# STATE OF MICHIGAN

# COURT OF APPEALS

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BRUCE ESSELMAN, as Personal Representative of the Estate of DAVID ESSELMAN, Deceased,

Plaintiff-Appellee,

v

GARDEN CITY HOSPITAL,

Defendant,

and

DAVID J. FERTEL, D.O., DAVID FERTEL, D.O., P.L.L.C., and D. FERTEL, D.O., P.C.,

Defendants-Appellants.

FOR PUBLICATION
June 4, 2009
9:00 a.m.

No. 280723
Wayne Circuit Court
LC No. 06-609170-NH

Advance Sheets Version

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No. 280816
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Before: Saad, C.J., and Davis and Servitto, JJ.

DAVIS, J.

In these consolidated appeals, the defendants appeal orders that denied their respective motions for summary disposition. This medical malpractice case arises out of David Esselman's death, while in the care of defendants, from gangrenous cholecystitis[1] and sepsis, each of which he apparently had for at least 24 hours before his death. Defendants contend that plaintiff's notice of intent and affidavits of merit were insufficient. The trial court disagreed. We affirm.

The decedent was admitted to Garden City Hospital on September 26, 2003. He was experiencing pain in his abdomen, back, and chest, and he was nauseous and vomiting. Initial testing revealed a small obstruction in the decedent's bowel. The next day, he continued to have the same symptoms, but additionally had a body temperature of 101 degrees Fahrenheit. Antibiotics and further testing were ordered, but no computerized tomography (CT) scan. On the next day, his temperature rose to 102 degrees. A CT scan and a dimethyl iminodiacetic acid (HIDA) scan were performed, from which it was concluded that his common bile duct was obstructed and that there were indications that the decedent suffered from acute cholecystitis. A second HIDA scan was ordered, though it appears it was not completed. Treating physicians ordered the attending nurses to report any rises in body temperature.

On September 29, 2003, the decedent's body temperature was recorded as being 102.7 degrees at 3:00 a.m., 102.6 degrees at 6:30 a.m., and 103 degrees by 8:00 a.m. At 1:30 p.m. that day, the decedent underwent surgery and died during the procedure. The certificate of death stated that he had died as a result of gangrenous cholecystitis and sepsis, each of which he had for at least 24 hours before his death.

On June 7, 2005, plaintiff received his letter of authority appointing him as personal representative of the decedent's estate. On September 26, 2005, plaintiff sent his notice of intent to file a claim (NOI) to the various defendants.[2] The NOI was 14 pages long and included a lengthy factual recitation of the decedent's stay at Garden City Hospital, including detailed discussions of the treatment provided by various individuals, as well as the acts and errors of the individual defendants. Furthermore, it contained the following statement of the "applicable standard of practice or care alleged":

> Pursuant to MCL 333.21513 entitled: "Duties and Responsibilities of Owner, Operator or Governing Body of Hospitals", 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.
>
> The standard of care required from the above-named physicians, residents, nurses, etc., and entities include the following but are not limited to:

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[1] Inflammation of the gallbladder.

[2] Plaintiff's NOI included allegations against defendants, as well as against individuals who agreed to settle with plaintiff and are no longer parties to this matter.

a. To timely diagnose and treat (an[d]/or refer to treat) gallbladder disease including but not limited to performance of timely ultrasound, HIDA scan, CT scan and/or MRI [magnetic resonance imaging] of the abdomen;

b. To fully and completely investigate and work up the patient for these disease processes including but not limited to appreciating the increasing laboratory values and deteriorating clinic[al] picture which began no later than Saturday, September 27, 2003; on Saturday, September 27, 2003 perform the above diagnostic testing so as to work up gallbladder disease which was clearly suggested by not only the clinical picture but also the laboratory results. To timely order and obtain a gastroenterological consultation and participation in the care of this patient so as to determine whether this was in fact gallbladder disease versus some other GI [gastroenterology] problem; and to timely determine whether a pre-operative ERCP [endoscopic retrograde cholangiopancreatography] and/or cholangiogram was necessary as well as to work up the blood in the stool and declining hemoglobin levels;

c. To timely perform a cholecystectomy on Saturday, September 27, 2003 or, at the very latest Sunday, September 28, 2003;

d. Failure to obtain serial abdomen films and exams as well as serial labs including arterial lactate as ordered on September 27, 2003 by the physicians and nursing staff;

e. On Sunday, September 28, 2003 failure by the physicians and nurses involved with Mr. Esselman's care to appreciate the findings as evidenced by the CT scan and HIDA scan that in fact this was acute cholecystitis and that Mr. Esselman had a deteriorating clinical picture including high fever, markedly abnormal laboratory values but especially significantly increased liver studies and white blood count, and that his abdominal examination revealed tympany necessitating an emergent operation on his gallbladder;

f. Not to unnecessarily delay Mr. Esselman's surgery such that it would be performed on either Saturday, September 27, 2003 or Sunday, September 28, 2003 at the very latest;

g. To order and obtain a timely gastroenterology consultation for a preoperative ERCP and in the event that one was unavailable, obtain those services from another GI [gastroenterologist] or alternatively proceed with the surgery without an ERCP;

h. Throughout the remainder of Sunday, September 28, 2003 that the nursing staff timely and immediately report signs of clinical deterioration such as increasing temperature and increasing abdominal symptoms to the attending physician after it was evident that the house officer would or did nothing with such information as well as failure by the nursing staff to record vital signs once every hour;

> i. On September 29, 2003 failure by the nursing staff to immediate[ly] report markedly abnormal laboratory values and increasing temperature to either the house officer and/or the attending physicians;
>
> j. Failure by the physicians and nursing staff to assure that an immediately and emergent operation was performed on Monday, September 29, 2003 instead of same occurring in the afternoon hours;
>
> k. Failure by the anesthesiologist and/or CRNA [certified registered nurse anesthetist] to closely monitor end tidals C02 such that once they began to rise the anesthesiologist should have been immediately notified and timely interaction should have occurred including, but not limited to[,] hyperventilating the patient, provide bicarbonate, etc.;
>
> l. Failure to timely prevent and otherwise identify and treat the signs and symptoms of sepsis; and,
>
> m. Any and all other breaches of the standard of care found to be violated through the course of discovery. [Underlining in original.]

On March 28, 2006, plaintiff filed his complaint, accompanied by four affidavits of merit.

Defendants moved for summary disposition; their motions made generally the same assertions that (1) the NOI failed to comply with MCL 600.2912b because it did not specifically state a particularized standard of care for each individual defendant and that (2) the affidavits of merit failed to comply with MCL 600.2912d because they did not explain how defendants' conduct caused the decedent's death. The trial court denied those motions, and this Court granted defendants' applications for leave to appeal.

This Court reviews a trial court's decision regarding summary disposition de novo. *Dressel v Ameribank*, 468 Mich 557, 561; 664 NW2d 151 (2003). This Court's review is limited to the evidence that was presented to the trial court. *Peña v Ingham Co Road Comm*, 255 Mich App 299, 313 n 4; 660 NW2d 351 (2003). Furthermore, this case presents an issue of statutory interpretation, which is also subject to review de novo. *Grossman v Brown*, 470 Mich 593, 598; 685 NW2d 198 (2004).

Pursuant to MCL 600.2912b(1), a person must send an NOI to a health care facility or professional at least 182 days before he or she commences any action for medical malpractice against the facility or professional. Furthermore, MCL 600.2912b(4) sets forth a number of requirements with which the NOI must comply. Specifically, it states:

> The notice given to a health professional or health facility under this section shall contain a statement of at least all of the following:
>
> (a) The factual basis for the claim.
>
> (b) The applicable standard of practice or care alleged by the claimant.

(c) The manner in which it is claimed that the applicable standard of practice or care was breached by the health professional or health facility.

(d) The alleged action that should have been taken to achieve compliance with the alleged standard of practice or care.

(e) The manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice.

(f) The names of all health professionals and health facilities the claimant is notifying under this section in relation to the claim.

The plain language of the statute therefore does not require multiple statements, nor does it state that plaintiffs must explicitly line qup particularized standards with individual defendants.

We are first urged to conclude that the Legislature *did* intend to require plaintiffs to explicitly provide such an analysis in NOIs on the basis that the Legislature used singular words in the above statute. However, that argument is entirely contrary to the dictates of MCL 8.3b, which states that in construing statutes, singular and plural words "extend to and embrace" or "may be applied and limited to" each other.

Defendants also rely on *Roberts v Mecosta Co Gen Hosp* (*After Remand*), 470 Mich 679; 684 NW2d 711 (2004). In that case, the plaintiff provided NOIs to the defendants, and each of those NOIs contained an identical (other than the name of each defendant) recitation of the applicable standard of care or practice. Our Supreme Court found this unacceptable, in *part* because the statements did not contain anything specifically and explicitly advising the corporate-entity defendants whether the plaintiff intended to proceed against them on a theory of direct liability or vicarious liability. *Id.* at 692-693. But our Supreme Court also explained more fully that the recitations in the NOIs were simply tautologies: in effect, they merely stated that the defendants violated the standard of care by violating the standard of care. *Id*. at 693-694. In contrast, the statement of standard of care in this case is clearly not a tautology, even when read in isolation from the recitation of facts.

Moreover, defendants' argument misconstrues what *Roberts* requires in the way of specifying vicarious or direct liability. The *Roberts* holding was that the statement therein "fails to *indicate* whether plaintiff was alleging" vicarious or direct liability, mostly because there was a confusing ambiguity between the complaint's apparent allegation of vicarious liability for the negligence of the hospital's agents, whereas the NOI "implied that plaintiff alleged direct negligence against these defendants for negligently hiring or negligently granting staff privileges to the individual defendants." *Id.* at 693 (emphasis added). In other words, the statement of the standard of care does not need to contain any explicit statement of whether a corporate defendant is directly or vicariously liable; rather, it only needs to "serve as adequate notice" to the defendants whether plaintiff intends to proceed against them on a vicarious liability theory. *Id.* Although all the information required by the statute must be "specifically identified in an ascertainable manner within the notice," it does not need to be set forth in any particular "method or format." *Id.* at 701.

Defendants further rely on this Court's recent decision in *Shember v Univ of Michigan Med Ctr*, 280 Mich App 309; 760 NW2d 699 (2008). We find *Shember* inapplicable for two significant reasons, either of which would be sufficient by itself. First, the NOI in this case was crafted in 2005, and *Shember* was decided three years later. Even if *Shember* imposed additional specificity requirements, which it did not, it would be unjust and unfair to evaluate the sufficiency of plaintiff's NOI under a standard more stringent than what existed *at the time* the NOI was drafted.

In any event, *Shember* involved a medical malpractice suit against a number of defendants, and it was alleged that the NOI failed to identify the applicable standard of practice or care with regard to some of those defendants. *Id.* at 319-320. This Court only recited what *Roberts* had already explained: (1) that the standard of care must be described as something more specific than literally "the standard of care," (2) that all named defendants must be able to discern from the NOI generally what theory they are expected to defend against, and (3) that different defendants might be expected to comply with different standards of care. *Shember* does not expand on *Roberts*; rather, it holds the same principle that if multiple defendants are involved, the NOI needs to provide enough information for each of those defendants to discern the general nature of what theory he, she, or it may expect to defend against, nothing more.

As discussed, *Roberts* did not hold that the NOI must explicitly state whether a plaintiff intends to proceed against a corporate defendant on a theory of direct or vicarious liability. Rather, plaintiffs should not present defendants with ambiguity regarding the nature of the action of which they are providing notice. In other words, the *Roberts* Court was concerned that each defendant must be reasonably able to discern the general nature of the cause of action that will be alleged against them.

Our Supreme Court has explained that even if an NOI "may conceivably have apprised [a defendant] of the nature and gravamen of [the] plaintiff's allegations," the applicable statutory standard nevertheless requires NOIs to contain "a 'statement' describing" all the items of information enumerated in MCL 600.2912b(4). *Boodt v Borgess Med Ctr*, 481 Mich 558, 560-561; 751 NW2d 44 (2008). However, our Supreme Court did not address, let alone criticize, this Court's prior discussion explaining that, otherwise, those statements did not need to be any more specific than would be required of allegations in a complaint or other pleading: they must only give fair notice to the other party. *Boodt v Borgess Med Ctr*, 272 Mich App 621, 626-628; 728 NW2d 471 (2006). Indeed, our Supreme Court reaffirmed that a plaintiff must only provide a good-faith statement of what is being claimed against each defendant, recognizing that discovery would not yet have begun. *Boodt*, 481 Mich at 561. Along those same lines, this Court observed that medical professionals surely keep records, particularly of any "mishaps"; consequently, as long as the technical requirements of the statute are complied with, it "strains credulity to conclude" that the defendants would not understand the nature of the suit plaintiff was planning to commence. See *Boodt*, 272 Mich App at 632-633.

Thus, the issues are whether the NOI contains "a statement" that provides information containing all the enumerated requirements of MCL 600.2912b(4), and whether those statements reasonably communicate to a medical professional or medical facility (which surely has better access to information than the plaintiff) the nature of the claim the plaintiff intends to pursue against the medical professional or medical facility. In other words, *Roberts* and *Boodt*, when

read together, hold that it is insufficient if an NOI *only* provides notice or *only* provides "a statement." It must do both. Here, it is clear that plaintiff did provide the requisite statement, and plaintiff unambiguously alleges a collective failure by all defendants, in *both* supervisory and direct roles, to take fairly specific actions on the basis of fairly specific information.

We agree with the trial court that plaintiff's NOI satisfied MCL 600.2912b.

Next, pursuant to MCL 600.2912d, a plaintiff in a medical malpractice cause of action must submit an affidavit of merit with the complaint. The affidavit must be signed by a health care professional that could reasonably qualify as an expert witness. MCL 600.2912d(1). The affidavit must set forth the following:

> (a) The applicable standard of practice or care.
>
> (b) The health professional's opinion that the applicable standard of practice or care was breached by the health professional or health facility receiving the notice.
>
> (c) The actions that should have been taken or omitted by the health professional or health facility in order to have complied with the applicable standard of practice or care.
>
> (d) The manner in which the breach of the standard of practice or care was the proximate cause of the injury alleged in the notice. [MCL 600.2912d(1).]

Defendants each allege that plaintiff's affidavits of merit failed to comply with MCL 600.2912d(1)(d) because they merely concluded that the allegedly negligent acts were the proximate cause of the decedent's death, without specifying exactly how the acts caused the death.

Defendants primarily rely on an unpublished, and therefore nonbinding, case from this Court that nevertheless fails to suggest that the affidavits of merit here were deficient. In *Bond v Cooper (On Reconsideration)*, unpublished opinion per curiam of the Court of Appeals, issued May 22, 2008 (Docket No. 273315), this Court observed that the plaintiff's affidavit of merit merely stated, "'the violations of the standard of care are a proximate cause of the damages claimed by the Plaintiff.'" *Id.* at 3. This Court stated, "[t]he deficiency of this affidavit of merit is apparent. Simply stating that violations of the standard of care 'are a proximate cause of the damages' does not fulfill the statutory requirement that the affidavit state the 'manner in which the breach of the standard of practice or care was the proximate cause of the injury alleged in the notice.'" *Id.* However, the Court continued to state that the deficiency in that case was "not remedied by an examination of the affidavit as a whole." *Id.* As this Court implied—and we now expressly state—the purpose of the affidavits of merit, as with NOIs, and as with documentary or statutory analysis in general, would not be furthered by examining individual

components in isolation from the whole.[3] Thus, even if a given section of the affidavit does not adequately address proximate cause, the dispositive question is whether the affidavit *as a whole* nevertheless explains how the alleged malpractice proximately caused the injury.

The actual sections of plaintiff's affidavits that address proximate cause are relatively conclusory in nature. Critically, however, the other portions of the affidavits are much more detailed. Each of the affidavits explains that the various health care professionals failed to treat the decedent's symptoms in a timely fashion, that his condition continued to deteriorate, that he developed sepsis and cholecystitis, and that he died. Moreover, defendants are sophisticated parties, knowledgeable in the field of medicine, and presumably in possession of reasonably illuminating records pertaining to the decedent's treatment and death. The affidavits of merit were not lacking in detail or difficult to decipher. They communicated that because of the alleged malpractice, the decedent's condition deteriorated and caused his death. To hold that they were deficient because the sections that addressed proximate cause lacked the specificity that other sections possessed would be to exalt form over substance.

We therefore agree with the trial court that plaintiff's affidavits of merit satisfied MCL 600.2912d.

Affirmed.

Servitto, J., concurred.

/s/ Alton T. Davis
/s/ Deborah A. Servitto

[3] In *Craig v Oakwood Hosp*, 471 Mich 67, 86-88; 684 NW2d 296 (2004), our Supreme Court explained that a mere correlation between alleged malpractice and an injury is insufficient to establish proximate cause; but *Craig* addressed the elements of a medical malpractice cause of action pursuant to MCL 600.2912a, not the sufficiency of an affidavit of merit. Given that an affidavit of merit is attached to a plaintiff's complaint, and is thus produced before the discovery period, it would be inappropriate to hold an affidavit of merit to the same standard.