Health Care Malpractice

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I. Overview

§6.1 Medical malpractice is a subspecialty of tort law that involves the professional negligence of licensed health care practitioners and facilities. The phrase licensed health care providers includes, inter alia, the following occupations: audiology, chiropractic, counseling, dentistry, medicine, nursing, occupational therapy, optometry, osteopathic medicine, pharmacy, physical therapy, podiatry, psychology, speech-language pathology, and social work. MCL 333.16101 et seq.; see also MCL 600.5838a(1)(b).

To prevail in a malpractice action against any of these professionals, a plaintiff must prove the elements of duty, breach, causation, and damages. Weymers v Khera, 454 Mich 639, 563 NW2d 647 (1997). Malpractice is defined as the professional’s deviation from the standard of care that would be followed by a reasonable and prudent professional of similar training under the same or similar circumstances. In general, 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 1993, the Michigan legislature passed an expansive piece of legislation that substantially altered Michigan law regarding health care malpractice claims. The legislature also repealed, in total, Michigan’s Medical Malpractice Arbitration Act (MMAA), MCL 600.5040 et seq., and replaced its provisions. In addition, significant changes were made that affected statutory provisions concerning the limitation period, a mandatory notice of intent (NOI), 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(8). 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; minors, MCL 600.5851(7), (8); and plaintiffs who later discover or should have discovered the claim, MCL 600.5838a(2). In certain circumstances, wrongful-death claims may be subject to additional time via a savings provision, not to exceed three years from the date on which the period of limitations runs. MCL 600.5852. Notably, there is a six-year statute of repose beyond which claims brought under the statutory discovery rule 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, which are specified in MCL 600.2912b. The contents of the notice must follow the requirements of MCL 600.2912b(4).

A complaint must be accompanied by an affidavit of merit that is signed by an expert who plaintiff’s counsel reasonably believes meets statutorily specified qualifications. MCL 600.2169, .2912d(1). The complaint must allege sufficient facts 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; MRE 702. The plaintiff must also prove the causal link between the alleged negligence and the injury to a reasonable degree of medical probability, i.e., more likely than not (50.1 percent). Causation may not be left to mere speculation or conjecture. *Serafin v Peoples Cnty Hosp Auth*, 67 Mich App 560, 242 NW2d 438 (1976). However, the plaintiff does not bear a higher burden of proof in proving causation in a malpractice case than in other tort actions. The supreme court has rejected the argument that a plaintiff must precisely quantify causation and has specifically held that a percentage-based quantitative analysis is not required in a medical malpractice case. The seminal case on this issue is *O’Neal v St John Hosp & Med Ctr*, 487 Mich 485, 496–497, 791 NW2d 853 (2010), where the supreme court instructed that it is “well-settled that proximate causation in a malpractice claim is treated no differently than in an ordinary negligence claim … . [T]he analysis is the same as in any other ordinary negligence claim.” Moreover, it is well established in Michigan law that causation in a medical malpractice action may be established by circumstantial evidence. *See* *Ykimoff v WA Foote Mem’l Hosp*, 285 Mich App 80, 87, 776 NW2d 114 (2009); *Robins v Garg (On Remand)*, 276 Mich App 351, 362, 741 NW2d 49 (2007); *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 496, 668 NW2d 402 (2003).

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 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 the damages caused by them. This area of the law has unique characteristics due to its distinct liability issues, legal framework, and the amount of medical knowledge required to effectively litigate a malpractice case.

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

A. Theories of Liability

1. In General

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 and may depend on the medical specialty being practiced at the time of the malpractice. 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 patient rooms. The Michigan Supreme Court held that the trial court had erred in concluding that the correct theory was ordinary negligence because the ordinary person does not know what type of supervision or monitoring 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 umbrella of medical malpractice, and therefore plaintiff was required to provide an NOI to sue and file an affidavit of merit.

Where there is no provider-patient relationship, the plaintiff has no cause of action for malpractice, though a claim for ordinary negligence may still be had. 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, rejected the referral, and instructed the hospital 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 on an informal, “curbside” basis); *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 examina-
tion (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 chiropractic 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:**

The seminal Michigan Supreme Court opinion outlining the distinction between ordinary negligence and medical malpractice is Bryant v Oakpointe Villa Nursing Ctr, Inc, 471 Mich 411, 684 NW2d 864 (2004). In Bryant, plaintiff’s decedent died from positional asphyxia after she became wedged between her mattress and the bed rails. 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 asphyxia 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 Bryant 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. The court noted two key characteristics that distinguish a medical malpractice action from a claim of ordinary negligence:

First, medical malpractice can occur only “within the course of a professional relationship.” Second, claims of medical malpractice necessarily “raise questions involving medical judgment.”

Bryant, 471 Mich at 422 (citation omitted). Based on these distinguishing characteristics, the court formulated a two-part analysis similar to that used in Dorris as follows:

Therefore, a court must ask two fundamental questions in determining whether a claim sounds in ordinary negligence or medical malpractice: (1) whether the claim pertains to an action that occurred within the course of a professional relationship; and (2) whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience.

471 Mich at 422. For a claim to sound in medical malpractice, both prongs of this analysis must be satisfied. Id. The court did not issue a broad, sweeping decree about which acts constitute medical malpractice and which constitute ordinary
negligence. To the contrary, the majority held that an individual analysis of each claim against the facts of that particular case was required, holding that “[t]he fact that an employee of a licensed health care facility was engaging in medical care at the time the alleged negligence occurred means that the plaintiff’s claim may possibly sound in medical malpractice; it does not mean that the plaintiff’s claim certainly sounds in medical malpractice.” Id. at 421.

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 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 could not substantiate any cause of action in ordinary negligence against the hospital. Likewise, the court of appeals has held that a health care provider has no legal duty to assist a discharged patient with transportation. Chelik v Capitol Transp, LLC, 313 Mich App 83, 880 NW2d 350 (2015).

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 Assoc, 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. The court rejected defendant doctors’ argument that the determination of whether there is “reasonable cause to suspect abuse” required the use of medical judgment, since the same reporting requirement applied to professions with no medical training.