STATE OF MICHIGAN

COURT OF APPEALS

LAWRENCE KWASNIEWSKI III, Personal Representative of the Estate of LAWRENCE KWASNIEWSKI JR., Plaintiff/Cross-Appellee-Appellant,	UNPUBLISHED July 3, 2007
v STEVEN D. HARRINGTON, M.D., and SOUTHEASTERN MICHIGAN CARDIAC SURGEONS, Defendants,	No. 268774 Wayne Circuit Court LC No. 04-401893-NH
and ST. JOHN HOSPITAL AND MEDICAL CENTER, Defendant/Cross-Appellant-Appellee	ON RECONSIDERATION

Before: Borrello, P.J., and Jansen and Cooper, JJ.

PER CURIAM.

Plaintiff appeals by leave granted, and defendant cross-appeals, the trial court's order granting defendant's motion for summary disposition pursuant to MCR 2.116(C)(10).[1] The trial court granted summary disposition, in relevant part, based on the inadequacy of plaintiff's notice of intent (NOI), MCL 600.2912b, as it related to Dr. Colleen App, a general surgery resident at defendant hospital. We affirm.

I. Facts and Procedural History

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[1] Plaintiff's appeal relates only to the trial court's grant of summary disposition as to defendant hospital's vicarious liability for one of its resident physicians, Dr. Colleen App, who was not named as a defendant in plaintiff's lawsuit against defendants. Dr. App's involvement in the care of plaintiff's decedent will be discussed more fully below.

On October 17, 2001, plaintiff's decedent underwent coronary artery bypass graft surgery. Defendant Dr. Steven D. Harrington performed the surgery at defendant hospital. About two hours after the decedent's surgery, immediately after he had been transferred to the intensive care unit, hospital personnel observed massive bleeding from his chest tube and a code was called. Dr. App, a resident in general surgery (and the chief resident in general surgery) at defendant hospital, responded to a page from the ICU. Defendant Dr. Harrington, who was driving home at the time, was contacted by cell phone. Apparently pursuant to Dr. Harrington's direction, Dr. App opened the decedent's chest and attempted to stop the bleeding, but without success. Dr. Harrington returned to the hospital, located the site of the bleeding, and surgically repaired it. The decedent was pronounced dead that day due to bleeding from the surgery site and aortic rupture.

Plaintiff filed his first NOI on September 4, 2002, and then filed an amended NOI on January 8, 2004. On January 22, 2004, plaintiff filed a wrongful death action against defendants. Plaintiff attached to his complaint the affidavit of Don Patrick, M.D., who was board certified in both surgery and thoracic surgery.

Defendant moved for summary disposition under MCR 2.116(C)(8) and (10), arguing that summary disposition should be granted as to all individual defendants other than Dr. Harrington. Regarding Dr. App, defendant argued that plaintiff did not have a viable claim against Dr. App because neither the NOI nor the affidavit of merit identified a claim based on her conduct. Defendant also claimed that because plaintiff's affidavit of merit was signed by Dr. Patrick, who defendant contended was a specialist in cardio thoracic surgery, plaintiff failed to satisfy MCL 600.2169 because Dr. Patrick was not qualified to address the standard of care for Dr. App, who was a resident in general surgery. The trial court granted defendant's motion for summary disposition. In granting the motion with respect to defendant hospital's vicarious liability for the conduct of Dr. App, the trial court stated:

> In the present case, because Plaintiff's NOI is silent with regard to any breach of the standard of care related to treating Plaintiff's decedent's post-operative hemorrhaging, the Plaintiff failed to minimally allege that Dr. App, as an agent of Defendant St. John Hospital, was at fault. Because the Court finds that the NOI failed to identify a claim based on Dr. App's conduct, it need not address Defendant's allegations that the Affidavit of Merit was deficient.

Plaintiff moved for reconsideration of the trial court's rulings related to Dr. App. The trial court denied plaintiff's motion, ruling:

> Throughout his pleadings, Plaintiff states that the standard of care applicable to Dr. App required her to (1) open Plaintiff's decedent's chest; (2) identify the source of bleeding; and (3) place her finger on the site of the bleeding to control it. Per Roberts II [*Roberts v Mecosta Co Gen Hosp (After Remand)*, 470 Mich 679, 686; 684 NW2d 711 (2004)], Plaintiff was not required to state such a detailed standard of care in his NOI. However, Plaintiff was required to state a standard of care and alleged breach sufficient to put St. John Hospital on notice as to Plaintiff's claim that its agent, Dr. App, had failed to properly treat the decedent's hemorrhage. Plaintiff's NOI does not state a standard of care that

even approximates "(1) open Plaintiff's decedent's chest; (2) identify the source of bleeding; and (3) place her finger on the site of the bleeding to control it."

II. Standard of Review

This Court's review of a trial court's grant of summary disposition pursuant to MCR 2.116(C)(10) is as follows:

> This Court reviews de novo a trial court's grant or denial of summary disposition under MCR 2.116(C)(10). *Spiek v Dep't of Transportation*, 456 Mich 331, 337; 572 NW2d 201 (1998). A motion brought under MCR 2.116(C)(10) tests the factual support for a claim. *Downey v Charlevoix Co Rd Comm'rs*, 227 Mich App 621, 625; 576 NW2d 712 (1998). The pleadings, affidavits, depositions, admissions, and any other documentary evidence submitted by the parties must be considered by the court when ruling on a motion brought under MCR 2.116(C)(10). *Downey*, *supra* at 626; MCR 2.116(G)(5). When reviewing a decision on a motion for summary disposition under MCR 2.116(C)(10), this Court "must consider the documentary evidence presented to the trial court 'in the light most favorable to the nonmoving party.'" *DeBrow v Century 21 Great Lakes, Inc (After Remand)*, 463 Mich 534, 539; 620 NW2d 836 (2001), quoting *Harts v Farmers Ins Exchange*, 461 Mich 1, 5; 597 NW2d 47 (1999). A trial court has properly granted a motion for summary disposition under MCR 2.116(C)(10) "if the affidavits or other documentary evidence show that there is no genuine issue in respect to any material fact, and the moving party is entitled to judgment as a matter of law." *Quinto v Cross & Peters Co*, 451 Mich 358, 362; 547 NW2d 314 (1996). [*Clerc v Chippewa Co War Memorial Hosp*, 267 Mich App 597, 601; 705 NW2d 703 (2005).]

III. Analysis

A. MCL 600.2912b(4)

Plaintiff argues that the trial court erred in granting defendant's motion for summary disposition based on the failure of plaintiff's NOIs to comply with MCL 600.2912b(4), as it related to Dr. App.

MCL 600.2912b(1) provides that a medical malpractice plaintiff is precluded from commencing suit against a health professional or health facility unless the plaintiff provides "written notice" to the health professional or health facility before the action is commenced. The "written notice," or NOI, must specify the factual and legal bases for the plaintiff's claim. MCL 600.2912b(4). Under MCL 600.2912b(4), a NOI must contain the following information:

> (a) The factual basis for the claim.
>
> (b) The applicable standard of practice or care alleged by the claimant.

(c) The manner in which it is claimed that the applicable standard of practice or care was breached by the health professional or health facility.

(d) The alleged action that should have been taken to achieve compliance with the alleged standard of practice or care.

(e) The manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice.

(f) The names of all health professionals and health facilities the claimant is notifying under this section in relation to the claim.

The plaintiff has the burden of complying with MCL 600.2912b. *Roberts*, *supra* at 691. The purpose of the NOI is to "set forth [the information sought by MCL 600.2912b(4)] with that degree of specificity which will put the potential defendants on notice as to the nature of the claim against them." *Id.* at 701. A plaintiff is "required to make a good-faith averment of *some* particularized standard for each of the professionals and facilities named in the notices." *Id.* at 694 (emphasis in original). However, as our Supreme Court explained in *Roberts*, the level of specificity of a NOI must be considered in light of the fact that discovery has not yet begun:

> [W]e acknowledge that the notice of intent is provided at the earliest stage of a medical malpractice proceeding. Indeed, the notice must be provided before the action can even be commenced. At the notice stage, discovery as contemplated in our court rules, MCR 2.300 *et seq*., has not been commenced, and it is likely that the claimant has not yet been provided access to the records of the professional or facility named in the notice. It is therefore reasonably anticipatable that plaintiff's averments as to the applicable standard may prove to be "inaccurate" or erroneous following formal discovery; moreover, it is probable that the alleged standard of care will be disputed by the defendants. In light of these circumstances, the claimant is not required to craft her notice with omniscience. . . . [*Id.* at 691 (footnotes omitted).]

Recently, this Court opined that "the specificity required of a notice of intent as it addresses each of the subsections under MCL 600.2912b is indistinguishable from the specificity required of a medical malpractice complaint." *Boodt v Borgess Medical Ctr*, 272 Mich App 621, 626-627; 728 NW2d 471 (2006). "Medical malpractice claims must be pleaded so as to "'advise the defendant with reasonable certainty, according to the circumstances of the case, of the facts upon which plaintiff proposes to rely, and will seek to prove . . . .'"" *Id.* at 626 (citations omitted). "The important principle is that a defendant must not be forced 'to guess upon what grounds plaintiff believes recovery is justified,' but at the same time plaintiffs should not be subject to the 'straitjacket' of '[e]xtreme formalism . . . .'" *Id.* at 627 (citations omitted).

Plaintiff's first NOI provided notice to St. John Hospital, St. John Hospital and Medical Center, George Haddad, M.D., Steven D. Harrington, M.D., Southeastern Michigan Cardiac Surgeons, and "any employees or agents, actual or ostensible, thereof, who were involved in the treatment of [plaintiff's decedent.]" The NOI asserted that the named individuals, hospitals, and corporate entities and their agents breached the following standards of care:

a. Obtain proper informed consent, including a thorough and complete explanation of all aspects of the surgery, as well as an explanation of all risks and alternative forms of therapy (including the risk of aortic rupture, the risk of bleeding/exsanguination from the cannula site, and the risk of death), prior to receiving and accepting the patient's consent to such a major surgery;

b. Properly decannulate the aorta so as to not cause an aortic tear, laceration, or rupture;

c. Properly close and suture the cannulation site of the aorta;

d. Properly inspect and observe the aortic cannulation site for any signs of tear, laceration, rupture, or insufficient closure/suture, prior to closing the chest;

e. Properly control the patient's blood pressure post-operatively with medications so as not to cause an aortic tear, laceration, or rupture at the cannulation site;

f. Refrain from over anti-coagulating the patient so as to prevent a significant bleed from the aortic cannulation site;

g. Properly monitor the patient post-operatively, including observing all vital signs and output from the chest tube, so as to timely recognize and diagnose a suspected aortic tear, laceration, or rupture;

h. Timely recognize and respond to patient's vital signs consisted [sic] with a suspected aortic tear, laceration, or rupture so that same could be corrected in order to prevent a premature and wrongful death;

i. Staff the ICU with sufficient number of qualified physicians, residents, PA's, nurses, and other medical staff, to enable a timely and appropriate response to a serious medical emergency such as an aortic tear, laceration or rupture.

Plaintiff's amended NOI, which provided notice to the same individuals, hospitals, and corporate entities as the original NOI, except for Dr. Haddad, included the aforementioned standards of care (although most were relettered), with the exception of items b, c, and f, and also added the following standards:

g. Refrain from leaving the hospital prior to the completion of surgery and the stabilization of the patient in the ICU to ensure that the coronary artery bypass graft X 5 has been adequately performed and that the patient has been properly cared for in the post-operative period;

h. Properly monitor and control the patient's blood Pressure pre, during and post operatively;

i. Properly provide coagulating agents following Application of Heparin after a CABG X 5[.]

In concluding that plaintiff's NOI was insufficient, the trial court did not specifically articulate on what basis or bases under MCL 600.2912b(4) plaintiff's NOI and amended NOI were not adequate. According to the trial court's statements in its order and opinion granting defendant's motion for summary disposition and its order denying plaintiff's motion for reconsideration, the NOI was silent regarding any breach of the standard of care related to treating the decedent's post-operative care, the NOI failed to identify a claim based on Dr. App's conduct, the NOI failed to set forth specific allegations to put defendant hospital on notice that plaintiff's medical malpractice lawsuit against defendant hospital was based, in part, on Dr. App's actions, and the NOI did not articulate what actions Dr. App should have done to comply with the standard of care. Based on the trial court's statements, we conclude that the trial court found plaintiff's NOI insufficient under MCL 600.2912b(4)(b), (c) and (d).

The fact that the neither of plaintiff's NOIs specifically named Dr. App did not render it noncompliant with MCL 600.2912b(4) because plaintiff's theory was that defendants were vicariously liable for the conduct of Dr. App, and plaintiff did not bring an action against Dr. App directly. Compare *Rheaume v Vandenberg*, 232 Mich App 417, 423-424; 591 NW2d 331 (1998) (holding that the plaintiff's NOI failed to comply with MCL 600.2912b(4)(f) when it did not specifically name a defendant in the case). Moreover, even though the NOIs did not explicitly identify or name Dr. App, they both clearly stated that the notice was intended to apply, in addition to the specifically named individuals, hospitals, and corporate entities, to "any employees or agents, actual or ostensible, thereof, who were involved in the treatment of the [plaintiff's decedent.]" This language sufficiently put defendant hospital on notice that plaintiff intended to proceed against it on a theory of vicarious liability based on the conduct of the hospital's staff or employees. The NOIs also both contained language indicating that after ICU staff noted plaintiff's decedent's hypotensive state and significant blood output from the chest tube, "two CTA's [sic] and the surgical resident staff on call participated in opening the chest." Presumably, the surgical resident on staff referred to Dr. App. This language, coupled with the above language, was sufficient to put defendant hospital on notice that plaintiff intended to proceed against it based on a theory of vicarious liability based on the conduct of its staff or employees, which included Dr. App.

Nevertheless, we hold that the trial court did not err in holding that plaintiff's NOIs did not comply with MCL 600.2912b(4). The NOIs complied with MCL 600.2912b(4) to the extent that they generally alleged in total how the standards of care were breached. However, in *Roberts*, our Supreme Court held that under MCL 600.2912b(4)(b), a plaintiff in a medical malpractice case must "make a good-faith effort to aver the specific standard of care that she *is claiming* to be applicable to each professional or facility that is named in the notice." *Roberts*, *supra* at 692 (emphasis in original). According to *Roberts*, if there is more than one defendant in a medical malpractice case, the NOI must contain a standard of care for each defendant ("Here, several different medical caregivers were alleged to have engaged in medical malpractice. Yet, rather than stating an alleged standard of practice or care for each of the various defendants—a hospital, a professional corporation, an obstetrician, a physician's assistant, and an emergency room physician—plaintiff's notices of intent allege an identical statement applicable to all defendants . . . ." *Id.*).

In this case, defendants were Dr. Harrington, a cardio thoracic surgeon, a professional corporation, and a hospital. Dr. App was a resident general surgeon. The standards of care for these individuals and entities are not the same. Yet the NOIs did not identify the standard of care specifically applicable to Dr. App. Furthermore, the statement in the NOI regarding the breach of the applicable standards of care merely stated that "[t]he above-described individuals, entities, and agents thereof, failed to do all those measures outlined in the above section . . . ." Thus, like the NOI in *Roberts*, the NOIs lumped the duties of all the defendants together and failed to specify which actions Dr. App was required to take in order to satisfy the standard of care that applied to her. Because the NOIs failed to indicate the specific standard of care applicable to Dr. App and failed to specifically articulate which actions should have been taken by Dr. App, we find that the trial court did not err in concluding that plaintiff's NOIs did not comply with MCL 600.2912b(4)(b), (c), and (d).

B. MCL 600.2169

Defendant argues that the trial court properly granted summary disposition because plaintiff's affidavit of merit failed to comply with MCL 600.2169.

In a medical malpractice action, the plaintiff's expert's qualifications must match the qualifications of the defendant. MCL 600.2169(1); *Decker v Flood*, 248 Mich App 75, 85; 638 NW2d 163 (2001). MCL 600.2169 provides, in relevant part:

> (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:
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> (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.
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> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
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> (*i*) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (*ii*) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

> (c) If the party against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
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> (*i*) Active clinical practice as a general practitioner.
>
> (*ii*) Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed.

In *Woodard v Custer*, 476 Mich 545; 719 NW2d 842 (2006), our Supreme Court broadly interpreted the term "specialist" in MCL 600.2169. According to *Woodard*'s definition of a "specialist," any physician who can potentially become board certified in a branch of medicine or surgery is a "specialist," and a physician does not have to be board certified to be a "specialist." *Id.* at 561. Recently, this Court ruled that *Woodard*'s broad definition of a "specialist" encompasses a resident physician. *Gonzalez v St. John Hosp & Med* Center, __ Mich App __; __ NW2d __ (Docket No. 272093, issued April 19, 2007), slip op at 5 ("[W]e read *Woodard* as overruling that portion of *Bahr* [*v Harper-Grace Hosps*, 198 Mich App 31; 497 NW2d 526 (1993), rev'd 448 Mich 135 (1995)] . . . that holds "residents are not 'specialists,'" and hold that those physicians who are residents that limit their training to a particular branch of medicine or surgery and who can potentially become board certified in that specialty are specialists for purposes of analysis under the framework provided in MCL 600.2169(1).").

The American Board of Medical Specialties offers board certification for general surgery. Defendant Dr. App, who was a resident physician in general surgery, could potentially become board certified in general surgery, and she is therefore is a "specialist" as that term is used in MCL 600.2169. *Id.* Because Dr. App is a specialist under MCL 600.2169(1), MCL 600.2169(1)(a) applies. Under MCL 600.2169(1)(a), "if a defendant physician is a specialist, the plaintiff's expert witness must have specialized in the same specialty as the defendant physician at the time of the alleged malpractice." *Woodard*, *supra* at 560-561. According to our Supreme Court in *Woodard*, "the plaintiff's expert witness must match the one most relevant standard of practice or care—the specialty engaged in by the defendant physician during the course of the alleged malpractice . . . ." *Id.* at 560. The question, therefore, is what specialty Dr. App was engaged in during the course of the alleged malpractice. Although as a resident in general surgery, Dr. App was a specialist in general surgery, *Rodriguez*, *supra*, slip op at 5, Dr. App was acting as a thoracic surgeon at the time of the alleged malpractice. At the time of the alleged malpractice, plaintiff's decedent was bleeding from his chest tube following coronary bypass graft surgery. Dr. App's care of plaintiff's decedent consisted of opening the decedent's chest and attempting to stop the bleeding in his chest. The website for the American Board of Medical Specialties provides that "[a] thoracic surgeon provides the operative, perioperative and critical care of patients with pathology conditions within the chest. Included is the surgical care of coronary artery disease . . . ." Therefore, we conclude that Dr. App was practicing outside her area of specialty and was engaged in the specialty of thoracic surgery while she was treating plaintiff's decedent.

This Court recently applied *Woodard* to a situation in which the defendant was a specialist but was practicing outside his area of specialty. In *Reeves v Carson City Hosp*, __ Mich App __ ; __ NW2d __ (Docket No. 266469; issued March 8, 2007), the defendant physician was board certified in family medicine but was practicing in emergency medicine. *Id.*, slip op at 4. The plaintiffs' expert witness was board certified in emergency medicine, but not in family medicine. *Id.*, slip op at 1. We determined that "[b]ecause 'the specialty engaged in by the defendant physician during the course of the alleged malpractice' was emergency medicine, it is the 'one most relevant standard of practice or care.'" *Id.*, slip op at 4. We further held that although the defendant doctor was not board certified in emergency medicine, she could potentially become board certified in emergency medicine, and therefore, under *Woodard*, she was a specialist in emergency medicine. *Id.* Therefore, we held that the plaintiffs' expert must be a specialist in emergency medicine and that the expert must have devoted a majority of his practice during the preceding year to the active clinical practice of emergency medicine or the instruction of students. *Id.*, slip op at 4-5.

Similarly, in the instant case, Dr. App was a specialist in general surgery, but was practicing as a thoracic surgeon at the time of the alleged malpractice. Although Dr. App was not board certified as a thoracic surgeon, the American Board of Medical Specialties offers board certification in thoracic surgery, and therefore, Dr. App could potentially become board certified in thoracic surgery. Under *Woodard*, then, Dr. App was acting as a specialist in thoracic surgery at the time of the alleged malpractice. *Woodard*, *supra* at 561. Therefore, plaintiff's expert, Dr. Patrick, was required to be a specialist in thoracic surgery and to have devoted a majority of his practice during the year preceding to the active clinical practice of thoracic surgery or the instruction of students. The websites for the American Board of Medical Specialties[2] and the American Medical Association[3] (AMA) indicate that Dr. Patrick is board certified in both surgery and thoracic surgery, and the AMA's website indicates that Dr. Patrick's specialty is thoracic surgery. Therefore, Dr. Patrick, as a board certified thoracic surgeon, would satisfy MCL 600.2169(1)(a). Furthermore, Dr. Patrick's deposition testimony established that in 2001, Dr. Patrick practiced medicine as a cardio thoracic surgeon and also performed some peripheral vascular repair and some thoracic surgery. Therefore, we conclude that Dr. Patrick devoted the majority of his practice in the year preceding defendants' alleged negligence to the active clinical practice of thoracic surgery.

In sum, because Dr. App was practicing as a thoracic surgeon at the time of the alleged malpractice and could potentially become board certified in thoracic surgery, she was a "specialist" in thoracic surgery according to the definition of "specialist" in *Woodard*. Therefore, plaintiff's expert must also be a specialist in thoracic surgery. Dr. Patrick, as a board certified thoracic surgeon, would satisfy this requirement.[4] Furthermore, because Dr. Patrick

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[2] The American Board of Medical Specialties is the primary standard-setting organization for medical doctors. The address for the website is: http://www.abms.org/.

[3] The address for the American Medical Association's website is http://www.ama-assn.org/.

[4] We observe that because Dr. App was not a board certified thoracic surgeon, Dr. Patrick was not *required* to be board certified in thoracic surgery. MCL 600.2169(1)(a); *Woodard*, *supra* at

(continued…)

devoted a majority of his practice during the preceding year to the active clinical practice of cardio thoracic surgery, MCL 600.2169(1)(b) is satisfied. Therefore, we conclude that, contrary to defendant's argument, plaintiff's expert witness satisfied MCL 600.2169.

IV. Conclusion

In sum, we hold that the trial court did not err in concluding that plaintiff's NOIs failed to comply with MCL 600.2912b(4). We also hold that plaintiff's affidavit of merit complied with MCL 600.2169.

Affirmed.

/s/ Stephen L. Borrello
/s/ Kathleen Jansen
/s/ Jessica R. Cooper

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