

STATE OF MICHIGAN
COURT OF APPEALS

SHADI MARKABANI,

Plaintiff-Appellant,

v

DR. JAI PRASAD, DR. MICHAEL WHITE, DR.
HEATHER DOLMAN, DR. HENRY, DETROIT
MEDICAL CENTER, d/b/a DETROIT
RECEIVING HOSPITAL and UNIVERSITY
HEALTH CENTER, an assumed name,

Defendants-Appellees,

and

DR. R.F. WILSON, DR. BLOCKSAM and DR.
STOCKMAN,

Defendants.

UNPUBLISHED

April 26, 2007

No. 266719

Wayne Circuit Court

LC No. 03-325559-NH

Before: Whitbeck, C.J., and Murphy and Cooper, JJ.

PER CURIAM.

Plaintiff Shadi Markabani appeals as of right from an order granting a directed verdict in favor of defendant Detroit Medical Center, d/b/a Detroit Receiving Hospital and University Health Center, an assumed name (DRH). We reverse.

I. Basic Facts And Procedural History

This medical malpractice action arises out of treatment rendered to Markabani during his admission to DRH from February 6, 2001, through February 26, 2001. On February 6, 2001, Markabani, a 27-year-old male, was injured at work while employed as a licensed auto mechanic at a service station. While working on a car in the garage, gasoline spilled on Markabani's clothes and ignited, causing him to suffer burns on his face, neck, and hands.

EMS was called to the scene and started an intravenous drip (IV) in the antecubital space (where the forearm bends at the elbow) in Markabani's right arm. An IV in the antecubital space accesses the basilic vein. A registered nurse in the emergency room placed a second IV in

Markabani's left forearm. The emergency room staff did not immediately remove or replace the IV that EMS inserted in Markabani's right arm.

Markabani was eventually transported from the emergency room of DRH to the intensive care burn unit. There, he was placed under the care of Dr. Jai Prasad. Dr. Prasad diagnosed Markabani's burn injuries, including third-degree burns on the back of his left hand. On February 8, 2001, Dr. Prasad performed skin graft surgery on Markabani's left hand. Dr. Prasad testified that Markabani tolerated the surgery and suffered no complications.

On the morning of February 9, 2001, Markabani began running a fever of 101. Dr. Prasad testified that he initially was not concerned because an elevated temperature is not uncommon after surgery. By that afternoon, Markabani's temperature rose to 102.8. On February 10, 2001, Markabani's temperature remained over 102. At this point, Dr. Prasad suspected that Markabani was suffering from an infection and ordered a blood culture.

Shortly before February 14, 2001, Markabani noticed redness in his right arm. After his morphine pump was removed on February 13, 2001, he also started experiencing pain his right arm. On February 14, 2001, Markabani's temperature spiked to 104.8. Markabani's white blood count, which had been normal on February 9, 2001, was elevated. According to Dr. Prasad, Markabani now had a serious infection.

On February 14, 2001, the blood culture revealed that Markabani suffered an infection from bacteria called enterobacter cloacae. Dr. Prasad prescribed an antibiotic designed to eliminate the bacteria. Markabani claimed that on that same day, Dr. Michael White examined Markabani's right arm and ordered the nurse to remove the IV, which Markabani testified was the "original" IV that was placed by the EMS. Dr. Prasad testified that Markabani's IV was removed from the right antecubital space. Markabani recalls that when the IV was removed, pus came out of the puncture site. The intensive care flow charts do not indicate that Markabani's IV had been changed or rotated before February 14, 2001. The intensive care flow chart on February 14, 2001, indicates that the IV in Markabani's right arm was "discontinued."

Dr. Prasad testified that Markabani's arm "had a very red streak with tenderness and swelling of the vein." He diagnosed Markabani as having "suppurative thrombophlebitis" of the basilic vein. The basilic vein, among others, courses through the antecubital space and, as stated, was the location where EMS had placed an IV in Markabani's arm at the garage.

Two days later, Dr. Prasad operated to remove the infected vein. Dr. Prasad found that there was thrombosis in Markabani's right basilic vein "from [the] antecubital space to the axilla." After surgery, Markabani's infection abated. The surgical incision required to remove the vein was purposefully left open to allow the infection to drain and was eventually closed on February 23, 2001. On February 26, 2001, Markabani was released from DRH.

Following Markabani's hospital stay, he was assigned a nurse case manager, Susan Ann Cline. Cline worked with Markabani for approximately 18 months following his hospital stay. Markabani often complained to Cline about constant pain and numbness in his right arm, his inability to fully extend his right arm and loss of grip strength in his right hand. Cline eventually referred Markabani to a neurologist, Dr. Anthony Emmer. Dr. Emmer diagnosed Markabani with a mild ulnar neuropathy and reflex sympathetic dystrophy (RSD). "The ulnar nerve

supplies sensation, in other words, feeling, as well as motor or muscle strength and movement to certain areas of the – the upper extremity” RSD “is a syndrome that occurs after traumatic injuries, that clinically results in symptoms of pain, burning, sometimes you can get discoloration of the extremity, impaired sweating of an extremity.” Emmer testified that, “more likely than not,” the right basilic vein infection caused Markabani’s ulnar nerve neuropathy but that it was “unlikely” that the infection caused Markabani’s RSD. Specifically, he opined that the ulnar nerve, which is located directly under the basilic vein, was likely compromised during surgery when the vein was removed.

Markabani filed a complaint against DRH and the various physicians that allegedly treated him from February 6, 2001, through February 26, 2001. Markabani’s complaint alleged malpractice by the individual physicians and nurses for their collective failure to properly monitor the IV placed in his right arm. Markabani further alleged that the DRH doctors and nurses negligently failed to replace the EMS IV and timely rotate his IV’s, which proximately caused the infection, need for surgery, and damage to his ulnar nerve. Markabani did not sue any of the nurses individually, but he alleged that DRH was vicariously liable.

At the beginning of trial, Markabani indicated that he would proceed only on his nursing malpractice claim against DRH and dismissed the named physicians as defendants. This left DRH as the only named defendant. Markabani claimed that DRH’s nurses breached their standard of care by failing to remove and relocate the EMS IV in Markabani’s right antecubital space upon transfer to the ICU and by failing to subsequently rotate the IV every 72 to 96 hours. Markabani further claimed that the nurses’ failure to change and rotate the IV caused his infection and damages.

Numerous witnesses on both sides testified that the standard of care required nurses in the intensive care unit to change any IV placed by an outside source, such as EMS, within 24 hours of admission or as soon as the patient is stable. They also testified that an IV must be rotated every 72 hours. Dr. Prasad explained that the purpose of the requirements for regularly changing and rotating IV’s is to prevent infection. Because of skin destruction, burn patients are especially susceptible to infection. An IV catheter acts as a colonizing agent for bacteria. Once an infection strikes a vein, “thrombosis,” or blood clots, can result. Dr. Neil Crane, Markabani’s infectious disease expert, agreed that changing and rotating IV’s is essential because of the risk of contamination, particularly if the original IV is placed while in a mechanic’s garage.

Nurse Sylvia Vanderkooy-Kempl was the first nurse to provide care to Markabani when he came to the intensive care burn unit. Kempl’s admission note states there were “two peripheral IVs upon admission.” Kempl had been a registered nurse for 11 years and had been working in the burn unit for 12 years. She testified that, based upon her experience, she had developed a habitual routine for patients, in which she would first get the patient situated comfortably in his or her room, perform a “head to toe assessment,” and then change any IV’s. Kempl also explained that following the change of the IV upon admission, her routine required that the IV be rotated every 72 hours. Kempl claimed that nurses do not ordinarily document events such as restarting IV’s. Rather, she explained that nurses are given verbal reports on each patient, including the patient’s IV status, at each shift change. The date the IV is started or changed is noted on a tape-like substance at the site. Kempl opined that Markabani’s claim that all the nurses who treated Markabani forgot to change his IV was “ridiculous.” Kempl, however, admitted that she had no independent recollection of changing Markabani’s IV’s.

Nurse Norma Dolney testified as Markabani's nursing expert. She is a circulating scrub nurse in the operating room and works in the intensive care unit where she treats patients with a variety of medical issues. She had never worked in a burn unit. Dolney testified that Kempl violated the standard of care in failing to restart the right arm IV within 24 hours of admission. She further claimed that all the nurses that treated Markabani failed to monitor his IV status to ensure that it was rotated every 72 to 96 hours. Dolney opined that if an action is not written in a chart, it did not occur. Dr. Crane testified that failure to change and rotate the IV caused the infection of Markabani's basilic vein and consequential need to have it surgically removed.

At the close of Markabani's proofs, DRH moved for a directed verdict. DRH argued three points in support of its motion. First, DRH argued that it was virtually undisputed that the infection and thrombosis that Markabani developed can occur even in the best circumstances. DRH contended that based on this evidence, Markabani's theory of liability was flawed because it assumed malpractice on merely a "bad outcome" and is something akin to a theory based on *res ipsa loquitor*. Second, DRH argued that Nurse Dolney was not qualified to provide standard of care testimony because she provided inconsistent testimony. Third, with respect to the vicarious liability claim, DRH pointed out that Markabani only identified one specific agent, Nurse Kempl; thus, DRH argued that all other claims not directly related to her negligence should be stricken.

Markabani responded, first arguing that there was no evidence that the IV had been changed and that Dr. Crane provided testimony establishing causation. Second, Markabani stated that the standard of care was established not only by Nurse Dolney's testimony, but by Nurse Kempl's testimony as well. Third, Markabani argued that his vicarious liability theory against DRH was sufficiently identified as being based on the negligence of Nurse Kempl.

The circuit court made the following ruling from the bench:

On the first morning of trial, [Markabani] dismissed every physician from the complaint of medical malpractice and proceeded to prosecute this action as a claim of nursing malpractice. [Markabani] did so despite a pre-trial Daubert hearing after which the Court ruled that the [Markabani's] expert, Dr. Neil Crane, M.D., would be allowed to testify as an infectious disease expert on the propriety or impropriety of IV monitoring in this particular case.

Paragraphs fourteen, fifteen and sixteen of the complaint filed by [Markabani] on August 4, 2003, set forth [Markabani's] allegations against the nursing staff as follows: Paragraph fourteen, upon accepting this patient in the hospital, the staff physician residents and nurses were aware or should have been aware of the fact that the right antecubital space IV had been started by EMS personnel in the field under non-sterile conditions and that said IV therefore posed an unnecessary risk of infection.

Paragraph fifteen, despite the high risk of infection caused by the right antecubital IV, the staff physician residents and other nurses failed to discontinue this IV even though another IV had been placed in the left arm as well by the ER staff. Paragraph sixteen, thereafter upon admission to the burn unit, the medical records contain no documentation that the IV was monitored appropriately by

doing such things as but not limited to checking for proper placement by obtaining a blood return, checking the skin at the IV site for signs of phlebitis, infiltration or infection and checking that IV push drugs were not compatible or toxic to the skin or vein.

Evidence adduced at the trial indicates from [Markabani's] position that no IV change was charted. Nurse Kempl testified that the IV was based on her custom and fourteen years of work experience that she always changed the IV after the admission of a burn patient who already had an IV upon admission. Her custom was to change the IV within the first twenty-four hours of admission or when the patient became stable. [Markabani's] nursing expert was Norma Dolney, R.N., who opined that Nurse Kempl's custom did not violate the requisite standard of care but since the change of IV was not charted, this procedure, that is the change of the IV, was not done by nurses in the burn unit.

Nurse Dolney's credentials as an expert were minimal in that she never taught nursing courses and her expertise was limited to a number of years of nursing practice and a review of a number of nursing malpractice files in the recent past. In her affidavit of merit, Nurse Dolney identified as evidence of nursing malpractice the following: Paragraph three (d) "discontinue the IV started by the EMS people in the field because there was a question about whether it was started under proper antiseptic conditions" and paragraph three (j), "document any and all actions pertaining to the IV."

Upon cross-examination, Nurse Dolney was less certain about the lack of documentation as an element of nursing malpractice than in her affidavit of merit. I find that she did not testify that a lack of documentation concerning the IV was itself malpractice but only could be evidence of malpractice. [Markabani] testified that he could not remember if the IV was changed or not.

Doctor Prasad, originally a defendant in the case, testified that Mr. Markabani's arm was filled with bacteria as a result of being burned in an accident at the garage. [Markabani] spent most of the trial developing the issue of causality for the injury to [Markabani's] ulnar nerve and the result in damages to [Markabani] including economic damages as a result of his inability to work as a licensed auto mechanic.

Lawyers for both parties agreed that the first question to be submitted to the jury would be as follows: "Did the Defendant commit nursing malpractice in one or more of the ways claimed by Plaintiff." I find no reasonable juror based on the evidence of this case could conclude that anyone committed nursing malpractice and the motion by [DRH] for a directed verdict of no liability is granted.

In sum, the circuit court seemingly granted DRH's motion based on Markabani's purported failure to set forth sufficient evidence that the nurses who treated Markabani breached the applicable standard of care and that any breach caused Markabani's injury. The circuit court entered an order for directed verdict in DRH's favor. Markabani now appeals.

II. Motion For A Directed Verdict

A. Standard Of Review

Markabani argues that the circuit court erred by granting DRH's motion for a directed verdict. We review a decision on a motion for a directed verdict de novo.¹

B. Legal Standards

To prevail in a medical malpractice action, a plaintiff must prove (a) the applicable standard of care, (b) the defendant breached the standard, (c) an injury, and (d) the breach proximately caused the injury.² Here, Markabani did not sue the nurses individually, but only DRH, under a vicarious liability theory founded on nursing malpractice. Accordingly, Markabani was required to prove the additional elements of vicarious liability. Specifically, Markabani was required to prove that the nurses who treated him and breached the standard of care were agents of DRH.³

To survive a directed verdict motion, a plaintiff must make a prima facie showing of each element.⁴ A directed verdict is appropriately granted when all the evidence fails to establish a question upon which reasonable minds could differ.⁵ In determining whether a question of fact existed that would preclude a directed verdict, we draw every reasonable inference in favor of the nonmoving party,⁶ while recognizing the trial court's superior opportunity to observe witnesses.⁷

C. Applicable Standard Of Care

Although nurses are licensed health care professionals, they do not engage in the practice of medicine.⁸ Neither the standard for general practitioners nor the standard for specialists applies to nurses.⁹ Rather, the common law standard of care applies to malpractice or negligence actions against nurses.¹⁰ "[T]he applicable standard of care is the skill and care ordinarily

¹ *Zsigo v Hurley Med Ctr*, 475 Mich 215, 220-221; 716 NW2d 220 (2006).

² *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 492; 668 NW2d 402 (2003).

³ *Cox v Flint Bd of Hosp Mgrs*, 467 Mich 1, 5, 11; 651 NW2d 356 (2002).

⁴ *Tobin v Providence Hosp*, 244 Mich App 626, 643; 624 NW2d 548 (2001).

⁵ *Smith v Foerster-Bolser Constr Inc*, 269 Mich App 424, 427-428; 711 NW2d 421 (2006).

⁶ *Zsigo, supra* at 220-221.

⁷ *Wiley, supra* at 491.

⁸ *Cox, supra* at 20.

⁹ *Id.* at 18.

¹⁰ *Id.* at 21.

possessed and exercised by practitioners of the profession in the same or similar localities.”¹¹ The standard of care required of a nurse must be established by expert testimony.¹² Expert testimony is necessary to establish the standard of care for nurses “because the ordinary layperson is not equipped by common knowledge and experience to judge the skill and competence of the service and determine whether it meets the standard of practice in the community.”¹³

Markabani’s nursing expert, Nurse Dolney, is a fully educated Michigan licensed Registered Nurse. Dolney has worked at Oakwood Hospital for many years, including its intensive care unit and critical care wards. She testified that she is familiar with the applicable standard of care. Although the circuit court opined that Dolney’s credentials were “minimal,” there is no legal requirement that she have extraordinary credentials, only that she satisfy MRE 702. Here, DRH did not challenge Dolney’s status as an expert witness with respect to nursing, and although the circuit court was not impressed with Dolney’s credentials, there is no indication in the record that the circuit court ruled that she failed to satisfy MRE 702.

There was ample evidence regarding the standard of care with respect to the changing and rotation of the IV inserted by EMS. Nurse Dolney, Dr. Prasad, and Nurse Kempl essentially agreed that Markabani’s IV should have been changed within 24 hours of his admission. Further, there was evidence presented that Markabani was stable immediately on admission to the intensive care unit and that his IV should have been promptly changed. The witnesses also agreed that a patient’s IV should be changed or rotated at least every 96 hours. Markabani, therefore, presented sufficient evidence to support the “applicable standard of care” element of his nursing malpractice claim.

D. Breach

With regard to the “breach” element, Markabani alleges that the nurses at DRH breached the standard of care by failing to timely change or rotate Markabani’s IV within 24 hours after his admission to the burn unit and every 96 hours thereafter. Markabani testified that the IV that EMS inserted in his right arm was not changed on February 6, 2001. Markabani testified that the “original” IV placed by EMS remained in his arm until February 14, 2001. Dr. Prasad confirmed that the IV removed from Markabani’s arm on February 14, 2001, was removed from the right antecubital space. This is the same place EMS inserted an IV into Markabani’s arm eight days earlier.

Nurse Kempl, however, claimed that it is her habit to change a patient’s IV once “I’ve got my patient comfortably in their room.” Kempl did not specifically recall changing Markabani’s IV, she merely assumed that she did because it is part of her routine habit to do so. The charts

¹¹ *Id.* at 21-22.

¹² *Wiley, supra* at 492.

¹³ *Id.*, citing *Locke v Pachtman*, 446 Mich 216, 223; 521 NW2d 786 (1994).

utilized in the intensive care unit, however, do not contain any indications that Markabani's IV was changed or rotated between Markabani's admission on February 6, 2001, and February 14, 2001. In this regard, the witnesses disagree whether the nurses are required to document IV disconnection or relocations in the patient's medical chart. Dolney testified that the DRH ICU nurses were required to do so, but Kempl stated that it was not required and thus she did not do so. The ICU flow charts introduced at trial, however, contain specific categories for documentation of "invasive line and date of insertion," "IV site appearance," and "tubing and dressing changes." Indeed, the February 14, 2001, chart clearly indicates that Markabani's IV was "discontinued."

Based on this evidence, reasonable minds could differ with regard to whether the nurses changed Markabani's IV within the first 24 hours of his admission on February 6, 2001, and even if so, whether it was changed within 96 hours thereafter; that is, by February 10, 2001. Markabani claims his IV was not changed, Nurse Kempl claims it was. Nurse Dolney testified that if it was changed, this should be reflected in the designated area in the ICU flow charts, just as it was on February 14, 2001. As stated, in determining whether a question of fact existed that would preclude a directed verdict, we draw every reasonable inference in favor of the nonmoving party.¹⁴ We conclude, therefore, that Markabani presented sufficient evidence to support the "breach" element of his nursing malpractice claim in opposition to DRH's motion for a directed verdict.

E. Causation

With regard to "causation," proximate cause is composed of two separate elements: cause in fact, and legal or proximate cause.¹⁵ "Generally, an act or omission is a cause in fact of an injury only if the injury could not have occurred without . . . that act or omission."¹⁶ "While a plaintiff need not prove that an act or omission was the *sole* catalyst for his injuries, he must introduce evidence permitting the jury to conclude that the act or omission was *a* cause."¹⁷

The issue of proximate cause is generally a question of fact.¹⁸ If, however, "the facts bearing upon proximate cause are not in dispute and reasonable persons could not differ about the application of the legal concept of proximate cause to those facts," the issue is a question of law for the court.¹⁹

¹⁴ *Zsigo, supra* at 220-221.

¹⁵ *Craig v Oakwood Hosp*, 471 Mich 67, 87; 684 NW2d 296 (2004).

¹⁶ *Id.*

¹⁷ *Id.* (emphasis original).

¹⁸ *Nichols v Dobler*, 253 Mich App 530, 532; 655 NW2d 787 (2002).

¹⁹ *Paddock v Tuscola & Saginaw Bay R Co, Inc*, 225 Mich App 526, 537; 571 NW2d 564 (1997).

Dr. Prasad testified that Markabani suffered “a very serious infection” and blood clotting that began at the right antecubital IV site. Dr. Prasad observed “a very red streak with tenderness and swelling in the [right basilic] vein.” When the IV was removed February 14, 2001, pus emitted from the puncture site. Dr. Prasad testified that the infection and thrombosis began at the IV site and that the infected vein was likely the same vein the IV was placed in.

Dr. Prasad testified that enterobacter cloacae, a bacteria common in unclean environments, infected Markabani’s vein. Dr. Prasad testified that the infection was unrelated to Markabani’s earlier skin graft surgery. Further, Dr. Neil Crane testified that DRH’s nurses’ failure to change and rotate the IV caused Markabani’s infection and subsequent injuries and damages. Dr. Anthony Emmer testified that, “more likely than not,” the right basilic vein infection caused Markabani’s ulnar nerve neuropathy. Based on this evidence, reasonable minds could differ with regard to whether the nurses’ alleged failure to change and rotate the IV caused Markabani’s damages.

F. Damages

With respect to damages, it is uncontroverted that Markabani suffered an infection in his right basilic vein that required surgery to alleviate the infection. Further, Markabani now suffers from ulnar neuropathy. There is an issue of fact concerning damages.

G. Vicarious Liability

As stated, because Markabani’s action against DRH is based on the actions of DRH’s nurses, Markabani must also present evidence that nurses who treated Markabani and breached the standard of care were agents of DRH.²⁰ “Vicarious liability is indirect responsibility imposed by operation of law.”²¹ In this respect, the following paragraph from *Cox*, is instructive:

The negligence of the agents working in the unit, however, could provide a basis for vicarious liability, provided plaintiffs met their burden of proving (1) the applicable standard of care, (2) breach of that standard, (3) injury, and (4) proximate causation between the alleged breach and the injury *with respect to each agent alleged to have been negligent*. . . . [P]laintiffs must prove the negligence of at least one agent of the hospital to give rise to vicarious liability. Instructing the jury that it must only find the “unit” negligent relieves plaintiffs of their burden of proof. Such an instruction allows the jury to find defendant vicariously liable without specifying which employee or agent had caused the injury by breaching the applicable standard of care.^[22]

²⁰ *Cox, supra* at 5, 11.

²¹ *Theophelis v Lansing Gen Hosp*, 430 Mich 473, 483; 424 NW2d 478 (1988).

²² *Cox, supra* at 12 (emphasis original).

The *Cox* Court clarified that its holding “requires plaintiffs to establish which agent committed the negligence for which the principal is liable as required by agency principles and medical malpractice law.”²³

DRH argued below that a directed verdict was appropriate on the independent ground that, because Markabani only identified Nurse Kempl, DRH could not be vicariously liable for any other nurse’s negligence. In light of its ruling on the merits of the negligence claim, the circuit court did not address this issue. However, Markabani specifically accused “at least one agent of the hospital” of nursing malpractice.²⁴ Thus, assuming Kempl was an agent of DRH, Markabani made a prima facie showing of vicarious liability sufficient to withstand a directed verdict.²⁵

On appeal, DRH now contends that Markabani failed to establish that any of the ICU nurses, including Kempl, were DRH employees. Because it was not raised below, this argument is unpreserved. Nevertheless, we note that Nurse Kempl testified that she was the ICU nurse that admitted Markabani to the burn unit. She testified that she worked a twelve-hour shift and that she had worked in DRH’s burn unit for twelve years. Therefore, Markabani created a question of fact regarding whether Kempl was an agent of DRH. Accordingly, this issue should be addressed on remand.

III. Conclusion

We conclude that Markabani set forth sufficient evidence to support each of the elements of its nurse malpractice vicarious liability claim against DRH. The circuit court therefore erred in granting DRH’s motion for a directed verdict.

We reverse and remand for further proceedings. We do not retain jurisdiction.

/s/ William C. Whitbeck

/s/ William B. Murphy

/s/ Jessica R. Cooper

²³ *Id.* at 12 n 12.

²⁴ *Id.* at 12.

²⁵ See *Tobin, supra* at 643.