STATE OF MICHIGAN

COURT OF APPEALS

AMY GARCIA,

Plaintiff-Appellee,

v

NORMAN GOVE, M.D., ANN ARBOR OB/GYN ASSOCIATES, P.C., and INTEGRATED HEALTH ASSOCIATES, INC.,

Defendants-Appellants,

and

KARENNA DICKERSON, M.D., ROMINA DUNNAM, D.O., and TRINITY HEALTH-MICHIGAN d/b/a ST. JOSEPH MERCY HOSPITAL-ANN ARBOR,

Defendants.[1]

UNPUBLISHED
November 12, 2013

No. 308302
Washtenaw Circuit Court
LC No. 10-000123-NH

AMY GARCIA,

Plaintiff-Appellee,

v

NORMAN GOVE, M.D., ANN ARBOR OB/GYN ASSOCIATES, P.C., and INTEGRATED HEALTH ASSOCIATES, INC.,

No. 308756
Washtenaw Circuit Court
LC No. 10-000123-NH

[1] On March 31, 2010, Romina Dunnam, D.O. and Karenna Dickerson, M.D. were dismissed from this case by stipulation and order. On February 7, 2012, St. Joseph Mercy Hospital – Ann Arbor, an assumed name of Trinity Health-Michigan, was dismissed from this case by stipulation and order.

Defendants-Appellants,

and

KARENNA DICKERSON, M.D., ROMINA DUNNAM, D.O., and TRINITY HEALTH-MICHIGAN d/b/a ST. JOSEPH MERCY HOSPITAL-ANN ARBOR,

Defendants.

AMY GARCIA,

Plaintiff-Appellee,

v

No. 308757
Washtenaw Circuit Court
LC No. 10-000123-NH

NORMAN GOVE, M.D., ANN ARBOR OB/GYN ASSOCIATES, P.C., and INTEGRATED HEALTH ASSOCIATES, INC.,

Defendants-Appellants,

and

KARENNA DICKERSON, M.D., ROMINA DUNNAM, D.O., and TRINITY HEALTH-MICHIGAN d/b/a ST. JOSEPH MERCY HOSPITAL-ANN ARBOR,

Defendants.

Before: MURPHY, C.J., and CAVANAGH and STEPHENS, JJ.

PER CURIAM.

Defendants, Norman Gove, M.D., Ann Arbor OB/GYN Associates, P.C., and Integrated Health Associates, Inc., appeal as of right a judgment entered in plaintiff's favor following a jury

trial in this medical malpractice action, as well as an order granting plaintiff case evaluation sanctions and costs.[2] We affirm.

On July 20, 2007, plaintiff began treating with Dr. Gove regarding the pregnancy at issue in this matter. At a visit on September 19, 2007, however, Dr. Gove concluded that plaintiff suffered an intrauterine fetal demise. A surgical procedure was required to remove the fetal remains. Plaintiff returned to Dr. Gove's office on September 24, 2007, at which time Dr. Gove's partner, Dr. Bryan Popp, placed laminaria inside her uterus. Laminaria is known to dilate and/or soften the uterus in preparation for removal of the fetal remains through a surgical procedure.

On September 25, 2007, plaintiff went to the hospital for the surgical procedure to be performed by Dr. Gove. He was being assisted in this procedure by a resident, Dr. Romina Dunnam, who had completed one year of OB/GYN residency and was starting her second year. After plaintiff was given anesthesia and rendered unconscious, the laminaria was removed. At that time it appears that Dr. Gove determined by digital examination that the internal portion, or "os," of the cervix was not dilated. Dilation of the cervix was necessary to permit removal of the fetal remains. Therefore, it was determined that the serial placement of dilators of increasing size was necessary to achieve dilation. Dilators are made of metal, are curved, and have blunt ends. Dr. Gove did not verify the position or angle of plaintiff's cervical canal with ultrasound or any other device before the dilators were inserted. And according to Dr. Gove, the insertion of dilators is a blind procedure; thus, no ultrasound was utilized to guide placement. Dr. Gove knew that plaintiff previously had a caesarian section and that she had an anteverted uterus. At trial Dr. Gove testified that, while he was applying counter-traction to plaintiff's cervix by grasping its anterior lip with polyp forceps and pulling down, Dr. Dunnam placed approximately five dilators and eventually achieved dilation of the external os. However, Dr. Dunnam testified that she attempted to dilate the cervical os, but at some point was unable to do so. Dilation was not progressing. Dr. Dunnam testified that she "attempted to insert a dilator in the cervix, the cervical os, but was unable to insert the dilator in properly." Therefore, Dr. Dunnam testified, Dr. Gove took over the dilation procedure. Dr. Gove denied that he placed any of the dilators or took over the dilation procedure.

After dilation of the external os was achieved, Dr. Gove did not perform an examination to confirm that the internal os was also dilated. Instead, Dr. Gove inserted ring forceps into plaintiff's uterus and grasped what he thought was fetal tissue. He rotated the tissue and pulled it downward, but lost his grasp. He then grasped tissue for a second time and pulled it out, but it was obvious that the tissue being removed was bowel, not fetal tissue. The first grasp removed several centimeters of tissue and the second grasp was a larger amount of tissue. The tissue extracted were sections of plaintiff's rectum and bowel. Dr. Gove eventually was successful at removing the fetal remains with a suction curette, but plaintiff had to undergo an emergency

[2] In this opinion, we will refer to all three defendants-appellants in the singular as "defendant" because Dr. Gove's practice is Ann Arbor Associates, PC and it is owned by Integrated Health Associates, Inc.

exploratory laparotomy to repair the rectum and bowel injuries. Additional surgical and medical procedures related to her rectum and bowel injuries were also required, and she continues to experience bowel abnormalities.

Subsequently, plaintiff filed this medical malpractice action alleging that Dr. Gove's negligence caused her rectum and bowel injuries. At the trial on this matter, several experts testified. Numerous issues were contested, including (1) whether plaintiff was in the first or second trimester of pregnancy at the time of the procedure; (2) whether the surgical procedure performed on plaintiff was a dilation and curettage (D & C) or a dilation and extraction/evacuation (D & E); (3) the proper method of performing this surgical procedure; and (4) whether removal of sections of rectum and bowel is a known risk or complication of this surgical procedure. We will consider testimony regarding each contested issue in turn.

First, we consider testimony regarding the issue whether plaintiff was in the first or second trimester of pregnancy at the time of the surgical procedure. On August 20, 2007, plaintiff's medical record at Dr. Gove's office indicated a gestational age of 10.3 weeks, which Dr. Gove changed to 9.6 weeks (one day short of ten weeks). On September 19, 2007, plaintiff's medical record indicated a gestational age of 14.3 weeks, but at that time it was determined that plaintiff suffered an intrauterine fetal demise. Based on the ultrasound, Dr. Gove determined the gestational age to be 11.5 weeks to 12.2 weeks. Dr. Gove testified that the second trimester begins after 13 and one-third weeks; thus, plaintiff was in her first trimester.

Plaintiff's Experts

Dr. Ronald Zack testified that up to 12 weeks of pregnancy is the first trimester and 12 to 24 weeks is the second trimester. In this case, plaintiff was between 12 and 14 weeks; thus, she was in the second trimester.

Dr. Fred Duboe testified that the second trimester begins at 12 weeks; thus, plaintiff was in the second trimester.

Dr. Jeffrey Soffer testified that plaintiff was in her second trimester of pregnancy.

Defendant's Experts

Dr. Bryan Popp testified that when a fetus is 12 weeks and one day, it is a second trimester pregnancy; but, in this case, he believed that plaintiff was at the end of the first trimester.

Dr. Robert Stager testified that it is common for pregnancy wheels (educational literature) to indicate that after 12 completed weeks, the second trimester begins. But he believed that any time before 14 weeks was a first trimester pregnancy.

Dr. Robert Goldfarb testified that each trimester is 13 weeks; thus, plaintiff was in her first trimester.

Dr. George Shade, Jr. testified that the first trimester is three months in length; but, here, plaintiff was in the first trimester. Dr. Shade did not disagree with a DMC Hutzel Hospital website health library document which stated that the first trimester is 12 weeks in length.

Second, we consider testimony regarding the issue whether the procedure performed on plaintiff was a dilation and curettage (D & C) or a dilation and extraction/evacuation (D & E). Dr. Gove testified that he performed a D & C on plaintiff and that D & E procedures are done in the second trimester, which occurs after 13 and one-third weeks.

Plaintiff's Experts

Dr. Zack testified that a D & E is generally done in second trimester pregnancies and it means that fetal parts are extracted using instruments, including ring forceps. A D & C procedure is performed using either a sharp curette or a suction curette and, up to 12 weeks, ring forceps are almost never used because the products can be evacuated with a suction curette.

Dr. Duboe testified that plaintiff's condition was treated as a second trimester pregnancy because laminaria and ring forceps were used in this procedure.

Dr. Soffer testified that a D & E is a dilation and evacuation. In this case, a D & E was performed because laminaria and ring forceps (not a suction curette) were used in this procedure.

Defendant's Experts

Dr. Stager testified that this was a suction D & C procedure, but admitted that he could see why some people would refer to this procedure as a D & E. However, it is the size of the fetal tissue that determines whether it is a D & E, not the use of particular instruments. But a procedure also could be considered a D & E based on the week of gestation and the 12-week definition is widely used across the country. Dr. Stager explained that a D & C means dilation and curettage, with "curettage" meaning the cleaning of the cavity, which can be done with suction. A D & E procedure means the contents of the cavity are evacuated and it is called "evacuation" because the suction curettage will not work; ring forceps are used to grasp the tissue.

Dr. Shade testified that in performing a D & C, a curette is used to scrape and remove tissue from the uterine cavity. A D & E can also be performed using a curette (either a sharp or suction curette) in conjunction with an instrument such as forceps which has a round ring surface to it. The "E" in a "D & E" procedure refers to extraction. Dr. Shade testified in his deposition, which was referenced during his trial testimony, as follows: "well once they put the ring forceps in that made it an extraction, yes."

Third, we consider testimony regarding the proper method of performing the dilation procedure. Dr. Gove testified that the resident doctor assisting him, Dr. Dunnam, performed the entire dilation procedure. Dr. Dunnam testified that she attempted to perform the dilation procedure "[a]t the very beginning of the case," but could not and so Dr. Gove took over and performed the dilation procedure. The perioperative registered nurse, Karen Kilar, who was in

the operating room during the surgery, did not recall who began or completed the dilation procedure. Dr. Gove also testified that he could tell how much pressure Dr. Dunnam was placing against plaintiff's cervix when he was applying counter-traction to the cervix during the dilation procedure.

Plaintiff's Experts

Dr. Zack testified that, because Dr. Dunnam was inexperienced in performing this procedure, Dr. Gove should have had his hands on her hands so that he could feel the tension and the give during the dilation procedure. Further, when a person is applying counter-traction to straighten the uterus, that person (a) cannot feel the amount of force that is being used by the person who is placing the dilators, (b) cannot feel the general give through the opening of the cervix, and (c) cannot know whether the approach angle to the cervix is proper.

Dr. Duboe testified that, when he was a resident and involved in the dilation of a cervix, an attending physician had his hands on his own hands, which were on the dilator, and showed him how hard to press, what he should feel, and what the proper resistance was during placement. In this case, because Dr. Dunnam was very inexperienced, Dr. Gove should have had his hands on hers during the dilation procedure.

Dr. Soffer testified that, because Dr. Dunnam was inexperienced in performing this procedure, Dr. Gove "needed complete hands-on supervision and guidance to perform this procedure." That is, the standard of practice required that Dr. Gove teach this resident by "putting his hand on top of her hand and showing her how to guide these dilators."

Defendant's Experts

Dr. Shade testified that, when a resident is having a problem with the dilation procedure, he would expect the attending physician to take over the procedure. And he would have anticipated Dr. Gove to do the dilation himself if the resident was uncomfortable and did not feel that she was appropriately using the dilators. However, it would be very difficult to place your hands on a resident's hands during the dilation procedure because the person actually holding the dilator would get the tactile feedback.

Dr. Goldfarb testified that an attending physician does not have to put his hands on a resident's hands to train them how to dilate a cervix.

Next, we consider testimony regarding the proper way to actually perform a dilation procedure. Dr. Gove testified that, before the dilation procedure began, he did not use ultrasound, a uterine sound, or other device to determine the position, angle, or length of plaintiff's uterus, although he knew that she had a previous caesarian section and an anteverted uterus.

Plaintiff's Experts

Dr. Zack testified that an ultrasound should have been used to determine the position and angle of plaintiff's uterus, particularly since she had the possibility of scar tissue from a previous caesarian section and she had an anteverted uterus.

Dr. Duboe testified that ultrasound or a uterine sound had to be used to determine the length, position, and angle of the uterine cavity after it was determined that the internal os was not dilated and before any potentially harmful instrument was inserted.

Dr. Soffer testified that the standard of practice required that an ultrasound be used to guide the dilators placement, particularly in this case where an inexperienced resident was involved in the dilation process.

Defendant's Experts

Dr. Goldfarb testified that the cause of the perforation in this case was the dilation procedure, but the anatomy of plaintiff's uterus was unexpected.

Dr. Gove testified also that he did not use an abdominal ultrasound to guide the placement of the dilators because: (1) this was a first trimester pregnancy, (2) he was taught not to use ultrasound during a first trimester D & C, and (3) the 12-week pregnant uterus would be under the pubic symphysis bone.

Plaintiff's Experts

Dr. Zack testified that an abdominal ultrasound should have been used to guide the placement of the dilators because it greatly reduces the risk of perforation especially when the uterus is anteverted and there is the possibility of scar tissue from a previous caesarian section. Further, the pubic symphysis bone would not block the use of an abdominal ultrasound. The use of ultrasound is the standard of practice because this was a second trimester pregnancy, plaintiff had a history of previous caesarian section and, because a resident was involved in this procedure, "an ultrasound has to be used."

Dr. Duboe testified that an abdominal ultrasound should have been used to guide the dilators, especially in this case where the internal os was not dilated, the uterus was not flexible, and there was resistance. The use of ultrasound would have taken about an additional five minutes. Further, the pubic symphysis bone would not have interfered with seeing the uterine cavity and was "completely irrelevant."

Dr. Soffer testified that the standard of practice required that an ultrasound be used to guide the dilators in this case.

Defendant's Experts

Dr. Popp testified that he did not know anyone who used ultrasound in the performance of a D & C procedure on a first trimester loss but, when he does a D & E in a second trimester

loss, he uses ultrasound for guidance because it helps you see the structures of the uterus and fetus.

Dr. Stager testified that the standard of practice does not require the use of ultrasound during the performance of a first trimester suction D & C. However, ultrasounds are used during second trimester D & E procedures because ultrasound guidance reduces the risk of perforation.

Dr. Goldfarb testified that the standard of practice does not require the use of ultrasound during a first trimester D & C. However, ultrasound could have been used to show the dilators as they were being passed into the uterus.

Dr. Shade testified that an abdominal ultrasound could have been used to localize instruments during the dilation procedure, but it is not the standard of practice.

Dr. Gove also testified that, after the dilators had been placed and the external os was dilated, he did not confirm that the internal os was also dilated—before he proceeded to enter the space with ring forceps and grasp tissue—because that is not how it is done.

Plaintiff's Experts

Dr. Zack testified that, after the pass of several dilators, the standard of practice required Dr. Gove to confirm that the internal os was dilated, at least through a digital examination which takes ten to 15 seconds.

Dr. Duboe testified that, after the external os was dilated, the standard of practice required Dr. Gove to confirm that the internal os was also dilated before inserting ring forceps, especially here because neither ultrasound nor a uterine sound was used to determine the position and angle of the uterus, and a resident purportedly performed the dilation procedure.

Dr. Soffer testified that the standard of practice required Dr. Gove to confirm the internal os was dilated following the dilation process, and before ring forceps were inserted, which could have been done by digital examination, ultrasound, or a uterine sound. This was especially important in this case where an inexperienced resident purportedly placed the dilators and Dr. Gove's failure to confirm dilation before inserting ring forceps was "inexcusable."

Defendant's Experts

Dr. Goldfarb testified that Dr. Gove could have verified dilation with his finger, an ultrasound, or a uterine sound and that it would be reasonable after allowing a resident to attempt dilation; but, the standard of practice did not require such confirmation. He agreed that, if Dr. Gove had inserted his finger or a uterine sound to check for dilation of the internal os, he may have discovered the perforation. Thus, the problem of perforation may have been diagnosed sooner, before the ring forceps were inserted and rectum and bowel tissue removed.

Dr. Shade testified that, after the cervical os was purportedly dilated, Dr. Gove could have verified that dilation occurred, although it is very difficult, and impractical, to assess dilation of the internal os with a digital examination. After dilation was purportedly achieved,

ultrasound could have been used to confirm the right location before forceps were inserted and tissue was grabbed, but that is not the standard of practice.

Fourth, we consider testimony regarding the issue whether removal of sections of rectum and bowel is a known risk or complication of this surgical procedure. Before the procedure, plaintiff signed a consent form which indicated that risks of the procedure may include: "bleeding, infection, damage to bowel, bladder, uterus, blood vessels, nerves, transfusion and/or formation of blood clots, uterine perforation."

Plaintiff's Experts

Dr. Zack testified that a perforation of the uterus can occur during the dilation procedure but when the uterus is perforated, it can be repaired sometimes even without opening the abdomen and there is no permanent damage. And although a consent form was signed in this case, the complication of bowel being extracted during this procedure is not the kind of complication referred to in the consent.

Dr. Duboe testified that most uterine perforations that occur as a complication of this procedure do not result in bowel injury. And, even if bowel injury is a possible complication of the procedure, tearing out a portion of the bowel is not such a complication.

Dr. Soffer testified that plaintiff signed the consent form but there is "a difference between what we call accepted complications and when it is a complication as a result of a doctor's negligence and substandard care." In this case, the complication "was clearly caused by negligent and substandard care . . . ." Further, he testified that the "complication" that occurred in this case was not the type of unforeseen complication referred to in the consent form and that this was not just a uterine perforation; rather, there was actual severing of plaintiff's bowel "as a result of carelessly going through that perforation not knowing where this ring forcep was going to be headed." If the uterine perforation had been discovered, there would have been no injury to plaintiff's bowel. Further, he testified, a perforation of the uterus will many times heal by itself and that "certainly just the perforation did not do this patient any harm."

Defendant's Experts

Dr. Stager testified that he had two residents perforate the uterus in the past, but there was no injury to the bowel. In this case, he agreed that the real damage was done when Dr. Gove went through the uterine perforation and grabbed rectum and bowel tissues and pulled them through the uterus.

Dr. Goldfarb testified that he has seen a uterus perforated, but not one requiring a bowel resection as in this case. And he had never removed a bowel during this procedure. He admitted that the damage to plaintiff's bowel did not occur because of uterine perforation; rather, it occurred because forceps were passed through that perforation and then rectum and bowel tissues were removed.

Dr. Shade agreed that the actual damage in this case was not the uterine perforation; rather, it was the removal of bowel tissue after ring forceps were inserted through that

perforation. He admitted that a perforated uterus can heal on its own or can be easily repaired without emergency or major surgery. And, although he had perforated a uterus in the past, he had never injured bowel tissue.

Following the witness testimony, jury instructions were discussed. Plaintiff requested the res ipsa loquitur jury instruction, Michigan Civil Jury Instruction 30.05. Defendant objected, arguing that the instruction

> would suggest that there is no other possibility and that the fact it occurs infers that there was negligence. I think that this case has been perhaps egregiously infused with testimony suggesting that there are other reasons for what happened, or that there is a basis for the occurrence of the injury other than the act of negligence. When the res ipsa charge is given . . . it is given when there is unequivocal evidence to suggest that the injury could only have occurred as a result of that fashion in which it is claimed by the plaintiff.
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> [T]heir expert testified that if this is a first trimester pregnancy, there is no need to use ultrasound. Their expert also testified . . . that when this procedure is performed if it is done as it should be done, this can still happen if, in fact, there are adhesions that the physician is not aware of or that he did not appropriately estimate.

The trial court ruled in favor of plaintiff, holding: "[H]aving reviewed [the instruction] in light of the testimony, in light of the use notes that makes reference to this instruction be[ing] given only if there is expert testimony that the injury does not ordinarily occur without negligence, certainly there was some evidence of that and, therefore, I'll allow 30.05." Accordingly, the jury was instructed, in part, as follows:

> If you find that the defendant had control over the instrumentality which caused the plaintiff's injury and that the plaintiff's injury is of a kind which does not ordinarily occur without someone's negligence, then you may infer that the defendant was negligent. However, you should weigh all of the evidence in this case in determining whether the defendant was negligent and whether that negligence was a proximate cause of plaintiff's injury.

Subsequently, the jury returned a verdict in plaintiff's favor, answering in the affirmative the questions whether defendants Dr. Gove, Ann Arbor OB/GYN Associates and Integrated Health Associates were "professionally negligent in one or more of the ways claimed by Plaintiff" and whether their "professional negligence [was] a proximate cause of the injury or damages to Plaintiff . . . ." Thereafter, a judgment consistent with the jury verdict was entered and these appeals followed. In docket numbers 308302 and 308756, defendant argues that the trial court committed reversible error by providing the res ipsa loquitur instruction to the jury. In docket number 308757, defendant argues that, if the judgment in plaintiff's favor is reversed by this Court, the order awarding plaintiff case evaluation sanctions and costs should also be reversed. On March 13, 2012, these appeals were consolidated by order of this Court.

We first consider defendant's claim that the trial court committed reversible error by providing the res ipsa loquitur instruction to the jury.

Pursuant to MCR 2.512(C), a party objecting to a jury instruction must state "specifically the matter to which the party objects and the grounds for the objection." See also *Bouverette v Westinghouse Electric Corp*, 245 Mich App 391, 403; 628 NW2d 86 (2001). On appeal, defendant argues that plaintiff failed to present sufficient evidence to establish that three of the four conditions of the res ipsa loquitur doctrine were met. However, these were not the specified grounds for defendant's objection in the trial court. As best we can discern, it appears that defendant's objection may have been that the evidence did not support plaintiff's res ipsa loquitur theory because there was also evidence that plaintiff's injuries could have occurred in the absence of negligence. But because defendant's issues on appeal also challenge the evidentiary support for the res ipsa loquitur instruction, we will consider these issues preserved for appellate review.

We review de novo claims of instructional error that involve questions of law. *Jackson v Nelson*, 252 Mich App 643, 647; 654 NW2d 604 (2002). The jury instructions "should include all the elements of the plaintiff's claims and should not omit material issues, defenses, or theories if the evidence supports them." *Case v Consumers Power Co*, 463 Mich 1, 6; 615 NW2d 17 (2000). A trial court's decision that a standard instruction was applicable to the facts of the case and was supported by the evidence is entitled to deference; accordingly, the decision is reviewed for an abuse of discretion. *Alfieri v Bertorelli*, 295 Mich App 189, 196; 813 NW2d 772 (2012); *Keywell & Rosenfeld v Bithell*, 254 Mich App 300, 339; 657 NW2d 759 (2002). An abuse of discretion occurs when the result is outside the range of principled outcomes. *Nelson v Dubose*, 291 Mich App 496, 500; 806 NW2d 333 (2011). Instructional error warrants reversal only if it "resulted in such unfair prejudice to the complaining party that the failure to vacate the jury verdict would be 'inconsistent with substantial justice.'" *Ward v Consolidated Rail Corp*, 472 Mich 77, 84; 693 NW2d 366 (2005), quoting *Johnson v Corbet*, 423 Mich 304, 327; 377 NW2d 713 (1985) and MCR 2.613(A).

In a medical malpractice case, the plaintiff has the burden of proving: "(1) the applicable standard of care, (2) breach of that standard by defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury." *Cox v Board of Hosp Managers for the City of Flint*, 467 Mich 1, 10; 651 NW2d 356 (2002). In *Jones v Porretta*, 428 Mich 132; 405 NW2d 863 (1987), our Supreme Court formally acknowledged "the Michigan version of res ipsa loquitur which entitles a plaintiff to a permissible inference of negligence from circumstantial evidence." *Id*. at 150. The *Jones* Court further explained that "[t]he major purpose of the doctrine of res ipsa loquitur is to create at least an inference of negligence when the plaintiff is unable to prove the actual occurrence of a negligent act." *Id*. Essentially, a prima facie res ipsa loquitur case proceeds on a theory that, but for negligence, the claimed injury does not ordinarily occur. *Id*. at 157. However, the claimed injury cannot merely be a bad or unsuccessful result. *Id*. at 151-152. The res ipsa loquitur instruction, M Civ JI 30.05, is consistent with the *Jones* holding and provides:

> If you find that the defendant had control over the *[body of the plaintiff/instrumentality which caused the plaintiff's injury]*, and that the plaintiff's injury is of a kind which does not ordinarily occur without someone's negligence, then you may infer that the defendant was negligent.

With regard to professional negligence cases, like medical malpractice cases, the *Jones* Court held:

> [I]n a normal professional negligence case, a bad result, *of itself*, is not evidence of negligence sufficient to raise an issue for the jury. This does not mean that a bad result cannot be presented by plaintiffs as part of their evidence of negligence, but, rather, that, standing alone, it is not adequate to create an issue for the jury. Something more is required, be it the common knowledge that the injury does not ordinarily occur without negligence or expert testimony to that effect. [*Jones*, 428 Mich at 154 (emphasis in original).]

The use note that follows M Civ JI 30.05 is consistent with the *Jones* holding and provides: "This instruction should be given only if there is expert testimony that the injury does not ordinarily occur without negligence, or if the court finds that such a determination could be made by the jury as a matter of common knowledge." Further, the *Jones* Court held that a plaintiff may only rely on the res ipsa loquitur doctrine if: (1) the event was of a kind that "ordinarily does not occur in the absence of someone's negligence;" (2) it was "caused by an agency or instrumentality within the exclusive control of the defendant;" (3) it was not caused by "any voluntary action or contribution on the part of the plaintiff;" and (4) evidence of the true explanation of the event was "more readily accessible to the defendant than to the plaintiff." *Jones*, 428 Mich at 150-151 (quotations and citations omitted); see also *Woodard v Custer*, 473 Mich 1, 7; 702 NW2d 522 (2005).

In this case, one of plaintiff's theories of liability was premised on the res ipsa loquitur doctrine. See, e.g., *Wischmeyer v Schanz*, 449 Mich 469, 483-484; 536 NW2d 760 (1995). Plaintiff argued that the removal of sections of rectum and bowel does not ordinarily occur during a surgical procedure to remove fetal remains from the uterus unless the surgeon is negligent in the performance of the surgery. That is, analogous to cases in which an inappropriate part of the anatomy is removed during surgery, like the wrong limb, the fact that sections of a patient's rectum and bowel are not ordinarily "ripped out" during a procedure to remove fetal remains from a uterus is so blatant that it is within the common knowledge of the jury, i.e., expert testimony is not even necessary. See *Jones*, 428 Mich at 152 n 7; see also *Sullivan v Russell*, 417 Mich 398, 407; 338 NW2d 181 (1983); *Lince v Monson*, 363 Mich 135, 141; 108 NW2d 845 (1961). However, plaintiff also presented expert testimony to prove that her injuries were not "just a bad result" or an "unsuccessful" surgery. See *Jones*, 428 Mich at 152. Plaintiff's experts testified that sections of a patient's rectum and bowel are not ordinarily removed during a surgical procedure to remove fetal remains from the uterus in the absence of negligence.

Plaintiff also argued that, as her experts testified, defendant was negligent because he did not properly perform the dilation part of this surgical procedure and/or because he did not properly perform the curettage or extraction part of this surgical procedure. More specifically, with regard to the dilation part of this procedure, plaintiff argued that defendant was negligent because he: (1) failed to determine the angle, position, and length of plaintiff's uterus before the dilators were inserted, (2) failed to properly supervise the resident physician, if she was involved in the dilator placement, and/or (3) failed to use ultrasound guidance during the placement of the dilators. With regard to the curettage or extraction part of this procedure, plaintiff argued that defendant was negligent because he: (1) failed to confirm that the internal os was dilated after the dilation process and before he inserted ring forceps into plaintiff's uterus in an attempt to remove the fetal remains, (2) failed to confirm that plaintiff's uterus was not perforated after the dilation process and before inserting any instruments into her uterus, (3) attempted to extract the fetal remains using ring forceps instead of a suction curette, and/or (4) failed to appreciate that the tissue he grasped with the ring forceps—not once, but twice—and forcibly removed, was rectum and bowel tissue rather than fetal tissue. Plaintiff also argued that the removal of sections of rectum and bowel are not known risks or complications of this surgical procedure and was not within the contemplation of the consent form that she signed.

As discussed above, defendant argues that plaintiff failed to establish a prima facie case under her res ipsa loquitur theory of recovery. He argues the evidence was insufficient with regard to three of the four conditions of the res ipsa loquitur doctrine; therefore, the jury should not have received the res ipsa loquitur instruction and the trial court reversibly erred by providing the instruction. We consider each of defendant's challenges in turn.

First, defendant argues that plaintiff failed to establish the second element of the doctrine, i.e., she failed to prove the instrumentality that caused her injuries was under his exclusive control. In support of that claim, defendant argues that a resident, Dr. Dunnam, was also involved in the dilation process. Defendant appears to claim that there was more than one "instrumentality" involved in causing plaintiff's injuries—the dilators that caused the uterine perforation and the ring forceps that were used to remove sections of plaintiff's rectum and bowel. And because there was evidence that a resident was involved in the placement of the dilators, defendant did not have exclusive control of the instrumentality of plaintiff's injuries. We disagree.

The surgery at issue is a two-step procedure: dilation and then curettage or extraction. As set forth above, plaintiff asserted that defendant was negligent during both steps of the procedure. A party may plead alternate theories of liability, MCR 2.111(A)(2), and there may be more than one proximate cause of injury. *Allen v Owens-Corning Fiberglas Corp*, 225 Mich App 397, 401; 571 NW2d 530 (1997). The evidence presented at trial established that, during this surgical procedure, plaintiff's uterus was perforated and sections of her rectum and bowel were removed. However, plaintiff did not allege in her complaint that she was entitled to damages because her uterus was perforated during this surgical procedure. Instead, the injuries that gave rise to this lawsuit were plaintiff's rectum and bowel injuries, which required extensive medical and surgical interventions, and resulted in associated permanent injuries. Specifically, plaintiff alleged that the removal of sections of her rectum and bowel required emergency surgical repair, i.e., an anterior proctosigmoidectomy with low colorectal anastomosis and construction of a loop ileostomy. She then had to undergo another surgical procedure to reverse

the colostomy, but continues to suffer from bowel abnormalities. Further, the evidence in this case, including all of the expert testimony, clearly established that the injuries at issue were plaintiff's rectum and bowel injuries, not the uterine perforation.

And the undisputed evidence established that plaintiff's rectum and bowel injuries were caused by ring forceps. Thus, the "instrumentality" that caused plaintiff's rectum and bowel injuries were ring forceps, not dilators. It is also undisputed that defendant had exclusive control of the ring forceps when he inserted them into plaintiff's uterus, when he used them to blindly grasp plaintiff's rectum and bowel tissue, and when he forcefully yanked on the sections of rectum and bowel grasped by those forceps, causing these tissues, rather than fetal tissue, to be removed from plaintiff's body. Accordingly, defendant's claim that the evidence was insufficient to establish that he had "exclusive control" of the instrumentality that caused plaintiff's rectum and bowel injuries is without merit. The second element of the res ipsa loquitur doctrine was sufficiently established by the evidence.

Second, defendant argues on appeal that plaintiff was not entitled to the res ipsa loquitur instruction because she failed to establish the fourth element of the doctrine, i.e., she failed to prove that evidence of the true explanation of the event was more readily accessible to him than to plaintiff. In support of his claim, defendant argues that plaintiff and her experts had access to "all of the facts, records, and testimony they needed" to establish her claims of negligence and there was no need for the jury to infer "whether something negligent had occurred." We disagree.

When defendant performed this surgical procedure, plaintiff was unconscious. Thus, to establish her negligence claims, plaintiff had to rely, in significant part, on the medical records related to the procedure; in particular, the operative report. As Dr. Soffer testified, "[t]he record speaks for the facts of the case." That is, he said, medical records are "key" to reviewing and evaluating a potential medical malpractice case. Dr. Soffer also testified that, in the case of a surgical procedure, the operative report is the step-by-step note which is supposed to state exactly what was done during the particular procedure and in "the sequence of events from start to finish."

In this case, the operative report for this surgical procedure was not detailed, was not in sequential order, was very brief, and was confusing. The negligence claims asserted by plaintiff included that defendant did not properly perform the dilation part of this surgical procedure and/or did not properly perform the curettage or extraction part of this surgical procedure. The deficient and confusing operative report, however, caused plaintiff to be at a significant disadvantage in attempting to prove her claims. For example, the operative report did not state exactly how the dilation procedure was performed or even who performed a substantial part of the procedure. While defendant testified that the resident physician performed the entire procedure, the same resident physician testified that she did not perform the entire procedure. Even the perioperative nurse who was present during the surgery did not know who actually had their hands on the dilators.

Plaintiff also claimed, for example, that defendant should have used an abdominal ultrasound during the dilation procedure. Defendant testified that it would not have been appropriate because of the location of the uterus in relation to plaintiff's pubic symphysis bone. However, there was evidence to suggest that defendant may have used an abdominal ultrasound to locate the uterine perforation after it occurred, as well as to extract the fetal remains.[3] Again, the operative report was brief and confusing in this regard. But if defendant did use the ultrasound after the injuries occurred, a jury might conclude that defendant's claim that ultrasound would not have been helpful with regard to the dilation process was without merit and, thus, find that defendant's failure to use ultrasound during the dilation procedure constituted negligence. Similarly, plaintiff claimed that defendant was negligent in his performance of the curettage or extraction part of this procedure because he failed to confirm that the internal os was dilated before inserting the ring forceps into her uterus. If defendant had checked for dilation of the internal os by digital examination after the laminaria was removed, a jury may have concluded that defendant was negligent for failing to check the internal os again after dilation of the external os was achieved. But, again, the operative record failed to set forth a detailed account of this procedure. Accordingly, we reject defendant's argument that plaintiff failed to establish the fourth element of the res ipsa loquitur doctrine. That evidence of the true explanation of the event was more readily accessible to defendant than to plaintiff was sufficiently established by the evidence.

Finally, defendant argues that plaintiff was not entitled to the res ipsa loquitur instruction because she failed to establish the first element of the doctrine, i.e., she failed to prove the event was of a kind that "ordinarily does not occur in the absence of someone's negligence." Defendant argues that plaintiff's experts admitted that injury to the bowel is a known risk or complication of this surgical procedure. Defendant further argues that plaintiff's experts did not testify that her injury is one that generally does not occur without negligence. We disagree.

The purpose of the surgical procedure at issue was to remove the fetal remains from plaintiff's uterus. There was contested testimony as to whether this was a D & C procedure or a D & E procedure, as well as regarding the correct method of performing either procedure, as set forth above. The consent form that plaintiff signed indicated that risks of the procedure included "damage to bowel" and "uterine perforation." However, in addition to defendant removing the fetal remains from plaintiff's uterus, he also removed sections of her rectum and bowel. Defendant appears to claim on appeal that the removal of sections of a patient's rectum and bowel is a common occurrence in procedures to remove fetal remains, even in the absence of a physician's negligence.

However, the testimony of defendant's three experts refutes this position. Dr. Stager testified that he was aware of two instances of uterine perforation, but in both cases there were no bowel injuries. Dr. Goldfarb testified that he had seen uterine perforations in the past, but not

[3] Both Dr. Popp and Dr. Goldfarb admitted that the operative report *could be* interpreted as saying that Dr. Gove used ultrasound to locate the perforation and remove the fetal remains after sections of plaintiff's rectum and bowel were already removed.

one requiring bowel resection as in this case. And he had never removed a bowel during this procedure. Dr. Shade admitted that, although he had perforated a uterus in the past, he had never injured bowel tissue. Similarly, plaintiff's expert, Dr. Zack, testified that bowel removal during this surgical procedure is not the type of complication or bowel injury that is referred to in the consent form. Plaintiff's expert, Dr. Duboe, testified that the removal of a section of a patient's bowel is not a known risk or complication of this procedure. And Dr. Soffer testified that there is "a difference between what we call accepted complications and when it is a complication as a result of a doctor's negligence and substandard care." . . . and the complication in this case "was clearly caused by negligent and substandard care . . . ." Dr. Soffer specifically testified that "whenever you undergo an operation, there are certain unforeseen complications in the best of hands in the most meticulous of surgeries. This does not qualify as one of those." We conclude that the evidence of record was sufficient to support plaintiff's claim that the removal of sections of rectum and bowel during a surgical procedure to remove fetal remains from a uterus was not a known risk or complication of the procedure and ordinarily does not occur without negligence. Accordingly, defendant's claim that plaintiff failed to establish the first element of the res ipsa loquitur doctrine is without merit.

In summary, we conclude that the trial court did not commit reversible error by providing the res ipsa loquitur instruction to the jury. In this case, reasonable minds could differ as to whether plaintiff's injuries could ordinarily happen but for negligence; thus, plaintiff was entitled to present her theory of liability premised on the res ipsa loquitur doctrine to the jury. See *Jones,* 428 Mich at 155.

However, even if the trial court did err in concluding that the res ipsa loquitur instruction was applicable, after review of the jury instructions in their entirety, we would conclude that such error was harmless. See MCR 2.613(A); *Case*, 463 Mich at 6. The jury was instructed that facts can be proven by both direct and circumstantial evidence, that "[c]ircumstantial evidence by itself or a combination of circumstantial and direct evidence can be used to prove or disprove a proposition" . . . and that it must "consider all the evidence both direct and circumstantial." Thus, the jury was instructed that it could find, on the basis of circumstantial evidence alone, that defendant was negligent with respect to any of the several claims raised by plaintiff. Further, before the res ipsa loquitur instruction was read to the jury, the jury was instructed that "[t]here are risks inherent in medical treatment that are not within a doctor's control. A doctor is not liable merely because of an adverse result." Then the res ipsa loquitur instruction was read to the jury. It is clearly a permissive instruction as denoted by the word "may." That is, the jury was not issued a directive that it must infer negligence if it concluded that defendant had control over the instrumentality which caused plaintiff's injury and that the injury was of a kind which does not ordinarily occur without someone's negligence. And immediately after the res ipsa loquitur instruction was read, the jury was instructed that it "should weigh all of the evidence in this case in determining whether the defendant was negligent and whether that negligence was a proximate cause of plaintiff's injury." It is clear that plaintiff was not relieved of her burden of proof as a consequence of the reading of the res ipsa loquitur instruction to the jury. In summary, defendant has not demonstrated that affirmance of the jury verdict would be inconsistent with substantial justice. See MCR 2.613(A).

In light of our resolution of this dispositive issue, we reject defendant's claim in docket number 308757 that the order awarding plaintiff case evaluation sanctions and costs should be reversed.

Affirmed. Plaintiff is entitled to costs as the prevailing party. See MCR 7.219(A).

/s/ William B. Murphy
/s/ Mark J. Cavanagh
/s/ Cynthia Diane Stephens