STATE OF MICHIGAN

COURT OF APPEALS

NANCY THURSTON, and CRAIG THURSTON,

Plaintiffs-Appellants,

v

PHYSICIAN HEALTHCARE NETWORK, PC, STACIE HILL, PA-C, and CHRISTINE LAMING,

Defendants,

and

MCLAREN PORT HURON, MARC JONES, D.O., COVENANT MEDICAL CENTER, INC., doing business as COVENANT HEALTHCARE, ANDREW BAZAKIS, M.D., and JAMES MLENJEK,

Defendants-Appellees.

UNPUBLISHED
July 27, 2023

No. 360071
St. Clair Circuit Court
LC No. 18-000480-NH

Before: LETICA, P.J., and BORRELLO and RIORDAN, JJ.

BORRELLO, J. (*dissenting*).

As pointed out by my colleagues in the majority, here, in this medical malpractice action, plaintiffs appeal as of right the trial court's order of dismissal and specifically challenge earlier orders by the trial court granting summary disposition in favor of defendants McLaren Port Huron, Marc Jones, D.O., Covenant Medical Center, and Andrew Bazakis, M.D. Because I believe that questions of material fact exist as to the claims set forth by plaintiffs, I respectfully dissent and would reverse the trial court's order of summary disposition and remand for further proceedings.

In their appeal, plaintiffs argue that the expert testimony of Dr. Zoarski provided evidence that Nancy Thurston (Nancy) suffered greater neurological injury as a result of the delay in transporting her to a facility capable of providing full treatment for her intracranial hemorrhage and aneurysm, which in turn was caused by Dr. Jones's failure to ensure that Covenant was fully capable of treating Nancy's condition before transferring her to that facility. Accordingly,

plaintiffs argue, the trial court erred in granting summary disposition to Dr. Jones and McLaren on the ground that causation could not be demonstrated.

"In order to establish a cause of action for medical malpractice, a plaintiff must establish four elements: (1) the appropriate standard of care governing the defendant's conduct at the time of the purported negligence, (2) that the defendant breached that standard of care, (3) that the plaintiff was injured, and (4) that the plaintiff's injuries were the proximate result of the defendant's breach of the applicable standard of care." *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004). " 'In an action alleging medical malpractice, the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants.' " *Robins v Garg*, 276 Mich App 351, 362; 741 NW2d 49 (2007), quoting MCL 600.2912a(2). " 'Proximate cause' is a legal term of art that incorporates both cause in fact and legal (or 'proximate') cause." *Craig*, 471 Mich at 86 (citation omitted).

> The cause in fact element generally requires showing that "but for" the defendant's actions, the plaintiff's injury would not have occurred. On the other hand, legal cause or "proximate cause" normally involves examining the foreseeability of consequences, and whether a defendant should be held legally responsible for such consequences. [*Teal v Prasad*, 283 Mich App 384, 391; 772 NW2d 57 (2009) (citation and some quotation marks omitted).]

Here, the trial court granted summary disposition based on its conclusion that plaintiff had not created a genuine issue of material fact regarding cause in fact, and the parties' appellate arguments accordingly focus on the issue of cause in fact. "As a matter of logic, a court must find that the defendant's negligence was a cause in fact of the plaintiff's injuries before it can hold that the defendant's negligence was the proximate or legal cause of those injuries." *Id*. (quotation marks and citation omitted). However, such inquiries by a trial court, particularly at this stage of the proceedings, must be done with the utmost care to ensure that the trial court does not invade the domain of the jury and become the trier of fact. My review of the record evidence presented in this matter leads me to conclude that the trial court substituted its judgment for that of the proper trier of fact, a jury, and because of this rudimentary error, improperly dismissed plaintiffs' causes of action.

"Cause in fact may be established by circumstantial evidence, but such proof must be subject to reasonable inferences, not mere speculation." *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 496; 668 NW2d 402 (2003). "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. While a plaintiff need not prove that an act or omission was the *sole* catalyst for his injuries, he must introduce evidence permitting the jury to conclude that the act or omission was *a* cause." *Craig*, 471 Mich at 87 (citation omitted). Our Supreme Court has further explained that it

> is important to bear in mind that a plaintiff cannot satisfy this burden by showing only that the defendant *may* have caused his injuries. Our case law requires more than a mere possibility or a plausible explanation. Rather, a plaintiff establishes that the defendant's conduct was a cause in fact of his injuries only if he set[s] forth specific facts that would support a reasonable inference of a logical sequence of

> cause and effect. A valid theory of causation, therefore, must be based on facts in evidence. And while [t]he evidence need not negate all other possible causes, this Court has consistently required that the evidence exclude other reasonable hypotheses with a fair amount of certainty. [*Craig*, 471 Mich at 87-88 (quotation marks and citations omitted; alterations in original).]

Here, there is no dispute that Nancy was transferred from McLaren Port Huron to Covenant, which was unable to treat the type of aneurysm and hemorrhage that she developed. Dr. Zoarski testified that it was more probable than not that she would have received appropriate treatment earlier than she did had she been transferred directly to a facility that could provide complete aneurysm treatment, including coiling, and that Nancy's permanent neurological deficits were made worse by the delay in her treatment that included traveling for about an hour and a half to a facility incapable of fully treating her condition. Dr. Zoarski maintained that this was true even if Nancy had been transferred directly to such a facility that was slightly further from McLaren Port Huron than Covenant was, such as the University of Michigan, and he further opined that the lengthy detour to Covenant only caused unnecessary delay that worsened her permanent injuries. Dr. Zoarski opined that a patient's prognosis declines as aneurysms re-bleed and that multiple hemorrhages adversely affect the long-term outcome, and the delay in Nancy's treatment allowed more time for her further re-hemorrhages to occur.

From this evidence, a reasonable jury could infer that transferring Nancy to Covenant, which could not provide the necessary treatment for all types of brain aneurysms, including Nancy's that required coiling, caused unnecessary and significant delay in treating Nancy's aneurysm that allowed further re-hemorrhaging and more severe permanent neurological injury to occur. Plaintiffs thus provided evidence creating a question of fact that but for Dr. Jones's failure to ensure that Nancy was transferred directly to a facility capable of complete brain aneurysm treatment, including coiling, Nancy would not have suffered as many re-hemorrhages and would have had less severe permanent neurological injuries. *Id.*; *Wiley*, 257 Mich App at 496. The evidence supports a conclusion that the transfer to Covenant was at least *a* cause of Nancy's neurological injuries. *Craig*, 471 Mich at 87. Accordingly, I would hold that the trial court erred by granting summary disposition in favor of Dr. Jones and McLaren on the basis of factual causation, and would vacate this ruling by the trial court and remand to the trial court for further proceedings.

Next, plaintiffs argue that the trial court erred by granting summary disposition in favor of Dr. Bazakis and Covenant on the ground that no physician-patient relationship existed between Dr. Bazakis and Nancy. Again, I respectfully dissent from the conclusions drawn from the record by my colleagues in the majority.

Whether a physician-patient relationship exists giving rise to a legal duty is a question of law to be decided by the court. *Oja v Kin*, 229 Mich App 184, 187; 581 NW2d 739 (1998). "A medical-malpractice claim is defined as a claim that arises during the course of a professional relationship and involves a question of medical judgment." *Lockwood v Mobile Med Response, Inc*, 293 Mich App 17, 23; 809 NW2d 403 (2011). "In medical malpractice actions, the duty owed by a physician arises from the physician-patient relationship," making the physician-patient relationship a "legal prerequisite" to establishing the duty element of a medical malpractice action. *Oja*, 229 Mich App at 187. "A physician-patient relationship exists where a doctor renders

professional services to a person who has contracted for such services." *Id*. (quotation marks and citation omitted). This Court has explained the contours of when a physician-patient relationship exists as follows:

> A physician-patient relationship is contractual and requires the consent, express or implied, of both the doctor and the patient. The consent of the patient is generally implied. The question is, Under what circumstances can the doctor's consent be implied? . . . [M]erely listening to another physician's description of a patient's problem and offering a professional opinion regarding the proper course of treatment is not enough. Under those circumstances, a doctor is not agreeing to enter into a contract with the patient. Instead, she is simply offering informal assistance to a colleague. At the other end of the spectrum, a doctor who is on call and who, on the phone or in person, receives a description of a patient's condition and then essentially directs the course of that patient's treatment, has consented to a physician-patient relationship. The difficulty arises in determining where, between these two extremes, a physician-patient relationship (and thus a duty) arises. This inquiry is necessarily conducted case by case, but we do not believe that a physician's on-call status alone is enough to support an implied consent to a physician-patient relationship. Thus, we conclude that an implied consent to a physician-patient relationship may be found only where a physician has done something, such as participate in the patient's diagnosis and treatment, that supports the implication that she consented to a physician-patient relationship. We conclude that such participation is necessary for, but by itself does not establish, an implied physician-patient relationship. [*Id*. at 190-191 (citations omitted).]

In *Oja*, this Court addressed the issue whether a physician-patient relationship had been established between an on-call physician and the decedent. *Id*. at 185-186. The decedent had presented to the emergency room with a gunshot wound to his right jaw, and the resident physician on duty that night telephoned the on-call ear, nose, and throat physician at home to request his presence at the hospital to help treat the decedent. *Id*. The on-call physician told the resident that he would not come to the hospital because he was not feeling well, and he further indicated that the resident should contact another physician for assistance. *Id*. at 186. The resident contacted the on-call physician two more times during the night about the decedent, and the on-call physician responded each time that he was not able to assist or come to the hospital and that the resident should find another physician to replace him. *Id*. The decedent died during the early morning hours of the next day. *Id*.

This Court held that a physician-patient relationship had not been created between the on-call physician and the decedent, affirming the trial court's grant of summary disposition for lack of a legally cognizable duty. *Id*. at 192, 194. This Court reasoned that there was unrebutted evidence showing that the on-call physician's only opportunity to provide treatment came during three phone calls from the same emergency room resident and that each time, the on-call physician declined to provide care, treatment, or advice regarding the decedent. *Id*. at 191-192. This Court further noted the unrebutted evidence that the on-call physician expressly told the resident to contact a different physician for assistance. *Id*. at 192. Hence, the record reflected that the on-call physician "did not take any action that would support a finding of implied consent." *Id*.

Here, there was evidence that Dr. Jones discussed Nancy's case in detail with Dr. Bazakis, including Nancy's CT scan results showing her intracranial hemorrhage, before Nancy was transferred to Covenant. There was further evidence that Dr. Bazakis contacted a neurosurgeon on staff at Covenant that night before accepting the transfer and that Dr. Bazakis believed there was an interventional radiologist on staff at Covenant. Dr. Jones testified that he inquired whether Covenant could provide the care and treatment Nancy needed and that McLaren Port Huron was unable to provide. Dr. Bazakis agreed to accept the transfer. Although Dr. Bazakis testified that it was customary to contact a specialist before accepting a transfer patient if a certain specialty is required by the transfer, he indicated that this is not always necessarily required and that he does not need to obtain permission before deciding to accept a transfer.

Thus, there was evidence that Dr. Bazakis implied that Covenant was capable of providing the treatment necessary, while in possession of the pertinent information about Nancy's condition. If not for Dr. Bazakis's acceptance of Nancy as a transfer patient, she would not have been transferred to Covenant for medical care. Unlike the on-call physician in *Oja*, Dr. Bazakis did not expressly decline to become involved in Nancy's treatment but instead took affirmative action that resulted altering the course of her treatment to include what turned out to be a fruitless detour to Covenant. This constitutes sufficient direction of her course of care to evidence a physician-patient relationship under these circumstances. *Oja*, 229 Mich App at 190-192.

Dr. Bazakis and Covenant rely on *Weaver v Univ of Mich Bd of Regents*, 201 Mich App 239, 242; 506 NW2d 264 (1993), in which this Court held that "a telephone call merely to schedule an appointment with a provider of medical services does not by itself establish a physician-patient relationship where the caller has no ongoing physician-patient relationship with the provider and does not seek or obtain medical advice during the conversation." In that case, the plaintiff's father had called the physician's office and had spoken to the office secretary to schedule an appointment with the physician. *Id*. at 241.

However, there is a qualitative difference between a scheduling conversation with an office secretary and a discussion between two physicians to determine whether a patient experiencing an acute intracranial hemorrhage will be able to obtain adequate medical treatment at the proposed transferee hospital. Defendants' arguments essentially seek to avoid the imposition of a duty on Dr. Bazakis by relegating a trained physician to a mere order taker of medical services. The circumstances of Dr. Bazakis's involvement certainly involved more medical knowledge and judgment than would be necessary to simply find an open day and time for an appointment. Thus, this Court's decision in *Weaver* does not dictate a different conclusion in the instant case.

Accordingly, I would hold that the trial court erred by granting summary disposition in favor of Dr. Bazakis and Covenant on the ground that there was no physician-patient relationship imposing a legal duty on Dr. Bazakis, and would vacate the trial court's decision and remand to that Court for further proceedings. For these reasons, I respectfully dissent.

/s/ Stephen L. Borrello