

STATE OF MICHIGAN
COURT OF APPEALS

JOHANNA WOODARD, Individually and as Next
Friend of AUSTIN D. WOODARD, a Minor, and
STEVEN WOODARD,

Plaintiffs-Appellants,

v

JOSEPH R. CUSTER, M.D.,

Defendant-Appellee,

and

MICHAEL K. LIPSCOMB, M.D., MICHELLE M.
NYPAVER, M.D., and MONA M. RISKALLA,
M.D.,

Defendants.

UNPUBLISHED
October 21, 2003

No. 239868
Washtenaw Circuit Court
LC No. 99-005364-NH

JOHANNA WOODARD, Individually and as Next
Friend of AUSTIN D. WOODARD, a Minor, and
STEVEN WOODARD,

Plaintiffs-Appellants,

v

UNIVERSITY OF MICHIGAN MEDICAL
CENTER,

Defendant-Appellee.

No. 239869
Court of Claims
LC No. 99-017432-CM

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

PER CURIAM.

In these consolidated medical malpractice cases against the physicians and the hospital who treated plaintiffs' infant son, plaintiffs appeal as of right from the trial court's order dismissing their medical malpractice claims with prejudice.

I. Facts and Procedural History

On January 30, 1997, plaintiffs' fifteen-day old infant son, Austin, was diagnosed with retrosyncytial virus bronchiolitis, a life-threatening respiratory disease that attacks infants, necessitating critical care treatment at the University of Michigan Medical Center's Pediatric Intensive Care Unit ("PICU") until February 10, 1997. The medical treatment included muscle relaxants and strong sedatives, mechanical ventilation and intubation, a feeding tube, and the placement of an arterial line in the femoral vein of the infant's right leg and a venous catheter inserted in the infant's left leg.

By February 10, 1997, the infant had made sufficient recovery that he was weaned from the sedatives and muscle relaxants. However, when he was moved from the intensive care unit to the general hospital ward, he became very agitated and he continuously cried. His left leg was purple in color and swollen as a result of the removal of the venous catheter from his left leg. An x-ray confirmed that deep vein thrombosis had developed in the left leg, a secondary condition to the venous catheter insertion. The x-ray also showed a fracture at the lower end of the femur in the infant's left leg. A subsequent skeletal survey revealed a fracture in the right leg, as well. The Medical Center's consultants were unable to determine the cause of the fractures.

In Docket No. 239868, plaintiffs filed suit against Dr. Joseph Custer, Director of the University of Michigan Medical Center's Pediatric Critical Care Medicine and the physicians who treated their son at the PICU. Plaintiffs raised claims of medical malpractice and negligent infliction of emotional distress. In Docket No. 239869, plaintiffs filed suit against the University of Michigan Medical Center, raising the same claims.

Dr. Custer and the other defendant physicians responded to the complaint in Docket No. 239868, by moving for summary disposition pursuant to MCR 2.116(4) (court lacks jurisdiction over subject matter), MCR 2.116(5) (lack of capacity to file suit in absence of an affidavit of merit), or MCR 2.116 (7) (the claim is barred for statutory reasons in the absence of an affidavit of merit). Dr. Custer and defendant physicians asserted that plaintiffs' affidavit of merit was untimely filed and that plaintiffs' medical expert, Anthony Casamassima, was not a qualified expert pursuant to MCL 600.2169, because he was not specialized in pediatric critical care or pediatric emergency medicine specialties as were Dr. Custer and defendant physicians.

At the time the trial court heard oral arguments for the motion, the two cases had been consolidated below. The court determined that the affidavit of merit signed by Dr. Casamassima was sufficient for the case to proceed but expressly stated on the record that it was not ruling on whether Dr. Casamassima was a qualified medical expert for purposes of trial testimony. The court informed defendants that they would be allowed to subsequently challenge Dr. Casamassima's qualifications as an expert witness.

All defendant physicians who treated the infant at the PICU were dismissed from the action by stipulation, leaving Dr. Custer and the Medical Center as the two remaining defendants in this case. After the two defendants deposed Dr. Casamassima, defendants filed four different

motions. The Medical Center filed a motion for summary disposition pursuant to MCR 2.116(C)(10), arguing that the testimony of plaintiffs' expert witness failed to support several claims against it because Dr. Casamassima did not provide the applicable standard of care and evidence of a breach of that standard. Dr. Custer filed a motion for summary disposition under MCR 2.116(C)(10), on the ground that plaintiffs cannot bring suit against him under a negligent supervision or respondeat superior theory. Both defendants jointly moved for partial summary disposition pursuant to MCR 2.116(C)(10), on the ground that plaintiffs' deposition testimony failed to support the claims of negligent infliction of emotional distress. Finally, both defendants jointly moved to strike Dr. Casamassima as an unqualified medical expert and to dismiss the case. In response to the above motions, plaintiffs asserted that the doctrine of res ipsa loquitur would allow an inference of negligence from the facts in this case. Specifically, plaintiffs argued that there was no need for an expert witness because an inference of negligence may be inferred from the fact that the infant was admitted to the PICU with healthy legs only to leave the PICU with fractured legs.

At the hearing for the above motions, defendants' counsel stated that the issue of the applicability of the doctrine of res ipsa loquitur should be reserved for an evidentiary hearing at a later date. Also at the hearing, plaintiffs agreed to dismiss the claims for negligent infliction of emotional distress. Following oral arguments, the trial court granted defendants' motion to strike plaintiffs' expert witness, ruling that Dr. Casamassima was not qualified as a medical expert under MCL 600.2169.

The scope of the trial court's decision at the hearing is unclear from the record and we cannot discern whether the court granted defendants summary disposition. Defendants appeared to have understood that the court did because they attempted to enter an order of dismissal. In response, plaintiffs objected to the entry of the order and they filed a motion for leave to file an amended complaint to assert negligence under the doctrine of res ipsa loquitur. Plaintiffs also filed a motion for a determination whether expert testimony was required in this case or, in the alternative, for leave to substitute their expert witness. In a written opinion and order following oral arguments, the court determined that the elements of the doctrine of res ipsa loquitur were not satisfied, that expert testimony was necessary because negligence could not be inferred from the facts, and that plaintiffs' request to substitute their expert was untimely. Accordingly, the court dismissed plaintiffs' case with prejudice, reasoning that without expert testimony plaintiffs could not prove their medical malpractice claims.

II. Standard of Review

It is unclear from the above-mentioned procedural history and from the written opinion and order dismissing the case whether the trial court determined the matter under defendants' motions for summary disposition pursuant to MCR 2.116(C)(10), or as a result of an evidentiary hearing in which the court ruled to dismiss the case because plaintiffs failed to support their claims. The former would be reviewed under a de novo standard, *Spiek v Dep't of Transportation*, 456 Mich 331, 337; 572 NW2d 201 (1998), while the latter would be under an abuse of discretion standard. See *Vicencio v Ramirez*, 211 Mich App 501, 506; 536 NW2d 280 (1995); *Zantop Int'l Airlines, Inc v Eastern Airlines*, 200 Mich App 344, 359; 503 NW2d 915 (1993).

The procedural history in this case indicates that plaintiffs' motion to amend its complaint to add the doctrine of *res ipsa loquitur* was unnecessary. Plaintiffs were not attempting to add new claims but only to assert the manner in which they were to prove their original claims. The doctrine was first raised in plaintiffs' response to the motions for summary disposition and it is unclear why it was not addressed at the hearing for the summary disposition motions when the necessary deposition testimony upon which plaintiffs relied was already before the trial court. The fact that the court did not address this argument at the hearing would suggest that it was obliged to do so as a continuation of its ruling on summary disposition. It is apparent that plaintiffs filed the motion to amend their complaint in an effort to salvage the case from premature dismissal. Accordingly, the court's ruling was determined as part of the continuation of the hearing on defendants' motions for summary disposition.

Summary disposition is appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Auto-Owners Ins Co v Allied Adjusters & Appraisers, Inc*, 238 Mich App 394, 397; 605 NW2d 685 (1999). In reviewing motions for summary disposition brought under MCR 2.116(C)(10), this Court considers the pleadings, affidavits, depositions, and other documentary evidence submitted by the parties in the light most favorable to the party opposing the motion. *Tate v Detroit Receiving Hosp*, 249 Mich App 212, 215; 642 NW2d 346 (2002). Whether a witness is qualified to render an expert opinion and the actual admissibility of the expert's testimony are within the trial court's discretion and such determinations are reviewed on appeal for an abuse of discretion. *Id.* In civil cases, an abuse of discretion is found only in extreme cases in which the result is so palpably and grossly violative of fact and logic that it evidences a perversity of will, a defiance of judgment, or the exercise of passion or bias. *Dep't of Transportation v Randolph*, 461 Mich 757, 768; 610 NW2d 893 (2000).

III. Analysis

A. Medical Expert Witness Qualifications

Plaintiffs argue that the trial court abused its discretion in determining that Dr. Casamassima was an unqualified medical expert. Specifically, plaintiffs claim that their theory of the case is not grounded in pediatric critical care but in general pediatric medicine, and that both Dr. Casamassima and Dr. Custer were board certified in pediatric medicine. Plaintiffs also assert that Dr. Custer's specialization in pediatric critical care was a "subspecialty" which Dr. Casamassima was not required to possess under MCL 600.2169.

In pertinent part, MCL 600.2169 provides:

(1) 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. [Emphasis added.]

Plaintiffs claim that the basis for the action is not grounded in pediatric critical care but in general pediatric medicine because the fractures were caused by “the manner in which the infant was handled and maneuvered” at the PICU. However, as further discussed in the second issue in this opinion, plaintiffs were unable to establish that the fractures were caused by the manner in which the infant was “handled and maneuvered” at the PICU. It was disputed whether the fractures occurred during the infant’s stay at the PICU and whether the injuries resulted from a pathological cause or child abuse. Accordingly, plaintiff’s claim that the fractures were caused by the mere “handling and maneuvering” of the infant during its stay at the PICU is without merit.¹

Moreover, plaintiffs have not established that the medical standard of care for an inpatient intensive care unit for critically ill infants is the same as that for general pediatric medicine. It appears from the record that it is not. Plaintiffs’ own expert witness, Dr. Casamassima, testified that a number of procedures that were performed on the infant at the PICU had the potential to cause fractures to the legs. He did not assert that those procedures were normally practiced in general pediatrics or that the standard of care for the treatment of critically ill infants was the same as that for general pediatric practice. Rather, he opined that the standard of care for the PICU was grounded in the policies and procedures established for those medical procedures – but he expressly testified that he did not know what the policies and procedures were. Accordingly, plaintiffs’ theory of the case was grounded not in general pediatric treatment but in pediatric intensive care.

Because the basis of the action is grounded in pediatric intensive care, plaintiffs were mandated by §2169(1)(a) to present an expert who possessed that specialization. Dr. Casamassima’s clinical practice during the year immediately preceding the instant injury, §2169(1)(b), did not involve pediatric critical care medicine. Given that Dr. Casamassima acknowledged that he was unaware of the precise standard of care for the treatment of critically ill infants, it is clear that plaintiffs were required to present an expert witness who was.

Plaintiffs rely on this Court’s decision in *Tate, supra*, and argue that §2169(1)(a) does not require Dr. Casamassima to possess the same “subspecialties” of pediatric critical care medicine and pediatric intensive care that Dr. Custer possessed. Plaintiffs misread the decision in *Tate*, which held:

Thus, where a defendant physician has several board certifications and the alleged malpractice involves only one of these specialties, §2169 requires an expert

¹ Plaintiffs argue that defendants failed to present evidence showing that the manner in which an infant should be “handled and maneuvered” is “unique” to critical care. However, it is the *plaintiff’s* burden of proof to show the standard of care in a medical malpractice case. *Locke v Pachtman*, 446 Mich 216, 222; 521 NW2d 786 (1994).

witness to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice. [*Tate, supra* at 220.]

Dr. Casamassima's testimony in this case was offered against Dr. Custer. It is undisputed that Dr. Custer was board certified in three specialty areas: pediatrics, pediatric critical care medicine, and neonatology-perinatology. Plaintiffs have provided nothing to establish that any of the three certifications was a "subspecialty." The decision in *Tate* mandates that, because plaintiffs' claims rested in the area of pediatric critical care medicine and because Dr. Custer was board certified in pediatric critical care medicine, plaintiffs' expert was required to possess that specialty. Insofar as the trial court determined that Dr. Casamassima was required to possess the same subspecialties as Dr. Custer and the physicians who treated the infant at the PICU, such ruling was erroneous, but harmless. Therefore, the trial court did not abuse its discretion when it determined that Dr. Casamassima did not meet the qualifications requirements set forth in §2169(1)(a), because he did not possess board certification in pediatric critical care medicine.

B. Exceptions to Expert Witness Testimony

Plaintiffs next argue that the trial court erred in determining that the doctrine of *res ipsa loquitur* was inapplicable in this case.

To prove a medical malpractice claim, a plaintiff must establish the following four factors: (1) the applicable standard of care, (2) breach of that standard of care by the defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury. *Locke v Pachtman*, 446 Mich 216, 222; 521 NW2d 786 (1994). "In an action alleging medical malpractice, the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants." MCL 600.2912a(2). Expert testimony is required in medical malpractice cases to establish the applicable standard of care and to demonstrate that the defendant somehow breached that standard. *Birmingham v Vance*, 204 Mich App 418, 421; 516 NW2d 95 (1994). However, "while expert testimony is the traditional and the preferred method of proving medical malpractice, exceptions to the need for expert testimony have been recognized" and one such exception is when a plaintiff's case satisfies the doctrine of *res ipsa loquitur*. *Locke, supra* at 230. Where the elements of the doctrine are satisfied, negligence can be inferred. *Thomas v McPherson Community Health Center*, 155 Mich App 700, 705; 400 NW2d 629 (1986). The following four factors are necessary to a *res ipsa loquitur* claim:

(1) the event must be of a kind which ordinarily does not occur in the absence of someone's negligence;

(2) it must be caused by an agency or instrumentality within the exclusive control of the defendant;

(3) it must not have been due to any voluntary action or contribution on the part of the plaintiff. . . .

[4] "[e]vidence of the true explanation of the event must be more readily accessible to the defendant than to the plaintiff." [*Locke, supra*, quoting *Jones v Porretta*, 428 Mich 132, 150-151; 405 NW2d 863 (1987).]

As to the first factor, “the fact that the injury complained of does not ordinarily occur in the absence of negligence must either be supported by expert testimony or must be within the common understanding of the jury.” *Locke, supra* at 231.

The trial court determined that expert testimony was required in this case in order to address whether the fractures could have occurred in the absence of negligence and to rule out the possibility that the fractures were caused as risks arising from the types of procedures performed at the PICU. It is unfortunate that the cause of the fractures or an exact timeframe in which the fractures occurred were never determined in this case, particularly because it appears that Austin may face extensive medical treatment due to the resulting difference in the length of his legs. However, as the court concluded, plaintiffs’ case cannot proceed without expert testimony which was necessary to establish that defendants actually caused an injury for purposes of the medical malpractice claim.

First, and contrary to plaintiffs’ contention on appeal, it is disputed whether the fractures occurred during the infant’s stay at the PICU. Plaintiffs rely on the deposition testimony of three adverse witnesses: in addition to Dr. Custer’s testimony, plaintiffs rely on the testimony of Dr. Randall Loder, an orthopedic surgeon at the Medical Center, and Dr. Clyde Owings, the medical director of the Child Protection Team at the Medical Center, both of whom investigated the causes of the fractures at the time the fractures were discovered.

Dr. Loder opined that the fractures were inflicted. He concluded that the bone growth surrounding the fractures indicated that the fracture in the left leg occurred within seven days of the February 11, 1997, x-ray. This would place the injury during the infant’s stay at the PICU. Dr. Loder also concluded that the fracture in the right leg occurred between fourteen to twenty-one days of the February 13, 1997 skeletal survey. This would place the injury’s occurrence on the first day the infant was admitted to the PICU or any time during the preceding week or so.

On the other hand, Dr. Owings concluded that the right leg was not fractured. Instead, he determined that the infant suffered from periosteal stripping in the right leg that can be pathologically caused in fifteen to thirty percent of the cases, and he doubted whether Dr. Loder was professionally capable of diagnosing this disease that was unrelated to the treatment of bones. Importantly, Dr. Owings opined that determining the age of fractures was similar to that of appraising art, and he did not rule out the possibility that the fracture in the left leg could have been caused at the time of the infant’s birth.

Although Dr. Custer did not dispute the existence of the fractures, he never determined when the fractures occurred. Similar to Dr. Owings’ determination, Dr. Custer did not rule out the possibility that the infant already had the fractures when he was admitted to hospital. Dr. Custer, who examined the infant upon admission, explained that he had personally missed diagnosing this specific type of fracture in the physical examination of infants and that a skeletal survey was the method used in such diagnosis. Dr. Loder supported the above testimony by explaining that it was difficult to discover this type of fracture through a physical examination because some infants simply do not cry to notify the examiner of anything that may be wrong. Dr. Owings also explained that the pain reaction of infants is considerably different than that of adults, and bone fractures of this sort were difficult to discover in an infant. Thus, even viewed in the light most favorable to plaintiffs, the testimony upon which they rely does not rule out the possibility that the fractures may have occurred before the infant was admitted to the hospital.

Second, the possibility of a pathological cause for the fractures was never ruled out by the witnesses upon whose testimony plaintiffs rely. While Dr. Custer testified that he could rule out the possibility of brittle bone disease from the record before him at the time of his deposition, he did not render an opinion with respect to any other type of pathological cause for the fractures. Dr. Owings discovered from his physical examination of the infant common forms of osteogenesis imperfecta, or brittle bone disease, but he left the proper diagnosis to the experts in the field. The record indicates that an expert in the field, a Dr. Innis, had examined the infant but it does not appear that he was deposed in this case. Dr. Loder agreed that Dr. Innis' examination of the infant at the time the fractures were discovered revealed no evidence of osteogenesis imperfecta, but he also added that osteogenesis imperfecta constituted a clinical diagnosis requiring the monitoring of the infant's growth. On this record, there is nothing to show that osteogenesis imperfecta or any other pathological cause were medically ruled out.

Third, and contrary to plaintiffs' assertion on appeal, an intentional injury under child abuse was also not ruled out in this case. Both Dr. Custer and Dr. Loder never formulated an opinion whether the fractures were caused as a result of child abuse. On the other hand, Dr. Owings did not find evidence sufficient to make a report for Child Protective Services, but he did not rule out the possibility of child abuse. It must be noted here that Dr. Owings also testified that, out of the hundreds of cases that he had investigated, this was the only one in which he had no record of his investigation. However, because Dr. Owings did not rule out child abuse as a cause for the fractures, plaintiffs' claim that child abuse was ruled out in this case is without merit.

Thus, given that plaintiffs failed to prove that the fractures actually occurred during the infant's stay at the PICU, plaintiffs have failed to show that defendants caused the injuries or that the injuries were of a kind that ordinarily do not occur in the absence of someone's negligence to satisfy the first factor for the doctrine of *res ipsa loquitur*.

Plaintiffs also failed to show that the fractures were caused by an agency or instrumentality within the exclusive control of defendants to satisfy the second factor for the doctrine of *res ipsa loquitur*. Even assuming that the fractures occurred during the infant's stay at the PICU, the proofs established that persons other than medical staff had access to the infant, including his parents, grandmother, and the parent of the child with whom the infant shared a hospital room.

Because the fractures could have occurred before the infant's hospitalization and because plaintiffs had access to the infant during his stay at the PICU, plaintiffs also failed to satisfy the third factor, which provides that the injuries must not have been caused by any voluntary action or contribution on the part of plaintiffs. As to the fourth factor, the results of the Medical Center's extensive medical investigation into the matter, involving experts from at least three different medical fields, was inconclusive. From this record, it cannot be said that the evidence of the true explanation of the event was more readily accessible to defendants than to plaintiffs to satisfy the fourth factor. Therefore, the elements of the doctrine of *res ipsa loquitur* were not met in this case.

Plaintiffs next argue that an expert witness was not required because the alleged negligence was "a matter of common knowledge and observation." Expert testimony may not be required when "the lack of professional care is so manifest that it would be within the common

knowledge and experience of the ordinary layman that the conduct was careless and not conformable to the standards of professional practice and care” *Locke, supra* at 232.

Assuming that the injuries were sustained during the infant’s stay at the PICU, there is nothing whatsoever on this record to indicate that the fractures were caused by the manner in which the infant was handled and maneuvered, as plaintiffs claim. Therefore, any inference of malpractice must derive from the treatment that the infant received. Such treatment included muscle relaxants and strong sedatives, mechanical ventilation and intubation, a feeding tube, and the placement of an arterial line in the femoral vein of the infant’s right leg and a venous catheter inserted in the infant’s left leg. Accordingly, the trial court did not err in finding that the procedures the infant underwent were not within the common knowledge of a reasonably prudent factfinder. Assuming that the fractures may have been caused by the placement of the lines in the infant’s legs, the risks associated with the placement of arterial lines or venous catheters in a newborn infant, and whether fractures ordinarily do not occur in the absence of negligence, are not within common knowledge of a reasonably prudent fact finder.

Plaintiffs’ reliance on the decisions in *Sullivan v Russell*, 417 Mich 398; 338 NW2d 181 (1983), and *Higdon v Carlebach*, 348 Mich 363; 83 NW2d 296 (1957) is misplaced. In those cases, healthy and undiseased parts of the body requiring no treatment were injured. It appears that plaintiffs assume that the fractures were caused by the placement of the arterial line and venous catheter in the infant’s legs. However, the infant’s mother testified that the placements were made because the physicians could not locate the relevant veins in the infant’s head. Plaintiffs do not dispute that such procedure was necessary for treating the life-threatening respiratory disease with which the infant was diagnosed. While the legs may have required no treatment, their use was necessary for the treatment of the diseased parts of the infant’s body. Thus, the trial court properly ruled that the medical practice in this case was not a matter of common knowledge.

/s/ Michael J. Talbot