# STATE OF MICHIGAN

# COURT OF APPEALS

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| DEBORAH COMPTON,<br><br>Plaintiff-Appellant/Cross-Appellee, | UNPUBLISHED<br>March 5, 2009 |
| v | No. 260362<br>Oakland Circuit Court |
| HELEN ALEXANDRA PASS, M.D., JANE E. PETTINGA, M.D., and WILLIAM BEAUMONT HOSPITAL, | LC No. 2003-048275-NH |
| Defendants-Appellees/Cross-Appellants. | ON REMAND |

Before: K.F. Kelly, P.J., and Markey and Meter, J.J.

PER CURIAM.

In this medical malpractice action, plaintiff Deborah Compton appealed as of right the judgment of no cause of action entered in favor of defendants Alexandra Helen Pass, M.D., Jane E. Pettinga, M.D., and William Beaumont Hospital. On appeal and cross-appeal, we found one issue to be dispositive and reversed the trial court's order denying defendants' motion for summary disposition on the basis of causation. *Compton v Pass* (*Compton I)*, unpublished opinion per curiam of the Court of Appeals, issued August 22, 2006 (Docket No. 260362). Plaintiff appealed this decision to the Supreme Court and, in lieu of granting leave to appeal, the Supreme Court vacated our opinion and remanded the case to this Court:

> for reconsideration, in light of *Stone v Williamson*, 482 Mich 144 (2008), of whether this is a lost-opportunity case and whether the defendants are entitled to summary disposition under MCL 600.2912a(2). On remand, the Court of Appeals shall also consider the other issues raised by the parties, but not addressed by that court during its initial review of this case, to the extent necessary to resolve this case. [*Compton v Pass*, ___ Mich ___ ; 757 NW2d 119 (2008).]

While concurring in the remand, Justice Markman stated:

> MCL 600.2912a(2) provides, in pertinent part, "In an action alleging medical malpractice, the plaintiff cannot recover for loss of an opportunity to survive or an opportunity to achieve a better result unless the opportunity was greater than 50%." We recently addressed this provision with some considerable lack of consensus in *Stone v Williamson,* 482 Mich 144 (2008).

> Plaintiff's expert testified that the decedent's [sic] premalpractice chance of not suffering from lymphedema or axillary cording was at least 97%, while her postmalpractice chance of not suffering from lymphedema was 82% and her postmalpractice of not suffering from axillary cording was 90%. I believe that this is a lost opportunity cause of action because "it is possible that the bad outcome would have occurred even if the patient had received proper treatment." *id.* at 218 (Markman, J., concurring in result only). Further, utilizing the formula described in my opinion in *Stone*, plaintiff satisfies the § 2912a requirement. I would reverse the Court of Appeals, but for the fact that my opinion did not carry the day. Therefore, I must accede to the remand order. [*Id.* at ___ (Markman, J., concurring).]

Pursuant to our Supreme Court's remand order, we now consider whether plaintiff presented a lost opportunity case in the trial court, and, if so, whether defendants were entitled to summary disposition. We hold that plaintiff did plead a claim for lost opportunity pursuant to MCL 600.2912a(2) and that the trial court erred in denying defendants summary disposition. Accordingly, we again reverse the trial court's order denying defendants' motion for summary disposition, remand the matter for entry of an order granting summary disposition in defendants' favor, and vacate all orders the trial court entered subsequent to the reversed order.

## I. Basic Facts and Procedural Background

In our original opinion we set forth the factual background of this case:

> This claim arises out of an axillary lymph node dissection treatment for cancer that Drs. Pettinga and Pass performed on plaintiff at Beaumont Hospital in April 2001. Plaintiff, who sought medical care from Dr. Pass for breast cancer, alleged that defendants surgically removed at least 18 of her right axillary lymph nodes as part of NSABP Clinical Trial B-32, without obtaining her informed consent. Plaintiff alleged that if she had been properly informed, she would have opted not to participate in the B-32 trial, but instead would have chosen to undergo the sentinel node removal. Plaintiff alleged that, as a result of defendants' failure to properly provide her with informed consent, she suffers permanent axillary cording and lymphedema.
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> In their motion for summary disposition, defendants argued that pursuant to MCL 600.2912a(2), plaintiff was required to establish a loss of opportunity to achieve a better result greater than 50 percent. Defendants asserted that all three of plaintiff's oncology experts, stated that the difference between lymphedema rates stemming from axillary dissection and sentinel node procedures is significantly less than 50 percent. Plaintiff responded contending that Beaumont Hospital's B-32 protocol "is the most crucial document in assessing the morbidity rates associated with axillary node dissections versus sentinel node biopsies." Plaintiff asserted that, according to the protocol, 82 percent of women undergoing the axillary node dissection experience some arm morbidity while the morbidity

> associated with the sentinel node biopsy is minimal to none. Plaintiff also cited the affidavit of her expert Burt M. Petersen, M.D., wherein he asserted that he agrees with these morbidity rates. Plaintiff also cited the deposition testimony of Vernon K. Sondak, M.D., stating that he agreed with the 82 percent morbidity rate identified in the protocol. Plaintiff further argued that she did not simply allege that she suffered "arm swelling," but alleged that she was caused pain, suffering, emotional distress, etc. associated with axillary cording and lymphedema. The trial court denied defendants' motion. On the record, the trial court stated that because plaintiff "alleged and testified at deposition that she suffers from multiple affects [sic] after the axillary dissection the Court finds there are questions of fact for the jury." [*Compton I*, *supra* (footnotes omitted).]

In *Compton I*, we determined that plaintiff had not established that she lost an opportunity for a better result that was greater than 50 percent. Relying on *Fulton v William Beaumont Hosp*, 253 Mich App 70, 83-84; 655 NW2d 569 (2002), and MCL 600.2912a(2), we concluded that to satisfy the proximate cause requirement of a medical malpractice case, plaintiff was required to make such a showing. Evidence presented to the trial court relevant to this determination included:

> (1) Robert Steele, M.D. opined that the risk of lymphedema was 18 percent with the axillary lymph node dissection and 0 to 3 percent with the sentinel node removal.
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> (2) Allen Meek, M.D. opined that the risk of lymphedema was 35 percent with the axillary lymph node dissection and 5 percent or less with the sentinel node removal.
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> (3) Dr. Meek opined that the risk of axillary cording was as high as 35 percent, but averaged approximately 12 to 15 percent, with the axillary lymph node dissection, and would be less than 5 percent with the sentinel node removal.[1]

We rejected plaintiff's argument that, in order to recover, she had to show a better than 50 percent chance that she had lost the opportunity for a better result *generally*; rather, we held that plaintiff was required to establish this lost opportunity with respect to the specific injuries — axillary cording and lymphedema. Thus, we held that plaintiff failed to establish a lost opportunity cause of action pursuant to MCL 600.2912a(2). Plaintiff thereafter applied for leave to appeal to our Supreme Court.

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[1] We disregarded the opinion of Burt M. Peterson, M.D., regarding the risks of developing lymphedema relative to both procedures, because the trial court ruled that his testimony lacked a scientific basis and that ruling was not challenged on appeal. However, he did opine "the arm morbidity rate associated with axillary node dissection is 82 percent, and is only about 3 percent with a sentinel node biopsy."

While plaintiff's application was pending, the Supreme Court released its plurality opinion in *Stone v Williamson*, 482 Mich 144; 753 NW2d 106 (2008). In *Stone*, the defendants failed to diagnose the plaintiff's abdominal aortic aneurysm, resulting in a rupture and emergency surgery with many complications. Moreover, in part due to a prior condition, the plaintiff's legs had to be amputated at the thigh; his home had to be reconfigured to accommodate him, and his wife quit her employment to care for him. The proofs at trial established that if the plaintiff had been properly diagnosed and undergone elective surgery, he would have had a 95 percent chance of a better outcome. The misdiagnosis led to a 10 percent chance of a good result. A majority of the Supreme Court concluded *Stone* did not present a lost opportunity case but instead sounded in traditional malpractice. At the conclusion of the lead opinion, Chief Justice Taylor set forth a summary of the three opinions:

> In an attempt to clarify for the reader the majority and minority positions on each issue, I provide the following summary:
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> All seven justices would affirm the result of the Court of Appeals decision and the judgment for plaintiff. Six of the justices believe that this is not a lost-opportunity case; Justice Markman would hold that it is such a case. All seven justices believe that *Fulton*'s analysis is incorrect or should be found to no longer be good law, though their reasons for doing so vary.[14] Justices Corrigan and Young and I would find that *Fulton* is no longer good law because we would hold that the statute is unenforceable as written. Justice Markman would hold that *Fulton* is inconsistent with the statutory language. Justices Weaver, Cavanagh, and Kelly would hold that *Fulton* is incorrect because it erroneously added words to the statute when analyzing the phrase "the opportunity." Of the four justices holding that the statute is not unenforceable as written (Justices Weaver, Cavanagh, Kelly, and Markman), only Justice Markman would define the term "opportunity" in accordance with the Waddell article, while the other three (Justices Weaver, Cavanagh, and Kelly) would define it in accordance with *Falcon*, but with a higher threshold than *Falcon* required. The same four justices (Justice Weaver, Cavanagh, Kelly, and Markman) would hold that loss of the opportunity is, by itself, a compensable injury, although the opportunity must be "lost"—that is, the bad result must occur—in order for a claim to accrue.
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> [14] However, because a majority of justices hold that this is not a lost-opportunity case, the issue of the correctness of *Fulton* cannot be reached, and *Fulton*'s approach remains undisturbed as the method of analyzing lost-opportunity cases. Nonetheless, because the patient in *Fulton* would likely have survived had she received a timely diagnosis, I would assert that the claim should have been treated as one for ordinary medical malpractice and that the lower courts erred in applying to it the doctrine of lost opportunity.
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[*Id.* at 164, (Taylor, C.J.).]

Following the release of *Stone*, the instant case was remanded to us for further consideration.

## II. Standard of Review

We review de novo a trial court's decision on a motion for summary disposition. *Spiek v Dep't of Transportation*, 456 Mich 331, 337; 572 NW2d 201 (1998). A motion for summary disposition based on lack of a material factual dispute is properly granted if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. MCR 2.116(C)(10); *Rice v Auto Club Ins Ass'n*, 252 Mich App 25, 31; 651 NW2d 188 (2002). "A genuine issue of material fact exists when the record, giving the benefit of reasonable doubt to the opposing party, leaves open an issue upon which reasonable minds might differ." *West v General Motors Corp*, 469 Mich 177, 183; 665 NW2d 468 (2003). In deciding a motion under MCR 2.116(C)(10), we must consider all the evidence, affidavits, pleadings, and admissions in the light most favorable to the nonmoving party. *Rice, supra* at 30-31.

## III. Analysis

Regardless of whether a plaintiff alleges an ordinary medical malpractice or lost opportunity claim, 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). Therefore, a lost opportunity claim may be properly asserted where, either standing alone or together with a traditional medical malpractice claim, a plaintiff can demonstrate, by a preponderance of the evidence, that a defendant's negligence proximately caused the complained of injury. *Falcon v Mem Hosp*, 436 Mich 443, 461-462; 462 NW2d 44 (1990) (injury resulting from medical malpractice is not only physical harm, but also includes the loss of opportunity of avoiding physical harm.) With respect to lost opportunity claims, the second sentence of MCL 600.2912a(2) defines the "injury" that plaintiff must show. That provision provides:

> 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. *In an action alleging medical malpractice, the plaintiff cannot recover for loss of an opportunity to survive or an opportunity to achieve a better result unless the opportunity was greater than 50%.* [Emphasis added.]

In *Lanigan v Huron Valley Hosp*, ___ Mich App ___; ___ NW2d ___ (2009), we noted that while the second sentence of §2912a(2) has generated a great deal of confusion, we are bound by this Court's prior opinion in *Fulton, supra* ("[T]he prevailing analysis for lost opportunity cases remains that set forth in *Fulton, Stone, supra* at 164 n 14, and regardless of whether we think *Fulton* was properly decided we are bound to follow it.").

Thus, pursuant to our Supreme Court's directive, we must address whether the present case is a traditional medical malpractice case or one of lost opportunity. If it is one of lost opportunity, we are bound to apply *Fulton. Lanigan, supra* at ___.

A. Traditional Medical Malpractice Claim vs. Lost Opportunity Claim

From the *Stone* pluralities on this issue, we glean that: (1) if the plaintiff can show that the defendant's acts or omissions more probably than not caused the physical injury or death, the plaintiff has a claim for traditional malpractice, as this states the requirement for a showing of proximate cause; and (2) if the plaintiff cannot show that a defendant proximately caused the injury, the plaintiff nonetheless may have a claim for lost opportunity if he can show that the defendant's acts or omissions more probably than not caused him to lose a chance of survival or a better result. Thus, the injury in the case of a traditional medical malpractice claim is the injury or loss of life itself, whereas the injury in a lost opportunity case is the loss of the opportunity for survival or a better result.

At the outset, we recognize that this is an informed consent case, not a case based on breach of the standard of care for performing the axillary lymph node dissection surgery itself. Moreover, the consent in this case had to do with an informed choice between two possible surgeries, as opposed to informed consent regarding whether to have a procedure at all.

The doctrine of informed consent requires a physician to warn a patient of the risks and consequences of a medical procedure. *Lincoln v Gupta*, 142 Mich App 615, 625; 370 NW2d 312 (1985). As previously noted, in a medical malpractice case, a plaintiff must establish: (1) the standard of care, (2) breach of that standard of care, (3) injury, and (4) proximate causation between the alleged breach and the injury. *Craig, supra* at 86. Here, the standard of care required that defendants obtain plaintiff's informed consent before performing the surgery, and the failure to do so was a breach of the standard of care. Since she suffered injury, the analysis turns on proximate cause. In other words, if plaintiff suffered an injury as the result of a procedure to which the plaintiff did not consent, and would not have had surgery at all if adequately informed, the plaintiff would have a traditional malpractice case, i.e., the plaintiff could show that the defendant's action—the surgery itself—more probably than not caused the injury. However, the plaintiff alleges that she would have had a less invasive surgery if adequately informed, which carried the same risk of injury but in significantly fewer cases.

It is undisputed that plaintiff was being treated for breast cancer and the plaintiff's complaint indicates that foregoing all surgery was never a contemplated option. Rather, the practical choice was between the two surgeries. Thus, the question becomes whether it was more probable than not that plaintiff would have suffered lymphedema and axillary cording from the axillary node dissection surgery, but not from the sentinel node dissection surgery. In other words, the issue is whether, by not being advised that there was an alternative with fewer risks, plaintiff lost an opportunity for a less invasive surgery with a potentially better result. In our opinion, this is a classic lost opportunity case, and we therefore apply the *Fulton* analysis: In order to satisfy the proximate cause element in a lost opportunity medical malpractice action, the plaintiff must show that the difference between the plaintiff's initial opportunity to survive or achieve a better result and the plaintiff's opportunity following the malpractice is greater than fifty percent. *Fulton, supra* at 83-84.

B. Application of *Fulton*

With regard to lymphedema, defendants contend that plaintiff's expert Robert Steele, M.D. testified that he agreed with the B-32 protocol indicating that the percent chance of

lymphedema alone following the axillary node procedure is 18 percent while the chance of lymphedema following the sentinel node procedure is from zero to three percent. Defendants also note that Allen Meek, M.D. testified that plaintiff's chance of developing arm lymphedema after the axillary node dissection was 35 percent and that the chance of lymphedema following the sentinel node procedure was five percent or less. With regard to axillary cording, Dr. Meek testified that plaintiff's risk of axillary cording with a sentinel node procedure was "less than 5 percent." He testified that her risk of axillary cording following an axillary node dissection would be "as high as 35 percent" and that a "good average number is somewhere between 12 and 15." According to this testimony, plaintiff did not lose an opportunity to achieve a better result that was greater than 50%. *Id*. at 82-84.

Plaintiff, on the other hand, relies on the portion of the B-32 protocol, which states,

> Arm morbidity is common with axillary dissection, and 82% of women undergoing it experience at least one arm problem, with associated psychological distress ranging from 17-50%. One study reported the following frequencies of adverse events in patients: numbness in 70%, pain in 33%, weakness in 25%, arm swelling in 18%, stiffness in 10% and reduced quality of life in 39%. . . .[2]

Plaintiff argues "[s]he also lost the opportunity to avoid the pain, axillary cording, weakness, pulling, and stinging of her arm that resulted from surgery. She lost the quality of life and psychological comfort that comes with having a healthy and useful right arm and hand." However, in her complaint, plaintiff specifically alleged that she suffered lymphedema and axillary cording:

> That as a direct and proximate result of the negligence of the Defendants herein, Plaintiff Deborah Compton has been caused to suffer severely disabling and permanent injuries. *She now suffers from painful and permanent axillary cording, and from permanent lymphedema*, which causes a painful swelling in her right arm, elbow joint, wrist, hand, fingers, and finger joints. She must wrap her right arm with surgical bandages from shoulder to fingertips at all times to attempt to minimize the painful swelling. Additionally, she must place her arm in a mechanical pressure pump several times per day for the swelling. She has to live with severe restrictions and limitations with regard to the use of her right arm from her axillary cording and lymphedema as follows . . . . [Emphasis added.]

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[2] Plaintiff also relied on the affidavit of Dr. Petersen, who attested, in agreement with the protocol, that the "morbidity rate associated with axillary node dissection is 82%, and is only about 3% with a sentinel node biopsy." Dr. Peterson's affidavit is dated November 11, 2004. However, an order precluding him from offering "any evidence regarding the statistical probability of developing lymphedema following an axillary dissection versus a sentinel node procedure" was entered November 8, 2004. On appeal, plaintiff did not take issue with this ruling.

While plaintiff specifically alleged axillary cording and lymphedema and pain and suffering associated with these injuries, she relies on statistical evidence to demonstrate that defendants' negligence caused her to suffer arm morbidity *in general*. Plaintiff's reliance is misplaced: she must offer proof that defendants' negligence caused these injuries, not morbidity generally, which could constitute any number of various other injuries not alleged or sustained. Moreover, the 82 percent rate of general arm morbidity applies to all women who undergo the axillary dissection, not necessarily limited to those similarly situated as plaintiff. As such, this general statistical evidence is without selective application to plaintiff. Without some connection to the plaintiff, the statistical evidence is, standing alone, only marginally relevant. *Lanigan*, *supra* at ___. Relevant evidence means "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." MRE 401. Accordingly, it must be material, that is, related to a fact of consequence to the action, as well as having probative force which is having a tendency to make the existence of a fact of consequence to the action, more probable or less probable than it would be without the evidence. *People v Sabin (After Remand)*, 463 Mich 43, 57; 614 NW2d 888 (2000). Plaintiff failed to establish that she had a greater than 50 percent opportunity to avoid the injuries she claims.

Nonetheless, plaintiff argues that *Fulton* was wrongly decided. In making this argument, plaintiff essentially adopts the conclusions of Roy W. Waddell, M.D.'s "A Doctor's View of Opportunity to Survive: *Fulton*'s Assumptions and Math are Wrong," published in the March, 2007 edition of the Michigan Bar Journal. The article criticizes *Fulton's* formula for calculating lost opportunity because it fails to distinguish "survival rate" from "opportunity to survive" and erroneously confuses a 50-percentage point differential with a 50 percent opportunity to achieve a better result. However, although critical of *Fulton*, our Supreme Court recently asserted: "*Fulton*'s approach remains undisturbed as the method of analyzing lost-opportunity cases." *Stone*, *supra* at 164 n 14 (Taylor, C.J.). Moreover, in *Lanigan, supra*, we held that *Fulton* remains applicable to lost opportunity cases. Thus, plaintiff's argument fails, and the court erred in denying defendants' motions for summary disposition.

## IV. Conclusion

We hold that plaintiff presented a lost opportunity case in the lower court. We further hold that at the time the motion for summary disposition was heard, plaintiff failed to present any evidence to establish that she had a greater than 50 percent chance of not suffering lymphedema

or axillary cording. *Fulton, supra.* Accordingly, we reverse the trial court's order denying defendants' motion for summary disposition, remand for entry of an order granting summary disposition in defendants' favor, and vacate all orders entered subsequent to the reversed order.[3] We do not retain jurisdiction.

/s/ Kirsten Frank Kelly
/s/ Jane E. Markey
/s/ Patrick M. Meter

[3] Because our decision on this issue resolves the case as a whole, we need not address the other issues on appeal.