STATE OF MICHIGAN

COURT OF APPEALS

JESUBEN ENGELHARDT and LORI ENGELHARDT,

Plaintiffs-Appellees,

v

ST. JOHN HEALTH SYSTEM—DETROIT-MACOMB CAMPUS, d/b/a ST JOHN MACOMB HOSPITAL,

Defendant-Appellant,

and

RAJESH C. BHAGAT, M.D. and RAJESH C. BHAGAT, M.D., P.C.,

Defendants.

UNPUBLISHED
April 19, 2012

No. 292143
Macomb Circuit Court
LC No. 2007-004652-NM

Before: WILDER, P.J., and WHITBECK and FORT HOOD, JJ.

PER CURIAM.

In this action alleging "negligent credentialing," defendant, St. John Health System—Detroit-Macomb Campus, d/b/a St. John Macomb Hospital, appeals, by order of the Supreme Court,[1] an order granting plaintiffs' motion for reconsideration and denying its motion for summary disposition. We reverse.

I. FACTS AND PROCEDURAL HISTORY

Plaintiff, [2] Jesuben Engelhardt, worked in a job requiring repetitive movements. He was diagnosed by a neurologist as having carpal tunnel syndrome. The neurologist referred plaintiff

[1] The Supreme Court remanded this appeal to this Court to consider St. John Macomb Hospital's appeal as on leave granted. *Engelhardt v St John Health Sys—Detroit-Macomb Campus*, 486 Mich 867; 780 NW2d 572 (2010).

[2] We use "plaintiff" to refer to Jesuben Engelhardt and "plaintiffs" when including Lori Engelhardt, whose claims are derivative.

to Dr. Rajesh C. Bhagat for hand surgery. Dr. Bhagat performed arthroscopic hand surgery on plaintiff in May 2005, at defendant hospital. Dr. Bhagat allegedly nicked a nerve, causing problems with pain and sensation in plaintiff's hand.

Plaintiffs commenced this action alleging, against defendant, negligent credentialing. Other claims were asserted that are not at issue on appeal. Plaintiffs alleged that, between 1984 and 2002, former patients of Dr. Bhagat filed 17 actions alleging medical malpractice, which should have raised a red flag, such that defendant should have denied recredentialing in 2004. Plaintiffs settled with Dr. Bhagat regarding the claims against him. Also, plaintiffs and defendant stipulated to the dismissal of the vicarious liability claims against defendant, leaving only the negligent credentialing claim as the only claim pending at the trial court.

Deposition testimony and other evidence revealed that Dr. Bhagat, a hand surgeon, received board certification for general surgery in 1977 and 1998, and board certification (or a certificate of added qualification) in hand surgery in 2001. He did not fail any of the examinations. Dr. Bhagat was a staff physician for defendant. Staff physicians were at all relevant times subject to the reappointment process every two years. Reappointments at defendant hospital for Dr. Bhagat, prior to the surgery in question, occurred in 1997, 1998, 2000, 2002, and 2004.

In or around 2004, Dr. Bhagat applied for recredentialing.[3] The credentials committee, also known as the medical executive committee, consisted, at that time, of 19 doctors, including Roberto Barretto, M.D., a physician adviser to defendant hospital who had previously been chief medical officer and vice-president of medical affairs for defendant. The credentialing committee granted Dr. Bhagat's 2004 application for recredentialing. Defendant's board of trustees (which is also its quality committee), made final decisions regarding recredentialing, after a recommendation by the credentialing committee. The Board of Trustees consisted of ten individuals, six of them doctors, including Dr. Barretto (and at least one lawyer, Richard Kitch). The credentialing decisions were made based on qualifications and criteria set forth in defendant's bylaws. Under defendant's bylaws, the applicant's professional competence and judgment are reviewed in the reappointment process. The applicant must disclose any "liability actions including adverse final judgments or settlements and pending liability claims." That information must be kept in the physician's medical staff file.

Dr. Bhagat testified that the past court actions were because of recognized complications of the surgeries performed. He stated that many of the prior actions were dropped or he was "acquitted." He testified that there were some nuisance lawsuits that the insurance carrier decided to settle. He denied that he committed malpractice.

[3] Credentialing means a hospital giving a doctor formal permission to treat specific conditions or to perform particular procedures at the hospital, based on the physician's experience, training, and performance criteria. See generally MCL 333.21513.

In contrast, plaintiffs presented their credentialing expert, Dr. Carungi, who testified to both the credentialing standard-of-care and causation. Dr. Carungi stated that defendant should have either denied recredentialing to Dr. Bhagat or mentored his care. He testified:

> *Q*. Now I believe you said that one of your options regarding Dr. Bhagat's privileges in 2004 would be to have him mentored; is that correct?
>
> *A*. Some type of review mentoring. Put something in place that would protect the public.
>
> *Q*. And what do you envision this being?
>
> *A*. After looking at the case, prior to him being credentialed in 2004, I would think that they would have asked him to – here is what you can do. You can ask someone if you're worried about their cognitive knowledge, to go take a review exam. You can ask them to take additional CMEs [continuing medical education courses]. You can have the other hand surgeons that are on staff . . . review his work concurrently [by] being in the operating room with him. You can trigger a retrospective review of the [past court] cases. There's a number of things that you can certainly do.

Dr. Carungi opined that the numerous past legal actions against Dr. Bhagat should have triggered defendant's credentialing committee to conduct an examination. This investigation would look at the past legal actions for patterns or increases in the severity of the cases, as well as looking at the types of injury. He claimed that the *dispositions* of the past actions are not as important as the *basis* for the claims and that the past actions should be investigated "[n]ot to determine what went on from a legal perspective, but [to determine if] there a practice pattern that is dangerous that going forward would cause or be a danger to the community."

Dr. Carungi testified that defendant should have had a robust credentialing process to protect the public. More specifically, Dr. Carungi testified that if problems exist with an applicant, the committee should either deny the application or provide mentoring by staff doctors to make sure injuries do not occur.

Dr. Carungi specified particular court actions by prior patients that should have been treated as red flags but emphasized that the sheer number of the cases (along with the fact that three of them were somewhat similar to this case) should have prompted defendant to investigate. Dr. Carungi testified that the large number of court actions by prior patients was indicative of negligence in the credentialing process:

> The problem that I have is that if you have a structure and the structure seems decent—or the process seems decent for credentialing, that means that you should have your process, and you have a process in place to achieve a desired end result. That desired end result, as all credentialing is, is for the protection and well-being of the community that that particular facility serves. If you look at the process, whether it's from either lack of internal reporting from the quality perspective; whether it's from lack of listening to people in your institution if some things aren't being done formerly [sic; formally]; if it's a lack of knowing

> and really looking back at someone's body of work or problems that they've had. And once someone gets through that process, I can appreciate having, over the course, a couple of problems that were actually gone forward and settled *but when you have a volume of problems that this doctor had*, looking at that particular process, either the process either isn't being followed or there's some holes in it someplace. [Emphasis added.]

Dr. Carungi specified the actions that could have been taken by defendant in response to the factors that should have called Dr. Bhagat's suitability into question (such as the prior actions). The hospital could have asked Dr. Bhagat to take a review exam, or additional continuing education courses, or have other similar physicians present in the operating room. But Dr. Carungi admitted that he had no knowledge of whether defendant did any of these things.

For his own investigation, Dr. Carungi reviewed the complaints in five of the prior actions against Dr. Bhagat (in the cases known as *Kelly*, *Weisel*, *Stevens*, *Kukola*, and *Goleniak*) and reviewed the complaint and some depositions in a sixth case (*Marion*). He was not aware of the outcome in any of the cases except *Marion*, which he believed was settled, but he did not know the settlement figure. Dr. Carungi did not speak to any of the attorneys or anyone else involved in the prior actions and did not know if any of the cases were reported to the data bank (the national practitioner data bank, a database about doctors). Regarding the significance of the prior actions, Dr. Carungi testified, by way of example, as follows regarding the *Kukola* action:

> *Q*. These are all the allegations?
>
> *A*. Yes; these are the allegations.
>
> *Q*. What about it, if anything, raised a red flag?
>
> *A*. Again, it's a red flag. Something *could* have been done wrong. Something could not have been done wrong. You take it in totality of everything else you have going on. [Emphasis added.]

Dr. Carungi did no investigation at all of the other 11 actions alleged by plaintiffs to have been filed against Dr. Bhagat between 1984 and 2002. He did not even know if those actions were against Dr. Bhagat, or another similarly situated physician, since he had not done any primary-source verification.

Defendant moved for summary disposition on the negligent credentialing claim, under MCR 2.116(C)(8) and (C)(10), arguing that plaintiffs did not establish causation-in-fact because, had the hospital provided mentoring for Dr. Bhagat (as Dr. Carungi alleged it should have done), this would not necessarily have prevented the injury. Defendant further argued that the mere number of past legal actions against Dr. Bhagat is an insufficient basis on which to deem Dr. Bhagat incompetent and to find that the hospital was negligent by recredentialing him.

Plaintiffs argued, in opposition, that had defendant used proper credentialing procedures, the fact of the numerous prior court actions against Dr. Bhagat would have resulted either in a rejection of his application or a provision for mentoring. In turn, Dr. Bhagat either would not have performed the surgery or would have received mentoring before it.

In its initial ruling, the circuit court agreed with defendant and granted summary disposition in its favor on the negligent credentialing claim, finding that Dr. Carungi failed to identify anything in defendant's procedures that violated the credentialing standard of care. The circuit court also found a lack of evidence of cause-in-fact. Accordingly, the court found plaintiffs' causation theory to be speculative.

Plaintiffs moved for reconsideration, attaching an affidavit by Dr. Carungi dated after his deposition and those of Dr. Guy Pierret (division chief for hand surgery), Marcia Webb (defendant's credentialing coordinator), and Dr. Barretto. Dr. Carungi opined that defendant was negligent in failing to investigate and review Dr. Bhagat's "malpractice history" and negligent in granting him privileges without conditions such as mentoring or supervision. Dr. Carungi also addressed causation:

> More likely than not, had the defendant hospital appropriately investigated and reviewed defendant Bhagat's long-term malpractice history, then the standards of practice and care required the hospital to either deny defendant Bhagat privileges, or grant privileges only with the condition that he only practice medicine with the mentor and/or under direct supervision.
>
> * * *
>
> More likely than not, Mr. Engelhardt's injuries would not have occurred but for the defendant hospital's negligent acts and omissions in either failing to deny defendant Bhagat privileges or in failing to grant privileges with the condition that he only practice medicine with a mentor and/or under direct supervision.

In sum, plaintiffs argued that, in light of Dr. Carungi's affidavit, they presented sufficient proofs of negligence and causation. The circuit court agreed with plaintiffs and reversed its summary disposition ruling, finding questions of fact regarding negligent credentialing and causation.

Defendant then, in turn, filed its own motion for reconsideration, which the trial court denied. Defendant applied to this Court for leave to appeal but was denied. *Engelhardt v St John Health Sys—Detroit-Macomb Campus*, unpublished order of the Court of Appeals, entered September 9, 2009 (Docket No. 292143). Defendant then applied to the Supreme Court, and the Supreme Court remanded to this Court for consideration as on leave granted. *Engelhardt v St John Health Sys—Detroit-Macomb Campus*, 486 Mich 867; 780 NW2d 572 (2010).

II. STANDARD OF REVIEW

A trial court's decision on a motion for summary disposition is reviewed de novo. *Willett v Waterford Charter Twp*, 271 Mich App 38, 45; 718 NW2d 386 (2006). A motion for summary disposition under subrule MCR 2.116(C)(8) tests the legal sufficiency of the pleadings, *Johnson-McIntosh v City of Detroit*, 266 Mich App 318, 322; 701 NW2d 179 (2005), and the pleadings are considered alone, without consideration of evidence, MCR 2.116(G)(5). So, where, as here, the parties rely on documentary evidence, appellate courts instead proceed under the standards of review applicable to a motion made under subrule MCR 2.116(C)(10). *The Healing Place at N Oakland Med Ctr v Allstate Ins Co*, 277 Mich App 51, 55; 744 NW2d 174 (2007). A motion

made under this subrule tests the factual support for a claim 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. *Id.* at 56. When the burden of proof at trial would rest on the nonmoving party, the nonmovant may not rely on mere allegations or denials in the pleadings, but must, by documentary evidence, set forth specific facts showing that there is a genuine issue for trial. *Id*. A genuine issue of material fact exists when the record leaves open an issue upon which reasonable minds could differ. *Id*.

In addition, duty is a question of law for the court, *In re Duane v Baldwin Trust*, 274 Mich App 387, 401; 733 NW2d 419 (2007), and is therefore reviewed de novo, *Brown v Brown*, 478 Mich 545, 552; 739 NW2d 313 (2007). Whether a causation theory is too speculative may be decided as a matter of law. *Mettler Walloon, LLC v Melrose Twp*, 281 Mich App 184, 217; 761 NW2d 293 (2008). Any underlying questions of statutory interpretation are also reviewed de novo. *McManamon v Redford Charter Twp*, 273 Mich App 131, 134; 730 NW2d 757 (2006).

III. ANALYSIS

Although conceding a general duty of care with respect to credentialing physicians, defendant first argues that the mere fact that malpractice lawsuits have been filed against a physician is not a sufficient basis upon which to establish physician incompetency and liability by a hospital for negligent credentialing. According to defendant, the existence of such lawsuits is irrelevant to a physician's competence and expertise, and therefore, creates no foreseeable risk of injury. Thus, defendant contends that a hospital's failure to take corrective action against a doctor based solely on the filing of lawsuits cannot be considered a proximate or legal cause of the injury to the plaintiff in this case. Defendant further asserts that, even if it did breach the standard of care by failing to adequately investigate the merits of the malpractice suits filed against Dr. Bhagat, liability cannot be imposed upon the hospital because plaintiffs and their expert, Dr. Carungi, presented no evidence regarding the underlying merits or outcomes of any of the malpractice claims. Defendants also contend that, in fact, the evidence established that the prior suits were without merit and that, similarly, plaintiffs assertion that the record has sufficient evidence of causation-in-fact is without merit because plaintiffs cannot show that any investigation by defendant would have resulted in mentoring or revocation of privileges that would have prevented plaintiff's injury.

"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." *Teal v Prasad*, 283 Mich App 384, 390-391; 772 NW2d 57 (2009), quoting MCL 600.2912a(2). "To establish medical malpractice, a plaintiff must prove the following elements: (1) the applicable standard of care, (2) breach of that standard, (3) injury, and (4) proximate causation between the alleged breach and the injury." *Velez v Tuma*, 283 Mich App 396, 398; 770 NW2d 89 (2009). In any negligence case, the plaintiff has the burden of producing evidence sufficient to support a prima facie case on each element, see *Berryman v Kmart Corp*, 193 Mich App 88, 91-92; 483 NW2d 642 (1992), and the mere occurrence of an accident is not evidence of negligence, *Clark v Kmart Corp*, 242 Mich App 137, 140; 617 NW2d 729 (2000), rev'd on other grounds 465 Mich 416 (2001). Generally expert testimony is required to establish the applicable standard of care and breach. *Locke v Pachtman*, 446 Mich 216, 230; 521 NW2d 786 (1994). A plaintiff's theory in a medical malpractice case

must be pleaded with specificity, and the proofs must accord with the theories pleaded. *Badalamenti v William Beaumont Hosp-Troy*, 237 Mich App 278, 284; 602 NW2d 854 (1999).

A. Duty

"The threshold question in a negligence action is whether the defendant owed a duty to the plaintiff. It is axiomatic that there can be no tort liability unless defendants owed a duty to plaintiff." *Fultz v Union-Commerce Assoc*, 470 Mich 460, 463; 683 NW2d 587 (2004) (internal quotation marks and citation omitted). A duty, in its general form, is an obligation that the defendant has to the particular claimant to avoid faulty conduct. See *Terry v City of Detroit*, 226 Mich App 418, 424; 573 NW2d 348 (1997). If a court determines as a matter of law that a defendant owed no duty, summary disposition is appropriate. *Id*. The question of duty turns on the relationship between the defendant and the person whose injury was allegedly caused by the defendant's acts or failures to act. *Krass v Tri-Co Security, Inc*, 233 Mich App 661, 668; 593 NW2d 578 (1999). Essentially, the question of duty is a public-policy question of whether the defendant should be held responsible for the conduct or inaction in question. See, e.g., *Williams v Cunningham Drug Stores, Inc*, 429 Mich 495, 500-501; 418 NW2d 381 (1988).

This Court has recognized that a hospital has the duty to insure the quality of its physicians[4] when it held that, "[o]ne of the hospital's primary functions is to screen its staff of physicians to 'insure' that only competent physicians are allowed to practice in the hospital." *Ferguson v Gonyaw*, 64 Mich App 685, 697; 236 NW2d 543 (1975). In that case, in evaluating a claim that the defendant hospital was negligent in allowing a doctor to be a staff member, this Court held the hospital to the standard of "a reasonably prudent hospital." *Id*. at 697-698.

Further, MCL 333.21513 provides certain duties for hospitals with respect to credentialing. It provides, in relevant part:

> The owner, operator, and governing body of a hospital licensed under this article:
>
> (a) *Are responsible for* all phases of the operation of the hospital, *selection of the medical staff*, and quality of care rendered in the hospital.
>
> * * *
>
> (c) Shall assure that physicians . . . admitted to practice in the hospital are granted hospital privileges consistent with their individual training, experience, and other qualifications. [Emphasis added.]

[4] "Negligent credentialing" has been held to be a valid common-law cause of action in some 28 sister states. E.g., *Archuleta v St Mark's Hosp*, 238 P3d 1044 (Utah, 2010) (analyzing how it is merely an application of common-law negligence rules). A majority of states that have considered the issue have concluded that negligent credentialing claims state a valid cause of action. See *Larson v Wasemiller*, 738 NW2d 300, 306-307 (Minn, 2007). The parties in this case treated the action as a medical malpractice claim.

Accordingly, as conceded by defendants, a hospital has a duty of due care in credentialing a physician. It is foreseeable that if the hospital does a poor job at credentialing, someone might be injured by an incompetent doctor.

B. Breach

Having concluded that defendants owed a duty to plaintiff, we next consider whether the trial court correctly concluded that there was sufficient evidence of a breach of that duty, such that denial of defendant's summary disposition motion was warranted.

Plaintiffs alleged, through Dr. Carungi's testimony, that the hospital breached its duty of due care when it failed to properly investigate Dr. Bhagat's litigation history, which if done properly, would have led to the hospital taking other actions. Specifically, plaintiffs allege these other actions could have included denying Dr. Bhagat's recredentialing or implementing some other safeguards, such as requiring additional training/testing or having other surgeons present while Dr. Bhagat operated on patients.

"The question whether a defendant has breached a duty of care is ordinarily a question of fact for the jury and not appropriate for summary disposition." *Latham by Perry v Nat'l Car Rental Sys, Inc*, 239 Mich App 330, 340; 608 NW2d 66 (2000). But if the evidence is insufficient to establish this element, similar to any other element, then summary disposition is proper. *Id.* Here, Dr. Webb testified that the committee did not receive information regarding the disposition of Dr. Bhagat's prior court actions. We find that this evidence was sufficient to create a question of fact regarding whether defendant breached its duty. Therefore, summary disposition is not warranted on this element.

C. Causation

"To establish proximate cause, [a] plaintiff must prove the existence of both cause in fact and legal cause." *Velez*, 283 Mich App at 398. "To prove cause in fact, the plaintiff must present substantial evidence from which a jury may conclude that more likely than not, but for the defendant's conduct, the plaintiff's injuries would not have occurred." *Id.* (internal quotations omitted); see also MCL 600.2912a(2). "To prove legal cause, the plaintiff must show that it was foreseeable that the defendant's conduct may create a risk of harm to the victim, and . . . [that] the result of that conduct and intervening causes were foreseeable." *Id.* (internal quotations omitted, brackets in original).

Regarding cause in fact, which is at issue here, our Supreme Court has explained:

> Generally, an act or omission is a cause in fact of an injury only if the injury could not have occurred without (or "but for") that act or omission. While a plaintiff need not prove that an act or omission was the sole catalyst for his injuries, he must introduce evidence permitting the jury to conclude that the act or omission was a cause.
>
> It is important to bear in mind that a plaintiff cannot satisfy this burden by showing only that the defendant may have caused his injuries. Our case law requires more than a mere possibility or a plausible explanation. Rather, a

> plaintiff establishes that the defendant's conduct was a cause in fact of his injuries only if he sets forth specific facts that would support a reasonable inference of a logical sequence of cause and effect. A valid theory of causation, therefore, must be based on facts in evidence. And while the evidence need not negate all other possible causes, this Court has consistently required that the evidence exclude other reasonable hypotheses with a fair amount of certainty. [*Craig v Oakwood Hosp*, 471 Mich 67, 87-88; 684 NW2d 296 (2004) (footnotes and emphasis omitted).]

In this case, there is not enough evidence of cause in fact, let alone legal cause, to support plaintiffs' claim. Plaintiffs failed to establish that, but for the hospital's failure to adequately investigate Dr. Bhagat's history, plaintiff would not have suffered his injury. First, no evidence was produced detailing the culpability of Dr. Bhagat in these prior lawsuits.[5] The fact that a doctor is sued in a medical malpractice lawsuit does not mean that the doctor committed the alleged negligent acts; a complaint is merely an *allegation*. See MCR 2.111(B)(1). The mere fact that lawsuits were filed against Dr. Bhagat, without more, is insufficient evidence that, had the credentialing committee known of the prior court actions *alleging* malpractice, they would or should have denied recredentialing. Plaintiff's suggestion that the hospital would have taken alternate action is the type of "mere possibility" that the Supreme Court deemed inadequate. *Craig*, 471 Mich at 87. Thus, we reject plaintiffs' contention that the mere knowledge of these prior allegations by the credentialing committee was more likely than not to have generated some action by the committee that would have prevented plaintiff's alleged harm.

In sum, based on the foregoing evidence and reasoning, it remains speculative whether plaintiff's injuries would have been prevented if the hospital had investigated and discovered the history of court actions against Dr. Bhagat. Accordingly, because plaintiffs' theory of causation-in-fact supporting their negligent credentialing claim is mere speculation, the circuit court erred in denying the hospital's motion for summary disposition.

Given our conclusion regarding causation, we need not address defendant's additional argument that Dr. Carungi's expert assertions regarding the standard of practice did not reflect actual customary credentialing practice and were not based on adequate or reliable data.

Reversed. Defendant, the prevailing party, may tax costs pursuant to MCR 7.219.

/s/ Kurtis T. Wilder
/s/ William C. Whitbeck

[5] In fact, Dr. Bhagat denied committing malpractice in these prior lawsuits, and plaintiffs presented no evidence to show that his denials were not accurate.