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STATE OF MICHIGAN

COURT OF APPEALS

AM, a minor, by Next Friend KALI GROUP,

Plaintiff-Appellant,

v

JACQUES BURGESS M.D. and INDIGO HEALTH PARTNERS PLC,

Defendants-Appellees.

UNPUBLISHED
March 31, 2025
10:15 AM

No. 366788
Grand Traverse Circuit Court
LC No. 2022-036061-NH

Before: GADOLA, C.J., and CAMERON and ACKERMAN, JJ.

PER CURIAM.

In this medical malpractice case involving an issue of causation, plaintiff appeals as of right the trial court's order granting summary disposition in favor of defendants[1] under MCR 2.116(C)(10) (no genuine issue of material fact). We affirm.

I. FACTUAL AND PROCEDURAL BACKGROUND

This case arises out of AM's repeated visits to the hospital between December 20, 2018, and December 30, 2018. On December 20, 2018, AM presented to the emergency department and was diagnosed with acute viral syndrome. He was seen by his primary care provider the following day, where he was diagnosed with a viral upper respiratory tract infection and pharyngitis. He returned to the emergency department on December 22, 2018, at which point he underwent a chest x-ray. The emergency department physician diagnosed AM with acute dehydration secondary to vomiting, and observed the x-ray showed no acute process. He was admitted to the hospital for rehydration and put under the care of Dr. Burgess. Dr. Burgess personally reviewed the chest x-ray, and agreed there was "no acute intrathoracic process," but noted "some air distention under the left hemidiaphragm, [but that the] chest [was] otherwise clear." Dr. Burgess examined AM

[1] There were numerous other defendants that were part of the earlier proceedings of this case, but only Dr. Burgess and iNDIGO Health Partners remained by the time the trial court entered the order being appealed. They are also the only appellees involved in this appeal.

the following morning, whose condition appeared to have improved drastically. Thus, AM was discharged and sent home.

AM returned to the emergency department on December 25, 2018. The emergency department physician diagnosed him with acute viral syndrome, acute persistent dehydration, and acute worsening hyponatremia. AM was admitted to the hospital and assigned to Dr. Burgess's care. Dr. Burgess examined AM again. For the first time since December 20, 2018, AM demonstrated tenderness in his abdomen. Dr. Burgess rereviewed AM's chest x-ray, noting "some significant nonspecific bowel distention but no acute intrathoracic process," and ordered an abdominal x-ray. The abdominal x-ray showed free air under AM's diaphragm, and Dr. Burgess sent AM to undergo an exploratory laparoscopy. The medical procedure revealed an intussusception[2] in AM's small intestine, which was remedied. AM was ultimately discharged from the hospital on December 30, 2018.

Plaintiff filed suit, arguing that Dr. Burgess negligently failed to adhere to the standard of care by failing to order an abdominal x-ray when he saw AM on December 22, 2018, or December 23, 2018. Plaintiff claimed that the x-ray would have allowed Dr. Burgess to "[p]roperly and timely diagnose bowel intussusception on 12/22/18 or 12/23/18[,]" which then could have been treated "with conservative, medical management" or at least treated with surgery before AM suffered additional complications.

Plaintiff retained two experts, Dr. Carol Miller and Dr. Steven Palder, to support these claims. In terms of proximate cause, Dr. Miller testified, as an expert general pediatrician, that she believed the intussusception existed on December 22, 2018. When asked what served as the basis for her opinion, Dr. Miller answered that her opinion was based on AM's chest x-ray showing a distended bowel coupled with a vague reference to his general clinical presentation. When asked whether she knew of any accepted methodology used by physicians to use the date an intussusception was discovered and backdate it to the date of its onset, Dr. Miller confirmed she did not. Dr. Miller further admitted she lacked the expertise to determine whether, had the intussusception been found sooner, AM could have avoided surgery. But Dr. Miller nonetheless contended the alleged delay deprived AM of the "opportunity to at least consider a nonsurgical intervention[.]"

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[2] According to the Mayo Clinic:

> Intussusception . . . is a serious condition in which part of the intestine slides into an adjacent part of the intestine. This telescoping action often blocks food or fluid from passing through. Intussusception also cuts off the blood supply to the part of the intestine that's affected. This can lead to infection, death of bowel tissue[,] or a tear in the bowel, called perforation. [Mayo Clinic, *Intussusception* <https://www.mayoclinic.org/diseases-conditions/intussusception/symptoms-causes/syc-20351452> (accessed February 12, 2025).]

Dr. Palder, who was added later as a witness and had not yet been formally admitted as an expert, testified as an expert in pediatric surgery that he, too, believed the intussusception existed on December 22, 2018. He had the following exchange with defense counsel:

> *Q*. So you've submitted an affidavit in which you opine that [AM] had a bowel intussusception on December 22[,] 2018, true?
>
> *A*. True.
>
> *Q*. And what is the basis for that opinion?
>
> *A*. The basis for that opinion is the clinical history, [his] clinical presentation would be . . . the basis for my opinion.
>
> *Q*. And anything else?
>
> *A*. Well, I would say for what we know from [the] surgery for what [was] found, we know that what [was] found had been there before [he] had it. And I believe that it was there when [he] came in on the 22nd.
>
> *Q*. What features . . . of [AM's] clinical history, clinical presentation, are you relying on as indicative of an intussusception being present on December 22[,] 2018?
>
> *A*. Well, [his] presentation when [he] came in was such that it mandated a diagnostic workup that then would have shown the diagnosis of intussusception.
>
> * * *
>
> [Dr. Palder asks counsel to repeat the question.]
>
> *Q*. Sure. My question is, what clinical history and what aspects of the clinical presentation lead you to conclude that a bowel intussusception was present on December 22[,] 2018?
>
> *A*. When [he] came in on the—okay, I would—I'm not able to say [he] specifically had an intussusception, okay? I'm able to say [he] had a condition that mandated an evaluation at which point you would have found that [he] had an intussusception.
>
> *Q*. Okay. So you've already told me that one of your opinions in this case is that there was an intussusception present on December 22[,] 2018.
>
> *A*. Yes.
>
> *Q*. And I asked you what the basis [was], you said, the clinical history and the clinical presentation.
>
> *A*. Yes.

> *Q*. So what aspects of the clinical history and the clinical presentation lead you to conclude that in your opinion there was a bowel intussusception on December 22[,] 2018?
>
> *A*. Then I need to clarify. I'm not saying that when [he] came in on the 22nd, I would have pointed to [him] and said [he] had an intussusception. I'm saying that when [he] came in on the 22nd, there were things about [his] clinical history, okay, [his] clinical presentation and what I saw on [his] x-rays would have said to me, I need to try to evaluate what's going on with this patient. And at that point I then would have made the diagnosis of intussusception. I'm not saying that—that when [he] came in, I would have said, ah-ha, [he] had an intussusception. I'm saying that there were things about [him] that—to me mandated that diagnostic working been done at which point the diagnosis of [an] intussusception would have been made.

This exchange is characteristic Dr. Palder's testimony in which he refused to provide any specific bases for his opinion outside a general reference to AM's clinical history and admitted there was nothing in AM's presentation that would lead him to immediately believe AM had an intussusception. Indeed, when counsel asked: "What can you point to other than your naked opinion . . . to demonstrate that [AM] had an intussusception on December 22nd or December 23rd of 2018[,]" Dr. Palder replied: "Just my opinion." Dr. Palder also testified that, given the type of intussusception AM had, even if it had been discovered earlier, he would still have required surgical intervention.

Defendants moved for summary disposition, arguing Dr. Palder's testimony should not be admitted because it failed to satisfy the requirements of MRE 702 and MCL 600.2955, and that, because his testimony could not be considered, plaintiff could not establish proximate cause. The trial court ruled that Dr. Palder's testimony was inadmissible and granted the motion, reasoning that plaintiff provided no evidence that any methodology existed to backdate an intussusception from the date it was discovered to its onset. Plaintiff now appeals.

II. STANDARD OF REVIEW

"We review de novo a trial court's decision on a motion for summary disposition." *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152, 159; 934 NW2d 665 (2019). "A motion under MCR 2.116(C)(10) . . . tests the factual sufficiency of a claim." *El-Khalil*, 504 Mich at 160 (emphasis omitted). "When considering such a motion, a trial court must consider all evidence submitted by the parties in the light most favorable to the party opposing the motion." *Id*. "A motion under MCR 2.116(C)(10) may only be granted when there is no genuine issue of material fact." *El-Khalil*, 504 Mich at 160. "A genuine issue of material fact exists when the record leaves open an issue upon which reasonable minds might differ." *Id*. (citation omitted).

III. ANALYSIS

Plaintiff argues the trial court erred by granting summary disposition in favor of defendants. We disagree.

> To establish a cause of action for medical malpractice, a plaintiff must establish four elements: (1) the appropriate standard of care governing the defendant's conduct at the time of the purported negligence, (2) that the defendant breached that standard of care, (3) that the plaintiff was injured, and (4) that the plaintiff's injuries were the proximate result of the defendant's breach of the applicable standard of care. [*Kalaj v Khan*, 295 Mich App 420, 429; 820 NW2d 223 (2012).]

The only issue on appeal concerns the fourth element: proximate cause. "Expert testimony is required to establish the standard of care and a breach of that standard, as well as causation." *Id.* (citations omitted).

We need not consider plaintiff's related argument as to whether the trial court erred in excluding Dr. Palder's testimony under MCL 600.2955. Regardless of whether Dr. Palder's opinion is considered, the outcome is the same. Dr. Miller's opinion was similar to Dr. Palder's: both doctors claimed that AM had an intussusception on December 22, 2018, or December 23, 2018, because of the chest x-ray showing a distended bowel, coupled with considerations of AM's unspecified "clinical presentation." Thus, Dr. Miller's testimony represents Dr. Palder's testimony, even if Dr, Palder's testimony is not considered.

" 'Proximate cause' is a legal term of art that incorporates both cause in fact and legal (or 'proximate') cause." *Taylor v Kent Radiology*, 286 Mich App 490, 511; 780 NW2d 900 (2009) (citation omitted). "In order to establish that a particular action was the cause in fact of an injury, the plaintiff must show that but for the defendant's actions, the plaintiff's injury would not have occurred." *Id.* (quotation marks omitted). "On the other hand, legal cause or proximate cause normally involves examining foreseeability of consequences, and whether a defendant should be held legally responsible for such consequences." *Id.* (quotation marks and citation omitted).

> Generally, an act or omission is a cause in fact of an injury only if the injury would not have occurred without (or "but for") that act or omission. While a plaintiff need not prove that the act or omission was the *sole* catalyst for his injuries, he must introduce evidence permitting the jury to conclude that the act or omission was *a* cause. [*Id.* (citation omitted).]

Plaintiff failed to provide adequate expert testimony to establish that the alleged failure of Dr. Burgess to investigate AM further was the cause in fact of AM's eventual harm. Plaintiff's complaint listed various alleged breaches by Dr. Burgess of the standard of care. These allegations all essentially contended that Dr. Burgess should have known to investigate further and order an abdominal x-ray on the basis of the December 22, 2018 chest x-ray and failed to "[p]roperly and timely diagnose bowel intussusception on 12/22/18 or 12/23/19[.]" While plaintiff argues the trial court conflated a decision on *whether* an intussusception existed with one on *when* it existed, this argument is a distinction without a difference. Plaintiff's claim relies on a finding that the intussusception existed on December 22, 2018, or December 23, 2018, because Dr. Burgess cannot have been negligent for failing to identify and treat a condition that did not yet exist.

Even viewing the evidence in a light most favorable to plaintiff, *El-Khalil*, 504 Mich at 160, plaintiff's claims fail. Plaintiff argued that, because of its rarity, there is a dearth of publications on which plaintiff could rely to support the claims in the complaint. Plaintiff

emphasizes that, in situations such as this, the absence of such publications is not dispositive. However, plaintiff's claim fails because the evidence plaintiff submitted was wholly insufficient to support plaintiff's theory of proximate cause. During her deposition, Dr. Miller was unable to provide a scientifically-sound basis for her conclusion that further testing would have revealed the intussusception earlier. For example, Dr. Miller's conclusion that an intussusception existed on December 22, 2018 was examined during her deposition:

> *Q*. Okay. So is it your opinion in this case that the air distention within the bowel that Dr. Burgess talks about in his consult note of 12-22-18 is due to an obstructing intussusception?
>
> *A*. What I'm saying is . . . that is a significantly abnormal finding. It would—and in the context of this child's abdominal complaints, that it required follow-up because there's no way to make a definitive diagnosis just based on that one film.
>
> *Q*. I'm asking you what your opinion is. Is it your opinion that the bowel distention seen on the x-ray of 12-22-18, the chest x-ray of 12-22-18, is due to an intussusception?
>
> *A*. Oh, I guess I misunderstood. Yes, it's my opinion it was due to intussusception.
>
> *Q*. And . . . is it your opinion that he had an intussusception that was causing at least a partial obstruction that caused bowel distention that is seen on the chest x-ray of December 22[,] 2018?
>
> *A*. That is my opinion.
>
> *Q*. And that's the only basis for any opinion you might have to the effect that [AM] had an intussusception on December 22nd or December 23rd of 2018; is that correct?
>
> *A*. I'm not sure that's correct. I'm not sure I understand that question.
>
> *Q*. You're relying on the chest x-ray of December 22[,] 2018, and what you consider to be appearance of bowel distention on that film to hypothesize that that distention in the bowel seen on the . . . chest x-ray was due to intussusception, true?
>
> *A*. Well, it's in the context of the clinical setting as well, his symptomology of vomiting, dehydration[,] that intussusception is in the differential, would be in the differential [diagnosis].
>
> *Q*. Do you believe that [AM] had intussusception at any time prior to December of 2018?
>
> *A*. I don't have enough information to be able to say that. It . . . is possible, but I would have to date his diagnosis from December 22nd.

Q. Based on the chest x-ray on that same date?

A. That's correct.

In other words, Dr. Miller asserted that, when considering the x-ray showing bowel distention alongside AM's symptoms of vomiting and dehydration, intussusception "would be in the differential [diagnosis]." As explained by the Cleveland Clinic:

> When you visit your healthcare provider with symptoms, they will begin a process to diagnose your condition. Since there are a lot of different conditions that often share similar symptoms, your provider will create a differential diagnosis, which is a list of possible conditions that could cause your symptoms. A differential diagnosis is not your official diagnosis, but a step before determining what could cause your symptoms. [Cleveland Clinic, *Differential Diagnosis*, <https://my.clevelandclinic.org/health/diagnostics/22327-differential-diagnosis> (accessed February 12, 2025).]

On appeal, plaintiff relies on the term "differential diagnosis" as proof that Dr. Miller used a proper, scientifically recognized method to reach her conclusion. We disagree. A differential diagnosis is a "*list of possible conditions*[,]" not an "official diagnosis." *Id*. (emphasis added). Plaintiff was obligated to present sufficient evidence to support the claim that the intussusception existed on December 22, 2018. Dr. Miller's opinion that an intussusception may have been one option among a "list of possible conditions" is insufficient to create a genuine issue of fact as to whether the condition did, in fact, exist on the date plaintiff claims.

More importantly, Dr. Miller acknowledged she was not aware of "any generally accepted methodology that pediatricians can use to take a case of intussusception at the time of diagnosis and reliably pinpoint when the intussusception began[.]" Thus, not only was Dr. Miller unable to properly support her contention that she would have *formally diagnosed* AM with an intussusception at the time he presented to the hospital on December 22, 2018, but she was equally unable to provide any support that she could trace the condition's origin after-the-fact. Simply put, Dr. Miller's testimony provided no scientifically-backed evidence that the condition even existed at that time.

Because plaintiff's experts[3] failed to provide any scientifically-based evidence supporting their conclusions that AM had an intussusception on December 22, 2018, plaintiff failed to

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[3] We acknowledge our above-analysis focuses on the faults solely present in Dr. Miller's testimony. But we reiterate that Dr. Palder's testimony was substantively the same as Dr. Miller's. Even if we consider Dr. Palder's testimony, he offered no explanations beyond those offered by Dr. Miller to support his claim that the intussusception existed on December 22, 2018.

establish a genuine issue of material fact that Dr. Burgess's conduct was the proximate cause of AM's injuries. Accordingly, the trial court properly dismissed the case.[4]

Affirmed.

/s/ Michael F. Gadola
/s/ Thomas C. Cameron
/s/ Matthew S. Ackerman

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[4] Because the medical-malpractice umbrella term "proximate cause" requires both cause in fact and true proximate cause (foreseeability), we need not address whether plaintiff demonstrated the latter. *Taylor*, 286 Mich App at 511.