STATE OF MICHIGAN

COURT OF APPEALS

CLARK EDWARDS,

Plaintiff-Appellant,

v

METROPOLITAN HOSPITAL, doing business as METRO HEALTH HOSPITAL, doing business as METRO HEART AND VASCULAR, and ERIC WALCHAK, D.O.,

Defendants-Appellees,

and

JIHAD MUSTAPHA, M.D., K. THOMAS CROCKER, D.O., P.C., and THOMAS CROCKER, D.O.,

Defendants.

UNPUBLISHED
December 20, 2016

No. 330216
Kent Circuit Court
LC No. 14-004815-NH

Before: WILDER, P.J., and MURPHY and O'BRIEN, JJ.

PER CURIAM.

Plaintiff Clark Edwards appeals as of right the trial court's order granting summary disposition in favor of defendants Metropolitan Hospital (Metro) and Eric Walchak, D.O., in this medical malpractice action. The trial court ruled that plaintiff did not have an expert witness who could competently testify with respect to causation; therefore, absent the ability to establish the necessary causal link at trial, Metro and Dr. Walchak were entitled to summary dismissal of plaintiff's lawsuit. We affirm.

I. PLAINTIFF'S COMPLAINT – ALLEGATIONS

Plaintiff filed his medical malpractice action on May 30, 2014. He alleged that in June 2010, he had been "diagnosed with right femoral and right popliteal vein DVT[,]" or deep vein thrombosis in his right leg, and was prescribed Coumadin. Plaintiff contended that in September 2010, he "underwent an unsuccessful attempt at vascular intervention, including, but not limited to, an attempted cannulation and venogram of popliteal and posterior tibial veins." It was

alleged that in October 2010, Dr. Walchak, an interventional cardiologist, performed "a diagnostic venogram of [plaintiff's] right lower extremity with angioplasty" at Metro. According to the complaint, "[n]o significant redirection of blood flow was noted through the balloon" and "[b]lood was noted to empty from [plaintiff's] right lower extremity via a large collateral distal to the totally occluded deep femoral vein." After the procedure, plaintiff was instructed to continue taking Coumadin, along with aspirin.

Plaintiff alleged that in September 2011, he was evaluated by a cardiologist, defendant Jihad Mustapha, M.D., concerning pain and swelling in plaintiff's right leg, and that Dr. Mustapha improperly recommended surgical intervention. Plaintiff maintained that on November 28, 2011, Dr. Mustapha "attempted a right lower extremity venous intervention via the popliteal vein" at Metro, but the procedure was unsuccessful, "as Dr. Mustapha was unable to cross the thrombus." Plaintiff asserted that he suffered injury to tissue and structures during the surgery and that, directly following the procedure, his "right popliteal area was very tender[] and painful with first ambulation" and there was some swelling and bruising after pressure dressing was removed. According to plaintiff, the next morning, November 29, 2011, "a small amount of bruising at the puncture site was noted behind his right knee, as well as edema[,]" and he was discharged without further treatment.

Plaintiff alleged that pain and swelling increased after he was discharged, so he went to his local hospital where an ultrasound was performed, which "demonstrated a hematoma in the popliteal space." Plaintiff maintained that he was transferred to Metro for further management on December 2, 2011, and was admitted under the care of Dr. Walchak, who "recommended altering [plaintiff's] anticoagulation medication." The complaint indicated that around noon on December 3, 2011, Dr. Walchak noted that plaintiff was complaining of foot numbness. And although plaintiff was still able to move his toes, it was painful to do so. Plaintiff alleged that "Dr. Walchak failed to order a vascular surgery consultation" and that plaintiff's condition continued to worsen, with an intensification of pain.

At 5:00 a.m. on December 4, 2011, defendant Dr. Thomas Crocker, an orthopedic surgeon, was consulted and, as alleged by plaintiff, Dr. Crocker contacted a Dr. Collier, "whom Dr. Crocker incorrectly and negligently believed was [plaintiff's] attending physician." But Dr. Crocker did recommend "a vascular surgery consult," believing that orthopedic expertise might not be appropriate. Plaintiff alleged that at 9:40 a.m. on December 4, 2011, Dr. Crocker came into the hospital and realized that Dr. Collier was not plaintiff's attending doctor. Allegedly, Dr. Crocker noted that sensation in plaintiff's right leg was slightly diminished to touch, that his motor function was within normal limits, and that his leg was tense. Plaintiff alleged that a vascular surgery consult was finally obtained and that at 11:00 a.m. on December 4 he was taken to the operating room, where he "underwent a three-compartment fasciotomy[.]"[1] In the complaint, plaintiff maintained that he now suffers from poor foot sensation, with "minimal

[1] The surgeon who performed the fasciotomy was not named as a defendant, nor has plaintiff presented any allegations suggesting that the fasciotomy was negligently or improperly performed.

dorsiflexion," that he has "foot drop," that he suffers from limited mobility, that he is greatly limited in regard to daily activities, that he requires assistance with household tasks, and that his quality of life has been greatly reduced.

Count I of the complaint alleged ordinary and medical negligence by Dr. Mustapha, mainly arising out of and connected to the surgery performed on plaintiff on November 28, 2011. Count II alleged ordinary negligence by the nursing staff involved in plaintiff's care. Count III alleged ordinary and medical negligence by Dr. Walchak, chiefly arising out of his failure to order a vascular surgery consultation on December 3, 2011, after seeing plaintiff around noon, which would have led to a diagnosis of compartment syndrome and an emergency fasciotomy on the third, as opposed to the next day when the fasciotomy was actually performed.[2] Ultimately, it is this claim against Dr. Walchak that is the subject of this appeal. Count V[3] alleged ordinary negligence by Dr. Crocker regarding the mix-up relative to the identification of plaintiff's attending physician and any delay in plaintiff's treatment. And count VI alleged ordinary and medical negligence by Metro on theories of direct and vicarious liability. Attached to the complaint, as required by MCL 600.2912d, was an affidavit of merit executed by Dr. Brian Swirsky, who averred that he "was board certified in the specialty of cardiology[] and spent the majority of [his] professional time practicing in that specialty." Dr. Swirsky's affidavit set forth the purported standard of care applicable to Drs. Mustapha and Walchak[4] and the numerous acts or failures to act that comprised the alleged breaches or violations of the standard of care. With respect to causation, Dr. Swirsky averred as follows relative to both doctors:

> As a consequence of the violations of the standard of care outlined above, [plaintiff] developed a compartment syndrome which prevented normal circulation in his lower extremity and damaged his nerves. Due to the delay in treatment, the compartment syndrome caused irreversible neurological damage. Furthermore, had the improper surgery not been performed in the first place [by Dr. Mustapha], [plaintiff] would not have developed compartment syndrome, foot drop, and the other complications. He required surgery and extensive

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[2] We found the following explanation in *Douglas v Children's Hosp*, 69 So3d 434, 454 (La App, 2010), concise and consistent with the record here:

> Compartment syndrome occurs when swelling eventuates in tissue that confines where the muscle is in the leg. Leg muscle is surrounded by skin and by very firm tissue known as fascia which does not stretch. Therefore, if there is swelling or bleeding within this compartment in which the muscles are contained, pressure builds up and can increase the pressure on the blood supply to the nerves and muscle. In compartment syndrome, the muscle can die, which is why the surgeons in this case performed a fasciotomy to cut the fascia open, because the restored blood supply would cause the starved muscle to swell.

[3] The complaint did not contain a count IV.

[4] The affidavit did not encompass Dr. Crocker because the claims against him were based on ordinary negligence and not medical negligence.

hospitalization and rehabilitation. He now suffers foot drop and limited mobility as well as discomfort and pain. All of these conditions were proximately caused by the violations of the standards of care, as outlined above.

II. PROCEDURAL HISTORY

In November 2014, Dr. Mustapha and Metro jointly filed a partial motion for summary disposition under MCR 2.116(C)(7), arguing that plaintiff's claims against Dr. Mustapha and those against Metro, as predicated on Metro's alleged vicarious liability for Dr. Mustapha's actions, were time-barred under the applicable statute of limitations. In December 2014, the trial court granted that motion for summary disposition in regard to all claims that accrued before or on November 28, 2011, in relation to Dr. Mustapha. This ruling has not been appealed by plaintiff. In February 2015, Dr. Crocker, as well as his P.C., filed a motion for summary disposition, contending that the claims against them sounded in medical malpractice and not ordinary negligence and, therefore, all of the procedural requirements pertaining to a medical malpractice action, e.g., the filing of an affidavit of merit, had to be satisfied, but there was no compliance. Metro joined in the motion to the extent that its vicarious liability was based on Dr. Crocker's actions. Also in February 2015, Dr. Walchak, Dr. Mustapha, and Metro filed a motion for partial summary disposition, arguing that the claims of ordinary negligence made against Drs. Walchak and Mustapha, Metro's nursing staff, and Metro directly could not be sustained, as they actually sounded in medical malpractice. In April 2015, the trial court issued an opinion and order on the two February motions for summary disposition concerning ordinary versus medical negligence, agreeing that all of plaintiff's claims sounded solely in medical negligence; there were no viable ordinary negligence claims. This ruling, which is not being appealed, resulted in the dismissal of counts II and V, leaving standing only the medical malpractice claims against Dr. Mustapha that were not time-barred, if any, the medical malpractice claims against Dr. Walchak, and the medical malpractice claims against Metro (direct and vicarious liability theories).

In May 2015, Dr. Mustapha filed an unchallenged affidavit of non-involvement in plaintiff's care and treatment pursuant to MCL 600.2912c relative to that period of time that fell within the two-year statute of limitations, and the trial court thus dismissed any lingering claims against Dr. Mustapha. This ruling is not being appealed. In July 2015, plaintiff filed a motion for leave to file and serve an expert witness list, given that plaintiff had failed to do so by January 31, 2015, six months earlier, as required by the trial court's scheduling order.[5] In the motion, plaintiff asserted that the filing and service failure was "[d]ue to administrative error and the transition of th[e] matter between attorneys at [p]laintiff's firm." Plaintiff also indicated that

[5] The scheduling order provided that "[*a*]*bsent good cause, expert witnesses not identified as required hereby will not be allowed to testify at trial*." (Emphasis in original.) The scheduling order further required that the disclosure of expert witnesses include all of the information specified in MCR 2.302(B)(4)(a)(i), which entails the subject matter of the expert's expected testimony, "the substance of the facts and opinions to which the expert is expected to testify[,] and a summary of the grounds for each opinion."

the failure to disclose expert witnesses "was merely a product of inadvertence, and was certainly not done willfully." Plaintiff attached a proposed witness list to his motion. The trial court denied the motion for leave, ruling that, while "[m]istakes happen," the length of the delay was inexcusable, that plaintiff's proposed witness list still did not comply with the court's scheduling order, where it failed to include the information specified in MCR 2.302(B)(4)(a)(i), and that plaintiff had boldly proposed 88 expert witnesses. The trial court concluded that the appropriate sanction was to preclude the testimony of all of plaintiff's proposed experts, except for Dr. Swirsky, who had been deposed and had executed the affidavit of merit. The trial court directed plaintiff to file a witness list, naming only lay witnesses, with the exception of Dr. Swirsky.[6] The court subsequently denied plaintiff's motion for reconsideration. Plaintiff filed an application for leave to appeal in this Court with respect to the trial court's ruling on plaintiff's motion for leave to file and serve an expert witness list. This Court denied the application without prejudice to the issues raised in the instant appeal by right. *Edwards v Metropolitan Hosp*, unpublished order of the Court of Appeals, entered December 16, 2015 (Docket No. 329157). In the appeal before us today, plaintiff does not present an argument challenging the sanction and denial of his motion for leave to file and serve an expert witness list; therefore, we will not examine that ruling.

Plaintiff filed a witness list identifying Dr. Swirsky as an expert, but the list also contained the names of numerous doctors and nurses who were or may have been involved in plaintiff's care, noting that those individuals "may be called upon to render opinion or other expert testimony." Alluding to this notation, Metro and Dr. Walchak, the only remaining defendants in the case, filed a motion to strike plaintiff's proposed expert witnesses in light of the trial court's earlier order. Pursuant to a stipulated order, plaintiff, in the context of his witnesses, was precluded from eliciting expert testimony or opinions from anyone but Dr. Swirsky.

On July 29, 2015, defendants Metro and Dr. Walchak filed a motion for summary disposition under MCR 2.116(C)(10) regarding the surviving claims. Defendants maintained that Dr. Swirsky was unqualified to render standard-of-care testimony, as he lacked the relevant board certifications and experience required under MCL 600.2169(1). Defendants further contended that even if Dr. Swirsky was so qualified, plaintiff could not establish causation, considering that according to his own deposition testimony, Dr. Swirsky would defer to experts in other medical specialties with respect to the causal link. Defendants' position focused on the argument that a vascular surgeon needed to establish the standard of care, breach of the standard, and causation. Again, the crux of plaintiff's action against Dr. Walchak was that he should have, given plaintiff's condition and symptoms, ordered a vascular surgery consultation on December 3, 2011, which would have revealed compartment syndrome, and which in turn would have resulted in an emergency fasciotomy being performed the day before it was actually performed. Thus, part of the causation element in this case concerned whether the delay in performing the

[6] The trial court noted that its decision would not prevent plaintiff from presenting and proving his case, considering that Dr. Swirsky was plaintiff's purported standard-of-care and causation expert.

fasciotomy made a difference in plaintiff's condition and caused the alleged damages. Plaintiff responded that "Dr. Swirsky has the relevant board certifications to render standard of care testimony against Dr. Walchak," that Dr. Swirsky was also qualified to render causation testimony at trial, and that because Dr. Swirsky could establish liability and causation, defendants were not entitled to summary disposition.

The trial court heard oral arguments on defendants' motion for summary disposition and took the matter under advisement. On September 28, 2015, the trial court issued a written opinion and order granting summary disposition in favor of Metro and Dr. Walchak. The court first ruled that plaintiff's response brief to defendants' motion for summary disposition failed to argue that Dr. Swirsky could provide standard-of-care testimony relative to the *direct* liability claims against Metro, thereby abandoning those claims. The court then turned its attention to the claims against Dr. Walchak and those against Metro that were premised on its potential vicarious liability for Dr. Walchak's actions and inactions. The trial court concentrated its analysis on the causation issue. The court determined that Dr. Swirsky had the knowledge, skill, and experience with cardiovascular disease such that he was qualified to give opinion testimony regarding whether, on December 3, 2011, a consulted vascular surgeon would have diagnosed plaintiff with compartment syndrome and performed an emergency fasciotomy. The trial court, however, also found that Dr. Swirsky was "not qualified to testify about whether the alleged delay in performing that procedure led to [plaintiff's] injuries." The court quoted some of Dr. Swirsky's deposition testimony, wherein he voiced a belief that, absent the delay, there would have been less damage, the injuries would have been much less likely, and permanent injury could potentially have been avoided. But, according to the court, when asked about specifics, Dr. Swirsky indicated that he would defer to experts in the fields of neurology, vascular surgery, and orthopedic surgery. The trial court noted that Dr. Swirsky was unable to testify concerning how and to what extent the result would have been better had the surgery been performed earlier. The court ruled that given Dr. Swirsky's lack of qualifications or inability to testify on causation, as framed above, plaintiff could not establish the necessary element of causation as a matter of law. Summary disposition was thus granted in favor of defendants Metro and Dr. Walchak. The trial court denied plaintiff's subsequent motion for reconsideration, and this appeal followed.

III. ANALYSIS

A. STANDARDS OF REVIEW

This Court reviews de novo a trial court's decision on a motion for summary disposition, *Loweke v Ann Arbor Ceiling & Partition Co, LLC*, 489 Mich 157, 162; 809 NW2d 553 (2011), as well as questions of law in general, *Oakland Co Bd of Co Rd Comm'rs v Mich Prop & Cas Guaranty Ass'n*, 456 Mich 590, 610; 575 NW2d 751 (1998). "However, this Court reviews a trial court's rulings concerning the qualifications of proposed expert witnesses to testify for an abuse of discretion." *Woodard v Custer*, 476 Mich 545, 557; 719 NW2d 842 (2006) (citation omitted). And "[a]n abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." *Id.*

B. SUMMARY DISPOSITION TEST

With respect to a motion for summary disposition brought pursuant to MCR 2.116(C)(10), this Court in *Pioneer State Mut Ins Co v Dells*, 301 Mich App 368, 377; 836 NW2d 257 (2013), articulated:

> In general, MCR 2.116(C)(10) provides for summary disposition when 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 motion brought under MCR 2.116(C)(10) tests the factual support for a party's claim. 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. 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. The trial court is not permitted to assess credibility, weigh the evidence, or resolve factual disputes, and if material evidence conflicts, it is not appropriate to grant a motion for summary disposition under MCR 2.116(C)(10). A court may only consider substantively admissible evidence actually proffered relative to a motion for summary disposition under MCR 2.116(C)(10). [Citations and quotation marks omitted.]

C. MEDICAL MALPRACTICE ACTIONS – CAUSATION ELEMENT

In *Cox v Flint Bd of Hosp Managers*, 467 Mich 1, 10; 651 NW2d 356 (2002), our Supreme Court observed:

> The plaintiff in a medical malpractice action bears the burden of proving: (1) the applicable standard of care, (2) breach of that standard by defendant, (3) injury, and (4) *proximate causation between the alleged breach and the injury*. Failure to prove any one of these elements is fatal. [Citation and quotation marks omitted.]

MCL 600.2912a provides, in part:

> (1) Subject to subsection (2), in an action alleging malpractice, the plaintiff has the burden of proving that in light of the state of the art existing at the time of the alleged malpractice:
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> * * *
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> (b) The defendant, if a specialist, failed to provide the recognized standard of practice or care within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances, and as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.

> (2) In an action alleging medical malpractice, the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants. In an action alleging medical malpractice, the plaintiff cannot recover for loss of an opportunity to survive or an opportunity to achieve a better result unless the opportunity was greater than 50%.

The first sentence in MCL 600.2912a(2) applies to traditional medical malpractice actions, whereas the second sentence in MCL 600.2912a(2) applies solely to loss-of-opportunity medical malpractice actions. *O'Neal v St John Hosp & Med Ctr*, 487 Mich 485, 493-498; 791 NW2d 853 (2010).[7] The *O'Neal* Court stated:

> The proper interpretation of proximate causation in a negligence action is well-settled in Michigan. In order to be a proximate cause, the negligent conduct must have been a cause of the plaintiff's injury and the plaintiff's injury must have been a natural and probable result of the negligent conduct. These two prongs are respectively described as "cause-in-fact" and "legal causation." While legal causation relates to the foreseeability of the consequences of the defendant's conduct, the cause-in-fact prong generally requires showing that "but for" the defendant's actions, the plaintiff's injury would not have occurred. It is equally well-settled that proximate causation in a malpractice claim is treated no differently than in an ordinary negligence claim, and it is well-established that there can be more than one proximate cause contributing to an injury. Finally, it is well-established that the proper standard for proximate causation in a negligence action is that the negligence must be "a proximate cause" not "the proximate cause." Thus, the burden of proof for proximate causation in traditional medical malpractice cases is analyzed according to its historical common-law definitions and the analysis is the same as in any other ordinary negligence claim. Nothing in this opinion changes or alters these well-settled principles. [*Id.* at 496-497 (citations and quotation marks omitted).[8]]

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[7] The parties do not engage in any pertinent discussion of MCL 600.2912a(2) and whether this is perhaps a loss-of-opportunity action, instead relying on traditional causation principles. The meaning of the loss-of-opportunity language in MCL 600.2912a(2) has alluded the courts and remains unsettled in Michigan. See *O'Neal*, 487 Mich at 506. Ultimately, plaintiff's action fails regardless of whether it is a traditional medical malpractice case or a loss-of-opportunity case.

[8] Establishing causation entails proving "two separate elements: (1) cause in fact, and (2) legal cause, also known as 'proximate cause.' " *Skinner v Square D Co*, 445 Mich 153, 162-163; 516 NW2d 475 (1994) (citation omitted). "A plaintiff must adequately establish cause in fact in order for legal cause or 'proximate cause' to become a relevant issue." *Id.* at 163. Circumstantial evidence and reasonable inferences arising from the evidence can be utilized to establish causation, but the evidence and inferences must amount to more than mere speculation and conjecture. *Id.* at 163-164. It is not sufficient to proffer "a causation theory that, while

D. EXPERT TESTIMONY – GENERAL PRINCIPLES

MRE 702 provides:

> If the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

The plain language of MRE 702 establishes that an expert witness must be qualified to render proposed testimony and, generally speaking, an expert can be qualified by virtue of his or her knowledge, skill, training, or education. *Craig v Oakwood Hosp*, 471 Mich 67, 78; 684 NW2d 296 (2004). MCL 600.2169(2), which applies to an expert's qualifications to give testimony on the issue of causation in a medical malpractice action, *Halloran v Bhan*, 470 Mich 572, 578 n 6; 683 NW2d 129 (2004), provides:

> In determining the qualifications of an expert witness in an action alleging medical malpractice, the court shall, at a minimum, evaluate all of the following:
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> (a) The educational and professional training of the expert witness.
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> (b) The area of specialization of the expert witness.
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> (c) The length of time the expert witness has been engaged in the active clinical practice or instruction of the health profession or the specialty.
>
> (d) The relevancy of the expert witness's testimony.

E. DISCUSSION

Plaintiff argues that Dr. Swirsky's testimony established that but for Dr. Walchak's failure to consult a vascular surgeon on December 3, 2011, plaintiff would have been diagnosed with compartment syndrome at that time and then sent to emergency surgery. Plaintiff further contends that Dr. Walchak's failure to timely diagnose plaintiff's condition and symptoms and to order a vascular surgery consultation proximately caused the additional and worsening of injuries

factually supported, is, at best, just as possible as another theory." *Id.* at 164. A "plaintiff must present substantial evidence from which a jury may conclude that more likely than not, but for the defendant's conduct, the plaintiff's injuries would not have occurred." *Id.* at 164-165. "[L]itigants do not have any right to submit an evidentiary record to the jury that would allow the jury to do nothing more than guess." *Id.* at 174. The *Skinner* Court further observed, however, that " '[t]he evidence need not negate all other possible causes' " and that absolute certainty relative to causation is not required. *Id.* at 166, quoting 57A Am Jur 2d, Negligence, § 461, p 442.

that plaintiff suffered. Therefore, according to plaintiff, the trial court erred in granting defendants' motion for summary disposition, as the court was presented with qualified expert testimony creating an issue of fact regarding whether Dr. Walchak's medical malpractice was the proximate cause of plaintiff's damages.

We find that, on close examination, we need not resolve whether Dr. Swirsky was qualified to give an opinion on causation in the context of the facts presented. Rather, Dr. Swirsky himself effectively indicated that he was not so qualified, declining to provide the opinion testimony necessary to create an issue of fact on the element of causation in regard to whether the delay in ordering a vascular surgery consultation resulted in recoverable damages.

In his deposition, Dr. Swirsky testified that when Dr. Walchak saw plaintiff around noon on December 3, 2011, plaintiff presented with a hematoma, increased pain, swelling, and "the advancing neurologic complaint of numbness," which, when taken together, were indicative of compartment syndrome and reflected a serious downturn in plaintiff's condition from December 2, 2011. Dr. Swirsky opined that Dr. Walchak should have obtained a vascular surgery consultation at that point, so that a doctor who specialized in compartment syndrome could take over plaintiff's care and management. Dr. Swirsky testified to his belief that a vascular surgeon would have undoubtedly diagnosed compartment syndrome and recommended surgery as soon as possible. Dr. Swirsky observed:

> [C]ompartment syndrome is a surgical emergency because compartment syndrome will cause a combination of nerve damage and vascular injury to muscle and other tissues, skin being other tissue. So it requires opening the area, relieving the pressure or the compression, a . . . fasciotomy . . ., to avoid further damage. The longer the nerve is compressed, the longer the arterial supply is diminished and there's ischemia, the more chance you will have for a permanent neurologic or motor injury.

Dr. Swirsky testified that there "would have been less damage" and that it would have been "much less likely" that plaintiff would have suffered foot drop had the fasciotomy been performed on December 3 instead of December 4. However, when pushed on the matter, Dr. Swirsky testified:

> I can only tell you that statistically, the time line would say that you could *potentially* avoid all permanent injury if a compartment syndrome is treated on a timely basis, such as December 3rd. I'm going to reserve all damage discussion to an expert in that area, such as a neurologist, or a vascular surgeon, or even an orthopedic surgeon, as to ongoing and current damage to [plaintiff.] [Emphasis added.]

Counsel asked Dr. Swirsky whether he was saying that, while the sooner compartment syndrome is operated on, the better the result in general, he would defer to experts with respect to plaintiff's specific case. And Dr. Swirsky confirmed that this was indeed his view. He later elaborated:

> I'm not going to have an opinion as to the degree of lesser injury, only to say qualitatively that the sooner the intervention, the less risk of harm, the less injury. But in terms of giving you a number, or a gradation to that damage, I don't have an opinion, nor will offer an opinion.
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> * * *
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> I would word it that to the degree of permanent injury, I would defer to others. But with the overriding statement as I said earlier, the sooner you intervene, the less risk of harm, and the less damage. I can't grade the damage for you. That's all.
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> * * *
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> The degree of damage should be assessed by either an orthopedic surgeon, a neurologist, a vascular surgeon, or a physical medicine expert. I know those people are involved, and I'm sure those treating records would provide good insight into that. And if necessary, a treating physician could come to trial and testify as to the degree of damage.

Dr. Swirsky noted that he did not even "have good knowledge" of plaintiff's condition and his injuries.

On this record, we cannot conclude that the trial court erred in summarily dismissing plaintiff's lawsuit. Dr. Swirsky's testimony that, in general, more favorable results will occur when a fasciotomy to treat compartment syndrome is performed sooner than later is simply insufficient for purposes of determining whether the delay *in this particular case* caused any injuries to plaintiff beyond those actually suffered by plaintiff. Plaintiff had to show that but for Dr. Walchak's alleged negligence, plaintiff would probably not have sustained the complained-of injuries, or that plaintiff's condition would probably have been measurably better as compared to his condition following the December 4 fasciotomy. Dr. Swirsky indicated that he was not prepared to testify, and that he would defer to doctors in other specialties, with regard to the degree of lesser injury or the grading of any difference in harm. Absent such testimony, a jury would be forced to engage in speculation and conjecture in determining whether, as caused by Dr. Walchak's failure to order a vascular surgery consultation on December 3, 2011, plaintiff was entitled to any damages and the amount of those damages. The possibility existed under Dr. Swirsky's testimony that any difference in plaintiff's condition had the fasciotomy been performed on December 3 instead of December 4 may have been negligible and ultimately immeasurable in terms of damages.[9] Indeed, Dr. Swirsky was unfamiliar with plaintiff's

[9] For example, while we recognize that, pursuant to Dr. Swirsky's testimony, plaintiff's condition would likely have been better had the fasciotomy been performed on December 3, 2011, the extent or degree of the "betterment," without additional expert testimony indicating otherwise, may have been so insignificant as to not justify a conclusion that the delay caused actual damages.

condition as a result of the December 4th fasciotomy, and he certainly was not prepared to testify with specifics and details that said unknown condition was worse given the delay, such that damages could be assessed, absent speculation, for injuries directly attributed to the delay.

IV. CONCLUSION

"Normally, the existence of cause in fact is a question for the jury to decide, but if there is no issue of material fact, the question may be decided by the court." *Genna v Jackson*, 286 Mich App 413, 418; 781 NW2d 124 (2009). Here, there is no genuine issue of material fact that plaintiff cannot establish by way of Dr. Swirsky's testimony the requisite causal connection between Dr. Walchak's alleged negligence and recoverable damages, where Dr. Swirsky was not prepared and declined to testify on the element of causation relative to showing "but for" the delay, plaintiff's condition would have been measurably better in terms of assessing damages. Given our ruling, it is unnecessary to examine defendants' alternative argument that we should affirm because Dr. Swirsky was not qualified to testify regarding the standard of care, considering that he did not share the same relevant subspecialties practiced by Dr. Walchak.

Affirmed. Having fully prevailed on appeal, defendants are awarded taxable costs under MCR 7.219.

/s/ Kurtis T. Wilder
/s/ William B. Murphy
/s/ Colleen A. O'Brien