

STATE OF MICHIGAN
COURT OF APPEALS

MARILYN CLEMONS, Individually and as Next
Friend of MILES HUGHEY, a Minor,

UNPUBLISHED
September 24, 2009

Plaintiff-Appellant,

v

RODERICK CAIRGLE, M.D., and SINAI
HOSPITAL OF GREATER DETROIT, d/b/a
SINAI-GRACE HOSPITAL,

No. 282520
Wayne Circuit Court
LC No. 06-602228-NH

Defendants-Appellees.

Before: Borrello, P.J., and Meter and Stephens, JJ.

PER CURIAM.

Plaintiff appeals by leave granted from a circuit court order granting partial summary disposition for defendants under MCR 2.116(C)(10). We reverse and remand.

This medical malpractice action arises out of alleged negligence that occurred during the birth of Miles Hughey. Miles suffers from Erb’s palsy, a form of paralysis near his shoulder, attributable to a brachial plexus injury. Plaintiff’s theory is that Miles suffered the brachial plexus injury as a result of shoulder dystocia (SD) that occurred when she gave birth to Miles. “Shoulder dystocia is caused by the impaction of the anterior fetal shoulder behind the maternal pubis symphysis [mother’s pubic bone].” American College of Obstetrics and Gynecology (ACOG) Practice Bulletin, No. 40, November 2002. Plaintiff argues that defendants’ failure to inform her of the option of delivering by Cesarean section (c-section) proximately caused Miles’s injury because she would have elected a c-section delivery if given the option and the risk of SD was foreseeable and actually occurred during the delivery, causing Miles’s injury.¹

We review de novo a trial court’s decision on a motion for summary disposition. *Spiek v Dep’t of Transportation*, 456 Mich 331, 337; 572 NW2d 201 (1998). A motion for summary disposition under MCR 2.116(C)(10) is properly granted if no factual dispute exists, thus entitling the moving party to judgment as a matter of law. *Rice v Auto Club Ins Ass’n*, 252 Mich

¹ Plaintiff also raised an “excessive traction” claim that is not at issue in this appeal.

App 25, 31; 651 NW2d 188 (2002). In deciding a motion brought under subrule (C)(10), a court considers all the evidence, affidavits, pleadings, and admissions in the light most favorable to the nonmoving party. *Rice, supra* at 30-31. The nonmoving party must present more than mere allegations to establish a genuine issue of material fact for resolution at trial. *Id.* at 31.

In order to establish a cause of action for medical malpractice, a plaintiff must establish four elements: (1) the appropriate standard of care governing the defendant's conduct at the time of the purported negligence, (2) that the defendant breached that standard of care, (3) that the plaintiff was injured, and (4) that the plaintiff's injuries were the proximate result of the defendant's breach of the applicable standard of care. [*Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004).]

Regarding the fourth prong, MCL 600.2912a(2) states, in part, that "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."

As our Supreme Court recognized in *Craig, supra* at 86, "[p]roximate cause' is a legal term of art that incorporates both cause in fact and legal (or 'proximate') cause."

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. [*Skinner v Square D Co*, 445 Mich 153, 163; 516 NW2d 475 (1994); see also *Craig, supra* at 86-87.]

"As a matter of logic, a court must find that the defendant's negligence was a cause in fact of the plaintiff's injuries before it can hold that the defendant's negligence was the proximate or legal cause of those injuries." *Id.* at 87. Here, the trial court agreed with plaintiff that the failure to inform her of the c-section option was a cause in fact or "but for" cause of Miles's injury. Therefore, this element is not in dispute in this appeal. Instead, at issue here is whether defendants' failure to inform plaintiff of the c-section option proximately caused Miles's injury. The trial court determined that plaintiff failed to present admissible evidence establishing a genuine issue of material fact regarding whether SD occurred. "To establish legal cause, the plaintiff must show that it was foreseeable that the defendant's conduct 'may create a risk of harm to the victim, and . . . [that] the result of that conduct and intervening causes were foreseeable.'" *Weymers v Khera*, 454 Mich 639, 648; 563 NW2d 647 (1997) (ellipsis and brackets in original), quoting *Moning v Alfonso*, 400 Mich 425, 439; 254 NW2d 759 (1977).

The difficulty in this case lies with the fact that "the diagnosis of shoulder dystocia has a subjective component" and there exist "clinical variation[s] in describing shoulder dystocia[.]" ACOG Practice Bulletin, *supra*. We conclude that plaintiff presented sufficient evidence to establish a question of fact regarding whether SD occurred.

Defendant Dr. Roderick Cairgle, M.D., the delivering physician, opined that SD did not occur during Miles's birth and the delivery record does not indicate that SD occurred. Plaintiff's expert, Dr. Bennett Walstatter, M.D., agrees that the medical records do not indicate that SD

occurred. Dr. Walstatter testified, however, that at the hospital where he practices, physicians follow a protocol defining SD as occurring only after a physician is unable to deliver a baby in one minute. He nevertheless recognized that although a baby's shoulder might not be trapped for one minute, SD damage may result. In his deposition, he testified:

- Q.* I want you to assume, Doctor, that this delivery was not complicated by shoulder dystocia, okay?
- A.* Okay. But now you're – we're going by the definition that – let's say that the shoulder – if they use the same definition of one minute with a trapped shoulder, what I'm saying is that you can still have a trapped shoulder, pull hard, never get to the point of what a defined shoulder dystocia is and still do the damage, so he could easily have pulled too hard, done the damage and still not had, by definition, a shoulder dystocia.

Dr. Walstatter's reference to a "defined shoulder dystocia" was based on his hospital's assumption that SD occurs only after a baby's shoulder is trapped for at least one minute.

In contrast, defendants' own expert, Dr. Robert Long, testified that although a certain amount of time is required to diagnose SD, there is no specific amount of time that shoulder impaction must occur in order to diagnose SD and that the determination whether SD occurs is made by the delivering physician on a case-by-case basis:

- Q.* What is your definition then of shoulder dystocia?
- A.* Shoulder dystocia by definition, if you want a scientific answer, is a significant delay between the delivery of the head and the delivery of the body.
- Q.* How would you define the term significant in that definition?
- A.* Significant means that the delivering physician needs to perform a or multiple maneuvers [sic] to achieve delivery of the body.
- Q.* Well, you connect the term significant and delay. Does it have to be a certain time or can you recognize it right away? In other words, the head has been delivered, can you immediately say okay, that is shoulder dystocia if you cannot deliver the rest of the body without some force in play?
- A.* No. You can have suspicion and there are some things that can heighten your suspicion for shoulder dystocia. A common term that many people will say is a turtle sign. That's just an example that would heighten the obstetrician's awareness, again, for shoulder dystocia. That's just an example.

* * *

- Q.* . . . What is your definition – you saw that Dr. Walstatter discussed [in his deposition] timing between when shoulder dystocia can be diagnosed, in other words, could be more than a minute or something like that. Do you have an

underlying basis or a rule that you use as an obstetrician before you can document or before you can say that this is a shoulder dystocia?

A. I don't have a specific number because it really relates to just making the diagnosis.

Q. Okay.

A. And to make the diagnosis does require a certain amount of time. I don't know how much time it takes, but there is time involved. There is time after the head comes out, then you have to do the suctioning and then you are examining before instructing the patient or the staff to do whatever you are going to do. So there is a delay.

Q. It's determined on a case-by-case basis, correct?

A. Correct.

Q. Could be as little as 30 seconds before you make that diagnosis, correct?

A. It could be as little as 30 seconds to make that diagnosis of shoulder dystocia, yes.

Thus, according to Dr. Long's testimony, there is no established amount of time that a baby's shoulder must be trapped in order to diagnose SD and a delivering physician makes such a diagnosis on a case-by-case basis.

Dr. Long's testimony is consistent with the medical literature recognizing that "the diagnosis of shoulder dystocia has a subjective component." Medical literature also recognizes that there exists "clinical variation in describing shoulder dystocia[.]" ACOG Practice Bulletin, *supra*. The medical literature also suggests that brachial plexus injuries oftentimes occur during deliveries in which the delivering physician does not record SD and that some physicians may use a more restrictive definition of SD than others. Gurewitsch, Johnson, et al, "Risk factors for brachial plexus injury with and without shoulder dystocia," 194 American Journal of Obstetrics & Gynecology No. 2 (2006).

In Dr. Walstatter's affidavit, he opined that Miles's delivery was "complicated by an undocumented shoulder dystocia and/or a shoulder dystocia defined as a 'shoulder trapped behind the mother's pubic bone.'" Dr. Walstatter's opinion reflects that the diagnosis of SD involves a subjective component and there exists no consistent description of the term. Defendants rely on *Badalamenti v William Beaumont Hosp-Troy*, 237 Mich App 278; 602 NW2d 854 (1999), and argue that Dr. Walstatter could have formed his opinion only by disparaging Dr. Cairgle's description of the delivery. In *Badalamenti*, this Court stated that an expert's opinion is objectionable when it "is inconsistent with the testimony of a witness who personally observed an event in question, and the expert is unable to reconcile his inconsistent testimony other than by disparaging the witness' power of observation." *Id.* at 286. Here, Dr. Walstatter's opinion that an undocumented SD occurred does not necessarily disparage Dr. Cairgle's power of observation. Rather, Dr. Walstatter's opinion is reconcilable with Dr. Cairgle's version of events

considering the variation in standards for diagnosing SD and the fact that diagnoses have a subjective component and are made on a case-by-case basis.

In addition, Dr. Walstatter's definition of SD in his affidavit as a "shoulder trapped behind the mother's pubic bone" is consistent with the medical literature as previously discussed. Dr. Walstatter also states in his affidavit that he reached his opinion after reviewing the "medical records, case materials, depositions and relevant medical literature[.]" Thus, his opinion and assertions are supported by medical literature and are admissible under MRE 702.² See *Nelson v American Sterilizer Co (On Remand)*, 223 Mich App 485, 490-492; 566 NW2d 671 (1997). Further, Dr. Walstatter's affidavit does not contradict his deposition testimony, which was based on the definition of SD that he uses in his practice, requiring that a baby's shoulder be trapped for at least one minute before such a diagnosis can be made.

We conclude that plaintiff presented sufficient evidence to at least create a genuine issue of material fact regarding whether SD occurred, based on Dr. Walstatter's definition of SD used in his affidavit, i.e., a "shoulder trapped behind the mother's pubic bone." Dr. Walstatter testified that there was a risk of SD based on plaintiff's prenatal condition, including her significant weight gain and obesity, and on data indicating that the fetus she was carrying was very large. He further testified that the fact that plaintiff suffered a third-degree laceration of the vagina into her rectal muscle during delivery indicated that SD occurred and that Dr. Cairgle used excessive traction to free the shoulder. In addition, the baby's father, Marcus Hughey, testified that he observed Dr. Cairgle place his hands on the baby's head and roughly pull him from plaintiff's body. Immediately after the delivery, it was noted that Miles had slow movement in his left arm. Further, the discharge summary indicates SD as the etiology of Miles's Erb's palsy. Although the trial court discounted this opinion in the discharge summary as pure speculation or conjecture, viewing the evidence in the light most favorable to plaintiff, the evidence was sufficient to create a genuine issue of material fact regarding whether SD occurred. Thus, the trial court erred by granting partial summary disposition for defendants.

In light of our decision, it is unnecessary to address plaintiff's argument that the trial court erred by denying plaintiff's motion for reconsideration.

Reversed and remanded. We do not retain jurisdiction.

/s/ Stephen L. Borrello

/s/ Patrick M. Meter

/s/ Cynthia Diane Stephens

² Although defendants correctly argue that the medical literature is inadmissible under MRE 707, Dr. Walstatter's opinions are admissible under MRE 702.