STATE OF MICHIGAN

COURT OF APPEALS

CATHERINE JOHNSON, as Personal Representative of the Estate of RICK ALAN JOHNSON, Deceased,

Plaintiff-Appellant/Cross-Appellee,

v

BOTSFORD GENERAL HOSPITAL,

Defendant-Appellee/Cross-Appellant,

and

G. SCOTT JENNINGS, IV, D.O., and G. SCOTT JENNINGS, IV, D.O., P.C.,

Defendants.

FOR PUBLICATION
March 11, 2008
9:00 a.m.

No. 272129
Oakland Circuit Court
LC No. 2004-055682-NH

Advance Sheets Version

Before: Zahra, P.J., and White and O'Connell, JJ.

O'CONNELL, J.

Plaintiff appeals as of right from several circuit court orders of dismissal in this wrongful-death case alleging medical malpractice and negligence. Defendant Botsford General Hospital cross-appeals. We affirm.

Plaintiff 's decedent, 59-year-old Rick Alan Johnson, was diagnosed in October 2002 with a large abdominal aortic aneurysm. The decedent's vascular surgeon, former codefendant Dr. G. Scott Jennings, IV, scheduled aneurysm-repair surgery for November 4, 2002, at defendant Botsford Hospital. The day before the scheduled surgery, the decedent received a presurgical workup at the hospital, but the surgery was cancelled when the decedent's blood tests showed abnormally low platelet counts.

This case arose out of events involving the decedent's discharge from the hospital on November 4, 2002. Before the decedent's discharge, hospital staff members and Dr. Jennings explained that they would have to postpone surgery until the decedent's blood-platelet level returned to a safe level. The decedent expressed complete understanding but also frustration at having spent two days in the hospital without having had surgery. He plainly stated a desire to leave the hospital, return home, and follow up with blood tests on an outpatient basis. When the

decedent's family, predominantly his son, inquired whether the decedent should remain hospitalized while the decedent's blood-platelet levels returned to operable levels, Dr. Jennings advised them that insurance would not cover it. He explained that hospitalization was not medically necessary to raise the decedent's platelet level and told the decedent that continued hospitalization could potentially cost him thousands of dollars a day.

Dr. Jennings then asked that someone from the hospital's administration speak to the decedent and his family to verify his interpretation of the decedent's insurance coverage and the hospital's policy. At Dr. Jennings's request, Joanne Van Camp, a registered nurse, whom the hospital employed in its continuing care and quality assessment department, spoke to the decedent and his family and advised them that there would be no insurance coverage for a hospital stay while the surgical team waited for the decedent's platelet level to improve. The decedent indicated a deep-seated aversion to staying in the hospital, but after the decedent's family persisted, Van Camp told them that she would call the insurance company to verify its position. However, the decedent expressed an unwillingness to be billed for hospital services, and he was discharged before Van Camp called the insurance provider. The hospital billed the insurance company for the day on which the decedent was discharged, but the insurer denied that specific claim.

After being discharged, the decedent was treated by a hematologist on an outpatient basis. On November 12, 2002, the decedent's blood tests demonstrated improved levels, and he was cleared for surgery. The decedent's aneurysm ruptured on November 14, 2002. On November 15, 2002, Dr. Jennings performed surgery to repair the ruptured aneurysm. Despite the surgery, the decedent died on December 14, 2002, from complications.

Plaintiff's amended complaint alleged medical malpractice against former codefendants Dr. Jennings and his professional corporation, as well as vicarious liability and active negligence on the part of the hospital. The 22 specific claims against the hospital were contained in the complaint's ¶ 21, §§ a to u, and included the claims that Van Camp misinformed the decedent about his medical coverage and that the hospital negligently discharged the decedent. After plaintiff's vicarious-liability claims were dismissed by stipulation, but while Dr. Jennings remained a party defendant, the hospital filed a motion for summary disposition. The motion argued that plaintiff's notice of intent to bring the action never raised an issue regarding the negligent failure to inform the decedent about his insurance, but, instead, only claimed that the hospital should not have discharged the decedent.

In response to the motion, plaintiff stipulated that "this is a medical malpractice case," and conceded that "the only claim Plaintiff is presently pursuing against Defendant Hospital is one premised on Defendant's failure to take steps to allow Plaintiff's decedent to remain hospitalized when the surgery . . . was postponed." Plaintiff again reiterated that "[t]his is a medical malpractice wrongful death case," and argued that "the decision to discharge decedent was one improperly based upon economic considerations, which were given more weight than the need to urgently address decedent's significant aneurysm." However, plaintiff supported her proposition with the testimony of a doctor who explained that the decedent should not have been discharged and the anticipated testimony of another doctor who specialized in hospital administration. Although plaintiff conceded that the issue related only to the decedent's discharge, she also argued that Van Camp should have called the insurance company and verified the decedent's coverage before advising the decedent's family. Plaintiff did not present

the testimony of a nurse whose credentials materially matched those of Van Camp. See MCL 600.2169; *McElhaney v Harper-Hutzel Hosp*, 269 Mich App 488, 496; 711 NW2d 795 (2006).

The trial court held that the notice of intent only advised the hospital of plaintiff's intent to sue for the negligent discharge of the decedent, the claim reflected in ¶ 21(n), so it dismissed plaintiff's other claims, including those related to Van Camp's failure to follow up with the decedent's insurer.

After the trial court dismissed 21 out of the 22 claims, the hospital moved for clarification regarding the propriety of the remaining claim, ¶ 21(n). The hospital argued that its only contact with the decedent was through Van Camp, who was a registered nurse, so plaintiff's expert witnesses, who were not nurses, could not testify about whether Van Camp met the standard of reasonable care. In response, plaintiff shifted her position substantially and argued that her claim against the hospital was not for medical malpractice at all, but for ordinary administrative negligence. Plaintiff argued that Van Camp had a duty, as an administrative professional, to provide accurate insurance information and that she failed to do so, causing the decedent to accept a premature discharge. The trial court rejected plaintiff's new position, and granted the hospital's motion for summary disposition.

On appeal, plaintiff again argues that her case against the hospital did not involve medical malpractice, but, instead, invoked only ordinary-negligence principles. However, even if we decided to overlook plaintiff's initial characterization of her claim against the hospital as a medical-malpractice action, her bare claims of negligence, without resort to questions of medical judgment, are fatally flawed. We review de novo a trial court's decision to grant summary disposition. *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999).

A claim sounds in medical malpractice rather than in ordinary negligence when the claim relies on a professional relationship and "the claim raises questions of medical judgment beyond the realm of common knowledge and experience." *Bryant v Oakpointe Villa Nursing Ctr, Inc*, 471 Mich 411, 422; 684 NW2d 864 (2004). Plaintiff contends that common knowledge and experience are sufficient to determine that it is negligent to misguide patients concerning their insurance coverage. However, plaintiff never presented any evidence that the nurse misled the decedent about whether his insurance company would pay the hospital to provide inpatient treatment to raise his platelet level. Instead, the insurance experts clarified that the hospital would not receive reimbursement from the decedent's insurer for such inpatient treatment. There is no factual dispute that the decedent's insurer, Blue Care Network, had preapproved the decedent's hospital stay on the assumption that he would receive surgery, and that the network would only reimburse the hospital a flat, lump-sum rate for all expenses associated with that surgery. Any additional expenses, including any extended stay in the hospital during the surgery's postponement, would not be reimbursed.

In fact, the hospital actually applied for separate, per diem compensation for the day on which the decedent was discharged, and the network's denied the hospital's request. The network representatives later deemed that the decedent was "covered" for his separate hospital stays only because the network "bundled" the expenses of the decedent's earlier, postponed surgery with those of his later emergency surgery and paid a single, flat rate associated with his later surgery. The network did not pay any additional money to the hospital to cover the expenses associated with the decedent's aborted surgery and would not have paid any additional money for an

extended, preoperative stay to raise the decedent's platelet level. The network even rejected the hospital's separate reimbursement claim for the preoperative inpatient care that led to the initial detection of the decedent's low platelet level. The network determined that the hospital should have detected the unacceptable levels before it admitted the decedent.

Given the limited "coverage" provided by the network, none of plaintiff's experts ventured to speculate about whether the hospital could or would directly bill the decedent for any additional days he spent hospitalized exclusively for monitoring and treatment for his platelet levels. Putting aside the serious nature of the decedent's condition, which would necessarily entail a degree of medical judgment, Van Camp was presented with a situation in which the decedent's doctor had preliminarily determined that he was stable enough to return home and receive treatment for his platelet level on an outpatient basis. The question presented was whether the decedent's insurer would pay for continued inpatient observation and blood treatment. Nothing in the record indicates that Van Camp misconstrued the hospital's billing policy or actually misinformed the decedent or his doctor about these relevant and pressing matters.[1] Notably, plaintiff's expert never opined that Van Camp breached any standard of care regarding the accuracy of the information she provided.

The standard of care that the administrative expert, Dr. Martin Merry, claimed that Van Camp breached was twofold. First, he averred that the applicable standard of practice or care required Van Camp to refrain from intervening in the decision to discharge the decedent for financial reasons. However, the record reflects that any "intervention" was at the behest of the decedent's primary caregiver, and that the "intervention" was directly related to financial considerations only because those were the immediate concerns that Dr. Jennings and the decedent's family had about the decedent's treatment options. We are not prepared to expand the duty of hospitals to include the obligation to "refrain" from giving requested advice pertaining to a patient's legitimate financial concerns.[2] The weakness of this aspect of Dr. Merry's proposed

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[1] It is worth noting that the question whether the decedent's insurer would "cover" an extended observational hospital stay concerns a matter of opinion, which is not usually susceptible to a later claim of negligent misrepresentation. Expressions of opinion are not false statements of independently verifiable facts. *Mable Cleary Trust v Edward-Marlah Muzyl Trust*, 262 Mich App 485, 502; 686 NW2d 770 (2004).

[2] Strictly speaking, this would not be a duty to refrain from negligent conduct, see *Dyer v Trachtman*, 470 Mich 45, 49; 679 NW2d 311 (2004), but a duty to refrain from giving any information about the adverse financial ramifications of various medical choices, no matter how accurately presented. Dr. Merry's restrictive standard suggests that the only way Van Camp could have avoided "negligent" conduct was to reassure the decedent that the hospital would house, treat, and monitor him free of charge, or at least free of any direct financial obligation, for however long it took to bring the decedent's platelet levels up to acceptable levels. Perhaps then Van Camp would be expected to explain, without regard to the accuracy of the statement, that the hospital would continue its benevolent billing policy for the duration of any inpatient preoperative preparations, the actual surgery (which was the only real basis for reimbursement by the insurer), and any inordinate amount of recovery time the decedent's family might request after he had stabilized enough to return home. The record simply does not validate the substance of these promises, and we see no reason to compel hospital staff to make such promises or to

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standard of care is underscored by his suggestions regarding how Van Camp could have met the standard of care in this case. Without venturing to speculate about the utility of the exercise, he suggested that Van Camp could have met the standard by telephoning the insurance company and inquiring into the decedent's coverage.

Not only does this hypothetical omission surpass the legal bounds of proximate causation on the facts presented, the suggestion ignores the fundamental basis for the primary duty that necessarily governed Van Camp's conduct: her relationship with the patient, the decedent. *Dyer v Trachtman*, 470 Mich 45, 49; 679 NW2d 311 (2004). It is undisputed that Van Camp offered to call the decedent's health insurance company, but did not call because the decedent told her that he did not want her to call and had no desire to prolong his hospital stay a moment longer. Because the law does not ordinarily require citizens to verify one another's insurance coverage in workaday situations, any actionable duty in this case necessarily derives from Van Camp's relationship to the decedent, which in turn derived from the hospital's professional relationship with the decedent. Without some showing of the decedent's inability to manage his medical affairs, any conceivable duty to investigate financial ramifications and report about them extends only to the decedent, not to third parties. In legal parlance, the decedent nullified any arguable duty to further investigate his insurance status when he informally, but quite expressly, released Van Camp and the hospital from that duty. It would transgress basic tenets of self-determination to require hospital personnel to intervene and postpone the discharge of a sane and fully conscious patient, contrary to that patient's express desire, because the patient's family does not think that the hospital staff has done enough to determine whether the unwanted hospitalization could continue at an affordable rate. Recognizing such a duty would necessarily transcend the hospital's fundamental relationship with the patient and could forseeably contravene its most personal and private aspects. Ultimately the social-policy considerations simply do not persuade us that we should create the duty suggested by Dr. Merry, at least not on these facts. See *id*.

Similarly, we reject, as a matter of law, the second aspect of Dr. Merry's standard of care. Dr. Merry opined that Van Camp violated a duty of care by failing to offer the patient or his family the alternative of directly paying for the extended hospitalization. Because the decedent directly and expressly rejected the option of paying for continued hospitalization, the record directly belies any notion that Van Camp failed to convey that the decedent could personally pay for continued hospitalization. Regarding Dr. Merry's opinion that Van Camp owed a duty to extend the direct payment alternative to the decedent's family, a hospital never owes a patient the duty to ask family members if they would prefer to pay for hospitalization or have their loved one discharged. The suggestion of such a duty insinuates that the hospital is obligated to present the option even if, as in this case, the patient has expressed a reluctance to personally pay for the hospitalization. Recognizing such an obligation would require an untenable extension of a hospital's provider/patient relationship beyond all bounds of confidentiality, discretion, and ordinary sensibility. See *id*. There exists no legal duty to press members of a patient's family for payment of a loved one's medical expenses, and we will not manufacture such a duty here.

Plaintiff argues that the decision to discharge the decedent was improperly influenced by economic considerations, specifically those injected by Van Camp. Again we will not fashion a

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otherwise obscure the economic consequences of choosing a given medical treatment.

duty that would prevent a nurse from informing a patient about the possible financial ramifications of a medical decision. In this case, the decedent did not want to stay in the hospital, did not want to delay his discharge, and did not want to receive any bill for any medical procedures. Although plaintiff emphasizes the decedent's unstable medical condition, plaintiff voluntarily dismissed her vicarious-liability claims against the hospital for Dr. Jennings's actions, voluntarily dismissed her claims arising from federal statutes that regulate the discharge of unstable patients, and no longer relies on any claim involving Van Camp's exercise of medical judgment. As the case now stands, it is impossible to craft a meaningful standard of care without inextricably entangling the issue with Dr. Jennings's medical judgment and ultimate decision to discharge the decedent. *Bryant*, *supra*. In other words, adopting plaintiff's argument would leave no room for hospitals to have frank discussions about economic realities with patients without subjecting the hospitals to the risk that a patient might refuse a treatment that, in hindsight, could have proven beneficial. This is not the law. Without evidence that Van Camp actually misinformed the decedent about the financial implications of an extended observational hospital stay, and lacking any indication that the decedent wanted to remain hospitalized and would have personally paid for the service, plaintiff fails to substantiate any cause of action grounded on ordinary negligence against the hospital.

Affirmed.

Zahra, P.J., concurred.

/s/ Peter D. O'Connell
/s/ Brian K. Zahra