STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF GRAND TRAVERSE

DAVID C. STEEN,

Plaintiff,

v

File No. 04-23572-NH
HON. PHILIP E. RODGERS, JR.

MUNSON HEALTHCARE, a Michigan Corporation; MUNSON MEDICAL CENTER and HOSPITALS, a Michigan Corporation; and MUNSON MEDICAL CENTER, a Michigan Corporation,

Defendants.
/

Jay B. Schreier (P38039)
Attorney for Plaintiff

David R. Johnson (P33822)
Barbara J. Kennedy (P53622)
Attorneys for Defendants

DECISION AND ORDER

Factual Background

Plaintiff David Steen ("Steen"). On September 20, 2001, Steen, 23 years of age, experienced severe fatigue. The following day, he experienced night sweats, nausea, vomiting, fever and chills. On September 22 or 23, he began to experience joint pain and could not perform activities of daily living.

On September 23, 2001, Steen consulted Defendants Munson urgent care clinic at Munson North. At the clinic, he noted chest pain, heart murmur and swollen skin, among other symptoms. He was examined by John Adams ("Adams"), a physician's assistant under the supervision of Defendant Richard Hartwell, D.O. ("Hartwell"). The examination revealed a lump on the back of Steen's neck, a lump on the right side of his scalp and a lump in the right thigh. Adams suggested he had a virus and discharged him with instructions to take Motrin for pain and apply warm compresses to the lumps.

Steen's symptoms persisted. He developed a rash on his back and the back of his hands. On September 25, 2001, he consulted his family practice physician Douglas Wigton, D.O. ("Wigton") who recommended that he go to the emergency room at Defendant Munson Medical Center ("MMC"). The emergency room physician, Defendant David Friar, M.D. ("Friar") noted that Steen had a fever of unknown origin and a rash. He also noted: "Doubt this is endocarditis, however, blood cultures are pending. . . Antibiotics will not be begun until an organism is identified." An infectious disease consultation was ordered for the following day.

Steen's initial white blood cell count was 15,890. The blood culture grew gram positive cocci, diagnosed as probable staphylococcus aureus. Vancomycin and nafcillin were initiated. A transthoracic echocardiogram revealed a bicuspid aortic valve with an echodensity of the inferior pole suspicious for endocarditis.

Steen ultimately underwent three (3) cardiac surgeries and several surgical procedures when the infection settled in his arm.

On March 22, 2004, Steen filed this action against three corporate Defendants: Munson Healthcare ("MHC"), Munson Medical Center and Hospitals ("MMCH") and MMC that own and operate and do business as both Munson Community - North ("North") a/k/a Munson Community Health Center and Munson Medical Center. Steen alleges that these corporate Defendants and their employees and agents were negligent in their care and treatment of him. More specifically, he alleges that the applicable standard of care required and the Defendants' failure to take a thorough history, perform a thorough physical examination and order appropriate diagnostic studies; formulate an appropriate differential diagnosis; and refer him to a cardiologist and/or infectious disease physician for urgent evaluation. Steen further alleges that their negligence was a proximate cause of the injuries and damages he sustained when the staphylococcus infection resulted in bacterial endocarditis and required multiple surgical procedures.

The Defendants have filed three motions for summary disposition, pursuant to MCR 2.116(C)(10). MCR 2.116(C)(10) provides that summary disposition may be entered on behalf of the moving party when it is established that, "except as to the amount of damages, there is no genuine issue as to any material fact, and the moving party is entitled to judgment or partial judgment as a matter of law." The Court entertained the parties' oral arguments on March 7, 2005

together with argument on Plaintiff's Motion to Strike Dr. Evans' Affidavit and took the matter under advisement.

Standard of Review

The applicable standard of review for a motion for summary disposition brought pursuant to MCR 2.116(C)(10) was set forth in *Smith v Globe Life Ins Co*, 460 Mich 446; 597 NW2d 28 (1999) as follows:

> This Court in *Quinto v Cross & Peters Co*, 451 Mich 358, 362-363; 547 NW2d 314 (1996), set forth the following standards for reviewing motions for summary disposition brought under MCR 2.116(C)(10):
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> > In reviewing a motion for summary disposition brought under MCR 2.116(C)(10), a trial court considers affidavits, pleadings, depositions, admissions, and documentary evidence filed in the action or submitted by the parties, MCR 2.116(G)(5), in the light most favorable to the party opposing the motion. A trial court may grant a motion for summary disposition under MCR 2.116(C)(10) if the affidavits or other documentary evidence show that there is no genuine issue in respect to any material fact, and the moving party is entitled to judgment as a matter of law. MCR 2.116(C)(10), (G)(4).
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> > In presenting a motion for summary disposition, the moving party has the initial burden of supporting its position by affidavits, depositions, admissions, or other documentary evidence. *Neubacher v Globe Furniture Rentals*, 205 Mich App 418, 420; 522 NW2d 335 (1994). The burden then shifts to the opposing party to establish that a genuine issue of disputed fact exists. *Id.* Where the burden of proof at trial on a dispositive issue rests on a nonmoving party, the nonmoving party may not rely on mere allegations or denials in pleadings, but must go beyond the pleadings to set forth specific facts showing that a genuine issue of material fact exists. *McCart v J. Walter Thompson*, 437 Mich 109, 115; 469 NW2d 284 (1991). If the opposing party fails to present documentary evidence establishing the existence of a material factual dispute, the motion is properly granted. *McCormic v Auto Club Ins Ass'n*, 202 Mich App 233, 237; 507 NW2d 741 (1993).

The Plaintiff has filed a motion to strike one of the Defendants' affidavits of meritorious defense and for entry of a default, pursuant to MCR 2.112 and MCL 600.2912e. The Defendants contend that the Plaintiff's motion is actually brought pursuant to MCR 2.116(B)(1) which provides: "[A] party against who a defense is asserted may move under this rule for summary disposition of the defense." MCR 2.116(C)(9) further provides that a plaintiff can seek summary disposition on the basis that "[T]he opposing party has failed to state a valid defense to the claim asserted against him or her." Summary disposition under MCR 2.116(C)(9) is proper if a defendant fails to plead a valid defense to a claim. *Nicita v Detroit (After Remand)*, 216 Mich App 746, 750; 550 NW2d 269 (1996). A motion under MCR 2.116(C)(9) tests the sufficiency of a defendant's pleadings by accepting all well-pleaded allegations as true. *Lepp v Cheboygan Area Schools*, 190 Mich App 726, 730; 476 NW2d 506 (1991). If the defenses are "'so clearly untenable as a matter of law that no factual development could possibly deny plaintiff's right to recovery,'" then summary disposition under this rule is proper. *Id*, quoting *Domako v Rowe*, 184 Mich App 137, 142; 457 NW2d 107 (1990).

I.

The Defendants' Motions for Summary Disposition

The Defendants filed a Motion for Summary Disposition pursuant to MCR 2.116(C)(10) seeking dismissal of the claims of negligence against all Defendants because there is no genuine issue of material fact as to whether Plaintiff, had more probably than not, he could have avoided surgery if antibiotic therapy had begun on September 23, 2001. The Defendants rely on MCL 600.2912a and *Fulton v Pontiac Gen Hosp*, 253 Mich App 70; 655 NW2d 569 (2002).

MCL 600.2912a(2) governs the burden of proof requirements for actions alleging medical malpractice, and provides:

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

In *Fulton*, the personal representative of a patient's estate brought a medical malpractice action against a hospital and specialist in obstetrics and gynecology for the patient's loss of opportunity to survive following allegedly negligent diagnosis of cervical cancer. The circuit court denied the defendants' motion for summary disposition, and defendants appealed. The Court of Appeals reversed, holding that "MCL § 600.2912a(2) requires a plaintiff to show that the loss of the opportunity to survive or achieve a better result exceeds fifty percent." *Id* at 83. In other words, MCL 600.2912a(2) requires the plaintiff to prove that the opportunity to survive or achieve a better result was reduced by greater than fifty percent because of the alleged malpractice. The patient's loss of the opportunity to survive or achieve a better result is measured by the percentage of loss from the initial opportunity to survive or achieve a better result had the defendant made a timely diagnosis to the percentage of opportunity to survive or achieve a better result at the time of actual diagnosis.[1]

The Defendants assert, without citing any authority, that the Plaintiff's infectious disease experts are not qualified to offer an opinion on the percentage of change in the opportunity to avoid surgery. The Defendants further claim that the Plaintiff's cardiac surgeon, Dr. Stirling, testified that he would have performed surgery regardless of whether antibiotic therapy had begun on September 23. Therefore, the Plaintiff cannot establish that the alleged negligence of the agents and employees of the Defendants was the cause in fact and the proximate cause of the Plaintiff's claimed injury.

The Plaintiff agrees with the Defendants' recitation of the law. He acknowledges that "[i]n a case alleging failure to diagnose, the plaintiff must show that the chance of survival or of a better result fell more than fifty percent between the time of the malpractice/failure to diagnose and the discovery of the illness," citing the recent Court of Appeals' case of *Klein v Kik* (Docket No. 250679)

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[1]On July 10, 2003, the Michigan Supreme Court granted leave to appeal, 468 Mich 947; 666 NW2d 663 (2003). On November 19, 2003, after the case had been briefed by the parties, the Supreme Court vacated its initial order granting leave to appeal and denied leave to appeal "because we are no longer persuaded the questions presented should be reviewed by this Court." 671 NW2d 876 (2003).

January 11, 2005. The Plaintiff disagrees, however, with the Defendants' contention that his infectious disease experts are unqualified to offer an opinion on the matter and he disagrees with the Defendants reading of Dr. Stirling's testimony.

The Plaintiff relies upon the testimony of two infectious disease experts.

Dr. Levy testified:

Q: All I'm doing Doctor, is attempting to establish from you that by the time he gets to Urgent Care there is at least some probability that this process cannot be arrested with systemic antibiotics.

MR. SCHREIER: Objection; form. Some probability is vague and confusing.

THE WITNESS: Yeah, I think there is a chance that it's already a surgical disease.

BY MR. NAFZIGER:

Q: And can you assign to that probability a specific percentage?

A: I don't think I can do that. I mean I would have thought it was low given what he looks like at that time and the time period.

MR. NAFZIGER: Okay. Well, that's fair. Okay. That's all.

RECROSS-EXAMINATION BY COUNSEL FOR PLAINTIFF BY MR. SCHREIER:

Q: One last one. Just so you're clear, according to the law probability means something that's greater than 50 percent. As of September 23rd was there a probability that he could avoid surgery? In other words, was there more than a 50 percent chance he could avoid surgery or was there less than a 50 percent chance he could avoid surgery?

A: On the 23rd?

Q: Yes.

MR. NAFZIGER: Objection to relevance and form.

THE WITNESS: No, I think there was a good chance he could have avoided surgery.

BY MR. SCHREIER:

Q: Meaning greater than 50 percent chance?

A: Fifty percent, yes.

Dr. Crane testified:

Q: But if you were to assign percentage probabilities to those two time frames, is that something you think you could do? I mean, does he have a change in 30 percent probability? Is it 25 and 55?

A: Well, when you catch staphorious endoarditis early - which would be September 23rd - the likelihood of requiring some kind of surgical intervention is maybe ten, 20 percent. And on the 25th, I have to keep in mind there's further 11 hours went by.

The Plaintiff relies upon MRE 702 and the unpublished opinion in *Hatchett v Surapaneni*, 2003 WL 22514628 (Mich App). In *Hatchett*, the plaintiff was admitted to the hospital under the care of a psychiatrist. She was heavily intoxicated. The next day she was found unresponsive and without a blood pressure or pulse. She was resuscitated but remained in a persistent vegetative state until her death a few years later. The plaintiff brought an action alleged that the defendants' failure to properly treat her decedent's acute alcohol intoxication caused her debilitating injuries, including cardiac arrest, anoxic encephalopathy and other related injuries. The psychiatrist signed the affidavit of merit. The defendants filed a motion in limine to preclude plaintiff's psychiatric expert from offering an opinion on the issue of causation related to the decedent's cardiac arrest, arguing that such testimony was not admissible under MRE 702. The plaintiff responded that the psychiatrist was an expert in alcohol withdrawal syndrome, including its potential complications like cardiac arrest and, thus, was qualified to offer his opinion on the issue of causation. The trial court held that the psychiatrist was not qualified to testify as to whether the decedent's cardiac arrest was caused by the failure to treat her alcohol withdrawal syndrome or a preexisting cardiac condition.

The Court of Appeals reversed, saying:

The plaintiff's psychiatrist was qualified under MCL 600.2169 to render testimony "on the appropriate standard of practice or care" against the defendant psychiatrist. However, the trial court prohibited him from testifying as to the causation element of

the case on the ground that the proposed testimony would not meet the admissibility requirements of MRE 702.

* * *

Expert testimony is admissible under MRE 702 if (1) the witness is qualified as an expert in a pertinent field, (2) the testimony is relevant in that it "assists the trier of fact to understand the evidence or to determine a fact in issue," and (3) the testimony is derived from "recognized scientific, technical, or other specialized knowledge. . ." People v Beckley, 434 Mich 691, 710-719; 456 NW2d 391 (1990). Here [plaintiff's psychiatrist] was qualified as an expert in alcohol withdrawal syndrome, a pertinent field, (2) the testimony was offered to assist the trier of fact in understanding the nature and risks of this alcohol-related disorder and to prove that [the decedent's] untreated or improperly treated alcohol withdrawal caused her to suffer from this syndrome which resulted in [her] experiencing a well-known risk of the syndrome, a cardiac event, and (3) the testimony was about a medical condition and, thus, derived from specialized knowledge.

* * *

Consistent with the longstanding principle that causation is generally an issue for the trier of fact, *Nichols v Dobler*, 253 Mich App 530, 532; 655 NW2d 787 (2002), it is for the jury to decide which of the experts' testimony is more persuasive.

The Court of Appeals held that the trial court abused its discretion in prohibiting the psychiatrist from testifying on the issue of causation because he was qualified under MCL 600.2169 and permitted under MRE 702 to render such an opinion.

The issue for this Court to decide is whether the Plaintiff's infectious disease experts are qualified to testify that the chance of a better result fell more than fifty percent between the time of the malpractice/failure to diagnose and the discovery of the illness and initiation of antibiotic therapy.

Expert testimony is admitted pursuant to MRE 702, which provided, in pertinent part, as follows:

> If the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise if (1)

the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

The plain language of MRE 702 establishes three broad preconditions to the admission of expert testimony. First, the proposed expert witness must be "qualified" to render the proposed testimony. Generally, the expert may be qualified by virtue of "knowledge, skill, experience, training, or education." In a medical malpractice action such as this one, the court's assessment of an expert's "qualifications" are now guided by MCL 600.2169(2):

> In determining the qualifications of an expert witness in an action alleging medical malpractice, the court shall, at a minimum, evaluate all of the following:
>
> (a) The educational and professional training of the expert witness.
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> (b) The area of specialization of the expert witness.
>
> (c) The length of time the expert witness has been engaged in the active clinical practice or instruction of the health profession or the specialty.
>
> (d) The relevancy of the expert witness's testimony.

Second, the proposed testimony must "assist the trier of fact to understand the evidence or to determine a fact in issue . . ." In other words, the expert opinion testimony "must serve to give the trier of fact a better understanding of the evidence or assist in determining a fact in issue."

Finally, under MRE 702, expert testimony must have been based on a "recognized" form of "scientific, technical, or other specialized knowledge."

In *Craig v Oakwood Hosp,* 471 Mich 67; 684 NW2d 296 (2004), the Court held that the admission of expert testimony is subject not only to the threshold requirements of MRE 702, but also to the standard articulated in *People v Davis*, 343 Mich 348; 72 NW2d 269 (1955), now generally known in Michigan as the *Davis-Frye* test. *Frye v United States*, 54 App DC 46; 293 F 1013 (1923). In *Davis*, the court held that expert opinion based on novel scientific techniques is admissible only if the underlying methodology is generally accepted within the scientific community. Thus, in determining whether the proposed expert opinion was grounded in a "recognized" field of scientific, technical, or other specialized knowledge as was required by MRE 702, a trial court was obligated to

ensure that the expert opinion was based on accurate and generally accepted methodologies. The proponent of expert testimony bears the burden of proving general acceptance under this standard. A *Davis-Frye* evidentiary hearing is warranted to determine whether a proposed medical expert is qualified to testify regarding causation where the party offering the expert fails to produce any authority that supports the expert's theory.

The Defendants challenge the "specialization" of the Plaintiff's causation experts, claiming that they are not qualified to testify about causation because they are infectious disease physicians and not cardiothoracic surgeons. They do not cite any authority in support of their position. While it is true that only a cardiothoracic surgeon may offer an opinion of the standard of practice or care applicable to a cardiothoracic surgeon and whether a cardiothoracic surgeon breached that standard of care, any expert qualified under MRE 702 and *Davis-Frye* is qualified to offer an opinion on causation. It seems logical that, where an infectious disease causes a need for surgery, an infectious disease expert would be qualified to testify as to the probability of surgery being required at any given point in the progression of the infectious disease.

Here, in view of the applicable standard of review the Court finds that Plaintiff has created a question of fact consistent with MCL 600.2912a(2) and *Fulton* and denies the Defendants' motion.

II.

Defendant MMC's Motion for Partial Summary Disposition

Defendant MMC filed a Motion for Partial Summary Disposition pursuant to MCR 2.116(C)(10) seeking dismissal of Plaintiff's claims of vicarious liability against Defendant MMC for the treatment rendered by Dr. Friar ("Friar") because there is no genuine issue of material fact as to whether Plaintiff would have required surgical treatment regardless of Friar's medical treatment.

MMC contends that it is entitled to summary disposition because there is no genuine issue of material fact as to whether their agent, Friar, could have caused the Plaintiff's injuries. M.C. contends that no matter what Friar did or did not do on and after September 25, 2001, the Plaintiff would still have suffered the same injuries because it was already too late to change the course of his infection.

The Plaintiff does not contest this motion.

Therefore, all claims of vicarious liability based on the conduct of Friar alone are dismissed. The Plaintiff concedes that Friar's negligence did not cause the Plaintiff's injuries. However, the Plaintiff may still offer evidence of Friar's delay in initiating antibiotic therapy because it illustrates the full length of the delay in properly diagnosing and treating the Plaintiff.

III.

Defendant Munson Healthcare's Motion for Summary Disposition

Defendant MHC filed a Motion for Summary Disposition pursuant to MCR 2.116(C)(10) because there is no genuine issue of material fact that Dr. Hartwell, although identified in the Complaint, did not actually treat or diagnose the Plaintiff. The Plaintiff was treated and diagnosed by Physician's Assistant Adams and the Plaintiff did not file an Affidavit of Merit executed by a Physician's Assistant which is necessary to properly perfect his claim against Adams.

In response, the Plaintiff points out that, by operation of law, a physician's assistant can and does act solely as the agent of and under the direction and control of the supervising physician, even if the supervising physician never meets the patient. The Plaintiff cites MCL 333.17001(1)(e); 333.17078; 333.16215(1); 333.16109(2); and *Cox v Board of Hospital Managers for the City of Flint*, 467 Mich 1, 11 (2002) which establish that the physician supervising a physician's assistant is vicariously liable for the negligence of the physician's assistant. Thus, a physician board-certified in emergency room medicine is qualified to sign an affidavit of merit and testify regarding the standard of care applicable to a physician's assistant acting under the supervision of an emergency room physician. This is precisely what the Plaintiff has offered in this case. No prejudice has been alleged by the Defendants, none has been shown and the Court finds no lack of clarity in the notice given to the Defendants relating to Adams' interaction with the Plaintiff.

IV.

Plaintiff's Motion to Strike
Jerry Evans, M.D.'s ("Evans") Affidavit of Meritorious Defense

The Plaintiff filed a Motion to Strike Jerry Evans, M.D.'s Affidavit of Meritorious Defense seeking a default against the Defendants. The Plaintiff claims that Evans' affidavit fails to meet the requirements of MCL 2912e because it fails to identify the factual basis for each defense; the

applicable standard of practice or care; the manner in which the Defendants complied with the standard of practice or care; and the manner in which the Defendants contend that the injury or damage to the Plaintiff is not related to the care and treatment that they rendered.

The Defendants filed a response in which they claim that Evans' affidavit of meritorious defense in substantively adequate and that entering a default or granting summary disposition for the Plaintiff would be inappropriate and an abuse of discretion.

In *Costa v Community Emergency Medical Services, Inc*, Docket Nos. 247983, 248104 (Mich App 2004), plaintiffs filed medical malpractice actions against an emergency medical services corporation and emergency medical services (EMS) employees. The trial court denied the EMS employees' motions for summary disposition. They appealed and the plaintiffs cross appealed the trial court's denial of their motion for summary disposition or default, which was based on the EMS employees' failure to comply with the statutory requirement to file an affidavit of meritorious defense, MCL 600.2912e. Affirming the trial court's denial of the plaintiffs' motions for summary disposition or default, the Court said:

> This Court has more than once rejected similar assertions that a medical malpractice defendant's failure to file an affidavit of meritorious defense pursuant to MCL 600.2912e mandates a default or other preclusion of the defendant from presenting a defense, and plaintiffs present no authority to the contrary. *Kowalski v Fiutowski*, 247 Mich App 156, 161-163, 165-166; 635 NW2d 502 (2001); *Wilhelm v Mustafa*, 243 Mich App 478, 483-486; 624 NW2d 435 (2000). Here, the trial court gave [the employees] additional time to file their affidavits, and we find no abuse of discretion. *Id.*

In *Wilhelm, supra* at 483-484, the Court held:

> While the requirement that a defendant file an affidavit of meritorious defense is mandatory, the statute is silent with regard to the remedy for noncompliance. There is nothing in the statute itself to indicate that default is the mandatory, or even appropriate, remedy when a defendant fails to file an affidavit of meritorious defense. Indeed, in *VandenBerg, supra* at 502-503; 586 NW2d 570, this Court found that dismissal is not always warranted when a medical malpractice plaintiff fails to file an affidavit of merit as required under MCL § 600.2912d; MSA 27A.2912(4). This Court noted that in revising § 2912d in 1993 to require, among other things, that a plaintiff file an affidavit of merit signed by a health professional, the Legislature eliminated the portion of § 2912d providing that the trial court could dismiss the complaint if the requirements of the statute were not met. *VandenBerg, supra* at 501; 586 NW2d 570. This Court further observed that even under the version of § 2912d

that specified consequences for noncompliance, dismissal was not mandated. *VandenBerg, supra* at 501; 586 NW2d 570.

> Likewise, in revising § 2912e, the Legislature eliminated the language providing that the court could strike the 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. Also, just as the dismissal for failure to comply with the statutory requirements was not mandated under the preamendment version of § 2912d, the severe sanction of default was not mandatory under the earlier version of § 2912e, but was left to the court's discretion. Accordingly, we conclude that the trial court was not compelled by the statute to enter a default against defendant for his failure to timely file an affidavit of meritorious defense.

While this case is distinguishable because the Defendants timely filed an affidavit, the Plaintiff claims that the affidavit is substantively deficient. If the trial courts cannot default a defendant who fails to file an affidavit, surely a defendant may not be defaulted for filing a deficient affidavit. The motion to strike the affidavit is denied.

IT IS SO ORDERED.

HONORABLE PHILIP E. RODGERS, JR.
Circuit Court Judge

Dated: 3/11/05