STATE OF MICHIGAN

COURT OF APPEALS

JACQUELYN HUBBARD, Personal Representative of the ESTATE OF SAMMIE DAVIS, Deceased.

Plaintiff-Appellee,

v

DETROIT MEDICAL CENTER/WAYNE STATE UNIVERSITY and HARPER HOSPITAL,

Defendants-Appellants,

and

SHIVKUMAR PRABHU, M.D., and SHIVKUMAR PRABHU, M.D., P.C.,

Defendants.

UNPUBLISHED
May 27, 2008

No. 275151
Wayne Circuit Court
LC No. 05-514083-NH

Before: Zahra, P.J., and Whitbeck and Beckering, JJ.

PER CURIAM.

Defendants, Detroit Medical Center/Wayne State University and Harper Hospital ("hospital defendants"), appeal by leave granted the order of the trial court denying their motion in limine to preclude allegations and arguments regarding emergency department care. We reverse.

I. Basic Facts and Procedural History

On December 17, 2002, the decedent, Sammie Davis, a 55-year-old male, reported to the emergency room at defendant Harper Hospital complaining of abdominal pain. He reported a history of cirrhosis of the liver and ascites. While he was in the emergency room, a paracentesis was performed. Later the same day, he was admitted to the hospital. Safwan A. Saker, M.D.,[1]

[1] Dr. Saker and Safwan A. Saker, M.D., P.C., were named as defendants, but were ultimately (continued…)

was listed as the admitting physician. The following day, upon referral from Dr. Saker, defendant Shivkumar Prabhu, M.D., a gastroenterologist, examined the decedent. Dr. Prabhu's impressions of the decedent's condition were as follows: "[d]ecompensated cirrhosis with ascites,[2] possible spontaneous bacterial peritonitis" ("SBP"),[3] malnutrition, recent weight loss, and anemia. Among other things, Dr. Prabhu recommended antibiotics for SBP, an ultrasound guided large volume paracentesis,[4] and oral Aldactone and Lasix "to achieve diuresis." Around 2:00 a.m. on December 21, 2002, the decedent went into cardio-respiratory arrest. Attempts at resuscitation failed, and the decedent was pronounced dead at 3:00 a.m.

Dr. Prabhu testified at his deposition that "[t]he paracentesis showed about 2,800 nucleated cells with about 400 red blood cells, predominately neutrophils. And the initial gram stain showed gram positive and gram negative bacilli." He admitted that these results would not typically be consistent with SBP and ascites because SBP does not normally contain more than one organism. However, he also testified that, given the decedent's medical history, the most likely cause of the laboratory result was contamination. He testified that the test was not repeated because the decedent was already "being treated with antibiotics which would be the treatment of choice, whether there is contamination or SBP, monoflora or micro—or polyflora," although he admitted that it would not be the treatment of choice if the decedent had a perforated viscus.

Werner U. Spitz, M.D., performed an autopsy on the decedent's body on December 21, 2002 at the Hutchinson Funeral Home in Detroit. He concluded that the decedent "died of acute fribrinopurulent peritonitis as a result of a ruptured viscus, possibly a diverticulum." Dr. Spitz found no evidence of liver cirrhosis or pancreatitis.

In her complaint, plaintiff Jacquelyn Hubbard, personal representative of the estate of the decedent, claimed that Drs. Saker and Prabhu were employees or agents of hospital defendants, and hospital defendants were liable for their actions. It alleged negligence, gross negligence, or willful misconduct on the part of each of the defendants; in particular, in failing to obtain the decedent's complete and accurate medical history, diagnose a perforated viscus, perform a CT

(…continued)

dismissed by the trial court for noninvolvement.

[2] Dr. Prabhu explained this diagnosis as follows: "[t]hat cirrhosis is not in a stable or controlled state, and the fact that the patient had ascites, which is fluid buildup in the abdomen, suggesting that the cirrhosis is not stable."

[3] According to Dr. Prabhu, "[w]hen somebody with cirrhosis has ascetic fluid, which is normally sterile, they are predisposed to several types of infection within that ascetic fluid. Spontaneous bacterial peritonitis reflects infection of the fluid in the absence of intraabdominal surgically treatable causes of infection." "There's no cause that is identifiable that can be rectified surgically."

[4] When asked during his deposition why he recommended this procedure, Dr. Prabhu stated, "[t]he large volume to reduce the amount of fluid that the patient had that was obviously causing the shortness of breath and discomfort. Ultrasound guided because it's safer than a blind puncture."

scan of the abdomen, order appropriate tests to rule out a perforated bowel, and timely review and appreciate laboratory findings.

Hospital defendants eventually filed a motion in limine to preclude arguments and allegations regarding emergency medical care and, in particular, the actions or inactions of a particular resident. They contended that such claims must be precluded because they were "raised" for the first time during the deposition of Dr. Michael Apstein, one of plaintiff's expert witnesses, and were not included in plaintiff's notice of intent or affidavit of merit. Hospital defendants also argued that plaintiff's claim against the resident was not adequately supported by an affidavit of merit because Dr. Apstein, a specialist in gastroenterology and internal medicine, was not qualified to testify against the resident under the statutory requirements. The trial court disagreed and denied hospital defendants' motion.

II. Expert Qualifications With Respect to the Resident

On appeal, hospital defendants first argue that the trial court erred in denying their motion in limine to preclude claims based on the alleged actions of the resident because these claims are not supported by testimony from a qualified expert. They argue that, because the resident was practicing within the area of emergency medicine at the time of the alleged malpractice, plaintiff was required to present testimony from an emergency medicine specialist, and Dr. Apstein, a specialist in gastroenterology and internal medicine, was not qualified under MCL 600.2169(1)(a) and (b) to offer testimony against the resident.[5] We agree.

This Court reviews questions of statutory interpretation de novo, and a trial court's rulings concerning the qualifications of proposed expert witnesses for an abuse of discretion. *Woodard v Custer*, 476 Mich 545, 557; 719 NW2d 842 (2006). "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." *Id*.

"In a medical malpractice case, the plaintiff bears the burden of proving: (1) the applicable standard of care; (2) breach of that standard by the defendant; (3) an injury; and (4) proximate causation between the alleged breach and the injury." *Gonzalez v St John Hosp & Medical Ctr*, 275 Mich App 290, 294; 739 NW2d 392 (2007). "Expert testimony is required to establish the applicable standard of care and to demonstrate that the defendant breached that standard." *Id*. In order to be qualified to offer standard of care testimony against a particular defendant, an expert witness's qualifications must match those of the defendant. *Id*. at 295-296; MCL 600.2169(1).

MCL 600.2169(1) provides, in pertinent part:

> 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

[5] A second expert, Stuart Friedman, M.D., who is board certified in internal medicine, is not at issue in this appeal because Dr. Friedman testified at his deposition that he was critical of Dr. Prabhu, and Dr. Borniva, an internist who is not a defendant in this case, and no one else.

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.

(b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:

(*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.

(*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.
[Emphasis added.]

The Michigan Supreme Court recently addressed the meaning of the term "specialist," as used in MCL 600.2169(1):

> Both the dictionary definition of "specialist" and the plain language of § 2169(1)(a) make it clear that a physician can be a specialist who is not board certified. They also make it clear that a "specialist" is somebody who can potentially become board certified. Therefore, a "specialty" is a particular branch of medicine or surgery in which one can potentially become board certified. Accordingly, if the defendant physician practices a particular branch of medicine or surgery in which one can potentially become board certified, the plaintiff's expert must practice or teach the same particular branch of medicine or surgery. [*Woodard*, *supra* at 561-562.]

Subsequent Michigan cases, applying *Woodard*, *supra*, support hospital defendants' argument that residents should be considered specialists in the area in which they were practicing at the time of the occurrence forming the basis of the malpractice action.

In *Reeves v Carson City Hosp* (*On Remand*), 274 Mich App 622, 623; 736 NW2d 284 (2007), the defendant physician was board certified in family practice, but was practicing in the emergency room at the time of the alleged malpractice. Quoting *Woodard*, *supra* at 560, this Court found that "[b]ecause 'the specialty engaged in by the defendant physician during the course of the alleged malpractice' was emergency medicine, it is the 'one most relevant standard of practice or care[.]'" *Reeves*, *supra* at 628 (change in *Reeves*). Although the defendant

physician was not board certified in emergency medicine, she could "potentially" become board certified. *Id*. at 629. Therefore, this Court concluded that the plaintiff's expert was required to be a specialist in emergency medicine, although not a board certified specialist. *Id*.

In *Gonzalez*, *supra*, involving a medical malpractice suit over the death of the decedent from complications resulting from colorectal surgery, this Court addressed expert witness requirements pertaining to a third-year surgical resident, Christopher N. Vashi, M.D. The trial court had held that the plaintiff's affidavit of merit from a board certified general surgeon was insufficient because the expert was a specialist, while the resident was a general practitioner. *Id*. at 293. Noting that it was undisputed "that Vashi was a third-year surgical resident practicing within that discrete specialty on the date of the occurrence," this Court turned to a review of the applicable case law. *Id*. at 297. It noted *Bahr v Harper-Grace Hosps*, 198 Mich App 31, 34; 497 NW2d 526 (1993), rev'd on other grounds 448 Mich 135 (1995), in which this Court had held, "[i]t is clear that interns and residents are not 'specialists,' and, therefore, we conclude that the applicable standard of care for such persons is that of the local community or similar communities." *Gonzalez*, *supra* at 297 (citation and quotation omitted; change in *Gonzalez*). This Court stated that *Bahr* had been the authority on the standard of care applicable to medical resident physicians since it was decided in 1993. *Id*. at 298. However, this Court then turned to a discussion of *Woodard*, and noted that, "[w]hen discussing its definition of 'specialist,' the Supreme Court broadly defined 'specialist' using the term 'physician,' which necessarily includes those physicians who are also residents." *Id*., citing *Woodard*, *supra* at 561-562. This Court found that, under *Woodard*, Vashi would be considered a "specialist," because he "was a physician who limited his training to surgery, and who could potentially become board certified on completion of his residency." *Id*. at 298-299. Accordingly, this Court read "*Woodard* as overruling that portion of *Bahr*, *supra*, that holds that residents are not specialists, and h[e]ld that those physicians who are residents and limit their training to a particular branch of medicine or surgery and who can potentially become board-certified in that specialty are specialists for purposes of the analysis under MCL 600.2169(1)." *Id*. at 299 (internal quotations and citation omitted).

Thus, after *Gonzalez*, it is clear that a resident can be a "specialist" within the meaning of MCL 600.2169(1). In this case, however, unlike in *Gonzalez*, it is not clear from the record whether the resident limited his or her training to a particular branch of medicine. However, other reasoning suggests that the fact that Vashi limited his training to surgery was not necessary to the result in *Gonzalez*. After discussing *Reeves*, *supra*, the *Gonzalez* Court found that, under *Reeves* and *Woodard*, the "one most relevant standard of practice or care" in the case before it was general surgery, because Vashi was practicing in general surgery at the time of the occurrence. *Gonzalez*, *supra* at 302, quoting *Reeves*, *supra* at 628 (internal quotation marks omitted).

Given *Gonzalez*, along with *Reeves*, where the physician was board certified in family practice but the Court held that the "one most relevant standard of practice or care" was emergency medicine because that was "the specialty engaged in by the defendant physician during the course of the alleged malpractice," *Reeves*, *supra* at 628, quoting *Woodard*, *supra* at 560 (internal quotation marks omitted), the resident in this case is properly considered a specialist in emergency medicine. Therefore, a specialist in emergency medicine, though not a board certified one, is required to testify regarding the standard of care applicable to the resident.

Because Dr. Apstein is not a specialist in emergency medicine, he is not qualified to testify as an expert witness against the resident.

Hospital defendants further argue that, even if the resident were considered a general practitioner, as was the case law interpretation of MCL 600.2169 with respect to residents at the time this matter was filed, Dr. Apstein is not qualified to testify regarding the required standard of care because he is not a general practitioner. Under MCL 600.2169(1)(c), "[i]f the party against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness" must have "devoted a majority of his or her professional time," during the year immediately preceding the relevant occurrence, to either "[a]ctive clinical practice as a general practitioner," or "[i]nstruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom . . . the testimony is offered is licensed." There was no evidence presented that Dr. Apstein was a general practitioner, and plaintiff admits that he is not. And although Dr. Apstein testified that he teaches at Harvard, there was no evidence to suggest that he spent a majority of his professional time doing so in the year before the occurrence that gave rise to this litigation.

Plaintiff argues that under the doctrine of res ipsa loquitur, she is entitled to a permissible inference of negligence on the part of the resident based on circumstantial evidence. Plaintiff's criticism of the resident, whose name remains unknown, is based on the resident's receipt of the results of the paracentesis performed while the decedent was in the emergency room, and his failure to call Dr. Saker, the attending physician, or a gastroenterological consult to learn the significance of the result. Plaintiff claims that a determination of the effect of this failure to relay the lab value and the ensuing misdiagnosis can be made as a matter of common understanding by the jury. Notwithstanding the fact that we feel the doctrine of res ipsa loquitur is inapplicable in this instance, plaintiff did not raise this argument below, and we decline to review issues not raised before or decided by a trial court. *Brown v Loveman*, 260 Mich App 576, 599; 680 NW2d 432 (2004).

Because Dr. Apstein is not properly qualified to testify against the resident in this case under MCL 600.2169(1), the trial court erred in failing to grant defendants' motion in limine precluding him from testifying against the resident at trial. In light of this conclusion, we need not address defendants' remaining arguments regarding the sufficiency of plaintiff's notice of intent and affidavit of merit.

Reversed.

/s/ Brian K. Zahra
/s/ William C. Whitbeck
/s/ Jane M. Beckering