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**STATE OF MICHIGAN**

**IN THE SUPREME COURT**

**DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI, as husband and wife,**

**Plaintiffs-Appellants,**

**-vs-**

**STEVEN D. HARRINGTON, M.D., and ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.,**

**Defendants-Appellees.**

**Supreme Court No. 162909**

**Court of Appeals No. 351773**

**Macomb County Circuit Court No. 2014-2247-NH**

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# PLAINTIFFS-APPELLANTS' APPENDIX

**MARK GRANZOTTO, P.C.**

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**TIMOTHY M. TAKALA (P72138)**
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# 2014-002247-NH KOSTADINOVSKI, DRAGO et al vs. HARRINGTON MD, STEVEN et al KAV

- Case Type:
- NH-MEDICAL MALPRACTICE
- Case Status:
- Closed
- File Date:
- 06/05/2014
- DCM Track:
- TRACK 210 DAYS DISCOVERY
- Action:
- WITH JURY DEMAND
- Status Date:
- 05/30/2019
- Case Judge:
- VIVIANO, KATHRYN A
- Next Event:
- 02/03/2020

All Information | Docket | Party | Event | Financial | Receipt | Disposition

## Docket Information

| Date | Description | *Docket Text* | Amount Owed |
|---|---|---|---|
| 06/05/2014 | ENTRY FEE | ENTRY FEE Receipt: 721527 Date: 06/05/2014 | $150.00 |
| 06/05/2014 | JURY FEE | JURY FEE Receipt: 721527 Date: 06/05/2014 | $85.00 |
| 06/05/2014 | COMPLAINT/PETITION FILED | COMPLAINT/PETITION FILED | |
| 06/05/2014 | JURY DEMAND | JURY DEMAND | |
| 06/05/2014 | SUMMONS ISSUED | SUMMONS ISSUED EXP 09-04-14 | |
| 06/05/2014 | CASE PLACED ON E-FILING STATUS PER ADMINISTRATIVE ORDER 2010-6 | CASE PLACED ON E-FILING STATUS PER ADMINISTRATIVE ORDER 2010-6 | |
| 06/17/2014 | SERVICE ON COMPLAINT FILED | SERVICE ON COMPLAINT FILED CERT/ 6-14-14/ ADVANCED CARDIOTHORACIC SURGEONS PLLC (DEFENDANT); *GRN CRD ATTCHD | |
| 06/17/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 06/17/2014 | SERVICE ON COMPLAINT FILED | SERVICE ON COMPLAINT FILED CERT/ 6-14-14/ STEVEN HARRINGTON MD (DEFENDANT); *GRN CRD ATTCHD | |
| 06/17/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 06/24/2014 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE Receipt: 790923 Date: 04/09/2015 | $8.00 |
| 06/25/2014 | APPEARANCE (LITIGANT'S ATTORNEY) | APPEARANCE (LITIGANT'S PRIMARY ATTORNEY) PAUL J. MANION (Attorney) on behalf of STEVEN HARRINGTON MD, ADVANCED CARDIOTHORACIC SURGEONS PLLC (DEFENDANT) | |

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| Date | Description | Docket Text | Amount Owed |
|---|---|---|---|
| 06/25/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 06/25/2014 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE Receipt: 726742 Date: 06/27/2014 | $8.00 |
| 07/14/2014 | SERVICE ON COMPLAINT FILED | SERVICE ON COMPLAINT FILED *CERT GREEN CARD ATTACHED*<br>CERT/06-20-14/STEVEN HARRINGTON MD (DEFENDANT)<br>CERT/06-20-14/ADVANCED CARDIOTHORACIC SURGEONS PLLC (DEFENDANT); | |
| 07/14/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 07/14/2014 | SERVICE ON COMPLAINT FILED | SERVICE ON COMPLAINT FILED *USPS TRACKING ATTACHED*<br>ACKN/06-20-14/ATTORNEY PAUL MANION OBO ADVANCED CARDIOTHORACIC SURGEONS PLLC (DEFENDANT); | |
| 07/14/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 07/14/2014 | SERVICE ON COMPLAINT FILED | SERVICE ON COMPLAINT FILED *USPS TRACKING ATTACHED*<br>ACKN/06-20-14/ATTORNEY PAUL MANION OBO STEVEN HARRINGTON MD (DEFENDANT); | |
| 07/14/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 07/14/2014 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE Receipt: 730518 Date: 07/15/2014 | $8.00 |
| 07/15/2014 | AFFIRMATIVE DEFENSES | AFFIRMATIVE DEFENSES | |
| 07/15/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 07/15/2014 | ANSWER TO COMPLAINT | ANSWER TO COMPLAINT<br>Attorney: MANION, PAUL J. (17049)<br>STEVEN HARRINGTON MD (DEFENDANT); ADVANCED CARDIOTHORACIC SURGEONS PLLC (DEFENDANT); | |
| 07/15/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 07/15/2014 | RELIANCE ON JURY DEMAND | RELIANCE ON JURY DEMAND | |
| 07/15/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 07/15/2014 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE Receipt: 730946 Date: 07/16/2014 | $8.00 |
| 07/16/2014 | IMAGE OF EVENT NOTICE SENT | IMAGE OF EVENT NOTICE SENT<br><br>(N) STATUS CONFERENCE PRIOR TO EDSC<br>Sent on: 07/16/2014 08:53:12.06 | |
| 07/16/2014 | INITIAL COURT CONFERENCE SCHEDULED | STATUS CONFERENCE PRIOR TO EDSC SCHEDULED<br>Event: STATUS CONFERENCE PRIOR TO EDSC<br>Date: 08/13/2014 Time: 8:00 am<br>Judge: FOSTER, JOHN C Location: COURTROOM SW - 4TH FLOOR<br><br>Result: ADJOURNED-OTHER REASONS | |
| 07/22/2014 | ANSWER TO AFFIRMATIVE DEFENSES | PLTFS RESPONSE TO DEFTS STEVEN D HARRINGTON MD AND ADVANCED CARDIOTHORACIC SURGEONS PLLCS AFFIRMATIVE DEFENSES & PRF OF SVC | |

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| Date | Description | Docket Text | Amount Owed |
|---|---|---|---|
| 07/22/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 07/22/2014 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE Receipt: 732820 Date: 07/24/2014 | $8.00 |
| 07/29/2014 | ADJOURNED - OTHER REASONS | ADJOURNED - OTHER REASONS--RESET FOR 9/26/14 AT 8:00AM--OTE<br>The following event: STATUS CONFERENCE PRIOR TO EDSC scheduled for 08/13/2014 at 8:00 am has been resulted as follows:<br><br>Result: ADJOURNED-OTHER REASONS<br>Judge: FOSTER, JOHN C Location: COURTROOM SW - 4TH FLOOR | |
| 07/29/2014 | INITIAL COURT CONFERENCE SCHEDULED | STATUS CONFERENCE PRIOR TO EDSC SCHEDULED<br><br>The following event: STATUS CONFERENCE PRIOR TO EDSC scheduled for 08/13/2014 at 8:00 am has been rescheduled as follows:<br><br>Event: STATUS CONFERENCE PRIOR TO EDSC<br>Date: 09/26/2014 Time: 8:00 am<br>Judge: FOSTER, JOHN C Location: COURTROOM SW - 4TH FLOOR<br><br>Result: ADJOURNED-STIPULATION & ORDER | |
| 07/29/2014 | INTERIM DISPOSITION ORDER - SGD | INTERIM DISPOSTION ORDER--SGD | |
| 07/29/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 09/04/2014 | AFFIDAVIT OF MERITORIOUS DEFENSE | AFFIDAVIT OF MERITORIOUS DEFENSE O/B/O STEVEN D HARRINGTON MD AND ADVANCED CARDIOTHORACIC SURGEONS PLLC PURSUANT TO MCL 600.2912e FOR J MICHAEL SMITH MD | |
| 09/04/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 09/04/2014 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE Receipt: 742763 Date: 09/05/2014 | $8.00 |
| 09/24/2014 | ADJOURNED - STIPULATION & ORDER | ADJOURNED - STIPULATION & ORDER<br>The following event: STATUS CONFERENCE PRIOR TO EDSC scheduled for 09/26/2014 at 8:00 am has been resulted as follows:<br><br>Result: ADJOURNED-STIPULATION & ORDER<br>Judge: FOSTER, JOHN C Location: COURTROOM SW - 4TH FLOOR | |
| 09/24/2014 | ORDER SIGNED: | STIPULATED ORDER ADJOURNING STATUS CONFERENCE DATE - SGD | |
| 09/24/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 09/24/2014 | PROOF OF SERVICE OF SIGNED ORDER | PROOF OF SERVICE OF SIGNED ORDER | |
| 09/24/2014 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE Receipt: 747575 Date: 09/24/2014 | $8.00 |
| 09/24/2014 | INITIAL COURT CONFERENCE SCHEDULED | STATUS CONFERENCE PRIOR TO EDSC SCHEDULED<br><br>The following event: STATUS CONFERENCE PRIOR TO EDSC scheduled for 09/26/2014 at 8:00 am has been rescheduled as follows: | |

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| Date | Description | Docket Text | Amount Owed |
|---|---|---|---|
| | | Event: STATUS CONFERENCE PRIOR TO EDSC<br>Date: 10/02/2014 Time: 8:00 am<br>Judge: FOSTER, JOHN C Location: COURTROOM SW - 4TH FLOOR<br><br>Result: HELD: NOT PLACED ON RECORD | |
| 10/03/2014 | HELD: NOT PLACED ON RECORD, | HELD: NOT PLACED ON RECORD--DISC REMAINS OPEN UNTIL FURTHER ORDER. STATUS CONF MAYBE ADJ'D, IF FACILITATION ORDER IS FILED W/NAMED FACILITATOR AND DATE, TO 1W THEREAFTER. SET STATUS CONF 3/31/15 AT 8:00AM--OTE<br>The following event: STATUS CONFERENCE PRIOR TO EDSC scheduled for 10/02/2014 at 8:00 am has been resulted as follows:<br><br>Result: HELD: NOT PLACED ON RECORD<br>Judge: FOSTER, JOHN C Location: COURTROOM SW - 4TH FLOOR | |
| 10/03/2014 | STATUS CONFERENCE SCHEDULED | STATUS CONFERENCE SCHEDULED<br>Event: STATUS CONFERENCE<br>Date: 03/31/2015 Time: 8:00 am<br>Judge: FOSTER, JOHN C Location: COURTROOM SW - 4TH FLOOR<br><br>Result: HELD: NOT PLACED ON RECORD | |
| 10/03/2014 | INTERIM DISPOSITION ORDER - SGD | INTERIM DISPOSTION ORDER--SGD | |
| 10/03/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 11/12/2014 | E-FILED REQUEST FOR HEARING | E-FILED REQUEST FOR HEARING (11-24-14 @ 8:A00AM - MEYERS) | |
| 11/12/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 11/12/2014 | MOTION TO COMPEL | MOTION TO COMPEL DEPOSITION OF DEFT AND BRIEF IN SUPPORT W/ PRF OF SRVC W/ ATTACHMENTS | |
| 11/12/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 11/12/2014 | NOTICE OF HEARING | NOTICE OF HEARING | |
| 11/12/2014 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE | |
| 11/12/2014 | MOTION FEE | MOTION FEE Receipt: 759389 Date: 11/17/2014 | $20.00 |
| 11/12/2014 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE Receipt: 759388 Date: 11/17/2014 | $8.00 |
| 11/17/2014 | HEARING: MTN TO COMPEL DEPOSITION SCHEDULED | HEARING: MTN TO COMPEL DEPOSITION SCHEDULED<br>Event: (E) MTN TO COMPEL DEPOSITION<br>Date: 11/24/2014 Time: 8:00 am<br>Judge: FOSTER, JOHN C Location: COURTROOM SW - 4TH FLOOR<br><br>MEYERS<br><br>Result: MOTION HEARING ADJOURNED | |
| 11/21/2014 | MOTION HEARING ADJOURNED | MOTION HEARING ADJOURNED TO 12-1-14 8AM PER ATTY MEYER'S OFFICE<br>The following event: (E) MTN TO COMPEL DEPOSITION scheduled for 11/24/2014 at 8:00 am has been resulted as follows:<br><br>Result: MOTION HEARING ADJOURNED<br>Judge: FOSTER, JOHN C Location: COURTROOM SW - 4TH | |

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| Date | Description | Docket Text | Amount Owed |
|---|---|---|---|
| | | FLOOR | |
| 11/21/2014 | HEARING: MTN TO COMPEL DEPOSITION SCHEDULED | HEARING: MTN TO COMPEL DEPOSITION SCHEDULED<br><br>The following event: (E) MTN TO COMPEL DEPOSITION scheduled for 11/24/2014 at 8:00 am has been rescheduled as follows:<br><br>Event: (E) MTN TO COMPEL DEPOSITION<br>Date: 12/01/2014 Time: 8:00 am<br>Judge: FOSTER, JOHN C Location: COURTROOM SW - 4TH FLOOR<br><br>MEYERS - MANION<br><br>Result: DISMISSAL OF MOTION | |
| 11/26/2014 | DISMISSAL OF MOTION | DISMISSAL OF MOTION PER MEYERS' OFFICE<br>The following event: (E) MTN TO COMPEL DEPOSITION scheduled for 12/01/2014 at 8:00 am has been resulted as follows:<br><br>Result: DISMISSAL OF MOTION<br>Judge: FOSTER, JOHN C Location: COURTROOM SW - 4TH FLOOR | |
| 03/31/2015 | HELD: NOT PLACED ON RECORD, | HELD: NOT PLACED ON RECORD--DISC REMAINS OPEN UNTIL FURTHER ORDER. PARTIES TO PREPARE AND FILE SCHEDULING ORDER. STATUS CONF MAY BE ADJ'D W/FACILITATION ORDER. SET STATUS CONF 6/25/15 AT 8:00AM--OTE<br>The following event: STATUS CONFERENCE scheduled for 03/31/2015 at 8:00 am has been resulted as follows:<br><br>Result: HELD: NOT PLACED ON RECORD<br>Judge: FOSTER, JOHN C Location: COURTROOM SW - 4TH FLOOR | |
| 03/31/2015 | STATUS CONFERENCE SCHEDULED | STATUS CONFERENCE SCHEDULED<br><br>The following event: STATUS CONFERENCE scheduled for 03/31/2015 at 8:00 am has been rescheduled as follows:<br><br>Event: STATUS CONFERENCE<br>Date: 06/25/2015 Time: 8:00 am<br>Judge: FOSTER, JOHN C Location: COURTROOM SW - 4TH FLOOR | |
| 03/31/2015 | INTERIM DISPOSITION ORDER - SGD | INTERIM DISPOSITION ORDER - SGD | |
| 03/31/2015 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=16658303). | |
| 04/02/2015 | STIP & ORDER SGD RE: | STIP & ORDER SGD RE:<br>STIPULATED SCHEDULING ORDER - SGD (OBDH=16704749). | |
| 04/02/2015 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=16704868). | |
| 04/02/2015 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>E-FILING FEE mt Receipt: Date: 4/9/2015 8:18:05 AM (OBDH=17289538) Receipt: 804406 Date: 06/05/2015 | $8.00 |
| 04/08/2015 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=17276751). | |
| 04/08/2015 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=17276751). | |

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| Date | Description | Docket Text | Amount Owed |
|---|---|---|---|
| 04/29/2015 | STATUS CONFERENCE SCHEDULED | STATUS CONFERENCE SCHEDULED<br>Event: STATUS CONFERENCE<br>Date: 06/25/2015 Time: 8:00 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>Result: HELD-CIVIL | |
| 04/29/2015 | CASELOAD TRANSFERRED | CASELOAD TRANSFERRED<br>The judge was changed from FOSTER, JOHN C to VIVIANO, KATHRYN . | |
| 04/29/2015 | NOTIFICATION OF CASELOAD TRANSFER TO BE SENT | NOTIFICATION OF CASELOAD TRANSFER TO BE SENT | |
| 04/30/2015 | NOTIFICATION OF CASELOAD TRANSFER MAILED | NOTIFICATION OF CASELOAD TRANSFER MAILED<br><br>(N) NOTICE OF CASELOAD TRANSFER<br>Sent on: 04/30/2015 11:16:52.99 | |
| 06/01/2015 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=17856488). | |
| 06/04/2015 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=17909321). | |
| 06/04/2015 | STIP & ORDER SGD RE: | STIP & ORDER SGD RE:<br>STIPULATED ORDER FOR QUALIFIED PROTECTIVE ORDER - SGD (OBDH=17856424). | |
| 06/04/2015 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=17909321). | |
| 06/04/2015 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>E-FILING FEE mt Receipt: Date: 6/5/2015 8:21:54 AM<br>(OBDH=17921036) Receipt: 810848 Date: 07/07/2015 | $8.00 |
| 06/25/2015 | HELD: | HELD: NOT PLACED ON REC, 1ST EXTENSION OF DISCOVERY ORDER OTE KAV<br>The following event: STATUS CONFERENCE scheduled for 06/25/2015 at 8:00 am has been resulted as follows:<br><br>Result: HELD-CIVIL<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR | |
| 06/25/2015 | ORDER EXTENDING DISCOVERY - SGD | STIPULATED ORDER FOR 1ST EXTENSION OF DISCOVERY AND/OR CASE EVALUATION DATES, DISCOVERY TO 9/25/15, SUMM DISPO 11/25/15, PWL 7/29/15, DWL 8/6/15- SGD KAV | |
| 06/26/2015 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=18209879) | |
| 06/26/2015 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=18209805) | |
| 06/29/2015 | DEFENDANTS WITNESS LIST | DEFENDANTS WITNESS LIST<br>(OBDH=18411147) DEFENDANTS STEVEN D HARRINGTON MD AND ADVANCED CARDIOTHORACIC SURGEONS PLLCS PRELIMINARY WITNESS LIST AND EXHIBIT LIST, PROOF OF SERVICE | |
| 06/29/2015 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=18411148) | |
| 06/29/2015 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=18929883) E-FILING FEE mt Receipt: Date: 7/7/2015 8:14:19 AM Receipt: 816459 Date: 07/29/2015 | $8.00 |
| 07/23/2015 | DOCUMENT FILED: | DOCUMENT FILED:<br>(OBDH=20300980) PLAINTIFFS' EXHIBIT LIST; PRF OF SRVC | |

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|---|---|---|---|
| 07/23/2015 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE (OBDH=20300990) | |
| 07/23/2015 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE (OBDH=20502644) E-FILING FEE mt Receipt: Date: 7/29/2015 9:17:17 AM Receipt: 818774 Date: 08/07/2015 | $8.00 |
| 07/23/2015 | PLAINTIFF'S WITNESS LIST | PLAINTIFF'S WITNESS LIST (OBDH=20300965) PLAINTIFF WITNESS LIST, CERT OF SERVICE | |
| 07/23/2015 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE (OBDH=20300996) | |
| 07/23/2015 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE (OBDH=20502715) E-FILING FEE mt Receipt: Date: 7/29/2015 9:22:36 AM Receipt: 816470 Date: 07/29/2015 | $8.00 |
| 08/03/2015 | DOCUMENT FILED: | DOCUMENT FILED: (OBDH=20626740) DEFTS PRELIM WITNESS LIST AND EXH LIST ADVANCED CARDIOTHORACIC SURGEONS PLLC (DEFENDANT); STEVEN HARRINGTON MD (DEFENDANT); | |
| 08/03/2015 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE (OBDH=20626949) | |
| 08/03/2015 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE (OBDH=20851103) E-FILING FEE mt Receipt: Date: 8/7/2015 11:30:13 AM Receipt: 836411 Date: 10/21/2015 | $8.00 |
| 09/25/2015 | CASE EVALUATION HEARING SCHEDULED | CASE EVALUATION HEARING SCHEDULED Event: CASE EVALUATION HEARING Date: 12/08/2015 Time: 10:30 am Judge: 3A120815 Location: CASE EVAL CONF ROOM A - 3RD FLOOR<br><br>Result: CASE EVALUATION ADJOURNED | |
| 09/25/2015 | CASE EVAL NOTICE SENT | CASE EVAL NOTICE SENT<br><br>CASE EVALUATION HEARING NOTICE Sent on: 09/25/2015 09:46:58.82 | |
| 10/13/2015 | DEFENDANTS WITNESS LIST | DEFENDANTS WITNESS LIST (OBDH=24344387) DEFENDANTS STEVEN D HARRINGTON MD AND ADVANCED CARDIOTHORACIC SURGEONS PLLCS SECOND AMENDED WITNESS LIST AND EXHIBIT LIST | |
| 10/13/2015 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE (OBDH=24344422) | |
| 10/13/2015 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE (OBDH=24761097) E-FILING FEE mt Receipt: Date: 10/21/2015 11:18:08 AM Receipt: 837462 Date: 10/26/2015 | $8.00 |
| 10/21/2015 | NOTICE OF HEARING | NOTICE OF HEARING (OBDH=24762264) NOTICE OF HEARING | |
| 10/21/2015 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE (OBDH=24763220) | |
| 10/21/2015 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE (OBDH=25084466) E-FILING FEE mt Receipt: Date: 10/26/2015 11:30:42 AM Receipt: 837535 Date: 10/26/2015 | $8.00 |
| 10/21/2015 | MOTION: | MOTION: (OBDH=24762263) PLAINTIFFS' MOTION & BRIEF TO ADJOURN SCHEDULING ORDER DATES; PRF OF SRVC | |

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| Date | Description | Docket Text | Amount Owed |
|---|---|---|---|
| 10/21/2015 | MOTION FEE | MOTION FEE<br>Filing Fee mt Receipt: Date: 10/21/2015 12:04:31 PM Receipt: 837463 Date: 10/26/2015 | $20.00 |
| 10/21/2015 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=24763226) | |
| 10/21/2015 | E-FILED REQUEST FOR HEARING | E-FILED REQUEST FOR HEARING<br>(OBDH=24762688) E-FILED REQUEST FOR HEARING: 11/9/15; PLTS MTN TO ADJ SCHEDULING ORDER DATES (MEYERS - MANION) | |
| 10/21/2015 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=24763225) | |
| 10/21/2015 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=25085827) E-FILING FEE mt Receipt: Date: 10/26/2015 1:48:17 PM Receipt: 837607 Date: 10/26/2015 | $8.00 |
| 10/21/2015 | E-FILED REQUEST FOR HEARING | E-FILED REQUEST FOR HEARING<br>(OBDH=24766517) E-FILED REQUEST FOR HEARING: 11/9/15; PLTS MTN TO ADJ SCHEDULING ORDER DATES (MEYERS - MANION) | |
| 10/21/2015 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=24766671) | |
| 10/21/2015 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=25086033) E-FILING FEE mt Receipt: Date: 10/26/2015 1:54:54 PM Receipt: 837548 Date: 10/26/2015 | $8.00 |
| 10/21/2015 | E-FILED REQUEST FOR HEARING | E-FILED REQUEST FOR HEARING<br>(OBDH=24762934) E-FILED REQUEST FOR HEARING; 11/9/15; PLTS MTN TO ADJ SCHEDULING ORDER DATES (MEYERS - MANION) | |
| 10/21/2015 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=24763221) | |
| 10/21/2015 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=25086011) E-FILING FEE mt Receipt: Date: 10/26/2015 1:54:08 PM Receipt: 837553 Date: 10/26/2015 | $8.00 |
| 10/23/2015 | E-FILED REQUEST FOR HEARING | E-FILED REQUEST FOR HEARING<br>(OBDH=24957793) E-FILED REQUEST FOR HEARING: 11/9/15; PLTS MTN TO ADJ SCHEDULING ORDER DATES (MEYERS - MANION) | |
| 10/23/2015 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=24958234) | |
| 10/23/2015 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=25086114) E-FILING FEE mt Receipt: Date: 10/26/2015 2:00:55 PM Receipt: 867381 Date: 02/26/2016 Receipt: 867397 Date: 02/26/2016 | $8.00 |
| 10/26/2015 | HEARING: MTN TO EXTEND SCHEDULING ORDER DATES | HEARING: MTN TO EXTEND SCHEDULING ORDER DATES<br>Event: (E) MTN TO EXTEND SCHEDULING ORDER DATES<br>Date: 11/09/2015 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>MEYERS<br><br>Result: HELD-CIVIL | |
| 11/09/2015 | HELD: | HELD, STATUS CONFERENCE SET FOR 11/19/15 AT 8:30 AM, MOTION TO EXT SCHED ORD IS ADJ TO 11/19/15 AT 8:30 AM - OTE<br>The following event: (E) MTN TO EXTEND SCHEDULING ORDER DATES scheduled for 11/09/2015 at 8:30 am has been resulted as | |

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| Date | Description | Docket Text | Amount Owed |
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| | | follows:<br><br>Result: HELD-CIVIL<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>HELD ON THE RECORD<br>COURT REPORTER: VIDEO<br>Certificate #: | |
| 11/09/2015 | ORDER SIGNED: | ORDER SETTING STATUS CONFERENCE FOR 11/19/15 AT 8:30 AM - SIGNED | |
| 11/09/2015 | HEARING: MTN TO EXTEND SCHEDULING ORDER DATES | HEARING: MTN TO EXTEND SCHEDULING ORDER DATES<br><br>The following event: (E) MTN TO EXTEND SCHEDULING ORDER DATES scheduled for 11/09/2015 at 8:30 am has been rescheduled as follows:<br><br>Event: (E) MTN TO EXTEND SCHEDULING ORDER DATES<br>Date: 11/19/2015 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>MEYERS<br><br>Result: MOTION HEARING ADJOURNED | |
| 11/09/2015 | STATUS CONFERENCE SCHEDULED | STATUS CONFERENCE SCHEDULED<br>Event: STATUS CONFERENCE<br>Date: 11/09/2015 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR | |
| 11/09/2015 | STATUS CONFERENCE SCHEDULED | STATUS CONFERENCE SCHEDULED<br>Event: STATUS CONFERENCE<br>Date: 11/19/2015 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>Result: HELD-CIVIL | |
| 11/09/2015 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=25584755) | |
| 11/19/2015 | HELD: | HELD: NOT PLACED ON REC, CASE EVAL SET FOR 12/8/2015 IS ADJOURNED TO DATE SET BY CRT, ADJ FEES ARE WAIVED, ATTY CONFRIM DATES FOR EXPERT DEPOSITIONS & BE PREPARED TO DISCUSS FIRM SCHEDULE THROUGH TRIAL DATE OTE KAV<br>The following event: STATUS CONFERENCE scheduled for 11/19/2015 at 8:30 am has been resulted as follows:<br><br>Result: HELD-CIVIL<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR | |
| 11/19/2015 | ORDER ADJOURNING CASE EVALUATION - SGD | ORDER ADJOURNING CASE EVALUATION & WAIVING ADJOURNMENT FEE, ADJOURNING STATUS CONFERENCE DATE- SGD KAV | |
| 11/19/2015 | STATUS CONFERENCE SCHEDULED | STATUS CONFERENCE SCHEDULED<br><br>The following event: STATUS CONFERENCE scheduled for 11/19/2015 at 8:30 am has been rescheduled as follows:<br><br>Event: STATUS CONFERENCE<br>Date: 12/08/2015 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - | |

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| | | 2ND FLOOR<br><br>Result: HELD-CIVIL | |
| 11/19/2015 | MOTION HEARING ADJOURNED | MOTION HEARING ADJOURNED TO 12/8/15 AT 8:30 W/STAUS CONFERENCE<br>The following event: (E) MTN TO EXTEND SCHEDULING ORDER DATES scheduled for 11/19/2015 at 8:30 am has been resulted as follows:<br><br>Result: MOTION HEARING ADJOURNED<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR | |
| 11/19/2015 | HEARING: MTN TO EXTEND SCHEDULING ORDER DATES | HEARING: MTN TO EXTEND SCHEDULING ORDER DATES<br><br>The following event: (E) MTN TO EXTEND SCHEDULING ORDER DATES scheduled for 11/19/2015 at 8:30 am has been rescheduled as follows:<br><br>Event: (E) MTN TO EXTEND SCHEDULING ORDER DATES<br>Date: 12/08/2015 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>MEYERS<br><br>Result: HELD-CIVIL | |
| 11/19/2015 | CASE EVALUATION HEARING TO BE RESCHEDULED | CASE EVALUATION HEARING TO BE RESCHEDULED<br>**11/19/15 - ORDER TO ADJ - NO NEW DATE - MTN FOR RESCHED DATES 12/8/15**<br>The following event: CASE EVALUATION HEARING scheduled for 12/08/2015 at 10:30 am has been resulted as follows:<br><br>Result: CASE EVALUATION ADJOURNED<br>Judge: 3A120815 Location: CASE EVAL CONF ROOM A - 3RD FLOOR | |
| 11/24/2015 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=26367789) | |
| 12/03/2015 | CASE EVALUATION HEARING SCHEDULED | CASE EVALUATION HEARING SCHEDULED<br>Event: CASE EVALUATION HEARING<br>Date: 02/02/2016 Time: 9:30 am<br>Judge: 3A020216 Location: CASE EVAL CONF ROOM A - 3RD FLOOR<br><br>Result: CASE EVALUATION ADJOURNED | |
| 12/03/2015 | CASE EVAL NOTICE SENT | CASE EVAL NOTICE SENT<br><br>CASE EVALUATION HEARING NOTICE<br>Sent on: 12/03/2015 09:44:40.26 | |
| 12/08/2015 | HELD: | HELD: NOT PLACED ON REC, SETTLEMENT CONFERENCE SET FOR 5/6/16 @ 8:30 AM, CASE EVAL ADJ FROM 2/2/16 TO 5/6/2016, PARTIES AGREE TO REDUCED ACCEPT/REJECT PERIOD TO 7 DAYS, DISCOVERY EXTENDED TO 4/1/16 LIMITED PURPOSE OF COMPLETING DEPOSITIONS CURRENTLY SCHEDULED, PRE TRIAL SET FOR 7/19/2016 AT 8:30 AM, TRIAL DATE FOR 7/19/2016 AT 10 AM (5 DAYS) OTE KAV<br>The following event: STATUS CONFERENCE scheduled for 12/08/2015 at 8:30 am has been resulted as follows:<br><br>Result: HELD-CIVIL<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - | |

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| | | 2ND FLOOR | |
| 12/08/2015 | SETTLEMENT CONFERENCE SCHEDULED | SETTLEMENT CONFERENCE SCHEDULED<br>Event: SETTLEMENT CONFERENCE<br>Date: 05/06/2016 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>Result: ADJOURNED-OTHER REASONS | |
| 12/08/2015 | HELD: | HELD: NOT PLACED ON REC, DISCOVERY EXTENDED TO 4/1/16 FOR LIMITED PURPOSE OF COMPLETING DEPOSITIONS CURRENTLY SCHEDULED OTE KAV<br>The following event: (E) MTN TO EXTEND SCHEDULING ORDER DATES scheduled for 12/08/2015 at 8:30 am has been resulted as follows:<br><br>Result: HELD-CIVIL<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR | |
| 12/08/2015 | PRETRIAL CONFERENCE SCHEDULED | PRETRIAL CONFERENCE SCHEDULED<br>Event: PRETRIAL CONFERENCE<br>Date: 07/19/2016 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>Result: SCHEDULED EVENT CANCELLED | |
| 12/08/2015 | ORDER REGARDING DISCOVERY AND CASE EVALUATION - SGD | ORDER REGARDING DISCOVERY 4/1/2016 FOR COMPLETING DEPOSITIONS AND CASE EVALUATION 4/5/2016 REJECT/ACCEPT NTC REDUCED TO 7 DAYS, TRIAL & PRETRIAL DATES- SGD KAV | |
| 12/08/2015 | TRIAL SCHEDULED | TRIAL SCHEDULED<br>Event: TRIAL<br>Date: 07/26/2016 Time: 10:00 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>Result: SCHEDULED EVENT CANCELLED | |
| 12/23/2015 | CASE EVALUATION HEARING TO BE RESCHEDULED | CASE EVALUATION HEARING TO BE RESCHEDULED 12/8/15 - ORDER TO ADJOURN CASE EVAL TO 4/5/16<br>The following event: CASE EVALUATION HEARING scheduled for 02/02/2016 at 9:30 am has been resulted as follows:<br><br>Result: CASE EVALUATION ADJOURNED<br>Judge: 3A020216 Location: CASE EVAL CONF ROOM A - 3RD FLOOR | |
| 12/23/2015 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=27312669) | |
| 02/01/2016 | CASE EVALUATION HEARING SCHEDULED | CASE EVALUATION HEARING SCHEDULED<br>Event: CASE EVALUATION HEARING<br>Date: 04/05/2016 Time: 9:30 am<br>Judge: 3A040516 Location: CASE EVAL CONF ROOM A - 3RD FLOOR<br><br>Result: CASE EVALUATION ADJOURNED | |
| 02/01/2016 | CASE EVAL NOTICE SENT | CASE EVAL NOTICE SENT<br><br>CASE EVALUATION HEARING NOTICE<br>Sent on: 02/01/2016 10:26:11.05 | |

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| 02/25/2016 | RESPONSE TO MOTION | RESPONSE TO MOTION<br>(OBDH=29642287) CONCURRENCE WITH MTN OF PLTFS TO ADJOURN TRIAL | |
| 02/25/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=29642329) | |
| 02/25/2016 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=29699419) E-FILING FEE mt Receipt: Date: 2/26/2016 11:30:21 AM Receipt: 868025 Date: 03/01/2016 Receipt: 869718 Date: 03/07/2016 | $5.00 |
| 02/25/2016 | RESPONSE TO MOTION | RESPONSE TO MOTION<br>(OBDH=29642994) CONCURRENCE WITH MTN OF PLTFS TO ADJOURN CASE EVALUATION | |
| 02/25/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=29642996) | |
| 02/25/2016 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=29699498) E-FILING FEE mt Receipt: Date: 2/26/2016 11:37:09 AM Receipt: 867397 Date: 02/26/2016 Receipt: 868025 Date: 03/01/2016 | $5.00 |
| 02/29/2016 | HEARING: MTN TO ADJOURN CASE EVALUATION SCHEDULED | HEARING: MTN TO ADJOURN CASE EVALUATION SCHEDULED<br>Event: (E) MTN TO ADJOURN CASE EVAL<br>Date: 03/07/2016 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>MEYERS<br><br>Result: MOTION GRANTED | |
| 02/29/2016 | E-FILED REQUEST FOR HEARING | E-FILED REQUEST FOR HEARING<br>(OBDH=29702847) E-FILED REQUEST FOR HEARING, NOTC OF HRG, PRRF OF SERV | |
| 02/29/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=29702850) | |
| 02/29/2016 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=29788229) E-FILING FEE mt Receipt: Date: 3/1/2016 8:33:27 AM Receipt: 869718 Date: 03/07/2016 Receipt: 874431 Date: 03/22/2016 | $5.00 |
| 02/29/2016 | NOTICE OF HEARING | NOTICE OF HEARING<br>(OBDH=29702846) NOTICE OF HEARING | |
| 02/29/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=29702849) | |
| 02/29/2016 | MOTION TO ADJOURN | MOTION TO ADJOURN<br>(OBDH=29702845) PLTFS MOTION TO ADJOURN CASE EVAL, BIS, PRF OF SERV | |
| 02/29/2016 | MOTION FEE | MOTION FEE<br>Filing Fee mt Receipt: Date: 2/29/2016 8:00:00 AM Receipt: 868029 Date: 03/01/2016 | $20.00 |
| 02/29/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=29702852) | |
| 03/03/2016 | DOCUMENT FILED: | DOCUMENT FILED:<br>(OBDH=29905608) PLAINTIFF'S EXHIBIT NO 1 | |
| 03/03/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=29905626) | |

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| 03/03/2016 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=30015682) E-FILING FEE mt Receipt: Date: 3/7/2016 8:13:14 AM Receipt: 874431 Date: 03/22/2016 Receipt: 875057 Date: 03/23/2016 | $5.00 |
| 03/07/2016 | MOTION GRANTED | MOTION GRANTED, CASE EVAL ADJ TO 5/24/16 AT 8:30 AM, PARTIES HAVE 7 DAYS TO ACCEPT REJECT CASE EVAL - OTE<br>The following event: (E) MTN TO ADJOURN CASE EVAL scheduled for 03/07/2016 at 8:30 am has been resulted as follows:<br><br>Result: MOTION GRANTED<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>HELD ON THE RECORD<br>COURT REPORTER: VIDEO<br>Certificate #: | |
| 03/07/2016 | ORDER ADJOURNING CASE EVALUATION - SGD | ORDER ADJOURNING CASE EVALUATION FROM 4/5/16 TO 5/24/16 AT 8:30 AM PARTIES SHALL HAVE 7 DAYS TO ACCEPT OR REJECT CASE EVAL - SGD | |
| 03/07/2016 | CASE EVALUATION HEARING TO BE RESCHEDULED | CASE EVALUATION HEARING TO BE RESCHEDULED **3/7/16 - ORDER TO ADJ TO 5/24/16**<br>The following event: CASE EVALUATION HEARING scheduled for 04/05/2016 at 9:30 am has been resulted as follows:<br><br>Result: CASE EVALUATION ADJOURNED<br>Judge: 3A040516 Location: CASE EVAL CONF ROOM A - 3RD FLOOR | |
| 03/07/2016 | ADJOURNED - OTHER REASONS | ADJOURNED TO 6/9/16 AT 8:30 AM<br>The following event: SETTLEMENT CONFERENCE scheduled for 05/06/2016 at 8:30 am has been resulted as follows:<br><br>Result: ADJOURNED-OTHER REASONS<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR | |
| 03/07/2016 | SETTLEMENT CONFERENCE SCHEDULED | SETTLEMENT CONFERENCE SCHEDULED<br><br>The following event: SETTLEMENT CONFERENCE scheduled for 05/06/2016 at 8:30 am has been rescheduled as follows:<br><br>Event: SETTLEMENT CONFERENCE<br>Date: 06/09/2016 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>Result: SCHEDULED EVENT CANCELLED | |
| 03/07/2016 | CASE EVALUATION HEARING SCHEDULED | CASE EVALUATION HEARING SCHEDULED<br>Event: CASE EVALUATION HEARING<br>Date: 05/24/2016 Time: 10:30 am<br>Judge: 3A052416 Location: CASE EVAL CONF ROOM A - 3RD FLOOR<br><br>Result: SCHEDULED EVENT CANCELLED | |
| 03/08/2016 | CASE EVAL NOTICE SENT | CASE EVAL NOTICE SENT<br><br>CASE EVALUATION HEARING NOTICE<br>Sent on: 03/08/2016 11:05:04.63 | |
| 03/08/2016 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=30063514) | |

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| 03/21/2016 | E-FILED REQUEST FOR HEARING | E-FILED REQUEST FOR HEARING<br>(OBDH=30849939) E-FILED REQUEST FOR HEARING: 4/25/16; MTN TO STRIKE & FOR SUMM DISPO (THOMAS - TAKALA) | |
| 03/21/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=30849977) | |
| 03/21/2016 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=30912695) E-FILING FEE mt Receipt: Date: 3/22/2016 12:00:42 PM Receipt: 875489 Date: 03/25/2016 Receipt: 875492 Date: 03/25/2016 | $5.00 |
| 03/21/2016 | MOTION: | MOTION:<br>(OBDH=30849940) DEFTS STEVENM D HARRINGTON MD AND ADVANCED CARDIOTHORACIC SURGEONS PLLCS MTN TO STRIKE ALLEGATIONS NOT CONTAINED IN THE NOTICE OF INTENT, COMPLA9INT & AFFIDAVITS OF MERIT & FOR SUMM DISPO | |
| 03/21/2016 | MOTION FEE | MOTION FEE<br>Filing Fee mt Receipt: Date: 3/21/2016 12:27:02 PM Receipt: 874441 Date: 03/22/2016 | $20.00 |
| 03/21/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=30849978) | |
| 03/21/2016 | BRIEF IN SUPPORT | BRIEF IN SUPPORT<br>(OBDH=30849941) BRIEF IN SUPPORT OF DEFTS STEVEN D HARRINGTON MD & ADVANCED CARDIOTHORACIC SURGEONS PLLCS MTN TO STRIKE ALLEGATIONS NOT CONTAINED INT EH NOTICE OF INTENT COMPLAINT & AFFIDAVITS OF MERIT & FOR SUMM DISPO W/ EXHIBITS | |
| 03/21/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=30849976) | |
| 03/21/2016 | MOTION: | MOTION:<br>(OBDH=30856143) PLAINTIFFS' MOTION & BRIEF TO AMEND COMPLAINT | |
| 03/21/2016 | MOTION FEE | MOTION FEE<br>Filing Fee mt Receipt: Date: 3/21/2016 3:51:07 PM Receipt: 875057 Date: 03/23/2016 | $20.00 |
| 03/21/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=30856176) | |
| 03/21/2016 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=30970755) E-FILING FEE mt Receipt: Date: 3/23/2016 12:00:45 PM Receipt: 875057 Date: 03/23/2016 Receipt: 875489 Date: 03/25/2016 | $5.00 |
| 03/21/2016 | E-FILED REQUEST FOR HEARING | E-FILED REQUEST FOR HEARING<br>(OBDH=30856173) E-FILED REQUEST FOR HEARING, NTC OF HRG, PRF OF SRVC<br>03-28-16 @ 8:30AM | |
| 03/21/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=30856179) | |
| 03/22/2016 | HEARING: MTN FOR SUMMARY DISP SCHEDULED | HEARING: MTN FOR SUMMARY DISP SCHEDULED<br>Event: MTN FOR SUMMARY DISPOSITION<br>Date: 04/25/2016 Time: 10:00 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>THOMAS<br><br>Result: HELD - TAKEN UNDER ADVISEMENT | |

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| 03/23/2016 | HEARING: MTN TO AMEND COMPLAINT SCHEDULED | HEARING: MTN TO AMEND COMPLAINT SCHEDULED<br>Event: (E) MTN TO AMEND COMPLAINT<br>Date: 03/28/2016 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>MEYERS<br><br>Result: HELD - TAKEN UNDER ADVISEMENT | |
| 03/23/2016 | DOCUMENT FILED: | DOCUMENT FILED:<br>(OBDH=30972506) PLTFS EXHIBIT NO 1 | |
| 03/23/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=30972548) | |
| 03/23/2016 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=31057754) E-FILING FEE mt Receipt: Date: 3/25/2016 8:06:18 AM Receipt: 879140 Date: 04/07/2016 Receipt: 883763 Date: 04/22/2016 | $5.00 |
| 03/23/2016 | RESPONSE TO MOTION | RESPONSE TO MOTION<br>(OBDH=30964269) DEFTS STEVEN D HARRINGTON MD AND ADVANCED CARDIOTHORACICS SURGEONS PLLCS RESPONSE TO PLTFS MOTION TO AMEND COMPLAINT WITH ATTCHDE EXHIBS 1 THROUGH 4 | |
| 03/23/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=30964271) | |
| 03/23/2016 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=31057829) E-FILING FEE mt Receipt: Date: 3/25/2016 8:08:38 AM Receipt: 875492 Date: 03/25/2016 Receipt: 879140 Date: 04/07/2016 | $5.00 |
| 03/28/2016 | HELD - TAKEN UNDER ADVISEMENT | HELD - TAKEN UNDER ADVISEMENT, SUPPLEMENTAL BRIEF TO BE FILED W/IN 7 DAYS - OTE<br>The following event: (E) MTN TO AMEND COMPLAINT scheduled for 03/28/2016 at 8:30 am has been resulted as follows:<br><br>Result: HELD - TAKEN UNDER ADVISEMENT<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>HELD ON THE RECORD<br>COURT REPORTER: VIDEO<br>Certificate #: | |
| 03/28/2016 | ORDER SIGNED: | ORDER OF REGARDING PLNTFS MTN TO AMEND - SIGNED | |
| 03/29/2016 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=31138472) | |
| 03/29/2016 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=31139756) | |
| 04/04/2016 | BRIEF IN SUPPORT OF MOTION | BRIEF IN SUPPORT OF MOTION<br>(OBDH=31343755) PLAINTIFFS' SUPPLEMENTAL BRIEF IN SUPPORT OF MOTION TO AMEND COMPLAINT, PROOF OF SERVICE | |
| 04/04/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=31343756) | |
| 04/04/2016 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=31480319) E-FILING FEE mt Receipt: Date: 4/7/2016 8:42:35 AM Receipt: 883763 Date: 04/22/2016 Receipt: 905391 Date: 07/07/2016 | $5.00 |

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| 04/21/2016 | RESPONSE TO MOTION | RESPONSE TO MOTION<br>(OBDH=32089210) PLTFS RESPONSE TO DEFTS MOTION FOR SUMMARY DISPOSITION; BRF IN SUPPORT W/EXHIBITS 1-3; PRF OF SRVC | |
| 04/21/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=32089228) | |
| 04/21/2016 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE<br>(OBDH=32197069) E-FILING FEE mt Receipt: Date: 4/22/2016 9:24:20 AM Receipt: 905391 Date: 07/07/2016 Receipt: 905663 Date: 07/07/2016 | $5.00 |
| 04/25/2016 | HELD - TAKEN UNDER ADVISEMENT | HELD - TAKEN UNDER ADVISEMENT<br>The following event: MTN FOR SUMMARY DISPOSITION scheduled for 04/25/2016 at 10:00 am has been resulted as follows:<br><br>Result: HELD - TAKEN UNDER ADVISEMENT<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR<br><br>HELD ON THE RECORD<br>COURT REPORTER: VIDEO<br>Certificate #: | |
| 04/25/2016 | ORDER SIGNED: | ORDER DISMISSING PLAINTIFF'S CLAIMS AS PLED IN THE NOI COMPLAINT AND AFFIDAVIT OF MERIT - SIGNED | |
| 04/26/2016 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=32312063) | |
| 04/29/2016 | OPINION & ORDER SIGNED | OPINION & ORDER DENYING PLAINTIFF'S MOTION TO AMEND COMPLAINT - SIGNED (CLOSES CASE) | |
| 04/29/2016 | SCHEDULED EVENT CANCELLED | SCHEDULED EVENT CANCELLED<br>The following event: SETTLEMENT CONFERENCE scheduled for 08/09/2016 at 8:30 am has been resulted as follows:<br><br>Result: SCHEDULED EVENT CANCELLED<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR | |
| 04/29/2016 | SCHEDULED EVENT CANCELLED | SCHEDULED EVENT CANCELLED<br>The following event: PRETRIAL CONFERENCE scheduled for 07/19/2016 at 8:30 am has been resulted as follows:<br><br>Result: SCHEDULED EVENT CANCELLED<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR | |
| 04/29/2016 | SCHEDULED EVENT CANCELLED | SCHEDULED EVENT CANCELLED<br>The following event: TRIAL scheduled for 07/26/2016 at 10:00 am has been resulted as follows:<br><br>Result: SCHEDULED EVENT CANCELLED<br>Judge: VIVIANO, KATHRYN A Location: COURTROOM 2 SW - 2ND FLOOR | |
| 04/29/2016 | PROOF OF SERVICE | PROOF OF SERVICE<br>(OBDH=32448701) | |
| 05/02/2016 | SCHEDULED EVENT CANCELLED | SCHEDULED EVENT CANCELLED<br>The following event: CASE EVALUATION HEARING scheduled for 05/24/2016 at 10:30 am has been resulted as follows:<br><br>Result: SCHEDULED EVENT CANCELLED<br>Judge: 3A052416 Location: CASE EVAL CONF ROOM A - 3RD FLOOR | |

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| Date | Description | Docket Text | Amount Owed |
|---|---|---|---|
| 07/05/2016 | REPORTER/RECORDER'S CERTIFICATE OF ORDER OF TRANSCRIPT ON APPEAL | REPORTER/RECORDER'S CERTIFICATE OF ORDER OF TRANSCRIPT ON APPEAL (OBDH=34782144) REPORTER/RECORDER CERTIFICATE OF ORDERING OF TRANSCRIPT ON APPEAL APPEAL TO: [ X ] COURT OF APPEALS | |
| 07/05/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE (OBDH=34782148) | |
| 07/05/2016 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE (OBDH=34874132) E-FILING FEE mt Receipt: Date: 7/7/2016 9:22:10 AM Receipt: 905663 Date: 07/07/2016 Receipt: 905665 Date: 07/07/2016 | $5.00 |
| 07/05/2016 | REPORTER/RECORDER'S CERTIFICATE OF ORDER OF TRANSCRIPT ON APPEAL | REPORTER/RECORDER'S CERTIFICATE OF ORDER OF TRANSCRIPT ON APPEAL (OBDH=34782157) REPORTER/RECORDER CERTIFICATE OF ORDERING OF TRANSCRIPT ON APPEAL APPEAL TO: [ X ] COURT OF APPEALS | |
| 07/05/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE (OBDH=34782158) | |
| 07/05/2016 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE (OBDH=34874277) E-FILING FEE mt Receipt: Date: 7/7/2016 9:23:47 AM Receipt: 905665 Date: 07/07/2016 Receipt: 1080699 Date: 12/21/2017 | $5.00 |
| 07/06/2016 | REPORTER'S NOTICE OF FILING TRANSCRIPT; CERTIFICATE OF SERVICE | REPORTER'S NOTICE OF FILING TRANSCRIPT; CERTIFICATE OF SERVICE (OBDH=34826240) REPORTERS NOTICE OF FILING TRANSCRIPT AND CERT OF SERVICE | |
| 07/06/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE (OBDH=34826243) | |
| 07/06/2016 | E-FILING FEE WITH SERVICE | E-FILING FEE WITH SERVICE (OBDH=34870157) E-FILING FEE mt Receipt: Date: 7/7/2016 8:06:04 AM | $5.00 |
| 07/06/2016 | E-FILED TRANSCRIPT OF: | E-FILED TRANSCRIPT OF: (OBDH=34826241) E-FILED TRANSCRIPT OF: PROCEEDINGS DTD 3-28-16 | |
| 07/06/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE (OBDH=34826245) | |
| 07/06/2016 | E-FILED TRANSCRIPT OF: | E-FILED TRANSCRIPT OF: (OBDH=34826242) E-FILED TRANSCRIPT OF: PROCEEDINGS DTD 4-25-16 | |
| 07/06/2016 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE (OBDH=34826244) | |
| 02/08/2017 | SENT TO COURT OF APPEALS | SENT TO COURT OF APPEALS CERT ROA, COMPLETE FILE, ELECT TRANS DTD 4-25-16, 3-28-16 | |
| 10/24/2017 | COPY OF ORDER FROM COURT OF APPEALS RECEIVED/FILED | COPY OF ORDER FROM COURT OF APPEALS RECEIVED/FILED | |
| 10/31/2017 | ORDER SIGNED: | SCHEDULING ORDER SETTING STATUS CONF ON 11/21/17 AT 8:30 AM- SIGNED APV/KAV | |
| 10/31/2017 | STATUS CONFERENCE SCHEDULED | STATUS CONFERENCE SCHEDULED Event: STATUS CONFERENCE Date: 11/21/2017 Time: 8:30 am Judge: VIVIANO, KATHRYN A Location: CIRCUIT COURT BUILDING - 2ND FLOOR - COURT ROOM 4 | |

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| Date | Description | Docket Text | Amount Owed |
|---|---|---|---|
| | | Result: HELD-CIVIL | |
| 10/31/2017 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=53873028) | |
| 11/03/2017 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=53996009) | |
| 11/21/2017 | HELD: | HELD: NOT PLACED ON REC, STATUS CONFERENCE SET FOR 12/7/2017 AT 8:30 AM OTE<br>The following event: STATUS CONFERENCE scheduled for 11/21/2017 at 8:30 am has been resulted as follows:<br><br>Result: HELD-CIVIL<br>Judge: VIVIANO, KATHRYN A Location: CIRCUIT COURT BUILDING - 2ND FLOOR - COURT ROOM 4 | |
| 11/21/2017 | ORDER SIGNED: | SCHEDULING ORDER-SGD KAV | |
| 11/21/2017 | STATUS CONFERENCE SCHEDULED | STATUS CONFERENCE SCHEDULED<br><br>The following event: STATUS CONFERENCE scheduled for 11/21/2017 at 8:30 am has been rescheduled as follows:<br><br>Event: STATUS CONFERENCE<br>Date: 12/07/2017 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: CIRCUIT COURT BUILDING - 2ND FLOOR - COURT ROOM 4<br><br>Result: SCHEDULED EVENT CANCELLED | |
| 11/27/2017 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=54811091) | |
| 12/05/2017 | DOCUMENT FILED: | DOCUMENT FILED:<br>(OBDH=55070876) NOTICE OF FILING SUPREME COURT APPLICATION FOR LEAVE TO APPEAL; CERRT OF SVC | |
| 12/07/2017 | SCHEDULED EVENT CANCELLED | SCHEDULED EVENT CANCELLED<br>The following event: STATUS CONFERENCE scheduled for 12/07/2017 at 8:30 am has been resulted as follows:<br><br>Result: SCHEDULED EVENT CANCELLED<br>Judge: VIVIANO, KATHRYN A Location: CIRCUIT COURT BUILDING - 2ND FLOOR - COURT ROOM 4 | |
| 12/21/2017 | E-FILING FEE | E-FILING FEE<br>(OBDH=55605135) E-FILING FEE mt Receipt: Date: 12/21/2017 9:15:23 AM | $2.50 |
| 01/03/2018 | CASE PLACED ON HOLD STATUS | CASE PLACED ON HOLD STATUS - CASE PENDING ON APPLICATION IN COA | |
| 05/01/2018 | CASE NOTE: | CASE NOTE: APPLICATION PENDING IN SUPREME COURT - NO STAY ISSUED AS OF TODAYS DATE | |
| 04/22/2019 | IMAGE OF EVENT NOTICE SENT | IMAGE OF EVENT NOTICE SENT<br><br>(N) COA REMAND STATUS CONFERENCE<br>Sent on: 04/22/2019 09:10:22.04 | |
| 04/22/2019 | COA REMAND STATUS CONFERENCE SCHEDULED | COA REMAND STATUS CONFERENCE SCHEDULED<br>Event: COA REMAND STATUS CONFERENCE<br>Date: 05/21/2019 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: CIRCUIT COURT BUILDING - 5TH FLOOR - COURT ROOM 3<br><br>Result: HELD-CIVIL | |
| 04/22/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=71629368) | |

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| Date | Description | Docket Text | Amount Owed |
|---|---|---|---|
| 04/25/2019 | APPEARANCE (LITIGANT'S ATTORNEY) | APPEARANCE (LITIGANT'S ATTORNEY) (OBDH=71768085) AMENDED APPEARANCE (LITIGANTS ATTORNEY) AND NOTICE OF APPEARANCE WITH PROOF OF SERV AS TO / DRAGO KOSTADINOVSKI (PLAINTIFF); BLAGA KOSTADINOVSKI (PLAINTIFF); | |
| 04/25/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE (OBDH=71768124) | |
| 04/25/2019 | APPEARANCE (LITIGANT'S ATTORNEY) | APPEARANCE (LITIGANT'S ATTORNEY) (OBDH=71768086) AMENDED APPEARANCE (LITIGANTS ATTORNEY) AND NOTICE OF APPEARANCE WITH PROOF OF SERV AS TO / DRAGO KOSTADINOVSKI (PLAINTIFF); BLAGA KOSTADINOVSKI (PLAINTIFF); | |
| 04/25/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE (OBDH=71768125) | |
| 05/21/2019 | HELD: | HELD: NOT PLACED ON REC, STATUS CONFERENCE IS SCHEDULED FOR 6/11/2019 AT 8:30 AM OTE<br>The following event: COA REMAND STATUS CONFERENCE scheduled for 05/21/2019 at 8:30 am has been resulted as follows:<br><br>Result: HELD-CIVIL<br>Judge: VIVIANO, KATHRYN A Location: CIRCUIT COURT BUILDING - 5TH FLOOR - COURT ROOM 3 | |
| 05/21/2019 | STATUS CONFERENCE SCHEDULED | STATUS CONFERENCE SCHEDULED<br>Event: STATUS CONFERENCE<br>Date: 06/11/2019 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: CIRCUIT COURT BUILDING - 2ND FLOOR - COURT ROOM 4<br><br>Result: HELD-CIVIL | |
| 05/21/2019 | ORDER SIGNED: | SCHEDULING ORDER-SGD | |
| 05/22/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE (OBDH=72584340) | |
| 06/11/2019 | HELD: | HELD: NOT PLACED ON REC, STATUS CONF SET FOR 10/10/2019 AT 8:30 AM, PLTF FILE MTN & BRIEF RE COA'S REMAND ON/BEFORE 7/15/2019, DEFTS RESPONSE ON OR BEFORE 8/5/2019, PTLF FILE REPLY ON/BEFORE 8/12/2019, ORAL ARGUMENT HEARD ON 8/19/2019 AT 10:00 AM, DISCOVERY INITIATION DEADLINE EXTENDED TO 8/15/2019, AMENDED PWL 7/15/2019, AMENDED DWL 7/30/2019 OTE<br>The following event: STATUS CONFERENCE scheduled for 06/11/2019 at 8:30 am has been resulted as follows:<br><br>Result: HELD-CIVIL<br>Judge: VIVIANO, KATHRYN A Location: CIRCUIT COURT BUILDING - 2ND FLOOR - COURT ROOM 4 | |
| 06/11/2019 | ORDER SIGNED: | ORDER OF SCHEDULING REGARDING REMAND-SGD | |
| 06/11/2019 | STATUS CONFERENCE SCHEDULED | STATUS CONFERENCE SCHEDULED<br>Event: STATUS CONFERENCE<br>Date: 10/10/2019 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: CIRCUIT COURT BUILDING - 2ND FLOOR - COURT ROOM 4 | |
| 06/11/2019 | ORAL ARGUMENTS SCHEDULED | ORAL ARGUMENTS SCHEDULED<br>Event: ORAL ARGUMENTS<br>Date: 08/19/2019 Time: 10:00 am<br>Judge: VIVIANO, KATHRYN A Location: CIRCUIT COURT BUILDING - 2ND FLOOR - COURT ROOM 4 | |

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| Date | Description | Docket Text | Amount Owed |
|---|---|---|---|
| | | Result: HELD - TAKEN UNDER ADVISEMENT | |
| 06/11/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=73171040) | |
| 07/15/2019 | DOCUMENT FILED: | DOCUMENT FILED:<br>(OBDH=74181839) PLTFS SUPPLEMENTAL BRIEF ON REMAND W/EXHIBITS | |
| 07/15/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=74181842) | |
| 07/23/2019 | DEFENDANTS WITNESS LIST | DEFENDANTS WITNESS LIST<br>(OBDH=74449975) DEFENDANTS STEVEN D HARRINGTON MD AND ADVANCED CARDIOTHORACIC SURGEONS, PLLCS THIRD AMENDED WITNESS LIST AND EXHIBIT LIST | |
| 07/23/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=74449979) | |
| 07/25/2019 | APPEARANCE (LITIGANT'S ATTORNEY) | APPEARANCE (LITIGANT'S ATTORNEY)<br>(OBDH=74582236) APPEARANCE (LITIGANTS ATTORNEY)OF CO-COUNSEL<br>MARK GRANZOTTO P31492<br>DRAGO KOSTADINOVSKI (PLAINTIFF); BLAGA KOSTADINOVSKI (PLAINTIFF); | |
| 07/25/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=74582242) | |
| 08/05/2019 | APPEARANCE (LITIGANT'S ATTORNEY) | APPEARANCE (LITIGANT'S ATTORNEY)<br>(OBDH=74900206) APPEARANCE (LITIGANTS ATTORNEY) WITH CERT OF SERV AS TO /<br>STEVEN HARRINGTON MD (DEFENDANT); ADVANCED CARDIOTHORACIC SURGEONS PLLC (DEFENDANT); | |
| 08/05/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=74900211) | |
| 08/05/2019 | DOCUMENT FILED: | DOCUMENT FILED:<br>(OBDH=74900210) DEFTS BRIEF ON REMAND WITH CERT OF SERV AND ATTCHD EXHIBS 1 THROUGH 11 | |
| 08/05/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=74900213) | |
| 08/12/2019 | BRIEF IN RESPONSE | BRIEF IN RESPONSE<br>(OBDH=75119983) PLNTFFS REPLY BRIEF; PRF OF SVC | |
| 08/12/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=75119988) | |
| 08/19/2019 | HELD - TAKEN UNDER ADVISEMENT | HELD - TAKEN UNDER ADVISEMENT, OPINON & ORDER TO BE ISSUED<br>The following event: ORAL ARGUMENTS scheduled for 08/19/2019 at 10:00 am has been resulted as follows:<br><br>Result: HELD - TAKEN UNDER ADVISEMENT<br>Judge: VIVIANO, KATHRYN A Location: CIRCUIT COURT BUILDING - 2ND FLOOR - COURT ROOM 4<br><br>HELD ON THE RECORD<br>COURT REPORTER: VIDEO CIRCUIT<br>Certificate #: | |
| 10/09/2019 | MOTION: | MOTION:<br>(OBDH=77140924) PLTFS MOTION FOR PROTECTIVE ORDER PURSUANT TO MCR 2.302(C); BRIEF IN SUPPORT; NOTICE OF HEARING | |

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| Date | Description | Docket Text | Amount Owed |
|---|---|---|---|
| 10/09/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=77140927) | |
| 10/09/2019 | E-FILED REQUEST FOR HEARING | E-FILED REQUEST FOR HEARING<br>(OBDH=77140925) E-FILED REQUEST FOR HEARING | |
| 10/09/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=77140926) | |
| 10/10/2019 | HELD: | HELD: NOT PLACED ON REC, TELEPHONE STATUS CONFERENCE SET FOR 10/24/2019 AT 8:30 AM OTE<br>The following event: STATUS CONFERENCE scheduled for 10/10/2019 at 8:30 am has been resulted as follows:<br><br>Result: HELD-CIVIL<br>Judge: VIVIANO, KATHRYN A Location: COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | |
| 10/10/2019 | TELEPHONE CONFERENCE SCHEDULED | TELEPHONE CONFERENCE SCHEDULED<br>Event: TELEPHONE CONFERENCE<br>Date: 10/24/2019 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURT BUILDING - 2ND FLOOR - COURTROOM 2SW<br><br>Result: HELD-CIVIL | |
| 10/10/2019 | ORDER SIGNED: | SCHEDULING ORDER ADJOURNING TELEPHONE STATUS CONFERENCE-SGD | |
| 10/10/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=77179936) | |
| 10/10/2019 | HEARING: MTN FOR PROTECTIVE ORDER SCHEDULED | HEARING: MTN FOR PROTECTIVE ORDER SCHEDULED<br>Event: (E) MTN FOR PROTECTIVE ORDER<br>Date: 10/21/2019 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURT BUILDING - 2ND FLOOR - COURTROOM 2SW<br><br>TAKALA<br><br>Result: MOTION HEARING ADJOURNED | |
| 10/10/2019 | MOTION FEE | MOTION FEE<br>Filing Fee mt Receipt: Date: 10/10/2019 3:31:13 PM Receipt: 1202505 Date: 10/10/2019 | $20.00 |
| 10/11/2019 | MOTION HEARING ADJOURNED | MOTION HEARING ADJOURNED TO 10/28/19 AT 830AM PER ATTY TAKALA OFFICE<br>The following event: (E) MTN FOR PROTECTIVE ORDER scheduled for 10/21/2019 at 8:30 am has been resulted as follows:<br><br>Result: MOTION HEARING ADJOURNED<br>Judge: VIVIANO, KATHRYN A Location: COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | |
| 10/11/2019 | HEARING: MTN FOR PROTECTIVE ORDER SCHEDULED | HEARING: MTN FOR PROTECTIVE ORDER SCHEDULED<br><br>The following event: (E) MTN FOR PROTECTIVE ORDER scheduled for 10/21/2019 at 8:30 am has been rescheduled as follows:<br><br>Event: (E) MTN FOR PROTECTIVE ORDER<br>Date: 10/28/2019 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURT BUILDING - 2ND FLOOR - COURTROOM 2SW<br><br>TAKALA<br><br>Result: MOTION HEARING ADJOURNED | |

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| Date | Description | Docket Text | Amount Owed |
|---|---|---|---|
| | | Result: MOTION HEARING ADJOURNED | |
| 10/11/2019 | RE-NOTICE OF HEARING | RE-NOTICE OF HEARING<br>(OBDH=77213800) RE-NOTICE OF HEARING | |
| 10/11/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=77213804) | |
| 10/11/2019 | E-FILED REQUEST FOR HEARING | E-FILED REQUEST FOR HEARING<br>(OBDH=77213798) E-FILED REQUEST FOR HEARING; NOTICE OF HEARING; PRF OF SRV | |
| 10/11/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=77213807) | |
| 10/24/2019 | HELD: | HELD: NOT PLACED ON REC, SETTLEMENT CONF SET FOR 2/13/2020 AT 8:30 AM, PRETRIAL SET FOR 3/3/2020 AT 8:30 AM, TRIAL (2 WEEKS) SET FOR 3/17/2020 AT 8:30 AM, PARTIES ARE OPTING OUT OF COURT CASE EVAL AND ARE GOING TO A PRIVATE FACILITATOR OTE<br>The following event: TELEPHONE CONFERENCE scheduled for 10/24/2019 at 8:30 am has been resulted as follows:<br><br>Result: HELD-CIVIL<br>Judge: VIVIANO, KATHRYN A Location: COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | |
| 10/24/2019 | SETTLEMENT CONFERENCE SCHEDULED | SETTLEMENT CONFERENCE SCHEDULED<br>Event: SETTLEMENT CONFERENCE<br>Date: 02/13/2020 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | |
| 10/24/2019 | PRETRIAL CONFERENCE SCHEDULED | PRETRIAL CONFERENCE SCHEDULED<br>Event: PRETRIAL CONFERENCE<br>Date: 03/03/2020 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | |
| 10/24/2019 | TRIAL SCHEDULED | TRIAL SCHEDULED<br>Event: TRIAL<br>Date: 03/17/2020 Time: 10:00 am<br>Judge: VIVIANO, KATHRYN A Location: COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | |
| 10/24/2019 | ORDER SIGNED: | SCHEDULING ORDER SETTING SETTLEMENT CONFERENCE, PRETRIAL, TRIAL & OPTING OUT OF CASE EVALUATION-SGD | |
| 10/24/2019 | ORDER FOR FACILITATION-SGD | ORDER FOR FACILITATION-SGD<br>(OBDH=77845429) STIPULATED ORDER REGARDING FACILITATIVE MEDIATION/CASE EVALUATION -SGD | |
| 10/24/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=77845441) | |
| 10/25/2019 | MOTION HEARING ADJOURNED | MOTION HEARING ADJOURNED TO 11/18 PER ATTY TAKALA OFFICE<br>The following event: (E) MTN FOR PROTECTIVE ORDER scheduled for 10/28/2019 at 8:30 am has been resulted as follows:<br><br>Result: MOTION HEARING ADJOURNED<br>Judge: VIVIANO, KATHRYN A Location: COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | |
| 10/25/2019 | HEARING: MTN FOR PROTECTIVE ORDER SCHEDULED | HEARING: MTN FOR PROTECTIVE ORDER SCHEDULED<br><br>The following event: (E) MTN FOR PROTECTIVE ORDER scheduled for 10/28/2019 at 8:30 am has been rescheduled as follows: | |

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| Date | Description | Docket Text | Amount Owed |
|---|---|---|---|
| | | Event: (E) MTN FOR PROTECTIVE ORDER<br>Date: 11/18/2019 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURT BUILDING - 2ND FLOOR - COURTROOM 2SW<br><br>TAKALA | |
| 10/25/2019 | HEARING: MTN FOR PROTECTIVE ORDER SCHEDULED | HEARING: MTN FOR PROTECTIVE ORDER SCHEDULED<br>Event: (E) MTN FOR PROTECTIVE ORDER<br>Date: 02/03/2020 Time: 8:30 am<br>Judge: VIVIANO, KATHRYN A Location: COURT BUILDING - 2ND FLOOR - COURTROOM 2SW<br><br>TAKALA | |
| 10/25/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=77897331) | |
| 10/25/2019 | E-FILED REQUEST FOR HEARING | E-FILED REQUEST FOR HEARING<br>(OBDH=77892932) E-FILED REQUEST FOR HEARING WITH NOTICE OF HEAR AND PROOF OF SERV FOR MOTION FOR PROTECTIVE ORDER MOTION FOR 02-03-2020 (PREVIOUSLY SCHEDULED) | |
| 10/25/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=77892936) | |
| 10/25/2019 | RE-NOTICE OF HEARING | RE-NOTICE OF HEARING<br>(OBDH=77892933) RE-NOTICE OF HEARING WITH PROOF OF SERV | |
| 10/25/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=77892934) | |
| 11/05/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=78346318) | |
| 11/18/2019 | OPINION & ORDER SIGNED | OPINION & ORDER ON REMAND FROM THE COURT OF APPEALS, PTLFS MTN FOR LEAVE TO FILE AN AMENDED COMPLAINT IS DENIED-SIGNED KAV (CLOSES CASE) | |
| 11/18/2019 | TRUEFILING PROOF OF SERVICE | TRUEFILING PROOF OF SERVICE<br>(OBDH=78750742) | |

## Party Information

**KOSTADINOVSKI, DRAGO**
**- PLAINTIFF**

- DOB
- DOD
- Disposition
- Disp Date

Alias

Party Attorney
- Attorney
- GRANZOTTO, MARK R.
- Bar Code
- 31492
- Attorney
- MEYERS, JEFFREY T.
- Bar Code
- 34348

More Party Information

**KOSTADINOVSKI, BLAGA**
**- PLAINTIFF**

- DOB

Alias

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- DOD
- Disposition
- Disp Date

**Party Attorney**
- Attorney
- GRANZOTTO, MARK R.
- Bar Code
- 31492
- Attorney
- MEYERS, JEFFREY T.
- Bar Code
- 34348

More Party Information

**HARRINGTON, MD, STEVEN**
**- DEFENDANT**

- DOB
- DOD
- Disposition
- Disp Date

Alias

**Party Attorney**
- Attorney
- COOK, MICHAEL JAMES
- Bar Code
- 71511
- Attorney
- MANION, PAUL J.
- Bar Code
- 17049

More Party Information

**ADVANCED CARDIOTHORACIC SURGEONS PLLC**
**- DEFENDANT**

- DOB
- DOD
- Disposition
- Disp Date

Alias

**Party Attorney**
- Attorney
- COOK, MICHAEL JAMES
- Bar Code
- 71511
- Attorney
- MANION, PAUL J.
- Bar Code
- 17049

More Party Information

## Events

| Date/Time | Location | Type | Result | Event Judge |
|---|---|---|---|---|
| 08/13/2014 08:00 AM | 4TH FLOOR COURTROOM SW - (586)469-5147 | INITIAL COURT CONFERENCE | ADJOURNED-OTHER REASONS | FOSTER, JOHN C |
| 09/26/2014 08:00 AM | 4TH FLOOR COURTROOM SW - (586)469-5147 | INITIAL COURT CONFERENCE | ADJOURNED-STIPULATION & ORDER | FOSTER, JOHN C |
| 10/02/2014 08:00 AM | 4TH FLOOR COURTROOM SW - (586)469-5147 | INITIAL COURT CONFERENCE | HELD: NOT PLACED ON RECORD | FOSTER, JOHN C |
| 11/24/2014 08:00 AM | 4TH FLOOR COURTROOM SW - (586)469-5147 | (E) MTN TO COMPEL DEPOSITION | MOTION HEARING ADJOURNED | FOSTER, JOHN C |
| 12/01/2014 08:00 AM | 4TH FLOOR COURTROOM SW - (586)469-5147 | (E) MTN TO COMPEL DEPOSITION | DISMISSAL OF MOTION | FOSTER, JOHN C |
| 03/31/2015 08:00 AM | 4TH FLOOR COURTROOM SW - (586)469-5147 | STATUS CONFERENCE | HELD: NOT PLACED ON RECORD | FOSTER, JOHN C |
| 06/25/2015 08:00 AM | COURTROOM 2SW - 2ND FLOOR | STATUS CONFERENCE | HELD-CIVIL | VIVIANO, KATHRYN A |

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| Date/Time | Location | Type | Result | Event Judge |
|---|---|---|---|---|
| 11/09/2015 08:30 AM | COURTROOM 2SW - 2ND FLOOR | (E) MTN TO EXTEND SCHEDULING ORDER DATES | HELD-CIVIL | VIVIANO, KATHRYN A |
| 11/19/2015 08:30 AM | COURTROOM 2SW - 2ND FLOOR | (E) MTN TO EXTEND SCHEDULING ORDER DATES | MOTION HEARING ADJOURNED | VIVIANO, KATHRYN A |
| 11/19/2015 08:30 AM | COURTROOM 2SW - 2ND FLOOR | STATUS CONFERENCE | HELD-CIVIL | VIVIANO, KATHRYN A |
| 12/08/2015 08:30 AM | COURTROOM 2SW - 2ND FLOOR | STATUS CONFERENCE | HELD-CIVIL | VIVIANO, KATHRYN A |
| 12/08/2015 08:30 AM | COURTROOM 2SW - 2ND FLOOR | (E) MTN TO EXTEND SCHEDULING ORDER DATES | HELD-CIVIL | VIVIANO, KATHRYN A |
| 12/08/2015 10:30 AM | CASE EVAL CONF ROOM A - 3RD FLOOR | CASE EVALUATION HEARING | CASE EVALUATION ADJOURNED | 3A120815 |
| 02/02/2016 09:30 AM | CASE EVAL CONF ROOM A - 3RD FLOOR | CASE EVALUATION HEARING | CASE EVALUATION ADJOURNED | 3A020216 |
| 03/07/2016 08:30 AM | COURTROOM 2SW - 2ND FLOOR | (E) MTN TO ADJOURN CASE EVAL | MOTION GRANTED | VIVIANO, KATHRYN A |
| 03/28/2016 08:30 AM | COURTROOM 2SW - 2ND FLOOR | (E) MTN TO AMEND COMPLAINT | HELD - TAKEN UNDER ADVISEMENT | VIVIANO, KATHRYN A |
| 04/05/2016 09:30 AM | CASE EVAL CONF ROOM A - 3RD FLOOR | CASE EVALUATION HEARING | CASE EVALUATION ADJOURNED | 3A040516 |
| 04/25/2016 10:00 AM | COURTROOM 2SW - 2ND FLOOR | MTN FOR SUMMARY DISPOSITION | HELD - TAKEN UNDER ADVISEMENT | VIVIANO, KATHRYN A |
| 05/06/2016 08:30 AM | COURTROOM 2SW - 2ND FLOOR | SETTLEMENT CONFERENCE | ADJOURNED-OTHER REASONS | VIVIANO, KATHRYN A |
| 05/24/2016 10:30 AM | CASE EVAL CONF ROOM A - 3RD FLOOR | CASE EVALUATION HEARING | SCHEDULED EVENT CANCELLED | 3A052416 |
| 06/09/2016 08:30 AM | COURTROOM 2SW - 2ND FLOOR | SETTLEMENT CONFERENCE | SCHEDULED EVENT CANCELLED | VIVIANO, KATHRYN A |
| 07/19/2016 08:30 AM | COURTROOM 2SW - 2ND FLOOR | PRETRIAL CONFERENCE | SCHEDULED EVENT CANCELLED | VIVIANO, KATHRYN A |
| 07/26/2016 10:00 AM | COURTROOM 2SW - 2ND FLOOR | TRIAL | SCHEDULED EVENT CANCELLED | VIVIANO, KATHRYN A |
| 11/21/2017 08:30 AM | CIRCUIT COURT BUILDING - 2ND FLOOR - COURT ROOM 4 | STATUS CONFERENCE | HELD-CIVIL | VIVIANO, KATHRYN A |
| 12/07/2017 08:30 AM | CIRCUIT COURT BUILDING - 2ND FLOOR - COURT ROOM 4 | STATUS CONFERENCE | SCHEDULED EVENT CANCELLED | VIVIANO, KATHRYN A |
| 05/21/2019 08:30 AM | CIRCUIT COURT BUILDING - 5TH FLOOR - COURT ROOM 3 | COA REMAND STATUS CONFERENCE | HELD-CIVIL | VIVIANO, KATHRYN A |
| 06/11/2019 08:30 AM | CIRCUIT COURT BUILDING - 2ND FLOOR - COURT ROOM 4 | STATUS CONFERENCE | HELD-CIVIL | VIVIANO, KATHRYN A |
| 08/19/2019 10:00 AM | CIRCUIT COURT BUILDING - 2ND FLOOR - COURT ROOM 4 | ORAL ARGUMENTS | HELD - TAKEN UNDER ADVISEMENT | VIVIANO, KATHRYN A |
| 10/10/2019 08:30 AM | COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | STATUS CONFERENCE | HELD-CIVIL | VIVIANO, KATHRYN A |
| 10/21/2019 08:30 AM | COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | (E) MTN FOR PROTECTIVE ORDER | MOTION HEARING ADJOURNED | VIVIANO, KATHRYN A |
| 10/24/2019 08:30 AM | COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | TELEPHONE CONFERENCE | HELD-CIVIL | VIVIANO, KATHRYN A |

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| Date/Time | Location | Type | Result | Event Judge |
|---|---|---|---|---|
| 10/28/2019 08:30 AM | COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | (E) MTN FOR PROTECTIVE ORDER | MOTION HEARING ADJOURNED | VIVIANO, KATHRYN A |
| 02/03/2020 08:30 AM | COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | (E) MTN FOR PROTECTIVE ORDER | | VIVIANO, KATHRYN A |
| 02/13/2020 08:30 AM | COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | SETTLEMENT CONFERENCE | | VIVIANO, KATHRYN A |
| 03/03/2020 08:30 AM | COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | PRETRIAL CONFERENCE | | VIVIANO, KATHRYN A |
| 03/17/2020 10:00 AM | COURT BUILDING - 2ND FLOOR - COURTROOM 2SW | TRIAL | | VIVIANO, KATHRYN A |

## Financial Summary

| Cost Type | Amount Owed | Amount Paid | Amount Adjusted | Amount Outstanding |
|---|---|---|---|---|
| FILING FEE | $462.50 | $454.50 | $0.00 | $8.00 |
| MOTION FEE | $120.00 | $120.00 | $0.00 | $0.00 |
| Total Total | Total $582.50 | Total $574.50 | Total $0.00 | Total $8.00 |

## Receipts

| Receipt Number | Receipt Date | Received From | Payment Amount |
|---|---|---|---|
| 721527 | 06/05/2014 | KOSTADINOVSKI, DRAGO | $235.00 |
| 726742 | 06/27/2014 | HARRINGTON MD, S | $8.00 |
| 730518 | 07/15/2014 | KOSTADINOVSKI, DRAGO | $8.00 |
| 730946 | 07/16/2014 | C | $8.00 |
| 732820 | 07/24/2014 | KOSTADINOVSKI, DRAGO | $8.00 |
| 742763 | 09/05/2014 | HARRINGTON | $8.00 |
| 747575 | 09/24/2014 | KOSTADINOVSKI, DRAGO | $8.00 |
| 759388 | 11/17/2014 | C | $8.00 |
| 759389 | 11/17/2014 | C | $20.00 |
| 790923 | 04/09/2015 | RMRTT1465536 | $8.00 |
| 804406 | 06/05/2015 | RMRTT1465536 | $8.00 |
| 810848 | 07/07/2015 | RMRTT1465536 | $8.00 |
| 816459 | 07/29/2015 | MORGANMEYERSPLC2120622 | $8.00 |
| 816470 | 07/29/2015 | MORGANMEYERSPLC2120622 | $8.00 |
| 818774 | 08/07/2015 | RMRTT1465536 | $8.00 |
| 836411 | 10/21/2015 | RMRTT1465536 | $8.00 |
| 837462 | 10/26/2015 | MORGANMEYERSPLC2120622 | $8.00 |
| 837463 | 10/26/2015 | MORGANMEYERSPLC2120622 | $20.00 |
| 837535 | 10/26/2015 | MORGANMEYERSPLC2120622 | $8.00 |
| Total | Total | Total | Total $574.50 |

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| Receipt Number | Receipt Date | Received From | Payment Amount |
|---|---|---|---|
| 837548 | 10/26/2015 | MORGANMEYERSPLC2120622 | $8.00 |
| 837553 | 10/26/2015 | MORGANMEYERSPLC2120622 | $8.00 |
| 837607 | 10/26/2015 | MORGANMEYERSPLC2120622 | $8.00 |
| 867381 | 02/26/2016 | RMRTT1465536 | $5.00 |
| 867397 | 02/26/2016 | RMRTT1465536 | $5.00 |
| 868025 | 03/01/2016 | MORGANMEYERSPLC2120622 | $5.00 |
| 868029 | 03/01/2016 | MORGANMEYERSPLC2120622 | $20.00 |
| 869718 | 03/07/2016 | MORGANMEYERSPLC2120622 | $5.00 |
| 874431 | 03/22/2016 | RMRTT1465536 | $5.00 |
| 874441 | 03/22/2016 | RMRTT1465536 | $20.00 |
| 875057 | 03/23/2016 | MORGANMEYERSPLC2120622 | $25.00 |
| 875489 | 03/25/2016 | MORGANMEYERSPLC2120622 | $5.00 |
| 875492 | 03/25/2016 | RMRTT1465536 | $5.00 |
| 879140 | 04/07/2016 | MORGANMEYERSPLC2120622 | $5.00 |
| 883763 | 04/22/2016 | MORGANMEYERSPLC2120622 | $5.00 |
| 905391 | 07/07/2016 | FEES WAIVED | $5.00 |
| 905663 | 07/07/2016 | FEES WAIVED | $5.00 |
| 905665 | 07/07/2016 | FEES WAIVED | $5.00 |
| 1080699 | 12/21/2017 | CEFCYNTHIA5245239 | $2.50 |
| 1202505 | 10/10/2019 | 25DCBFBF-A3E2-4179-E427-08D6E39C5887 | $20.00 |
| Total | Total | Total | Total $574.50 |

## Case Disposition

| Disposition | Date | Case Judge |
|---|---|---|
| DISMISSED BY COURT | 04/29/2016 | VIVIANO, KATHRYN A |
| UNCONTESTED/DEF/SETTLED | 11/18/2019 | VIVIANO, KATHRYN A |

**Court of Appeals Docket Sheet**

RECEIVED by MSC 2/18/2022 3:26:31 PM

COA 351773
MSC 162909

DRAGO KOSTADINOVSKI V STEVEN DHARRINGTON MD

Lower Court/Tribunal
MACOMB CIRCUIT COURT
Judge(s)
VIVIANO KATHRYN A

Docket Case Documents

# Case Information

## Case Header

Case Number

COA #351773 MSC #162909

Case Status

**MSC** Pending on Application
**COA** Case Concluded; File Open

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# Parties & Attorneys to the Case - Court of Appeals

**Court of Appeals Docket Sheet**

1

## KOSTADINOVSKI DRAGO

Plaintiff - Appellant

Attorney(s)

GRANZOTTO MARK
#31492, Retained

2

## KOSTADINOVSKI BLAGA

Plaintiff - Appellant

Attorney(s)

Same

3

## HARRINGTON STEVEN D MD

Defendant - Appellee

Attorney(s)

COOK MICHAEL J
#71511, Retained

4

## ADVANCED CARDIOTHORACIC SURGEONS PLLC

Defendant - Appellee

Attorney(s)

Same

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# Parties & Attorneys to the Case - Supreme Court
**Court of Appeals Docket Sheet**

1

## KOSTADINOVSKI DRAGO
Plaintiff

Attorney(s)

Mark R. Granzotto
#31492
Jeffrey T. Meyers
#34348

2

## KOSTADINOVSKI BLAGA
Plaintiff

3

## HARRINGTON STEVEN D MD
Defendant

Attorney(s)

Michael J. Cook
#71511

4

## ADVANCED CARDIOTHORACIC SURGEONS PLLC
Defendant

COLLAPSE ALL EXPAND ALL

# Court of Appeals Docket Sheet

RECEIVED by MSC 2/18/2022 3:26:31 PM

12/05/2019 1 Claim of Appeal - Civil

Attorney
ZACKS DAVID N
#34192

Service Date
12/05/2019

Fee Code
Electronic Payment

11/18/2019 2 Order Appealed From

Trial Court
MACOMB CIRCUIT COURT

Case Number
2014-002247-NH

Trial Court Judge
VIVIANO KATHRYN A
#60219

Nature Of Case
Civil Miscellaneous

12/05/2019 3 Transcript Requested By Atty Or Party

Attorney
GRANZOTTO MARK
#31492

Document Date
12/05/2019

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## Court of Appeals Docket Sheet

Reporter
DOYLE DEBORAH J #2179

Timely
Yes

Hearing Dates
08/19/2019

12/06/2019 4 Appearance - Appellee

Party
3. HARRINGTON STEVEN D MD

Attorney
COOK MICHAEL J
#71511

Service Date
12/06/2019

12/13/2019 5 Steno Certificate - Tr Request Received

Document Date
12/12/2019

Reporter
DOYLE DEBORAH J #2179

Timely
Yes

Hearing Dates
08/19/2019

12/19/2019 6 Notice Of Filing Transcript

Document Date
12/19/2019

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## Court of Appeals Docket Sheet

Reporter
DOYLE DEBORAH J #2179

Timely
Yes

Hearing Dates
08/19/2019

01/13/2020 7 Invol Dismissal Warning - No Dkt Stmt

Attorney
GRANZOTTO MARK
#31492

Due Date
02/03/2020

02/03/2020 8 Docketing Statement MCR 7.204H

Party
1. KOSTADINOVSKI DRAGO

Attorney
GRANZOTTO MARK
#31492

Service Date
02/03/2020

Joint Parties

02/18/2020 9 Motion: Extend Time - Appellant

Party
1. KOSTADINOVSKI DRAGO

Attorney
GRANZOTTO MARK

#31492

## Court of Appeals Docket Sheet

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Service Date
02/17/2020

Answer Due
02/24/2020

Fee Code
Electronic Payment

Requested Extension
04/09/2020

02/25/2020 11 Submitted on Administrative Motion Docket

Submitted Events
9. Motion: Extend Time - Appellant

02/26/2020 12 Order: Extend Time - Appellant Brief - Grant

Related Events
9. Motion: Extend Time - Appellant

Panel
Murray Christopher M

Attorney
GRANZOTTO MARK
#31492

Amount
$0.00

Extend To
04/09/2020

VIEW ORDER →

02/28/2020 13 Correspondence Received

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## Court of Appeals Docket Sheet

Party

3. HARRINGTON STEVEN D MD

Attorney

COOK MICHAEL J
#71511

Service Date

02/28/2020

Comments

Scheduling conflicts letter

05/11/2020 15 Brief: Appellant

Party

1. KOSTADINOVSKI DRAGO

Attorney

GRANZOTTO MARK
#31492

Service Date

05/11/2020

Oral Argument Requested

Yes

Joint Parties

Timely

Yes

Comments

timely per admin order 2020-04

06/16/2020 16 Noticed

Date Sent

06/17/2020

## Court of Appeals Docket Sheet

06/18/2020 17 Electronic Record Filed

06/26/2020 19 Brief: Appellee

Party
3. HARRINGTON STEVEN D MD

Attorney
COOK MICHAEL J
#71511

Service Date
06/26/2020

Oral Argument Requested
Yes

Joint Parties

Timely
Yes

01/19/2021 28 Email Contact

Party
1. KOSTADINOVSKI DRAGO

Attorney
GRANZOTTO MARK
#31492

Comments
email re zoom oral argument

02/10/2021 27 Submitted on Case Call

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## Court of Appeals Docket Sheet

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02/10/2021 29 Oral Argument Audio

LISTEN TO ORAL ARGUMENT →

03/11/2021 33 Opinion - Per Curiam - Unpublished

Result
L/Ct Judgment/Order Affirmed

Panel
Swartzle Brock A
Markey Jane E
Tukel Jonathan

Pages
9

READ OPINION →

04/22/2021 34 Application for Leave to SCt

Supreme Court Number
162909

Answer Due
05/20/2021

Party
1. KOSTADINOVSKI DRAGO

Attorney
GRANZOTTO MARK
#31492

04/23/2021 35 Supreme Court: SCt Case Caption

## Court of Appeals Docket Sheet

05/17/2021 36 Supreme Court: Answer - SCt Application/Complaint

Party

3

Attorney

COOK MICHAEL J
#71511

11/23/2021 37 Supreme Court Order: MOAA -Oral Argument on Lv Appl

Comments

Justice Viviano not participating.

VIEW ORDER →

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**NOTICE OF INTENT TO FILE CLAIM**
**PURSUANT TO MCL 600.2912(B)**

Henry Ford Macomb Hospital
Resident Agent: Edith L. Eisenmann
Governance Office
1 Ford Place, 5B
Detroit, MI 48202

Henry Ford Macomb Hospital
Resident Agent: Edith L. Eisenmann
15885 19 Mile Road
Mt. Clemens, MI 48043

Steven D. Harrington, M.D.
Advanced Cardiothoracic Surgeons
38800 Garfield
Clinton Township, MI 48038

Advanced Cardiothoracic Surgeons, PLLC
Registered Agent: Steven D. Harrington
49474 Compass Pte
New Baltimore, MI 48047

Steven D. Harrington, M.D.
49474 Compass Pte
New Baltimore, MI 48047

**This Notice is intended to apply to the above-referenced health care professionals, entities, and/or facilities as well as their employees or agents, actual or ostensible, who were involved in the treatment of Drago Kostadinovski, hereinafter referred to as Mr. Kostadinovski, date of birth 05/10/1941.**

At all times pertinent to this Notice Steven D. Harrington, M.D., was an agent, an apparent agent, ostensible agent, servant and/or employee of Henry Ford Macomb Hospital, hereinafter refered to as HFMH. As such, HFMH is vicariously liable for the negligent acts and/or omissions of Dr. Harrington, as more fully noted below.

At all times pertinent to this Notice Steven D. Harrington, M.D. was an agent, an apparent agent, ostensible agent, servant and/or employee of Advanced Cardiothoracic Surgeons, PLLC. As such, Advanced Cardiothoracic Surgeons, PLLC is vicariously liable for the negligent acts and/or omissions of Dr. Harrington, as more fully noted below.

At all times pertinent to this Notice of Intent, the unknown nurses described in the body of this Notice were agents, apparent agents, ostensible agents, servants and/or employees of HFMH. As such, HFMH is vicariously liable for the negligent acts and/or omissions of the unknown nurses, as more fully noted below.

It is difficult to determine based upon the medical records reviewed whether Mr. Kostadinovski was being evaluated and treated by resident physicians, attending physicians or consulting physicians, or a combination thereof. In the event it is later determined that Mr. Kostadinovski was being evaluated and treated by resident physicians, attending physicians and/or consulting physicians, other than those listed in the body of this Notice, Henry Ford Macomb Hospital shall be vicariously liable for the acts and/or omissions of those currently unknown physicians.



RINGTON/GALLICK 5862866960 To:13139565558 Page:2/17

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The statements set forth in this Notice are based upon entries made within the records of Henry Ford Macomb Hospital, Dr. Harrington, Dr. Al-Zagoum, M.D., Cardiovascular Institute of Michigan, Advanced Cardiothoracic Surgeons, PLLC, the Hartford Rehabilitation Institute and Dr. Abas Jafri. At this time, Claimant does not admit the truth of any of the statements contained within the medical records of Henry Ford Macomb Hospital, Dr. Harrington, Dr. Al-Zagoum, M.D., Cardiovascular Institute of Michigan, Advanced Cardiothoracic Surgeons, PLLC, the Hartford Rehabilitation Institute and Dr. Abas Jafri, and the recitation of various factual information as set forth below should not be interpreted as an adoption of any of those statements.

It should also be noted that the records of Henry Ford Macomb Hospital, Dr. Harrington, Dr. Al-Zagoum, M.D., Cardiovascular Institute of Michigan, Advanced Cardiothoracic Surgeons, PLLC, the Hartford Rehabilitation Institute and Dr. Abas Jafri, are illegible and/or unintelligible in many instances. As such, it is impossible for claimant to plead all theories of liability against Dr. Harrington at this time. Similarly, it is impossible for claimant to give a complete factual background regarding the treatment of Drago Kostadinovski given the illegibility and unintelligibility of the records of Henry Ford Macomb Hospital, Dr. Harrington, Dr. Al-Zagoum, M.D., Cardiovascular Institute of Michigan, Advanced Cardiothoracic Surgeons, PLLC, the Hartford Rehabilitation Institute and Dr. Abas Jafri.

Attorneys retained by Drago Kostadinovski are unable to more specifically plead additional violations of the standard of care, as well as actions which should have been taken to comply with the standard of care, due to the inability of counsel to take the depositions of witnesses involved in this matter, prior to the filing of this Notice. Because of the inability to conduct depositions, it is impossible for claimant to plead all theories of liability with more specificity at this time.

## A. FACTUAL BASIS FOR CLAIM

Prior to the events described in this Notice, Mr. Kostadinovski was a married man who was able to perform all of his activities of daily living independently as well as mobilize independently. Prior to the events described in this Notice, Mr. Kostadinovski was able to care for himself independently while living with his wife.

On July 30th, 2011, Drago Kostadinovski, a 70-year old male, date of birth, May 10th, 1941, presented to the Henry Ford Macomb Hospital Emergency Department stating that he had just completed an echocardiogram at the Henry Ford Out-Patient Clinic located at Fifteen Mile Road and Ryan. While at the clinic, Mr. Kostadinovski had informed the staff that he was having a hard time breathing and at times was having difficulty swallowing pills and drinking water.

Mr. Kostadinovski indicated that the staff at the Henry Ford Clinic sent him to the Emergency Department for further examination. Upon arrival at the Henry Ford Macomb Hospital Emergency Department, Mr. Kostadinovski was seen by Arti Bajpai, M.D. and



WINGTON/GALLICK 5862866960 To:13139656558 Page:3/17

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Patrician L. Milani, MD who indicated that the Mr. Kostadinovski presented with difficulty breathing and was unable to breathe at times during the night. These symptoms began approximately three days prior to the July 30th, 2011 admission and fluctuated in intensity.

Mr. Kostadinovski's medical history included hypertension, hyperlipidemia, diabetes and a social history of tobacco smoking, noting that Mr.Kostadinovski had quit tobacco one year ago. The impression of the ER physicians was dyspnea, with a plan to rule out cardiac causes, including myocardial infarction, angina, CHF. It was noted that Dr. Milani had discussed the case with Dr. Abas Jafri, Mr. Kostadinovski's primary care physician.

After Mr. Kostadinovski was examined in the Emergency Department, he was admitted to the in-patient telemetry unit and his care was transitioned to Maria B. Perry, M.D.

On August 1st, 2011, Mr. Kostadinovski underwent an echocardiogram for the clinical indication of CHF. The ordering physician was noted as Marius Laurinaitis, MD. The interpretation included demonstration of right ventricle with normal size and function. Left ventricle size, thickness and function were normal. The left ventricular ejection fraction was normal. The mitral leaflets appeared thickened, hooded and/or consistent with myxomatous degeneration with a moderate mitral regurgitation, and posterior mitral leaflet changes consistent with mitral prolapse and some mal opposition with moderate to severe MR.

Following the results of the echocardiogram, a transesophageal echocardiogram was recommended and performed in a two-dimensional fashion. Again, the mitral valve leaflets appeared thickened, hooded and/or consistent with myxomatous degeneration with moderate mitral regurgitation. A duplex extra cranial artery study was performed, which indicated 40 to 59 percent stenosis in the right internal carotid artery with homogenous plaque found. Less than 40 percent stenosis was noted in the left internal carotid artery. The study was interpreted by Rizk Youssef, D.O.

On August 3rd, 2011, under the attending care of Dr. Perry, and by order of Dr. Majid Al-Zagoum, Mr. Kostadinovski underwent a persantine myocardial perfusion scan with a noted history of chest pain, hypertension, diabetes and hypercholesterolemia. The report was read by Khurram Rashid, M.D., with an impression noting no scintigraphic evidence of reversible ischemia and with normal left ventricular wall motion and an ejection fraction of 69 percent.

On August 3rd, 2011, an exercise stress test was performed and interpreted by Durgadas Naria, M.D. The impression was negative per statin stress EKG, with occasional PBCs, stable vital signs which correlated with the myocardial scan report.

On August 4th, 2011, another two-dimensional transesophageal echocardiogram was performed. It was performed under the order of Dr. Al-Zagoum and interpreted by Dr. Al-Zagoum with an interpretation of moderate to severe mitral regurgitation. The mitral regurgitant jet was noted to be eccentrically directed. Prolapse of the anterior mitral leaflet ejection fraction was noted at 60 to 65 percent.



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On August 5th, 2011, Dr. Perry requested a consultation by Steven D. Harrington, M.D. The reason for the consultation was mitral insufficiency and dyspnea with exertion. In Dr. Harrington's consultation note, Dr. Harrington noted the history of the present illness as a 70-year old male who speaks limited English, originally from Macedonia. Dr. Harrington indicated that his son-in-law was at bedside and translated the conversation. Mr. Kostadinovski reported that he had been having increased shortness of breath and reported episodes of dyspnea while lying flat. He also reported episodes of reflux for the past several days; however, he denied any other accompanying symptoms.

Dr. Harrington's assessment of Mr. Kostadinovski at the date of the consultation was: (1) acute exacerbation of congestive heart failure secondary to mitral regurgitation; (2), status post-echocardiogram, no current TEE report is in the chart; however TD echocardiogram revealed the mitral valve leaflets to be thickened with hooded and/or consistent with myxomatous degeneration with moderate mitral regurgitation. Ejection fraction was estimated at 55 to 60 percent, three negative persantine stress EKG, 40 to 59 percent stenosis to the right internal carotid artery and less than 40 percent stenosis to the left internal carotid artery.

Dr. Harrington's plan was to order a transesophageal echocardiogram report which would be reviewed by Dr. Harrington. Dr. Harrington noted that Mr. Kostadinovski would need cardiac catheterization prior to a mitral valve repair/replacement. The cardiac catheterization would be to rule out coronary artery disease and the possible need for myocardial revascularization, as well as mitral valve repair/replacement. The note was dictated by Ryan Ramales, Physician's Assistant and was approved by Dr. Harrington on August 7th, 2011.

On August 4th, 2011, Mr. Kostadinovski was discharged from Henry Ford Macomb Hospital, noting that at 2D echo was suggestive of severe mitral valve insufficiency and was confirmed by transesophageal echocardiogram. The discharge summary included an evaluation by Dr. Harrington in the Cardiovascular Surgery Department and that out-patient follow-up was recommended. Mr. Kostadinovski was to follow up with Dr. Jafari in three to four days, to follow up with Dr. Al-Zagoum in five to seven days and to follow up with Dr. Harrington in ten to 14 days.

On September 12, 2011, Mr. Kostadinovski underwent cardiac catheterization at the Cardiac Catheterization Laboratory at Henry Ford Macomb Hospital. The cardiac catheterization was performed and reported by Dr. Al-Zagoum. Findings were noted as a normal left main coronary artery. "Left anterior descending artery has one major diagonal branch which appeared to be normal and the left anterior descending itself appeared to be within normal limits. The left circumflex artery had one major obtuse marginal artery branch which appeared to be normal and the right coronary artery was a dominant artery with no significant disease noted." Left ventriculography was done using pigtail catheter with ejection fraction about 35 to 40 percent with global hypokinesia. The impression was normal coronary arteries and moderate left ventricular dysfunction.



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On December 9th, 2011, Mr. Kostadinovski presented to Henry Ford Macomb Hospital under the care of Dr. Steven D. Harrington for a pre-surgical evaluation for mitral valve repair/replacement with robotic assistance. During this consultation report, Dr. Harrington noted the September 12, 2011 cardiac catheterization by Dr. Al-Zagoum, in which Mr. Kostadinovski was found to have normal coronary arteries and moderate left ventricular dysfunction. The ejection fraction was noted to be between 35 and 40 percent, and at that point, Mr. Kostadinovski was scheduled for surgery on December 14, 2011. An x-ray of the chest was performed on this date with a clinical history of "some difficulty in breathing/pre-operative study", which demonstrated no significant interval change from the prior x-ray which was performed on July 30, 2011. The interpreting and reporting radiologist, Joseph Metes, MD also noted that there was no active intrathoracic disease. No CT study of the chest, nor any CT angiogram was ordered or reviewed by Dr. Harrington on December 9, 2011 on the pre-surgical clearance admission, nor was any CT study or CT angiogram ordered and reviewed prior to the DaVinci mitral valve repair surgery on December 14, 2011.

On December 9, 2011, Dr. Harrington's assessment was mitral insufficiency with normal coronary arteries and diabetes myelitis type II. As far as prior testing, Dr. Harrington reported that on August 8th, 2011, Mr. Kostadinovski underwent a transesophageal echocardiogram which revealed severe mitral valve prolapse, prolapse of the anterior mitral leaflet with moderate to severe mitral regurgitation, and also noted that the tricuspid valve was normal and had mild tricuspid regurgitation. On December 9, 2011, Dr. Harrington did not recommend nor order that Mr. Kostadinovski undergo any further echocardiogram testing, CTA or other angiogram studies to determine any extent of atherosclerotic process or atherosclerosis in the aortic arch at this time. Informed consent was reported to be given after risks were discussed, and Mr. Kostadinovski was scheduled for surgery on December 14, 2011.

On December 14, 2011, Mr. Kostadinovski presented to Henry Ford Macomb Hospital for a DaVinci mitral valve complex repair with posterior leaflet resection and 28-millimeter, CG future band annuloplasty and ligation of left atrial appendage. The operation was performed by Steven D. Harrington, M.D. with the assistance of Shelly Klein, PA-C. Anesthesiology was performed by Dr. Zhang, who also performed a transesophageal echocardiogram (TEE), which was noted independently, as performed by anesthesia, although the body of the operative report indicates that Dr. Harrington interpreted and utilized the data from the intra-operative TEE study.

In the operative findings, Dr. Harrington noted that there was severe mitral insufficiency with torn P2 posterior segment allowing prolapse of both anterior and posterior leaflets. Dr. Harrington indicated that the repair had been accomplished with quadrangular resection of the P2 segment, primary repair, and a 28 millimeter CG future band angioplasty. Dr. Harrington indicated that Mr. Kostadinovski was in normal sinus rhythm pre-operatively and post-operatively and had "excellent" left ventricle function. Dr. Harrington further noted that post-operative repair showed no mitral insufficiency and no evidence of mitral stenosis.



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In the operative note in the indication for the procedure, Dr. Harrington noted that although this patient presented with minimal symptomatology, the left ventricular dysfunction began to develop and a decision was made to proceed with the repair before allowing any further damage.

During the procedure, Mr. Kostadinovski was placed in the supine position, prepared and draped in a sterile fashion and the right groin was opened, exposing the femoral artery and vein, and the was cannulated with a 23 arterial hemostatic valve catheter and a 25 venous Heart Port catheter in the vein, all positioned with transesophageal echo guidance.

At this point, the DaVinci robot was brought into position and docked and the EndoAortic clamp was brought into position with transesophageal echo guidance. Cardiopulmonary bypass was instituted and the EndoAortic clamp was inflated and the heart was arrested with administration of HTK cardioplegia injected into the aortic root. With the robot, the diaphragmatic stitch retraction was placed followed by opening the pericardium on and pericardial traction sutures.

At that point, Dr. Harrington noted the inter-arterial groove was then developed and opened and left atrial retractor placed exposing the valve. Dr. Harrington noted "obvious P2 segment that was torn and that was resected with quadrangular resection and repaired with a primary repair with No. 4 Gortex suture." After further repair, the valve was tested to see that it was secured and it was with no leak after injection of 250 milliliters of saline. The EndoAortic clamp was released and the patient returned spontaneously to a sinus rhythm.

Dr. Harrington noted adequate rewarming and reperfusion and a weaning from cardiopulmonary bypass and decannulization without difficulty, requiring no inotropes, only a small amount of neo-synephrine, which was quickly weaned off. After the operation, Mr. Kostadinovski was transferred to the Intensive Care Unit for recovery.

Dr. Harrington noted that a peri-operative transesophageal echocardiogram showed excellent cooptation of leaflets, no mitral insufficiency, normal sinus rhythm, and stable left ventricular function.

Upon transfer to the Intensive Care Unit, Mr. Kostadinovski's post-operative vital signs were recorded as follows: temperature 101.9 axillary, pulse 86, respirations 10, blood pressure 134/55, and $O_2$ sat a hundred percent on Fl $O_2$ of 40 percent. It was noted that Mr. Kostadinovski did not awaken post-operatively, and on December 15th, at 01:15 a.m., the nursing staff noted the presence of tonic-clonic movements lasting approximately 65 seconds. At that time, Mr. Kostadinovski remained unresponsive, despite attempts to stimulate him. He did not open his eyes or follow commands. It was also noted during the night of December 15, 2011, that Mr. Kostadinovski had 15 seconds of involuntary movements involving the left-side of his face and his eyes, prompting the administration of Keppra 500 milligrams, IV piggyback and Ativan, 2 milligrams, IV.



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Rajindar K. Sikand, M.D. was consulted who formulated a plan to rule out anesthesia versus neurological event post-op after being called to consult a non-responsive patient who was unable to follow commands and noted to be lethargic occurring overnight on the first day post-op.

On December 15, 2011, at approximately 14:00 hours, it was noted that medical staff had witnessed spontaneous movement of Mr. Kostadinovski's right arm, after he grasped on two occasions with his left hand and nursing staff noted some tremors in Mr. Kostadinovski's "saddle region." At that point, Dr. Wilma E. Agnello-Dimitrijevic, M.D., a neurologist, was consulted regarding Mr. Kostadinovski's condition. Dr. Agnello-Dimitrijevic noted at that time that Mr. Kostadinovski did not have a history of TIA stroke, seizure or syncope, and no known history of neuropathy or retinopathy.

On December 15, 2011, a CT of the brain was performed without contrast, and it was reported as demonstrating evidence of acute ischemic infarct within the right cerebral hemisphere, having the appearance of water shed distribution involving the right anterior cerebral artery distribution. There was no noted evidence of hemorrhage. That study was interpreted by Frank Randazzo, M.D., and it was also noted in the consultation note that Dr. Agnello-Dimitrijevic also interpreted the study and noted evidence of extensive sulcal effacement involving the right front temporal and parietal lobe, consistent with infarction, most notably in the ACA territory. There is also evidence of involvement of the MCA territory. There was no evidence of midline shift and no evidence of hemorrhage. No obvious sulcal effacement is noted in the left hemisphere.

An electroencephalogram (EEG) was performed on December 16, 2011 to rule out seizure. The impression of the reviewing physician, Dr. Shyam Moudgil, M.D. indicated the impression of an abnormal EEG, suggestive of diffuse cortical neuronal dysfunction, as seen in moderate encephalopathy and clinical correlation as to the etiology of the encephalopathy was recommended.

Dr. Agnello-Dimitrijevic's notable impressions were (1) encephalopathy, multifactorial secondary to embolic stroke/sedation, (2) acute right anterior cerebral artery and middle cerebral artery, ischemic infarcts, (3) mitral regurgitation, status post mitral valve repair, among other observations.

Dr. Agnello-Dimitrijevic noted clinically that Mr. Kostadinovski had evidence of not only right hemispheric ischemic stroke, but involvement of the contralateral corticospinal tracts. There was also evidence of not only an aberrant mentation, but bi-lateral Babinski reflexes sustained bilateral ankle clonus and left Hoffmann reflexes. It was noted by Dr. Agnello-Dimitrijevic at the time of this initial consultation that she discussed the findings with the patient's family at length and noted Mr. Kostadinovski's guarded prognosis and ultimate need for extensive rehabilitation.

An additional CT of the head and cervical spine, without contrast, and three-dimensional reconstruction with PACS was performed on December 16, 2011, which was compared to the prior examination from December 16th, 2011. The impression of Frank Randazzo,



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M.D. was acute right-sided water shed and interior cerebral artery infarctions, as before with no significant interval change.

On December 17, 2011, a CT of the head, without contrast, was performed and compared with the December 15, 2011 study. The impression was right-cerebral hemispheric stroke with edema and developing areas of encephalomalacia with the ventricular system remaining patent and left anterior cerebral artery distribution infarction, as well.

Also noted was concern for brain stem ischemic change and likely remote ischemic change of the right cerebellum and paranasal sinus findings. This was interpreted by Michele Keys, D.O.

On December 17th, 2011, the consultation of neurosurgeon Vittorio Morreale, M.D. was requested for the reason of a large infarct with mass affect. Dr. Morreale indicated that Mr. Kostadinovski developed infarct immediately with surgery and has remained intubated since. He further noted that Mr. Kostadinovski is non-verbal and has had dense left hemiplegia since surgery. It was Dr. Morreale's impression that Mr. Kostadinovski did not require intracranial pressure monitoring and that this treatment plan was discussed with Dr. Agnello-Dimitrijevic.

There is a rehabilitation consultation note from David K. Davis, M.D later on during Mr. Kostadinovski's hospital stay. Dr. Davis noted that radiology was reviewed that indicated that a head CT showed right cerebral edema with ischemia, anterior, middle and posterior cerebral arteries and subarachnoid hemorrhage was also seen with partial uncal herniation due to edema in the right temporal horn and ischemia right-posterior cerebral artery is also seen. The impression of Dr. Davis was a patient that was status post-acute large stroke, right side of the brain with dense left-sided weakness and left hemineglect and dysphagia, poor trunk control and very low functional level at the time of the consultation which was approximately 13 days from stroke.

Also, at the time of Dr. Davis' consultation, it was noted that Mr. Kostadinovski's function status was too low for in-patient rehab, which would signify a much longer time needed for recovery. Dr. Davis also indicated to continue PT and OT, and because his criteria would not meet in-patient rehab admission criteria, Dr. Davis would recommend sub-acute rehab admission at this time until his condition improved.

Mr. Kostadinovski remained on ventilator support until he was extubated on December 23rd, 2011 and was eventually transferred to a cardiac step-down unit where he had an extended hospital stay before ultimately being discharged on January 4, 2012 to Hartford Rehabilitation Center. Mr. Kostadinovski's discharge summary included diagnosis of ventilator dependent respiratory failure, right anterior cerebral artery infarct, for which he was being discharged to Hartford Rehab for further rehabilitation. Also noted was a new onset seizure disorder, which began on post-op day one.

Mr. Kostadinovski was discharged to Hartford Rehab Clinic with instructions to follow-up with Drs. Harrington, Al-Zagoum and Jafari.



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Mr. Kostadinovski underwent a pro-longed rehabilitation course and no longer has the ability to perform his ADL's and live a life as he did prior to the date of the surgery. Mr. Kostadinovski has suffered all other damages and injuries as noted throughout this Notice.

B. THE APPLICABLE STANDARD OF CARE OR PRACTICE ALLEGED

At all times pertinent to this Notice, the standard of care applicable to Dr. Steven D. Harrington required Dr. Harrington to maintain the standard of care of his peers within the professional community of cardiothoracic surgery. The requirements of the standard of care included, but are not limited to, the following:

1. On December 9, 2011, and continuously thereafter, Dr. Harrington was required to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

2. On December 9, 2011, and continuously thereafter, Dr. Harrington was required to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

3. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington was required to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

4. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington was required to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

5. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to immediately abort the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

6. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to use the care and technique of a reasonable surgeon performing



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the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

7. Dr. Harrington was required to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process.

C. THE MANNER THE APPLICABLE STANDARD OF CARE OR PRACTICE WAS BREACHED

Dr. Harrington breached the applicable standard of care in the manner set forth below:

1. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

2. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

3. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington failed to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

4. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington failed to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

5. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to immediately abort the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

6. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to use the care and technique of a reasonable surgeon performing the DaVinci



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mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

7. Dr. Harrington failed to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process.

D. THE ACTION THAT SHOULD HAVE BEEN TAKEN TO ACHIEVE COMPLIANCE WITH THE STANDARD OF PRACTICE OR CARE

Actions that should have been taken to achieve compliance with the standard of care include, but are not limited, to the following:

1. On December 9, 2011, and continuously thereafter, Dr. Harrington should have performed and appreciated a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

2. On December 9, 2011, and continuously thereafter, Dr. Harrington should have ordered and reviewed any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

3. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington should have refrained from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

4. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington should have evaluated the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consulted all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

5. On December 14, 2011 and continuously thereafter, Dr. Harrington should have immediately aborted the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;



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6. On December 14, 2011 and continuously thereafter, Dr. Harrington should have used the care and technique of a reasonable surgeon performing the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

7. Dr. Harrington was should have adhered to any and all additional requirements of the standard of care as may be revealed through the discovery process.

E. THE MANNER IN WHICH THE BREACH OF THE STANDARD OF PRACTICE OR CARE WAS THE PROXIMATE CAUSE OF THE INJURY CLAIMED IN THE NOTICE

Each injury and element of damage noted below was factually and foreseeably caused by the standard of care violations described above by Dr. Harrington and/or the staff at Henry Ford Macomb Hospital.

As a direct and proximate result of each breach of the standard of care as outlined above, Drago Kostadinovski suffered and continues to suffer a permanent impairment to his cognitive capacity rendering him incapable of making independent responsible life decisions and permanently incapable of independently performing the activities of normal daily living. As such, Drago Kostadinovski is entitled to the higher noneconomic damage cap pursuant to MCLA 600.1483.

As a result of each breach of the standard of care outlined above, Drago Kostadinovski suffered and continues to suffer pain and suffering, disability and disfigurement, emotional distress, anxiety, denial of social pleasures and enjoyments, humiliation, medical expenses, loss of earnings, and a loss of earning capacity.

As a direct and proximate result each violation of the standard of care outlined above, Drago Kostadinovski suffered and continues to suffer encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, a pro-longed hospital stay, pain and suffering, loss of ability to perform all activities of daily living, along with all other damages and injuries as noted within this notice.

Had Dr. Harrington followed the standard of care and performed and appreciated a full history and physical, ordered and reviewed all necessary pre-operative radiographic testing and/or studies, including, but not limited to, x-rays, CT studies, CT angiograms, and any and all other necessary radiographic testing, he would have been able to identify thrombus, clots, or calcium within the arterial tree which would embolize and/or cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve



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repair using an EndoClamp as was performed on December 14, 2011. Had Dr. Harrington performed the proper preoperative testing, he would have determined that the elective mitral valve repair was not necessary at that time and would have aborted the procedure and/or would have used a different technique aside from the use of an EndoClamp. Had Dr. Harrington declined to perform this elective mitral valve repair and/or refrained from using the EndoClamp, thrombus, clot or calcification would not have broken loose or formed causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this Notice.

Had Dr. Harrington followed the standard of care and properly monitored and observed the intraoperative transesophageal echocardiogram (TEE), he would have been able to identify thrombus, clots, or calcium within the arterial tree which would embolize and cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp. Had Dr. Harrington observed the standard of care in this respect, he would have aborted the procedure and/or used a different technique aside from the EndoClamp approach. Had Dr. Harrington declined to perform this elective mitral valve repair at this point and/or refrained from using the EndoClamp, thrombus, clot, or calcification would not have broken loose or formed causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this notice.

Had Dr. Harrington followed the standard of care and used the care and technique of a reasonable surgeon in performing the DaVinci mitral valve repair surgery, he would have avoided disrupting any calcium, thrombus or other build-up in the arterial tree during the operation and he would have avoided causing the above referenced injuries and damages to Mr. Kostadinovski. Had Dr. Harrington observed the standard of care in this respect, he would have aborted the surgery and/or used a different approach and/or surgical technique while performing the December 14, 2011 DaVinci mitral valve repair surgery. Had Dr. Harrington maintained the standard of care in this respect, thrombus, clot or calcification would not have broken loose or formed, causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this Notice.

Mrs. Kostadinovski, as the legal wife of Mr. Kostadinovski, is entitled to loss of consortium damages, which are the direct and proximate result of the damages and injuries described above caused by Dr. Harrington. Mr. Kostadinovski along with his wife, are entitled to damages as are deemed fair and just, including, but not limited to the following: reasonable compensation for the pain and suffering incurred by Mr. Kostadinovski, economic loss, emotional damage, loss of consortium, all medical expenses incurred along with a loss of economic opportunity and all other damages and injuries listed previously within this Notice. All rights to any additional and unmentioned damages are hereby preserved.



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Had Dr. Harrington followed the standard of care in all respects as outlined above, Mr. Kostadinoveki would not have suffered and continues to suffer encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, a pro-longed hospital stay, pain-suffering, loss of ability to perform all activities of daily living, as well as all damages and injuries previously noted within this Notice.

F. THE NAMES OF OTHER HEALTH PROFESSIONALS, ENTITIES AND FACILITIES NOTIFIED:

None other than those noted above.

**TO THOSE RECEIVING NOTICE: YOU SHOULD FURNISH THIS NOTICE TO ANY PERSON, ENTITY OR FACILITY, NOT SPECIFICALLY NAMED HEREIN, THAT YOU REASONABLY BELIEVE MIGHT BE ENCOMPASSED IN THIS CLAIM.**

MORGAN & MEYERS, PLC

BY _____

JEFFREY T. MEYERS (P34348)
TIMOTHY M. TAKALA (P72138)
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3200 Greenfield, Suite 260
Dearborn, Michigan 48120-1802
(313) 961-0130

DATED: December 9, 2013



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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF MACOMB

DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI, as Husband and Wife,

Plaintiffs,

v

STEVEN D. HARRINGTON, M.D., and ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.

Defendants.

14-2247-NH

Case No. 14- -NH
Hon. JOHN C. FOSTER

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JUN - 5 2014
CARMELLA SABAUGH
MACOMB COUNTY CLERK

JEFFREY T. MEYERS (P34348)
TIMOTHY M. TAKALA (P72138)
Attorneys for Plaintiff
3200 Greenfield, Suite 260
Dearborn, MI 48120
(313) 961-0130 Fax: 8178

*There is no other pending or resolved civil action arising out of the transaction or occurrence alleged in the complaint*

JEFFERY T. MEYERS (P34348)
TIMOTHY M. TAKALA (P72138)

**COMPLAINT AND DEMAND FOR JURY TRIAL**

NOW COMES Plaintiff herein, Drago Kostadinovski and Blaga Kostadinovski, as Husband and Wife, by and through their attorneys, MORGAN & MEYERS, PLC, and states as their cause of action against the above-named Defendants the following:

1. The amount in controversy is in excess of TWENTY FIVE THOUSAND ($25,000) DOLLARS.

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2. At all times pertinent to this Complaint, Drago Kostadinovski (hereinafter "Mr. Kostadinovski") was a resident of the County of Macomb, State of Michigan.

3. At all times pertinent to this Complaint, Blaga Kostadinovski (hereinafter "Mrs. Kostadinovski") was a resident of the County of Macomb, State of Michigan.

4. At all times pertinent to this Complaint, Steven D. Harrington, M.D. was a physician doing business in the County of Macomb, State of Michigan.

5. At all times pertinent to this Complaint, Advanced Cardiothoracic Surgeons, PLLC was a Michigan Limited Liability Company doing business in the County of Macomb, State of Michigan.

6. At all times pertinent to this Complaint, Dr. Harrington was an employee/agent at Advanced Cardiothoracic Surgeons P.L.L.C.

7. In paragraphs 8 – 67 as set forth below, Plaintiffs make reference to statements contained in the medical records of various health care providers. The recitation of these factual statements should not be interpreted as an admission by Plaintiffs as to the factual authenticity or truthfulness of these statements. The statements are set forth below to provide context as to the violations of the standards of care, also described below.

8. Prior to the events described in this Complaint, Mr. Kostadinovski was a married man who was able to perform all of his activities of daily living independently as well as mobilize independently.

9. Prior to the events described in this Complaint, Mr. Kostadinovski was able to care for himself independently while living with his wife.

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10. On July 30th, 2011, Drago Kostadinovski, a 70-year old male, date of birth, May 10th, 1941, presented to the Henry Ford Macomb Hospital Emergency Department stating that he had just completed an echocardiogram at the Henry Ford Out-Patient Clinic located at Fifteen Mile Road and Ryan.

11. While at the clinic, Mr. Kostadinovski had informed the staff that he was having a hard time breathing and at times was having difficulty swallowing pills and drinking water.

12. Mr. Kostadinovski indicated that the staff at the Henry Ford Clinic sent him to the Emergency Department for further examination. Upon arrival at the Henry Ford Macomb Hospital Emergency Department, Mr. Kostadinovski was seen by Arti Bajpai, M.D. and Patrician L. Milani, MD who indicated that the Mr. Kostadinovski presented with difficulty breathing and was unable to breathe at times during the night. These symptoms began approximately three days prior to the July 30th, 2011 admission and fluctuated in intensity.

13. Mr. Kostadinovski's medical history included hypertension, hyperlipidemia, diabetes and a social history of tobacco smoking, noting that Mr.Kostadinovski had quit tobacco one year ago. The impression of the ER physicians was dyspnea, with a plan to rule out cardiac causes, including myocardial infarction, angina, CHF. It was noted that Dr. Milani had discussed the case with Dr. Abas Jafri, Mr. Kostadinovski's primary care physician.

14. After Mr. Kostadinovski was examined in the Emergency Department, he was admitted to the in-patient telemetry unit and his care was transitioned to Maria B. Perry, M.D.

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15. On August 1st, 2011, Mr. Kostadinovski underwent an echocardiogram for the clinical indication of CHF. The ordering physician was noted as Marius Laurinaitis, MD. The interpretation included demonstration of right ventricle with normal size and function. Left ventricle size, thickness and function were normal. The left ventricular ejection fraction was normal. The mitral leaflets appeared thickened, hooded and/or consistent with myxomatous degeneration with a moderate mitral regurgitation, and posterior mitral leaflet changes consistent with mitral prolapse and some mal opposition with moderate to severe MR.

16. Following the results of the echocardiogram, a transesophageal echocardiogram was recommended and performed in a two-dimensional fashion.

17. Again, the mitral valve leaflets appeared thickened, hooded and/or consistent with myxomatous degeneration with moderate mitral regurgitation.

18. A duplex extra cranial artery study was performed, which indicated 40 to 59 percent stenosis in the right internal carotid artery with homogenous plaque found. Less than 40 percent stenosis was noted in the left internal carotid artery. The study was interpreted by Rizk Youssef, D.O.

19. On August 3rd, 2011, under the attending care of Dr. Perry, and by order of Dr. Majid Al-Zagoum, Mr. Kostadinovski underwent a persantine myocardial perfusion scan with a noted history of chest pain, hypertension, diabetes and hypercholesterolemia. The report was read by Khurram Rashid, M.D., with an impression noting no scintigraphic evidence of reversible ischemia and with normal left ventricular wall motion and an ejection fraction of 69 percent.

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20. On August 3rd, 2011, an exercise stress test was performed and interpreted by Durgadas Narla, M.D. The impression was negative per statin stress EKG, with occasional PBCs, stable vital signs which correlated with the myocardial scan report.

21. On August 4th, 2011, another two-dimensional transesophageal echocardiogram was performed. It was performed under the order of Dr. Al-Zagoum and interpreted by Dr. Al-Zagoum with an interpretation of moderate to severe mitral regurgitation. The mitral regurgitant jet was noted to be eccentrically directed. Prolapse of the anterior mitral leaflet ejection fraction was noted at 60 to 65 percent.

22. On August 5th, 2011, Dr. Perry requested a consultation by Steven D. Harrington, M.D. The reason for the consultation was mitral insufficiency and dyspnea with exertion.

23. In Dr. Harrington's consultation note, Dr. Harrington noted the history of the present illness as a 70-year old male who speaks limited English, originally from Macedonia.

24. Dr. Harrington indicated that his son-in-law was at bedside and translated the conversation. Mr. Kostadinovski reported that he had been having increased shortness of breath and reported episodes of dyspnea while lying flat. He also reported episodes of reflux for the past several days; however, he denied any other accompanying symptoms.

25. Dr. Harrington's assessment of Mr. Kostadinovski at the date of the consultation was: (1) acute exacerbation of congestive heart failure secondary to mitral regurgitation; (2), status post-echocardiogram, no current TEE report is in the chart; however TD echocardiogram revealed the mitral valve leaflets to be thickened with

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hooded and/or consistent with myxomatous degeneration with moderate mitral regurgitation. Ejection fraction was estimated at 55 to 60 percent, three negative persantine stress EKG, 40 to 59 percent stenosis to the right internal carotid artery and less than 40 percent stenosis to the left internal carotid artery.

26. Dr. Harrington's plan was to order a transesophageal echocardiogram report which would be reviewed by Dr. Harrington. Dr. Harrington noted that Mr. Kostadinovski would need cardiac catheterization prior to a mitral valve repair/replacement. The cardiac catheterization would be to rule out coronary artery disease and the possible need for myocardial revascularization, as well as mitral valve repair/replacement. The note was dictated by Ryan Ramales, Physician's Assistant and was approved by Dr. Harrington on August 7th, 2011.

27. On August 4th, 2011, Mr. Kostadinovski was discharged from Henry Ford Macomb Hospital, noting that at 2D echo was suggestive of severe mitral valve insufficiency and was confirmed by transesophageal echocardiogram. The discharge summary included an evaluation by Dr. Harrington in the Cardiovascular Surgery Department and that out-patient follow-up was recommended. Mr. Kostadinovski was to follow up with Dr. Jafari in three to four days, to follow up with Dr. Al-Zagoum in five to seven days and to follow up with Dr. Harrington in ten to 14 days.

28. On September 12, 2011, Mr. Kostadinovski underwent cardiac catheterization at the Cardiac Catheterization Laboratory at Henry Ford Macomb Hospital. The cardiac catheterization was performed and reported by Dr. Al-Zagoum. Findings were noted as a normal left main coronary artery. "Left anterior descending artery has one major diagonal branch which appeared to be normal and the left anterior descending itself

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appeared to be within normal limits. The left circumflex artery had one major obtuse marginal artery branch which appeared to be normal and the right coronary artery was a dominant artery with no significant disease noted." Left ventriculography was done using pigtail catheter with ejection fraction about 35 to 40 percent with global hypokinesia.

29. On December 9th, 2011, Mr. Kostadinovski presented to Henry Ford Macomb Hospital under the care of Dr. Steven D. Harrington for a pre-surgical evaluation for mitral valve repair/replacement with robotic assistance.

30. During this consultation report, Dr. Harrington noted the September 12, 2011 cardiac catheterization by Dr. Al-Zagoum, in which Mr. Kostadinovski was found to have normal coronary arteries and moderate left ventricular dysfunction. The ejection fraction was noted to be between 35 and 40 percent, and at that point, Mr. Kostadinovski was scheduled for surgery on December 14, 2011.

31. An x-ray of the chest was performed on this date with a clinical history of "some difficulty in breathing/pre-operative study", which demonstrated no significant interval change from the prior x-ray which was performed on July 30, 2011.

32. No CT study of the chest, nor any CT angiogram was ordered or reviewed by Dr. Harrington on December 9, 2011 on the pre-surgical clearance admission, nor was any CT study or CT angiogram ordered and reviewed prior to the DaVinci mitral valve repair surgery on December 14, 2011.

33. On December 9, 2011, Dr. Harrington's assessment was mitral insufficiency with normal coronary arteries and diabetes myelitis type II. As far as prior testing, Dr. Harrington reported that on August 8th, 2011, Mr. Kostadinovski underwent a transesophageal echocardiogram which revealed severe mitral valve prolapse, prolapse of

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the anterior mitral leaflet with moderate to severe mitral regurgitation, and also noted that the tricuspid valve was normal and had mild tricuspid regurgitation.

34. On December 9, 2011, Dr. Harrington did not recommend nor order that Mr. Kostadinovski undergo any further echocardiogram testing, CTA or other angiogram studies to determine any extent of atherosclerotic process or atherosclerosis in the aortic arch at this time. Informed consent was reported to be given after risks were discussed, and Mr. Kostadinovski was scheduled for surgery on December 14, 2011.

35. On December 14, 2011, Mr. Kostadinovski presented to Henry Ford Macomb Hospital for a DaVinici mitral valve complex repair with posterior leaflet resection and 28-millimeter, CG future band annuloplasty and ligation of left atrial appendage.

36. The operation was performed by Steven D. Harrington, M.D. with the assistance of Shelly Klein, PA-C. Anesthesiology was performed by Dr. Zhang, who also performed a transesophageal echocardiogram (TEE), which was noted independently, as performed by anesthesia, although the body of the operative report indicates that Dr. Harrington interpreted and utilized the data from the intra-operative TEE study.

37. In the operative findings, Dr. Harrington noted that there was severe mitral insufficiency with torn P2 posterior segment allowing prolapse of both anterior and posterior leaflets.

38. Dr. Harrington indicated that the repair had been accomplished with quadrangular resection of the P2 segment, primary repair, and a 28 millimeter CG future band angioplasty.

39. Dr. Harrington indicated that Mr. Kostadinovski was in normal sinus rhythm pre-operatively and post-operatively and had "excellent" left ventricle function. Dr.

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Harrington further noted that post-operative repair showed no mitral insufficiency and no evidence of mitral stenosis.

40. During the procedure, Mr. Kostadinovski was placed in the supine position, prepared and draped in a sterile fashion and the right groin was opened, exposing the femoral artery and vein, and the was cannulated with a 23 arterial hemostatic valve catheter and a 25 venous Heart Port catheter in the vein, all positioned with transesophageal echo guidance.

41. At this point, the DaVinci robot was brought into position and docked and the EndoAortic clamp was brought into position with transesophageal echo guidance.

42. Cardiopulmonary bypass was instituted and the EndoAortic clamp was inflated and the heart was arrested with administration of HTK cardioplegia injected into the aortic root. With the robot, the diaphragmatic stitch retraction was placed followed by opening the pericardium on and pericardial traction sutures.

43. At that point, Dr. Harrington noted the inter-arterial groove was then developed and opened and left atrial retractor placed exposing the valve. Dr. Harrington noted "obvious P2 segment that was torn and that was resected with quadrangular resection and repaired with a primary repair with No. 4 Gortex suture."

44. After further repair, the valve was tested to see that it was secured and it was with no leak after injection of 250 milliliters of saline. The EndoAortic clamp was released and the patient returned spontaneously to a sinus rhythm.

45. Dr. Harrington noted adequate rewarming and reperfusion and a weaning from cardiopulmonary bypass and decannulization without difficulty, requiring no inotropes,

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only a small amount of neo-synephrine, which was quickly weaned off. After the operation, Mr. Kostadinovski was transferred to the Intensive Care Unit for recovery.

46. Dr. Harrington noted that a peri-operative transesophageal echocardiogram showed excellent cooptation of leaflets, no mitral insufficiency, normal sinus rhythm, and stable left ventricular function.

47. Upon transfer to the Intensive Care Unit, Mr. Kostadinovski's post-operative vital signs were recorded as follows: temperature 101.9 axillary, pulse 86, respirations 10, blood pressure 134/55, and $O_2$ sat a hundred percent on FI $O_2$ of 40 percent.

48. It was noted that Mr. Kostadinovski did not awaken post-operatively, and on December 15th, at 01:15 a.m., the nursing staff noted the presence of tonic-clonic movements lasting approximately 65 seconds. At that time, Mr. Kostadinovski remained unresponsive, despite attempts to stimulate him. He did not open his eyes or follow commands.

49. It was also noted during the night of December 15, 2011, that Mr. Kostadinovski had 15 seconds of involuntary movements involving the left-side of his face and his eyes, prompting the administration of Keppra 500 milligrams, IV piggyback and Ativan, 2 milligrams, IV.

50. Rajindar K. Sikand, M.D. was consulted who formulated a plan to rule out anesthesia versus neurological event post-op after being called to consult a non-responsive patient who was unable to follow commands and noted to be lethargic occurring overnight on the first day post-op.

51. On December 15, 2011, at approximately 14:00 hours, it was noted that medical staff had witnessed spontaneous movement of Mr. Kostadinovski's right arm, after

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he grasped on two occasions with his left hand and nursing staff noted some tremors in Mr. Kostadinovski's "saddle region." At that point, Dr. Wilma E. Agnello-Dimitrijevic, M.D., a neurologist, was consulted regarding Mr. Kostadinovski's condition.

52. Dr. Agnello-Dimitrijevic noted at that time that Mr. Kostadinovski did not have a history of TIA stroke, seizure or syncope, and no known history of neuropathy or retinopathy.

53. On December 15, 2011, a CT of the brain was performed without contrast, and it was reported as demonstrating evidence of acute ischemic infarct within the right cerebral hemisphere, having the appearance of water shed distribution involving the right anterior cerebral artery distribution. There was no noted evidence of hemorrhage. That study was interpreted by Frank Randazzo, M.D., and it was also noted in the consultation note that Dr. Agnello-Dimitrijevic also interpreted the study and noted evidence of extensive sulcal effacement involving the right front temporal and parietal lobe, consistent with infarction, most notably in the ACA territory. There is also evidence of involvement of the MCA territory. There was no evidence of midline shift and no evidence of hemorrhage. No obvious sulcal effacement is noted in the left hemisphere.

54. An electroencephalogram (EEG) was performed on December 16, 2011 to rule out seizure. The impression of the reviewing physician, Dr. Shyam Moudgil, M.D. indicated the impression of an abnormal EEG, suggestive of diffuse cortical neuronal dysfunction, as seen in moderate encephalopathy and clinical correlation as to the etiology of the encephalopathy was recommended.

55. Dr. Agnello-Dimitrijevic's notable impressions were (1) encephalopathy, multifactorial secondary to embolic stroke/sedation, (2) acute right anterior cerebral artery

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and middle cerebral artery, ischemic infarcts, (3) mitral regurgitation, status post mitral valve repair, among other observations.

56. Dr. Agnello-Dimitrijevic noted clinically that Mr. Kostadinovski had evidence of not only right hemispheric ischemic stroke, but involvement of the contralateral corticospinal tracts. There was also evidence of not only an aberrant mentation, but bilateral Babinski reflexes sustained bilateral ankle clonus and left Hoffmann reflexes.

57. It was noted by Dr. Agnello-Dimitrijevic at the time of this initial consultation that she discussed the findings with the patient's family at length and noted Mr. Kostadinovski's guarded prognosis and ultimate need for extensive rehabilitation.

58. An additional CT of the head and cervical spine, without contrast, and three-dimensional reconstruction with PACS was performed on December 16, 2011, which was compared to the prior examination from December 15th, 2011. The impression of Frank Randazzo, M.D. was acute right-sided water shed and interior cerebral artery infarctions, as before with no significant interval change.

59. On December 17, 2011, a CT of the head, without contrast, was performed and compared with the December 15, 2011 study. The impression was right-cerebral hemispheric stroke with edema and developing areas of encephalomalacia with the ventricular system remaining patent and left anterior cerebral artery distribution infarction, as well.

60. Also noted was concern for brain stem ischemic change and likely remote ischemic change of the right cerebellum and paranasal sinus findings. This was interpreted by Michele Keys, D.O.

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61. On December 17th, 2011, the consultation of neurosurgeon Vittorio Morreale, M.D. was requested for the reason of a large infarct with mass affect. Dr. Morreale indicated that Mr. Kostadinovski developed infarct immediately with surgery and has remained intubated since. He further noted that Mr. Kostadinovski is non-verbal and has had dense left hemiplegia since surgery. It was Dr. Morreale's impression that Mr. Kostadinovski did not require intracranial pressure monitoring and that this treatment plan was discussed with Dr. Agnello-Dimitrijevic.

62. There is a rehabilitation consultation note from David K. Davis, M.D later on during Mr. Kostadinovski's hospital stay. Dr. Davis noted that radiology was reviewed that indicated that a head CT showed right cerebral edema with ischemia, anterior, middle and posterior cerebral arteries and subarachnoid hemorrhage was also seen with partial uncal herniation due to edema in the right temporal horn and ischemia right-posterior cerebral artery is also seen. The impression of Dr. Davis was a patient that was status post-acute large stroke, right side of the brain with dense left-sided weakness and left hemineglect and dysphagia, poor trunk control and very low functional level at the time of the consultation which was approximately 13 days from stroke.

63. Also, at the time of Dr. Davis' consultation, it was noted that Mr. Kostadinovski's function status was too low for in-patient rehab, which would signify a much longer time needed for recovery. Dr. Davis also indicated to continue PT and OT, and because his criteria would not meet in-patient rehab admission criteria, Dr. Davis would recommend sub-acute rehab admission at this time until his condition improved.

64. Mr. Kostadinovski remained on ventilator support until he was extubated on December 23rd, 2011 and was eventually transferred to a cardiac step-down unit where he

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had an extended hospital stay before ultimately being discharged on January 4, 2012 to Hartford Rehabilitation Center.

65. Mr. Kostadinovski's discharge summary included diagnosis of ventilator dependent respiratory failure, right anterior cerebral artery infarct, for which he was being discharged to Hartford Rehab for further rehabilitation.

66. Mr. Kostadinovski was discharged to Hartford Rehab Clinic with instructions to follow-up with Drs. Harrington, Al-Zagoum and Jafari.

67. Mr. Kostadinovski underwent a pro-longed rehabilitation course and no longer has the ability to perform his ADL's and live a life as he did prior to the date of the surgery. Mr. Kostadinovski has suffered all other damages and injuries as noted throughout this Complaint.

**COUNT I: MEDICAL NEGLIGENCE OF STEVEN D. HARRINGTON, M.D.**

The Plaintiffs hereby restate, reallege, and incorporate by reference each and every allegation set forth above and further states, in the alternative, the following:

68. At all times pertinent to this Notice, the standard of care applicable to Steven D. Harrington, M.D., required him to maintain the standard of care of his peers within the professional community of cardiothoracic surgeons.

69. The requirements of the standard of care included, but were not limited to, the

a. On December 9, 2011, and continuously thereafter, Dr. Harrington was required to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

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b. On December 9, 2011, and continuously thereafter, Dr. Harrington was required to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

c. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington was required to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

d. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington was required to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

e. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to immediately abort the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

f. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to use the care and technique of a reasonable surgeon performing the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

g. Dr. Harrington was required to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process.

70. Notwithstanding said obligations, and in breach thereof, Defendant Dr. Harrington violated the standard of care applicable in the manner set forth below:

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a. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

b. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

c. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington failed to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

d. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington failed to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

e. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to immediately abort the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

f. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to use the care and technique of a reasonable surgeon performing the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

g. Dr. Harrington failed to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process.

71. Each injury and element of damage noted below was factually and foreseeably caused by the standard of care violations described above by Dr. Harrington.

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72. As a direct and proximate result of each breach of the standard of care as outlined above, Drago Kostadinovski suffered and continues to suffer a permanent impairment to his cognitive capacity rendering him incapable of making independent responsible life decisions and permanently incapable of independently performing the activities of normal daily living. As such, Drago Kostadinovski is entitled to the higher noneconomic damage cap pursuant to MCLA 600.1483.

73. As a result of each breach of the standard of care outlined above, Drago Kostadinovski suffered and continues to suffer pain and suffering, disability and disfigurement, emotional distress, anxiety, denial of social pleasures and enjoyments, humiliation, medical expenses, loss of earnings, and a loss of earning capacity.

74. As a direct and proximate result each violation of the standard of care outlined above, Drago Kostadinovski suffered and continues to suffer encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, a pro-longed hospital stay, pain and suffering, loss of ability to perform all activities of daily living, along with all other damages and injuries as noted within this complaint.

75. Had Dr. Harrington followed the standard of care and performed and appreciated a full history and physical, ordered and reviewed all necessary pre-operative radiographic testing and/or studies, including, but not limited to, x-rays, CT studies, CT angiograms, and any and all other necessary radiographic testing, he would have been able to identify thrombus, clots, or calcium within the arterial tree which would embolize and/or cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp as was performed on December 14, 2011. Had

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Dr. Harrington performed the proper preoperative testing, he would have aborted the procedure and/or would have used a different technique aside from the use of an EndoClamp. Had Dr. Harrington declined to perform this elective mitral valve repair and/or refrained from using the EndoClamp, thrombus, clot or calcification would not have broken loose or formed causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

76. Had Dr. Harrington followed the standard of care and properly monitored and observed the intraoperative transesophageal echocardiogram (TEE), he would have been able to identify thrombus, clots, or calcium within the arterial tree which would embolize and cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp. Had Dr. Harrington observed the standard of care in this respect, he would have aborted the procedure and/or used a different technique aside from the EndoClamp approach. Had Dr. Harrington declined to perform this elective mitral valve repair at this point and/or refrained from using the EndoClamp, thrombus, clot, or calcification would not have broken loose or formed causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

77. Had Dr. Harrington followed the standard of care and used the care and technique of a reasonable surgeon in performing the DaVinci mitral valve repair surgery, he would have avoided disrupting any calcium, thrombus or other build-up in the arterial

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tree during the operation and he would have avoided causing the above referenced injuries and damages to Mr. Kostadinovski. Had Dr. Harrington observed the standard of care in this respect, he would have aborted the surgery and/or used a different approach and/or surgical technique while performing the December 14, 2011 DaVinci mitral valve repair surgery. Had Dr. Harrington maintained the standard of care in this respect, thrombus, clot or calcification would not have broken loose or formed, causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

78. Mrs. Kostadinovski, as the legal wife of Mr. Kostadinovski, is entitled to loss of consortium damages, which are the direct and proximate result of the damages and injuries described above caused by Dr. Harrington. Mr. Kostadinovski along with his wife, are entitled to damages as are deemed fair and just, including, but not limited to the following: reasonable compensation for the pain and suffering incurred by Mr. Kostadinovski, economic loss, emotional damage, loss of consortium, all medical expenses incurred along with a loss of economic opportunity and all other damages and injuries listed previously within this complaint.

79. Had Dr. Harrington followed the standard of care in all respects as outlined above, Mr. Kostadinovski would not have suffered and continues to suffer encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, a pro-longed hospital stay, pain-suffering, loss of ability to perform all activities of daily living, as well as all damages and injuries previously noted within this complaint.

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WHEREFORE, Plaintiffs respectfully request that this Honorable Court enter judgment against the Defendants in any amount in excess of TWENTY FIVE THOUSAND ($25,000.00) DOLLARS, together with interest, costs and attorney fees, to which the Plaintiff is deemed to be entitled.

## COUNT II: VICARIOUS LIABILITY OF ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.

The plaintiffs hereby restate, reallege, and incorporate by reference each and every allegation set forth above and further states, in the alternative, the following:

80. At all times pertinent to this Complaint, Dr. Steven D. Harrington, M.D., was an agent, ostensible agent, servant and/or employee of Advanced Cardiothoracic Surgeons, PLLC. As such, Advanced Cardiothoracic Surgeons, PLLC are vicariously liable for the negligent acts and/or omissions of Dr. Harrington as more fully described above, as well as the injuries and damages flowing from said acts and/or omissions.

WHEREFORE, plaintiffs respectfully request that this Honorable Court enter judgment against the defendants, jointly and severally, and in any amount in excess of TWENTY FIVE THOUSAND ($25,000.00) DOLLARS, together with interest, costs and attorney fees, to which the plaintiff is deemed to be entitled.

## COUNT III: LOSS OF CONSORTIUM

The plaintiffs hereby restate, re-allege and incorporate by reference each and every allegation set forth above and further state, in the alternative, the following:

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81. At all times pertinent to this Complaint, Blaga Kostadinovski was the lawfully wedded wife of Drago Kostadinovski.

82. As a direct and proximate result of the injuries and damages experienced by Drago Kostadinovski, Blaga Kostadinovski, has suffered the loss of her husband's consortium, society, and companionship; emotional distress and anxiety, past, present, and future; and denial of social pleasures and enjoyments, past, present, and future.

WHEREFORE, plaintiffs respectfully request that this Honorable Court enter judgment against the defendants, jointly and severally, and in any amount in excess of TWENTY FIVE THOUSAND ($25,000.00) DOLLARS, together with interest, costs and attorney fees, to which the plaintiff is deemed to be entitled.

RESPECTFULLY SUBMITTED,

MORGAN & MEYERS, PLC

BY _____

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DATED: June 5, 2014

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# KOSTADINOVSKI v. HARRINGTON, M.D., ET AL.

## HARRINGTON, M.D., STEVEN

II

September 22, 2015

*Prepared for you by*

BIENENSTOCK
NATIONWIDE COURT REPORTING & VIDEO

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STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF MACOMB

DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI, as Husband and Wife,
Plaintiffs,
vs. Case No. 14-2247-NH
Hon. John C. Foster
STEVEN D. HARRINGTON, M.D., and ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.,
Defendants.

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VOLUME II

The Continued Deposition of STEVEN HARRINGTON, M.D., Taken at 333 West Fort Street, Suite 1600, Detroit, Michigan, Commencing at 2:42 p.m., Tuesday, September 22, 2015, Before Becky L. Johnson, CSR-5395.



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Detroit, Michigan
Tuesday, September 22, 2015
2:42 p.m.

STEVEN HARRINGTON, M.D.,
was thereupon called as a witness herein, and after having first been duly sworn to testify to the truth, the whole truth and nothing but the truth, was examined and testified as follows:

MR. MEYERS: The record should reflect this is the continuation of the deposition of Dr. Steven Harrington.

CONTINUED EXAMINATION

BY MR. MEYERS:

Q. Good afternoon, sir.
**A. Good afternoon, Mr. Meyers.**
Q. We had an opportunity to get together and talk last May, specifically on May the 14th, and today is the date of the continuation of your deposition; do you understand?
**A. Yes.**
Q. Have you had an opportunity to review your deposition that was taken on May the 14th?
**A. Yes.**
Q. Are there any corrections that you'd like to make to

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it?
**A. No.**
Q. Now, we spent a lot of time in your deposition in May trying to figure out what chest films specifically you would have reviewed before the operation that you performed on this patient; is that correct?
**A. I recall that we had some discussions on that, yes.**
Q. Fine. Have you specifically now identified the chest films that you would have reviewed preoperatively?
**A. The answer -- I'll give you the same answer that I gave last time, which is that I would have reviewed the most recent chest x-rays that were available to me.**
Q. Can you point those out to me, please?
**A. How do you want me -- they're not here.**
Q. Point me -- well --
**A. I'm not sure what you want --**
Q. Okay. Here's what we did, last time around we made a specific point of talking about the fact that you understood the x-rays were part of the medical record and that you were supposed to bring with you everything that you had reviewed in preparation for your deposition or since the case has started; do you recall that discussion?
**A. I was to bring -- I recall the discussion and my**

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**understanding was that I was to bring my medical records.**
Q. And that you were to bring whatever you had reviewed since the case had started?
**A. That was not my understanding.**
Q. Well, that's what the deposition notice requested and we had a lengthy discussion about that. Have you reviewed these preoperative chest films as part of your review of the case?
**A. Yes, I have reviewed some of them, yes.**
Q. Okay. Identify them -- and Paul can help you, I don't care what you do, I just want to know -- look, this is not a dance, it's not a hide and seek. I want to know --
**A. I understand.**
Q. -- specifically what chest films you reviewed before you performed this operation on this man, that's all I want to know?
**A. Okay.**
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 7
2:45 p.m.
**A. I would have reviewed the chest x-ray of 7-30 of 2011 and the chest x-ray of 12-9 of 2011.**
BY MR. MEYERS:

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Q. Any other chest x-rays that you would have reviewed before the operation?
**A. Not that I can recall, no.**
Q. And is there a reference anywhere in your medical record to you having reviewed the chest x-ray of 7-30-11 before the operation or the chest film of 12-9-11 before the operation?
**A. Not that I can recall.**
Q. Did the standard of care that applied to you require you to review the chest films available prior to the operation -- strike the question.
Your operative report -- the date of the procedure was what, sir?
**A. I believe the surgical date was 12-14-2011.**
Q. Thank you. So here's the question, and again appreciate your patience, I'm trying to formulate a question that will make sense and be readable on paper. Did the standard of care require you to review those chest films prior to performing the operation on 12-14-11?
**A. Which chest films are you referring to?**
Q. The ones that you just got done describing --
**A. Okay. I just want to make sure that we have the same context.**
Q. Okay. The 7-30 --

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**A. The standard of care I believe --**
Q. No, you asked the question and I'm going to clarify.
**A. Okay.**
Q. You asked me what films -- what chest films I was referring to and I indicated those that you just referred to, the films of 7-30-11 and 12-9-11. Did the standard of care require you to review those films before the operation on 12-14-11?
**A. Yes.**
Q. Why?
**A. I'm not sure I understand your question.**
Q. Why did the standard of care require you to do that, why would a reasonably-prudent surgeon in your position be required to review those chest films?
**A. To make himself available to all the information possible that might assist him in performing that operation.**
Q. In what regard specific to this operation?
**A. There are a lot of things specific to this operation that it might -- you want to know the anatomy of the chest, you want to know the size of the heart, you want to know is there any lung disease that might affect how you might perform the operation. There's really a myriad of things that you want to look at. Could there even, you know, be unknown things you**

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**hadn't thought of, could he have a tumor hypothetically that would say wait a minute, we don't want to do this operation, there's something else going on with this patient. So there's a lot of reasons that you'd want to review those x-rays.**

Q. Would one of the reasons the standard of care would require you to review those preoperative chest films be to determine whether there was atherosclerotic plaque present in the aorta, is that one of the reasons to review the films?

**A. It could possibly be one of the reasons.**

Q. Pursuant to the standard of care is that one of the things that you look for in reviewing the chest films?

**A. I will look for calcifications, but chest x-rays by themselves are not a good marker for determining atherosclerosis of blood vessels.**

Q. All right. Be that as it may, would you have reviewed the chest films of the -- the chest films to determine the condition of the aorta particularly with regard to the presence or absence of atherosclerotic plaque or is that -- are you saying to me look, we just don't look at chest films to determine whether there's plaque present in the aorta because they're not good at depicting it?

**A. No, I look at it to look at the entire picture of the**

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**chest film. If I see significant atherosclerosis then I might change how I might do things, might, but it's not the only reason that I look at a chest x-ray. I look at a chest x-ray for a lot of reasons.**

Q. Thank you. And if I hear you correctly, you're saying to me the chest films are not particularly-good studies to determine whether there is significant atherosclerotic plaque present in the aorta, fair?

**A. Fair.**

Q. Okay. So in this case what studies did you review to determine whether there was significant plaque in the aorta before you did the operation?

**A. I reviewed the transesophageal echo and I reviewed the cardiac catheterization films.**

Q. Did you review any other studies to determine the condition of the aorta prior to performing this operation?

**A. Not that I recall at this time, no.**

Q. Could you explain anatomically where the EndoClamp is inflated when you perform the procedure?

**A. Yeah, the EndoClamp is inflated in the ascending aorta just above the sinotubular junction.**

MR. MEYERS: Read the answer back, please, Beck.

(The following requested portion of the

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record was read by the reporter at 2:52 p.m.:

**A. Yeah, the EndoClamp is inflated in the ascending aorta just above the sinotubular junction.)**

BY MR. MEYERS:

Q. Now, why is the EndoClamp placed in that location?

**A. The EndoClamp is placed in that location because that is where it will occlude the aorta without obstructing the aortic valve, the coronary ostia or the head and neck vessels.**

Q. Thank you. Now, in reviewing the TEE that was performed preoperatively, does the TEE show the ascending aorta in the area of the sinotubular junction?

**A. Yes.**

Q. And is there -- and that TEE was performed on what date, is that the day of the operative procedure itself or was it preoperatively?

**A. There was one performed preoperatively and there was also one performed intraoperatively.**

Q. Have you reviewed the preoperative TEE?

**A. Yes.**

Q. Okay. And is there any indication of atherosclerotic disease in the area where you planned to place the

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EndoClamp?

**A. Not to my knowledge.**

Q. Now, did you review the TEE that was performed preoperatively particularly with regard to -- strike the question.

In advance of the operation did you review the TEE specifically so as to determine whether there was atherosclerotic disease in that area where you intended to place the clamp, was that one of the reasons you reviewed it?

**A. Yes.**

Q. And did you review the TEE on the day of the operation for that reason as well?

**A. Yes.**

Q. And do the cardiac catheterization films also show this area of the aorta?

**A. Yes.**

Q. And did you review them particularly with regard to whether there was the presence of atherosclerotic disease in that location?

**A. One of the reasons, yes.**

Q. And was that required pursuant to the standard of care applicable to you?

**A. Yes.**

Q. And the same question with regard to the review of the

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TEEs that have been performed both preoperatively and intraoperatively, did the standard of care require you to review those images?
**A. Yes.**
Q. Can you explain to me -- well, is there a school of thought within your profession, sir, that CTAs of the vascular tree should be performed preoperatively?
MR. MANION: Object to the form of the question and foundation.
**A. There are some who may hold that to be true, yes.**
BY MR. MEYERS:
Q. Do you have an understanding as to why they would hold that to be true if in fact the TEE can give you good information as to the presence or absence of atherosclerotic disease in the aorta?
MR. MANION: Same objection.
**A. Can you rephrase the question, please?**
BY MR. MEYERS:
Q. Yes. Obviously there's costs associated with performing a CT angiogram, correct?
**A. Yes.**
Q. And obviously there's risks to the patient to performing the CT angiogram, correct?
**A. Yes.**
Q. If there are -- if a -- the performance of a TEE is

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done as a matter of course preoperatively, why would a school of thought hold that a CT angiogram should be done?
MR. MANION: Form and foundation.
**A. Are you asking me to explain the thoughts of others?**
BY MR. MEYERS:
Q. No, I'm asking you to explain your understanding of this school of thought --
MR. MANION: Form --
BY MR. MEYERS:
Q. -- if you have such an understanding?
MR. MANION: Form and foundation.
BY MR. MEYERS:
Q. Would you like me to rephrase the question?
**A. I would, I'm not sure I understand exactly what --**
Q. Okay. School of thought is -- I think you understand what I'm saying, there's a group of surgeons like you who perform these procedures who hold that CT angiograms should be performed in order to evaluate the condition of the aorta, among other vessels, prior to performing this operation, fair?
MR. MANION: Form and foundation.
**A. Are you referring to in 2011 --**
BY MR. MEYERS:
Q. Yes.

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**A. -- or are you referring to today?**
Q. 2011.
**A. Okay.**
MR. MANION: Just to foundation then.
**A. In 2011 there were some who held that -- your schoo of thought, as you mentioned.**
BY MR. MEYERS:
Q. Okay. And did you have that understanding in 2011?
**A. Did I understand in 2011 --**
Q. Did you have an understanding in 2011 that there were those within your field who held that a CT angiogram should be performed to define the vascular tree, including the aorta?
MR. MANION: Foundation.
BY MR. MEYERS:
Q. Did you have such an understanding?
**A. My understanding in 2011, whether that is -- that there were those who were trying to determine if that was or was not an essential part of the operation -- the preoperative evaluation of the operation, excuse me.**
Q. And did you have an understanding in 2011 as to why that was being investigated, if in fact it was true that it was only an investigation stage at that time?
MR. MANION: Foundation.

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**A. Can you rephrase that question again for me, please?**
BY MR. MEYERS:
Q. Why did they investigate this issue?
MR. MANION: Same objection.
**A. I can't -- surgeons are always investigating better ways to be able to determine the right way to do things.**
BY MR. MEYERS:
Q. Well, let me ask you a different question. Had you performed -- had you obtained CT angiograms of the aorta in contemplation of performing this operation prior to the procedure that you performed on Mr. K, had you used that technique to define the vascular tree?
**A. In other people?**
Q. Yes.
**A. Yes.**
Q. And you had done that before 2011?
**A. Yes.**
Q. All right. And so not only was it a school of thought that it could be used to define the vascular tree, it was a technique that you specifically had utilized?
**A. In certain cases, yes.**
Q. Sure. And why did you use that technique in other cases?

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**A. There's probably several reasons that I would have used that, in those indication -- in those patients where I had concerns about the anatomy of the aorta, the size for example, the -- whether there was tortuosity, whether the ileofemoral tree would be suitable for peripheral cannulation, whether there was any evidence of any obstructive disease between the iliac vessels and the aortic valve, any evidence of atherosclerosis that I could not determine otherwise were some of, but not inclusive of all, the possible reasons I could have used that.**

Q. Do you really believe that the TEE goes far enough down the aortic trunk in order to identify calcification in the area where the EndoClamp was going to be employed?

MR. MANION: It's been asked and answered.

**A. And I never stated that. That was not my implication, Mr. Meyers.**

BY MR. MEYERS:

Q. Okay. Well, let me --

**A. We were -- you were asking me about the ascending aorta.**

Q. No, I was asking you --

**A. Relative to that question --**

Q. Hold on, hold, let's make sure that we're clear

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because we don't want to close this record without making sure that we're communicating with one another. And by the way, you understand that if you have uncertainty as to what it is that I'm asking you're entitled to ask for a clarification, correct?

**A. I understand.**

Q. Okay. You're indicating to me that the standard of care applicable to you required you to have some understanding of the condition of the aorta in the area where the EndoClamp was going to be employed, correct?

**A. Yes.**

Q. Okay. And do you agree with me that the TEE does not show that area because the TEE does not go far enough down the aortic trunk in order to identify the area where the clamp would be employed, is that -- do you understand?

**A. I -- no, I don't think we are understanding each other. You'll have to -- do you want me explain or do you -- I'm going to ask you to explain your question again because I think that's the right way to do this here.**

Q. I hear you saying that yes, that the standard of care applicable to me as a surgeon required me to understand the condition of the aorta in the area

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where I was contemplating using the EndoClamp; do I have it right so far?

**A. No.**

Q. Okay. Let me use the alternative then. Is it your position that the standard of care did not require you to evaluate the condition of the aorta in the area where you were going to employ the EndoClamp?

**A. No, that's not what I said either.**

Q. Okay. Then give me your understanding of the standard of care as it applied to your responsibility to evaluate the aorta in the area where you were going to use the EndoClamp?

**A. Would you define for me then what you mean by the area where I am going to use the EndoClamp?**

Q. You described it earlier, you described the ascending aorta and the area of the sinotubular junction?

**A. Okay. Is that the area you're asking me about specifically right now?**

Q. If that's where you planned on deploying the EndoClamp, yes.

**A. Okay.**

Q. If you planned on deploying the EndoClamp at some other location we can talk about that, but maybe we should define it first. Was it your plan to deploy the EndoClamp in the ascending aorta, did you say just

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proximal to the sinotubular junction?

**A. Just above or just proximal to the, yes, sinotubular junction.**

Q. Okay. So let's make sure we have that understanding before we go any further. Before the operation you contemplated deploying the EndoClamp just above the sinotubular junction?

**A. Correct.**

Q. Okay. Now, does the TEE depict that area?

**A. Yes.**

Q. Does it depict that entire area?

**A. Fairly well, yes.**

Q. What is the length of the EndoClamp, what length of the aorta does it -- is it deployed against, are we talking about 1 centimeter, 2 centimeters, whatever measurement you want?

**A. Between 3 and 4 centimeters at most.**

Q. Okay. And --

MR. MANION: Sorry, go ahead. Well, did you just ask when inflated or not?

MR. MEYERS: I meant to ask that.

BY MR. MEYERS:

Q. When inflated, yes, is that how you understood the question?

**A. That's how I understood the question.**

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MR. MANION: Thank you.
MR. MEYERS: Thank you.
BY MR. MEYERS:
Q. And I just want to make sure that I understand it so that we're on the same page. If someone were to say that the TEE does not go far enough down the aortic trunk in order to depict the area just proximal to the sinotubular junction you would disagree with that?
**A. Yes, you're not -- yeah, you're talking about a different area.**
Q. I don't understand.
**A. I'm sure you don't. You're -- the question as you're posing it to me appears to be describing the descending thoracic aorta, which anatomically is totally different than the ascending aorta, so that's where perhaps we're having a -- some confusion as I'm trying to answer your question.**
Q. Just so we're clear on it so we don't get into a definitional battle, why don't you depict the aorta on this piece of paper and show me where you planned on deploying the clamp?
**A. And I assume this will be part of the record?**
Q. It will.
**A. Okay.**
Q. And I have a red pen if that will help you?

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**A. If it will help you, I'll be happy to use it. Perhaps that will help you understand so that we're talking about the same thing.**
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 8
3:08 p.m.
BY MR. MEYERS:
Q. Okay. And what you've indicated on Exhibit 8 in red is a bracketed portion of the descending aorta?
**A. Incorrect.**
Q. Ascending aorta?
**A. Ascending aorta.**
Q. I'll rephrase the question. You have depicted in Exhibit 8 an area of the ascending aorta where the EndoClamp was placed -- or was contemplated to be placed?
**A. That's is correct.**
Q. Okay. And you've drawn some dotted lines across the aorta; is that correct?
**A. That is correct.**
Q. Can you -- the lower one is a completed dotted line, could you make the upper one a complete dotted-in line as well in red?
**A. Sure.**
Q. Thank you.

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**A. I did not make it complete because I did not want to make that the -- confused with what is actually the sinotubular junction, which is the lower dotted line.**
Q. Okay. The lower dotted line is the --
**A. Anatomically the center --**
Q. Okay. You have labeled the lower line the sinotubular junction?
**A. Yes.**
Q. Okay. Now, in performing -- excuse me.
In evaluating the condition of the aorta in advance of the operation do you have any concern about the condition of the aorta in any other location within the thorax?
**A. We may, yes.**
Q. And is significant atherosclerotic disease in other areas of the aorta a risk to the patient -- strike the question.
Is the presence of significant atherosclerotic disease in other areas of the aorta, like areas A, B and C in your rough diagram, of concern as far as the potential for stroke in using the endovascular clamp?
**A. Possibly. And can I let the record reflect that I did not draw in areas A, B and C, Mr. Meyers drew in areas A, B and C?**

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Q. Yes, I did that, yes.
**A. Just to be clear.**
Q. And why would significant atherosclerotic disease in areas other than that depicted where the clamp would be employed pose a risk for stroke?
**A. They may pose a risk for stroke in the passage of the EndoClamp and/or in even retrograde perfusion techniques that are used in these types of procedures that could cause embolization.**
Q. Okay. And does -- did the standard of care applicable to you at the time you performed this operation require you to understand the condition of the aorta from the iliacs up to the heart in contemplation of using the EndoClamp?
**A. I think the standard of care required me to make an evaluation and a judgment whether I felt there was any conditions there that warranted further evaluation.**
Q. All right. Let's limit our discussion now to the presence of significant atherosclerotic disease of the aorta. Did the standard of care applicable to you in advance of this operation require you to understand the condition of the aorta from the standpoint of significant atherosclerotic disease from the area where the EndoClamp would be inserted up to the heart?
MR. MANION: It's been asked and answered.

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**A. I just answered that. My answer stands the same.**
BY MR. MEYERS:
Q. No, you said for other conditions and I want to make sure that we're talking about atherosclerotic disease?
**A. Okay. As well as -- the standard of care would have required me to make an evaluation to determine if I needed to do any further evaluation of that aorta and one of those conditions would be, yes, atherosclerotic disease as well as other conditions.**
Q. Did the standard of care require you to understand whether there was atherosclerotic disease present in the aorta from the area where the clamp would be inserted in the groin up to the heart, just so we can get it on the record?
**A. I just answered that. The standard of care required me to make my best judgment to -- in evaluation of that.**
Q. Okay. Of that geography, if you will?
**A. Of that anatomy.**
Q. Okay. And how did -- and in this case were there any studies that you looked at to understand the condition of the aorta from the iliacs up to the heart other than the TEE and the coronary catheterization?
**A. Nothing specifically, no.**
Q. Okay. And with regard to the TEE, can you draw in a

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dotted line someplace -- well, strike that.
Using Exhibit 8 how far down the aorta would be depicted by the TEE?
**A. Approximately the mid to distal thoracic aorta, descending thoracic aorta.**
Q. And can you depict that with -- could you also draw the iliacs in on the lower aspect of your drawing? Okay. So how far down the aorta would you be able to see in the TEE?
**A. Well, if I can put a black dotted line --**
Q. Sure.
**A. -- there for you?**
**Probably down no more than that level.**
Q. Thank you. And I'm going to label that line D in red. Have I done so?
**A. Yes.**
MR. MANION: Put TEE after it too just so we know that's what the line is about? Thank you.
BY MR. MEYERS:
Q. At Mr. Manion's request I've put a D with a period after it and TEE under the line. Have I done that correctly?
**A. Yes.**
Q. Okay. And now the same question with regard to the coronary catheterization films, how far down the aorta

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would you be able to visualize in the coronary catheterization films?
**A. On the catheterization films we will be able -- if they do an injection of the aortic root we can see the ascending aorta and the -- some delineation of the head and neck vessels and oftentimes they will also do a runoff of the femoral vessels at the end of the catheterization procedure prior to pulling out the catheter and putting some type of occlusion device.**
Q. Let's not talk about theoreticals, let's talk about in this case. Do I understand that you reviewed the coronary catheterization films in order to understand, at least in part, the condition of the aorta with regard to the presence or absence of significant atherosclerotic disease?
**A. Yes.**
Q. Okay. And with regard to what you did in this case how far down the aorta could you visualize?
**A. I could see the iliofemoral vessels.**
Q. Okay. Is that all you --
**A. As well as the ascending aorta, as we mentioned earlier.**
Q. Okay. So you could -- in the -- in the coronary catheterization films you could see everything depicted on Exhibit 8?

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**A. Not everything.**
Q. What could you not see depicted in the coronary catheterization films as far as Exhibit 8 is concerned?
**A. You would have trouble just looking at specifically the abdominal aorta.**
Q. Okay. And that would be, what, everything above the iliacs?
**A. That would be the area above the iliacs and below the dotted line that we put in there, a small area.**
Q. Okay. So I'll draw a dotted line in red.
**A. Your line is a little low.**
Q. Okay. Why don't you draw it?
**A. Why don't I draw it for you?**
Q. All right.
**A. Can I have your red pen?**
Q. Well, let's do it in black now that you want to correct me.
**A. The black line would typically then be the area that we -- and the arrow points down, that we would see from the catheterization.**
Q. Okay. And I'll label that E. Have I done so?
**A. You have.**
Q. As far as the coronary catheterization is concerned then, you cannot visualize the area below line E?

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**A. No, I can --**
Q. Strike the question, let me do it again.
**A. Above.**
Q. Okay. In the coronary catheterization images you contend that in this case you could visualize the aorta below line E?
**A. Yes.**
Q. Okay. And is that something that you were required to do pursuant to the standard of care?
**A. Yes.**
Q. Okay. Now, in the coronary catheterization images was there anything above line E that you could see depicting the condition of the aorta?
**A. I could see the area -- if I may draw a line again?**
Q. Sure.
**A. And how about if I label that line F and another line G. And I can see the area between areas -- between lines F and G. And perhaps it will help a little bit when I draw the line G, we'll make another line here called H because what I meant to include was the ascending aorta and some of the arch of the aorta. The cardiac catheterization will not show me the descending thoracic aorta, which is the area between in this diagram G, H and D.**
Q. But it's your contention that the TEE shows the area

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between lines G, H and D?
**A. The TEE can see this area between G, H and D, yes.**
Q. Okay. How are you able to determine whether there is significant atherosclerotic disease between lines D and E in Exhibit 8 -- I'm going to rephrase the question.
Were there any studies that you reviewed either preoperatively or intraoperatively which displayed the condition of the aorta between lines D and E?
**A. Not to my knowledge.**
Q. Did the standard of care require you to understand the condition of the aorta between those lines?
**A. The standard of care required that I be able to make some reasonable judgment as to what I thought that area of the aorta was like anatomically.**
Q. Why?
**A. Principally to prevent any potential complications from the procedure.**
Q. Specifically?
**A. Dissection, embolization, rupture, bleeding.**
Q. When you talk about embolization are you referring to the breaking off of plaque in the area or are you talking about the formation of blood clots?
**A. No, I'm talking about the breaking off of plaque.**

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Q. Did you understand that when the EndoClamp would be deflated at the end of the case any calcification of the order -- in the aorta below the clamp would have the potential to break loose because of increased pressure in the aorta during the case -- strike the question, I'll start again.
Does the placement of the EndoClamp increase pressure within the aorta after the EndoClamp is deployed?
**A. No.**
Q. How is it thought that the EndoClamp causes the disruption of plaque within the aorta?
**A. I guess I'm going to ask you to be a little more explicit under what circumstances you're referring --**
Q. You're indicating to me as I understand it that part of your job pursuant to the standard of care is to understand the anatomy of the aorta, correct so far?
**A. Yes.**
Q. And your responsibility to do that is -- to have such an understanding is so that you can understand whether there is a risk of plaque rupture in the event that you use this EndoClamp, yes?
**A. One of the reasons, yes.**
Q. Okay. How does the utilization of the EndoClamp have the potential to cause the disruption of plaque

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leading to stroke, what's the mechanism of injury, how does it happen?
**A. Well, it's thought the most primary mechanism of injury is simple mechanical trauma due to passage of the EndoClamp.**
Q. Okay. Are there any other risks associated with the use of the EndoClamp other than the passage of the clamp itself and disruption of the plaque by movement of the clamp and the catheter up through the aorta?
**A. In reference to?**
Q. In reference to disruption of the plaque causing stroke.
**A. Again, I'm going to have to --**
Q. I'm happy to do it, I'm happy to do it.
**A. I'm confused again so --**
Q. I'd much rather you ask for clarification than have a problem later. You're indicating to me that you understood that the risk associated with using the EndoClamp in a calcified aorta is that in the movement of the EndoClamp up the aorta there's a potential to disrupt plaque causing stroke, do I have it so far?
**A. That is one of the potential complications, yes.**
Q. With regard to the complication of stroke caused by the disruption of plaque within the aorta as a result of the utilization of the EndoClamp, are you familiar

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with any other way in which it is thought that the EndoClamp increases the risk of stroke as a result of the disruption of plaque?

**A. As a result of the disruption of plaque other than dissection, no.**

Q. By dissection you mean what?

**A. The passage of the EndoClamp causing a disruption of the inner wall of the aorta and dissection of blood between the layers of the wall that could cause obstruction to vessels and could cause stroke.**

Q. Are you describing that as a second mechanism of disruption of plaque or the only one you're familiar with?

**A. No, as a second method. You asked if that was the only method and I gave you another method.**

Q. So the first method is by simply passing the clamp up the aorta one may disrupt atherosclerotic plaque having the potential to cause stroke, do I have it right so far?

**A. Yes.**

Q. And the second is if the clamp actually causes dissection of the walls of the aorta there's an increased incidence or increased risk of stroke caused by disruption of the plaque in that scenario, yes?

**A. Yes.**

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Q. Are you familiar with any other mechanism by which plaque may come to be disrupted through utilization of the EndoClamp?

**A. During the passage of the clamp?**

Q. At any time.

**A. At any time?**

Q. In the procedure, yes. You're using this EndoClamp and from the time that you begin to use it by the insertion of the clamp into the vascular tree until the time it is removed are there any other times at which there may be disruption of plaque causing stroke?

**A. The answer would be yes, during either the inflation or deflation of the clamp.**

Q. Okay. Is there also a risk of disruption of the plaque when the clamp is being removed, withdrawn?

**A. Potentially, yes.**

Q. And you don't have an understanding that as part of the process of deflation the -- a pressure gradient change within the aorta may cause the disruption of plaque?

MR. MANION: It's been asked and answered. Go ahead.

**A. I'm not aware of that mechanism, no.**

BY MR. MEYERS:

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Q. Would you agree that the distal descending -- excuse me.

Do you agree that the distal ascending aorta is best visualized with a CTA?

**A. Clarify that for me one more time, exactly what area --**

Q. Do you agree that the distal ascending aorta is best visualized with the CTA?

**A. Not necessarily, no, I don't agree with that.**

Q. What's a better way of visualizing the distal ascending aorta other than the CTA?

**A. Transesophageal echo may be able to give you just as good of an evaluation of the inside of the ascending aorta as a CTA in that area.**

Q. Does that complete your answer?

**A. Yes.**

Q. Do you have an opinion as to what the cause of the stroke was in this case?

MR. MANION: It's been asked and answered.

**A. Nope.**

BY MR. MEYERS:

Q. Did you ask any of the neurologists involved what their opinion was?

MR. MANION: That too has been asked and answered.

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MR. MEYERS: I don't mean to be redundant, Paul, I checked the deposition.

MR. MANION: You asked those two specific questions, you already did, but go ahead.

**A. I don't recall specifically asking that question, but that doesn't mean I didn't.**

BY MR. MEYERS:

Q. What did you understand the contraindications to robotically-assisted mitral valve replacement surgery to be in 2011?

**A. I don't mean to take some time here, Mr. Meyers, but, you know, that -- this can be quite lengthy.**

MR. MANION: Take your time and be comprehensive, there's no hurry here.

**A. Well, let's begin with a contraindication may be the patient does not want robotic surgery. Number two, the patient may have concomitant disease where he might need other procedures done other than just mitral valve surgery. The patient may have aortic disease and aortic insufficiency, that would be a contraindication to this technique. The patient may have aortic disease with a severely-dilated aorta where this would not be a suitable technique.**

**The patient may have multiple other comorbidities where this operation in general may not**

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**be suitable for that individual. The patient may have other anatomic variations of the aorta, obstructive disease, occlusive disease, we mentioned atherosclerotic disease, tortuosity, all of which may be relative or absolute contraindications to the procedure. Patients may have abdominal or thoracic aortic aneurysms which may -- for which they should not have the operation. The patient may have a myriad of other medical problems for which maybe they don't need an operation at all.**

BY MR. MEYERS:

Q. I was talking specifically about the robotically-assisted approach as opposed to other approaches. I'm sorry for not being clear on that, so I'll rephrase the question.

What were the contraindications to robotically-assisted minimally-invasive mitral valve surgery as opposed to other approaches?

MR. MANION: Just generally speaking?

BY MR. MEYERS:

Q. Yes, what were the generally-recognized contraindications to robotically-assisted minimally-invasive mitral valve surgery, that is, that particular approach versus others?

**A. And again, Mr. Meyers, I think I just listed those for**

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**you.**

Q. You did, but you included more than -- I just -- if there's -- if you have anything else to add I'll take that answer, but obviously some of your response probably wasn't responsive to that question or maybe it was?

**A. I was trying to -- you know, you were asking I think a very broad and comprehensive question and as best I could I was trying to give a very broad and comprehensive answer for you. It's -- each individual circumstance is taken within its own context and each individual circumstance may have unique situations that may make them not a candidate for a robotic mitral valve approach and an attempt to try to list each and every single one of those unique circumstances is I think by definition probably impossible, if not absurd.**

Q. Well, I certainly don't want to be absurd. Can we talk about it in generalities then, what are the generally-accepted contraindications to robotically-assisted minimally-invasive mitral valve surgery?

**A. And again, I think I tried to give you as best I could a reasonable list just now. My answer is the same.**

Q. Okay. Now, we talked about the studies that were

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available to you preoperatively and intraoperatively to understand the condition of the aorta as far as the presence of atherosclerotic disease, correct?

**A. Yes.**

Q. Okay. What studies have you reviewed that were performed postoperatively, if anything, that tells you about the condition of this man's aorta, and I don't mean -- you don't have to make it up or read too much into it, but if you have reviewed images and you have concluded aha, the condition of the aorta is good, it doesn't have any atherosclerotic disease present and I can see that in this study or that study or this other study, I want to hear it; do you understand the question?

**A. I understand the question and I'm not aware of any specific studies that were done relative to the condition of the aorta.**

Q. Postoperatively?

**A. Postoperatively.**

Q. Okay.

**A. On Mr. K.**

Q. Either directly or indirectly?

**A. Either directly or indirectly.**

Q. Okay. So you didn't review any subsequent TEEs, you didn't review any subsequent coronary catheterization

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films, you didn't review any subsequently-performed chest films or any other study that depicts the condition of the aorta where one could say look, you can see in these studies that there's no atherosclerotic disease present; do I have it right?

**A. Yes.**

MR. MEYERS: Let's take five minutes.

(Recess taken at 3:35 p.m.)

(Back on the record at 3:41 p.m.)

BY MR. MEYERS:

Q. A couple other questions. During the operation are you monitoring the mean arterial pressure of the patient?

**A. Yes.**

Q. And you do that how?

**A. We monitor that with arterial pressure lines.**

Q. And as the surgeon how are you doing it?

**A. It's available for me on the monitor that I could see that's in front of me. There's a monitor provided for me to be able to see.**

Q. Okay. And how low -- a little inartful, let me try and do better.

At what point do you become concerned about a mean arterial pressure that's too low in the performance of this procedure?

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**A. To some extent that depends on the patient.**
Q. Can you talk in general terms?
**A. In general we'd like to see arterial -- mean arterial pressures -- and let me ask you for a clarification. What do you mean by mean arterial pressure, are you talking during the -- while the patient is on cardiopulmonary bypass, are you talking before or after?**
Q. While on bypass.
**A. While on bypass. So you're -- you want to know what the patient's blood pressure is on bypass?**
Q. No, I want you to tell me at what point while the patient is on bypass you become concerned when the mean arterial pressure drops?
**A. I'm sorry, I just was asking for that clarification, is that exactly where you were referring to?**
Q. I think it is, but I'm only the lawyer.
**A. Okay. So if you're referring to the time while the patient is on cardiopulmonary bypass and at what pressures would I be concerned about, generally we're looking for pressures between 60 and 80 as a standard range.**
Q. When the mean arterial pressure drops below 60 do you become concerned about potential for low-flow state?
**A. Potentially.**

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Q. Now, are you also monitoring the patient's hemoglobin and hematocrit during the case while on bypass?
**A. Yes, we are.**
Q. And how do you do that as the surgeon?
**A. The surgeon is doing that relying upon the perfusionist to be monitoring that during the operation.**
Q. Do you ask the perfusionist to report to you when the data becomes available?
**A. I would ask the perfusionist to report that to me if it reached critical levels --**
Q. So --
**A. -- we have --**
Q. You finish. Please, I interrupted you, I apologize.
MR. MANION: Why don't you finish, Dr. Harrington, okay?
**A. Okay. So we have set values that we agree upon, I will set a standard that the perfusionist will report to me for hematocrit, where we reach -- where if we reach a level below that they will report it to me.**
BY MR. MEYERS:
Q. Okay. And what is the set value that you have with the perfusionist?
**A. We generally set a level of hematocrit of 21 while on cardiopulmonary bypass.**

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Q. And so if that -- if the patient's hematocrit drops below 21 you become concerned?
**A. Then we have methods -- we become concerned and we will take methods to correct that.**
Q. Such as?
**A. If possible we'll transfuse the patient, give them blood.**
Q. How -- as the surgeon involved in the case how are you aware when the hemoglobin and hematocrit results become available, are they called out when they become available, explain the room, what's going on in the room or how do you monitor the hemoglobin and hematocrit?
**A. Well, the perfusionist, which is the person who runs the heart/lung machine, will on a regular scheduled basis monitor the hemoglobin and hematocrit as well as other blood chemistries. They have a machine in the room and they can monitor that on a regular scheduled basis if they're required to do.**
Q. And what is the regular scheduled basis?
**A. Usually be every 15, 30 minutes while on bypass.**
Q. Okay. And that's information that you want reported to you when it becomes available?
**A. I want that information reported to me, as I said, we just -- critical levels.**

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Q. Anything -- what do you mean -- and critical would be below 21?
**A. 21, as we just said.**
Q. Okay.
**A. As an example for hematocrit.**
Q. Who makes the decision as to when the patient needs to be transfused with regard to the hematocrit?
**A. As the team leader I'll make the final decision, but it's a decision that we as a team, meaning anesthesiologists, perfusionists, myself, C.R.N.A.s, we'll make that decision together.**
Q. When you say you make the final call, can you explain what you mean?
**A. Well, as the surgeon I may have the ability to override, veto or make a final decision as to whether we do or don't give a blood transfusion as an example.**
Q. You're the guy in charge?
**A. In essence, yes.**
Q. Okay. Have you reviewed the laboratory data for this particular operation with regard to the hemoglobin and hematocrit?
**A. Not specifically, I have not.**
Q. Have you reviewed whether or not the patient was ever transfused during the case?
**A. I don't recall.**



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Q. So if the patient's -- if the patient's hemoglobin was running at 5 during a number of the blood draws and it got up to 6 or 7 but never above 8 during the entire operation would that surprise you?
**A. That would surprise me.**
Q. Why?
**A. Because the -- a hemoglobin of 5 would probably translate into a hematocrit of 15 and if we had a hematocrit of 15 I should have been made aware of that.**
Q. Well, your team members are reporting to you when these readings become available, correct?
**A. Again, they're reporting them to me if they are at critical levels. If they're in acceptable ranges they would not be necessarily reporting them to me.**
Q. And if the patient wasn't transfused during the entire operation with a hemoglobin of 5 for a number of blood draws would that be confusing to you?
**A. Explain confusing.**
Q. Do you want me to redefine what the word confusing means?
**A. No, I want you to -- I guess I don't know what you mean by confusing in this context.**
Q. Go pull the operative report with regard to the hemoglobins that were being obtained during the case?

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Off the record.
(Recess taken at 3:48 p.m.)
(Back on the record at 3:50 p.m.)
(The following requested portion of the record was read by the reporter at 3:50 p.m.:
Q. Go pull the operative report with regard to the hemoglobins that were being obtained during the case?)
MR. MANION: Are you sure you meant the operative report?
MR. MEYERS: I'm sorry, any operative record depicting the hemoglobins during the case.
MR. MANION: Do you have them?
MR. MEYERS: I don't have it with me.
MR. MANION: I have to get the other volume, I didn't bring the other volume.
(Recess taken at 3:50 p.m.)
(Back on the record at 3:58 p.m.)
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 9
3:58 p.m.
BY MR. MEYERS:
Q. What is Exhibit 9?
**A. Exhibit 9 is page 2 of 2 of the perfusion record.**

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MR. MANION: Is that page 1?
**A. That's the checklist.**
BY MR. MEYERS:
Q. Can you show us what page?
**A. This is page -- it says 2 of 2 up on top.**
Q. Can you tell us during what time frame the patient was on a heart/lung machine based upon Exhibit 9?
**A. It appears the patient was on the heart/lung machine from approximately 11:07 until 1305.**
Q. That would be a period of just under three hours?
**A. Just two.**
Q. I apologize, just two hours. May I? And how do you obtain that information from Exhibit Number 9, how do you know when the patient went on the heart/lung and came off?
**A. Looking under the comments and verbal orders it says, and I'm interpreting the -- I'm doing my best to interpret the shorthand, if you will, of the perfusionist's writing. This is not my writing, this is the perfusionist's.**
Q. Yes, sir.
**A. On the first line on this entry it says pre-cardiopulmonary bypass baseline. The next line then says positive CPB, which I assume to mean positive -- that stands for when she initiated**

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**cardiopulmonary bypass because right after that it says cross clamp, which would be her, again, shorthand for the inflation of the EndoClamp in this particular case at 11:13 and then the last item on here is 1305 off CPB.**
Q. Thank you.
**A. Negative CPB, again, interpreting their shorthand. On the top lines up here is what I'm referring to.**
Q. Thank you. Now, it appears, maybe we can read together just to save some time, that between 11:07 and 1305 there were a number of blood draws obtained and a number of hemoglobins obtained, correct?
**A. Correct.**
Q. And at 11:24 it looks like 5.1, 11:32 5.1, 11:51 5.1, 12:00 -- is that 12:40?
**A. I can't see it. I can't tell if that's 12:40 or 12:00.**
Q. And the hemoglobin at that time?
**A. 7.1.**
Q. And then at 12:46 6.48?
**A. 6.8.**
Q. And then at 1315 6.5?
**A. Correct.**
Q. Okay. So during the entire time frame that the patient was on the heart/lung machine -- well, strike

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that, let's make sure we have it right.
From 11:24 up until 11:51 the patient's hemoglobin was reported on three separate occasions as being 5.1, correct?
**A. It would appear that way, yes.**
Q. And that would translate to a hematocrit of what?
**A. Approximately 15 to 16.**
Q. Okay. And then at 12:00 -- if it's 12:40, we'll use that as a -- 7.1 up until 12:46 where it's 6.8; is that right?
**A. Yes.**
Q. Okay.
**A. Yes, that's correct.**
Q. Okay. Now, do you believe you were aware that between 11:24 and 11:51 the patient's hemoglobin was 5.1?
**A. I have no independent recollection of that.**
Q. That wasn't my question. Do you believe you were aware of that given the normal thing -- the way that things normally run?
MR. MANION: Objection to the form of the question.
BY MR. MEYERS:
Q. Given the fact that you're in charge, as you previously testified to?
**A. I believe that if it were made aware to me I would**

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**remember that.**
Q. Well, you're expecting to be made aware of it every 15 minutes, as you've indicated, correct?
**A. I'm expecting to be made aware when there are critical values.**
Q. You say this person is -- how did you define this person that's making these recordings?
**A. That person is a perfusionist.**
Q. The perfusionist is acting as your eyes and ears with regard to the monitoring of this data, correct?
**A. That would be correct.**
Q. Is there -- where would the indication be on this record or in some other record if the patient was transfused during the operation?
**A. My understanding would be that if the patient were transfused it would be on this record.**
Q. On Exhibit Number --
**A. Exhibit labeled 9.**
MR. MEYERS: Paul, may I see that?
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 10
4:06 p.m.
BY MR. MEYERS:
Q. Doctor, you were looking also at the piece of paper that I'm holding up now, I'll mark it as Exhibit

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Number 10. What is Exhibit 10 just so we know what it is?
**A. Exhibit 10 is labeled cardiopulmonary bypass autologous blood salvage.**
Q. Okay. Now, this document, the cardio bypass -- cardiopulmonary bypass record, indicates it's page 2 of 2. Do you know where page 1 of 2 would be?
**A. I do not.**
MR. MANION: Object to foundation.
BY MR. MEYERS:
Q. Do you mind looking at the records?
**A. I've looked at the record and I'm not sure which -- there are several pages that are labeled page 1, but I don't see one labeled page 1 of 2.**
Q. Do you see another cardiopulmonary bypass record?
MR. MANION: We have a section here that we've looked at of the hospital records. There -- might be my fault, there are three volumes here. I'm looking in the area that I think is most resourceful and we don't seem to find a page 1 of 2. Again, it's not to mean it's not here somewhere, but --
BY MR. MEYERS:
Q. Okay. You're not able to locate another page 1 of 2 that would correspond to what we've marked as Exhibit Number 9, are you, Doctor?

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**A. I am not.**
Q. Okay. What is this document?
MR. MANION: That's not labeled.
**A. It's labeled 1 of 4.**
BY MR. MEYERS:
Q. Just a couple more questions about Exhibit Number 9. Could you read the mean arterial pressure that was present on 11:09, please?
**A. It appears that one of the entries says 55, but I can't read the -- can't make out the number before that. There are two numbers under that heading.**
Q. Right. There are -- do you know why there are two columns?
**A. It looks like left and --**
Q. Left and right what?
**A. Left and right arterial lines.**
Q. Thank you. And then the same question with regard to -- and I circled the time at 11:07 in red and I similarly circled the time at 11:30 in red. What's the mean arterial pressure at 11:30?
**A. It looks like left says 55 and right says 51.**
Q. Okay. And so looking at this record we know that at 11:30 if the patient's mean arterial pressure was between 55 and 51 and this was a time when the patient's hemoglobin was 5.1, can we agree that the

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patient would be at risk for stroke during that time frame?
**A. I think we can agree that he potentially would be at risk for hypoxic injury.**
Q. Now, at the bottom of -- first of all, are you familiar with this form, Exhibit Number 9?
**A. I'm familiar with it, it's not something that I routinely analyze or get opportunity to look at.**
Q. No problem. But during the operation you're familiar with the form to the extent you see that folks are filling it out?
**A. The short answer is yes.**
Q. Okay. Because at the bottom of the page it says transfusion, colon, record blood unit number and time given comments. Have I read that correctly?
**A. You have read that correctly.**
Q. Okay. And it looks to me like -- well, did the patient receive blood at 1350 based upon this record and at 1411 or am I misinterpreting that?
**A. I'm not able to interpret that. I can't make any judgment.**
Q. Well, if you wanted to figure out if your patient was transfused during the operation or at the conclusion of the operation you performed, what specific document would you want to look at?

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**A. I'll -- state your question again, please?**
Q. If you as the surgeon wanted to retrospectively look to determine whether the patient was transfused at any time during the operation or immediately thereafter what documents would you attempt to review?
**A. It would be several documents that I would review with that respect to that -- could review with respect to that.**
Q. And they are?
**A. Well, there would be transfusion records if the patient received blood from the blood bank that would have to be recorded. If it was given by anesthesia they would record it in their anesthetic record. If it was given by perfusion while the patient was on the heart/lung machine it would be recorded in the perfusion record. If it was given after surgery in the intensive-care unit or some time in the postoperative phase it would be recorded appropriately in the nursing notes and nursing records.**
Q. Do you recognize the name of this person I've circled down at the bottom of the page, it looks like Lynn Flores perhaps, do you recognize that person?
**A. Yes, I do.**
Q. Who is she?
**A. She was a perfusionist that was working for us at that time.**

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Q. And does she continue to work with you today?
**A. No, she does not.**
Q. Do you know where she works today?
**A. I believe she's on the west coast somewhere, I don't know exactly where.**
Q. When you say worked for us, who was she specifically employed by?
**A. She was specifically employed by Specialty Care and the hospital contracted with Specialty Care as a perfusion service to provide our perfusion services.**
Q. Okay. At 11:51 the patient's oxygen saturation level was noted to be 75; is that correct?
**A. That appears to be correct.**
Q. Do you have an explanation of that?
**A. I do not.**
Q. What are the possible causes of the patient's oxygen saturation level dropping to 75 during the case?
**A. I have no idea.**
Q. Well, during -- while the patient is on the heart/lung machine what are -- what causes the patient's oxygen saturation to fall, if anything, based upon your knowledge?
**A. In this particular case or in general?**
Q. Well, we can cut to the chase. In this case what --

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**A. I don't know, I have no idea.**
Q. All right. Then in general of all the patients on the heart/lung machine why would a patient's oxygen saturation --
**A. There could be a lot of reasons.**
Q. Such as?
**A. Oxygenated failure.**
Q. Others?
**A. Low flow.**
Q. Do you know what base excess is?
**A. Yes.**
Q. What is base excess?
**A. Base excess refers to the level of carbon dioxide in the blood, bicarb.**
Q. And do you have an explanation for why the patient's base excess is as high as 8 at 1315?
**A. I do not.**
Q. Can you give me a list of possibilities?
**A. Not really here, no, I can't.**
Q. Doesn't that suggest that the patient was deprived of oxygen for a significant period of time?
MR. MANION: Object --
BY MR. MEYERS:
Q. A base excess of 8?
**A. Not necessarily to me. I have no idea what this**

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means.
Q. You don't have any idea based -- strike the question.
You don't have any idea what it means for a patient to have a base excess of 8 contextually while the patient is on the heart/lung machine, such that I go out now and I ask another surgeon who does this operation, Doctor, what does a base excess of 8 suggest to you while the patient is on the heart/lung machine, you wouldn't expect one other of your colleagues, a general -- that does the operation you do to know the answer to that question?
MR. MANION: Object to foundation.
You can go ahead.
**A. I wouldn't expect him to be able to come up with a specific answer, no.**
BY MR. MEYERS:
Q. Would you expect him to be able to give a list of possibilities?
**A. Yeah --**
MR. MANION: Same objection.
**A. -- I would expect that.**
BY MR. MEYERS:
Q. Well, I'll take them from you then, what are the list of possibilities as to why the patient would have a base excess of 8?

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**A. It may refer to, you know, the way the oxygenator and the heart/lung machine is set up. You know, one of the purposes of that is to remove carbon dioxide and -- as with a supply oxygen and there's a technique they call using a sweep with the -- how they filter oxygen and carbon dioxide through the heart/lung machine.**
**They may have been making adjustments to that, there may have been a failure in that system and then you get into all kinds of scenarios that you could propose where there were poor perfusion, acid-based derangements, things that were given to the patient at the time. Again, there's a pretty long list of things that you could come up with.**
Q. Thank you and I thank you again for your patience. I'm circling an asterisk on the left-hand margin at 11:24 and then there's a note which states redraw with an arrow, drop in CO2 on field from 8 to 6. Can you explain what that note means to you?
**A. What I think that means is that they were concerned about having to -- when we do the operation, if you recall, we talked about infusing carbon dioxide into the operative field to help displace atmospheric -- atmospheric to prevent embolization and if we're running high levels then that's being sucked up into**

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**the heart/lung machine through vents that are placed in that -- that are sucking up blood and so forth that may be in the chambers so that we can see it absorb some of that CO2, and if the perfusionist notes that there's a high level they may ask us to decrease the amount of CO2 that we're insufflating into the cavity.**
Q. Okay. I've also circled the name of the perfusionist, can you read that name?
**A. No, I can't.**
Q. When you said that Ms. Flores was someplace on the west coast, do you know if she's working in a hospital or how Mr. Manion would go about finding her or I would go about finding her?
**A. The best way I could think of would to be contact her employer at that time and see if she -- they have any idea where she's at. I don't have any personal knowledge, no.**
Q. Okay. What's your knowledge that she went out to the west coast, how did you get that knowledge?
**A. I know when she left our institution that's where she said she was going.**
Q. West coast being California or --
**A. To the best of my knowledge she said somewhere in the San Francisco area, but I have no idea where.**
MR. MEYERS: Okay. All right. I have no

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further questions at this time.
MR. MANION: No questions.
(The deposition was concluded at 4:24 p.m. Signature of the witness was not requested by counsel for the respective parties hereto.)

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CERTIFICATE OF NOTARY

STATE OF MICHIGAN )
) SS
COUNTY OF OAKLAND )

I, BECKY JOHNSON, certify that this deposition was taken before me on the date hereinbefore set forth; that the foregoing questions and answers were recorded by me stenographically and reduced to computer transcription; that this is a true, full and correct transcript of my stenographic notes so taken; and that I am not related to, nor of counsel to, either party nor interested in the event of this cause.



BECKY JOHNSON, CSR-9395
Notary Public,
Oakland County, Michigan
My Commission expires: January 28, 2019

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# KOSTADINOVSKI, ET AL. v. HARRINGTON, M.D., ET AL.

## LYNN MASINICK

December 17, 2015

*Prepared for you by*

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LYNN MASINICK
December 17, 2015



STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF MACOMB

DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI, as Husband and Wife,
Plaintiffs,
vs.
STEVEN D. HARRINGTON, M.D. and ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.,
Defendants.

) No. 14-2247-NH

DEPOSITION OF LYNN MASINICK, taken on behalf of the Plaintiffs, at 2900 Adams Street, Suite C-130, Riverside, California, commencing at 7:57 a.m., Thursday, December 17, 2015, before ZINA TALLANT, Certified Shorthand Reporter No. 13341.



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RIVERSIDE, CALIFORNIA, THURSDAY, DECEMBER 17, 2015
7:57 A.M.

(The oath was administered to the deponent, LYNN MASINICK, as follows:)

THE REPORTER: Do you solemnly state that the testimony you are about to give in this matter shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: Yes.

THE REPORTER: Thank you.

MR. MANION: You're going to have to keep your voice up so everybody can hear.

THE WITNESS: Okay.

EXAMINATION

BY MR. MEYERS:

Q Would you say your full name for the record.

A **Lynn Kathleen Masinick.**

MR. MEYERS: And the record should reflect this is the deposition of Ms. Masinick, taken pursuant to notice, and used for all purposes contemplated by our Michigan court rules.

BY MR. MEYERS:

Q Good morning.

A **Good morning.**

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Q A few basics before we get into the substance. What is your residential address?
A 4653 Temescal, T-e-m-e-s-c-a-l, Canyon Road, 101, Corona, California 92883.
Q And your date of birth?
A 12/1/59.
Q And are you employed at the present time?
A Yes.
Q Where are you employed?
A I'm employed with SpecialtyCare.
Q In what capacity?
A As a clinical perfusionist.
Q And how long have you been employed with SpecialtyCare as a clinical perfusionist?
A 35 years.
Q Would you describe your educational background?
A Educational background. I hired on with -- it was initially called Perfusion Services, Incorporated. They trained me on the job, and I grandfathered in to sit for the written and oral exam for certifying myself in perfusion, and passed the exams, and have been certified ever since.
Q Thank you. Did you graduate from high school?
A Yes.

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Q In what year?
A '78.
Q In what year did you go to work for Perfusion Services?
A 18980.
Q And you have been continuously employed as a perfusionist since that time?
A Yes.
Q Now, you said you became ultimately certified as a perfusionist at some point in time?
A Yes. It was roughly two and a half year training on the job and then certified myself.
Q And what year was that that you became certified?
A I'm not exact on that. But I would think, doing the math, about '83 -- 1983/1984.
Q Did you have to sit for any type of examination?
A Yes.
Q And did you pass the examination the first time that you took it?
A Yes.
MR. MEYERS: One moment, please. I'll be back in just a minute.
I have returned.

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BY MR. MEYERS:
Q In the summer 2011 time frame, who was your employer?
A SpecialtyCare.
Q And where were you working during that time frame?
A Henry Ford Macomb Hospital and Crittenton Hospital, both in Michigan.
Q And how long was it that you had worked at Henry Ford Macomb as a Perfusionist for SpecialtyCare as of December 2011?
A Oh, I think it -- I'm not exactly sure, but at least five years.
Q And during that same period you were also working as a perfusionist for SpecialtyCare at Crittenton?
A Correct.
Q How long had you been at Crittenton, approximately?
A Probably one year.
Q And in the -- what materials have you reviewed in preparation for this deposition?
A I have reviewed the patient's chart and the perfusion record.
Q And as far as the patient perfusion records

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are concerned --
MR. MEYERS: And, Paul, you can help the witness with this.
BY MR. MEYERS:
Q -- were those records previously marked as Dr. Harrington Exhibits 9 and 10?
MR. MANION: She doesn't have them as marked in front of her, but she does have an unmarked copy of the perfusion record in front of her.
MR. MEYERS: How many pages?
MR. MANION: She has three pages in front of her.
MR. MEYERS: Paul, would you write this phone number down, and I'll ask if the court reporter there can fax them to my office so we're looking at the same exact pages that she's looking at. My fax number is (313) 961-8178.
MR. MANION: Sure. We'll do it right now.
MR. MEYERS: Off the record for a moment.
MR. MANION: Sure.
(Break in the proceedings.)
BY MR. MEYERS:
Q In the 2011 time frame, how many hours were you working a week, approximately?
A 25 to 30.

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Q Did you have any other jobs other than working as a perfusionist?
A No.
Q And what percentage of your time would have been spent at Henry Ford versus Crittenton?
A 90 percent.
Q 90 percent at Ford?
A Yes.
Q And you told me that you had reviewed Mr. K's medical record and the perfusion records after having had an opportunity -- well, how much time do you think you've spent reviewing the records in this case?
A An hour.
Q And have you had an opportunity to discuss the case with Mr. Manion?
A Yes.
Q And when did you -- how much time have you spent discussing the case with Mr. Manion?
A 30 minutes.
Q And when was that?
A Yesterday.
Q Thank you. And after reviewing the medical records and discussing the case with Mr. Manion, do you have any memory of this case --
A No.

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Q -- or this procedure?
A No.
Q Now, as a perfusionist, what types of operations would you be involved in?
A Any operation that required the heart/lung machine that doctors -- the surgeons at the hospital would schedule. We are a contract company, so we covered any cases they asked us to cover.
Q Give me examples of operations that you would be involved in.
A Coronary artery bypass grafts, aortic valve replacements, mitral valve replacements, robotic mitral valve replacements, and any combination of those.
Q Had you been involved in operations before December the 14th, 2011, with Dr. Harrington?
A Yes.
Q How much -- and I'm not asking for an exact number. But can you give me a sense of the numbers of times that you have been in operations with Dr. Harrington?
A I would say 250 plus.
Q 250 plus?
A Yes.
Q And that would have been before December 2011?
A No. Just in the -- my history with him

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working with him.
Q When did you leave Michigan?
A I left Michigan in 2014 August.
Q So can you give me a sense as to the number of operations -- I know it's an estimate -- that you would have been involved with Dr. Harrington prior to December 14, 2011?
A It's very hard, but -- I'm just going to have to guess -- I would say, like I said, 250 plus.
Q You started -- you said you estimated that you started working at Henry Ford Macomb about five years prior to December 2011?
A Correct.
Q That would take us back to sometime in 2006, yes?
A Yes.
Q And you worked there until 2014?
A Yes.
Q So in the five years -- are you saying that you would have done about 50 cases a year with Dr. Harrington up until December of 2011?
A Yes, and that's conservative. Probably it's more, but I don't have a number.
Q Do you think there's a fair estimate, though?
A Yes.

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Q Thank you.
Now, I would like you to explain your role in a -- first of all, what was the type of operation that was being performed in this case?
A A robotic mitral valve repair.
Q And what would your role have been in this operation? Be as specific as you can.
A As a perfusionist, we prepare the heart/lung machine. Dr. Harrington hooks the patient up to the heart/lung machine, and we take the place of the heart and lungs so he can stop the heart and work on the heart.
Q And what is your job? What do you do during the operation after the heart/lung machine is hooked up? What is your responsibility?
A We maintain all parameters for the patient until we come off bypass. We maintain flow.
Q Go ahead.
A We maintain blood flow. We maintain all the different parameters that are watched for. Adequate perfusion to the patient.
Q Do you have an understanding that during the operation, as you maintain all of those parameters for the patient, you're acting as Dr. Harrington's eyes and ears?

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A Yes.
MR. MEYERS: Let me go look at the fax machine. Off the record.
(Break in the proceedings.)
MR. MEYERS: Back on the record.
So I just received some records by facsimile, and I would like our court reporter to mark "Cardiopulmonary Bypass Record," page 1 of 4 as Exhibit Number 1.
THE REPORTER: Okay.
MR. MEYERS: Page -- the second page labeled up at the top, "Cardiopulmonary Bypass Record," it says, "2 of 2" --
MR. MANION: Got it.
MR. MEYERS: -- as Exhibit 2.
MR. MANION: Yes.
MR. MEYERS: The third page entitled, "Cardiopulmonary Bypass Record, Autologous Blood Salvage," as --
MR. MANION: Got it. They are all marked.
(Plaintiffs' Exhibits 1, 2, and 3 were marked for identification by the Reporter and are attached hereto.)
BY MR. MEYERS:
Q Now, ma'am, what are these three exhibits,

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please?
A Pardon me?
MR. MANION: His question is --
BY MR. MEYERS:
Q Are these three exhibits the perfusion records that you referred to earlier?
A Correct.
Q Is there anything else that should be part of the perfusion record that you have not been able to locate?
A No.
Q And let's go through Exhibit Number 1. Does your handwriting appear on the exhibit?
A Yes.
Q And where does your handwriting -- is the entire page yours?
A Yes.
Q I'll ask you the same question. Are all the entries on Exhibit 2 yours?
A Yes.
Q And same question for Exhibit 3. Are all the entries on that page yours?
A Yes.
Q Let's start with Exhibit 1 for a moment. Could you read in the entry under "Patient History and

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Diagnosis," please.
A He wants me to read it?
MS. FAULKNER: Uh-huh.
BY MR. MEYERS:
Q Read it into the record, and try and keep a normal conversational pace. That will make the court reporter's job easier.
A Okay. "Severe MR," mitral regurgitation, "increased shortness of breath, known mitral valve prolapse. Non-insulin dependent diabetes melitis. Hypertension, HLD, GERD."
Q What is HLD?
A High cholesterol.
Q Go ahead.
A "GERD, ejection fraction, 35 to 40 percent. Left ventricular and diastolic pressure 40. No -- zero coronary artery disease. Prolapse of the anterior leaflet. Severe mitral regurgitation. Mild tricuspid regurgitation, and a second EF of 60 to 65 percent."
Q And the entry under "Procedure"?
A It's RASTMVR, which stands for robotic assisted mitral valve repair.
Q Thank you. Go ahead and read entry -- the next area under "Equipment and Disposable Supplies." First of all, the kit number.

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A The Terumo oxygenator -- or under "Oxygenator" is "Terumo." Product RX25. All of these come in one kit, that's why I have the Terumo -- the marks under "Tubing Pack, Cardioplegia."
Q What's the entry under -- next in the line labeled "Tubing Pack."
A Oh, that is "X coating." Just specifying what type of tubing we use.
Q Thank you. And there's two numbers there that have arrows.
A Right. The top one is -- identifies the lot number of that total kit, and the bottom identifies the serial number of the oxygenator itself, so --
Q Read the numbers into the record.
A The kit number NG27. The serial number 515651K.
Q Thank you. The next line under "Cardioplegia."
A Cardioplegia is also Terumo. Conducer, same lot NG27.
Q Go down to the next line.
A "ALF," arterial line filter, Terumo. Capiox is the product.
Q Spell it.
A C-a-p-i-o-x.

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Q Thank you. And the lot number.
A The lot number 110108.
Q Go ahead.
A Next is ATS, which is page number 3 that we have marked. The numbers are on that page referencing the item number and lot number and expiration.
Q Thank you.
A The next line is UF device by Minntech.
Q Spell it for our court reporter.
A M-i-n-n-t-e-c-h.
Q Thank you.
A Product number HPH 1000 TS. Lot number 675844.
Q Thank you. The next line.
A Arterial cannula. Manufacturer, Edwards. Product number ER23. Lot number 831302.
Q Continue, please.
A Venous cannula, Edwards, QD25. Lot number 588336- and I think that's a -20. It's kind of light on this copy.
Q Thank you. Next line.
A Arterial pump, Terumo. System 1. ATS equipment, Cobe. Brat II, which was SC2418.
Q All right. Let's go through that line. ATS Equipment, Cobe. Is that C-o-b-e?

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A Oh, yes.
Q The next line under "Product, Brat II"?
A Correct.
Q B-r-a-t?
A B-r-a-t.
Q And the SB24- -- and I can't read the rest.
A SB2418.
Q Thank you. Next line.
A Heater/cooler. That's Medtronic, Medt. Bio CAL is the product machine.
Q Bio space A-L?
A C-A-L, yes.
Q Thank you. Is that -- under "heparin."
A Heparin at 1027 and 1049.
Q Does that mean you gave the patient heparin at 1027 and at 1049?
A Yes.
Q Next entry.
A Initial dose, 21,000 units.
Q I missed that. Where is that?
A I'm in -- oh, I'm sorry. Base ACT 138 seconds.
Q Second entry is, "Initial Dose, 21,000 units"?
A Yes.
Q Then "Additional 5,000 units"?

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A Yes.
Q The total is 26,000 units?
A Yes.
Q That's referring to the heparin that was administered?
A Yes.
Q The next entry, is that "Protamine"?
A Correct.
Q P-r-o-t-a-m-i-n-e at 1336?
A Yes.
Q That means you gave Protamine at 1336?
A Yes.
Q You gave a total dose of 250 milligrams?
A Yes.
Q And it says, "Post ACT." What does that mean?
A After Protamine is administered, we want to reverse our clotting, our anticoagulation, so we're going -- we're shooting for the base ACT at 138. We ended up with a post ACT of 114, indicating we reversed the heparin.
Q Thank you. And that's -- there are some timing entries to the right of the heparin and Protamine entries.
What do those refer to?
A The plus CPB is cardiopulmonary bypass. We --

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time, at 1104 went on bypass. And then the minus CPB, 1325, we came off bypass. Total was 141 minutes. Next line is "plus X clamp," 1113 is when the endoclamp was applied, and then minus X clamp at 1252 is when it was deflated.
Q What does the X clamp at 1113 represent?
A When we inflated the endoballoon to stop blood going into the heart.
Q Minus X clamp at 1252?
A Correct.
Q That means it was deflated at that time?
A Correct.
Q Now, next to the X clamp on that same row there's an entry to the right of it.
What is that entry?
A That's 98 minutes for the X clamp.
Q Thank you.
And then the handwritten entries are a little difficult to read above the 98.
What are those --
A That was the 114. I can see I did a cross-out and did my initials and then I put 141.
Q That's the number of minutes the patient is on bypass?
A Yes.

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Q Now, under "Pump Volume" there are some entries for crystalloid, mannitol, bicarbonate, heparin, et cetera.
Are there times that are noted -- that correspond to those entries?
A On page number 2 there are some that were on the chart. Others are not specifically put down. The prime is always when we initiated and went on CPB. That's what the patient sought -- you know, got.
Q All right. I'm trying to save us time, but maybe by trying to save it I'm actually taking longer. Just walk us through each entry and tell us what it means.
MR. MANION: We didn't get that. Can you restate it, please.
MR. MEYERS: Yeah. I'm just trying to save time, but maybe it's more efficient just to have her walk through --
BY MR. MEYERS:
Q So the crystalloid entry, read it into the record, and then skip down to mannitol, bicarbonate. Walk through them.
A I didn't understand what you said.
MR. MANION: Just a second, please. We're going to try and turn you up.

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MR. MEYERS: Is that better?
MR. MANION: Much better.
BY MR. MEYERS:
Q Okay. There's an entry for crystalloid, and then it says prime 1400.
What does that mean?
A That means what I primed my circuit with prior to bypass, and that's how much it took to deair and get the circuit primed and ready for surgery.
Q And what does the 500 entry mean?
A That's once we were on bypass, that was added during the case, during the bypass run.
Q There was 500, what, cc's of crystalloid added during the bypass?
A Yes.
Q Next entry for mannitol, just explain the entries and go through that same process.
A Okay. Mannitol, there was 50 mls in my prime, and then on bypass there was another 50 added.
Q Continue.
A And then bicarbonate, same, 50 in my prime. 50 was added during bypass. Heparin, 5 was in my prime. Nothing was added on bypass. Cardioplegia, nothing in the prime. Zero in the prime, but 2,000 was added on bypass.

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Q What would the purpose of the cardioplegia be, the 2,000?
A Pardon me?
MR. MANION: Could you --
BY MR. MEYERS:
Q How was the cardioplegia provided?
A How is it --
Q Go ahead.
A Cardioplegia is administered after the X clamp to stop the heart.
Q Thank you. Next entry.
A Albumin, 50 was in my prime. On bypass 250 was added.
Q Thank you. Next entry.
A Amicar, 20 in my prime. On bypass 40 added.
Q Amicar is A-m-i-c-o-r?
A -- c-a-r.
Q Thank you. And then sodium chloride, the NaCl, was 2,000?
A Correct. Added on bypass.
Q And why was -- what would the purpose of the sodium chloride have been?
A With the type of cardioplegia that we utilize, we need to go ahead and buffer the patient to pull off some of the electrolytes that get disturbed or changed

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during the cardioplegia delivery. So it's normal practice to go ahead and -- you zero balance a patient with this sodium chloride.
Q Thank you for the explanation.
The next entry.
A That is our retrograde autologous prime, which is 500 that we took off of our prime prior to going on bypass.
Q Next entry.
A Residual, 200 in my circuit that ended up just being in the garbage then. CPB urine on bypass was 100, and ultrafiltration was 5,400.
Q And what does the total represent, the 6,200?
A That's minus fluids from the fluid balance of the patient when we were on bypass. That's our negative.
Q And the total positive was what?
A Total positive was 1,570 -- let's see -- 1,075 plus 5,400, which was at 6,975.
Q Okay. So it's actually 1,575 plus 5,400?
A Yes.
Q Thank you. And you did some math over in the left-hand column.
What does that represent?
A That's -- see how I have the 6,975 as my

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total. And then I minused the 62 that was taken off of the patient, or the negative, and ended up with a balance of plus -- I can't read my math now. What is that -- plus 775.
Q Thank you. Go ahead down at the -- let's see. You've read those entries in already.
Is that -- is the surgeon's signature there?
A Yes.
Q And then the anesthesiologist's signature or the CRNA's signature?
A Yes.
Q And then your signature?
A Yes.
Q And there's a perfusion assistant signature?
A Yes.
Q Who is the perfusion assistant in this case?
A See Vang.
Q Spell it for the court reporter.
A I'm not sure on the first name. I think it's S-e-e. Last name, V-a-n-g.
Q Thank you.
What would the perfusion assistant's job have been during the case?
A Assisting me as a second set of eyes, a second pair of hands.

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Q I want you to go to Exhibit 2, please.
A All right.
Q My copy is poor, so I'm going to ask -- unfortunately, we have to go through these -- many of these entries. Let's start with 1003 and just -- I believe it's 1003 -- and read across that row, please, each of the entries.
A Okay. Under 1003, MAP for left side was 119 over 56. Right side 116 over 53. CVP 12. Temperature bladder 36. Pre-bypass urine -- my copy is bad also -- 125, I think it says. And pre-CPB/baseline is just our -- identifying what the pressures were at baseline prior to bypass.
Q What the patient's blood pressure was?
A Correct.
Q Thank you. The next entry, 1107. Go through the same process.
A 1107, left side pressure 54, right 55. Let's see. What is this? Root pressure 80. CVP 7. Line pressure 171. RPMs 2850. Blood flow 4.4. FIO2 100. Gas flow 4.0. Blank anesthesia gas. Let's see, the SVO2 79. Arterial blood temperature 32.9. Venous temperature 33- -- it's hard to read too -- 33.3. Bladder temperature 34.9. Vacuum minus 21. Blank for balloon. Blank for urine. S indicating surgeon

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directed, and then plus CPB 1104.
Q What does that mean?
A That means we went on bypass at 1101, as indicated on page 1.
Q Thank you.
A And then cross X clamp at 1113.
Q Go to 1115 -- the next entry is 1115?
A 66 for the left side. Right side 62. Root pressure 59. CVP 1. Line pressure 203. RPMs 20- -- that's a hard one to read too -- 2750. Blood flow 3.71. FIO2 60. Gas flow 2.25. Anesthesia gas 1.5. Venous saturation 80. SVO2 is 80. Arterial blood temp 32. Venous blood temp 32.3. Bladder 34.2. Out next entry is our vacuum at minus 35. Balloon pressure 318. Urine 20. S, and then that next entry is hard to read. It's indicating 1113, but I can't read -- but that's the cross clamp -- is when the cross clamp went on, so I'm going to have to guess that that's what I --
MS. FAULKNER: Don't guess.
THE WITNESS: I don't know what that's saying at 1113.
BY MR. MEYERS:
Q Does it look like something buffer, 2 buff.
A Okay. Yes. Z-buff, and that is the terminology we use for zero balancing ultrafiltration,

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and that's also started at 1113.
Q Thank you so much. And then the entries at 1130.
A Left side 55. Right MAP 51. Zero root pressure. CVP 5. Line pressure 247. RPMs 3,050. Blood flow 3.61 liters. FIO2 60. Gas flow 4.5 liters. Anesthesia gas zero. Venus saturation 83. Arterial blood temp 30.1. Bladder temp 34.1. Vacuum minus 30. Balloon pressure 304. Urine output continued to the next line showing an arrow and asks me for surgical surgeon preference, and my status just saying hemoconcentrator to --
Q Wait. Slow down. Go ahead. Read that slowly next to "Status," please.
A Hemoconcentrator with an arrow saying vacuum. So vacuum was applied to my hemoconcentrator to increase the amount of volume we can -- we can hemoconcentrate off. And then sweep was increased up to 6 liters.
Q Thank you. Next entry.
A 1145, left MAP was 69. Right MAP 64. Root pressure zero. CVP 3. Line pressure 239. RPMs 3,050. Blood flow 3.60. FIO2 60. Gas flow 6.0. Anesthesia gas 1.5. Venous saturation 86. Blood flow 30.0 -- I'm sorry. Arterial temp 30.0. Venous 30.1. Bladder 32.5. Vacuum minus 30. Balloon pressure 349. Urine 30, and

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that was also surgeon directed.
Q Could you actually read that entry in, please.
The next to --
A Status, at that time, or my parameters I just -- I charted, and then I noted sweep, arrow up, meaning increase to nine.
Q What does that mean?
A Under gas -- under our gas flow, that is also referred to as our sweep gas. And I see that at that point, at 1145, I increased my sweep to nine.
Q Why would you have done that?
A Based on my blood gas results.
Q Explain.
A Blood gas results -- so that was at 1145. Once we went on bypass, my first blood gas came back at -- we got -- once we were on pump came back at 1124, and it showed that we had a high PCO2, which by increasing my gas flow/sweep gas will decrease that value.
Q What was the PCO2 at 1124?
A 71.
Q Thank you. And you're reading from down below in the chart which we'll get to?
A Yes.
Q Go to 12 o'clock. The next entry up at the

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top of the page.
A Left arterial pressure was 64. Right is 60. Root pressure is zero. CVP 5. Line pressure 2- -- I can't read the center -- the middle number.
MS. FAULKNER: Don't guess.
THE WITNESS: I don't know -- 2 something.
BY MR. MEYERS:
Q 287 or 257?
A 257. RPMs 3,660. Blood flow 3.46. FIO2 60. Gas flow 9.0. Anesthesia gas 1.0. Venous saturation 86. Temperature -- arterial temperature 30. Venous temperature 30.1. Bladder temperature 32.2. Vacuum minus 35. Balloon pressure 331. Arrow indicating urine output is continuing. Next is surgeon directed, and then status with a slash indicating we started to rewarm the patient at 1210, and then slash Z-buff 500 mls were taken off.
Q Thank you. Explain those entries, the significance of rewarming the patient at 1210.
A Yes. Initially when we initiate bypass, we decrease the patient's temperature. And then when -- when requested by the surgeon, he will tell us when he would like us to start to rewarm the patient back to 36 degrees.
Q Thank you. And then Z-buff entry, what is the

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significance of that?
A That is indicating how much of my ultrafiltration I have taken off the patient so far.
Q Thank you. The entry at 1215.
A Left 63. Right mean 60. Root pressure zero. CVP 3. Line pressure 342. RPMs -- can't read that one.
Q 300?
A No, it's 3,000-something.
Q Okay.
A Blood flow 3.47. FIO2 60. Gas flow 9. Anesthesia gas 1.5. Venous saturation 85. Arterial blood temp 34.1. Venous blood temp 33- -- I can't read that. Bladder temp 31.8. Vacuum minus 30. Balloon 305. Urine 40. Again, indicating surgeon request status. Still rewarming. Z-buff another 200, and 5 grams of Amicar was administered.
Q Now, these entries that you're making, are they contemporaneous with the time? Meaning at 1215 would you have made these entries?
A Yeah, within -- between 1215 and 1230 those events took place.
Q And you're using a pen to write these entries down accurately?
A Yes.
Q Is it important to keep an accurate record

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during the procedure?
A Yes.
Q That's one of your primary job functions in addition to monitoring patients, keep an accurate record?
A Yes.
Q Thank you. The entries for 1230.
A 1230, left mean pressure 65. Right 61. Root pressure zero. CVP 6. Line pressure 286. RPMs 3,750. Blood flow 3.8. FIO2 25. Gas 8.0. Anesthesia gas 1.5. Venous saturation 81. Arterial blood temp 36.5. Venous 35.2. Bladder 32.7. Vacuum minus 24. Balloon pressure 291. Arrow indicating urine output continuing. And then the order from the surgeons, status at that time, and then 250 mls of 5 percent albumin was added.
Q Was given?
A Was given.
Q Why?
A Why?
Q Yes. Why would albumin have been given at that time?
A Volume perhaps. I don't recall exactly, but that is why I would give it, for volume. We needed more volume in our reservoir.
Q Thank you. And these -- when you say surgeon

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directed, what do you mean by that?
A The SA is either surgeon -- S or A is either surgeon or anesthesia doing a vocal order. It's an order.
Q Thank you.
And so what order are you referring to? When you say surgeon -- just as an example, at 1230 what is the surgeon ordering?
A He is ordering perhaps -- I can't recall, but I may have asked if I could give some albumin, and he said yes.
Q Okay. So you're keeping him up to date as to what's going on with the patient and then he's ordering certain things in response with you keeping him up to date?
A Yes.
Q Thank you. The next entry at 1245.
A 1245, left mean arterial pressure 73. Right 72. Zero root pressure. CVP is 5. Line pressure is 287. RPMs 3,250. Blood flow 3.5. FIO2 70. Gas flow 8.5. Anesthesia gas 1.5. Venous saturation 80. Arterial blood temp 36.8. Venous blood temp 36. Bladder 34.2. Vacuum is at minus 30. Our balloon pressure 291. Urine output is 50. And again with the surgeon, it's marked S. Status to give five grams of

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Amicar, and that was given at 1250.
Q Why was that medication given?
A That's routine. It was a routine, a standing order with Dr. Harrington.
Q The next entry at 1252.
A Next entry, left main arterial pressure 53. Right 53. Root -- let's see -- root zero. CVP 5. Line pressure 287. RPMs 3,250. Blood flow 3.5. FIO2 70. Gas flow 8.5. Let's see, anesthesia gas 1.5. Venous sat 80. Arterial blood temp 36.8. Venous 36. Bladder 34.2. Vacuum minus 30. Balloon pressure 291 -- wait. I'm sorry. I think I went up a line, didn't I?
Q You did.
A I'm sorry.
Q I think you did it for the root also. Could you go back to --
A Yeah. We got to go back to the 1252 and just start all over again.
Q Okay.
A Left 53. Right 53. Root pressure 16. CVP 6. Line pressure 284. RPM 3,230. Blood flow 4.1. FIO2 70. Gas flow 8.5. Anesthesia gas zero. Venous saturation 76. Arterial blood temp 36.6. Venous temp 35.6. Bladder temp 34.5. Vacuum minus 30. Balloon pressure zero. Arrow down indicating urine output

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continuing. An S for the verbal order with the under -- minus X CL is saying the X clamp was deflated, and that was at -- the time 13- -- 1252. And then 50 ml equivalents of sodium bicarb was given at 1305.
Q Okay. The entries at 1305, please.
A 1305, we had left pressure 62. Right 59. Root pressure 7. CVP 7. Line pressure 2010. RPMs 2410. Blood flow 3.47. FIO2 70. Gas flow 8.5. Anesthesia gas 0. Venous saturation -- I can't read it -- 66.
MS. FAULKNER: Don't guess.
THE WITNESS: That's a guess. I'm sorry, I don't know what it's saying.
BY MR. MEYERS:
Q Go ahead.
A Arterial temp 36.7. Venous temp 36.2. Bladder temp 35.6. Vacuum minus 30. Balloon 0. Continuing with our urine output at 90. Surgeon vocal order status, another 250 of 5 percent albumin was added.
Q Why was it given?
A To prepare to terminate cardiopulmonary bypass, I'm going to make sure I have enough volume, and albumin is our choice of fluids to add.
Q Thank you. The entry at 1315, I believe.

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A Yes. Let's see. Left side pressure 124 over 61. Right side I cannot read.
Q Continue.
A Bladder temp 36.1. Urine 90. Again, we were ordered by the surgeon to come off cardiopulmonary bypass is that minus CPB.
Q Thank you. And what does the entry, next entry at the line below, a circled 100, represent?
A That means that anesthesia must have found another 10 ccs to give me for bypass urine output.
Q Thank you. Let's go down to the bottom of the page. Let's go through the entries there in a similar fashion. I appreciate your patience.
A Okay. 0817, A, indicating arterial. PH 7.39. PCO2 44.7. PO2 94. HCO3 27.5. BE 3. Saturation 97. Hemoglobin 10.2. Hematocrit 30. Sodium 140. Potassium 4.8. Nothing in the calcium. Glucose 184. Nothing for ACT. Nothing for heparin protamine titration results. And the next says heparin units.
Q What does that mean, "heparin units"?
A During the course of the case, if there's any heparin added it would be in that column.
Q Okay. So you just labeled the column heparin?
A Yes.
Q Go ahead with the next entry.

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A Do you want me to go across or go down?
Q Whatever makes more sense to you -- go across.
A That wouldn't make more sense. That's a different event that's happening.
Q Right. So let's go down.
A Okay. At 945 A, indicating arterial gas PH 7.50. PCO2 --
Q Slow down. What does the "A" represent again?
A Arterial blood gas.
Q Thank you.
A PH 7.50. PCO2 35.6. PO2 518. HCO3 27.7. Base excess 5. Percent saturation 100. Hemoglobin 8.5 hematocrit 26. Sodium 146. Potassium 4.4. Glucose 173. ACT 138.
Q 1057.
A Arterial blood gas, PH 7.45. PCO2 37.2. PO2 188. HCO3 25.4. Base excess 2. Percent saturation 100. Hemoglobin 7.8. Hematocrit 23. Sodium 143. Potassium 3.5. Nothing for calcium. Glucose 72. ACT 660.
Q With regard to the blood -- the PH and PCO2 and PO2, are you -- how are you getting those readings?
A We have an analyzer in the room, which we --
Q Thank you. I interrupted you. I'm sorry.
A We have an analyzer in the room, which can

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perform blood gases at any time.
Q And with regard to the hemoglobin and hematocrit?
A Same.
Q Done in the room?
A Correct.
Q And so the time -- the last time you went through 1057; is that correct?
A Yes.
Q And at that time you wrote down hemoglobin was 7.8 and hematocrit was 23?
A Yes.
Q And what -- does that -- does that 1057 represent the draw time?
A Yes.
Q Not the result time, but the draw time?
A It indicates when the blood was put into the analyzer.
Q Okay. And how long does it take to analyze it?
A Two minutes.
Q Thank you. Go to the entry for 1124, please.
A 1124, arterial blood gas, PH 7.20. PCO2 71. PO2 287. HCO3 27.9. BE 0. Saturation 100. Hemoglobin 5.1. Hematocrit 15. Sodium 130. Potassium 3.8.

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Glucose 56 I. ACT -- I can't read it -- 755.
Q Let me ask you a couple questions here. With regard to the patient's hemoglobin being 5.1 at 1124, would you have reported that result to the surgeon?
A Yes.
Q And why would you report that to the surgeon?
A It was lower than the values we would like to have.
Q And is that your job to figure out whether or not the patient needs to be transfused or the surgeon's job?
A It has to be approved by him. Whether it's suggested or not, it has to be approved by him.
Q But it's the surgeon's job ultimately to make the decision?
A Yes.
Q And so what you're doing is you're reporting the hemoglobin and the hematocrit to him in the event he makes a decision as the surgeon to order transfusion. Do I have it right?
A Yes.
Q Thank you. Would you read the entry for 1132, please.
A Arterial blood gas. PH 722. PCO2 68. PO2 371. HCO3 28.1. BE 0. Saturation 100. Hemoglobin

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5.1. Hematocrit 15. Sodium 131. Potassium 3.9. Glucose 6.
Q And would it have been your custom and your routine, your practice to again report the hemoglobin and hematocrit to the surgeon at 1132?
A Yes.
Q Because it remained low?
A Yes.
Q Thank you. Go to the entry for 1151.
A Okay. 1151 is venous blood gas. PH 7.20. PCO2 66. PO2 50. HCO3 26. BE minus 2. Saturation 75. Hemoglobin 5.1. Hematocrit 15. Sodium 128. Potassium 4.2. Glucose 61.
Q Thank you. And would you, again, have reported the hemoglobin and the hematocrit to the surgeon pursuant to your custom, your routine, your habit?
A Yes.
Q Because it remained low?
A Yes.
Q Yes?
A Yes.
Q The next entry, please. What is that time?
A 12.
Q Is that 12 o'clock?

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A 12 o'clock. Arterial blood gas 7.33. PCO2 51. PO2 331. HCO3 27.4. Base excess 2. Saturation 100. Hemoglobin 7.1. Hematocrit 21. Sodium 132. Potassium 4.5. Glucose 120. ACT 655.
Q Just a question. Let's go back to 1132 for a moment. Can you, please?
A All right.
Q The hemoglobin was reported there at 5.1. You said the results would have been available within about two minutes?
A Yes.
Q Just tell me what the reconstruction -- so at around 1134, you would have reported those results to the surgeon?
A Yes.
Q Thank you. 1246, please.
A Arterial blood gas 7.28. PCO2 59. PO2 378. HCO3 28.4. Base excess 2. Saturation 100. Hemoglobin 6.8. Hematocrit 20. Sodium 133. Potassium 5.0. Glucose 115. ACT 595.
Q Next entry.
A 1315, arterial blood gas 7.59. PCO2 30. PO2 295. HCO3 29.6. Base excess 8. Saturation 100. Hemoglobin 6.5. Hematocrit 19. Sodium 134. Potassium 5.4. Glucose 154. ACT 549.

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Q Thank you. Next entry.
A There's a -- there's like a -- I can't see the time. There's a spot on my copy.
MR. MANION: You have to keep your voice up. Okay.
THE WITNESS: I can't read my time. There's a -- I don't know. With this copy there's something wrong. 13-something is the time of the blood gas.
BY MR. MEYERS:
Q Okay.
A Arterial blood gas.
Q And you're talking about the next column -- excuse me --
A After --
Q -- after 1315, correct?
A Yes.
Q Thank you. Go ahead.
A Arterial blood gas 7.41. PCO2 39. PO2 123. HCO3 is 25.2. Base excess 1. Saturation 99. Hemoglobin 6.8. Hematocrit 20. Sodium 135. Potassium 5.7. Glucose 187.
Q Thank you. Go down below there. There's an entry I have -- I'll read. I think it says redraw.
A Yes.
Q Explain what that means, please.

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A At -- I'm trying to see -- the blood gas was redrawn. And, again, I have a bad copy here. I can't -- do you have that same.
Q It looks like redraw, then there's an arrow, and then it says decrease CO2 on field from 8 to 6, I think; is that right?
A Yes. Yes. That's what it does say. And that --
Q What does that mean?
A At -- I'm trying to see -- I can't see the time. But that means at -- I did a redraw of my blood gas, and at -- because -- let's see. I wanted to check my levels to make sure that the blood gas was accurate, because sometimes it can be contaminated. And then with the decreased CO2 on the field from 8 to 6, I asked them -- the field, the sterile field, because I don't control that. I can't do anything. I asked them to decrease it from 8 liters to 6 to help me lower my PCO2 values.
Q I'm a little confused. And I appreciate your patience.
The PCO2 value that you would have been concerned with with regard to this time that we're having trouble deciphering with 39; is that correct?
A No. It's at 1134. I see now, because there's

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a pen mark. But see, I have an asterisk mark underneath that arrow at 1124. And the asterisk is what I have next to the redraw. So that asterisk is indicating that I redrew my blood gas. So that's -- usually we do a blood gas every half hour. But at 1124 when I got that result, I immediately made adjustments and then redrew it at 1132. And then at that point is when I asked them to turn their CO2 down from 8 to 6.
Q I want to make sure that I'm following this. You're indicating that the redraw happened at 1124?
A No, 1132.
Q It happened at 1132. And you were -- what were you concerned about at 1124?
A My PCO2.
Q Being 71?
A Yes.
Q You wanted to get it down?
A Correct.
Q So let's work our way through it. Under that redraw entry at the bottom of the page there's another time and another row.
What are those times?
A Under 1132?
Q No. At the bottom of the page.
A Oh, that was just an extension for, let's see,

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1353 it looks like -- I can't guess. 1350-something another arterial blood glass was drawn. PH 7.40. PCO2 42.9. PO2 349. HCO3 26.5. BE 2. Saturation 100. Hemoglobin 6.5. Hematocrit 19. Sodium 135. Potassium 5.1. Glucose 186. ACT 114. HPT 0.0.

Q Next entry.

A 1411, arterial blood gas 7.46. PCO2 40. PO2 311. HCO3 27.7. Base excess 2. Saturation 100. Hemoglobin 7.1. Hematocrit 21. Sodium 137. Potassium 4.9. Glucose 164.

Q Thank you. Now, let's go over to the column -- the other entries on the right side of the page, please.

A That's indicating our cardioplegia delivery. At 1113 when the X clamp was initiated, we gave HTK solution, route is aortic, A. Flow was 236. Pressure 130. Temperature 4.5. Volume was 1500.

Next entry?

Q Yes.

A 1140, HTK is our solution. Our route is aortic. Flow is 170. Pressure 76. Temperature 6.0. Volume 500.

Q Go down to the bottom, please.

A Bottom is an estimation for a calculation on how much this patient, based on his weight, should have

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delivered to him. And it says 1360 mls of HTK at 170 mls to 230 mls per minute.

Q Okay. Let's go to Exhibit 3, please.

What is Exhibit 3?

A Exhibit 3 is a record indicating how much blood -- the patient's blood we salvaged and processed and was able to give back to the patient --

Q Go ahead.

A -- of his own blood. You want me to go for the entries?

Q You might as well -- well, let's go through the units and times, please.

A Okay. Unit ID number 1. Time -- bad copy here -- 13- -- I would have to guess. I don't know.

MS. FAULKNER: Don't guess.

THE WITNESS: I can't read it. It's a bad copy.

BY MR. MEYERS:

Q Does it appear to be 1305 or 1325?

A Again, it would be a guess. I don't know.

Q It's your handwriting?

A Yes, but it's light. The copy is not good. That's why I'm having a hard time reading it. Let's see -- I can't guess. I don't know.

MR. MANION: She doesn't know.

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BY MR. MEYERS:

Q All right. Go ahead. But is it clearly a 13?

A Yes.

Q You can't tell what minute it was?

A No.

Q Go ahead and read it across.

A Processed 1,266. Anticoagulation volume 150. Irrigation 500. Wash 1,000. PRBC return volume 250. Fill 400. Wash 800. Excluded clear, yes. Clot free, yes. Physician chart accept, yes. CRNA indicating --

Q What does physician chart accept yes mean?

A That we know that his guidelines are to make sure that that unit has been washed with 1,000 mls of volume.

Q Okay. So dumb it down for me. What happened shortly -- what happened after 1 o'clock as far as this entry is concerned? What does it mean?

A This means that once we're -- once we can get enough process volume to process one PRBC bowl, which is 250 measure, we can get this from our circuit, and routinely it's post CPB. So we do not have to just waste this volume, and we can concentrate the red blood cells. And this is what this does. It's a centrifuge that concentrates the red blood tells. And that 1266 is the volume it took to process 250 RBCs.

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Q All right. So let me -- let me take a stab at it.

After the patient was off cardiopulmonary bypass, you gave him red blood cells?

A His own. We processed his own pump circuit blood and concentrated it, so, therefore, all we have left are the red blood cells that will be transfused back to the patient.

Q So you gave him blood, his own blood at some time after 1300?

A Yes.

Q And when I say his own blood, it was actually just the red blood cells?

A Correct.

Q Thank you. Go to entry number 2, please.

A Number 2, 1356. Process volume 1260. Anticoagulant 50. Irrigation 600. Wash volume 1,000. PRBC return volume 250. Speed 400. Wash 800. Clear, yes. Clot free, yes. Physician accepted, yes. Given to the CRNA.

Q There's some handwritten entry under "Comments."

Can you read those?

A Let's see -- which side?

MR. MANION: Under "Comments" or in the

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comment section.
THE WITNESS: That's the CRNA indicating it was given to the anesthesia, and they then transfused it back to the patient.
BY MR. MEYERS:
Q Can you read those entries, actually?
A Pardon me?
Q Can you read the entry?
A "CRNA."
Q And the rest?
A "CRNA."
Q Okay. I think we're probably -- this is the first time it's happened where we weren't following each other.
If you follow the row number 1 across, it says, "CRNA." And then you go immediately above that, there is -- there's an entry above where it says "CRNA."
A Oh. That is indicating a lot number and expiration date for our autotransfusion suction line that we use. The table suctions the blood back to our circuit. It's a disposable that was used. It goes along with the stickers that are there, the reference -- the two references there for our disposables that are used indicating that they were not expired.
Q Okay. Well, dumb it down for me. What does

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the entry mean and what are the figures?
A The AA -- AALCYA is the company's identification for cell saver suction tubing. The number -- it's a bad copy -- 146140015, and the expiration date, again is very faint. I can't read it.
Q Okay. The total down here at the bottom of the page, figures, what do they represent?
A Total processed volume. 2520 is the amount of volume that was collected in the cell saver reservoir.
Q The number is actually 2520?
A Yes.
Q Thank you. Go ahead.
A The anticoagulant that was used for the case was a total of 200.
Q Go ahead.
A Irrigation, total 1100. Wash volume total 2,000. Packed red blood cells return volume was 500.
Q Thank you. Just read the entry -- the rest of the entries --
A Volume given to anesthesia was 500. Processed volume returned to patient via extracorporeal circuit, ACC was 0. And the autotransfusion estimated blood loss is 720 mls.
Q This 500, is it referring to the 500 ccs of packed red blood cells that were returned to the

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patient?
A Yes.
Q And the 720 represents what?
A The amount that was wasted, that could not be saved. Other components of the blood, other than the red blood cells.
Q Now, a couple other questions. If during this operation the patient was transfused with red blood cells or whole blood, would there been a recording of that?
A Yes.
Q And if the patient was transfused during the operation, where would that reporting have occurred?
A It would have occurred underneath my blood gases. There's a transfusion record, blood unit number, and time given spot. And there was -- it would be also indicated on page 1 in the plus column for pump volume, and it would have been written in RBCs and the total amount given.
Q Okay. Based upon this recordkeeping, are you confident that the patient was not transfused during the operation?
A During cardiopulmonary bypass?
Q Correct.
A Yes.

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Q And the only transfusion that occurred was the 500 ccs of the patient's own blood that was given at some time after 1 o'clock initially and then again at 1356?
A Yes.
Q The entry -- go back to Exhibit 2 for just a minute. Okay?
A Uh-huh.
Q Are you there?
A Yes.
Q There's an entry at 1151. Do you see the entry down at the bottom of the page?
A Yes.
Q The next entry, is that 1240 or is 1200, because it looks like it was written over?
A 1200.
Q Does it look like it was written over?
A Yes.
Q Can you read what was underneath it?
A No, I can't read it -- 1206. That's a guess. I don't know.
Q It's the only timing entry that's written over on this page.
Do you have an explanation as to why it would have been written over?



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STATE OF MICHIGAN

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IN THE CIRCUIT COURT FOR THE COUNTY OF MACOMB

DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI, as Husband and Wife,

Plaintiffs,

v.

Case No. 14-2247-NH
Hon. Kathryn A. Viviano

STEVEN D. HARRINGTON, M.D., and ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.

Defendants.

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## PLAINTIFFS' MOTION TO AMEND COMPLAINT

NOW COME Plaintiffs, DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI, as Husband and Wife, by and through their attorneys, MORGAN & MEYERS, PLC, and respectfully requests that this Honorable Court enter an order allowing the Plaintiffs to amend their Complaint in a manner consistent with the proposed Amended Complaint, attached herein as **Exhibit No. 1** for the reasons set forth below:

1. This is a complex medical malpractice case involving a mitral valve replacement surgery.

2. During the operation, Plaintiff Drago Kostadinovski suffered a stroke.

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3. Discovery has recently been completed which has revealed that Plaintiff, Drago Kostadinovski was in a hypotensive state during the operation and was not adequately transfused.

4. This evidence came to light after the deposition of the perfusionist, Lynn Masinick, the continued deposition of Defendant Dr. Harrington, as well as the depositions of Plaintiffs' retained experts.

5. Prior to this recent discovery being completed, this information as to theories of failing to transfuse Plaintiff Drago Kostadinovski were not known.

6. Once these potential claims came to light after Ms. Masinick's deposition, the transcript was provided to Plaintiffs' experts **and counsel for Defendants were immediately informed of the newly discovered evidence and new theories of liability** prior to Plaintiffs' experts' depositions and prior to the filing of this motion

7. Plaintiffs move to amend the Complaint herein to add additional claims to Count I of Plaintiffs' Complaint alleging negligence against Dr. Harrington for failing to adequately monitor Mr. Kostadinovski's hypotension during the operation and failing to transfuse the patient so as to maintain the patient's blood pressure. (***Please see,* Plaintiffs' Exhibit 1 – Proposed First Amended Complaint, at ¶¶ 71(g), (h), 72, (g), (h)).**

8. These amended allegations have been supported by expert testimony of Plaintiffs' retained experts, Edgar Chedrawy, MD and Louis Samuels, MD.

9. Plaintiffs allege in the Amended Complaint that the named surgeon, Dr. Harrington, had a duty to monitor the patient's hypotensive status and immediately transfuse the patient.

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10. MCR 2.118(A)(2) provides that leave to amend a pleading "shall be freely given when justice so requires." It is well settled that an amended pleading can introduce new facts, new theories, or even a different cause of action, as long as the amendment arises from the same transactional setting that was set forth in the original pleading. *LaBar v Cooper*, 376 Mich 401, 406 (1965).

11. It is well settled that a complaint may be amended to add theories identified after filing and learned during discovery. *King v Reed*, 278 Mich App 504 (2008). See also, MCR 2.118(C)(2); *Froede v Holland Ladder and Manufacturing Co.*, 207 Mich App 127; 523 NW2d 849 (finding no abuse of discretion and permitting a plaintiff to add a count of negligent failure to warn when the trial court noted that defendants had notice of plaintiffs' claim well in advance of trial and the new claim could be inferred reasonably from plaintiffs' allegations in the second amended complaint).

12. Plaintiffs wish to amend their Complaint so as to add an allegation with regard to Dr. Harrington's failure to monitor Mr. Kostadinovski's hypotension and to transfuse the patient. Plaintiffs could not have known theories regarding a failure to monitor the blood pressures and transfuse the patient until after the completion of Dr. Harrington's continued deposition as well as the taking of the deposition of the perfusionist, Lynn Masinick as well as the depositions of Plaintiffs' retained experts.

13. Plaintiffs have attached a copy of their Proposed First Amended Complaint to this motion. (***Please see*, Plaintiffs' Exhibit 1 – Proposed First Amended Complaint**).

WHEREFORE, Plaintiffs respectfully requests this Honorable Court enter an order allowing Plaintiffs to amend their Complaint for the reasons set forth above.

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Respectfully submitted.

MORGAN & MEYERS, PLC

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DATED: March 21, 2016

**PLAINTIFFS' BRIEF IN SUPPORT**

Plaintiffs are currently completing discovery in a case which has alleged several breaches of the standard of care against Steven Harrington, MD during a mitral valve replacement surgery he performed on Plaintiff, Drago Kostadinovski. Dr. Harrington was deposed on two separate occasions, the latter having occurred in late 2015. After having completed the second deposition of Dr. Harrington, Plaintiff sought to investigate issues regarding perfusion of Mr. Kostadinovski during the surgery. In January of 2016, Plaintiff received the deposition transcript of Lynn Masinick, the perfusionist who worked with Dr. Harrington to monitor the patient's blood pressures during the valve replacement surgery.

After Ms. Masinick was deposed, Plaintiffs' experts were provided with her deposition to review. Plaintiffs' experts, Edgar Chedrawy. MD, Louis Samuels, MD and Thomas Naidich, MD were all deposed approximately a month and a half ago in February of 2016. Based upon the newly discovered evidence contained within the deposition of Ms. Masinick, Plaintiffs' experts opined that Dr. Harrington breached the standard of care by failing to monitor the patient's hypotension intra-operatively and by

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failing to transfuse the patient. (***Please see*, Plaintiffs' Exhibit 1 - Proposed First Amended Complaint**).

Based on the deposition testimony of Dr. Harrington, Ms. Masinick and Plaintiffs' retained experts, it is evident that Dr. Harrington should have been aware of Mr. Kostadinovski's hypotension intra-operatively and should have ordered that the patient be transfused. These claims have been supported by expert testimony. It is undisputed that Plaintiffs' claims regarding failing to monitor Mr. Kostadinovski's hypotension and/or failing to transfuse the patient have been supported by recently taken expert testimony. Furthermore, it is undisputed that Dr. Harrington has been aware of this lawsuit for over two years and has had a significant opportunity to prepare his defense. **Once Plaintiffs became aware of these potential claims, counsel for Defendants were immediately informed of the newly discovered evidence and new theories of liability** prior to the depositions of Plaintiffs' experts. Finally, Plaintiffs do not seek to add any additional parties; rather Plaintiffs simply seek to add additional claims based on newly discovered evidence. After the taking the necessary depositions, Plaintiffs now bring the instant motion to amend their complaint.

MCR 2.118(A)(2) provides that leave to amend a pleading "shall be freely given when justice so requires." It is well settled that an amended pleading can introduce new facts, new theories, or even a different cause of action, as long as the amendment arises from the same transactional setting that was set forth in the original pleading. *LaBar v Cooper*, 376 Mich 401, 406 (1965). In *Ben P. Fyke & Sons Inc. v Gunter Co.*, at 390 Mich 649 (1973), the Michigan Supreme Court clearly articulated a policy that

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favors amendments. As a result, a motion to amend ordinarily should be granted and should only be denied for the following particularized reasons:

> *[1] Undue delay;* [2] *Bad faith or dilatory motive on the part of the movant;* [3] *Repeated failure to cure the deficiencies by amendments previously allowed;* [4] *Undue prejudice to the opposing party by virtue of allowance of the amendment; and* [5] *Futility. Id. at 656.*

In this instance, none of these factors are present. This was a case which involves the medical treatment and negligence of Dr. Harrington. Furthermore, since Dr. Harrington is already a defendant in this matter, it cannot argued that he is prejudiced by the amendment of the claims as discovered by the deposition testimony which has recently been taken in this matter. Furthermore, these claims against Dr. Harrington could only be known after depositions were taken and demonstrate Dr. Harrington's level of involvement in the monitoring of hypotension, his duty to order a transfusion as well as additional facts which could only have been discovered once these depositions were completed.

As soon as plaintiff obtained this deposition testimony, potential claims were investigated with retained experts and the instant motion for leave to amend was prepared. As such, Plaintiffs are formally requesting an opportunity to amend their Complaint at this time pursuant to MCR 2.118(A)(2). A copy of Plaintiffs' First Proposed Amended Complaint is attached as **Exhibit 1**.

It is well settled that a complaint may be amended to add theories identified after filing and learned during discovery. *King v Reed*, 278 Mich App 504 (2008). See also, MCR 2.118(C)(2); *Froede v Holland Ladder and Manufacturing Co.*, 207 Mich App 127;

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523 NW2d 849 (finding no abuse of discretion and permitting a plaintiff to add a count of negligent failure to warn when the trial court noted that defendants had notice of plaintiffs' claim well in advance of trial and the new claim could be inferred reasonably from plaintiffs' allegations in the second amended complaint).

In this case, there has been no unjust delay, or repeated failure to amend to add claims of negligence of Dr. Harrington as these claims only became known during the course of discovery. Of course Defendants will have an opportunity to defend these claims on the merits and as such, they are not prejudiced in any way. For these reasons, there is just cause for Plaintiffs to be allowed to amend their Complaint to add these claims of negligence at this point in time pursuant to MCR. 2.118(A)(2) consistent with the proposed draft attached to the instant motion. (***Please see,* Plaintiffs' Exhibit 1 – Proposed First Amended Complaint).**

WHEREFORE, Plaintiffs respectfully requests this Honorable Court enter an order allowing Plaintiffs to amend their Complaint for the reasons set forth above.

Respectfully submitted,

MORGAN & MEYERS, PLC

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DATED: March 21, 2016

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STATE OF MICHIGAN

61524

IN THE CIRCUIT COURT FOR THE COUNTY OF MACOMB

DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI, as Husband and Wife,

Plaintiffs,

v.

Case No. 14-2247-NH
Hon. Kathryn A. Viviano

STEVEN D. HARRINGTON, M.D., and ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.

Defendants.

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**PLAINTIFFS' FIRST AMENDED COMPLAINT AND RELIANCE ON PREVIOUS DEMAND FOR JURY TRIAL**

NOW COMES Plaintiff herein, Drago Kostadinovski and Blaga Kostadinovski, as Husband and Wife, by and through their attorneys, MORGAN & MEYERS, PLC, and states as their cause of action against the above-named Defendants the following:

1. The amount in controversy is in excess of TWENTY FIVE THOUSAND ($25,000) DOLLARS.

2. At all times pertinent to this Complaint, Drago Kostadinovski (hereinafter "Mr. Kostadinovski") was a resident of the County of Macomb, State of Michigan.

3. At all times pertinent to this Complaint, Blaga Kostadinovski (hereinafter "Mrs. Kostadinovski") was a resident of the County of Macomb, State of Michigan.

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4. At all times pertinent to this Complaint, Steven D. Harrington, M.D. was a physician doing business in the County of Macomb, State of Michigan.

5. At all times pertinent to this Complaint, Advanced Cardiothoracic Surgeons, PLLC was a Michigan Limited Liability Company doing business in the County of Macomb, State of Michigan.

6. At all times pertinent to this Complaint, Dr. Harrington was an employee/agent at Advanced Cardiothoracic Surgeons P.L.L.C.

7. In paragraphs 8 – 69 as set forth below, Plaintiffs make reference to statements contained in the medical records of various health care providers. The recitation of these factual statements should not be interpreted as an admission by Plaintiffs as to the factual authenticity or truthfulness of these statements. The statements are set forth below to provide context as to the violations of the standards of care, also described below.

8. Prior to the events described in this Complaint, Mr. Kostadinovski was a married man who was able to perform all of his activities of daily living independently as well as mobilize independently.

9. Prior to the events described in this Complaint, Mr. Kostadinovski was able to care for himself independently while living with his wife.

10. On July 30th, 2011, Drago Kostadinovski, a 70-year old male, date of birth, May 10th, 1941, presented to the Henry Ford Macomb Hospital Emergency Department stating that he had just completed an echocardiogram at the Henry Ford Out-Patient Clinic located at Fifteen Mile Road and Ryan.

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11. While at the clinic, Mr. Kostadinovski had informed the staff that he was having a hard time breathing and at times was having difficulty swallowing pills and drinking water.

12. Mr. Kostadinovski indicated that the staff at the Henry Ford Clinic sent him to the Emergency Department for further examination. Upon arrival at the Henry Ford Macomb Hospital Emergency Department, Mr. Kostadinovski was seen by Arti Bajpai, M.D. and Patrician L. Milani, MD who indicated that the Mr. Kostadinovski presented with difficulty breathing and was unable to breathe at times during the night. These symptoms began approximately three days prior to the July 30th, 2011 admission and fluctuated in intensity.

13. Mr. Kostadinovski's medical history included hypertension, hyperlipidemia, diabetes and a social history of tobacco smoking, noting that Mr.Kostadinovski had quit tobacco one year ago. The impression of the ER physicians was dyspnea, with a plan to rule out cardiac causes, including myocardial infarction, angina, CHF. It was noted that Dr. Milani had discussed the case with Dr. Abas Jafri, Mr. Kostadinovski's primary care physician.

14. After Mr. Kostadinovski was examined in the Emergency Department, he was admitted to the in-patient telemetry unit and his care was transitioned to Maria B. Perry, M.D.

15. On August 1st, 2011, Mr. Kostadinovski underwent an echocardiogram for the clinical indication of CHF. The ordering physician was noted as Marius Laurinaitis, MD. The interpretation included demonstration of right ventricle with normal size and function. Left ventricle size, thickness and function were normal. The left ventricular ejection

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fraction was normal. The mitral leaflets appeared thickened, hooded and/or consistent with myxomatous degeneration with a moderate mitral regurgitation, and posterior mitral leaflet changes consistent with mitral prolapse and some mal opposition with moderate to severe MR.

16. Following the results of the echocardiogram, a transesophageal echocardiogram was recommended and performed in a two-dimensional fashion.

17. Again, the mitral valve leaflets appeared thickened, hooded and/or consistent with myxomatous degeneration with moderate mitral regurgitation.

18. A duplex extra cranial artery study was performed, which indicated 40 to 59 percent stenosis in the right internal carotid artery with homogenous plaque found. Less than 40 percent stenosis was noted in the left internal carotid artery. The study was interpreted by Rizk Youssef, D.O.

19. On August 3rd, 2011, under the attending care of Dr. Perry, and by order of Dr. Majid Al-Zagoum, Mr. Kostadinovski underwent a persantine myocardial perfusion scan with a noted history of chest pain, hypertension, diabetes and hypercholesterolemia. The report was read by Khurram Rashid, M.D., with an impression noting no scintigraphic evidence of reversible ischemia and with normal left ventricular wall motion and an ejection fraction of 69 percent.

20. On August 3rd, 2011, an exercise stress test was performed and interpreted by Durgadas Narla, M.D. The impression was negative per statin stress EKG, with occasional PBCs, stable vital signs which correlated with the myocardial scan report.

21. On August 4th, 2011, another two-dimensional transesophageal echocardiogram was performed. It was performed under the order of Dr. Al-Zagoum and

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interpreted by Dr. Al-Zagoum with an interpretation of moderate to severe mitral regurgitation. The mitral regurgitant jet was noted to be eccentrically directed. Prolapse of the anterior mitral leaflet ejection fraction was noted at 60 to 65 percent.

22. On August 5th, 2011, Dr. Perry requested a consultation by Steven D. Harrington, M.D. The reason for the consultation was mitral insufficiency and dyspnea with exertion.

23. In Dr. Harrington's consultation note, Dr. Harrington noted the history of the present illness as a 70-year old male who speaks limited English, originally from Macedonia.

24. Dr. Harrington indicated that his son-in-law was at bedside and translated the conversation. Mr. Kostadinovski reported that he had been having increased shortness of breath and reported episodes of dyspnea while lying flat. He also reported episodes of reflux for the past several days; however, he denied any other accompanying symptoms.

25. Dr. Harrington's assessment of Mr. Kostadinovski at the date of the consultation was: (1) acute exacerbation of congestive heart failure secondary to mitral regurgitation; (2), status post-echocardiogram, no current TEE report is in the chart; however TD echocardiogram revealed the mitral valve leaflets to be thickened with hooded and/or consistent with myxomatous degeneration with moderate mitral regurgitation. Ejection fraction was estimated at 55 to 60 percent, three negative persantine stress EKG, 40 to 59 percent stenosis to the right internal carotid artery and less than 40 percent stenosis to the left internal carotid artery.

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26. Dr. Harrington's plan was to order a transesophageal echocardiogram report which would be reviewed by Dr. Harrington. Dr. Harrington noted that Mr. Kostadinovski would need cardiac catheterization prior to a mitral valve repair/replacement. The cardiac catheterization would be to rule out coronary artery disease and the possible need for myocardial revascularization, as well as mitral valve repair/replacement. The note was dictated by Ryan Ramales, Physician's Assistant and was approved by Dr. Harrington on August 7th, 2011.

27. On August 4th, 2011, Mr. Kostadinovski was discharged from Henry Ford Macomb Hospital, noting that at 2D echo was suggestive of severe mitral valve insufficiency and was confirmed by transesophageal echocardiogram. The discharge summary included an evaluation by Dr. Harrington in the Cardiovascular Surgery Department and that out-patient follow-up was recommended. Mr. Kostadinovski was to follow up with Dr. Jafari in three to four days, to follow up with Dr. Al-Zagoum in five to seven days and to follow up with Dr. Harrington in ten to 14 days.

28. On September 12, 2011, Mr. Kostadinovski underwent cardiac catheterization at the Cardiac Catheterization Laboratory at Henry Ford Macomb Hospital. The cardiac catheterization was performed and reported by Dr. Al-Zagoum. Findings were noted as a normal left main coronary artery. "Left anterior descending artery has one major diagonal branch which appeared to be normal and the left anterior descending itself appeared to be within normal limits. The left circumflex artery had one major obtuse marginal artery branch which appeared to be normal and the right coronary artery was a dominant artery with no significant disease noted." Left ventriculography was done using pigtail catheter with ejection fraction about 35 to 40 percent with global hypokinesia.

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29. On December 9th, 2011, Mr. Kostadinovski presented to Henry Ford Macomb Hospital under the care of Dr. Steven D. Harrington for a pre-surgical evaluation for mitral valve repair/replacement with robotic assistance.

30. During this consultation report, Dr. Harrington noted the September 12, 2011 cardiac catheterization by Dr. Al-Zagoum, in which Mr. Kostadinovski was found to have normal coronary arteries and moderate left ventricular dysfunction. The ejection fraction was noted to be between 35 and 40 percent, and at that point, Mr. Kostadinovski was scheduled for surgery on December 14, 2011.

31. An x-ray of the chest was performed on this date with a clinical history of "some difficulty in breathing/pre-operative study", which demonstrated no significant interval change from the prior x-ray which was performed on July 30, 2011.

32. No CT study of the chest, nor any CT angiogram was ordered or reviewed by Dr. Harrington on December 9, 2011 on the pre-surgical clearance admission, nor was any CT study or CT angiogram ordered and reviewed prior to the DaVinci mitral valve repair surgery on December 14, 2011.

33. On December 9, 2011, Dr. Harrington's assessment was mitral insufficiency with normal coronary arteries and diabetes myelitis type II. As far as prior testing, Dr. Harrington reported that on August 8th, 2011, Mr. Kostadinovski underwent a transesophageal echocardiogram which revealed severe mitral valve prolapse, prolapse of the anterior mitral leaflet with moderate to severe mitral regurgitation, and also noted that the tricuspid valve was normal and had mild tricuspid regurgitation.

34. On December 9, 2011, Dr. Harrington did not recommend nor order that Mr. Kostadinovski undergo any further echocardiogram testing, CTA or other angiogram



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studies to determine any extent of atherosclerotic process or atherosclerosis in the aortic arch at this time. Informed consent was reported to be given after risks were discussed, and Mr. Kostadinovski was scheduled for surgery on December 14, 2011.

35. On December 14, 2011, Mr. Kostadinovski presented to Henry Ford Macomb Hospital for a DaVinici mitral valve complex repair with posterior leaflet resection and 28-millimeter, CG future band annuloplasty and ligation of left atrial appendage.

36. The operation was performed by Steven D. Harrington, M.D. with the assistance of Shelly Klein, PA-C. Anesthesiology was performed by Dr. Zhang, who also performed a transesophageal echocardiogram (TEE), which was noted independently, as performed by anesthesia, although the body of the operative report indicates that Dr. Harrington interpreted and utilized the data from the intra-operative TEE study.

37. In the operative findings, Dr. Harrington noted that there was severe mitral insufficiency with torn P2 posterior segment allowing prolapse of both anterior and posterior leaflets.

38. Dr. Harrington indicated that the repair had been accomplished with quadrangular resection of the P2 segment, primary repair, and a 28 millimeter CG future band angioplasty.

39. Dr. Harrington indicated that Mr. Kostadinovski was in normal sinus rhythm pre-operatively and post-operatively and had "excellent" left ventricle function. Dr. Harrington further noted that post-operative repair showed no mitral insufficiency and no evidence of mitral stenosis.

40. During the procedure, Mr. Kostadinovski was placed in the supine position, prepared and draped in a sterile fashion and the right groin was opened, exposing the

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femoral artery and vein, and the was cannulated with a 23 arterial hemostatic valve catheter and a 25 venous Heart Port catheter in the vein, all positioned with transesophageal echo guidance.

41. At this point, the DaVinci robot was brought into position and docked and the EndoAortic clamp was brought into position with transesophageal echo guidance.

42. Cardiopulmonary bypass was instituted and the EndoAortic clamp was inflated and the heart was arrested with administration of HTK cardioplegia injected into the aortic root. With the robot, the diaphragmatic stitch retraction was placed followed by opening the pericardium on and pericardial traction sutures.

43. At that point, Dr. Harrington noted the inter-arterial groove was then developed and opened and left atrial retractor placed exposing the valve. Dr. Harrington noted "obvious P2 segment that was torn and that was resected with quadrangular resection and repaired with a primary repair with No. 4 Gortex suture."

44. After further repair, the valve was tested to see that it was secured and it was with no leak after injection of 250 milliliters of saline. The EndoAortic clamp was released and the patient returned spontaneously to a sinus rhythm.

45. During the operation Mr. Kostadinovski's perfusion was monitored by Lynn Masinick and reported to Steven Harrington, MD

46. During the operation, Dr. Harrington failed to appreciate Mr. Kostadinovski's hypotensive status and transfuse the patient.

47. Dr. Harrington noted adequate rewarming and reperfusion and a weaning from cardiopulmonary bypass and decannulization without difficulty, requiring no inotropes,

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only a small amount of neo-synephrine, which was quickly weaned off. After the operation, Mr. Kostadinovski was transferred to the Intensive Care Unit for recovery.

48. Dr. Harrington noted that a peri-operative transesophageal echocardiogram showed excellent cooptation of leaflets, no mitral insufficiency, normal sinus rhythm, and stable left ventricular function.

49. Upon transfer to the Intensive Care Unit, Mr. Kostadinovski's post-operative vital signs were recorded as follows: temperature 101.9 axillary, pulse 86, respirations 10, blood pressure 134/55, and $O_2$ sat a hundred percent on FI $O_2$ of 40 percent.

50. It was noted that Mr. Kostadinovski did not awaken post-operatively, and on December 15th, at 01:15 a.m., the nursing staff noted the presence of tonic-clonic movements lasting approximately 65 seconds. At that time, Mr. Kostadinovski remained unresponsive, despite attempts to stimulate him. He did not open his eyes or follow commands.

51. It was also noted during the night of December 15, 2011, that Mr. Kostadinovski had 15 seconds of involuntary movements involving the left-side of his face and his eyes, prompting the administration of Keppra 500 milligrams, IV piggyback and Ativan, 2 milligrams, IV.

52. Rajindar K. Sikand, M.D. was consulted who formulated a plan to rule out anesthesia versus neurological event post-op after being called to consult a non-responsive patient who was unable to follow commands and noted to be lethargic occurring overnight on the first day post-op.

53. On December 15, 2011, at approximately 14:00 hours, it was noted that medical staff had witnessed spontaneous movement of Mr. Kostadinovski's right arm, after

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he grasped on two occasions with his left hand and nursing staff noted some tremors in Mr. Kostadinovski's "saddle region." At that point, Dr. Wilma E. Agnello-Dimitrijevic, M.D., a neurologist, was consulted regarding Mr. Kostadinovski's condition.

54. Dr. Agnello-Dimitrijevic noted at that time that Mr. Kostadinovski did not have a history of TIA stroke, seizure or syncope, and no known history of neuropathy or retinopathy.

55. On December 15, 2011, a CT of the brain was performed without contrast, and it was reported as demonstrating evidence of acute ischemic infarct within the right cerebral hemisphere, having the appearance of water shed distribution involving the right anterior cerebral artery distribution. There was no noted evidence of hemorrhage. That study was interpreted by Frank Randazzo, M.D., and it was also noted in the consultation note that Dr. Agnello-Dimitrijevic also interpreted the study and noted evidence of extensive sulcal effacement involving the right front temporal and parietal lobe, consistent with infarction, most notably in the ACA territory. There is also evidence of involvement of the MCA territory. There was no evidence of midline shift and no evidence of hemorrhage. No obvious sulcal effacement is noted in the left hemisphere.

56. An electroencephalogram (EEG) was performed on December 16, 2011 to rule out seizure. The impression of the reviewing physician, Dr. Shyam Moudgil, M.D. indicated the impression of an abnormal EEG, suggestive of diffuse cortical neuronal dysfunction, as seen in moderate encephalopathy and clinical correlation as to the etiology of the encephalopathy was recommended.

57. Dr. Agnello-Dimitrijevic's notable impressions were (1) encephalopathy, multifactorial secondary to embolic stroke/sedation, (2) acute right anterior cerebral artery



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and middle cerebral artery, ischemic infarcts, (3) mitral regurgitation, status post mitral valve repair, among other observations.

58. Dr. Agnello-Dimitrijevic noted clinically that Mr. Kostadinovski had evidence of not only right hemispheric ischemic stroke, but involvement of the contralateral corticospinal tracts. There was also evidence of not only an aberrant mentation, but bilateral Babinski reflexes sustained bilateral ankle clonus and left Hoffmann reflexes.

59. It was noted by Dr. Agnello-Dimitrijevic at the time of this initial consultation that she discussed the findings with the patient's family at length and noted Mr. Kostadinovski's guarded prognosis and ultimate need for extensive rehabilitation.

60. An additional CT of the head and cervical spine, without contrast, and three-dimensional reconstruction with PACS was performed on December 16, 2011, which was compared to the prior examination from December 15th, 2011. The impression of Frank Randazzo, M.D. was acute right-sided water shed and interior cerebral artery infarctions, as before with no significant interval change.

61. On December 17, 2011, a CT of the head, without contrast, was performed and compared with the December 15, 2011 study. The impression was right-cerebral hemispheric stroke with edema and developing areas of encephalomalacia with the ventricular system remaining patent and left anterior cerebral artery distribution infarction, as well.

62. Also noted was concern for brain stem ischemic change and likely remote ischemic change of the right cerebellum and paranasal sinus findings. This was interpreted by Michele Keys, D.O.

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63. On December 17th, 2011, the consultation of neurosurgeon Vittorio Morreale, M.D. was requested for the reason of a large infarct with mass affect. Dr. Morreale indicated that Mr. Kostadinovski developed infarct immediately with surgery and has remained intubated since. He further noted that Mr. Kostadinovski is non-verbal and has had dense left hemiplegia since surgery. It was Dr. Morreale's impression that Mr. Kostadinovski did not require intracranial pressure monitoring and that this treatment plan was discussed with Dr. Agnello-Dimitrijevic.

64. There is a rehabilitation consultation note from David K. Davis, M.D later on during Mr. Kostadinovski's hospital stay. Dr. Davis noted that radiology was reviewed that indicated that a head CT showed right cerebral edema with ischemia, anterior, middle and posterior cerebral arteries and subarachnoid hemorrhage was also seen with partial uncal herniation due to edema in the right temporal horn and ischemia right-posterior cerebral artery is also seen. The impression of Dr. Davis was a patient that was status post-acute large stroke, right side of the brain with dense left-sided weakness and left hemineglect and dysphagia, poor trunk control and very low functional level at the time of the consultation which was approximately 13 days from stroke.

65. Also, at the time of Dr. Davis' consultation, it was noted that Mr. Kostadinovski's function status was too low for in-patient rehab, which would signify a much longer time needed for recovery. Dr. Davis also indicated to continue PT and OT, and because his criteria would not meet in-patient rehab admission criteria, Dr. Davis would recommend sub-acute rehab admission at this time until his condition improved.

66. Mr. Kostadinovski remained on ventilator support until he was extubated on December 23rd, 2011 and was eventually transferred to a cardiac step-down unit where he



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had an extended hospital stay before ultimately being discharged on January 4, 2012 to Hartford Rehabilitation Center.

67. Mr. Kostadinovski's discharge summary included diagnosis of ventilator dependent respiratory failure, right anterior cerebral artery infarct, for which he was being discharged to Hartford Rehab for further rehabilitation.

68. Mr. Kostadinovski was discharged to Hartford Rehab Clinic with instructions to follow-up with Drs. Harrington, Al-Zagoum and Jafari.

69. Mr. Kostadinovski underwent a pro-longed rehabilitation course and no longer has the ability to perform his ADL's and live a life as he did prior to the date of the surgery. Mr. Kostadinovski has suffered all other damages and injuries as noted throughout this Complaint.

**COUNT I: MEDICAL NEGLIGENCE OF STEVEN D. HARRINGTON, M.D.**

The Plaintiffs hereby restate, reallege, and incorporate by reference each and every allegation set forth above and further states, in the alternative, the following:

70. At all times pertinent to this Notice, the standard of care applicable to Steven D. Harrington, M.D., required him to maintain the standard of care of his peers within the professional community of cardiothoracic surgeons.

71. The requirements of the standard of care included, but were not limited to, the

a. On December 9, 2011, and continuously thereafter, Dr. Harrington was required to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;



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b. On December 9, 2011, and continuously thereafter, Dr. Harrington was required to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

c. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington was required to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

d. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington was required to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

e. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to immediately abort the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

f. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to use the care and technique of a reasonable surgeon performing the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

g. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to adequately monitor Mr. Harrington's hypotensive status and communicate with Lynn Masinick intraoperatively so as to insure Mr. Kostadinovski received proper perfusion throughout the operation;

h. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to order that Mr. Kostadinovski be transfused when he became hypotensive intra-operatively;



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i. Dr. Harrington was required to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process.

72. Notwithstanding said obligations, and in breach thereof, Defendant Dr. Harrington violated the standard of care applicable in the manner set forth below:

a. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

b. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

c. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington failed to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

d. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington failed to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

e. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to immediately abort the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

f. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to use the care and technique of a reasonable surgeon performing the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot,



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thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

g. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to adequately monitor Mr. Harrington's hypotensive status and communicate with Lynn Masinick intraoperatively so as to insure Mr. Kostadinovski received proper perfusion throughout the operation;

h. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to order that Mr. Kostadinovski be transfused when he became hypotensive intra-operatively;

i. Dr. Harrington failed to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process.

73. Each injury and element of damage noted below was factually and foreseeably caused by the standard of care violations described above by Dr. Harrington.

74. As a direct and proximate result of each breach of the standard of care as outlined above, Drago Kostadinovski suffered and continues to suffer a permanent impairment to his cognitive capacity rendering him incapable of making independent responsible life decisions and permanently incapable of independently performing the activities of normal daily living. As such, Drago Kostadinovski is entitled to the higher noneconomic damage cap pursuant to MCLA 600.1483.

75. As a result of each breach of the standard of care outlined above, Drago Kostadinovski suffered and continues to suffer pain and suffering, disability and disfigurement, emotional distress, anxiety, denial of social pleasures and enjoyments, humiliation, medical expenses, loss of earnings, and a loss of earning capacity.

76. As a direct and proximate result each violation of the standard of care outlined above, Drago Kostadinovski suffered and continues to suffer encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral

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artery ischemic infarcts, newly onset seizure disorder, a pro-longed hospital stay, pain and suffering, loss of ability to perform all activities of daily living, along with all other damages and injuries as noted within this complaint.

77. Had Dr. Harrington followed the standard of care and performed and appreciated a full history and physical, ordered and reviewed all necessary pre-operative radiographic testing and/or studies, including, but not limited to, x-rays, CT studies, CT angiograms, and any and all other necessary radiographic testing, he would have been able to identify thrombus, clots, or calcium within the arterial tree which would embolize and/or cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp as was performed on December 14, 2011. Had Dr. Harrington performed the proper preoperative testing, he would have aborted the procedure and/or would have used a different technique aside from the use of an EndoClamp. Had Dr. Harrington declined to perform this elective mitral valve repair and/or refrained from using the EndoClamp, thrombus, clot or calcification would not have broken loose or formed causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

78. Had Dr. Harrington followed the standard of care and properly monitored and observed the intraoperative transesophageal echocardiogram (TEE), he would have been able to identify thrombus, clots, or calcium within the arterial tree which would embolize and cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp. Had Dr. Harrington observed the

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standard of care in this respect, he would have aborted the procedure and/or used a different technique aside from the EndoClamp approach. Had Dr. Harrington declined to perform this elective mitral valve repair at this point and/or refrained from using the EndoClamp, thrombus, clot, or calcification would not have broken loose or formed causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

79. Had Dr. Harrington followed the standard of care and used the care and technique of a reasonable surgeon in performing the DaVinci mitral valve repair surgery, he would have avoided disrupting any calcium, thrombus or other build-up in the arterial tree during the operation and he would have avoided causing the above referenced injuries and damages to Mr. Kostadinovski. Had Dr. Harrington observed the standard of care in this respect, he would have aborted the surgery and/or used a different approach and/or surgical technique while performing the December 14, 2011 DaVinci mitral valve repair surgery. Had Dr. Harrington maintained the standard of care in this respect, thrombus, clot or calcification would not have broken loose or formed, causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

80. Had Dr. Harrington adequately monitored Mr. Harrington's hypotensive status and communicate with Lynn Masinick intraoperatively so as to insure Mr. Kostadinovski received proper perfusion throughout the operation and had Dr. Harrington ordered that Mr. Kostadinovski be transfused when he became hypotensive intra-

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operatively, Mr. Kostadinovski would not have suffered low perfusion and/or stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

81. Mrs. Kostadinovski, as the legal wife of Mr. Kostadinovski, is entitled to loss of consortium damages, which are the direct and proximate result of the damages and injuries described above caused by Dr. Harrington. Mr. Kostadinovski along with his wife, are entitled to damages as are deemed fair and just, including, but not limited to the following: reasonable compensation for the pain and suffering incurred by Mr. Kostadinovski, economic loss, emotional damage, loss of consortium, all medical expenses incurred along with a loss of economic opportunity and all other damages and injuries listed previously within this complaint.

82. Had Dr. Harrington followed the standard of care in all respects as outlined above, Mr. Kostadinovski would not have suffered and continues to suffer encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, a pro-longed hospital stay, pain-suffering, loss of ability to perform all activities of daily living, as well as all damages and injuries previously noted within this complaint.

WHEREFORE, Plaintiffs respectfully request that this Honorable Court enter judgment against the Defendants in any amount in excess of TWENTY FIVE THOUSAND ($25,000.00) DOLLARS, together with interest, costs and attorney fees, to which the Plaintiff is deemed to be entitled.



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## COUNT II: VICARIOUS LIABILITY OF ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.

The plaintiffs hereby restate, reallege, and incorporate by reference each and every allegation set forth above and further states, in the alternative, the following:

83. At all times pertinent to this Complaint, Dr. Steven D. Harrington, M.D., was an agent, ostensible agent, servant and/or employee of Advanced Cardiothoracic Surgeons, PLLC. As such, Advanced Cardiothoracic Surgeons, PLLC are vicariously liable for the negligent acts and/or omissions of Dr. Harrington as more fully described above, as well as the injuries and damages flowing from said acts and/or omissions.

WHEREFORE, plaintiffs respectfully request that this Honorable Court enter judgment against the defendants, jointly and severally, and in any amount in excess of TWENTY FIVE THOUSAND ($25,000.00) DOLLARS, together with interest, costs and attorney fees, to which the plaintiff is deemed to be entitled.

## COUNT III: LOSS OF CONSORTIUM

The plaintiffs hereby restate, re-allege and incorporate by reference each and every allegation set forth above and further state, in the alternative, the following:

84. At all times pertinent to this Complaint, Blaga Kostadinovski was the lawfully wedded wife of Drago Kostadinovski.

85. As a direct and proximate result of the injuries and damages experienced by Drago Kostadinovski, Blaga Kostadinovski, has suffered the loss of her husband's consortium, society, and companionship; emotional distress and anxiety, past, present, and future; and denial of social pleasures and enjoyments, past, present, and future.

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WHEREFORE, plaintiffs respectfully request that this Honorable Court enter judgment against the defendants, jointly and severally, and in any amount in excess of TWENTY FIVE THOUSAND ($25,000.00) DOLLARS, together with interest, costs and attorney fees, to which the plaintiff is deemed to be entitled.

RESPECTFULLY SUBMITTED,

MORGAN & MEYERS, PLC

BY _____

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TIMOTHY M. TAKALA (P72138)
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DATED: March 21, 2016

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF MACOMB

DRAGO KOSTADINOVSKI AND BLAGA KOSTADINOVSKI, AS HUSBAND AND WIFE,

Plaintiffs,

Case No. 14-2247-NH
Hon. Kathryn A. Viviano

vs.

STEVEN D. HARRINGTON, M.D. AND ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.,

Defendants.

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**DEFENDANTS STEVEN D. HARRINGTON, M.D., AND ADVANCED CARDIOTHORACIC SURGEONS, PLLC'S RESPONSE TO PLAINTIFFS' MOTION TO AMEND COMPLAINT**

NOW COME Defendants, **STEVEN D. HARRINGTON, M.D.**, and **ADVANCED CARDIOTHORACIC SURGEONS, PLLC**, by and through their attorneys, **RUTLEDGE, MANION, RABAUT, TERRY & THOMAS, P.C.**, and for their Response to Plaintiffs' Motion to Amend Complaint, state as follows:

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Despite the fact that this case has been pending for almost two years, Plaintiffs now seek to amend their Complaint despite the fact that Plaintiffs have had in their possession the medical records which reflect a decrease in hemoglobin and hematocrit since the outset of this claim. It is these records, which now formulate the basis for these new, unpled allegations. At this stage of the case, allowing an amendment would be highly prejudicial to Defendants and futile as the same are barred by the applicable two-year statute of limitations. Accordingly, Plaintiffs' request to amend should be denied.

As an initial matter, an amendment as requested by Plaintiffs should not relate back to the original filing of the pleadings, as MCR 2.118(D) provides that an amendment which seeks to add a new claim, only relates back to the date of the original pleading *if* the new claim asserted arose out the conduct, transaction or occurrence in the original pleading. Here, Plaintiffs seek to add completely new allegations and theories, which were not part and parcel of those claims in the NOI, Complaint or Affidavit. Rather, the proposed amendment amounts to an entirely new pleading. The original pleading filed in this case focuses solely on the preoperative assessment and testing of the patient, which pre-dated the mitral valve surgery performed by Dr. Harrington on December 14, 2011. See **Exhibit 1**, Complaint, ¶70. See also,

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**Exhibit 2**, NOI at ¶C, p 10; and **Exhibit 3**, Affidavit of [illegible] at ¶11. The crux of the allegations as now pled [illegible] a failure by Dr. Harrington to conduct pre-operative diagnostic studies, including a CT angiogram, to assess the patient's arterial tree prior to performing a robotic assisted mitral valve repair with an EndoClamp.

Conversely, the new allegations have nothing to do with the preoperative work-up or assessment of the patient's arterial tree or use of the EndoClamp in the absence of preoperative CT angiography. Rather, the new theories [illegible] by Plaintiffs involve an alleged failure by Dr. [illegible] transfuse the patient when the patient's hemoglobin [illegible] hematocrit decreased to 5.1 and 15 at 11:24 a.m. as documented in the hospital records. See **Exhibit 4**, Cardiopulmonary Bypass Record. It should be noted that neither the deposition of Ms. Masinick nor the deposition of Dr. Harrington [illegible] any [illegible] change the reported values of the intraoperative hemoglobin hematocrit contained in the records attached as **Exhibit 4**.

Moreover, even if this Honorable Court were to find that an amendment could relate back to the original pleadings, the relief sought should still be denied as adding a completely new theory of medical negligence and causation this late in the case would be highly prejudicial to Defendants. Specifically, Defendants assert that Plaintiffs' Motion should be denied because of

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(1) undue delay; (2) undue prejudice; and (3) futility. As noted above, Plaintiffs' and their counsel have had access and possession of Mr. Kostadinovski's medical records, including the Cardiopulmonary Bypass Record since the onset of this litigation (and likely before), and Defendants should not be now prejudiced because the decision was made not to send the entire record to Plaintiffs' experts.

This case is at the tail end of discovery, which has been held open for the limited purpose of completing expert depositions; with Case Evaluation scheduled for May 24, 2016 followed by trial which is scheduled for July 26, 2016. Simply put, it is too late in the game for Plaintiffs to search for a new viable claim to keep their lawsuit alive, as they do not have the expert support to maintain the action as pled. It is patently unfair and prejudicial for Defendants to now have to defend an entirely new theory, when for the last two years, the focus has been entirely different. Further, this is a case of undue delay, which is evidenced by the very fact that Plaintiffs did not file the instant Motion until after Defendants filed their Motion to Strike these new allegations and for summary disposition.[1]

[1] Defendants' Motion to Strike and for Summary Disposition is currently scheduled to be heard on April 25, 2016.

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While amendments shall be freely given when justice so requires, *Weymers v Khera, 454 Mich 639, 657; 563 NW2d 647 (1997)* citing MCR 2.118(A)(2), a motion should be denied when there is a finding of undue delay, undue prejudice and futility. *Weymers, supra*. In *Ben P Fyke & Sons v Gunter Co., 390 Mich 649; 213 NW2d 134 (1973)*, the Supreme Court noted that in cases where the delay is so long and the amendment so substantial, an opposing party is necessarily denied a fair trial due to the delay, and is therefore prejudiced. *Id.* at p 663. The Weymers' Court reaffirmed this principle and specifically noted that a trial court may find prejudice when the moving party seeks to add a new claim or a new theory just before trial, and the opposing party shows that he did not have any reasonable notice of that new claim or theory. *Weymers, supra* at 657. The *Weymers* Court also found persuasive the reasoning in *Priddy v Edelman, 883 F2d 438, 446-447 (C.A.6, 1989)*, which held:

> A party is not entitled to wait until the discovery cutoff date has passed a motion for summary judgment has been filed on the basis of claims asserted in the original complaint before introducing entirely different legal theories in an amended complaint…. In complex cases such as this one, … it is particularly likely that drastic amendments on the eve of trial will prejudice the defendants…. Putting the defendants 'through the time and expense of continued litigation on a new theory, with the possibility of additional discovery,

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> would be manifestly unfair and unduly prejudicial.'

*Weymers, supra* at p 658.

While technically discovery remains open, it remains solely open to complete the expert depositions in this case. Indeed, trial is only three months away. This, coupled with the significance of the proposed amendment and wholesale change in theory, will result in the Defendants having no choice but to re-examine defense theories with their experts, which will necessarily lead to additional expense and likely the need for additional time to conduct discovery of other fact witnesses. Simply, Plaintiffs' proposed amendment is extremely prejudicial.

Moreover, Plaintiffs' proposed amendment would be futile because Plaintiffs' proposed new claim bypasses the statutory requirements for filing a medical malpractice action. As this Honorable Court is aware, pursuant to MCL 600.2912b(1), a medical malpractice action *shall* not be commenced unless a Notice of Intent to file a claim has been mailed to the last known address of each potential defendant 182 days before filing, which sets forth (a) the factual basis for the claim; (b) the applicable standard of practice or care alleged by the claimant; (c) *the manner in which it is claimed that the applicable standard of practice or care was breached by the health professional;* (d) *the alleged action that should have been taken to achieve compliance*

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*with the alleged standard of practice or care;* (e) *the manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice;* and (f) the names of all health professionals and health facilities the claimant is notifying in relation to the claim. The failure by Plaintiffs to include these new claims of malpractice in their Notice of Intent is fatal. *See Gulley-Reaves v Baciewicz, M.D., et al, 260 Mich App 478, 484; 679 NW2d 98 (2004).*

"The purpose of the notice requirement is to promote settlement without the need for formal litigation and reduce the cost of medical malpractice litigation while still providing compensation for meritorious medical malpractice claims that might otherwise be precluded from recovery because of litigation costs." See *Neal v Oakwood Hosp. Corp. 226 Mich App 701, 705; 575 NW2d 68 (1997).* Allowing a plaintiff to bypass these statutory requirements by simply amending a subsequent complaint, does not provide a defendant the opportunity to engage in any type of settlement negotiations with regard to any new claims as the defendant would not have been given prior notice of the existence of any such claim. *Gulley-Reaves, supra* at p 488.

In *Gulley-Reaves, supra,* plaintiff's complaint included allegations of malpractice regarding the administration of anesthetic and included claims for the actions and/or inactions

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of both an anesthesiologist as well as a CRNA. The Court noted that the plaintiff's notice of intent was deficient in that:

> . . . Plaintiff's Notice of Intent was silent with regard to any breach of the standard of care during the administration of anesthesia. Plaintiff did not minimally allege that the agents of the hospital that administered the anesthesia were at fault.

*Id.* at p 487.

In *Decker v Rochowiak, 287 Mich App 666; 791 NW2d 507 (2010)*, the Court of Appeals was asked to review whether a trial court acted within its discretion to allow a medical malpractice plaintiff to amend his complaint. In that case, the Court of Appeals examined the notice of intent filed, and when examined as a whole, the Court found that the plaintiff's NOI set forth sufficient claims which included the allegations that were subject of the proposed amendment. *Id.* at p 677. The Court specifically distinguished the facts before it from those in the *Gulley-Reaves, supra*, decision as outlined above, finding:

> The basis of the claims against these defendants did not change. The allegations in the amended complaint merely clarified with more specificity the manner in which the standards of care were breached, which could be discerned more clearly with the aid of the discovery process. This is not a case where, as in *Gulley-Reaves*, the plaintiff set forth a totally new and different potential cause of injury in an amended complaint compared to the potential cause of injury set forth in her NOI, e.g., the manner in which a particular surgical procedure was performed compared to the

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> manner in which anesthesia was administered during the surgery.

*Decker, supra* at pp 680-681.

Here, a review of Plaintiffs' Notice of Intent attached hereto as **Exhibit 2** reveals that all of the allegations in the NOI relate to the preoperative assessment of the arterial tree, and the breaking off of clot or thrombus with the use of an EndoClamp resulting in stroke. There is simply no mention, reference or inference to an alleged failure by Dr. Harrington to transfuse the patient secondary to a decreased hemoglobin and hematocrit during the December 14, 2011 surgery. Similarly, in the NOI, Plaintiffs make no assertion that the cause of the stroke was related to decreased oxygenation to the brain secondary to hemodilution (or hypotension) during the surgery and the failure to transfuse the patient. Rather, the NOI clearly identifies the cause of the stroke as being related to the alleged dislodging of thrombus, clot or calcification during the use of the EndoClamp. See **Exhibit 2**, pp 12-13.

This case is not like those facts found in *Decker, supra*, but rather, it is akin to the facts in *Gulley-Reaves, supra*, where there is a "totally new" and "different potential cause of injury" in the proposed Amended Complaint than those set forth in the NOI. As a result, the failure to adhere to the statutory mandates makes any proposed amendment futile, as these new

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allegations of negligence must fail as a matter of law. Accordingly, Plaintiffs' Motion to Amend should be denied.

WHEREFORE, for the reasons set forth above, Defendants, **STEVEN D. HARRINGTON, M.D.**, and **ADVANCED CARDIOTHORACIC SURGEONS, PLLC**, respectfully request that this Honorable Court DENY Plaintiffs' Motion to Amend Complaint.

Respectfully submitted,

RUTLEDGE, MANION, RABAUT,
TERRY & THOMAS, P.C.

BY: /s/ Matthew J. Thomas

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Dated: March 22, 2015

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STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF MACOMB

- - -

DRAGO KOSTADINOVSKI and
BLAGA KOSTADINOVSKI,

Plaintiffs,

vs. Case No. 14-2247 NH

STEVEN D. HARRINGTON M.D.,
and ADVANCED CARDIOTHORACIC
SURGEONS, PLLC,

Defendants.
_____/

PROCEEDINGS

BEFORE THE HONORABLE KATHRYN VIVIANO, JUDGE

Mount Clemens, Michigan - March 28, 2016

APPEARANCES:

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(No witnesses offered)

EXHIBITS:
Received
(No exhibits offered)

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Mount Clemens, Michigan

March 28, 2016

At about 9:27 a.m.

- - -

(REPORTER'S NOTE: "Indiscernible" means a word or words were not heard well enough to be able to discern a proper interpretation either because of shuffling of papers, or the speaker did not talk loud enough, or was not picked up by the microphones.)

(Court and Counsel present.)

THE COURT: Case number 2014-2247 NH. Calling Kostadinovski versus Harrington.

MR. MEYERS: Good morning, Judge. Jeff Meyers on behalf of the Plaintiff.

MR. THOMAS: Good morning, Matthew Thomas on behalf of the Defendant.

MR. MEYERS: Good morning, Judge. Judge, I first want --

This is a motion to amend the complaint. I would first like to address the Defendant's argument with regard to undue delay.

The complaint in this case was

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originally filed on June 5, 2014. Defendant's Answer was filed on July --

Excuse me, July 15, 2014. We noticed the Defendant's deposition Dr. Harrington to take place on July 22, 2014, immediately after the filing of the complaint.

The Defendants did not produce him --

By way of background, Dr. Harrington is a cardiovascular surgeon, a solo practitioner with a, what he contends and what I perceive to be an extremely busy practice, and we attempted to accommodate the schedule.

The deposition was not --

Although we requested it on numerous occasions, on November the 24th, so four months later, after it was originally noticed, we had to file a motion to compel his deposition.

The motion was adjourned by this Court to December the first.

Defendant --

THE COURT: Of 2014 now?

MR. MEYERS: Yes. Yes. So now we're six months --

THE COURT: So Judge Foster adjourned it.

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MR. MEYERS: It got adjourned for a week, and then we --

THE COURT: Somebody adjourned it, but, okay.

MR. MEYERS: Yeah. And then the motion was --

There was no order entered. The Defendant ultimately produced Dr. Harrington for deposition on May the 14, 2015.

Dr. Harrington cut the deposition short because of his surgery schedule.

We then re-noticed it to take place on June the 16th. It was adjourned by the Defendant.

July the 16th, again adjourned by the Defendant.

September the 10th adjourned, and then on, finally the deposition was completed on September the 22nd, 2015, after these numerous adjournments that we attempted to cooperate with the Defendant. Particularly Mr. Manion and I and brother counsel had a good relationship. We tried to work together, but this certainly was through no delay of mine.

We get into the deposition with Dr.

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Harrington and --

THE COURT: You mean in September.

MR. MEYERS: Yes, on September the 22nd, and showed him a document that is contained within the operative records some 4,000 pages of records, by the way. And we attempt to examine him about the document, and he indicates at page 157 of his deposition: It's illegible. He can't real read it.

So it is a perfusionist record. Perfusionist is the person that runs the heart/lung bypass machine during the operation.

And we say fine, okay. We'll take the perfusionist deposition. Perfusionist we then learn after Doctor Harrington's deposition had left Michigan. She was re-located to Riverside California, and we ultimately got her deposition on July --

Excuse me, December 17, 2015.

Before her deposition was taken, I alerted Mr. Manion in a session with this court on one of our scheduling conference date on July the 8th/there may be an issue with regard to the perfusionist issue, and particularly with regard to Dr. Harrington's role in the perfusion.

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I should note by background, I know I'm throwing a lot at you.

THE COURT: I'm following you.

MR. MEYERS: Dr. Harrington says during his surgery he doesn't know whether or not the information contained within the perfusionist record was even conveyed to him at the time of the operation. So we are without that evidence at that time.

We take the perfusionist's deposition on December the 17th. Perfusionist testifies: Yes, I certainly informed him of all of this data. And at that point we know what is going on.

I contacted --

So I had this conversation with Mr. Manion in December. And then on January the 14th, a week ahead of my first standard of care witness's deposition, I contacted both Mr. Manion and Mr. Thomas. I was in depositions in Sarasota Florida. I found them on my cell phone to let them know: Hey, heads up, this theory of liability is in play. You are going to hear it at the time of Doctor Chedrawy's deposition on December, on January the 22nd.

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They, in fact, heard it, record was made at the time of Doctor Chedrawy's deposition.

Then we took Doctor Samuels deposition in (indiscernible) Philadelphia on January the 25th. Again, that same theory was articulated.

February the 1st in the deposition of Dr. Naidich, my neuroradiologist in New York City, the deposition was articulated.

Excuse me, the theory was articulated and then finally on Good Friday, last Friday, we took the deposition of the defense's first witness on this issue who admitted he had known about the issue for months.

So there is no undue delay with regard to the articulation of this issue.

THE COURT: Okay.

MR. MEYERS: Second point. Relation back with regard to the statute of limitations. The statute of limitations in a medical malpractice matter doesn't toll until the injury occurs. The injury in this case occurred at the time of the operation.

The statute of limitations with regard to the operation that occurred on December 14th, 2011 was began when that injury occurred, the

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stroke that this man experienced as a result of the operation.

We alleged in the original complaint that the physician failed to do appropriate preoperative testing and should not have used a clamp during the operation.

So our allegations go to the events which occurred during the operation --

THE COURT: Which is when, I'm sorry.

MR. MEYERS: Pardon me.

THE COURT: Which was when.

MR. MEYERS: December 14, 2011.

THE COURT: Okay.

MR. MEYERS: So, our allegations with regard to in the original complaint focused on the surgery which occurred because we alleged that this injury occurred as result of a utilization of a particular clamp at the time of the surgery.

The point is that this new theory speaks to other acts that occurred at the time of surgery where the injuring occurred.

So there is no statute of limitations issue here with regard to the relation to that; there is just not.

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Final issue is the question with regard to the Notice of Intent. There's no requirement that every potential theory of liability can be contained within a Notice of Intent.

The theory of --

We didn't even know that the perfusionist had communicated the information in question to Dr. Harrington until her deposition which was taken on December the 17, 2015.

We have, obviously had no control of her leaving the State of Michigan, going to California. I didn't have any control over Dr. Harrington's surgery schedule. There will be --

The final point, I think the one that is often times most material to this court and others is, okay, so what does this mean with regard to the judicial management of this case.

It means nothing because the Defendants have been aware of this theory forever. Our plaintiff, our experts have already been deposed.

THE COURT: In other words, you say the prejudice they are saying doesn't require any kind of accommodation.

MR. MEYERS: There is, there is no prejudice because they have known about the

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theory of liability for months. It only became apparent in December. My experts have already been deposed. Mr. Thomas took the depositions of the experts that he --

He cross examined them very well. The experts spoke to the issue.

THE COURT: All right.

MR. MEYERS: And now in, probably the most material point is this. On Good Friday when I take their expert's deposition and I ask them about this theory of liability. The technical term is hypo oxygenation, low oxygenation during the operation. How long have you known about this? He said: I don't know exactly but it's been several months, maybe as long as six months.

So they have known about it. There is no prejudice. We only have two depositions to complete, and we are done. We have done everything that has been asked of us. So this theory of his --

THE COURT: Okay. Let's ask them.

Go ahead.

MR. THOMAS: Thank you, Judge. A couple things, I'll try and work at least in order as I set it forth in my response.

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THE COURT: I mean, he said --

What is the undue delay argument.

MR. THOMAS: Here is the thing, Judge, and --

THE COURT: Based on that recitation, what is the undue delay.

MR. THOMAS: Well, here is the --

THE COURT: It took them a year and a half to get a deposition from your client.

MR. THOMAS: I understand that, Judge. But here is the thing. Those perfusion records --

Their whole theory is based upon a 11-24 a.m. hemoglobin and hematocrit that were decreased. I attached those for the Court in Exhibit 4. Those are four pages that are continued within the operative section which accounts for about 20 pages of 4,000 records.

Mr. Meyers is correct, there is about 4,000 pages, but that is a long hospitalization. The operative records are 25 pages.

It is clear that it's a 5.1 and a 15 on the hemoglobin and hematocrit. Those should have been --

If that was, in fact, a theory, it

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should have been --

It doesn't matter what Ms. Masnick, the perfusionist says, or what Dr. Harrington says. Those are either low values or they are not low values.

THE COURT: All right. So your position is on the undue delay they should have known way back when they got these records.

MR. THOMAS: I do think that this should have been known.

THE COURT: Let's talk about the prejudice.

MR. THOMAS: I'm sorry, Judge.

THE COURT: The prejudice part.

MR. THOMAS: The prejudice? Well, the prejudice is two-fold.

Number one, I don't think these were way back. If you look at --

If you look at the NOI, the complaint, and the affidavit in this case, all of it has to do with preoperative assessment.

He brings up this EndoClamp that was used during surgery. The only reason there was any allegation with respect to the EndoClamp was it was his expert who originally said that if

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you're going to use this EndoClamp, which is a special type of way of stopping the blood of growing through the aorta, you have to do a preoperative CT angiogram and you didn't do so.

All the allegations --

They didn't have a problem with the use of the EndoClamp. They had a problem with using the EndoClamp when you haven't done a preoperative assessment.

The allegations in the case are assessment. And that is --

I invite the Court to look at the Exhibit of 1, 2, 3 which are the complaint, the NOI and the affidavit of merit.

THE COURT: You are not saying then prejudice, you are saying more futile because he can't make the claims.

MR. THOMAS: It is trifle actually. I believe there is some prejudice there. I think number one under 2.118(D) which only allows relation back when those theories are related to the original theories and they are not related.

It doesn't matter that it all occurred out of a surgery on December 14th because when you look at the allegations, the allegations are

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preoperative in nature, not operative in nature.

They don't have a problem with the way Dr. Harrington performed the surgery. They had a problem with his preoperative workup for the surgery.

Second of all, to that end they also, if you look at the causation statement, which they are required to provide us under the law. They are required. Their preoperative causation --

I'm sorry pre-litigation, causation statement and then their litigation, the way it is pled in the complaint, the way it is pled in the Affidavit of Merit, all relates to this breaking off of a clot.

So what they alleged is we should have done this preoperative screening. That would have shown there was some clot or some calcification of the patient's aorta. So that when we place this EndoClamp, which is a catheter that goes into the aorta. They blow up a balloon to stop the blood flow that that broke off some sort of clot or thrombus which embolized, went to the patient's brain and he had a stroke.

Now they are saying that is not what

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happened in this case. They are saying there was this decrease in hemoglobin and hematocrit which resulted in a failure to provide oxygen rich blood, nutrient rich blood to the patient's brain and resulted in a stroke, not this clot theory. The clot theory is gone.

So that is number one. It is 2.118 (D). I don't believe that this is (indiscernible) .

THE COURT: Which again is futile argument, right? You are saying it prevents --

It doesn't relate back which means it is barred by the statute of limitations.

MR. THOMAS: Correct. The other part of the futile argument, and I would point the Court to the Gulley-Reaves decision. You have to plead these theories in the (indiscernible).

The Courts have completely said that has to be done. And he is right. He doesn't have to plead every potential (indiscernible), but it has to be in the same arena, it has to be within the same stratosphere.

In this case it is completely different.

And a pointed, I cited to a case which was one of the more recent cases on this subject

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for the Court in my response and that is the Decker versus Rochoviak (phonetic) case which is a 2010 Court of Appeals decision.

In that case the Court looked at the underlying as a whole and said: You know what? These are close enough. This is more of a clarification. This is not like Gulley-Reaves, and that is what I am relying on.

And I think if you --

If the Court looks at that case and looks at Gulley-Reaves you will see this is much more like the Gulley-Reaves decision where the NOI has nothing to do with what these new complaints are, these new complaints that we learned in January.

Again to Mr. Meyers credit, he did alert me before the depositions and said this is going to be a theory. I made my objection on the record, he made a statement as well, we continued. I took these because we had to.

THE COURT: You're not really in the prejudice realm, you are more in the futile realm?

MR. THOMAS: I believe this is futile and I believe it also doesn't give a relation

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back due to the, under the Court Rules 2.118.

THE COURT: Okay. All right. Any reply? Brief.

MR. MEYERS: The case is about a surgery which occurred on a specific date. We alleged that the doctor should not have used a clamp during the surgery. That is negligent conduct during the surgery because he had not done certain preoperative workup, it was the use of the clamp during the surgery. The whole case is about the surgery.

We are now attempting to allege through this amendment that during the surgery that the doctor also did not monitor the patient's oxygenation level.

So it clearly relates back to the date of surgery. There was no injury two weeks before the surgery. The statute of limitations did not begin to run until the date of the injury. Mr. Thomas will acknowledge that.

So the relation back issue is wrong, clearly wrong.

With regard to this issue of the amendment of a complaint, the Defendant has not cited a single case that suggests that we, we are

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precluded from alleging a new theory of liability that falls outside the Notice of Intent as long as it relates back to the same event. The event in this case is the surgery.

This is not --

We're not alleging something that happened a week or two weeks later with a new injury or new act of malpractice causing some new enhanced injury.

THE COURT: Okay, fine.

MR. MEYERS: The final point is this. This combined effect of the hypo oxygenation, our experts will testify, a neurologist will testify that the hypo oxygenation, the low oxygen along with potentially with some embolic event caused totality of the harm. So that is our argument in summary.

If you want additional briefing on the relation back issue, or on the Gulley-Reaves case, I am happy to give it. I don't think it is necessary because --

THE COURT: Okay. It's up to you, if you think it's necessary. I'm satisfied. I have your briefs. I'm going to take it under advisement.

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I know you're on a tight time line, so I'm going to issue it relatively quickly. I understand you have case eval.

MR. THOMAS: Can I have some reply, real brief.

THE COURT: You have case eval on the 5th, so I'm assuming you briefed it up in front of me. What is missing in the briefs?

MR. MEYERS: Well, he raised this issue in his responsive brief with regard to his question of Gulley-Reaves, which I think is a complete red herring. I don't want you to be mislead by the issue. I will put it in context in a very short brief for you.

THE COURT: Can you do it --

I mean, I have to issue this opinion before 4-5. So how much --

Can you do it overnight?

MR. MEYERS: May I have until Wednesday.

MR. THOMAS: Actually, Judge, to --

I don't mean to help Mr. Meyers out here, but last time we were before you we were able to --

We were able to move case eval. It is

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now in May. So to that end --

MR. MEYERS: May I have a week.

THE COURT: Yes.

MR. THOMAS: And we have my summary disposition motion. This was filed after I filed my summary disposition. Judge, it is scheduled for April 20th, which involves not only this new allegations but with respect to the allegations that were currently (indiscernible) .

THE COURT: You are saying my deadline is 4-20.

MR. THOMAS: I think 4-20 is probably the --

THE COURT: So that is fine. I will give you, that gives you to what date? Give me some time line so I have a little bit --

That gives me a little bit more time. Seven days to file your supplemental. The sooner you can get it in the better, and then I will issue an opinion.

MR. THOMAS: Judge --

THE COURT: I do need a yellow order so I have memory of that. I'm taking the motion under advisement. You have seven days to submit your supplemental.

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MR. THOMAS: Do I have any right to reply? I responded to his original motion.

THE COURT: Again, I don't know. When do I cut it off at some point, right?

MR. THOMAS: No, I understand that, Judge.

THE COURT: I'm satisfied. The Court is satisfied. You have fully briefed it. You put the --

And I'm competent enough to read the briefs, and I think I have enough law and facts in front of me to make a decision on this. Okay. Just a supplemental in seven days. Thank you.

MR. THOMAS: Thank you.

# Circuit Court Order 04/25/2016

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| STATE OF MICHIGAN<br>COUNTY OF MACOMB<br>CIRCUIT COURT | ORDER | Case No.<br>14-2247-NH |
|---|---|---|

Kostadinovski Plaintiff(s) Attorney: Justin Hakala P# 72986

vs

Harrington, et al Defendant(s) Attorney: Matthew Thomas P# 60283

At a session of the Court, held on April 25, 2016

ORDER OF Dismissing Plaintiff's Claims as pled in the NOI, Complaint and Affidavit of Merit
Title of Order

IT IS ORDERED:

For the reasons stated on the record, Plaintiffs' allegations of negligence and theory of causation as pled in Plaintiffs' Notice of Intent, Complaint and Affidavits of Merit are hereby dismissed, with prejudice.

Plaintiffs' Motion to Amend Complaint remains taken under advisement, and the Court will issue an opinion. Additionally, the remaining issues raised in Defendants' Motion today are taken under advisement.

This is not a final order and does not close the case.

APR 25 2016

HON. KATHRYN A. VIVIANO CIRCUIT JUDGE

Approved as to form and substance by:

P72996
Signature of attorney for plaintiff

P60028
Signature of attorney for defendant

(5/25/04)

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STATE OF MICHIGAN

MACOMB COUNTY CIRCUIT COURT

DRAGO KOSTADINOVSKI
and BLAGA KOSTADINOVSKI,
as husband and wife,

Plaintiff,

Case No. 2014-2247-NH

vs.

STEVEN D. HARRINGTON, M.D., and
ADVANCED CARDIOTHORACIC
SURGEONS, P.L.L.C.,

Defendants.

/

OPINION AND ORDER

This matter is before the Court on plaintiffs' motion to amend complaint, as well as defendants' motion to strike allegations not contained in the notice of intent, complaint, and affidavits of merit and for summary disposition pursuant to MCR 2.116(C)(10).

I. Background

This case involves allegations of medical malpractice. On December 14, 2011, defendant Steven D. Harrington, M.D. performed a DaVinci mitral valve repair surgery on plaintiff Drago Kostadinovski. During the procedure, Mr. Kostadinovski suffered a stroke. On December 9, 2013, plaintiffs sent their notice of intent ("NOI") to Dr. Harrington and defendant Advanced Cardiothoracic Surgeons, PLLC ("ACS"). On October 13, 2015, plaintiffs' filed their complaint in this matter alleging a count of

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medical malpractice against Dr. Harrington, a count of vicarious liability against ACS, and a count for loss of consortium against defendants.

On March 21, 2016, defendants filed the instant motion to strike allegations not contained in the notice of intent, complaint, and affidavits of merit and for summary disposition pursuant to MCR 2.116(C)(10). The same day, plaintiffs filed the instant motion for leave to file an amend complaint alleging two additional ways that Dr. Harrington breached the applicable standards of care that were not included in their notice of intent, complaint, and affidavits of merit.

At a hearing on March 28, 2016, the Court heard the parties' arguments on plaintiffs' motion for leave to file an amended complaint and took the matter under advisement. On April 25, 2015, the Court heard the parties' arguments on defendants' aforementioned motion to strike and motion for summary disposition. After the hearing, the parties submitted a stipulated order dismissing plaintiffs' claims of negligence and theory of causation as plead in their notice of intent, complaint, and affidavits of merit with prejudice. Thus, the Court need not address defendants' arguments relating their motion for summary disposition of plaintiffs' claims raised in their original filings.

However, the stipulated order did not dispose of plaintiffs' motion for leave to file amended complaint. Because defendants' motion strike allegations not contained in the notice of intent, complaint, and affidavits of merit raises the same issues as plaintiffs' motion for leave to file amended complaint, the Court shall consider the parties' motions together.

## II. Arguments of the Parties

Plaintiffs argue that the Court should grant their motion for leave to amend their



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complaint to add an additional claims to Count I of their complaint alleging negligence against Dr. Harrington for failing to adequately monitor Mr. Kostadinovski's hypotension during the operation and failing to transfuse the patient so as to maintain his blood pressure. Plaintiffs contend that because their original complaint raised claims of negligence associated with the December 14, 2011, surgery performed by Dr. Harrington, the proposed amended claims arise out of the same "conduct, transaction, or occurrence" that was the subject of their original complaint pursuant to MCR 2.1118(D). Additionally, plaintiffs submit that there is no undue delay, bad faith, previous inadequate amendments, undue prejudice, or futility.

Defendants aver that the proposed amendment does not relate back to the original filing of the pleadings under MCR 2.118(D) because plaintiffs seek to add completely new allegations and theories, which were not part and parcel of those claims in the NOI, complaint, or affidavit of merit. Specifically, defendants argue that the original pleading focused solely on the preoperative assessment and testing of the patient, which predated the mitral valve surgery performed by Dr. Harrington. Defendants claim that the new allegations have nothing to do with the preoperative work-up or assessment of the patient's arterial tree or use of the EndoClamp in the absence of a preoperative CT angiography. Additionally, defendants state that even if the proposed amendment "relates back" to the complaint, the proposed amendment should be denied due to undue delay, undue prejudice, and futility.

III. Law & Analysis

MCR 2.118(D) provides that "[a]n amendment that adds a claim or defense relates back to the date of the original pleading if the claim or defense asserted in the



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amended pleading arose out of the conduct, transaction, or occurrence set forth, or attempted to be set forth, in the original pleading."

In *Doyle v Hutzel Hosp*, 241 Mich App 206; 615 NW2d 759 (2000), a plaintiff filed a complaint against defendants on October 14, 1996, asserting a medical malpractice claim arising out of a 1994 post-operative infection. *Id.* at 208. Specifically, plaintiff alleged that defendants negligently caused and allowed foreign material to remain in her body at the close of surgery. *Id.* at 209. In February of 1998, after the expiration of the applicable period of limitation pursuant to MCL 600.5805(4), defendants moved for summary disposition asserting that plaintiff could not support her allegation that foreign material was left in the surgical site during surgery or that any material was removed on August 16, 1994, was a foreign body. *Id.* In response, plaintiff moved to amend her complaint, seeking to add two theories of professional negligence against defendants. *Id.* at 2010. Namely, plaintiff's proposed amended complaint alleged that her post-operative infection was caused by defendants' performing the surgery without eliminating the possibility of prior infection in her ankle, and by defendants' failure to properly diagnose and treat the post-operative infections following surgery. *Id.*

The Michigan Court of Appeals held that the trial court erred in concluding that the amended complaint did not relate back to the original complaint pursuant to MCR 2.118(D). *Id.* at 211. The Court noted that "[i]t is well settled that the amended pleading can introduce new facts, new theories, or even a different cause of action as long as the amendment arises from the same transactional setting that was set forth in the original pleading." *Id.* at 212-213. The Court concluded the trial court's undue reliance on the temporal differences between the theories alleged in the amendment and original



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complaints clouded the broader analysis required by MCR 2.118. *Id.* at 218-220. The Court found that because "all the new theories of negligence proposed in the amended complaint arose out of the same conduct, transaction, or occurrence set forth in her original complaint, namely, 'the infection of plaintiff's right hip following surgery,'" the amendments relate back to the original complaint. *Id.* at 211, 220.

In this case, plaintiffs' NOI alleged that that Dr. Harrington negligently failed to obtain preoperative diagnostic tests, including a CT angiogram, which would have enabled him "to identify thrombus, clots, or calcium within the arterial tree which would embolize and/or cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp as was performed on December 14, 2011." Defendants' Exhibit 2, Plaintiffs' NOI at 12-13. According to plaintiffs' NOI, "[h]ad Dr. Harrington performed the proper preoperative testing, he would have aborted the procedure and/or would have use a different technique aside from the use of an EndoClamp." *Id.* at 13. The allegations in plaintiffs' complaint mirror the allegations made in the NOI. However, plaintiffs contend that during the course of discovery it was revealed that Dr. Harrington negligently failed to monitor Mr. Kostadinovski's hypotension during the operation and failed to transfuse him.

Given the foregoing, the Court is satisfied that the proposed amendment arises from the same transactional setting that was set forth in the original pleading. Indeed, the new theory of negligence proposed in the amended complaint arises out of the same conduct, transaction, or occurrence set forth in the original complaint – the DaVinci mitral valve repair surgery performed on December 14, 2011. Consequently,



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plaintiffs' proposed amended complaint relates back to the date the original complaint was filed – October 13, 2015 – pursuant to MCR 2.118(D).

Despite the conclusion that plaintiffs' proposed amended complaint relates back to the date of the original complaint was filed, the Court must further determine whether plaintiffs' motion to amend should nevertheless be denied, as argued by defendants.[1]

MCR 2.118(A)(2) provides that "[e]xcept as provided in subrule (A)(1), a party may amend a pleading only by leave of the court or by written consent of the adverse party. Leave shall be freely given when justice so requires." *Kemerko Clawson, LLC v RxIV Inc*, 269 Mich App 347, 352; 711 NW2d 801 (2005). "Because a court should freely grant leave to amend a complaint when justice so requires, a motion to amend should ordinarily be denied only for particularized reasons." *Wormsbacher v Seaver Title Co*, 284 Mich App 1, 8; 772 NW2d 827 (2009). "Reasons that justify denying leave to amend include undue delay, bad faith or dilatory motive, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the defendant, or futility." *Id.*

MCL 600.2912b(1) requires that the plaintiff in a medical malpractice action give the defendant written notice of the plaintiff's intent to file a claim at least 182 days before commencing a medical malpractice action against the defendant. *Tyra v Organ*

[1] The fact that plaintiffs' proposed amendment arises from the same conduct, transaction, or occurrence set forth in the original complaint – and thus, relates back to the date of the filing of the original complaint pursuant to MCR 2.118(D) – does not eliminate plaintiffs' duty to provide defendants with the requisite statutory notice pursuant to MCL 600.2912b. In other words, the determination that the new allegations in the proposed amended complaint relate back to the original complaint merely provides that the proposed amended complaint is deemed to have been filed on the same date the original complaint was filed – October 13, 2015. The relation back rule simply has no bearing on plaintiff's obligation to comply with MCL 600.2912b. For this reason, plaintiffs' reliance on *Doyle* is misplaced to the extent plaintiffs suggest the relation back rule allows amendments in a medical malpractice action despite the failure to comply with MCL 600.2912b.



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*Procurement Agency of Michigan*, 498 Mich 68, 78; 869 NW2d 213 (2015). MCL 600.2912b(4) mandates that a NOI contain a statement of the following:

> (a) The factual basis for the claim.
> (b) The applicable standard of practice or care alleged by the claimant.
> (c) The manner in which it is claimed that the applicable standard of practice or care was breached by the health professional or health facility.
> (d) The alleged action that should have been taken to achieve compliance with the alleged standard of practice or care.
> (e) The manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice.
> (f) The names of all health professionals and health facilities the claimant is notifying under this section in relation to the claim.

"A claimant is not required to ensure that such statements are correct, but the claimant must make a good-faith effort to set forth the required information with that degree of specificity which will put the potential defendants on notice as to the nature of the claim against them." *Tousey v Brennan*, 275 Mich App 535, 539; 739 NW2d 128 (2007). "The details need only allow the potential defendants to understand the claimed basis of the impending malpractice action." *Id.*(internal citation and punctuation omitted). "[A] plaintiff cannot commence an action before he or she files a notice of intent that contains all the information required under § 2912b(4)." *Boodt v Borgess Med Ctr*, 481 Mich 558, 562-563; 751 NW2d 44 (2008).

In *Gulley-Reaves v Baclewicz*, 260 Mich App 478; 679 NW2d 98 (2004), the plaintiff's NOI set forth as the basis of her claim a particular surgical procedure that resulted in damage to her vocal cords which "likely occurred because of the inexperience of the medical students or resident, who actually performed the procedure." *Id.* at 480. However, when the plaintiff filed her complaint, she included claims based on the anesthesia that was administered during the surgery. *Id.* at 481. On appeal, the Court held that "the notice did not set forth the minimal requirements to



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identify that the anesthesia was a potential cause of plaintiff's injury." *Id.* at 487. The Court also noted that "[d]efendant hospital was not given the opportunity to engage in any type of settlement negotiation with regard to the anesthesia claims because it was not given notice of the existence of any such claim." *Id.* at 488. Therefore, the Court held that the trial court erred in denying defendants' motion for summary disposition because "[p]laintiff failed to provide notice of the claim of breach of the standard of care with regard to the administration of anesthesia" as required by MCL 600.2912b(4)(c). *Id.* at 490.

In this case, as previously stated, plaintiffs' NOI alleged that that Dr. Harrington negligently failed to obtain preoperative diagnostic tests which would have enabled him "to identify thrombus, clots, or calcium within the arterial tree which would embolize and/or cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp as was performed on December 14, 2011." Defendants' Exhibit 2, Plaintiffs' NOI at 12-13. According to plaintiffs' NOI, "[h]ad Dr. Harrington performed the proper preoperative testing, he would have aborted the procedure and/or would have use a different technique aside from the use of an EndoClamp." *Id.* at 13.

Although the allegations in plaintiffs' complaint mirrored the allegations made in the NOI, now plaintiffs seek to amend their complaint to include allegations that Dr. Harrington negligently failed to monitor Mr. Kostadinovski's hypotension during the operation and failed to transfuse him. The Court finds that plaintiffs' NOI did not set forth the minimal requirements to provide notice of the claim of breach of the standard of care with regard to the failure to monitor hypotension levels during the operation and



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the failure to transfuse the patient was a potential cause of injury as required by MCL 600.2912b. Accordingly, defendants were not given the opportunity to engage in any type of settlement negotiation with regard to the hypotension and transfusion claims because they were not given notice of the existence of any such claims. Even if plaintiffs had included these new allegations in their original complaint, defendants lacked the requisite notice mandated by MCL 600.2912b because they were not raised in the NOI.

Plaintiffs' failure to adhere to the statutory mandates renders the new allegations contained in the proposed amended complaint futile, as these new allegations of medical malpractice must fail as a matter of law. See *Boodt*, 481 Mich at 562-563; *Gulley-Reaves*, 260 Mich App 490. Therefore, plaintiffs' motion to amend is properly denied.[2]

IV. Conclusion

For the reasons set forth above, plaintiffs' motion to amend complaint is DENIED. Defendants' motion to strike allegations not contained in the notice of intent, complaint, and affidavits of merit and for summary disposition pursuant to MCR 2.116(C)(10) is thus rendered moot. Pursuant to MCR 2.602(A)(3), this Opinion and Order resolves the last pending claim and closes the case.

IT IS SO ORDERED.

DATED: APR 29 2016

Kathryn A. Viviano

Hon. Kathryn A. Viviano
Circuit Judge

Cc:

[2] Given the Court's determination that plaintiffs' may not amend their complaint, defendants' motion to strike allegations not contained in the notice of intent, complaint, and affidavits of merit is moot and need not be addressed separately.



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STATE OF MICHIGAN

IN THE SUPREME COURT

| | |
|---|---|
| DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI, as Husband and Wife,<br><br>*Plaintiffs-Appellees,* | Supreme Court No. 156850<br>Court of Appeals No. 333034 |
| v.<br><br>STEVEN D. HARRINGTON, M.D. and ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.,<br><br>*Defendants-Appellants.* | Macomb County Circuit Court<br>No. 14-2247-NH<br>Hon. Kathryn A. Viviano |

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# DEFENDANTS-APPELLANTS STEVEN D. HARRINGTON, M.D. AND ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.'S SUPPLEMENTAL BRIEF

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## Order Appealed From and Jurisdictional Statement

On May 19, 2016, plaintiffs-appellees/cross-appellants Drago and Blaga Kostadinovski's filed a timely claim of appeal from the trial court's April 29, 2016 final Opinion and Order denying their motion to amend their complaint. See MCR 7.205(A).[1] On October 24, 2017, the Court of Appeals (Judges Murphy, Borrello, and Ronayne Krause) issued a published opinion reversing the trial court and remanding for further proceedings consistent with its opinion.[2]

Under MCL 600.215, MCR 7.303(B)(1), and MCR 7.305(H)(1), this Court may grant leave to appeal or order other relief after a decision of the Court of Appeals. An application for leave to appeal is timely when it is filed within forty-two days of the Court of Appeals' opinion. MCR 7.305(C)(2). Defendants-appellants/cross-appellees timely filed their application for leave to appeal on December 5, 2017.

A cross-application for leave to appeal is timely when it is filed within 28 days of the application. MCR 7.307(A). The Kostadinovskis timely filed their cross-application on December 27, 2017.

On September 27, 2018, this Court directed the clerk to schedule oral argument on the application and the cross-application.[3] This Court directed the parties to file supplemental briefs addressing the issues raised in the applications and, in particular, "how, consistent with MCL 600.2912b, a plaintiff in a medical malpractice case may amend the complaint to include newly discovered claims against an existing defendant."[4]

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[1] **Appendix 368-376**, Opinion and Order, dated Apr. 29, 2016.

[2] **Appendix 378-387**, Court of Appeals Opinion.

[3] **Appendix 389**, Supreme Court Order, dated September 27, 2018.

[4] *Id.*

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## Statement of Question Presented

**After the claims in Kostadinovski's[5] NOI and complaint proved meritless, he wanted to raise an entirely new theory. But he didn't send a new NOI. He argued that a new claim can be added without serving an NOI for it. The Court of Appeals disagreed, but held that the NOI could be amended under MCL 600.2301—an issue Kostadinovski didn't preserve. Was Kostadinovski required send a new notice, wait the notice period, and then move to amend his complaint?**

Plaintiffs-appellants answer, "no," arguing that Kostadinovski was free to amend new claims into the complaint without including them in a notice of intent to sue.

Defendants-appellees answer, "yes."

The trial court answered, "yes."

The Court of Appeals answered, "no," stating that MCL 600.2301 was "implicated and potentially applicable" when "discovery has shed new light on the case and given rise to a new liability theory."

[5] Blaga Kostadinovski's loss-of-consortium claim is derivative of her husband's claims. So, for simplicity, this brief refers to Drago Kostadinovski as "Kostadinovski."

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## Introduction

Medical-malpractice plaintiffs must give potential defendants notice of the claim they intend to sue on. The purpose is to give the parties an opportunity to resolve the claim without the burden and expense of formal litigation involving complex malpractice claims. This case involves the procedure when a plaintiff gives notice of one claim, but later wants to add an entirely new claim against an existing defendant. The parties and the Court of Appeals have come up with three options:

(1) Plaintiffs must serve a notice for the new theory, wait the notice period, and then move to amend their complaint.

(2) Plaintiffs are free to amend new claims into their complaint even if they weren't in a notice.

(3) Plaintiffs may amend their original notice under MCL 600.2301 to include the new claims and then address whether they can amend their complaint.

The first option is simple enough. It treats newly discovered claims like all other claims. Plaintiffs must put the new theory in a notice. The parties have the opportunity to resolve it before it's put into litigation. And, if they don't, the plaintiffs can sue on it, assuming there isn't a statute-of-limitations problem.

The second option is a novel way to subvert the legislated notice requirement. Notice of one claim is notice of all claims. Under this option, plaintiffs have a perverse incentive to sandbag. It would be easier for plaintiffs to add claims that they never tried to describe in their original notice than it is for them to include claims that they insufficiently described in the original notice.

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The third option has similar problems. It's a fiction. The defendant never receives the legislated notice. But, equally important, the third option isn't actually an option in this case. The Kostadinovskis didn't ask to amend their original notice under MCL 600.2301 in the trial court. So the trial court didn't abuse its discretion when it didn't grant that relief. As a result, there are only two ways for this Court to endorse the third option in this case—(1) in dicta, or (2) by ignoring established preservation rules and the abuse-of-discretion standard, like the Court of Appeals did. If this Court believes that the third option is the right answer, the correct course is to simply vacate the Court of Appeals opinion and reinstate the trial court's judgment.

This Court should choose option one and reverse the Court of Appeals. Kostadinovski only needed to do what the notice statute required—send a notice for his new theory. For unknown reasons, he didn't do that. He shouldn't be excused from the statutory requirement simply because he gave notice of other, meritless claims.

There's no criticism of the first option that doesn't apply to the notice procedure in general. Those criticisms should be directed to the Legislature. Until the Legislature is persuaded to change it, this Court must enforce defendants' statutory right to notice followed by the appropriate notice waiting period. Treating newly discovered claims the same as those discovered pre-suit protects that right. The Court of Appeals erred in holding that Kostadinovski may be able to circumvent that right. This Court should reverse.

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## Statement of Facts

Dr. Harrington and Advanced Cardiothoracic adopt the discussion of the factual and procedural background of this case that is in their application for leave to appeal.

## Standard of Review

This appeal concerns the trial court's denial of Kostadinovski's motion to amend his complaint. This Court reviews a circuit court's ruling on a motion to amend a complaint for an abuse of discretion. *Weymers v Khera*, 454 Mich 639, 654; 563 NW2d 647 (1997). Trial courts don't abuse their discretion unless their "decision falls outside this range of principled outcomes." *Pontiac Fire Fighters Union Local 376 v Pontiac*, 482 Mich 1, 8; 753 NW2d 595 (2008).

The Michigan Court Rules provide that "[l]eave to amend shall be freely given when justice so requires." MCR 2.118(A)(2). But, despite that general rule, leave to amend is properly denied for: "[1] undue delay, [2] bad faith or dilatory motive on the part of the movant, [3] repeated failure to cure deficiencies by amendments previously allowed, [4] undue prejudice to the opposing party by virtue of allowance of the amendment, [and 5] futility." *Weymers*, 454 Mich at 658. "'An amendment is futile where, ignoring the substantive merits of the claim, it is legally insufficient on its face.'" *Hakari v Ski Brule, Inc*, 230 Mich App 352, 355; 584 NW2d 345 (1998), quoting *Gonyea v Motor Parts Federal Credit Union*, 192 Mich App 74, 78; 480 NW2d 297 (1991).

Kostadinovski stipulated to dismiss the theory stated in his notice of intent to sue (NOI), complaint, and affidavit of merit. His proposed amended complaint would have

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added an entirely new theory that wasn't in his NOI.[6] The trial court held that the amendment was futile because, if it allowed the amendment, the court would have had to grant a summary-disposition motion on the new claim since it wasn't in an NOI.

## Argument

Again, the three potential procedural options for plaintiffs who discover a new theory against an existing defendant after filing suit are:

(1) Defendants' position: Plaintiffs must serve an NOI for the new theory, wait the NOI period, and then move to amend their complaint.

(2) Plaintiff's position: Plaintiffs are free to amend new claims into their complaint even if they weren't in an NOI.

(3) The Court of Appeals' position: Plaintiffs may amend their NOIs under MCL 600.2301 to include the new claims and then address whether they can amend their complaint.

The first option treats newly discovered claims like all others. It's business as usual. The second option is a free for all. Once the plaintiff gives adequate notice of one claim, they can amend whatever new claims they like into their complaint. The third option embraces fiction. Defendants never receive notice of the new claims before they're put into litigation, but the third option pretends that they did. This Court should hold that the first option is the correct procedure.

---

[6] The original causation theory was that an EndoClamp caused a clot to break loose and move to Drago Kostadinovski's brain. See Appendix 62-64, Complaint, ¶¶75-77. The new theory is that low blood pressure caused an "in adequate supply of oxygen and nutrients" to his brain, which resulted in his stroke. Appendix 233-234, 237, Naidich Dep., p. 30-31, 34; Appendix 363-364, Proposed Amended Complaint, ¶80.

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## A. Option 1—Business as usual

### 1. The NOI statute's structure and purpose.

The NOI statute, MCL 600.2912b, gives medical-malpractice defendants a "statutory right to a timely NOI followed by the appropriate notice waiting period." *Tyra v Organ Procurement*, 498 Mich 68, 92; 869 NW2d 213 (2015), quoting *Driver v Naini*, 490 Mich 239, 255; 802 NW2d 311 (2011). It's written in mandatory terms. The NOI must "contain a statement of at least all of the following:

> (a) The factual basis for **the claim**.
>
> (b) The applicable standard of practice or care alleged by the claimant.
>
> (c) The manner in which it is claimed that the applicable standard of practice or care was breached by the health professional or health facility.
>
> (d) The alleged action that should have been taken to achieve compliance with the alleged standard of practice or care.
>
> (e) The manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice.
>
> (f) The names of all health professionals and health facilities the claimant is notifying under this section in relation to **the claim**. [MCL 600.2912b(4) (emphasis added).]"

The content of the written notice is claim specific. The NOI statute doesn't require the plaintiff to describe merely "a" claim. The plaintiff must state the "factual basis for **the claim**" and identify the would-be defendants receiving notice "in relation to **the claim**." MCL 600.2912b(4)(a), (f) (emphasis added). Between those bookends, the

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statute requires the plaintiff to describe "the applicable standard," how it was breached, and how that breach was "the proximate cause." MCL 600.2912b(4)(b)-(e).

The purpose of the NOI requirement is to promote settlement without the expense and burdens of formal litigation. *Neal v Oakwood Hosp Corp*, 226 Mich App 701, 705; 575 NW2d 68 (1997). But defendants can't consider and settle a claim pre-litigation if they aren't given notice of it. So, to effectuate the NOI statute's purpose, plaintiffs are prohibited from commencing an action on a claim if they didn't give the statutorily required notice of it. MCL 600.2912b(1); *Boodt v Borgess Med Ctr*, 481 Mich 558, 562-563; 751 NW2d 44 (2008) ("[A] plaintiff cannot commence an action before he or she files a notice of intent that contains all the information required under § 2912b(4).").

A related concept is that notice of one claim isn't notice of all claims. So, for example, *Gulley-Reaves v Baciewicz*, 260 Mich App 478; 679 NW2d 98 (2004) ordered summary disposition when the plaintiff's complaint added a vicarious-liability claim against a hospital that wasn't in the NOI that the plaintiff sent to the hospital. *Id.* at 485 ("[T]he complaint must be limited to the issues raised in the notice of intent ....").

In *Gulley-Reaves*, the plaintiff served an NOI on a hospital alleging that it was vicariously liable for a surgeon and residents. But her complaint added a claim that the hospital was vicariously liable for an anesthesiologist and nurse anesthetist. The hospital moved for partial summary disposition, arguing that the NOI deficiently described the anesthesia claims. The trial court denied the motion. But the Court of Appeals agreed that the NOI was deficient and reversed. The NOI statute specifically "contemplates that additional notices of intent may be filed." *Gulley-Reaves*, 260 Mich

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App at 486, citing MCL 600.2912b(6). But the plaintiff didn't serve an NOI adding the anesthesia claim. So she "failed to provide notice of the claim of breach of the standard of care with regard to administration of anesthesia" and "the trial court erred in denying defendants' motion for summary disposition." *Id.* at 490.

*Gulley-Reaves* didn't involve a proposed amendment to a complaint. But *Decker v Rochowiak*, 287 Mich App 666; 791 NW2d 507 (2010) did.

In *Decker*, the court allowed an amended complaint that "merely clarified plaintiff's claims against the Spectrum defendants." *Id.* at 681. The plaintiff served several defendants with an NOI. After filing his complaint and conducting some discovery, the plaintiff moved to amend his complaint. He argued that the amendment "merely clarified allegations and issues." *Id.* at 671. The trial court and the Court of Appeals agreed.

The Court of Appeals repeatedly stated that *Gulley-Reaves* didn't apply because the amendments didn't set forth a new potential cause of the injury:

- "Contrary to the Spectrum defendants' argument, plaintiff's subsequently filed **amended complaint did not assert any 'new' potential causes of injury**." *Id.* at 678 (emphasis added).
- "[T]he allegations in plaintiff's amended complaint **merely set forth more specific details, clarifying plaintiff's claims** against the Spectrum defendants, including the registered nurses and physicians involved in Eric's medical management." *Id.* (emphasis added).
- "Unlike the plaintiff in *Gulley-Reaves*, plaintiff's amended complaint **did not allege any other potential cause of Eric's injury**." *Id.* at 680 (emphasis added).

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- **"This is not a case where, as in *Gulley-Reaves*, the plaintiff set forth a totally new and different potential cause** of injury in an amended complaint compared to the potential cause of injury set forth in her NOI …." *Id.* (emphasis added).

- The Court rejected the defendants' argument that the plaintiff had to wait out a new NOI period because, "The amended complaint did not name new defendant parties, MCL 600.2912b(3), and **it did not set forth any new potential causes of injury**." *Id.* at 681 (emphasis added).

*Decker*'s analysis leaves no doubt that if the amendment had set forth a new claim, it wouldn't have been allowed.

2. **Though he could have, Kostadinovski didn't send an NOI for his new claim. So the trial court correctly denied his motion to amend the complaint to add it.**

*Gulley-Reaves* and *Decker* are rooted in the text and purpose of the NOI statute. MCL 600.2912b. Again, the statute is mandatory; the notice "shall contain" the "factual basis for the claim," including "the applicable standard," how that was breached, and how that breach caused the injury. MCL 600.2912b(4)(a)-(e). Kostadinovski didn't do any of that for his hypotension-and-transfusion claim. There's no dispute about that.

There was a simple way for Kostadinovski to comply with the NOI statute: he could have sent a new NOI. The NOI statute specifically "contemplates that additional notices of intent may be filed." *Gulley-Reaves*, 260 Mich App at 486, citing MCL 600.2912b(6).[7] But Kostadinovski didn't serve one. It follows that Kostadinovski can't

[7] MCL 600.2912b(6) prohibits "tacking or addition of successive 182-day periods." So, for example, if a plaintiff sends 3 NOIs, the NOI period isn't 546 days. It's 182 days from each notice. Likewise, if a plaintiff sends an NOI but discovers another claim before the original NOI period expired, a new NOI doesn't tack 182 days onto the original wait period. Each NOI has its own 182-day notice period.

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maintain a malpractice action based on the hypotension-and-transfusion claim. The trial court correctly concluded that, even if he amended his complaint, the new claim was doomed to be dismissed and was therefore futile.

**B. Option 2—A free for all**

Despite *Gulley-Reaves*, *Decker*, and the claim-specific language in the NOI statute, Kostadinovski's argument is that sufficiently describing one claim is enough. Other claims, he contends, can be added later by amending the complaint even if they weren't in an NOI. His argument doesn't reconcile with the statutory text, the purpose of the NOI requirement, or case law.

**1. The text of the NOI statute doesn't support Kostadinovski's argument.**

Kostadinovski's interpretation would only require notice of "a" claim. But plaintiffs must give "written notice under [MCL 600.2912b]," which requires specifics on "the claim" that the plaintiff intends to sue on. MCL 600.2912b(1), (4)(a). "The" is a definite article that has a "specifying or particularizing effect" when placed before a noun. *Robinson v City of Lansing*, 486 Mich 1, 14; 782 NW2d 171 (2010), quoting *Massey v Mandell*, 462 Mich 375, 382 n. 5; 614 NW2d 70 (2000). Kostadinovski's argument would only work if the statute required notice of "a" claim; it doesn't.

Kostadinovski emphasizes that the NOI statute imposes requirements before an action may be commenced. But he also acknowledges that "a plaintiff cannot commence an action before he or she files a notice of intent that contains all the information required under § 2912b(4)." *Boodt*, 481 Mich at 562-563.

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Kostadinovski never commenced an action on the hypotension-and-transfusion claim. He couldn't. He never served "a notice of intent that contains all the information required under § 2912b(4)" for that claim. *Boodt*, 481 Mich at 562-563. He never gave notice of "The factual basis for the claim." MCL 600.2912b(4)(a). He never described "The applicable standard of practice or care" for the claim. MCL 600.2912b(4)(b). He didn't explain how Dr. Harrington breached the standard of practice and how that breach was "the proximate cause of the injury claimed in the notice." MCL 600.2912b(4)(c)-(e). Kostadinovski didn't do any of that for his hypotension-and-transfusion claim. So he couldn't commence an action on that claim.

**2. Kostadinovski's argument also undermines the purpose of the notice procedure.**

As the Court of Appeals correctly stated, "the approach suggested by plaintiffs would undermine the legislative intent and purpose behind MCL 600.2912b."[8] If defendants aren't given notice of the claim, they can't consider and settle it "without resort to formal litigation." *Neal*, 226 Mich App at 705; *Bush*, 484 Mich at 174.

This case illustrates the point. Kostadinovski gave notice of meritless claims. Dr. Harrington and Advanced Cardiothoracic, of course, didn't agree to settle those claims. If the trial court allowed Kostadinovski's proposed amendment, Dr. Harrington and Advanced Cardiothoracic would have been deprived of their statutory right to consider Kostadinovski's hypotension-and-transfusion claim "without resort to formal litigation." *Neal*, 226 Mich App at 705.

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[8] Appendix 386, Court of Appeals Opinion, p. 9 n.6.

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Consider another scenario based on *Gulley-Reaves*. The plaintiff sends a hospital notice that he intends to sue based on a surgeon's alleged error. The parties are unable to resolve the claim during the notice period. After the plaintiff files his complaint and the hospital answers, he amends his complaint as of right to add a slew of theories alleging errors by nurses, anesthesiologists, and new surgical errors. The hospital had no opportunity to resolve those claims outside formal litigation. The notice procedure was a farce. That's where Kostadinovski's argument leads.

### 3. Kostadinovski's argument fights with *Gulley-Reaves*, *Decker*, and this Court's holding in *Bush*.

Kostadinovski's argument would also upend established case law. Kostadinovski has argued that *Decker* allowed him to add a new theory in an amended complaint. But that argument was based on selective quotation. *Decker* stated, "Plaintiff was not required to file a second NOI with regard to these defendants after he was granted leave to file his amended complaint, **a complaint that merely clarified plaintiff's claims against the Spectrum defendants**." 287 Mich App at 681 (emphasis added). Kostadinovski's argument ignored the emphasized text.

It also ignored the rest of *Decker*'s analysis. The Court of Appeals correctly observed that "[i]f [Kostadinovski's argument] were the law, the entire analysis in *Decker* would have been completely unnecessary …."[9] *Decker* diligently compared the original and amended complaint to determine whether the plaintiff was adding a new claim. It made that detailed comparison because it was necessary to distinguish *Gulley-*

[9] Appendix 386, Court of Appeals Opinion, p. 9 n.6.

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*Reaves*. But that was pointless if, as Kostadinovski contends, the plaintiff was free to add new claims regardless whether they were in his NOI.

*Gulley-Reaves* analysis would also become moot. Instead of putting new theories in their original complaint, plaintiffs could simply amend them in after the defendant answers. So even when plaintiffs discover a new theory **before** litigation, they wouldn't have to give the statutorily required notice of it.

Kostadinovski's argument would gut both *Gulley-Reaves* and *Decker*. But it wouldn't stop there. His argument would also make this Court's analysis in *Bush v Shabahang*, 484 Mich 156; 772 NW2d 272 (2009) moot.

In *Bush*, the plaintiff's NOI sufficiently described several claims, but defectively described others. This Court held that plaintiffs could cure NOI deficiencies under MCL 600.2301 if they satisfied a two-pronged test. *Id.* at 177. But if Kostadinovski's argument is right, MCL 600.2301 and its two-prong test was irrelevant. According to Kostadinovski, the plaintiff in *Bush* was free to add the defectively described claims in an amended complaint because the NOI "statute has no application to theories added to a case by amendment."[10] So, though he doesn't acknowledge it, Kostadinovski's argument effectively asks this Court to overrule *Bush*.

**4. Kostadinovski offers two policy-based rationales that don't withstand scrutiny.**

Kostadinovski offers two policy-based rationales in support of his novel position. First, he argues that if the "notice requirement applies to theories developed during the

[10] Cross-Application, p. 6.

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course of discovery that must be added to a malpractice case by amendment, it would demand … that a presuit notice of intent be prepared with complete omniscience."[11] It's a strawman argument.[12]

Neither defendants' position nor, for that matter, the Court of Appeals' analysis requires omniscience. Dr. Harrington and Advanced Cardiothoracic have explained that Kostadinovski only needed to send a new NOI. The Court of Appeals held that plaintiffs like Kostadinovski should move to amend their NOI under MCL 600.2301. Neither approach requires omniscience or forever bars any claim that wasn't in the initial NOI. Kostadinovski's first rationale fights an imagined enemy.

Kostadinovski's second rationale fights the entire premise of a notice period. He argues that if plaintiffs who discover new claims during litigation must send a new NOI, "the court, the lawyers and the litigants would be compelled to sit around for a period of six months presumably doing nothing while §2912b's mandatory waiting period expires."[13] That's improperly dismissive of the legislated notice procedure. It's also hyperbolic.

If the parties don't embrace its purpose, the same dismissive critique could apply to the original notice period—it forces everyone to "sit around for a period of six months presumably doing nothing …." This Court has shown that it doesn't share

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[11] Cross-Application, p. 13.

[12] *State v Bowen*, 281 P3d 599 (Kan App, 2012) ("A strawman argument is where 'the arguer knocks down a misstated argument and concludes that the original argument was bad.'"), quoting Aldisert, *Logic for Lawyers: A Guide to Clear Legal Thinking*, p. 171 (3d ed, 1997).

[13] Cross-Application, p. 15.

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Kostadinovski's dim view of the notice period. In fact, this Court's opinions have emphasized that the notice period is a "statutory right" that courts cannot ignore. *Tyra*, 498 Mich at 92; *Driver*, 490 Mich at 255.

Kostadinovski's "presumably doing nothing" criticism is also overstated because plaintiffs could send a new NOI while they continue to litigate their other claims. For example, Kostadinovski's attorney admitted that he knew about the new claim by July 2015.[14] That was 6 months before his experts were deposed. And it was about 8 months before he moved to amend his complaint to add the new theory. So Kostadinovski could have given notice of his new claim, continued litigating his original claims, and amended his complaint around the time his experts were deposed. Instead, he waited 8 months and until after he abandoned his original claims. Any time spent "doing nothing" would have been the product of Kostadinovski's lack of diligence.[15] That's not a reason to excuse Kostadinovski (or future plaintiffs) from the notice requirement.

**5. Conclusion: Kostadinovski's proposed solution is unworkable. It doesn't reconcile with the statutory text, the purpose of the NOI requirement, or case law.**

Adopting Kostadinovski's argument would effectively wipe out *Gulley-Reaves*, *Decker*, and *Bush*. It would also subvert the NOI requirement, undermine its purpose (would-be defendants can't assess and settle pre-suit what isn't in a notice), and deny defendants their statutory right to notice. This Court should reject option two.

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[14] Appendix 314, Mar. 28, 2016 Hrg. Tr., p. 8.

[15] Of course, sending a new NOI doesn't guarantee that the trial court will grant leave to amend the complaint. Kostadinovski's undue delay also warranted denying his motion—a point that Dr. Harrington and Advanced Cardiothoracic preserved below, but the Court of Appeals left for the trial court to address on remand.

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### C. Option 3—Time travel

Not to be flippant, but the Court of Appeals' position—amending the NOI under MCL 600.2301—essentially advocates the fiction of time travel. It does this in two ways. Kostadinovski didn't preserve the issue and defendants never received an NOI for their new claim. The Court of Appeals engaged the fiction that both preservation and notice actually occurred.

#### 1. The Court of Appeals erred because it reversed based on an issue that Kostadinovski didn't preserve.

The first fiction concerns the specific facts of this case. Kostadinovski didn't move to amend his NOI or cite MCL 600.2301 in the trial court. That can't be undone. Defendants rely on their application[16] and won't belabor the point here. It's simple: the trial court wasn't required to raise amending the NOI or MCL 600.2301 for the Kostadinovskis and it certainly didn't abuse its discretion by not doing so. *Walters v Nadell*, 481 Mich 377, 388; 751 NW2d 431 (2008) ("Trial courts are not the research assistants of the litigants …."); *Napier v Jacobs*, 429 Mich 222, 228-229; 414 NW2d 862 (1987) ("'[T]here is something unseemly about telling a lower court it was wrong when it never was presented with the opportunity to be right.'"), quoting 3 LaFave & Israel, Criminal Procedure, § 26.5(c), pp. 251-252; *Duray Dev LLC v Perrin*, 288 Mich App 143, 161; 792 NW2d 749 (2010) ("Perrin did not raise the issue in the trial court, and the trial court did not err by not raising it for him.").

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[16] Application, pp. 12-18.

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The Court of Appels erred because it analyzed the issue as though it had been preserved. It hadn't. So, simply put, the third option isn't at issue and isn't actually an option in this case.

**2. MCL 600.2301 cannot allow plaintiffs to "amend" an NOI to include an entirely new theory.**

Leaving preservation and the standard of review aside, the Court of Appeals' analysis promotes another fiction—defendants received the legislatively required notice when a NOI is amended to add a new claim. It's one thing to amend an NOI to fix a deficiently described claim. The premise behind doing so is that the defendant could figure it out; they were, or at least should have been, aware of the deficiently described claim when the received the NOI. *Bush*, 484 Mich at 178. But it's pure fiction to suggest that adding an entirely new claim through an amendment provided the legislated notice. The amendment is a charade.

**a. A newly discovered claim can't meet *Bush*'s two-pronged test for applying MCL 600.2301.**

The Court of Appeals held that, "by analogy" to this Court's decision in *Bush*, "MCL 600.2301 is implicated and potentially applicable to save [Kostadinovski's] medical malpractice action …."[17] It's wrong. Under *Bush*, MCL 600.2301 only applies when (1) the amendment wouldn't affect a party's substantial rights, and (2) the plaintiff made a good-faith attempt to comply with the NOI requirements. 484 Mich at 177. Neither prong can be met for a claim that wasn't even alluded to in an NOI.

[17] Appendix 385, Court of Appeals Opinion, p. 8.

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In *Bush*, "the vast majority of the plaintiff's NOI was in compliance with [the NOI statute]." 484 Mich at 178. It sufficiently described several claims against various defendants. But the NOI also defectively described some claims:

> The notice merely provides that [West Michigan] Cardiovascular should have hired competent staff members and properly trained them.
>
> * * *
>
> Although plaintiff's notice alleges errors on the part of Spectrum Health's nursing staff and physician assistants, the notice does not purport to state a separate standard of care for the nurses and physician assistants.
>
> * * *
>
> Likewise, to the extent that plaintiff purported to give notice that Spectrum Health could be held directly liable for Bush's injuries on the basis of the theories that it negligently hired or failed to train its staff, for the same reasons we explained with regard to [West Michigan] Cardiovascular, we conclude that the notice did not meet the requirements of MCL 600.2912b. [*Bush*, 484 Mich at 179-180, quoting *Bush v Shabahang*, 278 Mich App 703, 711; 753 NW2d 271 (2008).]

So the NOI referred to several claims, but it didn't fully describe them as required by the NOI statute. *Bush*, 484 Mich at 179-180, citing MCL 600.2912b.

*Bush* considered whether MCL 600.2301 allowed the trial court to "amend" the NOI or "disregard" the defects in it. The statute allows courts to do so "in the furtherance of justice" and when it wouldn't "affect the substantial rights" of a party:

> The court in which any action or proceeding is pending, has power to amend any process, pleading or proceeding in such action or proceeding, either in form or substance, for the furtherance of justice, on such terms as are just, at any time before judgment rendered therein. The court at every stage of the action or proceeding shall disregard any error or defect in

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> the proceedings which do not affect the substantial rights of the parties. [MCL 600.2301.]

*Bush* held that "the applicability of § 2301 rests on a two-pronged test: first, whether a substantial right of a party is implicated and, second, whether a cure is in the furtherance of justice." *Bush*, 484 Mich at 177. The furtherance-of-justice prong is met "when a party makes a good-faith attempt to comply with the content requirements of §2912b." *Id.* at 178.

In *Bush*, the defendants' substantial rights were not implicated because they had "the ability to understand the nature of the claims being asserted against him or her even in the presence of defects in the NOI." *Id.* at 178. Amendment was also in the furtherance of justice because the plaintiff "made a good-faith attempt to comply with the content requirements of § 2912b." *Id.* at 161, 180-181.

The NOI in *Bush* referred to the claims, but didn't put any meat on the bones. Here, there are no bones for Kostadinovski's new claim. His NOI asserted that Dr. Harrington caused a clot to break loose, which led to his stroke. The NOI doesn't refer to hypotension or transfusion during surgery at all. So, unlike the defendants in *Bush*, Dr. Harrington and Advanced Cardiothoracic couldn't have possibly understood "the nature of the claims being asserted against him … even in the presence of defects in the NOI." *Id.* at 178. If amendment were allowed, they would have no opportunity to address the new claim outside the context of litigation. Kostadinovski also made no attempt, much less a good-faith attempt, to comply with the content requirements for his new claim. He could have sent a new NOI. See *Gulley-Reaves*, 260 Mich App at 486,

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citing MCL 600.2912b(6). But he didn't. Accordingly, Kostadinovski can't amend his NOI under *Bush* and MCL 600.2301.

**b. Applying MCL 600.2301 would deprive defendants of their statutory right to notice.**

Since *Bush*, this Court has confirmed that the NOI requirement isn't a mere formality that can be lightly cast aside. It's a statutory right. In *Driver* (2011), this Court held that MCL 600.2301 can't cure the plaintiff's failure to serve an NOI during a lawsuit and before the limitation period expired on a claim against a nonparty. 490 Mich at 255. In *Tyra* (2015), this Court held that MCL 600.2301 can't cure a plaintiff's failure to wait the NOI period before filing the complaint. 498 Mich at 92. Both opinions emphasized that allowing the amendment "'would deprive defendants of their statutory right to a timely NOI followed by the appropriate notice waiting period." *Tyra*, 498 Mich at 92, quoting *Driver*, 490 Mich at 255 (cleaned up).

As in *Driver* and *Tyra*, applying MCL 600.2301 in any case like this one would mean that defendants don't get the statutorily required notice before a claim is put into litigation. So, as *Tyra* stated, "ignoring the defects in these cases would not be 'for the furtherance of justice' and would affect defendants' 'substantial rights.'" *Tyra*, 498 Mich at 92, quoting MCL 600.2301.

That isn't necessarily the case when the plaintiff's NOI suggested or referred to a theory. E.g., *Bush*, 484 Mich at 179-180. In those cases, the defendant arguably had some opportunity to consider the claim unencumbered by litigation. See *id.* at 178. Not here though. And not in any case in which the plaintiff raises an entirely new theory during

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litigation. In those cases, allowing amendment under MCL 600.2301 can do only one thing—deprive defendants of their statutory right.

**c. Conclusion: The Court of Appeals's holding that MCL 600.2301 could be used to amend an NOI to include an entirely new claim is wrong.**

This isn't a fact-specific issue. The result should be the same any time a plaintiff tries to raise a new theory that wasn't in his NOI. MCL 600.2301 cannot be "potentially applicable"[18] when a claim isn't even alluded to in an NOI. If it were, Dr. Harrington and Advanced Cardiothoracic and all defendants like them will **never** get their statutory right to review and address the new claim outside the context of litigation.

This case illustrates the point. The Kostadinovskis made no attempt to comply with the NOI requirement for their new theory. Allowing amendment would deprive defendants of their "statutory right" to receive an NOI describing the claim before it's put into litigation. *Tyra*, 498 Mich at 92; MCL 600.2912b(4). So the analysis in Court of Appeals' published opinion is wrong. If this Court reaches this issue despite Kostadinovski's waiver, it should reject the Court of Appeals analysis.

## Conclusion and Relief Requested

The cure for the Kostadinovski's problem was simple—serve an NOI that described the new claim and wait the notice period. Nothing prevented Kostadinovski from doing so. His need to be excused from that simple requirement is the product of his refusal to play by the rules.

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[18] Appendix 385, Court of Appeals Opinion, p. 8.

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To cure his unexplained omission, Kostadinovski advocates a tectonic shift that would gut case law and the legislated notice procedure. That certainly is not what the Legislature intended. And the Court of Appeals' solution is no better. It reversed the trial court under abuse-of-discretion review based on an issue that Kostadinovski waived. That's error. MCL 600.2301 also cannot ever apply when a plaintiff seeks to raise a new theory that wasn't referenced in his NOI. The Court of Appeals erred in suggesting otherwise.

This Court should deny Kostadinovski's cross-application, reverse the Court of Appeals, and reinstate the trial court's order. Since Kostadinovski didn't send an NOI for his new theory and wait the NOI period, he couldn't amend his complaint to add the new theory. The trial court didn't abuse its discretion in denying Kostadinovski's motion to amend his complaint.

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Dated: November 8, 2018

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STATE OF MICHIGAN

IN THE MACOMB COUNTY CIRCUIT COURT

DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI, as husband and wife,

Plaintiffs,

-vs-

STEVEN D. HARRINGTON, M.D. and ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.,

Defendants.

Case No. 14-2247-NH

Honorable Kathryn A. Viviano

/

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## PLAINTIFFS' SUPPLEMENTAL BRIEF ON REMAND

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The court on June 11, 2019 issued a scheduling order on remand. A copy of that order is Exhibit A to this brief. In that order, the court instructed plaintiffs to file a brief addressing the Court of Appeals remand instructions. This brief is being submitted pursuant to the court's June 11, 2019 order.

## Statement Of Facts

This medical malpractice action arises out of a December 14, 2011 mitral valve repair surgery performed by Dr. Steven D. Harrington on Drago Kostadinovski. Complaint, ¶¶35-36. In the course of that surgery, Mr. Kostadinovski suffered a stroke. *Id.*, ¶¶55-56.

Mr. Kostadinovski retained counsel to investigate a potential medical malpractice claim against Dr. Harrington. On December 9, 2013, counsel for Mr. Kostadinovski mailed a Notice of Intent to File Claim ("NOI") in compliance with MCL 600.2912b. A copy of that NOI is Exhibit B to this brief. That NOI identified seven ways in which Dr. Harrington breached the standard of care in conjunction with the mitral valve repair surgery he performed on Mr. Kostadinovski:

1. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14, 2011.

2. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, DT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

3. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington failed to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

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4. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington failed to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

5. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to immediately abort the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

6. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to use the care and technique of a reasonable surgeon performing the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

7. Dr. Harrington failed to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process.

Notice of Intent (Exhibit B), at 10-11.

After waiting the period of time prescribed in MCL 600.2912b, Mr. Kostadinovski and his wife, Blaga Kostadinovski, filed this action on June 5, 2014 against Dr. Harrington and his professional corporation. The allegations in the complaint pertaining to the defendants' breaches of the standard of care mirrored those that were contained in the December 9, 2013 NOI. Complaint, ¶69a-g.

In July 2014, within one month after filing the case, plaintiffs noticed the deposition of the defendant, Dr. Harrington. Tr. 3/28/16, Exhibit C to this brief, at 4. The scheduling of that deposition proved to be difficult because of Dr. Harrington's busy schedule. Plaintiffs ultimately had to file a motion to compel Dr. Harrington's deposition. *Id.* Dr. Harrington was finally produced for a deposition in May 2015. *Id.*, at 5. That deposition could not be completed at that time because

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of Dr. Harrington's surgery schedule. Dr. Harrington's deposition finally completed on September 22, 2015. *Id.*

One of the medical records on which plaintiffs' counsel sought to examine Dr. Harrington during his deposition was a perfusionist record pertaining to Mr. Kostadinovski's December 2011 surgery. *Id.*, at 6. That record was not legible. After the completion of Dr. Harrington's deposition, plaintiffs' counsel then sought to take the deposition of the perfusionist who created this record. That perfusionist had since moved from Michigan to California and the scheduling of that deposition also proved difficult. The deposition of the perfusionist was taken on December 17, 2015. *Id.* But, even before this deposition was taken, counsel for the plaintiffs alerted lead counsel for defendants that there might be an issue with respect to Mr. Kostadinovski's perfusion during his December 2011 surgery that had not been pleaded in plaintiffs' original Complaint. *Id.* At her deposition, the perfusionist provided further testimony supporting a theory that there were perfusion errors during Mr. Kostadinovski's surgery.

In January and February 2016, plaintiffs' standard of care and causation experts were scheduled to be deposed. In advance of those depositions, plaintiffs' attorney contacted the defendants' counsel to inform them that plaintiffs' experts would be discussing this not-yet pleaded theory of liability. *Id.*, at 7. Plaintiff' expects, Dr. Edgar Chedrawy, Dr. Louis Samuels and Dr. Thomas Naidich, were deposed in early 2016 and each discussed during their depositions the theories that had come to light through discovery and, having been informed in advance of the experts' intent to present these new theories, counsel for defendants was able to cross-examine these experts on these subjects.

Based on the information that had come to light during discovery, plaintiffs' experts testified

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in their depositions that Dr. Harrington breached the standard of care by failing to monitor Mr. Kostadinovski's hypotension and by failing to transfuse him during his surgery. While plaintiffs' three experts offered support for these new theories of liability, they did not offer support for the theories of malpractice that had been asserted against Dr. Harrington in plaintiffs' original complaint.

On March 21, 2016, defendants filed a motion for summary disposition. In that motion, defendants argued that, based on the deposition testimony provided by plaintiffs' experts, all of the claims of malpractice alleged in plaintiffs' original complaint should be dismissed. In that same motion, defendants also sought to strike any allegations of malpractice that plaintiffs might pursue that were not contained in the December 2013 NOI or plaintiffs' June 2014 complaint.

The same day that the defendants file their motion for summary disposition, plaintiffs filed a motion to amend their complaint to include the claims that had already been explored at the depositions of plaintiffs' experts - that Dr. Harrington was responsible for malpractice in failing to realize that Mr. Kostadinovski was in a hypotensive state during his mitral valve repair surgery and in failing to adequately perfuse him during that surgery.

Defendants filed a response to plaintiffs' motion to amend. A copy of that response is Exhibit D to this brief. In that response, defendants proffered several reasons why, in their view, the motion to amend should be denied. Defendants contended that the motion should be denied as untimely and prejudicial. They further argued that the amendment should be denied because adding the two new theories of liability would be futile.

The defendants' futility argument rested on two different grounds. They first contended that the amendment to add the new claims would be futile because these additional claims would be

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barred by the statute of limitations. Second, defendants asserted that the amendment that plaintiffs proposed would be futile because the additional theories that they sought to add were not included in plaintiffs' December 2013 NOI. Citing to that NOI, defendants argued in response to plaintiffs' motion to amend that the amendment would be futile because, "there is no mention, reference or inference [in the NOI] to an alleged failure by Dr. Harrington to transfuse the patient secondary to a decreased hemoglobin and hematoint during the December 14, 2011 surgery." Response (Exhibit D), at 9.

A hearing was held before this court on plaintiffs' motion to amend on March 28, 2016. *See* Transcript (Exhibit C). At that hearing, plaintiffs' counsel noted that defendants' attorney had known for some time of the theories that plaintiffs sought to add to the case. Tr. 3/28/16 (Exhibit C), at 7-11. And, defense counsel confirmed at that hearing that plaintiffs' counsel "did alert me before the [expert] depositions and said this is going to be a theory." *Id.*, at 17.

At the March 28, 2016 hearing, the court pressed counsel for defendants to explain how his clients would be prejudiced by the amendment that plaintiffs were proposing. *Id.*, at 13-17. Counsel for defendant tentatively expressed the view that "I believe there is some prejudice here." *Id.*, at 14. At the conclusion of the March 28, 2016 hearing, the court took plaintiffs' motion to amend under advisement. *Id.*, at 19.

On April 25, 2016, prior to issuing its decision on the pending motion to amend, the court conducted a hearing on defendants' motion for summary disposition on the claims asserted in plaintiffs' original complaint. At that hearing, plaintiffs offered no objection to the dismissal of these claims. The court signed an order dated April 25, 2016 dismissing the claims of professional negligence stated in the original complaint. The April 25, 2016 order noted that it was not a final

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order since the court still had the plaintiffs' motion to amend their complaint under advisement.

The court issued a written opinion addressing plaintiffs' motion to amend on April 29, 2016. A copy of that opinion is Exhibit E to this brief. In that opinion, the court first addressed defendants' argument that the amendment that plaintiffs proposed would be futile because any new claims contained in that amended pleading would be barred by the statute of limitations. The court rejected that argument. It concluded that, if allowed, plaintiffs' amendment would be timely for limitations purposes because it would relate back to the date of the filing of their original complaint under MCR 2.118(D) since the theories that plaintiff sought to add by amendment arose out of the same "conduct, transaction, or occurrence" as the claims made in the original complaint. Opinion (Exhibit E), at 3-6.

The court in its April 29, 2016 decision then turned to the other component of the defendants' futility argument - that the proposed amendment should not be allowed because the additional theories that plaintiffs sought to add by amendment had not been included in the presuit NOI mailed in December 2013. The court found this argument persuasive, concluding that allowing the amendment that plaintiffs proposed would be inconsistent with the requirements set out in MCL 600.2912b:

> Although the allegations in plaintiffs' complaint mirrored the allegations made in the NOI, now plaintiffs seek to amend their complaint to include allegations that Dr. Harrington negligently failed to monitor Mr. Kostadinovski's hypotension during the operation and failed to transfuse him. The Court finds that plaintiffs' NOI did not set forth the minimal requirements to provide notice of the claim of breach of the standard of care with regard to the failure to monitor hypotension levels during the operation and failed to transfuse him. The Court finds that plaintiffs' NOI did not set forth the minimal requirements to provide notice of the claim of breach of the standard of care with regard to the failure to monitor hypotension levels during the operation and the failure to transfuse the patient was a potential cause of injury as required by MCL 600.2912b. Accordingly, defendants were not given the

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> opportunity to engage in any type of settlement negotiation with regard to the hypotension and transfusion claims because they were not given notice of the existence of any such claims. Even if plaintiffs had included these new allegations in their original complaint, defendants lacked the requisite notice mandated by MCL 600.2912b because they were not raised in the NOI.
>
> Plaintiffs' failure to adhere to the statutory mandates renders the new allegations contained in the proposed amended complaint futile, as these new allegations of medical malpractice must fall as a matter of law. *See Boodt*, 481 Mich at 562-563; *Gulley-Reaves*, 260 Mich App 490. Therefore, plaintiffs' motion to amend is properly denied.
>
> Opinion (Exhibit E), at 8-9.

Thus, the court concluded that the two new theories that plaintiffs sought to add to the case by amendment - that Dr. Harrington did not properly monitor Mr. Kostadinovski's hypotension levels during the December 14, 2011 surgery and that he failed to properly transfuse Mr. Kostadinovski - could not be added to the case because these theories had not been included in the December 2013 NOI. Based on its conclusion that plaintiffs failed to comply with MCL 600.2912b's notice requirement, the circuit court determined that plaintiffs' motion to amend the complaint would be denied as futile.

Plaintiffs appealed the court's April 29, 2016 decision to the Michigan Court of Appeals. A panel of that Court on October 24, 2017 issued a decision reversing the denial of plaintiffs' request to amend. *Kostadinovski v Harrington*, 321 Mich App 736; 909 NW2d 907 (2017). In that opinion, the panel ruled on the basis of a Michigan statute, MCL 600.2301, and the Supreme Court's decision in *Bush v Shabahang*, 484 Mich 156; 772 NW2d 272 (2009), that the case had to be remanded for a determination of whether plaintiffs should be given the opportunity to amend their notice of intent. 321 Mich App at 751-754.

In its October 24, 2017 decision, the Court of Appeals remanded the case to this court "to

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engage in an analysis under MCL 600.2301 to determine whether amendment of the NOI or disregard of the prospective NOI defect would be appropriate." 321 Mich App at 753. The Court of Appeals further instructed that, if this court on remand determined that MCL 600.2301 supports amendment of the NOI, thereby negating the court's prior futility analysis, the court was to examine the other objections that defendant offered to plaintiffs' proposed amendment - undue delay or undue prejudice - that were not resolved by this court originally. 321 Mich App at 754.

The defendants filed an application for leave to appeal in the Supreme Court, seeking review of the Court of Appeals October 24, 2017 opinion. Plaintiffs filed a cross application for leave to appeal in the Supreme Court.

On September 27, 2018, the Supreme Court issued an order directing the Clerk to schedule oral argument on both applications. *Kostadinovski v Harrington*, 503 Mich 869; 917 NW2d 403 (2018). Both parties filed Supplemental Briefs in the Michigan Supreme Court. Exhibit F to this brief is the Supplemental Brief that the defendants filed in the Supreme Court.

In that brief, the defendants no longer took the position that the amendment that plaintiffs proposed would be futile unless the new claims that plaintiffs sought to add were contained in the original NOI. Instead, the defendants argued in the Supreme Court that, all that plaintiffs had to do to comply with MCL 600.2912b's notice requirement in these circumstances was to prepare a new NOI containing the new theories that plaintiffs sought to add to the case by amendment. As the defendants put it in their Supplemental Brief to the Supreme Court: "There was a simple way for Kostadinovski to comply with the NOI statute: he could have sent a new NOI." Defs' Supplemental Brf. (Exhibit F), at 8.

Thus, the defendants argued in the Supreme Court that plaintiffs were free to file an amended

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complaint containing new theories of recovery that were not mentioned in the NOI. According to defendants, to pursue these amended theories, plaintiffs needed only to prepare a new NOI that included those new theories of recovery and otherwise comply with the requirements of MCL 600.2912b.

In the Supplemental Brief that they filed in the Supreme Court, plaintiffs did not dispute that the defendants' proposal that plaintiffs prepare a new NOI with any amended theories in that notice represented one way of addressing the issue presented in this case. Plaintiffs, however, argued before the Supreme Court that resort to a new NOI was not necessary in light of the text of MCL 600.2912b.

After conducting oral argument on the parties' applications for leave to appeal, the Supreme Court on April 19, 2019 issued an order denying both parties' applications for leave to appeal. *Kostadinovski v Harrington*, ___ Mich ___; 925 NW2d 202 (2019).

**Argument**

This Court ruled in its April 29, 2016 Opinion and Order (Exhibit E) that plaintiffs would not be allowed to amend their complaint to add two new theories of liability because such an amendment would be futile. The court reached this result on the basis of MCL 600.2912b, the notice of intent statute. The court ruled that because the amended theories were not included in the NOI that was mailed to defendants in December 2013, the amendment that plaintiffs proposed would be futile. The Court of Appeals reversed that ruling and remanded the case for a determination of whether plaintiffs could satisfy the requirements of the notice of intent statute, MCL 600.2912b, by amending their NOI as set out in the Supreme Court's decision in *Bush v Shabahang*.

## I. PLAINTIFFS' REQUEST TO AMEND THEIR

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## MALPRACTICE COMPLAINT CANNOT BE DENIED AS FUTILE.

There are two distinct reasons why the amendment that plaintiffs have requested cannot be deemed futile. These two reasons will be addressed separately.

### A. The Amendment Is Not Futile Under MCL 600.2301 And The Supreme Court's Decision In *Bush*.

The Court of Appeals ruled in its October 24, 2017 decision that the Michigan Supreme Court's 2009 decision in *Bush* "controls our analysis" on the question of whether plaintiffs should have been allowed to amend their complaint. 321 Mich App at 750.

In *Bush*, the Supreme Court concluded that the plaintiff's presuit notice of intent did not fully comply with the requirements of the notice of intent statute. 484 Mich at 178-181. The issue presented in *Bush* was "what a court must do when presented with a defective NOI." *Id.*, at 170. The defendant argued in *Bush* that a defective NOI should result in the dismissal with prejudice of the plaintiff's claims. The Supreme Court rejected that argument.

The Supreme Court in *Bush* began its analysis by noting that §2912b was "silent regarding the consequences of filing a defective NOI." *Id.*, at 172. And, after examining the legislative history behind §2912b and the presuit notice requirement, the *Bush* Court determined that "the Legislature did not intend for a defect in an NOI to be grounds for dismissal with prejudice based on §2912b." 484 Mich at 173.

The *Bush* Court ruled, instead, that the Revised Judicature Act provided a mechanism for curing any defects in an NOI through the amendment of that notice. The basis for the right to amend identified by the Court in *Bush* was a Michigan statute, MCL 600.2301. That statute provides:

The court in which any action or proceeding is pending, has power to amend any

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> process, pleading or proceeding in such action or proceeding, either in form or substance, for the furtherance of justice, on such terms as are just, at any time before judgment rendered therein. The court at every stage of the action or proceeding shall disregard any error or defect in the proceedings which do not affect the substantial rights of the parties.
>
> MCL 600.2301.

MCL 600.2301 gives a court the authority to amend any "process, pleading or proceeding" in the furtherance of justice. The Supreme Court ruled in *Bush* that the mailing of an NOI is part of the "process" or "proceeding" of a malpractice case and could, therefore, be amended under §2301. 484 Mich at 176. The *Bush* Court further found in the text of §2301 a two-pronged test governing circumstances in which a court should permit the amendment of a notice of intent to correct a defect in that notice:

> We recognize that § 2301 allows for amendment of errors or defects, whether the defect is in form or in substance, but only when the amendment would be "for the furtherance of justice." Additionally, § 2301 mandates that courts disregard errors or defects when those errors or defects do not affect the substantial rights of the parties. Thus, the applicability of § 2301 rests on a two-pronged test: first, whether a substantial right of a party is implicated and, second, whether a cure is in the furtherance of justice. If both of these prongs are satisfied, a cure will be allowed "on such terms as are just.
>
> *Id.*, at 177-178.

The Court in *Bush* found that the first of these two requirements is met in medical malpractice cases based on the nature of NOI's and the sophistication of the doctors and institutions served with such NOI's:

> Given that NOIs are served at such an early stage in the proceedings, so-called "defects" are to be expected. The statute contemplates that medical records may not have been turned over before the NOI is mailed to the defendant. Defendants who receive these notices are sophisticated health professionals with extensive medical background and training. Indeed, these same defendants are allowed to act as their

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> own reviewing experts. A defendant who has enough medical expertise to opine in his or her own defense certainly has the ability to understand the nature of claims being asserted against him or her even in the presence of defects in the NOI. Accordingly, we conclude that no substantial right of a health care provider is implicated.
>
> *Id.*, at 178.

The Court in *Bush* ruled that the second prong of the analysis under §2301, which requires that an amendment be in "the furtherance of justice," is satisfied where a party "makes a good-faith attempt to comply with the content requirements of §2912b." 484 Mich at 178. Thus, the Court found in *Bush* that it is only when a plaintiff in preparing his/her original NOI "has not made a good faith attempt to comply with §2912b(4) that a trial court should consider dismissal of an action without prejudice." 484 Mich at 178.

Applying this two part test, the Supreme Court went on to rule in *Bush* that, despite the fact that plaintiff's NOI in that case was found to be defective under §2912b, plaintiff had made a good faith attempt to comply with §2912b(4). 484 Mich at 179-181. As a result, the Court held in *Bush* that any defect in a plaintiff's notice of intent could be corrected through amendment. The *Bush* Court further held that the amendment of a NOI under §2301 would relate back to the date of the filing of the original notice of intent. *Id.*, at 181, n. 44. As a result, the Court ruled that the plaintiff's cause of action was not to be dismissed because of a defect in the presuit notice. Instead, the Court remanded the case to the circuit court with instructions to allow plaintiff to prepare an amended NOI under the procedures it had set out. 484 Mich at 180-181.

In its October 24, 2017 decision in this case, the Court of Appeals found the defendants' challenge to the addition of the two theories that plaintiff sought to add by amendment to be governed by the analysis employed by the Supreme Court in *Bush* based on §2301:

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> If MCL 600.2301 is implicated and potentially applicable to save a medical malpractice action when an NOI is defective because of a failure to include negligence or causation theories required by MCL 600.2912b(4), then, by analogy, MCL 600.2301 must likewise be implicated and potentially applicable when an NOI is deemed defective because it no longer includes the negligence or causation theories required by MCL 600.2912b(4) and alleged in the complaint due to a postcomplaint change in the theories being advanced by a plaintiff as a result of information gleaned from discovery.
>
> 321 Mich App at 750.

Under the test adopted in *Bush*, the court must conclude that plaintiffs have the right to prepare an amended NOI to include the additional theories that they seek to add by amendment. The first part of the two-part *Bush* test is satisfied for the reasons expressed by the Supreme Court in *Bush*. The Court recognized that it can be anticipated that an NOI, drafted at the earliest stages of the litigation process before any discovery has been conducted and before all of the pertinent records are obtained, may not be perfectly drafted. 484 Mich at 178.

The second part of the test for application of §2301 in these circumstances focuses on whether the plaintiffs in drafting their original NOI "made a good faith attempt to comply with the content requirements of §2912b." 484 Mich at 178. This question must be resolved in favor of the plaintiffs for one simple reason - plaintiffs' original NOI *did* comply with the content requirements of §2912b at the time it was drafted. The defendants have never suggested that, in terms of the allegations contained in plaintiffs' original complaint, the NOI mailed in December 2013 was in any way defective. The only argument that defendants have made in this case is that the NOI was "defective" in that it did not list the additional theories that plaintiffs uncovered during the discovery process and which plaintiffs seek to add to this case by amendment.

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In its October 24, 2017 decision, the Court of Appeals made note of this fact. The panel recognized that this was a particularly appropriate case for the application of the amendment process set out in §2301 since plaintiffs' original NOI was *not* defective as to the claims included in the original complaint:

> There is no sound or valid reason that the principles from Bush should not be applied here. Indeed, as a general observation, the factual circumstances are even more compelling for the invocation of MCL 600.2301 when an NOI is not defective from the outset but becomes defective because discovery has shed new light on the case and given rise to a new liability theory.
>
> 321 Mich App at 750-751.

The two part *Bush* test for allowing the filing of an amended NOI is satisfied in this case. For that reason, any "defect" in plaintiffs' original notice of intent - including a "defect" associated with not including in that document the theories that plaintiffs seek to add by amendment - is to be corrected through the mailing of an amended NOI.

One final point must be made regarding the application of *Bush*'s holding to this case. The Supreme Court indicated in that case that dismissal *with* prejudice of a claim based on a defect in an NOI is not appropriate. 484 Mich at 174-175. The Court held in *Bush* that "only when a plaintiff has not made a good faith attempt to comply with §2912b(4) should a court consider dismissal of an action *without prejudice*." 484 Mich at 178 (emphasis added).

Thus, in a situation covered by *Bush*, even if the plaintiffs were unable to satisfy the two-part test for the application of §2301, the end result would *not* be the dismissal of the plaintiffs' claims with prejudice. Rather, the dismissal would be without prejudice to the plaintiffs' right to refile those claims. The same thing should hold true here. If the court were somehow convinced that plaintiffs cannot establish that they made a good faith attempt to comply with §2912b(4), the court

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would have to fashion an order that preserves plaintiffs' right to refile their claims by disposing of those claims without prejudice.

### B. The Amendment Is Not Futile For The Reasons That Defendant Stated In Their Appellate Briefs.

There is a second, independent reason why the amendment that plaintiffs have proposed would not be futile. It is important to note that this second reason was urged on the Michigan Supreme Court *by the defendants*.

The position that defendants took in this case with respect to the purported "futility" of plaintiffs' proposed amendment changed rather substantially while this case was making its way up the appellate ladder. As the court is aware, when the case was originally in the circuit court, the defendants argued that the amendment to add two new theories could only be allowed in a manner consistent with §2912b if these new theories were actually contained in the original NOI that was mailed before the case was even filed.

On appeal, the defendants altered their position. By the time this case got to the Supreme Court, defendants discarded any suggestion that the amended theories that plaintiffs sought to add would be futile because these theories were not contained in plaintiffs' December 2013 NOI. Instead, defendants took the position on appeal that plaintiffs could easily avoid any such futility.

The defendants in their briefing before the Supreme Court made the following statement as to three "options" that the parties were offering as to how this case would be approached:

> This case involves the procedure when a plaintiff gives notice of one claim, but later wants to add an entirely new claim against an existing defendant. The parties and the Court of Appeals have come up with three options:
>
> (1) Plaintiffs must serve a notice for the new theory, wait the notice period, and then move to amend their complaint.

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> (2) Plaintiffs are freed to am end new claims into their complaint even if they weren't in a notice.
>
> (3) Plaintiffs may amend their original notice under MCL 600.2301 to include the new claims and then address whether they can amend their complaint.
>
> Defs' Supplemental Brief (Exhibit F), at 1.

What defendants asserted in the Supreme Court was that the solution to this case was to be found in the first of these three options. As the defendants stated later in their Supplemental Brief to the Supreme Court: "*The cure for the Kostadinovski's problem was simple - serve an NOI that described the new claim and wait the notice period.* Nothing prevented Kostadinovski from doing so." Supplemental Brief (Exhibit F), at 20.

What the defendants argued before the Supreme Court was directly at odds with what defendants asserted before this court originally. When this case was first before this court, defendants argued that the amendment that plaintiffs proposed was futile *unless* the amended claims were also contained in plaintiffs' original NOI. But, by the time this case got to the Supreme Court, the defendants were arguing that there was a very "simple" way for plaintiffs to avoid this futility - all plaintiffs had to do was draft a new NOI containing the new theories that plaintiffs sought to add by amendment, wait the mandatory waiting period applicable under §2912b, and then file their amended complaint.

For the reasons that have been discussed in the previous section of this brief, plaintiffs do not believe that they are required to follow the procedure that the defendants advocated before the Michigan Supreme Court. But if this Court were to reject plaintiffs' arguments based on *Bush* and §2301, the court must recognize that *even the defendants have acknowledged during the appellate proceedings in this case that futility argument that they made before this court previously is wrong.*

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Defendants have, instead, explicitly acknowledged that there is a way in which plaintiffs can fully comply with §2912's notice requirement in adding the additional claims that they seek to add by amendment. According to defendants, all that the plaintiffs need to do is prepare a new NOI construing these additional theories, mail that new NOI to defendants and, after doing so, wait the time period called for by §2912b before filing their amended complaint.

The defendants have now acknowledged, at least before the State's highest court, that plaintiffs' proposed amendment would not be futile. For this reason as well, plaintiffs' request to amend cannot be denied on the grounds of futility even if this Court were to reject plaintiffs' arguments based on *Bush* and §2301.

## II. PLAINTIFFS' REQUEST TO AMEND CANNOT BE DENIED ON THE GROUNDS OF UNDUE DELAY OR UNDUE PREJUDICE.

In its remand instructions, the Court of Appeals further indicated that this Court would have to take up on remand two other objections that defendants raised to plaintiffs' proposed amendment that have yet to be resolved, undue delay or undue prejudice.

MCR 2.118(A)(2) specifies that leave to amend "shall be freely given when justice so requires." A motion to amend ordinarily should be granted and should be denied only for a limited number of reasons. *Weymers v Khera*, 454 Mich 639, 658; 563 NW2d 647 (1997). The limited circumstances in which a motion to amend may be denied were addressed by the Court of Appeals in its decision in this case:

> A court must give a particularized reason for denying leave to amend a pleading, and acceptable reasons for denial include undue delay, bad faith or dilatory motive by the party seeking leave, repeated failures to cure deficiencies after previously allowed amendments, undue prejudice to the nonmoving party, and futility.
>
> 331 Mich App at 743.

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In its remand instructions, the Court of Appeals suggested there were two separate considerations that this court was to take up, undue delay and undue prejudice. In actuality, these two considerations are interrelated. The Michigan Supreme Court held in *Weymers*, that "[d]elay alone, does not warrant denial of a motion to amend." 454 Mich at 659. The Supreme Court added that a court may deny a request to amend "if the delay was in bad faith or if the opposing party suffered actual prejudice as a result." *Id.*

Here, there was no bad faith delay in bringing the motion to amend. In their response to plaintiffs' motion to amend, defendants made much of the fact that the motion was filed approximately 22 months after the case was filed. But, one of the primary reasons why these additional theories were uncovered late in the discovery process was due to the delays in completing the deposition of the defendant, Dr. Harrington. Because of Dr. Harrington's schedule, that deposition was not completed until September 2015, fifteen months after the case was filed.

In December 2015, plaintiffs were able to take the deposition of the perfusionist who assisted during Mr. Kostadinovski's surgery. Following that deposition, plaintiffs' counsel notified defendants' counsel of the fact that there were additional theories of malpractice that plaintiffs would be pursuing.

Here, there was no undue delay in the bringing of plaintiffs' motion to amend and there certainly was no bad faith delay as the Supreme Court in *Weymers* required.

The only other rationale that the defendants offered for denying plaintiffs' motion to amend is undue prejudice. Such a claim of prejudice is undermined by the fact that there is, at present, no trial date or other significant cut-off date presently set for this case.

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When defendants responded to plaintiffs' motion to amend in March 2016, they cited as potential prejudice only the fact that the case evaluation was (at the time) set for May 24, 2016 and that the trial was (at the time) set for July 26, 2016. Response (Exhibit D), at 4. Thus, defendants' principal claim of prejudice was that "trial is only three months away." *Id.*, at 6.

Obviously, any claim of prejudice associated with the scheduling that existed at the time the court originally denied plaintiffs' motion to amend is no longer pertinent. The court has issued a scheduling order on remand that set the time for the filing of this brief and which set a new discovery initiation date of August 15, 2019 and a status conference for October 10, 2019. Order (Exhibit A). No new trial date has yet been set.

The Supreme Court has made it clear that, to defeat a request to amend a pleading, any claim of undue prejudice must consist of prejudice "that arises when the amendment would prevent the party from having a fair trial." *Sands Appliance Services, Inc. v Wilson*, 463 Mich 231, 239, fn. 6; 615 NW2d 241 (2000); *Weymers*, 454 Mich at 659-660. There is no question that, in the present posture of this case, the amendment that plaintiffs have requested will not deny the defendants a fair trial.

The Court should further note that plaintiffs' counsel took steps to minimize any possible prejudice to the defendants associated with the new theories that plaintiffs seek to add. Even before formally moving to amend the complaint to add these new theories, counsel for plaintiffs advised defendants' attorneys that plaintiffs' expert would be discussing these additional theories in their depositions conducted in January and February 2016. Thus, defense counsel has already been able to cross-examine plaintiffs' experts on the theories that plaintiffs seek to add by amendment.

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## Conclusion

Based on the foregoing, plaintiffs, Drago Kostadinovski and Blaga Kostadinovski, request that the court grant their motion to amend.

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Dated: July 15, 2019

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STATE OF MICHIGAN

MACOMB COUNTY CIRCUIT COURT

DRAGO KOSTADINOVSKI
and BLAGA KOSTADINOVSKI,
as husband and wife,

Plaintiffs,

Case No. 2014-2247-NH

vs.

STEVEN D. HARRINGTON, M.D., and
ADVANCED CARDIOTHORACIC
SURGEONS, P.L.L.C.,

Defendants.
_____/

OPINION AND ORDER

This matter is before the Court on remand from the Court of Appeals.

I. Background

On October 24, 2017, the Court of Appeals reversed this Court's April 29, 2016 Opinion and Order and remanded the matter for further proceedings under MCL 600.2301. *Kostadinovski v Harrington*, 321 Mich App 736, 740; 909 NW2d 907 (2017). Specifically, the Court of Appeals held that pursuant to *Bush v Shabahang*, 484 Mich 156; 772 NW2d 272 (2009), "the trial court – as opposed to automatically disallowing plaintiffs to amend their complaint because of the NOI conundrum that would be created — was required to assess whether the NOI defect could be disregarded or cured by an amendment of the NOI under MCL 600.2301 in the context of futility analysis." *Id.*

In reaching its decision, the Court of Appeals opined that "[i]f MCL 600.2301 is implicated and potentially applicable to save a medical malpractice action when an NOI is defective because of a failure to include negligence or causation theories required by MCL 600.2912b(4), then, by analogy, MCL 600.2301 must likewise be implicated and

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potentially applicable when an NOI is deemed defective because it no longer includes the negligence or causation theories required by MCL 600.2912b(4) and alleged in the complaint due to a postcomplaint change in the theories being advanced by a plaintiff as a result of information gleaned from discovery." *Id.* The Court of Appeals provided the following directions to this Court on remand:

> The trial court is to engage in an analysis under MCL 600.2301 to determine whether amendment of the NOI or disregard of the prospective NOI defect would be appropriate. If the trial court concludes that amendment or disregard of the defect would not be proper under MCL 600.2301, the court's prior futility analysis relative to plaintiff's motion to amend the complaint shall stand and the motion to amend the complaint shall be denied, ending the case, subject, of course, to appeal on the § 2301 analysis. If the trial court determines that MCL 600.2301 supports amendment of the NOI or disregard of the NOI defect, thereby negating the court's prior futility analysis, amendment of the complaint shall be allowed, with one caveat. Aside from futility, defendants had proffered additional reasons why amendment of the complaint should not be allowed, i.e., undue delay and undue prejudice, which were not reached by the trial court and are repeated by defendants in their appellate brief as alternative bases to affirm. The trial court shall entertain those arguments if the court rules in plaintiffs' favor on MCL 600.2301. [(Citation omitted).] *Id.* at 753-754 (citation omitted).

The parties have submitted briefs addressing *Bush* and the applicability of MCL 600.2301 which had not been provided to the Court in connection with Plaintiffs' motion to amend their complaint. On August 19, 2019, after hearing the parties' oral arguments, the Court took the matter under advisement.

## II. Law and Analysis

### A. Applicability of MCL 600.2301

MCL 600.2301 provides:

> The court in which any action or proceeding is pending, has power to amend any process, pleading or proceeding in such action or proceeding, either in form or substance, for the furtherance of justice, on such terms as are just, at any time before judgment rendered therein. The court at every

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> stage of the action or proceeding shall disregard any error or defect in the proceedings which do not affect the substantial rights of the parties.

In *Bush*, the Michigan Supreme Court held that "§ 2301 may be employed to cure defects in an NOI." *Bush*, 484 Mich at 177. In this regard, the *Bush* Court stated:

> We recognize that § 2301 allows for amendment of errors or defects, whether the defect is in form or in substance, but only when the amendment would be "for the furtherance of justice." Additionally, § 2301 mandates that courts disregard errors or defects when those errors or defects do not affect the substantial rights of the parties. Thus, the applicability of § 2301 rests on a two-pronged test: first, whether a substantial right of a party is implicated and, second, whether a cure is in the furtherance of justice. If both of these prongs are satisfied, a cure will be allowed "on such terms as are just." Given that NOIs are served at such an early stage in the proceedings, so-called "defects" are to be expected. The statute contemplates that medical records may not have been turned over before the NOI is mailed to the defendant. Defendants who receive these notices are sophisticated health professionals with extensive medical background and training. Indeed, these same defendants are allowed to act as their own reviewing experts. A defendant who has enough medical expertise to opine in his or her own defense certainly has the ability to understand the nature of claims being asserted against him or her even in the presence of defects in the NOI. Accordingly, we conclude that no substantial right of a health care provider is implicated. Further, we hold that the second prong of the test, which requires that the cure be in the furtherance of justice, is satisfied when a party makes a good-faith attempt to comply with the content requirements of § 2912b. Thus, only when a plaintiff has not made a good-faith attempt to comply with § 2912b(4) should a trial court consider dismissal of an action without prejudice. [*Id.* at 177-178.]

On remand, the parties agree that the Court's determination regarding the applicability of § 2301 and whether "amendment of the NOI or disregard of the prospective defective would be appropriate" in this case rests on the two-pronged test set forth in *Bush,* specifically: (1) whether a substantial right of a party is implicated and (2) whether a cure is in the furtherance of justice.[1]

[1] Plaintiffs' brief on remand at 11-14; Defendants' brief on remand at 10-13.

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1. Whether a Substantial Right of a Party is Implicated

In order to determine whether § 2301 permits an "amendment of the NOI or disregard of the prospective NOI defect," the Court must first consider "whether a substantial right of a party is implicated." *Id.* at 177.

Plaintiffs argue that this prong "is satisfied for the reasons expressed by the Supreme Court in *Bush*."[2] In summary fashion, Plaintiffs contend that Defendants' substantial rights are not implicated because "it can be anticipated that an NOI, drafted at the earliest stages of the litigation process before any discovery has been conducted and before all of the pertinent records are obtained, may not be perfectly drafted."[3]

Conversely, Defendants claim that their substantial rights are implicated because permitting Plaintiffs to submit an amended NOI or disregarding the prospective NOI defect would deprive them of an "opportunity to address the new claim outside the context of litigation, which is the entire point of the NOI statute."[4] According to Defendants, granting Plaintiffs' relief under § 2301 would strip them of a substantial, statutory right under § 2912b, which provides that defendants in a medical malpractice action are entitled to receive a timely NOI followed by the appropriate notice waiting period.[5] Additionally, Defendants argue that permitting Plaintiffs' to amend the NOI or disregard the prospective NOI defect would rob them of another substantial right – a statute of limitations defense.[6]

"With the enactment of MCL 600.2912b, our Legislature instituted a requirement

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[2] Plaintiffs' brief on remand at 13.
[3] *Id.*
[4] Defendants' brief on remand at 11.
[5] *Id.*
[6] *Id.* at 12.

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that the alleged injured party in a medical-malpractice action provide advance notice to a defendant medical provider before filing a complaint." *DeCosta v Gossage*, 486 Mich 116, 122; 782 NW2d 734 (2010). "The stated purpose of § 2912b was to provide a mechanism for promoting settlement without the need for formal litigation, reducing the cost of medical malpractice litigation, and providing compensation for meritorious medical malpractice claims that would otherwise be precluded from recovery because of litigation costs." *Bush*, 484 Mich at 174. "[T]he heightened particularity required by the statute fosters this goal by providing a defendant with a clear understanding of the plaintiff's allegations." *Roberts v Mecosta Co Hosp*, 470 Mich 679, 700, fn 17; 684 NW2d 711 (2004).

A "substantial right" means "[a]n *essential right* that potentially affects the outcome of a lawsuit and is capable of legal enforcement and protection, as distinguished from a mere technical or procedural right." *Priority Health v Commr of Office of Fin & Ins Services*, 489 Mich 67, 82 fn 13; 803 NW2d 132 (2011) (citing Black's Law Dictionary (8th ed.), p. 1349). In the context of medical malpractice litigation, the Michigan Supreme Court has recognized that the Legislature's enactment of § 2912b granted healthcare providers "substantial rights" – the right to receive a written NOI and the right to a 182-day notice period a medical malpractice action can be commenced against them. *See Driver v Naini*, 490 Mich 239; 802 NW2d 311 (2011); see also *Tyra v Organ Procurement Agency of Michigan*, 498 Mich 68; 869 NW2d 213 (2015).

For example, in *Driver*, the Michigan Supreme Court held that "a plaintiff is not entitled to amend an original NOI to add nonparty defendants" under § 2301 because it

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"would not be for the furtherance of justice and would affect [their] substantial rights." *Driver*, 490 Mich at 242, 254. The *Driver* Court held that applying § 2301 would deprive the nonparty defendant of its "statutory right to a timely NOI followed by the appropriate notice waiting period" and deny it "an opportunity to consider settlement." *Id.* at 255. Finally, the *Driver* Court observed that the nonparty defendant "would also be denied its right to a statute-of-limitations defense." *Id.*

Similarly, in *Tyra*, the Michigan Supreme Court rejected the contention that a plaintiff could cure the failure to wait for the expiration of the NOI period before filing a complaint under § 2301 because the defects "would not be for the furtherance of justice and would affect defendants' substantial rights." *Tyra*, 498 Mich at 92. The *Tyra* Court held that, like *Driver*, application of § 2301 "would deprive defendants of their statutory right to a timely NOI followed by the appropriate waiting period and they would also be denied their right to a statute-of-limitations defense." *Id.*

Contrary to Plaintiffs' contention, *Bush* does not stand for the proposition that a healthcare provider's substantial rights cannot be implicated in a medical malpractice action. In *Bush*, the plaintiff's NOI failed to adequately address the standard of care applicable to a defendant under a direct theory of liability for failure to properly train or hire and another defendant for errors on the part of its nursing staff and physician assistants. *Bush*, 484 Mich at 180. While the *Bush* Court found that these omissions constituted defects in the NOI, it held that § 2301 required the defects to be "disregarded or cured by amendment." *Id.* In arriving at this conclusion, the Michigan Supreme Court held that a defective NOI did not implicate a "substantial right of a health care provider" because (1) "NOIs are served at such an early stage in the proceedings"

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and "so-called 'defects' are to be expected," (2) "medical records may not have been turned over before the NOI is mailed to the defendant," and (3) the defendants "who receive these notices are sophisticated health professionals with extensive medical background and training" and have "the ability to understand the nature of claims being asserted against him or her even in the presence of defects in the NOI." *Id.* at 178.

In this case, Plaintiffs' NOI failed to allege a breach of the standard of care with regard to an entirely new theories of liability, the failure to monitor hypotension levels during the operation and the failure to transfuse the patient as a potential cause of injury. Unlike *Bush*, where the plaintiff's defective NOI included enough information to give the defendants notice of the asserted claims, it is undisputed that Plaintiffs' NOI did not include *any information* about this newly asserted theories of medical malpractice liability. Indeed, Plaintiffs' NOI does not refer to hypotension or transfusion during surgery at all. Thus, unlike *Bush*, no amount of sophistication would have enabled Defendants to understand that Plaintiffs were asserting such a claim in the presence of this omission. While an NOI is served at an early stage in the proceedings and certain defects are to be expected, unlike the circumstances in *Bush*, this defect wholly deprived Defendants of their statutory right to receive timely notice of a claim of medical malpractice liability followed by the appropriate waiting period. Defendants were not given the opportunity to engage in any type of settlement negotiations with regard to the hypotension and transfusion claims because Plaintiffs' NOI failed to refer to or even hint at the existence of any such claims.

Therefore, under the first prong of the test set forth in *Bush* concerning the applicability of § 2301, the Court finds that Defendants' substantial rights are implicated.

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2. Whether a Cure is in the Furtherance of Justice

The Court now turns to the second prong of the *Bush*'s test, "whether a cure is in the furtherance of justice", to determine the applicability of § 2301 in this case. *Bush*, 484 Mich at 177.

Plaintiffs contend that permitting an amendment to their NOI or disregarding the prospective NOI defect is in the furtherance of justice because they made a good faith effort to comply with the content requirements of § 2912b.[7] In this regard, Plaintiffs claim that the second prong is satisfied because – the NOI served on December 9, 2013 "*did* comply with the content requirements of § 2912b at the time it was drafted."[8] Plaintiffs observe that Defendants "have never suggested that, in terms of the allegations contained in [Plaintiffs'] original complaint, the NOI mailed in December [of] 2013 was in any way defective."[9] According to Plaintiffs, "any 'defect' in plaintiffs' original NOI including a 'defect' associated with not including in that document the theories that plaintiffs seek to add by amendment - is to be corrected through the mailing of an amended NOI" under *Bush*.[10] Notably, it is undisputed that Plaintiffs have never filed or served Defendants with an amended NOI.

Defendants argue in response that Plaintiffs are unable to demonstrate "good faith" because they "made no attempt, much less a good-faith attempt, to comply with the content requirements" for the new claims of medical malpractice.[11] According to

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[7] Plaintiffs' supplemental brief on remand at 13.
[8] *Id.*
[9] *Id.*
[10] *Id.* at 14.
[11] Defendants' brief on remand at 11.

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Defendants, Plaintiffs "could have sent a new NOI" but "didn't send one."[12] Defendants also maintain that Plaintiffs had the necessary information to plead these claims from the start of the case.[13]

In *Bush*, the Michigan Supreme Court held that amendment of the NOI or disregard of the prospective NOI defect is in the furtherance of justice "when a party makes a good-faith attempt to comply with the content requirements of § 2912b." *Bush*, 484 Mich at 178. Only when a plaintiff has not made a good-faith attempt to comply with § 2912b(4) should a trial court consider dismissal of an action without prejudice. *Id.* In reaching its determination of the applicability of § 2301, the *Bush* court found that the defective NOI at issue included all relevant facts necessary for the defendants to ascertain the nature of the claims against them. In this case, however, as set forth above, Plaintiffs' NOI wholly failed to allege any facts regarding the failure to monitor Mr. Kostadinovski's low blood pressure and transfuse him. Accordingly, this Court finds *Bush* is distinguishable.

Moreover, the Court does not find Plaintiffs' claim of "good faith" premised on the assertion that the NOI was not defective from the outset because it included all of the allegations raised in the complaint to be persuasive. The Court of Appeals expressly rejected Plaintiffs' argument that § 2912b "simply requires the service of an NOI before suit is filed and that once this is accomplished through the service of a proper and compliant NOI, *as judged at the time suit is filed and by the language in the original complaint*, the requirements of the statute have been satisfied, absent the need to revisit the NOI even if a new theory of negligence or causation is later developed that

[12] *Id.* at 12.

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was not included in the NOI and that forms the basis of an amended complaint." *Kostadinovski*, 321 Mich App at 751, fn 6. As stated by the Court of Appeals, "the approach suggested by plaintiffs would undermine the legislative intent and purpose behind MCL 600.2912b." *Id.* Plaintiff makes the same argument but now in the context of the "good faith" prong of the *Bush* test. This Court similarly finds that such an approach, especially where Defendants substantial rights have been implicated as in this case, would undermine the legislative intent and purpose behind MCL 600.2912b.

Finally, Plaintiffs' contention that the NOI was not defective from the outset because their new claims of medical malpractice could not have been uncovered until the case was in discovery, is not supported by the record. Plaintiffs assert that their new theories of liability – that Defendants breached the standard of care by failing to adequately monitor Mr. Kostadinovski's hypotension (low blood pressure) and transfuse him, which resulted in a stroke – were based on information gleaned from discovery.[14] However, Plaintiffs provide no support for this contention. Plaintiffs' hypotension and transfusion claims are based on Mr. Kostadinovski's Henry Ford Macomb Hospital records, specifically surgical/operative records dated December 14, 2013.[15] A perfusion record contained in Mr. Kostadinoski's surgical/operative records provides that Mr. Kostadinovski's hemoglobin and hematocrit levels (HGB/HCT) changed from 7.8/23 at 10:57 a.m. to 5.1/15 at 11:24 a.m., 11:32 a.m., and 11:51 a.m.[16] While Plaintiffs claim

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[13] *Id.* at 14, 17.
[14] Plaintiffs' supplemental brief on remand at 2-4.
[15] Defendants' Exhibit 7, Mr. Kostadinoski's Surgical/Operative Records, at 1859; Plaintiffs' Exhibit C, Transcript of Proceedings, dated March 28, 2016, at 12.
[16] Defendants' Exhibit 7 at 1859.

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this record was not legible, it was legible enough for Plaintiffs' counsel to ask Dr. Harrington questions about Mr. Kostadinovski's HGB/HCT levels at his deposition,[17] as well as the deposition of the perfusionist, Lynn Katheen Masinick.[18] The Court was also able to read and consider this record. Although Plaintiffs also claim that depositions were necessary before their new theory of medical malpractice liability based on the failure to adequately monitor Mr. Kostadinovski's hypotension and transfuse him, they cite to no specific testimony and the record demonstrates that the relevant medical records were in their possession before the NOI and complaint were drafted. Indeed, Plaintiffs' NOI states that medical records from Henry Ford Macomb Hospital were reviewed and provides specific details of Mr. Kostadinovski's December 14, 2011 surgery based on Dr. Harrington's operative report, operative note, and operative findings.[19]

Therefore, for the reasons stated above, the Court finds that amendment of the NOI or disregard of the prospective NOI defect is not "in the furtherance of justice." *Bush*, 484 Mich at 177.

3. Conclusion Regarding Applicability of MCL 600.2301

Accordingly, because Defendants' substantial rights are implicated and amendment of the NOI or disregard of the prospective NOI defect is not in the furtherance of justice, the Court finds that § 2301 is not applicable in this case.

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[17] Defendants' Exhibit 9, Transcript of Dr. Harrington's Deposition, dated September 22, 2015, Vol. II at 154-155.
[18] Defendants' Exhibit 9, Transcript of Ms. Masinick's Deposition, dated December 17, 2015, at 43-44, 66.
[19] Plaintiffs' Exhibit A, Notice of Intent, dated December 9, 2013, at 2, 5-6.

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B. Motion for Leave to File Amended Complaint

MCR 2.118(A)(2) provides that "[e]xcept as provided in subrule (A)(1), a party may amend a pleading only by leave of the court or by written consent of the adverse party. Leave shall be freely given when justice so requires." *Kemerko Clawson, LLC v RxIV Inc*, 269 Mich App 347, 352; 711 NW2d 801 (2005). "Because a court should freely grant leave to amend a complaint when justice so requires, a motion to amend should ordinarily be denied only for particularized reasons." *Wormsbacher v Seaver Title Co*, 284 Mich App 1, 8; 772 NW2d 827 (2009). "Reasons that justify denying leave to amend include undue delay, bad faith or dilatory motive, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the defendant, or futility." *Id.*

Here, the Court of Appeals' remand instructions provide that "[I]f the trial court concludes that amendment or disregard of the defect would not be proper under MCL 600.2301, the court's prior futility analysis relative to plaintiff's motion to amend the complaint shall stand and the motion to amend the complaint shall be denied, ending the case, subject, of course, to appeal on the § 2301 analysis." *Kostadinovski*, 321 Mich App at 753. Thus, because amendment or disregard of the defect is not proper under § 2301, Plaintiffs' failure to adhere to the statutory mandates renders the new allegations contained in the proposed amended complaint futile, as these new allegations of medical malpractice must fail as a matter of law.[20]

[20] Given the Court's determination that Plaintiffs are not entitled to relief under § 2301 and amendment of their complaint is futile, the Court need not address whether Plaintiffs' motion for leave to file an amended complaint should be denied due to undue delay and undue prejudice.

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Therefore, Plaintiffs' motion for leave to file an amended complaint is denied.

III. Conclusion

For the reasons set forth above, plaintiffs' motion for leave to file an amended complaint is DENIED. Pursuant to MCR 2.602(A)(3), this *Opinion and Order* resolves the last pending claim and closes the case.

IT IS SO ORDERED.

Dated: NOV 18 2019

Kathryn A. Viviano

Hon. Kathryn A. Viviano, Circuit Court Judge

*If this opinion indicates that it is "FOR PUBLICATION," it is subject to revision until final publication in the Michigan Appeals Reports.*

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# STATE OF MICHIGAN

# COURT OF APPEALS

DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI,

Plaintiffs-Appellants,

v

STEVEN D. HARRINGTON, M.D. and ADVANCED CARDIOTHORACIC SURGEONS, PLLC,

Defendants-Appellees.

UNPUBLISHED
March 11, 2021

No. 351773
Macomb Circuit Court
LC No. 2014-002247-NH

Before: SWARTZLE, P.J., and MARKEY and TUKEL, JJ.

PER CURIAM.

In this medical malpractice action, plaintiffs appeal as of right the trial court's order denying their motion to amend their complaint. This case has been before this Court once before. *Kostadinovski v Harrington*, 321 Mich App 736; 909 NW2d 907 (2017) (*Kostadinovski I*). In *Kostadinovski I*, this Court reversed the trial court's denial of plaintiffs' motion to amend and instructed the trial court to determine on remand whether plaintiffs were entitled to amend their Notice of Intent to File Claim ("NOI") under MCL 600.2301. *Kostadinovski I*, 321 Mich App at 753-754. Plaintiffs now appeal the decision on remand, in which the trial court denied their motion to amend their complaint, reasoning that the amended complaint was futile; the trial court ruled that amending the complaint would run afoul of the requirement of providing a Notice of Intent to sue prior to filing a complaint for medical malpractice. See MCL 600.2912b. For the reasons set forth below, we affirm.[1]

[1] Plaintiffs forthrightly and correctly note that because of the posture in which we receive this case, viz., an appeal from the trial court's actions following remand from this Court, "law of the case principles probably preclude this Court from revisiting" issues previously decided. Our review is very narrowly focused, in accordance with this Court's prior opinion, which we discuss below.

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## I. UNDERLYING FACTS

This Court's prior opinion set forth the operative facts and background of this case:

> On December 9, 2013, plaintiffs served defendants with the NOI, asserting that on December 14, 2011, the doctor [Dr. Steven D. Harrington] had performed robotic-assisted [mitral valve repair] surgery on Mr. Kostadinovski and that, as subsequently determined, Mr. Kostadinovski suffered a stroke during the course of the procedure. The NOI listed six specific theories with respect to the manner in which the doctor allegedly breached the applicable standard of care relative to the surgery and preparation for the surgery, along with identifying related causation claims. On June 4, 2014, an expert for plaintiffs executed an affidavit of merit that listed the same six negligence theories outlined in the NOI in regard to the alleged breaches of the standard of care. On June 5, 2014, plaintiffs filed their medical malpractice complaint against defendants, along with the affidavit of merit, alleging that the doctor breached the standard of care in the six ways identified in the NOI and affidavit of merit. The causation claims were also identical in all three legal documents.
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> * * *
>
> On March 21, 2016, defendants filed a motion for summary disposition, arguing that, as revealed during discovery, plaintiffs' expert witnesses could not validate or support the six negligence theories set forth in the NOI, affidavit of merit, and complaint. On that same date, March 21, 2016, plaintiffs filed a motion to amend their complaint. Plaintiffs asserted that discovery had recently been completed and that discovery showed that Mr. Kostadinovski "was in a hypotensive state during the operation and was not adequately transfused." According to plaintiffs, this evidence was previously unknown and only came to light following the deposition of the perfusionist [Lynn Masinick], the continuing deposition of the doctor, and the depositions of plaintiffs' retained experts. Plaintiffs sought to amend the complaint to allege negligence against the doctor "for failing to adequately monitor Mr. Kostadinovski's hypotension during the operation and failing to transfuse the patient so as to maintain the patient's blood pressure." On March 28, 2016, a hearing was held on plaintiffs' motion to amend the complaint, and the trial court decided to take the matter under advisement. On April 25, 2016,

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"The law of the case doctrine holds that a ruling by an appellate court on a particular issue binds the appellate court and all lower tribunals with respect to that issue. Thus, a question of law decided by an appellate court will not be decided differently on remand or in a subsequent appeal in the same case." *Ashker ex rel Estate of Ashker v Ford Motor Co*, 245 Mich App 9, 13; 627 NW2d 1 (2001) (citations omitted). "The primary purpose of the doctrine is to maintain consistency and avoid reconsideration of matters once decided during the course of a single continuing lawsuit." *Id.*

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> a hearing was conducted on defendants' motion for summary disposition, at which time plaintiffs agreed to the dismissal of their original complaint, given that their theories of negligence now lacked expert support, as did the causation claims that had been linked to the defunct negligence theories. Plaintiffs' motion to amend the complaint remained pending.
>
> On April 29, 2016, the trial court issued a written opinion and order denying plaintiffs' motion to amend the complaint. [*Kostadinovski I*, 321 Mich App at 740-742 (footnotes omitted).]

As discussed earlier, this Court reversed the trial court's order denying plaintiffs' motion to amend. *Kostadinovski I*, 321 Mich App at 754. Relying on our Supreme Court's opinion in *Bush v Shabahang*, 484 Mich 156; 772 NW2d 272 (2009), the *Kostadinovski I* Court stated:

> If MCL 600.2301 is implicated and potentially applicable to save a medical malpractice action when an NOI is defective because of a failure to include negligence or causation theories required by MCL 600.2912b(4), then, by analogy, MCL 600.2301 must likewise be implicated and potentially applicable when an NOI is deemed defective because it no longer includes the negligence or causation theories required by MCL 600.2912b(4) and alleged in the complaint due to a postcomplaint change in the theories being advanced by a plaintiff as a result of information gleaned from discovery. There is no sound or valid reason that the principles from *Bush* should not be applied here. Indeed, as a general observation, the factual circumstances are even more compelling for the invocation of MCL 600.2301 when an NOI is not defective from the outset but becomes defective because discovery has shed new light on the case and given rise to a new liability theory. [*Kostadinovski I*, 321 Mich App at 750-751 (footnote omitted).]

This Court provided detailed directions for the trial court to follow on remand, stating:

> For purposes of guidance on remand, we provide the following direction. The trial court is to engage in an analysis under MCL 600.2301 to determine whether amendment of the NOI or disregard of the prospective NOI defect would be appropriate. If the trial court concludes that amendment or disregard of the defect would not be proper under MCL 600.2301, the court's prior futility analysis relative to plaintiff's [sic] motion to amend the complaint shall stand and the motion to amend the complaint shall be denied, ending the case, subject, of course, to appeal on the § 2301 analysis. If the trial court determines that MCL 600.2301 supports amendment of the NOI or disregard of the NOI defect, thereby negating the court's prior futility analysis, amendment of the complaint shall be allowed, with one caveat. Aside from futility, defendants had proffered additional reasons why amendment of the complaint should not be allowed, i.e., undue delay and undue prejudice, see *Miller* [*v Chapman Contracting*, 477 Mich 102, 105; 730 NW2d 462 (2007)], which were not reached by the trial court and are repeated by defendants in their appellate brief as alternative bases to affirm. The trial court shall entertain those arguments if the court rules in plaintiffs' favor on MCL 600.2301. [*Id.* at 753-754 (footnote omitted).]

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On remand, the parties submitted supplemental briefs addressing the application of MCL 600.2301 to plaintiffs' attempt to amend. In a written opinion and order, the trial court once again denied plaintiffs' motion to amend. The trial court held that permitting the amendment would implicate defendants' substantial rights to presuit notice, as required by MCL 600.2912b. Unlike *Bush*, which involved a defective NOI, in that it omitted some but not all of the relevant information, the trial court concluded plaintiffs' NOI was devoid of any reference to plaintiffs' new theories of liability that would enable defendants to understand the claims against them. The trial court also concluded that permitting the amendment would not further the interests of justice because plaintiffs had the relevant information to assert their new theories at the outset of the litigation, and could have done so from the suit's inception. This appeal followed.

## II. STANDARD OF REVIEW

"Decisions granting or denying motions to amend pleadings, are within the sound discretion of the trial court and reversal is only appropriate when the trial court abuses that discretion." *Doyle v Hutzel Hosp*, 241 Mich App 206, 212; 615 NW2d 759 (2000) (quotation marks, citation, and alteration omitted). "An abuse of discretion occurs when the decision resulted in an outcome falling outside the range of principled outcomes." *Hayford v Hayford*, 279 Mich App 324, 325; 760 NW2d 503 (2008). "An error of law necessarily constitutes an abuse of discretion." *Denton v Dep't of Treasury*, 317 Mich App 303, 314; 894 NW2d 694 (2016). "This Court reviews a trial court's findings of fact for clear error." *Kuhlgert v Mich State Univ*, 328 Mich App 357, 368; 937 NW2d 716 (2019). "A finding of fact is clearly erroneous when no evidence supports the finding or, on the entire record, this Court is left with a definite and firm conviction that a mistake has been made." *King v Mich State Police Dep't*, 303 Mich App 162, 185; 841 NW2d 914 (2013).

In addition, "[t]his Court reviews questions of statutory interpretation de novo." *Herald Co, Inc v Eastern Mich Univ Bd of Regents*, 475 Mich 463, 470; 719 NW2d 19 (2006). "The role of this Court in interpreting statutory language is to ascertain the legislative intent that may reasonably be inferred from the words in a statute." *Mich Ass'n of Home Builders v Troy*, 504 Mich 204, 212; 934 NW2d 713 (2019) (quotation marks and citations omitted). "[W]here the statutory language is clear and unambiguous, the statute must be applied as written." *Id.* (quotation marks and citations omitted) (alteration in original).

## III. AMENDMENT OF THE COMPLAINT AND NOI

Plaintiffs sought to amend the complaint to add a new theory of liability, which was not alleged in the initial complaint; such an amendment arguably also would require an amendment of the Notice of Intent to sue, which is a prerequisite to filing a valid medical practice suit. See MCL 600.2912b. Thus, this Court held in *Kostadinovski I* that "[t]he trial court is to engage in an analysis under MCL 600.2301 to determine whether amendment of the NOI or disregard of the prospective NOI defect would be appropriate." *Kostadinovski I*, 321 Mich App at 753 (footnote omitted).

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Under MCL 600.2301:

> The court in which any action or proceeding is pending, has power to amend any process, pleading or proceeding in such action or proceeding, either in form or substance, for the furtherance of justice, on such terms as are just, at any time before judgment rendered therein. The court at every stage of the action or proceeding shall disregard any error or defect in the proceedings which do not affect the substantial rights of the parties.

Our Supreme Court has interpreted MCL 600.2301 as setting forth two factors which control the analysis of whether relief is appropriate:

> [T]he applicability of § 2301 rests on a two-pronged test: first, whether a substantial right of a party is implicated and, second, whether a cure is in the furtherance of justice. If both of these prongs are satisfied, a cure will be allowed "on such terms as are just." [*Bush*, 484 Mich at 177, quoting MCL 600.2301.]

"[T]he second prong of the test, which requires that the cure be in the furtherance of justice, is satisfied when a party makes a good-faith attempt to comply with the content requirements of § 2912b." *Id.* at 178.

Plaintiffs assert that no substantial interest of defendants would be affected by permitting plaintiffs' amendment, because, unlike in the case of a defective NOI, litigation already was ongoing between the parties, such that, per *Bush*, defendants already had notice that their conduct was under scrutiny. The *Bush* Court further noted the background and experience of a defendant in such a situation would allow that defendant to discern what was at issue in a particular case, and thus such a defendant would not be prejudiced by a lack of information. See *Bush*, 484 Mich at 156 ("Defendants who receive these notices are sophisticated health professionals with extensive medical background and training. . . . A defendant who has enough medical expertise to opine in his or her own defense certainly has the ability to understand the nature of claims being asserted against him or her even in the presence of defects in the NOI.").

The trial court concluded, however, that defendants' substantial interests were in fact implicated for a different reason. The trial court found that amendment of the NOI and complaint would deprive defendants of presuit notice and the opportunity to negotiate settlement without litigation. See MCL 600.2912b(1) ("[A] person shall not commence an action alleging medical malpractice against a health professional or health facility unless the person has given the health professional or health facility written notice under this section not less than 182 days before the action is commenced."); *Kostadinovski I*, 321 Mich App at 746, quoting *Bush*, 484 Mich at 174 ("The stated purpose of § 2912b was to provide a mechanism for promoting settlement without the need for formal litigation, reducing the cost of medical malpractice litigation, and providing compensation for meritorious medical malpractice claims that would otherwise be precluded from recovery because of litigation costs.").

In contrast with *Bush*, which concerned defects in the original NOI, plaintiffs' original NOI had no apparent defects on the face of the document. The only defect, to the extent that term is

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appropriate, is that plaintiffs' original NOI did not include the theories of liability that plaintiffs later wanted to assert against defendants.

Nowhere in the NOI or complaint did plaintiffs refer to Drago's hypotension or the failure to transfuse Drago during the procedure. That fact makes this case quite different from *Bush*, because the NOI in *Bush*, although defective, still included enough information for the defendants to understand the nature of the claims raised against them. See *Bush*, 484 Mich at 178. Unlike in *Bush*, defendants in this case did not have the ability to understand the nature of plaintiffs' claims regarding hypotension and transfusion because those claims were not even referenced in plaintiffs' NOI. Thus, the trial court did not err when it concluded that defendants' substantial interests were implicated. See *Tyra v Organ Procurement*, 498 Mich 68, 92; 869 NW2d 213 (2015) (holding that "just as in *Driver*, '[a]pplying MCL 600.2301 in the present case[s] would deprive [defendants] of [their] statutory right to a timely NOI followed by the appropriate notice waiting period[.]' "); *Driver v Naini*, 490 Mich 239, 255; 802 NW2d 311 (2011) (concluding that the trial court abused its discretion when it permitted amendment to NOI to add nonparty as a defendant because it would "deprive [the nonparty] of its statutory right to a timely NOI followed by the appropriate notice waiting period, and [the nonparty] would be denied an opportunity to consider settlement"). Because plaintiffs' proposed amendment of the complaint would deprive defendants of a substantial right, § 2301 is not available to remedy the flaws in the NOI.

With respect to whether plaintiffs' proposed amendment would be in furtherance of justice, plaintiffs argue their original NOI was drafted in good faith because it was drafted on the basis of the information they had at the time. Plaintiffs assert that they could not have included the claims of hypotension and transfusion before they deposed Dr. Harrington and Masinick because the records that would have revealed those claims were illegible. The trial court disagreed, and there is nothing in its fact finding in that regard which is clearly erroneous. See MCR 2.613(C) ("Findings of fact by the trial court may not be set aside unless clearly erroneous. In the application of this principle, regard shall be given to the special opportunity of the trial court to judge the credibility of the witnesses who appeared before it."). The trial court found, referring to plaintiff's perfusion record, that "While plaintiff claims this record was not legible, it was legible enough for plaintiffs' counsel to ask Dr. Harrington questions about Mr. Kostadinovski's HGB/HCT levels at his deposition, as well as the deposition of the perfusionist, Lynn Kathleen Mastick. The Court was also able to read and consider this record."

During Dr. Harrington's deposition, he was asked by plaintiffs whether he would be surprised if "the patient's hemoglobin was running at 5 during a number of the blood draws and it got up to 6 or 7 but never above 8 during the entire operation." In addition, while reading from one of Drago's medical records, plaintiffs asked Dr. Harrington: "From 11:24 up until 11:51 the patient's hemoglobin was reported on three separate occasions as being 5.1, correct?"

It is clear from Dr. Harrington's deposition, which, according to the record, took place at least in part before any of the other depositions, that plaintiffs understood what Drago's blood levels were during the operation. This belies any claim by plaintiffs that the trial court erred in finding that discovery was unnecessary to uncover these claims. There was no technical "defect," on the face of plaintiffs' original NOI; nothing was omitted or overlooked, or given cursory treatment. Rather, the NOI simply did not address a theory of liability that plaintiffs could have made but did not. Plaintiffs' actions had the effect of depriving defendants, prior to the filing of a

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complaint making the allegation, of the information necessary to understand what they were alleged to have done incorrectly. That is a "substantial right." *Tyra*, 498 Mich at 92. We need not determine whether plaintiffs' actions nonetheless constituted "a good-faith attempt to comply with the content requirements of § 2912b," *Bush*, 484 Mich at 178, because a plaintiff is required to show both good faith and the lack of prejudice to a substantial right of a defendant in order to invoke the saving provision of § 2301; the fact that defendant's amendment would impair a substantial right in and of itself makes § 2301 unavailable. See *Bush*, 484 Mich at 180–81 ("[W]e hold that the alleged defects can be cured pursuant to § 2301 because the substantial rights of the parties are not affected, and 'disregard' or 'amendment' of the defect is in the furtherance of justice when a party has made a good-faith attempt to comply with the content provisions of § 2912b.").

Plaintiffs contend that if the trial court's decision is allowed to stand, no plaintiff in a medical malpractice case will ever be able to assert a new claim on the basis of facts uncovered during discovery. Plaintiffs are wrong for more than one reason. First, and simply as a factual matter as discussed earlier, plaintiffs did not uncover the facts supporting their hypotension and transfusion claims during discovery; at best, discovery confirmed what they already suspected, i.e., that Drago's hemoglobin and hematocrit levels were low, and he was not transfused as plaintiffs allege he should have been. And second, plaintiffs never attempted to cure the omissions of their original NOI by sending an amended NOI to defendants. See *Gulley-Reaves v Baciewicz*, 260 Mich App 478, 486-487; 679 NW2d 98 (2004) (stating that MCL 600.2912b "contemplates that additional notices of intent may be filed, and the defendant is required to respond to the notice of intent."). Thus, plaintiffs' argument regarding the effects of this case on the flexibility to amend a complaint are without merit.

## IV. DISMISSAL WITH PREJUDICE

Plaintiffs also contend that if the trial court was not going to permit amendment of the complaint, it should not have dismissed their original claims with prejudice, which would have allowed them to continue to pursue those claims. Plaintiffs' assertion may be true as a general matter. See *Bush*, 484 Mich at 178 ("[O]nly when a plaintiff has not made a good-faith attempt to comply with § 2912b(4) should a trial court consider dismissal of an action without prejudice."). But plaintiffs' procedural predicament is a quandary of their own making. When it became clear that their original theories of liability were not supported by the testimony of their own experts, plaintiffs responded to defendants' motion for summary disposition regarding those theories, stating: "With regard to Plaintiffs' remaining theories of liability, Plaintiff [sic] will not be going forward with those theories of liability." At the hearing on defendants' summary disposition motion, plaintiffs agreed with the trial court's statement that "there is a stipulation as it relates to" dismissal of plaintiffs' original claims. Thus, by the time the trial court ruled on plaintiffs' motion to amend, it already had dismissed plaintiffs' initial claims with prejudice. In other words, if plaintiffs believed in the soundness of their original claims, plaintiffs could have conditioned their stipulation on the trial court's decision on their motion to amend. Despite now having seller's remorse over stipulating unconditionally to the dismissal of their original claims, plaintiffs cannot now change their minds and resurrect those claims. See *In re Koch Estate*, 322 Mich App 383, 402-403; 912 NW2d 205 (2017) ("A party may not appeal an error that the party created.").

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## V. LAW OF THE CASE

With respect to plaintiffs' final argument, that MCL 600.2912b does not apply to a party's attempt to amend a complaint, this Court resolved that issue for these parties in *Kostadinovski I*, when it was raised by plaintiffs. This Court stated:

> Plaintiffs argue that MCL 600.2912b simply requires the service of an NOI before suit is filed and that once this is accomplished through the service of a proper and compliant NOI, as judged at the time suit is filed and by the language in the original complaint, the requirements of the statute have been satisfied, absent the need to revisit the NOI even if a new theory of negligence or causation is later developed that was not included in the NOI and that forms the basis of an amended complaint. [*Kostadinovski I*, 321 Mich App at 751 n 6.]

This Court rejected that argument:

> If this were the law, the entire analysis in *Decker* [*v Rochowiak*, 287 Mich App 666; 791 NW2d 507 (2010)] would have been completely unnecessary because a proper and compliant NOI had been served on the defendants, as judged on the date the original complaint was filed and by the language in that complaint. Moreover, the approach suggested by plaintiffs would undermine the legislative intent and purpose behind MCL 600.2912b. [*Id.*]

Based on this Court having previously decided this issue against them, plaintiffs' argument that MCL 600.2912b does not apply to an amended complaint is foreclosed as law of the case, as a question of law decided by an appellate court will not be decided differently on remand or in a subsequent appeal in the same case. See Note 1 of this opinion.[2]

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[2] And finally, as appellee notes, the implication of our holding that the trial court did not abuse its discretion in denying plaintiffs' motion to amend also is controlled by the law of the case doctrine. This Court held in *Kostadinovski I*:

> If the trial court concludes that amendment or disregard of the defect would not be proper under MCL 600.2301, the court's prior futility analysis relative to plaintiff's motion to amend the complaint shall stand and the motion to amend the complaint shall be denied, ending the case, subject of course to an appeal on the § 2301 analysis. [*Kostadinovski I*, 321 Mich App at 753.]

The trial court did rule that "amendment or disregard of the defect would not be proper under MCL 600.2301," and thus "the court's prior futility analysis relative to plaintiffs' motion to amend the complaint," stood. Consequently, as directed by the previous panel, the trial court's denial on remand of the motion to amend "end[s] the case, subject of course to an appeal of the § 2301 analysis." The "appeal of the § 2301 analysis" has not changed that result, as this opinion sets forth. Consequently, under the previous order of this Court, this case is now ended. As this is an appeal from the trial court's grant of defendants' motion for summary disposition, the case already

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## VI. CONCLUSION

For the reasons stated in this opinion, the trial court's order denying plaintiffs' motion to amend their complaint is affirmed. Defendants, as the prevailing parties, may tax costs pursuant to MCR 7.219.

/s/ Brock A. Swartzle
/s/ Jane E. Markey
/s/ Jonathan Tukel

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is dismissed, so there is nothing further for the trial court to do. We note simply that under the decision in *Kostadinovski I*, the case has ended and the trial court may not entertain further attempts to pursue this case, absent an order from our Supreme Court to the contrary.

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# Order

Michigan Supreme Court
Lansing, Michigan

Bridget M. McCormack,
Chief Justice

Brian K. Zahra
David F. Viviano
Richard H. Bernstein
Elizabeth T. Clement
Megan K. Cavanagh
Elizabeth M. Welch,
Justices

November 23, 2021

162909

DRAGO KOSTADINOVSKI and
BLAGA KOSTADINOVSKI,
Plaintiffs-Appellants,

v

SC: 162909
COA: 351773
Macomb CC: 2014-002247-NH

STEVEN D. HARRINGTON, M.D., and
ADVANCED CARDIOTHORACIC
SURGEONS, PLLC,
Defendants-Appellees.

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On order of the Court, the application for leave to appeal the March 11, 2021 judgment of the Court of Appeals is considered. We direct the Clerk to schedule oral argument on the application. MCR 7.305(H)(1).

The appellants shall file a supplemental brief addressing: (1) whether MCL 600.2912b applies where the plaintiff seeks to add new theories of recovery against an already-named defendant; and (2) if so, when and how a plaintiff seeking to add such new theories may satisfy the requirements of MCL 600.2912b, see *Bush v Shabahang*, 484 Mich 156 (2009), and MCL 600.2301. The appellants' brief shall be filed by February 28, 2022, with no extensions except upon a showing of good cause. In the brief, citations to the record must provide the appendix page numbers as required by MCR 7.312(B)(1). The appellees shall file a supplemental brief within 21 days of being served with the appellants' brief. A reply, if any, must be filed by the appellants within 14 days of being served with the appellees' brief. The parties should not submit mere restatements of their application papers.

VIVIANO, J., did not participate due to a familial relationship with the presiding circuit court judge in this case.

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I, Larry S. Royster, Clerk of the Michigan Supreme Court, certify that the foregoing is a true and complete copy of the order entered at the direction of the Court.

November 23, 2021

Clerk