

STATE OF MICHIGAN  
IN THE SUPREME COURT

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TOD MCLAIN, Personal Representative of the  
ESTATE OF TRACY MCLAIN,

Plaintiff-Appellant,

v

CITY OF LANSING FIRE DEPARTMENT,  
CITY OF LANSING, and JEFFREY  
WILLIAMS,

Defendants-Appellees

and

MICHAEL DEMPS,

Defendant.

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Supreme Court No. 151421

Court of Appeals No. 318927

Ingham County Circuit Court  
No. 11-000859-NH

Hon. James S. Jamo

John J. Bursch (P57679)  
WARNER NORCROSS & JUDD LLP  
900 Fifth Third Center  
111 Lyon Street, N.W.  
Grand Rapids, Michigan 49503-2487  
616.752.2000  
jbursch@wnj.com

Courtney E. Morgan, Jr. (P29137)  
MORGAN & MEYERS PLC  
3200 Greenfield Road, Suite 260  
Dearborn, Michigan 48120-1800  
313.961.0130  
cmorgan@morganmeyers.com

*Attorneys for Plaintiff-Appellant*

Karen Elizabeth Beach (P75172)  
PLUNKETT COONEY  
38505 Woodward Avenue, Suite 2000  
Bloomfield Hills, Michigan 48304-5096  
248.901.4098  
kbeach@plunkettcooney.com

*Attorneys for Defendants-Appellees*

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**ESTATE OF TRACY MCLAIN'S  
SUPPLEMENTAL BRIEF IN SUPPORT OF  
APPLICATION FOR LEAVE TO APPEAL**

**ORAL ARGUMENT REQUESTED**

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## STATEMENT OF QUESTIONS PRESENTED

1. Whether a hospital's medical progress notes of a patient's condition and diagnoses is admissible evidence.

Plaintiff-Appellant answers: Yes.

Defendants-Appellees answer: No.

The Court of Appeals answered: Possibly yes.

The trial court answered: No.

2. Whether there is sufficient evidence of gross negligence in the record to submit this case to a jury.

Plaintiff-Appellant answers: Yes.

Defendants-Appellees answer: No.

The Court of Appeals answered: No.

The trial court answered: No (based in part on its answering "no" to the first Question).

## RULES INVOLVED

The hospital records at issue here implicate two hearsay exceptions (medical-treatment and business-record) in Michigan Rule of Evidence 803 which states, in relevant part:

(4) **Statements made for purposes of medical treatment or medical diagnosis in connection with treatment.** Statements made for purposes of medical treatment or medical diagnosis in connection with treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably necessary to such diagnosis and treatment.

\* \* \*

(6) **Records of regularly conducted activity.** A memorandum, report, record, or data compilation, in any form, of acts, transactions, occurrences, events, conditions, opinions, or diagnoses, made at or near the time by, or from information transmitted by, a person with knowledge, if kept in the course of a regularly conducted business activity, and if it was the regular practice of that business activity to make the memorandum, report, record, or data compilation, all as shown by the testimony of the custodian or other qualified witness, or by certification that complies with a rule promulgated by the supreme court or a statute permitting certification, unless the source of information or the method or circumstances of preparation indicate lack of trustworthiness. The term “business” as used in this paragraph includes business, institution, association, profession, occupation, and calling of every kind, whether or not conducted for profit.

## INTRODUCTION

This is a medical-malpractice action involving Defendants' gross negligence in treating decedent, Tracy McLain. In February 2009, Mrs. McLain suffered a respiratory attack and could not breathe. Defendants attempted to intubate Mrs. McLain but did not take any vital signs or otherwise monitor her oxygen levels *after* the procedure. When Mrs. McLain arrived at the hospital 8 minutes later, hospital personnel discovered the breathing tube lodged in Mrs. McLain's esophagus, not her trachea; the tube had been there for at least five minutes; and Mrs. McLain's vital signs showed no pulse and very low blood-oxygen levels (SpO2 45%). Mrs. McLain's vital signs rebounded when the hospital properly intubated her, but she had already suffered brain damage from the lack of oxygen, and she died after having been removed from life support.

On February 5, 2016, this Court granted oral argument on the application and directed the parties to address two issues: (1) the admissibility of hospital notes documenting the misplacement of the breathing tube, and (2) whether the record creates a jury-submissible issue regarding Defendants' gross negligence. As to issue one, the hospital notes were admissible as a business record under MRE 803(6), and the statements about the breathing tube's location are admissible under MRE 803(4) because they relate to Mrs. McLain's medical treatment and diagnosis. *Merrow v Bofferding*, 458 Mich 617, 627 n 8, 630-633; 581 NW2d 696 (1998).

On issue two, the hospital notes alone are sufficient to create a question of material fact regarding Defendants' gross negligence. But even if those notes are not considered, the issue must go to a jury because Defendants failed to check Mrs. McLain's vital signs or monitor her oxygen levels after intubation. Had they done so, the mal-positioned tube would have been readily discovered. A reasonable jury could conclude that this failure constituted gross negligence that cost Mrs. McLain her life.

## SUMMARY OF FACTS

The Estate provided a comprehensive statement of facts and proceedings in its application for leave (pp 4-6, 15-25). The most important undisputed facts pertinent to the two questions the Court has asked the parties to address are as follows:

- On February 7, 2009, Mrs. McLain had a respiratory attack and could not breathe. Her husband dialed 911 and Defendant EMT-Paramedic Jeffrey Williams and EMT-Basic Michael Demps responded. They arrived to find Mrs. McLain “grey in color, with severe difficulty breathing.” (Appl Ex D, Incident Report 2.)
- While Williams and Kemp were present, Mrs. McLain “went into respiratory arrest.” (*Id.* at 3.) At 8:16 p.m., Williams and Kemp took their first—and only—read of Mrs. McLain’s vital signs. (Appl Ex E, Pre-Hospital Care Report 2.) Mrs. McLain had no pulse, and her blood-oxygen level (SpO<sub>2</sub>) was 85. (The 85 SpO<sub>2</sub> reading means that her red-blood cells were made up of 85% oxygenated and 15% non-oxygenated hemoglobin; SpO<sub>2</sub> is normally between 95 and 100.)
- At 8:20 p.m., Defendants attempted to intubate. (Appl Ex E, Pre-Hospital Care Report 2.) Defendants’ report says that the attempt was successful and indicates that there was “tube misting” (*id.*), an indication that the tube was in the trachea, where it belonged. But in the ambulance, when Mr. McLain asked Defendants whether his wife would be o.k., one EMT said “This isn’t working,” and the other responded “I’ve done this hundreds of times.” (Appl Ex F, McLain Dep 46.)
- Defendants left Mrs. McLain’s home at 8:25 p.m. and arrived at the Ingham Regional Medical Center at 8:28 p.m. (Appl Ex E, Pre-Hospital Care Report 3.) As shown on Defendants’ own medical report, there is no record Defendants took or recorded *any* additional vital signs throughout Mrs. McLain’s time as a patient under their care. (*Id.* at 2.) There are no vital signs reported whatsoever post-intubation, even though at least eight minutes elapsed between the intubation and arrival at the hospital. (*Id.*) The standard of care for a patient who has difficulty breathing is to assess vital signs at least every five minutes. (Appl Ex J, Expert Krause Dep 27-28.)
- Upon arrival at the hospital, Mrs. McLain’s SpO<sub>2</sub> had dropped into the 40s. (Appl Ex I 1.)
- There are actually three sets of notes documenting Mrs. McLain’s condition when she arrived at the hospital. The first is Dr. Joel M. Post, D.O.’s contemporaneous, handwritten “Patient’s Progress Notes.” (Appl Ex H.) These notes reflect that when Mrs. McLain arrived at the emergency room, the intubation “tube [was] found to be in esophagus (estimation 5 minutes).” (*Id.* at 1.) The hospital re-intubated Mrs. McLain, and her vital signs immediately rebounded. (*Id.*) Her SpO<sub>2</sub> rose to 100% after proper intubation. (Appl Ex I 1.)

- Dr. Post also dictated a “History and Physical” report. (Appl Ex G.) This report lists Justin S. Kisaka, D.O., as attending and similarly states: “On presentation to the emergency department, it was discovered the endotracheal tube was in the esophagus. The believed duration of this tube placement was thought to be 5 minutes. The tube was withdrawn, and the patient was reintubated.” (*Id.* at 1.)
- Finally, Dr. Jason Henney dictated his own “Patient’s Progress Notes.” (Appl Ex I.) These notes likewise memorialize the fact that when Mrs. McLain arrived in the emergency room, “[t]here were not good breath sounds & the larynx was visualized with laryngoscope. ET tube seen in esophagus & immediately removed.” (*Id.* at 1.) After Mrs. McLain was re-intubated, she immediately improved and her “SpO2 gradually increased to 100%.” (*Id.*)
- After these events, the hospital’s Dr. Kowalczyk took Mr. McLain to a separate room to talk. Dr. Kowalczyk “said, ‘I have seen this happen other times.’ He said that, ‘your wife was not properly intubated,’ like that. And all the time that they was supposedly giv[ing] her oxygen, it was going into her stomach, and her brain died. And he said, ‘I’ve seen this happen before.’ And he said, ‘I’m very sorry.’” (Appl Ex F, McLain Dep 42-43.)
- Dr. Kowalczyk continued, “ ‘I talked [to] and I read the reports from the emergency room doctors, and when they brought Tracy in, they told me that once they looked at her, they saw that the intubation tube was stuck into her stomach, and not in her lungs, and she went all that time without any oxygen going to her brain.’ And he said, ‘That’s where the fault lies.’ He said, ‘If they would have done it right at the right—when they first intubated her, she’d probably be home with you right now.’ But when they got her in the emergency room, the doctors in there saw the problem, fixed it, and all her normal blood oxygen stuff went all back to normal. But it was too late, they told him, and then he passed it onto me that she went too long without getting any oxygen to her brain.” (*Id.* at 43.)
- The estate’s expert witness, paramedic Robert Krause, M.S., concluded that the vital signs the hospital took of Mrs. McLain are consistent with the intubation tube being improperly placed. (Appl Ex J, Expert Krause Dep 41-43.) The “airway problem was corrected [at the hospital], the tube was placed appropriately, the medications were then put on board, and because of the correction of the hypoxia, she responded to the medications.” (*Id.* at 75.)
- Contrary to Defendants’ report, Mr. Krause opined that “the [intubation] tube was not placed appropriately [initially], that it, in fact, it was placed in the esophagus, and that he [Defendant Williams] did not have good lung sounds.” (*Id.* at 82.) Although there “are numerous techniques for determining that an intubation has been done improperly,” Defendant Williams “repeatedly failed to take any of them, in failing to follow checklists and protocols, and ultimately in failing to recognize a failed intubation and do anything about it to save this patient’s life.” (Appl Ex K, Krause First Am Aff of Merit 5-6, ¶ 14.)

- The Estate’s expert pulmonologist, Alvin Bowles, M.D., opined that the taking of Mrs. McLain’s vitals at least every five minutes, namely at 8:21 p.m. and 8:26 p.m. “would have showed [Defendants] that there were dangerous difficulties caused by improper intubation.” (*Id.* ¶ 23.) And a “reasonably prudent pulmonologist would find it more likely than not that had Mrs. McLain either been re-intubated, with the improper intubation tube then removed, or extubated and then re-intubated, she would not have had prolonged respiratory distress, would not have had unconsciousness, and would not have died.” (*Id.* ¶ 26.)
- Defendants do not deny that watching a patient’s “O2 level rise” post intubation is a reliable method to verify the effectiveness of an intubation. (Appl Ex P, Williams Dep 44.) Yet it is undisputed that Defendants never took this action after intubation and before turning Mrs. McLain over to hospital personnel, a period of at least eight minutes, even though Defendants were aware of Mrs. McLain’s poor vital signs before intubation.

### STANDARD OF REVIEW

When deciding a dispositive motion regarding qualified immunity, “evidence of the non-movant is to be believed, and all justifiable inferences are to be drawn in his favor.” *Tolan v Cotton*, 134 S Ct 1861, 1863 (2014), quoting *Anderson v Liberty Lobby, Inc*, 477 US 242, 255 (1986). E.g., *Patterson v Kleiman*, 447 Mich 429; 526 NW2d 879 (1994) (affirming summary disposition under MCR 2.116(C)(7) was inappropriate in a case alleging a faulty insertion of an endotracheal tube; though defendants submitted affidavits that they had no involvement in inserting the tube, the plaintiff created a dispute of material fact by submitting a physician letter concluding that the tube had been inserted in a grossly negligent manner, and a hospital report showing that the disputed tube had been inserted before the patient arrived there).

Although a summary-disposition motion must be supported or opposed by *substantively* admissible evidence, the evidence “does not have to be in admissible form.” *Barnard Mfg Co v Gates Performance Eng’g, Inc*, 285 Mich App 362, 373; 775 NW2d 618 (2009), citing *Maiden v Rozwood*, 461 Mich 109, 124 n 6; 597 NW2d 817 (1999).

## SUPPLEMENTAL ARGUMENT

### I. The hospital records are admissible under MRE 803(4) and (6).

#### A. The hospital notes are admissible as business records.

As Defendants acknowledged in their brief opposing the application for leave, “hospital records are generally admissible under the business records exception to the rule against hearsay.” (Defs’ Br in Opp’n 32.) This is because a hospital record meets all the criteria of a business record under MRE 803(6): it is a “memorandum” or “report” of “events,” “opinions, or diagnoses, made at or near the time by, or from information transmitted by, a person with knowledge,” “kept in the course of a regularly conducted business activity,” and being in “the regular practice of that business activity to make the memorandum” or “report.” Thus, in *Merrow v Bofferding*, 458 Mich 617, 627; 581 NW2d 696 (1998), this Court held that a medical record is generally admissible under MRE 803(6). Accordingly, Dr. Post’s notes and those of Dr. Henney are all admissible.

#### B. The statements within the hospital notes are admissible as medical records.

In *Merrow*, this Court went on to examine a particular sentence within a medical record to the effect that the plaintiff had been “involved in a fight with his girlfriend and subsequently put his right arm through a plate glass window.” 458 Mich at 621. Agreeing with the Court of Appeals’ decision in *Bradbury v Ford Motor Co*, 123 Mich App 179, 187; 333 NW2 214 (1983), the Court said that, to be admissible, a particular statement in a medical report must also be medically relevant, i.e., “necessary for diagnosis and treatment.” *Id.* at 630, citing MRE 803(4). Accordingly, the “statement in the medical record relating that the plaintiff’s injury resulted from his arm going through a plate glass window *was* information reasonably necessary for diagnosis and treatment.” *Id.* (emphasis added). That “statement carries with it the inherent indicia of

trustworthiness in accordance with the rationale underlying the medical records exception.” *Id.* Conversely, “the statement in the medical record relating what occurred before the plaintiff’s arm went through the window, i.e., that he had a fight with his girlfriend, was *not* reasonably necessary for diagnosis and treatment and, thus,” fell outside the scope of MRE 803(4). *Id.*

Under this Court’s rationale in *Merrow*, the statements in the hospital records here that “the endotracheal tube was in the esophagus” are likewise admissible under MCR 803(4). These statements were made exclusively “for purposes of medical treatment or medical diagnosis in connection with treatment and describing medical history.” MRE 803(4). The statements were also made for the purpose of documenting “present symptoms” and of “the cause or external source thereof insofar as reasonably necessary to such diagnosis and treatment.” *Id.*

Specifically, Dr. Post acknowledged that he made the handwritten Progress Notes and dictated the History and Physical report. (Appl Ex C, Post Dep 27-32, 35-36, 38-39, 50-52.) Dr. Post testified that the information most likely came from another medical person; if he had obtained the information from a non-medically licensed person (e.g., Mr. McLain or his daughter), he would have made a notation to that effect. (*Id.* at 39-40, 53-56, 65-68, 81-83.) For his part, Dr. Henney testified that while he had no independent recollection of the medical records, any information he provided for the report would have been to “help in prognosis going forward.” (Appl Ex B, Henney Dep 53, 68, 73-74.) In sum, the disputed statements were made by medical personnel to document Mrs. McLain’s condition, treatment provided, and her response to those treatments. The statements about the tube therefore fall easily within the scope of MRE 803(4)’s plain language.

Defendants have not alleged the hospital records have no medical relevance. Instead, their challenge is based on a purported lack of foundation: the understandable inability of the record makers to recall, at their depositions, events that took place several years earlier in their hospital emergency room. Defendants support this argument in their brief opposing the application by characterizing this Court's decision in *Merrow* as having excluded the statement about the plaintiff's fight with his girlfriend because the defendants failed to lay a sufficient foundation regarding the source of the statement. (Defs' Br in Opp'n 33.)

But that is not what *Merrow* held. After examining whether the statement about the fight was justified under the medical-records exception, MRE 803(4), the Court considered whether the defendants laid a "sufficient foundation regarding the source of the statement in order to allow its admission under a *nonhearsay* justification." 458 Mich at 628 (emphasis added). Specifically, the Court analyzed whether the statement was a previous inconsistent statement of a witness, admissible to impeach credibility under MRE 613(b). By definition, MRE 613(b) includes a foundational prerequisite: that the statement was made by the witness the opposing party seeks to impeach. The defendants in *Merrow* could not provide that foundation. 458 Mich at 631-632. For the same reason, this Court concluded that the statement about the fight could not be justified under MRE 801(d)(2); defendants could not establish that the statement came from a party. *Id.* at 633.

In contrast here, the whole point of the business-record and medical-treatment exceptions is that a party proffering such records need not establish who made the statement, because the documents themselves are considered reliable even if *no one* remembers who made the statement. The only foundational element is whether the statement was made "in the regular course of business" or medical care. *Id.* at 627 n 8. When the "declarant" (as opposed to the scrivener)

is a physician acting in the regular course of business and treatment, all statements are admissible. But even where the declarant is the patient “*or some unknown source*,” statements “concerning the patient’s past medical history, etc., would be admissible as statements made for purposes of diagnosis and treatment under MRE 803(4).” *Id.* (emphasis added). So the Estate has no obligation to prove the “source” of the information, recorded in the hospital records, that “the endotracheal tube was in the esophagus” for an estimated five minutes (or more).<sup>1</sup>

Accepting Defendants’ position would have the practical effect of writing 803(4) and (6) out of the Rules of Evidence entirely for all medical settings. In a context where doctors and nurses see countless patients, in rapid succession and over a very brief period of time, it is to be expected that over time they may not remember the details of a particular case, or even that they treated a particular patient. And while the admission of the disputed evidence here benefits the Estate, the admission of similar evidence in other gross-negligence (or even garden-variety medical malpractice) cases is equally likely to benefit the doctors who made the notes and the hospitals where treatment was provided. Indeed, leaving intact the Court of Appeals’ published, precedentially-binding opinion will bring all use of the business-record exception to a halt in all manner of cases. This Court should rejected Defendants’ invitation to use this case as a vehicle to abolish these important hearsay exceptions.

Significantly, the whole point of the hearsay doctrine is to exclude potentially unreliable testimony, yet there is nothing unreliable about Dr. Post’s and Dr. Henney’s medical notes in this case. The hospital staff found these records reliable enough to make life-and-death decisions

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<sup>1</sup> The Court of Appeals reiterated this principle in *People v Yost*, 278 Mich App 341; 749 NW2d 753 (2008). “The hearsay exception stated in MRE 803(4) is not limited to statements made by the person being diagnosed or treated.” *Id.* at 362 n 2. Rather, the rule extends to any statement made “for purposes of medical treatment or medical diagnosis in connection with medical treatment,” even if made by non-physician “third parties.” *Id.*

about Mrs. McLain's diagnosis and treatment; the trial court should have considered them reliable enough to consider in deciding Defendants' summary disposition motion. And while the Court of Appeals felt that the records were possibly admissible under MRE 803(6), it should have reached that conclusion unequivocally. In fact, the Court of Appeals' disregard of the hospital records simply because Dr. Post could not precisely recall the source of the information is anathema to the hearsay exception's purpose and amounts to an impermissible judgment on the credibility of the non-moving party's evidence. This Court's guidance is sorely needed to explain to lower courts and parties that statements regarding medical history and treatment in hospital business records are admissible under MRE 803(4) and (6), and that the credibility of such statements is always the province of the trier of fact, not the Court.

**II. With or without the hospital records, there is adequate lay and expert evidence in the record to create a question of material fact regarding Defendants' gross negligence.**

**A. The hospital records create a question of material fact regarding Defendants' gross negligence.**

After concluding the hospital records were possibly admissible, the Court of Appeals then discounted the information in the records because Dr. Post "did not have direct knowledge of where the tube was located, and did not know from whom he received the information he recorded." Slip Op 6. While that may possibly be a point to make on cross-examination at trial, the Court of Appeals misunderstood the nature of emergency-room practice (which, as noted above, will often result in attending physicians being unable to recall a particular patient, diagnosis, or treatment). The Court of Appeals also contravened this Court's decision in *Merrow*, which made clear that hospital records documenting a patient's medical decision are valid evidence, even if the statement comes from an "unknown source." at 627 n 8. And the Court of Appeals misunderstood its role in reviewing a summary-disposition decision.

As noted above, the standard of review when considering a motion for summary disposition based on immunity under MCR 2.116(C)(7) requires that all of the non-moving party's evidence be believed and all inferences drawn in his favor. For purposes of evaluating Defendants' motion here, once this Court determines that the hospital records were admissible, it must assume as true that the endotracheal tube was in Mrs. McLain's esophagus for an estimated period of at least five minutes. From that starting point, a reasonable jury could then draw one of two conclusions: (1) Defendants placed the tube in Mrs. McLain's esophagus and failed to verify proper placement or rectify improper placement; or (2) Defendants placed the tube in Mrs. McLain's trachea and the tube somehow relocated itself at some point into her esophagus in route to the hospital (though there is no mention of such a possible event in Defendants' own pre-hospital record). Drawing all inferences in the Estate's favor, this Court must assume that Defendants placed the tube in Mrs. McLain's esophagus, did not verify its placement as Defendants have alleged, and left the tube there for at least five minutes. But either way, Defendants' failure to check Mrs. McLain's vital signs even one time after the intubation procedure was complete is evidence of gross negligence, as the Estate's expert has unequivocally testified. (Appl Ex J, Krause Dep 105.)

**B. Even absent the hospital records, there is ample evidence creating a dispute of material fact regarding Defendants' gross negligence.**

The Court of Appeals erroneously boiled all of the Estate's evidence down to two things: (1) the hospital records, and (2) the Estate's assertions that Williams' testimony was not credible. Weighing these two items against Defendant Williams' self-serving testimony that he committed no errors when attending Mrs. McLain, the Court of Appeals concluded that the Estate's evidence was "insufficient to rebut" Defendants' evidence. Such judicial *ipse dixit* has no place when evaluating a motion for summary disposition.

To reiterate the standard, this Court must assume the truth of all the Estate's evidence and draw all reasonable inferences in favor of the Estate. Under that standard, there is more than ample evidence for a reasonable jury to conclude Defendants were grossly negligent, wholly aside from the hospital records.

In *Jennings v Southwood*, 446 Mich 125, 128; 521 NW2d 230 (1994), this Court determined that, in the context of the EMSA (MCL 333.20965), "gross negligence" means conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results. One of the companion cases the *Jennings* Court sent back to the trial court, *Boroditsch v Community EMS*, 444 Mich 893; 511 NW2d 687 (1993), similarly involved the placement of an endotracheal tube into the esophagus, and the failure to discover this fact in a timely manner.

As in *Boroditsch*, the record here, taken in a light most favorable to the Estate, supports the conclusion that Defendants failed to verify the tube's position or otherwise measure Mrs. McLain's vital signs, including oxygenation, at any time after intubation. A reasonable jury could conclude this is gross negligence, i.e., conduct so reckless that it shows a substantial lack of concern whether an injury results. A tube in the esophagus actually *prevents* the flow of oxygen into the lungs; it *prevents* a patient's ability to breathe on their own. It is therefore vital to reliably ascertain that the tube is in the trachea and not the esophagus. Otherwise, brain damage is inevitable (as this case demonstrates). While Defendants' pre-hospital care report contains evidence that tube placement was verified, this report is directly contradicted by Mrs. McLain's condition when she arrived at the hospital: after the hospital staff removed the tube Defendants inserted and re-intubated, Mrs. McLain's vital signs immediately rebounded, and her SpO2 jumped from the 40s to 100%. And Defendants prepared their own report *after* Mrs. McLain was already admitted to the hospital, with full knowledge of the disastrous outcome.

To reiterate, the hospital record flatly contradicts Defendants' pre-hospital report asserting proper tube placement and verification. The hospital record shows a patient who has suffered a prolonged period of oxygen deprivation, who responded immediately to proper intubation once that event occurred and was verified. These facts lead to one of two reasonable inferences: that Defendants placed the tube and never bothered to verify its placement or its effect on the patient's emergent state of health, or Defendants observed the tube was out of place and did nothing about it. Both scenarios would allow a jury to find gross negligence, and possibly even willful misconduct. Where there are two competing medical records—one, prepared by Defendants, that supports Defendant's position, and the other, prepared by hospital personnel, that supports the Estate's position—the weight and credibility to be afforded these records is quintessentially a jury question. Unfortunately, both the trial court and the Court of Appeals improperly mixed the issues of evidence credibility and admissibility together, and it is this mischief which this Court should not hesitate to untangle, lest it be repeated in future cases.

Three additional notes. First, there is no record evidence that Defendants checked Mrs. McLain's vital signs to determine that she was receiving adequate oxygen post-intubation. This violated Defendants' standard of care—to check vital signs at least every five minutes—as the Estate's expert testified. (Appl Ex J, Krause Dep 27-28.) Even Defendants admit that monitoring a patient's oxygen after intubation is a reliable way to determine if the intubation is effective. (Appl Ex P, Williams Dep 44.) Had Defendants checked Mrs. McLain's vital signs at *any* point post-intubation and observed her dangerously low, and still falling, oxygen levels, they could have responded. Defendants' gross negligence is not just an improper intubation, but a failure to check and discover the procedure was unsuccessful. (*Id.* at 105 (“The important element here is the recognition that [the tube is] in the esophagus [and] to correct that problem.”).)

Second, the undisputed evidence establishes that within a few moments of the problem being corrected, Mrs. McLain's breathing and other vital functions promptly returned, with her SpO2 jumping from the 40s to 100%. (Appl Ex J, Krause Dep 75.) The most reasonable inference to draw from that undisputed fact is that Defendants' attempted intubation did not restore Mrs. McLain's breathing, yet Defendants did not notice that fact for several minutes, when the patient's airway should have been their main focus and where Defendants' inattention resulted in permanent brain damage. Indeed, that is the *only* inference that can be drawn.

Third, the record establishes significant problems with Defendant Williams' testimony and report. For example, Williams testified that PEA (Pulseless Electrical Activity, i.e., cardiac arrest) and intubation have nothing to do with each other, whereas Krause, the Estate's expert, explained at length why that testimony is "clearly incorrect." (Appl Ex J, Krause Dep 34-35.) Williams' testimony that there were no problems with the intubation is contradicted by the few vital signs of Mrs. McLain that do exist. (*Id.* at 42-43.) Williams' report lacks fundamental information that (according to the report template) was required to be documented, such as the depth of the intubation and the use of an esophageal detection device. (*Id.* at 58.) Williams testified that he had complete control of the intubation procedure but doesn't know who (if anyone) actually checked the tube placement. (*Id.* at 60.) Williams' report does not indicate any abdominal distension (stomach expansion) post-intubation, a crucial breathing sign that an EMT would have documented in the report had it been actually observed. (*Id.* at 90.)

A jury is entitled to weigh the evidence and determine Defendant Williams' credibility. Given all the problems with the report—and the additional undisputed fact that Williams filled out his report after Mrs. McLain had already been re-intubated at the hospital and it was clear that she had suffered brain damage from a lack of oxygen while in Defendants' care—a

reasonable inference is that Williams falsified his report. At a minimum, the self-serving nature of this evidence damages its credibility, if not its admissibility. See *Solomon v Shuell*, 435 Mich 104, 119; 457 NW2d 669 (1990). Taken in a light most favor to the Estate, a jury could wholly discount this evidence and find in favor of the Estate.

In Defendants' brief in opposition, they trumpet their own version of events and their own evidence, arguing that their proofs trump those of the Estate. (Defs' Br in Opp'n 36-44.) These are arguments to present to a jury, and they require the weighing of evidence and assessment of credibility. As a result, Defendants' evidence and inferences are wholly inadequate to warrant summary disposition. Just as in *Patterson v Kleiman*, 447 Mich 429; 526 NW2d 879 (1994), this Court should hold that summary disposition under MCR 2.116(C)(7) is inappropriate where conflicting evidence exists regarding the circumstances surrounding the faulty insertion of an endotracheal tube.

## **CONCLUSION AND REQUESTED RELIEF**

The Estate appreciates the substantial commitment that EMTs make to serve the residents of their communities. That appreciation is embodied in Michigan immunity law, which prohibits lawsuits against EMTs alleging mere negligence and requires proof of gross negligence. But when an EMT takes the serious step of cutting off a patient's airway by inserting a plastic tube, it is incumbent on the EMT to conduct regular checks to ensure the patient is actually receiving oxygen after the procedure. The record shows that Defendant Williams failed to take that necessary step here—a failure that the Estate's experts have correctly characterized as gross negligence. But for that gross negligence, Tod McLain would still have his wife, Tabbetha McLain would still have her mother, and Tracy McLain would still have her life.

The Estate is entitled to have the hospital's records admitted, and is further entitled to have a jury consider the entire record and determine whether Defendants did act in a grossly negligent manner. Accordingly, the Estate respectfully requests that this Court reverse the grant of summary disposition, affirm the admission of the hospital records, and remand for trial.

Respectfully submitted,

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WARNER NORCROSS & JUDD LLP

By /s/ John J. Bursch

John J. Bursch (P57679)  
900 Fifth Third Center  
111 Lyon Street, N.W.  
Grand Rapids, Michigan 49503-2487  
616.752.2000  
jbursch@wnj.com

Courtney E. Morgan, Jr. (P29137)  
MORGAN & MEYERS PLC  
3200 Greenfield Road, Suite 260  
Dearborn, Michigan 48120-1800  
313.961.0130  
cmorgan@morganmeyers.com

*Attorneys for Plaintiff-Appellant*

14026473