STATE OF MICHIGAN

COURT OF APPEALS

MARGO THOMAS, Individually and as Personal Representative of the ESTATE OF MARGARET THOMAS,

Plaintiff-Appellant,

v

A. ROBERT VANTUINEN, M.D., DAVID H. WESORICK, M.D., and GRAND RAPIDS ASSOCIATED INTERNISTS,

Defendants-Appellees.

UNPUBLISHED
February 20, 2007

No. 263613
Kent Circuit Court
LC No. 02-006993-NH

Before: Murray, P.J., and Fitzgerald and Owens, JJ.

PER CURIAM.

Plaintiff appeals by leave granted a March 25, 2004, order granting in part and denying in part defendants' motion for summary disposition and a June 9, 2005, final order granting defendants' renewed motion for summary disposition. Plaintiff, in her capacity as personal representative of the deceased, claims that defendants' medical malpractice caused the death of her mother. Plaintiff, in her individual capacity, also makes a claim of negligent infliction of emotional distress. We reverse and remand.

In September 1999, the decedent, then 82 years old, suffered a "neurological event" and began receiving treatment for a blood and vascular condition from defendants Dr. VanTuinen and Dr. Wesorick, two internists and members of defendant Grand Rapids Associated Internists (GRAI). VanTuinen prescribed Coumadin, an anticoagulant. Four times between January 6, 2000, and April 14, 2000, defendants monitored the decedent's "internalized normalized ratio" or INR, which reveals the effect of an anticoagulant on the blood. Apparently, a person's INR should be between 2.0 and 3.0. Although the decedent continued to take Coumadin, defendants did not monitor the decedent's INR after April 14, 2000.

On September 7, 2000, Robert Lamberts, a dermatologist, prescribed the decedent Cipro, an antibacterial agent, without consulting with defendants. A pharmacist subsequently contacted Lamberts about the fact that Cipro is known to sometimes increase Coumadin's power as an anticoagulant.

The decedent was admitted to the emergency room of Spectrum Hospital on the afternoon of September 14, 2000. At that time, she had an extremely prolonged prothombin time[1] of 90.6 seconds and an INR of 9.0. Although VanTuinen was listed as the attending physician for the decedent, her medical records demonstrate that a number of doctors treated her at the hospital, including Dr. Verbrugge, an emergency room doctor, Dr. Bodley, a board-certified internist, and Dr. Heilman, an intern. The records note that Dr. Bodley, who is also an employee of GRAI, was covering for Dr. VanTuinen. Dr. Bodley conferred with emergency room doctors before the decedent's admission to the hospital.

At approximately 2:00 a.m. on September 15, the antibiotic Levaquin, which is known to increase the anticoagulant effect of Coumadin, was administered to the decedent. At that time, the decedent's prothrombin time was 98.3 seconds and her INR was 9.8. At 9:00 a.m. Dr. VanTuinen saw the decedent for the first time. He noted his plan to order oral Vitamin K, but he apparently never made the order. At approximately 1:25 p.m. the decedent exhibited signs and symptoms of hemorrhagic shock. Critical care doctors then gave her Vitamin K and fresh frozen plasma at 4:30 p.m. to reverse the effects of Coumadin. Shortly thereafter, the decedent died from gastrointestinal bleeding due to coagulopathy.

On July 18, 2002, plaintiff, the decedent's daughter, filed her complaint against Dr. Wesorick, Dr. VanTuinen, and GRAI, alleging that defendants breached the standard of care owed to the decedent by failing to monitor her INR and by not immediately giving her potassium, Vitamin K and plasma when she arrived at the emergency room (count I) and that defendants negligently inflicted emotional distress on plaintiff (count II).

On October 8, 2003, plaintiff deposed Alan Neiberg, M.D., who opined that Drs. Wesorick and VanTuinen breached the standard of care in two ways that caused the decedent's death: (1) by not correcting the decedent's prothrombin time level and reducing her INR at the time of her admission to the hospital, and (2) by prescribing Levaquin. With regard to the first breach, Dr. Neiberg testified that the decedent's presenting INR of 9.0 indicated a "poison level" of Coumadin and severe coagulopathy, which demanded immediate treatment. He indicated that the appropriate treatment for an 82-year-old patient with INR levels as high as those of the decedent would have been to give her fresh frozen plasma immediately to counteract the Coumadin. With regard to the second breach, Dr. Neiberg testified that the Levaquin caused the increase in INR observed after the decedent's admission to the hospital.

On January 23, 2004, defendants Wesorick, VanTuinen and GRAI filed a joint motion for summary disposition. The trial court heard defendants' motion February 20, 2004. The trial court granted the motion in part and denied the motion in part on March 25, 2004. The malpractice claim against Dr. Wesorick was dismissed because plaintiff provided no evidence that he was involved in the decedent's care during the relevant time period.

With regard to Dr. VanTuinen, the trial court granted summary disposition of plaintiff's malpractice claim "to the extent that it relies on [the] purported breach of the standard of care"

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[1] Prothombin time is the "blood clotting time." A normal prothombin time is 11.5 to 12 seconds.

for failure to immediately treat the decedent's prothrombin level when she was admitted to the hospital. During the hearing on the motion, defense counsel alleged that the signature on the order for Levaquin belonged to a Dr. VanDyke and that Dr. Neiberg mistook Dr. VanDyke's name for Dr. VanTuinen's name. However, the trial court found that "defendant VanTuinen's signature is on the very physician's order that he purports not to have made." Therefore, the court denied the motion with regard to the remaining malpractice claim against Dr. VanTuinen because genuine issues of material fact remained as to whether he breached the standard of care by administering Levaquin to the decedent.

Defendants renewed their motion for summary disposition on February 23, 2005, based on new evidence that allegedly resolved the outstanding factual issue related to the signature on the Levaquin order. They alleged that the signature on the order belonged to a senior resident at Spectrum, named "Dr. Varma." The deposition of Dr. Heilman was presented on this point. During her deposition, Dr. Heilman reviewed the Levaquin order and testified that, based on the handwriting and the signature, that Dr. Varma signed the order. Dr. Heilman stated that it was customary practice not to involve an attending physician for whom another doctor was on call in decisions about which drugs to order for a patient. Defendants also cited the deposition testimony of Dr. Bodley, who was on call for Dr. VanTuinen until 7:00 a.m. on September 15, 2002. Dr. Bodley was not asked to identify the signature on the Levaquin order, but he did testify that a senior resident has the authority to prepare the order and have it filled by the hospital pharmacy without approval from an attending physician. He also testified that, under customary practice, the treating doctors would not have consulted with Dr. VanTuinen about the Levaquin.

Along with the argument about the persons responsible for the Levaquin order, defendants argued that they were entitled to summary disposition as a matter of law because plaintiff failed to establish causation. Defendants characterized the deposition testimony of Dr. Neiberg as stating that the decedent's coagulopathy was irreversible by 9:00 a.m. on September 15, 2000. Therefore, any malpractice by Dr. VanTuinen after that time was not the proximate cause of her death. Based on these arguments, the trial court granted defendants' motion.

Plaintiff first argues that the trial court erred in making findings of fact and granting summary disposition in favor of Dr. VanTuinen and GRIA where questions of material fact existed. Under MCR 2.116(C)(10), summary disposition is proper where, except as to the amount of damages, there is no genuine issue as to any material fact and the moving party is entitled to judgment or partial judgment as a matter of law. This Court reviews a trial court's decision on a motion for summary disposition de novo. *Dressel v Ameribank*, 468 Mich 557, 561; 664 NW2d 151 (2003).

"Proof of a medical malpractice claim requires the demonstration of: (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). A prima facie case of medical malpractice must establish that "the defendant, if a specialist, failed to provide the recognized standard of practice or care within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances, and as a proximate result of defendant failing to provide that standard, the plaintiff suffered an injury." MCL 600.2912a. Furthermore,

proximate causation under MCL 600.2912a(2) must be proven by a preponderance of the evidence. *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004).

Here, the record establishes at least two unresolved issues of material fact regarding Dr. VanTuinen's participation in medical decisions that, according to Dr. Neiberg, violated the standard of care and caused the decedent's death. Dr. Neiberg indicated that giving Levaquin to a patient with an INR of 9.0 violated the relevant standard of care for a board-certified internist. Plaintiff alleged that Dr. VanTuinen either made the order for Levaquin or approved of its use when time remained to reverse the decedent's coagulopathy. In contrast, defendants argued that hospital protocol proves that Dr. VanTuinen would not have been involved in drug orders made at a time when another doctor was on-call for him. With regard to the signature, defendants assert that Dr. Neiberg mistakenly identified the signature on the pharmacy order for Levaquin as that of Dr. VanTuinen. In fact, they allege, the signature belonged to another doctor. Defendants asserted that a "Dr. VanDyke" signed the order.

The trial court initially rejected the argument that plaintiff misidentified the signature, finding that "VanTuinen's signature is on the very physician's order that he purports not to have made." At the time of the second motion hearing, defendants presented testimony from an intern that she "thought" she recognized the handwriting and the signature as that of one of her senior residents, Dr. Varma. The trial court then resolved the disputed factual issue in favor of the moving party based on this very slight evidence.

Furthermore, evidence in the record supports plaintiff's claim that Dr. VanTuinen agreed with the Levaquin order, even if he did not sign the order. Dr. VanTuinen testified that he did not discontinue the Levaquin when he saw the decedent at 9:00 a.m. on September 15. Instead, the Levaquin was discontinued only after the decedent was transferred to critical care that afternoon. Viewing the evidence and the reasonable inferences arising from it in the light most favorable to plaintiff, the evidence was sufficient to create a question of fact concerning whether Dr. VanTuinen was responsible for the initial or continued use of the Levaquin, the use of which was identified by Dr. Neiberg as a breach of the standard of care.

A genuine issue of fact also exists with regard to the time on September 15 at which the decedent became "medically unsalvageable." Defendants argued in their renewed motion that Dr. Neiberg's testimony conceded that the decedent was not salvageable as of 9:00 a.m. on September 15 when Dr. VanTuinen saw her. Therefore, they maintained that plaintiff failed to establish that any malpractice committed by Dr. VanTuinen contributed to causing the death.

Dr. Neiberg testified at his first deposition that, without fresh frozen plasma,"[b]y about 10 o'clock the door was closed." Neiberg gave an extended explanation of his interpretation of the decedent's laboratory results during the day of September 15, 2000. He estimated her progression of blood loss based on the patterns in her laboratory levels of chlorides, potassium, phosphorus, and her INR. Neiberg said, with the benefit of hindsight, he saw the "curves colliding" at approximately 10 a.m., at which point all of these levels would have been at or above toxic levels. He admitted it was possible the decedent was already unsalvageable at 9:00 a.m. but stated that his best guess put that point between 9:00 and 10:00 a.m.

In his second deposition, Neiberg testified:

> "The patient was salvageable at 9:00 in the morning. The patient was hemodynamically stable with reversible forms of shock from the way it came out. Looking at what evolved and looking at the, where the patient came from, and looking at the information that's there, I truly believe that at 9:00 in the morning the patient could have had the coagulopathy reversed and the bleeding stopped.

Clearly, the contention that the decedent's condition at 9:00 a.m. was not in dispute is not an accurate reflection of the record. Because of the competing evidence on whether Dr. VanTuinen's conduct contributed to the death, summary disposition was inappropriate. Viewed in the light most favorable to plaintiff, the evidence was sufficient evidence to survive a motion for summary disposition on the issue of causation. "[A] court may not weigh the evidence before it or make findings of fact; *if the evidence before it is conflicting*, summary disposition is improper." *Hines v Volkswagen of America, Inc*, 265 Mich 432, 437; 695 NW2d 84 (2005), quoting *Lysogorski v Bridgeport Charter Twp*, 256 Mich App 297, 299; 662 NW2d 108 (2003). Therefore, the trial court erred in granting summary disposition in favor of defendants Dr. VanTuinen and GRAI.

Plaintiff also argues that summary disposition in favor of defendants Dr. VanTuinen and GRAI was improper because a genuine issue of fact exists with regard to whether the residents or other treating physicians were under the control of Dr. VanTuinen. We agree.

As previously discussed, plaintiff provided evidence that the decedent was admitted to the hospital under Dr. VanTuinen's care, that she was treated by his on-call colleague, that Dr. VanTuinen reviewed her chart after the Levaquin order was administered, and that he made no changes to those orders. Even if the disputed question of the signature on the Levaquin order were resolved in favor of defendants, summary disposition in favor of defendants is improper because plaintiff submitted sufficient evidence to refute the factual question of whether Dr. VanTuinen was the principle of any intern, resident, or on-call physician who negligently prescribed the Levaquin. MCR 2.116(G)(4). Thus, the existence and scope of an agency relationship between Dr. VanTuinen and the treating physicians are questions of fact for the jury. *Whitmore v Fabi*, 155 Mich App 333, 338; 399 NW2d 520 (1986).

The vicarious liability of attending physicians is analyzed under the general principles of agency. *Barnes v Mitchell*, 341 Mich 7, 10; 67 NW2d 208 (1954) (finding physician vicariously liable for the negligence of nurse in performing X-ray within the scope of her employment). "Vicarious liability is based upon principal-agent and master-servant relationships and involves the imputation of negligence of the agent or servant to the principal or master without regard to the fault of the principal or master." *McClaine v Alger*, 150 Mich App 306, 316-317; 388 NW2d 349 (1986).

As a general rule, a supervising physician is vicariously liable for the negligence of subordinate physicians acting as his agent. For example, in *Orozco v Henry Ford Hosp*, 408 Mich 248, 253; 290 NW2d 363 (1980), the Court found that the doctor with primary responsibility for an operation was bound by the admission of an unknown fellow doctor, overheard by the patient, that he made a cut in the wrong part of the body. Supervisory physicians may also be held directly liable for negligent supervision of a resident. See *McCullough v Hutzel Hospital*, 88 Mich App 235, 238; 276 NW2d 569 (1979), where this Court upheld a jury verdict in favor of a patient whose tubal ligation surgery was negligently

performed by a resident working under the supervision of the defendant physicians. Although the issue in that case related to the qualification of an expert witness, as part of its decision this Court described the duty that an attending physician owes to the patient of one of his residents:

> When plaintiff entered Hutzel Hospital for gynecological surgery, defendants assumed responsibility for her care. Even though the surgical procedure was actually performed by a resident, defendants were under a duty to see that it was performed properly. It is their skill and training as specialists which fits them for that task, and their advanced learning which enables them to judge the competency of the resident's performance. Their failure to take reasonable care in ascertaining that the surgery was competently performed renders them liable for the resulting damages. We reject defendants' argument that supervision of a patient's care does not constitute practice of medicine. [*McCullough*, *supra* at 239.]

If the facts ultimately establish that Dr. VanTuinen was serving in a supervisory position to the resident and intern who allegedly wrote the Levaquin order, he could be held liable based on either negligent supervision or vicarious liability. Moreover, there was evidence presented that Dr. VanTuinen failed to exercise reasonable care in making sure that the treatment the decedent received before he saw her, specifically the prescribing of Levaquin, was competent. Likewise, if Dr. Bodley ordered Levaquin for the decedent, Dr. VanTuinen may be liable for Dr. Bodley's negligence as his principal. At the time of the decedent's death, Dr. Bodley was a partner in the professional corporation of which Dr. VanTuinen was the president.[2] This Court acknowledged that one physician might be the agent of another in a variety of factual scenarios, including where they are jointly employed or acting jointly on a case. *Whitmore*, *supra* at 338-339.

One problem with both parties' vicarious liability arguments is that they rely on generic labels to describe the relationships between the physicians. For example, defendants argue that Dr. Bodley was "on-call" for Dr. VanTuinen. They cite a somewhat analogous case of the New York Court of Appeals holding that the negligence of an "on-call" doctor will not be imputed to the attending doctor. *Kavanaugh v Gonzalez*, 71 NY2d 535, 547; 523 NE2d 284; 528 NYS2d 8 (1988). However, the facts in that case are easily distinguishable from the facts that are ascertainable from the record as it now stands. There, the physicians were not partners in a practice, did not share an office, and had no fee sharing arrangement. *Id.* at 545. The New York court found that, "in the absence of some recognized traditional legal relationship such as partnership, master and servant, or agency, between physicians in the treatment of patients, the imposition of liability on one for the negligence of the other has been largely limited to situations of joint control in the diagnosis or treatment of one by the other." *Id*. at 547, quoting *Graddy v New York Med Coll*, 19 AD2d 426, 429; 243 NYS2d 940 (NY App, 1963). Here, Dr. Bodley was "on call" for VanTuinen, but the underlying relationship was apparently a traditional

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[2] Defense counsel asserted, at the May 13, 2005 hearing, that Dr. Bodley was not a member of the professional corporation in September 2000. Thus, his professional status at the time of the incident is also a disputed factual issue.

partnership. Furthermore, there are disputed factual issues regarding the joint action to diagnose and treat the decedent in this case. A reasonable inference from the record is that Dr. VanTuinen's 9:00 a.m. examination of plaintiff's decedent, during which he failed to terminate the Levaquin or to order fresh frozen plasma, created joint action with Dr. Bodley, the residents, and the other treating physicians.

Based on the record before us, Dr. VanTuinen clearly had a physician-patient relationship with the decedent independent of the hospital setting. She was admitted to the hospital under his care, and Dr. VanTuinen consulted with residential medical staff of the hospital about her care on the morning of September 15,2005. Because genuine issues of material fact exist regarding the existence and scope of an agency relationship, it cannot be said as a matter of law that Dr. VanTuinen is not liable for the negligence of the resident alleged to have ordered the Levaquin for the decedent. Summary disposition in favor of Dr. VanTuinen and GRIA was improper.

Reversed and remanded. Jurisdiction is not retained.

/s/ Christopher M. Murray
/s/ E. Thomas Fitzgerald
/s/ Donald S. Owens