STATE OF MICHIGAN

IN THE SUPREME COURT

MARY ANNE MARKEL,

Plaintiff-Appellant,

v.

WILLIAM BEAUMONT HOSPITAL,

Defendant-Appellee,

and

HOSPITAL CONSULTANTS, PC, LINET LONAPPAN, MD, and IOANA MORARIU,

Defendants.

Supreme Court No. 163086

Court of Appeals Case No. 350655

Oakland County Circuit Court
Case No. 18-164979-NH

Hon. Nanci Grant

APPENDIX OF EXHIBITS TO DEFENDANT-APPELLEE WILLIAM BEAUMONT HOSPITAL'S BRIEF ON APPEAL

Volume I

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

Mary Anne Markel,

Plaintiff,

v.

William Beaumont Hospital, Hospital Consultants, P.C.,Linet Lonappan, M.D., and Ioana Morariu, M.D., Jointly and Severally,

Defendants.

_____/

2018-164979-NH

JUDGE NANCI J. GRANT

Case No.: 18- -NH

Hon.

This case has been designated as an eFiling case. To review a copy of the Notice of Mandatory eFiling visit www.oakgov.com/clerkrod/Pages/efiling.

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_____/

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

/s/Justin J. Hakala

COMPLAINT
DEMAND FOR JURY TRIAL

NOW COME the above named Plaintiff, by and through her attorneys, MORGAN & MEYERS, PLC, and states as her cause of action against the above-named Defendants the following:

1. The acts and occurrences which form the basis for this Complaint occurred within the Oakland County, Michigan.

2. The original injury, which forms the basis for this Complaint, occurred in Oakland County.

3. The amount in controversy is in excess of TWENTY-FIVE THOUSAND ($25,000.00) DOLLARS.

4. At all times pertinent to this Complaint, Mary Anne Markel was a resident of the County of Oakland, State of Michigan.

5. At all times pertinent to this Complaint, Linet Lonappan, M.D. ("Dr. Lonappan") was a physician practicing medicine in the County of Oakland, State of Michigan.

6. At all times pertinent to this Complaint, Ioana Morariu, M.D. ("Dr. Morariu") was a physician practicing medicine in the County of Oakland, State of Michigan.

7. At all times pertinent to this Complaint, Hospital Consultants, P.C. ("Hospital Consultants") was a Michigan Professional Corporation, with its principal place of business in Michigan, doing business in the County of Oakland, State of Michigan.

8. At all times pertinent to this Complaint, William Beaumont Hospital ("Beaumont" or "William Beaumont Hospital") was a Michigan Corporation, with its principal place of business in Michigan, doing business in the County of Oakland, State of Michigan.

9. In paragraphs 10 - 26 as set forth below, Plaintiff makes reference to statements contained in the medical records of various health care providers. The recitations of these factual statements should not be interpreted as an admission by Plaintiff 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 standard of care, also described below.

10. On October 2, 2015, Ms. Markel underwent endometrial ablation with Novasure and TruClear procedure performed.

11. On October 9, 2015, Ms. Markel presented to the Emergency Department at William Beaumont Hospital Royal Oak complaining of numbness in her feet, ten out of ten pain located in her left lumbar spine, and a history of inability to urinate. Her back pain was noted to radiate to her left lower extremity. A complete blood count was ordered in the Emergency Department which revealed a white blood cells of 13,800. Ms. Markel was admitted to Beaumont Hospital for additional workup.

12. The CT scan of the abdomen performed in the evening of October 9, 2015, revealed a stable three centimeter lesion in the area of the left adnexa and degenerative disc disease in the lumbar spine, but was otherwise negative. An MRI of the lumbar spine revealed spinal pathology throughout the lumbar spine with disc extrusions and protrusions noted at multiple levels. Neurosurgical consultation performed by Dr. Ricky Olsen revealed an exacerbation of lower back pain with radicular symptoms. Dr. Olsen recommended pain control and an anesthesiology/pain management consultation was placed.

13. A urinalysis performed the evening of October 9, 2015, revealed dark yellow urine, cloudy in appearance that was positive for bilirubin at one plus, positive for trace ketones, positive for leukocytes, and positive for white blood counts at 11 to 25. Crystal was also found in the urine and identified them via microscopy to be calcium oxalate.

14. On October 10, 2015, Linet Lonappan, M.D., completed a history and physical noting that Ms. Market was unable to urinate earlier, but had urinated the morning of the 10th. A stat urinalysis was ordered at 1:49 p.m. and a urine culture was ordered at the same time. At 8:00 on October 10, 2015, Ms. Markel was noted to have a fever of 100.9 and shortly thereafter at 9:09 p.m. the urinalysis was resulted. The urinalysis from that afternoon revealed dark yellow urine with trace ketones, two plus leukocytes, white blood cells of 11 to 25, cast and epithelial cells both present.

15. An overnight nursing note entered by Megan Kaiser, N.P., noted that the patient was running a fever of 100.9 at 10:10 the prior evening, now at 98.1. The note indicates that Dr. Moraru (believed to be Dr. Ioana Morariu, M.D.) was contacted per the standing order to contact with temperatures above 100.4. The nursing note indicates "PT's UA is neg and culture is pending from previous night specimen. PT states she is doing well and feels better than she is in a while. DR said to just continue to watch her."

16. A pain management consultation performed by Daniel Sapeika, M.D., recommended lumbar epidural versus caudal epidural injections at the Pain Clinic or in the hospital if Ms. Markel remained admitted.

17. On October 11, 2015, at approximately 2:33 p.m., Linet Lonappan, M.D. discharged Ms. Markel from the hospital. Approximately three hours after that order was entered at 5:47 p.m., a preliminary result for Ms. Markel's urine culture returned a positive result for streptococcus agalactiae (group B greater than 100,000 colony forming units per milliliter.) This result was never communicated to Ms. Markel.

18. The following day on October 12, 2015, Ms. Markel underwent epidural steroid injections on an outpatient basis.

19. The final read for the urine culture was resulted on October 12, 2015 at 8:38 p.m. and was abnormal for streptococcus agalactiae greater than 100,000 CFU/ml.

20. The following day on October 13, 2015, Ms. Markel again presented to the Emergency Department at Beaumont Hospital. A history and physical entered by Dr. Lonappan indicates that Ms. Markel underwent an ESI on Monday, October 12, 2015 and began to experience bilateral knee joint pain and swelling, plus a fever of 102 at home after the injection. Initial white blood count from blood obtained at 7:30 p.m. on the October 13, 2015 revealed an elevated count of 13,800. The repeat lab performed on a specimen obtained on October 14, 2017 a 7:39 a.m. revealed a white blood count of 16,400.

21. Infectious disease was consulted and saw Ms. Markel on October 14, 2015. Dr. John Szela indicated that he believed Ms. Markel had acute polyarticular arthritis with synovitis. He noted that "in the abstinence of leukocytosis, persistent fever and toxicity, gout and infectious etiology . . . instead, highly suspected inflammatory process most likely pseudogout. Dr. Szela discontinued antibiotics, however, just over two hours later an addendum entered by his fellow, Adam Skrzynski, M.D., indicated that a high white blood count in the clinical setting was a "very unlikely clinical presentation for polyarticular arthritis, but will need to treat. Will start vancomycin." Synovial fluid cultures obtained from both Ms. Markel's left and right knees were positive for grand positive cocci, white blood cells and crystals and ultimately group B strep in cultures.

22. On October 14, 2015, Ms. Markel underwent bilateral revision of her total knee arthroplasties in which both sites were irrigated and debrided and cultures were then obtained.

23. On October 19, 2015, Ms. Markel underwent an aspiration of her right sternal clavicular joint, which also was found to be infected with group B strep. An arthrotomy of her right sternum clavicular joint was performed on October 21, 2015, that included an arrogation and drainage, excisions of the manubrium and distal clavicle, and placement of a mediport.

24. Additional surgical revisions were performed on October 26, 2015, in which one component of both knees was placed. Drains were also placed and new cultures were obtained.

25. On November 2, 2015, Ms. Markel was discharged to inpatient rehabilitation at William Beaumont Hospital.

26. Ms. Markel was also diagnosed with an epidural abscess requiring surgical drainage. Subsequently Ms. Markel was found to have neurological sequela including foot drop.

COUNT I: NEGLIGENCE
DR. LONAPPAN

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

27. At all times pertinent to this Complaint Dr. Lonappan owed Plaintiff a duty to maintain the standard of care and treatment of her peers within the professional community of internal medicine physicians.

28. The requirements of the standard of care included, but were not limited to, the following:

a. Dr. Lonappan was required to order the administration of empirical broad-spectrum antibiotic treatment for an elevated white blood count and suspected infection beginning on October 9, 2015, and continually thereafter;

b. Dr. Lonappan was required to order a repeat complete blood count on October 10, 2015;

c. Dr. Lonappan was required to order the administration of appropriate antibiotics upon learning Ms. Markel had a fever on October 10, 2015 and continually thereafter;

d. Dr. Lonappan was required to determine whether Ms. Markel's urine culture had grown abnormal organisms prior to ordering her discharge on October 11, 2015;

e. Dr. Lonappan was required to notify Ms. Markel and instruct that she either return to the emergency department or hospital to begin antibiotic administration or to prescribe an appropriate antibiotic and instruct Ms. Markel to immediately fill the prescription and begin antibiotics after the preliminary urine culture result on October 11, 2015, 5:47 p.m. revealed an streptococcus agalactiae (Group B).

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

a. Dr. Lonappan failed to order the administration of empirical broad-spectrum antibiotic treatment for an elevated white blood count and suspected infection beginning on October 9, 2015, and continually thereafter;

b. Dr. Lonappan failed to order a repeat complete blood count on October 10, 2015;

c. Dr. Lonappan failed to order the administration appropriate antibiotics upon learning Ms. Markel had a fever on October 10, 2015 and continually thereafter;

d. Dr. Lonappan failed to determine whether Ms. Markel's urine culture had grown abnormal organisms prior to ordering her discharge on October 11, 2015;

e. Dr. Lonappan failed to notify Ms. Markel and instruct that she either return to the emergency department or hospital to begin antibiotic administration or to prescribe an appropriate antibiotic and instruct Ms. Markel to immediately fill the prescription and begin antibiotics

after the preliminary urine culture result on October 11, 2015, 5:47 p.m. revealed an streptococcus agalactiae (Group B).

30. In order to comply with the standard of care, Dr. Lonappan should have taken the following steps:

a. Dr. Lonappan should have ordered the administration of empirical broad-spectrum antibiotic treatment for an elevated white blood count and suspected infection beginning on October 9, 2015, and continually thereafter;

b. Dr. Lonappan should have ordered a repeat complete blood count on October 10, 2015;

c. Dr. Lonappan should have ordered the administration of appropriate antibiotics upon learning Ms. Markel had a fever on October 10, 2015 and continually thereafter;

d. Dr. Lonappan should have determined whether Ms. Markel's urine culture had grown abnormal organisms prior to ordering her discharge on October 11, 2015;

e. Dr. Lonappan should have notified Ms. Markel and instruct that she either return to the emergency department or hospital to begin antibiotic administration or to prescribe an appropriate antibiotic and instruct Ms. Markel to immediately fill the prescription and begin antibiotics after the preliminary urine culture result on October 11, 2015, 5:47 p.m. revealed an streptococcus agalactiae (Group B).

31. Each injury and element of damage noted below was factually and foreseeably caused by the standard of care violation by Dr. Lonappan.

32. As a direct and proximate cause of each breach of the standard of care of Linet Lonappan, M.D., Ms. Markel's infection went untreated, she received an epidural injection for pain management, and the infectious process worsened. As a result of the worsening of the infectious process in conjunction with the epidural injection, she developed an epidural abscess that ultimately required surgical drainage and caused neurologic deficits including pain, loss of motor function, loss of sensation, and foot drop. In addition, as a result of the worsening of the infectious process the infection

spread to her clavicle, manubrium, and caused infection in both knees and in preexisting implants used for total knee replacements bilaterally. Because of the spread of infection, Ms. Markel required medical management, antibiotics, an extended hospitalization, surgical debridements of her knees, bilateral surgical revision of her total knee replacements, and other medical care.

33. Had Dr. Lonappan acted in accordance with the standard of care more completely described above, she would have promptly initiated antibiotic therapy, kept Ms. Markel in the hospital for a period of time long enough to treat the infection, and prevent the spread of infection other parts of Ms. Markel's body including her knees, spine, and chest. These steps would have prevented the development of epidural abscess and prevented the need for spine surgery, multiple knee surgeries, surgical intervention at the clavicle and manubrium and other medical management.

34. As a result, Plaintiff is entitled to damages, including, but not limited to the following:

a. Pain and suffering, past, present, and future;

b. Emotional distress and anxiety;

c. Mental anguish, past present and future;

d. Fright and shock, past present and future;

e. Denial of social pleasure and enjoyments, past, present and future;

f. Embarrassment, humiliation, and mortification, past present and future;

g. Disability and disfigurement;

h. Reasonable expenses of necessary medical care, treatment and services, past, present, and future;

i. The loss of earning capacity; and

j. Other injuries and/or damages to be determined throughout the course of discovery.

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

COUNT II: NEGLIGENCE
DR. MORARIU

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

35. At all times pertinent to this Complaint Dr. Morariu owed Plaintiff a duty to maintain the standard of care and treatment of her peers within the professional community of internal medicine physicians.

36. The requirements of the standard of care included, but were not limited to, the following:

a. Dr. Morariu was required to administer an appropriate antimicrobial medication upon learning Ms. Markel had a fever on October 10, 2015;

b. Dr. Morariu was required to order a repeat complete blood count upon learning Ms. Markel had a fever on October 10, 2015.

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

a. Dr. Morariu failed to administer an appropriate antimicrobial medication upon learning Ms. Markel had a fever on October 10, 2015;

b. Dr. Morariu failed to order a repeat complete blood count upon learning Ms. Markel had a fever on October 10, 2015.

38. In order to comply with the standard of care, Dr. Morariu should have taken the following steps:

a. Dr. Morariu should have administered an appropriate antimicrobial medication upon learning Ms. Markel had a fever on October 10, 2015;

b. Dr. Morariu should have ordered a repeat complete blood count upon learning Ms. Markel had a fever on October 10, 2015.

39. Each injury and element of damage noted below was factually and foreseeably caused by the standard of care violation by Dr. Morariu.

40. As a direct and proximate cause of each breach of the standard of care of Dr. Morariu, Ms. Markel's infection went untreated, she received an epidural injection for pain management, and the infectious process worsened. As a result of the worsening of the infectious process in conjunction with the epidural injection, she developed an epidural abscess that ultimately required surgical drainage and caused neurologic deficits including pain, loss of motor function, loss of sensation, and foot drop. In addition, as a result of the worsening of the infectious process the infection spread to her clavicle, manubrium, and caused infection in both knees and in preexisting implants used for total knee replacements bilaterally. Because of the spread of infection, Ms. Markel required medical management, antibiotics, an extended hospitalization, surgical debridements of her knees, bilateral surgical revision of her total knee replacements, and other medical care.

41. Had Dr. Morariu acted in accordance with the standard of care more completely described above, she would have promptly initiated antibiotic therapy, kept Ms. Markel in the hospital for a period of time long enough to treat the infection, and

prevent the spread of infection other parts of Ms. Markel's body including her knees, spine, and chest. These steps would have prevented the development of epidural abscess and prevented the need for spine surgery, multiple knee surgeries, surgical intervention at the clavicle and manubrium and other medical management. As a result, Plaintiff is entitled to damages, including, but not limited to the following:

a. Pain and suffering, past, present, and future;

b. Emotional distress and anxiety;

c. Mental anguish, past present and future;

d. Fright and shock, past present and future;

e. Denial of social pleasure and enjoyments, past, present and future;

f. Embarrassment, humiliation, and mortification, past present and future;

g. Disability and disfigurement;

h. Reasonable expenses of necessary medical care, treatment and services, past, present, and future;

i. The loss of earning capacity; and

j. Other injuries and/or damages to be determined throughout the course of discovery.

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

COUNT III: NEGLIGENCE
WILLIAM BEAUMONT HOSPITAL FOR JANAY WARNER, PA-C

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

42. At all times pertinent to this Complaint Janay Warner, PA-C owed Plaintiff a duty to maintain the standard of care and treatment of her peers within the professional community of physician assistants.

43. At all times pertinent to this Complaint, Janay Warner, PA-C was employed by William Beaumont Hospital and was an actual agent of the Defendant Beaumont.

44. Defendant Beaumont is vicariously liable for the acts, omissions, and negligence of its agent and employee, Janay Warner, PA-C.

45. The requirements of the standard of care applicable to Janay Warner, PA-C included, but were not limited to, the following:

a. Ms. Warner was required to notify Dr. Lonappan or another appropriate physician of Ms. Markel's lab results immediately after learning the preliminary urine culture result on October 11, 2015, 5:47 p.m. revealed an streptococcus agalactiae (Group B);

b. Ms. Warner was required to notify Ms. Markel of her lab results immediately after learning the preliminary urine culture result on October 11, 2015, 5:47 p.m. revealed an streptococcus agalactiae (Group B);

c. Ms. Warner was required to notify Ms. Markel and instruct that she either return to the emergency department/hospital to begin antibiotic administration or to cause an appropriate antibiotic to be prescribed and instruct Ms. Markel to immediately fill the prescription and begin antibiotics after the preliminary urine culture result on October 11, 2015, 5:47 p.m. revealed an streptococcus agalactiae (Group B).

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

a. Ms. Warner failed to notify Dr. Lonappan or another appropriate physician of Ms. Markel's lab results immediately after learning the

preliminary urine culture result on October 11, 2015, 5:47 p.m. revealed an streptococcus agalactiae (Group B);

b. Ms. Warner failed to notify Ms. Markel of her lab results immediately after learning the preliminary urine culture result on October 11, 2015, 5:47 p.m. revealed an streptococcus agalactiae (Group B);

c. Ms. Warner failed to notify Ms. Markel and instruct that she either return to the emergency department/hospital to begin antibiotic administration or to cause an appropriate antibiotic to be prescribed and instruct Ms. Markel to immediately fill the prescription and begin antibiotics after the preliminary urine culture result on October 11, 2015, 5:47 p.m. revealed an streptococcus agalactiae (Group B).

47. In order to comply with the standard of care, Defendant should have taken the following steps:

a. Ms. Warner should have notified Dr. Lonappan or another appropriate physician of Ms. Markel's lab results immediately after learning the preliminary urine culture result on October 11, 2015, 5:47 p.m. revealed an streptococcus agalactiae (Group B);

b. Ms. Warner should have notified Ms. Markel of her lab results immediately after learning the preliminary urine culture result on October 11, 2015, 5:47 p.m. revealed an streptococcus agalactiae (Group B);

c. Ms. Warner should have notified Ms. Markel and instruct that she either return to the emergency department/hospital to begin antibiotic administration or to cause an appropriate antibiotic to be prescribed and instruct Ms. Markel to immediately fill the prescription and begin antibiotics after the preliminary urine culture result on October 11, 2015, 5:47 p.m. revealed an streptococcus agalactiae (Group B).

48. Each injury and element of damage noted below was factually and foreseeably caused by the standard of care violation by Ms. Warner.

49. As a direct and proximate cause of each breach of the standard of care of Ms. Warner, Ms. Markel's infection went untreated, she received an epidural injection for pain management, and the infectious process worsened. As a result of the worsening of the infectious process in conjunction with the epidural injection, she developed an

epidural abscess that ultimately required surgical drainage and caused neurologic deficits including pain, loss of motor function, loss of sensation, and foot drop. In addition, as a result of the worsening of the infectious process the infection spread to her clavicle, manubrium, and caused infection in both knees and in preexisting implants used for total knee replacements bilaterally. Because of the spread of infection, Ms. Markel required medical management, antibiotics, an extended hospitalization, surgical debridements of her knees, bilateral surgical revision of her total knee replacements, and other medical care.

50. Had Janay Warner, PA-C acted in accordance with the standard of care more completely described above, she would have promptly notified Ms. Markels' attending physician of the laboratory results and an antibiotic therapy would have been promptly initiated. The spread of infection would have been prevented and other parts of Ms. Markel's body including her knees, spine, and chest would not have been infected and affected. These steps would have prevented the development of epidural abscess and prevented the need for spine surgery, multiple knee surgeries, surgical intervention at the clavicle and manubrium and other medical management.

51. As a result, Plaintiff is entitled to damages, including, but not limited to the following:

a. Pain and suffering, past, present, and future;

b. Emotional distress and anxiety;

c. Mental anguish, past present and future;

d. Fright and shock, past present and future;

e. Denial of social pleasure and enjoyments, past, present and future;

f. Embarrassment, humiliation, and mortification, past present and future;

g. Disability and disfigurement;

h. Reasonable expenses of necessary medical care, treatment and services, past, present, and future;

i. The loss of earning capacity; and

j. Other injuries and/or damages to be determined throughout the course of discovery.

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

COUNT IV: NEGLIGENCE
WILLIAM BEAUMONT HOSPITAL ADMINISTRATORS

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

52. At all times pertinent to this Complaint the William Beaumont Hospital Administrators owed Plaintiff a duty to maintain the standard of care and treatment of their peers within the professional community of hospital administration.

53. At all times pertinent to this Complaint the William Beaumont Hospital Administrators were employed by William Beaumont Hospital and were actual, apparent, or ostensible agents of the Defendant Beaumont.

54. Defendant Beaumont is vicariously liable for the acts, omissions, and negligence of the Hospital Administrators.

55. The requirements of the standard of care applicable to the Hospital Administrators included, but were not limited to, the following:

a. Establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the attending physician or another appropriate physician;

b. Establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the patient if the patient has already been discharged from the hospital.

c. Establish, implement, and maintain a policy requiring that the discharge process include all information needed for the patient's follow up care.

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

a. They failed to establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the attending physician or another appropriate physician;

b. They failed to establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the patient if the patient has already been discharged from the hospital;

c. They failed to establish, implement, and maintain a policy requiring that the discharge process include all information needed for the patient's follow up care

57. In order to comply with the standard of care, Defendant should have taken the following steps:

a. They should have established, implemented, and maintained a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the attending physician or another appropriate physician;

b. They should have established, implemented, and maintained a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the patient if the patient has already been discharged from the hospital;

c. They should have established, implemented, and maintained a policy requiring that the discharge process include all information needed for the patient's follow up care.

58. Each injury and element of damage noted below was factually and foreseeably caused by the standard of care violations of the Hospital Administrators.

59. As a direct and proximate cause of each breach of the standard of care of the Hospital Administrators, Ms. Markel's infection went untreated, she received an epidural injection for pain management, and the infectious process worsened. As a result of the worsening of the infectious process in conjunction with the epidural injection, she developed an epidural abscess that ultimately required surgical drainage and caused neurologic deficits including pain, loss of motor function, loss of sensation, and foot drop. In addition, as a result of the worsening of the infectious process the infection spread to her clavicle, manubrium, and caused infection in both knees and in preexisting implants used for total knee replacements bilaterally. Because of the spread of infection, Ms. Markel required medical management, antibiotics, an extended hospitalization, surgical debridements of her knees, bilateral surgical revision of her total knee replacements, and other medical care.

60. Had the Hospital Administrators acted in accordance with the standard of care more completely described above, an attending physician, Ms. Markel's primary care physician, or Ms. Markel would have been timely notified of the abnormal preliminary lab result. Had any of those steps been taken, Ms. Markel would have been

aware of the preliminary urine culture result and returned to the hospital to receive antibiotics. She would not have had an epidural injection and would not have developed an epidural abscess. Similarly, the infection would not have spread to her knees and she would not have required knee surgery, back surgery, or spine surgery. Ms. Markel would have timely initiated antibiotic therapy and been treated to prevent the spread of infection other parts of Ms. Markel's body including her knees, spine, and chest. These steps would have prevented the development of epidural abscess and prevented the need for spine surgery, multiple knee surgeries, surgical intervention at the clavicle and manubrium and other medical management.

61. As a result, Plaintiff is entitled to damages, including, but not limited to the following:

a. Pain and suffering, past, present, and future;

b. Emotional distress and anxiety;

c. Mental anguish, past present and future;

d. Fright and shock, past present and future;

e. Denial of social pleasure and enjoyments, past, present and future;

f. Embarrassment, humiliation, and mortification, past present and future;

g. Disability and disfigurement;

h. Reasonable expenses of necessary medical care, treatment and services, past, present, and future;

i. The loss of earning capacity; and

j. Other injuries and/or damages to be determined throughout the course of discovery.

WHEREFORE, Plaintiff respectfully requests that this Honorable Court enter Judgment against Defendants in any amount in excess of TWENTY-FIVE THOUSAND

($25,000.00) DOLLARS, together with interest, costs and attorney fees, to which Plaintiff is deemed to be entitled.

COUNT V: VICARIOUS LIABILITY
HOSPITAL CONSULTANTS, P.C.

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

62. At all times pertinent to this Complaint, Dr. Lonnapan and Dr. Morariu were actual agents, apparent agents, ostensible agents, servant and/or employees of Hospital Consultants, P.C.

63. As such, Hospital Consultants, P.C. is vicariously liable for the negligent acts and/or omissions of these physicians as more fully described above, as well as the injuries and damages flowing from said acts and/or omissions.

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

COUNT VI: VICARIOUS LIABILITY
WILLIAM BEAUMONT HOSPITAL.

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

64. At all times pertinent to this Complaint, Dr. Lonnapan and Dr. Morariu were actual agents, apparent agents, ostensible agents, servant and/or employees of William Beaumont Hospital.

65. As such, William Beaumont Hospital is vicariously liable for the negligent acts and/or omissions of these physicians as more fully described above, as well as the injuries and damages flowing from said acts and/or omissions.

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

Respectfully submitted,

MORGAN & MEYERS, PLC

By: /s/Justin J. Hakala
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DATED: April 9, 2018

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

Mary Anne Markel,

Plaintiff,

v.

Case No.: 18- -NH
Hon.

William Beaumont Hospital, Hospital Consultants, P.C.,Linet Lonappan, M.D., and Ioana Morariu, M.D., Jointly and Severally,

Defendants.
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JEFFREY T. MEYERS (P34348)
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_____/

DEMAND FOR JURY TRIAL

NOW COMES the above-named Plaintiffs, by and through their attorneys, MORGAN & MEYERS, PLC, and hereby demands a jury trial in the above-captioned cause of action.

Respectfully submitted,

MORGAN & MEYERS, PLC

By: /s/Justin J. Hakala
JEFFREY T. MEYERS (P34348)
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DATED: April 9, 2018

In the Matter Of:

MARKEL vs WILLIAM BEAUMONT HOSPITAL, ET AL.

MARY ANNE MARKEL

September 07, 2018

Prepared for you by

Bingham Farms/Southfield • Grand Rapids
Ann Arbor • Detroit • Flint • Jackson • Lansing • Mt. Clemens • Saginaw • Troy

MARKEL, MARY ANNE
09/07/2018

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

Mary Anne Markel,
Plaintiff,
vs. Case No. 2018-164979-NH
Hon. Nanci J. Grant
William Beaumont Hospital, Hospital Consultauts, P.C., Linet Lonappan, M.D., and Ioana Morariu, M.D., Jointly and Severally,
Defendants.

The Deposition of MARY ANNE MARKEL,
Taken at 1 Towne Square, Suite 1400,
Southfield, Michigan,
Commencing at 10:55 a.m.,
Friday, September 7, 2018,
Before Wendy M. Taylor, CSR-6922.

APPEARANCES:

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EXHIBITS

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Southfield, Michigan
Friday, September 7, 2018
10:55 a.m.

MARY ANNE MARKEL,
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. WARWICK: Let the record reflect this is the deposition of the plaintiff Mary Anne Markel taken pursuant to notice.

EXAMINATION

BY MR. WARWICK:

Q. Hi, Ms. Markel. My name is Don Warwick. I introduced myself to you a few moments ago. I represent William Beaumont Hospital in the lawsuit. I have some questions for you as does the co-defense attorney, Mr. Sinkoff, and your own counsel may as well.

If at any time you don't understand a question, don't hesitate to mention that and I'll certainly repeat or rephrase it.

A. Yes.

Q. If you answer the question I'm going to assume you understood it, fair?

A. Yes.

Q. Have you ever given your deposition before?

A. For this?

Q. Have you ever testified in any matter?

A. I did a long time ago as a nurse.

Q. Under what type of setting?

A. There was a patient that was potentially injured at the hospital and I had to go over my notes with them and say what my notes showed.

Q. Was that an actual deposition or did you just meet with attorneys for the hospital?

A. I think that's what I did. I never went. I don't think we ever had a court person here, it was 25 years ago.

Q. Okay. So this is probably your first deposition?

A. I believe so, yes, sir.

Q. Mr. Hakala, I'm sure, has given you some advice about how to answer questions, et cetera, but just listen carefully to my entire question and then see if he objects. There probably won't be many objections but see if your attorney objects and as long as he lets you answer the question, that's fine, you can answer at that point but it's a little unnatural with questions, objections, answers, et cetera.

A. Okay.

Q. You are doing a very nice job of waiting to let me complete my question and if I interrupt you at all I apologize in advance. I'll make sure to clear up the record so we have a clear record for the court reporter, okay?

A. Yes, sir.

Q. You're doing a nice job again of speaking verbally, which again, is what we need instead of uh-huh or huh-uh or a shake of the head, okay?

A. Yes.

Q. What is your date of birth?

A. March 15, 1960.

MR. SINKOFF: '50 or '60?

THE WITNESS: '60.

BY MR. WARWICK:

Q. I was provided with some answers to interrogatories yesterday, which were unsigned. You must have provided some written information to your attorney, is that correct?

A. Yes, sir.

MR. WARWICK: Do we have the signed answers by any chance or can she sign them now so the court reporter can witness it? Maybe at the end of the deposition we'll do it.

THE WITNESS: Do I need to read anything?

MR. HAKALA: I have to get my glasses. One minute.

BY MR. WARWICK:

Q. Sure. So I have from your answers to interrogatories that you are 58 years of age, is that correct?

A. Yes, sir.

Q. And that you reside at 1882 Bacon, B-a-c-o-n, Avenue in Berkley, Michigan?

A. Yes.

Q. Since 1990?

A. Yes.

Q. And who do you live there with?

A. My son and my daughter.

Q. And what is your daughter's name?

A. Cindy, C-i-n-d-y.

Q. And the last name?

A. Markel, M-a-r-k-e-l.

Q. And what is her date of birth?

A. May 13th of 2001.

Q. And your son's name?

A. Matthew Markel.

Q. His date of birth?

A. 10-24 of '97.

Q. Do you have any other children?

A. I do not and these children are adopted, if that makes

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a difference?
Q. Okay. So when were they adopted?
A. I adopted them on October 23rd of 2013.
Q. Are they natural siblings?
A. Yes.
Q. You have never been married, is that correct?
A. That is correct.
Q. What type of house or residence do you live in?
A. My own home, it's a bungalow so it's two stories with a basement.
Q. How many bedrooms?
A. Three.
Q. Where is your bedroom in the house? I only ask this because I see in the answers to interrogatories discussions about mobility.
A. Yeah.
Q. None of my questions are intended to offend you.
A. That's okay.
Q. I'm representing my client.
A. Sure. My bedroom is upstairs on the upper level.
Q. So it's a two-story bungalow with a basement and you live upstairs in the bungalow, is that correct?
A. Yes.
Q. Three bedrooms, did you say?
A. Yes.

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Q. What type of bathroom, shower or bathtub, et cetera, do you have upstairs?
A. I have a very small bathroom, like a six-foot bathroom, it has a toilet and a sink and it has a tub but I don't use the tub up there.
Q. What do you use in terms of showers or baths?
A. I have to come to the main floor and use that bathroom.
Q. What type of method, do you take a shower or bath?
A. I'm usually a bath person, that has been a challenge getting in and out of the tub but I don't have the stamina to stand to take a shower.
Q. So downstairs on the main floor when you take a bath or shower, do you -- is it a tub?
A. It's a tub, it's a shower in it with a tub enclosure and then my brother put in grip bars for me so I can get in and out both inside and outside.
Q. You're able to take a bath in that manner?
A. Yes.
Q. What is your brother's name?
A. Michael.
Q. Last name?
A. Markel.
Q. What does he do?
A. He's a junior, if that makes a difference?

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Q. Okay.
A. He is a chief nursing officer at Henry Ford Hospital.
Q. Is he clinically actively working as a nurse or supervising nurses?
A. He's supervising.
Q. Do you know his date of birth?
A. Yes, December 21st, 1958.
Q. Okay. Did any relatives go with you to William Beaumont Hospital during your treatment from October 9 to October 11, 2015?
A. My son Matthew took me.
Q. And was Matthew present during any substantive discussions with any doctors or medical professionals during that admission?
A. No.
Q. Would Matthew have any knowledge, to your understanding, of any of the discussions about your medical treatment during that October 9 through October 11, 2015 treatment?
A. No.
Q. Okay. So you're the only person, from your perspective from family members, et cetera, who has firsthand knowledge of your treatment at Beaumont Hospital from October 9th to October 11th, 2015, is that correct?

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A. Yes.
Q. Are you employed by Beaumont Hospital?
A. I am.
Q. How long have you been employed by Beaumont Hospital?
A. 35 years.
Q. Which Beaumont Hospital?
A. I work at Royal Oak. I'm part of the Royal Oak system but I work in the PNC building.
Q. PNC building?
A. Yes, sir.
Q. The one in Troy?
A. Yes, 75 and Sixteen.
Q. Yeah, that's close to my office. You work at the PNC office on Big Beaver Road in Troy?
A. Yes.
Q. How long have you worked there?
A. At the PNC building?
Q. Right.
A. I think we're on the 10th year on our lease.
Q. What's your position there?
A. I'm a registered nurse. I'm called an anesthesia prescreening nurse.
Q. Are any actual anesthesia procedures performed at the PNC building?
A. No.

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Q. Is this a prescreening nurse process before patients then undergo surgery, et cetera, at a later date?
A. Yes.
Q. You've had that position for the last 10 years?
A. No, I've been in that department -- in different facilities, I've been in that department since 1998.
Q. Okay.
A. Yes, 1998.
Q. When you say, that department, you mean the anesthesia prescreening department?
A. I have to get my dates right. One second.
Q. Sure.
A. I had a latex reaction so I'm trying to figure out when I went there. '98 is when I went to anesthesia prescreening, before that I worked in the PACU.
Q. Your work at the PNC building in anesthesia prescreening has been for approximately the last 10 years, from 2008 to 2018, is that right?
A. In that building, yes, sir.
Q. Prior to that where were you working at physically?
A. We were in Barnum, the old Barnum school in Birmingham until they took that down.
Q. Can you spell that?
A. B-a-r-n-u-m, it was near --
Q. Is that near Pierce?

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A. Yeah, but then they took it down.
Q. Okay.
A. Prior to that we were in the medical office building.
Q. How long were you at Barnum, roughly?
A. Ballpark, five years.
Q. Prior to that you said --
A. In the PNC building -- no, the medical office building on campus on the 7th floor.
Q. The medical office campus in Royal Oak?
A. Yes.
Q. And your answers to interrogatories indicate that you've never been married, is that correct?
A. Yes, sir.
Q. And you graduated from Holy Cross in 1978, is that true?
A. Yes.
Q. And from Oakland University you earned a bachelor of science in nursing in 1983, is that right?
A. Yes.
Q. And then a master of arts in humanistic studies in 1994, is that right?
A. Humanistic and clinical psych, yes, 1994.
Q. Did you ever practice as a professional in humanistic and clinical psychology?
A. I did.

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Q. For how long?
A. Probably about six or seven years.
Q. So when did you start and when did you stop?
A. I started in '94 when I graduated and I ended -- again, I'm kind of ballparking.
Q. Sure.
A. Probably about early 2000s, 2001, 2002.
Q. Where did you work?
A. I was in private practice.
Q. As a psychologist?
A. Limited license psychologist, yes, sir.
Q. Where was your office at?
A. Again, a couple different places. I had one in Southfield. I had one on Ryan Road in -- that was the group practice, Ryan Road in either Madison Heights or -- I don't know what the city is there and also an office at my home for a while.
Q. The reason you stopped that work?
A. It just wasn't feasible working full time as a nurse and trying to build a practice at the same time.
Q. Were you also working as a registered nurse during that period of time?
A. Yes, sir.
Q. How many hours roughly were you working? I'm looking for a little background information. How many hours

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typically were you working per week as a limited licensed psychologist during that time?
A. About 15.
Q. How many hours were you typically working as a registered nurse?
A. Between 40 and 50.
Q. Okay. And what type of registered nurse work were you doing during that period?
A. I was a recovery room nurse, PACU.
Q. At Beaumont Royal Oak?
A. Yes.
Q. Did you continue that PACU work until you went to the preanesthesia work in 1998?
A. I had one small window. I developed -- I had a latex reaction doing CPR training so the next day they were like, you're done, you can't be in the PACU anymore, so I did a transition. I was in a transition period from February to June and I worked with MQPM getting ready for the joint commission visit so I did a lot of our chart review, quality assurance.
Q. That would have been from February until June 1998?
A. Yes, sir.
Q. You started your preanesthesia work?
A. Yes, sir.
Q. So I take it you've not been actively involved in

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patient care since 1998, is that correct?
A. Not in physical patient care.
Q. Right. You've done the work of -- the preanesthesia work since that period of time?
A. Yes, sir.
Q. And when you said you had a reaction to latex, what type of reaction did you have?
A. My mouth split open. They knew I had an allergy but we worked around it and the mouthpiece was latex. My mouth split open and I had a hard time breathing.
Q. Has that ever happened since that time?
A. No.
Q. And what type of latex device did you have in your mouth?
A. The mouthpiece for the CPR mannequin.
Q. Okay. You've never been in the Armed Forces, is that correct?
A. Correct.
Q. Is this your only lawsuit --
A. Yes.
Q. -- in your life?
Have you ever made any claims short of a lawsuit in your life? Have you ever made any claim for any alleged injuries but not filed a lawsuit in your life?

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A. No, sir.
Q. What type of health insurance do you have?
A. I have the Beaumont Employee Health Plan.
Q. So that's referred to as BEHP in your answers to interrogatories, correct?
MR. HAKALA: The policy number is in there.
A. Yes, sir.
BY MR. WARWICK:
Q. And your Beaumont Employee Health Plan insurance paid for all of your medical bills related to the issues involved in this case?
A. Some of them.
Q. Okay. I thought I saw in the answers to interrogatories that all of your medical bills were paid related to --
A. They didn't pay any of the copays, they didn't pay all of those parts of that, is that what you're asking?
Q. I'll work my way through that.
A. Okay.
Q. So other than copays, what else did they not pay related to the treatment that you're suing for in this case?
A. I want to make sure I'm understanding. So the grab bars in my home, is that --
Q. Well, anything. I guess it's a pretty broad question

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so I appreciate that.
A. It is.
Q. To begin with, your Beaumont Employee Health Plan, did that pay for the vast majority of all your medical bills?
A. Yes. Yes.
Q. And you're doing a nice job and it's an unnatural process but just keep in mind to let me finish my entire question.
A. Sorry.
Q. That's fine, it's not a natural process.
MR. HAKALA: It makes it easier for her.
BY MR. WARWICK:
Q. Three months down the road it will make it easier to read the transcript that way. Okay. So the Beaumont Employee Health Plan paid for your overwhelming amount of medical bills, expenses, et cetera, related to the treatment that you're suing for in this case, is that correct?
A. Yes, sir.
Q. So then the types of things they did not pay for, you mentioned copays, is that one?
A. That's one.
Q. And what is your typical copay?
A. Anywhere between 20 and $50 per visit.

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Q. If you had to just estimate of the number of -- strike that.
If you had to estimate the total amount of copays that you paid yourself, can you give us a ballpark figure?
A. I know for my healthcare reimbursement account, which I take out every year, $2,600, so those were mostly gone by April to June the last several years. After that I've paid my own out-of-pocket, I would say -- this is purely my best estimate -- probably $8,000 between --
Q. Total?
A. Yes, sir.
Q. You have an HRA, did you say?
A. Yes.
Q. You contribute to that every year?
A. Yes, sir.
Q. To your knowledge, there's no lien from the Beaumont Employee Health Plan related to this lawsuit, is there?
A. Not that I know of.
Q. You haven't received notice of any lien related to this lawsuit from the Beaumont Employee Health Plan, have you?
A. No.

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Q. Okay. I'm not suggesting you should.
A. Okay.
Q. I want to make sure that I just have the answer.
A. Yes.
Q. Okay.
MR. HAKALA: We are expecting one, in fairness.
MR. WARWICK: Have you received some notice?
MR. HAKALA: Not yet.
BY MR. WARWICK:
Q. Okay. And the answers to interrogatories reference Aflac Insurance. What would that be related to?
A. I had like supplemental insurance, again, this was three years ago so it's -- one was like for hospitalization, one was for cancer and one was for something else and they -- like because I had surgeries, they paid an amount of that and, again, I'd have to go back and dig -- I had a flood at my house after this happened so I don't have some of the paperwork but they paid -- for instance, if you had a surgery they might pay $100 for the surgery, it's a supplemental thing I paid into.
Q. Do you still have that insurance?
A. I do not.

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Q. When did you stop with that Aflac?
A. When we had the hospital merger they went to a different whole system and I didn't continue it.
Q. Okay. And your short-term disability insurance that's referenced in your answers to interrogatories, which company is that through?
A. Whatever Beaumont has.
Q. Were you paid short-term disability benefits?
A. Yes, sir.
Q. So what periods of time were you off work totally after October 11, 2015?
A. I was off until April of 2016.
Q. And did you receive short-term disability benefits during that period of time?
A. Yes.
Q. How much of your income was covered by the short-term disability insurance?
A. 60 percent.
Q. Was the other 40 percent covered by anything?
A. No.
Q. Do you know the name of that short-term disability insurance company?
A. I don't.
Q. Okay. Do you have any paperwork related to that short-term disability insurance company?

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A. I don't believe so.
Q. Okay. I'm trying to find out the name of the entity, you personally don't have it though?
A. No, like when I went on disability I went through our HR department and they submitted all that to the -- to that company.
Q. Okay. So it indicates here you were off work from 10-9 -- strike that.
I guess this is a typo perhaps. You were off work 10-9-18 to 4-7-16, this is on page 6 of your answers to interrogatories, you probably mean 10-9-15 to April 7, 2016, is that correct?
A. Correct.
Q. And then returned full time April 18, 2016, is that correct?
A. Yes.
Q. And you've continued to work at the Beaumont preanesthesia facility in the PNC building from April 18, 2016 to the current time, is that correct?
A. Yes.
Q. Are there any other times where you have not worked since April 18, 2016?
A. Just vacation time.
Q. Would you mind going to page 6 of your answers to the co-defendant Dr. Lonappan, et al's, interrogatories,

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you probably want to write in the correct answer there, it's at the top of the page?
MR. HAKALA: This should be '15 so make that --
BY MR. WARWICK:
Q. Just maybe write it and initial it.
A. Sure.
Q. Thank you. How much vacation time typically have you received per year since 2016?
A. Well, it was really short in '16 because I'd been off. Normally -- I've been at Beaumont for 35 years so normally I have -- it's like four and a half weeks, five weeks, whatever shows up on my paycheck.
Q. And your current plans continue to be -- to work at Beaumont into the foreseeable future?
A. That is questionable.
Q. Tell me what you mean by that?
A. I'm having immense fatigue. I am -- I am working full time right now but at the expense of having the rest of my life.
Q. So how many hours per week are you working at the current time?
A. 40.
Q. Have you worked 40 hours per week other than vacation time since April of 2016?

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A. I have.
Q. What are your usual hours?
A. I normally work 7:30 to 4:00.
Q. You brought with you here today a walker device, is that correct?
A. Yes, sir.
Q. How long have you been utilizing the walker device?
A. Since I went back to the hospital on the date after this occurrence, which was like the Tuesday night, October.
Q. So when you returned to Beaumont Hospital on October 13, 2015, is that when you're saying you've used the walker since then?
A. Yes.
Q. How were you provided with the walker?
A. I bought it.
Q. Have you utilized the same walker since that time?
A. I had one from my mom and I bought one.
Q. Where did you buy it from?
A. I bought it from Amazon.
Q. And how often do you use the walker?
A. Every day.
Q. As you were walking in here I noticed that you use the walker to assist you but then you did have independence for that short period of sitting down in

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the chair, correct?
A. Yes.
Q. Your purpose for using the walker is?
A. I have -- one of the things that happened is I have dropfoot on my right side so even with the walker I can walk around like in my home, I can hang onto things but, for instance, yesterday I walked down to lunch with my walker, I tripped three times with my walker walking down to lunch and twice on the way back because I can't pick my foot up. I'm doing it because I don't have any balance.
Q. And when did you first develop footdrop?
A. When I went in the hospital on the 13th.
Q. The 13th of October, 2015?
A. Yes, sir, it happened in that hospitalization time.
Q. So did you have footdrop when you first went to Beaumont Hospital on October 13, 2015?
A. No.
Q. Did it happen during the hospitalization?
A. It happened during the hospitalization.
Q. Did any doctors or medical professionals -- strike that.
Did any doctors tell you why you developed the right footdrop?
A. They did not specifically say.

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Q. Okay. That's fine. So just to be clear, you seem to have a little question in your mind so I don't want you to -- I want to make sure I have a clear record. Did any doctors tell you why you developed right footdrop?
A. Yes.
Q. Who told you?
A. The neurosurgeon -- I mean, the orthopedic surgeon who did my back.
Q. Who was that?
A. Dr. Khalil.
Q. How do you spell that name?
A. His first name is Jad, J-a-d, the last name is Khalil, K-h-a-l-i-l.
Q. Did he do a surgery during that October 13th admission?
A. Yes.
Q. What is your understanding of the surgery that he performed during that admission?
A. I had an epidural abscess that they cleaned out and he did some type of laminectomy at the same time.
Q. Did you ever treat with Dr. Khalil at his office?
A. Only afterwards for postop.
Q. Sorry?
A. Only afterwards for postop, follow up.

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Q. Do you know where his office is located at?
A. Yes, Lahser Road in Southfield.
Q. The authorizations -- let me --
A. It's Michigan Orthopedic Institute.
Q. Let me make sure I have that in the list of authorizations. The authorizations I have here are Generations OB-GYN, that's the office where you've had gynecologic treatment over the years?
A. Correct.
Q. You had the gynecologic procedure there on October 2nd, I want to say -- or let me make sure the record's clear.
You actually had the preprocedure, history and physical, the records show, on September 23, 2015 and then you had a procedure performed there by Dr. Mark Dykowski, D-y-k-o-w-s-k-i, on October 2nd, 2015, is that correct?
A. Yes.
Q. You underwent an operative hysteroscopy and polypectomy, those are medical terms, but you had polyps removed essentially and other gynecologic procedures performed by Dr. Dykowski on October 2, 2015, correct?
A. Yes.
Q. You were discharged from the hospital the same day, if

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I'm understanding correctly?
A. Yes.
Q. Okay. Now, you did treat with Dr. Dykowski and medical professionals from his office at Generations OB-GYN at different times, is that correct?
A. Yes.
Q. Have you continued to treat there?
A. No.
Q. Where do you get your gynecologic treatment at the current time?
A. Steven Dean.
Q. Dr. Dean left that practice at a certain point, correct?
A. Yes, sir.
Q. Was Dr. Dean your primary gynecologist at Generations OB-GYN?
A. No, Dr. Dykowski was.
Q. How long have you treated with Dr. Dean?
A. Since -- this will be two years this fall.
Q. Okay. And what is the name of his practice?
A. I don't know.
Q. Okay.
A. He's by himself so I have a phone number. Want me to get that for you, and the address?
Q. Yeah. Probably, if you don't mind.

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MR. SINKOFF: It's on page 8 of the interrogatories.
BY MR. WARWICK:
Q. So on pages 7 and 8 to the co-defendants interrogatories there are different medical physicians and physicians listed?
A. Okay.
Q. I guess the way to do this -- first of all, let me go through both of them together. Dr. Rick Olson, what type of physician is he?
A. He's a neurosurgeon.
Q. And is he affiliated with Beaumont Neurosurgical Affiliates?
A. I believe so.
Q. And then Dr. Brett Wiater and Dr. Jad Khalil, K-h-a-l-i-l, and Dr. Thomas Magnell, M-a-g-n-e-l-l, those are orthopedic surgeons, correct?
A. Yes, sir.
Q. And are they at Beverly Hills Orthopedic Surgery?
A. Dr. Khalil is not, he's at Michigan Orthopedic Institute. Dr. Magnell and Dr. Brett Wiater are at the Beverly Hills location.
Q. So I have authorizations for both of those. Dr. Cain, C-a-i-n, Dimon or Dimon, D-i-m-o-n, is that a pain management physician?

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A. Yes.
Q. Where is his office located at?
A. He's in the Beaumont facility on Coolidge.
Q. Okay. It doesn't look like I have that one in an authorization so I'm going to fill it out while we're here, if you don't mind, so I don't forget.
A. Okay.
Q. Is there a wrong address on --
A. Dr. Bretz, the chiropractor, that's not his address. Do you need that address?
Q. I'll work my way through it.
MR. SINKOFF: You can pull it out while he's doing that.
Q. Good idea. So Dr. Donald Bretz, what type of -- is Donald Bretz a chiropractor it appears?
A. Yes, sir, he is.
Q. What is the correct address for Dr. Bretz?
A. 39083 Garfield, Clinton Township, Michigan 48316.
Q. So I should have written 39083 Garfield?
A. Clinton Township, Michigan 48316.
Q. You probably want to make that revision on your answers to interrogatories as well, if you could? Then your answer to interrogatory number 12 on page 8 says you treated with Dr. Paul Chittick, C-h-i-t-t-i-c-k?

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A. That's correct.
Q. That is a physician, is that right?
A. Yes, sir, he's an M.D., Beaumont Hospital.
Q. So when's the most recent time you've treated with Dr. Chittick?
A. I last saw him in March.
Q. 2018?
A. Yes, sir.
Q. When's the most recent time you've treated with Dr. Bretz, roughly?
A. About a month ago.
Q. So roughly August 2018?
A. Yes, sir.
Q. Dr. Dimon or Dimon, when's the most recent time you treated with him?
A. I only saw him one time, that was on the Monday after this weekend thing so that was the --
Q. The Monday after?
A. So the -- I don't have my calendar so I was in the hospital.
Q. The 12th of October, 2015?
A. Yes.
Q. Let me make sure I have the calendar correct. So you treated with Dr. Dimon on that 12th in the interim period of time between your October 9th to 11th

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admission and your return on October 13, 2015, is that right?
A. Yes, sir.
Q. Yeah, the 12th was a Monday so your memory is correct there. Dr. Rick Olson, when's the most recent time you treated with him?
A. He saw me in the emergency room the weekend of the night of the 11th. He was my orthopedic neurosurgeon years ago and he happened to be there so I saw him just in the ER and I don't remember much about it other than that I saw him.
Q. So why was he your neurosurgeon years ago?
A. When I was 29 I got hurt moving a patient and so I had to have surgery and he did my surgery then and then when I was 36 there was another issue from my back and he had to do surgery again then.
Q. So what type of surgery did he perform when you were 29?
A. A lumbar discectomy.
Q. Which area?
A. I don't know if it L4-5 or L5-S1. I don't know.
Q. And then the second type of surgery he did?
A. The second one, there was a piece of cartilage that had broken off that was laying on the nerve so he did basically a similar thing, another diskectomy.

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Q. So if you were born in 1960 then you were 29 in roughly 1989, is that correct?
A. Yes.
Q. That's the time of the first surgery?
A. Yes.
Q. And then the second surgery took place at what age?
A. 36.
Q. So you would have been -- that would have been 1996 then?
A. That sounds correct.
Q. Did you treat with Dr. Olson at any time between 1996 and when you saw him in the emergency center at Beaumont in October 2015?
A. No.
Q. Have you treated with him since that time period?
A. No.
Q. Okay. Dr. Brett Wiater, when's the most recent time you treated with him?
A. I saw him postoperatively after I got out of the hospital. I want to say I saw him about like a few months after then. I saw him about six months after. I have not seen him since.
Q. Okay. Dr. Khalil, K-h-a-l-i-l, when's the most recent time you treated with him?
A. I saw him after surgery and I saw him again -- again

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in -- I'm not sure of the time frame, probably within the next year because I was having some back issues and some leg issues. They were concerned the abscess was back so I went to see him -- I'm sorry, that's not correct. I went to see him because my wound was opening and they were concerned about it but it was like one stitch. He said it was going to heal, it would be fine.
Q. How long after the October 2015 admission was this?
A. I'd say within four months. Four months.
Q. So that was the only time you treated with him at his office?
A. That I recall, yes, sir.
Q. Dr. Thomas Magnell, when is the most recent time you treated with him?
A. I only saw him in the hospital.
Q. During the October 13, 2015 admission?
A. Yes. Yes.
Q. Okay. Dr. Paul Chittick, I think you told me, and I could be mistaken, that you only saw him in the hospital?
A. No. No. No, he's my infectious disease guy.
Q. You still see him?
A. I will be forever.
Q. On page 8 on your answers to interrogatories, can you

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write in he's a doctor?
A. Just put M.D. after his name? Sure.
Q. When you treat with him it's at the professional building there next to Beaumont?
A. Yes, and I actually see him -- there's two clinics. I see him in the hepatic clinic, that's where I ended up getting scheduled.
Q. Okay. When's the most recent time you treated with Dr. Chittick?
A. March of this year.
Q. And are you scheduled to treat with him again?
A. We were going to -- going to yearly visits to see how that's going to work out.
Q. Okay.
A. I'll see him March of next year.
(Off the record at 11:34 a.m.)
(Back on the record at 11:36 a.m.)
BY MR. WARWICK:
Q. We talked about Dr. Steven Dean --
A. Yes.
Q. -- and we have his address here.
A. Yes.
Q. When's the most recent time you've treated with Dr. Dean, Steven Dean?
A. I had some hormone treatment in May and then I'm

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seeing him for my physical in October.
Q. Your hormone treatment is?
A. Like an injection, it's a separate thing. I have to go in every quarter and get it done.
Q. Your hormone treatment is separate from any issues related to this lawsuit, correct?
A. Absolutely. Yes.
Q. You probably treat with Dr. -- well, I could be wrong, okay. Let me strike that.
Is Dr. Dean the physician you treat with related to the hormone issues?
A. Yes.
Q. Do you treat with any other physicians for the hormone issues?
A. My internist for my thyroid.
Q. Who is that?
A. John Bonema.
Q. Okay. He is at Troy Internal Medicine?
A. Yes, sir.
Q. It doesn't look like he is referenced in your answers to interrogatories, unless I'm mistaken?
A. Do you need his address?
Q. So it's Troy?
MR. SINKOFF: Investment Drive.
A. Suite 300.

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BY MR. WARWICK:
Q. Suite 300, Troy, Michigan?
A. Yes.
Q. Okay. Troy Internal -- have you ever treated with any other physicians at Troy Internal Medicine?
A. Yes.
Q. They would all still be at the same location?
A. Yes, sir, sometimes if I have to go in and it's the weekend, you'll see one of the partners but Bonema is my primary.
Q. How long has Dr. Bonema been your primary physician?
A. Probably 30 years. It is 48098.
Q. Dr. Fernando Diaz, when is the most recent time you treated with him?
A. I saw him last year, I want to say early December.
Q. What did you treat with him for last year in December?
A. I was having urinary and fecal incontinence and they thought, again, that -- they were concerned the abscess was back again in my back.
Q. But it was not?
A. It was not and he sent me to his partner, Daniel Michael, the next day because he was going out of town.
MR. SINKOFF: Did you see him in Pontiac or on Northwestern?

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THE WITNESS: I saw Diaz at Northwestern and Michael at the hospital.
MR. SINKOFF: St. Joe Oakland?
THE WITNESS: No, the Royal Oak neuroscience building.
MR. SINKOFF: Your interrogatory shows Diaz on Woodward Avenue, that's incorrect?
THE WITNESS: Incorrect.
MR. SINKOFF: He's on Northwestern Highway in Farmington Hills.
MR. WARWICK: Okay. We'll find that out.
MR. SINKOFF: Michigan Head & Neck.
BY MR. WARWICK:
Q. Dr. Perry Greene, you treated with him most recently when?
A. Do you want this address for Diaz?
Q. Sure.
A. 29275 Northwestern Highway, Suite 100, Southfield, 48034.
Q. Thank you.
A. You're welcome.
Q. And what about -- strike that.
We have the correct address in your answers for Dr. Dimon, right, page 7, it's just the previous page, it's the address on Coolidge Highway?

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A. Yes.
Q. So Dr. Perry Greene, you were about to say when you most recently treated with him?
A. I saw him after my surgery. I saw him on the day my mom died so December 8 of '15.
Q. Okay. You saw him at his office on October 8, 2015?
A. No, December 8.
Q. Sorry, you saw him at his office on December 8, 2015?
A. Yes, sir.
Q. And it's the same day you said your mother passed away?
A. Yes.
Q. I'm sorry to hear that.
A. Thank you.
Q. Have you treated with him since December 8, 2015?
A. I don't believe so.
Q. What did you treat with Dr. Greene for?
A. My knees were septic so he had to go in two different times on both knees to clean them out. He was doing a postop visit.
Q. Okay. Dr. Atulkumar, A-t-u-l-k-u-m-a-r, Patel, P-a-t-e-l, he's a gastroenterologist?
A. Yes.
Q. When is the most recent time you treated with him?
A. Probably a year ago.

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Q. For what reason?
A. I have a gastric reflux and it's -- so I just see him, you know, as needed.
Q. Does he give you gastric reflux medication?
A. I'm not on anything right now. I had some surgery to help prevent some of that.
Q. We're almost finished through the list. Dr. Mark Siegel, glaucoma it says.
A. Yes.
Q. When's was the most recent time you saw him?
A. I saw him in March or April of this year.
Q. How long have you had glaucoma, to your knowledge?
A. I got it when I was in grad school so '93 or '94.
Q. What type of treatment have you had for glaucoma?
A. I've had some laser treatment. We did -- he did -- we did drops for a while and then he did laser. I have a congenital type of glaucoma.
Q. Okay. To your knowledge, is your condition stable at the current time?
A. Yes, sir.
Q. Have you treated with any other doctors or medical professionals other than the ones that we've talked about since October 9, 2015?
A. Dr. Wasvary, Harry Wasvary.
Q. I didn't talk about Dr. Wasvary, sorry.

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A. That's all right.
Q. When is the most recent time you've treated with Dr. Wasvary W-a-s-v-a-r-y, Harry Wasvary, M.D.?
A. Probably in the spring. I was having some rectal bleeding.
Q. That's unrelated to the allegations in this case, is that correct?
A. We think it's because I'm taking so much Aleve for all the pain.
Q. I'm sorry?
A. They think it's because I'm taking so much Aleve for the pain that it's causing the bleeding.
Q. Who are the they?
A. Dr. Wasvary.
Q. He told you -- Dr. Wasvary told you your rectal bleeding is likely from taking Aleve medication?
A. That's what they're suspecting.
Q. Do you take over-the-counter Aleve medication?
A. Yes.
Q. Before I get to that, have you treated with any other doctors or medical professionals outside of William Beaumont Hospital since October 9, 2015, other than the ones you've just told me about?
A. We did Dr. Bretz, right, the chiropractor? We did him?

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Q. Yes, we did. Yes.
A. As far as I know this list is complete.
Q. Do you have any current appointments scheduled with any physicians?
A. I have an appointment with Dr. Dean for my physical. My next one with Chittick is not until March. Siegel is not until later. I don't believe so.
Q. Your appointments with Dr. Chittick are now down to an annual basis, correct?
A. Yes.
Q. So you treated with him -- strike that.
You treated with Dr. Chittick in March of 2018 and he told you you could now go to March of 2019?
A. Yes.
Q. Do you treat with any other infectious disease physicians?
A. No.
Q. Have you treated with any other infectious disease physicians since October 9th, 2015?
A. No.
Q. Where do you get your prescriptions filled?
A. At Royal Oak Beaumont.
Q. When you say you get your prescriptions filled at Beaumont Hospital, where at?

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A. Inside the hospital proper at Royal Oak but most of them come from Pharmacy Solutions on Mound Road.
Q. So if I wanted to request your prescription records, do you know the name of the entity that --
A. Yes, it's called -- one moment, please.
Q. Sure. Thank you.
A. There's one more doctor I forgot too.
Q. Let me finish this first.
A. It's called Beaumont Pharmacy Solutions. I don't have the address. I do know it's on Mound. I do have a phone number, if that would be helpful?
Q. Yes, give me one second, please.
A. Sure.
Q. Is this the only place, other than inside Beaumont Hospital, where you've had your prescriptions filled since October 9, 2015?
A. I believe so.
Q. You don't go to CVS, Rite Aid?
A. Once in a great while if it's an antibiotic, if the hospital's closed. I did get some of my hormone treatment from Dr. Dean that he ordered at it's a compounding pharmacy.
Q. That's unrelated to this?
A. Correct, nothing to do with this. Yes, sir.
Q. Have you gone since October 2015 to CVS or Rite Aid,

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Walgreens, any of those pharmacies?
A. Not that I can recall off the top of my head.
MR. HAKALA: I can give you the address, 27027 Mound Road, Suite 100, that's in Warren.
MR. WARWICK: Warren, Michigan, does it have a --
MR. HAKALA: 48092.
MR. WARWICK: Thank you.
BY MR. WARWICK:
Q. Then when you get your prescriptions filled at Beaumont -- did you say at Beaumont Royal Oak?
A. Yes.
Q. Is there a pharmacy on the first floor?
A. Yes, the outpatient pharmacy in the hospital proper so it's the Beaumont outpatient pharmacy.
MR. SINKOFF: What about in the office?.
THE WITNESS: I don't use that one at all.
BY MR. WARWICK:
Q. So you've told me about the places since October 9, 2015 where you've had your prescriptions filled, is that correct?
A. Yes, sir.
Q. And have you been employed at any other location other than the PNC building since October 2015?
A. No.

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Q. How many -- strike that.
You've already told me you're currently working 40 hours per week there?
A. Yes.
MR. SINKOFF: She had another doctor.
A. Do you need to know that I work at home part time?
BY MR. WARWICK:
Q. Yeah, we'll talk about that --
A. Yeah.
Q. -- but let's talk about the other doctor first.
A. Ronald Taylor, he's at LaBan and Taylor inside the medical building. I don't know if I have --
MR. SINKOFF: LMT Rehab?
THE WITNESS: Yes.
BY MR. WARWICK:
Q. Have you only treated with Dr. Taylor at LMT Rehabilitation?
A. Yes, sir.
Q. When's the most recent time you've treated with him?
A. I saw him in late December of last year.
Q. What did he do for you in terms of treatment in December 2017?
A. He did EMG testing on my arms and my legs.
MR. SINKOFF: Do you only see him at the medical office building in Royal Oak or Investment

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Drive?
A. No, just Royal Oak and I only saw him the one time. I seen him years and years ago but I only seen him the one time.
BY MR. WARWICK:
Q. In the professional building there?
A. Yes, sir.
Q. Okay. So let's step back into the shoes of October 2015. You underwent a gynecologic procedure with Dr. Dykowski on October 2, 2015, right?
A. Yes.
Q. You had that done on an outpatient basis at William Beaumont Hospital in Royal Oak?
A. Yes.
Q. Then did you work during the interim period of time between October 2, 2015 and October 9, 2015?
A. Yes.
Q. Were you working full time during that period of time?
A. Yes.
Q. Then what happened that led you to go to William Beaumont Hospital on October 9, 2015?
A. I started having really severe back pain at work that I couldn't manage.
Q. When did that pain start?
A. Some time after lunch.

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Q. And the calendar indicates that October 9, 2015 was a Friday. Is that consistent with your memory?
A. Yes, sir.
Q. Did the pain literally start some time after lunch?
A. Yes.
Q. How would you describe the pain?
A. Burning, stabbing.
Q. Which area of your back?
A. My lower back.
Q. Did you have any symptoms at all between October 2 and October 9, 2015 until this period of time after lunch?
A. No.
Q. And what time of the day are we talking about?
A. Probably -- I used to go to lunch 12:00 to 1:00 so 1:00-ish or so.
Q. What did you do about the issue?
A. I like laid on the floor in my office. I tried to stretch my back out. I took some Aleve but by about 3:00 it was so severe I asked my boss if I could go home.
Q. Which boss was that?
A. Linda Baily, R.N. She's my direct manager.
Q. Okay. Did you go home?
A. I did, my secretary had to walk me out to my car because I couldn't carry my purse.

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Q. And what's your secretary's name?
A. Leslie Feeman.
Q. What is the spelling of the last name?
A. F-e-e-m-a-n.
Q. Okay. Did you drive home?
A. I did.
Q. Did you contact Beaumont Hospital or any doctors or medical professionals at any point before you went to Beaumont Hospital?
A. No.
Q. So what time roughly on the 9th of October 2015 did you go to Beaumont Hospital?
A. I don't remember.
Q. Okay.
A. It was in the evening.
Q. Did you drive yourself?
A. No, my son drove me.
Q. Your son's name again?
A. Matthew.
Q. But it was Matthew driving you, just the two of you, is that right?
A. I don't remember if my daughter came with us as well or it was just the two of us.
Q. The records reflect that you arrived at Beaumont shortly after 5:00 p.m. on the 9th of October. Does

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that seem consistent with your memory?
A. That sounds about right.
Q. What do you recall happening when you went to Beaumont Hospital, which department were you in?
A. I went to the emergency room.
Q. And do you recall the names of any doctors or medical professionals that you treated with in the emergency room?
A. I do not.
Q. Do you recall how long you stayed in the emergency room?
A. I don't.
Q. In the medical records it indicates the pain was in your left lower back and down your left leg?
A. I don't remember which leg but I remember it was in my leg and in my back but I don't remember which leg.
Q. Okay. The medical records reflect that you said that you, quote, feel weird, unquote, and unsteady, is that consistent with your recollection?
A. Yes.
Q. That you had numbness to both feet, worse on the left, do you have a memory of that?
A. I do.
Q. That you had difficulty urinating earlier today but has since urinated?

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A. Yes.
Q. Do you remember giving this history to any medical professionals in the emergency department at Beaumont Hospital or does this just sound consistent with how you were feeling?
A. It does, it sounds consistent.
Q. Do you have an independent recollection of talking to doctors or medical professionals at Beaumont Royal Oak in the emergency center on October 9, 2015?
A. I do not.
Q. So do you know the name of any doctors or medical professionals who saw you in the emergency center on October 9, 2015?
A. I do not.
Q. Do you know what the results of your x-rays to your spine were on October 9?
A. They told me there was a lot of, I believe they said, stenosis in my spine, that's what I recall.
Q. When you say, they told you, you just have a recollection of being told that but you don't know who specifically told you?
A. Correct.
Q. Okay. There is a physician's assistant named Janay, J-a-n-a-y, Warner, W-a-r-n-e-r, who was involved in your care at a certain point. Do you recall that name

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at all?
A. No.
Q. Do you know what role Physician's Assistant Warner played in your medical care at all on October 10, 2015?
A. No.
Q. Okay. Who's the first physician or medical professional that you recall seeing at Beaumont Hospital during that admission?
A. I saw a doctor but I don't know who that was.
Q. Do you, as you sit here today, even know the names of any of the doctors who provided treatments to you?
A. I do not.
Q. Okay. Do you know Dr. Rick Olson though, I think you said you saw him in the emergency center?
A. I did.
Q. Other than Dr. Olson, do you know the names of any other doctors who were involved in your medical care?
A. No, sir.
Q. Were the doctors always -- strike that.
The doctors were always pleasant and professional, polite to you, et cetera, correct?
A. As far as I recall, yes, sir.
Q. And the nurses, the other medical professionals involved in your care, they were always pleasant,

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professional, et cetera?
A. As far as I recall, yes.
Q. Did you tell anyone that you were a nurse at the Beaumont Hospital facility?
A. Probably.
Q. That seems natural that it would come up.
A. It kind of just does. They had to break the glass to get into your chart so they said, what do you do here?
Q. When you said, break the glass --
A. When you go into the electronic chart, if you're a Beaumont employee, it's called break the glass, you have to put in why you're in the chart, who you are, what you're doing.
Q. Got it. So you're familiar with the Beaumont electronic medical system?
A. Yes, sir.
Q. Do you use the Epic system at your facility?
A. I do.
Q. Do you recall Dr. Olson performing any type of examination on you at any point?
A. I don't.
Q. So as you sit here today then, the treatment that you received from October 9, 2015 at roughly 5:00 p.m. up until you were discharged from the hospital on October the 11th, 2015 at approximately 2:33 p.m., other than

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Dr. Olson, you don't know the names of any doctors or medical professionals who were involved in your care, correct?
A. That is correct.
Q. Do you recall having a urine culture study performed at a certain point?
A. I don't.
Q. Okay. Do you recall any discussions with doctors or medical professionals about the various test results that had been performed on you?
A. Only the one about my back.
Q. And which test result was that?
A. I believe they did a CAT scan because they thought when I went in they thought that I had a kidney stone, that's what they thought was going on and they did whatever -- it was either -- I don't think it was an MRI, I think a CAT scan but I don't know and then were basically telling me, your back is kind of messed up.
Q. And when you say, they, again, you're speaking generally?
A. Yes, that is correct.
Q. And when you say, they said that -- I'll be more specific, when you say that a physician said that to you, that would be -- that would be a layperson's way of referencing the fact that you did have some prior

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medical history with your back, correct?
A. Yes.
Q. And if the record reflects that the doctors were aware of that and they were talking to you about those issues, that would be consistent with your history, correct?
A. Yes.
Q. And there were various types of doctors from various specialties who saw you during that admission, you're aware of that, right?
A. The only one I remember seeing was the -- they sent one of the pain doctors up about potentially doing an epidural but they couldn't do it because it was the weekend.
Q. So if there were different doctors from different specialties seeing you to look at what you had going on medically and to try to evaluate it from different perspectives, you may not recall their names but you do recall seeing different doctors, correct?
A. I don't.
Q. Okay. Do you know which room you were in when you were at Beaumont Hospital?
A. I do not.
Q. Do you know where you went from the emergency center?
A. I went to some -- to a floor but I don't remember

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where.
Q. Okay. Did you go to different areas of the emergency center when you were there?
A. I don't know. I don't remember.
Q. Did you go to something called an observation unit in the emergency center area when you were there?
A. I think I did.
Q. Then when you went to that area do you recall anything about how long you were there or no?
A. I don't.
Q. And then you went to a floor but you're not sure exactly which floor?
A. Correct.
Q. There's a co-defendant in the case represented by Mr. Sinkoff, her name is Dr. Linet, L-i-n-e-t, Lonappan, L-o-n-a-p-p-a-n, that name is not familiar to you either then?
A. Not at all.
Q. Okay. There was a doctor here today, Dr. Ioana Morariu, M-o-r-a-r-i-u, that name is not familiar to you at all, correct?
A. No, sir.
Q. So that's correct?
A. Yeah.
Q. So when you were discharged from William Beaumont

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Hospital on October 11, 2015 at about 2:30 p.m., do you recall what you were told in terms of discharge instructions?

A. They told me basically go home and rest and then I was going to see -- I was supposed to make -- they made an appointment or I was supposed to call in the morning to make an appointment, I don't remember how that part played out, to go and have to see the pain doctor to have an epidural steroid.

Q. That is the pain doctor that you have already told us you saw on October 12, 2015?

A. Dr. Dimon, yes.

Q. Okay. So to step back just for a moment, when you were at Beaumont Hospital on October 9, 2015 there were x-rays done on your spine, you recall those, right?

A. I do.

Q. And there was an MRI of your spine performed on October 9, 2015, do you recall that?

A. Again, I don't know if it was an MRI, they said some kind of test, either an MRI or a CAT scan so...

Q. There was a CAT scan of your abdomen and pelvis and a kidney stone protocol on October 9, 2015, I think you touched base on having some recollection of that?

A. Yes.

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Q. You were seen by -- the record shows Dr. Rick Olson on October the 9th but you don't recall that?

A. I recall seeing him but I don't really recall much of the conversation.

Q. Okay. Janay Warner was involved in your care and you've already told me you don't recall her name or what she -- what her role was, is that correct?

A. Correct.

Q. Okay. There was a physical medicine rehabilitation physician Dr. Bret, B-r-e-t, Burlingane, B-u-r-l-i-n-g-a-n-e, involved in your care but you don't recall that physician, correct?

A. Correct.

Q. Do you recall that they were evaluating you having some urinary difficulties prior to coming to the hospital but that condition stabilized, do you recall that happening?

A. I remember having a hard time going to the bathroom at home, to urinate at home some time in that afternoon but that's all I remember of that. I don't remember having any trouble after that.

Q. Okay. When you were home between the time of leaving work and going to Beaumont, it sounds like you're home for about two hours or less, is that right?

A. Yes.

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Q. Did your pain continue to increase?

A. It was worse, yes.

Q. What would you say your symptoms were during that period of time?

A. Just the -- really bad back pain.

Q. Okay. There was a Dr. Daniel Sapeika, S-a-p-e-i-k-a, and he's a medical doctor who saw you on October 11th in the morning. Do you recall anything about that treatment?

A. No.

Q. Did you have any contact or communication with Dr. Bonema at any point during that admission from October 9 to October 11, 2015?

A. No.

Q. And October 12, 2015 did you actually have the lumbar epidural steroid injection?

A. I did.

Q. Now, when you returned to the hospital October 13, 2015, did you go to the emergency room?

A. Yes, sir.

Q. How did you get to the hospital that day?

A. My son Matthew took me.

Q. Okay. Did your son Matthew stay with you the entire time of treatment on the 9th at Beaumont or did he go home at some point that evening?

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A. I don't know. He probably went home.

Q. Makes sense.

A. My daughter was only like 14 or whatever at the time and I'm single.

Q. How old was your son at that point?

A. He was -- my math brain is --

Q. That's fine.

A. He was probably 17, 18.

Q. Okay.

A. He was a senior in high school.

Q. Okay. Is your son going to college now, by the way?

A. No.

Q. What is he doing for a living?

A. Working part time at a coffee shop.

Q. What does your daughter do?

A. She's a junior in high school.

Could I have a break?

MR. WARWICK: Sure. Let's go off the record.

(Recess taken at 12:08 p.m.)

(Back on the record at 12:13 p.m.)

BY MR. WARWICK:

Q. You went to Beaumont Hospital again on October 13, 2015, is that correct?

A. Yes, sir.

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Q. So after you had the epidural shot on October 12th, tell us about the rest of your day, what did you do on that day?
A. I just went home and rested. They told me to not work until Thursday, take some time off so I just went home and just laid low.
Q. Okay. And then what time on October 13th, to your recollection, did you return to Beaumont Hospital?
A. I want to say evening but I don't really remember.
Q. Okay. The records show that you went to Beaumont around 6:00 p.m. on October 13, does that sound consistent?
A. That sounds about right, yes, sir.
Q. Do you remember the name of any doctors or medical professionals you treated with in the emergency center during that admission?
A. I do not.
Q. Your son took you to the hospital on October 13th?
A. Yes.
Q. Did anyone else come with you to the hospital on October 13th?
A. Again, I don't know if my daughter came or not.
Q. Did your son, to your knowledge, have any discussions or was he present during any substantive discussions with any medical doctors or professionals about your

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condition?
A. I don't know.
Q. Other than your son being a loving son who took his mom to the hospital, he really wouldn't have any firsthand information, is that correct?
A. Correct.
Q. Okay. What do you recall being told about your condition when you returned to the hospital on October 13th?
A. I don't recall. I just remember my knees hurt really, really bad.
Q. Do you recall the names of any of your doctors or medical professionals during that admission to Beaumont Hospital?
A. I remember Dr. Magnell came to see me about my hand.
Q. Tell me about your hand?
A. I was having pain in this knuckle right here.
Q. Which knuckle is that?
A. The left index finger, this knuckle. My knees were hurting, my back was hurting, I had pain up here, and they didn't know why.
Q. So when you say, up here, do you mean by your neck area?
A. Collarbone.
Q. Your right collarbone area?

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A. My right collarbone and I remember they put me in a room and I remember like a resident or a fellow, it was a Wednesday because I remember I do orthopedic surgery screenings, so he's in the OR and he sent up someone to do like tapping so they did -- they took -- tried to take fluid out of my knees, checked up here, checked my hand, that's all I remember from then.
Q. Okay. And did you have surgeries during that admission to the hospital?
A. Several.
Q. Do you know which areas of your body you had the surgeries on?
A. Yes, I had surgeries on both my knee replacements, two different times, and they did surgery on -- then they did this surgery up here on my collarbone thing and then they did surgery on my back.
Q. Do you know who did the surgery on your knee replacements?
A. Dr. Perry Greene.
Q. Do you know what type of surgery was performed?
A. He called it -- what did he call it? It was like a revision. I think they called it a revision. He had to go in there and there was apparently infected fluid in there and he had to take out some kind of a liner and put a new liner back in and clean it out on both

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sides.
Q. He did that bilaterally?
A. Yes, sir.
Q. He did it on the left and right knee?
A. Yes, sir.
Q. It looks like in the records that Dr. Greene -- that's G-r-e-e-n-e, first name Perry, P-e-r-r-y -- performed that surgery on October 14, 2015, is that consistent with your memory --
A. Sounds --
Q. -- or you don't have a memory?
A. I don't have a lot of memory. I remember it was late, it was really late at night when he did it.
Q. Was that the only surgery that was done on your knees though?
A. No, he had to do again.
Q. During the same admission?
A. Yes.
Q. And what is your understanding of the surgery that he performed the second time?
A. Same thing. Sorry, he did -- he was going to do the second one because we thought it was cleared up but this, whatever was going on up here, started swelling so the second time I was supposed to have the knees done, he took me in the OR and did whatever he did

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here to basically check this.
Q. When you say, here, you mean your right collarbone?
A. Yes, sir.
Q. And what is your understanding what Dr. Greene did to your right collarbone area?
A. I believe he just did fluid. I think he just took a culture, in essence, and then that's when he told me there was a bad infection. He said there was an infection there and he had me see Dr. Brett Wiater.
Q. Do you have some type of indentation or surgical issue related to that?
A. Yeah.
Q. Okay. This could be a personal preference but you tell me, and it would be helpful to us if I can take a photograph of just that limited area that shows the scar, is it okay with your attorney?
A. That's fine.
MR. SINKOFF: Let's have Wendy do it and attach it to the dep.
BY MR. WARWICK:
Q. Do you have any other scars from surgeries, et cetera, during that admission?
A. Both my knees and my back.
Q. Okay. Are your knees -- are you wearing a skirt today or what are you wearing?

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A. Do you need to see my --
Q. Do you mind if we just took the same type of photograph of the knees to show the scars. I can come around that way. So you're showing me your knees and you had previous knee replacement surgeries?
A. Yes.
Q. And when did you have those surgeries?
A. It was either '06 and '07 or '07 and '08.
Q. What led you to have those surgeries?
A. Arthritis.
Q. Okay. And when did your arthritis start, just roughly?
A. Gosh, probably five years before that.
Q. Who did you treat with for your arthritis issues?
A. Just my internist then I saw Dr. Greene and -- sorry, I saw -- that's not true. I saw Jurist, Ken Jurist, before that.
Q. Okay.
A. He did like a knee scope and then he did a microfracture, trying to buy me some time to not have to do the knee replacements.
Q. Where did you see Dr. Jurist at?
A. You know, he used to be in Bingham Farms but I don't think he's there anymore.
Q. Did you only see Dr. Jurist at his office?

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A. Yes, sir.
Q. Okay. So your actual knee replacement surgeries were performed by Dr. Greene though?
A. Yes, sir.
Q. That was through Oakland Orthopedics?
A. Yes.
Q. You believe you had those, again, in what year?
A. '06 and '07 or '07 and '08.
Q. What one did you have first?
A. The left one.
Q. Did you have any arthritis issues related to your knees between '07 or 2008 and 2015?
A. No.
Q. Did you have any treatment with Dr. Greene or anyone at his office during that interim period of time?
A. Just to check to make sure there was nothing wrong with my hips and as a routine, come see me.
Q. Did you have any treatment with any rheumatologist or arthritis specialists during that interim period of time?
A. No.
Q. Okay. Did you have any further issues with your knees during that interim period of time?
A. No.
Q. Did you walk with any assistive devices during that

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period of time?
A. No.
Q. So the first time you've used a walker or any type of assistive device was October 13th, 2015 to the present period of time?
A. Other than when I was recovering from my knee replacements, yeah, I used it then but nothing since then.
Q. And do you use a cane or anything else other than this device?
A. They don't recommend it, no.
Q. So I'm going to take a photo of your knees, okay?
A. Yep.
Q. I'll take a second one and your scars that you're referring to from the washout procedures or the procedures Dr. Greene did on two occasions, are vertical scars above your knee going down below your knee, is that right?
A. Yes, sir.
Q. And it's on each knee, is that right?
A. Yes, sir.
Q. So that's fine and thank you very much for that. Then you said you have some kind of scar on your back or something of that nature?
A. Right.

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Q. That's probably not possible to take a photograph of it but what part of your back is it?
A. The lumbar spine, lower spine.
Q. Did Dr. Greene do that procedure?
A. No, Dr. Khalil did that.
Q. That's right, you already told us about that. What did he do during that procedure to your recollection?
A. My understanding was he did a lumbar laminectomy and then there was an epidural abscess that he cleaned out, removed.
Q. Okay. That was during the same admission?
A. Yes.
Q. Did you have any types of surgeries after your discharge from William Beaumont Hospital in November of 2015?
A. Anymore surgery?
Q. Right.
A. No, sir.
Q. So I am going to, for the record, forward these three -- I've taken three photographs, one of your right collarbone area --
A. Okay.
Q. -- and then two more photographs of your knees.
I'm going to forward those to the court reporter and I think I have her --

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A. Do you need the spine one? We can figure something out if you need a picture of that.
Q. How could -- I don't know how we could to that.
MR. SINKOFF: Your daughter could take it.
A. I mean, I have underwear on. I mean, it's --
BY MR. WARWICK:
Q. Why don't you have your daughter -- that's a good idea. Let's have your daughter take a photograph at home and then send it to your attorney, something of that nature?
A. Okay.
Q. Is it possible to do that within the next seven days?
A. Sure.
Q. Just so we have a full understanding of --
A. Can she take it?
Q. If you turn it to your -- oh, that's a good idea actually. I'm going to send these three photographs to the court reporter now and then that's an excellent idea, why don't you take my phone and then go to an area of privacy and take one good photograph of her scar area?
(Recess taken at 12:26 p.m.)
(Back on the record at 12:29 p.m.)
BY MR. WARWICK:
Q. So while we stepped out the court reporter,

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Ms. Taylor, took two photographs of your back area and the scaring from that area, is that correct?
A. Yes, sir.
Q. These are the two photographs?
A. Yes.
Q. Thank you very much. So we should have five photographs total and we'll mark each of them as an exhibit, 1 through 5, and you just told me that you have not had any other surgeries since that last discharge from the hospital in November of 2015, is that correct?
A. Correct.
Q. It looks like you were at Beaumont from October 13, 2015 to November 2nd, 2015 and then you were transferred to an inpatient rehabilitation unit from November 2nd to November 5th, do you recall that?
A. Yes.
Q. Then you were transferred back to inpatient from November 5th until November 10th, do you recall that?
A. Yes.
Q. You were transferred back to the rehabilitation unit from November 10th to November 22nd, do you recall that?
A. Yes.
Q. Do you recall why you went back and forth between the

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rehabilitation unit?
A. Yes, I was doing better. They sent me to rehab. One day, I believe it was on the 5th, my back pain was so excruciating they -- I was trying to do stairs and I couldn't do it and I said, I'm going to fall down, so they took me -- that's when they did another MRI and found out I had an abscess and then I had surgery so that's when Dr. Khalil did surgery and they put me back on the surgical floor.
Q. That's the surgery on your back area?
A. Yes.
Q. They put you back on a surgical floor and after a period of time you went back to rehabilitation?
A. Correct.
Q. You were discharged from rehabilitation subsequently, is that correct?
A. Yes.
Q. Okay. That final discharge was on November 22nd, 2015, is that right?
A. It sounds right.
Q. Did you go home after that?
A. I did.
Q. Have you remained in your residence since that time?
A. Yes, sir.
Q. Have you had any other hospitalizations of any type

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since that time?
A. Yes, I had to go back to the hospital in March, I believe it was March of '16.
Q. Did you go to Beaumont Hospital?
A. Yes.
Q. What did you go to Beaumont Hospital for in March of 2016?
A. I was having really bad abdominal pain and they found out I had C. Diff, I think it was March.
Q. How long did you stay in the hospital during that period of time?
A. I believe five days.
Q. And that was unrelated to the issues in this lawsuit?
A. Well, they were -- my understanding was the C. Diff was related to the antibiotics I'm on.
Q. What antibiotics were you on chronically during that period of time?
A. Amoxicillin, 2000 milligrams a day.
Q. When you were discharged from Beaumont Hospital on October 22, 2015 did you have any type of IV antibiotics that you were still on at home?
A. Yes, it was November 22nd, not October.
Q. Thank you. I'm sorry. Thanks for correcting that. When you were discharged from Beaumont on November 22, 2015 were you discharged with IV antibiotics or oral?

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A. IV.
Q. How long did that remain the case?
A. I believe until December 18th.
Q. And then since December 18th, 2015 have you had any IV antibiotics outside of the hospital?
A. No.
Q. To go back to that admission from October 13, 2015 until November 22nd, 2015, which includes both inpatient and rehabilitation, do you recall the names of doctors who provided treatment to you during that period of time, other than the ones you've already told us about?
A. Let me see. I'm trying to remember the rehab guy, who was fantastic. I don't recall his name. I don't recall most of the names. I mean, I know there was a really great internal medicine guy. Other than the surgeons, I mean, I don't really remember anybody else.
Q. So the doctors who really stand out to you during that admission are Dr. Perry Greene and Dr. Khalil, is that correct?
A. And Dr. Wiater.
Q. Tell me about what Dr. Wiater did?
A. He did this.
Q. The right collarbone?

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A. Right, there was a big abscess under the collarbone.
Q. Greene did your knees, Wiater did your right collarbone and Khalil did your spine work?
A. Yes, I believe in the record it says it's Brett Wiater's brother. I remember there's some -- I work in OR and there's something about --
Q. There are two Wiaters?
A. It's about somebody had OR time and Brett couldn't get it so then he put it under his brother, it's the whole OR game but Brett did the surgery, as far as I know.
Q. No doctor was ever critical of any other doctors to you related to your treatment at Beaumont Hospital, were they?
A. Not that I recall.
Q. And no medical professional was ever critical of any type of medical professional related to your treatment at Beaumont Hospital, is that correct?
A. Could you --
Q. Sure. You were at Beaumont Hospital from October 9, 2015 to October 11, 2015, then you returned from October 13, 2015 until November 22, 2015, no doctor or any type of medical professional has criticized to you the care you received during those two admissions from other medical professionals or physicians, correct?
A. That's correct.

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Q. So when you left the hospital on October 11, 2015, what was your understanding of the diagnosis or potential diagnoses that have been looked at?
A. That I had spinal stenosis and that an epidural would probably help the pain.
Q. And do you know who told you that information?
A. As far as I remember it was the -- whoever was on call for the pain clinic, one of the anesthesiologists, but I don't recall who that was.
Q. Was that a male or a female doctor?
A. I believe it was a male doctor.
Q. And that was after different testing had been performed, including x-rays, MRIs, CT scans, et cetera, correct?
A. Yes.
Q. Then when you went and had the epidural injection on the 12th of October, was that helpful to you?
A. It was, I mean, it seemed to -- it didn't make the pain go away but it seemed to bring it down.
Q. Have you now told us everything you can recall about both the October 9, 2015 to October 11, 2015 admission and the October 13, 2015 to November 22, 2013 admission?
MR. HAKALA: Form.
You can answer.

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BY MR. WARWICK:
Q. Is there anything else about your medical treatment or medical care during that period that you recall that you haven't already told us about?
A. No, I mean, I was -- I was really out of it. I was in a lot of pain. I don't have a lot of recollection of the majority of that time.
Q. So I should parse that out a little bit. October 9 to October 11, 2015, have you told us everything you recall about that admission to the hospital?
A. Yes.
Q. Okay. And when you left the hospital on October 11, 2015 you were feeling better at that time?
A. I was feeling fair. They'd come in that morning and basically said they couldn't do the epidural and that I could stay and do it the next day but my insurance wasn't probably going to take care of it so I had a choice to go home, so I said I might as well go home and do it the next day as an outpatient.
Q. Who were the they that said that?
A. I don't remember. I think it was a case manager that came in but I don't recall.
Q. So this person came in and gave you the option of either staying in the hospital or going home and having the epidural on an outpatient basis?

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A. Correct.
Q. And you decided to go home and have it done on an outpatient basis?
A. Correct.
Q. Now, have you told me everything about that admission that you recall from October 9 to October 11, 2015?
A. Yes, sir.
Q. Did you have any contact with anyone at William Beaumont Hospital between the time of your discharge on October 11, 2015 and the time you returned on October 13?
A. Just the epidural at the pain clinic.
Q. Okay.
A. But no one else.
Q. You didn't call Beaumont or anything of that nature?
A. No.
Q. Okay. Then from October 13 to November 22nd, 2015 have you now told us everything you recall about that admission?
A. I mean, yeah, as much.
Q. It's a broad question but is there anything else that stands out about your medical treatment or the doctors or any care that you had during that period then, if you could tell us now?
A. I remember -- I remember going into the hospital with

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my knees hurting. I remember being in a room and then doing the tap thing. I remember being told I needed surgery and it happened really late at night. My brother and sister-in-law came.
Q. What are their names?
A. Michael and Connie Markel. Mike and -- his wife is a nurse practitioner and they came, it was late, really late, like 11:00, 10:00.
Q. On the 13th?
A. On the 14th, whatever day he did the surgery.
Q. He being Dr. Greene?
A. Yes, sir. I remember almost nothing after that, it's a lot of blur.
Q. It was a lengthy admission?
A. It was.
Q. By the time you were nearing discharge, do you begin to recall what was -- how you were feeling at that point, et cetera, or no?
A. I was feeling better as I was getting ready to go home. I mean, there was a lot still going on. I was on the antibiotics. I was doing physical therapy.
You know, I adopted my kids when I was 52. I'm the only mom they really know and I was driven to get home. I remember them having to come in and help me to learn how to put a plate in the microwave and

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help me to get dressed. You know, these are things teenagers shouldn't have to do. Those are the parts I remember of just, like I say, being driven like how am I going to get home, how am I going to manage at home, that's when my brother said, we'll go and put up handrails, all of that, and my mom was not well and so I just -- I'd not seen my mom since the day I was in the ICU, was the last time I saw my mom until Thanksgiving and a week later she died so I'm pretty tough. I don't think -- I don't think if I was as tough as I am I don't think I'd be right here, I think I'd be dead. I had a strong will to fight like I have got to get through this.
Q. And you got through it.
A. I did.
Q. When you were in the hospital during that period of time you talked about the different periods of time in rehab and then back to the floor for your back surgery, et cetera, but you were undergoing physical therapy and occupational therapy during that period of time?
A. Yes.
Q. Then when you left the hospital you had some continuing home care?
A. Yes.

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Q. Is that right?
A. Yes.
Q. Was that including physical therapy?
A. Yes.
Q. And the discharge records reflect that at the time of discharge you were able to walk on your own for about 150 feet but this is something you said was a process for you, you were kind of regaining strength?
A. With the walker, not by myself, yes.
Q. Okay. And then was there ever a period of time when you just kind of walked around without your walker since that time to the current day?
A. I can some in my house. I don't usually have it in my house.
Q. What about when you're working, do you use your walker then?
A. It depends, if I have to go down the hallway for sure, usually I bring it in. I have a cube so I'm sitting there in my cubicle so I don't need it for that. If I have something to hang onto, I'm okay, I can walk without it but I stumble a lot. I probably fall three, four times a week, even with my walker.
Q. Is this mostly related to the right footdrop issue?
A. Yes.
Q. And you use the walker as a safety device essentially

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to keep you from having difficulties as you're walking longer distances?
A. Correct.
Q. Now, when you go up the stairs or down the stairs to your bedroom, how do you do that?
A. I have a handrail so I can do that sometimes, sometimes I crawl, it just depends on the day.
Q. But you don't have any other type of electronic device or anything of that nature?
A. I do not, no.
Q. And you've been able to live upstairs in your bedroom, sleep up there, et cetera, from the time you returned home in November 2015 to the current time?
A. No, I was on the first floor, I was on the main floor for well over a year.
Q. Okay. So when did you move back upstairs to your bedroom then in terms of spending the night?
A. About a year ago.
Q. Your attorney hasn't sent you to any doctors or anything of that nature, have they?
A. No.
Q. I didn't anticipate he had. I just need to make sure I preserve the record.
A. Yes.
Q. You've filed your federal and state income tax records

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over the last 10 years?
A. Yes, sir.
Q. So in your answers to the co-defendant, Dr. Lonappan's interrogatories, number 20, you're asked what problems you currently have and you indicate, chronic infection suppression, daily antibiotics to keep infection suppressed, biweekly or monthly Diflucan, D-i-f-l-u-c-a-n, treatment for yeast infections arising from chronic antibiotics.
Where do you get the biweekly or monthly Diflucan treatment?
A. It's a pill and I get it from Dr. Chittick.
Q. Essentially you're taking a pill every other week or monthly?
A. Correct.
Q. What about now, monthly or every other week?
A. Depends, I can tell when it starts and I --
Q. What tells you something is starting?
A. I can feel it. I can feel a yeast infection.
Q. Right footdrop necessitating the use of a walker and foot support balance issues because of footdrop and multiple falls. What type of foot support do you have?
A. I have an AFO.
Q. Is that -- tell me what that is?

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A. It's a brace that keeps my foot up so I don't fall.
Q. Are you wearing that now?
A. I wear it at times. I don't wear it all the time.
Q. Are you wearing it now?
A. Right this minute, no.
Q. Do you have it with you?
A. No.
Q. How long have you been using that device?
A. I got it in December of '15.
Q. Pardon my -- is it a hard device or soft?
A. It's hard, it basically fits in my shoe and I have to wear a special shoe and it fits in there.
Q. Like this?
A. Yes, exactly.
Q. It's essentially a boot-type device?
A. It's more like a --
Q. Not a boot?
A. Yeah, but it sticks in the shoe, it has a back thing up the thing, it wraps around my calf.
Q. How frequently do you wear this, if at all now?
A. I wear it probably once or twice a week, it depends what I'm doing.
Q. What would lead you to wear it?
A. If I'm knowing I'm going to be walking a long distance. I can't drive with it on, it's too hard to

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drive with it on.
Q. And you use it on the foot you have the footdrop on?
A. Yes.
Q. That's your right foot?
A. Yes, sir.
Q. Do you usually use it if your foot is tired, is that what's going on?
A. No, it's more like if I know I'm going somewhere and I'm going to be walking a lot. For instance, I took my kids to Cedar Point. I don't do Cedar Point but I thought at least I'll walk in the park. I took it then and put it on to have a lot of support for my foot, have less chance of falling.
Q. Were you able to walk around with the device at Cedar Point during that period of time?
A. I was.
Q. What year was that?
A. I think it was last year so 2017.
Q. Okay. How long were you there walking around?
A. We were there all day. I was mostly sitting in Starbuck's but when I got bored I'd get up and go for a walk.
Q. Okay. You say in this answer, number 20, that you have had multiple falls. How many falls do you believe you've had?

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A. I couldn't tell you. I've had four this week.
Q. You never been injured in any of these falls?
A. Just bruising.
Q. Have you had any falls while using your walker?
A. Yes.
Q. Have you treated with any doctor for any falls since October of 2015?
A. Just when I see Dr. Bonema we'll talk about it and try to figure out if there's something better we can do.
Q. You say in answer to number 20, right sternoclavicular joint instability manifesting in right shoulder and neck pain and clavicle pain and compromised respiratory function, to repair would require open chest procedure to secure the clavicle to the sternum again as the ligaments were destroyed by the infection. Who told you that information?
A. Brett Wiater.
Q. So Dr. Wiater told you that information?
A. Yes.
Q. Have you -- when's the last time you treated with Dr. Wiater?
A. I saw him about a year ago, that's when he said the only way we can fix this, what's happening is I'm having all these -- more lung infections than I've ever had in my whole life. They think it might be the

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anatomy now, this is not attached, it's not attached to my sternum.
Q. So you're saying what is not attached?
A. The collar -- clavicle is not attached to the sternum because the ligaments are gone.
Q. Dr. Wiater said he could perform that surgery?
A. He could but he would have to do basically a thoracotomy. They'd have to go under the collarbone, attach it underneath, decompress the lung.
Q. To the current time you've not wanted to have that surgery?
A. Yeah, I'm pretty scared to have any kind of surgery.
Q. Chronic daily back pain, knee pain, clavicle pain?
A. Yes.
Q. You told me who you treated with related to those issues?
A. Yes.
Q. The most recent time you treated with a physician for back pain was when?
A. I couldn't tell you, it's just -- this year. I've seen Bonema about it.
Q. The most recent time you treated with a physician for knee pain was when?
A. Same thing, when I see Bonema we talk about those.
Q. What's the most recent time you treated with a

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physician for the clavicle?
A. Same thing.
Q. What about with a specialist, when's the most recent time you've treated with a specialist, orthopedic specialist for back pain?
A. That would have been Chittick, that would have been in March.
Q. Of 2018?
A. Yes, sir.
Q. Then he said you can see him again next March, 2019?
A. Correct.
Q. What about knee pain?
A. He checks all three of those when I see him.
Q. For knee pain and clavicle pain, the most recent time you've seen a specialist was March of 2017?
A. Yes, sir.
Q. And you're scheduled again for 2019?
A. Yes.
Q. What about orthopedic surgery for any of those issues, back pain, knee pain, clavicle pain?
A. There's nothing they told me to come back for.
Q. So you don't have any current scheduled appointments with any of your orthopedic surgeons?
A. Correct.
Q. Then your -- the footdrop has made many common ADLs

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challenging, if not impossible, it is a challenge to drive more than 30 minutes. What type of vehicle do you drive?

A. I have a van, a Dodge Caravan.

Q. What year is it?

A. 2013.

Q. Has it been fitted with any special devices for you?

A. No.

Q. When's the most recent time you've had your driver's license renewed?

A. 2016.

Q. So that was the year after this treatment?

A. Yes.

Q. And you don't have any restrictions on your driver's license?

A. I do not.

Q. Okay. Carrying things, even on flat ground is nearly impossible. I need to have my arm out if I do not use my walker for balance. Which arm would that be?

A. I use the right arm out so thet I can balance.

Q. I cannot carry anything up or down stairs like laundry, groceries, et cetera. I have had to use -- I have had to have handrails installed in my home to enable me to get in and out safely. Where are the handrails installed in your home?

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A. They are going in the side of my house so there's four going in the side on the stairs and then --

Q. Up the stairs on the outside of the house?

A. No, inside because I have one step so there's a handrail right -- if I open up the door there's one right inside and I can grab onto it to get in and then there's one on the left and two when you go up higher into my house.

Q. I see what you're saying. Side door, handrails on the entranceway to the side door of your house?

A. Right, and then inside so up the two stairs to get into the kitchen.

Q. So in your house it's a bungalow, right?

A. Yes.

Q. Your house has some stairs into the house and then another set of stairs, you turn left into the kitchen area?

A. Correct, and also in the bathroom.

Q. Your brother installed all of these handrails?

A. He did.

Q. When did he install the handrail?

A. While I was in the hospital.

Q. 2015?

A. Yes.

Q. Those have worked since that period of time?

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A. Yeah, I couldn't use them for a long time. I had to use a bench to get in the shower, but yes.

Q. When you were able to use the handrails you found them to be a benefit?

A. I did, they were -- made me feel much safer so I could get out of the tub.

Q. Are there any other handrails that you would like to have that you don't have?

A. I'd like another one. If I'm going to stay in this house I need another one on the other side of the stairs going up and down to the basement or upstairs so I can hang onto both sides, it's hard to hang onto one side.

Q. What's in your basement now?

A. Laundry, it's a finished basement, laundry, family room, my office.

Q. Who does the laundry in your house?

A. I do but the kids have to carry it down so I can do the physical laundry when it gets there, I just can't carry it up or down the stairs.

Q. The kids take the laundry down the stairs but you do the laundry?

A. Yes, sir.

Q. I need a walker or cart if I go shopping due to balance problems. I can no longer care for the

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outside of my home, go to the beach or get in a pool without assistance, it's difficult to get into the tub to bathe. I think you told us -- I apologize, I was thinking of other -- your other types of handrails, did you say you have handrails around your bathtub --

A. I do.

Q. -- and your brother installed those in 2015?

A. Yes, sir.

Q. Tell us what those look like again?

A. So one -- so I have a very small bathroom, here's the tub, here's the spigot part so there's one like above the spigot, it's probably between there and the shower thing and there's a long one on the other side and then there's also one to hang onto to actually get in the tub on the outside of the shower.

Q. I understand. So there's a rail, a handrail on the outside of the tub you can kind of hold onto to get into the shower --

A. Yes.

Q. -- and then once you're in the shower there's one between the faucet on the bottom of the showerhead and there's also one along the wall area --

A. Correct.

Q. -- to help you get up and down?

A. Yes.

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Q. Those have been a benefit to you?
A. Very much.
Q. I do not have a shower and getting in and out of the tub requires a lot of energy. I had to have grab bars installed inside and outside the tub for safety. I will eventually need to move to a one-level home with a handicap-accessible bathroom and a first-floor laundry once my children no longer live with me probably in about two years, end paren. Is your house paid off?
A. No.
Q. How much more, as an estimate, do you owe on the house?
A. Probably about 100, 110,000.
Q. What do you think the value of your house is?
A. Probably about 250. They're flying in Berkley.
Q. You said there was a flood problem at a certain point that flooded your house?
A. Twice.
Q. Was that when we had these big rains?
A. The major flood in '14 completely took out the whole basement for everything and then we had another one in Berkley in a -- year ago in '17.
Q. Okay. I have been able to work but at the cost of doing much else in my life. I take a nap almost every

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day for my lunch hour and I come home from work and usually have to go either directly to bed or sleep for a couple hours in order to have enough energy to make dinner for my children or attend to household things. My home is in a constant state of disarray because I'm using the energy I have to work to provide for my children. Are those the areas of damages that you're claiming?
A. Those are the biggest ones, it's a lot of -- the fatigue is one of the biggest things. The fatigue is just -- you know, I've always been an overweight gal but I can run circles around my friends that are half my size, I always have been but this is just taking a lot out of me, you know.
Q. So when you say here in answer to number 21, I had to start physical therapy again in the fall of 2017 for back pain manifesting and fecal incontinence. You don't have any fecal incontinence now, do you?
A. It's been periodic but it's way better than it was then.
Q. For how long was that a problem that --
A. About two months, three months.
Q. What did any doctors or medical professionals tell you caused the problem?
A. They redid an MRI thinking there was more -- they were

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looking for another abscess, which they did not find but there was no stenosis in my back.
Q. And was that MRI performed at Beaumont Hospital?
A. Yes, sir.
Q. Okay. So your medications that you were on -- I'm taking medications I was not on prior to this event, amoxicillin, Buspar, B-u-s-p-a-r, Diflucan, D-i-f-l-u-c-a-n, gabapentin, g-a-b-a-p-e-n-t-i-n, Robaxin, R-o-b-a-x-i-n, trazodone, t-r-a-z-o-d-o-n-e, are those all the current medications you're on?
A. No.
Q. Okay. What else are you on or which of those are you no longer on?
A. I'm on all of those but I have my -- those were -- I was on medicine before that. I was on blood pressure medicine. Do you need that list?
Q. Sure. So before October of 2015 you had other medications?
A. Yes, sir.
Q. What were those other medications?
A. I was on Armour Thyroid, I was on Lasix, I was on amiloride, potassium. I don't remember when the progesterone started, I've been on it and off it, that's a female hormone thing. I don't have my list with me. I take Xanax because I have really bad

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post-traumatic stress disorder, Lexapro.
Q. Were you taking the Xanax before October 2015?
A. Yes.
Q. Is the post-traumatic stress disorder from something before then?
A. I had a history years ago from some abuse.
Q. Okay. So who did you treat with during the 10 years prior to October 2015 as a doctor?
A. Gosh, Bonema and -- so most of these are the usual suspects, I mean -- poor term, sorry.
Q. I'm just trying to get a feel for -- I mean, as we're talking there are some -- like Dr. Jurist and some other medical issues that are coming up but did -- I'm just wondering, did you treat with a number of different doctors before October 2015 or --
A. Just my -- so, for instance, I saw Patel because I had the GI thing. I saw Wasvary because I had colon surgery with him back in 2000.
Q. So when you say, the usual suspects, you mean that you treated with most of those doctors who are listed in the answers to interrogatories prior to October 2015?
A. Except for a few like I didn't see so...
Q. I'm wondering are there other doctors that you treated with prior to October 2015, say that 10 years prior to that that you haven't told us about?

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A. Jurist you know about, Dykowski, I believe that's everyone, I mean, my routine healthcare maintenance stuff.
Q. Okay. And you're eligible for retirement at the age of 67?
A. Yes.
Q. Do you plan on working until 67?
A. I don't know, that's the discussion my internist and I are having now.
Q. No doctor has ever told you that you're disabled from work, have they?
A. He's -- Bonema has suggested that.
Q. When did Dr. Bonema suggest that?
A. Every time I've seen him in the last year and a half.
Q. What has he said to you?
A. He said to me, are you working, and, why are you still working? He has insinuated, just hasn't come directly out and said, you need to go on disability, but, I can do the paperwork for disability for you.
Q. Do you find it helpful to get out into the world and interact with others, et cetera, in your professional life?
A. I do, I mean --
Q. I would imagine, right, you've done it for a long period of time?

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A. Yeah, and I like what I do.
Q. So that would be preferable to just sitting at home without interacting, right?
A. It would be. My dilemma is it's impacting my kids in a really bad way. This has really thrown my kids -- is it okay to interject now?
Q. Sure.
A. This has really impacted my children in a big way. Both of my children are full blood gypsy so they've come from a background that's very, very traumatic. Their dad was in prison when I adopted them. Their mom's a cocaine addict. I'm the only stability they've known so we're making a family life and all of a sudden I get sick. My daughter was an 8th grader. She become anorexic. Her weight went to 90 pounds. She had a 504 because they never went to school other than one year before I got them so she's going into 5th grade and been in school one year. My son was going into 9th grade and had been in school one and a half years, ever, so I've watched my kids fall apart over this, which is tragic.
Q. When did you adopt your children?
A. In 2013.
Q. And you said they were full --
A. Gypsy, full blooded Romani gypsy.

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Q. Tell me what you mean by that?
A. Gypsy?
Q. That's their heritage?
A. Heritage.
Q. Where were they adopted from?
A. I adopted them from Catholic Social Services in Oakland County, St. Francis Center. So they were born in the United States, mom and dad are gypsy and they're 100 percent the gypsy culture. They were brought up to steal, they were brought up to do home invasions, that's how they live their life.
Q. Did you ever have any problems with them in terms of school or behavior or difficulties before October 2015?
A. I did not.
Q. So how would that be -- how would someone raised in that culture -- pardon me, I'm not asking this to offend you.
A. Not at all.
Q. You're saying they're having difficulties because of your medical treatment, is what you're saying?
A. I am.
Q. Now you know they're not parties to the lawsuit to begin with, right?
A. Yeah, I don't know what that means, but yeah.

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Q. But as it relates to what you just told us, they came to live with you in 2013?
A. No, '12, June 28, 2012.
Q. But they had this background that you talked about where they were raised by both parents to steal, be deceptive, et cetera, to get by essentially?
A. Yes.
Q. Okay. And you had no problems whatsoever with them adjusting to your life then between 2012 and October 2015?
A. That's correct.
Q. No problems with school?
A. I mean, school was challenging like, for instance, when my daughter came she couldn't read but within the year I would read to her and she -- I got her on that plan and she's now an 11 grader reading on task, on time. They both have very profound ADD. My daughter now has depression and PTSD. My son has bipolar, which, obviously, didn't come from this but he went to drugs, that's what he did, went to drugs, it's been a mess.
Q. Okay. But all those stressors you're indicating, is that they took place after October 2015 to the current time?
A. Correct, my family life fell apart at that time. We

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had a beloved pet we had to -- we had to get rid of that was my daughter's pet because he was a big lab, a puppy. He was going to knock me down. He had knocked me down before I got sick.

Q. So when you say that your children will leave in approximately 2020, what is the basis for that?

A. My son, because of the drugs he's got into some legal trouble. He's almost done with probation. He will be leaving within the next three to four months.

Q. So when you say, he'll be leaving within the next three to four months, leaving your household?

A. Yes.

Q. What type of legal trouble did he get in, without going into any great detail?

A. He was doing drugs, got stopped for that so driving under the influence. He did a home invasion looking for drugs.

Q. Okay. So other than your medical issues, you've got quite a bit of personal chaos going on, trying to be a good person and adopt the two children and care for them and meanwhile having all of those stressors in your life, fair?

A. Yeah.

MR. WARWICK: Okay. I think I'm going to pass now. I might have a few more questions but I

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greatly appreciate your time.

THE WITNESS: Okay. Sure.

EXAMINATION

BY MR. SINKOFF:

Q. My name is Steve Sinkoff. I represent Hospital Consultants and Dr. Lonappan. I just have a few questions.

I think you've said you don't have a clue who Dr. Lonappan is, correct?

A. I do not.

Q. Okay. Do you know what Hospital Consultants is?

A. I do.

Q. What's your understanding with that?

A. My understanding is my internists don't go to the hospital so if I have to go to the hospital they need someone medical to treat me they refer it to this kind of a group.

Q. And do you know anybody in the group?

A. I don't.

Q. Okay. Do you recall any -- during the hospitalization from October 9th through the 11th, do you recall any specific conversations with any healthcare providers, doctors, nurses, P.A.s?

A. Only the emergency room when they talked about my back, they thought it was the back, not a kidney stone

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and then the --

Q. Pain doctor?

A. -- pain doctor.

Q. Nobody else?

A. No.

Q. And you've told us about all the treatment that you have a recollection of that occurred during that admission?

A. Yes, sir.

Q. All the treatment that you have a recollection of during the subsequent admission on the 11th?

A. Yes.

Q. Do you recall any conversations with any internal medicine-type doctors during either of those two admissions?

A. I remember one doctor in the second -- like the long one, I don't remember his name but he was -- he was really good. He seemed to follow like little nuisances and stuff and go, I'm concerned because this happened. Now, I'm a nurse but kind of going over my head but I remember -- I remember having conversations with him but I couldn't tell you any of the gist of the conversations.

Q. So you remember you talked but you don't remember what you talked about?

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A. Yes.

Q. Did you take any notes while you were in the hospital from October 9th through the 11th?

A. No.

Q. How about during the subsequent admission from October 13th to November 22nd?

A. No.

Q. Have you taken any notes or written any notes yourself or memos, anything like that, since getting out of the hospital November 22nd, 2015?

A. No, I used to journal all the time and I can't even get anything on -- I can't -- everything is just a jumble, it's not --

Q. Is there anything you've put on the computer rather than on paper?

A. Well, I wrote down stuff that's happened to me, I mean, I wrote it, he said write down the impact, how much -- if you would like that --

Q. Yes.

A. Sure. Do you want a copy? It's basically the impact on my life is all it is, what I've seen happen.

Q. Sure. When did you prepare this document?

A. I wrote it last night so I'd have something to go by if I had to talk about this.

Q. Is there anything in here that you haven't already

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told us today in the deposition?
A. I don't believe so but you can go through it and ask me anything if you need me to clarify it.
Q. Do you have a calendar that you've kept that lists information regarding --
A. Only on my phone, doctor visits, those kinds of things.
Q. Doctor visits, I don't understand what those kinds of things are?
A. Doctor visits, so if I had to go to physical therapy, if the nurse was coming. I don't know how far back they stay on my phone.
Q. Just appointments?
A. Yes, sir.
Q. No comments about what was said at any of those appointments?
A. No.
Q. Have you reviewed your medical records from Beaumont?
A. I have.
Q. Have you shared them with anybody other than through your attorney?
A. I talked to my brother and sister-in-law about it a little bit. My sister-in-law Connie is a nurse practitioner and she at one point did infectious disease so -- but, again, it was kind of more a

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generalized, you know, this is what they're giving me for medication, you know, and she was like, yeah, that seems like what you're supposed to be taking.
Q. How many times do you think you've gone through your medical records?
A. I couldn't tell you. I don't know, 15, 20.
Q. Have you gleaned any information from those records in terms of what you may have said to different physicians at different times during your admissions?
A. I haven't. I mostly looked at my blood work, what was going on here.
Q. Have you ever treated with a psychiatrist or a psychologist?
A. Yes.
Q. When is the first time you did that?
A. The first time, probably about, I'm guessing, 20 years ago, maybe, that was a psychologist.
Q. Okay. Since October of 2015 have you seen a psychiatrist?
A. No.
Q. Have you seen a psychologist?
A. Yes.
Q. Who is that?
A. Christine Erwart.
Q. Where is she?

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A. Royal Oak. Do you need an address for her?
Q. Sure.
MR. WARWICK: If you can.
MR. SINKOFF: He'll put it on the authorization.
A. It's E-r-w-a-r-t, her last name.
MR. WARWICK: Christine with a C or --
THE WITNESS: With a C, Christine Elwart.
MR. WARWICK: Spell the last name.
THE WITNESS: E-l-w-a-r-t, I know her address is on Rosland, I want to say 2007, I think, is the right address, it's J.C. Elwart & Associates is the name of the business.
MR. WARWICK: The initials J.C.?
THE WITNESS: Yes, sir, it might be under Joseph, that's her husband, he's also a psychologist.
MR. WARWICK: Okay.
THE WITNESS: Yeah, I don't -- I know it's on Rosland and it's in Royal Oak and I do have a phone number for her office, if that would help you?
MR. WARWICK: Is it -- I have 1205 North Main in Royal Oak.
THE WITNESS: No, that's not them, they're on -- I can find it for you. One second, please.
MR. HAKALA: Rosland.

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THE WITNESS: Rosland.
MR. HAKALA: I have 2007 Rosland --
THE WITNESS: That's right.
MR. HAKALA: -- Avenue.
MR. WARWICK: 2007 Rosland, R-o-s-l-a-n-d.
MR. HAKALA: Yes.
MR. WARWICK: Thanks.
THE WITNESS: It's 48073.
BY MR. SINKOFF:
Q. Is she the only psychologist you've seen since October of 2015?
A. Yes.
Q. Are there any plans to see a psychiatrist or another psychologist?
A. No.
Q. How frequently do you see her?
A. I had been seeing her weekly or biweekly. I've taken a break since probably about March or April.
Q. You haven't seen her in the last five or six months?
A. Correct.
Q. When is the first time you saw her?
A. Probably 15 years ago.
Q. And you saw her on a weekly basis for that?
A. Weekly or biweekly.
Q. It was as a result of whatever assaultive behavior you

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were subjected to?
A. I had some abuse trauma in the past.
Q. Have you discussed your situation with any healthcare providers at Beaumont who are not your treating physicians?
A. No.
Q. Okay. Your job now basically is to sit in the office, review records, make sure patients are -- have adequate evaluations prior to undergoing --
A. I assess them. I assess them, send them for testing. I work for the anesthesiologist. My job is to make sure when they show up they're ready for anesthesia.
Q. So the patient comes to your office?
A. No, by phone.
Q. So it's all looking at the Epic system and talking to them on the phone?
A. That's correct.

MR. SINKOFF: I think that's all I have. Thank you.

RE-EXAMINATION

BY MR. WARWICK:

Q. I have very few follow-up questions.

You don't have any photos and you're not aware of any photos from either your admission from October 9 to October 11 or October 13 to November 22, 2015?
A. I have one my friend sent me. Let's see if I can find it. I think I have one on Facebook with -- I had a monitor on, it was like my Beaumont jewelry. Let me see. These are the ones my friend sent me. You can have them, there's like four of them.
Q. What period of time was that?
A. That was after they did this, the clavicle surgery.
Q. That was the time period of the October 13 to November 22 admission?
A. Yes, sir.
Q. Is it possible to send those to the court reporter perhaps or to your attorney? You can --
A. I can do it from here, right?
Q. You could text them to her.

(Discussion off the record at 1:18 p.m.)
(Back on the record at 1:20 p.m.)

BY MR. WARWICK:

Q. So we've just had you text four photographs that a friend of yours took while you were admitted to Beaumont from October 13 to November 22, 2015 to the court reporter, correct?
A. Correct.
Q. Who was the friend?
A. Nicole Walker.

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Q. And is Nicole a nurse?
A. No.
Q. Do yon have any videos from either of those admissions, October 9 to October 11 or October 13 to November 22nd, at Beanmont Hospital?
A. No.
Q. Do you have any audio recordings or are you aware of any videos or audio recordings dnring either of those admissions?
A. No.
Q. Who do yon get the acupuncture with?
A. I got it with Mike, I can't remember his last name. He's at the Beanmont Integrative Medicine. Mike Tokel, I think his last name is.
Q. At Beanmont Integrative Medicine?
A. Yes.
Q. I'm fairly familiar with that but I just don't remember exactly where it's at?
A. It's in the cancer treatment center on the second level and that's where I got my medical massage as well.
Q. That was my next questiou, so your acupuncture, your medical massage were at Beaumont Integrative Medicine?
A. Yes.
Q. Okay. And were those helpful for you?

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A. The acupuncture was for a while. I'm still getting the medical masaage, it's more sporadic.
Q. Wheu is the most recent time you've had acupuncture?
A. Probably about a year ago, maybe 15 months.
Q. Wheu is the most receut time you've had the medical massage?
A. I had one about -- I have oue coming up in the next week or two.
Q. And Dr. Jurist, where was his office located at when you treated with him?
A. Bingham Farms, he was with the same group. He's with Guettler.
Q. Right. Right. Joseph Guettler?
A. I think Bicos is in there. I know it's orthopedic but I'm screening on a different service right now but I think it'a Bicos, Guettler, Karadsheh is in there, it's --
Q. So the uame of the group is --
A. Premier Ortho, maybe, or Premier Orthopedics. Yes, Performance Orthopedics.
Q. I think you're right about that.
A. Performance Orthopedics. You're really stretching this brain.
Q. I'm trying to fiud the locatiou.
A. Let me look here.

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MR. SINKOFF: It's Telegraph and --
THE WITNESS: It's in that area.
BY MR. WARWICK:
Q. Performance Orthopedics, when's the most recent time you've treated with Dr. Jurist?
A. Back before I did my knee replacements with Dr. Greene so '05 maybe, '06.
MR. HAKALA: Did you get the address?
MR. WARWICK: I thonght I did. There we go, it says 24255 West Thirteen Mile, Bingham Farms.
A. Yeah, that sonnds right, it's a little office complex on the corner by Telegraph.
MR. WARWICK: Those are all the questions I have. I appreciate your time. Best wishes to you.
MR. HAKALA: I don't have anything.
MR. SINKOFF: You're all set.
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBITS 1-10
1:24 p.m.
(The deposition was concluded at 1:24 p.m. Signature of the witness was not requested by counsel for the respective parties hereto.)

CERTIFICATE OF NOTARY

STATE OF MICHIGAN)
) SS
COUNTY OF LIVINGSTON)

I, WENDY M. TAYLOR, 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 rednced to compnter 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 canse.

WENDY M. TAYLOR, CSR-6922
Notary Pnblic,
Livingston County, Michigan
My Commission expires: 1-10-23

BEAUMONT HEALTH
ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

PATIENT FACESHEET

Patient Demographics

Name	Patient ID	SSN	Sex	Birth Date
Markel, Mary Anne	1568410	xxx-xx-8555	Female	03/15/60 (55 yrs)

Address	Phone	Email	Employer
1882 BACON AVE BERKLEY MI 48072-1060	248-398-3151 (H) 248-273-8151 (W) 248-890-9414 (M)	mamarkel@yahoo.com	BEAUMONT HEALTH SYSTEM 3601 W. 13 Mile Rd Royal Oak MI 48073 248-273-8147

Reg Status	PCP	Date Last Verified	Next Review Date
Verified	Bonema, John D, MD248-267-5000	11/18/17	02/16/18

Marital Status
Single

Religion
Catholic/Roman Catholic

Notices
Latex

Patient Preferred Languages

Interpreter Needed	Spoken Language	Written Language
No	English	English

PCP and Center

Primary Care Provider	Phone	Center
John D Bonema, MD	248-267-5000	ROYAL OAK HOSPITAL

Contact Information

Name	Relation	Home	Work	Mobile
Markel,Connie	Sister	248-330-4784		248-330-4784
Markel,Mike	Brother		248-330-4783	**248-330-4783**

Hospital Account

Name	Acct ID	Class	Status	Primary Coverage
Markel, Mary Anne	15684102123	Outpatient - Procedure/Medical	Closed	BEAUMONT HEALTH EMPLOYEE HEALTH PLAN - 2016 BEHP CLASSIC

Guarantor Account (for Hospital Account #15684102123)

Name	Relation to Pt	Service Area	Active?	Acct Type
Markel, Mary Anne	Self	BH	Yes	Personal/Family

BEAUMONT HEALTH

ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

Guarantor Account (for Hospital Account #15684102123) (continued)

Address	Phone
1882 BACON AVE BERKLEY, MI 48072-1060	248-890-9414(H) 248-273-8151(O)

Coverage Information (for Hospital Account #15684102123)

F/O Payor/Plan		Subscriber DOB	Precert #
BEAUMONT HEALTH EMPLOYEE HEALTH PLAN/2016 BEHP CLASSIC		03/15/60	na
Subscriber		**Relation to Pt**	**Subscriber #**
Markel, Mary Anne		Self	Y13682625
Grp # 76430087			
Address	**Phone**		
UMR BEHP UNIT PO BOX 30541 SALT LAKE CITY, UT 84130-0541			
Policy Number		**Effective Date**	
Y13682625		01/01/06	
Auth/Cert na			

Admission Information

Attending Provider	Admitting Provider	Admission Type	Admission Date/Time
Lonappan, Linet P, MD	Lonappan, Linet P, MD	Emergent	10/09/15 1713
Discharge Date	**Hospital Service**	**Auth/Cert Status**	**Service Area**
10/11/15	.RO-MED	OPPM Complete	BEAUMONT HEALTH SYSTEM
Unit	**Room/Bed**	**Admission Status**	**Referring Provider**
6 ST GYN TEAM CARE A	6305/06/6306	Discharged (Confirmed)	
Point of Origin BHS - Home			
Accident Date	**Accident Time**		

Admission

Complaint
Left-sided low back pain with left-sided sciatica [M54.42] Lumbar radiculopathy [M54.16] , Lumbar Spinal Stenosis

Admission Diagnoses / Reasons for Visit (ICD-10-CM)

Code	Description	Comments
M54.16	Radiculopathy, lumbar region	
M54.42	Lumbago with sciatica, left side	

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
M54.16 **[Principal]**	Radiculopathy, lumbar region				

BEAUMONT HEALTH
ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
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Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

Final Diagnoses (ICD-10-CM) (continued)

Code	Description	POA	CC	HAC	Affects DRG
I10	Essential (primary) hypertension				
E03.9	Hypothyroidism, unspecified				
Z23	Encounter for immunization				

Discharge Information - Hospital Account/Patient Record

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
10/11/2015 12:45 PM	Home Or Self Care	Homes	Lonappan, Linet P, MD	6 ST GYN TEAM CARE A

No data filed

Allergies as of 10/11/2015 Reviewed on: **10/11/2015**

	Noted	Reaction Type	Reactions
Latex			**Anaphylaxis/Shock**
Ivp Dye [iodinated Diagnostic Agents]			**Rash/Itching, Short of Breath/Wheezing**
DELETED: **Serevent Diskus [salmeterol]**	02/03/2009		Short of Breath/Wheezing
Avocado			Short of Breath/Wheezing
Banana			Short of Breath/Wheezing
Aciphex [rabeprazole Sodium]			Rash/Itching
DELETED: **Bumetanide**			Rash/Itching
Bumex [bumetanide]	05/11/2010		Rash/Itching
Celebrex [celecoxib] Given w/Lyrica	02/03/2009		Rash/Itching, Short of Breath/Wheezing
Ciprofloxacin			Short of Breath/Wheezing
Flovent [fluticasone Propionate]			Short of Breath/Wheezing
DELETED: **Fluticasone-salmeterol**			Short of Breath/Wheezing
DELETED: **Hctz** duplicate			Rash/Itching
Kiwi Extract	02/03/2009		Short of Breath/Wheezing
Lisinopril cough			Other
Lyrica [pregabalin] Given w/Celebrex	02/03/2009		Short of Breath/Wheezing
Maxzide [hydrochlorothiazide W-triamterene]			Rash/Itching
DELETED: **Metoprolol Succinate** Denies allergy 5/11/10			Swelling, generalized
DELETED: **Prevacid**			Short of Breath/Wheezing
DELETED: **Salmeterol Xinafoate** Exacerbates asthma	05/11/2010		Short of Breath/Wheezing
Sulfa Antibiotics			Rash/Itching
DELETED: **Sulfa Drugs Cross Reactors** mouth sores, mouth sores			Rash/Itching, Other

BEAUMONT HEALTH

ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102117
Adm: 9/2/2015, Dsc: 9/2/2015

Patient Education

No education to display

Recent Education Comments

No education comments to display

Smoking Cessation Counseling [PN-4] Performance Indicator Data Elements

Comfort Measures Only:	**4: No comfort measures have been documented**	Clinical Trial:	**No documentation found**
Chest X-ray or CT Scan Result:	**3: Patient did not have a chest x-ray or CT scan the day prior to arrival or during hospital stay**		
Adult Smoking History:	**No documentation found**	Adult Smoking Counseling:	**No documentation found**

BEAUMONT HEALTH
ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

Lab Results (continued)

BASIC METABOLIC PANEL (BMP) [586475058] (Abnormal) (continued) Resulted: 10/09/15 1800, Result status: Final result

GFR African American	92	>59 mL/min/1.73m2	—

Comment:
Glomerular Filtration Rate is estimated from serum creatinine, age, gender, and race using the CKD-EPI equation. GFR categories in CKD are for both African American and Non-African American:
G1: Normal GFR: >=90
G2: Mildly decreased GFR: 60-89
G3a: Mildly to moderately decreased GFR: 45-59
G3b: Moderately to severely decreased GFR: 30-44
G4: Severely decreased GFR: 15-29
G5: Kidney failure GFR: <15

Calcium	9.2	8.4 - 10.4 mg/dL	—

Additional Resulting Lab Information
Received: 201510091739

URINALYSIS [586475056] (Abnormal) Resulted: 10/09/15 2323, Result status: Final result

Ordering provider: Joseph, Amy E, PA-C 10/09/15 1733 Resulting lab: LABORATORY INFORMATION SYSTEM

Dt/Tm Coll	Type	Source	Collected By
	—	—	9FSA1 10/09/15 2249

Components

Component	Value	Reference Range	Flag
Color	DkYellow	—	—
Clarity	Cloudy	—	A
Glucose	Negative	Negative	—
Bilirubin	1+	Negative	A

Comment:
Positive bilirubin by dipstick. Unable to exclude color interference. Suggest clinical correlation.

Ketones	Trace	Negative	A
Specific Gravity, Urine	1.043	1.005 - 1.030	H
Blood	Negative	Negative	—
pH	5.5	5.0 - 8.0	—
Protein	Negative	Negative	—
Urobilinogen	1.0	0.2 - 1.0	—
Nitrites	Negative	Negative	—
Leukocyte Esterase	2+	Negative	A
RBC	0-3	0 - 3 /hpf	—
WBC	11-25	0 - 5 /hpf	A
Epithelial, Squamous	6-50	/lpf	—
Casts, Hyaline	0-2	0 - 2 /lpf	—
Bacteria	Negative	Negative /hpf	—
Crystal	Calcium	—	—

BEAUMONT HEALTH
ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

Lab Results (continued)

Resulted: 10/09/15 2323, Result status: Final result

URINALYSIS [586475056] (Abnormal) (continued)

Comment	Oxalate see below	—	—

Comment: Microscopic manually verified.

Additional Resulting Lab Information
Received: 201510092254

Resulted: 10/10/15 2201, Result status: Final result

URINALYSIS [586562410] (Abnormal)

Ordering provider: Warner, Janay, PA-C 10/10/15 1349 Resulting lab: LABORATORY INFORMATION SYSTEM

Dt/Tm Coll

Type	Source	Collected By
—	—	9BROY 10/10/15 2109

Components

Component	Value	Reference Range	Flag
Color	DkYellow	—	—
Clarity	Clear	—	—
Glucose	Negative	Negative	—
Bilirubin	Negative	Negative	—
Ketones	Trace	Negative	A
Specific Gravity, Urine	1.030	1.005 - 1.030	—
Blood	Trace	Negative	A
pH	6.0	5.0 - 8.0	—
Protein	Trace	Negative	A
Urobilinogen	1.0	0.2 - 1.0	—
Nitrites	Negative	Negative	—
Leukocyte Esterase	2+	Negative	A
RBC	5	0 - 3 /hpf	H
WBC	>100	0 - 5 /hpf	H
Epithelial, Squamous	21	/lpf	—
Casts, Hyaline	18	0 - 2 /lpf	H
Bacteria	Negative	Negative /hpf	—

Additional Resulting Lab Information
Received: 201510102142

Resulted: 10/12/15 2038, Result status: Final result

CULTURE, URINE [586562411] (Abnormal)

Ordering provider: Warner, Janay, PA-C 10/10/15 1349 Resulting lab: LABORATORY INFORMATION SYSTEM

Dt/Tm Coll

Type	Source	Collected By
—	Urine	9BROY 10/10/15 2110

Components

Component	Value	Reference Range	Flag
Flag Status	This report has been flagged as abnormal	—	A

BEAUMONT HEALTH
ROYAL OAK HOSPITAL
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ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

ED Notes (continued)

ED Obs Nurse Notes by Salem, Feras, RN 10/10/15 0306

Author: Salem, Feras, RN | Service: Emergency Medicine | Author Type: Registered Nurse
Filed: 10/10/15 0306 | Date of Service: 10/10/15 0306 | Status: Signed
Editor: Salem, Feras, RN (Registered Nurse)

Patient given ice pack as requested to help with her back pain. Patient stated relief.

ED Nurse Notes by Yang, Sun-Yoon, RN 10/10/15 0430

Author: Yang, Sun-Yoon, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 0438 | Date of Service: 10/10/15 0430 | Status: Addendum
Editor: Yang, Sun-Yoon, RN (Registered Nurse)
Related Notes: Original Note by Yang, Sun-Yoon, RN (Registered Nurse) filed at 10/10/15 0432

Pt first encounter. Pt c/o severe back pain. Established new IV line due to infiltration of previous IV. Dilaudid given per order. Assisted pt to put bedpan. Applied ice pack to back. wctm.

ED Nurse Notes by Vang, Yer, RN 10/10/15 0720

Author: Vang, Yer, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 0826 | Date of Service: 10/10/15 0720 | Status: Signed
Editor: Vang, Yer, RN (Registered Nurse)

Pt assisted to commode. No distress. Am med given with dilaudid. VSS. Waiting for consults.

ED Nurse Notes by Vang, Yer, RN 10/10/15 0847

Author: Vang, Yer, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 0847 | Date of Service: 10/10/15 0847 | Status: Signed
Editor: Vang, Yer, RN (Registered Nurse)

Robaxin given. Pt alert x3. No distress.

ED Nurse Notes by Vang, Yer, RN 10/10/15 1059

Author: Vang, Yer, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 1100 | Date of Service: 10/10/15 1059 | Status: Signed
Editor: Vang, Yer, RN (Registered Nurse)

Pt given percocet for pain. PMR and neurosurg was here to see pt. VSS. Waiting for further orders.

ED Obs Provider Notes by Warner, Janay, PA-C 10/10/15 0808

Author: Warner, Janay, PA-C | Service: (none) | Author Type: Physician Assistant
Filed: 10/10/15 1226 | Date of Service: 10/10/15 0808 | Status: Signed
Editor: Warner, Janay, PA-C (Physician Assistant) | Cosigner: Berger, David A, MD at 10/23/15 1842

Observation Note

ED Notes (continued)

ED Obs Provider Notes by Warner, Janay, PA-C (continued) 10/10/15 0808

This patient has been seen by PA/NP: janay warner pa-c.

The Observation Physician has reviewed the following: EC records, observation records and nursing notes.

Past Medical History

Diagnosis	Date
• Hypertension	
• Hypothyroidism	
• Asthma	
• Glaucoma	
• GERD (gastroesophageal reflux disease)	
• Diverticulitis	
• Dysphagia	
• Anxiety disorder	
• Postoperative nausea and vomiting	

Past Surgical History

Procedure	Laterality	Date
• Pa esophagogastric fundoplasty nissens		2005
• Discectomy, lumbar		
• Tonsilectomy		
• Cholecystectomy		2005
• Removal, cataract		
• Colectomy		
• Laminectomy		
• Arthroplasty, total knee, left		
• Arthroplasty, total knee, right		
• Hernia repair ventral		
• Other surgical history *sphincteroplasty*		
• Esophagogastroduodenoscopy (egd) *x 10*		
• Colonoscopy		
• Arthroscopy, knee		

History

Social History

• Marital Status:	Single
Spouse Name:	N/A
Number of Children:	N/A
• Years of Education:	N/A

Social History Main Topics

ED Notes (continued)

ED Obs Provider Notes by Warner, Janay, PA-C (continued) 10/10/15 0808

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol Use: No
- Drug Use: No
- Sexual Activity: Not on file

Other Topics — Concern
- Not on file

Social History Narrative

Family History

Problem	Relation	Age of Onset
Cancer - Other	Father	
MI	Mother	
Heart Failure	Mother	

Physician Focused Physical Exam
Nursing note and vitals reviewed.

Mild visible distress
Laying in stretcher in left lateral decubitis

EC OU Course:
Pt. Sent to EC observation for evaluation of left lumbar back pain radiating into LLE. MRI of LS spine shows moderate/severe stonosis of spine with multiple disc extrusions/protrusions at multiple levels.

Pt. Was evaluated by Neurosurgery and PM&R who both recommended anesthesia pain consult. Pt. Is an anesthesia nurse here at beaumont.

4mg Decadron given along with Robaxin as recommended by specialists. Will consider additional 4mg dose of decadron later today. Pt. Continues to c/o severe pain despite IV and po medications and is unable to ambulate d/t pain.

Discussed care plan with pain service who will not be able to see pt. Today but plan to round on her tomorrow am.

WBC 13.8
UA awaiting repeat

Final Diagnosis: 1. Lumber radiculopathy 2. Acute on chronic lower back pain

BEAUMONT HEALTH

ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

ED Notes (continued)

ED Obs Provider Notes by Warner, Janay, PA-C (continued) 10/10/15 0808

Encounter Diagnoses

Name	Primary?
• Left-sided low back pain with left-sided sciatica	Yes

Treatment Plan: Admit (see Order to Admit) in stable condition to Haas/Wease, Dr. Lonappan. Pt. Agreeable with plan for PT evaluation, pain control and pain service consult for epidural. PM&R and neurosurgery (Dr. Olsen) to follow. Pt. Agreeable.

ED Provider Notes by Hang, Bophal S, MD 10/09/15 1733

Author: Hang, Bophal S, MD | Service: (none) | Author Type: Physician
Filed: 10/25/15 2258 | Date of Service: 10/09/15 1733 | Status: Addendum
Editor: Hang, Bophal S, MD (Physician)
Related Notes: Original Note by Joseph, Amy E, PA-C (Physician Assistant) filed at 10/23/15 1916

No chief complaint on file.

HPI Comments: Pt is a 55 y/o F presenting with acute low back pain with left leg radicular symptoms. She is a nurse at Beaumont and the pain started today at work. Her pain is in the left lower back and down her left leg. She denies any heavy lifting today or any injury/trauma. She left work early, went home, tried heat, aleve, norco, and warm bath without any relief. She says her legs "feel weird" and unsteady. She has numbness to both feet, worse on the left. She had difficulty urinating earlier today but has since urinated. She has remote hx of back surgery with Dr. Olsen about 20 years ago.

Review of Systems
Constitutional: Negative for fever and chills.
Respiratory: Negative for cough.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for nausea, vomiting and abdominal pain.
Genitourinary: Negative for dysuria.
Musculoskeletal: Positive for back pain. Negative for falls.
Neurological: Positive for sensory change.

Patient's Medications

New Prescriptions
No medications on file

Previous Medications

ALBUTEROL (PROVENTIL, VENTOLIN) 108 (90 BASE) MCG/ACT INHAL AERO SOLN	inhale 2 Puffs into the lungs as needed.

Progress Notes (continued)

Progress Notes by Keiser, Megan, RN NP-C (continued) 10/10/15 0906

clinic with Dr. Olson in 3-4 weeks. Will sign off - please call with questions or concerns.

MKeiser, RN, NP 10/10/2015 9:09AM
Pager 23298

Attribution Key
Attribution information is not available for this note.

Nsg Progress Note by Rabon, Camie D, RN 10/11/15 0413

Author: Rabon, Camie D, RN | Service: (none) | Author Type: Nursing
Filed: 10/11/15 0440 | Date of Service: 10/11/15 0413 | Status: Addendum
Editor: Rabon, Camie D, RN (Registered Nurse)
Related Notes: Original Note by Rabon, Camie D, RN (Registered Nurse) filed at 10/11/15 0415

Pt was running a temperature of 100.9 at 20:00 (10/10). Pt is now 98.1 Per orders to contact dr if temp>100.4, Dr Moraru was called.

Dr Moraru called. Pt's UA is neg and culture is pending from previous night specimen. Pt states she is doing well and feels better than she has in a while. Dr said to just continue to watch her.

Attribution Key
Attribution information is not available for this note.

All Other Notes

Nsg Admit Note by Magolan, Angela S, RN 10/10/15 1426

Author: Magolan, Angela S, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 1427 | Date of Service: 10/10/15 1426 | Status: Signed
Editor: Magolan, Angela S, RN (Registered Nurse)

RN Admit Note

Patient received from: EC

Reason for admit/transfer: back pain

Condition of patient and pertinent physical findings on arrival: aox3, denies DIB, SOB

Presence of pain/score: 6/10

Condition of skin: intact (if skin breakdown noted see LDA)

All Other Notes (continued)

Nsg Admit Note by Magolan, Angela S, RN (continued) 10/10/15 1426

Patient/family oriented to room, white board, hourly rounding explained, and fall prevention techniques implemented. Call light and phone placed within reach. Bed low and wheels locked.

Angela Magolan, RN

Attribution Key
Attribution information is not available for this note.

Nsg Admit Note by Rautiola, Nicole Teresa, RN 10/10/15 1449

Author: Rautiola, Nicole Teresa, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 1450 | Date of Service: 10/10/15 1449 | Status: Signed
Editor: Rautiola, Nicole Teresa, RN (Registered Nurse)

Admit Note

Patient received from: EC
Reason for admit: back pain
Condition of patient and pertinent physical findings on arrival: A&Ox3
Presence of pain/score: 6/10
4-eye skin assessment completed with: Angie M RN
Condition of skin: CDI

Patient/family orientated to room, white board, hourly rounding explained and fall prevention techniques implemented. Call light and phone placed in reach. Bed low and wheels locked.

Nicole Rautiola, RN

Attribution Key
Attribution information is not available for this note.

Care Plan Note by Rautiola, Nicole Teresa, RN 10/10/15 1900

Author: Rautiola, Nicole Teresa, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 1900 | Date of Service: 10/10/15 1900 | Status: Signed
Editor: Rautiola, Nicole Teresa, RN (Registered Nurse)

ED Notes (continued)

ED Provider Notes by Hang, Bophal S, MD (continued) 10/09/15 1733

History & Physical Notes

H&P by Lonappan, Linet P, MD 10/10/15 1441

Author: Lonappan, Linet P, MD | Service: Internal Medicine | Author Type: Physician
Filed: 10/10/15 1633 | Date of Service: 10/10/15 1441 | Status: Signed
Editor: Lonappan, Linet P, MD (Physician)

Hospital Consultants
Specialized Care for Hospitalized Patients

Attending Physician: Lonappan, Linet P, MD
Primary Care Physician: Bonema, John D, MD

Date of Admission: 10/9/2015

Chief Complaint:
Low back pain

Source of Information:
Patient and Available medical record

History of Present Illness:
This is a 55y.o. female the past medical history of hypertension, hypothyroidism, low back pain presenting with complaints of acute onset of low back pain With radiation to the left lower extremity that started yesterday while at work. She works as a RN in the preop assessment area. She had to leave work secondary to acute onset of low back pain. No trauma to the back. She tried Aleeve, norco, heat and cold to the back without any improvement in her symptoms. She has family, daughter dysfunction due to pain. The back pain was radiating to the left lower extremity, although has some numbness on both lower extremities, more on the left side. No urinary or bowel incontinence, although she felt she was unable to urinate earlier. Has urinated ×3 since this morning.
Denies any chest pain, palpitations, fever, chills, nausea, vomiting.

BEAUMONT HEALTH

ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

History & Physical Notes (continued)

H&P by Lonappan, Linet P, MD (continued) 10/10/15 1441

Past Medical History

Diagnosis	Date
• Hypertension	
• Hypothyroidism	
• Asthma	
• Glaucoma	
• GERD (gastroesophageal reflux disease)	
• Diverticulitis	
• Dysphagia	
• Anxiety disorder	
• Postoperative nausea and vomiting	

Past Surgical History

Procedure	Laterality	Date
• Pa esophagogastic fundoplasty nissens		2005
• Discectomy, lumbar		
• Tonsilectomy		
• Cholecystectomy		2005
• Removal, cataract		
• Colectomy		
• Laminectomy		
• Arthroplasty, total knee, left		
• Arthroplasty, total knee, right		
• Hernia repair ventral		
• Other surgical history *sphincteroplasty*		
• Esophagogastroduodenoscopy (egd) *x 10*		
• Colonoscopy		
• Arthroscopy, knee		
• Dilatation and curettage, hysteroscopy, endometrial ablation		10/9/15

Family History

Problem	Relation	Age of Onset
• Cancer - Other	Father	
• MI	Mother	
• Heart Failure	Mother	

History

Social History

• Marital Status:	Single
Spouse Name:	N/A
Number of Children:	N/A

History & Physical Notes (continued)

H&P by Lonappan, Linet P, MD (continued) 10/10/15 1441

- Years of Education: N/A

Social History Main Topics
- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol Use: No
- Drug Use: No
- Sexual Activity: Not on file

Other Topics — Concern
- Not on file

Social History Narrative

Home Medications

History & Physical Notes (continued)

H&P by Lonappan, Linet P, MD (continued) 10/10/15 1441

Reviewed by Bondy, Shannen L., RN (Registered Nurse) on 10/09/15 at 2141

Med	Sig	Taking ?	Last Dose Dt/Time
albuterol (PROVENTIL, VENTOLIN) 108 (90 BASE) MCG/ACT INHAL Aero Soln	inhale 2 Puffs into the lungs as needed.	No	
alprazolam (XANAX) 0.5 MG PO Tab	take 0.5 mg by mouth twice daily as needed.	No	
AMILORIDE HCL PO	take 20 mg by mouth once every night at bedtime.	No	
calcium citrate (CITRACAL) 950 MG PO Tab	take 950 mg by mouth once daily.	No	
escitalopram (LEXAPRO) 20 MG PO Tab	take 20 mg by mouth once every night at bedtime.	No	
hydrocodone-acetaminophen (NORCO) 5-325 MG PO Tab	take 1 Tab by mouth every 4 hours as needed for FOR PAIN.	No	
Irbesartan (AVAPRO) 150 MG PO Tab	take 150 mg by mouth once every night at bedtime.	No	
Naproxen Sodium 220 MG PO Cap	take 440 mg by mouth as needed.	No	
omeprazole (PRILOSEC) 20 MG PO CAPSULE DELAYED RELEASE	take 20 mg by mouth once every night at bedtime.	No	
potassium chloride (KLOR CON) 20 MEQ PO Pack	take 20 mEq by mouth once every night at bedtime.	No	
Thyroid (ARMOUR) 180 MG PO Tab	take 180 mg by mouth once every night at bedtime.	No	
Vitamin D, Ergocalciferol, 50000 UNIT PO Cap	take by mouth once weekly.	No	

Allergies:

Allergen	Reactions
• Latex	Anaphylaxis/Shock
• Ivp Dye [Iodinated Contrast Media]	Rash/Itching and Short of Breath/Wheezing
• Avocado	Short of Breath/Wheezing
• Banana	Short of Breath/Wheezing
• Aciphex [Rabeprazole Sodium]	Rash/Itching
• Bumex [Bumetanide]	Rash/Itching
• Celebrex [Celecoxib] *Given w/Lyrica*	Rash/Itching and Short of Breath/Wheezing
• Ciprofloxacin	Short of Breath/Wheezing

History & Physical Notes (continued)

H&P by Lonappan, Linet P, MD (continued) 10/10/15 1441

• Flovent [Fluticasone Propionate]	Short of Breath/Wheezing
• Kiwi Extract	Short of Breath/Wheezing
• Lisinopril *cough*	Other
• Lyrica [Pregabalin] *Given w/Celebrex*	Short of Breath/Wheezing
• Maxzide [Hydrochlorothiazide W-Triamterene]	Rash/Itching
• Sulfa Antibiotics	Rash/Itching
• Sulfites [Sulfites]	Rash/Itching
• Xalatan [Latanoprost] *eye itching*	Other
• Zocor [Simvastatin] *myalgia*	Other
• Chestnuts *water chestnuts*	Swelling, generalized

Review of Systems:
Please refer to HPI for positive findings. A complete ROS was performed and is otherwise negative.

Physical Examination:

Vital Signs: BP 144/57 mmHg | Pulse 79 | Temp(Src) 99 °F (37.2 °C) (Oral) | Resp 18 | Ht 172.7 cm (5' 8") | Wt 125.193 kg (276 lb) | BMI 41.98 kg/m2 | SpO2 100% | LMP 11/28/2010
General: healthy appearing 55y.o. female who appears to be in no acute distress.
Eyes: pupils reactive, ocular movements intact, no pallor or icterus.
ENT: moist mucous membranes, no nasal drainage.
Neck: Supple, no JVD, thyromegaly, or masses. No cervical or supraclavicular lymphadenopathy.
CV: regular rate and rhythm.
Lungs: clear to auscultation, no use of accessory muscles.
Abdomen: non-tender, no hepatosplenomegaly.
Extremities: no cyanosis, difficult to assess secondary to pain
Neurologic: cranial nerves intact

DATA:

WBC	Hgb	Hct	Plt
13.8 (10/09 1735)	12.9 (10/09 1735)	37.8 (10/09 1735)	362 (10/09 1735)
NA	**K**	**Cl**	**CO_2**
137 (10/09 1735)	4.0 (10/09 1735)	104 (10/09 1735)	23 (10/09 1735)
BUN	**Creat**	**Glucose**	
23 (10/09 1735)	0.83 (10/09 1735)	134 (10/09 1735)	
PT	**PTT**	**INR**	

BEAUMONT HEALTH
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Adm: 10/9/2015, Dsc: 10/11/2015

History & Physical Notes (continued)

H&P by Lonappan, Linet P, MD (continued) 10/10/15 1441

MRI of the lumbar spine- multilevel mild vomiting and severe stenosis of central spinal canal And multilevel stenosis of the neural foramina, worse on the right side

IMPRESSION:
Active Hospital Problems
Diagnosis
- Principal Problem: Lumbar radiculopathy, acute- left
- Essential hypertension
- Acute low back pain
- Hypothyroidism
- Post traumatic stress disorder (PTSD)

Resolved Hospital Problems
Diagnosis
No resolved problems to display.

PLAN:
Admit.
Pain control-Toradol, dilaudid, decadron, muscle relaxants..
Consult Dr Olson, PMR and pain managment
No emergency neurosurgical intervention at this time
Resume other OP medications

DVT prophylaxis : SCDs until decision regarding ESI is made

Linet Lonappan MD
Pager 27550

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Attribution Key
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Consult Notes

Consults by Clippard, Megan O, RN NP-C 10/09/15 2237

BEAUMONT HEALTH
ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

Discharge Summary Notes (continued)

Discharge Summaries by Lonappan, Linet P, MD 10/11/15 1106

Author: Lonappan, Linet P, MD | Service: Internal Medicine | Author Type: Physician
Filed: 10/11/15 1433 | Date of Service: 10/11/15 1106 | Status: Signed
Editor: Lonappan, Linet P, MD (Physician)

Discharge Summary

Hospital Consultants
Specialized Care for Hospitalized Patients
248-691-8646

Primary Care Physician: Bonema, John D
Attending Physician: Lonappan, Linet P, MD

Date of Admission: 10/9/2015
Date of Discharge: 10/11/2015

Hospital Principal Problem:
Lumbar radiculopathy, acute

Other Hospital Problems
Active Hospital Problems
Diagnosis
- Principal Problem: Lumbar radiculopathy, acute- left
- Essential hypertension
- Acute low back pain
- Hypothyroidism
- Post traumatic stress disorder (PTSD)

Resolved Hospital Problems
Diagnosis
No resolved problems to display.

Consultants:

Provider	Role	From	To
Olson, Ricky E, MD	Consulting Physician	10/09/15 1941	10/10/15 0910
Laban, Myron M, MD	Consulting Physician	10/09/15 1941	---
Dimon, Cain E, MD	Consulting Physician	10/10/15 0950	10/11/15 0913

Studies Pending or Needing Follow Up
Outpatient follow-up with pain management clinic

Discharge Summary Notes (continued)

Discharge Summaries by Lonappan, Linet P, MD (continued) 10/11/15 1106

Procedures Performed:
MRI of the lumbosacral spine shows multilevel mid, moderate and severe stenosis of central spinal canal associated with multilevel stenosis of neural foramina, worse on the right side

Hospital Course:
Patient is 55y.o. female who presented to the hospital with complaints of acute onset of low back pain with radiation to bilateral lower extremities. She was admitted for lumbar radiculopathy.
She was started on IV steroids, muscle relaxants, pain control. She was evaluated by neurosurgery, pain management and PMR. Her symptoms improved. Pain management suggested outpatient follow-up for ESI. She was discharged in a stable condition for outpatient follow-up.

She was instructed not to take any NSAIDs until seen by pain management clinic

Evaluation on Day of Discharge:
BP 116/57 mmHg | Pulse 53 | Temp(Src) 97.5 °F (36.4 °C) (Oral) | Resp 18 | Ht 172.7 cm (5' 8") | Wt 125.193 kg (276 lb) | BMI 41.98 kg/m2 | SpO2 99% | LMP 11/28/2010
Gen.: Alert, awake, oriented, in no acute distress.
Chest: Breath sounds are normal bilaterally, no accessory muscle.
CVS: S1, S2, normal, regular.
Extremities: No edema, no cyosis

Time spent on evaluating, preparing and coordinating discharge: 25 minutes.

Discharge Instructions:
Follow-up Information

Follow up with Olson, Ricky E, MD in 3 weeks.
Specialty: Neurosurgery
Contact information:
4203 W 13 Mile Rd
Royal Oak MI 48073
248-288-2025

Follow up with Bonema, John D, MD. Schedule an appointment as soon as possible for a visit in 2 weeks.
Specialty: Internal Medicine
Contact information:
4600 Investment Dr #300
Troy MI 48098
248-267-5000

Follow up with Beaumont pain clinic . Call in 1 day.

Discharge Summary Notes (continued)

Discharge Summaries by Lonappan, Linet P, MD (continued) 10/11/15 1106

Why: for ESI

Current Discharge Medication List

START taking these medications

	Refills	AM	Noon	PM	Bedtime
dexamethasone 4 MG Tabs take 1 Tab by mouth every 6 hours for 2 days. Quantity: 8 Tab Commonly known as: DECADRON,HEXADROL	Refills: 0				
diazepam 5 MG Tabs take 1 Tab by mouth every 6 hours as needed for FOR ANXIETY or FOR SEDATION. Quantity: 20 Tab Commonly known as: VALIUM	Refills: 0				
oxycoDONE-acetaminophen 10-325 MG Tabs take 1 Tab by mouth every 6 hours as needed for FOR MODERATE PAIN. Quantity: 30 Tab Commonly known as: PERCOCET Replaces: **oxycoDONE-acetaminophen 5-325 MG Tabs**	Refills: 0				

CONTINUE taking these medications

Discharge Summary Notes (continued)

Discharge Summaries by Lonappan, Linet P, MD (continued) 10/11/15 1106

	Refills	AM	Noon	PM	Bedtime
albuterol 108 (90 BASE) MCG/ACT Aers inhale 2 Puffs into the lungs as needed. Commonly known as: PROVENTIL, VENTOLIN	Refills: 0				
alprazolam 0.5 MG Tabs take 0.5 mg by mouth twice daily as needed. Commonly known as: XANAX	Refills: 0				
AMILORIDE HCL PO take 20 mg by mouth once every night at bedtime.	Refills: 0				
calcium citrate 950 MG Tabs take 950 mg by mouth once daily. Commonly known as: CITRACAL	Refills: 0				
escitalopram 20 MG Tabs take 20 mg by mouth once every night at bedtime. Commonly known as: LEXAPRO	Refills: 0				
Irbesartan 150 MG Tabs take 150 mg by mouth once every night at bedtime. Commonly known as: AVAPRO	Refills: 0				
omeprazole 20 MG Cpdr take 20 mg by mouth once every night at bedtime. Commonly known as: PRILOSEC	Refills: 0				
potassium chloride 20 MEQ Pack take 20 mEq by mouth once every night at bedtime.	Refills: 0				

Discharge Summary Notes (continued)

Discharge Summaries by Lonappan, Linet P, MD (continued) 10/11/15 1106

	Refills	AM	Noon	PM	Bedtime
Commonly known as: KLOR CON					
Thyroid 180 MG Tabs take 180 mg by mouth once every night at bedtime. Commonly known as: ARMOUR	Refills: 0				
vitamin D 50000 UNITS Caps take by mouth once weekly. Commonly known as: ERGOCALCIFEROL	Refills: 0				

STOP taking these medications

cyclobenzaprine 10 MG Tabs
Commonly known as: FLEXERIL

hydrocodone-acetaminophen 5-325 MG Tabs
Commonly known as: NORCO

Naproxen Sodium 220 MG Caps

oxycoDONE-acetaminophen 5-325 MG Tabs
Commonly known as: PERCOCET
Replaced by: **oxycoDONE-acetaminophen 10-325 MG Tabs**

Linet Lonappan MD
Pager 27550

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ED Notes

ED Nurse Notes by Slusser, Catherine Anne, RN 10/09/15 1724

Author: Slusser, Catherine Anne, RN Service: (none) Author Type: Registered Nurse
Filed: 10/09/15 1726 Date of Service: 10/09/15 1724 Status: Signed
Editor: Slusser, Catherine Anne, RN (Registered Nurse)

Consult Notes (continued)

Consults by Burlingame, Bret L, DO (continued) 10/10/15 0935

When identified, these errors have been corrected. While every attempt was made to correct errors during dictation, errors may still exist.

Attribution Key

Attribution information is not available for this note.

Consults by Sapeika, Daniel A, MD 10/11/15 0851

Author: Sapeika, Daniel A, MD | Service: Anesthesiology | Author Type: Physician
Filed: 10/11/15 0910 | Date of Service: 10/11/15 0851 | Status: Signed
Editor: Sapeika, Daniel A, MD (Physician)

Consult Orders:
1. CONSULT TO PHYSICIAN [586540822] ordered by Warner, Janay, PA-C at 10/10/15 0950

Pain Management Specialists of Southeast Michigan
An Affiliate of American Anesthesiology of Michigan

Consult Note

Attending Physician: Lonappan, Linet P, MD

Consultation Information:
Consultant: Daniel Sapeika, MD
Specialty: Anesthesia Pain Medicine
Reason for Consultation/Indicaton: lumbar radicular pain

Date of Consultation: 10/11/2015

Date of Admission: 10/9/2015

Source of Information: patient and EMR

Chief Complaint: back and leg pain

History of Present Illness:
This is a 55y.o. female who works in OR/Anesthesia pre-op presents with new back and leg pain. She has a hx of prior laminectomy 20 years ago x 2 from Dr. Olson at L4-L5 and L5-S1. The patient has been doing quite well after those surgeries and had only been on OTC NSAID (aleve) for her arthritic pains. Then this past Friday while working she had an acute episode of left greater than right low back/buttock pain with radiation to the left greater than right posterior/lateral leg to the knee on the left and to the groin on the right. Associated to this she has bilateral feet numbness. Denies any weakness. Also, reported initial inability to urinate but otherwise no bowel dysfunction or saddle anesthesia. Her pain was so severe as incapacitate her to the point

Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

where she was unable to ambulate thus prompting her to head to the ER for evaluation. At home she tried Norco and flexeril from an old supply that did not help. Her pain now is actually better and down to a 5/10. Her pain regimen includes Decadron 4 mg q 6 hours, Valium 5 mg q 8 hours (used only x1 yesterday), IVP Dilaudid 1 mg q 3 hours, Toradol 30 mg q 8 hours, and Percocet 10/325 mg q 6 hours. She has been evaluated by both neurosurgery and PMR. Currently no surgery has been offered and PT is going to evaluate her today to see if she can ambulate as she would like to go home today if possible.

Past Medical History

Diagnosis	Date
• Hypertension	
• Hypothyroidism	
• Asthma	
• Glaucoma	
• GERD (gastroesophageal reflux disease)	
• Diverticulitis	
• Dysphagia	
• Anxiety disorder	
• Postoperative nausea and vomiting	

Past Surgical History

Procedure	Laterality	Date
• Pa esophagogastic fundoplasty nissens		2005
• Discectomy, lumbar		
• Tonsilectomy		
• Cholecystectomy		2005
• Removal, cataract		
• Colectomy		
• Laminectomy		
• Arthroplasty, total knee, left		
• Arthroplasty, total knee, right		
• Hernia repair ventral		
• Other surgical history *sphincteroplasty*		
• Esophagogastroduodenoscopy (egd) *x 10*		
• Colonoscopy		
• Arthroscopy, knee		
• Dilatation and curettage, hysteroscopy, endometrial ablation		10/9/15

Family History

Problem	Relation	Age of Onset
• Cancer - Other	Father	
• MI	Mother	
• Heart Failure	Mother	

Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

History

Social History

- Marital Status: Single
  - Spouse Name: N/A
  - Number of Children: N/A
- Years of Education: N/A

Social History Main Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol Use: No
- Drug Use: No
- Sexual Activity: Not on file

Other Topics — Concern

- Not on file

Social History Narrative

Home Medications:
Home Medications

Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

Reviewed by Bondy, Shannen L., RN (Registered Nurse) on 10/09/15 at 2141

Med	Sig	Taking ?	Last Dose Dt/Time
albuterol (PROVENTIL, VENTOLIN) 108 (90 BASE) MCG/ACT INHAL Aero Soln	inhale 2 Puffs into the lungs as needed.	No	
alprazolam (XANAX) 0.5 MG PO Tab	take 0.5 mg by mouth twice daily as needed.	No	
AMILORIDE HCL PO	take 20 mg by mouth once every night at bedtime.	No	
calcium citrate (CITRACAL) 950 MG PO Tab	take 950 mg by mouth once daily.	No	
escitalopram (LEXAPRO) 20 MG PO Tab	take 20 mg by mouth once every night at bedtime.	No	
hydrocodone-acetaminophen (NORCO) 5-325 MG PO Tab	take 1 Tab by mouth every 4 hours as needed for FOR PAIN.	No	
Irbesartan (AVAPRO) 150 MG PO Tab	take 150 mg by mouth once every night at bedtime.	No	
Naproxen Sodium 220 MG PO Cap	take 440 mg by mouth as needed.	No	
omeprazole (PRILOSEC) 20 MG PO CAPSULE DELAYED RELEASE	take 20 mg by mouth once every night at bedtime.	No	
potassium chloride (KLOR CON) 20 MEQ PO Pack	take 20 mEq by mouth once every night at bedtime.	No	
Thyroid (ARMOUR) 180 MG PO Tab	take 180 mg by mouth once every night at bedtime.	No	
Vitamin D, Ergocalciferol, 50000 UNIT PO Cap	take by mouth once weekly.	No	

Inpatient Medications: Current facility-administered medications: acetaminophen (TYLENOL) tablet 650 mg, 650 mg, Oral, Q 6 H PRN, Warner, Janay, PA-C; sodium chloride 0.9 % flush injection 3 mL, 3 mL, Intravenous, Q 8 H, Warner, Janay, PA-C, 3 mL at 10/10/15 2236; oxycoDONE-acetaminophen (PERCOCET) 10-325 MG tablet 1 Tab, 1 Tab, Oral, Q 6 H PRN, Warner, Janay, PA-C, 1 Tab at 10/11/15 0358 ketorolac (TORADOL) injection 30 mg, 30 mg, Intravenous, Q 8 H PRN, Lonappan, Linet P, MD, 30 mg at 10/11/15 0157; influenza virus vaccine (FLUZONE, FLUARIX) injection 0.5 mL, 0.5 mL, Intramuscular, Prior to discharge, Lonappan, Linet P, MD; pneumococcal vaccine (PNEUMOVAX 23) injection 0.5 mL, 0.5 mL, Intramuscular, Prior to discharge, Lonappan, Linet P, MD HYDROmorphONE injection 1 mg, 1 mg, Intravenous, Q 3 H PRN, Joseph, Amy E, PA-C, 1 mg at 10/11/15 0046; diazepam (VALIUM) tablet 5 mg, 5 mg, Oral, Q 8 H PRN, Joseph, Amy E, PA-C, 5 mg at 10/10/15 1342; amiloRIDe (MIDAMORE) tablet 20 mg, 20 mg, Oral, Q HS, Joseph, Amy E, PA-C, 20 mg at 10/10/15 2235; losartan (COZAAR) tablet 50 mg, 50 mg, Oral, DAILY, Joseph, Amy E, PA-C, 50 mg at 10/10/15 0730

BEAUMONT HEALTH
ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

escitalopram (LEXAPRO) tablet 20 mg, 20 mg, Oral, Q HS, Joseph, Amy E, PA-C, 20 mg at 10/10/15 2146; thyroid (ARMOUR THYROID) tablet 180 mg, 180 mg, Oral, Q HS, Joseph, Amy E, PA-C, 180 mg at 10/10/15 2235; dexamethasone (DECADRON) injection 4 mg, 4 mg, Intravenous, Q 6 H, Clippard, Megan O, RN NP-C, 4 mg at 10/11/15 0357; omeprazole (PRILOSEC) DR capsule 20 mg, 20 mg, Oral, AC DINNER, Clippard, Megan O, RN NP-C, 20 mg at 10/10/15 1658
PATIENT SPECIFIC MEDICATIONS 1 Each, 1 Each, Does not apply, Per Administration Instructions, Laban, Myron M, MD

Allergies:

Allergen	Reactions
• Latex	Anaphylaxis/Shock
• Ivp Dye [Iodinated Contrast Media]	Rash/Itching and Short of Breath/Wheezing
• Avocado	Short of Breath/Wheezing
• Banana	Short of Breath/Wheezing
• Aciphex [Rabeprazole Sodium]	Rash/Itching
• Bumex [Bumetanide]	Rash/Itching
• Celebrex [Celecoxib] *Given w/Lyrica*	Rash/Itching and Short of Breath/Wheezing
• Ciprofloxacin	Short of Breath/Wheezing
• Flovent [Fluticasone Propionate]	Short of Breath/Wheezing
• Kiwi Extract	Short of Breath/Wheezing
• Lisinopril *cough*	Other
• Lyrica [Pregabalin] *Given w/Celebrex*	Short of Breath/Wheezing
• Maxzide [Hydrochlorothiazide W-Triamterene]	Rash/Itching
• Sulfa Antibiotics	Rash/Itching
• Sulfites [Sulfites]	Rash/Itching
• Xalatan [Latanoprost] *eye itching*	Other
• Zocor [Simvastatin] *myalgia*	Other
• Chestnuts *water chestnuts*	Swelling, generalized

I personally reviewed the patient's history as listed above from the electronic medical record on 10/11/2015.

Review of Systems:
Constitutional: Denies fevers, generalized weakness, fatigue
Neuro: Denies headaches, dizziness, numbness
HEENT: Denies tinnitus, decreased hearing, or difficulty swallowing
Cardiac: Denies chest pains, palpitations

Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

Pulmonary: Denies cough, shortness of breath
Gastrointestinal: Denies abdominal pains, nausea/vomiting, diarrhea/constipation
Genitourinary: Denies urinary incontinence
Hematologic/Lymphatic: Denies excessive bruising or bleeding
Musculoskeletal: Denies back pain, joint pain, swelling in the joints, or arthritis
Skin: Denies any skin infections
Psych: Denies feeling depressed, anxious, or memory loss

Review of Systems negative except for the following: feet numbness, back pain, leg pain

Physical Examination:
Vital Signs: BP 116/57 mmHg | Pulse 53 | Temp(Src) 97.5 °F (36.4 °C) (Oral) | Resp 18 | Ht 172.7 cm (5' 8") | Wt 125.193 kg (276 lb) | BMI 41.98 kg/m2 | SpO2 99% | LMP 11/28/2010

- **General:** Well developed, well nourished; in no acute distress, lying in bed with lights off
- **Head:** Normochepalic, Atraumatic
- **Eyes:** No scleral icterus; pupils are round; equal in size, extraocular eye movements are intact
- **ENT:** Ears and nose are grossly normal upon inspection
- **Neck:** Supple; non-tender
- **Lungs:** unlabored breathing
- **Extremities:** No lower extremity edema appreciated.
- **Skin:** Warm, dry, no sores, rashes, lesions noted
- **Musculoskeletal:** Full range of motion of the upper/lower limbs; Strength is 5/5 in the bilateral upper and lower extremities.
  1. negative SLR bilaterally
- **Neurologic:** Cranial Nerves II-XII are grossly intact; sensation intact x lower extremities
- **Psychologic:** Patient's affect and mood are congruent with situation

Recent selective lab results (may not include all current labs):

WBC	Hgb	Hct	Plt
NA	K	Cl	CO_2
BUN	Creat	Glucose	
PT	PTT	INR	

Diagnostic Studies:
MRI of the lumbosacral spine without contrast October 9, 2015.
Indication:

Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

Low back pain with radicular symptoms.
Based located on the left side of the lower back. There is left-sided sciatica.
The examination consisted of sagittal and axial T1-weighted and turbo spin-echo T2-weighted images and sagittal STIR images of the entire lumbosacral spine.
Findings:
The vertebral heights are well-preserved.
Moderate degenerative disc disease noted at T12-L1 with evidence of paracentral small disc extrusion extending slightly to the left. The neural foramina are preserved.
Mild degenerative disc disease at the L1-L2 associated with mild degenerative change of the facet joints.
Mild degenerative disc disease at L2-L3 level associated with moderate degenerative change of the facets with hypertrophy of ligamenta flava leading to mild central canal stenosis. The neural foramina are preserved.
Moderate degenerative disc disease at L3-L4 level associated with severe degenerative changes of the facets, hypertrophy of ligamenta flava, and severe central canal stenosis. There is severe stenosis of L3-L4 neural foramen on the right side and mild stenosis on the left.
Severe degenerative disc disease at L4-L5 associated with discogenic vertebral changes Modic type II. There is disc extrusion at this level and moderate stenosis of the central canal. There is evidence of laminectomy of L4 on the left. There is moderate stenosis of the L4-L5 neural foramen on the right.
Degenerative disc disease at L5-S1 level with central disc extrusion associated with severe degenerative changes of the facets and hypertrophy of ligamenta flava leading to severe central spinal canal stenosis. There is evidence of L5 laminectomy on the right. There is severe stenosis of bilateral neural foramina. There are discogenic vertebral changes Modic type II at this level as well.
The spinal cord and conus medullaris appear normal.
Conclusion:
Multilevel mild, moderate and severe stenosis of central spinal canal associated with multilevel stenosis of neural foramina, worse on the right side.
There is evidence of laminectomy of L4 on the left and L5 on the right.
Discogenic vertebral changes Modic type II at L4-L5 and L5-S1 levels.
Disc extrusions and disc protrusions noted at multiple levels.
Please see detailed discussion above

Final

Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

Assessment:
Acute lumbar radicular pain
Hx of Laminectomy 20 yrs ago x 2 by Dr. Olson at L4-L5 and L5-S1

Recommendations:
Agree with PT evaluation
Agree with Decadron
Can continue current regimen of PRN Valium, Percocet, and IV Dilaudid
Stop Toradol IV (last dose last night) prior to procedure
Recommend Lumbar epidural vs Caudal epidural tomorrow either at BHC pain clinic if discharged today or PM on 10/12/15 inpatient if still in hospital (We will follow up with her to coordinate)

Thank you for allowing us to assist in the care of your patient.

Daniel Sapeika, MD

On Call Pain Pager at Royal Oak - 52009
On Call Pain Pager at Troy - 52010

Attribution Key
Attribution information is not available for this note.

Progress Notes

Progress Notes by Keiser, Megan, RN NP-C 10/10/15 0906

Author: Keiser, Megan, RN NP-C | Service: Neurosurgery | Author Type: Nurse Practitioner
Filed: 10/10/15 0909 | Date of Service: 10/10/15 0906 | Status: Signed
Editor: Keiser, Megan, RN NP-C (Nurse Practitioner) | Cosigner: Olson, Ricky E, MD at 10/12/15 0923

Neurosurgery Rounding Note:

Please see full consult in Epic. Patient was seen and examined on rounds with Dr. Olson and he reviewed her MRI. No urgent neurosurgical intervention warranted at this time. Recommend starting patient on Robaxin and request anesthesia pain service consult for possible ESI. She can be discharged home and should remain on bedrest for 5-7 fays. After that time, she should start a course of physical therapy. F/u in

Red 1

Results History

CULTURE, URINE (Order 586562411)

Entry Information

Entry Date and Time	Lab Status	Entered by
10/12/2015 8:38 PM	Final result	Interface, Lab

Component Results

Component

Flag Status (Abnormal)

This report has been flagged as abnormal

Specimen Source

Urine

Culture, Urine

Culture, Urine

Streptococcus agalactiae (Group B)
>100,000 CFU/ml

Culture & Susceptibility

STREPTOCOCCUS AGALACTIAE (GROUP B)

Antibiotic	Sensitivity	MIC	Unit	Status
Ampicillin	Susceptible	0.12	mcg/mL	Final
Ceftriaxone	Susceptible	<=0.25	mcg/mL	Final
Penicillin	Susceptible	0.06	mcg/mL	Final
Tetracycline	Resistant	>4	mcg/mL	Final
Vancomycin	Susceptible	0.5	mcg/mL	Final

Entry Information

Entry Date and Time	Lab Status	Entered by
10/11/2015 5:47 PM	Preliminary result	Interface, Lab

Component Results

Component

Flag Status (Abnormal)

This report has been flagged as abnormal

Specimen Source

Urine

Culture, Urine

Culture, Urine

Streptococcus agalactiae (Group B)
>100,000 CFU/ml
-susceptibility to follow

Entry Information

Entry Date and Time	Lab Status	Entered by
10/10/2015 11:12 PM	In process	Interface, Lab

Entry Information

Entry Date and Time	Lab Status	Entered by
10/10/2015 9:10 PM	In process	Interface, Lab

BEAUMONT HEALTH
ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

Lab Results (continued)

URINALYSIS [586475056] (Abnormal) (continued)
Resulted: 10/09/15 2323, Result status: Final result

Comment	Oxalate see below	—	—

Comment: Microscopic manually verified.

Additional Resulting Lab Information
Received: 201510092254

URINALYSIS [586562410] (Abnormal)
Resulted: 10/10/15 2201, Result status: Final result

Ordering provider: Warner, Janay, PA-C 10/10/15 1349 Resulting lab: LABORATORY INFORMATION SYSTEM

Dt/Tm Coll

Type	Source	Collected By
—	—	9BROY 10/10/15 2109

Components

Component	Value	Reference Range	Flag
Color	DkYellow	—	—
Clarity	Clear	—	—
Glucose	Negative	Negative	—
Bilirubin	Negative	Negative	—
Ketones	Trace	Negative	A
Specific Gravity, Urine	1.030	1.005 - 1.030	—
Blood	Trace	Negative	A
pH	6.0	5.0 - 8.0	—
Protein	Trace	Negative	A
Urobilinogen	1.0	0.2 - 1.0	—
Nitrites	Negative	Negative	—
Leukocyte Esterase	2+	Negative	A
RBC	5	0 - 3 /hpf	H
WBC	>100	0 - 5 /hpf	H
Epithelial, Squamous	21	/lpf	—
Casts, Hyaline	18	0 - 2 /lpf	H
Bacteria	Negative	Negative /hpf	—

Additional Resulting Lab Information
Received: 201510102142

CULTURE, URINE [586562411] (Abnormal)
Resulted: 10/12/15 2038, Result status: Final result

Ordering provider: Warner, Janay, PA-C 10/10/15 1349 Resulting lab: LABORATORY INFORMATION SYSTEM

Dt/Tm Coll

Type	Source	Collected By
—	Urine	9BROY 10/10/15 2110

Components

Component	Value	Reference Range	Flag
Flag Status	This report has been flagged as abnormal	—	A

Lab Results (continued)

CULTURE, URINE [586562411] (Abnormal) (continued) Resulted: 10/12/15 2038, Result status: Final result

Specimen Source	Urine	—	—
Culture, Urine	--	—	—
Culture, Urine	--	—	—

Result:
Streptococcus agalactiae (Group B)
>100,000 CFU/ml

Additional Resulting Lab Information
Received: 201510102312

IMG Results

LUMBOSACRAL SPINE MINIMUM 4 VIEWS [586475832] Resulted: 10/09/15 1812, Result status: Final result

Ordering provider: Joseph, Amy E, PA-C 10/09/15 1739 Resulted by: Donovan, Kent R, MD
Performed: 10/09/15 1809 - 10/09/15 1809 Resulting lab: MISYS
Performing Department: RAD GEN EC RO
Diagnosis: Left-sided low back pain with left-sided sciatica [M54.42 (ICD-10-CM)]
Narrative:

```
Lumbar spine

Indication: Back pain

5 images were obtained. There is moderate disc narrowing at L4-5 and L5-S1
with endplate sclerosis and marginal spurring. There is no compression
deformity; there is facet arthropathy bilaterally at L4-5 and L5-S1 without
spondylitic defects. There is osteopenia. There is a 2 mm anterolisthesis of 3
upon L4.
```

Accession #

ID	Type	Source	Collected By
A17143204	—	—	10/09/15 1810

CT ABDOMEN/PELVIS NO CONTRAST KIDNEY STONE PROTOCOL [586475661] Resulted: 10/09/15 1823, Result status: Final result

Ordering provider: Joseph, Amy E, PA-C 10/09/15 1737 Resulted by: Donovan, Kent R, MD
Performed: 10/09/15 1810 - 10/09/15 1817 Resulting lab: MISYS
Performing Department: RAD CT EC RO
Diagnosis: Left-sided low back pain with left-sided sciatica [M54.42 (ICD-10-CM)]
Narrative:

```
CT abdomen pelvis without contrast

Indication: Low back pain

Comparison: 8/17/2015
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In the Matter Of:

MARKEL vs WILLIAM BEAUMONT HOSPITAL, ET AL.

JANAY A. WARNER, PA-C

February 26, 2019

Prepared for you by

Bingham Farms/Southfield • Grand Rapids

Ann Arbor • Detroit • Flint • Jackson • Lansing • Mt. Clemens • Saginaw • Troy

WARNER, PA-C, JANAY A.
02/26/2019

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

MARY ANNE MARKEL,

Plaintiff,

vs. Case No. 18-164979-NH

Hon. Nanci J. Grant

WILLIAM BEAUMONT HOSPITAL,
HOSPITAL CONSULTANTS, P.C.,
and LINET LONAPPAN, M.D.,
Jointly and Severally,

Defendants.

The Videotaped Deposition of JANAY A. WARNER, PA-C,
Taken at 99 Monroe Avenue, N.W.,
Suite 975,
Grand Rapids, Michigan,
Commencing at 11:58 a.m.,
Tuesday, February 26, 2019,
Before Peggy S. Savage, CSR-4189, RPR.

APPEARANCES:

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ALSO PRESENT:
Shawn Capron - Video Technician

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EXHIBITS

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Grand Rapids, Michigan
Tuesday, February 26, 2019
11:58 a.m.

PREMARKED FOR IDENTIFICATION
DEPOSITION EXHIBITS 1-10
11:58 a.m.

VIDEO TECHNICIAN: We are now on the record. This is the video-recorded deposition of Janay Warren, PA-C, being taken on Tuesday, Feb- --

MR. WARWICK: May I -- may I interrupt?

VIDEO TECHNICIAN: Yes, sir.

MR. WARWICK: It's Janay Warner.

VIDEO TECHNICIAN: Warner.

MR. WARWICK: Yes. So if you just make sure --

VIDEO TECHNICIAN: Yes, sir.

MR. WARWICK: Okay. Thanka.

VIDEO TECHNICIAN: We're now on the record in the depoaition of Janay Warner, PA-C, being taken Tuesday, February 26, 2019. The time is now 11:58 a.m. We are located at 99 Monroe Avenne, Grand Rapids, Michigan. We are here in the matter of Mary Anne Markel versus William Beaumont Hospital, et al, Case Number 2018-164979-NH. This matter is being held

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in the State of Michigan, Oakland County Circuit Court. My name is Shawn Capron, video technician.

Will the court reporter swear in the witness and the attorneys identify themselves for the record, please?

COURT REPORTER: Raise your right hand, please. Do you solemnly swear or affirm that the testimony you are about to give in this matter will be the truth, the whole truth, and nothing but the truth so help you God?

THE WITNESS: I do.

COURT REPORTER: Thank you.

MS. ALI: Muskan Ali for plaintiff.

MR. WARWICK: Don Warwick on behalf of William Beaumont Hospital.

MR. SINKOFF: Steven Sinkoff on behalf of Hospital Consultants and Dr. Louappan.

EXAMINATION

BY MS. ALI:

Q. Okay. Cau you pleaae state your full name for the record?

A. Janay Ann Warner.

Q. A-n-n?

A. Yep.

MS. ALI: Okay. And let the record reflect

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that this is the deposition of Janay Ann Warner, taken pursuant to notice and agreement between counsel as to time and place, whose testimony will be used for the purposes as allowed under our Michigan Court Rules, as well as our Michigan Rules of Evidence.

BY MS. ALI:

Q. Ms. Warner, my name is Muskan Ali, and I represent Mary Markel in this matter.

Do you understand that we are here regarding the care and treatment that was provided to Ms. Markel in October 2015, at William Beaumont Hospital in Royal Oak?

A. Yes. That's what I gathered from the -- from the record.

Q. Have you ever given a deposition before?

A. No.

Q. Okay. So I'm sure your attorney has gone over the rules of a deposition with you, but I'm going to go over a few as we sit here right now.

When I -- this is a question-answer format. When I ask a question, I ask that you respond in a -- with a verbal response so that they can record -- so that it can be properly recorded. It's human nature to, you know, nod or to do "mmm-hmm." And if I respond with "yes" or "no," I'm not trying to be rude.

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I just want to make sure that we have your answer on the record; is that fair?

A. Fair.

Q. Okay. And if you do not understand a question that I ask, please let me know; otherwise, the answer that you put on the record will be as if you have understood my question and understood that -- strike that -- that you have understood my question, fair?

A. Fair.

Q. Okay. And I will do my best to make sure I allow you to finish a question before I proceed with my next question. But if at any time you have not finished an answer, please let me know and I will give you the opportunity to finish the answer; and vice versa, please let me finish my question before you start your answer. Good?

A. Okay.

Q. Okay. So you have provided us with your curriculum vi- -- vitae, and I've marked that as Exhibit 10. So we're going to start backwards a little, and we're going to go into a few of your background questions.

And you told me you have not done a deposition before?

A. Correct --

Q. Have you --

WARNER, PA-C, JANAY A.
02/26/2019

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A. -- I've never done one.
Q. Okay. Have you ever been named as a defendant?
A. No.
Q. Okay. So you obtained your bachelor of science from Alma College in 2003?
A. Correct.
Q. Okay. And then did you immediately begin your physician assistant program at University of Detroit Mercy?
A. Yes.
Q. Okay. And when did you graduate?
A. In 2005. I think it was August 2005.
Q. Okay. It was a three-year-long program?
A. It was two years.
Q. Okay. Did that include the clinical rotations?
A. Correct.
Q. Okay. Did you do clinical rotations in family medicine?
A. Yes, among other things.
Q. Actually, can you tell me which -- which areas of medicine did you do your rotations in?
A. I'm not sure if I'm going to remember them all, but we did ER, we did family practice, pediatrics, OB-GYN, surgery, radiology, cardiology, dermatology.
Q. Okay. And were you a full-time student or were you

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also working?
A. Full-time student.
Q. When did you take the physician assistant certified exam?
A. I -- I mean, it was sometime that summer of 2005. I wouldn't be able to remember exactly what month.
Q. Okay. And did you only take it once?
A. Yes.
Q. Okay. And you were certified in the summer of 2005?
A. Correct.
Q. And then did you receive the state license --
A. Correct.
Q. -- right away?
A. Yes.
Q. Okay. Have you had to recertify?
A. Yep. Twice.
Q. Okay. What years?
A. I -- it's every six years. So I would have done it, yeah, six years after 2005, and then --
Q. So I'm going to say --
A. -- another six.
Q. -- 2011.
A. And then recently, I think, I just recertified --
Q. 2017?
A. -- 2017. Yeah.

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Q. And for each recertification, did you pass the first time?
A. Yep.
Q. Okay. Did you immediately begin working with William Beaumont Hospital after becoming certified as a P.A.?
A. No. I worked first at a pediat- -- pediatric office.
Q. How long were you there?
A. For a couple years, and then I started with Beaumont in 2007.
Q. Okay. And I believe off the record you said you -- you have moved to Grand Haven recently, correct?
A. Correct.
Q. And how long have you been in this area now?
A. We moved here October of 2017.
Q. Okay. So from 2007 to 2017, were you consecutively working -- were you an employee of William Beaumont Hospital?
A. Yes, and I'm still employed there.
Q. Okay.
A. Just now, as a contingent employee, since I live over here.
Q. Okay. From 2007 to 2017, were you at the Royal Oak campus?
A. Yes.
Q. Okay. When you began working at William Beaumont

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Hospital in 2007, what area of medicine were you a P.A.?
A. I've always been in the emergency room.
Q. Do you have any teaching responsibilities?
A. We precept students, P.A. students, and sometimes medical students.
Q. What does "precept" mean?
A. So like when I did my rotations as a P.A. student, we have pre-arranged assignments; so we -- you know, we help out local schools, typically, as Wayne State and University of Detroit Mercy, but we have P.A. students from -- from all of the schools, really, in Michigan. So they do a rotation with us for about a month --
Q. Okay. Perfect. That was my next --
A. -- and work shifts with us. Yeah.
Q. Perfect. Thank you.
So, briefly, what are your responsibilities as a physician's assistant in the emergency department?
A. So we see patients. We, yeah, assess and diagnose and treat patients as part of the ER team.
Q. Who is a part of that ER team that you just mentioned in terms of medical providers?
A. Yep. So we work alongside our attending physician, and, typically, yeah, it's a -- so you're -- you're

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not counting -- like, I mean, we work with the nurses, as well, and ...

Q. So the ER team you referred to, correct me if I'm wrong, it would include you -- I mean, a physician's assistant, the attending physician, it would include the ER nurses --

A. Correct.

Q. -- and --

A. And a tech.

Q. -- and techs --

A. Yeah.

Q. -- nursing assistants, fair?

A. Fair.

Q. Okay. And the description you had where you assess, diagnose, as part of an ER team, and treat the patient in an emergency department, that was the same in 2015 for you, the same responsibilities?

A. Cor- -- in 2015?

Q. Yes.

A. Correct.

Q. In the year 2015.

Okay. When you round on patients, what does that cons- -- what does that mean to you as a physician's assistant?

A. So can you clarify the question? I mean, are we

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talking specifically about in a certain area of the ER or ...

Q. When -- okay. Say in a patient -- patient has been assigned to you --

A. Okay.

Q. -- and you have to round on that patient, what would you do -- what would "rounding on the patient" mean to you?

A. So the only area in the ER that we would round on patients is our observation area. We don't round on patients in any other area of the ER.

Q. Okay. So what is the observation area?

A. So the observation area is a 21-bed area within the observation -- or within the emergency room where patients are placed because they don't necessarily meet admission criteria but we don't feel comfortable letting them go home. They're not ready to be discharged; so they're either waiting for a consultant or waiting for a test. And so that's the only area that a patient would have someone round on them.

Q. What does "admission criteria" mean?

A. If -- if they're sick enough to warrant -- if they're not stable for discharge home.

Q. When you round on your patients in the observatory area of the emergency department --

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A. Mmm-hmm.

Q. -- do you report -- do you have clinical findings as well as physical examinations?

A. So, basically, the plan has already been set up by the initial providers who saw the patient in the ER; so they saw the patient, assessed the patient, formulated a diagnosis, and then they decided to transfer the patient to the observation area. So when working in the observation area, we are following their plan.

And when we round on a patient, we come in at 6:00 a.m., and we look up all our patients from six to seven, the P.A. does, and then we round with our attending physician starting at seven on the -- however many patients are in the unit.

Q. And the --

A. And we just make sure that we're aware of the plan, the patient's aware of the plan.

Q. When you round with the attending, do you -- at 7:00 a.m.?

A. We usually start rounds at seven, mmm-hmm.

Q. And the description that you just provided to me, where you round with the attending where the plan is set by the initial providers --

A. Mmm-hmm.

Q. -- was that true for -- was that the same case in

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2015?

A. Correct.

Q. Okay. Can you put in orders for the patients that you examine?

A. Yes.

Q. And are there any limitations to those orders?

A. What do you mean "limitations"?

Q. As opposed to a physician. Can you put in the same orders that a physician could for a patient?

A. Yes.

Q. Okay. And was that the same in 2015?

A. Yes.

Q. Okay. What EMR system does William Beaumont Hospital have?

A. Epic.

Q. Okay. And do you have access to everything that a physician would have access to in the EMR for a patient?

A. I should.

Q. And was that the same in 2015?

A. Yes.

Q. Okay. So in 2015, during your shifts, when you come in at -- was it 6:00 a.m.?

A. Yes.

Q. Okay.

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A. If I'm working in the obs area.
Q. Okay.
A. There's different shift times. But if you were working in obs, it starts at six, or there's a 10:00 shift, as well.
Q. So if it's the 10:00 a.m. shift, would that go to 11:00 p.m. then?
A. Ten to ten.
Q. Okay. So in 2015, during your shifts, when you come on, you know, come in for your shift, do you log into the EMR system --
A. Yes.
Q. -- the Epic system?
A. Yes.
Q. Okay. And do you have access to the Epic charts for your patient?
A. The Epic charts for my patient that I'm signing into?
Q. Yes.
A. Yes, if it's -- if I'm going to sign up for a patient, then I have access to their chart.
Q. Okay. And so correct me if I'm wrong, but you have access to the same Epic charts that the attending physician would have access to, correct?
A. Yeah. I don't see why it would be any different.
Q. Okay.

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A. I've never been told it's different.
Q. Okay. And when you log on, you have a patient list; is that true?
A. Are we talking -- if we're talking about the observation area, correct. If we're talking about other areas, then I would just see patients as I sign up for them.
Q. Okay. Okay. So I'm going to tell you what I just understood and then correct me if I'm wrong.
A. Okay.
Q. If you're in the ob- -- obser- -- observation area, you have a patient list; so when you log on, you can access the -- the patients?
A. Or -- yeah. So, basically, if I am working in the observation area, I have 21 beds that I sign into that area, and those are the patients in my area.
Q. Okay. So on any given day, you wouldn't have more than 21 patients?
A. That would be the max, yeah. That's the capacity for the unit.
Q. Okay. And -- strike that.
So once you became a P.A., you were trained to -- when you come on your shift and you're in the observation area -- to log onto the EMR system and to access your patients' charts, correct?

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A. Correct. We can see who is in the unit, mmm-hmm.
Q. Okay. And if there's any outstanding labs or radiology results or anything for a patient that's outstanding that has been ordered earlier, you would access those, correct?
A. If it's already been -- what do you mean? I can see everything that's been ordered, correct, and any of the lab results.
Q. Okay. So, hypothetically, you come in, you had a patient that was discharged and there's outstanding lab work that you had ordered and it has not come in but the patient has been discharged, would you go into the system when you come on your shift and access the outstanding results?
A. No.
MR. WARWICK: Just object to the form of the question. It's too vague. Go ahead.
THE WITNESS: Yeah. I'm not understanding -- so I only see the patients that are in the unit at the time. I don't see who's been discharged from the unit. I can only see the active patients who are in the observation unit, if we're still speaking of the observation unit.
BY MS. ALI:
Q. Okay. So there's never -- there's never a time where

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you would be accessing results for a patient that has been discharged?
A. Correct. Yeah. If they're -- if they're not someone I'm taking care of, I would not open up someone's chart that is not in my -- someone that I -- is in my unit.
Q. Okay. So you -- if a pa- -- if a patient is discharged, you have nothing to do with that patient after the fact --
A. Discharged from the --
Q. -- after they have been discharged?
A. -- observation unit?
Q. Yes.
A. Correct.
Q. Okay. And so while a patient is in the observation area -- observation unit and there's outstanding lab work that is -- that still has not come back, you know, has -- the results haven't come back, you would have -- and the patient gets discharged, you would have -- you would never go back into that patient's charts to access the results?
MR. WARWICK: So just object to the form because -- well, object to the form. And if -- if you're trying to apply it to the facts of this case, this is a patient who was admitted to the hospital

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after leaving the observation unit. So I object to the form. Go ahead, you can answer the question to --

BY MS. ALI:

Q. If you don't understand my --

MR. WARWICK: And, actually, you've already answered the question, so I -- it's also been asked and answered.

THE WITNESS: So --

MR. WARWICK: You can answer it again.

THE WITNESS: No, I wouldn't be responsible for looking up any further results on a patient.

MS. ALI: Okay. Perfect.

BY MS. ALI:

Q. As a P.A., has there been circumstances where you had to contact a patient after the patient has been discharged?

MR. WARWICK: Just objection to the form.

MR. SINKOFF: From the observation unit or for any?

MS. ALI: From the observation unit.

THE WITNESS: From the observation unit? Yeah, I can think of a few examples of -- I -- when I might have called a patient. Say I was finishing a -- a chart, my -- a note, and I realized that there was like a pulmonary nodule on an x-ray and just wanted to

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communicate with the patient so that they could follow up, something like that, that I might have taken it upon myself to call them.

BY MS. ALI:

Q. Okay. And has there ever been a time where you've received critical lab results and had to contact the patient and let them know?

A. No.

Q. Okay. And -- and just so we're clear, you would not see a patient that's not in the observation room, correct? You would not be rounding or be treating a patient that's not in the observation room?

A. No. I work in all areas of the ER.

Q. Okay. And --

A. So I'm only in the ob- -- the observation unit when I'm assigned to be there, but it's not every shift. I -- all of the ER staff rotates through different areas, so I'm not -- yeah.

Q. What are the other areas of the emergency department?

A. Well, they're all renamed now, because they just went through a remodel, but there used to be A, B, C, D, E, F, peds, obs, but they're all renamed now. Trauma room.

Q. And was -- were these rooms, A, B, C, D, E, F, peds, obs, trauma, were those the same -- were those areas

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of the emergency department in 2015?

A. Correct.

Q. Okay. Hypothetically, a patient is in the observ- -- obs- -- I don't know why this is so hard for me to say, but -- observation room, and there are outstanding orders that have not been -- the results have not come in yet, would it be -- to your knowledge, is it usually the physician -- the attending physician that would contact the patient who has been discharged from the observation room and let them know of the results?

MR. SINKOFF: Object to foundation.

MR. WARWICK: Same.

MR. SINKOFF: Identify what you mean by "attending physician."

BY MS. ALI:

Q. The attending physician that's rounding on the patient with you.

MR. WARWICK: So just the same objection, form and foundation, because you're not differentiating between the patient being discharged directly from ER or observation and a patient that gets admitted to the hospital and has an attending.

BY MS. ALI:

Q. Discharged to the hospital.

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A. Someone that's discharged, you're asking if the attending I rounded with would --

Q. Mmm-hmm.

A. -- would contact the patient?

Q. Mmm-hmm.

A. No.

Q. Okay.

MR. WARWICK: Just so the record is clear, it's not actually discharged to the hospital. It's admitted to the hospital.

MS. ALI: Yeah.

BY MS. ALI:

Q. Do you, as a P.A., have authorization to discharge a patient without the approval of an attending physician?

MR. WARWICK: Just object to the form. Again, you're talking direct discharge from the observation unit --

THE WITNESS: Like let them go home?

MR. WARWICK: Hold on. Hold on a second.

THE WITNESS: Sorry.

MR. WARWICK: You're talking about direct discharge from the observation unit to home?

MS. ALI: Yes.

MR. WARWICK: So I object to the relevance,

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as well, as patient -- it didn't happen in this case, so I'm not sure what we're doing here. But this is a patient who was admitted to the hospital, she had a very limited role, and then the patient was admitted. And the urine culture results itself -- the urine culture test didn't even take place until the patient was on the floor.

So, I mean, we could take four hours for this deposition, but this should be very limited question. It's very quick that she was involved in this case.

MS. ALI: I understand that. The --

MR. WARWICK: So, I mean, we're trying to --

MS. ALI: -- attending physician was --

MR. WARWICK: It doesn't make any sense to me why we're asking questions about direct discharge from the emergency center --

MS. ALI: Mmm-hmm.

MR. WARWICK: -- when the patient was not directly discharged from the emergency center. The patient was admitted to the hospital, had an attending physician in the hospital --

MS. ALI: Mmm-hmm.

MR. WARWICK: -- the urine culture results

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that you're alleging were not properly followed up on. That urine culture, that sample, wasn't even taken until hours after P.A. Warner had any role whatsoever in this case.

MS. ALI: The urine cultures were ordered by Ms. Warner.

MR. WARWICK: Right, and then the -- the actual urine cultural sample itself took place on the floor. This has nothing do with a patient who gets discharged directly from the EC, has nothing to do even -- you know, I could continue this objection. I just want to cut to the chase a little bit on this, because it doesn't make any sense to ask those kind of questions.

MS. ALI: We can have a -- an objection as to any questions. You can place --

MR. WARWICK: Well, what's the point?

MS. ALI: You can place --

MR. WARWICK: What's the point?

MS. ALI: You can place an objection.

MR. WARWICK: No, I object to the form of the question, because it's completely irrelevant as it relates to --

MS. ALI: That's --

MR. WARWICK: -- the case.

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MS. ALI: Okay. So you can have an objection as to any questions regarding a discharge from the obser- -- observation room to home.

MR. WARWICK: It's not whether --

MS. ALI: We can have --

MR. WARWICK: -- I can have an objection.

MS. ALI: -- a continuing objection.

MR. WARWICK: It's not whether I can have an objection. It's that if I object to the form --

MS. ALI: But if --

MR. WARWICK: -- I think you have a responsibility then, under the court rules, to say why it is relevant, because it's completely irrelevant to the case.

MS. ALI: It -- irrelevancy is up -- is up for me to decide.

MR. WARWICK: No, it's not.

MS. ALI: And anything is --

MR. WARWICK: It's really up to the judge to decide.

MS. ALI: Okay. So that's fine, we can take that up to --

MR. WARWICK: Okay.

MS. ALI: -- the judge. You can object as you -- as you wish.

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MR. WARWICK: Well, what's the point? If I --

MS. ALI: That's --

MR. WARWICK: -- object to the form of the question about someone and you're asking questions over and over again about discharge from the -- the observation unit when that didn't happen in this case, what's the possible, conceivable relevance? And --

MS. ALI: She --

MR. WARWICK: -- the standard is whether it's reasonably calculated to lead to the discovery of admissible evidence. What's the possible relevance in this case? And we've done it for 15 minutes now.

MS. ALI: You can object and have a standing objection, and we can -- if you want, you can file a motion and we can take this up to the judge. I'm allowed to ask whatever I want from the deponent. So as long as --

MR. WARWICK: Well, you're really not allowed to ask whatever you want --

MS. ALI: That's fine, but --

MR. WARWICK: -- from the deponent.

MS. ALI: So are you telling your -- your client to not answer my question? Because I --

MR. WARWICK: No. I'm asking you to ask

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relevant --
MS. ALI: Okay.
MR. WARWICK: -- questions.
MS. ALI: So if you want, that's fine, you can place an objection on the record.
MR. WARWICK: Okay.
MS. ALI: Okay.
BY MS. ALI:
Q. Anyway, my question was, Ms. Warner, as a physician assistant, are you authorized to discharge a patient from the observation room to -- without the approval of an attending physician --
MR. WARWICK: Just --
BY MS. ALI:
Q. -- discharge home?
MR. WARWICK: Same, form, foundation. Go ahead and answer it again.
THE WITNESS: So, yes, if there is, hypothetically, a patient that has completed the testing or the plan that was set forth and there were no other reasons to keep the patient, say they completed a stress test and it was normal, then, yes, I can discharge them home.
BY MS. ALI:
Q. Okay. And do you have a State of Michigan Controlled

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Substance License?
A. Yes.
Q. Okay. And did you have one in 2015?
A. Yes.
Q. Okay.
A. Well, I think so. I forget when that first came out. I've always had a DEA license to prescribe narcotics, but I know that the Controlled License -- the Controlled Substance License is more recent that the State required that. I can't actually say a hundred percent when that -- when that started.
Q. Okay. So we are on Exhibit -- I believe this is what it was. Yep. So -- okay. Actually, one moment.
So if you're taking care of patients in the observation room and you suspect there is an infection, what course of treatment do you proceed with as a physician's assistant?
MR. WARWICK: Just objection to the form.
THE WITNESS: What type of infection?
BY MS. ALI:
Q. If --
MR. WARWICK: Grossly overbroad.
BY MS. ALI:
Q. If --
MR. WARWICK: Go ahead.

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BY MS. ALI:
Q. If you fear that there may be an infection, that there's inflammatory responses in the patient, how do you go about with the treatment for the patient? Do you prescribe antibiotics?
A. I mean, that's really vague. It could be -- there's so many different scenarios that that could fit.
Q. Mmm-hmm. So say a patient is pre- -- strike that.
So this is marked as Exhibit 1. I'm going to hand -- actually, you have a copy of Exhibit 1 in front of you.
A. Okay.
Q. Okay. So this is on -- what -- what does this sheet tell you?
A. To me, it tells me the time line of the patient's care, kind of a time line of when she came into the ER and --
Q. Does it also tell you the providers that were participating in the care and treatment of Ms. Markel?
MR. WARWICK: Just objection to foundation, but go ahead. You can speak for yourself.
THE WITNESS: It looks like there's a lot of names listed here, people that were in her chart, yes.
BY MS. ALI:

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Q. Okay. So do you see your name towards the bottom of the page?
A. Yes.
Q. Okay. And the Treatment Team, the -- underneath that, where it says "Role," what does "Physician Extender" mean?
A. That's --
Q. If you know.
A. That's just identifying me as a P.A.
Q. Okay. And the specialty for you is emergency medicine?
A. Correct.
Q. Okay. And the "Active From" and "Active to," I'm seeing dates 10/10/2015 at 6:38 a.m. --
A. Correct.
Q. -- to 10/10/2015 at 2:04 p.m.?
A. Correct.
Q. Okay. And what does that tell me?
A. So that tells me that I first accessed the patient's chart at 6:38, probably she was halfway through my list of people I was looking up in the morning when I came in, and it looks like I last accessed the patient's chart around 2:00, right before she was admitted.
Q. And when you say "admitted," do you mean --

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A. Or transferred --
Q. Okay.
A. -- I'm sorry, to the floor.
It looks like I admitted her at 12:18, or I placed the admission orders.
Q. And where did you get this admitted information from?
A. I think it's on one of your exhibits. Let's see. Yeah. It's on Exhibit 8. Or, sorry, 9.
Q. And you're referring to the orders, page 138, Exhibit 9, where the first order on the page is "Admit without TMS"?
A. Correct.
Q. Okay.
A. At 12:18.
Q. And where were you admitting Ms. Markel?
A. Where, as in to -- I mean, to the hospital? What do you mean?
Q. Yep. Where -- in a specific area of the hospital? Where was she being admitted?
A. I wouldn't know what area she would go to. But yeah, I was admitting her to the medicine team at Beaumont Hospital.
Q. What do you -- who do you mean by "medicine team"?
A. It looks like Hospital Consultants or Haas/Wease.
Q. What have you reviewed for your deposition today?

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A. I reviewed this, the records.
Q. Okay.
A. And, actually, these are just the same. They're just my charting pulled out of the records and Dr. Lonappan's charting pulled out of the records, and then I was given a copy of Dr. Lonappan's deposition, as well.
Q. Okay. And who provided these -- this information to you?
A. My attorney.
Q. Did you take any notes?
A. No. I put --
Q. I see tabs -- I see stickies in there.
A. Yeah. They're almost exactly the same as your exhibits.
Q. Okay.
A. It was just for ease of reference, because it was hard to find my -- where my notes were.
Q. Have you gone back into the electronic medical records of Ms. Markel since you received the Notice of Intent?
A. No.
Q. Okay. And outside of the records that you have reviewed on Dr. Lonappan's deposition, do you have any independent memory of Ms. Markel in October 2015?
A. No, I don't.

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Q. Okay. And -- and based on your review of the records, can we agree that Ms. Markel presented to the emergency department in -- on October 9, 2015, of William Beaumont Hospital?
A. Yes. She came to the ER.
Q. Okay. And she was taken to the observation room at 11:12 a.m., on October 9, 2015, is that true, based on --
A. At what time?
Q. At 11:12 a.m., which is on Exhibit 2. I'm referring to Exhibit 2.
A. Okay.
Q. I didn't know if that was entered by --
A. I have to look.
Q. -- Nurse Shannon Davis, towards the ba- -- the bottom. ED observation -- I mean -- yeah, nurse notes by Shannon Davis.
A. Okay. Yeah, it looks like she arrived pretty late that night --
Q. Mmm-hmm.
A. -- at 11:45 p.m.
MR. SINKOFF: Just object to the form of the question. 1112 is the room number.
MS. ALI: Oh, I see.
MR. WARWICK: Yeah, exactly.

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MS. ALI: I understand. Thank you.
MR. WARWICK: Same objection.
BY MS. ALI:
Q. Going back to Exhibit 1 that we were looking at earlier, who was the attending provider based on this sheet?
MR. SINKOFF: Where?
MR. WARWICK: Just object to the form.
MS. ALI: On the first page.
MR. SINKOFF: Where?
MS. ALI: For Ms. Markel.
MR. SINKOFF: Attending where?
MS. ALI: Attending in the William Beaumont Hospital.
MR. WARWICK: No. So --
MR. SINKOFF: Where?
MR. WARWICK: -- objection to the form. You mean in the --
MR. SINKOFF: In the emergency department? In the observation --
MR. WARWICK: You mean the observation unit?
MR. SINKOFF: -- unit? On the floor? Where?
MS. ALI: In the emergency department.

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MR. SINKOFF: Thank you.
THE WITNESS: It looks like --
MR. WARWICK: So wait. So let me --
THE WITNESS: Okay.
MR. WARWICK: -- make sure. Objection to the form and foundation. You can -- if you can glean from the record in the emergency department, you can tell her what your understanding is from the record; otherwise, you can tell who -- who the attending was in the observation unit in the emergency department when you were involved.
THE WITNESS: Which -- am I understanding the question? Do you want to know who saw her in the emergency room?
MS. ALI: Yes, please.

BY MS. ALI:

Q. Who was the attending physician assigned to Ms. Markel in the emergency department, if you can -- if you can tell me that, based on this sheet of paper?

A. Based on --

MR. WARWICK: Just a minute.
THE WITNESS: Yeah.
MR. WARWICK: Just object to the foundation, but go ahead, based upon the record.
THE WITNESS: I mean, just reading the record, it looks like Dr. Hang saw her initially in the emergency room on 10/9, with Amy Joseph.

BY MS. ALI:

Q. And that would be the ER team you -- you referred to before, where a P.A. is assigned to an attending physician; is that true?
MR. WARWICK: Just object to the form. I -- go ahead. I think she was referring to her involvement, but go ahead and answer the question.
THE WITNESS: I'm getting confused, so --
MS. ALI: That's okay. We can strike that question.
THE WITNESS: Okay.
MS. ALI: No worries. Yep.

BY MS. ALI:

Q. Do you know who Dr. Linet Lonappan is?

A. I know who she is.

Q. Okay. Have you worked with her before?

A. I believe I've spoken to her on the phone before. She's -- Hospital Consultants takes a lot of admissions from the ER.

Q. Okay. And since her deposition, have you had -- since the notice -- since you received the Notice of Intent, have you had any discussions with her regarding this case?

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A. No.

Q. Regarding anything?

A. No.

Q. Okay. In October 2015, what were your shifts, if you recall?

A. Like what were the different shifts that I might work?

Q. Yeah.

MR. WARWICK: Just foundation. Go ahead.
THE WITNESS: Yeah, that would be --
MR. WARWICK: Form -- form -- I should say form of the question, but go ahead.
THE WITNESS: I think --
MR. WARWICK: You mean in the ER or in observation?
MS. ALI: In the observation.
THE WITNESS: Oh, observation. So there were only two shifts in the observation unit. There was a 6:00 a.m. to 4:00 p.m. shift, and then there was another ten to ten -- 10:00 a.m. to 10:00 p.m. shift, but there were lots of other shifts within the ER in the different areas.

BY MS. ALI:

Q. And it would be dependent on the different departments in the ER, correct?

A. Correct, what times they were, yeah.

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Q. Okay. And based on your review of the records of Ms. Markel, can you tell me what shift you were on in October 2015, when you were providing care and treatment to her?

A. Yeah. I can tell I was the 6:00 to 4:00 shift, because I was, yeah, reviewing her chart at 6:00 a.m.

Q. Okay. And when did you first start taking care of Ms. Markel?

A. Well, my shift is from six to four, so I would be, yeah, caring for the patients in that area --

Q. Okay.

A. -- during those hours. So, I guess, maybe -- I can't -- I don't know exactly the first time I would have seen Ms. Markel, but I'm assuming it was 8:08, is when I opened a note on her.

Q. Mmm-hmm.

A. So I'm assuming it was just after 8:00 a.m. that I met her.

Q. Okay. So were you solely in the observation room on that day?

A. Correct. That shift is in the observation area only.

Q. I believe you referred to a note at 8:08 a.m., correct? You referred to a note that you --

A. Yeah, that's the first time.

Q. So that's -- can you go to Exhibit 3, please? Is that

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the note you were referring to?
A. Correct.
Q. When was this note entered into the electronic medical record system?
MR. WARWICK: Just object to the form. To the best you can answer it, go ahead.
THE WITNESS: So as we round on all of our patients, we open a note on everyone.
MS. ALI: Mmm-hmm.
THE WITNESS: So we open and start our note, but we don't complete it until the plan is complete.
BY MS. ALI:
Q. Okay. So 10/10/15 0808, what does -- what does that tell me, if I'm looking at your note?
A. So that tells me that's probably when we saw the patient and we opened the note.
Q. Okay. And I'm going a little bit further down from where it says, "ED Obs Provider Notes By Warner, Janay, PA-C," where it, in bold, has "Observation Note."
Does that tell me that this is a note because you're in the observation area?
A. Yeah. I would assume it's just -- yeah.
Q. Okay. So I'm reading: "The Observation Physician has

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reviewed the following: EC records, observation records and nursing notes."
Who is the observation physician for Ms. Markel?
A. Dr. David Berger.
Q. And he's the cosigner of this note?
A. Correct.
Q. Okay. What are the EC records?
A. The EC records would have been what Dr. Hang and Dr. -- and Amy Joseph would have completed.
Q. And how -- if you know, how did the past medical history and past surgical history get into your observation note, or is that just normal for the history and the -- the history of the patient to be part of that note when you go in and put your note in?
A. Correct, it's prepopulated.
Q. Okay. So I'm looking at page 26, which is the third page of Exhibit 3. And towards the middle of the page, I see that there's a "WBC 13.8," and it's in bold. And underneath it, there is a "UA awaiting repeat."
Can you tell me what that means to you?
A. So, yeah, I just summarized the patient's course in the EC observation area, and I usually just write down any labs that -- yeah, that I would -- that were done

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in the observation area. I probably wanted them to know that the urine was not done yet --
Q. Okay.
A. -- for some reason, so I put it await -- awaiting repeat.
Q. Okay. And the "WBC 13.8" --
A. Mmm-hmm.
Q. -- that's white blood count 13.8?
A. Correct.
Q. Okay. And that -- that was significant to you?
A. It could be. I think I just must have put it down to be complete.
Q. Okay. 13.8 is a high white blood count, correct?
MR. WARWICK: Just objection to the form.
MR. SINKOFF: Join.
BY MS. ALI:
Q. Is a 13.8 white blood count high?
A. It's with -- it's outside of the normal range that Beaumont sets.
Q. And what is the normal range?
A. I'd have to look.
Q. Could you --
A. Is that on one of the --
Q. Is it fair to say that you included it in your note because it's outside the normal range?

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A. Correct.
Q. Okay. And towards -- underneath the white blood count 13.8 --
MR. WARWICK: So -- I mean, not to interrupt you.
MS. ALI: Mmm-hmm.
MR. WARWICK: I apologize. But your Exhibit 6 does reference the -- the range, if you are interested in that.
MS. ALI: Oh, thank you.
MR. WARWICK: Yeah.
BY MS. ALI:
Q. What is the normal reference range?
A. So it looks like for Beaumont, it's 10.7, is the high end --
Q. Okay.
A. -- 3.3 is the low end.
Q. So in your note where it says white blood count 13.8 for Ms. Markel, that's high, correct --
MR. WARWICK: Just objection to form.
BY MS. ALI:
Q. -- based on the range that William Beaumont Hospital has given and provided?
MR. WARWICK: Just --
THE WITNESS: So I'm indicating that it's

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abnormal outside the range, the reference range.

MS. ALI: Thank you.

BY MS. ALI:

Q. So I'm back to Exhibit 3. And underneath the white blood count, underneath the urinalysis awaiting repeat, I see that there's a treatment plan. And would that treatment plan have been made by you and the attending physician?

A. It looks like -- oh, the treatment plan --

Q. That's in your note.

A. What attending physician?

Q. Are you currently rounding with the -- on Ms. Markel in the observation room with an attending physician?

A. So we just round in the morning --

Q. Okay. And who --

A. -- on all the patients.

Q. And who would you have rounded with?

A. Dr. Berger.

Q. Okay. And this treatment plan that's in your note, who would have come up with this plan?

A. So it looks like neurosurgery, PM&R are the ones -- the specialists who kind of came up with the plan for admission; is that what you're --

Q. That's -- yep.

A. And I would be part of that, as well.

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Q. Okay. And who -- who is Haas -- okay. So I'm reading in the treatment plan. "Admit (see Order to Admit) in stable condition to Haas/Wease."

A. Yep.

Q. Who are they, if you know?

A. So I believe that that's the hospital consultant team. They're also known as Haas/Wease.

Q. Okay. And Dr. -- Dr. Lonappan then, as well?

A. I'm assuming that she works for them. That's -- yeah, that's --

MR. SINKOFF: Object to the foundation.

BY MS. ALI:

Q. Okay. I'm on the next page of Exhibit 3, and -- actually, strike that.

In your experience as a physician's assistant, why would it be important to know if a patient is having trouble urinating?

A. Specifically for this case?

Q. In general.

MR. WARWICK: Just object to the form. Go ahead. It's overbroad, but go ahead.

THE WITNESS: Yeah, that's really -- there's so many scenarios that I feel like you could talk for hours about.

BY MS. ALI:

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Q. Could -- could infection -- a suspected infection be a reason for it --

MR. WARWICK: Just objection --

BY MS. ALI:

Q. -- UTI?

MR. WARWICK: -- same, form. Unless you're talking about this patient, it's grossly overbroad.

THE WITNESS: For difficulty urinating?

MS. ALI: Yes.

THE WITNESS: Specifically with this patient?

MS. ALI: No. In general.

MR. WARWICK: So same objection to the form.

THE WITNESS: With this patient, difficulty urinating was a -- a red flag for neurogenic, potential cord compression. So, yeah, more so -- more so for something else going on with the lumbar radiculopathy.

BY MS. ALI:

Q. Okay. When you round on your patients in the observation room, do you check their lab work?

A. Yep. That's one of the things we do, we go over their labs.

Q. Okay. And you check their history?

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A. Correct.

Q. Medical? Family?

A. Correct. We kind of review everything at the bedside with the patient, myself, and the doctor.

Q. Okay. In your note that we -- it was in Exhibit -- Exhibit 3, where it says, on page 26, "UA awaiting repeat," does that tell me the urinalysis is being reordered, that there -- there's a repeat UA that needs to be done?

A. Correct.

Q. And we're awaiting the results?

A. Correct.

Q. Okay.

MR. WARWICK: Well, actually, object to the form. It says, "UA awaiting repeat." I mean, it doesn't mean waiting -- awaiting results. I think it means awaiting --

THE WITNESS: Like it --

MR. WARWICK: -- repeat --

THE WITNESS: -- hadn't been done yet.

BY MS. ALI:

Q. Okay. And I'm looking at Exhibit 3 again. And in the -- in the history, the past surgical history, it is noted that Ms. Markel had an arthroplasty of the total knee left and arthroplasty of the total knee

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right, correct?
A. Yes.
Q. And that means a total knee replacement, correct?
A. Correct.
Q. Okay. Are there any vitals noted in your obser- -- observatory note, which is marked as Exhibit 3, for the patient?
A. Inside my note?
Q. Yeah.
A. I'm not sure. I'd have to look. I don't see any in my -- inside my note.
Q. Do you usually check the vitals of a patient, as well, before --
A. Yeah.
Q. -- I mean, while you're rounding?
A. Their vitals get checked all the time in the obs area. It would be on the vital sheet, yeah.
Q. Does -- does the observation note usually have vitals listed for the patient?
A. No, not always. It's more just a summary of the -- of the course while in the ED -- or in the E- -- EC obs unit.
Q. I'm looking at Exhibit 7, and there are vit- -- there's an order for vital signs by Amy Joseph. Do you see wha- -- do you see that at the top of the

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page?
A. Yes.
Q. And the frequency is put in as "stat" ongoing, correct?
A. Correct.
Q. And why -- what does "stat" mean?
A. So it means as soon as possible.
Q. Okay. And ongoing?
A. So she would have wanted it to -- them to do vitals when the patient arrived to the observation room and then ongoing per their protocol.
Q. Okay. And what date was this order plan?
A. It looks like it's on the 9th.
Q. At what time?
A. At 19:41.
Q. I'm now on Exhibit 8.
A. 8?
Q. Yes. Page 2 -- page 135, which is the second page of Exhibit 8. And these are orders by you, correct, on the second page?
A. On the second page?
Q. Yes.
A. Yes.
Q. Okay. I'm looking at the second order from the top, which is -- oh, my apologies. I'm looking at the

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first order.
A. Okay.
Q. And can you tell me what this order is?
A. So these are just standard admission orders. There's like an order set that we use to admit a patient, and these are just standard. So the first one looks like it's telling the nurse to call -- call doctor.
Q. Mmm-hmm. And why -- what -- what would the reason be, if you can tell me?
A. This one says for temperature.
Q. Okay. And for temperature above 100.4, correct?
A. Correct, that's what the order says.
Q. Okay. And you're saying this is a standard order that you put in?
A. Yeah. It comes with all admission sets.
Q. Okay. Which is for 100.4 degrees Fahrenheit?
MR. WARWICK: Just object to the form. I want to make sure the record is clear. Tell her why -- tell her what this order means. It's not saying "this patient at 100.4 temperature." It's saying "call the physician if the patient develops a temperature above 100.4."
THE WITNESS: Correct. Yes.
BY MS. ALI:
Q. And --

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MR. WARWICK: I -- I shouldn't be asking the question, though. So can you explain that?
THE WITNESS: Yes. So these orders are just, basically, so tha nurse knows what to do if the patient develops a temperature above 100.4, then they're asking the nurse to contact a physician.
BY MS. ALI:
Q. Why -- why would you want a doc- -- a nurse to contact a doctor if a patient's temperature is over 100.4?
A. So 100.4 is what we consider a fever.
Q. Okay. And why would it be of significance if a patient has a fever?
MR. SINKOFF: Object to foundation --
MR. WARWICK: Same objection --
MR. SINKOFF: -- overbroad.
MR. WARWICK: Same objection, form and foundation.
BY MS. ALI:
Q. How about -- let me rephrase. If a patient has a high white -- white blood count and a patient has a -- over a hundred -- has a fever, would that be of significance to you?
MR. WARWICK: Just same, form --
MR. SINKOFF: Object to foundation, form.
MR. WARWICK: Same, form and foundation.

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THE WITNESS: It may not be significant, but the nurse should contact the physician to discuss it.

BY MS. ALI:

Q. And why?

A. Because the physician should be aware of any changes that are occurring with their patient.

Q. Okay. And are you familiar with SIRS?

A. Yes.

Q. Okay. And if a patient has a fever and a patient has a high white blood count, would that be significant to you?

MR. WARWICK: Just same, form and foundation.

MR. SINKOFF: Form and foundation and relevance. The patient never had SIRS.

THE WITNESS: It could be concerning, which is why they're asking the nurse to communicate with the physician and let the physici- -- physician decide if there's something further that they'd like to do.

MS. ALI: Okay. My apologies, I did not hand this earlier. This will also be marked as an exhibit.

MR. WARWICK: Well, then we should take a break and make a copy.

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MS. ALI: I think I might have enough copies here.

MR. WARWICK: Okay.

MR. SINKOFF: This is 11 or 12?

COURT REPORTER: 11.

MS. ALI: And, of course, I do not.

MR. WARWICK: Is that the same as this or --

MR. SINKOFF: I have three pages starting October. 135, 136, 137. Exhibit 12?

COURT REPORTER: 11.

MS. ALI: We're going to mark this as Exhibit --

COURT REPORTER: Here it is.

MS. ALI: Thank you -- 11. Oh. You have it as 135, 136, 30- -- 137?

MR. SINKOFF: I do.

MS. ALI: Thank you.

MARKED FOR IDENTIFICATION
DEPOSITION EXHIBIT 11
1:02 p.m.

BY MS. ALI:

Q. Okay, Ms. Warner, I'm looking on Exhibit 11, page 135, 136, and 137. And we just reviewed, on the top, the first order said to call -- that you entered -- you entered an order where the nurse needs to call the doctor if the patient's temperature goes over 100.4 degrees, correct?

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A. Correct.

Q. Okay. And now I'm looking at page 136. And towards the bottom, the last order on this page, was that by you?

A. The order for UA?

Q. Yes.

A. Yes. That's also part of the standard admission order set.

Q. Okay. So can you read to me what this order is?

A. It says, "Order UA and urine culture and sensitivity for new onset dysuria (non-catheterized patients only)."

Q. Okay. "New onset dysuria," am I saying that correctly?

A. Dysuria.

Q. Dysuria. It's -- I'm not going to say it correctly. As long as you know what I'm talking about.

And so you're saying this is typical -- typically put into a patient's records -- orders?

A. Yes. It comes up with all admission orders.

Q. Okay. So this order does not tell me that there was a new onset dysuria for the patient?

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A. Correct. It's telling the nurse, please order a urine if there's new onset dysuria that the patient is complaining of.

Q. Understood. And it would be under the discussion of the nurse to place this order then -- I mean to --

A. I'm not sure how it works on the floor, honestly.

Q. Okay.

MR. WARWICK: Just object to foundation.

MS. ALI: Can we go off the record, please?

VIDEO TECHNICIAN: We're going off the record. The time is 1:02 p.m. We're off the record.

(Off the record at 1:02 p.m.)

(Back on the record at 1:06 p.m.)

VIDEO TECHNICIAN: We are now back on the record. The time is 1:06 p.m.

BY MS. ALI:

Q. Ms. Warner, I'm looking at Exhibit 6. These are results for Ms. Markel, correct?

A. Correct.

Q. And would you have reviewed these while you were rounding on her?

A. Correct.

Q. Okay. And I'm looking at the one -- the first one, where it's a complete blood count. And is that a normal lab result?

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MR. WARWICK: Do you mean -- which one are we talking about?
MS. ALI: The first one -- oh, my apologies. Which resulted on 10/9/2015, at 5:42 p.m.
THE WITNESS: So the very first one --
MS. ALI: The first one.
THE WITNESS: -- CBC?
MS. ALI: Yes.
THE WITNESS: So, yeah, we already discussed that, that --
MS. ALI: Mmm-hmm.
THE WITNESS: -- 13.8 is outside of the normal range.

BY MS. ALI:

Q. Okay. Is that the only abnormal results in this CBC?
A. It looks like the neutrophils and the monocytes are also outside the normal range.
Q. Okay. And now I'm looking at the next result, which is -- oh, wait. My apologies. Strike that.
And in that CBC, the neutrophils, does this lab results list that they're high?
A. It looks like they're slightly elevated outside the normal range.
Q. Okay. And what are "neutrophils"?
A. So it's another type of cell that can be helpful in looking for in- -- inflammation or -- yeah. It can be present, along with some of the other components of the CBC.
Q. Okay. And what are "monocytes"?
A. They're another component of the CBC. You want me to get into the pathophysiology of the --
Q. No, that's okay.
What -- if -- if they're high, what does that indicate to you?
A. If the monocytes are high?
Q. Mmm-hmm.
A. It could be many different things.
Q. Okay. And could it be indicative of inflammation?
A. It's possible.
Q. Okay. What about neutrophils?
A. What could they indicate if they're high?
Q. Mmm-hmm.
A. Many things, again. Could be a virus or -- yeah, other inflammatory process.
Q. Okay. I'm looking on Exhibit 6 still, and I'm looking at the -- page 61, the basic metabolic panel --
A. Mmm-hmm.
Q. -- on the top. Is that a norm- -- is that a normal result, as well, lab result?
A. For the BUN?

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Q. Yes.
A. It's essentially normal. It's one outside of the normal range. But no, I guess you would have to say it's outside the normal range because it's slightly elevated.
Q. Okay. And now I'm looking at the urinalysis, the second lab results on page 61.
A. Okay.
Q. Is that abnormal, as well?
A. The urinalysis result?
Q. Yes.
A. It is, but it looks like it's a contaminated sample.
Q. Okay. So then we go to the -- how do -- how do you know that it's a contaminated sample?
A. On page 62, it looks like there's squamous cells --
Q. Mmm-hmm. Okay.
A. -- so it's not a clean sample. It can't be -- yeah, it's just -- isn't an equivocal test. It's not really good information if it's contaminated.
Q. Okay. So then we're looking at page 62, and there's another urinalysis that was done, correct?
A. Correct.
Q. And was this one done by -- ordered by you?
A. Yep, it looks like it was ordered by me.
Q. Okay. And is this abnormal, as well?

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A. It still looks like it's abnormal.
Q. Okay. And can you tell me what the abnormal results are in this urinalysis?
A. In the one that I ordered?
Q. Yes.
A. There's white blood cells greater than 100. Leukocyte esterase 2+.
Q. Is that it?
A. There's some other trace blood. It looks like a few RBCs and -- but the bacteria is negative.
Q. Okay. And now I'm looking on page 63 of Exhibit 6. And you ordered urine cultures, correct?
A. I ordered it at the same time as the urinalysis in case it was contaminated again.
Q. Okay. In case the urinalysis --
A. Probably. I guess I can't speak to why I did it.
Q. Okay. And what are the findings of this urine culture? Strike that.
Is this urine culture abnormal?
A. The urine culture grew Group B strep -- is that what you're referring to?
Q. Mmm-hmm.
A. -- greater than 1,000 [sic].
Q. Okay. And what does that indicate?
A. So that indicates that the culture grew out a bacteria

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called Group B strep.
Q. Okay. And when did you order this -- the urine cultures?
A. The urine culture and the urinalysis order were placed at the same time, I believe.
Q. Okay. And why did you order the urine cultures?
MR. WARWICK: Well, let's -- let's let her answer the question about when she ordered it.
THE WITNESS: The 13:4- -- 49, I ordered both of them at the same time. It's an order set you can choose, urinalysis with culture.
BY MS. ALI:
Q. Okay. So what inclined you towards ordering urine cultures for this patient?
A. And the urinalysis?
Q. Mmm-hmm.
A. Because they're like kind of an order set. I guess I can't say a hundred percent, but it's common that I review all the patient's chart before they are transferred to the floor, and I may have just seen that she had a contaminated sample before and wanted to be complete.
Q. Okay. And so, specifically, in her presentation and symptomology, you ordered the urine culture. It's -- what I'm understanding is that you ordered the urine

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culture is because you wanted to be sure that the -- the abnormal urinalysis from before, that you had something else to verify, as well?
MR. WARWICK: So just object to the form.
BY MS. ALI:
Q. I guess --
MR. WARWICK: Explain why you ordered it, if -- if you can.
THE WITNESS: So, I mean, I don't recall this patient or --
MS. ALI: Mmm-hmm.
THE WITNESS: -- the scenario, but I'm -- from what I usually do in the emergency observation area, I would normally order a urine with a culture.
BY MS. ALI:
Q. And do you do that for all patients that --
A. Not all patients --
Q. What --
A. -- but most patients. Because if -- yeah, you want to -- if it's positive, then you want to know what -- what grows out, what the final result is for. So there would be very few patients that I wouldn't order it. If maybe it was just someone in the ER that I was going to discharge, a patient that I was seeing outside of the observation area, I would just order a

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regular urine, and, yeah, I wouldn't necessarily order a culture on a patient like that, so ...
Q. Okay. So what makes -- you said earlier if there's positive, then you order the culture because you want to know what?
A. If it's contaminated.
Q. You want to know what's contaminating the urine?
MR. WARWICK: Well, object to the form.
BY MS. ALI:
Q. Is that what you're --
THE WITNESS: No. No.
MR. SINKOFF: Object to the form.
THE WITNESS: So it was a poor sample. So it looks like the first sample that they did in the ER, the one that I presume I was reviewing before I sent her up to the floor, was just contaminated. So that means she didn't give us a good sample. She didn't wipe good. She didn't give us a midstream, clean catch. So in that case, it's -- it's common to order a urine and a urine culture.
MS. ALI: Okay.
THE WITNESS: Because you want to get a good sample.
MS. ALI: Can we go off the record for a minute?

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VIDEO TECHNICIAN: Going off the record. The time is 1:15 p.m. We're off the record.
(Off the record at 1:15 p.m.)
(Back on the record at 1:29 p.m.)
VIDEO TECHNICIAN: We are now back on the record. The time is 1:29 p.m.
BY MS. ALI:
Q. Prior to the break, Ms. Warner, we discussed that you had ordered another urinalysis with urine cultures for Ms. Markel on October 10, 2015, at 1:49 p.m.; is that true? I'm looking at Exhibit 6, page 63.
A. Yes. It looks like I ordered a urinalysis and a urine culture at 13:49, on 10/10.
Q. Okay. And did you relate to me earlier that the reason you ordered the urinalysis with the culture was because the first urinalysis was contaminated?
A. I don't remember why I ordered the urine or the urine culture, but I can just assume, from my practice, that I was probably just reviewing her results and saw that the first urine was contaminated. So that would be something I typically would do --
Q. Okay.
A. -- if I saw a contaminated sample.
Q. Okay. And what is the purpose of ordering urine cultures if the urinalysis is contaminated?

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A. Because the culture will grow out an organism or a bacteria that's positive.
Q. Okay. And that would tell us whether or not the first --
A. It's concerning.
Q. And if the urinalysis was actually contaminated or not versus a bacteria, correct?
MR. SINKOFF: Objection to foundation.
MR. WARWICK: Same.
THE WITNESS: It could. It could be more -- it could give us more information, yes.
BY MS. ALI:
Q. Okay. And that is why it -- it might be a standard or protocol for you to order another urinalysis --
MR. WARWICK: Just --
BY MS. ALI:
Q. -- with cultures?
MR. WARWICK: Just object to the form about protocol, but -- so don't talk about hospital protocols, but --
THE WITNESS: Yeah.
MR. WARWICK: -- if it means -- if protocol means your usual course of performance, you can say -- you can answer the question from that perspective.
THE WITNESS: Yeah, like I said, I usually

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just review the patient's records before they're admitted and just make sure that there's nothing else that was overlooked, and so I probably just saw her first urinalysis was contaminated, so I thought it would be a good idea to repeat it.
BY MS. ALI:
Q. To make sure that it wasn't -- that -- strike that.
Because you want to verify for that patient that it -- that it was not -- strike that.
And in this case, for Ms. Markel, the cultures did come back with bacteria, correct?
MR. SINKOFF: Object to foundation.
MR. WARWICK: Same -- same objection.
THE WITNESS: It looks like the urine culture grew out strep Group B.
BY MS. ALI:
Q. And does that tell us that the patient was infected -- that there was an infection?
MR. WARWICK: Just same, foundation.
MR. SINKOFF: Join.
MR. WARWICK: You can tell her what the results show; other than that, you should defer to others.
THE WITNESS: Yeah.
MS. ALI: Okay. You're doing a lot of

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speaking objections, and that's not okay, so --
MR. WARWICK: Well, it is okay.
MS. ALI: No, it's not.
MR. WARWICK: You've already -- number one, you've already asked --
MS. ALI: Form and foundation --
MR. WARWICK: You've already asked the question three times, and she's already answered it before.
MS. ALI: Well, then you can object as to asked and answered. You cannot do speaking objections.
MR. WARWICK: Well, you can't keep asking the same question over again when --
MS. ALI: Yes, I can.
MR. WARWICK: -- she doesn't have the foundation -- she doesn't have the foundation to testify as -- as a physician would as to that issue, so that's the reason for my objection.
MS. ALI: Okay.
MR. WARWICK: I can raise the objection if I want to, and you don't get to just keep asking the same question over and over again.
MS. ALI: Well, you can make an objection as to asked and answered, but you cannot keep

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continuously put on speaking objections on the record.
MR. WARWICK: I haven't.
MS. ALI: Okay.
MR. WARWICK: I haven't. I think the record will be very clear about I put on one speaking objection because you're asking about a patient who was discharged immediately from the emergency room.
BY MS. ALI:
Q. Okay. So looking at the urine cultures that resulted on -- on October 12th, 2015, what does a urine culture tell you as a physician assistant?
MR. SINKOFF: Object to foundation --
MR. WARWICK: Same.
MR. SINKOFF: -- relevance.
MR. WARWICK: Same, form, foundation, asked and answered. You can go ahead and answer, from your perspective, again.
THE WITNESS: So I would not have been there on the 12th to review this urine culture. And, yeah, I wouldn't have been able to assess the patient to -- to know what this might indicate for the patient.
BY MS. ALI:
Q. Okay. Reading the results currently, can you tell me what -- what the results are to you -- what -- what

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they mean to you as a physician assistant?
MR. WARWICK: Same, form and foundation, relevance.
MR. SINKOFF: Join.
THE WITNESS: So it means that they grew out strep B, which is a common bacteria that colonizes the perineal area for a woman. So, yeah, that -- it looks like it grew out Group B, which is a common bacteria in that area.

BY MS. ALI:

Q. Okay. And with the benefit, of course, of hindsight and looking at the results in front of you right now for the urine culture, do you believe the patient was infected?
MR. SINKOFF: Object to the foundation.
MR. WARWICK: Foundation, form. You shouldn't speculate about anything.
THE WITNESS: Yeah, I can't spec- -- I mean, in my notes, I didn't document any dysuria or frequency or any urinary symptoms in my note for tha patient, so it looked like she wasn't having any symptoms --
MS. ALI: Okay.
THE WITNESS: -- from my note. I don't remember, but, yeah, I didn't document anything.

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BY MS. ALI:

Q. The urine cultures don't indicate to you that the -- that on October 10, 2015, Ms. Markel had an infection?
MR. SINKOFF: Asked and answered --
MR. WARWICK: Same --
MR. SINKOFF: -- foundation.
MR. WARWICK: -- asked and answered, foundation, form.
MR. SINKOFF: Assuming you make a diagnosis based on a lab test.
THE WITNESS: Yeah, I can't make a diagnosis based on the lab test without have -- having the patient's symptoms.

BY MS. ALI:

Q. Okay. And in the presence of -- strike that.
MS. ALI: I have no further questions.
MR. SINKOFF: I have no questions.

EXAMINATION

BY MR. WARWICK:

Q. Physician Assistant Warner, I have just a few questions for you. If you don't understand a question, don't hesitate to mention that, and I will certainly repeat it or rephrase it, okay?
A. Okay.
Q. If you could go to Exhibit 1, please. And plaintiff's

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counsel asked you about this exhibit earlier. It references your identity, third from the bottom of that page; is that correct?
A. Correct.
Q. And what does the 10/10/2015, at 6:38 a.m., mean to you?
A. That is likely when I accessed her chart for the first time, when I was reviewing her chart prior to our observation rounds.
Q. Okay. So on that date, October 10, 2015, your shift in the observation unit would have started at 6:00 a.m.; is that right?
A. Correct.
Q. And then this 6:38 a.m. is when you likely looked at her chart in the system; is that right?
A. Correct.
Q. Okay. And then you would have rounded with Dr. Berger --
A. Mmm-hmm.
Q. -- is that right?
A. Correct. Dr. David Berger.
Q. Okay. And the patient would have been seen with you and Dr. Berger; is that right?
A. Correct. Yep.
Q. And -- and the previous charting, et cetera, would

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have been reviewed --
A. Correct.
Q. -- is that right?
Okay. And then neurosurgery and physical medicine and rehabilitation consultants came in; is that right?
A. Correct.
Q. And Exhibit 3 references your report as it relates to the patient's condition in the observation unit on October 10, 2015; is that right?
A. Correct.
Q. And a white blood count of 13.8, would it be fair to say that was mildly elevated?
A. Correct.
Q. And UA awaiting repeat, there was a question by plaintiff's counsel about waiting -- awaiting results. You were actually awaiting having the urinalysis collected again; is that right?
A. Correct. It looks like, yep, it had not been done; so --
Q. Okay.
A. -- awaiting repeat.
Q. And the previous urinalysis that you testified to was contaminated; likely, that was based upon what from the results?

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A. That was the elevated number of squamous cells.
Q. Okay. And do we all have squamous cells on our skin?
A. Yes.
Q. And when you talked about not getting a clean catch or not wiping appropriately beforehand, if -- if that were to happen, that could result in having squamous cells in the -- as evidenced in the results; is that right?
A. Easily, yeah.
Q. Okay. So then you wanted another urine sample to be done for urinalysis and urine culture; is that right?
A. I would assume that's what I was, yep --
Q. Okay.
A. -- was doing by ordering a repeat.
Q. And then what time of the day did you end your work as it related to reporting with Ms. Markel? I believe that's Exhibit 1 again.
A. Yeah. I mean, it looks like the -- yeah, the last order I would have placed was that urine at 13:49, but then it shows that I was last in her chart maybe at 2:04 p.m., was the last --
Q. Okay.
A. -- review I did.
Q. And 13:49 would be what time of the day?
A. 1:49 --

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Q. Okay. So --
A. -- p.m.
Q. So if 1:39 -- I'm sorry. Strike that.
If 1:30 -- strike that.
If 1:49 p.m. was the time frame of the order for the second urine study with urine cultural, and then your charting says you were last in her records at 2:04 p.m., that would all be consistent; is that right?
A. Correct.
Q. Okay. And, in fact, it's now Exhibit 6, page 63 in the bottom, lower, left-hand corner, that's your order for the urine culture; is that right?
A. Correct.
Q. And it says, "Ordering provider Janay Warner, PA-C, 10/10/15, at 13:49"; is that right?
A. Correct.
Q. So that would be 1:49 --
A. 1:49 --
Q. -- p.m.?
A. -- p.m.
Q. And it says, the next line down, "Collect By 9BROY 10/10/15, at 21:10"; is that right?
A. Mmm-hmm. Correct.
Q. So --

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A. 9:10.
Q. Okay. So that would be well after you were last involved in Ms. Markel's care; is that right?
A. Correct.
Q. And the patient would have already been on the floor at that point; is that right?
A. Yes.
Q. And you don't see patients on the floor; is that right?
A. Correct, I do not see patients on the floor.
Q. And you wouldn't have back at this time frame, either; is that correct?
A. Correct.
Q. And then the results came in on 10/12/15, at 20:38; do you see that?
A. Yes.
Q. Okay. Those results wouldn't have gone back to you, either, would they?
A. No.
Q. Okay. Your role in this case would have finished when you last saw Ms. Markel on October 10, 2015, in the observation unit; is that fair?
A. Yes, that's fair.
Q. Okay. And then from the records, Ms. Markel's primary care physician was a Dr. John Bonema, B-o-n-e-m-a, and

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he's with Troy Internal Medicine. Did you see that from the records?
A. Yes.
Q. Okay. And then in your report, it references, in Exhibit 3, that -- I thought it was Exhibit 3 -- that -- yes. In treatment plan, page 20, admit in stable condition to Haas, H-a-a-s, forward slash, Wease, W-e-a-s-e, Dr. Lonappan.
Is there -- is there something you enter into the system to determine if a primary care physician has certain hospitalists that they have patients see on their behalf in the hospital?
A. Yes. So there is -- when you go to admit a patient, each patient has a PPG, which is a physician preference guide; so it tells you who their primary doctor admits to, so it tells you who to call.
Q. Okay. Is that, then, likely how you obtain that information?
A. Correct. So then we would ask our secretary to page whatever hospitalist service that that physician is requesting or uses.
Q. Okay. That that primary care physician is utilizing as --
A. Yes.
Q. -- a hospitalist?

A. So Dr. Bonema, yeah, his reference guide would have specified that he uses Hospital Consultants or Haas/Wease.

Q. Okay. And then after your involvement in the case, if the patient was seen by Dr. Lonappan or seen by other medical personnel, nurses, et cetera, you would obviously defer to them in terms of their role in the case and -- and their testimony, et cetera, correct?

A. After -- I don't understand. Like after she was admitted?

Q. Right. When you were no longer involved, if Dr. Lonappan was involved -- you've seen she's testified; right?

A. Yes.

Q. Okay. So Dr. Lona- -- Lon- -- Dr. Lonappan can testify on her own behalf; anyone else who's a caregiver after you're involved, they can testify on their own behalf, correct?

A. Correct.

Q. Okay. And your role, as we say, ended at that time, in the early afternoon, before the urine sample was even collected; is that correct?

A. Correct.

MR. WARWICK: Okay. Those are all the questions I have.

MS. ALI: I don't have any follow-up questions.

MR. SINKOFF: We're done.

VIDEO TECHNICIAN: This concludes the videotaped deposition. We're now going off the record at 1:44 p.m. We're off the record.

(The videotaped deposition was concluded at 1:44 p.m. Signature of the witness was not requested by counsel for the respective parties hereto.)

CERTIFICATE OF NOTARY

STATE OF MICHIGAN)
) SS
COUNTY OF OTTAWA)

I, PEGGY S. SAVAGE, certify that this videotaped 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.

Peggy S Savage

PEGGY S. SAVAGE, CSR-4189, RPR
Notary Public,
Ottawa County, Michigan.
My Commission expires: 7-13-19

In the Matter Of:

MARKEL vs WILLIAM BEAUMONT HOSPITAL, ET AL.

LINET LONAPPAN, M.D.

December 04, 2018

Prepared for you by

Bingham Farms/Southfield • Grand Rapids
Ann Arbor • Detroit • Flint • Jackson • Lansing • Mt. Clemens • Saginaw • Troy

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

Mary Anne Markel,
Plaintiff,
vs. Case No. 18-164979-NH
Hon. Nanci J. Grant
William Beaumont Hospital, Hospital Consultants, P.C., and Linet Lonappan, M.D., Jointly and Severally,
Defendants.

The Deposition of LINET LONAPPAN, M.D.,
Taken at One Towne Square, Suite 1400,
Southfield, Michigan,
Commencing at 2:05 p.m.,
Tuesday, December 4, 2018,
Before Becky L. Johnson, CSR-5395.

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APPEARANCES:

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EXHIBITS

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Southfield, Michigan
Tuesday, December 4, 2018
2:05 p.m.

LINET LONAPPAN, 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:

EXAMINATION

BY MR. TAKALA:

Q. Can you please state your full name for the record?

A. Linet Palayoor Lonappan.

MR. TAKALA: Let the record reflect that this is the deposition of Dr. Linet Lonappan taken pursuant to notice and agreement between counsel as to time and place whose testimony will be used for all purposes as allowed under our Michigan Court Rules as well as our Michigan Rules of Evidence.

BY MR. TAKALA:

Q. Dr. Lonappan, my name is Tim Takala, I represent Mary Markel in this case. I have some questions to ask you about your background, as well as your involvement with Ms. Markel's treatment at Beaumont Hospital, but I'm going to first ask you for your date of birth?

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A. 8-4-81.

Q. And your residential address?

MR. SINKOFF: No, you can get her through me.

MR. TAKALA: Okay.

BY MR. TAKALA:

Q. Are you currently employed?

A. Yes.

Q. Where at?

A. Through Hospital Consultants, P.C.

Q. How long have you been employed through Hospital Consultants, P.C.?

A. July 2011, since that time.

Q. Have you been deposed before?

A. Yes.

Q. How many times?

A. I was a witness for a deposition once.

Q. Okay. When was that?

A. That was in 2011.

Q. Okay. Were you a named defendant in that case or were you just a witness in the medical chart?

A. I was a witness in the medical chart.

Q. What type of case was it, if you know?

A. I don't recall it right now.

Q. Let me ask it differently. Do you know whether it

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was -- involved allegations of medical malpractice against another physician?

A. I think so.

Q. Okay. And you don't remember the name of either the plaintiff or the defendant in that case from seven years ago, do you?

A. I don't.

Q. All right. Just a couple ground rules just because it's been a while since you've last been through this process. It's important to give verbal answers and it's important for only one of us to talk at a time, okay?

A. Okay.

Q. More importantly than that, if I ask a bad question that you don't understand, will you agree to tell me so?

A. Yes.

Q. Okay. And you'll do that instead of answering the question?

A. Correct.

Q. All right. That way I'll presume you understood my question if you give me an answer, fair?

A. Okay.

Q. Also, if at any point I cut your answer off, will you agree to tell me that I did so?

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A. Yes.
Q. All right. Otherwise, I'm going to presume that you gave a full answer to my question. I'm here to get your full answer and if I interrupt you, I do so unintentionally, but I won't know that I've done that unless you tell me, okay?
A. Okay.
Q. You were kind enough to provide me a copy of your curriculum vitae prior to the deposition?
A. Yes.
Q. I'll mark that as Plaintiff's Exhibit 1 and just show you a copy and ask you if that is current and up to date?

MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 1
2:08 p.m.

A. Yes.
BY MR. TAKALA:
Q. Thank you. By the way, when you testified on that one prior occasion, I assume that you testified honestly, truthfully and to the best of your ability?
A. Yes.
Q. All right. Just tell me, and I know that -- I won't belabor the point because it's contained in Plaintiff's Exhibit 1, but tell me a little bit about

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your educational background, starting with your undergraduate education, please?
A. Yes. I did my schooling in India and I did my medical school in India. And then I came here, did my residency at Crozer-Chester in Philadelphia, and then that's -- that was my internal medicine residency from 2008 until 2011.
Q. Okay. How does medical school look in India, is it a four-year program?
A. It's a four-year, plus one year of house surgency, which is like a residency, mini residency, that we do here, yep.
Q. So five years of medical school in India?
A. Yep.
Q. Okay. How many years of undergraduate school in India?
A. So we usually have -- soon after high school, after the 12th grade, we can apply for the medical school. So we don't have to have a separate undergraduate course.
Q. Okay. And were both of these at the medical college at the University of Kerala in India?
A. That's correct.
Q. Okay.
A. T.D. Medical College.

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Q. T.D. Medical College, thank you. And then when you came here to the States, what year was that?
A. That was in -- you mean -- I'm sorry, the question as to what year I started the residency or what year did I come to U.S., is that the question?
Q. What year did you come to the United States?
A. In 2006.
Q. All right. So you would have completed your one-year house residency program in India in 2005?
A. Correct.
Q. Okay. Then when you -- by the way, were you ever licensed to practice medicine in India?
A. Yes.
Q. Did you have to take an exam?
A. That was involved with the medical school. I didn't have to do a separate licensing exam.
Q. Okay. So you were licensed based upon your matriculation through T.D. Medical College?
A. Correct.
Q. You come to the States in 2006. Do you have to take an exam here?
A. We have to pass the USMLE steps before applying for residency.
Q. And I forget, how many steps are they?
A. There are three steps.

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Q. And did you pass each one of those steps on your first attempt?
A. Yes.
Q. And then you applied for a residency program at Crozer --
A. Chester, yes, Medical Center.
Q. Good. And that's on your curriculum vitae here?
A. Correct.
Q. And you complete that program between 2008 and 2011?
A. Correct.
Q. All right. What was your residency in?
A. Internal medicine.
Q. Okay. And what happens in 2011, do you take your board exams?
A. Yes.
Q. What specialty do you take your board exams in?
A. Internal medicine.
Q. Okay. Are you currently practicing as an internal medicine physician?
A. Yes.
Q. Do you practice at all on an outpatient basis?
A. No.
Q. All of your work is in the hospital?
A. Yes.
Q. Is there a separate board certification for

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hospitalist medicine within the field of internal medicine?
A. Yes.
Q. Have you sat for that board exam?
A. No.
Q. Do you have any plans to?
A. Not currently.
Q. Nonetheless, through your experience as a hospitalist at Hospital Consultants, P.C., you've become familiar with the standard of care of internal medicine physicians practicing within a hospital setting?
A. Correct.
Q. All right. I know the answer to this, but I'm going to ask anyway. Have you ever been named in a medical malpractice lawsuit?
A. No.
Q. Okay. And you've never reviewed any medical-legal cases, have you?
A. No.
Q. I think that we probably gave Mr. Sinkoff a copy of a deposition notice. Do you recall seeing any copy of a deposition notice asking you to be here today and bring with you certain materials?
MR. SINKOFF: I never showed it to her because all you asked for was the medical record.

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MR. TAKALA: No problem.
BY MR. TAKALA:
Q. Did you bring anything with you here to the deposition?
A. The medical records and my C.V.
Q. Okay. I'm sorry. And where did you get that copy of the medical records from, if you know?
A. Through Mr. Sinkoff.
Q. And there are certain Post-it flags on there. Are those your Post-it flags?
A. Yes.
Q. All right. They're different colors. Is there any system to the coloring?
A. No.
Q. Okay. Is there any reason why you flagged certain pages?
A. Just for ease of reference.
Q. Okay. Is there anything that you have reviewed for preparation for your deposition that you did not bring here today?
A. No.
Q. All right. Did you take any notes while you were reading through the medical records or any other materials that you've been provided in this case?
A. No.

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Q. Okay. Did you ever look at the medical records on a computer terminal at Beaumont Hospital?
A. No.
MR. SINKOFF: Well, when you say ever, you mean since the notice of intent?
MR. TAKALA: Correct. Thank you, Steve.
BY MR. TAKALA:
Q. Since the notice of intent was sent out and suit was commenced, have you had a chance to look at Ms. Markel's medical records on a Beaumont terminal?
A. No.
Q. Okay. Can you give me a sense as to how much time you've spent reviewing those medical records?
A. I don't know the exact number, but I have spent some time.
Q. Okay. More than five hours, less than five hours?
A. Maybe three or four hours.
Q. Okay. And that's the total amount of time that you've spent?
A. I think so.
Q. Okay. And no problem, I know that you didn't sit down and keep track of the time, but I'm just trying to get a sense as to how much time you've invested into preparing for this deposition, and your answer is about three or four hours total?

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A. I would say so.
Q. Okay. Any of those hours spent within the last couple of days getting ready for your deposition?
A. Yes.
Q. About how many?
A. One or two.
Q. Thank you. At some point in time did you receive a copy of the notice of intent to sue in this case, it was something that looked like this?
A. Yes.
Q. Did you read it?
A. Yes.
Q. All right. Do you have an understanding as to the allegations that have been made against you in this case?
A. Yes.
Q. Can you tell me what your understanding of those allegations is?
A. So --
Q. I promise, I'm not trying to trick you with the question, I just want to know what you think this document says that you did wrong?
MR. SINKOFF: Well, let me just object because it's irrelevant what the notice of intent says. The case is based on your complaint, not on the

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notice of intent.
MR. WARWICK: Same objection.
BY MR. TAKALA:
Q. Go ahead. What's your understanding as to the claims that have been brought against you?
A. So let me clarify the question. So you are trying to understand what I understood from the claim, is that the question or --
Q. Yes, ma'am.
A. Okay. So you're trying -- my understanding is you are saying on the complaint that I did not do certain things that might have affected the patient's outcome, is basically what I'm understanding from the --
Q. Okay. And after reviewing those general allegations, do you believe you did everything that you were required to do as an internal medicine physician when treating Ms. Markel?
MR. SINKOFF: Object to the form.
A. Yes.
BY MR. TAKALA:
Q. Okay. And some of those things that the complaint and the notice of intent allege that you did wrong was failing to provide antibiotics, correct?
A. Yes.
Q. Did you provide any antibiotics to Ms. Markel?

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A. No.
Q. Okay. Were you required to provide any antibiotics to Ms. Markel pursuant to your standard of care?
MR. SINKOFF: Go ahead. You can answer.
A. No.
BY MR. TAKALA:
Q. And we'll get into the nitty gritty a little bit later, but, I'm sorry, I just can't help myself. There's also an allegation that you failed to contact Ms. Markel after some results of a urine culture came back positive. Do you remember reading that?
A. Yes.
Q. All right. Did you ever contact Ms. Markel regarding results of that urine culture?
A. No.
Q. Do you know whether you ever received a copy of the results of that urine culture?
A. Yes.
Q. Okay. When did you receive a copy of the results to that urine culture?
A. On October 12th, sometime during the day.
Q. And where would you have received it?
A. On the Epic chart.
Q. So when you log into the Epic chart, just explain to me how that works. Is there a result that pops up for

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each patient that you're assigned to?
A. No. So when you -- when I open the EMR, the Epic chart, there's a list of patients that are my current patient list. And then when you go into each patient's chart, there is a section for results that you have to open and then that will show up -- the results of the patient. For discharged patients, you have to look into their chart to get the results of the -- the outstanding -- outstanding results.
Q. Okay. So on October 12th Ms. Markel was a discharged patient, correct?
A. Correct.
Q. And you would have had access to click on her chart to get the results of that urine culture?
A. That's correct.
Q. And you would have had access to her phone number, correct?
A. Yes.
Q. And you would have had access to an emergency contact phone number, correct?
A. Yes.
Q. But you never contacted Ms. Markel with those positive urine culture results, did you?
A. No.
Q. Do you believe your standard of care required you to

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contact Ms. Markel with those positive urine culture results on October 12th when you saw them in the Epic computer?
A. No. Only if I'm planning to do all antibiotics or any kind of intervention with those results, I need to contact the patient.
Q. Okay. Fair enough. So I understand what you're saying, but let me get it out on paper, okay?
Did your standard of care -- and I'll take a yes or no answer and then I'll let you explain. Did your standard of care require you to contact Ms. Markel when you saw the positive urine culture results in the Epic system on October 12th, 2015?
A. No.
Q. Okay. And why is it that you did not contact Ms. Markel with those results?
A. Because it was not relevant to her care at that point.
Q. Okay. So you're saying that even in the face of a positive urine culture, she's not a patient that's indicated for antibiotic coverage?
A. Correct.
Q. And you hold that opinion to a reasonable degree of medical certainty?
A. Yes.
Q. Okay. And sorry I didn't ask you this and Steve

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brought up a fair point. This is the complaint that was filed in the circuit court. Did you ever have a chance to review the complaint?

A. Yes.

Q. Okay. Did you review the affidavits of merit that were attached to the back, signing on to the standard of care?

A. Yes.

Q. Okay. Have you had a chance to review any of the affidavits of meritorious defense that have been filed in this case on behalf of your care?

A. Yes.

Q. Okay. Did you help prepare any of those?

A. No.

Q. Do you know who signed those affidavits of meritorious defense?

A. I don't recall specifically.

Q. Do you know whether you had -- and, quite frankly, I don't have them with me or I don't have the names handy, but do you have any social relationship with any of the physicians that signed those affidavits of meritorious defense?

A. No.

Q. Do you know Dr. John Bonema, the primary care physician in this case?

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A. I don't know him personally.

Q. Okay. You have not authored any affidavits of meritorious defense in this case, have you?

A. No.

Q. You haven't authored any affidavits, period, in regards to this case, fair?

A. No.

Q. Okay. Have you performed any literature research to prepare for your deposition regarding whether antibiotic coverage is indicated in a patient like Ms. Markel?

A. No.

Q. Have you performed any literature research, period, regarding this case?

A. No.

Q. How did you learn about the standard of care in regards to which patients get antibiotics in the face of a positive urine culture and which don't?

A. From my medical knowledge from the medical school and residency.

Q. So that's something they taught you at T.D. Medical College?

A. Yes.

Q. And something they taught you in your residency program in Philadelphia?

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A. Correct.

Q. Is that anything that you've continued to study on since you completed your Philadelphia residency program in 2011?

A. Yes.

Q. How have you continued to study on that?

A. We do CMEs.

Q. And what's a CME?

A. A continuing medical education.

Q. Okay. And how do you do a CME, what do you read, where do you go, how do you research?

A. We have monthly business meetings. Also online, UpToDate researches. That's basically it.

Q. Okay. PubMed, do you use PubMed at all?

A. Yep.

Q. Do you use UpToDate?

A. Yes.

Q. And those are good resources where you go and you try and find the up-to-date information on evolving medical topics?

MR. SINKOFF: Object to foundation. You can answer.

BY MR. TAKALA:

Q. Right?

MR. WARWICK: Same.

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BY MR. TAKALA:

Q. Let me try and ask it differently and I'll let Steve and Don object to the question.

But UpToDate and PubMed are good sources to look to in order to keep abreast of the evolving medical education that you're participating in, right?

MR. SINKOFF: Object to foundation.

MR. WARWICK: Same.

A. Yes.

BY MR. TAKALA:

Q. Okay. Are there any other texts or sources of literature that you go to to try and keep yourself knowledgeable about the changes in internal medicine?

A. There are other continuing medical education courses that provide and --

Q. Who provides those -- I'm sorry if I cut you off?

A. No, it's, you know, certified continuing medical education courses.

Q. And would you sit for those courses, like -- I mean, are they conferences around the country, are they school, classroom-type --

A. Yes, sorry, conferences around the country.

Q. Okay. Any textbooks that you use in your practice of internal medicine?

A. No.

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Q. Do you use Harrison's?
A. I have learned it for the medical school and residency.
Q. Okay. Any other medical texts that you use, you've already told me that you use PubMed and UpToDate, any other texts that you use on a daily basis -- or a regular basis, I should say?
A. No.
Q. Okay. Are there any journals that you subscribe to to keep yourself informed about continuing medical topics?
A. Yes.
Q. What are those journals?
A. NEJM, New England Journal of Medicine.
Q. Anything else?
A. No.
Q. Okay. Have you done any research on NEJM regarding treatment of either upper or lower urinary tract infections?
A. No.
Q. Okay. Have you done any research on UpToDate regarding upper or lower urinary tract infections and the treatment that should occur?
A. No.
Q. Okay. Same question with PubMed?

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A. No.
Q. All right. Do you intend -- and maybe this is an unfair question and I'll give Steve his objection or I'll let him make it after I finish the question.
At this point do you intend to rely upon any literature for your position at the time of trial?
MR. SINKOFF: Object to foundation. That's a decision I'll make at the appropriate time.
MR. WARWICK: Same objection.
A. No.
BY MR. TAKALA:
Q. You've been continuously employed at Hospital Consultants, P.C.?
A. Yes.
Q. Since 2011 when you finished your residency program?
A. Yes.
Q. Sorry, that was a poor question. What is Hospital Consultants, P.C.?
A. It's an organization that employs physicians and contracts with the hospital, employed hospitalists, internal medicine physicians.
Q. Do you know how many physicians are employed by Hospital Consultants, P.C.?
A. I don't.
Q. I'll take your best guess. More than 20?

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A. I would say so.
Q. More than 40?
A. No.
Q. And if this is outside of your knowledge, that's fine, but do you know whether Hospital Consultants has a contract with any of the local hospitals to provide medical care?
MR. WARWICK: Foundation.
A. I don't know.
BY MR. TAKALA:
Q. Do you yourself have any contracts with Hospital Consultants, P.C. in your employment with that group?
A. Yes.
Q. Okay. Does that define the scope of your care and your responsibilities?
MR. SINKOFF: Object to the form of the question.
MR. WARWICK: Same.
A. Yes.
BY MR. TAKALA:
Q. Okay. It tells you what your responsibilities are as an employee of Hospital Consultants, P.C., correct?
A. Yes.
Q. Do you have privileges at the Beaumont Health System?
A. Yes.

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Q. Do you have privileges at any other hospitals in the local area?
A. No.
Q. Do you see patients at any other hospitals aside from Beaumont Royal Oak?
A. Yes.
Q. Okay. And I'm sorry that I don't know the answer to this question, but is that where you saw Ms. Markel, was it Beaumont Royal Oak?
A. Yes.
Q. Okay. What other hospitals do you see patients at?
A. Beaumont Troy.
Q. Any others?
A. No.
Q. Is there anything in your contract with Hospital Consultants, P.C. that designates the services that you should -- that you would provide to each hospital, Beaumont Royal Oak and Beaumont Troy?
MR. WARWICK: Just form and foundation.
MR. SINKOFF: What do you mean by services?
BY MR. TAKALA:
Q. Well, what I'm trying to figure out is the scope of the work that's to be performed pursuant to contract between Hospital Consultants the Beaumont facilities?
MR. SINKOFF: She gets a schedule when

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she's supposed to work and at which hospital and she goes and she acts as an internal medicine specialist.

MR. TAKALA: Is that written down anywhere?

MR. SINKOFF: I've never looked at the contract, but they don't -- I know that they don't designate do this, this and this.

MR. TAKALA: Okay. Fair enough.

MR. SINKOFF: Just go and practice.

MR. TAKALA: Understood.

BY MR. TAKALA:

Q. Just so I get your answer instead of Mr. Sinkoff's, do you have a schedule that tells you which hospitals to go to at which times?

A. Yes.

Q. Okay. Who makes that schedule, if you know?

A. It's Dr. Batke.

Q. Can you spell that?

A. B-A-T-K-E.

Q. Who is Dr. Batke?

A. He is with Hospital Consultants, P.C. He does the scheduling for all of us.

Q. Is he an administrator?

A. No.

Q. Okay. And sorry if I already asked this, but do you know whether Hospital Consultants, P.C. has any

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contracts with the Beaumont Health System?

MR. WARWICK: Just form, foundation.

A. I don't.

BY MR. TAKALA:

Q. Okay. Thank you. And by the way, I apologize, I did already ask that.

So tell me a little bit about what you do as a hospitalist at Beaumont Royal Oak or Beaumont Troy?

A. So I come in and there are patients assigned to me on a daily basis. I do a history and physical exam on the patient and formulate a plan for their diagnosis and treatment and discuss with patients' families, that is --

Q. And I suppose that -- and that's -- I know that your responsibilities probably go far beyond that, but that gives me a good outline.

Part of developing a plan of care would be discussing the patient's either history and future care with other medical personnel at the hospital, right?

A. Yes.

Q. Okay. And that would involve nurses, right?

A. Correct.

Q. And that would include consultants, correct?

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A. Yes.

Q. And may include emergency department physicians, correct?

A. Yes.

Q. May include physicians' assistants that are working in the emergency department, correct?

A. Yes.

Q. All right. Can you give me a sense as to how many patients you might be assigned on a typical shift?

A. Yes. I might have anywhere from 10 to 20 patients.

Q. And those are active patients that are either there to be screened for admission or patients that actually have been admitted to the hospital, correct?

A. Yes.

Q. Okay. Can you break down the 10 to 20 patients between the two categories that I've listed? And if that's a poor question, I'll try and do better.

A. So at a given day I might have 4 or 5 new admitted patients and then 10 to 12 patients already admitted to the hospital.

Q. Thank you very much. Do you work with residents at all?

A. No.

Q. Do you continue your care with any patients outside of the hospital setting?

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A. I did not quite understand the question.

Q. Yeah, fair enough, it was a bad question.

So you have responsibility for discharging patients that are assigned to your service at the hospital, right?

A. Yes.

Q. After you discharge a patient, you've told me that you have access to his or her chart and you could see new test results, right?

A. Yes.

Q. Would there ever be a circumstance where you would continue your care of a discharged patient outside of the hospital setting?

A. Yes.

Q. Okay. Explain to me those circumstances?

A. If there are outstanding culture results and that needs to be treated or some further action needs to be taken, then I contact the patient even -- even if they are discharged from the hospital.

Q. Okay. And how would you contact the patient?

A. Based on -- there's an inpatient face sheet that has the patient's information, so based on that.

Q. Okay. Good. And since you brought it up, I'll just mark as Plaintiff's Exhibit 2 the face sheet. This is probably what you're talking about?

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MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 2
2:30 p.m.

A. Yes. I have a -- I don't usually print it out, it's on the computer. So I have the information on the computer.

BY MR. TAKALA:

Q. Very good, thank you. But it would be a phone call that you would make to the patient if there was some sort of result that you thought needed to be acted upon, correct?

A. Correct.

Q. All right. And you've done that in your practice?

A. Yes.

Q. And can you give me a sense as to how often that happens?

A. Maybe three or four times a week roughly, it's not an exact number.

Q. Understood. And I appreciate you helping give me some guidance. And I -- this could probably happen with radiographic results, lab results, any sort of critical value that comes back after the patient is discharged, right, it doesn't have to be a culture?

MR. SINKOFF: Object to foundation -- actually the form of the question and the foundation.

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MR. WARWICK: Same.

A. It does with culture results.

BY MR. TAKALA:

Q. And is that because cultures take time to grow?

A. Yes.

Q. Okay. Instead of me answering the question for you, I should let you.

Why is it specific to culture results that you -- that you follow up with patients three to four times per week?

A. Culture results -- based on the results, if it needs to be acted upon, I would want the patient to get the treatment as soon as possible rather than waiting until they see their family doctor.

Q. Okay. And that happens about three or four times per week where you get culture results that need to be acted upon swiftly, fair?

A. Fair.

Q. In this case, I think that you had indicated that Ms. Markel should see her family doctor within two weeks of discharge, correct?

A. Correct.

Q. All right. If you felt it was necessary for Ms. Markel to act upon those positive urine culture results sooner, you would have called her?

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A. Correct.

Q. You do that in your practice three to four times per week?

A. Fairly.

Q. Okay. You don't have any administrative responsibilities in your position at Hospital Consultants, P.C., do you?

A. No.

Q. All right. And we kind of narrowed it down that there are 20 to 40 physicians that are employed by Hospital Consultants, P.C., rough estimate, fair?

A. Yes.

Q. Do you know whether there are any Dr. Ms in that practice? And I'll have difficulty saying the name, but are there multiple Dr. Ms or multiple physicians with the name beginning with M?

A. Yes.

Q. All right. Do you know which Dr. M was involved in Ms. Markel's care?

A. I don't.

Q. Okay. Do you know the names of each Dr. M?

Steven, I'm sorry, I just want her to do this without her looking at any notes.

MR. SINKOFF: Go ahead. Well, then make the record clear that -- because the name is clearly

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typed in the notes.

MR. TAKALA: Okay. Fair enough.

BY MR. TAKALA:

Q. Do you know which Dr. M was involved in this case?

MR. SINKOFF: With looking at the records or without?

MR. TAKALA: Without.

A. Without looking at the records? No.

BY MR. TAKALA:

Q. Okay. And one is Dr. Morariu, M-O-R-A-R-I-U, correct?

A. Yes.

Q. And one is Dr. Muraru, M-U-R-A-R-U?

A. Yes.

Q. Okay. And you've reviewed the records, right?

A. Yes.

Q. Do you know who you consulted from neurosurgery in this case?

A. Yes.

Q. Okay. What was that person's name?

A. Dr. Olson.

Q. Okay. Do you know the patient's primary care physician?

A. Yes.

Q. Who is that?

A. Dr. Bonema.

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Q. Okay. Do you know who the emergency room physician was in this case?
A. I don't know offhand, I have to look.
Q. Okay. And was there another hospitalist from your group that was involved in this case, if you know?
A. Yes.
Q. Okay. Do you know which -- do you know that doctor's name?
A. In the records?
Q. Well, yeah, the one that was involved in the care?
MR. SINKOFF: No, she's asking do you want her to look at the record.
BY MR. TAKALA:
Q. No, without the records.
A. Without the records, it was Dr. Muraru or Morariu.
Q. Okay. So --
MR. SINKOFF: Just -- it might help if you just use first names rather than last names just because they're pronounced fairly similarly?
MR. TAKALA: Yeah, fair enough.
MR. SINKOFF: One is a male and one is a female, that might help.
MR. TAKALA: Gotcha.
BY MR. TAKALA:
Q. Let's do it this way and then we'll do it Steve's way.

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Do you know whether it was Dr. Morariu, M-O-R-A-R-I-U, or Dr. Muraru, M-U-R-A-R-U, without looking at the records?
A. It's Muraru.
Q. And that's M-U-R-A-R-U?
A. Yes.
Q. Okay. And there's -- and in Steve's suggestion, there's an Ioana, I-O-A-N-A? Sorry if I'm saying that wrong.
A. Ioana, yeah.
Q. And M-I-H-A-I, can you help me --
A. Mihai.
Q. Okay. And one is a male and one is a female?
A. Yes.
Q. Which is the male and which is the female?
A. Mihai is male, Ioana is female.
Q. Okay. And do you have any independent recollection of a male hospitalist picking up at all during the care of Ms. Markel? Sorry if that's a bad question.
MR. SINKOFF: Object to the foundation.
MR. WARWICK: Same.
A. No.
BY MR. TAKALA:
Q. Okay. That's okay, we can move on. Does your -- strike that.

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Do your responsibilities change at all whether you are at Beaumont Royal Oak or Beaumont Troy?
A. No.
Q. And you told me that part of your responsibilities as a hospitalist is to do a history and physical, develop a plan, discuss conditions with family, correct?
A. Yes.
Q. Okay. You also agree that it's your responsibility to diagnose conditions, right, that would be part of the plan?
A. Yes.
Q. And treat conditions, part of the plan, right?
A. Yes.
Q. All right. Prescribe a course of action, that's included in the plan, right?
A. Yes.
Q. Okay. And follow up on healing, right?
A. If they're admitted to the hospital, yes.
Q. Okay. And in certain circumstances when they're discharged, right?
A. Yes.
Q. Okay. Sorry if I -- I know I already asked this, but 100 percent of your time is spent as a hospitalist?
A. Yes.

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Q. Okay. You don't see any patients in a clinical setting outside the hospital?
A. No.
Q. Have you ever had your privileges revoked, suspended or disciplined in any way?
A. No.
Q. Okay. Same question with your -- well, I should ask first, are you licensed to practice medicine in the State of Michigan?
A. Yes.
Q. Okay. Ever had any disciplinary action against your license in the State of Michigan?
A. No.
Q. Are you licensed to practice medicine in any other states?
A. No.
Q. Just tell me how it is that you came to treat Ms. Markel, if you -- if you know?
A. I was assigned Ms. Markel's case on October 10th, that's how I got her.
Q. Okay. And she came to the hospital on October 9th, right?
A. Yes.
Q. And you didn't see her until October 10th?
A. Correct.

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Q. And this was in 2015, correct?
A. Yes.
Q. All right. Three years ago -- more than three years ago?
A. Yes.
Q. All right. Do you have any -- and this is an important question and before you answer I'll make sure that we understand the term. I'm going to ask whether you had an independent recollection of treating Ms. Markel, okay? And when I use the term independent recollection, I mean something that you remember specifically about Ms. Markel, whether it be a conversation with her, a conversation with a family member, a conversation with a consultant, something that's not contained in the medical records.
Do you understand what I mean by independent recollection, first of all?
A. Yes.
Q. Okay. Do you have any independent recollection of treating Ms. Markel on October 10th, 2015?
A. No.
Q. Okay. You're just going solely based upon what you documented in the medical record, right?
A. Yes.
Q. Because if you're seeing 10 to 20 patients per day and

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you're working, whatever it might be, 200-some days per year, maybe 300 days per year, you're seeing, what, thousands of patients per year?
A. Yes.
Q. All right. By the way, did you have a typical schedule, typical days that you would work each week?
A. Yes.
Q. And what were those days?
A. So usually -- we have a winding up and winding down schedule. So Monday or Tuesday we start the week and then we continue taking new patients until the following Monday and then we start winding down where we don't take any new patients, but continue to discharge the patients. So at that time we work about 10 or 11 days.
Q. You did a fine job, I think, but the problem is I zoned out about halfway through it. So you work about 10 or 11 days in a row?
A. Yeah.
Q. Okay. And part of that schedule is winding up and part of it is winding down?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. And do you work the same number of hours each day?

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A. Not necessarily -- I mean, not necessarily. We carry the pager from 8:00 until 5:00 p.m. every day.
Q. And then at 5:00 p.m. you leave the hospital?
A. Correct.
Q. And the patient's service is transferred or no?
A. We have an on-call person who takes over from 5:00 p.m. until the next morning at 8:00.
Q. Got it. And are there occasions where you would have to take call in the middle of the night for your patients or does that on-call physician handle the responsibilities while you're not physically present at the hospital?
A. Yes, the on-call physician will take care of the responsibilities.
Q. Okay. So you're not getting calls in the middle of the night when your patients, whatever, spike a fever or something else happens?
A. Unless I'm on call that night, I won't be getting.
Q. How does your on-call schedule work?
A. Once or twice a month.
Q. And is that while you're on duty, like during this 10-to-11-day shift?
A. Yes.
Q. Okay. And when you take call what does that mean? I think I know what you mean, but just go ahead and

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explain for the record.
A. So when the nurses call for any issues, we answer them and then give the necessary guidance.
Q. Okay. Real briefly, let's try to go through this winding up and winding down work schedule. When you're -- so you typically start this 10-or-11-day stretch on a Tuesday or a Wednesday?
A. Could be Monday too.
Q. Okay. So the days vary?
A. Yep.
Q. But it will always be this block of 10 to 11 days?
A. Mostly.
Q. Okay. Understood. And explain to me the winding up and winding down portion one more time and I'll try and pay better attention to you?
A. Winding up is when you start taking new patients. So the first week that we are working, we will be taking new patients every day. The following week, the following Monday or Tuesday, we start winding down, meaning we don't necessarily take new patients, we keep on discharging the patients from our list.
Q. Okay. And I imagine, and maybe Dr. Batke or whoever helps out with the schedules can answer this, but I imagine that the hospitalist schedules are staggered; so when you're winding up, somebody else might be

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winding down?
A. Correct.
Q. Okay. Are there situations where you're winding down, but you can't discharge every patient from your roster?
A. Correct.
Q. What happens in that situation, does somebody else come on as the attending physician or do you stay on as attending?
A. Somebody else comes on as attending.
Q. Okay. So you wouldn't have any further responsibility for that patient, you would transfer it to whoever was taking over your spot as the hospitalist?
A. Yes.
Q. Okay. Do you know whether you ever met Ms. Markel prior to October 10th, 2015?
A. No.
Q. You know that you hadn't or you just don't know?
A. I know that I hadn't.
Q. Okay. Do you know whether you ever saw Ms. Markel after October 13th, 2015? And just to put things in context a little bit, you probably know this, but Ms. Markel is at Beaumont Royal Oak from October 9th through October 11th and then she comes back on October 13th.

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A. Correct.
Q. Okay. Do you know whether you ever saw -- and you did an H&P on October 13th.
A. October 14th.
Q. Okay. Fair enough. Do you know whether you ever saw Ms. Markel after October 14th?
A. Yes.
Q. Okay. Do you know what the last day was that you saw Ms. Markel?
A. October 16th.
Q. And then what happens on October 16th, does your service end for that 10-or-11-day period?
A. Correct.
Q. All right. And so her care is transferred to another physician?
A. Yes.
Q. In this case I think it was transferred to a Dr. Perry Greene. Do you recall seeing that?
MR. WARWICK: Just foundation.
MR. SINKOFF: Foundation.
A. No.
MR. WARWICK: Perry Greene is an orthopedic surgeon.
MR. TAKALA: Yeah, that's fair enough.
BY MR. TAKALA:

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Q. And the only reason I say that is because -- and I'll just -- I'll do this a little bit out of order, but I'm going to mark as Plaintiff's Exhibit 3 the discharge summary from November 2nd, 2015 and I'll show that to you.
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 3
2:43 p.m.
BY MR. TAKALA:
Q. Can you read who it says attending physician at the top?
A. Perry Greene.
Q. Okay. Is Dr. Greene a member of Hospital Consultants, P.C.?
A. No.
Q. Okay. Do you know -- and if you don't, it's fine, this may be unfair to you. Do you know whether Dr. Greene was the attending physician after you ended your service on October 16th, 2015?
MR. WARWICK: Just foundation.
MR. SINKOFF: If you know.
A. No.
BY MR. TAKALA:
Q. Okay. Thank you. And again, I don't mean to belabor this, but you don't remember independently meeting

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Ms. Markel for the first time on October 10th, correct?
A. Correct.
Q. You don't remember coming to her room, you don't remember who else was in her room or whether you saw her somewhere else in the hospital, correct?
A. No.
Q. All right.
MR. WARWICK: I'm not sure we have a clear record there. You're asking her questions about correct and she's saying no.
MR. TAKALA: Fair enough. Thank you, Don.
BY MR. TAKALA:
Q. Am I correct in my statement that you don't remember where you saw Ms. Markel when you first made contact with her on October 10th?
A. Yes.
Q. Okay. Thank you.
(Discussion off the record at 2:44 p.m.)
(Back on the record at 2:45 p.m.)
BY MR. TAKALA:
Q. When you are assigned to your 10-or-11-day shift at Beaumont Royal Oak do you wear a white lab coat?
A. Yes.
Q. All right. And do you wear credentials that indicate

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who you are and that you're a physician?
A. Yes.
Q. And it says Beaumont Health System or something like that on the credentials?
A. Yes.
Q. Does it say Hospital Consultants, P.C.?
A. Yes.
Q. Okay. And that's on your credentials?
A. Yes.
Q. All right. Do you have a copy of your credentials here today?
A. No.
Q. Okay. Do you know whether you were wearing those credentials when you saw Ms. Markel on October 10th?
A. I don't have a specific recollection.
Q. Okay. But whenever you're in the hospital you're wearing a white lab coat and you're wearing your credentials, right?
A. Yes.
Q. So unless there was some unusual circumstances, you would have presented to her with a white lab coat and your picture and your ID, right?
A. Yes.
Q. Okay. Do you introduce yourself when you typically meet a patient for the first time?

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A. Yes.
Q. How do you introduce yourself?
A. Dr. Lonappan.
Q. Okay. Do you say I'm Dr. Lonappan at Beaumont or I'm Dr. Lonappan at Hospital Consultants, P.C. or just I'm Dr. Lonappan?
A. I'm Dr. Lonappan.
Q. Okay. And you were assigned Ms. Markel's service by William Beaumont Hospital?
A. Yes.
Q. Okay.
MR. WARWICK: Just foundation.
BY MR. TAKALA:
Q. And again, just to test your memory and I know that you've already given me your answer, but you don't remember talking with any other healthcare providers about Ms. Markel on October 10th, do you?
A. No.
Q. You don't remember talking with her family about her condition, do you?
A. No.
Q. Okay. After spending three or four or five hours reading the records in preparation for the deposition today, did that trigger any recollection?
A. No.

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Q. Okay. All right. The reason why I marked Plaintiff's Exhibit 2 -- well, one of the reasons -- and I think it reflects the same information on what I'll mark as Plaintiff's Exhibit 4.
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 4
2:47 p.m.
BY MR. TAKALA:
Q. Based upon Plaintiff's Exhibit 2 and Plaintiff's Exhibit 4, can you tell what time Ms. Markel presented to the hospital or when she hit the door, date and time?
A. On what day?
Q. Well, I'm asking you and I've given you -- Plaintiff's Exhibit 2 is the face sheet and Plaintiff's Exhibit 4 is some other demographic information about each patient's hospitalization and this is printed off from Epic.
A. Okay.
Q. Okay. And all I'm trying to do, and I promise, I'm not trying to trick you in any way, but I just want to define a couple of data points, okay?
A. Okay.
Q. And one of the data points is when Ms. Markel hits the door at Beaumont Hospital for treatment. Can you tell

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that date and time based upon either of those records?
MR. WARWICK: Just object to the form.
A. No.
BY MR. TAKALA:
Q. Okay. And what is -- what is the date and time that she hits the door for treatment?
A. 10-9-15, 1713.
Q. And then on Plaintiff's Exhibit 5, which is a continuation of Plaintiff's Exhibit 4, there's several pages in between -- or actually there aren't, I think those are successive pages, at least when I print them out.
Can you tell from Plaintiff's Exhibit 5 when Ms. Markel was discharged from Beaumont Royal Oak, where she was signed off and she could go home?
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 5
2:48 p.m.
A. Yes.
BY MR. TAKALA:
Q. All right. And what's that date and time?
A. Discharge date, 10-11-2015. Time, 12:45 p.m.
Q. Okay. So between 10-9-15 at 1713 and 10-11-2015 at 12:45 she's there for less than 48 hours, right?
A. Yes.

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Q. Okay. And the first time you make contact with Ms. Markel is on October 10th, correct?
A. Yes.
Q. I'll mark as Plaintiff's Exhibit 6 your history and physical. Would this be the first -- I'll let you review that for a second.

MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 6
2:49 p.m.

BY MR. TAKALA:
Q. You've seen that document before, right?
A. Yes.
Q. Is the history and physical the first documentation in a patient's medical chart that you make when you're assigned a new patient?
A. Yes.
Q. All right. Can you tell based upon Plaintiff's Exhibit 6 what time you first made contact with the patient?
A. 10-10-15, 1441.
Q. And now in fairness to you, I know there are probably a couple different dates and times that are stamped on that note. Are you confident that 1441 represents the time that you would have encountered the patient and taken the history and physical from her?

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A. So can I explain?
Q. Sure.
A. Usually I see the patient and then I write down the history and physical. So, you know, like from -- 1441 is the time when I'm writing down the -- entering the records into the patient's chart.
Q. Okay. And do you actually make keystrokes or do you dictate?
A. It can be both. I mean, in cases where I dictate, I specifically say that in the notes.
Q. Okay. And it's your habit and practice and -- that when you start a note, you would have been typing between 1441 and then finish it, however long it takes you to make that history and physical, right?
A. Yes.
Q. All right. And then do you usually sign the note after you finish the dictation or the keystrokes?
A. Yes.
Q. All right. Can you tell me what time you signed the note in this case, and I'll try to help you?
A. I don't see --
Q. You might be right, it might not be on here.

MR. SINKOFF: It's not on here.
MR. TAKALA: Okay. No problem.

BY MR. TAKALA:

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Q. All right. If you go to page 1, sorry, there's a file time. Do you know what that file time represents? In this case it's 1633 and in fairness to you that's, whatever, about an hour and 45 minutes after you start your note.
A. Yep, yes.
Q. Do you know what that file time represents?
A. That's when we signed the note and it's filed to the system.
Q. Okay. And I don't want to belabor this too much, but what does it involve in doing a history and physical with a new patient at the hospital at Royal Oak like Ms. Markel?
A. Okay. So going in and see the patient, you -- I get her medical history, get the history of present illness, which is why she came into the hospital, the details of that. And we go through the past medical history, surgical history, family history, medication list, allergies and then physical examination.
It's reviewing the data, which involves the lab results and imaging studies. And then the impression and plan, which is what the active medical problems are and what the treatment would be for that medical problems.
Q. Okay. Using -- and thank you, I appreciate your

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patience with me to understand that process.
You're not responsible for the patient prior to seeing her on October 10th at 1441, right?
A. Yes.
Q. You can't be responsible for somebody that you haven't seen, right?
A. Correct.
Q. Okay. After you do that history and physical, is Ms. Markel your responsibility as a hospitalist at Beaumont Royal Oak?
A. Yes.
Q. Okay. And that continues up until Ms. Markel's discharged on October 11th at 12:45, true?
A. Yes.
Q. Okay. And fair to say that -- and I know that you don't believe that Ms. Markel should have been contacted because she didn't need any antibiotics, but using a hypothetical question, if there was a culture result that came back positive and Ms. Markel needed to be contacted, would that be your responsibility to contact her after she was discharged as her attending physician?
A. Yes.
Q. Okay. And so, for the example, let's say it was a blood culture and the blood grew a positive bacteria,

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would that be a situation where Ms. Markel needed to be contacted?
A. Yes.
Q. Your standard of care would require you to pick up a phone and call her and let her know that result, right?
A. Yes.
Q. All right. And that's true even though you're not the one who ordered that culture, right?
A. Yes.
Q. Okay. And that's due to your responsibility as the attending physician?
A. Yes.
Q. Okay. If you know, fine, and if not, you let me know that it's an unfair question. Do you know who's responsibility for Ms. Markel's care prior to your involvement on October 10th at 1441?
MR. WARWICK: Just object to foundation.
MR. SINKOFF: Prior to -- while she's in the hospital?
MR. TAKALA: Yeah.
MR. WARWICK: Foundation.
BY MR. TAKALA:
Q. If you don't know, it's okay.
A. No.

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Q. Okay. Who decides to discharge a patient?
A. The attending physician does.
Q. Okay. And in this case it was your decision to discharge Ms. Markel, right?
A. Yes.
Q. Okay. Do you consult with any other medical personnel in your normal habit and routine before you discharge a patient or is this something that you do so frequently you know when a patient needs to be kept and when a patient can be discharged?
MR. SINKOFF: Object to the form and foundation.
MR. WARWICK: Same.
A. Yes.
BY MR. TAKALA:
Q. Okay. Which one? I'm sorry, it was a bad question.
A. I know when I -- when the patient is ready for discharge.
Q. Okay. So you don't need to speak with other consultants and get them to sign off, it's your decision and you're comfortable making that decision when you're presented with a patient like Ms. Markel, correct?
A. When other consultants are on the case, I do make decisions based on their input as well.

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Q. Okay. But before making the decision to discharge a patient like Ms. Markel, do you pick up the phone or try and track down these consultants in the hospital and ask whether it's okay to discharge the patient or do you make that decision on your own?
A. I make the decision on my own.
Q. Okay. And in fairness to you, there are probably some patients that have a different history that may require input from other consultants before you make that decision, right?
A. Yes.
Q. All right. Do you remember any conversations with any other medical personnel; nurses, P.A.s, consultants, ER docs, anybody prior to discharging Ms. Markel on October 11th at 12:45?
A. No.
Q. All right. Does that mean that it didn't happen -- or strike that.
Let me try and do it differently. If you did have a conversation with other medical personnel, would you have noted that in your discharge summary?
A. Not always.
Q. Okay. By the way, if you need to take a break at any point, you just let me know, okay? It's not necessarily an endurance contest -- in fact, it's

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definitely not an endurance contest.
A. Okay.
Q. On Plaintiff's Exhibit, I think it's 4 -- I'm sorry, it's actually 5, under -- and I don't know if I highlighted it or not, but under unit it says 6-ST GYN team. Does that have any significance to you?
A. It says 6 South, gynecology team.
Q. Okay. Was Ms. Markel admitted to a gynecology service?
A. No.
Q. Okay. And does the reference to care A have any special meaning to you?
A. No.
Q. All right. Prior to your involvement with Ms. Markel did you see that a urinalysis had been ordered?
A. Prior to my involvement?
Q. Yeah.
A. No.
Q. Okay.
MR. WARWICK: Form of the question.
MR. SINKOFF: The question is -- the form is disastrous --
MR. TAKALA: You're right. Let me --
MR. SINKOFF: -- at best.
MR. TAKALA: Thanks for --

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MR. SINKOFF: I couldn't think of another word.
MR. TAKALA: -- putting it politely, but I do agree.
MR. SINKOFF: What he's trying to ask is when you saw this patient, were you aware there were prior urinalyses done?
A. Yes.
MR. TAKALA: Now Steve is asking questions and answering them, both.
MR. SINKOFF: That's what happens when you've been around for a while.
MR. TAKALA: You should get paid for both sides of the table.
MR. SINKOFF: Okay.
BY MR. TAKALA:
Q. He's right though. Okay. What I'm trying to find out is when you do your history and physical at 1441 on October 10th, do you have access to prior test results?
A. Yes.
Q. Okay. And I know you don't have an independent recollection, but that's probably something you would have went back in the chart and looked at when you're performing your history and physical, correct?

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A. Yes.
Q. All right. And you would have seen that a urinalysis had been ordered, right?
A. Yes.
Q. And it was ordered by somebody in the emergency department?
A. Yes.
MR. WARWICK: Just objection to foundation.
BY MR. TAKALA:
Q. Okay. Do you know why that urinalysis was ordered?
A. No.
Q. Okay. Do you know whether it demonstrated any abnormal results?
A. When I reviewed the records, yes, I know.
Q. Okay. And that's something you would have had access to when you performed your history and physical on October 10th as well?
A. Yes.
Q. All right. What are the abnormalities when you reviewed the record that you were able to identify on the urinalysis?
A. Can I use the --
Q. Yes, sure, please.
MR. WARWICK: I'm not sure she has the same page of the records I sent to you, but there should be a little Bates stamp if she did, would you be kind enough to --
MR. SINKOFF: Yep, let her get to it.
MR. WARWICK: Great.
A. Yes.
MR. SINKOFF: Page 75.
MR. WARWICK: Thanks a lot.
BY MR. TAKALA:
Q. Can you give me the date and time of the urinalysis that you're looking at?
A. 10-9-15, 2323.
Q. Bear with me while I catch up.
MR. SINKOFF: 852 on the hospital's pages -- 862.
MR. TAKALA: Thank you.
BY MR. TAKALA:
Q. So go ahead and tell me what's abnormal about this urinalysis from 2323 on October 9th?
A. Leukocytes, 2 plus. WBC, 11 to 25. Epithelial squamous, 6 to 50. Crystal calcium oxalate.
Q. What does it mean when the leukocytes are 2 plus?
A. It means there is WBCs in the -- there is leukocytes in the urine.
Q. And is that an indication of an infection?
A. No.

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Q. Is that an indication of bacteria?
A. No.
Q. What's the -- what does it indicate to you as a hospitalist?
A. It indicates inflammation.
Q. And that inflammation can be coming from a lot of different sources, right?
A. Yes.
Q. One of those is infection?
A. Yes.
Q. All right. The WBC, 11 to 25 range, that's abnormal as well you told me?
A. Yes.
Q. Same answer, it demonstrates inflammation?
A. Yes.
Q. And that can be caused by infection, right?
A. It could be.
Q. And it could be caused by other things as well, right?
A. Yes.
Q. The epithelial squamous range, that's abnormal you told me?
A. Yes.
Q. Same thing, is that an inflammatory response?
A. No, it means it's not a clean urine sample.
Q. Okay. And help me understand as a layperson when --

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what you mean by not a clean urine sample?
A. Meaning normally for a clean urine sample we need a midstream urine sample, which means not the first urine that comes out because the first urine that comes out has some epithelial cells that's at the orifice of the urethra. So midstream urine sample is the ideal urine sample, which does not have any epithelial cells.
Q. Okay. And then the squamous cells, what's the importance of that?
A. That's the kind of cell, is called a squamous cell.
Q. And is that at the start of the urine stream, the end, both?
A. Yeah, it's usually at the start of the urine --
Q. All right.
A. -- sample.
Q. The calcium oxalate crystal result, you noted that as abnormal as well, right?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. What does that indicate to you as a hospitalist?
A. That's not necessarily indicating anything -- anything specific.
Q. Okay. I'm a layperson asking the question. Is it an

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inflammatory response, is it a potential bacteria, help me -- give me -- help give me the four corners?
A. It just indicates that there were some crystals in the urine.
Q. How can crystals becomes present in the urine, what causes that?
A. Dehydration could be one of the causes.
Q. What else?
A. There are other causes that -- I'm not exactly -- I don't exactly recall all the causes.
Q. Is it -- can infection be a cause of crystal formation in the urine?
A. No.
Q. Okay. Is dehydration -- or can dehydration be a symptom of infection?
A. No.
Q. Okay. Did you make any determination as to what was going on to cause these inflammatory responses in Ms. Markel on October 10th?
A. There was no symptoms to look for that --
Q. Okay. So --
A. -- responses --
Q. Sorry. So there were a couple of these inflammatory biomarkers on her urinalysis, but you didn't make a determination as to what was causing these

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inflammatory biomarkers?
A. It was not needed to look for the cause.
Q. No problem. And I understand what you're saying, but just so the question and answer is clear on paper, you didn't make any determination as to what was causing these inflammatory biomarkers on Ms. Markel's urinalysis?
MR. SINKOFF: Asked and answered.
MR. WARWICK: Same.
BY MR. TAKALA:
Q. Yes or no?
MR. SINKOFF: Well, no, she can explain her answer.
A. I'm sorry?
MR. SINKOFF: You can answer any way you want to. He can't limit you to yes or no.
A. Yeah, so a test becomes relevant only if there are any symptoms that needs to, you know, follow up on so --
BY MR. TAKALA:
Q. And what are the symptoms of a urinary tract infection?
A. Urinary tract infection symptoms are urinary frequency, urinary urgency, dysuria, hematuria, suprapubic pain.
Q. How about an upper urinary tract infection?

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A. You can have fevers and chills. Those are all symptoms of urinary tract infection.
Q. Flank pain?
A. Flank pain.
Q. Nausea, vomiting?
A. Could be, not specific for urinary tract infection.
Q. What is -- fair enough. But that can be a symptom of an upper urinary tract infection, right?
A. It can be.
Q. Okay. And that -- and sorry if I'm saying this wrong, but pyelonephritis?
A. Pyelonephritis.
Q. Thank you. And a lower urinary tract infection is cystitis?
A. Yes.
Q. Okay. And each one has different signs and clinical symptoms, right?
A. Yes.
Q. And you just listed those for me?
A. Yes.
Q. What is costovertebral angle tenderness?
A. Costovertebral angle tenderness, it's pain at the site of kidney location, near the patient's back.
Q. Can you help define a fever for me, is there a certain cutoff?

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A. In the normal patient, 99.9 or more can be considered as a fever.
Q. Okay. Did Ms. Markel have a temperature that was greater than 99.9 at any point between October 9th at 1713 and October 11th, 2015 at 12:45?
A. Yes.
Q. Okay. Did Ms. Markel have any flank pain between those two bookends?
A. No.
Q. Okay. What is flank pain?
A. Flank pain is pain at the site of -- it's pain in the flank, site of kidney.
Q. Now, when you -- you just kind of reached and you kind of reached on your side, like lower back side, right?
A. No. It's in -- you know, in the flank, which is --
MR. SINKOFF: The side.
A. Which is the side.
BY MR. TAKALA:
Q. Okay. Ms. Markel did have lower back pain on this admission, right?
A. Yes.
Q. And it did radiate, correct?
A. Radiate down her legs, yes.
Q. Okay. Did you -- were you able to diagnose or come up with a reason for that radiating lower back pain?

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A. Yes.
Q. What was that?
A. It was lumbar radiculopathy.
Q. And that was part of your plan, right?
A. Yes.
Q. And that was part of your impression, right?
A. Yes.
Q. You actually ordered a consultant to help address that problem, right?
A. Yes.
Q. And you actually told Ms. Markel that she should go for an epidural injection the following day?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. Okay. Obviously you would have had access to consult an infectious disease specialist if you felt it was appropriate, right?
A. Yes.
Q. All right. And you've done that in your practice before, fair?
A. Yes.
Q. All right. And if you had come to the conclusion, in a hypothetical question, that infection, whether it was an upper or lower urinary tract infection, was

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part of the diagnosis, you would have had an infectious disease specialist available to you to consult if you felt it was necessary, right?
A. Yes.
Q. Okay. And is it within your scope of practice and expertise to prescribe antibiotics for either an upper or lower urinary tract infection?
A. Yes.
Q. And are there some cases where antibiotics are indicated for either an upper or lower urinary tract infection?
A. Yes.
Q. Does it differ -- does the criteria differ for lower urinary tract infection versus an upper urinary tract infection?
A. I did not understand the question.
Q. No problem. Is there a different criteria or a different patient population which you would prescribe antibiotics for for a lower urinary tract infection or cystitis versus pyelonephritis?
A. If it is determined that the patient has infection, even if it's for -- even if it is lower or upper, we would provide antibiotics.
Q. Okay. Was it ever determined that there was an infection, either in the upper or lower urinary tract,

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in Ms. Markel?
A. No.
Q. Okay. The fact that the culture grew out, did it grow out bacteria?
A. Yes.
Q. All right. Does that give you an indication as to whether there was bacteria in the urine?
A. It indicates bacteria in the urine.
Q. Okay. Fair enough. I'm going to take a step back for one second. There was another urinalysis that was performed and this, I believe, is on the same page, page 62 from the packet of records that Don provided, I believe? Do you see --
MR. WARWICK: I'm not sure, what's the number on the --
MR. TAKALA: I've got some -- off the record.
(Discussion off the record at 3:10 p.m.)
(Back on the record at 3:10 p.m.)
BY MR. TAKALA:
Q. So I'm looking at a urinalysis from October 10th, 2015 at 2201. Do you see that on your page or can you locate that in your chart?
A. 2201, yes.
Q. And it looks like it was ordered by an individual by

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the name of Janay, J-A-N-A-Y, Warner, W-A-R-N-E-R?
A. Yes.
Q. Okay. Do you know Janay Warner?
A. No.
Q. Okay. Do you know who Janay Warner is employed by?
A. No.
Q. Okay. These results from this urinalysis at 2201 on October 10th, are there abnormal results from that urinalysis?
A. Yes.
Q. Can you just go through and indicate to me what's abnormal about that UA?
A. Ketones, trace. There is nitrates negative -- or leukocyte S trace 2 plus, which is abnormal. RBC, 5. WBC, more than 100. Epithelial squamous, 21. Casts --
Q. All right.
MR. WARWICK: So just -- I'm sorry for interrupting, but just so -- so we all have the same pages, that page of records with those results are on page 2456 of the records I provided to everyone, if you need to reference it in the future -- or if we all need to reference it together.
MR. TAKALA: Got it. Thank you, Don.
MR. WARWICK: Thanks.

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BY MR. TAKALA:
Q. Let's -- we'll try to get through this quick, I'm falling behind where I probably should be.
The ketones, the trace amount of ketones, what does that indicate to you?
A. When you're dehydrated and when you're not eating much, it could cause ketones in your urine.
Q. Okay. And we already talked about the leukocytes and the epithelial and the white blood cell count, those are -- well, strike that.
The leukocytes and the white blood cell counts are inflammatory markers, right?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. And the epithelial is the sign of a bad catch?
A. Correct.
Q. What's the significance of the RBC coming in at 5?
A. There are some blood in the urine.
Q. Did you come up with any diagnosis or understanding as to what was causing the blood in the urine?
A. No.
Q. The casts, what is -- what's the significance of the casts or the presence of casts in the urine?
A. It means -- dehydration can cause hyaline casts in the urine.

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Q. Okay. Thank you. Sorry I'm going back and forth a little bit, but you told me that there are some patients with cystitis that you would treat with antibiotics?
A. Yes.
Q. Do you treat all patients with cystitis with antibiotics?
A. If they are -- yeah, if there is determined to be an infection and cystitis, yes.
Q. Okay. Same question with pyelonephritis, do you treat all patients with pyelonephritis with antibiotics?
A. Yes.
Q. Do you have an opinion as to whether Ms. Markel had either -- well, I'll ask them one at a time.
Do you have an opinion as to whether Ms. Markel had cystitis?
A. She did not have cystitis.
Q. Okay. Do you have an opinion as to whether she had pyelonephritis?
A. She did not have pyelonephritis.
Q. Do you have an opinion as to what was causing the bacteria in the urine that grew out from the culture?
A. It is a contaminated specimen and it is called asymptomatic bacteria.

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Q. Okay. When -- you saw -- you saw Ms. Markel on October 14th, 2015 when she came back to the hospital, right?
A. On October 14th, yes.
Q. Okay. Was she infected at that point in time?
A. There was a suspicion for infection.
Q. Okay. Where was the infection?
A. In her joints.
Q. Do you know whether there was any bacteria in the urine at that point in time?
A. When she came back?
Q. Yeah.
A. I knew from the previous culture that -- from the 10-11 culture that she had bacteria in the urine.
Q. Okay. After Ms. Markel comes back and you get more of the story, so to speak, and you come to the conclusion that there's a joint infection, did that give you any indication as to whether the bacteria that grew out in the urine was a contaminated specimen or a good result?
MR. SINKOFF: Object to the form.
MR. WARWICK: Same.
BY MR. TAKALA:
Q. Let me try and do better. Knowing what you knew on October 14th, knowing that Ms. Markel had a joint

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infection -- are you with me?
A. Yes.
Q. Are you still of the opinion that the urine that grew out bacteria on October 12th that was collected, I think on --
A. The 10th.
Q. -- October 10th was from a contaminated source?
A. Correct.
Q. Do you ever treat patients -- when I use the word empirical treatment, what does that mean to you in the field of medicine, I just want to make sure we're talking about the same thing?
A. You are treating a patient with antibiotics without specific signs of infection.
Q. Do you ever treat patients empirically for infection?
A. It depends on the kind of patients that you're treating.
Q. Okay. How about a patient with a history of joint replacement with inflammatory urinalysis, is that a patient that you would treat empirically with antibiotics?
MR. SINKOFF: Object to foundation and form.
MR. WARWICK: Same.
A. No, unless the patient has symptoms.

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BY MR. TAKALA:
Q. Okay. And those symptoms?
A. Of urinary tract infection.
Q. And that would include fever of greater than 99.9, right?
A. If it's persistent, yes.
Q. Okay. And that would include flank pain, right?
A. Yeah.
Q. And that would include nausea and vomiting, right?
A. Again, not just nausea and vomiting, it's not a symptom of infection.
Q. Fair enough. But --
A. So if you have other -- flank pain and fever, persistent fever, along with urinary tract infection symptoms.
Q. Okay. Did Ms. Markel have any nausea and vomiting between October 9 and October 11th?
A. Not that I can recall.
Q. Okay. Bear with me just one second.
So the -- where I get vomiting from, and maybe it was somewhere else I saw it in the chart too -- if you want to flip to Plaintiff's Exhibit, I think it's 2, it's your H&P from October 10th -- I'm sorry, it's 6?
MR. WARWICK: What's the date and time of

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this report?
MR. TAKALA: So I don't have the same Bates stamp. On the exhibit --
MR. SINKOFF: 10-10, 1441.
MR. WARWICK: Thanks.
BY MR. TAKALA:
Q. Go to the last page. So if you go to -- I don't know whose typing that is, maybe it's yours, maybe it's somebody else's; can you tell me?
A. It's mine.
Q. All right. You say MRI of the lumbar spine, dash, multilevel, mild vomiting and severe stenosis of the central spinal canal.
When you say mild vomiting, what does that mean?
A. That was -- so the voice processing software error that happened there.
Q. Okay. Do you know what you meant there?
A. Multilevel mild, moderate and severe stenosis would have been right.
Q. What was the word again?
A. Moderate.
Q. Moderate?
MR. SINKOFF: It's hard to have vomiting in the spinal canal.

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MR. TAKALA: No, I get it. I understand.
BY MR. TAKALA:
Q. Thank you for helping me with that. Getting back to what got me to this point in the first place though, there are some patients that you would start on empiric antibiotics, fair?
A. Yes.
Q. Okay. And those would involve patients that are demonstrating signs of either cystitis or pyelonephritis, right?
A. Yes.
Q. All right. Would your standard of care require you to start a patient on empiric antibiotics with signs of pyelonephritis?
MR. SINKOFF: Object to the foundation, it doesn't give enough information.
MR. WARWICK: Same.
BY MR. TAKALA:
Q. I think you just answered the question for me, but I'll -- I think you just said yes?
MR. SINKOFF: No, she didn't say yes, this is a different question.
MR. TAKALA: Okay. We'll read the transcript later and I'll ask the question again.
BY MR. TAKALA:

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Q. Would you start a patient on empiric antibiotics with signs of pyelonephritis?
MR. SINKOFF: Object to the foundation, it doesn't contain sufficient information to answer that question.
MR. WARWICK: Same.
MR. SINKOFF: You can answer subject to the objection.
A. Can you explain more?
BY MR. TAKALA:
Q. Sure. If a patient has fever, flank pain and nausea and vomiting, for example, would you start empiric antibiotics for pyelonephritis?
A. No.
Q. Okay. And if a patient has fever, flank pain, nausea, vomiting and chills, do you start that patient for pyelonephritis?
A. If she -- if the patient has symptoms of -- urinary symptoms of UTI, which I described earlier as frequency, urgency, dysuria, hematuria.
Q. Okay. So in order for you to start empiric antibiotics for pyelonephritis you would need to see dysuria, frequency, urgency, suprapubic pain or hematuria?
A. Hematuria, along with flank pain and persistent

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fevers.
MR. WARWICK: I think your question said, or, and I just object to the form so -- go ahead. I didn't mean to interrupt.
MR. TAKALA: That's fine. It's a fair objection, I understand.
BY MR. TAKALA:
Q. Do you need to see multiple symptoms -- or problems with urination before you start empiric antibiotics for a urinary tract infection?
A. At least some symptoms, some urinary symptoms.
Q. Does that mean at least one?
A. Yes.
Q. Okay. So any one of the dysuria, frequency, urgency, suprapubic pain or hematuria?
A. Yeah.
Q. Okay. In addition to temperature and flank pain, right?
A. Correct.
Q. All right. Was there any indication in the chart from the emergency department notes or otherwise that Ms. Markel was having problems with urination at all?
A. It said -- there was some mention of inability to urinate.
Q. Okay. What is that called in medical terms?

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A. Inability to urinate.
Q. Okay. Is that a sign of cystitis?
A. No.
Q. All right. Were there any other comments made about the frequency or anything else about Ms. Markel's urination either in the emergency room or upon your examination?
A. Yes. I did mention in my history and physical that patient was able to urinate -- was able to urinate.
Q. Got it. Do you know who ordered the culture in this case, I think it was the same P.A. that I had mentioned before?
A. Yes.
Q. All right. Do you know -- again, if you don't know, it's fine, but I'm here to ask the questions. Do you know why that culture was ordered?
MR. WARWICK: Well, just object to the form. I think you -- you asked two questions in one there and I'm not sure which question she answered about knowing the P.A. She previously said she didn't know the P.A. and then you said -- you asked a second part of the question. I just want to make sure the record is clear. It's my understanding the P.A. doesn't know this doctor, but go ahead.
MR. TAKALA: Fair enough.

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BY MR. TAKALA:
Q. Do you know the P.A. that ordered the urine culture, that's Janay Warner?
A. Do I personally know her, is that the question or --
Q. Yeah.
A. No.
Q. Okay. Now, do you know why P.A. Warner ordered the urine culture in this case?
A. I do not know.
Q. Thank you.
MR. WARWICK: Thanks. Sorry, I apologize for interrupting.
MR. TAKALA: You don't have to apologize, it's not a problem.
BY MR. TAKALA:
Q. Have you ordered urine cultures in your practice as an internal medicine physician --
A. Yes.
Q. -- seeing patients in the hospital?
What would -- what would lead you to order a urine culture in your practice?
A. If the patient has urinary symptoms of UTI, like hematuria or dysuria, frequency, then I order urine culture and urinalysis.
Q. Okay. No other circumstances where you're ordering a

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urine culture except for urinary symptoms that include either dysuria, frequency, urgency, suprapubic pain or hematuria?

A. It depends on the patient population too.

Q. Okay. Help me understand a situation where you would order a urine culture in the absence of one of these urinary symptoms?

A. If a patient is immunocompromised, then -- and they present with signs of infection, then we order -- trying to figure out what the source of infection is, usually order urinalysis and a urine culture.

Q. Okay. Was Ms. Markel immunocompromised in any way?

A. No.

Q. Okay. Did she have any signs of infection that you saw?

A. No.

Q. Okay. Are there any other circumstances in your practice as an internal medicine doctor in the hospital that you would order a urine culture that I'm missing?

A. In elderly patients when they present with a change in their mental status, trying to figure out if there is an underlying infection, you can order a urinary analysis and urine culture.

Q. Okay. And Ms. Markel was not elderly and she didn't

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have a change in mental status, right?

A. Yes.

Q. My statement is correct, thank you. Any other situations where you would order a urine culture in your practice aside from what we've talked about already?

A. No.

Q. Okay. And when I have -- when I have the chance to talk with P.A. Warner, I can ask P.A. Warner this question, but if there were no urinary symptoms, there was no dysuria, frequency, urgency, suprapubic pain, hematuria, wasn't an immunocompromised patient and it wasn't an elderly patient that had mental status changes, there's no reason why you would order a urine culture in your practice, right?

A. In a young, healthy -- otherwise healthy patient, yes, I would not order.

Q. Okay. Is there any increased risk of infection for patients that have a history of artificial joints?

A. Just because of the artificial joints?

Q. Yes.

A. No.

Q. Okay. Did you know that Ms. Markel had artificial joints when you took your history and physical on October 10th?

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A. Yes.

Q. And, I'm sorry, I didn't see it in there maybe, I was -- didn't -- maybe I missed it. Did you note it in your history and physical that I marked as Plaintiff's Exhibit 6?

A. Say under past surgical history.

Q. And in fairness to you, you do have it in here. Arthroplasty, total knee left, arthroplasty, total knee right?

A. Correct.

Q. Okay. Thank you. Do you treat patients with a history of artificial joints differently when it comes to antibiotic treatment?

A. No.

Q. Okay. Does the -- strike that.

Sorry to cover ground that we've already been over and I appreciate your patience with me. Agree that these are clinical manifestations of cystitis, okay? Dysuria?

MR. SINKOFF: Object to -- this has been asked and answered at least three times already.

MR. TAKALA: You're right, and I -- but I still want to make sure we go over this.

BY MR. TAKALA:

Q. Dysuria, yes or no? It will take 20 seconds.

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A. Yes.

Q. Frequency?

A. Yes.

Q. Urgency?

A. Yes.

Q. Suprapubic pain?

A. Yes.

Q. Hematuria?

A. Yes.

Q. Am I missing anything?

A. No.

Q. Okay. Again, bear with me for ten seconds. Signs of pyelonephritis include elevated temperature?

A. Persistently elevated, yes.

Q. Okay. Meaning persistently elevated above 99.9?

A. Yes.

Q. Okay. Chills?

A. Yes.

Q. Flank pain?

A. Yes.

Q. Nausea and vomiting?

A. Yes.

Q. Am I missing anything?

A. Urinary symptoms.

Q. Okay. Anything else that we could add to that list,

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signs of pyelonephritis?
A. No.
Q. Okay. What's the antibiotic of choice for cystitis?
MR. SINKOFF: In an otherwise healthy young person?
MR. TAKALA: Yeah, well, let me ask that question first.
BY MR. TAKALA:
Q. In an otherwise young, healthy patient, do you prescribe antibiotics for cystitis?
A. Yes.
Q. Okay. What antibiotics?
A. We can do either Macrobid or Bactrim, usually the common choices.
Q. Are those oral antibiotics?
A. Yes.
Q. Okay. Same question for pyelonephritis, do you prescribe antibiotics for an otherwise young, healthy patient with pyelonephritis?
A. Yes.
Q. What's the antibiotic of choice for pyelonephritis, same or different?
A. Depends on the severity of the infection. The patient can be treated as an outpatient, usually we do Ciprofloxacin. If the patient is admitted to the

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hospital with pyelonephritis we can do IV ceftriaxone.
Q. And this is all within the scope of an internal medicine physician or would you consult an ID specialist when you're choosing antibiotics for a pyelonephritis patient?
A. We do not have to always consult infectious disease. Internal medicine physicians can treat pyelonephritis.
Q. And in a young, otherwise healthy patient who you suspect to have pyelonephritis, are you managing the antibiotic treatment?
A. Yes.
Q. All right. Same question with cystitis, you're managing the antibiotic treatment?
A. Yes.
Q. Okay. When you have signs of pyelonephritis -- and I'll apologize to Steve if I already asked this question -- would you start empiric antibiotics in certain patients?
MR. SINKOFF: Object to asked and answered at least twice.
A. Based on the -- as we discussed previously, immunocompromised patients we do start empiric antibiotic treatments.
BY MR. TAKALA:
Q. Okay. Any other groups of patients that you would

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start empiric antibiotics on with signs of pyelonephritis?
A. If I'm suspecting pyelonephritis, is that -- does that clarify the --
Q. Yes, ma'am.
A. -- I mean, is that what you're asking?
Q. Yes, ma'am.
A. If I'm suspecting pyelonephritis, I would treat the patient with antibiotics.
Q. On an empiric basis before cultures came back?
A. Yes.
Q. All right. Would you order cultures as well?
A. Yes.
Q. All right. Is that the same for cystitis, if you suspect cystitis do you start a patient on empiric antibiotics without --
A. Without culture results?
Q. Correct.
A. Yes.
Q. Okay. And that's true in an otherwise young, healthy patient?
A. If the patient has symptoms of acute cystitis, yes.
Q. Go it. Thank you. You agree that one of the reasons why you prescribe or start empiric antibiotics is because that's important and affects the outcomes, it

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prevents the infection from spreading? Sorry if I did bad with that question.
MR. SINKOFF: Object to foundation.
A. Yeah, you'll have to --
BY MR. TAKALA:
Q. Okay. Is there a reason why you start empiric antibiotics before you get the culture back?
A. Yes.
Q. Why?
A. To prevent the infection from spreading.
Q. Why is it bad if an infection spreads?
A. It can get to your bloodstream and can go to different parts of your body.
Q. What happens if it gets in the bloodstream, the infection?
A. The infection can go to the different parts of your body.
Q. Can a patient die from an infection in the bloodstream?
A. Yes.
Q. Okay. What happens if an infection gets into the joints, is that bad?
A. You get septic arthritis.
Q. Okay. And you agree that it is important to stop that early on and the way you do that as an internal

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medicine doctor is empiric antibiotics?
A. Empiric antibiotics if the patient is symptomatic.
Q. Let's go through your history and physical, and I promise, I'm not going to spend a lot of time on it, but there were a couple of things I wanted to ask you about on it, okay? So that's Plaintiff's Exhibit 6.
A. Okay.
Q. At the start, we already talked about the times.
A. Yes.
Q. Chief complaint, low back pain, right?
A. Yes.
Q. That's different than flank pain?
A. Yes.
Q. All right. The last sentence in the history of present illness -- or maybe the second to last sentence --
MR. SINKOFF: Starting where?
BY MR. TAKALA:
Q. The line starts, urinary or bowel incontinence?
A. Yep, yes.
Q. And this is where we --
MR. SINKOFF: Actually it says no urinary or bowel --
MR. TAKALA: Fair enough, yeah, I was just trying to --

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MR. SINKOFF: I understand. I understand.
BY MR. TAKALA:
Q. That sentence continues. Although she felt she was unable to urinate earlier, period. Has urinated times three since this morning.
You're writing this note at 1441, so it's about 2:41 p.m. is -- you know, I mean, what's the importance of indicating three urinations or three times urinating since this morning?
A. Because she was unable to urinate earlier, so I'm saying that she was able to urinate after that --
Q. Okay.
A. -- after that complaint.
Q. Okay. Fair enough. And denies any chest pain, palpitations, fever, chills, nausea or vomiting?
A. Yes.
Q. As part of the vital signs, and I'm on -- it says page 36 in the lower left corner. You record or somebody records a temperature of 99 degrees Fahrenheit?
A. Yep.
Q. Does that qualify for fever?
A. No.
Q. Okay. And if you go to the last page, your plan was to admit, right?
A. Yes.

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Q. And what was the purpose for the admission?
A. For pain control, to consult Dr. Olson, PM & R and pain management and to diagnose and treat her condition.
Q. And do I have it right, you're deferring that portion of the treatment to the consultants, right? You're bringing the consultants on to treat the pain?
A. No. She's already getting the pain control and that's Toradol, Dilaudid, Decadron and muscle relaxants, which is a plan of -- with the pain control.
Q. Fair enough. Do you know whether you saw Ms. Markel at any point prior to writing your discharge note from October 11th, 2015, and I'm marking that as Plaintiff's Exhibit 7?
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 7
3:36 p.m.
A. I'm sorry, what's the question again?
BY MR. TAKALA:
Q. Sure. I'm sorry, I mismarked this. What I marked as Plaintiff's Exhibit 7 was -- sorry. So Plaintiff's Exhibit 7 is going to be the discharge summary from October 11th, 2015, okay?
A. Okay.
Q. Here you go now.

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MR. SINKOFF: Just before you start, so the record is clear, on each of these exhibits there's highlighting all placed by Mr. Takala or somebody in his office.
MR. TAKALA: That's correct, yep.
BY MR. TAKALA:
Q. Okay. So I just marked the discharge summary as Plaintiff's Exhibit 7. And again, using the times at the top, can you tell me when you started this process and when you finished it?
A. Note time, 10-11-15, 11:06 and filed 10-11-15, 1433.
Q. So that means you would have started the note at 11:06 a.m. and you would have finished it or signed off on it at 1433?
A. Yes.
Q. Okay. Do you know if you saw Ms. Markel between the history and physical and the discharge summary?
A. So I saw her on 10-10 for that history and physical and then -- no, next day would be around 11:06.
Q. Okay. But, I mean -- and I think you already told me that there's another hospitalist that's on duty from -- that takes the night call, right?
A. Yes.
Q. All right. So you don't have any indication that you saw or provided any treatment to Ms. Markel between

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your note on October 10th and then your discharge summary on October 11th, right?

A. Yes.

Q. All right. Did you see that overnight a temperature had been reported of 100.9 degrees by the nursing staff?

A. Yes.

Q. All right. And that's something that you would have realized on October 11th, 2015 as part of your habit and practice, you're going back and trying to figure out what's going on with the patient so you can get up to speed treating going forward, right?

A. Correct.

Q. Okay. Did you attribute that temperature to a sign of infection at that point in time?

A. No.

Q. Why not?

A. Because there was no persistent elevation of the temperatures after that one episode.

Q. Okay. Do you know if Ms. Markel's temperature did persist in reality after she was discharged on October 11th?

A. Not after discharge.

MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 8

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3:39 p.m.

BY MR. TAKALA:

Q. I'll mark as Plaintiff's Exhibit 8 the history and physical from October 14th. Again, can you identify the times on your H&P from October 14th when you would have seen the patient and when you would have started and ended your note?

A. Okay. 10-14-15, 11:34. Filed 10-14-15, 1436.

Q. Again, that means you would have started your note at 11:34 in the morning?

A. Yes.

Q. And you would have finished your note and signed off on it at 1436?

A. Yes.

Q. Okay. In the history of present illness, and this is about halfway through, it says she also had a fever, 102 at home. Do you see that in there?

A. Yes.

Q. All right. Agree in a hypothetical world if Ms. Markel had a 100.9 degree temperature in the early morning hours of October 11th and then had a fever of 102 on October 12th and then she comes to the hospital with a fever, is that a persistent fever?

A. No.

Q. Okay. What's your definition of a persistent fever?

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A. If you have consecutive readings of temperature more than 99.9 throughout, from 10-11 -- I mean, 10-10 at 8:00 p.m. until the time I saw her on 10-11 at 11:06, that would be persistent fever, otherwise it would be intermittent fever.

Q. Okay. Can certain medications mask a fever?

A. Yes.

MR. TAKALA: All right. I'll tell you what, I'll ask for a five-minute break.

(Recess taken at 3:40 p.m.)

(Back on the record at 3:46 p.m.)

BY MR. TAKALA:

Q. We talked about your habit and routine for how you do a history and physical. Can you take me through your habit and routine of a discharge summary? So I think I marked the discharge summary as what Number?

A. 7.

Q. Okay. Just take me through that process, as in your -- in your scope of expertise or your scope of practice?

A. Yes. Usually when you document, there's the date of admission and the date of discharge and the hospital brings up the problem. And then it's -- you know, it will list the consultants that were on the case, as for last studies that needs to be followed up on, what

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procedures were done. And then a brief hospital course as to what happened with the patient, how did we treat the patient, what's the plan for followup.

And then it has a section that says evaluation on the day of discharge. And then the discharge instructions, which includes the medication list, as for labs -- should be a discharge -- it is not in here, but it's -- there's a discharge instruction that we provide the patient, a page -- a page in discharge instructions.

Q. Good. And that's page 15 in the lower left corner?

A. Yes.

Q. All right.

A. So that's the whole discharge package that we do for the patients.

Q. Okay. And you have something circled on that page in your chart, right?

A. Yes.

Q. All right. What's that that you have circled?

A. It says to contact your doctor if your temperature is over 100.5 and you're unable to urinate, that's the circled one. And there are other -- other reasons to contact your doctor too; so if you have nausea and vomiting, if you have shortness of breath or if you have chest pains.

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Q. All right. Got it. Being unable to urinate, why is that important?
A. If you cannot urinate -- obviously, you know, you need to urinate. So if you can't urinate for a certain period of time, then it's an abnormal -- natural process, so you have to contact somebody.
Q. Is the inability to urinate a sign -- what -- strike that.
What is -- what can cause the inability to urinate?
A. Urinary retention, if there's any blockage to your path of urination, that can cause urinary retention.
Q. Okay. And why is it important for a patient to follow up if a fever persists over 100.5 degrees?
A. If there's a persistent fever, then that could be a sign of infection.
Q. Okay. And in fairness to you, on your discharge summary you noted that the temperature -- or somebody noted the temperature on the day of discharge was 97.5, that's on page 18?
A. Yes.
Q. Okay. And we talked about certain masking agents for temperature. In the medication list on page 19 there's oxycodone, acetaminophen. Is that a masking agent for temperature?

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A. Oxycodone, acetaminophen -- acetaminophen can sometimes decrease the temperatures.
Q. Okay. Any other medications on that list that can decrease temperature?
A. No.
Q. Okay. This isn't too important, but on page 18 there's a line right above where it says discharge instructions, time spent on evaluating, preparing and coordinating discharge, colon, 25 minutes?
A. Yes.
Q. All right. Help me understand how that fits with the times that we were talking about earlier where you started at 11:06 a.m. and finish at 1433 on the top of your note?
A. Yes. So I can stop note -- it doesn't say it's the note time, it says the time spent on evaluating, preparing and coordinating the discharge. So that's the actual time that I had spent with the patient, examining her, talking to the nurse and finalizing the discharge paperwork and all that.
Q. No problem. Just help me understand how that fits though, if you're spending 25 minutes coordinating the discharge, deciding on discharge, if your note starts at 11:06, shouldn't it be signed at 11:46 or something like that?

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A. We have the option to, you know, come back to the note. We can pen the note and come back to the note and finish it off at a later time.
Q. Okay. The actual discharge time on Plaintiff's Exhibit 4 was 1713. Does this help us at all with the sequence of events --
A. That's -- I'm sorry to interrupt, that's the admission time.
Q. Sorry. Thank you. The discharge time is 12:45 p.m.?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. Okay. Does that help us at all coordinate what was going on here? So to help you, you start your note at 11:06, you spend about 25 minutes and the discharge is at 12:45 and you sign the note at 1433?
A. Okay.
Q. Help me understand what happens?
A. So discharge note, filing time, you know, I can file that anytime during the day. So it could be 1433, it could be 1600. The discharge date and time here on Exhibit 5, that's the time when the patient is discharged from the hospital, I believe, not 100 percent sure.
Q. Okay. That's okay. It makes sense to me. You file

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your note or you electronically sign your note after the patient has already been discharged?
A. Right.
Q. Okay. And what does it mean to file a note, do you click a button on the Epic system?
A. I sign the note. There's a button called signing and if I click it, then that becomes -- it gets filed.
Q. Okay. Thank you. The culture that eventually grew out, this Group B streptococcus, help me with this word?
A. Streptococcus agalactiae.
Q. Thank you. By the way, did the -- the culture was a contaminated culture, you think?
A. Yes.
Q. All right. What information from that culture leads you to believe it was a contaminant?
A. First of all, it's a Group B streptococcus, which is a normal colonizing bacteria in the urethra, rectum, vaginal, cervix. And it's collected off of the -- it's collected the same time as the urinalysis from 10-10-15 at 2109.
Q. Okay. So the fact that they were collected at the same time as the urinalysis has epithelial cells, you're doubting whether there was a good catch or a good specimen?

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A. Correct.
Q. All right. Obviously the culture results -- and I'm reading from the urine culture. They were not resulted at the time you discharged Ms. Markel, correct?
A. Correct.
Q. All right. What's the practice with whom these cultures are reported to, we know that P.A. Warner orders the test, but you still have access to the results because you're the attending physician?
A. Correct.
Q. All right. Do you know who else would get notification of the results of that urine culture?
MR. WARWICK: Just foundation.
A. I'm not sure.
BY MR. TAKALA:
Q. Fair enough. Thank you. And you already told me that your role in this process, if it's a urine culture that comes back and you believe that it requires treatment, it's your job to call the patient as the attending physician, right?
A. Yes.
Q. All right. Do you know whether there was any written policy and procedure about who receives notice of a positive urine culture at Beaumont Hospital?

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MR. WARWICK: Just form and foundation. And if she does, it shouldn't be turned over. I'm assuming she doesn't have policies and procedures, but I would object to --
A. I do not know.
BY MR. TAKALA:
Q. Okay. Obviously they did not teach you about the workflow at William Beaumont Hospital when you were in medical school in India, right?
A. No.
Q. They didn't teach you about the workflow at William Beaumont Hospital and how urine cultures were reported while you were in Philadelphia in your residency, right?
A. No.
Q. Okay. How did you learn about how those results were reported on Epic and whose responsibility it was to consult the patient in the event of abnormal results at William Beaumont Hospital?
A. As I practiced, through my years of practice.
Q. Okay. You learned about that on the job, right?
A. Yes.
Q. You learned about it. Do you do any training on how results are reported on Epic and how a doctor gets results and reports results?

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A. We get training on the Epic and about where results -- where we should look for the results.
Q. Okay. Do you get any training or inservice or any sort of coordination of care as to whose responsibility it's going to be to contact the patient in the event that there was an abnormal result that the patient needed to be called about?
A. There's no official training.
Q. Okay. How do -- how do you know that it's your job to do that?
A. That is the standard of practice --
Q. Okay.
A. -- you know.
Q. But that varies from hospital to hospital. For example, in this case if there's a P.A. that's ordering the culture in the emergency department and you're sitting here telling me as the admitting hospitalist that it's your job to follow up, right?
A. My job is to follow up if there are any results that are outstanding at the time I received the patient's care.
Q. Okay. But the point I'm trying to make is in a different health system, that may be a different process. Maybe it's the ordering physician that has to follow up on the ordered tests, right?

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MR. SINKOFF: Just objection to relevance --
A. I would not know.
MR. SINKOFF: -- what's the difference --
MR. WARWICK: Join.
MR. SINKOFF: We're talking about Beaumont.
A. I don't know.
MR. TAKALA: Yeah, but the point is that there's a way that Dr. Lonappan learns about this process and I want to know what that process is.
MR. SINKOFF: She told you, through her experience working there.
MR. TAKALA: Okay.
A. Through my practice, yes.
BY MR. TAKALA:
Q. All right. I mean, was there a physician that told you how this worked?
A. I don't recall --
Q. Okay.
A. -- specifically.
Q. Has it changed since you started at -- in 2011 and today's date?
A. Has what changed?
Q. The process as far as who would be responsible for following up on outstanding results of a discharged

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patient?
MR. WARWICK: Just foundation.
A. I do not know if it has changed. For my practice it has not changed.
BY MR. TAKALA:
Q. Did you have Epic when you started in 2011?
A. Yes.
Q. Okay. And it was always -- that's true?
A. Yes.
Q. Okay. And it's always been the attending physician whose responsibility it was to follow up with outstanding test results?
A. It is admitting physician's responsibility to follow up on the results or let the patient know to follow up with whoever needs to be followed up with.
Q. Okay. Have you ever practiced in a hospital or a setting where the results would be sent to the ordering physician and the ordering physician would have to follow up on those results?
A. I only practiced at Beaumont Hospital so I don't have any other practice or -- any other practice.
Q. Okay. This was a patient that was admitted to an observation -- was it observation or was it an actual med/surg floor?
A. It was observation based on the admission orders.

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Q. It was a GYN service?
A. I don't -- I don't know specifically as to why she went to the GYN floor. There was -- I don't know offhand, I'll have to look through the records to find out that specific order for admission, you know. Do you want me to go through the records to find that out?
Q. No, I don't think that's important.
A. Okay. She was admitted as an observation patient, I know that.
Q. Okay.
A. I'm sorry.
Q. She was admitted to be observed about her pain though, right?
A. Yes.
Q. All right. She wasn't admitted for any other reason?
A. She was admitted for the back pain and the pain that went down her legs, yes.
Q. Okay. And there was no other reason why she was admitted?
A. No.
Q. If it wasn't for that radiating back pain down to her legs, she would have been discharged the same day or you would have seen her and made the decision not to even admit her, right?

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A. Right.
Q. Okay. By the way, if you know, how is it that you become involved in this patient's care, does -- because obviously I'm sure there's patients that come to the ER and the ER doctor doesn't even call the hospitalist, right?
A. Yes.
Q. Okay. Is that a decision that you're involved in or is that the ER doctor's decision to call you or to put the patient on your service?
MR. WARWICK: Just foundation.
Go ahead.
A. So when Dr. Bonema's patients come to the hospital, if they need to be admitted to the hospital, then the ER physicians calls the on-call physician for our group and that physician decides which patient -- which physician the patient would be admitted under.
BY MR. TAKALA:
Q. Got it. Are there certain patients where they might have a different PCP and that PCP actually treats the patient in the hospital at Beaumont?
A. Yes.
Q. Okay. Are you aware of any policies and procedures at Beaumont that you've received?
MR. WARWICK: Just form, foundation.

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MR. SINKOFF: About what?
MR. TAKALA: Anything.
MR. WARWICK: Privileged, confidential.
MR. SINKOFF: You can answer, but they're not admissible.
A. About the privileges, have got information.
MR. TAKALA: Okay. Well -- and I think it's a little different in this case because we've made hospital administration claims, I believe.
MR. SINKOFF: Well, you can take that up with Don.
MR. WARWICK: Well, you haven't made valid hospital administration claims, but go ahead.
MR. TAKALA: Okay. Well, I mean, I suppose that's an issue that needs to be debated later, but until there's a motion for summary disposition on those claims, I mean, I think I get to ask questions about --
MR. WARWICK: Well, you can ask questions, but I object to, if she has any policies and procedures, to turning over any such policies and procedures. That would be something that would need to be discussed with the court and ordered by the court.
MR. TAKALA: Fair enough.

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BY MR. TAKALA:
Q. Do those policies and procedures exist, otherwise stated and subject to Don's objection and I get it, are you in possession of policies and procedures from Beaumont?
A. No.
Q. Okay. Are you in possession of any policies and procedures from Hospital Consultants, P.C.?
MR. SINKOFF: I'm going to object to the foundation of that.
A. What do you mean by policies and procedures, regarding a specific thing or just general policies and procedures?
BY MR. TAKALA:
Q. Yeah. General policies and procedures, something that you've received in writing, whether it's an employee handbook or a manual or this is how we do things at Beaumont or this is how we do things at Hospital Consultants, P.C.? Do you understand what I mean by --
A. Yes, yes.
Q. Okay. Do you have any policies and procedures from Beaumont Hospital?
A. No.
Q. Okay. Do you have any policies and procedures from

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Hospital Consultants, P.C.?
A. Yes.
Q. Okay. And those are written down instructions as to how to handle certain things?
A. I believe so.
Q. Okay. Have you read them?
A. I read them when I joined the group.
Q. Do you have them in hard copy, electronic copy?
A. I think I have it in hard copy.
Q. Okay. Do you know whether you have access to it electronically?
A. I do not know.
Q. Do you know whether there's anything written down in those policies and procedures about contacting a patient when a result comes back after discharge?
MR. SINKOFF: I'm going to let her answer, but I want a clarification. This whole line of questioning you're asking about Hospital Consultants, P.C. policies and procedures relative to patient care as opposed to employee status type of stuff?
MR. TAKALA: Yes.
A. About patient care?
MR. SINKOFF: Yes.
BY MR. TAKALA:
Q. Yes.

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A. I don't know.
Q. Okay. You told me that you learned about how to -- you know, who follows up on these results on the job or as part of your training because you started working at Beaumont and that's how you learned it, right?
A. Yes.
Q. Okay. Do you know whether that was written down anywhere or is that just something that you learned on the job that somebody else taught you?
A. I learned on the job, I think.
Q. These policies and procedures, as I call them, or the written down material that you have, is it updated year to year or is it just one copy that you received in 2011 and that's it?
A. It was one copy that I received in 2011.
Q. Do you know who else sees the urine culture results, for example, in this case for Ms. Markel?
MR. WARWICK: Just foundation.
A. Who else?
BY MR. TAKALA:
Q. Yeah. And if you don't know, that's fine. For example, the P.A. that ordered the results, do you know if the P.A. would have access or be alerted to these results?

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A. I do not know.
Q. Okay. Do you know of anybody else that would have access to these results besides you as the attending physician?
A. No.
Q. Okay. Obviously it's okay to discharge patients with culture results pending?
A. Yes.
Q. But it's your responsibility to follow up on those results and act appropriately after they come back?
A. Correct.
Q. Did you ever order a repeat CBC when you saw Ms. Markel on October 10th?
A. No.
Q. Did you order a repeat CBC before discharging her on October 11th?
A. No.
Q. Would the repeat CBC have assisted you in obtaining clinical information about the reason of those inflammatory biomarkers or the fact that the prior UA may have been a contaminant?
A. Can you explain that question again?
Q. Sure. Let me start with this one and it will make more sense to you. Was it your standard of care to order a repeat CBC before discharging Ms. Markel on

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October 11th?
A. No.
Q. Okay. On prior UAs there were signs of inflammation, correct?
A. Yes.
Q. There were prior UAs with signs of contamination, correct?
A. Yes.
Q. Help me understand why you didn't -- why you did not have an obligation to order a CBC with a clean sample or a sample you felt was clean?
MR. SINKOFF: Object to foundation.
MR. WARWICK: Same.
MR. SINKOFF: CBCs are blood samples.
MR. TAKALA: I'm sorry.
BY MR. TAKALA:
Q. A UA?
MR. SINKOFF: Start over.
MR. TAKALA: Sure thing.
MR. SINKOFF: Let's clear that up, please.
MR. TAKALA: Thank you.
BY MR. TAKALA:
Q. The UA that was ordered on October 10th had inflammatory biomarkers, right?
A. Yes.

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Q. Contaminant biomarkers?
A. Yes.
Q. Did you order a repeat UA before discharging Ms. Markel on the 11th?
A. No.
Q. Were you required to order a repeat UA?
A. No.
Q. Okay. Why not, considering the fact that there were prior abnormal results on the UA from the day before?
A. Because she did not have any symptoms suspecting UTI, so there was no reason to order a test, that is unnecessary.
Q. Okay. She did have a fever overnight, right?
A. Yes.
Q. Okay. And that is a sign of UTI, right?
A. It could be a sign of UTI, but she did not have persistent fevers.
Q. All right. Have there been circumstances in your practice where you've ordered antibiotics for a patient that had been discharged from the hospital?
A. Yes.
Q. Okay. Would those be oral antibiotics?
A. Yes.
Q. Okay. And you do that with a phone call and tell the patient that you're going to write a script and they

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can pick it up wherever?
A. Usually I call the patient and I call the pharmacy to send in the script.
Q. Thank you. Have you spoken with anybody about this deposition aside from Mr. Sinkoff or a member of his firm?
A. No.
Q. Have you spoken with anybody in your practice about this deposition?
A. No.
Q. You don't remember, after sitting with me for, whatever, over two hours now, anything independently from October 2015 and the treatment you provided to Ms. Markel, aside from what you've documented in your records?
A. No.
Q. I'm trying to think about the most efficient way to do this. I want to know what notes you put on the records and why. I haven't even seen them. Can I come around to your side of the table for a minute -- or you can pass that over to me, if you don't mind? Thank you, that's fine.
So you have a Post-it note that indicates discharge instructions?
A. Yes.

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Q. Discharge summary?
A. Yeah. ER nurses note, ER nurse recorded IV filtration.
Q. Why is that important to you?
A. Because she had an infiltrated IV, that can sometimes cause inflammation and cause fevers.
Q. Okay. Do you think that's what was causing the inflammation and fever in this case?
A. Could be.
Q. Okay. Knowing what you know about October 13th and beyond, do you believe that the IV infiltration is what was causing the fevers and the inflammation?
A. Clarify that question again?
Q. Sure. Using the benefit of hindsight, knowing that when Ms. Markel comes to the hospital on the 14th, can you go back and reconstruct what was causing that inflammation on the 10th?
MR. SINKOFF: Object to relevance.
Go ahead.
MR. WARWICK: Same.
A. So you're asking me -- just to clarify the question, you're asking me do I know what caused --
BY MR. TAKALA:
Q. The inflammatory -- let's just say the leukocytes and the elevated white blood cell count, do you have an

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opinion as to what was causing that on October 10th when it was resulted?
A. Yes.
Q. Okay. What is it, knowing what you know now?
A. Because she had a procedure on the 2nd of October, which was a gynecology procedure, D & C, and that can cause colonization of bacteria and that can cause inflammation in the urine.
Q. Okay. But you would have known that on October 10th, right, that she had this prior procedure and that can cause a colonization of bacteria?
A. I knew that she had a prior procedure.
Q. And you also knew that it could cause a colonization of bacteria in the bladder?
A. It could cause, yes.
Q. Okay. But you saw these inflammatory responses, but you didn't think it was a result of bacteria, right?
A. It's not a result -- infection.
Q. Okay. And I'm being a little bit unfair to you because I was asking you retrospective questions and I think what you were trying to tell me is that she has this procedure on -- and don't let me put words in your mouth, but she has this procedure on October 2nd, that can cause colonization of bacteria in the bladder, and that colonization of bacteria in the

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bladder got into her joints. That's what we know happened after the fact, right?
A. Yes.
Q. Okay. But when you discharged the patient on October 11th, 2015, you didn't know that it was in the joints, right?
A. No.
Q. And it wasn't your standard of care to perform any further workup or evaluation for this potential colonization of bacteria, knowing that she had this GYN procedure on October 2nd?
A. So that would -- I did not have to do anything further knowing that it's a colonization.
Q. Okay. Got it. Sorry, the -- I want to finish going through these notes. Thank you for your patience with me.
It looks like -- and there's some, you know, pink writing, I don't know if that's intentional or --
A. That was not, sorry.
Q. Okay. Can you read this note?
A. Observation, P.A. note, 10-10-15.
Q. Why is that important?
A. Just reviewing her records, that's it.
Q. No problem. H & P on page 33?

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A. Yes.
Q. That's yours, right?
A. Yes.
Q. Okay. You have some writing on there?
A. Yeah. Because it was illegible as to -- it mentioned she has family and daughter dysfunction, which was -- actually meant ambulatory dysfunction.
Q. Got it. So another transcript error when you're doing voice dictation?
A. Correct.
Q. Okay. A little bit -- you had some other writing on here. No significance, right?
A. No, we already discussed that.
Q. Okay. There's some other pages where I don't know whether these marks are intentional or unintentional?
A. No. It's the recommendations, nothing that -- I'm specifically trying to say anything or --
Q. I understand. But you made a mark on this page and you underlined a sentence, right, that's your --
A. Yes.
Q. -- handwriting?
A. Yes.
Q. This note, please?
A. R.N. notes regarding calling Dr. Muraru.
UA results.

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Urine culture results.
Septic screen.
Sorry, that's also unintentional.
Temperature log.
Q. No other Post-its there -- are these your records or are those Steve's?
MR. SINKOFF: They're mine and they're just copies.
MR. TAKALA: Okay.
BY MR. TAKALA:
Q. I think that you told me that you didn't see Ms. Markel after October 16th, 2015?
A. Yes.
Q. Okay. I think she was discharged on November 2nd, if my memory serves -- yeah, November 2nd. Would you have worked another block of your 10 or 11 days in a row between October 16th and November 2nd?
A. Yes.
Q. Okay. Would you typically be assigned to patients that you had prior responsibility for or how does that work?
A. Yes. When I signed out and if I come back to the same hospital, I usually pick up with -- if the patients are still in the hospital, I usually pick those patients up back on my patient list.

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Q. Okay. Any other understanding as to why you didn't pick Ms. Markel back up?
A. I believe I was working at Troy Beaumont for that next schedule.
Q. Fair enough. There would probably be some sort of log or time sheet --
A. Yeah.
Q. -- we could go back to?
A. Yes.
Q. Okay. Do you have any sort of written policies regarding your employment and employment practices with Hospital Consultants, P.C., like you have to work X amount of days per week or X amount of hours per month?
MR. SINKOFF: Object to foundation.
BY MR. TAKALA:
Q. Anything like that? I'm just using that by example.
A. I do not know specifically.
Q. Okay. How about the same question with regard to Beaumont?
A. No.
Q. Okay. If you just bear with me for just a few minutes, I'll check my notes and make sure I have everything marked that I wanted to mark.
A. Okay.

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MR. TAKALA: I will, if you don't mind, unless Steve has an objection, mark these records? If you have an objection, Steve, I won't, but --
MR. SINKOFF: You can mark them, but they're going to stay in her possession.
MR. TAKALA: That's fine with me.
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 9
4:15 p.m.
MR. TAKALA: I'll mark this as Plaintiff's Exhibit 9.
BY MR. TAKALA:
Q. Do you have any social relationships with any of the other physicians involved in Ms. Markel's care, names that you would have seen in the records?
A. No.
Q. Okay. I'm sure you know a lot of these physicians professionally and you've worked with them?
A. Yes.
Q. But you haven't spoken with any of them about Ms. Markel or her care?
A. No.
Q. Okay. You haven't spoken -- and obviously since --
A. Right, right, no.
Q. -- the notice of intent --

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A. No.
Q. Just because I suppose it's my last chance to ask you, anything else that has come to your memory about this October 2015 time period as it pertains to Ms. Markel?
MR. SINKOFF: Object to the foundation and --
A. No.
MR. SINKOFF: -- form of the question. There may be many things that she testifies to depending on the questions that are asked.
A. No.
BY MR. TAKALA:
Q. Okay. As you sit here today and the way I'm asking the question, is there anything that you remember independently about Ms. Markel's care that isn't documented somewhere in your records? And I'll -- subject to Steve's objection, of course.
A. No.
MR. TAKALA: All right. I don't have any further questions for you, Dr. Lonappan, and I do thank you sincerely for your patience and your time.
THE WITNESS: Thank you.
EXAMINATION
BY MR. WARWICK:
Q. Dr. Lonappan, I have just a few questions for you. If

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at any time you don't understand it, don't hesitate to mention that and I'll certainly repeat it or rephrase it, okay?
A. Okay.
Q. Back in October 2015 you were employed by Hospital Consultants, P.C.; is that correct?
A. Yes.
Q. And you've already testified that you were employed by them beginning in 2011; is that right?
A. Yes.
Q. You were not employed by William Beaumont Hospital; is that correct?
A. Yes.
Q. And from your previous testimony, it's my understanding that you would have been scheduled by Hospital Consultants, P.C. through a Dr. Jason Batke; is that correct?
A. Yes.
Q. And the reason you were at William Beaumont Hospital October 10 and October 11th of 2015 was because you had been scheduled by your employer, Hospital Consultants, P.C., to work at the hospital on those days; is that correct?
A. Yes.
Q. And from your testimony previously, it's your

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understanding that if patients come in from Troy Internal Medicine, and specifically in this case Dr. John Bonema, who is an internal medicine physician at Troy Internal Medicine, then -- and if the patients are admitted, then your group of physicians from Hospital Consultants, P.C. would see the patients in the hospital; is that right?

A. If the ER physician calls our group for admission, then we'll see the patient.

Q. Okay. So in this case, Ms. Markel was admitted to hospital and this was Dr. Bonema's patient, as her primary care physician. So then it makes sense that that's why your group is contacted and that you became involved in her care, fair?

A. That's correct.

Q. Okay. And she's not a named defendant, but she was referenced in the notice of intent, her name is Janay, J-A-N-A-Y, Warner, W-A-R-N-E-R. She's a physician assistant and she saw Ms. Markel in the observation department at William Beaumont Hospital.

You didn't provide treatment to patients in the observation unit, did you?

A. No, not in the ER observation unit, no.

Q. Right. And you don't know Janay Warner, P.A. personally at all, do you?

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A. No.

Q. Okay. And from the records, it looks like a urinalysis was first done on October 9th, 2015 at 2249 and you've already testified about those results. Do you remember that?

A. Yes.

Q. Okay. Then P.A. Warner became involved in the patient's care, I want you to assume, when Ms. Markel was in the observation unit and she ordered a repeat urinalysis and a urine culture and those were ordered on October 10th, 2015 at 1349.

You became involved, it's my understanding, in Ms. Markel's care on the floor October 10th, 2015, at least your note is signed -- your history and physical at 1441; is that right?

A. Signed at -- yes, note is signed at 1441.

Q. Okay. So P.A. Warner would have ordered the repeat urinalysis and the urine culture in the observation unit, then the patient was transferred to the floor, according to the records, on October 10th, 2015 at 1426?

A. Okay.

Q. That's pages 2451 and 2452 of my set of records. And then shortly thereafter you would have seen the patient on the floor and then entered your report at

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1441; is that correct?

A. Yes.

Q. Okay. Then from page 2456 of my set of records, the urine sample and urine culture were then collected on October 10, 2015 at 2109 and 2110; is that correct?

A. Yes.

Q. Okay. So when you first saw Ms. Markel on the floor, you would have known that these urinalysis and urine culture had been ordered, but not done yet; is that right?

A. Yes.

Q. Okay. And then it looks like the results came back from those studies on October 10, 2015 at about 2201; is that right?

A. Yes.

Q. Okay.

A. From the urinalysis.

MR. SINKOFF: Not the culture.

BY MR. WARWICK:

Q. From the urinalysis. And the urine culture was -- we know did not come back until October the 12th; is that right?

A. Yeah, final results.

Q. Okay. Let me make sure my question is a little clearer. The urinalysis result was resulted from page

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2456 on October 10, 2015 at 2201; is that right?

A. Urinalysis results were resulted, yep.

Q. Okay. And then the urine culture result was resulted on October 12th, 2015 at 2038; is that right?

A. Yes.

Q. Okay. And then Dr. Mihai Muraru, is it your understanding he was a physician who was also employed by Hospital Consultants, P.C. back in October of 2015?

A. Yes.

Q. And if he was called by a nurse on October 11, 2015 at approximately 0413, would that likely have been because he was the on-call physician for Hospital Consultants, P.C. at that time?

A. Yes.

Q. Okay. But you didn't have any direct communication with the patient or the nurses or anyone of that nature October 11th, 2015 at 0413, correct?

A. Correct.

Q. Okay. And this whole process of urinalysis results and urine culture results, where you as the hospitalist are aware of tests being ordered, sometimes it takes a period of time until after the patient is discharged for the final results to come back, obtaining the results and then looking and determining whether or not those results are relevant

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or followup is necessary, everything in this case happened as it would normally happen with your practice, right, you received results and then looked at that issue and made determinations; is that fair?

A. Yes.

MR. WARWICK: Okay. I appreciate your time, thanks a lot.

THE WITNESS: Thank you.

RE-EXAMINATION

BY MR. TAKALA:

Q. I have just a couple quick followups.

When you made contact with Ms. Markel, you didn't tell her that you were seeing her because of her relationship or Dr. Bonema's relationship with Troy Internal Medicine, would you?

A. I would, that's my usual practice. When I say I'm Dr. Lonappan and then I would say I'm seeing you for your family doctor, I'm a hospitalist associated for Dr. Bonema.

Q. Okay. So that's not what you told me earlier?

A. You -- no, that's -- I said I would introduce myself as Dr. Lonappan, that's what you asked.

Q. Okay. And then I thought I asked would you say, you know, Beaumont Hospital or Hospital Consultants, P.C. and you said no and no?

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A. Yeah, I said I usually don't bring up Hospital Consultants, P.C. because it doesn't matter to the patient. I do bring up that I'm seeing them for their family doctor.

Q. Okay. And do you tell them who you're employed by?

A. No.

Q. Okay. Do you tell them that you're employed by Troy Internal Medicine, for example?

A. No.

Q. You don't tell them you're employed by Beaumont, right?

A. No.

Q. You don't tell them you're employed by Hospital Consultants, P.C.?

A. No.

Q. Okay. But you do tell them that you're seeing them in place of their PCP?

A. Correct.

Q. And would you mention Dr. Bonema by name?

A. Yes.

Q. Okay. Sorry to get into a couple of other tangential issues. I didn't ask you about the CBC or the complete blood count that was done on October 9th, 2015?

A. Okay.

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Q. I'll just show you. Are there any abnormal results from the CBC?

A. WBC is abnormal, it's 13.8. And then neutrophils, 8.7.

Q. That's it?

A. Then there is monocytes, 1.

Q. Okay. And are those inflammatory markers?

A. The WBC and neutrophils.

Q. Okay. When you got to the hospital at 8:00 a.m. on October 11th, you would have been able to go back in the chart and see that an elevated temperature had been reported during the middle of the night, correct?

A. Yes.

Q. You would have seen that Dr. Muraru had been consulted?

A. Yes.

Q. Okay. And if you believe that a CBC was necessary and Dr. Muraru did not order the CBC, you would have had that opportunity to do so at 8:00 a.m. when you were back on call, right?

A. If I thought that the test would give us -- give me more information to treat the patient, yes, I would have.

Q. Same question with regard to administration of antibiotics, if you saw there was an elevated

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temperature and you saw that Dr. Muraru didn't decide to start antibiotics and you thought it was appropriate, you would have made that determination in the morning when you started your shift on October 11th, correct?

MR. SINKOFF: Object to the foundation.

MR. WARWICK: Same.

A. Yes, when I see the patient on October 11th I would make that determination and I would have started her on antibiotics if I thought she needed them.

BY MR. TAKALA:

Q. Okay. And that's irrespective of what Dr. Muraru did, you would make that decision for yourself?

A. Correct.

MR. TAKALA: All right. That's all I have. Thank you very much.

(The deposition was concluded at 4:29 p.m. Signature of the witness was not requested by counsel for the respective parties hereto.)

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-5395
Notary Public,
Oakland County, Michigan
My Commission expires: January 28, 2019

MARKEL v. WILLIAM BEAUMONT HOSPITAL, ET AL.

MIHAI DAN MURARU, M.D.

February 27, 2019

Prepared for you by

U.S. Legal Support

Bingham Farms/Southfield • Grand Rapids
Ann Arbor • Detroit • Flint • Jackson • Lansing • Mt. Clemens • Saginaw • Troy

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

MARY ANNE MARKEL,)
)
Plaintiff,)
)
-v-) CASE NO. 18-164979-NH
) Hon. Nanci J. Grant
WILLIAM BEAUMONT HOSPITAL,)
HOSPITAL CONSULTANTS, P.C.,)
and LINET LONAPPAN, M.D.,)
Jointly and Severally,)
)
Defendants.)

The deposition upon oral examination of MIHAI DAN MURARU, M.D., a witness produced and sworn before me, Patrice E. Morrison, RMR, CRR, Notary Public in and for the County of Marion, State of Indiana, taken on behalf of the Plaintiff at the offices of Regus Business Center, 201 North Illinois Street, Suite 1600, Indianapolis,, Indiana, on February 27, 2019, at 1:05 p.m., pursuant to all applicable rules.

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INDEX OF EXAMINATION

INDEX OF PLAINTIFF'S EXHIBITS

MIHAI DAN MURARU, M.D.,
having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, took the stand and testified as follows:

EXAMINATION

BY MR. TAKALA:

Q Sir, can you please state your full name for the record.

A Mihai Dan Muraru.

Q And your last name is spelled M-u-r-a-r-u?

A Correct.

MR. TAKALA: Let the record reflect this is the deposition of Dr. Mihai Muraru taken pursuant to notice and agreement between counsel as to time and place, whose testimony will be used for all purposes as allowed under our Michigan Court Rules, as well as our Michigan Rules of Evidence.

Q Dr. Muraru, my name is Tim Takala. We met just briefly before we started. I represent Mary Anne Markel. I've got some questions to ask you about your background as well as any involvement you may recall in regards to Ms. Markel's care back in October 2015. I'll start by asking you your date of birth, though.

A 9/11/1980.

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Q And are you currently employed?
A I am.
Q Where at?
A Northside Internal Medicine.
Q And where is that located?
A Indianapolis. 2010 West 86th Street.
Q How long have you been employed with that group in Indianapolis?
A Coming on three years now.
Q Prior to that, were you employed in the medical field?
A Yes.
Q Where at?
A I worked for Hospital Consultants.
Q And that's in the Metro Detroit area?
A Yeah, yeah, yeah.
Q What brought you from the Metro Detroit area to Indianapolis, personal or professional?
A Professional. I wanted to focus on outpatient internal medicine.
Q What type of medicine do you practice with the group here in Indianapolis?
A Outpatient internal medicine.
Q Thank you. And at Hospital Consultants, what did your practice consist of.

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A In hospital hospitalist.
Q All work was within the hospital?
A Yes.
Q Okay. Have you given depositions before?
A No.
Q Your residential address?
MR. POWE: Can we just go off the record for a minute.
(A discussion was held off the record.)
Q Because you haven't been deposed before, Doctor, and I'm sure Mr. Powe has went through the ground rules, it's important that only one of us talks at a time. More important than that, it's important that you understand my question before answering, so will you agree to tell me if I ask a goofy question that does not make any sense to you?
A I will.
Q And then I will rephrase it.
Also, I would like you to be able to give your full and complete answer, but I won't know I cut your answer off unless you tell me. Will you please tell me if I cut your answer off at any point in time?
A I will.
Q Thank you, sir. Otherwise, I'll presume that you gave a full and complete answer.
Do you have any curriculum vitae or resume that has your professional and educational experience saved at home or in an office?
A I do.
Q And if I made a request through Mr. Powe after this deposition, could you provide that to him? It will save us some time here today.
A I can.
Q Thank you.
MR. TAKALA: And Doug, would you -- if the doctor passed that on to you, would you pass that on.
MR. POWE: Absolutely.
MR. TAKALA: Thank you.
MR. SINKOFF: Doug, I would want a copy as well if you do that.
MR. POWE: Okay. You bet.
MR. SINKOFF: Thank you.
Q You don't have a copy of that with you today, do you?
A I don't have it printed.
Q That's okay.
A Unfortunately.
Q Did you bring anything with you to the deposition that pertains to this case?
MR. WARWICK: Sorry to interrupt. I'd just like to get a copy as well, if I could, please. Okay?
MR. POWE: Yes. Absolutely.
(A discussion was held off the record.)
Q I'll reask it. Did you bring anything with you to the deposition that you -- that pertains to this case?
A I do.
Q Okay. What did you bring?
A I have a copy of the medical record that was given to me and a few -- a few notes.
Q Do you mind if I look at those? Obviously, subject to Mr. Powe's objections or anything based on my review.
MR. POWE: No, that's fine.
A (Hands documents.)
Q I'll probably ask you to help me read those into the record at some point. I could decipher some, not all.
Your curriculum vitae that I'll ask you to provide to Mr. Powe, is it current and up to date? Does it contain all of your educational and professional experience?

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A Yes.
Q All right. Any publications on there that relates to septic infections or infections like Ms. Markel was dealing with in October of 2015?
A No.
Q Are you board-certified?
A Internal medicine, yes.
THE REPORTER: Did somebody object?
MR. WARWICK: I objected to the question to form, for board certification.
Q Any other board certifications besides internal medicine?
A No.
Q Do you have any subspecialty as a hospitalist?
A I did two years of training in infectious diseases.
Q Are you board-certified in infectious disease?
A No.
Q When did you complete your training in infectious disease?
A 2016.
Q 2016 to -- was that 2014 to '16?
A '14 to '16, yes.
Q And was that --
MR. SINKOFF: We can't hear the answers. We can't hear the answers.

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THE WITNESS: Oh, okay.
MR. SINKOFF: What years was it?
THE WITNESS: 2014 to 2016.
MR. SINKOFF: Thank you.
Q And where did you receive that training? Was it through a university, a residency program, where was it through?
A University of Kansas.
Q Were you still working with Hospital Consultants when you received that training?
A No.
Q All right. Help me with the timeline. You're in Metro Detroit, you're practicing as a board-certified internal medicine physician?
A I'm sorry, I think I made a mistake. So actually my training was between 2012 and 2014. Sorry. My training in infectious disease.
MR. SINKOFF: Doctor, your answers keep getting cut off. All I could hear is my training in infectious disease was, but I don't hear the dates.
THE WITNESS: Yeah, I did a mistake, actually. So my training in infectious disease was from 2012 to 2014.
MR. TAKALA: Guys, let's go off.

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MR. SINKOFF: 2014? Okay. Thank you.
MR. WARWICK: So can I just ask a question. I think the problem is, I don't know, do you have your phone on mute or not mute?
MR. SINKOFF: I had it on mute till I started to say something.
MR. WARWICK: Okay. So it's not feedback then. Okay.
(A discussion was held off the record.)
(A recess was taken, 1:12 p.m. - 1:15 p.m.)
MR. TAKALA: Thanks for the break.
Q So Doctor, why don't you tell me so I have a timeline, when did you complete your medical school training?
A So medical school training, I did in Romania, and I finished it in 2005.
Q And after you finished medical school in 2005, did you practice in Romania or come to the States?
A I did. I did for -- until 2008. I was in training for family medicine. And then in 2009, I came to the United States when, in Boston, I did my training in internal medicine.
Q And did you have to take the USMLE?
A I did. I did.
Q And did you attend a residency program or apply for

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a residency program in the States?
A Yes, I did, with Carney Hospital with Tufts University in Boston.
Q Thank you, sir. And this is all on your CV, I presume?
A Yes, absolutely.
Q What year did you finish your residency program?
A 2012.
Q And then after you finished your residency program did you sit for the board exams for internal medicine?
A I did.
Q Pass on your first attempt?
A Yes.
Q And did you stay in practice in the Boston area or did you move geographically?
A I moved to Kansas for the infectious disease fellowship.
Q And that was in 2012?
A Correct.
Q And the infectious disease fellowship at the University of Kansas was between 2012 and 2014?
A Yes.
Q Did you sit for any board exam to become board-certified in infectious disease?

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A No.
Q Have you ever practiced as an infectious disease doctor?
A No.
Q Do you have any infectious disease practice here in Indianapolis?
A No.
Q You practice solely as an internal medicine physician?
A Outpatient, yes.
Q And you've always practiced as an internal medicine physician, although some times it was in the hospital and now what's purely outpatient.
A Correct.
Q In 2014 when you finished your fellowship in infectious disease, did you move geographically?
A Yes. To Michigan.
Q And you became employed at Hospital Consultants?
A Correct.
Q Did you have any other employers between your fellowship and when you came here to Indianapolis?
A No.
Q Can you tell me just a little bit about -- and I don't want to belabor this -- what your employment entailed at Hospital Consultants, P.C.?

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A I was employed as a hospitalist seeing patients in the hospital.
Q Would you cover other hospitals aside from the Beaumont Health System?
A No.
Q By the way, let's get this out of the way too. You had a chance to review medical records in this case; correct?
A I did.
Q All right. Based upon your review of the medical records and your recollection of these events, do you believe you ever saw Ms. Markel at any point in time as a physician?
A I did not physically see her. I provided care through the phone.
Q Okay. And that's what I thought too, and I've pulled one page of records where your name appears. I'm sure you've seen this. I'll mark it as an exhibit and clean up at the end.
MR. TAKALA: Don and Steve, just so you know, it's a nursing progress note by Camie, C-a-m-i-e, Rabon, R-a-b-o-n, and this is around 4 a.m. on October 11th.
Q Based upon this note, can you reconstruct what happened and what your participation was in

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Ms. Markel's care, if any?
A Sure. So 4 a.m., around 4 a.m., I received a phone call. I was on call from home. And so the nurse called saying that the patient had a fever at 8 p.m. the day before. And they called now, I am unsure why. I was not called at 8 p.m. The only time I was called was eight hours later. So I asked what's going on. I was told that the patient was doing well, vital signs were stable.
And then I -- I was able to review the record through the computer, and so I reviewed the record. The patient was stable. And at that time I did not feel that any direct or active interventions were required. And I asked the nurse to monitor the patient, check vital signs in one hour, and call me with updates.
Q Okay. Did the nurse call you back with updates?
A No.
Q When you were able to -- and you were able to access the electronic medical record through your home computer?
A Yes.
Q Did you see that Ms. Markel had an elevated white blood cell count upon presentation?
A I saw that.

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Q All right. Did you come up with an idea or a differential as to what was causing that elevated white blood cell count?
A I did.
Q What was that?
A The patient showed up in the hospital complaining of acute back pain radiating to the leg. She was seen by the emergency room physician, who put a diagnosis, presumed a diagnosis of lumbar radiculopathy.
So she was in pain, and pain can explain leukocytosis. In the emergency room, the patient received a high dose of IV steroids. IV steroids cause increased leukocytes. So those two can explain the white blood cell count.
Q Okay. And I think what you're telling me is that the pain and the IV steroids were the most likely cause of the elevated white blood cell count?
A It is possible.
Q Okay. What are the other possibilities that would lead a patient to have an elevated white blood cell count? I think it was 13.8.
A 13.8 is not that much. But at the time, upon reviewing the medical record, those were my number one in the differential.

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Q Okay. Obviously -- well, I shouldn't say obviously. Can infection be a cause of an elevated white blood cell count?

A Among other things, yes.

Q Were you able to rule out infection as a cause of Ms. Markel's elevated white blood cell count when you were consulted on the evening of or early morning hours of October 11?

A When I was called, I was able to review the work that was done by the previous doctors. She was seen by emergency room physician, neuro -- neurologic -- neurosurgery, the hospitalist, and physical medicine doctors. So four physicians saw her. All of them agreed that the diagnosis was acute lumbar radiculopathy after examining the patient.

There was no mention anywhere of any suspicion of infection. The patient had -- they did a urinalysis, and I reviewed those. The culture was not available at the time, so I reviewed those results, and they did not indicate infection as an obvious cause. So that's one.

Second thing is the person who checked vital signs at 8 p.m., the day prior, was different than the person who called me at 4 a.m. So it was

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not -- I'm not sure why I wasn't called, but anyway.

So that was my thinking at the time upon reviewing the medical records.

Q Understood. Did you have an explanation or a differential diagnosis as to what was causing the elevated temperature of 100.9 that had been reported at 8 p.m. the previous evening?

A Well, the problem with that one was that there was no way for me to verify. As a physician, every time when there is an abnormal vital signs, the first thing we are required to do is check, because there can always be malfunction of thermometer or an error. I was unable to do that. The person who checked the vital signs was not available for me to discuss. So all I had was just this entry which may or may not be -- I didn't know.

The patient at the time when I was contacted was doing very well, had no complaints, vital signs were stable. And I also reviewed the medical records from -- notes from previous doctors, and all of them, they mentioned no complaints of fever, no complaints of burning with urination or other signs or symptoms to indicate infection as a reason of concern.

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Q Okay. Let's assume that the temperature was taken appropriately, and if I have to ask it as a hypothetical I will, but let's just assume for this question the temperature was appropriately read at 100.9. What is your differential diagnosis when you're called by the nurse and the nurse tells you about this elevated temperature?

A Well, the number one thing that we do is obviously check the patient at the time, check the temperature, and ask the patient how she feels. If the patient feels well, has no complaints, vital signs are stable, just one episode of temperature, you have to always, as a physician, look at everything in context. And, I mean, having a dose of steroids could always cause an elevated temperature.

But, I mean, just a temperature at that point in space, just one time, it's -- it's not -- it's not the easiest way to say whether or not it can be an infection.

Q Fair enough. You would agree with me that an elevated temperature is a sign of infection; correct?

A If verified and accurate, yes, can be.

Q Okay. All right. And what you're telling me -- I

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think I'm understanding you -- is that one isolated elevated temperature doesn't necessarily lead you to conclude, as a reasonable physician, that there is an infection present; right?

A Depends. You have to review all the facts and take into consideration everything. If you can double-check it and it's an accurate elevated temperature, then you have to look in the chart and see if there are other indications of possible infection, and also ask the patient if there are any signs of infection.

Just an elevated temperature by itself without everything -- and everything else normal doesn't necessarily mean infection.

Q Do you know whether Ms. Markel was on any antipyretics at the time when the nurse called you? Let's just isolate that time. 4 a.m. on October 11, approximately.

A I know that there was a standing order for her to be on pain medication. I was not able to find exactly when they were administered, but I know that that order exists.

Q Okay. And was it the acetaminophen that's in pain medication that causes an antipyretic effect?

A Yes.

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Q Given the information that you had at 4 a.m. or when you were contacted by this nurse on October 11, was it your thought process that the elevated temperature was inaccurately reported?
A There was no way for me to know.
Q Okay. Was it your thought process that that elevated temperature was a result of the steroids that had been administered?
A It was not out of possibility.
Q Was it your thought that that elevated temperature could have been related to an infectious process?
A As a physician, you always have to take into consideration the possibility.
Q Okay. Just so it's clear on paper later, with the elevated temperature, one of the things you're thinking about and you're considering as a physician when you're contacted by the nurse is that there's an infectious process going on; right?
A Well, that's true. How it usually happens is, anyway, nurses are supposed to call the physician at the time the temperature is registered so the physician has a chance to double-check. In this particular case, unfortunately, it had been eight hours and the condition changed.
Even if that temperature may or may not be

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accurate, by the time I was contacted, the patient's clinical condition was stable, she had no complaints, and feeling well.
Q Okay. Totally understand --
MR. WARWICK: I just for the record have to object to him talking about what nurses should do. Michigan has very tight tort reform. There are no nursing claims. There shouldn't be any testimony about what nurses should do or have that somehow be intuited that it's a criticism from a standard of care perspective, just for the record. Thanks.
THE WITNESS: Sure. No criticism.
Q Okay. So I totally understand what you're saying, Doctor, and in fairness to you, when this nurse is on the phone with you, she's reporting, at least in the note, that a temperature is 98.1, which is a normal reading; correct?
A Yes.
Q All right. And this is just something that lawyers do, but just so it's clear on paper, and I know you've already answered the question, but when you're contacted at 4 a.m. and you're told about a temperature of 100.9 earlier in the night, one of the things you're thinking about, as a reasonable physician, is infection; true?

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A Correct.
Q Thank you. And you made the clinical judgment that there was no further treatment necessary at that time you were called to either further test for or treat a potential infection; correct?
A Correct.
Q All right. And again, let me just try and bracket this so it's clear to me, or at least when I read this deposition later it will be clear to me.
Ms. Markel is admitted to Beaumont on October 9 at 17:13. You didn't review any records prior to that admission on October 9 the evening that you were contacted; correct?
A No. I only reviewed that admission.
Q Yes. You were reviewing the notes from October 9 and October 10 and the very early morning hours of October 11 before you were called; right?
A Correct.
Q Have you reviewed any prior records since that point in time, say after I asked for your deposition?
A The only thing I reviewed was that records that I received.
Q Okay. Fair enough. And I have not went through all these records, but it looks like they're all

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from the admission between October 9, 2015, and October 11, 2015. Is that your understanding?
A Correct.
Q All right. You have not seen any records from the subsequent admission. Ms. Markel, I think, presented to the hospital again on October 13, 2015, but you haven't seen any of those records; correct?
A No.
Q You have no idea what happened to Ms. Markel; correct?
A Well, I received a notification from, I think it was the office of the lawyer, Mr. Sinkoff, and there, there was, I don't know, like a timeline, if you will, and there was a mention of other things, but that's all I -- just that notification from the lawyer's office. That's all I received.
Q Okay. And I don't know whether I'd be entitled to it anyway, but do you still have that documentation, that paperwork that you received from Mr. Sinkoff's office?
MR. SINKOFF: Let me just object because if he has anything from my office, it would have gone through Doug, so attorney work product privilege, and it should not be produced. He is an employee

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of my professional corporation, so I object to it being produced.

MR. TAKALA: Fair enough. Thanks for muting the phone again, Steve, and your objection is noted. You may be right; you may be wrong, but I won't pursue it any further.

MR. SINKOFF: Appreciate it. Thanks.

Q Well, I won't pursue it any further except for asking whether you have that information, Doctor. And if you have it, fine, and if you don't, fine.

A I have it in the e-mail that I received.

Q Okay. Thank you, sir. That's good enough.

You never traveled to the hospital to examine Ms. Markel during this admission, October 9 through October 11; correct?

A Yes. I did not.

Q One more time, please.

A I did not travel to the hospital.

Q Okay. Do you remember how long the conversation lasted with the nurse that contacted you around 4 a.m. on October 11?

A Exactly, no. Probably a few minutes.

Q No problem. Do you know if you called her back or whether it was one continuous conversation and you reviewed the records on your computer as you spoke

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with the nurse?

A I believe that I -- so she called me and I asked for some information. I reviewed the records and I asked her to talk to the patient and ask the patient directly how she feels and if she has any symptoms of any kind, yes.

Q Okay. And that was during the one phone conversation you had with the nurse?

A Yes.

Q All right. And she must have went back, asked the patient, reported the information back to you. Do you know whether she called you back -- and by the way, if you don't remember, it's okay, but I'm just asking the question.

A I only received that one phone call. I asked the nurse to check the temperature in one hour and call me if there's any change. I was not called back.

Q All right. You wanted to be contacted whether there was change or no change, just to see how the patient was doing; right?

A Yeah. If there was anything bad going on, any problems, I wanted to know.

Q Okay. If everything remained constant, was it your expectation that you were going to receive a phone call or no?

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A No. If patient continued to do well without any complaints of change in her vitals, no.

Q Can you give me a sense as to how many calls -- well, before I ask that question, I take it that you were one of the on-call physicians for your hospitalist group on the early morning hours of October 11?

A Yes.

Q Can you give me a sense as to how many phone calls per night you might get when you're on call? And if that's an unfair question, you could let me know.

A Hmm. How many. It's difficult for me to approximate. So during the whole on call, 40, I would say. Maybe 40 calls. But it's -- it's difficult to say exactly.

Q No problem. I appreciate you helping me put a range to it. How long are you on call for?

A From 5 p.m. to 8 a.m.

Q And obviously, if you thought it was necessary, you would have the ability to contact other physicians that were involved in Ms. Markel's care; correct?

A Sure.

Q But you didn't think it was necessary in this case; fair?

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A Yes.

Q All right. Were you ever contacted again regarding Ms. Markel's care at any point after October 11 at 4 a.m.?

A No.

Q So the extent of your involvement in Ms. Markel's care at any point in time to the best of your understanding was this short phone call that lasted between, let's just say two to five minutes.

A Yes. This was the only time I was involved in her care.

Q Would that be a fair approximation of the phone call, two to five minutes? If you don't remember, it's okay.

A Five minutes, I would say. It's difficult to say exactly.

Q Did you have a cell phone or a pager that you were assigned from the Hospital Consultants on which this nurse reached you?

A Yes.

Q Do you know the phone number for that? Was it a cell phone or a pager?

A So the answering service has our own for the whole group, has the cell phone number, so they called my phone.

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Q All right. And do you still have that same phone number?
A Yes.
Q What's the phone number?
A (617)717-4746.
Q Same service provider that you had back in 2015?
A Yes.
Q And who is the service provider?
A AT&T.
Q Okay. Have you reviewed anything else aside from these stack of records that you were provided by Mr. Sinkoff's office, I think?
A No. That was the only thing I reviewed.
Q All right. You didn't review anything on the computer on your own time, did you?
A No.
Q Can you give me a sense as to how much time you spent reviewing the medical records in preparation for your deposition?
A A few hours. I would say maybe six. Six hours, maybe.
Q Okay. Have you spent any time within the last 48 hours preparing for the deposition to the last two days getting ready to testify?
A I did.

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Q About how much time?
A Maybe two to three hours.
Q And is that in addition to the six hours or is that six hours total?
A In addition. I would say in addition.
Q All right. So about eight to nine hours total that you spent getting ready for this deposition?
A Well, I mean, initially I reviewed the records at the time, so it's been a few months, before I knew about the deposition. So for the deposition itself, I would say maybe three hours, two to three hours.
Q Got it. Do you have an understanding, as you sit here today -- and I guess I should tell you that I represent the plaintiff who has filed a medical malpractice case alleging acts of negligence.
Do you have any understanding as to what those allegations are or what the malpractice is that's been alleged?
A The only information I have what I received from Mr. Sinkoff's, from his office, in that e-mail format.
Q Okay. No problem. So you received these hard copy records which you've provided to me, and I'll mark as a copy before I leave here just for

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organizational purposes. And then you received some e-mails that are being asserted work product that you have on your computer; right?
A Yeah. From the lawyer's office.
Q Good enough. Do you have an understanding as to what the allegations are in this case? Not that I expect you to, but if you do, I'd ask you what your understanding is.
A To some degree, yes.
Q All right. What's your understanding?
A That -- okay. So that I -- me as a physician, I should have checked the CBC and started antibiotics.
Q When you were contacted in the middle of the night on the 11th of October?
A Yes.
Q All right. Do you have any other understanding as to what's been alleged in this case against other health care providers? Not that I expect you to.
A Very limited.
Q All right. Let me add a hypothetical wrinkle to this conversation that happened on October 11. Okay? Let's assume that there was an elevated temperature reported -- and this is a hypothetical question -- elevated temperature, you see there's

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an elevated white blood cell count, and there's also a positive urine culture. Does that change your thought process in regards to the treatment that is provided when you're contacted on the evening of the 11th, or the early morning hours of the 11th?
MR. POWE: Object to the form of the question.
MR. SINKOFF: Object to the foundation.
MR. POWE: As well.
MR. WARWICK: I have same objection. Form. Foundation.
MR. TAKALA: You can go ahead and answer.
A Well, so we are talking about the hypothetical case, completely unrelated to this one.
Q Correct.
A And the physician is called and the temperature happens at the time of the call and there is the white blood cell count and the result of the urine cultures available at the time?
Q Correct.
A In that particular scenario, if the cultures are positive, this would indicate an infection.
Q And would require treatment?
A In that particular case, yes.
Q With antibiotics?

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A Yes.
Q And they'd be started immediately?
A Sure.
Q Same hypothetical but let's back the elevated temperature eight hours. Okay? So the elevated temperature of 100.9 occurs eight hours earlier, it's normal when you're contacted -- again, another hypothetical question -- where there's a positive culture, an elevated white blood cell count. Does that still require antibiotic treatment in this hypothetical question?
MR. SINKOFF: Same objection to form and foundation.
MR. POWE: I'll join.
MR. WARWICK: I join as well.
A Well, in this particular case, we go by the result of the urine culture. If the urine culture was positive for a pathogenic bacterium, yes, we would have to consider urinary tract infection. And upon evaluating the patient, treatment would probably be required.
Q Okay. What would you want to evaluate before you probably started treatment?
A Well, first of all, you have to know if patient has any allergies, so that you're sure. And then you

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need to know if patient has any other comorbidities so you can choose the proper -- the proper antibiotic.
I mean, when we say that the culture was positive, was it -- was it available. Do we mean just the name of the pathogen or the sensitivities to antibiotics as well?
Q Sensitivities as well.
A Well, you would review that and the list of allergies, if any, and then discuss with patient and pick an antibiotic that is appropriate.
Q And if there were no sensitivities, you'd -- what would you want to do? If you just identified the pathogen in the urine culture.
A Well, you would look at the list of allergies and then you would have to treat empirically.
Q All right. So what you're trying to do when you want to evaluate the patient, you're just trying to make sure you get the right antibiotics on board, that there's not going to be a reaction to, and that work against the pathogen; correct?
A Yes.
Q Okay. Do you know of another doctor with a similar name to yours? I think the spelling is Dr. -- bear with me one second -- Morariu, it's M-o-r-a-r-i-u,

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first name is Ioana, I-o-a-n-a. Do you know of this individual that used to practice or practiced with you at Hospital Consultants?
A I do.
Q Maybe a silly question, but were there ever instances where physicians, nurses, patients, confused those two names or had mistaken you for Dr. Morariu, M-o-r-a-r-i-u?
MR. SINKOFF: Object to foundation and relevancy.
A Not that I can recall.
Q Okay. After having reviewed these medical records from this short admission, I'll call it a short admission, from about, what is it, three days, did you come to any conclusion as to whether Ms. Markel was infected or had an infection during that admission?
MR. SINKOFF: Again object to the foundation.
MR. POWE: I'm going to object as well. He's not really here to provide expert testimony for you. He's told you what he looked at and what his involvement on the case was. I think you're going far afield on that regard, but...
MR. TAKALA: And you know what? Mr. Powe may be right. And if the answer is no --

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Sorry, Don, if I cut you off.
MR. WARWICK: No, just saying form and foundation. Thanks.
Q And I'm not saying that Doug is wrong, but if you do have an opinion and you're going to talk about it at some later point in time, I want to know what it is.
If you don't plan to talk about it or you don't have an opinion as to whether Ms. Markel was infected, that's fine, but I just don't want to be stung by it later. That's all I'm worried about.
A I don't know. I was only involved in that particular time, and I was only granted access to that medical records. Upon reviewing the medical records, I saw that there was a positive culture; but other than that, I cannot mention because I was not involved in her care.
Q I understand, and I won't press this too much further, but based upon that positive culture, can you conclude that Ms. Markel did, in fact, have an infection during this admission?
MR. POWE: I'll object again.
MR. SINKOFF: Object to foundation, relevance.
He hasn't seen enough to make those types of conclusions.

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MR. WARWICK: Same objection.
A I don't know if I can make that -- make that decision.
Q No problem. I understand. Thank you, sir. I appreciate your patience with me.
You have three or four pages of handwritten notes here, and I'm sorry to make you do this, but just because I have a difficult -- I'm going to have a difficult time reading these, would you mind reading these into the record? It's going to take a little bit of time. Try and do it as slow as you can so Pat can get it all down. And I do appreciate your patience.
A Okay. So these are just a few notes I made while reviewing the records.
MR. WARWICK: Before he starts, I just have an objection. Is there any opinions in these notes? I haven't seen them, I haven't been provided with a copy of them. And obviously, other than his own expert area of board-certified internal medicine, if there are opinions or statements about what he expected of others, et cetera, then I would object to those being read into the evidence.
MR. TAKALA: Well, I think they're going to be read into the evidence, and if a judge later rules

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that he can't opine about a nursing standard of care, I think that's different than what he has written down. I haven't read all the notes either, but they're going to be read into evidence, Don.
Go ahead, Doctor.
MR. WARWICK: I guess then my only other point, my only other objection is I don't know if these are notes that are made at the request of an attorney or not, and I'm certainly not privy to that. But if they are, then they're likely privileged notes. I'm not sure why the witness is writing four pages of notes.
MR. TAKALA: Don, they're little -- it's probably about a five-inch notepad. I think they're historical notes that the doctor took while he was reviewing the medical records.
Doctor, you can straighten me out if I'm wrong.
But they've been produced. They're here. We'll just see what they say, and if we have to fight about them later we will.
A Yeah, those are just a few notes that I had while reviewing the medical records just to kind of make things clear in my mind.
Q Sure. If you can just go ahead and -- one of the

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attorneys for Beaumont is just protecting the record and his objections that he may have because he hasn't seen the notes yet.
But go ahead and read those, and he's preserved his objections.
A So patient is on oral steroids, which can cause increased white blood cell count.
Q I'm sorry to interrupt you right off the bat, but I don't have a copy of the notes, but does it say can increase elevated white blood cell count or is that just your -- are you adding to the notes?
A No. Just the line. It's just a line that I put.
Q Oh, good. I'm sorry. Yeah, all right, keep going. Thank you, sir.
A Yeah. And oral steroids also lower immunity. Patient has multiple allergies, including ciprofloxacin and sulfa antibiotics.
Past medical history: Anxiety, PTSD, colectomy, and bilateral arthroplasty.
Patient was initially admitted under hospital observation. Arrival 10/9 at 5 p.m. Fever 100.9 one time.
And this was just a question for me. How was the temperature taken? That was just for me to try to understand.

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IV steroids. S-I-R-S, that's SIRS. 10/9/15, urine was sent.
White blood cell count 13.8 with increased neutrophils, and then I make a note steroids. My thinking was that steroids can cause that.
Page 27, review of system, no dysuria or fever noted. H&P review of system, no dysuria.
NS, neurosurgery, and hospitalist H&P, all evaluated patient, radiculopathy.
On Tylenol 650 milligrams q six hours PRN. That's a standing order that I noticed.
Decadron IV and oral.
10/11/15, page 54, review of system, no urinary symptoms. And then something I don't understand myself, so...
Urine study on page 62. Just for me to know where to look.
Urine culture final result came on 10/12/15 at 20:38 p.m. Urinary tract normal, page 87, per RN. RN, nurse.
And then I had a question on page 89 of the medical records, what does PV -- PFV risk indicator mean. It was something for me to try to understand. There was a note there from the nurse.
And then there's a sepsis screen mentioned

somewhere on page 93.
Page 94, a person with the initials BR recorded temperature.
And then there's another note. I told RN to check temperature one hour after and it was okay. Patient was doing well.
White blood cell count 13.8 on 10/9/17 17:42 p.m. First urinalysis result came back on 10/9/15 at 23:23. Second urinalysis came back 10/10/15 at 22:00, page 62.
Steroids can cause leukocyte esterase positive in the urine.
Squamous epithelial cells in the urine mean contamination.
It is highly likely that 100.9 temperature was an error. Operator, machinery, et cetera. Any unverified abnormality must be considered an error.
What is the first thing a physician does when there is an abnormal vital sign? Repeats the vital signs.
Phone call 4 a.m. October 11, 2015.
Fever on 10/10/15 8 p.m. 100.9 recorded by initials, the person initials BR.
H&P shows review of system no urinary issues, no fever, no dysuria. And low back pain.

Neurosurgery, hospitalist, PM&R, all of them are -- all of them mentioned the same thing.
RN note page on 70. This one (indicating). Under the name of Camie Rabon, which is not the same person that took the temperature.
Note was entered 10/11/15 at 4:40 p.m.
Check temperature in one hour, and it was negative.
IV steroids in emergency room can cause increased white blood cell count, neutrophils, and leukocyte esterase in the urine.
When asked by RN patient voiced no complaints. She was afebrile. No need for antibiotics.
I did not have result of urine culture yet.
Both urines showed no bacteria and positive squamous cells meaning contamination.
We do not treat the urinalysis results; we treat symptoms.
And then a note from the nurse with initials CR on 10/10/15 at 21:47, urinary tract within normal limits. Patient alert and calm.
BR is Beverly Ray. CR, Camie Rabon.
End of my notes.

Q Thank you very much, sir.
Do you know why the urine culture was ordered in this case? If you don't, that's fine, but I'm just asking the question.

A No, I'm not sure specifically why it was ordered.
Q If there were squamous cells in a urinalysis and you believe it's a contaminant, is a urine culture a good thing to do to see if there is actually any bacteria in the urine?
A A urine culture --
MR. TAKALA: Sorry, guys, we didn't get that if there was an objection.
MR. SINKOFF: I was going to object to foundation.
MR. TAKALA: Go ahead, Doc.
A Urine culture is always good to have. I'm not sure what happened in this particular case, if the urine culture was ordered after the urinalysis or at the same time.
Q When you were reading your notes at the end, I think you say that you treat symptoms and not urinalysis, something along those lines.
A Yes.
Q What are the symptoms of urinary tract infection or cystitis?
A Burning with urination, frequent urination, pressure.

Q Anything else?
A Well, those are the major ones if it's a urinary tract infection.
Q Hematuria?
A Well, that's more of a -- not necessarily a symptom, more of a sign. But hematuria, per se, doesn't necessarily mean urinary tract infection.
Q What's the difference between a sign and a symptom as you're thinking about it as a physician?
A Well, a review of system, when you ask the patient how they feel. If they have any symptoms, pain, for example. Pain, pressure, burning.
If they have blood in their urine, that's something different.
Q What are some of the other signs of a urinary tract infection?
A Outside of what the patient reports?
Q Yes, sir.
A Sometimes people can complain of change in the color or smell of urine. If it goes long enough, it can cause -- the discomfort can lead to pain in the bladder area. Those are usually the signs that it's a urinary tract infection. It can obviously lead to fever.
Q Got it. And then you already told me that an

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elevated white blood cell count or leukocytosis is a nonspecific finding but can be associated with infection?

A Sure.

Q Okay. How about pyelonephritis? What are the signs and symptoms of pyelonephritis?

A Pyelonephritis is where the infection has advanced. It went from the bladder possibly to the kidneys. This is where you have pain in the lower back or the side. This is where you get fever, more discomfort, and this is where vital signs can -- you know, you can have maybe low blood pressure. You can start to have more advanced signs of infection, if you will.

Q Would you agree that antibiotics that are started early would prevent a systemic infection?

MR. SINKOFF: Object to foundation.

MR. POWE: I'm going to join as well.

A Sure.

Q The goal is to get antibiotics on board before the infection advances from a UTI to the kidneys and maybe to the blood; right?

A If you find an infection in the urine, yes.

Q And the point being, or the point that I'm trying to make is that earlier treatment with antibiotics

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for a suspected infection is better; right?

A Yes.

Q Leads to better outcomes.

MR. SINKOFF: Let me object to this attempt to back door expert testimony from an individual who's not a defendant, never been a defendant, and hasn't had an opportunity to review all of the pertinent medical records.

MR. WARWICK: I just object to this whole line of questioning as well.

MR. TAKALA: I won't go much further. Those may be fair objections.

But go ahead and answer.

A Yes, as a general rule, treating the infection is a good thing.

Q All right. Last one, and I'll give these gentlemen their objections. But if you know, do patients with artificial joints -- let me try and do it better.

Are patients with artificial joints at risk of increased infection?

MR. SINKOFF: Same objection.

MR. POWE: I'm going to join the objection as well.

MR. SINKOFF: Going way far afield.

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MR. WARWICK: Same.

A To be honest, at this point, my involvement in the case was specifically, that I can question, I'm not sure I can give an answer. Are we talking about in general or --

Q In general. And if you can't answer that, that's okay. But patients in general that have joint replacements, that's a place where infection can seed; right?

MR. SINKOFF: I object to this whole line of questioning. You're really asking him expert questions in a case where he has not had the opportunity to evaluate the entire perspective, and it's unfair and it's unreasonable and I don't think it's permissible.

MR. WARWICK: Same objection. Form. Foundation.

MR. POWE: And I'm going to join.

And Doctor, I'm not going to -- I can't tell you not to answer the question, but I think we're far afield from your involvement in this case.

MR. TAKALA: Guys, you got to mute your phone. You guys, I'll give you your objections, and this is the last question I'm asking on this line, and I'll take the doctor's answer.

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Q And I'm only asking in general.

A I don't know if I can give a -- if I can give an answer.

Q Understood. Thank you, sir.

I take it you've never been named in a medical malpractice lawsuit before?

A I was not.

Q Have you reviewed any subsequent records -- sorry if I asked you this -- aside from what you've provided me here?

A No.

Q You didn't perform any literature research for your deposition, did you?

A No.

Q Maybe a little bit of an unfair and out-of-order question, and I'll take a sentence or two on it if you can give it to me. But what's the role of a hospitalist that's on call when you get a call in the middle of the night like this? This isn't a patient that's assigned to you, but you're the on-call physician. What is your role when you get this call?

A So the way it works, we cover by rotation the patients for the group, and the on call is from home. So when there's a change in the health of a

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patient, vital signs or a new complaint, the nurse notifies the on-call physician. And we talk to the nurse, we ask questions, we review the medical records on the computer, and we address the problem.

Q Good. And if it's something you could address over the phone, you address it over the phone. If it's something that you need to address in person and examine the patient, you would get in your car and travel to the hospital.

A The way my employer set up the on call, if there was something that I deemed I could not handle over the phone, there are nurse practitioners in the hospital that we can call to examine the patient. And obviously, I mean, there are other doctors available, specialists or so.

Q Okay. So you wouldn't necessarily get in your car and travel to the hospital, but you could go up the chain of command through your group and talk with either nurse practitioners or other physicians at the hospital to get their assessment of the patient, if necessary.

A Yes.

Q All right. Do you know Dr. Linet Lonappan, L-o-n-a-p-p-a-n?

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A I do.

Q Have you spoken with Dr. Lonappan at all about this case?

A No.

Q Do you remember having any conversations about Ms. Markel with Dr. Lonappan back in the October 2015 time period?

A No.

Q Maybe my biggest objective in coming down here and asking you questions, I do want to make sure that your only involvement with this case was this five- or ten-minute window when you received a call at 4 a.m., you spoke with the nurse, you asked her questions, you looked on your computer, you ended the phone call, and you were done; right?

A Yes.

Q And you made the determination that no further medical treatment was necessary at that time; correct?

A Yes.

Q You asked the nurse to call you back in one hour after rechecking the temperature; correct?

A Yes.

Q And you never received any call back; correct?

A I did not.

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Q All right. Your treatment of this patient was done at that point in time, as you saw it; correct?

A Yes.

Q Is there anything else that you remember independently about that phone conversation, the sequence of events, anything that happened in the middle of the night on October 11 that you haven't told me about at some point today?

Let me try and do better. And what I'm trying to do is make sure I walk out of this room exhausting your memory on this note. The note is a very limited interaction, and you've already shared more information than what the note contains. I'm wondering whether there's anything additionally that you remember about that interaction or anything that you did in regards to Ms. Markel's treatment that you haven't told me about at some point.

A One thing would be the fact that, as I instructed the nurse to check the temperature in one hour, the temperature was normal.

Q Got it. So your point being that maybe if it was a normal temperature, that's not an abnormal finding, so you wouldn't necessarily expect a call back.

A No. If it was normal and the patient had no other

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complaints or change, no.

Q And also, it's your understanding that there's another attending physician on duty, that's Dr. Lonappan, who is going to be in the next day, so if there were any symptoms that manifested themselves outside of that hour or two hours, the nurse could tell Dr. Lonappan about those signs as well; they don't necessarily have to call you. Correct?

A Well, if there's something going on during my on-call, they will call me.

Q Got it. Your call would have ended, I think you said, 5 p.m. to 8 a.m.?

A That's correct.

Q All right. Based upon your schedule as you understood it at Hospital Consultants, most likely your call schedule would have ended at 8 a.m. on October 11; right?

A Yes.

Q All right. And if there was any continuing problems, there would be another on-call physician that could take those calls if necessary?

A Well, I mean, from 8 a.m. on forward, it's not the on-call doctor; it's the day hospitalist.

Q All right. There's somebody that's at the hospital

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that's being assigned to Ms. Markel.
A Correct.
Q All right. And that's the physician that would be responsible for any changes in condition after 8 a.m. or after your call ended during the day shift.
A Yes.
Q All right. We got a little bit afar afield. You've told me about -- I was asking you about anything else you remembered about this conversation or this interaction from October 11, and you said you had asked the nurse to call you back in an hour, but the temperature was normal.
Was there anything else that comes to your mind, as you sit here today, about that interaction?
A I don't think so, no.
Q All right. And I surely understand the way the human memory works, you may think of something as you drive home. All I could ask you about, as you sit here today. You're telling me that's all you remember; right?
A Correct.
Q You haven't spoken with anybody about this case aside from either Mr. Sinkoff or Mr. Powe; correct?

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A Correct.
Q You haven't spoken with any other health care providers about this case that have either given depositions or have been asked to give depositions; right?
A I did not.
Q And after having spent eight or nine hours reviewing the medical records, two or three in the last 48 hours, you still believe that there was no medical treatment that was necessary at 4 a.m. on October 11 when that nurse called you with the information; right?
A I do.
Q Bear with me, I just want to look over my notes very quickly. I think I'm all set. I do appreciate your patience.
Oh, this is going to seem kind of silly, but, obviously, when you're on call, you're employed by Hospital Consultants; you're not employed by Beaumont. Right?
A Correct.
Q But you don't convey that information to either the nursing staff or the patient that you have this separate relationship with Hospital Consultants when you're the on-call physician, do you?

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A I don't understand the question.
Q Sure. The nurse calls you and gives you medical information, and you're giving your opinion as to how to treat the patient and how to proceed over the phone; right?
A Yes.
Q You don't tell that nurse, "Make sure to tell the patient that she knows that I'm employed by Hospital Consultants, P.C., and not Beaumont," do you?
A No.
Q That would seem really silly; right?
A It was never asked of me.
Q Right. You just provide the medical opinion to the nurse and then the nurse carries out your medical plan; right?
A Correct.
Q And that's what happened in this case.
A Yes.
Q All right. And you don't have any reason to believe that you've ever met Ms. Markel face-to-face; correct?
A I never met her, no.
Q Just before we go off the record, I'll just mark a few exhibits, or at least before I end my

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questioning.
MR. SINKOFF: Well, before you do, Tim, I would like Doug to look at the exhibits, and if there's any correspondence or copies of e-mails from me, to pull those out.
MR. TAKALA: Absolutely.
MR. POWE: Steve, the only correspondence is the medical records that your office sent to the doctor, and it's just a cover letter.
MR. TAKALA: I'm sorry to even interrupt, but you could take -- I don't care if you take that off. Maybe it's easier just to take that cover letter off.
MR. POWE: All right. We will do that.
MR. SINKOFF: Okay. Thank you. And could you just repeat your phone number.
MR. WARWICK: I'm going to have a few questions when he's done.
MR. SINKOFF: Yeah, and I'll probably have some after that, but while they're marking everything, Doctor, what's your phone -- the phone number you gave?
THE WITNESS: (617)717-4746.
MR. SINKOFF: So 617 is the area code?
THE WITNESS: Yes.

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MR. SINKOFF: Okay. And you said that was AT&T?
THE WITNESS: Yes.
MR. SINKOFF: Thank you.
Q And that was the phone number that you had back in October of 2015; correct?
A Uh-huh.
Q Yes?
A Yes. Yes.
MR. TAKALA: So as Plaintiff's Exhibit 1, I'll mark the hard copy record that the doctor produced that he reviewed.
As Plaintiff's Exhibit 2, I'll mark this single page that I provided the doctor, and that was the nursing note from Camie Rabon, R-a-b-o-n, that indicated that she had contacted Dr. Muraru.
Am I saying that properly?
THE WITNESS: Yes.
MR. TAKALA: Thank you, sir.
And then as Plaintiff's Exhibit 3, I'll mark three pages of handwritten notes that are on front and back on loose-leaf paper.
That's all I have, guys.
(Plaintiff's Exhibit 1, Exhibit 2, and Exhibit 3 were marked for identification.)

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MR. SINKOFF: Go ahead, Don.
MR. WARWICK: You want me to go first, Steve? Okay.
EXAMINATION
BY MR. WARWICK:
Q So Doctor, this is Don Warwick. I represent William Beaumont Hospital in the case. I have just a few questions for you. If at any time you don't understand a question, don't hesitate to mention that, and I'll certainly repeat it or phrase it. Okay?
A Sure.
Q And I'm going to make every effort, since I'm doing this by telephone, to give a pause between your answer so I can hear it and we have a clear record. If you could just do the same thing as well when I finish my question, just give it a second and then go ahead and answer. Okay?
A Sure.
Q Back in October of 2015, you were employed by Hospital Consultants, P.C.; is that correct?
A Correct.
Q And Dr. Lonappan, to your knowledge, was also employed by Hospital Consultants, P.C.; is that correct?

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A Yes.
Q And having reviewed the medical records -- let me strike that.
Do you have an independent recollection of this phone call on the early morning hours of October 11, 2015, or are you relying upon the medical records?
A I do remember, so I have my own memory, and supplemented by the medical records.
Q Okay. And from your memory then, I would take it, and also supplemented by the medical records, you know that Dr. Lonappan had previously seen Ms. Markel at William Beaumont Hospital the afternoon of October 10, 2015; is that correct?
A Yes. I read the notes.
Q And if Dr. Lonappan gave a deposition, have you read her deposition testimony?
A No.
Q Okay. Dr. Lonappan testified that this was a patient of a Dr. John Bonema, who was with Troy Internal Medicine. Are you familiar with Dr. Bonema?
A No.
Q Okay. Do you know Troy Internal Medicine?
A It is an outpatient internal medicine group.

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Q Yes. So Dr. Lonappan's testimony was that she became involved in the care of Ms. Markel because your hospital group had a contract with Troy Internal Medicine to handle the hospitalist work for that group.
MR. SINKOFF: I object to that. I didn't mean to cut you off.
MR. WARWICK: Go ahead.
MR. SINKOFF: I'm just objecting to your reference to a contract, which doesn't exist, but there's no question.
MR. WARWICK: So let me withdraw the question then.
Q Okay. Dr. Lonappan has testified that Hospital Consultants, P.C., handled at that time the hospitalist work for Troy Internal Medicine. Do you have any understanding of that as well, or no?
A It is possible. I do not know any specifics.
Q Okay. But in any event, at the time that you received this phone call from Nurse Rabon on October 11, 2015, at around 4:13 in the morning, you were an on-call physician for Hospital Consultants, P.C.; is that correct?
A Yes.
Q And that's why you received this phone call;

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correct?
A Yes.
Q And Dr. Lonappan had previously seen the patient the afternoon before, October 10. You're aware of that; right?
A Yes. I read the notes.
Q And at the time that you saw -- strike that.
At the time that this phone call came in from Nurse Rabon, she charted that, quote, Patient was running a temperature of 100.9 at 20:00, which is 8 p.m., on October 10. You see that; right?
A Yes.
Q Patient is now 98.1. You see that note; right?
A Yes.
Q Her orders to contact doctor if temperature greater than 100.4. Dr. Muraru was called. And that's the purpose for her call then to you; is that correct?
MR. POWE: Object to foundation.
Q Is that correct?
MR. TAKALA: I'll join too.
A Well, I was not called when the temperature was high, which was at 8 p.m. I was only called at 4 in the morning.
Q I know you're saying that you were called later, but it says -- her charting is the reason she was

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calling you is because if the temperature was greater than 100.4 to call you. That's why she charted that she called you. Is that correct?
MR. TAKALA: Foundation. Same.
MR. POWE: I'll join. Lack of foundation.
A I'm not sure what her thinking was. All I can say is nobody called me at 8 p.m. So the person who --
Q I understand.
A I'm sorry.
Q I think you're overthinking it. I'm just asking you what's in the record. The record is that there was an order, and there is an order in the file, in the records, that says call the doctor if the temperature goes over 100.4. And it's noted by Nurse Rabon that the temperature at 20:00 on October 10 was 100.9. You saw that; right?
A Yeah. I have the note in front of me.
Q Okay. And at the time she called you, the nurse at least charted that she was calling you because the temperature had previously been 100.4; correct?
A That's what it says. It says that she called because the temperature was high eight hours prior, yes.
Q Right. And then it says Dr. Muraru called, patient's urinalysis is negative and culture is

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pending from previous night's specimen. Is that correct?
A Yes.
Q And you would have had that discussion with her that the urinalysis was negative; true?
A Yes.
Q And Nurse Rabon told you that Ms. Markel was doing well and she feels better than she has in a while. Did she say something along those lines to you?
A Yes. I cannot remember exactly, but yes, she mentioned that the patient was doing well.
Q Okay. And then she said doctor said to just continue to watch her. And your testimony here today, is it that you told Nurse Rabon that if the problem continued -- or strike that.
Is it your testimony that you told Nurse Rabon to call you within an hour, or only to call you if there was any additional problem?
A I told the nurse to continue to monitor the patient closely, check the temperature in one hour, and if any changes or abnormalities to call me.
Q Okay. And then from the records, on October 11 at 5 a.m., the temperature was 98.2, which is normal; correct?
A Yes.

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Q And October 11 at 7 a.m., the temperature was 97.5; correct?
A I don't have that in front of me.
Q Okay. But if it was, at 7 a.m. on the 11th, 97.5, that would be normal as well; correct?
A Yes.
Q And then if when Dr. Lonappan saw the patient at around 11 a.m. on October the 11th and the temperature was 97.5, again, that would fall within the normal range; correct?
A Well, I can only comment on the temperature being normal. I was not involved by the time, so that's all I can say.
Q That's my point. That's my point. All we have here is one temperature that was recorded at 100.9 on October 10 at 8 p.m. And then from the records, all of the other temperatures were not elevated, they were within the normal range, until the time of discharge, to your knowledge; correct?
A Yes.
MR. WARWICK: Okay. Those are all the questions I have. I appreciate it.
THE WITNESS: Sure.

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EXAMINATION
BY MR. SINKOFF:
Q Doctor, this is Steve Sinkoff, and I just have a few questions for you.
It was your belief after speaking with the nurse at 4 a.m. on October 11, and having reviewed the information available in the electronic medical record on your computer, that more likely than not this one episode of a temperature of 100.9 degrees was the result of the steroid use during the prior hours of the admission in the emergency department?
A Well --
Q Is that correct?
A Well, what I can say is what my thinking was at the time.
Q Sure.
A The number one thing was that I had no way to verify the temperature if it was indeed 100.9. I was unable to talk to the patient -- to the person who took the temperature. So I was unsure if it was a real number or not. That's number one.
Number two is she received very high does of steroids in the emergency room, and those can do a lot of things, including elevating the temperature, do changes in the urinalysis, and increase the

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white blood cell count.
Q And that would include increasing the leukocytes and the neutrophils.
A Yes.
Q And it was your reasoned medical opinion based on the information that you had available to you at the time of this phone call that the patient did not need any intervention by way of providing antibiotics or other treatment other than to monitor the subsequent temperature levels; is that correct?
A Yes.
Q And you said earlier that it was your understanding that the temperature at the time of the telephone call was within normal range?
A Yes. It's noted here.
Q Correct?
A It's here in the note, 98.1, yes.
Q Okay. And you now know either from looking at the records or from Mr. Warwick's questions that the subsequent temperatures were all within the normal parameters; correct?
A Yes.
Q Does that indicate to you that if the one 100.9 temperature was accurate, that it's an aberration

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probably caused by the steroid usage, and as the steroid effect wore down, that it -- the temperature normalized?
MR. TAKALA: Form and foundation.
Go ahead.
A It is possible.
Q Matter of fact, it's likely, isn't it?
MR. TAKALA: Form and foundation.
Go ahead.
A It's very difficult for me to say. It's one of the possibilities. It could have been an error. I don't know.
Q Okay. If it was an error, then it's an aberration and it doesn't fit in with the current, at the time of your phone call, normal blood pressure or the normal -- temperature, rather, or the normal temperatures after that; correct?
A Correct.
Q And if it was an accurate temperature, it's still an aberration, likely caused by the high dose steroid usage in the emergency department and not the result of infection, given all of the subsequent normal temperatures and the lack of any indication in the records of any signs of dysuria or urinary tract infection or pyelonephritis;

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correct?
MR. TAKALA: Form and foundation.
Go ahead.
A I cannot really say that. I was involved only briefly in the case. I cannot really say that for sure.
Q All right. Okay. So you would leave that to others who would have had more involvement, either clinically or through a more thorough review of the medical records; correct?
A Exactly. As I said, my only interaction with this case was that particular phone call. It's very difficult to make a judgment based on the limited, you know, as I said, only a few minutes.
MR. SINKOFF: Fair enough. Okay. That's all I have. Thank you, Doctor.
THE WITNESS: Sure. You're welcome.
EXAMINATION
BY MR. TAKALA:
Q Last question I have, just out of curiosity more than anything. What was it about a hospitalist practice that you didn't like where you wanted to be more of an outpatient physician?
A It wasn't that I didn't like. It's just that I -- I like more the idea of seeing the patient,

continuously taking care of their problems. In the hospital, you just see them like a day or two and then -- so I like that part a little bit more.

Q You like having the relationship, getting to know your patients?

A Yes.

MR. TAKALA: Okay, thanks. That's all I have.

MR. POWE: I think we're done, gentlemen.

MR. SINKOFF: I would like to order an electronic with copies of the exhibits, please.

MR. WARWICK: I want the same thing, just all electronic of the transcript E-Trans and the exhibits as well, and I don't know if you have our e-mail addresses or not.

THE REPORTER: Yes, I do have the e-mails.

(A discussion was held off the record.)

MR. POWE: We'll take the same. Copy, electronic, with the exhibits.

MR. TAKALA: U.S. Legal will have a standing order for us. That's probably easiest.

(The deposition concluded at 2:32 p.m.)

STATE OF INDIANA
COUNTY OF MARION

I, Patrice E. Morrison, a Notary Public in and for said county and state, do hereby certify that the deponent herein was by me first duly sworn to tell the truth, the whole truth, and nothing but the truth in the aforementioned matter;

That the foregoing deposition was taken on behalf of the Plaintiff; that said deposition was taken at the time and place heretofore mentioned between 1:05 p.m. and 2:32 p.m.;

That said deposition was taken down in stenograph notes and afterwards reduced to typewriting under my direction; and that the typewritten transcript is a true record of the testimony given by said deponent;

I do further certify that I am a disinterested person in this cause of action; that I am not a relative of the attorneys for any of the parties.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 5th day of March, 2019.

_____
Patrice E. Morrison, Notary Public

My commission expires: September 28, 2025

STATE OF MICHIGAN

IN THE SUPREME COURT

MARY ANNE MARKEL,

Plaintiff-Appellant,

v.

WILLIAM BEAUMONT HOSPITAL,

Defendant-Appellee,

and

HOSPITAL CONSULTANTS, PC, LINET LONAPPAN, MD, and IOANA MORARIU,

Defendants.

Supreme Court No. 163086

Court of Appeals Case No. 350655

Oakland County Circuit Court
Case No. 18-164979-NH

Hon. Nanci Grant

APPENDIX OF EXHIBITS TO DEFENDANT-APPELLEE WILLIAM BEAUMONT HOSPITAL'S BRIEF ON APPEAL

Volume II

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

Mary Anne Markel,

Plaintiff,

v.

Case No. 2018-164979-NH

William Beaumont Hospital, Hospital Consultants, P.C. and Linet Lonappan, M.D., Jointly and Severally

Hon. Nanci J. Grant

Defendants.

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DEFENDANT, WILLIAM BEAUMONT HOSPITAL'S MOTION FOR SUMMARY DISPOSITION, PURSUANT TO MCR 2.116(C)(10)

Defendant, William Beaumont Hospital, by its attorneys, Giarmarco, Mullins & Horton, P.C., for its Motion for Summary Disposition, brought pursuant to MCR 2.116(C)(10), states as follows:

1. This is a medical malpractice action, in which it is alleged that Co-Defendant, Linet Lonappan, M.D., a board-certified Internal Medicine physician and

FEE

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Hospitalist employed by Co-Defendant, Hospital Consultants, P.C., failed to timely diagnose and treat Plaintiff, Mary Anne Markel for a Group B Streptococcus infection. Plaintiff alleges that Defendant, William Beaumont Hospital is vicariously liable, related to the treatment provided by Co-Defendant, Dr. Lonappan. However, Plaintiff has failed to create a genuine issue of material fact to establish that Defendant, William Beaumont Hospital is vicariously liable, related to the allegations against Co-Defendant, Dr. Lonappan, pursuant to MCR 2.116(C)(10). *Grewe v Mount Clemens Gen Hosp*, 404 Mich 240, 250; 273 NW2d 429 (1978); *Chapa v St. Mary's Hosp of Saginaw*, 192 Mich App 29, 31; 480 NW2d 590 (1991); *VanStelle v Macaskill*, 255 Mich App 1, 8; 662 NW2d 41 (2003); *Laster v Henry Ford Health Sys*, 316 Mich App 726, 734; 892 NW2d 443 (2016).

2. Plaintiff also alleges that Defendant, William Beaumont Hospital's employee, Janay Warner, P.A., an Observation Unit Physician Assistant, failed to timely diagnose and treat Ms. Markel's Group B Streptococcus infection. However, the undisputed evidence shows that Defendant, P.A. Warner was not involved in Ms. Markel's treatment, at any time relevant to the allegations in this lawsuit. As such, Plaintiff has failed to create a genuine issue of material fact to show that P.A. Warner breached the standard of care or caused any injury to Ms. Markel, pursuant to MCR 2.116(C)(10). *Wischmeyer v Schanz*, 449 Mich 469, 484; 536 NW2d 760 (1995); *Locke v Pachtman*, 446 Mich 216, 222; 521 NW2d 786 (1994); *Cox v Hartman*, 322 Mich App 292, 299; 911 NW2d 219 (2017).

3. Finally, Plaintiff alleges that Defendant, William Beaumont Hospital is directly liable, related to the alleged delay in reporting the results of the subject urine

culture study, to Plaintiff, Mary Anne Markel. However, Co-Defendant, Dr. Lonappan has testified that it was her responsibility, as Ms. Markel's attending physician, to obtain the urine culture results and decide whether to report any findings to Ms. Markel – even after the patient had been discharged. Co-Defendant, Dr. Lonappan has also testified that she was aware of the positive Group B Streptococcus result on 10/12/15, that she did not believe the standard of care required her to contact Ms. Markel with the results and that the results were not relevant to Ms. Markel's care. As such, Plaintiff has failed to create a genuine issue of material fact to show that Defendant, William Beaumont Hospital is directly liable or caused any injury to Ms. Markel, pursuant to MCR 2.116(C)(10).

For the above reasons, Defendant, William Beaumont Hospital is entitled to summary disposition, with prejudice, pursuant to MCR 2.116(C)(10).

This Motion is supported by the accompanying Brief.

Respectfully submitted,
Giarmarco, Mullins & Horton, P.C.

By: /s/Donald K. Warwick
Donald K. Warwick (P44619)
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Dated: July 10, 2019

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BRIEF IN SUPPORT OF DEFENDANT, WILLIAM BEAUMONT HOSPITAL'S MOTION FOR SUMMARY DISPOSITION, PURSUANT TO MCR 2.116(C)(10)

FACTS

Plaintiff, Mary Anne Markel was born on 3/15/60. She was 55 years of age, in October 2015.

Ms. Markel had a history of uterine bleeding, polyps, etc., going back a number of years. She also had a history of back laminectomy surgery x 2, performed by Neurosurgeon, Ricky Olson, M.D., approximately 20 years earlier. In addition, she underwent total left knee arthroplasty in 2006 and total right knee arthroplasty in 2008.

On 10/2/15, board-certified Obstetrician/Gynecologist, Mark Dykowski, M.D. performed hysteroscopy, endometrial polypectomy, with dilatation curettage surgery on Ms. Markel, on an outpatient basis, at Defendant, William Beaumont Hospital ("WBH") for endometrial hyperplasia, polyps and pelvic pain. Ms. Markel was discharged, the same day.

Ms. Markel presented to Defendant, WBH's Emergency Center on 10/9/15 at 5:13 p.m., complaining of acute left-sided low back pain, radicular pain and bilateral foot numbness (worse in the left foot). (Exhibit A – Plaintiff, Mary Anne Markel's Medical Records from Defendant, William Beaumont Hospital). Various tests were ordered, including an MRI of the spine and a urinalysis. (Exhibit A). She was seen by her previous treating Neurosurgeon, Dr. Olson (Exhibit A).

During the morning of 10/10/15, Ms. Markel was transferred to Defendant, WBH's Observation Unit. The Observation Unit is located within the Emergency Center.

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Janay Warner, P.A., an employee of WBH, first saw Ms. Markel in the Observation Unit, on 10/10/15 at approximately 8:00 a.m. (Exhibit A; Exhibit B – Deposition Transcript of Janay Warner, P.A., p. 71). P.A. Warner reviewed Ms. Markel's chart, took a history and performed a physical examination. (Exhibit A). P.A. Warner entered various orders. This included an order for a repeat urinalysis and a urine culture study. (Exhibit A).

Ms. Markel was transferred from the Defendant, WBH's Observation Unit and admitted to the floor on 10/10/15 at 2:26 p.m. (Exhibit A).

Co-Defendant, Linet Lonappan, M.D. is board-certified in Internal Medicine and a Hospitalist. (Exhibit C – Deposition Transcript of Co-Defendant, Linet Lonappan, M.D., p. 128). Dr. Lonappan has been employed by Co-Defendant, Hospital Consultants, P.C., since 2011. (Exhibit C, p. 128).

Co-Defendant, Hospital Consultants, P.C. had an agreement with Ms. Markel's treating Internal Medicine physician, John Bonema, M.D.'s group, Troy Internal Medicine, P.C., to provide treatment for their patients, at Defendant, William Beaumont Hospital. (Exhibit C, pp. 128 – 129). It is undisputed that this is how Co-Defendant, Dr. Lonappan became involved in Ms. Markel's treatment. (Exhibit B, pp. 76 – 77; Exhibit C, pp. 128 - 129).

Co-Defendant, Dr. Lonappan first saw Ms. Markel, on 10/10/15 at 2:41 p.m. (Exhibit A; Exhibit C, p. 130). Ms. Markel does recall Co-Defendant, Dr. Lonappan. (Exhibit D – Deposition Transcript of Plaintiff, Mary Anne Markel, p. 56).

At her deposition, Co-Defendant, Dr. Lonappan acknowledged that it was her responsibility to know which studies had been previously been ordered, when she

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became Ms. Markel's attending physician, on 10/10/15. (Exhibit C, p.131). Co-Defendant, Dr. Lonappan has also testified that she was aware that the urine culture study and repeat urinalysis had been ordered, when she took over Ms. Markel's treatment, on 10/10/15. (Exhibit C, p. 131).

Ms. Markel's urine sample, to perform the urine culture study and repeat urinalysis, was taken, on 10/10/15 at 9:09 p.m. and 9:10 p.m. (Exhibit A; Exhibit C, p. 131).

On 10/11/15 at 4:13 a.m., Co-Defendant, Dr. Lonappan's colleague, Mihai Muraru, M.D., also a board-certified Internal Medicine physician and Hospitalist employed by Co-Defendant, Hospital Consultants, P.C., was contacted by Camie Rabon, R.N., related to a 1-time spike in Ms. Markel's temperature, recorded on 10/10/15 at 8:00 p.m. (Exhibit A). It is undisputed that Dr. Muraru was contacted because he was the on-call Hospitalist for Co-Defendant, Hospital Consultants, P.C. (Exhibit C – p. 132; Exhibit E – Deposition Transcript of Mihai Muraru, M.D., pp. 60-61). Ms. Markel's temperature had normalized to 98.1, when Nurse Rabon spoke with Dr. Muraru. (Exhibit A). It was noted that the urinalysis was negative and that the urine culture study was pending. (Exhibit A). Dr. Muraru advised Nurse Rabon to continue to watch Ms. Markel's condition.

Pain Medicine physician, Daniel Sapeika, M.D. saw Ms. Markel, on 10/11/15 at approximately 9:00 a.m. Dr. Sapeika noted Ms. Markel's previous history of Laminectomy x 2 by her treating Neurosurgeon, Dr. Olson. (Exhibit A). An MRI showed multilevel moderate-severe stenosis. He noted that Ms. Markel wanted to be discharged, if possible. Dr. Sapeika diagnosed lumbar radicular pain. He

recommended that, if Ms. Markel was to be discharged that day, an epidural be performed on 10/12/15, on an outpatient basis. (Exhibit A).

Co-Defendant, Dr. Lonappan saw Ms. Markel again, on 10/11/15 at approximately 11:00 a.m. Co-Defendant, Dr. Lonappan felt that it was appropriate to discharge Ms. Markel, based upon the evaluations performed by Neurosurgeon, Dr. Olson and Pain Medicine specialist, Dr. Sapeika, as well as the MRI and other test results. (Exhibit A).

Co-Defendant, Dr. Lonappan discharged Ms. Markel from Defendant, William Beaumont Hospital on 10/11/15, at approximately 12:45 p.m. (Exhibit A). Co-Defendant, Dr. Lonappan dictated the 10/11/15 Discharge Report, diagnosing acute left lumbar radiculopathy. (Exhibit A). Co-Defendant, Dr. Lonappan instructed Ms. Markel to follow-up with Pain Medicine, Neurosurgery and Internal Medicine. (Exhibit A).

A preliminary report, from the 10/10/15 urine culture study, was reported on 10/11/15 at 5:47 p.m. (Exhibit A). The final report from the 10/10/15 urine culture study, was resulted on 10/12/15 at 8:38 p.m. (Exhibit A). The final urine culture report was positive for Group B Streptococcus. (Exhibit A).

Co-Defendant, Dr. Lonappan has testified that it was her responsibility, as the attending physician, to follow-up regarding the urine culture results, even after Ms. Markel was discharged. (Exhibit C, pp. 132 – 133). Co-Defendant, Dr. Lonappan has testified that she was aware of the positive Group B Streptococcus result on 10/12/15, that she did not believe the standard of care required her to contact Ms. Markel with the results and that the results were not relevant to Ms. Markel's care. (Exhibit C, pp. 19 – 20).

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Ms. Markel returned to Defendant, WBH on 10/13/15 with complaints of bilateral knee pain, along with pain in multiple joints. The 10/12/15 urine culture results were noted. Intravenous antibiotics were started. She remained admitted to Defendant, WBH until 11/22/15.

STANDARD OF REVIEW

A motion under MCR 2.116(C)(10) tests the factual sufficiency of the complaint. *Maiden v Rozwood*, 461 Mich 109, 119; 597 NW2d 817 (1999). In evaluating a motion for summary disposition under subrule (C)(10), a trial court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties. *Maiden*, *supra* at 119-120 (Citing, MCR 2.116(G)(5)). The party opposing a motion brought under MCR 2.116(C)(10) may not rest upon the mere allegations of his or her pleadings, but must, by sworn testimony or otherwise, set forth specific facts showing that there is a genuine issue for trial. *Maiden*, *supra* at 120. The Court considers the "substantively admissible" evidence proffered in opposition to the motion. *Id.* at 121. Where the proffered evidence fails to establish a genuine issue regarding any material fact, the moving party is entitled to judgment as a matter of law. *Id.* at 120.

ARGUMENT I

PLAINTIFF HAS FAILED TO CREATE A GENUINE ISSUE OF MATERIAL FACT, PURSUANT TO MCR 2.116(C)(10), TO ESTABLISH THAT DEFENDANT, WILLIAM BEAUMONT HOSPITAL IS VICARIOUSLY LIABLE REGARDING THE TREATMENT PROVIDED BY CO-DEFENDANT, LINET LONAPPAN, M.D.

In Michigan, liability will typically be imposed "upon a defendant only for his or her own negligence, not the alleged tortious conduct of others." *Laster v Henry Ford Health Sys*, 316 Mich App 726, 734; 892 NW2d 443 (2016). Generally speaking, a hospital is not vicariously liable for the alleged negligence of a physician who is an

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independent contractor and merely uses the hospital's facilities to render treatment to his patients." *Grewe v Mount Clemens Gen Hosp*, 404 Mich 240, 250; 273 NW2d 429 (1978).

However, "[I]f the patient looked to the hospital to provide medical treatment and the hospital made a representation that medical treatment would be afforded by physicians working at the hospital, an agency by estoppel may be found." *VanStelle v Macaskill*, 255 Mich App 1, 8; 662 NW2d 41 (2003). "Agency by estoppel" is commonly referred to as "ostensible agency." *Chapa v St. Mary's Hosp of Saginaw*, 192 Mich App 29, 31; 480 NW2d 590 (1991).

A critical question is "***whether the plaintiff, at the time of her admission to the hospital, was looking to the hospital for treatment of her physical ailments or merely viewed the hospital as the situs where her physician would treat her for her problems."*** *Grewe*, 404 Mich at 251. While this is a critical question, Michigan appellate courts have consistently held ***that this is not the only question***. *Chapa*, 192 Mich App at 32-33. **"[N]othing in Grewe indicates that a hospital is liable for the alleged malpractice of independent contractors merely because the patient 'looked to' the hospital at the time of admission." *Chapa*, 192 Mich App at 33. *Agency "does not arise merely because one goes to a hospital for medical care."*** *VanStelle, 255 Mich App at 11, quoting Sasseen v Community Hosp Foundation, 159 Mich App 231, 240; 406 NW2d 193 (1986).* **"There must be some action or representation by the principal (hospital) to lead the third person (plaintiff) to reasonably believe an agency in fact existed**." *VanStelle*, 255 Mich App at 11.

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In this case, it is undisputed that: (1) Co-Defendant, Dr. Lonappan has been employed by Co-Defendant, Hospital Consultants, P.C., at all times relevant to this lawsuit; (2) Co-Defendant, Dr. Lonappan has not been employed by Defendant, WBH, at any time relevant to this lawsuit; (3) Co-Defendant, Dr. Lonappan became involved in Ms. Markel's treatment through the agreement between Dr. Lonappan's employer, Co-Defendant, Hospital Consultants and Ms. Markel's treating Internal Medicine physician, John Bonema, M.D.'s group, Troy Internal Medicine, P.C.; (4) Co-Defendant, Dr. Lonappan became involved in Ms. Markel's treatment on 10/10/15 because her employer, Co-Defendant, Hospital Consultants, P.C. scheduled her for work at the hospital, that day; and (5) Defendant, WBH did not make any representation to Ms. Markel to lead her to believe that an agency existed between the hospital and Co-Defendant, Dr. Lonappan.

Under *Grewe, Chapa, VanStelle* and their progeny, Defendant, William Beaumont Hospital is not vicariously liable related to the allegations against Co-Defendant, Dr. Lonappan. Defendant, William Beaumont Hospital is entitled to summary disposition, pursuant to MCR 2.116(C)(10), as to this claim.

ARGUMENT II

PLAINTIFF HAS FAILED TO CREATE A GENUINE ISSUE OF MATERIAL FACT TO ESTABLISH THAT DEFENDANT, WILLIAM BEAUMONT HOSPITAL'S EMPLOYEE, JANAY WARNER, P.A. BREACHED THE STANDARD OF CARE OR CAUSED ANY INJURY TO MS. MARKEL

In a medical malpractice action, the plaintiff must prove: "(1) the applicable standard of care; (2) breach of that standard by defendant; (3) injury; and (4) proximate causation between the alleged breach and the injury." *Cox v Hartman*, 322 Mich App 292, 299; 911 NW2d 219 (2017); *Wischmeyer v Schanz*, 449 Mich 469, 484; 536 NW2d

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760 (1995); *Locke v Pachtman*, 446 Mich 216, 222; 521 NW2d 786 (1994). Failure to prove any one of these elements is fatal to the claim. *Wischmeyer*, *supra*.

Expert testimony is essential to establish a breach of the standard of care and a causal link between the alleged negligence and the alleged injury. *Pennington v Longabaugh*, 271 Mich App 101, 104; 719 NW2d 616 (2006). Plaintiff must establish a breach of the standard of care and causal connection between the defendant's breach of the applicable standard of care and the plaintiff's injuries. *Craig v Oakwood Hosp*, 471 Mich 67, 90; 684 NW2d 296 (2004).

Establishing causation requires proof of two separate elements: (1) cause in fact; and (2) legal cause, also known as "proximate cause." *Weymers v Khera*, 454 Mich 639, 647; 563 NW2d 647 (1997). **To establish cause in fact**, the first-tier of the two-prong causation requirement, a plaintiff "must present *substantial evidence* from which a jury could conclude that, more likely than not, but for the defendant's conduct, the plaintiff's injuries would not have occurred." *Badalamenti v William Beaumont Hospital,* 237 Mich App 278, 285; 602 NW2d 854 (1999)(emphasis in original); *Weymers*, *supra* at 647-648; *Skinner v Square D Co*, 445 Mich 153, 162-163; 516 NW2d 475 (1994). **A mere possibility of causation is not enough**. *Id.* Speculation or conjecture "is simply an explanation consistent with known facts or conditions, but not deducible from them as a reasonable inference." *Id.* at 164. **Proximate cause**, the second tier of the causation requirement, involves examining the foreseeability of consequences and whether a defendant should be held legally responsible for such consequences even given a negligent acts or omissions. *Craig,supra* at 87; *Skinner v Square D Co*, 445 Mich 153, 163; 516 NW2d 475 (1994). Proximate cause must be "a foreseeable,

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natural, and probable cause." *Shinholster v Annapolis Hosp*, 471 Mich 540, 546; 685 NW2d 275 (2004); *Nielsen v Stevens*, 368 Mich 216, 220; 118 NW2d 397 (1962).

In this case, it is undisputed that: (1) Janay Warner, P.A. only provided medical care to Ms. Markel in Defendant, WBH's Observation Unit, on 10/10/15, from approximately 8:00 a.m. – 2:00 p.m.; (2) P.A. Warner was not involved in Ms. Markel's treatment, after her transfer to the floor and Co-Defendant, Dr. Lonappan saw Ms. Markel, as her attending physician, on 10/10/15 at approximately 2:41 p.m.; (2) Co-Defendant, Dr. Lonappan was aware that P.A. Warner had ordered the urine culture study and repeat urinalysis, when she became Ms. Markel's attending physician, on 10/10/15 at approximately 2:41 p.m.; (3) the urine sample related to urine culture and repeat urinalysis was not taken, on the floor, until 10/10/15 at 9:09 p.m. and 9:10 p.m. – long after P.A. Warner had last seen Ms. Markel in the Observation Unit; (4) Co-Defendant, Dr. Lonappan has admitted that, as Ms. Markel's attending physician, it was her responsibility to follow-up regarding the urine culture results – even after Ms. Markel was discharged from Defendant, WBH; (5) P.A. Warner would not have received the urine culture results, after Ms. Markel was admitted to the hospital floor; and (6) P.A. Warner did not have a responsibility to follow-up regarding the urine culture results.

Plaintiff has failed to create a genuine issue of material fact to show that Janay Warner, P.A. breached the standard of care or caused any injury to Ms. Markel. As such, Defendant, William Beaumont Hospital is entitled to summary disposition as to this claim, under MCR 2.116(C)(10).

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ARGUMENT III

PLAINTIFF HAS FAILED TO CREATE A GENUINE ISSUE OF MATERIAL FACT, PURSUANT TO MCR 2.116(C), TO ESTABLISH THAT DEFENDANT, WILLIAM BEAUMONT HOSPITAL IS LIABLE OR CAUSED ANY INJURY TO MS. MARKEL, UNDER A DIRECT LIABILITY THEORY

Plaintiff alleges that Defendant, WBH is directly liable, related to the alleged delay in reporting the results of the subject urine culture study to Plaintiff, Mary Anne Markel. However, Co-Defendant, Dr. Lonappan has testified that it was her responsibility, as Ms. Markel's attending physician, to obtain the urine culture results and decide whether to report the findings to Ms. Markel – even after the patient had been discharged from the hospital. (Exhibit C – pp. 132 – 133). Indeed, Co-Defendant, Dr. Lonappan has testified that she was aware of the positive urine culture results on 10/12/15. Dr. Lonappan has testified that she did not believe the standard of care required her to contact Ms. Markel with the results and that the results were not relevant to Ms. Markel's care. (Exhibit C, pp. 19 – 20).

There is no evidence to show that there was a flaw in Defendant, William Beaumont Hospital's reporting process, related to Ms. Markel's urine culture results. Co-Defendant, Dr. Lonappan has acknowledged that it was her responsibility to obtain the urine culture results, that she did so and that she did not believe the results were relevant to Ms. Markel's condition. As such, Plaintiff has failed to create a genuine issue of material fact to show that Defendant, William Beaumont Hospital is directly liable or caused any injury to Ms. Markel, under MCR 2.116(C)(10).

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CONCLUSION

For the above reasons, Defendant, William Beaumont Hospital is entitled to summary disposition and to be dismissed from this lawsuit, with prejudice, pursuant to MCR 2.116(C)(10).

Respectfully submitted,
Giarmarco, Mullins & Horton, P.C.

By: /s/Donald K. Warwick
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Dated: July 10, 2019

NOTICE OF HEARING

Please take note that Defendant, William Beaumont Hospital's Motion for Summary Disposition Pursuant to MCR 2.116(C)(10) shall be brought on for hearing before the Honorable Nanci J. Grant, in her courtroom, located in the Oakland County Circuit Court, on **Wednesday, July 31, 2019 at 8:30 a.m.,** or as soon thereafter as counsel may be heard.

Respectfully submitted,
Giarmarco, Mullins & Horton, P.C.

By: /s/Donald K. Warwick
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Dated: July 10, 2019

GMH GIARMARCO, MULLINS & HORTON, P.C.
ATTORNEYS AND COUNSELORS AT LAW
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PROOF OF SERVICE

Kathleen A. Rochon certifies that on July 10, 2019 she served upon the attorneys for Plaintiff and Co-Defendants, copies of:

- Defendant, William Beaumont Hospital's Motion for Summary Disposition Pursuant to MCR 2.116(C)(10)
- Brief in Support of Motion
- Notice of Hearing

via the Oakland County Circuit Court electronic filing system.

Kathleen A. Rochon
Kathleen A. Rochon

EXHIBIT A

BEAUMONT HEALTH
ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

PATIENT FACESHEET

Patient Demographics

Name	Patient ID	SSN	Sex	Birth Date
Markel, Mary Anne	1568410	xxx-xx-8555	Female	03/15/60 (55 yrs)

Address	Phone	Email	Employer
1882 BACON AVE BERKLEY MI 48072-1060	248-398-3151 (H) 248-273-8151 (W) 248-890-9414 (M)	mamarkel@yahoo.com	BEAUMONT HEALTH SYSTEM 3601 W. 13 Mile Rd Royal Oak MI 48073 248-273-8147

Reg Status	PCP	Date Last Verified	Next Review Date
Verified	Bonema, John D, MD248-267-5000	11/18/17	02/16/18

Marital Status	Religion
Single	Catholic/Roman Catholic

Notices
Latex

Patient Preferred Languages

Interpreter Needed	Spoken Language	Written Language
No	English	English

PCP and Center

Primary Care Provider	Phone	Center
John D Bonema, MD	248-267-5000	ROYAL OAK HOSPITAL

Contact Information

Name	Relation	Home	Work	Mobile
Markel,Connie	Sister	248-330-4784		248-330-4784
Markel,Mike	Brother		248-330-4783	**248-330-4783**

Hospital Account

Name	Acct ID	Class	Status	Primary Coverage
Markel, Mary Anne	15684102123	Outpatient - Procedure/Medical	Closed	BEAUMONT HEALTH EMPLOYEE HEALTH PLAN - 2016 BEHP CLASSIC

Guarantor Account (for Hospital Account #15684102123)

Name	Relation to Pt	Service Area	Active?	Acct Type
Markel, Mary Anne	Self	BH	Yes	Personal/Family

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Adm: 10/9/2015, Dsc: 10/11/2015

Guarantor Account (for Hospital Account #15684102123) (continued)

Address	Phone
1882 BACON AVE BERKLEY, MI 48072-1060	248-890-9414(H) 248-273-8151(O)

Coverage Information (for Hospital Account #15684102123)

F/O Payor/Plan		Subscriber DOB	Precert #
BEAUMONT HEALTH EMPLOYEE HEALTH PLAN/2016 BEHP CLASSIC		03/15/60	na
Subscriber		**Relation to Pt**	**Subscriber #**
Markel, Mary Anne		Self	Y13682625
Grp #			
76430087			
Address	**Phone**		
UMR BEHP UNIT PO BOX 30541 SALT LAKE CITY, UT 84130-0541			
Policy Number		**Effective Date**	
Y13682625		01/01/06	
Auth/Cert			
na			

Admission Information

Attending Provider	Admitting Provider	Admission Type	Admission Date/Time
Lonappan, Linet P, MD	Lonappan, Linet P, MD	Emergent	10/09/15 1713
Discharge Date	**Hospital Service**	**Auth/Cert Status**	**Service Area**
10/11/15	.RO-MED	OPPM Complete	BEAUMONT HEALTH SYSTEM
Unit	**Room/Bed**	**Admission Status**	**Referring Provider**
6 ST GYN TEAM CARE A	6305/06/6306	Discharged (Confirmed)	
Point of Origin			
BHS - Home			
Accident Date	**Accident Time**		

Admission

Complaint
Left-sided low back pain with left-sided sciatica [M54.42] Lumbar radiculopathy [M54.16] , Lumbar Spinal Stenosis

Admission Diagnoses / Reasons for Visit (ICD-10-CM)

Code	Description	Comments
M54.16	Radiculopathy, lumbar region	
M54.42	Lumbago with sciatica, left side	

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
M54.16 **[Principal]**	Radiculopathy, lumbar region				

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Final Diagnoses (ICD-10-CM) (continued)

Code	Description	POA	CC	HAC	Affects DRG
I10	Essential (primary) hypertension				
E03.9	Hypothyroidism, unspecified				
Z23	Encounter for immunization				

Discharge Information - Hospital Account/Patient Record

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
10/11/2015 12:45 PM	Home Or Self Care	Homes	Lonappan, Linet P, MD	6 ST GYN TEAM CARE A

No data filed

Allergies as of 10/11/2015 Reviewed on: **10/11/2015**

	Noted	Reaction Type	Reactions
Latex			**Anaphylaxis/Shock**
Ivp Dye [iodinated Diagnostic Agents]			**Rash/Itching, Short of Breath/Wheezing**
DELETED: **Serevent Diskus [salmeterol]**	02/03/2009		Short of Breath/Wheezing
Avocado			Short of Breath/Wheezing
Banana			Short of Breath/Wheezing
Aciphex [rabeprazole Sodium]			Rash/Itching
DELETED: **Bumetanide**			Rash/Itching
Bumex [bumetanide]	05/11/2010		Rash/Itching
Celebrex [celecoxib] Given w/Lyrica	02/03/2009		Rash/Itching, Short of Breath/Wheezing
Ciprofloxacin			Short of Breath/Wheezing
Flovent [fluticasone Propionate]			Short of Breath/Wheezing
DELETED: **Fluticasone-salmeterol**			Short of Breath/Wheezing
DELETED: **Hctz** duplicate			Rash/Itching
Kiwi Extract	02/03/2009		Short of Breath/Wheezing
Lisinopril cough			Other
Lyrica [pregabalin] Given w/Celebrex	02/03/2009		Short of Breath/Wheezing
Maxzide [hydrochlorothiazide W-triamterene]			Rash/Itching
DELETED: **Metoprolol Succinate** Denies allergy 5/11/10			Swelling, generalized
DELETED: **Prevacid**			Short of Breath/Wheezing
DELETED: **Salmeterol Xinafoate** Exacerbates asthma	05/11/2010		Short of Breath/Wheezing
Sulfa Antibiotics			Rash/Itching
DELETED: **Sulfa Drugs Cross Reactors** mouth sores, mouth sores			Rash/Itching, Other

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Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102117
Adm: 9/2/2015, Dsc: 9/2/2015

Patient Education

No education to display

Recent Education Comments

No education comments to display

Smoking Cessation Counseling [PN-4] Performance Indicator Data Elements

Comfort Measures Only:	**4: No comfort measures have been documented**	Clinical Trial:	**No documentation found**
Chest X-ray or CT Scan Result:	**3: Patient did not have a chest x-ray or CT scan the day prior to arrival or during hospital stay**		
Adult Smoking History:	**No documentation found**	Adult Smoking Counseling:	**No documentation found**

Lab Results (continued)

BASIC METABOLIC PANEL (BMP) [586475058] (Abnormal) (continued) Resulted: 10/09/15 1800, Result status: Final result

GFR African American	92	>59 mL/min/1.73m2	—
Comment: Glomerular Filtration Rate is estimated from serum creatinine, age, gender, and race using the CKD-EPI equation. GFR categories in CKD are for both African American and Non-African American: G1: Normal GFR: >=90 G2: Mildly decreased GFR: 60-89 G3a: Mildly to moderately decreased GFR: 45-59 G3b: Moderately to severely decreased GFR: 30-44 G4: Severely decreased GFR: 15-29 G5: Kidney failure GFR: <15			
Calcium	9.2	8.4 - 10.4 mg/dL	—

Additional Resulting Lab Information
Received: 201510091739

URINALYSIS [586475056] (Abnormal) Resulted: 10/09/15 2323, Result status: Final result

Ordering provider: Joseph, Amy E, PA-C 10/09/15 1733 Resulting lab: LABORATORY INFORMATION SYSTEM

Dt/Tm Coll

Type	Source	Collected By
—	—	9FSA1 10/09/15 2249

Components

Component	Value	Reference Range	Flag
Color	DkYellow	—	—
Clarity	Cloudy	—	A
Glucose	Negative	Negative	—
Bilirubin	1+	Negative	A
Comment: Positive bilirubin by dipstick. Unable to exclude color interference. Suggest clinical correlation.			
Ketones	Trace	Negative	A
Specific Gravity, Urine	1.043	1.005 - 1.030	H
Blood	Negative	Negative	—
pH	5.5	5.0 - 8.0	—
Protein	Negative	Negative	—
Urobilinogen	1.0	0.2 - 1.0	—
Nitrites	Negative	Negative	—
Leukocyte Esterase	2+	Negative	A
RBC	0-3	0 - 3 /hpf	—
WBC	11-25	0 - 5 /hpf	A
Epithelial, Squamous	6-50	/lpf	—
Casts, Hyaline	0-2	0 - 2 /lpf	—
Bacteria	Negative	Negative /hpf	—
Crystal	Calcium	—	—

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Lab Results (continued)

Resulted: 10/09/15 2323, Result status: Final result

URINALYSIS [586475056] (Abnormal) (continued)

Comment	Oxalate see below	—	—

Comment: Microscopic manually verified.

Additional Resulting Lab Information
Received: 201510092254

Resulted: 10/10/15 2201, Result status: Final result

URINALYSIS [586562410] (Abnormal)

Ordering provider: Warner, Janay, PA-C 10/10/15 1349 Resulting lab: LABORATORY INFORMATION SYSTEM

Dt/Tm Coll

Type	Source	Collected By
—	—	9BROY 10/10/15 2109

Components

Component	Value	Reference Range	Flag
Color	DkYellow	—	—
Clarity	Clear	—	—
Glucose	Negative	Negative	—
Bilirubin	Negative	Negative	—
Ketones	Trace	Negative	A
Specific Gravity, Urine	1.030	1.005 - 1.030	—
Blood	Trace	Negative	A
pH	6.0	5.0 - 8.0	—
Protein	Trace	Negative	A
Urobilinogen	1.0	0.2 - 1.0	—
Nitrites	Negative	Negative	—
Leukocyte Esterase	2+	Negative	A
RBC	5	0 - 3 /hpf	H
WBC	>100	0 - 5 /hpf	H
Epithelial, Squamous	21	/lpf	—
Casts, Hyaline	18	0 - 2 /lpf	H
Bacteria	Negative	Negative /hpf	—

Additional Resulting Lab Information
Received: 201510102142

Resulted: 10/12/15 2038, Result status: Final result

CULTURE, URINE [586562411] (Abnormal)

Ordering provider: Warner, Janay, PA-C 10/10/15 1349 Resulting lab: LABORATORY INFORMATION SYSTEM

Dt/Tm Coll

Type	Source	Collected By
—	Urine	9BROY 10/10/15 2110

Components

Component	Value	Reference Range	Flag
Flag Status	This report has been flagged as abnormal	—	A

ED Notes (continued)

ED Obs Nurse Notes by Salem, Feras, RN 10/10/15 0306

Author: Salem, Feras, RN | Service: Emergency Medicine | Author Type: Registered Nurse
Filed: 10/10/15 0306 | Date of Service: 10/10/15 0306 | Status: Signed
Editor: Salem, Feras, RN (Registered Nurse)

Patient given ice pack as requested to help with her back pain. Patient stated relief.

ED Nurse Notes by Yang, Sun-Yoon, RN 10/10/15 0430

Author: Yang, Sun-Yoon, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 0438 | Date of Service: 10/10/15 0430 | Status: Addendum
Editor: Yang, Sun-Yoon, RN (Registered Nurse)
Related Notes: Original Note by Yang, Sun-Yoon, RN (Registered Nurse) filed at 10/10/15 0432

Pt first encounter. Pt c/o severe back pain. Established new IV line due to infiltration of previous IV. Dilaudid given per order. Assisted pt to put bedpan. Applied ice pack to back. wctm.

ED Nurse Notes by Vang, Yer, RN 10/10/15 0720

Author: Vang, Yer, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 0826 | Date of Service: 10/10/15 0720 | Status: Signed
Editor: Vang, Yer, RN (Registered Nurse)

Pt assisted to commode. No distress. Am med given with dilaudid. VSS. Waiting for consults.

ED Nurse Notes by Vang, Yer, RN 10/10/15 0847

Author: Vang, Yer, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 0847 | Date of Service: 10/10/15 0847 | Status: Signed
Editor: Vang, Yer, RN (Registered Nurse)

Robaxin given. Pt alert x3. No distress.

ED Nurse Notes by Vang, Yer, RN 10/10/15 1059

Author: Vang, Yer, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 1100 | Date of Service: 10/10/15 1059 | Status: Signed
Editor: Vang, Yer, RN (Registered Nurse)

Pt given percocet for pain. PMR and neurosurg was here to see pt. VSS. Waiting for further orders.

ED Obs Provider Notes by Warner, Janay, PA-C 10/10/15 0808

Author: Warner, Janay, PA-C | Service: (none) | Author Type: Physician Assistant
Filed: 10/10/15 1226 | Date of Service: 10/10/15 0808 | Status: Signed
Editor: Warner, Janay, PA-C (Physician Assistant) | Cosigner: Berger, David A, MD at 10/23/15 1842

Observation Note

ED Notes (continued)

ED Obs Provider Notes by Warner, Janay, PA-C (continued) 10/10/15 0808

This patient has been seen by PA/NP: janay warner pa-c.

The Observation Physician has reviewed the following: EC records, observation records and nursing notes.

Past Medical History

Diagnosis	Date
• Hypertension	
• Hypothyroidism	
• Asthma	
• Glaucoma	
• GERD (gastroesophageal reflux disease)	
• Diverticulitis	
• Dysphagia	
• Anxiety disorder	
• Postoperative nausea and vomiting	

Past Surgical History

Procedure	Laterality	Date
• Pa esophagogastic fundoplasty nissens		2005
• Discectomy, lumbar		
• Tonsilectomy		
• Cholecystectomy		2005
• Removal, cataract		
• Colectomy		
• Laminectomy		
• Arthroplasty, total knee, left		
• Arthroplasty, total knee, right		
• Hernia repair ventral		
• Other surgical history *sphincteroplasty*		
• Esophagogastroduodenoscopy (egd) *x 10*		
• Colonoscopy		
• Arthroscopy, knee		

History

Social History

• Marital Status:	Single
Spouse Name:	N/A
Number of Children:	N/A
• Years of Education:	N/A

Social History Main Topics

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ED Notes (continued)

ED Obs Provider Notes by Warner, Janay, PA-C (continued) 10/10/15 0808

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol Use: No
- Drug Use: No
- Sexual Activity: Not on file

Other Topics — Concern
- Not on file

Social History Narrative

Family History

Problem	Relation	Age of Onset
Cancer - Other	Father	
MI	Mother	
Heart Failure	Mother	

Physician Focused Physical Exam
Nursing note and vitals reviewed.

Mild visible distress
Laying in stretcher in left lateral decubitis

EC OU Course:
Pt. Sent to EC observation for evaluation of left lumbar back pain radiating into LLE. MRI of LS spine shows moderate/severe stonosis of spine with multiple disc extrusions/protrusions at multiple levels.

Pt. Was evaluated by Neurosurgery and PM&R who both recommended anesthesia pain consult. Pt. Is an anesthesia nurse here at beaumont.

4mg Decadron given along with Robaxin as recommended by specialists. Will consider additional 4mg dose of decadron later today. Pt. Continues to c/o severe pain despite IV and po medications and is unable to ambulate d/t pain.

Discussed care plan with pain service who will not be able to see pt. Today but plan to round on her tomorrow am.

WBC 13.8
UA awaiting repeat

Final Diagnosis: 1. Lumber radiculopathy 2. Acute on chronic lower back pain

ED Notes (continued)

ED Obs Provider Notes by Warner, Janay, PA-C (continued) 10/10/15 0808

Encounter Diagnoses

Name	Primary?
• Left-sided low back pain with left-sided sciatica	Yes

Treatment Plan: Admit (see Order to Admit) in stable condition to Haas/Wease, Dr. Lonappan. Pt. Agreeable with plan for PT evaluation, pain control and pain service consult for epidural. PM&R and neurosurgery (Dr. Olsen) to follow. Pt. Agreeable.

ED Provider Notes by Hang, Bophal S, MD 10/09/15 1733

Author: Hang, Bophal S, MD | Service: (none) | Author Type: Physician
Filed: 10/25/15 2258 | Date of Service: 10/09/15 1733 | Status: Addendum
Editor: Hang, Bophal S, MD (Physician)
Related Notes: Original Note by Joseph, Amy E, PA-C (Physician Assistant) filed at 10/23/15 1916

No chief complaint on file.

HPI Comments: Pt is a 55 y/o F presenting with acute low back pain with left leg radicular symptoms. She is a nurse at Beaumont and the pain started today at work. Her pain is in the left lower back and down her left leg. She denies any heavy lifting today or any injury/trauma. She left work early, went home, tried heat, aleve, norco, and warm bath without any relief. She says her legs "feel weird" and unsteady. She has numbness to both feet, worse on the left. She had difficulty urinating earlier today but has since urinated. She has remote hx of back surgery with Dr. Olsen about 20 years ago.

Review of Systems
Constitutional: Negative for fever and chills.
Respiratory: Negative for cough.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for nausea, vomiting and abdominal pain.
Genitourinary: Negative for dysuria.
Musculoskeletal: Positive for back pain. Negative for falls.
Neurological: Positive for sensory change.

Patient's Medications

New Prescriptions
No medications on file

Previous Medications

ALBUTEROL (PROVENTIL, VENTOLIN) 108 (90 BASE) MCG/ACT INHAL AERO SOLN	inhale 2 Puffs into the lungs as needed.

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Progress Notes (continued)

Progress Notes by Keiser, Megan, RN NP-C (continued) 10/10/15 0906

clinic with Dr. Olson in 3-4 weeks. Will sign off - please call with questions or concerns.

MKeiser, RN, NP 10/10/2015 9:09AM
Pager 23298

Attribution Key
Attribution information is not available for this note.

Nsg Progress Note by Rabon, Camie D, RN 10/11/15 0413

Author: Rabon, Camie D, RN | Service: (none) | Author Type: Nursing
Filed: 10/11/15 0440 | Date of Service: 10/11/15 0413 | Status: Addendum
Editor: Rabon, Camie D, RN (Registered Nurse)
Related Notes: Original Note by Rabon, Camie D, RN (Registered Nurse) filed at 10/11/15 0415

Pt was running a temperature of 100.9 at 20:00 (10/10). Pt is now 98.1 Per orders to contact dr if temp>100.4, Dr Moraru was called.

Dr Moraru called. Pt's UA is neg and culture is pending from previous night specimen. Pt states she is doing well and feels better than she has in a while. Dr said to just continue to watch her.

Attribution Key
Attribution information is not available for this note.

All Other Notes

Nsg Admit Note by Magolan, Angela S, RN 10/10/15 1426

Author: Magolan, Angela S, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 1427 | Date of Service: 10/10/15 1426 | Status: Signed
Editor: Magolan, Angela S, RN (Registered Nurse)

RN Admit Note

Patient received from: EC

Reason for admit/transfer: back pain

Condition of patient and pertinent physical findings on arrival: aox3, denies DIB, SOB

Presence of pain/score: 6/10

Condition of skin: intact (if skin breakdown noted see LDA)

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All Other Notes (continued)

Nsg Admit Note by Magolan, Angela S, RN (continued) 10/10/15 1426

Patient/family oriented to room, white board, hourly rounding explained, and fall prevention techniques implemented. Call light and phone placed within reach. Bed low and wheels locked.

Angela Magolan, RN

Attribution Key
Attribution information is not available for this note.

Nsg Admit Note by Rautiola, Nicole Teresa, RN 10/10/15 1449

Author: Rautiola, Nicole Teresa, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 1450 | Date of Service: 10/10/15 1449 | Status: Signed
Editor: Rautiola, Nicole Teresa, RN (Registered Nurse)

Admit Note

Patient received from: EC
Reason for admit: back pain
Condition of patient and pertinent physical findings on arrival: A&Ox3
Presence of pain/score: 6/10
4-eye skin assessment completed with: Angie M RN
Condition of skin: CDI

Patient/family orientated to room, white board, hourly rounding explained and fall prevention techniques implemented. Call light and phone placed in reach. Bed low and wheels locked.

Nicole Rautiola, RN

Attribution Key
Attribution information is not available for this note.

Care Plan Note by Rautiola, Nicole Teresa, RN 10/10/15 1900

Author: Rautiola, Nicole Teresa, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/10/15 1900 | Date of Service: 10/10/15 1900 | Status: Signed
Editor: Rautiola, Nicole Teresa, RN (Registered Nurse)

ED Notes (continued)

ED Provider Notes by Hang, Bophal S, MD (continued) 10/09/15 1733

History & Physical Notes

H&P by Lonappan, Linet P, MD 10/10/15 1441

Author: Lonappan, Linet P, MD | Service: Internal Medicine | Author Type: Physician
Filed: 10/10/15 1633 | Date of Service: 10/10/15 1441 | Status: Signed
Editor: Lonappan, Linet P, MD (Physician)

Hospital Consultants
Specialized Care for Hospitalized Patients

Attending Physician: Lonappan, Linet P, MD
Primary Care Physician: Bonema, John D, MD

Date of Admission: 10/9/2015

Chief Complaint:
Low back pain

Source of Information:
Patient and Available medical record

History of Present Illness:
This is a 55y.o. female the past medical history of hypertension, hypothyroidism, low back pain presenting with complaints of acute onset of low back pain With radiation to the left lower extremity that started yesterday while at work. She works as a RN in the preop assessment area. She had to leave work secondary to acute onset of low back pain. No trauma to the back. She tried Aleeve, norco, heat and cold to the back without any improvement in her symptoms. She has family, daughter dysfunction due to pain. The back pain was radiating to the left lower extremity, although has some numbness on both lower extremities, more on the left side. No urinary or bowel incontinence, although she felt she was unable to urinate earlier. Has urinated ×3 since this morning.
Denies any chest pain, palpitations, fever, chills, nausea, vomiting.

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History & Physical Notes (continued)

H&P by Lonappan, Linet P, MD (continued) 10/10/15 1441

Past Medical History

Diagnosis	Date
• Hypertension	
• Hypothyroidism	
• Asthma	
• Glaucoma	
• GERD (gastroesophageal reflux disease)	
• Diverticulitis	
• Dysphagia	
• Anxiety disorder	
• Postoperative nausea and vomiting	

Past Surgical History

Procedure	Laterality	Date
• Pa esophagogastic fundoplasty nissens		2005
• Discectomy, lumbar		
• Tonsilectomy		
• Cholecystectomy		2005
• Removal, cataract		
• Colectomy		
• Laminectomy		
• Arthroplasty, total knee, left		
• Arthroplasty, total knee, right		
• Hernia repair ventral		
• Other surgical history *sphincteroplasty*		
• Esophagogastroduodenoscopy (egd) *x 10*		
• Colonoscopy		
• Arthroscopy, knee		
• Dilatation and curettage, hysteroscopy, endometrial ablation		10/9/15

Family History

Problem	Relation	Age of Onset
• Cancer - Other	Father	
• MI	Mother	
• Heart Failure	Mother	

History

Social History

• Marital Status:	Single
Spouse Name:	N/A
Number of Children:	N/A

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History & Physical Notes (continued)

H&P by Lonappan, Linet P, MD (continued) 10/10/15 1441

- Years of Education: N/A

Social History Main Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol Use: No
- Drug Use: No
- Sexual Activity: Not on file

Other Topics — Concern

- Not on file

Social History Narrative

Home Medications

BEAUMONT HEALTH

ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

History & Physical Notes (continued)

H&P by Lonappan, Linet P, MD (continued) 10/10/15 1441

Reviewed by Bondy, Shannen L., RN (Registered Nurse) on 10/09/15 at 2141

Med	Sig	Taking ?	Last Dose Dt/Time
albuterol (PROVENTIL, VENTOLIN) 108 (90 BASE) MCG/ACT INHAL Aero Soln	inhale 2 Puffs into the lungs as needed.	No	
alprazolam (XANAX) 0.5 MG PO Tab	take 0.5 mg by mouth twice daily as needed.	No	
AMILORIDE HCL PO	take 20 mg by mouth once every night at bedtime.	No	
calcium citrate (CITRACAL) 950 MG PO Tab	take 950 mg by mouth once daily.	No	
escitalopram (LEXAPRO) 20 MG PO Tab	take 20 mg by mouth once every night at bedtime.	No	
hydrocodone-acetaminophen (NORCO) 5-325 MG PO Tab	take 1 Tab by mouth every 4 hours as needed for FOR PAIN.	No	
Irbesartan (AVAPRO) 150 MG PO Tab	take 150 mg by mouth once every night at bedtime.	No	
Naproxen Sodium 220 MG PO Cap	take 440 mg by mouth as needed.	No	
omeprazole (PRILOSEC) 20 MG PO CAPSULE DELAYED RELEASE	take 20 mg by mouth once every night at bedtime.	No	
potassium chloride (KLOR CON) 20 MEQ PO Pack	take 20 mEq by mouth once every night at bedtime.	No	
Thyroid (ARMOUR) 180 MG PO Tab	take 180 mg by mouth once every night at bedtime.	No	
Vitamin D, Ergocalciferol, 50000 UNIT PO Cap	take by mouth once weekly.	No	

Allergies:

Allergen	Reactions
• Latex	Anaphylaxis/Shock
• Ivp Dye [Iodinated Contrast Media]	Rash/Itching and Short of Breath/Wheezing
• Avocado	Short of Breath/Wheezing
• Banana	Short of Breath/Wheezing
• Aciphex [Rabeprazole Sodium]	Rash/Itching
• Bumex [Bumetanide]	Rash/Itching
• Celebrex [Celecoxib] *Given w/Lyrica*	Rash/Itching and Short of Breath/Wheezing
• Ciprofloxacin	Short of Breath/Wheezing

History & Physical Notes (continued)

H&P by Lonappan, Linet P, MD (continued) 10/10/15 1441

• Flovent [Fluticasone Propionate]	Short of Breath/Wheezing
• Kiwi Extract	Short of Breath/Wheezing
• Lisinopril *cough*	Other
• Lyrica [Pregabalin] *Given w/Celebrex*	Short of Breath/Wheezing
• Maxzide [Hydrochlorothiazide W-Triamterene]	Rash/Itching
• Sulfa Antibiotics	Rash/Itching
• Sulfites [Sulfites]	Rash/Itching
• Xalatan [Latanoprost] *eye itching*	Other
• Zocor [Simvastatin] *myalgia*	Other
• Chestnuts *water chestnuts*	Swelling, generalized

Review of Systems:
Please refer to HPI for positive findings. A complete ROS was performed and is otherwise negative.

Physical Examination:

Vital Signs: BP 144/57 mmHg | Pulse 79 | Temp(Src) 99 °F (37.2 °C) (Oral) | Resp 18 | Ht 172.7 cm (5' 8") | Wt 125.193 kg (276 lb) | BMI 41.98 kg/m2 | SpO2 100% | LMP 11/28/2010
General: healthy appearing 55y.o. female who appears to be in no acute distress.
Eyes: pupils reactive, ocular movements intact, no pallor or icterus.
ENT: moist mucous membranes, no nasal drainage.
Neck: Supple, no JVD, thyromegaly, or masses. No cervical or supraclavicular lymphadenopathy.
CV: regular rate and rhythm.
Lungs: clear to auscultation, no use of accessory muscles.
Abdomen: non-tender, no hepatosplenomegaly.
Extremities: no cyanosis, difficult to assess secondary to pain
Neurologic: cranial nerves intact

DATA:

WBC	Hgb	Hct	Plt
13.8 (10/09 1735)	12.9 (10/09 1735)	37.8 (10/09 1735)	362 (10/09 1735)
NA	**K**	**Cl**	**CO_2**
137 (10/09 1735)	4.0 (10/09 1735)	104 (10/09 1735)	23 (10/09 1735)
BUN	**Creat**	**Glucose**	
23 (10/09 1735)	0.83 (10/09 1735)	134 (10/09 1735)	
PT	**PTT**	**INR**	

BEAUMONT HEALTH

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Acct #: 15684102123
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History & Physical Notes (continued)

H&P by Lonappan, Linet P, MD (continued) 10/10/15 1441

MRI of the lumbar spine- multilevel mild vomiting and severe stenosis of central spinal canal And multilevel stenosis of the neural foramina, worse on the right side

IMPRESSION:

Active Hospital Problems

Diagnosis

- Principal Problem: Lumbar radiculopathy, acute- left
- Essential hypertension
- Acute low back pain
- Hypothyroidism
- Post traumatic stress disorder (PTSD)

Resolved Hospital Problems

Diagnosis

No resolved problems to display.

PLAN:

Admit.
Pain control-Toradol, dilaudid, decadron, muscle relaxants..
Consult Dr Olson, PMR and pain managment
No emergency neurosurgical intervention at this time
Resume other OP medications

DVT prophylaxis : SCDs until decision regarding ESI is made

Linet Lonappan MD
Pager 27550

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Attribution Key

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Consult Notes

Consults by Clippard, Megan O, RN NP-C 10/09/15 2237

Discharge Summary Notes (continued)

Discharge Summaries by Lonappan, Linet P, MD 10/11/15 1106

Author: Lonappan, Linet P, MD | Service: Internal Medicine | Author Type: Physician
Filed: 10/11/15 1433 | Date of Service: 10/11/15 1106 | Status: Signed
Editor: Lonappan, Linet P, MD (Physician)

Discharge Summary

Hospital Consultants
Specialized Care for Hospitalized Patients
248-691-8646

Primary Care Physician: Bonema, John D
Attending Physician: Lonappan, Linet P, MD

Date of Admission: 10/9/2015
Date of Discharge: 10/11/2015

Hospital Principal Problem:
Lumbar radiculopathy, acute

Other Hospital Problems
Active Hospital Problems
Diagnosis
- Principal Problem: Lumbar radiculopathy, acute- left
- Essential hypertension
- Acute low back pain
- Hypothyroidism
- Post traumatic stress disorder (PTSD)

Resolved Hospital Problems
Diagnosis
No resolved problems to display.

Consultants:

Provider	Role	From	To
Olson, Ricky E, MD	Consulting Physician	10/09/15 1941	10/10/15 0910
Laban, Myron M, MD	Consulting Physician	10/09/15 1941	---
Dimon, Cain E, MD	Consulting Physician	10/10/15 0950	10/11/15 0913

Studies Pending or Needing Follow Up
Outpatient follow-up with pain management clinic

BEAUMONT HEALTH

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Discharge Summary Notes (continued)

Discharge Summaries by Lonappan, Linet P, MD (continued) 10/11/15 1106

Procedures Performed:
MRI of the lumbosacral spine shows multilevel mid, moderate and severe stenosis of central spinal canal associated with multilevel stenosis of neural foramina, worse on the right side

Hospital Course:
Patient is 55y.o. female who presented to the hospital with complaints of acute onset of low back pain with radiation to bilateral lower extremities. She was admitted for lumbar radiculopathy.
She was started on IV steroids, muscle relaxants, pain control. She was evaluated by neurosurgery, pain management and PMR. Her symptoms improved. Pain management suggested outpatient follow-up for ESI. She was discharged in a stable condition for outpatient follow-up.

She was instructed not to take any NSAIDs until seen by pain management clinic

Evaluation on Day of Discharge:
BP 116/57 mmHg | Pulse 53 | Temp(Src) 97.5 °F (36.4 °C) (Oral) | Resp 18 | Ht 172.7 cm (5' 8") | Wt 125.193 kg (276 lb) | BMI 41.98 kg/m2 | SpO2 99% | LMP 11/28/2010
Gen.: Alert, awake, oriented, in no acute distress.
Chest: Breath sounds are normal bilaterally, no accessory muscle.
CVS: S1, S2, normal, regular.
Extremities: No edema, no cyosis

Time spent on evaluating, preparing and coordinating discharge: 25 minutes.

Discharge Instructions:
Follow-up Information

Follow up with Olson, Ricky E, MD in 3 weeks.
Specialty: Neurosurgery
Contact information:
4203 W 13 Mile Rd
Royal Oak MI 48073
248-288-2025

Follow up with Bonema, John D, MD. Schedule an appointment as soon as possible for a visit in 2 weeks.
Specialty: Internal Medicine
Contact information:
4600 Investment Dr #300
Troy MI 48098
248-267-5000

Follow up with Beaumont pain clinic . Call in 1 day.

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Discharge Summary Notes (continued)

Discharge Summaries by Lonappan, Linet P, MD (continued) 10/11/15 1106

Why: for ESI

Current Discharge Medication List

START taking these medications

	Refills	AM	Noon	PM	Bedtime
dexamethasone 4 MG Tabs take 1 Tab by mouth every 6 hours for 2 days. Quantity: 8 Tab Commonly known as: DECADRON,HEXADROL	Refills: 0				
diazepam 5 MG Tabs take 1 Tab by mouth every 6 hours as needed for FOR ANXIETY or FOR SEDATION. Quantity: 20 Tab Commonly known as: VALIUM	Refills: 0				
oxycoDONE-acetaminophen 10-325 MG Tabs take 1 Tab by mouth every 6 hours as needed for FOR MODERATE PAIN. Quantity: 30 Tab Commonly known as: PERCOCET Replaces: **oxycoDONE-acetaminophen 5-325 MG Tabs**	Refills: 0				

CONTINUE taking these medications

BEAUMONT HEALTH
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Discharge Summary Notes (continued)

Discharge Summaries by Lonappan, Linet P, MD (continued) 10/11/15 1106

	Refills	AM	Noon	PM	Bedtime
albuterol 108 (90 BASE) MCG/ACT Aers inhale 2 Puffs into the lungs as needed. Commonly known as: PROVENTIL, VENTOLIN	Refills: 0				
alprazolam 0.5 MG Tabs take 0.5 mg by mouth twice daily as needed. Commonly known as: XANAX	Refills: 0				
AMILORIDE HCL PO take 20 mg by mouth once every night at bedtime.	Refills: 0				
calcium citrate 950 MG Tabs take 950 mg by mouth once daily. Commonly known as: CITRACAL	Refills: 0				
escitalopram 20 MG Tabs take 20 mg by mouth once every night at bedtime. Commonly known as: LEXAPRO	Refills: 0				
Irbesartan 150 MG Tabs take 150 mg by mouth once every night at bedtime. Commonly known as: AVAPRO	Refills: 0				
omeprazole 20 MG Cpdr take 20 mg by mouth once every night at bedtime. Commonly known as: PRILOSEC	Refills: 0				
potassium chloride 20 MEQ Pack take 20 mEq by mouth once every night at bedtime.	Refills: 0				

BEAUMONT HEALTH
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Discharge Summary Notes (continued)

Discharge Summaries by Lonappan, Linet P, MD (continued) 10/11/15 1106

	Refills	AM	Noon	PM	Bedtime
Commonly known as: KLOR CON					
Thyroid 180 MG Tabs take 180 mg by mouth once every night at bedtime. Commonly known as: ARMOUR	Refills: 0				
vitamin D 50000 UNITS Caps take by mouth once weekly. Commonly known as: ERGOCALCIFEROL	Refills: 0				

STOP taking these medications

cyclobenzaprine 10 MG Tabs
Commonly known as: FLEXERIL

hydrocodone-acetaminophen 5-325 MG Tabs
Commonly known as: NORCO

Naproxen Sodium 220 MG Caps

oxycoDONE-acetaminophen 5-325 MG Tabs
Commonly known as: PERCOCET
Replaced by: **oxycoDONE-acetaminophen 10-325 MG Tabs**

Linet Lonappan MD
Pager 27550

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ED Notes

ED Nurse Notes by Slusser, Catherine Anne, RN 10/09/15 1724

Author: Slusser, Catherine Anne, RN Service: (none) Author Type: Registered Nurse
Filed: 10/09/15 1726 Date of Service: 10/09/15 1724 Status: Signed
Editor: Slusser, Catherine Anne, RN (Registered Nurse)

Consult Notes (continued)

Consults by Burlingame, Bret L, DO (continued) 10/10/15 0935

When identified, these errors have been corrected. While every attempt was made to correct errors during dictation, errors may still exist.

Attribution Key

Attribution information is not available for this note.

Consults by Sapeika, Daniel A, MD 10/11/15 0851

Author: Sapeika, Daniel A, MD | Service: Anesthesiology | Author Type: Physician
Filed: 10/11/15 0910 | Date of Service: 10/11/15 0851 | Status: Signed
Editor: Sapeika, Daniel A, MD (Physician)

Consult Orders:

1. CONSULT TO PHYSICIAN [586540822] ordered by Warner, Janay, PA-C at 10/10/15 0950

Pain Management Specialists of Southeast Michigan
An Affiliate of American Anesthesiology of Michigan

Consult Note

Attending Physician: Lonappan, Linet P, MD

Consultation Information:
Consultant: Daniel Sapeika, MD
Specialty: Anesthesia Pain Medicine
Reason for Consultation/Indicaton: lumbar radicular pain

Date of Consultation: 10/11/2015

Date of Admission: 10/9/2015

Source of Information: patient and EMR

Chief Complaint: back and leg pain

History of Present Illness:
This is a 55y.o. female who works in OR/Anesthesia pre-op presents with new back and leg pain. She has a hx of prior laminectomy 20 years ago x 2 from Dr. Olson at L4-L5 and L5-S1. The patient has been doing quite well after those surgeries and had only been on OTC NSAID (aleve) for her arthritic pains. Then this past Friday while working she had an acute episode of left greater than right low back/buttock pain with radiation to the left greater than right posterior/lateral leg to the knee on the left and to the groin on the right. Associated to this she has bilateral feet numbness. Denies any weakness. Also, reported initial inability to urinate but otherwise no bowel dysfunction or saddle anesthesia. Her pain was so severe as incapacitate her to the point

Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

where she was unable to ambulate thus prompting her to head to the ER for evaluation. At home she tried Norco and flexeril from an old supply that did not help. Her pain now is actually better and down to a 5/10. Her pain regimen includes Decadron 4 mg q 6 hours, Valium 5 mg q 8 hours (used only x1 yesterday), IVP Dilaudid 1 mg q 3 hours, Toradol 30 mg q 8 hours, and Percocet 10/325 mg q 6 hours. She has been evaluated by both neurosurgery and PMR. Currently no surgery has been offered and PT is going to evaluate her today to see if she can ambulate as she would like to go home today if possible.

Past Medical History

Diagnosis	Date
• Hypertension	
• Hypothyroidism	
• Asthma	
• Glaucoma	
• GERD (gastroesophageal reflux disease)	
• Diverticulitis	
• Dysphagia	
• Anxiety disorder	
• Postoperative nausea and vomiting	

Past Surgical History

Procedure	Laterality	Date
• Pa esophagogastic fundoplasty nissens		2005
• Discectomy, lumbar		
• Tonsilectomy		
• Cholecystectomy		2005
• Removal, cataract		
• Colectomy		
• Laminectomy		
• Arthroplasty, total knee, left		
• Arthroplasty, total knee, right		
• Hernia repair ventral		
• Other surgical history *sphincteroplasty*		
• Esophagogastroduodenoscopy (egd) *x 10*		
• Colonoscopy		
• Arthroscopy, knee		
• Dilatation and curettage, hysteroscopy, endometrial ablation		10/9/15

Family History

Problem	Relation	Age of Onset
• Cancer - Other	Father	
• MI	Mother	
• Heart Failure	Mother	

Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

History

Social History

- Marital Status: Single
  - Spouse Name: N/A
  - Number of Children: N/A
- Years of Education: N/A

Social History Main Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol Use: No
- Drug Use: No
- Sexual Activity: Not on file

Other Topics — Concern

- Not on file

Social History Narrative

Home Medications:
Home Medications

Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

Reviewed by Bondy, Shannen L., RN (Registered Nurse) on 10/09/15 at 2141

Med	Sig	Taking ?	Last Dose Dt/Time
albuterol (PROVENTIL, VENTOLIN) 108 (90 BASE) MCG/ACT INHAL Aero Soln	inhale 2 Puffs into the lungs as needed.	No	
alprazolam (XANAX) 0.5 MG PO Tab	take 0.5 mg by mouth twice daily as needed.	No	
AMILORIDE HCL PO	take 20 mg by mouth once every night at bedtime.	No	
calcium citrate (CITRACAL) 950 MG PO Tab	take 950 mg by mouth once daily.	No	
escitalopram (LEXAPRO) 20 MG PO Tab	take 20 mg by mouth once every night at bedtime.	No	
hydrocodone-acetaminophen (NORCO) 5-325 MG PO Tab	take 1 Tab by mouth every 4 hours as needed for FOR PAIN.	No	
Irbesartan (AVAPRO) 150 MG PO Tab	take 150 mg by mouth once every night at bedtime.	No	
Naproxen Sodium 220 MG PO Cap	take 440 mg by mouth as needed.	No	
omeprazole (PRILOSEC) 20 MG PO CAPSULE DELAYED RELEASE	take 20 mg by mouth once every night at bedtime.	No	
potassium chloride (KLOR CON) 20 MEQ PO Pack	take 20 mEq by mouth once every night at bedtime.	No	
Thyroid (ARMOUR) 180 MG PO Tab	take 180 mg by mouth once every night at bedtime.	No	
Vitamin D, Ergocalciferol, 50000 UNIT PO Cap	take by mouth once weekly.	No	

Inpatient Medications: Current facility-administered medications: acetaminophen (TYLENOL) tablet 650 mg, 650 mg, Oral, Q 6 H PRN, Warner, Janay, PA-C; sodium chloride 0.9 % flush injection 3 mL, 3 mL, Intravenous, Q 8 H, Warner, Janay, PA-C, 3 mL at 10/10/15 2236; oxycoDONE-acetaminophen (PERCOCET) 10-325 MG tablet 1 Tab, 1 Tab, Oral, Q 6 H PRN, Warner, Janay, PA-C, 1 Tab at 10/11/15 0358
ketorolac (TORADOL) injection 30 mg, 30 mg, Intravenous, Q 8 H PRN, Lonappan, Linet P, MD, 30 mg at 10/11/15 0157; influenza virus vaccine (FLUZONE, FLUARIX) injection 0.5 mL, 0.5 mL, Intramuscular, Prior to discharge, Lonappan, Linet P, MD; pneumococcal vaccine (PNEUMOVAX 23) injection 0.5 mL, 0.5 mL, Intramuscular, Prior to discharge, Lonappan, Linet P, MD
HYDROmorphONE injection 1 mg, 1 mg, Intravenous, Q 3 H PRN, Joseph, Amy E, PA-C, 1 mg at 10/11/15 0046; diazepam (VALIUM) tablet 5 mg, 5 mg, Oral, Q 8 H PRN, Joseph, Amy E, PA-C, 5 mg at 10/10/15 1342; amiloRIDe (MIDAMORE) tablet 20 mg, 20 mg, Oral, Q HS, Joseph, Amy E, PA-C, 20 mg at 10/10/15 2235; losartan (COZAAR) tablet 50 mg, 50 mg, Oral, DAILY, Joseph, Amy E, PA-C, 50 mg at 10/10/15 0730

BEAUMONT HEALTH

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Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

escitalopram (LEXAPRO) tablet 20 mg, 20 mg, Oral, Q HS, Joseph, Amy E, PA-C, 20 mg at 10/10/15 2146; thyroid (ARMOUR THYROID) tablet 180 mg, 180 mg, Oral, Q HS, Joseph, Amy E, PA-C, 180 mg at 10/10/15 2235; dexamethasone (DECADRON) injection 4 mg, 4 mg, Intravenous, Q 6 H, Clippard, Megan O, RN NP-C, 4 mg at 10/11/15 0357; omeprazole (PRILOSEC) DR capsule 20 mg, 20 mg, Oral, AC DINNER, Clippard, Megan O, RN NP-C, 20 mg at 10/10/15 1658
PATIENT SPECIFIC MEDICATIONS 1 Each, 1 Each, Does not apply, Per Administration Instructions, Laban, Myron M, MD

Allergies:

Allergen	Reactions
• Latex	Anaphylaxis/Shock
• Ivp Dye [Iodinated Contrast Media]	Rash/Itching and Short of Breath/Wheezing
• Avocado	Short of Breath/Wheezing
• Banana	Short of Breath/Wheezing
• Aciphex [Rabeprazole Sodium]	Rash/Itching
• Bumex [Bumetanide]	Rash/Itching
• Celebrex [Celecoxib] *Given w/Lyrica*	Rash/Itching and Short of Breath/Wheezing
• Ciprofloxacin	Short of Breath/Wheezing
• Flovent [Fluticasone Propionate]	Short of Breath/Wheezing
• Kiwi Extract	Short of Breath/Wheezing
• Lisinopril *cough*	Other
• Lyrica [Pregabalin] *Given w/Celebrex*	Short of Breath/Wheezing
• Maxzide [Hydrochlorothiazide W-Triamterene]	Rash/Itching
• Sulfa Antibiotics	Rash/Itching
• Sulfites [Sulfites]	Rash/Itching
• Xalatan [Latanoprost] *eye itching*	Other
• Zocor [Simvastatin] *myalgia*	Other
• Chestnuts *water chestnuts*	Swelling, generalized

I personally reviewed the patient's history as listed above from the electronic medical record on 10/11/2015.

Review of Systems:
Constitutional: Denies fevers, generalized weakness, fatigue
Neuro: Denies headaches, dizziness, numbness
HEENT: Denies tinnitus, decreased hearing, or difficulty swallowing
Cardiac: Denies chest pains, palpitations

Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

Pulmonary: Denies cough, shortness of breath
Gastrointestinal: Denies abdominal pains, nausea/vomiting, diarrhea/constipation
Genitourinary: Denies urinary incontinence
Hematologic/Lymphatic: Denies excessive bruising or bleeding
Musculoskeletal: Denies back pain, joint pain, swelling in the joints, or arthritis
Skin: Denies any skin infections
Psych: Denies feeling depressed, anxious, or memory loss

Review of Systems negative except for the following: feet numbness, back pain, leg pain

Physical Examination:
Vital Signs: BP 116/57 mmHg | Pulse 53 | Temp(Src) 97.5 °F (36.4 °C) (Oral) | Resp 18 | Ht 172.7 cm (5' 8") | Wt 125.193 kg (276 lb) | BMI 41.98 kg/m2 | SpO2 99% | LMP 11/28/2010

- **General:** Well developed, well nourished; in no acute distress, lying in bed with lights off
- **Head:** Normochepalic, Atraumatic
- **Eyes:** No scleral icterus; pupils are round; equal in size, extraocular eye movements are intact
- **ENT:** Ears and nose are grossly normal upon inspection
- **Neck:** Supple; non-tender
- **Lungs:** unlabored breathing
- **Extremities:** No lower extremity edema appreciated.
- **Skin:** Warm, dry, no sores, rashes, lesions noted
- **Musculoskeletal:** Full range of motion of the upper/lower limbs; Strength is 5/5 in the bilateral upper and lower extremities.
  1. negative SLR bilaterally
- **Neurologic:** Cranial Nerves II-XII are grossly intact; sensation intact x lower extremities
- **Psychologic:** Patient's affect and mood are congruent with situation

Recent selective lab results (may not include all current labs):

WBC	Hgb	Hct	Plt
NA	K	Cl	CO_2
BUN	Creat	Glucose	
PT	PTT	INR	

Diagnostic Studies:
MRI of the lumbosacral spine without contrast October 9, 2015.
Indication:

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Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

Low back pain with radicular symptoms.
Based located on the left side of the lower back. There is left-sided sciatica.
The examination consisted of sagittal and axial T1-weighted and turbo spin-echo T2-weighted images and sagittal STIR images of the entire lumbosacral spine.
Findings:
The vertebral heights are well-preserved.
Moderate degenerative disc disease noted at T12-L1 with evidence of paracentral small disc extrusion extending slightly to the left. The neural foramina are preserved.
Mild degenerative disc disease at the L1-L2 associated with mild degenerative change of the facet joints.
Mild degenerative disc disease at L2-L3 level associated with moderate degenerative change of the facets with hypertrophy of ligamenta flava leading to mild central canal stenosis. The neural foramina are preserved.
Moderate degenerative disc disease at L3-L4 level associated with severe degenerative changes of the facets, hypertrophy of ligamenta flava, and severe central canal stenosis. There is severe stenosis of L3-L4 neural foramen on the right side and mild stenosis on the left.
Severe degenerative disc disease at L4-L5 associated with discogenic vertebral changes Modic type II. There is disc extrusion at this level and moderate stenosis of the central canal. There is evidence of laminectomy of L4 on the left. There is moderate stenosis of the L4-L5 neural foramen on the right.
Degenerative disc disease at L5-S1 level with central disc extrusion associated with severe degenerative changes of the facets and hypertrophy of ligamenta flava leading to severe central spinal canal stenosis. There is evidence of L5 laminectomy on the right. There is severe stenosis of bilateral neural foramina. There are discogenic vertebral changes Modic type II at this level as well.
The spinal cord and conus medullaris appear normal.
Conclusion:
Multilevel mild, moderate and severe stenosis of central spinal canal associated with multilevel stenosis of neural foramina, worse on the right side.
There is evidence of laminectomy of L4 on the left and L5 on the right.
Discogenic vertebral changes Modic type II at L4-L5 and L5-S1 levels.
Disc extrusions and disc protrusions noted at multiple levels.
Please see detailed discussion above

Final

BEAUMONT HEALTH

ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

Consult Notes (continued)

Consults by Sapeika, Daniel A, MD (continued) 10/11/15 0851

Assessment:
Acute lumbar radicular pain
Hx of Laminectomy 20 yrs ago x 2 by Dr. Olson at L4-L5 and L5-S1

Recommendations:
Agree with PT evaluation
Agree with Decadron
Can continue current regimen of PRN Valium, Percocet, and IV Dilaudid
Stop Toradol IV (last dose last night) prior to procedure
Recommend Lumbar epidural vs Caudal epidural tomorrow either at BHC pain clinic if discharged today or PM on 10/12/15 inpatient if still in hospital (We will follow up with her to coordinate)

Thank you for allowing us to assist in the care of your patient.

Daniel Sapeika, MD

On Call Pain Pager at Royal Oak - 52009
On Call Pain Pager at Troy - 52010

Attribution Key
Attribution information is not available for this note.

Progress Notes

Progress Notes by Keiser, Megan, RN NP-C 10/10/15 0906

Author: Keiser, Megan, RN NP-C
Filed: 10/10/15 0909
Editor: Keiser, Megan, RN NP-C (Nurse Practitioner)
Service: Neurosurgery
Date of Service: 10/10/15 0906
Author Type: Nurse Practitioner
Status: Signed
Cosigner: Olson, Ricky E, MD at 10/12/15 0923

Neurosurgery Rounding Note:

Please see full consult in Epic. Patient was seen and examined on rounds with Dr. Olson and he reviewed her MRI. No urgent neurosurgical intervention warranted at this time. Recommend starting patient on Robaxin and request anesthesia pain service consult for possible ESI. She can be discharged home and should remain on bedrest for 5-7 fays. After that time, she should start a course of physical therapy. F/u in

Markel, Mary Anne (MR # 1568410)

Red 1

Results History

CULTURE, URINE (Order 586562411)

Entry Information

Entry Date and Time	Lab Status	Entered by
10/12/2015 8:38 PM	Final result	Interface, Lab

Component Results

Component

Flag Status (Abnormal)

This report has been flagged as abnormal

Specimen Source

Urine

Culture, Urine

Culture, Urine

Streptococcus agalactiae (Group B)
>100,000 CFU/ml

Culture & Susceptibility

STREPTOCOCCUS AGALACTIAE (GROUP B)

Antibiotic	Sensitivity	MIC	Unit	Status
Ampicillin	Susceptible	0.12	mcg/mL	Final
Ceftriaxone	Susceptible	<=0.25	mcg/mL	Final
Penicillin	Susceptible	0.06	mcg/mL	Final
Tetracycline	Resistant	>4	mcg/mL	Final
Vancomycin	Susceptible	0.5	mcg/mL	Final

Entry Information

Entry Date and Time	Lab Status	Entered by
10/11/2015 5:47 PM	Preliminary result	Interface, Lab

Component Results

Component

Flag Status (Abnormal)

This report has been flagged as abnormal

Specimen Source

Urine

Culture, Urine

Culture, Urine

Streptococcus agalactiae (Group B)
>100,000 CFU/ml
-susceptibility to follow

Entry Information

Entry Date and Time	Lab Status	Entered by
10/10/2015 11:12 PM	In process	Interface, Lab

Entry Information

Entry Date and Time	Lab Status	Entered by
10/10/2015 9:10 PM	In process	Interface, Lab

BEAUMONT HEALTH
ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

Lab Results (continued)

Resulted: 10/09/15 2323, Result status: Final result

URINALYSIS [586475056] (Abnormal) (continued)

Comment	Oxalate see below	—	—

Comment: Microscopic manually verified.

Additional Resulting Lab Information
Received: 201510092254

Resulted: 10/10/15 2201, Result status: Final result

URINALYSIS [586562410] (Abnormal)

Ordering provider: Warner, Janay, PA-C 10/10/15 1349 Resulting lab: LABORATORY INFORMATION SYSTEM

Dt/Tm Coll

Type	Source	Collected By
—	—	9BROY 10/10/15 2109

Components

Component	Value	Reference Range	Flag
Color	DkYellow	—	—
Clarity	Clear	—	—
Glucose	Negative	Negative	—
Bilirubin	Negative	Negative	—
Ketones	Trace	Negative	A
Specific Gravity, Urine	1.030	1.005 - 1.030	—
Blood	Trace	Negative	A
pH	6.0	5.0 - 8.0	—
Protein	Trace	Negative	A
Urobilinogen	1.0	0.2 - 1.0	—
Nitrites	Negative	Negative	—
Leukocyte Esterase	2+	Negative	A
RBC	5	0 - 3 /hpf	H
WBC	>100	0 - 5 /hpf	H
Epithelial, Squamous	21	/lpf	—
Casts, Hyaline	18	0 - 2 /lpf	H
Bacteria	Negative	Negative /hpf	—

Additional Resulting Lab Information
Received: 201510102142

Resulted: 10/12/15 2038, Result status: Final result

CULTURE, URINE [586562411] (Abnormal)

Ordering provider: Warner, Janay, PA-C 10/10/15 1349 Resulting lab: LABORATORY INFORMATION SYSTEM

Dt/Tm Coll

Type	Source	Collected By
—	Urine	9BROY 10/10/15 2110

Components

Component	Value	Reference Range	Flag
Flag Status	This report has been flagged as abnormal	—	A

BEAUMONT HEALTH

ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

Markel, Mary Anne
MRN: 1568410, DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015, Dsc: 10/11/2015

Lab Results (continued)

CULTURE, URINE [586562411] (Abnormal) (continued) — Resulted: 10/12/15 2038, Result status: Final result

Specimen Source	Urine	—	—
Culture, Urine	--	—	—
Culture, Urine	--	—	—

Result:
Streptococcus agalactiae (Group B)
>100,000 CFU/ml

Additional Resulting Lab Information
Received: 201510102312

IMG Results

LUMBOSACRAL SPINE MINIMUM 4 VIEWS [586475832] — Resulted: 10/09/15 1812, Result status: Final result

Ordering provider: Joseph, Amy E, PA-C 10/09/15 1739 — Resulted by: Donovan, Kent R, MD
Performed: 10/09/15 1809 - 10/09/15 1809 — Resulting lab: MISYS
Performing Department: RAD GEN EC RO
Diagnosis: Left-sided low back pain with left-sided sciatica [M54.42 (ICD-10-CM)]
Narrative:

Lumbar spine

Indication: Back pain

5 images were obtained. There is moderate disc narrowing at L4-5 and L5-S1 with endplate sclerosis and marginal spurring. There is no compression deformity; there is facet arthropathy bilaterally at L4-5 and L5-S1 without spondylitic defects. There is osteopenia. There is a 2 mm anterolisthesis of 3 upon L4.

Accession #

ID	Type	Source	Collected By
A17143204	—	—	10/09/15 1810

CT ABDOMEN/PELVIS NO CONTRAST KIDNEY STONE PROTOCOL [586475661] — Resulted: 10/09/15 1823, Result status: Final result

Ordering provider: Joseph, Amy E, PA-C 10/09/15 1737 — Resulted by: Donovan, Kent R, MD
Performed: 10/09/15 1810 - 10/09/15 1817 — Resulting lab: MISYS
Performing Department: RAD CT EC RO
Diagnosis: Left-sided low back pain with left-sided sciatica [M54.42 (ICD-10-CM)]
Narrative:

CT abdomen pelvis without contrast

Indication: Low back pain

Comparison: 8/17/2015

EXHIBIT B

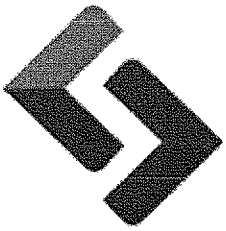
In the Matter Of:

MARKEL vs WILLIAM BEAUMONT HOSPITAL, ET AL.

JANAY A. WARNER, PA-C

February 26, 2019

Prepared for you by



U.S. Legal Support

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they mean to you as a physician assistant?
MR. WARWICK: Same, form and foundation, relevance.
MR. SINKOFF: Join.
THE WITNESS: So it means that they grew out strep B, which is a common bacteria that colonizes the perineal area for a woman. So, yeah, that -- it looks like it grew out Group B, which is a common bacteria in that area.

BY MS. ALI:

Q. Okay. And with the benefit, of course, of hindsight and looking at the results in front of you right now for the urine culture, do you believe the patient was infected?
MR. SINKOFF: Object to the foundation.
MR. WARWICK: Foundation, form. You shouldn't speculate about anything.
THE WITNESS: Yeah, I can't spec- -- I mean, in my notes, I didn't document any dysuria or frequency or any urinary symptoms in my note for the patient, so it looked like she wasn't having any symptoms --
MS. ALI: Okay.
THE WITNESS: -- from my note. I don't remember, but, yeah, I didn't document anything.

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BY MS. ALI:

Q. The urine cultures don't indicate to you that the -- that on October 10, 2015, Ms. Markel had an infection?
MR. SINKOFF: Asked and answered --
MR. WARWICK: Same --
MR. SINKOFF: -- foundation.
MR. WARWICK: -- asked and answered, foundation, form.
MR. SINKOFF: Assuming you make a diagnosis based on a lab test.
THE WITNESS: Yeah, I can't make a diagnosis based on the lab test without have -- having the patient's symptoms.

BY MS. ALI:

Q. Okay. And in the presence of -- strike that.
MS. ALI: I have no further questions.
MR. SINKOFF: I have no questions.

EXAMINATION

BY MR. WARWICK:

Q. Physician Assistant Warner, I have just a few questions for you. If you don't understand a question, don't hesitate to mention that, and I will certainly repeat it or rephrase it, okay?

A. Okay.

Q. If you could go to Exhibit 1, please. And plaintiff's

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counsel asked you about this exhibit earlier. It references your identity, third from the bottom of that page; is that correct?

A. Correct.

Q. And what does the 10/10/2015, at 6:38 a.m., mean to you?

A. That is likely when I accessed her chart for the first time, when I was reviewing her chart prior to our observation rounds.

Q. Okay. So on that date, October 10, 2015, your shift in the observation unit would have started at 6:00 a.m.; is that right?

A. Correct.

Q. And then this 6:38 a.m. is when you likely looked at her chart in the system; is that right?

A. Correct.

Q. Okay. And then you would have rounded with Dr. Berger --

A. Mmm-hmm.

Q. -- is that right?

A. Correct. Dr. David Berger.

Q. Okay. And the patient would have been seen with you and Dr. Berger; is that right?

A. Correct. Yep.

Q. And -- and the previous charting, et cetera, would

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have been reviewed --

A. Correct.

Q. -- is that right?
Okay. And then neurosurgery and physical medicine and rehabilitation consultants came in; is that right?

A. Correct.

Q. And Exhibit 3 references your report as it relates to the patient's condition in the observation unit on October 10, 2015; is that right?

A. Correct.

Q. And a white blood count of 13.8, would it be fair to say that was mildly elevated?

A. Correct.

Q. And UA awaiting repeat, there was a question by plaintiff's counsel about waiting -- awaiting results. You were actually awaiting having the urinalysis collected again; is that right?

A. Correct. It looks like, yep, it had not been done; so --

Q. Okay.

A. -- awaiting repeat.

Q. And the previous urinalysis that you testified to was contaminated; likely, that was based upon what from the results?

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A. That was the elevated number of squamous cells.
Q. Okay. And do we all have squamous cells on our skin?
A. Yes.
Q. And when you talked about not getting a clean catch or not wiping appropriately beforehand, if -- if that were to happen, that could result in having squamous cells in the -- as evidenced in the results; is that right?
A. Easily, yeah.
Q. Okay. So then you wanted another urine sample to be done for urinalysis and urine culture; is that right?
A. I would assume that's what I was, yep --
Q. Okay.
A. -- was doing by ordering a repeat.
Q. And then what time of the day did you end your work as it related to reporting with Ms. Markel? I believe that's Exhibit 1 again.
A. Yeah. I mean, it looks like the -- yeah, the last order I would have placed was that urine at 13:49, but then it shows that I was last in her chart maybe at 2:04 p.m., was the last --
Q. Okay.
A. -- review I did.
Q. And 13:49 would be what time of the day?
A. 1:49 --

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Q. Okay. So --
A. -- p.m.
Q. So if 1:39 -- I'm sorry. Strike that.
If 1:30 -- strike that.
If 1:49 p.m. was the time frame of the order for the second urine study with urine cultural, and then your charting says you were last in her records at 2:04 p.m., that would all be consistent; is that right?
A. Correct.
Q. Okay. And, in fact, it's now Exhibit 6, page 63 in the bottom, lower, left-hand corner, that's your order for the urine culture; is that right?
A. Correct.
Q. And it says, "Ordering provider Janay Warner, PA-C, 10/10/15, at 13:49"; is that right?
A. Correct.
Q. So that would be 1:49 --
A. 1:49 --
Q. -- p.m.?
A. -- p.m.
Q. And it says, the next line down, "Collect By 9BROY 10/10/15, at 21:10"; is that right?
A. Mmm-hmm. Correct.
Q. So --

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A. 9:10.
Q. Okay. So that would be well after you were last involved in Ms. Markel's care; is that right?
A. Correct.
Q. And the patient would have already been on the floor at that point; is that right?
A. Yes.
Q. And you don't see patients on the floor; is that right?
A. Correct, I do not see patients on the floor.
Q. And you wouldn't have back at this time frame, either; is that correct?
A. Correct.
Q. And then the results came in on 10/12/15, at 20:38; do you see that?
A. Yes.
Q. Okay. Those results wouldn't have gone back to you, either, would they?
A. No.
Q. Okay. Your role in this case would have finished when you last saw Ms. Markel on October 10, 2015, in the observation unit; is that fair?
A. Yes, that's fair.
Q. Okay. And then from the records, Ms. Markel's primary care physician was a Dr. John Bonema, B-o-n-e-m-a, and

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he's with Troy Internal Medicine. Did you see that from the records?
A. Yes.
Q. Okay. And then in your report, it references, in Exhibit 3, that -- I thought it was Exhibit 3 -- that -- yes. In treatment plan, page 20, admit in stable condition to Haas, H-a-a-s, forward slash, Wease, W-e-a-s-e, Dr. Lonappan.
Is there -- is there something you enter into the system to determine if a primary care physician has certain hospitalists that they have patients see on their behalf in the hospital?
A. Yes. So there is -- when you go to admit a patient, each patient has a PPG, which is a physician preference guide; so it tells you who their primary doctor admits to, so it tells you who to call.
Q. Okay. Is that, then, likely how you obtain that information?
A. Correct. So then we would ask our secretary to page whatever hospitalist service that that physician is requesting or uses.
Q. Okay. That that primary care physician is utilizing as --
A. Yes.
Q. -- a hospitalist?

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A. So Dr. Bonema, yeah, his reference guide would have specified that he uses Hospital Consultants or Haas/Wease.

Q. Okay. And then after your involvement in the case, if the patient was seen by Dr. Lonappan or seen by other medical personnel, nurses, et cetera, you would obviously defer to them in terms of their role in the case and -- and their testimony, et cetera, correct?

A. After -- I don't understand. Like after she was admitted?

Q. Right. When you were no longer involved, if Dr. Lonappan was involved -- you've seen she's testified; right?

A. Yes.

Q. Okay. So Dr. Lona- -- Lon- -- Dr. Lonappan can testify on her own behalf; anyone else who's a caregiver after you're involved, they can testify on their own behalf, correct?

A. Correct.

Q. Okay. And your role, as we say, ended at that time, in the early afternoon, before the urine sample was even collected; is that correct?

A. Correct.

MR. WARWICK: Okay. Those are all the questions I have.

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MS. ALI: I don't have any follow-up questions.

MR. SINKOFF: We're done.

VIDEO TECHNICIAN: This concludes the videotaped deposition. We're now going off the record at 1:44 p.m. We're off the record.

(The videotaped deposition was concluded at 1:44 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 OTTAWA)

I, PEGGY S. SAVAGE, certify that this videotaped 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.

Peggy S Savage

PEGGY S. SAVAGE, CSR-4189, RPR
Notary Public,
Ottawa County, Michigan.
My Commission expires: 7-13-19

EXHIBIT C

In the Matter Of:

MARKEL vs WILLIAM BEAUMONT HOSPITAL, ET AL.

LINET LONAPPAN, M.D.

December 04, 2018

Prepared for you by

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notice of intent.

MR. WARWICK: Same objection.

BY MR. TAKALA:

Q. Go ahead. What's your understanding as to the claims that have been brought against you?

A. So let me clarify the question. So you are trying to understand what I understood from the claim, is that the question or --

Q. Yes, ma'am.

A. Okay. So you're trying -- my understanding is you are saying on the complaint that I did not do certain things that might have affected the patient's outcome, is basically what I'm understanding from the --

Q. Okay. And after reviewing those general allegations, do you believe you did everything that you were required to do as an internal medicine physician when treating Ms. Markel?

MR. SINKOFF: Object to the form.

A. Yes.

BY MR. TAKALA:

Q. Okay. And some of those things that the complaint and the notice of intent allege that you did wrong was failing to provide antibiotics, correct?

A. Yes.

Q. Did you provide any antibiotics to Ms. Markel?

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A. No.

Q. Okay. Were you required to provide any antibiotics to Ms. Markel pursuant to your standard of care?

MR. SINKOFF: Go ahead. You can answer.

A. No.

BY MR. TAKALA:

Q. And we'll get into the nitty gritty a little bit later, but, I'm sorry, I just can't help myself. There's also an allegation that you failed to contact Ms. Markel after some results of a urine culture came back positive. Do you remember reading that?

A. Yes.

Q. All right. Did you ever contact Ms. Markel regarding results of that urine culture?

A. No.

Q. Do you know whether you ever received a copy of the results of that urine culture?

A. Yes.

Q. Okay. When did you receive a copy of the results to that urine culture?

A. On October 12th, sometime during the day.

Q. And where would you have received it?

A. On the Epic chart.

Q. So when you log into the Epic chart, just explain to me how that works. Is there a result that pops up for each patient that you're assigned to?

A. No. So when you -- when I open the EMR, the Epic chart, there's a list of patients that are my current patient list. And then when you go into each patient's chart, there is a section for results that you have to open and then that will show up -- the results of the patient. For discharged patients, you have to look into their chart to get the results of the -- the outstanding -- outstanding results.

Q. Okay. So on October 12th Ms. Markel was a discharged patient, correct?

A. Correct.

Q. And you would have had access to click on her chart to get the results of that urine culture?

A. That's correct.

Q. And you would have had access to her phone number, correct?

A. Yes.

Q. And you would have had access to an emergency contact phone number, correct?

A. Yes.

Q. But you never contacted Ms. Markel with those positive urine culture results, did you?

A. No.

Q. Do you believe your standard of care required you to

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contact Ms. Markel with those positive urine culture results on October 12th when you saw them in the Epic computer?

A. No. Only if I'm planning to do all antibiotics or any kind of intervention with those results, I need to contact the patient.

Q. Okay. Fair enough. So I understand what you're saying, but let me get it out on paper, okay?

Did your standard of care -- and I'll take a yes or no answer and then I'll let you explain. Did your standard of care require you to contact Ms. Markel when you saw the positive urine culture results in the Epic system on October 12th, 2015?

A. No.

Q. Okay. And why is it that you did not contact Ms. Markel with those results?

A. Because it was not relevant to her care at that point.

Q. Okay. So you're saying that even in the face of a positive urine culture, she's not a patient that's indicated for antibiotic coverage?

A. Correct.

Q. And you hold that opinion to a reasonable degree of medical certainty?

A. Yes.

Q. Okay. And sorry I didn't ask you this and Steve

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Q. Okay. Any other understanding as to why you didn't pick Ms. Markel back up?
A. I believe I was working at Troy Beaumont for that next schedule.
Q. Fair enough. There would probably be some sort of log or time sheet --
A. Yeah.
Q. -- we could go back to?
A. Yes.
Q. Okay. Do you have any sort of written policies regarding your employment and employment practices with Hospital Consultants, P.C., like you have to work X amount of days per week or X amount of hours per month?
MR. SINKOFF: Object to foundation.
BY MR. TAKALA:
Q. Anything like that? I'm just using that by example.
A. I do not know specifically.
Q. Okay. How about the same question with regard to Beaumont?
A. No.
Q. Okay. If you just bear with me for just a few minutes, I'll check my notes and make sure I have everything marked that I wanted to mark.
A. Okay.

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MR. TAKALA: I will, if you don't mind, unless Steve has an objection, mark these records? If you have an objection, Steve, I won't, but --
MR. SINKOFF: You can mark them, but they're going to stay in her possession.
MR. TAKALA: That's fine with me.
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 9
4:15 p.m.
MR. TAKALA: I'll mark this as Plaintiff's Exhibit 9.
BY MR. TAKALA:
Q. Do you have any social relationships with any of the other physicians involved in Ms. Markel's care, names that you would have seen in the records?
A. No.
Q. Okay. I'm sure you know a lot of these physicians professionally and you've worked with them?
A. Yes.
Q. But you haven't spoken with any of them about Ms. Markel or her care?
A. No.
Q. Okay. You haven't spoken -- and obviously since --
A. Right, right, no.
Q. -- the notice of intent --

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A. No.
Q. Just because I suppose it's my last chance to ask you, anything else that has come to your memory about this October 2015 time period as it pertains to Ms. Markel?
MR. SINKOFF: Object to the foundation and --
A. No.
MR. SINKOFF: -- form of the question. There may be many things that she testifies to depending on the questions that are asked.
A. No.
BY MR. TAKALA:
Q. Okay. As you sit here today and the way I'm asking the question, is there anything that you remember independently about Ms. Markel's care that isn't documented somewhere in your records? And I'll -- subject to Steve's objection, of course.
A. No.
MR. TAKALA: All right. I don't have any further questions for you, Dr. Lonappan, and I do thank you sincerely for your patience and your time.
THE WITNESS: Thank you.

EXAMINATION

BY MR. WARWICK:
Q. Dr. Lonappan, I have just a few questions for you. If

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at any time you don't understand it, don't hesitate to mention that and I'll certainly repeat it or rephrase it, okay?
A. Okay.
Q. Back in October 2015 you were employed by Hospital Consultants, P.C.; is that correct?
A. Yes.
Q. And you've already testified that you were employed by them beginning in 2011; is that right?
A. Yes.
Q. You were not employed by William Beaumont Hospital; is that correct?
A. Yes.
Q. And from your previous testimony, it's my understanding that you would have been scheduled by Hospital Consultants, P.C. through a Dr. Jason Batke; is that correct?
A. Yes.
Q. And the reason you were at William Beaumont Hospital October 10 and October 11th of 2015 was because you had been scheduled by your employer, Hospital Consultants, P.C., to work at the hospital on those days; is that correct?
A. Yes.
Q. And from your testimony previously, it's your

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understanding that if patients come in from Troy Internal Medicine, and specifically in this case Dr. John Bonema, who is an internal medicine physician at Troy Internal Medicine, then -- and if the patients are admitted, then your group of physicians from Hospital Consultants, P.C. would see the patients in the hospital; is that right?

A. If the ER physician calls our group for admission, then we'll see the patient.

Q. Okay. So in this case, Ms. Markel was admitted to hospital and this was Dr. Bonema's patient, as her primary care physician. So then it makes sense that that's why your group is contacted and that you became involved in her care, fair?

A. That's correct.

Q. Okay. And she's not a named defendant, but she was referenced in the notice of intent, her name is Janay, J-A-N-A-Y, Warner, W-A-R-N-E-R. She's a physician assistant and she saw Ms. Markel in the observation department at William Beaumont Hospital.

You didn't provide treatment to patients in the observation unit, did you?

A. No, not in the ER observation unit, no.

Q. Right. And you don't know Janay Warner, P.A. personally at all, do you?

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A. No.

Q. Okay. And from the records, it looks like a urinalysis was first done on October 9th, 2015 at 2249 and you've already testified about those results. Do you remember that?

A. Yes.

Q. Okay. Then P.A. Warner became involved in the patient's care, I want you to assume, when Ms. Markel was in the observation unit and she ordered a repeat urinalysis and a urine culture and those were ordered on October 10th, 2015 at 1349.

You became involved, it's my understanding, in Ms. Markel's care on the floor October 10th, 2015, at least your note is signed -- your history and physical at 1441; is that right?

A. Signed at -- yes, note is signed at 1441.

Q. Okay. So P.A. Warner would have ordered the repeat urinalysis and the urine culture in the observation unit, then the patient was transferred to the floor, according to the records, on October 10th, 2015 at 1426?

A. Okay.

Q. That's pages 2451 and 2452 of my set of records. And then shortly thereafter you would have seen the patient on the floor and then entered your report at 1441; is that correct?

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A. Yes.

Q. Okay. Then from page 2456 of my set of records, the urine sample and urine culture were then collected on October 10, 2015 at 2109 and 2110; is that correct?

A. Yes.

Q. Okay. So when you first saw Ms. Markel on the floor, you would have known that these urinalysis and urine culture had been ordered, but not done yet; is that right?

A. Yes.

Q. Okay. And then it looks like the results came back from those studies on October 10, 2015 at about 2201; is that right?

A. Yes.

Q. Okay.

A. From the urinalysis.

MR. SINKOFF: Not the culture.

BY MR. WARWICK:

Q. From the urinalysis. And the urine culture was -- we know did not come back until October the 12th; is that right?

A. Yeah, final results.

Q. Okay. Let me make sure my question is a little clearer. The urinalysis result was resulted from page 2456 on October 10, 2015 at 2201; is that right?

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A. Urinalysis results were resulted, yep.

Q. Okay. And then the urine culture result was resulted on October 12th, 2015 at 2038; is that right?

A. Yes.

Q. Okay. And then Dr. Mihai Muraru, is it your understanding he was a physician who was also employed by Hospital Consultants, P.C. back in October of 2015?

A. Yes.

Q. And if he was called by a nurse on October 11, 2015 at approximately 0413, would that likely have been because he was the on-call physician for Hospital Consultants, P.C. at that time?

A. Yes.

Q. Okay. But you didn't have any direct communication with the patient or the nurses or anyone of that nature October 11th, 2015 at 0413, correct?

A. Correct.

Q. Okay. And this whole process of urinalysis results and urine culture results, where you as the hospitalist are aware of tests being ordered, sometimes it takes a period of time until after the patient is discharged for the final results to come back, obtaining the results and then looking and determining whether or not those results are relevant

or followup is necessary, everything in this case happened as it would normally happen with your practice, right, you received results and then looked at that issue and made determinations; is that fair?

A. Yes.

MR. WARWICK: Okay. I appreciate your time, thanks a lot.

THE WITNESS: Thank you.

RE-EXAMINATION

BY MR. TAKALA:

Q. I have just a couple quick followups.

When you made contact with Ms. Markel, you didn't tell her that you were seeing her because of her relationship or Dr. Bonema's relationship with Troy Internal Medicine, would you?

A. I would, that's my usual practice. When I say I'm Dr. Lonappan and then I would say I'm seeing you for your family doctor, I'm a hospitalist associated for Dr. Bonema.

Q. Okay. So that's not what you told me earlier?

A. You -- no, that's -- I said I would introduce myself as Dr. Lonappan, that's what you asked.

Q. Okay. And then I thought I asked would you say, you know, Beaumont Hospital or Hospital Consultants, P.C. and you said no and no?

A. Yeah, I said I usually don't bring up Hospital Consultants, P.C. because it doesn't matter to the patient. I do bring up that I'm seeing them for their family doctor.

Q. Okay. And do you tell them who you're employed by?

A. No.

Q. Okay. Do you tell them that you're employed by Troy Internal Medicine, for example?

A. No.

Q. You don't tell them you're employed by Beaumont, right?

A. No.

Q. You don't tell them you're employed by Hospital Consultants, P.C.?

A. No.

Q. Okay. But you do tell them that you're seeing them in place of their PCP?

A. Correct.

Q. And would you mention Dr. Bonema by name?

A. Yes.

Q. Okay. Sorry to get into a couple of other tangential issues. I didn't ask you about the CBC or the complete blood count that was done on October 9th, 2015?

A. Okay.

Q. I'll just show you. Are there any abnormal results from the CBC?

A. WBC is abnormal, it's 13.8. And then neutrophils, 8.7.

Q. That's it?

A. Then there is monocytes, 1.

Q. Okay. And are those inflammatory markers?

A. The WBC and neutrophils.

Q. Okay. When you got to the hospital at 8:00 a.m. on October 11th, you would have been able to go back in the chart and see that an elevated temperature had been reported during the middle of the night, correct?

A. Yes.

Q. You would have seen that Dr. Muraru had been consulted?

A. Yes.

Q. Okay. And if you believe that a CBC was necessary and Dr. Muraru did not order the CBC, you would have had that opportunity to do so at 8:00 a.m. when you were back on call, right?

A. If I thought that the test would give us -- give me more information to treat the patient, yes, I would have.

Q. Same question with regard to administration of antibiotics, if you saw there was an elevated

temperature and you saw that Dr. Muraru didn't decide to start antibiotics and you thought it was appropriate, you would have made that determination in the morning when you started your shift on October 11th, correct?

MR. SINKOFF: Object to the foundation.

MR. WARWICK: Same.

A. Yes, when I see the patient on October 11th I would make that determination and I would have started her on antibiotics if I thought she needed them.

BY MR. TAKALA:

Q. Okay. And that's irrespective of what Dr. Muraru did, you would make that decision for yourself?

A. Correct.

MR. TAKALA: All right. That's all I have. Thank you very much.

(The deposition was concluded at 4:29 p.m. Signature of the witness was not requested by counsel for the respective parties hereto.)

EXHIBIT D

In the Matter Of:

MARKEL vs WILLIAM BEAUMONT HOSPITAL, ET AL.

MARY ANNE MARKEL

September 07, 2018

Prepared for you by

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professional, et cetera?
A. As far as I recall, yes.
Q. Did you tell anyone that you were a nurse at the Beaumont Hospital facility?
A. Probably.
Q. That seems natural that it would come up.
A. It kind of just does. They had to break the glass to get into your chart so they said, what do you do here?
Q. When you said, break the glass --
A. When you go into the electronic chart, if you're a Beaumont employee, it's called break the glass, you have to put in why you're in the chart, who you are, what you're doing.
Q. Got it. So you're familiar with the Beaumont electronic medical system?
A. Yes, sir.
Q. Do you use the Epic system at your facility?
A. I do.
Q. Do you recall Dr. Olson performing any type of examination on you at any point?
A. I don't.
Q. So as you sit here today then, the treatment that you received from October 9, 2015 at roughly 5:00 p.m. up until you were discharged from the hospital on October the 11th, 2015 at approximately 2:33 p.m., other than

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Dr. Olson, you don't know the names of any doctors or medical professionals who were involved in your care, correct?
A. That is correct.
Q. Do you recall having a urine culture study performed at a certain point?
A. I don't.
Q. Okay. Do you recall any discussions with doctors or medical professionals about the various test results that had been performed on you?
A. Only the one about my back.
Q. And which test result was that?
A. I believe they did a CAT scan because they thought when I went in they thought that I had a kidney stone, that's what they thought was going on and they did whatever -- it was either -- I don't think it was an MRI, I think a CAT scan but I don't know and then were basically telling me, your back is kind of messed up.
Q. And when you say, they, again, you're speaking generally?
A. Yes, that is correct.
Q. And when you say, they said that -- I'll be more specific, when you say that a physician said that to you, that would be -- that would be a layperson's way of referencing the fact that you did have some prior

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medical history with your back, correct?
A. Yes.
Q. And if the record reflects that the doctors were aware of that and they were talking to you about those issues, that would be consistent with your history, correct?
A. Yes.
Q. And there were various types of doctors from various specialties who saw you during that admission, you're aware of that, right?
A. The only one I remember seeing was the -- they sent one of the pain doctors up about potentially doing an epidural but they couldn't do it because it was the weekend.
Q. So if there were different doctors from different specialties seeing you to look at what you had going on medically and to try to evaluate it from different perspectives, you may not recall their names but you do recall seeing different doctors, correct?
A. I don't.
Q. Okay. Do you know which room you were in when you were at Beaumont Hospital?
A. I do not.
Q. Do you know where you went from the emergency center?
A. I went to some -- to a floor but I don't remember

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where.
Q. Okay. Did you go to different areas of the emergency center when you were there?
A. I don't know. I don't remember.
Q. Did you go to something called an observation unit in the emergency center area when you were there?
A. I think I did.
Q. Then when you went to that area do you recall anything about how long you were there or no?
A. I don't.
Q. And then you went to a floor but you're not sure exactly which floor?
A. Correct.
Q. There's a co-defendant in the case represented by Mr. Sinkoff, her name is Dr. Linet, L-i-n-e-t, Lonappan, L-o-n-a-p-p-a-n, that name is not familiar to you either then?
A. Not at all.
Q. Okay. There was a doctor here today, Dr. Ioana Morariu, M-o-r-a-r-i-u, that name is not familiar to you at all, correct?
A. No, sir.
Q. So that's correct?
A. Yeah.
Q. So when you were discharged from William Beaumont

EXHIBIT E

MARKEL v. WILLIAM BEAUMONT HOSPITAL, ET AL.

MIHAI DAN MURARU, M.D.

February 27, 2019

Prepared for you by

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MIHAI DAN MURARU, M.D.
February 27, 2019

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MR. SINKOFF: Okay. And you said that was AT&T?
THE WITNESS: Yes.
MR. SINKOFF: Thank you.
Q And that was the phone number that you had back in October of 2015; correct?
A Uh-huh.
Q Yes?
A Yes. Yes.
MR. TAKALA: So as Plaintiff's Exhibit 1, I'll mark the hard copy record that the doctor produced that he reviewed.
As Plaintiff's Exhibit 2, I'll mark this single page that I provided the doctor, and that was the nursing note from Camie Rabon, R-a-b-o-n, that indicated that she had contacted Dr. Muraru.
Am I saying that properly?
THE WITNESS: Yes.
MR. TAKALA: Thank you, sir.
And then as Plaintiff's Exhibit 3, I'll mark three pages of handwritten notes that are on front and back on loose-leaf paper.
That's all I have, guys.
(Plaintiff's Exhibit 1, Exhibit 2, and Exhibit 3 were marked for identification.)

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MR. SINKOFF: Go ahead, Don.
MR. WARWICK: You want me to go first, Steve? Okay.
EXAMINATION
BY MR. WARWICK:
Q So Doctor, this is Don Warwick. I represent William Beaumont Hospital in the case. I have just a few questions for you. If at any time you don't understand a question, don't hesitate to mention that, and I'll certainly repeat it or phrase it. Okay?
A Sure.
Q And I'm going to make every effort, since I'm doing this by telephone, to give a pause between your answer so I can hear it and we have a clear record. If you could just do the same thing as well when I finish my question, just give it a second and then go ahead and answer. Okay?
A Sure.
Q Back in October of 2015, you were employed by Hospital Consultants, P.C.; is that correct?
A Correct.
Q And Dr. Lonappan, to your knowledge, was also employed by Hospital Consultants, P.C.; is that correct?

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A Yes.
Q And having reviewed the medical records -- let me strike that.
Do you have an independent recollection of this phone call on the early morning hours of October 11, 2015, or are you relying upon the medical records?
A I do remember, so I have my own memory, and supplemented by the medical records.
Q Okay. And from your memory then, I would take it, and also supplemented by the medical records, you know that Dr. Lonappan had previously seen Ms. Markel at William Beaumont Hospital the afternoon of October 10, 2015; is that correct?
A Yes. I read the notes.
Q And if Dr. Lonappan gave a deposition, have you read her deposition testimony?
A No.
Q Okay. Dr. Lonappan testified that this was a patient of a Dr. John Bonema, who was with Troy Internal Medicine. Are you familiar with Dr. Bonema?
A No.
Q Okay. Do you know Troy Internal Medicine?
A It is an outpatient internal medicine group.

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Q Yes. So Dr. Lonappan's testimony was that she became involved in the care of Ms. Markel because your hospital group had a contract with Troy Internal Medicine to handle the hospitalist work for that group.
MR. SINKOFF: I object to that. I didn't mean to cut you off.
MR. WARWICK: Go ahead.
MR. SINKOFF: I'm just objecting to your reference to a contract, which doesn't exist, but there's no question.
MR. WARWICK: So let me withdraw the question then.
Q Okay. Dr. Lonappan has testified that Hospital Consultants, P.C., handled at that time the hospitalist work for Troy Internal Medicine. Do you have any understanding of that as well, or no?
A It is possible. I do not know any specifics.
Q Okay. But in any event, at the time that you received this phone call from Nurse Rabon on October 11, 2015, at around 4:13 in the morning, you were an on-call physician for Hospital Consultants, P.C.; is that correct?
A Yes.
Q And that's why you received this phone call;

MIHAI DAN MURARU, M.D.
February 27, 2019

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correct?
A Yes.
Q And Dr. Lonappan had previously seen the patient the afternoon before, October 10. You're aware of that; right?
A Yes. I read the notes.
Q And at the time that you saw -- strike that.
At the time that this phone call came in from Nurse Rabon, she charted that, quote, Patient was running a temperature of 100.9 at 20:00, which is 8 p.m., on October 10. You see that; right?
A Yes.
Q Patient is now 98.1. You see that note; right?
A Yes.
Q Her orders to contact doctor if temperature greater than 100.4. Dr. Muraru was called. And that's the purpose for her call then to you; is that correct?
MR. POWE: Object to foundation.
Q Is that correct?
MR. TAKALA: I'll join too.
A Well, I was not called when the temperature was high, which was at 8 p.m. I was only called at 4 in the morning.
Q I know you're saying that you were called later, but it says -- her charting is the reason she was

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calling you is because if the temperature was greater than 100.4 to call you. That's why she charted that she called you. Is that correct?
MR. TAKALA: Foundation. Same.
MR. POWE: I'll join. Lack of foundation.
A I'm not sure what her thinking was. All I can say is nobody called me at 8 p.m. So the person who --
Q I understand.
A I'm sorry.
Q I think you're overthinking it. I'm just asking you what's in the record. The record is that there was an order, and there is an order in the file, in the records, that says call the doctor if the temperature goes over 100.4. And it's noted by Nurse Rabon that the temperature at 20:00 on October 10 was 100.9. You saw that; right?
A Yeah. I have the note in front of me.
Q Okay. And at the time she called you, the nurse at least charted that she was calling you because the temperature had previously been 100.4; correct?
A That's what it says. It says that she called because the temperature was high eight hours prior, yes.
Q Right. And then it says Dr. Muraru called, patient's urinalysis is negative and culture is

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pending from previous night's specimen. Is that correct?
A Yes.
Q And you would have had that discussion with her that the urinalysis was negative; true?
A Yes.
Q And Nurse Rabon told you that Ms. Markel was doing well and she feels better than she has in a while. Did she say something along those lines to you?
A Yes. I cannot remember exactly, but yes, she mentioned that the patient was doing well.
Q Okay. And then she said doctor said to just continue to watch her. And your testimony here today, is it that you told Nurse Rabon that if the problem continued -- or strike that.
Is it your testimony that you told Nurse Rabon to call you within an hour, or only to call you if there was any additional problem?
A I told the nurse to continue to monitor the patient closely, check the temperature in one hour, and if any changes or abnormalities to call me.
Q Okay. And then from the records, on October 11 at 5 a.m., the temperature was 98.2, which is normal; correct?
A Yes.

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Q And October 11 at 7 a.m., the temperature was 97.5; correct?
A I don't have that in front of me.
Q Okay. But if it was, at 7 a.m. on the 11th, 97.5, that would be normal as well; correct?
A Yes.
Q And then if when Dr. Lonappan saw the patient at around 11 a.m. on October the 11th and the temperature was 97.5, again, that would fall within the normal range; correct?
A Well, I can only comment on the temperature being normal. I was not involved by the time, so that's all I can say.
Q That's my point. That's my point. All we have here is one temperature that was recorded at 100.9 on October 10 at 8 p.m. And then from the records, all of the other temperatures were not elevated, they were within the normal range, until the time of discharge, to your knowledge; correct?
A Yes.
MR. WARWICK: Okay. Those are all the questions I have. I appreciate it.
THE WITNESS: Sure.

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

MARY ANNE MARKEL,

Plaintiff,
v.

Case No.: 18-164979 -NH
Hon. Nanci J. Grant

WILLIAM BEAUMONT HOSPITAL, HOSPITAL CONSULTANTS, P.C., AND LINET LONAPPAN, M.D. JOINTLY AND SEVERALLY,

Defendants.

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PLAINTIFF'S RESPONSE TO DEFENDANT, WILLIAM BEAUMONT HOSPITAL'S MOTION FOR SUMMARY DISPOSITION, PURSUANT TO MCR 2.116(C)(10

NOW COMES Plaintiff, MARY ANNE MARKEL, by and through her attorneys, MEYERS LAW, PLLC, and in response to Defendant, William Beaumont Hospital's Motion for Summary Disposition, Pursuant to MCR 2.116(C)(10, states as follows:

- **THE *GREWE* COURT STATED: "AGENCY IS ALWAYS A QUESTION OF FACT FOR THE JURY."** *Grewe v Mount Clemens Gen Hosp,* 404 Mich 240, 250, 253, 273 NW2d 429 (1978); (emphasis added).

- **FURTHERMORE, UNDISPUTED THAT DEFENDANT DR. LONAPPAN PROVIDED CARE AND TREATMENT TO PLAINTIFF MARY ANNE MARKEL AT DEFENDANT WILLIAM BEAUMONT HOSPITAL *IN* A WHITE LAB COAT *WITH* WILLIAM BEAUMONT HOSPITAL INSIGNIA.** (*Please see*, **Exhibit 1** – Deposition Excerpt of Linet Lonappan, M.D., p. 49)

- **UNDISPUTED THAT DEFENDANT DR. LONAPPAN WAS ASSIGNED TO PLAINTIFF'S CARE AND TREATMENT BY DEFENDANT WILLIAM BEAUMONT HOSPITAL TO BE PLAINTIFF'S "ATTENDING" PHYSICIAN.** (*Please see*, **Exhibit 1** – Deposition Excerpt of Linet Lonappan, M.D., p. 45, 50, 56 – 58, 105, 116).

- **UNDISPUTED THAT PLAINTIFF HAD NEVER TREATED WITH, MET, OR OTHERWISE KNOWN DEFENDANT DR. LONAPPAN UNTIL HER ADMISSION TO DEFENDANT HOSPITAL.** (*Please see*, **Exhibit 1** – Deposition Excerpt of Linet Lonappan, M.D., p. 50 and **Exhibit 2** – Affidavit of Mary Anne Markel).

- **UNDISPUTED THAT PLAINTIFF MARKEL REASONABLY BELIEVED TO BEING TREATED BY WILLIAM BEAUMONT HOSPITAL MEDICAL PROVIDERS.** (*Please see*, **Exhibit 2** – Affidavit of Mary Anne Markel)

- **DEFENDANT DR. LONAPPAN IS AN AGENT AND/OR APPARENT AGENT OF THE HOSPITAL AND AS SUCH, DEFENDANT WILLIAM BEAUMONT HOSPITAL IS VICARIOUSLY LIABLE FOR DR. LONAPPAN'S NEGLIGENCE.** *Grewe v Mount Clemens Gen Hosp,* 404 Mich 240, 250, 273 NW2d 429 (1978);

- **THERE IS NO EVIDENCE THAT DISTINGUISHED DEFENDANT DR. LONAPPAN FROM THE DEFENDANT HOSPITAL'S EMPLOYEES.**

- **UNDISPUTED THAT DEFENDANT P.A. WALKER ORDERED THE SECOND URINALYSIS FOR PLAINTIFF, WHICH INDICATED INFECTION, HOWEVER, DEFENDANT P.A. WALKER FAILED TO NOTIFY PLAINTIFF OF HER POSITIVE LAB RESULTS.** (*Please see*, **Exhibit 3** – Deposition Excerpt of Janay Warner, PA-C, p. 65 - 66).

- **UNDISPUTED THAT PLAINTIFF WAS DISCHARGED FROM DEFENDANT WILLIAM BEAUMONT HOSPITAL AND WAS NOT INFORMED OF HER ABNORMAL LAB RESULTS, ONCE THE LAB RESULTS WERE REPORTED.**

- **PLAINTIFF'S HEALTHCARE ADMINISTRATION EXPERT, DR. BOJKO, ESTABLISHES THE FAILURE OF DEFENDANT WILLIAM BEAUMONT HOSPITAL FROM ESTABLISHING AND IMPLEMENTING A POLICY REQUIRING ABNORMAL LAB RESULTS TO BE IMMEDIATELY REPORTED TO THE PATIENT'S PHYSICIAN AND PATIENT IF THE PATIENT HAS ALREADY BEEN DISCHARGED FROM THE HOSPITAL.**

- **THERE ARE CLEAR GENUINE ISSUES OF MATERIAL FACTS IN THIS ACTION, THEREFORE, DEFENDANT WILLIAM BEAUMONT HOSPITAL IS NOT ENTITLED TO SUMMARY DISPOSTION PURSUANT TO MCR 2.116(C)(10).**

1. Admitted in part and denied in part. Admitted that this is a medical malpractice claim alleging failure to timely diagnose and treat Plaintiff, Mary Anne Markel, for a Group B Streptococcus infection by Defendant, Linet Lonappan, M.D., hospitalist.

Further admit that Plaintiff alleges that Defendant William Beaumont Hospital is vicariously liable related to the treatment provided by Co-Defendant, Dr. Lonappan. Denied that Plaintiff has failed to create a genuine issue of material fact to establish that Defendant, William Beaumont Hospital, is vicariously liable, related to the allegations against Co-Defendant, Dr. Lonappan, pursuant to MCR 2.116(C)(10). Plaintiff and Defendant Dr. Lonappan testimony establishes that Plaintiff had reasonable belief that Dr. Lonappan was acting on behalf of Defendant Hospital and that Dr. Lonappan was assigned to the care and treatment of Plaintiff. *Grewe v Mount Clemens Gen Hosp,* 404 Mich 240, 250, 273 NW2d 429 (1978);

2. Admitted in part and denied in part. Admitted as to the allegations by Plaintiff that Defendant William Beaumont Hospital's employee, Janay Warner, P.A., failed to timely diagnose and treat Ms. Markel's Group B Streptococcus infection. Denied that evidence shows that Defendant, P.A. Warner, was not involved in Ms. Markel's treatment, at any time relevant to the allegations in this lawsuit. Defendant Warner ordered the second urinalysis for Plaintiff, which indicated infection for the patient, however, Defendant Warner failed to follow-up with the patient or verify the results of the test she ordered. (*Please see,* **Exhibit 3** – Deposition of Janay Warner, PA-C, p. 65 – 66).

3. Admitted in part and denied in part. Admitted that Plaintiff alleges that Defendant William Beaumont Hospital is directly liable for the delay in reporting the results of the subject urine study to Plaintiff, irrespective of Defendant Dr. Lonappan's testimony that it was her responsibility to obtain urine culture results and decide whether to report any findings to Ms. Markel. Plaintiff's expert on healthcare administration, Thomas Bojko, M.D., M.S., J.D., F.C.L.M., establishes that the hospital administrators of Defendant

William Beaumont Hospital are required to "establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth or abnormal or infectious organisms be immediately reported to the patient and the patient's physician if the patient has already been discharged from the hospital." (*Please see,* **Exhibit 4** – Affidavit of Merit of Thomas Bojko, MD, MS, JD, FCLM). There is clearly a genuine issue of material fact through the sworn statement of Dr. Thomas Bojko. The Affidavit of Merit of Dr. Bojko is a critical piece of documentary evidence and ***must be evaluated and weighed when the court is deciding on this motion***. In evaluating a motion for summary disposition brought under this MCR 2.116(C)(10), a trial court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties, MCR 2.116(G)(5), in the light most favorable to the party opposing the motion.

WHEREFORE, Plaintiff respectfully requests that this Honorable Court **DENY** Defendant, William Beaumont Hospital's Motion for Summary Disposition pursuant to MCR 2.116(C)(10).

Respectfully submitted,
MEYERS LAW, PLLC

By: /s/Timothy M. Takala
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DATED: July 24, 2019

BRIEF IN RESPONSE TO DEFENDANTS' MOTION FOR SUMMARY DISPOSITION

The law in Michigan is long and well-established that the issue of whether an agency relationship exists is a question of fact for the jury and not the proper subject for a motion for summary disposition. *Grewe v Mt. Clemens General Hospital*, 404 Mich 240;

273 NW2d 429 (1978); Moreover, in this case, there is no dispute that Linet Lonappan, M.D., was the admitting physician for Mary Anne Markel when she was a patient at William Beaumont Hospital, assigned by Defendant William Beaumont Hospital. (*Please see*, **Exhibit 1** – Deposition Excerpt of Linet Lonappan, M.D., p. 45, 50, 56 – 58, 105, 116). Dr. Lonappan, as the admitting physician, had responsibility for the care and treatment of this patient. Dr. Lonappan testified that she had never met Ms. Markel prior to her care and treatment of her at William Beaumont Hospital in October of 2015. (*Please see*, **Exhibit 1** – Deposition Excerpt of Linet Lonappan, M.D., p. 45). Dr. Lonappan testified that during her shifts at Defendant William Beaumont Hospital, she would wear a white lab coat with credentials indicating Beaumont Health System. (*Please see*, **Exhibit 1** – Deposition Excerpt of Linet Lonappan, M.D., p. 49 - 50). Dr. Lonappan further testified that her introductions to patients includes her name [Dr. Lonappan] and that she was assigned to the patient's care and treatment by William Beaumont Hospital. *Id.* Plaintiff further affirms that she did not know Dr. Lonappan prior to October of 2015, and that she believed she was being treated by William Beaumont Hospital's physicians. (*Please see*, **Exhibit 2** – Affidavit of Mary Anne Markel). Therefore, Defendant William Beaumont Hospital is vicariously liable for the negligence of Dr. Lonappan. *Grewe v Mount Clemens Gen Hosp,* 404 Mich 240, 250, 273 NW2d 429 (1978);

Defendants further request Summary Disposition pursuant to MCR 2.116(C)(10) on the grounds that Plaintiff failed to create a genuine issue of material fact to show that Defendant William Beaumont Hospital's employee, Janay Warner, P.A., failed to timely diagnose and treat Ms. Markel's Group B Streptococcus infection. Evidence shows that Defendant, P.A. Warner, was the medical treater who ordered the second urinalysis for

Plaintiff, which indicated infection for the patient, however, Defendant Warner failed to follow-up with the results of the test she ordered, even though she admits that she has contacted patients in the past with their results so that they may "follow up." (*Please see,* **Exhibit 3** – Deposition of Janay Warner, PA-C, p. 21 – 22, and 65 – 66). Defendant Warner was required to follow-up with the urinalysis that she ordered in order to timely diagnose and treat Ms. Markel's Group B Streptococcus infection.

Finally, Defendants request Summary Disposition pursuant MCR 2.116(C)(10) on the grounds that Plaintiff failed to create a genuine issue of material fact to show that Defendant William Beaumont Hospital is directly liable for the delay in reporting the results of the subject urine study to Plaintiff. Plaintiff's expert on healthcare administration, Thomas Bojko, M.D., M.S., J.D., F.C.L.M., establishes that the hospital administrators of Defendant William Beaumont Hospital were required to "establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth or abnormal or infectious organisms be immediately reported to the patient and the patient's physician if the patient has already been discharged from the hospital." (*Please see,* **Exhibit 4** – Affidavit of Merit of Thomas Bojko, MD, MS, JD, FCLM). There is clearly a genuine issue of material fact through the sworn statement of Dr. Thomas Bojko. The Affidavit of Merit of Dr. Bojko is a critical piece of documentary evidence and ***must be evaluated and weighed when the court is deciding on this motion***. In evaluating a motion for summary disposition brought under this MCR 2.116(C)(10), a trial court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties, MCR 2.116(G)(5), in the light most favorable to the party opposing the motion.

For all of these reasons, Plaintiff would respectfully request that this Honorable Court deny Defendants' motion in its entirety.

I. FACTUAL BACKGROUND

On October 2, 2015, Ms. Markel underwent endometrial ablation with Novasure and TruClear procedure performed.

On October 9, 2015, Ms. Markel presented to the Emergency Department at William Beaumont Hospital Royal Oak complaining of numbness in her feet, ten out of ten pain located in her left lumbar spine, and a history of inability to urinate. Her back pain was noted to radiate to her left lower extremity. A complete blood count was ordered in the Emergency Department which revealed a white blood cells of 13,800. Ms. Markel was admitted to Beaumont Hospital for additional workup.

A urinalysis performed the evening of October 9, 2015, revealed dark yellow urine, cloudy in appearance that was positive for bilirubin at one plus, positive for trace ketones, positive for leukocytes, and positive for white blood counts at 11 to 25. Crystal was also found in the urine and identified them via microscopy to be calcium oxalate.

On October 10, 2015, Defendant Linet Lonappan, M.D., completed a history and physical noting that Ms. Market was unable to urinate earlier, but had urinated the morning of the 10th. A stat urinalysis and urine cultures were ordered at 1:49 p.m. by Defendant Janay Warner, PA-C. At 8:00 p.m. on October 10, 2015, Ms. Markel was noted to have a fever of 100.9 and shortly thereafter at 9:09 p.m. the urinalysis was resulted. The urinalysis from that afternoon revealed dark yellow urine with trace ketones, two plus leukocytes, white blood cells of 11 to 25, cast and epithelial cells both present. An overnight nursing note entered by Megan Kaiser, N.P., noted that the patient was running a fever of 100.9 at 10:10 the prior

evening, now at 98.1. The note indicates that Dr. Moraru (believed to be Dr. Ioana Morariu, M.D.) was contacted per the standing order to contact with temperatures above 100.4.

On October 11, 2015, at approximately 2:33 p.m., Linet Lonappan, M.D. discharged Ms. Markel from the hospital. Approximately three hours after that order was entered at 5:47 p.m., a preliminary result for Ms. Markel's urine culture returned a positive result for streptococcus agalactiae (group B greater than 100,000 colony forming units per milliliter.) This result was never communicated to Ms. Markel.

The following day on October 12, 2015, Ms. Markel underwent epidural steroid injections on an outpatient basis. The final read for the urine culture was resulted on October 12, 2015 at 8:38 p.m. and was abnormal for streptococcus agalactiae greater than 100,000 CFU/ml.

II. STANDARD OF REVIEW

Defendant cites, as their sole legal basis for their Motion for Summary Disposition, MCR 2.116(C)(10). Under that sub-rule, the relevant inquiry is whether there is a genuine issue of a material fact and the movant has the initial burden of supporting its position with affidavits, depositions, admissions, or other documentary proofs. *Maiden v Rozwood,* 461 Mich 109, 120-121; 597 NW2d 817 (1999). ***In deciding such a motion, the Court must consider the pleadings, affidavits, depositions, admissions and any other evidence in favor of the non-moving party and grant the benefit of any reasonable doubt to the non-moving party***. *Id.* (emphasis added) "The contents of the complaint are accepted as true unless contradicted" by the evidence provided. *Id.,* at 119; *Odom v Wayne County,* 482 Mich 459, 466; 760 NW2d 217 (2008). Further, the Court may not make factual findings or weigh the evidence or credibility of the witnesses.

Manning v Hazel Park, 202 Mich App 685, 689-690; 509 NW2d 874 (1993). The Court must examine the facts of the case ***in a light most favorable to the non-moving party, who is the Plaintiff in this case***. *Id.*

Plaintiff respectfully submits that Defendants, have not met any of these standards warranting summary disposition in this case.

III. LEGAL ANALYSIS

RESPONSE TO DEFENDANT'S ARGUMENT I

In this case, Defendant William Beaumont Hospital improperly and incorrectly asserts that the Defendant Hospital is not vicariously liable for the negligence of Defendant Dr. Lonappan.

The law in Michigan is long and well-established that the issue of whether an agency relationship exists is a question of fact for the jury and not the proper subject for a motion for summary disposition. *Grewe v Mt. Clemens General Hospital*, 404 Mich 240; 273 NW2d 429 (1978); *Strach v St John Hospital Corporation*, 160 Mich App 251; 408 NW2d 441 (1987); *Brackens v Detroit Osteopathic Hospital*, 174 Mich App 290; 435 NW2d 472 (1989).

Furthermore, "The leading case in Michigan regarding the apparent authority of physicians to act on behalf of a hospital, also referred to as "ostensible agency," is *Grewe v Mount Clemens Gen Hosp,* 404 Mich 240, 250, 273 NW2d 429 (1978);" *Chapa v. St. Mary's Hosp. of Saginaw*, 192 Mich. App. 29, 31, 480 N.W.2d 590, 591 (1991). The applicable judicial rules of implied agency, apparent agency and ostensible agency based on *Grewe v Mount Clemens General Hospital* are analyzed below.

A hospital certainly may be held vicariously liable for the negligent acts of its nurses, aides, physician employees, residents, interns, and auxiliary personnel actually employed by the hospital to provide medical care and treatment to its patients. *McClaine v Alger*, 150 Mich App 306, 311–313, 388 NW2d 349 (1986).

The creation of an agency relationship is determined by the facts, whether or not the parties to it understand that the consequence of their acts or agreements is to create an agency agreement. *Van Pelt v Paul,* 6 Mich App 618, 624; 150 NW2d 185 (1967). Thus, the labels that the parties use are not determinative. *Caldwell v Cleveland-Cliffs Iron Co,* 11 Mich App 721, 732; 315 NW2d 186 (1981); *Universal Life Church, Inc v Commr of Lottery,* 96 Mich App 385, 388; 292 NW2d 169 (1980); *Lincoln v Fairfield-Nobel Co,* 76 Mich App 514, 520; 257 NW2d 148 (1977). One may, however, be both an agent and an "independent" contractor at the same time. *City of Detroit v Corey,* 9 Mich 165, 183 (1861); 1 Restatement (2d) of Agency, §14N, at p 80 (1958). A party also may be liable for the negligence of an "independent contractor" where the party retains and exercises control over the contract or where the work is inherently dangerous. *Funk v GMC*, 392 Mich 91, 108–110; 220 NW2d 641 (1974), *overruled in part on other grounds in Hardy v Monsanto Enviro-Chem Sys, Inc*, 414 Mich 29; 323 NW2d 270 (1982); *Schoenherr v Stuart Frankel Dev Co*, 260 Mich App 172; 679 NW2d 147 (2003).

A. Existence of Agency Relation is a Question of Fact

An agent is one who acts on behalf of another, particularly with regard to the conduct of business transactions. Even though an agent is not necessarily an employee (or "servant"), a principal is still responsible for the acts of his or her agent if done within the scope of the agent's authority. *Lincoln v Fairfield-Nobel Co*, 76 Mich App 514; 257

NW2d 148 (1977). If an act done by one person on behalf of another is in its essential nature one of agency, he or she is an agent regardless of the title bestowed on him or her. *Id.* at 520.

The actions of an agent bind a principal where the agent acts with either actual or apparent authority. *Echelon Homes, LLC v Carter Lumber Co*, 261 Mich App 424, 683 NW2d 171 (2004), *rev'd on other grounds,* 472 Mich 192, 694 NW2d 544 (2005). Apparent authority may arise when acts and appearances lead a third person reasonably to believe that an agency relationship exists. *Meretta v Peach*, 195 Mich App 695, 698-699; 491 NW2d 278 (1992). But "apparent authority must be traceable to the principal and cannot be established by the acts and conduct of the agent." *Id.* at 699. "[A]pparent authority to do an act is created as to a third person by written or spoken words or any other conduct of the principal which, reasonably interpreted, causes the third person to believe that the principal consents to have the act done on his behalf by the person purporting to act for him." 1 Restatement Agency, 2d, § 27, p 103.

Even if a contract purports to define the principal-agent relation between Defendant Hospital and its "staff" physicians, the existence of the relation is a question of fact for the jury to decide. *Thon v Saginaw Paint Mfg Co,* 120 Mich App 745, 749-750; 327 NW2d 551 (1982); *Lincoln v Fairfield-Nobel, supra,* at 519

One may, however, be both an agent and an "independent" contractor at the same time. *City of Detroit v Corey,* 9 Mich 165, 183 (1861); Restatement (2d) of Agency, §14N, at p 80 (1958).

Similarly, a principal is liable for the torts which its agent commits within the scope of the agency's authority. *Kerry v Turnage,* 154 Mich App 275; 397 NW2d 543 (1986);

Lincoln v Fairfield-Nobel Co, 76 Mich App 514; 257 NW2d 148 (1977). Whether a person is an agent of the principal generally is a question of fact. *Id.,* at 520.

B. Defendant Hospital Was the Implied, Apparent (or Ostensible) or Actual Principal of the "Staff" Physicians the Hospital Assigned to Care for Ms. Markel

Parties may be involved in more than one principal-agent relationship while engaged in any given activity at any given time and place. Justice Campbell explained in *Roberts v Pebble,* 55 Mich 367, 369; 21 NW 319 (1884), "Usually, agency is a simple question of fact, although it may in some cases be less plain of solution than in others."

i. Agency By Estoppel

Hospitals also may be found liable for the acts of negligence of their ostensible agents, as well as actual agents or employees in the care of a patient. Under certain factual circumstances, a staff physician who is not an employee of a hospital may be found to be the ostensible agent of a hospital. *Grewe v Mount Clemens Gen Hosp*, 404 Mich 240, 250, 273 NW2d 429 (1978). To determine whether a staff physician was an employee or agent of a hospital under this theory, the *Grewe* Court established the following guidelines:

> [I]f the individual looked to the hospital to provide him with medical treatment and there has been a representation by the hospital that medical treatment would be afforded by physicians working therein, an agency by estoppel can be found.
>
> In our view, the critical question is whether the plaintiff, at the time of his admission to the hospital, was looking to the hospital for treatment of his physical ailments or merely viewed the hospital as the situs where his physician would treat him for his problems. A relevant factor in this determination involves resolution of the question of whether the hospital provided the plaintiff with Dr. Katzowitz or whether the plaintiff and Dr. Katzowitz had a patient-physician relationship independent of the hospital setting.

Id. at 250–251 (citations omitted).

Plaintiff Grewe visited a clinic for treatment after suffering a shoulder injury at work, and then went to the defendant Mount Clemens General Hospital. *Id.,* at 246. Mr. Grewe was admitted and initially examined by an internist, Dr. Gerald Hoffman, who sought a consultation from an orthopedic surgeon, Dr. Robert Fagen. *Id.* Dr. Fagen diagnosed the plaintiff as suffering a dislocated shoulder. Dr. Hoffman's associate, Dr. A. Lewis Katzowitz, who had staff privileges at the hospital, saw the plaintiff suffering and attempted to reduce the dislocated shoulder. Mr. Grewe alleged that Dr. Katzowitz injured him when attempting to reduce the dislocation. *Id.* at 245-246.

In *Grewe,* the Supreme Court identified the critical question to be whether the plaintiff, at the time of his admission to the hospital, looked to the hospital for treatment of his physical ailments or merely viewed the hospital as the situs where his physician would treat him for his problems. *Id.,* at 251. The Court noted that a "relevant factor in this determination involves resolution of the question of whether the hospital provided the plaintiff with Dr. Katzowitz or whether the plaintiff and Dr. Katzowitz had a patient-physician relationship independent of the hospital setting." *Id.* The *Grewe* Court reasoned: "[W]e see nothing in the record which should have put the plaintiff on notice that Dr. Katzowitz, when he attempted to reduce the plaintiff's shoulder separation, was an independent contractor as opposed to an employee of the hospital." *Id.* at 253. *See also Brackens v Detroit Osteopathic Hosp*, 174 Mich App 290, 435 NW2d 472 (1989).

The following three-part test has been used by the Court of Appeals to determine whether ostensible agency exists:

> [First] The person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one; [second] such belief must be generated by some act or neglect of the principal sought to be charged; [third] and the third person relying on the agent's apparent authority must not be guilty of negligence.
>
> *Little v Howard Johnson Co,* 183 Mich App 675, 683; 455 NW2d 390 (1990) (citations omitted).

For example, *Strach v St John Hosp Corp*, 160 Mich App 251, 260–271, 408 NW2d 441 (1987), discusses the type of evidence needed to establish an ostensible agency relationship, including testimony about the "St. John team" which performed plaintiff's surgery at issue. The Court of Appeals also found it "significant" that neither plaintiff Strach nor his wife recalled being told the name of a specific surgeon who would treat them at St. John Hospital. In *Strach,* a factual question was presented when a doctor's testimony that he had informed the plaintiffs that he was an independent contractor was contradicted by the plaintiffs' testimony that they did not recall so being told. The Court of Appeals also acknowledged that acquiescence by the principal may be a decisive fact in establishing ostensible agency:

> That the defendant hospital acquiesced in the use of the vernacular "St. John Hospital team" and in the direct exercise of authority over its employees is conduct of the principal tending to create ostensible agency. See *Shinabarger v Phillips*, 370 Mich 135; 121 NW2d 693 (1963) (acquiescence by the principal in an agent's exercise and display of authority is sufficient to establish ostensible agency).

The *Strach* Court further held a jury could disregard a physician's "unrebutted" testimony, reasoning that "a jury may disbelieve the most positive evidence even when it stands uncontradicted, and the judge cannot take from them their right of judgment[.]" *Id.,* at 271. A number of published opinions further demonstrate this theory of liability.

Setterington v Pontiac Gen Hosp, 223 Mich App 594, 568 NW2d 93 (1997), upheld the jury's finding that an agency relationship existed between a radiologist and the hospital because the radiologist did not have a physician-patient relationship with the patient independent of the hospital setting but was merely on duty when the patient arrived at the hospital. By comparison, Defendant cites *Chapa v St Mary's Hosp*, 192 Mich App 29, 480 NW2d 590 (1991). The *Chapa* Court held that the allegedly negligent doctor (who was hired by a hospitalized patient's family and not the hospital to assume the care of the patient) was not an ostensible agent of the hospital merely because the patient looked to the hospital for care when he was first admitted. The key test under *Grewe* as applied to the facts of this case is not to whom the patient looked for care at the time of her admission, but, rather, whether the hospital did something that would create the reasonable belief in the patient's mind that the negligent doctor was acting on behalf of the hospital.

In this case, it is clear that the patient had reasonable belief that Defendant Dr. Lonappan was acting on behalf of the hospital. It is undisputed that (1) Ms. Markel and Defendant Dr. Lonappan had no prior dealings with one another prior to the initial treatment in October of 2015, (2) Defendant Dr. Lonappan wore a white lab coat with Defendant Hospital credentialing while providing care and treatment to Ms. Markel, (3) Dr. Lonappan introductions to patients includes her name [Dr. Lonappan] and that she was ASSIGNED TO THE PATIENT'S CARE AND TREATMENT BY WILLIAM BEAUMONT HOSPITAL, and (4) Defendant Dr. Lonappan made no statements or took affirmative action to indicate to Ms. Markel that she was not an employ of the hospital.

Defendant Dr. Lonappan testified as follows:

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Q. Okay. Do you know whether you ever met Ms. Markel prior to October 10th, 2015?
A. No.
Q. You know that you hadn't or you just don't know?
A. I know that I hadn't.

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Q. When you are assigned to your 10-or-11-day shift at Beaumont Royal Oak do you wear a white lab coat?
A. Yes.
Q. All right. And do you wear credentials that indicate who you are and that you're a physician?
A. Yes.
Q. And it says Beaumont Health System or something like that on the credentials?
A. Yes.
Q. Does it say Hospital Consultants, P.C.?
A. Yes.
Q. Okay. And that's on your credentials?
A. Yes.
Q. All right. Do you have a copy of your credentials here today?
A. No.
Q. Okay. Do you know whether you were wearing those credentials when you saw Ms. Markel on October 10th?
A. I don't have a specific recollection.
Q. Okay. But whenever you're in the hospital you're wearing a white lab coat and you're wearing your credentials, right?
A. Yes.
Q. So unless there was some unusual circumstances, you would have presented to her with a white lab coat and your picture and your ID, right?
A. Yes.
Q. Okay. Do you introduce yourself when you typically meet a patient for the first time?
A. Yes.
Q. How do you introduce yourself?
A. Dr. Lonappan.
Q. Okay. Do you say I'm Dr. Lonappan at Beaumont or I'm Dr. Lonappan at Hospital Consultants, P.C. or just I'm Dr. Lonappan?
A. I'm Dr. Lonappan.
Q. Okay. And you were assigned Ms. Markel's service by William Beaumont Hospital?
A. Yes.

Q. Okay.

(*Please see*, **Exhibit 1 –** Deposition Excerpt of Linet Lonappan, M.D., p. 45, 48 - 50).

The Defendant Hospital is vicariously liable for the negligence of its ostensible agent, Defendant Dr. Lonappan. Furthermore, the *Grewe* Court stated: **"Agency is always a question of fact for the jury."** *Id.,* at 253 (emphasis added). This remains the law today, and this matter should be presented to the jurors.

RESPONSE TO DEFENDANT'S ARGUMENT II

Defendant William Beaumont Hospital wrongfully asserts that Plaintiff has failed to create a genuine issue of material fact, pursuant to MCR 2.11(C)(10) to establish that Defendant Janay Warner, P.A., breached the standard of care or caused any injury to Ms. Markel.

Plaintiff asserts that Defendant William Beaumont Hospital's employee, Janay Warner, P.A., failed to timely diagnose and treat Ms. Markel's Group B Streptococcus infection. Defendant Warner ordered the second urinalysis for Plaintiff along with cultures, which indicated infection for the patient, however, Defendant Warner failed to follow-up with the patient or verify the results of the test she ordered. (*Please see,* **Exhibit 3** – Deposition of Janay Warner, PA-C, p. 65 – 66, and **Exhibit 5** – Lab Orders for Urinalysis and Cultures by Defendant Warner). Due to Defendant Warner's failure to follow-up with the patient regarding the abnormal lab results, Ms. Markel did not return to the hospital to receive antibiotics. Had she been aware of the abnormal results of the test ordered by Defendant Warner, Ms. Markel would not have had an epidural injection, would not have

developed an epidural abscess, and timely intervention would have prevented the spread and worsening of infection.

Furthermore, Defendant Warner admits that she has contacted patients in the past with abnormal findings so that they may follow-up, as follows:

> Q. As a P.A., has there been circumstances where you had to contact a patient after the patient has been discharged?
>
> MR. WARWICK: Just objection to the form.
> MR. SINKOFF: From the observation unit or for any?
> MS. ALI: From the observation unit.
>
> A. **From the observation unit? Yeah, I can think of a few examples of -- I -- when I might have called a patient. Say I was finishing a -- a chart, my -- a note, and I realized that there was like a pulmonary nodule on an x-ray and just wanted to communicate with the patient so that they could follow up, something like that, that I might have taken it upon myself to call them.**

(*Please see,* **Exhibit 3** – Deposition of Janay Warner, PA-C, p. 21 – 22).

However, Defendant Warner failed to contact Ms. Markel with her abnormal lab results, and a general issue of material fact exists as to Defendant Warner's failure to follow-up with the patient regarding the positive cultures. Furthermore, as discussed below, due to Defendant William Beaumont Hospital's **failure to implement a policy requiring that preliminary or interim urine culture results that reveal significant growth or abnormal or infectious organisms be immediately reported to the patient and the patient's physician if the patient has already been discharged from the hospital, Defendant Warren failed to report the infection to Ms. Markel.**

RESPONSE TO DEFENDANT'S ARGUMENT III

Defendant William Beaumont Hospital wrongfully asserts that Plaintiff has failed to create a genuine issue of material fact, pursuant to MCR 2.11(C)(10) to establish that Defendant William Beaumont Hospital is liable or caused any injury to Ms. Markel, under a direct liability theory.

Thomas Bojko, M.D., M.S., J.D., F.C.L.M, Plaintiff's expert on healthcare administration, opines that the **hospital administrators of Defendant William Beaumont Hospital are required to "establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth or abnormal or infectious organisms be immediately reported to the patient and the patient's physician if the patient has already been discharged from the hospital."** (*Please see,* **Exhibit 4** – Affidavit of Merit of Thomas Bojko, MD, MS, JD, FCLM). Furthermore, **Dr. Bojko opines "...that had the Hospital Administrators acted in accordance with the standard of care more completely described above...Ms. Markel would have been timely notified of the abnormal preliminary lab result. Had those steps been taken, Ms. Markel would have been aware of the preliminary urine culture result and returned to the hospital to receive antibiotics, she would not have had an epidural injection, would not have developed an epidural abscess, and timely intervention would have prevented the spread and worsening of infection."** *Id.* There is clearly a genuine issue of material fact through the sworn statement of Dr. Thomas Bojko. The Affidavit of Merit of Dr. Bojko is a critical piece of documentary evidence and ***must be evaluated and weighed when the court is deciding on this motion***. In evaluating a motion for summary disposition brought under this MCR

2.116(C)(10), a trial court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties, MCR 2.116(G)(5), in the light most favorable to the party opposing the motion.

IV. CONCLUSION

Questions of agency are not the proper subject for a motion for summary disposition. However, in this case, the evidence shows, at a minimum, questions of material fact whether Plaintiff has claims for the Defendant William Beaumont Hospital's vicarious liability for the acts of Defendant Dr. Lonappan, as agent and/or ostensible agent of the Defendant Hospital in providing care and treatment to Mary Anne Markel as a patient assigned by the Defendant Hospital. Additionally, Defendant PA Warner concedes that she has contacted patients in the past regarding their test results, however, failed to do so in the instant matter. Finally, Plaintiff establishes through expert Dr. Bojko that Defendant William Beaumont Hospital is directly liable for the delay in reporting the results of the subject urine study to Plaintiff. Therefore, Defendant William Beaumont Hospital's motion for summary disposition should be denied in its entirety.

WHEREFORE, Plaintiff respectfully requests that this Honorable Court **DENY** Defendant, William Beaumont Hospital's Motion for Summary Disposition pursuant to MCR 2.116(C)(10).

Respectfully submitted,
MEYERS LAW, PLLC

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DATED: July 24, 2019

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

MARY ANNE MARKEL,

Plaintiff,
v.

Case No.: 18-164979 -NH
Hon. Nanci J. Grant

WILLIAM BEAUMONT HOSPITAL, HOSPITAL CONSULTANTS, P.C., AND LINET LONAPPAN, M.D. JOINTLY AND SEVERALLY,

Defendants.

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PROOF OF SERVICE

I, Penny E. Sidick, hereby certify that on July 24, 2019, I electronically e-filed Plaintiff's Response To Defendant, William Beaumont Hospital's Motion For Summary Disposition, Pursuant to MCR 2.116(C)(10), Brief in Support and this Proof of Service, with the Oakland County Circuit Court using MiFile File and Serve System, which will send notification of such filing to the following:

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I declare under the penalties of perjury that the foregoing statements are true and correct to the best of my information and belief.

/s/Penny E. Sidick
Penny E. Sidick

EXHIBIT 1

In the Matter Of:

MARKEL vs WILLIAM BEAUMONT HOSPITAL, ET AL.

LINET LONAPPAN, M.D.

December 04, 2018

Prepared for you by

LONAPPAN, M.D., LINET
12/04/2018

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

Mary Anne Markel,
Plaintiff,
vs. Case No. 18-164979-NH
Hon. Nanci J. Grant
William Beaumont Hospital, Hospital Consultants, P.C., and Linet Lonappan, M.D., Jointly and Severally,
Defendants.

The Deposition of LINET LONAPPAN, M.D.,
Taken at One Towne Square, Suite 1400,
Southfield, Michigan,
Commencing at 2:05 p.m.,
Tuesday, December 4, 2018,
Before Becky L. Johnson, CSR-5395.

APPEARANCES:

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Southfield, Michigan
Tuesday, December 4, 2018
2:05 p.m.

LINET LONAPPAN, 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:

EXAMINATION

BY MR. TAKALA:

Q. Can you please state your full name for the record?

A. Linet Palayoor Lonappan.

MR. TAKALA: Let the record reflect that this is the deposition of Dr. Linet Lonappan taken pursuant to notice and agreement between counsel as to time and place whose testimony will be used for all purposes as allowed under our Michigan Court Rules as well as our Michigan Rules of Evidence.

BY MR. TAKALA:

Q. Dr. Lonappan, my name is Tim Takala, I represent Mary Markel in this case. I have some questions to ask you about your background, as well as your involvement with Ms. Markel's treatment at Beaumont Hospital, but I'm going to first ask you for your date of birth?

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A. 8-4-81.

Q. And your residential address?

MR. SINKOFF: No, you can get her through me.

MR. TAKALA: Okay.

BY MR. TAKALA:

Q. Are you currently employed?

A. Yes.

Q. Where at?

A. Through Hospital Consultants, P.C.

Q. How long have you been employed through Hospital Consultants, P.C.?

A. July 2011, since that time.

Q. Have you been deposed before?

A. Yes.

Q. How many times?

A. I was a witness for a deposition once.

Q. Okay. When was that?

A. That was in 2011.

Q. Okay. Were you a named defendant in that case or were you just a witness in the medical chart?

A. I was a witness in the medical chart.

Q. What type of case was it, if you know?

A. I don't recall it right now.

Q. Let me ask it differently. Do you know whether it

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was -- involved allegations of medical malpractice against another physician?

A. I think so.

Q. Okay. And you don't remember the name of either the plaintiff or the defendant in that case from seven years ago, do you?

A. I don't.

Q. All right. Just a couple ground rules just because it's been a while since you've last been through this process. It's important to give verbal answers and it's important for only one of us to talk at a time, okay?

A. Okay.

Q. More importantly than that, if I ask a bad question that you don't understand, will you agree to tell me so?

A. Yes.

Q. Okay. And you'll do that instead of answering the question?

A. Correct.

Q. All right. That way I'll presume you understood my question if you give me an answer, fair?

A. Okay.

Q. Also, if at any point I cut your answer off, will you agree to tell me that I did so?

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A. Yes.
Q. All right. Otherwise, I'm going to presume that you gave a full answer to my question. I'm here to get your full answer and if I interrupt you, I do so unintentionally, but I won't know that I've done that unless you tell me, okay?
A. Okay.
Q. You were kind enough to provide me a copy of your curriculum vitae prior to the deposition?
A. Yes.
Q. I'll mark that as Plaintiff's Exhibit 1 and just show you a copy and ask you if that is current and up to date?

MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 1
2:08 p.m.

A. Yes.
BY MR. TAKALA:
Q. Thank you. By the way, when you testified on that one prior occasion, I assume that you testified honestly, truthfully and to the best of your ability?
A. Yes.
Q. All right. Just tell me, and I know that -- I won't belabor the point because it's contained in Plaintiff's Exhibit 1, but tell me a little bit about

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your educational background, starting with your undergraduate education, please?
A. Yes. I did my schooling in India and I did my medical school in India. And then I came here, did my residency at Crozer-Chester in Philadelphia, and then that's -- that was my internal medicine residency from 2008 until 2011.
Q. Okay. How does medical school look in India, is it a four-year program?
A. It's a four-year, plus one year of house surgency, which is like a residency, mini residency, that we do here, yep.
Q. So five years of medical school in India?
A. Yep.
Q. Okay. How many years of undergraduate school in India?
A. So we usually have -- soon after high school, after the 12th grade, we can apply for the medical school. So we don't have to have a separate undergraduate course.
Q. Okay. And were both of these at the medical college at the University of Kerala in India?
A. That's correct.
Q. Okay.
A. T.D. Medical College.

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Q. T.D. Medical College, thank you. And then when you came here to the States, what year was that?
A. That was in -- you mean -- I'm sorry, the question as to what year I started the residency or what year did I come to U.S., is that the question?
Q. What year did you come to the United States?
A. In 2006.
Q. All right. So you would have completed your one-year house residency program in India in 2005?
A. Correct.
Q. Okay. Then when you -- by the way, were you ever licensed to practice medicine in India?
A. Yes.
Q. Did you have to take an exam?
A. That was involved with the medical school. I didn't have to do a separate licensing exam.
Q. Okay. So you were licensed based upon your matriculation through T.D. Medical College?
A. Correct.
Q. You come to the States in 2006. Do you have to take an exam here?
A. We have to pass the USMLE steps before applying for residency.
Q. And I forget, how many steps are they?
A. There are three steps.

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Q. And did you pass each one of those steps on your first attempt?
A. Yes.
Q. And then you applied for a residency program at Crozer --
A. Chester, yes, Medical Center.
Q. Good. And that's on your curriculum vitae here?
A. Correct.
Q. And you complete that program between 2008 and 2011?
A. Correct.
Q. All right. What was your residency in?
A. Internal medicine.
Q. Okay. And what happens in 2011, do you take your board exams?
A. Yes.
Q. What specialty do you take your board exams in?
A. Internal medicine.
Q. Okay. Are you currently practicing as an internal medicine physician?
A. Yes.
Q. Do you practice at all on an outpatient basis?
A. No.
Q. All of your work is in the hospital?
A. Yes.
Q. Is there a separate board certification for

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hospitalist medicine within the field of internal medicine?
A. Yes.
Q. Have you sat for that board exam?
A. No.
Q. Do you have any plans to?
A. Not currently.
Q. Nonetheless, through your experience as a hospitalist at Hospital Consultants, P.C., you've become familiar with the standard of care of internal medicine physicians practicing within a hospital setting?
A. Correct.
Q. All right. I know the answer to this, but I'm going to ask anyway. Have you ever been named in a medical malpractice lawsuit?
A. No.
Q. Okay. And you've never reviewed any medical-legal cases, have you?
A. No.
Q. I think that we probably gave Mr. Sinkoff a copy of a deposition notice. Do you recall seeing any copy of a deposition notice asking you to be here today and bring with you certain materials?
MR. SINKOFF: I never showed it to her because all you asked for was the medical record.

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MR. TAKALA: No problem.
BY MR. TAKALA:
Q. Did you bring anything with you here to the deposition?
A. The medical records and my C.V.
Q. Okay. I'm sorry. And where did you get that copy of the medical records from, if you know?
A. Through Mr. Sinkoff.
Q. And there are certain Post-it flags on there. Are those your Post-it flags?
A. Yes.
Q. All right. They're different colors. Is there any system to the coloring?
A. No.
Q. Okay. Is there any reason why you flagged certain pages?
A. Just for ease of reference.
Q. Okay. Is there anything that you have reviewed for preparation for your deposition that you did not bring here today?
A. No.
Q. All right. Did you take any notes while you were reading through the medical records or any other materials that you've been provided in this case?
A. No.

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Q. Okay. Did you ever look at the medical records on a computer terminal at Beaumont Hospital?
A. No.
MR. SINKOFF: Well, when you say ever, you mean since the notice of intent?
MR. TAKALA: Correct. Thank you, Steve.
BY MR. TAKALA:
Q. Since the notice of intent was sent out and suit was commenced, have you had a chance to look at Ms. Markel's medical records on a Beaumont terminal?
A. No.
Q. Okay. Can you give me a sense as to how much time you've spent reviewing those medical records?
A. I don't know the exact number, but I have spent some time.
Q. Okay. More than five hours, less than five hours?
A. Maybe three or four hours.
Q. Okay. And that's the total amount of time that you've spent?
A. I think so.
Q. Okay. And no problem, I know that you didn't sit down and keep track of the time, but I'm just trying to get a sense as to how much time you've invested into preparing for this deposition, and your answer is about three or four hours total?

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A. I would say so.
Q. Okay. Any of those hours spent within the last couple of days getting ready for your deposition?
A. Yes.
Q. About how many?
A. One or two.
Q. Thank you. At some point in time did you receive a copy of the notice of intent to sue in this case, it was something that looked like this?
A. Yes.
Q. Did you read it?
A. Yes.
Q. All right. Do you have an understanding as to the allegations that have been made against you in this case?
A. Yes.
Q. Can you tell me what your understanding of those allegations is?
A. So --
Q. I promise, I'm not trying to trick you with the question, I just want to know what you think this document says that you did wrong?
MR. SINKOFF: Well, let me just object because it's irrelevant what the notice of intent says. The case is based on your complaint, not on the

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notice of intent.
MR. WARWICK: Same objection.
BY MR. TAKALA:
Q. Go ahead. What's your understanding as to the claims that have been brought against you?
A. So let me clarify the question. So you are trying to understand what I understood from the claim, is that the question or --
Q. Yes, ma'am.
A. Okay. So you're trying -- my understanding is you are saying on the complaint that I did not do certain things that might have affected the patient's outcome, is basically what I'm understanding from the --
Q. Okay. And after reviewing those general allegations, do you believe you did everything that you were required to do as an internal medicine physician when treating Ms. Markel?
MR. SINKOFF: Object to the form.
A. Yes.
BY MR. TAKALA:
Q. Okay. And some of those things that the complaint and the notice of intent allege that you did wrong was failing to provide antibiotics, correct?
A. Yes.
Q. Did you provide any antibiotics to Ms. Markel?

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A. No.
Q. Okay. Were you required to provide any antibiotics to Ms. Markel pursuant to your standard of care?
MR. SINKOFF: Go ahead. You can answer.
A. No.
BY MR. TAKALA:
Q. And we'll get into the nitty gritty a little bit later, but, I'm sorry, I just can't help myself. There's also an allegation that you failed to contact Ms. Markel after some results of a urine culture came back positive. Do you remember reading that?
A. Yes.
Q. All right. Did you ever contact Ms. Markel regarding results of that urine culture?
A. No.
Q. Do you know whether you ever received a copy of the results of that urine culture?
A. Yes.
Q. Okay. When did you receive a copy of the results to that urine culture?
A. On October 12th, sometime during the day.
Q. And where would you have received it?
A. On the Epic chart.
Q. So when you log into the Epic chart, just explain to me how that works. Is there a result that pops up for

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each patient that you're assigned to?
A. No. So when you -- when I open the EMR, the Epic chart, there's a list of patients that are my current patient list. And then when you go into each patient's chart, there is a section for results that you have to open and then that will show up -- the results of the patient. For discharged patients, you have to look into their chart to get the results of the -- the outstanding -- outstanding results.
Q. Okay. So on October 12th Ms. Markel was a discharged patient, correct?
A. Correct.
Q. And you would have had access to click on her chart to get the results of that urine culture?
A. That's correct.
Q. And you would have had access to her phone number, correct?
A. Yes.
Q. And you would have had access to an emergency contact phone number, correct?
A. Yes.
Q. But you never contacted Ms. Markel with those positive urine culture results, did you?
A. No.
Q. Do you believe your standard of care required you to

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contact Ms. Markel with those positive urine culture results on October 12th when you saw them in the Epic computer?
A. No. Only if I'm planning to do all antibiotics or any kind of intervention with those results, I need to contact the patient.
Q. Okay. Fair enough. So I understand what you're saying, but let me get it out on paper, okay?
Did your standard of care -- and I'll take a yes or no answer and then I'll let you explain. Did your standard of care require you to contact Ms. Markel when you saw the positive urine culture results in the Epic system on October 12th, 2015?
A. No.
Q. Okay. And why is it that you did not contact Ms. Markel with those results?
A. Because it was not relevant to her care at that point.
Q. Okay. So you're saying that even in the face of a positive urine culture, she's not a patient that's indicated for antibiotic coverage?
A. Correct.
Q. And you hold that opinion to a reasonable degree of medical certainty?
A. Yes.
Q. Okay. And sorry I didn't ask you this and Steve

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brought up a fair point. This is the complaint that was filed in the circuit court. Did you ever have a chance to review the complaint?

A. Yes.

Q. Okay. Did you review the affidavits of merit that were attached to the back, signing on to the standard of care?

A. Yes.

Q. Okay. Have you had a chance to review any of the affidavits of meritorious defense that have been filed in this case on behalf of your care?

A. Yes.

Q. Okay. Did you help prepare any of those?

A. No.

Q. Do you know who signed those affidavits of meritorious defense?

A. I don't recall specifically.

Q. Do you know whether you had -- and, quite frankly, I don't have them with me or I don't have the names handy, but do you have any social relationship with any of the physicians that signed those affidavits of meritorious defense?

A. No.

Q. Do you know Dr. John Bonema, the primary care physician in this case?

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A. I don't know him personally.

Q. Okay. You have not authored any affidavits of meritorious defense in this case, have you?

A. No.

Q. You haven't authored any affidavits, period, in regards to this case, fair?

A. No.

Q. Okay. Have you performed any literature research to prepare for your deposition regarding whether antibiotic coverage is indicated in a patient like Ms. Markel?

A. No.

Q. Have you performed any literature research, period, regarding this case?

A. No.

Q. How did you learn about the standard of care in regards to which patients get antibiotics in the face of a positive urine culture and which don't?

A. From my medical knowledge from the medical school and residency.

Q. So that's something they taught you at T.D. Medical College?

A. Yes.

Q. And something they taught you in your residency program in Philadelphia?

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A. Correct.

Q. Is that anything that you've continued to study on since you completed your Philadelphia residency program in 2011?

A. Yes.

Q. How have you continued to study on that?

A. We do CMEs.

Q. And what's a CME?

A. A continuing medical education.

Q. Okay. And how do you do a CME, what do you read, where do you go, how do you research?

A. We have monthly business meetings. Also online, UpToDate researches. That's basically it.

Q. Okay. PubMed, do you use PubMed at all?

A. Yep.

Q. Do you use UpToDate?

A. Yes.

Q. And those are good resources where you go and you try and find the up-to-date information on evolving medical topics?

MR. SINKOFF: Object to foundation. You can answer.

BY MR. TAKALA:

Q. Right?

MR. WARWICK: Same.

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BY MR. TAKALA:

Q. Let me try and ask it differently and I'll let Steve and Don object to the question.

But UpToDate and PubMed are good sources to look to in order to keep abreast of the evolving medical education that you're participating in, right?

MR. SINKOFF: Object to foundation.

MR. WARWICK: Same.

A. Yes.

BY MR. TAKALA:

Q. Okay. Are there any other texts or sources of literature that you go to to try and keep yourself knowledgeable about the changes in internal medicine?

A. There are other continuing medical education courses that provide and --

Q. Who provides those -- I'm sorry if I cut you off?

A. No, it's, you know, certified continuing medical education courses.

Q. And would you sit for those courses, like -- I mean, are they conferences around the country, are they school, classroom-type --

A. Yes, sorry, conferences around the country.

Q. Okay. Any textbooks that you use in your practice of internal medicine?

A. No.

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Q. Do you use Harrison's?
A. I have learned it for the medical school and residency.
Q. Okay. Any other medical texts that you use, you've already told me that you use PubMed and UpToDate, any other texts that you use on a daily basis -- or a regular basis, I should say?
A. No.
Q. Okay. Are there any journals that you subscribe to to keep yourself informed about continuing medical topics?
A. Yes.
Q. What are those journals?
A. NEJM, New England Journal of Medicine.
Q. Anything else?
A. No.
Q. Okay. Have you done any research on NEJM regarding treatment of either upper or lower urinary tract infections?
A. No.
Q. Okay. Have you done any research on UpToDate regarding upper or lower urinary tract infections and the treatment that should occur?
A. No.
Q. Okay. Same question with PubMed?

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A. No.
Q. All right. Do you intend -- and maybe this is an unfair question and I'll give Steve his objection or I'll let him make it after I finish the question.
At this point do you intend to rely upon any literature for your position at the time of trial?
MR. SINKOFF: Object to foundation. That's a decision I'll make at the appropriate time.
MR. WARWICK: Same objection.
A. No.
BY MR. TAKALA:
Q. You've been continuously employed at Hospital Consultants, P.C.?
A. Yes.
Q. Since 2011 when you finished your residency program?
A. Yes.
Q. Sorry, that was a poor question. What is Hospital Consultants, P.C.?
A. It's an organization that employs physicians and contracts with the hospital, employed hospitalists, internal medicine physicians.
Q. Do you know how many physicians are employed by Hospital Consultants, P.C.?
A. I don't.
Q. I'll take your best guess. More than 20?

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A. I would say so.
Q. More than 40?
A. No.
Q. And if this is outside of your knowledge, that's fine, but do you know whether Hospital Consultants has a contract with any of the local hospitals to provide medical care?
MR. WARWICK: Foundation.
A. I don't know.
BY MR. TAKALA:
Q. Do you yourself have any contracts with Hospital Consultants, P.C. in your employment with that group?
A. Yes.
Q. Okay. Does that define the scope of your care and your responsibilities?
MR. SINKOFF: Object to the form of the question.
MR. WARWICK: Same.
A. Yes.
BY MR. TAKALA:
Q. Okay. It tells you what your responsibilities are as an employee of Hospital Consultants, P.C., correct?
A. Yes.
Q. Do you have privileges at the Beaumont Health System?
A. Yes.

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Q. Do you have privileges at any other hospitals in the local area?
A. No.
Q. Do you see patients at any other hospitals aside from Beaumont Royal Oak?
A. Yes.
Q. Okay. And I'm sorry that I don't know the answer to this question, but is that where you saw Ms. Markel, was it Beaumont Royal Oak?
A. Yes.
Q. Okay. What other hospitals do you see patients at?
A. Beaumont Troy.
Q. Any others?
A. No.
Q. Is there anything in your contract with Hospital Consultants, P.C. that designates the services that you should -- that you would provide to each hospital, Beaumont Royal Oak and Beaumont Troy?
MR. WARWICK: Just form and foundation.
MR. SINKOFF: What do you mean by services?
BY MR. TAKALA:
Q. Well, what I'm trying to figure out is the scope of the work that's to be performed pursuant to contract between Hospital Consultants the Beaumont facilities?
MR. SINKOFF: She gets a schedule when

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she's supposed to work and at which hospital and she goes and she acts as an internal medicine specialist.

MR. TAKALA: Is that written down anywhere?

MR. SINKOFF: I've never looked at the contract, but they don't -- I know that they don't designate do this, this and this.

MR. TAKALA: Okay. Fair enough.

MR. SINKOFF: Just go and practice.

MR. TAKALA: Understood.

BY MR. TAKALA:

Q. Just so I get your answer instead of Mr. Sinkoff's, do you have a schedule that tells you which hospitals to go to at which times?

A. Yes.

Q. Okay. Who makes that schedule, if you know?

A. It's Dr. Batke.

Q. Can you spell that?

A. B-A-T-K-E.

Q. Who is Dr. Batke?

A. He is with Hospital Consultants, P.C. He does the scheduling for all of us.

Q. Is he an administrator?

A. No.

Q. Okay. And sorry if I already asked this, but do you know whether Hospital Consultants, P.C. has any

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contracts with the Beaumont Health System?

MR. WARWICK: Just form, foundation.

A. I don't.

BY MR. TAKALA:

Q. Okay. Thank you. And by the way, I apologize, I did already ask that.

So tell me a little bit about what you do as a hospitalist at Beaumont Royal Oak or Beaumont Troy?

A. So I come in and there are patients assigned to me on a daily basis. I do a history and physical exam on the patient and formulate a plan for their diagnosis and treatment and discuss with patients' families, that is --

Q. And I suppose that -- and that's -- I know that your responsibilities probably go far beyond that, but that gives me a good outline.

Part of developing a plan of care would be discussing the patient's either history and future care with other medical personnel at the hospital, right?

A. Yes.

Q. Okay. And that would involve nurses, right?

A. Correct.

Q. And that would include consultants, correct?

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A. Yes.

Q. And may include emergency department physicians, correct?

A. Yes.

Q. May include physicians' assistants that are working in the emergency department, correct?

A. Yes.

Q. All right. Can you give me a sense as to how many patients you might be assigned on a typical shift?

A. Yes. I might have anywhere from 10 to 20 patients.

Q. And those are active patients that are either there to be screened for admission or patients that actually have been admitted to the hospital, correct?

A. Yes.

Q. Okay. Can you break down the 10 to 20 patients between the two categories that I've listed? And if that's a poor question, I'll try and do better.

A. So at a given day I might have 4 or 5 new admitted patients and then 10 to 12 patients already admitted to the hospital.

Q. Thank you very much. Do you work with residents at all?

A. No.

Q. Do you continue your care with any patients outside of the hospital setting?

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A. I did not quite understand the question.

Q. Yeah, fair enough, it was a bad question.

So you have responsibility for discharging patients that are assigned to your service at the hospital, right?

A. Yes.

Q. After you discharge a patient, you've told me that you have access to his or her chart and you could see new test results, right?

A. Yes.

Q. Would there ever be a circumstance where you would continue your care of a discharged patient outside of the hospital setting?

A. Yes.

Q. Okay. Explain to me those circumstances?

A. If there are outstanding culture results and that needs to be treated or some further action needs to be taken, then I contact the patient even -- even if they are discharged from the hospital.

Q. Okay. And how would you contact the patient?

A. Based on -- there's an inpatient face sheet that has the patient's information, so based on that.

Q. Okay. Good. And since you brought it up, I'll just mark as Plaintiff's Exhibit 2 the face sheet. This is probably what you're talking about?

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MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 2
2:30 p.m.

A. Yes. I have a -- I don't usually print it out, it's on the computer. So I have the information on the computer.

BY MR. TAKALA:

Q. Very good, thank you. But it would be a phone call that you would make to the patient if there was some sort of result that you thought needed to be acted upon, correct?

A. Correct.

Q. All right. And you've done that in your practice?

A. Yes.

Q. And can you give me a sense as to how often that happens?

A. Maybe three or four times a week roughly, it's not an exact number.

Q. Understood. And I appreciate you helping give me some guidance. And I -- this could probably happen with radiographic results, lab results, any sort of critical value that comes back after the patient is discharged, right, it doesn't have to be a culture?

MR. SINKOFF: Object to foundation -- actually the form of the question and the foundation.

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MR. WARWICK: Same.

A. It does with culture results.

BY MR. TAKALA:

Q. And is that because cultures take time to grow?

A. Yes.

Q. Okay. Instead of me answering the question for you, I should let you.

Why is it specific to culture results that you -- that you follow up with patients three to four times per week?

A. Culture results -- based on the results, if it needs to be acted upon, I would want the patient to get the treatment as soon as possible rather than waiting until they see their family doctor.

Q. Okay. And that happens about three or four times per week where you get culture results that need to be acted upon swiftly, fair?

A. Fair.

Q. In this case, I think that you had indicated that Ms. Markel should see her family doctor within two weeks of discharge, correct?

A. Correct.

Q. All right. If you felt it was necessary for Ms. Markel to act upon those positive urine culture results sooner, you would have called her?

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A. Correct.

Q. You do that in your practice three to four times per week?

A. Fairly.

Q. Okay. You don't have any administrative responsibilities in your position at Hospital Consultants, P.C., do you?

A. No.

Q. All right. And we kind of narrowed it down that there are 20 to 40 physicians that are employed by Hospital Consultants, P.C., rough estimate, fair?

A. Yes.

Q. Do you know whether there are any Dr. Ms in that practice? And I'll have difficulty saying the name, but are there multiple Dr. Ms or multiple physicians with the name beginning with M?

A. Yes.

Q. All right. Do you know which Dr. M was involved in Ms. Markel's care?

A. I don't.

Q. Okay. Do you know the names of each Dr. M?

Steven, I'm sorry, I just want her to do this without her looking at any notes.

MR. SINKOFF: Go ahead. Well, then make the record clear that -- because the name is clearly

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typed in the notes.

MR. TAKALA: Okay. Fair enough.

BY MR. TAKALA:

Q. Do you know which Dr. M was involved in this case?

MR. SINKOFF: With looking at the records or without?

MR. TAKALA: Without.

A. Without looking at the records? No.

BY MR. TAKALA:

Q. Okay. And one is Dr. Morariu, M-O-R-A-R-I-U, correct?

A. Yes.

Q. And one is Dr. Muraru, M-U-R-A-R-U?

A. Yes.

Q. Okay. And you've reviewed the records, right?

A. Yes.

Q. Do you know who you consulted from neurosurgery in this case?

A. Yes.

Q. Okay. What was that person's name?

A. Dr. Olson.

Q. Okay. Do you know the patient's primary care physician?

A. Yes.

Q. Who is that?

A. Dr. Bonema.

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Q. Okay. Do you know who the emergency room physician was in this case?
A. I don't know offhand, I have to look.
Q. Okay. And was there another hospitalist from your group that was involved in this case, if you know?
A. Yes.
Q. Okay. Do you know which -- do you know that doctor's name?
A. In the records?
Q. Well, yeah, the one that was involved in the care?
MR. SINKOFF: No, she's asking do you want her to look at the record.
BY MR. TAKALA:
Q. No, without the records.
A. Without the records, it was Dr. Muraru or Morariu.
Q. Okay. So --
MR. SINKOFF: Just -- it might help if you just use first names rather than last names just because they're pronounced fairly similarly?
MR. TAKALA: Yeah, fair enough.
MR. SINKOFF: One is a male and one is a female, that might help.
MR. TAKALA: Gotcha.
BY MR. TAKALA:
Q. Let's do it this way and then we'll do it Steve's way.

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Do you know whether it was Dr. Morariu, M-O-R-A-R-I-U, or Dr. Muraru, M-U-R-A-R-U, without looking at the records?
A. It's Muraru.
Q. And that's M-U-R-A-R-U?
A. Yes.
Q. Okay. And there's -- and in Steve's suggestion, there's an Ioana, I-O-A-N-A? Sorry if I'm saying that wrong.
A. Ioana, yeah.
Q. And M-I-H-A-I, can you help me --
A. Mihai.
Q. Okay. And one is a male and one is a female?
A. Yes.
Q. Which is the male and which is the female?
A. Mihai is male, Ioana is female.
Q. Okay. And do you have any independent recollection of a male hospitalist picking up at all during the care of Ms. Markel? Sorry if that's a bad question.
MR. SINKOFF: Object to the foundation.
MR. WARWICK: Same.
A. No.
BY MR. TAKALA:
Q. Okay. That's okay, we can move on. Does your -- strike that.

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Do your responsibilities change at all whether you are at Beaumont Royal Oak or Beaumont Troy?
A. No.
Q. And you told me that part of your responsibilities as a hospitalist is to do a history and physical, develop a plan, discuss conditions with family, correct?
A. Yes.
Q. Okay. You also agree that it's your responsibility to diagnose conditions, right, that would be part of the plan?
A. Yes.
Q. And treat conditions, part of the plan, right?
A. Yes.
Q. All right. Prescribe a course of action, that's included in the plan, right?
A. Yes.
Q. Okay. And follow up on healing, right?
A. If they're admitted to the hospital, yes.
Q. Okay. And in certain circumstances when they're discharged, right?
A. Yes.
Q. Okay. Sorry if I -- I know I already asked this, but 100 percent of your time is spent as a hospitalist?
A. Yes.

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Q. Okay. You don't see any patients in a clinical setting outside the hospital?
A. No.
Q. Have you ever had your privileges revoked, suspended or disciplined in any way?
A. No.
Q. Okay. Same question with your -- well, I should ask first, are you licensed to practice medicine in the State of Michigan?
A. Yes.
Q. Okay. Ever had any disciplinary action against your license in the State of Michigan?
A. No.
Q. Are you licensed to practice medicine in any other states?
A. No.
Q. Just tell me how it is that you came to treat Ms. Markel, if you -- if you know?
A. I was assigned Ms. Markel's case on October 10th, that's how I got her.
Q. Okay. And she came to the hospital on October 9th, right?
A. Yes.
Q. And you didn't see her until October 10th?
A. Correct.

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Q. And this was in 2015, correct?
A. Yes.
Q. All right. Three years ago -- more than three years ago?
A. Yes.
Q. All right. Do you have any -- and this is an important question and before you answer I'll make sure that we understand the term. I'm going to ask whether you had an independent recollection of treating Ms. Markel, okay? And when I use the term independent recollection, I mean something that you remember specifically about Ms. Markel, whether it be a conversation with her, a conversation with a family member, a conversation with a consultant, something that's not contained in the medical records.

Do you understand what I mean by independent recollection, first of all?
A. Yes.
Q. Okay. Do you have any independent recollection of treating Ms. Markel on October 10th, 2015?
A. No.
Q. Okay. You're just going solely based upon what you documented in the medical record, right?
A. Yes.
Q. Because if you're seeing 10 to 20 patients per day and

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you're working, whatever it might be, 200-some days per year, maybe 300 days per year, you're seeing, what, thousands of patients per year?
A. Yes.
Q. All right. By the way, did you have a typical schedule, typical days that you would work each week?
A. Yes.
Q. And what were those days?
A. So usually -- we have a winding up and winding down schedule. So Monday or Tuesday we start the week and then we continue taking new patients until the following Monday and then we start winding down where we don't take any new patients, but continue to discharge the patients. So at that time we work about 10 or 11 days.
Q. You did a fine job, I think, but the problem is I zoned out about halfway through it. So you work about 10 or 11 days in a row?
A. Yeah.
Q. Okay. And part of that schedule is winding up and part of it is winding down?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. And do you work the same number of hours each day?

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A. Not necessarily -- I mean, not necessarily. We carry the pager from 8:00 until 5:00 p.m. every day.
Q. And then at 5:00 p.m. you leave the hospital?
A. Correct.
Q. And the patient's service is transferred or no?
A. We have an on-call person who takes over from 5:00 p.m. until the next morning at 8:00.
Q. Got it. And are there occasions where you would have to take call in the middle of the night for your patients or does that on-call physician handle the responsibilities while you're not physically present at the hospital?
A. Yes, the on-call physician will take care of the responsibilities.
Q. Okay. So you're not getting calls in the middle of the night when your patients, whatever, spike a fever or something else happens?
A. Unless I'm on call that night, I won't be getting.
Q. How does your on-call schedule work?
A. Once or twice a month.
Q. And is that while you're on duty, like during this 10-to-11-day shift?
A. Yes.
Q. Okay. And when you take call what does that mean? I think I know what you mean, but just go ahead and

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explain for the record.
A. So when the nurses call for any issues, we answer them and then give the necessary guidance.
Q. Okay. Real briefly, let's try to go through this winding up and winding down work schedule. When you're -- so you typically start this 10-or-11-day stretch on a Tuesday or a Wednesday?
A. Could be Monday too.
Q. Okay. So the days vary?
A. Yep.
Q. But it will always be this block of 10 to 11 days?
A. Mostly.
Q. Okay. Understood. And explain to me the winding up and winding down portion one more time and I'll try and pay better attention to you?
A. Winding up is when you start taking new patients. So the first week that we are working, we will be taking new patients every day. The following week, the following Monday or Tuesday, we start winding down, meaning we don't necessarily take new patients, we keep on discharging the patients from our list.
Q. Okay. And I imagine, and maybe Dr. Batke or whoever helps out with the schedules can answer this, but I imagine that the hospitalist schedules are staggered; so when you're winding up, somebody else might be

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winding down?
A. Correct.
Q. Okay. Are there situations where you're winding down, but you can't discharge every patient from your roster?
A. Correct.
Q. What happens in that situation, does somebody else come on as the attending physician or do you stay on as attending?
A. Somebody else comes on as attending.
Q. Okay. So you wouldn't have any further responsibility for that patient, you would transfer it to whoever was taking over your spot as the hospitalist?
A. Yes.
Q. Okay. Do you know whether you ever met Ms. Markel prior to October 10th, 2015?
A. No.
Q. You know that you hadn't or you just don't know?
A. I know that I hadn't.
Q. Okay. Do you know whether you ever saw Ms. Markel after October 13th, 2015? And just to put things in context a little bit, you probably know this, but Ms. Markel is at Beaumont Royal Oak from October 9th through October 11th and then she comes back on October 13th.

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A. Correct.
Q. Okay. Do you know whether you ever saw -- and you did an H&P on October 13th.
A. October 14th.
Q. Okay. Fair enough. Do you know whether you ever saw Ms. Markel after October 14th?
A. Yes.
Q. Okay. Do you know what the last day was that you saw Ms. Markel?
A. October 16th.
Q. And then what happens on October 16th, does your service end for that 10-or-11-day period?
A. Correct.
Q. All right. And so her care is transferred to another physician?
A. Yes.
Q. In this case I think it was transferred to a Dr. Perry Greene. Do you recall seeing that?
MR. WARWICK: Just foundation.
MR. SINKOFF: Foundation.
A. No.
MR. WARWICK: Perry Greene is an orthopedic surgeon.
MR. TAKALA: Yeah, that's fair enough.
BY MR. TAKALA:

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Q. And the only reason I say that is because -- and I'll just -- I'll do this a little bit out of order, but I'm going to mark as Plaintiff's Exhibit 3 the discharge summary from November 2nd, 2015 and I'll show that to you.
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 3
2:43 p.m.
BY MR. TAKALA:
Q. Can you read who it says attending physician at the top?
A. Perry Greene.
Q. Okay. Is Dr. Greene a member of Hospital Consultants, P.C.?
A. No.
Q. Okay. Do you know -- and if you don't, it's fine, this may be unfair to you. Do you know whether Dr. Greene was the attending physician after you ended your service on October 16th, 2015?
MR. WARWICK: Just foundation.
MR. SINKOFF: If you know.
A. No.
BY MR. TAKALA:
Q. Okay. Thank you. And again, I don't mean to belabor this, but you don't remember independently meeting

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Ms. Markel for the first time on October 10th, correct?
A. Correct.
Q. You don't remember coming to her room, you don't remember who else was in her room or whether you saw her somewhere else in the hospital, correct?
A. No.
Q. All right.
MR. WARWICK: I'm not sure we have a clear record there. You're asking her questions about correct and she's saying no.
MR. TAKALA: Fair enough. Thank you, Don.
BY MR. TAKALA:
Q. Am I correct in my statement that you don't remember where you saw Ms. Markel when you first made contact with her on October 10th?
A. Yes.
Q. Okay. Thank you.
(Discussion off the record at 2:44 p.m.)
(Back on the record at 2:45 p.m.)
BY MR. TAKALA:
Q. When you are assigned to your 10-or-11-day shift at Beaumont Royal Oak do you wear a white lab coat?
A. Yes.
Q. All right. And do you wear credentials that indicate

who you are and that you're a physician?
A. Yes.
Q. And it says Beaumont Health System or something like that on the credentials?
A. Yes.
Q. Does it say Hospital Consultants, P.C.?
A. Yes.
Q. Okay. And that's on your credentials?
A. Yes.
Q. All right. Do you have a copy of your credentials here today?
A. No.
Q. Okay. Do you know whether you were wearing those credentials when you saw Ms. Markel on October 10th?
A. I don't have a specific recollection.
Q. Okay. But whenever you're in the hospital you're wearing a white lab coat and you're wearing your credentials, right?
A. Yes.
Q. So unless there was some unusual circumstances, you would have presented to her with a white lab coat and your picture and your ID, right?
A. Yes.
Q. Okay. Do you introduce yourself when you typically meet a patient for the first time?

A. Yes.
Q. How do you introduce yourself?
A. Dr. Lonappan.
Q. Okay. Do you say I'm Dr. Lonappan at Beaumont or I'm Dr. Lonappan at Hospital Consultants, P.C. or just I'm Dr. Lonappan?
A. I'm Dr. Lonappan.
Q. Okay. And you were assigned Ms. Markel's service by William Beaumont Hospital?
A. Yes.
Q. Okay.
MR. WARWICK: Just foundation.
BY MR. TAKALA:
Q. And again, just to test your memory and I know that you've already given me your answer, but you don't remember talking with any other healthcare providers about Ms. Markel on October 10th, do you?
A. No.
Q. You don't remember talking with her family about her condition, do you?
A. No.
Q. Okay. After spending three or four or five hours reading the records in preparation for the deposition today, did that trigger any recollection?
A. No.

Q. Okay. All right. The reason why I marked Plaintiff's Exhibit 2 -- well, one of the reasons -- and I think it reflects the same information on what I'll mark as Plaintiff's Exhibit 4.
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 4
2:47 p.m.
BY MR. TAKALA:
Q. Based upon Plaintiff's Exhibit 2 and Plaintiff's Exhibit 4, can you tell what time Ms. Markel presented to the hospital or when she hit the door, date and time?
A. On what day?
Q. Well, I'm asking you and I've given you -- Plaintiff's Exhibit 2 is the face sheet and Plaintiff's Exhibit 4 is some other demographic information about each patient's hospitalization and this is printed off from Epic.
A. Okay.
Q. Okay. And all I'm trying to do, and I promise, I'm not trying to trick you in any way, but I just want to define a couple of data points, okay?
A. Okay.
Q. And one of the data points is when Ms. Markel hits the door at Beaumont Hospital for treatment. Can you tell

that date and time based upon either of those records?
MR. WARWICK: Just object to the form.
A. No.
BY MR. TAKALA:
Q. Okay. And what is -- what is the date and time that she hits the door for treatment?
A. 10-9-15, 1713.
Q. And then on Plaintiff's Exhibit 5, which is a continuation of Plaintiff's Exhibit 4, there's several pages in between -- or actually there aren't, I think those are successive pages, at least when I print them out.
Can you tell from Plaintiff's Exhibit 5 when Ms. Markel was discharged from Beaumont Royal Oak, where she was signed off and she could go home?
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 5
2:48 p.m.
A. Yes.
BY MR. TAKALA:
Q. All right. And what's that date and time?
A. Discharge date, 10-11-2015. Time, 12:45 p.m.
Q. Okay. So between 10-9-15 at 1713 and 10-11-2015 at 12:45 she's there for less than 48 hours, right?
A. Yes.

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Q. Okay. And the first time you make contact with Ms. Markel is on October 10th, correct?
A. Yes.
Q. I'll mark as Plaintiff's Exhibit 6 your history and physical. Would this be the first -- I'll let you review that for a second.

MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 6
2:49 p.m.

BY MR. TAKALA:
Q. You've seen that document before, right?
A. Yes.
Q. Is the history and physical the first documentation in a patient's medical chart that you make when you're assigned a new patient?
A. Yes.
Q. All right. Can you tell based upon Plaintiff's Exhibit 6 what time you first made contact with the patient?
A. 10-10-15, 1441.
Q. And now in fairness to you, I know there are probably a couple different dates and times that are stamped on that note. Are you confident that 1441 represents the time that you would have encountered the patient and taken the history and physical from her?

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A. So can I explain?
Q. Sure.
A. Usually I see the patient and then I write down the history and physical. So, you know, like from -- 1441 is the time when I'm writing down the -- entering the records into the patient's chart.
Q. Okay. And do you actually make keystrokes or do you dictate?
A. It can be both. I mean, in cases where I dictate, I specifically say that in the notes.
Q. Okay. And it's your habit and practice and -- that when you start a note, you would have been typing between 1441 and then finish it, however long it takes you to make that history and physical, right?
A. Yes.
Q. All right. And then do you usually sign the note after you finish the dictation or the keystrokes?
A. Yes.
Q. All right. Can you tell me what time you signed the note in this case, and I'll try to help you?
A. I don't see --
Q. You might be right, it might not be on here.

MR. SINKOFF: It's not on here.
MR. TAKALA: Okay. No problem.

BY MR. TAKALA:

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Q. All right. If you go to page 1, sorry, there's a file time. Do you know what that file time represents? In this case it's 1633 and in fairness to you that's, whatever, about an hour and 45 minutes after you start your note.
A. Yep, yes.
Q. Do you know what that file time represents?
A. That's when we signed the note and it's filed to the system.
Q. Okay. And I don't want to belabor this too much, but what does it involve in doing a history and physical with a new patient at the hospital at Royal Oak like Ms. Markel?
A. Okay. So going in and see the patient, you -- I get her medical history, get the history of present illness, which is why she came into the hospital, the details of that. And we go through the past medical history, surgical history, family history, medication list, allergies and then physical examination.
It's reviewing the data, which involves the lab results and imaging studies. And then the impression and plan, which is what the active medical problems are and what the treatment would be for that medical problems.
Q. Okay. Using -- and thank you, I appreciate your

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patience with me to understand that process.
You're not responsible for the patient prior to seeing her on October 10th at 1441, right?
A. Yes.
Q. You can't be responsible for somebody that you haven't seen, right?
A. Correct.
Q. Okay. After you do that history and physical, is Ms. Markel your responsibility as a hospitalist at Beaumont Royal Oak?
A. Yes.
Q. Okay. And that continues up until Ms. Markel's discharged on October 11th at 12:45, true?
A. Yes.
Q. Okay. And fair to say that -- and I know that you don't believe that Ms. Markel should have been contacted because she didn't need any antibiotics, but using a hypothetical question, if there was a culture result that came back positive and Ms. Markel needed to be contacted, would that be your responsibility to contact her after she was discharged as her attending physician?
A. Yes.
Q. Okay. And so, for the example, let's say it was a blood culture and the blood grew a positive bacteria,

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would that be a situation where Ms. Markel needed to be contacted?
A. Yes.
Q. Your standard of care would require you to pick up a phone and call her and let her know that result, right?
A. Yes.
Q. All right. And that's true even though you're not the one who ordered that culture, right?
A. Yes.
Q. Okay. And that's due to your responsibility as the attending physician?
A. Yes.
Q. Okay. If you know, fine, and if not, you let me know that it's an unfair question. Do you know who's responsibility for Ms. Markel's care prior to your involvement on October 10th at 1441?
MR. WARWICK: Just object to foundation.
MR. SINKOFF: Prior to -- while she's in the hospital?
MR. TAKALA: Yeah.
MR. WARWICK: Foundation.
BY MR. TAKALA:
Q. If you don't know, it's okay.
A. No.

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Q. Okay. Who decides to discharge a patient?
A. The attending physician does.
Q. Okay. And in this case it was your decision to discharge Ms. Markel, right?
A. Yes.
Q. Okay. Do you consult with any other medical personnel in your normal habit and routine before you discharge a patient or is this something that you do so frequently you know when a patient needs to be kept and when a patient can be discharged?
MR. SINKOFF: Object to the form and foundation.
MR. WARWICK: Same.
A. Yes.
BY MR. TAKALA:
Q. Okay. Which one? I'm sorry, it was a bad question.
A. I know when I -- when the patient is ready for discharge.
Q. Okay. So you don't need to speak with other consultants and get them to sign off, it's your decision and you're comfortable making that decision when you're presented with a patient like Ms. Markel, correct?
A. When other consultants are on the case, I do make decisions based on their input as well.

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Q. Okay. But before making the decision to discharge a patient like Ms. Markel, do you pick up the phone or try and track down these consultants in the hospital and ask whether it's okay to discharge the patient or do you make that decision on your own?
A. I make the decision on my own.
Q. Okay. And in fairness to you, there are probably some patients that have a different history that may require input from other consultants before you make that decision, right?
A. Yes.
Q. All right. Do you remember any conversations with any other medical personnel; nurses, P.A.s, consultants, ER docs, anybody prior to discharging Ms. Markel on October 11th at 12:45?
A. No.
Q. All right. Does that mean that it didn't happen -- or strike that.
Let me try and do it differently. If you did have a conversation with other medical personnel, would you have noted that in your discharge summary?
A. Not always.
Q. Okay. By the way, if you need to take a break at any point, you just let me know, okay? It's not necessarily an endurance contest -- in fact, it's

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definitely not an endurance contest.
A. Okay.
Q. On Plaintiff's Exhibit, I think it's 4 -- I'm sorry, it's actually 5, under -- and I don't know if I highlighted it or not, but under unit it says 6-ST GYN team. Does that have any significance to you?
A. It says 6 South, gynecology team.
Q. Okay. Was Ms. Markel admitted to a gynecology service?
A. No.
Q. Okay. And does the reference to care A have any special meaning to you?
A. No.
Q. All right. Prior to your involvement with Ms. Markel did you see that a urinalysis had been ordered?
A. Prior to my involvement?
Q. Yeah.
A. No.
Q. Okay.
MR. WARWICK: Form of the question.
MR. SINKOFF: The question is -- the form is disastrous --
MR. TAKALA: You're right. Let me --
MR. SINKOFF: -- at best.
MR. TAKALA: Thanks for --

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MR. SINKOFF: I couldn't think of another word.

MR. TAKALA: -- putting it politely, but I do agree.

MR. SINKOFF: What he's trying to ask is when you saw this patient, were you aware there were prior urinalyses done?

A. Yes.

MR. TAKALA: Now Steve is asking questions and answering them, both.

MR. SINKOFF: That's what happens when you've been around for a while.

MR. TAKALA: You should get paid for both sides of the table.

MR. SINKOFF: Okay.

BY MR. TAKALA:

Q. He's right though. Okay. What I'm trying to find out is when you do your history and physical at 1441 on October 10th, do you have access to prior test results?

A. Yes.

Q. Okay. And I know you don't have an independent recollection, but that's probably something you would have went back in the chart and looked at when you're performing your history and physical, correct?

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A. Yes.

Q. All right. And you would have seen that a urinalysis had been ordered, right?

A. Yes.

Q. And it was ordered by somebody in the emergency department?

A. Yes.

MR. WARWICK: Just objection to foundation.

BY MR. TAKALA:

Q. Okay. Do you know why that urinalysis was ordered?

A. No.

Q. Okay. Do you know whether it demonstrated any abnormal results?

A. When I reviewed the records, yes, I know.

Q. Okay. And that's something you would have had access to when you performed your history and physical on October 10th as well?

A. Yes.

Q. All right. What are the abnormalities when you reviewed the record that you were able to identify on the urinalysis?

A. Can I use the --

Q. Yes, sure, please.

MR. WARWICK: I'm not sure she has the same page of the records I sent to you, but there should be a little Bates stamp if she did, would you be kind enough to --

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MR. SINKOFF: Yep, let her get to it.

MR. WARWICK: Great.

A. Yes.

MR. SINKOFF: Page 75.

MR. WARWICK: Thanks a lot.

BY MR. TAKALA:

Q. Can you give me the date and time of the urinalysis that you're looking at?

A. 10-9-15, 2323.

Q. Bear with me while I catch up.

MR. SINKOFF: 852 on the hospital's pages -- 862.

MR. TAKALA: Thank you.

BY MR. TAKALA:

Q. So go ahead and tell me what's abnormal about this urinalysis from 2323 on October 9th?

A. Leukocytes, 2 plus. WBC, 11 to 25. Epithelial squamous, 6 to 50. Crystal calcium oxalate.

Q. What does it mean when the leukocytes are 2 plus?

A. It means there is WBCs in the -- there is leukocytes in the urine.

Q. And is that an indication of an infection?

A. No.

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Q. Is that an indication of bacteria?

A. No.

Q. What's the -- what does it indicate to you as a hospitalist?

A. It indicates inflammation.

Q. And that inflammation can be coming from a lot of different sources, right?

A. Yes.

Q. One of those is infection?

A. Yes.

Q. All right. The WBC, 11 to 25 range, that's abnormal as well you told me?

A. Yes.

Q. Same answer, it demonstrates inflammation?

A. Yes.

Q. And that can be caused by infection, right?

A. It could be.

Q. And it could be caused by other things as well, right?

A. Yes.

Q. The epithelial squamous range, that's abnormal you told me?

A. Yes.

Q. Same thing, is that an inflammatory response?

A. No, it means it's not a clean urine sample.

Q. Okay. And help me understand as a layperson when --

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what you mean by not a clean urine sample?
A. Meaning normally for a clean urine sample we need a midstream urine sample, which means not the first urine that comes out because the first urine that comes out has some epithelial cells that's at the orifice of the urethra. So midstream urine sample is the ideal urine sample, which does not have any epithelial cells.
Q. Okay. And then the squamous cells, what's the importance of that?
A. That's the kind of cell, is called a squamous cell.
Q. And is that at the start of the urine stream, the end, both?
A. Yeah, it's usually at the start of the urine --
Q. All right.
A. -- sample.
Q. The calcium oxalate crystal result, you noted that as abnormal as well, right?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. What does that indicate to you as a hospitalist?
A. That's not necessarily indicating anything -- anything specific.
Q. Okay. I'm a layperson asking the question. Is it an

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inflammatory response, is it a potential bacteria, help me -- give me -- help give me the four corners?
A. It just indicates that there were some crystals in the urine.
Q. How can crystals becomes present in the urine, what causes that?
A. Dehydration could be one of the causes.
Q. What else?
A. There are other causes that -- I'm not exactly -- I don't exactly recall all the causes.
Q. Is it -- can infection be a cause of crystal formation in the urine?
A. No.
Q. Okay. Is dehydration -- or can dehydration be a symptom of infection?
A. No.
Q. Okay. Did you make any determination as to what was going on to cause these inflammatory responses in Ms. Markel on October 10th?
A. There was no symptoms to look for that --
Q. Okay. So --
A. -- responses --
Q. Sorry. So there were a couple of these inflammatory biomarkers on her urinalysis, but you didn't make a determination as to what was causing these

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inflammatory biomarkers?
A. It was not needed to look for the cause.
Q. No problem. And I understand what you're saying, but just so the question and answer is clear on paper, you didn't make any determination as to what was causing these inflammatory biomarkers on Ms. Markel's urinalysis?
MR. SINKOFF: Asked and answered.
MR. WARWICK: Same.
BY MR. TAKALA:
Q. Yes or no?
MR. SINKOFF: Well, no, she can explain her answer.
A. I'm sorry?
MR. SINKOFF: You can answer any way you want to. He can't limit you to yes or no.
A. Yeah, so a test becomes relevant only if there are any symptoms that needs to, you know, follow up on so --
BY MR. TAKALA:
Q. And what are the symptoms of a urinary tract infection?
A. Urinary tract infection symptoms are urinary frequency, urinary urgency, dysuria, hematuria, suprapubic pain.
Q. How about an upper urinary tract infection?

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A. You can have fevers and chills. Those are all symptoms of urinary tract infection.
Q. Flank pain?
A. Flank pain.
Q. Nausea, vomiting?
A. Could be, not specific for urinary tract infection.
Q. What is -- fair enough. But that can be a symptom of an upper urinary tract infection, right?
A. It can be.
Q. Okay. And that -- and sorry if I'm saying this wrong, but pyelonephritis?
A. Pyelonephritis.
Q. Thank you. And a lower urinary tract infection is cystitis?
A. Yes.
Q. Okay. And each one has different signs and clinical symptoms, right?
A. Yes.
Q. And you just listed those for me?
A. Yes.
Q. What is costovertebral angle tenderness?
A. Costovertebral angle tenderness, it's pain at the site of kidney location, near the patient's back.
Q. Can you help define a fever for me, is there a certain cutoff?

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A. In the normal patient, 99.9 or more can be considered as a fever.
Q. Okay. Did Ms. Markel have a temperature that was greater than 99.9 at any point between October 9th at 1713 and October 11th, 2015 at 12:45?
A. Yes.
Q. Okay. Did Ms. Markel have any flank pain between those two bookends?
A. No.
Q. Okay. What is flank pain?
A. Flank pain is pain at the site of -- it's pain in the flank, site of kidney.
Q. Now, when you -- you just kind of reached and you kind of reached on your side, like lower back side, right?
A. No. It's in -- you know, in the flank, which is --
MR. SINKOFF: The side.
A. Which is the side.
BY MR. TAKALA:
Q. Okay. Ms. Markel did have lower back pain on this admission, right?
A. Yes.
Q. And it did radiate, correct?
A. Radiate down her legs, yes.
Q. Okay. Did you -- were you able to diagnose or come up with a reason for that radiating lower back pain?

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A. Yes.
Q. What was that?
A. It was lumbar radiculopathy.
Q. And that was part of your plan, right?
A. Yes.
Q. And that was part of your impression, right?
A. Yes.
Q. You actually ordered a consultant to help address that problem, right?
A. Yes.
Q. And you actually told Ms. Markel that she should go for an epidural injection the following day?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. Okay. Obviously you would have had access to consult an infectious disease specialist if you felt it was appropriate, right?
A. Yes.
Q. All right. And you've done that in your practice before, fair?
A. Yes.
Q. All right. And if you had come to the conclusion, in a hypothetical question, that infection, whether it was an upper or lower urinary tract infection, was

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part of the diagnosis, you would have had an infectious disease specialist available to you to consult if you felt it was necessary, right?
A. Yes.
Q. Okay. And is it within your scope of practice and expertise to prescribe antibiotics for either an upper or lower urinary tract infection?
A. Yes.
Q. And are there some cases where antibiotics are indicated for either an upper or lower urinary tract infection?
A. Yes.
Q. Does it differ -- does the criteria differ for lower urinary tract infection versus an upper urinary tract infection?
A. I did not understand the question.
Q. No problem. Is there a different criteria or a different patient population which you would prescribe antibiotics for for a lower urinary tract infection or cystitis versus pyelonephritis?
A. If it is determined that the patient has infection, even if it's for -- even if it is lower or upper, we would provide antibiotics.
Q. Okay. Was it ever determined that there was an infection, either in the upper or lower urinary tract,

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in Ms. Markel?
A. No.
Q. Okay. The fact that the culture grew out, did it grow out bacteria?
A. Yes.
Q. All right. Does that give you an indication as to whether there was bacteria in the urine?
A. It indicates bacteria in the urine.
Q. Okay. Fair enough. I'm going to take a step back for one second. There was another urinalysis that was performed and this, I believe, is on the same page, page 62 from the packet of records that Don provided, I believe? Do you see --
MR. WARWICK: I'm not sure, what's the number on the --
MR. TAKALA: I've got some -- off the record.
(Discussion off the record at 3:10 p.m.)
(Back on the record at 3:10 p.m.)
BY MR. TAKALA:
Q. So I'm looking at a urinalysis from October 10th, 2015 at 2201. Do you see that on your page or can you locate that in your chart?
A. 2201, yes.
Q. And it looks like it was ordered by an individual by

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the name of Janay, J-A-N-A-Y, Warner, W-A-R-N-E-R?
A. Yes.
Q. Okay. Do you know Janay Warner?
A. No.
Q. Okay. Do you know who Janay Warner is employed by?
A. No.
Q. Okay. These results from this urinalysis at 2201 on October 10th, are there abnormal results from that urinalysis?
A. Yes.
Q. Can you just go through and indicate to me what's abnormal about that UA?
A. Ketones, trace. There is nitrates negative -- or leukocyte S trace 2 plus, which is abnormal. RBC, 5. WBC, more than 100. Epithelial squamous, 21. Casts --
Q. All right.
MR. WARWICK: So just -- I'm sorry for interrupting, but just so -- so we all have the same pages, that page of records with those results are on page 2456 of the records I provided to everyone, if you need to reference it in the future -- or if we all need to reference it together.
MR. TAKALA: Got it. Thank you, Don.
MR. WARWICK: Thanks.

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BY MR. TAKALA:
Q. Let's -- we'll try to get through this quick, I'm falling behind where I probably should be.
The ketones, the trace amount of ketones, what does that indicate to you?
A. When you're dehydrated and when you're not eating much, it could cause ketones in your urine.
Q. Okay. And we already talked about the leukocytes and the epithelial and the white blood cell count, those are -- well, strike that.
The leukocytes and the white blood cell counts are inflammatory markers, right?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. And the epithelial is the sign of a bad catch?
A. Correct.
Q. What's the significance of the RBC coming in at 5?
A. There are some blood in the urine.
Q. Did you come up with any diagnosis or understanding as to what was causing the blood in the urine?
A. No.
Q. The casts, what is -- what's the significance of the casts or the presence of casts in the urine?
A. It means -- dehydration can cause hyaline casts in the urine.

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Q. Okay. Thank you. Sorry I'm going back and forth a little bit, but you told me that there are some patients with cystitis that you would treat with antibiotics?
A. Yes.
Q. Do you treat all patients with cystitis with antibiotics?
A. If they are -- yeah, if there is determined to be an infection and cystitis, yes.
Q. Okay. Same question with pyelonephritis, do you treat all patients with pyelonephritis with antibiotics?
A. Yes.
Q. Do you have an opinion as to whether Ms. Markel had either -- well, I'll ask them one at a time.
Do you have an opinion as to whether Ms. Markel had cystitis?
A. She did not have cystitis.
Q. Okay. Do you have an opinion as to whether she had pyelonephritis?
A. She did not have pyelonephritis.
Q. Do you have an opinion as to what was causing the bacteria in the urine that grew out from the culture?
A. It is a contaminated specimen and it is called asymptomatic bacteria.

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Q. Okay. When -- you saw -- you saw Ms. Markel on October 14th, 2015 when she came back to the hospital, right?
A. On October 14th, yes.
Q. Okay. Was she infected at that point in time?
A. There was a suspicion for infection.
Q. Okay. Where was the infection?
A. In her joints.
Q. Do you know whether there was any bacteria in the urine at that point in time?
A. When she came back?
Q. Yeah.
A. I knew from the previous culture that -- from the 10-11 culture that she had bacteria in the urine.
Q. Okay. After Ms. Markel comes back and you get more of the story, so to speak, and you come to the conclusion that there's a joint infection, did that give you any indication as to whether the bacteria that grew out in the urine was a contaminated specimen or a good result?
MR. SINKOFF: Object to the form.
MR. WARWICK: Same.
BY MR. TAKALA:
Q. Let me try and do better. Knowing what you knew on October 14th, knowing that Ms. Markel had a joint

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infection -- are you with me?
A. Yes.
Q. Are you still of the opinion that the urine that grew out bacteria on October 12th that was collected, I think on --
A. The 10th.
Q. -- October 10th was from a contaminated source?
A. Correct.
Q. Do you ever treat patients -- when I use the word empirical treatment, what does that mean to you in the field of medicine, I just want to make sure we're talking about the same thing?
A. You are treating a patient with antibiotics without specific signs of infection.
Q. Do you ever treat patients empirically for infection?
A. It depends on the kind of patients that you're treating.
Q. Okay. How about a patient with a history of joint replacement with inflammatory urinalysis, is that a patient that you would treat empirically with antibiotics?
MR. SINKOFF: Object to foundation and form.
MR. WARWICK: Same.
A. No, unless the patient has symptoms.

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BY MR. TAKALA:
Q. Okay. And those symptoms?
A. Of urinary tract infection.
Q. And that would include fever of greater than 99.9, right?
A. If it's persistent, yes.
Q. Okay. And that would include flank pain, right?
A. Yeah.
Q. And that would include nausea and vomiting, right?
A. Again, not just nausea and vomiting, it's not a symptom of infection.
Q. Fair enough. But --
A. So if you have other -- flank pain and fever, persistent fever, along with urinary tract infection symptoms.
Q. Okay. Did Ms. Markel have any nausea and vomiting between October 9 and October 11th?
A. Not that I can recall.
Q. Okay. Bear with me just one second.
So the -- where I get vomiting from, and maybe it was somewhere else I saw it in the chart too -- if you want to flip to Plaintiff's Exhibit, I think it's 2, it's your H&P from October 10th -- I'm sorry, it's 6?
MR. WARWICK: What's the date and time of

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this report?
MR. TAKALA: So I don't have the same Bates stamp. On the exhibit --
MR. SINKOFF: 10-10, 1441.
MR. WARWICK: Thanks.
BY MR. TAKALA:
Q. Go to the last page. So if you go to -- I don't know whose typing that is, maybe it's yours, maybe it's somebody else's; can you tell me?
A. It's mine.
Q. All right. You say MRI of the lumbar spine, dash, multilevel, mild vomiting and severe stenosis of the central spinal canal.
When you say mild vomiting, what does that mean?
A. That was -- so the voice processing software error that happened there.
Q. Okay. Do you know what you meant there?
A. Multilevel mild, moderate and severe stenosis would have been right.
Q. What was the word again?
A. Moderate.
Q. Moderate?
MR. SINKOFF: It's hard to have vomiting in the spinal canal.

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MR. TAKALA: No, I get it. I understand.
BY MR. TAKALA:
Q. Thank you for helping me with that. Getting back to what got me to this point in the first place though, there are some patients that you would start on empiric antibiotics, fair?
A. Yes.
Q. Okay. And those would involve patients that are demonstrating signs of either cystitis or pyelonephritis, right?
A. Yes.
Q. All right. Would your standard of care require you to start a patient on empiric antibiotics with signs of pyelonephritis?
MR. SINKOFF: Object to the foundation, it doesn't give enough information.
MR. WARWICK: Same.
BY MR. TAKALA:
Q. I think you just answered the question for me, but I'll -- I think you just said yes?
MR. SINKOFF: No, she didn't say yes, this is a different question.
MR. TAKALA: Okay. We'll read the transcript later and I'll ask the question again.
BY MR. TAKALA:

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Q. Would you start a patient on empiric antibiotics with signs of pyelonephritis?

MR. SINKOFF: Object to the foundation, it doesn't contain sufficient information to answer that question.

MR. WARWICK: Same.

MR. SINKOFF: You can answer subject to the objection.

A. Can you explain more?

BY MR. TAKALA:

Q. Sure. If a patient has fever, flank pain and nausea and vomiting, for example, would you start empiric antibiotics for pyelonephritis?

A. No.

Q. Okay. And if a patient has fever, flank pain, nausea, vomiting and chills, do you start that patient for pyelonephritis?

A. If she -- if the patient has symptoms of -- urinary symptoms of UTI, which I described earlier as frequency, urgency, dysuria, hematuria.

Q. Okay. So in order for you to start empiric antibiotics for pyelonephritis you would need to see dysuria, frequency, urgency, suprapubic pain or hematuria?

A. Hematuria, along with flank pain and persistent

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fevers.

MR. WARWICK: I think your question said, or, and I just object to the form so -- go ahead. I didn't mean to interrupt.

MR. TAKALA: That's fine. It's a fair objection, I understand.

BY MR. TAKALA:

Q. Do you need to see multiple symptoms -- or problems with urination before you start empiric antibiotics for a urinary tract infection?

A. At least some symptoms, some urinary symptoms.

Q. Does that mean at least one?

A. Yes.

Q. Okay. So any one of the dysuria, frequency, urgency, suprapubic pain or hematuria?

A. Yeah.

Q. Okay. In addition to temperature and flank pain, right?

A. Correct.

Q. All right. Was there any indication in the chart from the emergency department notes or otherwise that Ms. Markel was having problems with urination at all?

A. It said -- there was some mention of inability to urinate.

Q. Okay. What is that called in medical terms?

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A. Inability to urinate.

Q. Okay. Is that a sign of cystitis?

A. No.

Q. All right. Were there any other comments made about the frequency or anything else about Ms. Markel's urination either in the emergency room or upon your examination?

A. Yes. I did mention in my history and physical that patient was able to urinate -- was able to urinate.

Q. Got it. Do you know who ordered the culture in this case, I think it was the same P.A. that I had mentioned before?

A. Yes.

Q. All right. Do you know -- again, if you don't know, it's fine, but I'm here to ask the questions. Do you know why that culture was ordered?

MR. WARWICK: Well, just object to the form. I think you -- you asked two questions in one there and I'm not sure which question she answered about knowing the P.A. She previously said she didn't know the P.A. and then you said -- you asked a second part of the question. I just want to make sure the record is clear. It's my understanding the P.A. doesn't know this doctor, but go ahead.

MR. TAKALA: Fair enough.

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BY MR. TAKALA:

Q. Do you know the P.A. that ordered the urine culture, that's Janay Warner?

A. Do I personally know her, is that the question or --

Q. Yeah.

A. No.

Q. Okay. Now, do you know why P.A. Warner ordered the urine culture in this case?

A. I do not know.

Q. Thank you.

MR. WARWICK: Thanks. Sorry, I apologize for interrupting.

MR. TAKALA: You don't have to apologize, it's not a problem.

BY MR. TAKALA:

Q. Have you ordered urine cultures in your practice as an internal medicine physician --

A. Yes.

Q. -- seeing patients in the hospital?

What would -- what would lead you to order a urine culture in your practice?

A. If the patient has urinary symptoms of UTI, like hematuria or dysuria, frequency, then I order urine culture and urinalysis.

Q. Okay. No other circumstances where you're ordering a

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urine culture except for urinary symptoms that include either dysuria, frequency, urgency, suprapubic pain or hematuria?

A. It depends on the patient population too.

Q. Okay. Help me understand a situation where you would order a urine culture in the absence of one of these urinary symptoms?

A. If a patient is immunocompromised, then -- and they present with signs of infection, then we order -- trying to figure out what the source of infection is, usually order urinalysis and a urine culture.

Q. Okay. Was Ms. Markel immunocompromised in any way?

A. No.

Q. Okay. Did she have any signs of infection that you saw?

A. No.

Q. Okay. Are there any other circumstances in your practice as an internal medicine doctor in the hospital that you would order a urine culture that I'm missing?

A. In elderly patients when they present with a change in their mental status, trying to figure out if there is an underlying infection, you can order a urinary analysis and urine culture.

Q. Okay. And Ms. Markel was not elderly and she didn't

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have a change in mental status, right?

A. Yes.

Q. My statement is correct, thank you. Any other situations where you would order a urine culture in your practice aside from what we've talked about already?

A. No.

Q. Okay. And when I have -- when I have the chance to talk with P.A. Warner, I can ask P.A. Warner this question, but if there were no urinary symptoms, there was no dysuria, frequency, urgency, suprapubic pain, hematuria, wasn't an immunocompromised patient and it wasn't an elderly patient that had mental status changes, there's no reason why you would order a urine culture in your practice, right?

A. In a young, healthy -- otherwise healthy patient, yes, I would not order.

Q. Okay. Is there any increased risk of infection for patients that have a history of artificial joints?

A. Just because of the artificial joints?

Q. Yes.

A. No.

Q. Okay. Did you know that Ms. Markel had artificial joints when you took your history and physical on October 10th?

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A. Yes.

Q. And, I'm sorry, I didn't see it in there maybe, I was -- didn't -- maybe I missed it. Did you note it in your history and physical that I marked as Plaintiff's Exhibit 6?

A. Say under past surgical history.

Q. And in fairness to you, you do have it in here. Arthroplasty, total knee left, arthroplasty, total knee right?

A. Correct.

Q. Okay. Thank you. Do you treat patients with a history of artificial joints differently when it comes to antibiotic treatment?

A. No.

Q. Okay. Does the -- strike that.

Sorry to cover ground that we've already been over and I appreciate your patience with me. Agree that these are clinical manifestations of cystitis, okay? Dysuria?

MR. SINKOFF: Object to -- this has been asked and answered at least three times already.

MR. TAKALA: You're right, and I -- but I still want to make sure we go over this.

BY MR. TAKALA:

Q. Dysuria, yes or no? It will take 20 seconds.

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A. Yes.

Q. Frequency?

A. Yes.

Q. Urgency?

A. Yes.

Q. Suprapubic pain?

A. Yes.

Q. Hematuria?

A. Yes.

Q. Am I missing anything?

A. No.

Q. Okay. Again, bear with me for ten seconds. Signs of pyelonephritis include elevated temperature?

A. Persistently elevated, yes.

Q. Okay. Meaning persistently elevated above 99.9?

A. Yes.

Q. Okay. Chills?

A. Yes.

Q. Flank pain?

A. Yes.

Q. Nausea and vomiting?

A. Yes.

Q. Am I missing anything?

A. Urinary symptoms.

Q. Okay. Anything else that we could add to that list,

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signs of pyelonephritis?
A. No.
Q. Okay. What's the antibiotic of choice for cystitis?
MR. SINKOFF: In an otherwise healthy young person?
MR. TAKALA: Yeah, well, let me ask that question first.
BY MR. TAKALA:
Q. In an otherwise young, healthy patient, do you prescribe antibiotics for cystitis?
A. Yes.
Q. Okay. What antibiotics?
A. We can do either Macrobid or Bactrim, usually the common choices.
Q. Are those oral antibiotics?
A. Yes.
Q. Okay. Same question for pyelonephritis, do you prescribe antibiotics for an otherwise young, healthy patient with pyelonephritis?
A. Yes.
Q. What's the antibiotic of choice for pyelonephritis, same or different?
A. Depends on the severity of the infection. The patient can be treated as an outpatient, usually we do Ciprofloxacin. If the patient is admitted to the

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hospital with pyelonephritis we can do IV ceftriaxone.
Q. And this is all within the scope of an internal medicine physician or would you consult an ID specialist when you're choosing antibiotics for a pyelonephritis patient?
A. We do not have to always consult infectious disease. Internal medicine physicians can treat pyelonephritis.
Q. And in a young, otherwise healthy patient who you suspect to have pyelonephritis, are you managing the antibiotic treatment?
A. Yes.
Q. All right. Same question with cystitis, you're managing the antibiotic treatment?
A. Yes.
Q. Okay. When you have signs of pyelonephritis -- and I'll apologize to Steve if I already asked this question -- would you start empiric antibiotics in certain patients?
MR. SINKOFF: Object to asked and answered at least twice.
A. Based on the -- as we discussed previously, immunocompromised patients we do start empiric antibiotic treatments.
BY MR. TAKALA:
Q. Okay. Any other groups of patients that you would

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start empiric antibiotics on with signs of pyelonephritis?
A. If I'm suspecting pyelonephritis, is that -- does that clarify the --
Q. Yes, ma'am.
A. -- I mean, is that what you're asking?
Q. Yes, ma'am.
A. If I'm suspecting pyelonephritis, I would treat the patient with antibiotics.
Q. On an empiric basis before cultures came back?
A. Yes.
Q. All right. Would you order cultures as well?
A. Yes.
Q. All right. Is that the same for cystitis, if you suspect cystitis do you start a patient on empiric antibiotics without --
A. Without culture results?
Q. Correct.
A. Yes.
Q. Okay. And that's true in an otherwise young, healthy patient?
A. If the patient has symptoms of acute cystitis, yes.
Q. Go it. Thank you. You agree that one of the reasons why you prescribe or start empiric antibiotics is because that's important and affects the outcomes, it

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prevents the infection from spreading? Sorry if I did bad with that question.
MR. SINKOFF: Object to foundation.
A. Yeah, you'll have to --
BY MR. TAKALA:
Q. Okay. Is there a reason why you start empiric antibiotics before you get the culture back?
A. Yes.
Q. Why?
A. To prevent the infection from spreading.
Q. Why is it bad if an infection spreads?
A. It can get to your bloodstream and can go to different parts of your body.
Q. What happens if it gets in the bloodstream, the infection?
A. The infection can go to the different parts of your body.
Q. Can a patient die from an infection in the bloodstream?
A. Yes.
Q. Okay. What happens if an infection gets into the joints, is that bad?
A. You get septic arthritis.
Q. Okay. And you agree that it is important to stop that early on and the way you do that as an internal

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medicine doctor is empiric antibiotics?
A. Empiric antibiotics if the patient is symptomatic.
Q. Let's go through your history and physical, and I promise, I'm not going to spend a lot of time on it, but there were a couple of things I wanted to ask you about on it, okay? So that's Plaintiff's Exhibit 6.
A. Okay.
Q. At the start, we already talked about the times.
A. Yes.
Q. Chief complaint, low back pain, right?
A. Yes.
Q. That's different than flank pain?
A. Yes.
Q. All right. The last sentence in the history of present illness -- or maybe the second to last sentence --

MR. SINKOFF: Starting where?

BY MR. TAKALA:

Q. The line starts, urinary or bowel incontinence?
A. Yep, yes.
Q. And this is where we --

MR. SINKOFF: Actually it says no urinary or bowel --

MR. TAKALA: Fair enough, yeah, I was just trying to --

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MR. SINKOFF: I understand. I understand.

BY MR. TAKALA:

Q. That sentence continues. Although she felt she was unable to urinate earlier, period. Has urinated times three since this morning.

You're writing this note at 1441, so it's about 2:41 p.m. is -- you know, I mean, what's the importance of indicating three urinations or three times urinating since this morning?
A. Because she was unable to urinate earlier, so I'm saying that she was able to urinate after that --
Q. Okay.
A. -- after that complaint.
Q. Okay. Fair enough. And denies any chest pain, palpitations, fever, chills, nausea or vomiting?
A. Yes.
Q. As part of the vital signs, and I'm on -- it says page 36 in the lower left corner. You record or somebody records a temperature of 99 degrees Fahrenheit?
A. Yep.
Q. Does that qualify for fever?
A. No.
Q. Okay. And if you go to the last page, your plan was to admit, right?
A. Yes.

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Q. And what was the purpose for the admission?
A. For pain control, to consult Dr. Olson, PM & R and pain management and to diagnose and treat her condition.
Q. And do I have it right, you're deferring that portion of the treatment to the consultants, right? You're bringing the consultants on to treat the pain?
A. No. She's already getting the pain control and that's Toradol, Dilaudid, Decadron and muscle relaxants, which is a plan of -- with the pain control.
Q. Fair enough. Do you know whether you saw Ms. Markel at any point prior to writing your discharge note from October 11th, 2015, and I'm marking that as Plaintiff's Exhibit 7?

MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 7
3:36 p.m.

A. I'm sorry, what's the question again?

BY MR. TAKALA:

Q. Sure. I'm sorry, I mismarked this. What I marked as Plaintiff's Exhibit 7 was -- sorry. So Plaintiff's Exhibit 7 is going to be the discharge summary from October 11th, 2015, okay?
A. Okay.
Q. Here you go now.

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MR. SINKOFF: Just before you start, so the record is clear, on each of these exhibits there's highlighting all placed by Mr. Takala or somebody in his office.

MR. TAKALA: That's correct, yep.

BY MR. TAKALA:

Q. Okay. So I just marked the discharge summary as Plaintiff's Exhibit 7. And again, using the times at the top, can you tell me when you started this process and when you finished it?
A. Note time, 10-11-15, 11:06 and filed 10-11-15, 1433.
Q. So that means you would have started the note at 11:06 a.m. and you would have finished it or signed off on it at 1433?
A. Yes.
Q. Okay. Do you know if you saw Ms. Markel between the history and physical and the discharge summary?
A. So I saw her on 10-10 for that history and physical and then -- no, next day would be around 11:06.
Q. Okay. But, I mean -- and I think you already told me that there's another hospitalist that's on duty from -- that takes the night call, right?
A. Yes.
Q. All right. So you don't have any indication that you saw or provided any treatment to Ms. Markel between

your note on October 10th and then your discharge summary on October 11th, right?

A. Yes.

Q. All right. Did you see that overnight a temperature had been reported of 100.9 degrees by the nursing staff?

A. Yes.

Q. All right. And that's something that you would have realized on October 11th, 2015 as part of your habit and practice, you're going back and trying to figure out what's going on with the patient so you can get up to speed treating going forward, right?

A. Correct.

Q. Okay. Did you attribute that temperature to a sign of infection at that point in time?

A. No.

Q. Why not?

A. Because there was no persistent elevation of the temperatures after that one episode.

Q. Okay. Do you know if Ms. Markel's temperature did persist in reality after she was discharged on October 11th?

A. Not after discharge.

MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 8

3:39 p.m.

BY MR. TAKALA:

Q. I'll mark as Plaintiff's Exhibit 8 the history and physical from October 14th. Again, can you identify the times on your H&P from October 14th when you would have seen the patient and when you would have started and ended your note?

A. Okay. 10-14-15, 11:34. Filed 10-14-15, 1436.

Q. Again, that means you would have started your note at 11:34 in the morning?

A. Yes.

Q. And you would have finished your note and signed off on it at 1436?

A. Yes.

Q. Okay. In the history of present illness, and this is about halfway through, it says she also had a fever, 102 at home. Do you see that in there?

A. Yes.

Q. All right. Agree in a hypothetical world if Ms. Markel had a 100.9 degree temperature in the early morning hours of October 11th and then had a fever of 102 on October 12th and then she comes to the hospital with a fever, is that a persistent fever?

A. No.

Q. Okay. What's your definition of a persistent fever?

A. If you have consecutive readings of temperature more than 99.9 throughout, from 10-11 -- I mean, 10-10 at 8:00 p.m. until the time I saw her on 10-11 at 11:06, that would be persistent fever, otherwise it would be intermittent fever.

Q. Okay. Can certain medications mask a fever?

A. Yes.

MR. TAKALA: All right. I'll tell you what, I'll ask for a five-minute break.

(Recess taken at 3:40 p.m.)

(Back on the record at 3:46 p.m.)

BY MR. TAKALA:

Q. We talked about your habit and routine for how you do a history and physical. Can you take me through your habit and routine of a discharge summary? So I think I marked the discharge summary as what Number?

A. 7.

Q. Okay. Just take me through that process, as in your -- in your scope of expertise or your scope of practice?

A. Yes. Usually when you document, there's the date of admission and the date of discharge and the hospital brings up the problem. And then it's -- you know, it will list the consultants that were on the case, as for last studies that needs to be followed up on, what

procedures were done. And then a brief hospital course as to what happened with the patient, how did we treat the patient, what's the plan for followup. And then it has a section that says evaluation on the day of discharge. And then the discharge instructions, which includes the medication list, as for labs -- should be a discharge -- it is not in here, but it's -- there's a discharge instruction that we provide the patient, a page -- a page in discharge instructions.

Q. Good. And that's page 15 in the lower left corner?

A. Yes.

Q. All right.

A. So that's the whole discharge package that we do for the patients.

Q. Okay. And you have something circled on that page in your chart, right?

A. Yes.

Q. All right. What's that that you have circled?

A. It says to contact your doctor if your temperature is over 100.5 and you're unable to urinate, that's the circled one. And there are other -- other reasons to contact your doctor too; so if you have nausea and vomiting, if you have shortness of breath or if you have chest pains.

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Q. All right. Got it. Being unable to urinate, why is that important?
A. If you cannot urinate -- obviously, you know, you need to urinate. So if you can't urinate for a certain period of time, then it's an abnormal -- natural process, so you have to contact somebody.
Q. Is the inability to urinate a sign -- what -- strike that.
What is -- what can cause the inability to urinate?
A. Urinary retention, if there's any blockage to your path of urination, that can cause urinary retention.
Q. Okay. And why is it important for a patient to follow up if a fever persists over 100.5 degrees?
A. If there's a persistent fever, then that could be a sign of infection.
Q. Okay. And in fairness to you, on your discharge summary you noted that the temperature -- or somebody noted the temperature on the day of discharge was 97.5, that's on page 18?
A. Yes.
Q. Okay. And we talked about certain masking agents for temperature. In the medication list on page 19 there's oxycodone, acetaminophen. Is that a masking agent for temperature?

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A. Oxycodone, acetaminophen -- acetaminophen can sometimes decrease the temperatures.
Q. Okay. Any other medications on that list that can decrease temperature?
A. No.
Q. Okay. This isn't too important, but on page 18 there's a line right above where it says discharge instructions, time spent on evaluating, preparing and coordinating discharge, colon, 25 minutes?
A. Yes.
Q. All right. Help me understand how that fits with the times that we were talking about earlier where you started at 11:06 a.m. and finish at 1433 on the top of your note?
A. Yes. So I can stop note -- it doesn't say it's the note time, it says the time spent on evaluating, preparing and coordinating the discharge. So that's the actual time that I had spent with the patient, examining her, talking to the nurse and finalizing the discharge paperwork and all that.
Q. No problem. Just help me understand how that fits though, if you're spending 25 minutes coordinating the discharge, deciding on discharge, if your note starts at 11:06, shouldn't it be signed at 11:46 or something like that?

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A. We have the option to, you know, come back to the note. We can pen the note and come back to the note and finish it off at a later time.
Q. Okay. The actual discharge time on Plaintiff's Exhibit 4 was 1713. Does this help us at all with the sequence of events --
A. That's -- I'm sorry to interrupt, that's the admission time.
Q. Sorry. Thank you. The discharge time is 12:45 p.m.?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. Okay. Does that help us at all coordinate what was going on here? So to help you, you start your note at 11:06, you spend about 25 minutes and the discharge is at 12:45 and you sign the note at 1433?
A. Okay.
Q. Help me understand what happens?
A. So discharge note, filing time, you know, I can file that anytime during the day. So it could be 1433, it could be 1600. The discharge date and time here on Exhibit 5, that's the time when the patient is discharged from the hospital, I believe, not 100 percent sure.
Q. Okay. That's okay. It makes sense to me. You file

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your note or you electronically sign your note after the patient has already been discharged?
A. Right.
Q. Okay. And what does it mean to file a note, do you click a button on the Epic system?
A. I sign the note. There's a button called signing and if I click it, then that becomes -- it gets filed.
Q. Okay. Thank you. The culture that eventually grew out, this Group B streptococcus, help me with this word?
A. Streptococcus agalactiae.
Q. Thank you. By the way, did the -- the culture was a contaminated culture, you think?
A. Yes.
Q. All right. What information from that culture leads you to believe it was a contaminant?
A. First of all, it's a Group B streptococcus, which is a normal colonizing bacteria in the urethra, rectum, vaginal, cervix. And it's collected off of the -- it's collected the same time as the urinalysis from 10-10-15 at 2109.
Q. Okay. So the fact that they were collected at the same time as the urinalysis has epithelial cells, you're doubting whether there was a good catch or a good specimen?

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A. Correct.
Q. All right. Obviously the culture results -- and I'm reading from the urine culture. They were not resulted at the time you discharged Ms. Markel, correct?
A. Correct.
Q. All right. What's the practice with whom these cultures are reported to, we know that P.A. Warner orders the test, but you still have access to the results because you're the attending physician?
A. Correct.
Q. All right. Do you know who else would get notification of the results of that urine culture?
MR. WARWICK: Just foundation.
A. I'm not sure.
BY MR. TAKALA:
Q. Fair enough. Thank you. And you already told me that your role in this process, if it's a urine culture that comes back and you believe that it requires treatment, it's your job to call the patient as the attending physician, right?
A. Yes.
Q. All right. Do you know whether there was any written policy and procedure about who receives notice of a positive urine culture at Beaumont Hospital?

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MR. WARWICK: Just form and foundation. And if she does, it shouldn't be turned over. I'm assuming she doesn't have policies and procedures, but I would object to --
A. I do not know.
BY MR. TAKALA:
Q. Okay. Obviously they did not teach you about the workflow at William Beaumont Hospital when you were in medical school in India, right?
A. No.
Q. They didn't teach you about the workflow at William Beaumont Hospital and how urine cultures were reported while you were in Philadelphia in your residency, right?
A. No.
Q. Okay. How did you learn about how those results were reported on Epic and whose responsibility it was to consult the patient in the event of abnormal results at William Beaumont Hospital?
A. As I practiced, through my years of practice.
Q. Okay. You learned about that on the job, right?
A. Yes.
Q. You learned about it. Do you do any training on how results are reported on Epic and how a doctor gets results and reports results?

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A. We get training on the Epic and about where results -- where we should look for the results.
Q. Okay. Do you get any training or inservice or any sort of coordination of care as to whose responsibility it's going to be to contact the patient in the event that there was an abnormal result that the patient needed to be called about?
A. There's no official training.
Q. Okay. How do -- how do you know that it's your job to do that?
A. That is the standard of practice --
Q. Okay.
A. -- you know.
Q. But that varies from hospital to hospital. For example, in this case if there's a P.A. that's ordering the culture in the emergency department and you're sitting here telling me as the admitting hospitalist that it's your job to follow up, right?
A. My job is to follow up if there are any results that are outstanding at the time I received the patient's care.
Q. Okay. But the point I'm trying to make is in a different health system, that may be a different process. Maybe it's the ordering physician that has to follow up on the ordered tests, right?

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MR. SINKOFF: Just objection to relevance --
A. I would not know.
MR. SINKOFF: -- what's the difference --
MR. WARWICK: Join.
MR. SINKOFF: We're talking about Beaumont.
A. I don't know.
MR. TAKALA: Yeah, but the point is that there's a way that Dr. Lonappan learns about this process and I want to know what that process is.
MR. SINKOFF: She told you, through her experience working there.
MR. TAKALA: Okay.
A. Through my practice, yes.
BY MR. TAKALA:
Q. All right. I mean, was there a physician that told you how this worked?
A. I don't recall --
Q. Okay.
A. -- specifically.
Q. Has it changed since you started at -- in 2011 and today's date?
A. Has what changed?
Q. The process as far as who would be responsible for following up on outstanding results of a discharged

patient?

MR. WARWICK: Just foundation.

A. I do not know if it has changed. For my practice it has not changed.

BY MR. TAKALA:

Q. Did you have Epic when you started in 2011?

A. Yes.

Q. Okay. And it was always -- that's true?

A. Yes.

Q. Okay. And it's always been the attending physician whose responsibility it was to follow up with outstanding test results?

A. It is admitting physician's responsibility to follow up on the results or let the patient know to follow up with whoever needs to be followed up with.

Q. Okay. Have you ever practiced in a hospital or a setting where the results would be sent to the ordering physician and the ordering physician would have to follow up on those results?

A. I only practiced at Beaumont Hospital so I don't have any other practice or -- any other practice.

Q. Okay. This was a patient that was admitted to an observation -- was it observation or was it an actual med/surg floor?

A. It was observation based on the admission orders.

Q. It was a GYN service?

A. I don't -- I don't know specifically as to why she went to the GYN floor. There was -- I don't know offhand, I'll have to look through the records to find out that specific order for admission, you know. Do you want me to go through the records to find that out?

Q. No, I don't think that's important.

A. Okay. She was admitted as an observation patient, I know that.

Q. Okay.

A. I'm sorry.

Q. She was admitted to be observed about her pain though, right?

A. Yes.

Q. All right. She wasn't admitted for any other reason?

A. She was admitted for the back pain and the pain that went down her legs, yes.

Q. Okay. And there was no other reason why she was admitted?

A. No.

Q. If it wasn't for that radiating back pain down to her legs, she would have been discharged the same day or you would have seen her and made the decision not to even admit her, right?

A. Right.

Q. Okay. By the way, if you know, how is it that you become involved in this patient's care, does -- because obviously I'm sure there's patients that come to the ER and the ER doctor doesn't even call the hospitalist, right?

A. Yes.

Q. Okay. Is that a decision that you're involved in or is that the ER doctor's decision to call you or to put the patient on your service?

MR. WARWICK: Just foundation.

Go ahead.

A. So when Dr. Bonema's patients come to the hospital, if they need to be admitted to the hospital, then the ER physicians calls the on-call physician for our group and that physician decides which patient -- which physician the patient would be admitted under.

BY MR. TAKALA:

Q. Got it. Are there certain patients where they might have a different PCP and that PCP actually treats the patient in the hospital at Beaumont?

A. Yes.

Q. Okay. Are you aware of any policies and procedures at Beaumont that you've received?

MR. WARWICK: Just form, foundation.

MR. SINKOFF: About what?

MR. TAKALA: Anything.

MR. WARWICK: Privileged, confidential.

MR. SINKOFF: You can answer, but they're not admissible.

A. About the privileges, have got information.

MR. TAKALA: Okay. Well -- and I think it's a little different in this case because we've made hospital administration claims, I believe.

MR. SINKOFF: Well, you can take that up with Don.

MR. WARWICK: Well, you haven't made valid hospital administration claims, but go ahead.

MR. TAKALA: Okay. Well, I mean, I suppose that's an issue that needs to be debated later, but until there's a motion for summary disposition on those claims, I mean, I think I get to ask questions about --

MR. WARWICK: Well, you can ask questions, but I object to, if she has any policies and procedures, to turning over any such policies and procedures. That would be something that would need to be discussed with the court and ordered by the court.

MR. TAKALA: Fair enough.

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BY MR. TAKALA:
Q. Do those policies and procedures exist, otherwise stated and subject to Don's objection and I get it, are you in possession of policies and procedures from Beaumont?
A. No.
Q. Okay. Are you in possession of any policies and procedures from Hospital Consultants, P.C.?
MR. SINKOFF: I'm going to object to the foundation of that.
A. What do you mean by policies and procedures, regarding a specific thing or just general policies and procedures?
BY MR. TAKALA:
Q. Yeah. General policies and procedures, something that you've received in writing, whether it's an employee handbook or a manual or this is how we do things at Beaumont or this is how we do things at Hospital Consultants, P.C.? Do you understand what I mean by --
A. Yes, yes.
Q. Okay. Do you have any policies and procedures from Beaumont Hospital?
A. No.
Q. Okay. Do you have any policies and procedures from

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Hospital Consultants, P.C.?
A. Yes.
Q. Okay. And those are written down instructions as to how to handle certain things?
A. I believe so.
Q. Okay. Have you read them?
A. I read them when I joined the group.
Q. Do you have them in hard copy, electronic copy?
A. I think I have it in hard copy.
Q. Okay. Do you know whether you have access to it electronically?
A. I do not know.
Q. Do you know whether there's anything written down in those policies and procedures about contacting a patient when a result comes back after discharge?
MR. SINKOFF: I'm going to let her answer, but I want a clarification. This whole line of questioning you're asking about Hospital Consultants, P.C. policies and procedures relative to patient care as opposed to employee status type of stuff?
MR. TAKALA: Yes.
A. About patient care?
MR. SINKOFF: Yes.
BY MR. TAKALA:
Q. Yes.

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A. I don't know.
Q. Okay. You told me that you learned about how to -- you know, who follows up on these results on the job or as part of your training because you started working at Beaumont and that's how you learned it, right?
A. Yes.
Q. Okay. Do you know whether that was written down anywhere or is that just something that you learned on the job that somebody else taught you?
A. I learned on the job, I think.
Q. These policies and procedures, as I call them, or the written down material that you have, is it updated year to year or is it just one copy that you received in 2011 and that's it?
A. It was one copy that I received in 2011.
Q. Do you know who else sees the urine culture results, for example, in this case for Ms. Markel?
MR. WARWICK: Just foundation.
A. Who else?
BY MR. TAKALA:
Q. Yeah. And if you don't know, that's fine. For example, the P.A. that ordered the results, do you know if the P.A. would have access or be alerted to these results?

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A. I do not know.
Q. Okay. Do you know of anybody else that would have access to these results besides you as the attending physician?
A. No.
Q. Okay. Obviously it's okay to discharge patients with culture results pending?
A. Yes.
Q. But it's your responsibility to follow up on those results and act appropriately after they come back?
A. Correct.
Q. Did you ever order a repeat CBC when you saw Ms. Markel on October 10th?
A. No.
Q. Did you order a repeat CBC before discharging her on October 11th?
A. No.
Q. Would the repeat CBC have assisted you in obtaining clinical information about the reason of those inflammatory biomarkers or the fact that the prior UA may have been a contaminant?
A. Can you explain that question again?
Q. Sure. Let me start with this one and it will make more sense to you. Was it your standard of care to order a repeat CBC before discharging Ms. Markel on

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October 11th?
A. No.
Q. Okay. On prior UAs there were signs of inflammation, correct?
A. Yes.
Q. There were prior UAs with signs of contamination, correct?
A. Yes.
Q. Help me understand why you didn't -- why you did not have an obligation to order a CBC with a clean sample or a sample you felt was clean?
MR. SINKOFF: Object to foundation.
MR. WARWICK: Same.
MR. SINKOFF: CBCs are blood samples.
MR. TAKALA: I'm sorry.
BY MR. TAKALA:
Q. A UA?
MR. SINKOFF: Start over.
MR. TAKALA: Sure thing.
MR. SINKOFF: Let's clear that up, please.
MR. TAKALA: Thank you.
BY MR. TAKALA:
Q. The UA that was ordered on October 10th had inflammatory biomarkers, right?
A. Yes.

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Q. Contaminant biomarkers?
A. Yes.
Q. Did you order a repeat UA before discharging Ms. Markel on the 11th?
A. No.
Q. Were you required to order a repeat UA?
A. No.
Q. Okay. Why not, considering the fact that there were prior abnormal results on the UA from the day before?
A. Because she did not have any symptoms suspecting UTI, so there was no reason to order a test, that is unnecessary.
Q. Okay. She did have a fever overnight, right?
A. Yes.
Q. Okay. And that is a sign of UTI, right?
A. It could be a sign of UTI, but she did not have persistent fevers.
Q. All right. Have there been circumstances in your practice where you've ordered antibiotics for a patient that had been discharged from the hospital?
A. Yes.
Q. Okay. Would those be oral antibiotics?
A. Yes.
Q. Okay. And you do that with a phone call and tell the patient that you're going to write a script and they

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can pick it up wherever?
A. Usually I call the patient and I call the pharmacy to send in the script.
Q. Thank you. Have you spoken with anybody about this deposition aside from Mr. Sinkoff or a member of his firm?
A. No.
Q. Have you spoken with anybody in your practice about this deposition?
A. No.
Q. You don't remember, after sitting with me for, whatever, over two hours now, anything independently from October 2015 and the treatment you provided to Ms. Markel, aside from what you've documented in your records?
A. No.
Q. I'm trying to think about the most efficient way to do this. I want to know what notes you put on the records and why. I haven't even seen them. Can I come around to your side of the table for a minute -- or you can pass that over to me, if you don't mind? Thank you, that's fine.
So you have a Post-it note that indicates discharge instructions?
A. Yes.

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Q. Discharge summary?
A. Yeah. ER nurses note, ER nurse recorded IV filtration.
Q. Why is that important to you?
A. Because she had an infiltrated IV, that can sometimes cause inflammation and cause fevers.
Q. Okay. Do you think that's what was causing the inflammation and fever in this case?
A. Could be.
Q. Okay. Knowing what you know about October 13th and beyond, do you believe that the IV infiltration is what was causing the fevers and the inflammation?
A. Clarify that question again?
Q. Sure. Using the benefit of hindsight, knowing that when Ms. Markel comes to the hospital on the 14th, can you go back and reconstruct what was causing that inflammation on the 10th?
MR. SINKOFF: Object to relevance.
Go ahead.
MR. WARWICK: Same.
A. So you're asking me -- just to clarify the question, you're asking me do I know what caused --
BY MR. TAKALA:
Q. The inflammatory -- let's just say the leukocytes and the elevated white blood cell count, do you have an

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opinion as to what was causing that on October 10th when it was resulted?
A. Yes.
Q. Okay. What is it, knowing what you know now?
A. Because she had a procedure on the 2nd of October, which was a gynecology procedure, D & C, and that can cause colonization of bacteria and that can cause inflammation in the urine.
Q. Okay. But you would have known that on October 10th, right, that she had this prior procedure and that can cause a colonization of bacteria?
A. I knew that she had a prior procedure.
Q. And you also knew that it could cause a colonization of bacteria in the bladder?
A. It could cause, yes.
Q. Okay. But you saw these inflammatory responses, but you didn't think it was a result of bacteria, right?
A. It's not a result -- infection.
Q. Okay. And I'm being a little bit unfair to you because I was asking you retrospective questions and I think what you were trying to tell me is that she has this procedure on -- and don't let me put words in your mouth, but she has this procedure on October 2nd, that can cause colonization of bacteria in the bladder, and that colonization of bacteria in the

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bladder got into her joints. That's what we know happened after the fact, right?
A. Yes.
Q. Okay. But when you discharged the patient on October 11th, 2015, you didn't know that it was in the joints, right?
A. No.
Q. And it wasn't your standard of care to perform any further workup or evaluation for this potential colonization of bacteria, knowing that she had this GYN procedure on October 2nd?
A. So that would -- I did not have to do anything further knowing that it's a colonization.
Q. Okay. Got it. Sorry, the -- I want to finish going through these notes. Thank you for your patience with me.
It looks like -- and there's some, you know, pink writing, I don't know if that's intentional or --
A. That was not, sorry.
Q. Okay. Can you read this note?
A. Observation, P.A. note, 10-10-15.
Q. Why is that important?
A. Just reviewing her records, that's it.
Q. No problem. H & P on page 33?

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A. Yes.
Q. That's yours, right?
A. Yes.
Q. Okay. You have some writing on there?
A. Yeah. Because it was illegible as to -- it mentioned she has family and daughter dysfunction, which was -- actually meant ambulatory dysfunction.
Q. Got it. So another transcript error when you're doing voice dictation?
A. Correct.
Q. Okay. A little bit -- you had some other writing on here. No significance, right?
A. No, we already discussed that.
Q. Okay. There's some other pages where I don't know whether these marks are intentional or unintentional?
A. No. It's the recommendations, nothing that -- I'm specifically trying to say anything or --
Q. I understand. But you made a mark on this page and you underlined a sentence, right, that's your --
A. Yes.
Q. -- handwriting?
A. Yes.
Q. This note, please?
A. R.N. notes regarding calling Dr. Muraru.
UA results.

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Urine culture results.
Septic screen.
Sorry, that's also unintentional.
Temperature log.
Q. No other Post-its there -- are these your records or are those Steve's?
MR. SINKOFF: They're mine and they're just copies.
MR. TAKALA: Okay.
BY MR. TAKALA:
Q. I think that you told me that you didn't see Ms. Markel after October 16th, 2015?
A. Yes.
Q. Okay. I think she was discharged on November 2nd, if my memory serves -- yeah, November 2nd. Would you have worked another block of your 10 or 11 days in a row between October 16th and November 2nd?
A. Yes.
Q. Okay. Would you typically be assigned to patients that you had prior responsibility for or how does that work?
A. Yes. When I signed out and if I come back to the same hospital, I usually pick up with -- if the patients are still in the hospital, I usually pick those patients up back on my patient list.

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Q. Okay. Any other understanding as to why you didn't pick Ms. Markel back up?
A. I believe I was working at Troy Beaumont for that next schedule.
Q. Fair enough. There would probably be some sort of log or time sheet --
A. Yeah.
Q. -- we could go back to?
A. Yes.
Q. Okay. Do you have any sort of written policies regarding your employment and employment practices with Hospital Consultants, P.C., like you have to work X amount of days per week or X amount of hours per month?
MR. SINKOFF: Object to foundation.
BY MR. TAKALA:
Q. Anything like that? I'm just using that by example.
A. I do not know specifically.
Q. Okay. How about the same question with regard to Beaumont?
A. No.
Q. Okay. If you just bear with me for just a few minutes, I'll check my notes and make sure I have everything marked that I wanted to mark.
A. Okay.

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MR. TAKALA: I will, if you don't mind, unless Steve has an objection, mark these records? If you have an objection, Steve, I won't, but --
MR. SINKOFF: You can mark them, but they're going to stay in her possession.
MR. TAKALA: That's fine with me.
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 9
4:15 p.m.
MR. TAKALA: I'll mark this as Plaintiff's Exhibit 9.
BY MR. TAKALA:
Q. Do you have any social relationships with any of the other physicians involved in Ms. Markel's care, names that you would have seen in the records?
A. No.
Q. Okay. I'm sure you know a lot of these physicians professionally and you've worked with them?
A. Yes.
Q. But you haven't spoken with any of them about Ms. Markel or her care?
A. No.
Q. Okay. You haven't spoken -- and obviously since --
A. Right, right, no.
Q. -- the notice of intent --

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A. No.
Q. Just because I suppose it's my last chance to ask you, anything else that has come to your memory about this October 2015 time period as it pertains to Ms. Markel?
MR. SINKOFF: Object to the foundation and --
A. No.
MR. SINKOFF: -- form of the question. There may be many things that she testifies to depending on the questions that are asked.
A. No.
BY MR. TAKALA:
Q. Okay. As you sit here today and the way I'm asking the question, is there anything that you remember independently about Ms. Markel's care that isn't documented somewhere in your records? And I'll -- subject to Steve's objection, of course.
A. No.
MR. TAKALA: All right. I don't have any further questions for you, Dr. Lonappan, and I do thank you sincerely for your patience and your time.
THE WITNESS: Thank you.
EXAMINATION
BY MR. WARWICK:
Q. Dr. Lonappan, I have just a few questions for you. If

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at any time you don't understand it, don't hesitate to mention that and I'll certainly repeat it or rephrase it, okay?
A. Okay.
Q. Back in October 2015 you were employed by Hospital Consultants, P.C.; is that correct?
A. Yes.
Q. And you've already testified that you were employed by them beginning in 2011; is that right?
A. Yes.
Q. You were not employed by William Beaumont Hospital; is that correct?
A. Yes.
Q. And from your previous testimony, it's my understanding that you would have been scheduled by Hospital Consultants, P.C. through a Dr. Jason Batke; is that correct?
A. Yes.
Q. And the reason you were at William Beaumont Hospital October 10 and October 11th of 2015 was because you had been scheduled by your employer, Hospital Consultants, P.C., to work at the hospital on those days; is that correct?
A. Yes.
Q. And from your testimony previously, it's your

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understanding that if patients come in from Troy Internal Medicine, and specifically in this case Dr. John Bonema, who is an internal medicine physician at Troy Internal Medicine, then -- and if the patients are admitted, then your group of physicians from Hospital Consultants, P.C. would see the patients in the hospital; is that right?

A. If the ER physician calls our group for admission, then we'll see the patient.

Q. Okay. So in this case, Ms. Markel was admitted to hospital and this was Dr. Bonema's patient, as her primary care physician. So then it makes sense that that's why your group is contacted and that you became involved in her care, fair?

A. That's correct.

Q. Okay. And she's not a named defendant, but she was referenced in the notice of intent, her name is Janay, J-A-N-A-Y, Warner, W-A-R-N-E-R. She's a physician assistant and she saw Ms. Markel in the observation department at William Beaumont Hospital.

You didn't provide treatment to patients in the observation unit, did you?

A. No, not in the ER observation unit, no.

Q. Right. And you don't know Janay Warner, P.A. personally at all, do you?

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A. No.

Q. Okay. And from the records, it looks like a urinalysis was first done on October 9th, 2015 at 2249 and you've already testified about those results. Do you remember that?

A. Yes.

Q. Okay. Then P.A. Warner became involved in the patient's care, I want you to assume, when Ms. Markel was in the observation unit and she ordered a repeat urinalysis and a urine culture and those were ordered on October 10th, 2015 at 1349.

You became involved, it's my understanding, in Ms. Markel's care on the floor October 10th, 2015, at least your note is signed -- your history and physical at 1441; is that right?

A. Signed at -- yes, note is signed at 1441.

Q. Okay. So P.A. Warner would have ordered the repeat urinalysis and the urine culture in the observation unit, then the patient was transferred to the floor, according to the records, on October 10th, 2015 at 1426?

A. Okay.

Q. That's pages 2451 and 2452 of my set of records. And then shortly thereafter you would have seen the patient on the floor and then entered your report at 1441; is that correct?

A. Yes.

Q. Okay. Then from page 2456 of my set of records, the urine sample and urine culture were then collected on October 10, 2015 at 2109 and 2110; is that correct?

A. Yes.

Q. Okay. So when you first saw Ms. Markel on the floor, you would have known that these urinalysis and urine culture had been ordered, but not done yet; is that right?

A. Yes.

Q. Okay. And then it looks like the results came back from those studies on October 10, 2015 at about 2201; is that right?

A. Yes.

Q. Okay.

A. From the urinalysis.

MR. SINKOFF: Not the culture.

BY MR. WARWICK:

Q. From the urinalysis. And the urine culture was -- we know did not come back until October the 12th; is that right?

A. Yeah, final results.

Q. Okay. Let me make sure my question is a little clearer. The urinalysis result was resulted from page 2456 on October 10, 2015 at 2201; is that right?

A. Urinalysis results were resulted, yep.

Q. Okay. And then the urine culture result was resulted on October 12th, 2015 at 2038; is that right?

A. Yes.

Q. Okay. And then Dr. Mihai Muraru, is it your understanding he was a physician who was also employed by Hospital Consultants, P.C. back in October of 2015?

A. Yes.

Q. And if he was called by a nurse on October 11, 2015 at approximately 0413, would that likely have been because he was the on-call physician for Hospital Consultants, P.C. at that time?

A. Yes.

Q. Okay. But you didn't have any direct communication with the patient or the nurses or anyone of that nature October 11th, 2015 at 0413, correct?

A. Correct.

Q. Okay. And this whole process of urinalysis results and urine culture results, where you as the hospitalist are aware of tests being ordered, sometimes it takes a period of time until after the patient is discharged for the final results to come back, obtaining the results and then looking and determining whether or not those results are relevant

or followup is necessary, everything in this case happened as it would normally happen with your practice, right, you received results and then looked at that issue and made determinations; is that fair?

A. Yes.

MR. WARWICK: Okay. I appreciate your time, thanks a lot.

THE WITNESS: Thank you.

RE-EXAMINATION

BY MR. TAKALA:

Q. I have just a couple quick followups.

When you made contact with Ms. Markel, you didn't tell her that you were seeing her because of her relationship or Dr. Bonema's relationship with Troy Internal Medicine, would you?

A. I would, that's my usual practice. When I say I'm Dr. Lonappan and then I would say I'm seeing you for your family doctor, I'm a hospitalist associated for Dr. Bonema.

Q. Okay. So that's not what you told me earlier?

A. You -- no, that's -- I said I would introduce myself as Dr. Lonappan, that's what you asked.

Q. Okay. And then I thought I asked would you say, you know, Beaumont Hospital or Hospital Consultants, P.C. and you said no and no?

A. Yeah, I said I usually don't bring up Hospital Consultants, P.C. because it doesn't matter to the patient. I do bring up that I'm seeing them for their family doctor.

Q. Okay. And do you tell them who you're employed by?

A. No.

Q. Okay. Do you tell them that you're employed by Troy Internal Medicine, for example?

A. No.

Q. You don't tell them you're employed by Beaumont, right?

A. No.

Q. You don't tell them you're employed by Hospital Consultants, P.C.?

A. No.

Q. Okay. But you do tell them that you're seeing them in place of their PCP?

A. Correct.

Q. And would you mention Dr. Bonema by name?

A. Yes.

Q. Okay. Sorry to get into a couple of other tangential issues. I didn't ask you about the CBC or the complete blood count that was done on October 9th, 2015?

A. Okay.

Q. I'll just show you. Are there any abnormal results from the CBC?

A. WBC is abnormal, it's 13.8. And then neutrophils, 8.7.

Q. That's it?

A. Then there is monocytes, 1.

Q. Okay. And are those inflammatory markers?

A. The WBC and neutrophils.

Q. Okay. When you got to the hospital at 8:00 a.m. on October 11th, you would have been able to go back in the chart and see that an elevated temperature had been reported during the middle of the night, correct?

A. Yes.

Q. You would have seen that Dr. Muraru had been consulted?

A. Yes.

Q. Okay. And if you believe that a CBC was necessary and Dr. Muraru did not order the CBC, you would have had that opportunity to do so at 8:00 a.m. when you were back on call, right?

A. If I thought that the test would give us -- give me more information to treat the patient, yes, I would have.

Q. Same question with regard to administration of antibiotics, if you saw there was an elevated

temperature and you saw that Dr. Muraru didn't decide to start antibiotics and you thought it was appropriate, you would have made that determination in the morning when you started your shift on October 11th, correct?

MR. SINKOFF: Object to the foundation.

MR. WARWICK: Same.

A. Yes, when I see the patient on October 11th I would make that determination and I would have started her on antibiotics if I thought she needed them.

BY MR. TAKALA:

Q. Okay. And that's irrespective of what Dr. Muraru did, you would make that decision for yourself?

A. Correct.

MR. TAKALA: All right. That's all I have. Thank you very much.

(The deposition was concluded at 4:29 p.m. Signature of the witness was not requested by counsel for the respective parties hereto.)

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

BECKY JOHNSON, CSR-5395
Notary Public,
Oakland County, Michigan

My Commission expires: January 28, 2019

EXHIBIT 2

AFFIDAVIT OF MARY ANNE MARKEL

STATE OF MICHIGAN)
) ss.
COUNTY OF OAKLAND)

I, Mary Anne Markel, being first duly sworn depose and say according to my personal knowledge, information, and belief:

1. I am fully competent to testify in the foregoing matter.

2. On October 9th, 2015, I presented to William Beaumont Hospital in Royal Oak, Michigan.

3. I was treated by multiple medical care providers at William Beaumont Hospital – Royal Oak, including Dr. Linet Lonappan.

4. That I did not know Dr. Linet Lonappan prior to my admission at William Beaumont Hospital on October 9th, 2015.

5. That while Dr. Lonappan provided medical treatment to me during my admission of October 9th, 2015, I was at all times under the impression that Dr. Linet Lonappan, as well as the other medical staff at Beaumont Hospital – Royal Oak, were employees of Beaumont Hospital - Royal Oak.

6. That at no time during my admission of October 9th, 2015 did Dr. Linet Lonappan make any statements or take any affirmative action to indicate to me that she was not employed by Beaumont Hospital – Royal Oak.

7. That I have worked for Beaumont Hospital through the Royal Oak system for over thirty (30) years, and as of October 2015, I was unaware that the physicians were not employees of the hospital.

I declare under penalty of perjury that the foregoing is true and correct.

Mary Anne Markel

Mary Anne Markel

Subscribed and sworn to before me

this 23 day of July, 2018

Jessica Page Weber

Notary Public Jessica Page Weber
Acting in ~~Wayne~~ County

Personally known ___ OR Produced Identification _____
Type of Identification Produced Drivers License MI

JESSICA PAGE WEBER
NOTARY PUBLIC - STATE OF MICHIGAN
OAKLAND COUNTY
MY COMMISSION EXPIRES 6/19/22
ACTING IN THE COUNTY OF Oakland

EXHIBIT 3

In the Matter Of:

MARKEL vs WILLIAM BEAUMONT HOSPITAL, ET AL.

JANAY A. WARNER, PA-C

February 26, 2019

Prepared for you by

Bingham Farms/Southfield • Grand Rapids
Ann Arbor • Detroit • Flint • Jackson • Lansing • Mt. Clemens • Saginaw • Troy

WARNER, PA-C, JANAY A.
02/26/2019

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

MARY ANNE MARKEL,
Plaintiff,
vs. Case No. 18-164979-NH
Hon. Nanci J. Grant
WILLIAM BEAUMONT HOSPITAL,
HOSPITAL CONSULTANTS, P.C.,
and LINET LONAPPAN, M.D.,
Jointly and Severally,
Defendants.

The Videotaped Deposition of JANAY A. WARNER, PA-C,
Taken at 99 Monroe Avenue, N.W.,
Suite 975,
Grand Rapids, Michigan,
Commencing at 11:58 a.m.,
Tuesday, February 26, 2019,
Before Peggy S. Savage, CSR-4189, RPR.

APPEARANCES:

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ALSO PRESENT:
Shawn Capron - Video Technician

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Grand Rapids, Michigan
Tuesday, February 26, 2019
11:58 a.m.

PREMARKED FOR IDENTIFICATION
DEPOSITION EXHIBITS 1-10
11:58 a.m.

VIDEO TECHNICIAN: We are now on the record. This is the video-recorded deposition of Janay Warren, PA-C, being taken on Tuesday, Feb- --

MR. WARWICK: May I -- may I interrupt?

VIDEO TECHNICIAN: Yes, sir.

MR. WARWICK: It's Janay Warner.

VIDEO TECHNICIAN: Warner.

MR. WARWICK: Yes. So if you just make sure --

VIDEO TECHNICIAN: Yes, sir.

MR. WARWICK: Okay. Thanks.

VIDEO TECHNICIAN: We're now on the record in the deposition of Janay Warner, PA-C, being taken Tuesday, February 26, 2019. The time is now 11:58 a.m. We are located at 99 Monroe Avenue, Grand Rapids, Michigan. We are here in the matter of Mary Anne Markel versus William Beaumont Hospital, et al, Case Number 2018-164979-NH. This matter is being held

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in the State of Michigan, Oakland County Circuit Court. My name is Shawn Capron, video technician.

Will the court reporter swear in the witness and the attorneys identify themselves for the record, please?

COURT REPORTER: Raise your right hand, please. Do you solemnly swear or affirm that the testimony you are about to give in this matter will be the truth, the whole truth, and nothing but the truth so help you God?

THE WITNESS: I do.

COURT REPORTER: Thank you.

MS. ALI: Muskan Ali for plaintiff.

MR. WARWICK: Don Warwick on behalf of William Beaumont Hospital.

MR. SINKOFF: Steven Sinkoff on behalf of Hospital Consultants and Dr. Lonappan.

EXAMINATION

BY MS. ALI:

Q. Okay. Can you please state your full name for the record?

A. Janay Ann Warner.

Q. A-n-n?

A. Yep.

MS. ALI: Okay. And let the record reflect

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that this is the deposition of Janay Ann Warner, taken pursuant to notice and agreement between counsel as to time and place, whose testimony will be used for the purposes as allowed under our Michigan Court Rules, as well as our Michigan Rules of Evidence.

BY MS. ALI:

Q. Ms. Warner, my name is Muskan Ali, and I represent Mary Markel in this matter.

Do you understand that we are here regarding the care and treatment that was provided to Ms. Markel in October 2015, at William Beaumont Hospital in Royal Oak?

A. Yes. That's what I gathered from the -- from the record.

Q. Have you ever given a deposition before?

A. No.

Q. Okay. So I'm sure your attorney has gone over the rules of a deposition with you, but I'm going to go over a few as we sit here right now.

When I -- this is a question-answer format. When I ask a question, I ask that you respond in a -- with a verbal response so that they can record -- so that it can be properly recorded. It's human nature to, you know, nod or to do "mmm-hmm." And if I respond with "yes" or "no," I'm not trying to be rude.

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I just want to make sure that we have your answer on the record; is that fair?

A. Fair.

Q. Okay. And if you do not understand a question that I ask, please let me know; otherwise, the answer that you put on the record will be as if you have understood my question and understood that -- strike that -- that you have understood my question, fair?

A. Fair.

Q. Okay. And I will do my best to make sure I allow you to finish a question before I proceed with my next question. But if at any time you have not finished an answer, please let me know and I will give you the opportunity to finish the answer; and vice versa, please let me finish my question before you start your answer. Good?

A. Okay.

Q. Okay. So you have provided us with your curriculum vi- -- vitae, and I've marked that as Exhibit 10. So we're going to start backwards a little, and we're going to go into a few of your background questions.

And you told me you have not done a deposition before?

A. Correct --

Q. Have you --

WARNER, PA-C, JANAY A.
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A. -- I've never done one.
Q. Okay. Have you ever been named as a defendant?
A. No.
Q. Okay. So you obtained your bachelor of science from Alma College in 2003?
A. Correct.
Q. Okay. And then did you immediately begin your physician assistant program at University of Detroit Mercy?
A. Yes.
Q. Okay. And when did you graduate?
A. In 2005. I think it was August 2005.
Q. Okay. It was a three-year-long program?
A. It was two years.
Q. Okay. Did that include the clinical rotations?
A. Correct.
Q. Okay. Did you do clinical rotations in family medicine?
A. Yes, among other things.
Q. Actually, can you tell me which -- which areas of medicine did you do your rotations in?
A. I'm not sure if I'm going to remember them all, but we did ER, we did family practice, pediatrics, OB-GYN, surgery, radiology, cardiology, dermatology.
Q. Okay. And were you a full-time student or were you

also working?
A. Full-time student.
Q. When did you take the physician assistant certified exam?
A. I -- I mean, it was sometime that summer of 2005. I wouldn't be able to remember exactly what month.
Q. Okay. And did you only take it once?
A. Yes.
Q. Okay. And you were certified in the summer of 2005?
A. Correct.
Q. And then did you receive the state license --
A. Correct.
Q. -- right away?
A. Yes.
Q. Okay. Have you had to recertify?
A. Yep. Twice.
Q. Okay. What years?
A. I -- it's every six years. So I would have done it, yeah, six years after 2005, and then --
Q. So I'm going to say --
A. -- another six.
Q. -- 2011.
A. And then recently, I think, I just recertified --
Q. 2017?
A. -- 2017. Yeah.

Q. And for each recertification, did you pass the first time?
A. Yep.
Q. Okay. Did you immediately begin working with William Beaumont Hospital after becoming certified as a P.A.?
A. No. I worked first at a pediat- -- pediatric office.
Q. How long were you there?
A. For a couple years, and then I started with Beaumont in 2007.
Q. Okay. And I believe off the record you said you -- you have moved to Grand Haven recently, correct?
A. Correct.
Q. And how long have you been in this area now?
A. We moved here October of 2017.
Q. Okay. So from 2007 to 2017, were you consecutively working -- were you an employee of William Beaumont Hospital?
A. Yes, and I'm still employed there.
Q. Okay.
A. Just now, as a contingent employee, since I live over here.
Q. Okay. From 2007 to 2017, were you at the Royal Oak campus?
A. Yes.
Q. Okay. When you began working at William Beaumont

Hospital in 2007, what area of medicine were you a P.A.?
A. I've always been in the emergency room.
Q. Do you have any teaching responsibilities?
A. We precept students, P.A. students, and sometimes medical students.
Q. What does "precept" mean?
A. So like when I did my rotations as a P.A. student, we have pre-arranged assignments; so we -- you know, we help out local schools, typically, as Wayne State and University of Detroit Mercy, but we have P.A. students from -- from all of the schools, really, in Michigan. So they do a rotation with us for about a month --
Q. Okay. Perfect. That was my next --
A. -- and work shifts with us. Yeah.
Q. Perfect. Thank you.
So, briefly, what are your responsibilities as a physician's assistant in the emergency department?
A. So we see patients. We, yeah, assess and diagnose and treat patients as part of the ER team.
Q. Who is a part of that ER team that you just mentioned in terms of medical providers?
A. Yep. So we work alongside our attending physician, and, typically, yeah, it's a -- so you're -- you're

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not counting -- like, I mean, we work with the nurses, as well, and ...

Q. So the ER team you referred to, correct me if I'm wrong, it would include you -- I mean, a physician's assistant, the attending physician, it would include the ER nurses --

A. Correct.

Q. -- and --

A. And a tech.

Q. -- and techs --

A. Yeah.

Q. -- nursing assistants, fair?

A. Fair.

Q. Okay. And the description you had where you assess, diagnose, as part of an ER team, and treat the patient in an emergency department, that was the same in 2015 for you, the same responsibilities?

A. Cor- -- in 2015?

Q. Yes.

A. Correct.

Q. In the year 2015.

Okay. When you round on patients, what does that cons- -- what does that mean to you as a physician's assistant?

A. So can you clarify the question? I mean, are we

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talking specifically about in a certain area of the ER or ...

Q. When -- okay. Say in a patient -- patient has been assigned to you --

A. Okay.

Q. -- and you have to round on that patient, what would you do -- what would "rounding on the patient" mean to you?

A. So the only area in the ER that we would round on patients is our observation area. We don't round on patients in any other area of the ER.

Q. Okay. So what is the observation area?

A. So the observation area is a 21-bed area within the observation -- or within the emergency room where patients are placed because they don't necessarily meet admission criteria but we don't feel comfortable letting them go home. They're not ready to be discharged; so they're either waiting for a consultant or waiting for a test. And so that's the only area that a patient would have someone round on them.

Q. What does "admission criteria" mean?

A. If -- if they're sick enough to warrant -- if they're not stable for discharge home.

Q. When you round on your patients in the observatory area of the emergency department --

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A. Mmm-hmm.

Q. -- do you report -- do you have clinical findings as well as physical examinations?

A. So, basically, the plan has already been set up by the initial providers who saw the patient in the ER; so they saw the patient, assessed the patient, formulated a diagnosis, and then they decided to transfer the patient to the observation area. So when working in the observation area, we are following their plan.

And when we round on a patient, we come in at 6:00 a.m., and we look up all our patients from six to seven, the P.A. does, and then we round with our attending physician starting at seven on the -- however many patients are in the unit.

Q. And the --

A. And we just make sure that we're aware of the plan, the patient's aware of the plan.

Q. When you round with the attending, do you -- at 7:00 a.m.?

A. We usually start rounds at seven, mmm-hmm.

Q. And the description that you just provided to me, where you round with the attending where the plan is set by the initial providers --

A. Mmm-hmm.

Q. -- was that true for -- was that the same case in

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2015?

A. Correct.

Q. Okay. Can you put in orders for the patients that you examine?

A. Yes.

Q. And are there any limitations to those orders?

A. What do you mean "limitations"?

Q. As opposed to a physician. Can you put in the same orders that a physician could for a patient?

A. Yes.

Q. Okay. And was that the same in 2015?

A. Yes.

Q. Okay. What EMR system does William Beaumont Hospital have?

A. Epic.

Q. Okay. And do you have access to everything that a physician would have access to in the EMR for a patient?

A. I should.

Q. And was that the same in 2015?

A. Yes.

Q. Okay. So in 2015, during your shifts, when you come in at -- was it 6:00 a.m.?

A. Yes.

Q. Okay.

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A. If I'm working in the obs area.
Q. Okay.
A. There's different shift times. But if you were working in obs, it starts at six, or there's a 10:00 shift, as well.
Q. So if it's the 10:00 a.m. shift, would that go to 11:00 p.m. then?
A. Ten to ten.
Q. Okay. So in 2015, during your shifts, when you come on, you know, come in for your shift, do you log into the EMR system --
A. Yes.
Q. -- the Epic system?
A. Yes.
Q. Okay. And do you have access to the Epic charts for your patient?
A. The Epic charts for my patient that I'm signing into?
Q. Yes.
A. Yes, if it's -- if I'm going to sign up for a patient, then I have access to their chart.
Q. Okay. And so correct me if I'm wrong, but you have access to the same Epic charts that the attending physician would have access to, correct?
A. Yeah. I don't see why it would be any different.
Q. Okay.

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A. I've never been told it's different.
Q. Okay. And when you log on, you have a patient list; is that true?
A. Are we talking -- if we're talking about the observation area, correct. If we're talking about other areas, then I would just see patients as I sign up for them.
Q. Okay. Okay. So I'm going to tell you what I just understood and then correct me if I'm wrong.
A. Okay.
Q. If you're in the ob- -- obser- -- observation area, you have a patient list; so when you log on, you can access the -- the patients?
A. Or -- yeah. So, basically, if I am working in the observation area, I have 21 beds that I sign into that area, and those are the patients in my area.
Q. Okay. So on any given day, you wouldn't have more than 21 patients?
A. That would be the max, yeah. That's the capacity for the unit.
Q. Okay. And -- strike that.
So once you became a P.A., you were trained to -- when you come on your shift and you're in the observation area -- to log onto the EMR system and to access your patients' charts, correct?

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A. Correct. We can see who is in the unit, mmm-hmm.
Q. Okay. And if there's any outstanding labs or radiology results or anything for a patient that's outstanding that has been ordered earlier, you would access those, correct?
A. If it's already been -- what do you mean? I can see everything that's been ordered, correct, and any of the lab results.
Q. Okay. So, hypothetically, you come in, you had a patient that was discharged and there's outstanding lab work that you had ordered and it has not come in but the patient has been discharged, would you go into the system when you come on your shift and access the outstanding results?
A. No.
MR. WARWICK: Just object to the form of the question. It's too vague. Go ahead.
THE WITNESS: Yeah. I'm not understanding -- so I only see the patients that are in the unit at the time. I don't see who's been discharged from the unit. I can only see the active patients who are in the observation unit, if we're still speaking of the observation unit.
BY MS. ALI:
Q. Okay. So there's never -- there's never a time where

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you would be accessing results for a patient that has been discharged?
A. Correct. Yeah. If they're -- if they're not someone I'm taking care of, I would not open up someone's chart that is not in my -- someone that I -- is in my unit.
Q. Okay. So you -- if a pa- -- if a patient is discharged, you have nothing to do with that patient after the fact --
A. Discharged from the --
Q. -- after they have been discharged?
A. -- observation unit?
Q. Yes.
A. Correct.
Q. Okay. And so while a patient is in the observation area -- observation unit and there's outstanding lab work that is -- that still has not come back, you know, has -- the results haven't come back, you would have -- and the patient gets discharged, you would have -- you would never go back into that patient's charts to access the results?
MR. WARWICK: So just object to the form because -- well, object to the form. And if -- if you're trying to apply it to the facts of this case, this is a patient who was admitted to the hospital

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after leaving the observation unit. So I object to the form. Go ahead, you can answer the question to --

BY MS. ALI:

Q. If you don't understand my --

MR. WARWICK: And, actually, you've already answered the question, so I -- it's also been asked and answered.

THE WITNESS: So --

MR. WARWICK: You can answer it again.

THE WITNESS: No, I wouldn't be responsible for looking up any further results on a patient.

MS. ALI: Okay. Perfect.

BY MS. ALI:

Q. As a P.A., has there been circumstances where you had to contact a patient after the patient has been discharged?

MR. WARWICK: Just objection to the form.

MR. SINKOFF: From the observation unit or for any?

MS. ALI: From the observation unit.

THE WITNESS: From the observation unit? Yeah, I can think of a few examples of -- I -- when I might have called a patient. Say I was finishing a -- a chart, my -- a note, and I realized that there was like a pulmonary nodule on an x-ray and just wanted to

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communicate with the patient so that they could follow up, something like that, that I might have taken it upon myself to call them.

BY MS. ALI:

Q. Okay. And has there ever been a time where you've received critical lab results and had to contact the patient and let them know?

A. No.

Q. Okay. And -- and just so we're clear, you would not see a patient that's not in the observation room, correct? You would not be rounding or be treating a patient that's not in the observation room?

A. No. I work in all areas of the ER.

Q. Okay. And --

A. So I'm only in the ob- -- the observation unit when I'm assigned to be there, but it's not every shift. I -- all of the ER staff rotates through different areas, so I'm not -- yeah.

Q. What are the other areas of the emergency department?

A. Well, they're all renamed now, because they just went through a remodel, but there used to be A, B, C, D, E, F, peds, obs, but they're all renamed now. Trauma room.

Q. And was -- were these rooms, A, B, C, D, E, F, peds, obs, trauma, were those the same -- were those areas

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of the emergency department in 2015?

A. Correct.

Q. Okay. Hypothetically, a patient is in the observ- -- obs- -- I don't know why this is so hard for me to say, but -- observation room, and there are outstanding orders that have not been -- the results have not come in yet, would it be -- to your knowledge, is it usually the physician -- the attending physician that would contact the patient who has been discharged from the observation room and let them know of the results?

MR. SINKOFF: Object to foundation.

MR. WARWICK: Same.

MR. SINKOFF: Identify what you mean by "attending physician."

BY MS. ALI:

Q. The attending physician that's rounding on the patient with you.

MR. WARWICK: So just the same objection, form and foundation, because you're not differentiating between the patient being discharged directly from ER or observation and a patient that gets admitted to the hospital and has an attending.

BY MS. ALI:

Q. Discharged to the hospital.

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A. Someone that's discharged, you're asking if the attending I rounded with would --

Q. Mmm-hmm.

A. -- would contact the patient?

Q. Mmm-hmm.

A. No.

Q. Okay.

MR. WARWICK: Just so the record is clear, it's not actually discharged to the hospital. It's admitted to the hospital.

MS. ALI: Yeah.

BY MS. ALI:

Q. Do you, as a P.A., have authorization to discharge a patient without the approval of an attending physician?

MR. WARWICK: Just object to the form. Again, you're talking direct discharge from the observation unit --

THE WITNESS: Like let them go home?

MR. WARWICK: Hold on. Hold on a second.

THE WITNESS: Sorry.

MR. WARWICK: You're talking about direct discharge from the observation unit to home?

MS. ALI: Yes.

MR. WARWICK: So I object to the relevance,

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as well, as patient -- it didn't happen in this case, so I'm not sure what we're doing here. But this is a patient who was admitted to the hospital, she had a very limited role, and then the patient was admitted. And the urine culture results itself -- the urine culture test didn't even take place until the patient was on the floor.

So, I mean, we could take four hours for this deposition, but this should be very limited question. It's very quick that she was involved in this case.

MS. ALI: I understand that. The --

MR. WARWICK: So, I mean, we're trying to --

MS. ALI: -- attending physician was --

MR. WARWICK: It doesn't make any sense to me why we're asking questions about direct discharge from the emergency center --

MS. ALI: Mmm-hmm.

MR. WARWICK: -- when the patient was not directly discharged from the emergency center. The patient was admitted to the hospital, had an attending physician in the hospital --

MS. ALI: Mmm-hmm.

MR. WARWICK: -- the urine culture results

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that you're alleging were not properly followed up on. That urine culture, that sample, wasn't even taken until hours after P.A. Warner had any role whatsoever in this case.

MS. ALI: The urine cultures were ordered by Ms. Warner.

MR. WARWICK: Right, and then the -- the actual urine cultural sample itself took place on the floor. This has nothing do with a patient who gets discharged directly from the EC, has nothing to do even -- you know, I could continue this objection. I just want to cut to the chase a little bit on this, because it doesn't make any sense to ask those kind of questions.

MS. ALI: We can have a -- an objection as to any questions. You can place --

MR. WARWICK: Well, what's the point?

MS. ALI: You can place --

MR. WARWICK: What's the point?

MS. ALI: You can place an objection.

MR. WARWICK: No, I object to the form of the question, because it's completely irrelevant as it relates to --

MS. ALI: That's --

MR. WARWICK: -- the case.

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MS. ALI: Okay. So you can have an objection as to any questions regarding a discharge from the obser- -- observation room to home.

MR. WARWICK: It's not whether --

MS. ALI: We can have --

MR. WARWICK: -- I can have an objection.

MS. ALI: -- a continuing objection.

MR. WARWICK: It's not whether I can have an objection. It's that if I object to the form --

MS. ALI: But if --

MR. WARWICK: -- I think you have a responsibility then, under the court rules, to say why it is relevant, because it's completely irrelevant to the case.

MS. ALI: It -- irrelevancy is up -- is up for me to decide.

MR. WARWICK: No, it's not.

MS. ALI: And anything is --

MR. WARWICK: It's really up to the judge to decide.

MS. ALI: Okay. So that's fine, we can take that up to --

MR. WARWICK: Okay.

MS. ALI: -- the judge. You can object as you -- as you wish.

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MR. WARWICK: Well, what's the point? If I --

MS. ALI: That's --

MR. WARWICK: -- object to the form of the question about someone and you're asking questions over and over again about discharge from the -- the observation unit when that didn't happen in this case, what's the possible, conceivable relevance? And --

MS. ALI: She --

MR. WARWICK: -- the standard is whether it's reasonably calculated to lead to the discovery of admissible evidence. What's the possible relevance in this case? And we've done it for 15 minutes now.

MS. ALI: You can object and have a standing objection, and we can -- if you want, you can file a motion and we can take this up to the judge. I'm allowed to ask whatever I want from the deponent. So as long as --

MR. WARWICK: Well, you're really not allowed to ask whatever you want --

MS. ALI: That's fine, but --

MR. WARWICK: -- from the deponent.

MS. ALI: So are you telling your -- your client to not answer my question? Because I --

MR. WARWICK: No. I'm asking you to ask

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relevant --
MS. ALI: Okay.
MR. WARWICK: -- questions.
MS. ALI: So if you want, that's fine, you can place an objection on the record.
MR. WARWICK: Okay.
MS. ALI: Okay.
BY MS. ALI:
Q. Anyway, my question was, Ms. Warner, as a physician assistant, are you authorized to discharge a patient from the observation room to -- without the approval of an attending physician --
MR. WARWICK: Just --
BY MS. ALI:
Q. -- discharge home?
MR. WARWICK: Same, form, foundation. Go ahead and answer it again.
THE WITNESS: So, yes, if there is, hypothetically, a patient that has completed the testing or the plan that was set forth and there were no other reasons to keep the patient, say they completed a stress test and it was normal, then, yes, I can discharge them home.
BY MS. ALI:
Q. Okay. And do you have a State of Michigan Controlled

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Substance License?
A. Yes.
Q. Okay. And did you have one in 2015?
A. Yes.
Q. Okay.
A. Well, I think so. I forget when that first came out. I've always had a DEA license to prescribe narcotics, but I know that the Controlled License -- the Controlled Substance License is more recent that the State required that. I can't actually say a hundred percent when that -- when that started.
Q. Okay. So we are on Exhibit -- I believe this is what it was. Yep. So -- okay. Actually, one moment.
So if you're taking care of patients in the observation room and you suspect there is an infection, what course of treatment do you proceed with as a physician's assistant?
MR. WARWICK: Just objection to the form.
THE WITNESS: What type of infection?
BY MS. ALI:
Q. If --
MR. WARWICK: Grossly overbroad.
BY MS. ALI:
Q. If --
MR. WARWICK: Go ahead.

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BY MS. ALI:
Q. If you fear that there may be an infection, that there's inflammatory responses in the patient, how do you go about with the treatment for the patient? Do you prescribe antibiotics?
A. I mean, that's really vague. It could be -- there's so many different scenarios that that could fit.
Q. Mmm-hmm. So say a patient is pre- -- strike that.
So this is marked as Exhibit 1. I'm going to hand -- actually, you have a copy of Exhibit 1 in front of you.
A. Okay.
Q. Okay. So this is on -- what -- what does this sheet tell you?
A. To me, it tells me the time line of the patient's care, kind of a time line of when she came into the ER and --
Q. Does it also tell you the providers that were participating in the care and treatment of Ms. Markel?
MR. WARWICK: Just objection to foundation, but go ahead. You can speak for yourself.
THE WITNESS: It looks like there's a lot of names listed here, people that were in her chart, yes.
BY MS. ALI:

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Q. Okay. So do you see your name towards the bottom of the page?
A. Yes.
Q. Okay. And the Treatment Team, the -- underneath that, where it says "Role," what does "Physician Extender" mean?
A. That's --
Q. If you know.
A. That's just identifying me as a P.A.
Q. Okay. And the specialty for you is emergency medicine?
A. Correct.
Q. Okay. And the "Active From" and "Active to," I'm seeing dates 10/10/2015 at 6:38 a.m. --
A. Correct.
Q. -- to 10/10/2015 at 2:04 p.m.?
A. Correct.
Q. Okay. And what does that tell me?
A. So that tells me that I first accessed the patient's chart at 6:38, probably she was halfway through my list of people I was looking up in the morning when I came in, and it looks like I last accessed the patient's chart around 2:00, right before she was admitted.
Q. And when you say "admitted," do you mean --

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A. Or transferred --
Q. Okay.
A. -- I'm sorry, to the floor.
It looks like I admitted her at 12:18, or I placed the admission orders.
Q. And where did you get this admitted information from?
A. I think it's on one of your exhibits. Let's see. Yeah. It's on Exhibit 8. Or, sorry, 9.
Q. And you're referring to the orders, page 138, Exhibit 9, where the first order on the page is "Admit without TMS"?
A. Correct.
Q. Okay.
A. At 12:18.
Q. And where were you admitting Ms. Markel?
A. Where, as in to -- I mean, to the hospital? What do you mean?
Q. Yep. Where -- in a specific area of the hospital? Where was she being admitted?
A. I wouldn't know what area she would go to. But yeah, I was admitting her to the medicine team at Beaumont Hospital.
Q. What do you -- who do you mean by "medicine team"?
A. It looks like Hospital Consultants or Haas/Wease.
Q. What have you reviewed for your deposition today?

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A. I reviewed this, the records.
Q. Okay.
A. And, actually, these are just the same. They're just my charting pulled out of the records and Dr. Lonappan's charting pulled out of the records, and then I was given a copy of Dr. Lonappan's deposition, as well.
Q. Okay. And who provided these -- this information to you?
A. My attorney.
Q. Did you take any notes?
A. No. I put --
Q. I see tabs -- I see stickies in there.
A. Yeah. They're almost exactly the same as your exhibits.
Q. Okay.
A. It was just for ease of reference, because it was hard to find my -- where my notes were.
Q. Have you gone back into the electronic medical records of Ms. Markel since you received the Notice of Intent?
A. No.
Q. Okay. And outside of the records that you have reviewed on Dr. Lonappan's deposition, do you have any independent memory of Ms. Markel in October 2015?
A. No, I don't.

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Q. Okay. And -- and based on your review of the records, can we agree that Ms. Markel presented to the emergency department in -- on October 9, 2015, of William Beaumont Hospital?
A. Yes. She came to the ER.
Q. Okay. And she was taken to the observation room at 11:12 a.m., on October 9, 2015, is that true, based on --
A. At what time?
Q. At 11:12 a.m., which is on Exhibit 2. I'm referring to Exhibit 2.
A. Okay.
Q. I didn't know if that was entered by --
A. I have to look.
Q. -- Nurse Shannon Davis, towards the ba- -- the bottom. ED observation -- I mean -- yeah, nurse notes by Shannon Davis.
A. Okay. Yeah, it looks like she arrived pretty late that night --
Q. Mmm-hmm.
A. -- at 11:45 p.m.
MR. SINKOFF: Just object to the form of the question. 1112 is the room number.
MS. ALI: Oh, I see.
MR. WARWICK: Yeah, exactly.

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MS. ALI: I understand. Thank you.
MR. WARWICK: Same objection.
BY MS. ALI:
Q. Going back to Exhibit 1 that we were looking at earlier, who was the attending provider based on this sheet?
MR. SINKOFF: Where?
MR. WARWICK: Just object to the form.
MS. ALI: On the first page.
MR. SINKOFF: Where?
MS. ALI: For Ms. Markel.
MR. SINKOFF: Attending where?
MS. ALI: Attending in the William Beaumont Hospital.
MR. WARWICK: No. So --
MR. SINKOFF: Where?
MR. WARWICK: -- objection to the form. You mean in the --
MR. SINKOFF: In the emergency department? In the observation --
MR. WARWICK: You mean the observation unit?
MR. SINKOFF: -- unit? On the floor? Where?
MS. ALI: In the emergency department.

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MR. SINKOFF: Thank you.
THE WITNESS: It looks like --
MR. WARWICK: So wait. So let me --
THE WITNESS: Okay.
MR. WARWICK: -- make sure. Objection to the form and foundation. You can -- if you can glean from the record in the emergency department, you can tell her what your understanding is from the record; otherwise, you can tell who -- who the attending was in the observation unit in the emergency department when you were involved.
THE WITNESS: Which -- am I understanding the question? Do you want to know who saw her in the emergency room?
MS. ALI: Yes, please.

BY MS. ALI:

Q. Who was the attending physician assigned to Ms. Markel in the emergency department, if you can -- if you can tell me that, based on this sheet of paper?

A. Based on --

MR. WARWICK: Just a minute.
THE WITNESS: Yeah.
MR. WARWICK: Just object to the foundation, but go ahead, based upon the record.
THE WITNESS: I mean, just reading the record, it looks like Dr. Hang saw her initially in the emergency room on 10/9, with Amy Joseph.

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BY MS. ALI:

Q. And that would be the ER team you -- you referred to before, where a P.A. is assigned to an attending physician; is that true?

MR. WARWICK: Just object to the form. I -- go ahead. I think she was referring to her involvement, but go ahead and answer the question.
THE WITNESS: I'm getting confused, so --
MS. ALI: That's okay. We can strike that question.
THE WITNESS: Okay.
MS. ALI: No worries. Yep.

BY MS. ALI:

Q. Do you know who Dr. Linet Lonappan is?

A. I know who she is.

Q. Okay. Have you worked with her before?

A. I believe I've spoken to her on the phone before. She's -- Hospital Consultants takes a lot of admissions from the ER.

Q. Okay. And since her deposition, have you had -- since the notice -- since you received the Notice of Intent, have you had any discussions with her regarding this case?

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A. No.

Q. Regarding anything?

A. No.

Q. Okay. In October 2015, what were your shifts, if you recall?

A. Like what were the different shifts that I might work?

Q. Yeah.

MR. WARWICK: Just foundation. Go ahead.
THE WITNESS: Yeah, that would be --
MR. WARWICK: Form -- form -- I should say form of the question, but go ahead.
THE WITNESS: I think --
MR. WARWICK: You mean in the ER or in observation?
MS. ALI: In the observation.
THE WITNESS: Oh, observation. So there were only two shifts in the observation unit. There was a 6:00 a.m. to 4:00 p.m. shift, and then there was another ten to ten -- 10:00 a.m. to 10:00 p.m. shift, but there were lots of other shifts within the ER in the different areas.

BY MS. ALI:

Q. And it would be dependent on the different departments in the ER, correct?

A. Correct, what times they were, yeah.

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Q. Okay. And based on your review of the records of Ms. Markel, can you tell me what shift you were on in October 2015, when you were providing care and treatment to her?

A. Yeah. I can tell I was the 6:00 to 4:00 shift, because I was, yeah, reviewing her chart at 6:00 a.m.

Q. Okay. And when did you first start taking care of Ms. Markel?

A. Well, my shift is from six to four, so I would be, yeah, caring for the patients in that area --

Q. Okay.

A. -- during those hours. So, I guess, maybe -- I can't -- I don't know exactly the first time I would have seen Ms. Markel, but I'm assuming it was 8:08, is when I opened a note on her.

Q. Mmm-hmm.

A. So I'm assuming it was just after 8:00 a.m. that I met her.

Q. Okay. So were you solely in the observation room on that day?

A. Correct. That shift is in the observation area only.

Q. I believe you referred to a note at 8:08 a.m., correct? You referred to a note that you --

A. Yeah, that's the first time.

Q. So that's -- can you go to Exhibit 3, please? Is that

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the note you were referring to?
A. Correct.
Q. When was this note entered into the electronic medical record system?
MR. WARWICK: Just object to the form. To the best you can answer it, go ahead.
THE WITNESS: So as we round on all of our patients, we open a note on everyone.
MS. ALI: Mmm-hmm.
THE WITNESS: So we open and start our note, but we don't complete it until the plan is complete.
BY MS. ALI:
Q. Okay. So 10/10/15 0808, what does -- what does that tell me, if I'm looking at your note?
A. So that tells me that's probably when we saw the patient and we opened the note.
Q. Okay. And I'm going a little bit further down from where it says, "ED Obs Provider Notes By Warner, Janay, PA-C," where it, in bold, has "Observation Note."
Does that tell me that this is a note because you're in the observation area?
A. Yeah. I would assume it's just -- yeah.
Q. Okay. So I'm reading: "The Observation Physician has

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reviewed the following: EC records, observation records and nursing notes."
Who is the observation physician for Ms. Markel?
A. Dr. David Berger.
Q. And he's the cosigner of this note?
A. Correct.
Q. Okay. What are the EC records?
A. The EC records would have been what Dr. Hang and Dr. -- and Amy Joseph would have completed.
Q. And how -- if you know, how did the past medical history and past surgical history get into your observation note, or is that just normal for the history and the -- the history of the patient to be part of that note when you go in and put your note in?
A. Correct, it's prepopulated.
Q. Okay. So I'm looking at page 26, which is the third page of Exhibit 3. And towards the middle of the page, I see that there's a "WBC 13.8," and it's in bold. And underneath it, there is a "UA awaiting repeat."
Can you tell me what that means to you?
A. So, yeah, I just summarized the patient's course in the EC observation area, and I usually just write down any labs that -- yeah, that I would -- that were done

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in the observation area. I probably wanted them to know that the urine was not done yet --
Q. Okay.
A. -- for some reason, so I put it await -- awaiting repeat.
Q. Okay. And the "WBC 13.8" --
A. Mmm-hmm.
Q. -- that's white blood count 13.8?
A. Correct.
Q. Okay. And that -- that was significant to you?
A. It could be. I think I just must have put it down to be complete.
Q. Okay. 13.8 is a high white blood count, correct?
MR. WARWICK: Just objection to the form.
MR. SINKOFF: Join.
BY MS. ALI:
Q. Is a 13.8 white blood count high?
A. It's with -- it's outside of the normal range that Beaumont sets.
Q. And what is the normal range?
A. I'd have to look.
Q. Could you --
A. Is that on one of the --
Q. Is it fair to say that you included it in your note because it's outside the normal range?

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A. Correct.
Q. Okay. And towards -- underneath the white blood count 13.8 --
MR. WARWICK: So -- I mean, not to interrupt you.
MS. ALI: Mmm-hmm.
MR. WARWICK: I apologize. But your Exhibit 6 does reference the -- the range, if you are interested in that.
MS. ALI: Oh, thank you.
MR. WARWICK: Yeah.
BY MS. ALI:
Q. What is the normal reference range?
A. So it looks like for Beaumont, it's 10.7, is the high end --
Q. Okay.
A. -- 3.3 is the low end.
Q. So in your note where it says white blood count 13.8 for Ms. Markel, that's high, correct --
MR. WARWICK: Just objection to form.
BY MS. ALI:
Q. -- based on the range that William Beaumont Hospital has given and provided?
MR. WARWICK: Just --
THE WITNESS: So I'm indicating that it's

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abnormal outside the range, the reference range.

MS. ALI: Thank you.

BY MS. ALI:

Q. So I'm back to Exhibit 3. And underneath the white blood count, underneath the urinalysis awaiting repeat, I see that there's a treatment plan. And would that treatment plan have been made by you and the attending physician?

A. It looks like -- oh, the treatment plan --

Q. That's in your note.

A. What attending physician?

Q. Are you currently rounding with the -- on Ms. Markel in the observation room with an attending physician?

A. So we just round in the morning --

Q. Okay. And who --

A. -- on all the patients.

Q. And who would you have rounded with?

A. Dr. Berger.

Q. Okay. And this treatment plan that's in your note, who would have come up with this plan?

A. So it looks like neurosurgery, PM&R are the ones -- the specialists who kind of came up with the plan for admission; is that what you're --

Q. That's -- yep.

A. And I would be part of that, as well.

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Q. Okay. And who -- who is Haas -- okay. So I'm reading in the treatment plan. "Admit (see Order to Admit) in stable condition to Haas/Wease."

A. Yep.

Q. Who are they, if you know?

A. So I believe that that's the hospital consultant team. They're also known as Haas/Wease.

Q. Okay. And Dr. -- Dr. Lonappan then, as well?

A. I'm assuming that she works for them. That's -- yeah, that's --

MR. SINKOFF: Object to the foundation.

BY MS. ALI:

Q. Okay. I'm on the next page of Exhibit 3, and -- actually, strike that.

In your experience as a physician's assistant, why would it be important to know if a patient is having trouble urinating?

A. Specifically for this case?

Q. In general.

MR. WARWICK: Just object to the form. Go ahead. It's overbroad, but go ahead.

THE WITNESS: Yeah, that's really -- there's so many scenarios that I feel like you could talk for hours about.

BY MS. ALI:

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Q. Could -- could infection -- a suspected infection be a reason for it --

MR. WARWICK: Just objection --

BY MS. ALI:

Q. -- UTI?

MR. WARWICK: -- same, form. Unless you're talking about this patient, it's grossly overbroad.

THE WITNESS: For difficulty urinating?

MS. ALI: Yes.

THE WITNESS: Specifically with this patient?

MS. ALI: No. In general.

MR. WARWICK: So same objection to the form.

THE WITNESS: With this patient, difficulty urinating was a -- a red flag for neurogenic, potential cord compression. So, yeah, more so -- more so for something else going on with the lumbar radiculopathy.

BY MS. ALI:

Q. Okay. When you round on your patients in the observation room, do you check their lab work?

A. Yep. That's one of the things we do, we go over their labs.

Q. Okay. And you check their history?

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A. Correct.

Q. Medical? Family?

A. Correct. We kind of review everything at the bedside with the patient, myself, and the doctor.

Q. Okay. In your note that we -- it was in Exhibit -- Exhibit 3, where it says, on page 26, "UA awaiting repeat," does that tell me the urinalysis is being reordered, that there -- there's a repeat UA that needs to be done?

A. Correct.

Q. And we're awaiting the results?

A. Correct.

Q. Okay.

MR. WARWICK: Well, actually, object to the form. It says, "UA awaiting repeat." I mean, it doesn't mean waiting -- awaiting results. I think it means awaiting --

THE WITNESS: Like it --

MR. WARWICK: -- repeat --

THE WITNESS: -- hadn't been done yet.

BY MS. ALI:

Q. Okay. And I'm looking at Exhibit 3 again. And in the -- in the history, the past surgical history, it is noted that Ms. Markel had an arthroplasty of the total knee left and arthroplasty of the total knee

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right, correct?
A. Yes.
Q. And that means a total knee replacement, correct?
A. Correct.
Q. Okay. Are there any vitals noted in your obser- -- observatory note, which is marked as Exhibit 3, for the patient?
A. Inside my note?
Q. Yeah.
A. I'm not sure. I'd have to look. I don't see any in my -- inside my note.
Q. Do you usually check the vitals of a patient, as well, before --
A. Yeah.
Q. -- I mean, while you're rounding?
A. Their vitals get checked all the time in the obs area. It would be on the vital sheet, yeah.
Q. Does -- does the observation note usually have vitals listed for the patient?
A. No, not always. It's more just a summary of the -- of the course while in the ED -- or in the E- -- EC obs unit.
Q. I'm looking at Exhibit 7, and there are vit- -- there's an order for vital signs by Amy Joseph. Do you see wha- -- do you see that at the top of the

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page?
A. Yes.
Q. And the frequency is put in as "stat" ongoing, correct?
A. Correct.
Q. And why -- what does "stat" mean?
A. So it means as soon as possible.
Q. Okay. And ongoing?
A. So she would have wanted it to -- them to do vitals when the patient arrived to the observation room and then ongoing per their protocol.
Q. Okay. And what date was this order plan?
A. It looks like it's on the 9th.
Q. At what time?
A. At 19:41.
Q. I'm now on Exhibit 8.
A. 8?
Q. Yes. Page 2 -- page 135, which is the second page of Exhibit 8. And these are orders by you, correct, on the second page?
A. On the second page?
Q. Yes.
A. Yes.
Q. Okay. I'm looking at the second order from the top, which is -- oh, my apologies. I'm looking at the

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first order.
A. Okay.
Q. And can you tell me what this order is?
A. So these are just standard admission orders. There's like an order set that we use to admit a patient, and these are just standard. So the first one looks like it's telling the nurse to call -- call doctor.
Q. Mmm-hmm. And why -- what -- what would the reason be, if you can tell me?
A. This one says for temperature.
Q. Okay. And for temperature above 100.4, correct?
A. Correct, that's what the order says.
Q. Okay. And you're saying this is a standard order that you put in?
A. Yeah. It comes with all admission sets.
Q. Okay. Which is for 100.4 degrees Fahrenheit?
MR. WARWICK: Just object to the form. I want to make sure the record is clear. Tell her why -- tell her what this order means. It's not saying "this patient at 100.4 temperature." It's saying "call the physician if the patient develops a temperature above 100.4."
THE WITNESS: Correct. Yes.
BY MS. ALI:
Q. And --

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MR. WARWICK: I -- I shouldn't be asking the question, though. So can you explain that?
THE WITNESS: Yes. So these orders are just, basically, so the nurse knows what to do if the patient develops a temperature above 100.4, then they're asking the nurse to contact a physician.
BY MS. ALI:
Q. Why -- why would you want a doc- -- a nurse to contact a doctor if a patient's temperature is over 100.4?
A. So 100.4 is what we consider a fever.
Q. Okay. And why would it be of significance if a patient has a fever?
MR. SINKOFF: Object to foundation --
MR. WARWICK: Same objection --
MR. SINKOFF: -- overbroad.
MR. WARWICK: Same objection, form and foundation.
BY MS. ALI:
Q. How about -- let me rephrase. If a patient has a high white -- white blood count and a patient has a -- over a hundred -- has a fever, would that be of significance to you?
MR. WARWICK: Just same, form --
MR. SINKOFF: Object to foundation, form.
MR. WARWICK: Same, form and foundation.

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THE WITNESS: It may not be significant, but the nurse should contact the physician to discuss it.

BY MS. ALI:

Q. And why?

A. Because the physician should be aware of any changes that are occurring with their patient.

Q. Okay. And are you familiar with SIRS?

A. Yes.

Q. Okay. And if a patient has a fever and a patient has a high white blood count, would that be significant to you?

MR. WARWICK: Just same, form and foundation.

MR. SINKOFF: Form and foundation and relevance. The patient never had SIRS.

THE WITNESS: It could be concerning, which is why they're asking the nurse to communicate with the physician and let the physici- -- physician decide if there's something further that they'd like to do.

MS. ALI: Okay. My apologies, I did not hand this earlier. This will also be marked as an exhibit.

MR. WARWICK: Well, then we should take a break and make a copy.

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MS. ALI: I think I might have enough copies here.

MR. WARWICK: Okay.

MR. SINKOFF: This is 11 or 12?

COURT REPORTER: 11.

MS. ALI: And, of course, I do not.

MR. WARWICK: Is that the same as this or --

MR. SINKOFF: I have three pages starting October. 135, 136, 137. Exhibit 12?

COURT REPORTER: 11.

MS. ALI: We're going to mark this as Exhibit --

COURT REPORTER: Here it is.

MS. ALI: Thank you -- 11. Oh. You have it as 135, 136, 30- -- 137?

MR. SINKOFF: I do.

MS. ALI: Thank you.

MARKED FOR IDENTIFICATION
DEPOSITION EXHIBIT 11
1:02 p.m.

BY MS. ALI:

Q. Okay, Ms. Warner, I'm looking on Exhibit 11, page 135, 136, and 137. And we just reviewed, on the top, the first order said to call -- that you entered -- you

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entered an order where the nurse needs to call the doctor if the patient's temperature goes over 100.4 degrees, correct?

A. Correct.

Q. Okay. And now I'm looking at page 136. And towards the bottom, the last order on this page, was that by you?

A. The order for UA?

Q. Yes.

A. Yes. That's also part of the standard admission order set.

Q. Okay. So can you read to me what this order is?

A. It says, "Order UA and urine culture and sensitivity for new onset dysuria (non-catheterized patients only)."

Q. Okay. "New onset dysuria," am I saying that correctly?

A. Dysuria.

Q. Dysuria. It's -- I'm not going to say it correctly. As long as you know what I'm talking about.

And so you're saying this is typical -- typically put into a patient's records -- orders?

A. Yes. It comes up with all admission orders.

Q. Okay. So this order does not tell me that there was a new onset dysuria for the patient?

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A. Correct. It's telling the nurse, please order a urine if there's new onset dysuria that the patient is complaining of.

Q. Understood. And it would be under the discussion of the nurse to place this order then -- I mean to --

A. I'm not sure how it works on the floor, honestly.

Q. Okay.

MR. WARWICK: Just object to foundation.

MS. ALI: Can we go off the record, please?

VIDEO TECHNICIAN: We're going off the record. The time is 1:02 p.m. We're off the record.

(Off the record at 1:02 p.m.)

(Back on the record at 1:06 p.m.)

VIDEO TECHNICIAN: We are now back on the record. The time is 1:06 p.m.

BY MS. ALI:

Q. Ms. Warner, I'm looking at Exhibit 6. These are results for Ms. Markel, correct?

A. Correct.

Q. And would you have reviewed these while you were rounding on her?

A. Correct.

Q. Okay. And I'm looking at the one -- the first one, where it's a complete blood count. And is that a normal lab result?

MR. WARWICK: Do you mean -- which one are we talking about?

MS. ALI: The first one -- oh, my apologies. Which resulted on 10/9/2015, at 5:42 p.m.

THE WITNESS: So the very first one --

MS. ALI: The first one.

THE WITNESS: -- CBC?

MS. ALI: Yes.

THE WITNESS: So, yeah, we already discussed that, that --

MS. ALI: Mmm-hmm.

THE WITNESS: -- 13.8 is outside of the normal range.

BY MS. ALI:

Q. Okay. Is that the only abnormal results in this CBC?

A. It looks like the neutrophils and the monocytes are also outside the normal range.

Q. Okay. And now I'm looking at the next result, which is -- oh, wait. My apologies. Strike that.

And in that CBC, the neutrophils, does this lab results list that they're high?

A. It looks like they're slightly elevated outside the normal range.

Q. Okay. And what are "neutrophils"?

A. So it's another type of cell that can be helpful in looking for in- -- inflammation or -- yeah. It can be present, along with some of the other components of the CBC.

Q. Okay. And what are "monocytes"?

A. They're another component of the CBC. You want me to get into the pathophysiology of the --

Q. No, that's okay.

What -- if -- if they're high, what does that indicate to you?

A. If the monocytes are high?

Q. Mmm-hmm.

A. It could be many different things.

Q. Okay. And could it be indicative of inflammation?

A. It's possible.

Q. Okay. What about neutrophils?

A. What could they indicate if they're high?

Q. Mmm-hmm.

A. Many things, again. Could be a virus or -- yeah, other inflammatory process.

Q. Okay. I'm looking on Exhibit 6 still, and I'm looking at the -- page 61, the basic metabolic panel --

A. Mmm-hmm.

Q. -- on the top. Is that a norm- -- is that a normal result, as well, lab result?

A. For the BUN?

Q. Yes.

A. It's essentially normal. It's one outside of the normal range. But no, I guess you would have to say it's outside the normal range because it's slightly elevated.

Q. Okay. And now I'm looking at the urinalysis, the second lab results on page 61.

A. Okay.

Q. Is that abnormal, as well?

A. The urinalysis result?

Q. Yes.

A. It is, but it looks like it's a contaminated sample.

Q. Okay. So then we go to the -- how do -- how do you know that it's a contaminated sample?

A. On page 62, it looks like there's squamous cells --

Q. Mmm-hmm. Okay.

A. -- so it's not a clean sample. It can't be -- yeah, it's just -- isn't an equivocal test. It's not really good information if it's contaminated.

Q. Okay. So then we're looking at page 62, and there's another urinalysis that was done, correct?

A. Correct.

Q. And was this one done by -- ordered by you?

A. Yep, it looks like it was ordered by me.

Q. Okay. And is this abnormal, as well?

A. It still looks like it's abnormal.

Q. Okay. And can you tell me what the abnormal results are in this urinalysis?

A. In the one that I ordered?

Q. Yes.

A. There's white blood cells greater than 100. Leukocyte esterase 2+.

Q. Is that it?

A. There's some other trace blood. It looks like a few RBCs and -- but the bacteria is negative.

Q. Okay. And now I'm looking on page 63 of Exhibit 6. And you ordered urine cultures, correct?

A. I ordered it at the same time as the urinalysis in case it was contaminated again.

Q. Okay. In case the urinalysis --

A. Probably. I guess I can't speak to why I did it.

Q. Okay. And what are the findings of this urine culture? Strike that.

Is this urine culture abnormal?

A. The urine culture grew Group B strep -- is that what you're referring to?

Q. Mmm-hmm.

A. -- greater than 1,000 [sic].

Q. Okay. And what does that indicate?

A. So that indicates that the culture grew out a bacteria

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called Group B strep.
Q. Okay. And when did you order this -- the urine cultures?
A. The urine culture and the urinalysis order were placed at the same time, I believe.
Q. Okay. And why did you order the urine cultures?
MR. WARWICK: Well, let's -- let's let her answer the question about when she ordered it.
THE WITNESS: The 13:4- -- 49, I ordered both of them at the same time. It's an order set you can choose, urinalysis with culture.
BY MS. ALI:
Q. Okay. So what inclined you towards ordering urine cultures for this patient?
A. And the urinalysis?
Q. Mmm-hmm.
A. Because they're like kind of an order set. I guess I can't say a hundred percent, but it's common that I review all the patient's chart before they are transferred to the floor, and I may have just seen that she had a contaminated sample before and wanted to be complete.
Q. Okay. And so, specifically, in her presentation and symptomology, you ordered the urine culture. It's -- what I'm understanding is that you ordered the urine

Page 62

culture is because you wanted to be sure that the -- the abnormal urinalysis from before, that you had something else to verify, as well?
MR. WARWICK: So just object to the form.
BY MS. ALI:
Q. I guess --
MR. WARWICK: Explain why you ordered it, if -- if you can.
THE WITNESS: So, I mean, I don't recall this patient or --
MS. ALI: Mmm-hmm.
THE WITNESS: -- the scenario, but I'm -- from what I usually do in the emergency observation area, I would normally order a urine with a culture.
BY MS. ALI:
Q. And do you do that for all patients that --
A. Not all patients --
Q. What --
A. -- but most patients. Because if -- yeah, you want to -- if it's positive, then you want to know what -- what grows out, what the final result is for. So there would be very few patients that I wouldn't order it. If maybe it was just someone in the ER that I was going to discharge, a patient that I was seeing outside of the observation area, I would just order a

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regular urine, and, yeah, I wouldn't necessarily order a culture on a patient like that, so ...
Q. Okay. So what makes -- you said earlier if there's positive, then you order the culture because you want to know what?
A. If it's contaminated.
Q. You want to know what's contaminating the urine?
MR. WARWICK: Well, object to the form.
BY MS. ALI:
Q. Is that what you're --
THE WITNESS: No. No.
MR. SINKOFF: Object to the form.
THE WITNESS: So it was a poor sample. So it looks like the first sample that they did in the ER, the one that I presume I was reviewing before I sent her up to the floor, was just contaminated. So that means she didn't give us a good sample. She didn't wipe good. She didn't give us a midstream, clean catch. So in that case, it's -- it's common to order a urine and a urine culture.
MS. ALI: Okay.
THE WITNESS: Because you want to get a good sample.
MS. ALI: Can we go off the record for a minute?

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VIDEO TECHNICIAN: Going off the record. The time is 1:15 p.m. We're off the record.
(Off the record at 1:15 p.m.)
(Back on the record at 1:29 p.m.)
VIDEO TECHNICIAN: We are now back on the record. The time is 1:29 p.m.
BY MS. ALI:
Q. Prior to the break, Ms. Warner, we discussed that you had ordered another urinalysis with urine cultures for Ms. Markel on October 10, 2015, at 1:49 p.m.; is that true? I'm looking at Exhibit 6, page 63.
A. Yes. It looks like I ordered a urinalysis and a urine culture at 13:49, on 10/10.
Q. Okay. And did you relate to me earlier that the reason you ordered the urinalysis with the culture was because the first urinalysis was contaminated?
A. I don't remember why I ordered the urine or the urine culture, but I can just assume, from my practice, that I was probably just reviewing her results and saw that the first urine was contaminated. So that would be something I typically would do --
Q. Okay.
A. -- if I saw a contaminated sample.
Q. Okay. And what is the purpose of ordering urine cultures if the urinalysis is contaminated?

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A. Because the culture will grow out an organism or a bacteria that's positive.
Q. Okay. And that would tell us whether or not the first --
A. It's concerning.
Q. And if the urinalysis was actually contaminated or not versus a bacteria, correct?
MR. SINKOFF: Objection to foundation.
MR. WARWICK: Same.
THE WITNESS: It could. It could be more -- it could give us more information, yes.
BY MS. ALI:
Q. Okay. And that is why it -- it might be a standard or protocol for you to order another urinalysis --
MR. WARWICK: Just --
BY MS. ALI:
Q. -- with cultures?
MR. WARWICK: Just object to the form about protocol, but -- so don't talk about hospital protocols, but --
THE WITNESS: Yeah.
MR. WARWICK: -- if it means -- if protocol means your usual course of performance, you can say -- you can answer the question from that perspective.
THE WITNESS: Yeah, like I said, I usually

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just review the patient's records before they're admitted and just make sure that there's nothing else that was overlooked, and so I probably just saw her first urinalysis was contaminated, so I thought it would be a good idea to repeat it.
BY MS. ALI:
Q. To make sure that it wasn't -- that -- strike that.
Because you want to verify for that patient that it -- that it was not -- strike that.
And in this case, for Ms. Markel, the cultures did come back with bacteria, correct?
MR. SINKOFF: Object to foundation.
MR. WARWICK: Same -- same objection.
THE WITNESS: It looks like the urine culture grew out strep Group B.
BY MS. ALI:
Q. And does that tell us that the patient was infected -- that there was an infection?
MR. WARWICK: Just same, foundation.
MR. SINKOFF: Join.
MR. WARWICK: You can tell her what the results show; other than that, you should defer to others.
THE WITNESS: Yeah.
MS. ALI: Okay. You're doing a lot of

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speaking objections, and that's not okay, so --
MR. WARWICK: Well, it is okay.
MS. ALI: No, it's not.
MR. WARWICK: You've already -- number one, you've already asked --
MS. ALI: Form and foundation --
MR. WARWICK: You've already asked the question three times, and she's already answered it before.
MS. ALI: Well, then you can object as to asked and answered. You cannot do speaking objections.
MR. WARWICK: Well, you can't keep asking the same question over again when --
MS. ALI: Yes, I can.
MR. WARWICK: -- she doesn't have the foundation -- she doesn't have the foundation to testify as -- as a physician would as to that issue, so that's the reason for my objection.
MS. ALI: Okay.
MR. WARWICK: I can raise the objection if I want to, and you don't get to just keep asking the same question over and over again.
MS. ALI: Well, you can make an objection as to asked and answered, but you cannot keep

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continuously put on speaking objections on the record.
MR. WARWICK: I haven't.
MS. ALI: Okay.
MR. WARWICK: I haven't. I think the record will be very clear about I put on one speaking objection because you're asking about a patient who was discharged immediately from the emergency room.
BY MS. ALI:
Q. Okay. So looking at the urine cultures that resulted on -- on October 12th, 2015, what does a urine culture tell you as a physician assistant?
MR. SINKOFF: Object to foundation --
MR. WARWICK: Same.
MR. SINKOFF: -- relevance.
MR. WARWICK: Same, form, foundation, asked and answered. You can go ahead and answer, from your perspective, again.
THE WITNESS: So I would not have been there on the 12th to review this urine culture. And, yeah, I wouldn't have been able to assess the patient to -- to know what this might indicate for the patient.
BY MS. ALI:
Q. Okay. Reading the results currently, can you tell me what -- what the results are to you -- what -- what

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they mean to you as a physician assistant?
MR. WARWICK: Same, form and foundation, relevance.
MR. SINKOFF: Join.
THE WITNESS: So it means that they grew out strep B, which is a common bacteria that colonizes the perineal area for a woman. So, yeah, that -- it looks like it grew out Group B, which is a common bacteria in that area.
BY MS. ALI:
Q. Okay. And with the benefit, of course, of hindsight and looking at the results in front of you right now for the urine culture, do you believe the patient was infected?
MR. SINKOFF: Object to the foundation.
MR. WARWICK: Foundation, form. You shouldn't speculate about anything.
THE WITNESS: Yeah, I can't spec- -- I mean, in my notes, I didn't document any dysuria or frequency or any urinary symptoms in my note for the patient, so it looked like she wasn't having any symptoms --
MS. ALI: Okay.
THE WITNESS: -- from my note. I don't remember, but, yeah, I didn't document anything.

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BY MS. ALI:
Q. The urine cultures don't indicate to you that the -- that on October 10, 2015, Ms. Markel had an infection?
MR. SINKOFF: Asked and answered --
MR. WARWICK: Same --
MR. SINKOFF: -- foundation.
MR. WARWICK: -- asked and answered, foundation, form.
MR. SINKOFF: Assuming you make a diagnosis based on a lab test.
THE WITNESS: Yeah, I can't make a diagnosis based on the lab test without have -- having the patient's symptoms.
BY MS. ALI:
Q. Okay. And in the presence of -- strike that.
MS. ALI: I have no further questions.
MR. SINKOFF: I have no questions.
EXAMINATION
BY MR. WARWICK:
Q. Physician Assistant Warner, I have just a few questions for you. If you don't understand a question, don't hesitate to mention that, and I will certainly repeat it or rephrase it, okay?
A. Okay.
Q. If you could go to Exhibit 1, please. And plaintiff's

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counsel asked you about this exhibit earlier. It references your identity, third from the bottom of that page; is that correct?
A. Correct.
Q. And what does the 10/10/2015, at 6:38 a.m., mean to you?
A. That is likely when I accessed her chart for the first time, when I was reviewing her chart prior to our observation rounds.
Q. Okay. So on that date, October 10, 2015, your shift in the observation unit would have started at 6:00 a.m.; is that right?
A. Correct.
Q. And then this 6:38 a.m. is when you likely looked at her chart in the system; is that right?
A. Correct.
Q. Okay. And then you would have rounded with Dr. Berger --
A. Mmm-hmm.
Q. -- is that right?
A. Correct. Dr. David Berger.
Q. Okay. And the patient would have been seen with you and Dr. Berger; is that right?
A. Correct. Yep.
Q. And -- and the previous charting, et cetera, would

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have been reviewed --
A. Correct.
Q. -- is that right?
Okay. And then neurosurgery and physical medicine and rehabilitation consultants came in; is that right?
A. Correct.
Q. And Exhibit 3 references your report as it relates to the patient's condition in the observation unit on October 10, 2015; is that right?
A. Correct.
Q. And a white blood count of 13.8, would it be fair to say that was mildly elevated?
A. Correct.
Q. And UA awaiting repeat, there was a question by plaintiff's counsel about waiting -- awaiting results. You were actually awaiting having the urinalysis collected again; is that right?
A. Correct. It looks like, yep, it had not been done; so --
Q. Okay.
A. -- awaiting repeat.
Q. And the previous urinalysis that you testified to was contaminated; likely, that was based upon what from the results?

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A. That was the elevated number of squamous cells.
Q. Okay. And do we all have squamous cells on our skin?
A. Yes.
Q. And when you talked about not getting a clean catch or not wiping appropriately beforehand, if -- if that were to happen, that could result in having squamous cells in the -- as evidenced in the results; is that right?
A. Easily, yeah.
Q. Okay. So then you wanted another urine sample to be done for urinalysis and urine culture; is that right?
A. I would assume that's what I was, yep --
Q. Okay.
A. -- was doing by ordering a repeat.
Q. And then what time of the day did you end your work as it related to reporting with Ms. Markel? I believe that's Exhibit 1 again.
A. Yeah. I mean, it looks like the -- yeah, the last order I would have placed was that urine at 13:49, but then it shows that I was last in her chart maybe at 2:04 p.m., was the last --
Q. Okay.
A. -- review I did.
Q. And 13:49 would be what time of the day?
A. 1:49 --

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Q. Okay. So --
A. -- p.m.
Q. So if 1:39 -- I'm sorry. Strike that.
If 1:30 -- strike that.
If 1:49 p.m. was the time frame of the order for the second urine study with urine cultural, and then your charting says you were last in her records at 2:04 p.m., that would all be consistent; is that right?
A. Correct.
Q. Okay. And, in fact, it's now Exhibit 6, page 63 in the bottom, lower, left-hand corner, that's your order for the urine culture; is that right?
A. Correct.
Q. And it says, "Ordering provider Janay Warner, PA-C, 10/10/15, at 13:49"; is that right?
A. Correct.
Q. So that would be 1:49 --
A. 1:49 --
Q. -- p.m.?
A. -- p.m.
Q. And it says, the next line down, "Collect By 9BROY 10/10/15, at 21:10"; is that right?
A. Mmm-hmm. Correct.
Q. So --

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A. 9:10.
Q. Okay. So that would be well after you were last involved in Ms. Markel's care; is that right?
A. Correct.
Q. And the patient would have already been on the floor at that point; is that right?
A. Yes.
Q. And you don't see patients on the floor; is that right?
A. Correct, I do not see patients on the floor.
Q. And you wouldn't have back at this time frame, either; is that correct?
A. Correct.
Q. And then the results came in on 10/12/15, at 20:38; do you see that?
A. Yes.
Q. Okay. Those results wouldn't have gone back to you, either, would they?
A. No.
Q. Okay. Your role in this case would have finished when you last saw Ms. Markel on October 10, 2015, in the observation unit; is that fair?
A. Yes, that's fair.
Q. Okay. And then from the records, Ms. Markel's primary care physician was a Dr. John Bonema, B-o-n-e-m-a, and

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he's with Troy Internal Medicine. Did you see that from the records?
A. Yes.
Q. Okay. And then in your report, it references, in Exhibit 3, that -- I thought it was Exhibit 3 -- that -- yes. In treatment plan, page 20, admit in stable condition to Haas, H-a-a-s, forward slash, Wease, W-e-a-s-e, Dr. Lonappan.
Is there -- is there something you enter into the system to determine if a primary care physician has certain hospitalists that they have patients see on their behalf in the hospital?
A. Yes. So there is -- when you go to admit a patient, each patient has a PPG, which is a physician preference guide; so it tells you who their primary doctor admits to, so it tells you who to call.
Q. Okay. Is that, then, likely how you obtain that information?
A. Correct. So then we would ask our secretary to page whatever hospitalist service that that physician is requesting or uses.
Q. Okay. That that primary care physician is utilizing as --
A. Yes.
Q. -- a hospitalist?

A. So Dr. Bonema, yeah, his reference guide would have specified that he uses Hospital Consultants or Haas/Wease.

Q. Okay. And then after your involvement in the case, if the patient was seen by Dr. Lonappan or seen by other medical personnel, nurses, et cetera, you would obviously defer to them in terms of their role in the case and -- and their testimony, et cetera, correct?

A. After -- I don't understand. Like after she was admitted?

Q. Right. When you were no longer involved, if Dr. Lonappan was involved -- you've seen she's testified; right?

A. Yes.

Q. Okay. So Dr. Lona- -- Lon- -- Dr. Lonappan can testify on her own behalf; anyone else who's a caregiver after you're involved, they can testify on their own behalf, correct?

A. Correct.

Q. Okay. And your role, as we say, ended at that time, in the early afternoon, before the urine sample was even collected; is that correct?

A. Correct.

MR. WARWICK: Okay. Those are all the questions I have.

MS. ALI: I don't have any follow-up questions.

MR. SINKOFF: We're done.

VIDEO TECHNICIAN: This concludes the videotaped deposition. We're now going off the record at 1:44 p.m. We're off the record.

(The videotaped deposition was concluded at 1:44 p.m. Signature of the witness was not requested by counsel for the respective parties hereto.)

CERTIFICATE OF NOTARY

STATE OF MICHIGAN)
) SS
COUNTY OF OTTAWA)

I, PEGGY S. SAVAGE, certify that this videotaped 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.

Peggy S Savage

PEGGY S. SAVAGE, CSR-4189, RPR
Notary Public,
Ottawa County, Michigan.
My Commission expires: 7-13-19

EXHIBIT 4

STATE OF NEW JERSEY)
) ss.
COUNTY OF MONMOUTH)

AFFIDAVIT OF MERIT – THOMAS BOJKO, MD, MS, JD, FCLM

I, Thomas Bojko, M.D., M.S., J.D., being first duly sworn, deposes and says:

1. I attended medical school at the University of Rome "La Sapienza" in Rome, Italy, graduating in 1985
2. In 1987 I completed a rotating internship at Chaim Sheba Medical Center, Sackler School of Medicine, Tel Aviv University Israel.
3. In 1991 I completed a pediatric residency at Newark Beth Israel Medical Center, University of Medicine & Dentistry, in Newark, New Jersey.
4. In 1995 I completed a pediatric critical care fellowship at the New York Hospital, Cornell University Medical College in New York, New York.
5. In 2001 I obtained a Master of Science in Health Care Administration, Management and Policy from the Robert F. Wagner School of Public Service, New York University in New York, New York.
6. I am currently licensed to practice medicine in the States of New York and New Jersey.
7. I was Board Certified by the American Board of Pediatrics in 1991, with recertifications in 1998 and 2006.
8. I was Board Certified by the American Board of Pediatrics, Sub-board of Pediatric Critical Care Medicine in 1994, with recertifications in 2002 and 2010.
9. During the year prior to October 11, 2015, I devoted the majority of my professional time to consulting and teaching on issues of healthcare administration.
10. At the request of attorney Justin Hakala, I have reviewed medical records of Mary Anne Markel as generated by William Beaumont Hospital.
11. I have also reviewed the Notice of Intent to File Claim pursuant to MCL 600.2912b dated October 6, 2017 sent on behalf of Mary Anne Markel.
12. I affirm that I have personal knowledge of the facts stated in this Affidavit.
13. If sworn as a witness, I can testify competently to the facts stated in this Affidavit.
14. I have advised attorney Jeffrey Meyers that I believe reasonable cause exists for the filing of the lawsuit concerning the medical treatment that Mary Anne Markel.
15. This opinion and the opinions stated below are based upon the information currently available to me. I reserve the right to modify my opinions as additional information becomes available subsequent to the lawsuit of this matter being filed.
16. I am of the opinion that the standard of care applicable to the William Beaumont Hospital administration was that of hospital administrators.
17. It is my opinion that the requirements of the standard of care applicable to the hospital administrators included, but were not limited to, the following:
    a. Establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the attending physician or another appropriate clinician;

    b. Establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the patient and the patient's physician if the patient has already been discharged from the

hospital.

c. Establish, implement, and maintain a policy requiring that the discharge process include all information needed for the patient's follow up care

18. It is my opinion that the standard of care was violated for the following reasons:

a. They failed to establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the attending physician or another appropriate clinician;

b. They failed to establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the patient and the patient's physician if the patient has already been discharged from the hospital.

c. They failed to establish, implement, and maintain a policy requiring that the discharge process include all information needed for the patient's follow up care

19. It is my opinion that the following steps should have been taken in order to comply with the standard of care:

a. They should have established, implemented, and maintained a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the attending physician or another appropriate clinician;

b. They should have established, implemented, and maintained a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the patient and the patient's physician if the patient has already been discharged from the hospital.

c. They should have established, implemented, and maintained a policy requiring that the discharge process include all information needed for the patient's follow up care

20. It is further my opinion that had the Hospital Administrators acted in accordance with the standard of care more completely described above, an attending physician or Ms. Markel would have been timely notified of the abnormal preliminary lab result. Had those steps been taken, Ms. Markel would have been aware of the preliminary urine culture result and returned to the hospital to receive antibiotics, she would not have had an epidural injection, would not have developed an epidural abscess, and timely intervention would have prevented the spread and worsening of infection.

Thomas Bojko, M.D

Subscribed and sworn to before me

this 3rd day of April, 2018

Kelly A Krail

My Commission Expires _____.
Acting in the County of _____.
Attorney at Law
State of New Jersey

Personally known X or Produced Identification ___
Type of Identification Produced _____

4

EXHIBIT 5

BEAUMONT HEALTH
ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

MARKEL,MARY ANNE
MRN: 1568410
DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015 Dsc: 10/11/2015

Lab Results (10/09/15 - 10/12/15) (continued)

Resulted: 10/09/15 2323, Result status: Final result

URINALYSIS [586475056] (Abnormal) (continued)

Blood	Negative	Negative	
pH	5.5	5.0 - 8.0	
Protein	Negative	Negative	
Urobilinogen	1.0	0.2 - 1.0	
Nitrites	Negative	Negative	
Leukocyte Esterase	2+	Negative	A
RBC	0-3	0 - 3 /hpf	
WBC	11-25	0 - 5 /hpf	A
Epithelial, Squamous	6-50	/lpf	
Casts, Hyaline	0-2	0 - 2 /lpf	
Bacteria	Negative	Negative /hpf	
Crystal	Calcium Oxalate		
Comment	see below		

Comment: Microscopic manually verified.

Additional Resulting Lab Information:
Received: 201510092254

Resulted: 10/10/15 2201, Result status: Final result

URINALYSIS [586562410] (Abnormal)

Ordering provider: Warner, Janay, PA-C 10/10/15 1349 Resulting lab: LABORATORY INFORMATION SYSTEM

Dt/Tm Coll

Type	Source	Collected By
		9BROY 10/10/15 2109

Components

	Value	Reference Range	Flag
Color	DkYellow		
Clarity	Clear		
Glucose	Negative	Negative	
Bilirubin	Negative	Negative	
Ketones	Trace	Negative	A
Specific Gravity, Urine	1.030	1.005 - 1.030	
Blood	Trace	Negative	A
pH	6.0	5.0 - 8.0	
Protein	Trace	Negative	A
Urobilinogen	1.0	0.2 - 1.0	
Nitrites	Negative	Negative	
Leukocyte Esterase	2+	Negative	A
RBC	5	0 - 3 /hpf	H
WBC	>100	0 - 5 /hpf	H
Epithelial, Squamous	21	/lpf	
Casts, Hyaline	18	0 - 2 /lpf	H
Bacteria	Negative	Negative /hpf	

Additional Resulting Lab Information:

BEAUMONT HEALTH

ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Discharge Summary

MARKEL,MARY ANNE
MRN: 1568410
DOB: 3/15/1960, Sex: F
Acct #: 15684102123
Adm: 10/9/2015 Dsc: 10/11/2015

Lab Results (10/09/15 - 10/12/15) (continued)

Resulted: 10/10/15 2201, Result status: Final result

URINALYSIS [586562410] (Abnormal) (continued)

Received: 201510102142

Resulted: 10/12/15 2038, Result status: Final result

CULTURE, URINE [586562411] (Abnormal)

Ordering provider: Warner, Janay, PA-C 10/10/15 1349 Resulting lab: LABORATORY INFORMATION SYSTEM

Dt/Tm Coll

Type	Source	Collected By
	Urine	9BROY 10/10/15 2110

Components

	Value	Reference Range	Flag
Flag Status	This report has been flagged as abnormal		A
Specimen Source	Urine		
Culture, Urine	--		
Culture, Urine	--		

Result:
Streptococcus agalactiae (Group B)
>100,000 CFU/ml

Additional Resulting Lab Information:
Received: 201510102312

IMG Results (10/09/15 - 10/09/15)

Resulted: 10/09/15 1812, Result status: Final result

LUMBOSACRAL SPINE MINIMUM 4 VIEWS [586475832]

Ordering provider: Joseph, Amy E, PA-C 10/09/15 1739
Performed: 10/09/15 1809 - 10/09/15 1809
Performing Department: RAD GEN EC RO
Fluoro time: 0
Resulted by: Donovan, Kent R, MD
Resulting lab: MISYS
Diagnosis: Left-sided low back pain with left-sided sciatica [M54.42 (ICD-10-CM)]

Narrative:

```
Lumbar spine

Indication: Back pain

5 images were obtained. There is moderate disc narrowing at L4-5 and L5-S1
with endplate sclerosis and marginal spurring. There is no compression
deformity; there is facet arthropathy bilaterally at L4-5 and L5-S1 without
spondylitic defects. There is osteopenia. There is a 2 mm anterolisthesis of 3
upon L4.
```

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

Mary Anne Markel,

Plaintiff,

v. Case No. 2018-164979-NH

William Beaumont Hospital, Hospital Consultants, P.C. and Linet Lonappan, M.D., Jointly and Severally

Hon. Nanci J. Grant

Defendants.

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DEFENDANT, WILLIAM BEAUMONT HOSPITAL'S REPLY TO PLAINTIFF'S RESPONSE TO MOTION FOR SUMMARY DISPOSITION, PURSUANT TO MCR 2.116(C)(10)

Defendant, William Beaumont Hospital, by its attorneys, Giarmarco, Mullins & Horton, P.C., for its Reply to Plaintiff's Response to Motion for Summary Disposition, brought pursuant to MCR 2.116(C)(10), states as follows:

GMH GIARMARCO, MULLINS & HORTON, P.C.
ATTORNEYS AND COUNSELORS AT LAW
Tenth Floor Columbia Center ▾ 101 West Big Beaver Road ▾ Troy, Michigan 48084-5280 ▾ P: (248) 457-7000 ▾ F: (248) 457-7001 ▾ www.gmhlaw.com

ARGUMENT I – PLAINTIFF'S VICARIOUS LIABILITY CLAIM

In her Response, Plaintiff makes the bald assertion that "agency is always a question of fact for a jury", directly contrary to 28+ years of published Michigan case law (and a myriad of unpublished Michigan Court of Appeals cases, citing to these published opinions). *Laster v Henry Ford Health Sys*, 316 Mich App 726, 734; 892 NW2d 443 (2016); *VanStelle v Macaskill*, 255 Mich App 1, 8; 662 NW2d 41 (2003); *Chapa v St. Mary's Hosp of Saginaw*, 192 Mich App 29, 31; 480 NW2d 590 (1991); *Wiegand v Yamasaki*; 503 Mich 871; 917 NW2d 630 (2018), Appeal Denied from 2017 WL 6502938, Mich App, Dec. 19, 2017.

Plaintiff completely ignores the undisputed evidence that Co-Defendant, Linet Lonappan, M.D. became involved in Plaintiff, Mary Anne Markel's treatment through the agreement between Dr. Lonappan's employer, Co-Defendant, Hospital Consultants and Ms. Markel's treating Internal Medicine physician, John Bonema, M.D.'s group, Troy Internal Medicine, P.C. (Exhibit C to Defendant, William Beaumont Hospital's Motion for Summary Disposition, pp. 76-77 and 128-129).

Plaintiff fails to provide any evidence whatsoever that Defendant, William Beaumont Hospital made any representation to lead Ms. Markel to reasonably believe that an agency existed between the hospital and Co-Defendant, Dr. Lonappan. **Agency "does not arise merely because one goes to a hospital for medical care." *VanStelle*, 255 Mich App at 11. "There must be some action or representation by the principal (hospital) to lead the third person (plaintiff) to reasonably believe that an agency in fact existed." *VanStelle*, 255 Mich App at 11.**

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Finally, Ms. Markel's testimony in her Affidavit, attached as Exhibit No. 2 to Plaintiff's Response, that she was "under the impression" that Co-Defendant, Dr. Lonappan was an employee of Defendant, William Beaumont Hospital at the time of treatment is directly contradicted by her deposition testimony that she did not remember Dr. Lonappan. (Exhibit D to Defendant, William Beaumont Hospital's Motion for Summary Disposition, p. 56). A party may not "contrive factual issues by relying on an affidavit when unfavorable deposition testimony shows that the assertion in the affidavit is unfounded." *Dykes v William Beaumont Hosp*, 246 Mich App 471, 481; 633 NW2d 440 (2001).

ARGUMENT II – PLAINTIFF'S CLAIM REGARDING JANAY WARNER, P.A.

Plaintiff completely ignores the undisputed fact that Co-Defendant, Dr. Lonappan was aware that Janay Warner, P.A. previously ordered the subject urine culture study and repeat urinalysis, when Dr. Lonappan became Ms. Markel's attending physician, on 10/10/15 at approximately 2:41 p.m. (Exhibit C to Defendant, William Beaumont Hospital's Motion for Summary Disposition, p. 131). Plaintiff completely ignores the undisputed fact that the urine sample related to urine culture and repeat urinalysis was not taken, on the floor, until 10/10/15 at 9:09 p.m. and 9:10 p.m. – long after P.A. Warner had last seen Ms. Markel in the Observation Unit. (Exhibit A to Defendant, William Beaumont Hospital's Motion for Summary Disposition; Exhibit C, p. 131). Plaintiff completely ignores the undisputed fact that **Co-Defendant, Dr. Lonappan has admitted that, as Ms. Markel's attending physician, it was her responsibility to follow-up regarding the urine culture results – even after Ms. Markel was discharged from Defendant, William Beaumont Hospital**. (Exhibit C, pp. 132 – 133).

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The undisputed evidence shows that P.A. Warner did not breach the standard of care or cause any injury to Ms. Markel.

ARGUMENT III – PLAINTIFF'S DIRECT LIABILITY CLAIM

Plaintiff completely ignores the undisputed fact that Co-Defendant, Dr. Lonappan admitted at her deposition that it was her responsibility, as Ms. Markel's attending physician, to obtain the urine culture results and decide whether to report the findings to Ms. Markel – even after the patient had been discharged from the hospital. (Exhibit C, p. 131). Plaintiff also completely ignores the undisputed fact that Co-Defendant, Dr. Lonappan testified that she was aware of the positive Group B Streptococcus result on 10/12/15, that she did not believe the standard of care required her to contact Ms. Markel with the results and that she did not feel the results were relevant to Ms. Markel's care. (Exhibit C, pp. 19-20).

The undisputed evidence shows that Defendant, William Beaumont Hospital's laboratory reporting system worked appropriately. Co-Defendant, Dr. Lonappan acknowledges that, as the attending physician, she was responsible for obtaining the results, analyzing the results and deciding whether to report the results to Ms. Markel. There is no evidence of any purported flaw in Defendant, William Beaumont Hospital's laboratory reporting process or that any alleged flaw caused injury to Ms. Markel.

For the above reasons, as well as the reasons set forth in its Motion for Summary Disposition and Brief in Support, Defendant, William Beaumont Hospital is entitled to summary disposition and to be dismissed from this lawsuit, with prejudice, pursuant to MCR 2.116(C)(10).

Respectfully submitted,
Giarmarco, Mullins & Horton, P.C.

By: /s/Donald K. Warwick
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(248) 457-7072

Dated: July 29, 2019

PROOF OF SERVICE

Kathleen A. Rochon certifies that on July 29, 2019, she served upon the attorneys for Plaintiff and Co-Defendants, copies of:

- Defendant, William Beaumont Hospital's Reply to Plaintiff's Response to Motion for Summary Disposition, brought pursuant to MCR 2.116(C)(10),

via transmission through the Oakland County Circuit Court electronic filing system.

/s/ Kathleen A. Rochon
Kathleen A. Rochon

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STATE OF MICHIGAN

SIXTH JUDICIAL CIRCUIT COURT (OAKLAND COUNTY)

MARY ANNE MARKEL,

Plaintiff,

-vs- Case No. 18-164979-NH

WILLIAM BEAUMONT HOSPITAL, HOSPITAL CONSULTANTS, PC, and LINET LONAPPAN, M.D., Jointly and Severally,

Defendants.
_____/

MOTION

BEFORE THE HONORABLE NANCI J. GRANT, CIRCUIT JUDGE

Pontiac, Michigan - Wednesday, July 31, 2019

APPEARANCES:

For the Plaintiff: MUSKAN B. ALI (P80701)
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For Wm. Beaumont: DONALD K. WARWICK (P44619)
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(248) 935-5190

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Pontiac, Michigan

Wednesday, July 31, 2019 - 8:54 a.m.

THE CLERK: Your Honor, now calling docket number 3. Mary Anne Markel versus William Beaumont Hospital. 2018-164979-NH.

MR. WARWICK: Good morning, your Honor. Don Warwick, on behalf of William Beaumont Hospital.

MS. ALI: Muskan Ali, on behalf of plaintiff.

THE COURT: I'm sorry, what's your last name?

MS. ALI: Ali, A-L-I.

THE COURT: Thank you.

MR. POWE: And Douglas Powe, on behalf of the Hospital Consultants, Dr. Lonappan.

THE COURT: I'm sorry, last name again, sir?

MR. POWE: Powe, P-O-W-E.

THE COURT: Thank you.

MR. POWER: You're welcome.

THE COURT: Okay. Ms. Ali, you note in your responsive pleading that Dr. Lonappan wore, quote, "A white lab coat with credentials indicating Beaumont Health System on it," end

quote.

MS. ALI: Yes.

THE COURT: But isn't it correct that Dr. Lonappan herself testified their lab coat indicated Hospital Consultants, PC on it?

MS. ALI: So, your Honor, she said that it does but at the time that she was with -- and I can quote from her deposition -- at the time -- she is unaware at the time that she was actually in front of Ms. Markel, the plaintiff, whether that was the actual credentialing.

What she could testify for sure was there was Beaumont on her lab coat. But as to the Hospital Consultants, her testimony was as follows.

(Brief pause.)

THE COURT: Were you --

"When you were assigned to your 10 or 11-day shift at Beaumont in Royal Oak, do you wear a white lab coat?

Yes.

All right. And do you wear credentials that indicate who you are and that you're a physician?

Yes.

And it says Beaumont Health System or stuff like that on the credentials?

Yes.

Does it say Hospital Consultants, PC?

Yes.

Okay. And that's on your credentials?

Yes."

Am I quoting it right?

MS. ALI: Yes. And then she continues to say:

"And do you know whether you were wearing these credentials when you saw Ms. Markel on October 10?

I don't have a specific recollection.

But whenever -- whenever you're in the hospital you're wearing a lab coat with credentials, right?

Yes."

And then she continues on to say -- which is the other parts of the argument, but in terms of the credentials, she's unsure if she's -- she's wearing them the day that she met Ms. Markel herself.

And then there's other issues that would

also indicate as to the actual ostensible agency.

MR. WARWICK: Your Honor, there's no evidence, as she just read. She's not even sure if she was wearing this coat that day. There's actually unpublished Court of Appeals cases -- I didn't bring it with me -- that talk about how that doesn't create reliability.

Beyond that, there's no evidence that Ms. Markel relied upon that name tag to -- to believe that she was an agent of Beaumont Hospital. And the case law is very clear that the hospital must do something to make --

THE COURT: That's my next question, is that, Ms. Ali, you also argue that Dr. Lonappan testified that, quote:

> "Her introductions to patients includes her name and that she was assigned to the patient's care and treatment by William Beaumont Hospital."

What supports that William Beaumont Hospital either encouraged Dr. Lonappan to say this or acquiesced in the use of this vernacular?

MS. ALI: The fact that she's not saying

that she's an employee of Hospital Consultants in itself shows that she's an agent.

And that's all really she needs to establish under ostensible agencies, the fact that she's not giving the patient knowledge that she's associated with Hospital Consultants. Rather, just William Beaumont Hospital.

And the reasonable belief by the patient is what would be taken --

THE COURT: I'm sorry.

MS. ALI: -- into consideration.

THE COURT: Back up again. Where is it that Beaumont either instructed her to do it or knew that she was doing it and they said go ahead. That's an agency. So what she has to be able to say is Beaumont was aware that she was going around saying hi, I'm Dr. Lonappan, I'm with Beaumont Health.

MS. ALI: So William Beaumont Hospital has to let their contractors know that you can't be introducing yourself as our -- that you're --

THE COURT: Now you're saying that it's up to Beaumont to specifically say to their contractors, you better not use our name out of your mouth? There's law for that? That seems

rather -- so now -- now you're making it that con -- that Beaumont has an affirmative duty. Where is law on that?

MS. ALI: I understand. That's -- that's not what I'm trying to --

THE COURT: That's exactly what you said, though.

MS. ALI: My apologies.

THE COURT: Okay. So -- and also, let's be clear, your client doesn't remember seeing Dr. Lonappan and Dr. Lonappan doesn't remember specifically seeing your client. Correct?

MS. ALI: Yes, your Honor.

THE COURT: Okay.

MR. WARWICK: Your Honor, may I just add one thing as to that issue, very briefly?

THE COURT: Sure.

MR. WARWICK: On page 133 of her transcript, plaintiff's counsel is questioning her and Dr. Lonappan says when she sees the patient:

> "When I say I'm Dr. Lonappan, when I say I'm Dr. Lonappan and then I would say I'm seeing you for your family doctor, I'm a hospitalist associated for Dr. Bonema."

Who is the -- the primary care physician, treating physician who has the agreement with Dr. Lonappan's group and that's why she's there to treat --

THE COURT: Right. She also says:

"Yeah, I usually don't bring up Hospital Consultants, PC, because it doesn't matter to the patient. I do bring up that I'm seeing them for their family doctor."

Okay. How can it be said that your client harbored -- again, a reasonable belief that Dr. Lonappan was acting as a hospital employee when, as I said, she essentially testified she doesn't recall interacting with Dr. Lonappan?

MS. ALI: So, your Honor, she -- Dr. Lonappan testified that when she goes and makes her introductions to her patients, she states that she's assigned to their care by William Beaumont Hospital. And she also wears a lab coat with the credentialing of Beaumont Hospital.

THE COURT: Again, you've got your client that doesn't remember seeing Lonappan and Lonappan not remember seeing your client. So

none of that really matters because nobody can say -- how can you say I'm going to rely on something that nobody remembers seeing?

MS. ALI: In -- okay. So --

THE COURT: Again, I'm going to -- no. I'm going to -- I'm going to ask a question and I'm going to ask you to answer the question and not try to talk around the question. Because I am telling you, I am the wrong person to do that with. I come prepared, out of respect for you as attorneys. So in respect, in turn, I ask you a question, don't keep doing that. You have done it continuously now.

MS. ALI: My apologies.

THE COURT: Here we go. Neither your client remembers seeing Dr. Lonappan, Dr. Lonappan doesn't remember seeing your client. So how can anybody rely on either what was coming out of her mouth on who she was representing, she was there on behalf of, or her lab coat?

MS. ALI: Because Dr. Lonappan -- and I understand, they -- they are not --

THE COURT: How can there be a reasonable belief of reliance if nobody remembers seeing

each other?

MS. ALI: I'm trying to answer it the best way I can.

THE COURT: Don't talk around it then. If -- how can you reasonably have -- how can you state a reasonable reliance on something you don't remember seeing?

MS. ALI: Because Dr. Lonappan's usual protocol --

THE COURT: It doesn't matter. We're talking about her reliance. You can't do that. You can't say my client doesn't remember anything but if she -- but if she had remembered everything, this is what would have happened.

We have to deal with what your client has stated. Your client has stated she doesn't remember seeing Dr. Lonappan. How can there be a reasonable reliance now?

MS. ALI: That is -- I understand. Okay.

THE COURT: Answer the question. And I'm --

MS. ALI: So she does not have to --

THE COURT: -- going to get out the oath that you took not so long ago. Answer the question. How can there be a reasonable

reliance on something she doesn't remember seeing?

MS. ALI: There can't.

THE COURT: Thank you. All right.

MS. ALI: Your Honor --

THE COURT: With respect to your client's claims against Jenae (phonetic) Warner.

MS. ALI: We had stipulated prior to coming in that Jenae Warner, we will stipulate to --

THE COURT: That she's out?

MS. ALI: That William Beaumont --

MR. WARWICK: They agreed to dismiss Beaumont. Jenae Warner was not a named defendant, but they agreed to dismiss the claims against Beaumont with prejudice related to --

THE COURT: As to Warner?

MR. WARWICK: -- P.A. Warner just before the hearing, your Honor.

THE COURT: Perfect.

MS. ALI: Correct.

THE COURT: And how do you respond to plaintiff's argument that Dr. Thomas Bojko(phonetic) --

MS. ALI: Bojko.

THE COURT: Bojko, thank you -- affidavit

precludes this court from granting summary disposition under claim that your client is directly liable as a result of its failure to promulgate and implement certain policies and procedures?

MR. WARWICK: Certainly, your Honor. So as to that argument, there's an affidavit of merit filed at the beginning of the lawsuit. As I indicate in my reply brief, Dr. Lonappan herself testified that she was responsible.

They're arguing that there's a flaw in the system that keeps the reporting from accurately reporting the results to the patients. Dr. Lonappan, on pages 56 and 132, 133 of her deposition testimony, admits that she was aware of the order that had been entered by P.A. Warner, that it was her responsibility to follow up on the order, even after discharge of the patient and -- and that, your Honor, cuts off any liability because this system worked as it was designed to work.

The -- the attending internal medicine physician was aware of what needed to take place. She testified that she was aware of the results on the 12th. There may be an issue as

to Dr. Lonappan, whether she was really aware of those results on the 12th, but she admitted that she was required to be aware of that. That is the process.

The attending physician follows up and obtains the results, decides whether it's important to contact the patient. In this case decided not to contact the patient. In fact, their last hospitalist expert testified yesterday and he said exactly that, your Honor.

So this claim that the hospital had some flaw in its system in the reporting is just not accurate.

If you think about that, P.A. Warner orders a lab result eight hours before the urine sample is even taken. To suggest that the hospital has some flaw in its system when there's an attending who is assigned to the patient, who admits at her deposition that it was her responsibility to follow up with the patent, even after discharge. And then says that she made an informed decision not to follow up.

To say that that's a direct liability claim against the hospital is beyond credibility, your Honor.

THE COURT: As a matter of practicality for me and educating me, explain to me how -- how your client -- your client was suffering from back pain that apparently also came from -- her disks were looked at and there was pain in her -- bilateral knees, if I remember. How was it that she wasn't told about the urinary infection, how that prevented her from getting an epidural?

MS. ALI: So if the infection had been told to her, that she does have positive lab results.

THE COURT: Right.

MS. ALI: She would have been able to let her future treaters know that there is an infection. And the epidural wouldn't be -- the orthopaedic expert will opine that we wouldn't have done a procedure without treating her for the infection first because it would be a risk of spreading the infection. So --

THE COURT: Well, is your -- is your malpractice claim that because they didn't -- they did the epidural without knowing about the infection, therefore, her infection spread because of the epidural?

MS. ALI: Yes. Because there was other

things that --

THE COURT: You've got an expert saying that the infection spread because of the -- because of an epidural injection?

MS. ALI: Yes. And I -- I leave it for the medical --

THE COURT: No, I'm asking you. Do you have an expert that says that when you have an UTI that's not being treated and then you get an epidural, spinal epidural, that spreads infection to other joints?

MS. ALI: Yes. And that's what caused --

THE COURT: Oh. Who is that expert?

MS. ALI: -- her surgeries later on.

MR. WARWICK: That's a new one to me, your Honor.

THE COURT: That's why I was asking. Because I was trying to figure out what -- I mean, yes, in a perfect world, if you're going to have a culture done, someone should -- you would think logically -- I'm not making a ruling on this, but I would think logically you would like to know that there's a UTI. I'm trying to figure out how not knowing about the UTI affected her joint pain.

MS. ALI: So it --

THE COURT: That had to be treated.

MS. ALI: The infection worsened and she wasn't able to be treated prior to future treatment and it caused a lot of issues for her moving forward. And that's why we are making the claim that she should have been aware of her results, at the very least, so she could inform -- because a patient is a medical historian of their own medical history and they should be able to tell their future treaters as to their --

THE COURT: So now -- so now you have a claim of malpractice based on she can't tell -- she can't tell her future treaters.

MS. ALI: That the patient should be aware of her abnormal lab results regardless. And why do you need to be aware of your abnormal --

THE COURT: And that's a -- that's a medical malpractice case that you're bringing now, because she wasn't able to tell her treaters at the time -- she would have gotten the epidural anyhow, correct?

MS. ALI: If she -- if she wasn't aware of her abnormal lab results, no.

THE COURT: Well, that's what your expert is going to say. Your --

MS. ALI: Yes.

THE COURT: Again, your expert is going to say that giving her the spinal epidural spread the infection?

MS. ALI: The medical --

THE COURT: Did the infection spread after the epidural?

MS. ALI: Yes. It -- she worsened, definitely, from a medical standpoint.

THE COURT: I understand she worsened. Did it -- did the infection spread to other parts of her because of the epidural?

MS. ALI: Yes.

THE COURT: And who is your expert that's going to say that?

MS. ALI: Dr. -- we have an infectious disease and an orthopedic. I can't think of the orthopedic's name.

THE COURT: Do they practice in Michigan?

MS. ALI: One of them is in Ohio, I believe. I don't know where -- what state they're out of.

THE COURT: Okay.

MS. ALI: Yes.

THE COURT: Anything else, for the record?

MR. WARWICK: Your Honor, let me just note, they -- those experts filed affidavits of meritorious claim as well. They didn't raise such claims in their affidavit of meritorious claim.

The argument, to my understanding, was that this had seeded and was not diagnosed by Dr. Lonappan, et cetera. This whole thing that it somehow spread, okay, that one -- you know, that's what they're saying. They can't just say anything. You can't say the moon is made out of cheese, your Honor.

THE COURT: Well, you can say it but then try and prove it.

MR. WARWICK: Right. And to get back just briefly to this Dr. Bojko's affidavit, he says, you know, policies and procedures are not appropriate, number one, under Gallagher(phonetic) and its progeny. Policies and procedures are never allowed in trial under Michigan -- long-established Michigan precedence.

And then just as a matter of, you know,

factual basis in this case, he's saying what happened here is the reporting did not allow contact to the patient as to that issue. And here we have the treating attending internal medicine doctor saying I got the results. I was aware the test results or that a urine culture had been ordered. It was my responsibility to follow up. I did not feel it was necessary to follow up. I did not think it was an infection.

So the process worked exactly as it --

THE COURT: But she got -- she didn't think the UTI was an infection?

MR. WARWICK: She did not think that she had a urinary tract infection during admission. That's why -- this patient went to Beaumont, was admitted.

THE COURT: Right.

MR. WARWICK: Dr. Lonappan became involved and got other --

THE COURT: And then she was discharged, it was after she was discharged that it came -- the second culture came out.

MR. WARWICK: Right. The culture came out.

THE COURT: Right.

MR. WARWICK: And then, as she -- at that

point Dr. Lonappan testified she became aware of the results and she did not at that point think that it was necessary or relevant to her treatment.

So the treating attending as to causation -- and it's part of my argument -- the treating attending physician was aware of the results. So that shows there's no flaw in the system.

And then beyond that, she didn't -- wouldn't have done anything with the results anyway because she decided that that was not relevant to the treatment, your Honor.

THE COURT: And where exactly did Ms. Markel work as a nurse?

MS. ALI: Well, William Beaumont Hospital.

THE COURT: Yes.

MS. ALI: She worked on a -- in Royal Oak campus.

THE COURT: Right.

MS. ALI: And not at the hospital itself, but an out-setting.

THE COURT: Where did she work?

MR. WARWICK: She worked on Big Beaver Road at an outpatient facility that does that type of outpatient work, not in William Beaumont

Hospital, your Honor.

THE COURT: Okay. Thank you.

MR. WARWICK: So she had no foundation to talk about those types of issues about employees, et cetera.

THE COURT: Thank you.

MS. ALI: Your Honor, if I may, as to the epidural injection.

THE COURT: Mm-hmm.

MS. ALI: Our doctor, just so I can clarify, is that -- the patient developed an abscess. An abscess is developed, an epidural abscess. And of course they're going to correlate between the injection and the abscess.

But the abscess developed after the epidural injection and that's where the infection was, which caused later more injuries to the patient. And that's the medical causation that our experts are going to opine to in terms of our discussion earlier.

And if I may discuss the Grouix(phonetic) analysis in terms of vicarious liability --

THE COURT: I've asked the questions that I -- if you're going to discuss any kind of analysis that you didn't put in your pleadings,

that would be fascinating. Are you going to discuss any --

MS. ALI: No. They're -- they're all in the --

THE COURT: Excellent. Okay. I'll issue a written opinion. It actually should be out by Friday.

MR. WARWICK: Thank you very much, your Honor.

MS. ALI: Thank you, your Honor.

THE COURT: Great argument.

MR. POWE: Thank you.

(At 9:11 a.m., proceedings concluded.)

- - -

STATE OF MICHIGAN)
) ss.
COUNTY OF OAKLAND)

I, Marguerite H. Anderson, CER, CSR-2334, do hereby certify that this transcript, consisting of 24 pages, is a complete, true and correct rendition of the videotape of the proceedings as recorded in this case on July 31, 2019.

/s/ Marguerite H. Anderson
_____
Marguerite H. Anderson, CER, CSR-2334
78 Bobolink Street
Rochester Hills, Michigan 48309
(248) 935-5190

Dated: August 10, 2019.

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

MARY ANNE MARKEL,

Plaintiff,

-v-

Case Number: 2018-164979-NH
Honorable Nanci J. Grant

WILLIAM BEAUMONT HOSPITAL,
HOSPITAL CONSULTANTS, P.C., and
LINET LONAPPAN, M.D., Jointly and Severally,

Defendants,
_____/

ORDER AND OPINION

At a session of said Court, held in the Courthouse in the City of Pontiac, County of Oakland, State of Michigan on the 31st day of July, 2019.

PRESENT: HONORABLE NANCI J. GRANT, CIRCUIT JUDGE

The matter is before the Court on Defendant William Beaumont Hospital's ("Defendant") motion for summary disposition. After hearing oral arguments on July 31, 2019, the Court took the matter under advisement. For the following reasons, Defendant's motion is granted in part and denied in part:

This matter arises from Plaintiff being treated by Physician's Assistant Janay Warner and Dr. Linet Lonappan when she was a patient at Defendant's facility from October 9, 2015 through October 11, 2015. According to Plaintiff, Dr. Lonappan and Physician's Assistant Warner failed to timely diagnose and treat her Group B Streptococcus infection during this time and Defendant is vicariously liable for their malpractice. Plaintiff also alleges that Defendant is directly liable as a result of its failure to promulgate and enforce certain policies and procedures. Defendant now moves for summary disposition on multiple grounds.[1]

[1] At oral arguments on July 31, 2019, the parties reported that the claim related to Physician's Assistant Warner would be dismissed with prejudice via a forthcoming stipulated order. Accordingly, it is not necessary for this Court to rule on Defendant's motion with respect to the vicarious liability claim related to Physician's Assistant Warner, who was Defendant's employee at all relevant times. See *Federated Publications, Inc v City of Lansing,* 467 Mich 98, 112 (2002),

Defendant first argues that summary disposition is proper on Plaintiff's claim that it is vicariously liable for the alleged malpractice of Dr. Lonappan because the undisputed evidence establishes that Dr. Lonappan was not an actual employee or agent of the hospital. The Court agrees.

Generally, Michigan law will impose liability upon a defendant only for his or her own acts of negligence, not the tortious conduct of others. However, an exception exists under the theory of *respondeat superior*, wherein an employer may be liable for the negligent acts of its employee if the employee was acting within the scope of his employment. *Hamed v Wayne Co,* 490 Mich 1, 10-11 (2011). Similarly, in the absence of an employer-employee relationship, vicarious liability may also attach through the concept of agency. As the Court of Appeals has explained:

> A principal may be vicariously liable to a third party for harms inflicted by his or her agent even though the principal did not participate by act or omission in the agent's tort. Vicarious liability is indirect responsibility imposed by operation of law. Courts impose indirect responsibility on the principal for his or her agent's torts as a matter of public policy, but the principal, having committed no tortious act, is not a "tortfeasor" as that term is commonly defined. Because liability is imputed by law, a plaintiff does not have to prove that the principal acted negligently. Rather, to succeed on a vicarious liability claim, a plaintiff need only prove that an agent has acted negligently. Concomitantly, if the agent has not breached a duty owed to the third party, the principal cannot be held vicariously liable for the agent's actions or omissions. [*Bailey v Schaaf (On Remand),* 304 Mich App 324, 347 (2014) (quotation marks and citations omitted), vacated in part on other grounds 497 Mich 927 (2014).]

In an agency relationship, it is the power or ability of the principal to control the agent that justifies the imposition of vicarious liability. See *Breighner v Mich High Sch Athletic Ass'n, Inc,* 255 Mich App 567, 583 (2003); *Little v Howard Johnson Co,* 183 Mich App 675, 680 (1990). Conversely, it is this absence of control that explains why an employer is generally not liable for the actions of an independent contractor. See *Campbell v Kovich,* 273 Mich App 227, 233-234 (2006). "An independent contractor is one who, carrying on an independent business, contracts to do a piece of work *according to his own methods,* and without being subject to control of his

---

abrogated in part on other grounds *Herald Co, Inc v Eastern Mich Univ Bd of Regents*, 475 Mich 463, 471-472 (2006) (holding that courts need not decide moot issues).

employer *as to the means by which the result is to be accomplished,* but only as to the result of the work." *Utley v Taylor & Gaskin, Inc.,* 305 Mich 561, 570 (1943) (quotation marks and citation omitted; emphasis added). The labels that the parties use in such a relationship are not dispositive. Instead,

> [t]he test for whether a worker is an independent contractor or an employee is whether the worker has control *over the method of his or her work:* If the employer of a person or business ostensibly labeled an "independent contractor" retains control *over the method of the work,* there is in fact no contractee-contractor relationship, and the employer may be vicariously liable under the principles of master and servant. [*Campbell,* 273 Mich App at 234 (quotation marks and citations omitted; emphasis added).]

"For this reason, it is clear that not just any type of control will suffice to transform an independent contractor into an employee or agent; rather, the control must relate to the method of the work being done." *Laster v Henry Ford Health Sys*, 316 Mich App 726, 736 (2016).

Consistent with this case law, a hospital will not be held vicariously liable for the negligence of a physician who is an independent contractor, unless the hospital has assumed control over the physician. *Grewe v Mount Clemens Gen Hosp,* 404 Mich 240, 250 (1978). Here, the parties do not dispute that Dr. Lonappan was employed by Hospital Consultants, P.C.—not Defendant—at all relevant times. According to Dr. Lonappan's deposition testimony, Hospital Consultants is "an organization that employs physicians and contracts with the hospital. . . ." As relevant here, Hospital Consultants had an agreement with Dr. John Bonema's medical group (Troy Internal Medicine) to provide treatment to its patients at Defendant's facility.[2] When necessary, Defendant assigned patients to the physicians who worked for Hospital Consultants.

Dr. Lonappan testified that, after Defendant assigned her a patient, it was her job to examine the patient and to "formulate a plan for [his or her] diagnosis and treatment." Dr. Lonappan also testified that it is her decision whether to discharge her patients. There is no evidence to suggest that anyone other than Dr. Lonappan had the final say concerning how Plaintiff (or any other patient) would be treated. Accordingly, because it is undisputed that Plaintiff's medical malpractice claim is predicated on Dr. Lonappan's exercise of professional judgment—over which Defendant had no control or influence—Dr. Lonappan was not an actual agent of

[2] Dr. Bonema was Plaintiff's primary care physician at all relevant times.

Defendant at any relevant time. See *Laster*, 316 Mich App at 739. Although Plaintiff adamantly argues that the question of actual agency is one for the jury and provides citations to legal authority to support this, the Court finds that it is proper for it to decide this issue given that the undisputed evidence clearly establishes that an actual agency relationship did not exist.

Next, Plaintiff argues that summary disposition is improper on her vicarious liability claim against Defendant relating to Dr. Lonappan because an ostensible agency existed. "[A] hospital may be vicariously liable for the malpractice of . . . apparent agents." *VanStelle v Macaskill*, 255 Mich App 1, 10 (2003) (quotation marks and citation omitted). To demonstrate ostensible agency, a party must show three elements:

> (1) the person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one, (2) the belief must be generated by some act or neglect on the part of the principal sought to be charged, and (3) the person relying on the agent's authority must not be guilty of negligence. [*Id.* (quotation marks and citation omitted).]

Critically, a hospital will not be held vicariously "liable for the malpractice of independent contractors merely because the patient 'looked to' the hospital at the time of admission or even was treated briefly by an actual nonnegligent agent of the hospital." *Id.* (quotation marks and citation omitted). Furthermore, an ostensible agency relationship will not arise simply because the plaintiff went to the hospital for care or because a physician used the hospital to treat the plaintiff. *Id.* at 11. Rather, "the defendant as the putative principal must *have done something that would create in the patient's mind* the reasonable belief that the doctors were acting on behalf of the defendant hospital." *Id.* at 10.

In the present case, Plaintiff testified at her September 7, 2018 deposition that she only recalled seeing a "pain doctor" during her time at Defendant's facility from October 9 through October 11, 2015. More specifically, she testified as follows:

> Q. And there were various types of doctors from various specialties who saw you during that admission, you're aware of that?
>
> A. The only one I remember seeing was the—they sent one of the pain doctors up about potentially doing an epidural but they couldn't do it because it was the weekend.
>
> Q. So if there were different doctors from different specialties seeing you to look at what you had going on medically and to try to

> evaluate it from different perspectives, you may not recall their names but you do recall seeing different doctors, correct?
>
> A. I don't.

Thus, Plaintiff essentially testified that she had no recollection of Dr. Lonappan. Without any recollection of Dr. Lonappan, there is nothing to support Plaintiff's claim that she harbored a reasonable belief that Dr. Lonappan was acting as a hospital employee. Although Plaintiff has provided this Court with an affidavit that indicates that she "was at all times under the impression that Dr. Linet Lonappan, as well as other medical staff at Beaumont Hospital—Royal Oak, were employees of Beaumont Hospital—Royal Oak," this Court cannot consider Plaintiff's affidavit because it conflicts with her previous deposition testimony. See *Casey v Auto Owners Ins Co*, 273 Mich App 388, 396 (2006) ("a witness is bound by his or her deposition testimony, and that testimony cannot be contradicted by affidavit in an attempt to defeat a motion for summary disposition").

Further, although Plaintiff repeatedly points to the fact that Dr. Lonappan testified that she typically reports to patients that she was assigned to their service by Defendant, there is no indication that Defendant encouraged Dr. Lonappan to say this or that it acquiesced in the use of this vernacular. Cf. *Strach v St John Hosp Corp*, 160 Mich App 251, 270 (1987) ("That the defendant hospital acquiesced in the use of the vernacular 'St. John Hospital team' and in the direct exercise of authority over its employees is conduct of the principal tending to create ostensible agency."). The only evidence that could potentially support that Defendant—as opposed to Dr. Lonappan—had taken some action as to encourage a belief that Dr. Lonappan was its employee or agent is that it provided her with a lab coat that indicated that she was affiliated with Beaumont Health Systems. However, the lab coat also reflected that Dr. Lonappan was affiliated with Hospital Consultants. Furthermore, what was printed on the lab coat is immaterial given that Plaintiff does not even recall having seen it. Therefore, because Plaintiff has failed to establish a genuine issue of material fact regarding the elements of ostensible agency, summary disposition in favor of Defendant is proper with respect to Plaintiff's claims of vicarious liability related to Dr. Lonappan.

Finally, Defendant argues that summary disposition is proper on Plaintiff's direct claim of malpractice against it. More specifically, the relevant portion of the complaint provides the following allegations:

> 56. . . . Defendant violated the standard of care applicable in the matter set forth below:
>
> a. They failed to establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the attending physician or another appropriate physician;
>
> b. They failed to establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the patient if the patient has already been discharged from the hospital. . . .

"In a medical malpractice case, the plaintiff bears the burden of proving: (1) the applicable standard of care, (2) breach of that standard by defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury." *Decker v Rochowiak,* 287 Mich App 666, 685 (2010) (quotation marks omitted). Expert testimony is required to establish the standard of care and to demonstrate a defendant's breach of that standard. *Id.* It is well settled that a hospital may be directly liable for malpractice through claims of negligence in selection and retention of medical staff, in supervision of medical staff, and in patient monitoring. *Cox v Flint Bd of Hosp Managers,* 467 Mich 1, 11 (2002).

Here, with respect to Plaintiff's claim that Defendant improperly failed to establish and implement policies requiring physicians to report test results to their patients, Defendant correctly notes that Dr. Lonappan unequivocally testified that it was her responsibility to review test results and to decide whether to communicate the test results to patients. However, in response to this argument, Plaintiff provides this Court with the affidavit of Dr. Thomas Bojko, who has a background in hospital administration. In the affidavit, Dr. Bojko avers as follows:

> 17. It is my opinion that the requirements of the standard of care applicable to the hospital administrators included, but were not limited to, the following:
>
> * * *
>
> b. Establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms *be immediately reported to the patient* and the patient's physician if the patient has already been discharged from the hospital.

* * *

> 20. It is further my opinion that had the Hospital Administrators acted in accordance with the standard of care more completely described above, an attending physician or Ms. Markel would have been timely notified of the abnormal preliminary lab result. Had those steps been taken, Ms. Markel would have been aware of the preliminary urine culture result and returned to the hospital to receive antibiotics, she would not have had an epidural injection, would not have developed an epidural abscess and timely intervention would have prevented the spread and worsening of the infection. [Emphasis added.]

Accordingly, because Plaintiff has provided this Court with evidence to support that Defendant breached the standard of care by failing to create and implement policies that required physicians to report test results to patients and that Defendant's alleged breach caused Plaintiff injury, summary disposition is improper on that claim at this time. See *Decker,* 287 Mich App at 685.

With respect to Plaintiff's claim that Defendant improperly failed to establish, implement, and maintain a policy requiring that abnormal urine culture results be immediately reported to the patient's attending physician, the Court finds that summary disposition on that claim is proper. There is no evidence before this Court to suggest that Plaintiff's test results were not reported to Dr. Lonappan in a timely manner. In fact, the record establishes that the final results of Plaintiff's urine culture "resulted" on October 12, 2015 at 8:38 p.m. Dr. Lonappan testified that she reviewed the results on October 12, 2015. Accordingly, because the undisputed evidence establishes that the results of Plaintiff's urine culture results were able to be accessed by Dr. Lonappan in a timely manner, summary disposition on that claim is proper. See *id.*

Defendant's motion is granted in part and denied in part.

IT IS SO ORDERED.

NANCI J. GRANT, Circuit Court Judge

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

Mary Anne Markel,

Plaintiff,

v.

Case No. 2018-164979-NH

Hon. Nanci J. Grant

William Beaumont Hospital, Hospital Consultants, P.C., Linet Lonappan, M.D., and Ioana Morariu, M.D., Jointly and Severally

Defendants.

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STIPULATION DISMISSING PLAINTIFF'S REMAINING DIRECT LIABILITY CLAIM AGAINST DEFENDANT, WILLIAM BEAUMONT HOSPITAL, WITH PREJUDICE

It is stipulated that Plaintiff's remaining direct liability claim against Defendant, William Beaumont Hospital is dismissed, with prejudice.

Meyers Law, P.L.L.C.

By: /s/ Muskan B. Ali (with permission)
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Giarmarco, Mullins & Horton, P.C.

By: /s/ Donald K. Warwick
Donald K. Warwick (P44619)
Attorney for William Beaumont Hospital

ORDER DISMISSING PLAINTIFF'S REMAINING DIRECT LIABILITY CLAIM AGAINST DEFENDANT, WILLIAM BEAUMONT HOSPITAL, WITH PREJUDICE

Pursuant to the above Stipulation,

It is ordered that Plaintiff's remaining direct liability claim against Defendant, William Beaumont Hospital is dismissed, with prejudice.

THIS IS NOT A FINAL ORDER AND IT DOES NOT CLOSE THE CASE.

/s/ Nanci J. Grant
Circuit Court Judge SL
Nanci J. Grant

Dated: 9/12/2019

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

MARY ANNE MARKEL,

Plaintiff,

v.

Case No.: 18-164979 -NH
Hon. Nanci J. Grant

WILLIAM BEAUMONT HOSPITAL, HOSPITAL CONSULTANTS, P.C., AND LINET LONAPPAN, M.D. JOINTLY AND SEVERALLY,

Defendants.

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PROOF OF SERVICE

I, Jessica P. Weber, hereby certify that on August 19, 2019, I electronically e-filed Plaintiff's Motion for Reconsideration of this Honorable Court's Opinion and Order Granting Defendant's Motion to for Summary Disposition Regarding William Beaumont Hospital's Vicarious Liability of Defendant Linet Lonappan, M.D., Brief in Support, and

FEE

this Proof of Service, with the MiFile File and Serve System, which will send notification of such filing to the following:

RANDY J. HACKNEY (P28980)
rhackney@hackneygroverlaw.com

DONALD K. WARWICK (P44619)
dwarwick@gmhlaw.com

I declare under the penalties of perjury that the foregoing statements are true and correct to the best of my information and belief.

/s/Jessica P. Weber
Jessica P. Weber

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

MARY ANNE MARKEL,

Plaintiff,

v.

Case No.: 18-164979 -NH
Hon. Nanci J. Grant

WILLIAM BEAUMONT HOSPITAL, HOSPITAL CONSULTANTS, P.C., AND LINET LONAPPAN, M.D. JOINTLY AND SEVERALLY,

Defendants.

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NOTICE OF HEARING

PLEASE TAKE NOTICE that Plaintiff's Motion for Reconsideration of this Honorable Court's Opinion and Order Granting Defendant's Motion to for Summary Disposition Regarding William Beaumont Hospital's Vicarious Liability of Defendant Linet Lonappan, M.D., Brief in Support, and this Proof of Service will be heard before the Court in its Courtroom in the City of Pontiac, Oakland County, Michigan on Wednesday, August

28, 2019 before the Honorable Nanci J. Grant, or as soon thereafter as said matter can be heard.

Respectfully submitted,

MORGAN & MEYERS, PLC

BY: /s/ Timothy M. Takala
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DATED: August 19, 2019

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

MARY ANNE MARKEL,

Plaintiff,

v.

Case No.: 18-164979 -NH
Hon. Nanci J. Grant

WILLIAM BEAUMONT HOSPITAL, HOSPITAL CONSULTANTS, P.C., AND LINET LONAPPAN, M.D. JOINTLY AND SEVERALLY,

Defendants.

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PLAINTIFF'S MOTION FOR RECONSIDERATION OF THIS HONORABLE COURT'S OPINION AND ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY DISPOSITION REGARDING WILLIAM BEAUMONT HOSPITAL'S VICARIOUS LIABILITY OF DEFENDANT LINET LONAPPAN, M.D.

NOW COMES Plaintiff, MARY ANNE MARKEL, by and through her attorneys, MEYERS LAW, PLLC, and in support of her Plaintiff's Motion for Reconsideration of this Honorable Court's Opinion and Order Granting Defendant's Motion for Summary

Disposition Regarding William Beaumont Hospital's Vicarious Liability of Defendant Linet Lonappan, M.D., states as follows:

1. This Honorable Court is intimately familiar with the facts of this case.

2. This Honorable Court dismissed the vicarious liability claims against Defendant William Beaumont Hospital in relation to Defendant Linet Lonappan based upon *VanStelle v Macaskill,* 255 Mich App 1, 10 (2003), which holds that the hospital must have done something that would create a reasonable belief in the patient's mind that the doctors were acting on behalf of the defendant hospital. This Court reasoned that "Without any recollection of Dr. Lonappan, there is nothing to support Plaintiff's claim that she harbored a reasonable belief that Dr. Lonappan was acting as a hospital employee." (**Exhibit 1** – Hon. Nanci J. Grant's Order and Opinion dated 7/31/2019).

3. The Plaintiff respectfully files this motion within 21 days of the Court's Order pursuant to MCR 2.119(F) contending for the reasons that follow, that there were palpable errors and that a different disposition of the motion must result from correction of the errors.

4. It was palpable error for the Court to have found that there is "...nothing to support Plaintiff's claim that she harbored a reasonable belief that Dr. Lonappan was acting as a hospital employee," in the presence of Defendant Dr. Lonappan's unequivocal testimony that her introductions to patients included her name and that she was assigned to the care and treatment of the patient by Defendant Hospital, while wearing a lab coat that included Defendant William Beaumont Hospital's credentials. (**Exhibit 2** – Deposition of Linet Lonappan, M.D., p 45, 48-50). Although Plaintiff Markel did not recall the physicians that she encountered at Defendant Hospital during her deposition, it does not

negate that she had reasonable belief *at the time that care and treatment was being provided to her at Defendant Hospital* that the negligent doctor was acting on behalf of the hospital, especially in the presence of Dr. Lonappan's testimony regarding her habit and custom while treating her patients at Defendant Hospital. Furthermore, as analyzed in *Grewe v Mount Clemens Gen Hosp,* 404 Mich 240, 250 (1978), the key test, as applied to the facts of this case, is not to whom the patient looked for care at the time of her admission, but, rather, whether the hospital did something that would create the reasonable belief in the patient's mind that the negligent doctor was acting on behalf of the hospital. Here, the Defendant Hospital's affirmative action was to provide/allow Defendant Dr. Lonappan to wear a lab coat with its' credentials, irrespective of whether it includes the signage of Hospital Consultants, because Plaintiff patient cannot be expected to differentiate between the two credentials in conjunction with receiving medical care and treatment for her severe pain, which is described in her medical records to be "ten out of ten pain." (**Exhibit 3** – Medical Record of Mary Anne Markel). As supported and analyzed in *Grewe,* "…it cannot seriously be contended that respondent, when he was being carried from room to room suffering excruciating pain, should have inquired whether the individual doctors who examined him are employees of the college or were independent contractors. Agency is always a question of fact for the jury. The evidence produced on this issue is sufficient to support the jury's implied finding that Dr. Joyant was the ostensible agent of appellant college." *54 Cal.App.2d 141, 146, 128 P.2d 705, 708." Id.* Finally, Plaintiff Markel and Defendant Lonappan testified that they had no pre-existing physician-patient relationship, therefore, Plaintiff was not in a position to know what business arrangements the Defendants had created amongst themselves. At

the very least, an argument as to the material facts of the case should be considered, and the fact finders should be able to determine whether Plaintiff Markel had "reasonable belief" given the facts of this case.

WHEREFORE, Plaintiff respectfully requests that this Honorable Court Reconsider the basis for its ruling and enter an Order **DENYING** Defendant's Motion for Summary Disposition in favor of Defendant in respect to Plaintiff's claims of vicarious liability related to Dr. Lonappan.

Respectfully submitted,
MEYERS LAW, PLLC

BY: /s/ Timothy M. Takala
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DATED: August 19, 2019

BRIEF IN SUPPORT

Based on the foregoing, Plaintiff, Mary Anne Markel, requests that the court reconsider its July 31, 2019 opinion and, on reconsideration, deny Defendant's Motion for Summary Disposition in favor of Defendant in respect to Plaintiff's claims of vicarious liability related to Dr. Lonappan.

Respectfully submitted,
MEYERS LAW, PLLC

BY: /s/ Timothy M. Takala
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DATED: August 19, 2019

EXHIBIT ONE

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

MARY ANNE MARKEL,

Plaintiff,

-v-

Case Number: 2018-164979-NH
Honorable Nanci J. Grant

WILLIAM BEAUMONT HOSPITAL,
HOSPITAL CONSULTANTS, P.C., and
LINET LONAPPAN, M.D., Jointly and Severally,

Defendants,
_____/

ORDER AND OPINION

At a session of said Court, held in the Courthouse in the City of Pontiac, County of Oakland, State of Michigan on the 31st day of July, 2019.

PRESENT: HONORABLE NANCI J. GRANT, CIRCUIT JUDGE

The matter is before the Court on Defendant William Beaumont Hospital's ("Defendant") motion for summary disposition. After hearing oral arguments on July 31, 2019, the Court took the matter under advisement. For the following reasons, Defendant's motion is granted in part and denied in part:

This matter arises from Plaintiff being treated by Physician's Assistant Janay Warner and Dr. Linet Lonappan when she was a patient at Defendant's facility from October 9, 2015 through October 11, 2015. According to Plaintiff, Dr. Lonappan and Physician's Assistant Warner failed to timely diagnose and treat her Group B Streptococcus infection during this time and Defendant is vicariously liable for their malpractice. Plaintiff also alleges that Defendant is directly liable as a result of its failure to promulgate and enforce certain policies and procedures. Defendant now moves for summary disposition on multiple grounds.[1]

[1] At oral arguments on July 31, 2019, the parties reported that the claim related to Physician's Assistant Warner would be dismissed with prejudice via a forthcoming stipulated order. Accordingly, it is not necessary for this Court to rule on Defendant's motion with respect to the vicarious liability claim related to Physician's Assistant Warner, who was Defendant's employee at all relevant times. See *Federated Publications, Inc v City of Lansing,* 467 Mich 98, 112 (2002),

Defendant first argues that summary disposition is proper on Plaintiff's claim that it is vicariously liable for the alleged malpractice of Dr. Lonappan because the undisputed evidence establishes that Dr. Lonappan was not an actual employee or agent of the hospital. The Court agrees.

Generally, Michigan law will impose liability upon a defendant only for his or her own acts of negligence, not the tortious conduct of others. However, an exception exists under the theory of *respondeat superior*, wherein an employer may be liable for the negligent acts of its employee if the employee was acting within the scope of his employment. *Hamed v Wayne Co,* 490 Mich 1, 10-11 (2011). Similarly, in the absence of an employer-employee relationship, vicarious liability may also attach through the concept of agency. As the Court of Appeals has explained:

> A principal may be vicariously liable to a third party for harms inflicted by his or her agent even though the principal did not participate by act or omission in the agent's tort. Vicarious liability is indirect responsibility imposed by operation of law. Courts impose indirect responsibility on the principal for his or her agent's torts as a matter of public policy, but the principal, having committed no tortious act, is not a "tortfeasor" as that term is commonly defined. Because liability is imputed by law, a plaintiff does not have to prove that the principal acted negligently. Rather, to succeed on a vicarious liability claim, a plaintiff need only prove that an agent has acted negligently. Concomitantly, if the agent has not breached a duty owed to the third party, the principal cannot be held vicariously liable for the agent's actions or omissions. [*Bailey v Schaaf (On Remand),* 304 Mich App 324, 347 (2014) (quotation marks and citations omitted), vacated in part on other grounds 497 Mich 927 (2014).]

In an agency relationship, it is the power or ability of the principal to control the agent that justifies the imposition of vicarious liability. See *Breighner v Mich High Sch Athletic Ass'n, Inc,* 255 Mich App 567, 583 (2003); *Little v Howard Johnson Co,* 183 Mich App 675, 680 (1990). Conversely, it is this absence of control that explains why an employer is generally not liable for the actions of an independent contractor. See *Campbell v Kovich,* 273 Mich App 227, 233-234 (2006). "An independent contractor is one who, carrying on an independent business, contracts to do a piece of work *according to his own methods,* and without being subject to control of his

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abrogated in part on other grounds *Herald Co, Inc v Eastern Mich Univ Bd of Regents*, 475 Mich 463, 471-472 (2006) (holding that courts need not decide moot issues).

employer *as to the means by which the result is to be accomplished,* but only as to the result of the work." *Utley v Taylor & Gaskin, Inc.*, 305 Mich 561, 570 (1943) (quotation marks and citation omitted; emphasis added). The labels that the parties use in such a relationship are not dispositive. Instead,

> [t]he test for whether a worker is an independent contractor or an employee is whether the worker has control *over the method of his or her work:* If the employer of a person or business ostensibly labeled an "independent contractor" retains control *over the method of the work,* there is in fact no contractee-contractor relationship, and the employer may be vicariously liable under the principles of master and servant. [*Campbell,* 273 Mich App at 234 (quotation marks and citations omitted; emphasis added).]

"For this reason, it is clear that not just any type of control will suffice to transform an independent contractor into an employee or agent; rather, the control must relate to the method of the work being done." *Laster v Henry Ford Health Sys*, 316 Mich App 726, 736 (2016).

Consistent with this case law, a hospital will not be held vicariously liable for the negligence of a physician who is an independent contractor, unless the hospital has assumed control over the physician. *Grewe v Mount Clemens Gen Hosp,* 404 Mich 240, 250 (1978). Here, the parties do not dispute that Dr. Lonappan was employed by Hospital Consultants, P.C.—not Defendant—at all relevant times. According to Dr. Lonappan's deposition testimony, Hospital Consultants is "an organization that employs physicians and contracts with the hospital. . . ." As relevant here, Hospital Consultants had an agreement with Dr. John Bonema's medical group (Troy Internal Medicine) to provide treatment to its patients at Defendant's facility.[2] When necessary, Defendant assigned patients to the physicians who worked for Hospital Consultants.

Dr. Lonappan testified that, after Defendant assigned her a patient, it was her job to examine the patient and to "formulate a plan for [his or her] diagnosis and treatment." Dr. Lonappan also testified that it is her decision whether to discharge her patients. There is no evidence to suggest that anyone other than Dr. Lonappan had the final say concerning how Plaintiff (or any other patient) would be treated. Accordingly, because it is undisputed that Plaintiff's medical malpractice claim is predicated on Dr. Lonappan's exercise of professional judgment—over which Defendant had no control or influence—Dr. Lonappan was not an actual agent of

[2] Dr. Bonema was Plaintiff's primary care physician at all relevant times.

Defendant at any relevant time. See *Laster*, 316 Mich App at 739. Although Plaintiff adamantly argues that the question of actual agency is one for the jury and provides citations to legal authority to support this, the Court finds that it is proper for it to decide this issue given that the undisputed evidence clearly establishes that an actual agency relationship did not exist.

Next, Plaintiff argues that summary disposition is improper on her vicarious liability claim against Defendant relating to Dr. Lonappan because an ostensible agency existed. "[A] hospital may be vicariously liable for the malpractice of . . . apparent agents." *VanStelle v Macaskill*, 255 Mich App 1, 10 (2003) (quotation marks and citation omitted). To demonstrate ostensible agency, a party must show three elements:

> (1) the person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one, (2) the belief must be generated by some act or neglect on the part of the principal sought to be charged, and (3) the person relying on the agent's authority must not be guilty of negligence. [*Id.* (quotation marks and citation omitted).]

Critically, a hospital will not be held vicariously "liable for the malpractice of independent contractors merely because the patient 'looked to' the hospital at the time of admission or even was treated briefly by an actual nonnegligent agent of the hospital." *Id.* (quotation marks and citation omitted). Furthermore, an ostensible agency relationship will not arise simply because the plaintiff went to the hospital for care or because a physician used the hospital to treat the plaintiff. *Id.* at 11. Rather, "the defendant as the putative principal must *have done something that would create in the patient's mind* the reasonable belief that the doctors were acting on behalf of the defendant hospital." *Id.* at 10.

In the present case, Plaintiff testified at her September 7, 2018 deposition that she only recalled seeing a "pain doctor" during her time at Defendant's facility from October 9 through October 11, 2015. More specifically, she testified as follows:

> Q. And there were various types of doctors from various specialties who saw you during that admission, you're aware of that?
>
> A. The only one I remember seeing was the—they sent one of the pain doctors up about potentially doing an epidural but they couldn't do it because it was the weekend.
>
> Q. So if there were different doctors from different specialties seeing you to look at what you had going on medically and to try to

> evaluate it from different perspectives, you may not recall their names but you do recall seeing different doctors, correct?
>
> A. I don't.

Thus, Plaintiff essentially testified that she had no recollection of Dr. Lonappan. Without any recollection of Dr. Lonappan, there is nothing to support Plaintiff's claim that she harbored a reasonable belief that Dr. Lonappan was acting as a hospital employee. Although Plaintiff has provided this Court with an affidavit that indicates that she "was at all times under the impression that Dr. Linet Lonappan, as well as other medical staff at Beaumont Hospital—Royal Oak, were employees of Beaumont Hospital—Royal Oak," this Court cannot consider Plaintiff's affidavit because it conflicts with her previous deposition testimony. See *Casey v Auto Owners Ins Co*, 273 Mich App 388, 396 (2006) ("a witness is bound by his or her deposition testimony, and that testimony cannot be contradicted by affidavit in an attempt to defeat a motion for summary disposition").

Further, although Plaintiff repeatedly points to the fact that Dr. Lonappan testified that she typically reports to patients that she was assigned to their service by Defendant, there is no indication that Defendant encouraged Dr. Lonappan to say this or that it acquiesced in the use of this vernacular. Cf. *Strach v St John Hosp Corp*, 160 Mich App 251, 270 (1987) ("That the defendant hospital acquiesced in the use of the vernacular 'St. John Hospital team' and in the direct exercise of authority over its employees is conduct of the principal tending to create ostensible agency."). The only evidence that could potentially support that Defendant—as opposed to Dr. Lonappan—had taken some action as to encourage a belief that Dr. Lonappan was its employee or agent is that it provided her with a lab coat that indicated that she was affiliated with Beaumont Health Systems. However, the lab coat also reflected that Dr. Lonappan was affiliated with Hospital Consultants. Furthermore, what was printed on the lab coat is immaterial given that Plaintiff does not even recall having seen it. Therefore, because Plaintiff has failed to establish a genuine issue of material fact regarding the elements of ostensible agency, summary disposition in favor of Defendant is proper with respect to Plaintiff's claims of vicarious liability related to Dr. Lonappan.

Finally, Defendant argues that summary disposition is proper on Plaintiff's direct claim of malpractice against it. More specifically, the relevant portion of the complaint provides the following allegations:

> 56. . . . Defendant violated the standard of care applicable in the matter set forth below:
>
> a. They failed to establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the attending physician or another appropriate physician;
>
> b. They failed to establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms be immediately reported to the patient if the patient has already been discharged from the hospital. . . .

"In a medical malpractice case, the plaintiff bears the burden of proving: (1) the applicable standard of care, (2) breach of that standard by defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury." *Decker v Rochowiak,* 287 Mich App 666, 685 (2010) (quotation marks omitted). Expert testimony is required to establish the standard of care and to demonstrate a defendant's breach of that standard. *Id.* It is well settled that a hospital may be directly liable for malpractice through claims of negligence in selection and retention of medical staff, in supervision of medical staff, and in patient monitoring. *Cox v Flint Bd of Hosp Managers,* 467 Mich 1, 11 (2002).

Here, with respect to Plaintiff's claim that Defendant improperly failed to establish and implement policies requiring physicians to report test results to their patients, Defendant correctly notes that Dr. Lonappan unequivocally testified that it was her responsibility to review test results and to decide whether to communicate the test results to patients. However, in response to this argument, Plaintiff provides this Court with the affidavit of Dr. Thomas Bojko, who has a background in hospital administration. In the affidavit, Dr. Bojko avers as follows:

> 17. It is my opinion that the requirements of the standard of care applicable to the hospital administrators included, but were not limited to, the following:
>
> * * *
>
> b. Establish, implement, and maintain a policy requiring that preliminary or interim urine culture results that reveal significant growth of abnormal or infectious organisms *be immediately reported to the patient* and the patient's physician if the patient has already been discharged from the hospital.

* * *

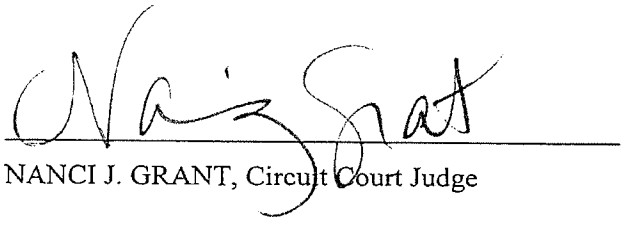
> 20. It is further my opinion that had the Hospital Administrators acted in accordance with the standard of care more completely described above, an attending physician or Ms. Markel would have been timely notified of the abnormal preliminary lab result. Had those steps been taken, Ms. Markel would have been aware of the preliminary urine culture result and returned to the hospital to receive antibiotics, she would not have had an epidural injection, would not have developed an epidural abscess and timely intervention would have prevented the spread and worsening of the infection. [Emphasis added.]

Accordingly, because Plaintiff has provided this Court with evidence to support that Defendant breached the standard of care by failing to create and implement policies that required physicians to report test results to patients and that Defendant's alleged breach caused Plaintiff injury, summary disposition is improper on that claim at this time. See *Decker,* 287 Mich App at 685.

With respect to Plaintiff's claim that Defendant improperly failed to establish, implement, and maintain a policy requiring that abnormal urine culture results be immediately reported to the patient's attending physician, the Court finds that summary disposition on that claim is proper. There is no evidence before this Court to suggest that Plaintiff's test results were not reported to Dr. Lonappan in a timely manner. In fact, the record establishes that the final results of Plaintiff's urine culture "resulted" on October 12, 2015 at 8:38 p.m. Dr. Lonappan testified that she reviewed the results on October 12, 2015. Accordingly, because the undisputed evidence establishes that the results of Plaintiff's urine culture results were able to be accessed by Dr. Lonappan in a timely manner, summary disposition on that claim is proper. See *id.*

Defendant's motion is granted in part and denied in part.

IT IS SO ORDERED.



NANCI J. GRANT, Circuit Court Judge

EXHIBIT TWO

LONAPPAN, M.D., LINET
12/04/2018

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

Mary Anne Markel,
Plaintiff,
vs. Case No. 18-164979-NH
Hon. Nanci J. Grant
William Beaumont Hospital, Hospital Consultants, P.C., and Linet Lonappan, M.D., Jointly and Severally,
Defendants.

The Deposition of LINET LONAPPAN, M.D.,
Taken at One Towne Square, Suite 1400,
Southfield, Michigan,
Commencing at 2:05 p.m.,
Tuesday, December 4, 2018,
Before Becky L. Johnson, CSR-5395.

APPEARANCES:

TIMOTHY M. TAKALA
Morgan & Meyers, P.L.C.
3200 Greenfield Road
Suite 260
Dearborn, Michigan 48120
(313) 961-0130
ttakala@morganmeyers.com
Appearing on behalf of the Plaintiff.

DONALD K. WARWICK
Giarmarco, Mullins & Horton, P.C.
101 West Big Beaver Road
10th Floor
Troy, Michigan 48084
(248) 457-7072
dwarwick@gmhlaw.com
Appearing on behalf of the Defendant, William Beaumont Hospital.

STEVEN B. SINKOFF
Siemion Huckabay, P.C.
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Southfield, Michigan 48076
(248) 357-1400
ssinkoff@siemion-huckabay.com
Appearing on behalf of the Defendants, Hospital Consultants, P.C. and Linet Lonappan, M.D.

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EXHIBITS

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winding down?
A. Correct.
Q. Okay. Are there situations where you're winding down, but you can't discharge every patient from your roster?
A. Correct.
Q. What happens in that situation, does somebody else come on as the attending physician or do you stay on as attending?
A. Somebody else comes on as attending.
Q. Okay. So you wouldn't have any further responsibility for that patient, you would transfer it to whoever was taking over your spot as the hospitalist?
A. Yes.
Q. Okay. Do you know whether you ever met Ms. Markel prior to October 10th, 2015?
A. No.
Q. You know that you hadn't or you just don't know?
A. I know that I hadn't.
Q. Okay. Do you know whether you ever saw Ms. Markel after October 13th, 2015? And just to put things in context a little bit, you probably know this, but Ms. Markel is at Beaumont Royal Oak from October 9th through October 11th and then she comes back on October 13th.

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A. Correct.
Q. Okay. Do you know whether you ever saw -- and you did an H&P on October 13th.
A. October 14th.
Q. Okay. Fair enough. Do you know whether you ever saw Ms. Markel after October 14th?
A. Yes.
Q. Okay. Do you know what the last day was that you saw Ms. Markel?
A. October 16th.
Q. And then what happens on October 16th, does your service end for that 10-or-11-day period?
A. Correct.
Q. All right. And so her care is transferred to another physician?
A. Yes.
Q. In this case I think it was transferred to a Dr. Perry Greene. Do you recall seeing that?
MR. WARWICK: Just foundation.
MR. SINKOFF: Foundation.
A. No.
MR. WARWICK: Perry Greene is an orthopedic surgeon.
MR. TAKALA: Yeah, that's fair enough.
BY MR. TAKALA:

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Q. And the only reason I say that is because -- and I'll just -- I'll do this a little bit out of order, but I'm going to mark as Plaintiff's Exhibit 3 the discharge summary from November 2nd, 2015 and I'll show that to you.
MARKED FOR IDENTIFICATION:
DEPOSITION EXHIBIT 3
2:43 p.m.
BY MR. TAKALA:
Q. Can you read who it says attending physician at the top?
A. Perry Greene.
Q. Okay. Is Dr. Greene a member of Hospital Consultants, P.C.?
A. No.
Q. Okay. Do you know -- and if you don't, it's fine, this may be unfair to you. Do you know whether Dr. Greene was the attending physician after you ended your service on October 16th, 2015?
MR. WARWICK: Just foundation.
MR. SINKOFF: If you know.
A. No.
BY MR. TAKALA:
Q. Okay. Thank you. And again, I don't mean to belabor this, but you don't remember independently meeting

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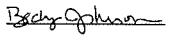
Ms. Markel for the first time on October 10th, correct?
A. Correct.
Q. You don't remember coming to her room, you don't remember who else was in her room or whether you saw her somewhere else in the hospital, correct?
A. No.
Q. All right.
MR. WARWICK: I'm not sure we have a clear record there. You're asking her questions about correct and she's saying no.
MR. TAKALA: Fair enough. Thank you, Don.
BY MR. TAKALA:
Q. Am I correct in my statement that you don't remember where you saw Ms. Markel when you first made contact with her on October 10th?
A. Yes.
Q. Okay. Thank you.
(Discussion off the record at 2:44 p.m.)
(Back on the record at 2:45 p.m.)
BY MR. TAKALA:
Q. When you are assigned to your 10-or-11-day shift at Beaumont Royal Oak do you wear a white lab coat?
A. Yes.
Q. All right. And do you wear credentials that indicate

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-5395
Notary Public,
Oakland County, Michigan
My Commission expires: January 28, 2019

EXHIBIT THREE

Encounter Notes (continued)

Progress Notes by Greene, Perry W III, MD at 10/21/2015 7:47 AM (continued)

Nsg Progress Note by Hess, Tori N, RN at 10/21/2015 4:00 AM

Author: Hess, Tori N, RN | Service: (none) | Author Type: Nursing
Filed: 10/21/2015 8:54 AM | Date of Service: 10/21/2015 4:00 AM | Status: Signed
Editor: Hess, Tori N, RN (Registered Nurse)

A&Ox3. Pt pain was well controlled throughout night with roxicodone. Pt experienced increase in pain after hibiclens shower in am. Pain 10/10. Gave IV dilaudid and used refocusing/relaxation/deep breathing techniques. Pt ambulates to bathroom with walker. Tolerates well. Balance in tact and gait steady with support. TMS 226. Pt voiding without difficulty. Educated on IS 10 times an hour while awake. Encouraged to call for pain meds and assistance. Last BM 10/21. No drainage at procedure sites. IV site cdi. No other breakdown noted. WCTM.

Nsg Progress Note by Hess, Tori N, RN at 10/21/2015 5:41 AM

Author: Hess, Tori N, RN | Service: (none) | Author Type: Nursing
Filed: 10/21/2015 5:43 AM | Date of Service: 10/21/2015 5:41 AM | Status: Signed
Editor: Hess, Tori N, RN (Registered Nurse)

TMS called for 4-beat vtach run at 0400. Notified wright with VS BP 159/67 HR 78 o2 92% Temp 99.9. Pt denies SOB or chest pain. 10 min prior to tms call, pt was having anxiety. Gave valium prn per eMAR. Wright is aware and re-addressed the order for BMP at 0530. WCTM.

Progress Notes by Wiater, Brett P, MD at 10/20/2015 10:53 PM

Author: Wiater, Brett P, MD | Service: Orthopedic Surgery | Author Type: Physician
Filed: 10/20/2015 10:55 PM | Date of Service: 10/20/2015 10:53 PM | Status: Signed
Editor: Wiater, Brett P, MD (Physician)

ORTHO PROGRESS NOTE

Subjective: Complains of right shoulder pain.

Objective:

Filed Vitals:

	10/20/15 0510	10/20/15 0937	10/20/15 1629	10/20/15 2000
BP:	140/74	130/68	129/49	131/47
Pulse:	63	69	63	66
Temp:	95.7 °F (35.4 °C)	98.1 °F (36.7 °C)	98.9 °F (37.2 °C)	98.8 °F (37.1 °C)
TempSrc:	Oral	Oral	Oral	Oral
Resp:	16	18	20	19
Height:				
Weight:				
SpO2:	96%	98%	100%	96%

Recent Labs

ROYAL OAK HOSPITAL
3601 W THIRTEEN MILE RD
ROYAL OAK MI 48073-6712
Inpt/OR Legal Record

Markel, Mary Anne
MRN: 1568410, DOB: [redacted]1960, Sex: F
Adm: 10/13/2015, D/C: 11/2/2015

Encounter Notes (continued)

Consults by Mannina, Rosie L, RN NP-C at 10/22/2015 4:09 PM (continued)

Date of Admission: 10/13/2015

Date/Time of Consult: 10/22/2015 4:09 PM

Chief Complaint:
Low back pain
Source of Information:
Patient and Available medical record

History of Present Illness:
This is a 55y.o. Female S/P D&C on 9/25. She is known to Dr. Olson, has a hx of 2 lumbar laminectomies approx 25 years ago. She was seen in the EC on 10/09 by the neurosurgery NP and then by Dr. Olson on 10/10 for back pain with left leg radiculopathy. MRI at that time showed multilevel mild, moderate and severe stenosis, neural foraminal stenosis, disc extrusions and protrusions. Dr. Olson recommended robaxin and EDSI by pain service and then PT. She states she went home from EC obs on 10/11 but her pain was worsening. That day she developed burning pain in both knees. On 10/12 she had an EDSI in the pain clinic which helped the pain somewhat. She returned to the EC with severe pain and a Tmax of 103.7 on 10/13 and was admitted. She went to the OR on 10/14 for I & D and revision of bilateral total knee replacements. She has group B strep polyarticular arthritis and is on penicillin G. She had an I&D of a right sternoclavicular abscess yesterday. MRI of the lumbar spine was repeated because of intractable back pain and concern for seeding of infection. She reports her back pain is currently 8/10

MRI lumbar spine w & w/o contrast 10/18/2015

New facet effusions at L3-4 and edema adjacent to the facets at L2-3 and L3-4. There is suggestion of subtle edema on sagittal STIR images involving the posterior elements of L2, L3, and L4. There is mild dural enhancement at L3-4. No abnormal fluid collection is evident. Findings are concerning for soft tissue inflammatory/infectious process within the areas of edema and
enhancement without epidural abscess.
Similar advanced degenerative changes described above with severe spinal stenosis at L3-4 and L4-5. Similar multilevel neural foramen stenosis described above.

Past Medical History:
Past Medical History

Diagnosis	Date
• Hypertension	
• Hypothyroidism	
• Asthma	
• Glaucoma	
• GERD (gastroesophageal reflux disease)	
• Diverticulitis	
• Dysphagia	
• Anxiety disorder	
• Postoperative nausea and vomiting	
• Group B streptococcal infection	10/2015

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

MARY ANNE MARKEL,

Plaintiff,

-v-

Case Number: 2018-164979-NH
Honorable Nanci J. Grant

WILLIAM BEAUMONT HOSPITAL,
HOSPITAL CONSULTANTS, P.C., and
LINET LONAPPAN, M.D., Jointly and Severally,

Defendants,
_____/

ORDER AND OPINION

At a session of said Court, held in the Courthouse in the City of Pontiac, County of Oakland, State of Michigan on the 27th day of August, 2019.

PRESENT: HONORABLE NANCI J. GRANT, CIRCUIT JUDGE

The matter is before the Court on Plaintiff Mary Anne Markel's Motion for Reconsideration of this Court's decision to grant Defendant William Beaumont Hospital's motion for summary disposition as to Plaintiff's vicarious liability claims of Dr. Linet Lonappan. For the following reasons, Plaintiff's motion is denied:

A hospital will not be held vicariously liable for the negligence of a physician who is an independent contractor, unless the hospital has assumed control over the physician. *Grewe v Mount Clemens Gen Hosp,* 404 Mich 240, 250 (1978). It is undisputed that Plaintiff's claim arises from Dr. Lonappan's professional judgment. Again, and as already addressed by this Court, there is no evidence that the Defendant Hospital had any final say concerning how the Plaintiff would be treated. Plaintiff argues, however, that summary disposition was improper because an ostensible agency existed between the Defendant Hospital and Dr. Lonappan.

"[A] hospital may be vicariously liable for the malpractice of . . . apparent agents." *VanStelle v Macaskill*, 255 Mich App 1, 10 (2003) (quotation marks and citation omitted). To demonstrate ostensible agency, a party must show three elements:

> (1) the person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one, (2) the belief must be generated by some act or neglect on the part of the principal sought to be charged, and (3) the person relying on the agent's authority must not be guilty of negligence. [*Id.* (quotation marks and citation omitted).]

Critically, a hospital will not be held vicariously "liable for the malpractice of independent contractors merely because the patient 'looked to' the hospital at the time of admission or even was treated briefly by an actual nonnegligent agent of the hospital." *Id.* (quotation marks and citation omitted). Furthermore, an ostensible agency relationship will not arise simply because the plaintiff went to the hospital for care or because a physician used the hospital to treat the plaintiff. *Id.* at 11. Rather, "the defendant as the putative principal must *have done something that would create in the patient's mind* the reasonable belief that the doctors were acting on behalf of the defendant hospital." *Id.* at 10.

In her Motion for Reconsideration, Plaintiff argues that this Court committed palpable error when it determined that there was "…nothing to support Plaintiff's claim that she harbored a reasonable belief that Dr. Lonappan was acting as a hospital employee." Plaintiff relies on testimony of Dr. Lonappan wherein she stated that it was her habit and custom to introduce herself to patients by stating her name and stating that she was assigned to their care and treatment by the Defendant Hospital. Further, Plaintiff argues that Dr. Lonappan wore a lab coat with the Beaumont logo so therefore this Court committed palpable error when it found that Plaintiff had failed to show a genuine issue of material fact as to ostensible agency.

The Court addressed these arguments in its Opinion and Order dated August 6, 2019. Absent proof that the Defendant Hospital acquiesced in Dr. Lonappan's habit of telling patients she was assigned to their service by Defendant Hospital, there is no creation of an ostensible agency. See *Strach v St John Hosp Corp*, 160 Mich App 251, 270 (1987) ("That the defendant hospital acquiesced in the use of the vernacular 'St. John Hospital team' and in the direct exercise of authority over its employees is conduct of the principal tending to create ostensible agency."). Plaintiff's motion does not present any evidence that Defendant Hospital acquiesced in Dr. Lonappan's habit of telling patients that she was assigned by the Hospital to treat them.

Plaintiff also argues that Dr. Lonappan's lab coat showing a Beaumont insignia created a "reasonable belief that [Dr. Lonappan] was acting on behalf of" the Defendant Hospital. Again,

the Court addressed this argument in its last opinion. While the Beaumont insignia was displayed on Dr. Lonappan's lab coat, the Hospital Consultants insignia was also displayed. Further, as noted by the Court previously, Plaintiff testified that she did not remember Dr. Lonappan. Therefore, she has not set forth any evidence tending to show a reasonable belief that Dr. Lonappan was acting on behalf of the Hospital.

The Court addressed these arguments in its Opinion and Order dated August 6, 2019. "Generally, and without restricting the discretion of the court, a motion for rehearing or reconsideration which merely presents the same issues ruled on by the court, either expressly or by reasonable implication, will not be granted. The moving party must demonstrate a palpable error by which the court and the parties have been misled and show that a different disposition of the motion must result from correction of the error." MCR 2.116(F)(3).

The Court finds that no palpable error exists. See MCR 2.119(F)(3). Plaintiff's motion is therefore denied.

IT IS SO ORDERED.

NANCI J. GRANT, Circuit Court Judge

STATE OF MICHIGAN

IN THE SUPREME COURT

MARY ANNE MARKEL,

Plaintiff-Appellant,

v.

WILLIAM BEAUMONT HOSPITAL,

Defendant-Appellee,

and

HOSPITAL CONSULTANTS, PC, LINET LONAPPAN, MD, and IOANA MORARIU,

Defendants.

Supreme Court No. 163086

Court of Appeals Case No. 350655

Oakland County Circuit Court
Case No. 18-164979-NH

Hon. Nanci Grant

APPENDIX OF EXHIBITS TO DEFENDANT-APPELLEE WILLIAM BEAUMONT HOSPITAL'S BRIEF ON APPEAL

Volume III

2021 WL 3117675
Only the Westlaw citation is currently available.

UNPUBLISHED
Court of Appeals of Michigan.

IN RE ESTATE OF Patricia Ann BEAN.
Audrey Whitfield, Individually and as Personal Representative of the Estate of Patricia Ann Bean, Plaintiff-Appellee,
v.
Ascension Health, St. John Providence, doing business as St. John Health System, Eastpointe Radiologists, PC, and Dr. Pierre A. Zayat, Defendants,
and
Ascension St. John Hospital, doing business as St. John Hospital & Medical Center, Defendant-Appellant.

No. 353960
|
July 22, 2021

Wayne Circuit Court, LC No. 18-015354-NH

Before: Tukel, P.J., and Sawyer and Cameron, JJ.

Opinion

Per Curiam.

***1** In this medical malpractice and wrongful death action, defendant Ascension St. John Hospital, doing business as St. John Hospital & Medical Center (the hospital), appeals a June 1, 2020 order, which denied the hospital's motion for summary disposition. We reverse and remand for further proceedings consistent with this opinion.

I. BACKGROUND

On December 12, 2015, Patricia Ann Bean (Bean) was brought to the hospital by ambulance because of pain and weakness in her legs. Bean also had shortness of breath. She was admitted to the hospital, and diagnostic testing was performed. It was discovered that Bean had a mass in her right lung. A bronchoscopy was performed, but it did not yield diagnostic results. It was recommended that Bean "undergo a CT Core Biopsy to rule out carcinoma versus pneumonitis." Defendant Dr. Pierre Zayat, who worked for defendant Eastpointe Radiologists, PC, was contacted. On December 21, 2015, Dr. Zayat performed the biopsy at the hospital using a large-gauge needle. A short period of time after the procedure was complete, Bean "arrested" and died.

In December 2018, Audrey Whitfield, individually and as the personal representative of the Estate of Patricia Ann Bean, filed a complaint. The complaint named, in relevant part, Dr. Zayat, Eastpointe Radiologists, and the hospital.[1] The complaint alleged that Dr. Zayat performed "an unnecessary, unindicated and negligently performed CT guided core biopsy of [Bean's] lung mass" at the hospital. According to Whitfield, the large-gauge needle used to perform the biopsy injured one of the "large pulmonary blood vessels" that was located near the mass, causing severe bleeding, "cardiopulmonary arrest," and Bean's death. Whitfield also alleged that Eastpointe Radiologists and the hospital were vicariously liable for Dr. Zayat's negligence. Whitfield further alleged that, as an heir-at-law, she sustained economic and noneconomic damages. The hospital, Dr. Zayat, and Eastpointe Radiologists answered the complaint and generally denied liability.

Before the close of discovery, the hospital moved for summary disposition under MCR 2.116(C)(10) (no genuine issue of material fact), arguing that Dr. Zayat was not employed by the hospital and that Whitfield could not show an ostensible agency relationship between the hospital and Dr. Zayat. Whitfield opposed the motion, arguing that a genuine issue of material fact existed as to whether there was an ostensible agency. Whitfield also argued that summary disposition was premature because discovery was ongoing. On June 1, 2020, the trial court denied the hospital's motion without oral argument and without explanation. The hospital filed an interlocutory application for leave to appeal, and this Court granted leave. *Estate of Patricia Ann Bean v Ascension Health*, unpublished order of the Court of Appeals, entered September 22, 2020 (Docket No. 353960).

II. STANDARD OF REVIEW

***2** "We review de novo a trial court's decision on a motion for summary disposition." *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152, 159; 934 NW2d 665 (2019).

> A motion under MCR 2.116(C)(10) ... tests the factual sufficiency of a claim. When considering such a motion, a trial court must consider all evidence submitted by the parties in the light most favorable to the party opposing the motion. A motion under MCR 2.116(C)(10) may only be granted when there is no genuine issue of material fact. A genuine issue of material fact exists when the record leaves open an issue upon which reasonable minds might differ. [*Id.* at 160 (quotation marks, citations, and emphasis omitted).]

"Courts are liberal in finding a factual dispute sufficient to withstand summary disposition." *Innovative Adult Foster Care, Inc v Ragin*, 285 Mich App 466, 476; 776 NW2d 398 (2009) (citation omitted).

III. ANALYSIS

The hospital argues that the trial court erred by denying its motion for summary disposition because Whitfield failed to show that a question of fact existed as to whether there was an ostensible agency relationship between the hospital and Dr. Zayat. We agree.

In *Grewe v Mt Clemens Gen Hosp*, 404 Mich 240, 250; 273 NW2d 429 (1978), our Supreme Court held that, "[g]enerally speaking, a hospital is not vicariously liable for the negligence of a physician who is an independent contractor and merely uses the hospital's facilities to render treatment to his patients." A hospital will not be held vicariously liable for the actions of medical personnel who are independent contractors unless an ostensible agency relationship is shown. *VanStelle v Macaskill*, 255 Mich App 1, 10; 662 NW2d 41 (2003).

> [T]he following three elements ... are necessary to establish the creation of an ostensible agency: (1) the person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one, (2) the belief must be generated by some act or neglect on the part of the principal sought to be charged, and (3) the person relying on the agent's authority must not be guilty of negligence. [*Chapa v St Mary's Hosp of Saginaw*, 192 Mich App 29, 33-34; 480 NW2d 590 (1991).]

Critically, a hospital will not be held vicariously "liable for the malpractice of independent contractors merely because the patient 'looked to' the hospital at the time of admission or even was treated briefly by an actual nonnegligent agent of the hospital." *VanStelle*, 255 Mich App at 10 (quotation marks and citation omitted). Furthermore, an ostensible agency will not arise simply because the plaintiff went to the hospital for care or because a physician used the hospital's facilities to treat the plaintiff. *Id.* at 11. Rather, "the defendant as the putative principal must have done something that would create in the patient's mind the reasonable belief that the doctors were acting on behalf of the defendant hospital." *Id.* at 10.

In this case, Bean is deceased and cannot testify about her beliefs. The testimony of Bean's family members does not support that Bean believed that Dr. Zayat was employed by the hospital. Dr. Zayat testified that he had no memory of Bean and that he did not recall anything that he may have said to her. Thus, there is no evidence to support Whitfield's claim that Bean harbored a belief that Dr. Zayat was acting as a hospital employee when he performed her biopsy. Even if there was evidence that Bean had held such a belief, it would not have been reasonable because Bean signed a consent form that placed her on notice that some of the physicians in the hospital were independent contractors and were not the hospital's agents or employees. Indeed, the consent form explicitly disavowed that all physicians were hospital employees. The fact that Bean had the biopsy performed at the hospital was immaterial. See *VanStelle*, 255 Mich App at 10. Therefore, we conclude that Whitfield failed to establish that a genuine issue of material fact existed as to whether an ostensible agency relationship existed between the hospital and Dr. Zayat.

***3** In so holding, we acknowledge that Whitfield correctly notes that discovery was ongoing at the time the motion was denied. "Generally, a motion for summary disposition is premature if granted before discovery on a disputed issue is complete. However, summary disposition may nevertheless be appropriate if further discovery does not stand a reasonable chance of uncovering factual support for the opposing party's position." *Peterson Novelties, Inc v Berkley*, 259 Mich App 1, 24-25; 672 NW2d 351 (2003) (citations omitted). "[A] party opposing summary disposition cannot simply state that summary disposition is premature without

identifying a disputed issue and supporting that issue with independent evidence." *Marilyn Froling Revocable Living Trust v Bloomfield Hills Country Club*, 283 Mich App 264, 292; 769 NW2d 234 (2009).

While Whitfield is correct that discovery was ongoing at the time the trial court denied the hospital's motion, Whitfield does not explain what evidence would support that Bean reasonably believed that Dr. Zayat was an employee or agent of the hospital. Nor can we discern what evidence could have been uncovered. Indeed, when the motion for summary disposition was denied on June 1, 2020, the case had been pending for over 17 months and discovery was scheduled to close on June 11, 2020. Whitfield, two other member of Bean's family, and Dr. Zayat had already been deposed. None of these individuals were able to provide testimony to support Whitfield's ostensible agency argument. Moreover, given that the consent form specifically indicated that not everyone who directed Bean's treatment was an employee or agent of the hospital, we fail to see how any belief on the part of Bean could be considered reasonable. Consequently, because further discovery did not stand a reasonable chance of uncovering factual support for Whitfield's position, summary disposition was not premature. The trial court erred by denying the hospital's motion for summary disposition.[2]

Reversed and remanded for entry of an order granting summary disposition in favor of the hospital. We do not retain jurisdiction.

All Citations

Not Reported in N.W. Rptr., 2021 WL 3117675

Footnotes

1 The complaint also named Ascension Health and St. John Providence, doing business as St. John Health System. However, the parties later stipulated to dismiss Ascension Health and St. John Providence as parties to the action.

2 Whitfield argues that agency is always a question of fact for the jury and cites *Grewe*, 404 Mich at 253, to support this argument. However, the *Grewe* Court did not specifically hold that summary disposition on a claim of ostensible agency is never proper. Rather, the *Grewe* Court indicated that it found certain California case law on the issue of ostensible agency to be "enlightening" and quoted a large portion of *Stanhope v Los Angeles College of Chiropractic*, 54 Cal App 2d 141, 146; 128 P2d 705 (1942). *Grewe*, 404 Mich at 252-253. Although a portion of the *Stanhope* case that was cited provided that "[a]gency is always a question of fact for the jury," *Stanhope*, 54 Cal App 2d at 146, there is no indication that the *Grewe* Court adopted this statement.

STATE OF MICHIGAN

COURT OF APPEALS

JOANNE JOHNSON, Next Friend of SAMANTHA JOHNSON, a minor, and JOANNE JOHNSON individually, Plaintiff-Appellants, v OUTBACK LODGE & EQUESTRIAN CENTER, LLC, and OUTBACK LODGE, LLC, Defendants, and GIRL SCOUTS OF NORTHERN INDIANA-MICHIANA, INC., Defendant-Appellee.	UNPUBLISHED March 10, 2016 No. 323556 Mecosta Circuit Court LC No. 12-020925-NO

Before: BOONSTRA, P.J., and SAWYER and MARKEY, JJ.

PER CURIAM.

Plaintiffs appeal by right the order granting summary disposition to defendant Girl Scouts of Northern Indiana-Michiana Inc. pursuant to MCR 2.116(C)(10).[1] We affirm in part, reverse in part, and remand for further proceedings.

I. PERTINENT FACTS AND PROCEDURAL HISTORY

In July 2010, plaintiff Samantha Johnson, a minor, attended a horseback riding camp sponsored by defendant and held on the property of Outback, a horse ranch. Defendant's

[1] Defendants Outback Lodge & Equestrian Center, LLC and Outback Lodge, LLC (collectively, "Outback") are not parties to this appeal, having stipulated with plaintiffs to dismissal of the action against it with prejudice. We will therefore refer to defendant Girl Scouts of Northern Indiana-Michiana, Inc. as "defendant" or "GSNIM."

previous camp director testified that in the past, defendant had held horseback riding camps on its own properties, but had decided to host a camp on Outback's grounds in 2009 and 2010. Samantha was not an experienced horseback rider, and testified that two tests were administered to her and her fellow campers in order to assess their riding ability and familiarity with horses. One test was described as a written "quiz," that asked campers basic questions about interacting with horses[2]. The second was a practical test during which one of the managers of Outback watched the campers ride horses in a corral or arena.

Samantha was paired with a small horse or "show pony" for the arena test. However, the pony was unable to be utilized for a trail ride the following day, so Samantha was paired with a full-size horse. Prior to the trail ride, Samantha and the other campers were instructed to select riding helmets. Samantha picked a helmet that was too large, and she informed two "counselors" or "leaders," who may have been employees of either defendant or Outback. According to Samantha, one leader told her to find the best fit that she could and "go," while the other pulled the chin strap of her helmet as tight as it could go, which still left the helmet loose.

Samantha recalled that during a break in the trail ride to fix a camper's saddle that was slipping, her horse began to walk around of its own volition, which frightened her. Samantha testified that she expressed her discomfort to one of defendant's counselors, who dismounted her horse and stood with Samantha for a time until they were directed to remount by the leader of the trail ride, an Outback employee. Either before or just after the trail ride resumed, the horse Samantha was riding became "spooked," perhaps by another horse biting or kicking it, and ran away from the rest of the group. Samantha testified that the helmet she was wearing came loose and slid to the back of her head while the horse was running. Samantha was injured when she hit a tree branch and fell from the horse.

Plaintiffs brought suit alleging that defendant was liable for Samantha's injury. At summary disposition, defendant argued that it was immune from liability under the Equine Activity Liability Act (EALA), MCL 691.1661 *et seq.*, and further that there was no genuine issue of material fact regarding the existence of or breach of a duty owed by defendants to Samantha. In response to defendant's motion for summary disposition, plaintiffs argued additionally that defendant was liable for the actions of Outback pursuant to an ostensible agency theory, and sought to amend their complaint to add a separate count to that effect. The trial court considered plaintiffs' ostensible agency argument, but ultimately granted defendant's motion for summary disposition, and therefore denied plaintiffs' motion to amend their complaint. This appeal followed.

II. EALA

Section 3 of the EALA, MCL 691.1663, provides that "an equine activity sponsor, an equine professional, or another person is not liable for an injury to or the death of a participant or

[2] The manager of Outback testified that a typical question on the quiz might be as follows: when approaching a horse, "should you A, run up to them really fast and scream[?]"

property damage resulting from an inherent risk of an equine activity" except as otherwise provided in § 5 of the statute, MCL 691.1665. An "equine activity sponsor" is defined as "an individual, group, club, partnership, or corporation, whether or not operating for profit, that sponsors, organizes, or provides the facilities for an equine activity[.]" MCL 691.1662(d). An "equine activity" includes, *inter alia*, "[r]iding, inspecting, or evaluating an equine belonging to another . . . ." MCL 691.1662(c)(v). The § 5 exceptions to § 3's limitation on liability apply if the equine activity sponsor or professional has done any of the following:

> (a) Provides equipment or tack and knows or should know that the equipment or tack is faulty, and the equipment or tack is faulty to the extent that it is a proximate cause of the injury, death, or damage.
>
> (b) Provides an equine and fails to make reasonable and prudent efforts to determine the ability of the participant to engage safely in the equine activity and to determine the ability of the participant to safely manage the particular equine. A person shall not rely upon a participant's representations of his or her ability unless these representations are supported by reasonably sufficient detail.
>
> (c) Owns, leases, rents, has authorized use of, or otherwise is in lawful possession and control of land or facilities on which the participant sustained injury because of a dangerous latent condition of the land or facilities that is known to the equine activity sponsor, equine professional, or other person and for which warning signs are not conspicuously posted.
>
> (d) Commits a negligent act or omission that constitutes a proximate cause of the injury, death, or damage.

Defendant argued that it was not liable under § 3 of the EALA based on its status as an "equine activity sponsor," and that any liability for plaintiff's damages fell on Outback because it had provided the tack, equipment, and horses used by Samantha. The trial court found that while the EALA did not preclude a finding of liability against defendant, plaintiffs had not established that any of the exceptions in § 5 of the statute applied to their case. We agree with regard to MCL 691.1665(a) and (b), but disagree with regards to (d).

A. MCL 691.1665(a) AND (b)

The trial court found that defendant was not liable under MCL 691.1665(a) or (b) because the statute required the equine activity sponsor to "actually provide the equipment or tack in the case of subsection (a) and the horse in subsection (b)" and plaintiffs had not rebutted the testimony that "Outback Lodge, not GSNIM, picked the horse for each participant and provided those horses" and equipment. We agree.

The exceptions to the EALA's broad grant of immunity are set forth in MCL 691.1665. Those exceptions include that "[MCL 691.1663] does not prevent or limit the liability of an equine activity sponsor . . . if the equine activity sponsor . . . does any of the following".

> (a) *Provides equipment or tack and* knows or should know that the equipment or tack is faulty, and the equipment or tack is faulty to the extent that it is a proximate cause of the injury, death, or damage.
>
> (b) *Provides an equine and* fails to make reasonable and prudent efforts to determine the ability of the participant to engage safely in the equine activity and to determine the ability of the participant to safely manage the particular equine. A person shall not rely upon a participant's representations of his or her ability unless these representations are supported by reasonably sufficient detail. [Emphasis added.]

The trial court found that the record in this case reflects the absence of any evidence of conduct by defendant to "[p]rovide[] equipment or tack" or to "[p]rovide[] an equine." MCL 691.1665(a) and (b). To the contrary, defendant presented evidence that any such conduct was solely that of Outback[3], and not of defendant. By contrast, Samantha testified that she thought the person who provided her with a horse was from Outback, and that she did not know whether the individuals who fitted and adjusted her helmet were from Outback or defendant, but that she knew that none of those individuals was the one counselor whom she knew to be from defendant. Consequently, the evidence that defendant did not "[p]rovide[] equipment or tack" or "[p]rovide[] an equine," MCL 691.1665(a), (b), was uncontested other than by speculation that is insufficient to create a genuine issue of material fact. See *Skinner v Square D Co*, 445 Mich 153, 164; 516 NW2d 475 (1994), overruled in part on other grounds, *Smith v Globe Life Ins Co*, 460 Mich 446, 454 n 2; 597 NW2d 28 (1999), superseded in part by statute as stated in *McLiechey v Bristol West Ins Co*, 408 F Supp 2d 516, 523-524 (WD Mich, 2006). We therefore affirm the trial court's grant of summary disposition regarding the provision of the equine, tack, and equipment.

B. MCL 691.1665(d) AND NEGLIGENCE

MCL 691.1665(d) provides that an equine activity sponsor may be held liable for a "negligent act or omission that constitutes a proximate cause of the injury, death, or damage."[4] Plaintiffs argue that defendant is liable for Samantha's injuries under MCL 691.1665(d) due to its negligent selection of Outback as the site of its camp because Outback lacked certified instructors, which defendant had "promised" to provide, and liability insurance, which was required by defendant for stable operators by its "Safety-Wise" manual, a safety handbook

[3] The evidence does not does not distinguish as between defendants Outback Lodge & Equestrian Center, LLC and Outback Lodge, LLC; nor does the trial court's opinion. However, the distinction is immaterial for purposes of this analysis.

[4] The current version of the statute, amended September 21, 2015, states that the act or omission must constitute "a willful or wanton disregard for the safety of the participant" as well as be a proximate cause of the injury, death or damage. See MCL 691.1665 as amended by 2015 PA 87 (effective date September 21, 2015). The instant injury occurred while the previous version of the EALA was in effect.

published by the Girl Scouts of the United States of America and adhered to by defendant. Plaintiffs also cite language from the "Challenge Adventure Program Participation Agreement" (the Agreement) included in defendant's registration documents and signed by Samantha and her mother, plaintiff Joanne Johnson, before Samantha participated in the camp. The Agreement stated that defendant's employees had "received extensive training and will work to protect the emotional and physical safety of myself and/or my child."

The trial court found that, contrary to the Agreement, none of defendant's counselors "had received any training with regard to horses," and defendant had instead relied on Outback to provide all horse-related supervision and instruction. The court also acknowledged that the evidence supported plaintiffs' argument that defendant was negligent for failing to ascertain whether Outback held liability insurance coverage and provided qualified instructors as required by defendant's Safety-Wise guidelines. However, the court found that no standard of care was created by either defendant's Safety-Wise manual or by the Agreement. The court further concluded that in order to survive a motion for summary disposition under MCR 2.116(C)(10), plaintiffs had to show with "precision" the extent of such a duty and how it was breached. We disagree.

In *MEEMIC Ins Co v DTE Energy Co*, 292 Mich App 278, 281; 807 NW2d 407 (2011), we held that a plaintiff must establish four elements in order to bring a negligence claim: "(1) duty, (2) breach of duty, (3) causation, and (4) damages." "'Duty' is a legally recognized obligation to conform to a particular standard of conduct toward another so as to avoid unreasonable risk of harm" which "may arise by contract, statute, constitution, or common law." *Cummins v Robinson Twp*, 283 Mich App 677, 692; 770 NW2d 421 (2009); *West American Ins Co v Gutekunst*, 230 Mich App 305, 310; 583 NW2d 548 (1998). With respect to the general duty of care imposed by common law, "every person is under the general duty to so act, or to use that which he controls, as not to injure another." *Clark v Dalman*, 379 Mich 251, 261; 150 NW2d 755 (1967), impliedly overruled on other grounds by *Fultz v Union Commerce Assocs*, 470 Mich 460; 683 NW2d 587 (2004), as stated in *Lakeland Reg'l Health Sys v Walgreens Health Initiatives, Inc*, 604 F Supp 2d 983, 999 (WD Mich, 2009).

Generally, a person does not have an affirmative legal duty to aid or protect another person. *Hill v Sears, Roebuck & Co*, 492 Mich 651, 660; 822 NW2d 190 (2012). However, this Court has held that a duty to aid or protect may be imposed where a "special relationship" exists between parties. *Dykema v Gus Macker Enterprises, Inc*, 196 Mich App 6, 8-9; 492 NW2d 472 (1992). "Some generally recognized 'special relationships' include common carrier-passenger, innkeeper-guest, employer-employee, landlord[-]tenant, and invitor-invitee." *Id*. at 8. The underlying rationale for a special relationship is the element of control; "[t]hus, the determination whether a duty-imposing special relationship exists in a particular case involves the determination whether the plaintiff entrusted himself to the control and protection of the defendant, with a consequent loss of control to protect himself." *Id*. at 8-9. "The ultimate inquiry in determining whether a legal duty should be imposed is whether the social benefits of imposing a duty outweigh the social costs of imposing a duty." *Hill*, 492 Mich at 661 (brackets, internal quotation marks, and citation omitted). "Factors relevant to the determination whether a legal duty exists include the relationship of the parties, the foreseeability of the harm, the burden on the defendant, and the nature of the risk presented." *Id*. (internal quotation marks and citation omitted).

In *Terrell v LBJ Electronics*, 188 Mich App 717, 718-719; 470 NW2d 98 (1991), the plaintiff, a minor, argued that a special relationship arose between himself and the defendant when the defendant volunteered to drive him home from a Boy Scout meeting. We held that it was reasonable to impose a duty of care on a person who volunteered to drive a child to his home, as there was "little utility in a rule which would permit a person to volunteer to drive a child to his home without imposing on that person a duty to do it with due care." *Id*. at 722. Similarly, in the instant case, a special relationship arose between defendant and Samantha when she registered for the camp and agreed, along with her mother, to place herself under the control of defendant for the duration of the camp. In *Terrell*, we did not point to any requirement that the plaintiff had to show the "extent" of the duty "with precision" in order to defeat the defendant's motion for summary disposition. Rather, we stated that whether the defendant's actions "were reasonable under the circumstances or constituted a breach of his duty of due care is a jury question," and we held that "under the facts pleaded in the complaint, [the defendant] owed a duty of due care to plaintiff." *Id*.

Similarly, under the facts pleaded in the instant case, plaintiffs have established that defendant owed Samantha a duty of care, and it should be left to a jury to decide whether defendant's actions and omissions breached that duty of care. This includes, for example, whether defendant, through its counselors, was negligent in directing to Samantha to remount her horse and continue on the ride, or in failing to respond appropriately notwithstanding their knowledge, if any, of Samantha's discomfort and lack of confidence in her ability to control her horse. We add the following caveat, however. As discussed above, defendant is immune from liability for Outback's conduct related to the provision of an equine, tack, and equipment. Consequently, for example, although plaintiff has asserted that defendant's counselors were negligent in failing to check Samantha's helmet, it is clear from the record that Outback assumed the responsibility of instructing the group on helmet usage and insuring that the group's helmets fit as well as possible. In addition to there being no evidence that defendant's counselors owed Samantha a duty to independently check her helmet, defendant is immune from liability on this issue under MCL 691.1665(a), as discussed above.

Further, the trial court did not address proximate cause. "To find proximate cause, it must be determined that the connection between the wrongful conduct and the injury is of such a nature that it is socially and economically desirable to hold the wrongdoer liable." *Helmus*, 238 Mich App at 256. Here, defendant's selection of Outback for the activity is obviously a "but for" cause of Samantha's injuries (as she would not otherwise have been riding that particular horse on that particular trail on that particular day), and plaintiffs must additionally demonstrate to the trial court that the facts (assuming them to be true) that Outback's instructors lacked the certification required by defendant's safety manual, that Outback lacked proper liability insurance,[5] or that defendant's counselors were not specifically trained in horseback riding, were a proximate cause of the accident. On remand, the trial court should assess proximate cause and,

[5] We note that evidence concerning the presence or absence of liability insurance is generally not admissible in negligence actions, apart from certain exceptions that have not been raised in the instant case. MRE 411.

in doing so, should, ensure that evidence related to proximate cause does not effect an "end-run" around the grant of immunity provided by the EALA, but instead demonstrates that "the connection between the wrongful conduct and the injury is of such a nature that it is socially and economically desirable to hold the wrongdoer liable." *Helmus*, 238 Mich App at 256.

IV. OSTENSIBLE AGENCY

Finally, we agree with the trial court that plaintiffs presented no evidence that Samantha's injury was caused by her mother's perception that Outback was an agent of defendant.

Three elements must be satisfied to establish ostensible agency (agency by estoppel): "(1) the person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one, (2) the belief must be generated by some act or neglect on the part of the principal sought to be charged, and (3) the person relying on the agent's authority must not be guilty of negligence." *Chapa v St Mary's Hosp*, 192 Mich App 29, 33-34; 480 NW2d 590 (1991). In sum, "the alleged principal must have made a representation that leads the plaintiff to reasonably believe that an agency existed and to suffer harm on account of a justifiable reliance thereon." *Little v Howard Johnson Co*, 183 Mich App 675, 683; 455 NW2d 390 (1990).

Plaintiffs claimed that they reasonably believed that an ostensible agency relationship existed between defendant and Outback based on Samantha's testimony that she did not make a distinction between their respective employees, and because the promotional and registration materials for the camp did not mention Outback or indicate that the horseback riding camp was different from any of several other camps offered by defendant for Girl Scouts. Plaintiffs further claim that their belief in the agency relationship was generated by defendant, and not by any unreasonable assumptions made by Samantha. Lastly, plaintiffs noted that the evidence did not suggest that Samantha was negligent in trusting her counselors and leaders when it came to selecting a helmet, and helping to control her horse. The trial court agreed that plaintiffs had established a genuine issue of material fact as to the three requirements of ostensible agency, but concluded that plaintiffs had not presented any evidence that Samantha's injuries resulted from an ostensible agency relationship between Outback and defendant. We agree. *Id*. Plaintiffs presented no evidence indicating, for example, that Samantha's mother would not have sent her on the trip had she known that defendant had hired a third party to provide equine instruction. Plaintiffs thus did not present a genuine issue of material fact with regard to an ostensible agency, because they failed to present any evidence that Samantha was harmed "as a result of relying on the perceived fact" that Outback was an agent of defendant. *Little v Howard Johnson Co*, 183 Mich App 675, 683; 455 NW2d 390 (1990).[6]

[6] Having considered the merits of plaintiff's ostensible agency argument, and having rejected it, we affirm the trial court's denial of plaintiffs' motion to amend the complaint to assert that legal theory in a separate count.

Affirmed in part, reversed in part, and remanded for proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Mark T. Boonstra
/s/ David H. Sawyer
/s/ Jane E. Markey

2021 WL 2877958
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

UNPUBLISHED
Court of Appeals of Michigan.

Keegan MAITLAND, BY NEXT FRIEND Meghan MAITLAND, Plaintiff-Appellee,
v.
Holly JASKIERNY, DO, and Joseph Kingsbury, DO, Defendants,
and
Genesys Regional Medical Center, Defendant-Appellant

No. 348216
|
July 8, 2021

Genesee Circuit Court, LC No. 18-110537-NH

Before: Redford, P.J., and Borrello and Tukel, JJ.

Opinion

Per Curiam.

***1** In this medical malpractice action, defendant, Genesys Regional Medical Center, appeals by leave granted[1] the trial court's order denying its motion for summary disposition. The trial court concluded that a dispute of material fact prevented it from ruling on whether Genesys was vicariously liable for the alleged malpractice of defendants Dr. Holly Jaskierny, DO, and Dr. Joseph Kingsbury, DO. In doing so, the trial court agreed with plaintiff Meghan Maitland, as next friend of her minor daughter Keegan Maitland.

On appeal, Genesys argues that no disputes of material fact prevent summary disposition in this case and that Dr. Jaskierny was not acting as its ostensible agent, actual agent, employee, or part of a joint venture at the time of the alleged malpractice.[2] Meghan disagrees and argues that disputes of material fact prevent any grant of summary disposition. We agree with Genesys; no dispute of material fact exists regarding the ostensible agency, actual agency, and scope of employment issues and the trial court erred by denying Genesys's motion for summary disposition on those issues. Finally, the joint venture issue is not properly before us.

I. UNDERLYING FACTS

This case arises out the birth of Meghan's second child, Keegan. After Meghan discovered she was pregnant with Keegan, she decided to find an obstetrician for her prenatal care. Meghan searched Blue Cross's website for obstetricians near her and eventually chose Dr. Jaskierny because Meghan believed Dr. Jaskierny was a "Genesys doctor," Dr. Jaskierny's office was inside Genesys's building, and Meghan wanted a female doctor. At all relevant times, Dr. Jaskierny was employed in private practice by Joseph A. Kingsbury, DO, PC (Kingsbury PC); she was simultaneously employed by Genesys on a part time basis. Dr. Jaskierny treated Meghan at Kingsbury PC's office inside Genesys's building.

Dr. Jaskierny primarily handled Meghan's prenatal visits, but Dr. Kingsbury did treat her during one of the visits; he also was the doctor who delivered Keegan. Meghan's first prenatal appointment with Dr. Jaskierny occurred on October 18, 2011, and Meghan returned to Dr. Jaskierny regularly for prenatal visits throughout her pregnancy. On March 15, 2012, Meghan had a prenatal appointment at Dr. Jaskierny's office. Dr. Jaskierny swabbed Meghan's vagina for a "Group B test" during the appointment.[3] According to Meghan, Dr. Jaskierny did not swab her rectum.[4] The test came back negative for Strep B.

***2** Keegan was born on April 15, 2012. Keegan's birth was quick, but otherwise uneventful. Everything appeared normal with Keegan when the Maitlands returned home from the hospital. On May 2, 2012, however, the Maitlands took Keegan to the hospital because "her color had changed from the morning" and she appeared lethargic; the doctors at the hospital told the Maitlands that Keegan's situation was "extremely serious" and that they were not sure if she would "make it." At the hospital, the doctors informed the Maitlands that Keegan had late onset meningitis. Keegan suffered serious brain damage as a result of her late onset meningitis. As of September 2018, Keegan could not move herself, had daily seizures, was "cortically blind," could not vocalize words, and required feeding.

Meghan eventually filed a complaint, alleging that Dr. Jaskierny committed medical malpractice by failing to properly perform the March 15, 2012 Group B test. This improper test allegedly led to Keegan's late onset meningitis. Meghan further alleged that Genesys was vicariously liable for Dr. Jaskierny's conduct based on multiple legal theories. Genesys then moved for summary disposition, but the trial court denied Genesys' motion because it concluded that disputes of material fact precluded any grant of summary disposition at the time. This appeal followed.

II. STANDARD OF REVIEW

A motion for summary disposition under MCR 2.116(C)(10) tests the factual sufficiency of a complaint and is reviewed de novo. *Joseph v. Auto Club Ins. Ass'n*, 491 Mich. 200, 205-206; 815 N.W.2d 412 (2012). This Court reviews a motion brought under MCR 2.116(C)(10) "by considering the pleadings, admissions, and other evidence submitted by the parties in the light most favorable to the nonmoving party." *Patrick v. Turkelson*, 322 Mich. App. 595, 605; 913 N.W.2d 369 (2018). "The trial court is not permitted to assess credibility, weigh the evidence, or resolve factual disputes, and if material evidence conflicts, it is not appropriate to grant a motion for summary disposition under MCR 2.116(C)(10)." *Barnes v. 21st Century Premier Ins. Co.*, —— Mich. App. ——, ——; —— N.W.2d —— (2020) (Docket No. 347120); slip op. at 4. Rather, summary disposition "is appropriate if there is no genuine issue regarding any material fact and the moving party is entitled to judgment as a matter of law." *Patrick*, 322 Mich. App. at 605. "There is a genuine issue of material fact when reasonable minds could differ on an issue after viewing the record in the light most favorable to the nonmoving party." *Allison v. AEW Capital Mgt., L.L.P.*, 481 Mich. 419, 425; 751 N.W.2d 8 (2008). "Only the substantively admissible evidence actually proffered may be considered." *1300 LaFayette East Coop., Inc. v. Savoy*, 284 Mich. App. 522, 525; 773 N.W.2d 57 (2009) (quotation marks and citation omitted). "Circumstantial evidence can be sufficient to establish a genuine issue of material fact, but mere conjecture or speculation is insufficient." *McNeill-Marks v. Midmichigan Med. Ctr.-Gratiot*, 316 Mich. App. 1, 16; 891 N.W.2d 528 (2016).

The moving party has the initial burden to support its claim with documentary evidence, but once the moving party has met this burden, the burden then shifts to the nonmoving party to establish that a genuine issue of material fact exists. *AFSCME v. Detroit*, 267 Mich. App. 255, 261; 704 N.W.2d 712 (2005). Additionally, if the moving party demonstrates that the nonmovant lacks evidence to support an essential element of one of his or her claims, the burden shifts to the nonmovant to present sufficient evidence to dispute that fact. *Lowrey v. LMPS & LMPJ, Inc.*, 500 Mich. 1, 7; 890 N.W.2d 344 (2016).

III. OSTENSIBLE AGENCY

Genesys argues that Dr. Jaskierny was not acting as its ostensible agent when she committed the alleged malpractice on March 15, 2012. We agree.

***3** As explained by our Supreme Court in *Grewe v. Mt. Clemens Gen. Hosp.*, 404 Mich. 240, 250-251; 273 N.W.2d 429 (1978), hospitals are generally not vicariously liable for the negligence of independent contractor physicians who use the hospital's facilities:

> Generally speaking, a hospital is not vicariously liable for the negligence of a physician who is an independent contractor and merely uses the hospital's facilities to render treatment to his patients. However, if the individual looked to the hospital to provide him with medical treatment and there has been a representation by the hospital that medical treatment would be afforded by physicians working therein, an agency by estoppel can be found.
>
> In our view, the critical question is whether the plaintiff, at the time of his admission to the hospital, was looking to the hospital for treatment of his physical ailments or merely viewed the hospital as the situs where his physician would treat him for his problems. A relevant factor in this determination involves resolution of the question of whether the hospital provided the plaintiff with Dr. Katzowitz or whether the plaintiff and Dr. Katzowitz had a patient-physician relationship independent of the hospital setting. [Citations omitted.]

The case law therefore requires that the principal's actions cause a belief that the doctor was its agent. See *Chapa v. St. Mary's Hosp. of Saginaw*, 192 Mich. App. 29, 33-34; 480 N.W.2d 590 (1991). Indeed, as stated in *Chapa*, an ostensible agency requires the following three elements:

> (1) the person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one, (2) the belief must be generated by some act or neglect on the part of the principal sought to be charged, and (3) the

person relying on the agent's authority must not be guilty of negligence. [*Id.*]

When addressing the second element, the *Chapa* Court explained that "[s]imply put, defendant, as putative principal, must have done something that would create in [the patient's] mind the *reasonable* belief that [the doctors] were acting on behalf of defendant." *Chapa*, 192 Mich. App. at 34. "[T]he fact that a doctor used a hospital's facilities to treat a patient is not sufficient to give the patient a reasonable belief that the doctor was an agent of the hospital." *VanStelle v. Macaskill*, 255 Mich. App. 1, 11; 662 N.W.2d 41 (2003). Genesys does not argue that Meghan was negligent. As such, that element of ostensible agency is not at issue on appeal.

As stated in *Grewe*, the critical question is whether Meghan sought treatment at Genesys, rather than merely viewing Genesys as the situs of treatment by her physician. Meghan's deposition testimony reflects that she looked to Genesys for treatment, as she specifically sought out Genesys doctors, and rejected those doctors who were not located within the hospital. Meghan also testified that she believed Dr. Jaskierny was a "Genesys doctor" because of her affiliation with the hospital.

Genesys argues, however, that Meghan had a preexisting relationship with Dr. Jaskierny and that this preexisting relationship prevented the formation of an ostensible agency. "[A]n independent relationship between a doctor and a patient that preceded a patient's admission to a hospital precludes a finding of ostensible agency, unless the acts or omissions of the hospital override the impressions created by the preexisting relationship and create a reasonable belief that the doctor is an agent of the hospital." *Zdrojewski v. Murphy*, 254 Mich. App. 50, 66; 657 N.W.2d 721 (2002). Here, Genesys argues that Meghan had an independent relationship with Dr. Jaskierny because she had treated Meghan before the alleged malpractice occurred. But that fact is not dispositive, given that Dr. Jaskierny's office is located within the Genesys facility; thus, an argument may be made that the evidence does not show Meghan had a relationship with Dr. Jaskierny outside of the hospital setting. Further, as noted, Meghan testified that she chose Dr. Jaskierny because she was a "Genesys doctor." Thus, to the extent Meghan and Dr. Jaskierny had a doctor-patient relationship before the alleged malpractice, that relationship began as part of Meghan's prenatal care, all of which occurred at Dr. Jaskierny's office within Genesys' building. Accordingly, Meghan's deposition testimony is sufficient to withstand summary disposition based on a preexisting relationship that would prevent the formation of an ostensible agency.

***4** The next step in the ostensible agency analysis is to determine whether Meghan's belief that Dr. Jaskierny was Genesys's agent was reasonable. Dr. Jaskierny appeared in Meghan's internet search as a doctor who practiced at Genesys hospital. Additionally, Dr. Jaskierny's office was in Genesys's building and she clearly had treating privileges in the hospital. Thus, viewing the record in the light most favorable to Meghan, her belief that Dr. Jaskierny was Genesys's agent was reasonable. The final question though, whether Genesys caused this reasonable belief, is a much closer question.

Genesys contends that Meghan's belief that Dr. Jaskierny was its agent did not arise from any act on its part. As discussed, an ostensible agency relationship requires that the hospital have engaged in some act or omission that led the patient reasonably to believe an agency existed. *Chapa*, 192 Mich. App. at 33-34. See also *VanStelle*, 255 Mich. App. at 17 (noting that the plaintiffs had not necessarily shown that the hospital defendants reasonably caused the plaintiffs to believe the doctor was acting as their agent; the mere fact that a patient goes to a hospital for treatment is insufficient).

Meghan first argues that Genesys caused her belief that Dr. Jaskierny was Genesys's agent because she discovered Dr. Jaskierny through Genesys's website. The record, however, fails to establish that Meghan found Dr. Jaskierny through a search for a doctor on Genesys's website. Rather, Meghan repeatedly testified, at her deposition, that she found Dr. Jaskierny through Blue Cross's website after she selected a tab limiting her search to Genesys doctors. Meghan did not testify that she found Dr. Jaskierny by searching for a doctor on Genesys's website or that her Blue Cross search sent her to Genesys's website. Additionally, Ryan testified that Meghan "went to the Genesys system to find someone" during the search that led her to Dr. Jaskierny. Ryan did not, however, know the name of the website Meghan used during that search. As such, reasonable minds could not view Ryan's testimony as establishing that Meghan found Dr. Jaskierny through a search of Genesys's website. Consequently, no evidence in the record establishes that Meghan found Dr. Jaskierny because of Genesys's website. Instead, the evidence establishes that Meghan learned that Dr. Jaskierny was a "Genesys doctor" because of her search on Blue Cross's website. Thus, based on her internet search, Genesys was not responsible for Meghan believing that Dr. Jaskierny was a "Genesys doctor."

Meghan's next argument is that Genesys caused her belief that Dr. Jaskierny was Genesys's agent because Dr. Jaskierny's office was in Genesys's building. Alternatively, Meghan argues that her reasonable belief was caused by Genesys's failure to notify her that the location of Dr. Jaskierny's office did not mean Dr. Jaskierny was Genesys's employee. Meghan is correct that Genesys did not go out of its way to inform her that patients treated in Dr. Jaskierny's office were patients of Kingsbury PC and not Genesys. But this omission alone could not have caused Meghan's belief that Dr. Jaskierny was Genesys's agent. Indeed, Meghan learned of the location of Dr. Jaskierny's office from the Blue Cross website, not Genesys's. As such, for Genesys to have caused Meghan's belief that Dr. Jaskierny was its agent based on the location of Dr. Jaskierny's office it would have to have done something, or failed to do something, after Meghan already knew that information. But the bell had already been rung; at most, Genesys tacitly confirmed Meghan's belief that Dr. Jaskierny was its agent. Confirming a belief and causing a belief, however, are two different things. Additionally, the location of Dr. Jaskierny's office, without more, could not support a reasonable belief that Dr. Jaskierny was Genesys's agent. Thus, the location of Dr. Jaskierny's office did not establish an ostensible agency.

***5** The remaining record evidence similarly fails to establish that Genesys caused Meghan's belief that Dr. Jaskierny was Genesys's agent. Dr. Jaskierny's identification badge identified her as a physician and stated "GENESYS" in large letters across the top; it did not identify her as an employee of Kingsbury PC. But Dr. Jaskierny testified at her deposition that, at the time of the alleged malpractice, she routinely left her identification badge in her vehicle and did not wear it in the hospital. Furthermore, Meghan chose Dr. Jaskierny as her doctor before she ever had an opportunity to see Dr. Jaskierny's identification badge. Consequently, Meghan would not have seen Dr. Jaskierny's identification badge when the alleged malpractice occurred and, therefore, it could not have caused Meghan to believe that Dr. Jaskierny was Genesys's agent.

Similarly, Genesys acknowledged, in its response to Meghan's interrogatories, that "the purpose of having physicians listed on the website is to allow patients to find a staff physician who has privileges at Genesys Regional Medical Center" and that "a possible benefit to Genesys Regional Medical Center, would be to provide a service to the community and also if a patient made the decision to utilize a physician listed on the website and then the patient utilized the services of Genesys Regional Medical Center, this could potentially lead to a benefit for Genesys." Indeed, Dr. Jaskierny had her own page on Genesys's website under the "Find a Physician" tab. But, as discussed, the record establishes that Meghan did not use Genesys's website when she found Dr. Jaskierny. Instead, the record establishes that Meghan found Dr. Jaskierny through Blue Cross's website. Consequently, Genesys's website could not have caused Meghan's belief that Dr. Jaskierny was Genesys's agent.

Finally, Meghan's prenatal medical records stated "Genesys Regional Medical Center" in the top left; the top right listed Drs. Kingsbury and Jaskierny as well as the address for their office. Meghan's prenatal medical records did not state whether Dr. Jaskierny treated Meghan in her capacity as an employee of Genesys or as an employee of Kingsbury PC. These records, however, were apparently generated by Kingsbury PC as part of Dr. Jaskierny's treatment of Meghan. As such, Kingsbury PC, not Genesys, was responsible for these documents. Additionally, the record fails to establish whether Meghan ever actually saw these medical records before the alleged malpractice occurred. The record similarly fails to establish if Genesys was aware that medical records generated by Kingsbury PC stated "Genesys Regional Medical Center" in the top left. Consequently, Meghan cannot point to any act or omission by Genesys related to these documents that could have caused her reasonable belief that Dr. Jaskierny was Genesys's agent. As such, the trial court erred by denying Genesys's motion for summary disposition on this issue.

IV. SCOPE OF EMPLOYMENT

Genesys argues that Dr. Jaskierny was not acting as its employee when she treated Meghan on March 15, 2012. We agree.

Meghan's argument that Genesys is vicariously liable for Dr. Jaskierny's alleged malpractice due to her employment with Genesys relies on the legal doctrine of respondeat superior. As explained by our Supreme Court in *Hamed v. Wayne Co.*, 490 Mich. 1, 10-11; 803 N.W.2d 237 (2011):

> The doctrine of respondeat superior is well established in this state: An employer is generally liable for the torts its employees commit within the scope of their employment. It follows that "an employer is not liable for

> the torts ... committed by an employee when those torts are beyond the scope of the employer's business." This Court has defined "within the scope of employment" to mean " 'engaged in the service of his master, or while about his master's business.' " Independent action, intended solely to further the employee's individual interests, cannot be fairly characterized as falling within the scope of employment. Although an act may be contrary to an employer's instructions, liability will nonetheless attach if the employee accomplished the act in furtherance, or the interest, of the employer's business. [Footnotes omitted.]

***6** Dr. Jaskierny's employment agreement with Genesys specifically stated that it permitted her to engage in private practice. The employment agreement also established that Dr. Jaskierny must provide "on average, twenty one (21) hours per week of Services" and that she was considered Genesys's employee when engaged in these services. The agreement defined "services" as:

> i. Physician shall provide one half-day (four hours) on Wednesday mornings of precepting services weekly and one (1) Friday morning (four hours) per month in the West Flint Campus Obstetrical Clinic.
>
> ii. Physician shall provide one (1) Day Time Unit of Staff Call Service on one (1) Monday each month. Day Time Hospital Units of Service; Commence at 8:00 am and end at 5:00 pm on the same day (i.e., 9 hours)....
>
> iii. Physician shall provide two (2) Night Time Units of Staff Call Service each month. Night Time Hospital Units of Service: Commence at 5:00 pm and end at 8:00 am the next morning (i.e., 15 hours)....
>
> iv. "Precepting Services" means direct patient care and supervision through precepting of Residents furnishing medical services.
>
> v. Physician will dedicate at least six (6) hours per week to development and delivery of medical student didactics, as well as provide evaluations, workshops and exit interviews.
>
> vi. Physician shall schedule and staff resident surgeries for an average of two (2) hours weekly....
>
> vii. Physician shall participate in resident evaluation activities, faculty development and resident recruitment activities as needed.

Dr. Jaskierny opined that, between July 1, 2011 and March 15, 2012, she spent between 25% and 40% of her professional time performing the "services" defined in her employment contract with Genesys. Additionally, Dr. Jaskierny testified, at her deposition, that her prenatal treatment of Meghan was "part of [her] private practice with Dr. Kingsbury," and not "part of the work that [she] did for Genesys as far as being on call or [her] role in the residency program." Similarly, Dr. Kingsbury testified, at his deposition, that Dr. Jaskierny treated Meghan as a private practice patient.

Dr. Jaskierny clearly had many responsibilities as part of her employment contract with Genesys, but she and Dr. Kingsbury specifically testified that Dr. Jaskierny treated Meghan as her private practice patient, not in her role as Genesys's employee. Dr. Jaskierny's employment agreement with Genesys specifically permitted her to engage in private practice. Additionally, the employment agreement specified that Dr. Jaskierny acted as Genesys's employee when engaged in the "services" listed above. Meghan's Group B test did not fall within any of the "services" outlined above. That, coupled with the testimony of Drs. Jaskierny and Kingsbury, establishes that Dr. Jaskierny's alleged malpractice occurred while Dr. Jaskierny was treating Meghan in her private practice and not within the scope of her employment with Genesys. Thus, Genesys cannot be liable for Dr. Jaskierny's alleged malpractice under the theory of respondeat superior. The trial court erred by concluding that a dispute of material fact prevented a grant of summary disposition to Genesys on this issue.

V. ACTUAL AGENCY

Genesys argues that Dr. Jaskierny was not acting as its agent when she treated Meghan on March 15, 2012. We agree.

Generally speaking, "the principal is bound by, and liable for, the agent's lawful actions performed under the auspices of the principal's actual or apparent authority." *Persinger v. Holst*, 248 Mich. App. 499, 505; 639 N.W.2d 594 (2001). "It is well settled ... that the existence and scope of an agency relationship are questions of fact ...." *Whitmore v. Fabi*, 155 Mich. App. 333, 338; 399 N.W.2d 520 (1986).[5] Furthermore, "[w]hen there is a disputed question of agency, if there is any testimony, either direct or inferential, tending to establish it, it becomes a question of fact." *St. Clair Intermediate School Dist. v. Intermediate Ed. Ass'n/Mich. Ed. Ass'n*, 458 Mich.

540, 556; 581 N.W.2d 707 (1998) (citation and quotation marks omitted).

> ***7** Under the common law of agency, in determining whether an agency has been created, we consider the relations of the parties as they in fact exist under their agreements or acts and note that in its broadest sense agency includes every relation in which one person acts for or represents another by his authority.... [T]he characteristic of the agent is that he is a business representative. His function is to bring about, modify, affect, accept performance of, or terminate contractual obligations between his principal and third persons. Also fundamental to the existence of an agency relationship is the right to control the conduct of the agent with respect to the matters entrusted to him. [*Id.* at 557 (quotation marks, citations, and brackets omitted).]

Indeed, "an essential component of the relationship is the principal's right to control, at least at some point, the conduct and actions of his agent." *Persinger*, 248 Mich. App. at 504. Thus, Dr. Jaskierny could have acted as Genesys's agent only if Genesys had a right to control her treatment of Meghan.

Dr. Jaskierny's employment agreement with Genesys specifically provided that it "shall not be interpreted to vest in [Genesys] the authority to direct or supervise [Dr. Jaskierny] in the exercise of any medical judgment or to otherwise engage in the practice of medicine in violation of applicable law." But the employment agreement also required Dr. Jaskierny to evaluate the performance of medical residents, have professional liability insurance coverage, treat all "staff patients"[6] with a high level of care, and maintain a high level of professional qualifications (such as being licensed and board certified). Thus, Genesys did exhibit at least some general control over how Dr. Jaskierny practiced medicine.

Nonetheless, as explained in the preceding section addressing respondeat superior, Dr. Jaskierny was not treating Meghan on Genesys's behalf when the alleged malpractice occurred. Instead, Dr. Jaskierny treated Meghan as her private practice patient. This treatment fell outside the scope of Dr. Jaskierny's employment agreement with Genesys and, by extension, outside the scope of her employment. When not acting as Genesys's employee, the only relevant limitations the employment agreement imposed on Dr. Jaskierny related to her malpractice insurance and professional qualifications. Neither of these had anything to do with how Dr. Jaskierny chose to treat Meghan. Thus, Genesys did not exercise control over Dr. Jaskierny when the alleged malpractice occurred and, therefore, Dr. Jaskierny was not acting as Genesys's agent at that time. See *Persinger*, 248 Mich. App. at 504.

Nevertheless, Meghan argues that this court should affirm the trial court's order denying Genesys's motion for summary disposition on this issue because discovery was ongoing when the trial court entered its order and, therefore, any grant of summary disposition on the issue would be premature. Genesys argues that this Court should not address the discovery issue because Meghan raises it for the first time on appeal and, therefore, the argument is unpreserved. We choose to address the discovery issue because it presents as an alternative ground for affirmance. See, e.g., *Middlebrooks v. Wayne Co.*, 446 Mich. 151, 166 n. 41; 521 N.W.2d 774 (1994) (citation omitted) ("[A]n appellee need not take a cross appeal in order to urge, in support of relief afforded him below, reasons other than those adopted by or those rejected by the lower court."); *Mueller v. Brannigan Bros. Restaurants & Taverns LLC*, 323 Mich. App. 566, 585-586; 918 N.W.2d 545 (2018) (citation omitted) ("While minimal, appellate consideration is not precluded merely because a party makes a more developed or sophisticated argument on appeal. We prefer to resolve issues on their merits when possible ...."); *Forest Hills Co-operative v. City of Ann Arbor*, 305 Mich. App. 572, 615 n. 41; 854 N.W.2d 172 (2014) ("This Court will not reverse a trial court's order of summary disposition when the right result was reached for the wrong reason.").

***8** Summary disposition "is generally premature if discovery has not been completed unless there is no fair likelihood that further discovery will yield support for the nonmoving party's position." *Liparoto Constr., Inc. v. Gen. Shale Brick, Inc.*, 284 Mich. App. 25, 33-34; 772 N.W.2d 801 (2009). "In addition, a party opposing summary disposition cannot simply state that summary disposition is premature without identifying a disputed issue and supporting that issue with independent evidence. The party opposing summary disposition must offer the required MCR 2.116(H) affidavits, with the probable testimony to support its contentions." *Marilyn Froling Revocable Living Trust v. Bloomfield Hills Country Club*, 283 Mich. App. 264, 292-293; 769 N.W.2d 234 (2009) (footnotes omitted).

Meghan already has Dr. Jaskierny's employment contract with Genesys and has not specified any alternative theory that could support her actual agency argument other than that further discovery may reveal unspecified "other relationship[s] that [Dr. Jaskierny] may have had with

Genesys." While Meghan's argument could be seen as raising a disputed issue, she failed to support it with independent evidence as required by MCR 2.116(H). Thus, Meghan failed to establish that granting summary disposition to Genesys on this issue would be premature. See *Marilyn Froling Revocable Living Trust*, 283 Mich. App. at 292-293.

VI. JOINT VENTURE

The joint venture issue is not properly before us.

"As an error-correcting court, this Court's review is generally limited to matters actually decided by the lower court ...." *Jawad A. Shah, M.D., PC*, 324 Mich. App. at 210 (citation omitted). Meghan expressly asked the trial court to wait to rule on her motion to amend her complaint to add a joint venture theory of liability and Genesys concedes, in its brief on appeal, that the trial court granted this request. Additionally, Genesys argued in its brief that

> [t]o the extent that [Meghan] contends that Genesys is vicariously liable for the actions of Dr. Jaskierny by virtue of the existence of a "joint venture," there is no genuine issue of material fact that Genesys is not vicariously liable for Dr. Jaskierny's treatment of [Meghan] by virtue of the existence of a joint venture, where the facts in evidence demonstrate that the required elements of a joint venture do not exist here.

Meghan does not so contend on appeal; instead, she argues that this issue is not properly before this Court because the trial court never ruled on the issue and, therefore, it was not part of the pleadings when the trial court denied Genesys's motion for summary disposition. We agree with Meghan that the issue is not properly before this Court. Meghan asked the trial court to wait to rule on her motion and Genesys did not object to that decision at the trial court level. Now, on appeal, Genesys asks this Court to address the issue in the first instance. But doing so would not be in keeping with this Court's role as an error correcting court. Meghan's motion to amend her complaint may well be futile, but the trial court did not abuse its discretion by permitting Meghan to defer a ruling on her motion until a later date.

VII. CONCLUSION

For the reasons stated in this opinion, we reverse the trial court's order denying Genesys's motion for summary disposition and remand for proceedings consistent with this opinion. We do not retain jurisdiction.

All Citations

Not Reported in N.W. Rptr., 2021 WL 2877958

Footnotes

1 This Court denied Genesys's application for leave to appeal in *Maitland v. Jaskierny*, unpublished order of the Court of Appeals, entered July 11, 2019 (Docket No. 348216), but our Supreme Court remanded "this case to the Court of Appeals for consideration as on leave granted," *Maitland v. Jaskierny*, 505 Mich. 960 (2020).

2 The parties agree that all claims against Dr. Kingsbury have been dismissed and, therefore, the only remaining malpractice claim relates to Dr. Jaskierny's alleged malpractice.

3 According to the Centers for Disease Control (CDC)

> Group B Streptococcus (group B strep, GBS) are bacteria that come and go naturally in the body. Most of the time the bacteria are not harmful, but they can cause serious illness in people of all ages. In fact, group B strep disease is a common cause of severe infection in newborns. While GBS disease can be deadly, there are steps pregnant women can take to help protect their babies. [Centers for Disease Control, *Group B Strep* https://www.cdc.gov/groupbstrep/index.html#:~:text=Group% 20B% 20Streptococcus% 20(group% 20B,of% 20severe% 20infection% 20in% 20newborns. (accessed April 2, 2021).]

4 As explained by Dr. Jaskierny, the CDC and the American College of Obstetrics and Gynecologists (ACOG) recommend swabbing the vagina and anus when conducting a Strep B test. The CDC guidelines call for either one or two swabs to be used during the test.

5 "Although cases decided before November 1, 1990, are not binding precedent, MCR 7.215(J)(1), they nevertheless can be considered persuasive authority." *In re Stillwell Trust*, 299 Mich. App. 289, 299 n. 1; 829 N.W.2d 353 (2012) (citation omitted).

6 The agreement defined "staff patients" as "(i) any patient listed as 'no physician assigned', (ii) all patients of the academic teaching clinics; and (iii) any patient whose attending physician does not have admitting privileges at Genesys Regional Medical Center."

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STATE OF MICHIGAN

COURT OF APPEALS

MARY ANNE MARKEL,

Plaintiff-Appellant,

v

WILLIAM BEAUMONT HOSPITAL,

Defendant-Appellee,

and

HOSPITAL CONSULTANTS, PC, LINET LONAPPAN, M.D., and IOANA MORARIU,

Defendants.

UNPUBLISHED
April 22, 2021

No. 350655
Oakland Circuit Court
LC No. 2018-164979-NH

Before: BECKERING, P.J., and FORT HOOD and RIORDAN, JJ.

PER CURIAM.

Plaintiff appeals as on leave granted[1] the trial court's order granting in part, and denying in part, William Beaumont Hospital's (Beaumont) motion for summary disposition. We affirm in part and reverse in part.

I. FACTUAL BACKGROUND AND PROCEDURAL HISTORY

In early October 2015, plaintiff underwent an endometrial ablation and was discharged the same day. A week later, on October 9, 2015, plaintiff went to Beaumont's emergency department

[1] *Markel v William Beaumont Hosp*, 505 Mich 961 (2020).

complaining of numbness in her feet, back pain, and an inability to urinate. After a blood count, CT scan, and MRI, it was determined plaintiff had degenerative disc disease in her lumbar spine, with several disc extrusions and protrusions, and a urinalysis was conducted. On October 10, 2015, plaintiff was transferred to Beaumont's observation unit and a physician's assistant, Janay Warner, ordered another urinalysis and a urine culture study. Later that afternoon, plaintiff was admitted to the hospital and seen by defendant, Dr. Linet Lonappan. Dr. Lonappan, a board-certified internist and hospitalist, was employed by defendant, Hospital Consultants, PC. Hospital Consultants had an agreement with plaintiff's physician, Dr. John Bonema, to provide treatment for his patients that presented to Beaumont. Dr. Lonappan completed a history of plaintiff, performed a physical examination, and was aware a urine culture study and urinalysis had been ordered.

On the morning of October 11, 2015, plaintiff, whose fever spiked the night before but had returned to normal since, spoke with a pain-medicine physician, Dr. Daniel Sapeika, regarding her back pain. Dr. Sapeika noted plaintiff's desire to be discharged and recommended that, if she were discharged that day, she was to receive an epidural on October 12, 2015, on an outpatient basis. On the afternoon of October 11, 2015, Dr. Lonappan discharged plaintiff from the hospital and instructed her to follow up with neurosurgery, internal medicine, and pain medicine. Approximately three hours later, at 5:47 p.m., a preliminary result from plaintiff's urine culture tested positive for streptococcus agalactiae. Dr. Lonappan testified that although she was aware of the result of plaintiff's urine culture study, she did not believe the standard of care required her to contact plaintiff with the results, nor that the results were relevant to plaintiff's care. On October 12, 2015, the final report for the urine culture study was released and showed plaintiff was positive for Group B Streptococcus. On October 13, 2015, plaintiff returned to Beaumont's emergency department complaining of pain in both knees and pain in multiple joints. Plaintiff was provided intravenous antibiotics, and had surgical drainage of an epidural abscess and revision of her knee replacements. Plaintiff remained admitted to Beaumont until November 22, 2015.

Plaintiff filed a complaint alleging, relevant here, that Dr. Lonappan was negligent and Beaumont was vicariously liable for Dr. Lonappan's negligent acts. Plaintiff alleged Dr. Lonappan was an "actual agent[], apparent agent[], ostensible agent[], servant and/or employee[] of William Beaumont Hospital" and, as a result, Beaumont was "vicariously liable for the negligent acts and/or omissions" of Dr. Lonappan. Beaumont moved for summary disposition under MCR 2.116(C)(10), asserting, in relevant part, that it was not vicariously liable for the allegations against Dr. Lonappan under either an ostensible-agency theory or an actual agency theory. Beaumont argued that it was undisputed that Dr. Lonappan was employed by Hospital Consultants but never employed by Beaumont. Beaumont further asserted that Dr. Lonappan became involved in plaintiff's treatment through an agreement between Hospital Consultants and Dr. Bonema, and asserted that Beaumont did not make any representations to plaintiff to "lead her to believe that an agency existed between the hospital" and Dr. Lonappan. Beaumont noted that, as a result, and on the basis of existing caselaw, it was not vicariously liable for the allegations against Dr. Lonappan and was entitled to summary disposition under MCR 2.116(C)(10).

Plaintiff responded, arguing the existence of an agency relationship was a question of fact for the jury. Plaintiff also argued that, under *Grewe v Mt Clemens Gen Hosp*, 404 Mich 240; 273 NW2d 429 (1978), and its progeny, Dr. Lonappan was the ostensible agent of Beaumont. Plaintiff, pointing to Dr. Lonappan's deposition testimony, asserted she had a reasonable belief that Dr.

Lonappan was acting on Beaumont's behalf. Plaintiff noted that Dr. Lonappan wore a white laboratory coat with credentials from Beaumont as she provided care and treatment to plaintiff, and that Dr. Lonappan introduced herself to patients by stating her name and indicating she was assigned to their care by Beaumont. Further, plaintiff asserted that Dr. Lonappan "made no statements" and "took [no] affirmative action to indicate to [plaintiff] that she was not an employ[ee] of the hospital."

In reply, Beaumont asserted that plaintiff failed to present evidence establishing that Beaumont "made any representation to lead [plaintiff] to reasonably believe that an agency existed between the hospital and" Dr. Lonappan. Quoting this Court's decision in *VanStelle v Macaskill*, 255 Mich App 1; 662 NW2d 41 (2003), Beaumont noted that an agency relationship did not arise simply by virtue of plaintiff going to a hospital for medical care and receiving treatment. Rather, there had to be an action or representation by the medical professional to lead plaintiff to reasonably believe an agency relationship existed. Moreover, Beaumont argued that statements in plaintiff's affidavit were directly contradicted by her deposition testimony, and that she was improperly trying to create a factual issue through her affidavit.

Following a hearing on Beaumont's motion for summary disposition, the trial court concluded Dr. Lonappan was not an actual agent of Beaumont, noting that once Beaumont assigned Dr. Lonappan a patient, Dr. Lonappan was responsible for examining the patient, coming up with a plan for that patient's diagnosis and treatment, and ultimately deciding whether to discharge the patient. The trial court found there was no evidence suggesting "anyone other than Dr. Lonappan had the final say concerning how [p]laintiff (or any other patient) would be treated." Thus, the trial court agreed that summary disposition of plaintiff's claim for vicarious liability against Beaumont was proper because "the undisputed evidence establishe[d] that Dr. Lonappan was not an actual employee or agent of the hospital."

The trial court also agreed with Beaumont that an ostensible agency did not exist between Beaumont and Dr. Lonappan, and, as a result, summary disposition of plaintiff's vicarious-liability claim was also proper on that basis. The trial court found that plaintiff only recalled seeing a "pain doctor" during her time at Beaumont from October 9, 2015 to October 11, 2015, and plaintiff "essentially testified she had no recollection of Dr. Lonappan." The trial court concluded that, "[w]ithout any recollection of Dr. Lonappan, there [was] nothing to support [p]laintiff's claim that she harbored a reasonable belief that Dr. Lonappan was acting as a hospital employee." Moreover, the trial court concluded it could not consider plaintiff's affidavit because it "conflict[ed] with her previous deposition testimony." The trial court also found that while Dr. Lonappan testified she typically informed patients that Beaumont assigned her to their care, there was no indication Beaumont "encouraged Dr. Lonappan to say this or that it acquiesced in the use of this vernacular." The trial court recognized that Dr. Lonappan's laboratory coat indicated an affiliation with Beaumont, potentially supporting a conclusion Beaumont encouraged a belief that Dr. Lonappan was its employee or agent. However, the trial court noted that Dr. Lonappan's laboratory coat also reflected her affiliation with Hospital Consultants. Additionally, the trial court found the affiliations printed on the laboratory coat "immaterial given that Plaintiff does not even recall having seen it."

Plaintiff moved for reconsideration, which was denied. Plaintiff then applied for leave to appeal the trial court's order. This Court denied plaintiff's application for leave to appeal. *Markel*

v William Beaumont Hosp, unpublished order of the Court of Appeals, entered November 6, 2019 (Docket No. 350655). Subsequently, plaintiff applied for leave to appeal in our Supreme Court, which remanded the matter to this Court for consideration as on leave granted. *Markel v William Beaumont Hosp*, 505 Mich 961 (2020).

II. OSTENSIBLE AGENCY

Plaintiff first argues that the trial court erred in concluding Dr. Lonappan was not an ostensible agent of Beaumont and, therefore, wrongly granted summary disposition in Beaumont's favor. We disagree.

This Court reviews a trial court's decision whether to grant or deny a motion for summary disposition de novo. *Ingham Co v Mich Co Rd Comm Self-Ins Pool*, 321 Mich App 574, 579; 909 NW2d 533 (2017), remanded on other grounds by 503 Mich 917 (2018).

> A motion under MCR 2.116(C)(10) tests the factual sufficiency of the complaint. In evaluating a motion for summary disposition brought under this subsection, a trial court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties, MCR 2.116(G)(5), in the light most favorable to the party opposing the motion. Where the proffered evidence fails to establish a genuine issue regarding any material fact, the moving party is entitled to judgment as a matter of law. [*Maiden v Rozwood*, 461 Mich 109, 120; 597 NW2d 817 (1999) (citations and quotation marks omitted).]

"Generally speaking, a hospital is not vicariously liable for the negligence of a physician who is an independent contractor and merely uses the hospital's facilities to render treatment to his patients." *Grewe*, 404 Mich at 250. However, a hospital can be "be vicariously liable for the malpractice of actual or apparent agents." *Chapa v St Mary's Hosp of Saginaw*, 192 Mich App 29, 33; 480 NW2d 590 (1991).

> [T]he following three elements . . . are necessary to establish the creation of an ostensible agency: (1) the person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one, (2) the belief must be generated by some act or neglect on the part of the principal sought to be charged, and (3) the person relying on the agent's authority must not be guilty of negligence. [*Id*. at 33-34.]

"To put it another way, the defendant as the putative principal must have done something that would create in the patient's mind the reasonable belief that the doctors were acting on behalf of the defendant hospital." *VanStelle*, 255 Mich App at 10.

> Agency "does not arise merely because one goes to a hospital for medical care. There must be some action or representation by the principal (hospital) to lead the third person (plaintiff) to reasonably believe an agency in fact existed." *Sasseen v Community Hosp Foundation*, 159 Mich App 231, 240; 406 NW2d 193 (1986). Further, the fact that a doctor used a hospital's facilities to treat a patient is not sufficient to give the patient a reasonable belief that the doctor was an agent

> of the hospital. *Heins v Synkonis*, 58 Mich App 119, 124; 227 NW2d 247 (1975). [*VanStelle*, 255 Mich App at 11.]

In granting summary disposition to Beaumont on plaintiff's claim of vicarious liability under an ostensible-agency theory, the trial court found plaintiff could not have reasonably believed Dr. Lonappan acted on Beaumont's behalf when, according to her deposition testimony, plaintiff did not actually recall Dr. Lonappan at all. At her deposition, plaintiff testified that "[t]he only [doctor] I remember seeing was . . . they sent one of the pain doctors up about potentially doing an epidural but they couldn't do it because it was the weekend." The following exchange also took place during plaintiff's deposition:

> *Q*. So if there were different doctors from different specialties seeing you to look at what you had going on medically and to try to evaluate it from different perspectives, you may not recall their names but you do recall seeing different doctors, correct?
>
> *A*. I don't.
>
> * * *
>
> *Q*. There's a co-defendant in the case represented by Mr. Sinkoff, her name is Dr. Linet, L-i-n-e-t, Lonappan, L-o-n-a-p-p-a-n, that name is not familiar to you either then?
>
> *A*. Not at all.

Plaintiff's ostensible agency theory was premised an affidavit she attached to her response to Beaumont's motion for summary disposition. In her affidavit, plaintiff contradicted her deposition testimony by stating that she was treated by multiple medical care providers at Beaumont, including Dr. Lonappan. Plaintiff also stated that while Dr. Lonappan provided medical treatment to her, plaintiff "was at all times under the impression" that Dr. Lonappan was Beaumont's employee, and that Dr. Lonappan did not make any statements or take any affirmative actions to indicate to plaintiff that she was not employed by Beaumont. Plaintiff also stated that she "worked for Beaumont Hospital through the Royal Oak system for over thirty (30) years, and as of October 2015, [she] was unaware that the physicians were not employees of the hospital."

The trial court concluded that it could not consider plaintiff's affidavit because it conflicted with her deposition testimony. On appeal, plaintiff asserts the trial court's decision to not consider plaintiff's affidavit was erroneous. We disagree.

"It is well settled that a party may not create an issue of fact by submitting an affidavit that contradicts prior deposition testimony." *Atkinson v City of Detroit*, 222 Mich App 7, 11; 564 NW2d 473 (1997); see also *Casey v Auto Owners Ins Co*, 273 Mich App 388, 396; 729 NW2d 277 (2006) ("[A] witness is bound by his or her deposition testimony, and that testimony cannot be contradicted by affidavit in an attempt to defeat a motion for summary disposition."). In her deposition testimony, in response to whether she recalled seeing doctors other than the "pain doctor[]," plaintiff stated, "I don't." And, when explicitly asked whether Dr. Lonappan's name was familiar to her, plaintiff stated, "Not at all." However, in her affidavit, plaintiff states she was

"treated by multiple medical care providers at William Beaumont Hospital–Royal Oak, including Dr. Linet Lonappan." Plaintiff's affidavit improperly attempts to create an issue of fact that contradicts her previous deposition testimony and, as a result, the trial court did not err in declining to consider it. *Atkinson*, 222 Mich App at 11; *Casey*, 273 Mich App at 396.

Plaintiff alternatively argues that her belief that Dr. Lonappan was Beaumont's ostensible agent was reasonable because (1) Dr. Lonappan's laboratory coat indicated an affiliation with Beaumont and (2) Dr. Lonappan's testimony that she introduced herself to patients by stating her name and indicating Beaumont assigned her to the patient's care. We disagree.

Dr. Lonappan testified that, when working at Beaumont, she typically wore a white laboratory coat with credentials from both Beaumont Health Systems and Hospital Consultants. Dr. Lonappan indicated she did not "have a specific recollection" regarding whether she was wearing those credentials when she saw plaintiff in October 2015, but acknowledged that when she was in the hospital, she wore her laboratory coat and credential. Dr. Lonappan also testified that when she meets a patient for the first time, she introduces herself as Dr. Lonappan. The following exchange took place at Dr. Lonappan's deposition:

> *Q*. Okay. Do you say I'm Dr. Lonappan at Beaumont or I'm Dr. Lonappan at Hospital Consultants, P.C., or just I'm Dr. Lonappan?
>
> *A*. I'm Dr. Lonappan.
>
> *Q*. Okay. And you were assigned Ms. Markel's service by William Beaumont Hospital?
>
> *A*. Yes.
>
> *Q*. Okay. Just foundation.

With respect to the laboratory coat, as the trial court concluded and Dr. Lonappan testified, Dr. Lonappan's laboratory coat indicated not only an affiliation with Beaumont but also with Hospital Consultants. See *VanStelle*, 255 Mich App at 15 (indicating that where a doctor's business card references both a hospital and medical office, there is not necessarily an inference that the doctor is employed by the hospital). Next, although plaintiff repeatedly characterized Dr. Lonappan's testimony as being that Dr. Lonappan typically indicated to patients that she was assigned to their care by Beaumont, the actual testimony of Dr. Lonappan that plaintiff refers to does not state what plaintiff claims. As noted above, Dr. Lonappan was not asked whether she told patients that Beaumont assigned her to their care. Rather, Dr. Lonappan was asked, "[j]ust [for] foundation" purposes whether she was assigned specifically to plaintiff's service by Beaumont. Thus, plaintiff's interpretation of Dr. Lonappan's testimony is incorrect and does not demonstrate that she would inform her patients by whom, or which entity, she was assigned to their care.

Moreover, Dr. Lonappan actually testified that it was her "usual practice" to tell patients she was a "seeing [a patient] for your family doctor . . . ." And, as the trial court also concluded (after properly declining to consider plaintiff's affidavit), we agree that whether Dr. Lonappan's laboratory coat indicated she was affiliated with Beaumont, Hospital Consultants, or both, and

whether Dr. Lonappan told patients she was assigned to their care by Beaumont, was immaterial because the evidence demonstrates plaintiff did not recall seeing any doctors other than a "pain doctor[]" when she was in the hospital in October 2015. Because we agree that the evidence demonstrates plaintiff did not recall seeing Dr. Lonappan, the trial court did not err in concluding that plaintiff's belief that Dr. Lonappan was an ostensible agent of Beaumont was not reasonable. Accordingly, the trial court properly granted summary disposition of plaintiff's claim of vicarious liability against Beaumont on an ostensible-agency theory.

III. ACTUAL AGENCY

Plaintiff also argues that the trial court erred in granting summary disposition of her claim of vicarious liability against Beaumont under an actual-agency theory because, under MCR 2.116(G)(4), Beaumont's motion for summary disposition did not specifically identify that aspect of plaintiff's claim as being challenged and failed to support its motion with documentary evidence. We agree.

"Generally, an issue must be raised, addressed, and decided in the trial court to be preserved for review." *Dell v Citizens Ins Co of America*, 312 Mich App 734, 751 n 40; 880 NW2d 280 (2015). In her response to Beaumont's motion for summary disposition, plaintiff did not argue that Beaumont's motion did not adhere to the requirements of MCR 2.116(G)(4). Therefore, the issue is unpreserved for appellate review. This Court reviews unpreserved issues for plain error affecting a party's substantial rights. *Rivette v Rose-Molina*, 278 Mich App 327, 328; 750 NW2d 603 (2008). " 'To avoid forfeiture under the plain-error rule, three requirements must be met: (1) an error must have occurred; (2) the error was plain, i.e., clear or obvious, and (3) the plain error affected substantial rights.' " *Kern v Blethen-Coluni*, 240 Mich App 333, 336; 612 NW2d 838 (2000), quoting *People v Carines*, 460 Mich 750, 763; 597 NW2d 130 (1999). "[A]n error affects substantial rights if it caused prejudice, i.e., it affected the outcome of the proceedings." *Lawrence v Mich Unemployment Ins Agency*, 320 Mich App 422, 443; 906 NW2d 482 (2017) (alteration in original, citation and quotation marks omitted).

When filing a motion under MCR 2.116(C)(10), the moving party must "specifically identify the issues as to which the moving party believes there is no genuine issue as to any material fact." MCR 2.116(G)(4). MCR 2.116(G)(4) further states:

> When a motion under subrule (C)(10) is made *and supported as provided in this rule*, an adverse party may not rest upon the mere allegations or denials of his or her pleading, but must, by affidavits or as otherwise provided in this rule, set forth specific facts showing that there is a genuine issue for trial. If the adverse party does not so respond, judgment, if appropriate, shall be entered against him or her. [Emphasis added.]

"The level of specificity required under MCR 2.116(G)(4) is that which would place the nonmoving party on notice of the need to respond to the motion made under MCR 2.116(C)(10)." *Barnard Mfg Co, Inc v Gates Performance Engineering, Inc*, 285 Mich App 362, 369; 775 NW2d 618 (2009). Additionally, a motion for summary disposition under MCR 2.116(C)(10) must be supported with documentary evidence. *Meyer v City of Center Line*, 242 Mich App 560, 574; 619 NW2d 182 (2000). If the motion is not properly supported, "the nonmoving party has no duty to

respond and the trial court should deny the motion." *Barnard Mfg Co, Inc*, 285 Mich App at 370; MCR 2.116(G)(4). See also *Meyer*, 242 Mich App at 575 (concluding that the trial court erred when it granted an improperly supported motion for summary disposition under MCR 2.116(C)(10)).

MCR 2.116(I) states, in relevant part, that "[i]f the pleadings show that a party is entitled to judgment as a matter of law, or if the affidavits or other proofs shows that there is no genuine issue of material fact, the court shall render judgment without delay." "Although a trial court may sua sponte grant summary disposition under MCR 2.116(I), the trial court may not do so in contravention of a party's due process rights." *Sandstone Creek Solar, LLC v Twp of Benton*, ___ Mich App ___, ___; ___ NW2d ___ (2021) (Docket No. 352910); slip op at 14, citing *Lamkin v Hamburg Twp*, 318 Mich App 546, 550; 899 NW2d 408 (2017). "Due process requires that a party receive notice of the proceedings against it and a meaningful opportunity to be heard." *Bonner v City of Brighton*, 495 Mich 209, 235; 848 NW2d 380 (2014).

The trial court should not have granted summary disposition of plaintiff's claim of vicarious liability against Beaumont under an actual-agency theory. Beaumont claims it identified plaintiff's actual-agency theory in its motion for summary disposition by citing to this Court's decision in *Laster v Henry Ford Health Sys*, 316 Mich App 726, 739; 892 NW2d 442 (2016). But Beaumont's motion and brief in support cited *Laster* twice: once in the motion itself as part of a string of citations after asserting plaintiff failed to create a genuine issue of material fact to establish Beaumont was vicariously liable related to the allegations against Dr. Lonappan, and again for the proposition that, in Michigan, "liability will typically be imposed 'upon a defendant only for his or her own negligence, not the alleged tortious conduct of others.' " Although *Laster* may, in part, address the control test for purposes of actual agency, Beaumont's motion for summary disposition presented no argument regarding this issue, contrary to its claim on appeal.

Although Beaumont's motion for summary disposition only addressed plaintiff's argument regarding vicarious liability under an ostensible-agency theory, the trial court summarized Beaumont's motion as asserting that the "undisputed evidence establishe[d] that Dr. Lonappan was not an actual employee or agent of the hospital." The trial court noted that a hospital will not be liable for the negligence of an independent-contractor physician, unless the hospital has assumed control over the physician. The trial court found that Dr. Lonappan was employed by Hospital Consultants, not Beaumont, but noted that Beaumont assigned patients to physicians who worked for Hospital Consultants. The trial court also noted Dr. Lonappan's testimony that, once Beaumont assigned her a patient, it was her job to formulate a plan for the patient's diagnosis and treatment, and was her decision whether to discharge patients. The trial court concluded that there was no evidence suggesting "anyone other than Dr. Lonappan had the final say concerning how Plaintiff (or any other patient) would be treated." Thus, the trial court found Dr. Lonappan was not Beaumont's actual agent.

The record does not demonstrate plaintiff was on notice that the trial court was prepared to consider the dismissal of her claim of vicarious liability under an actual-agency theory. Although the record contained some evidence regarding the extent of control Dr. Lonappan had over her treatment of patients in Beaumont, notably through her deposition testimony, none of that was provided in Beaumont's motion for summary disposition. The excerpts of Dr. Lonappan's deposition testimony provided by Beaumont dealt with background information regarding the

events concerning plaintiff's care and which entity employed her. It was not until plaintiff's response that a full transcript of Dr. Lonappan's deposition testimony was provided.

And, as noted, the arguments in Beaumont's motion related to the vicarious-liability claim focused on the ostensible-agency theory. Further, during those portions of argument related to plaintiff's vicarious-liability claim at the hearing on Beaumont's motion for summary disposition, the parties and trial court focused on facts and argument related to the ostensible-agency theory. Thus, while a trial court "may sua sponte grant summary disposition under MCR 2.116(I), the trial court may not do so in contravention of a party's due process rights." *Sandstone Creek Solar, LLC*, ___ Mich App at ___; slip op at 14. Because Beaumont's motion for summary disposition did not specifically indicate it was challenging plaintiff's actual-agency theory of vicarious liability, plaintiff was not put on notice of the need to respond. *Barnard Mfg Co, Inc*, 285 Mich App at 369. Further, because Beaumont did not support its motion with a complete copy of Dr. Lonappan's transcript, but, rather, portions of the transcript not relevant to the actual-agency theory, plaintiff had no duty to respond. *Id*. at 370. Because plaintiff was not put on notice that Beaumont's motion encompassed a challenge to her actual-agency theory, and was not provided an opportunity to address that issue given the lack of notice or any indication the trial court would address the issue, the trial court improperly granted summary disposition of plaintiff's vicarious-liability claim under an actual-agency theory. *Sandstone Creek Solar, LLC*, ___ Mich App at ___; slip op at 14.

IV. CONCLUSION

Affirmed in part, reversed in part, and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Karen M. Fort Hood
/s/ Michael J. Riordan

STATE OF MICHIGAN

COURT OF APPEALS

MARY ANNE MARKEL,

Plaintiff-Appellant,

v

WILLIAM BEAUMONT HOSPITAL,

Defendant-Appellee,

and

HOSPITAL CONSULTANTS, PC, LINET LONAPPAN, M.D., and IOANA MORARIU,

Defendants.

UNPUBLISHED
April 22, 2021

No. 350655
Oakland Circuit Court
LC No. 2018-164979-NH

Before: BECKERING, P.J., and FORT HOOD and RIORDAN, JJ.

BECKERING, P.J. (*concurring*).

I concur in the result. I write separately to address the issue of ostensible agency. Were this Court not bound by the Michigan Supreme Court's order in *Reeves v Midmichigan Health*, 489 Mich 908; 769 NW2d 468 (Mem) (2011), I would conclude that the Supreme Court's detailed analysis of ostensible agency and its ruling in *Grewe v Mt Clemens Hosp*, 404 Mich 240; 273 NW2d 429 (1978), supports a reversal of the trial court's ruling in the present case. But for *Reeves*, I would hold that plaintiff, Mary Anne Markel, has established a question of fact for the jury with respect to whether defendant Linet Lonappan, M.D. was an ostensible agent of defendant William Beaumont Hospital under the circumstances presented.

In the wake of *Grewe*, our Court's rulings have lacked consistency with respect to ostensible agency, and some have added a greater obligation upon a plaintiff than the Supreme Court arguably intended in *Grewe*. In *Grewe*, after receiving an electric shock that caused him to suffer a dislocated shoulder, the plaintiff went to the defendant hospital, where he was admitted after being seen in the emergency room. *Id*. at 245-246, 255. After his admission, the plaintiff was treated by Dr. Gerald Hoffman, an internist. Dr. Hoffman's associate, Dr. Lewis Katzowitz,

an internist with staff privileges at the defendant hospital, also treated the plaintiff. Dr. Katzowitz unsuccessfully attempted to reduce the plaintiff's shoulder dislocation with efforts including placing his foot on the plaintiff's chest and pulling his arm, without first having viewed x-rays. *Id.* at 246. The plaintiff sued for medical negligence, contending that these attempts at reducing his shoulder dislocation resulted in a brachial plexus injury and a fracture of the greater tuberosity. *Id*. The matter eventually went to a second jury trial in which the jury found the defendant hospital negligent and awarded the plaintiff $120,000 in damages. *Id*. at 247. The defendant hospital argued that it could not be held liable for Dr. Katzowitz's negligence because Dr. Katzowitz was not its employee; he merely had staff privileges, and the hospital asserted that it had no control over his treatment of the plaintiff. *Id.* at 247, 250. The Supreme Court disagreed, concluding that a hospital could be held liable for the negligence of a doctor who was an independent contractor under certain conditions:

> Generally speaking, a hospital is not vicariously liable for the negligence of a physician who is an independent contractor and merely uses the hospital's facilities to render treatment to his patients. See Anno: *Hospital-Liability-Neglect of Doctor*, 69 ALR2d 305, 315-316. However, if the individual looked to the hospital to provide him with medical treatment and there has been a representation by the hospital that medical treatment would be afforded by physicians working therein, an agency by estoppel can be found. See *Howard v Park*, 37 Mich App 496; 195 NW2d 39 (1972), *lv den* 387 Mich 782 (1972). See also *Schagrin v Wilmington Medical Center, Inc*, 304 A2d 61 (Del Super Ct, 1973).
>
> In our view, the critical question is whether the plaintiff, at the time of his admission to the hospital, was looking to the hospital for treatment of his physical ailments or merely viewed the hospital as the situs where his physician would treat him for his problems. A relevant factor in this determination involves resolution of the question of whether the hospital provided the plaintiff with Dr. Katzowitz or whether the plaintiff and Dr. Katzowitz had a patient-physician relationship independent of the hospital setting. [*Id.* at 250-251.]

The Supreme Court further stated:

> The relationship between a given physician and a hospital may well be that of an independent contractor performing services for, but not subject to, the direct control of the hospital. However, that is not of critical importance to the patient who is the ultimate victim of that physician's malpractice. In *Howard v Park*, *supra*, the Court of Appeals quoted with approval from the opinion in *Stanhope v Los Angeles College of Chiropractic*, 54 Cal App 2d 141; 128 P2d 705 (1942). We too find the California Court's analysis of this area enlightening:
>
> > " 'An agency is ostensible when the principal intentionally or by want of ordinary care, causes a third person to believe another to be his agent who is not really employed by him.' § 2300, Civ Code. In this connection it is urged by appellant that 'before a recovery can be had against a principal for the alleged acts of an ostensible agent, three things must be proved, *to wit*:' (quoting from *Hill v*

> *Citizens National Tr & Sav Bank*, 9 Cal 2d 172, 176; 69 P2d 853, 855 (1937)); (First) The person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one; (second) such belief must be generated by some act or neglect of the principal sought to be charged; [third] and the third person relying on the agent's apparent authority must not be guilty of negligence. 1 Cal Jur 739; *Weintraub v. Weingart*, 98 Cal App 690; 277 P 752 [1929].' " [*Id.* at 252-253.[1]]

The Supreme Court concluded that there was nothing in the record that should have put the plaintiff on notice that Dr. Katzowitz was an independent contractor, as opposed to an employee, of the defendant hospital. *Id.* at 253. It explained that the plaintiff's testimony demonstrated he went to the defendant hospital for treatment and expected to be treated by the hospital. There was no evidence that he had any preexisting patient-physician relationship with any doctor who treated him. *Id.* at 253-254. It also explained that the plaintiff was treated by Dr. Hoffman and Dr. Katzowitz because the emergency room doctor had referred him to Dr. Hoffman. *Id.* at 254-255. The Supreme Court concluded that it was "abundantly clear on the strength of this record that the plaintiff looked to the defendant hospital for his treatment and was treated by medical personnel who were ostensible agents of defendant hospital." *Id.* at 255.

One of the leading cases on ostensible agency from this Court is *Chapa v St Mary's Hosp*, 192 Mich App 29; 480 NW2d 590 (1991). In *Chapa*, after the plaintiff took a fall and was rendered unconscious, he was admitted to the defendant hospital through its emergency room. He was treated by the on-call neurologist. *Id.* at 30-31. The next day, the plaintiff's daughter called Dr. Thepveera, the plaintiff's long-time family doctor, who then took over his treatment. *Id.* at 31. The plaintiff alleged that Dr. Thepveera and Dr. Penput, who treated the plaintiff at Dr. Thepveera's request when he was out of town, were negligent. *Id.* At issue was whether Dr. Thepveera and Dr. Penput were ostensible agents of the defendant hospital. *Id.* The plaintiff argued that, based on *Grewe* and what the Supreme Court stated was the "critical test," the relevant inquiry was whether the plaintiff looked to the defendant hospital for treatment at the time of his admission. *Id.* at 32. This Court rejected the plaintiff's framing of the test. *Id.* It explained:

> It is obvious that *Grewe* so framed the "critical question" because of the facts of that case, which differ substantially from those herein. In *Grewe*, the plaintiff, who suffered a dislocated shoulder at work, was admitted on an emergency basis and immediately was (mis)treated by two hospital physicians, apparently on call, with whom he had no prior doctor-patient relationship. It was that treatment that gave rise to the cause of action for malpractice. In this case, [the plaintiff] was treated by a hospital doctor the day he was admitted. There was a question of fact whether [the plaintiff's] family instigated the replacement of defendant's personnel with the

[1] In *Stanhope*, the court concluded that the "appellant did nothing to put respondent on notice that the X-ray laboratory was not an integral part of appellant institution, and it cannot seriously be contended that respondent, when he was being carried from room to room suffering excruciating pain, should have inquired whether the individual doctors who examined him are employees of the college or were independent contractors." *Stanhope*, 54 Cal App 2d at 146.

> family doctor, but it was clear that the family doctor did take over on the day after [the plaintiff's] admission. And it is undisputed that the acts of alleged malpractice began five days after admission. . . .
>
> The essence of *Grewe* is that a hospital may be vicariously liable for the malpractice of actual or apparent agents. Nothing in *Grewe* indicates that a hospital is liable for the malpractice of independent contractors merely because the patient "looked to" the hospital at the time of admission or even was treated briefly by an actual nonnegligent agent of the hospital. Such a holding would not only be illogical, but also would not comport with fundamental agency principles noted in *Grewe* and subsequent cases. Those principles have been distilled into the following three elements that are necessary to establish the creation of an ostensible agency: (1) the person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one, (2) the belief must be generated by some act or neglect on the part of the principal sought to be charged, and (3) the person relying on the agent's authority must not be guilty of negligence. *Grewe*, *supra*, pp 252-253; *Strach v St John Hosp Corp*, 160 Mich App 251, 261; 408 NW2d 441 (1987).
>
> Simply put, defendant, as putative principal, must have done something that would create in [the plaintiff's] mind the *reasonable* belief that Drs. Thepveera and Penput were acting on behalf of defendant. *Grewe, supra* . . . . If, as defendant contended below, [the plaintiff's] family arranged for Dr. Thepveera to replace Dr. Schanz, then the question becomes whether it was reasonable for [the plaintiff] to continue to believe that he was being treated by agents of defendant hospital. The reasonableness of the patient's belief in light of the representations and actions of the hospital is the "key test" embodied in *Grewe.* [*Id.* at 32-34.]

In the present case, William Beaumont Hospital argues that Markel cannot show she had a reasonable belief that defendant Dr. Lonappan was acting on behalf of William Beaumont Hospital, and she cannot show that any such belief was generated by it. It relies on the rule that "[a]gency does not arise merely because one goes to a hospital for medical care. There must be some action or representation by the principal (hospital) to lead the third person (plaintiff) to reasonably believe an agency in fact existed." *VanStelle v Macaskill*, 255 Mich App 1, 11; 662 NW2d 41 (2003) (citation and internal quotation marks omitted).

I would submit that, on the basis of *Grewe*, there is a genuine issue of material fact whether Markel had a reasonable belief that Dr. Lonappan was acting on behalf of William Beaumont Hospital when Markel went to William Beaumont Hospital seeking treatment, William Beaumont Hospital assigned Dr. Lonappan to treat Markel, and Dr. Lonappan assumed Markel's in-hospital care. William Beaumont Hospital has produced no document showing that Markel was advised that Dr. Lonappan was not, in fact, its agent.[2] According to *Grewe*, the critical question is whether

[2] Evidence indicated that Dr. Lonappan wore a lab coat with the William Beaumont Hospital insignia, as well as that of Hospital Consultants, P.C., but Dr. Lonappan also testified that she did

Markel, at the time of her presentation to the hospital, was looking to William Beaumont Hospital for treatment of her physical ailments or merely viewed the hospital as the situs where her physician would treat her for her problems, *Grewe*, 404 Mich at 251. In this case, Markel attested to the fact that she was looking to the hospital for her care; she was not viewing it as the situs where her physician would treat her for her problems. And line with *Chapa*, Markel's affidavit makes clear that her expectations did not change while at the hospital; in other words, she made no arrangements to obtain care from her own doctor at any point during her stay. Contrary to the conclusion of my colleagues, I do not deem Markel's statements in her affidavit to contradict her deposition testimony. Simply because she testified at her deposition that she did not remember meeting Dr. Lonappan does not mean should could not have had the reasonable expectation that all medical care providers who were assigned to and attended to her while she was at William Beaumont Hospital were agents of the hospital.[3] Moreover, she did not know Dr. Lonappan prior to her admission to the hospital.

The evidence establishes that Markel went to the William Beaumont Hospital's emergency department because she was experiencing numbness in her feet, back pain, and an inability to urinate a week after an endometrial ablation. Following the results of a blood test, she was admitted to the hospital for additional testing and observation. The hospital provided her with a neurological consult. She was observed by a physician's assistant. She was transferred from the observation unit and admitted to the hospital. The hospital assigned Dr. Lonappan, a board-certified internist and *hospitalist*,[4] to Markel's care. Dr. Lonappan completed a history and performed a physical examination. Dr. Lonappan agreed at her deposition that she was responsible for knowing which studies had been previously ordered for Markel with results pending, she was the doctor responsible for having discharged Markel, and she was the doctor responsible for following up regarding the results of the tests. Importantly, a urine culture showed that Markel was positive for Group B Streptococcus, and Dr. Lonappan did not follow up with Markel. Although Markel did not remember Dr. Lonappan, she did not choose Dr. Lonappan as her doctor. Markel went to the hospital for care and treatment, and the hospital assigned Dr. Lonappan to her care.[5] These facts do not suggest that Markel merely viewed William Beaumont Hospital as the situs where her physician would treat her problems. *Id.* When the benefit of reasonable doubt is

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not tell patients she was serving as an independent contractor while treating her assigned hospital patients. In any event, Markel does not recall meeting Dr. Lonappan because she was in so much pain.

[3] Neither she nor anyone in her family made arrangements with her doctor to meet Dr. Lonappan or any other doctor at the hospital.

[4] In *Grewe*, the Supreme Court agreed with a New York court's rationale that hospitals should shoulder the responsibilities of respondeat superior, just like every other employer, "where medical personnel such as physicians and nurses, though independent contractors, were performing medical services ordinarily performed by the hospital." *Id*. at 252.

[5] While Dr. Lonappan testified that William Beaumont Hospital assigned her to Markel's hospital care based on a contractual arrangement between her professional corporation and Markel's primary physician for when one of his patients presented to the hospital, there is no dispute that this was not made known to Markel.

given to plaintiff, I would conclude based on *Grewe* that reasonable minds could differ as to whether Dr. Lonappan was an ostensible agent of William Beaumont Hospital. *West v Gen Motors Corp*, 469 Mich 177, 183; 665 NW2d 468 (2003). See *Setterington v Pontiac Hosp*, 223 Mich App 594, 603; 568 NW2d 93 (1997) (stating that the evidence supported the jury's finding of an agency between the radiologists and the defendant hospital when there was no patient-physician relationship between the plaintiff and the radiologists outside the hospital setting, the radiologists just happened to be on duty when the plaintiff arrived at the defendant hospital, and the defendant hospital held the radiology department out as part of the hospital); *Johnson v Kolachalam*, unpublished per curiam opinion of the Court of Appeals, issued July 21, 2016 (Docket No. 326615), pp 12-13 (stating that given the plaintiff's pain and distress when she arrived at the hospital, she did not unreasonably fail to ask whether the individual doctor who performed her gallbladder surgery was an employee of the hospital or an independent contractor, and she reasonably could have believed that the surgeon was an employee of the hospital); *Crawford v William Beaumont Hosp*, unpublished per curiam opinion of the Court of Appeals, issued October 2, 2012 (Docket No. 298914), pp 7-8 (stating that there were questions of fact whether an ostensible agency existed when the plaintiff went to the emergency room, he was placed under the care of one of the doctors after his diagnosis of atrial fibrillation, and no one broached the topic of the doctors' status as independent contractors with the defendant hospital with the plaintiff).

This Court's decision in *Chapa* does not change my conclusion that there is a genuine issue of material fact whether Dr. Lonappan was an ostensible agent of William Beaumont Hospital. The Supreme Court in *Grewe*, 404 Mich at 251, stated that the "critical question" was whether the plaintiff, at the time of his admission to the hospital, was looking to the hospital for treatment of his physical ailments. This Court in *Chapa*, 192 Mich App at 32, 34, stated that the Supreme Court framed the "critical question" in this manner because of the facts before the Supreme Court, which were substantially different from the facts before it, and this Court then reframed the critical question for those substantially different facts. But the facts in the present case are not substantially different from those in *Grewe*—in both cases, the plaintiff went to the hospital seeking emergency care and, while at the hospital, received care by a physician with whom there was no preexisting patient-physician relationship. Accordingly, there is no need to reframe the critical question for the present case. Additionally, although the Supreme Court in *Grewe*, 404 Mich at 252, referenced the three factors for ostensible agency, it did not engage in an analysis of each of those factors before determining that the jury's verdict was supported by the evidence. See *id.* at 253-255. Based on *Grewe*, I would conclude that the trial court erred in granting William Beaumont Hospital's motion for summary disposition with respect to the ostensible agency of Dr. Lonappan.

But, as I mentioned at the outset, I am bound by the Supreme Court's order in *Reeves*.[6] In *Reeves*, the Supreme Court reversed this Court's conclusion that a question of fact existed with respect to ostensible agency for reasons set forth in the Court of Appeals' dissenting opinion. *Reeves*, 489 Mich at 908. The dissenting opinion noted that the "[n]either the admission consent form nor the discharge instructions discuss the relationship between defendant and the physicians providing treatment in its emergency room," the doctor who had been assigned to the patient's[7]

[6] I believe other Court of Appeals opinions are factually distinguishable.

[7] The patient was plaintiff's husband. He suffered a catastrophic stroke and remained in a "vegetative state" after being discharged from the emergency room at Gratiot Medical Center

case . . . . "never discussed his employment status with [the patient], . . . and there is no evidence in the record that defendant did or failed to do anything that would create a reasonable belief that [the doctor] was acting on its behalf." *Reeves v Midmichigan Health*, unpublished per curiam opinion of the Court of Appeals, issued September 30, 2010 (Docket No. 291855), p 5 (HOEKSTRA, J., dissenting). In other words, silence on the part of the hospital and reasonable assumptions on the part of the plaintiff do not provide the plaintiff with a reasonable question of fact when it comes to ostensible agency, the hospital has to do or fail to do something more than that to create a reasonable belief.[8] Because Markel has failed to produce evidence that William Beaumont Hospital did or failed to do anything that would create a reasonable belief that Dr. Lonappan was acting on its behalf, I must concur that summary disposition was proper here.

I implore our Supreme Court to revisit and clarify the proper legal framework for ostensible agency. Too many patients select and seek care from a hospital based on its highly branded, "premier" reputation, and they rightly expect that they will be in the good hands of the hospital's carefully curated, premier medical employees, only to learn later that they merely entered a brick building filled with independent contractors.[9] And when a mistake is made, they learn that the hospital bears no legal responsibility for care that fails to meet expectations, let alone the bare minimum standard of care.

/s/ Jane M. Beckering

where the defendant doctor had treated him. *Reeves v Midmichigan Health*, unpublished per curiam opinion of the Court of Appeals, issued September 30, 2010 (Docket No. 291855), p 1.

[8] Under this framing of the *Grewe* test, not even the plaintiff in *Grewe* would pass the test.

[9] If a hospital chooses to make clear through consent forms that doctors are independent contractors, those forms should be sufficiently clear so that no innocent assumptions remain.

2008 WL 5197155
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

UNPUBLISHED
Court of Appeals of Michigan.

Christopher PURCELL, Plaintiff-Appellee,
v.
STURGIS HOSPITAL,
Defendant-Appellant,
and
Edward Griffin, M.D., Edward Griffin, M.D., P.C., John Colin Kirkpatrick, M.D., John Colin Kirkpatrick, M.D., P.C., Rome Ahuja, M .D., Rome Ahuja, M.D., P.C., Yahya Albeer, M.D., Yahya Albeer, M.D., P.C., Raymond Randonovich, D.O., Raymond Randonovich, D.O., P.C., and Thomas Brenner, M.D., Defendants.

Docket Nos. 277793, 277794, 277795.
|
Dec. 11, 2008.

St. Joseph Circuit Court; LC No. 03-000617-NH.

Before: HOEKSTRA, P.J., and BANDSTRA and DONOFRIO, JJ.

Opinion

PER CURIAM.

***1** In this medical malpractice action, defendant Sturgis Hospital appeals as on leave granted three lower court orders: (1) an order denying Sturgis Hospital's motion for summary disposition on plaintiff's vicarious liability claims (Docket No. 277795); (2) an order granting plaintiff's motion to strike Sturgis Hospital's answer, and entering a default as to Sturgis Hospital on claims against the radiologist defendants Dr. Rome Ahuja, Dr. Yahya Albeer, Dr. John Kirkpatrick, and Dr. Raymond Randonovich (Docket No. 277793); and (3) an order partially denying Sturgis Hospital's motion for summary disposition regarding plaintiff's claims of vicarious liability for the alleged negligence of Ahuja, Albeer, and Randonovich (Docket No. 277794).[1] Because plaintiff failed to establish the existence of a genuine issue of fact to support his claim of ostensible agency, we reverse and remand.

Defendant hospital argues that plaintiff failed to establish that these nonparty radiologist defendants were ostensible agents of the hospital, and the trial court should have dismissed plaintiff's complaint against Sturgis Hospital in its entirety.

Sturgis Hospital moved for summary disposition pursuant to MCR 2.116(C)(10), asserting that plaintiff failed to establish the existence of a genuine issue of fact to support his claim of ostensible agency. The trial court disagreed and denied that motion. We review de novo a trial court's ruling on a motion for summary disposition pursuant to MCR 2.116(C)(10), considering the pleadings, depositions, admissions, and other documentary evidence in the light most favorable to the nonmoving party. *Morris & Doherty, PC v. Lockwood,* 259 Mich.App. 38, 41-42, 672 N.W.2d 884 (2003). If the evidence fails to demonstrate a genuine issue of material fact, the moving party is entitled to judgment as a matter of law. *Franchino v. Franchino,* 263 Mich.App. 172, 181, 687 N.W.2d 620 (2004). The moving party has the burden of supporting its position with documentary evidence with respect to a motion under MCR 2.116(C)(10), and, if so supported, the burden then shifts to the opposing party to establish the existence of a genuine issue of disputed fact. *Quinto v. Cross & Peters Co.,* 451 Mich. 358, 362, 547 N.W.2d 314 (1996). "Where the burden of proof at trial on a dispositive issue rests on a nonmoving party, the nonmoving party may not rely on mere allegations or denials in [the] pleadings, but must go beyond the pleadings to set forth specific facts showing that a genuine issue of material fact exists." *Id.*

A hospital may be held vicariously liable for the acts of its agents. *Nippa v. Botsford Gen. Hosp. (On Remand),* 257 Mich.App. 387, 390, 668 N.W.2d 628 (2003). "For all practical purposes the hospital stands in the shoes of its agents (the doctors)." *Id.* at 391, 668 N.W.2d 628. Nevertheless, a hospital is generally not vicariously liable for the negligence of an independent contractor, who merely uses the hospital's facilities to render treatment to patients. *Grewe v. Mount Clemens Gen. Hosp.,* 404 Mich. 240, 250, 273 N.W.2d 429 (1978). "However, if the individual looked to the hospital to provide him with medical treatment and there has been a representation by the hospital that medical

treatment would be afforded by physicians working therein, an agency by estoppel can be found." *Id.* at 250-251, 273 N.W.2d 429. To prove that the radiologists in the instant case were the ostensible agents of Sturgis Hospital, plaintiff must demonstrate that (1) he dealt with the radiologists with a reasonable belief in the radiologists' authority as agents of Sturgis Hospital, (2) his belief was generated by some act or neglect on the part of Sturgis Hospital, and (3) he was not guilty of negligence. *Zdrojewski v. Murphy,* 254 Mich.App. 50, 66, 657 N.W.2d 721 (2002). Plaintiff has failed to create a justiciable question of fact on the three factors.

***2** Regarding the first element, our review of the record reveals that plaintiff was taken to Sturgis Hospital following a sledding accident without any input regarding his medical care preference. Plaintiff specifically averred that he did not choose Sturgis Hospital. Plaintiff did not have a patient-physician relationship with the emergency room physicians, the orthopedic surgeon, or the initial radiologist, independent of the hospital setting. Plaintiff did not recall having any conversations with the radiologists. At his deposition, plaintiff testified that he did not recall any statements by Sturgis Hospital staff, or by radiologists in particular, during the course of his treatment. Further, plaintiff did not recall any discussion about the x-rays with any physicians, including radiologists. In sum, plaintiff admitted that he never spoke to or dealt with any of the radiologists in any capacity.

Specifically in regard to the non-party defendants, Dr. Ahuja, Dr. Albeer, and Dr. Randonovich, the record reveals that they provided radiological services to plaintiff only after his initial hospitalization. Following plaintiff's initial hospitalization, plaintiff continued under the care of his orthopedic surgeon, Dr. Griffin, who prescribed interim x-ray evaluations. During some, but not all, of plaintiff's subsequent evaluations, Dr. Ahuja, Dr. Albeer, and Dr. Randonovich, provided radiological services. These services included reading the x-rays taken on site at the hospital as prescribed by plaintiff's treating physician and then rendering reports. During plaintiff's post-hospitalization care, prior to receiving radiology services, plaintiff executed consent and release forms, entitled "Inpatient/Outpatient/Emergency Registration Release Assignment Form[s]." Plaintiff executed the consent and release forms eleven separate times, each time before radiology services were provided. The consent and release forms were dated March 4, 2001, June 1, 2001, July 3, 2001, August 1, 2001, September 4, 2001, October 22, 2001, October 25, 2001, November 2, 2001, December 17, 2001, December 21, 2001, and January 2, 2002. These forms specified that the radiologists were not employees of the hospital and specifically identified radiologists as "independent contractors and ... not agents of the Hospital." Thus, any belief plaintiff had regarding the radiologists' authority as agents of Sturgis Hospital was not reasonable. For these reasons, plaintiff cannot show that he dealt with the radiologists with a reasonable belief in the radiologists' authority as agents of Sturgis Hospital. *Zdrojewski, supra* at 66, 657 N.W.2d 721.

Next, regarding the second element, even if plaintiff somehow believed in the radiologists' authority as agents of Sturgis Hospital, this belief was not generated by some act or neglect on the part of Sturgis Hospital. The only evidence regarding the relationship between the radiologists and Sturgis Hospital contained in the record are the consent and release forms. Initially, when plaintiff was admitted to Sturgis Hospital's emergency department, because plaintiff was unable to, his mother signed the first "inpatient/outpatient/emergency registration release assignment form," included in the record that provided in part:

> ***3** I recognize that the Hospital is not liable for any act or omission in following the instructions of my above designated physician, his/her assistant(s), and/or his/her designee(s) and that all physicians, physician's assistants and other specialized personnel furnishing services to me, including radiologists, pathologists, anesthesiologists, and any others who are not actual employees of the Hospital, are independent contractors and are not agents of the Hospital and that Hospital has no responsibility for their acts or omissions.[2]

Again, on eleven subsequent visits, plaintiff signed a consent and release form containing the same provision. These forms specifically identify defendant radiologists as "independent contractors and ... not agents of the Hospital." Thus, any belief plaintiff had regarding the radiologists' authority as agents of Sturgis Hospital was specifically negated by the plain language contained in the consent and release forms and was not generated by some act or neglect on the part of Sturgis Hospital.

Plaintiff proffered ten medical imaging reports to demonstrate his purported reasonable belief that that the radiology department was apparently part of Sturgis Hospital. Indeed, these reports are marked with the Sturgis Hospital logo, provide its location at the bottom of the form, and are signed by various radiologists, including Ahuja, Albeer,

and Kirkpatrick. But these medical imaging reports were generated only after plaintiff received his imaging. Thus, these reports could not have created a reasonable belief in plaintiff at the time of his imaging that the radiology service was being provided by rather than at Sturgis Hospital. This is especially true when coupled with the language in the consent and release forms plaintiff signed each and every time before receiving radiology services. Thus, the medical imaging reports are insufficient evidence to create a question of fact on the second element that plaintiff's belief was generated by some act or neglect on the part of the hospital. *Zdrojewski, supra* at 66, 657 N.W.2d 721.

Third, it is apparent that plaintiff did not read the consent and release forms that he signed. Plaintiff was given the form and he signed it eleven times. Plaintiff thus had eleven opportunities to read the plain language of the forms. The language of the forms identifies defendant radiologists as independent contractors and not agents or employees of Sturgis Hospital. If plaintiff had read the form even one out of eleven times, he should have understood that the radiologists are independent contractors and not agents or employees of Sturgis Hospital. Because the plain language of the consent and release forms are clear, the only conclusion that can be advanced is that plaintiff did not read the forms before signing and as such, plaintiff cannot display that he was not guilty of some level of negligence in his asserted belief that the radiology services were provided by, rather than at Sturgis Hospital. *Zdrojewski, supra* at 66, 657 N.W.2d 721.

***4** Finally, Sturgis Hospital made no representations that would lead plaintiff to reasonably believe that the radiologists were its agents. See *VanStelle v. Macaskill,* 255 Mich.App. 1, 14, 662 N.W.2d 41 (2003). There is no evidence, other than plaintiff's conclusory statements that he "believed that the radiology department of Sturgis Hospital was part of the hospital and that its staff, including technicians and radiologists, were part of the hospital." *Quinto, supra* at 371-372, 547 N.W.2d 314 (mere conclusory allegations that are devoid of detail are insufficient to avoid summary disposition under MCR 2.116(C)(10)). Ultimately, we conclude that Sturgis Hospital was entitled to judgment as a matter of law, because the evidence failed to demonstrate a genuine issue of material fact. *Franchino, supra* at 181, 687 N.W.2d 620.

Because this issue is dispositive, we need not address Sturgis Hospital's remaining issues on appeal.

Reversed and remanded for entry of an order granting summary disposition in favor of Sturgis Hospital. We do not retain jurisdiction.

All Citations

Not Reported in N.W.2d, 2008 WL 5197155

Footnotes

1 Plaintiff has settled all claims with respect to Dr. Edward Griffin, Dr. John Kirkpatrick, and their professional corporations, and dismissed the ostensible agency claims against Sturgis Hospital with respect to these doctors' alleged liabilities. Dr. Thomas Brenner has been dismissed from the action. Similarly, Dr. Ahuja, Dr. Albeer, and Dr. Randonovich and their respective professional corporations have been dismissed for want of service. All that remains are the ostensible agency claims against Sturgis Hospital concerning three subsequent treating radiologists, Dr. Ahuja, Dr. Albeer, and Dr. Randonovich.

2 Neither Dr. Ahuja, Dr. Albeer, nor Dr. Randonovich were attending radiologists or radiology providers to the inpatient plaintiff.

2006 WL 171514
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Court of Appeals of Michigan.

Winston MITEEN, Plaintiff-Appellee,
v.
GENESYS REGIONAL MEDICAL CENTER, Defendant-Appellant,
and
JOHN TOLFREE HEALTH SYSTEM CORP, d/b/a West Branch Regional Medical Center, Dr. Roger Black, Dr. Stewart Weiner, Dr. Mark Rittenger, Dr. Scott Garner, and Dr. Alan Ippolito, Defendants.

No. 262410.
|
Jan. 24, 2006.

Before: CAVANAGH, P.J., and HOEKSTRA and MARKEY, JJ.

[UNPUBLISHED]

PER CURIAM.

***1** Defendant, Genesys Regional Medical Center ("Genesys"), appeals by leave granted from an order denying its motion for summary disposition. We reverse.

Defendant argues that the trial court erred by ruling that an issue of material fact exists with respect to plaintiff's vicarious liability claim against Genesys based on ostensible agency. We agree.

This Court reviews a trial court's decision on a motion for summary disposition de novo. *Spiek v. Dep't of Transportation,* 456 Mich. 331, 337; 572 NW2d 201 (1998). A motion brought under MCR 2 .116(C)(10) tests the factual support for a claim. *Id.* When deciding a motion for summary disposition, a court must consider the entire record in a light most favorable to the nonmoving party. *Corley v. Detroit Bd of Ed,* 470 Mich. 274, 278; 681 NW2d 342 (2004). The court properly grants a motion for summary disposition under MCR 2.116(C)(10) when the proffered evidence fails to establish a genuine issue regarding any material fact and the moving party is entitled to judgment as a matter of law. *Id.*

Plaintiff alleges that Genesys is vicariously liable for the acts of the individually named doctors. The trial court ruled:
... looking at the evidence in the light most favorable to the plaintiff, as I must do in this motion, I find that there is at the very least a fact question on the issue of whether or not Mr. Miteen had a reasonable belief. The use of the phrase reasonable belief is a clear invitation to a jury resolution or a fact finder resolution. That applies ... to Genesys....

"Generally speaking, a hospital is not vicariously liable for the negligence of a physician who is an independent contractor and merely uses the hospital's facilities to render treatment to his patients." *Grewe v. Mt Clemens General Hosp,* 404 Mich. 240, 250; 273 NW2d 429 (1978); see also *Chapa v. St Mary's Hospital,* 192 Mich.App 29, 33-34; 480 NW2d 590 (1991). Here, it is undisputed that the individual treating physicians were not employees of Genesys.

However, our Supreme Court acknowledged in *Wilson v. Stilwill,* 411 Mich. 587, 609-610; 309 NW2d 898 (1981), that a hospital may be liable for the acts of medical personnel who are the hospital's ostensible agents when a plaintiff looks to the hospital for treatment and does not merely view the hospital as the location where his physician will treat him. For plaintiff to prove his ostensible agency theory, he must show that he dealt with the physician with a reasonable belief in the physician's authority as an agent of the hospital, that his belief was generated by an act or neglect on the part of the hospital, and that he was not guilty of negligence. *Zdrojewski v. Murphy,* 254 Mich.App 50, 66; 657 NW2d 721 (2002). Thus, when an independent doctor-patient relationship exists before the patient's admission to a hospital, a finding of ostensible agency is generally precluded unless the acts or omissions of the hospital override the impressions created by the preexisting relationship to create a reasonable belief that the doctor is an agent of the hospital. *Id.; Chapa, supra* at 33-34.

***2** The record presented to this Court indicates that the only basis for plaintiff's belief that the doctors were employees of Genesys was the fact that they were present and working at the hospital. Nevertheless, plaintiff argues that because he was transferred to Genesys without knowledge of who his treating physician would be at that hospital, Genesys is liable under an ostensible agency theory of liability, i.e., plaintiff "looked to" Genesys for treatment. Plaintiff, however, relies primarily on his counsel's recitation of the facts at the summary disposition hearing, with virtually no citation to the lower court record. Plaintiff devotes significant effort explaining his erroneous belief that the doctors who treated him at Genesys were agents of Genesys was reasonable. But, his brief cites no evidence supporting the second element of ostensible agency: that his belief was generated by an act or neglect on the part of the hospital. *Zdrojewski, supra* at 66.

Plaintiff's deposition testimony demonstrates that neither Genesys nor the doctors who treated him there comported themselves in any manner to create his belief that these treating physicians were employees of Genesys. To the contrary, when plaintiff was asked during his deposition about what he recalled about being at Genesys, he candidly testified, "not very much." Plaintiff offers no evidence that Genesys' actions or neglect generated his purported belief that his treating physicians were employees of Genesys. Therefore, plaintiff's ostensible agency theory of vicarious liability fails as a matter of law. "Simply put, defendant, as putative principal, must have done something that would create in [plaintiff's] mind the reasonable belief that [the individual doctor] was acting on behalf of defendant." *Chapa, supra* at 33-34. "Apparent authority must be traceable to the principal and cannot be established only by the acts and conduct of the agent." *Alar v. Mercy Mem Hosp,* 208 Mich.App 518, 528; 529 NW2d 318 (1995). The trial court should have granted Genesys summary disposition. MCR 2.116(C)(10). Because resolution of this issue in Genesys' favor resolves plaintiff's action against Genesys, we need not address the remaining issues Genesys raises on appeal.

We reverse and remand for entry of judgment for defendant. We do not retain jurisdiction.

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UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

UNPUBLISHED
Court of Appeals of Michigan.

ESTATE OF Keith WIEGAND, BY Mary WIEGAND, Personal Representative, Plaintiff–Appellee,
v.
Hiroshi YAMASAKI, M.D., Eastside Cardiovascular Medicine, PC, Kishan K. Jasti, M.D., and Osama N. Nunu, M.D., Defendants,
and
St. John Hospital and Medical Center, Defendant–Appellant.

No. 334598
|
December 19, 2017

Macomb Circuit Court, LC No. 2014–002700–NH

Before: Talbot, C.J., and Borrello and Riordan, JJ.

Opinion

Per Curiam.

***1** In this medical malpractice action, defendant[1] appeals by leave granted[2] the trial court's order denying defendant's motion for summary disposition pursuant to MCR 2.116(C)(10). We reverse and remand for entry of an order granting that motion.

I. FACTS AND PROCEDURAL HISTORY

The decedent went to defendant hospital's emergency room complaining of shortness of breath. He was admitted and treated by three doctors who plaintiff alleges were negligent, and ultimately caused the decedent's death. The decedent's wife, on behalf of his estate, sued defendant hospital on a theory of vicarious liability arising out of the doctors' alleged negligence. Because the doctors were not employees or actual agents of defendant hospital, plaintiff argued ostensible agency as grounds for vicarious liability. Defendant moved the trial court for summary disposition pursuant to MCR 2.116(C)(10), arguing that plaintiff failed to provide any evidence of ostensible agency. The trial court denied that motion and this appeal followed.[3]

II. OSTENSIBLE AGENCY

Defendant argues that the trial court improperly denied its motion for summary disposition as there was no genuine issue of material fact regarding the existence of an ostensible agency. We agree.

A. STANDARD OF REVIEW AND APPLICABLE LAW

"This Court [ ] reviews de novo decisions on motions for summary disposition brought under MCR 2.116(C)(10)." *Pace v. Edel–Harrelson*, 499 Mich. 1, 5; 878 N.W.2d 784 (2016). A motion for summary disposition pursuant to MCR 2.116(C)(10) "tests the factual sufficiency of the complaint." *Joseph v. Auto Club Ins. Assoc.*, 491 Mich. 200, 206; 815 N.W.2d 412 (2012). "In evaluating a motion for summary disposition brought under this subsection, a trial court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties, MCR 2.116(G)(5), in the light most favorable to the party opposing the motion." *Maiden v. Rozwood*, 461 Mich. 109, 120; 597 N.W.2d 817 (1999). Summary disposition is proper where there is no "genuine issue regarding any material fact." *Id.* "A reviewing court may not employ a standard citing the mere possibility that the claim might be supported by evidence produced at trial. A mere promise is insufficient under our court rules." *Bennett v. Detroit Police Chief*, 274 Mich. App. 307, 317; 732 N.W.2d 164 (2006).

In Michigan, liability will typically be imposed "upon a defendant only for his or her own acts of negligence, not the tortious conduct of others." *Laster v. Henry Ford Health Sys.*, 316 Mich. App. 726, 734; 892 N.W.2d 443 (2016). "However, an exception exists under the theory of respondeat superior, wherein an employer may be liable for the negligent acts of its employee if the employee was acting within the scope of his employment." *Id.* Consequently, "[g]enerally speaking,

a hospital is not vicariously liable for the negligence of a physician who is an independent contractor and merely uses the hospital's facilities to render treatment to his patients." *Grewe v. Mount Clemens Gen. Hosp.*, 404 Mich. 240, 250; 273 N.W.2d 429 (1978). "However, if the patient looked to the hospital to provide medical treatment and the hospital made a representation that medical treatment would be afforded by physicians working at the hospital, an agency by estoppel may be found." *VanStelle v. Macaskill*, 255 Mich. App. 1, 8; 662 N.W.2d 41 (2003). "Agency by estoppel" is often referred to as "ostensible agency." *Chapa v. St. Mary's Hosp. of Saginaw*, 192 Mich. App. 29, 31; 480 N.W.2d 590 (1991).

***2** In considering whether an ostensible agency exists, the Michigan Supreme Court has held that "the critical question is whether the plaintiff, at the time of his admission to the hospital, was looking to the hospital for treatment of his physical ailments or merely viewed the hospital as the situs where his physician would treat him for his problems." *Grewe*, 404 Mich. at 251. While that is the critical question, this Court has clarified that it is not the *only* question. See *Chapa*, 192 Mich. App. at 32–33. Indeed, this Court has ruled that "[n]othing in *Grewe* indicates that a hospital is liable for the malpractice of independent contractors merely because the patient 'looked to' the hospital at the time of admission or even was treated briefly by an actual nonnegligent agent of the hospital." *Id.* at 33.

> Those principles have been distilled into the following three elements that are necessary to establish the creation of an ostensible agency: (1) the person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one, (2) the belief must be generated by some act or neglect on the part of the principal sought to be charged, and (3) the person relying on the agent's authority must not be guilty of negligence. [*Id.* at 33–34.]

"The reasonableness of the patient's belief in light of the representations and actions of the hospital is the 'key test' embodied in *Grewe*." *Id.* at 34. "Agency 'does not arise merely because one goes to a hospital for medical care. There must be some action or representation by the principal (hospital) to lead the third person (plaintiff) to reasonably believe an agency in fact existed.' " *VanStelle*, 255 Mich. App. at 11, quoting *Sasseen v. Community Hosp. Foundation*, 159 Mich. App. 231, 240; 406 N.W.2d 193 (1986). "Simply put, defendant, as putative principal, must have done something that would create in [the patient's] mind the reasonable belief that [the doctors] were acting on behalf of defendant." *Chapa*, 192 Mich. App. at 34. "[T]he fact that a doctor used a hospital's facilities to treat a patient is not sufficient to give the patient a reasonable belief that the doctor was an agent of the hospital." *VanStelle*, 255 Mich. App. at 11.

B. ANALYSIS

Considering the evidence in the light most favorable to plaintiff, as we must, the record shows that the decedent sought emergency care from defendant and did not have an established doctor-patient relationship with any of the three allegedly negligent doctors. After complaining of shortness of breath in the emergency room, the decedent was admitted to defendant hospital and treated by the three doctors. There is nothing in the record to suggest that the decedent had some role in choosing his treating doctors. Before being treated, the decedent's wife signed a consent to treat agreement on the decedent's behalf, which contained a clause stating that some doctors at defendant hospital were independent contractors rather than employees.

Assuming without deciding that the decedent reasonably believed that the allegedly negligent doctors were agents or employees of defendant, summary disposition was required because plaintiff failed to provide any evidence that defendant made any action or was negligent in any manner that would have caused the decedent's belief. See *Chapa*, 192 Mich. App. at 34. In order to establish ostensible agency, plaintiff is required to present evidence that defendant did "something that would create in [the decedent's] mind the reasonable belief that [the doctors] were acting on behalf of defendant." *Id.* Evidence that the decedent looked to defendant for treatment of his maladies, did not have a previous relationship with the doctors, and was treated at defendant hospital was not enough to satisfy the requirements for ostensible agency announced in *Grewe*, 404 Mich. at 250–251, and clarified in *Chapa*, 192 Mich. App. at 33–34. Instead, plaintiff was required to provide evidence of "some action or representation by [defendant] to lead [the decedent] to reasonably believe an agency in fact existed." *VanStelle*, 255 Mich. App. at 11 (internal quotation marks omitted). Considering that the record lacks any such evidence here, the trial court erred when it denied defendant's motion for summary disposition. See *Id.*[4]

III. CONCLUSION

***3** Regardless of whether the decedent reasonably believed that the doctors were agents or employees of defendant,

summary disposition was required because plaintiff failed to provide evidence of "some action or representation by [defendant] to lead [the decedent] to reasonably believe an agency in fact existed." *Id.* (internal quotation marks omitted). See also *Chapa*, 192 Mich. App. at 33–34.

Reversed and remanded for entry of an order granting defendant's motion for summary disposition. We do not retain jurisdiction.

All Citations

Not Reported in N.W. Rptr., 2017 WL 6502938

Footnotes

1 We use "defendant" to refer only to St. John Hospital and Medical Center because all other defendants have been dismissed from this action without prejudice and are not involved in this appeal.

2 *Estate of Wiegand v. Yamasaki*, unpublished order of the Court of Appeals, entered October 31, 2016 (Docket No. 334598) (SAAD, J., would have peremptorily reversed in lieu of granting leave to appeal).

3 We previously granted defendant's motion to stay the trial court proceedings pending this appeal.

4 A discharge summary report issued by defendant to the decedent in 2009, which indicated that the decedent should call Dr. Hiroshi Yamasaki for a follow-up, is not, in any way, sufficient to create a reasonable belief by the decedent that Dr. Yamaski's treatment of the decedent more than three years later in 2012 was performed as an agent or employee of defendant.

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2018 WL 3788365
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

UNPUBLISHED
Court of Appeals of Michigan.

Abigail SCHMITT, Plaintiff-Appellee,
v.
GENESYS REGIONAL MEDICAL CENTER, Defendant-Appellant,
and
Henry Hagenstein, D.O., PC, and Henry Hagenstein, D.O., Defendants.

No. 337619
|
August 9, 2018

Genesee Circuit Court, LC No. 15-105334-NH

Before: Riordan, P.J., and K. F. Kelly and Boonstra, JJ.

Opinion

Per Curiam.

***1** In this interlocutory appeal, defendant Genesys Regional Medical Center (Genesys)[1] appeals by leave granted[2] the trial court's order denying its motion for summary disposition in this medical malpractice action. We reverse and remand for entry of an order granting summary disposition in favor of defendant.

I. PERTINENT FACTS AND PROCEDURAL HISTORY

This medical malpractice case arises from Dr. Henry Hagenstein's alleged negligent treatment of plaintiff following a February 19, 2013 incident in which plaintiff was struck on the side of her face during a basketball game. Over the next few days, plaintiff began experiencing headaches and dizziness. She went to her primary care doctor, Dr. Antony Daros, with whom she had treated since she was five years old. Dr. Daros referred her to Dr. Hagenstein for a neurological evaluation. Plaintiff testified at her deposition that Dr. Daros described Dr. Hagenstein as "my neuro guy" and stated that he was "in Genesys" or "at Genesys." At some point after contacting Dr. Hagenstein for an appointment, plaintiff received an appointment form from Dr. Hagenstein's office, at the top of which was printed, "Genesys Regional Medical Center Health Park."[3] The form also listed Dr. Hagenstein's address as "3635 Genesys Parkway" in Grand Blanc. Plaintiff and her mother both testified that they did not look to Genesys to provide them with a neurologist, but rather to Dr. Daros, who referred them to Dr. Hagenstein by name. Plaintiff also stated that she would have gone to see Dr. Hagenstein even if he were affiliated with another hospital.

Dr. Hagenstein's office is located in a medical office building situated on the Genesys campus, not in the Genesys hospital. The campus has one sign directing traffic to the hospital and another directing traffic to the medical building. Dr. Hagenstein testified at his deposition that he was unsure whether there was any signage for his office in front of the medical building, but stated that his name is listed on the directory located on the first floor. Dr. Hagenstein has staff privileges at the hospital, but is not a Genesys employee. He rents office space for his practice from Genesys Regional Medical Center Health Park. Dr. Hagenstein does not wear a coat or other clothing with defendant's logo on it. Dr. Hagenstein does possess an identification badge with his name and that of "Genesys Regional Medical Center." The identification badge was issued by defendant to allow him, as part of his staff privileges, to enter the parking lot and access secured sections of the hospital. However, he does not wear the badge in his private practice, never showed plaintiff the badge, and did not introduce himself to plaintiff as a Genesys doctor.

***2** Dr. Hagenstein ordered medical tests and gave plaintiff an appointment form with the Genesys logo at the top. Dr. Hagenstein testified that he never sought permission to use that logo, and that, to his knowledge, defendant was neither aware that he used it nor had ever asked him to refrain from doing so. Dr. Hagenstein treated plaintiff only at his office and never treated her at the Genesys hospital. After an MRI revealed a lesion that could potentially cause a stroke, Dr. Hagenstein prescribed the statin drug "Simvastatin."

Plaintiff filed this medical malpractice action against Dr. Hagenstein, his corporation, and Genesys, alleging that Dr. Hagenstein had negligently prescribed Simvastatin and that the drug had caused extreme pain and weakness in her

leg muscles; she asserted that the other defendants were vicariously liable for Dr. Hagenstein's alleged negligence. Defendant filed a motion for summary disposition under MCR 2.116(C)(10), arguing that there was no genuine issue of material fact that Dr. Hagenstein was not an agent of Genesys. Plaintiff filed a response to the motion, arguing that it was reasonable for plaintiff and her mother to believe that Dr. Hagenstein was an agent of Genesys. Plaintiff claimed that she had relied on Dr. Daros' representation that Dr. Hagenstein was a "Genesys" doctor and on the fact that all the paperwork[4] reflected the word "Genesys" at the top. Plaintiff also indicated that she had relied on the fact that Dr. Hagenstein's identification badge states "Genesys Regional Medical Center" and on Dr. Hagenstein's testimony that he could "understand" why plaintiff believed that he was an agent of Genesys.

The trial court denied defendant's motion. The court noted that Dr. Daros had referred to Dr. Hagenstein as a "Genesys" doctor, that the appointment forms reflected the Genesys logo, that Dr. Hagenstein possessed an identification badge with that logo, and that signage outside Dr. Hagenstein's office also displayed the logo. The court also noted plaintiff's mother's testimony that she believed that Dr. Hagenstein was a "Genesys doctor" because Dr. Daros is a "Genesys doctor."[5]

As stated, this Court granted defendant's application for leave to appeal the trial court's order.

II. STANDARD OF REVIEW

We review de novo a trial court's ruling on a summary disposition motion. See *Johnson v. Recca*, 492 Mich. 169, 173; 821 N.W.2d 520 (2012). Defendant brought its motion for summary disposition under MCR 2.116(C)(10). "A motion under MCR 2.116(C)(10) tests the factual sufficiency of the complaint. In evaluating a motion for summary disposition brought under this subsection, a trial court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties, MCR 2.116(G)(5)." *Maiden v. Rozwood*, 461 Mich. 109, 120; 597 N.W.2d 817 (1999). "Where the proffered evidence fails to establish a genuine issue regarding any material fact, the moving party is entitled to judgment as a matter of law." *Id.* A genuine issue of material fact exists when, after viewing the evidence in a light most favorable to the nonmoving party, reasonable minds could differ on the issue. See *Allison v. AEW Capital Mgt., LLP*, 481 Mich. 419, 425; 751 N.W.2d 8 (2008).

III. ANALYSIS

***3** Defendant argues that the trial court erred by concluding that there was a genuine issue of material fact regarding whether Dr. Hagenstein was defendant's actual or apparent agent, and therefore by denying its motion for summary disposition. We agree.

"[I]n general, a hospital is not vicariously liable for the negligence of a physician who is an independent contractor and simply uses the hospital's facilities to provide treatment to his patients." *VanStelle v. Macaskill*, 255 Mich. App. 1, 8; 662 N.W.2d 41 (2003), citing *Grewe v. Mt. Clemens Gen. Hosp.*, 404 Mich. 240, 250; 273 N.W.2d 429 (1978). A medical facility may, however, "be vicariously liable for the malpractice of actual or apparent agents." *VanStelle*, 255 Mich. App. at 10, quoting *Chapa v. St. Mary's Hosp. of Saginaw*, 192 Mich. App. 29, 33; 480 N.W.2d 590 (1991). If a patient looked to the hospital for treatment, rather than viewed the hospital merely as the place where his physician would treat him, the hospital may be liable. *VanStelle*, 255 Mich. App. at 8, citing *Grewe*, 404 Mich. at 251.

The parties do not dispute that Dr. Hagenstein was not an actual employee of Genesys. The trial court's denial of defendant's motion was based on its conclusion that a factual issue existed regarding whether Dr. Hagenstein was an agent of Genesys. This Court has articulated a three-part test to determine whether a physician is an apparent or ostensible agent:

> [T]he following three elements ... are necessary to establish the creation of an ostensible agency: (1) the person dealing with the agent must do so with belief in the agent's authority and this belief must be a reasonable one, (2) the belief must be generated by some act or neglect on the part of the principal sought to be charged, and (3) the person relying on the agent's authority must not be guilty of negligence. [*VanStelle*, 255 Mich. App. at 10, quoting *Chapa*, 192 Mich. App. at 33-34.]

Regarding the second factor of the test, "the defendant as the putative principal must have done something that would create in the patient's mind the reasonable belief that the doctors were acting on behalf of the defendant hospital." *VanStelle*, 255 Mich. App. at 10.

> Agency "does not arise merely because one goes to a hospital for medical care. There must be some action or

> representation by the principal (hospital) to lead the third person (plaintiff) to reasonably believe an agency in fact existed." *Sasseen v. Community Hosp. Foundation*, 159 Mich. App. 231, 240; 406 N.W.2d 193 (1986). [*VanStelle*, 255 Mich. App. at 11.]

Defendant argues that there is no question of fact that it took no action and made no representation to convey that Dr. Hagenstein was its agent. We agree. Although Dr. Daros told plaintiff that Dr. Hagenstein was "a Genesys doctor," Dr. Daros did not speak for defendant, as there is no evidence that he was defendant's agent, or that plaintiff's mother's belief that Dr. Daros was a "Genesys doctor" was reasonable—as stated, the record is devoid of evidence linking Dr. Daros to defendant other than plaintiff's mother's bare statement that "all of our doctors are Genesys doctors." Defendant was entirely uninvolved in Dr. Daros's conversation with plaintiff. And although Dr. Hagenstein had an ID badge issued by defendant, he used this badge in the course of exercising his staff privileges at defendant's hospital, not in his private practice. Dr. Hagenstein never showed plaintiff the badge or treated her at defendant's hospital. Dr. Hagenstein used defendant's logo on his appointment forms, but he testified that he had not asked permission from defendant to do so. None of the above facts raise a genuine issue of material fact regarding whether defendant did something to make plaintiff believe that Dr. Hagenstein was its agent.

***4** Further, while Dr. Hagenstein's practice is located on defendant's campus, and Dr. Hagenstein possessed staff privileges at defendant's hospital, "[t]he sole fact that a defendant hospital's facilities were used by an alleged negligent physician is insufficient to create the appearance of an agency relationship between the defendant hospital and the physician." *VanStelle*, 255 Mich. App. at 12. Thus, the location of Dr. Hagenstein's office is insufficient to create an appearance of agency, as are the maps, signs, and directory entries that merely aid patients in locating his office.

Plaintiff argues that defendant could also create the appearance of agency by omission, i.e., by failing to take certain actions that would have informed patients that Dr. Hagenstein was not an agent of defendant. However, the cases cited by plaintiff on this point are factually distinguishable because the plaintiffs in those cases were referred to a defendant hospital or an entity that provided specific services within the hospital, who then assigned them a treating physician; they were not referred to a specific physician with a private practice and staff privileges at a defendant hospital. See *Grewe*, 404 Mich. at 254-255 ("We are convinced, as the jury must have been, that the plaintiff, when he entered the hospital, was seeking treatment from the hospital itself.... It is abundantly clear on the strength of this record that the plaintiff looked to defendant hospital for his treatment and was treated by medical personnel who were the ostensible agents of defendant hospital.")[6] In those cases, the question was whether a plaintiff who had been admitted to a hospital looked to the hospital for treatment of his physical ailments or merely viewed the hospital as the situs where his physician would treat him for his problems. In this case, by contrast, plaintiff was never admitted to defendant's hospital, was referred to Dr. Hagenstein specifically, and was treated by him at his office, rather than defendant's hospital. These cases thus do not aid plaintiff's argument.

Further, even viewed in the light most favorable to plaintiff, defendant's conduct in failing to prevent plaintiff from forming the impression that Dr. Hagenstein was an agent of defendant was not negligent. See *VanStelle*, 255 Mich. App. at 10, quoting *Chapa*, 192 Mich. App. at 33-34 (noting that "the belief must be generated by some act or neglect on the part of the principal sought to be charged ...."). Dr. Hagenstein testified, and this testimony was not rebutted, that he never asked defendant's permission to use its logo on his appointment forms. Nor did Dr. Hagenstein ever show plaintiff his ID badge from defendant, rendering it irrelevant whether defendant should have indicated on the badge that Dr. Hagenstein was *not* an employee. We find plaintiff's argument that defendant created the appearance of agency by omission to be unpersuasive.

Given our resolution of the issue of whether defendant intentionally or negligently generated the alleged belief that Dr. Hagenstein was its agent, we do not address whether any such belief was reasonable.[7] The trial court erred by denying defendant's motion for summary disposition.

***5** Reversed and remanded for entry of an order granting summary disposition in favor of defendant. We do not retain jurisdiction.

All Citations

Not Reported in N.W. Rptr., 2018 WL 3788365

Footnotes

1 Defendants Henry Hagenstein, D.O., P.C. and Henry Hagenstein, D.O. are not parties to this appeal. We sometimes use "defendant" in this opinion to refer to Genesys.

2 *Schmitt v. Genesys Regional Med. Ctr.*, unpublished order of the Court of Appeals entered August 16, 2017 (Docket No. 337619).

3 Plaintiff and her mother referred to the appointment form attached to plaintiff's response to defendant's motion for summary disposition as a "follow-up form" that they received after plaintiff's initial appointment with Dr. Hagenstein. Plaintiff's mother also stated in her deposition that she believed she had received a similar form from Dr. Hagenstein's office when she made the initial appointment.

4 Although the record only contains an appointment form used by Dr. Hagenstein with the Genesys logo on it, plaintiff's mother testified at her deposition that the logo was on "any kind of paperwork or appointment card" that she received from Dr. Hagenstein and that she believed, although she was not sure, that the logo was on the "initial paperwork."

5 None of the correspondence or medical records contained in the lower court record that refer to Dr. Daros or his practice indicate that he is affiliated with or employed by defendant. Defendant has denied employing Dr. Daros. It is not clear how plaintiff's mother formed the belief that Dr. Daros was a "Genesys doctor;" she merely testified that "all of our doctors are Genesys doctors." In any event, the record does not contain any evidence supporting her belief.

6 Plaintiff also cites to an unpublished decision of this Court that is similarly distinguishable. Unpublished decisions of this Court are not, in any event, binding on future panels of this Court. MCR 7.215(C)(1).

7 We note, however, that both plaintiff and her mother testified that they did not look to defendant to be provided with a physician. This would appear to undercut their reliance, however reasonable, on any perceived status of Dr. Hagenstein as an agent of defendant. See *VanStelle*, 255 Mich. App. at 8, citing *Grewe*, 404 Mich. at 251.