the x-ray showed no problems.

Dr. Bhesania testified that he has performed close to 2000 lap band surgeries. He testified that prolapse of the stomach after such surgeries is rare, but if it is sufficiently severe, it can cause vascular compromise to the stomach called ischemia, and the progression of ischemia can lead to necrosis. According to Dr. Bhesania, ischemia is a gradual process, not sudden. Dr. Bhesania testified that prolapse does not always require surgery. He testified that if there is no obstruction, in some cases fluid is removed from the lap band and the patient is watched to see if the prolapse has resolved.

Dr. Bhesania testified that he reviewed the first x-ray taken of plaintiff's stomach on April [*10] 1, 2006, at St. Mary's hospital and that the x-ray does not even show the lap band. He testified that a second x-ray taken at St. Mary's Hospital on April 3, 2006, shows that the lap band is rotated and that the tubing is coming off, thus presenting a suspicion of prolapse. Dr. Bhesania testified that based upon plaintiff's symptoms and the records he has seen, plaintiff had the prolapse before she went to St. Mary's hospital on April 1, 2006. Dr. Bhesania testified that by the time plaintiff came into his care on April 3, 2006, the ischemic and necrotic process had been going on for over 24 hours. He further testified that had plaintiff been in his care 24 to 36 hours prior to April 3, 2006, he quite possibly could have prevented the necrosis. Dr. Bhesania also testified that plaintiff's developing adult respiratory distress syndrome after her surgery to repair the prolapse was related to an infection in her stomach. He testified that if he had been able to intervene in her treatment to prevent the necrosis and infection, more likely than not plaintiff would not have developed the adult respiratory distress syndrome.

Dr. Dennis Smith, a general surgeon, also testified that plaintiff's [*11] prolapse developed before she came to St. Mary's Hospital, around the time she started having

pain and vomiting. Dr. Smith further testified that it is more probable than not that plaintiff was developing the ischemia when she was in St. Mary's emergency room and was experiencing severe pain and was vomiting blood, and that the condition probably advanced to necrosis early Monday morning, April 3, 2006. Dr. Smith testified that plaintiff developed infectious complications as a result of her stomach being necrotic and that the necrosis and later infectious complications were preventable within a reasonable probability. According to Dr. Smith, if the prolapse was considered as a potential source of her problems initially, it would not have progressed to the necrosis.

Dr. Leonard Milewski, a general surgeon, testified that plaintiff presented at St. Mary's Hospital Saturday, April 1, 2006, with classic symptoms of someone having problems with a gastric lap band, i.e., severe abdominal pain and vomiting. He testified that several physicians at St. Mary's saw her and formulated diagnoses without taking the lap band into consideration at all. Dr. Milewski further testified that there was [*12] very poor communication between the persons associated with plaintiff's care, with no one really doing anything for her for the three days she was there. According to Dr. Milewski, the delay led to a segment of her stomach necrosing. Dr. Milewski testified that a surgeon or bariatric surgeon should have been consulted immediately and that if one had, the fluid could have been removed from her lap band, allowing additional blood flow to her stomach so that it would not have suffered necrosis. Dr. Milewski believes that the ischemic process was probably beginning when she was first at the hospital, with the necrotic process beginning late Sunday into early Monday, when her blood pressure began to lower and her pulse began to rise.

Dr. Robert Buynak testified that when a patient with a lap band presents with intestinal issues, one's differential diagnosis must include potential problems with the lap band. Dr. Buynak further testified that a CAT scan or upper GI test allows the best indication of whether the lap band is causing the problem. Dr. Buynak testified that in plaintiff's case, the need was for an urgent evaluation by a surgeon, because her pain was severe enough to require her [*13] to remain in the hospital on an IV with narcotic painkillers.

Based upon the testimony of the medical experts, but for defendant's failure to diagnose plaintiff's prolapsed stomach, caused by her misplaced lap band, plaintiff would not have suffered ischemia and later necrosis of her stomach. All of the medical experts who gave an opinion as to when the prolapse occurred agreed that plaintiff presented at St. Mary's Hospital with a prolapse. All who gave opinions also agreed that plaintiff's symptoms were consistent with a prolapse and that when a patient provides a history of lap band surgery and also presents with vomiting blood and severe abdominal pain, the doctor must consider a lap band complication as a part of the differential diagnosis. The majority of the experts also agreed that ischemia is a gradual process that was

progressing over the two days that plaintiff was in defendant's care and while they were not considering her lap band or a prolapse as a potential diagnosis, and that the necrosis likely began late Sunday April 2, 2006, to early Monday April 3, 2006. At least one doctor opined that had fluid been removed from her lap band soon after admission at St. Mary's Hospital, [*14] the portion of her stomach suffering from necrosis would not have died.

There is no dispute that plaintiff was admitted to Port Huron on April 3, 2006, under the care of Dr. Bhesania and underwent surgery to repair a prolapsed stomach and necrosis of the same on the same day. According to Dr. Bhesania, plaintiff suffered from adult respiratory distress syndrome as a complication of her surgery, related to the infection in her stomach. There is no dispute that the complications plaintiff suffered after surgery required her to remain hospitalized for over one month. Dr. Bhesania testified that had plaintiff been in his care 24 to 36 hours prior to April 3, 2006, he "quite possibly" could have prevented the necrosis and her subsequent adult respiratory distress syndrome. Dr. Smith similarly testified that if defendant's employees had initially considered prolapse as a potential source of plaintiff's problems, it would not have progressed to the necrosis and that both the necrosis and later infectious complications were preventable within a reasonable probability. The above presents sufficient evidence that plaintiff was at Port Huron Hospital solely due to defendant's failure to diagnose [*15] and treat her stomach prolapse. Further, while the actual medical bills were not submitted as evidence at trial, some of plaintiff's medical records, detailing her treatment at Port Huron Hospital, were submitted. A reasonable jury could thus conclude that any and all expenses incurred at Port Huron Hospital were attributable to defendant's negligence.

Defendant contends that a lack of evidence concerning economic damages is underscored through the jury's questions presented to the trial court during deliberations. The jury submitted the following two questions to the trial court:

- 1) Regarding economic damages, is there a way to determine Plaintiff's total amount of medical bills incurred?
- 2) Can we use the \$213,000 figure provided by the plaintiff's attorney in closing argument?

The trial court responded:

- 1) There was a stipulation that the amount was \$213,000.00.
- 2) Yes.

If there is any other question, or if these answers do not fully address the questions presented, please let me know in writing.

Defendant argues that the answer given by the trial court was an improper interpretation by the trial court of plaintiff's *economic damages*. However, the jury's specific question was not the total [*16] amount of plaintiff's economic damages, but rather what was the total amount of plaintiff's *medical bills incurred*.

On the fifth day of trial, plaintiff's counsel stated, "In addition, your Honor, [defense counsel] and I have agreed and stipulated that the medical bills at issue in this case are \$213,000 . . ." Defense counsel replied, "Your Honor, I-I do stipulate that that is the amount of the Port Huron Hospital bill correct?" Plaintiff's counsel acknowledged that it was and defense counsel stated, "For the admission of April 3 through May 13. I do not stipulate, however, that those are causally related to any claim of malpractice." Based upon the above stipulation, the trial court properly responded to the jury's question that the parties had stipulated that plaintiff's *medical bills* totaled \$213,000.00.

And, contrary to defendant's assertion otherwise, defendant did not expressly state that it did not stipulate the billing amounts were reasonable and necessary. Defendant only stated that it was not stipulating that the expenses were "causally related to any claim of malpractice." Moreover, while defendant contends that plaintiff presented no evidence that the medical expenses were [*17] reasonable or necessary, some of plaintiff's inpatient records from Port Huron Hospital were admitted into evidence. The billing notes are also found in the records from Port Huron Hospital. The records and notes, coupled with the testimony of Dr. Bhesania, were sufficient to allow a reasonable jury to conclude that the services rendered to plaintiff were reasonable and necessary. The trial court did not err in denying defendant's motions for directed verdict or JNOV.

Defendant next contends that the jury's award should have been set off by the amount negotiated as a discount by plaintiff's insurance company pursuant to MCL 600.6303. On reconsideration, defendant argued to the trial court that while plaintiff's medical bills were, indeed \$213,000, her health care insurer, Blue Cross and Blue Shield, negotiated a payment in full for far less, which was accepted as full payment for the services rendered by her health care providers. Defendant reasserts on appeal that payment of the medical bills in full by plaintiff's health care insurer requires setting off the judgment pursuant to the collateral source payment statute, MCL 600.6303, to the amount actually paid by the insurer, adjusted [*18] for comparative negligence. We disagree.

Issues of statutory interpretation are questions of law that this Court reviews de novo. Spectrum Health Hospitals v Farm Bureau Mutual Insurance Company of Michigan, 492 Mich 503, 506; NW2d (2012). This Court interprets and applies statutes to give effect to the plain meaning of their text. Ligon v Crittenton Hosp. 490 Mich 61, 70; 803 NW2d 271 (2011). Thus, if the statutory language is clear and unambiguous, judicial construction is neither required nor permitted, and we apply the statute as written. Rose Hill Ctr, Inc v Holly Twp, 224 Mich App 28, 32; 568 NW2d 332 (1997).

MCL 600.6303 provides:

(1) In a personal injury action in which the plaintiff seeks to recover for the expense of medical care, rehabilitation services, loss of earnings, loss of earning capacity, or other economic loss, evidence to establish that the expense or loss was paid or is payable, in whole or in part, by a collateral source shall be admissible to the court in which the action was brought after a verdict for the plaintiff and before a judgment is entered on the verdict. Subject to subsection (5), if the court determines that all or part of the plaintiff's expense [*19] or loss has been paid or is payable by a collateral source, the court shall reduce that portion of the judgment which represents damages paid or payable by a collateral source by an amount equal to the sum determined pursuant to subsection (2). This reduction shall not exceed the amount of the judgment for economic loss or that portion of the verdict which represents damages paid or payable by a collateral source.

(2) The court shall determine the amount of the plaintiff's expense or loss which has been paid or is payable by a collateral source. Except for premiums on insurance which is required by law, that amount shall then be reduced by a sum equal to the premiums, or that portion of the premiums paid for the particular benefit by the plaintiff or the plaintiff's family or incurred by the plaintiff's employer on behalf of the plaintiff in securing the benefits received or receivable from the collateral source.

(3) Within 10 days after a verdict for the plaintiff, plaintiff's attorney shall send notice of the verdict by registered mail to all persons entitled by contract to a lien against the proceeds of plaintiff's recovery. If a contractual lien holder does not exercise the lien [*20] holder's right of subrogation within 20 days after receipt of the notice of the verdict, the lien holder shall lose the right of subrogation. This subsection shall only apply to contracts executed or renewed on or after the effective date of this section.

(4) As used in this section, "collateral source" means benefits received or receivable from an insurance policy; benefits payable pursuant to a contract with a health care corporation, dental care corporation, or health maintenance organization; employee benefits; social security benefits; worker's compensation benefits; or medicare benefits. Collateral source does not include life insurance benefits or benefits paid by a person, partnership, association, corporation, or other legal entity entitled by law to a lien against the proceeds of a recovery by a plaintiff in a civil action for damages. Collateral source does not include benefits paid or payable by a person, partnership, association, corporation, or

other legal entity entitled by contract to a lien against the proceeds of a recovery by a plaintiff in a civil action for damages, if the contractual lien has been exercised pursuant to subsection (3).

(5) For purposes of this section, [*21] benefits from a collateral source shall not be considered payable or receivable unless the court makes a determination that there is a previously existing contractual or statutory obligation on the part of the collateral source to pay the benefits.

The collateral source rule, *MCL 600.6303*, prevents a plaintiff from recovering the same expenses from both a defendant and a collateral source. *Haberkorn v Chrysler Corp (Two Cases)*, 210 Mich App 354, 374; 533 NW2d 373 (1995).

In the instant matter, documents in the record indicate that plaintiff's health care insurer, Blue Cross Blue Shield, made payments to Port Huron Hospital and its staff for plaintiff's medical care. These would initially qualify as "collateral source" under *MCL 600.6303(4)*. However, *MCL 600.6303(4)* also states that, "collateral source does not include . . . benefits paid by a person, partnership, association, corporation, or other legal entity entitled by law to a lien against the proceeds of a recovery by a plaintiff in a civil action for damages," and that "collateral source does not include benefits paid or payable by a person, partnership, association, corporation, or other legal entity entitled by contract to a [*22] lien against the proceeds of a recovery by a plaintiff in a civil action for damages, if the contractual lien has been exercised pursuant to subsection (3)." Here, the record reflects that Blue Cross Blue Shield ("BCBS") exercised its right to a lien on plaintiff's verdict.

Prior to the verdict, counsel for plaintiff's insurer advised that BCBS had paid benefits in the amount of \$120,948.75 on plaintiff's behalf and that plaintiff would be obligated to reimburse BCBS for the same out of any settlement or damages received at trial. The jury verdict in favor of plaintiff for medical expenses was entered on August 17, 2011. On August 31, 2011, counsel for plaintiff's insurer wrote a letter to plaintiff's counsel indicating his understanding that plaintiff had received a favorable verdict in which medical damages were included. Counsel indicated in the letter that its client had an equitable lien right on plaintiff's recovery and requested that plaintiff hold the recovery funds in trust until the matter of how much BCBS is to be repaid is determined through either settlement or a court order.

Because BCBS properly exercised its lien rights, those benefits actually paid or payable by BCBS [*23] are not a collateral source pursuant to *MCL 600.6303(4)*. See, *Zdrojewski v Murphy*, 254 Mich App 50, 70; 657 NW2d 721(2002)("[T]he statute clearly states that benefits subject to an exercised lien do not qualify as a collateral source . . ."). Defendant acknowledges the same but contends that those amounts "written off" by

plaintiff's health care providers and not subject to any lien by BCBS present an entirely different scenario.

Plaintiff's health care providers "wrote off" over \$100,000 in medical expenses for which BCBS was initially charged. Defendant contends that any amount awarded to plaintiff for medical expenses above and beyond the amount actually paid by BCBS (i.e., the amount written off) is a "collateral source" and that the verdict should be set off by the same. Defendant is incorrect.

The plain language of MCL 600.6303(1) states that "if the court determines that all or part of the plaintiff's expense or loss has been paid or is payable by a collateral source, the court shall reduce that portion of the judgment which represents damages paid or payable by a collateral source by an amount equal to the sum determined pursuant to subsection (2)." In its simplest terms, the [*24] trial court may reduce the plaintiff's judgment only by the amount by which plaintiff's loss *has been paid or is payable*. An amount that has been written off has not been paid, nor is it payable, such that it is not a collateral source.

Defendant classifies the write offs as "benefits" plaintiff has received from her health care providers, contending that such classification places the write offs within the meaning of a collateral source. "Collateral source" means "benefits received or receivable from an insurance policy; benefits payable pursuant to a contract with a health care corporation, dental care corporation, or health maintenance organization; employee benefits; social security benefits; worker's compensation benefits; or medicare benefits." MCL 600.6303(4). If, as defendant asserts, the write off was a benefit plaintiff received from her health care providers, it is not a benefit received or receivable from an insurance policy, nor is it a benefit payable pursuant to a contract with a health care corporation. Any "benefit" plaintiff received from the write offs thus does not fall within the statutory definition of "collateral source."

Finally, defendant focuses heavily on the [*25] supposed windfall that would be bestowed upon plaintiff if collateral source setoff were not imposed in this matter. First, where BCBS was a paid insurer, if BCBS was able to negotiate a reduced medical payment, it could be argued that plaintiff is nevertheless still entitled to the full value of the medical services rendered on her behalf. See, e.g., Bozeman v State, 879 So2d 692, 705-706 (2004). Second, defendant ignores that a jury found it negligent and causing plaintiff's damages. Had plaintiff been wholly uninsured, defendant would be liable for every penny of her medical expenses. Because plaintiff's medical care providers elected to absorb some of the cost of her care does not make defendant any less negligent, nor does the fact that she was insured. Should a windfall arise due to the action of an outside party (here, the "write off" by a medical provider), that would be

a function of the statute, and we do not venture into that area of public policy..

Affirmed.

/s/ Deborah A. Servitto

/s/ Jane E. Markey

/s/ Christopher M. Murray

A Neutral

As of: March 6, 2015 10:24 AM EST

Hall v. Neysa

Court of Appeals of Michigan

March 29, 2011, Decided

No. 288293, No. 290147

Reporter

2011 Mich. App. LEXIS 596

EVANGELINE HALL, Plaintiff-Appellee, v NEYSA BARTLETT, D.O., MARTHA WALSH, M.D., MARK WALKER, M.D., MANSION STREET OBSTETRICS & GYNECOLOGY, P.C., and OAKLAWN HOSPITAL, Defendants, and CARON WARNSBY, M.D., and GENERAL SURGICAL ASSOCIATES-WMB, Defendants-Appellants. EVANGELINE HALL, Plaintiff-Appellee, v NEYSA BARTLETT, D.O., MANSION STREET OBSTETRICS & GYNECOLOGY, P.C., MARTHA WALSH, M.D., MARK WALKER, M.D., CARON WARNSBY, M.D., CARON WARNSBY M.D., P.C., GENERAL SURGICAL ASSOCIATES, P.C., and GENERAL SURGICAL ASSOCIATES-WMB, Defendants, and OAKLAWN HOSPITAL, Defendant-Appellant.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Subsequent History: Leave to appeal denied by *Hall v. Bartlett*, 2011 Mich. LEXIS 1554 (Mich., Sept. 6, 2011)

Prior History: [*1] Calhoun Circuit Court. LC No. 06-002001-NH. Calhoun Circuit Court. LC No. 06-002001-NH.

Core Terms

trial court, nurses, patient, subrule, sanctions, second sentence, injuries, surgery, costs, argues, prevailing party, diagnosed, diagnosis, records, standard of care, perforation, bowel, medical malpractice claim, lost opportunity, medical expenses, proximate cause, chain of command, medical records, provides, applies, aggregate, destroyed, jury's, opined, healthcare provider

Judges: Before: SAWYER, P.J., and FITZGERALD and SAAD, JJ.

Opinion

PER CURIAM.

In Docket No. 288293, defendants Caron Warnsby, M.D. and General Surgical Associates-WMB ("the Warnsby defendants") appeal as of right from the trial court's order denying their motion for case evaluation sanctions following a jury verdict of no cause of action in this medical malpractice action. In Docket No. 290147, defendant Oaklawn Hospital ("Oaklawn") appeals as of right from a judgment in favor of plaintiff, including the imposition of case evaluation sanctions, following a jury trial. We affirm in both appeals.

I. CASE EVALUATION SANCTIONS (DOCKET NO. 288293)

In Docket No. 288293, the Warnsby defendants argue that the trial court erred by failing to award them case evaluation sanctions pursuant to MCR 2.403. We disagree. We review de novo as a question of law a trial court's decision whether to award case evaluation sanctions. Jerico Constr. Inc v Quadrants, Inc., 257 Mich App 22, 28; 666 NW2d 310 (2003). The interpretation of a court rule also presents a question of law that we review de novo. ISB Sales Co v Dave's Cakes, 258 Mich App 520, 526; 672 NW2d 181 (2003).

MCR 2.403(O)(1) [*2] provides:

If a party has rejected an evaluation and the action proceeds to verdict, that party must pay the opposing party's actual costs unless the verdict is more favorable to the rejecting party than the case evaluation. However, if the opposing party has also rejected the evaluation, a party is entitled to costs only if the verdict is more favorable to that party than the case evaluation.

MCR 2.403(O)(4) specifically addresses cases involving multiple defendants. That provision provides, in relevant part:

(a) *Except as provided in subrule (O)(4)(b)*, in determining whether the verdict is more favorable to a party than the case evaluation, the court shall consider only the amount of the evaluation and verdict as to the particular pair of parties, rather than the aggregate evaluation or verdict as to all parties. *However, costs may not be imposed on a plaintiff who obtains an aggregate verdict more favorable to the plaintiff than the aggregate evaluation.*

(b) If the verdict against more than one defendant is based on their joint and several liability, the plaintiff may not recover costs unless the verdict is more favorable to the plaintiff than the total case evaluation as to those defendants,

[*3] and a defendant may not recover costs unless the verdict is more favorable to that defendant than the case evaluation as to that defendant. [Emphasis added.]

The Warnsby defendants argue that subrule (O)(4)(b) applies because this case involves multiple defendants and joint and several liability. They contend that the phrase "[e]xcept as provided in subrule (O)(4)(b)" indicates that subrule (O)(4)(a) applies only in cases in which subrule (O)(4)(b) does not apply. Plaintiff, on the other hand, argues that that phrase pertains only to the first sentence of subrule (O)(4)(a) and that the second sentence applies regardless of whether a verdict is based on joint and several liability as discussed in subrule (O)(4)(b). The trial court agreed with plaintiff and determined that the second sentence of subrule (O)(4)(a) controls this case.

The legal principles that govern the interpretation of statutes apply to the interpretation of court rules as well. *ISB Sales Co*, 258 Mich App at 526. If the plain and ordinary meaning of the language is clear, judicial construction is neither necessary nor permitted. *Yudashkin v Holden*, 247 Mich App 642, 649; 637 NW2d 257 (2001). Words are accorded their plain, [*4] commonly understood meanings. *Marketos v American Employers Ins Co*, 465 Mich 407, 413; 633 NW2d 371 (2001).

Random House Webster's College Dictionary (2001) defines "however," as "nevertheless," "yet," "on the other hand," and "in spite of that." Thus, the second sentence of subrule (O)(4)(a) creates an exception to the rule set forth in the first sentence of the subrule. The first sentence states that, "[e]xcept as provided in subrule (O)(4)(b)," when determining whether a verdict is more favorable to a party than the case evaluation, only the evaluations and verdicts between each pair of parties are considered. The second sentence, beginning with "[h]owever," provides an exception to that rule and indicates that notwithstanding that rule, costs may not be assessed against a plaintiff who obtains an aggregate verdict more favorable than the aggregate case evaluation. The exception applies to the entire rule set forth in the first sentence, including the first phrase. Nothing in subrule (O)(4)(a) indicates that the second sentence applies only to that portion of the first sentence that follows the introductory phrase. In other words, the remainder of subrule (O)(4)(a) is not inapplicable [*5] if subrule (O)(4)(b) applies.¹

Our analysis based on the plain language of the court rule is consistent with the 1995 report of the Supreme Court mediation rule committee, 451 Mich 1205. The Supreme Court appointed the committee for the purpose of analyzing *MCR 2.403* and making

¹ The Warnsby defendants rely on *Williams v Chelsea Community Hosp*, unpublished opinion per curiam of the Court of Appeals, issued December 28, 2006 (Docket No. 261946), in support of their interpretation of the court rule. Because that case is unpublished, it is not precedentially binding under the rule of stare decisis. *MCR 7.215(C)*. Regardless, their reliance is misplaced because *Williams* involved case evaluation sanctions awarded to the plaintiff rather than to the defendants. Thus, the second sentence of subrule (O)(4)(a), regarding costs imposed on a plaintiff, was inapplicable. *Id.* at 8-10.

recommendations regarding proposed amendments to the rule. *Id.* With respect to subrule (O)(4)(a), the committee explained:

The controversy involves the last sentence. To illustrate, assume that the mediation panel awards \$100,000 to Plaintiff against Defendant A and \$50,000 against Defendant B. Plaintiff rejects. If at [*6] trial Plaintiff recovers a verdict of \$200,000 against Defendant A and nothing against Defendant B, Defendant B has certainly obtained a verdict more favorable to it than the mediation award. However, because of the last sentence of subrule (O)(4)(a), Defendant B may not recover costs from Plaintiff.

The scenario described in the above example is identical to this case. It is undisputed that plaintiff received a \$175,000 case evaluation award against the Warnsby defendants, which she rejected. Plaintiff was also awarded a total of \$575,000 against Dr. Martha Walsh, Dr. Neysa Bartlett, and Oaklawn, which she rejected. At trial, the Warnsby defendants received a verdict of no cause of action, but Dr. Bartlett and Oaklawn were determined to be liable in the amount of \$3,365,000. Pursuant to the above example provided by the committee, the Warnsby defendants may not collect case evaluation sanctions from plaintiff because plaintiff obtained an aggregate verdict more favorable than the aggregate case evaluation, as stated in subrule (O)(4)(a). Although the Warnsby defendants argue that the example provided by the committee does not necessarily support plaintiff's position because it does [*7] not state whether the defendants are jointly and severally liable, that factor is irrelevant because the second sentence of subrule (O)(4)(a) applies regardless of whether the defendants are jointly and severally liable, i.e, regardless of whether subrule (O)(4)(b) applies, as previously discussed. Accordingly, the trial court properly denied the Warnsby defendants' motion for case evaluation sanctions.

II. TAXABLE COSTS

The Warnsby defendants next argue that the trial court abused its discretion by refusing to award them taxable costs as prevailing parties. We again disagree. "This Court reviews for an abuse of discretion a trial court's decision on a motion for costs under MCR 2.625." *Mason v City of Menominee*, 282 Mich App 525, 530; 766 NW2d 888 (2009). A trial court abuses its discretion when its decision is outside the range of reasonable and principled outcomes. *Id.* But the determination whether a party is a "prevailing party" under MCR 2.625 is a question of law that we review de novo. *Klinke v Mitsubishi Motors Corp*, 219 Mich App 500, 521; 556 NW2d 528 (1996), aff'd 458 Mich 582 (1998).

Generally, a "prevailing party" may tax costs pursuant to MCR 2.625(A)(1). *Mason*, 282

Mich App at 530. [*8] That provision states:

Costs will be allowed to the prevailing party in an action, unless prohibited by statute or by these rules or unless the court directs otherwise, for reasons stated in writing and filed in the action.

The issue presented here involves the definition of "prevailing party." MCR 2.625(B), entitled "Rules for Determining Prevailing Party," states, in relevant part:

(3) *Actions With Several Defendants.* If there are several defendants in one action, and judgment for or dismissal of one or more of them is entered, those defendants are deemed prevailing parties, even though the plaintiff ultimately prevails over the remaining defendants.

Relying on this language, the Warnsby defendants argue that they are prevailing parties entitled to costs.

Conversely, plaintiff argues that MCR 2.625(A)(1) and MCR 2.403(O)(6), when read together, require that the Warnsby defendants be denied taxable costs. MCR 2.403(O)(6) provides, in relevant part:

For the purpose of determining taxable costs under this subrule and under MCR 2.625, the party entitled to recover actual costs under this rule shall be considered the prevailing party.

According to plaintiff, because she was awarded case evaluation [*9] sanctions pursuant to MCR 2.403, the Warnsby defendants cannot be considered prevailing parties under MCR 2.625.

The Warnsby defendants argue that there is no need to look to MCR 2.403(O) to determine whether a party is a "prevailing party" because that term is defined in MCR 2.625. This Court has previously held to the contrary. In Forest City Enterprises, Inc v Leemon Oil Co, 228 Mich App 57, 81; 577 NW2d 150 (1998), this Court determined that, when read together, MCR 2.625(B)(2) and MCR 2.403(O)(6) indicate that "the party entitled to actual costs under the mediation rule for a cause of action shall also be deemed the prevailing party under MCR 2.625(B)(2) on the entire record." See also Ivezaj v Auto Club Ins Ass'n, 275 Mich App 349, 367-368; 737 NW2d 807 (2007); Brown v Gainey Transp Servs, Inc, 256 Mich App 380, 385; 663 NW2d 519 (2003). That holding is consistent with the principle that if two court rules can be interpreted harmoniously so that they do not conflict, that interpretation controls. Costa v Community Emergency Med Servs, Inc, 263 Mich App 572, 584; 689 NW2d 712 (2004), aff'd 475 Mich 403 (2006). Moreover, this interpretation does not render nugatory the

definition [*10] of "prevailing party" in MCR 2.625(B)(3), because MCR 2.403(O)(6) is inapplicable in cases in which no party is entitled to case evaluation sanctions.

The Warnsby defendants rely on Klinke, 219 Mich App 500, in support of their argument that MCR 2.403 and MCR 2.625 provide two separate and distinct means of determining whether a party is a prevailing party. Klinke fails to support their position because the plaintiff in that case accepted the case evaluation, thus precluding the defendant from recovering case evaluation sanctions. Klinke, 219 Mich App at 518. Because no party in that case was entitled to recover case evaluation sanctions, MCR 2.403(O)(6) was inapplicable. In this case, because plaintiff recovered case evaluation sanctions, she was the prevailing party under both MCR 2.403(O)(6) and MCR 2.625, as stated in MCR 2.403(O)(6). Accordingly, the trial court properly denied the Warnsby defendants' motion to tax costs.

III. BUT FOR CAUSATION

In Docket No. 290147, Oaklawn argues that the trial court erred by denying its motions for a directed verdict and judgment notwithstanding the verdict ("JNOV") because plaintiff failed to present evidence that, but for the conduct of the nursing [*11] staff, she would have been diagnosed and received surgery sooner. We review de novo a trial court's ruling on a motion for a directed verdict or JNOV. Sniecinski v Blue Cross & Blue Shield of Mich, 469 Mich 124, 131; 666 NW2d 186 (2003). We review the evidence and all inferences in the light most favorable to the nonmoving party to determine whether the evidence fails to establish a claim as a matter of law. *Id.*

To establish a medical malpractice claim, "a plaintiff must establish four elements: (1) the appropriate standard of care governing the defendant's conduct at the time of the purported negligence, (2) that the defendant breached that standard of care, (3) that the plaintiff was injured, and (4) that the plaintiff's injuries were the proximate result of the defendant's breach of the applicable standard of care." Craig v Oakwood Hosp, 471 Mich 67, 86; 684 NW2d 296 (2004). Regarding the fourth prong, MCL 600.2912a(2) states that "the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants."

As our Supreme Court recognized in Craig, 471 Mich at 86, "[p]roximate cause' [*12] is a legal term of art that incorporates both cause in fact and legal (or 'proximate') cause."

The cause in fact element generally requires showing that "but for" the defendant's actions, the plaintiff's injury would not have occurred. On the other

hand, legal cause or "proximate cause" normally involves examining the foreseeability of consequences, and whether a defendant should be held legally responsible for such consequences. [*Skinner v Square D Co*, 445 Mich 153, 163; 516 NW2d 475 (1994) (citations omitted).]

"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. When causation is based on circumstantial evidence, "the plaintiff must present substantial evidence from which a jury may conclude that more likely than not, but for the defendant's conduct, the plaintiff's injuries would not have occurred." *Skinner*, 445 Mich at 164-165.

Oaklawn argues that plaintiff failed to present evidence establishing that but for the actions or inactions of the nursing staff, plaintiff would have been diagnosed [*13] and undergone surgery sooner. We disagree. One of plaintiff's nursing experts, Patricia Waldron, R.N., testified regarding the chain of command, a process that a nurse may implement when she questions a doctor's treatment of a patient. The chain of command begins with the nurse collaborating with the doctor regarding the patient's course of treatment. If the nurse disagrees with the course of treatment after collaboration, the chain of command requires the nurse to contact the "charge" nurse, or supervisory nurse, to possibly "trump" the doctor's orders. According to Waldron, implementing the chain of command encompasses transferring a patient to a higher level of care, such as the intensive care unit, or "ICU." Oaklawn had a chain of command procedure in place during plaintiff's hospitalization.

Dr. Brendan Carroll testified regarding the proximate cause between the nurses' actions and inactions and plaintiff's injuries. He testified as follows:

Q. Now, you have talked a little bit about bowel perforations being life-threatening conditions, and you have described some of the complications that resulted as a result of her bowel perforation.

I would like to focus for a bit here on the [*14] care or the lack of care provided by the healthcare providers at Oaklawn Hospital and whether or not, in your opinion, that was what the law calls a proximate cause, a proximate cause of Ms. Hall's injury and damage in this case. Okay?

A. Yes.

Q. Do you have opinions as to what caused Ms. Hall's injury and damage?

A. The beginning cause was a nick in the bowel.

Q. Right.

A. What caused that nick is a matter of speculation, but the nick is what started the process going.

The delay in diagnosis of the nick is what made it a hundred times worse. And so it was a combination between the nick and then the failure to appreciate the nick that made this much worse. And as the timeline proceeded, the longer that it went—

* * *

The delay in diagnosis is what led to all of the complications, because if the nick had been recognized in the first surgery, it would have been fixed with one or two stitches and there would have been no consequences. There would have been no ventilator, no sepsis, no bandemia. The patient probably would have gone home within a week of the surgery with no consequences. If it was not recognized until the next day, more consequences; the next day, more consequences; and after that, [*15] more consequences.

Q. Right. Let me just ask it in a general sense first. Is it your opinion in this case that the delay in diagnosing this injury was a cause, a cause of Ms. Hall's injury and damage?

A. Absolutely.

Q. Now, you started to talk a little bit about what happened in the continuum of time after the initial surgery.

Is a bowel perforation, in terms of the injury to the patient, something that progresses on a continuum?

A. Definitely.

Q. Do you believe that's what happened here; in other words, that the effect of the perforation to the bowel continued to progress?

A. It did happen here, yes.

Dr. Carroll further testified that if plaintiff's bowel injury had been diagnosed after the first blood test (on the night of July 21, 2004) revealed the presence of bands, plaintiff would have experienced only a limited amount of leakage because she would not have been administered cathartics and likely would not have required a ventilator or suffered renal failure. Dr. Carroll also opined that if plaintiff's bowel perforation was diagnosed after the second post-operative day, July 22, 2004, her prognosis would have been worse than if she had been diagnosed sooner, but she likely would not have [*16] experienced the catastrophic complications of the sepsis that resulted from the leakage.

Accordingly, Dr. Carroll's testimony showed that the extent of plaintiff's injuries was directly related to the delay in properly diagnosing her. Both Waldron and plaintiff's other nursing expert, Grace McCallum, testified that Oaklawn's nursing staff breached the standard of care by failing to implement the chain of command. Oaklawn contends that plaintiff failed to present evidence showing that if the nursing staff had implemented the chain of command, plaintiff would have been transferred to the ICU and diagnosed sooner. Oaklawn in fact maintains that the alleged nursing negligence did not impact plaintiff's care.

In Martin v Ledingham, 282 Mich App 158, 159; 774 NW2d 328 (2009), rev'd 488 Mich 987; 791 NW2d 122 (2010), this Court upheld the dismissal of a medical malpractice action because the plaintiff failed to show that the nursing staff's failure to report her worsening condition to physicians had any effect on her treatment. In that case, the defendant presented the affidavits of Drs. Jeffrey Beaudoin and David Rynbrandt averring that they would not have changed the plaintiff's course of [*17] treatment if the nurses had informed them of the plaintiff's condition. *Id.* at 159-163. This Court determined that there was no factual support for the plaintiff's claim that she would have received better treatment if the nurses had "gone up the chain of command[.]" This Court reasoned that Dr. Beaudoin was the chair of the general surgery department and had authority over Dr. Rynbrandt and that Dr. Beaudoin's affidavit indicated that he would not have altered the plaintiff's treatment if he had been summoned sooner, as the plaintiff contended the nurses should have done. *Id.* at 162. Thus, this Court concluded that the evidence did not show that the nurses' alleged negligence was a cause in fact of the plaintiff's injuries. *Id.* at 163.

In lieu of granting leave to appeal, the Supreme Court reversed the judgment of this Court and remanded to the trial court for entry of an order denying the defendant's motion for summary disposition. The Court stated:

Because the plaintiff's expert witness testified at his deposition that, if the nurses had timely informed the treating physician of the plaintiff's deteriorating condition, the standard of care would have required the treating physician [*18] to treat the plaintiff differently than he did, while the treating physician averred in his affidavit that he would not have treated the plaintiff any differently than he did even if the nurses had timely informed him of the plaintiff's deteriorating condition, a question of material fact exists that must be resolved by a jury. That is, having presented expert testimony regarding the treatment that the plaintiff, pursuant to the standard of care, should have received in the first 72 hours post-surgery, the treating physician's averment that he would have acted in a manner contrary to this standard of care presents a question of fact and an issue of credibility for the jury to resolve. [Martin, 488 Mich at 987-988.]

In *Ykimoff v W A Foote Mem Hosp.*, 285 Mich App 80; 776 NW2d 114 (2009), this Court addressed a similar situation. In that case, the defendant hospital argued that the plaintiff did not establish proximate cause because Dr. David Eggert indicated that he would not have intervened sooner if the nursing staff had contacted him regarding the plaintiff's changed condition. *Id.* at 88. The *Ykimoff* Court determined that *Martin* was factually distinguishable. *Id.* at 91, 99. This Court [*19] reasoned that the treating physician in *Martin* was apprised of the plaintiff's condition on an ongoing basis but elected not to alter the course of treatment despite the information. Thus, *Martin* involved the physician's conduct based on the actual scenario presented and did not involve speculation or hindsight. This Court stated that, in contrast, Dr. Eggert's assertion that he would not have altered the course of treatment if he had been informed of the plaintiff's changed condition "was speculative at best and self-serving at worst." *Id.* at 91. This Court reasoned that discrepancies in Dr. Eggert's testimony and the immediacy of his initiation of surgery after arriving at the hospital rendered suspect his claim that he would not have intervened sooner if he had been adequately informed. *Id.* at 91-93. Further, this Court recognized that proximate cause determinations are highly fact-dependent and stated that *Martin* and similar cases should be construed very narrowly. *Id.* at 99.

Oaklawn acknowledges that only Dr. Mark Walker was questioned at trial regarding the impact of the nurses' alleged negligence on his course of treatment. Shortly after 5:30 p.m. on the day after plaintiff's [*20] hysterectomy, July 21, 2004, Dr. Walker directed Nurse Irene Richter to obtain a complete blood count, or "CBC" on plaintiff. Although the lab results were available at approximately 10:00 p.m., the nurse on duty at that time did not contact Dr. Walker with the results. Rather, Dr. Bartlett reviewed the results of the test the following morning. The results indicated that plaintiff's band level was abnormal at 40 percent. When asked about his course of treatment during trial, Dr. Walker testified:

Q. Hypothetically, if the nurse had contacted you around 10:00 p.m. with the results of the C.B.C., would the results have been of any significance to you in your following of her while you were on-call Wednesday night?

A. I wouldn't have done anything different at that point.

Q. Why not?

A. Because based on what has transpired, based on the results here, there is nothing that tells me that we are dealing with a significant problem.

* * *

Q. And even if you had been called back with the results of that blood test that evening, your testimony to this jury is, you would not have been concerned about an infection; right?

A. Not at that time. In the clinical context of the patient, there was nothing [*21] to indicate otherwise.

Oaklawn contends that Dr. Walker's testimony shows that the nurse's failure to contact him with the test results on the night of July 21 did not delay plaintiff's diagnosis or surgery. Like the testimony in *Ykimoff*, however, Dr. Walker's testimony was speculative and hypothetical. Moreover, because he was a defendant in this case, his testimony may be viewed as self-serving. Oaklawn argues that the jury must have believed Dr. Walker's testimony because it determined that he was not negligent. The jury was free to believe or disbelieve all or portions of Dr. Walker's testimony. See *People v Perry*, 460 Mich. 55, 63; 594 NW2d 477 (1999). The jury's determination that Dr. Walker was not professionally negligent does not necessarily mean that it credited his testimony that his course of treatment would not have changed in the hypothetical scenario that he was timely informed of the test results. Moreover, even if the jury credited Dr. Walker's testimony, it could have believed that the nurses' conduct had not resulted in a delay in plaintiff's diagnosis or treatment *at that time*.

We conclude that plaintiff presented substantial evidence from which the jury could conclude, [*22] more likely than not, that the nurses' failure to implement the chain of command to transfer plaintiff to the ICU resulted in the delayed diagnosis of and surgery for plaintiff's perforated bowel. As previously discussed, Dr. Carroll testified that the delay in diagnosis was directly related to the extent of plaintiff's injuries. Plaintiff's condition continually worsened until she was finally properly diagnosed after being transferred to the ICU on July 23, 2004, three days after her hysterectomy. Both Waldron and McCallum testified that the standard of care required the nurses to implement the chain of command to transfer plaintiff to a higher level of care. Waldron asserted that it was abnormal for the nurses to call physicians upwards of 14 times regarding plaintiff's worsening condition on July 22 and 23. Dr. Carroll opined that an overwhelming infection could be the only cause of bandemia as high as 40 percent, even on the day after plaintiff's hysterectomy.

On the morning of July 23, a charge nurse became involved in plaintiff's care and was instrumental in effectuating plaintiff's transfer to the ICU. Once in the ICU, it was immediately suspected that plaintiff had sustained [*23] a bowel perforation. During his initial assessment of plaintiff, Dr. Gil-Acosta suspected that "there was something major going on in her abdomen, like a perforation, which happened to be the case[.]" He also recognized that plaintiff's extreme bandemia indicated overwhelming infection .

Although he testified that he would not have been concerned about a 40 percent bandemia level on the first day after plaintiff's hysterectomy because of the stress of the surgery, he maintained that the 60 percent bandemia level concerned him because it was so high. Plaintiff's 60 percent bandemia level was not discovered until approximately 5:30 a.m. on July 23. Plaintiff underwent surgery at approximately 3:00 p.m. that day and it was then discovered that she had suffered a bowel perforation.

Therefore, based on the unique facts of this case, a reasonable jury could conclude that, more likely than not, if plaintiff had been transferred to the ICU sooner, her bowel perforation would have been discovered and treated sooner. The facts of this case show that once the charge nurse became involved, plaintiff was transferred to the ICU and properly diagnosed. Thus, the jury's determination that the nurses' [*24] failure to follow the standard of care proximately caused plaintiff's injuries was not based on mere speculation, but rather on events that actually occurred. Plaintiff's circumstantial evidence facilitated a reasonable inference of causation based on established facts as discussed in *Skinner*, 445 Mich at 164. To the extent that it may be argued that plaintiff's transfer to the ICU was a result of the severity of her condition at the time of her transfer and that she would not have been transferred sooner if the nurses had implemented the chain of command, this question is a factual determination for the jury to make. The jury obviously believed that the nurses' conduct and failure to adhere to the standard of care resulted in plaintiff's delayed diagnosis and treatment. Plaintiff presented substantial evidence to support that determination.

IV. NURSE MCCALLUM'S PROXIMATE CAUSE TESTIMONY

Oaklawn next argues that the trial court erred by admitting nurse McCallum's expert testimony regarding proximate cause. "[T]his Court reviews a trial court's rulings concerning the qualifications of proposed expert witnesses to testify for an abuse of discretion." *Woodard v Custer*, 476 Mich 545, 557; 719 NW2d 842 (2006). [*25] "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." *Id.*

In a medical malpractice action, a plaintiff must establish proximate causation between the breach of the standard of care and the plaintiff's injuries. *Craig*, 471 Mich at 86, 90. Expert testimony is essential to establish this causal link. *Pennington v Longabaugh*, 271 Mich App 101, 104; 719 NW2d 616 (2006).

Oaklawn argues that the trial court erred by allowing McCallum to offer proximate cause testimony because she is a registered nurse who does not engage in the practice of medicine and, therefore, does not have the training, experience, skill, knowledge, or

education to offer such testimony under MRE 702.² Oaklawn relies on Cox v Flint Bd of Hosp Managers, 467 Mich 1, 19; 651 NW2d 356 (2002), in which our Supreme Court held that “[n]urses do not engage in the practice of medicine.” The Court relied in part on former MCL 333.17001(1)(d), which defined “[p]ractice of medicine” as

the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition, by attendance, advice, device, diagnostic [*26] test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts.³ [*Id.* at 19-20.]

Because McCallum’s challenged testimony did not involve the practice of medicine, the trial court did not abuse its discretion by admitting it. McCallum testified as follows:

Q. Based on your review of the materials in this case, Nurse McCallum, was there any effort to communicate the bandemia or the elevated bands on that blood test on the evening of July 21 to the doctor who ordered them, that would be Dr. Walker?

A. No, there was [*27] no effort.

Q. And what did the standard of care require that nurse on duty to do, I believe it was Nurse Dunithan, when the blood test results came back showing the elevated bands? What did the standard of care require?

A. The standard of care required that the nurse call the physician that ordered the test and report the results, especially if there are abnormal values in the lab results.

Q. And would that be nursing negligence, in your opinion?

A. Yes.

Q. We are going to follow this particular issue through in terms of what happened with the issue of the bands and so forth as the patient progressed or didn’t progress in her post-operative course.

² 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.

³ The identical definition is now provided in MCL 333.17001(1)(f).

* * *

Q. Did the failure to report the bands cause some problem with this patient's outcome?

A. Yes.

Q. And what effect did it have on her outcome, the failure to report the bands that evening?

A. The conduct of the nurse that failed to report the lab results to the doctor was in violation of the standard of conduct that is expected of nurses. And what that means is, the failure to report pertinent information such as this and other things, and failure to collaborate, can result in a significant delay in treatment.

Q. Is that what happened here?

A. [*28] Yes.

Thus, McCallum testified that the nurse's failure to adhere to the standard of care resulted in a significant *delay* in treatment. McCallum did not testify regarding plaintiff's ultimate diagnosis or treatment, matters specifically reserved for the practice of medicine. Oaklawn argues that in order for McCallum to testify that the nurse's actions affected the timing of plaintiff's diagnosis, she necessarily had to have the knowledge, skill, and training to make the diagnosis. We disagree. It is undisputed that plaintiff suffered from a perforated bowel, a condition that progressively becomes worse the longer that it remains undiagnosed. Thus, it was not necessary that McCallum have the knowledge and training to diagnose the condition in order to testify that the nurse's actions led to a delay in diagnosis and treatment.

Oaklawn also relies on *Snelson v Kamm*, 319 Ill App 3d 116; 745 NE2d 128 (2001), aff'd in part & rev'd in part 204 Ill 2d 1 (2003), in support of its argument that McCallum was not qualified to offer proximate cause testimony between the nursing staff's breach of the standard of care and the delay in diagnosis and surgery. In that case, McCallum testified that "the [*29] failure to follow the nursing process increases the likelihood of an unfavorable outcome." *Id. at 126*. McCallum declined to offer an opinion regarding what ultimately caused the plaintiff's injury, stating that she "would leave that for 'medicine to decide.'" *Id.* Thus, McCallum acknowledged that she did not possess the medical knowledge to form an opinion regarding proximate cause in that case. *Id. at 130*. Here, it is undisputed that the bowel perforation ultimately caused plaintiff's injury. McCallum's testimony pertained to the delay in diagnosing and treating the injury as a result of the negligence of Oaklawn's nursing staff rather than the ultimate cause of the injury itself. Because this matter was within McCallum's expertise, the trial court did not abuse its discretion by admitting the testimony. In any

event, as previously discussed, plaintiff presented other expert witness testimony establishing proximate cause between the nursing negligence and her injuries.

V. TRADITIONAL MALPRACTICE VS. LOST OPPORTUNITY

Oaklawn next argues that the trial court erred by denying its motions for a directed verdict and JNOV because plaintiff failed to present evidence that she suffered a greater [*30] than 50 percent opportunity for a better result. Thus, Oaklawn asserts that plaintiff alleged a loss of opportunity claim rather than a traditional medical malpractice claim.

MCL 600.2912a(2) provides:

In an action alleging medical malpractice, the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants. In an action alleging medical malpractice, the plaintiff cannot recover for loss of an opportunity to survive or an opportunity to achieve a better result unless the opportunity was greater than 50%.

In Fulton v William Beaumont Hosp, 253 Mich App 70, 84; 655 NW2d 569 (2002), overruled by O'Neal v St. John Hosp & Med Ctr, 487 Mich 485; 791 NW2d 853 (2010), this Court held that, in order to satisfy the second sentence of § 2912a(2), a plaintiff must show that the defendant's malpractice resulted in a loss of opportunity greater than 50 percent. The plaintiff in *Fulton* alleged that the defendants' failure to properly diagnose and treat her resulted in a loss of opportunity to survive. Fulton, 253 Mich App at 73.

In Stone v Williamson, 482 Mich 144, 147; 753 NW2d 106 (2008), our [*31] Supreme Court addressed the *Fulton* Court's interpretation of § 2912a(2). In the lead opinion, Chief Justice Taylor opined that the two sentences in § 2912a(2) create a paradox by allowing claims under the second sentence that are precluded by the first. Id. at 157 (TAYLOR, C.J.) He determined that the second sentence is incomprehensible and unenforceable and that this Court's interpretation of the sentence in *Fulton* is no longer good law. Id. at 161-162. However, Chief Justice Taylor determined that a new trial was unnecessary because, regardless of the jury's finding with respect to lost opportunity, the jury determined that the traditional elements of medical malpractice, set forth in the first sentence of § 2912a(2), had been met. Id. at 162-163. Justices Corrigan and Young concurred with Chief Justice Taylor. Id. at 165. Although Justices Cavanagh, Weaver, and Kelly agreed that *Stone* involved a traditional medical malpractice claim, they did not agree that the second sentence of § 2912a(2) is incomprehensible and unenforceable. Id. at 165, 185 (CAVANAGH, J.). Likewise, Justice Markman determined that the "lost

opportunity" provision of § 2912a(2) is enforceable, but he opined that [*32] the case presented a lost opportunity claim rather than a traditional medical malpractice claim. *Id. at 185-187.* (MARKMAN, J.).

Recently in *O'Neal*, our Supreme Court revisited this Court's decision in *Fulton* and issued another plurality opinion. In *O'Neal*, the plaintiff suffered from acute chest syndrome ("ACS"), a complication of sickle cell anemia. The plaintiff alleged that he suffered a stroke as a result of the defendants' failure to timely perform a blood transfusion or exchange transfusion. His complaint alleged a traditional medical malpractice claim rather than a lost opportunity claim. *O'Neal, 487 Mich at 491* (HATHAWAY, J.) Notwithstanding, the defendants moved for summary disposition, arguing that both sentences of § 2912a(2) controlled and that the plaintiff failed to establish a loss of opportunity greater than 50 percent. The plaintiff argued that his experts' testimony showed that he suffered injuries that were, more probably than not, proximately caused by the defendants' negligence. *Id. at 492.* The trial court agreed and denied the defendants' motion. *Id.* On appeal, this Court relied on *Fulton* and held that the plaintiff had alleged a lost opportunity claim and that [*33] he failed to establish his burden of proof. *Id.*

Our Supreme Court granted leave to appeal in *O'Neal*, directing the parties to address, inter alia, "whether the requirements set forth in the second sentence of *MCL 600.2912a(2)* apply in this case[.]" *O'Neal, 487 Mich at 493.* Writing the lead opinion, Justice Hathaway, joined by Justice Weaver, recognized that the first sentence of § 2912a(2) states the well-established rule for proving proximate causation in medical malpractice claims. *Id. at 494, 507.* She further stated:

Thus, the burden of proof for proximate causation in traditional medical malpractice cases is analyzed according to its historical common law definitions and the analysis is the same as in any other ordinary negligence claim. Nothing in this opinion changes or alters these well-settled principles. [*Id. at 497.*]

Justice Hathaway next considered whether this Court erred by relying on *Fulton* and applying the second sentence of § 2912a(2) to the plaintiff's claims. *Id. at 497.* She opined that the second sentence of § 2912a(2) clearly applies to loss of opportunity cases based on its plain language and that it does not apply to traditional malpractice cases. Justice Hathaway [*34] then stated that because this Court relied on *Fulton*, "which erroneously applied the second sentence to a traditional malpractice case," it was necessary to determine if *Fulton* has any continuing validity. *Id. at 498* (emphasis added). Justice Hathaway proceeded to analyze the test that this Court applied in *Fulton* and concluded that "*Fulton's* simple subtraction analysis is wrong and unsupportable." *Id. at 504.* She further opined that the incorrect *Fulton* mathematical formula "is being

used to transform the burden of proof in traditional malpractice cases.” Finally, Justice Hathaway concluded that “the second sentence of § 2912a(2) applies only to medical malpractice cases that plead loss of opportunity and not to those that plead traditional medical malpractice; we do not address the scope, extent, or nature of loss-of-opportunity claims as that issue is not before us.”⁴ *Id. at 506.*

In determining that *O’Neal* involved a traditional medical malpractice claim rather than a lost opportunity claim, Justice Hathaway offered little analysis. She recognized that the plaintiff suffered a stroke and that his claim was thus for an actual injury rather than the mere possibility of an injury. *O’Neal, 487 Mich at 503.* She further stated:

Plaintiff’s injury is no longer a statistical probability, it is a reality. The focus, once he was injured, is on the connection between defendants’ conduct and the injury. The relevant inquiry for proximate causation is whether the negligent conduct was a cause of plaintiff’s injury and whether plaintiff’s injury was a natural and probable result of the negligent conduct. [*Id.*]

Justice [*36] Cavanagh, joined by Chief Justice Kelly, concurred in the result. He opined that this Court erred by treating the case as a lost opportunity case rather than a traditional medical malpractice action and thus determined that the second sentence of § 2912a(2) was inapplicable. *O’Neal, 487 Mich at 507 (CAVANAGH, J.)* He further stated that *Fulton* should be overruled “to the extent that courts have relied on it to improperly transform what could be traditional medical malpractice claims into loss-of-opportunity claims.” *Id.* Regarding the first sentence of § 2912a(2), Justice Cavanagh stated, “I would hold that this threshold is met if the plaintiff can show that the alleged negligence was responsible for a majority, or ‘more than fifty percent,’ of the risk of the bad result occurring.” *Id. at 509.*

Finally, Justices Markman and Young, joined by Justice Corrigan, concluded that *O’Neal* presented a lost opportunity claim rather than a traditional medical malpractice claim. *O’Neal, 487 Mich at 515 (MARKMAN, J.); Id. at 549 (YOUNG, J.)*. Thus, although a majority of Justices believed that *O’Neal* involved a traditional medical malpractice case, the reasons for their determination were not discussed [*37] at any length and *O’Neal* did not set forth a new test for determining whether a claim presents a traditional malpractice or a lost opportunity claim.

⁴ Justice Hathaway offered no reasoning for her determination that *Fulton* involved a traditional medical malpractice claim rather than a lost opportunity claim. In *Fulton, 253 Mich App at 73*, the plaintiff alleged in her complaint that the defendants’ failure to properly diagnose and treat her resulted in [*35] a loss of opportunity to survive. This Court clearly regarded the plaintiff’s claim as one asserting loss of opportunity and therefore examined the second sentence of § 2912a(2) in deciding that case. *Id. at 77-84.* Because Justice Hathaway opined that *O’Neal* involved a traditional medical malpractice claim rather than a lost opportunity claim, her examination of this Court’s analysis in *Fulton*, which was based on the second sentence of § 2912a(2), is arguably dicta.

As previously recognized, six Justices in *Stone* agreed that that case involved a claim alleging traditional medical malpractice rather than lost opportunity. *Stone*, 482 Mich at 162-163 (TAYLOR, C.J.), 165 (CAVANAGH, J.) As Chief Justice Taylor recognized, "'This theory [i.e., loss of opportunity] is potentially available in situations where a plaintiff cannot prove that a defendant's actions were the cause of his injuries, but can prove that the defendant's actions deprived him of a chance to avoid those injuries.'" *Stone*, 482 Mich at 152 (TAYLOR, C.J.), quoting *Vitale v Reddy*, 150 Mich App 492, 502; 389 NW2d 456 (1986), vacated 430 Mich 894 (1988). In *Stone*, the plaintiff suffered an abdominal aortic aneurysm that was undetected despite examinations and testing. *Id.* at 147. He underwent emergency surgery to repair the rupture, but he suffered complications and ultimately required amputation of both of his legs at mid-thigh. *Id.* at 148.

In *Taylor v Kent Radiology, PC*, 286 Mich App 490, 494; 780 NW2d 900 (2009), the injured plaintiff fell [*38] and fractured his foot. Following x-rays, he was informed that his foot was not broken but was merely sprained. *Id.* at 495-496. Several months later, following another x-ray, he was advised that his foot was broken. *Id.* at 496. In his complaint, the plaintiff alleged that the first radiologist violated the standard of care by failing to properly review and interpret his x-rays, which caused his fracture to remain undiagnosed and untreated, requiring extensive surgical intervention. *Id.* at 507-508. This Court stated that it was evident from the plaintiff's complaint that he alleged a traditional malpractice action and that the complaint contained no reference to a loss of opportunity to achieve a better result. This Court recognized that the plaintiff alleged that the radiologist breached the standard of care, which proximately caused a worsening of his fracture. *Id.* at 508.

In *Shivers v Schmiede*, 285 Mich App 636, 638; 776 NW2d 669 (2009), the 70-year-old plaintiff was admitted to the hospital to have his bladder removed. Complications occurred during the surgery, and a nurse reported weakness in both of his hands following the surgery. Later that evening, a nurse noted that the plaintiff's [*39] left arm and hand were normal but that his right arm was abducting, or involuntary moving up and away from his torso. His condition did not improve throughout the night, and he lost sensation in both of his hands by midnight. By 3:47 a.m., he had lost feeling in both arms and was unable to move his fingers. *Id.* Later that morning, doctors discovered that the plaintiff could not move his left arm and that his right arm evidenced significant neurological difficulties. Doctors performed an emergency decompressive cervical laminectomy, but by that time the plaintiff had already lost most of the use of his hands and arms. Thereafter, he required a significant level of care. *Id.* at 639. This Court determined that the case involved a traditional medical malpractice claim rather than a loss of opportunity claim. *Id.* at 640.

This case is very similar to *Shivers* in that plaintiff underwent surgery and thereafter experienced complications that required a second surgery. In *Shivers*, 285 Mich App at 641, this Court opined from the evidence that an earlier surgical procedure would have helped the plaintiff's condition. Likewise, in this case, if plaintiff had undergone surgery to correct the bowel [*40] perforation sooner, the effects of the perforation would not have been as injurious and she would not have suffered as severely. This is not a situation where, as Chief Justice Taylor stated in *Stone*, 482 Mich at 152, the plaintiff was unable to prove that the defendant's actions caused her injuries but was able to prove that they deprived her of a chance to avoid her injuries. As previously discussed, plaintiff presented sufficient evidence for the jury to determine that, but for the nurses' conduct, she more likely than not would have been diagnosed and undergone surgery sooner. Moreover, plaintiff did not allege in her complaint the loss of an opportunity to obtain a better result. In any event, Oaklawn admits that plaintiff withdrew the loss of opportunity theory during trial and that the jury was not instructed on that theory. Accordingly, this case involves a traditional medical malpractice claim rather than a loss of opportunity claim. The trial court did not err by denying Oaklawn's motion for a directed verdict or JNOV on this basis.

VI. SPOILIATION OF EVIDENCE

Oaklawn next argues that the trial court erred by admitting evidence regarding the alteration and spoliation of a medical [*41] record and by instructing the jury in this regard. Specifically, Oaklawn challenges the admission of McCallum's testimony regarding a discrepancy on one page of plaintiff's hospital record. Because Oaklawn did not object to the testimony regarding the discrepancy, this issue is not preserved for our review. We review unpreserved issues for plain error affecting substantial rights. To avoid forfeiture, a party must show that an error occurred, that it was plain, i.e., clear or obvious, and that it affected substantial rights. *Kern v Blethen-Coluni*, 240 Mich App 333, 336; 612 NW2d 838 (2000).

The admission of McCallum's testimony regarding the discrepancy between the medical records did not constitute plain error. McCallum merely testified that there was indeed a discrepancy between the two records and that it was "a big change." The two records were admitted as evidence and the jury was able to observe the discrepancy between the records firsthand. Moreover, the testimony reflected only 1-1/2 transcript pages of trial testimony in a trial that lasted more than 14 days. As the trial court observed, "This is a mountain out of a mole hill, I know. There are two numbers on two pieces of [*42] paper out of the thousands of sheets out of all the testimony of the experts[.]" Thus, Oaklawn has not established a plain error regarding the admission of McCallum's testimony. Although Oaklawn also contends that the trial court erred by admitting

McCallum's testimony regarding a hospital's obligation to preserve a patient's original medical record, the trial court sustained Oaklawn's objection to that question and McCallum did not answer it.

Oaklawn also argues that the trial court erred by instructing the jury in accordance with statutory law pertaining to the destruction of medical records. We review for an abuse of discretion a trial court's determination whether a jury instruction is applicable to the facts of a case. *Bordeaux v Celotex Corp.*, 203 Mich App 158, 168-169; 511 NW2d 899 (1993).

The trial court instructed the jury nearly verbatim on the following portions of *MCL 333.20175*:

(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization. . . . [A] health facility or agency shall [*43] keep and retain each record for a minimum of 7 years from the date of service to which the record pertains. A health facility or agency shall maintain the records in such a manner as to protect their integrity, to ensure their confidentiality and proper use[.]. . . A health facility or agency may destroy a record that is less than 7 years old only if both of the following are satisfied:

(a) The health facility or agency sends a written notice to the patient at the last known address of that patient informing the patient that the record is about to be destroyed, offering the patient the opportunity to request a copy of that record, and requesting the patient's written authorization to destroy the record.

(b) The health facility or agency receives written authorization from the patient or his or her authorized representative agreeing to the destruction of the record. Except as otherwise provided under federal or state laws and regulations, records required to be maintained under this subsection may be destroyed or otherwise disposed of after being maintained for 7 years. If records maintained in accordance with this section are subsequently destroyed or otherwise disposed of, those records [*44] shall be shredded, incinerated, electronically deleted, or otherwise disposed of in a manner that ensures continued confidentiality of the patient's health care information and any other personal information relating to the patient. . . .

(2) A hospital shall take precautions to assure that the records required by subsection (1) are not wrongfully altered or destroyed. . . .

The trial court further instructed the jury regarding the definition of "medical record"

and "record" set forth in MCL 333.20175a(5), which provides:

As used in this section:

(a) "Medical record" or "record" means information, oral or recorded in any form or medium, that pertains to a patient's health care, medical history, diagnosis, prognosis, or medical condition and that is maintained by a licensee in the process of providing medical services.

Further, the trial court instructed the jury nearly verbatim regarding MCL 750.492a, which provides:

(1) Except as otherwise provided in subsection (3), a health care provider or other person, knowing that the information is misleading or inaccurate, shall not intentionally, willfully, or recklessly place or direct another to place in a patient's medical record or chart misleading [*45] or inaccurate information regarding the diagnosis, treatment, or cause of a patient's condition. A violation of this subsection is punishable as follows:

(a) A health care provider who intentionally or willfully violates this subsection is guilty of a felony.

(b) A health care provider who recklessly violates this subsection is guilty of a misdemeanor, punishable by imprisonment for not more than 1 year, or a fine of not more than \$1,000.00, or both.

(d) A person other than a health care provider who recklessly violates this subsection is guilty of a misdemeanor.

(2) Except as otherwise provided in subsection (3), a health care provider or other person shall not intentionally or willfully alter or destroy or direct another to alter or destroy a patient's medical records or charts for the purpose of concealing his or her responsibility for the patient's injury, sickness, or death. A health care provider who violates this subsection is guilty of a felony. A person other than a health care provider who violates this subsection is guilty of a misdemeanor punishable by imprisonment for not more than 1 year, or a fine of not more than \$1,000.00, or both.

(3) Subsections (1) and (2) do not apply [*46] to either of the following:

(a) Destruction of a patient's original medical record or chart if all of the information contained in or on the medical record or chart is otherwise retained by means of mechanical or electronic recording, chemical reproduction, or other equivalent techniques that accurately reproduce all of the information contained

in or on the original or by reproduction pursuant to the records media act that accurately reproduces all of the information contained in or on the original.

(b) Supplementation of information or correction of an error in a patient's medical record or chart in a manner that reasonably discloses that the supplementation or correction was performed and that does not conceal or alter prior entries.

(4) This section does not create or provide a basis for a civil cause of action for damages.

(c) A person other than a health care provider who intentionally or willfully violates this subsection is guilty of a misdemeanor, punishable by imprisonment for not more than 1 year, or a fine of not more than \$1,000.00, or both.

The statutes do not favor either plaintiff or Oaklawn. They do not require Oaklawn to maintain original copies of records, but rather [*47] allow Oaklawn to store records "in any form or medium." Moreover, no evidence was presented that Oaklawn's personnel willfully and intentionally recorded inaccurate information or destroyed plaintiff's records for the purpose of concealing responsibility for her injuries. Rather, the facts show that plaintiff's original record was destroyed after being preserved in electronic form, which is permitted under MCL 750.492a(3)(a) if the record is accurately reproduced. It appears that the discrepancy between the two records is the likely result of one copy simply being clearer and easier to read than the other. Thus, the jury could have easily determined that the record was accurately reproduced in electronic form. Moreover, as previously discussed, the statutory law is irrelevant to the issues that the jury was asked to determine and indicate on the verdict form. In any event, it is incomprehensible that the discrepancy regarding the single blood pressure entry would have affected the jury's decision in light of the extensive evidence presented during trial. Accordingly, even if the trial court abused its discretion by instructing the jury as such, reversal is not warranted.

VII. REBUTTAL [*48] TESTIMONY

Oaklawn next argues that the trial court erred by refusing to admit the rebuttal testimony of forensic document analyst Erich J. Speckin, and by denying its motion for a new trial on this ground. We review a motion for a new trial under the abuse of discretion standard. Hilgendorf v St John Hosp & Med Ctr Corp, 245 Mich App 670 682; 630 NW2d 356 (2001). Similarly, we review for an abuse of discretion a trial court's decision whether to admit rebuttal testimony. Winiemko v Valenti, 203 Mich App 411, 418; 513 NW2d 181 (1994).

Rebuttal evidence must relate to a substantive rather than a collateral matter. City of Westland v Okopski, 208 Mich App 66, 72; 527 NW2d 780 (1994). As previously

discussed, the purported testimony pertained to a collateral matter rather than a substantive matter. The trial court appropriately recognized that the discrepancy involved “two numbers on two pieces of paper out of the thousands of sheets” and that the impact on the jury would be “infinitesimal at best.” The trial court further indicated that it would not conduct a “trial within a trial” regarding the issue. Because the matter involved a collateral matter and was not particularly relevant to [*49] the jury’s determination considering the overall evidence presented, the trial court did not abuse its discretion by refusing to admit Speckin’s testimony. The trial court also properly denied Oaklawn’s motion for a new trial on this basis.

VIII. REDUCTION OF PAST MEDICAL EXPENSES

Oaklawn next contends that the trial court erred by refusing to reduce plaintiff’s award of past medical expenses to the amount actually paid on her behalf. We review de novo as a question of law a trial court’s interpretation and application of MCL 600.6303, the collateral source rule. *Shivers*, 285 Mich App at 653.

Oaklawn argues that the trial court erred by failing to apply the collateral source rule⁵ to reduce plaintiff’s \$450,000 award for past medical expenses to \$325,441.47, the amount of medical expenses actually paid by plaintiff’s health insurers. This argument lacks merit.

MCL 600.6303 provides, in relevant part:

(1) In a personal injury action in which the plaintiff seeks to recover for the expense of medical care . . . evidence to establish that the expense or loss was paid or is payable, in whole or in [*50] part, by a collateral source shall be admissible to the court in which the action was brought after a verdict for the plaintiff and before a judgment is entered on the verdict. Subject to subsection (5), if the court determines that all or part of the plaintiff’s expense or loss has been paid or is payable by a collateral source, the court shall reduce that portion of the judgment which represents damages paid or payable by a collateral source by an amount equal to the sum determined pursuant to subsection (2). This reduction shall not exceed the amount of the judgment for economic loss or that portion of the verdict which represents damages paid or payable by a collateral source.

* * *

(3) Within 10 days after a verdict for the plaintiff, plaintiff’s attorney shall send notice of the verdict by registered mail to all persons entitled by contract to a lien against the proceeds of plaintiff’s recovery. If a contractual lien holder does not

⁵ Although Oaklawn uses the term “remittitur,” it cites MCL 600.6303, the collateral source rule.

exercise the lien holder's right of subrogation within 20 days after receipt of the notice of the verdict, the lien holder shall lose the right of subrogation. . . .

(4) As used in this section, "collateral source" means benefits received or receivable [*51] from an insurance policy *Collateral source does not include benefits paid or payable by a person, partnership, association, corporation, or other legal entity entitled by contract to a lien against the proceeds of a recovery by a plaintiff in a civil action for damages, if the contractual lien has been exercised pursuant to subsection (3).* [Emphasis added.]

In *Zdrojewski v Murphy*, 254 Mich App 50, 59; 657 NW2d 721 (2002), the plaintiff was awarded \$256,678 in past economic damages. The plaintiff's health care insurers paid more than \$88,000 of her medical expenses, but claimed liens against the plaintiff's judgment totaling less than \$30,000. *Id. at 68, 70*. Relying on the last sentence of *MCL 600.6303(4)*, emphasized above, this Court opined that the collateral source rule does not encompass a situation in which a lienholder exercises a lien, but for less than the amount that the lienholder is entitled to recover. This Court held that "[b]ecause the statute clearly states that benefits subject to an exercised lien do not qualify as a collateral source," and because the insurers exercised liens, the insurance benefits did not constitute a collateral source under *MCL 600.6303(4)*. [*52] *Id. at 70*.

Nothing meaningfully distinguishes this case from *Zdrojewski*. Thus, under *MCL 600.6303*, as interpreted in *Zdrojewski*, the trial court did not err by declining to reduce the jury's past medical expenses award by \$124,558.53.

Oaklawn also argues that the trial court erred by refusing to exercise its powers of remittitur under *MCL 600.6098* and *MCR 2.611(E)* to reduce the past medical expenses award to the value of expenses paid. Although plaintiff contends that Oaklawn waived appellate review of this argument by failing to file a motion for remittitur in the trial court, we will review this issue because Oaklawn's substantive argument in opposition to plaintiff's motion for entry of judgment in the trial court was sufficient to raise this issue. We review for an abuse of discretion a trial court's decision on a motion for remitter. *Unibar Maintenance Servs, Inc v Saigh*, 283 Mich App 609, 629; 769 NW2d 911 (2009).

"The power of remittitur should be exercised with restraint." *Shaw v City of Ecorse*, 283 Mich App 1, 17; 770 NW2d 31 (2009). *MCR 2.611(E)(1)*⁶ governs remittitur, which is justified only if the jury's verdict is excessive, or greater than the highest amount that

⁶ *MCR 2.611(E)(1)*, pertaining to remittitur and additur, provides:

If the court finds that the only error in the trial is the inadequacy or excessiveness of the verdict, it may deny a motion for new trial on condition that within 14 days the nonmoving party consent in writing to the entry of judgment in an amount

the evidence [*53] will support. *Heaton v Benton Constr Co*, 286 Mich App 528, 539; 780 NW2d 618 (2009). "If the award falls reasonably within the range of the evidence and within the limits of what reasonable minds would deem just compensation, it should not be disturbed." *Shaw*, 283 Mich App at 17. This Court reviews the evidence in the light most favorable to the nonmoving party. *Id.*

Here, the evidence supported the jury's award for past medical expenses in the amount of \$450,000. Plaintiff testified that she incurred costs of approximately \$450,000 for her medical care. James Marsh, with whom plaintiff lived, testified that plaintiff's medical expenses totaled \$446,463.85. Oaklawn failed to [*54] challenge this testimony during trial. Because the jury did not award past medical expenses in an amount greater than the highest amount supported by the evidence, the trial court did not abuse its discretion by denying remittitur.

IX. CASE EVALUATION SANCTIONS (DOCKET NO. 290147)

Oaklawn next argues that the trial court erred by awarding plaintiff case evaluation sanctions. We disagree. Oaklawn asserts that the trial court erred by failing to apply the noneconomic damages cap to the jury's verdict in determining whether plaintiff is entitled to case evaluation sanctions. The language of MCR 2.403(O)(3) fails to support Oaklawn's argument. That provision states that, for purposes of determining whether a party is entitled to case evaluation sanctions under MCR 2.403(O)(1), that

a verdict must be adjusted by adding to it assessable costs and interest on the amount of the verdict from the filing of the complaint to the date of the case evaluation, and, if applicable, by making the adjustment of future damages as provided by MCL 600.6306. After this adjustment, the verdict is considered more favorable to a defendant if it is more than 10 percent below the evaluation, and is considered more [*55] favorable to the plaintiff if it is more than 10 percent above the evaluation. If the evaluation was zero, a verdict finding that a defendant is not liable to the plaintiff shall be deemed more favorable to the defendant.

Nothing in this provision requires that a verdict be adjusted to apply the noneconomic damages cap and Oaklawn fails to identify any authority requiring such an adjustment. In any event, even if the noneconomic damages cap is applied, plaintiff is entitled to case evaluation sanctions as discussed below.

Oaklawn also argues that the trial court erred by failing to reduce plaintiff's past medical expenses to the amount actually paid for purposes of determining plaintiff's entitlement

found by the court to be the lowest (if the verdict was inadequate) or highest (if the verdict was excessive) amount the evidence will support.

MCL 600.6098(2)(d) is substantially similar to MCR 2.611(E)(1).

to case evaluation sanctions. As previously discussed, the trial court did not err by refusing to reduce plaintiff's past medical expenses to the amounts paid. Because Oaklawn was not entitled to such an adjustment with respect to the judgment, it was likewise not entitled to the adjustment regarding the verdict for purposes of determining case evaluation sanctions.

Oaklawn's primary argument is that the trial court erred by refusing to consider Oaklawn's percentage of fault in comparison [*56] to that of Dr. Bartlett. The jury determined that Oaklawn was 15 percent at fault and that Dr. Bartlett was 85 percent at fault for plaintiff's injuries. Thus, Oaklawn contends that, in determining whether to award case evaluation sanctions, the trial court should have compared the case evaluation against Oaklawn in the amount of \$175,000 to only 15 percent of the verdict. Oaklawn's argument lacks merit. MCR 2.403(O)(4) provides, in relevant part:

(a) Except as provided in subrule (O)(4)(b), in determining whether the verdict is more favorable to a party than the case evaluation, the court shall consider only the amount of the evaluation and verdict as to the particular pair of parties, rather than the aggregate evaluation or verdict as to all parties. However, costs may not be imposed on a plaintiff who obtains an aggregate verdict more favorable to the plaintiff than the aggregate evaluation.

(b) *If the verdict against more than one defendant is based on their joint and several liability, the plaintiff may not recover costs unless the verdict is more favorable to the plaintiff than the total case evaluation as to those defendants, and a defendant may not recover costs unless the verdict [*57] is more favorable to that defendant than the case evaluation as to that defendant. [Emphasis added.]*

Here, because plaintiff was without fault, Oaklawn and Dr. Bartlett are jointly and severally liable pursuant to MCL 600.6304(6)(a). Thus, subrule (O)(4)(b) applies in this case. Because the jury's verdict in excess of \$3.6 million is more favorable to plaintiff than the total case evaluation against Oaklawn and Dr. Bartlett in the amount of \$525,000, plaintiff is entitled to sanctions under subrule (O)(4)(b). Even assuming for the sake of argument that the noneconomic damages cap should have been applied to the jury verdict as Oaklawn argues, the verdict would still be more favorable to plaintiff than the total case evaluation against Oakland and Dr. Bartlett. The noneconomic damages cap was applied to the judgment, which exceeds \$1.2 million. That number is more than ten percent higher than Oaklawn and Dr. Bartlett's combined case evaluation of \$525,000. Accordingly, the trial court properly awarded plaintiff case evaluation sanctions against Oaklawn.

Affirmed.

/s/ E. Thomas Fitzgerald

/s/ David H. Sawyer

/s/ Henry William Saad

No Shepard's Signal™

As of: March 6, 2015 10:24 AM EST

Rocha v. Better Built Mfg.

Court of Appeals of Michigan

June 21, 2011, Decided

No. 297090

Reporter

2011 Mich. App. LEXIS 1111; 2011 WL 2464191

GLORIA ROCHA, Plaintiff-Appellant, v BETTER BUILT MANUFACTURING, INC., and ROY PETERSON, Defendants-Appellees.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Prior History: [*1] Montcalm Circuit Court. LC No. 09-011528-NP.

Core Terms

economic damages, trial court, damages, workers' compensation benefits, offset, pain and suffering, medical expenses, valid lien, Manufacturing, comprise, expenses, proofs, uncontroverted evidence, workers' compensation, collateral source, awarding damages, reasonable basis, clear error, wage loss, demonstrating, out-of-pocket, computation, noneconomic, replacement, contends, definite, amounts, ignores, machine, vacate

Judges: Before: TALBOT, P.J., and GLEICHER and M. J. KELLY, JJ.

Opinion

PER CURIAM.

Gloria Rocha challenges the trial court's failure to award her any economic damages in her judgment against Better Built Manufacturing, Inc. and Roy Peterson for the serious injuries she incurred while their employee. We vacate and remand.

Rocha was injured at work when her sweatshirt sleeve caught on the conveyor of a potato seed cutting machine. Rocha's arm was pulled into the machinery, resulting in a below the elbow amputation. Rocha sued both Better Built Manufacturing, Inc. and its president Roy Peterson because both were involved in manufacturing the allegedly

defective machine. Neither Peterson nor Better Built filed an answer and a default judgment was entered. A hearing was conducted regarding Rocha's damages, and the trial court ultimately awarded her \$1.5 million for pain and suffering along with interest and costs for a total judgment of \$1,542,188.55. The judgment indicated that the trial court awarded Rocha no economic damages. Rocha contends that the trial court erred by ignoring the uncontroverted evidence of her economic damages in determining an award.

We review [*2] the damage award in a bench trial for clear error.¹ "Clear error exists where, after a review of the record, the reviewing court is left with a firm and definite conviction that a mistake has been made."² "A party asserting a claim has the burden of proving its damages with reasonable certainty," but "damages are not speculative merely because they cannot be ascertained with mathematical precision."³ Approximate amounts are sufficient to constitute a reasonable basis for damage computation.⁴

Rocha submitted evidence of economic damages, including wage loss, medical expenses to date, future medical expenses, and future prosthesis replacement expenses. The evidence consisted of Rocha's testimony, figures calculated by the worker's compensation insurer, deposition testimony of her treating physician, expert opinions, and information obtained from online sources. Rocha testified that she was unable to perform many tasks, would not be able to return to her former job, and that she experiences pain and psychological [*3] problems as a result of the injury. Evidence was provided demonstrating that Rocha's prosthetic arm will require periodic replacement and that she will likely be involved in therapy for the remainder of her life. Neither Peterson nor Better Built challenged Rocha's proofs.

We find it difficult to reconcile the trial court's acknowledgment regarding Rocha's proofs with its ruling declining to enter an award for economic damages. When a verdict ignores uncontroverted damages the verdict is deemed to be inadequate and must be reversed.⁵ On the record before us, we find that Rocha submitted adequate proofs to provide a reasonable basis for computation of her current and future economic damages. The failure of the trial court to award such damages constituted error.⁶

It would appear that the trial court omitted an award of economic damages based on Rocha's indication that she was the recipient of worker's compensation benefits.

¹ *Marshall Lasser, PC v George*, 252 Mich App 104, 110; 651 NW2d 158 (2002).

² *Id.* (citation omitted).

³ *Hofmann v Auto Club Ins Ass'n*, 211 Mich App 55, 108; 535 NW2d 529 (1995).

⁴ *Id.*

⁵ *Bosak v Hutchinson*, 422 Mich 712, 732; 375 NW2d 333 (1985), overruled in part on other grounds *DeShambo v Nielsen*, 471 Mich 27, 40; 684 NW2d 332 (2004).

⁶ *Marshall Lasser, PC*, 252 Mich App at 110.

Although Rocha would not be entitled to a double recovery, it is not clear [*4] from the record that an offset of all proven economic damages was either necessary or warranted in this case. As a collateral source, worker's compensation benefits should be offset from a damages award unless the recovery is subject to a valid lien held by the worker's compensation insurance carrier.⁷ While the lower court record lacks any definitive documentation demonstrating whether the worker's compensation benefits received by Rocha were subject a lien, trial counsel and the court both indicated that a valid lien did exist. Assuming the existence of a valid lien, an offset was not permissible.

In addition, we observe that the trial court did not fully comply with statutory requirements⁸ specifying any breakdown and distinction between future and present damages.⁹ The record is also deficient with regard to evidence pertaining to the types of worker's compensation benefits being received by Rocha and the specific amounts.¹⁰ We do find that the trial court erred in failing to award economic damages based on the uncontroverted evidence. If on remand there is verification regarding the existence of a [*5] lien, in accordance with statute, workers compensation benefits do not comprise a collateral source and are not subject to an offset.¹¹

Rocha also contends that the trial court erred because the record clearly demonstrated that the trial court misconstrued and failed to recognize the inherent distinction of what comprises noneconomic and economic damages. While we need not reach this argument based on our determination of other reversible error by the trial court, we note that Rocha premises this argument on the trial court's denial of reconsideration when it indicated that it considered out-of-pocket expenses in the award of pain and suffering damages. As correctly recognized by Rocha, out-of-pocket expenses comprise economic damages while pain and suffering is a noneconomic damage.

We vacate only that portion of the judgment awarding zero economic damages and remand for further [*6] proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Michael J. Talbot

/s/ Elizabeth L. Gleicher

/s/ Michael J. Kelly

⁷ *Heinz v Chicago Rd Investment Co.*, 216 Mich App 289, 296-297; 549 NW2d 47 (1996).

⁸ MCL 600.6306.

⁹ *Campbell v Dep't of Human Servs.*, 286 Mich App 230, 244-245; 780 NW2d 586 (2009).

¹⁰ "Worker's compensation benefits address medical expenses and wage loss, but not 'general damages' or loss of consortium suffered when the injured party is still alive." *Heinz*, 216 Mich App at 305.

¹¹ MCL 600.6306(4).

A Neutral

As of: March 6, 2015 10:24 AM EST

Josephine Wilson v. Keim

Court of Appeals of Michigan

July 24, 2008, Decided

No. 275997, No. 276022, No. 276446

Reporter

2008 Mich. App. LEXIS 1535; 2008 WL 2861665

JOSEPHINE WILSON, as Personal Representative of the ESTATE OF RONALD WILSON, Deceased, Plaintiff-Appellee, v MARY KEIM, CRNA, Defendant-Appellant, and HENRY FORD HEALTH SYSTEM and S. GOVINDASWAMY, M.D., Defendants. JOSEPHINE WILSON, as Personal Representative of the ESTATE OF RONALD WILSON, Deceased, Plaintiff-Appellant, v MARY KEIM, CRNA, Defendant-Appellee, and HENRY FORD HEALTH SYSTEM, HENRY FORD HOSPITAL, and S. GOVINDASWAMY, M.D., Defendants. JOSEPHINE WILSON, as Personal Representative of the ESTATE OF RONALD WILSON, Deceased, Plaintiff-Appellee, v MARY KEIM, CRNA, Defendant-Appellant, and HENRY FORD HEALTH SYSTEM, d/b/a HENRY FORD HOSPITAL, and S. GOVINDASWAMY, M.D., Defendants.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Subsequent History: Appeal denied by *Wilson v. Keim*, 2009 Mich. LEXIS 224 (Mich., Mar. 6, 2009)

Prior History: [*1] Wayne Circuit Court. LC No. 03-330454-NH.

Disposition: Affirmed in part, reversed in part, and remanded for further proceedings in accordance with this opinion. We do not retain jurisdiction.

Core Terms

trial court, standard of care, atropine, patient, costs, reversal, set forth, contends, chart, case-evaluation, anesthesia, damages, cardiac arrest, malpractice, argues, dose, defendant argues, causation, attorney's fees, deposition, breached, economic damages, remittitur, fault, cap, directed verdict motion, collateral source, neostigmine, sanctions, records

Judges: Before: Meter, P.J., Talbot and Servitto, JJ.

Opinion

PER CURIAM.

Defendant Mary Keim (defendant), a certified registered nurse anesthetist (CRNA), appeals as of right from a jury verdict in favor of plaintiff. She raises multiple allegations of error. Plaintiff also appeals, arguing that the trial court erred in (1) applying the lower noneconomic damages cap under MCL 600.1483 and (2) reducing the jury's award of past economic damages. We affirm the finding of liability but vacate certain portions of the award of costs. We also remand this case for a new determination regarding attorney fees and regarding whether the higher noneconomic damages cap applies, and we slightly modify the trial court's ruling concerning the past economic damages.

Plaintiff's decedent, Ronald Wilson, had eye surgery at Henry Ford Hospital on May 29, 2001. He suffered a cardiac arrest during the reversal of his anesthesia, and he died on July 13, 2001, as a result of complications from that cardiac arrest. Plaintiff sued defendant, as well [*2] as Henry Ford Health System and Dr. Sunitha Govindaswamy, M.D., the anesthesiologist. These appeals deal solely with the case against defendant.

The jury found for plaintiff and awarded \$ 500,000 in past economic damages and \$ 2,000,000 in past noneconomic damages. It concluded that defendant was twenty percent at fault for Wilson's death and that Henry Ford and Dr. Govindaswamy were eighty percent at fault. ¹

I

Defendant argues that the trial court should have granted her motion for summary disposition, brought under MCR 2.116(C)(10), because plaintiff failed to bring forth sufficient causation evidence. Specifically, defendant contends that plaintiff's standard-of-care experts offered conflicting reasons for the cause of death.

We review de novo a trial court's grant or denial of summary disposition. Pinckney Community Schools v Continental Casualty Co., 213 Mich. App. 521, 525; 540 N.W.2d 748 (1995). [*3] "A motion for summary disposition may be granted pursuant to MCR 2.116(C)(10) when, except with regard to the amount of damages, there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law." Pinckney Community Schools, *supra* at 525. The moving party has the initial burden of supporting its position that there is no genuine issue of material fact by pointing to

¹ The record reveals that a "percentage of fault" question was submitted to the jury, despite the fact that joint-and-several liability applied in this medical-malpractice case, because of concerns surrounding the eventual payment of insurance benefits by the different defendants' various insurance carriers.

affidavits, depositions, admissions, or other documentary evidence in the record. *Neubacher v Globe Furniture Rentals*, 205 Mich. App. 418, 420; 522 N.W.2d 335 (1994). The burden then shifts to the nonmoving party to show that a genuine issue of material fact does exist. *Id.*

At his deposition, Charles M. Bauman, CRNA, one of plaintiff's expert witnesses, opined that Wilson had a cardiac arrest because of the effects of neostigmine, an anesthesia reversal agent. He stated that "neostigmine can cause a profound and irreversible bradycardia."² He further stated that, based on his review of the record, Wilson did not get "an adequate amount of . . . Robinul, to counteract the neostigmine." He indicated that Wilson had been given 4 milligrams (mgs) of neostigmine and .8 mgs of Robinul [*4] and that he would have given different amounts. Bauman clarified, however, that he did not view it as a breach of the standard of care for defendant to administer 4 mgs of neostigmine and .8 mgs of Robinul. What he did view as a breach was defendant's failure, after Wilson began experiencing bradycardia, to administer a single shot of 1 mg of atropine. Instead, defendant administered two shots of .4 mg of atropine. He stated that "administering fragmented doses of atropine in small amounts can cause a paradoxical reaction to the atropine and [the patient] can have . . . more . . . bradycardia." Bauman testified that he was not critical of defendant for administering morphine.

When asked to describe in what ways defendant breached the standard of care, Bauman stated:

First breach in my opinion is that she failed to manage the anesthetic properly during the . . . surgery. In failing to manage that properly, she didn't keep the patient deep enough, and so that allowed the patient to buck during the anesthetic. That is against the standard of care, especially during an intraocular procedure. I feel . . . in my professional [*5] opinion she failed to manage the reversal of the anesthetic, and more specifically reversal of the neuromuscular blocker, which [resulted in] profound bradycardia and subsequent cardiac arrest.

She failed to use the appropriate anesthetic and paralytic agents during the ocular procedure, and failed to use the appropriate reversal agent . . . atropine in the correct amounts to combat the profound bradycardia. And it is my opinion that she quite likely failed to ventilate the patient for a period of time, which may have compounded the bradycardia. I believe that's it.

As far as causation of injury, Bauman stated, "I think the failure to monitor properly the patient's heart rate after she gave the neostigmine was the critical point." He later elaborated by stating:

² Bradycardia, alternately known as brachycardia, refers to a low heart rate.

I believe what happened, and I base this opinion on what I can see from the chart and the numeric values here on the chart, I believe she reversed the neuromuscular blocker [Nimbex] with neostigmine and Robinul and for some reason failed to pick up - immediately pick up on a rapid[ly] decreasing heart rate.

The following exchange also occurred:

Q. Are you able to give a percentage that more likely than not had 1 milligram been [*6] given to this patient at the time that [defendant] administered the .4 atropine followed by the 3.4 that the outcome would be different?

A. No.

Q. And why is that?

A. Because I don't know what the percentage would be, if there is a percentage. I don't know if there had ever been any studies done on that. All I know is that low doses of atropine cause a paradoxical reaction.

Dr. James Futrell, Jr., M.D., another of plaintiff's experts, offered primarily to establish the negligence of Dr. Govindaswamy and Henry Ford, testified at his deposition that he was critical of the fact that Wilson had been given morphine. He opined that Wilson suffered "a cardiac arrest caused by a preliminary respiratory arrest because he was not ventilated." He stated that morphine itself was not necessarily contraindicated, but

the administration of morphine at that particular time created an . . . additional duty upon the nurse anesthetist and her superior, Dr. Govindaswamy, to monitor and to support this patient's respiration because of the potential for additive respiratory depression.

He stated that Wilson should have been monitored more closely and given breathing support.

When asked whether the administration [*7] of any drugs, besides morphine, contributed to Wilson's problems, he answered:

The drugs that could have interacted along [the] way . . . included . . . the neostigmine [that was] given. Certainly [n]eostigmine is known and, in fact, a very dangerous drug even though we use it commonly for reversal. If you're not aware of the . . . muscarinic effect . . . of [n]eostigmine which is to stimulate the . . . vagus nerve and could cause brachycardia and cardiac arrest.

That's the reason why Robinul . . . is given, to reverse the complicated side effect of [n]eostigmine. So those drugs were all part and were given along in that period

creating some interesting chemistry in a patient who is cold, overventilated, given narcotics and then reversed and then not ventilated.

When asked about the administration of atropine, Dr. Futrell testified:

The [a]tropine in the dose that it was given in - for a patient that's 255 pounds when you have a - a pulse rate of 20 was low. .4 of [a]tropine is probably the lowest initial dosage to be giving any adult patient. In fact, the literature supports evidence that the lower doses of [a]tropine can, in fact, cause paradoxical effects. And, you know, the more appropriate[] [*8] dose for this patient in this particular setting might be one milligram to two milligrams of [a]tropine to reverse what they thought would be the effects of neostigmine.

Dr. Futrell stated that he was critical of the fact that Wilson was given a first dose of only .4 mgs of [a]tropine.

After defendant moved for summary disposition, arguing that plaintiff did not prove causation because Bauman and Dr. Futrell provided conflicting testimony regarding the cause of death, the court denied the motion, stating:

It was defendant Mary Kiem, a certified registered nurse anesthetist or CRNA that [sic] moved for summary disposition. This is a claim that alleges the negligent administration of anesthesia that lead [sic] to the death of the deceased.

Plaintiff of course must prove that the defendant breached the standard of care and that the defendant's negligent conduct caused damage.

Plaintiff must also prove that the opportunity to survive or achieve a better result was reduced by greater than 50 percent because of the malpractice.

Expert testimony in malpractice cases is usually required to prove the breach of the standard of care and causation.

Here, the plaintiff[']s standard of practice expert [*9] Bauman . . . indicated that the deceased suffered cardiac arrest, that the defendant failed to note a decreased heart rate soon enough and administered too low a [dose] of [a]trophine [sic] in an attempt to resuscitate the plaintiff [sic].

Plaintiff's causation expert, Futrell, . . . indicated that the deceased suffered respiratory arrest which was due to the defendant's negligent administration of morphine to an underventilated patient.

The deposition testimony of Bauman [and] Futrell, Bauman at page 50 lines 1 through 7 and Futrell page 103 lines 20 through 25, indicate that the failure to

ventilate the patient contributed to the death. Importantly, causation expert Futrell indicated that that particular failure breached the standard of care.

It is in this respect that the testimony of the 2 experts can and should be harmonized. There are certainly instances wherein their testimony appears contradictory, such will be for a jury to sort out.

Additionally, plaintiff has met her burden that the deceased lost greater than a 50 percent chance of survival as a result of defendant's negligence.

Each of the experts testified that if the appropriate care had been rendered, the patient would [*10] not have arrested, suffered brain damage and death. Proper monitoring and ventilation would likely have not resulted in cardiac arrest and/or respiratory failure and thus death.

Accordingly the motion for summary disposition is denied.

The trial court did not err in denying the motion for summary disposition. The two experts' testimony was not clearly inconsistent. Bauman mentioned a lack of ventilation of Wilson, and Dr. Futrell was critical regarding the dose of atropine. While, as the trial court noted, there were inconsistencies in their deposition testimony, the testimony nonetheless left open a genuine question of material fact.

Defendant also takes issue with Bauman's inability to quantify, with specificity, the chance of a different outcome if Wilson had been given 1 mg of atropine. However, despite Bauman's reluctance to provide a specific percentage, he testified that the failure to give 1 mg of atropine in a single shot "[a]bsolutely" made a "difference." We view this deposition testimony as sufficient to establish the requisite causation. See MCL 600.2912a(2). Reversal is unwarranted.

II

Defendant additionally contends that the trial court should have granted her motion [*11] for a directed verdict based on a lack of causation evidence at trial.³ As noted in Smith v Jones, 246 Mich. App. 270, 273; 632 N.W.2d 509 (2001):

Motions for a directed verdict are reviewed de novo. In reviewing a denied motion for a directed verdict, this Court must determine whether the party opposing the motion offered evidence on which reasonable minds could differ. The test is whether, viewing the evidence in the light most favorable to the adverse party, reasonable persons could reach a different conclusion. If so, the case is properly left to the jury to decide. [Citations omitted.]

³ The trial court denied defendant's directed verdict motion without providing specific reasoning.

Plaintiff contends that there was no admissible causation evidence concerning plaintiff's "atropine" theory of liability because (1) plaintiff's attorney admitted that Bauman was not qualified to testify about the effects of atropine and (2) the trial court sustained defendant's objections to Dr. Futrell's offering testimony concerning the possible change in outcome if the deceased had been given a different dose of atropine.

Defendant misinterprets the record. Plaintiff's attorney did not admit that Bauman [*12] was not qualified to testify about the effects of atropine. Instead, he admitted that Bauman was not qualified to testify about the difference it would have made if defendant had called a Code Blue ⁴ sooner. ⁵ Moreover, Dr. Futrell testified, *without objection*, that had Wilson been administered the appropriate dose of atropine at the appropriate time, it was more likely than not that "the cardiac arrest could have been eliminated." Dr. Futrell gave this testimony in response to plaintiff's attorney's question regarding whether a different administration of atropine "would have made a difference in my client's outcome." It was only when plaintiff's attorney asked the following question that defendant's foundational objection was sustained: "And had likewise that been done in the matter [sic] you just described, do you have an opinion as to whether my client would likely have survived and lived what was a normal life for him?" In light of this record, we reject defendant's assertion that the trial court precluded Dr. Futrell from offering any testimony concerning the possible change in outcome if Wilson had been given a different dose of atropine. Defendant's appellate argument concerning [*13] the atropine claim is without merit.

Defendant additionally contends that plaintiff's "delay" claim, concerning the calling of the Code Blue, was untenable because there was insufficient evidence that defendant delayed in calling the Code Blue. She contends that the trial court should have granted a directed verdict with regard to this theory.

Defendant's notes in the anesthesia record indicate that Wilson's heart rate dropped precipitously at around 2:50 p.m.; however, defendant testified that she mistakenly recorded the heart-rate drop in the wrong time-frame box. She indicated that the drop actually occurred at 3:00 p.m., which is when the Code Blue was called. Tanya ⁶ Livingston, an assisting nurse, testified, [*14] based on her notes, that Wilson's heart rate dropped at 2:53 p.m. She testified that she then called for Dr. Govindaswamy and then pressed the Code Blue button. She stated that she was not sure if she looked at a

⁴ A liability theory advanced by plaintiff at trial was that defendant failed to call a Code Blue in a timely manner after Wilson suffered a cardiac arrest. It was explained at trial that a Code Blue is "called" when a patient is in imminent danger of dying. Pushing the Code Blue button alerts appropriate personnel who have been trained to respond to such a crisis.

⁵ Plaintiff's attorney indicated that Dr. Futrell could "fill[] in" the proximate cause gaps in Bauman's testimony.

⁶ This name is also, at times, spelled "Tayna" in the record.

clock when recording the 2:53 p.m. time in her notes.

Defendant argues that the times recorded in defendant's and Livingston's notes were mistakes or inaccurate estimates that occurred because of the cardiac emergency and that no reasonable juror could conclude that a delay occurred. We disagree. The charts were evidence that Wilson's heart rate dropped precipitously at around 2:53 p.m., and additional evidence established that the Code Blue was called at 3:00 p.m. Accordingly, there was sufficient evidence in the record of a delay, and defendant's appellate argument is unavailing.

III

Defendant claims that the trial court committed errors requiring reversal in failing to enforce three of its own orders. This issue could be viewed as involving questions of law. We review questions of law de novo. *Shinkle v Shinkle*, 255 Mich. App. 221, 224; 663 N.W.2d 481 (2003). Given that the issue also involves the admission of evidence [*15] and the denial of mistrial motions, it may also be appropriate to review this issue using the abuse-of-discretion standard. *Persichini v William Beaumont Hosp.*, 238 Mich. App. 626, 635; 607 N.W.2d 100 (1999); *Hottmann v Hottmann*, 226 Mich. App. 171, 177; 572 N.W.2d 259 (1997). At any rate, under either standard of review, we find no basis for reversal.

First, we note that we are critical of defendant's failure to include specific page references to the transcripts as part of her appellate argument. Instead, defendant refers back, in general, to her statement of facts. This is inappropriate. As noted in *MCR 7.212(C)(7)*, the argument portion of an appellant's brief is to contain specific page references to the appropriate portion of the record. Nevertheless, we will review the issue, although it is not entirely clear to us to which of the trial court's actions defendant specifically objects.

Defendant first claims that the trial court failed to enforce its order that Dr. Futrell could not offer standard-of-care testimony against defendant. In response to a motion filed by defendant, the court issued an order stating that "Dr. Futrell shall not testify concerning standards of practice [*16] applicable to Defendant Mary Keim, CRNA, nor alleged violations of those standards." At trial, Dr. Futrell criticized defendant's recordkeeping. He also indicated that a 1 mg dose of atropine should have been administered. Defendant moved for a mistrial, stating that Dr. Futrell had improperly offered standard-of-care testimony against defendant. The court denied the motion, stating, in part:

First, I do not believe that Dr. Futrell has testified with regard to any breach of the standard of care by Nurse Keim.

He can permissibly testify to what he believes occurred, how it occurred, what occurred, why it occurred. And that's what he has testified to.

We find no error requiring reversal. Dr. Futrell's testimony was not specifically directed toward establishing that defendant violated the standard of care for CRNAs. Instead, he gave an overview of what he believed happened in the case. This was appropriate and was necessary to place his testimony against Dr. Govindaswamy in context.

Defendant next claims that the trial court failed to enforce its order that plaintiff could not argue or infer negligence based on the lack of complications from a November 2000 surgery that Wilson had undergone. [*17] Before trial, the court had ruled that "no negligence can be drawn" from the fact that Wilson did not suffer complications during a prior surgery. However, it also ruled that the prior surgery was admissible as it related to "causation and . . . damages." At trial, Dr. Futrell indicated that the prior surgery was significant because it showed that "the patient would be able to undergo a similar procedure under similar circumstances with appropriate monitoring, etcetera, without any particular expected complication." He later testified that the prior surgery "demonstrates that with appropriate management, there's a reasonable expectation . . . that you will be able to manage the patient without any unusual expected complications again." Defendant moved for a mistrial, and the trial court denied the motion, stating:

I'm satisfied all the testimony goes to the assessment of risk. And that's what is I think is the thrust of the questioning. And it does not go to the issue that was addressed, and that is because if there was [sic] - how can I put it - it is not evidence of malpractice now that there was no bad result before.

The trial court did not err in its ruling. Evidence of the prior [*18] surgery was relevant, as the trial court stated, because it helped to demonstrate that Wilson was not subject to any increased risk of harm from anesthesia. Moreover, the trial court instructed the jurors as follows:

I also charge you that in considering any breach of the standard of care by Henry Ford Health System or Mary Keim, you are not to draw any inference of whether or not there was negligent care on May 29th 2001, from the lack of complications following the November 2 thousand [sic] eye surgery.

Under the circumstances, reversal is unwarranted.

Defendant next claims that the trial court failed to enforce its order that there could be no allegations of malpractice based on defendant's alleged failure to chart appropriately. Before trial, the court ruled, in response to a motion filed by defendant, as follows:

"With regard to charting, . . . the charting is clearly admissible. It's not - it cannot be malpractice in and of itself. But it certainly can be evidence that tends in that direction or the other direction. To relevant evidence [sic], it can be introduced." The court also stated, "what a professional puts in the chart or doesn't put in the chart, is certainly admissible." [*19] It added, "[The defense attorneys] can't argue that the failure to chart or the chart is incorrect, the chart is malpractice itself. They cannot argue that."

Defendant has pointed to no instance in which plaintiff violated the trial court's order regarding charting. The testimony by certain witnesses about improper charting was allowable; plaintiff was merely precluded from arguing that the improper charting itself constituted malpractice. Defendant has not demonstrated that this occurred, and reversal is unwarranted.

IV

Defendant argues that the trial court should have granted her motion for a directed verdict or her motion for a judgment notwithstanding the verdict (JNOV) because plaintiff failed to comply with MCL 600.2912b.⁷ The standard of review applicable to a motion for a directed verdict is set forth in section II of this opinion. The standard of review applicable to a motion for a JNOV is the same. Smith, supra at 273-274.

Defendant claims that the notice of intent (NOI) required by MCL 600.2912b was not at all directed toward defendant, [*20] the standard of care provided was nonspecific, there was no appropriate statement regarding the manner in which the standard of care was breached, the list of actions required to comply with the standard of care was inadequate, and it was not sufficiently alleged that a breach of the standard of care was a proximate cause of the death.

We conclude that the trial court correctly determined the NOI to be compliant with the statutory requirements and correctly denied the motions for a directed verdict and a JNOV.

MCL 600.2912b(4) mandates that a NOI contain the following information:

- (a) The factual basis for the claim.
- (b) The applicable standard of practice or care alleged by the claimant.
- (c) The manner in which it is claimed that the applicable standard of practice or care was breached by the health professional or health facility.
- (d) The alleged action that should have been taken to achieve compliance with the alleged standard of practice or care.

⁷ In denying defendant's motion for a directed verdict and her motion for a JNOV, the trial court rejected this argument without elaboration.

(e) The manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice.

The purpose of the NOI is to notify "potential malpractice defendants of the basis of the claims [*21] against them." *Roberts v Mecosta Co Gen Hosp (Aft Rem)*, 470 Mich. 679, 696 n 14; 684 N.W.2d 711 (2004). "The expected level of specificity must be considered in light of the fact that discovery would not yet have begun." *Boodt v Borgess Med Ctr (Boodt I)*, 272 Mich. App. 621, 626; 728 N.W.2d 471 (2006), reversed on other grounds *Boodt v Borgess Med Ctr (Boodt II)*, __ Mich. __; __ N.W.2d __; 2008 WL 2601350 (2008).⁸ There must be enough details to "allow the potential defendants to understand the claimed basis of the impending malpractice action . . ." *Roberts, supra at 691-692 n 7*. Additionally, the NOI only need have the required information present in an accessible, discernable form. *Boodt I, supra at 628*. "The important principle is that [when reading a NOI] a defendant must not be forced 'to guess upon what grounds plaintiff believes recovery is justified,' but at the same time plaintiffs should not be subject to the 'straightjacket' of '[e]xtreme formalism . . .'" *Id. at 627*, quoting *Dacon v Transue*, 441 Mich. 315, 329; 490 N.W.2d 369 (1992). Therefore, a NOI is reviewed as a whole. *Boodt I, supra at 630*.

The NOI was sufficient according to the statutory requirements and the above case law. Paragraph 1 provided a lengthy statement of facts establishing the factual basis for the claim. See *MCL 600.2912b(4)(a)*. Defendant's claim that the NOI was not directed towards her is unfounded because defendant was mentioned in paragraph 1 as the attending CRNA, and further sections of the NOI set forth the standard of care, breach, actions that should have been taken to avoid the breach, and proximate [*23] cause of the injury with regard to the CRNA. The lack of specific negligent acts or omissions directly attributed to defendant in the NOI was by no means fatal; discovery had not yet taken place, so a high level of specificity was not required. See *Boodt I, supra at 626*. It was clear that this document was directed towards defendant, among others, and it gave appropriate notice regarding the basis of the suit against her.

The standard of care was also properly stated in paragraph 2. This paragraph stated, in part, that the CRNA and others were required to:

a. Properly manage the administration of anesthesia during an ocular procedure;

⁸ Although in *Boodt II*, 2008 WL 2601350, 1, the Supreme Court declared [*22] the NOI involved in the case to be invalid for not properly stating the manner in which the breach of the standard of care was the proximate cause of the injury, it did not overrule the general principles from *Boodt I* that are cited in this opinion. In fact, it appears that the Supreme Court found the statement of proximate cause insufficient in spite of its consideration of the general principles from *Boodt I*; the Court ruled, "[e]ven when the notice is read in its entirety, it does not describe the manner in which the breach was the proximate cause of the injury." *Id.* (emphasis added). The Supreme Court also noted that a NOI is provided early in the proceedings and that it need not be perfect. *Id.*

- b. Properly monitor a patient under anesthesia during an ocular procedure, so as to avoid causing the patient to "buck" during the procedure;
- c. Properly manage the reversal of anesthesia following an ocular procedure;
- * * *
- e. Use the appropriate anesthetic and paralytic agents during an ocular procedure;
- f. Use the appropriate reversal agents following the administration of anesthesia;
- g. Appreciate a patient's medical history when determining the appropriate anesthesia agents and procedures

These statements were sufficient to provide clear notice [*24] about the basis of the malpractice action. The fact that this standard of care was attributed to not just defendant but to several others was not fatal because the same standard of care could apply to personnel in other positions.

Additionally, the allegations of the manner that the standard of care was breached (paragraph 3) and the statement of which actions should have been taken to comply with the standard of care (paragraph 4) were proper. Although both sections repeat what was alleged in the "standard of care" paragraph, that does not cripple the NOI because both sections fulfill the statutory purpose, and, again, there need not have been a high level of specificity, considering that discovery had not yet taken place. *Id.* Further, the NOI suitably stated that the breach was the proximate cause of death in paragraph 5 by referring back to the standard of care in paragraph 2 and to the way that standard was breached in paragraph 3. Paragraph 5 also indicated that Wilson suffered a cardiac arrest as a result of the breach and that this led to his death.

The Supreme Court recently declared a statement of proximate cause in a NOI insufficient because it did not set forth the manner [*25] in which it was alleged that the breach was the proximate cause of the injury. *Boodt II*, 2008 WL 2601350, 1. We conclude that this holding does not affect our opinion in the present case because the NOI in the present case did contain the required information - as noted, it alleged that defendant's breach induced a cardiac arrest that ultimately led to death.

When the NOI is viewed as a whole, we find no basis for reversal.

V

Defendant contends that the trial court should have granted her motion for a directed verdict or her motion for a JNOV because Bauman was not familiar with the applicable standard of care.

Defendant takes issue with the following exchange that occurred during Bauman's testimony:

Q. And didn't you testify that you're not familiar with how other CRNA's provide care? You only know what you do and what you were taught?

A. Yes.

Q. And you would expect that you were taught the best practice, not the average level of practice, right?

A. I absolutely believe that. Yes.

Defendant contends that Bauman was only qualified to testify about his own practices and not about the average level of practice. Defendant made a similar argument in her motion for a directed verdict. The [*26] trial court rejected the argument without any specific reasoning. Defendant also made a similar argument in her motion for a JNOV, and the trial court again rejected the argument without elaboration.

We find no basis for reversal. Bauman testified that a reasonably prudent CRNA would not start a case without having a 1 mg syringe of atropine drawn up and ready to go. He also testified that a reasonably prudent CRNA would immediately call a Code Blue when a patient goes into cardiac arrest. There were other instances, too, in which Bauman testified about what a reasonably prudent CRNA would do. Despite his belief that he was given a superior education, and despite his acknowledgment that he was not familiar with precisely how other CRNAs provide care, the record ultimately reflects that Bauman was indeed familiar with the standard of care applicable in this case.

Defendant also suggests that Bauman was not familiar "with the local standard of practice for CRNA's in Detroit in 2001, because his only testimony was that he had not worked in the Detroit [sic] since the early 1990's." This argument is without merit. There is simply no indication that the standard of practice in Detroit in [*27] 2001 was somehow different from the standard of care with which Bauman was familiar. Bauman testified regarding what a reasonably prudent CRNA would do, and there is no reason to believe that these actions should somehow have been different in the Detroit area.

VI

Defendant argues that the trial court should have granted her motion for a directed verdict or her motion for a JNOV because plaintiff failed to file an affidavit of merit that complied with MCL 600.2912d.⁹ Specifically, defendant claims that the affidavit

⁹ In denying defendant's motion for a directed verdict and her motion for a JNOV, the trial court rejected this argument without elaboration.

contained no standard of care for a CRNA, contained no statement of actions that should have been taken to comply with the standard of care, and did not state the manner in which defendant's negligent acts were a proximate cause of the plaintiff's death. Also, defendant argues that there was no statement that the standard of care was breached by the health professional receiving the notice, because the affidavit only stated that "[d]efendants" deviated from the standard of care.

MCL 600.2912d(1) requires that an affidavit of merit set [*28] forth the following:

- (a) The applicable standard of practice or care.
- (b) The health professional's opinion that the applicable standard of practice or care was breached by the health professional or health facility receiving the notice.
- (c) The actions that should have been taken or omitted by the health professional or health facility in order to have complied with the applicable standard of practice or care.
- (d) The manner in which the breach of the standard of practice or care was the proximate cause of the injury alleged in the notice.

We conclude that Bauman's affidavit of merit was acceptable. The affidavit in question did not have the mandatory information enumerated in separate paragraphs, but the information was discernable within the entire document. The requirements of a standard of care, breach, and actions that should have been taken to comply with the standard of care could be found in paragraph 4. This paragraph stated, in part, that defendants should have:

- a. Properly managed the administration of anesthesia during an ocular procedure;
- b. Properly monitored a patient under anesthesia during an ocular procedure, so as to avoid causing the patient to 'buck' during the procedure; [*29]
- c. Properly managed the reversal of anesthesia following an ocular procedure;
- * * *
- e. Used the appropriate anesthetic and paralytic agents during an ocular procedure;
- f. Used the appropriate reversal agents following the administration of anesthesia;
- g. Appreciated a patient's medical history when determining the appropriate anesthesia agents and procedures

There is no reason to believe that a reader would be forced to guess what the standard of care was or guess the manner in which the standard was breached. Moreover, the

statement of proximate cause in paragraph 5 was appropriate because it referred back to paragraph 4; a reader could properly understand that, but for the negligent acts or omissions in paragraph 4, the patient would not have died. Paragraph 5 stated: "As a proximate result of negligent acts and/or omissions of [d]efendants as set forth above, [p]laintiff [sic] suffered unnecessary pain and ultimately died." While *Boodt II*, 2008 WL 2601350, 1, indicated that a general statement of proximate cause such as this is insufficient, we do not view *Boodt II* as binding with respect to this issue because *Boodt II* dealt with a NOI and not an affidavit of merit.¹⁰ The [*30] affidavit's information was sufficiently specific, considering that discovery had not yet taken place. The affidavit fulfilled its purpose of ensuring trustworthy medical testimony and discouraging frivolous lawsuits. *Nippa v Botsford Gen Hosp.*, 257 Mich. App. 387, 394; 668 N.W.2d 628 (2003).

Additionally, it was of no import that the affidavit was directed only towards the "defendants," because Bauman is clearly a CRNA, as stated in paragraph 2, and could only certify claims against another CRNA. Defendant was identified as a CRNA in the caption, and the affidavit properly set forth her alleged negligence.

The trial court correctly found Bauman's affidavit of merit to be sufficient and appropriately denied defendant's motions for a directed verdict and for a JNOV.¹¹

VII

Defendant argues that the court erred in failing to find that the jury's award for medical expenses should have been lower. Defendant asserts that the jury's award included \$ 124,168 for past medical expenses. Defendant contends that Health Alliance Plan (HAP) essentially agreed to reduce the charges of \$ 124,168 because it paid \$ 4,271 and asserted a lien for \$ 4,271; defendant argues that this amount, therefore, represented the actual medical expenses. Defendant contends that the trial court should have reduced the jury's award by \$ 119,897 (\$ 124,168 minus \$ 4,271).

The parties frame this issue as one involving a "collateral source." See *MCL 600.6303*. Defendant states that \$ 119,897 was "subject to collateral source reduction." *MCL 600.6303(2)* states that "[t]he court shall determine the amount of the plaintiff's expense or loss which has been paid or is payable by a collateral source," and *MCL 600.6303(1)* indicates that a judgment must be reduced [*32] by the collateral-source amount.

¹⁰ As explained in section IV of this opinion, the NOI in this case contained a sufficient statement of proximate cause.

¹¹ Defendant makes the additional argument that plaintiff's attorney admitted at the directed-verdict motion hearing that Bauman was not qualified to offer opinions concerning proximate cause. Defendant argues that this provides additional support for her argument that the affidavit of merit was inadequate. [*31] This argument actually goes towards the sufficiency of the evidence at trial, not the sufficiency of the affidavit of merit. See, e.g., *Sturgis Bank & Trust Co v Hillsdale Comm Health*, 268 Mich. App. 484, 494-495; 708 N.W.2d 453 (2005).

Evidently, defendant believes that the \$ 119,897 should be viewed as "paid or . . . payable by a collateral source" because HAP essentially agreed to absorb that amount of money and instead settle for \$ 4,271.

We find no abuse of discretion.¹² The trial court did not err in refusing to order a new trial, remittitur, or relief from judgment.

We initially note that the amount of the lien as set forth in the documentation and as argued at the post-trial motion hearing was \$ 4,241.54, not \$ 4,271. The September 2006 letter from HAP stated, in part:

Per my correspondence, I indicated I need to confirm the total amount paid by the Plan relating to this claim. The Plan has confirmed payment in excess [*33] of \$ 100,000, however, most of those claims are "capitulated" and therefore will not be asserted for reimbursement. The total amount of paid claims for which the Plan seeks reimbursement is \$ 4,241.54.

This will confirm that the Plan has agreed to resolve this matter for the sum of \$ 4,241.54 as full and final payment.

At the motion hearing, plaintiff's attorney argued:

They [HAP] said the bill has been some term that means like recycled or recapitulated so they weren't asking us to reimburse that.

But the fact of the matter is under the wrongful death statute we are entitled to the medical expenses. We put in the medical expenses which were a hundred and 24 thousand.

The attorney also argued that

the jury may not even have given us that hundred and 24 thousand dollars. Those past economic damages could have been for wages and services around the house and all the other economic damages that we asked for. And it would be inappropriate to reduce that without some showing. I mean, the defendants have the burden of proof on this issue [and] they haven't come forward [with] anything.

After the defense attorneys made their arguments for a reduction in the damages award, the court stated:

¹² Defendant frames this issue in the context of the trial court's refusal to order a new trial, remittitur, or relief from judgment. The abuse-of-discretion standard of review is applicable. *Kelly v Builders Square, Inc.*, 465 Mich. 29, 34; 632 N.W.2d 912 (2001) (new trial); *Coble v Green*, 271 Mich. App. 382, 392; 722 N.W.2d 898 (2006) (remittitur); *Blue Water Fabricators, Inc v New Apex Co. Inc.*, 205 Mich. App. 295, 300; 517 N.W.2d 319 (1994) (relief from judgment).

But [*34] see, here you're addressing what is a fundamental process and that is trying to determine what the jury meant when they came back with a specific dollar amount.

I mean at the heart of the jury system is the discretion we give these folks in effect to do what they want to do.

One of the defense attorneys responded that the only basis in the record for economic loss were the three figures recited by plaintiff's attorney: \$ 169,000 for lost wages, \$ 21,403 for lost household services, and \$ 124,168 for medical bills, for a total of \$ 314,571. The defense attorney stated:

So, since the jury verdict exceeded that amount,¹³ and there is no other basis to support it, they must have included the medical bill and therefore you don't need a specific breakdown, because there is no other possible way to explain the magnitude then of the economic award because the only three things they argued add up to less than [sic].

Plaintiff's attorney responded that her client had a bill for \$ 124,168 at the time of trial in July 2006 and that the jury properly considered it.

The [*35] trial court concluded that there should be no reduction in the damages amount based on the medical bill. As far as reasoning, it stated only that "given the posture of this case there should be no reduction."¹⁴ We find no abuse of discretion in the court's ruling.¹⁵ The trial court did not err in refusing to order a new trial, remittitur, or relief from judgment.

The pertinent case is *Zdrojewski v Murphy*, 254 Mich. App. 50; 657 N.W.2d 721 (2002). In that case, the defendants made a similar argument to that made by defendant here. This Court stated:

¹³ The jury awarded \$ 500,000 for "medical expenses, loss of financial support, loss of service and/or loss of gifts or valuable gratuities."

¹⁴ A couple of months later, in December 2006, after defendant argued that the evidence supported no amount of past economic damages beyond the \$ 314,571 recited by plaintiff's attorney, the court ruled:

I am satisfied the record does not support recovery of more than 3 hundred 14 thousand 5 hundred and 71 dollars for past economic loss in this case. It's quantifiable to the penny under the circumstances of this case. So the judgment is reduced from 5 hundred thousand to 3 hundred 14 thousand 5 hundred 71 with regard to past economic damages.

¹⁵ Defendant frames this issue in the context of the trial court's refusal to order a new trial, remittitur, or relief from judgment. The abuse-of-discretion standard of review is applicable. *Kelly v Builders Square, Inc.*, 465 Mich. 29, 34; 632 N.W.2d 912 (2001) (new trial); *Coble v Green*, 271 Mich. App. 382, 392; 722 N.W.2d 898 (2006) [*36] (remittitur); *Blue Water Fabricators, Inc v New Apex Co, Inc.*, 205 Mich. App. 295, 300; 517 N.W.2d 319 (1994) (relief from judgment).

In this case, plaintiff's health care insurers, Blue Cross Blue Shield of Michigan (BCBSM) and Medicare[,] made payments for plaintiff's medical care. Under MCL 600.6303(4), these payments would meet the initial definition of a collateral source benefit. However, BCBSM and Medicare also exercised their right to liens against plaintiff's verdict. According to documents filed in the lower court record, as of April 1999, Medicare was seeking approximately \$ 20,000 in benefits paid and BCBSM was seeking approximately \$ 1,700. MCL 600.6303(4) further states that "benefits paid or payable by a . . . corporation, or other legal entity entitled by contract to a lien against the proceeds of a recovery by a plaintiff in a civil action for damages, if the contractual lien has been exercised pursuant to subsection (3)" are not a collateral source. Here, as of April 1999, BCBSM and [*37] Medicare properly exercised their liens under the statute. The record is not clear whether they have further exercised their lien rights since then or whether they may do so in the future. *Regardless of those considerations, the statute does not make any provision for a situation where a lien has been exercised, but for an amount less than the lienholder would be legally entitled to recover.* Because the statute clearly states that benefits subject to an exercised lien do not qualify as a collateral source, and BCBSM and Medicare exercised their liens, health insurance benefits provided by BCBSM and Medicare to plaintiff do not constitute a collateral source under MCL 600.6303(4). [*Zdrojewski, supra at 70* (emphasis added).]

Here, defendant admits that HAP exercised a lien. This lien was arguably for a lesser amount than it was entitled to recover. *Zdrojewski* instructs that in this situation, the health insurance benefits do not constitute a collateral source under the law. Accordingly, defendant's argument on appeal is without merit.

VIII

Defendant claims that the trial court erred in allowing plaintiff to argue to the jury that defendant (1) failed to review Wilson's medical records [*38] from the previous procedure, (2) failed to respond to Wilson's cardiac arrest, (3) failed to hand-bag ¹⁶ Wilson, (4) failed to administer an appropriate initial dose of atropine, and (5) failed to call a Code Blue sooner. Defendant claims that plaintiff was not entitled to argue these theories because they were not sufficiently set forth in the NOI or Bauman's affidavit of merit and were also not sufficiently apparent from the discovery process. This argument is simply a rehash of the arguments set forth in sections IV and VI of this opinion and need not be decided anew. The pre-suit notice was sufficient; plaintiff simply refined her theories as the case progressed.

¹⁶ This term refers to manual, artificial ventilation.

Defendant also claims that plaintiff was not entitled to argue some of these theories before the jury because the trial court had earlier ruled that the only viable theories related to the administration of atropine and the alleged delay in calling the Code Blue. We decline to address this issue because it was not listed as part of the statement of questions presented for appeal. City of Lansing v Hartsuff, 213 Mich. App. 338, 351; 539 N.W.2d 781 (1995).

IX

Defendant [*39] next argues that there was no admissible causation evidence concerning the atropine claim because (1) plaintiff admitted that Bauman was not qualified to testify regarding the cardiac effects of atropine and (2) the trial court sustained defendant's objection to having Dr. Futrell offer that testimony. Defendant argues that the court should have granted her a directed verdict on the atropine claim. Defendant's argument is without merit. It is merely a reiteration of part of defendant's argument set forth in section II of this opinion, and we again reject it.

Defendant additionally contends that the trial court failed to inquire into the scientific bases of Bauman's and Futrell's testimony. See MCL 600.2955.

The day before trial, defendant's attorney mentioned that he might have objections to certain expert testimony, "depending on their testimony" at trial. Then, after the second day of trial and after Dr. Futrell had offered some testimony, defendant argued that Dr. Futrell was obligated to produce literature to support some of his medical testimony. Defendant's attorney stated:

And I think Your Honor has a gate keeping role with regard to keeping evidence in or out that does not have [*40] a scientific basis.

And this witness had not done any personal research on these drugs, so he has to look somewhere else. And we don't have any idea where he's looking for the information.

Plaintiff responded that defendant had waited too long to raise such a challenge. The trial court stated, "in the Final Pre-Trial Order and the discussions we had Thursday, there was never a specific objection to specific portions of any expert's testimony or the basis thereof." The court also stated: "The witness testified in this particular area, which [i]s now apparently being challenged, that this is common knowledge within the profession. That this is well-known and accepted." The court stated that it had a responsibility to move the case along and that defendant had waited too long to challenge the scientific basis for the testimony.

We find no abuse of discretion in the trial court's ruling. See Hottman, supra at 177 (admission of evidence is reviewed for an abuse of discretion). Dr. Futrell had given a

pretrial deposition, and defendant could have raised an objection to the scientific foundation of his testimony before the second day of trial. Dr. Futrell testified that he had been practicing [*41] for twenty-six years, that he specialized in anesthesiology, that he had taught anesthesiology residents. He also testified that he was a member of a committee that dealt with "safety" and the "reduction of complications" in anesthesiology. Later, after giving some specific medical testimony and being asked how he learned the information, he stated that it was "part and parcel" of his training. We conclude that the trial court properly considered the lateness of the request and the nature of Dr. Futrell's testimony and properly exercised its discretion in declining to hold an evidentiary hearing.

As for Bauman, the portions of the record to which defendant refers contain no request for a hearing regarding the scientific basis of Bauman's testimony. They reveal that defendant simply made a brief objection with regard to "foundation," which the trial court overruled. Accordingly, defendant's appellate argument that the trial court should have held a hearing is unavailing.

X

Defendant argues that the trial court erred in granting plaintiff's motion for costs.¹⁷ We review this issue using the abuse-of-discretion standard. Blue Cross & Blue Shield of Michigan v Eaton Rapids Comm Hosp, 221 Mich. App. 301, 308; 561 N.W.2d 488 (1997).

Defendant makes the bald statement that "[p]laintiff's request for expert witness fees as costs did not include a breakdown of charges, the hourly rate, or the tasks that went into generating the fees." However, defendant cites no authority indicating that these items were necessary before costs could be awarded. As noted in Wilson v Taylor, 457 Mich. 232, 243; 577 N.W.2d 100 (1998), quoting Mitcham v Detroit, 355 Mich. 182, 203; 94 N.W.2d 388 (1959),

[i]t is not sufficient for a party "simply to announce a position or assert an error and then leave it up to this Court to discover and rationalize the basis for his claims, or unravel and elaborate for him his arguments, and then search for authority either to sustain or reject his position."

Defendant also states that there was no basis for awarding fees to three of the experts because they did not testify at trial. However, MCL 600.2164, the statute dealing with expert witness fees, does not require that an expert testify in order to receive compensation. Defendant then states that "[p]laintiff's remaining experts did not

¹⁷ The [*42] court granted \$ 97,718.23 in costs.

provide documentation to support their exorbitant fees.” We conclude that this [*43] general, nonspecific statement is simply insufficient to raise an issue before this Court. See *Blazer Foods, Inc v Restaurant Properties, Inc*, 259 Mich. App. 241, 253; 673 N.W.2d 805 (2003) (dealing with inadequate briefing). Defendant also contends that a hearing should have been held with regard to various expert witness fees. Once again, defendant fails to support her argument and has therefore waived it. *Wilson, supra at 243*.

Defendant mentions that plaintiff was awarded \$ 6,311.95 for photocopying and shipping records to experts. She contends that there was no statutory authority to award costs for these activities because “[t]here is no provision within the court rules or statute[s] permitting recoupment of costs for photocopying and mailing records.” However, *MCR 2.625(A)(1)* states that “[c]osts will be allowed to the prevailing party in an action, unless prohibited by statute or by these rules or unless the court directs otherwise, for reasons stated in writing and filed in the action.” There is no statute or court rule prohibiting “costs” from including the expenses associated with photocopying and shipping records to experts. These expenses were, in fact, costs incurred; [*44] as the trial court noted, “[t]hey [were] actual real costs.” At first blush, then, it appears that the \$ 6,311.95 was allowable. However, in *JC Building Corp II v Parkhurst Homes, Inc*, 217 Mich. App. 421, 429; 552 N.W.2d 466 (1996), a party had obtained reimbursement for the expenses associated with “certified copies of [a] criminal conviction, [a] mediation fee, and [an] exhibit enlargement” This Court reversed, stating that “there [was] no statutory authority” to award those particular costs. *Id.* The Court essentially indicated that costs are allowable only if a statute or court rule provides for the particular type of costs at issue. *Id.* *JC Building Corp II* is binding on us under *MCR 7.215(J)(1)*. Therefore, we must reverse the award of \$ 6,311.95 in costs. Further support for this conclusion is found in *Beach v State Farm Mut Auto Ins Co*, 216 Mich. App. 612, 622; 550 N.W.2d 580 (1996).

Defendant next mentions that the trial court awarded reimbursement for the costs of depositions, for a total of \$ 9,644.55.¹⁸ Defendant contends that plaintiff failed to provide any documentation to verify that the transcripts were filed with the clerk’s office, as required by *Rickwalt v Richfield Lakes Corp*, 246 Mich. App. 450, 465; 633 N.W.2d 418 (2001). [*45] We agree. *MCL 600.2549* states:

Reasonable and actual fees paid for depositions of witnesses filed in any clerk’s office and for the certified copies of documents or papers recorded or filed in any public office shall be allowed in the taxation of costs only if, at the trial or when damages were assessed, the depositions were read in evidence, except for impeachment purposes, or the documents or papers were necessarily used.

¹⁸ As with the \$ 6,311.95, the trial court allowed the \$ 9,644.55 because it was an “actual real cost[.]”

Under this plain statutory language and in accordance with *Rickwalt, supra at 465*, the deposition expenses here were not recoverable as costs because there was no evidence that the deposition transcripts were filed in a clerk's office or read into evidence. We must reverse the award of \$ 9,644.55 in costs.

Defendant next argues that the trial court erred in awarding \$ 2,249.18 for "subpoena/service fees" and \$ 415 for motion fees.¹⁹ Defendant contends that there was no statutory authority for awarding the "subpoena/service fees." We agree. Plaintiff cites no provision allowing for these types of costs, and therefore we must reverse the award. See, generally, *JC Building Corp II, supra at 429*. [*46] With regard to the \$ 415, defendant argues that plaintiff failed to provide documentation regarding that amount of money. We disagree. Plaintiff attached to its bill of costs photocopies of various records supporting its request for the \$ 415. Defendant also argues that there is no statutory authority for recovering case-evaluation fees as costs. The documentation indicates that the \$ 415 included \$ 150 for those fees. Plaintiff cites no provision for allowing these case-evaluation fees as costs, and therefore we must reverse the \$ 150 award of costs associated with case-evaluation fees.

Defendant next argues that the trial court erred in failing to allocate costs between defendant and Henry Ford. To support her argument, defendant cites a case that interprets the case-evaluation court rule, MCR 2.430. As set forth in section XI of this opinion, the trial court did not err in its interpretation of the case-evaluation court rule. Defendant was responsible for reimbursing all allowable costs in this case involving joint-and-several liability.

XI

Defendant next asserts that the trial court erred in awarding [*47] plaintiff case-evaluation sanctions. The case-evaluation panel had awarded plaintiff \$ 585,000 against defendant and \$ 65,000 against Henry Ford. Defendant rejected the case-evaluation award. The verdict, after the trial court's adjustments, amounted to \$ 812,295.²⁰ Defendant contends that this verdict, for purposes of deciding whether case-evaluation sanctions apply, should be apportioned according to the percentage of fault found by the jury.²¹

This issue involves a question of statutory and court-rule interpretation and is thus reviewed de novo. *Marketos v American Employers Ins Co, 465 Mich. 407, 412; 633 N.W.2d 371 (2001)*.

¹⁹ The court awarded these fees because they were actual costs incurred by plaintiff.

²⁰ The judgment will be slightly higher based on our instant opinion and may be higher still after the proceedings on remand.

²¹ The trial court merely ruled that "plaintiff is clearly entitled to attorney fees under the case evaluation sanction rule."

MCR 2.403(O) governs the awarding of case-evaluation sanctions. Sanctions were appropriate here if the verdict against defendant was "more than 10 percent below the evaluation" MCR 2.403(O)(3). In addition, "[e]xcept as provided by subrule (O)(10), in a personal injury action . . . the verdict against a particular [*48] defendant shall not be adjusted by applying that defendant's proportion of fault" MCR 2.403(O)(4)(c). Given this rule, the trial court correctly weighed the verdict against the case-evaluation award without making an adjustment based on defendant's relative fault.

However, defendant contends that the verdict should have been apportioned according to MCR 2.403(O)(10), which states that in actions filed on or after March 28, 1996, "a verdict awarding damages for personal injury . . . or wrongful death shall be adjusted for relative fault as provided by MCL 600.6304." We reject defendant's argument. Indeed, MCL 600.6304(6)(a) states that liability based on a medical malpractice claim is joint and several if the plaintiff is found to be without fault. There were no allegations here of fault on the part of plaintiff. Accordingly, the liability here was joint and several, and payment according to the percentage of fault was not mandated. See MCL 600.6304(6). Under these circumstances, an apportionment for purposes of applying the case-evaluation rule is inappropriate. The court did not err in determining that plaintiff was entitled to case-evaluation sanctions from defendant.²²

Defendant next argues that the amount of attorney fees awarded to plaintiff as sanctions was excessive. The trial court, without a full evidentiary hearing, awarded attorney fees of \$ 231,710, based on an hourly rate of \$ 600 and \$ 400 for plaintiff's two attorneys. Defendant contends that the approved hourly rate was excessive by being two to three times the size of the accepted, average rate for a malpractice case in the area and that use of an hourly rate to calculate attorney fees was not the correct measure because the case was taken on a contingency fee basis.

We review this issue for an abuse of discretion. Stallworth v Stallworth, 275 Mich. App. 282, 288; 738 N.W.2d 264 (2007). Certain criteria that a court should use for determining the reasonableness of attorney fees are set forth in Crawley v Schick, 48 Mich. App. 728, 737; 211 N.W.2d 217 (1973):

²² In [*49] response to certain arguments raised by defendant, we note that unpublished opinions are not precedentially binding in this Court. MCR 7.215(C)(1).

(1) the professional standing and experience of the attorney; (2) the skill, time and labor involved; (3) the amount in question and the results achieved;²³ (4) the difficulty of the [*50] case; (5) the expenses incurred; and (6) the nature and length of the professional relationship with the client.

The *Crawley* court acknowledged that there is no "precise formula for computing the reasonableness of an attorney's fee" and that the facts that should be considered are not limited to the items mentioned above. *Id.* The Supreme Court agreed when it adopted the *Crawley* guidelines. *Wood v DAIIE*, 413 Mich. 573, 588; 321 N.W.2d 653 (1982).

In *Smith v Khouri*, __Mich. __; __N.W.2d __; 2008 WL 2601346, 5 (2008), the Supreme Court elaborated on the method for calculating attorney fees as case-evaluation sanctions, stating:

We conclude that our current multi-factor approach needs some fine tuning. We hold that a trial court should begin its analysis by determining the fee customarily charged in the locality for similar legal services, i.e., factor 3 under *MRPC 1.5(a)*. In determining [*51] this number the court should use reliable surveys or other credible evidence of the legal market. This number should be multiplied by the reasonable number of hours expended in the case (factor 1 under *MRPC 1.5[a]* and factor 2 under *Wood*). The number produced by this calculation should serve as the starting point for calculating a reasonable attorney fee. We believe that having the trial court consider these two factors first will lead to greater consistency in awards. Thereafter, the court should consider the remaining *Wood*/*MRPC* factors to determine whether an up or down adjustment is appropriate. And, in order to aid appellate review, a trial court should briefly discuss its view of the remaining factors.

The *Smith* Court also stated:

If a factual dispute exists over the reasonableness of the hours billed or hourly rate claimed by the fee applicant, the party opposing the fee request is entitled to an evidentiary hearing to challenge the applicant's evidence and to present any countervailing evidence. [*Smith*, 2008 WL 2601346, 5.]

Here, defendant requested an evidentiary hearing, but the court declined to grant "a full blown hearing." In light of *Smith*, we remand for a hearing regarding [*52] attorney fees

²³ The lead opinion in *Smith v Khouri*, __Mich. __; __N.W.2d __; 2008 WL 2601346, 6 n 20 (2008), indicated that factor 3 is not an appropriate consideration "in determining a reasonable attorney fee for case-evaluation sanctions." However, this conclusion was not adopted by a majority of the justices.

and for a recalculation of those fees.²⁴

XII

Defendant next argues that the trial court erred in denying two mistrial motions. Defendant's argument, however, is merely a rehash of a portion of her argument set forth in section III of this opinion. We need not revisit it here.

XIII

Defendant argues that plaintiff's attorney and plaintiff's witnesses unfairly prejudiced her to such an extent that reversal is required. As noted in Reetz v Kinsman Marine Transit Co., 416 Mich. 97, 102-103; 330 N.W.2d 638 (1982):

When [*53] reviewing an appeal asserting improper conduct of an attorney, the appellate court should first determine whether or not the claimed error was in fact error and, if so, whether it was harmless. If the claimed error was not harmless, the court must then ask if the error was properly preserved by objection and request for instruction or motion for mistrial. If the error is so preserved, then there is a right to appellate review; if not, the court must still make one further inquiry. It must decide whether a new trial should nevertheless be ordered because what occurred may have caused the result or played too large a part and may have denied a party a fair trial. If the court cannot say that the result was not affected, then a new trial may be granted.

Additionally,

an attorney's comments during trial warrant reversal where they indicate a deliberate course of conduct aimed at preventing a fair and impartial trial or where counsel's remarks were such as to deflect the jury's attention from the issues involved and had a controlling influence on the verdict. [Wiley v Henry Ford Cottage Hosp., 257 Mich. App. 488; 668 N.W.2d 402 (2003) (internal citation and quotation marks omitted).]

The first [*54] part of defendant's argument is merely a rehash of her argument set forth in section III of this opinion. We again reject it. Defendant next argues that plaintiff's attorney improperly questioned defendant about, and Bauman improperly testified

²⁴ We note that the application of *Smith* to this case is appropriate in accordance with the factors set forth in Adams v Department of Transportation, 253 Mich. App. 431, 435-440; 655 N.W.2d 625 (2002) (discussing prospective versus retroactive application of court opinions). We further note that defendant's argument that the court's award of attorney fees was wrongly calculated because the case was taken on a contingent-fee basis is without merit. MCR 2.403(O)(6) provides that, when assessing sanctions, the trial judge is to calculate "a reasonable attorney fee based on a reasonable hourly or daily rate . . ." See also Temple v Kelel Distributing Co., 183 Mich. App. 326, 331-332; 454 N.W.2d 610 (1990).

about, defendant's response to Wilson's history of atrial fibrillation, "even though [p]laintiff was not claiming . . . a breach" with regard to it. Any error in this regard was harmless; indeed, defendant concedes that "no causation argument was ever made relative to that alleged breach." Therefore, the jury would not have based a finding of liability on it.

Defendant also argues that plaintiff's attorney improperly inquired about the "bucking" incident that occurred when Wilson was anesthetized, even though the "bucking" was not a theory of liability. However, defendant's citation to the record reveals that (1) one reference to "bucking" was made by a witness without prompting by plaintiff's attorney and (2) when the attorney did ask about "bucking," it was in reference to whether defendant had properly charted the incident. As noted in section III of this opinion, and contrary to defendant's implication on appeal, the trial court had ruled [*55] that evidence about charting was in fact admissible; plaintiff merely was not allowed to argue that improper charting was malpractice in itself. No improper course of conduct is apparent with regard to the questions and testimony defendant cites concerning charting.²⁵

Next, defendant argues that Bauman prejudiced her by handing a juror some notes that had fallen out of the jury box. This argument is patently without merit. Bauman stated as follows: "The gentleman that was sitting in the back row knocked his stuff off the ledge. I merely went over, picked it up, and set it on there; never said a word to the guy; never even looked at him." This simple act of picking up something that had fallen was not an improper, prejudicial act.

Defendant next argues that plaintiff's attorney admitted that the only two theories against defendant related to the administration of atropine and the delay in calling the Code Blue. Defendant contends [*56] that plaintiff's attorney improperly argued in closing that the failure to hand-bag Wilson and the "bucking" incident were also evidence of negligence. Earlier, during the motion for a directed verdict, plaintiff's attorney mentioned that defendant breached the standard of care by failing to call a Code Blue soon enough and by giving an inappropriate dose of atropine. The following exchange occurred:

THE COURT: So it is really a two-pronged argument with regard to defendant Keim[-] one[, a]tropine; two, delay in response.

MR. JOHNSON [plaintiff's counsel]: Absolutely.

The parties and the court then continued discussing the directed-verdict motion, and the

²⁵ In the context of this issue, defendant refers again to her belief that plaintiff's attorney admitted that Bauman was not qualified to offer any causation testimony. This is an inaccurate representation of the record, as set forth in section II of this opinion.

court stated:

There is no - there can be no claimed breach here for any pre-operative evaluation or breach of contract, and there is clearly insufficient proof that Nurse Keim was an agent, actual or ostensible. Therefore, there can be no vicarious liability on the part of Henry Ford Hospital based upon ostensible agency.

So the case will go to the jury on those issues as indicated by Mr. Johnson and no more. . . .

With regard to defendant's argument concerning hand-bagging, in counsel's initial reference to hand-bagging, he was simply [*57] pointing out that, under his view of the evidence, defendant's indication during opening arguments that the evidence would show that hand-bagging had taken place had never actually materialized. That was not improper. With regard to the additional references to hand-bagging, we simply cannot conclude that counsel's argument resulted in undue prejudice, because counsel did not directly argue that the lack of hand-bagging was the cause of Wilson's death. Counsel instead argued that his client "paid" for defendant's failure to call a prompt Code Blue.

With regard to the "bucking" incident, counsel stated, "And to be clear we're not claiming that because the patient bucked, it had any [e]ffect on the outcome of his health" Accordingly, the jury was properly informed that this was not a basis for liability, and no prejudice is apparent.

Defendant next argues that plaintiff's attorney improperly insinuated that defendant's departure from employment with Henry Ford was related to her negligence. Defendant states:

Plaintiff also asked the jury to speculate and infer negligence based upon the fact that Keim has not worked at Henry [F]ord Hospital since the date of the incident, even [*58] though the only testimony at trial was that Keim was scheduled to start a new assignment at a differen[t] hospital the following week.

Plaintiff's counsel stated the following during closing arguments:

She's gone. Last day of work at Henry Ford, ladies and gentlemen. She was there from March of 1999 until May 29, 2001 and she's going to sit in that witness stand and she's going to look you in the face under oath and ask you to believe that it is just a coincidence that she never set foot in that hospital ever again. Just a coincidence. She's gone, never to go back.

Defendant had testified that it was just a coincidence that she ceased work at Henry Ford

on the same date as the incident with Wilson; she stated that her agency had scheduled her, in advance, for a job at a different hospital. It is clear that plaintiff's attorney was attempting to discredit defendant's testimony. Defendant has set forth no reasoned argument and has cited no authority for why that was improper. Accordingly, she has abandoned this argument for purposes of appeal. *Wilson, supra at 243*. At any rate, the trial court instructed the jury as follows: "Arguments, statements and remarks of attorneys are not evidence. [*59] And you should disregard anything said by an attorney which is not supported by evidence, or by your own general knowledge and experience." We find no basis on which to reverse.

Defendant also argues that plaintiff's attorney improperly referred to the number of witnesses that appeared for each side and improperly referred to the fact that plaintiff's future damages would be reduced by a third. Once again, however, defendant cites no authority in support of his arguments and has thus abandoned them. *Id.* Moreover, we note that the court sustained defendant's objection to the reduction-in-future-damages arguments.

Under the circumstances, we find no basis for reversal. We reject defendant's allegation of a pattern of blatant, prejudicial conduct on the plaintiff's attorney.

XIV

Plaintiff argues that the trial court erred in applying the lower noneconomic damages cap set forth in *MCL 600.1483*. This statute states, in part:

(1) In an action for damages alleging medical malpractice by or against a person or party, the total amount of damages for noneconomic loss recoverable by all plaintiffs, resulting from the negligence of all defendants, shall not exceed \$ 280,000.00 unless, as the result [*60] of the negligence of 1 or more of the defendants, 1 or more of the following exceptions apply as determined by the court pursuant to section 6304, in which case damages for noneconomic loss shall not exceed \$ 500,000.00:

* * *

(b) The plaintiff has permanently impaired cognitive capacity rendering him or her incapable of making independent, responsible life decisions and permanently incapable of independently performing the activities of normal, daily living.

The trial court, in applying the lower cap, stated that the injured person "must have the impairment at issue here at the time of the filing of the lawsuit." Plaintiff disagrees, arguing that because Wilson had a qualifying injury before his death, the higher cap

applies. We agree. This issue involves statutory interpretation, which is reviewed de novo. *Marketos, supra at 412*.

The Supreme Court considered a similar issue in *Shinholster v Annapolis Hosp.*, 471 Mich. 540; 685 N.W.2d 275 (2004). Justices Markman and Weaver agreed with plaintiff's interpretation in the instant case, *id. at 562, 572*, while Justices Cavanagh and Kelly concurred with the result only, *id. at 572*. The reasoning of Justices Markman and Weaver was adopted by [*61] this Court in *Young v Nandi*, 276 Mich. App. 67, 75-76; 740 N.W.2d 508 (2007). This Court rejected an argument parallel to that set forth by defendant in the present case, ruling that as long as it can be shown that the deceased suffered one of the qualifying injuries before death, than the higher cap applies in a wrongful-death case. *Id.* Accordingly, if Wilson did experience a qualifying injury before death as a result of defendant's negligence, the higher cap applies.²⁶

The jury answered "yes" when asked the following question:

After May 29, 2001, but before his death, did Ronald Wilson have permanently impaired cognitive capacity rendering him incapable of making independent, responsible life decisions and permanently incapable of independently performing the activities of normal daily living?

However, despite this finding by the jury, *MCL 600.1483(1)* states that the court shall make the pertinent findings. See also *Shinholster, supra at 591 (Corrigan, J.)*. Here, the court did not make a decision on the issue because it concluded that Wilson's [*62] death mandated the application of the lower cap. Therefore, we must remand this case for further proceedings. The trial court must determine whether Wilson suffered a qualifying injury such that the higher cap applies.

XV

Plaintiff next argues that the trial court erred in granting defendant's motion for remittitur. We review the trial court's decision for an abuse of discretion. *Coble v Green*, 271 Mich. App. 382, 392; 722 N.W.2d 898 (2006). As mentioned earlier in this opinion, defendant argued that the evidence supported no amount of past economic damages beyond the \$ 314,571 recited by plaintiff's attorney. The court ruled:

I am satisfied the record does not support recovery of more than 3 hundred 14 thousand 5 hundred and 71 dollars for past economic loss in this case. It's quantifiable to the penny under the circumstances of this case. So the judgment

²⁶ We reject defendant's argument that the lower cap must apply because the "plaintiff" in this case was the estate. See *Young, supra at 72-73*.

is reduced from 5 hundred thousand to 3 hundred 14 thousand 5 hundred 71 with regard to past economic damages.

Plaintiff argues that there was no evidence that the jury was influenced by passion or prejudice and that the \$ 500,000 award for past economic loss should be reinstated.

"In [evaluating] a motion for remittitur, the trial [*63] court must decide whether the jury award was supported by the evidence." *Henry v Detroit*, 234 Mich. App. 405, 415; 594 N.W.2d 107 (1999). "The trial court's inquiry is limited to objective considerations regarding the evidence adduced and the conduct of the trial." *Weiss v Hodge*, 223 Mich. App. 620, 637; 567 N.W.2d 468 (1997). As stated in *Palenkas v Beaumont Hosp*, 432 Mich. 527, 531; 443 N.W.2d 354 (1989):

The trial court, having witnessed all the testimony and evidence as well as having had the unique opportunity to evaluate the jury's reaction to the proofs and to the individual witnesses, is in the best position to make an informed decision regarding the excessiveness of the verdict. Accordingly, an appellate court must accord due deference to the trial court's decision

In his closing argument, plaintiff's attorney set forth the following as past economic damages: \$ 169,000 for lost wages, \$ 21,403 for lost household services, and \$ 124,168 for medical bills, for a total of \$ 314,571. Plaintiff does not argue that the evidence supported a greater award for medical expenses or lost household services. Plaintiff focuses on the award for lost wages, arguing that the evidence [*64] supported an amount greater than \$ 169,000.

A vocational rehabilitation counselor testified that Wilson's earning capacity was \$ 25,000 to \$ 30,000 a year and that he did not use the upper-end figures for janitors (\$ 50,000 to \$ 60,000 a year) because those figures were for the automobile industry and the witness "had no information that [Wilson] ever applied for a job in the auto industry." The witness also testified that fringe benefits amount to twenty percent or twenty-five percent of a person's salary. Another of plaintiff's witnesses testified that Wilson's past job-related loss, using an annual salary in the mid-\$ 30,000-range, amounted to \$ 169,000, which is the figure plaintiff's attorney argued to the jury. However, the witness indicated that the \$ 169,000 represented the loss until the date of his report and that there would be "let's say another roughly . . . 20 thousand dollars in past loss" by August 1, 2006.²⁷

It is true that if the jury chose to use the upper-end salary for janitors, calculated the value of fringe benefits, and then considered the medical expenses and the value of the

²⁷ The jury rendered its verdict on July 27, 2006.

lost household services, the \$ 500,000 [*65] award was tenable. The problem, however, is that there was simply no evidence that Wilson would have been making the upper-end salary in the five years between his incapacitation and the time of trial. In light of this fact, and in light of the fact that we must give considerable deference to the trial court's decision, *Palenkas, supra 531*, we cannot conclude that the trial court erred in granting the motion for remittitur. However, we do conclude that \$ 20,000 should be added back to the verdict amount, based on the evidence that the \$ 169,000 figure did not include \$ 20,000 in additional past wage loss that would have occurred by the time of trial.²⁸

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

/s/ Patrick M. Meter

/s/ Michael J. Talbot

/s/ Deborah A. Servitto

²⁸ We do not consider defendant's argument that remittitur should have been granted in a greater amount because defendant did not raise the argument by way of a cross-appeal. *In re Herbach Estate*, 230 Mich. App. 276, 284; 583 N.W.2d 541 (1998). Also, we reject plaintiff's brief argument relating to "gifts/gratuities" provided by Wilson to her; it is unclear to us how these items mentioned by plaintiff would fall under the category of past economic losses; presumably these items would have been purchased by Wilson using lost wages, which [*66] were already included in the past economic losses.