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STATE OF MICHIGAN

COURT OF APPEALS

GARY CAIN,

Plaintiff-Appellant,

v

JOHN NIEMELA, DPM and JOHN NIEMELA, DPM, PLLC,

Defendants-Appellees.

UNPUBLISHED
July 23, 2020

No. 350553
Marquette Circuit Court
LC No. 17-056005-NH

Before: GADOLA, P.J., and GLEICHER and STEPHENS, JJ.

PER CURIAM.

MCL 600.2912a(1)(a) provides that the standard of care of a general practitioner is "the recognized standard of acceptable professional practice or care in the community in which the defendant practices or in a similar community." This does not mean that only a doctor practicing in the same community as the defendant can testify as a medical-malpractice expert. Rather, the plaintiff must proffer an expert familiar with the standard of care in the defendant's community or a similar location. With the proliferation of information, education, and training on the Internet, the standards in communities across the United States, and even the world, are closing together, broadening the spectrum of potentially qualified experts.

The medical procedures at issue in this case are among the most commonly performed by podiatrists, who are held to a local standard of care. The podiatrists who testified in this case all agreed that a particular (and very commonplace) procedure was indicated for the patient's commonplace condition. The expert witness proffered by the patient demonstrated a solid understanding of the issues, sagely explained how the standard of care for this particular locality was the same as the standard in any locality across the nation, and also explained his familiarity with communities similar to Marquette, where this surgery was performed.

Under these circumstances, the circuit court abused its discretion in striking plaintiff's expert and dismissing the action in its entirety. We vacate that order and remand for further proceedings.

I. BACKGROUND

This case is about an extremely common foot malady—a bunion.

> A bunion is a bony bump that forms on the joint at the base of your big toe. It occurs when some of the bones in the front part of your foot move out of place. This causes the tip of your big toe to get pulled toward the smaller toes and forces the joint at the base of your big toe to stick out. [*Bunions*, available at <https://www.mayoclinic.org/diseases-conditions/bunions/symptoms-causes/syc-20354799#:~:text=A%20bunion%20is%20a%20bony,big%20toe%20to%20stick%20out.> (accessed June 22, 2020).]

There are multiple surgical techniques to correct a bunion. The severity of the bunion angle (also known as the intermetatarsal or IM angle) is a key factor in determining which technique offers the best possible outcome. A normal angle is nine degrees. See Knipe and Weerakkody, *Intermetatarsal angle*, available at <https://radiopaedia.org/articles/intermetatarsal-angle?lang=us> (accessed June 22, 2020). When the angle is over 16 degrees, a Lapidus procedure is recommended. As described by defendant in this action—Dr. John Niemela—a Lapidus is an "arthrodesis of the first metatarsal cuneiform joint,"[1] along with a reduction of the IM angle by manipulating "the entire first metatarsal into a rectus alignment," fusing the first metatarsal to the first cuneiform "into a straight position," and then fixing the joint with cannulated screws. Plaintiff Gary Cain's expert—Dr. Howard Shapiro—explained the process in layperson's terms as:

> [A] bunion procedure where you're basically fusing the first metatarsal cuneiform joint . . . . [Y]ou're removing the cartilage and you're correcting the deformity of the first metatarsal by making it more parallel to the second metatarsal. And you're doing that by . . . those various techniques, screws, plates, staples, pins, combination of any of those to keep the bones opposed so they can heal and fuse.

For milder bunions, an Austin with an Akin can be performed. "[A]n Austin bunionectomy is [a] Chevron or a . . . 'V' osteotomy of the first metatarsal neck and/or shaft."[2] "The osteotomy decreases the intermetatarsal angle between the first and second metatarsal with displacement." The surgeon then places hardware "for permanent fixation." If "the hallux [big toe] is not in a complete rectus position" after the Austin, an Akin osteotomy can be added. An Akin is "a V-shaped or a wedge-shaped osteotomy at the base of the proximal phalanx of the hallux with the wedge being located medially and the apex being located laterally." This allows the surgeon to "fixate in multiple different ways," i.e. gives the doctor more wiggle room to straighten the toe.

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[1] Arthrodesis is "the surgical immobilization of a joint so that the bones grow solidly together." <https://www.merriam-webster.com/dictionary/arthrodesis> (accessed June 22, 2020).

[2] An osteotomy is "a surgical operation in which a bone is divided or a piece of bone is excised (as to correct a deformity)." < https://www.merriam-webster.com/medical/osteotomy> (accessed June 22, 2020).

Cain presented to podiatrist Niemela for treatment of a bunion on his left big toe with an IM angle of 20.5, which is considered moderate to severe. Dr. Niemela agreed that a Lapidus procedure was the ideal treatment for Cain, and recommended it. Cain expressed concern about remaining nonweightbearing for six weeks. Dr. Niemela also advised Cain of the Austin/Akin procedure, told him of the risks, and reminded him that the Lapidus was preferred. Cain nevertheless opted for the Austin/Akin. Cain conceded this point in his complaint:

> Dr. Niemela also discussed the Lapidus and Austin bunionectomy options. He recommended the Lapidus, but Mr. Cain opted for the Austin procedure due to weightbearing. Dr. Niemela scheduled an Austin bunionectomy with possible Akin osteotomy and explained the risks which included recurrence of bunion deformity, hallux varus,[3] stiff great toe joint, delayed or non union, hardware failure, RSD, pain, swelling, scar, and painful scar.

There is no doubt in this case that Lapidus was the preferred procedure for Cain. Dr. Niemela expressly stated that "[t]here's more disadvantages than advantages" to selecting the Austin or Akin procedure to remedy a moderate to severe bunion. "[T]he only advantage" is that the patient "can bear weight on it" the same day as the surgery.

Cain's recovery did not go well, requiring several corrective surgeries. Cain filed suit, alleging that Dr. Niemela breached the standard of care by performing the wrong type of surgery, and by even offering an Austin/Akin procedure as a treatment option.

Dr. Niemela is a podiatrist, board certified in foot surgery and rearfoot ankle reconstruction. He attended Scholl College of Podiatric Medicine in Chicago, and completed a three-year residency at a Level 1 trauma center in Portland, Oregon. He worked in private practice in Marquette for 10 years before moving to Manistique. In Marquette, Dr. Niemela performed surgeries at Marquette General Hospital, a Level 2 trauma center with approximately 300 beds. Dr. Niemela performs Austin/Akin procedures about once a week and has performed thousands of Lapidus procedures over the years.

Cain's proffered expert witness, podiatrist Howard Shapiro, is also board certified in foot surgery. He studied at Temple University School of Podiatric Medicine in Philadelphia and did his residency at Hahnemann University Hospital. See <https://www.buxmontpodiatry.com/about-us/meet-the-team/> (accessed June 22, 2020). Dr. Shapiro owns one podiatric practice and practices as an independent contractor at a second in Newtown and Warminster, Pennsylvania. He performs surgery two days a week at St. Mary's Medical Center, a Level 2 trauma center with 371 beds, and previously at Hahnemann. Hahnemann was connected with Drexel University College of Medicine and was a Level 1 and Level 2 trauma center that closed in 2019. See George, *Hahnemann Closes Trauma Center, Nurses Say Supplies in Short Supply at Hospital*, Philadelphia Business Journal, June 29, 2019, available at <https://www.bizjournals.com/philadelphia/

[3] "Hallux varus is a clinical condition characterized by medial deviation of the great toe at metatarsophalangeal (MTP) joint." Munir and Morgan, *Hallux Varus*, available at <https://www.ncbi.nlm.nih.gov/books/NBK470261/> (accessed June 23, 2020).

news/2019/06/29/hahnemann-closes-trauma-center-nurses-say-supplies.html> (accessed June 22, 2020).

In his affidavit of merit accompanying Cain's complaint, Dr. Shapiro asserted that Dr. Niemela was required to meet the following standard of care:

> The podiatrist must treat any and all lower extremity or foot pain, appropriately and timely, including determining whether surgical intervention is required. If surgery is indicated, the standard of care requires that the podiatrist properly identify the appropriate procedure to perform given the physical examination and radiology findings. The podiatrist is then required to properly perform the indicated and appropriate surgery. Under the circumstances in this case, the standard of care required Dr. Niemela to perform a Lapidus procedure for Mr. Cain's severe bunion deformity.
>
> Additionally, the podiatrist is required to fully inform a patient regarding the elements of risk involved in any care and treatment rendered, including the nature and possible consequences of the treatment, prospects for success, prognosis if the procedure is not performed, and alternative methods of treatment. . . .

Dr. Shapiro then opined that Dr. Niemela breached the standard of care as described in the complaint, "[b]y failing to perform a Lapidus bunionectomy" and "[b]y failing to fully inform" Cain of the risks associated with the Austin/Akin procedure.

During discovery, Dr. Shapiro expounded on the standard of care as follows:

> *Q.* . . . My question is, how do you define these recognized standards of care?
>
> *A.* It would be what a reasonably prudent podiatrist would do under the same or similar circumstance.
>
> *Q.* Is this a national standard?
>
> *A.* Absolutely.

Under this standard of care, Dr. Shapiro opined that Dr. Niemela should have performed a Lapidus procedure given the severity of Cain's bunion. Dr. Shapiro was "critical" of Dr. Niemela's decision to explain both the Lapidus and Austin/Akin procedures to Cain:

> Although Dr. Niemela gave him . . . two choices, the Lapidus or an Austin with Akin, the Austin with Akin is not an appropriate choice for this type of deformity. It's below the standard of care to perform those procedures on a person with this type of deformity. So, that shouldn't have even been an option.

If Cain had actually determined that he wanted a less intensive procedure with quicker recovery time, Dr. Shapiro opined that it would be below the standard of care to simply comply with Cain's wishes: "if the patient does not want the procedure that's indicated for him, then you just don't do

the procedure. You say, sorry, you know, there's nothing that I would be able to do that's going to correct your problem." Specifically, "if the Lapidus was not going to be done, then essentially, Dr. Niemela should not have done any surgery[.]"

When Cain's counsel took over the questioning, he redirected Dr. Shapiro on the standard of care:

> *Q.* And I had advised you that under Michigan law, there is what's known as the locality rule with regard to standard of care, and you understood that?
>
> *A.* I do, yes.
>
> *Q.* And I had asked you to do some research on Marquette as well as Marquette General Hospital, and you also reviewed the physician transcript of Dr. Niemela's practice.
>
> Is there anything different about the community of Marquette or Marquette General Hospital of Dr. Niemela's practice that is different than either your practice [sic]?
>
> * * *
>
> *A.* No. I feel that . . . our practices are the same. We're a general podiatry practice that handles all aspects of . . . foot and ankle, both conservative and surgical treatment.
>
> . . . I did look up Marquette, Michigan, and . . . my office [is] in Warminster. Your populations are pretty close to the same, in the mid . . . 20,000s.
>
> Marquette General Hospital . . . I saw was a Level 2 trauma center, around 300 beds. St. Mary's that I work at is very similar, Level 2 trauma center. It has about 371 beds, serves a local commonly [sic]. . . . I don't think that anything that would . . . be available at St. Mary's Medical Center would [sic not] be available at Marquette and . . . the same standard of care for treating a bunion would be the same at both locations.
>
> *Q.* Was there anything different about Dr. Niemela's practice in Marquette as opposed to your practice where you perform podiatric services?
>
> *A.* I don't think so, no.
>
> *Q.* Are there are any differences between the hospitals where you performed surgery, including an Austin or a Lapidus procedure and Marquette General Hospital?
>
> * * *
>
> *A.* No.

* * *

Q. Is there anything from your review of the records, your review of the depositions, your knowledge of podiatric medicine and your research of Marquette as well as Marquette General Hospital that would lead you to believe that there's a difference between a local standard of care versus a national standard of care for the issues presented in this case?

* * *

A. No, there's no difference in local versus national standard of care.

Dr. Shapiro further testified that Lapidus and Austin/Akin procedures are "both nationally taught the same way." Overall, there was no difference between the local and national standard in this case, in Dr. Shapiro's estimation.

Dr. Niemela presented his own expert witness—Dr. Jeffrey Szczepanski. Dr. Szczepanski is a podiatrist who studied in Cleveland and did his residency in Youngstown, Ohio. Dr. Szczepanski has practiced podiatry in the Traverse City area since 2007, and practiced in Detroit before that. Dr. Szczepanski testified that he had performed 500 to 700 Austin, Akin, and Lapidus procedures in his career. He agreed that when the IM angle is greater than 16, a Lapidus procedure is indicated. And as Cain's IM angle was 20.5, a Lapidus should have been performed in this case.

Dr. Szczepanski defined the standard of care as "what a similar practicing podiatrist would do in a similar or like situation." When asked by Cain's counsel if he perceived "any difference between the standard of care in Marquette, Traverse City, Philadelphia, California," Szczepanski replied that he did, but cited only the example of regional occurrences of frostbite. Cain's counsel then zeroed in on the issue in this case:

Q. . . . . [I]s there any difference in the standard of care for whether to do a Lapidus versus an Austin/Akin?

A. I do believe there is. There's a regional nature of it. . . . [W]hen I practiced when I was in the Detroit area and there is a heavy favorite for Austin/Akin in that area. During my residency in Youngstown, Ohio, which is near Pittsburgh, there's a heavy favorite on Lapidus procedures. So I really do believe there is a regionality to what doctors are comfortable with doing.

The treatment of bunions in general is different in different localities Dr. Szczepanski asserted based on weather:

Q. Dr. Szczepanski, how specifically would the treatment of a bunion, such as Mr. Cain's, be different in Marquette versus anywhere else in the country?

A. One simple answer is, if you're doing surgery in wintertime on patients in Marquette and Traverse City we have a whole lot of lake effect snow. If you're doing surgery on a patient in Florida so when it comes time to use postoperative

devices, crutches, knee walkers, wheelchairs, it's quite a bit different in the middle of winter than it is, let's say, summertime or a different region.

Q. Any other differences?

A. The - - once again your cases that you're going to decide how to fix them are among your experience and your locality and what you do and what's accepted in your community and that's how you make your decision.

After discussing the impact of the weather on surgical decisions, Dr. Szczepanski admitted that there was no indication in Dr. Niemela's records that weather played a role in the decision-making process in this case.

Dr. Niemela filed a motion to strike Dr. Shapiro as an expert witness and for summary disposition under MCR 2.116(C)(10). Dr. Niemela contended that a podiatrist is a general practitioner judged under a local standard of care under MCL 600.2912a. Dr. Niemela practices in Marquette, and Dr. Shapiro's testimony revealed "that he is not familiar with the local standard of care which would be applicable to Dr. Niemela," he argued. Dr. Shapiro merely asserted that Warminster and Marquette had similar population sizes. He did not consult with any podiatrist in northern Michigan to compare the standards for treating bunions before declaring that the standard was the same nationwide. And even if the population sizes were similar, Marquette and Warminster are not comparable communities, Dr. Niemela contended. Marquette's total metropolitan area has a population of only 66,516, while Warminster is a suburb in a large metropolitan area of over 6 million people. As such, Dr. Niemela asserted, Dr. Shapiro did "not possess the requisite foundational background to offer an expert opinion in this case" and must be struck from Cain's witness list. As Cain presented no other qualified expert witness, Dr. Niemela contended, Cain could not prove his case and summary disposition was warranted under MCR 2.116(C)(10).

Cain retorted that Dr. Shapiro was able to testify to the local standard of care as he practices general podiatry in a community with similar demographics to Marquette. Moreover, Cain argued, "Dr. Shapiro has testified that the issues involved in this case, the surgical correction of a bunion, are so commonplace that the local standard of care is the same everywhere and is likewise a national standard." Cain conceded that podiatrists are governed by a local standard of care under Michigan law. But Cain cited a series of cases supporting that out-of-state experts may gain familiarity with the local standard of care to testify against defendant doctors. Citing *LeBlanc v Lentini*, 82 Mich App 5; 266 NW2d 643 (1978), and *Decker v Rochowiak*, 287 Mich App 666; 791 NW2d 507 (2010), Cain contended that sometimes the local standard of care is the same as the national standard. The only challenge to finding the local and national standards to be the same in this case, Cain asserted, was "Dr. Szczepanski's suspect testimony about weather affecting a surgical decision."

At the hearing on his motions, Dr. Niemela argued that Dr. Shapiro cited no foundation for opining that there was a single national standard of care regarding the type of procedure to perform to correct a bunion. Cain's counsel retorted that bunionectomies are "a bread and butter surgical procedure" that all the doctors testifying in this case had done hundreds to thousands of them. All agreed that the guidelines were to perform a Lapidus, rather than an Austin/Akin procedure, when

the IM angle is greater than 16 degrees. As Cain's angle was 20.5, all agreed that a Lapidus was "recommended." Cain further noted that Dr. Niemela and his own expert agreed that the disadvantages of performing an Austin/Akin procedure here outweighed the advantages and that a doctor does not "do a surgery" under those circumstances.

The circuit court struck Dr. Shapiro's testimony. In doing so, the court noted that Cain was tasked with "demonstrat[ing] that Dr. Shapiro is familiar with the standard of care in the community in which Dr. Niemela practices – Marquette, Michigan – or in a similar community." Yet, in the court's estimation, Cain elicited no testimony from Dr. Shapiro demonstrating his "familiarity with the standard of care in the community in which Dr. Niemela practices, or in a similar community." The court continued that in Michigan medical malpractice cases, "there is no national standard of care for any physician regardless of the nature of his or her practice." Rather, under the plain language of MCL 600.2912a, "the standard of care for both general practitioners and specialists refers to the community." Dr. Shapiro testified "[i]n conclusory fashion," that the national standard and the local standard were the same in this instance. And Cain relied upon *LeBlanc*, 82 Mich App 5, which the court found distinguishable because "it involved a sponge that had been left in a patient following surgery."

Ultimately, the court ruled:

> Here Dr. Shapiro did little to become familiar with the local standard of care in Marquette, Michigan for a podiatrist. He compared demographic information, but did not take other steps to familiarize himself with the local standard of care (i.e. consult with other podiatrists in the area, examine various written materials regarding the Michigan hospitals in the area).
>
> All-in-all, this court concludes that there is no foundation to show the medical standard of care in Marquette County, Michigan is similar to Bucks County/Philadelphia Pennsylvania, where Dr. Shapiro practices. Further, Dr. Shapiro's belief that the national standard of care is applicable is fatal in this instance. Accordingly, this Court concludes that Dr. Shapiro is not qualified to testify in this matter and must be stricken as an expert witness.

Absent any qualified expert to articulate the standard of care applicable to Dr. Niemela, the court concluded, Cain could not support his case. The court therefore summarily dismissed the action.

II. ANALYSIS

"A plaintiff in a medical malpractice action must establish," among other elements, "the applicable standard of care" governing the defendant doctor's actions and that the defendant doctor breached that standard. *Elher v Misra*, 499 Mich 11; 878 NW2d 790 (2016) (quotation marks and citation omitted). "Generally, expert testimony is required in a malpractice case in order to establish the applicable standard of care and to demonstrate that the professional breached that standard." *Id*. (quotation marks and citation omitted). We review for an abuse of discretion a trial court's determination "[w]hether a witness is qualified to render an expert opinion and the actual admissibility of the expert's testimony." *Tate v Detroit Receiving Hosp*, 249 Mich App 212, 215; 642 NW2d 346 (2002). When a trial court excludes evidence based on an erroneous interpretation

or application of the law, it necessarily abuses its discretion. *Kidder v. Ptacin*, 284 Mich App 166, 170; 771 NW2d 806 (2009).

In relation to the standard of care in a medical malpractice action, MCL 600.2912a(1) provides:

> 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:
>
> (a) The defendant, if a general practitioner, failed to provide the plaintiff the recognized standard of acceptable professional practice or care in the community in which the defendant practices or in a similar community, and that as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.
>
> (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.

Under Michigan law, a podiatrist is considered a general practitioner, not a specialist. See *Jalaba v Borovoy*, 206 Mich App 17, 21; 520 NW2d 349 (1994). Accordingly, Cain was required to present an expert witness who could testify to "the recognized standard of acceptable professional practice or care in the community in which the defendant practices or in a similar community." MCL 600.2912a(1)(a). "An expert familiar with the standard of care in a community may testify concerning the standard of care in that community, although he has not practiced in the community." *Bahr v Harper-Grace Hosps*, 448 Mich 135, 141; 528 NW2d 170 (1995).

In *Decker*, 287 Mich App at 686, this Court held that "[a] nonlocal expert may be qualified to testify if he or she demonstrates a familiarity with the standard of care in an area similar to the community in which the defendant practiced." The defendant in *Decker* was a nurse, not a doctor, and her standard of care was governed by the common law, rather than statute. But the common-law standard matched that of a general practitioner under the statute: "the skill and care ordinarily possessed and exercised by practitioners of the profession in the same or similar localities." *Id.* (quotation marks and citation omitted). As in this case, the expert witness in *Decker* testified that a "national" standard of care governed the defendant's actions. *Id.* And like in this case, the expert actually explained that the national and local standards were the same under the circumstances:

> [T]he actual substance of [the expert's] lengthy testimony was that the procedures at issue here *are so commonplace* that the same standard of care applied locally and nationally. In other words, for example, no matter where a nurse is practicing: (1) central lines must be monitored and evaluated for patency, as well as utilized correctly, (2) particularized care must be given to a patient on the basis of the patient's medical condition, (3) physician orders must be followed, and (4) nurses must record, apprise, and report to physicians and other providers significant

> changes in a patient's condition, as well as record such verbal communications. Thus, plaintiff's expert applied the proper standard of care, which happened to be the same locally as well as nationally. [*Decker*, 287 Mich App at 686-687, citing *LeBlanc*, 82 Mich App at 19 (emphasis added).]

In *LeBlanc*, the plaintiff accused the defendant doctor of committing medical malpractice by performing unnecessary surgery to treat an esophageal hiatus hernia and duodenal ulcer when more conservative treatment was warranted, failing to adequately advise the plaintiff before securing his consent for surgery, leaving a sponge inside the plaintiff following the surgery, and failing to properly close the incision after performing a second surgery to remove the sponge. *LeBlanc*, 82 Mich App at 7-8. The defendant doctor, who practiced in Cheboygan, asserted "that he was a general practitioner who had performed hundreds of surgical operations of the same magnitude as the ones performed on Samuel LeBlanc, and that he spent approximately two weeks per year attending post graduate courses in various parts of the United States." *Id*. at 18. The plaintiff's proposed expert testified:

> that he was familiar with the standards of practice for general practitioners with respect to the diagnosis and treatment of duodenal ulcers and hiatal hernias in Norway, Maine, at the time of his practice there and that the general standard of treatment for duodenal ulcers had not changed significantly since that time and that the known causes and basic treatment of the two conditions had remained unchanged from the time he practiced in Norway, Maine, and that the standard of practice in treating duodenal ulcers is the same throughout the United States; that he has treated duodenal ulcer and hiatus hernia patients in his own practice; and that duodenal ulcer and hiatal hernia "is one of the most popular subjects that are discussed, because it is *one of the most frequent and common recurring symptoms in our society*". [*Id*. at 19 (emphasis added).]

"Considering the background of the witness and the nature of the medical conditions involved," this Court determined that the plaintiff's expert witness was qualified to testify regarding the defendant doctor's standard of care, despite that he had never practiced in Cheboygan "and was generally unfamiliar with the area." *Id*.[4]

And in *Turbin v Graesser*, 214 Mich App 215, 218-219; 542 NW2d 607 (1995), we deemed an expert from Florida qualified to testify to a local standard of care based on his review of written information regarding the location of the treatment at issue including a "metropolitan profile" and summaries of the community's hospital data, "coupled with his impeccable credentials and experience[.]" We noted that the expert's residence and the defendant's city of practice "had

[4] In arguing that *LeBlanc* is not analogous to the current matter, Dr. Niemela incorrectly contends that the medical malpractice in *LeBlanc* was limited to leaving a sponge inside the patient and inaccurately asserts that this Court "found that the standard of care locally and nationally were the same with respect to unintentionally failing to remove a sponge following a surgery." The facts before this Court in *LeBlanc* were not so limited.

similar populations, a similar scope of medical specialties, similar available procedures, and similar technology." *Id.*

Decker, *LeBlanc*, and *Turbin* support admission of Dr. Shapiro as plaintiff's expert witness. All the medical witnesses in this case asserted that the treatment of bunions is commonplace in the practice of podiatry. Indeed, Dr. Niemela performs surgery to correct bunions at least once a week. As described by the experts, there were no relevant differences in their education and training. Moreover, both Dr. Shapiro and Dr. Niemela learned how to treat bunions at medical schools in large metropolitan areas and did their residencies in hospitals with Level 1 trauma centers. Significantly, both experts now practice at Level 2 trauma centers. Because the designation of a trauma service level derives from national criteria, Dr. Shapiro had no need to conduct research regarding the staffing, equipment, and other resources available to Dr. Niemela, or to ascertain further specifics regarding the standard of care. On this record, there is no doubt that "the procedures at issue here are so commonplace that the same standard of care applied locally and nationally." *Decker*, 287 Mich App at 686. This was all Dr. Shapiro claimed—that the treatment of bunions through Lapidus, Austin, and Akin procedures is so common, and is taught so uniformly, such that there can be no difference in the standard of care between his locality and that of Dr. Niemela. Contrary to the trial court's ruling, Dr. Shapiro's belief that the standard of care under the circumstances of the case was the same nationwide was not "fatal" to qualification as an expert.

Moreover, the standard of care dispute presented in this case is quite narrow, boiling down to whether the standard permitted Dr. Niemela to offer and perform the Austin and Akin procedure given Cain's moderate to severe IM angle. No evidence was presented that podiatrists evaluated the risks and benefits differently depending on the size or characteristics of their home communities. We note that although weather conditions may influence the information a podiatrist imparts to an individual patient, the locality rule focuses on a comparison of available facilities, technology, and the availability of specialty consultation. See, e.g., *Callahan v William Beaumont Hosp*, 67 Mich App 306, 311; 240 NW2d 781 (1976).

Moreover, Dr. Shapiro's testimony established that he was fully familiar with the standard of care in the locality at issue in this case—Marquette, Michigan. Both Dr. Shapiro and Dr. Niemela trained at universities in major cities and completed residencies at large city, Level 1 trauma centers. Both doctors currently work out of Level 2 trauma center hospitals with 300-400 beds. The population of Warminster and Marquette are similar. Dr. Niemela and his counsel attempt to portray Marquette as a rural, unsophisticated area merely because it is in the Upper Peninsula. However, Marquette is the largest city in the Upper Peninsula, a university town, and boasts the amenities of a larger city or a sophisticated suburb.

Ultimately, the circuit court abused its discretion in striking Dr. Shapiro's expert testimony. With the admission of Dr. Shapiro's testimony, Cain can establish a genuine issue of material fact

that Dr. Niemela breached his duty of care. Therefore, the circuit court also erred in summarily dismissing Cain's medical malpractice complaint under MCR 2.116(C)(10).[5]

We vacate the circuit court's order striking the testimony of Dr. Shapiro and summarily dismissing Cain's complaint, and remand for further proceedings. We do not retain jurisdiction.

/s/ Michael F. Gadola
/s/ Elizabeth L. Gleicher
/s/ Cynthia Diane Stephens

[5] Given our resolution of this issue, we need not resolve Cain's alternative argument that the testimony of Dr. Niemela and Dr. Szczepanski sufficed to establish the proper standard of care.