STATE OF MICHIGAN

COURT OF APPEALS

KEVIN WAYNE FORTH,

Plaintiff-Appellant,

v

PARVIZ SAMII, M.D., and PARVIZ SAMII, M.D., P.C.,

Defendants-Appellees.

UNPUBLISHED
October 4, 1996

No. 178209
LC No. 91-057645 NH

Before: White, P.J., and Sawyer and R.M. Pajtas,* JJ.

PER CURIAM.

Plaintiff appeals the trial court's judgment of no cause of action, entered following a jury verdict that defendant committed medical malpractice but the malpractice was not a proximate cause of plaintiff's injuries. Defendant performed a total colectomy and ileostomy on plaintiff, who was twenty-nine years old at the time and had begun having symptoms of ulcerative colitis six months before surgery. Plaintiff's challenges on appeal include that the trial court erred in granting defendant's motion for partial directed verdict on the issue of informed consent; the court improperly denied plaintiff's motion for new trial or judgment notwithstanding the verdict; the verdict is inconsistent, contrary to law and against the great weight of the evidence; and there was misconduct by defense counsel and absence of judicial impartiality. We affirm.

I

We first consider plaintiff's argument that the jury verdict that defendant was negligent, but that his negligence was not a proximate cause of the injury or damages, was inconsistent, contrary to law, and against the great weight of the evidence. The general rule is that where a verdict in a civil case is inconsistent and contradictory, it will be set aside and a new trial will be granted. *Payton v Detroit*, 211 Mich App 375, 397; 536 NW2d 233 (1995). "However, 'it is fundamental that every attempt must be made to harmonize a jury's verdicts' because '[o]nly where verdicts are so logically and legally inconsistent that they cannot be reconciled will they be set aside.'" *Hughes v Park Place Motor Inn,*

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* Circuit judge, sitting on the Court of Appeals by assignment.

180 Mich App 213, 218; 446 NW2d 885 (1989) (quoting *Granger v Fruehauf Corp,* 429 Mich 1,9; 412 NW2d 199 (1987)).

In support of the verdict, defendant cites testimony of one of its experts, Dr. McGillicuddy, as supporting "the intractable nature of the Plaintiff's diseased colon and the fact that surgery was essentially inevitable." Plaintiff counters by arguing that defendant's arguments go to the issue of negligence, and that once the jury rejected those arguments and concluded that surgery was not necessary at the time it was performed, the jury could only have concluded that defendant proximately caused plaintiff's injury or damage, which consisted of the unnecessary, or at least premature, removal of his colon. Applying the standard set forth above, we conclude that the verdict was not inconsistent.

Defendant presented the following pertinent expert testimony. Dr. McGillicuddy testified that he would classify plaintiff's ulcerative colitis as "moderately severe." He opined that defendant did not violate the standard of care:

> Because given the symptoms and clinical situation of Mr. Forth and the severity of the disease process, along with my past experience with this disease, I feel that to offer him the surgery that he did and conduct it in the way that Dr. Samii did was not only the correct decision but was appropriate at that time. It was done propitiously and with skill.
>
> Q. In [sic] what clinical symptomatology are you referring to, et cetera, that supports, in your opinion, the fact that surgery was warranted here?
>
> A. The man had had symptoms of the disease, by his own testimony, from September until he had his surgery, which was approximately six months. That it was significantly worsening for a six-week period prior to his surgery.
>
> The symptoms included bloody diarrhea, cramping, mucus in his stools, which we call bloody flux, and had, from his doctor's testimony, lost weight, developed signs of nutritional deficiency, and had an adequate, more than adequate, medical attempt at treatment using medications and had no significant success with that.

Dr. McGillicuddy also testified in reference to plaintiff's having received medication called Azulfidine while at the Ionia infirmary, that "the only treatment, the only cure that we know of for this condition is surgery, is removal of the target organ, which is the large intestine . . ."

On cross-examination, Dr. McGillicuddy testified (in line with plaintiff's experts) that the risk of cancer in a patient with ulcerative colitis increases significantly after the patient has had the disease for a number of years:

> The textbooks like to use the word ten, some use fifteen, others is seven. But any time you have the lining cells beset by the kind of inflammatory condition that this disease presents, you begin to see an increase in cancer. It's not much initially, I admit.

Dr. McGillicuddy also testified that plaintiff's condition was in a more acute state before he went to Foote Hospital on March 2, 1989 than after. Dr. McGillicuddy conceded that Dr. Harvey on March 2, 1989 characterized plaintiff's ulcerative colitis as moderate to mild, and Dr. McGillicuddy testified that he accepted Dr. Harvey's assessment.

On further cross-examination, Dr. McGillicuddy testified that the percentage of patients with severe ulcerative colitis that require a total colectomy is 5 to 15 percent. As to patients with moderate ulcerative colitis he testified that "that's a harder number to come up with" but denied that it was less than 5 to 15 percent. Dr. McGillicuddy acknowledged that the risk of cancer "would have been small with this disease only being there for approximately six months."

Defendant specifically relies on Dr. McGillicuddy's testimony as follows:

> Q. Now, if I understand your testimony, the, quote unquote, only sure cure for ulcerative colitis is what?
>
> A. Is removing the target organ, the mucosa, the lining of the large intestine.
>
> Q. Considering the severe nature as you've described it of the ulcerative colitis in this matter, even if surgery had not been done at the time it was done here, what's the probability at this point that he would—at that time—that he would have had to have had that removed as some point in the future, in any event?
>
> A. Very great.
>
> Q. Why do you say that?
>
> A. Because of the natural history of the disease. Because even in patients that you can get through the initial so-called acute attack, why, they eventually keep having these attacks and having them and having them, and most people will actually beg for the surgery after enough of these. But usually by that time the decision has been made to remove the colon and give the patient relief.

Defendant also cites to three pages of testimony from defense expert Dr. MacKeigan, specifically, his testimony that ". . . I think if he had gone on further, he would have been at risk for having more trouble." This testimony was part of a lengthy answer responding to defense counsel's request to explain what Dr. MacKeigan meant by "immature forms of the white blood cell," which was part of a previous question whether it was within the standard of care to have operated on plaintiff. Dr. MacKeigan testified that he thought that defendant "carried out an appropriate operation at an appropriate time," within the standard of care. When asked whether he had an opinion as to whether surgery was the appropriate thing to do, as contrasted with continuing medical treatment, Dr. MacKeigan testified:

> A: I do.

* * *

> Well, I reiterate, some of the basis for my opinion in that I thought that he had received adequate therapy. I don't think he necessarily received maximal medical therapy. I think he could have gone on longer. That's what I mean when I say maximum.
>
> He could have gone on longer with medical treatment, but then I think he risked a greater risk, a mortality, a morbidity that he may not have been able to survive.
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> Most indications for surgery in ulcerative colitis are for intractability. That basically means when the doctor and the patient feel that they have been—that they've had enough of medical management and before you do harm with medical management; that is, continuing on to a point where the bowel gets acutely ill and sick and perforates.

Later, Dr. MacKeigan testified:

> Q. Let's assume theoretically that you hadn't done surgery on March 15 of '89, and considering the degree of ulcerative colitis that this patient had in your opinion, at some point, in your opinion, would he had to have had surgery?
>
> A. Well, figures vary, but if somebody has a fairly acute episode requiring hospitalization and medical management, anywhere from 40-some-odd percent to 75 percent of patients in the next year will come to surgery because of a relapse and another severe episode that threatens them.

Defendant also cites the testimony of a pathologist at Foote Hospital who examined plaintiff's colon post-surgery. The pathologist testified that plaintiff's colon was "seriously diseased." When asked how extensive the ulcerative colitis was, he responded:

> A. To some degree or other it involves practically two-thirds of it, I would say, or maybe a little more.

Lastly, defendant cites to two pages of the testimony of Dr. Anderson, a radiologist who interpreted a barium enema study performed prior to surgery. She testified that from looking at the x-ray she would characterize plaintiff's case as one of the worst cases she had ever seen. However, on cross-examination, Anderson testified that she did not attempt to classify the disease in her report as severe or moderate or mild.

Dr. McGillicuddy's testimony that the probability was very great that plaintiff would later require that his colon be removed, and Dr. MacKeigan's testimony that approximately forty to seventy-five percent of patients having suffered a fairly acute episode requiring hospitalization and medical management "in the next year will come to surgery," provided a basis on which the jury could have concluded that although defendant was negligent in prematurely removing plaintiff's colon and not further pursuing medical management options, the surgery would have occurred soon after in any event. The

jury could also have concluded that the damages plaintiff suffered as a result of the premature surgery were no greater than those he would have suffered had he been continued on less radical and invasive medical treatment for some period. [1] Further, while both parties assume that the jury's finding of negligence was necessarily a finding that plaintiff's colon was unnecessarily removed, our review of the record reveals that the case was presented to the jury in a fashion that would permit a conclusion that defendant was negligent because he believed plaintiff had polyps when he did not, or because he did not recognize the aggravating potential of the various tests that were conducted, but that the surgery was nevertheless warranted. In sum, the jury's answers to the special questions can be harmonized, and the jury's verdict is not so logically and legally inconsistent that it cannot be reconciled. *Hughes, supra.*

Similarly, we conclude that the trial court did not abuse its discretion in denying plaintiff's motion for new trial based on the great weight of the evidence. A trial court's determination that a verdict is not against the great weight of the evidence will be given substantial deference, and it is incumbent on a reviewing court to engage in an in-depth analysis of the record on appeal. *Arrington v DOH (On Remand),* 196 Mich App 544, 560; 493 NW2d 492 (1990). Where there is conflicting evidence, questions of credibility should be left to the factfinder. *Whitson v Whiteley Poultry Co*, 11 Mich App 598, 601; 162 NW2d 10 (1968). We have reviewed the record and conclude that the trial court's decision should not be disturbed.

II

We next address plaintiff's argument that the trial court improperly granted a directed verdict on the informed consent issue. The trial court granted defendant's motion for partial directed verdict on the issue whether plaintiff's consent to surgery was ineffective because induced by defendant's appealing to his drug-seeking behavior, ruling that the theory was neither pleaded nor supported by the evidence.

Plaintiff argues that there was significant evidence on the record to uphold the allegation. We have reviewed the testimony cited by plaintiff in this regard, and agree with the trial court that there was no expert testimony on this issue. While Dr. Goldstone's testimony reviewing plaintiff's medical record established a time sequence that would lend support to the allegation, there was no expert testimony that defendant violated the standard of care in this regard. We recognize that the trial court sustained defendant's objections to some of plaintiff's questions of the experts apparently aimed at eliciting pertinent testimony in this regard. However, even if we assume plaintiff would have secured the requisite expert testimony, there was no testimony that plaintiff was told that he would receive drugs if he consented to surgery, or that plaintiff believed that was the case, or consented to surgery on that basis. Further, defendant's involvement in the withholding and admistration of the Demerol was not established.

III

Plaintiff next argues that misconduct of defense counsel deprived him of a fair trial and constituted an irregularity in the proceeding. Plaintiff argues that defense counsel often crossed the bounds of permissible conduct during trial, citing three such instances principally. Plaintiff first complains

that defense counsel improperly argued the issue of informed consent in closing argument after the court granted defendant's motion and precluded plaintiff from addressing the issue in plaintiff's closing argument. Plaintiff's counsel did not object to the argument when made, but allowed defense counsel to finish his argument, and then objected after requesting that the jury be excused before rebuttal argument. We find no reversible error.

Defendant sought a directed verdict on plaintiff's informed consent claim. Argument focused on the aspect of the claim regarding the withholding and then ordering of Demerol. While the court did not expressly state that the motion was granted only as to this aspect of the claim, all indications are that this is the case. The court ruled:

> …the informed consent business concerns me. This was not pled in the pleadings. And as I've indicated, I didn't hear any direct testimony. The only testimony that I've heard is the questioning by [plaintiff's counsel] trying to make a point of it and the coincidence of the drug being administered shortly after the consent was given, nothing before.
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> * * *
>
> . . . It's something that was not pled, something that has come up during the course of this trial only, that I can see, through the examination of counsel for Plaintiff, only through his questioning, and has not been collaborated by any other proofs other than his questions.
>
> There isn't—I don't see any evidence at all in this record that there wasn't informed consent. The fact that it was coincidental, that he got some drugs after he gave the consent, I don't think it's probative at all on that point.
>
> So I am not going to let you argue that to the jury…. That's the only thing that I can grant specifically to [sic] [defense counsel's] motion.

In responding to the court's ruling, plaintiff's counsel addressed only the drug issue. Further, in his brief on appeal, at page 36, plaintiff states:

> Plaintiff presented several theories in support of the allegation that the Defendant doctor failed to "properly, adequately, and sufficiently inform the Plaintiff of alternate treatment options in the course of obtaining consent to a colectomy." . . . One explanation was that Mr. Forth was misinformed about the status of the disease. As far as he was concerned, exigent surgery was required due to the cancerous condition of the colon. Another theory postulated by Plaintiff was that he could elect to consent, and forego a second medical opinion, or face returning to prison without any treatment whatsoever. A third theory was that Plaintiff was induced to consent to surgery by appealing to his insatiable drug seeking behavior. All three were integral contributing

> factors to Mr. Forth's acquiescence. **Plaintiff was allowed to expound on the first two theories and had a right to argue the third.** [Emphasis added.]

It also appears that requests for jury instructions were submitted before defendant's motion for directed verdict, and that plaintiff requested no specific instruction on informed consent, leaving the issue to be covered by the general medical malpractice/ professional negligence instruction.

In closing argument, plaintiff's counsel followed the court's direction and refrained from addressing the drug aspect of the informed consent issue. However, counsel did argue that plaintiff was wrongly told that he had cancer and that he consented to the surgery for this reason, that he was not told that what was involved was a lifestyle choice and that had he been told he would never have consented to the surgery, and that he was never given the opportunity to obtain a second opinion, although he had requested one. Given this context, defense counsel's comments in closing regarding the informed consent issue, which did not address the drug aspect of the issue, but did address plaintiff's argument, were responsive and did not deprive plaintiff of a fair trial.

Plaintiff's second and third arguments are that defense counsel continually and repeatedly fabricated objections in order to disrupt crucial testimony, and that defense counsel employed ambush tactics when plaintiff's counsel attempted to use deposition testimony at trial. We agree that defense counsel's objections were repetitious and excessive. We also observe that the trial court would have been justified in circumscribing counsel's objections and in cautioning counsel that the court, not counsel, controls the proceedings. In fact, it would have been prudent to do so. Nevertheless, we conclude that defense counsel's conduct and the court's response did not deprive plaintiff of a fair trial. Our review of the record does not leave us with the impression that defense counsel's repeated objections, arguments and comments impeded plaintiff's counsel's ability to make the desired points. While plaintiff's counsel's and the court's tasks were made unnecessarily difficult, we cannot say that the proceedings as a whole were affected.

Nor are we persuaded that the court's conduct necessitates a new trial. While the court often sustained defense counsel's objections without giving plaintiff's counsel an opportunity to respond, plaintiff's counsel was permitted to make an adequate record when he sought to do so. Further, the court's comments when ruling on objections were not improper.

Lastly, plaintiff argues that the court erred in allowing Dr. MacKeigan to testify regarding the standard of care applicable to a general surgeon. We disagree. Defendant was required to establish that Dr. MacKeigan specialized in the same or a related relevant area of medicine and that he devoted a substantial portion of his professional time to either the active clinical practice or the instruction of students in the same specialty or a related, relevant area. MCL 600.2169; MSA 27A.2169. Dr. MacKeigan's testimony that he is board certified in general and colorectal surgery, that colorectal surgery is a sub-specialty of general surgery, and that he teaches general surgery was sufficient to support the trial court's conclusion that his testimony was admissible under the statute.

Affirmed.

/s/ Helene N. White
/s/ David H. Sawyer
/s/ Richard M. Pajtas

[1] We observe that plaintiff did not present an intermediate position to the jury in this context. While plaintiff's argument addressing damages acknowledged that the jury might take into account that plaintiff might have developed complications requiring surgery after ten, twenty or thirty years, plaintiff did not argue that even if the jury concludes that plaintiff would have required the surgery soon after in any event, he nevertheless suffered damages from the premature removal of his colon.