

STATE OF MICHIGAN
COURT OF APPEALS

GAIL YOUNG,

Plaintiff-Appellee,

v

JAMES J. FAREMOUTH, M.D. and JAMES J.
FAREMOUTH, M.D., P.C.,

Defendants-Appellants.

UNPUBLISHED

July 26, 2007

No. 269730

Macomb Circuit Court

LC No. 04-000819-NH

Before: Davis, P.J., and Hoekstra and Donofrio, JJ.

PER CURIAM.

In this suit for medical malpractice, defendants appeal as of right a judgment awarding plaintiff damages in the amount of \$110,000. We affirm.

I. Basic Facts and Procedural History

This case arises from a total hip arthroplasty performed by defendant James J. Faremouth, M.D., on the right hip of plaintiff Gail Young.¹ It is not disputed that Young's right leg was between one and one and one-half inches longer than her left following the surgery. When this discrepancy failed to correct itself with time, Young filed the instant suit alleging that Faremouth breached the standard of care owed by him as a board-certified orthopedic surgeon by failing to, among other things, inform her of the possibility of a leg length discrepancy before obtaining her consent to the surgery, and "accurately check for leg length discrepancy" both before and during the surgery.

At the subsequent trial of these claims before a jury, Faremouth acknowledged that he took no measurements of Young's leg lengths either before or during the surgery. Both he and his expert witness asserted, however, that the standard of care applicable to a total hip arthroplasty did not require that the surgeon attempt to achieve leg length equality. Rather,

¹ Because the liability of defendant James J. Faremouth, M.D., P.C., is premised solely on a theory of respondeat superior, all subsequent references to "defendant" or "Faremouth" are to defendant James J. Faremouth, M.D. alone.

Faremouth testified, stability of the hip prosthesis is the primary concern of the surgeon. Thus, although a resulting equality of leg lengths was “a plus,” the failure to take either preoperative or intraoperative measurements was not a breach of the standard of care. Faremouth and his expert additionally asserted that defendants had met the standard of care for obtaining informed consent to the surgery by discussing the possibility of a leg length discrepancy with Young before the surgery, as evidenced by documentation in which Young acknowledged having been informed of the risk of such a “complication” by her signature. Defendants supported this testimony with that of registered nurse Karen Buckles, who testified that she witnessed Young sign documentation listing an “undesirable change in the length of the leg” as a possible complication of the surgery after having expressly discussed that matter with Young.

Young acknowledged her signature on the form purportedly presented to her by Buckles, but testified that she did not recall signing the document. Young and her long-time roommate, who attended most of Young’s preoperative meetings with Faremouth and Buckles, further testified that even if Young had signed the document, the possibility of a discrepancy in the lengths of her legs was not highlighted or otherwise expressly discussed with her at anytime before the surgery by either Buckles or Faremouth.

Young also presented the testimony of board-certified orthopedic surgeon George Nichols, M.D., who opined that the standard of care applicable to a total hip arthroplasty required that the surgeon substantively discuss the possibility of a leg length discrepancy with the patient “eyeball to eyeball,” and that the standard of care is not met if the surgeon merely requires that the patient sign a document in which it is stated that there is a possibility of an “undesirable leg length.” Nichols additionally testified that the standard of care requires that the surgeon attempt to achieve equality of leg lengths and avoid a discrepancy. This in turn, Nichols testified, requires preoperative and intraoperative measurement of the patient’s leg lengths.

Following the close of proofs, the jury found Faremouth to have been “professionally negligent in one or more of the ways alleged by [Young],” and returned a verdict awarding her future medical expenses and noneconomic damages. The trial court thereafter denied both an earlier motion by defendants for a directed verdict, and a later motion for judgment notwithstanding the verdict (JNOV) or for a new trial. This appeal followed.

II. Analysis

Defendants alleged that the trial court erred in denying their motion for a directed verdict, which was made by defendants at the close of Young’s proofs but not decided by the court until after the jury had rendered its verdict. Defendants also argue that the court erroneously denied their motion for JNOV or a new trial, in which they raised the same arguments earlier rejected by the trial court in denying their motion for a directed verdict. We disagree.

We review a trial court’s decision regarding a motion for directed verdict de novo, considering the evidence presented in the light most favorable to the nonmoving party to determine whether there existed a material question of fact upon which reasonable minds could differ. *Smith v Foerster-Bolser Constr, Inc*, 269 Mich App 424, 427-428; 711 NW2d 421 (2006). A trial court’s decision regarding a motion for JNOV is also reviewed de novo, and similarly entails consideration of the evidence and all reasonable inferences arising therefrom in the light most favorable to the nonmoving party to determine whether the facts presented

preclude judgment for the nonmoving party as a matter of law. *Merkur Steel Supply, Inc v Detroit*, 261 Mich App 116, 123-124; 680 NW2d 485 (2004). If the evidence is such that reasonable jurors could disagree, neither a directed verdict nor JNOV may properly be granted. *Foreman v Foreman*, 266 Mich App 132, 136; 701 NW2d 167 (2005); *Cacevic v Simplimatic Engineering Co (On Remand)*, 248 Mich App 670, 679-680; 645 NW2d 287 (2001).

A. Informed Consent

Defendants first argue, as they did below, that Nichols made several concessions fatal to Young's theory that Faremouth had violated the standard of care for obtaining informed consent. As support for their argument in this regard, defendants cite Nichols' acknowledgement during his testimony at trial that (1) he had not reviewed any of the informed consent documentation from Faremouth's office before trial, (2) the informational documentation provided to Young by Buckles was more "complete" than that provided by him to his own patients, (3) the reason for documenting informed consent is to have a record of what was discussed with the patient, whose signature on the documentation represents an acknowledgement that the information contained therein was discussed with the patient, (4) a patient's signature on informed consent documentation is a reliable way of determining what was in fact discussed with the patient, and (5) he had not reviewed the deposition testimony of either Young or Buckles and was thus not aware of their testimony regarding any informed consent discussions between the two.

We agree with the trial court, however, that when the evidence presented is viewed as a whole and in a light most favorable to Young, these concessions by Nichols do not amount to an admission by Nichols that "defendants properly obtained an informed consent from plaintiff." Indeed, in addition to the testimony cited by defendants, Nichols expressly testified that the standard of care for obtaining informed consent requires that the possibility of a leg length discrepancy be substantively discussed with the patient "eyeball to eyeball" and "face to face," and is not met by merely burying such information in documentation that the patient is required to sign. Moreover, while Buckles and Faremouth both testified that oral discussion of the possibility of a leg length discrepancy was had with Young on several occasions, Young and her roommate both denied that such possibility was ever expressly brought to Young's attention through face to face discussion. The directly competing nature of this testimony left open the question whether defendants had complied with the standard of care for obtaining informed consent, and precluded a directed verdict or JNOV in favor of defendants. The trial court did not, therefore, err in denying defendants' motions. *Foreman, supra*; *Cacevic, supra*. To the contrary, it was the responsibility of the jury to determine the credibility and weight of the competing evidence. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003).

Defendants further argue, however, that Nichols' acknowledgement that he was not "sure" what the "national standard of care" required with regard to informed consent itself compelled a verdict in their favor. Specifically, defendants argue that the fact that Nichols was unfamiliar with the requirements of the national standard precluded his testimony on the issue of informed consent at trial, without which Young could not prove her claim that the standard had been violated by Faremouth. Because this issue concerns the trial court's ruling regarding Nichols' qualifications as an expert witness, our review is limited to a determining whether the court abused its discretion. *Woodard v Custer*, 476 Mich 545, 557, 719 NW2d 842 (2006) (an appellate court "reviews a trial court's rulings concerning the qualifications of proposed expert

witnesses to testify for an abuse of discretion”). “An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes.” *Id.*

In a medical malpractice action, an expert witness is required to establish the applicable standard of care, *Locke v Pachtman*, 446 Mich 216, 223; 521 NW2d 786 (1994), and the party offering the expert testimony must demonstrate the witness’ knowledge of the applicable standard of care, *Turbin v Graesser (On Remand)*, 214 Mich App 215, 217; 542 NW2d 607 (1995). The relevant standard of care is based on how other physicians in the defendant’s field of medicine would act, rather than on how any particular physician would act. *Carbonell v Bluhm*, 114 Mich App 216, 224; 318 NW2d 659 (1982).

Here, Young argued in response to defendants’ challenge to Nichols’ expert qualifications that, despite the testimonial excerpts relied on by defendants, Nichols’ testimony ultimately showed that he was in fact familiar with the standard of care for obtaining informed consent. In support of this argument, Young pointed to testimony in which Nichols indicated that he became familiar with the standard of care for informed consent through his training, during which he was “instructed that you need to sit down with every patient and explain to them what potentially can happen or could not happen during the surgery” The trial court concluded that this testimony was “sufficient to indicate that [Nichols] has a knowledge of the standard of care” for obtaining informed consent. However, recognizing that Nichols’ testimony in this regard contradicted that relied on by defendants, the trial court found that its function as the “gatekeeper” of evidence required that it also determine whether Nichols’ testimony was ultimately adequate for Young to sustain her burden of establishing his qualification to offer expert testimony on the standard of care for informed consent. The court went on to rule that there “was adequate testimony . . . to establish that [Nichols] had knowledge of the national standard, albeit some contradictory testimony.” We find no abuse of discretion in the trial court’s decision in this regard.

Indeed, when read in its entirety, Nichols’ testimony was sufficient to support his familiarity with the standard of care for obtaining informed consent. *Turbin, supra*. In addition to the testimony cited by defendants, as well as that relied on by the trial court, Nichols testified that “any orthopedic surgeon who is doing any surgery at all—this is what’s hammered into us through our training—needs to discuss the potential complications of any surgery, be it whatever it is, and that is really the standard of care.” He further explained that the standard of care “boils down to” what the average surgeon is supposed to do in order to correctly care for a patient, and that these processes and procedures are not expressly taught to doctors as being the “standard of care,” but rather, simply as what should be done to “deliver the best care” and obtain the results hoped to be achieved in providing that care. That Nichols earlier offered evidence contradictory to his familiarity with this standard of care did not preclude him testifying at trial, but rather was a matter for consideration by the jury in adjudging the credibility and weight to be accorded his testimony. See, e.g., *People v Way*, 303 Mich 303, 306; 6 NW2d 523 (1942) (argument that witness’ “testimony was ‘contradictory and without merit’ goes to the credibility of the witness and the weight to be given his testimony”). Thus, we do not conclude that the trial court abused its discretion in finding Nichols sufficiently familiar with the applicable standard of care to be qualified to testify at trial. *Woodard, supra*.

B. Preoperative and Intraoperative Measurement

Next, defendants argue that the trial court erred in denying their motions for a directed verdict or JNOV regarding Young's theory that Faremouth violated the standard of care for performing a total hip arthroplasty by failing to take preoperative and intraoperative measurements of Young's leg lengths because, during his pretrial deposition, Nichols opined that such measurements are not required by the standard of care, but rather, are merely "recommended." Because the evidence, when viewed as a whole and in the light most favorable to Young does not support defendants' argument, we disagree.

Regarding whether the standard of care requires taking preoperative and intraoperative measurements, the testimony of Nichols and Faremouth was directly contradictory. Nichols testified that such measurements are required by the standard of care in order to achieve, as nearly as possible, leg-length equality. He further testified that intraoperative measurements were usually and customarily made by orthopedic surgeons that perform many hip replacements. Conversely, Faremouth opined that such measurements were not required because although leg-length equality was something he would "like to" achieve, it is not required by the standard of care. In this context, Nichols' acknowledgement of his prior testimony was not dispositive of Young's theory that Faremouth violated the standard of care by failing to take preoperative and intraoperative measurements. To the contrary, the acknowledgement, which was clearly sought for the purpose of impeaching Nichols' trial testimony that such measurements were in fact "required" by the standard of care for performing a total hip arthroplasty, merely affected the weight and force of his testimony on that issue at trial. As previously noted, it is for the jury to decide the weight to be assessed conflicting or contradictory evidence, *Way, supra*, and defendants were not, therefore, entitled to a direct verdict or JNOV on this ground. Rather, it was the province of the jury to decide, in light of Nichols' conflicting testimony, whether the standard of care applicable to performing a total hip arthroplasty required preoperative and intraoperative measurements of the patient's leg lengths. *Id.*; see also *Wiley, supra*. Accordingly, the trial court did not err in denying defendants' motions for a directed verdict and JNOV.

C. Nichols' Qualification under MCL 600.2169(1)(b)(i)

Defendants next argue that Young failed to meet her burden of establishing Nichols' qualifications to offer expert testimony. Noting that to permissibly offer such testimony MCL 600.2169 requires that a majority of the expert's professional time during the preceding year have been spent in "[t]he active clinical practice of the same health profession in which the party against whom . . . the testimony is offered is licensed," see MCL 600.2169(1)(b)(i), defendants assert that Young failed to establish such facts during Nichols' testimony. Thus, defendants argue, Nichols should not have been permitted to offer standard of care testimony, without which Young could not prove her case. The trial court's ruling on this evidentiary question is again reviewed for an abuse of discretion. *Woodard, supra*. We find no such abuse by the trial court. As noted by the trial court in denying defendants' motion for a directed verdict, Nichols testified that he has performed more than 200 hip replacement surgeries each year for the past ten years. The trial court's conclusion that this testimony was sufficient to support that Nichols was qualified under MCL 600.2169(1)(b)(i) as having been engaged in the same active clinical practice as Faremouth during the year preceding Young's operation is within the range of principled outcomes, and thus not an abuse of its discretion.

D. Causation

Finally, defendants assert that Young failed to establish a prima facie case of causation, and that a directed verdict or JNOV on this ground was erroneously denied by the trial court. In particular, defendants argue that Young offered no testimony or other evidence to show that a discrepancy in the lengths of her legs could have been avoided had the measurements discussed by Nichols been taken. We do not agree.

Although raised by defendants in their motions for a directed verdict or JNOV, the trial court did not address the assertion that Young had failed to establish causation, i.e., that Faremouth's failure to take preoperative and intraoperative measurements resulted in the discrepancy between the lengths of her legs. Because the trial court did not address the issue, it has not been properly preserved for appellate review, *Brown v Loveman*, 260 Mich App 576, 599; 680 NW2d 432 (2004), and will be reviewed only for plain error affecting substantial rights, *Kern v Blethen-Coluni*, 240 Mich App 333, 336; 612 NW2d 838 (2000). We find no such error.

As support for their challenge to the establishment of causation, defendants cite Nichols' agreement that Young's hip replacement was well-performed and otherwise properly executed by Faremouth, and that even if full caution is taken and all measurements done, a leg length discrepancy can still occur. In addition to this testimony, however, Nichols expressly testified that that the leg length discrepancy at issue here could have been avoided by preoperative examination and measurement, followed by intraoperative measurement using "some sort of measuring device, be it calipers, be it pins, to assess the leg length discrepancy before putting the final implants in." Such testimony addressing placement of the implant in the context of leg length and resultant leg lengths discrepancy was sufficient to establish the causative element of Young's case. That Nichols also agreed that the surgery was otherwise properly and well performed simply has no bearing on the issue of causation, and thus does not serve to render the trial court's denial of defendants' motions plainly erroneous.

Affirmed.

/s/ Alton T. Davis
/s/ Joel P. Hoekstra
/s/ Pat M. Donofrio