STATE OF MICHIGAN

COURT OF APPEALS

MICHELLE JONES, Personal Representative of the ESTATE OF TONY L. JONES,

Plaintiff-Appellant,

v

JAMAL ZARGHAMI, M.D., and HEART CARDIOLOGY CONSULTANTS, P.C., doing business as HEART CARDIOLOGY CONSULTANTS,

Defendants-Appellees.

UNPUBLISHED
June 27, 2024

No. 362644
Oakland Circuit Court
LC No. 2019-178140-NH

Before: GADOLA, C.J., and BORRELLO and BOONSTRA, JJ.

PER CURIAM.

In this medical malpractice action, plaintiff, as personal representative of the decedent's estate, appeals as of right the trial court's order granting defendants' motion for summary disposition and dismissing this action. Plaintiff asserts the trial court violated her due process rights when it granted summary disposition to defendants on a basis that was not argued in defendants' motion for summary disposition. Plaintiff further argues that the trial court erred in granting summary disposition when it found that plaintiff's expert's opinion was based on assumptions that were contrary to the established facts. We affirm.

I. FACTS

On May 17, 2018, two days after undergoing bariatric surgery, the 49-year-old decedent, Tony L. Jones, suddenly went into cardiac arrest and died at the hospital. Following an autopsy, the medical examiner determined that the cause of death was pulmonary embolism (PE) due to deep vein thrombosis (DVT). The medical examiner further determined that the decedent's obesity and post-abdominal-surgical status were contributory causes to his death.

Plaintiff initiated this action against defendant Dr. Jamal Zarghami, the cardiologist who had cleared the decedent for surgery in March 2018, and his practice, defendant Heart Cardiology Consultants, P.C., for medical malpractice. Plaintiff alleged that the decedent had an existing DVT

condition before the surgery, which ultimately resulted in the PE, and that Dr. Zarghami breached the standard of care by failing to refer the decedent for a venous doppler ultrasound, or other testing to rule out the existence of DVT, before approving him for the surgery. Plaintiff alleged that Dr. Zarghami's failure to timely diagnose the decedent's DVT proximately caused the decedent's death from PE following the surgery.

Dr. Mubashir Sabir was the surgeon who performed the decedent's bariatric surgery. The decedent first consulted with Dr. Sabir on January 26, 2018, about undergoing laparoscopic sleeve gastrectomy (or bariatric) surgery for weight loss. The records from this appointment reflect that the decedent was 6 feet, 4 inches tall, weighed 419 pounds, and had a body mass index (BMI) of 51. Before the surgery could be performed, the decedent needed to be cleared by his primary care physician and a cardiologist. After receiving clearance from his primary care physician, Dr. Dell, the decedent was referred to Dr. Zarghami for a cardiac assessment.

The decedent met with Dr. Zarghami on February 28, 2018, for a preoperative cardiac risk assessment. The medical records from this visit indicate that the decedent reported a history of exertional dyspnea (shortness of breath), obesity, and significant swelling of his legs that was worse on the right side. Dr. Zarghami's diagnosis indicated that the decedent had hypertension, shortness of breath that was "likely secondary to obesity" and localized edema "likely secondary to dependent edema as well as possibly secondary" to one of the decedent's medications. The records indicate Dr. Zarghami ordered an electrocardiogram (EKG), a transthoracic echocardiogram (TTE), and a cardiovascular stress test. The TTE test showed normal size of the atriums and ventricles with an estimated ejection fraction of 60-65% (ejection fraction is the measurement of blood leaving the heart)[1]. Dr. Zarghami noted that he might need to order a reflux abnormality study and a DVT study, and he opined that the decedent was a "moderate risk cardiac patient from cardiovascular [sic] point of view for surgery."

On March 1, 2018, the decedent presented for laboratory tests. He visited Dr. Zarghami for a follow-up appointment on March 28, 2018, where it was noted that no edema was present. Dr. Zarghami reviewed the results of the decedent's lab tests. Dr. Zarghami never ordered a DVT study or further testing.

On May 15, 2018, the decedent underwent the bariatric surgery. Dr. Sabir performed the surgery. The medical records indicate that measures were put in place to minimize the risk of DVT. Further, the record shows there were no pre-operative symptoms of DVT. According to Dr. Sabir, the surgery was a success. The day after the surgery, nursing staff continued to document DVT prevention measures. At 10:58 a.m., 1:03 p.m., and 4:09 p.m., nursing staff indicated that Jones showed no symptoms of DVT.

[1] An ejection fraction of about 50% to 70% is categorized as normal. Rekha Mankad, M.D., *Ejection fraction: What does it measure?* Mayo Clinic, <https://www.mayoclinic.org/tests-procedures/ekg/expert-answers/ejection-fraction/faq-20058286#:%7E:text=Ejection%20fraction%20is%20a%20measurement,The%20heart%20contracts%20and%20relaxes> (access June 12, 2024).

As previously noted, the decedent went into cardiac arrest and died two days later while in the hospital recovering from surgery. On May 18, 2018, an autopsy was performed by medical examiner Dr. Ruben Ortiz-Reyes. Dr. Ortiz-Reyes noted that Jones's pulmonary arteries were normally developed and were filled with emboli extending from large- to medium-sized vessels. The dissection of both legs revealed DVTs. On the death certificate, the medical examiner listed the cause of death as a PE due to DVT, and indicated that the approximate interval between onset of the fatal PE due to DVT condition and the decedent's death was "Secs-Mins." Dr. Ortiz-Reyes passed away before he could be deposed in this lawsuit.

Dr. Sabir testified in his deposition that there was no record that the decedent had DVTs at the time of surgery and that he would not have operated on anybody whom he knew to have existing DVTs. He explained that surgery puts a patient in a stressful situation and that existing, untreated DVTs present too high a risk such that a person with them is not fit for surgery. Plaintiff's expert witness, cardiologist Dr. Raphael Bonita, explained in his deposition that a DVT is a blood clot that forms in the deep veins of the extremities and can travel to the lungs. A clot that blocks arteries in the lungs is a PE. Dr. Bonita testified that Dr. Zarghami should have evaluated the decedent for DVT using venous doppler or other testing, based on the observations made during Dr. Zarghami's physical examination. Dr. Bonita explained that the asymmetrical leg swelling experienced by the decedent over the previous year, along with the shortness of breath and morbid obesity, suggested the presence of a chronic condition and warranted further evaluation for DVT. Dr. Bonita acknowledged that a 2016 ultrasound performed on the decedent's legs by his primary care physician was negative for DVT. However, Dr. Bonita indicated that he would not have relied on this study at the time the decedent was examined by Dr. Zarghami in 2018 in light of the condition in which the decedent presented.

Defendants moved for summary disposition under MCR 2.116(C)(10). Defendants argued that the medical examiner concluded that Jones died from a DVT and PE, which developed within seconds to minutes before his death. Defendants' expert, Dr. Creagh Milford, believed that the DVT that caused Jones's death did not exist at the time Dr. Zarghami saw Jones. In response, plaintiff argued that summary disposition was inappropriate because there were genuine issues of material fact regarding proximate cause, given that the autopsy revealed DVTs in both legs. It was plaintiff's theory that Jones should not have been cleared for surgery because he had symptoms of DVT at the time Dr. Zarghami evaluated him, and Dr. Zarghami should have referred Jones for an ultrasound. Plaintiff's expert, Dr. Werner Spitz, refuted Dr. Ortiz-Reyes's conclusions in the autopsy report. Dr. Spitz agreed that Jones died from PE as a result of DVT, but disagreed that it was caused within seconds to minutes. Dr. Spitz believed that it would have taken longer for multiple clots to form and travel to the lungs. Thus, Dr. Spitz explained it was possible that Jones had blood clots when he presented with edema and shortness of breath to Dr. Zarghami.

Defendants submitted a reply brief in which they explained that the timing of the DVT and PE were established by the medical examiner's notation on a form included with the autopsy report, which listed the DVT and PE as causing death at intervals of "sec.-min." Defendants argued that plaintiff's experts' opinions were not competent because they depended on assumptions not supported by the facts in the medical examiner's report. Defendants also submitted with their reply brief affidavits from Dr. Bader Cassin and Dr. Scott Garner, who addressed the autopsy findings. It was their opinion, upon review of the autopsy report and

attached photos, that Jones developed the DVT that caused the PE was acute, or of recent origin, and occurred because of the surgery.

The trial court granted defendants summary disposition. The court concluded that there was a genuine issue of material fact regarding whether defendants breached the standard of care by failing to complete a DVT study in light of the decedent's condition when he presented to defendants for surgical clearance. However, the court concluded that did not matter because plaintiff could not establish causation, reasoning that Dr. Spitz's opinions were based on assumptions not in accordance with established facts. The trial court denied plaintiff's motion for reconsideration. Plaintiff now appeals.

II. DUE PROCESS

Plaintiff first argues that she was denied due process because the trial court granted summary disposition sua sponte based on an argument not raised in defendants' motion for summary disposition. However, the record shows that the trial court did not grant summary disposition sua sponte and instead granted summary disposition on a basis asserted in defendant's motion.

A. STANDARD OF REVIEW

Whether a party has been afforded due process is a question of law, *Al-Maliki v LaGrant*, 286 Mich App 483, 485; 781 NW2d 853 (2009), subject to review de novo, *In re Contempt of Henry*, 282 Mich App 656, 668; 765 NW2d 44 (2009).

B. ANALYSIS

Plaintiff argues that the trial court granted summary disposition based on an argument that defendants did not argue in their brief in support of their motion for summary disposition and only mentioned in their reply brief. Plaintiff contends the trial court's ruling violated her due process rights. We disagree.

"Due process is a flexible concept, the essence of which requires fundamental fairness." *Al-Maliki*, 286 Mich App at 485. "The basic requirements of due process in a civil case include notice of the proceeding and a meaningful opportunity to be heard." *Id*. Under MCR 2.116(I)(1), the trial court has the authority to grant summary disposition sua sponte, but "may not do so in contravention of a party's due process rights." *Id*. at 489. Further, "[w]here a court considers an issue sua sponte, due process can be satisfied by affording a party an opportunity for rehearing." *Id.* at 485-486. A trial court has unrestricted discretion to review its previous decisions under MCR 2.119(F)(3). *Prentis Family Foundation, Inc v Barbara Ann Karmanos Cancer Institute*, 266 Mich App 39, 52-53; 698 NW2d 900 (2005). Therefore, any error in granting summary disposition without affording a party an adequate opportunity to be heard may be deemed harmless under MCR 2.613(A) when a party is permitted to fully brief and present her argument in a motion for reconsideration. *Al-Maliki*, 286 Mich App at 486; see also *Boulton v Fenton Twp*, 272 Mich App 456, 463-464; 726 NW2d 733 (2006).

The trial court granted defendants summary disposition because plaintiff could not prove causation. The court concluded that the opinions of plaintiff's experts could not support plaintiff's theory because their opinions were contrary to the objective facts found in the postsurgical medical records. Thus, the trial court found that reasonable minds could not differ in concluding that plaintiff could not establish factual causation because the medical records show that Jones did not have symptoms of DVT post-surgery.

We conclude that defendants' original motion for summary disposition provided plaintiff with sufficient notice that defendants were seeking summary disposition on the ground of causation, and that plaintiff was required to present evidence to establish factual support for her theory of malpractice to avoid dismissal of her claims.

First, plaintiff argues that it was improper for defendants to offer new evidence with their reply brief. However, plaintiff cites cases applying MCR 7.212(G), which applies to reply briefs on appeal. See *Bronson Methodist Hosp v Mich Assigned Claims Facility*, 298 Mich App 192, 199; 826 NW2d 197 (2012). Plaintiff does not cite a similar rule that restricts the contents of reply briefs in the trial court. To comport with due process, however, a party must be afforded a meaningful opportunity to address and be heard regarding new arguments in a reply brief. See *Al-Maliki*, 286 Mich App at 485.

Plaintiff is incorrect that defendants' reply brief raised new arguments. Defendants did introduce new evidence in the form of affidavits from Dr. Cassin and Dr. Garner. But those affidavits further addressed defendants' arguments in their original motion for summary disposition. We also disagree with plaintiff's argument that the trial court deviated from defendants' arguments in their original motion when it granted summary disposition. Defendants had challenged plaintiff's ability to prove malpractice by Dr. Zarghami for failing to diagnose DVT during the cardiac assessment by arguing that there was no competent evidence that Jones had a DVT condition at the time of his evaluation. The trial court's ruling addressed whether plaintiff could produce competent evidence to establish factual support for her claim. Nothing about the trial court's ruling was outside the scope of defendants' original motion. Further, the trial court acknowledged at the hearing on defendants' motion that defendants had submitted new evidence with their reply brief and it afforded plaintiff an opportunity to address that evidence. The record also indicates that defendants offered to make Dr. Cassin and Dr. Garner available for depositions, but plaintiff never asked to depose them. Plaintiff also had an additional opportunity to address defendants' evidence and to respond to the trial court's decision in her motion for reconsideration. Accordingly, the record does not support plaintiff's claim that her right to due process was violated.

III. MEDICAL MALPRACTICE

Plaintiff next argues that the trial court erred by granting defendants summary disposition because the opinions of plaintiff's experts that the DVTs were chronic and existed before the surgery presented a question of fact for the jury. We disagree.

A. STANDARD OF REVIEW

A trial court's decision on a motion for summary disposition is reviewed de novo. *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 support for a claim. *Id*. at 160. When reviewing a motion under MCR 2.116(C)(10), "a trial court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties . . . in the light most favorable to the party opposing the motion." *Innovation Ventures v Liquid Mfg*, 499 Mich 491, 507; 885 NW2d 861 (2016) (quotation marks and citation omitted; ellipsis in original). "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 facts exists when the record leaves open an issue upon which reasonable minds might differ." *Id*. (citation omitted).

B. ANALYSIS

To assert 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), quoting *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004). Failure to prove any of these elements is fatal to the claim. *Cox v Flint Bd of Hosp Managers*, 467 Mich 1, 10; 651 NW2d 356 (2002); see also MCL 600.2912a.

The fourth element requires proof of "proximate cause," which is a legal term of art that incorporates both cause in fact and legal (or "proximate") cause. *Craig*, 471 Mich at 86. As explained in *Craig*,

> The cause in fact element generally requires showing that "but for" the defendant's actions, the plaintiff's injury would not have occurred. On the other hand, legal cause or "proximate cause" normally involves examining the foreseeability of consequences, and whether a defendant should be held legally responsible for such consequences.

> As a matter of logic, a court must find that the defendant's negligence was a cause in fact of the plaintiff's injuries before it can hold that the defendant's negligence was the proximate or legal cause of those injuries.
>
> Generally, an act or omission is a cause in fact of an injury only if the injury could not have occurred without (or "but for") that act or omission. While a plaintiff need not prove that an 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.
>
> It is important to bear in mind that a plaintiff cannot satisfy this burden by showing only that the defendant *may* have caused his injuries. Our case law requires more than a mere possibility or a plausible explanation. Rather, a plaintiff establishes that the defendant's conduct was a cause in fact of his injuries only if

> he "set[s] forth specific facts that would support a reasonable inference of a logical sequence of cause and effect." A valid theory of causation, therefore, must be based on facts in evidence. And while " '[t]he evidence need not negate all other possible causes,' " this Court has consistently required that the evidence " 'exclude other reasonable hypotheses with a fair amount of certainty.' " [*Craig*, 471 Mich at 86-88 (citations omitted, emphasis in original).]

The trial court found that a question of fact existed as to the second element: whether Dr. Zarghami breached the standard of care by failing to complete a DVT study. But the trial court found that whether Dr. Zarghami breached the standard of care was inconsequential because plaintiff could not prove causation. Thus, without deciding whether there was a question of fact as to the breach element, we will not disturb the trial court's ruling on this issue because appellant does not challenge it.

Whether plaintiff could prove malpractice depended on her ability to show that Dr. Zarghami's failure to refer Jones for an ultrasound was a cause-in-fact of Jones's fatal PE from a DVT. Plaintiff's theory depended on evidence that DVTs existed in Jones's leg or legs when he was seen by Dr. Zarghami, which went undiagnosed because Dr. Zarghami failed to refer him for an ultrasound. Dr. Cassin's and Dr. Garner's affidavits put forth evidence, consistent with the medical examiner's finding, that the blood clots that caused Jones's death were of recent origin and occurred because of the surgery. To avoid summary disposition, plaintiff was required to present evidence that disputed the autopsy results and refuted Dr. Cassin's examination of the tissue samples from the autopsy to create an issue of fact whether Jones had DVTs at the time he was seen by Dr. Zarghami. Plaintiff relied on Jones's symptoms at the time he was seen by Dr. Zarghami, which suggested, as Dr. Spitz believed, that Jones had DVTs, which could have been diagnosed with an ultrasound.

However, plaintiff failed to establish a question of fact whether the alleged breach was a proximate cause of Jones's death, as the trial court found. The significance of the testimony from plaintiff's experts was that it provided factual support for plaintiff's theory that Dr. Zarghami breached the standard of care by failing to refer Jones for an ultrasound to evaluate him for DVTs, given his symptoms of leg swelling and shortness of breath. However, Dr. Cassin's and Dr. Garner's affidavits explained how they forensically determined, through additional testing and examination, that the DVTs and PE that caused Jones's death were of recent origin, which refuted the underlying assumptions made by plaintiff's experts that Jones had a chronic DVT condition that existed at the time he was evaluated by Dr. Zarghami.

In granting summary disposition for defendants, the trial court relied on this Court's decision in *Badalamenti v William Beaumont Hosp-Troy*, 237 Mich App 278; 602 NW2d 854 (1999). In that case, the plaintiff's theory was that the defendant, a cardiologist, failed to diagnose and treat him for cardiogenic shock by treating his low blood pressure when he was admitted to the hospital for a heart attack. *Id.* at 281-282. As a result, gangrene developed and the plaintiff's fingers, thumbs, and legs were amputated. The defendants maintained that the plaintiff did not suffer cardiogenic shock, but had an unexpected and rare reaction to a drug that was administered, which caused the events that resulted in the amputations. *Id.* at 282. The defendants challenged the trial court's failure to grant them judgment notwithstanding the verdict (JNOV) on the basis that there was no support for the testimony of the plaintiff's expert, Dr. Wohlgelernter, who

believed that the plaintiff suffered from cardiogenic shock. *Id.* To prove that the cardiologist was negligent in diagnosing and treating the plaintiff, the plaintiff was required to prove that he actually suffered cardiogenic shock while under the cardiologist's care. *Id*. at 285. This Court found that plaintiff failed to present legally sufficient evidence to establish that the decedent suffered from cardiogenic shock. *Id*. at 289.

This case is similar to *Badalamenti* because plaintiff's experts premised their testimony on the assumption that Jones possibly had DVTs in March 2018, when he was seen by Dr. Zarghami, given his clinical symptoms. However, it could not be determined whether he actually had DVTs at that time, despite Dr. Spitz's testimony that it is not uncommon for morbidly obese people to have DVTs. That an untrasound performed in March 2018 would have revealed the presence of DVTs is pure speculation, plaintiff having produced no substantive evidence that they were in fact present at that time.

Unlike plaintiffs' experts, defendants' expert witnesses, Dr. Cassin and Dr. Garner, reviewed slides and photographs of the autopsy and explained, consistent with the medical examiner's conclusion, why that medical evidence indicated that the DVT and PE that caused Jones's death were acute and together likely caused Jones's death within seconds or minutes. This autopsy evidence refuted the assumption of plaintiff's experts that Jones's death could be attributed to a chronic DVT condition that existed at the time Jones was evaluated by Dr. Zarghami.

Contrary to plaintiff's argument, the autopsy report, supplemented by Dr. Cassin's and Dr. Garner's review of evidence collected during the autopsy, were facts associated with Jones's death. To avoid summary disposition, plaintiff was required to respond to that evidence and demonstrate that a question of fact existed regarding the origin of the DVT that caused Jones's fatal PE. Plaintiff did not produce any factual support for her theory that the DVT that caused Jones's death originated from a chronic condition that existed when Jones was examined by Dr. Zarghami. Plaintiff's expert, Dr. Spitz, did not conduct a tissue examination of the autopsy evidence and plaintiff's other expert, Dr. Ardehali, testified that he was not experienced in that area.

Plaintiff failed to refute the autopsy evidence and Dr. Cassin's and Dr. Garner's explanations of how that evidence demonstrated that the DVT that caused Jones's PE was of recent origin. As in *Badalamenti*, plaintiff's experts' opinions were not in line with the established facts. Plaintiff argues that Dr. Cassin and Dr. Garner were merely interpreting the autopsy report and that there are no established objective findings from the autopsy. We disagree. First, Dr. Spitz agreed that the age of a blood clot can be determined by examining its color and condition, which is exactly what occurred here. The color and condition of the DVTs and PE observed during the autopsy are objective findings. Second, even if Dr. Cassin's and Dr. Garner's proposed testimony regarding the age of the DVTs and the PE can be considered an interpretation of the autopsy findings, plaintiff has not offered another interpretation of these findings to support her theory that Jones died from a chronic DVT condition. Compare *Robins v Garg (On Remand),* 276 Mich App 351, 362-363; 741 NW2d 49 (2007). Summary disposition was properly granted to defendants because plaintiff relied on mere speculation that Jones may have had a DVT condition that could have been detected by an ultrasound when he was evaluated by Dr. Zarghami.

Plaintiff asserts that the trial court treated notes in the medical records, mostly made by nurses, as established facts to find that Jones did not show signs of DVT after the surgery. Viewing

the court's decision as a whole, it is apparent that the court focused on Dr. Cassin's and Dr. Garner's explanation of the autopsy findings and applied *Badalamenti* to that evidence. The court noted that plaintiff was not challenging the surgeon's care of Jones after surgery. The trial court generally concluded that "the records from the surgery and postsurgery remain uncontroverted and therefore Dr. Spitz's opinion is based on assumptions that are not in accord with established facts." The fact that there was no other evidence to indicate that Jones had a DVT before the day he died is further support for concluding that plaintiff's experts' opinions were based on speculation, not actual facts involving Jones's condition.[2]

Plaintiff also appears to challenge the admissibility of all evidence from the autopsy on the ground that the autopsy report is hearsay and that its author, Dr. Ortiz-Reyes, is now deceased.[3] Because Dr. Ortiz-Reyes is deceased and unavailable, defendants proposed calling Dr. Cassin and Dr. Garner to explain the significance of the evidence collected during the autopsy. The facts or data used by an expert to form an opinion must be in evidence. MRE 703. The autopsy report is admissible under the hearsay exception in MRE 803(8) as a public record or report, and under MRE 803(6), as a report of a regularly conducted activity. The death certificate is admissible under MRE 803(9) as a vital record.

Furthermore, the trial court did not err by considering Dr. Cassin's and Dr. Garner's affidavits that were submitted with defendants' reply brief because, as discussed earlier, plaintiff was given an opportunity to address this new evidence. She also had the opportunity to depose these witnesses during discovery, but she chose not to do so. The proposed testimony from Drs. Cassin and Garner properly could be considered by the trial court because they were identified as witnesses for defendants and their testimony directly addressed the cause of Jones's death.

For these reasons, we affirm the trial court's order granting defendants' motion for summary disposition.

IV. RECONSIDERATION

Plaintiff also argues that the trial court erred by denying her motion for reconsideration. We disagree.

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[2] While plaintiff emphasizes that the medical records showed that Jones had swelling one day after the surgery, we fail to see how this showed that Dr. Zarghami would have discovered DVTs two months earlier. Furthermore, it was consistent with Jones's preoperative condition and does not prove that he had DVTs before surgery.

[3] There is no indication in the record that plaintiff made a timely argument that the court could not consider the autopsy report or the death certificate because they were inadmissible hearsay. However, the trial court could not grant summary disposition on the basis of inadmissible evidence because MCR 2.116(G)(6) provides that affidavits and documentary evidence offered in support of or in opposition to a motion for summary disposition under MCR 2.16(C)(10) shall only be considered to the extent that the contents or substance would be admissible as evidence to establish or deny the grounds in the motion.

A trial court's decision on a motion for reconsideration is reviewed for an abuse of discretion. *In re Beglinger Trust*, 221 Mich App 273, 279; 561 NW2d 130 (1997). MCR 2.119(F)(3) provides:

> Generally, and without restricting the discretion of the court, a motion for rehearing or reconsideration which merely presents the same issues ruled on by the court, either expressly or by reasonable implication, will not be granted. The moving party must demonstrate a palpable error by which the court and the parties have been misled and show that a different disposition of the motion must result from correction of the error.

Plaintiff argues that the trial court erred by denying her motion for reconsideration when the court granted judgment for defendants solely because the medical records indicated that Jones did not suffer a DVT until after the surgery. As explained earlier, the trial court properly determined that defendants were entitled to judgment because the autopsy evidence established the timing of the PE and DVT that caused Jones's death, and Dr. Cassin and Dr. Garner explained in their affidavits how that evidence established that the PE and DVT that caused his death could not have existed when Dr. Zarghami saw Jones. The court's statement about the lack of signs of DVT in the medical records after surgery was simply further undisputed support for defendants' argument that there was no evidence that Jones had a DVT before the day he died.

As previously explained, the trial court did not err by granting defendants' motion for summary disposition when plaintiff was given the opportunity to respond to the evidence produced with defendants' reply brief and failed to establish a question of fact whether the DVT that caused Jones's death existed at the time he was examined by Dr. Zarghami. Because plaintiff failed to show that the trial court erred by granting summary disposition for defendants, there were no grounds for granting reconsideration.

Affirmed.

/s/ Michael F. Gadola
/s/ Mark T. Boonstra

STATE OF MICHIGAN

COURT OF APPEALS

MICHELLE JONES, Personal Representative of the ESTATE OF TONY L. JONES,

Plaintiff-Appellant,

v

JAMAL ZARGHAMI, M.D., and HEART CARDIOLOGY CONSULTANTS, P.C., doing business as HEART CARDIOLOGY CONSULTANTS,

Defendants-Appellees.

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Before: GADOLA, C.J., and BORRELLO and BOONSTRA, JJ.

BORRELLO, J. (d*issenting*)

In this medical malpractice and wrongful death action, plaintiff, as personal representative of the decedent's estate, appeals as of right the trial court's order granting defendants' motion for summary disposition and dismissing this action. For the reasons stated more fully below, I respectfully dissent from the decision of my colleagues to affirm the trial court.

I. BACKGROUND

My statement of the facts and that of the majority have little variance. I restate them in order that my dissent has proper context.

As stated by the majority, on May 17, 2018, two days after undergoing bariatric surgery, the decedent suddenly went into cardiac arrest and died. Following an autopsy, the medical examiner determined that the cause of death was pulmonary embolism (PE) due to deep vein thrombosis (DVT). The medical examiner further determined that the decedent's obesity and post-abdominal-surgical status were contributary causes.

Plaintiff initiated this action against defendant Dr. Jamal Zarghami, a cardiologist who had cleared the decedent for surgery in March 2018, and his practice, defendant Heart Cardiology Consultants, P.C., for medical malpractice. Plaintiff alleged that the decedent had an existing DVT

condition before the surgery, which ultimately resulted in the PE, and that Dr. Zarghami breached the standard of care by failing to refer the decedent for a venous doppler ultrasound, or other testing to rule out the existence of DVT, before approving him for the surgery. Plaintiff alleged that Dr. Zarghami's failure to timely diagnose the decedent's DVT proximately caused the decedent's death from PE following the surgery.

Dr. Mubashir Sabir was the surgeon who performed the decedent's bariatric surgery. The 49-year-old decedent first consulted Dr. Sabir on January 26, 2018, about undergoing laparoscopic sleeve gastrectomy (or bariatric) surgery. The records from this appointment reflect that the decedent was 6 feet, 4 inches tall, weighed 419 pounds, and had a body mass index (BMI) of 51. Before the surgery could be performed, the decedent needed to be cleared by his primary care physician and a cardiologist. After receiving clearance from his primary care physician, the decedent was referred to Dr. Zarghami for a cardiac assessment.

The decedent met with Dr. Zarghami on February 28, 2018 for a preoperative cardiac risk assessment. The medical records from this visit indicate that the decedent reported a history of exertional dyspnea and significant swelling of his legs that was worse on the right side over the course of the past year. Dr. Zarghami's diagnosis indicated that the decedent had hypertension, shortness of breath that was "likely" due to "obesity and deconditioning," and lower extremity edema that was "possibly" due to one of the decedent's medications. Dr. Zarghami noted that he might need to order a DVT study, and he opined that the decedent was a "moderate risk cardiac patient from cardiovascular [sic] point of view for surgery." The decedent visited Dr. Zarghami for a follow-up appointment on March 28, 2018, where it was noted that no edema was present.

Dr. Sabir performed the surgical procedure on May 15, 2018. As previously noted, the decedent went into cardiac arrest and died two days later while still in the hospital. In the autopsy report, the medical examiner noted that the decedent's pulmonary arteries were "filled with emboli extending from the large to medium sized vessels" and that "[d]issections of both legs reveal deep leg veins thrombosis." There were "[m]ultiple thrombi in vessels of both legs." On the death certificate, the medical examiner indicated that the approximate interval between onset of the fatal PE due to DVT condition and the decedent's death was "Secs-Mins." The medical examiner who performed the autopsy passed away before he could be deposed in this lawsuit.

Dr. Sabir testified in his deposition that there was no record that the decedent had DVTs at the time of surgery and that he would not have operated on anybody whom he knew to have existing DVTs. He explained that surgery puts a patient in a stressful situation and that existing, untreated DVTs present too high a risk such that a person with them is not fit for surgery.

Plaintiff's expert witness, Dr. Raphael Bonita, explained in his deposition that a DVT is a blood clot that forms in the deep veins of the extremities and can travel to the lungs. A clot that blocks arteries in the lungs is a PE. Dr. Bonita testified that Dr. Zarghami should have evaluated the decedent for DVT using venous doppler or other testing, based on the observations documented during Dr. Zarghami's physical examination. Dr. Bonita explained that the asymmetrical leg swelling experienced by the decedent over the previous year, along with the shortness of breath and morbid obesity, suggested the presence of a chronic condition and warranted further evaluation for DVT. Pursuant to the classification scale for measuring swelling, the lower extremity edema documented in the decedent's medical records was at the top of the scale for severity, which further

warranted additional testing to rule out DVT. According to the decedent's medical records, Dr. Zarghami did not perform any testing to rule out DVT.

Dr. Bonita acknowledged that a 2016 ultrasound performed on the decedent's legs by his primary care physician was negative for DVT. However, Dr. Bonita indicated that he would not have relied on this study at the time the decedent was examined by Dr. Zarghami in light of the condition in which the decedent presented.

Dr. Werner Spitz testified in his deposition that he agreed that the decedent died from a PE that resulted from a DVT and that most PEs are caused by blood clots that originate in the legs. However, Dr. Spitz opined that the severe swelling in the decedent's legs showed that he had existing blood clots in the veins of his legs, causing the stagnation of blood flow in the lower extremities. Dr. Spitz further opined that based on the decedent's medical records, the development of blood clots and associated swelling in the legs was a longstanding chronic problem, and the decedent did not suddenly develop these issues on the last day of his life. After explaining that old blood clots could be distinguished from "fresh" blood clots based on color, degree of organization, and whether the clot had become attached to the wall of the blood vessel, Dr. Spitz stated that the blood clots that actually caused the decedent's death "traveled on the day that he died" and therefore must have been fresh clots because old clots become attached to the vessel wall and do not travel. Dr. Spitz was then examined as follows:

> *Q.* So I'm looking at the death certificate. [The medical examiner] says -- at least the death certificate says pulmonary embolism, approximate interval between onset and death, seconds to minutes. Deep vein thrombosis, approximate interval between onset and death, seconds to minutes. Did you see that?
>
> *A.* Yes.
>
> *Q.* Are you in a position to agree or disagree with that?
>
> *A.* You know, it's a matter of interpretation because it is my opinion that seconds to minutes is correct if you say from the time that those particular blood clots that caused the death occurred towards the time that he died, but the clots were in the legs able to travel before that, and because the legs were swollen and the history of what goes on with this man existed in its entirety, and the formation of blood clots dates way back. So the formation of blood clots keeps coming, developing in a person like that, in a patient like that, without stopping all the time, and that has to be recognized when you see the patient walking into your clinic.
>
> *Q.* Let me ask you more about the death certificate if I can. You don't disagree that the pulmonary embolism that took the patient's life developed seconds to minutes before his death–
>
> *A.* No.
>
> *Q.* -- correct?

A. No, I don't believe that. I don't believe that. He developed the blood clots all of them to cause -- eventually they caused the death, but they were -- he was a time bomb for this outcome because nothing was done with him when he was alive.

Q. And let me ask you this–

A. Those legs were developing blood clots. Some of them were adherent and some of them were not adherent and developed within days or within the last weeks or the last months. He went to the doctor in February of the same year, and nothing was done to diagnose in what condition the vascular system in the legs was.

* * *

Q. The pulmonary embolism that is listed on the death certificate as a cause of death, the medical examiner here . . . indicates developed seconds to minutes before the patient died, and I hear you saying that you think DVT may have been present earlier, but you don't disagree with the PE that took his life developing seconds to minutes before death, correct?

A. No, I do not believe that that's correct.

Q. All right. And the same as it comes to the DVT seconds to minutes before he died, you disagree with that as well?

A. I don't believe that these showers of emboli that [the medical examiner] described in his report, that they all necessarily developed within seconds or minutes. They were on route to the lung between the legs and the heart long before seconds or minutes. These clots took time to travel from the legs into the heart. Eventually they arrived causing more shortness of breath, causing difficulty in oxygenation to enable the tissues that normally depend on blood flow to suffer anoxia or hypoxia and eventually the patient died, but all this occurred within the same day, but these blood clots -- or many of these blood clots developed before that time. They were still in the leg, and on the 17th they all traveled because there were multiple clots all over the lungs here and there and everywhere, and those clots didn't all develop on that day. It would be strange and almost impossible for all the blood clots that caused his death to have traveled into the lungs all at the same time. That didn't happen.

Q. But they were all fresh clots?

A. They were what?

Q. Fresh clots.

A. They all traveled, but they were in existence somewhere else in the body, namely, in the legs. Those were DVTs, deep vein thromboses, and they traveled at 8:00, at 7:00, at 9:00, at who knows when until the lungs were full of blood clots.

* * *

Q. Dr. Spitz, can I ask a question, please? The clots that traveled that you referred to can be described as fresh clots, correct?

A. I can -- yes, I believe that they were probably fresh clots, not maybe completely fresh, but I think they were of different ages because blood clots, when they come in multitude, will have like in this case described in the autopsy report, that they were of different sizes. Different sizes to me means also that they were of different ages.

Q. Right. You told us fresh clots travel, old clots don't. Remember that testimony?

A. Yeah. When they were really old, yes. They become part of the wall of the blood vessel in the legs and then they don't travel, but the blood clots in the legs, as long as they're in the legs, is a foreign body. It doesn't belong there. The body treats it as a foreign body, so they will try and what is called organize these blood clots to become part of the blood vessel at which time scar tissue is growing into the blood clots and prevents them from moving. At the same time–

Q. How long does that take?

A. Excuse me. But at the same time, new blood is forming in those blood vessels in which there is a reduced circulation, and new blood vessels will also clot with time and connect with the blood -- with the wall of the blood vessel, but they don't all connect at the same time, either. This is a process, and these keep causing this gentleman difficulty breathing. Eventually he goes to the doctor. The doctor gives him a certificate that he can go into surgery for his stomach to reduce weight.

* * *

Q. How long does it take the clot to organize so that it doesn't move?

A. Probably some weeks.

Q. How many weeks?

A. Probably maybe -- I don't know. I would say two or three weeks. Maybe a little less. Maybe a little more.

Dr. Spitz provided further clarification about this process:

Q. The autopsy notes multiple DVTs in both legs. Do you agree that there were multiple DVTs in both legs of [the decedent]?

A. Absolutely. I agree that these multiple DVTs, deep vein thrombosis. That means blood clots in the deep veins in the legs. That's where they are -- almost

always where these blood clots come from because they would have come when they will shoot up into the heart and lung and then there's nothing you can do because it's all too fast. There's nothing -- you cannot change that.

* * *

Q. If you have DVTs that go untreated and undiagnosed, does that make you more susceptible to having more DVTs?

A. DVTs are never -- it's not like one little DVT or something. There are usually a lot of DVTs. DVTs means blood clots here, blood clots there. Some of these blood clots will get attached to the wall. Some will not get attached to the wall because of difference in size, because of all kind of -- nature is -- always goes the same way. You think this is the first time that I'm seeing an autopsy on somebody that died of a pulmonary embolism? My God, not. The blood clots -- the more DVTs there are, the more DVTs there will be at the end not because it's the body thrives to make DVTs, no, but as blood vessels are closed, other blood vessels need to be returning the blood to the -- through the heart, so, therefore, there will be more DVTs, more blood clots, and the condition becomes worse.

Dr. Spitz thus opined that the decedent had, for some time, been "throwing blood clots" that traveled from his legs into his lungs and that this process had "continue[d] and continue[d] and continue[d]."

Similarly, Dr. Hossein Ardehali testified in his deposition about this process leading up to the decedent's death:

I believe that the patient had blood clots in his leg and that didn't happen overnight. They were present over for several days, maybe months. I believe that they migrated to his lungs not just in one day. It was over a period of time, but there were migrations of these clots to his lungs on the day he died. Not all of them because they had been going on for a while.

Specifically, Dr. Ardehali was asked if he agreed with the statement on the death certificate that the time between onset of the PE and death was seconds to minutes, and Dr. Ardehali answered as follows:

Well, I agree that there was a series of (inaudible) that migrated from his legs to his lungs and this was happening over a period of time. Eventually it got to a point that (inaudible) over the fence and that lead to his death. It wasn't just one event. It was a series of events that led to his death, but there was probably one eventual migration of these thrombi that eventually lead to his death.

* * *

To answer your question I want to emphasize that trauma formation is a dynamic process. I disagree that deep vein thrombosis was formed over seconds

and minutes and I don't think the person who signed this form believed that the deep vein thrombosis was formed over seconds or minutes.

As I mentioned earlier, this is a chronic process and happens over several days, maybe up to weeks or months. You know, this is not just one step. There are several steps that are involved and it can be a chronic process. I believe that he got to a point that additional migration, additional, you know, emboli pushed him over the fence. I believe this is what is indicated here and I disagree that any statement that what happened to him only happened over seconds or minutes.

Dr. Ardehali explained the nuances in attempting to distinguish between chronic and acute clots:

Q. Yes. Is it true that acute or fresh clots can travel, that is, move, whereas chronic clots usually do not move?

A. I don't disagree with that and that's exactly what I was saying earlier that you can't just separate a clot as chronic versus acute. Clot formation is a dynamic process. If you have a chronic clot, there can be additional acute clot that is formed on top of it. You can [sic] just generalize and say that old chronic clots cannot move and they're stable. Every acute clot can move. I think that's not a scientifically-based statement and I base that on the fact that clot is a dynamic process and it goes to -- let me step back. We have two systems in our body to lyse a clot and form a clot. This is again an ongoing process and you can have a fresh clot on top of a chronic clot.

* * *

. . . Again, the concern is that this patient had formed clots and if they are having symptoms you have to assume that maybe they are forming fresh clots on top of that.

Defendants submitted an affidavit by Dr. Scott Garner opining that based on his review of the autopsy report, autopsy photographs,[1] and death certificate, the decedent developed DVTs on the day of the surgery that developed into acute PE the next morning within seconds to minutes of the decedent's death. Dr. Garner opined that the autopsy photographs depicted fresh thrombi, or blood clots, rather than old or chronic clots. He averred that there was no evidence of chronic DVTs in the photographs. Defendants also submitted an affidavit by Dr. Bader Cassin, who similarly opined that the same evidence demonstrated that the decedent developed DVT within seconds to minutes of his death. Dr. Cassin also based his opinion on his own microscopic review of slides made from tissue samples collected during the autopsy.

Additionally, Dr. Creagh Milford testified in his deposition that the decedent's DVTs developed during surgery, noting the length of the procedure, the decedent's weight of over 400

[1] Both Dr. Ardehali and Dr. Spitz also indicated that they had reviewed the autopsy photographs.

pounds, and the effects of anesthesia. Dr. Milford did not believe, based on his review of the records, that the decedent had DVTs at the time he was evaluated by Dr. Zarghami or that lower extremity imaging was necessary at that time because the condition of the decedent's legs was consistent with chronic venous insufficiency rather than the presence of DVTs.

There were indications in the decedent's medical records from the day of the surgery and the following days, up until he suddenly fainted and went into cardiac arrest, that he did not have any symptoms of DVT.

The trial court granted summary disposition in defendants' favor. The trial court concluded that there was a genuine issue of material fact regarding whether defendants breached the standard of care by failing to complete a DVT study in light of the decedent's condition when he presented to defendants for surgical clearance. However, the court concluded that plaintiff could not establish causation, reasoning that Dr. Spitz's opinions were based on assumptions not in accordance with established facts.

The trial court denied plaintiff's motion for reconsideration. This appeal followed.

II. STANDARD OF REVIEW

A trial court's decision on a motion for summary disposition is reviewed de novo. *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152, 159; 934 NW2d 665 (2019). Here, the trial court granted defendants' motion under MCR 2.116(C)(10). A motion under MCR 2.116(C)(10) tests the factual support for a claim. *Innovation Ventures v Liquid Mfg*, 499 Mich 491, 507; 885 NW2d 861 (2016). When reviewing a motion under MCR 2.116(C)(10), "a trial court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties . . . in the light most favorable to the party opposing the motion." *Id*. (quotation marks and citation omitted; ellipsis in original). "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. If "the record leaves open an issue upon which reasonable minds might differ," then a genuine issue of material fact exists and summary disposition is precluded. *Id*. (quotation marks and citation omitted).

III. ANALYSIS

"The plaintiff in a medical malpractice action bears 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. Failure to prove any one of these elements is fatal." *Cox v Flint Bd of Hosp Managers*, 467 Mich 1, 10; 651 NW2d 356 (2002) (quotation marks and citation omitted); see also MCL 600.2912a. In this case, the trial court's decision to grant summary disposition was solely based on its finding that plaintiff had not demonstrated factual causation. Therefore, the focus of this appeal is whether, based on the record evidence viewed in the light most favorable to the nonmoving party, a factual causation exists. Because I believe that factual causation exists within the record presented, I respectfully dissent.

As explained in *Craig v Oakwood Hosp*, 471 Mich 67, 86-88; 684 NW2d 296 (2004):

> "Proximate cause" is a legal term of art that incorporates both cause in fact and legal (or "proximate") cause. . ..

> The cause in fact element generally requires showing that "but for" the defendant's actions, the plaintiff's injury would not have occurred. On the other hand, legal cause or "proximate cause" normally involves examining the foreseeability of consequences, and whether a defendant should be held legally responsible for such consequences.
>
> As a matter of logic, a court must find that the defendant's negligence was a cause in fact of the plaintiff's injuries before it can hold that the defendant's negligence was the proximate or legal cause of those injuries.
>
> Generally, an act or omission is a cause in fact of an injury only if the injury could not have occurred without (or "but for") that act or omission. While a plaintiff need not prove that an 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.
>
> It is important to bear in mind that a plaintiff cannot satisfy this burden by showing only that the defendant *may* have caused his injuries. Our case law requires more than a mere possibility or a plausible explanation. Rather, a plaintiff establishes that the defendant's conduct was a cause in fact of his injuries only if he "set[s] forth specific facts that would support a reasonable inference of a logical sequence of cause and effect." A valid theory of causation, therefore, must be based on facts in evidence. And while " '[t]he evidence need not negate all other possible causes,' " this Court has consistently required that the evidence " 'exclude other reasonable hypotheses with a fair amount of certainty.' " [Citations omitted; emphasis and alterations in original.]

The plaintiff provided expert testimony stating that the development of deep vein thrombosis (DVT) is a dynamic process and that the patient's condition when he saw Dr. Zarghami for clearance showed that DVTs were already present and migrating to the lungs to form pulmonary embolisms (PEs). It was noted that Dr. Zarghami did not conduct further testing to rule out DVTs before approving the patient for surgery, despite the patient's condition. Another doctor testified that he would not have performed the surgical procedure if he had known about the DVTs as surgery could pose a significant risk for patients with untreated DVTs. Based on this evidence, it is reasonable to infer a cause-and-effect relationship between Dr. Zarghami's failure to test for and detect the DVTs and the patient's subsequent death from PE resulting from the DVTs after the surgery.

I acknowledge that the defendants presented evidence contradicting the plaintiff's theory and supporting the conclusion that the DVTs (Deep Vein Thrombosis) and resulting PE (Pulmonary Embolism) all developed after the surgery and within seconds to minutes of the decedent's death. However, the plaintiff's experts stated that it would be almost impossible for the number of DVTs and PEs that the decedent had to have developed so quickly. The experts explained that although there may have been a short time between the point at which the PEs became acutely life-threatening and the point at which they ultimately became fatal, there had been a much longer process of pathological development dating back at least to when the decedent

visited Dr. Zarghami before that tipping point was reached. Based on this conflicting evidence, there was a genuine issue of material fact regarding factual causation. The trial court erred by granting the defendants' motion for summary disposition. In *Patrick v Turkelson*, 322 Mich App 595, 605; 913 NW2d 369 (2018), it was stated, "[A] court may not make findings of fact; if the evidence before it is conflicting, summary disposition is improper." Again, because there exist questions of fact on conflicting evidence, I would reverse the trial court's grant of summary disposition.

The plaintiff's theory of causation is not disproven by the fact that the decedent's medical records did not show any symptoms of deep vein thrombosis (DVT) from the time immediately following the surgery until his death. According to the plaintiff's experts, the process of forming blood clots that traveled from the decedent's legs to his lungs was occurring during this time, based on his observable symptoms, regardless of whether the process was diagnosed. Additionally, the experts stated that the process of blood clot formation was ongoing and dynamic, continuing without interruption. Therefore, this testimony contradicted the evidence cited by the trial court, which claimed that it was "uncontroverted" that no clots existed post-surgery until seconds or minutes before the decedent's death. Given this conflicting evidence on causation, summary disposition was improper.

I strongly disagree with the trial court's conclusion that the plaintiff's experts based their testimony on assumptions contrary to "established" facts. The court stated that if an expert's opinion contradicts "established" facts, it is objectionable. The plaintiff's experts disagreed with the conclusions of the medical examiner and the defendant's experts. This is not analogous to contradicting "established" facts. Rather, the record reveals that plaintiff's experts were able to support their opinions with the factual findings from the autopsy report rather than simply criticizing the work of the medical examiner or the defendant's experts. This demonstrates that their opinions were not based on unfounded assumptions.

The trial court's conclusion that plaintiff's experts contradicted "established" facts is weakened by the evidence in the record, which shows that the plaintiff's experts provided opinions based on their own interpretations of the facts. These interpretations differed from those provided by the medical examiner and the defendants' experts. However, this doesn't mean that the plaintiff's experts' opinions are "contrary to established facts," unless one considers the defendants' experts' opinions as "established facts," as the trial court did in this case. The plaintiff's experts generally agreed with the medical examiner's findings about the cause of death, but they provided an interpretation that expanded on the brief finding in the death certificate about the onset of the condition occurring seconds to minutes before death. Therefore, the testimony of the plaintiff's experts was sufficient to create a question of fact under these circumstances. This finding is supported by this Court's opinion in *Robins v Garg* (On Remand), 276 Mich App 351, 362-363; 741 NW2d 49 (2007), which concluded that questions of fact on causation existed when the plaintiff's expert disagreed with the medical examiner regarding the cause of death and disagreed with the medical examiner's interpretation of the findings based on the decedent's clinical presentation, while not disagreeing with the medical examiner's objective findings.

I believe that the trial court made a mistake by incorrectly establishing the facts in this case during the defendants' motions for summary disposition. Consequently, the trial court erred in

granting the defendants' motions. In my view, the trial court's decision should be reversed and the case should be sent back for further proceedings based on this opinion.

Considering my disposition of this issue, it is unnecessary for me to address any of plaintiff's additional arguments.

For these reasons, I respectfully dissent.

/s/ Stephen L. Borrello