

STATE OF MICHIGAN
COURT OF APPEALS

JEROME E. CRAWFORD,

Plaintiff-Appellant/Cross-Appellee,

v

WILLIAM BEAUMONT HOSPITAL,

Defendant-Appellee,

and

CARDIOLOGY ASSOCIATES OF
BIRMINGHAM, P.C., DANIEL G. WALSH,
M.D., and STEVEN M. KOROTKIN,

Defendants-Appellees/Cross-
Appellants.

UNPUBLISHED
October 2, 2012

No. 298914
Oakland Circuit Court
LC No. 2008-093768-NH

Before: JANSEN, P.J., and BORRELLO and BECKERING, JJ.

PER CURIAM.

In this medical malpractice action, plaintiff Jerome E. Crawford appeals as of right, challenging two circuit court orders that granted summary disposition to defendants William Beaumont Hospital and Dr. Steven M. Korotkin. Plaintiff also challenges an order denying his motion for leave to file a second amended complaint. In a cross-appeal, defendants Cardiology Associates of Birmingham, P.C., Dr. Daniel G. Walsh, and Dr. Korotkin (collectively the “Cardiology Associates defendants”) challenge the circuit court’s order denying their motion for summary disposition and an order denying their motion to exclude testimony by one of plaintiff’s experts. For the reasons set forth in this opinion, we affirm in part, reverse in part, and remand for further proceedings.

I. FACTS & PROCEDURAL HISTORY

On August 13, 2008, plaintiff commenced this medical malpractice litigation against Beaumont Hospital, Cardiology Associates, and Drs. Walsh and Korotkin, who allegedly were “actual or ostensible agent[s] and/or employee[s] of” both the hospital and Cardiology Associates. Plaintiff averred that at approximately 8:00 a.m. on May 6, 2007, he went to the

emergency room of Beaumont Hospital in Royal Oak “because he was experiencing shortness of breath and chest tightness.” According to the complaint, plaintiff found himself in the care of cardiologists Dr. Walsh and Dr. Korotkin, “and Karen Kacer, PA-C [a certified physician’s assistant], all of wh[om] are affiliated with Cardiology Associates[.]” Plaintiff’s treatment team performed an electrocardiogram, took a chest x-ray that “revealed evidence of cardiomegaly,” diagnosed plaintiff with atrial fibrillation, gave him intravenous Heparin, Cardizem, and Rythmol, and admitted plaintiff to the hospital at 5:22 p.m. An echocardiogram the next day, May 7, 2007, “confirmed the diagnosis of atrial fibrillation.” That same day, Dr. Walsh performed on plaintiff “a transesophageal echocardiogram (TEE) guided cardioversion,” and plaintiff “was discharged from the hospital” on May 8, 2007. Plaintiff complained that although he had received Heparin during his hospital stay, his “discharge medications did not include an anticoagulant.”

On May 9, 2007, plaintiff visited Cardiology Associates where Kacer “evaluated [plaintiff] and placed him on a 24-hour ECG monitor,” but again no one prescribed plaintiff an anticoagulant. Nine days later, on May 18, 2007, plaintiff returned to Beaumont Hospital after experiencing “dizziness, confusion, right sided weakness, facial droop and aphasia,” and “was diagnosed with having suffered an acute cerebrovascular accident,” which caused permanent brain injury and cognitive impairment. Count I of the complaint alleged professional negligence against Dr. Walsh for failing to prescribe for plaintiff, or ensure that he received a prescription for, “therapeutic anticoagulants after cardioversion and upon discharge from the hospital on May 8, 2007.” Count II claimed professional negligence by Dr. Korotkin in the following particulars: failing to prescribe for plaintiff, or ensure that he received a prescription for, therapeutic anticoagulants, both (a) “after cardioversion and upon discharge from the hospital on May 8, 2007,” and (b) “upon presenting to the offices of Cardiology Associates . . . on May 9, 2007.” Count III asserted professional negligence by Kacer, another purported “actual or ostensible agent and/or employee” of Beaumont Hospital and Cardiology Associates; the averments in a first amended complaint that plaintiff filed on May 6, 2009, contend that Kacer “failed to prescribe [plaintiff] the appropriate course of therapeutic anticoagulants” at Cardiology Associates “on May 9, 2007, pending a discussion with” Dr. Korotkin, or to timely inform Dr. Korotkin on May 9, 2007, that plaintiff “was not on the appropriate course of therapeutic anticoagulants[.]”¹

Defendants filed three motions for summary disposition. Dr. Korotkin filed the first motion on December 23, 2009, seeking summary disposition of the claims against him “under MCR 2.116(C)(10) . . . because there is no genuine issue of material fact that Dr. Korotkin did not breach the standard of practice.” Dr. Korotkin maintained that the evidence undisputedly showed that he “had no involvement in the decision whether to prescribe Coumadin to” plaintiff, and “no plausible theory of liability [existed] against Dr. Korotkin[.]” Dr. Korotkin added that even plaintiff’s “cardiology expert . . . does not believe that Dr. Korotkin breached the standard of practice.”

¹ Other than different specific assertions against Kacer, plaintiff’s first amended complaint contained the same allegations as the original complaint.

Plaintiff responded that ample evidence gave rise to a material issue of fact concerning Dr. Korotkin's negligent failure to prescribe an anticoagulant when plaintiff went to the Cardiology Associates office on May 9, 2007. Plaintiff conceded that he had no personal contact with Dr. Korotkin at Cardiology Associates on May 9, 2007, an unscheduled visit occasioned by "an adverse reaction to Lisinopril." However, plaintiff identified the following evidence as raising a genuine issue of fact relating to Dr. Korotkin's negligent treatment: a note by Kacer that documented plaintiff's recent symptoms and treatment and his medications at the time of his May 9, 2007, visit to Cardiology Associates; Kacer's deposition testimony that "she consulted with Dr. Korotkin, while [plaintiff] was in the office, with respect to whether or not the Lisinopril should be discontinued," and "they did not discuss other medications that [plaintiff] was on"; testimony by plaintiff's certified physician's assistant expert "that the standard of care required . . . Kacer to advise Dr. Korotkin as to the hospitalization and the pertinent findings and therapies that were provided during the hospitalization, including the fact that [plaintiff] was discharged without anticoagulation"; and plaintiff's two cardiology experts agreed that, assuming Kacer had fully advised Dr. Korotkin of plaintiff's health issues and medications, Dr. Korotkin should have prescribed plaintiff an anticoagulant. Plaintiff also pointed out that pursuant to MCL 333.17078(1) "Dr. Korotkin is vicariously liable for the negligence of . . . Kacer. . . by operation of law."

At a March 31, 2010, hearing, the circuit court granted Dr. Korotkin's motion for summary disposition. The court concluded as follows:

As to Dr. Korotkin's motion for summary disposition the Court grants this motion for the reason there's no genuine issue of material fact that Dr. Korotkin did not breach the standard of care.

Here Dr. Korotkin did not see plaintiff during his hospitalization from May sixth to May eighth, 2007. He did not see the plaintiff on May ninth when plaintiff presented to the Cardiology Associates for an unscheduled appointment due to plaintiff's reaction to Lisinopril. Nor did the defendant see plaintiff on May 10th when he dropped off his monitor and diary. . . .

That same day, the circuit court entered a written order granting Dr. Korotkin's motion "for the reasons stated on the record."

The Cardiology Associates defendants filed a motion for summary disposition under MCR 2.116(C)(10), on the basis that "no genuine issue of material fact [existed] that Plaintiff cannot establish that Defendants [sic] alleged malpractice was a proximate cause of Plaintiff's stroke nor that Plaintiff's alleged loss of an opportunity to achieve a better result exceeds 50%." The Cardiology Associates defendants first insisted that even had they "breached the standard of practice" by failing "to prescribe [plaintiff] Coumadin after successful cardioversion," "no credible evidence . . . [showed] that the failure to prescribe Coumadin was a proximate cause of the stroke." They theorized that because plaintiff's cardiology expert "could not say with medical certainty" that an anticoagulant prescription would have prevented plaintiff's stroke, "Plaintiff is unable to show that his stroke was more probably than not proximately caused by the negligence of the Defendants." Regarding the Cardiology Associates defendants' lost opportunity argument, they summarized that "[t]aking the numbers most favorable to plaintiff,

the specific risk of stroke suffered by plaintiff was .33% for Coumadin and 2% for inadequate anticoagulation: a paltry difference of 1.66%,” for which MCL 600.2912a(2) prohibited his recovery of damages.

Plaintiff responded that genuine issues of material fact concerning the Cardiology Associates defendants’ causation of his stroke precluded summary disposition. Plaintiff asserted:

Because it is a well established medical phenomenon that atrial fibrillation and cardioversion cause an increased risk of clot formation and stroke, the recommended treatment—the standard of care—for patients having a two day or longer episode of atrial fibrillation treated by cardioversion is to administer heparin in the hospital and then Coumadin upon discharge (or a similar anticoagulant) for four weeks.

Plaintiff contended that evidence showed that the Cardiology Associates defendants violated the standard of care by prescribing him only aspirin after his cardioversion, and that his two cardiology experts “testified unequivocally that more likely than not, plaintiff would not have suffered a stroke if appropriate anticoagulation had been administered and prescribed.” With respect to the Cardiology Associates defendants’ lost opportunity argument, plaintiff emphasized that the doctrine did not “apply to a ‘traditional’ medical malpractice case [like this one] where damages are sought for a discrete injury that the plaintiff has suffered because of the defendant’s malpractice rather than for the ‘loss of an opportunity’ to achieve a better result.”

At the March 31, 2010, summary disposition hearing, the circuit court denied the Cardiology Associates defendants’ motion on the basis that “this is not a lost opportunity case and the plaintiff has presented sufficient evidence concerning causation.” That same day, the court entered a written order denying the Cardiology Associates defendants’ motion “for the reasons stated on the record.”

On January 12, 2010, Beaumont Hospital filed its motion for summary disposition under MCR 2.116(C)(10), on the basis that no evidence established that the Cardiology Associates defendants “were . . . employees or agents, either actual or ostensible, of Beaumont [Hospital].” The hospital highlighted that at the time of plaintiff’s deposition plaintiff could not remember “with whom he spoke while in the Emergency Department” or “how he was admitted to Dr. Walsh’s care or even that Dr. Walsh was a cardiologist,” and plaintiff “had previously made an appointment to see Dr. Korotkin and identified Dr. Korotkin as his future cardiologist.” Beaumont Hospital argued that “[b]ecause [plaintiff] had a prior professional relationship with Dr. Korotkin and Cardiology Associates,” and the hospital took “no action . . . which would reasonably lead [plaintiff] to believe that Dr. Walsh, Dr. Korotkin or . . . Kacer were agents of the Hospital . . . , plaintiff cannot prove ostensible agency and . . . [the hospital] is entitled to dismissal.”

Plaintiff responded that “the circumstances of this case present genuine issues of material fact as to whether Dr. Walsh and/or . . . Kacer. . . were either ostensible or actual agents of the

Hospital.”² Regarding actual agency, plaintiff maintained that as a matter of law a doctor can qualify as an agent of a hospital while an independent contractor with an independent practice. Concerning ostensible agency, plaintiff insisted that this issue should go to a jury in light of the evidence that by keeping “an emergency room open, staffed, and operating 24 hours a day every day of the year” Beaumont Hospital had represented that “treatment will be afforded by its physicians working therein”; plaintiff “was looking to the hospital for treatment”; plaintiff “had no [preexisting] physician-patient relationship with Dr. Walsh or Dr. Korotkin independent of the hospital”; and Beaumont Hospital’s emergency room doctor selected Dr. Walsh to treat plaintiff.

At the March 31, 2010, hearing, the circuit court granted Beaumont Hospital’s motion for summary disposition, reasoning as follows:

In looking at the evidence in the light most favorable to the plaintiff, the Court grants defendant Beaumont’s motion for summary disposition for [the] reason that the plaintiff has failed to create any genuine issue of material fact regarding ostensible agency between Dr. Walsh, . . . [Kacer], and the hospital. In addition, the plaintiff has failed to create any genuine issue of material fact regarding actual agency, joint tenancy [sic], or a partnership between the hospital and the co-defendants.

That same day, the court entered a written order granting Beaumont Hospital’s motion “for the reasons stated on the record.”

II. PLAINTIFF’S APPEAL

A

Plaintiff initially contends that the circuit court erred in denying his motion for leave to file a second amended complaint. “[D]ecisions granting or denying motions to amend pleadings . . . are within the sound discretion of the trial court and reversal is only appropriate when the trial court abuses that discretion.” *Weymers v Khera*, 454 Mich 639, 654; 563 NW2d 647 (1997).

The Michigan Court Rules govern the amendment of pleadings. The subrule applicable here, MCR 2.118(A)(2) states, “Except as provided in subrule (A)(1), a party may amend a pleading only by leave of the court or by written consent of the adverse party. Leave shall be freely given when justice so requires.” Michigan courts have interpreted subrule (A)(2) as ordinarily authorizing a party to amend his pleading, and have reasoned that a court should deny the opportunity to amend only for the following reasons: (1) undue delay by the moving party; (2) the moving party’s dilatory motive or bad faith in seeking amendment; (3) the moving party’s “repeated failures to cure deficiencies by amendments previously allowed”; (4) the granting of

² Plaintiff agreed to dismiss his “claim that . . . Beaumont Hospital is vicariously liable for Co-Defendant Steven M. Korotkin, M.D.”

the motion to amend would cause the opposing party undue prejudice; and (5) futility of the proposed amendment. *Weymers*, 454 Mich at 658-659, quoting *Ben P Fyke & Sons, Inc v Gunter Co*, 390 Mich 649, 656; 213 NW2d 134 (1973).

The allegations comprising plaintiff's original and first amended complaints focused on his hospitalization at Beaumont's Royal Oak location between May 6, 2007, and May 8, 2007, and plaintiff's visit to the offices of Cardiology Associates on May 9, 2007. Shortly after plaintiff arrived at Beaumont Hospital, he was diagnosed with atrial fibrillation, underwent a cardioversion procedure on May 7, 2007, and was discharged from the hospital the next day. The complaints maintained that defendants, Dr. Walsh, and certified physician's assistant Karen Kacer, negligently failed to prescribe a four-week course of anticoagulant medication at the time of plaintiff's hospital discharge, which caused him to suffer a stroke on May 18, 2007. The complaints also averred that Dr. Korotkin and Kacer should have prescribed plaintiff anticoagulants when he appeared at Cardiology Associates on May 9, 2007. Plaintiff sought leave to file a second amended complaint to "add[] allegations of nursing negligence as to the [hospital's] treating nurses" and "an allegation of negligence against . . . Dr. Walsh," on the basis that the nurses had not properly administered Dr. Walsh's "order for anticoagulation treatment" at the hospital, and Dr. Walsh "fail[ed] to properly adjust [plaintiff's] Heparin anticoagulation therapy to achieve a therapeutic range during his hospitalization."

Plaintiff sought leave to file the second amended complaint in February 2010, more than 18 months after he had commenced this action in August 2008. Plaintiff offered no legitimate reason for failing to detect purportedly low Heparin dosage information in the hospital records, even after several of his experts had reviewed the records. Nothing in plaintiff's February 2008 notice of intent to pursue this malpractice litigation or his original and first amended complaints reasonably suggested that he might challenge the adequacy of his Heparin dosage while hospitalized in early May 2007. Case evaluation occurred in December 2009. Dr. Korotkin and the Cardiology Associates filed motions for summary disposition later in December 2009, and Beaumont Hospital filed its motion for summary disposition in January 2010. Although discovery had not officially closed, the circuit court scheduled a previously adjourned trial for June 2010, a date within four months of plaintiff's motion for leave to file the second amended complaint.

We cannot characterize as an abuse of discretion the circuit court's denial of plaintiff's motion for leave to file a second amended complaint in light of: (1) plaintiff's undue delay in bringing the motion to amend the complaint a second time to add a new theory of liability; (2) the substantial progression of the case by the time plaintiff sought to amend the complaint again, more than 1-1/2 years after litigation commenced and a relatively short time before trial; and (3) defendants' lack of prior notice that they could face liability arising from plaintiff's inadequate Heparin dosage while hospitalized. See *Weymers*, 454 Mich at 666, and *Jager v Nationwide Truck Brokers, Inc*, 252 Mich App 464, 488; 652 NW2d 503 (2002), overruled on other grounds *Elezovic v Ford Motor Co*, 472 Mich 408, 431; 697 NW2d 851 (2005).

Plaintiff next submits that the circuit court erred in granting Beaumont Hospital's motion for summary disposition pursuant to MCR 2.116(C)(10), on the basis that no questions of fact existed concerning Dr. Walsh's and Kacer's ostensible agency relationship with Beaumont Hospital during plaintiff's early May 2007 hospitalization.

We review de novo a circuit court's summary disposition ruling. *Corley v Detroit Bd of Ed*, 470 Mich 274, 277; 681 NW2d 342 (2004). A motion brought pursuant to MCR 2.116(C)(10) "tests the factual support of a plaintiff's claim." *Walsh v Taylor*, 263 Mich App 618, 621; 689 NW2d 506 (2004). "Summary disposition is appropriate under MCR 2.116(C)(10) if there is no genuine issue regarding any material fact and the moving party is entitled to judgment as a matter of law." *West v Gen Motors Corp*, 469 Mich 177, 183; 665 NW2d 468 (2003). "In reviewing a motion under MCR 2.116(C)(10), this Court considers the pleadings, admissions, affidavits, and other relevant documentary evidence of record in the light most favorable to the nonmoving party to determine whether any genuine issue of material fact exists to warrant a trial." *Walsh*, 263 Mich App at 621. "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*, 469 Mich at 183.

In *Grewe v Mt Clemens Gen Hosp*, 404 Mich 240, 250-253; 273 NW2d 429 (1978), the Michigan Supreme Court explained:

Generally speaking, a hospital is not vicariously liable for the negligence of a physician who is an independent contractor and merely uses the hospital's facilities to render treatment to his patients. However, if the individual looked to the hospital to provide him with medical treatment and there has been a representation by the hospital that medical treatment would be afforded by physicians working therein, an agency by estoppel can be found.

* * *

An agency is ostensible when the principal intentionally or by want of ordinary care, causes a third person to believe another to be his agent who is not really employed by him. . . . [B]efore a recovery can be had against a principal for the alleged acts of an ostensible agent, three things must be proved . . . : First the person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one; second such belief must be generated by some act or neglect of the principal sought to be charged; third and the third person relying on the agent's apparent authority must not be guilty of negligence. [Citations omitted.]

The Supreme Court in *Grewe, id.* at 251, also emphasized the following:

[T]he critical question is whether the plaintiff, at the time of his admission to the hospital, was looking to the hospital for treatment of his physical ailments or merely viewed the hospital as the situs where his physician would treat him for his problems. A relevant factor in this determination involves resolution of the question of whether the hospital provided the plaintiff with . . . [the allegedly

negligent physician] or whether the plaintiff and . . . [the allegedly negligent physician] had a patient-physician relationship independent of the hospital setting.

Plaintiff testified that he went to Beaumont Hospital's emergency room on May 6, 2007, on the basis of Beaumont Hospital representations that they have the best doctors. Shortly after plaintiff's diagnosis of atrial fibrillation in the hospital's emergency room, he was placed in the care of cardiologist Dr. Walsh, with whom plaintiff had no prior relationship. Nothing in the record tends to prove that during plaintiff's hospitalization anyone broached the topic of Dr. Walsh's or Kacer's status as independent contractors with Beaumont Hospital. Given plaintiff's distress from serious atrial fibrillation when he arrived at the hospital, a jury could reasonably find that plaintiff was not negligent to the extent that he failed to ask "whether the individual doctors who examined him are employees of the [hospital] or were independent contractors." *Grewe*, 404 Mich at 253 (internal quotation and citation omitted). Beaumont Hospital argues that Dr. Walsh and Dr. Korotkin were employees of Cardiology Associates, and that Dr. Korotkin and plaintiff shared a cardiologist-patient relationship predating plaintiff's early May 2007 hospitalization. However, the specific testimony on this point from Kacer revealed that at some time before plaintiff went to the emergency room he had scheduled an initial appointment for a cardiology examination by Dr. Korotkin at Cardiology Associates, and that the appointment had not occurred at the time of the hospitalization. Because questions of fact exist concerning Dr. Walsh's and Kacer's ostensible agency relationship with Beaumont Hospital during plaintiff's early May 2007 hospitalization, the circuit court incorrectly granted the hospital's motion for summary disposition.

C

Next, plaintiff contends that the circuit court erred in granting Dr. Korotkin's motion for summary disposition under subrule (C)(10), on the basis that there was no evidence that tended to show that Dr. Korotkin breached the standard of care at the time of plaintiff's May 9, 2007, visit to Cardiology Associates. Plaintiff alternatively theorizes that "[e]ven if the Court were to find that there was no question of fact as to whether Dr. Korotkin breached the standard of care, . . . summary disposition was inappropriate as to Dr. Korotkin . . . because . . . Dr. Korotkin is vicariously liable for the negligence of . . . [physician's assistant] Kacer . . . by operation of law."

Kacer testified that she worked as a physician's assistant for Drs. Korotkin and Walsh at Cardiology Associates, and that she saw plaintiff on May 9, 2007, when he arrived at Cardiology Associates with lip swelling caused by Lisinopril, an antihypertensive medication. Kacer remembered speaking with Dr. Korotkin in the office on May 9, 2007, about whether to discontinue the Lisinopril, although Dr. Korotkin did not see or interact with plaintiff; Dr. Korotkin approved the discontinuation of Lisinopril and decided to "reevaluate him the next day." Kacer confirmed that on May 9, 2007, she recorded some information regarding plaintiff's recent illness, vital signs, and an assessment and plan for his care. However, Kacer denied that she had mentioned to Dr. Korotkin "the other medications that [plaintiff] was on," or that she and Dr. Korotkin discussed "the fact that [plaintiff] was not on Coumadin[.]" Dr. Korotkin testified that he did not independently recall a May 9, 2007, conversation he may have had with Kacer about plaintiff.

Kacer assented that she likely dictated to a transcriptionist information concerning plaintiff's "medical history and medication history" on May 9, 2007, and the record contains a one-page document from Cardiology Associates's records, on which appears Kacer's name and typed medical information about plaintiff, dated May 9, 2007. Under the heading "History of Present Illness," the document states:

[C]o lip swelling after first dose of lisinopril. [R]ecent onset of atrial fib with rvr. [P]resented to hospital 3 days after onset of SOB and chest pain while supine. [D]id not feel palpitations. [T]ee showed cardiomyopathy and then was successfully cardioverted. [L]otrel (for htn) dc'd. [S]tarted on lopressor, lisinopril, aldactone, asa, and lipitor. [A]dvised to stop decongestants for allergies.

In an affidavit, Richard Roodbergen, "a licensed physicians assistant specializing in . . . Cardiology," attested that he had reviewed plaintiff's medical records and arrived at several conclusions: (1) the standard of care applicable to Kacer obligated her to (a) "[t]imely advise . . . [Dr.] Korotkin . . . that [plaintiff] was not on the appropriate course of therapeutic anticoagulants upon [plaintiff's] presentation to the offices of Cardiology Associates . . . on May 9, 2007"; and (b) "[p]rescribe [plaintiff] the appropriate course of therapeutic anticoagulants upon his presentation to the offices of Cardiology Associates . . . on May 9, 2007, pending a discussion with . . . [Dr.] Korotkin." Roodbergen also opined that Kacer breached both standards of care.

We reject plaintiff's suggestion that the record gives rise to a material question of fact that Dr. Korotkin engaged in any negligent conduct on May 9, 2007. Although no evidence gives rise to a reasonable inference of direct negligence by Dr. Korotkin, a genuine issue of fact exists with respect to whether Kacer breached the standard of care applicable to physician's assistants on May 9, 2007, by failing to tell Dr. Korotkin that plaintiff was not taking therapeutic anticoagulants, and not ensuring that Dr. Korotkin approved a prescription of anticoagulants. In MCL 333.17078(1), our Legislature has directed that "[a] physician's assistant is the agent of his or her supervising physician[.]" The Legislature also has set forth that "[a] physician shall not delegate ultimate responsibility for the quality of medical care services, even if the medical care services are provided by a physician's assistant." MCL 333.17548(4). This plain statutory language signifies that Dr. Korotkin may face vicarious liability for any instance of physician assistant Kacer's malpractice on May 9, 2007. *Pohutski v City of Allen Park*, 465 Mich 675, 683; 641 NW2d 219 (2002) (observing that when the Legislature has drafted unambiguous statutory language, this Court should "presume that the Legislature intended the meaning clearly expressed") (internal quotation and citation omitted); see also *Barnes v Mitchell*, 341 Mich 7, 17-21; 67 NW2d 208 (1954) (concluding that under Michigan's common law, the defendant chiropractor could face liability for negligent conduct of an assistant because sufficient evidence showed that the defendant "authorized the X-ray treatment" at issue, and his assistant "gave the X-ray within the course of her employment and to further the interest of the defendant rather than her own interest").

Dr. Korotkin insists that he cannot be vicariously liable for Kacer's conduct on May 9, 2007, given that the first amended complaint did not place him on notice of a potential claim premised on his derivative liability. The first amended complaint identified that Kacer, Dr. Korotkin, and Dr. Walsh shared an affiliation with Cardiology Associates, and that Dr. Korotkin

was an agent or employee of Cardiology Associates. In Count II, the complaint asserted that Dr. Korotkin had breached the standard of care by (1) “fail[ing] to ensure that Plaintiff . . . be prescribed the appropriate course of therapeutic anticoagulants upon presenting to the offices of Cardiology Associates . . . on May 9, 2007”; and (2) “fail[ing] to prescribe an appropriate course of therapeutic anticoagulants to Plaintiff . . . on May 9, 2007.” Count III, entitled “[p]rofessional negligence: Karen Kacer, PA-C,” contains the following relevant allegations:

40. At all relevant times . . . , KAREN M. KACER, PA-C, was the actual or ostensible agent and/or employee of Defendant, CARDIOLOGY ASSOCIATES OF BIRMINGHAM, P.C., thereby imposing liability upon . . . [Cardiology Associates] for the negligent conduct of . . . [Kacer] . . . by virtue of the doctrine of respondeat superior and MCL 333.17078(2).

* * *

42. [Kacer] . . . and [Cardiology Associates] . . . violated . . . duties owed to Plaintiff in the following manner:

a. . . . Kacer . . . failed to timely advise . . . [Dr.] Korotkin . . . that [plaintiff] was not on the appropriate course of therapeutic anticoagulants upon [plaintiff’s] presentation to the offices of Cardiology Associates . . . on May 9, 2007;

b. . . . Kacer . . . failed to prescribe [plaintiff] the appropriate course of therapeutic anticoagulants upon [plaintiff’s] presentation to the offices of Cardiology Associates . . . on May 9, 2007, pending a discussion with . . . [Dr.] Korotkin

We conclude that the first amended complaint reasonably apprised Dr. Korotkin of plaintiff’s vicarious liability claim premised on Kacer’s conduct, in conformity with MCR 2.111(B)(1) (“[a] complaint . . . must contain . . . [a] statement of the facts, without repetition, on which the pleader relies in stating the cause of action, with the specific allegations necessary reasonably to inform the adverse party of the nature of the claims the adverse party is called on to defend”).³

III. THE CARDIOLOGY ASSOCIATES DEFENDANTS’ CROSS-APPEAL

A

³ Because the first amended complaint filed by plaintiff reasonably apprised Dr. Korotkin of plaintiff’s vicarious liability claim premised on Kacer’s negligent conduct on May 9, 2007, in conformity with MCR 2.111(B)(1), we need not address plaintiff’s claim that the circuit court should have allowed him to amend the complaint again to more specifically allege Dr. Korotkin’s vicarious liability.

The Cardiology Associates defendants first argue that the circuit court improperly denied summary disposition under subrule (C)(10) on their claim that “Plaintiff cannot establish through expert testimony that Defendants’ decision not to prescribe Coumadin proximately caused Plaintiff’s stroke.” In their view, the miniscule increased percentage in the likelihood of a stroke absent a postcardioversion anticoagulant therapy, as estimated by plaintiff’s expert witnesses (between 1.66% and 3%), signified that “it is still ‘more likely than not’ . . . that Plaintiff would not have a stroke,” and he thus cannot establish causation as required under MCL 600.2912a(2).

In MCL 600.2912a(2), our Legislature set forth the proximate causation standard in medical malpractice actions:

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%.

In *O’Neal v St John Hosp & Med Ctr*, 487 Mich 485, 493 (opinion by HATHAWAY, J.), 507 (concurring opinion by CAVANAGH, J.), 513 (concurring opinion by KELLY, C.J.); 791 NW2d 853 (2010), our Supreme Court construed MCL 600.2912a(2), in relevant part, as follows:

The proper method of determining whether defendant’s conduct more probably than not proximately caused the injury involves a comparative analysis, which is dependent upon the facts and circumstances and expert opinion in a given case.

* * *

. . . While § 2912a(2) does not mandate the use of statistics or require any particular mathematical formula, the historic analysis of proximate cause must be followed . . . : the analysis or formulation used cannot require that the cause must be *the* proximate cause rather than *a* proximate cause.

* * *

It is also important to emphasize that not all traditional medical malpractice cases can or will be expressed in statistical or percentage terms, nor is a plaintiff required to express proximate causation in percentage terms. The plain language of the statute requires that proximate causation in traditional malpractice cases be expressed by showing that the defendant’s conduct was *more probably than not* a cause of the injury, not by statistical or percentage terms.

* * *

We emphasize that we hold that the second sentence of § 2912a(2) applies only to medical malpractice cases that plead loss of opportunity and not to those

that plead traditional medical malpractice [*Id.* at 504-506 (opinion by HATHAWAY, J.) (emphasis in original).]

The Court concluded:

The case before us presents a traditional malpractice claim. It does not present a claim for loss of opportunity. In traditional malpractice cases, the plaintiff is required to prove that the defendant's negligence more probably than not caused the plaintiff's injury. In this case, the testimony of plaintiff's expert witnesses supports plaintiff's position on proximate causation. While that testimony is not dispositive, it is sufficient to raise a question of fact to defeat a motion for summary disposition, allowing the issue to be adjudicated on the merits by the trier of fact. . . . [*Id.* at 507 (opinion by HATHAWAY, J.).]

Here, plaintiff pleaded traditional medical malpractice claims against Beaumont Hospital and Cardiology Associates defendants; thus the second sentence of MCL 600.2912a(2) did not apply in this case. Furthermore, plaintiff's cardiology experts both offered deposition testimony that defendants' failures to proscribe plaintiff an anticoagulant for four weeks at the time of his discharge on May 8, 2007, more likely than not contributed to plaintiff's stroke. Specifically, plaintiff's cardiology expert, Dr. Anton, answered affirmatively that he could testify "that the defendants breached the standard of care during [plaintiff]'s May 2007 hospitalization for atrial fibrillation by . . . failing to insure plaintiff received the appropriate course of therapeutic anticoagulant after a cardioversion and upon discharge from the hospital on May 8," and by neglecting to prescribe an anticoagulant for four weeks after plaintiff's discharge from the hospital. Dr. Anton also responded affirmatively to this question: "And you think that because that didn't occur, . . . plaintiff . . . suffered an acute cerebrovascular accident . . . ?" Dr. Anton concluded that the failure to prescribe an anticoagulant more likely than not contributed to plaintiff's stroke:

Q. Doctor, in your opinion, why do the guidelines recommend the use of Coumadin in the postconversion period for those patients who have had afib for more than 48 hours as opposed to aspirin or any other antiplatelet or anticoagulant?

A. Well, it's because it's more effective in reducing stroke in that four-week period postcardioversion.

Q. And had Coumadin been given to [plaintiff] as opposed to aspirin, do you believe he would have suffered a stroke?

A. I don't believe so.

* * *

Q. And why is it your opinion that he would not have suffered the stroke had he been on Coumadin as opposed to aspirin?

A. Well, I believe there was a temporal relationship between the cardioversion and the stroke, which means that this stroke related to a thrombus formed in the atrium postconversion that became an embolus and caused the stroke.

Q. Do you believe that would have happened had he been on Coumadin?

A. No, I don't.

Dr. Wohlgelernter, plaintiff's second cardiology expert, described the applicable standard of care in the following manner:

As far as the specific context of new onset atrial fibrillation post-cardioversion, . . . there is no sustained role for aspirin being the therapy. The guidelines are very clear, unequivocally adamant about the need for anticoagulation with Coumadin for four weeks after cardioversion.

Wohlgelernter replied, "Yes," to plaintiff's counsel's inquiry, "[I]f the standard of care had been complied with, there's an 80 percent likelihood he would not have had a stroke?"

In sum, plaintiff pleaded a traditional medical malpractice claim and submitted evidence to create a genuine issue of fact regarding whether defendants' failure to prescribe plaintiff an anticoagulant for four weeks after the cardioversion procedure in early May 2007 more probably than not caused the stroke that he suffered on May 18, 2007. As such, the circuit court correctly denied the Cardiology Associates defendants' motion for summary disposition.

B

Finally, the Cardiology Associates defendants contend that the circuit court erred in denying their motion in limine seeking to exclude testimony by Dr. Steven Anton, one of plaintiff's cardiology experts, under MRE 702 and MCL 600.2955(1). In the view of the Cardiology Associates defendants, Dr. Anton's opinion that plaintiff "would not have suffered a stroke had Coumadin been prescribed as opposed to [a]spirin" "is not based on sufficient facts or data and is not reliable because he is unable to give any specific facts, technique, methodology, or reasoning that he relied on to form the basis for his" opinion.

[T]he qualification of a witness as an expert and the admissibility of the testimony of the witness are in the trial court's discretion and we will not reverse on appeal absent an abuse of that discretion. An abuse of discretion exists if the decision results in an outcome outside the range of principled outcomes. [*Surman v Surman*, 277 Mich App 287, 304-305; 745 NW2d 802 (2007).]

Dr. Anton testified that he had worked as a practicing cardiologist for 27 years, he possessed "[v]ast" experience with patients in atrial fibrillation, and he frequently performed cardioversions. Dr. Anton specified that in preparation for his testimony he had reviewed medical literature, including "the ACC [American College of Cardiology]/AHA [American Heart Association] guidelines from 2006 [and 2001] on atrial fibrillation," a "European Journal article in 2001 discussing treatment post cardioversion atrial fibrillation and the mechanisms of

stunning and hypercoagulability,” and “an up-to-date reprint on Anticoagulation Prior to and After Restoration of Sinus Rhythm in Atrial Fibrillation.” One of the publications referenced by Dr. Anton, “ACC/AHA/ESC [European Society of Cardiology] 2006 Guidelines for the Management of Patients with Atrial Fibrillation,” in a section entitled, “Prevention of Thromboembolism in Patients with Atrial Fibrillation Undergoing Cardioversion,” contains the following relevant recommendations:

For patients with AF [atrial fibrillation] of more than 48-h[our] duration requiring immediate cardioversion because of hemodynamic instability, heparin should be administered concurrently (unless contraindicated) Thereafter, oral anticoagulation . . . should be provided for at least 4 wk, as for patients undergoing elective cardioversion. . . .

Another article that Dr. Anton mentioned summarized:

Anticoagulation is an important component of the strategy used to restore sinus rhythm in patients with atrial fibrillation (AF). The efficacy of anticoagulation is related both to the presence of preexisting thrombi (which form because of hemodynamic and coagulation abnormalities during AF) and to the risk of de novo thrombus formation following cardioversion.

* * *

Patients undergoing cardioversion of AF of more than 48 hours duration represent a high-risk group with an embolic risk of about 1 to 2 percent in the first month in the absence of anticoagulation. Almost all embolic events in patients who remain in sinus rhythm occur within the first 10 days after cardioversion.

Among patients with AF for more than 48 hours, the risk of thromboembolism after cardioversion can be diminished to less than 1 percent by the use of three to four weeks of anticoagulation prior to and then for one month after cardioversion.

In a manner consistent with the scientific principles presented in the medical literature and Dr. Anton’s extensive experience as a cardiologist, he opined that “defendants breached the standard of care during [plaintiff]’s May 2007 hospitalization for atrial fibrillation by . . . failing to insure plaintiff received the appropriate course of therapeutic anticoagulant after a cardioversion and upon discharge from the hospital on May 8,” and by neglecting to prescribe an anticoagulant for four weeks after plaintiff’s discharge from the hospital. Dr. Anton also concluded that plaintiff’s stroke would not have occurred had defendants prescribed him an anticoagulant for four weeks after the early May 2007 cardioversion, instead of aspirin. According to Dr. Anton, aspirin, which is not an anticoagulant, had only “[l]imited efficacy” in preventing clot formation.”

We conclude that Dr. Anton’s testimony rests on sound and well-established medical principles, and Dr. Anton reliably applied his scientific knowledge to the facts of this case in a manner that will assist the jury. MCL 600.2955(1); MRE 702; *Chapin v A & L Parts, Inc*, 274 Mich App 122, 126-127, 139-140 (opinion by DAVIS, J.), 141 (concurring opinion by METER,

J.); 732 NW2d 578 (2007). Notably, plaintiff's other cardiology expert, Dr. Daniel Wohlgernter, applied the same medical principles to the facts of this case and reached a conclusion substantially similar to that reached by Dr. Anton, and defendants did not challenge the admissibility of Dr. Wohlgernter's testimony. Defendants also did not submit with their motion in limine any data or studies showing or suggesting that plaintiff's taking of aspirin after his cardioversion could have reduced the risk of a stroke to the same extent as an anticoagulant, or otherwise tending to undercut the basis for plaintiff's cardiologists' testimony.

In conclusion, the circuit court did not abuse its discretion when it denied the motion challenging the admissibility of Dr. Anton's testimony. *Surman*, 277 Mich App at 304-305.

IV. CONCLUSION

We affirm the circuit court's denials of (1) plaintiff's motion for leave to file a second amended complaint, (2) the Cardiology Associates defendants' motion for summary disposition, and (3) defendants' motion challenging the admissibility of Dr. Anton's testimony. We reverse the circuit court's orders granting (1) Beaumont Hospital's motion for summary disposition asserting a lack of agency with Dr. Walsh or Kacer, and (2) Dr. Korotkin's motion for summary disposition asserting a lack of evidence that he breached the standard of care.

Affirmed in part, reversed in part, and remanded for further proceedings not inconsistent with this opinion. We do not retain jurisdiction.

/s/ Kathleen Jansen
/s/ Stephen L. Borrello
/s/ Jane M. Beckering