STATE OF MICHIGAN

COURT OF APPEALS

PAMELA MOCERI, Personal Representative of the Estate of JOSEPH C. MOCERI, Deceased,

Plaintiff-Appellant,

v

MACOMB HOSPITAL CENTER and SANDOZ PHARMACEUTICALS CORP.,

Defendants,

and

ROBERTO M. BARRETTO, M.D.,

Defendant-Appellee.

UNPUBLISHED
April 21, 2000

No. 202791
Macomb Circuit Court
LC No. 94-001832 NH

Before: White, P.J., and Hood and Jansen, JJ.

PER CURIAM.

Plaintiff appeals by leave granted the circuit court's order granting defendant summary disposition in this medical malpractice case, challenging the court's determinations that plaintiff's expert was not qualified to testify, that his testimony would be confusing, and that there were no genuine issues of material fact. We reverse.

I

Plaintiff's decedent, Joseph Moceri, was a thirty-nine-year-old with chronic schizophrenia. Mr. Moceri had been under a psychiatrist's care, and his condition was being treated with the neuroleptic drug clozapine.[1] On December 24, 1993, Mr. Moceri was admitted to Macomb Hospital Center where he was diagnosed as suffering from pneumonia. Defendant Dr. Barretto took charge of Mr. Moceri's care. An EKG revealed a rapid heart rate and a left-axis deviation. A psychiatrist was called in to consult regarding Mr. Moceri's psychiatric care and medications. Mr. Moceri was started on a

course of antibiotics. His condition worsened, however, and on December 29, 1993, he died of respiratory arrest caused by fluid in and the collapse of his left lung. Plaintiff brought this suit on various theories of medical malpractice and products liability.[2] Plaintiff alleges that Dr. Barretto breached the standard of care by failing to consider the effects of clozapine when treating Mr. Moceri.

Plaintiff presented Dr. John Davis Palmer as an expert, who opined at deposition that defendant breached the standard of care by failing to conduct a proper risk/benefit assessment of the continued use of clozapine. Dr. Palmer testified that one could conduct such an analysis by reviewing the available information, such as product labeling, the Physician's Desk Reference (PDR), and medical texts. The manufacturer advised that the drug be used with caution in patients with heart disease.

At deposition, Dr. Palmer testified that he was of the opinion that there was a causal relationship between clozapine and Mr. Moceri's death, and opined, within a reasonable degree of medical certainty, that had the clozapine been stopped on hospitalization, Mr. Moceri would have lived.

II

This Court reviews the circuit court's grant or denial of a motion for summary disposition de novo. *Smith v Globe Life Ins Co*, 460 Mich 446, 454; 597 NW2d 28 (1999). When reviewing a motion for summary disposition based on MCR 2.116(C)(10), a circuit court must consider the affidavits, pleadings, depositions, admissions, and documentary evidence filed or submitted by the parties in the light most favorable to the nonmoving party. *Id.* at 454-455, citing *Quinto v Cross & Peters Co*, 451 Mich 358, 362-363; 547 NW2d 314 (1996). The moving party has the burden of supporting its position by affidavits, depositions, admissions, or other documentary evidence. *Id.* The burden then shifts to the nonmovant to establish that a genuine issue of disputed fact exists. *Id.* at 455. If the nonmoving party fails to present documentary evidence establishing that a material factual dispute exists, the motion is properly granted. *Id.*

We review a circuit court's decision regarding the qualification of an expert witness for abuse of discretion. *Bahr v Harper Grace Hosp*, 448 Mich 135, 141; 528 NW2d 170 (1995). We also review a "decision to admit expert testimony or to exclude it as speculative" for abuse of discretion. *Carpenter v Consumers Power*, 230 Mich App 547, 561; 584 NW2d 375 (1998), lv gt'd 603 NW2d 779 (1999). "An abuse of discretion exists where an unprejudiced person, considering the facts on which the trial court made its decision, would conclude that there is no justification for the ruling made." *Id.* at 562.

In a medical malpractice action, the plaintiff 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." *Locke v Pachtman*, 446 Mich 216, 222; 521 NW2d 786 (1994). Expert testimony is almost always required to establish the standard of care. *Id.* at 223-24. An adverse party's or adverse witness' testimony may establish the standard of care. *Rice v Jaskolski*, 412 Mich 206, 212-213; 313 NW2d 893 (1981); *Grewe v Mt Clemens Gen Hosp*, 404 Mich 240,

255-256; 273 NW2d 429 (1978); *Niemi v UP Orthopedic Assoc*, 173 Mich App 326, 331; 433 NW2d 363 (1988). The issue whether the standard of care was breached may be left to the factfinder. *Id.* at 331.

The circuit court dismissed plaintiff's claims under MCR 2.116(C)(10) on the basis that plaintiff's expert was not qualified under MCL 600.2169; MSA 27A.2169.[3] Plaintiff moved for reconsideration on the grounds that the circuit court applied the wrong version of the statute, and that certain statements by defendant were sufficient to establish the standard of care. The court concluded that even if plaintiff's expert qualified under the appropriate version of the statute, the expert's testimony was inadmissible under MRE 401, 702, and 403.

On appeal, plaintiff originally challenged the constitutionality of MCL 600.2169; MSA 27A.2169, based on this Court's decision in *McDougall v Eliuk*, 218 Mich App 501; 554 NW2d 56 (1996), rev'd sub nom *McDougall v Schanz*, 461 Mich 15; 597 NW2d 148 (1999). The Supreme Court subsequently reversed *McDougall*, and plaintiff withdrew the issue at oral argument before this Court. That issue is therefore moot.

Plaintiff argues that her expert was qualified under the applicable version of MCL 600.2169; MSA 27A.2169 and the rules of evidence. Plaintiff also argues that even without the disqualified expert, defendant's own statements on the record are sufficient to defeat summary disposition.

A

Plaintiff first claims error in the circuit court's determination that Dr. Palmer was not qualified to give expert testimony. We agree.

Plaintiff filed this action on March 30, 1994. The circuit court originally decided defendant's motion on the basis of the amended text of § 2169, which took effect on April 1, 1994. On plaintiff's motion for reconsideration,[4] the court conceded that the former text applied, but concluded that under that version of the statute Dr. Palmer did not meet the criteria of subsection (1)(b). The applicable provision provided that:

> (1) In an action alleging medical malpractice, if the defendant is a specialist, a person shall not give expert testimony on the appropriate standard of care unless the person is or was a physician licensed to practice medicine or osteopathic medicine and surgery, or a dentist licensed to practice dentistry in this or another state and meets both of the following criteria:
>
> (a) Specializes, or specialized at the time of the occurrence which is the basis for the action, in the same specialty or a related, relevant area of medicine or osteopathic medicine and surgery or dentistry as the specialist who is the defendant in the medical malpractice action.

> (b) Devotes, or devoted at the time of the occurrence which is the basis for the action, a substantial portion of his or her professional time to the active clinical practice of medicine or osteopathic medicine and surgery or the active clinical practice of dentistry, or to the instruction of students in an accredited medical school, osteopathic medical school, or dental school in the same specialty or a related, relevant area of health care as the specialist who is the defendant in the medical malpractice action. [Former MCL 600.2169(1)(b).]

The circuit court was "concerned that Dr. Palmer had not devoted a substantial portion of his professional time to internal medicine, as opposed to pharmacology." The court further stated that even if Dr. Palmer satisfied the requirements of the statute, the court would find his testimony failed the relevancy test of MRE 401, since Dr. Palmer stated that he had never been in a position similar to Dr. Baretto, i.e., he had never been assigned a patient who was taking Clozaril, and he was not authorized to prescribe the drug and was uncertain as to which group provides the requisite authorization. The court continued that even if it determined the testimony relevant, it would exclude it under MRE 403 and MRE 702, since the testimony was contradictory and would confuse the jury, because Dr. Palmer testified both that Dr. Barretto violated the standard of care by failing to engage in a risk/benefit analysis with respect to Clozaril, and that the information provided by the manufacturer was insufficient to enable a physician to engage in such an analysis.

Dr. Baretto is trained in and practices internal medicine. Dr. Palmer is trained in and practices internal medicine,[5] and has a Ph.D. in pharmacology. Dr. Palmer practices internal medicine at a Veterans Administration hospital for four months each year, and spends the rest of the year teaching internal medicine to third-year medical students, and pharmacology to second- and fourth-year students. Dr. Palmer therefore met the requirements of former subsection (1)(b), in that he devoted a substantial portion of his professional time to the clinical practice of medicine or the instruction of students in an accredited medical school in the same specialty (internal medicine) as Dr. Baretto. That Dr. Palmer also has a degree in and teaches pharmacology does not undermine his qualifications in internal medicine. Dr. Palmer also met the other statutory requirements, as he was licensed to practice medicine, and specialized in internal medicine as well as pharmacology. Therefore, we conclude that the circuit court improperly determined that Dr. Palmer did not meet the requirements of the appropriate version of § 2169.[6]

The circuit court also determined that Dr. Palmer's testimony was irrelevant under MRE 401 in that he "had never been assigned to a patient who was taking Clozaril," and was not authorized to prescribe it. The record indicates that Clozaril was a fairly infrequently prescribed drug that could only be prescribed by certain authorized practitioners. Like Dr. Palmer, defendant had never been in the position of treating a patient on Clozaril until Mr. Moceri came under his care, and was not himself authorized to prescribe Clozaril. Given that Dr. Palmer was similarly situated to defendant's position at the time of Mr. Moceri's hospitalization, we cannot agree that Dr. Palmer's testimony could not meet the test of logical relevance. See Robinson, Longhofer, & Ankers, Michigan Court Rules Practice, Evidence, § 401.2, pp 185-188. Dr. Palmer was qualified to give testimony relevant to the question what a reasonably prudent internal medicine specialist would do when presented with a patient with

heart disease and pneumonia, who was taking Clozaril for schizophrenia, as prescribed by an authorized physician. Indeed, had Dr. Palmer possessed the experience and credentials defendant argues he lacked, it is likely that defendant would have objected on the basis of "overqualification," i.e., that Dr. Palmer would be testifying on the basis of specialized knowledge not possessed by the ordinary internal medicine specialist.

The circuit court also concluded that, even assuming that Dr. Palmer met the statutory requirements, his testimony was inadmissible under MRE 403 and 702 because his testimony was contradictory and confusing. The circuit court's determination was based on Dr. Palmer's "discovery only" deposition. The circuit court focused on Dr. Palmer's testimony regarding the treating physicians on one hand, and the manufacturer on the other. It is not contradictory to simultaneously take the positions that 1) the physician in charge of the patient violated the standard of care by failing to conduct a risk/benefit analysis regarding a drug, which analysis would have led a prudent physician, even with the limited information given, to conclude that the administration of the drug should be discontinued; and 2) while the manufacturer of the drug provided some indication that heightened caution should be employed where patients present with a particular condition, the indication provided was inadequate to convey the magnitude of the risk and the degree of caution required given the magnitude of the risk. We conclude that a jury faced with such testimony could properly sort out what testimony is relevant to which defendant, and the extent to which each defendant bears responsibility, if at all.

A circuit court's determination of admissibility is entitled to great deference, and should be disturbed on appeal only where it is clear that there was an abuse of discretion. *Carpenter*, *supra*, at 561. However, decisions regarding the admission of evidence frequently involve preliminary questions of law, e.g., whether a statute precludes the admission of the evidence. Questions of law are reviewed de novo. *People v Lukity*, 460 Mich 484, 488; 596 NW2d 607 (1999). Here the expert was qualified under the then-applicable statute. As to each of the circuit court's other bases for disqualification, we conclude that there was an abuse of discretion for the reasons stated above. Whether only portions of the expert's testimony are admissible at trial remains in the discretion of the circuit court.

In light of our conclusions regarding the admissibility of Dr. Palmer's proposed testimony, we need not reach plaintiff's argument that there was sufficient evidence to create a genuine issue of material fact even without Dr. Palmer's testimony.

We reverse the grant of summary disposition, and remand for further proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Helene N. White
/s/ Harold Hood
/s/ Kathleen Jansen

[1] The proprietary name of the drug is Clozaril.

[2] Defendant Sandoz, the pharmaceutical manufacturer, is not a party to this appeal. The products liability claims are not before us.

[3] The legislature amended MCL 600.2169 in 1993, effective 1 April 1994. The original complaint in this case was filed on 30 March 1994.

[4] Defendant filed a response to the motion for reconsideration. MCR 2.119(F)(2) does not allow responses unless directed by the court. We find no indication in the record that any such direction was given. Plaintiff filed a motion to strike the response, but the circuit court did not address it.

[5] Dr. Palmer is board-eligible, but not board certified in internal medicine. This distinction, by itself, is irrelevant under the applicable statute.

[6] There is no question that Dr. Palmer would not qualify under the new, and more restrictive, text of MCL 600.2169; MSA 27A.2169.