STATE OF MICHIGAN

COURT OF APPEALS

ESTATE OF CATHLEEN ALLEN, by TERRENCE PETER CALO, Personal Representative,

Plaintiff-Appellee,

v

VIJAY K. DIXIT, M.D., and COSMETIC AND PLASTIC SURGERY CLINIC, PC,

Defendants,

and

HENRY FORD MACOMB HOSPITAL CORPORATION, doing business as HENRY FORD MACOMB HOSPITAL-CLINTON TOWNSHIP CAMPUS,

Defendant-Appellant.

UNPUBLISHED
March 11, 2021

No. 352665
Macomb Circuit Court
LC No. 2019-004793-NH

Before: LETICA, P.J., and CAVANAGH and FORT HOOD, JJ.

PER CURIAM.

Defendant Henry Ford Macomb Hospital Corporation appeals by leave granted, *Estate of Cathleen Allen v Dixit*, unpublished order of the Court of Appeals, entered May 13, 2020 (Docket No. 352665), an order denying its motion for partial summary disposition in this case arising from the death of plaintiff's decedent, Cathleen Allen, shortly after a surgical procedure. We affirm in part, reverse in part, and remand for further proceedings.

In 2013, Allen had undergone bariatric surgery. On May 26, 2017, Dr. Vijay Dixit, a plastic surgeon, performed surgery to remove her excess skin. On June 2, 2017, Allen reported to defendant's emergency room with complaints of weakness, confusion, and bleeding. A doctor noted that Allen was exhibiting signs of septic shock with the abdominal surgery as the possible source. Allen was admitted to the ICU with a diagnosis of altered mental status and was given

intravenous antibiotics. Dixit saw Allen on June 3, 2017, and determined that he would not immediately operate; he noted that he saw no clinical signs of infection. Two hours earlier, two other physicians had noted a high probability of life-threatening deterioration. Within an hour of Dixit's visit, Allen required intubation, ventilator support, and renal dialysis. On June 4, 2017, thick brown drainage from Allen's abdomen was sent for culture and she was given additional antibiotics. An EEG showed encephalopathy, and her skin was becoming cool and mottled. On June 5, 2017, Dixit noted obvious sepsis, but opined that surgical intervention was unnecessary. Dixit operated on June 6, 2017, to debride the skin and abdominal wall. Allen died on June 7, 2017, from cardiac arrest. She was 41 years old.

Plaintiff filed the instant lawsuit accompanied by affidavits of merit from four doctors. Plaintiff alleged direct liability of Dr. Dixit and defendant. Plaintiff also alleged that defendant was vicariously liable for the treatment provided by Dixit, other doctors, nurses and/or healthcare professionals. Within those allegations, plaintiff alleged violations of the Public Health Code. Plaintiff also averred that defendant had a duty to exercise reasonable care to supervise its physicians, monitor patients, and implement policies and procedures to protect and prevent harm to its patients including Allen.

Defendant moved for partial summary disposition under MCR 2.116(C)(7) and (C)(8). It argued that no private cause of action existed under the Public Health Code, so the court should dismiss that allegation. Further, Michigan malpractice law does not recognize claims of strict liability. And to the extent plaintiff claims ordinary negligence, such claims should be rejected because the case involves medical malpractice. Further, plaintiff failed to allege with specificity the purported claim of administrative negligence. Also, claims regarding nursing care must be dismissed because plaintiff did not provide an affidavit of merit from a nurse.

Plaintiff responded that a violation of the Public Health Code could be evidence of negligence, so that allegation should stand. And plaintiff did not assert a strict liability theory. Plaintiff also asked the court to ignore defendant's attempt to pigeonhole all the claims as medical malpractice, as it was premature absent discovery. Plaintiff argued that the complaint set forth specific claims against defendant regarding its direct and vicarious liability. Plaintiff added that the claims regarding nurses and other nonphysician staff fell within direct negligence or vicarious liability based on defendant's supervision and retention of staff.

Defendant replied that the court must dismiss plaintiff's allegations of Public Health Code violations because the code does not create a private cause of action. Defendant also argued that plaintiff should stipulate to the dismissal of any claim based on strict liability. Further, defendant argued, none of plaintiff's allegations supported a claim of ordinary negligence for Allen's post-surgical care and plaintiff's administrative negligence claim must be dismissed as vague because plaintiff failed to identify any specific negligent actors. And because plaintiff provided no affidavit of merit to support any claims against defendant's nursing staff, such malpractice claims must be dismissed. Accordingly, all claims against defendant hospital should be dismissed except those claims of respondeat superior related to Dr. Dixit.

At a hearing on defendant's motion, the parties argued consistently with their briefs. The trial court held that the motion was premature, and thus, it was denied without prejudice. This appeal followed.

Defendant argues that the trial court erred in denying its motion for partial summary disposition and thereby permitting discovery on claims that must be dismissed as a matter of law. We agree, in part.

A decision on a motion for summary disposition is reviewed de novo. *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999). It appears defendant sought dismissal of any claims of ordinary negligence under MCR 2.116(C)(7). See *Bryant v Oakpointe Villa Nursing Ctr*, 471 Mich 411, 419; 684 NW2d 864 (2004) (a court considers whether the nature of a claim is ordinary negligence or medical malpractice under MCR 2.116(C)(7)). In reaching its decision on a motion brought under this subrule, a trial court considers all documentary evidence submitted by the parties, accepting as true the allegations set forth in the complaint unless contradicted by the documentary evidence. *Maiden*, 461 Mich at 119. Defendant also brought its motion under MCR 2.116(C)(8), which tests the legal sufficiency of the complaint and may be granted only where the claims alleged in the complaint are " 'so clearly unenforceable as a matter of law that no factual development could possibly justify recovery.' " *Id*., quoting *Wade v Dep't of Corrections*, 439 Mich 158, 163; 483 NW2d 26 (1992).

Defendant argues that the trial court should have dismissed plaintiff's allegations under the Public Health Code because no such private cause of action exists. We agree, in part.

With regard to the Public Health Code, plaintiff alleges:

> 71. Defendant Henry Ford Macomb Hospital had a duty to exercise reasonable and due care to protect Ms. Allen from foreseeable, severe harm with respect to the quality of care rendered in the hospital pursuant to Michigan common law and statutory law including but not limited to MCL 333.21513, MCL 333.20201(e) and MCL 600.5838a. Violations of the statutes creates a prima facie showing of negligence.

MCL 333.21513 of the Public Health Code sets forth the duties of the owner of a hospital to assure that the staff members are properly licensed, have training, review professional practices, do not discriminate, adhere to medical protocols, and have a plan for handling biohazards. However, as set forth in *Fisher v W A Foote Mem Hosp*, 261 Mich App 727, 730; 683 NW2d 248 (2004), MCL 333.21513 does not create a private cause of action. Thus, to the extent plaintiff is alleging a cause of action based on alleged violations of the Public Health Code, it should have been dismissed by the trial court. Second, MCL 333.20201(e) is a part of the patient's bill of rights and our Legislature specifically provided that liability is not to be imposed for failing to comply. See MCL 333.20203(1) (providing in part that "[a]n individual shall not be civilly or criminally liable for failure to comply"). Therefore, no private cause of action arises from violation of these statutes and the trial court should have stricken any such claims by plaintiff.

However, defendant does not address plaintiff's claim that defendant's alleged statutory violations may lead to a rebuttable presumption of negligence. See, e.g., *Klanseck v Anderson Sales & Serv, Inc*, 426 Mich 78, 86-87; 393 NW2d 356 (1986); *Candelaria v BC Gen Contractors, Inc*, 236 Mich App 67, 82 n 5; 600 NW2d 348 (1999). Because defendant does not provide any argument supported by legal authority to refute plaintiff's claim in this regard, any such challenge

is deemed abandoned on appeal. See *Peterson Novelties, Inc v City of Berkley*, 259 Mich App 1, 14; 672 NW2d 351 (2003).

Next, defendant argues that the trial court erred in not dismissing plaintiff's claims of ordinary negligence. We agree.

"The key to a medical malpractice claim is whether it is alleged that the negligence occurred within the course of a professional relationship." *Dorris v Detroit Osteopathic Hosp Corp*, 460 Mich 26, 45; 594 NW2d 455 (1999), quoting *Bronson v Sisters of Mercy Health Corp*, 175 Mich App 647, 652; 438 NW2d 276 (1989). A complaint cannot avoid the procedural requirements of a medical malpractice action by pleading in terms of ordinary negligence. *Dorris*, 460 Mich at 43 (citation omitted). Whether a claim sounds in medical malpractice as opposed to ordinary negligence depends on whether the facts raise issues that are "within the common knowledge and experience of the jury or, alternatively, raise questions involving medical judgment." *Id.* at 45-46; see also *Bryant*, 471 Mich at 422 (the two distinguishing factors to consider in determining whether a matter involves medical malpractice or ordinary negligence are whether a professional relationship existed and whether medical judgment is involved).

In this case, all of plaintiff's claims as pleaded sound in medical malpractice only. First, the claims focus on events that occurred during the course of a professional relationship between Dixit, defendant, defendant's personnel, and Allen regarding Allen's treatment before her death. Second, plaintiff's claims focus on questions of medical judgment beyond the realm of common knowledge and experience. With respect to plaintiff's direct liability claim against defendant, plaintiff alleges that defendant had a duty to supervise its physicians, nurses, and other personnel to the extent they were providing medical care and treatment to patients. With respect to its vicarious liability claim against defendant, plaintiff alleges that defendant is responsible for the actions of Dixit and other hospital personnel during the course of Allen's medical treatment. These allegations sound in medical malpractice. A jury comprised of laypersons could not rely on their general knowledge to decide, for example, whether the decision not to operate on Allen earlier or provide her different medical care constituted ordinary negligence. Treatment for a patient with sepsis is a matter of medical judgment and does not relate to jurors' common knowledge or experience. Accordingly, the trial court erred in denying defendant's motion for summary disposition with regard to plaintiff's claims of ordinary negligence.

Next, defendant argues that plaintiff's claim of administrative negligence should have been dismissed because plaintiff failed to identify a person at the hospital who is alleged to have breached the standard of care, and plaintiff failed to identify what purported hospital actions should have occurred. We disagree.

A plaintiff need not identify specific individuals to survive a motion for summary disposition brought under MCR 2.116(C)(8). This is particularly true where plaintiff has submitted an affidavit of merit from which defendant may glean clarifying information. As correctly noted by defendant, a plaintiff suing an institutional defendant for medical malpractice must submit "an affidavit of merit from a physician who specializes or is board-certified in the same specialty as that of the institutional defendant's agents involved in the alleged negligent conduct." *Nippa v Botsford Gen Hosp (On Remand)*, 257 Mich App 387, 393; 668 NW2d 628 (2003). But there is no requirement in MCL 600.2912d(1), the caselaw interpreting and applying it, or any other

relevant caselaw requiring that a plaintiff "identify by title or by name any person" involved in a medical malpractice claim against a healthcare facility. And the cases cited by defendant in support of such argument are not persuasive; they state no such requirement.

Furthermore, plaintiff's complaint, notice, and affidavits of merit do describe what the administrators failed to do and should have done. For example, plaintiff's complaint sets forth numerous allegations, including that defendant breached the relevant standard of care by failing to do the following:

> a. Implement and ensure enforcement of policies that ensure patients are provided safe and needed care in a timely manner;
>
> b. Implement and ensure enforcement of policies that ensure any person providing treatment to the patient in the hospital who observes or otherwise has knowledge of likely unsafe/substandard care, report the potential imminent threat to the wellbeing of the patient to an administrative supervisor who has the authority to ensure timely corrective action is taken for the safety and wellbeing of the patient;
>
> c. Ensure policies written or unwritten do not exist that discourage the reporting of potential and likely imminent patient harm being caused by unsafe/substandard care being provided to a patient of the hospital;
>
> d. Ensure a proper "chain of command" type policy is implemented, practiced and enforced to protect patients from foreseeable and likely imminent harm at the hands of unsafe/substandard care[;]
>
> e. Reasonably and properly supervise doctors, nurses and other persons providing treatment and/or medical care to patients including Ms. Allen[;]
>
> f. Reasonably and properly make decisions regarding credentialing, selection and retention of medical staff[;]
>
> g. Reasonably and properly supervise the doctors and other persons providing care and treatment to patients in the hospital and monitor the care as needed for the reasonable safety of the patient; and
>
> h. Take other reasonable steps for the safety of the patient as further delineated during discovery.

Defendant can sufficiently discern plaintiff's allegations against it and may seek clarification during the discovery process. Therefore, the trial court properly denied defendant's motion for partial summary disposition with regard to this claim.

Finally, defendant asserts that the trial court should have dismissed plaintiff's claims against its nurses and "other staff" because plaintiff failed to provide an affidavit of merit from someone with respect to those professions. We agree.

"The plain language of [MCL 600.2912d(1)] indicates that an affidavit of merit is required in every medical malpractice action, including those initiated against nonphysicians." *McElhaney v Harper-Hutzel Hosp*, 269 Mich App 488, 494-495; 711 NW2d 795 (2006). A plaintiff alleging nursing malpractice must present evidence concerning the applicable standard of care through expert testimony. *Gay v Select Specialty Hosp*, 295 Mich App 284, 292; 813 NW2d 354 (2012). Here, plaintiff did not submit an affidavit of merit with respect to the relevant standard of care for nurses or any other nonphysician staff directly involved in Allen's care. The individuals who did provide affidavits of merit did not devote a majority of their professional time to the active clinical practice of a nurse or other nonphysician staff member. See *McElhaney*, 269 Mich App at 494, quoting MCL 600.2169(1)(b)(*i*). Thus, plaintiff did not comply with the statutory requirement and the trial court erred in denying defendant's motion for summary disposition with regard to plaintiff's medical malpractice claims against defendant's nurses and "other staff."

However, this conclusion does not apply to defendant's administrators, as discussed above, with respect to plaintiff's claim of administrative negligence. Plaintiff provided the requisite affidavit with respect to hospital administration by including the affidavit of Dr. John Charles Hyde. In that affidavit, Hyde identifies himself as an expert in the field of "health care administration." Hyde offers opinions with respect to defendant's administrative "policies and procedures," which are expressly at issue in plaintiff's claim against defendant.

We affirm in part, reverse in part, and remand for further proceedings. We do not retain jurisdiction.

/s/ Anica Letica
/s/ Mark J. Cavanagh
/s/ Karen M. Fort Hood