STATE OF MICHIGAN

COURT OF APPEALS

JENNIFER CLIFTON,

Plaintiff-Appellant,

v

ANTON BAHU, D.O., and FAMILY PRACTICE CENTRE OF LIVONIA, P.C., d/b/a FAMILY PRACTICE CENTRE OF LIVONIA,

Defendants-Appellees.

UNPUBLISHED
August 13, 2020

No. 348794
Wayne Circuit Court
LC No. 17-008315-NH

Before: MARKEY, P.J., and M. J. KELLY and BOONSTRA, JJ.

MARKEY, P.J. (*dissenting*).

In this medical malpractice action, plaintiff Jennifer Clifton appeals by right the trial court's order granting summary disposition in favor of defendants Dr. Anton Bahu and Family Practice Centre of Livonia, P.C. The trial court determined that plaintiff failed to establish a genuine issue of material fact with respect to whether Dr. Bahu's alleged negligence caused plaintiff to suffer a ruptured ectopic pregnancy,[1] which resulted in required surgical intervention to remove her right fallopian tube and effectively left her infertile. Contrary to the holding of the majority, I conclude that plaintiff submitted sufficient documentary evidence to create a factual question for a jury on the issue of causation. Therefore, I would reverse and remand for further proceedings. Accordingly, I respectfully dissent.

I. FACTUAL BACKGROUND AND PROCEDURAL HISTORY

Plaintiff, who was a married 37-year-old woman with no children, learned that she was pregnant on May 13, 2015, after taking two home pregnancy tests. The next day, May 14, 2015,[2]

[1] An ectopic pregnancy is a pregnancy in which the fertilized ovum is implanted outside the intrauterine cavity.

[2] Nearly all of the pertinent events occurred in 2015; therefore, for the remainder of this opinion, all dates shall pertain to 2015 unless otherwise indicated.

plaintiff was seen by Dr. Bahu at his office at Family Practice Centre of Livonia. Dr. Bahu was plaintiff's primary care doctor, and he was a licensed family practice physician. Laboratory testing during the visit confirmed that plaintiff was indeed pregnant. It was plaintiff's first pregnancy. Her beta human chorionic gonadotropin (hCG), which is a hormone produced during pregnancy, was 544.13 at the time. Dr. Bahu did not handle pregnancies or deliver babies, which plaintiff knew, and plaintiff did not have an obstetrician-gynecologist (OB-GYN) when she learned of her pregnancy. Either through a referral by Dr. Bahu or by way of a friend's recommendation (or both), plaintiff settled on Dr. Timothy Johnson to be her OB-GYN relative to the pregnancy.

On the evening of May 14th and during the day on May 15th, which was a Friday, plaintiff had vaginal spotting, so she called Dr. Bahu's office. Dr. Bahu originally planned to have her come in that Friday afternoon, but he then decided it would be best for plaintiff to go to the emergency room (ER). In the late afternoon of May 15th, plaintiff went to the ER at St. Mary's Hospital. ER records indicated that plaintiff complained of "lower abdominal cramping and vaginal spotting." Plaintiff's hCG level was 611. ER notes stated that the cramping and spotting had "significantly improved."

An ultrasound was performed on plaintiff, and the ER notes provided that the "[u]ltrasound could not reliably rule in a[n] intrauterine pregnancy." The "impression" from the ultrasound was as follows: "No intrauterine gestation seen. Ectopic pregnancy not excluded." According to the ER records, plaintiff was informed that "the possibility of an ectopic pregnancy cannot be ruled out and [that] she must return to the [ER] immediately for any worsening abdominal pain[,] fever[,] nausea[,] vomiting[,] bleeding[,] or for any concerns any time." The ER records further reflected that "[p]atient was [told] that she must follow up with her OB/GYN for repeat labs and possible repeat ultrasound." Plaintiff testified at her deposition that the ER doctor did not mention the possibility of a tubal pregnancy. The "discharge diagnosis" in the ER records was "[t]hreatened abortion." Written discharge instructions indicated that plaintiff was to follow up with Dr. Johnson in two days, by May 17th, and with Dr. Bahu as needed. Plaintiff testified that she did not recall seeing these particular discharge instructions; she only remembered being told "to follow up with your doctor" as soon as possible, absent any specification to either Dr. Johnson or Dr. Bahu.

Because she was discharged from the ER late on a Friday at the start of the weekend, plaintiff waited to call anyone until Monday morning on May 18th. She scheduled an appointment with Dr. Bahu for the next day. Plaintiff also contacted Dr. Johnson's office, but, according to plaintiff, she was told that she had to be six to eight weeks pregnant before Dr. Johnson would see her. Consequently, her appointment with Dr. Johnson was not scheduled until June 9th. Plaintiff acknowledged in her deposition that when scheduling the appointment, she did not inform Dr. Johnson's office that she had been in the ER a few days earlier in regard to the pregnancy. Plaintiff explained that she did not do so because she "was under the assumption that everything was normal."[3]

[3] At her deposition, plaintiff testified that she did not realize that an ectopic pregnancy was the same as a tubal pregnancy. Indeed, she stated that she did not know what "ectopic" meant, as the term had not been explained to her at the hospital.

On Tuesday, May 19th, plaintiff saw Dr. Bahu, and it is this office visit that forms the basis of plaintiff's medical malpractice suit. Plaintiff told Dr. Bahu that she was still spotting and had mild gas pains. Lab testing revealed that plaintiff's beta hCG level was 2751.66. Dr. Bahu's notes indicated a "[t]hreatened [m]iscarriage."[4] Those notes also acknowledged that plaintiff had an appointment on June 9th with Dr. Johnson, and Dr. Bahu testified that he knew about that scheduled appointment. Dr. Bahu did not advise plaintiff to see Dr. Johnson any sooner than June 9th, and plaintiff confirmed in her deposition that Dr. Bahu did not tell her that she needed to see Dr. Johnson earlier than June 9th. Dr. Bahu testified that he could have called Dr. Johnson's office and made a request for an earlier appointment, but he chose not to do so because plaintiff was doing about the same if not a little better as compared to the day of her ER visit. Plaintiff testified that if there was an emergency situation, Dr. Johnson would have seen her sooner than June 9th. Plaintiff claimed that she "was under the assumption that everything was normal" on May 19th. Plaintiff did state that Dr. Bahu told her that a tubal pregnancy could not be ruled out. According to plaintiff, Dr. Bahu further explained to her:

> If I feel sick, if I am running any fevers, if I have any cramping, any heavy bleeding, anything more persistent than what was going on at that point in time, that I was to immediately go back to the [ER].

Dr. Bahu sent lab test results to Dr. Johnson's office. Dr. Bahu did not order an ultrasound, nor did he advise plaintiff to obtain an ultrasound.

Around dinnertime on June 6th, plaintiff began sweating, appeared pale, and had difficulty walking, and her husband took her to the ER at St. Mary's Hospital. With respect to the period from May 19th until she started feeling ill on June 6th, plaintiff claimed that the only health issue that she had was some intermittent light spotting, "nothing heavy." Regarding this timeframe, plaintiff testified:

> *Q.* And you were still working full-time during this time?
>
> *A.* Yes, ma'am.
>
> *Q.* Were you taking your temperature daily to see - -
>
> *A.* No.
>
> *Q.* Did you ever feel feverish?
>
> *A.* No.

[4] Dr. Bahu testified at his deposition that he wrote down "threatened miscarriage" most likely on the basis of his review of the ER notes. Dr. Bahu stated that a threatened miscarriage was not his personal diagnosis or impression. Dr. Bahu testified that had he "thought it was an acute threatened miscarriage, [he] would have sent [plaintiff] right back to the hospital."

Q. Did you have any cramping?

A. No, no.

Q. So the first time that you experienced any significant pain after seeing Dr. Bahu on May 19th is on June 6th when you go to the ER?

A. Yes, ma'am.

ER notes from the June 6th visit indicated that plaintiff complained of abdominal pain and spotting and was pale and diaphoretic. An ultrasound was quickly performed, and it was "compatible with a ruptured ectopic pregnancy."[5] Shortly thereafter, plaintiff went to the operating room where surgery was performed, which was described, in part, as follows:

> Her right fallopian tube was distorted and had a clot coming out of it and the whole end of the tube was unrecognizable. The [ruptured] fallopian tube was elevated and cut toward the junction to the uterus. The tube itself was removed totally and the bleeding was then secured.

According to plaintiff, nearly two years later, in March 2017, a hysterosalpingiography was performed on her left fallopian tube to determine whether it was viable. The procedure revealed that plaintiff's left fallopian tube was not viable and that plaintiff would not be able to conceive children naturally.

In June 2017, plaintiff filed a medical malpractice action against Dr. Bahu and Family Practice Centre of Livonia, P.C. Plaintiff supported her complaint with an affidavit of merit by Dr. Richard M. Hays, who was a licensed and board-certified physician in family medicine. Count I alleged negligence by Dr. Bahu. Plaintiff contended that Dr. Bahu breached the applicable standard of practice or care in the following ways:

> a. Failed to timely perform the proper testing including but not limited to bloodwork to determine the patient's Beta HCG levels;
>
> b. Failed to perform an ultrasound on May 19, 2015 after the patient's Beta HCG levels were not properly increasing and she had a negative ultrasound on May 15, 2015;
>
> c. Failed to address the patient's concerns and symptoms;
>
> d. Failed to diagnose the patient with an ectopic pregnancy on May 19, 2015;

[5] The ER records noted that plaintiff had seen her primary care doctor after the earlier ER visit "but never had an ultrasound done."

> e. Failed to timely treat the ectopic pregnancy with Methotrexate,[6] including but not limited to timely referring the patient to an OB/GYN for administration of Methotrexate; and
>
> f. Failed to provide the appropriate follow up care and treatment for the patient depending on information that was or should have been available.

Plaintiff alleged that as a direct and proximate result of Dr. Bahu's breaches of the standard of care, plaintiff "suffered a ruptured ectopic pregnancy which resulted in the removal of her right fallopian tube, which required surgical intervention and extensive medical treatment." Plaintiff further alleged that her right fallopian tube was her only viable fallopian tube; therefore, the removal of her right fallopian tube caused her "to lose her fertility."

Count II of the complaint concerned defendant Family Practice Centre of Livonia, P.C., and it essentially mimicked the allegations in Count I but sought damages on a vicarious liability theory.

After initially filing an answer to the complaint,[7] defendants proceeded to file a motion for summary disposition pursuant to MCR 2.116(C)(10), supporting the motion with documentary evidence. Defendants set forth the background facts and the elements of a medical malpractice action, including the need to establish "proximate cause." They recited well-established principles regarding causation. Defendants then asserted that plaintiff would be unable to prove the requisite element of proximate cause, arguing:

> Here, there was a break of 18 days between when [plaintiff] sought care with Dr. Bahu and the subsequent rupture of her tube, nearly three weeks later. And, there had been no contact by [plaintiff] to Dr. Bahu or any other health care provider regarding any concern with her pregnancy. Further, the patient-physician relationship between [plaintiff] and Dr. Bahu with respect to the management of her pregnancy had ended with the proverbial torch having been passed to . . . Dr. Johnson.

Plaintiff subsequently filed a response in opposition to the motion for summary disposition, attaching supporting documentary evidence. Plaintiff argued that her right fallopian tube ruptured and had to be removed because Dr. Bahu failed to take appropriate action on May 19th. She maintained that Dr. Bahu should have pursued further testing or sent plaintiff immediately to Dr. Johnson or another OB-GYN who would have performed the appropriate testing, made the diagnosis of an ectopic pregnancy, and treated plaintiff before the rupture. Plaintiff further contended:

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[6] Methotrexate is used to treat an ectopic pregnancy and works by stopping the growth of the fertilized egg before a rupture occurs. In an affidavit, plaintiff averred that if she had been "offered Methotrexate as treatment to resolve [her] ectopic pregnancy, [she] would have consented to receiving it, over risking the rupture and loss of [her] fallopian tube."

[7] Defendants supported their answer with an affidavit of meritorious defense executed by Dr. Bahu.

> Just because Dr. Bahu got a blood test result and sent it on to Dr. Johnson knowing that [plaintiff] had an appointment there in three weeks did not relieve him of his obligations under the standard of care. The fact that the defendants even make this argument is ludicrous. This is analogous to a patient who has chest pain and sees their family doctor who chooses not to take the appropriate action because the patient has an appointment with a cardiologist in three weeks. Of course, the family medicine physician would have to take some action. The family medicine doctor cannot rely on the fact that the patient has an appointment with a cardiologist in the future and not take the proper care at that time. This is because it is conceivable that the patient may have a heart attack, so a proper plan or immediate referral would be necessary.
>
> Just because Dr. Bahu expected Dr. Johnson to manage the patient's pregnancy doesn't mean that he was excused from acting on what he was presented with on May 19th. You don't simply get a "pass" when you elect to see and treat a patient. The fact that Dr. Bahu doesn't follow pregnancies is of no consequence. This is precisely the reason he needed to arrange to have [plaintiff] seen by Dr. Johnson immediately. The defense's argument makes no sense and quite frankly, if applied in everyday life would allow for terrible, below the standard of care, medical care.

I turn next to the documentary evidence regarding expert opinions in my analysis section to the extent that it is relevant to the issues raised on appeal.

A hearing was held on defendants' motion for summary disposition, and the trial court ruled from the bench, granting the motion. The trial court's ruling was at points internally inconsistent, did not show good command of the evidence, and was occasionally unsupported by the record. The trial court observed that St. Mary's diagnosed an ectopic pregnancy on May 15th, that St. Mary's told plaintiff that she "might have an ectopic pregnancy" and to go to her OB-GYN, not Dr. Bahu, within two days, that plaintiff failed to go to Dr. Johnson within two days or indicate to him that time was of the essence, that she instead saw Dr. Bahu, that Dr. Bahu told plaintiff to go to Dr. Johnson, and that plaintiff scheduled an appointment with Dr. Johnson for June 6th. The trial court noted that plaintiff was not complaining that Dr. Bahu failed to treat her but that he did not tell her to go to an OB-GYN; however, the record was clear that Dr. Bahu informed her to see Dr. Johnson. The trial court further found that there was no evidence of a causal link between Dr. Bahu's discharge of plaintiff on May 19th and the ruptured fallopian tube. Throughout the court's ruling, it blamed plaintiff for not doing as she was instructed by the hospital and by Dr. Bahu, and it repeatedly observed that Dr. Bahu did not handle pregnancies. The court also stated that on May 19th there was no indication that there was a critical problem and that plaintiff did nothing in the following weeks, such as returning to the hospital or calling Dr. Johnson. The trial court concluded that there was no evidence of factual, legal, or proximate cause. And the court adopted the arguments in defendants' brief. Subsequently, an order was entered granting summary disposition in favor of defendants for the reasons stated on the record. This appeal ensued.

II. ANALYSIS

A. STANDARD OF REVIEW AND SUMMARY DISPOSITION PRINCIPLES

"This Court reviews de novo a trial court's decision on a motion for summary disposition." *Johnson v Vanderkooi*, 502 Mich 751, 761; 918 NW2d 785 (2018). We also review de novo issues of statutory interpretation. *Estes v Titus*, 481 Mich 573, 578-579; 751 NW2d 493 (2008).

MCR 2.116(C)(10) provides that summary disposition is appropriate when, "[e]xcept as to the amount of damages, there is no genuine issue as to any material fact, and the moving party is entitled to judgment or partial judgment as a matter of law." A motion brought pursuant to MCR 2.116(C)(10) tests the factual support for a party's action. *Pioneer State Mut Ins Co v Dells*, 301 Mich App 368, 377; 836 NW2d 257 (2013). "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." *Id.* "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). 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). *Pioneer State*, 301 Mich App at 377. A court may only consider substantively admissible evidence actually proffered by the parties when ruling on the motion. *Maiden v Rozwood*, 461 Mich 109, 121; 597 NW2d 817 (1999). "Like the trial court's inquiry, when an appellate court reviews a motion for summary disposition, it makes all legitimate inferences in favor of the nonmoving party." *Skinner v Square D Co*, 445 Mich 153, 162; 516 NW2d 475 (1994).

B. DISCUSSION

On appeal, plaintiff first argues that the trial court made a number of inaccurate factual statements and legal conclusions that led to the improper dismissal of the medical malpractice action. Plaintiff additionally contends that the trial court erroneously found that there was no cause in fact and no legal cause. Further, plaintiff maintains that the trial court invaded the province of the jury by essentially making a ruling on comparative negligence and finding plaintiff at fault. Plaintiff also asserts that the court improperly made a credibility assessment, rejecting and in fact ignoring the opinions of plaintiff's medical experts concerning proximate cause.

Defendants argue that plaintiff failed to present admissible evidence to create a genuine issue of material fact regarding cause in fact and that plaintiff's case relies on pure speculation. Defendants also claim that plaintiff's causation theory is too remote in time or place to satisfy the legal causation requirement. Defendants further contend that the trial court's ruling was not based on erroneous factual and legal findings. Finally, defendants assert that the trial court correctly granted their motion for summary disposition because under Michigan's avoidable-consequence doctrine, the documentary evidence established that plaintiff's failure to follow up with Dr. Johnson as expressly instructed resulted in her alleged damages.

"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." *Cox v Bd of Hosp Managers for the City of Flint*, 467 Mich 1, 10; 651 NW2d 356 (2002) (quotation marks and citation omitted; emphasis added). Failure to establish any one of these four elements is fatal to a plaintiff's medical malpractice suit. *Id*.

The issue of proximate cause in a medical malpractice case is statutorily addressed in MCL 600.2912a(2), which provides:

> 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%.

In *Ykimoff v Foote Mem Hosp*, 285 Mich App 80, 87; 776 NW2d 114 (2009), this Court defined the parameters of the term "proximate cause," explaining

> "Proximate cause" is a term of art that encompasses both cause in fact and legal cause. 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. 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. 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. 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 been obtained. [Quotation marks and citations omitted.]

"[L]egal causation relates to the foreseeability of the consequences of the defendant's conduct[.]" *O'Neal v St John Hosp & Med Ctr*, 487 Mich 485, 496; 791 NW2d 853 (2010). "[P]roximate 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." *Id.* at 496-497. "[T]he proper standard for proximate causation in a negligence action is that the negligence must be 'a proximate cause' not 'the proximate cause.' " *Id.* at 497.

"Expert testimony is essential to establish a causal link between the alleged negligence and the alleged injury." *Pennington v Longabaugh*, 271 Mich App 101, 104; 719 NW2d 616 (2006). "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). A court must dismiss an action when causation remains an issue of pure speculation and conjecture, or the probabilities are evenly balanced at best. *Id*.[8]

Under the avoidable-consequences doctrine, where a person has committed a tort, breach of contract, or some other legal wrong against an individual, it is incumbent upon the latter to use such means as are reasonable under the circumstances to avoid or minimize the damages, and the wronged individual cannot recover for any item of damage that could thus have been avoided. *Braverman v Granger*, 303 Mich App 587, 597-598; 844 NW2d 485 (2014).

With respect to plaintiff's office visit with Dr. Bahu on May 19th, she presented evidence that the doctor knew about plaintiff's ER visit and related testing from four days earlier, that he was aware that her current hCG level was 2751.66, that he did not order or recommend a new ultrasound, that he knew that plaintiff's scheduled appointment with Dr. Johnson was still three weeks away, that he did not tell plaintiff of the need to see Dr. Johnson or another OB-GYN as soon as possible, and that Dr. Bahu made no attempt himself to reach out to Dr. Johnson to move up the appointment. There was also evidence that plaintiff believed the pregnancy was normal after visiting Dr. Bahu on May 19th, that she could and would have seen Dr. Johnson sooner than June 9th had she been so advised, that she would have taken methotrexate to avoid a ruptured fallopian tube, and that she only had unalarming light spotting between May 19th and June 6th, at which point she was hospitalized.

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[8] The landmark Michigan case on causation is *Skinner*, 445 Mich 153. Our Supreme Court in *Skinner* explained that establishing causation entails proving "two separate elements: (1) cause in fact, and (2) legal cause, also known as 'proximate cause.' " *Id.* at 162-163. The Supreme Court further observed:

> The cause in fact element generally requires showing that "but for" the defendant's actions, the plaintiff's injury would not have occurred. On the other hand, legal cause or "proximate cause" normally involves examining the foreseeability of consequences, and whether a defendant should be held legally responsible for such consequences. A plaintiff must adequately establish cause in fact in order for legal cause or "proximate cause" to become a relevant issue. [*Id*. at 163 (citations omitted).]

Circumstantial evidence and reasonable inferences arising from the evidence can be utilized to establish causation. *Id*. at 163-164. But it is not sufficient to proffer "a causation theory that, while 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 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.

Plaintiff's expert, Dr. Hays, gave testimony in a deposition. The following are relevant snippets from Dr. Hays's testimony:

> [Dr. Bahu] had the records from the [ER] that showed that [plaintiff] did not have - - there was on the ultrasound no evidence of [a] viable pregnancy, so a board certified, properly trained family physician should and must be aware that a patient with an ultrasound that can be . . . an ectopic as occurred, one way or another when you have an ultrasound that . . . does not show products of conception in the uterus and you have a rising beta HCG[, you] must be prepared to evaluate that patient for an ectopic pregnancy. Now, that evaluation can [be] . . . conducted by themselves or conducted by an OB/GYN. However, the expectation that a patient has an appointment several weeks down the road to see that OB/GYN is not sufficient evaluation, and so if he was, in fact, handing over the care to Dr. Johnson . . ., then it would have been his obligation to ensure that the patient had a more proximate appointment to be evaluated . . . .
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> * * *
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> And much more importantly, she had an ultrasound which did not show products of conception in the uterus. So that again places the ball in the court of the family physician to either hand it off directly to an OB/GYN, and honestly for exactly this reason, I mean that because . . . at that point the risk of ectopic pregnancy is significantly higher and the overall risks of rupture and potentially even maternal death are there, so that's what makes it, you know, the standard dictate that you must . . . manage the situation.
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> * * *
>
> [A]nd it doesn't appear that [Dr. Bahu] either recognized or provided [plaintiff] information about what her situation really [was] . . . .
>
> * * *
>
> Oh, to be honest, I think the answer in this case is very simple. [Dr. Bahu] should have picked up the phone, called Dr. Johnson's office and got her in there the next day . . . and told him this is not a normal uncomplicated intrauterine pregnancy . . . .
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> * * *
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> [F]or a family physician faced with a pregnant woman with an abnormal ultrasound, you're either handling it or you're not. If you're not handling it, then you need to hand it off and you need to ensure that that patient is handed off now . . . .

Plaintiff's causation expert was an OB-GYN, Dr. James Wheeler. Dr. Wheeler explained that if an OB-GYN were contacted by Dr. Bahu on May 19th and given the information about plaintiff's beta hCG, prior ultrasound, and condition, a reasonable and prudent OB-GYN would

have seen plaintiff that day or the next morning, would have warned her against engaging in certain conduct, and would have told her to go to the ER if she had sudden pain before being able to see the OB-GYN. Dr. Wheeler testified that given the hCG level of around 2700 on May 19th, there was only a 10% or 20% chance that an ultrasound on that date would have shown a *tubal* pregnancy, but "an ultrasound at that point would [also] have been 90-plus percent identifying an intrauterine pregnancy. And in the absence of that, you presume it's ectopic."

With respect to what he, as an OB-GYN, would have done upon seeing plaintiff on May 19th or the day after, Dr. Wheeler proffered the following approach:

> We would have done an ultrasound on the spot. We would have, with better than 90 percent certainty, seen an empty uterus. We may or may not have seen the ectopic pregnancy, but we would have been highly suspicious and we would have consented in a hemodynamically stable patient for methotrexate. We would have sent her for blood drawing to check her liver and kidneys and the next morning administered 50 milligrams per meter squared methotrexate with her consent. That's the exact scenario.

Dr. Wheeler testified that considering plaintiff's beta hCG level of 2751 on May 19th, there was a "reasonable medical probability that methotrexate would" have resolved an ectopic pregnancy. It did not surprise Dr. Wheeler that the ultrasound performed on May 15th in the ER did not reveal either an intrauterine pregnancy or an ectopic pregnancy in light of the 611 hCG level. Again, Dr. Wheeler indicated that the hCG level of 2751 on May 19th was sufficiently high such that, with the exception of some very limited circumstances, an ultrasound would have shown an intrauterine pregnancy if one had existed. According to Dr. Wheeler, with respect to the information available and known on May 19th, there theoretically could have been an intrauterine or ectopic pregnancy, but he opined that an ultrasound would likely have demonstrated an ectopic pregnancy under the circumstances.

I would hold that plaintiff presented evidence, detailed above, sufficient to create a genuine issue of material fact with respect to whether plaintiff suffered an injury that more probably than not was proximately caused by the alleged negligence of Dr. Bahu. MCL 600.2912a(2). For purposes of cause-in-fact, a reasonable juror could conclude on the basis of the evidence that the rupture of plaintiff's fallopian tube would not have occurred but for Dr. Bahu's failure to obtain an ultrasound, failure to inform plaintiff of the urgency of the situation on May 19th, failure to contact Dr. Johnson about the precarious nature of plaintiff's pregnancy, and/or failure to insist that plaintiff see Dr. Johnson much sooner than June 9th. On the issue of an ultrasound, Dr. Wheeler testified that had one been performed on May 19th, there was a 90%-plus likelihood that an intrauterine pregnancy would have been ruled out, meaning that an ectopic pregnancy would have been presumed. And plaintiff averred that she would have used methotrexate to stop the growth of the fertilized egg, thereby preventing a future rupture. Setting aside the issue of whether Dr. Bahu should have ordered an ultrasound, I conclude that he knew that there was a chance of an ectopic pregnancy, yet he knowingly left open a three-week window in which plaintiff had no scheduled medical appointments. Moreover, a reasonable juror could find that had Dr. Bahu taken steps to involve Dr. Johnson earlier, an ectopic pregnancy would have been identified and terminated before plaintiff's right fallopian tube ruptured. In sum, a reasonable juror could conclude, without guessing, speculating, or conjecturing, that Dr. Bahu's alleged negligence

caused or resulted in the ruptured ectopic pregnancy involving plaintiff's fallopian tube.[9] And in regard to legal causation, the same evidence I relied on above to find a question of fact on factual causation also supports a determination that a foreseeable consequence of Dr. Bahu's inaction and omissions on May 19th was a ruptured ectopic pregnancy.

I do find it imperative to discuss some associated issues and arguments. There was evidence in the form of written discharge instructions that plaintiff was advised by ER personnel on Friday, May 15th, to follow up with Dr. Johnson within two days, which she indisputably did not do. Plaintiff testified, however, that she did not recall seeing those specific discharge instructions, and she claimed that she was verbally advised to merely see her "doctor" within two days. Moreover, plaintiff did in fact contact Dr. Johnson's office on May 18th,[10] but she could not get an appointment until June 9th. Regardless of whether plaintiff failed to comply with discharge instructions, failed to communicate the actual urgency of the situation when calling Dr. Johnson's office, and failed to first visit Dr. Johnson instead of Dr. Bahu, she nonetheless did indeed see Dr. Bahu on May 19th, and he owed a duty to provide healthcare services to plaintiff that conformed to the standard of practice for family physicians regardless of any shortcomings and failures by plaintiff leading up to that point in time. To the extent that the trial court believed that plaintiff's failure to follow ER discharge instructions somehow relieved Dr. Bahu of his obligations to provide nonnegligent medical services, the court's position, in my view, was untenable and constituted error. Additionally, a reasonable juror could conclude that upon seeing Dr. Bahu on May 19th, it was entirely reasonable for plaintiff to go forward on the basis of Dr. Bahu's evaluation, comments, and direction, absent further consideration of St. Mary's findings and instructions from four days earlier. Furthermore, with respect to the period between May 19th and June 6th and plaintiff's failure to seek medical treatment during that timeframe, plaintiff testified that she had no health issues other than intermittent light spotting, which was no different from what she was experiencing when she saw Dr. Bahu. A reasonable juror could conclude that there was nothing unreasonable about plaintiff's deciding not to go to a healthcare provider during the three-week span, especially when one could construe Dr. Bahu's actions as lulling plaintiff into a false belief that time was not of the essence and that her light spotting was not a significant concern.

The discussion in the preceding paragraph touched on the various issues raised by defendants and the trial court about plaintiff's behaviors, failures, and omissions. And these matters effectively concerned comparative negligence and allocation of fault, with the court focusing blame on plaintiff. See *Zaremba Equip, Inc v Harco Nat'l Ins Co*, 280 Mich App 16, 33; 761 NW2d 151 (2008) (comparative fault requires that every actor exercise reasonable care and the general standard of care for purposes of comparative negligence requires one to act as a reasonable person for his or her own protection as evaluated under like circumstances). But the trial court did not assess *as a matter of law* that plaintiff's conduct or lack of action amounted to negligence or fault under the governing legal standards. Moreover, as alluded to above, the

[9] Other than his own deposition testimony, Dr. Bahu did not submit testimony by any experts hired by Dr. Bahu.

[10] Although she did not call Dr. Johnson's office by May 17th—a Sunday—I question whether a weekend phone call would have resulted in a different outcome than the Monday morning phone call.

reasonableness of plaintiff's actions is subject to genuine dispute under the facts presented at summary disposition. Further, there can be more than one proximate cause of harm, e.g., negligence by plaintiff *and* Dr. Bahu. In light of all of the surrounding circumstances, I believe that a jury must judge and resolve the issues of causation, fault, and negligence. Summary dismissal of this medical malpractice action was patently improper.

The main thrust of defendants' argument is that the lengthy three-week period between the May 19th appointment with Dr. Bahu and the June 6th ER visit as a matter of law effectively severed any causal link between Dr. Bahu's conduct and plaintiff's suffering a ruptured fallopian tube from an ectopic pregnancy. I disagree. First, the three-week period can reasonably be viewed as actually reinforcing plaintiff's position because it reflects a serious delay between scheduled doctor visits despite Dr. Bahu's knowledge that an ectopic pregnancy was a distinct possibility. Furthermore, a reasonable view of the evidence does not demonstrate an intervening, superseding occurrence, force, or act that took place during the three weeks that would have disrupted the causal link between Dr. Bahu's actions and the injury.[11] Plaintiff testified that she merely had light intermittent spotting that was no different from past events before becoming seriously ill and ending up in the ER from the rupture. There was no evidence that plaintiff was running fevers, having cramping, or experiencing heavy bleeding—events mentioned by Dr. Bahu to plaintiff as requiring immediate action—during the three-week period that plaintiff disregarded and ignored. The course of events that actually transpired was reasonably foreseeable.

Defendants' reliance on *Teal v Prasad*, 283 Mich App 384; 772 NW2d 57 (2009), is misplaced. In *Teal*, the personal representative of hospital-patient Teal's estate brought suit against the hospital and physicians, alleging malpractice for failure to properly diagnose and treat Teal and by discharging him from the hospital prematurely and without formulating a proper treatment plan, which negligence ultimately caused Teal to commit suicide. *Id.* at 386-390. The *Teal* panel ruled:

> Plaintiff fails to establish that defendants' decision to discharge Teal early and without a discharge plan was the "but for" cause of Teal's suicide. Admittedly, if defendants had locked Teal away for the rest of his life without access to a piece of rope or cord, he likely would not have hanged himself at his home on March 30, 2004. But this Court cannot determine whether defendants were the cause in fact of Teal's suicide by imagining every possible scenario and determining whether the likelihood of Teal's death would have diminished in each situation. Instead, the

[11] In *Hickey v Zezulka*, 439 Mich 408, 436-437; 487 NW2d 106 (1992), our Supreme Court observed:

> A superseding cause is one that intervenes to prevent a defendant from being liable for harm to a plaintiff that the defendant's antecedent negligence is a substantial factor in bringing about. We have previously held that in order to be a superseding cause, thereby relieving a negligent defendant from liability, an intervening force must not have been reasonably foreseeable. [A] defendant will not be liable for injury caused by an intervening force that was not reasonably foreseeable. [Citations omitted.]

> requirement is affirmative: plaintiff must provide sufficient evidence to establish a reasonable inference of a logical sequence of cause and effect, and not merely speculate, on the basis of a tenuous connection, that Teal would not have committed suicide if he had not been discharged on a given day more than a week before.
>
> In this case, Teal's suicide occurred eight days after his discharge from the hospital psychiatric ward. The evidence presented to the trial court established that Teal had been discharged after he realized that suicide was not the answer to his problems, received medication, and recognized the need to resume attending AA meetings and to receive treatment for his mental condition and alcoholism. When he was discharged, Teal agreed to live with a family member, continue taking psychiatric medications, resume AA meetings, and attend follow-up meetings with a therapist and, if necessary, a psychiatrist. Yet after his discharge, Teal's whereabouts were largely unknown until March 29, 2004. The parties presented no conclusive information regarding Teal's mental state during this time, his changing moods over this time, or whether he was taking the medication prescribed for him on his release from the hospital. Plaintiff also presented no evidence indicating how Teal's discharge, whether premature or not, triggered a chain of events leading to Teal's suicide. In the absence of such evidence, plaintiff's claim that defendants' alleged malpractice caused Teal's death eight days later constitutes mere speculation. [*Id.* at 392-393 (quotation marks and citations omitted).]

Here, there is evidence of what transpired during the three-week period by way of plaintiff's testimony regarding her actions and state of health; there is no indication that some unknown, superseding act or event triggered or caused the rupture. Rather, it is quite clear that the continuing untreated ectopic pregnancy developed and progressed to the point of rupture, which, viewing the evidence in a light most favorable to plaintiff, could have been avoided had Dr. Bahu taken appropriate, nonnegligent measures. Additionally, contrary to the circumstances in *Teal*, plaintiff presented evidence, chiefly expert testimony, specifically indicating how Dr. Bahu's negligence led to and resulted in the ruptured ectopic pregnancy.

Defendants also argue that plaintiff did not plead a claim that Dr. Bahu breached the standard of care by failing to take steps to involve Dr. Johnson's timely participation. Plaintiff, however, did in fact plead that Dr. Bahu "[f]ailed to provide the appropriate follow up care and treatment," and that he did not "timely refer[] the patient to an OB/GYN." Accordingly, I would reject this argument.

With respect to the avoidable-consequences doctrine, there was sufficient evidence to create a genuine issue of material fact regarding whether plaintiff acted reasonably under the circumstances to avoid or minimize damages after Dr. Bahu's alleged negligence on May 19th. Again, there was no evidence that plaintiff was running fevers, having cramping, or experiencing heavy bleeding during the three-week lapse in professional medical care. And whether the intermittent light spotting, or any other circumstance, should have triggered action on plaintiff's part to obtain medical care prior to the rupture is a question for a jury, not for a court as a matter of law.

Finally, it is necessary to address the majority's reasoning and analysis. It appears that the entire premise of the majority's ruling is that there was no evidence regarding the steps, if any, that Dr. Johnson would have taken had Dr. Bahu actually contacted his office on May 19th. And therefore, as a matter of law, there was no evidence to show cause-in-fact, just pure speculation. Essentially, the majority is concluding that plaintiff's action fails because there was no deposition testimony or affidavit by Dr. Johnson as necessary to complete the causal link between the negligence and the injury. First, defendants never made this argument to the trial court, nor did the trial court base its ruling on the proposition now set forth sua sponte by the majority. Defendants did not contend that causation could not be established because there was no evidence that Dr. Johnson would have taken the measures described by Dr. Wheeler. Consequently, plaintiff had no obligation to present documentary evidence on the matter. See MCR 2.116(G)(4).[12] Dr. Johnson was on plaintiff's witness list, and during Dr. Wheeler's deposition, defense counsel noted that "we have not taken Dr. Johnson's deposition testimony yet."[13]

Also, in the trial court, defendants relied in part on plaintiff's deposition testimony that Dr. Johnson would have seen her sooner had she asked. Defendants fully accepted the premise that Dr. Johnson would have seen plaintiff sooner because it formed the basis for their argument that plaintiff was the person entirely at fault as she did not seek timely medical attention from Dr. Johnson, which would have prevented the ruptured fallopian tube. The majority opinion runs contrary to this theory of defense.

Setting aside the procedural flaws and unfairness in the majority's holding, I do not believe that evidence regarding what Dr. Johnson's actual response would have been was necessary to create a genuine issue of material fact on the element of causation. Dr. Wheeler opined that an ultrasound, if performed on May 19th, would have shown an empty uterus, that an OB-GYN, to meet the standard of care, would have seen plaintiff on May 19th or the morning after and performed an ultrasound based on the suspicion of an ectopic pregnancy, that plaintiff would have been a candidate for methotrexate during most of the three-week period after she saw Dr. Bahu on May 19th, and that the methotrexate, by a reasonable medical probability, would have resolved the matter. Viewing this evidence in a light most favorable to plaintiff, making all legitimate

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[12] MCR 2.116(G)(4) provides:

> A motion under subrule (C)(10) must specifically identify the issues as to which the moving party believes there is no genuine issue as to any material fact. *When a motion under subrule (C)(10) is made and supported as provided in this rule*, an adverse party may not rest upon the mere allegations or denials of his or her pleading, but must, by affidavits or as otherwise provided in this rule, set forth specific facts showing that there is a genuine issue for trial. If the adverse party does not so respond, judgment, if appropriate, shall be entered against him or her. [Emphasis added.]

[13] The motion for summary disposition was filed six months after Dr. Wheeler's deposition. It is unclear to me whether Dr. Johnson was actually deposed. If his deposition was taken, no part of the transcript was submitted for purposes of summary disposition, which would be understandable because the issue that the majority raises was not a topic below.

inferences in her favor, and recognizing that the rupture occurred on or about June 6th, a juror could reasonably conclude that Dr. Bahu's negligence caused plaintiff's injuries.

The majority's analysis overinflates the role of Dr. Johnson in the causation analysis. Indeed, I believe that the hypothetical questions regarding whether Dr. Johnson would have seen plaintiff within a day and ordered an ultrasound may not even be relevant to causation; rather, the pertinent questions, in my view, concern whether the standard of care would have required Dr. Johnson or any other OB-GYN to see plaintiff within a day and order an ultrasound. And plaintiff presented evidence of the latter through Dr. Wheeler's testimony. If plaintiff had never settled on or chosen any particular OB-GYN, it would seem that the majority's reasoning for dismissing the case would fall apart or evaporate and that Dr. Wheeler's testimony would suffice for purposes of showing causation. Plaintiff's case should not rise or fall on whether she had an identifiable OB-GYN. I simply and respectfully cannot agree with the majority's analysis.

III. CONCLUSION

I conclude that plaintiff submitted sufficient documentary evidence to create a genuine issue of material fact on the issue of causation. I therefore would reverse and remand for further proceedings. Accordingly, I respectfully dissent.

/s/ Jane E. Markey