LAW OFFICES
SOMMERS SCHWARTZ, P.C.
ONE TOWNE SQUARE • 17TH FLOOR • SOUTHFIELD, MICHIGAN 48076 • (248) 355-0300

STATE OF MICHIGAN

IN THE SUPREME COURT

JOELYNN T. STOKES, Successor
Personal Representative of the
Estate of LINDA HORN, deceased,

Plaintiff-Appellee,

-vs-

MICHAEL J. SWOFFORD, D.O. and
SOUTHFIELD RADIOLOGY ASSOCIATES, PLLC,

Defendants-Appellant.

Supreme Court No: 162302

Court of Appeals No: 349522

Oakland Circuit No: 2018-164148 NH
Hon. Cheryl A. Matthews

_____/

KENNETH T. WATKINS (P46231)
RAMONA C. HOWARD (P48996)
Attorneys for Plaintiff-Appellee
SOMMERS SCHWARTZ, P.C.
One Towne Square, 17th Floor
Southfield, Michigan 48076
Telephone: (248) 355-0300
kwatkins@sommerspc.com
rhoward@sommerspc.com

MICHAEL J. COOK (P71511)
Collins Einhorn Farrell, P.C.
Attorneys for Defendants-Appellants
4000 Town Center, 9th Floor
Southfield, MI 48075
Telephone: (248) 355-4141
Michael.Cook@ceflawyers.com

_____/

APPENDIX TO PLAINTIFF-APPELLEE'S BRIEF ON APPEAL

Exhibit	Document Description	Pages
A	*Halloran v Bhan*, unpublished per curiam opinion of the Court of Appeals, issued March 8, 2002 (Docket No 224548)	1-5
B	*Reeves v Carson City Hosp,* unpublished per curiam opinion of the Court of Appeals, issued April 6, 2006 (Docket No 266469)	6-7
C	*Johnson v Bhimani*, unpublished per curiam opinion of the Court of Appeals, issued February 10, 2011(Docket No 292327)	8-17
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	the Court of Appeals, issued October 18, 2016 (Docket No 323802)	
E	*Stevens v Lansing Anesthesiologists, P.C.*, unpublished per curiam opinion of the Court of Appeals, issued November 17, 2016 (Docket No 328971)	33-40
F	*Perez v Henry Ford Hosp,* unpublished per curiam opinion of the Court of Appeals, issued December 4, 2018 (Docket No 340082)	41-51
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Respectfully submitted,

SOMMERS SCHWARTZ, P.C.

By: */s/ Ramona C. Howard*
KENNETH T. WATKINS (P46231)
RAMONA C. HOWARD (P48996)
Attorneys for Plaintiffs-Appellants
One Towne Square, 17th Floor
Southfield, MI 48076
Telephone: (248) 355-0300
kwatkins@sommerspc.com

Dated: March 21, 2023

LAW OFFICES
SOMMERS SCHWARTZ, P.C.
ONE TOWNE SQUARE • SUITE 1700 • SOUTHFIELD, MICHIGAN 48076 • (248) 355-0300

Exhibit A

2002 WL 393044
Only the Westlaw citation
is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Court of Appeals of Michigan.

Eileen HALLORAN, Temporary Personal Representative of the Estate of Dennis J. Halloran, Deceased, Plaintiff-Appellant,
v.
Raakesh C. BHAN, M.D., Critical Care Pulmonary Medicine, P.C., and Battle Creek Health Systems, Defendants-Appellees.

No. 224548.
|
March 8, 2002.

Before: FITZGERALD, P.J., and HOEKSTRA and MARKEY, JJ.

UNPUBLISHED

PER CURIAM.

***1** In this medical malpractice action, plaintiff appeals by leave granted the trial court's order striking plaintiff's expert witness because the expert's board certification did not match the board certification of defendant Bhan.[1] M.C.L. § 600.2169(1)(a). We reverse and remand.

At the time of the treatment giving rise to plaintiff's cause of action, defendant was board certified by the American Board of Internal Medicine (ABIM) and held a certificate of added qualification in critical care medicine, also from the ABIM. The parties agree that no separate board certification exists for critical care medicine. Rather, the different primary boards of medicine issue certificates of added qualifications in various subspecialties, including critical care medicine. In his answer to plaintiff's complaint in this matter, defendant admitted that he was practicing critical care medicine at the time he was caring for plaintiff's decedent.

Dr. Thomas Gallagher signed the required affidavit of merit that was attached to plaintiff's complaint, and plaintiff also filed an expert witness list naming Gallagher as an expert witness who would testify regarding the standard of care applicable to defendant. In his affidavit, Gallagher testified that he "practice[d] the specialty of critical care medicine." Gallagher testified at his deposition that he is board certified in anesthesiology by the American Board of Anesthesiology and holds a certificate of special qualification from that primary board of medicine (ABA) in critical care medicine.

Defendant moved the trial court for an order striking Dr. Gallagher as an expert witness because he did not meet the statutory requirements for an expert to provide standard of care testimony for or against defendant established by M.C.L. § 600.2169(1)(a). The parties submitted briefs, and the trial court heard oral arguments. Defendant argued that because Dr. Gallagher was not certified by

the American Board of Internal Medicine, as defendant was, Gallagher did not meet the criteria of the statute (emphasizing the certification by the primary board of medicine). Plaintiff countered that where the area of actual medicine practiced and at issue (here the subspecialty of critical care) lacked its own board granting certification, the focus should be on the actual subspecialty being practiced and out of which the alleged malpractice stems. Furthermore, plaintiff asserted that because both defendant and Gallagher held certificates of added qualifications (albeit from different primary boards of medicine), and both practiced critical care medicine as a specialty (that does not offer board certification), under the circumstances of this case, Dr. Gallagher was qualified to serve as an expert witness.

The trial court construed M.C.L. § 600.2169(1)(a) consistent with defendant's position, finding that the Legislature intended to refer to primary board certifications and because Gallagher was not board certified in the same primary specialty as defendant, he was not qualified to render standard of care testimony for or against defendant. The trial court therefore granted defendant's motion to strike.

***2** MCL 600.2169(1)(a) provides in pertinent part:

(1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:

(a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

Plaintiff asserts that the first sentence of subparagraph (a) of subsection (1) provides that if the defendant is a specialist at the time of the occurrence, then the expert witness must specialize in that same specialty that serves as the basis for the action. Plaintiff further argues that the last sentence of subparagraph (a) of subsection (1) does not apply to this case because the subspecialty at issue, critical care medicine, does not have a primary board of medicine offering certification. We agree. Whether a witness is qualified to serve as an expert witness and the actual admissibility of the expert's testimony are within the trial court's discretion. *Tate v. Detroit Receiving Hosp*, ___ Mich.App ___; ___ NW2d ___ (Docket No. 225833, issued January 15, 2002), slip op at 2. We review the trial court's decision for an abuse of discretion. *Id.*

The primary goal in construing a statute is to determine and give effect to the intent of the Legislature. *Frankenmuth Mutual Ins Co v. Marlette Homes, Inc*, 456 Mich. 511, 515; 573 NW2d 611 (1998). The specific language of the statute is the first source for determining the Legislature's intent, *In re MCI Telecommunications Complaint*, 460 Mich. 396, 411; 596 NW2d 164 (1999), and when the plain and ordinary meaning of

the language is clear, judicial construction is normally not needed or permitted, *Sun Valley Foods Co v. Ward*, 460 Mich. 230, 236; 596 NW2d 119 (1999). Courts can look beyond the statutory language only if it is ambiguous. *Nawrocki v. Macomb Co Rd Comm'n*, 463 Mich. 143, 159; 615 NW2d 702 (2000). In such cases, courts must seek to give effect to the Legislature's intent through a reasonable construction. *Macomb Co Prosecutor v. Murphy*, 464 Mich. 149, 158; 627 NW2d 247 (2001); *Tate, supra*, slip op at 4.

In deciding this case, we rely on this Court's analysis and holding in the recent opinion of *Tate, supra*. In the medical malpractice action in *Tate, supra*, slip op at 1-2, the plaintiff proffered an expert witness who was board certified and a specialist in internal medicine to testify against the defendant hospital's physician who was board certified in several specialties, including internal medicine. The plaintiff's theory in *Tate* was that the medical malpractice occurred during the practice of internal medicine and not during the practice of the other specialties. *Id.* at 5. The trial court concluded, however, that because the expert witness was not board certified in the exact same specialties as the defendant's physician, the expert witness was unqualified to testify. *Id.* at 2. This Court examined M.C.L. § 600.6129(1)(a), the statute at issue in the present case, and reversed the trial court. This Court stated:

***3** [MCL 600.]2169(1)(a) specifically states that an expert witness must "specialize[ ] at the time of the occurrence that is the basis for the action" in the same specialty as the defendant physician. The statute further discusses board certified specialists and requires that experts testifying against or on behalf of such specialists also be "board certified in that specialty." The use of the phrase "at the time of the occurrence that is the basis for the action" clearly indicates that an expert's specialty is limited to the actual malpractice. Moreover, the statute expressly uses the word "specialty," as opposed to "specialties," thereby implying that the specialty requirement is tied to the occurrence of the alleged malpractice and not unrelated specialties that a defendant physician may hold. Indeed, *McDougall [v Schanz*, 461 Mich. 15, 24-25; 597 NW2d 148 (1999)], states that "the statute operates to preclude certain witnesses from testifying solely on the basis of the witness' lack of practice or teaching experience in the *relevant* specialty."

Certainly § 2169 cannot be read or interpreted to require an exact match of every board certification held by a defendant physician. Such a "perfect match" requirement would be an onerous task and in many cases make it virtually impossible to bring a medical malpractice case.... [W]e do not believe that *McDougall* stands for such a proposition.... Thus, where a defendant physician has several board certifications and the alleged malpractice only involves one of these specialties, § 2169 requires an expert witness to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice. [*Tate, supra*, slip op at 4-5; emphasis in original.]

Similarly, the alleged malpractice in the instant case that serves as the basis for the action involves critical care medicine and not other

specialties in which Gallagher and defendant are certified. There is no dispute that both defendant and Gallagher specialize in critical care medicine and are certified in critical care medicine. The fact that Dr. Gallagher lacks a board certification in internal medicine is irrelevant because plaintiff has not alleged malpractice against defendant for treatment rendered by defendant acting as an internist. As stated in *Tate, supra,* slip op at 4, "specialty" as it is used in M.C.L. § 600.2169(1)(a) is tied to the occurrence of the alleged malpractice and not the unrelated specialties that the physician may possess. Thus, contrary to defendant's assertion, the second sentence of § 2169(1)(a), which states that "if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified *in that specialty,*" refers to the critical care specialty that serves as the basis for the action and not the specialty of internal medicine. Because there is no board certification for critical care medicine, the last sentence of § 2169(1)(a) does not apply to the present case. Therefore, Dr. Gallagher's and defendant's qualifications were matched for purposes of the statute.

***4** We reverse and remand for further proceedings. We do not retain jurisdiction.

HOEKSTRA, J. (dissenting).

***4** I respectfully dissent.

In this case, it is undisputed that defendant Bahn was board certified by the American Board of Internal Medicine (ABIM) and held a certificate of added qualification in critical care medicine from the ABIM and that plaintiff offered as her expert witness Dr. Thomas Gallagher, who is board certified by the American Board of Anesthesiology (ABA) and holds a certificate of special qualification in critical care medicine from the ABA.

On these facts, I respectfully disagree with the conclusion of the majority that the second sentence of M.C.L. § 600.2169(1)(a) does not apply in this case. Defendant Bahn's board certification plainly invoked the board certification provision of section 2169(1)(a) relative to physicians who testify either on his behalf or against him. Unlike the majority, I view the board certification itself, not the certificate of added or special qualification, to be the defining credential for purposes of analyzing the applicability of the second sentence of section 2169(1)(a)[1].

I also believe that the majority's reliance upon *Tate v. Detroit Receiving Hosp,* ___ Mich.App ___; ___ NW2d ___ (Docket No. 225833, issued 1/15/2002) is misplaced. *Tate* is distinguishable because, ultimately, the operative board certifications of the two doctors at issue in *Tate* were the same. Here, they are different.

All Citations

Not Reported in N.W.2d, 2002 WL 393044

Footnotes

1 The issue presented in this appeal relates to defendant hospital Battle Creek Health Systems (BCHS) and Critical Care Pulmonary Medicine, P.C., Bhan's professional corporation, only on agency principles, and therefore the singular "defendant" will refer only to defendant Bhan.

1 Although not dispositive, in my opinion, I also question whether the critical care certifications are comparable in this case. I find no evidence in the record upon which to conclude whether critical care certification by the ABIM and the ABA require the same or even similar training and expertise.

End of Document

Exhibit B

KeyCite Red Flag - Severe Negative Treatment
Judgment Vacated by Reeves v. Carson City Hosp., Mich., November 29, 2006

2006 WL 891022
Only the Westlaw citation
is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Court of Appeals of Michigan.

Catherine Ruth REEVES and Anthony Lynn Reeves, Plaintiffs-Appellants,
v.
CARSON CITY HOSPITAL and Lynn Squanda, D.O., Defendants-Appellees.

No. 266469.
|
April 6, 2006.

Before: NEFF, P.J., and SAAD and BANDSTRA, JJ.

[UNPUBLISHED]

PER CURIAM.

***1** Plaintiffs appeal as of right from the trial court's order granting defendants' motion to strike their expert witness and granting summary disposition in favor of defendants. We affirm. This appeal is being decided without oral argument pursuant to MCR 7.214(E).

This case involves a claim of medical malpractice related to the treatment of Catherine Reeves' ectopic pregnancy by Dr. Squanda, a physician who is board certified in family medicine but who was working in the emergency room of Carson City Hospital at the time the alleged malpractice occurred. Plaintiffs filed suit alleging that Squanda committed medical malpractice in her treatment of Catherine Reeves. Plaintiffs filed an affidavit of merit signed by Eric Davis, M.D., who is board certified in emergency medicine but not in family medicine.

Defendants moved to strike Davis as an expert witness, arguing that Davis was not qualified to testify against Squanda under MCL 600.2169 because he was not board certified in family medicine. Defendants relied on *Halloran v. Bhan*, 470 Mich. 572, 577; 683 NW2d 129 (2004), in which the Supreme Court held that an expert in a medical malpractice case must have the same board certification in a specialty as does the party against whom or on whose behalf his testimony is offered. The trial court found that Davis was not qualified to testify as an expert witness against Squanda because he was not board certified in family medicine. The trial court granted defendants' motion to strike plaintiffs' expert witness, and subsequently granted summary disposition in favor of defendants.

We review an issue of statutory interpretation de novo. *Id.* at 576. We review a trial court's decision as to whether a witness is qualified as an expert for an abuse of discretion. *Tate v. Detroit Receiving Hosp.*, 249 Mich.App 212, 215; 642 NW2d 346 (2002).

MCL 600.2169(1)(a) provides that if a "party against whom or on whose behalf" testimony is offered in a medical malpractice case is board

certified in a specialty, "the expert witness must be a specialist who is board certified in that specialty."

We affirm. In *Halloran, supra,* the plaintiff alleged that the defendant, who was board certified in internal medicine and who also held a certificate of added qualification in critical care medicine, committed malpractice during his treatment of the decedent in the emergency room. The plaintiff's proposed expert witness was board certified in anesthesiology, and also held a certificate of added qualification in critical care medicine. The defendant moved to strike the plaintiff's expert witness on the ground that he failed to satisfy the criteria of MCL 600.2169(1)(a). The trial court granted the motion, finding that the witness was not qualified to testify as an expert witness because he and the defendant did not share the same board certification. We reversed the trial court's decision, concluding that because the plaintiff's expert and the defendant shared the same subspecialty, the expert met the requirements of MCL 600.2169(1)(a). *Halloran, supra* at 575-576. The *Halloran* Court reversed this Court's decision, concluding that "MCL 600.2169(1)(a) requires that the proposed expert witness must have the same board certification as the party against whom or on whose behalf the testimony is offered." *Id.* at 574. The *Halloran* Court concluded that because the plaintiff's expert witness was not board certified in the same specialty as the defendant, he was not qualified to testify as an expert witness under MCL 600.2169(1)(a). *Id.* at 579. Here, *Halloran, supra,* supports the trial court's decision that Davis was not qualified under MCL 600.2169(1)(a) to give expert testimony against Squanda.

***2** Finally, we reject plaintiffs' argument that the trial court erred in considering defendants' motion because it was in reality an untimely motion for summary disposition. The transcript of the hearing on the motion reveals that after the trial court struck plaintiffs' expert witness, it declined to grant summary disposition for the reason that the motion did not seek that relief. Defendants indicate that plaintiffs' counsel sought entry of an order granting summary disposition pursuant to MCR 2.116(C)(10). Plaintiffs have not sought to contradict this assertion. Given that defendants could have sought summary disposition pursuant to MCR 2.116(C)(10) "at any time[,]" MCR 2.116(D)(3), and that plaintiffs advocated the entry of summary disposition following the trial court's ruling, we find that the trial court did not err by considering defendants' motion.

Affirmed.

All Citations

Not Reported in N.W.2d, 2006 WL 891022

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Exhibit C

2011 WL 476443
Only the Westlaw citation
is currently available.

UNPUBLISHED OPINION. CHECK
COURT RULES BEFORE CITING.

UNPUBLISHED
Court of Appeals of Michigan.

Scott JOHNSON and Kathleen Johnson, Plaintiffs–Appellants,
v.
Sultan BHIMANI, M.D. and Advanced Diagnostic Imaging, P.C., Defendants–Appellees,
and
Covenant Healthcare System, Defendant.

Docket No. 292327.
|
Feb. 10, 2011.

Saginaw Circuit Court; LC No. 04–054130–NH.

Before: CAVANAGH, P.J., and HOEKSTRA and GLEICHER, JJ.

Opinion

PER CURIAM.

***1** Plaintiffs appeal as of right from the trial court's order that granted defendants' motion to strike plaintiffs' expert radiology witness, Harold Parnes, M.D., and dismissed plaintiffs' lawsuit with prejudice. We affirm.

Plaintiff Scott Johnson[1] suffered pelvic injuries that eventually required surgery as a result of falling off a ladder. Plaintiffs alleged that defendant Sultan Bhimani, M.D., a radiologist at the hospital, initially failed to diagnose plaintiff's injury causing complications and a worsening of his condition.

Plaintiffs argue that the trial court incorrectly determined that Parnes was not qualified as an expert witness under MCL 600.2169. We disagree.

A trial court's ruling regarding a proposed expert's qualifications to testify is reviewed for an abuse of discretion. *Kiefer v. Markley*, 283 Mich.App 555, 556; 769 NW2d 271 (2009). An abuse of discretion occurs when the decision results in an outcome falling outside the range of principled outcomes. *Id.*

In malpractice actions, parties are obligated to provide an expert witness to articulate the applicable standard of care involved. MCL 600.2912d(1)(a); *Tate ex rel Estate of Hall v. Detroit Receiving Hosp*, 249 Mich.App 212, 216; 642 NW2d 346 (2002). A person cannot give expert testimony in a malpractice suit unless the person meets the list of qualifications of MCL 600.2169. MCL 600.2169(1); *Grossman v. Brown*, 470 Mich. 593, 599; 685 NW2d 198 (2004). MCL 600.2169(1)(a) specifically states that an expert witness must "specialize[ ] at the time of the occurrence that is the basis for the action" in the same specialty as the defendant physician. The specialty requirement is tied to the specialty engaged in during the occurrence of the alleged malpractice and not unrelated specialties that a defendant physician may hold. *Halloran v. Bhan*, 470 Mich. 572, 577 n 5; 683 NW2d 129 (2004). The specialty or subspecialty that

the defendant physician was practicing at the time of the alleged malpractice is the one most relevant specialty or subspecialty that must be matched by the proposed expert. *Woodard v. Custer*, 476 Mich. 545, 566; 719 NW2d 842 (2006). It is not disputed that diagnostic radiology is the one most relevant specialty involved here, and that both defendant Bhimani and Parnes were board certified in general diagnostic radiology. Thus, the requirements of MCL 600.2169(1)(a) were met.

However, whether Parnes satisfied MCL 600.2169(1)(b) is the dispute. The trial court granted defendants' motion to strike Parnes as an expert because it found he had not devoted the majority of his professional time during the year preceding the alleged malpractice practicing diagnostic radiology. According to MCL 600.2169(1)(b), the proposed expert must have devoted a majority of his or her professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the one most relevant specialty the defendant physician was practicing at the time of the alleged malpractice. In *Kiefer*, 283 Mich.App at 559, this Court held that "majority" of professional time meant that a proposed expert physician was required to "spend greater than 50 percent of his or her professional time practicing the relevant specialty the year before the alleged malpractice."

***2** Here, Parnes was questioned extensively regarding how he spent his professional time. Parnes stated that, although the specialty he engaged in was determined by the needs of his patients, he spent the majority of his professional time in neuroradiology. Parnes estimated that he spent 50 to 80 percent of his professional time in neuroradiology. Therefore, Parnes was not able to meet the requirements of MCR 600.2169(1)(b) because he did not spend more than 50 percent of his professional time practicing the one relevant specialty of general diagnostic radiology.

Plaintiffs argue that, because neuroradiology is a subspecialty of diagnostic radiology and there is considerable overlap of the fields, the trial court should have found that Parnes spent the majority of his time practicing diagnostic radiology. Parnes explained that neuroradiology was a subspecialty of general radiology that involved imaging of the brain, spine, and nerves, with different modalities. Defendant Bhimani also stated that neuroradiology was a branch of radiology that deals with the brain, spinal cord, and central nervous system, and that general radiology is the branch dealing with imaging the rest of the body, including the lumbar region and pelvis at issue here. Parnes indicated that muscular skeletal films and diagnostic films would be within the realm of neuroradiology if they were related to the spine or even sacroiliac joint, but that they were also in the realm of diagnostic radiology. Parnes also asserted that components of neuroradiology were muscular skeletal because all systems worked together as one, meaning that muscular skeletal was related to the nervous system.

However, general diagnostic radiology and neuroradiology are two distinct specialties, and practicing neuroradiology is not the same as practicing general diagnostic radiology. A "specialty" is a particular branch of medicine or surgery in which one can potentially

become board certified. *Woodard*, 476 Mich. at 561. A "subspecialty" is a particular branch of medicine or surgery in which one can potentially become board certified that falls under a specialty or within the hierarchy of that specialty. *Id.* at 562. "A subspecialty, although a more particularized specialty, is nevertheless a specialty." *Id.* For the purposes of MCL 600.2169(1)(b), a subspecialty is a specialty. *Id.* at 566 n 12. Therefore, the specialties of diagnostic radiology and neuroradiology are distinct from each other.

The case of *Hamilton v. Kuligowski*, 261 Mich.App 608, 611–612; 684 NW2d 366 (2004), rev'd sub nom *Woodard v. Custer*, 476 Mich. 545, 566; 719 NW2d 842 (2006), is factually similar to the instant case because the defendant's one relevant specialty was internal medicine and the proposed expert also specialized in internal medicine, but spent the majority of his professional time practicing a subspecialty of internal medicine, infectious diseases. This Court held that the proposed expert was qualified as a witness because, by practicing the infectious diseases subspecialty, "he devoted the majority of his professional time to the 'active clinical practice' of defendant's 'internal medicine specialty.' " *Hamilton*, 261 Mich.App at 611–612. However, the Supreme Court reversed, finding that the proposed expert witness was not qualified under MCL 600.2169(1)(b) because he did not devote a majority of his professional time to practicing the one most relevant specialty or subspecialty that the defendant physician was practicing at the time of the alleged malpractice. *Woodard*, 476 Mich. at 578–579.[2] Even though the proposed expert practiced a subspecialty of the defendant's one most relevant specialty, the Supreme Court specifically found that the "plaintiff's proposed expert witness did not devote a majority of his time to practicing or teaching general internal medicine. Instead, he devoted a majority of his professional time to treating infectious diseases." *Id.* at 577–578. Similarly, here, Parnes did not devote a majority of his time practicing the one most relevant specialty of defendant Bhimani, i.e., diagnostic radiology. Rather, Parnes testified that he devoted the majority of his professional time to neuroradiology. Therefore, the trial court did not abuse its discretion in finding that Parnes was not qualified as an expert witness under MCL 600.2169(1)(b).

***3** Affirmed.

GLEICHER, J. (dissenting).

***3** Plaintiffs' expert witness in this medical malpractice case, Dr. Harold Parnes, is board-certified in diagnostic radiology. Defendant Sultan Bhimani, M.D., is board-certified in diagnostic radiology. Both physicians possess certificates of added qualification in neuroradiology. The radiologic images at issue depict the lumbosacral spine and sacroiliac joint, closely related anatomical areas falling within the purview of both specialties. The majority concludes that Parnes lacked the requisite qualifications under MCL 600.2169(1)(b) because he "did not spend more than 50 percent of his professional time practicing the one relevant specialty of general diagnostic radiology." *Ante* at 3. I respectfully disagree with the majority, and would find Parnes fully qualified to testify in this case.

Plaintiff Scott Johnson fell from a ladder, and presented at defendant Covenant Healthcare System complaining of pain in his abdomen, groin and hips. An emergency room physician ordered an x-ray of Johnson's lumbosacral spine. A short time later, the physician ordered a CT scan of Johnson's abdomen and pelvis. Bhimani interpreted all the radiologic studies as negative for fractures or other abnormalities. Bhimani described as follows at his deposition the "possible fractures" that a CT scan of the pelvis and abdomen may reveal: "Well, the CT study is involved from the upper part of the thoracic spine all the way to the pubic symphysis, so [that] includes the thoracic spine, the lumbar spine, the iliac bone, and the sacrum." The sacrum is "the triangular bone just below the lumbar vertebrae, formed usually by five fused vertebrae (sacral vertebrae) that are wedged dorsally between the two hip bones." Dorland's Illustrated Medical Dictionary, 1373 (25th ed, 1974). The term sacroiliac pertains "to the sacrum and ilium; denoting the joint or articulation between the sacrum and ilium and the ligaments associated therewith." *Id.* The ilium is "the expansive superior portion of the hip bone." *Id.* at 763. Indisputably, the lumbar vertebrae and sacrum are structures of the spine.

Parnes opined that Bhimani failed to detect on the lumbosacral spine x-rays "separation of the left SI [sacroiliac] joint compared to the right [,] asymmetric." Regarding the CT scan, Parnes observed:

> If you look at the CT scan ... you can see that there is a widening of the pubic symphysis on the scalp image which is basically the image that's used to sort of coordinate where all the image slices are going to be. So the scalp image shows the widening of the pubic symphysis. Additionally, on the individual images themselves, there is a fracture of the anterior left sacrum and a widening of the left SI joint as compared to the right side. Asymmetric.

According to Parnes, films like those at issue in this case are read by diagnostic radiologists and neuroradiologists:

> *Q.* Muscular skeletal films, diagnostic films, that doesn't fall within the realm of neuroradiology, correct?
>
> ***4** *A.* It falls within the realm of it as far as whether there was something related to the spine, or even sacroiliac joint, which we image, but it also falls in the realm of diagnostic radiology.

The American Board of Radiology agrees with Parnes's description of neuroradiology practice. The board defines neuroradiology as "a subspecialty of diagnostic radiology that utilizes diagnostic and interventional techniques, including computed tomography, magnetic resonance imaging, angiography, myelography, and radiographs to evaluate and treat conditions of the central nervous system, *spine,* and head and neck." < *http://www.theabr.org/moc/mocneurolanding.html* >, accessed January 16, 2011 (emphasis added).

In addition to their precisely matching specialties and subspecialties, Barnes and Bhimani share remarkably similar practice histories. After they achieved board certification in diagnostic radiology, both successfully completed fellowship training in neuroradiology. At his 2005 deposition, Bhimani testified that he "currently practice[s]"

both "general radiology" and neuroradiology, and holds himself out as a neuroradiologist. Bhimani acknowledged that he held himself out as a neuroradiologist at the time the alleged medical malpractice occurred:

> *Q.* Did you hold yourself out to be a neuroradiologist in April 2002?
>
> *A.* I was a neuroradiologist during that time, too.

Bhimani estimated that in April 2002, when he reviewed Johnson's radiographs, "about 50 percent [of my practice] was neuro and 50 percent was general." During part of the year preceding the asserted malpractice, April 2001 through January 2002, Bhimani worked at McLaren Hospital. He recalled that "[d]uring the time, the job changed, and I was roughly figuring out to working about 25 percent neuro and 75 percent general diagnostic radiology." From 1985 to 2000, Bhimani practiced with Associated Radiologists of Flint. Throughout that time, his practice "was ... close to about 70 percent neuro and 30 percent general."

Parnes estimated that he spent "somewhere between maybe 50 percent, 60 percent" of his professional time practicing neuroradiology.[1] He continued, "It is hard to say because if you consider lumbar spine, cervical spine, you know, head and neck, it depends also on a daily basis." Later in the deposition, he clarified that "50 to 80 percent" of his time "is neuroradiology."

The relevant statute, MCL 600.2169(1), delineates as follows the criteria necessary for qualification of an expert witness in a medical malpractice action:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. *However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.*
>
> ***5** (b) *Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:*
>
> *(i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.*
>
> (*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited

> health professional school or accredited residency or clinical research program in the same specialty. [Emphasis added.][2]

The majority correctly observes that Parnes met the conditions in MCL 600.2169(1)(a), given that both he and Bhimani are board-certified radiologists. *Ante* at 2. But the majority finds that Parnes cannot fulfill the requirements of § 2169(1)(b)(*i*) "because he did not spend more than 50 percent of his professional time practicing the one relevant specialty of general diagnostic radiology." *Ante* at 3. The majority's focus on "the one relevant specialty" derives from *Woodard v. Custer*, 476 Mich. 545, 566; 719 NW2d 842 (2006), in which our Supreme Court held that

> in order to be qualified to testify under § 2169(1)(b), the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty.

Although the majority acknowledges the "overlap" present in this case between anatomical structures within the purview of both diagnostic radiology and neuroradiology, the majority rules that "the specialties of diagnostic radiology and neuroradiology are distinct from each other," and "practicing neuroradiology is not the same as practicing general diagnostic radiology." *Ante* at 3–4. While I agree that the two disciplines are "distinct from each other," *ante* at 4, I strongly disagree that any *meaningful* distinction between the two specialties exists in this case. In my view, Bhimani practiced both diagnostic radiology and neuroradiology, or either specialty, when he interpreted Johnson's films. Irrespective whether Bhimani claims to have worn the hat of a neuroradiologist or a diagnostic radiologist at the moment he interpreted Johnson's films, the standard of care governing his interpretation had no relationship to the label he attached to his specialty. Therefore, I would hold that Parnes possesses the requisite qualifications to give expert testimony under MCL 600.2169. In reaching this conclusion, I rely on the text of § 2169, relevant case law and common sense.

***6** "We need not leave our common sense at the doorstep when we interpret a statute." *Price Waterhouse v. Hopkins*, 490 U.S. 228, 241; 109 S Ct 1775; 104 L.Ed.2d 268 (1989), superseded in part by statute on other grounds as noted in *Landgraf v. USI Film Products*, 511 U.S. 244, 251; 114 S Ct 1483; 128 L.Ed.2d 229 (1994). When endeavoring to interpret a statute in a manner faithful to the Legislature's intent, "a court should not abandon the canons of common sense." *Marquis v. Hartford Accident & Indemnity*, 444 Mich. 638, 644; 513 NW2d 799 (1994). The majority presumes that because Bhimani claims to have been practicing diagnostic radiology at the time he interpreted films depicting Johnson's spine and pelvis, he could not have been practicing neuroradiology. Alternatively stated, the majority concludes that while interpreting films of Johnson's spine and pelvis, Bhimani somehow avoided drawing on his knowledge, training and extensive experience as a neuroradiologist,

even though at the same time he held himself out to the public as a neuroradiologist. According to the majority's reasoning, Bhimani somehow isolated his neuroradiology training and experience from his diagnostic radiologic consideration of Johnson's films, and reviewed the x-rays while utilizing only those neurons dedicated to diagnostic radiology methods. In my view, it simply defies logic to conclude that two radiologists sharing identical board certifications and certificates of added qualifications, whose practices involve substantial time commitments to precisely the same specialty and subspecialty, would observe different standards of care when interpreting films of an anatomic area falling within the realm of their mutual expertise.

Aside from common sense, case law does not support the disqualification of an expert whose qualifications and relevant practice mirror those of the defendant. In *Woodard*, 476 Mich. at 560, our Supreme Court emphasized the role of relevance in interpreting MCL 600.2169:

> Because the plaintiff's expert will be providing expert testimony on the appropriate or relevant standard of practice or care, not an inappropriate or irrelevant standard of practice or care, it follows that the plaintiff's expert witness must match the one most relevant standard of practice or care—the specialty engaged in by the defendant physician during the course of the alleged malpractice, and, if the defendant physician is board certified in that specialty, the plaintiff's expert must also be board certified in that specialty.

The Court in *Woodard* applied the relevant specialty test in two different cases. The first, *Woodard v. Custer*, involved a defendant physician who possessed board certification in pediatrics and certificates of special qualifications in pediatric critical care medicine and neonatal-perinatal medicine. *Id.* at 554. The plaintiff's proposed expert witness had board certification in pediatrics, but lacked any certificates of added qualifications. *Id.* at 554–555. The alleged malpractice arose from the defendant's placement of an arterial line in an infant patient's leg while the infant was a patient in a pediatric intensive care unit. *Id.* at 554, 575. The Supreme Court held "that the trial court did not abuse its discretion in finding that the defendant physician was practicing pediatric critical care medicine at the time of the alleged malpractice, and, thus, pediatric critical care medicine is the one most relevant specialty." *Id.* at 576.

*7 In the second case discussed in *Woodard*, *Hamilton v. Kuligowski*, the defendant physician specialized in general internal medicine and practiced that specialty at the time of the alleged malpractice. *Id.* at 577–578. The plaintiff's proposed expert witness was also board certified in general internal medicine, but devoted the majority of his professional time to the practice of infectious diseases, a subspecialty of internal medicine. *Id.* at 556, 578. The plaintiff averred that the defendant "failed to properly diagnose and treat the decedent while she exhibited prestroke symptoms." *Id.* at 556. The plaintiff's expert admitted that he was "not sure what the average internist sees day in and day out." *Id.* at 578. The malpractice asserted in *Hamilton* had no connection to infection or the subspecialty of infectious diseases. The Supreme Court affirmed the trial court's finding that the plaintiff's proposed expert lacked the

requisite qualification under MCL 600.2169(1)(b) because he failed to "satisfy the same practice/instruction requirement." *Id.*

Because § 2169(1) uses the word "specialty" rather than "specialties," the Supreme Court determined that the statute "requires the matching of a singular specialty, not multiple specialties." *Woodard*, 476 Mich. at 559. The Supreme Court further explained that "the specialty requirement is tied to the occurrence of the alleged malpractice and not unrelated specialties that a defendant physician may hold." *Id.* The Supreme Court then addressed § 2169(1)(b), which requires that the plaintiff's expert have " 'devoted a *majority* of his or her professional time to either' the 'active clinical practice' or the 'instruction of students' in 'the same specialty' as the defendant." *Id.* at 559–560 (emphasis in original). The Supreme Court added, "Obviously, a specialist can only devote a *majority* of his professional time to *one* specialty." *Id.* at 560 (emphasis in original).

Here, the purported malpractice arises from the interpretation of spine and hip films, which falls within the realm of two radiology specialties. The specialty requirement "tied to the ... occurrence of the alleged malpractice" could include either diagnostic radiology or neuroradiology, depending on the qualifications of the physician who read the films. *Ante* at 2. Under the circumstances presented in this case, the two specialties qualify as closely related; indeed, they implicate interchangeable professional skills. Because the interpretation of spine and hip films fell within the intersection of diagnostic and radiology and neuroradiology, either constituted a relevant specialty.

Although Parnes and Bhimani share matching board certifications and virtually identical practice experience, the majority concludes that a mathematical calculation disqualifies Parnes from offering testimony in this case. In the majority's estimation, because Parnes "did not spend more than 50 percent of his professional time practicing the one relevant specialty of general diagnostic radiology," he cannot meet the statutory condition that a specialist has "devoted a majority of his or her professional time to ... [t]he active clinical practice" of the specialty practiced by the defendant "at the time of the occurrence that is the basis for the action." *Ante* at 3; MCL 600.2169(1)(a) and (b). The Legislature incorporated in MCL 600.2169(b) a 50–percent practice requirement as a second indicator of a proposed expert's familiarity with the standard of care. In addition to sharing the same board certification, the proposed expert must also have regular, hands-on experience in the medical field practiced by the defendant *at the time of the alleged malpractice.* As a simple measure of experience within a medical discipline, the Legislature established a 50–percent rule; the proposed expert must devote at least half his or her professional efforts to the specialty engaged in by the defendant at the time of the "occurrence" giving rise to the case. § 2169(a), (b)(*i*). A physician who spends half his time in a particular specialty likely has familiarity with the standard of care governing professional conduct in that field.

***8** With respect to the majority's statement, "It is not disputed that diagnostic radiology is the one most relevant specialty involve here," I respectfully submit that the majority

has mischaracterized plaintiff's position in this case. *Ante* at 2. At the hearing on Bhimani's motion for summary disposition, plaintiffs' counsel insisted that "there's a lot of overlapping" between the two fields, and explained that "when a radiologist is looking, say, at a spine film, there's a merging there because, you know, you've got nerves in the spine, you've got bones in the spine." Because the professional conduct at issue here falls within the realms of both neuroradiology and diagnostic radiology, the 50–percent calculus reasonably applies to *either* discipline. Stated differently, when interpreting images of the spine and immediately surrounding structures, a physician certified in both diagnostic radiology and neuroradiology engages in professional conduct implicating equally two professional disciplines. Under the circumstances presented here, the specialties are intimately related, and both are relevant.[3] Because Parnes devotes at least half his professional efforts to neuroradiology, I would hold that the text of MCL 600.2169(1)(b) sanctions Parnes's eligibility to testify in this case.

My analysis also comports with the Legislature's intent. In *McDougall v. Schanz*, 461 Mich. 15, 24–25; 597 NW2d 148 (1999), the Supreme Court explained that MCL 600.2169(1) "operates to preclude certain witnesses from testifying solely on the basis of the witness' lack of practice or teaching experience in the relevant specialty." In a footnote, the Supreme Court quoted the legislative history: " 'This proposal is designed to make sure that expert witnesses actually practice or teach medicine. In other words, to make sure that experts will have firsthand practical expertise in the subject matter about which they are testifying.' " *Id.* at 25 n 9. Parnes lacked neither training nor recent practice experience in interpreting spine and hip films. Regardless whether the mathematical calculation applies to time spent in diagnostic radiology or neuroradiology, Parnes's board certifications and regular practice experience equip him with firsthand knowledge of the standard of care applicable to Bhimani's interpretation of Johnson's spine and hip films. Consequently, I would reverse the circuit court's grant of summary disposition to Bhimani.

All Citations

Not Reported in N.W.2d, 2011 WL 476443

Footnotes

1 References to "plaintiff" in the singular throughout this opinion are to Scott Johnson because Kathleen Johnson's claim for loss of consortium is derivative to his primary claim of medical malpractice.

2 *Hamilton v. Kuligowski* was decided as a companion case to *Woodard v. Custer*.

1 Neither counsel requested that Parnes provide a statistical breakdown of his practice over the course of the year before the occurrence at issue.

2 Subsection (c) concerns general practitioners and has no relevance here.

3 In contrast, the plaintiff's expert in *Hamilton*, 476 Mich. at 556, devoted the majority of his professional time to the practice of an unrelated and irrelevant specialty.

End of Document

Exhibit D

2016 WL 9245786
Only the Westlaw citation
is currently available.

UNPUBLISHED
Court of Appeals of Michigan.

IN RE ESTATE OF
Linda **ROBERDEAUX**.
Dennis **Roberdeaux**, Sr., Personal
Representative, Plaintiff–Appellant,
v.
Evangelical Homes of Michigan,
doing business as Evangelical Home–
Saline, and Michigan Sports Medicine
& Orthopedic Center, Defendants,
and
Washtenaw Medicine, P.C., doing
business as Washtenaw Internal
Medicine Associates, Cheryl A.
Huckins, M.D., and Mark A. Kelley,
M.D., Defendants–Appellees.

No. 323802
|
October 18, 2016

Washtenaw Circuit Court, LC No. 13–000675–NH

Before: Servitto, P.J., and Wilder and Boonstra, JJ.

Opinion

Per Curiam.

***1** In this medical malpractice matter, plaintiff, as personal representative of the Estate of Linda **Roberdeaux** (hereinafter Linda or Linda **Roberdeaux**), appeals as of right the trial court's order dismissing with prejudice defendant, Evangelical Homes of Michigan, d/b/a Evangelical Home–Saline (hereinafter "Evangelical Saline"). Plaintiff also appeals from the judgment of no cause for action entered in favor of defendants, Washtenaw Medicine, P.C., d/b/a Washtenaw Internal Medicine Associates, P.C. (hereinafter "Washtenaw"), Cheryl Huckins, M.D., and Mark A. Kelley, M.D. We affirm in part, reverse in part, vacate in part, and remand for further proceedings consistent with this opinion.

I

This case arises from Linda **Roberdeaux's** death on October 14, 2009, from a pulmonary embolism. Linda underwent a total left knee replacement surgery on August 28, 2009, which was performed by Dr. Kelley. On August 31, 2009, Dr. Kelley ordered a venous Doppler study of Linda's leg based on her complaints of pain in her left calf and swelling. The Doppler did not reveal any sign of a blood clot.

Linda was discharged from the hospital on August 31, 2009, and moved to Evangelical Saline, a nursing facility, where she was treated by Dr. Huckins, an internal medicine physician. Dr. Huckins ordered another Doppler for Linda on September 8, 2009, because she had increased pain and swelling in her left calf.

Dr. Huckins's note in the records from September 9, 2009, indicated "Doppler left

negative." She did not recall when and if she reviewed the report from the Doppler, although she testified that it would have been her practice to do so. The Doppler report indicated that there was no clot in the veins in the thigh, several veins were incompletely visualized, the exam was incomplete, and "isolated tibial vein thrombosis" could not be ruled out. Dr. Huckins believed this meant that even though certain veins were not well-visualized, "the physician reading the report did not feel that there was a question about those veins." Dr. Huckins testified that the Doppler was negative for the vessels that she was most concerned about. After reviewing the results of the Doppler, the contents did not cause her to change her care of Linda because it was her practice to follow up clinically with patients in similar situations and order a Doppler if there was any change in the patient's condition. There was no medical reason to place Linda on therapeutic anticoagulation medication. There is a risk-benefit analysis that must be conducted in deciding whether to administer anticoagulation therapy because of the risk of bleeding.

Linda traveled from Evangelical Saline to her first follow-up visit with Dr. Kelley on September 10, 2009. The purpose of the appointment was, in part, to check the wound and remove staples. Linda did not tell Dr. Kelley that she had a Doppler or had pain or swelling in her leg. Dr. Kelley also did not know that a Doppler had been performed, but he testified that he would not expect to be informed every time a doctor at Evangelical Saline ordered a Doppler. Moreover, Linda did not have any of the symptoms that she had complained of on September 8, 2009, her calves were soft, and she did not complain of pain or swelling.

***2** Linda was discharged from Evangelical Saline and returned home on September 18, 2009. She visited Dr. Kelley again on September 28, 2009, October 8, 2009, and October 13, 2009. Dr. Kelley observed no signs of blood clots on September 28, 2009, and Linda did not complain of any pain, tenderness, or redness. The October 8, 2009 visit was unscheduled, and Linda had pain and redness around the scar, but she did not have swelling or tenderness in her calf.

According to Linda's mother, Theresa Collins, Linda visited Collins at least every other day after she returned home. Theresa Jackson, a licensed practical nurse (LPN) who assisted Collins daily, testified that she saw Linda at Collins's home on October 12, 2009, two days before her death. When Linda arrived, she was grimacing and indicated that she was in pain. Jackson observed Linda's legs and saw swelling on the left knee, calf, and ankle. Jackson encouraged Linda to discuss these issues with her doctor the next day. Linda's records from physical therapy on October 12, 2009, however, did not indicate that she had complaints of pain or swelling on that date.

At Linda's visit with Dr. Kelley on October 13, 2009, Linda had stiffness in the knee joint, but the redness was going away. Her leg was not warm or swollen. Dr. Kelley and Linda discussed Linda's plans to go to Florida and Dr. Kelley told Linda that she could travel to Florida. However, he did not clear her for Florida at that appointment and she was scheduled to see him again the next week.

According to Dr. Kelley, if at any time Linda had exhibited any clinical signs or symptoms of a clot, or she had complained of pain or swelling, he would have ordered a Doppler. Linda visited Collins after her appointment on October 13, 2009.

Plaintiff, Linda's husband, testified that, at 11:00 p.m. on the night before her death, Linda "seemed okay." On the morning of October 14, 2009, Linda was nonresponsive when plaintiff tried to wake her up. Plaintiff called 911 and began performing CPR, but he believed she had already passed away. Plaintiff testified that he called Dr. Kelley that day and had a brief conversation with him in which plaintiff asked Dr. Kelley some questions. Dr. Kelley recalled plaintiff calling his office, but he did not recall plaintiff asking him questions, only informing him that Linda had passed away. According to plaintiff, the swelling in Linda's leg never went down after the surgery.

On July 3, 2013, plaintiff filed this medical malpractice action against defendants,[1] alleging that, despite Linda having experienced deep vein thrombosis (DVT) and/or pulmonary embolism before her death, her condition was not properly or timely diagnosed and treated. He further alleged that both Dr. Kelley and Dr. Huckins knew or should have known about Linda's risk factors, signs, and symptoms for DVT or pulmonary embolism. Plaintiff asserted that both doctors were negligent in failing to take further action after the Doppler study performed on September 9, 2009, which did not adequately rule out DVT. He claimed that, on October 13, 2009, Dr. Kelley told Linda that she had blood clots, but she did not need to worry because the clots would not travel to her lungs. Plaintiff claimed also that Dr. Kelley admitted, in the telephone conversation with plaintiff on October 14, 2009, that he had told Linda during the last visit that she had blood clots in her leg. Plaintiff alleged that defendants breached the standard of care resulting in Linda's death of a pulmonary embolism and that appropriate treatment and care would have prevented her death. Plaintiff sought economic and noneconomic damages.

***3** Before trial, Dr. Kelley filed a motion to exclude hearsay. Specifically, Dr. Kelley sought to preclude plaintiff's testimony that Linda told him, after her visit with Dr. Kelley on October 13, 2009, that Dr. Kelley had said she had clots in her legs, but she should not worry about them because they would not move. Dr. Kelley denied making such statement and argued that the testimony was double hearsay that was not admissible under any exception to the hearsay rule. Plaintiff responded that the motion was premature and that he did not intend to offer any hearsay statements at trial.

Also before trial, plaintiff filed a motion to strike or disqualify Dr. Huckins's expert, Dr. John Voytas, from testifying at trial. Plaintiff argued that Dr. Huckins was board-certified in internal medicine and, at the time of the alleged malpractice, was practicing in the specialty area of internal medicine. He argued that Dr. Voytas did not meet the requirement of MCL 600.2169(1)(b) that, during the year before the alleged malpractice, the expert must have devoted a majority of his professional time to the active clinical practice of the specialty at issue. Plaintiff claimed that, during the relevant time, Dr. Voytas was board-

certified in geriatric medicine and devoted a majority of his professional time to the clinical practice of geriatric medicine. Plaintiff argued that, while Dr. Huckins may claim that Dr. Voytas's geriatric practice overlaps with the field of internal medicine, geriatrics and internal medicine are two distinct specialties, or branches of medicine in which one can potentially become board-certified. Plaintiff cited and attached portions of deposition testimony of Dr. Voytas from 2009 in an unrelated case, as well as portions of Dr. Voytas's deposition testimony in this case.

In the unrelated case, Dr. Voytas testified that from 1984 to 1993 he was employed as an internal medicine physician. In 1994, he left the internal medicine practice, completed a mid-career geriatrics fellowship, and accepted a position in the Division of Geriatrics at Beaumont Hospital. He testified that internal medicine "involves the evaluation and management of medical conditions primarily in the adult," but internists "may also see some older patients either in their offices or in the hospital." Dr. Voytas also testified that "most geriatricians are internal medicine [doctors] by training." In 2009, Dr. Voytas spent two-thirds of his time as a medical director in the nursing home business and one-third of his time as a program director at Beaumont Hospital, training other physicians how to care for elderly patients.

In his deposition in this case, Dr. Voytas testified as follows:

> *Q*. Now, you have been listed as a geriatric physician; is that right?
>
> *A*. An internist and geriatrician, yes.
>
> *Q*. A geriatrician, is that something that has its own—you had a fellowship in that particular area, didn't you?
>
> *A*. Yes, I took a fellowship.
>
> *Q*. If I understand it, sir, from your prior testimony that I have read, that in 1994 you left the internal medicine practice and completed a mid-career geriatrics fellowship at the Medical College of Pennsylvania; is that correct?
>
> *A*. Correct.
>
> *Q*. And since 1994 you have been doing geriatric medicine since?
>
> *A*. Predominantly. I mean I have ages that are under 65, if you consider 65 the beginning of geriatrics, but the predominance has been people 65 and older.
>
> *Q*. But your testimony has been that since that time, after taking your fellowship and being board certified as a geriatrician, greater than 50 percent of your practice has been regarding geriatric medicine?
>
> ***4** *A*. Correct, 65 and older.
>
> * * *
>
> *Q*. Okay. In prior testimony, sir, you have indicated that the majority of your practice is as a geriatric physician. Is that still true?
>
> *A*. Taking care of people over 65, if you call that geriatrics, yes.

Q. In your prior testimony you have indicated that the majority of your practice is geriatrics; is that correct?

A. Correct.

Q. And that was true in the years we are talking about, 2009.

A. Correct.

Q. And also in 2008, right?

A. Correct.

Dr. Voytas also testified that he is board-certified in geriatric medicine and most of his clinical work is in a nursing home environment, where the average age is approximately 82. He testified that, in 2008 and 2009, he had a full-time practice of geriatric medicine. During that time, he saw patients who were at risk for DVT. From 1994 to 2012, Dr. Voytas was on the medical staff in the geriatric division at Beaumont Hospital and was also an attending physician and medical director at Woodward Hills Nursing Home.

Dr. Huckins and Washtenaw filed a response to plaintiff's motion in which they argued that Dr. Huckins's and Dr. Voytas's active clinical practices were the same because they both devoted 100% of their time to the care and treatment of elderly patients. They argued that Dr. Huckins described her practice as "a skilled nursing facility specialist" under the broad umbrella of internal medicine. Dr. Voytas used the term geriatrics to describe his practice of taking care of patients 65 or older, which is a sub-specialty under the broad umbrella of internal medicine. Dr. Huckins and Washtenaw argued that it was undisputed that the majority of Dr. Voytas's clinical practice is exactly the same as Dr. Huckins's clinical practice. They further argued that either Dr. Huckins's and Dr. Voytas's practices were both 100% nursing home/subacute rehab under the umbrella of internal medicine, or, alternatively, considering what Dr. Huckins was actually doing at the time of the alleged malpractice, she was practicing geriatrics. They further argued that a physician does not have to be board-certified in a specialty to practice it. The purpose of the practice requirement is to prevent professional witnesses from testifying, but Dr. Voytas had a full-time practice at the time of the alleged malpractice. Dr. Huckins testified that she was a "skilled nursing facility specialist," and Dr. Voytas testified that the majority of his practice was the same as what Dr. Huckins did. The relevant area of inquiry regarding the practice requirement is what the physician was doing at the time of the alleged malpractice.

Dr. Huckins and Washtenaw attached Dr. Huckins's deposition testimony, in which she testified that, in 2008, she joined Washtenaw Medicine, a primary care practice. Before that time, she was a skilled nursing facility specialist with St. Joseph Mercy Medical Group. Dr. Huckins is board-certified in internal medicine. She testified that, in 2009, she "was doing a full-time practice in several different nursing homes." She saw patients, including Linda, as an internal medicine physician. Her role was as the "doctor of record," which was similar to an attending physician. Dr. Huckins and Washtenaw also attached Dr. Huckins's affidavit, in which she averred that, in 2009, the average age of her patients was 80 and 88% of her patients were 65 years of age or older.

*5 At a hearing on various pretrial motions, Dr. Kelley argued that he denied making the alleged statement to Linda and nothing in his records or the physical therapy records from the day before the October 13, 2009 appointment would support the presence of clots. Dr. Kelley further argued that plaintiff testified that Linda's brother drove her to the visit when the alleged statements were made and then drove Linda to Collins's house where she repeated the statement; however, Linda's brother denied taking her to the visit, Collins said that only Jackson was also present during the conversation (not plaintiff), and Jackson testified that she was not at Collins' home on that date. Dr. Kelley argued that the inconsistent testimony regarding the alleged statements showed that the testimony was inherently unreliable and should not be admitted. He also argued that the trial court did not have to wait until trial to make a ruling. Plaintiff responded that he should able to reference the conversation regarding Linda's ability to go to Florida without admitting hearsay. The trial court granted Dr. Kelley's motion and excluded any testimony about purported statements made by Dr. Kelley to Linda on October 13, 2009, regarding clots in her legs. The trial court found that it was not premature to make a ruling on what clearly constituted hearsay, but would rule on any other related evidentiary issues as they arose at trial. The trial court's order provided that "neither counsel nor any witness shall comment upon/refer to/or testify regarding alleged discussions as occurred between [Linda] and Dr. Kelley at the office visit of October 13, 2009 with respect to blood clots being in [Linda's] leg but that such clots would not move."

Regarding the motion to strike Dr. Voytas as an expert witness, the parties argued consistently with their briefs. Plaintiff also argued in rebuttal that there was no board specialty in nursing home practice. The trial court found that Dr. Huckins and Dr. Voytas practiced "the exact same medicine." The trial court stated:

> [T]he fact of matter is that they were each practicing more than 50 percent of their time practicing medicine on elderly patients. We all know that Geriatrics is fundamentally Internal Medicine for older patients. So there is no question that Dr. Voitus [sic] is qualified. They were both internists—Internal Medicine Board-certified and they're both doing the exact same kind of work, so motion is denied.[2]

At trial, plaintiff called three expert witnesses. Before Jackson's testimony, Dr. Kelley's counsel objected to Jackson giving diagnosis testimony, which he argued was not permissible. Plaintiff's counsel responded that Jackson would only testify to what she saw and did. Dr. Kelley's counsel requested that Jackson be prohibited from testifying about her discussion with Linda regarding Coumadin, which she argued was "expert testimony." Plaintiff's counsel responded that Jackson's statement to Linda that "you must be on Coumadin" was not hearsay and merely led to Jackson looking at Linda's legs. The trial court ruled that it would allow Jackson to testify regarding what she saw, but that her statement implied that Linda should be on Coumadin, which was "sort of [a] medical judgment." The trial court also ruled that Jackson could not testify that she told Linda that she could go and

have a Doppler because such testimony was also a medical judgment and was not relevant.

Outside the presence of the jury, Jackson testified that she made a statement to Linda that she suspected she was on blood thinner after her surgery. When Linda said that she was not, Jackson was stunned because she works with numerous individuals who have had hip or knee replacements and 90% of the time they are on Coumadin or a blood thinner. After examining Linda's legs, Jackson encouraged Linda to go to the emergency room for testing. When Linda said she was going to see her doctor the next day, Jackson told her to show her doctor where it hurts. Jackson told Linda that the worst case scenario was a pulmonary embolism.

After plaintiff rested his case, plaintiff's counsel indicated that she had honored the trial court's ruling regarding conversations with Dr. Kelley about blood clots, but that she wanted to make a record of testimony that she would have elicited from plaintiff. She read plaintiff's deposition testimony in which he testified that he called Dr. Kelley on October 14, 2009, and Dr. Kelley confirmed that he told Linda that she had blood clots in her legs, but they would not move. Plaintiff's counsel also read Collins's deposition testimony in which she testified that Linda told her that Dr. Kelley said she had a blood clot, but he did not think it would not move. Plaintiff's counsel argued that his statement was not hearsay because he was the declarant, Dr. Kelley's statement was admissible as a party admission, and Collins's statement was admissible under MRE 803(24) (the "catch-all" hearsay exception). Dr. Kelley's counsel responded that the trial court properly ruled that such statements were hearsay and reiterated her argument that there was inconsistent testimony from the depositions regarding who was present when Linda's statements were made. The trial court stood by its rulings, finding that the statements were hearsay without an exception and there was no "inherent reliability factor in this instance."

***6** Defendants presented the testimony of three experts at trial—Dr. Voytas testified regarding the standard of care applicable to Dr. Huckins, Dr. Casey Bartman testified regarding the standard of care applicable to Dr. Kelley, and Dr. Thomas Gravelyn testified regarding causation. The jury returned a verdict finding that neither Dr. Huckins nor Dr. Kelley was professionally negligent and the trial court entered a judgment of no cause for action in favor of Washtenaw, Dr. Huckins, and Dr. Kelley.

Following entry of the judgment, Dr. Huckins and Washtenaw filed a motion for case evaluation sanctions and taxable costs in the amount of $84,212.22. The trial court entered an order finding that plaintiff's counsel had first priority to any settlement proceeds and assets of the estate, Dr. Huckins and Washtenaw had second priority, the amount of taxed costs was $7,840, and the amount of case evaluations sanctions was $78,811.82.

After stipulation of the parties, the trial court entered an order dismissing Evangelical Saline *nunc pro tunc*, as of September 10, 2014. This appeal ensued.

II

Plaintiff first contends that the trial court erred by allowing Dr. Voytas to provide standard-of-care testimony because he was not qualified to do so under MCL 600.2169(1)(b). We disagree.

"This Court reviews for an abuse of discretion a trial court's determination of the qualifications of a proposed expert witness." *Chapin v. A & L Parts, Inc.*, 274 Mich. App. 122, 126; 732 N.W.2d 578 (2007). "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." *Woodard v. Custer*, 476 Mich. 545, 557; 719 N.W.2d 842 (2006). "Questions of statutory interpretation are reviewed de novo. *Id.*

MCL 600.2169(1) provides, in relevant part:

> In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.

In *Woodard*, 476 Mich. at 560, the Michigan Supreme Court held that, under MCL 600.2169(1), "the plaintiff's expert witness must match the one most relevant standard of practice or care—the specialty engaged in by the defendant physician during the course of the alleged malpractice, and, if the defendant physician is board certified in that specialty, the plaintiff's expert must also be board certified in that specialty." The Court further held that "a 'specialty' is a particular branch of medicine or surgery in which one can potentially become board certified." *Id.* at 561. Therefore, "if the defendant physician practices a particular branch of medicine or surgery in which one can potentially become board certified, the plaintiff's expert must practice or teach the same particular branch of medicine or surgery." *Id.* at 561–562. Moreover, "a 'subspecialty' is a particular branch of medicine or surgery in which one can potentially become board certified that falls under a specialty or within the hierarchy of that specialty," and is also considered a specialty. *Id.* at 562. The Court also stated that, under MCL 600.2169(1)(a), "the proposed expert witness must have the same board certification as the party against whom or on whose behalf the testimony is offered." *Id.* at 562–563 (citation and quotation marks omitted). The Court held that

> *7 in order to be qualified to testify under § 2169(1)(b), the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty. [*Id.* at 566.]

In the companion case to *Woodard*, *Hamilton v. Kuligowski*, the Court held that the proposed expert did not satisfy the practice requirement of MCL 600.2169(1)(b) where the defendant physician specialized in general internal medicine and was practicing general internal medicine at the time of the alleged malpractice, but the proposed expert did not devote a majority of his professional time to practicing or teaching general internal medicine in the year immediately preceding the alleged malpractice. *Woodard*, 476 Mich. at 577–578. Rather, the proposed expert spent a majority of his professional time treating infectious diseases, a subspecialty of internal medicine. *Id.* at 556, 578.

A defendant doctor may, however, be practicing outside his or her area of board-certification at the time the alleged malpractice occurs. In *Reeves v. Carson City Hosp (On Remand)*, 274 Mich. App. 622, 623, 628; 736 N.W.2d 284 (2007), the defendant doctor was board-certified in family medicine, but was working in the emergency room at the time of the alleged malpractice. The Court concluded that because the defendant doctor was practicing emergency medicine at the time of the alleged malpractice and could potentially become board-certified in emergency medicine, she was a specialist in emergency medicine. *Id.* at 628–630. Therefore, the Court held that the plaintiff needed a specialist in emergency medicine to satisfy MCL 600.2169. *Id.* at 630. The proposed expert was board-certified in emergency medicine, but the Court remanded for the trial court to determine whether the proposed expert devoted a majority of his professional time during the year preceding the alleged malpractice to the active clinical practice of emergency medicine or the instruction of students. *Id.*

There is no dispute that Dr. Voytas satisfied the requirement of MCL 600.2169(1)(a). Dr. Huckins was board-certified in internal medicine and Dr. Voytas was board-certified in internal medicine as well as geriatric medicine. At issue in this case is the practice requirement of MCL 600.2169(1)(b). Plaintiff contends that because Dr. Huckins testified that she was practicing internal medicine when she treated Linda and, because Dr. Voytas testified that he spent the majority of his time during the relevant period practicing geriatric medicine, Dr. Voytas was not qualified under MCL 600.2169(1)(b).

Geriatric medicine and internal medicine are distinct specialties, as one can become board-certified in either and geriatric medicine is also a subspecialty of internal medicine. *Woodard*, 476 Mich. at 561–562. "Internal medicine" is "the branch of medicine concerned with nonsurgical diseases in adults, but not including diseases limited to the skin or to the nervous system." *Stedman's Medical Dictionary* (28th ed). "Geriatric medicine" is "a specialty of

medicine that is concerned with the disease and health problems of older people, usually those over 65 year of age. Considered a subspecialty of internal medicine." Accordingly, if Dr. Huckins was practicing internal medicine at the time of the alleged malpractice and Dr. Voytas devoted the majority of his professional time during the year preceding the alleged malpractice to geriatric medicine, a subspecialty of internal medicine, then Dr. Voytas did not satisfy the practice requirement. See *Woodard*, 476 Mich. at 577–578. However, Dr. Huckins and Washtenaw argue that, considering what Dr. Huckins and Dr. Voytas were actually doing at the relevant times, then either (1) Dr. Huckins was actually practicing geriatric medicine at the time of the alleged malpractice, or (2) Dr. Voytas was actually practicing internal medicine in the year preceding the alleged malpractice.

***8** The trial court did not clearly identify the relevant specialty, but instructed the jury that the standard of care applicable to Dr. Huckins was that of an internal medicine doctor. We agree with the trial court and reject Dr. Huckins and Washtenaw's argument that Dr. Huckins was actually practicing geriatric medicine at the time of the alleged malpractice. As the above definitions show, geriatrics is not merely about the age of the patients—it relates to problems and diseases related to old age. Moreover, internal medicine is broad and may include the treatment of elderly patients. Accordingly, this case is unlike *Reeves*, in which the defendant doctor working in the emergency room was clearly practicing emergency medicine and not family medicine. See *Reeves*, 274 Mich. App. at 628. Rather, a doctor treating elderly patients in a nursing home could be practicing internal medicine or geriatric medicine. And in this case, there was no evidence that Dr. Huckins was dealing with problems related to old age, rather than practicing internal medicine with patients who were predominantly elderly. Accordingly, the trial court properly found that the applicable standard of care was that of an internal medicine physician at the time of the alleged malpractice.

Nonetheless, the trial court could have found that Dr. Voytas spent the majority of his time practicing internal medicine in the year preceding the alleged malpractice. Dr. Voytas's testimony that he predominantly practiced "geriatrics" is not conclusive of what he was actually practicing during the relevant period, particularly where he described his "geriatric" practice merely as "[t]aking care of people over 65." Again, the definitions show that geriatrics is about more than the age of the patient and Dr. Voytas testified that internists may also treat elderly patients. It is necessary to consider what Dr. Voytas actually did in his practice. In this case, Dr. Voytas predominantly treated patients 65 or older as a medical director and attending physician in a nursing home. Similarly, at the time of the alleged malpractice, Dr. Huckins was treating Linda, who was 65 years old, in a nursing home as the "doctor of record," similar to an attending physician. Both saw patients who were at risk for DVT. Although there was no further testimony regarding the particular issues, problems, or diseases that either doctor treated, the trial court did not abuse its discretion in finding that Dr. Voytas did the same thing as Dr. Huckins, internal medicine, based on the record before it. Because Dr. Voytas spent a majority of his professional time practicing in the specialty of internal

medicine in the year preceding the alleged malpractice, Dr. Voytas was qualified under MCL 600.2169(1)(b). Because Dr. Voytas was qualified, the trial court did not abuse its discretion in allowing him to testify at trial.

III

Next, plaintiff contends that the trial court committed error requiring reversal by refusing to admit the substance of his telephone conversation with Dr. Kelley on the day of Linda's death. According to plaintiff, he asked Dr. Kelley whether Dr. Kelley told Linda that she had blood clots, and Dr. Kelley said that he did. Plaintiff argues that his questions to Dr. Kelley did not constitute hearsay because they were not assertions. Plaintiff further argues that Dr. Kelley's response was exempt from the hearsay rule as a statement of a party opponent under MRE 801(d)(2)(A). We agree in both respects.[3]

"A trial court's decision whether to admit evidence is reviewed for an abuse of discretion, but preliminary legal determinations of admissibility are reviewed de novo." *Albro v. Drayer*, 303 Mich. App. 758, 760; 846 N.W.2d 70 (2014). "An abuse of discretion occurs when the trial court's decision results in an outcome falling outside the range of principled outcomes." *Dep't of Transp v. Gilling*, 289 Mich. App. 219, 243; 796 N.W.2d 476 (2010).

***9** " 'Hearsay' is a statement, other than the one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted." MRE 801(c). "A 'statement' is (1) an oral or written *assertion* or (2) nonverbal conduct of a person, if it is intended by the person as an *assertion*." MRE 801(a) (emphasis added). We agree with plaintiff that his questions to Dr. Kelley were not assertions and, therefore, did not constitute hearsay. However, the questions alone, without Dr. Kelley's response, would not have been helpful to plaintiff's case, and the trial court's failure to admit plaintiff's testimony regarding the questions alone is harmless. See MCR 2.613(A). The determinative issue is whether plaintiff's testimony regarding Dr. Kelley's response, which was an assertion, was admissible as non-hearsay.

MRE 801(d)(2) provides that "[a] statement is not hearsay if—"

> The statement is offered against a party and is (A) the party's own statement, in either an individual or a representative capacity, except statements made in connection with a guilty plea to a misdemeanor motor vehicle violation or an admission of responsibility for a civil infraction under laws pertaining to motor vehicles, or (B) a statement of which the party has manifested an adoption or belief in its truth, or (C) a statement by a person authorized by the party to make a statement concerning the subject, or (D) a statement by the party's agent or servant concerning a matter within the scope of the agency or employment, made during the existence of the relationship, or (E) a statement by a coconspirator of a party during the course and in furtherance of the conspiracy on independent proof of the conspiracy.

The above rule "allows admission of a statement offered against a party when it is the party's own statement, in either an individual

or a representative capacity." *Merrow v. Bofferding*, 458 Mich. 617, 633; 581 N.W.2d 696 (1998). The party seeking to introduce the statement has the burden of proving, by a preponderance of the evidence, that the alleged proponent actually said it. *Id.* at 633 n 14. But the fact that the alleged proponent denies making the statement "does not render the statement inadmissible[.]" *Bradbury v. Ford Motor Co*, 123 Mich. App. 179, 188; 333 N.W.2d 214 (1983), judgment mod by 419 Mich. 550 (1984). Rather, "if he denies it, a jury question of credibility is raised." *Id.*

Here, plaintiff laid a proper foundation regarding the source of the statement in question. Specifically, plaintiff testified unequivocally that the source of the statement was Dr. Kelley, who is a named defendant and therefore plaintiff's party opponent. It is true that Dr. Kelley did not recall plaintiff asking him any questions during the telephone conversation. Additionally, in his motion to exclude hearsay, Dr. Kelley denied having told plaintiff that he told Linda that she had blood clots. But Dr. Kelley's denial in that regard did not make plaintiff's proffered testimony inadmissible. Instead, the denial created a credibility issue that should have been submitted to the jury. Thus, the trial court erred by concluding that the testimony at issue was inadmissible. Such error resulted in an abuse of discretion. See *Kidder v. Ptacin*, 284 Mich. App. 166, 170; 771 N.W.2d 806 (2009) ("A court by definition abuses its discretion when it makes an error of law.") (quotation marks and citation omitted).

Moreover, we cannot conclude that the trial court's error was harmless. In pertinent part, MCR 103(a) provides, "Error may not be predicated upon a ruling which admits or excludes evidence unless a substantial right of the party is affected[.]" Similarly, MCR 2.613(A) provides, in pertinent part, "An error in the admission or the exclusion of evidence ... is not ground for granting a new trial, for setting aside a verdict, or for vacating, modifying, or otherwise disturbing a judgment or order, unless refusal to take this action appears to the court inconsistent with substantial justice." The testimony at issue here is directly material and presents an issue of witness credibility. As established by an offer of proof at trial, plaintiff would have testified that he called Dr. Kelley on October 14, 2009—the day the decedent died—and during that telephone conversation Dr. Kelley admitted that, during his appointment with the decedent the day prior, he told her that she had blood clots in her legs, but they would not move. If believed by the jury, plaintiff's testimony was evidence that just a day before the decedent suffered her fatal pulmonary embolism, Dr. Kelley was aware that she had blood clots in her legs but took no measures to treat the condition. Thus, we cannot conclude that the trial court's failure to admit the evidence was harmless. Consequently, we reverse the trial court's evidentiary ruling and remand for a new trial as to Dr. Kelley only.

IV

***10** Plaintiff also argues that the trial court erred by refusing to allow Jackson to testify regarding her reaction to what she saw or her conversation with Linda regarding Coumadin on October 12, 2009. We disagree.

"We review for an abuse of discretion a trial court's decision to admit or exclude evidence. An abuse of discretion occurs when the trial court's decision results in an outcome falling outside the range of principled outcomes." *Gilling*, 289 Mich. App. at 243 (citations omitted).

Because Jackson was not qualified as an expert, the admissibility of her testimony is governed by MRE 701, which provides:

> If the witness is not testifying as an expert, the witness' testimony in the form of opinions or inferences is limited to those opinions or inferences which are (a) rationally based on the perception of the witness and (b) helpful to a clear understanding of the witness' testimony or the determination of a fact in issue.

Plaintiff argues that Jackson's testimony was not relevant as a diagnosis, but was relevant because "even a person with her level of training and experience had serious concerns based on [Linda's] condition and the symptoms she was reporting." However, whether Linda should have been on a blood thinner, whether Linda should have gone to the emergency room to have a Doppler performed, and whether Linda was at risk for a pulmonary embolism are beyond the scope of lay knowledge. Jackson's excluded testimony itself showed that her statements about blood thinners were based on her specialized knowledge as a nurse, not merely her observations. Cf. *Mitchell v. Steward Oldford & Sons, Inc.*, 163 Mich. App. 622, 630; 415 N.W.2d 224 (1987) (concluding that the police officer's testimony "was not overly dependent on scientific, technical or other specialized knowledge"). Jackson's opinion was not helpful to the jury in determining whether Linda should have been on a blood thinner. Therefore, the trial court did not abuse its discretion in excluding Jackson's testimony. See *Gilling*, 289 Mich. App. at 243.

V

Next, plaintiff contends that the trial court erred by refusing to allow plaintiff and Collins to testify that Linda stated that Dr. Kelley told her, during the October 13, 2009 appointment, that she had blood clots, but they would not move. Plaintiff argues that such testimony was admissible under MRE 803(24). We disagree.

We note that plaintiff only argued below that Collins's testimony was admissible under MRE 803(24). Nonetheless, because the content of Collins's testimony regarding Linda's statement was the same as plaintiff's testimony, we are considering such testimony together, and the result would be the same under the plain error standard of review, we will consider this issue as preserved. "We review for an abuse of discretion a trial court's decision to admit or exclude evidence. An abuse of discretion occurs when the trial court's decision results in an outcome falling outside the range of principled outcomes." *Gilling*, 289 Mich. App. at 243 (citations omitted).

MRE 803(24) provides:

> A statement not specifically covered by any of the foregoing exceptions but having equivalent circumstantial guarantees of trustworthiness, if the court determines that (A) the statement is offered as evidence of

> a material fact, (B) the statement is more probative on the point for which it is offered than any other evidence that the proponent can procure through reasonable efforts, and (C) the general purposes of these rules and the interests of justice will best be served by admission of the statement into evidence. However, a statement may not be admitted under this exception unless the proponent of the statement makes known to the adverse party, sufficiently in advance of the trial or hearing to provide the adverse party with a fair opportunity to prepare to meet it, the proponent's intention to offer the statement and the particulars of it, including the name and address of the declarant.

***11** This Court has stated:

> MRE 803(24) is the "catch-all" exception to the hearsay rule. Evidence admitted under MRE 803(24) must satisfy four elements: "(1) it must have circumstantial guarantees of trustworthiness equal to the categorical exceptions, (2) it must tend to establish a material fact, (3) it must be the most probative evidence on the fact that the offering party could produce through reasonable efforts, and (4) its admission must serve the interests of justice." [*Detroit/Wayne Co Stadium Auth v. Drinkwater, Taylor, and Merrill, Inc.*, 267 Mich. App. 625, 651; 705 N.W.2d 549 (2005) (citation omitted).]

In considering "double hearsay," such as Linda's statement regarding what Dr. Kelley said at the October 13, 2009 appointment, each statement must fall within a hearsay exception. See *Solomon v. Shuell*, 435 Mich. 104, 129, 457 N.W.2d 669 (1990) ("Under MRE 805, hearsay within hearsay is excluded where no foundation has been established to bring each independent hearsay statement within a hearsay exception."). Therefore, in order for plaintiff's and Collins's testimony to be admissible, both Linda's statement and Dr. Kelley's statement must have satisfied the requirements of MRE 803(24).

Even assuming that the statements had circumstantial guarantees of trustworthiness and tended to establish a material fact, i.e., that Dr. Kelley was aware that Linda had blood clots on October 13, 2009, the statements were not the most probative evidence on that fact that plaintiff could produce through reasonable efforts. See *Detroit/Wayne Co Stadium Auth*, 267 Mich. App. at 651. Rather, Dr. Kelley's testimony and the medical records were the most probative evidence of whether Dr. Kelley knew that Linda had blood clots on October 13, 2009, both of which were produced at trial.[4] Moreover, given Dr. Kelley's argument regarding the inconsistencies in the testimony that she would have elicited, the admission of such statements would not have served the interests of justice. Accordingly, the trial court did not abuse its discretion in excluding the testimony of plaintiff and Collins.

VI

Finally, plaintiff argues that because the trial court's judgment must be reversed, the trial court's award of case evaluation sanctions must also be reversed. Having concluded that remand for a new trial is necessary, we vacate the trial court's order granting defendants case evaluation sanctions.

Affirmed in part, reversed in part, vacated in part, and remanded for further proceedings consistent with this opinion. No party having prevailed in full, no costs may be taxed under MCR 7.219. We do not retain jurisdiction.

All Citations

Not Reported in N.W.2d, 2016 WL 9245786

Footnotes

1 The trial court granted defendant Michigan Sports Medicine & Orthopedic Center's motion for summary disposition and dismissed the complaint against it.

2 The trial court denied a similar motion filed by Dr. Huckins and Washtenaw to exclude plaintiff's expert, stating that "both sides are making way too much of an artificial distinction between—between nursing home medicine and medicine."

3 Because plaintiff did not raise this issue at trial until after he rested his case, it is arguably unpreserved. See *Hines v. Volkswagen of America, Inc.*, 265 Mich. App. 432, 443, 695 N.W.2d 84 (2005). Nevertheless, we exercise our discretion to review this issue because doing so is necessary to properly decide this matter and because the record is sufficient to permit our consideration of the legal questions involved. See *Smith v. Foerster–Bolser Constr., Inc.*, 269 Mich. App. 424, 427, 711 N.W.2d 421 (2006).

4 This Court may not, however, consider whether the evidence produced at trial corroborates the statement. *People v. Lee*, 243 Mich. App. 163, 178, 622 N.W.2d 71 (2000).

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Exhibit E

2016 WL 6825789
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UNPUBLISHED OPINION. CHECK
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UNPUBLISHED
Court of Appeals of Michigan.

Cindy STEVENS and Steve
Stevens, Plaintiffs–Appellants,
v.
LANSING ANESTHESIOLOGISTS, P.C.,
Ingham Regional Medical Center, and
Mclaren Health Care Corp, Defendants,
and
Douglas Bez, D.O., Defendant–Appellee.

Docket No. 328971.
|
Nov. 17, 2016.

Ingham Circuit Court; LC No. 13–000056–NH.

Before: OWENS, P.J., and HOEKSTRA and BECKERING, JJ.

Opinion

PER CURIAM.

***1** In this medical malpractice action, plaintiffs Cindy Stevens and Steve Stevens appeal as of right the trial court's order granting a directed verdict to defendant Douglas Bez, D.O. based on plaintiffs' failure to proffer a qualified expert on the standard of care under MCL 600.2169(1)(b)(*i*).[1] Because the trial court did not abuse its discretion by excluding the opinion of plaintiffs' expert, the trial court's grant of a directed verdict was not erroneous given the absence of expert testimony supporting plaintiffs' medical malpractice claim, and the trial court did not abuse its discretion by denying plaintiffs' request to add an unidentified replacement expert to their witness list mid-trial, we affirm.

I. FACTS & PROCEDURAL HISTORY

In October 2011, plaintiff underwent coronary arterial bypass graft (CABG) surgery. The CABG surgery was successful, but plaintiff experienced complications related to the injection of sodium bicarbonate through a peripheral intravenous ("IV") line placed in her right hand, which caused the tissue to become necrotic and required multiple surgeries. As a result, plaintiff has significant scarring and she continues to suffer pain as well as loss of function in her hand.

In 2012, plaintiffs provided defendant, the anesthesiologist in charge of plaintiff's medications during the surgery, with a notice of intent to file suit.[2] Plaintiffs later filed a three-count complaint, alleging medical malpractice, ordinary and gross negligence, and loss of consortium. Plaintiffs' theory was that defendant breached the standard of care by administering sodium bicarbonate, the caustic substance that caused plaintiff's injury, through the IV in plaintiff's hand rather than through the central IV line.

Plaintiffs attached an affidavit of merit (AOM) to their complaint, provided by Jason Brajer, M.D. With respect to Dr. Brajer's qualifications, the AOM provided:

2. I graduated from Johns Hopkins University in 1976 with a Bachelor of Arts, and received my Doctor of Medicine degree from Hahnemann Medical College in 1980. I completed an internship at Albert Einstein Medical Center in 1981, and an Anesthesiology Residency at Thomas Jefferson University in 1984. I completed a fellowship in Cardiovascular Anesthesia and Obstetrical Anesthesia at Thomas Jefferson University in 1985;

3. During the year preceding the alleged malpractice I practiced on a full time basis as an anesthesiologist with 100% of my time devoted to clinical practice. I currently practice as a full time anesthesiologist with 100% of my time devoted to clinical practice at Grossinger NeuroPain Specialists in Ridley Park, Pennsylvania[.]

During discovery, Dr. Brajer testified at his deposition that the last time he performed anesthesia in a CABG procedure was in 1988. He indicated that he left the hospital system altogether in 2008, after which he did some "part-time anesthesia" through early 2009, but "basically, effective[ ], as of September of 2008," he had been practicing "office-based pain management." He explained that his pain management practice entailed x-ray guided interventional spine and large joint injections for the treatment of semi-acute and chronic pain.

***2** Trial ensued during which plaintiffs, after presenting eight of their witnesses, sought to introduce Dr. Brajer as an expert in the "field of anesthesiology" in order to establish the applicable standard of care. Dr. Brajer testified that he currently practiced in "pain management," but that he had participated in "at least a thousand" cardiac surgeries as an anesthesiologist. During voir dire, he clarified that he had not participated as an anesthesiologist in a hospital procedure for "[a] little less than three years" before plaintiff's CABG procedure. He further admitted that he had not participated in a CABG procedure since 1988, 23 years earlier. Upon further questioning, he confirmed that he was board certified in pain management, which he admitted does not require one to be an anesthesiologist.

Defendant then moved to strike Dr. Brajer as an expert witness under MCL 600.2169(1). The trial court granted defendant's request, concluding that defendant's specialty was anesthesiology and that, although Dr. Brajer was a board certified anesthesiologist, Dr. Brajer was not qualified as an expert witness "based on the *Woodard*[3] case" because he "was not practicing anesthesiology in the year prior to the incident in this matter [as required by MCL 600.2169(1)(b)(*i*)]. He was practicing pain management." The trial court then granted defendant's related motion for a directed verdict and denied plaintiffs' motion to amend their witness list to add a new, yet to be identified, expert. Plaintiffs appeal as of right.

II. MOTION TO STRIKE & DIRECTED VERDICT

Plaintiffs first argue that the trial court erred by granting defendant's motion for a directed verdict because, according to plaintiffs, Dr. Brajer qualified as an expert.

Specifically, plaintiffs assert that the trial court, in considering Dr. Brajer's qualifications, was only permitted to consider the evidence presented before or up to the point when defendant moved for a directed verdict. Plaintiffs maintain that the trial record at the time of defendant's motion was insufficient to support the trial court's findings regarding Dr. Brajer's qualifications, or lack thereof, to testify as an expert. Thus, plaintiffs argue that the trial court abused its discretion by excluding Dr. Brajer's testimony and that the directed verdict was premature. We disagree.

"A trial court's rulings concerning the qualifications of proposed expert witnesses are reviewed for an abuse of discretion." *Rock v. Crocker*, 499 Mich. 247, 260; 884 NW2d 227 (2016). "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." *Woodard*, 476 Mich. at 557. We review de novo a trial court's decision to grant a directed verdict motion. *Aroma Wines & Equip., Inc. v. Columbian Distribution Servs., Inc.*, 497 Mich. 337, 345; 871 NW2d 136 (2015). "A party is entitled to a directed verdict if the evidence, when viewed in the light most favorable to the nonmoving party, fails to establish a claim as a matter of law." *Id.*

***3** In a medical malpractice action, it is the plaintiff's burden to prove: "(1) the applicable standard of care, (2) breach of that standard by defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury." *Wischmeyer v. Schanz*, 449 Mich. 469, 484; 536 NW2d 760 (1995). "Failure to prove any one of these elements is fatal." *Wiley v. Henry Ford Cottage Hosp.*, 257 Mich.App 488, 492; 668 NW2d 402 (2003). With respect to the standard of care, a plaintiff must show "that the medical care provided by the defendant fell below the standard of medical care applicable at the time the care was provided." *Rock*, 499 Mich. at 260. The relevant standard of care must be established through expert testimony. *Gonzalez v. St. John Hosp. & Med. Ctr.*, 275 Mich.App 290, 294; 739 NW2d 392 (2007).

To testify as an expert in a medical malpractice action, an individual must satisfy the requirements of MCL 600.2169, which provides, in part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c) [not relevant], *during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to* either or both of the following:

> *(i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.*
>
> (*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty. [Emphasis added.]

Briefly stated, MCL 600.2169(1) requires "that the qualifications of a purported expert match the qualifications of the defendant against whom that expert intends to testify." *Decker v. Flood*, 248 Mich.App 75, 85; 638 NW2d 163 (2001).

More specifically, at issue in this case is MCL 600.2169(1)(b)(*i*). Under this provision, if, as in this case, a defendant physician is a specialist, in order to qualify as an expert, "the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty." *Woodard*, 476 Mich. at 566. A "specialty" is "a particular branch of medicine or surgery in which one can potentially become board certified." *Woodard*, 476 Mich. at 561. Moreover, a "subspecialty is a specialty" for purposes of MCL 600.2169(1), meaning that "if the defendant physician specializes in a subspecialty and was doing so at the time of the alleged malpractice, the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching that subspecialty." *Woodard*, 476 Mich. at 562, 566 n 12. Conversely, a physician devoting a majority of his or her time to a subspecialty would not qualify as an expert relative to a defendant physician who practiced the more general specialty. See *id.* at 577–578. For example, in *Hamilton v. Kuligowski*, a companion case to *Woodard*, the defendant physician was board certified in internal medicine and practicing general internal medicine while the proposed expert was also board certified in internal medicine but primarily worked as an infectious disease specialist, which was a subspecialty of internal medicine. See *id.* at 556, 577–578. The Court held:

> ***4** [P]laintiff's proposed expert witness did not devote a majority of his time to practicing or teaching general internal medicine. Instead, he devoted a majority of his professional time to treating infectious diseases. As he himself acknowledged, he is "not sure what the average internist sees day in and day out." Therefore, plaintiff's proposed expert witness does not satisfy the same practice/instruction requirement[.] [*Id.* at 578.]

In the instant matter, defendant was engaged in the practice of anesthesiology at the time of the alleged malpractice, making anesthesiology the one most relevant specialty. See *id.* at 560, 566.

Dr. Brajer was board certified in anesthesiology and board certified in pain management.[4] It is undisputed that he did not devote a majority of his time to anesthesiology in the year preceding the alleged malpractice. Indeed, Dr. Brajer conceded that he had not acted as an anesthesiologist for a hospital surgical procedure for years before the procedure in question and he had not participated in a CABG surgery since 1988. Cf. *id.* at 577 n 21 (criticizing proposed expert who had not performed "the specific medical procedure that was allegedly performed negligently in this case, since his residency in the early 1980's"). Instead, he was engaged in clinical pain management. Because he did not, in the year preceding the alleged malpractice, devote a majority of his professional time to the same specialty as that practiced by defendant, and there is no indication that Dr. Brajer instructed students in this field, we conclude that the trial court did not abuse its discretion by finding that Dr. Brajer did not qualify as an expert witness under MCL 600.2169(1)(b). Consequently, the trial court properly excluded Dr. Brajer's proposed testimony.

In contrast to our conclusion that the trial court did not abuse its discretion by determining that Dr. Brajer was not qualified to testify, plaintiffs assert that the evidence was insufficient to support the trial court's findings and that this ruling was "premature."[5] Specifically, plaintiffs take issue with the trial court's finding that "[defendant was] not practicing pain management in any fashion whereas Doctor Brajer is [,]" suggesting that this finding is without support because defendant had not yet testified with regard to the specialty he practiced at the time of the alleged malpractice. Absent sufficient evidence of defendant's specialty and what that specialty entailed, plaintiffs maintain the trial court could not reasonably conclude that defendant's and Dr. Brajer's specialties did not match for purposes of MCL 600.2169(1).

However, witnesses at trial, including, for example, a resident physician present in the operating room, identified defendant as the attending anesthesiologist for the surgery in question. Given this evidence, the trial court did not abuse its discretion by determining that anesthesiology was the relevant specialty. See *Woodard*, 476 Mich. at 569 n 15 & 576 n 19. Indeed, while plaintiffs now contest defendant's relevant specialty for purposes of comparison to Dr. Brajer's area of practice, in the trial court, plaintiffs attempted to offer Dr. Brajer as an expert in anesthesiology. Further, during argument concerning Dr. Brajer's qualifications, plaintiffs' counsel stated that the relevant specialty "is anesthesiology" and counsel argued that Dr. Brajer was a qualified expert in this area because pain management is "part and parcel of anesthesiology." In other words, plaintiffs' counsel conceded that defendant was practicing anesthesiology at the time of the alleged malpractice. In conceding these facts, plaintiffs have waived any argument on appeal that the trial court's finding regarding the relevant specialty was erroneous. See *Bates Assoc, LLC v. 132 Assoc., LLC*, 290 Mich.App 52, 64; 799 NW2d 177 (2010) ("A party may not claim as error on appeal an issue that the party deemed proper in the trial court because doing so would permit the party to harbor error as an appellate parachute.").

***5** In sum, the trial court's finding that Dr. Brajer was not qualified as an expert witness and its decision to grant defendant's motion to strike was not an abuse of discretion. See *Rock*, 499 Mich. at 260. Because plaintiffs had no expert witness to testify to the standard of care applicable at the time of the surgery, plaintiffs failed to meet their burden of proving the elements of their medical malpractice claim. See *Gonzalez*, 275 Mich.App at 294. In the absence of evidence establishing the standard of care, the trial court did not err by granting a directed verdict for defendant. Cf. *Woodard*, 476 Mich. at 578.

III. MOTION TO AMEND WITNESS LIST

Finally, plaintiffs argue that the trial court erred by denying their request to amend their witness list to add a new expert witness in place of Dr. Brajer. According to plaintiffs, good cause for the amendment existed because plaintiffs were surprised by defendant's motion to strike and plaintiffs had diligently pursued their case causing no delays in the litigation.

A trial court's decision on a motion to amend a witness list and to adjourn the proceedings is reviewed for an abuse of discretion. *Tisbury v. Armstrong*, 194 Mich.App 19, 20; 486 NW2d 51 (1991). As part of the discovery process, the trial court, under MCR 2.401(I)(1), sets the time period for submitting witness lists and disclosing whether any witness is an expert. In the event that a witness is "not listed in accordance with this rule[,]" the trial court "may order that" the witness "will be prohibited from testifying at trial except upon good cause shown." MCR 2.401(I)(2). In considering whether a witness not properly named on a witness list should be allowed to testify, the trial court may consider the following non-exhaustive list of factors:

> (1) whether the violation was wilful or accidental; (2) the party's history of refusing to comply with discovery requests (or refusal to disclose witnesses); (3) the prejudice to the defendant; (4) actual notice to the defendant of the witness and the length of time prior to trial that the defendant received such actual notice; (5) whether there exists a history of [the movant] engaging in deliberate delay; (6) the degree of compliance by the [movant] with other provisions of the court's order; (7) an attempt by the [movant] to timely cure the defect[;] and (8) whether a lesser sanction would better serve the interests of justice. [*Duray Development, LLC v. Perrin*, 288 Mich.App 143, 165; 792 NW2d 749 (2010) (footnote omitted).]

In this matter, the trial court's scheduling order required disclosure of plaintiffs' expert witnesses by October 1, 2013. Plaintiffs listed Dr. Brajer in their witness list and did not move to amend their list until the third day of trial. Notably, at the time plaintiffs sought to amend their witness list, they did not have another expert available. Before ruling on plaintiffs' motion, the trial court questioned plaintiffs whether any other witness on their list could testify to their proposed standard of care and considered the qualifications of each proposed witness, but concluded that each would not qualify. The trial court queried what it was to do with the jury that had already been sworn during a period when plaintiffs must look for another expert witness and the court also noted

that defendant was ready to proceed with trial. In the context of an ongoing jury trial, the court concluded that it simply could not suspend trial for "however long it would take, 90 days or 120 days," to allow the plaintiffs to obtain a new expert and permit depositions. Ultimately, there being no lesser sanctions available, the trial court denied plaintiffs' motion to amend their witness list and struck Dr. Brajer.

***6** We acknowledge that Michigan courts prefer disposition of litigation on the merits, *Tisbury*, 194 Mich.App at 21, but we cannot conclude under the present circumstances that the trial court's denial of plaintiffs' motion to amend their witness list was an abuse of discretion. While plaintiffs' failure to name a qualified expert on their witness list does not appear to have been a willful omission, the factual aspects of this case do not otherwise demonstrate good cause. Despite plaintiffs' claim of surprise, there is nothing new about the requirements of MCL 600.2169(1) and indeed the *Woodward* decision outlining these requirements in detail was decided more than a decade ago. Given the existing state of the law and the substance of Dr. Brajer's deposition testimony, plaintiffs knew, or should have known, that Dr. Brajer's qualifications were problematic well before trial. See generally *Rock*, 499 Mich. at 267 (noting that the requirements of MCL 600.2169 allow "a plaintiff to ensure that an expert is qualified well in advance of the time of the testimony"); *Sturgis Bank & Trust Co. v. Hillsdale Community Health Ctr.*, 268 Mich.App 484, 494; 708 NW2d 453 (2005) (describing a plaintiff attorney's obligation to use the benefit of discovery to better ascertain the qualifications of the defendant physician to confirm that a proposed expert is qualified under MCL 600.2169). Indeed, plaintiffs admit on appeal that the issue of Dr. Brajer's qualifications was "foreseeable," and they offer no reason why they did not exercise reasonable diligence to cure the defect before trial.[6] In the face of plaintiffs' inadequate preparation and apparent lack of foresight, given the age of the case, the trial court did not abuse its discretion by denying plaintiffs additional time to search for an unidentified expert to add to their witness list mid-trial, well after the close of discovery. See *Grubor Enterprises, Inc. v. Kortidis*, 201 Mich.App 625, 630; 506 NW2d 614 (1993); *Bates v. Detroit*, 66 Mich.App 701, 706; 239 NW2d 716 (1976).

This is particularly true given that defendant had no notice of who the unidentified expert witness might be or how the unknown expert might testify, and defendant would have had to expend more resources litigating this matter, perhaps requiring retention of a counter-expert and development of a new strategy mid-trial. Cf. *Kalamazoo Oil Co. v. Boerman*, 242 Mich.App 75, 90–91; 618 NW2d 66 (2000) (disallowing late expert testimony when the opposing party had "no chance to conduct any discovery of the expert and that it would be unfair to require [the opposing party] to prepare on such short notice"). Moreover, despite plaintiffs' assertion that defendant was the only party to cause delay in this case, the record reflects that plaintiffs repeatedly refused to comply with discovery deadlines, causing defendant to file numerous motions to compel. Overall, plaintiffs did not demonstrate good cause to support amendment of their witness list. We therefore conclude that the trial

court did not abuse its discretion by denying plaintiffs' leave to amend.

*7 Affirmed.

All Citations

Not Reported in N.W.2d, 2016 WL 6825789

Footnotes

1 Throughout this opinion, "plaintiff" refers to Cindy Stevens individually, whereas "plaintiffs" refers to both Cindy and Steve Stevens.

2 Plaintiffs also filed suit against Lansing Anesthesiologists, P.C., Ingham Regional Medical Center, and McClaren Health Care Corporation. These parties were dismissed from the action by stipulation.

3 *Woodard v. Custer*, 476 Mich. 545; 719 NW2d 842 (2006).

4 On appeal, plaintiffs suggest that pain management is not necessarily a distinct specialty from anesthesiology. However, this assertion is plainly belied by Dr. Brajer's own testimony. In addition to his board certification in anesthesiology, Dr. Brajer indicated that he was certified in "pain management" by the American Academy of Pain Management. He further testified that "pain management" was a recognized subspecialty by the American Board of Medical Specialties and that, while Dr. Brajer was an anesthesiologist, one did not need to be an anesthesiologist in particular to specialize in "pain management." Under *Woodward*, this type of subspecialty for which certification is available constitutes a "specialty" for purposes of MCL 600.2169(1). See *Woodard*, 476 Mich. at 561–562, 565; *Jones v. Botsford Continuing Care Corp.*, 310 Mich.App. 192, 210; 871 NW2d 15 (2015).

5 In making this argument, plaintiffs contend that the trial court was only permitted to consider evidence offered at trial up to the time of defendant's directed verdict motion. This argument confuses the standards applicable to motions for a directed verdict and the qualification of expert witnesses. While a motion for a directed verdict involves consideration of all the evidence presented up to the point of the motion to determine whether a fact question exists, *Heaton v. Benton Const. Co.*, 286 Mich.App. 528, 532; 780 NW2d 618 (2009), consideration of a proposed expert's qualifications is a preliminary question entrusted to the discretion of the trial court, *Woodard*, 476 Mich. at 571 n. 16; *Gilbert v. DaimlerChrysler Corp.*, 470 Mich. 749, 780–781; 685 NW2d 391 (2004). When determining a preliminary question, a trial court is not bound by the rules of evidence and may consider evidence presented by the proponent and, if applicable, the opponent of the expert witness. See MRE 104(a); *Gay v. Select Specialty Hosp.*, 295 Mich.App. 284, 293; 813 NW2d 354 (2012). Ultimately, there was nothing improper in the evidence relied on by the trial court or premature in the timing of the trial court's decision.

6 While ostensibly conceding in their brief that defendant did not have to challenge Dr. Brajer's qualifications before trial, much of plaintiffs' argument nonetheless focuses on the assertion that plaintiffs' failure to timely identify a qualified witness should be excused because defendant engaged in gamesmanship by waiting until trial to challenge the admissibility of Dr. Brajer's testimony. To be clear, there is no rule that an opposing party must challenge a medical malpractice expert before trial or within a reasonable time of learning the expert's identity. See *Cox. v. Bd. of Hosp. Managers for Flint*, 467 Mich. 1, 17 n. 18; 651 NW2d 356 (2002); *Greathouse v. Rhodes*, 465 Mich. 885; 636 NW2d 138 (2001). Instead, it is ultimately the *proponent* of expert testimony in a medical malpractice case who "must satisfy the court that the expert is qualified." *Elher v. Misra*, 499 Mich. 11, 22; 878 NW2d 790 (2016) (citation omitted). Quite simply, it was plaintiffs' obligation, not defendant's, to ensure that plaintiffs had a qualified expert for trial.

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Exhibit F

2018 WL 6331343
Only the Westlaw citation
is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

UNPUBLISHED
Court of Appeals of Michigan.

ESTATE OF Aura Argentina PEREZ, BY Jenny Nasyelly PEREZ, Personal Representative, and Ruben Perez, Plaintiffs-Appellees/Cross-Appellants,
v.
HENRY FORD HEALTH SYSTEM, Defendant-Appellant/Cross-Appellee,
and
Daniel Morris, M.D., Dr. Frank McGeorge, Dr. Olesya Krivospitskaya, Dr. Tarek Toubia, Dr. Michelle Slezak, Dr. Gregory Hays, Dr. Heather Evanson, Dr. E. Jenkins Brown, Dr. Denise Leung, Dr. Laurie Rolland, Vivek Rai, M.D., Dr. Andrew Russman, Dr. Sathyavani Ramanujam, and Dr. Asha Shajahan, Defendants.

No. 340082
|
December 4, 2018

Wayne Circuit Court, LC No. 15-014697-NH

Before: Shapiro, P.J., and Cavanagh and K. F. Kelly, JJ.

Opinion

Per Curiam.

***1** Defendant appeals by leave granted an order denying its motion to strike plaintiffs' expert witness, Dr. Chitra Venkatasubramanian, and for summary disposition under MCR 2.116(C)(10). We reverse in part and affirm in part. On cross-appeal, plaintiffs challenge an order denying their motion for leave to file a second amended witness list. We reverse.

On November 13, 2010, plaintiff's decedent Aura Perez went to defendant's emergency room with complaints that included hand numbness, difficulty walking, headache, and shortness of breath. She died on November 18, 2010. In this medical malpractice action, plaintiffs contend that Dr. Howard Feit, a board-certified general neurologist, failed to diagnose an acute peripheral or neuropathic disease process, likely botulism, which led to paralysis of breathing muscles, respiratory failure, and death. Plaintiffs' complaint was filed on November 11, 2015, with an affidavit of merit by Dr. Venkatasubramanian. On February 27, 2017, a stipulated order was entered naming the parties' expert witnesses and striking extraneous experts from their witness lists. On March 7, 2017, the deposition of Dr. Venkatasubramanian was taken.

On May 1, 2017, defendant filed a motion to strike plaintiffs' expert witness, Dr. Venkatasubramanian, under MCL 600.2169(1), and for summary disposition under MCR 2.116(C)(10). Defendant argued that Dr. Venkatasubramanian is not qualified to testify regarding whether general neurologist Dr. Feit met the standard of care. Relying on MCL 600.2169(1), defendant argued that Dr. Venkatasubramanian's testimony showed

that she did not spend a majority of her professional time practicing in the area of general neurology. In particular, defendant noted that Dr. Venkatasubramanian testified that she is board certified in neurology, neurocritical care, and vascular neurology; neurocritical care and vascular neurology are subspecialty board certifications of neurology. Dr. Venkatasubramanian also testified that she is a clinical associate professor of neurology. In the relevant time period, November 2009 through November 2010, about 20-25% of her professional time was spent in education and research, while 75-80% of her time was spent in clinical practice. Of her clinical practice, 60-65% was spent as a "neurointensivist," with the rest of her time split between general neurology and vascular neurology.[1] As a neurointensivist, she saw patients in the emergency room and in the neurointensive care unit. More specifically, Dr. Venkatasubramanian testified:

> *Q.* ... So 60 to 65 percent of your time was devoted to work as a neurointensivist, and we're talking 2009-2010; is that accurate?
>
> *A.* So of my clinical time, 60 to 65 percent was as a neurointensivist. The rest of my clinical time was split between vascular neurology and general neurology.
>
> *Q.* Okay, so 20 percent vascular neurology, 20 percent neurology; is that accurate?
>
> *A.* Give or take.

Later in her deposition, Dr. Venkatasubramanian agreed with the description that "approximately 20 percent general, 20 percent vascular, and 60 percent of your work was devoted to neurointensivist work," and then she added, "I don't know where to throw clinic in there, but clinic also gets mixed in." Thus, defendant argued, because Dr. Feit is only board certified in general neurology, and his entire clinical practice is devoted to the treatment of general neurology patients, Dr. Venkatasubramanian, who devoted a majority of her professional practice to neurocritical care—and not general neurology—at the time of the alleged occurrence, is not qualified under MCL 600.2169(1) to provide standard of care testimony against Dr. Feit. Further, because she is not qualified to offer testimony against Dr. Feit, plaintiffs are unable to satisfy their burden of proof that he was professionally negligent and, thus, defendant was entitled to summary disposition under MCR 2.116(C)(10).

***2** Plaintiffs responded to defendant's motion, arguing that the majority of Dr. Venkatasubramanian's time was spent practicing neurology even as a neurointensivist and she considered herself a neurologist first. That is, "the two titles 'general neurology' and 'neurocritical care' flow together." Further, her additional knowledge made her more qualified to offer opinion testimony, not less qualified. Thus, defendant's motion to strike plaintiffs' expert witness and for summary disposition should be denied.

Defendant replied to plaintiffs' response, arguing that general neurology is the relevant specialty in this case and plaintiffs' expert only devoted about 20% of her clinical practice to general neurology. Thus, she is not qualified under MCL 600.2169(1) to provide standard of care testimony in this case and defendant is entitled to summary disposition.

Plaintiffs then filed a supplemental response which consisted of an affidavit from Dr. Venkatasubramanian. In the affidavit, she averred that 100% of her professional time as an associate professor is spent teaching in the specialty of general neurology. "This teaching takes place primarily in a clinical setting, but also in a didactic setting." The affidavit is written in the present tense and does not refer to the 2009-2010 time period. She stated:

> Between my work on the general neurology floor, my continued treatment of patients in the ICU and Vascular Neurologic service for what includes their general neurologic needs and my teaching/academic work which is 100% devoted to general neurology, I am confident that I can accurately state under oath by way of this sworn affidavit, that well over 50% of my professional time involves practice in the field of general neurology.

Defendant filed a supplemental reply to plaintiffs' supplemental response, arguing that the affidavit was an attempt to create a genuine issue of fact in contrast to her harmful, but clear and unequivocal deposition testimony; thus, it may not be considered.

Following oral arguments on defendant's motion, the court ruled:

> The Court is going to deny the Motion to Strike. I do believe that, and I'll make this clear, that the Affidavit does come in. I know, you are objecting. You can appeal me on that one. I think that Mr. Sanfield [plaintiffs' counsel] is correct. I think that his [sic] just saying, "That's only the deposition testimony and nothing else" could be considered. I think, that is not – not only is not fair, I don't think that's the law. She did sign an Affidavit indicating that her practice is 100% in General Neurology. She teaches. This is her field. I don't – I don't see a problem with her. I think that she is qualified to testify as an expert.
>
> The Court will respectfully deny your motion.

On June 28, 2017, the court entered an order denying defendant's motion.

Defendant then moved for reconsideration. Defendant argued that even considering Dr. Venkatasubramanian's time spent teaching she only spent 45% of her professional time in the clinical practice and instruction of general neurology. More specifically, she testified that she devoted 20% of her professional practice to general neurology and that she devoted 20-25% of her professional time to teaching and research; thus, she was not qualified under MCL 600.2169(1) to provide standard of care testimony against Dr. Feit, a board-certified general neurologist.

Plaintiffs then filed a motion seeking relief from the previously entered stipulated order specifically naming the parties' expert witnesses, and for leave to file a second amended witness list. Plaintiffs argued that, although Dr. Venkatasubramanian was extremely qualified to give standard of care expert testimony in this case, to avoid further delay plaintiffs retained another expert in general neurology, Dr. Michael Gold. Thus, plaintiffs sought leave to file an amended witness list naming Dr. Gold as their expert in general neurology. Plaintiffs averred that adding this expert witness would not cause

undue delay or alter the theories and issues in this case because the substance of Dr. Gold's testimony was to be similar to Dr. Venkatasubramanian's testimony, and thus, defendant would not be prejudiced by the amendment. Defendant opposed this motion to amend plaintiffs' witness list, arguing that the issue was moot since the court agreed that Dr. Venkatasubramanian was qualified to testify. Further, plaintiffs are bound by the stipulated order naming their expert witnesses and to permit the naming of a different witness, who was not on their witness list, would prejudice defendant and delay the proceedings.

***3** On August 18, 2017, the court heard oral argument on plaintiffs' motion.[2] Plaintiffs argued that the parties had agreed to limit their experts in the interest of reducing costs and streamlining the issues but, after they agreed to do so, defendant filed a motion to strike plaintiffs' sole standard of care expert. And although the trial court denied the motion, defendant was seeking leave to appeal on the matter. In the interest of expediting this case so that it could be heard on its merits, plaintiffs sought leave to add a different standard of care expert to their witness list, Dr. Gold. Plaintiffs argued that trial was months away, Dr. Gold's opinions were substantially the same as Dr. Venkatasubramanian's, and that defendant could depose Dr. Gold without objection; thus, there was no prejudice to defendant. Defendant argued that plaintiffs entered into a stipulated order to limit their expert witness to Dr. Venkatasubramanian and they are bound by that order. The trial court denied plaintiffs' motion to amend their witness list, apparently relying on its prior ruling that Dr. Venkatasubramanian is qualified to testify as a standard of care expert in this case. On August 23, 2017, orders denying defendant's motion for reconsideration and denying plaintiffs' motion were entered by the trial court.

On September 11, 2017, defendant filed an application for leave to appeal the order denying its motion to strike plaintiffs' expert witness, Dr. Venkatasubramanian, and for summary disposition under MCR 2.116(C)(10), as well as a motion to stay pending appeal.

On November 2, 2017, this Court entered an order granting defendant's application for leave to appeal, limited to the issues raised in the application and supporting brief, and granting the motion to stay pending appeal. *Estate of Aura Argentina Perez v. Henry Ford Hosp.*, unpublished order of the Court of Appeals, entered November 2, 2017 (Docket No. 340082).

On November 15, 2017, plaintiffs filed a claim of cross-appeal, challenging the trial court's order denying plaintiffs' motion to amend their witness list to add a different standard of care expert. On November 20, 2017, the trial court entered an order for stay of proceedings pending appeal.

On appeal, defendant first argues that the trial court erred in denying its motion to strike plaintiffs' expert witness, Dr. Venkatasubramanian, as unqualified under MCL 600.2169(1). We agree.

The interpretation of MCL 600.2169(1) is reviewed de novo. *Woodard v. Custer*, 476 Mich. 545, 557; 719 N.W.2d 842

(2006). The trial court's decision whether Dr. Venkatasubramanian is qualified to render an expert opinion under MCL 600.2169(1) is reviewed for an abuse of discretion. *Id.* "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." *Id.* When a court's ruling is premised on an incorrect interpretation of the law, the ruling is necessarily an abuse of discretion. *Gay v. Select Specialty Hosp.*, 295 Mich. App. 284, 292; 813 N.W.2d 354 (2012).

MCL 600.2169(1) sets forth the criteria a proposed expert must satisfy in order to testify regarding the appropriate standard of practice or care, *Rock v. Crocker*, 499 Mich. 247, 260; 884 N.W.2d 227 (2016), and states in pertinent part:

> In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> ***4** (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

In *Woodard*, the Court explained that a "specialty" is "a particular branch of medicine or surgery in which one can potentially become board certified." *Woodard*, 476 Mich. at 561. A "subspecialty" is "a particular branch of medicine or surgery in which one can potentially become board certified that falls under a specialty or within the hierarchy of that specialty." *Id.* at 562. A subspecialty is itself a "specialty" within the meaning of the statute. *Id.*

In this case, there is no dispute that Dr. Feit is a board-certified neurologist who was practicing as a general neurologist at the time of the alleged malpractice. At issue here is whether Dr. Venkatasubramanian meets the qualifications set forth under § 2169(1)(b). While she is board certified in neurology, she

was also board certified in neurocritical care and vascular neurology which are subspecialty board certifications of neurology. As our Supreme Court explained in *Woodard*:

> [I]n order to be qualified to testify under § 2169(1)(b), the plaintiff's expert witness must have devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice, i.e., the one most relevant specialty. [*Woodard*, 476 Mich. at 566 (footnote omitted).]

In *Kiefer v. Markley*, 283 Mich. App. 555, 559; 769 N.W.2d 271 (2009), this Court clarified that the word "majority" in the statute means that a proposed expert physician must have spent "greater than 50 percent of his or her professional time practicing the relevant specialty the year before the alleged malpractice."

In this case, because the specialty Dr. Feit was practicing at the time of the alleged malpractice was general neurology, a proposed standard of care expert testifying against Dr. Feit must have spent greater than 50% of her time practicing or instructing students in general neurology the year before the alleged malpractice. Dr. Venkatasubramanian testified in her deposition that during the relevant time, she spent about 75-80% of her professional time in clinical practice, and 20-25% in research and education. With regard to her clinical practice, she spent 60-65% of her professional time practicing as a neurointensivist, about 20% of her time practicing general neurology, and 20% of her time practicing vascular neurology. Clearly, then, Dr. Venkatasubramanian did not spend a majority of her professional time *practicing* general neurology during the relevant time.

In *Hamilton v. Kuligowski*, the companion case to *Woodard*, our Supreme Court was faced with a similar factual scenario as presents in this case, i.e., a plaintiff's proposed expert witness who devoted a majority of time to a subspecialty rather than the general specialty at issue. *Id.* at 556. In that case, the defendant physician was board certified in general internal medicine, specialized in general internal medicine, and was practicing general internal medicine at the time of the alleged malpractice. *Woodard*, 476 Mich. at 556, 577-578. The plaintiff's proposed expert was also board certified in general internal medicine; however, he spent the majority of his professional time treating infectious diseases, a subspecialty of internal medicine. *Id.* at 556, 578. Our Supreme Court concluded that because the plaintiff's expert devoted a majority of his professional time to treating infectious diseases, the subspecialty, and not general internal medicine, he did "not satisfy the same practice/instruction requirement of § 2169(1)(b)." *Woodard*, 476 Mich. at 578. Similarly, in this case, Dr. Venkatasubramanian was not qualified under § 2169(1)(b) because she did not spend the majority of her time practicing general neurology.

***5** In a supplemental response to defendant's motion, plaintiff filed an affidavit from Dr. Venkatasubramanian which attempted to clarify her deposition testimony. Although defendant argued that the trial court was not permitted to consider this affidavit because

it was an attempt to essentially rehabilitate damaging testimony, the trial court correctly rejected this argument. The affidavit did not contradict the deposition testimony as much as it clarified a point that was not explored—the subject area of Dr. Venkatasubramanian's research and teaching. But even considering the affidavit, the conclusion remains the same—she did not spend a majority of her professional time during the year immediately preceding the alleged malpractice practicing or teaching general neurology. According to her affidavit, 100% of her teaching/academic work was devoted to general neurology. But, again, she testified that only 20-25% of her professional time was devoted to teaching/academic work. The other 75-80% of her time was devoted to clinical practice, but only 20% of her clinical practice was devoted to general neurology which, combined, still amounts to less than a majority of her time, i.e., less than 50 percent (20% of 80% = .2 x .80 = .16 or 16% plus teaching/academics at most 25% = 41%).

In summary, Dr. Venkatasubramanian did not meet the requirements set forth under MCL 600.2169(1) because she did not spend a majority of her professional time practicing or instructing students in general neurology; thus, she was not qualified to render standard of practice or care testimony against Dr. Feit. Accordingly, the trial court abused its discretion in concluding that she was qualified to render such testimony and erred when it denied defendant's motion to strike this expert witness.

Next, defendant argues that, because plaintiff does not have an expert qualified under MCL 600.2169(1) to testify to the standard of care, defendant is entitled to summary disposition under MCR 2.116(C)(10). The trial court denied defendant's motion for summary disposition after concluding that Dr. Venkatasubramanian was a qualified expert witness. Generally, a decision on a motion for summary disposition is reviewed de novo. *Maiden v. Rozwood*, 461 Mich. 109, 118; 597 N.W.2d 817 (1999).

There are two issues relevant to defendant's argument: plaintiffs' cross-appeal and the stipulated order entered on February 27, 2017 naming the parties' expert witnesses. We first address these matters.

Plaintiffs argue on cross-appeal that if Dr. Venkatasubramanian is determined to be unqualified, they should be allowed to amend their witness list to add a substitute expert witness, Dr. Michael Gold. In fact, the only reason the trial court denied their motion to amend their witness list was because the court also believed Dr. Venkatasubramanian to be a qualified expert in this case. A trial court's decision on a motion to amend a witness list is reviewed for an abuse of discretion. *Tisbury v. Armstrong*, 194 Mich. App. 19, 20; 486 N.W.2d 51 (1991). We agree that plaintiffs' motion for leave to file an amended witness list to add Dr. Gold as a standard of care expert should have been granted.

MCR 2.401(I)(1) mandates that parties file and serve witness lists in the time directed by the trial court's scheduling order. And if a witness is not listed in such a witness list, the court may prohibit that witness from testifying at trial except upon good cause shown. MCR 2.401(I)(2). However, before such a sanction

is imposed—which may be equivalent to a dismissal—the trial court should consider a number of relevant factors, including but not limited to: "(1) whether the violation was wilful or accidental; (2) the party's history of refusing to comply with discovery requests (or refusal to disclose witnesses); (3) the prejudice to the defendant; (4) actual notice to the defendant of the witness and the length of time prior to trial that the defendant received such actual notice; (5) whether there exists a history of plaintiff's engaging in deliberate delay; (6) the degree of compliance by the plaintiff with other provisions of the court's order; (7) an attempt by the plaintiff to timely cure the defect[;] and (8) whether a lesser sanction would better serve the interests of justice." *Dean v. Tucker*, 182 Mich. App. 27, 32-33; 451 N.W.2d 571 (1990) (footnotes omitted); see also *Duray Dev, LLC v. Perrin*, 288 Mich. App. 143, 165; 792 N.W.2d 749 (2010). Further, the trial court should be mindful that the policy of this state favors the meritorious determination of issues. *Tisbury*, 194 Mich. App. at 21.

***6** In this case, plaintiffs moved for leave to file a second amended witness list after defendant's motion to strike plaintiffs' expert was denied by the trial court. Plaintiffs offered that, to avoid further delay, they retained another expert in general neurology, Dr. Gold, who they would call as an expert in the place of Dr. Venkatasubramanian. Plaintiffs averred that the substance of Dr. Gold's testimony was the same or similar to Dr. Venkatasubramanian's testimony, and thus, would not alter the theories or issues in this case and would not cause undue delay or prejudice. However, the trial court denied the motion because it deemed the substitution unnecessary—Dr. Venkatasubramanian was sufficiently qualified to testify. There was no evidence that plaintiffs' negligently or wilfully retained an unqualified expert witness and, in fact, even the trial court believed the witness was qualified. See *Dean*, 182 Mich. App. at 32. Further, because of defendant's challenge, plaintiffs almost immediately retained another expert witness who they identified by name and offered for deposition. Defendant did not argue that plaintiffs had a history of discovery violations or engaged in deliberate delay. Defendant did claim that it would be prejudiced because discovery was closed and trial was scheduled for a few months later. However, the delay that resulted from the pursuit of this appeal was far greater than would have been occasioned by an amendment to plaintiffs' witness list and the taking of Dr. Gold's deposition. Further, any prejudice to defendant would be minimal considering that, as argued by plaintiffs, Dr. Gold shared the same or similar opinions as Dr. Venkatasubramanian. Moreover, review of the lower court record shows that this case had been timely litigated up through the time that plaintiffs sought leave to amend their witness list. And the consequence of striking plaintiffs' sole standard of care expert is that this case will be dismissed rather than decided on its merits, contrary to this state's policy. See *Tisbury*, 194 Mich. App. at 21.

Defendant argues, however, that the parties had stipulated to a reciprocal order limiting their experts and striking extraneous experts from their witness lists; thus, the trial court was prevented from granting plaintiffs' motion for leave to file an amended witness list. It is true that stipulated orders that are entered by the trial court are generally construed under

the same rules that apply to contracts, as an agreement reached by and between the parties. See *Eaton Co. Bd. of Co. Rd. Comm'rs v. Schultz*, 205 Mich. App. 371, 378-379; 521 N.W.2d 847 (1994). And in contract interpretation, the goal is to determine and then enforce the intent of the parties based on the plain language of the contract. *St. Clair Med., PC v. Borgiel*, 270 Mich. App. 260, 264; 715 N.W.2d 914 (2006). That is, the plain and unambiguous contract language must be enforced as written unless the contract is contrary to law or public policy. *Rory v. Continental Ins. Co.*, 473 Mich. 457, 468-470; 703 N.W.2d 23 (2005).

The provision of the stipulated order at issue provides: "IT IS HEREBY STIPULATED, by and between counsel for the parties hereto, that Plaintiffs shall only utilize, at the time of trial, independent experts Dr. Chitra Venkatasubramanian (neurology), Dr. Daniel Spitz (forensic pathology), and Dr. Michael Thomson (economics)[.]" According the words their ordinary and plain meaning as we must, in relevant part, this provision states that the parties agreed that Dr. Venkatasubramanian was plaintiffs' neurology expert who would testify at trial. The only way to "utilize" an expert witness "at the time of trial" is through the provision of testimony. But contrary to the parties' agreement, this doctor may not testify at trial because she is not qualified as an expert witness. Because the parties' contract in this regard is contrary to the law, it will not be enforced. See *id.* at 470. Further, this stipulated order in no way impaired the trial court's discretion regarding plaintiffs' motion for leave to file a second amended witness list.

We conclude that, under all of the circumstances of this case, the trial court should have found that good cause existed to support plaintiffs' motion for leave to file a second amended witness list to add Dr. Gold as an expert witness in general neurology. Therefore, the trial court abused its discretion by denying plaintiffs' motion. In light of this holding, we also conclude that the trial court properly denied defendant's motion for summary disposition under MCR 2.116(C)(10), premised on the claim that plaintiffs had no expert qualified to testify to the standard of care. At minimum, defendant's motion is premature in light of our holding.

In summary, the trial court's order denying defendant's motion to strike plaintiffs' expert witness Dr. Venkatasubramanian is reversed, but we affirm the denial of defendant's motion for summary disposition. We also reverse the trial court's order denying plaintiffs' motion for leave to file a second amended witness list.

***7** Affirmed in part, reversed in part, and remanded for further proceedings. We do not retain jurisdiction.

Shapiro, J. (concurring in part and dissenting in part).

I concur with the majority's conclusion that plaintiff should be permitted to amend her witness list to add a new expert given the reversal of the trial court's ruling as to Dr. Chitra Venkatasubramanian's qualifications. However, under the circumstances of this case, I do not agree that Dr. Venkatasubramanian's subspecialty certifications in neurological critical care and vascular neurology and her

practice in those subspecialties disqualifies her as an expert witness.

Plaintiffs' medical malpractice action concerns Dr. Howard Feit, a board-certified neurologist. Dr. Venkatasubramanian is also a board-certified neurologist and therefore satisfies MCL 600.2169(1)(a), which provides:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

The issue in this case is whether Dr. Venkatasubramanian satisfies MCL 600.2169(1)(b), which requires that the expert witness must have

> during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

The majority determines that the key question is whether more than 50% of Dr. Venkatasubramanian's time was spent in the practice of "general neurology" as opposed to neurocritical care or vascular neurology and arithmetically concludes that it was less than 50%. Even assuming that the majority's calculation is correct, I would conclude that Dr. Venkatasubramanian's is qualified to testify as an expert witness in this case.

It is clear that a general specialist may not testify against a subspecialist regarding performance of that subspecialty. However, the inverse is not necessarily the case. Depending on the nature of the subspecialty and the expert's particular practice, a subspecialist may testify as to the standard of care in his or her general specialty. The only published decision in which a specialist was disqualified on the basis of spending more than 50% of his or her time performing a subspecialty is *Hamilton v. Kuligowski*, the companion case to *Woodard v. Custer*, 476 Mich. 545; 719 N.W.2d 842 (2006). In *Hamilton*, the Supreme Court held that an internist with a subspecialty in infectious diseases could not testify to

the standard of care of an internist with no subspecialty, but the Court did not set out a bright-line rule barring any subspecialist from testifying as to the standard of care for the more general specialty. *Id.* at 577-578. Instead, the Court concluded that the proposed expert did not spend a majority of his time practicing general internal medicine because his practice was completely focused on infectious diseases and he agreed that he was "not sure what the average internist sees day in and day out." *Id.* at 578 (quotation marks omitted). By contrast, in this case Dr. Venkatasubramanian made it clear that her practice as a consulting neurologist, whether with the general medical unit or the intensive care unit, involves caring for all of a patient's neurological needs.[1] Thus, I would conclude that Dr. Venkatasubramanian satisfies MCL 600.2169(1)(b)'s practice requirement and is able to testify to whether Dr. Feit's actions met the applicable standard of care.

All Citations

Not Reported in N.W. Rptr., 2018 WL 6331343

Footnotes

1 It appears from the evidence that work as a "neurointensivist" relates to the board certification in neurocritical care.

2 Because the court had not ordered oral argument on defendant's motion for reconsideration, arguments were not made in its regard but the court denied the motion on the record.

1 Notably, the subspecialties within internal medicine are unusual in that internal medicine is an extraordinarily broad specialty. Subspecialties within internal medicine represent widely divergent areas of practice including nephrology, cardiology, infectious diseases, hepatology, gastroenterology, and endocrinology. A gastroenterologist may recognize that his or her patient should be referred to a cardiologist, but is extraordinarily unlikely to diagnose or treat a patient's heart, while a neurologist with a subspecialty can (and often does) treat all of a patient's neurological conditions.

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Exhibit G

2020 WL 7414184
Only the Westlaw citation
is currently available.

UNPUBLISHED
Court of Appeals of Michigan.

ESTATE OF Douglas P. **KLETT**,
BY Martin **KLETT**, Personal
Representative, Plaintiff-Appellee,
v.
Subbarao **CHAVALI**,
M.D., Defendant-Appellant

No. 350382
|
December 17, 2020

Bay Circuit Court, LC No. 18-003279-NH

Before: O'Brien, P.J., and M. J. Kelly and Redford, JJ.

Opinion

Per Curiam.

***1** Defendant appeals by leave granted[1] the trial court's order granting plaintiff's motion to preclude defendant from offering standard of care testimony at trial because he did not meet the qualifications of an expert witness under MCL 600.2169(1). Defendant argues that MCL 600.2169(1) does not apply to a party-physician and if it does, the statute prevents him from presenting an adequate defense. We affirm.

I. FACTUAL BACKGROUND

Defendant, a medical doctor with board-certified specialties in cardiology and internal medicine, testified during his deposition that he spent the majority of his professional time practicing cardiology. Plaintiff sued defendant for medical malpractice after plaintiff's decedent died from a pulmonary embolism while under defendant's care. Plaintiff alleged that defendant breached his duty of care by, among other things, failing to recognize and appreciate decedent's prior history and other risk factors. Plaintiff moved to preclude defendant from testifying as an expert witness about the applicable standard of care for internal medicine, the specialty that defendant practiced when the alleged malpractice occurred. Plaintiff argued that under MCL 600.2169(1), defendant did not qualify to testify as an expert witness because he did not spend the majority of his professional time in the preceding year practicing or teaching internal medicine. Defendant countered that MCL 600.2169(1) did not apply to bar a defendant from testifying as an expert witness. The circuit court disagreed, holding that defendant failed to qualify as an expert witness under MCL 600.2169(1).

II. STANDARDS OF REVIEW

In *Elher v. Misra*, 499 Mich. 11, 21; 878 N.W.2d 790 (2016) (quotation marks and citations omitted), our Supreme Court set forth the standards of review applicable to appellate review of a trial court's ruling to exclude expert

testimony in a medical malpractice action as follows:

> We review the circuit court's decision to exclude evidence for an abuse of discretion. An abuse of discretion occurs when the trial court chooses an outcome falling outside the range of principled outcomes. We review de novo questions of law underlying evidentiary rulings, including the interpretation of statutes and court rules. The admission or exclusion of evidence because of an erroneous interpretation of law is necessarily an abuse of discretion.

III. ANALYSIS

Defendant argues that MCL 600.2169(1) does not apply to party-physicians. We disagree.

In *Elher*, our Supreme Court explained:

> A plaintiff in a medical malpractice action must establish (1) the applicable standard of care, (2) breach of that standard of care by the defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury. Generally, expert testimony is required in a malpractice case in order to establish the applicable standard of care and to demonstrate that the professional breached that standard. An exception exists when the professional's breach of the standard of care is so obvious that it is within the common knowledge and experience of an ordinary layperson. The proponent of the evidence has the burden of establishing its relevance and admissibility.
>
> ***2** The proponent of expert testimony in a medical malpractice case must satisfy the court that the expert is qualified under MRE 702, MCL 600.2955 and MCL 600.2169. [*Elher*, 499 Mich. at 21-22 (quotation marks and citations omitted).]

Defendant argues that the trial court should not have precluded him from testifying on his own behalf regarding the applicable standard of care. MCL 600.2169(1) guides trial court's decision-making in this regard and provides in relevant part:

> In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:

(*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.

(*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

"When interpreting statutory language, we begin with the plain language of the statute." *Jesperson v. Auto Club Ins. Ass'n*, 499 Mich. 29, 34; 878 N.W.2d 799 (2016) (citation omitted). "We must give effect to the Legislature's intent, and the best indicator of the Legislature's intent is the words used." *Id.* (quotation marks and citation omitted). "Additionally, when determining this intent we must give effect to every word, phrase, and clause in a statute and avoid an interpretation that renders nugatory or surplusage any part of a statute." *Id.* (quotation marks and citation omitted).

Defendant first argues that he is qualified to testify on his own behalf under MCL 600.2169(1) because the qualifications of a proposed expert are determined on the basis of the qualifications of the defendant. Although the experience of an expert witness under MCL 600.2169(1)(a) directly corresponds to the experience of the party against whom or on whose behalf the testimony is offered, this argument ignores the additional requirements of MCL 600.2169(1)(b), which requires that the specialist must have devoted *a majority* of his or her professional time to active clinical practice or instruction of the specialty. Defendant testified that he practiced the majority of the time within the year immediately preceding the alleged occurrence of malpractice in his cardiology specialty, not internal medicine. Defendant, therefore, did not qualify under MCL 600.2169(1)(b).

***3** Defendant next argues that a party-physician is not an expert witness under MCL 600.2169(1). The plain language of MCL 600.2169(1), however, states that "a person shall not give expert testimony on the appropriate standard of practice or care" unless the person meets the specified statutory criteria. The statute does not set forth any exception to the requirement regarding standard of practice or care. Our Supreme Court noted in *Rock v. Crocker*, 499 Mich. 247, 260; 884 N.W.2d 227 (2016), that a "physician who testifies regarding the standard of care at issue must satisfy the requirements of MCL 600.2169(1)," without making any distinction between a party-physician and a nonparty expert witness. Further, we are unaware of any caselaw recognizing a party-defendant exception for which defendant advocates and we are "not required to search for authority to sustain or reject a position raised by a party without citation of authority." *Mettler Walloon, L.L.C. v. Melrose Twp.*, 281 Mich. App. 184, 220; 761 N.W.2d 293 (2008) (citation omitted). Accordingly, regardless whether the testimony is sought from a party or a nonparty physician

expert witness, such person may not testify regarding the applicable standard of care unless the person meets all of the essential statutory criteria.

Defendant argues that because the plain language of MCL 600.2169(1) distinguishes between "the party against whom or on whose behalf the testimony is offered" and "the expert witness," a party-physician is naturally excluded from being considered an expert witness. Nowhere in MCL 600.2169, however, does the Legislature distinguish a party witness from a nonparty witness. Again, we point out that MCL 600.2169(1) very specifically directs that "*a person* shall not give expert testimony on the appropriate standard of practice or care unless *the person* is licensed as a health professional in this state or another state and meets [the specified statutory] criteria." (Emphasis added.) If the Legislature intended to make a specific exception for a party-physician who chooses to testify as an expert witness regarding the applicable standard of care, it could have done so, but has not.

Defendant also argues that precluding him from offering testimony about the applicable standard of care would prevent him from being able to present an adequate defense. We disagree. Defendant is free to testify as to the actions he took and the reasons he believed they were appropriate. Pursuant to MCL 600.2169(1), however, because he did not practice the majority of his time in the internal medicine specialty within the last year before the incident, he cannot testify regarding the applicable standard of care for internal medicine. Defendant will have to rely upon the testimony of a physician expert who specializes in internal medicine and devoted the majority of his or her professional time to the active clinical practice within that specialty or in the instruction of students in an accredited health professional school or accredited residency or clinical research program in the same specialty as required under MCL 600.2169(1)(b). Defendant, therefore, is not prevented from adequately defending himself.

The trial court did not err by granting plaintiff's motion because defendant did not spend the majority of his professional time practicing or teaching the specialty of internal medicine in the year preceding the alleged malpractice occurrence. The trial court correctly interpreted and applied MCL 600.2169, and appropriately ruled that defendant lacked the qualification to testify regarding the standard of practice or care in this case.

Affirmed.

All Citations

Not Reported in N.W. Rptr., 2020 WL 7414184

Footnotes

1 *Estate of* ***Klett*** *v.* ***Chavali***, unpublished order of the Court of Appeals, entered January 16, 2020 (Docket No. 350382).

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