

STATE OF MICHIGAN
IN THE SUPREME COURT

(ON APPEAL FROM THE MICHIGAN COURT OF APPEALS)

TOD McLAIN, as Personal Representative
of the Estate of TRACY McLAIN, Deceased,

Plaintiff-Appellant,

v

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

Defendants-Appellees,

and

MICHAEL DEMPS,

Defendant.

SC No. 151421
COA No. 318927
LC No. 11-859-NH
(Ingham County Circuit Court)

**DEFENDANTS-APPELLEES' BRIEF IN OPPOSITION TO APPLICATION FOR
LEAVE TO APPEAL**

PROOF OF SERVICE/STATEMENT REGARDING E-SERVICE

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COUNTER-STATEMENT OF THE QUESTIONS PRESENTED

I.

WHETHER THE TRIAL COURT ERRED OR ABUSED ITS DISCRETION BY DENYING PLAINTIFF'S REQUEST FOR SUMMARY DISPOSITION OR DEFAULT WHERE MICHIGAN LAW DOES NOT REQUIRE EMERGENCY MEDICAL SERVICE PROVIDERS TO FILE AFFIDAVITS OF MERITORIOUS DEFENSE UNLESS AND UNTIL A COURT HAS RULED THEY ARE NOT ENTITLED TO IMMUNITY FROM SUIT?

Plaintiff-Appellant says "yes."

Defendants-Appellees say "no."

The trial court says "no."

The Court of Appeals says "no."

II.

WHETHER THE TRIAL COURT ERRED BY GRANTING SUMMARY DISPOSITION UNDER MCR 2.116(C)(7) AND THE EMERGENCY MEDICAL SERVICES ACT, MCL 333.20965, WHERE PLAINTIFF PROFFERED NO ADMISSIBLE EVIDENCE CREATING A GENUINE ISSUE OF FACT AS TO WHETHER DEFENDANTS WERE GROSSLY NEGLIGENT OR COMMITTED WILLFUL MISCONDUCT?

Plaintiff-Appellant says "yes."

Defendants-Appellees say "no."

The trial court says "no."

The Court of Appeals says "no."

COUNTER-STATEMENT OF APPELLATE JURISDICTION

The statement of appellate jurisdiction on page iv of the Application for Leave to Appeal of Plaintiff-Appellant Tod McLain, Personal Representative of the Estate of Tracy McLain, Deceased (“Plaintiff”), is complete and correct as to this Court’s jurisdiction over Plaintiff’s request for leave to appeal the March 3, 2015 opinion of the Court of Appeals in favor of Defendants-Appellants City of Lansing Fire Department, City of Lansing and Jeffrey Williams (collectively, “Defendants”).

COUNTER-STATEMENT OF FACTS

A. Introduction.

Despite a successful intubation, Paramedic Jeffrey Williams and two of his colleagues were unable to save Plaintiff's decedent, Tracy McLain, from the consequences of a severe asthmatic attack she suffered on February 7, 2009. In defense of ensuing litigation, Defendants asserted their entitlement to immunity from suit under the Emergency Medical Services Act ("EMSA"), MCL 333.20965, which limits the liability of emergency medical personnel to conduct constituting gross negligence or willful misconduct. In an effort to overcome Defendants' request for summary disposition on the basis of immunity, Plaintiff argued that Defendants had improperly intubated the decedent in her esophagus and failed to realize this mistake, based entirely on a hearsay statement in the decedent's hospital care report (**Exhibit A**) ("Hospital Record") stating that the tube was found in her esophagus upon arrival at the hospital. However, discovery revealed that none of the decedent's treating doctors, including the doctor who dictated the Hospital Record, could verify the source of that alleged information, nor did any doctor remember discovering an improper intubation or reintubating the decedent. Plaintiff's reliance on this inadmissible statement regarding improper intubation was insufficient to create an issue of fact as to whether Defendants were grossly negligent or committed willful misconduct. Even if admissible, the hearsay statement in the Hospital Record does not establish gross negligence because a failed intubation would only be evidence of ordinary negligence. Moreover, Defendants proffered admissible evidence, including the testimony of the treating paramedics and the report authored by Williams, showing that the decedent was in fact properly intubated, and intubation was both verified and monitored during the ambulance ride. The trial court correctly granted summary disposition to Defendants under MCR 2.116(C)(7) (immunity

granted by law), and also correctly ruled that Defendants were not required to submit affidavits of meritorious defense unless and until they were found to not be immune from suit.

In a published opinion issued March 3, 2015 (**Exhibit T**), a panel of the Court of Appeals affirmed the trial court's grant of summary disposition, finding that Plaintiff had failed to create a question of fact to abrogate Defendants' immunity from suit. The panel found that the statement in the Hospital Record regarding the tube's location upon arrival at the hospital was hearsay lacking a reliable foundation as to the source of the statement, and that Plaintiff had failed to present any testimony to oppose Williams' testimony that he and his colleagues properly cared for the decedent—" [Plaintiff's expert] simply alleged that they were wrong" (*Id.* at 6). The panel also affirmed the trial court's denial of default or summary disposition based on Defendants' failure to file affidavits of meritorious defense, holding that the protections afforded to medical malpractice defendants claiming governmental immunity under MCL 691.1407, the Governmental Tort Liability Act ("GTLA") applied equally to defendants claiming immunity as emergency medical services providers under the EMSA, because this Court previously held that the statutes share a common purpose and are to be read *in pari materia* (**Exhibit T**, pp 4-5); *Jennings v Southwood*, 446 Mich 125, 136; 521 NW2d 230 (1994).

This Court should deny leave to appeal because the only issue in this case with any jurisprudential significance—the extension to EMSA defendants of this Court's holding in *Costa v Community Emergency Medical Services, Inc*, 475 Mich 403; 716 NW2d 236 (2006), that GTLA defendants asserting statutory immunity need not file affidavits of meritorious defense unless and until the court issues an order finding them not immune—was correctly decided by the panel's sound application of this Court's holdings in *Costa* and *Jennings*. See Argument I, *infra*. The other issue raised by Plaintiff—a garden-variety disagreement that no genuine issue of fact existed as to whether Defendants were grossly negligent in treating the decedent—was

also correctly decided by the Court of Appeals, as the evidence of improper intubation, even when viewed in the light most favorable to Plaintiff and assumed to be admissible, creates only a question of fact as to ordinary negligence. Plaintiff admits that in order to show gross negligence, he would have to establish that Defendants took no actions to verify proper intubation while in the ambulance. Testimony from Williams and Captain Murphy, as well as the report written by Williams, establishes that such actions were taken. Plaintiff cannot create an issue of fact as to gross negligence by proffering an expert witness who merely disbelieves this testimony and insists that Williams instead was reporting the results of tests not actually performed. See Argument II, *infra*.

B. Material facts.¹

1. Plaintiff's decedent suffers a severe asthma attack and unfortunately expires despite a successful intubation from her paramedics.

This case arises out of the response by Jeffrey Williams, EMT-Paramedic and Michael Demps – EMT-Basic, to a dispatch on a 9-1-1 call for a medical emergency at 620 Jessop Street for Tracy McLain on February 7, 2009. The 9-1-1 call was received at 20:12:42 (8:12:42 p.m.). Dispatch was at 20:14:08 (8:14:08 p.m.). (**Exhibit B**, Murphy deposition, pp 33-34).

Fire apparatus E49 arrived at the scene first at 20:16:33 (8:16:33 p.m.) with Captain Margaret Murphy, a Captain/paramedic with the Lansing Fire Department, firefighter/paramedic Christopher Norris and engineer/paramedic Jeffrey Brown.² The ambulance M-49 carrying Williams and Demps arrived at 20:17:29 (8:17:29 p.m.) (*Id.* at 19, 24, 26, 35). Murphy observed

¹ Defendants refer this Court to the medical glossary found at pages VI-XVII of Plaintiff's Court of Appeals brief for assistance in understanding the medical terms used within this brief.

² Neither Norris nor Brown have an independent recollection of the event and their recollection was not refreshed by viewing the Fire Department Incident Report or the Prehospital Care Report.

the decedent struggling to breathe and trying to use an albuterol inhaler. While Murphy was obtaining a history from a gentleman in the house, Paramedics Norris and Brown were treating the patient. The gentleman, later identified as Mr. McLain, gave Murphy the decedent's history of breathing trouble and prior intubations for respiratory issues. He also stated he and the decedent had been traveling that day. Murphy observed the decedent trying to use an inhaler. When the decedent stopped breathing Captain Murphy switched her role from captain and command on the scene to treating the patient along with the two other paramedics on E49, Norris and Brown. They began administering oxygen with a bag valve mask. Captain Murphy communicated the urgency of the situation to the medic (ambulance) crew, Williams and Demps (*Id.* at 37-41, 93-96).

Because the decedent was near the front door, she was placed on a backboard ("boarded") in the house for CPR and the decision was made to move her into the ambulance for the intubation to be performed. Murphy believes that the decedent went into respiratory arrest in the house before she was boarded (*Id.* at 40-41, 47-48).

Captain Murphy was in the back of the ambulance behind Williams at the head of the patient. She recalls Jeff Williams intubating and most likely Norris starting the IV. Murphy usually draws up the medications, hands the equipment to the medic and records the medications given. She does not recall seeing any signs of stomach distension after intubation. She did not see anything inappropriate or not going well or she would have become more involved in the patient care (*Id.* at 60-63).

According to Captain Murphy, based on her 20 years of experience, the only time an intubation would come out of the trachea would be if the patient was having spontaneous respirations and gagging and also when the patient is taken out of the back of the ambulance and the transfer to the hospital bed (*Id.* at 76-78).

Paramedic Williams' testimony regarding the incident was as follows: The ambulance (M49) pulled up behind the fire engine and Williams got out to walk up to the house with the "blue bag" containing the equipment. As he was walking up, Captain Murphy yelled out the door to get the airway kit ready and that the decedent would be brought to the ambulance. Demps went toward the house and Williams got in the back of the ambulance, got the airway kit ready and waited for the decedent to be brought to him. It takes between 40 and 60 seconds for him to open the airway kit and get the tools put together and check them. As soon as he finished preparing the airway kit, the decedent was rolling into the back of the ambulance on the "cot." As soon as the decedent was in the ambulance Williams went to work. According to Williams, Norris, Brown, Murphy, Demps and he were in the back of the ambulance. Someone tried to climb into the back of the ambulance and bumped him. Williams was busy treating the patient and someone else addressed that issue. (**Exhibit C**, Williams deposition, pp 60-71).

The decedent was being bagged when she was placed in the ambulance. Williams was situated in the "captain's chair" so that the decedent's head was between his legs. Williams bagged her and then someone else took over while he arranged the laryngoscope and tube in his hands. Once he hyperventilated the decedent to visualize her vocal cords, he intubated her. There was no vomit so it was clear for Williams to visualize the intubation. The intubation was complete at 20:20 (8:20 p.m.). The intubation was successful. There was no vomit in the tube, there was mist in the tube and there were lung sounds. The four lobes in the lungs and the abdomen were checked for air sounds and distention with a stethoscope. There was upper and lower lung air movement. When a person is being bagged gastric sounds are not heard. Mist in the tube means that the tube fills with mist after air has been pushed in and the bag is let out for 8 to 12 seconds. There was normal tube misting for the decedent. There was continuous monitoring of the chest rise, the abdomen not rising and mist in the tube which was noted on the

report as “patent airway.” The heart monitor placed on Mrs. McLain showed “sinus-Brady.” Williams noted on the report the “sinus Brady” and “without pulse”. The “sinus Brady” means the heart is putting out electric activity but is not pumping blood. “Without pulse” added to that means there was pulseless electric activity (PEA), which Williams did not believe was associated with the intubation. While the ambulance was parked, Murphy, Norris, Brown, Demps and Williams were in the back of the ambulance. Enroute to the hospital, Brown would have driven the fire engine and Demps drove the ambulance, leaving three people in the back of the ambulance to care for the patient. The ambulance left the house at 20:25 (8:25 p.m.) and arrived at the hospital at 20:28 (8:28 p.m.). Between the time the decedent was intubated at approximately 20:20 (8:20 p.m.) and 20:25 (8:25 p.m.) when the ambulance left the house the IV was put in. Drugs were administered enroute to the hospital by a paramedic other than Williams. Williams was bagging the patient while enroute to the hospital. Williams continued bagging the decedent while they were rolling her on the cot into the ER and stopped only when she was transferred to the care of the ER staff (*Id.* at 71-83, 91-92, 97).

Williams prepared the Prehospital Care Report (**Exhibit D**) reflecting the decedent’s treatment by EMS at the hospital between about 20:30 and 20:40 (8:30 and 8:40 p.m.) after the decedent was transferred to the hospital medical staff. Although Williams did not have a personal memory of every aspect of the decedent’s care at the time of his deposition over two years later, he remembered visualizing the intubation into the trachea and checking for improper intubation, and testified that if he wrote it on the report, the monitoring of misting, lung sounds and chest rise was performed by one of the medical professionals attending to the decedent (**Exhibit C**, pp 71-72, 83-84, 97, 99-102).

EMT Demps testified that in the back of the ambulance he turned on the monitor, hooked the decedent up to the monitor and hooked up the O2 line to the port in the back of the

ambulance. He recalls they were establishing an IV and the intubation kit was out. He recalls four fire department personnel in the back of the ambulance before it proceeded to the hospital – Williams, Brown, Demps and someone whom he cannot recall. While Demps was hooking up the monitor to the decedent, the gentleman Demps believed to be a relative who was seated in the passenger seat of the ambulance proceeded to crawl in between the two front seats and into a small area that led to the back of the ambulance. He was shouting about giving the patient a shot. At that point in time everyone was doing what they needed to do. Demps had to stop and look at him and tell him forcefully to get back to the front seat. This relative of the patient rode in the passenger seat of the ambulance to the hospital. Demps drove the ambulance to the hospital (**Exhibit E**, Demps deposition, pp 45-47, 49-52, 55-61). The ambulance arrived at Ingham Regional Medical Center four minutes later, at 8:29 p.m. (**Exhibit D**).

At some point after the decedent arrived in the ER, Dr. Jason Henney, then an ER resident, came to assist with her care. An hour later, her care was transferred to Dr. Joel Post, an ICU resident, who later dictated the Hospital Record (**Exhibit A**). The Hospital Record includes a statement that “[o]n 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.” When deposed, Dr. Henney did not recall treating the decedent, nor did he remember reintubating her or having any conversations regarding her care with other doctors (**Exhibit F**, Henney deposition, pp 41-43, 66). Dr. Post did not remember where this information came from (only that it had been told to him by another individual or individuals, possibly Dr. Henney), and denied having any direct information as to where the tube was located upon arrival or whether the decedent was reintubated at the hospital (**Exhibit G**, Post deposition, pp 31-32, 35-36, 39).

The decedent was declared brain dead on February 15, 2009 and died shortly thereafter. Her death certificate named asthma as the cause of death.

2. Summary disposition under MCR 2.116(C)(7) is granted to Defendants because there was no evidence creating a genuine issue of fact as to whether Defendants were grossly negligent or committed willful misconduct.

Plaintiff filed a medical malpractice complaint against Defendants on August 8, 2011 alleging that the Defendants' failure to properly intubate the decedent, combined with their subsequent failure to realize that improper intubation had occurred and reintubate her successfully, proximately caused her death. Defendants moved for summary disposition under MCR 2.116(C)(7) (immunity granted by law), the GTLA, and the EMSA, which provides immunity to emergency medical services providers "[u]nless an act or omission is the result of gross negligence or willful misconduct." Plaintiff moved for summary disposition under MCR 2.116(C)(9) or alternatively, for default to be entered against Defendants under MCR 2.603(A), because Defendants had not filed affidavits of meritorious defense under MCL 600.2912e.

On June 20, 2012, the Honorable Paula J.M. Manderfield denied Defendants' request for summary disposition, allowing Plaintiff to file an amended complaint and amended affidavits of merit alleging gross negligence by Defendants (**Exhibit H**, 6/20/12 hearing transcript, p 27). Judge Manderfield denied Plaintiff's request for default, ruling that Defendants would not be required to file affidavits of meritorious defense unless and until the court determined Defendants did not have immunity under the EMSA (*Id.* at 26). Judge Manderfield invited Defendants to refile their motion for summary disposition based on immunity after Plaintiff's amended complaint was filed (*Id.*).

After Plaintiff inserted the words "gross negligence" and "willful misconduct" into his amended complaint (**Exhibit I**) and amended affidavits of merit (**Exhibits J and K**), Defendants

refiled their motion for summary disposition under MCR 2.116(C)(7) and the EMSA. The case had since been transferred to the Honorable James S. Jamo. At the summary disposition hearing held on September 25, 2013, Judge Jamo noted that although both parties had submitted substantial amounts of evidence, the immunity issue boiled down to whether the Hospital Record dictated by Dr. Post—the genesis of Plaintiff’s allegation that the decedent was improperly intubated en route to the hospital—was admissible evidence creating a genuine issue of fact as to Defendants’ immunity under the EMSA. Judge Jamo agreed with Defendants’ position that because none of the doctors attending the decedent could establish who had discovered the improper intubation, there was no admissible evidence supporting Plaintiff’s theory that the tube was improperly inserted in the ambulance (**Exhibit L**, 9/25/13 hearing transcript, pp 5-6, 43-44). Absent admissible evidence of gross negligence, Plaintiff’s theory came down to a witness credibility challenge, which was insufficient to create an issue for trial. Judge Jamo’s ruling on the record was as follows:

All right. It seems to me that given the standard that needs to be met, which is gross negligence under MCL 333.20965, the emergency services statute, and looking at all of the testimony and evidence that has been presented by both sides, and there are volumes of it that have been submitted in connection with these—these motion, it really does come down to, in large part, this entry, which is Exhibit 4 to Plaintiff’s brief, this medical record entry by Dr. Post, which sort of sets in motion the suggestion that the tube was in the esophagus and not the trachea, and whether or not that—that creates some fact question that sort of you can backtrack into what Williams did or did not do in terms of was he negligent in terms of not observing something, or was he grossly negligent, as that term was defined and adopted under the case law that’s defined under the Tort Liability Act, which is conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results?

And when I looked at the testimony of Dr. Post, it seems clear in his testimony that he doesn’t remember what he did at the time. It seems clear in his testimony that he was not the person who had any direct information as to where the tube was located. And there are—there are several pages that are cited in Defendants’ brief as to specifically testimony on this point. But, ultimately, when you review that testimony, it basically says that he doesn’t know where the information came from other than, as he says on page 35 and 36, it’s sort of a subjective note of the

person writing the note's best sense, or, as he says "A note written to the best of their knowledge."

That's not—in my view, that's not really evidence that's admissible in response to the—to the obligation on the part of the non-moving party to refute this motion for summary disposition.

Absent that, all we are left with, really, is this argument, as Defense counsel indicates, is this argument that it's a credibility issue, and that we should submit to the jury whether or not Williams is credible in what he says he did even though there is no other testimony that really challenges that other than this—this medical note.

So I'm going to find that the standard, the gross negligence standard or willful conduct standard has not been met sufficiently to create a jury question or jury submissible question and grant the Defendants' motion for summary disposition.

(*Id.* at 42-44) (emphasis supplied). Because Plaintiff could not come forward with any admissible evidence creating a genuine issue of fact as to whether Defendants had acted with gross negligence or willful misconduct, Defendants were entitled to immunity as a matter of law and to summary disposition under MCR 2.116(C)(7).³

Plaintiff's timely appeal from the October 16, 2013 order granting Defendants' motion for summary disposition and the June 29, 2012 Order denying Plaintiff's request for default or summary disposition followed (**Exhibits M and N**).

The Court of Appeals affirmed the trial court's decisions in a published opinion issued March 3, 2015 (**Exhibit T**). Regarding the requirement to file an affidavit of meritorious defense, the panel found that because this Court had held in *Jennings* that the GTLA and the EMSA were to be read *in pari materia*, the rule in *Costa* for GTLA defendants applied with equal force to EMSA defendants, such that "a defendant who claims immunity under the EMSA may not lose the benefit of that immunity merely by failing to timely file an affidavit of

³ The trial court did not reach Defendants' argument below that the City of Lansing Fire Department was not an entity subject to suit separate from the City of Lansing itself. See Defendant's brief in support of summary disposition, p 6.

meritorious defense under MCL 600.2912e” (**Exhibit T**, pp 4-5). Likewise, the panel rejected Plaintiff’s argument that the trial court erred in not granting his request for default or summary judgment for failure to file an affidavit of meritorious defense, noting that this argument is “the exact sort of hollow proceduralism the Michigan Supreme Court cautioned against in *Costa*” (*Id.* at 5 n 7).

Regarding the merits of Plaintiff’s medical malpractice claims, the panel upheld the trial court’s grant of summary disposition under MCR 2.116(C)(7) because Plaintiff failed to create a question of fact that Defendants treated the decedent with gross negligence or willful misconduct such that EMSA immunity did not apply. The panel found that the medical progress note dictated by the medical intern, and Plaintiff’s protestations against the credibility of Williams’ testimony that he properly intubated and monitored the decedent during her ambulance ride, were insufficient to rebut Defendants’ evidence that Williams did not commit any errors constituting gross negligence when he attended to the decedent (*Id.* at 6). In rendering its decision, the panel did not reach the issue of whether the medical progress note was admissible because it was not necessary to resolve the case (*Id.* at 6 n 5).

STATEMENT OPPOSING SUPREME COURT REVIEW

Under MCR 7.302(A), it is incumbent upon Plaintiff as the Applicant to demonstrate grounds justifying this Court's review and resolution of the issues presented. While this case does present an issue of first impression under Michigan law, the issue was resolved in a jurisprudentially sound manner by the Court of Appeals panel, which applied two of this Court's prior opinions to reach a straightforward legal conclusion.

Plaintiff would have this Court disregard its prior opinions in *Costa* and *Jennings* to find that medical malpractice defendants claiming immunity under the EMSA are somehow not deserving of the protections afforded under *Costa* to defendants claiming immunity under the GTLA, contrary to this Court's statement in *Jennings* that "the GTLA and the EMSA share the common purpose of immunizing certain agents from ordinary negligence and permitting liability for gross negligence." 446 Mich at 136. Granting the relief requested by Plaintiff would undermine the legal force and precedential effect of this Court's holding in *Costa* because the Court concludes therein that the affidavit of meritorious defense requirement does not apply to GTLA defendants who are only liable for acts constituting gross negligence. As Plaintiff acknowledges Defendants are likewise only liable under the EMSA for acts constituting gross negligence, imposing the affidavit of meritorious defense requirement on Defendants here would call into question the soundness of *Costa*. In the same way, granting leave to appeal and drawing the distinction urged by Plaintiff between the GTLA and the EMSA would undermine the holding in *Jennings* that the statutes share a common purpose and are to be read *in pari materia* with respect to protecting defendants claiming immunity under both statutes from defending against ordinary negligence claims. To the extent the Court of Appeals decision in this case "sets aside" the requirement in MCL 600.2912e for timely filing an affidavit of meritorious defense, that judgment call has already been made by this Court in *Costa*, and is now relied upon

by medical malpractice litigants in cases involving assertions of immunity from suit. There is simply no compelling reason set forth by Plaintiff to revisit this judgment call, or to call into question the soundness of the holdings in *Costa* and *Jennings*, which were properly and soundly applied by the Court of Appeals to develop Michigan jurisprudence. Setting aside the Court of Appeals decision would undermine stare decisis with respect to those cases and impair the doctrine's goal of "promot[ing] the evenhanded, predictable, and consistent development of legal principles, foster[ing] reliance on judicial decisions, and contribut[ing] to the actual and perceived integrity of the judicial process." *McCormick v Carrier*, 487 Mich 180, 210; 795 NW2d 517 (2010), citing *Payne v Tennessee*, 501 US 808, 827 (1991). The current membership of this Court has thus far avoided the ugly specter of needlessly disregarding and overruling this Court's prior decisions, and should continue to do so by denying leave to appeal in this case.

Plaintiff's other issue on appeal is a decidedly pedestrian disagreement with the trial court's finding that no genuine issue of material fact existed to avoid summary disposition. This issue holds no jurisprudential significance and does not warrant the attention of this Court's limited resources, which are more properly devoted to issues with significant impact on Michigan law and litigants beyond this case. Defendants recognize that this Court's June 10, 2015 Order granting leave to appeal in *Yono v Dep't of Transportation*, Docket No. 150364, indicates that this Court will be reviewing whether questions of fact on a motion for summary disposition involving governmental immunity under MCR 2.116(C)(7) must be resolved by the trial court at a hearing or submitted to a jury. Defendants contend that the Court of Appeals decision in *Dextrom v Wexford Co*, 287 Mich App 406, 428-429, 430-432; 789 NW2d 211 (2010) correctly states that the threshold determination of whether a defendant is entitled to immunity is a question for the court to decide as a matter of law. Plaintiff cites cases applying

MCR 2.116(C)(10) in support of his contention that the trial court and Court of Appeals applied the incorrect summary disposition standard (Plaintiff's brief, pp 12-14).

More importantly, however, the question before this Court in *Yono* is irrelevant for purposes of this case because, as the trial court and the Court of Appeals correctly found, Plaintiff has failed to raise a factual dispute regarding gross negligence for resolution by either a jury or a trial court. The standard of care set forth in Plaintiff's amended affidavit of merit indicates that Defendants can only be found grossly negligent if they initially placed the breathing tube in the decedent's esophagus *and* did nothing during the ambulance ride to verify the tube's placement (**Exhibit K**, ¶ 11). As discussed in section 2 of Argument II, *infra*, Plaintiff's gross negligence claim fails because there is no admissible evidence of the predicate fact of an improper intubation by Defendants. However, even assuming *arguendo* that the hearsay statement in the Hospital Record was somehow admissible evidence that the decedent arrived at the emergency department with the tube located in her esophagus, this fact alone also fails to create a question of fact as to gross negligence because an improperly located tube is evidence only of *ordinary negligence*. The testimony of Williams and Murphy and the Prehospital Care Report all provide admissible record evidence that the decedent was intubated properly and that intubation was verified through visualization, lung sounds, chest rising, tube misting, and lack of abdominal distension. As discussed in subsections 3 and 4 of Argument II, *infra*, Plaintiff cannot create an issue of fact as to this compliance with the alleged standard of care by proffering an expert who simply disbelieves this evidence but cannot point to any support in the record for his speculative opinions that these steps were not taken, and that Williams reported the results of tests not actually performed. See *Badalamenti v William Beaumont Hospital*, 237 Mich App 278, 286; 602 NW2d 854 (1999) ("an expert's opinion is objectionable where it is based on assumptions that are not in accord with established

facts....[t]his is true where an expert witness' testimony is inconsistent with the testimony of a witness who personally observed an event in question, and the expert is unable to reconcile his inconsistent testimony other than by disparaging the witness' power of observation"), citing *Green v Jerome-Duncan Ford, Inc*, 195 Mich App 493, 499; 491 NW2d 243 (1992), and *Thornhill v Detroit*, 142 Mich App 656, 658; 369 NW2d 871 (1985). Plaintiff's allegations that Defendants were negligent for failing to verify intubation using tools which were not available to the ambulance crew likewise fail to create an issue of fact. Thus, it is clear that any factual dispute in this case would feature an expert witness telling the finder of fact that the medical records and eyewitness testimony regarding intubation and steps taken to verify intubation are not to be believed, without any admissible evidence in the record supporting that opinion. Such an exercise is prohibited under MRE 703 (requiring an expert's opinions to be based on facts in evidence), *Craig v Oakwood Hosp*, 471 Mich 67, 93; 684 NW2d 296 (2004) (finding speculation is insufficient to support a plaintiff's medical malpractice theory), and the above-cited cases. Here, the Court of Appeals correctly concluded that "[a]s for plaintiff's assertions that Williams' testimony lacked credibility, plaintiff did not present any testimony to oppose Williams' version of events—he simply alleged that they were wrong" (**Exhibit T**, p 6). Where the evidence proffered by Plaintiff fails to create a genuine issue of fact as to immunity, this Court's review is unnecessary to determine whether cases that do involve genuine issues of fact should be resolved by a judge or a jury under MCR 2.116(C)(7). That inquiry is best left to this Court's impending review of the case in *Yono, supra*.

ARGUMENT I

THE TRIAL COURT DID NOT ERR OR ABUSE ITS DISCRETION BY DENYING PLAINTIFF'S REQUEST FOR SUMMARY DISPOSITION OR DEFAULT WHERE MICHIGAN LAW DOES NOT REQUIRE EMERGENCY MEDICAL SERVICE PROVIDERS TO FILE AFFIDAVITS OF MERITORIOUS DEFENSE UNLESS AND UNTIL A COURT HAS RULED THEY ARE NOT ENTITLED TO IMMUNITY FROM SUIT.

A. Introduction.

The Court of Appeals correctly resolved the question of first impression presented in this case by extending the protection afforded to medical malpractice defendants claiming GTLA immunity under *Costa* to defendants claiming EMSA immunity, based on this Court's decision in *Jennings* finding the two statutes *in pari materia*. Plaintiff has afforded no basis or reason for disregarding this Court's statement in *Jennings* that "the GTLA and the EMSA share the common purpose of immunizing certain agents from ordinary negligence and permitting liability for gross negligence." 446 Mich at 136. This statement, when applied to the question of whether EMSA defendants should be afforded the same protection from medical malpractice filing requirements as was granted to GTLA defendants in *Costa*, compels the result reached by the trial court and the Court of Appeals: that EMSA defendants are likewise relieved from filing affidavits of meritorious defense unless and until a trial court issues an order finding them not immune from suit, and thus potentially liable on theories of ordinary negligence presented in an affidavit of merit.

Plaintiff continues to insist that he is entitled to a default against Defendants because MCL 600.2912e broadly requires that all medical malpractice defendants "shall" file affidavits of meritorious defense 91 days after being served with affidavits of merit, and Defendants did not do so in this case. This argument ignores this Court's holding in *Costa* that the statutory

timeline as written does not apply to defendants claiming immunity from suit, as well as the finding in that case that default would not be an appropriate sanction even if the defendant claiming immunity was required to comply with the statute. 475 Mich at 412-413. The Court of Appeals and trial court properly declined to enter a default under MCR 2.603(A)(1), because Defendants appeared and otherwise defended the action by filing an answer asserting EMSA and GTLA immunity.

B. Standard of review and supporting authority.

A trial court's decision on a motion for summary disposition under MCR 2.116(C)(9) is reviewed de novo. *In re Smith Estate*, 226 Mich App 285, 287; 574 NW2d 388 (1997). A motion brought under MCR 2.116(C)(9) seeks a determination whether the opposing party has failed to state a valid defense to the claim asserted against it, and is tested by the pleadings alone, with the court accepting all well-pleaded allegations as true. *Id.* at 288. The test is whether the defendant's defenses are so clearly untenable as a matter of law that no factual development could possibly deny a plaintiff's right to recovery. *Id.*

Issues of law, including the interpretation and application of court rules and statutes, are also reviewed de novo. *Huntington Nat Bank v Ristich*, 292 Mich App 376, 383; 808 NW2d 511 (2011). This Court reviews a trial court's decision on a motion to grant a default under MCR 2.603(A) for an abuse of discretion. *Id.* A trial court abuses its discretion when it reaches a decision that falls outside the range of principled outcomes. *Id.*

C. Under *Costa*, this Court does not require defendants asserting GTLA immunity to file an affidavit of meritorious defense unless and until the court issues an order finding the defendant not immune from suit.

In *Costa*, 475 Mich at 412-413, this Court held that a defendant in a medical malpractice action who asserts the affirmative defense of governmental immunity under the GTLA is not obligated to file an affidavit of meritorious defense under MCR 600.2912e unless and until the

court finds that the defendant is not entitled to governmental immunity as a matter of law. The Court's ruling hinged on the heightened burden the plaintiff has to show that a defendant otherwise entitled to governmental immunity was grossly negligent, rather than merely negligent:

Moreover, we note that the affidavit required by MCL 600.2912e must address whether the medical malpractice defendant complied with the applicable medical "standard of practice or care." A claim that a defendant has violated an applicable standard of practice or care sounds in ordinary negligence. However, the plain language of the governmental immunity statute indicates that the Legislature limited governmental employee liability to "gross negligence"—situations in which the contested conduct was substantially more than negligent. "Gross negligence" is defined by the GTLA as "conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results." MCL 691.1407(7)(a). Thus, MCL 600.2912e permits the assertion of a violation of the standard of care of ordinary negligence, which is a distinct and lesser standard of care than the gross negligence standard set forth in the GTLA. As such, even if a plaintiff could show that a government employee defendant's conduct breached "the applicable standard of practice or care," such a showing would not be sufficient to impose liability upon the employee. Rather, such a plaintiff would still have to make the additional showing that the employee's conduct amounted to "gross negligence" that was "the proximate cause" of the injury. Because the affidavit only requires a plaintiff to address the irrelevant question of ordinary negligence, and not the ultimate question of gross negligence, we conclude that the Legislature could not have intended that a governmental employee's failure to timely comply with the affidavit of merit requirements would deprive that employee of governmental immunity from tort liability.

Because governmental employees are immune from breaches of the standard of ordinary care, the affidavit of merit requirements of MCL 600.2912e are not relevant to a defendant otherwise entitled to governmental immunity, and we therefore conclude that such a defendant may not lose the benefit of that immunity merely by failing to timely file the affidavit of meritorious defense.

Id. at 411-413 (footnotes omitted) (emphasis supplied). The Court went on to note that failure to file an affidavit of meritorious defense before governmental immunity had been denied would not entitle a plaintiff to entry of default under MCR 2.603(A) for failure to defend:

In addition, we note that under the Michigan Court Rules, entry of a default would not be permitted under the instant circumstances. MCR 2.603(A)(1) provides: "If a party against whom a judgment for affirmative relief is sought *has failed to plead or otherwise defend* as provided by these rules, and that fact is made to appear by affidavit or otherwise, the clerk must enter the default of that party."

(Emphasis added.) Defendants here did not fail to defend; rather, defendants asserted the complete defense of governmental immunity in their answer. As such, the provisions of the court rule pertaining to the entry of default are, by their own language, inapplicable.

Costa, 475 Mich at 413 n 5 (emphasis original). The Court concluded that if an order was entered denying governmental immunity, the defendant would then be required to file an affidavit of meritorious defense complying with MCL 600.2912e. *Id.* at 414. The requirement of compliance would be stayed throughout the pendency of any appeal of that order. *Id.*

D. The Court of Appeals and trial court properly extended the holding in *Costa* to defendants claiming EMSA immunity because EMSA and GTLA are read *in pari materia*, with the shared purpose of immunizing certain defendants from claims of ordinary negligence.

Plaintiff unsuccessfully attempts to distinguish *Costa* in arguing that Plaintiff was entitled to a default when Defendants did not file affidavits of meritorious defense after claiming immunity from suit. There is no dispute that Defendants timely asserted immunity under both the GTLA and the EMSA in their amended affirmative defenses filed by leave of the trial court. Plaintiff's proposition that defendants claiming immunity under the EMSA should be treated differently for purposes of MCL 600.2912e than defendants claiming immunity under the GTLA is defeated by this Court's holding in *Jennings* that the standard for gross negligence under the GTLA should be applied to gross negligence under the EMSA, because the two statutes are to be read *in pari materia*:

In enacting the EMSA, the Legislature intended to immunize EMS personnel from liability for ordinary negligence. Similarly, in enacting § 7 of the GTLA, the Legislature intended to immunize government agents from liability for ordinary negligence. The Legislature recognized the need to provide limited immunity to government agents as well as EMS personnel, as a means of encouraging participation in the respective fields. *In this sense, the GTLA and the EMSA share the common purpose of immunizing certain agents from ordinary negligence and permitting liability for gross negligence.* Because the provisions have a common purpose, the terms of the provisions should be read *in pari materia*.

Jennings, 446 Mich at 136 (emphasis supplied). “The object of the rule *in pari materia* is to carry into effect the purpose of the legislature as found in harmonious statutes on a subject.” *Wayne Co v Auditor General*, 250 Mich 227, 233; 229 NW 911 (1930). It is a canon of construction that statutes that are *in pari materia* may be construed together, so that inconsistencies in one statute may be resolved by looking at another statute on the same subject. Black’s Law Dictionary (8th ed.), p 807.

Costa strikes an appropriate balance between the requirements of MCL 600.2912e governing medical malpractice actions sounding in ordinary negligence and the heightened showing of gross negligence required against a defendant asserting governmental immunity. As the same heightened showing of gross negligence is required against a defendant asserting immunity under the EMSA, there is no reason why the same balance should not be struck in the instant case, where the GTLA and the EMSA are read *in pari materia* as sharing a common purpose: immunizing defendants from litigating cases where gross negligence has not been established. There is no merit to Plaintiff’s contention that the purpose of the relevant portions of GTLA and EMSA “diverge significantly.” In fact, this Court in *Jennings* held just the opposite, finding that the statutes share the “common purpose of immunizing certain agents from ordinary negligence and permitting liability for gross negligence.” 446 Mich at 136. In *Costa*, this Court relied upon the general legal definition of “immunity” in support of its conclusion that the governmental immunity granted by the GTLA exempted governmental employees “from performing at least some duties that the law generally requires other citizens to perform,” namely, filing an affidavit of meritorious defense. 475 Mich at 410 n 2. This general legal definition of “immunity” applies equally to EMSA immunity, and this Court’s use of the definition to justify excusing GTLA defendants from compliance with MCL 600.2912e therefore applies equally to EMSA defendants. Defendants reasonably and in good faith relied on *Costa* in

declining to file affidavits of meritorious defense unless and until the trial court entered an order denying Defendants' asserted immunity under the EMSA.

Plaintiff erroneously assumes that this Court held by implication in *Costa* that the EMSA did not shield a defendant from timely providing an affidavit of meritorious defense. In *Costa*, the plaintiffs sought summary disposition or a default judgment only against the two defendants claiming GTLA immunity for their failure to file affidavits of meritorious defense. 475 Mich at 407. Common legal sense dictates that, had the two defendants claiming EMSA immunity likewise failed to file affidavits of meritorious defense, the plaintiffs would have also sought summary disposition or a default judgment against them on the same basis as the GTLA defendants. Thus, the Court of Appeals' ruling in this case that an EMSA defendant is not required to file an affidavit of meritorious defense absent an order denying immunity is not in conflict with *Costa*, because the EMSA defendants in *Costa* appear to have filed affidavits of meritorious defense within the 91-day filing requirement of MCL 600.2912e, obviating the *Costa* Court's need to resolve the issue raised in the instant case.

Plaintiff raises an irrelevant distinction between the GTLA's grant of absolute immunity and the EMSA's grant of qualified immunity. What this Court has deemed relevant under *Jennings* is that both statutes are intended to shield certain actors from liability for ordinary negligence. 446 Mich at 136. In *Costa*, this Court concluded that a defendant's governmental immunity from liability for ordinary negligence meant that the defendant was not required to file an affidavit of meritorious defense unless and until an order was issued denying that immunity from ordinary negligence through a showing of gross negligence. 475 Mich at 412. Regardless of whether GTLA immunity reaches farther than EMSA immunity in other areas, it is clear that both statutes provide immunity from liability for the ordinary negligence alleged by affidavits of

merit under MCL 600.2912d. Therefore, both statutes are properly read *in pari materia* with respect to the requirement of filing affidavits of meritorious defense under MCL 600.2912e.

Plaintiff mischaracterizes the 2000 amendment of the GTLA as an indication that the Legislature post-*Costa* did not intend to protect governmental employees providing emergency medical services from filing an affidavit of meritorious defense. The legislative history of 2000 PA 318, which amended section 4 of MCL 691.1407, shows that the language of section 4 was amended to close a loophole which had previously provided medical staff working for Michigan State University's medical school and the school itself an immunity from medical malpractice suits which was not extended to medical staff working for the hospitals owned and operated by the medical schools of the University of Michigan and Wayne State University (**Exhibit U**, House Legislative Analysis, HB 5063 and 5803, October 25, 2000); see *Vargo v Sauer*, 457 Mich 49, 59, 64; 576 NW2d 656 (1998) (recognizing "hospital exception" to governmental immunity applies to U of M and WSU, but not to MSU, but finding exception constitutional). The 2000 amendment of the GTLA's hospital exception was not directed towards emergency medical service providers or affidavits of meritorious defense, and thus Plaintiff cannot rely on the amendment as evidence of legislative support for her interpretation of the EMSA, the GTLA, and MCL 600.2912e. Moreover, in amending the GTLA's hospital exception, the Legislature is presumed to have been aware of and legislated in harmony with the EMSA's grant of immunity for emergency medical providers, which, as Plaintiff counsel represented to the trial court, treats government and private EMT service providers equally, giving both groups immunity from claims of ordinary negligence (**Exhibit H**, p 10); *Walen v Dep't of Corrections*, 443 Mich 240, 248; 505 NW2d 519 (1993).

E. The Court of Appeals and trial court properly applied *Costa* in rejecting Plaintiff's request for default.

As the Court of Appeals correctly observed, this Court has squarely rejected the notion that a defendant in a medical malpractice suit who claims immunity is subject to default for failure to timely file an affidavit of meritorious defense (**Exhibit T**, p 5 n 7); *Costa*, 475 Mich at 413 n 5. The assertion of statutory immunity as a defense renders default an inappropriate sanction under the court rule governing default, MCR 2.603(A)(1), because the immune defendant has not “failed to plead or otherwise defend.” *Id.* Again, given the shared purpose and nature of the GTLA and the EMSA, the Court of Appeals did not err by finding the trial court properly chose not to enter a default (**Exhibit T**, p 5 n 7). Moreover, in amending MCL 600.2912e in 1993, the Legislature eliminated language providing that the court could strike a defendant’s answer and enter a default against the defendant if the defendant failed to comply with the requirements of that section of the statute—namely, filing an affidavit of meritorious defense within 91 days of the plaintiff’s filing an affidavit of merit. *Kowalski v Fiutowski*, 247 Mich App 156, 161; 635 NW2d 502 (2001).

Plaintiff mischaracterizes the record by alleging that the trial court “gave no reasons why Defendants did not have to file an affidavit of meritorious defense” (Plaintiff’s brief, p 7). A review of the relevant portion of the June 20, 2012 hearing transcript shows that Judge Manderfield applied *Costa* in denying Plaintiff’s request for summary disposition or default:

I’m not done. *But under the Costa case, the requirement that Defendants file an affidavit of meritorious defense is not required until after the Defendants—until it’s determined whether or not they have immunity.*

So Defendant doesn’t—under the tort—Governmental Tort Liability Act, you can’t hide behind that, *but it’s still to be determined whether or not you have immunity under the emergency managers—er, Emergency Medical Services Act.*

So you’re going to have to re-bring your motion after the complaint is amended, Defendant, whether or not they meet the requirements at that point.

(**Exhibit H**, p 26) (emphasis supplied). This Court should decline Plaintiff's invitation to ignore its prior holdings in *Costa* and *Jennings* to find that Defendants were required to file affidavits of meritorious defense absent an order ruling they were not entitled to immunity under the EMSA.

ARGUMENT II

THE TRIAL COURT DID NOT ERR BY GRANTING SUMMARY DISPOSITION UNDER MCR 2.116(C)(7) AND THE EMERGENCY MEDICAL SERVICES ACT, MCL 333.20965, WHERE PLAINTIFF PROFFERED NO ADMISSIBLE EVIDENCE CREATING A GENUINE ISSUE OF FACT AS TO WHETHER DEFENDANTS WERE GROSSLY NEGLIGENT OR COMMITTED WILLFUL MISCONDUCT.

A. Introduction.

Plaintiff had the burden to come forth with admissible evidence creating a genuine issue of fact as to whether Defendants had acted with gross negligence or willful misconduct, such that immunity under the EMSA did not apply as a matter of law. Plaintiff's entire theory, and all of its "evidence" relating to gross negligence, relies on an inadmissible piece of evidence: the portion of the Hospital Record wherein Dr. Post noted that the tube was located in the decedent's esophagus when she arrived to the hospital. There is no other independent basis in the record for concluding that the decedent was improperly intubated (and even this "evidence" does not establish that point, as the tube could have been dislodged from the trachea during or after the ambulance ride). Plaintiff's theory relies on the existence of an improper intubation—a fact which cannot be proven with admissible evidence. The opinion of Plaintiff's EMT expert Robert Krause is entirely premised upon the unsupportable supposition that the decedent was improperly intubated, and he can therefore only speculate that Defendants committed gross negligence or willful misconduct by allegedly failing to discover and correct a failed intubation. Once the foundational premise of Plaintiff's gross negligence theory is deemed inadmissible and thus unavailable for trial, Plaintiff's theory collapses, and summary disposition as a matter of law is appropriate.

Even assuming *arguendo* the statement in the Hospital Record that the breathing tube was found in the decedent's esophagus upon presentation to the Emergency Department was

somehow admissible, this is only evidence of ordinary negligence, which cannot create a material question of fact concerning gross negligence. *Maiden*, 461 Mich at 122-123. Plaintiff cannot otherwise avoid summary disposition simply by disparaging Williams' and Murphy's eyewitness accounts of the decedent's care, including their deposition testimony and entries in the Prehospital Care Report showing they properly intubated the decedent in the ambulance and made observations verifying the intubation during her ambulance ride. Indeed, Plaintiff admits that Krause's opinions are in "direct opposition" to the facts contained in the Prehospital Care Report (Plaintiff's brief, pp 5-6). Plaintiff also claims Williams was grossly negligent for failing to use technology and tools which were not available to him when caring for the decedent. The entries in the report and the testimony of Williams that the tube was initially properly placed in the decedent's trachea, and that tube placement was properly verified through tube misting, chest rise and lung sounds, is admissible evidence which Plaintiff cannot refute or simply disregard in forming expert opinions. It is not enough to assert, without any admissible evidence challenging a witness' testimony, that a "credibility" issue will be created for the jury with respect to whether a fact witness is telling the truth. This is all that Plaintiff promised, and the trial court and Court of Appeals correctly rejected this approach in favor of granting summary disposition as a matter of law.

B. Standard of review and supporting authority.

This Court reviews decisions on summary disposition de novo. *Michigan Mutual Insurance Company v Dowell*, 204 Mich App 81, 86; 514 NW2d 185 (1994). Summary disposition under MCR 2.116(C)(7) is proper when a claim is barred by immunity granted by law to a defendant, and to survive a motion based on immunity, the plaintiff must plead and prove facts justifying the application of an *exception* to immunity. *Fane v Detroit Library Comm*, 465 Mich 68, 74; 631 NW2d 678 (2001) (citations omitted). In reviewing a motion under

subrule (C)(7), a court accepts as true the plaintiff's well-pleaded allegations of fact, construing them in the plaintiff's favor, *Hanley v Mazda Motor Corp*, 239 Mich App 596, 600; 609 NW2d 203 (2000), unless contradicted by other evidence. *In re Bradley Estate*, 296 Mich App 31, 36; 815 NW2d 799, 802 (2012); *Shay v Aldrich*, 487 Mich 648, 656; 790 NW2d 629 (2010). Further, “[a] trial is not the proper remedial avenue to take in resolving factual questions under MCR 2.116(C)(7) dealing with [immunity].” *Strozier*, 295 Mich App at 87-88, quoting *Dextrom*, 287 Mich App at 431. The Court must consider affidavits, pleadings, depositions, admissions, and any other documentary evidence submitted by the parties, to determine whether a genuine issue of material fact exists. *Id.* But these materials are considered only to the extent that they are admissible in evidence. MCR 2.116(G)(6); *Driver v Naini*, 287 Mich App 339, 343-344; 788 NW2d 848 (2010) *aff'd in part, rev'd in part on other grounds*, 490 Mich 239; 802 NW2d 311 (2011). “If no facts are in dispute, and if reasonable minds could not differ regarding the legal effect of the facts, the question of whether the claim is barred [by immunity] is an issue of law for the court.” *Dextrom*, 287 Mich App at 431 (quoting *Guerra v Garratt*, 222 Mich App 285, 289; 564 NW2d 121 (1997)).

C. Governing law.

The Emergency Medical Services Act, MCL 333.20901 et seq., was enacted in an effort to (1) provide for the uniform regulation of emergency medical services, and (2) limit emergency personnel's exposure to liability. *Jennings*, 446 Mich at 133. Under MCL 333.20965, unless the acts or omissions of the EMS personnel constitute gross negligence or willful misconduct, there is no liability. Further, for the governmental unit to be subject to vicarious liability under the EMSA, the acts or omissions of the EMS personnel must constitute gross negligence or willful misconduct.

In *Jennings*, 446 Mich at 136-137, this Court adopted the definition of gross negligence in the GTLA as the standard to apply to a determination of gross negligence under the EMSA. The gross negligence standard of the EMSA requires evidence of “conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results.” *Jennings*, 446 Mich at 136-137. The Court also found that “willful misconduct” under the EMSA requires an actual intent to harm. *Id.* at 142. Additionally, “evidence of ordinary negligence is not enough to establish a material question of fact regarding whether a government employee was grossly negligent.” *Maiden*, 461 Mich at 122–123. Rather, a plaintiff must adduce proof of conduct “so reckless as to demonstrate a substantial lack of concern for whether an injury results.” *Jennings*, 446 Mich at 136-137. The content or substance of the evidence proffered must be admissible in evidence to establish the existence of gross negligence. *Maiden*, 461 Mich at 122-123. To establish gross negligence, a plaintiff must focus on the actions of the defendants, not on the result of those actions. *Id.* at 127 n 10. The mere fact that a death results from the defendants’ actions is insufficient to prove that the defendants were grossly negligent. *Id.*

An expert witness’ opinion must be based on facts in evidence. MRE 703. It is well-settled that “an expert’s opinion is objectionable where it is based on assumptions that are not in accord with established facts.” *Badalamenti*, 237 Mich App at 286, citing *Green*, 195 Mich App at 499, and *Thornhill*, 142 Mich App at 658. “This is true where an expert witness’ testimony is inconsistent with the testimony of a witness who personally observed an event in question, and the expert is unable to reconcile his inconsistent testimony other than by disparaging the witness’ power of observation.” *Badalamenti*, 237 Mich App at 286, quoting *Green*, 195 Mich App at 500. Mere speculation is insufficient to support a plaintiff’s medical malpractice theory. *Badalamenti*, 237 Mich App at 285-286; *Craig*, 471 Mich at 93.

D. Argument.

1. The Court of Appeals and the trial court applied the correct summary disposition standard under MCR 2.116(C)(7) to find that no genuine issue of fact existed.

This Court's review is not needed, as Plaintiff suggests, to clarify the correct summary disposition standard under MCR 2.116(C)(7) because the Court of Appeals and the trial court both applied the proper standard in reaching their decisions. The Court of Appeals articulated this standard as follows:

A trial court's decision on a motion for summary disposition is reviewed de novo. *Ardt v Titan Ins Co*, 233 Mich App 685, 688; 593 NW2d 215 (1999). When it grants a motion under MCR 2.116(C)(7), a trial court should examine all documentary evidence submitted by the parties, accept all well-pleaded allegations as true, and construe all evidence and pleadings in the light most favorable to the nonmoving party. *Tarlea v Crabtree*, 263 Mich App 80, 87; 687 NW2d 333 (2004).

(**Exhibit T**, pp 3-4). Both the trial court and the Court of Appeals examined all of the documentary evidence properly submitted by the parties, accepted well-pleaded allegations as true, construed the evidence and pleadings in the light most favorable to Plaintiff, the nonmoving party, and concluded that the evidence failed to create a question of fact. Most of the key allegations of negligence and gross negligence in Plaintiff's complaint were "specifically contradicted by the affidavits or other appropriate documentation" submitted by Defendants, and therefore the courts below properly declined to accept the contents of the complaint as true.⁴ *Patterson v Kleiman*, 447 Mich 429 at 434 n 6; 526 NW2d 879 (1994). Importantly, as discovery is complete and all fact witnesses have been deposed, there is no factual development available in this case which could create a genuine issue of fact as to gross negligence to bar summary disposition. *Dextrom*, 287 Mich App at 429. Although Plaintiff may disagree with the

⁴ See **Exhibit I**, ¶ 40.

panel's conclusion that the evidence submitted failed to create a genuine issue of fact as to Defendants' entitlement to immunity, it is evident that the correct standard was applied.

The decision of the Court of Appeals to not conclusively resolve whether the statement in the Hospital Record regarding tube placement was admissible evidence does not change the outcome reached under this standard. Assuming *arguendo* the statement is admissible, even when viewed in the light most favorable to Plaintiff, at most it establishes that the breathing tube was found in the decedent's esophagus upon her presentation to the hospital's emergency department. Contrary to Plaintiff's arguments, this does not establish that the tube was: (a) improperly placed by Williams; (b) improperly located in the decedent's esophagus for the entire duration of the ambulance ride (as breathing tubes can become dislodged from the trachea during the ambulance ride or when the patient is moved from the ambulance into the hospital);⁵ or (c) that Williams failed to check for signs of proper tube placement during the ambulance ride. This last point is the most critical, as Plaintiff admits that mere improper placement of the breathing tube does not constitute gross negligence to avoid EMSA immunity (Plaintiff's brief, p 14). "[E]vidence of ordinary negligence does not create a material question of fact concerning gross negligence." *Maiden*, 461 Mich at 122-123. Rather, only the failure of Williams to check for signs of proper tube placement during the ambulance ride could constitute gross negligence or willful misconduct (Plaintiff's brief, pp 14-15). *Nothing in the Hospital Record can be viewed as evidence which contradicts Williams' and Murphy's eyewitness testimony and written report*

⁵ See **Exhibit R**, pp 116-117, 194-195 (Hammond describing incident where tube became dislodged when patient was transported from ambulance to emergency department, and explaining risk of tube displacement any time a patient is moved, particularly when the patient is unresponsive and unconscious); **Exhibit F**, pp 50-51 (describing Dr. Henney's experience with intubation tubes slipping from the trachea into the esophagus when patients are moved, and noting "[i]t's almost impossible, I think, for anyone to know that that's happened"); **Exhibit O**, p 96 (Krause admitting that paramedic training and literature discusses situations where tubes become dislodged from trachea into esophagus during transport or in the emergency room).

that the team members visually verified tube placement in the trachea and monitored for tube misting, chest rise, lung sounds, and the absence of abdominal distension:

Q. When it says “Recheck – Patent,” I know what the word “patent” means. What is the “recheck” supposed to be?

A. Basically, it’s continuous monitoring of the chest rise and the abdomen not rising and mist in the tube. It’s a patent airway so you’re continuously monitoring that.

Q. Okay. And if it says “Patent,” it means it’s obvious you could see that all those were happening; is that a fair understanding?

A. It’s fair.

* * *

Q. So you had the continuous monitoring, the chest rise, the abdomen not rising, and the moisture in the tube?

A. Yes.

(Exhibit C, pp 77-78).

Q. Okay. Did you check for an improper intubation while Ms. McLain was in the ambulance?

A. Yes.

(*Id.* at 102).

A. I don’t believe she died because of esophageal intubation by Jeff Williams because there’s—it would be impossible to bag for five minutes or whatever our transport time was without gastric distension or regurgitation. She would have vomited out of that tube into the bag valve mask—

Q. Okay.

A. --and then I would have pushed Jeff Williams aside and I would have reintubated myself.

(Exhibit B, p 91). Likewise, nothing in the remainder of the trial court record, including the testimony of Plaintiff’s expert, creates a material factual dispute or a credibility contest barring summary disposition.

2. The statement regarding improper intubation in the Hospital Record is inadmissible.⁶

The depositions of the decedent’s treating physicians at the hospital revealed that no one could determine who was the source of the information in the Hospital Record that the decedent had allegedly been improperly intubated. Dr. Post could not say, without speculating, whether the information had come from Dr. Henney, the patient’s family members, or another medical professional (**Exhibit G**, pp 31-32, 35-36, 39). Dr. Henney, who treated the decedent for the first hour of her hospitalization before Dr. Post took over, denied personal knowledge of the fact of the decedent’s allegedly improper intubation and also denied being the source of this information in the Hospital Record (**Exhibit F**, pp 41-43, 66).

Although they constitute hearsay under MRE 801(c), hospital records are generally admissible under the business records exception to the rule against hearsay, MRE 803(6). However, a hearsay statement contained within the record itself—“double” hearsay—must be independently evaluated to determine whether that statement is itself admissible as nonhearsay or under an exception to the rule against hearsay. This requirement was illustrated by the Court’s analysis in *Merrow v Bofferding*, 458 Mich 617, 626-629; 581 NW2d 696 (1998), of the admissibility of a statement in a plaintiff’s medical record regarding the cause of his injuries, where the hospital staff could not establish the source of the statement:

We note that in this case, the two levels of hearsay consist of (1) the document itself found in the medical record labeled “History and Physical” and signed by Dr. Yasuda, and (2) the statement in the document indicating that the injury occurred after the plaintiff had a fight with his girlfriend.

* * *

The defense, through the testimony of Ms. Leptich, established that the “History and Physical” is a record that is compiled and kept in the regular course of

⁶ Plaintiff did not raise as an issue on appeal the trial court’s underlying finding that the statement in the Hospital Record regarding improper intubation was not admissible evidence.

business by the hospital. Consequently, we find that the document itself was admissible under MRE 803(6).

However, not every statement contained within the document is admissible merely because the document as a whole is one kept in the regular course of business. Where, as here, the document contains a contested hearsay statement, a separate justification must exist for its admission, i.e., it must qualify under an exception to the hearsay rule or be properly admissible as nonhearsay.

We conclude that because the second level of hearsay is not justified under an exception to the hearsay rule and because the defendants failed to lay a sufficient foundation regarding the source of the statement in order to allow its admission under a nonhearsay justification, the statement concerning the “fight with his girlfriend” was improperly admitted.

458 Mich at 626-629 (footnotes omitted) (emphasis supplied); see also 2 McCormick, Evidence (4th ed), § 293, p 279. Here too, Plaintiff has failed to lay a sufficient foundation regarding the source of the statement that the decedent was improperly intubated by Defendants.⁷ Thus, that statement is inadmissible as hearsay not falling within any exception to the rule against hearsay, and cannot be considered in opposing the motion for summary disposition under MCR 2.116(C)(7). *Maiden*, 461 Mich at 124-125 (hearsay statements within otherwise admissible police report are inadmissible evidence which cannot be considered in opposing motion for summary disposition under MCR 2.116(C)(7)). While it is true that evidence need not be in

⁷ Plaintiff speculates on application to this Court that Williams or one of the other defendant EMTs was the source of the statement regarding the tube placement (Plaintiff’s brief, p 15 n 6); *but see* Plaintiff’s Court of Appeals reply brief, pp 5-6 (stating that Dr. Post most likely gathered the information regarding the tube placement from an emergency department physician, namely Dr. Henney). Not only can Plaintiff not supplement the factual record by means of conjecture, but this conjecture does not make logical sense. Plaintiff acknowledges that Williams produced the Prehospital Care Report at the hospital, after he finished caring for the decedent. If Williams or one of his fellow EMTs had indeed told a hospital employee upon arrival that the decedent’s breathing tube was lodged in her esophagus, it is inexplicable that this detail would not have appeared in his written report. None of the EMTs caring for the decedent testified that they remembered finding the decedent’s breathing tube in her esophagus upon arriving at the hospital. Lacking objective evidence in the record to support his theory, Plaintiff instead accuses Williams of falsifying his documentation of the decedent’s care—an unsupportable conspiracy theory that has no business being submitted to a jury, and is insufficient to create a question of fact for trial (Plaintiff’s brief, p 17).

admissible form when proffered to oppose summary disposition, the nonmoving party must show that the content or substance of the evidence will be admissible at trial. *Maiden*, 461 Mich at 122-123. Here, Plaintiff cannot overcome the hearsay objection to the statement in the Hospital Record regarding the tube's location because Plaintiff has failed, through the completion of discovery and the deposition of all fact witnesses, to locate the source of the statement or any witness with personal knowledge of the tube's location. Thus, the necessary foundation cannot be laid, and the statement will not be admissible at trial.

It is important to distinguish between the admissibility of the Prehospital Care Report as a business record under MRE 803(6), and the inadmissibility of the statement regarding improper intubation in the Hospital Record. Unlike the Hospital Record, the Prehospital Care Report is admissible because Williams, a qualified witness, was available to testify as to the foundation for the contents of the report and the circumstances surrounding its drafting. No witness can lay a similar foundation for the statement in the Hospital Record regarding the allegedly improper intubation. Trustworthiness of a business record is presumed when the party offering the evidence establishes the necessary foundation, which requires testimony of the custodian or other qualified witness. MRE 803(6); *Solomon v Shuell*, 435 Mich 104, 125-126; 457 NW2d 669 (1990); *People v Fackelman*, 489 Mich 515, 536-537; 802 NW2d 552 (2011). Defendant laid the requisite foundation through the testimony of Williams, and thus the report is presumed trustworthy and admissible.

In the Court of Appeals, Plaintiff challenged the trustworthiness of the Prehospital Care Report by reference to Williams' inability to recall with precision, over two years later, which of the four persons caring for the decedent simultaneously during her thirteen minutes of treatment by EMS performed which specific tasks to verify proper placement of the tube. The testimony of Williams and Murphy shows that while their recall of events was not perfect, it was sufficient

to establish the trustworthiness of the activities recorded in the Prehospital Care Report as part of the ordinary course of Defendants' business. Williams remembers intubating the decedent and remembers that one of the team members checked for chest rising, lung sounds and tube misting during the short ride to the hospital (**Exhibit C**, pp 71-83, 90-92, 97, 99-101). Murphy, drawing on 20 years of experience, does not remember any inappropriate care or problems with the intubation performed by Williams and relied on the detailed report written by Williams as to the specifics of the care provided (**Exhibit B**, pp 60-63). Krause himself admitted that he would rely on a written report rather than his own memory as to an ambulance run which occurred over two years ago (**Exhibit O**, Krause deposition, p 86).

Nor do Plaintiff's arguments regarding default settings in the computer program used to prepare the Prehospital Care Report call into question the report's trustworthiness, or suggest in any way that Williams reported results of tests not actually performed. When Plaintiff challenged the accuracy of the entries in the Prehospital Care Report, Defendants took the extra step of having the metadata from the computer program retrieved and analyzed for that specific report. Deputy Chief Atkins and Lieutenant Garlitz testified that they examined the metadata and concluded that none of the entries in the report related to the actual intubation itself were default entries. In other words, every piece of information relating to the intubation—notation of breath sounds, abdominal assessment, tube misting and recheck of these items—was actually entered by Williams in making the Prehospital Care Report on the decedent, and was not supplied by default entries (**Exhibit L**, pp 8, 41-42) (**Exhibit P**, Garlitz deposition, pp 67-71). Nothing in either the record or caselaw supports Krause's conclusion that "sloppy" record-keeping is indicative of "sloppy" medical care (**Exhibit O**, pp 57-58). Williams' offhand comment about not fully documenting "BS calls" is irrelevant to the instant case because Williams never indicated or suggested that the decedent's emergency was a "BS call." His

testimony and the metadata show that the decedent's intubation was well-documented in the Prehospital Care Report, and disprove Plaintiff's allegation that Williams willfully reported results of testing not actually performed (**Exhibit K**, ¶ 11A) (**Exhibit I**, ¶ 39A).

3. Plaintiff expert Krause's opinions are insufficient to prevent summary disposition because they lack sufficient foundation or are inconsistent with established facts.

Plaintiff relies heavily on the opinions of his EMT expert, Robert Krause, to create an issue of fact as to gross negligence or willful misconduct. His opinions fail to do so because they either stem from the inadmissible evidence regarding the decedent's allegedly improper intubation (discussed in section 2, *supra*) or are otherwise inconsistent with established facts in the medical records and the testimony of the eyewitnesses to the decedent's care in the ambulance.

The following portions of Krause's deposition testimony reveal that his standard of care opinions are inextricably linked to, and dependent upon, the inadmissible statement in the medical record that the decedent suffered an improper intubation:

- The cause of her PEA was hypoxia induced by asthma and failed intubation (**Exhibit O**, pp 36, 38-39);
- The medical report (which Krause erroneously believed was authored by Dr. Henney) indicated to Krause that the decedent had suffered a failed intubation (*Id.* at 39-40);
- He acknowledged both Dr. Post and Dr. Kowalczyk denied having any personal knowledge of the allegedly failed intubation (*Id.* at 49, 51-52);
- He admitted the intubation entries in the paramedic report were filled in by Defendants (*Id.* at 57-58);
- He agreed that nothing in the hospital nursing record or other medical records reported any stomach distension or other signs of improper intubation in the decedent upon her admission to the emergency department (*Id.* at 70, 83).

Krause's testimony is faulty under MRE 703 because it is not based on facts in evidence. Instead, it is based on the alleged existence of a failed intubation—a fact which will never be in evidence because its documentation in the Hospital Record constitutes inadmissible hearsay.

A recent unpublished opinion from the Court of Appeals illustrates this point perfectly. In *Green v Henry Ford Wyandotte Hosp*, Court of Appeals Docket No. 310768, *rel'd* February 11, 2014; 2014 WL 547610 (unpublished) (**Exhibit Q**), the plaintiff's expert witness, Dr. Pollak, opined that the defendant orthopedic surgeon, Dr. Baghdoian, had breached the standard of care by essentially placing the plaintiff's knee replacement prosthesis backwards. The factual foundation for this opinion came from Dr. Pollak's review of the medical notes and deposition testimony of the plaintiff's treating physician, Dr. Morawa, who performed revision surgery after the defendant's surgery. The notes from the revision surgery indicated that "the polyethylene insert was rotated 180 degrees from the way it was supposed to be in. In other words, the back was in the front and the front was at the back." *Id.* at *1. Dr. Morawa testified in his deposition that the most likely explanation for the backwards position of the prosthesis was that it was installed backwards by Dr. Baghdoian. Dr. Morawa was subsequently unavailable to testify at trial, and the trial court granted the defendants' motion to strike Dr. Pollak's testimony because his testimony relied on records and facts which were not admitted into evidence as required by MRE 703. The trial court also granted a directed verdict for the defendants because the plaintiff was unable to prove his case without expert testimony. The Court of Appeals upheld the ruling, finding that Dr. Pollak's testimony was based entirely on Dr. Morawa's report indicating the misplacement of the prosthesis, which was never received into evidence. *Id.* at *3. The panel also found that Dr. Morawa's deposition testimony and medical records were not admissible under any exception to the rule against hearsay, including MRE 803(6). *Id.* at *4-6. Here, as in *Green*, Plaintiff's expert lacks personal knowledge of the facts and circumstances of the case, and relied on inadmissible evidence in testifying there was an improper intubation.

Lacking a foundation for his opinions in the record evidence, Krause resorts to simply disparaging the eyewitness testimony of the three medical professionals in the ambulance with

the decedent. Krause's deposition and affidavit of merit are replete with statements disagreeing with Williams and Murphy's personal observations of the decedent's care, both as recalled by their respective memories at the time of their depositions and as recorded in the Prehospital Care Report:

- Krause disagrees that proper intubation was verified using observations and lung sounds, even though Williams testified he observed another paramedic watching the decedent and listening for lung sounds as he intubated her, and did not see regurgitation indicating improper tube placement (**Exhibit C**, pp 77, 99-100) (**Exhibit O**, pp 82, 85);
- Krause alleges Defendants failed to continuously monitor the decedent's condition, even though Williams testified the decedent was monitored throughout her ambulance ride for tube misting, chest rise and abdominal distension (**Exhibit C**, pp 77, 83-84) (**Exhibit K**, ¶ 11D);
- Krause admits the absence of a notion of abdominal distension in the Prehospital Care Report is consistent with the hospital record noting no abdominal distension, but still claims that Williams was grossly negligent for failing to note abdominal distension if it was present (**Exhibit O**, pp 87-88, 90-91) (**Exhibit K**, ¶ 11A);
- Krause admits there is nothing in the Prehospital Care Report or Williams' testimony to indicate that Williams "willfully misreported tube misting where the intubation was done incorrectly" (**Exhibit K**, ¶ 11A) (**Exhibit O**, pp 87-90);
- Williams had a personal recollection of responding to the call and intubating the decedent (**Exhibit C**, pp 58, 71-72);
- Although Krause alleges Williams failed to visualize intubation into the trachea (**Exhibit K**, ¶ 11E), Krause admitted Williams testified that he visualized the intubation into the trachea by using a laryngoscope, and that he was able to visualize the intubation because there was no vomit present (**Exhibit C**, pp 71-72) (**Exhibit O**, pp 94-95);
- Krause acknowledged that it was possible Williams did not have a personal recollection of all aspects of the decedent's care at the time he was deposed over two years later, and admitted that he himself would rely on his patient care report rather than his own memory in those circumstances (**Exhibit O**, p 86).

Krause's opinions are not based on the established fact of the decedent's successful intubation, as set forth by the admissible evidence. Instead, they are based solely on the inadmissible statement regarding esophageal intubation in the Hospital Record and Krause's disparagement of Williams' and Murphy's powers of observation as eyewitnesses to the events in question. Under *Badalamenti*, Krause's opinions and "findings" are not admissible evidence which Plaintiff can

rely upon to establish gross negligence or willful misconduct in avoidance of immunity. 237 Mich App at 286. In *Badalamenti*, the plaintiff's expert based his opinion that the plaintiff was in cardiogenic shock on his "skepticism" of the echocardiogram performed by one of the plaintiff's treating doctors, and his unwillingness to accept that doctor's finding that the wall function of the plaintiff's heart was nearly normal. *Id.* at 287. The Court of Appeals reversed the jury's verdict, finding that the expert testimony was "legally insufficient" to support the plaintiff's theory because there was no reasonable basis in evidence to support his opinion, which was based only on his skepticism and disparagement of the treating doctor's findings. *Id.* at 288-289. Krause's opinions in this case are no better than those found legally insufficient in *Badalamenti*, as they rely only on his skepticism and disparagement of the treating paramedics' observations of the decedent's intubation. See **Exhibit T**, p 6.

Plaintiff also resorts to mischaracterizing and disparaging the deposition testimony of defense expert Hammond, criticizing him for basing his opinions in the record evidence, including the Prehospital Care Report (Plaintiff's brief, pp 21-22). Hammond was not critical of Defendants for failing to serially check the decedent's pulse oximetry levels on the way to the hospital because the five-minute serial vital signs check guideline suggested by the American Heart Association is predicated upon six caregivers being around the patient's side, rather than the three present in this case to care for a patient already in full cardiac arrest (**Exhibit R**, Hammond deposition, pp 102-104, 174). He also noted that a pulse oximetry reading is slow to respond to treatment (*Id.* at 102). He agreed with Captain Murphy's testimony that there would be no reason to suspect a failed intubation if the caregivers observed equal chest rise, positive lung sounds, and uninhibited bagging (*Id.* at 143). He also agreed that treating the symptoms of PEA rather than determining its cause was the best course of treatment given the short transport time, the belief that the tube was in place, and the fact that all three caregivers were busy bagging

the patient, performing CPR, and administering medications (*Id.* at 143-150). He disagreed with Plaintiff's allegation that the paramedics had reported the results of tests not performed (*Id.* at 159, 164-165). He opined that the Prehospital Care Report and the incident report contained adequate documentation to suggest that intubation was properly performed (*Id.* at 180-181). He believes Williams adequately performed his duties to properly intubate the decedent and confirm intubation with the available tools (*Id.* at 211-212).

4. Even if the Hospital Record was admissible to suggest a failed intubation, Plaintiff cannot avoid summary disposition by disputing Williams' and Murphy's "credibility" regarding the decedent's care.

Plaintiff suggests that summary disposition under MCR 2.116(C)(7) is inappropriate because the jury can simply "disbelieve" Williams' testimony and the Prehospital Care Report establishing that the decedent was successfully intubated and that Williams monitored the decedent and observed positive signs of intubation. As Plaintiff counsel stated during the summary disposition hearing, "we don't believe that Mr. Williams did what he said he was doing" (**Exhibit L**, p 38); see **Exhibit K**, ¶ 11A and **Exhibit I**, ¶ 39A (alleging that Williams committed willful misconduct by "willfully report[ing] the results of tests not actually performed"). Plaintiff proffers Krause as a witness to challenge Williams' and Murphy's "credibility," but this case does not implicate a credibility dispute, as the facts at issue are neither subjective nor difficult to verify. Cf. *Oliver v Smith*, 290 Mich App 678, 685-686; 810 NW2d 57 (2010) (finding genuine issue of fact regarding gross negligence turning on credibility determination where evidence presented by plaintiff as to actual injury versus mere pain from tight handcuffs would be "generally subjective and difficult to verify"). Williams and Murphy both testified that proper intubation was visualized and verified through checking of lung sounds, chest rise, tube misting, and lack of abdominal distension. This testimony is verified by the Prehospital Care Report indicating that these tasks were performed, and metadata showing that

the entries in the report were not default entries. These are not “subjective” matters that can be called into question by other admissible evidence in this case, or by Krause’s opinion that the eyewitnesses to the decedent’s care are simply lying about what they did and observed. *Badalamenti*, 237 Mich App at 288-289. Assuming *arguendo* the admissibility of the hearsay statement in the Hospital Record regarding the tube’s location in the decedent’s esophagus upon arrival to the emergency department, this evidence does not establish a credibility dispute as to gross negligence, but only as to ordinary negligence, because Plaintiff admits that the mere fact of a failed intubation does not constitute gross negligence (and the equally likely possibility that the tube dislodged itself from the trachea into the esophagus when the decedent was removed from the ambulance is not evidence of gross negligence).

5. The decedent’s blood gas values, the affidavit of merit of Dr. Bowles, and the Life Support Manual do not help Plaintiff establish gross negligence or willful misconduct.

Plaintiff argues that in addition to the inadmissible statement in the Hospital Record regarding an improper intubation and Krause’s opinions on the standard of care, gross negligence and/or willful misconduct can be established using Plaintiff’s blood gas values, the causation affidavit of merit submitted by Dr. Bowles, and the American Heart Association’s Advanced Cardiovascular Life Support Provider Manual (Plaintiff’s brief, pp 19-21). None of these meets Plaintiff’s burden under MCR 2.116(C)(7) to show facts in avoidance of immunity under the EMSA.

Plaintiff relies on arterial blood gas values drawn from the decedent which Krause asserts show the decedent was acidotic (indicating hypoxia from improper tube placement) when

she arrived at the hospital (**Exhibit O**, pp 41-43).⁸ However, this bloodwork was drawn at 10:15 p.m., after the decedent had been treated at the hospital for nearly two hours, had been given additional medications, and was on a ventilator. The bloodwork drawn earlier at 8:40 p.m.—shortly after the decedent’s arrival at the hospital—showed her arterial blood gas pH to be 7.31, within what Krause testified was “normal” range (Plaintiff’s Exhibit I, p 2) (**Exhibit O**, p 41). Even assuming *arguendo* the decedent was acidotic at any time, Krause admits that her underlying hypoxic condition was caused by her asthma attack (**Exhibit O**, pp 36, 38-39). Defendants’ EMT expert Gregory Hammond testified that he has seen severely asthmatic patients like the decedent die even when properly intubated (**Exhibit R**, p 171). Thus, the decedent’s allegedly acidotic state two hours after her arrival at the hospital is not reliable evidence that she was improperly intubated on her way to the hospital.

Plaintiff’s “key circumstantial evidence” that the decedent’s oxygen levels “rebounded” after her reintubation at the hospital does not create an issue of fact as to gross negligence because, as the trial court noted, this at most only constitutes evidence of a failed intubation or a dislodged tube, which is insufficient to establish gross negligence (**Exhibit L**, pp 23-24).

Plaintiff asserts that he will rely on the testimony of pulmonologist Dr. Bowles to establish that if the decedent would have been properly intubated, she more likely than not would have lived and not suffered brain damage (Plaintiff’s brief, p 22). There are several problems with this argument. First, as the trial court noted, the testimony of Plaintiff’s causation expert Dr. Bowles cannot be used to save or bolster the inadequate testimony of Plaintiff’s standard of care expert Krause (**Exhibit L**, p 29). Dr. Bowles has no experience with the duties or standard

⁸ Defendants argued below that Krause, an EMT, was not qualified to render opinions regarding the clinical significance of blood gas values (See Defendants’ brief in support of summary disposition, p 14).

of care for EMTs. Second, and more fundamentally, Plaintiff's preview of Dr. Bowles' testimony shows that it too is inconsistent with the established facts in the case. Again, this stems from the unsupported premise that the decedent was improperly intubated by Williams. Although Williams testified that he properly visualized the intubation into the trachea, Dr. Bowles will apparently testify that if Williams had actually been looking and had rechecked his visualization, he would have realized that the tube was actually in the esophagus (*Id.* at 30-31). According to Plaintiff, this testimony will challenge Williams' credibility and allow the jury to conclude that "he's not telling the truth" (*Id.* at 31). Dr. Bowles is no better qualified than Krause to dispute the eyewitness testimony and recollection of Williams and Murphy as to what happened in the ambulance, as recorded in the Prehospital Care Report. Third, Plaintiff cannot avoid summary disposition by promising, without any corresponding statements in the affidavit of merit, that Dr. Bowles will testify at trial that proper tube placement does not correlate to the oxygen saturation readings shown in Williams' charting (Plaintiff's brief, p 21). Plaintiff's mere promise to produce admissible evidence creating an issue of fact for trial is insufficient to survive summary disposition—the evidence must be produced in response to the summary disposition motion for consideration by the trial court. *Maiden*, 461 Mich at 121.

As for the American Heart Association manual (**Exhibit S**), it merely shows that hypoxia is linked to PEA. As discussed above, the decedent's hypoxia (and corresponding PEA) was also attributable to her severely asthmatic state, which Defendants did not cause. Williams' denial of a link between improper intubation and PEA, even if incorrect, has nothing to do with his testimony regarding the care rendered to the decedent, including the Prehospital Care Report showing the measures taken to verify proper intubation. Once again, Plaintiff premises his argument upon the unsupportable allegation that the decedent was improperly intubated.

6. Williams' failure to use capnography and colorimetric tools to verify intubation did not constitute gross negligence.

Krause and Plaintiff allege Williams was grossly negligent because he failed to use capnography and colorimetric tools to verify proper placement of the tube (**Exhibit K**, ¶¶ 11B-C) (**Exhibit I**, ¶¶ 39B-C). However, Krause admits that capnography technology was not available for Williams to use in 2009, and further admits that he did not know whether colorimetric tools were available on the particular ambulance used to transport the decedent (**Exhibit O**, pp 91, 92) (**Exhibit C**, p 44). Williams cannot be found grossly negligent for failing to use equipment which was not available to him. Moreover, even if colorimetric tools might have been available, the fact that the decedent's breath sounds were checked in all four quadrants of her lungs and proper intubation was otherwise verified mitigates any effect the use of this tool may have had on the outcome of her condition (**Exhibit C**, pp 74-75).

RELIEF REQUESTED

WHEREFORE, Defendants-Appellees request this Court deny leave to appeal, affirm the March 3, 2015 decision of the Court of Appeals, deny Plaintiff's requested relief, and grant all other relief deemed appropriate, including costs so wrongfully sustained in defending this matter on appeal.

Respectfully submitted,

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