STATE OF MICHIGAN

COURT OF APPEALS

MAHENDRA DALMIA,

Plaintiff-Appellant,

V

CARL PALFFY, M.D., and EMERGENCY PHYSICIANS ASSOCIATES, P.C.,

Defendants-Appellees,

and

ST. JOSEPH MERCY HOSPITAL PONTIAC, a/k/a TRINITY HEALTH-MICHIGAN,

Defendant.

UNPUBLISHED
December 1, 2009

No. 281706
Oakland Circuit Court
LC No. 2003-052350-NH

Before: Jansen, P.J., and Borrello and Stephens, JJ

PER CURIAM.

Plaintiff appeals as of right an order dismissing his medical malpractice suit. On appeal, he challenges the trial court's earlier order finding the standard of care opinion of his expert witness, Dr. Ira Mehlman, unreliable and inadmissible. Plaintiff maintains that Dr. Mehlman's opinion was reliable and it was the jury's duty to weigh his opinion against that of the opposing expert witness of defendants, Carl Palffy, M.D. ("Dr. Palffy") and Emergency Physicians Associates, P.C. ("EPA"). We affirm.

Plaintiff suffered a stroke in his home and was transported to St. Joseph Mercy Hospital in Pontiac (St. Joseph). A resident in the emergency department initially treated plaintiff, but he consulted Dr. Palffy approximately one hour after plaintiff arrived at St. Joseph. Soon afterward, plaintiff received a CT scan, which ruled out a hemorrhage from the stroke. Plaintiff claimed that his wife, thereafter, requested that the health professionals administer tissue plasminogen

activator ("t-PA").[1] Dr. Palffy could not recall discussing t-PA with plaintiff's family. However, at his deposition, Dr. Palffy concluded that the possible benefits from t-PA for plaintiff's small stroke would not have outweighed the high risks associated with the treatment.

Plaintiff was admitted to St. Joseph. The next day, he complained of a severe headache. Another CT scan was performed. It revealed an acute infarct in the posterior cerebral artery and a hemorrhage in the infarct. When he was discharged from St. Joseph, plaintiff continued to exhibit "left hemisensory deficits and a perceived left hemiparesis." He was transferred to a rehabilitation unit for physical and occupational therapy.

Plaintiff subsequently filed medical malpractice suit against Dr. Palffy, St. Joseph, and the company contracting to provide emergency services to St. Joseph, EPA.[2] Plaintiff alleged that defendants negligently failed to administer appropriate medications, including t-PA. Dr. Mehlman prepared to testify that this failure constituted a breach of the standard of care. At his deposition, however, Dr. Mehlman failed to produce literature upon which his opinion was based. Consequently, the trial court granted defendants' motion to strike Dr. Mehlman's testimony because, without supportive literature, the opinion lacked reliability pursuant to MRE 702 and MCL 600.2955(1). Because the standard of care testimony was inadmissible, the trial court dismissed plaintiff's case.

Plaintiff appealed the decision. This Court reversed the trial court's order striking Dr. Mehlman's testimony and dismissing plaintiff's suit because it was unduly harsh. *Dalmia v Palffy*, unpublished opinion per curiam of the Court of Appeals, issued February 6, 2007 (Docket No. 264088), slip op, pp 1, 4. It remanded for an evidentiary hearing in which Dr. Mehlman could produce supporting documentation and the trial court could make a reliability determination. *Id.*, pp 3, 9.

Dr. Mehlman and defendants' expert, Dr. Michael Yagey, testified at the evidentiary hearing. The trial court thereafter found Dr. Mehlman's testimony regarding the standard of care unreliable and inadmissible. Again, it dismissed plaintiff's case and he appealed.

Plaintiff argues that the trial court abused its discretion when it found Dr. Mehlman's testimony unreliable and inadmissible. We disagree. This Court reviews the "qualification of a

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[1] T-PA is a Food and Drug Administration-approved "clot buster" that is administered intravenously. According to a 1995 National Institute of Neurological Disorders and Stroke ("NINDS") study, t-PA can reverse the molecular biology of a stroke. Dr. Mehlman estimated that 30 to 40 percent of t-PA patients in the NINDS study experienced positive outcomes. However, the treatment criteria were restrictive. First, t-PA must be administered within three hours of the onset of the stroke. Second, medical histories may not include, among other things, seizure, low or high glucose, high blood pressure, or recent major surgery. Third, patients must have a score above three and below 22 on the NIH stroke scale, which characterizes the severity of a stroke.

[2] Plaintiff's claim against St. Joseph was resolved in case evaluation and dismissed prior to this appeal.

witness as an expert and the admissibility of the testimony of the witness" for an abuse of discretion. *Surman v Surman*, 277 Mich App 287, 304-305; 745 NW2d 802 (2007).

In a medical malpractice action, the plaintiff must prove: (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). In this case, plaintiff proposed Dr. Mehlman's opinion that the standard of care mandated the use of t-PA to satisfy his burden to prove the first element. However, expert testimony on the appropriate standard of care must satisfy the criteria in MCL 600.2169, MCL 600.2955, and MRE 702. *Woodard v Custer*, 476 Mich 545, 574; 719 NW2d 842 (2006). The trial court's determination regarding the criteria "is a precondition to admissibility." *Gilbert v DaimlerChrysler Corp*, 470 Mich 749, 780 n 46; 685 NW2d 391 (2004).

MCL 600.2169 provides:

> "(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.
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> * * *
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> (2) In determining the qualifications of an expert witness in an action alleging medical malpractice, the court shall, at a minimum, evaluate all of the following:
>
> (a) The educational and professional training of the expert witness.
>
> (b) The area of specialization of the expert witness.
>
> (c) The length of time the expert witness has been engaged in the active clinical practice or instruction of the health profession or the specialty.
>
> (d) The relevancy of the expert witness's testimony." [*Woodard, supra*, pp 557-558, 572, quoting MCL 600.2169(1) and (2).]

The parties do not dispute that Dr. Mehlman is a licensed health professional who specialized in emergency medicine, like Dr. Palffy. Dr. Mehlman was board certified in emergency medicine and served as the director of emergency medicine at a community hospital at the time of plaintiff's stroke. Therefore, Dr. Mehlman would have been qualified under MCL 600.2169.

Plaintiff argues that Dr. Mehlman's qualifications, which included 21 years of emergency room practice, should have been a determining factor in the trial court's reliability determination. He claims that supportive literature, such as position papers and hospital guidelines, should not substitute for Dr. Mehlman's clinical judgment. However, a trial court may "disqualify an expert

witness on grounds other than the qualifications set forth" in MCL 600.2169. *Woodard, supra,* p 572. Pursuant to MCL 600.2955:

> "(1) In an action for the death of a person or for injury to a person or property, a scientific opinion rendered by an otherwise qualified expert is not admissible unless the court determines that the opinion is reliable and will assist the trier of fact. In making that determination, the court shall examine the opinion and the basis for the opinion, which basis includes the facts, technique, methodology, and reasoning relied on by the expert, and shall consider all of the following factors:
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> (a) Whether the opinion and its basis have been subjected to scientific testing and replication.
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> (b) Whether the opinion and its basis have been subjected to peer review publication.
>
> (c) The existence and maintenance of generally accepted standards governing the application and interpretation of a methodology or technique and whether the opinion and its basis are consistent with those standards.
>
> (d) The known or potential error rate of the opinion and its basis.
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> (e) The degree to which the opinion and its basis are generally accepted within the relevant expert community. As used in this subdivision, "relevant expert community" means individuals who are knowledgeable in the field of study and are gainfully employed applying that knowledge on the free market.
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> (f) Whether the basis for the opinion is reliable and whether experts in that field would rely on the same basis to reach the type of opinion being proffered.
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> (g) Whether the opinion or methodology is relied upon by experts outside of the context of litigation.
>
> (2) A novel methodology or form of scientific evidence may be admitted into evidence only if its proponent establishes that it has achieved general scientific acceptance among impartial and disinterested experts in the field." [*Id.*, p 573, quoting MCL 600.2955.]

Finally, pursuant to MRE 702:

> If the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case. [*Id.*, p 574, quoting MRE 702.]

In effect, the trial court serves as a gatekeeper to "ensure that each aspect of an expert witness's proffered testimony . . . is reliable." *Gilbert, supra,* p 779.

In his opinion, the trial judge wrote that "[t]he standard of practice is an objective, discernible standard - it is not a "what should be" standard, but a "what is" standard…" Yet the very nature of a standard of practice renders it less than objective. The literature offers two measures for the standard of care in medicine. One measure is found in the "generally accepted" consensus of the scientific community. That standard would require an expert to aver that majority of the practitioners and scholars have an agreement about a particular method of care. The other measure comes painfully close to the "what should be" standard. Where there is controversy among a scientific community, a methodology may be the standard of care when it is supported by "evidence–based science". Williams, *Evidence Based Medicine In the Law Beyond Clinical Practice Guidelines: What Effect will EBM have on the Standard of Care*, 61 Wash & Lee L Rev 479 (2004). In this case the trial judge found that the expert was unable to demonstrate that his articulation of the standard was generally accepted or was supported by strong science methods. We cannot find that either fact-finding was outside the range of principled outcomes.

Plaintiff failed to offer any reliable evidence to support his opinion regarding whether the standard of care was generally accepted in the relevant expert community. Although Dr. Mehlman identified several major hospitals, such as Stanford and Harvard, that utilized t-PA five years after plaintiff's stroke, the majority of hospitals failed to administer it in a study that included 2001. He was unable to offer any example other than his own practice of an institution utilizing t-PA in 2001. The defense expert testified in an unqualified manner that the administration of t-pa was not the standard as of 2001. The court considered articles and bulletins offered by the defense that were critical of the use of t-PA. within one year of the treatment of plaintiff. Several organizations, such as the American College of Emergency Physicians ("ACEP"), the American Academy of Emergency Medicine, and the Society for Academic Emergency Medicine, released position statements soon after plaintiff's stroke stating that the standard of care did not yet mandate the use of t-PA in clinical practice. See Adams, *The Society for Academic Emergency Medicine Position on Optimizing Care of the Stroke Patient,* 10 Academic Emergency Medicine 805 (2003); Uraneck, *ACEP Crafts t-PA For Stroke Policy*, ACEP News (May 2002). Furthermore, other experts and the Canadian Association of Emergency Physicians explained that further research was necessary before it could be the standard of care in clinical practice. Ingall, *Findings From the Reanalysis of the NINDS Tissue Plasminogen Activator for Acute Ischemic Stroke Treatment Trial*, 35 Stroke 2418 (2004).

As such, the evidence shows that t-PA was administered infrequently in the emergency medical community at the time of plaintiff's stroke and afterward. Schumacher, *Use of Thrombolysis in Acute Ischemic Stroke: Analysis of the Nationwide Inpatient Sample 1999 to 2004*, 50 Annals of Emergency Medicine 99 (2007). Even five years after plaintiff's stroke, 24 percent of emergency physicians surveyed were unlikely or very unlikely to use t-PA and 16 percent were uncertain whether they would use t-PA with an ideal candidate. Glauser, *Will EPs' Reluctance to Embrace Thrombolysis for Stroke Lead to Lawsuits?: Part 2 in a Series*, 28 Emergency Medicine News 28 (2006).

The Court also found that the use of t-PA was not supported by "good science." Dr. Mehlman based his opinion that the administration of t-PA was the standard of care in part on

the positive outcomes in the NINDS study. The court evaluated that study in light of MCL 600.2955(1)(A) and found that it had insufficient indicia of reliability. The results of the NINDS study were not replicated in five other randomized controlled studies occurring prior to plaintiff's stroke, but were replicated in community-based studies in 1998 and 2000. See Buchan, *Effectiveness of t-PA in Acute Ischemic Stroke,* 54 Neurology 679 (2000); Katzan, *Use of Tissue-Type Plasminogen Activator for Acute Ischemic Stroke: The Cleveland Area Experience*, 283 The Journal of the American Medical Association 1151 (2000); Toni, *Early Intravenous Thrombolysis for Acute Ischemic Stroke in a Community-Based Approach,* 29 Stroke 1544 (1998). Dr. Mehlman testified that the positive outcomes necessitated the standard of care. Regardless of the positive outcomes, Dr. Mehlman acknowledged that the scientific testing also found negative outcomes and risks. The NINDS study revealed that t-PA patients were ten times more likely than placebo patients to experience hemorrhaging. Also, one community-based study revealed higher mortality rates in t-PA patients. See Katzan, *supra.* Because of its negative outcomes and risks, peer review publications suggested that the use of t-PA was controversial. Thus, the scientific findings and peer review publications demonstrating controversy and significant risks involving t-PA undermined the reliability of Dr. Mehlman's opinion of the standard of care based only on t-PA's positive outcomes. Consequently, we conclude that it was not outside the range of principled outcomes when the trial court found Dr. Mehlman's testimony unreliable and inadmissible.

In addition, plaintiff argues that the trial court should have allowed the jury to weigh Dr. Mehlman's testimony regarding the standard of care against the conflicting testimony from defendants' experts. We disagree.

> [W]hen determining whether a witness is qualified as an expert, the trial court should not weigh the proffered witness's credibility. Rather, a trial court's doubts pertaining to credibility, or an opposing party's disagreement with an expert's opinion or interpretation of facts, present issues regarding the weight to be given the testimony, and not its admissibility. [*Surman, supra*, pp 309-310.]

We acknowledge that the trial court's opinion was laced with references to credibility. The trial court noted, "[b]ased on the Court's evaluation of the witnesses demeanor, veracity, honesty and integrity, the court finds . . ." However at the end of the opinion the court noted, "[t]here is overwhelming evidence before the Court that use of t-PA is controversial among emergency physicians and that it was not the standard of care in 2001." The opinion must be read as a whole. While the references to reliability are plentiful, so are the findings regarding reliability. The trial court was obliged to answer the preliminary question of Dr. Mehlman's reliability before the question of fact regarding the standard of care could be presented to the jury. To gauge reliability pursuant to MRE 702 and MCL 600.2955, the trial court could not rest on Dr. Mehlman's testimony regarding his qualifications. Instead, the trial court evaluated Dr. Mehlman's opinion in light of the facts presented at the evidentiary hearing, scientific testing, replication, peer review, and acceptance within the relevant expert community. *Woodard*, *supra*, p 572. The trial court's reliability determination was necessary for admissibility purposes, not a determination of the weight of Dr. Mehlman's testimony. This method of gate-keeping did not invade the province of the jury. Following *Surman, supra*, pp 309-310, the trial court erred when it weighed Dr. Yagey's opinion against Dr. Mehlman's opinion. Nevertheless, the error was harmless given the independent finding that Dr. Mehlman's testimony was neither scientifically

reliable nor generally accepted within the relevant expert community, and therefore, unreliable. Absent the trial court's error in considering Dr. Yagey's testimony and credibility, Dr. Mehlman's testimony would have still been inadmissible.

Affirmed.

/s/ Kathleen Jansen
/s/ Stephen L. Borrello
/s/ Cynthia Diane Stephens