STATE OF MICHIGAN

COURT OF APPEALS

GAYNELL MCINTYRE, Personal Representative of the Estate of LORENE PENDLEY, Deceased,

Plaintiff-Appellee,

v

KOCHUNNIK MOHAN, MD,

Defendant-Appellant,

and

SUBBA CHAVALI, MD,

Defendant.

UNPUBLISHED
March 13, 2008

No. 274462
Bay Circuit Court
LC No. 04-003784-NH

GAYNELL MCINTYRE, Personal Representative of the Estate of LORENE PENDLEY, Deceased,

Plaintiff-Appellee,

v

SUBBA CHAVALI, MD,

Defendant-Appellant,

and

KUIMIL K. MOHAN, MD,

Defendant.

No. 274526
Bay Circuit Court
LC No. 04-003784-NH

Before: Saad, C.J., and Murphy and Donofrio, JJ.

PER CURIAM.

In this consolidated appeal, defendants[1] Kochunni K. Mohan, M.D., and Subba Chavali, M.D., appeal by limited leave granted from the order denying their respective motions for summary disposition in this wrongful death medical malpractice action. Because the trial court did not err in concluding that the relevant specialty at the time of the alleged malpractice was cardiology, we affirm.

I

This action arose out of the death of the decedent Lorene Pendley following surgery by Dr. Mohan who performed a left heart catherization, coronary angiography, and percutaneous transluminal angioplasty with stent placement of the left anterior descending (LAD) artery. Both Dr. Mohan and Dr. Chavali oversaw her postoperative treatment and care. Following surgery, the decedent experienced complications and eventually died. Thereafter, plaintiff was appointed personal representative of the decedent's estate, served defendants with notices of intent, and filed this medical malpractice action against them, alleging that defendants failed to properly address the postoperative complications. Plaintiff did not allege that any malpractice occurred during the operation.

Plaintiff elected to use only Daniel Wohlgelernter, M.D., who is board certified in internal medicine and has a subspecialty in cardiology and interventional cardiology, as her standard of care witness at trial. Dr. Chavali, who is board certified in cardiology, moved for summary disposition and to strike Dr. Wohlgelernter as a witness, maintaining that he was unqualified to testify against him under MCL 600.2169 and *Woodard v Custer*, 476 Mich 545; 719 NW2d 842 (2006). Dr. Mohan, who is board certified in cardiology and interventional cardiology, moved, in part, under MCR 2.116(C)(10), maintaining that Dr. Wohlgelernter was unqualified to testify against him as well. The trial court denied defendants' motions, holding that the relevant specialty was cardiology and that Dr. Wohlgelernter was qualified to testify as a cardiologist. Defendants sought leave to appeal. While defendants raised myriad issues, we granted leave to appeal to consider only whether plaintiff's expert witness is qualified to testify against defendants under MCL 600.2169 and *Woodard*. *McIntyre v Bay Medical Center, Inc* (*McIntyre I*), unpublished order of the Court of Appeals, issued June 21, 2007 (Docket No. 274462); *McIntyre v Bay Medical Center, Inc* (*McIntyre II*), unpublished order of the Court of Appeals, issued June 21, 2007 (Docket No. 274526).

II

A trial court's decision on a motion for summary disposition is reviewed de novo. *Collins v Comerica Bank*, 468 Mich 628, 631; 664 NW2d 713 (2003). A motion made under MCR 2.116(C)(10) tests the factual support for a claim, *Dressel v Ameribank*, 468 Mich 557, 561, 664 NW2d 151 (2003), and should be granted when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law, *Miller v Purcell*, 246 Mich

[1] Because former defendants Bay Regional Medical Center and Kuimil Mohan, M.D., are no longer parties to this action, any reference to "defendants" in this opinion refers to Dr. Mohan and Dr. Chavali.

App 244, 246; 631 NW2d 760 (2001). A genuine issue of material fact exists when the record, drawing all reasonable inferences in favor of the nonmoving party, leaves open an issue upon which reasonable minds could differ. *West v Gen Motors Corp*, 469 Mich 177, 183; 665 NW2d 468 (2003). When deciding a motion for summary disposition under this rule, a court must consider the pleadings, affidavits, depositions, admissions, and other documentary evidence then filed in the action or submitted by the parties in the light most favorable to the nonmoving party. MCR 2.116(G)(5); *Ritchie-Gamester v City of Berkley*, 461 Mich 73, 76; 597 NW2d 517 (1999).

III

Dr. Mohan argues on appeal that the relevant specialty engaged in during the time of the alleged malpractice was interventional cardiology, not cardiology and thus, the trial court erred when it concluded that the most relevant standard of care was cardiology. Plaintiff counters that, because the alleged negligence occurred post-operatively and did not involve the invasion of a blood vessel, the trial court appropriately concluded that the relevant specialty was cardiology. Resolving this issue involves a question of statutory interpretation, which is a question of law reviewed de novo. *Griffith v State Farm Mut Automobile Ins Co*, 472 Mich 521, 525-526; 697 NW2d 895 (2005).

MCL 600.2169 provides, in relevant part, as follows:

> (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.

This statute requires that the specialty of a standard of care witness match the relevant specialty of the defendant. *Woodard, supra* at 558-560. If the expert is to testify against a board certified specialist, then the expert must be board certified in the same specialty. *Halloran v Bhan*, 470 Mich 572, 577; 683 NW2d 129 (2004). "[A] 'specialty' is a particular branch of medicine or surgery in which one can potentially become board certified." *Woodard*, *supra* at 561. [I]f a defendant physician specializes in a subspecialty, the plaintiff's expert witness must have specialized in the same subspecialty as the defendant physician at the time of the occurrence that is the basis for the action." *Id*. at 562. "[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*.

To determine whether it is appropriate for the plaintiff's standard of care witness to testify, the plaintiff's expert witness must match the relevant 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." *Woodard, supra* at 560. Accordingly, the important focus for comparing or matching of specialties is based on the actual area of practice being performed at the time of the alleged malpractice. The court must look to the actual area of practice the plaintiff challenges in order to determine whether the proffered expert has the capacity to offer an opinion regarding the standard of care. MCL 600.2169(1)(a); *Gonzalez v St John Hospital & Medical Center*, 275 Mich App 290, 302-303; 739 NW2d 392 (2007).

The trial court here concluded that the relevant specialty being performed at the time of the alleged malpractice was cardiology and not interventional cardiology. A physician who is board certified in internal medicine can obtain subspecialty certification in cardiovascular disease, also known as cardiology, and interventional cardiology. According to the American Board of Internal Medicine (ABIM), for subspecialty certification in cardiovascular disease, a physician is required to complete a minimum of 36 months of training, including 24 months of clinical training in the following procedures:

- Advanced cardiac life support (ACLS), including cardioversion
- Electrocardiography, including ambulatory monitoring and exercise testing
- Echocardiography
- Arterial catheter insertion
- Right-heart catheterization, including insertion and management of temporary pacemakers.[2]

For subspecialty certification in interventional cardiology, the following is required:

> The training pathway requires 12 months of satisfactory clinical fellowship training in interventional cardiology in addition to the required three years of cardiovascular disease training.
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> * * *
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> During training in interventional cardiology, the fellow must have performed at least 250 therapeutic interventional cardiac procedures, documented in a case list and attested to by the training program director. In addition, the training program director must judge the clinical skill, judgment and technical expertise of the fellow as satisfactory.

[2] ABIM, http://www.abim.org/certification/policies/imss/card.aspx (accessed February 29, 2008).

To receive credit for performance of a therapeutic interventional cardiac procedure in the training pathway, a fellow must meet the following criteria:

- Participate in procedural planning, including indications for the procedure and the selection of appropriate procedures or instruments.

- Perform critical technical manipulations of the case. (Regardless of how many manipulations are performed in any one "case", each case may count as only one procedure.)

- Be substantially involved in postprocedural management of the case.

- Be supervised by the faculty member responsible for the procedure. (Only one fellow can receive credit for each case even if others were present.)[3]

Based on the foregoing as well as the testimony of Dr. Mohan, it is plain that the practice of cardiology involves a great deal of overlap with interventional cardiology. But, it is clear that Dr. Mohan was practicing interventional cardiology when he performed a left heart catherization, coronary angiography, and percutaneous transluminal angioplasty with stent placement of the LAD artery on the decedent. And, it is equally clear that at the time of the alleged medical malpractice, during post-operative care, Dr. Mohan was practicing cardiology. Our conclusion is further supported by the fact that Dr. Chavali, a cardiologist, provided the same care and treatment that Dr. Mohan, an interventional and general cardiologist, provided to the decedent immediately after the surgical procedures ended. Moreover, our review of the record reveals no indication that Dr. Chavali was not qualified to provide that care and treatment. Consequently, we conclude that trial court correctly concluded that the relevant specialty being engaged in at the time of the alleged medical malpractice was cardiology.

IV

Defendants also argue in their briefs on appeal that Dr. Wohlgelertner was unqualified to testify against them under MCL 600.2169(1)(b) because they allege that Dr. Wohlgelernter did not devote a majority of his time to the active clinical practice or instruction of interventional cardiology in the year preceding the alleged malpractice. But at oral argument on appeal, counsel for Dr. Mohan agreed that Dr. Wohlgelertner is qualified to testify on general cardiology subjects pursuant to MCL 600.2169(1)(b) because he meets the majority practice requirements. Regarding Dr. Chavali, he argued in the trial court that Dr. Wohlgelertner meets the general cardiology requirements as well. Dr. Chavali argues here that Dr. Wohlgelertner cannot testify on the specific issue of Dr. Chavali's failure to take plaintiff's decedent to the catheterization laboratory because that ultimately necessitates an opinion of an interventional cardiologist. But

[3] ABIM, http://www.abim.org/certification/policies/imss/icard.aspx (accessed February 29, 2008).

we, like the trial court, conclude that the most relevant specialty or sub-specialty involved is the standard of care of a cardiologist, therefore, Dr. Chavali's argument fails.

V

Defendants' raise additional issues on appeal to this Court. The remaining arguments exceed the scope of review outlined by our orders granting leave to appeal. The orders are directives and limit the issues to be reviewed on appeal to addressing the relevant specialty being practiced at the time of the alleged malpractice and whether plaintiff's expert witness is qualified to testify against defendants. As such, we are not permitted to review any of the remaining issues because they are outside of the scope of review allowed by our orders granting leave to appeal. MCR 7.205(D)(4).

Affirmed.

/s/ Henry William Saad
/s/ William B. Murphy
/s/ Pat M. Donofrio