

STATE OF MICHIGAN
COURT OF APPEALS

DEREK T. NOLEN, Personal Representative of
the Estate of VASTENE SUANE NOLEN,

UNPUBLISHED
March 13, 2014

Plaintiff-Appellant/Cross-Appellee,

v

No. 307627
Oakland Circuit Court
LC Nos. 2008-092901-NH;
2009-099976-NH

WILLIAM BEAUMONT HOSPITAL, MICHAEL
LAZAR, M.D., RODOLFO FARHY, M.D., and
RODOLFO D. FARHY, M.D., F.A.C.C.,
F.A.H.A., P.L.L.C.,

Defendants-Appellees/Cross-
Appellants,

and

CHARLES DAVIS, M.D., PEARCE
HOSPITALIST SERVICE, EDWARD Y.
MISHAL, D.O., and OAKLAND FAMILY
MEDICINE, a/k/a EDWARD MISHAL, D.O.,
P.C.,

Defendants-Appellees.

Before: JANSEN, P.J., and K. F. KELLY and SERVITTO, JJ.

PER CURIAM.

Plaintiff appeals by right the circuit court's separate orders entering judgment in favor of defendants William Beaumont Hospital, Michael Lazar, M.D., Rodolfo Farhy, M.D., and Rodolfo Farhy, M.D., F.A.C.C., F.A.H.A., P.L.L.C. following the jury's verdict of no cause of action. Defendants William Beaumont Hospital and Michael Lazar, M.D. have cross-appealed, arguing among other things that they were entitled to a directed verdict in their favor and that plaintiff's expert was not qualified to offer standard-of-care testimony. Defendants Rodolfo Farhy, M.D. and Rodolfo Farhy, M.D., F.A.C.C., F.A.H.A., P.L.L.C. have also cross-appealed, arguing among other things that they were entitled to a directed verdict in their favor. We affirm.

I. BASIC FACTS AND PROCEDURAL HISTORY

On March 14, 2007, plaintiff's decedent ("the decedent") underwent an abdominoplasty and associated liposuction procedure at William Beaumont Hospital. The procedure was performed by Lauran Bryan, M.D., a board-certified plastic surgeon. According to Bryan, "[a]n abdominoplasty entails removing the skin and fat that essentially hangs below the naval" and "includes tightening the muscles along the lining of the abdomen." Bryan confirmed that she "took out a significant amount of skin, muscle, and fat" and that the liposuction component of the procedure "injures many small arteries or arterioles." However, the decedent lost only a small amount of blood and suffered no other complications during the procedure. Bryan testified that the surgery was a success and that the decedent "recovered fine." The decedent was discharged from the hospital the following day.¹

At 11:26 p.m. on March 17, 2007, the decedent went to the emergency department at William Beaumont Hospital complaining of chest pains, leg pains, rapid heartbeat, and difficulty breathing. Suspecting pulmonary embolism, the emergency room physician, Dr. James Getzinger, order a CT scan and chest x-ray. The CT scan was performed at approximately 12:15 a.m. on March 18, 2007, and was completed by 12:27 a.m. According to radiologist Kent Donovan, M.D., the CT scan confirmed the existence of several blood clots in the decedent's right and left pulmonary arteries. One of the decedent's main pulmonary arteries was 80 to 85 percent blocked and her other main pulmonary artery was 90 to 95 percent blocked.²

Getzinger called Bryan to inform her of the decedent's condition and started the decedent on Heparin at 12:20 a.m. After the CT scan was read, Getzinger inquired whether the decedent should be admitted to the intensive care unit ("ICU"). Jeffrey Decker, M.D., a third-year resident in internal medicine, was working in the ICU that night. Decker came to the emergency department by 12:41 a.m. to assess the decedent's condition. At 1:40 a.m., Decker signed an order transferring the decedent to the ICU and ordering two additional tests: (1) a venous Doppler of the lower extremities to check for additional blood clots in the legs, and (2) an echocardiogram. Decker also called for a pulmonary consultation with Michael Lazar, M.D., a board-certified pulmonologist, who was the critical-care specialist on call that night. Hospital records show that Lazar was paged at approximately 2:30 a.m.

The decedent was transferred to the ICU just after 2:00 a.m. The echocardiogram was not performed until 9:00 a.m. The venous Doppler of the decedent's lower extremities was never performed.

¹ According to Bryan, although the decedent had shown no preoperative risk factors for pulmonary embolism, "[t]he combination of anesthesia and surgery does increase the risk of deep vein thrombosis."

² Because the decedent's primary care physician was not on staff, Charles Davis, M.D. of Pearce Hospitalist Service was initially assigned to her. However, it is beyond dispute that Davis never had any contact with the decedent and had no involvement in her treatment.

Lazar arrived at the hospital at 7:00 a.m. on March 18, 2007, and did his rounds from 7:30 until 8:30 a.m. Lazar spoke with the decedent for approximately 45 minutes, beginning at about 9:30 a.m. While Lazar was speaking with the decedent, the echocardiogram technician, Naomi Tainsky, placed a notation in the decedent's chart at 9:47 a.m.

At 9:47 a.m., Decker signed an order requesting that cardiologist Rodolfo Farhy, M.D., come to read the echocardiogram.³ Farhy did not come immediately, but was then called once again at 10:47 a.m. He arrived shortly thereafter. The echocardiogram showed a large blood clot inside the right atrium of the decedent's heart. Sometime after 10:50 a.m., Farhy spoke with the decedent and examined her lower extremities. Farhy then consulted with Lazar; they agreed that the thrombolytic agent tPA was not indicated in light of the decedent's recent surgery and associated risk of bleeding. They also decided that embolectomy surgery or percutaneous clot removal would be too risky because such procedures might dislodge the clot in the right atrium, causing even greater problems, and would not allow access to the clots in the smaller branches of the pulmonary arteries. Thus, Farhy and Lazar decided to keep the decedent on intravenous Heparin. In his dictation, which he finished at about 12:20 p.m., Farhy noted that the decedent was hemodynamically stable (with the exception of slight tachycardia) and that she would remain on "I.V. Heparin for now."

The decedent coded at approximately 1:00 p.m. on March 18, 2007. Various attempts to resuscitate her continued for about an hour. Hospital records indicate that Lazar was present throughout the resuscitation efforts. The decedent was pronounced dead at 2:15 p.m.

Michele Rooney, M.D., a pathologist, conducted an autopsy of the decedent at William Beaumont Hospital. Rooney confirmed that the decedent's two pulmonary arteries were "fill[ed]" with clots and that the cause of the decedent's death was "acute embolus obstructing the left and right main pulmonary arteries." Rooney described the blockage as "extensive."

On July 11, 2008, plaintiff commenced Oakland Circuit Case No. 2008-092901-NH by filing his complaint against defendants William Beaumont Hospital, Michael Lazar, M.D., Rodolfo Farhy, M.D., Charles Davis, M.D., and Pearce Hospitalist Service.⁴ The complaint alleged that Lazar, Farhy, and Davis had negligently failed to properly diagnose and treat the decedent's condition, resulting in her death. The complaint further alleged that William Beaumont Hospital was vicariously liable for the professional negligence of its agents. Lastly, the complaint alleged in conclusory fashion that William Beaumont Hospital was directly liable

³ Plaintiff insists that the 9:47 a.m. order contained the word "now," and should have been interpreted as an "immediate" or "STAT" order. However, the 9:47 a.m. order clearly stated, "Routine within 24 hours. If urgent a doctor should call." The record indicates that when Farhy was again called at 10:47 a.m., he arrived within minutes.

⁴ On January 23, 2008, a notice of intent to sue had been served on William Beaumont Hospital, Lazar, Farhy, Davis, and Pearce Hospitalist Service. On March 21, 2008, the Wayne County Probate Court had appointed plaintiff Derek T. Nolan, the decedent's husband, as personal representative of the decedent's estate.

for (1) failing to draft and adopt sufficient rules, regulations, policies, and protocols to prevent situations such as that leading to the decedent's death, (2) failing to have proper nursing staff, support staff, and technical equipment, and (3) failing to employ physicians, including specialists, who would exercise that degree of skill possessed by physicians of ordinary learning and judgment. Plaintiff submitted an affidavit of merit executed by Peter G. Terry, M.D., who is board certified in pulmonary medicine and critical-care medicine. Plaintiff also submitted an affidavit of merit executed by John S. MacGregor, M.D., who is board certified in internal medicine, cardiology, and interventional cardiology. Lastly, plaintiff submitted an affidavit of merit executed by Dennis M. Moritz, M.D., who is board certified in cardiothoracic surgery.

On April 14, 2009, plaintiff commenced Oakland Circuit Case No. 2009-099976-NH by filing a complaint against defendants Edward Y. Mishal, D.O., Oakland Family Medicine, also known as Edward Y. Mishal, D.O., P.C., and William Beaumont Hospital.⁵ The complaint alleged that Mishal and Oakland Family Medicine had failed to properly diagnose and treat the decedent's condition, resulting in her death. The complaint further alleged that William Beaumont Hospital was vicariously liable for the professional negligence of Mishal. The complaint also set forth conclusory claims of direct liability that were substantially similar to those alleged in Oakland Circuit Case No. 2008-092901-NH. Plaintiff again submitted an affidavit of merit executed by Peter G. Terry, M.D., who is board certified in pulmonary medicine and critical-care medicine.

On August 27, 2009, the circuit court entered a stipulated order consolidating Oakland Circuit Case Nos. 2008-092901-NH and 2009-099976-NH for purposes of discovery and trial. On September 16, 2009, the circuit court entered a stipulated order permitting plaintiff to add Rodolfo Farhy, M.D., F.A.C.C., F.A.H.A., P.L.L.C. as a defendant.

On August 18, 2010, defendants Davis, Pearce Hospitalist Service, Mishal, and Oakland Family Medicine moved for summary disposition pursuant to MCR 2.116(C)(8) and (10). The circuit court ultimately granted the motion, dismissing all claims against Davis, Pearce Hospitalist Service, Mishal, and Oakland Family Medicine. The circuit court ruled that it was beyond factual dispute that the decedent never had a physician-patient relationship with Davis. The court further ruled that plaintiff had failed to name an expert witness who was qualified to testify regarding the standard of care applicable to Mishal.

On September 8, 2010, plaintiff filed a motion seeking to amend his complaints to set forth a new claim that the remaining defendants had negligently "fail[ed] to order an immediate or STAT echocardiogram." Plaintiff asserted that, had the echocardiogram been performed sooner, the decedent would have had a greater chance of recovery. Plaintiff believed that his existing pleadings were already broad enough to encompass this claim, but explained that he wished to make this specific allegation of malpractice abundantly clear "to avoid gamesmanship at the time of trial on behalf of Defendants" Plaintiff believed that the amendment would be

⁵ Like Davis, Mishal was merely assigned to the decedent while she was an inpatient at the hospital. On October 30, 2008, a separate notice of intent to sue was served on defendants Mishal, Oakland Family Medicine, and William Beaumont Hospital.

in the interests of justice and would not prejudice defendants because they were already aware that this was an issue in the case.

On January 4, 2011, the circuit court ruled on several motions in limine that had been filed by the parties. Among other things, the circuit court granted defendants' motion in limine seeking to prevent plaintiff from offering medical literature as substantively admissible evidence. The court ruled that, pursuant to MRE 707, learned treatises and medical literature could be used for impeachment purposes only.

The circuit court also denied plaintiff's motion to amend his complaints to assert his "STAT echocardiogram" theory of negligence. The circuit court explained that neither Lazar nor Farhy was yet involved in the decedent's treatment at the time the echocardiogram was ordered by Decker and Getzinger at 1:40 a.m. on March 18, 2007. Accordingly, the court determined that the amendment would be futile with regard to Lazar and Farhy. With respect to defendant William Beaumont Hospital, itself, the circuit court explained that plaintiff had failed to serve Decker and Getzinger with notices of intent to sue and had not identified any expert who would be qualified to opine on the standard of care applicable to Decker and Getzinger. Consequently, the court ruled that the hospital could not be found vicariously liable for the acts or omissions of Decker and Getzinger as a matter of law, and that any amendment would therefore be futile with regard to William Beaumont Hospital.

Plaintiff moved for reconsideration of the circuit court's decision. On February 1, 2011, the circuit court again noted that plaintiff had not identified any expert who would be qualified to opine on the standard of care applicable to Getzinger, a practitioner of emergency medicine. But the court noted that Decker, the third-year resident in charge of ICU admissions, was practicing critical-care medicine rather than emergency medicine at the time of the alleged failure to order a STAT echocardiogram. Thus, the court reversed its earlier determination and agreed with plaintiff that one of his named experts, Peter G. Terry, M.D., *would* be qualified to opine concerning the standard of care applicable to Decker. Furthermore, relying on *Bush v Shabahang*, 484 Mich 156, 176-177; 772 NW2d 272 (2009), the circuit court ruled that plaintiff's failure to serve Decker with a notice of intent could be cured and that plaintiff could add Decker as a defendant.

Nonetheless, the circuit court believed that plaintiff's proposed amendment might cause William Beaumont Hospital unfair prejudice. The court noted that the failure to order an immediate echocardiogram had not been raised directly in the pleadings. And although plaintiff had questioned two of defendants' experts during their depositions regarding the importance of an immediate echocardiogram, the court noted that these were isolated questions and that the parties had never actually explored whether Decker should have ordered an immediate echocardiogram. The circuit court ordered supplemental briefing on the issue whether plaintiff's addition of a claim predicated on Decker's failure to order an immediate echocardiogram would prejudice defendant William Beaumont Hospital.

After supplemental briefs were submitted, the circuit court denied plaintiff's motion for reconsideration and disallowed plaintiff's proposed amendment of the pleadings on the grounds that it would unfairly prejudice defendant William Beaumont Hospital and cause undue delay. The circuit court noted that the "STAT echocardiogram theory" was never raised prior to

Decker's deposition of January 26, 2010, and that even though it was briefly mentioned at two other depositions, there was never any indication that plaintiff believed Decker had breached the standard of care in this regard and it was not clear whether it was even possible to conduct an immediate echocardiogram in the middle of the night. Accordingly, the court found that defendants had no notice that plaintiff intended to assert a claim of negligence based on his "STAT echocardiogram theory" until September 8, 2010, when he filed his motion to amend. The circuit court remarked that, if the amendment were permitted, defendant William Beaumont Hospital would be entitled to redepose plaintiff's expert and would be entitled to name a new expert to testify on behalf of Decker. This would require the court to reopen discovery and result in even more delays.⁶

The matter proceeded to jury trial on September 8, 2011. After the close of proofs and the arguments of counsel, the jury was instructed. Among other things, the circuit court specifically instructed the jurors:

There are three defendants in this trial and each defendant is entitled to separate consideration

If you find one of the defendants to be liable, you should determine the amount of damages he caused and return a verdict in that amount. If you find more than one of the defendants to be liable, you shall return a separate verdict for the amount of damages you determine each defendant has caused.

* * *

In this case, Derek Nolen, the personal representative of the estate of Vastene Suane Nolen, the deceased, is suing William Beaumont Hospital, including agents of William Beaumont Hospital, Michael Lazar, M.D., Rodolfo Farhy, M.D., the defendants.^{7]}

Before the end of trial, plaintiff and defendants each submitted a proposed verdict form. The circuit court ultimately chose the verdict form submitted by defendants. It appears that plaintiff timely objected to the use of defendants' proposed verdict form. Among other things, the verdict form proposed by defendants included questions that asked whether Lazar and Farhy had been professionally negligent. The verdict form *did not* include a question asking whether

⁶ The circuit court also noted that plaintiff had failed to explain why he waited so long to assert this new theory of negligence. Plaintiff had been aware of his "STAT echocardiogram theory" since at least January 2010, and possibly earlier. The circuit court observed that plaintiff should have moved to amend the pleadings to assert this claim before the close of discovery in August 2010.

⁷ The circuit court omitted mention of Farhy's professional limited liability company, defendant Rodolfo Farhy, M.D., F.A.C.C., F.A.H.A., P.L.L.C. However, this oversight was clearly harmless in light of the jury's ultimate determination that Farhy was not professionally negligent.

William Beaumont Hospital had been professionally negligent; nor did it contain any other reference to institutional defendant William Beaumont Hospital.⁸

During deliberations, the jury sent a handwritten note to the circuit court stating, “We need clarification. It was mentioned in the jury instructions that there were three defendants. But we see no reference to Beaumont on the verdict form.” The circuit judge wrote back to the jury, explaining, “You must rely on your collective memories and jury instruction 45.01.”⁹

The jury thereafter returned a unanimous verdict of no cause of action, finding that neither Lazar nor Farhy had been professionally negligent. Following the jury’s verdict, the circuit court entered judgment in favor of defendants William Beaumont Hospital, Lazar, Farhy, and Rodolfo Farhy, M.D., F.A.C.C., F.A.H.A., P.L.L.C.

On October 24, 2011, plaintiff moved for a new trial pursuant to MCR 2.611(A)(1), arguing that he had been denied a fair trial by the circuit court’s errors. In particular, plaintiff argued that (1) the circuit court had abused its discretion by allowing defendants’ counsel to display and read aloud from the medical literature during closing argument, and (2) the circuit court had abused its discretion by overruling plaintiff’s objection to the verdict form, thereby precluding the jury from considering claims of direct liability against institutional defendant William Beaumont Hospital. Plaintiff maintained that it had asserted direct claims of medical malpractice and ordinary negligence against William Beaumont Hospital and that it had pursued these theories of direct liability at trial. On November 23, 2011, the circuit court denied plaintiff’s motion for a new trial.

II. STANDARDS OF REVIEW

We review for an abuse of discretion the circuit court’s denial of a motion to amend the pleadings. *Ormsby v Capital Welding, Inc*, 471 Mich 45, 53; 684 NW2d 320 (2004). We similarly review for an abuse of discretion the circuit court’s decision to admit or exclude evidence, *Craig v Oakwood Hospital*, 471 Mich 67, 76; 684 NW2d 296 (2004), and the circuit court’s decision to deny a motion for a new trial, *Gilbert v DaimlerChrysler Corp*, 470 Mich 749, 761-762; 685 NW2d 391 (2004). An abuse of discretion occurs when the circuit court

⁸ In contrast, the proposed verdict form submitted by plaintiff contained a separate question asking whether institutional defendant William Beaumont Hospital had been professionally negligent.

⁹ Consistent with M Civ JI 45.01, the circuit court had instructed the jurors in relevant part: “We have a law in Michigan known as the Wrongful Death Act. This law permits the personal representative of the estate of a deceased person to bring an action whenever the death of a person or injuries resulting in the death of a person have been caused by the negligence of another. In this case, Derek Nolen, the personal representative of the estate of Vastene Suane Nolen, the deceased, is suing William Beaumont Hospital, including agents of William Beaumont Hospital, Michael Lazar, M.D., Rodolfo Farhy, M.D., the defendants.”

reaches a decision that falls outside the range of reasonable and principled outcomes. *Maldonado v Ford Motor Co*, 476 Mich 372, 388; 719 NW2d 809 (2006).

We review de novo whether the verdict form was consistent with the jury instructions and the evidence introduced at trial. See *People v Wade*, 283 Mich App 462, 464; 771 NW2d 447 (2009). The qualifications and competency of an expert witness are generally matters within the discretion of the circuit court. *Gay v Select Specialty Hospital*, 295 Mich App 284, 290; 813 NW2d 354 (2012). However, we review de novo whether the circuit court properly interpreted and applied the law with respect to an expert witness. *Id.* at 291.

III. AMENDMENT OF THE PLEADINGS

Plaintiff argues that the circuit court abused its discretion by denying his motion to amend the pleadings to assert his “STAT echocardiogram” theory of negligence against defendant William Beaumont Hospital. We disagree.

Neither Dr. Getzinger, the emergency physician, nor Dr. Decker, the ICU resident, was named in either of plaintiff’s complaints. Moreover, the alleged failure to order a STAT echocardiogram was never raised in the pleadings. While isolated questions concerning the importance of an immediate echocardiogram were asked during the depositions of at least two experts, plaintiff never specifically argued that Decker was negligent for failing to order an immediate or STAT echocardiogram.

As the circuit court correctly noted, plaintiff’s “STAT echocardiogram theory” was never raised prior to Decker’s deposition of January 26, 2010, and even though it was mentioned at two other depositions, plaintiff never argued that Decker had breached the standard of care in this regard. Defendants first received notice that plaintiff intended to assert a claim of negligence based on Decker’s failure to order an immediate echocardiogram on September 8, 2010, when plaintiff filed his motion to amend the pleadings. As the circuit court correctly observed, if plaintiff’s motion to amend had been granted, William Beaumont Hospital would have been entitled to redepose plaintiff’s expert, Peter G. Terry, M.D., and would have been entitled to name a new expert to testify on behalf of Decker. This would have required the circuit court to reopen discovery, resulting in further delays.

Plaintiff fails to explain why he never brought any claim against Decker in the first instance and why he waited so long to assert this theory of negligence. This is not a situation in which the new claim was belatedly brought to light through the discovery of new evidence. Plaintiff had been aware of his “STAT echocardiogram” theory since at least January 2010, and probably earlier. Nonetheless, he never named Decker as a defendant. Because Decker was never named, defendant William Beaumont Hospital could not have known that plaintiff intended to pursue this theory at trial. Given plaintiff’s undue delay in bringing this claim, as well as the unfair prejudice that defendant William Beaumont Hospital would have suffered, the circuit court did not abuse its discretion by denying plaintiff’s motion to amend the pleadings to assert the claim. See *Weymers v Khera*, 454 Mich 639, 659; 563 NW2d 647 (1997).

IV. VERDICT FORM

Plaintiff next argues that the circuit court erred by providing an incomplete verdict form that did not comport with his theories of liability or the jury instructions. We agree that the court erred in this regard, but conclude that the error was harmless.

We recognize that plaintiff pursued claims of vicarious liability against institutional defendant William Beaumont Hospital in this case. Accordingly, William Beaumont Hospital should have been listed separately on the verdict form. In general, a verdict form must fairly present the issues to be decided by the jury and conform to the jury instructions. See MCR 2.515(A); *Rodriguez v ASE Industries, Inc*, 275 Mich App 8, 15; 738 NW2d 238 (2007). The circuit court erred by submitting to the jury a verdict form that did not separately list William Beaumont Hospital or allow the jurors to apportion liability to William Beaumont Hospital.

However, there were no viable claims of direct liability asserted against William Beaumont Hospital in this case. We have thoroughly examined the lower court record. Although plaintiff's complaints contained a small number of conclusory, direct medical-malpractice claims against William Beaumont Hospital, plaintiff called no experts at trial to substantiate any of his direct-liability claims against the hospital. A plaintiff must do more than merely plead his direct claims of negligence in the complaint; he must actively pursue those claims at trial. *Cox v Flint Bd of Hospital Managers*, 467 Mich 1, 11 n 11; 651 NW2d 356 (2002); see also *Sharp v Lansing*, 464 Mich 792, 800-801; 629 NW2d 873 (2001). And it is well settled that, in medical-malpractice actions, "[e]xpert testimony is required to establish the standard of care and a breach of that standard . . . as well as causation." *Kalaj v Khan*, 295 Mich App 420, 429; 820 NW2d 223 (2012). Plaintiff abandoned any direct claims of medical-malpractice against William Beaumont Hospital by failing to prosecute them at trial.

Further, contrary to plaintiff's argument on appeal, he did not plead any direct claims of ordinary negligence against William Beaumont Hospital. No direct claims of ordinary negligence against William Beaumont Hospital were alleged in either complaint, and no evidence of ordinary negligence by the hospital was introduced at trial.

Given the jury's determination on the merits¹⁰ that Lazar and Farhy were not professionally negligent, the jury could not have attributed any vicarious liability to their principal, institutional defendant William Beaumont Hospital, as a matter of law. *Al-Shimmari v Detroit Med Center*, 477 Mich 280, 295; 731 NW2d 29 (2007); see also *Cox*, 467 Mich at 12. Consequently, any error in omitting William Beaumont Hospital from the verdict form was harmless.

¹⁰ It is axiomatic that a jury's verdict of no cause of action constitutes an adjudication on the merits. *Swindlehurst v American Fidelity Fire Ins Co*, 2 Mich App 329, 335; 139 NW2d 910 (1966).

V. USE OF MEDICAL LITERATURE AND GUIDELINES

Plaintiff argues that the circuit court abused its discretion by allowing defense counsel to enlarge, display, and read aloud from medical literature and medical guidelines during closing argument. We cannot agree.

Defense counsel had previously used the medical literature and guidelines to impeach plaintiff's expert, Peter G. Terry, M.D., during cross-examination. This use of the medical literature for impeachment purposes comported with MRE 707 and was consistent with the circuit court's earlier order in limine.

The problem, according to plaintiff, is that defense counsel then enlarged, displayed, and extensively read aloud from the medical literature during closing argument. During that process, defense counsel explained to the jurors that he was "attempting to discredit [Terry's] testimony by showing you that indeed what he was saying was not only wrong, it was misplaced. [It] was . . . really not scientifically based."

As plaintiff correctly argues, learned treatises, journal articles, and similar materials are not substantively admissible, and may be used for impeachment purposes only. MRE 707. Such impeachment materials may not be received as exhibits. *Id.* During closing argument, it is improper for counsel to comment on evidence that has not been admitted at trial. See *People v Finley*, 161 Mich App 1, 9; 410 NW2d 282 (1987). Thus, counsel may not read from learned treatises or scientific literature during closing argument if the materials have not been admitted for a proper purpose. See *Bivens v Detroit Osteopathic Hospital*, 403 Mich 820, 820-821 (1978).

However, even though "learned treatises cannot be used as substantive evidence in a case," this Court has held that "they may used for other relevant, nonhearsay reasons that are not substantially more prejudicial than probative." *Hilgendorf v St John Hospital & Med Center Corp*, 245 Mich App 670, 702; 630 NW2d 356 (2001), citing *Stachowiak v Subczynski*, 411 Mich 459, 463-465; 307 NW2d 677 (1981). "[N]o matter how strict the prohibition against using learned treatises in direct examination of an expert witness may be, MRE 707 does not absolutely forbid using learned treatises at other stages of a trial or for other reasons." *Hilgendorf*, 245 Mich App at 702. Moreover, counsel is entitled to question the veracity of a witness or characterize the witness's testimony as unworthy of belief during closing argument. *Wilson v Gen Motors Corp*, 183 Mich App 21, 27-28; 454 NW2d 405 (1990); see also *Heintz v Akbar*, 161 Mich App 533, 539; 411 NW2d 736, 738 (1987) (noting that "[i]n closing arguments, reasonable inferences from the testimony may be drawn by counsel"). And this Court has held that learned treatises used for impeachment, though not substantively admissible, may be displayed to the jury. *Klinke v Mitsubishi Motors Corp*, 219 Mich App 500, 512; 556 NW2d 528 (1996). Therefore, it was not improper for defense counsel to remind the jurors during closing argument that Dr. Terry had been impeached with the medical literature and to display the impeachment materials to the jury.

Furthermore, even if defense counsel's extensive use of the medical literature during closing argument was improper, this error was harmless. Any improper use of the medical literature during defense counsel's closing argument was not sufficiently prejudicial to warrant a new trial. See *Sponenburgh v Wayne Co*, 106 Mich App 628, 642-646; 308 NW2d 589 (1981).

As in *Sponenburgh*, defense counsel had already referenced the same literature for proper impeachment purposes during his earlier cross-examination of plaintiff's expert witness. In addition, the jury was properly instructed that it could consider only the testimony of the witnesses and the exhibits that had been received; the circuit court specifically instructed the jury that the arguments of counsel did not constitute evidence. "[J]urors are . . . presumed to understand and follow the court's instructions." *Bordeaux v Celotex Corp*, 203 Mich App 158, 164; 511 NW2d 899 (1993). We perceive no error requiring reversal with respect to this issue.

VI. MOTION FOR A NEW TRIAL

We reject plaintiff's argument that the circuit court abused its discretion by denying his motion for a new trial. Plaintiff's motion for a new trial was based on (1) defense counsel's allegedly improper use of the medical literature and guidelines during closing argument, and (2) the omission of institutional defendant William Beaumont Hospital from the verdict form. As we have already determined, neither of these alleged errors resulted in any outcome-determinative prejudice or denied plaintiff a fair trial. Accordingly, we conclude that the circuit court properly denied plaintiff's motion. See MCR 2.611(A)(1); see also *In re Kanable Estate*, 47 Mich App 299, 305; 209 NW2d 452 (1973).

VII. QUALIFICATIONS OF DR. KVALE

Lastly, plaintiff argues that the circuit court erred by denying his motion to preclude defendants' expert, Paul Kvale, M.D., from offering testimony on the standard of care applicable to Dr. Lazar pursuant to MCL 600.2169(1). We disagree.

Lazar is board-certified in both pulmonary medicine and critical-care medicine. The circuit court had already determined at a pretrial hearing on April 20, 2011, that Lazar was "primarily" practicing critical-care medicine at the time he treated the decedent. At that same hearing, however, the circuit court also ruled that Kvale, who is board-certified in pulmonary medicine only, could testify concerning the standard of care applicable to Lazar. In other words, these earlier rulings by the circuit court were internally inconsistent and do not offer us any useful guidance.

MCL 600.2169(1) provides in pertinent part:

In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:

(a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

Thus, “[i]f the defendant is a specialist, the expert witness must, at the time of the occurrence that forms the basis of the action, specialize in the same specialty, and subspecialty if applicable, as the defendant.” *Gonzalez v St John Hospital & Med Center*, 275 Mich App 290, 296-297; 739 NW2d 392 (2007). Pulmonary medicine and critical-care medicine are separate “specialt[ies]” within the meaning of the statute because each is “a particular branch of medicine or surgery in which one can potentially become board certified.” *Woodard v Custer*, 476 Mich 545, 561; 719 NW2d 842 (2006).

It cannot be denied that specialists in both critical-care medicine and pulmonary medicine treat pulmonary emboli. However, even though Lazar is board-certified in both specialties, he could not have been practicing in both fields simultaneously at the time of the alleged malpractice. A physician may certainly have more than one specialty. See *id.* at 560. But by using the singular phrase “the same specialty” in MCL 600.2169(1)(a), the Legislature has indicated that a physician may practice in only one specialty at any given time. Accordingly, the salient question is which of the two specialties Lazar was practicing at the time of the alleged malpractice in this case.

We conclude that Dr. Lazar was practicing pulmonary medicine rather than critical-care medicine at the time he was called to treat the decedent for her pulmonary embolism. Despite the fact that Lazar was the critical-care specialist on duty in the ICU, the overwhelming evidence admitted at trial established that he was called for the purpose of a *pulmonary* consultation. Indeed, Lazar testified that as between his two specialties, “[p]ulmonary medicine” was “the field that . . . was applicable to [the decedent].” Thus, because Lazar was practicing pulmonary medicine at the time he treated the decedent, and because Kvale is board-certified in pulmonary medicine, Kvale was qualified to testify concerning the standard care applicable to Lazar pursuant to MCL 600.2169(1)(a).¹¹ Plaintiff’s claim of error on this issue is without merit.

VIII. QUALIFICATIONS OF DR. TERRY

On cross-appeal, defendants Lazar and William Beaumont Hospital argue that if Lazar was practicing pulmonary medicine rather than critical-care medicine at the time of the alleged malpractice in this case, plaintiff’s expert, Peter G. Terry, M.D., was not qualified to offer testimony concerning the standard of care applicable to Lazar. We agree.

As explained previously, Lazar was practicing pulmonary medicine at the time he treated the decedent in this case. It is true that Terry is board-certified in both pulmonary medicine and critical-care medicine. However, Terry admitted that he spends the majority of his professional time practicing critical-care medicine in an ICU. Thus, Terry was not qualified to testify concerning the pulmonary-medicine standard of care applicable to Lazar at the time of the

¹¹ The parties do not address the circuit court’s apparent failure to go beyond the requirements of MCL 600.2169(1) and determine whether Dr. Kvale was “qualified as an expert by knowledge, skill, experience, training, or education[.]” MRE 702; see also MCL 600.2955; *Clerc v Chippewa Co War Mem Hospital*, 477 Mich 1067, 1067-1068 (2007). We do not discuss the issue further because it was not addressed below and has not been raised on appeal.

alleged malpractice. See MCL 600.2169(1)(b) (requiring an expert to spend at least 50 percent of his or her time actively practicing or teaching in the same specialty as the defendant in the year preceding the alleged malpractice); see also *Kiefer v Markley*, 283 Mich App 555, 559; 769 NW2d 271 (2009).

We conclude that the circuit court erred by permitting Terry to testify concerning the standard of care applicable to Lazar at the time of the alleged malpractice. But in light of the jury's verdict of no cause of action with respect to Lazar, this error was plainly harmless. See *Kohn v Ford Motor Co*, 151 Mich App 300, 309; 390 NW2d 709 (1986); *Shepard v Barnette*, 4 Mich App 243, 245; 144 NW2d 685 (1966).

IX. CONCLUSION

In light of our foregoing conclusions, we need not address the remaining arguments raised by defendants on cross-appeal.

Affirmed. Defendants, having prevailed on appeal, may tax their costs pursuant to MCR 7.219.

/s/ Kathleen Jansen
/s/ Kirsten Frank Kelly
/s/ Deborah A. Servitto