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STATE OF MICHIGAN

COURT OF APPEALS

TOMIKA JORDAN, Personal Representative of the ESTATE OF ELIZABETH JORDAN,

Plaintiff-Appellee,

V

HEART AND VASCULAR CONSULTANTS, PLLC, and MAHMOUD OTHMAN, M.D.,

Defendants-Appellants,

and

STRAITH HOSPITAL FOR SPECIAL SURGERY, ALLISON PAIGE HATHAWAY, CAA, and KENNETH LOCK, M.D.,

Defendants.

UNPUBLISHED
August 25, 2026
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No. 370206
Oakland Circuit Court
LC No. 2022-193403-NH

TOMIKA JORDAN, Personal Representative of the ESTATE OF ELIZABETH JORDAN,

Plaintiff-Appellant,

V

HEART AND VASCULAR CONSULTANTS, PLLC, STRAITH HOSPITAL FOR SPECIAL SURGERY, MAHMOUD OTHMAN, M.D., and KENNETH LOCK, M.D.,

Defendants,

and

No. 370778
Oakland Circuit Court
LC No. 2022-193403-NH

ALLISON PAIGE HATHAWAY, CAA,

Defendant-Appellee.

Before: MARIANI, P.J., and MURRAY and PATEL, JJ.

PER CURIAM.

In Docket No. 370206 of these consolidated appeals,[1] Dr. Mahmoud Othman and Heart and Vascular Consultants, PLLC (the Othman defendants) appeal by leave granted[2] the trial court's order granting in part and denying in part their motion for summary disposition under MCR 2.116(C)(10) as to plaintiff's claim that defendant Othman was negligent for failing to recommend that the surgery take place at a level 1 trauma center. We reverse and remand for further proceedings consistent with this opinion.

In Docket No. 370778, plaintiff appeals by leave granted[3] the same order, which also granted defendant Allison Paige Hathaway, CAA's motion to strike plaintiff's certified anesthesiology assistant (CAA) expert and Hathaway's motion for summary disposition under MCR 2.116(C)(10). We affirm.

I. BACKGROUND

In June 2019, plaintiff's decedent, Elizabeth Jordan, underwent elective eye surgery for a nonclearing vitreous hemorrhage. Elizabeth was 66 at the time of the surgery. She had multiple serious underlying medical conditions, including end-stage renal disease requiring dialysis, congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, diabetes, hypertension, and obesity. During the surgery, Elizabeth's heart rate dropped. Elizabeth was hospitalized. Testing revealed anoxic brain injury, and blood cultures grew oxygen-resistant staph bacteria. Elizabeth passed away a month later. Her death certificate indicates a brain aneurysm as the cause of death.

In January 2019, Dr. Randee Miller Watson recommended that Elizabeth undergo a vitrectomy for a nonclearing vitreous hemorrhage. Because there was a risk of bleeding associated with the procedure, Dr. Watson instructed Elizabeth to obtain clearance from her physician to stop taking her prescribed blood thinners one week before the surgery.

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[1] *Jordan v Heart & Vascular Consultants, PLLC*, unpublished order of the Court of Appeals, entered October 25, 2024 (Docket Nos. 370206 and 370778).

[2] *Jordan v Heart & Vascular Consultants, PLLC*, unpublished order of the Court of Appeals, entered October 25, 2024 (Docket No. 370206).

[3] *Jordan v Heart & Vascular Consultants, PLLC*, unpublished order of the Court of Appeals, entered October 25, 2024 (Docket No. 370778).

Elizabeth's primary care physician, Dr. Shyran Hines, evaluated Elizabeth in March 2019. Dr. Hines noted that Elizabeth had been hospitalized with chest pain in February 2019 and failed to follow up with a cardiologist as instructed. Consequently, Dr. Hines instructed that Elizabeth obtain a cardiology clearance before undergoing the eye surgery.

Defendant Othman conducted a cardiac evaluation in April 2019, at which time Elizabeth complained of chest discomfort and shortness of breath. Defendant Othman reviewed three echocardiograms in Elizabeth's history, which showed that her ejection fraction (EF)[4] had decreased from 55-60% in January 2016 to 45% in February 2019. Given Elizabeth's prior medical history, risk factors, and her symptoms, defendant Othman ordered a stress test to evaluate obstructive coronary artery disease. The stress test revealed that Elizabeth's EF had decreased to 34%. The reviewing physician also noted, "There is a moderate sized, moderate to severe intensity, mostly fixed defect involving the inferolateral wall" and "a small area of reversibility suggesting peri-infarct ischemia."[5]

Elizabeth returned to defendant Othman for a follow-up visit in May 2019. Because Elizabeth's hypertension was uncontrolled, defendant Othman recommended increasing her blood pressure medications and adhering to a low salt diet. No additional testing was ordered. Defendant Othman cleared Elizabeth for the surgery, classifying her as an "intermediate" risk for cardiac complications. He also approved Dr. Watson's request that Elizabeth discontinue her dual antiplatelet therapy for five days before the surgery and instructed Elizabeth to resume the medications when safe.

Dr. Watson performed Elizabeth's vitrectomy on June 12, 2019, at defendant Straith Hospital for Special Surgery. Defendants Dr. Kenneth Lock and Hathaway were responsible for the anesthesiology during the procedure. Elizabeth was originally sedated with a combination of Versed and fentanyl. She became restless during the procedure, so she was given three more doses of fentanyl followed by Benadryl and propofol. As the last suture was being tied, Elizabeth's heart rate dropped to approximately 20 beats per minute. A code was called and the anesthesia team worked to stabilize Elizabeth. She was transported to Providence Hospital Emergency Room, and then later transferred to Sinai-Grace Hospital. Elizabeth remained comatose for more than a month and passed away on July 16, 2019.

In August 2021, plaintiff commenced this action alleging medical malpractice claims against the individual defendants and corresponding vicarious liability and direct liability claims against defendants Heart and Vascular Consultants and Straith Hospital. Relevant to this appeal, plaintiff alleged that defendant Othman breached the standard of care by failing to address and

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[4] The ejection fraction is "the ratio of the volume of blood the heart empties during systole to the volume of blood in the heart at the end of diastole expressed as a percentage usually between 50 and 80 percent." Merriam-Webster, *Merriam-Webster.com Medical Dictionary* <https://www.merriam-webster.com/medical/ejection%20fraction> (accessed August 6, 2026).

[5] Plaintiff's cardiology expert, Dr. Daniel Fintel explained in his deposition that a peri-infarct ischemia means there is a part of the heart muscle that is dead (infarct) and the living tissue that borders the dead tissue is not receiving an adequate degree of blood flow.

manage Elizabeth's "decreasing heart function prior to providing clearance for elective eye surgery" and by providing cardiac clearance without directing the surgery to be performed in a level 1 trauma center or other facility with advanced cardiac resources better equipped to handle any cardiac issues that could arise during the procedure. Plaintiff also asserted that defendant Hathaway negligently administered anesthesia during the surgery.

After discovery, defendant Hathaway moved to strike plaintiff's CAA expert, Daniel Zagorski, arguing that he was not qualified to provide standard-of-care testimony because he was not familiar with the standard of care applicable to a CAA in Southfield, Michigan, where defendant Hathaway practiced or the delegatory model that CAAs in Michigan operate under. Defendant Hathaway also moved for summary disposition under MCR 2.116(C)(10) asserting that plaintiff's claim against Hathaway must be dismissed because she failed to present a qualified expert on the CAA standard of care. Plaintiff argued that Zagorski was qualified to testify about the standard of care applicable to defendant Hathaway and his opinions supported her claims against defendant Hathaway.

The Othman defendants also moved for summary disposition under MCR 2.116(C)(10). Relevant to this appeal, the Othman defendants argued that the testimony of plaintiff's cardiology standard-of-care expert, Dr. Daniel Fintel, was deficient because it did not establish factual or "but for" causation for plaintiff's claim that defendant Othman was negligent for failing to recommend that the eye procedure be performed at a major medical center. The Othman defendants argued that Dr. Fintel did not testify that, more likely than not, Elizabeth's injuries and death would not have occurred if defendant Othman had made the recommendation. Plaintiff argued that Dr. Fintel's testimony was sufficient to establish a question of fact for the jury on causation. Specifically, Dr. Fintel testified that if the surgery had been performed at a larger facility, other resources would have been available to Elizabeth, including a full electrolyte panel which would have provided her anesthesiologist with more information about her condition. He also opined that an extracorporeal membrane oxygenation (ECMO) device would have been available. In their reply, the Othman defendants asserted that Dr. Fintel's testimony was "wildly speculative" on the potential differences between the care Elizabeth received at Straith Hospital and the care she would have received at a larger hospital.

The court dispensed with oral argument under MCR 2.119(E)(3) and issued a written opinion and order granting defendant Hathaway's motion to strike and motion for summary disposition and, relevant to this appeal, denying summary disposition to the Othman defendants as to plaintiff's claims against Dr. Othman.[6] In striking Zagorski, the trial court emphasized that Zagorski admitted he did nothing to familiarize himself with the local standard of care. Additionally, Zagorski had never practiced under a delegatory authority model, and he did not do any research into what CAAs in Michigan were or were not permitted to do. The trial court ultimately granted summary disposition in favor of defendant Hathaway.

[6] The trial court granted the motion as to the direct liability claims against defendant Heart and Vascular Consultants but that holding is not challenged in this appeal.

The trial court further concluded that Dr. Fintel's testimony created a genuine issue of fact as to whether defendant Othman breached the standard of care and whether that breach was a proximate cause of Elizabeth's death. The trial court concluded that Dr. Fintel's testimony that defendant Othman improperly classified Elizabeth as an intermediate risk and instructed her to stop taking her blood thinner medication was not speculative because if she had been assigned a higher-risk category, "the standard of care would have demanded more detailed management of her condition as well as additional tests." As to defendant Othman's failure to recommend that Elizabeth's surgery be performed at a larger hospital, the trial court opined:

> Defendants also argue Dr. Fintel's testimony was speculative regarding his failure to request the surgery be performed at a level 1 trauma center rather than an outpatient surgery center. Again, this relates to Dr. Othman's alleged failure to properly classify the Decedent as "high" risk. As stated above, there is a genuine issue of material fact as to whether this classification error breached the standard of care and caused the death because, according to Dr. Fintel, had Decedent been properly classified as high risk, the standard of care would have required additional testing and precautions. The Motion is denied as to this issue.

Plaintiff moved for reconsideration of the trial court's grant of summary disposition in favor of defendant Hathaway and the Othman defendants moved for reconsideration of the court's denial of their motion for summary disposition. The trial court denied both motions, and these appeals followed.

II. DOCKET NO. 370206

The Othman defendants argue that the trial court erred by denying their motion for summary disposition of plaintiff's claim that defendant Othman was negligent in failing to recommend that Elizabeth's surgery take place at a major medical institution because plaintiff did not establish a genuine issue of material fact regarding proximate causation. We agree.

A. STANDARD OF REVIEW

"We review de novo a trial court's decision on a motion for summary disposition." *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152, 159; 934 NW2d 665 (2019). Summary disposition under MCR 2.116(C)(10) is warranted when, "[e]xcept as to the amount of damages, there is no genuine issue as to any material fact, and the moving party is entitled to judgment or partial judgment as a matter of law." MCR 2.116(C)(10). "A genuine issue of material fact exists when the record leaves open an issue upon which reasonable minds might differ." *El-Khalil*, 504 Mich at 160 (cleaned up). When reviewing a motion for summary disposition under MCR 2.116(C)(10), a court must consider the evidence submitted by the parties in the light most favorable to the nonmoving party. *Id*.

B. PROXIMATE CAUSE

To establish a claim of medical malpractice, a plaintiff must demonstrate (1) the applicable standard of care, (2) that the defendant breached that standard, (3) that the plaintiff was injured, and (4) that the plaintiff's injuries were proximately caused by the defendant's breach of the

applicable standard of care. *Rock v Crocker*, 499 Mich 247, 255; 884 NW2d 227 (2016). "[T]he plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants." MCL 600.2912a(2). Failure to establish any one of the four elements is fatal to a plaintiff's medical malpractice suit. *Benigni v Alsawah*, 343 Mich App 200, 213; 996 NW2d 821 (2022).

In a medical malpractice action, expert testimony is essential to establishing a causal link between the alleged negligence and the alleged injury. *Kalaj v Khan*, 295 Mich App 420, 429; 820 NW2d 223 (2012). "Proximate cause is a question for the jury to decide unless reasonable minds could not differ regarding the issue." *Lockridge v Oakwood Hosp*, 285 Mich App 678, 684; 777 NW2d 511 (2009). This Court has explained:

> "Proximate cause" is a term of art that encompasses both cause in fact and legal cause. Generally, an act or omission is a cause in fact of an injury only if the injury could not have occurred without (or but for) that act or omission. Cause in fact may be established by circumstantial evidence, but the circumstantial evidence must not be speculative and must support a reasonable inference of causation. All that is necessary is that the proof amount to a reasonable likelihood of probability rather than a possibility. The evidence need not negate all other possible causes, but such evidence must exclude other reasonable hypotheses with a fair amount of certainty. Summary disposition is not appropriate when the plaintiff offers evidence that shows that it is more likely than not that, but for defendant's conduct, a different result would have been obtained. [*Benigni*, 343 Mich App at 213-214 (cleaned up).]

Plaintiff argues that her claim that defendant Othman was negligent for failing to "assess and properly manage [Elizabeth's] heart function prior to providing clearance for elective eye surgery" includes three distinct breaches of the standard of care by defendant Othman: (1) concluding that Elizabeth was an intermediate risk instead of high risk, (2) instructing Elizabeth to stop taking Aspirin and Plavix five days before surgery, and (3) failing to have a discussion with Dr. Watson in which he recommended to Dr. Watson that the surgery be conducted at a major medical center. The trial court concluded that defendant Othman's failure to request that the surgery be performed at a level 1 trauma center "relates to Dr. Othman's alleged failure to properly classify [Elizabeth] as 'high' risk." The trial court determined that plaintiff had established a genuine issue of material fact as to whether this alleged classification error breached the standard of care and whether this breach was a proximate cause of Elizabeth's injury.

Dr. Fintel testified that Elizabeth was a high-risk individual with a revised cardiac risk index of 4, explaining that an index number of 4 "[e]stablishes a very high-risk patient who can deteriorate at any time due to the stress of the anesthesia and surgical manipulation . . . ." Dr. Fintel opined that performing the surgery at "a more sophisticated center with a greater degree of resources in terms of cardiac resuscitation, would have reduced the adverse neurological outcome that occurred here with severe brain damage." Dr. Fintel highlighted certain resources that would have likely been available at a larger hospital, such as the ability to perform a full electrolyte panel before the surgery and an ECMO device that could have provided circulatory support. If the surgery was performed at a larger hospital, Dr. Fintel opined, "to a reasonable degree of medical

certainty, her chances for not experiencing this cardiac arrest and being more rapidly resuscitated from it would have been increased; and then given that she arrested in an operating room would not have sustained that kind of brain damage." Dr. Fintel conceded that "the standard of care doesn't specifically refer to picking the institution for a procedure[.]" But he opined that "a high-risk patient should not be operated on in a small outpatient facility" and the standard of care required defendant Othman "to have a discussion with [Dr. Watson] that he was concerned about a number of potential cardiac problems developing during the case. And the procedure should be performed in the most comprehensive place within reason that [Elizabeth's] insurance would allow her to go to[.]"

Although Dr. Fintel's testimony established a genuine issue of material fact whether defendant Othman breached the standard of care, plaintiff must also demonstrate the existence of a disputed issue of fact on the issue of causation. *Barnard Mfg Co, Inc v Gates Performance Engineering, Inc*, 285 Mich App 362, 370; 775 NW2d 618 (2009) (stating that the nonmoving party must present evidence that demonstrates that a factual dispute remains that must be resolved by the finder of fact). To meet this burden, plaintiff must present substantial evidence from which a jury could conclude that more likely than not, the injuries would not have occurred but for defendant Othman's conduct. See *Benigni*, 343 Mich App at 213-214. Relevant to this appeal, plaintiff must offer evidence that shows, if defendant Othman recommended that the surgery take place at a level 1 trauma center, there was "a reasonable likelihood of probability" and "a fair amount of certainty" that Elizabeth would have experienced a different result. See *id*. at 214.

Dr. Fintel backtracked from his initial testimony, clarifying that surgery at a larger hospital *might* have led to a better outcome for Elizabeth:

> *Q*. . . . You spoke a few moments ago about the—if this was done in a larger hospital setting, there would have been a more rapid resuscitation. Did you say something like that?
>
> *A*. Yes.
>
> *Q*. You don't—
>
> *A*. Or the outcome of resuscitation *might* have been better.
>
> *Q*. *Might* have been, correct?
>
> *A*. Yes.
>
> *Q*. You can't state that beyond—more likely than not it would have been better. You can't tell us that, correct?
>
> *A*. I think the entire environment would have been different, and the likelihood of that bradycardic arrest at the end of surgery would have been *possibly* different. *But I can't say that to a reasonable degree of medical certainty*. I can't prove that. [Emphasis added.]

Expert testimony is required to establish causation in a medical malpractice action. *Kalaj*, 295 Mich App at 429. But the proof must "amount to a reasonable likelihood of probability rather than a *possibility*." *Benigni*, 343 Mich App at 213-214 (cleaned up; emphasis added). Dr. Fintel's testimony that it was *possible* "the outcome of resuscitation *might* have been better" was not sufficient evidence to demonstrate the existence of a disputed issue of fact on the issue of causation. Accordingly, the trial court erred by denying summary disposition to the Othman defendants on plaintiff's claim that defendant Othman breached the standard of care by failing to recommend that Elizabeth's surgery be performed at a level 1 trauma center.[7]

III. DOCKET NO. 370778

Plaintiff argues that the trial court abused its discretion when it denied her motion for reconsideration of the court's order granting defendant Hathaway's motion to strike plaintiff's expert and granting summary disposition in favor of defendant Hathaway. We disagree.

A. STANDARD OF REVIEW

We review a trial court's denial of reconsideration for an abuse of discretion. *Tindle v Legend Health, PLLC*, 346 Mich App 468, 474; 12 NW3d 667 (2023). A trial court abuses its discretion "only when the trial court's decision is outside the range of reasonable and principled outcomes." *Id*. (cleaned up). Likewise, we review the trial court's decision to admit or exclude evidence for an abuse of discretion. *Craig v Oakwood Hosp*, 471 Mich 67, 76; 684 NW2d 296 (2004). "However, any error in the admission or exclusion of evidence will not warrant appellate relief 'unless refusal to take this action appears . . . inconsistent with substantial justice,' or affects 'a substantial right of the [opposing] party.' " *Id*. (citations omitted).

B. ANALYSIS

The parties do not dispute that the applicable standard of care for a nonphysician such as a CAA "is the skill and care ordinarily possessed and exercised by practitioners of the profession in the same or similar localities." *Cox*, 467 Mich at 21-22. Generally, to establish the standard of care and that the standard of care was breached requires the testimony of an expert witness, *Danhoff v Fahim*, 513 Mich 427, 432; 15 NW3d 262 (2024), unless the breach was so obvious that it is within the common knowledge and experience of an ordinary layperson, *Elher v Misra*, 499 Mich 11, 21-22; 878 NW2d 790 (2016). "A nonlocal expert may be qualified to testify if he or she demonstrates a familiarity with the standard of care in an area similar to the community in

[7] The Othman defendants also argue that plaintiff did not establish proximate causation because even if Defendant Othman recommended to Dr. Watson that she conduct Elizabeth's surgery at a level 1 trauma center, Dr. Watson could not have accepted his recommendation because Dr. Watson did not have admitting privileges at a larger hospital. This argument is a non sequitur because it presumes that Dr. Watson was the only surgeon who could have performed Elizabeth's surgery. But there is nothing in the record to suggest that if defendant Othman had recommended that Elizabeth's surgery take place at a level 1 trauma center, another surgeon could not have performed the surgery. Consequently, this argument is not persuasive.

which the defendant practiced." *Decker v Rochowiak*, 287 Mich App 666, 686; 791 NW2d 507 (2010).

In this case, plaintiff's expert, Zagorski, is licensed in Ohio and practices in Cleveland at a level 1 trauma center. Zagorski and defendant Hathaway have the same education and national certifications. Because CAAs are nationally certified, Zagorski testified that he believed that a national standard of care applied to CAAs. Michigan does not have a state licensure for CAAs but defendant Hathaway is permitted to practice in Michigan because she has national certification.[8] Similarly, Zagorski could practice in Michigan with his national certification. Although Zagorski had done little research on Straith Hospital and was not aware that it was near Detroit, he testified that Detroit and the surrounding community is comparable to Cleveland. But he admitted he had not researched Southfield or the local standard of care. He also conceded that the resources available to defendant Hathaway may have been different at the outpatient facility compared to a level 1 trauma center and that a CAA must work within the resources available at the facility. Zagorski testified that he has worked as a CAA in "hundreds" of eye procedures, but none of them have been at an outpatient facility.

Additionally, Zagorski testified that Ohio is a licensure state regarding CAAs, while Michigan is a delegatory authority state. Zagorski explained, "[I]n a delegatory state pretty much the CAA can do anything that the attending anesthesiologist deems delegation, whereas as licensure state there is [sic] rules . . . by the state medical board dictating what the . . . scope of practice is." Zagorski admitted that he has never worked as a licensed CAA in a delegatory authority state and that he was not familiar with the limitations of a CAA's authority under Michigan's delegatory authority.[9] But he testified that he works daily under the supervision and guidelines of a licensed anesthesiologist, and the national standard is the same regardless of whether a CAA is practicing in a delegatory state or a licensure state.

Similar to this case, the expert witness in *Decker* testified that a "national" standard of care governed the defendant nurse's actions. *Id*. This Court concluded that "the actual substance of [the expert's] lengthy testimony was that the procedures at issue here are so commonplace that the *same* standard of care applied locally and nationally" and "[t]hus, plaintiff's expert applied the proper standard of care, which happened to be the same locally as well as nationally." *Id*. at 686-687.

Zagorski's testimony supports the fact that the standard of care for CAAs is the same throughout the country. In other words, for example, no matter where a CAA is practicing, he or she must "[p]rovide safe and adequate sedation, so as to protect [the patient's] airway and avoid potential obstruction of the airway." Because the standard of care was the same locally and nationally, Zagorski applied the proper standard of care. See *id*. But Zagorski also conceded that he was not familiar with Southfield or Straith Hospital or the resources available at the outpatient facility. He simply maintained that he knew that Straith Hospital was not located in a rural area.

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[8] Defendant Hathaway was licensed in South Carolina at the time of Elizabeth's procedure.

[9] Although Ohio was a delegatory authority state when Zagorski was a student, it became a licensure state the same year that he obtained his license.

Although Zagorski testified that a national standard of care applied, he was unable to demonstrate his familiarity with the standard of care in an area similar to the community in which defendant Hathaway practiced and thus was not qualified to testify. See *id*. Accordingly, the trial court did not abuse its discretion by denying plaintiff's motion for reconsideration.

IV. CONCLUSION

In Docket No. 370206, we reverse the trial court's order denying the Othman defendants' motion for summary disposition under MCR 2.116(C)(10) as to plaintiff's claim that defendant Othman was negligent for failing to recommend that Elizabeth's surgery take place at a Level 1 trauma center. In Docket No. 370778, we affirm the trial court's order denying plaintiff's motion for reconsideration of its decision striking Zagorski and granting Hathaway's motion for summary disposition. The case is remanded for further proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Philip P. Mariani
/s/ Christopher M. Murray
/s/ Sima G. Patel