STATE OF MICHIGAN
IN THE SUPREME COURT

ESTATE OF DANIEL D. JILEK, Deceased
by JOY A. JILEK, Personal Representative,

Plaintiff-Appellee,

v.

CARLIN C. STOCKSON, M.D., and
EPMG of MICHIGAN, P.C., a Michigan
corporation, jointly and severally,

Defendants-Appellants.

Supreme Court Docket No. 141727

Court of Appeals No. 289488

Washtenaw County Circuit
Court Case No. 05-268-NH

BRIEF OF AMICUS CURIAE MICHIGAN STATE MEDICAL SOCIETY

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STATEMENT IDENTIFYING JUDGMENT OR ORDER APPEALED FROM AND RELIEF SOUGHT

Defendants Carlin Stockson, M.D., and EPMG of Michigan, P.C., seek leave to appeal from the non-unanimous Michigan Court of Appeals' decision in *Jilek v Stockson*, ___ Mich App ___; ___ NW2d ___; 2010 Mich App LEXIS 1492 (Mich Ct App July 29, 2010), which held that a physician board certified in family medicine practicing in an urgent care clinic must be held to the standard of care applicable to an emergency room physician. Further, departing from a century of Michigan jurisprudence, the majority also held that internal policies and procedures were admissible to prove the standard of care. Amicus Curiae Michigan State Medical Society supports Defendants' application for leave to appeal and urges this Court to review and ultimately reverse these rulings.

STATEMENT OF QUESTIONS PRESENTED FOR REVIEW

1. Do MCL 600.2912a and MCL 600.2169(1) require that a physician who is board certified in family medicine be held to the standard of care governing family medicine, rather than emergency medicine, where the alleged malpractice occurred when the Defendant was providing treatment in an urgent care clinic?

The Court of Appeals answered "no."

Plaintiff-Appellee answers "No."

Defendants-Appellants answer "Yes."

The Trial Court answered "Yes."

Amicus Curiae MSMS answers "Yes."

2. Are a defendant's internal policies and procedures admissible to establish the standard of care?

The Court of Appeals answered "Yes."

Plaintiff-Appellee answers "Yes."

Defendants-Appellants answer "No."

The Trial Court answered "No."

Amicus Curiae MSMS answers "No."

STATEMENT OF INTEREST OF MICHIGAN STATE MEDICAL SOCIETY

Amicus Curiae Michigan State Medical Society ("MSMS") is a professional association that 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 a continuing interest in issues which affect the medical profession and the patients it serves. Over the course of many years, this Court has graciously permitted MSMS to share its views when legal issues affecting physicians have been presented to this Court. The application for leave to appeal the majority decision in *Jilek v Stockson*, ___ Mich App ___; ___ NW2d ___; 2010 Mich App LEXIS 1492 (Mich Ct App July 29, 2010), Exhibit A, presents such issues.

The plaintiff in *Jilek* filed a wrongful death action against Dr. Carlin Stockson, who is board certified in family medicine, and her employer, Emergency Physicians Medical Group ("EPMG"), alleging that Dr. Stockson was negligent in her treatment of Mr. Jilek at Maple Urgent Care, a free-standing urgent care clinic affiliated with the St. Joseph Mercy Hospital system. *Id.* at *1. Mr. Jilek was seen at the clinic on March 1, 2002, complaining of "continued sinus/respiratory congestion" for several months. He died of a heart attack five days later while exercising. The estate's allegations of medical malpractice were tried to a jury, which returned a verdict of no cause for action. *Id.* at *1. Plaintiff appealed.

In a non-unanimous opinion, the Court of Appeals reversed and remanded for a new trial. The majority (Judges Shapiro and Borrello) found "reversible error" in "the trial court's instruction regarding the applicable standard of care" and "in the manner by which the trial court made that determination." The trial court had instructed the jury "that the applicable standard of care was that of 'a physician specializing in family practice and working in an urgent care center.'" *Id.* at *13. Rejecting the instruction as non-complaint with this Court's ruling in *Woodard v Custer*, 476 Mich 545, 560; 719 NW2d 842 (2006), the majority concluded that "the

trial court erred by not determining what single recognized medical specialty constituted 'the one most relevant specialty,'" and held that the governing specialty in this case was emergency medicine. *Id.* at *4. Explaining further, the majority said:

> In *Woodard*, the Supreme Court foreclosed the notion of multiple or hybrid standards of care and instead made clear that the sole standard to be applied is that flowing from the one most applicable medical specialty. *Id.* at 560. Specifically, the *Woodard* Court held that expert witnesses must "match the one most relevant standard of practice or care – the specialty engaged in by the defendant physician during the course of the alleged malpractice." *Id.* The Court went on to define "specialty" as "a particular branch of medicine or surgery in which one can potentially become board certified." *Id.* at 561. As there is no board certification titled "family practice in an urgent care center" this cannot be considered a specialty defining the most relevant standard of care, let alone the "one most relevant" standard.

Id. at *13-14.

The majority rejected Defendants' assertion that the relevant standard of care is controlled by Dr. Stockson's board certification in family practice, opining that "Dr. Stockson's residency and board certification as a family practitioner ***is not relevant to standard of care***, if the locus or substance of the medicine she was practicing at the time of the alleged malpractice defines a different specialty." *Id.* at *14 (emphasis added). The majority relied upon *Reeves v Carson City Hospital (On Remand),* 274 Mich App 622, 630; 736 NW2d 284 (2007), for the proposition that a physician board certified in family practice but practicing in the emergency room is held to the standard of an emergency medicine physician, and also alluded to various representations made by EPMG and St. Joseph Mercy Hospital – but not Dr. Stockson – that Dr. Stockson was an emergency physician. *Id.* at *14-15. The majority also turned to the dictionary definition of "urgent," finding the term "far more consistent with the scope of emergency medicine ... than family practice." *Id.* at *17. The majority thus concluded "[a]s a matter of law" that the proper standard of care was that of an emergency medicine specialist, and it was error to allow "experts in varying specialties to testify at trial as to their differing views of

what medical specialty was being practiced at the time of the alleged malpractice" as "only testimony by experts specializing in emergency medicine should have been admitted." *Id.* at *4-5.

With all due respect, the majority's erroneous conclusion on this issue distorts the *Woodard* decision and runs far afield of the governing statutes. *Woodard's* "one most relevant specialty" analysis is only triggered when a defendant has multiple board certifications, some of which are not relevant to the alleged malpractice. It simply does not apply when competing board certifications are not at issue and does not permit a physician's sole board certification to be disregarded on the ostensible basis that the physician was practicing outside his specialty. To the contrary, the clear intent of MCL 600.2912a, which codifies the standard of care in Michigan, and MCL 600.2169(1), which prescribes the requirements for a standard of care expert, is to insure that physicians are held to a standard of care that is commensurate with their education, certification, training and experience. Furtherance of this purpose is accomplished by the requirement that the credentials and experience of a standard of care expert match the credentials and experience of the physician against whom, or on whose behalf, the expert will testify. Yet ironically, and contrary to the express language of both statutes, the majority has directed that "Dr. Stockson's residency and board certification as a family practitioner ***is not relevant to standard of care*** ..." *Id.* at *14 (emphasis added), and holds Dr. Stockson to the standard of the specialist to whom Plaintiff alleges Dr. Stockson ***should have referred*** Mr. Jilek, i.e., the emergency room physician. [1] *Jilek's* distortion of *Woodard* and its progeny portends dire

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[1] Dissenting Judge Bandstra disagreed with the majority, explaining:

> Dr. Stockson is a specialist board certified in family medicine, not emergency medicine. Thus, defendants were properly allowed to present expert testimony in defense of the claims against Dr. Stockson by board certified family medicine

consequences for the medical community and runs afoul of the Legislative intent. Granting leave will allow this Court to clarify the realm of *Woodard* and to unequivocally establish that the plain meaning of the statute must be given effect.

A second issue addressed in *Jilek* is whether a defendant's internal policies and procedures are admissible to prove the standard of care. Ignoring over a century of established jurisprudence, the *Jilek* majority held that to the extent internal guidelines and policies are "relevant and are not otherwise infirm under the rules of evidence, they are admissible." *Id.* at *21. The majority found that no statute or privilege bars their admission, and rejected the notion that the Court of Appeals decision in *Gallagher v Detroit-Macomb Hosp Ass'n*, 171 Mich App 761; 41 NW2d 90 (1988), did so, stating:

> [D]efendants ignore *Gallagher's* recognition that "a hospital's rules could be admissible as reflecting the community's standard where they were adopted by the relevant medical staff and where there is a causal relationship between the violation of the rule and the injury." *Id.* at 767. This principle clearly applies in this case and should be the standard by which admission of internal policies, guidelines, and procedures are governed in medical malpractice cases.

___Mich App at __; 2010 Mich App LEXIS 1492, at *22-23 (footnote omitted). The majority thus held that "while internal policies and guidelines do not in and of themselves set the standard

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> specialists. Similarly, the trial court did not err in instructing the jury that the applicable standard of care was that of "a physician specializing in family practice..."

Id. at *35. In the end, plaintiff's expert testified to a standard of care that he attributed to both emergency medicine and family medicine. As dissenting Judge Bandstra explained in *Jilek*, "[t]he jury had heard testimony from experts presented by both sides regarding the differences between an urgent care facility and an emergency room, as well as the standards Dr. Stockson should have complied with as a family medicine physician working in an urgent care setting. To the extent that Dr. Stockson was thus held to a higher standard of care because of the place in which she practiced her family medicine and to the extent that plaintiff was allowed to present testimony from emergency room experts against Stockson, plaintiff's case was strengthened, not weakened." *Id.* at *36-37. Under such circumstances, any error would have been harmless.

of care, they should be admitted so long as they are relevant to the applicable specialty's standard of care and to the injury alleged." *Id.* at *34.[2]

Jilek is a published decision and will have far-reaching and untoward repercussions in the medical malpractice arena. It is, in fact, the latest in a series of cases that have taken the *Woodard* ruling further and further away from the express language of the governing statute. This Court has denied leave to consider these cases. *See, e.g., Reeves v Carson City Hosp.*, 480 Mich 1056; 743 NW2d 894 (2008); *Gonzalez v St. John Hosp.*, 480 Mich 1109; 745 NW2d 749 (2008); *Kwasniewski v Harrington*, 482 Mich 1006; 756 NW2d 83 (2008). It is now time to return the expert witness/standard of care analysis to the plain meaning of the governing statutes and to correct the erroneous ruling regarding the admissibility of internal rules. MSMS respectfully urges this Court to grant the application for leave to appeal.

CONCISE STATEMENT OF FACTS AND PROCEEDINGS

Amicus Curiae Michigan State Medical Society relies upon the facts recited in Defendants' Application for Leave to Appeal.

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[2] Judge Bandstra authored a vigorous dissent, noting:

> The majority ... conclud[es] that it is either "not bound to follow" the only Michigan precedent directly on point . . . or that the holding of *Gallagher* should be ignored while dictum within that precedent should be followed. I disagree with the majority that two precedents that are binding upon us and which applied or reiterated the *Gallagher* holding rather than its dictum can be distinguished away. See *Buczkowski v McKay*, 441 Mich 96; 490 NW2d 330 (1992) and *Zedrojewski v Murphy*, 254 Mich App 50; 657 NW2d 721 (2002).

Id. at *37-38.

ARGUMENT

I. The Court of Appeals Erred in Holding Dr. Stockson to the Standard of Care Applicable to an Emergency Medicine Physician.

A. The Standard of Review

The application for leave to appeal raises issues of statutory construction, which are reviewed de novo on appeal. *Wickens v Oakwood Health Care Sys*, 465 Mich 53, 59; 631 NW2d 686 (2001). However, the appeal also involves an expert's qualification to testify. This Court reviews a trial court's ruling regarding an expert's qualification to testify for an abuse of discretion. *Woodard v Custer,* 476 Mich 545, 557; 719 NW2d 842 (2006). "Discretion is abused when the decision results in an outcome falling outside [the] principled range of outcomes." *City of Novi v Robert Adell Children's Funded Trust*, 473 Mich 242, 254; 701 NW2d 144 (2005) (internal quotations and citations omitted).

B. The Court Should Have Concluded That the Applicable Standard of Care is Family Practice.

The application for leave to appeal addresses the highly important standard of care/expert witness requirement in medical malpractice cases. Although not mentioned in the majority's analysis, MCL 600.2912a, which was enacted in 1977 and amended in 1993, governs the appropriate standard of care in Michigan. The directive of the statute is clear and unambiguous: a ***specialist*** is to be governed by the standard of care recognized within "***that specialty***:"

> (1) Subject to subsection (2), in an action alleging malpractice, the plaintiff has the burden of proving that in light of the state of the art existing at the time of the alleged malpractice:
>
> . . .
>
> (b) ***The defendant, if a specialist***, failed to provide ***the recognized standard of practice or care within that specialty*** as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances, and as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.

MCL 600.2912a (emphasis added).

This Court has not addressed the meaning of "that specialty" within the context of the standard of care statute, and in this case, there was no reason to deviate from its plain meaning. The *Jilek* majority, however, analyzed the question as an expert qualification issue, invoking the application accorded the term under MCL 600.2169. Section 2169(1)(a) provides that if the party against whom or on whose behalf the testimony is offered is a specialist, the expert must also specialize at the time of the occurrence that is the basis for the action "in the ***same specialty*** as the party against whom or on whose behalf the testimony is offered," and if the defendant "is a specialist who is board certified, the expert witness must be a specialist who is board certified in ***that specialty***." MCL 600.2169(1)(a) (emphasis added). The expert must also have devoted a majority of his or her professional time in the year immediately preceding the occurrence to active clinical practice or teaching in "that specialty." MCL 600.2169(1)(b).[3]

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[3] MCL 600.2169 provides in pertinent part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.

Facially, MCL 600.2169 does not address the "standard of care" or how "that specialty" within the meaning of the standard of care statute is to be determined. It has nonetheless become the springboard for making those determinations. And in this case, the *Jilek* majority has turned the plain meaning of the statute on its head.

1. Because Dr. Stockson Did Not Possess "Multiple Specialties," *Woodard* Does Not Apply and There Was No Reason to Deviate From the Plain Language of the Statute.

In *Woodard v Custer, supra*, this Court gave meaning to the term "that specialty" under MCL 600.2169.[4] The defendant physician in *Woodard* treated the plaintiff in the pediatric intensive care unit and was board-certified in pediatrics, with certificates of special qualifications in pediatric critical care medicine and neonatal-perinatal medicine. Plaintiff's proposed expert was board certified in pediatrics but did not have any certificate of special qualification. *Id.* at 554-555. In the companion case, *Hamilton v Kuligowski*, defendant physician and plaintiff's proposed expert were both board certified in internal medicine. However, defendant specialized in general internal medicine, while the expert devoted a majority of his professional time treating infectious diseases, a subspecialty of internal medicine. *Id.* at 556.

In determining whether the proposed experts were qualified to testify, this Court observed that Section 2169(1) does not require an expert to specialize or possess board certificates in areas that are not relevant to the standard of care "about which the witness is to

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> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

MCL 600.2169(1)(a), (b).

[4] Various justices disputed in *Woodard* which opinion was the majority. References to "this Court" in *Woodard* are to the lead opinion.

testify." *Id.* at 559. Section 2169(1) "requires the matching of a singular specialty, not multiple specialties," this Court said, and implies "that the specialty requirement is tied to the occurrence of the alleged malpractice and not unrelated specialties that a defendant physician may hold," quoting *Tate v. Detroit Receiving Hosp,* 249 Mich App 212, 218; 642 NW2d 346 (2002). This Court explained:

> Because the plaintiff's expert will be providing expert testimony on the appropriate or relevant standard of practice or care, not an inappropriate or irrelevant standard of practice or care, it follows that the ***plaintiff's expert witness must match the one most relevant standard of practice or care – the specialty engaged in by the defendant physician during the course of the alleged malpractice***, and, if the defendant physician is board certified in ***that specialty***, the plaintiff's expert must also be board certified in ***that specialty***.

Id. at 560 (emphasis added).

For purposes of determining the one most relevant specialty under MCL 600.2169, *Woodard* defined "specialty" to mean "a particular branch of medicine or surgery in which ***one can potentially become board certified***," and defined "board certified" to mean that the specialist has "received certification from an official group of persons who direct or supervise the practice of medicine that provides evidence of one's medical qualifications." *Id.* at 563-64 (emphasis added). Applying these principles, the majority concluded that the plaintiff's expert was not qualified in *Woodard.* The most relevant specialty in which the defendant physician was engaged at the time of the alleged malpractice was pediatric critical care and because the "defendant physician is board certified in pediatric critical care medicine," the statute required that the proposed expert also have this certificate of special qualifications. *Id.* at 577. The expert was also unqualified in *Hamilton* because, despite the matching board certifications, the expert had not devoted the majority of his professional time in the previous year to general internal medicine.

The *Woodard* rule was intended to apply when a defendant has multiple specialties, only one of which was being practiced at the time of the alleged malpractice. *See e.g,* 476 Mich at 560 ("Therefore, it is clear that § 2169(1) only requires the plaintiff's expert to match one of the ***defendant physician's specialties***.") (emphasis added); 476 Mich at 581 (concurring) ("***[W]here a defendant physician specializes in multiple specialties***, §2169(1)(a) requires an expert witness to specialize only in the same specialty engaged in by the defendant physician during the course of the alleged malpractice, i.e., the one most relevant specialty. And, if the defendant physician is board-certified in 'that specialty' – the one most relevant specialty – the plaintiff's expert witness must also be board certified in that specialty.") (emphasis added).

The premise for the *Woodard* inquiry does not exist in *Jilek.* Dr. Stockson did not possess multiple board certifications and specialties – only one. Because no expert testified that "urgent care" was a specialty in which one could become board certified, "multiple" competing specialties did not exist in the *Reeves* sense and the issue addressed in *Reeves* was not presented. Under the plain language of the governing statute, Dr. Stockson's board certification and specialization in family medicine should have determined the applicable standard of care. *Woodard* does not authorize the *Jilek* majority to elect among specialties if the defendant does not possess multiple specialties and is not practicing another "specialty" outside her "specialty" at the time of the alleged malpractice. It certainly does not allow the court to direct that the standard of care is a specialty that the defendant physician does not possess and that was not being practiced at the time of the alleged malpractice.

2. Because Dr. Stockson Was Not Practicing "Outside" Her Specialty or Practicing "Another Specialty" At the Time of the Alleged Malpractice, *Reeves* and *Gonzalez* Do Not Apply.

Jilek purports to rely upon the Court of Appeals' decisions in *Reeves* and *Gonzalez* but goes well beyond the rationale of those rulings. In purported reliance on *Woodard*, *Reeves* held

that plaintiffs' emergency medicine expert was qualified to render standard of care testimony against the defendant family practice physician because emergency medicine was the "'one most relevant standard of practice or care,'" *Id.* at 628, and defendant was a "specialist" "practicing emergency medicine at the time of the alleged malpractice and potentially could obtain a board certification in emergency medicine." *Id.* at 630. The Court did not suggest any indicators that would make the defendant's acquisition of a board certification in emergency medicine probable – such as, for example, that she concentrated her practice in emergency medicine, or had extensive experience or additional training and education in emergency medicine. In fact, the *Reeves* Court acknowledged that the record was incomplete on that issue, stating "[t]he briefs do not suggest that the record established what is required for board certification in emergency medicine, but presumably a physician can undertake an additional residency and pass whatever boards are required for certification." *Id.* at 629. In the end, the sole underpinning for the Court's conclusion was that defendant was practicing in the hospital emergency room at the time of the alleged malpractice and *could* become board certified in that medical specialty.

In *Gonzalez v. St. John Hosp.*, 275 Mich App 290, 302; 739 NW2d 392 (2007), the Court held a resident who was practicing general surgery at the time of the alleged malpractice to the standard of care applicable to a surgeon. *Gonzalez* relied on this Court's definition that "a 'specialist' is somebody who can potentially become board certified", *Id.* at 303 (quoting *Woodard*, 476 Mich at 561-62) and on *Reeves* for the proposition that "if 'the specialty engaged in by the defendant physician during the course of the alleged malpractice' was outside the defendant physician's practice, that specialty is the 'one most relevant standard of practice or care.'" *Gonzalez, supra* at 302 (quoting *Reeves*, 274 Mich App at 628). Contrary to the plain meaning of the statute, the *Gonzalez* Court concluded that "[e]ssentially, one must look to the

area of practice the plaintiff challenges in order to determine who has the capacity to offer an opinion regarding standard of care," and ultimately held a third-year surgical resident "was a physician who limited his training to surgery, and who could potentially become board-certified on completion of his residency." He would therefore "be considered a 'specialist.'" *Id.* 298-299, 302.[5]

Kwasniewski v Harrington (On Reconsideration), unpublished opinion per curiam of the Court of Appeals, issued July 3, 2007 (Docket No. 268774); 2008 Mich App LEXIS 1707 (Mich Ct App Oct 1, 2008), takes *Gonzalez* even further. In that case, the Court of Appeals addressed the question of whether the expert who provided the plaintiff's affidavit of merit fulfilled the requirements of MCL 600.2169. The defendant was a general surgery resident; the expert was board certified in both surgery and thoracic surgery. *Kwasniewski, supra*, at *2. Following *Gonzalez*, the Court first held that a resident could be a specialist, and that as a resident in

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[5] The *Gonzalez* Court admitted in so many words that the implication of its holding is that whether or not a defendant is a specialist will be determined without regard to his or her education, training, and experience, but rather will depend upon "the area of practice the plaintiff challenges." 275 Mich App at 302. This is not in keeping with the statutory directive. As Justice Corrigan explained in dissenting from the Supreme Court's denial of leave in *Gonzalez*:

> *Woodard* addressed the meaning of "specialist" for purposes of determining how the term applies when a defendant physician practices in a specialty or subspecialty but is not board-certified as a specialist. [476 Mich] at 560-562. In light of this context, the Court of Appeals applies *Woodard* too broadly in this case to mean that the term "specialist" includes *any* physician who practices a particular branch of medicine "in which one can potentially become board certified." *Id.* at 561-562; *Gonzalez, supra* at 298-299. The more relevant definition, for our purposes, is the basic definition of "specialist" as "a physician whose *practice* is limited to a particular branch of medicine or surgery, especially one who, by virtue of advanced training, is certified by a specialty board as being qualified to so limit his practice." *Woodard, supra* at 561, quoting *Dorland's Illustrated Medical Dictionary* (28th ed). . . [S]uch an overbroad application of *Woodard* would largely eliminate the statutory distinction between specialists and general practitioners altogether; any general practitioner who has the "potential" to become board-certified will automatically qualify as a specialist.

Gonzalez v. St. John Hosp., 480 Mich 1109, 1110-11 (2008).

general surgery who "could potentially become board certified in general surgery," the defendant was a specialist in general surgery. *Id* at *18. However, observing that "[a]t the time of the alleged malpractice," the defendant's "care of plaintiff's decedent consisted of opening the decedent's chest and attempting to stop the bleeding in his chest," the Court concluded that the resident was also a specialist in thoracic surgery. *Id.* at *19. The Court based this conclusion on the fact that, according to the American Board of Medical Specialties, thoracic surgeons provide, among other things, "critical care of patients with pathological conditions within the chest," including "coronary artery disease," and the decedent was recovering from bypass surgery at the time of his death. *Id.* at *2, 19. The Court noted that thoracic surgery was "outside [the defendant's] area of specialty," but held that although the defendant "was not board certified as a thoracic surgeon, the American Board of Medical Specialties offers board certification in thoracic surgery, and therefore, the defendant "could potentially become board certified in thoracic surgery." *Id.* at *18. Consequently, the Court concluded that the defendant, ***who had yet to complete his training in general surgery, was a specialist in thoracic surgery*** (a field that typically requires extensive training and experience beyond that required for general surgery).

Each of the above cases has inappropriately moved the *Woodard* analysis away from the plain meaning of the statute, holding the defendant physician to the standard of the specialty that was ostensibly being practiced at the time of the alleged malpractice without regard to the defendant's training, certification and experience. *Jilek* goes even further. In *Jilek*, the majority holds Dr. Stockson to the standard of a specialty ***that was not being practiced*** at the time of the alleged malpractice.

But even if the rules articulated in *Gonzalez* and *Reeves* bear some relationship to the statutes – which MSMS vigorously disputes – the premise for the *Gonzalez* and *Reeves* rules is

lacking here. The "one most relevant specialty" analysis requires a determination "that the specialty engaged in by the defendant physician was ***outside*** the defendant physician's practice. *See e.g.,* 275 Mich App at 302 ("Applying the reasoning of *Woodard, Reeves* teaches that if 'the specialty engaged in by the defendant physician during the course of the alleged malpractice' was outside the defendant physician's practice, that specialty is the 'one most relevant standard of practice or care.'"). If the defendant physician's specialty training and certification is not "outside" the practice engaged in at the time of the alleged malpractice, and if the defendant physician is not practicing another "specialty," even *Reeves* and *Gonzalez* do not permit the court to elect the "one most relevant specialty."

In *Jilek*, it cannot be veritably argued that family practice is not "tied to the occurrence of the alleged malpractice" or that it is an "unrelated specialty." To the contrary, Dr. Stockson was practicing family medicine in an urgent care setting. There was no reason for the *Jilek* majority to leapfrog over the relevant specialty and board certification that Dr. Stockson actually possessed and hold her to a specialty she not only does not possess but was not practicing at the time of the alleged malpractice.

Further, no expert contended that urgent care was a "specialty." The "hybrid" analysis that *Jilek* purported to apply is, according to *Gonzalez*, triggered when the physician is "not board certified in the challenged area of practice but ***is practicing within a specialty***." 275 Mich App at 302 (emphasis added). *Gonzalez* explained the analysis as follows:

> Essentially, one must look to the area of practice the plaintiff challenges in order to determine who has the capacity to offer an opinion regarding standard of care. There are three possibilities. First, if the area of practice being challenged is general practice and is not a specialty, then the plaintiff must offer qualifying testimony from a qualified general practitioner practicing in general practice pursuant to MCL 600.2169(1)(c). Second, if the area of practice being challenged is a specialty and the defendant physician is board-certified in the specialty that is being challenged, then MCL 600.2169(1)(a) is implicated and the plaintiff must

> offer qualifying testimony from a qualified practitioner who is also board-certified in the challenged area of practice.
>
> The third situation is not as straightforward as the first two. It is a hybrid situation that is presented ***if the defendant physician is not board-certified in the challenged area of practice but is practicing <u>within a specialty</u>***.

Id. at 302 (emphasis added). Obviously, if the area of practice being challenged is not a "specialty," the "hybrid" option is not invoked. The *Jilek* majority understood this. The opinion acknowledges that the premise for ignoring the physician's own residency and board certification credentials is that the "locus or substance of the medicine" being practiced at the time of the alleged malpractice defines a different "specialty." *Jilek*, __ Mich App at __; 2010 Mich App LEXIS 1492 at *14 ("Dr. Stockson's residency and board certification as a family practitioner is not relevant to standard of care, ***if*** the locus or substance of the medicine she was practicing at the time of the alleged malpractice defines a different specialty") (emphasis added). Irrespective of the "facts" the *Jilek* majority purported to rely upon in holding Dr. Stockson to an emergency medicine standard, Dr. Stockson was not practicing emergency medicine – a different specialty – in an emergency room at the time of the alleged malpractice, and did not practice emergency medicine.[6] It is undisputed that the practice context was urgent care, and plaintiff never argued that urgent care was a specialty within the meaning of *Woodard*.[7]

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[6] The *Jilek* majority alludes to various representations regarding Dr. Stockson's status as an emergency physician that, without her knowledge, were made by St. Joseph Mercy Hospital, with which the Maple Care urgent care center was affiliated, and other signage and forms that she did not control. But this is an inadequate basis for the majority's holding. As explained by Justice Taylor in *Woodard*:

> [W]e first note that some indication regarding the meaning of the term "specialist" can be gleaned from the relationship of MCL 600.2169 to MCL 600.2912d(1). The latter statute, in conjunction with MCL 600.2169, requires the plaintiff's counsel to file an affidavit of merit with the complaint that is signed by a physician who counsel *reasonably believes* specializes in the same specialty as the defendant physician. Accordingly, the Legislature intended for a plaintiff to be able to form a reasonable belief regarding whether a defendant doctor is a

In *Woodard*, this Court defined "specialty" to mean "a particular branch of medicine or surgery in which ***one can potentially become board certified.***" 476 Mich at 561. Board certification in a particular specialty is typically obtained through one of the 24 medical specialty member boards of the American Board of Medical Specialties ("ABMS"), which "assist[s] its Member Boards in developing and implementing educational and professional standards to evaluate and certify physician specialists."[8] In addition to board certifications, the ABMS Member Boards offer certificates in well over 100 designated subspecialties.[9]

None of the parties to this appeal argue that urgent care – the undisputed context for the allegations of malpractice – is a medical specialty in which one can potentially become board certified. To the contrary, the parties' experts testified that urgent care was not a medical specialty. *See* Pl. App. at 3-4, 10-11. Thus, the premise for the hybrid inquiry – that the defendant is practicing within a "specialty" in which he or she is not board certified – does not exist.

> specialist at the commencement of an action – i.e., before the discovery process. Therefore, it is reasonable to conclude that the Legislature intended for the determination whether a defendant doctor is a specialist ***to correlate to how the defendant doctor subjectively represents himself or herself; in other words, whether the doctor holds himself or herself out as a specialist***.

476 Mich at 605 (footnote omitted) (bold italics added).

[7] While the parties do not argue that "urgent care medicine" is a recognized medical specialty, the Court of Appeals did not "foreclose the possibility that in a different case, given appropriate evidence and findings, a trial court could conclude that there is a specialty of 'urgent care medicine' and that it is the one most relevant specialty." *Id.* at *17-18, n 9.

[8] *See* http:/www.abms.org. The specialty boards include: Allergy and Immunology, Anesthesiology, Colon and Rectal Surgery, Dermatology, Emergency Medicine, Family Medicine, Internal Medicine, Medical Genetics, Neurological Surgery, Nuclear Medicine, Obstetrics and Gynecology, Opthalmology, Orthopaedic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine & Rehabilitation, Plastic Surgery, Preventive Medicine, Psychiatry & Neurology, Radiology, Surgery, Thoracic Surgery and Urology.

[9] *See* "Specialty and Subspecialty Certificates," *Id.*

Defendants surmise that the juxtaposition of the standard of care/expert qualification question into a multiple specialties issue was orchestrated by plaintiff so he could use as an expert an emergency medicine physician formerly employed by EPMG who would "speak to the jury with an authority unique among all the experts: he personally knew the practices and procedures in place at EPMG." Pl's App. at 11. As Defendants have explained, "[t]o use him as a standard of care expert plaintiff needed to convince the trial court that when Dr. Stockson treated Jilek for his sinus and cold symptoms at a walk-in urgent care clinic she was practicing emergency medicine." *Id.* The majority erroneously accepted this sleight of hand and equated urgent care with emergency medicine, an area in which Dr. Stockson does not practice and is not eligible for board certification. And suddenly, contrary to the well-accepted rules of statutory construction, the plain language of the statutes was rendered meaningless.

When reviewing statutory matters, a Court's primary purpose is to discern and give effect to the legislative intent. "Legislative intent is to be derived from the actual language of the statute, and when the language is clear and unambiguous, no further interpretation is necessary." *Storey v Meijer, Inc*, 431 Mich 368, 376; 429 NW2d 169 (1988). *See also, Eggleston v Bio-Medical Applications of Detroit, Inc,* 468 Mich 29, 32; 658 NW2d 139, 141 (2003) ("If the language of a statute is clear, no further analysis is necessary or allowed."); *Omelenchuck v City of Warren,* 461 Mich 567, 575; 609 NW2d 177 (2000) (refusing to rewrite the tolling statute to add words to the statute). Words of a statute must be given their plain and ordinary meaning. *People v Herron,* 464 Mich 593, 611; 628 NW2d 528 (2001). A court may not speculate about the Legislature's intent beyond the words expressed, *Rheaume v Vandenberg,* 232 Mich App 417, 422; 591 NW2d 331 (1998), but must enforce the law as written. Nor may the court second-guess the wisdom of the statute and use rules of construction as a means of imposing its

own policy preferences. As this Court explained in *In re Certified Question, Henes Special Projects Procurement, Marketing and Consulting Corp v Continental Biomass Industries, Inc,* 468 Mich 109; 659 NW2d 597 (2003):

> A fundamental principle of statutory construction is that "a clear and unambiguous statute leaves no room for judicial construction or interpretation." *Coleman v Gurwin,* 443 Mich 59, 65; 503 NW2d 435 (1993). The statutory language must be read and understood in its grammatical context, unless it is clear that something different was intended. *Sun Valley Foods Co v Ward,* 460 Mich 230; 596 NW2d 119 (1999). When a legislature has unambiguously conveyed its intent in a statute, the statute speaks for itself and there is no need for judicial construction; the proper role of a court is simply to apply the terms of the statute to the circumstances in a particular case. *Turner v Auto Club Ins Ass'n,* 448 Mich 22, 27; 528 NW2d 681 (1995).

Id. at 113.

The result in this case cannot be squared with the governing rules of statutory construction and the plain language of the statutes, which require that the standard of care be determined by reference to Dr. Stockson's "specialty" and "board certification." The *Jilek* majority ignored these credentials, opining that "***Dr. Stockson's residency and board certification as a family practitioner is not relevant to standard of care,*** if the locus or substance of the medicine she was practicing at the time of the alleged malpractice defines a different specialty." *Id.* at *14. The locus (urgent care) and substance (cold and sinus symptoms) ***did not*** "define a different specialty" and Dr. Stockson was not practicing outside her board certification at the time of the alleged malpractice. Nor did the parties argue that urgent care was a "specialty" in which one could become "board certified." *See Woodard,* 476 Mich at 561.

The *Jilek* majority ventures into new territory. Although it had no reason to do so, it elected emergency medicine as the governing standard because, in the majority's view, emergency medicine is closer medically to urgent care (a non-specialty) than family practice,

even though Dr. Stockson was not trained in emergency medicine, was not board certified in emergency medicine, and did not practice in an emergency room. Nothing in the *Woodard* decision permits a court to hold a physician to a specialty she does not possess and was not practicing at the time of the alleged malpractice. Indeed, that tack was banished by statute. The first enacted – and now superseded - version of MCL 600.2169 permitted the proffered expert to specialize and practice in an area of medicine that was "related" and "relevant" to the defendant's specialty. This meant that a specialist in one field could testify against a specialist in another field "as long as the two fields were connected to each other and had practical value to one another and as long as the proposed expert practiced or taught in the associated, pertinent area of health care." *McClellan v Collar,* 240 Mich App 403, 410; 613 NW2d 729 (2000). The 1993 amendment (the present statute) eliminated this leeway by requiring that the expert specialize in the ***same*** specialty as the defendant.[10] "Same" does not mean related or relevant. "Same" means identical. *See e.g., Oxford English Reference Dictionary* (Rev. 2d ed, 2002) (defining same to mean "... identical; not different; unchanged ..."); *Webster's Universal College Dictionary* (2001) (defining "same" as "identical with what is about to be or has just been mentioned ..."). Regrettably, ignoring the legislative will, *Jilek* takes the law backwards.[11]

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[10] This Court has characterized the 1993 statute as "more restrictive" than the 1986 version. *McDougall v Schanz,* 461 Mich 15, 21, n2; 597 NW2d 148 (1999). Other Courts have reached the same conclusion. *See e.g., McClellan v Collar,* 240 Mich App at 408 n. 2 ("The 1993 amendments are more restrictive than the requirements set out in the version of § 2169 that applies to this case"); *Shenduk v Harper Hospital,* unpublished opinion per curiam of the Court of Appeals, decided October 29, 1999 (Docket Nos. 199547, 200389); 1999 Mich App LEXIS 2571 at *24 (1999) (Murphy J, concurring and dissenting) ("the increased restriction of the current 1993 version, not allowing for specialists of a *related* discipline, indicates that strict adherence is intended.").

[11] In *Woodard*, three justices of this Court (Taylor, Corrigan and Young, JJ.) concluded that directing the trial court to determine exactly which specialty the defendant was practicing at the time of the alleged malpractice is "not grounded in the statutory language" and permits the trial

By holding Dr. Stockson to the standard of care of a specialist in emergency medicine, *Jilek* ignores the realities of medical practice. Urgent care is not emergency medicine. Emergency medicine is a separate medical specialty governed by the American Board of Emergency Medicine, and it differs significantly from urgent care. For example, urgent care clinics do not have the same diagnostic resources as emergency rooms; visits are billed under separate reimbursement codes; they are staffed differently; and their hours vary. There is likewise a difference in the nature of the maladies treated. Emergency medicine physicians treat patients who require immediate medical care to relieve pain and suffering and to prevent death and disability. Urgent care clinics treat acute medical conditions that are less severe and time-sensitive and have only simple office-based laboratory tests and x-ray. They lack immediate access to extensive laboratory testing, advanced imaging, and on-site specialists.

Indeed, one of the allegations in this case is that Dr. Stockson failed to refer Mr. Jilek to the emergency room. *See* Pl. App. at 9. This assertion, in and of itself, is recognition that the two medical practices are not the same, as Plaintiff's own experts have acknowledged. *See e.g.,* testimony of Dr. Stephen D. Reinhardt who, in defining the difference between an urgent care center and an emergency room said that "an emergency room is equipped to handle a much broader variety of emergency problems" such as "myocardial infarction which leads to an admission to the hospital or pulmonary edema or congestive heart failure or abdominal aortic aneurysm or intestinal obstruction ... respiratory failure, traumatic amputations, severe lacerations, puncture wounds, [and] gunshot wounds, which urgent care simply [do] not handle." Pl's App at 13 (quoting Reinhardt Dep at 80-81). In contrast, urgent care centers "handle the

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court to exercise a power of theory preclusion "heretofore unknown in our jurisprudence" in violation of due process. *Woodard*, 476 Mich at 618-19.

routine ordinary things that we see on a day-to-day basis every day" and are basically a family practice office that stays open late or has longer hours. *Id.*[12]

The Court of Appeals has recognized that "it is unreasonable to equate urgent care with emergency medicine." *Lutz v. Mercy Mt. Clemens Corp*, unpublished opinion per curiam of the Court of Appeals, decided December 20, 2005 (Docket No. 261465); 2005 Mich App LEXIS 3199 at *5 (2005). The contrary conclusion of the *Jilek* majority, particularly in light of the testimony of Plaintiff's own experts, is an enigma. The repercussions of this ruling are far-reaching. The *Woodard* progeny has gotten out of hand. The review of this Court is warranted.

3. *Jilek* Ignores the Statutory Requirement that Board Certifications and Active Clinical Practices Match.

Jilek has also largely ignored the requirement that an expert's board certification and active clinical practice match that of the defendant. *See* MCL 600.2169(1)(a) and MCL 600.2169(1)(b)(i). The board certification is a representation of the training and qualifications of the holder. If relevant board certifications do not match, the requirement of the statute has not been fulfilled. As *Woodard* teaches, if an expert is not board certified in at least one of the board certifications defendant has attained, i.e., the one most relevant specialty, he cannot testify.

An expert board certified in emergency medicine is not, by the plain language of the statute, qualified to testify against a physician board certified in family medicine. These opposing certifications are issued by different boards, which represent separate and distinct branches of medicine, each with its own training and credentialing programs. Because Dr.

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[12] Plaintiff's expert, Dr. Birrer testified accordingly, admitting that he would evaluate an urgent care doctor according to a family practice standard, Pl's App at 13-14 (quoting Birrer Dep at 21, 54, 56), but apparently later equated the emergency medicine and family practice standard of care. Pl's App at 16-17. *See also,* Pl's App at 12 (discussing another of Plaintiff's experts on this issue, Dr. Sama, and quoting Sama Dep at 13).

Stockson is board certified in family medicine, the *Jilek* majority was not empowered to ignore the matching board certification and active clinical practice requirements.

This Court considered the matching board certification requirement of Section 2169(1)(a) in *Halloran v Bhan*, 470 Mich 572; 683 NW2d 129 (2004). In that case, the proposed standard of care expert was board certified in anesthesiology and had a certificate of added qualification in critical care from the anesthesia board. The defendant physician was board certified in internal medicine with a certificate of added qualification in critical care from the Board of Internal Medicine. Because the defendant and the expert were not board certified in the same specialty, the majority concluded that the expert was not qualified to testify under the plain meaning of the statute. 470 Mich at 579. In reaching this conclusion, the majority rejected the Court of Appeals' ruling that it was sufficient under the statute if the expert witness and the defendant doctor shared the same critical care sub-specialty, stating that "'in spite of' the specialty requirement in the first sentence [of Section 2169(1)(a)], the witness must also share the same board certification as the party against whom or on whose behalf the testimony is offered." *Id.* at 578. The *Jilek* majority's analysis is inconsistent with the statute and this Court's decisions in *Halloran* and *Woodard*. For this reason as well, leave to appeal should be granted.

II. The Majority Erred in Ordering the Admission of Internal Policies and Procedures.

A. The Standard of Review.

This Court reviews a trial court's decision to admit or exclude evidence for an abuse of discretion. *Chmielewski v Xermac, Inc*, 457 Mich 593, 614; 580 NW2d 817 (1998).

B. The Trial Court's Exclusion of Internal Policies and Procedures Was Consonant With the Well-Established Jurisprudence of This State and Was Not An Abuse of Discretion.

The *Jilek* majority likewise erred in holding that internal policies and procedures of Defendant EPMG, Maple Urgent Care, and other organizations are admissible to prove the standard of care.[13] For over a century, Michigan jurisprudence has held that such evidence is irrelevant to the standard of care. In *McKernan v Detroit Citizens' Street-Railway Co,* 138 Mich 519; 101 NW 812 (1904), an action involving a collision between a street car and a fire engine, this Court held that disregard of a railway company rule which required the street car to go no faster than four miles per hour when passing an engine house was not evidence of negligence. The Court reasoned that a contrary ruling would "induce reluctance to adopt new measures and regulations." *Id.* at 527. The Court explained:

> [T]he law recognizes the right of the railroads to make rules for their own convenience and benefit, and the courts would be likely to uphold as reasonable a rule, made out of abundant caution, having for its object the reduction of danger to a point far below that attained by ordinarily prudent management, which is the common test prescribed by law. ***And it would be unfortunate if such a practice were to be penalized by permitting the fact of extraordinary care to increase the responsibility imposed by law, the natural if not inevitable consequence of which would be to induce reluctance to adopt new measures and regulations.***
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> . . .
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> The law regulates this by rules which do not depend upon the existence or nonexistence of corporate regulations. ***It neither permits corporations to legislate away their responsibilities by rules, nor imposes discriminating liabilities upon them by reason of their efforts to lessen public danger.***

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[13] Specifically, according to Plaintiff, the majority reversed the Trial Court's decision ***not to admit*** the American College of Emergency Physicians ("ACEP") policy for "initial approach to adults presenting with chief complaint of chest pain...", EPMG's chest pain guideline, an internal Maple Urgent Care/EPMG protocol for addressing an adult patient with chest pain, a Maple Urgent Care guideline for the nursing staff, a patient check-in guideline, and Maple Urgent Care's operational guidelines. *See* Pl. App. at 38-39.

Id. at 527-32 (Hooker, J., concurring) (emphasis added).[14]

The same reasoning was applied in *Dixon v. Grand Trunk Western Railway Co,* 155 Mich 169; 118 NW 946 (1908), where the trial court declined to allow the jury to decide whether defendant was negligent for failing to enforce its rule to lock switches. Affirming, this Court explained:

> These rules define the duties of certain employes [sic] to whom the running and immediate control of trains is confided. They are essentially private regulations of the defendant in the orderly and prudent conduct of its business. These rules do not fix the operations and liability of the defendant to its employes [sic], nor even to third persons and the public. Those are fixed by law. They could not be diminished by such rules, neither are they increased ordinarily thereby.

Id. at 173. *See also, Brown v Detroit United Railway,* 179 Mich 404; 146 NW 278 (1914) (company rules fixing the care required of its motormen and warning them to approach switches with the car under control were inadmissible).

The Court of Appeals relied upon *Dixon* in *Wilson v W A Foote Memorial Hosp,* 91 Mich App 90; 284 NW2d 126 (1979), *superseded on other grounds*, *Kueppers v Chrysler Corp,* 108 Mich App 192; 327 NW2d 327 (1981), which held that the trial court properly denied plaintiff's motion to compel discovery of internal hospital documents because good cause had not been established. In making that determination, the Court observed that "the internal regulations of the hospital do not establish the applicable standard of care." *Id.* at 95.

The admissibility of internal policies was also addressed in *Gallagher v Detroit-Macomb Hosp Ass'n*, 171 Mich App 761; 431 NW2d 90 (1988). In that case, plaintiff's decedent was found on the floor at the foot his hospital bed, confused and mumbling incoherently. It was later determined that he had fractured his hip as a result of the fall. *Id.* at 763-64. Plaintiff appealed

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[14] *See also,* 138 Mich at 524 (Op, Montgomery, J) ("The existence of this rule did not add to the defendant's obligations to the public, as shown by the opinion of Mr. Justice HOOKER, filed herewith.").

the no cause verdict, alleging that the trial court erred in prohibiting her from introducing at trial the hospital's internal rules and regulations. Affirming the trial court's decision, the Court explained that "the standard required of physicians and nurses is that they possess and carefully apply such skill and learning as are ordinarily possessed by practitioners in their community" and "is not established by internal, administrative rules." *Id.* at 766. The Court distinguished between rules and regulations that are mandated by statute and those that are "more in the nature of guidelines for the day-to-day operations" of the hospital. *Id.* at 767. Acknowledging that a hospital's rules might conceivably be admissible as reflective of community standards if they were "adopted by the relevant medical staff and where there is a causal relationship between the violation of the rule and the injury," the Court found that not to be the case in *Gallagher*:

> [T]he ultimate question is what responsibility has the hospital assumed regarding the care of the patient. ***In Michigan, we look to the standard practiced in the community rather than internal rules and regulations to determine that responsibility in a malpractice action.*** Given the facts of this case, we do not find plaintiff's arguments so compelling as to require deviation from the rule set forth in *McKernan* and *Dixon*.

Id. at 768 (emphasis added). *See also, Zdrojewski v Murphy*, 254 Mich App 50, 62; 657 NW2d 721 (2002) ("Defendants are correct in their assertion that internal policies of an institution, including a hospital, cannot be used to establish a legal duty in a negligence claim," citing *Gallagher* and *Buczkowski*); *Call v. Chambers,* unpublished opinion per curiam of the Court of Appeals, decided February 16, 2001 (Docket No. 218865); 2001 Mich App LEXIS 1748 at *8 (2001) ("[B]ecause McLaren [Hospital]'s bylaws, rules, regulations, and procedures with regard to credentialing have not been promulgated pursuant to law, they are inadmissible at trial").

Michigan courts have applied this rule in numerous contexts outside the medical malpractice arena. *See e.g., Hartmann v. Shearson Lehman Hutton*, 194 Mich App 25, 29; 486 NW2d 53 (1992) (finding defendant's policy and procedures manual irrelevant to the standard

applicable to a stockbroker's obligation to advise an investor regarding the tax consequences of recommended investment options); *Buczkowski v McKay*, 441 Mich 96, 99 n1; 490 NW2d 330 (1992) (reversing, as contrary to public policy, the trial court's finding that Kmart's internal policy of not selling ammunition to intoxicated customers was sufficient evidence to impose a legal duty because "[s]uch a rule would encourage retailers to abandon all policies enacted for the protection of others in an effort to avoid future liability"); *Premo v General Motors*, 210 Mich App 121, 123-24; 533 NW2d 332 (1995) ("Defendant's internal policy of preventing intoxicated employees from driving did not, as a matter of public policy, amount to General Motors' assumption of a duty to protect the public at large"); *Transportation Ins Co v Detroit Edison Co*, unpublished opinion per curiam of the Court of Appeals, decided December 16, 2003 (Docket Nos. 239142-44); 2003 Mich App LEXIS 3262 (2003) (affirming exclusion of Detroit Edison internal procedure manuals at trial, stating "[i]t is well settled in Michigan that internal company manuals, guidelines or rules are not admissible to establish the standard of care in a negligence action"); *James v Harbortown Development Partnership,* unpublished opinion per curiam of the Court of Appeals, decided April 27, 2001 (Docket No. 215963); 2001 Mich App LEXIS 811 at *9, n2 (2001) ("[W]hether defendants adhered to their own rules and regulations governing the management of their business is irrelevant. A person cannot, by the adoption of private rules, fix the standard of his duty to others"); *Burnside Ind, LLC v Ellis*, unpublished opinion per curiam of the Court of Appeals, decided August 22, 2006 (Docket No. 268343); 2006 Mich App LEXIS 2585 at *7 (2006) ("finding no basis for imposing a duty on [defendant] to protect plaintiff on the basis of [an] internal company email" because "[a]s a general rule, internal company policies may not be used to establish a legal duty in a negligence claim" and explaining that "[t]he rationale for this rule is that imposing a duty on companies that, by means

of work rules or policies, undertake to protect their employees or customers would encourage companies to abandon all efforts that could benefit such employees or customers, in order to avoid future liability"); *Bay Mills Resort & Casino v Gerbig*, unpublished opinion per curiam of the Court of Appeals, decided October 2, 2008 (Docket No. 281549); 2008 Mich App LEXIS 1896 at *9 (2008) ("imposing legal liability on companies that undertake to protect their employees or customers by means of work rules or policies if these rules or policies are not followed would simply encourage companies to abandon all efforts to implement rules to protect employees and customers in order to avoid future liability").

In *Jilek*, the Court of Appeals disregarded this overwhelming authority, disputed the rationale that the admission of internal policies would discourage their creation, and considered persuasive the "opinions of sister jurisdictions" which allow the admission of internal policies as relevant to the standard of the care. The majority rejected "defendants' reading of *Gallagher*," relying instead upon dicta that "a hospital's rules could be admissible as reflecting the community's standard where they were adopted by the relevant medical staff and where there is a causal relationship between the violation of the rule and the injury." *Id.* at *22. It ultimately held, purportedly "consistent with *Gallagher*," that "while internal policies and guidelines do not in and of themselves set the standard of care, they should be admitted so long as they are relevant to the applicable specialty's standard of care and to the injury alleged."

Regrettably, the majority's holding is not consistent with *Gallagher* or its finding that analogous internal policies were inadmissible. Nor can it be reconciled with this Court's decisions in *McKernan*, *Dixon,* and *Buczkowski* or the Court of Appeals' holding in *Zdrojewski*. As dissenting Judge Bandstra pointed out, "I disagree with the majority that two precedents that are binding upon us and which applied or reiterated the Gallagher holding rather than its dictum

can be distinguished away," citing *Buczkowski* and *Zdrojewski*. *Id.* at *38. The public policy ramifications of this ruling cannot be overstated. This Court should grant leave to address the issue.

RELIEF REQUESTED

Jilek raises two issues of utmost importance to the jurisprudence of this State. MSMS respectfully urges this Court to grant leave to appeal to consider these perplexing developments and to ultimately reverse the *Jilek* decision.

Respectfully submitted,

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Dated: December 23, 2010