

# 6

## Health Care Malpractice

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- I. Overview §6.1
- II. Scope of the Cause of Action for Health Care Malpractice
  - A. Theories of Liability
    - 1. In General §6.2
    - 2. Negligent Treatment
      - a. Direct Liability §6.3
      - b. Vicarious Liability of Physicians §6.4
      - c. Vicarious Liability of Hospitals §6.5
    - 3. Failure to Diagnose/Loss of Opportunity to Survive §6.6
    - 4. Wrongful Birth §6.7
  - B. Intervening Negligence §6.8
  - C. Parties
    - 1. Potential Plaintiffs §6.9
    - 2. Special Considerations with Fetuses §6.10
    - 3. Potential Defendants §6.11
- III. Presuit Considerations
  - A. Investigation §6.12
  - B. Arbitration
    - 1. When Arbitration Is Presently Available §6.13
    - 2. Minimum Requirements for Arbitration §6.14
    - 3. Procedures and Discovery Issues §6.15
    - 4. The Arbitrator's Duties §6.16
  - C. Statute of Limitations
    - 1. General Rule §6.17
    - 2. Exceptions
      - a. Disability §6.18
      - b. Discovery Rule
        - i. In General §6.19
        - ii. When the Malpractice Becomes Known §6.20
        - iii. When the Plaintiff Should Have Discovered the Claim

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- (1) The Reasonable Person Test §6.21
    - (2) When the Discovery Period Begins to Run §6.22
    - (3) Issue for the Jury or for the Court §6.23
  - c. Limitation of the Discovery Rule §6.24
  - 3. Minors §6.25
  - 4. Wrongful Death Actions §6.26
- D. Governmental Immunity §6.27
- E. Expert Consultation
  - 1. In General §6.28
  - 2. Discovery of Opinions of Nontestifying Experts §6.29
- F. Notice Requirement
  - 1. In General §6.30
  - 2. Exceptions to the 182-Day Notice Rule §6.31
  - 3. Requirements for Notice
    - a. Content §6.32
    - b. Mailing §6.33
  - 4. Tolling of the Statute of Limitations §6.34
  - 5. Special Discovery Rules Under the 56-Day Requirement §6.35
  - 6. Written Response from the Health Care Professional or Facility §6.36
  - 7. When May a Complaint Be Filed? §6.37
- IV. Pleading Requirements
  - A. Affidavit of Merit
    - 1. In General §6.38
    - 2. Time Requirements §6.39
    - 3. Affiant's Qualifications §6.40
    - 4. Signature and Authentication Requirements §6.41
  - B. Complaint
    - 1. Requirement of Specificity §6.42
    - 2. Venue §6.43
  - C. Special Requirements: Minors and Wrongful Death Cases §6.44
  - D. Answer
    - 1. Affidavit of Noninvolvement §6.45
    - 2. Affidavit of Meritorious Defense §6.46
  - E. Affirmative Defenses §6.47
- V. Discovery Issues
  - A. Records and Translation of Handwritten Records §6.48
  - B. Hospital Documents
    - 1. In General §6.49
    - 2. Rules, Regulations, Protocols, and Bylaws §6.50
    - 3. Committee Reports and Proceedings and Incident Reports §6.51
  - C. Information on Other Patients §6.52
  - D. Insurance Coverage §6.53
  - E. Former Agents of a Party §6.54
  - F. The Physician-Patient Privilege and Ex Parte Communications with Treating Physicians §6.55

- G. Sample Interrogatories §6.56
  - VI. Evidentiary Issues
    - A. Expert Evidence on the Standard of Care
      - 1. The Need for Expert Evidence §6.57
      - 2. Expert Qualifications
        - a. In General §6.58
        - b. Discovery of Expert Qualifications §6.59
      - 3. National Versus Local Standards §6.60
      - 4. Permissible and Impermissible Opinions §6.61
    - B. Proof of Causation §6.62
    - C. Proof of Knowledge §6.63
    - D. Expressions of Sympathy §6.64
  - VII. Limits on Liability
    - A. Joint and Several Liability §6.65
    - B. Indemnification §6.66
    - C. Caps on Noneconomic Losses §6.67
    - D. The Good Samaritan Statute §6.68
    - E. Comparative Negligence §6.69
    - F. Nonemergency Health Care Provided Without Compensation §6.70
  - VIII. Case Evaluation and Settlement
    - A. Case Evaluation
      - 1. In General §6.71
      - 2. Composition and Selection of Panels §6.72
    - B. Settlement Considerations
      - 1. In General §6.73
      - 2. Physician's Insurance Coverage §6.74
      - 3. Filing Requirements for Settlement Agreements §6.75
  - IX. Jury Instructions §6.76
- Forms
- 6.1 Notice of Intent to Sue (Medical Malpractice)
  - 6.2 Plaintiff's Affidavit of Merit (Medical Malpractice)
  - 6.3 Complaint for Medical Malpractice
  - 6.4 Affidavit of Noninvolvement (Medical Malpractice Action)
  - 6.5 Affidavit of Meritorious Defense (Medical Malpractice Action)
  - 6.6 Interrogatories to Defendant Doctor (Medical Malpractice)
  - 6.7 Sample Interrogatories to Defendant Doctor's Professional Corporation (Medical Malpractice)
  - 6.8 Sample Interrogatories to Defendant Hospital (Obstetrical Medical Malpractice)

## I. Overview

**§6.1** Medical malpractice is a subspecialty of tort law that analyzes the professional conduct of licensed health care practitioners and facilities. The phrase *licensed health care providers* includes the following occupations: chiropractic, dentistry, medicine, nursing, optometry, osteopathic medicine, pharmacy, physical

therapy, podiatry, and psychology. MCL 333.16101 et seq.; *see also* MCL 600.5838a(1)(b).

To prevail in a malpractice action against any of these professionals, the plaintiff must prove the elements of duty, breach, causation, and damages. *Weymers v Khera*, 454 Mich 639, 563 NW2d 647 (1997). The malpractice of the professional is the professional's deviation from the standard of care that would be followed by a reasonably prudent professional of similar training under the same or similar circumstances. There must be a provider-patient relationship established for liability to attach. *Weaver v University of Michigan Bd of Regents*, 201 Mich App 239, 506 NW2d 264 (1993); *Rogers v Horvath*, 65 Mich App 644, 237 NW2d 595 (1975).

In October 1993, the Michigan legislature passed an expansive piece of legislation that substantially altered Michigan law regarding health care malpractice claims. The legislature added provisions providing for a written notice of intent to file suit, a waiver of the doctor-patient privilege, and a filing requirement for settlement agreements. The legislature also repealed, in total, Michigan's Medical Malpractice Arbitration Act (MMAA), MCL 600.5040 et seq., and replaced it with all new provisions. In addition, significant changes were made that affected statutory provisions concerning the limitation period, a mandatory notice of intent, affidavits of meritorious claim and defense, burden of proof, and caps on noneconomic damages.

A two-year statute of limitations applies to actions for health care malpractice. MCL 600.5838a; *see also* MCL 600.5805(5). This period is measured from the date of the act or omission that is the basis for the malpractice action. MCL 600.5838a. There are special rules providing exceptions for persons under disabilities, MCL 600.5851–.5855; minors, MCL 600.5851(7), (8); and plaintiffs who later discover or should have discovered the claim, MCL 600.5838a(2). However, there is a six-year statute of repose beyond which claims may not be brought at all, except in very narrowly defined circumstances. *Id.*

A plaintiff who intends to bring a health care malpractice action must give written notice of his or her intent to file a claim 182 days before commencing the action. MCL 600.2912b(1). This period may be shortened in some situations specified in MCL 600.2912b. The contents of the notice must follow the requirements of MCL 600.2912b(4).

When the plaintiff files his or her complaint, it must be accompanied by an affidavit of merit that is signed by an expert who is reasonably believed to meet statutorily specified qualifications. MCL 600.2169, .2912d(1). The complaint must allege every fact necessary to constitute a cause of action. *Simonelli v Cassidy*, 336 Mich 635, 59 NW2d 28 (1953).

At trial, expert testimony is generally required to establish the standard of care and the defendant's breach of that standard. *Lince v Monson*, 363 Mich 135, 108 NW2d 845 (1961). The statutory requirements for the expert to qualify as an expert witness and for admissibility of the testimony itself must be adhered to carefully, *see* MCL 600.2169, .2955, because in most cases, the plaintiff will not be able to prove his or her case without this testimony. The plaintiff must also prove the causal link between the defendant's alleged negligence and the injury to a rea-

sonable degree of medical certainty. Causation may not be left to speculation or conjecture. *Serafin v Peoples Cmty Hosp Auth*, 67 Mich App 560, 242 NW2d 438 (1976).

As modern medicine becomes more complex, so does medical malpractice law. A thorough understanding of the medicine and medical procedures involved in each case is essential to properly identify any deviations in the standard of care by the individuals involved in the treatment of the patient and to determine the causal relationship between the deviations and any damages suffered. This area of the law has unique characteristics due to its distinct liability issues, the legal relationships between medical providers, and the special provisions of the tort reform act.

## II. Scope of the Cause of Action for Health Care Malpractice

### A. Theories of Liability

#### 1. In General

§6.2 Although handling a health care malpractice action requires education concerning complex modern health care procedures, a health care malpractice action is basically a negligence suit. The same four elements that apply to all ordinary negligence cases apply to health care malpractice actions. *Malik v William Beaumont Hosp*, 168 Mich App 159, 168, 423 NW2d 920 (1988). A plaintiff must prove (1) a duty the defendant owed to the plaintiff, (2) a breach of that duty, (3) proximate cause, and (4) damages. *Moning v Alfonso*, 400 Mich 425, 437, 254 NW2d 759 (1977); accord *Weymers v Khera*, 454 Mich 639, 563 NW2d 647 (1997). To establish proximate cause, the plaintiff must prove the existence of both cause in fact and legal cause. *Skinner v Square D Co*, 445 Mich 153, 516 NW2d 475 (1994).

The applicable duty owed to the plaintiff and the breach of that duty are the factors that distinguish a malpractice case from other negligence actions. In malpractice cases, the general duty of reasonable care the health care provider owes arises from the provider-patient relationship. *Rogers v Horvath*, 65 Mich App 644, 646–647, 237 NW2d 595 (1975). The specific factual elements of that duty are a matter of proof. Malpractice is defined as the deviation from the standard of care or the failure to act as a reasonably prudent physician or medical professional of similar training would have acted under the same or similar circumstances.

#### *Provider-patient relationship requirement:*

The consolidated cases of *Dorris v Detroit Osteopathic Hosp Corp* and *Gregory v Heritage Hosp*, 460 Mich 26, 594 NW2d 455 (1999), illustrate the distinguishing factor of the provider-patient relationship. In *Gregory*, plaintiff was attacked by a psychiatric patient while she was a patient at defendant hospital. Plaintiff filed an ordinary negligence claim against defendant, alleging that defendant did not have sufficient staff to monitor its patients and should not have allowed patients with violent propensities to roam around the hospital and enter patients' rooms. The Michigan Supreme Court held that the trial court had erred in concluding that the correct theory was ordinary negligence because the ordinary layperson does not know the type of supervision or monitoring that is required for

psychiatric patients in a psychiatric ward. Similarly, the court held in *Dorris* that an assault claim against hospital employees administering a drug despite a patient's refusal falls under the medical malpractice act requiring plaintiff to provide a notice of intent to sue and affidavit of merit.

Where there is no provider-patient relationship, the plaintiff has no cause of action for malpractice. *See, e.g., Kuznar v Raksha Corp*, 481 Mich 169, 750 NW2d 121 (2008) (neither pharmacy nor its employee qualified as licensed health care professional or licensed health facility; therefore, alleged negligent acts of defendants did not occur in course of professional relationship with plaintiff). In *Weaver v University of Michigan Bd of Regents*, 201 Mich App 239, 506 NW2d 264 (1993), the Michigan Court of Appeals held that no provider-patient relationship is established when a caller makes a telephone call merely to schedule an appointment with a medical services provider, has no ongoing provider-patient relationship, and does not seek or obtain medical advice during the conversation. *See also Oja v Kin*, 229 Mich App 184, 581 NW2d 739 (1998) (no provider-patient relationship where defendant on-call physician told resident on duty that he was ill and that plaintiff's decedent should contact another physician); *NBD Bank, NA v Barry*, 223 Mich App 370, 566 NW2d 47 (1997) (no provider-patient relationship between patient and physician with whom plaintiff's doctor consulted); *Hill v Kokosky*, 186 Mich App 300, 302-304, 463 NW2d 265 (1990) (same).

In *Dyer v Trachtman*, 470 Mich 45, 679 NW2d 311 (2004), the supreme court held that a plaintiff who is injured during an independent medical examination (IME) has a cause of action in medical malpractice. The court concluded that an IME physician has a limited physician-patient relationship with the examinee that gives rise to limited duties to exercise professional care. This limited relationship does not involve the full panoply of the physician's typical responsibilities to diagnose and treat the examinee for medical conditions. It imposes a duty on the IME physician to perform the examination in a manner not to cause physical harm to the examinee. The court also held that to the extent that *Rogers* and its progeny are inconsistent, they are overruled.

Note that in *Bureau of Health Professions v Serven*, 303 Mich App 305, 842 NW2d 561 (2013), the court held that a chiropractor who performed an independent chiropractor examination (ICE) at the request of State Farm had a duty only to State Farm (which he fulfilled by performing the ICE) and that he owed no additional duty of care to the patient beyond the limited duty outlined in *Dyer*.

#### *Claims sounding in ordinary negligence:*

In *Bryant v Oakpointe Villa Nursing Ctr, Inc*, 471 Mich 411, 684 NW2d 864 (2004), plaintiff's aunt died from positional asphyxiation while in defendant's care, and plaintiff claimed that defendant nursing home was negligent by, inter alia, (1) failing to train its certified evaluated nursing assistants (CENAs) to recognize and counter the risk of positional asphyxiation posed by bed rails, (2) failing to take adequate corrective measures after finding plaintiff's aunt entangled in her bedding on the day before her asphyxiation, and (3) failing to inspect plaintiff's bed arrangements to eliminate the risk of positional asphyxia. The supreme

court held that the first and second claims required expert testimony and therefore sounded in medical malpractice, but that the third claim sounded in ordinary negligence. The court also held that because of the confusion over the nature of plaintiff's claims, the medical malpractice claims were not time-barred.

In *Kuznar*, where plaintiff filed suit against a pharmacy and an unlicensed pharmacy employee for refilling a prescription with eight times the prescribed dosage, the supreme court held that plaintiffs' claims sounded in ordinary negligence, not medical malpractice. Neither the pharmacy nor its employee qualified as a licensed health care professional or a licensed health facility; therefore, the alleged negligent acts of defendants did not occur in the course of a professional relationship with plaintiff.

A hospital has no duty to inform a patient about the possible financial ramifications of a medical decision (in this case, to receive outpatient treatment rather than to remain in the hospital). In *Johnson v Botsford Gen Hosp*, 278 Mich App 146, 748 NW2d 907 (2008), decedent did not want to stay in the hospital, did not want to delay his discharge, and did not want to receive any bill for any medical procedures. Without evidence that the hospital actually misinformed decedent about his health insurance coverage and the financial implications of an extended observational hospital stay, and lacking any indication that decedent wanted to remain hospitalized and would have personally paid for the service, plaintiff refused to substantiate any cause of action in ordinary negligence against the hospital.

In *Dorris*, an assault in a psychiatric ward was held to be malpractice, not ordinary negligence. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 668 NW2d 402 (2003), held that an injury during a nurse's transfer of a patient sounded in medical malpractice. *Regalski v Cardiology Assocs, PC*, 459 Mich 891, 587 NW2d 502 (1998), held that a technician injuring a patient during a transfer also sounded in medical malpractice. In *David v Sternberg*, 272 Mich App 377, 726 NW2d 89 (2006), the court concluded that discerning infection, capillary flow, and postsurgical condition of plaintiff's surgical site were not within the realm of common knowledge and that plaintiff's claims sounded in medical malpractice.

In *Lee v Detroit Med Ctr*, 285 Mich App 51, 775 NW2d 326 (2009), the court held that an action for failure to report suspected child abuse under the Child Protection Law, MCL 722.623, sounds in ordinary negligence, not medical malpractice. Thus, plaintiffs need not meet medical malpractice filing requirements. Additionally, medical facilities may be held vicariously liable for a doctor-employee's failure to report.

#### ***Patient abandonment:***

Patient abandonment is a viable medical malpractice claim. *Tierney v University of Michigan Regents*, 257 Mich App 681, 669 NW2d 575 (2003) (plaintiff's doctor refused to perform a cerclage procedure after learning that plaintiff had filed lawsuit against his colleague).

The Emergency Medical Treatment and Active Labor Act (EMTALA), 42 USC 1395dd requires a hospital to provide appropriate medical screening to

determine if a medical emergency exists when an individual is brought to the hospital emergency room. Although EMTALA was enacted to protect patients without insurance, it is broad in scope and is not limited to “patient dumping” situations. Sanctions for EMTALA violations include fines against both doctors and hospitals, and hospitals are subject to civil suits by patients injured as a result of an EMTALA violation. See Christopher L. Riegler, *The Emergency Medical Treatment and Active Labor Act*, 71 Mich BJ 1296 (1992).

Additionally, *patients* harmed by violation of EMTALA are not the only persons with standing to sue. In *Moses v Providence Hosp & Med Ctrs, Inc*, 561 F3d 573 (6th Cir 2009), the Sixth Circuit held that under the plain and “very broad” statutory language, “any individual who suffers personal harm as a direct result’ of a hospital’s EMTALA violation may sue.” *Id.* at 580 (quoting 42 USC 1395dd(d)(2)(A)). Thus, the estate of a woman murdered by a released patient had standing to sue under the act.

#### *Consumer protection act:*

The Michigan Consumer Protection Act (MCPA) is not a basis for a malpractice claim. In *Nelson v Ho*, 222 Mich App 74, 564 NW2d 482 (1997), plaintiff alleged that defendant doctor violated the MCPA, MCL 445.901 et seq., in rendering medical care to her. The court of appeals held that claims against a physician under the MCPA are appropriate only if the physician’s alleged wrongful conduct occurred in connection with the business aspect of his or her practice and are not appropriate if it occurred in the actual performance of medical services. See also *Tipton v William Beaumont Hosp*, 266 Mich App 27, 697 NW2d 552 (2005) (where alleged representations or omissions implicate medical professional’s ability to provide medical care and damages resulting from that care, case raises questions of medical judgment and gravamen of case is medical malpractice).

#### *Doctrine of avoidable consequences:*

In *Braverman v Granger*, 303 Mich App 587, 844 NW2d 485 (2014), the patient refused a blood transfusion on religious grounds and subsequently died. The court of appeals held that the trial court correctly determined that the doctrine of avoidable consequences, when applied objectively to satisfy the First Amendment’s requirement of government neutrality toward religion, precluded the plaintiff personal representative from recovering damages. The court explained that the objective approach to the doctrine of avoidable consequences eliminates all subjective reasons from consideration and therefore only incidentally burdens faith-based reasons. Because the blood transfusion was an objectively reasonable means to avoid or minimize damages following the patient’s original injury given the circumstances of the case, defendants were entitled to summary disposition.

## 2. Negligent Treatment

### a. Direct Liability

§6.3 The classic health care malpractice case is an action against a health care provider whose negligence in the care and treatment of his or her