STATE OF MICHIGAN
IN THE SUPREME COURT

AUDREY TROWELL,

Plaintiff-Appellee,

v.

PROVIDENCE HOSPITAL AND MEDICAL CENTERS, INC., a Michigan Non-Profit Corporation,

Defendant-Appellant.

Michigan Supreme Court No. 154476

Court of Appeals No. 327525

Oakland County Circuit Case
No. 14-141798-NO
Hon. Colleen A. O'Brien

BRIEF OF AMICI CURIAE THE AMERICAN MEDICAL ASSOCIATION AND MICHIGAN STATE MEDICAL SOCIETY IN SUPPORT OF DEFENDANT-APPELLANT PROVIDENCE HOSPITAL AND MEDICAL CENTERS, INC.'S APPLICATION FOR LEAVE TO APPEAL

KERR, RUSSELL AND WEBER, PLC
Joanne Geha Swanson (P33594)
Jacquelyn A. Klima (P69403)
Attorneys for Amici Curiae
American Medical Association and
Michigan State Medical Society
500 Woodward Avenue, Suite 2500
Detroit, MI 48226-3427
(313) 961-0200; FAX (313) 961-0388
E-mail: jswanson@kerr-russell.com

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STATEMENT OF QUESTION PRESENTED

The question presented is whether the Court of Appeals, in contemplation of speculative and unpled factual scenarios, erred in reversing and remanding this case to the Trial Court for factual development during the course of discovery as to whether Plaintiff's claims sound in medical malpractice or ordinary negligence.

In the view of Amici Curiae, the Court of Appeals' approach will thwart the statutory protocol established for medical malpractice actions. Here, the Trial Court properly relied upon the facts alleged in the complaint in holding that Plaintiff's claims, which arose when Plaintiff fell while a nurse's aide was assisting her to the bathroom in the ICU, sound in medical malpractice because they invoke the exercise of medical judgment and require expert testimony to address the alleged breaches. To accomplish the Legislature's tort reform purpose and enforce the statutorily-mandated prerequisites to a medical malpractice action, this issue must be resolved at the outset of litigation in accordance with the test established by this Court in *Bryant v Oakpointe Villa Nursing Ctr, Inc*, 471 Mich 411; 684 NW2d 864 (2004).

STATEMENT OF INTEREST OF AMICI CURIAE AMERICAN MEDICAL ASSOCIATION AND MICHIGAN STATE MEDICAL SOCIETY

Defendant-Appellant Providence Hospital and Medical Centers, Inc. seeks leave to appeal the published Michigan Court of Appeals' decision in *Trowell v Providence Hospital and Medical Centers, Inc.*, 316 Mich App 680; 893 NW2d 112 (2016), reversing the trial court's grant of summary disposition for failure of plaintiff to take the mandatory procedural steps associated with a medical malpractice action and to properly commence the action within the time period provided for medical malpractice actions. The Court of Appeals concluded that "the allegations in the complaint did not lend themselves to a definitive determination that the negligence claims in plaintiff's suit necessarily sounded in medical malpractice" and remanded the case to the trial court for discovery and further factual development. *Id*. at 114.

Amicus Curiae American Medical Association ("AMA") is the largest professional association of physicians, residents and medical students in the United States. Through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents and medical students in the United States are represented in the AMA's policy-making process. AMA members practice and reside in all states, including Michigan. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

Amicus Curiae Michigan State Medical Society ("MSMS") is a professional association which represents the interests of over 14,000 physicians in the State of Michigan. Organized to promote and protect the public health and to preserve the interests of its members, MSMS has

frequently been afforded the privilege of acting as *amicus curiae* with respect to legal issues of significance to the medical profession.

The *Trowell* decision presents issues of immense importance to the AMA and MSMS. *Trowell* purports to apply the test articulated in *Bryant v Oakpointe Villa Nursing Ctr, Inc*, 471 Mich 411; 684 NW2d 864 (2004), for determining whether a complaint sounds in negligence or medical malpractice. However, instead of reaching a conclusion under the *Bryant* standard, the Court of Appeals remanded the case for further evidentiary development on the ostensible basis that certain imagined facts – not alleged in the complaint – might remove the claim from the realm of medical malpractice.

The Court of Appeals' refusal to decide the issue on the basis of the facts actually pled, and to delay consideration pending discovery and expert evaluation, side-steps the important tort reform protocol governing medical malpractice actions, which was designed to weed out non-meritorious cases at an early stage in the proceedings. This Court has strictly enforced the letter and spirit of the statutory requirements. In accordance with the *Bryant* test, the Court should have held that Mrs. Trowell's complaint sounded in medical malpractice and was therefore properly dismissed for failure to timely assert the claim and comply with the statutory prerequisites for a medical malpractice action.

For reasons more fully explained below, the AMA and MSMS join Defendant in urging this Court to grant the application for leave to appeal and to peremptorily reverse or reverse after full appeal the erroneous decision in *Trowell*.

STATEMENT OF FACTS AND PROCEEDINGS

Amici Curiae rely upon the Statement of Facts set forth in Defendant-Appellant's Application for Leave to Appeal and Supplemental Brief in Support of Application.

ARGUMENT

I. This Court Should Reverse the Erroneous Decision in *Trowell*, Which (1) Disregards the Test Established in *Bryant* for Determining Whether An Action Sounds in Ordinary Negligence or Medical Malpractice, and (2) Undermines the Tort Reform Protocol Established By the Legislature to Weed Out Non-Meritorious Cases at an Early Stage in the Proceedings.

The underlying issue raised by this appeal is whether the allegations of negligence require the exercise of medical judgment. That query, along with determining whether the claim is being brought against a person or entity that is capable of malpractice and whether the alleged negligence occurred in the course of a professional relationship, are the factors a court must consider in deciding whether the claim sounds in ordinary negligence or medical malpractice. *Bryant*, 471 Mich at 420-422.

In *Trowell*, Plaintiff's direct and vicarious liability theories challenged the decision to use one nurse's aide to assist the medically challenged Plaintiff to the bathroom rather than two aides or nurses. The manner in which the nurse's aide physically handled Plaintiff while providing transport assistance was also alleged to be a breach of the standard of care. *Trowell*, 316 Mich App at 682-684. The Trial Court properly concluded that allegations regarding staffing decisions and appropriate patient monitoring invoke questions of medical management, not issues of ordinary negligence, and thus sound in medical malpractice. But the Court of Appeals, while acknowledging that medical judgment could be implicated if the manner and staffing of patient transport is affected by a patient's physical and mental state or condition (illness, surgery, anesthesia, and medications), nonetheless held that the complaint allegations alone were an inadequate basis upon which to decide the issue.

Although not alleged in the complaint, the Court speculated that medical judgment might be immaterial if the evidence showed that the aide dropped the patient because she decided to answer a cell phone call during transport or held the plaintiff with "an extremely and ridiculously

loose grip." 316 Mich App at 700. Because the Court deemed itself unable to decide whether its imagined scenario – or another like it – might have actually occurred, it reversed the grant of summary disposition and remanded the case back to the Trial Court where evidence developed during the normal course of discovery might illuminate the issue.

This Court might well recognize the multiple problems that will result from the decision-making protocol adopted in *Trowell*. First, the result in *Trowell* conflicts with this Court's decision in *Bryant,* which had no reservations about deciding the issue based upon the plain allegations of the complaint in the same manner that other preliminary issues are frequently decided. It has always been the plaintiff's burden to plead a cognizable claim in conformity with all legal requirements. Although *Bryant* cautioned future plaintiffs to plead alternatively in the face of uncertainty, *Trowell* removes that burden from the plaintiff and rewards vague and malleable allegations.

Second, *Trowell's* refusal to decide the issue preliminarily undermines the effectiveness of the tort reform protocol, which the Legislature established to eliminate non-meritorious claims and the economic burdens they impose. Under the holding of *Trowell*, motions which seek dismissal for failure to comply with the medical malpractice requirements must be placed on the back-burner until discovery and expert testimony can flush out all imagined factual scenarios. This will allow non-meritorious claims to flourish despite noncompliance with the statutory prerequisites, contrary to the strict enforcement this Court has required over the three decades since enactment.

A. The *Trowell* Decision Disregards *Bryant*.

In this case, the Trial Court properly determined that Ms. Trowell's claim was brought against an entity that is capable of malpractice, that the alleged negligence occurred in the course of a professional relationship, and that the claim raised questions of medical judgment beyond the realm of common knowledge and experience, such that expert testimony would be necessary to

decide whether the standard of care had been breached. *Trowell*, 316 Mich App at 687. This determination was faithful to *Bryant*.

Bryant came before this Court in the context of a summary disposition ruling. 471 Mich at 420. This Court explained that "[i]n determining whether the nature of a claim is ordinary negligence or medical malpractice …, a court does so under MCR 2.116(C)(7)," considering all documentary evidence submitted by the parties and accepting as true the contents of the complaint unless affidavits or other appropriate documents specifically contradict it. *Id.* at 419. Nothing in the *Bryant* opinion requires that every imagined factual scenario be capable of exclusion or that decision on the nature of a claim await discovery and expert review. Quite the contrary, particularly with respect to medical malpractice actions, the determination must rest upon the claims actually pled.

It is the plaintiff's burden to plead a factually supported claim. This is particularly true with respect to a claim for medical malpractice. It has long been held that an action for medical malpractice must be pled more specifically than other types of negligence. See *Simonelli v Cassidy*, 336 Mich 635, 644; 59 NW2d 28 (1953). See also, *Badalamenti v William Beaumont Hosp – Troy*, 237 Mich App 278, 284; 602 NW2d 854 (1999) (a claim for medical malpractice must be pled with specificity). And beyond that, additional obligations are imposed by the statutory malpractice protocol.

As is more fully explained below, even before an action is commenced, the factual basis for the claim must be articulated in a "notice of intent." MCL 600.2912b(1). By the time of filing, a plaintiff must have obtained expert support for the claim in the form of a sworn "affidavit of merit," which must be filed with the complaint. MCL 600.2912d(1). The statutes also provide for

the early exchange of medical records, upon which the expert can base his or her review. See MCL 600.2912b(5) and MCL 600.2912d(3).

While this Court recognized in *Bryant* that "[t]he distinction between actions sounding in medical malpractice and those sounding in ordinary negligence is one that has troubled the bench and bar in Michigan," it cautioned future litigants to ***plead alternatively*** in order to preserve their right to proceed:

> [I]n future cases of this nature, in which the line between ordinary negligence and medical malpractice is not easily distinguishable, ***plaintiffs are advised as a matter of prudence to file their claims alternatively in medical malpractice and ordinary negligence within the applicable period of limitations***.[19]
>
> _____
>
> [19] If the trial court thereafter rules that the claim sounds in ordinary negligence and not in medical malpractice, and may thus proceed in ordinary negligence, and this ruling is subsequently reversed on appeal, the plaintiff will nonetheless have preserved the right to proceed with the medical malpractice cause of action by having filed in medical malpractice within the period of limitations. [471 Mich at 432-433 (emphasis added)].

The approach endorsed by the Court of Appeals does not heed this caution. Stepping out of its expected role, the *Trowell* Court undermines *Bryant*'s respectful but serious forewarning. It was not for the *Trowell* Court to conjure up unpled factual scenarios that might remove the claim from the realm of medical malpractice and launch the case forward to discovery. Indeed, the *Trowell* Court's contemplation of facts that might invoke ordinary negligence scenarios should have played no part in the summary disposition ruling.

Plaintiff had the opportunity and the obligation to investigate her claim and, if uncertainty still existed, to plead alternatively as this Court suggested, satisfying not only the statute of limitations but the malpractice reform requirements as well. In demanding less, the *Trowell* decision disregards *Bryant* and undermines the statutory regimen that this Court has faithfully enforced over the several decades since its enactment. Therefore, when a plaintiff fails to heed the

warning of alternative pleading, this Court should direct that if a claim arises within the course of a professional health care relationship and the plaintiff fails to plead facts sufficient to show that the claim is not based on questions of medical judgment, the need for medical judgment should be presumed. This properly places the onus of inadequate pleading on the party in control of the complaint.

B. The *Trowell* Decision Thwarts the Malpractice Reform Protocol and Defeats the Legislature's Intent to Deter Non-Meritorious Claims.

The published *Trowell* decision cannot be reconciled with the strict enforcement this Court has afforded to the comprehensive statutory protocol applicable to medical malpractice actions. Implemented by the Legislature over an approximate ten-year period, the protocol was designed to address the dramatic increase in lawsuit filings and exorbitant medical malpractice judgments. Among the Legislature's ongoing goals were to reduce liability costs and increase the availability of health care while, at the same time, improving patient care and physician accountability, and reducing malpractice. This was to be accomplished by "promoting settlement without the need for formal litigation, reducing the cost of medical malpractice litigation and providing compensation for meritorious medical malpractice claims that would otherwise be precluded from recovery because of litigation costs." See Summary on Medical Malpractice Liability, House Legislative Analysis Section (Exhibit A). Ideally, this would assist in alleviating the medical malpractice crisis and thereby increase the availability - and decrease the cost - of health care in this state.

Michigan's appellate courts have repeatedly recognized the Legislature's legitimate interest in this goal. See e.g., *Bissell v Kommareddi*, 202 Mich App 578, 581; 509 NW2d 542 (1993) ("the state unquestionably has a legitimate interest in securing adequate and affordable health care for its residents"); *Sills v Oakland General Hospital*, 220 Mich App 303, 313; 559 NW2d 348 (1996) ("Michigan has a legitimate interest in supporting affordable and adequate

health care for its residents"); *Neal v Oakwood Hospital*, 226 Mich App 701, 720; 575 NW2d 68 (1997) (notice period "is rationally related to the Legislature's objective because it is reasonable to assume that claims informally resolved or settled without resort to formal litigation will help reduce the cost of formal medical malpractice litigation.").

Reforms enacted in 1986, 1993 and 1995 touched nearly every aspect of the substantive process from a pre-filing notice requirement (MCL 600.2912b), to an expedited means for the exchange of releases and medical records (MCL 600.2912b(5)), to the requirement that complaints and answers be supported by an affidavit of merit (MCL 600.2912d(1)). Other provisions include: a procedure for the consensual arbitration of medical malpractice claims after the required notice is given (MCL 600.2912g); more stringent criteria for expert standard of care testimony (MCL 600.2169); rules regarding the burden of proof (MCL 600.2912a); a reduced statute of limitations period for minors (MCL 600.5851); a six-year statute of repose (MCL 600.5838a); interest penalties if medical records are not provided in accordance with the records exchange requirements (MCL 600.6013(11)-(12)); specific rules governing joint and several liability (MCL 600.6304(6)(a) and (b)); specific findings of allocated fault among parties and other persons (MCL 600.6304); and a cap on noneconomic damages (MCL 600.1483).

The notice statute in particular is an integral component of this interrelated network of legislative reforms. Pursuant to the statute, a person shall not commence an action for medical malpractice unless the person notifies each defendant at least 182 days before a complaint is filed of the intent to file a claim. The statute is specific with respect to the content of the notice, requiring that the claimant state the factual basis for the claim; the applicable standard of practice or care alleged by the claimant; the manner in which it is claimed that the applicable standard of practice or care was breached; the alleged action that should have been taken to achieve

compliance with the alleged standard of practice or care; 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; and the names of all health professionals and health facilities the claimant is notifying in relation to the claim. MCL 600.2912b(4). If compliant notice is given, a limitations period that would otherwise expire during the notice period is tolled for the number of days in the applicable notice period. MCL 600.5856(c).[1]

This Court has recognized the worthy purpose and intent of the notice provision. See e.g., *Driver v Naini*, 490 Mich 239, 254-255; 802 NW2d 311 (2011) (stating that "[t]he legislative purpose behind the notice requirement [includes] reducing the cost of medical malpractice litigation …") (citation omitted). The collective aim of the notice requirement and its companion provisions is to provide the parties with an opportunity to exchange information, undertake an investigation, and assess the strengths and weaknesses of their relative positions so that meaningful settlement negotiations can be conducted prior to the commencement of litigation.

This Court has required strict enforcement of the notice provision, directing dismissal of the complaint if proper notice is not given. *Roberts v Mecosta Co Gen Hospital*, 466 Mich 57, 70-71; 642 NW2d 663 (2002). Indeed, in *Dorris v Detroit Osteopathic Hospital*, 460 Mich 26, 47; 594 NW2d 455 (1999), where one of the issues was whether the claim sounded in ordinary negligence or medical malpractice, this Court noted that the appropriate sanction for failure to comply with the statutory notice of intent requirement was dismissal without prejudice.

Strict compliance with other tort reform provisions has also been the predominant rule. The affidavit of merit statute requires a plaintiff to file with the complaint, an affidavit of merit

[1] Similar information is to be provided by the health professional or facility to whom the notice is directed. MCL 600.2912b(7).

signed by an expert in the same specialty as the defendant, attesting to the applicable standard of care, the expert's belief that the standard of care was breached, the actions that should have been taken or omitted to comply with the standard of care, and the manner in which the breach proximately caused plaintiff's alleged injuries. MCL 600.2912d.

This Court has recognized that "[t]he purpose of the affidavits of merit is to deter frivolous medical malpractice claims," *Barnett v Hidalgo*, 478 Mich 151, 164; 732 NW2d 472 (2007), and it has strictly enforced the requirement. In *Dorris*, this Court held that dismissal without prejudice was the appropriate sanction for plaintiff's failure to comply with the affidavit of merit requirement. 460 Mich at 47-48.

Further, a medical malpractice complaint that is not accompanied by an affidavit of merit does not properly commence the action and does not toll the statute of limitations period. In *Scarsella v Pollak*, 461 Mich 547, 549; 607 NW2d 711 (2000), this Court rejected the plaintiff's partial attempt to comply with the statutory affidavit of merit requirement because such a reading would have conflicted with the plain language of the statute. Noting that the Legislature's use of the word "shall" indicates "that an affidavit accompanying the complaint is mandatory and imperative," this Court held that "for statute of limitations purposes in a medical malpractice case, the mere tendering of a complaint without the required affidavit of merit is insufficient to commence the lawsuit" and "did not toll the period of limitation." *Id.* at 549-550.

More specific to the present issue, in *Scarsella*, this Court rejected the plaintiff's assertion that he should have been permitted to amend the complaint by appending an untimely affidavit, which would then relate back to the original date of filing, stating:

> We reject this argument for the reason that it effectively repeals the statutory affidavit of merit requirement. Were we to accept plaintiff's contention, medical malpractice plaintiffs could routinely file their complaints without an affidavit of merit, in contravention of the court rule and the statutory requirement, and "amend"

> by supplementing the filing with an affidavit at some later date. This, of course, completely subverts the requirement of MCL 600.2912d(1); MSA 27A.2912(4)(1), that the plaintiff "shall file with the complaint an affidavit of merit," as well as the legislative remedy of MCL 600.2912d(2); MSA 27A.2912(4)(2), allowing a twenty-eight-day extension in instances where an affidavit cannot accompany the complaint. [*Scarsella*, 461 Mich at 550.] [2]

The very same could be said of the procedural facts here. It appears obvious that the utility and enforcement of this statutory tort reform regimen will be thwarted if, contrary to *Roberts* and *Scarsella*, a plaintiff can take her case through discovery and expert evaluation before submitting to a determination that her claim sounds in medical malpractice. The *Trowell* decision does not explain how timely and mandatory compliance with the notice of intent and affidavit of merit requirements – repeatedly demanded by this Court – could ever be achieved if the action is ultimately found to be one for medical malpractice. Thus, despite decades of rigorous enforcement, the *Trowell* decision has now carved out an exception to compliance with these rules without even acknowledging this effect. This Court has intervened to address such issues when the effect of the lower court rulings is to undermine the legislative will and to deviate from the jurisprudential direction provided by this Court. On these important issues, the disregard displayed by the published *Trowell* opinion should not be the last word.

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[2] See also, *Holmes v Michigan Capital Medical Center*, 242 Mich App 703, 708; 620 NW2d 319 (2000), where the Court of Appeals held that courts may not excuse the late filing of an affidavit of merit based upon an amorphous finding of "good cause," and *Barlett v North Ottawa Community Hospital*, 244 Mich App 685, 693-694; 625 NW2d 470 (2001), where the Court of Appeals affirmed the dismissal of plaintiff's complaint *with prejudice* because plaintiff failed to file the requisite affidavit of merit. Although plaintiff had filed a motion to extend the time for filing the affidavit, plaintiff did not notice the motion for hearing and it was not called to the Trial Court's attention until more than four months after the statute of limitations expired.

II. The *Trowell* Decision Unfairly Creates Two Classes of Medical Malpractice Claimants.

As a result of the *Trowell* decision, there are now two classes of medical malpractice claimants, distinguished only by the level of pleading and investigation that precedes the filing of the complaint. The door is now open for plaintiffs who want to avoid the rigor of the malpractice claim protocol. They need only avoid specifics and the particularized language that undeniably signals the invocation of a malpractice claim, and they will be permitted to proceed unhindered by the safeguards the Legislature deemed necessary to enact. This creates a slippery slope of unintended consequences and unanswered questions. The first class of medical malpractice claimants is subject to *Roberts*, *Scarsella* and mandatory enforcement of the statutory prerequisites for a medical malpractice action. The second class is pliable – maybe it is or maybe it isn't a medical malpractice action – and consequently gets a license to pursue the claim free from the constraints of statutory compliance.

This dichotomy is unworkable and prejudicial. In the first class of cases, a plaintiff must be diligent in investigating the claim to comply with the factually intensive notice of intent and affidavit of merit requirements. Class two cases are not so constrained. For the class two cases, the clarity of these plain statutory provisions is replaced with permissible noncompliance or the uncertainty that something less than full compliance will be required. Inaccurate, speculative and sketchy pleading will likely flourish under such a standard and inconsistent application is bound to occur. The ambiguity will cause plaintiffs to provide less, rather than more, information, and the validity of the claim (and the applicable rules) will be difficult to ascertain, preventing early evaluation and a meaningful response. The intended purpose of the statutory provisions will be eviscerated with the concomitant alteration of the statutory framework.

The *Trowell* decision is a slippery slope that leaves many questions unanswered. For example, what if there is a factual dispute as to how the incident occurred? Will it then be for the "fact-finder" to decide whether the claim sounds in ordinary negligence or medical malpractice (a decision typically reserved for the court)? At what point in the proceedings is this decision to be made?[3] It is unworkable and unfair to delay until verdict the parties' knowledge of the applicable rules (e.g. the noneconomic damages cap, the statute of limitations) and to burden the jury with alternative sets of instructions. Indeed, the effort and expense of trial will be for naught if it is ultimately determined that the claim should have been dismissed at the outset for the failure of the plaintiff to satisfy the medical malpractice tort reform requirements and to timely file the claim within the malpractice limitations period. Or are defendants stuck in this quandary not to be afforded these statutory defenses? Even if they do ultimately prevail on the basis of statutory noncompliance, is it fair to have required them to endure the uncertainty of prolonged discovery and trial in the interim? These might be questions the *Trowell* court never considered. But given that the decision is published, they are now front and center.

RELIEF REQUESTED

For the reasons explained above, Amici Curiae The American Medical Association and Michigan State Medical Society join Defendant-Appellant Providence Hospital and Medical Centers, Inc. in urging this Court to grant leave to appeal and peremptorily reverse, or reverse after hearing, the decision in *Trowell*.

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[3] The *Trowell* Court did not address how, when, or even if an ultimate decision would be made. See *e.g., Trowell*, 316 Mich App at 702 ("Although we are not ruling out the possibility that medical judgment was implicated with regard to the second dropping given the complete lack of documentary evidence, ***if the trial court eventually returns to the issue of whether plaintiff's action sounded in medical malpractice or ordinary negligence***, the court must keep in mind that the first and second "droppings" may be distinguishable under *Bryant*.") (emphasis added).

Dated: August 10, 2017

Respectfully submitted,

KERR, RUSSELL AND WEBER, PLC

By:*/s/Joanne Geha Swanson*

Joanne Geha Swanson (P33594)
Jacquelyn A. Klima (P69403)
Attorneys for Amici Curiae
American Medical Association and
Michigan State Medical Society
500 Woodward Avenue, Suite 2500
Detroit, MI 48226-3427
(313) 961-0200; FAX (313) 961-0388
E-mail: jswanson@kerr-russell.com

CERTIFICATE OF SERVICE

Cynthia J. Villeneuve says that on August 10, 2017 she filed the foregoing Brief of Amici Curiae The American Medical Association and Michigan State Medical Society in Support of Defendant-Appellant Providence Hospital and Medical Centers Inc.'s Application for Leave to Appeal with the Clerk of the Court using the Court's electronic filing system, which will electronically serve all parties of record.

/s/ Cynthia J. Villeneuve
Cynthia J. Villeneuve

Exhibit A

House
Legislative
Analysis
Section

Olds Plaza Building, 10th Floor
Lansing, Michigan 48909
Phone: 517/373-6466

MEDICAL MALPRACTICE LIABILITY

Senate Bill 270 (Substitute H-1)
Sponsor: Senator Dan L. DeGrow

House Bill 4033 (Substitute H-3)
Sponsor: Rep. David M. Gubow

House Bill 4403 (Substitute H-1)
Sponsor: Rep. Lynn Owen

House Bill 4404 (Substitute H-1)
Sponsor: Rep. Lynn Owen

Second Analysis (4-20-93)
Senate Committee (SB 270): Judiciary
House Committee (HB 4033): Mental Health
House Committee (other bills): Judiciary

MASTER FILE

THE APPARENT PROBLEM:

In 1986, the legislature enacted a series of reforms aimed at growing concerns about the effect of the medical liability system on the availability and affordability of health care in Michigan. Reforms that specifically addressed medical liability included limiting awards for noneconomic loss (that is, pain and suffering) to $225,000 (with exceptions), specifying qualifications for expert witnesses, constricting the statute of limitations for bringing a medical malpractice lawsuit, providing for the dismissal of a defendant upon an affidavit of noninvolvement, requiring mediation, and requiring each party either to provide security for costs or to file an affidavit of meritorious claim or defense.

Opinion is widespread in the medical community and elsewhere that these reforms have proved inadequate. Providers of medical care and malpractice insurance cite numerous statistics to support their case. For both doctors and hospitals, medical malpractice insurance costs much more in Michigan than elsewhere; Detroit area hospitals pay the highest liability rates in the country, and even smaller, outstate hospitals pay more than some urban hospitals elsewhere. The average liability cost per bed is $1,400 nationally, $4,600 for the state as a whole, and $6,900 in Detroit, while the $2,800 per bed average for rural Michigan is higher than figures cited for Chicago and Cleveland. A 1990 report of the U.S. Government Accounting Office (GAO) confirms that while rates declined in the nation and adjacent states since about 1988, Michigan rates have continued to increase, although at a slower rate since 1986.

Reports are that only 37 cents of each dollar spent on medical liability premiums goes to victims of malpractice, while roughly half of the money paid in premiums goes to legal fees (plaintiff and defense combined) and court costs. Payouts per claim are increasing; one hospital insurer reports a 173 percent increase--from $51,000 to $139,000--in its average payout per claim between 1986 and 1990. Lawsuits, too, are on the rise, threatening to widen the gap between Michigan and other states; nationally, about a half-dozen lawsuits are filed annually for every 100 physicians, but the figure for Michigan is closer to 20 lawsuits per 100 physicians.

Using survey results and anecdotal evidence, critics of the current system maintain that litigiousness and the high cost of insurance in Michigan drive out physicians, either literally out of the state, or out of practice through early retirement. Many other physicians choose to remain in practice, but eliminate costly elements such as obstetrics that carry a comparatively high risk for lawsuits (for example, obstetrical coverage in Detroit costs $134,000 annually for $1 million per occurrence/$3 million aggregate coverage; for $100,000/$300,000

coverage, the annual cost is $63,000). The medical liability climate thus is held at least partly responsible for problems that people in urban centers and rural areas have in obtaining medical care, and responsible for increasing health care costs by forcing physicians to practice "defensive medicine."

One thing that carries the potential to reduce the time and expense of malpractice lawsuits is the use of binding arbitration. However, existing arbitration provisions, which date to 1975, are little used; lack of participation has been attributed to patients' distrust of the current makeup of arbitration panels (which must have a physician as one of the three members), physician reluctance to serve on panels, the unwieldy process, and a lack of incentives to participate.

To alleviate problems with the state's medical liability system and address widespread dissatisfaction with it, further reforms have been proposed.

THE CONTENT OF THE BILLS:

Senate Bill 270 would amend the Revised Judicature Act (MCL 600.1483 et al.) to do the following with regard to medical malpractice actions: revise limits on noneconomic damages and link them to compliance with proposed financial responsibility requirements, limit attorneys' contingency fees, require expert witnesses to be of the same board-certified specialty or health profession as the defendant, bar a plaintiff from receiving payment for the loss of an opportunity to survive, require a plaintiff to notify a defendant 182 days before filing a suit, provide for the waiver of the physician-patient privilege when a malpractice suit is commenced, enact new provisions on voluntary binding arbitration, generally constrict the statute of limitations on suing for injuries done to minors, and eliminate the tolling (suspension) of the statute of limitations when a foreign object was left in the body.

The bill is tie-barred to House Bills 4033, 4403, 4404, and the "physician discipline" package (House Bills 4076, 4295, and companion bills). Generally speaking, provisions that are procedural in nature (such as those dealing with expert witnesses, arbitration, and the 182-day notice requirement) would apply to cases filed on or after October 1, 1993, while substantive provisions (such as those dealing with noneconomic loss limits and statutes of limitations) would apply to causes of action arising on or after October 1, 1993.

A more detailed explanation follows.

Noneconomic losses. The bill would replace the current $225,000 limit on noneconomic losses (which statutory adjustments for inflation have increased to a reported $280,000) and the exceptions to it with a two-tier limit. Generally, payment for noneconomic losses could not exceed $500,000. However, the limit would be $1 million if there had been a death, if there were a permanent disability due to an injury to the brain or spinal cord, if damage to a reproductive organ left a person unable to procreate, or if a medical record had been illegally destroyed or falsified. The award caps would be halved for a defendant who was in compliance with the financial responsibility requirements proposed by House Bill 4404. Caps would be annually adjusted for inflation.

Contingency fees. An attorney's contingency fee would be limited to 15 percent of the amount recovered if the claim was settled before mediation or arbitration, 25 percent if settled after mediation or arbitration but before trial, and 33-1/3 percent if the claim went to trial. (Court rules limit contingency fees to 33-1/3 percent.) The bill would prescribe the manner of computing the fee, require a contingency fee agreement to be in writing, and require an attorney to make certain disclosures regarding fees. An attorney whose contingency fee agreement provided for a contingency fee in excess of that allowed could not collect more than what would be received under his or her usual hourly rate of compensation, up to the amount provided by the applicable contingency fee limit.

Expert witnesses. At present, if the defendant physician or dentist is a specialist, an expert witness must be of the same or related specialty and at the time devoting a substantial portion of his or her professional time to either active clinical practice or medical or dental school instruction. Under the bill, each expert witness (not just those in cases involving specialists) would have to have spent a substantial portion of the preceding year in active clinical practice in the same health profession as the defendant or in the instruction of students. If a defendant was board-certified, the witness would have to be, and if the defendant was a general

practitioner, the witness would have to either be a general practitioner or instructing students.

Neither the tax returns nor the personal diary or calendar of an expert witness could be sought or used by counsel to determine whether an expert witness was qualified, and counsel would be forbidden from interviewing the witness's family members concerning the amount of time the witness spent engaged in his or her health profession.

Lost opportunity to survive. A plaintiff would be barred from recovering for a lost opportunity to survive. (This would override the 1990 decision of the Michigan Supreme Court in Falcon v. Memorial Hospital, 436 Mich. 443. In that case, the court held that in medical malpractice actions, loss of an opportunity to survive is compensable in proportion to the extent of the lost opportunity, even though the opportunity was less than fifty percent and it was not probable that an unfavorable result would or could have been avoided. Under this decision, the plaintiff must establish that the defendant more probably than not reduced the opportunity of avoiding harm.)

Advance notice of suit. For the stated purposes of promoting settlement without the need for formal litigation, reducing the cost of medical malpractice litigation, and providing compensation for meritorious medical malpractice claims that would otherwise be precluded from recovery because of litigation costs, the bill would require a plaintiff planning to file suit to notify a defendant at least 182 days before commencing court action. The notice could be filed later if a statute of limitations was about to apply. Meeting the 182-day requirement for one defendant would cover meeting it for any future defendants added to the suit. The notice would have to contain certain minimum information about the case and its basis.

The claimant and the defendant would have to give each other access to each other's medical records within 91 days after the notice. A defendant's failure to allow timely access to records would be penalized under provisions regarding affidavits of merit and interest on judgments (see below). Within 126 days after the notice, the defendant would have to furnish the claimant with a written response with certain information about the defense; failure to provide the information on time would entitle the claimant to file suit immediately.

Affidavits of merit. Existing law requires plaintiffs and defendants either to post a $2,000 bond or other financial security for payment of costs, or to file an affidavit of meritorious claim or defense. The bill would delete provisions allowing security for costs to be filed in lieu of an affidavit. Affidavits would have to contain information on the basis and allegations of the case, as prescribed by the bill (this information would parallel that to be exchanged under the 182-day notice provisions). If the defendant failed to allow access to medical records as required by the 182-day notice provisions, a plaintiff's affidavit could be filed 91 days after the complaint.

Professional privilege. Someone claiming malpractice would be considered to have waived the physician-patient privilege or similar privilege with respect to a person or entity who was involved, whether or not that person was a party to the claim or action. A defendant could communicate with other health facilities or professionals to obtain relevant information and prepare a defense; disclosure of that information to the defendant would not constitute a violation of the physician-patient privilege.

Arbitration. The bill would repeal Chapter 50a of the act, which provides for arbitration of medical malpractice lawsuits, and replace it with provisions for voluntary binding arbitration that would apply to cases where damages claimed amounted to $75,000 or less, including interest and costs. The bill's arbitration procedures would be available during the 182-day notice period (that is, after notice was given but before a case was filed). Unlike current law, which calls for an arbitration panel consisting of a doctor, a lawyer, and someone who is neither, under the bill the parties would agree to a process for the selection of a single arbitrator. The arbitration agreement would also apportion the costs of the arbitration and contain waivers of the right to trial and appeal; defendants would waive the question of liability. The parties could agree to a total amount of damages greater than $75,000.

There would be no live testimony, and court rules on discovery would not apply, although certain information would have to be exchanged upon request under deadlines established by the arbitrator. The arbitrator could issue the decision with or without holding a formal hearing, although he or she would have to conduct at least one telephone conference call or meeting with the

parties. If there was a hearing, it would have to be limited to presentation of oral arguments. The arbitrator would issue a written decision stating the factual basis for it and the amount of any award. There would be no right to appeal the award.

Settlements. If a case was settled (with or without court supervision), the parties would have to file a copy of the settlement agreement with the appropriate bureau of the Department of Commerce. The information would be confidential except for use by the department in an investigation; it would not be subject to the Freedom of Information Act.

Mediation. Current law provides for mediation of medical malpractice suits. Under the bill, if a defendant rejected a mediation panel's evaluation, but the plaintiff did not, and the case went to trial, the defendant's insurer would be liable for the plaintiff's costs unless the verdict was more favorable to the defendant than the mediation evaluation.

Statute of limitations--general. Generally, a medical malpractice action must be commenced within two years after the injury was caused, or six months after it was or should have been discovered, whichever was later; however, in no event may it be commenced more than six years after the injury was caused. However, for certain injuries, this six-year statute of repose does not apply; the bill would eliminate an exception for situations where a foreign object was wrongfully left in the patient's body, and limit an exception for reproductive injuries to those where there was a loss of the ability to procreate in someone under 35 years old. An exception for fraudulent conduct of a health care provider would be retained. Giving 182-day notice as required by the bill would toll (suspend the running of) the statute of limitations.

Statute of limitations--minors. The running of the statute of limitations is suspended until someone reaches age 13. For injuries to a child that occur before age thirteen, action must be commenced by the time the child reaches age 15; after age 13 the regular medical malpractice statute of limitations applies. Under the bill, the running of the statute of limitations would be suspended until a child reached age 10, and an action for a child under that age would have to be commenced before the child's twelfth birthday, or within the regular medical malpractice period of limitations, whichever was later (the six-year statute of repose would not apply).

However, if an injury to the reproductive system of someone under age 13 was claimed, the claim would have to be brought before his or her fifteenth birthday or before the regular medical malpractice statute of limitations would apply, whichever was later (the six-year statute of repose would not apply).

Interest on judgments. The law now provides for the calculation and payment of interest on judgments. Under the bill, if a medical malpractice defendant failed to allow access to records as required by the 182-day notice provisions, the court would order that interest be calculated from the date notice was given to the date of satisfaction of the judgment. The injured party, and not his or her attorney, would receive the interest accruing on the portion of a judgment represented by the attorney's fee.

House Bill 4403 would amend the Insurance Code (MCL 500.2204) to require an commercial liability insurer to pay the plaintiff's attorney fees and court costs when an insured defendant had rejected a mediation evaluation under the Revised Judicature Act, the plaintiff had not rejected it, and the case went to trial. However, the payment requirement would not apply if the verdict was more favorable to the defendant than the mediation evaluation. The bill could not take effect unless Senate Bill 270 was enacted.

House Bill 4404 would amend the Public Health Code (MCL 333.16280 and 333.21517) to require each physician, dentist, psychologist, chiropractor, and podiatrist to maintain financial responsibility for medical malpractice actions. The financial responsibility would have to be one of the following: a $200,000 surety bond or irrevocable letter of credit; an escrow account containing at least $200,000 in cash or unencumbered securities; or professional liability insurance coverage with limits of at least $200,000 per claim and $600,000 in the aggregate.

Someone licensed on or before October 1, 1993 would have to file proof of financial responsibility with his or her licensing board by January 1, 1994. Others would have to file proof within 90 days after the issuance of a license. After the initial filing, proof would have to be filed annually.

Financial responsibility requirements would not apply to someone with a hospital affiliation, if the hospital provided the equivalent amount of financial responsibility. However, if the person practiced outside of the hospital, he or she would have to maintain financial responsibility for that portion of his or her practice performed outside the hospital. Financial responsibility requirements would not apply to someone whose practice outside of a hospital consisted of at least 25 percent uninsured and Medicaid patients, based on the total number of patients treated annually by the person. Proof of such a practice would have to be filed with the person's board.

A hospital would be prohibited from granting privileges to a physician unless financial responsibility requirements were met. Compliance with the bill would not be a condition of licensure for a physician or other person required to maintain financial responsibility.

The bill could not take effect unless Senate Bill 270 was enacted.

House Bill 4033 would amend the Mental Health Code to forbid a licensee under the code (a mental hospital, psychiatric hospital, or psychiatric unit) from granting privileges to physician who was not in compliance with the financial responsiblity requirements of House Bill 4404, unless the licensee covered the physician as allowed by House Bill 4404. The bill could not take effect unless Senate Bill 270 was enacted.

HOUSE COMMITTEE ACTION:

The House Judiciary Committee adopted a substitute for Senate Bill 270 that differed from the Senate-passed bill in proposing new provisions on arbititration, and linking medical malpractice reform to requirements for financial responsibility. The substitute's provisions on contingency fees, noneconomic losses, expert witnesses, and the statute of limitations also differed from those in the Senate-passed version.

FISCAL IMPLICATIONS:

Fiscal information is not available at present.

ARGUMENTS:

For:

The bills would go far to discourage unjustified medical malpractice lawsuits and reduce the costs of the medical malpractice liability system, thus helping to contain spiraling health care costs, stem the flight of physicians out of Michigan, and assure the citizens of this state access to affordable health care. Stricter limits on pain and suffering awards, limits on contingency fees, early notice requirements, and new arbitration provisions would reduce litigation costs by encouraging arbitration and early settlement and curbing excessive awards.

New limits on pain and suffering awards and the medical malpractice statute of limitations would further help to reduce insurance costs by addressing the uncertainties and long period of exposure in this highly volatile area of insurance. Without such measures and controls on the costs of litigation, there is little to be done to reduce premiums, for neither they nor profits are inflated: the major malpractice insurers are customer-owned (that is owned by physicians or hospitals), and the insurance bureau reports a healthy degree of competition in the marketplace.

Victims of medical malpractice would not be ignored, however: requirements for physicians to maintain financial responsibility, provisions on payment of judgment interest, and incentives to arbitrate small suits that might otherwise go begging for legal representation all would help to put money in injured patients' pockets. Links to the physician discipline package would recognize the need to also protect patients by reducing the incidence of malpractice. And, eventually, the bills would help patients by holding back health care costs, and not only through effects on premiums; far greater savings are likely through easing physicians' litigation fears, thus reducing the need to practice "defensive medicine" which drives up the cost of health care through the use of high technology and second opinions.

The bills offer a balanced compromise that should streamline the system to the ultimate benefit of both patients and health care providers.

Against:

Many dispute whether there really is any sort of malpractice "crisis" that demands resolution, especially a resolution that restricts legal recourse for victims of malpractice. If Michigan has more than its share of malpractice lawsuits, it is because Michigan ranks low in its effectiveness in getting bad doctors out of business, and because insufficient attention has been devoted to risk management in hospitals, where the vast majority of malpractice claims arise. If insurance costs too much, it is because insurers are charging too much; profits are up in recent years, but premiums continue to rise. More carriers are writing malpractice insurance in Michigan, and availability problems have decreased.

The numbers of physicians are up, not down, thus countering assertions that Michigan's malpractice climate has led to problems in obtaining care. Moreover, it is unreasonable to hold the medical malpractice system responsible for the lack of health care for residents of poor urban and rural areas of Michigan; recruiting doctors to such places is a problem across the country, and has long been so.

If rising costs of health care are a real concern, then attacking the medical liability system would have little effect: insurance premiums represent only one or two percent of total health care costs, and "defensive medicine" habits are unlikely to be affected (nor should they, say some, as the caution and thoroughness that characterize "defensive" medicine also characterize good medicine).

Virtually every assertion made by the proponents of medical liability reform has been challenged with conflicting data. Many believe the picture is not as clear as some present it, and urge restraint before prematurely assuming the reforms of 1986 need strengthening. Rather than again taking aim at the victims of malpractice, reformers should first look to the defects of the insurance and physician discipline systems.

Against:

While the reforms are a step in the right direction, they do not go far enough. Overly broad exceptions to caps on noneconomic awards would continue to allow half or more of major cases to get out from under the limits, as the language could be stretched to allow the exemption of many relatively minor injuries. A permanent limp, for example, could be argued to meet the exception for permanent disability.

Contingency fee provisions also are inadequate: without firm limits on attorneys' financial incentives to seek windfall awards in marginal cases, case filings are unlikely to decline. Worse, the proposed sliding scale would give attorneys an incentive to push for trial by giving them a bigger take than if they settled out of court or accepted arbitration.

Finally, Senate Bill 270 would do nothing to rid the system of professional witnesses. By allowing expert witnesses to qualify if they spend a "substantial portion" of their time in the necessary fields, the bill would continue to allow justice to be subverted by traveling "guns for hire."

Against:

Limits on contingency fees raise a number of constitutional issues. Being a matter of practice and procedure, contingency fees are properly within the constitutionally-determined purview of the supreme court, and are at present set by supreme court rule. An attempt to regulate contingency fees in statute would conflict with the court's constitutional rule-making authority and the doctrine of separation of powers. Statutory limits on plaintiffs' attorney fees may also violate constitutional provisions for equal protection, if defendants' fees are not also regulated. Finally, by inserting itself into a matter that is between attorney and client, Senate Bill 270 may intrude on the right to contract.

Against:

A major problem with the current state of affairs is the heavy financial burdens that a physician must assume to practice in Michigan. Rather than ease those burdens, the legislation would add to them by requiring physicians to maintain a specified form of financial responsibility or lose hospital privileges. The financial responsibility requirements would tend to exacerbate problems with physicians leaving practice in Michigan.

POSITIONS:

The State Bar of Michigan opposed Senate Bill 270 as passed by the Senate, has concerns about the constitutionality of provisions on contingency fees, and is supportive of portions of the House substitute. (3-30-93)

The Michigan Trial Lawyers Association does not support the package. (3-30-93)

The Advocacy Organization for Patients and Providers does not believe the package will resolve the problem, in part because it is not linked to insurance reform. (3-30-93)

Physicians Insurance Company of Michigan (PICOM) opposes the package, but could support it with amendments. (3-30-93)

The Michigan Medical Liability Reform Coalition opposes the bills. (3-30-93) Organizations in the 75-member coalition include the following:

Greater Detroit Chamber of Commerce
Michigan Association for Local Public Health
Michigan Association of Osteopathic Physicians and Surgeons
Michigan Dental Association
Michigan Farm Bureau
Michigan Hospital Association
Michigan Hospital Association Mutual Insurance Company
Michigan Insurance Federation
Michigan Manufacturers Association
Michigan Physicians Mutual Liability Company
Michigan State Medical Society
Physicians Insurance Company of Michigan