STATE OF MICHIGAN

COURT OF APPEALS

ERIC SESSOMS,

Plaintiff-Appellee,

v

BAY REGIONAL MEDICAL CENTER, ROBERT J. FERENCE, M.D. and TERRENCE J. CHERWIN, D.O.,

Defendants-Appellants.

UNPUBLISHED
August 22, 2006

No. 260516
Bay Circuit Court
LC No. 04-003448-NH

Before: Cavanagh, P.J., and Smolenski and Talbot, JJ.

PER CURIAM.

Defendants appeal by leave granted[1] from the trial court's order denying, in part, defendants' motions for summary disposition. We reverse and remand for entry of summary disposition in favor of defendants.

I. Background

On July 6, 2002, plaintiff, a then 25-year-old Ohio resident, suffered a broken leg after rolling down a hill while vacationing in Bay City, Michigan. He was first admitted to Standish Community Hospital, which transferred him to defendant Bay Regional Medical Center (BMC), where he was diagnosed as having broken his left tibia and fibula and was admitted as a patient. The following day[2] defendant Dr. Robert Ference, a board certified orthopedic surgeon, performed surgery described as an "intermedullary rodding of the left tibia."

Following the surgery, Ference did not return to check the wound, but on July 12, 2002, went on vacation, at which time defendant Dr. Terrence Cherwin, who is also a board certified orthopedic surgeon, took over as plaintiff's attending physician. On July 13, 2002, at

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[1] *Sessoms v Bay Regional Medical Ctr*, unpublished order of the Court of Appeals, issued March 21, 2005 (Docket No. 260516).

[2] Although it is not clear from the record when the surgery was performed, plaintiff alleges that it occurred the day after he was admitted.

approximately 4:00 A.M., staff at the hospital unwrapped plaintiff's bandages for the first time. The gauze had healed into the wound and the incision was discolored, weeping, and had a foul odor. At approximately 10:00 A.M. that day, Cherwin checked on plaintiff and examined the wound. He ordered bacteriological cultures of the wound for immediate testing, but plaintiff requested to be discharged before the test results were returned. On the condition that plaintiff would go directly to a hospital in Toledo, Ohio, Cherwin released plaintiff from BMC that day with a prescription for Keflex, an antibiotic.

Upon plaintiff's release, his mother had him immediately admitted to St. Vincent's Hospital in Toledo. The medical records BMC had provided plaintiff with contained no information about his leg. St. Vincent's called BMC for additional information, but the additional records BMC faxed to St. Vincent's also did not contain any information relevant to plaintiff's post-surgical condition. On July 17, 2002, plaintiff was transferred to the Medical College of Ohio (MCO), where he was admitted for emergency surgery and treatment of the infection.

Meanwhile, on July 15, 2002, BMC received the final results of the bacteriological culture that identified the infecting microbe as a strain of aeromonas, a dangerous antibiotic-resistant bacterium. This information was not provided to anyone outside BMC until August 5, 2002, when Ference wrote a letter to plaintiff advising him to follow up on his postoperative care. Over the next six months, plaintiff was given intensive antibiotic treatment and underwent 13 surgeries on his leg to clean out the wound. Over time, the wound became so large that it would not close, and doctors at MCO attempted to graft plaintiff's latissimus dorsi muscle over the wound; however, the graft did not take. Eventually, plaintiff's leg had to be amputated to stop the spread of the infection.

After filing his notice of intent to file suit, plaintiff filed the complaint in this case on June 28, 2004, alleging negligence and medical malpractice against Ference and Cherwin, and negligence, respondeat superior/agency liability, and res ipsa loquitur against BMC. Two affidavits of merit accompanied the complaint: one from Ross Hewitt, M.D., an internist specializing in infectious disease, and one from Eric Muñoz, M.D., who is board certified in general surgery. In September 2004, defendants moved for summary disposition pursuant to MCR 2.116 (C)(7), (8), and (10). Ference and Cherwin argued that the affidavits of merit filed in this case failed to comply with MCL 600.2912d and 600.2169 because both defendants are board certified in orthopedic surgery, but neither affiant is so certified, contrary to the statutory "same specialty" requirement. BMC argued that it was entitled to summary disposition because plaintiff failed to allege a claim of direct negligence against it, failed to name any specific agent that was negligent in support of his vicarious liability claim, and failed to allege a prima facie case of res ipsa loquitur.

The trial court held that, even though the affiants who signed the affidavit of merit did not have the same board certifications as Ference and Cherwin, defendants' board certifications in orthopedic surgery were not relevant to the alleged malpractice in postoperative care. The trial court, however, dismissed the malpractice claims against BMC with respect to the alleged malpractice of the nursing staff because plaintiff provided no affidavit of merit from a nurse. Additionally, the trial court refused to dismiss the claims against BMC for ordinary negligence and res ipsa loquitur.

II. Standard of Review

This Court reviews de novo decisions on summary disposition motions. *Woodard v Custer* (*Woodard I*), 473 Mich 1, 5; 702 NW2d 522 (2005), citing *Grossman v Brown*, 470 Mich 593, 598; 685 NW2d 198 (2004). This case also involves the interpretation of MCL 600.2912d(1) and MCL 600.2169(1).

> This Court reviews questions of statutory interpretation de novo. *Halloran v Bhan*, 470 Mich 572, 576; 683 NW2d 129 (2004). However, this Court reviews a trial court's rulings concerning the qualifications of proposed expert witnesses to testify for an abuse of discretion. *Cox v Flint Bd of Hosp Managers*, 467 Mich 1, 16 n 16; 651 NW2d 356 (2002). An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes. *Novi v Robert Adell Children's Funded Trust*, 473 Mich 242, 254; 701 NW2d 144 (2005). [*Woodard v Custer* (*Woodard II*), ___ Mich ___; ___ NW2d ___ (2006).]

III. Discussion

A. Medical Malpractice

Defendants argue on appeal that the trial court erred in finding that the relevant standard of practice or care was postoperative care, that Ference's and Cherwin's board certifications in orthopedic surgery were irrelevant to that standard of care, and that plaintiff's expert witnesses were, therefore, not required to be board certified in orthopedic surgery. We agree.

MCL 600.2912d(1) provides, in relevant part:

> [I]n an action alleging medical malpractice . . . the plaintiff's attorney shall file with the complaint an affidavit of merit signed by a health professional who the plaintiff's attorney reasonably believes[3] meets the requirements for an expert witness under section 2169. [Footnote added.]

MCL 600.2169 provides:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:

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[3] Although this section merely requires that plaintiff's attorney reasonably believed that Hewitt and Muñoz met the requirements for an expert under § 2169, plaintiff failed to raise this argument below and has not briefed it on appeal; therefore, the argument is abandoned. See *Etefia v Credit Technologies, Inc*, 245 Mich App 466, 471; 628 NW2d 577 (2001).

> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

In applying this section, our Supreme Court has recently stated:

> Although specialties and board certificates must match, not *all* specialties and board certificates must match. Rather, § 2169(1) states that "a person shall not give expert testimony on the *appropriate* standard of practice or care unless . . . ." (Emphasis added.) That is, § 2169(1) addresses the necessary qualifications of an expert witness to testify regarding the "*appropriate* standard of practice or care," not regarding an inappropriate or irrelevant standard of medical practice or care. Because an expert witness is not required to testify regarding an inappropriate or irrelevant standard of medical practice or care, § 2169(1) should not be understood to require such witness to specialize in specialties and possess board certificates that are not relevant to the standard of medical practice or care about which the witness is to testify. [*Woodard II, supra* at ___.]

The Court further stated, "Because the plaintiff's expert will be providing expert testimony on the appropriate or relevant standard of practice or care, not an inappropriate or irrelevant standard of practice or care, it follows that the plaintiff's expert witness must match the one most relevant standard of practice or care—*the specialty engaged in by the defendant physician during the course of the alleged malpractice, and, if the defendant physician is board certified in that specialty, the plaintiff's expert must also be board certified in that specialty*." *Woodard II, supra* at ___ (emphasis added). Thus, a trial court's first task in determining whether an expert witness is qualified to testify under § 2169(1) is to determine the one most relevant standard of practice or care, which is "the specialty engaged in by the defendant physician during the course of the alleged malpractice." *Id.*

Here, plaintiff argued, and the trial court agreed, that the claimed malpractice is not alleged to have occurred while Ference and Cherwin were practicing their board certified specialty of orthopedic surgery, but rather during plaintiff's postoperative care. Thus, the trial court held that "expert testimony in the area of orthopaedic [sic] surgery would not be very relevant, germaine [sic] and/or helpful to the trier of fact in this case," but "because the claimed malpractice is alleged to have occurred during the post operative care of plaintiff, expert testimony in the area of internal medicine, infectious disease and/or general surgery *would be* very relevant." (Emphasis original.) The trial court found that plaintiff's experts are "more than qualified to attest to the common and general standard of care to be taken post operatively in the prevention of infectious disease, regardless of the type of underlying surgery which is irrelevant to the nature of such case," and, therefore, "the fact that plaintiff's experts are not board certified in orthopaedic [sic] surgery is not determinative and does not render plaintiff's affidavits of merit insufficient."

We find that the trial court abused its discretion by determining that the one most relevant standard or practice of care is postoperative care. Plaintiff alleges that malpractice occurred

during the postoperative care phase of his treatment at BMC rather than during the surgery itself, but plaintiff has no evidence to support his assertion that the infection, in fact, occurred during the post operative care as opposed to during the surgery. To the contrary, plaintiff's attorney argued before this Court on appeal that, because aeromonas is a water-born bacteria, it was present on plaintiff's leg when he was initially injured and, therefore, the malpractice must have occurred either before or during surgery because the surgical site was never properly cleaned.[4]

The doctors responsible for plaintiff's care during his entire course of treatment at BMC, including both the surgery and the postoperative care, were board certified orthopedic surgeons. Plaintiff has no support, other than his own bare assertion, for his argument that the relevant standard of practice or care during his course of treatment somehow changed between the preoperative and surgical phases and the postoperative phase so as to render the only board certifications of both of his treating physicians irrelevant. Plaintiff's attempt to separate the phases of his treatment and define, out of whole cloth, a new specialty in which his treating physicians were not certified would render the matching certifications requirement of § 2169 meaningless. We will not interpret a statute in a manner that renders any of its language meaningless or nugatory, *Hoste v Shanty Creek Mgt, Inc*, 459 Mich 561, 574; 592 NW2d 360 (1999), nor are we bound by plaintiff's choice of labels for the alleged malpractice because to do so would exalt form over substance, *Johnston v City of Livonia*, 177 Mich App 200, 208; 441 NW2d 41 (1989).

Moreover, despite the trial court's determination that postoperative care was the relevant specialty, the trial court held that the expert testimony of plaintiff's affiant Muñoz, a board certified general surgeon, would be relevant, germane, and helpful to the trier of fact. Thus, by plaintiff's and the trial court's own reasoning, the testimony of a surgeon is relevant to the standard of care at issue. Our Supreme Court, however, held that "if a defendant physician has received certification from a medical organization [in the relevant specialty area], the plaintiff's expert witness must also have obtained the same certification in order to be qualified to testify concerning the appropriate standard of medical practice or care." *Woodard II*, *supra* at ___. In other words, where the expert testimony of a surgeon, such as Muñoz, is required to set forth the relevant standard of practice or care during post surgical treatment and the defendant surgeon is board certified in orthopedic surgery, under § 2169(1) the plaintiff's expert must also be board certified in orthopedic surgery.

Because the trial court's decision renders the matching certifications requirement of § 2169(1) meaningless and is contrary to our Supreme Court's holding in *Woodard II*, it "results in an outcome falling outside the principled range of outcomes" and therefore constitutes an abuse of discretion. *Woodard II*, *supra* at ___. The relevant standard of practice or care in this case is that which is required before, during, and after plaintiff's surgery—not merely postoperatively.

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[4] We realize that plaintiff's attorney is not qualified to give expert testimony with regard to the alleged malpractice and that her statements were merely argument; however, her argument demonstrates the trial court's error in relying on such lay argument to determine that postoperative care is the relevant specialty, to the exclusion of surgical care, in which Ference and Cherwin hold board certifications in orthopedic surgery.

Because Ference and Cherwin are both board certified in orthopedic surgery, for plaintiff's affidavits of merit to meet the requirements of § 2912d(1), plaintiff's expert witnesses must also hold board certifications in orthopedic surgery. The trial court, therefore, erred in denying defendants' motion for summary disposition with regard to plaintiff's claims against Ference and Cherwin.

B. Ordinary Negligence

Defendants next argue that the trial court erred by refusing to dismiss plaintiff's negligence claims against BMC because those claims actually sound in medical malpractice. We agree.

Paragraph 31 of plaintiff's complaint sets forth the following claims of ordinary negligence against BMC:

> In addition to the medial malpractice of its doctors, incorporated herein, [BMC's] staff had a duty to proper patient care [sic], including but not limited to: (1) surveillance of the post-operative wound; (2) changing the dressing despite the lack of doctor's orders; (3) bring to the doctor's attention that the dressing had not yet been changed; (4) observe and report to the doctors the sign of infection; (5) conduct proper discharge planning, including providing proper medical records, arranging for care with subsequent providers, and providing transportation thereto; (6) response to St. Vincent's inquiry as to [plaintiff's] infection; (7) provide appropriate medical records at St. Vincent's request; and (8) alert [plaintiff] and/or his subsequent medical providers upon identification of bacteria to be the ultra dangerous Aeromonas.

Although the trial court ruled that subparagraphs (1) through (4) all sound in medical malpractice and dismissed those claims, plaintiff argues on appeal, without having filed a cross appeal, that BMC staff had a duty to implement and enforce postoperative care procedures that would give rise to an ordinary negligence claim. Because plaintiff has not filed a cross appeal with regard to these arguments, and resolving these arguments in favor of plaintiff as to subparagraphs (1) to (4) would give plaintiff a theory of recovery against BMC that was denied by the trial court, the trial court's decision with respect to these arguments has not been presented for appellate review. See *In re Estate of Herbach*, 230 Mich App 276, 284; 583 NW2d 541 (1998) ("[A] cross appeal is necessary to obtain a decision more favorable than that rendered by the lower tribunal."). We therefore decline to address plaintiff's argument with regard to subparagraphs (1) through (4).

With respect to subparagraphs (5) through (8) regarding the BMC staff's duties relative to patient discharge, record transfer, response to record requests, and its duty to forward life-threatening test results, *all* allegations concern aspects of medical judgment that are beyond the common knowledge or experience of a juror. The average juror would know nothing about the standard of care applicable to patient transfer without an expert setting forth the appropriate standard of care and, without expert testimony, could only speculate what duties the hospital staff would have. In other words, with respect to the staff's duty to forward medical records, respond to record requests, and follow-up with test results, the average juror would not know what information should be provided in such records, requests, or follow-ups because such a

determination would be based on medical judgment. Neither would an average juror know what risk an aeromonas infection could pose. Thus, a jury could not rely on common knowledge or experience to find that BMC or anyone was negligent. Moreover, *all* of plaintiff's admissible evidence that aeromonas is potentially threatening to life or limb is based solely on expert testimony. Although the trial court held that BMC staff had breached a duty giving rise to a claim of ordinary negligence because plaintiff's condition was potentially life threatening, the court's conclusion regarding the seriousness of the infection could only have been based on expert testimony. See *Sturgis Bank & Trust Co v Hillsdale Community Health Ctr*, 268 Mich App 484, 497; 708 NW2d 453 (2005), quoting *Bryant v Oakpointe Villa Nursing Ctr*, 471 Mich 411, 423-424; 684 NW2d 864 (2004) ("[W]hether a claim will be held to the standards of proof and procedural requirements of a medical malpractice claim as opposed to an ordinary negligence claim depends on whether *the facts* allegedly raise issues that are within the common knowledge and experience of the jury or, alternatively, raise questions involving medical judgment." (emphasis added)).

Moreover, in analyzing what information would be within the realm of medical judgment and could not give rise to a claim of ordinary negligence, our Supreme Court in *Dorris v Detroit Osteopathic Hosp Corp*, 460 Mich 26, 46-47; 594 NW2d 455 (1999), reasoned that questions of "medical management" are essentially synonymous with "medical judgment." "[M]edical management [is] to be established by expert testimony," and "allegations concerning staffing decisions and patient monitoring involve questions of profession medical management and not issues of ordinary negligence that can be judged by the common knowledge and experience of a jury." *Id*. (citations omitted). Clearly, implementing and overseeing procedures for hospital discharge, records transfer, and following up with test results concern medical management.

Plaintiff, nonetheless, argues that *McClaine v Alger*, 150 Mich App 306, 313; 388 NW2d 349 (1986), established that a claim that a hospital failed to provide appropriate records is a claim for ordinary negligence and quotes language from the opinion that referred to the claim as a "simple negligence claim." However, because plaintiff has taken this quote out of context, plaintiff's argument is without merit. In disposing of an argument that a second hospital should have discovered plaintiff's broken bone even without the requested x-rays or correct diagnosis from the first hospital, the Court "decline[d] to shift the duty to defendant doctors under the 'learned intermediary' doctrine, heretofore applicable only to prescription drug products liability actions, in this simple negligence claim." *Id.* However, the Court's use of language here could not have been a ruling that plaintiff's claim was for ordinary negligence as opposed to professional negligence, or medical malpractice, because that issue was not before the Court, nor was there any argument that such a ruling would be in any way relevant. To the contrary, the Court repeatedly stated that the claim was one for medical malpractice. *Id.* at 313, 315, 316. Thus, even if the Court in *McClaine* ruled that the claim was for ordinary negligence, which it did not do, any such holding would have been dicta. See *Meyer v Mitnick*, 244 Mich App 697, 701; 625 NW2d 136 (2001) (holding that "[s]tatements regarding a rule of law that are not essential to the outcome of the case do not create a binding rule of law"). Furthermore, although *McClaine* presents a similar fact pattern, plaintiff's claim in the present case fails for reasons not considered in *McClaine*, because the earliest version of MCL 600.2912d was adopted in 1993, well after *McClaine* was decided. In any event, we are not bound by the Court's ruling in *McClaine* because it was decided before November 1, 1990. MCR 7.215(J)(1).

We find that plaintiff's alleged claims of ordinary negligence against BMC, in fact, sound in medical malpractice. Because plaintiff failed to comply with the statutory requirements for a medical malpractice action against BMC, the trial court erred in refusing to grant defendants' motion for summary disposition.

C. Res Ipsa Loquitur

Lastly, defendants argue that the trial court erred in refusing to dismiss plaintiff's claim based on the doctrine of res ipsa loquitur. We agree.

In order to avail himself of the doctrine of res ipsa loquitur, plaintiff must meet the following conditions:

> (1) the event must be of a kind which ordinarily does not occur in the absence of someone's negligence;
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> (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant;
>
> (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff; and
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> (4) evidence of the true explanation of the event must be more readily accessible to the defendant than to the plaintiff.

[*Woodard I, supra* at 7 (citations and internal quotation marks omitted).]

Plaintiff has failed to meet these conditions in several respects. First, "[t]he mere occurrence of a post-operative infection is not a situation which gives rise to an inference of negligence when no more has been shown than the facts that an infection has occurred and that an infection is rare." *Wilson v Stilwill*, 411 Mich 587, 608; 309 NW2d 898 (1981) In other words, even if plaintiff had proven that infections are statistically rare at BMC, "this fact does not suggest that when an infection does occur, it is the result of negligence." *Id*. Second, because plaintiff already had the infection when he left the hospital, defendant's exclusive control argument is questionable. We also note that plaintiff's conclusion in this regard is supported entirely by expert testimony presented in invalid affidavits of merit and inadmissible evidence. In any event, with respect to the fourth element, this is not a case where "evidence of the true explanation of the event [would] be more readily accessible to the defendant than to the plaintiff," *Woodard I, supra* at 7, because plaintiff knows what happened to cause the loss of his leg. This also demonstrates that plaintiff is not trying to utilize res ipsa loquitur to permit an inference of negligence when the true cause is unknown, which is the rationale behind the rule. *Jones v Porretta*, 428 Mich 132, 150; 405 NW2d 863 (1987). Thus, plaintiff has not provided adequate support for his res ipsa loquitur claim.

Although the trial court concluded that amputation following surgery for an allegedly minor leg break was more than a mere bad result and would support an inference of negligence, "a prima facie res ipsa medical malpractice case requires more than a showing of bad result." *Jones, supra* at 152. The trial court's conclusion is also contrary to our Supreme Court's holding

in *Woodard I, supra* at 7, that "whether a leg may be fractured in the absence of negligence when placing an arterial line or a venous catheter in a newborn's leg is not within the common understanding of the jury." Similarly, that aeromonas cannot be treated with Keflex is not within a jury's common understanding or experience. Just as the procedure at issue in *Woodard I* was "not within the common knowledge of a reasonably prudent jury," an "intermedullary rodding of the left tibia" and the postoperative risks are beyond the common knowledge of the average jury.

IV. Conclusion

The trial court abused its discretion in determining that the relevant standard or practice of care was that which applied to postoperative care. The trial court erred in determining that plaintiff's affidavits of merit met the requirements of MCL 600.2912d(1) and in denying defendant's motion for summary disposition with regard to plaintiff's claims against Ference and Cherwin. The trial court also erred by refusing to dismiss plaintiff's negligence claims against BMC because those claims actually sound in medical malpractice. Lastly, the trial court erred in refusing to dismiss plaintiff's claim based on the doctrine of res ipsa loquitur because that doctrine does not apply to the facts of this case.

Reversed and remanded for entry of summary disposition in favor of defendants. We do not retain jurisdiction.

/s/ Mark J. Cavanagh
/s/ Michael R. Smolenski
/s/ Michael J. Talbot