STATE OF MICHIGAN

COURT OF APPEALS

ALAN A. MAY, Personal Representative of the ESTATE of BURR NEEDHAM,

Plaintiff-Appellant,

v

MERCY MEMORIAL NURSING CENTER, a/k/a MONROE COMMUNITY HEALTH SERVICES, ARUN GUPTA, M.D., WILLINE BELOW, LPN, RETA OBLINGER, LPN, S. SCOTT, LPN, TINA DALE, LPN, and JULIE CEBINA, LPN,

Defendants-Appellees.

UNPUBLISHED
January 20, 2009

No. 280174
Monroe Circuit Court
LC No. 05-019213-NH

Before: Murphy, P.J., and Sawyer and Whitbeck, JJ.

PER CURIAM.

Plaintiff appeals as of right the trial court's orders granting summary disposition in favor of defendants in this action arising out of the death of nursing home patient Burr Needham. Plaintiff Alan May, personal representative of Mr. Needham's estate, alleged that the decedent died from acute morphine intoxication. Various causes of action were pursued and all summarily dismissed by the trial court, which ruled, in part, that plaintiff failed to establish a genuine issue of material fact regarding whether morphine intoxication was the cause of death. We affirm in part, reverse in part, and remand for further proceedings.

Decedent fractured his hip on April 24, 2002. He received non-surgical treatment from the University of Michigan Hospital and was transferred on April 26, 2002, to defendant Mercy Memorial Nursing Center (Mercy Memorial) for rehabilitation. Decedent had not been a candidate for surgical treatment due to existing health problems, which included, in part, diabetes, coronary artery disease, Parkinson's disease, and orthostatic hypotension. Although decedent was alert and oriented upon admission to Mercy Memorial, his health began to decline fairly rapidly, and he died on May 2, 2002.

When decedent was admitted to Mercy Memorial, he was considered "full code," meaning that the nursing home should take all possible steps to revive him in an emergency situation. He did not, however, sign the paperwork indicating his resuscitation preferences; rather, "full code" was a default status. Decedent was treated with narcotic medications to ease his pain upon admission to Mercy Memorial and throughout his entire stay. As decedent's health

began to decline, defendant Dr. Arun Gupta[1] recommended that decedent be transferred to a hospital for testing and diagnosis. At around this time, decedent's wife, Betty Needham, began making healthcare decisions for decedent under a durable power of attorney (DPOA). Mrs. Needham refused to have decedent transferred to a hospital setting for testing, stating that as a Jehovah's Witness, decedent would not want additional medical procedures to be undertaken.

Mrs. Needham, while refusing to consent to the decedent's transfer to a hospital, did permit the nursing home to continue administering pain relief medications to her husband. Mrs. Needham claimed that she was never fully informed about the seriousness of her husband's condition. Decedent's condition kept deteriorating, he continued to receive pain medications in the nursing home, and when his health worsened further on May 1, 2002, Dr. Gupta again recommended transfer to a hospital. The doctor stated that decedent would be transferred unless Mrs. Needham produced the DPOA paperwork. Mrs. Needham then brought in the DPOA and continued to refuse to allow for decedent's transfer. Dr. Gupta prescribed additional pain medications for decedent. Burr Needham died on May 2, 2002, while at Mercy Memorial.

Plaintiff filed the instant lawsuit under Michigan's Wrongful Death Act (WDA), MCL 600.2922, alleging that decedent "died on May 2, 2002, at 2:45 p.m. of acute morphine intoxication." The complaint named Mercy Memorial, Dr. Gupta, and five licensed practical nurses (LPNs) who provided care for decedent as defendants. Count I of the complaint alleged that Mercy Memorial was liable under a theory of direct institutional liability pursuant to, in part, 42 USC 1395 *et seq.*, 42 CFR 483.1 *et seq.*, MCL 333.21701 *et seq.*, and 2007 AC, R 325.20101 *et seq.*, which are state and federal statutes and regulations governing the operation of nursing homes. Count II of the complaint alleged that Mercy Memorial was vicariously liable for the negligent acts of its nursing staff. Count III of the complaint alleged negligence by Dr. Gupta. Count IV sought to hold Mercy Memorial vicariously liable for Dr. Gupta's alleged negligence. Count V alleged negligence on the part of the individual nurses. Count VI alleged battery, with plaintiff asserting that one or more of the defendant nurses injected the decedent with morphine in an amount and at a time not ordered by decedent's doctor, that morphine was not requested by decedent or Mrs. Needham, and that the administration of morphine was an intentional, harmful, and offensive touching of Mr. Needham.

Defendants moved for partial summary disposition with respect to the battery claim, arguing that there was no evidence of an "injection of morphine;" rather, oral morphine was used to relief the decedent's pain. Defendants also filed a motion to strike plaintiff's claim for economic damages in regard to lost business and trust income and lost household services, which issue arose when plaintiff's economic expert calculated damages for such losses.[2] Additionally, defendants moved for partial summary disposition on plaintiff's claim against Mercy Memorial

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[1] Dr. Gupta was decedent's attending physician and the medical director at Mercy Memorial.

[2] Defendants later filed a supplemental brief in which they argued that "loss of services" is not an item of damages permitted under the WDA, that "loss of services" is already compensated for as part of any recovery for loss of society and companionship, and that the "loss of services" claim should be dismissed because there was no supporting evidence.

alleging direct institutional liability. Defendants argued that the institutional liability count was simply a straightforward claim of medical malpractice unsupported by expert testimony. Defendants later filed an additional motion for summary disposition, arguing that plaintiffs failed to create a factual dispute on the issue of causation, where the documentary evidence failed to show that the decedent died of a morphine overdose. This motion also made a request to strike the testimony of plaintiff's expert, Dr. Werner Spitz, on the issue of causation because it was speculative.

At the hearing on the multiple motions filed by defendants, the parties first stipulated to withdrawal of the claim regarding lost trust income, the trial court ruled that a claim for lost business income could be pursued, and the court found that the claim for loss of household services must be struck because the WDA made no provision for such damages. Further, the trial court ruled that the direct institutional liability claim failed because plaintiff did not submit any expert documentary evidence necessary to create a genuine issue of fact on the claim. With respect to the battery claim, defense counsel contended that there was absolutely no evidence of an intentional overdose of morphine. Plaintiff's counsel responded by first indicating that, through discovery, information was obtained that supported a reformulation of the battery claim, and counsel sought permission from the court to amend the complaint with regard to the battery count.[3] The trial court stated that the case did not present an "angel-of-death scenario, where a healthcare provider seeing someone suffering decides to take the powers into their own hands and suggests that someone might be better off dead . . . and [then] administers some lethal dose of some type of drug[.]" The court thus found that the battery claim as alleged failed. The trial court also found plaintiff's new battery theory to be novel but dismissal was still appropriate because there was no proof of an intentional administration of morphine that would constitute a battery, because Mrs. Needham had the authority to make necessary healthcare decisions, and because defendants rightfully abided by those wishes. The trial court concluded that there would be no point in allowing amendment of the complaint, given that the new battery theory would fail as a matter of law. Finally, the parties argued the motion concerning causation and the striking of Dr. Spitz's deposition testimony on proximate cause. The court took those matters under advisement.

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[3] In responding to defendants' motion for summary disposition as to the battery claim, plaintiff challenged the validity of Mrs. Needham's DPOA, argued that the claim was not one of medical malpractice, and asserted as follows:

> Based on the legally insufficient, and otherwise factually ill informed wishes of Betty Needham, Dr. Gupta put Burr Needham on Roxanol (an oral form of morphine) to end his pain – forever. Burr Needham himself did not consent to this end of life decision, and he certainly did not consent to being given "Roxanol" to end his pain – forever. Such unrequested and otherwise illegal treatment constitutes an assault and battery by operation of law.

In a subsequent written opinion, the trial court ruled that plaintiff's expert failed "to establish but-for causation because he testified that therapeutic levels of the drug 'probably would not have killed decedent,' that he had 'no way to know' what the morphine levels were at the time of decedent's death and that he could not say more likely than not, the decedent possessed a higher than normal therapeutic morphine blood level at the time of his death." The court further commented that plaintiff's expert "clearly acknowledges that he cannot testify that it's more likely than not that morphine killed decedent because there is no way to know how much morphine was in decedent's blood stream," and therefore, plaintiff was unable to satisfy the requisite standard for proximate cause.

Orders on all of the court's rulings were entered, and one of the orders indicated that the court also granted the motion to preclude speculative proximate cause testimony by Dr. Spitz.

On appeal, plaintiff argues that the orders granting summary disposition violated plaintiff's due process rights, that, given the evidence, the court erred in concluding that plaintiff was unable to establish "but for" causation, that the court erred in dismissing the battery claim where the decedent did not consent to the administration of morphine to end his pain forever, that the court erred in dismissing the direct institutional liability claim where there was supporting expert testimony of state and federal violations of nursing home laws, and that the court erred in striking a damage claim for loss of services where such a claim is permitted by the WDA.

This Court reviews de novo a trial court's decision on a motion for summary disposition. *Kreiner v Fischer*, 471 Mich 109, 129; 683 NW2d 611 (2004). Constitutional issues are also reviewed de novo on appeal. *Wayne Co v Hathcock*, 471 Mich 445, 455; 684 NW2d 765 (2004).[4]

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[4] MCR 2.116(C)(10) is implicated in this case. MCR 2.116(C)(10) provides for summary disposition where there is no genuine issue regarding any material fact, and the moving party is entitled to judgment or partial judgment as a matter of law. A trial court may grant a motion for summary disposition under MCR 2.116(C)(10) if the pleadings, affidavits, and other documentary evidence, when viewed in a light most favorable to the nonmovant, show that there is no genuine issue with respect to any material fact. *Quinto v Cross & Peters Co*, 451 Mich 358, 362; 547 NW2d 314 (1996), citing MCR 2.116(G)(5). Initially, the moving party has the burden of supporting its position with documentary evidence, and, if so supported, the burden then shifts to the opposing party to establish the existence of a genuine issue of disputed fact. *Quinto, supra* at 362; see also MCR 2.116(G)(3) and (4). "Where the burden of proof at trial on a dispositive issue rests on a nonmoving party, the nonmoving party may not rely on mere allegations or denials in [the] pleadings, but must go beyond the pleadings to set forth specific facts showing that a genuine issue of material fact exists." *Quinto, supra* at 362. Where the opposing party fails to present documentary evidence establishing the existence of a material factual dispute, the motion is properly granted. *Id.* at 363. "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 v Gen Motors Corp*, 469 Mich 177, 183; 665 NW2d 468 (2003). Circumstantial evidence may present a factual issue. *Bergen v Baker*, 264 Mich App 376, 387; 691 NW2d 770 (2004). Speculation and conjecture are (continued…)

We first address the issue concerning causation. The Legislature has dictated the causation standard to be applied in medical malpractice cases. MCL 600.2912a(2) provides that "[i]n 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 *Robins v Garg (On Remand)*, 276 Mich App 351, 362; 741 NW2d 49 (2007), this Court, after quoting MCL 600.2912a(2), discussed the general principles regarding causation in the context of a medical malpractice action:

> "Proximate cause" is a term of art that encompasses both cause in fact and legal cause. *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004). "Generally, an act or omission is a cause in fact of an injury only if the injury could not have occurred without (or 'but for') that act or omission." *Id.* at 87. Cause in fact may be established by circumstantial evidence, but the circumstantial evidence must not be speculative and must support a reasonable inference of causation. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 496; 668 NW2d 402 (2003). "'All that is necessary is that the proof amount to a reasonable likelihood of probability rather than a possibility. The evidence need not negate all other possible causes, but such evidence must exclude other reasonable hypotheses with a fair amount of certainty.'" *Skinner v Square D Co*, 445 Mich 153, 166; 516 NW2d 475 (1994) . . . . Summary disposition is not appropriate when the plaintiff offers evidence that shows "that it is more likely than not that, but for defendant's conduct, a different result would have obtained." *Dykes v William Beaumont Hosp*, 246 Mich App 471, 479 n 7; 633 NW2d 440 (2001).

If there is reliance on circumstantial evidence, it must facilitate a reasonable inference of causation, not mere speculation, and the causation theory must have some basis in established fact. *Skinner, supra* at 164. Quoting *Kaminski v Grand Trunk W R Co*, 347 Mich 417, 422; 79 NW2d 899 (1956), the *Skinner* Court stated:

> "As a theory of causation, a conjecture is simply an explanation consistent with known facts or conditions, but not deducible from them as a reasonable inference. There may be 2 or more plausible explanations as to how an event happened or what produced it; yet, if the evidence is without selective application to any 1 of them, they remain conjectures only. On the other hand, if there is evidence which points to any 1 theory of causation, indicating a logical sequence of cause and effect, then there is a juridical basis for such a determination, notwithstanding the existence of other plausible theories with or without support in the evidence." [*Skinner, supra* at 164.]

(…continued)

insufficient, but an opposing party need not rebut every possible theory that the evidence could support. *Ghaffari v Turner Construction Co (On Remand)*, 268 Mich App 460, 464; 708 NW2d 448 (2005). A court may not make factual findings or weigh credibility. *Skinner v Square D Co*, 445 Mich 153, 161; 516 NW2d 475 (1994). A court may only consider substantively admissible evidence actually proffered relative to a motion for summary disposition under MCR 2.116(C)(10). *Maiden v Rozwood*, 461 Mich 109, 121; 597 NW2d 817 (1999).

The circumstantial evidence must afford a reliable basis from which reasonable minds could infer that, more probably than not, but for the [wrong] no injury would have occurred. *Id.* at 171.

At the heart of the trial court's ruling on causation and defendants' position below and on appeal is the deposition testimony of plaintiff's expert Dr. Werner Spitz that he could not determine the decedent's blood morphine level at the time of death on the basis of two blood draws and the toxicology report. Therefore, according to the court and defendants, any assertion that the decedent died of acute morphine intoxication is mere speculation, entitling defendants to summary disposition.

Dr. Spitz testified that the decedent died of acute morphine intoxication and that he had a level of morphine in his system that went beyond normal therapeutic levels. However, Spitz did state that there was no way for him to calculate from the blood draws what decedent's blood morphine level was at the time of death. Dr. Spitz explained that because of redistribution and pooling, morphine levels can vary on the basis of where blood is drawn from the body, and he "d[i]dn't know where this blood was taken from." Two blood samples had been taken from the body five days after death and revealed a blood morphine level "five times higher than normal." At a point in the deposition, Dr. Spitz stated that he could not say that it was more likely than not that the decedent's morphine level was higher than a normal therapeutic level at the time of death. However, Spitz's entire testimony must be examined and evaluated, and the apparent concession is taken out of context because it was part of the discussion regarding the blood draws and their revelations.

Dr. Spitz's deposition covered two days; the two days were separated by nearly three months. During the interim, Dr. Spitz had the opportunity to examine seven microscopic slides of autopsy tissues, coming from the heart (2), the lungs (3), the liver (1), and the kidneys (1). With respect to the heart tissues, Dr. Spitz testified that there was no evidence of an acute myocardial infarction. In regard to the lung tissues, Spitz indicated that the slides revealed mild emphysema, a small bit of pneumonia, and, significantly, a severe or advanced pulmonary edema. Dr. Spitz further testified that the liver looked good and that the kidneys showed some arteriosclerosis. With respect to chronic diseases identifiable from the microscopic slides, Spitz pointed to the emphysema and arteriosclerosis. The autopsy results also revealed coronary artery disease, which Spitz preferred to call "stenosis of a coronary artery," and which stenosis was 70 percent. Dr. Spitz stated that it was his original opinion, and it remained his opinion, that the death certificate, which listed acute morphine intoxication as the cause of death, was accurate.

Spitz then proceeded to testify:

> If morphine [here Roxanol] is withdrawn as the cause of death, then I have some difficulty to explain why this individual died. Because he does not have any other condition that would acutely – would explain the acute mode or the acute way in which he died.
>
> He did not die of the pneumonia. People don't die of that degree of pneumonia. Some people would go to work with that, and that includes me, with that degree of pneumonia. But he did die of respiratory problems, or with

respiratory problems occasioned by filling up the air sacs with proteinaceous fluid.

And sure, the alveoli have to be filled with air and not with protein. So that is called edema. And it is my opinion that that edema was brought on, not by any congestive heart failure, but by morphine intoxication.

* * *

The conditions that he had, lumping them together as arteriosclerosis and hypertension, both involving the cardiovascular system, may have rendered his body more susceptible to other cause of death.

But if you take a situation of morphine intoxication as well into the mix, then people die of morphine intoxication . . . .

* * *

I mean, it [morphine] pushed him over the cliff. . . . Pushing somebody over the cliff by causing this degree of lung edema, with no other real good cause – That's exactly what I said today, really, if you think of it – with arteriosclerosis, hypertension in an individual, predisposing him to die from a morphine overdose.

Normally he may need – he may need a – maybe a somewhat larger dose to cause him to die. But he died of morphine intoxication. There's no question in my mind.

* * *

[In response to a question asking what other causes, aside from morphine or narcotics, could result in an acute pulmonary edema] Congestive heart failure will cause pulmonary edema. It is rare that congestive heart failure will cause pulmonary edema to the extent of 1,000 grams each lung. While morphine is commonly known to cause that.

I can tell you that I've done hundreds, maybe several thousands of autopsies on heroin victims. . . . And these people invariably had lungs just like that.

* * *

[The morphine levels determined at the postmortem examination] are consistent with a level that would cause the manifestation that they did and sudden death. You see, there are – there's more to it than just a level, too. There is the rapidity of death. There is what led up to the death with the developing edema. There is the fact that there is no other cause that would bring this combination of facts about.

> So all this has to be considered. You cannot just base an opinion only on a level. Unless that level is some astronomical level, you are stuck with interpreting a situation where you need to take everything into account. And everything – taking everything into account, you have to consider the clinical manifestations and the level. The level is consistent. But in view of the clinical manifestations and the findings at the autopsy, as a whole, not just the toxicology, I think you have to concede that there is really no other way this man could have died.

When questioned whether pulmonary edema could have been the cause of death instead of morphine intoxication, Dr. Spitz explained that an edema is a result and not a cause; it must be brought on by something or some event, such as morphine intoxication. Spitz further explained that there is no such thing as a normal level of morphine, that there is a therapeutic level, that the decedent had beyond a therapeutic level of morphine, that a therapeutic level probably would not have killed the decedent, and that it was impossible to tell what the decedent's actual morphine level was at the time of death. Dr. Spitz stated that he had to presume that the blood morphine level was beyond a therapeutic level; however, he then clarified, "But in view of everything I know of this case, that's the only legitimate conclusion I can come to." At this point in his testimony, Dr. Spitz explained why he could not determine the decedent's actual morphine level at the time of death, stating:

> Literature will tell you that there is [a] possibility of redistribution, and that the morphine level would have been lower at one time in certain places, and may be augmented in some places, and other places it went down. I don't know where this blood was taken from, so I cannot really tell you. Although they did take it from two places, and in both places it's close to each other. As I've stated many times, you need – it needs to be – this case, as any case, needs to be considered together with the clinical manifestations, the autopsy findings, the microscopic slides and the toxicology; not any one of these individually. And when you do that, I think that's the only conclusion you can come to.

This testimony related directly to the blood draws and toxicology report and the impossibility, according to Spitz, to derive an accurate blood morphine level at the time of death from those sources, but this did not preclude Spitz from opining that the decedent died of acute morphine intoxication. At that juncture in his testimony, Dr. Spitz indicated that he could not say that it was more likely than not that the decedent's morphine level was higher than a normal therapeutic level at the time of death. But the doctor was clearly speaking only in terms of the blood draws and toxicology report. Defendants are thus taking the testimony entirely out of context and simply ignoring the other testimony provided by Dr. Spitz.

By analogy, one could accurately conclude that a person is intoxicated through the intake of liquor, even absent a blood or breathalyzer test, if there is evidence of slurred speech, the heavy smell of alcohol on the person's breath, walking difficulties, an inability to follow simple directions, loss of balance, a concession that the person had been drinking alcohol, and the

presence of nearby empty liquor containers; no other conclusion would be reasonable under a totality of the circumstances. Dr. Spitz could not place reliance on the blood draws and toxicology report; however, he could conclude, from a totality of the circumstances, that the decedent died from acute morphine intoxication.[5]

Additionally, another expert, Dr. Karl Steinberg, explained that the basis of his conclusion that the decedent was given too much narcotic pain medication was, in part, the decedent's level of alertness and his cognitive or mental status.[6] And the medical records certainly established that the decedent was receiving substantial amounts of pain medications.

Moreover, the assistant medical examiner listed "(pending) acute morphine intoxication" as the cause of death. The postmortem report prepared by the chief medical examiner concluded that the decedent "died of acute morphine intoxication," and that "[t]he blood morphine level at the time of death was about five times larger than the average therapeutic level."[7] A narrative summary of the postmortem examination did not suggest any other possible cause of death.

We conclude that an issue of fact exists regarding whether it is more probable than not that the decedent died of acute morphine intoxication. The fact that Dr. Spitz could not state that blood samples taken from the body five days after death established a higher than therapeutic level of morphine does not mean that plaintiff lacked the ability to prove death by morphine intoxication. Other indices of morphine intoxication, as testified to by Dr. Spitz, facilitated a reasonable inference of causation, not mere speculation, and they created, minimally, a factual dispute on causation. Spitz testified that there was only one plausible physiological explanation as to why the death occurred, and the circumstantial evidence afforded a reliable basis from which reasonable minds could infer that, more probable than not, death was caused by morphine intoxication. And the postmortem report, which indicated a blood morphine level five times above a normal therapeutic level at the time of death, cannot be ignored and discounted for purposes of a motion under MCR 2.116(C)(10), and the report reflected direct evidence of morphine intoxication. Accordingly, the trial court erred with respect to its ruling on causation, and it was error to strike Dr. Spitz's proximate cause testimony.

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[5] Although plaintiff's counsel suggested at oral argument that providing any amount of morphine to the decedent caused the death, this position is not supported by the record. Dr. Spitz and Dr. Jack Kaufman did indicate that administering any morphine to the decedent was improper and negligent given the decedent's physical condition and the fact that he was already receiving the powerful pain medication Fentanyl via a three-day Duragesic patch. However, we are concerned with causation and the documentary evidence did not show a causal link between the morphine and decedent's death until the amount of morphine reached a higher than therapeutic level for Mr. Needham.

[6] We also note that there were inaccuracies in the records regarding the total amount of morphine that was dispensed.

[7] Although defendants asserted at oral argument that the medical examiner had recanted with regard to some of his original findings at the time of the autopsy for purposes of other proceedings examining the nursing home death, supporting documentary evidence was not presented in this litigation.

In regard to the battery claim, plaintiff proceeds with his argument as if the trial court allowed him to amend the battery count such that the claim is now predicated on the delivery of oral doses of morphine at lethal levels without valid consent. Amendment was not allowed when plaintiff's counsel orally moved to amend the battery claim at the hearing on the motions for summary disposition. The only battery claim properly before us for consideration is the claim as alleged in the first amended complaint, and there is no evidence of an *injection* of morphine as alleged therein, nor is plaintiff still claiming that the nurses administered the morphine in an amount and at a time not ordered by Dr. Gupta. Plaintiff's appellate brief presents an argument that summary disposition was improper because the new battery theory is viable under the law and is supported by the evidence. But that argument cannot be considered unless plaintiff is permitted to amend the complaint so that it conforms to the argument with respect to battery. However, plaintiff makes no argument in his main brief on appeal that the trial court erred in denying his effort to amend the complaint and no analysis is provided regarding the legal concepts applicable to amendment of pleadings. Therefore, reversal is unwarranted.

Moreover, the reformulated battery claim is not sustainable. Medical treatment administered without a patient's consent can constitute a tortious battery. *In re Rosebush*, 195 Mich App 675, 680-681; 491 NW2d 633 (1992). A battery is the willful and harmful or offensive touching of another person resulting from an act intended to cause contact, *VanVorous v Burmeister*, 262 Mich App 467, 483; 687 NW2d 132 (2004), but there is no battery if the recipient consented to the contact, *People v Starks*, 473 Mich 227, 234; 701 NW2d 136 (2005). The evidence reflects that both the decedent and Mrs. Needham consented to the administration of pain medication to comfort the decedent. There was, however, no evidence that consent was given by either decedent or Mrs. Needham to administer narcotics to the decedent in order to, as framed by plaintiff, end decedent's pain forever, assuming that consent on such a matter was even legally recognizable. Plaintiff's claim goes beyond a mere battery allegation and suggests a homicide, but, as stated by the trial court, there was no evidence whatsoever that anyone intentionally administered a lethal dose of morphine. And that being the case, all that is left is possible negligent administration of a lethal dose of morphine, which would constitute a standard medical malpractice action. Therefore, the battery claim would be subsumed by the medical malpractice claim. No claim for battery exists in this case.

With respect to plaintiff's claim of direct institutional liability, some of the alleged breaches of duty are clearly claims premised on traditional principles of vicarious liability tied to acts or omissions of the defendant nurses and Dr. Gupta and already encompassed in the other vicarious liability counts, e.g., "harmfully neglecting Burr Needham through excessive administration of narcotic drugs . . . ." However, some of the alleged breaches of duty concern Mercy Memorial's policies and procedures and supervision of staff, e.g., "failing to train and/or supervise its nursing staff" and "failing to limit access to controlled substances." In *Cox v Flint Bd of Hosp Managers*, 467 Mich 1, 11; 651 NW2d 356 (2002), our Supreme Court stated:

> A hospital may be 1) directly liable for malpractice, through claims of negligence in supervision of staff physicians as well as selection and retention of medical staff, or 2) vicariously liable for the negligence of its agents. Here, plaintiffs have not advanced claims of direct negligence on the part of defendant hospital. Therefore, defendant's liability must rest on a theory of vicarious

> liability. Vicarious liability is "indirect responsibility imposed by operation of law." [Footnote and citations omitted.][8]

In support of the above proposition, the *Cox* Court relied, in part, on *Theophelis v Lansing Gen Hosp*, 430 Mich 473, 478 n 3; 424 NW2d 478 (1988) (opinion by GRIFFIN, J.). Justice Griffin stated in *Theophelis, id.*:

> Our use of the term, "independent negligence," is intended only for the purpose of indentifying those claims by plaintiffs which were directed to hospital policies and procedures as opposed to those claims which rested directly upon the negligent acts of Nurse Palmer and Dr. Gilmore and are referred to as "vicarious liability" claims. Obviously, if claims directed to hospital policies and procedures involved acts of directors, officers or agents of the hospital during the scope of corporate activity, any liability of the hospital for such acts would also be "vicarious." Plaintiffs did not name the particular officers or agents of the hospital in their complaint.

Thus, under Michigan law, there does exist a recognizable claim for direct institutional liability or independent negligence that can be pursued against a medical facility. The alleged breaches of duty contained in plaintiff's complaint under this count are clearly claims that raise "questions of medical judgment beyond the realm of common knowledge and experience." *Bryant v Oakpointe Villa Nursing Ctr*, 471 Mich 411, 422; 684 NW2d 864 (2004). And they certainly pertain to events occurring during the course of a professional relationship. *Id.* Accordingly, plaintiff was required to support the direct institutional liability claim with expert testimony and evidence.

The direct institutional liability count lists 13 alleged breaches of duty, and one of those allegations is actually broken down into 5 separate and distinct alleged breaches. The expansive count relies, in part, on alleged violations of state and federal statutes and regulations governing the operation of nursing homes. In plaintiff's brief on appeal, he sets forth some of the language in the statutes and regulations. On the issue of evidentiary support, plaintiff first refers to the "extensive breaches by Dr. Gupta (and the facility itself)" as testified to by Dr. Jack Kaufman, and plaintiff then simply cites numerous page numbers relative to Kaufman's deposition transcript. Plaintiff fails to point out the relevant testimony from these pages, fails to explain how the testimony relates to direct institutional liability as opposed to being a basis for traditional vicarious liability, and fails to explain how the testimony specifically supports one of the 18 alleged breaches of duty. Plaintiff essentially leaves it up to us to unravel his claims and to connect all of the proverbial dots. We choose not to entertain the invitation. "'It is not enough for an appellant in his brief simply to announce a position or assert an error and then leave it up

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[8] In *Bronson v Sisters of Mercy Health Corp*, 175 Mich App 647, 650; 438 NW2d 276 (1989), a case cited in *Cox*, this Court noted that "[a] review of plaintiff's complaint reveals that plaintiff seeks to impose liability on defendant hospital for independent acts of negligence committed by the hospital; plaintiff does not seek to hold defendant vicariously liable for [the doctor's] alleged malpractice."

to this Court to discover and rationalize the basis for his claims, or unravel and elaborate for him his arguments, and then search for authority either to sustain or reject his position.'" *Mudge v Macomb Co*, 458 Mich 87, 105; 580 NW2d 845 (1998), quoting *Mitcham v Detroit*, 355 Mich 182, 203; 94 NW2d 388 (1959).

Plaintiff next refers to Dr. Steinberg's criticism of "the entire staff for failing to handle the situation appropriately," which is then followed by three pages of quoted excerpts from Steinberg's deposition. The quoted materials revealed Dr. Steinberg's opinions that a discussion resulting in a patient being given a DNR status should be documented, that the whole situation was handled negligently by staff as to honoring the decedent's wishes given his status as "full code," and that medical personnel breached a standard of care by not taking the time to fully discuss all of the decedent's health issues with Mrs. Needham, but instead relied on the DPOA and Mrs. Needham's uninformed directive. Steinberg further opined that there were indications that the decedent desired lifesaving measures to be taken and never refused testing and treatment, that matters should have been more fully discussed with the decedent, and that it was suspicious that the paperwork showing the decedent as "full code" had language later added indicating that he was "full code" because "he refused to sign." Finally, Steinberg opined that medical personnel failed to fully disclose the severity of decedent's illness and his prognosis if left untreated, that decedent was given too much narcotic medication, and that the nurses were unfamiliar with narcotics.

Again, plaintiff does not take the time to explain why this testimony relates to direct institutional liability as opposed to being a basis for traditional vicarious liability, and plaintiff fails to expressly link the testimony to one of the alleged 18 alleged breaches of duty. The testimony could have a possible bearing on the allegations that Mercy Memorial failed "to train and/or supervise its nursing staff so that the nursing standard of practice was complied with in the care of Burr Needham," that Mercy Memorial failed to notify Mrs. Needham of the life-threatening change in decedent's condition, and on the allegations pertaining to the administration and handling of narcotics. But to the extent that any of these allegations actually relate to direct institutional liability, Steinberg's testimony did not connect the alleged negligent acts or omissions to Mercy Memorial policies, procedures, training, oversight, commands, directives, or to the nursing home's administrators. Indeed, when asked whether a nursing home worker who dealt with decedent was not properly trained, Steinberg responded:

> No. I'm not specifically saying that. She did – I just think that – *I don't know anything about her training*. I just think the way this whole situation was handled – not just by her and the other social-service people, but basically by everybody – was negligent. . . . [Emphasis added.]

The matter of direct institutional liability is insufficiently briefed with respect to Steinberg's testimony, and even if we are accurately unraveling plaintiff's argument, the testimony was insufficient to survive summary disposition.

Plaintiff next refers to the deposition testimony of his nursing expert, Laura Conklin, and her "allegations of misconduct." But we are then simply directed to 24 pages of deposition transcript without explanation and reasoning. Therefore, the matter is insufficiently briefed for the same reasons given above with regard to Dr. Kaufman's testimony.

Finally, with respect to the direct institutional liability claim, plaintiff quotes from Conklin's affidavit of merit. Assuming that we can even consider an affidavit of merit for purposes of determining whether an issue of fact exists under MCR 2.116(C)(10), the affidavit merely provides a laundry list of allegedly negligent acts committed by the nursing staff without tying them to Mercy Memorial policies, procedures, training, oversight, commands, directives, or to the nursing home's administrators. Accordingly, we find no error in the summary dismissal of plaintiff's claim of direct institutional liability.

We next address plaintiff's argument that the trial court erred in striking a damage claim for loss of household services. The trial court found that the WDA does not provide for such damages. Defendants agree with the trial court, but they then proceed to additionally argue that damages for loss of society and companionship, which are expressly included in the WDA's list of recoverable damages, "necessarily include[] compensation for 'loss of services' performed by family members for each other." Defendants are apparently of the position that damages for loss of services are not recoverable, but if they are recoverable, such damages would fall under the heading of society and companionship, thereby constituting noneconomic damages subject to the medical malpractice cap in MCL 600.1483.

MCL 600.2922(6) provides:

> In every action under this section, the court or jury may award damages as the court or jury shall consider fair and equitable, under all the circumstances including reasonable medical, hospital, funeral, and burial expenses for which the estate is liable; reasonable compensation for the pain and suffering, while conscious, undergone by the deceased during the period intervening between the time of the injury and death; and damages for the loss of financial support and the loss of the society and companionship of the deceased. . . . .

This Court recently answered the questions that we are currently confronting. In *Thorn v Mercy Mem Hosp Corp*, __ Mich App __; __ NW2d __ (2008), issued December 11, 2008 (Docket No. 277935), slip op at 13, this Court held:

> We find that the statutory language of MCL 600.2922(6) does not preclude plaintiff's claim for loss of service damages. Further, we reject defendants' assertion that loss of service is merely a component of a claim for the loss of society and companionship or the equivalent of a claim for loss of consortium. As a result, plaintiff's claim for loss of service comprises an economic damage, which is not subject to the damages cap of MCL 600.1483.

Accordingly, the trial court here erred in ruling that damages for loss of services were not recoverable under the WDA. Although the documentary evidence suggests that the decedent did not provide any actual household services, it is not appropriate under MCR 2.116(C) to summarily dismiss an element or single component of damages given our reversal and remand

on the underlying cause of action of medical malpractice. Plaintiff is free to submit evidence of such damages, if they exist, at trial.[9]

Finally, with respect to plaintiff's due process argument, the argument is merely a contention that the trial court deprived plaintiff of due process because it ignored facts in rendering its rulings. We have addressed all the concerns raised in the due process argument in the context of analyzing the other issues on appeal, and no further discussion is necessary.

Affirmed in part, reversed in part, and remanded in part for further proceedings consistent with this opinion. No costs are awarded under MCR 7.219, no party having fully prevailed. We do not retain jurisdiction.

/s/ William B. Murphy
/s/ David H. Sawyer
/s/ William C. Whitbeck

[9] We do, however, reject plaintiff's argument suggesting that recovery of damages for loss of services is appropriate even absent proof that decedent actually provided services. The standard jury instruction allows a jury to award damages for loss of services and other losses "to the extent [the jury] find[s] they have been proved by the evidence." M Civ JI 45.02. Contrary to plaintiff's argument, the case of *Zolton v Rotter*, 321 Mich 1; 32 NW2d 30 (1948), does not in any manner support his position.