STATE OF MICHIGAN

IN THE SUPREME COURT

SARON E. MARQUARDT, Personal Representative of the ESTATE OF SANDRA MARQUARDT (Dec.)	Supreme Court Case No. 160772
Plaintiff-Appellant,	Court of Appeals Case No. 343248
v.	Washtenaw County Case No. 12-621-NH
VELLAIAH DURAI UMASHANKAR, M.D.,	Hon. David S. Swartz
Defendant-Appellee.	

APPENDIX OF EXHIBITS IN SUPPORT OF DEFENDANT-APPELLEE VELLAIAH DURAI UMASHANKAR, M.D.'S SUPPLEMENTAL BRIEF

Volume I

Exhibit 1

Register of Actions
Case No. 12-000621-NH

Marquardt, Saron E-Pr vs Umashankar, Vellaiah Durai

§
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§
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§
§

Case Type: **Medical Malpractice (NH)**
Date Filed: **06/07/2012**
Location: **Civil**
Judicial Officer: **Swartz, David S.**
eNACT Case Number: **GCW-2012-0000621**

Party Information

		Attorneys
Plaintiff	**Marquardt, Sandra D-Estate Of**	
Plaintiff	**Marquardt, Saron E-Pr**	**Thomas C Miller** *Retained* (248) 210-3211(W)

Events & Orders of the Court

DISPOSITIONS

11/21/2013 **Final - Dismissed Other**

OTHER EVENTS AND HEARINGS

06/07/2012 **Entry fee assessed**
Comment: Entry fee assessed cfff 119.00 ccgf 31.00 00000000
Amount: 150.00

06/07/2012 **Payment received**
Comment: Payment received receipt # - 00248131
Amount: 150.00

06/07/2012 **Complaint filed summons issued**
Comment: Complaint & affidavit of merit fd(summ iss)

07/16/2012 **Payment received**
Comment: Payment received receipt # - 00250169
Amount: 20.00

07/16/2012 **Motion**
Comment: Motion for summary disposition fd
Amount: 20.00

07/16/2012 **Notice of hearing filed**
Comment: Notice of hearing filed

07/16/2012 **Brief in support filed**
Comment: Brief in support fd

07/16/2012 **Proof of service filed**
Comment: Proof of service fd

08/02/2012 **Proof of service filed**
Comment: Proof of service fd

08/02/2012 **Answer filed**
Comment: Answer to deft hafts motion for summary disposition fd

08/02/2012 **Brief in support filed**
Comment: Brief in support fd

08/06/2012 **Reply to**
Comment: Reply in support of motion for summary disposition fd HAFT, JONATHAN

08/06/2012 **Proof of service filed**
Comment: Proof of service fd

08/08/2012 **Motion heard/under adv/op to follow (type)**
Comment: Def motion heard/under adv/written op to follow (swartz/cc3/digital/ angelocci cer7901)

08/08/2012 **Motion for Summary Disposition** (1:30 PM) (Judicial Officer Judge, Historical)
EXTENSION_COUNT: 0001 Directive: DEF JONATHAN HAFT/
Result: EVENT HELD AS SCHEDULED

08/21/2012 **Payment received**
Comment: Payment received receipt # - 00252287
Amount: 20.00

08/21/2012 **Motion**
Comment: Motion to extend summons expiration date fd
Amount: 20.00

08/21/2012 **Notice of hearing filed**
Comment: Notice of hearing fd

08/21/2012 **Proof of service filed**
Comment: Proof of service fd

08/24/2012 **Renotice of hearing filed**

Comment: Revised notice of hearing fd

08/24/2012 **Proof of service filed**
Comment: Proof of service fd

09/12/2012 **Motion not hrd/praecipe dism/nothing on record**
Comment: Motion not hrd/praecipe dism/nothing on record

09/12/2012 *CANCELED* **Motion Hearing** (1:30 PM) (Judicial Officer Judge, Historical)
Cancel
EXTENSION_COUNT: 0001 Directive: PLTF/ TO EXTEND SUMMONS

09/20/2012 **Order**
Comment: Order fd(sgd 09/17/2012)(see order)

09/20/2012 **Summons issued - exp**
Comment: Summons issued - exp 03/18/2013

11/15/2012 **Supplemental Document**
Comment: Supplemental brief in support fd

11/15/2012 **Proof of service filed**
Comment: Proof of service fd

11/29/2012 **Brief in support filed**
Comment: Supplemental brief in support fd

11/29/2012 **Proof of service filed**
Comment: Proof of service fd

02/19/2013 **Order granting motion**
Comment: Order granting deft hafts motion for summary disposition & dismissing pltfs claims against deft haft only with prejudice/proof of service fd(sgd 02/19/2013)(mf 02/27/13 pg 27241-46)

03/05/2013 **Payment received**
Comment: Payment received receipt # - 00262005
Amount: 20.00

03/05/2013 **Motion**
Comment: Motion for substituted service fd
Amount: 20.00

03/05/2013 **Notice of hearing filed**
Comment: Notice of hearing filed

03/13/2013 **Summons issued - exp**
Comment: Summons issued/order fd (sgd 03 13 13) - exp 04 10 13

03/13/2013 **Adjourned (what adjourned to when)**
Comment: Pltf motion for substituted service heard & adjourned to 3/20/13 @ 1:30 p.m./summons extended 30 days/(cc3/swartz/digital/e streeter ceo 8526)

03/13/2013 **Motion Hearing** (1:30 PM) (Judicial Officer Judge, Historical)
EXTENSION_COUNT: 0001 Directive: PLTF/ SUBSTITUTED SERVICE
Result: ADJ. BY COURT

03/20/2013 **Adjourned (what adjourned to when)**
Comment: Pltf motion for substituted service adjourned to 4/3/13 @ 1:30 p.m.

03/20/2013 **Motion Hearing** (1:30 PM) (Judicial Officer Judge, Historical)
EXTENSION_COUNT: 0002 Directive: PLTF/ SUBSTITUTED SERVICE Notes: ADJ 3/13
Result: ADJ. BY PLAINTIFF

03/28/2013 **Notice of hearing filed**
Comment: Notice of hearing filed

03/28/2013 **Proof of service filed**
Comment: Proof of service fd

03/28/2013 **Response to**
Comment: Response to plaintiff's motion for substituted service fd

04/02/2013 **Proof of service filed**
Comment: Proof of service fd

04/02/2013 **Reply to**
Comment: Reply brief fd

04/03/2013 **Plaintiffs motion**
Comment: Plaintiffs motion for substituted service denied/court granted extention of summons to 09/15/13/order signed(swartz/cc#3/ digital/cjones ceo8134)

04/03/2013 **Order**
Comment: Order regarding motion fd (sgd 04 03 13)(motion for extension of summons granted/new summons be issued until 09 15 13)

04/03/2013 **Motion Hearing** (1:30 PM) (Judicial Officer Judge, Historical)
EXTENSION_COUNT: 0002 Directive: PLTF/ SUBSTITUTED SERVICE Notes: ADJ 3/13; 3/20
Result: MOTION HEARD - DENIED

07/10/2013 **Event notice generated**
Comment: Event notice generated, miller, thomas c , #03539017

07/25/2013 **Scheduling conference held**
Comment: Scheduling conference not held/adjourned to: september 26, 2013 at 11:20am

07/25/2013 **Settlement Conference** (11:20 AM) (Judicial Officer Judge, Historical)
*EXTENSION_COUNT: 0001 Directive: **SET PER JB***
Result: ADJ. BY COURT

07/29/2013 **Event notice generated**
Comment: Event notice generated, miller, thomas c , #03541331

09/05/2013 **Appearance by attorney filed**
Comment: Appearance by attorney filed

09/05/2013 **Proof of service filed**
Comment: Proof of service fd

09/26/2013 **Scheduling conference**
Comment: Scheduling conference not held/summons expired on 09/15/13/dismiss for lack of service

09/26/2013 **Settlement Conference** (11:20 AM) (Judicial Officer Judge, Historical)
*EXTENSION_COUNT: 0004 Directive: **SET PER JB** Notes: **NOTICE FOR THOMAS MILLER RETURNED FOR INCORRECT Notes: ADDRESS** Notes: ADJ 7/25*
Result: EVENT CANCEL BY COURT

09/30/2013 **Payment received**
Comment: Payment received receipt # - 00272737
Amount: 20.00

09/30/2013 **Motion**
Comment: Motion for summary disposition fd
Amount: 20.00
09/30/2013 **Notice of hearing filed**
Comment: Notice of hearing filed
09/30/2013 **Brief in support filed**
Comment: Brief in support fd
09/30/2013 **Proof of service filed**
Comment: Proof of service fd
10/24/2013 **Answer to motion**
Comment: Answer to motion for summary disposition fd
10/24/2013 **Brief in support filed**
Comment: Brief in support of answer fd
10/24/2013 **Proof of service filed**
Comment: Proof of service fd
10/29/2013 **Reply to**
Comment: Reply in support of defendant vellaiah durai umashankar md's motion for summary disposition fd
10/30/2013 **Defendants motion**
Comment: Defendants motion for summary disposition heard and granted/order to be submitted (cc#3/swartz/digital/n.edmonds cer 6809)
10/30/2013 **Motion for Summary Disposition** (1:30 PM) (Judicial Officer Judge, Historical)
EXTENSION_COUNT: 0001 Directive: DEF/ SUMMARY DISPOSITION
Result: MOTION HEARD - GRANTED
11/05/2013 **Notice of Submission - Copy of Order - Proof of Service**
Comment: Not submission/order (copy)/pr of serv 11/04/2013 fd UMASHANKAR, VELLAIAH DURAI
11/21/2013 **Final-dismissed other by court**
Comment: Final-dismissed other by court
11/21/2013 **Order**
Comment: Order granting defendant vellaiah durai umashankar md's motion for summary disposition and dismissing the case with prejudice fd (sgd 11 19 13) mf 12/06/13 (pg 44341-44342)
12/13/2013 **Payment received**
Comment: Payment received receipt # - 00276714
Amount: 25.00
12/13/2013 **Payment received**
Comment: Payment received receipt # - 00276716
Amount: 6.00
12/13/2013 **Claim of appeal filed**
Comment: Claim of appeal fd
Amount: 25.00
01/23/2014 **Payment received**
Comment: Payment received receipt # - 00278328
Amount: 15.00
01/23/2014 **Payment received**
Comment: Payment received receipt # - 00278329
Amount: 3.50
02/27/2014 **Notice**
Comment: Notice of filing of transcript and affidavit of mailing fd
02/27/2014 **Transcript**
Comment: Transcript of audiotape held on 10/30/14 fd
07/23/2014 **Request from court of appeals re sub of file filed**
Comment: Request from court of appeals re sub of file fd
07/23/2014 **Notice of trans record to court of appeals filed**
Comment: Notice of trans record to court of appeals fd
07/23/2014 **File sent to court of appeals/attorneys notified**
Comment: File sent to court of appeals/attorneys notified
07/23/2014 **Clerks notation - type in**
Comment: Clerks notation - 2 files sent
10/27/2014 **Entire File**
#1 4/7/12 to 9/5/13
10/27/2014 **Entire File**
#2 2/27/14 to 7/23/14
03/30/2015 **Order**
Court of Appeals Affirmed
05/28/2015 **Notice**
of filing application for leave to appeal
10/04/2017 **Copy of Supreme Court Order**
12/18/2017 **Notice of Motion Hearing and Proof of Service**
12/18/2017 **Motion for Summary Disposition**
01/04/2018 **Proof of Service**
01/04/2018 **Answer**
To Defendant Vellaiah Durai Umashankar M.D.'s post- remand motion for summary disposition
01/08/2018 **Proof of Service**
01/08/2018 **Reply**
in support of post-remand motion for summary disposition
01/10/2018 **Motion for Summary Disposition** (1:30 PM) (Judicial Officer Swartz, David S.)
Deft/ Motion for Summary Disposition
Parties Present
Result: Held
03/16/2018 **Order**
granting Defendant's post-remand motion for summary disposition (sgd 03 15 18)
04/10/2018 **Claim of Appeal (not new filing)**
08/15/2018 **Transcript**
of motion hearing held on 01 10 18
08/15/2018 **Notice of Filing of Transcript and Affidavit of Mailing**

02/08/2019	**File Sent**
	paperless file sent to court of appeals
02/25/2019	**Notice of Transmission of Record on Appeal to Ct of Appeals**
11/26/2019	**Copy of Court of Appeals Order**
01/29/2020	**Application**
	For leave to appeal
01/29/2020	**Proof of Service**

Financial Information

Plaintiff Marquardt, Saron E-Pr

	Total Financial Assessment			349.50
	Total Payments and Credits			349.50
	Balance Due as of 08/06/2020			**0.00**
06/07/2012	Transaction Assessment			150.00
06/07/2012	Payment Over the Counter	Receipt # 00248131	MILLER, THOMAS C	(150.00)
07/16/2012	Transaction Assessment			20.00
07/16/2012	Payment Over the Counter	Receipt # 00250169	MCLAIN, PATRICK	(20.00)
08/21/2012	Transaction Assessment			20.00
08/21/2012	Payment Over the Counter	Receipt # 00252287	MILLER, THOMAS C	(20.00)
03/05/2013	Transaction Assessment			20.00
03/05/2013	Payment Over the Counter	Receipt # 00262005	MILLER, THOMAS C	(20.00)
09/30/2013	Transaction Assessment			20.00
09/30/2013	Payment Over the Counter	Receipt # 00272737	KERR RUSSELL AND WEBER	(20.00)
12/13/2013	Transaction Assessment			25.00
12/13/2013	Payment Over the Counter	Receipt # 00276714	THOMAS MILLER	(25.00)
12/13/2013	Transaction Assessment			6.00
12/13/2013	Payment Over the Counter	Receipt # 00276716	THOMAS MILLER	(6.00)
01/23/2014	Transaction Assessment			18.50
01/23/2014	Payment Over the Counter	Receipt # 00278328	THOMAS MILLER	(15.00)
01/23/2014	Payment Over the Counter	Receipt # 00278329	THOMAS MILLER	(3.50)
05/28/2015	Transaction Assessment			25.00
05/28/2015	Payment Received By Mail	Receipt # CC-2015-7068	Miller, Thomas C.	(25.00)
12/18/2017	Transaction Assessment			20.00
12/18/2017	Payment Received By Mail	Receipt # CC-2017-17009	Umashankar, Vellaiah Durai	(20.00)
04/10/2018	Transaction Assessment			25.00
04/10/2018	Payment Received By Mail	Receipt # CC-2018-5118	Miller, Thomas C.	(25.00)

Case Search

Case Docket Number Search Results - 343248

Appellate Docket Sheet

COA Case Number: 343248

MSC Case Number: 160772

ESTATE OF SANDRA D MARQUARDT V VELLAIAH DURAI UMASHANKAR MD

1	MARQUARDT SANDRA D ESTATE OF	ZZ		
2	MARQUARDT SARON E PERSONAL REPRESENTATIVE Oral Argument: Y Timely: Y	PL-AT	RET	(17786) **MILLER THOMAS C**
3	UMASHANKAR VELLAIAH DURAI MD Oral Argument: Y Timely: Y	DF-AE	RET	(33594) **SWANSON JOANNE GEHA**

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

04/05/2018 1 Claim of Appeal - Civil
- Proof of Service Date: 04/05/2018
- Jurisdictional Checklist: Y
- Register of Actions: Y
- Attorney: 17786 - MILLER THOMAS C

03/16/2018 2 Order Appealed From
- From: WASHTENAW CIRCUIT COURT
- Case Number: 12-000621-NH
- Trial Court Judge: 22850 SWARTZ DAVID SCOTT
- Nature of Case:
  - Summary Disposition Granted
- Comments: order signed 3/15/18 entered in register of actions 3/16/18

04/05/2018 3 Other
- For Party: 2 MARQUARDT SARON E PERSONAL REPRESENTATIVE PL-AT
- Attorney: 17786 - MILLER THOMAS C
- Comments: 1/10/18 transcript has been requested

04/05/2018 4 Docketing Statement MCR 7.204H
- For Party: 2 MARQUARDT SARON E PERSONAL REPRESENTATIVE PL-AT
- Proof of Service Date: 04/05/2018
- Filed By Attorney: 17786 - MILLER THOMAS C

04/16/2018 5 Appearance - Appellee
- Date: 04/16/2018
- For Party: 3 UMASHANKAR VELLAIAH DURAI MD DF-AE
- Attorney: 33594 - SWANSON JOANNE GEHA

04/25/2018 6 Invol Dismissal Warning - No Steno Cert
- Attorney: 17786 - MILLER THOMAS C
- Due Date: 05/16/2018

05/14/2018 7 Steno Certificate - Tr Request Received
- Date: 05/11/2018
- Timely: Y
- Reporter: 7118 - TRASKOS SANDRA J
- Hearings:

01/10/2018

08/14/2018 8 Transcript Overdue - Notice to Reporter
Mail Date: 08/14/2018
Reporter: 7118 - TRASKOS SANDRA J
Comments: 1/10/18

08/14/2018 9 Notice Of Filing Transcript
Date: 08/14/2018
Reporter: 7118 - TRASKOS SANDRA J
Hearings:
01/10/2018

10/09/2018 10 Stips: Extend Time - AT Brief
Extend Until: 11/06/2018
Filed By Attorney: 17786 - MILLER THOMAS C
For Party: 2 MARQUARDT SARON E PERSONAL REPRESENTATIVE PL-AT
P/S Date: 10/09/2018

11/05/2018 11 Motion: Extend Time - Appellant
Proof of Service Date: 11/05/2018
Filed By Attorney: 17786 - MILLER THOMAS C
For Party: 2 MARQUARDT SARON E PERSONAL REPRESENTATIVE PL-AT
Fee Code: EPAY
Requested Extension: 12/04/2018
Answer Due: 11/12/2018
Comments: e-filing rec'd on weekend docketed as rec'd next business day

11/13/2018 12 Submitted on Administrative Motion Docket
Event: 11 Extend Time - Appellant
District: G
Item #: 1

11/13/2018 13 Order: Extend Time - Appellant Brief - Grant
View document in PDF format
Event: 11 Extend Time - Appellant
Panel: JMB
Attorney: 17786 - MILLER THOMAS C
Extension Date: 12/04/2018

12/04/2018 14 Brief: Appellant
Proof of Service Date: 12/04/2018
Oral Argument Requested: Y
Timely Filed: Y
Filed By Attorney: 17786 - MILLER THOMAS C
For Party: 2 MARQUARDT SARON E PERSONAL REPRESENTATIVE PL-AT

12/04/2018 15 Brief: Appendices in Support of Brief
Proof of Service Date: 12/04/2018
Oral Argument Requested:
Timely Filed:
Filed By Attorney: 17786 - MILLER THOMAS C
For Party: 2 MARQUARDT SARON E PERSONAL REPRESENTATIVE PL-AT
Comments: Exhibits 11-29

12/05/2018 16 Other
Date: 12/05/2018
For Party: 2 MARQUARDT SARON E PERSONAL REPRESENTATIVE PL-AT
Attorney: 17786 - MILLER THOMAS C
Comments: Relief requested & signature page of Bf-AT

12/20/2018 17 Stips: Extend Time - AE Brief

Extend Until: 02/05/2019
Filed By Attorney: 33594 - SWANSON JOANNE GEHA
For Party: 3 UMASHANKAR VELLAIAH DURAI MD DF-AE
P/S Date: 12/20/2018

01/29/2019 18 Brief: Appendices in Support of Brief
Proof of Service Date: 01/29/2019
Oral Argument Requested:
Timely Filed:
Filed By Attorney: 17786 - MILLER THOMAS C
For Party: 2 MARQUARDT SARON E PERSONAL REPRESENTATIVE PL-AT
Comments: amended exhibits 6, 7 & 11; e-filing rec'd on wknd dktd as rec'd next business day

02/05/2019 20 Brief: Appellee
Proof of Service Date: 02/05/2019
Oral Argument Requested: Y
Timely Filed: Y
Filed By Attorney: 33594 - SWANSON JOANNE GEHA
For Party: 3 UMASHANKAR VELLAIAH DURAI MD DF-AE

02/06/2019 19 Noticed
Record: REQST
Mail Date: 02/07/2019

02/14/2019 21 Record Filed
File Location:
Comments: 3 FILES (TRNS INCL)

02/14/2019 23 Electronic Record - Scanned by COA
File Location:

11/08/2019 28 Submitted on Case Call
District: L
Item #: 20
Panel: SLB,KFK,DAS

11/08/2019 32 Oral Argument Audio
Listen to audio in MP3 format

11/26/2019 37 Opinion - Per Curiam - Unpublished
View document in PDF format
Pages: 6
Panel: SLB,KFK,DAS
Result: L/Ct Judgment/Order Affirmed
Comments: Defendant may tax costs

01/07/2020 38 SCt: Application for Leave to SCt
Supreme Court No: 160772
Answer Due: 02/04/2020
Fee: Paid
For Party: 2
Attorney: 17786 - MILLER THOMAS C

01/07/2020 41 SCt Case Caption
Proof Of Service Date: 01/07/2020

01/15/2020 39 Other
Date: 01/07/2020
For Party: 2 MARQUARDT SARON E PERSONAL REPRESENTATIVE PL-AT
Attorney: 17786 - MILLER THOMAS C
Comments: Notice of filing for leave to appeal in the Supreme Court

02/04/2020 40 SCt: Answer - SCt Application/Complaint

Filing Date: 02/04/2020
For Party: 3 UMASHANKAR VELLAIAH DURAI MD DF-AE
Filed By Attorney: 33594 - SWANSON JOANNE GEHA

02/24/2020 42 SCt Motion: Housekeeping
Party: 2
Filed by Attorney: 17786 - MILLER THOMAS C
Comments: Motion to extend time to 03-10-2020 to file reply

02/24/2020 43 SCt: Miscellaneous Filing
Filing Date: 02/24/2020
For Party: 2 MARQUARDT SARON E PERSONAL REPRESENTATIVE PL-AT
Filed By Attorney: 17786 - MILLER THOMAS C
Comments: Defect correction; pmt for event 42

02/25/2020 44 SCt Order: Chief Justice - Grant
View document in PDF format
Comments: Grant PLAT motion to extend the time for filing his reply to 3-10-2020.

03/10/2020 45 SCt: Reply - SCt Application/Complaint
Filing Date: 03/10/2020
For Party: 2 MARQUARDT SARON E PERSONAL REPRESENTATIVE PL-AT
Filed By Attorney: 17786 - MILLER THOMAS C

05/27/2020 46 SCt Order: MOAA -Oral Argument on Lv Appl
View document in PDF format
Comments: Invited AC=MI Assn for Justice, MI Defense Trial Counsel, MI Health & Hosp Assn. Justice Bernstein not participating.

07/20/2020 47 SCt: MOAA - AT supp'l brf
Filing Date: 07/20/2020
For Party: 2 MARQUARDT SARON E PERSONAL REPRESENTATIVE PL-AT
Filed By Attorney: 17786 - MILLER THOMAS C
Comments: Requires amended brief and appendices (MCR 7.312(D))

07/20/2020 48 Correspondence Sent
Proof Of Service Date: 07/20/2020
Comments: SC email re defective appendix - MCR 7.312(D)

07/22/2020 49 SCt: Miscellaneous Filing
Filing Date: 07/22/2020
For Party: 2 MARQUARDT SARON E PERSONAL REPRESENTATIVE PL-AT
Filed By Attorney: 17786 - MILLER THOMAS C
Comments: Amended AE Appendix

Case Listing Complete

Exhibit 2

2019 WL 6339912
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

UNPUBLISHED
Court of Appeals of Michigan.

Saron E. MARQUARDT, Personal Representative of the Estate of Sandra D. Marquardt, Plaintiff-Appellant,
v.
Vellaiah Durai UMASHANKAR, M.D., Defendant-Appellee.

No. 343248
|
November 26, 2019

Washtenaw Circuit Court, LC No. 12-000621-NH

Before: Borrello, P.J., and K. F. Kelly and Servitto, JJ.

Opinion

Per Curiam.

***1** In this medical malpractice action, plaintiff appeals as of right the trial court's order granting summary disposition in defendant's favor following remand from our Supreme Court. For the reasons set forth in this opinion, we affirm.

I. FACTUAL AND PROCEDURAL BACKGROUND

This Court having been previously presented with this matter, and because certain record evidence is relevant to our disposition of the issues now before us, we reiterate the underlying factual circumstances of plaintiff's medical malpractice claim from our prior decision:

> On July 20, 2007, the decedent, Sandra Marquardt, underwent mitral valve replacement surgery at the University of Michigan Hospital. Plaintiff claims that during the surgery, the deceased was negligently administered the drug Trasylol. On July 20, 2009, a notice of intent (NOI) to file a medical malpractice claim pursuant to MCL 600.2912b was sent. The NOI was addressed to the risk manager of the University of Michigan Health System. In the body of the NOI, plaintiff expressly stated that decedent "Marquardt intends to file suit against Jonathan Haft, M.D., Umashankar Vellaiah, M.D., Ranjiv Saran, M.D., and the University of Michigan Health System, Inc." In January 2010, the decedent filed suit against the University of Michigan Board of Regents, but did not name defendant Umashankar as a defendant. The decedent died on January 27, 2010, allegedly as a result of complications resulting from the administration of the Trasylol. Plaintiff was appointed personal representative of the estate, which was substituted as plaintiff.
>
> Defendant moved for summary disposition on the grounds that plaintiff failed to file her cause of action within the statute of limitations and that she failed to satisfy the notice provision of MCL 600.6431(3). The trial court granted summary disposition in favor of defendant on the ground that plaintiff failed to satisfy the notice provision in MCL 600.6431(3).
>
> This Court affirmed the Court of Claims' dismissal of that claim because plaintiff failed to comply with the notice provision of MCL 600.6431(3).
>
> Plaintiff served defendant Umashankar with a new NOI on September 2, 2011, and filed suit against him on June 7, 2012. Defendant Umashankar moved for summary disposition, which the trial court granted on the ground that plaintiff's claim against Umashankar was barred by the statute of limitations. On appeal, plaintiff challenges the dismissal, arguing that the statute of limitations tolling provision extended the time period in which she could file suit until January 18, 2010, and that the wrongful-death savings provision in MCL 600.5852 saved the claim until June 14, 2012, because the decedent died within 30 days of the January 18, 2010 expiration of the statute of limitations. [*Marquardt v. Umashankar*, unpublished per curiam opinion of the Court of Appeals, issued March 26, 2015 (Docket No. 319615), pp. 1-2, vacated 501 Mich. 870 (2017) (citations omitted).]

In our prior decision, we affirmed the trial court's summary disposition ruling for essentially three independent reasons. *Id.* at 3-4. Seemingly, our rationale depended on our foundational determination that the two-year limitations period applicable to medical malpractice actions, MCL 600.5805(8),[1] was set to expire (absent tolling) on July 20, 2009 because plaintiff's claim had accrued, pursuant to MCL 600.5838a(1), on July 20, 2007. *Marquardt*, unpub. op. at 2 & n. 2. We noted, however, that the statute of limitations may be "tolled for up to 182 days pursuant to MCL 600.2912b(1),

which requires a plaintiff to provide a NOI to file a medical malpractice action and then wait up to 182 days before filing suit." *Marquardt*, unpub. op. at 2-3, citing MCL 600.5856. We then proceeded to conclude that the initial NOI filed on July 20, 2009, which was the last day of the two-year limitations period, did not serve to toll the period because "the 182 tolling period did not start until July 21, 2009, which was one day *after* the limitations period had expired." *Marquardt*, unpub. op. at 3. Next, we concluded that the wrongful-death savings provision in MCL 600.5852 did not apply because the limitations period expired on July 20, 2009, and the decedent's death on January 27, 2010, therefore "did not occur before the period of limitations had run or within 30 days after that date." *Marquardt*, unpub. op. at 3. Finally, we also concluded that *regardless of the timeliness* of the initial July 20, 2009 NOI, that NOI "did not toll the statute of limitations with regard to defendant Umashankar because it was not directed or addressed to him." *Id.* at 3, 4.

***2** Our opinion was vacated by our Supreme Court in an order that stated as follows:

> By order of November 23, 2016, the application for leave to appeal the March 26, 2015 judgment of the Court of Appeals was held in abeyance pending the decision in *Haksluoto v. Mt. Clemens Regional Medical Center* (Docket No. 153723). On order of the Court, the case having been decided on June 27, 2017, 500 Mich. [304] (2017), the application is again considered. Pursuant to MCR 7.305(H)(1), in lieu of granting leave to appeal, we VACATE the judgment of the Court of Appeals and REMAND this case to the Washtenaw Circuit Court for reconsideration in light of *Haksluoto*. [*Marquardt v. Umashankar*, 501 Mich. 870 (2017).]

Our Supreme Court's decision in *Haksluoto* directly pertains to the first two grounds on which we had affirmed the trial court's summary disposition ruling. In *Haksluoto*, the Court addressed the question whether the limitations period is tolled when the NOI is filed on the last day of the limitations period, leaving no whole days of the limitations period to toll. *Haksluoto v. Mt. Clemens Regional Med. Ctr.*, 500 Mich. 304, 307; 901 N.W.2d 577 (2017). The *Haksluoto* Court concluded "that the limitations period *is* tolled under such circumstances." *Id.* The Court explained its holding as follows:

> We hold, therefore, that applying our common-law jurisprudence of fractional days produces a conclusion that a timely NOI preserves the day the NOI is filed as a day to be used once the limitations period begins running after the notice period ends. Notably, this applies to any NOI that triggers tolling under MCL 600.5856(c), whether filed on the final day of the limitations period or on some earlier day. The rule is that once the notice period ends and the time for the plaintiff to bring a claim once again begins to run, it will run for the number of whole days remaining in the limitations period when the NOI was filed, plus one day to reflect the fractional day remaining when the NOI itself was filed. There is no principled reason to treat the last day differently from any other—the abacus bead does not slide over until the day is over, and that applies with equal force to the ultimate and penultimate days of the limitations period. [*Id.* at 322-323.]

Returning to the instant case, the trial court again granted summary disposition in defendant's favor following our Supreme Court's remand order. The trial court concluded that *Haksluoto* did not govern the outcome of its prior decision. The trial court further concluded that summary disposition in defendant's favor was warranted on reconsideration because there was "no dispute that Plaintiff's NOI sent on July 20, 2009 was directed and addressed only to the risk manager at University of Michigan Health System," the NOI was not addressed or directed to defendant, and the NOI consequently did not toll the statute of limitations with respect to defendant. In support of its ruling, the trial court adopted this Court's reasoning from our prior opinion with respect this specific issue.

II. STANDARD OF REVIEW

We review a trial court's summary disposition ruling de novo. *Maiden v. Rozwood*, 461 Mich. 109, 118; 597 N.W.2d 817 (1999). When an action is barred by a statute of limitations, summary disposition is properly granted under MCR 2.116(C)(7). *Al-Shimmari v. Detroit Med. Ctr.*, 477 Mich. 280, 288; 731 N.W.2d 29 (2007). "When reviewing a motion under MCR 2.117(C)(7), this Court must accept the plaintiff's well-pleaded allegations as true and construe them in the plaintiff's favor." *Sills v. Oakland Gen. Hosp.*, 220 Mich. App. 303, 307; 559 N.W.2d 348 (1996). In this context, we accept the contents of the complaint as true "unless contradicted by documentation submitted by the movant." *Maiden*, 461 Mich. at 119. "If the facts are not in dispute, whether the statute bars the claim is a question of law for the court." *Sills*, 220 Mich. App. at 307. Questions of law are also reviewed de novo. *Id.*

III. ANALYSIS

***3** In this case, the parties agree that plaintiff's claim accrued on July 20, 2007, the date of her surgery. MCL 600.5838a(1). The general limitations period for medical malpractice actions is two years. MCL 600.5805(8). Accordingly, and as the parties agree, the period of limitations for this action was set to expire on July 20, 2009, unless the limitations period was tolled. Plaintiff filed his complaint and initiated this action against defendant on June 7, 2012.

Thus, absent any applicable tolling, the parties also agree that plaintiff failed to file this action before the limitations period expired. On appeal, plaintiff argues the same basic theory that he argued in his prior appeal, contending that this action against defendant was timely filed. Plaintiff's theory begins with the foundational premise that the July 20, 2009 NOI tolled the statute of limitations with respect to defendant. While it seems that this NOI was timely under *Haksluoto*, 500 Mich. at 307, 322-323, the holding in that case has no bearing on the question whether the NOI was effective *as to defendant specifically*. The timeliness of the NOI, and its effect with respect to this particular defendant, are two distinct questions.

"MCL 600.2912b(1) requires a claimant to submit an NOI to a potential defendant before commencing a medical malpractice suit. This requirement is mandatory and applies equally to individuals and professional entities, including professional corporations." *Driver v. Naini*, 490 Mich. 239, 247; 802 N.W.2d 311 (2011) (citations omitted). Filing an NOI before the limitations period has expired tolls the statute of limitations for the notice period, which may be up to 182 days, "if during that period a claim would be barred by the statute of limitations or repose." MCL 600.5856(c); see also MCL 600.2912b; *Haksluoto*, 500 Mich. at 312, 322-323; *Driver*, 490 Mich. at 249. But "a medical malpractice plaintiff must provide *every* defendant a timely NOI in order to toll the limitations period applicable to the recipient of the NOI." *Driver*, 490 Mich. at 251. "When a claimant files an NOI with time remaining on the applicable statute of limitations, that NOI tolls the statute of limitations for up to 182 days *with regard to the recipients of the NOI*." *Id.* at 249.

In order for plaintiff to prevail, we must find that the July 20, 2009 NOI was effective as to defendant so as to toll the statute of limitations with respect to defendant. We addressed this exact question in our previous opinion. We concur with the trial court that *Haksluoto* has no bearing on this narrow question. We further agree with the trial court that our prior analysis of this particular issue was correct; hence we adopt our prior analysis:

> The parties also dispute whether the July 20, 2009, NOI did or would have tolled the statute of limitations with respect to defendant Umashankar at all, regardless of the timeliness. MCL 600.2912b provides in pertinent part as follows:
>
> > (1) Except as otherwise provided in this section, a person shall not commence an action alleging medical malpractice against a health professional or health facility unless the person has given the health professional or health facility written notice under this section not less than 182 days before the action is commenced.
> >
> > (2) The notice of intent to file a claim required under subsection (1) shall be mailed to the last known professional business address or residential address of the health professional or health facility who is the subject of the claim. Proof of the mailing constitutes prima facie evidence of compliance with this section. If no last known professional business or residential address can reasonably be ascertained, notice may be mailed to the health facility where the care that is the basis for the claim was rendered.

***4** Subsection (1) makes it clear that a plaintiff cannot commence an action unless he or she first gives the party against whom relief is sought (the health professional or

health facility) written notice. Subsection (2) makes it clear that the plaintiff can mail the NOI to either the last known professional business address or residential address of the responding party. The parallel construction of the two provisions makes it clear that the written notice in subsection (1) must be sent to subject party of the notice. That is, if the responding party is a health professional, the NOI must be sent to the professional business or residential address of that professional. If neither address "can reasonably be ascertained," then the NOI can be sent to the healthcare facility where the care rendered by that professional was rendered. However, in order to effectuate the required notice, the NOI must be directed to or addressed to the defendant professional to whom the NOI is intended to provide notice.

The July 20, 2009, NOI was addressed and mailed to the risk manager for University of Michigan Health System. Though the body of the NOI indicated the decedent's intent to file suit against Umashankar, "a medical malpractice plaintiff must provide *every* defendant a timely NOI in order to toll the limitations period applicable to the recipient of the NOI ...." Our Supreme Court explicitly stated that it has interpreted MCL 600.2912b:

> as containing a dual requirement: A plaintiff must (1) submit an NOI to *every* health professional or health facility before filing a complaint and (2) wait the applicable notice waiting period with respect to each defendant before he or she can commence an action.

Accordingly, the NOI did not toll the statute of limitations with regard to defendant Umashankar because it was not directed or addressed to him. [*Marquardt*, unpub. op. at 3-4 (ellipsis in original), quoting *Driver*, 490 Mich. at 251, 255.]

For the reasons stated above, the trial court did not err by granting summary disposition in defendant's favor.

Affirmed. Defendant having prevailed in full, may tax costs. MCR 7.219(A).

All Citations

Not Reported in N.W. Rptr., 2019 WL 6339912

Footnotes

1 At the time of our previous opinion, this provision was contained in MCL 600.5805(6); the provision has since been moved to Subsection (8) without any change in the language of this provision. See 2018 PA 183.

End of Document

Exhibit 3

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of the Estate of SANDRA D. MARQUARDT,

Plaintiff,

Case No. 12-621-NH
Honorable David S. Swartz

v

VELLAIAH DURAI UMASHANKAR, MD,

Defendant.

Thomas C. Miller (P17786)
Attorney for Plaintiff
P.O. Box 785
Southfield, MI 48037
(248) 210-3211 / FAX (313) 964-4991

Joanne Geha Swanson (P33594)
Attorney for Defendant Umashankar
500 Woodward Avenue, Suite 2500
Detroit, MI 48226-3427
(313) 961-0200 / FAX (313) 961-0388

ORDER GRANTING DEFENDANT'S POST-REMAND MOTION FOR SUMMARY DISPOSITION

At a Session of Court held in the
Washtenaw County Trial Court
City of Ann Arbor, on March 15, 2018.

PRESENT: HONORABLE DAVID S. SWARTZ, CIRCUIT COURT JUDGE

On September 27, 2017, the Michigan Supreme Court entered an order stating that, "[P]ursuant to MCR 7.305(H)(1), in lieu of granting leave to appeal, we VACATE the judgment of the Court of Appeals and REMAND this case to the Washtenaw Circuit Court for reconsideration in light of *Haksluoto*." In response to the directive, the Court requested and received briefs from the parties addressing summary disposition and whether, on reconsideration, the decision in *Haksluoto v. Mt. Clemens Regional Medical Center* impacts the Court's decision to grant summary disposition and dismiss Plaintiff's case.

On review, the Court concludes that *Haksluoto* does not impact the Court's decision. The Court disagrees with Plaintiff's position that the Supreme Court's "vacate and remand" order reinstated Plaintiff's medical malpractice claim against Defendant and entitles Plaintiff to a jury trial. Nor does the Court agree with Plaintiff's argument that such relief is appropriate because "... this Court's grant of summary disposition was based entirely on the rationale struck down by the Michigan Supreme Court in its unanimous decision in *Haksluoto*."

As Defendant argues, pursuant to issues raised and argued by the parties, the Court of Appeals articulated the following alternative ground for dismissal of Plaintiff's claim:

"The parties also dispute whether the July 20, 2009, NOI did or would have tolled the statute of limitations with respect to defendant Umashankar at all, regardless of the timeliness. MCL 600.2912b provides in pertinent part as follows:
(1) Except as otherwise provided in this section, a person shall not commence an action alleging medical malpractice against a health professional or health facility

unless the person has given the health professional or health facility written notice under this section not less than 182 days before the action is commenced. The notice of intent to file a claim required under subsection (1) shall be mailed to the last known professional business address or residential address of the health professional or health facility who is the subject of the claim. Proof of the mailing constitutes prima facie evidence of compliance with this section. If no last known professional business or residential address can reasonably be ascertained, notice may be mailed to the health facility where the care that is the basis for the claim was rendered.

Subsection (1) makes it clear that a plaintiff cannot commence an action unless he or she first gives the party against whom relief is sought (the health professional or health facility) written notice. Subsection (2) makes it clear that the plaintiff can mail the NOI to either the last known professional business address or residential address of the responding party. The parallel construction of the two provisions makes it clear that the written notice in subsection (1) must be sent to subject party of the notice. That is, if the responding party is a health professional, the NOI must be sent to the professional business or residential address of that professional. If neither address "can reasonably be ascertained," then the NOI can be sent to the healthcare facility where the care rendered by that professional was rendered. However, in order to effectuate the required notice, the NOI must be directed to or addressed to the defendant professional to whom the NOI is intended to provide notice.

The July 20, 2009, NOI was addressed and mailed to the risk manager for University of Michigan Health System. Though the body of the NOI indicated the decedent's intent to file suit against Umashankar, "a medical malpractice plaintiff must provide *every* defendant a timely NOI in order to toll the limitations period applicable to the recipient of the NOI...." *Driver v. Naini,* 490 Mich. 239, 251; 802 NW2d 311 (2011). Our Supreme Court explicitly stated that it has interpreted MCL 600.2912b: as containing a dual requirement: A plaintiff must (1) submit an NOI to *every* health professional or health facility before filing a complaint and (2) wait the applicable notice waiting period with respect to each defendant before he or she can commence an action. [*Driver,* 490 Mich. at 255] (emphasis in original).

Accordingly, the NOI did not toll the statute of limitations with regard to defendant Umashankar because it was not directed or addressed to him. *Marquardt v. Umashankar*, No. 319615, 2015 WL 1396590, at 2–3 (Mich. Ct. App. Mar. 26, 2015), vacated, 501 Mich. 870, 901 N.W.2d 854 (2017)."

There is no dispute that Plaintiff's NOI sent on July 20, 2009 was directed and addressed only to the risk manager at University of Michigan Health System. As the Court of Appeals held, "Accordingly,

the NOI did not toll the statute of limitations with regard to defendant Umashankar because it was not directed or addressed to him." MCL 600.2912b. As Defendant argues, *Haksluoto* involved only the issue of timeliness of an NOI and "did not decide whether a notice of intent directed to a hospital satisfies the pre-suit notice requirement for a physician."

Further, the absence of an "express analysis" by this Court regarding Plaintiff's noncompliance with MCL 600.2912b does not alter the result. Plaintiff's noncompliance with MCL 600.2912b was previously raised and argued by the parties, considered and ruled on by the Court of Appeals, and is effectively embodied in the Court's grant of summary disposition in favor of Defendant "for the reasons stated in defendant's motion." Pursuant to established law, a court's decision is properly affirmed or upheld on appeal where the right result issued, albeit for the wrong reason. *Gleason v. Michigan Dep't of Transp.*, 256 Mich. App. 1, 3 (2003).

On remand and reconsideration, the Court hereby adopts the reasoning articulated by the Court of Appeals and holds, contrary to Plaintiff's position, that, regardless of the issue of timeliness, the NOI sent by Plaintiff to the risk manager for the University of Michigan Health System did not comply with the explicit provisions of MCL 600.2912b. As the Court of Appeals opined, Section 2912b requires that the NOI be specifically directed to or addressed to "every health

professional." It is not sufficient that the body of the NOI indicated Plaintiff's intent to file suit against Defendant.

Plaintiff's argument that the NOI sent to the risk manager should be considered actual notice because it was "more likely to have resulted in Defendant being informed in a timely manner regarding the potential claim being made against him", is without merit. The statute required Plaintiff to send the NOI directly to "every defendant" in order to toll the statute of limitations. *Driver v. Naini*, 490 Mich 239, 251 (2011).

For all the reasons stated by Defendant, the Court finds that the *Haksluoto* opinion does not alter the Court's disposition of the case.

Defendant's post-remand motion for summary disposition is GRANTED, and, on remand and reconsideration, the Court's grant of summary disposition in favor of Defendant is AFFIRMED.

Plaintiff's action is dismissed in its entirety with prejudice.

This is a final order that closes the case.

IT IS SO ORDERED.

David S. Swartz,
Circuit Court Judge

Exhibit 4

2015 WL 1396590
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

UNPUBLISHED
Court of Appeals of Michigan.

Saron E. MARQUARDT, Personal Representative for the Estate of Sandra Marquardt, Plaintiff–Appellant,
v.
Vellaiah Durai UMASHANKAR, MD, Defendant–Appellee,
and
Jonathan Haft, Defendant.

Docket No. 319615.
|
March 26, 2015.

Washtenaw Circuit Court; LC No. 12–000621–NH.

Before: WILDER, P.J., and SERVITTO, and STEPHENS, JJ.

Opinion

PER CURIAM.

***1** In this medical malpractice action, plaintiff appeals as of right from an order of the trial court granting summary disposition in favor of defendant Vellaiah Durai Umashankar, M.D., on the ground that plaintiff's claim is barred by the statute of limitations. We affirm.

On July 20, 2007, the decedent, Sandra Marquardt, underwent mitral valve replacement surgery at the University of Michigan Hospital. Plaintiff claims that during the surgery, the deceased was negligently administered the drug Trasylol. On July 20, 2009, a notice of intent (NOI) to file a medical malpractice claim pursuant to MCL 600.2912b was sent. The NOI was addressed to the risk manager of the University of Michigan Health System. In the body of the NOI, plaintiff expressly stated that decedent "Marquardt intends to file suit against Jonathan Haft, M.D., Umashankar Vellaiah, M.D., Ranjiv Saran, M.D., and the University of Michigan Health System, Inc." In January 2010, the decedent filed suit against the University of Michigan Board of Regents, but did not name defendant Umashankar as a defendant. The decedent died on January 27, 2010, allegedly as a result of complications resulting from the administration of the Trasylol. Plaintiff was appointed personal representative of the estate, which was substituted as plaintiff.

> Defendant moved for summary disposition on the grounds that plaintiff failed to file her cause of action within the statute of limitations and that she failed to satisfy the notice provision of MCL 600.6431(3). The trial court granted summary disposition in favor of defendant on the ground that plaintiff failed to satisfy the notice provision in MCL 600.6431(3). [*In re Estate of Marquardt,* unpublished opinion per curiam of the Court of Appeals, issued November 27, 2012 (Docket No 307917), pp 1–2.]

This Court affirmed the Court of Claims' dismissal of that claim because plaintiff failed to comply with the notice provision of MCL 600.6431(3). *Id.*, unpub op at 2–3.

Plaintiff served defendant Umashankar with a new NOI on September 2, 2011, and filed suit against him on June 7, 2012.[1] Defendant Umashankar moved for summary disposition, which the trial court granted on the ground that plaintiff's claim against Umashankar was barred by the statute of limitations. On appeal, plaintiff challenges the dismissal, arguing that the statute of limitations tolling provision extended the time period in which she could file suit until January 18, 2010, and that the wrongful-death savings provision in MCL 600.5852 saved the claim until June 14, 2012, because the decedent died within 30 days of the January 18, 2010 expiration of the statute of limitations.

The circuit court's grant of summary disposition is reviewed de novo. *Hinkle v. Wayne Co. Clerk,* 467 Mich. 337, 340; 654 NW2d 315 (2002). Summary disposition is properly granted under MCR 2.116(C)(7) when the plaintiff's complaint is barred by the applicable statute of limitations. *Sills v. Oakland Gen. Hosp.,* 220 Mich.App 303, 307; 559 NW2d 348 (1996). "In reviewing a motion under MCR 2.116(C)(7), this

Court accepts as true the plaintiff's well-pleaded allegations, construing them in the plaintiff's favor." *Hanley v. Mazda Motor Corp.*, 239 Mich.App 596, 600; 609 NW2d 203 (2000). "If the facts are not in dispute, whether the statute bars the claim is a question of law for the court." *Sills*, 220 Mich.App at 307.

***2** Absent tolling, the statute of limitations for medical malpractice is two years. MCL 600.5805(6). Accordingly, because plaintiff's claim accrued on July 20, 2007,[2] the limitations period was set to expire on July 20, 2009. The statute of limitations, however, could be tolled for up to 182 days pursuant to MCL 600.2912b(1), which requires a plaintiff to provide a NOI to file a medical malpractice action and then wait up to 182 days before filing suit. See MCL 600.5856. Here, plaintiff filed the initial NOI on July 20, 2009, the last day in the two-year limitations period. However, MCR 1.108(1) provides:

> (1) *The day of the act, event, or default after which the designated period of time begins to run is not included.* The last day of the period is included unless it is a Saturday, Sunday, legal holiday, or day on which the court is closed pursuant to court order; in that event the period runs until the end of the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is closed pursuant to court order. [Emphasis added.]
>
> Thus, the 182 tolling period did not start until July 21, 2009, which was one day *after* the limitations period had expired. Moreover, the decedent's death on January 27, 2010, was not within the time limits provided in the wrongful-death savings provision in MCL 600.5852
>
> MCL 600.5852(1) provides:
>
> > If a person dies before the period of limitations has run or within 30 days after the period of limitations has run, an action that survives by law may be commenced by the personal representative of the deceased person at any time within 2 years after letters of authority are issued although the period of limitations has run.
>
> Again, the two year limitations period expired on July 20, 2009. Thus, the decedent's death on January 27, 2010, did not occur before the period of limitations had run or within 30 days after that date.

The parties also dispute whether the July 20, 2009, NOI did or would have tolled the statute of limitations with respect to defendant Umashankar at all, regardless of the timeliness. MCL 600.2912b provides in pertinent part as follows:

> (1) Except as otherwise provided in this section, a person shall not commence an action alleging medical malpractice against a health professional or health facility unless the person has given the health professional or health facility written notice under this section not less than 182 days before the action is commenced.
>
> The notice of intent to file a claim required under subsection (1) shall be mailed to the last known professional business address or residential address of the health professional or health facility who is the subject of the claim. Proof of the mailing constitutes prima facie evidence of compliance with this section. If no last known professional business or residential address can reasonably be ascertained, notice may be mailed to the health facility where the care that is the basis for the claim was rendered.

***3** Subsection (1) makes it clear that a plaintiff cannot commence an action unless he or she first gives the party against whom relief is sought (the health professional or health facility) written notice. Subsection (2) makes it clear that the plaintiff can mail the NOI to either the last known professional business address or residential address of the responding party. The parallel construction of the two provisions makes it clear that the written notice in subsection (1) must be sent to subject party of the notice. That is, if the responding party is a health professional, the NOI must be sent to the professional business or residential address of that professional. If neither address "can reasonably be ascertained," then the NOI can be sent to the healthcare facility where the care rendered by that professional was rendered. However, in order to effectuate the required notice, the NOI must be directed to or addressed to the defendant professional to whom the NOI is intended to provide notice.

The July 20, 2009, NOI was addressed and mailed to the risk manager for University of Michigan Health System. Though the body of the NOI indicated the decedent's intent to file suit against Umashankar, "a medical malpractice plaintiff must provide *every* defendant a timely NOI in order to toll the limitations period applicable to the recipient of the NOI...." *Driver v. Naini*, 490 Mich. 239, 251; 802 NW2d 311 (2011). Our Supreme Court explicitly stated that it has interpreted MCL 600.2912b:

> as containing a dual requirement: A plaintiff must (1) submit an NOI to *every* health professional or health facility before filing a complaint and (2) wait the applicable notice waiting period with respect to each defendant before he or she can commence an action. [*Driver,* 490 Mich. at 255] (emphasis in original).

Accordingly, the NOI did not toll the statute of limitations with regard to defendant Umashankar because it was not directed or addressed to him.

Affirmed.

All Citations

Not Reported in N.W.2d, 2015 WL 1396590

Footnotes

1 Jonathan Haft, M.D., was also named as a defendant. The trial court granted summary disposition as to Haft, concluding that the affidavit of merit submitted was nonconforming and that there was no time remaining in the limitations period within which plaintiff could refile against him.

2 MCL 600.5838a(1) provides in pertinent part:
For purposes of this act, a claim based on the medical malpractice of a person or entity who is or who holds himself or herself out to be a licensed health care professional ... accrues at the time of the act or omission that is the basis for the claim of medical malpractice, regardless of the time the plaintiff discovers or otherwise has knowledge of the claim.

End of Document

Exhibit 5

Approved, SCAO | Original - Court, 1st copy - Defendant | 2nd copy - Plaintiff, 3rd copy - Return

STATE OF MICHIGAN
JUDICIAL DISTRICT
Court of Claims JUDICIAL CIRCUIT
COUNTY PROBATE

SUMMONS AND COMPLAINT

CASE NO. 10-4-MH

Court address | Court telephone no.

ROSEMARIE E. AQUILINA

Plaintiff's name(s), address(es), and telephone no(s).	v	Defendant's name(s), address(es), and telephone no(s).
SANDRA D. MARQUARDT 3049 VILLAGE LANE BROOKLYN, MI 48230		THE UNIVERSITY OF MICHIGAN BOARD OF REGENTS (UNIVERSITY OF MICHIGAN HOSPITAL) ED REYNOLDS (ASST. GENERAL COUNSEL) 300 N. INGALLS #~~2108~~ 3 B of ANN ARBOR, MI ~~48109-0486~~
Plaintiff's attorney, bar no., address, and telephone no. THOMAS C. MILLER (P17786) P.O. BOX 785 SOUTHFIELD, MI 48037		

RECEIVED BY
JAN 2 2 2010
HEALTH SYSTEM
LEGAL OFFICE

SUMMONS NOTICE TO THE DEFENDANT: In the name of the people of the State of Michigan you are notified:

1. You are being sued.
2. YOU HAVE 21 DAYS after receiving this summons to file a written answer with the court and serve a copy on the other party or take other lawful action with the court (28 days if you were served by mail or you were served outside this state). (MCR 2.111[C])
3. If you do not answer or take other action within the time allowed, judgment may be entered against you for the relief demanded in the complaint.

Issued	This summons expires	Court clerk
JAN 19 2010	APR 20 2010	MIKE BRYANTON

*This summons is invalid unless served on or before its expiration date.
This document must be sealed by the seal of the court.

COMPLAINT *Instruction: The following is information that is required to be in the caption of every complaint and is to be completed by the plaintiff. Actual allegations and the claim for relief must be stated on additional complaint pages and attached to this form.*

Family Division Cases

☐ There is no other pending or resolved action within the jurisdiction of the family division of circuit court involving the family or family members of the parties.

☐ An action within the jurisdiction of the family division of the circuit court involving the family or family members of the parties has been previously filed in _____ Court.

The action ☐ remains ☐ is no longer pending. The docket number and the judge assigned to the action are:

Docket no.	Judge	Bar no.

General Civil Cases

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

☐ A civil action between these parties or other parties arising out of the transaction or occurrence alleged in the complaint has been previously filed in _____ Court.

The action ☐ remains ☐ is no longer pending. The docket number and the judge assigned to the action are:

Docket no.	Judge	Bar no.

VENUE

Plaintiff(s) residence (include city, township, or village)	Defendant(s) residence (include city, township, or village)
JACKSON COUNTY	WASHTENAW COUNTY
Place where action arose or business conducted WASHTENAW COUNTY	

01/19/2010
Date

Signature of attorney/plaintiff

If you require special accommodations to use the court because of a disability or if you require a foreign language interpreter to help you fully participate in court proceedings, please contact the court immediately to make arrangements.

MC 01 (3/08) **SUMMONS AND COMPLAINT** MCR 2.102(B)(11), MCR 2.104, MCR 2.105, MCR 2.107, MCR 2.113(C)(2)(a), (b), MCR 3.206(A)

1/19

PROOF OF SERVICE

SUMMONS AND COMPLAINT
Case No.

TO PROCESS SERVER: You are to serve the summons and complaint not later than 91 days from the date of filing or the date of expiration on the order for second summons. You must make and file your return with the court clerk. If you are unable to complete service you must return this original and all copies to the court clerk.

CERTIFICATE/AFFIDAVIT OF SERVICE/NONSERVICE

☐ **OFFICER CERTIFICATE**
I certify that I am a sheriff, deputy sheriff, bailiff, appointed court officer, or attorney for a party (MCR 2.104[A][2]), and that: (notarization not required)

OR

☐ **AFFIDAVIT OF PROCESS SERVER**
Being first duly sworn, I state that I am a legally competent adult who is not a party or an officer of a corporate party, and that: (notarization required)

☐ I served personally a copy of the summons and complaint,
☐ I served by registered or certified mail (copy of return receipt attached) a copy of the summons and complaint, together with _____
List all documents served with the Summons and Complaint

_____ on the defendant(s):

Defendant's name	Complete address(es) of service	Day, date, time

☐ I have personally attempted to serve the summons and complaint, together with any attachments, on the following defendant(s) and have been unable to complete service.

Defendant's name	Complete address(es) of service	Day, date, time

I declare that the statements above are true to the best of my information, knowledge, and belief.

Service fee	Miles traveled	Mileage fee	Total fee
$		$	$

_____
Signature

_____
Name (type or print)

_____
Title

Subscribed and sworn to before me on _____ (Date), _____ County, Michigan.

My commission expires: _____ (Date) Signature: _____ (Deputy court clerk/Notary public)

Notary public, State of Michigan, County of _____

ACKNOWLEDGMENT OF SERVICE

I acknowledge that I have received service of the summons and complaint, together with _____ (Attachments)

_____ on _____ (Day, date, time)

_____ on behalf of _____
Signature

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

SANDRA D. MARQUARDT

PLAINTIFF

VS. CIVIL ACTION NO. 10-4 ~~NH~~ MH

ROSEMARIE E. AQUILINA

THE UNIVERSITY OF MICHIGAN BOARD OF REGENTS
(UNIVERSITY OF MICHIGAN HOSPITALS AND
HEALTH CENTERS)

DEFENDANT

/

THOMAS C. MILLER (P17786)
ATTORNEY FOR PLAINTIFF
P.O. BOX 785
SOUTHFIELD, MICHIGAN 48037
(248) 210-3211

/

COMPLAINT AND AFFIDAVIT OF MERIT

[There is no other pending or resolved civil action arising out of the same transaction or occurrence as alleged in the complaint.]

NOW COMES Plaintiff Sandra Marquardt, by and through their attorney Thomas C. Miller, and states:

1. Plaintiff resides in Jackson County.

2. Defendant maintains numerous health care facilities in Washtenaw County.

3. Defendant is the duly elected governing board for the University of Michigan, which operates the University of Michigan Hospitals and Health Centers.

4. Plaintiff claims an exemption from governmental immunity pursuant to MCL 691.1413.

5. The anesthesiologists and anesthesiology residents and fellows, who participated in the subject mitral valve surgery, were all employees and/or agents of Defendant.

6. The University of Michigan Hospitals and Health Centers was served with a notice of intent to sue on or about July 20, 2009, pursuant to MCL 600.2912b.

7. Plaintiff Sandra D. Marquardt was a patient at the University of Michigan Hospitals and Health Centers from July 17, 2007 through December 4, 2007. During that admission Ms. Marquardt underwent mitral valve replacement surgery on July 20, 2007.

8. Defendant, though its agents and employees, had a duty to provide medical and surgical care consistent with applicable standards of care for anesthesiologists. The standards of care for anesthesiologists, who are involved with cardiothoracic surgery to replace a mitral valve (after November 2006), require that the drug Trasylol not be used during such surgery given the changes made by the manufacturer regarding the indications for the use of the drug, and given the cautionary warnings issued by the FDA and the manufacturer prior to that date. The manufacturer's changes to its insert and the FDA advisories regarding the indications for the use of Trasylol clearly stated that the drug was to be used exclusively for patients with a risk of bleeding ***and*** who were undergoing coronary artery bypass graft surgery. Ms. Marquardt met neither of these indications. In addition to the published warnings detailed above, the standards of care would prohibit the use of Trasylol in a patient that had evidence of possible preoperative renal insufficiency. In addition Ms. Marquardt's history of other

drug allergies would also have been a contraindication for the use of Trasylol. Once the decision was reached to administer the Trasylol, the standards of care required that a test dose be administered ten minutes before the loading dose, and that the administration of the loading dose be accomplished over a 20-30 minute time period before the sternotomy and before the infusing of the drug began.

9. The anesthesiologists, who were involved with the subject mitral valve replacement surgery, breached applicable standards of care, as they relate to the use of Trasylol, in the following ways:

a. They used Trasylol before and during mitral valve replacement surgery, despite the revised indications and warnings published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current regarding the indications and warnings regarding Trasylol, and used the drug during off-label surgery.

b. They used Trasylol during off-label mitral valve replacement surgery, when the FDA and the manufacturer, who were aware of such off-label uses for the drug, cautioned against using the drug for any procedure other than a CABG procedure where the patient was at an increased risk of bleeding, until the drug's safety could be fully reviewed.

c. They also ignored Ms. Marquardt's preoperative history of other drug allergies and possible renal insufficiency, which placed her at an increased risk of a reaction to Trasylol and/or at an increased risk of further renal disease from the drug.

d. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.

e. They failed to take the requisite 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, before the sternotomy was performed and before the infusion of the drug was commenced, as recommended by the manufacturer.

11. As a direct and proximate result of Ms. Marquardt being given Trasylol during her mitral valve replacement procedure on July 20, 2007, Ms. Marquardt developed a significant pre-renal condition complicated by an obstructive condition of the kidneys. She also was suffered from a coagulopathy that was caused by the Trasylol, and aggravated by the lack of effective treatment in the postoperative period of time. Her renal disease, coagulopathy, multi-organ dysfunction, acidosis and significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, and severe depression during her lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months. Upon discharge she was on hemodialysis; she was oxygen dependent upon discharge due to changes in he lungs from ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis; and she was discharged still suffering from renal disease, ongoing liver

disease, and heart problems that must be treated with an extensive array of drug therapies and continue to cause severe debilitation. Ms. Marquardt went from an independent person, who was able to perform all ADL's, except when her mitral valve failed, to a person totally dependent on he husband and others. These problems are more likely than not directly related to complications from the use of Trasylol during her cardiothoracic surgery.

12. As a result of the above injuries, Plaintiff Sandra D. Marquardt has suffered considerable pain, suffering, mental anguish, disability, lost income, and medical expenses. The injuries are likely permanent in nature, and the above damages will continue.

WHEREFORE, Plaintiff Sandra D. Marquardt request that this Court grant them a judgment that fairly, reasonably and adequately compensates them for their injuries and damages.

Respectfully submitted,

Thomas C. Miller (P17786)

Dated: January 18, 2010

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

SANDRA D. MARQUARDT

PLAINTIFFS

VS. CIVIL ACTION NO. NH

THE UNIVERSITY OF MICHIGAN BOARD OF REGENTS
(UNIVERSITY OF MICHIGAN HOSPITALS AND
HEALTH CENTERS)

DEFENDANT

AFFIDAVIT OF MERIT

I, Javier H. Campos, M.D., having been duly sworn, state:

1. I am licensed to practice medicine in the State of Iowa, and I was so licensed at all times relevant to this litigation.

2. I am a professor in anesthesiology and director of cardiothoracic anesthesia at the University of Iowa Healthcare

3. I am engaged in the full time clinical practice of anesthesia/cardiothoracic anesthesia, and I was so engaged at all times relevant to this litigation.

4. I have received and reviewed the notice of intent provided to me by counsel for Ms. Marquardt.

5. I have received and reviewed medical records from counsel for Ms. Marquardt.

6. I am familiar with the standards of care for anesthesiologists, as they relate to the indications for the use of Trasylol (after November 2006) during mitral valve replacement surgery.

7. The standards of care for anesthesiologists, who are involved with cardiothoracic surgery to replace a mitral valve (after November 2006), require that Trasylol not be used during such surgery given the changes made by the manufacturer regarding the indications for the use of the drug, and given the cautionary

warnings issued by the FDA and the manufacturer prior to that date. The manufacturer's changes to its insert and the FDA advisories regarding the indications for the use of Trasylol clearly indicated that the drug was to be used exclusively for patients with a risk of bleeding *and* who were undergoing coronary artery bypass graft surgery. In addition to the published warnings detailed above, the standards of care would prohibit the use of Trasylol in a patient that had evidence of possible preoperative renal insufficiency. Once the decision was reached to administer the Trasylol, the standards of care required that a test dose be administered ten minutes before the loading dose, and that the administration of the loading dose be accomplished over a 20-30 minute time period before the sternotomy and before the infusing of the drug began.

8. The anesthesiologists, who were involved with the subject mitral valve replacement procedure, breached the applicable standards of care, as they relate to the use of Trasylol, in the following ways:

   a. They used Trasylol before and during mitral valve replacement surgery, despite the revised indications and warnings published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current regarding the indications and warnings regarding Trasylol, and used the drug during off-label surgery.
   b. They used Trasylol during off-label mitral valve replacement surgery, when the FDA and the manufacturer, who were aware of such off-label uses for the drug, cautioned against using the drug for any procedure other than a CABG procedure where the patient was at an increased risk of bleeding, until the drug's safety could be fully reviewed.
   c. They also ignored Ms. Marquardt's preoperative history of other drug allergies and possible renal insufficiency, which placed her at an increased risk of a reaction to Trasylol and/or at an increased risk of further renal disease from the drug.
   d. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.
   e. They failed to take the requisite 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, as recommended by the manufacturer.

9. The anesthesiologists that participated in the mitral valve replacement surgery on Ms. Marquardt would have complied with applicable standards of care, if they had insisted that Trasylol not be used, in light of the FDA warnings and the changes made by the manufacturer regarding the indications for use of the drug. Additionally, an alternative drug should have been used due to the patient's preoperative evidence of possible renal insufficiency and the patient's history of other drug allergies.

10. As a direct and proximate result of Ms. Marquardt being given Trasylol during her mitral valve replacement procedure on July 20, 2007, Ms. Marquardt

developed a significant renal condition complicated by an obstructive condition of the kidneys. Her renal disease, coagulopathy, multi-organ dysfunction, acidosis and significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, and severe depression during her lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months. Upon discharge she was on hemodialysis; she was oxygen dependent upon discharge due to changes in he lungs from ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis; and she was discharged still suffering from renal disease, ongoing liver disease, and heart problems that must be treated with an extensive array of drug therapies and continue to cause severe debilitation. Ms. Marquardt went from an independent person, who was able to perform all ADL's, except when her mitral valve failed, to a person totally dependent on her husband and others. These problems are more likely than not directly related to complications from the use of Trasylol during her cardiothoracic surgery.

Respectfully submitted,

Javier H. Campos, M.D.

STATE OF IOWA)
§
COUNTY OF)

On the 15 day of January, 2010, Javier H. Campos, M.D. appeared before me, a Notary Public, personally and being duly sworn, acknowledged signing this Affidavit of Merit as her/his free act and deed.

, Notary Public
JOHNSON County, Iowa
My Commission Expires: 4/7/12

Exhibit 6

Approved, SCAO

JIS CODE: LET

STATE OF MICHIGAN PROBATE COURT COUNTY OF JACKSON	LETTERS OF AUTHORITY FOR PERSONAL REPRESENTATIVE	FILE NO. 10011754 -DE

Estate of SANDRA D. MARQUARDT (DEC)

TO:

Name and address	Telephone no.
SARON E. MARQUARDT 3049 VILLAGE LANE BROOKLYN, MI 49230	(517) 917-5889

You have been appointed and qualified as personal representative of the estate on 06/14/2010 (Date). You are authorized to perform all acts authorized by law unless exceptions are specified below.

☐ Your authority is limited in the following way:

☒ You have no authority over the estate's real estate or ownership interests in a business entity that you identified on your acceptance of appointment.

☐ Other restrictions or limitations are:

☐ These letters expire: _____ (Date)

06/14/2010
Date

Judge (formal proceedings)/Register (informal proceedings) Bar no.

SEE NOTICE OF DUTIES ON SECOND PAGE

THOMAS C. MILLER (P17786)
Attorney name (type or print) Bar no.

P.O. BOX 785
Address

SOUTHFIELD, MI 48037 (248) 210-3211
City, state, zip Telephone no.

I certify that I have compared this copy with the original on file and that it is a correct copy of the original, and on this date, these letters are in full force and effect.

JUN 23 2010
Date

Deputy register

Do not write below this line - For Probate Court use only

FILED
JUN 14 2010
Jackson County Probate Court

TRUE COPY
of the original on file
in said Proceedings.
JUN 23 2010
Jackson County Probate Court

PC 572 (10/07) LETTERS OF AUTHORITY FOR PERSONAL REPRESENTATIVE MCL 700.3103, MCL 700.3307, MCL 700.3414, MCL 700.3504, MCL 700.3601, MCR 5.202, MCR 5.206, MCR 5.307, MCR 5.310

The following provisions are mandatory reporting duties specified in Michigan law and Michigan court rules and are not the only duties required of you. See MCL 700.3701 through MCL 700.3722 for other duties. Your failure to comply may result in the court suspending your powers and appointing a special fiduciary in your place. It may also result in your removal as fiduciary.

CONTINUED ADMINISTRATION: If the estate is not settled within 1 year after the first personal representative's appointment, you must file with the court and send to each interested person a notice that the estate remains under administration, specifying the reasons for the continued administration. You must give this notice within 28 days of the first anniversary of the first personal representative's appointment and all subsequent anniversaries during which the administration remains uncompleted. If such a notice is not received, an interested person may petition the court for a hearing on the necessity for continued administration or for closure of the estate. [MCL 700.3703(4), MCL 700.3951(3), MCR 5.144, MCR 5.307, MCR 5.310]

DUTY TO COMPLETE ADMINISTRATION OF ESTATE: You must complete the administration of the estate and file appropriate closing papers with the court. Failure to do so may result in personal assessment of costs. [MCR 5.310]

CHANGE OF ADDRESS: You are required to inform the court and all interested persons of any change in your address within 7 days of the change.

Additional Duties for Supervised Administration

If this is a supervised administration, in addition to the above reporting duties, you are also required to prepare and file with this court the following written reports or information.

INVENTORY: You are required to file with the probate court an inventory of the assets of the estate within 91 days of the date your letters of authority are issued or as ordered by the court. You must send a copy of the inventory to all presumptive distributees and all other interested persons who request it. The inventory must list in reasonable detail all the property owned by the decedent at the time of death. Each listed item must indicate the fair market value at the time of the decedent's death and the type and amount of any encumbrance. If the value of any item has been obtained through an appraiser, the inventory should include the appraiser's name and address with the item or items appraised by that appraiser. You must also provide the name and address of each financial institution listed on your inventory at the time the inventory is presented to the court. The address for a financial institution shall be either that of the institution's main headquarters or the branch used most frequently by the personal representative. [MCL 700.3706, MCR 5.307, MCR 5.310(E)]

ACCOUNTS: You are required to file with this court once a year, either on the anniversary date that your letters of authority were issued or on another date you choose (you must notify the court of this date) or more often if the court directs, a complete itemized accounting of your administration of the estate. This itemized accounting must show in detail all income and disbursements and the remaining property, together with the form of the property. Subsequent annual and final accountings must be filed within 56 days following the close of the accounting period. When the estate is ready for closing, you are also required to file a final account with a description of property remaining in the estate. All accounts must be served on the required persons at the same time they are filed with the court, along with proof of service.

ESTATE (OR INHERITANCE) TAX INFORMATION: You are required to submit to the court proof that no estate (or inheritance) taxes are due or that the estate (or inheritance) taxes have been paid. Note: The estate may be subject to inheritance tax.

Additional Duties for Unsupervised Administration

If this is an unsupervised administration, in addition to the above reporting duties, you are also required to prepare and provide to all interested persons the following written reports or information.

INVENTORY: You are required to prepare an inventory of the assets of the estate within 91 days from the date your letters of authority are issued and to send a copy of the inventory to all presumptive distributees and all other interested persons who request it. You are also required within 91 days from the date your letters of authority are issued, to submit to the court the information necessary to calculate the probate inventory fee that you must pay to the probate court. You may use the original inventory for this purpose. [MCL 700.3706, MCR 5.307]

ESTATE (OR INHERITANCE) TAX INFORMATION: You may be required to submit to the court proof that no estate (or inheritance) taxes are due or that the estate (or inheritance) taxes have been paid. Note: The estate may be subject to inheritance tax.

Exhibit 7

LAW OFFICES
OF
THOMAS C. MILLER
P.O. BOX 785
SOUTHFIELD, MICHIGAN 48037
248-210-3211

September 2, 2011

Jonathan W. Haft, M.D.
University of Michigan Cardiovascular Center
Section of Cardiac Surgery
1500 E. Medical Center Drive, Floor 3
Ann Arbor, MI 48109-5853

Re: Sandra D. Marquardt

Dear Dr. Haft:

You are hereby notified that Sandra D. Marquardt intends to file suit against Jonathan Haft, M.D., and Vellaiah Durai Umashanker, M.D. upon the expiration of 182 days from the above date. This notice is being provided pursuant to MCL 600.2912b. This same statute places certain requirements upon each of you as well. One of those obligations is to provide the undersigned with a notice of meritorious defense, which must be provided within 154 days from the date above.

Ms. Marquardt's medical history is well documented in the University of Michigan Hospitals and Medical Centers' chart covering the above admission. Ms. Marquardt agrees that it contains the relevant medical history necessary for this notice of intent. In addition, all of the relevant medical treatment regarding this notice of intent is contained in that hospital chart. Certain portions of the care and treatment provided to Ms. Marquardt should be highlighted below, so that there is sufficient context to explain the claims being made below.

Ms. Marquardt was known to have suffered drug reactions to penicillin and ceftriaxone. Her baseline or pre-operative renal function studies revealed some degree of renal insufficiency. Specifically, her pre-operative creatinine level was reported to be 1.4 (on two occasions), her pre-operative BUN level was reported to be 21 (on two

9/2

occasions) and there was evidence of significant levels of blood in her pre-operative urinalysis.

Dr. Haft admitted Ms. Marquardt in order to stabilize her cardiovascular status before performing a mitral valve replacement procedure. He was particularly interested in getting her off her Coumadin and onto IV Heparin, so that her coagulation could be more closely controlled during and after the surgery. He wanted the INR to be equal to or less than 2.0 and he wanted her PTT levels to be between 50 and 70 before proceeding with the surgery. Her INR was 2.8 on admission and had fallen to 1.6 by July 19th. Her PTT was 42.9 on admission and fell to 33.7 by July 19th. He initially planned on surgery for July 24th; however, that date was subsequently moved up to July 20th.

The Anesthesia Record, which was prepared incident to the mitral valve replacement procedure performed on July 20th, established the following timeline:

1. The anesthesia was started at 0645.
2. The patient was brought to the operating room at 0702.
3. The anesthesia induction ended at 0801.
4. The patient was placed in the left lateral decubitus position at 0804.
5. The baseline ACT was drawn at 0804 and reported to be 157 (the exact equipment used is not reflected on the chart).
6. The surgical incision was made at 0839. [**No test dose or loading dose of Trasylol was administered before the incision and thoracotomy as required by the manufacturer in its insert.**]
7. The 200 ml loading dose of Trasylol was given at 0909. [**No test dose was given before the loading dose, as required by the manufacturer in its insert.**]
8. The first ACT level obtained after the loading dose of Trasylol was reported as 999, which was apparently the highest level that could be digitally displayed by the equipment, at about 0915.
9. The Trasylol infusion dose of 50 ml/hr was begun at 0918.
10. The first dose of Heparin was administered at 0930. [There was confusion in the record as to the exact dosage given at that time. The written chronology indicates that 25,000 units were given. The graphic summary indicates that 2,500 units were given; however, the total on the graphic summary indicates that 35,000 total units were given during the procedure, which would have included 10,000 units at 1230. Dr. Haft indicates in his operative report that she was "systemically heparinized with 3 mg/kg sodium heparin", which would mean that she was given about 250 mg. given her known weight of 77.1 kg.]
11. Full cardiopulmonary bypass was initiated at 0942.
12. The first ACT level obtained after the Trasylol and Heparin were given reflected a continuing level of 999 at 1015.
13. The ACT level obtained at about 1115 revealed a level of 545.
14. The ACT level obtained at about 1215 revealed a level of 499.
15. The second dose of Heparin containing 10,000 or 1,000 units was given at 1230.
16. The ACT level obtained at about 1300 revealed a level of 387.

17. The cardiopulmonary bypass was terminated at 1311. [The total time spent on the bypass equipment was reported by Dr. Haft to have been 209 minutes.]
18. The ACT level obtained at about 1315 revealed a level of 590.
19. A 250 mg dose of Protamine was given at about 1330.
20. A 50 mg dose of Protamine was given at about 1400.
21. The ACT level obtained at about 1400 revealed a level of 158.
22. The surgical dressing was completed at 1445.
23. The patient was transferred to the TICU at 1501.
24. The anesthesia was ended at 1515.
25. The Trasylol infusion was terminated at about 1530.

In January 2006 a group of physicians and research experts published the results of an extensive study comparing the drug Trasylol with two other similar acting drugs. Their findings were accepted for publication in the prestigious *New England Journal of Medicine*. That article, together with a similar smaller study published in the March 2006 issue of *Transfusion*, began to raise serious questions about the safety of Trasylol. The FDA apparently became aware of those two studies and responded by publishing a "Public Health Advisory for Trasylol" dated February 8, 2006. In that advisory they informed the medical profession, particularly the cardiac surgeons and anesthesiologists, that they were aware of two studies that were reporting an increased risk of death and serious injury due to renal and heart disease incident to the use of Trasylol, when compared to the incidence of such results in patients who received two similar acting drugs. Following the FDA investigation and following consultations with the drug's manufacturer, the FDA adopted a revised insert to be distributed to all physicians who were the end users of the drug. That new insert was published and made available to the relevant physicians in November 2006. In that publication the manufacturer added additional information and cautionary content regarding the risk of renal, cardiac and vascular risks with the use of the drug. Of particular note was the manufacturer's "Indications and Usage" section. Trasylol was indicated for prophylactic use to reduce perioperative blood loss and the need for blood transfusion in **patients undergoing cardiopulmonary bypass in the course of coronary artery bypass graft surgery who are at an increased risk for blood loss and blood transfusion.**

It should be noted that the earlier insert also limited the indications to patients undergoing coronary artery bypass graft procedures in which cardiopulmonary bypass equipment was used; however, both the medical specialists involved and the manufacturer itself were aware that the drug was being used for off-label surgeries including cardiac valve replacements. In December 2006 the FDA again advised the medical community that it was very concerned about Trasylol; however, it wanted more information before making a decision regarding the safety of the drug. The FDA requested and Bayer agreed to inform its customers that the drug was to be used in strict compliance with the insert. Specifically, the manufacturer told its users to adhere strictly to the indications contained in the old and new insert, i.e. it was to be used only in CABG procedures. The FDA issued a press release regarding the new insert in December 2006, and Bayer drafted a form letter, which it sent to each of its customers in the same month. The FDA indicated that it wanted the physicians to "understand the new warnings and use the product as directed by the [insert]". The new insert specifically stated that the

drug was to be used only during CABG procedures. In the December letter the company also made it very clear to the physicians that the drug was to be used incident to CABG procedures only. They also advised the physicians of the renal and cardiac risks raised in the literature. The letter highlighted the changes in the new insert, which had been published in November 2006. It is believed that the information from the FDA and from Bayer was communicated directly to Dr. Haft, Dr. Umashankar and/or the University of Michigan Hospitals and Medical Centers in late 2006.

The revised 2006 insert made many critical points relevant to the facts in this matter. First, the use of the drug was to be restricted to CABG procedures, and was not to be used for valve replacement procedures. Second, patients with pre-existing renal insufficiency were at an increased risk of developing renal complications from the use of Trasylol. Third, patients with other drug allergies were more likely to have a reaction to Trasylol. Fourth, a test dose of Trasylol was to be given at least ten minutes before the loading dose of the drug. Fifth, the loading dose was to be given over a 20-30 minute time period before infusion of the drug. Sixth, the patient was to be placed in a supine position during administration of the test dose and the loading dose. Seventh, the patient was to be closely monitored closely for possible coagulopathy when Trasylol and Heparin were administered concurrently. An elevated ACT level might not reflect a high therapeutic level of Heparin, when Heparin was administered concurrently with Trasylol. Eighth, Protamine titration should be used to establish the adequacy of Heparin levels before any Trasylol is given, so that the anti-coagulation effects of the two drugs can be separated, and so that the results of that titration could be used to determine the effect of the Heparin therapy throughout the operative and post-operative phases. Ninth, the therapeutic level of Heparin must be kept above certain levels during the procedure (reflected by careful monitoring of coagulation studies) independent of the anti-coagulation effect created by the Trasylol given concurrently with Heparin.

The medical records of Ms. Marquardt reflect that no test dose of Trasylol was administered ten minutes before the loading dose. The patient was not in a supine position when she was given the loading dose of Trasylol. The loading dose was not given slowly over a 20-30 minute period of time (only nine minutes separated the loading dose from the start of the infusion of Trasylol). Ms. Marquardt had a history of two different drug allergies. The procedure was a valve replacement procedure and not a CABG procedure. Ms. Marquardt did have evidence of pre-operative kidney dysfunction. Lastly, she was not closely monitored after the administration of Trasylol and Heparin to determine the anti-coagulation effect of Heparin alone versus the synergistic anti-coagulation effect of the two drugs in combination.

Following the surgery, during which Ms. Marquardt received Heparin and Trasylol, she began to manifest significant clinical signs and symptoms of renal disease, which led to multiple other organ system problems. The lack of attention to her renal complications from the Trasylol resulted in other iatrogenic complications and nosocomial infections. Despite numerous medical diagnoses formulated by the numerous physicians who treated Ms. Marquardt over the four months of post-operative care, the diagnosis of Trasylol induced pathology never appeared. It was not even mentioned as part of anyone's differential diagnoses. The various treating physicians did proffer opinions regarding the etiology of her renal disease specifically that they were post-op complications and that may have been related to the lengthy period of time spent on the

bypass equipment; however, they never once mentioned the drug Trasylol as a possible factor.

During the time Ms. Marquardt was an inpatient at the University of Michigan Hospital; the following diagnoses were made and repeated often by the various physicians charged with providing her with care for her post-operative complications:

1. Various nosocomial infections, bacteremia and sepsis.
2. Hyperglycemia secondary to surgical stress requiring Tight Glycemic Control
3. Oliguric
4. Diminished Coronary Output/Coronary Index
5. Hemolysis secondary to long coronary bypass machine time
6. Fluid overload
7. Renal Hypoperfusion
8. Polyuric Renal Failure secondary to prolonged pump time
9. Acute Tubular Necrosis (ATN)
10. Hyperphosphatemia
11. Acute Kidney Injury (AKI) secondary to ATN
12. Hypotension
13. Pulmonary Edema
14. Non-oliguric Renal Failure
15. Acute Respiratory Distress Syndrome (ARDS)
16. Systemic Inflammatory Response Syndrome (SIRS)
17. Prolonged Respiratory Failure
18. Hematuria
19. Metabolic Acidosis
20. Pleural Effusion
21. Swallowing Dysfunction
22. Hypothyroidism
23. Hypercarbia
24. Hypoxemia
25. Clinical Depression
26. Peri-operative vascular leak
27. Respiratory Acidosis
28. Anemia
29. Atrial Fibrillation
30. Sick Euthyroid Syndrome
31. Prerenal Azotemia
32. Moderate Differentiated Encephalopathy
33. End Stage Renal Disease
34. Pulmonary Vein Stenosis
35. Urinary Tract Infection (UTI)
36. Adrenal Insufficiency
37. Cholecystitis
38. Wound Dehiscence
39. Extracellular Fluid Volume Depletion

Each of the above diagnoses appear to be related to Ms. Marquardt's underlying

renal disease, the iatrogenic efforts made by the medical staff to diagnose and treat the underlying renal disease, the nosocomial infections resulting from her long hospital stay, problems caused by the inability of the medical staff to correct the fluid imbalance situation caused by her renal dysfunction, or from the effects of the long-term hospital stay and the decompensation caused by the overwhelming medical and emotional conditions.

Ms. Marquardt has been followed by her primary care physician Raymond Cole, D.O, 107 W. Chicago, Brooklyn, MI 49230, her nephrologists R.V. Nagesh, M.D., 205 N. East Avenue, Jackson, MI 49201, her pulmonologist Robert D. Albertson, M.D., 900 E. Michigan Avenue, Jackson, MI 49201, and her cardiologist Bischan Hassunizadeh, M.D., 205 Page Avenue, Suite B, Jackson, MI 49201.

The standards of care for anesthesiologists and cardio-thoracic surgeons assisting in cardiac surgeries involving the use of cardiopulmonary bypass equipment require that Trasylol not be used during cardiac valve procedures performed after November 2006, given the advisories issued by the FDA and Bayer. The standards of care for both specialties also require that Trasylol induced renal disease should be ruled out as soon as possible, if renal disease is diagnosed or suspected following a surgical procedure in which Trasylol was used. These same standards require the appropriate use of Heparin in conjunction with the concurrent use of Trasylol. The anti-coagulation effect of Heparin must be isolated from the overall anti-coagulation effect of Heparin and Trasylol in combination. Trasylol should not be used as a Heparin sparing agent. Additional Heparin therapy may be needed even if ACT levels are elevated. Protamine titration to measure Heparin therapeutic levels must be performed before the administration of Trasylol and that baseline level must be used to determine if Heparin is needed to maintain anti-coagulation therapy intra-operatively and post-operatively, given that the Trasylol in a renal insufficient patient might be long-lasting and affect anti-coagulation test results, leading to reduced Heparin therapy post-operatively. These standards of care also require the physician to identify, carefully monitor and effectively treat fluid levels to avoid cardiopulmonary complications due to fluid overload or due to extracellular fluid volume depletion. If diagnosed, Trasylol induced renal disease must be aggressively treated with appropriate anti-thrombotic drug therapy, and therapeutic Heparin levels must be implemented to counter the Trasylol induced coagulopathy. If Trasylol is indicated, the applicable standards of care require that a test dose of 1 ml be given at least ten minutes before the loading dose. Then the loading dose should be given slowly over a 20-30 minute time period after induction of anesthesia and before the sternotomy, while the patient is in a supine position. Then the constant infusion of the drug is begun and continued until the surgery is completed and the patient leaves the operating room.

Drs. Haft and Umashankar, together with their associates, residents and fellows, breached applicable standards of care for cardiac surgeons and/or anesthesiologists assisting in cardiac procedures in the following ways:

1. They used Trasylol incident to a mitral valve replacement procedure, despite the indications published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current on the indications for the drug and used the drug during an off-label procedure.
2. They used Trasylol for an off-label purpose, when the FDA and the manufacturer, who were aware of the off-label uses of the drug, cautioned

against using the drug for any procedure other than a CABG procedure, until the drug's safety could be fully reviewed.

3. They ignored Ms. Marquardt's preoperative history of other drug allergies and renal insufficiency, which placed her at an increased risk of an allergic reaction to Trasylol and/or at an increased risk of further renal disease from the drug.
4. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.
5. They failed to take 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, before the sternotomy was performed and before the infusion of the drug was commenced.
6. They failed to adequately separate any coagulopathy caused by the Trasylol from any coagulopathy caused by Heparin therapy or the lack of that therapy, and, in so doing, they decreased or withheld Heparin therapy from the patient when she actually needed the therapy to counteract the Trasylol effects on the kidneys.
7. The failed to recognize the connection between Trasylol (thrombosis) and the hypocoagulopathy demonstrated in the laboratory results.
8. They failed to institute dialysis and/or appropriate diuretic therapy in a timely manner to maintain an appropriate fluid balance.
9. They failed to diagnose Trasylol induced renal disease, and treat it appropriately in a timely manner.
10. They failed to diagnose the prerenal disease caused by the Trasylol and recognize that the problems they were encountering in regards to pulmonary edema, cardiac dysfunction and other organ system failures were directly related to the renal disease, iatrogenic consequences of the inappropriate treatment protocols, nosocomial infections and/or from long periods of ventilation, decompensation and debilitation.

Drs. Haft and Umashankar, together with their associates, residents and fellows, would have complied with applicable standards of care, if they had decided not to use Trasylol during Ms. Marquardt's mitral valve repair procedure on July 20, 2007, given the FDA and manufacturer warnings against using it for such procedures. If they felt that the procedure and patient warranted the use of Trasylol, then they needed to recognize the other risk factors presented by her prior drug allergies and pre-existing renal insufficiency. They also had to use the drug as indicated in the insert regarding a test dose, the loading dose and coagulation assessments during and after the procedure. They also had to rule out Trasylol induced renal disease given the problems that presented in the immediate postoperative period. Then they needed to treat the Trasylol induced renal disease, the coagulopathy, the fluid imbalance and the effects of the renal disease on other organ systems in a timely manner.

As a direct and proximate result of the above negligent acts by Drs. Haft and Umashankar (together with their associates, residents and fellows), Ms. Marquardt was given a contraindicated drug during her mitral valve repair procedure on July 20, 2007. This drug then caused a prerenal condition complicated by an obstructive condition of the kidneys. She also was suffering from a coagulopathy that was caused by the Trasylol, and aggravated by the lack of effective treatment in the postoperative period of time. Her

renal disease, coagulopathy, multi-organ dysfunction, acidosis and a significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, severe depression, as she tried to cope with the lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months, was discharged on hemodialysis, is oxygen dependent due to changes in he lungs from the ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis, ongoing renal disease, ongoing liver disease, heart problems that must be treated with medication and severely debilitated. Her multiple medical problems that began following the above surgery and post-operative complications eventually led to her death on January 27, 2010. She went from an independent person who was able to perform all of her ADL's, except when her mitral valve failed, to a person totally dependent on he husband and others to perform her ADL's and eventually death from renal failure complications. She was also completely oxygen dependent and severely disabled due to the poor care and treatment she received during her four and one-half months of hospitalization. These problems were directly related to the complications from a drug she should not have been given and directly related to the ineffective care and treatment she was given thereafter.

Respectfully submitted,

Thomas C. Miller

TCM:mls

Exhibit 8

LAW OFFICES
OF
THOMAS C. MILLER
P.O. BOX 785
SOUTHFIELD, MICHIGAN 48037
248-210-3211

September 2, 2011

Vellaiah Durai Umashankar, M.D.
c/o University of Michigan Cardiovascular Center
Department of Anesthesia
1500 E. Medical Center Drive, SPC 5861
Ann Arbor, MI 48109

Re: Sandra D. Marquardt

Dear Dr. Umashankar:

You are hereby notified that Sandra D. Marquardt intends to file suit against Jonathan Haft, M.D., and Vellaiah Durai Umashankar, M.D. upon the expiration of 182 days from the above date. This notice is being provided pursuant to MCL 600.2912b. This same statute places certain requirements upon each of you as well. One of those obligations is to provide the undersigned with a notice of meritorious defense, which must be provided within 154 days from the date above.

Ms. Marquardt's medical history is well documented in the University of Michigan Hospitals and Medical Centers' chart covering the above admission. Ms. Marquardt agrees that it contains the relevant medical history necessary for this notice of intent. In addition, all of the relevant medical treatment regarding this notice of intent is contained in that hospital chart. Certain portions of the care and treatment provided to Ms. Marquardt should be highlighted below, so that there is sufficient context to explain the claims being made below.

Ms. Marquardt was known to have suffered drug reactions to penicillin and ceftriaxone. Her baseline or pre-operative renal function studies revealed some degree of renal insufficiency. Specifically, her pre-operative creatinine level was reported to be 1.4 (on two occasions), her pre-operative BUN level was reported to be 21 (on two

9/2

occasions) and there was evidence of significant levels of blood in her pre-operative urinalysis.

Dr. Haft admitted Ms. Marquardt in order to stabilize her cardiovascular status before performing a mitral valve replacement procedure. He was particularly interested in getting her off her Coumadin and onto IV Heparin, so that her coagulation could be more closely controlled during and after the surgery. He wanted the INR to be equal to or less than 2.0 and he wanted her PTT levels to be between 50 and 70 before proceeding with the surgery. Her INR was 2.8 on admission and had fallen to 1.6 by July 19th. Her PTT was 42.9 on admission and fell to 33.7 by July 19th. He initially planned on surgery for July 24th; however, that date was subsequently moved up to July 20th.

The Anesthesia Record, which was prepared incident to the mitral valve replacement procedure performed on July 20th, established the following timeline:

1. The anesthesia was started at 0645.
2. The patient was brought to the operating room at 0702.
3. The anesthesia induction ended at 0801.
4. The patient was placed in the left lateral decubitus position at 0804.
5. The baseline ACT was drawn at 0804 and reported to be 157 (the exact equipment used is not reflected on the chart).
6. The surgical incision was made at 0839. [**No test dose or loading dose of Trasylol was administered before the incision and thoracotomy as required by the manufacturer in its insert.**]
7. The 200 ml loading dose of Trasylol was given at 0909. [**No test dose was given before the loading dose, as required by the manufacturer in its insert.**]
8. The first ACT level obtained after the loading dose of Trasylol was reported as 999, which was apparently the highest level that could be digitally displayed by the equipment, at about 0915.
9. The Trasylol infusion dose of 50 ml/hr was begun at 0918.
10. The first dose of Heparin was administered at 0930. [There was confusion in the record as to the exact dosage given at that time. The written chronology indicates that 25,000 units were given. The graphic summary indicates that 2,500 units were given; however, the total on the graphic summary indicates that 35,000 total units were given during the procedure, which would have included 10,000 units at 1230. Dr. Haft indicates in his operative report that she was "systemically heparinized with 3 mg/kg sodium heparin", which would mean that she was given about 250 mg. given her known weight of 77.1 kg.]
11. Full cardiopulmonary bypass was initiated at 0942.
12. The first ACT level obtained after the Trasylol and Heparin were given reflected a continuing level of 999 at 1015.
13. The ACT level obtained at about 1115 revealed a level of 545.
14. The ACT level obtained at about 1215 revealed a level of 499.
15. The second dose of Heparin containing 10,000 or 1,000 units was given at 1230.
16. The ACT level obtained at about 1300 revealed a level of 387.

17. The cardiopulmonary bypass was terminated at 1311. [The total time spent on the bypass equipment was reported by Dr. Haft to have been 209 minutes.]
18. The ACT level obtained at about 1315 revealed a level of 590.
19. A 250 mg dose of Protamine was given at about 1330.
20. A 50 mg dose of Protamine was given at about 1400.
21. The ACT level obtained at about 1400 revealed a level of 158.
22. The surgical dressing was completed at 1445.
23. The patient was transferred to the TICU at 1501.
24. The anesthesia was ended at 1515.
25. The Trasylol infusion was terminated at about 1530.

In January 2006 a group of physicians and research experts published the results of an extensive study comparing the drug Trasylol with two other similar acting drugs. Their findings were accepted for publication in the prestigious *New England Journal of Medicine*. That article, together with a similar smaller study published in the March 2006 issue of *Transfusion*, began to raise serious questions about the safety of Trasylol. The FDA apparently became aware of those two studies and responded by publishing a "Public Health Advisory for Trasylol" dated February 8, 2006. In that advisory they informed the medical profession, particularly the cardiac surgeons and anesthesiologists, that they were aware of two studies that were reporting an increased risk of death and serious injury due to renal and heart disease incident to the use of Trasylol, when compared to the incidence of such results in patients who received two similar acting drugs. Following the FDA investigation and following consultations with the drug's manufacturer, the FDA adopted a revised insert to be distributed to all physicians who were the end users of the drug. That new insert was published and made available to the relevant physicians in November 2006. In that publication the manufacturer added additional information and cautionary content regarding the risk of renal, cardiac and vascular risks with the use of the drug. Of particular note was the manufacturer's "Indications and Usage" section. Trasylol was indicated for prophylactic use to reduce perioperative blood loss and the need for blood transfusion in **patients undergoing cardiopulmonary bypass in the course of coronary artery bypass graft surgery who are at an increased risk for blood loss and blood transfusion.**

It should be noted that the earlier insert also limited the indications to patients undergoing coronary artery bypass graft procedures in which cardiopulmonary bypass equipment was used; however, both the medical specialists involved and the manufacturer itself were aware that the drug was being used for off-label surgeries including cardiac valve replacements. In December 2006 the FDA again advised the medical community that it was very concerned about Trasylol; however, it wanted more information before making a decision regarding the safety of the drug. The FDA requested and Bayer agreed to inform its customers that the drug was to be used in strict compliance with the insert. Specifically, the manufacturer told its users to adhere strictly to the indications contained in the old and new insert, i.e. it was to be used only in CABG procedures. The FDA issued a press release regarding the new insert in December 2006, and Bayer drafted a form letter, which it sent to each of its customers in the same month. The FDA indicated that it wanted the physicians to "understand the new warnings and use the product as directed by the [insert]". The new insert specifically stated that the

drug was to be used only during CABG procedures. In the December letter the company also made it very clear to the physicians that the drug was to be used incident to CABG procedures only. They also advised the physicians of the renal and cardiac risks raised in the literature. The letter highlighted the changes in the new insert, which had been published in November 2006. It is believed that the information from the FDA and from Bayer was communicated directly to Dr. Haft, Dr. Umashankar and/or the University of Michigan Hospitals and Medical Centers in late 2006.

The revised 2006 insert made many critical points relevant to the facts in this matter. First, the use of the drug was to be restricted to CABG procedures, and was not to be used for valve replacement procedures. Second, patients with pre-existing renal insufficiency were at an increased risk of developing renal complications from the use of Trasylol. Third, patients with other drug allergies were more likely to have a reaction to Trasylol. Fourth, a test dose of Trasylol was to be given at least ten minutes before the loading dose of the drug. Fifth, the loading dose was to be given over a 20-30 minute time period before infusion of the drug. Sixth, the patient was to be placed in a supine position during administration of the test dose and the loading dose. Seventh, the patient was to be closely monitored closely for possible coagulopathy when Trasylol and Heparin were administered concurrently. An elevated ACT level might not reflect a high therapeutic level of Heparin, when Heparin was administered concurrently with Trasylol. Eighth, Protamine titration should be used to establish the adequacy of Heparin levels before any Trasylol is given, so that the anti-coagulation effects of the two drugs can be separated, and so that the results of that titration could be used to determine the effect of the Heparin therapy throughout the operative and post-operative phases. Ninth, the therapeutic level of Heparin must be kept above certain levels during the procedure (reflected by careful monitoring of coagulation studies) independent of the anti-coagulation effect created by the Trasylol given concurrently with Heparin.

The medical records of Ms. Marquardt reflect that no test dose of Trasylol was administered ten minutes before the loading dose. The patient was not in a supine position when she was given the loading dose of Trasylol. The loading dose was not given slowly over a 20-30 minute period of time (only nine minutes separated the loading dose from the start of the infusion of Trasylol). Ms. Marquardt had a history of two different drug allergies. The procedure was a valve replacement procedure and not a CABG procedure. Ms. Marquardt did have evidence of pre-operative kidney dysfunction. Lastly, she was not closely monitored after the administration of Trasylol and Heparin to determine the anti-coagulation effect of Heparin alone versus the synergistic anti-coagulation effect of the two drugs in combination.

Following the surgery, during which Ms. Marquardt received Heparin and Trasylol, she began to manifest significant clinical signs and symptoms of renal disease, which led to multiple other organ system problems. The lack of attention to her renal complications from the Trasylol resulted in other iatrogenic complications and nosocomial infections. Despite numerous medical diagnoses formulated by the numerous physicians who treated Ms. Marquardt over the four months of post-operative care, the diagnosis of Trasylol induced pathology never appeared. It was not even mentioned as part of anyone's differential diagnoses. The various treating physicians did proffer opinions regarding the etiology of her renal disease specifically that they were post-op complications and that may have been related to the lengthy period of time spent on the

bypass equipment; however, they never once mentioned the drug Trasylol as a possible factor.

During the time Ms. Marquardt was an inpatient at the University of Michigan Hospital, the following diagnoses were made and repeated often by the various physicians charged with providing her with care for her post-operative complications:

1. Various nosocomial infections, bacteremia and sepsis.
2. Hyperglycemia secondary to surgical stress requiring Tight Glycemic Control
3. Oliguric
4. Diminished Coronary Output/Coronary Index
5. Hemolysis secondary to long coronary bypass machine time
6. Fluid overload
7. Renal Hypoperfusion
8. Polyuric Renal Failure secondary to prolonged pump time
9. Acute Tubular Necrosis (ATN)
10. Hyperphosphatemia
11. Acute Kidney Injury (AKI) secondary to ATN
12. Hypotension
13. Pulmonary Edema
14. Non-oliguric Renal Failure
15. Acute Respiratory Distress Syndrome (ARDS)
16. Systemic Inflammatory Response Syndrome (SIRS)
17. Prolonged Respiratory Failure
18. Hematuria
19. Metabolic Acidosis
20. Pleural Effusion
21. Swallowing Dysfunction
22. Hypothyroidism
23. Hypercarbia
24. Hypoxemia
25. Clinical Depression
26. Peri-operative vascular leak
27. Respiratory Acidosis
28. Anemia
29. Atrial Fibrillation
30. Sick Euthyroid Syndrome
31. Prerenal Azotemia
32. Moderate Differentiated Encephalopathy
33. End Stage Renal Disease
34. Pulmonary Vein Stenosis
35. Urinary Tract Infection (UTI)
36. Adrenal Insufficiency
37. Cholecystitis
38. Wound Dehiscence
39. Extracellular Fluid Volume Depletion

Each of the above diagnoses appear to be related to Ms. Marquardt's underlying

renal disease, the iatrogenic efforts made by the medical staff to diagnose and treat the underlying renal disease, the nosocomial infections resulting from her long hospital stay, problems caused by the inability of the medical staff to correct the fluid imbalance situation caused by her renal dysfunction, or from the effects of the long-term hospital stay and the decompensation caused by the overwhelming medical and emotional conditions.

Ms. Marquardt has been followed by her primary care physician Raymond Cole, D.O, 107 W. Chicago, Brooklyn, MI 49230, her nephrologists R.V. Nagesh, M.D., 205 N. East Avenue, Jackson, MI 49201, her pulmonologist Robert D. Albertson, M.D., 900 E. Michigan Avenue, Jackson, MI 49201, and her cardiologist Bischan Hassunizadeh, M.D., 205 Page Avenue, Suite B, Jackson, MI 49201.

The standards of care for anesthesiologists and cardio-thoracic surgeons assisting in cardiac surgeries involving the use of cardiopulmonary bypass equipment require that Trasylol not be used during cardiac valve procedures performed after November 2006, given the advisories issued by the FDA and Bayer. The standards of care for both specialties also require that Trasylol induced renal disease should be ruled out as soon as possible, if renal disease is diagnosed or suspected following a surgical procedure in which Trasylol was used. These same standards require the appropriate use of Heparin in conjunction with the concurrent use of Trasylol. The anti-coagulation effect of Heparin must be isolated from the overall anti-coagulation effect of Heparin and Trasylol in combination. Trasylol should not be used as a Heparin sparing agent. Additional Heparin therapy may be needed even if ACT levels are elevated. Protamine titration to measure Heparin therapeutic levels must be performed before the administration of Trasylol and that baseline level must be used to determine if Heparin is needed to maintain anti-coagulation therapy intra-operatively and post-operatively, given that the Trasylol in a renal insufficient patient might be long-lasting and affect anti-coagulation test results, leading to reduced Heparin therapy post-operatively. These standards of care also require the physician to identify, carefully monitor and effectively treat fluid levels to avoid cardiopulmonary complications due to fluid overload or due to extracellular fluid volume depletion. If diagnosed, Trasylol induced renal disease must be aggressively treated with appropriate anti-thrombotic drug therapy, and therapeutic Heparin levels must be implemented to counter the Trasylol induced coagulopathy. If Trasylol is indicated, the applicable standards of care require that a test dose of 1 ml be given at least ten minutes before the loading dose. Then the loading dose should be given slowly over a 20-30 minute time period after induction of anesthesia and before the sternotomy, while the patient is in a supine position. Then the constant infusion of the drug is begun and continued until the surgery is completed and the patient leaves the operating room.

Drs. Haft and Umashankar, together with their associates, residents and fellows, breached applicable standards of care for cardiac surgeons and/or anesthesiologists assisting in cardiac procedures in the following ways:

1. They used Trasylol incident to a mitral valve replacement procedure, despite the indications published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current on the indications for the drug and used the drug during an off-label procedure.
2. They used Trasylol for an off-label purpose, when the FDA and the manufacturer, who were aware of the off-label uses of the drug, cautioned

against using the drug for any procedure other than a CABG procedure, until the drug's safety could be fully reviewed.

3. They ignored Ms. Marquardt's preoperative history of other drug allergies and renal insufficiency, which placed her at an increased risk of an allergic reaction to Trasylol and/or at an increased risk of further renal disease from the drug.
4. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.
5. They failed to take 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, before the sternotomy was performed and before the infusion of the drug was commenced.
6. They failed to adequately separate any coagulopathy caused by the Trasylol from any coagulopathy caused by Heparin therapy or the lack of that therapy, and, in so doing, they decreased or withheld Heparin therapy from the patient when she actually needed the therapy to counteract the Trasylol effects on the kidneys.
7. The failed to recognize the connection between Trasylol (thrombosis) and the hypocoagulopathy demonstrated in the laboratory results.
8. They failed to institute dialysis and/or appropriate diuretic therapy in a timely manner to maintain an appropriate fluid balance.
9. They failed to diagnose Trasylol induced renal disease, and treat it appropriately in a timely manner.
10. They failed to diagnose the prerenal disease caused by the Trasylol and recognize that the problems they were encountering in regards to pulmonary edema, cardiac dysfunction and other organ system failures were directly related to the renal disease, iatrogenic consequences of the inappropriate treatment protocols, nosocomial infections and/or from long periods of ventilation, decompensation and debilitation.

Drs. Haft and Umashankar, together with their associates, residents and fellows, would have complied with applicable standards of care, if they had decided not to use Trasylol during Ms. Marquardt's mitral valve repair procedure on July 20, 2007, given the FDA and manufacturer warnings against using it for such procedures. If they felt that the procedure and patient warranted the use of Trasylol, then they needed to recognize the other risk factors presented by her prior drug allergies and pre-existing renal insufficiency. They also had to use the drug as indicated in the insert regarding a test dose, the loading dose and coagulation assessments during and after the procedure. They also had to rule out Trasylol induced renal disease given the problems that presented in the immediate postoperative period. Then they needed to treat the Trasylol induced renal disease, the coagulopathy, the fluid imbalance and the effects of the renal disease on other organ systems in a timely manner.

As a direct and proximate result of the above negligent acts by Drs. Haft and Umashankar (together with their associates, residents and fellows), Ms. Marquardt was given a contraindicated drug during her mitral valve repair procedure on July 20, 2007. This drug then caused a prerenal condition complicated by an obstructive condition of the kidneys. She also was suffering from a coagulopathy that was caused by the Trasylol, and aggravated by the lack of effective treatment in the postoperative period of time. Her

renal disease, coagulopathy, multi-organ dysfunction, acidosis and a significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, severe depression, as she tried to cope with the lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months, was discharged on hemodialysis, is oxygen dependent due to changes in he lungs from the ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis, ongoing renal disease, ongoing liver disease, heart problems that must be treated with medication and severely debilitated. Her multiple medical problems that began following the above surgery and post-operative complications eventually led to her death on January 27, 2010. She went from an independent person who was able to perform all of her ADL's, except when her mitral valve failed, to a person totally dependent on he husband and others to perform her ADL's and eventually death from renal failure complications. She was also completely oxygen dependent and severely disabled due to the poor care and treatment she received during her four and one-half months of hospitalization. These problems were directly related to the complications from a drug she should not have been given and directly related to the ineffective care and treatment she was given thereafter.

Respectfully submitted,

Thomas C. Miller

TCM:mls

Exhibit 9

XFINITY Connect millertc@comcast.net

Font Size

Notice of Intent

From : millertc@comcast.net
Subject : Notice of Intent
To : umashankar@hotmail.co.uk

Sat, Nov 12, 2011 04:05 PM
1 attachment

Dear Dr. Umashankar:

I have attached a copy of the notice of intent that was sent to the University of Michigan Department of Anesthesiology In September 2011. I am not sure that you were advised of this because I believe you are back in in India.

I am sending you another copy by e-mail, so that you have notice of the claim. I would suggest that you contact Ms. Nugent as soon as you receive this e-mail.

Thomas C. Miller

Marquardt Notice of intent # 2.doc
51 KB

Exhibit 10

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

SARON E. MARQUARDT, Personal Representative of the Estate of SANDRA D. MARQUARDT,

Plaintiff,

v

UNIVERSITY OF MICHIGAN BOARD OF REGENTS,

Defendant.

OPINION AND ORDER

HON. ROSEMARIE E. AQUILINA

Docket No. 10-4-MH

At a session of said Court held in the City of Lansing, County of Ingham, State of Michigan this 6th day of December, 2011

PRESENT: The Honorable Rosemarie E. Aquilina
Court of Claims Judge

This matter comes before the Court on Defendant University of Michigan Board of Regent's ("Defendant") *Motion for Summary Disposition*. This Court, having reviewed Defendant's brief in support and Plaintiff's response; having reviewed all supporting documents and correspondence; having heard oral argument; and being fully apprised of the issues, states the following:

BACKGROUND FACTS

On July 20, 2007, open heart surgery was performed on Sandra D. Marquardt ("Ms. Marquardt") to replace a valve at the University of Michigan Health System by their surgical and anesthesia staffs. During the procedure, the drug Trasylol was used to control bleeding. Ms. Marquardt spent the next four months in the hospital dealing with significant complications from the surgery. On December 31, 2007, Ms. Marquardt retained counsel to investigate the case

against the University of Michigan Health System's surgical and anesthesia staff, which are answerable to the University of Michigan Board of Regents, Defendant. On February 8, 2008, a request for medical records was sent to Defendant. On May 8, 2008, Defendant produced the medical records.

On January 15, 2009, the Federal Drug Administration documents and medical journal articles regarding the drug Trasylol were reviewed by Plaintiff's counsel. Plaintiff's counsel and Ms. Marquardt decided liability rested with Bayer and not with Defendant. A letter was sent to Bayer informing them that Ms. Marquardt wished to make a claim for damages. About four or five months later, Plaintiff's counsel received a call from a representative of Bayer in which it was revealed that the various advisories and revised package inserts had been sent to Defendant in a timely manner. The revised package inserts had advised using the drug for coronary artery bypass grafts procedures only.

On July 20, 2009, the two year statute for medical malpractice claims approached, and Plaintiff's counsel advised the Ms. Marquardt that a notice of intent should be sent to Defendant, just in case the claim against Bayer could not be settled. The notice of intent would permit counsel time to obtain a consultation from a specialist regarding whether or not this was malpractice. On July 20, 2009, the notice of intent was sent to Defendant. On January 19, 2010, the first day the Court of Claims was open for business following the expiration of the tolling period, Plaintiff's counsel filed the complaint. On January 27, 2010, Ms. Marquardt died allegedly as a result of injuries she had sustained following surgery on July 20, 2007. On May 20, 2010, this Court entered an order substituting the Estate of Sandra Marquardt in place of the individual Sandra Marquardt, after a petition for commencement proceedings had been filed with the Jackson County Probate Court. On June 14, 2010, letters of authority were issued to Saron

Marquardt ("Plaintiff") by the Jackson County Probate Court.

DEFENDANT'S ARGUMENT

The claims against Defendant are barred as a matter of law based on the expiration of the statute of limitations, pursuant to MCR 2.116(C)(7). A complete reading of the plain language of MCL 600.5658(c) confirms that the tolling period does not begin to run until the day after the notice of intent is served. Only the remaining days in the statutory period remain at the end of the notice period. In this case, there are no days left remaining in the statutory period after the date Plaintiff gave notice.

Since the notice of intent was served on July 20, 2009, the tolling period began to run on July 21, 2009, with zero days remaining on the statute of limitations. When the tolling period ended, the statute of limitations had already expired and there was no time left to file a complaint. *Dewan v Khoury* 2006 Mich App LEXIS 884 is directly on point in this case. *Dewan* provides that if the notice of intent is served on the last day of the statute of limitations, the tolling period does not apply.

Plaintiff improperly relies on *Omelenchuk v City of Warren* 461 Mich 567 (2000), *Decosta v Gossage*, 486 Mich 116 (2010), *Dunlap v Sheffield*, 193 Mich App 313 (1992), and *Buscaino v Rhodes*, 385 Mich 474 (1971), in support of his claim. Neither *Decosta* nor *Dunlap* provide support for Plaintiff's claim. *Decosta* merely stands for the proposition that a notice of intent is determined filed on the day it is served, and *Dunlap* supports Defendant's position that the tolling period began the day after the notice is served. Plaintiff's reliance on *Omelenchuk* is inapplicable to this case because the *Omelenhuck* case deals with a notice of intent filed well within the statute of limitations and did not address the issue in this case where the statute of limitations had expired.

MCL 600.5856(c) and MCR 1.108(1) clearly contradict Plaintiff's arguments based on *Omelenchuk*, and state that the tolling period begins the day after the notice of intent is filed. The statutes are to be followed as written and following the statutes as written, as well as the interpretation in *Dewan*, the statute of limitations in this case expired before the tolling period began and summary disposition is appropriate.

Plaintiff has failed to comply with MCL 600.6431(3), which provides that in all actions for personal injuries against a State institution, the claimant shall file with the Clerk of the Court of Claims a notice of intention to file a claim, or file the claim itself, within 6 months following the occurrence that gives rise to the potential cause of action. The Court of Appeals in *McCahan* specifically stated that the MCL 600.6431(3) filing requirement is a condition precedent to sue the state in a personal injury action. *McCahan v Brennan, et al*, 2011 Mich App LEXIS 210 (Mich Ct. App, Feb 1, 2011). The *McCahan* court also stated that substantial compliance does not satisfy the requirements of MCL 600.6431(3). *Id.* The July 20, 2009 notice of intent, which was not filed with the Clerk, was provided for two years after the event giving rise to the cause of action. MCL 600.6431(3) clearly requires that a plaintiff with a personal injury claim against the state must file with the clerk of the Court of Claims a notice of intent to sue or an actual claim within six months of the date of the events giving rise to the claim. Plaintiff failed to do so because the surgery took place on July 20, 2007, and Plaintiff filed on July 20, 2009.

Finally, MCL 600.6431 does not require that the defendant demonstrate prejudice when a plaintiff fails to comply with a statutory requirement. *Id.* The Court of Appeals reaffirmed the controlling nature of *McCahan* in *Kline v Department of Transportation*, 2011 Mich App LEXIS 411, even though the panel disagreed with the ruling of *McCahan*.

The death savings provision of MCL 600.582 does not apply in this case.

PLAINTIFF'S ARGUMENT

Defendant relies principally upon dictum contained in the unpublished decision in *Dewan v Khoury* 2006 Mich App LEXIS 884, which was decided in March 2006. The dictum contained in *Dewan* and relied upon by Defendant is actually inconsistent with the holding in the case, and that dictum was inconsistent with the Michigan Supreme Court decision in *Omelenchuk v City of Warren*, 461 Mich 567 (2000).

In *Dewan*, the claimed negligence occurred on June 4, 2002. The plaintiff in *Dewan* filed a notice of intent on June 4, 2004, which was the last day of the statute of limitations. The Court of Appeals found that the 182 day tolling period ended on December 3, 2004. The plaintiff in the *Dewan* matter did not file her complaint until December 6, 2004, which was Monday. Defendant mistakenly relies on dictum in *Dewan*. The *Dewan* court, in affirming the trial court's granting of summary disposition, stated, in dictum, that "[t]he 182 day tolling period began running on June 5, 2004, MCR 1.108(1) and expired on Friday, December 3, 2004." The Court also stated that since the entire 182 days had to be allowed to run, the complaint could not be filed on December 3, 2004. That finding was inconsistent with the Court's decision affirming summary disposition because the complaint was not timely filed on December 3, 2004, but rather December 6, 2004.

In contrast, the Court of Appeals in *Zwiers v Growney*, 286 Mich App 38, 40-41 (2009), stated plaintiff could have timely filed her complaint 182 days from the date of filing notice of intent. The plaintiff in *Zwiers* suffered injuries on September 2, 2005. On August 30, 2007, plaintiff served her notice of intent on defendants. On February 27, 2008, 181 days after serving notice of intent on the defendant, plaintiff filed her complaint. The *Zwiers* court stated that "[t]o be in compliance with MCL 600.2912b(1), the complaint and affidavit needed to be filed on or

after February 28, 2008," 182 days after the filing the notice of intent. The Court specifically identified that a plaintiff may file a complaint on or after 182 days after notice of intent was sent.

If this claim against the Defendant actually accrued on July 20, 2007, the statute of limitations would have expired at the end of the day on July 20, 2009, pursuant to MCR 1.108(1) and MCL 600.5838a(1), unless the applicable statute of limitations was tolled. *Dunlap v Sheffield*, 193 Mich App 313, 314 (1992). Plaintiff relies upon the unambiguous language contained in MCL 600.5658(c), which contains the tolling provision relevant to this litigation. That statute clearly states that the tolling begins at the time notice is given, which in this case was July 20, 2009. The statute of limitations had not expired on July 20, 2009 when the notice of intent was served upon Defendant.

The Michigan Supreme Court addressed this very issue in *Decosta*. *Decosta* at 118. The Court held that if the notice of intent was timely filed, then the statute of limitations was tolled pursuant to MCL 600.5856(c). Once the statute of limitations was tolled pursuant to MCL 600.5856(c), it remained tolled for the full 182 days permitted by MCL 600.2912b(1), even if Defendant failed to provide a notice of meritorious defense within 154 days. The Court of Appeals in *Decker v Rochowiak*, 287 Mich App 666, 667 (2010), citing the Supreme Court's decision in *Bush*, stated quite unambiguously that once notice of intent is given, the applicable statute of limitations is tolled by MCL 600.5856. In *Omelenchuk*, the Supreme Court was confronted with facts that revealed that the notice of intent was mailed to the defendant on December 11, 1995. The Court clearly stated that the tolling period of 182 days ran from December 11, 1995 until June 10, 1996 (182 days).

In contrast, in *Buscaino v Rhodes*, 385 Mich 474, 481-82 (1971), the Supreme Court clearly stated the tolling occurred the moment the complaint was filed. Plaintiff asserts that that

holding can easily be used to hold that the moment the notice of intent was mailed the applicable statute of limitations was tolled. Defendant has relied on an unpublished decision, *Lancaster v Wease*, 2010 Mich App LEXIS 1819, and *Dewan*, both of which used date calculations which were clearly inconsistent with those proffered by the Supreme Court in *Omelenchuk*.

In addition, the notice provisions contained in MCL 600.6431(3) were met. The notice requirements contained in MCL 600.6431(3) were not activated until a claim actually accrued. *Oak Construction Co. v Highway Department*, 33 Mich App 561, 565-67 (1971) and *Cooke v Highway Department #1*, 55 Mich App 336, 338-39 (1974) support the proposition that a claim does not accrue, pursuant to MCL 600.6431(1), until the state has rejected the administrative claim, and the time limits imposed by that statute did not begin to run until the administrative efforts had been denied. Plaintiff did not appreciate that there was a potential claim against Defendant until its letter to Bayer, sent on January 15, 2009, generated a call from Bayer regarding the nature and extent of the notice that Bayer had provided to Defendant regarding the restricted use of Trasylol in the middle of 2009. This is when he first became aware of a possible claim against Defendant. Then on July 20, 2009, an administrative claim was filed with Defendant, pursuant to MCL 600.2912b, which was consistent with the requirements contained in MCL 600.6431(3), and the claim was filed within 6 months of when the claim accrued. When Defendant failed to settle the matter administratively by January 18, 2010, it became evident that Defendant had no intention of settling the case and a lawsuit would be required. This became the happening of the event giving rise to the cause of action as set forth in MCL 600.6431(3), which then required Plaintiff to file a notice of intention to file a claim or the claim itself.

In addition, a significant number of appellate decisions have long established that the state must show actual prejudice in order to move for summary disposition based upon a

plaintiff's failure to comply with the notice requirements contained in MCL 600.6431(3). The Michigan Supreme Court in *Rowland* did not address whether or not the notice requirements contained in MCL 600.6431 were affected by its decision, nor did it hold that all statutorily created notice requirements were to be treated in the same manner. The decision in *May v Department of Natural Resources*, 140 Mich App 730, (1985), should remain the controlling authority of showing actual prejudice.

Lastly, MCL 600.6452 establishes a three year statue of limitations for claims filed against the State of Michigan which is controlling in this case. In addition, MCL 600.5852 provides "the claim possessed by decedent would have been saved for up to three years from the date the statute of limitations would have expired, provided Decedent died within the applicable statute of limitations period, or, Decedent died within 30 days after the statute of limitations had expired." Therefore, Plaintiff could have timely filed the complaint on or before June 14, 2012, two years after the letters of authority were issued on June 14, 2010.

CONCLUSIONS OF LAW

Summary disposition is available, pursuant to MCR 2.116(C)(7), when a claim is barred by the statute of limitations. A defendant who files a *Motion for Summary Disposition*, pursuant to MCR 2.116(C)(7), may, but is not required to file supportive material such as affidavits, depositions, admissions, or other documentary evidence. *Turner v Mercy Hospitals & Health Services of Detroit*, 210 Mich App 345, 348 (1995). When reviewing a motion pursuant to MCR 2.116(C)(7), a court must consider all affidavits, pleadings, and other documentary evidence submitted by the parties and construe the pleadings and evidence in favor of the nonmoving party. *Doe v Roman Catholic Archbishop of the Archdiocese of Detroit*, 264 Mich App 632, 638 (2004).

MCL 600.5838a(1) provides "a medical malpractice action accrues at the time of the act or omission that is the basis for the claim of medical malpractice, regardless of the time the plaintiff discovers or otherwise has knowledge of the claim." The Court of Appeals in *McKiney v Clayman*, 237 Mich App 198, 204 (1999) held that the accrual date of medical malpractice claims is on the occasion of the act or omission complained of. In this case, it is July 20, 2007, the date of surgery. Plaintiff claims that the accrual date was when Defendant failed to settle the matter administratively by January 18, 2010. Plaintiff relies on *Oak v Construction Co. v Highway Department*, 33 Mich App 561, 565-67 (1971) and *Cooke v Highway Department #1*, 55 Mich App 336, 338-39 (1974), for support of the principle that the accrual date did not begin until the exhaustion of administrative remedies. However, the cases relied on by Plaintiff dealt specifically with state employers who had contracts providing that in order to file a complaint or sue, the employee must pursue all administrative remedies first. There is nothing of the sort in this case and the cases are not applicable. Therefore, the date of accrual is not when Plaintiff found there was a potential claim against Defendant when receiving a response from Bayer, it is the date of surgery, July 20, 2007.

Mailing of a notice of intent before the statute of limitations expires is a prima face case for compliance with MCL 600.2912b. *Decosta* at 118. Here, Plaintiff mailed the notice of intent on the last day of the statute of limitations, July 20, 2009, and therefore complied with MCL 600.2912b. If Plaintiff had filed the notice of intent on July 21, 2009, then the mailing would not be in compliance with MCL 600.2912b because the statute of limitations would have expired.

MCL 600.2912b states in relevant part:

> (1) Except as otherwise provided in this section, a person shall not commence an action alleging medical malpractice against a health professional or health facility unless the person has given the health professional or health facility written notice under this section not less than

> 182 days before the action is commenced.
>
> (7) Within 154 days after receipt of notice under this section, the health professional or health facility against whom the claim is made shall furnish to the claimant or his or her authorized representative a written response that contains the information required by MCL 600.6912b(7) (a)-(d);
>
> (8) If the claimant does not receive the written response required under subsection (7) within the required 154-day time period, the claimant may commence an action alleging medical malpractice upon the expiration of the 154-day period.
>
> (9) If at any time during the applicable notice period under this section a health professional or health facility receiving notice under this section informs the claimant in writing that the health professional or health facility does not intend to settle the claim within the applicable notice period, the claimant may commence an action alleging medical malpractice against the health professional or health facility, so long as the claim is not barred by the statute of limitations.

These subsections set forth a number of requirements. A plaintiff cannot file suit without giving the notice required by subsection (1). No suit can be filed for 182 days after notice is given. The interval of 182 days during which a suit cannot be filed can be reduced to 154 days if the health professional or health facility fails to respond to the notice. The interval can also be reduced if the health professional or health facility responds that it will not settle.

Plaintiff timely filed her complaint 182 days from the date of filing notice of intent. In *Zwiers*, the Court of Appeals stated that "[t]o be in compliance with MCL 600.2912b(1), the complaint and affidavit needed to be filed on or after February 28, 2008," 182 days after the filing of the notice of intent. *Zwiers* at 40-41. The Court specifically identified that a plaintiff may file a complaint on or after 182 days after notice of intent was sent. In this case, 182 days ended on January 18, 2010. However, this Court was closed in observance of Martin Luther King Day. Plaintiff filed the complaint on January 19, 2010, which was 182 days after the notice of intent was sent, when the Court resumed. Therefore, it was timely pursuant to MCL

600.2912b.

However, MCL 600.6431(3) provides "in all actions for property damage or personal injuries, claimant shall file with the clerk of the court of claims giving a notice of intention to file a claim or the claim itself within 6 months following the happening of the event giving rise to the cause of action." Section (3) clearly states that a "claimant *shall* file with the clerk of the Court of Claims. . . . within 6 months following the happening of the event." The word "shall" designates a mandatory provision. *Walters v Nadell*, 481 Mich 377, 383 (2008). Clear statutory language must be enforced as written. *Flour-Enterprises, Inc v Dep't of Treas*, 477 Mich 170, 174 (2007). It is clear Plaintiff has failed to comply with MCL 600.6431(3). Plaintiff filed the notice of intent two years after the date of accrual on July 20, 2007. Therefore, Plaintiff has not timely filed the claim against Defendant, pursuant to MCL 600.6431(3).

Prejudice does not have to be shown when a plaintiff does not comply with a statutory filing requirement. In *Rowland*, the Michigan Supreme Court overturned several cases that had required the state to show actual prejudice when a plaintiff failed to comply with a statutory filing requirement. *Rowland v Washtenaw County Rd Comm'n*, 477 Mich 197, 219 (2007). The Supreme Court in *Rowland* stated that because the language of the statute was clear on the filing requirement, the Supreme Court would not give the statute any judicial construction. The filing requirement was strictly applied. *Id.* The filing requirement must be applied as it is written without a reading of prejudice into the statute.

The Court of Appeals recently addressed the notice requirements in MCL 600.6431 in *McCahan v Brennan, et al*, 2011 Mich App Lexis 210 (Mich Ct. App, Feb 1, 2011). The *McCahan* court, relying on *Rowland*, reasoned that the notice requirements contained in MCL 600.6431(3) should be treated the same way that the Supreme Court treated the notice

requirements in *Rowland*. Furthermore, the Court of Appeals reaffirmed the principle in *Kline v Department*, 2011 WL 711042. Thus, the notice requirement of MCL 600.6431(3) cannot have prejudice read into the statute as was held in *Rowland*.

MCL 600.5852 is also inapplicable because the statute applies where a potential plaintiff dies within 30 days of the expiration of the statute of limitations. Here, Ms. Marquardt died on January 27, 2010 more than six months after the statute of limitations expired on July 20, 2009. Therefore, the wrongful death savings provision does not apply here.

THEREFORE, IT IS ORDERED that Defendant's *Motion for Summary Disposition* is **GRANTED**, pursuant to MCR 2.116(C)(7). In compliance with MCR 2.602(A)(3), this Court finds that this decision resolves the last pending claims and closes the case.

IT IS SO ORDERED.

Hon. Rosemarie E. Aquilina (P37670)
Court of Claims Judge

PROOF OF SERVICE

I hereby certify I served a copy of the above Order upon Plaintiff and upon Defendant by placing the Order in sealed envelopes addressed to the attorney of each party and deposited them for mailing with the United States Mail at Lansing, Michigan, on December 6, 2011.

Luke A. Goodrich (P72090)
Law Clerk

Exhibit 11

STATE OF MICHIGAN

COURT OF APPEALS

In re Estate of SANDRA D. MARQUARDT.

SARON E. MARQUARDT, Personal Representative of the Estate of SANDRA D. MARQUARDT,

Plaintiff-Appellant,

v

UNIVERSITY OF MICHIGAN BOARD OF REGENTS,

Defendant-Appellee.

UNPUBLISHED
November 27, 2012

No. 307917
Court of Claims
LC No. 10-000004-MH

Before: BORRELLO, P.J., and FITZGERALD and OWENS, JJ.

PER CURIAM.

In this medical malpractice action, plaintiff appeals as of right the order granting summary disposition in favor of defendant on the ground that plaintiff failed to comply with the notice provision of MCL 600.6431(3). We affirm.

On July 20, 2007, Sandra Marquardt underwent mitral valve replacement surgery at the University of Michigan Hospital and Health Center. Defendant University of Michigan Board of Regents governs the hospital, MCL 390.3, and may sue and be sued on behalf of the hospital. MCL 390.4. According to plaintiff's complaint, during the surgery the hospital negligently administered to Marquardt the drug Trasylol. Marquardt died on January 27, 2010, allegedly as a result of complications resulting from administration of the Trasylol.

On July 20, 2009, counsel sent a notice of intent to file a medical malpractice claim pursuant to MCL 600.2912b to defendant and three doctors who performed the surgery. On January 19, 2010, Marquardt filed a complaint alleging medical malpractice in the Court of Claims. After Marquardt's death, plaintiff was appointed personal representative of Marquardt's estate and the estate was substituted as plaintiff in this action.

Defendant moved for summary disposition on the grounds that plaintiff failed to file her cause of action within the statute of limitations and that she failed to satisfy the notice provision

of MCL 600.6431(3). The trial court granted summary disposition in favor of defendant on the ground that plaintiff failed to satisfy the notice provision in MCL 600.6431(3).

We review de novo a trial court's ruling on a motion for summary disposition. *Jimkoski v Shupe*, 282 Mich App 1, 4; 763 NW2d 1 (2008). We also review de novo issues of statutory interpretation. *Driver v Naini*, 490 Mich 239, 246; 802 NW2d 311 (2011).

There is no dispute that the Court of Claims has jurisdiction over this personal injury claim. MCL 600.6419(1)(a). Cases brought in the Court of Claims are subject to the notice provisions of MCL 600.6431. MCL 600.6431(3) provides:

> In all actions for property damage or personal injuries, claimant shall file with the clerk of the court of claims a notice of intention to file a claim or the claim itself within 6 months following the happening of the event giving rise to the cause of action.

"A claim based on the medical malpractice . . . accrues at the time of the act or omission that is the basis for the claim of medical malpractice, regardless of the time the plaintiff discovers or otherwise has knowledge of the claim." MCL 600.5838a(1); see also *McKiney v Clayman*, 237 Mich App 198, 203-204; 602 NW2d 612 (1999). Thus, the "happening of the event giving rise to the cause of action" in this case was the allegedly negligent administration of Trasylol during Marquardt's surgery on July 20, 2007. MCL 600.6431(3). In order to pursue her claim against defendant, Marquardt was required to file "a notice of intention to file a claim or the claim itself" in the Court of Claims within six months of July 20, 2007. *Id.* The claim was not filed until January 19, 2010. Thus, summary disposition in favor of defendant was appropriate.

Plaintiff argues on behalf of the estate that MCL 600.6431's notice provision is inapplicable because it conflicts with the medical malpractice notice provision of MCL 600.2912b. The two statutory notice provisions do not conflict and both can be met by a medical malpractice plaintiff. MCL 600.6431(3) requires that notice of intent to file a claim must be filed with the clerk of the Court of Claims within six months after the conduct giving rise to the claim. The notice must state "the time when and the place where such claim arose and in detail the nature of the same and of the items of damage alleged or claimed to have been sustained." MCL 600.6431(1). MCL 600.2912b(1) requires that notice of the claim be provided to the medical malpractice defendant not less than 182 days before the action is commenced. That notice must state the "factual basis for the claim," the "applicable standard of practice or care," the manner in which the defendant breached the standard of care, how the defendant could have avoided the breach, how the breach caused the plaintiff's injury, and the "names of all health professionals and health facilities" being notified. MCL 600.2912b(4). Nothing prevents a plaintiff from complying with both statutory notice provisions. There simply is no conflict entitling the estate to avoid strict compliance.

Plaintiff argues that, despite her failure to comply with MCL 600.6431(3), the trial court should not have dismissed the action without a showing of actual prejudice by defendant. This argument was considered and rejected in *McCahan v Brennan*, ___ Mich ___; ___ NW2d ___ (Docket No. 142765, decided August 20, 2012), slip op at 16-17 ("when the Legislature

specifically qualifies the ability to bring a claim against the state or its subdivisions on a plaintiff's meeting certain requirements that the plaintiff fails to meet, no saving construction—such as requiring a defendant to prove actual prejudice—is allowed"). Thus, the trial court did not err in ruling that defendant was not required to prove actual prejudice and dismissing plaintiff's claim.

We decline to address plaintiff's unpreserved argument that the application of MCL 600.6431(3) to medical malpractice cases has no "rational basis." The "interest of justice and judicial economy" do not dictate that we disregard the preservation requirements in this case. See *STC, Inc v Dep't of Treasury*, 257 Mich App 528, 538; 669 NW2d 594 (2003). Further, decisions of our Supreme Court and this Court have repeatedly upheld the constitutionality of notice provisions and rejected the idea that such provisions unconstitutionally favor government defendants. See, e.g., *Rowland v Washtenaw Co Rd Comm*, 477 Mich 197, 210; 731 NW2d 41 (2007); *Gleason v Dep't of Transp*, 256 Mich App 1, 2-3; 662 NW2d 822 (2003).

Affirmed.

/s/ Stephen L. Borrello
/s/ E. Thomas Fitzgerald
/s/ Donald S. Owens

Exhibit 12

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of the Estate of Sandra D. Marquardt,

Plaintiff,

v.

VELLAIAH DURAI UMASHANKAR, M.D.

Defendants.

Case No. 12-621-NH

Honorable David S. Swartz

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DEFENDANT VELLAIAH DURAI UMASHANKAR, M.D.'S
MOTION FOR SUMMARY DISPOSITION

Defendant Vellaiah Durai Umashankar, M.D., through his undersigned counsel, moves for summary disposition in his favor pursuant to MCR 2.116(C)(7) and MCR 2.119 because the action is barred by the statute of limitations. On September 26, 2013, Dr. Umashankar, through counsel, sought the concurrence of Plaintiff Saron E. Marquardt, Personal Representative of the Estate of Sandra Marquardt, in the relief requested but concurrence was denied. Dr. Umashankar therefore requests that his motion be granted and that the Complaint be dismissed with prejudice.

Respectfully submitted,

KERR, RUSSEL AND WEBER, PLC

By: _____
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Dated: September 26, 2013

{34784/15/DT791325.DOC;1}

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of the Estate of Sandra D. Marquardt,

Plaintiff,

v.

VELLAIAH DURAI UMASHANKAR, M.D.

Defendants.

Case No. 12-621-NH

Honorable David S. Swartz

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BRIEF IN SUPPORT OF DEFENDANT VELLAIAH DURAI UMASHANKAR, M.D.'S MOTION FOR SUMMARY DISPOSITION

STATEMENT OF QUESTION PRESENTED

The question presented is whether the Complaint is barred by the statute of limitations.

STATEMENT OF FACTS AND PROCEEDINGS

Plaintiff Saron E. Marquardt, Personal Representative of the Estate of Sandra D. Marquardt, commenced this action on June 6, 2012 asserting that Dr. Jonathan Haft and Dr. Vellaiah Durai Umashankar breached the standard of care in administering the drug Trasylol (a/k/a Aprotinin) to Sandra Marquardt in the course of mitral valve replacement surgery. See Complaint, Exhibit A, ¶ 9. The surgery was performed on July 20, 2007. Complaint, ¶7. Mr. Marquardt *alleges* that the drug, which was administered to control bleeding during the surgery, caused Sandra Marquardt to develop a "significant pre-renal condition complicated by an obstructive kidney condition" and "coagulopathy," ultimately leading to death. Complaint, ¶11.

The Complaint alleges that "Defendants were initially served with notices of intent pursuant to MCL 600.2912b on July 20, 2009" and again on November 14, 2011. Complaint, ¶ 6. But the July 20, 2009 notice was not directed to Dr. Haft or Dr. Umashankar; it was directed to "Risk Manager University of Michigan Health System." See July 20, 2009 NOI, Exhibit B. Further, the University of Michigan was the only named defendant when, on January 19, 2010 (after expiration of the notice-tolling period), Sandra Marquardt commenced an action in the Court of Claims. See Complaint against Board of Regents, Exhibit C.

Sandra Marquardt died on January 27, 2010 while the Court of Claims action against U of M remained pending. Complaint (Exhibit A), ¶12. Her husband, Saron Marquardt, was appointed personal representative on June 14, 2010 and continued the Court of Claims suit on behalf of Sandra's estate. See Letters of Authority, Exhibit D. On August 31, 2011, U of M filed a motion for summary disposition in the Court of Claims action asserting (1) that the applicable statute of limitations expired before the Court of Claims complaint was filed; and (2)

that plaintiff's failure to comply with the Court of Claims notice filing requirement barred the action. While the motion for summary disposition was pending in the Court of Claims action, Mr. Marquardt sent individual notices of intent to Dr. Haft and Dr. Umashankar. See Notice of Intent to Dr. Haft dated September 2, 2011 (Exhibit E) and Notice of Intent to Dr. Umashankar dated September 2, 2011 (Exhibit F). Unlike the July 20, 2009 NOI, which was directed to:

> Risk Manager
> University of Michigan Health System
> 1500 E. Medical Center Drive
> Ann Arbor, MI 48109-5912

the September 2, 2011 NOI to Dr. Haft was expressly addressed to:

> Jonathan W. Haft, M.D.
> University of Michigan Cardiovascular Center
> Section of Cardiac Surgery
> 1500 E. Medical Center Drive, Floor 3
> Ann Arbor, MI 48109-5853

and the NOI to Dr. Umashankar was addressed to:

> Vellaiah Durai Umashankar, M.D.
> c/o University of Michigan Cardiovascular Center
> Department of Anesthesia
> 1500 E. Medical Center Drive, SPC 5861
> Ann Arbor, MI 48109

(Exhibits E and F).

Summary disposition was granted to the University of Michigan in the Court of Claims action on December 6, 2011 due to Mrs. Marquardt's failure to file the requisite Court of Claims notice. The Court rejected the statute of limitations grounds for the motion (which differs from the statute of limitations grounds invoked here).[1] Thereafter, on June 6, 2012, Mr. Marquardt

---

[1] The statute of limitations argument made in the Court of Claims action asserted that because the medical malpractice notice of intent was served on the last day of the limitations period, there was no time left in the limitations period within which to commence the action after the requisite tolling period expired.

commenced this action against Dr. Haft and Dr. Umashankar. Dr. Haft was immediately served and later dismissed on summary disposition due to Mr. Marquardt's failure to file the requisite affidavit of merit as to Dr. Haft with the complaint. See 2/13/13 Order (Exhibit G). Dr. Umashankar was only recently served through the Hague Convention, and now seeks summary disposition based upon Mrs. Marquardt's failure to commence the action within the applicable limitations period.

ARGUMENT

I. Summary Disposition Is Required Because the Complaint Against Dr. Umashankar is Barred By the Applicable Statute of Limitations.

Under the statute of limitations period applicable to medical malpractice claims and the concomitant accrual, notice, tolling and savings provisions, the statute of limitations which governs the claims against Dr. Umashankar expired on July 20, 2009. The requisite pre-suit notice of intent was not directed to Dr. Umashankar until September 2, 2011 – over two years after the statute of limitations expired.[2] Consequently, the notice-tolling provision had no effect and did not extend the statute of limitations beyond the July 20, 2009 expiration date. Likewise, the wrongful death savings provision does not extend the time for suit against Dr. Umashankar because Sandra Marquardt died on January 27, 2010, more than 30 days after the statute of limitations expired on July 20, 2009. For these reasons, which are more fully explained below, summary disposition for Dr. Umashankar is required.

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[2] The Complaint erroneously asserts that Dr. Umashankar was served with a notice of intent "on or about November 14, 2011." The date discrepancy is irrelevant to the analysis. Irrespective of whether the NOI was served on September 2, 2011 or November 14, 2011, the limitations period had long since expired and was not subject to tolling.

A. Pursuant to MCL 600.5838a, the Claim Against Dr. Umashankar Accrued On July 20, 2007, Which Is the Time of the Act or Omission Giving Rise to the Claim.

By statute, a claim for medical malpractice accrues at the time of the act or omission giving rise to the claim. MCL 600.5838a(1) states, in pertinent part, that a claim based on the medical malpractice of a person who holds himself out to be a licensed health care professional "accrues at the time of the act or omission that is the basis for the claim of medical malpractice, regardless of the time the plaintiff discovers or otherwise has knowledge of the claim."

In this case, the basis for the claim against Dr. Umashankar is the administration of Trasylol during mitral valve surgery. See Complaint, ¶s 8-12. As the Complaint acknowledges, the surgery was performed on July 20, 2007 (Complaint, ¶7). Consequently, the claim accrued on July 20, 2007.

B. The Discovery Rule Does Not Extend the Limitations Period.

In some cases, a malpractice claim may be properly commenced within six months after the plaintiff discovers or should have discovered the existence of the claim (if that is later than the otherwise applicable limitations period). MCL 600.5838a(2). The burden of proving that the claim was not earlier discovered "is on the plaintiff." *Id.* In this case, Mr. Marquardt does not - and cannot - allege that discovery was delayed until six months before the initiation of this action because the case against U of M arising out of the very same allegations was filed on January 19, 2010 (two and a half years before the action against Dr. Umashankar was commenced). Consequently, Mr. Marquardt unquestionably discovered the claim more than six months before the initiation of the action against Dr. Umashankar, and the discovery rule has no bearing on the timeliness of Mr. Marquardt's claim.

C. The Two-Year Statute of Limitations Applicable To This Claim Expired on July 20, 2009.

Once a claim accrues, a medical malpractice plaintiff has two years within which to commence an action. MCL 600.5805(6) states that "[e]xcept as otherwise provided in this chapter, the period of limitations is 2 years for an action charging malpractice." In this case, the claim against Dr. Umashankar accrued on July 20, 2007 and expired two years later, on July 20, 2009. The Complaint against Dr. Umashankar was filed on June 6, 2012 and is therefore time-barred.

D. Because Notice Was Given After the Statute of Limitations Expired, It Does Not Toll the Limitations Period.

At least 182 days prior to commencing an action for medical malpractice, a plaintiff must give the health professional written notice of intent to file the claim. MCL 600.2912b(1).[3] The statute of limitations is then tolled for a period "not longer than the number of days equal to the number of days remaining in the applicable notice period after the date notice is given" if during that period a claim would be barred by the statute of limitations. MCL 600.5856(c). After the initial notice is given, "the tacking or addition of successive 182-day periods is not allowed, irrespective of how many additional notices are subsequently filed for that claim and irrespective of the number of health professionals or health facilities notified." MCL 600.2912b(1).

In this case, the statute of limitations expired nearly two years before the pre-suit notice of intent was directed to Dr. Umashankar on September 2, 2011. Therefore, irrespective of

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[3] The required notice is shortened to 91 days if the notice was previously filed against other health professionals or facilities involved in the claim, the notice period has expired as to those health professionals and facilities, an action has been commenced against one or more of them, and the ***claimant did not identify, and could not reasonably have identified*** the additional health professional as a potential party before filing the complaint. MCL 600.2912b(3). Mr. Marquardt does not and cannot allege that he was previously unable to identify Dr. Umashankar as a potential party to the action.

whether the limitations period was tolled during the initial notice period (commenced when a pre-suit NOI was directed to the University and culminated in the Court of Claims action against the University), the MCL 600.5856(c) notice tolling provision has no impact on the timeliness of Mr. Marquardt's claim against Dr. Umashankar.

E. The Statute of Limitations Period Is Not Extended By the Wrongful Death Savings Provision Because Sandra Marquardt Died More Than Thirty Days After the Statute of Limitations Expired.

The time within which Mr. Marquardt was required to sue Dr. Umashankar is not extended by the wrongful death savings provision. MCL 600.5852 states:

> If a person dies ***before the period of limitations has run or within 30 days after the period of limitations has run***, an action which survives by law may be commenced by the personal representative of the deceased person at any time within 2 years after letters of authority are issued although the period of limitations has run. But an action shall not be brought under this provision unless the personal representative commences it within 3 years after the period of limitations has run.

(emphasis added). The statute of limitations expired on Mrs. Marquardt's claim more than 30 days before the action was commenced against Dr. Umashankar. Consequently, the wrongful death savings provision does not extend the time for filing suit against Dr. Umashankar.

1. Mrs. Marquardt Died More Than Thirty Days After the Statute of Limitations Expired.

The statute of limitations expired on the claim against Dr. Umashankar on July 20, 2009, two years after the claim accrued on July 20, 2007. Because Sandra Marquardt died on January 27, 2010, more than 30 days after the period of limitations expired, there was no action surviving by law at the time of her death. Thus, the additional time to sue afforded by MCL 600.5852 does not apply to this case. As a result, the statute of limitations expired before Mr. Marquardt filed this action on June 6, 2012 and the action is time-barred.

2. The Pre-Suit NOI Directed to the University Health System Risk Manager on July 20, 2009 Did Not Toll the Statute of Limitations As To Dr. Umashankar.

The pre-suit notice of intent directed to the University of Michigan Health System Risk Manager on July 20, 2009 did not toll the statute of limitations with respect to the claims against Dr. Umashankar because it was not directed to Dr. Umashankar. In *Driver v Naini*, 490 Mich 239, 249; 802 NW2d 311 (2011), the Michigan Supreme Court expressly stated that "[w]hen a claimant files an NOI with time remaining on the applicable statute of limitations, that NOI tolls the statute of limitations for up to 182 days *with regard to the recipients of the NOI.*" (emphasis in original). In *Driver*, the NOI was directed to a doctor and his professional corporation but was not directed to a second professional corporation with which the doctor was associated during the period of treatment. The Court explained:

> There is no dispute that plaintiff timely filed suit within this six-month period with respect to Dr. Naini and MCA. Plaintiff provided those defendants an NOI in April 2006 and then waited 182 days before filing his complaint in October 2006. Plaintiff, however, first provided CCA an NOI in February 2007 and filed a complaint against CCA in March 2007, long after the six-month discovery period expired in May 2006. Because a medical malpractice plaintiff must provide *every* defendant a timely NOI in order to toll the limitations period applicable to the recipient of the NOI, plaintiff failed to toll the limitations period applicable to CCA. Hence plaintiff's complaint was time-barred with regard to CCA, and the Court of Appeals properly remanded the case for entry of summary disposition in CCA's favor.

Id. at 251 (emphasis in original) (footnotes omitted). See also, *Burton v Reed City Hosp Corp*, 471 Mich 745, 753; 691 NW2d 424 (2005) (stating that compliance with MCLA 600.2912b is mandatory before tolling may occur and that this clear, unambiguous statute requires full compliance with its provisions as written", citing *Roberts v Mecosta Co Gen Hosp*, 466 Mich 57, 65-67; 642 NW2d 663 (2002) (*Roberts I*)).

As discussed above, the July 20, 2009 NOI was directed to the Risk Manager University of Michigan Health Systems, not to Dr. Umashankar; thus, the NOI did not toll the limitations

period as to Dr. Umashankar. This result is not altered by the pre-suit notice provision which permits a NOI to be mailed to the health facility if the doctor's last known address cannot be determined. See MCL 600.2912b. Even when MCL 600.2912b permits the pre-suit notice to be mailed to the hospital because the physician-defendant's address is unknown, the pre-suit notice must still be directed to the physician-defendant. In other words, one must not confuse the address to which the NOI is mailed with the person or entity to whom it is to be given. Nothing in the statute permits a plaintiff to direct notice intended for a physician to the risk manager of the hospital. The pre-suit notice must still be "given" to the physician although under certain circumstances, it may be "mailed" to the physician at the hospital. MCL 600.2912b states in part (with emphasis added):

> Sec. 2912b. (1) Except as otherwise provided in this section, ***a person shall not commence an action alleging medical malpractice against a health professional*** or health facility ***unless the person has given the health professional*** or health facility ***written notice under this section*** not less than 182 days before the action is commenced.
>
> (2) The notice of intent to file a claim required under subsection (1) ***shall be mailed to the last known professional business address or residential address of the health professional*** or health facility ***who is the subject of the claim***. Proof of the mailing constitutes prima facie evidence of compliance with this section. ***If no last known professional business or residential address can reasonably be ascertained, notice may be mailed to the health facility where the care that is the basis for the claim was rendered.***

And in fact, when the pre-suit NOI intended for Dr. Umashankar was directed to him on September 2, 2011, it was specifically addressed to Dr. Umashankar at the hospital in the following manner:

> Vellaiah Durai Umashankar, M.D.
> c/o University of Michigan Cardiovascular Center
> Department of Anesthesia
> 1500 E. Medical Center Drive, SPC 5861
> Ann Arbor, MI 48109

(Exhibit F), unlike the July 20, 2009 NOI, which was directed to "Risk Manager, University of Michigan Health System, 1500 E. Medical Center Drive, Ann Arbor, MI 48109-5912." (Exhibit B). The facility at 1500 E. Medical Center Drive is a huge complex where thousands of people maintain offices. The variations in departments, floors and zip codes belie any assertion that directing the NOI to the Risk Manager at 1500 E. Medical Center Drive is the same as directing the NOI to Dr. Umashankar c/o University of Michigan Cardiovascular Center, Department of Anesthesia, 1500 Medical Center Drive, SPC 5861.[4]

3. The Michigan Supreme Court Cases of *McCahan* and *Atkins* Reject the Assertion That Actual Notice Substitutes For Failure to Give the Required Statutory Notice.

In previously addressing this issue, Mr. Marquardt has proffered a series of rhetorical questions and speculative assumptions regarding whether and when Dr. Haft and Dr. Umashankar might have learned of the July 20, 2009 notice of intent directed to the Hospital's Risk Manager, and whether there is a difference between sending notice directly to the individual doctors or relying upon the Risk Manager to notify them of the claim. The difference is, in fact, significant: the first method complies with the statute, while the second method does not. There is no authority for the proposition that the NOI requirement can be disregarded if the defendant had actual notice of the claim. The statute itself belies any such supposition, stating in pertinent part that "Proof of the mailing constitutes prima facie evidence of compliance with this section."

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[4] Mr. Marquardt will likely argue that the intent to sue Dr. Umashankar along with the University Health System and other physicians was expressed in the body of the July 20, 2009 NOI. That is not something Dr. Umashankar would know if the NOI was not directed to him in the first instance. Nothing in MCL 600.2912b permits a plaintiff to direct notice intended for a physician to another intended defendant. Expressing an intent to sue a non-recipient physician in the body of a NOI directed to another intended defendant does not comply with the statute.

MCL 600.2912b(2). The clear thrust of this provision is that compliance requires the specified physical mailing to the named individual, and nothing less.[5]

Two recent opinions issued by the Michigan Supreme Court in *McCahan v University of Michigan Regents*, 492 Mich 730; 822 NW2d 747 (2012), and *Atkins v Suburban Mobility Authority for Regional Transportation*, 492 Mich 707; 822 NW2d 522 (2012), support Dr. Umashankar's argument that the pre-suit NOI directed to the "Risk Manager University of Michigan Health System" on July 20, 2009 did not toll the statute of limitations as to Dr. Umashankar because it was not directed to Dr. Umashankar in conformity with the statutory requirements of MCL 600.2912(b), irrespective of whether Dr. Umashankar at some point received ***actual notice*** of the claim.

In *McCahan*, despite plaintiff's failure to effectuate notice as required by the applicable Court of Claims notice statute, defendant had actual notice of plaintiff's intent to pursue a lawsuit, was fully apprised of relevant details regarding the claim, and had communicated with plaintiff and her counsel within the six-month notice period. Nonetheless, the Michigan Supreme Court concluded that plaintiff's failure to file the required notice barred her action "regardless of whether the university was otherwise put on notice of plaintiff's apparent intent to pursue a claim," 492 Mich at 732-733, and irrespective of whether actual prejudice (resulting from the failure of notice) could be shown. *Id.* at 746-747.[6] The Court confirmed that ***statutory***

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[5] The date of mailing is obviously important because it is the date after which the tolling period begins. That date would not be as easily defined if "actual notice" were sufficient to trigger the tolling period. One can only imagine the multiplication of proceedings that would become necessary to pinpoint the actual notice-tolling date including, as Mr. Marquardt suggested in response to Dr. Haft's motion, extensive discovery and depositions as to "exactly how Defendant Haft learned about the July 20, 2009 notice of intent." Pl.'s Resp. to Dr. Haft's Mot. (Exhibit H) at 14.

[6] The required notice was prescribed by MCL 600.6431.

notice requirements must be interpreted and enforced as plainly written, and ***courts may not require a showing of actual prejudice*** as a condition to enforcement ***or otherwise diminish the claimant's obligation to fully comply***. The Court thus concluded that McCahan's failure to timely file the required notice in the Court of Claims barred her action against the University ***regardless of whether the University was informed in some other manner of McCahan's intent to pursue a claim***.

Similarly, in *Atkins*, the Michigan Supreme Court held that a common carrier's presumed institutional knowledge of an injury or occurrence does not relieve the claimant of the obligation to formally give the required statutory notice. 492 Mich at 711-712.[7] In *Atkins*, the Court of Appeals had concluded that the carrier's knowledge of plaintiff's no-fault claim and the aggregate information plaintiff provided were sufficient notice of the subsequently filed third-party tort claim. In ***rejecting*** that conclusion, the Supreme Court in part explained:

> By providing that the accumulated information obtained by SMART from other sources, in addition to a no-fault application, substantially met the requirement that plaintiff provide written notice of her tort claims, the Court of Appeals replaced a simple and clear statutory test with a test based on apparent or imputed knowledge. The Court of Appeals' holding would require SMART and its counterparts to *anticipate* when a tort claim is likely to be filed on the basis of the underlying facts. In short, it would require a governmental agency to divine the intentions of an injured or potentially injured person and then notify itself that the person may file a suit in tort. This approach entirely subverts the notice process instituted by the Legislature.

Id. at 721.

Here, MCL 600.5856(c) tolls the statute of limitations only with respect to claims against persons to whom notice is given. Because no notice of intent was directed to Dr. Umashankar on July 20, 2009, the statute of limitations as to claims against Dr. Umashankar was not tolled.

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[7] The notice was required under the Metropolitan Transportation Authorities Act, MCL 124.419.

Rhetorical questions and speculative assumptions regarding whether and when Dr. Umashankar might have learned of the NOI directed to the Health System's Risk Manager have no bearing on the tolling issue as to Dr. Umashankar. Under the authority of *McCahan* and *Atkins*, actual knowledge does not excuse a failure to give notice in accordance with the statutory notice requirements.

Further, ***no claim was in fact asserted against Dr. Umashankar when the July 20, 2009 notice period expired.*** The subsequently-filed complaint was against the University of Michigan Board of Regents. In *Atkins*, the Supreme Court concluded that "[t]he claim asserted in plaintiff's application for no-fault benefits was qualitatively different from a claim for recovery in tort and could not reasonably apprise SMART that plaintiff would pursue a tort action," explaining:

> Plaintiff's interpretation, and that of the Court of Appeals, essentially rewrites the statutory text to provide that notice of any one claim – however distinct – suffices as notice of any other claim that plaintiff may pursue even when the statute plainly requires "written notice …"

Id. at 720. The Court further explained that a claim is "not merely an occurrence; it is a demand for payment pursuant to a legal right as a result of that occurrence" and "[k]nowledge of operative facts is not equivalent to written notice of a claim." *Id.* at 720-721. In the same vein, notice of a claim directed to the Risk Manager University of Michigan Health Center is not notice of a claim directed to and against Dr. Umashankar, particularly when the complaint filed when the notice period expired did not name Dr. Umashankar as a defendant.

Consequently, the July 20, 2009 NOI did not toll the statute of limitations as to the claim against Dr. Umashankar, which expired on July 20, 2009. Because Mrs. Marquardt died on January 27, 2010, more than 30 days after the statute of limitations expired, the wrongful death savings provision did not extend the time within which Mr. Marquardt, the personal

representative of Mrs. Marquardt's estate, could commence this action. The Complaint filed against Dr. Umashankar on June 6, 2012 is barred.[8]

4. Any Purported "Good Faith" Attempt to Comply With the NOI Statute Does Not Make the July 20, 2009 NOI Applicable to Dr. Umashankar.

It is clear that Mrs. Marquardt did not in fact intend to sue Dr. Umashankar at (or after) the time the July 20, 2009 NOI was sent. As Mr. Marquardt admits, "It was only when the University of Michigan decided to file a motion for summary disposition based upon a technical requirement regarding the filing of a claim with the Court of Claims that it became necessary to file this action against the individual doctors rather than finish the litigation directly against the University of Michigan." Pl's Resp. to Dr. Haft's Mot. (Exhibit H) at 12. Mr. Marquardt also states that "counsel for Plaintiff anticipated that Sandra Marquardt's claim could have been resolved through the Court of Claims litigation without actually naming the individual doctors in

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[8] Without discussion or legal authority, Mr. Marquardt has previously argued that the statute of limitations defense is barred by "collateral estoppel" arising from the decision of Judge Aquilina in the Court of Claims action against the University of Michigan Board of Regents rejecting the Regents' statute of limitations defense. In other words, Mr. Marquardt argued that this Court must find that the Complaint filed by *Mr. Saron Marquardt* against the physician-defendants on *June 6, 2012* is timely because Judge Aquilina found that the Complaint filed by *Mrs. Sandra Marquardt* against the *University of Michigan* on *January 19, 2010* was timely. This "assertion" is without merit. Judge Aquilina did not decide whether the July 20, 2009 pre-suit NOI tolled the statute of limitations as to Dr. Umashankar. Further, the issue in the Court of Claims case was whether the Complaint was timely filed on January 19, 2010, the day after the 182-day notice period expired, when notice was given on the last day of the limitations period and there was thus no time remaining in the limitations period after the notice period expired within which to commence the action. This disparity of issues, as well as an inability to satisfy other necessary elements, makes collateral estoppel a non-issue. See *Monat v State Farm*, 469 Mich 679, 682; 677 NW2d 843 (2004) (addressing elements). Nonetheless, this Court might note that Judge Aquilina did conclude the following: "***MCL 600.5852 is also inapplicable because the statute applies where a potential plaintiff dies within 30 days of the expiration of the statute of limitations. Here, Ms. Marquardt died on January 27, 2010 more than six months after the statute of limitations expired on July 20, 2009. Therefore, the wrongful death savings provision does not apply here.***" 12/6/2011 Opinion and Order (emphases added), attached as Exhibit K to Pl.'s Resp. to Dr. Haft's Mot. (which is Exhibit H to this brief.).

Washtenaw County." Pl.'s Resp. to Dr. Haft's Mot. at 13. See also, Pl.'s Resp to Haft's Mot. at 14 ("the interests of justice would be served by ignoring the technical error that occurred when counsel for Plaintiff, while acting in good faith, attempted to litigate this claim directly against the University without the necessity of filing two separate lawsuits in two different venues."). This explains why the July 20, 2009 NOI was not directed to Dr. Umashankar. Practically speaking, the only intended action was against the Hospital and consequently, the July 20, 2009 NOI was only served upon the Hospital, as Mr. Marquardt admits. See Pl's Resp. to Dr. Haft's Mot. at 3 ("July 20, 2009 – Counsel for Sandra Marquardt served a notice of intent upon the University of Michigan Health System pursuant to MCL 600.2912b.")

Neither Mr. Marquardt's "good faith," "MCL 600.2301," nor "*Bush v Shabahang*"[9] excuse Plaintiff's failure to direct a NOI to Dr. Umashankar. In *Driver v Naini*, 490 Mich 239, 249; 802 NW2d 311 (2011), plaintiff argued that MCL 600.2301 and *Bush* required that he be allowed to amend a NOI to add an entity as to whom a notice of non-party fault had been filed although that entity was not an addressee in the original NOI. In rejecting that assertion, the Michigan Supreme Court explained:

> [A]mendment of the original NOI to allow plaintiff to add CCA would not be "'for the furtherance of justice'" and would affect CCA's "substantial rights." Every defendant in a medical malpractice suit is entitled to a timely NOI ... Applying MCL 600.2301 in the present case would deprive CCA of its statutory right to a timely NOI followed by the appropriate notice waiting period, and CCA would be denied an opportunity to consider settlement. CCA would also be denied its right to a statute-of-limitations defense. These outcomes are plainly contrary to, and would not be in furtherance of, the Legislature's intent in enacting MCL 600.2912b. . . .
>
> . . . A plaintiff must (1) submit an NOI to every health professional or health facility before filing a complaint and (2) wait the applicable notice waiting period with respect to each defendant before he or she can commence an action. A

[9] 484 Mich 156; 772 NW2d 272 (2009).

> plaintiff has the burden of ensuring compliance with these mandates. ***With regard to the requirement that a plaintiff provide every defendant an NOI during the applicable limitations period before filing a complaint, nothing in Bush eliminates this requirement. Permitting amendment to add time-barred nonparty defendants to an original NOI on the basis of Bush would render the NOI requirement meaningless and the provision pertaining to nonparty defendants, MCL 600.2912b(3), nugatory.***

Id. at 254-256 (footnotes omitted) (emphases added).

Similarly, in *Fournier v Mercy Community Health Care System*, 254 Mich App 461; 657 NW2d 550 (2002), the Court of Appeals rejected the assertion that a good faith effort to mail the NOIs to defendants was all that the statute required. In *Fournier*, one day before the statute of limitations expired, plaintiff prepared NOIs to six intended defendants but due to a clerical error, all six letters were placed in the same Federal Express envelope and delivered to the home of one of the NOI addressees, a physician. When the doctor returned from vacation three days later, he delivered the notices of intent to the risk management department at the hospital. Defendants argued that the statute of limitations had not been tolled by the NOIs because plaintiff failed to mail them to defendants' last known residential or business addresses. The Court of Appeals agreed, stating:

> ... MCL 600.2912b does not contain a good faith requirement, but, rather, a specific requirement that the notices be mailed to the last known business or residential address of defendants. For the same reason, it is irrelevant that defendants "may have actually received the notice earlier" than if plaintiff had mailed the notices by regular mail. Likewise, the fact that defendants cannot show prejudice or delay is also irrelevant because the language of the statute is clear.

254 Mich App at 469.

For the same reasons, and because the Michigan Supreme Court directed enforcement despite similar arguments in *McCahan* and *Atkins*, good faith cannot carry the day here.[10] Summary disposition is required

CONCLUSION

For these reasons, the statute of limitations bars Mr. Marquardt's claim against Dr. Umashankar. Summary disposition is required.

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Dated: September 26, 2013

[10] In response to Dr. Haft's motion, Mr. Marquardt erroneously asserted that at the time the initial NOI was sent in July 2009, "based upon more than 40 years of *stare decisis*, a lawsuit could have been filed against the University ... without having previously filed a notice of claim with that court." Pl's Resp. to Dr. Haft's Mot. at 13. In fact, the law changed in 2007 when the Michigan Supreme Court issued its decision in *Rowland v Washtenaw County Road Comm'n*, 477 Mich 197; 731 NW2d 41 (2007) ("This Court previously held in *Hobbs v Michigan State Highway Dep't* 398 Mich 90, 96; 247 NW2d 754 (1976), and *Brown v Manistee Co Rd Comm*, 452 Mich 354, 356-357; 550 NW2d 215 (1996), that absent a showing of actual prejudice to the governmental agency, failure to comply with the notice provision is not a bar to claims filed pursuant to the defective highway exception. Those cases are overruled.").

Exhibit A

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of
the Estate of Sandra D. Marquardt

Plaintiff

VS. Civil Action No. 12-621 NH

David S. Swartz

VELLAIAH DURAI UMASHANKAR, M.D.
AND JONATHAN HAFT, M.D.

Defendants

THOMAS C. MILLER (P17786)
Attorney for Plaintiff
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COMPLAINT AND AFFIDAVIT OF MERIT

There is no other civil action between these parties arising out of the same transaction or occurrence as alleged in this Complaint pending in this Court, nor has any such action been previously filed and dismissed or transferred after having been assigned to a judge, nor do I know of any other civil action, not between these parties, arising out of the same transaction or occurrence as alleged in this Complaint that is either pending or was previously filed and dismissed, transferred, or otherwise disposed of after having been assigned to a judge in this Court.

NOW COMES Plaintiff Saron E. Marquardt, Personal Representative of the Estate of Sandra Marquardt, by and through his attorney Thomas C. Miller, and states:

1. Decedent resided in Jackson County at all times relevant to this litigation.

2. Defendants maintained their professional practices of medicine and/or surgery in Washtenaw County at all times relevant to this litigation.

3. Defendants were employees of the University of Michigan Health System at all times relevant to this litigation.

4. Plaintiff claims an exemption from governmental immunity pursuant to MCL 691.1407 (4).

6. Defendants were initially served with notices of intent pursuant to MCL 600.2912b on July 20, 2009, and they were again served with notices of intent on or about November 14, 2011.

7. Decedent Sandra D. Marquardt was a patient at the University of Michigan Hospital from July 17, 2007 through December 4, 2007. During that admission Decedent underwent mitral valve replacement surgery on July 20, 2007.

8. Defendants had a duty to provide medical and surgical care consistent with applicable standards of care for anesthesiologists or consistent with applicable standards of care for cardiac surgeons. Those standards of care required that Trasylol not be used during mitral valve surgery given the changes made by the manufacturer regarding the indications for the use of the drug before Decedent's surgery, and given the cautionary warnings issued by the FDA and the manufacturer prior to Decedent's surgery. The manufacturer's changes to its insert and the FDA advisories regarding the indications for the use of Trasylol clearly stated that the drug was to be used only for patients with a high risk of bleeding ***and*** who were undergoing coronary

artery bypass graft surgery. Decedent surgery did not meet both of those indications. In addition to the published warnings detailed above, the standards of care prohibited the use of Trasylol in a patient that had evidence of possible preoperative renal insufficiency. In addition Ms. Marquardt's history of other drug allergies was also a contraindication for the use of Trasylol. Once the decision was reached to administer the Trasylol, the standards of care required that a test dose be administered ten minutes before the loading dose, and that the administration of the loading dose be accomplished over a 20-30 minute time period before the sternotomy and before the infusing of the drug began during the actual surgery. The standards of care for both anesthesiologists and cardiac surgeons are more clearly set forth in the attached affidavit of merit and incorporated by reference into this Complaint. Both Defendants have testified that the decision to use Trasylol during Decedent's valve replacement surgery was a joint decision, and therefore, the standard of care detailed in the attached affidavit of merit is applicable to both Defendants even though they are engaged in different specialties.

9. Defendants breached the applicable standards of care, as they relate to the use of Trasylol, in the following ways:

a. They used Trasylol before and during mitral valve replacement surgery, despite the revised indications and warnings published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current regarding the indications and warnings regarding Trasylol, and used the drug during off-label surgery.

b. They used Trasylol during off-label mitral valve replacement surgery, when the FDA and the manufacturer, who were aware of such off-label uses for the drug, cautioned against using the drug for any procedure other than a CABG procedure where the

patient was at an increased risk of bleeding, until the drug's safety could be fully reviewed.

c. They also ignored Decedent's preoperative history of other drug allergies and possible renal insufficiency, which placed her at an increased risk of a reaction to Trasylol and/or at an increased risk of further renal disease from the drug.

d. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.

e. They failed to take the requisite 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, before the sternotomy was performed and before the infusion of the drug was commenced, as recommended by the manufacturer.

11. As a direct and proximate result of Decedent being given Trasylol during her mitral valve replacement procedure on July 20, 2007, she developed a significant pre-renal condition complicated by an obstructive kidney condition. She also suffered from a coagulopathy that was caused by the Trasylol, and aggravated by the lack of effective treatment in the postoperative period of time. Her renal disease, coagulopathy, multi-organ dysfunction, acidosis and significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long period of time. The lack of effective treatment and an accurate diagnosis led to a series of iatrogenic complications due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Decedent's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, and severe depression during her lengthy hospitalization and extreme debilitation. She remained

hospitalized for four and one-half months. Upon discharge she was on hemodialysis; she was oxygen due to changes in her lungs from ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis; and she was discharged suffering from an end-stage renal disease, ongoing liver disease, and heart problems that required an extensive array of drug therapies and continue to cause severe debilitation. Decedent went from an independent person, who was able to perform all ADL's except when her mitral valve failed, to a person totally dependent on her husband and others. Those problems were more likely than not directly related to complications from the use of Trasylol during her valve replacement surgery. As a result of her chronic kidney and pulmonary complications, Decedent passed away on January 27, 2010 from those medical complications.

12. As a result of the above injuries, Decedent suffered considerable pain, suffering, mental anguish, disability and medical expense before her death. Those same injuries resulted in her death on January 27, 2010.

13. Saron E. Marquardt was appointed the Personal Representative of the Estate of Sandra Marquardt by the Jackson County Probate Court under # 10011754-DE. His letters of authority were issued on June 14, 2010.

14. Decedent was survived by a son, several sisters and a spouse.

15. As a result of the death of Sandra Marquardt, her son, her sisters and her husband were denied her love, society and companionship.

14. As a result of her death the Estate of Sandra Marquardt has become obligated for the costs of her funeral, burial and last illness.

WHEREFORE, Plaintiff Saron E. Marquardt, the Personal Representative of the Estate of Sandra Marquardt, requests that this Court grant the Estate of Sandra Marquardt a judgment that

fairly, reasonably and adequately compensates Decedent for the pain, suffering, mental anguish, disability and denial of social pleasures and enjoyment she sustained before her death. Additionally, Plaintiff requests that the Estate be compensated for the losses suffered by her heirs at law and for the funeral, burial and last illness expenses incurred.

Respectfully submitted,

Thomas C. Miller (P17786)

6-4-12

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of
the Estate of Sandra D. Marquardt

Plaintiff

VS. Civil Action No. NH

VELLAIAH DURAI UMASHANKAR, M.D.
AND JONATHAN HAFT, M.D.

Defendants

/

THOMAS C. MILLER (P17786)
Attorney for Plaintiff
P.O. Box 785
Southfield, MI 48037
(248) 210-3211
millertc@comcast.net

/

AFFIDAVIT OF MERIT
(Previously filed in the Court of Claims # 10-4 NH)

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

SANDRA D. MARQUARDT

PLAINTIFFS

VS. CIVIL ACTION NO. NH

THE UNIVERSITY OF MICHIGAN BOARD OF REGENTS
(UNIVERSITY OF MICHIGAN HOSPITALS AND
HEALTH CENTERS)

DEFENDANT

_____/

AFFIDAVIT OF MERIT

I, Javier H. Campos, M.D., having been duly sworn, state:

1. I am licensed to practice medicine in the State of Iowa, and I was so licensed at all times relevant to this litigation.

2. I am a professor in anesthesiology and director of cardiothoracic anesthesia at the University of Iowa Healthcare

3. I am engaged in the full time clinical practice of anesthesia/cardiothoracic anesthesia, and I was so engaged at all times relevant to this litigation.

4. I have received and reviewed the notice of intent provided to me by counsel for Ms. Marquardt.

5. I have received and reviewed medical records from counsel for Ms. Marquardt.

6. I am familiar with the standards of care for anesthesiologists, as they relate to the indications for the use of Trasylol (after November 2006) during mitral valve replacement surgery.

7. The standards of care for anesthesiologists, who are involved with cardiothoracic surgery to replace a mitral valve (after November 2006), require that Trasylol not be used during such surgery given the changes made by the manufacturer regarding the indications for the use of the drug, and given the cautionary

warnings issued by the FDA and the manufacturer prior to that date. The manufacturer's changes to its insert and the FDA advisories regarding the indications for the use of Trasylol clearly indicated that the drug was to be used exclusively for patients with a risk of bleeding ***and*** who were undergoing coronary artery bypass graft surgery. In addition to the published warnings detailed above, the standards of care would prohibit the use of Trasylol in a patient that had evidence of possible preoperative renal insufficiency. Once the decision was reached to administer the Trasylol, the standards of care required that a test dose be administered ten minutes before the loading dose, and that the administration of the loading dose be accomplished over a 20-30 minute time period before the sternotomy and before the infusing of the drug began.

8. The anesthesiologists, who were involved with the subject mitral valve replacement procedure, breached the applicable standards of care, as they relate to the use of Trasylol, in the following ways:

   a. They used Trasylol before and during mitral valve replacement surgery, despite the revised indications and warnings published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current regarding the indications and warnings regarding Trasylol, and used the drug during off-label surgery.
   b. They used Trasylol during off-label mitral valve replacement surgery, when the FDA and the manufacturer, who were aware of such off-label uses for the drug, cautioned against using the drug for any procedure other than a CABG procedure where the patient was at an increased risk of bleeding, until the drug's safety could be fully reviewed.
   c. They also ignored Ms. Marquardt's preoperative history of other drug allergies and possible renal insufficiency, which placed her at an increased risk of a reaction to Trasylol and/or at an increased risk of further renal disease from the drug.
   d. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.
   e. They failed to take the requisite 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, as recommended by the manufacturer.

9. The anesthesiologists that participated in the mitral valve replacement surgery on Ms. Marquardt would have complied with applicable standards of care, if they had insisted that Trasylol not be used, in light of the FDA warnings and the changes made by the manufacturer regarding the indications for use of the drug. Additionally, an alternative drug should have been used due to the patient's preoperative evidence of possible renal insufficiency and the patient's history of other drug allergies.

10. As a direct and proximate result of Ms. Marquardt being given Trasylol during her mitral valve replacement procedure on July 20, 2007, Ms. Marquardt

developed a significant renal condition complicated by an obstructive condition of the kidneys. Her renal disease, coagulopathy, multi-organ dysfunction, acidosis and significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, and severe depression during her lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months. Upon discharge she was on hemodialysis; she was oxygen dependent upon discharge due to changes in he lungs from ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis; and she was discharged still suffering from renal disease, ongoing liver disease, and heart problems that must be treated with an extensive array of drug therapies and continue to cause severe debilitation. Ms. Marquardt went from an independent person, who was able to perform all ADL's, except when her mitral valve failed, to a person totally dependent on her husband and others. These problems are more likely than not directly related to complications from the use of Trasylol during her cardiothoracic surgery.

Respectfully submitted,

Javier H. Campos, M.D.

STATE OF IOWA)
§
COUNTY OF)

On the 15 day of January, 2010, Javier H. Campos, M.D. appeared before me, a Notary Public, personally and being duly sworn, acknowledged signing this Affidavit of Merit as her/his free act and deed.

Kelly Bo
, Notary Public
Johnson County, Iowa
My Commission Expires: 4/7/12

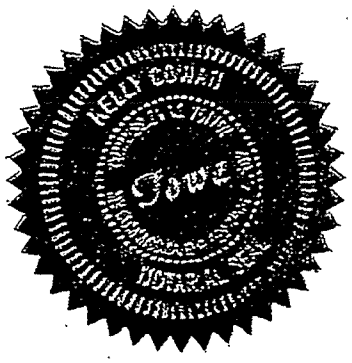


Exhibit B

LAW OFFICES
OF
THOMAS C. MILLER
P.O. BOX 785
SOUTHFIELD, MICHIGAN 48037
248-210-3211

July 20, 2009

Risk Manager
University of Michigan Health System
1500 E. Medical Center Drive
Ann Arbor, MI 48109-5912

Re: Sandra D. Marquardt

Dear Risk Manager:

You are hereby notified that Sandra D. Marquardt intends to file suit against Jonathan Haft, M.D., Umashankar Vellaiah, M.D., Ranjiv Saran, M.D. and the University of Michigan Health System, Inc. (University of Michigan Hospitals and Health Centers), upon the expiration of 182 days from the above date. This notice is being provided pursuant to MCL 600.2912b. This same statute places certain obligations upon each of you as well. One of those obligations is to provide the undersigned with a copy of all medical records covering the care and treatment of Ms. Marquardt. The undersigned has already received the full hospital chart covering Ms. Marquardt's inpatient stay from July 17, 2007 to December 4, 2007, however, the clinical records covering her pre-admission assessments and her post-operative care have not been supplied, so a specific request is made for these records.

Drs. Haft, Vellaiah and Saran, together with their associates, residents and fellows, were all agents/employees of the University of Michigan Health System, Inc, and the University of Michigan Health System, Inc is responsible for their actions under principles of *respondeat superior*.

Ms. Marquardt's medical history is well documented in the University of Michigan Hospitals and Medical Centers' chart covering the above admission. Ms. Marquardt agrees that it contains the relevant medical history necessary for this notice of intent. In addition, all of the relevant medical treatment regarding this notice of intent is contained in that hospital chart. Certain portions of the care and treatment provided to Ms. Marquardt should be highlighted below, so that there is sufficient context to explain the claims being made below.

Ms. Marquardt was known to have suffered drug reactions to penicillin and ceftriaxone. Her baseline or pre-operative renal function studies revealed some degree of renal insufficiency. Specifically, her pre-operative creatinine level was reported to be 1.4 (on two occasions), her pre-operative BUN level was reported to be 21 (on two occasions) and there was evidence of significant levels of blood in her pre-operative urinalysis.

Dr. Haft admitted Ms. Marquardt in order to stabilize her cardiovascular status before performing a mitral valve replacement procedure. He was particularly interested in getting her off her Coumadin and onto IV Heparin, so that her coagulation could be more closely controlled during and after the surgery. He wanted the INR to be equal to or less than 2.0 and he wanted her PTT levels to be between 50 and 70 before proceeding with the surgery. Her INR was 2.8 on admission and had fallen to 1.6 by July 19th. Her PTT was 42.9 on admission and fell to 33.7 by July 19th. He initially planned on surgery for July 24th; however, that date was subsequently moved up to July 20th.

The Anesthesia Record, which was prepared incident to the mitral valve replacement procedure performed on July 20th, established the following timeline:

1. The anesthesia was started at 0645.
2. The patient was brought to the operating room at 0702.
3. The anesthesia induction ended at 0801.
4. The patient was placed in the left lateral decubitus position at 0804.
5. The baseline ACT was drawn at 0804 and reported to be 157 (the exact equipment used is not reflected on the chart).
6. The surgical incision was made at 0839. [**No test dose or loading dose of Trasylol was administered before the incision and thoracotomy as required by the manufacturer in its insert.**]
7. The 200 ml loading dose of Trasylol was given at 0909. [**No test dose was given before the loading dose, as required by the manufacturer in its insert.**]
8. The first ACT level obtained after the loading dose of Trasylolwas reported as 999, which was apparently the highest level that could be digitally displayed by the equipment, at about 0915.
9. The Trasylol infusion dose of 50 ml/hr was begun at 0918.
10. The first dose of Heparin was administered at 0930. [There was confusion in the record as to the exact dosage given at that time. The written chronology indicates that 25,000 units were given. The graphic summary indicates that 2,500 units were given; however, the total on the graphic summary indicates that 35,000 total units were given during the procedure, which would have included 10,000 units at 1230. Dr. Haft indicates in his operative report that she was "systemically heparinized with 3 mg/kg sodium heparin", which would mean that she was given about 250 mg. given her known weight of 77.1 kg.]
11. Full cardiopulmonary bypass was initiated at 0942.
12. The first ACT level obtained after the Trasylol and Heparin were given reflected a continuing level of 999 at 1015..
13. The ACT level obtained at about 1115 revealed a level of 545.
14. The ACT level obtained at about 1215 revealed a level of 499.

15. The second dose of Heparin containing 10,000 or 1,000 units was given at 1230.
16. The ACT level obtained at about 1300 revealed a level of 387.
17. The cardiopulmonary bypass was terminated at 1311. **[The total time spent on the bypass equipment was reported by Dr. Haft to have been 209 minutes.]**
18. The ACT level obtained at about 1315 revealed a level of 590.
19. A 250 mg dose of Protamine was given at about 1330.
20. A 50 mg dose of Protamine was given at about 1400.
21. The ACT level obtained at about 1400 revealed a level of 158.
22. The surgical dressing was completed at 1445.
23. The patient was transferred to the TICU at 1501.
24. The anesthesia was ended at 1515.
25. The Trasylol infusion was terminated at about 1530.

In January 2006 a group of physicians and research experts published the results of an extensive study comparing the drug Trasylol with two other similar acting drugs. Their findings were accepted for publication in the prestigious *New England Journal of Medicine*. That article, together with a similar smaller study published in the March 2006 issue of *Transfusion*, began to raise serious questions about the safety of Trasylol. The FDA apparently became aware of those two studies and responded by publishing a "Public Health Advisory for Trasylol" dated February 8, 2006. In that advisory they informed the medical profession, particularly the cardiac surgeons and anesthesiologists, that they were aware of two studies that were reporting an increased risk of death and serious injury due to renal and heart disease incident to the use of Trasylol, when compared to the incidence of such results in patients who received two similar acting drugs. Following the FDA investigation and following consultations with the drug's manufacturer, the FDA adopted a revised insert to be distributed to all physicians who were the end users of the drug. That new insert was published and made available to the relevant physicians in November 2006. In that publication the manufacturer added additional information and cautionary content regarding the risk of renal, cardiac and vascular risks with the use of the drug. Of particular note was the manufacturer's "Indications and Usage" section. Trasylol was indicated for prophylactic use to reduce perioperative blood loss and the need for blood transfusion in **patients undergoing cardiopulmonary bypass in the course of coronary artery bypass graft surgery who are at an increased risk for blood loss and blood transfusion.**

It should be noted that the earlier insert also limited the indications to patients undergoing coronary artery bypass graft procedures in which cardiopulmonary bypass equipment was used; however, both the medical specialists involved and the manufacturer itself were aware that the drug was being used for off-label surgeries including cardiac valve replacements. In December 2006 the FDA again advised the medical community that it was very concerned about Trasylol; however, it wanted more information before making a decision regarding the safety of the drug. The FDA requested and Bayer agreed to inform its customers that the drug was to be used in strict compliance with the insert. Specifically, the manufacturer told its users to adhere strictly to the indications contained in the old and new insert, i.e. it was to be used only in CABG procedures. The FDA issued a press release regarding the new insert in December 2006,

and Bayer drafted a form letter, which it sent to each of its customers in the same month. The FDA indicated that it wanted the physicians to "understand the new warnings and use the product as directed by the [insert]". The new insert specifically stated that the drug was to be used only during CABG procedures. In the December letter the company also made it very clear to the physicians that the drug was to be used incident to CABG procedures only. They also advised the physicians of the renal and cardiac risks raised in the literature. The letter highlighted the changes in the new insert, which had been published in November 2006. It is believed that the information from the FDA and from Bayer was communicated directly to Dr. Haft, Dr. Vellaiah and/or the University of Michigan Hospitals and Medical Centers in late 2006.

The revised 2006 insert made many critical points relevant to the facts in this matter. First, the use of the drug was to be restricted to CABG procedures, and was not to be used for valve replacement procedures. Second, patients with pre-existing renal insufficiency were at an increased risk of developing renal complications from the use of Trasylol. Third, patients with other drug allergies were more likely to have a reaction to Trasylol. Fourth, a test dose of Trasylol was to be given at least ten minutes before the loading dose of the drug. Fifth, the loading dose was to be given over a 20-30 minute time period before infusion of the drug. Sixth, the patient was to be placed in a supine position during administration of the test dose and the loading dose. Seventh, the patient was to be closely monitored closely for possible coagulopathy when Trasylol and Heparin were administered concurrently. An elevated ACT level might not reflect a high therapeutic level of Heparin, when Heparin was administered concurrently with Trasylol. Eighth, Protamine titration should be used to establish the adequacy of Heparin levels before any Trasylol is given, so that the anti-coagulation effects of the two drugs can be separated, and so that the results of that titration could be used to determine the effect of the Heparin therapy throughout the operative and post-operative phases. Ninth, the therapeutic level of Heparin must be kept above certain levels during the procedure (reflected by careful monitoring of coagulation studies) independent of the anti-coagulation effect created by the Trasylol given concurrently with Heparin.

The medical records of Ms. Marquardt reflect that no test dose of Trasylol was administered ten minutes before the loading dose. The patient was not in a supine position when she was given the loading dose of Trasylol. The loading dose was not given slowly over a 20-30 minute period of time (only nine minutes separated the loading dose from the start of the infusion of Traslol). Ms. Marquardt had a history of two different drug allergies. The procedure was a valve replacement procedure and not a CABG procedure. Ms. Marquardt did have evidence of pre-operative kidney dysfunction. Lastly, she was not closely monitored after the administration of Trasylol and Heparin to determine the anti-coagulation effect of Heparin alone versus the synergistic anti-coagulation effect of the two drugs in combination.

Following the surgery, during which Ms. Marquardt received Heparin and Trasylol, she began to manifest significant clinical signs and symptoms of renal disease, which led to multiple other organ system problems. The lack of attention to her renal complications from the Trasylol resulted in other iatrogenic complications and nosocomial infections. Despite numerous medical diagnoses formulated by the numerous physicians who treated Ms. Marquardt over the four months of post-operative care, the diagnosis of Trasylol induced pathology never appeared. It was not even mentioned as

part of anyone's differential diagnoses. The various treating physicians did proffer opinions regarding the etiology of her renal disease, specifically that they were post-op complications and that may have been related to the lengthy period of time spent on the bypass equipment; however, they never once mentioned the drug Trasylol as a possible factor.

During the time Ms. Marquardt was an inpatient at the University of Michigan Hospital, the following diagnoses were made and repeated often by the various physicians charged with providing her with care for her post-operative complications:

1. Various nosocomial infections, bacteremia and sepsis.
2. Hyperglycemia secondary to surgical stress requiring Tight Glycemic Control
3. Oliguric
4. Diminished Coronary Output/Coronary Index
5. Hemolysis secondary to long coronary bypass machine time
6. Fluid overload
7. Renal Hypoperfusion
8. Polyuric Renal Failure secondary to prolonged pump time
9. Acute Tubular Necrosis (ATN)
10. Hyperphosphatemia
11. Acute Kidney Injury (AKI) secondary to ATN
12. Hypotension
13. Pulmonary Edema
14. Non-oliguric Renal Failure
15. Acute Respiratory Distress Syndrome (ARDS)
16. Systemic Inflammatory Response Syndrome (SIRS)
17. Prolonged Respiratory Failure
18. Hematuria
19. Metabolic Acidosis
20. Pleural Effusion
21. Swallowing Dysfunction
22. Hypothyroidism
23. Hypercarbia
24. Hypoxemia
25. Clinical Depression
26. Peri-operative vascular leak
27. Respiratory Acidosis
28. Anemia
29. Atrial Fibrillation
30. Sick Euthyroid Syndrome
31. Prerenal Azotemia
32. Moderate Differentiated Encephalopathy
33. End Stage Renal Disease
34. Pulmonary Vein Stenosis
35. Urinary Tract Infection (UTI)
36. Adrenal Insufficiency
37. Cholecystitis

38. Wound Dehiscence
39. Extracellular Fluid Volume Depletion

Each of the above diagnoses appear to be related to Ms. Marquardt's underlying renal disease, the iatrogenic efforts made by the medical staff to diagnose and treat the underlying renal disease, the nosocomial infections resulting from her long hospital stay, problems caused by the inability of the medical staff to correct the fluid imbalance situation caused by her renal dysfunction, or from the effects of the long-term hospital stay and the decompensation caused by the overwhelming medical and emotional conditions.

Ms. Marquardt has been followed by her primary care physician Raymond Cole, D.O, 107 W. Chicago, Brooklyn, MI 49230, her nephrologists R.V. Nagesh, M.D., 205 N. East Avenue, Jackson, MI 49201, her pulmonologist Robert D. Albertson, M.D., 900 E. Michigan Avenue, Jackson, MI 49201, and her cardiologist Bischan Hassunizadeh, M.D., 205 Page Avenue, Suite B, Jackson, MI 49201.

The standards of care for anesthesiologists assisting in cardiac surgeries involving the use of cardiopulmonary bypass equipment and cardiac surgeons require that Trasylol not be used during cardiac valve procedures performed after November 2006, given the advisories issued by the FDA and Bayer. The standards of care for both specialties also require that Trasylol induced renal disease should be ruled out as soon as possible, if renal disease is diagnosed or suspected following a surgical procedure in which Trasylol was used. These same standards require the appropriate use of Heparin in conjunction with the concurrent use of Trasylol. The anti-coagulation effect of Heparin must be isolated from the overall anti-coagulation effect of Heparin and Trasylol in combination. Trasylol should not be used as a Heparin sparing agent. Additional Heparin therapy may be needed even if ACT levels are elevated. Protamine titration to measure Heparin therapeutic levels must be performed before the administration of Trasylol and that baseline level must be used to determine if Heparin is needed to maintain anti-coagulation therapy intra-operatively and post-operatively, given that the Trasylol in a renal insufficient patient might be long-lasting and affect anti-coagulation test results, leading to reduced Heparin therapy post-operatively. These standards of care also require the physician to identify, carefully monitor and effectively treat fluid levels to avoid cardiopulmonary complications due to fluid overload or due to extracellular fluid volume depletion. If diagnosed, Trasylol induced renal disease must be aggressively treated with appropriate anti-thrombotic drug therapy, and therapeutic Heparin levels must be implemented to counter the Trasylol induced coagulopathy. If Trasylol is indicated, the applicable standards of care require that a test dose of 1 ml be given at least ten minutes before the loading dose. Then the loading dose should be given slowly over a 20-30 minute time period after induction of anesthesia and before the sternotomy, while the patient is in a supine position. Then the constant infusion of the drug is begun and continued until the surgery is completed and the patient leaves the operating room.

The standards of care for nephrologists require that Trasylol be considered as a possible cause for acute prerenal kidney disease, when a patient in 2007 undergoes a mitral valve replacement and develops ARF within hours of that procedure. Trasylol induced kidney disease must be ruled out in such circumstances. If Heparin and Trasylol were both given during the procedure, then the standards of care require that the consulting nephrologist assess abnormal coagulation studies to determine whether or not

the abnormality is related to the anti-coagulation effect of Heparin or the anti-coagulation effect of Trasylol, and then treat the patient accordingly. These same standards require that the patient's fluid imbalance be assessed and treated appropriately. If the abnormal fluid level condition cannot be resolved effectively with diuretics and the patient has evidence of ARF, then the patient must be placed on some form of temporary dialysis to manage the fluid abnormality, especially if the fluid fluctuations are causing generalized edema, pulmonary edema and/or cardiac dysfunction. The fluid level fluctuations and renal function test results should not be treated symptomatically; instead, a cause must be established for the renal dysfunction and treated in a timely manner. The anti-coagulation effect of Heparin must be isolated from the overall anti-coagulation effect of Heparin and Trasylol in combination. Trasylol should not be used as a Heparin sparing agent. Additional Heparin therapy may be needed, even if ACT levels and other measures of hypocoagulation are elevated. If diagnosed, Trasylol induced renal disease must be aggressively treated with appropriate anti-thrombotic drug therapy, and therapeutic Heparin levels must be implemented to counter the Trasylol induced coagulopathy.

Drs. Haft and Vellaiah, together with their associates, residents and fellows, breached applicable standards of care for cardiac surgeons and/or anesthesiologists assisting in cardiac procedures in the following ways:

1. They used Trasylol incident to a mitral valve replacement procedure, despite the indications published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current on the indications for the drug and used the drug during an off-label procedure.
2. They used Trasylol for an off-label purpose, when the FDA and the manufacturer, who were aware of the off-label uses of the drug, cautioned against using the drug for any procedure other than a CABG procedure, until the drug's safety could be fully reviewed.
3. They ignored Ms. Marquardt's preoperative history of other drug allergies and renal insufficiency, which placed her at an increased risk of an allergic reaction to Trasylol and/or at an increased risk of further renal disease from the drug.
4. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.
5. They failed to take 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, before the sternotomy was performed and before the infusion of the drug was commenced.
6. They failed to adequately separate any coagulopathy caused by the Trasylol from any coagulopathy caused by Heparin therapy or the lack of that therapy, and, in so doing, they decreased or withheld Heparin therapy from the patient when she actually needed the therapy to counteract the Trasylol effects on the kidneys.
7. The failed to recognize the connection between Trasylol (thrombosis) and the hypocoagulopathy demonstrated in the laboratory results.
8. They failed to institute dialysis and/or appropriate diuretic therapy in a timely manner to maintain an appropriate fluid balance.

9. They failed to diagnose Trasylol induced renal disease, and treat it appropriately in a timely manner.
10. They failed to diagnose the prerenal disease caused by the Trasylol and recognize that the problems they were encountering in regards to pulmonary edema, cardiac dysfunction and other organ system failures were directly related to the renal disease, iatrogenic consequences of the inappropriate treatment protocols, nosocomial infections and/or from long periods of ventilation, decompensation and debilitation.

Drs. Haft and Vellaiah, together with their associates, residents and fellows, would have complied with applicable standards of care, if they had decided not to use Trasylol during Ms. Marquardt's mitral valve repair procedure on July 20, 2007, given the FDA and manufacturer warnings against using it for such procedures. If they felt that the procedure and patient warranted the use of Trasylol, then they needed to recognize the other risk factors presented by her prior drug allergies and pre-existing renal insufficiency. They also had to use the drug as indicated in the insert regarding a test dose, the loading dose and coagulation assessments during and after the procedure. They also had to rule out Trasylol induced renal disease given the problems that presented in the immediate postoperative period. Then they needed to treat the Trasylol induced renal disease, the coagulopathy, the fluid imbalance and the effects of the renal disease on other organ systems in a timely manner.

Dr. Saran, his associates, fellows and residents breached applicable standards of care in the following ways:

1. They failed to diagnose and treat Trasylol induced acute renal failure in a timely manner. In fact, the diagnosis was not mentioned at all in the various progress notes prepared by Nephrology over the many months that the department under the initial leadership of Dr. Saran.
2. They failed to institute timely dialysis to address an abnormal fluid level problem that was a major problem for many weeks. Instead, the problems were addressed with varying attempts at diuresis, which provided only temporary relief at best. Despite numerous suggestions to implement dialysis, the process was not started for more than one month following the onset of ARF.
3. They failed to appreciate that the obstructive prerenal kidney disease that appeared evident was caused by Trasylol, and that the patient needed to be placed on dialysis.
4. They failed to appreciate that despite the hypocoagulable the Trasylol related kidney disease needed to be treated with aggressive anti-coagulation therapy and anti-thombotic agents.

Dr. Saran, his associates, residents and fellows would have complied with applicable standards of care for nephrologists if they had diagnosed and treated the Trasylol induced renal failure in a timely manner. They also had to treat the fluid level problems with a temporary form of dialysis in a timely manner, given the significant problems in the pulmonary and cardiac systems that the fluid or lack of fluid was causing. The fluid levels, which were directly related to the underlying renal disease, needed to be treated by diagnosing the underlying disease process and by treating that disease process, not by using diuretics to try to remove the fluids. During the early treatment process, the

patient should have been placed on temporary dialysis to more effectively remove excess fluid to reduce the fluid overload or to increase fluid levels to force renal perfusion.

As a direct and proximate result of the above negligent acts by Drs. Haft, Saran, and Vellaiah (together with their associates, residents and fellows), Ms. Marquardt was given a contraindicated drug during her mitral valve repair procedure on July 20, 2007. This drug then caused a prerenal condition complicated by an obstructive condition of the kidneys. She also was suffering from a coagulopathy that was caused by the Trasylol, and aggravated by the lack of effective treatment in the postoperative period of time. Her renal disease, coagulopathy, multi-organ dysfunction, acidosis and a significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, severe depression, as she tried to cope with the lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months, was discharged on hemodialysis, is oxygen dependent due to changes in he lungs from the ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis, ongoing renal disease, ongoing liver disease, heart problems that must be treated with medication and severely debilitated. She went from an independent person who was able to perform all of her ADL's, except when her mitral valve failed, to a person totally dependent on he husband and others to perform her ADL's. She is also completely oxygen dependent and severely disabled due to the poor care and treatment she received during her four and one-half months of hospitalization. These problems are directly related to the complications from a drug she should not have been given and directly related to the ineffective care and treatment she was given thereafter.

Respectfully submitted,

Thomas C. Miller

TCM:mls

Exhibit C

Approved, SCAO | Original - Court, 1st copy - Defendant | 2nd copy - Plaintiff, 3rd copy - Return

STATE OF MICHIGAN
JUDICIAL DISTRICT
COUNTY OF Cedars JUDICIAL CIRCUIT
PROBATE

SUMMONS AND COMPLAINT

CASE NO. 10-4-NH

Court address | Court telephone no.

ROSEMARIE E. AQUILINA

Plaintiff's name(s), address(es), and telephone no(s).	v	Defendant's name(s), address(es), and telephone no(s).
SANDRA D. MARQUARDT 3049 VILLAGE LANE BROOKLYN, MI 48230		THE UNIVERSITY OF MICHIGAN BOARD OF-REGENTS (UNIVERSITY OF MICHIGAN HOSPITAL) ED REYNOLDS (ASST. GENERAL COUNSEL) 300 N. INGALLS ~~#3b0R~~ 3604 ANN ARBOR, MI ~~48109-0477~~
Plaintiff's attorney, bar no., address, and telephone no. THOMAS C. MILLER (P17786) P.O. BOX 785 SOUTHFIELD, MI 48037		

RECEIVED BY
JAN 22 2010
HEALTH SYSTEM
LEGAL OFFICE

SUMMONS **NOTICE TO THE DEFENDANT:** In the name of the people of the State of Michigan you are notified:

1. You are being sued.
2. **YOU HAVE 21 DAYS** after receiving this summons to **file a written answer with the court** and serve a copy on the other party **or take other lawful action with the court** (28 days if you were served by mail or you were served outside this state). (MCR 2.111[C])
3. If you do not answer or take other action within the time allowed, judgment may be entered against you for the relief demanded in the complaint.

Issued	This summons expires	Court clerk
JAN 19 2010	APR 20 2010	MIKE BRYANTON

*This summons is invalid unless served on or before its expiration date.
This document must be sealed by the seal of the court.

COMPLAINT ***Instruction: The following is information that is required to be in the caption of every complaint and is to be completed by the plaintiff. Actual allegations and the claim for relief must be stated on additional complaint pages and attached to this form.***

Family Division Cases

☐ There is no other pending or resolved action within the jurisdiction of the family division of circuit court involving the family or family members of the parties.

☐ An action within the jurisdiction of the family division of the circuit court involving the family or family members of the parties has been previously filed in _____ Court.

The action ☐ remains ☐ is no longer pending. The docket number and the judge assigned to the action are:

Docket no.	Judge	Bar no.

General Civil Cases

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

☐ A civil action between these parties or other parties arising out of the transaction or occurrence alleged in the complaint has been previously filed in _____ Court.

The action ☐ remains ☐ is no longer pending. The docket number and the judge assigned to the action are:

Docket no.	Judge	Bar no.

VENUE

Plaintiff(s) residence (include city, township, or village)	Defendant(s) residence (include city, township, or village)
JACKSON COUNTY	WASHTENAW COUNTY

Place where action arose or business conducted
WASHTENAW COUNTY

01/19/2010
Date

Thomas C. Miller
Signature of attorney/plaintiff

If you require special accommodations to use the court because of a disability or if you require a foreign language interpreter to help you fully participate in court proceedings, please contact the court immediately to make arrangements.

MC 01 (3/08) **SUMMONS AND COMPLAINT** MCR 2.102(B)(11), MCR 2.104, MCR 2.105, MCR 2.107, MCR 2.113(C)(2)(a), (b), MCR 3.206(A)

1/19

PROOF OF SERVICE

SUMMONS AND COMPLAINT
Case No.

TO PROCESS SERVER: You are to serve the summons and complaint not later than 91 days from the date of filing or the date of expiration on the order for second summons. You must make and file your return with the court clerk. If you are unable to complete service you must return this original and all copies to the court clerk.

CERTIFICATE / AFFIDAVIT OF SERVICE / NONSERVICE

☐ **OFFICER CERTIFICATE**
I certify that I am a sheriff, deputy sheriff, bailiff, appointed court officer, or attorney for a party (MCR 2.104[A][2]), and that: (notarization not required)

OR

☐ **AFFIDAVIT OF PROCESS SERVER**
Being first duly sworn, I state that I am a legally competent adult who is not a party or an officer of a corporate party, and that: (notarization required)

☐ I served personally a copy of the summons and complaint,
☐ I served by registered or certified mail (copy of return receipt attached) a copy of the summons and complaint,
together with _____
List all documents served with the Summons and Complaint

_____ on the defendant(s):

Defendant's name	Complete address(es) of service	Day, date, time

☐ I have personally attempted to serve the summons and complaint, together with any attachments, on the following defendant(s) and have been unable to complete service.

Defendant's name	Complete address(es) of service	Day, date, time

I declare that the statements above are true to the best of my information, knowledge, and belief.

Service fee	Miles traveled	Mileage fee	Total fee
$		$	$

_____
Signature

_____
Name (type or print)

_____
Title

Subscribed and sworn to before me on _____ (Date), _____ County, Michigan.

My commission expires: _____ (Date) Signature: _____ (Deputy court clerk/Notary public)

Notary public, State of Michigan, County of _____

ACKNOWLEDGMENT OF SERVICE

I acknowledge that I have received service of the summons and complaint, together with _____ (Attachments)

_____ on _____ (Day, date, time)

_____ on behalf of _____.
Signature

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

SANDRA D. MARQUARDT

PLAINTIFF

VS. CIVIL ACTION NO. 10-4 ~~NH~~ MK

ROSEMARIE E. AQUILINA

THE UNIVERSITY OF MICHIGAN BOARD OF REGENTS
(UNIVERSITY OF MICHIGAN HOSPITALS AND
HEALTH CENTERS)

DEFENDANT

/

THOMAS C. MILLER (P17786)
ATTORNEY FOR PLAINTIFF
P.O. BOX 785
SOUTHFIELD, MICHIGAN 48037
(248) 210-3211

/

COMPLAINT AND AFFIDAVIT OF MERIT

[There is no other pending or resolved civil action arising out of the same transaction or occurrence as alleged in the complaint.]

NOW COMES Plaintiff Sandra Marquardt, by and through their attorney Thomas C. Miller, and states:

1. Plaintiff resides in Jackson County.

2. Defendant maintains numerous health care facilities in Washtenaw County.

3. Defendant is the duly elected governing board for the University of Michigan, which operates the University of Michigan Hospitals and Health Centers.

4. Plaintiff claims an exemption from governmental immunity pursuant to MCL 691.1413.

5. The anesthesiologists and anesthesiology residents and fellows, who participated in the subject mitral valve surgery, were all employees and/or agents of Defendant.

6. The University of Michigan Hospitals and Health Centers was served with a notice of intent to sue on or about July 20, 2009, pursuant to MCL 600.2912b.

7. Plaintiff Sandra D. Marquardt was a patient at the University of Michigan Hospitals and Health Centers from July 17, 2007 through December 4, 2007. During that admission Ms. Marquardt underwent mitral valve replacement surgery on July 20, 2007.

8. Defendant, though its agents and employees, had a duty to provide medical and surgical care consistent with applicable standards of care for anesthesiologists. The standards of care for anesthesiologists, who are involved with cardiothoracic surgery to replace a mitral valve (after November 2006), require that the drug Trasylol not be used during such surgery given the changes made by the manufacturer regarding the indications for the use of the drug, and given the cautionary warnings issued by the FDA and the manufacturer prior to that date. The manufacturer's changes to its insert and the FDA advisories regarding the indications for the use of Trasylol clearly stated that the drug was to be used exclusively for patients with a risk of bleeding ***and*** who were undergoing coronary artery bypass graft surgery. Ms. Marquardt met neither of these indications. In addition to the published warnings detailed above, the standards of care would prohibit the use of Trasylol in a patient that had evidence of possible preoperative renal insufficiency. In addition Ms. Marquardt's history of other

d. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.

e. They failed to take the requisite 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, before the sternotomy was performed and before the infusion of the drug was commenced, as recommended by the manufacturer.

11. As a direct and proximate result of Ms. Marquardt being given Trasylol during her mitral valve replacement procedure on July 20, 2007, Ms. Marquardt developed a significant pre-renal condition complicated by an obstructive condition of the kidneys. She also was suffered from a coagulopathy that was caused by the Trasylol, and aggravated by the lack of effective treatment in the postoperative period of time. Her renal disease, coagulopathy, multi-organ dysfunction, acidosis and significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, and severe depression during her lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months. Upon discharge she was on hemodialysis; she was oxygen dependent upon discharge due to changes in he lungs from ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis; and she was discharged still suffering from renal disease, ongoing liver

disease, and heart problems that must be treated with an extensive array of drug therapies and continue to cause severe debilitation. Ms. Marquardt went from an independent person, who was able to perform all ADL's, except when her mitral valve failed, to a person totally dependent on he husband and others. These problems are more likely than not directly related to complications from the use of Trasylol during her cardiothoracic surgery.

12. As a result of the above injuries, Plaintiff Sandra D. Marquardt has suffered considerable pain, suffering, mental anguish, disability, lost income, and medical expenses. The injuries are likely permanent in nature, and the above damages will continue.

WHEREFORE, Plaintiff Sandra D. Marquardt request that this Court grant them a judgment that fairly, reasonably and adequately compensates them for their injuries and damages.

Respectfully submitted,

Thomas C. Miller (P17786)

Dated: January 18, 2010

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

SANDRA D. MARQUARDT

PLAINTIFFS

VS. CIVIL ACTION NO. NH

THE UNIVERSITY OF MICHIGAN BOARD OF REGENTS
(UNIVERSITY OF MICHIGAN HOSPITALS AND
HEALTH CENTERS)

DEFENDANT

AFFIDAVIT OF MERIT

I, Javier H. Campos, M.D., having been duly sworn, state:

1. I am licensed to practice medicine in the State of Iowa, and I was so licensed at all times relevant to this litigation.

2. I am a professor in anesthesiology and director of cardiothoracic anesthesia at the University of Iowa Healthcare

3. I am engaged in the full time clinical practice of anesthesia/cardiothoracic anesthesia, and I was so engaged at all times relevant to this litigation.

4. I have received and reviewed the notice of intent provided to me by counsel for Ms. Marquardt.

5. I have received and reviewed medical records from counsel for Ms. Marquardt.

6. I am familiar with the standards of care for anesthesiologists, as they relate to the indications for the use of Trasylol (after November 2006) during mitral valve replacement surgery.

7. The standards of care for anesthesiologists, who are involved with cardiothoracic surgery to replace a mitral valve (after November 2006), require that Trasylol not be used during such surgery given the changes made by the manufacturer regarding the indications for the use of the drug, and given the cautionary

warnings issued by the FDA and the manufacturer prior to that date. The manufacturer's changes to its insert and the FDA advisories regarding the indications for the use of Trasylol clearly indicated that the drug was to be used exclusively for patients with a risk of bleeding ***and*** who were undergoing coronary artery bypass graft surgery. In addition to the published warnings detailed above, the standards of care would prohibit the use of Trasylol in a patient that had evidence of possible preoperative renal insufficiency. Once the decision was reached to administer the Trasylol, the standards of care required that a test dose be administered ten minutes before the loading dose, and that the administration of the loading dose be accomplished over a 20-30 minute time period before the sternotomy and before the infusing of the drug began.

8. The anesthesiologists, who were involved with the subject mitral valve replacement procedure, breached the applicable standards of care, as they relate to the use of Trasylol, in the following ways:

   a. They used Trasylol before and during mitral valve replacement surgery, despite the revised indications and warnings published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current regarding the indications and warnings regarding Trasylol, and used the drug during off-label surgery.
   b. They used Trasylol during off-label mitral valve replacement surgery, when the FDA and the manufacturer, who were aware of such off-label uses for the drug, cautioned against using the drug for any procedure other than a CABG procedure where the patient was at an increased risk of bleeding, until the drug's safety could be fully reviewed.
   c. They also ignored Ms. Marquardt's preoperative history of other drug allergies and possible renal insufficiency, which placed her at an increased risk of a reaction to Trasylol and/or at an increased risk of further renal disease from the drug.
   d. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.
   e. They failed to take the requisite 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, as recommended by the manufacturer.

9. The anesthesiologists that participated in the mitral valve replacement surgery on Ms. Marquardt would have complied with applicable standards of care, if they had insisted that Trasylol not be used, in light of the FDA warnings and the changes made by the manufacturer regarding the indications for use of the drug. Additionally, an alternative drug should have been used due to the patient's preoperative evidence of possible renal insufficiency and the patient's history of other drug allergies.

10. As a direct and proximate result of Ms. Marquardt being given Trasylol during her mitral valve replacement procedure on July 20, 2007, Ms. Marquardt

developed a significant renal condition complicated by an obstructive condition of the kidneys. Her renal disease, coagulopathy, multi-organ dysfunction, acidosis and significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, and severe depression during her lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months. Upon discharge she was on hemodialysis; she was oxygen dependent upon discharge due to changes in he lungs from ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis; and she was discharged still suffering from renal disease, ongoing liver disease, and heart problems that must be treated with an extensive array of drug therapies and continue to cause severe debilitation. Ms. Marquardt went from an independent person, who was able to perform all ADL's, except when her mitral valve failed, to a person totally dependent on her husband and others. These problems are more likely than not directly related to complications from the use of Trasylol during her cardiothoracic surgery.

Respectfully submitted,

Javier H. Campos, M.D.

STATE OF IOWA)
§
COUNTY OF)

On the 15 day of January, 2010, Javier H. Campos, M.D. appeared before me, a Notary Public, personally and being duly sworn, acknowledged signing this Affidavit of Merit as her/his free act and deed.

, Notary Public
Johnson County, Iowa
My Commission Expires: 4/7/13

Exhibit D

Approved, SCAO

JIS CODE: LET

STATE OF MICHIGAN PROBATE COURT COUNTY OF JACKSON	LETTERS OF AUTHORITY FOR PERSONAL REPRESENTATIVE	FILE NO. 10011754 -DE

Estate of SANDRA D. MARQUARDT (DEC)

TO:

Name and address	Telephone no.
SARON E. MARQUARDT 3049 VILLAGE LANE BROOKLYN, MI 49230	(517) 917-5889

You have been appointed and qualified as personal representative of the estate on 06/14/2010 (Date). You are authorized to perform all acts authorized by law unless exceptions are specified below.

☐ Your authority is limited in the following way:

☐ You have no authority over the estate's real estate or ownership interests in a business entity that you identified on your acceptance of appointment.

☐ Other restrictions or limitations are:

☐ These letters expire: _____ (Date).

06/14/2010
Date

Judge (formal proceedings)/Register (informal proceedings) Bar no.

SEE NOTICE OF DUTIES ON SECOND PAGE

THOMAS C. MILLER (P17786)
Attorney name (type or print) Bar no.

P.O. BOX 785
Address

SOUTHFIELD, MI 48037 (248) 210-3211
City, state, zip Telephone no.

I certify that I have compared this copy with the original on file and that it is a correct copy of the original, and on this date, these letters are in full force and effect.

JUN 23 2010
Date

Deputy register

Do not write below this line - For court use only

FILED
JUN 14 2010
Jackson County Probate Court

TRUE COPY
of the original on file
in said Proceedings.
JUN 23 2010
Jackson County Probate Court

PC 572 (10/07) LETTERS OF AUTHORITY FOR PERSONAL REPRESENTATIVE MCL 700.3103, MCL 700.3307, MCL 700.3414, MCL 700.3504, MCL 700.3601, MCR 5.202, MCR 5.206, MCR 5.307, MCR 5.310

The following provisions are mandatory reporting duties specified in Michigan law and Michigan court rules and are not the only duties required of you. See MCL 700.3701 through MCL 700.3722 for other duties. Your failure to comply may result in the court suspending your powers and appointing a special fiduciary in your place. It may also result in your removal as fiduciary.

CONTINUED ADMINISTRATION: If the estate is not settled within 1 year after the first personal representative's appointment, you must file with the court and send to each interested person a notice that the estate remains under administration, specifying the reasons for the continued administration. You must give this notice within 28 days of the first anniversary of the first personal representative's appointment and all subsequent anniversaries during which the administration remains uncompleted. If such a notice is not received, an interested person may petition the court for a hearing on the necessity for continued administration or for closure of the estate. [MCL 700.3703(4), MCL 700.3951(3), MCR 5.144, MCR 5.307, MCR 5.310]

DUTY TO COMPLETE ADMINISTRATION OF ESTATE: You must complete the administration of the estate and file appropriate closing papers with the court. Failure to do so may result in personal assessment of costs. [MCR 5.310]

CHANGE OF ADDRESS: You are required to inform the court and all interested persons of any change in your address within 7 days of the change.

Additional Duties for Supervised Administration

If this is a supervised administration, in addition to the above reporting duties, you are also required to prepare and file with this court the following written reports or information.

INVENTORY: You are required to file with the probate court an inventory of the assets of the estate within 91 days of the date your letters of authority are issued or as ordered by the court. You must send a copy of the inventory to all presumptive distributees and all other interested persons who request it. The inventory must list in reasonable detail all the property owned by the decedent at the time of death. Each listed item must indicate the fair market value at the time of the decedent's death and the type and amount of any encumbrance. If the value of any item has been obtained through an appraiser, the inventory should include the appraiser's name and address with the item or items appraised by that appraiser. You must also provide the name and address of each financial institution listed on your inventory at the time the inventory is presented to the court. The address for a financial institution shall be either that of the institution's main headquarters or the branch used most frequently by the personal representative. [MCL 700.3706, MCR 5.307, MCR 5.310(E)]

ACCOUNTS: You are required to file with this court once a year, either on the anniversary date that your letters of authority were issued or on another date you choose (you must notify the court of this date) or more often if the court directs, a complete itemized accounting of your administration of the estate. This itemized accounting must show in detail all income and disbursements and the remaining property, together with the form of the property. Subsequent annual and final accountings must be filed within 56 days following the close of the accounting period. When the estate is ready for closing, you are also required to file a final account with a description of property remaining in the estate. All accounts must be served on the required persons at the same time they are filed with the court, along with proof of service.

ESTATE (OR INHERITANCE) TAX INFORMATION: You are required to submit to the court proof that no estate (or inheritance) taxes are due or that the estate (or inheritance) taxes have been paid. **Note:** The estate may be subject to inheritance tax.

Additional Duties for Unsupervised Administration

If this is an unsupervised administration, in addition to the above reporting duties, you are also required to prepare and provide to all interested persons the following written reports or information.

INVENTORY: You are required to prepare an inventory of the assets of the estate within 91 days from the date your letters of authority are issued and to send a copy of the inventory to all presumptive distributees and all other interested persons who request it. You are also required within 91 days from the date your letters of authority are issued, to submit to the court the information necessary to calculate the probate inventory fee that you must pay to the probate court. You may use the original inventory for this purpose. [MCL 700.3706, MCR 5.307]

ESTATE (OR INHERITANCE) TAX INFORMATION: You may be required to submit to the court proof that no estate (or inheritance) taxes are due or that the estate (or inheritance) taxes have been paid. **Note:** The estate may be subject to inheritance tax.

Exhibit E

LAW OFFICES
OF
THOMAS C. MILLER
P.O. BOX 785
SOUTHFIELD, MICHIGAN 48037
248-210-3211

September 2, 2011

Jonathan W. Haft, M.D.
University of Michigan Cardiovascular Center
Section of Cardiac Surgery
1500 E. Medical Center Drive, Floor 3
Ann Arbor, MI 48109-5853

Re: Sandra D. Marquardt

Dear Dr. Haft:

You are hereby notified that Sandra D. Marquardt intends to file suit against Jonathan Haft, M.D., and Vellaiah Durai Umashankar, M.D. upon the expiration of 182 days from the above date. This notice is being provided pursuant to MCL 600.2912b. This same statute places certain requirements upon each of you as well. One of those obligations is to provide the undersigned with a notice of meritorious defense, which must be provided within 154 days from the date above.

Ms. Marquardt's medical history is well documented in the University of Michigan Hospitals and Medical Centers' chart covering the above admission. Ms. Marquardt agrees that it contains the relevant medical history necessary for this notice of intent. In addition, all of the relevant medical treatment regarding this notice of intent is contained in that hospital chart. Certain portions of the care and treatment provided to Ms. Marquardt should be highlighted below, so that there is sufficient context to explain the claims being made below.

Ms. Marquardt was known to have suffered drug reactions to penicillin and ceftriaxone. Her baseline or pre-operative renal function studies revealed some degree of renal insufficiency. Specifically, her pre-operative creatinine level was reported to be 1.4 (on two occasions), her pre-operative BUN level was reported to be 21 (on two

9|2

occasions) and there was evidence of significant levels of blood in her pre-operative urinalysis.

Dr. Haft admitted Ms. Marquardt in order to stabilize her cardiovascular status before performing a mitral valve replacement procedure. He was particularly interested in getting her off her Coumadin and onto IV Heparin, so that her coagulation could be more closely controlled during and after the surgery. He wanted the INR to be equal to or less than 2.0 and he wanted her PTT levels to be between 50 and 70 before proceeding with the surgery. Her INR was 2.8 on admission and had fallen to 1.6 by July 19th. Her PTT was 42.9 on admission and fell to 33.7 by July 19th. He initially planned on surgery for July 24th; however, that date was subsequently moved up to July 20th.

The Anesthesia Record, which was prepared incident to the mitral valve replacement procedure performed on July 20th, established the following timeline:

1. The anesthesia was started at 0645.
2. The patient was brought to the operating room at 0702.
3. The anesthesia induction ended at 0801.
4. The patient was placed in the left lateral decubitus position at 0804.
5. The baseline ACT was drawn at 0804 and reported to be 157 (the exact equipment used is not reflected on the chart).
6. The surgical incision was made at 0839. [**No test dose or loading dose of Trasylol was administered before the incision and thoracotomy as required by the manufacturer in its insert.**]
7. The 200 ml loading dose of Trasylol was given at 0909. [**No test dose was given before the loading dose, as required by the manufacturer in its insert.**]
8. The first ACT level obtained after the loading dose of Trasylol was reported as 999, which was apparently the highest level that could be digitally displayed by the equipment, at about 0915.
9. The Trasylol infusion dose of 50 ml/hr was begun at 0918.
10. The first dose of Heparin was administered at 0930. [There was confusion in the record as to the exact dosage given at that time. The written chronology indicates that 25,000 units were given. The graphic summary indicates that 2,500 units were given; however, the total on the graphic summary indicates that 35,000 total units were given during the procedure, which would have included 10,000 units at 1230. Dr. Haft indicates in his operative report that she was "systemically heparinized with 3 mg/kg sodium heparin", which would mean that she was given about 250 mg. given her known weight of 77.1 kg.]
11. Full cardiopulmonary bypass was initiated at 0942.
12. The first ACT level obtained after the Trasylol and Heparin were given reflected a continuing level of 999 at 1015.
13. The ACT level obtained at about 1115 revealed a level of 545.
14. The ACT level obtained at about 1215 revealed a level of 499.
15. The second dose of Heparin containing 10,000 or 1,000 units was given at 1230.
16. The ACT level obtained at about 1300 revealed a level of 387.

17. The cardiopulmonary bypass was terminated at 1311. [**The total time spent on the bypass equipment was reported by Dr. Haft to have been 209 minutes.**]
18. The ACT level obtained at about 1315 revealed a level of 590.
19. A 250 mg dose of Protamine was given at about 1330.
20. A 50 mg dose of Protamine was given at about 1400.
21. The ACT level obtained at about 1400 revealed a level of 158.
22. The surgical dressing was completed at 1445.
23. The patient was transferred to the TICU at 1501.
24. The anesthesia was ended at 1515.
25. The Trasylol infusion was terminated at about 1530.

In January 2006 a group of physicians and research experts published the results of an extensive study comparing the drug Trasylol with two other similar acting drugs. Their findings were accepted for publication in the prestigious *New England Journal of Medicine*. That article, together with a similar smaller study published in the March 2006 issue of *Transfusion*, began to raise serious questions about the safety of Trasylol. The FDA apparently became aware of those two studies and responded by publishing a "Public Health Advisory for Trasylol" dated February 8, 2006. In that advisory they informed the medical profession, particularly the cardiac surgeons and anesthesiologists, that they were aware of two studies that were reporting an increased risk of death and serious injury due to renal and heart disease incident to the use of Trasylol, when compared to the incidence of such results in patients who received two similar acting drugs. Following the FDA investigation and following consultations with the drug's manufacturer, the FDA adopted a revised insert to be distributed to all physicians who were the end users of the drug. That new insert was published and made available to the relevant physicians in November 2006. In that publication the manufacturer added additional information and cautionary content regarding the risk of renal, cardiac and vascular risks with the use of the drug. Of particular note was the manufacturer's "Indications and Usage" section. Trasylol was indicated for prophylactic use to reduce perioperative blood loss and the need for blood transfusion in **patients undergoing cardiopulmonary bypass in the course of coronary artery bypass graft surgery who are at an increased risk for blood loss and blood transfusion.**

It should be noted that the earlier insert also limited the indications to patients undergoing coronary artery bypass graft procedures in which cardiopulmonary bypass equipment was used; however, both the medical specialists involved and the manufacturer itself were aware that the drug was being used for off-label surgeries including cardiac valve replacements. In December 2006 the FDA again advised the medical community that it was very concerned about Trasylol; however, it wanted more information before making a decision regarding the safety of the drug. The FDA requested and Bayer agreed to inform its customers that the drug was to be used in strict compliance with the insert. Specifically, the manufacturer told its users to adhere strictly to the indications contained in the old and new insert, i.e. it was to be used only in CABG procedures. The FDA issued a press release regarding the new insert in December 2006, and Bayer drafted a form letter, which it sent to each of its customers in the same month. The FDA indicated that it wanted the physicians to "understand the new warnings and use the product as directed by the [insert]". The new insert specifically stated that the

drug was to be used only during CABG procedures. In the December letter the company also made it very clear to the physicians that the drug was to be used incident to CABG procedures only. They also advised the physicians of the renal and cardiac risks raised in the literature. The letter highlighted the changes in the new insert, which had been published in November 2006. It is believed that the information from the FDA and from Bayer was communicated directly to Dr. Haft, Dr. Umashankar and/or the University of Michigan Hospitals and Medical Centers in late 2006.

The revised 2006 insert made many critical points relevant to the facts in this matter. First, the use of the drug was to be restricted to CABG procedures, and was not to be used for valve replacement procedures. Second, patients with pre-existing renal insufficiency were at an increased risk of developing renal complications from the use of Trasylol. Third, patients with other drug allergies were more likely to have a reaction to Trasylol. Fourth, a test dose of Trasylol was to be given at least ten minutes before the loading dose of the drug. Fifth, the loading dose was to be given over a 20-30 minute time period before infusion of the drug. Sixth, the patient was to be placed in a supine position during administration of the test dose and the loading dose. Seventh, the patient was to be closely monitored closely for possible coagulopathy when Trasylol and Heparin were administered concurrently. An elevated ACT level might not reflect a high therapeutic level of Heparin, when Heparin was administered concurrently with Trasylol. Eighth, Protamine titration should be used to establish the adequacy of Heparin levels before any Trasylol is given, so that the anti-coagulation effects of the two drugs can be separated, and so that the results of that titration could be used to determine the effect of the Heparin therapy throughout the operative and post-operative phases. Ninth, the therapeutic level of Heparin must be kept above certain levels during the procedure (reflected by careful monitoring of coagulation studies) independent of the anti-coagulation effect created by the Trasylol given concurrently with Heparin.

The medical records of Ms. Marquardt reflect that no test dose of Trasylol was administered ten minutes before the loading dose. The patient was not in a supine position when she was given the loading dose of Trasylol. The loading dose was not given slowly over a 20-30 minute period of time (only nine minutes separated the loading dose from the start of the infusion of Trasylol). Ms. Marquardt had a history of two different drug allergies. The procedure was a valve replacement procedure and not a CABG procedure. Ms. Marquardt did have evidence of pre-operative kidney dysfunction. Lastly, she was not closely monitored after the administration of Trasylol and Heparin to determine the anti-coagulation effect of Heparin alone versus the synergistic anti-coagulation effect of the two drugs in combination.

Following the surgery, during which Ms. Marquardt received Heparin and Trasylol, she began to manifest significant clinical signs and symptoms of renal disease, which led to multiple other organ system problems. The lack of attention to her renal complications from the Trasylol resulted in other iatrogenic complications and nosocomial infections. Despite numerous medical diagnoses formulated by the numerous physicians who treated Ms. Marquardt over the four months of post-operative care, the diagnosis of Trasylol induced pathology never appeared. It was not even mentioned as part of anyone's differential diagnoses. The various treating physicians did proffer opinions regarding the etiology of her renal disease specifically that they were post-op complications and that may have been related to the lengthy period of time spent on the

bypass equipment; however, they never once mentioned the drug Trasylol as a possible factor.

During the time Ms. Marquardt was an inpatient at the University of Michigan Hospital; the following diagnoses were made and repeated often by the various physicians charged with providing her with care for her post-operative complications:

1. Various nosocomial infections, bacteremia and sepsis.
2. Hyperglycemia secondary to surgical stress requiring Tight Glycemic Control
3. Oliguric
4. Diminished Coronary Output/Coronary Index
5. Hemolysis secondary to long coronary bypass machine time
6. Fluid overload
7. Renal Hypoperfusion
8. Polyuric Renal Failure secondary to prolonged pump time
9. Acute Tubular Necrosis (ATN)
10. Hyperphosphatemia
11. Acute Kidney Injury (AKI) secondary to ATN
12. Hypotension
13. Pulmonary Edema
14. Non-oliguric Renal Failure
15. Acute Respiratory Distress Syndrome (ARDS)
16. Systemic Inflammatory Response Syndrome (SIRS)
17. Prolonged Respiratory Failure
18. Hematuria
19. Metabolic Acidosis
20. Pleural Effusion
21. Swallowing Dysfunction
22. Hypothyroidism
23. Hypercarbia
24. Hypoxemia
25. Clinical Depression
26. Peri-operative vascular leak
27. Respiratory Acidosis
28. Anemia
29. Atrial Fibrillation
30. Sick Euthyroid Syndrome
31. Prerenal Azotemia
32. Moderate Differentiated Encephalopathy
33. End Stage Renal Disease
34. Pulmonary Vein Stenosis
35. Urinary Tract Infection (UTI)
36. Adrenal Insufficiency
37. Cholecystitis
38. Wound Dehiscence
39. Extracellular Fluid Volume Depletion

Each of the above diagnoses appear to be related to Ms. Marquardt's underlying

renal disease, the iatrogenic efforts made by the medical staff to diagnose and treat the underlying renal disease, the nosocomial infections resulting from her long hospital stay, problems caused by the inability of the medical staff to correct the fluid imbalance situation caused by her renal dysfunction, or from the effects of the long-term hospital stay and the decompensation caused by the overwhelming medical and emotional conditions.

Ms. Marquardt has been followed by her primary care physician Raymond Cole, D.O, 107 W. Chicago, Brooklyn, MI 49230, her nephrologists R.V. Nagesh, M.D., 205 N. East Avenue, Jackson, MI 49201, her pulmonologist Robert D. Albertson, M.D., 900 E. Michigan Avenue, Jackson, MI 49201, and her cardiologist Bischan Hassunizadeh, M.D., 205 Page Avenue, Suite B, Jackson, MI 49201.

The standards of care for anesthesiologists and cardio-thoracic surgeons assisting in cardiac surgeries involving the use of cardiopulmonary bypass equipment require that Trasylol not be used during cardiac valve procedures performed after November 2006, given the advisories issued by the FDA and Bayer. The standards of care for both specialties also require that Trasylol induced renal disease should be ruled out as soon as possible, if renal disease is diagnosed or suspected following a surgical procedure in which Trasylol was used. These same standards require the appropriate use of Heparin in conjunction with the concurrent use of Trasylol. The anti-coagulation effect of Heparin must be isolated from the overall anti-coagulation effect of Heparin and Trasylol in combination. Trasylol should not be used as a Heparin sparing agent. Additional Heparin therapy may be needed even if ACT levels are elevated. Protamine titration to measure Heparin therapeutic levels must be performed before the administration of Trasylol and that baseline level must be used to determine if Heparin is needed to maintain anti-coagulation therapy intra-operatively and post-operatively, given that the Trasylol in a renal insufficient patient might be long-lasting and affect anti-coagulation test results, leading to reduced Heparin therapy post-operatively. These standards of care also require the physician to identify, carefully monitor and effectively treat fluid levels to avoid cardiopulmonary complications due to fluid overload or due to extracellular fluid volume depletion. If diagnosed, Trasylol induced renal disease must be aggressively treated with appropriate anti-thrombotic drug therapy, and therapeutic Heparin levels must be implemented to counter the Trasylol induced coagulopathy. If Trasylol is indicated, the applicable standards of care require that a test dose of 1 ml be given at least ten minutes before the loading dose. Then the loading dose should be given slowly over a 20-30 minute time period after induction of anesthesia and before the sternotomy, while the patient is in a supine position. Then the constant infusion of the drug is begun and continued until the surgery is completed and the patient leaves the operating room.

Drs. Haft and Umashankar, together with their associates, residents and fellows, breached applicable standards of care for cardiac surgeons and/or anesthesiologists assisting in cardiac procedures in the following ways:

1. They used Trasylol incident to a mitral valve replacement procedure, despite the indications published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current on the indications for the drug and used the drug during an off-label procedure.
2. They used Trasylol for an off-label purpose, when the FDA and the manufacturer, who were aware of the off-label uses of the drug, cautioned

against using the drug for any procedure other than a CABG procedure, until the drug's safety could be fully reviewed.

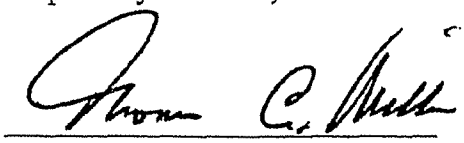
3. They ignored Ms. Marquardt's preoperative history of other drug allergies and renal insufficiency, which placed her at an increased risk of an allergic reaction to Trasylol and/or at an increased risk of further renal disease from the drug.
4. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.
5. They failed to take 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, before the sternotomy was performed and before the infusion of the drug was commenced.
6. They failed to adequately separate any coagulopathy caused by the Trasylol from any coagulopathy caused by Heparin therapy or the lack of that therapy, and, in so doing, they decreased or withheld Heparin therapy from the patient when she actually needed the therapy to counteract the Trasylol effects on the kidneys.
7. The failed to recognize the connection between Trasylol (thrombosis) and the hypocoagulopathy demonstrated in the laboratory results.
8. They failed to institute dialysis and/or appropriate diuretic therapy in a timely manner to maintain an appropriate fluid balance.
9. They failed to diagnose Trasylol induced renal disease, and treat it appropriately in a timely manner.
10. They failed to diagnose the prerenal disease caused by the Trasylol and recognize that the problems they were encountering in regards to pulmonary edema, cardiac dysfunction and other organ system failures were directly related to the renal disease, iatrogenic consequences of the inappropriate treatment protocols, nosocomial infections and/or from long periods of ventilation, decompensation and debilitation.

Drs. Haft and Umashankar, together with their associates, residents and fellows, would have complied with applicable standards of care, if they had decided not to use Trasylol during Ms. Marquardt's mitral valve repair procedure on July 20, 2007, given the FDA and manufacturer warnings against using it for such procedures. If they felt that the procedure and patient warranted the use of Trasylol, then they needed to recognize the other risk factors presented by her prior drug allergies and pre-existing renal insufficiency. They also had to use the drug as indicated in the insert regarding a test dose, the loading dose and coagulation assessments during and after the procedure. They also had to rule out Trasylol induced renal disease given the problems that presented in the immediate postoperative period. Then they needed to treat the Trasylol induced renal disease, the coagulopathy, the fluid imbalance and the effects of the renal disease on other organ systems in a timely manner.

As a direct and proximate result of the above negligent acts by Drs. Haft and Umashankar (together with their associates, residents and fellows), Ms. Marquardt was given a contraindicated drug during her mitral valve repair procedure on July 20, 2007. This drug then caused a prerenal condition complicated by an obstructive condition of the kidneys. She also was suffering from a coagulopathy that was caused by the Trasylol, and aggravated by the lack of effective treatment in the postoperative period of time. Her

renal disease, coagulopathy, multi-organ dysfunction, acidosis and a significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, severe depression, as she tried to cope with the lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months, was discharged on hemodialysis, is oxygen dependent due to changes in he lungs from the ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis, ongoing renal disease, ongoing liver disease, heart problems that must be treated with medication and severely debilitated. Her multiple medical problems that began following the above surgery and post-operative complications eventually led to her death on January 27, 2010. She went from an independent person who was able to perform all of her ADL's, except when her mitral valve failed, to a person totally dependent on he husband and others to perform her ADL's and eventually death from renal failure complications. She was also completely oxygen dependent and severely disabled due to the poor care and treatment she received during her four and one-half months of hospitalization. These problems were directly related to the complications from a drug she should not have been given and directly related to the ineffective care and treatment she was given thereafter.

Respectfully submitted,



Thomas C. Miller

TCM:mls

Exhibit F

LAW OFFICES
OF
THOMAS C. MILLER
P.O. BOX 785
SOUTHFIELD, MICHIGAN 48037
248-210-3211

September 2, 2011

Vellaiah Durai Umashankar, M.D.
c/o University of Michigan Cardiovascular Center
Department of Anesthesia
1500 E. Medical Center Drive, SPC 5861
Ann Arbor, MI 48109

Re: Sandra D. Marquardt

Dear Dr. Umashankar:

You are hereby notified that Sandra D. Marquardt intends to file suit against Jonathan Haft, M.D., and Vellaiah Durai Umashankar, M.D. upon the expiration of 182 days from the above date. This notice is being provided pursuant to MCL 600.2912b. This same statute places certain requirements upon each of you as well. One of those obligations is to provide the undersigned with a notice of meritorious defense, which must be provided within 154 days from the date above.

Ms. Marquardt's medical history is well documented in the University of Michigan Hospitals and Medical Centers' chart covering the above admission. Ms. Marquardt agrees that it contains the relevant medical history necessary for this notice of intent. In addition, all of the relevant medical treatment regarding this notice of intent is contained in that hospital chart. Certain portions of the care and treatment provided to Ms. Marquardt should be highlighted below, so that there is sufficient context to explain the claims being made below.

Ms. Marquardt was known to have suffered drug reactions to penicillin and ceftriaxone. Her baseline or pre-operative renal function studies revealed some degree of renal insufficiency. Specifically, her pre-operative creatinine level was reported to be 1.4 (on two occasions), her pre-operative BUN level was reported to be 21 (on two

9/2

occasions) and there was evidence of significant levels of blood in her pre-operative urinalysis.

Dr. Haft admitted Ms. Marquardt in order to stabilize her cardiovascular status before performing a mitral valve replacement procedure. He was particularly interested in getting her off her Coumadin and onto IV Heparin, so that her coagulation could be more closely controlled during and after the surgery. He wanted the INR to be equal to or less than 2.0 and he wanted her PTT levels to be between 50 and 70 before proceeding with the surgery. Her INR was 2.8 on admission and had fallen to 1.6 by July 19th. Her PTT was 42.9 on admission and fell to 33.7 by July 19th. He initially planned on surgery for July 24th; however, that date was subsequently moved up to July 20th.

The Anesthesia Record, which was prepared incident to the mitral valve replacement procedure performed on July 20th, established the following timeline:

1. The anesthesia was started at 0645.
2. The patient was brought to the operating room at 0702.
3. The anesthesia induction ended at 0801.
4. The patient was placed in the left lateral decubitus position at 0804.
5. The baseline ACT was drawn at 0804 and reported to be 157 (the exact equipment used is not reflected on the chart).
6. The surgical incision was made at 0839. [**No test dose or loading dose of Trasylol was administered before the incision and thoracotomy as required by the manufacturer in its insert.**]
7. The 200 ml loading dose of Trasylol was given at 0909. [**No test dose was given before the loading dose, as required by the manufacturer in its insert.**]
8. The first ACT level obtained after the loading dose of Trasylol was reported as 999, which was apparently the highest level that could be digitally displayed by the equipment, at about 0915.
9. The Trasylol infusion dose of 50 ml/hr was begun at 0918.
10. The first dose of Heparin was administered at 0930. [There was confusion in the record as to the exact dosage given at that time. The written chronology indicates that 25,000 units were given. The graphic summary indicates that 2,500 units were given; however, the total on the graphic summary indicates that 35,000 total units were given during the procedure, which would have included 10,000 units at 1230. Dr. Haft indicates in his operative report that she was "systemically heparinized with 3 mg/kg sodium heparin", which would mean that she was given about 250 mg. given her known weight of 77.1 kg.]
11. Full cardiopulmonary bypass was initiated at 0942.
12. The first ACT level obtained after the Trasylol and Heparin were given reflected a continuing level of 999 at 1015.
13. The ACT level obtained at about 1115 revealed a level of 545.
14. The ACT level obtained at about 1215 revealed a level of 499.
15. The second dose of Heparin containing 10,000 or 1,000 units was given at 1230.
16. The ACT level obtained at about 1300 revealed a level of 387.

17. The cardiopulmonary bypass was terminated at 1311. [**The total time spent on the bypass equipment was reported by Dr. Haft to have been 209 minutes.**]
18. The ACT level obtained at about 1315 revealed a level of 590.
19. A 250 mg dose of Protamine was given at about 1330.
20. A 50 mg dose of Protamine was given at about 1400.
21. The ACT level obtained at about 1400 revealed a level of 158.
22. The surgical dressing was completed at 1445.
23. The patient was transferred to the TICU at 1501.
24. The anesthesia was ended at 1515.
25. The Trasylol infusion was terminated at about 1530.

In January 2006 a group of physicians and research experts published the results of an extensive study comparing the drug Trasylol with two other similar acting drugs. Their findings were accepted for publication in the prestigious *New England Journal of Medicine*. That article, together with a similar smaller study published in the March 2006 issue of *Transfusion*, began to raise serious questions about the safety of Trasylol. The FDA apparently became aware of those two studies and responded by publishing a "Public Health Advisory for Trasylol" dated February 8, 2006. In that advisory they informed the medical profession, particularly the cardiac surgeons and anesthesiologists, that they were aware of two studies that were reporting an increased risk of death and serious injury due to renal and heart disease incident to the use of Trasylol, when compared to the incidence of such results in patients who received two similar acting drugs. Following the FDA investigation and following consultations with the drug's manufacturer, the FDA adopted a revised insert to be distributed to all physicians who were the end users of the drug. That new insert was published and made available to the relevant physicians in November 2006. In that publication the manufacturer added additional information and cautionary content regarding the risk of renal, cardiac and vascular risks with the use of the drug. Of particular note was the manufacturer's "Indications and Usage" section. Trasylol was indicated for prophylactic use to reduce perioperative blood loss and the need for blood transfusion in **patients undergoing cardiopulmonary bypass in the course of coronary artery bypass graft surgery who are at an increased risk for blood loss and blood transfusion.**

It should be noted that the earlier insert also limited the indications to patients undergoing coronary artery bypass graft procedures in which cardiopulmonary bypass equipment was used; however, both the medical specialists involved and the manufacturer itself were aware that the drug was being used for off-label surgeries including cardiac valve replacements. In December 2006 the FDA again advised the medical community that it was very concerned about Trasylol; however, it wanted more information before making a decision regarding the safety of the drug. The FDA requested and Bayer agreed to inform its customers that the drug was to be used in strict compliance with the insert. Specifically, the manufacturer told its users to adhere strictly to the indications contained in the old and new insert, i.e. it was to be used only in CABG procedures. The FDA issued a press release regarding the new insert in December 2006, and Bayer drafted a form letter, which it sent to each of its customers in the same month. The FDA indicated that it wanted the physicians to "understand the new warnings and use the product as directed by the [insert]". The new insert specifically stated that the

drug was to be used only during CABG procedures. In the December letter the company also made it very clear to the physicians that the drug was to be used incident to CABG procedures only. They also advised the physicians of the renal and cardiac risks raised in the literature. The letter highlighted the changes in the new insert, which had been published in November 2006. It is believed that the information from the FDA and from Bayer was communicated directly to Dr. Haft, Dr. Umashankar and/or the University of Michigan Hospitals and Medical Centers in late 2006.

The revised 2006 insert made many critical points relevant to the facts in this matter. First, the use of the drug was to be restricted to CABG procedures, and was not to be used for valve replacement procedures. Second, patients with pre-existing renal insufficiency were at an increased risk of developing renal complications from the use of Trasylol. Third, patients with other drug allergies were more likely to have a reaction to Trasylol. Fourth, a test dose of Trasylol was to be given at least ten minutes before the loading dose of the drug. Fifth, the loading dose was to be given over a 20-30 minute time period before infusion of the drug. Sixth, the patient was to be placed in a supine position during administration of the test dose and the loading dose. Seventh, the patient was to be closely monitored closely for possible coagulopathy when Trasylol and Heparin were administered concurrently. An elevated ACT level might not reflect a high therapeutic level of Heparin, when Heparin was administered concurrently with Trasylol. Eighth, Protamine titration should be used to establish the adequacy of Heparin levels before any Trasylol is given, so that the anti-coagulation effects of the two drugs can be separated, and so that the results of that titration could be used to determine the effect of the Heparin therapy throughout the operative and post-operative phases. Ninth, the therapeutic level of Heparin must be kept above certain levels during the procedure (reflected by careful monitoring of coagulation studies) independent of the anti-coagulation effect created by the Trasylol given concurrently with Heparin.

The medical records of Ms. Marquardt reflect that no test dose of Trasylol was administered ten minutes before the loading dose. The patient was not in a supine position when she was given the loading dose of Trasylol. The loading dose was not given slowly over a 20-30 minute period of time (only nine minutes separated the loading dose from the start of the infusion of Trasylol). Ms. Marquardt had a history of two different drug allergies. The procedure was a valve replacement procedure and not a CABG procedure. Ms. Marquardt did have evidence of pre-operative kidney dysfunction. Lastly, she was not closely monitored after the administration of Trasylol and Heparin to determine the anti-coagulation effect of Heparin alone versus the synergistic anti-coagulation effect of the two drugs in combination.

Following the surgery, during which Ms. Marquardt received Heparin and Trasylol, she began to manifest significant clinical signs and symptoms of renal disease, which led to multiple other organ system problems. The lack of attention to her renal complications from the Trasylol resulted in other iatrogenic complications and nosocomial infections. Despite numerous medical diagnoses formulated by the numerous physicians who treated Ms. Marquardt over the four months of post-operative care, the diagnosis of Trasylol induced pathology never appeared. It was not even mentioned as part of anyone's differential diagnoses. The various treating physicians did proffer opinions regarding the etiology of her renal disease specifically that they were post-op complications and that may have been related to the lengthy period of time spent on the

bypass equipment; however, they never once mentioned the drug Trasylol as a possible factor.

During the time Ms. Marquardt was an inpatient at the University of Michigan Hospital; the following diagnoses were made and repeated often by the various physicians charged with providing her with care for her post-operative complications:

1. Various nosocomial infections, bacteremia and sepsis.
2. Hyperglycemia secondary to surgical stress requiring Tight Glycemic Control
3. Oliguric
4. Diminished Coronary Output/Coronary Index
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18. Hematuria
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20. Pleural Effusion
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22. Hypothyroidism
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35. Urinary Tract Infection (UTI)
36. Adrenal Insufficiency
37. Cholecystitis
38. Wound Dehiscence
39. Extracellular Fluid Volume Depletion

Each of the above diagnoses appear to be related to Ms. Marquardt's underlying

renal disease, the iatrogenic efforts made by the medical staff to diagnose and treat the underlying renal disease, the nosocomial infections resulting from her long hospital stay, problems caused by the inability of the medical staff to correct the fluid imbalance situation caused by her renal dysfunction, or from the effects of the long-term hospital stay and the decompensation caused by the overwhelming medical and emotional conditions.

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The standards of care for anesthesiologists and cardio-thoracic surgeons assisting in cardiac surgeries involving the use of cardiopulmonary bypass equipment require that Trasylol not be used during cardiac valve procedures performed after November 2006, given the advisories issued by the FDA and Bayer. The standards of care for both specialties also require that Trasylol induced renal disease should be ruled out as soon as possible, if renal disease is diagnosed or suspected following a surgical procedure in which Trasylol was used. These same standards require the appropriate use of Heparin in conjunction with the concurrent use of Trasylol. The anti-coagulation effect of Heparin must be isolated from the overall anti-coagulation effect of Heparin and Trasylol in combination. Trasylol should not be used as a Heparin sparing agent. Additional Heparin therapy may be needed even if ACT levels are elevated. Protamine titration to measure Heparin therapeutic levels must be performed before the administration of Trasylol and that baseline level must be used to determine if Heparin is needed to maintain anti-coagulation therapy intra-operatively and post-operatively, given that the Trasylol in a renal insufficient patient might be long-lasting and affect anti-coagulation test results, leading to reduced Heparin therapy post-operatively. These standards of care also require the physician to identify, carefully monitor and effectively treat fluid levels to avoid cardiopulmonary complications due to fluid overload or due to extracellular fluid volume depletion. If diagnosed, Trasylol induced renal disease must be aggressively treated with appropriate anti-thrombotic drug therapy, and therapeutic Heparin levels must be implemented to counter the Trasylol induced coagulopathy. If Trasylol is indicated, the applicable standards of care require that a test dose of 1 ml be given at least ten minutes before the loading dose. Then the loading dose should be given slowly over a 20-30 minute time period after induction of anesthesia and before the sternotomy, while the patient is in a supine position. Then the constant infusion of the drug is begun and continued until the surgery is completed and the patient leaves the operating room.

Drs. Haft and Umashankar, together with their associates, residents and fellows, breached applicable standards of care for cardiac surgeons and/or anesthesiologists assisting in cardiac procedures in the following ways:

1. They used Trasylol incident to a mitral valve replacement procedure, despite the indications published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current on the indications for the drug and used the drug during an off-label procedure.
2. They used Trasylol for an off-label purpose, when the FDA and the manufacturer, who were aware of the off-label uses of the drug, cautioned

against using the drug for any procedure other than a CABG procedure, until the drug's safety could be fully reviewed.

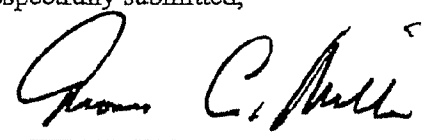
3. They ignored Ms. Marquardt's preoperative history of other drug allergies and renal insufficiency, which placed her at an increased risk of an allergic reaction to Trasylol and/or at an increased risk of further renal disease from the drug.
4. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.
5. They failed to take 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, before the sternotomy was performed and before the infusion of the drug was commenced.
6. They failed to adequately separate any coagulopathy caused by the Trasylol from any coagulopathy caused by Heparin therapy or the lack of that therapy, and, in so doing, they decreased or withheld Heparin therapy from the patient when she actually needed the therapy to counteract the Trasylol effects on the kidneys.
7. The failed to recognize the connection between Trasylol (thrombosis) and the hypocoagulopathy demonstrated in the laboratory results.
8. They failed to institute dialysis and/or appropriate diuretic therapy in a timely manner to maintain an appropriate fluid balance.
9. They failed to diagnose Trasylol induced renal disease, and treat it appropriately in a timely manner.
10. They failed to diagnose the prerenal disease caused by the Trasylol and recognize that the problems they were encountering in regards to pulmonary edema, cardiac dysfunction and other organ system failures were directly related to the renal disease, iatrogenic consequences of the inappropriate treatment protocols, nosocomial infections and/or from long periods of ventilation, decompensation and debilitation.

Drs. Haft and Umashankar, together with their associates, residents and fellows, would have complied with applicable standards of care, if they had decided not to use Trasylol during Ms. Marquardt's mitral valve repair procedure on July 20, 2007, given the FDA and manufacturer warnings against using it for such procedures. If they felt that the procedure and patient warranted the use of Trasylol, then they needed to recognize the other risk factors presented by her prior drug allergies and pre-existing renal insufficiency. They also had to use the drug as indicated in the insert regarding a test dose, the loading dose and coagulation assessments during and after the procedure. They also had to rule out Trasylol induced renal disease given the problems that presented in the immediate postoperative period. Then they needed to treat the Trasylol induced renal disease, the coagulopathy, the fluid imbalance and the effects of the renal disease on other organ systems in a timely manner.

As a direct and proximate result of the above negligent acts by Drs. Haft and Umashankar (together with their associates, residents and fellows), Ms. Marquardt was given a contraindicated drug during her mitral valve repair procedure on July 20, 2007. This drug then caused a prerenal condition complicated by an obstructive condition of the kidneys. She also was suffering from a coagulopathy that was caused by the Trasylol, and aggravated by the lack of effective treatment in the postoperative period of time. Her

renal disease, coagulopathy, multi-organ dysfunction, acidosis and a significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, severe depression, as she tried to cope with the lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months, was discharged on hemodialysis, is oxygen dependent due to changes in he lungs from the ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis, ongoing renal disease, ongoing liver disease, heart problems that must be treated with medication and severely debilitated. Her multiple medical problems that began following the above surgery and post-operative complications eventually led to her death on January 27, 2010. She went from an independent person who was able to perform all of her ADL's, except when her mitral valve failed, to a person totally dependent on he husband and others to perform her ADL's and eventually death from renal failure complications. She was also completely oxygen dependent and severely disabled due to the poor care and treatment she received during her four and one-half months of hospitalization. These problems were directly related to the complications from a drug she should not have been given and directly related to the ineffective care and treatment she was given thereafter.

Respectfully submitted,



Thomas C. Miller

TCM:mls

Exhibit G

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of the Estate of SANDRA MARQUARDT, Deceased,

Plaintiff,

Case No. 12-621-NH
Honorable David S. Swartz

v

VELLAIAH DURAI UMASHANKAR, M.D., and JONATHAN HAFT, M.D.,

Defendants.

Thomas C. Miller (P17786)
Attorney for Plaintiff
P.O. Box 785
Southfield, MI 48037
(248) 210-3211

Patrick McLain (P25458)
Attorney for Defendant Haft
600 Woodward Avenue, Suite 2500
Detroit, MI 48226-3427
(313) 961-0200

ORDER GRANTING DEFENDANT HAFT'S MOTION FOR SUMMARY DISPOSITION AND DISMISSING PLAINTIFF'S CLAIMS AGAINST DEFENDANT HAFT ONLY WITH PREJUDICE

At a Session of Court held in the
Washtenaw County Trial Court
City of Ann Arbor, on February 13, 2013.

PRESENT: HONORABLE DAVID S. SWARTZ, Circuit Court Judge

Defendant Haft (Defendant) filed a motion for summary disposition seeking dismissal with prejudice of Plaintiff's medical malpractice claims. The

Court reviewed the respective briefs and attached exhibits, heard oral argument and took the matter under advisement before issuing its opinion.

The Court finds determinative Defendant's argument that Plaintiff's claim is subject to dismissal because the affidavit of merit (AOM) is invalid. Defendant argues that because Defendant is a specialist who is board certified, Plaintiff's expert must also be a specialist who is board certified in the same specialty. Defendant's specialty is surgery and he is board certified in thoracic surgery. Plaintiff's expert is not board certified in surgery and his specialty is anesthesia. In the absence of an identical "match" of specialties and board certifications, Defendant submits that Plaintiff's expert is not qualified to sign an AOM or render standard-of-care testimony against Defendant.

Further, Defendant submits that, "[D]ismissal with prejudice should be ordered." While acknowledging that Section MCL 600.2301 applies, and that MCR 2.112(L)(2)(b) specifically provides for retroactive amendment of an AOM, Defendant asserts that relief is barred because: "In this case, given the knowledge possessed from the litigation against U of M, justice does not warrant that an amendment be allowed. Plaintiff is well aware of Dr. Haft's area of specialization and could have easily determined his board certifications. Plaintiff's failure to comply with the affidavit of merit requirement is blatant and wholly unjustified. One can only conclude that Plaintiff does not have a cardiac surgery expert supportive of the claims against Dr. Haft, and should never have filed this Complaint against Dr. Haft."

Plaintiff states in response that Defendant's motion is a "gotcha exercise" that raises "technical" defects and errors and "insignificant procedural matters" rather than the merits of Plaintiff's medical malpractice claims against Defendant. Addressing the AOM challenge only "in passing", Plaintiff characterizes the argument as "absurd" and asserts that the standards of care "relating to the use of Trasylol" are the same for cardiothoracic surgeons and cardiothoracic anesthesiologists. The standards of care "cannot be different" because, Plaintiff posits, the Defendants, represented by the same counsel, "have all testified that the decision to use Trasylol was a joint decision made by the anesthesia and cardiac physicians" who "jointly decided to disregard the FDA and manufacturer on July 20, 2007 and use Trasylol during a valve replacement procedure."

Plaintiff does not offer an amended or replacement AOM pursuant to MCR 2.118 and, in particular, MCR 2.112(L)(2)(b) which provides in part:

(2) In a medical malpractice action, unless the court allows a later challenge for good cause:

* * *

(b) all challenges to an affidavit of merit or affidavit of meritorious defense, including challenges to the qualifications of the signer, must be made by motion, filed pursuant to MCR 2.119, within 63 days of service of the affidavit on the opposing party. An affidavit of merit or meritorious defense may be amended in accordance with the terms and conditions set forth in MCR 2.118 and MCL 600.2301.

Instead, Plaintiff asserts that the Court may properly "disregard" errors or defects in the pleadings and grant a waiver of the statutory requirements. Section 2301 provides:

The court in which any action or proceeding is pending, has power to amend any process, pleading or proceeding in such action or proceeding, either in form or substance, for the furtherance of justice, on such terms as are just, at any time before judgment rendered therein. The court at every stage of the action or

proceeding shall disregard any error or defect in the proceedings which do not affect the substantial rights of the parties.

Plaintiff advises that the Legislature "envisioned such relief" for medical malpractice plaintiffs when it enacted Section 2301 and "decided to give the judiciary the statutory authority to halt such efforts before the system completely evolves into a system where procedure trumps substance."

It is well-established that an AOM is presumed valid when filed. *Jackson v. Detroit Medical Center*, 278 Mich.App. 532, 541-542 (2008). However, when challenged, a plaintiff must demonstrate that the AOM meets the requirements set forth in the statutes. *Kirkaldy v. Rim*, 478 Mich. 581 (2007). MCL 600.2912d provides as follows:

(1) Subject to subsection (2), the plaintiff in an action alleging medical malpractice or, if the plaintiff is represented by an attorney, the plaintiff's attorney shall file with the complaint an affidavit of merit signed by a health professional who the plaintiff's attorney reasonably believes meets the requirements for an expert witness under section 2169.

MCL 600.2169 provides:

Sec. 2169. (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:

If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

The statute mandates that plaintiff's counsel must possess a "reasonable belief" that the health professional signing the AOM meets the expert witness requirements set forth in MCL 600.2169. *Geralds v. Munson Healthcare*, 259

Mich.App. 225, 233 (2003). The "reasonableness" of the belief is determined by the medical records and information available to the plaintiff's attorney before or at commencement of the case. *Grossman v. Brown*, 470 Mich. 593, 599-600 (2004). A trial court is not required to conduct mini-trials concerning the ultimate validity of the contents of the AOM. *Sturgis Bank & Trust Co. v. Hillsdale Community Health Ctr.*, 268 Mich.App. 484, 493 (2005). Rather, the inquiry is limited to whether, on its face, the AOM reflects the necessary "reasonable belief." *Kalaj v. Khan*, 295 Mich.App. 420, 428-429 (2012).

Plaintiff's AOM is signed by an expert who is not board certified in cardiothoracic surgery, the "specialty engaged in by the defendant physician during the course of the alleged malpractice." *Gonzalez v. St. John Hosp. & Med. Ctr.* (*On Reconsideration*), 275 Mich.App. 290, 302–303 (2007). Based on the blatant lack of "matching" qualifications, Plaintiff's counsel could not have reasonably believed that the health professional signing the AOM met the requirements of MCL 600.2169. *Grossman, supra, at* 600. Because the AOM, on its face, does not comply with the statutory requirements, the Court finds, as a matter of law, that Plaintiff's AOM is invalid.

Section 2301 clearly states that the Court may not disregard defects and errors in the proceedings that affect a party's substantial rights. Further, Plaintiff has presented no authority in support of a waiver of the statutory requirements pertaining to submission of AOMs. Thus, despite the uncontroverted "joint decision", Plaintiff was required to file an AOM signed by an expert engaged in the "specialty engaged in by the defendant physician during the course of the

alleged malpractice" and "board certified in that specialty." *Hoffman v. Barrett* (On Remand), 295 Mich.App. 649, 663-664 (2012). There is no dispute that Plaintiff failed to comply with those mandates.

Considering that Plaintiff does not offer an amended or replacement AOM and that no time remains in the limitations period within which Plaintiff could file a new complaint against Defendant with a conforming AOM, the Court GRANTS Plaintiff's request for dismissal of the claims with prejudice.

Defendant's Motion for Summary Disposition is GRANTED. Plaintiff's claims against Defendant Haft only are DISMISSED WITH PREJUDICE.

This is not a final order.

IT IS SO ORDERED.

PROOF OF SERVICE
The undersigned certifies that the foregoing instrument was served upon all parties to the above cause to each of the attorneys of record herein at their respective addresses disclosed on the pleadings on 9/12, 2013
By U.S. Mail ___ Express Mail
Hand Delivered ___ Fax ___ Hour Office
Signature

David S. Swartz,
Circuit Court Judge

Exhibit H

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of
the Estate of SANDRA D. MARQUARDT

Plaintiff

VS. Civil Action No. 12-621 NH

VELLAIAH DURAI UMASHANKAR, M.D.
AND JONATHAN HAFT, M.D.

Defendants
_____/

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JOANNE GEHA SWANSON (P33594)
Attorneys for Defendant Jonathan Haft, M.D.
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Detroit, MI 48226-3427
(313) 961-0200
_____/

PLAINTIFF'S ANSWER TO DEFENDANT HAFT'S MOTION FOR SUMMARY DISPOSITION

NOW COMES Plaintiff Saron E. Marquardt, Personal Representative of the Estate of Sandra Marquardt, by and through his attorney Thomas C. Miller and states:

Plaintiff Saron E. Marquardt is the duly appointed Personal Representative of the Estate of Sandra Marquardt having been appointed to that position by the Jackson County Probate Court on Jun 14, 2010. Plaintiff further asserts that Defendant Haft's Motion for Summary Disposition is without merit since Plaintiff's Complaint is not barred by the applicable statutes of limitation, and it is clearly not barred by the provisions contained in MCL 600.2912d regarding affidavits of merit in medical malpractice claims. Plaintiff Saron E. Marquardt requests that this motion be denied.

Respectfully submitted,

Thomas C. Miller (P17786)
Attorney for Plaintiff

Dated: July 31, 2912

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of
the Estate of SANDRA D. MARQUARDT

Plaintiff

VS. Civil Action No. 12-621 NH

VELLAIAH DURAI UMASHANKAR, M.D.
AND JONATHAN HAFT, M.D.

Defendants
_____/

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PATRICK McLAIN (P25458)
JOANNE GEHA SWANSON (P33594)
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_____/

PLAINTIFF'S BRIEF IN SUPPORT OF PLAINTIFF'S ANSWER TO DEFENDANT HAFT'S MOTION FOR SUMMARY DISPOSITION

FACTUAL AND PROCEDURAL OVERVIEW

Plaintiff would like to first correct an error in Defendant's brief. Counsel for Defendant Haft wrongly cited MCL 600.5856a in a couple of places in his brief. The correct citation should have been MCL 600.5838a. (See Defendant's Brief pages 3 (heading) and page 4.)

It is not surprising that Defendant Haft has purposely omitted several critical facts from his brief, likely because the inclusion of those critical facts would expose the fatal flaws in his motion. The following chronology and recitation of critical facts are not in dispute, and the impact of those critical facts taken in their totality should demonstrate to this Court that Defendant's motion is baseless:

January 26, 2006—An article appeared in the *New England Journal of Medicine* authored by Dennis T. Mangano, Ph.D., M.D. and other learned scientists. In that article the authors described the ***increased risk of severe life threatening complications for patients that received the drug Trasylol*** (its generic drug was named Aprotinin) when compared with similar drugs used to control bleeding during open heart procedures when the patient was placed on the heart bypass machine. (See Plaintiff's Exhibit P.)

February 8, 2006—The FDA published an advisory bulletin regarding the use of Trasylol. (See Plaintiff's Exhibit Q.) That was the ***first step in an FDA process that would eventually lead to the removal of Trasylol from the market on November 5, 2007.***

November 2006—The manufacturer of the drug Trasylol published a new package insert for physicians in which it placed ***a "black box warning" that clearly stated that Trasylol was to be used cautiously given the studies that linked the drug to significant post-operative***

complications. Additionally, the new insert clearly indicated that ***Trasylol was to be used only in coronary artery bypass graft surgery (known as CABG surgery).*** (See Plaintiff's Exhibit R.)

December 2006—The manufacturer followed up on its publication of a new package insert with an ***advisory letter to physicians in which it reiterated that Trasylol was to be used only in CABG procedures and enclosed a copy of its new package insert***. (See Plaintiff's Exhibit S.)

December 15, 2006—***The FDA issued its own advisory letter to physicians that repeated and reinforced the steps taken by the manufacturer to restrict the use of Trasylol to CABG procedures.*** (See Plaintiff's Exhibit T.)

July 20, 2007—Sandra Marquardt underwent open heart surgery at the University of Michigan. The surgery involved the removal of her damaged aortic and the placement of a synthetic aortic valve. ***That surgery did not involve a CABG procedure; however, during that surgery she was administered the drug Trasylol to control bleeding both pre-operatively and intra-operatively. That usage of Trasylol was contrary to the FDA advisory and the manufacturer's package insert. Defendant Haft, Defendant Umashankar and Dr. Umashankar's fellow Dr. Chang jointly decided to administer Trasylol to Sandra Marquardt before the drug was actually given to her by Defendant Umashankar.*** (See Plaintiff's Exhibits H, page 25, I page 22, and J pages 16 and 35.) Defendant Haft and Defendant Umashankar were employees of the University of Michigan Health System, Inc. at the time of the surgery.

July 20, 2009—Counsel for Sandra Marquardt served a notice of intent upon the University of Michigan Health System pursuant to MCL 600.2912b. (See Defendant's Exhibit B.) ***In that document counsel clearly identified Defendant Haft, Defendant Umashankar and the University of Michigan Health System, Inc. as the individuals and corporate identity that***

were the subjects of that notice. During the deposition of Dr. Umashankar, which was taken as part of the Court of Claims discovery process, it was learned that Dr. Umashankar had returned to India in 2007. Dr. Umashankar also indicated that he had been at the University of Michigan for only one year; specifically, he was part of the University of Michigan medical staff from October 1, 2006 through September 30, 2007. (See Exhibit I, pages 3-4.) ***That meant that Dr. Umashankar was not at the University of Michigan when the notice of intent was served on July 20, 2009, so pursuant to MCL 600.2912b (2) his notice was properly served by sending it to the University of Michigan Health System, Inc.*** It should also be noted that ***Defendant Haft was still employed by the University of Michigan Health System in July 2009 when the notice of intent was sent to his employer.*** Dr. Haft's office and an office for the risk manager were both located at 1500 E. Medical Center Drive, Ann Arbor, MI 48109 in 2009 when the notice of intent was sent to that location.

January 19, 2010—Counsel for Sandra Marquardt filed a complaint naming the University of Michigan Board of Regents as the only defendant in a Court of Claims action. (See Defendant's Exhibit C.) ***Sandra Marquardt was still alive on that date, and the complaint was filed under her name.*** It should be noted at this point that the University of Michigan Board of Regents filed a motion for summary disposition in August 2011 in the Court of Claims, which was more than one and one-half years after the complaint had been filed. In that motion the University of Michigan Board of Regents asserted the statute of limitations had expired before Sandra Marquardt filed her complaint on January 19, 2010. ***After Judge Aquilina had heard oral arguments on that issue she found that the statute of limitations had not expired prior to Sandra Marquardt filing her complaint on January 19, 2010, because the statute of limitations had been tolled pursuant to MCL 600.5856 (c) for 182 days while the notice of intent was***

pending, and the filing of the complaint had been delayed by at least one day by the fact that the court was closed for the Martin Luther King holiday on January 18, 2010. (See Plaintiff's Exhibit K, pages 8-11.)

January 27, 2010—Sandra Marquardt passed away. An appropriate Suggestion of Death was filed. Probate proceedings were initiated in the Jackson County Probate Court, and ***Letters of Authority were issued to Saron E. Marquardt on June 14, 2010***. (See Defendant's Exhibit D.) Since Sandra Marquardt passed away within 30 days of the expiration of the statute of limitations (the statute of limitations would have expired on January 18, 2010, after having been saved for 182 days following service of the notice of intent on July 20, 2009) her cause of action was now saved again for an additional two years following the appointment of a personal representative pursuant to MCL 600.5852, which meant that ***the Estate of Sandra Marquardt had until June 14, 2012, to initiate legal proceedings against any potential defendant.***

September 2, 2011—***Counsel for Plaintiff served new notices of intent upon Defendant Haft and Defendant Umashankar, shortly after the University of Michigan filed its motion for summary disposition in the Court of Claims action***. (See Defendant's Exhibits E and F.) It should be noted that counsel for Plaintiff sent the notice of intent addressed to Defendant Umashankar by regular mail and by certified mail to the University of Michigan Hospital pursuant to MCL 600.2912b (2), and each notice was returned with a note that it was to be returned to sender. (See Plaintiff's Exhibit L.) During the deposition of Dr. Umashankar in the Court of Claims action, it was learned that Dr. Umashankar had returned to India, so another copy of the new notice of intent was sent by e-mail and by regular mail to his address in India. The new notices of intent, which were sent to Defendant Haft and Defendant Umashankar in September 2011, contained the new allegation that had not been included in the July 20, 2009

notice of intent, specifically, that the negligence and subsequent injuries had resulted in the death of Sandra Marquardt. Counsel for the Estate of Sandra Marquardt served the new notices of intent to avoid a later motion for summary disposition claiming that there had been no claim filed by the Personal Representative of the Estate of Sandra Marquardt indicating that Decedent's death had been caused by the negligence of Defendant Umashankar and Defendant Haft. ***Since there was time to serve a new notice of intent on both Defendants before the savings provisions contained in MCL 600.5852 expired on June 14, 2012, it seemed only prudent to file the new notices of intent and make that issue moot once the new complaint was filed.*** *Waltz v Wyse*, 469 Mich 642 (2004)

June 6, 2012—Counsel for the Estate of Sandra Marquardt filed this complaint against Defendant Haft and Defendant Umashankar. ***The complaint was timely filed, because MCL 600.5852 saved the cause of action until June 14, 2012, which was two years after the Letters of Authority were issued to Saron E. Marquardt as Personal Representative of the Estate of Sandra Marquardt. In addition, it was filed within three years of when the original statute of limitations would have expired on either July 20, 2012 or January 18, 2013***.

It is appropriate that this point to delineate those points raised by Defendant Haft with which Plaintiff has no opposition. First, Plaintiff concedes that MCL 600.5838a establishes a two-year statute of limitations for medical malpractice claims; specifically, absent any tolling or saving provisions, the statute of limitations in the instant case would have expired July 20, 2009, if no action had been commenced by Plaintiff. Second, Plaintiff agrees that MCL 600.5838a clearly establishes the date of accrual for medical malpractice claims as the date of the negligence; specifically, in the instant case the cause of action accrued on July 20, 2007. Third, Plaintiff agrees that the discovery provisions contained in MCL 600.5838a are not applicable to

the instant case, and Plaintiff has never asserted that the discovery provisions were applicable to the instant litigation. Fourth, Plaintiff agrees that if Defendant Haft and Defendant Umashankar were not served with a notice of intent on July 20, 2009, which was the date that the first notice of intent was mailed to the University of Michigan Health System, Plaintiff has failed to comply with MCL 600.2912b (1) and (2). (***It should be made clear that the first notice of intent clearly identified Defendant Haft and Defendant Umashankar as potential defendants in any subsequent litigation.***) Fifth, Plaintiff agrees that if Defendant Haft and Defendant Umashankar were not served with a timely notice of intent pursuant to MCL 600.2912b the lawsuit filed against Defendant Haft and Defendant Umashankar was not timely filed. ***That all having been said, if the July 20, 2009 notice of intent that was served upon Defendants' employer pursuant to MCL 600.2912b (1) and (2) did in fact provide Defendant Haft and Defendant Umashankar with a notice of Sandra Marquardt's intent to sue them; or, if the July 20, 2009 notice of intent, demonstrated a good faith effort to comply with MCL 600.2912b, then Plaintiff satisfied the notice provisions contained in MCL 600.2912b (1) and (2) and the statute of limitations as to both Defendant Haft and Defendant Umashankar was tolled for 182 days pursuant to MCL 600.2301 as interpreted by the Michigan Supreme Court in Bush v. Shabahang, 484 Mich 156 (2009). Then when Sandra Marquardt passed away on January 27, 2010, the Estate of Sandra Marquardt's cause of action against both Defendant Haft and Defendant Umashankar was saved until June 14, 2012, pursuant to MCL 600.5852, because she died within 30 days after the expiration of the statute of limitations on January 18, 2010.***

ARGUMENT

After reviewing the critical facts detailed above, it is easy to understand why Plaintiff believes that Defendant Haft's Motion for Summary Disposition is without merit. First, applying principles of collateral estoppel Judge Aquilina after hearing oral arguments and after having reviewed the same facts that are detailed above has ruled that the complaint filed in the Court of Claims was timely filed, which means that if Defendant Haft and Defendant Umashankar were provided with a notice of intent to sue on July 20, 2009, by way of their employer the statute of limitations applicable to both Defendant Haft and Defendant Umashankar was tolled until January 19, 2010. (See Exhibit K.) Second, there is no dispute that Sandra Marquardt died within 30 days after the statute of limitations had extinguished her claim against both Defendant Haft and Defendant Umashankar. Third, pursuant to MCL 600.5852 her claim against Defendant Haft and Defendant Umashankar was resurrected and it was saved until June 14, 2012, which was two years after the Letters of Authority were issued to Saron E. Marquardt by the Jackson County Probate Court. *Hawkins v. Regional Medical*, 415 Mich 420 (1982)

Resolution of this motion comes down to two relatively simple issues that need to be addressed by this Court in order to resolve Defendant Haft's Motion for Summary Disposition. First, did the July 20, 2009 notice of intent sent to the University of Michigan Health System, Inc. at 1500 E. Medical Center Drive, Ann Arbor, 48109 put Defendant Haft and Defendant Umashankar on notice that Sandra Marquardt intended on filing suit against them as a result of the surgery that was performed on July 20, 2007. Second, in the alternative, did the July 20, 2009 notice of intent that was served upon the University of Michigan Health System, Inc. demonstrate a good faith effort on the part of Sandra Marquardt to comply with the notice provisions contained in MCL 600.2912b (1) and (2)? If so, should this Court rely upon the

provisions of MCL 600.2301 and "disregard" an "error or defect in the proceedings which do not affect the substantial rights of the parties".

Plaintiff would of course argue that the July 20, 2009 notice of intent that was served upon the University of Michigan Health System, Inc. clearly identified Defendant Haft and Defendant Umashankar in the first and second paragraphs of the notice of intent. (See Defendant Haft's Exhibit B page 1. Defendant Umashankar was incorrectly identified as Umashankar Vellaiah, M.D. and Dr. Vellaiah because of how his name appeared in the chart; however, his correct name is Dr. Umashankar according to his curriculum vitae-See Plaintiff's Exhibit M.) Then later in the notice of intent their separate specialties were mentioned; specifically, "anesthesiologists assisting in cardiac surgeries involving the use of cardiopulmonary bypass equipment" and "cardiac surgeons". (See Defendant Haft's Exhibit B page 6.) Still further, both Defendants were identified by name when the specific violations of the applicable standards of care were enumerated in the same document. (See Defendant Haft's Exhibit B pages 7-8.) Both Defendants were again identified by name when the document identified the actions that should have been taken by them to be in compliance with the applicable standards of care. (See Defendant Haft's Exhibit B page 8.) Finally, in the concluding paragraph of that notice of intent both Defendants were again mentioned by name when issues regarding proximate cause were detailed. (See Defendant Haft's Exhibit B page 9.)

Plaintiff would also argue that the July 20, 2009 notice of intent was sent to the address where both the risk manager and Defendant Haft maintained their offices. Both the risk manager and Defendant Haft had offices located at 1500 E. Medical Center Drive, Ann Arbor in 2009. In fact, when the second notice of intent was sent to Defendant Haft on September 2, 2011, it too was sent to the 1500 E. Medical Center Drive location. (See Plaintiff's Exhibit N and Defendant

Haft's Exhibit E.) The July 20, 2009 notice of intent was mailed on July 20th and the risk manager's office sent a letter dated July 22, 2009, acknowledging receipt of the notice of intent. (See Plaintiff's Exhibit O.) This fast response was significant given that Defendant Haft claims that he did not receive notice of his involvement in the possible litigation.

The fact that Defendant Haft's Affidavit, which was attached to Defendant's Motion for Summary Disposition, did ***not*** contain a statement by him that he was unaware of the July 20, 2009 notice of intent, which identified him as a possible defendant in future litigation, speaks volumes regarding whether or not he received a copy of the notice of intent that was served upon his employer. ***Does counsel for Defendant want this Court to believe that the risk manager sent a letter to counsel for Sandra Marquardt acknowledging receipt of the notice of intent but did not immediately contact both Defendant Haft and Defendant Umashankar regarding the claims made against them in the notice of intent? If Defendant Haft had not been made aware of the July 20, 2009 notice of intent immediately upon the receipt of that notice by his employer, wouldn't it seem reasonable for him to have made such a statement in his affidavit? What kind of employer would simply have gone about addressing that claim without discussing the merits of the claim with the employees involved?*** Those may seem like rhetorical questions; however, they point out the absurdity of this motion. There should be no question as to whether or not the risk manager's office contacted both Defendants as soon as practical, if they had not already contacted the two Defendants know about a possible claim given that Sandra Marquardt had been hospitalized for almost four months with significant complications from the drug. Sandra Marquardt was not discharged from the University of Michigan Hospital until December 4, 2007. ***Isn't it reasonable to assume that the risk manager had been made aware of the problems contemporaneously with the hospital stay; and isn't it***

equally reasonable that Defendant Haft and Defendant Umashankar would have been consulted by the risk manager while Sandra Marquardt was still in the hospital?

All that having been said, the notice of intent served on July 20, 2009, alerted the risk manager that Defendant Haft and Defendant Umashankar were clearly identified as potential defendants in any future litigation, and she certainly knew that both individuals had been employees of the University of Michigan Health System at the time of Sandra Marquardt's surgery. It is also reasonable to conclude that the risk manager contacted both Defendants as soon as possible. One can reasonably assume that if the notice of intent had been mailed directly to Defendant Haft, he would have made sure that the document made its way to the risk manager. ***What is the real difference between the notice of intent being mailed directly to Defendant Haft and sent to the risk manager for handling; and the notice of intent being mailed directly to the risk manager and Defendant Haft being notified by the risk manager that he had been identified as a possible defendant in future litigation?***

When the language of MCL 600.2912b (1) and (2) is carefully examined, it appears quite clear that the Legislature anticipated that it might be difficult, if not impossible to notify the individual doctors or locate them months after the events. They addressed that possible problem by providing that the notice of intent could be sent to the "health facility where the care that is the basis for the claim was rendered." MCL 600.2912b (2). In the instant case Defendant Haft was an employee of the University of Michigan Health System who had the same address as the risk manager. In addition, Defendant Umashankar had already left the hospital and returned to India by 2009. If counsel for Plaintiff had not obtained the curriculum vitae of Defendant Umashankar at the time of his deposition in the Court of Claims action, counsel would not have been able to send the second notice of intent to him in India. *A search*

of the internet in 2011failed to provide counsel with a current address for Defendant Umashankar, and it was also impossible to find a current address in 2009; as a result, counsel was clearly in compliance with MCL 600.2912b (2) when the notice of intent was sent to the risk manager for the University of Michigan Health System on behalf of Defendant Umashankar.

MCL 600.2301 was enacted in 1963 by the Legislature to provide the judges in this state with the authority to ignore certain procedural and substantive errors or defects, when justice would be served by ignoring such errors or defects that might result in a party losing their right to have the merits of their claim heard within the legal system simply because a "t" was not crossed or an "i" was not dotted. The Michigan Supreme Court in *Bush* found that MCL 600.2301 afforded the trial courts an opportunity to overlook minor procedural errors or defects if a party had made those errors despite acting in good faith. In the instant case, the notice of intent clearly identified Defendants by their name, by their specialty and by the actions that they undertook to cause Sandra Marquardt to suffer significant injuries and damages. Counsel for Sandra Marquardt made a good faith effort to identify the responsible individuals in the July 20, 2009 notice of intent, and the employer of those individuals was notified in a timely manner. The notice of intent provided the risk manager with all of the necessary information to investigate the claim fully. It was only when the University of Michigan decided to file a motion for summary disposition based upon a technical requirement regarding the filing of a claim with the Court of Claims that it became necessary to file this action against the individual doctors rather than finish the litigation directly against the University of Michigan. There is no doubt that any judgment that is rendered against the individual doctors in this litigation will be paid by the University of Michigan Health System, and there is no doubt that the defense costs for

defending the individual doctors is being paid by the University of Michigan Health System or its carrier. Counsel for Sandra Marquardt acted in good faith when the July 20, 2009 notice of intent was drafted and sent to the University of Michigan Health System. At that time, based upon more than 40 years of *stare decisis*, a lawsuit could have been filed against the University of Michigan Health System in the Court of Claims without having previously filed a notice of claim with that court. Counsel for Plaintiff relied upon that well established case law that required that the University of Michigan Hospital show actual prejudice in order to move for summary disposition, and counsel for Plaintiff anticipated that Sandra Marquardt's claim could have been resolved through the Court of Claims litigation without actually naming the individual doctors in Washtenaw County. Counsel for Plaintiff acted in good faith when the individuals were identified in the July 20, 2009 notice of intent, and when the notice of intent was sent to the risk manager for the University of Michigan Health System. No one could have anticipated that almost two years into the litigation in the Court of Claims and after more than fifteen depositions had been taken or scheduled, counsel for the University of Michigan would file a motion for summary disposition based upon Plaintiff's failure to file a worthless claim form with the Court of Claims within six months of the negligence. In the instant case, that claim would have had to be filed in the Court of Claims approximately one and one-half months after Sandra Gordon was discharged from the hospital and while she was still recovering at home. MCL 600.2301 is the appropriate statutory safety valve for this type of miscarriage of justice. Counsel for Plaintiff acted in good faith when he sent the notice of intent on July 20, 2009, and counsel for Plaintiff acted appropriately when he filed this litigation against the individual doctors. The facts exposed in the instant case demonstrate the hardship that is caused when the legal system evolves into a "gotcha" exercise.

In the case of Defendant Umashankar, the notice of intent was served in strict compliance with MCL 699.2912b (2), because Dr. Umashankar was residing in India when the notice of intent was served, and the health facility where the care was provided was correctly notified. In the case of Defendant Haft, the notice was served appropriately given that his office and one of the risk management offices were both situated in the same building when the July 20, 2009 notice of intent was served. In addition, Defendant Haft has not proffered any evidence that would establish that he was not made aware of the notice of intent in July 2009. Plaintiff asserts that the notice of intent that was served upon the risk manager for the University of Michigan complied with the provisions of MCL 600.2012b (1) and (2). If, however, this Court determines that Defendant Haft was not notified directly, as opposed to indirectly through the office of the risk manager for the University of Michigan Health System, then Plaintiff would suggest that MCL 600.2301, as interpreted by the Michigan Supreme Court in *Bush*, should be used to avoid having to grant summary disposition as to Defendant Haft, because the interests of justice would be served by ignoring the technical error that occurred when counsel for Plaintiff, while acting in good faith, attempted to litigate this claim directly against the University of Michigan Health System without the necessity of filing two separate lawsuits in two different venues.

If this Court wishes to know exactly how Defendant Haft learned about the July 20, 2009 notice of intent, Plaintiff's counsel would suggest that this motion be denied without prejudice. Then counsel would also suggest that he be permitted to depose the risk management staff and Defendant Haft to address the notice issues, which would be beneficial in determining whether or not MCL 600.2301 should be used to permit Plaintiff to proceed with this litigation.

Finally, Defendant Haft has also raised another issue that apparently needs to be addressed in passing. Defendant Haft requests that this Court grant him summary disposition of Plaintiff's claims, because Plaintiff has not provided an affidavit of merit that satisfies MCL 600.2912d. If this Court reviews the excerpts from the depositions of Defendant Haft, Defendant Umashankar and Dr. Chang together with the actions that had been taken by the FDA and Bayer prior to July 20, 2007, the absurdity of Defendant Haft's position should be exposed. Defendant Haft, Defendant Umashankar and Dr. Chang have all testified that the decision to use Trasylol was a joint decision made by the anesthesia and cardiac surgery physicians. (See Exhibits H, I and J.) ***If the decision to use Trasylol was a joint decision, how could the standards of care for each specialty be different in regards to whether or not the use of Trasylol was appropriate?*** In the Court of Claims action, the actions of Defendant Haft and Defendant Umashankar were defended by the same attorney. If there was a difference in the standard of care between the cardiac surgeon and the anesthesiologist, how could their actions have been represented by the same attorney without there being a conflict of interest? If Counsel for Defendant Haft intends on representing Defendant Umashankar at some point in time the undersigned would suggest that there is a conflict of interest, unless counsel understands that the standard of care is the same for both specialties, given that the decision to use the drug was a joint decision.

This position advocated by Defendant Haft is without merit. Both the FDA and the manufacturer of Trasylol had told all American physicians that Trasylol should be used only in CABG procedures more than eight months before Sandra Marquardt's surgery. Both Defendant Umashankar and Defendant Haft have testified that they were aware of that restriction when the manufacturer published the new package insert in late 2006. (See Exhibit I pages 14-15 and Exhibit H pages 36.) ***How can there be different standards of care relating to the use of***

Trasylol by cardiothoracic anesthesiologists and cardiothoracic surgeons when both Defendant Haft and Defendant Umashankar have testified that they were aware that the FDA and Bayer had indicated that Trasylol was to be used only in CABG procedures. In addition both Defendant Haft and Defendant Umashankar have testified that they jointly decided to disregard the FDA and the manufacturer on July 20, 2007, and use Trasylol during a valve replacement procedure.

CONCLUSION

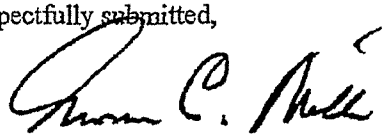
This motion demonstrates the problem with how medical malpractice cases are litigated in this state. The typical medical malpractice claim is defended on its merits only after extensive effort is expended by defense counsel in hopes finding some insignificant procedural issue that can be used to have the claim thrown out of court without ever addressing the merits of the claim. This "gotcha" mentality has overwhelmed our legal system, and in retaliation the same efforts are now being expended on behalf of the claimant. So much time and effort is being expended on the "trees" when compared with the effort being expended on the "forest". It is astounding that this litigation was filed because the University of Michigan obtained summary disposition relief from the Court of Claims in the companion litigation, because Plaintiff had failed to file a notice of claim with the Court of Claims within six months of the negligent conduct. The Court of Claims notice provisions were intended to alert the State of Michigan of possible future claims that might be filed; however, since the University of Michigan Health System manages its own claims, retains its own counsel and pays any settlements the State of Michigan is never involved in medical malpractice litigation. There is no attorney general

involved in this litigation. Again, Plaintiff was forced to initiate this litigation because the University of Michigan Health System cannot be sued unless the Court of Claims notice provisions are strictly followed, even though the State of Michigan is not involved in that litigation process. The absurdity of that situation is that Plaintiffs will now file that notice of claim with the Court of Claims if possible, and they will be forced to file a lawsuit against the doctors in Washtenaw County and a lawsuit against the University of Michigan in the Court of Claims. Who is being served by imposing such a procedural nuisance on the legal system? In the short run, the University of Michigan may benefit by getting a few cases dismissed; however, in the long run it will burden the University of Michigan with additional legal costs; it will burden the Washtenaw County Circuit Court with additional litigation that likely would have been tried in the Court of Claims; and it will require counsel for claimants to expend significant time and money on a two track legal process when it is so unnecessary. Again, "gotcha" efforts prevail at the expense of reason.

This litigation was mandated because the Michigan Supreme Court decided to reverse more than 40 years of precedence retroactively involving administrative claims in highway design cases; and then defense counsel in the medical malpractice area, who are always looking for a "gotcha" opening felt that they had discovered yet another technicality that could be used for a short term benefit, and they pounced on the opportunity to expand the highway design decision to medical malpractice claims filed against the University of Michigan Health System. Any reasonable person would have questioned whether or not the Court of Claims notice provision was intended to apply to medical malpractice claims filed against the University of Michigan, since the State of Michigan is not involved at all in that litigation, but short term expediency prevailed over reason and the "gotcha" defense was too good to resist. As a result

this litigation was commenced, this motion was filed and this Court has been forced to expend considerable time in an effort to resolve the issues that have been raised. Is this a great day for our judicial system, or what? The Legislature envisioned just such situations when it enacted MCL 600.2301 and decided to give the judiciary the statutory authority to halt such efforts before the system completely evolves into a system where procedure trumps substance.

Respectfully submitted,



Thomas C. Miller (P17786)
Attorney for Plaintiff

Dated: July 31, 2012

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of
the Estate of SANDRA D. MARQUARDT

Plaintiff

VS. Civil Action No. 12-621 NH

VELLAIAH DURAI UMASHANKAR, M.D.
AND JONATHAN HAFT, M.D.

Defendants
_____/

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_____/

PROOF OF SERVICE

The undersigned certifies that a copy of Plaintiff's Answer to Defendant Haft's Motion for Summary Disposition and Plaintiff's Brief in Support of Plaintiff's Answer to

Defendant Haft's Motion for Summary Disposition were served upon counsel for Defendant Haft at the above address on July 31, 2012, by regular mail.

Respectfully submitted

Thomas C. Miller (P17786)
Attorney for Plaintiff

Dated: July 31, 2012

have a high rate of complications.

Q In that article he references animal studies that were done in Germany.

A I don't recall.

Q Would that add credibility, if there were animal studies that indicated that they were blind or properly set up?

A Well, the human randomized trials did not show an increased incidence of renal failure or death.

Obviously, a human trial that's randomized is a lot more helpful than an animal trial.

Q Were you aware of — do you know — did you know of Dr. Mangano before this study?

A No.

Q Were you aware of his participation in the postoperative use of aspirin in the early 2000s relative to the effectivness of that to prevent clotting?

A No, I was not aware of his participation in that.

Q You were probably too young to be doing cardiothoracic surgery at that time; right?

A Probably.

Q 2002?

A Yes. I was not doing cardiac surgery at the time.

Q And this may be in your studies. Have you seen that article by Dr. Mangano?

A I have not read it.

Q Are you familiar with the work, though, that led to the use of aspirin postoperatively in CABG procedures?

A No.

Q There's a Dr. Nicholas Kouchouka who works in a hospital in St. Louis; does that help?

A No.

Q K-o-u-c-h-o-u-k-a. Do you know Dr. Kouchouka or know of him?

A I know of him.

Q He is a cardiac thoracic surgeon of some note?

A Yes.

Q In your — I assume you do — you're involved in the cardiothoracic fellowship program here working with the fellows?

A Correct.

Q Is his textbook used?

A I'm not familiar with his textbook.

Q Were you aware of his prospective study that was discontinued in, I think 2002 or 2004, because of renal problems?

A I'm not aware of that study.

Q If you had been, would that have caused you to put more credibility in Dr. Mangano's studies?

A If there was a published prospective randomized trial using Trasylol which showed increased incidence of complications,

sure.

Q Did you become aware — strike that.

When you read the article and said — well, obviously, they are not taking into account the different profiles on the patients and things like that, so be it.

Did any of your colleagues come to you and talk about it?

A Yes.

Q Was this discussed?

A Yes.

Q Were there meetings within the department to discuss the article?

A Well, as an anecdote, shortly after the article was published, a colleague of mine and myself were traveling to Louisville on a training course and the topic of the New England Journal Mangano paper you referenced came up and all of the surgeons that were present felt that the limitations of the study and its observational nature discredited the validity of the study. And the conclusions, we all felt, were flawed.

This was not a departmental meeting. This was a colleague of mine and myself discussing it.

And then at a division faculty meeting we did discuss the use of Aprotinin. I don't know exactly what time frame it was, but it was after the release of

Mangano's paper. We discussed its use and felt we would still use it for high-risk cases.

Q Does cardiothoracic surgical anesthesia participate in those group meetings?

A No. This was just the surgeons.

Q Am I correct that the University of Michigan — the decision as to what drugs are to be used is a joint decision between surgery and anesthesia?

A I think that's fair. At the time of this particular case, anesthesiologists would usually ask the surgeons what our preference was for antifibrinolytic agents and if we felt the patient was high risk, the surgeon would request Aprotinin.

Q They are looking for input at that point.

Is it their call to make?

A I think it's fair to say it's a joint decision. The anesthesiologist asks the surgeon what our preference is and they certainly have the right to refuse to give the drug; although we never encountered that.

Q We talked for a few moments about the size of Dr. Mangano's study, which was 4,374 patients.

Would you agree with me that that — and I understand your criticism of it, that it is an observational or retrospective study — but would you agree with me that that is a significant number of patients for

H

Dr. Mangano's article plus, I think, a couple of others that are referenced by the anesthesia staff in their abstract, caused the FDA to set up an evidentiary hearing regarding the drug.

The article came out in March of '05 — February of '06. That study group was to meet in September of '06. This study was started around February of '06.

It was not reported at the meeting in September, but Bayer later admitted that they did have the results but did not publish them to the FDA.

Soon thereafter Dr. Walker went public and said, "I don't know why they didn't publish my report."

Do you remember that at all?

A. No.

Q. Do you remember becoming aware of a study that involved almost 80,000 patients that were — case files that were assessed retrospectively?

A. No.

Q. When you were using Trasylol in 2007, were you aware that it was an off-label use — strike that.

When it's used in connection with a valve replacement, were you aware that it was off-label usage?

A. Yes, I was.

Q. You would agree with me that the only indication in the package insert by the drug companies was that it was to be

used in CABG procedures, right —

A. Yes.

Q. — where there was a risk of increased blood loss?

A. Yes.

Q. Do you remember when — strike that.

When you began to study for your fellowship here, and perhaps even before that in your surgery, how far back do you remember it being used for valve procedures — Trasylol?

A. Well, I started my fellowship in 2003 and it was used at that time.

Q. I think your surgery was served here, too?

A. Right. I had no immediate knowledge of what the cardiothoracic surgeons were using.

Q. You didn't rotate through that service?

A. I certainly have no knowledge.

Q. So 2002 it was in use off label?

A. 2003 is when I became aware that it was used.

Q. Excuse me.

Did you have any discussion with anyone about that or did you know at that time that it was off-label usage?

A. I don't think I was aware that it was off-label usage until the controversy regarding the observational study was published.

Q. So at that time you did, then, become aware that Bayer published a new package insert where both Bayer and the FDA highlighted the fact that it was to be used for CABG; right?

A. Yes, I was aware.

Q. And do you remember getting or seeing the FDA information about it being used for CABG?

A. I don't remember seeing the information, but I certainly was aware.

Q. And I can show you — there's the name of the doctor I was looking for before.

Here's the letter that I am making reference to from the FDA dated February 8 — September 29, 2006. It talks about — that was the FDA publication. Here was the letter from Bayer in December of '06.

Do you remember seeing either of those documents relative to the changes with the indications — indication paragraph of the package insert?

A. (Witness reviewing document.) I don't remember reading these particular documents, but I was aware that it had revised indications and that its indications were for CABG.

Q. Now, when you had your surgery meeting amongst the staff, and we'll even include the plane ride down to Tennessee, or whatever, was there any discussion about that part of it,

the reinforcement of the indications?

A. Well, again, our approach had been to use the drugs for patients that were at high risk for bleeding complications.

CABG patients, in general, are at low risk for bleeding complications; at least in our practice they represent among the lower risk patients for bleeding.

Q. But my question is, was that discussed? In other words, obviously, you're talking about what Dr. Mangano had written in his report and whatever brouhaha may have been going on at that point, but did anyone specifically say: Well, we got this information from Bayer and the FDA that says: Hey, it's to be used only for CABG?

A. I don't remember that being specifically discussed.

Q. But there weren't any changes? You didn't stop using it for valve procedures?

A. We did not stop using it for patients we felt were at high risk for bleeding.

Q. Did you subsequently become aware that there was a BART study going on in Canada relative to the use of Trasylol?

A. Yes.

Q. Were you aware of it *becoming* — in other words, was that published in the articles, or somewhere?

A. I remember, yes. I remember the BART trial.

Q. Now, when Dr. Walker went public with his 70 to 80,000 case analyses that he indicated had been done for Bayer, and to

Vellaiah Durai Umashankar

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EXHIBITS
(Attached)

Deposition Exhibit	Description	Page Marked
1	Curriculum Vitae	3

Ann Arbor, Michigan
Tuesday, August 2, 2011
About 11:50 a.m.

(Exhibit 1 was marked for identification.)

MR. MILLER: Let the record reflect that this is the deposition of –

And, again, the Curriculum Vitae has Umashankar as the last name, for our purposes, so I'll use it that way –

THE WITNESS: Yes.

MR. MILLER: – just to avoid some confusion. It's the deposition of Dr. Umashankar being taken pursuant to Notice for all purposes contained in the Michigan Court Rules.

VELLAIAH DURAI UMASHANKAR, M.D., a Witness herein, having been first duly sworn, testified as follows:

EXAMINATION

BY MR. MILLER:

Q Dr. Umashankar, when did you come to the University of Michigan?

Have you been here more than one – I'm not talking about visiting, but were you in the anesthesia department?

A For a year. From 2006, October 1st – October 2006 to 30th of September 2007.

Q Okay. And during that time you were an attending anesthesiologist?

MR. ANDREE: You mean 2007?

A That's right.

MR. ANDREE: October of '06 to –

BY MR. MILLER:

Q September '07.

A '07.

MR. ANDREE: Okay.

MR. MILLER: All right. I must have misheard it, too.

BY MR. MILLER:

Q During that time you were what we term an attending anesthesiologist?

A Yeah.

Q And as such you had both clinical and education responsibilities within the department?

A True.

Q And were you assigned, during your clinical assignments, to cardiothoracic anesthesia or all areas of anesthesia?

A Assigned to all areas of anesthesia with importance to cardiothoracic, which means at least two days in the week I'd be doing cardiothoracic anesthesia.

Q And you provided us with a Curriculum Vitae that recites your professional education and experience; correct?

A Yes.

Q And is that, essentially, accurate to the present time?

A Yes.

Q Now, when you came to the University of Michigan, did you come from another institution within the United States or did you come from India?

A From UK.

Q Okay. And where in the UK were you before you came to the University of Michigan?

A University Hospital of South Hampton.

Q And did you work in cardiothoracic anesthesia at that institution?

A Yeah.

Q Were you aware, in early 2006, of the articles published by Dr. Mangano?

A Yeah.

Q Were you also aware of the article published in transfusion about Aprotinin around almost the same time?

A Not at that time, but then I read the article at a later period.

Q Okay. Was your knowledge of Dr. Mangano's article contemporaneous with its publication? In other words,

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concerns about the use of Aprotinin?
A. Not anything in particular.
Q. Okay. Now, during the time you were here, did you become aware of the fact that the FDA was investigating the drug?
A. Yes, I was aware.
Q. And did you become aware of the Walker study that had been commissioned by Bayer?
A. Not while I was here.
Q. All right. Were you -- and since I put a name on it, let me ask it this way.
Were you ever aware of any other studies, other than Dr. Mangano's, during the time that you were at the University of Michigan?
A. Not any major article.
Q. Okay. Did you become aware while you were here of a change in Bayer's, for lack of a better term, package insert relative to the drug Aprotinin?
A. At that time in 2006, yes, we were aware that they brought a change.
Q. Now, did you become aware that during 2006 that the FDA recommended, and Bayer published, revised inserts indicating that the drug was only to be used in CABG procedures?
MR. ANDREE: Object to the form of the

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question. Assumes facts that are not in evidence and will not be in evidence.
BY MR. MILLER:
Q. Doctor?
A. We were aware what -- I could just tell what we were aware of. What we understood.
We understood that Bayer has given a clear information to the clinicians who wants to use the drug to respirate, or limit it to the patients whom we think are with a higher risk for -- at a high risk of bleeding postoperatively, or who are going to have complex surgeries under cardiopulmonary bypass?
We didn't get the message that it could be used only purely for coronary artery bypass.
Q. Now, while you were in the UK --
A. Yes.
Q. -- did you do cardiothoracic anesthesia during the time you were at that institution in the UK?
A. It is the senior part of my training because it's -- the anesthesiology training that we undergo for seven years.
Q. Okay.
A. The final two years were concentrated on the specialty training which we want to choose.
Q. Okay.
A. And after my senior registrarship, what we call it, my

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senior registrar, I was training in cardiac anesthesia for the whole time.
Q. So the nine years that you spent at that institution in the UK, seven of those years are what we term a residency or residency/fellowship?
A. That's right.
Q. Okay. And then the other two years were as an attending? Or was that still part of the --
A. Still part --
Q. -- fellowship?
A. -- of the fellowship.
Q. Okay. So seven would have been residency and two would have been the fellowship?
A. Yeah.
Q. And the fellowship is in cardiothoracic anesthesia or several different specialty classes of anesthesia?
A. Cardiothoracic anesthesia.
Q. Okay. So when you became familiar with cardiothoracic anesthesia, both as a resident and then later as a fellow in the UK, was Aprotinin being used for both valve procedures and CABG procedures?
A. Yes.
Q. And while you were in the UK, did -- strike that.
Are you aware that in each of Bayer's package inserts the indication is listed as for CABG procedures?

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Are you aware of that?
As the sole indication, that's what's in the insert, are you aware of that?
MR. ANDREE: Object to the form of the question.
A. No, I'm not aware that it is indicated as a sole indication.
BY MR. MILLER:
Q. Okay.
A. As I told you, we were all -- I was aware that it should be limited to cases where the clinician thinks there's increase of bleeding and going on to cardiopulmonary bypass.
Q. And what I will tell you is that -- and I'll just ask you to assume these things to be true.
That the drug went on the market in late 1993. And it had the same package insert up until the latter part of 2006, September or December, depending on what was sent out to doctors and everything. And then after that it had a different package insert.
I'm asking you whether or not you're familiar that the first package insert that lasted for 13 years, whether or not the only indication in that package insert was for CABG procedures?
MR. ANDREE: Object to the form of the

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A (Witness nods head yes.)
MR. ANDREE: You have to say "Yes" or "No."
A Yes.
BY MR. MILLER:
Q Okay. Can you tell me how it would be decided preoperatively which ones would be used on an individual basis?
A In 2006, after the Mangano study, the department policy was to use aminocaproic acid for all routine cardiac surgeries, except for cases which are done under cardiopulmonary bypass. Particularly the ones which like redo surgeries or the ones that come second time for heart surgery, complex valve procedures and the aortic root surgeries.
In these cases the addition to use Aprotinin was not mandatory, it is addition, which is arrived after the surgeon and the anesthesiologist discuss with each other and decide to use the drug.
Q And am I correct that the decision about which of the these drugs would be used is a joint decision between the thoracic surgeon, or the cardiothoracic surgeon, and the cardiothoracic anesthesiologist?
A Yes.
Q And is this decision made at the time of the procedure or is this made at some earlier time?

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A At the time of the procedure.
Q Okay. And is it – is the decision a default one; that is Aprotinin, unless another one is recommended? Or do you – do the two of you have to say we're going to use Aprotinin?
MR. ANDREE: Well, I –
BY MR. MILLER:
Q Does my question make sense?
MR. ANDREE: I'm going to object to the form of the question.
BY MR. MILLER:
Q. Okay. Let me ask you.
You said that Aprotinin was used, I think you said in all cardiopulmonary bypass machine procedures; right?
A I said "particularly," which means all of them at U of M, most of them, 99 percent are done at cardiopulmonary bypass.
Q Okay.
A So we reserve this particularly to the cases that undergo cardiopulmonary bypass but also have complex procedures and increased risk of bleeding.
Q All right. Now, in this case am I correct that a repeat procedure would include someone – strike that.
This case was a mitral valve replacement;

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right?
A Right.
Q A repeat procedure, or a repeat patient would include a patient who had a previous aortic valve; true?
A Any previous heart surgery. Even it could be a CABD.
Q All right. And what is it about that that put that person at an increased risk? The fact that they had a had had a previous, I guess, stint on a machine; right?
A No.
Q "No"?
A The factor's different.
The previous surgery means the thoracic cage has already been opened. So now for the second time when the surgeon opens, it's a very difficult procedure because all the tissues – how to say – are adherent to each other. Or lots of additions. So it makes the risk of bleeding more.
Q So you're not talking then a risk of coronary bleeding. You're talking about just bleeding incident to the procedure?
A From the tissues.
Q And it's not at all related to the fact that whether the patient was on a bypass machine several years earlier or not? It's just the fact that the chest has to be opened?
A That's right.

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Q So since we know that Mrs. Marquardt had a previous aortic valve replaced –
A Yeah.
Q – some nine years earlier – ten years earlier – or 20 years –
A Twenty years, '97.
Q So even that long ago she was still at an increased risk by reason that she had had that sternotomy; right?
A Right.
Q And so in those patients is Aprotinin automatically used?
A No.
MR. ANDREE: I'm sorry, in what patients?
MR. MILLER: With a patient who had a previous sternotomy.
MR. ANDREE: Only that? That's only –
MR. MILLER: Yeah.
BY MR. MILLER:
Q Because you said that was the increased risk, right, of bleeding, was a repeat sternotomy?
A But it's not used as a default. In those cases we do consider Aprotinin. It's a joint effort, as we told you, after discussing with the surgeon.
Q Were you aware, in July of '07, that the Bayer insert, the package insert, the second edition that was published in late '06, had indicated that prior – or a history of

A Yes. So after -- yes, after the -- after we see the patient the morning of surgery, if there's anything different or new, we'll usually point that out or discuss it again with Dr. Umashankar.

If everything is the same, then we usually say, hey, you know, everything is similar to what we discussed yesterday.

Q So both your -- the summary that you prepared after reviewing CareWeb and getting the relevant documents and transferring that over to Syntricity, you prepare a summary -- you discuss it with Dr. U, then the next day you see the patient. Is that the sequence?

A Right.

Q And when you see the patient, are you merely trying to confirm the information, or do you do a physical examination?

A Both.

Q Okay.

A So we confirm and then we also, you know, do a physical exam sometimes.

Q And do you then -- do you probe the patient regarding specific areas that deal with the anesthesia?

A Yes.

Q Perhaps prior experiences with the anesthesia, that type of thing?

A Correct.

Q Allergies, that kind of thing?

A That's correct.

Q And is that then put into the Syntricity system?

A Yes.

Q And then if there is something that comes up during that discussion you then contact Dr. U and say, well, you should be aware of this, this and this. Fair?

A That's correct.

Q And in 2007 this procedure then was right at the beginning of your third year then; right?

A This --

Q July 1st starts the third year?

A This was toward the end of my third year, actually. And that's because I started on August 1st.

Q Oh, okay. Okay.

And at that time do you recall whether -- strike that.

How often were you doing cardiopulmonary bypass machine procedures during that last month, or last -- I guess it would have been the last month because you had the whole month rotation; right?

A Yeah. I, to be honest --

Q Okay. Were they daily?

A I don't recall.

Q Who decided what -- you're familiar with the drug Trasylol?

A Um-hmm.

Q Who decides whether that drug is going to be used, or one of the two lysing agents?

A That's typically the decision of Dr. Umashankar along with the cardiac surgeon.

Q Okay. But it falls to the anesthesiologist to administer the drug; right?

A Correct.

Q And to both preoperatively, intraoperatively and with some drugs postoperatively?

A Typically pre-op and intra-op.

Postoperatively the patient goes to the intensive care unit and the anesthesiologist does not follow them into the intensive care unit.

Q Does an order follow the patient into the PACU?

A Yes.

Q Okay. During your -- strike that.

Other than a couple possible weeks then, you only had that one month in cardiothoracic surgery; right? That last month of your residency?

A Right. So I had one month during my second year --

Q Second, okay.

A -- one month during my third year.

Q Right.

A I don't remember, and I had probably a couple extra weeks during my third year --

Q Right.

A And I think this might have fallen in those extra weeks.

Q Oh, okay.

A But I'm not sure exactly where.

Q Okay. During any of your time in cardiothoracic surgery on rotation, either in what would have been 2006 -- I guess, it could have been 2005, 2006 or 2007, which would have been the two years; right?

A Um-hmm.

Q You have to say "Yes" or "No."

A Yes.

Q Okay. Did you become aware of a controversy in medicine about the use of Trasylol?

MS. NUGENT: Object to form.

A I had heard something about it, but I was not -- I had not reviewed anything.

BY MR. MILLER:

Q Okay. So during the time you were a resident, did you become aware of it at that time or later?

A More of later. I had heard that there was something going on with withdrawal of the agent, but I didn't know exactly what was going on.

J

I

BY MR. MILLER:

Q And you mentioned that you think maybe you participated in about 30 of these. When you are in that support room – I think in the second year you said you were just kind of an extra pair of hands.

In the third year do you do certain things in the operating room?

A Yes. And –

Q Monitoring, recordkeeping, that type of thing?

A Yes.

Q But the decisions about what drugs and dosages, that's up to Dr. U?

A That's correct.

Q Okay. And so you, I assume, have been part of these discussions between the cardiothoracic surgeon and the anesthesiologist?

A Yes.

Q And in those discussions is Trasylol always discussed between the two of them, or only if Trasylol is not going to be used?

A Typically there is a discussion as to which one to use. Usually the question will be, you know, should we use Trasylol for this procedure. And then, you know, discussion "Yes" or "No."

Q Okay. And then one or – one of them may say, maybe we

should use the lysing agents, or the other one will say, well, do we need Trasylol, something like that?

A Correct.

Q Can we do it with the lysing?

A Correct.

Q And then the two of them agree and then the anesthesiologist administers?

A Yes. Or me as the anesthesia resident may be the one to administer.

Q But the decision to what may be administered and the dose is left to Dr. U?

A Correct. And the cardiac surgeon.

Q Okay. And during the second year procedures do you go into the operating room?

A You're referring to when I'm a second year?

Q Yeah, second-year residents.

A Yes.

Q So you're in there – in both years you're in the operating room. You do work preoperatively and then you go into the operating room; just the functions within the operating room may differ from year to year?

A Yes.

Q Then do you also see the patient in the PACU during the third year? I'm sure you don't do it during the second year, but –

A The patient typically will go directly from the operating room to the intensive care; to the ICU.

Q Okay. So the anesthesia role ends when the patient leaves the operating room?

A Correct.

MR. MILLER: Thank you, Dr. Chang.

THE WITNESS: Okay. Thanks.

(Concluded at about 10:40 a.m.)

STATE OF MICHIGAN)
) SS.
COUNTY OF WAYNE)

CERTIFICATE OF NOTARY PUBLIC

I, Sharon Julian, a duly commissioned and qualified Notary Public for the County of Wayne, State of Michigan, do hereby certify that the witness, whose attached testimony was taken by me in the entitled cause on Thursday, November 11, 2010, was by me first duly sworn to testify the whole truth in the aforesaid cause, that the testimony contained herein was taken down by me in machine shorthand, transcribed upon a computer under my personal supervision, and is a true and correct transcript of the whole of the testimony given by said witness.

I do further certify that I have delivered the original transcript into the possession of THOMAS C. MILLER, ESQ.

I do further certify that I am not connected by blood or marriage with any of the parties or their attorneys; that I am not an employee of any of them nor interested directly or indirectly in the matter in controversy, as counsel, attorney, or otherwise.

IN WITNESS WHEREOF, I have hereunto set my hand at Dearborn, County of Wayne, State of Michigan, this 24th day of November, 2010.

Sharon Julian, CSR-3376
Certified Shorthand Reporter
Registered Professional Reporter
Notary Public, Wayne County, Michigan
My Commission expires: January 21, 2014

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

SARON E. MARQUARDT, Personal Representative of the Estate of SANDRA D. MARQUARDT,

Plaintiff,

v

UNIVERSITY OF MICHIGAN BOARD OF REGENTS,

Defendant.

OPINION AND ORDER

HON. ROSEMARIE E. AQUILINA

Docket No. 10-4-MH

At a session of said Court held in the City of Lansing, County of Ingham, State of Michigan this 6th day of December, 2011

PRESENT: The Honorable Rosemarie E. Aquilina Court of Claims Judge

This matter comes before the Court on Defendant University of Michigan Board of Regent's ("Defendant") *Motion for Summary Disposition.* This Court, having reviewed Defendant's brief in support and Plaintiff's response; having reviewed all supporting documents and correspondence; having heard oral argument; and being fully apprised of the issues, states the following:

BACKGROUND FACTS

On July 20, 2007, open heart surgery was performed on Sandra D. Marquardt ("Ms. Marquardt") to replace a valve at the University of Michigan Health System by their surgical and anesthesia staffs. During the procedure, the drug Trasylol was used to control bleeding. Ms. Marquardt spent the next four months in the hospital dealing with significant complications from the surgery. On December 31, 2007, Ms. Marquardt retained counsel to investigate the case

against the University of Michigan Health System's surgical and anesthesia staff, which are answerable to the University of Michigan Board of Regents, Defendant. On February 8, 2008, a request for medical records was sent to Defendant. On May 8, 2008, Defendant produced the medical records.

On January 15, 2009, the Federal Drug Administration documents and medical journal articles regarding the drug Trasylol were reviewed by Plaintiff's counsel. Plaintiff's counsel and Ms. Marquardt decided liability rested with Bayer and not with Defendant. A letter was sent to Bayer informing them that Ms. Marquardt wished to make a claim for damages. About four or five months later, Plaintiff's counsel received a call from a representative of Bayer in which it was revealed that the various advisories and revised package inserts had been sent to Defendant in a timely manner. The revised package inserts had advised using the drug for coronary artery bypass grafts procedures only.

On July 20, 2009, the two year statute for medical malpractice claims approached, and Plaintiff's counsel advised the Ms. Marquardt that a notice of intent should be sent to Defendant, just in case the claim against Bayer could not be settled. The notice of intent would permit counsel time to obtain a consultation from a specialist regarding whether or not this was malpractice. On July 20, 2009, the notice of intent was sent to Defendant. On January 19, 2010, the first day the Court of Claims was open for business following the expiration of the tolling period, Plaintiff's counsel filed the complaint. On January 27, 2010, Ms. Marquardt died allegedly as a result of injuries she had sustained following surgery on July 20, 2007. On May 20, 2010, this Court entered an order substituting the Estate of Sandra Marquardt in place of the individual Sandra Marquardt, after a petition for commencement proceedings had been filed with the Jackson County Probate Court. On June 14, 2010, letters of authority were issued to Saron

Marquardt ("Plaintiff") by the Jackson County Probate Court.

DEFENDANT'S ARGUMENT

The claims against Defendant are barred as a matter of law based on the expiration of the statute of limitations, pursuant to MCR 2.116(C)(7). A complete reading of the plain language of MCL 600.5658(c) confirms that the tolling period does not begin to run until the day after the notice of intent is served. Only the remaining days in the statutory period remain at the end of the notice period. In this case, there are no days left remaining in the statutory period after the date Plaintiff gave notice.

Since the notice of intent was served on July 20, 2009, the tolling period began to run on July 21, 2009, with zero days remaining on the statute of limitations. When the tolling period ended, the statute of limitations had already expired and there was no time left to file a complaint. *Dewan v Khoury* 2006 Mich App LEXIS 884 is directly on point in this case. *Dewan* provides that if the notice of intent is served on the last day of the statute of limitations, the tolling period does not apply.

Plaintiff improperly relies on *Omelenchuk v City of Warren* 461 Mich 567 (2000), *Decosta v Gossage,* 486 Mich 116 (2010), *Dunlap v Sheffield,* 193 Mich App 313 (1992), and *Buscaino v Rhodes,* 385 Mich 474 (1971), in support of his claim. Neither *Decosta* nor *Dunlap* provide support for Plaintiff's claim. *Decosta* merely stands for the proposition that a notice of intent is determined filed on the day it is served, and *Dunlap* supports Defendant's position that the tolling period began the day after the notice is served. Plaintiff's reliance on *Omelenchuk* is inapplicable to this case because the *Omelenhuck* case deals with a notice of intent filed well within the statute of limitations and did not address the issue in this case where the statute of limitations had expired.

MCL 600.5856(c) and MCR 1.108(1) clearly contradict Plaintiff's arguments based on *Omelenchuk*, and state that the tolling period begins the day after the notice of intent is filed. The statutes are to be followed as written and following the statutes as written, as well as the interpretation in *Dewan*, the statute of limitations in this case expired before the tolling period began and summary disposition is appropriate.

Plaintiff has failed to comply with MCL 600.6431(3), which provides that in all actions for personal injuries against a State institution, the claimant shall file with the Clerk of the Court of Claims a notice of intention to file a claim, or file the claim itself, within 6 months following the occurrence that gives rise to the potential cause of action. The Court of Appeals in *McCahan* specifically stated that the MCL 600.6431(3) filing requirement is a condition precedent to sue the state in a personal injury action. *McCahan v Brennan, et al*, 2011 Mich App LEXIS 210 (Mich Ct. App, Feb 1, 2011). The *McCahan* court also stated that substantial compliance does not satisfy the requirements of MCL 600.6431(3). *Id.* The July 20, 2009 notice of intent, which was not filed with the Clerk, was provided for two years after the event giving rise to the cause of action. MCL 600.6431(3) clearly requires that a plaintiff with a personal injury claim against the state must file with the clerk of the Court of Claims a notice of intent to sue or an actual claim within six months of the date of the events giving rise to the claim. Plaintiff failed to do so because the surgery took place on July 20, 2007, and Plaintiff filed on July 20, 2009.

Finally, MCL 600.6431 does not require that the defendant demonstrate prejudice when a plaintiff fails to comply with a statutory requirement. *Id.* The Court of Appeals reaffirmed the controlling nature of *McCahan* in *Kline v Department of Transportation*, 2011 Mich App LEXIS 411, even though the panel disagreed with the ruling of *McCahan*.

The death savings provision of MCL 600.582 does not apply in this case.

PLAINTIFF'S ARGUMENT

Defendant relies principally upon dictum contained in the unpublished decision in *Dewan v Khoury* 2006 Mich App LEXIS 884, which was decided in March 2006. The dictum contained in *Dewan* and relied upon by Defendant is actually inconsistent with the holding in the case, and that dictum was inconsistent with the Michigan Supreme Court decision in *Omelenchuk v City of Warren*, 461 Mich 567 (2000).

In *Dewan*, the claimed negligence occurred on June 4, 2002. The plaintiff in *Dewan* filed a notice of intent on June 4, 2004, which was the last day of the statute of limitations. The Court of Appeals found that the 182 day tolling period ended on December 3, 2004. The plaintiff in the *Dewan* matter did not file her complaint until December 6, 2004, which was Monday. Defendant mistakenly relies on dictum in *Dewan*. The *Dewan* court, in affirming the trial court's granting of summary disposition, stated, in dictum, that "[t]he 182 day tolling period began running on June 5, 2004, MCR 1.108(1) and expired on Friday, December 3, 2004." The Court also stated that since the entire 182 days had to be allowed to run, the complaint could not be filed on December 3, 2004. That finding was inconsistent with the Court's decision affirming summary disposition because the complaint was not timely filed on December 3, 2004, but rather December 6, 2004.

In contrast, the Court of Appeals in *Zwiers v Growney*, 286 Mich App 38, 40-41 (2009), stated plaintiff could have timely filed her complaint 182 days from the date of filing notice of intent. The plaintiff in *Zwiers* suffered injuries on September 2, 2005. On August 30, 2007, plaintiff served her notice of intent on defendants. On February 27, 2008, 181 days after serving notice of intent on the defendant, plaintiff filed her complaint. The *Zwiers* court stated that "[t]o be in compliance with MCL 600.2912b(1), the complaint and affidavit needed to be filed on or

after February 28, 2008," 182 days after the filing the notice of intent. The Court specifically identified that a plaintiff may file a complaint on or after 182 days after notice of intent was sent.

If this claim against the Defendant actually accrued on July 20, 2007, the statute of limitations would have expired at the end of the day on July 20, 2009, pursuant to MCR 1.108(1) and MCL 600.5838a(1), unless the applicable statute of limitations was tolled. *Dunlap v Sheffield,* 193 Mich App 313, 314 (1992). Plaintiff relies upon the unambiguous language contained in MCL 600.5658(c), which contains the tolling provision relevant to this litigation. That statute clearly states that the tolling begins at the time notice is given, which in this case was July 20, 2009. The statute of limitations had not expired on July 20, 2009 when the notice of intent was served upon Defendant.

The Michigan Supreme Court addressed this very issue in *Decosta. Decosta* at 118. The Court held that if the notice of intent was timely filed, then the statute of limitations was tolled pursuant to MCL 600.5856(c). Once the statute of limitations was tolled pursuant to MCL 600.5856(c), it remained tolled for the full 182 days permitted by MCL 600.2912b(1), even if Defendant failed to provide a notice of meritorious defense within 154 days. The Court of Appeals in *Decker v Rochowiak,* 287 Mich App 666, 667 (2010), citing the Supreme Court's decision in *Bush,* stated quite unambiguously that once notice of intent is given, the applicable statute of limitations is tolled by MCL 600.5856. In *Omelenchuk,* the Supreme Court was confronted with facts that revealed that the notice of intent was mailed to the defendant on December 11, 1995. The Court clearly stated that the tolling period of 182 days ran from December 11, 1995 until June 10, 1996 (182 days).

In contrast, in *Buscaino v Rhodes,* 385 Mich 474, 481-82 (1971), the Supreme Court clearly stated the tolling occurred the moment the complaint was filed. Plaintiff asserts that that

holding can easily be used to hold that the moment the notice of intent was mailed the applicable statute of limitations was tolled. Defendant has relied on an unpublished decision, *Lancaster v Wease,* 2010 Mich App LEXIS 1819, and *Dewan,* both of which used date calculations which were clearly inconsistent with those proffered by the Supreme Court in *Omelenchuk.*

In addition, the notice provisions contained in MCL 600.6431(3) were met. The notice requirements contained in MCL 600.6431(3) were not activated until a claim actually accrued. *Oak Construction Co. v Highway Department,* 33 Mich App 561, 565-67 (1971) and *Cooke v Highway Department #1,* 55 Mich App 336, 338-39 (1974) support the proposition that a claim does not accrue, pursuant to MCL 600.6431(1), until the state has rejected the administrative claim, and the time limits imposed by that statute did not begin to run until the administrative efforts had been denied. Plaintiff did not appreciate that there was a potential claim against Defendant until its letter to Bayer, sent on January 15, 2009, generated a call from Bayer regarding the nature and extent of the notice that Bayer had provided to Defendant regarding the restricted use of Trasylol in the middle of 2009. This is when he first became aware of a possible claim against Defendant. Then on July 20, 2009, an administrative claim was filed with Defendant, pursuant to MCL 600.2912b, which was consistent with the requirements contained in MCL 600.6431(3), and the claim was filed within 6 months of when the claim accrued. When Defendant failed to settle the matter administratively by January 18, 2010, it became evident that Defendant had no intention of settling the case and a lawsuit would be required. This became the happening of the event giving rise to the cause of action as set forth in MCL 600.6431(3), which then required Plaintiff to file a notice of intention to file a claim or the claim itself.

In addition, a significant number of appellate decisions have long established that the state must show actual prejudice in order to move for summary disposition based upon a

plaintiff's failure to comply with the notice requirements contained in MCL 600.6431(3). The Michigan Supreme Court in *Rowland* did not address whether or not the notice requirements contained in MCL 600.6431 were affected by its decision, nor did it hold that all statutorily created notice requirements were to be treated in the same manner. The decision in *May v Department of Natural Resources,* 140 Mich App 730, (1985), should remain the controlling authority of showing actual prejudice.

Lastly, MCL 600.6452 establishes a three year statue of limitations for claims filed against the State of Michigan which is controlling in this case. In addition, MCL 600.5852 provides "the claim possessed by decedent would have been saved for up to three years from the date the statute of limitations would have expired, provided Decedent died within the applicable statute of limitations period, or, Decedent died within 30 days after the statute of limitations had expired." Therefore, Plaintiff could have timely filed the complaint on or before June 14, 2012, two years after the letters of authority were issued on June 14, 2010.

CONCLUSIONS OF LAW

Summary disposition is available, pursuant to MCR 2.116(C)(7), when a claim is barred by the statute of limitations. A defendant who files a *Motion for Summary Disposition,* pursuant to MCR 2.116(C)(7), may, but is not required to file supportive material such as affidavits, depositions, admissions, or other documentary evidence. *Turner v Mercy Hospitals & Health Services of Detroit,* 210 Mich App 345, 348 (1995). When reviewing a motion pursuant to MCR 2.116(C)(7), a court must consider all affidavits, pleadings, and other documentary evidence submitted by the parties and construe the pleadings and evidence in favor of the nonmoving party. *Doe v Roman Catholic Archbishop of the Archdiocese of Detroit,* 264 Mich App 632, 638 (2004).

MCL 600.5838a(1) provides "a medical malpractice action accrues at the time of the act or omission that is the basis for the claim of medical malpractice, regardless of the time the plaintiff discovers or otherwise has knowledge of the claim." The Court of Appeals in *McKiney v Clayman,* 237 Mich App 198, 204 (1999) held that the accrual date of medical malpractice claims is on the occasion of the act or omission complained of. In this case, it is July 20, 2007, the date of surgery. Plaintiff claims that the accrual date was when Defendant failed to settle the matter administratively by January 18, 2010. Plaintiff relies on *Oak v Construction Co. v Highway Department,* 33 Mich App 561, 565-67 (1971) and *Cooke v Highway Department #1,* 55 Mich App 336, 338-39 (1974), for support of the principle that the accrual date did not begin until the exhaustion of administrative remedies. However, the cases relied on by Plaintiff dealt specifically with state employers who had contracts providing that in order to file a complaint or sue, the employee must pursue all administrative remedies first. There is nothing of the sort in this case and the cases are not applicable. Therefore, the date of accrual is not when Plaintiff found there was a potential claim against Defendant when receiving a response from Bayer, it is the date of surgery, July 20, 2007.

Mailing of a notice of intent before the statute of limitations expires is a prima face case for compliance with MCL 600.2912b. *Decosta* at 118. Here, Plaintiff mailed the notice of intent on the last day of the statute of limitations, July 20, 2009, and therefore complied with MCL 600.2912b. If Plaintiff had filed the notice of intent on July 21, 2009, then the mailing would not be in compliance with MCL 600.2912b because the statute of limitations would have expired.

MCL 600.2912b states in relevant part:

> (1) Except as otherwise provided in this section, a person shall not commence an action alleging medical malpractice against a health professional or health facility unless the person has given the health professional or health facility written notice under this section not less than

> 182 days before the action is commenced.
>
> . . .
>
> (7) Within 154 days after receipt of notice under this section, the health professional or health facility against whom the claim is made shall furnish to the claimant or his or her authorized representative a written response that contains the information required by MCL 600.6912b(7) (a)-(d);
>
> (8) If the claimant does not receive the written response required under subsection (7) within the required 154-day time period, the claimant may commence an action alleging medical malpractice upon the expiration of the 154-day period.
>
> (9) If at any time during the applicable notice period under this section a health professional or health facility receiving notice under this section informs the claimant in writing that the health professional or health facility does not intend to settle the claim within the applicable notice period, the claimant may commence an action alleging medical malpractice against the health professional or health facility, so long as the claim is not barred by the statute of limitations.

These subsections set forth a number of requirements. A plaintiff cannot file suit without giving the notice required by subsection (1). No suit can be filed for 182 days after notice is given. The interval of 182 days during which a suit cannot be filed can be reduced to 154 days if the health professional or health facility fails to respond to the notice. The interval can also be reduced if the health professional or health facility responds that it will not settle.

Plaintiff timely filed her complaint 182 days from the date of filing notice of intent. In *Zwiers*, the Court of Appeals stated that "[t]o be in compliance with MCL 600.2912b(1), the complaint and affidavit needed to be filed on or after February 28, 2008," 182 days after the filing of the notice of intent. *Zwiers* at 40-41. The Court specifically identified that a plaintiff may file a complaint on or after 182 days after notice of intent was sent. In this case, 182 days ended on January 18, 2010. However, this Court was closed in observance of Martin Luther King Day. Plaintiff filed the complaint on January 19, 2010, which was 182 days after the notice of intent was sent, when the Court resumed. Therefore, it was timely pursuant to MCL

600.2912b.

However, MCL 600.6431(3) provides "in all actions for property damage or personal injuries, claimant shall file with the clerk of the court of claims giving a notice of intention to file a claim or the claim itself within 6 months following the happening of the event giving rise to the cause of action." Section (3) clearly states that a "claimant *shall* file with the clerk of the Court of Claims. . . . within 6 months following the happening of the event." The word "shall" designates a mandatory provision. *Walters v Nadell*, 481 Mich 377, 383 (2008). Clear statutory language must be enforced as written. *Flour-Enterprises, Inc v Dep't of Treas*, 477 Mich 170, 174 (2007). It is clear Plaintiff has failed to comply with MCL 600.6431(3). Plaintiff filed the notice of intent two years after the date of accrual on July 20, 2007. Therefore, Plaintiff has not timely filed the claim against Defendant, pursuant to MCL 600.6431(3).

Prejudice does not have to be shown when a plaintiff does not comply with a statutory filing requirement. In *Rowland*, the Michigan Supreme Court overturned several cases that had required the state to show actual prejudice when a plaintiff failed to comply with a statutory filing requirement. *Rowland v Washtenaw County Rd Comm'n*, 477 Mich 197, 219 (2007). The Supreme Court in *Rowland* stated that because the language of the statute was clear on the filing requirement, the Supreme Court would not give the statute any judicial construction. The filing requirement was strictly applied. *Id.* The filing requirement must be applied as it is written without a reading of prejudice into the statute.

The Court of Appeals recently addressed the notice requirements in MCL 600.6431 in *McCahan v Brennan, et al*, 2011 Mich App Lexis 210 (Mich Ct. App, Feb 1, 2011). The *McCahan* court, relying on *Rowland*, reasoned that the notice requirements contained in MCL 600.6431(3) should be treated the same way that the Supreme Court treated the notice

requirements in *Rowland*. Furthermore, the Court of Appeals reaffirmed the principle in *Kline v Department*, 2011 WL 711042. Thus, the notice requirement of MCL 600.6431(3) cannot have prejudice read into the statute as was held in *Rowland*.

MCL 600.5852 is also inapplicable because the statute applies where a potential plaintiff dies within 30 days of the expiration of the statute of limitations. Here, Ms. Marquardt died on January 27, 2010 more than six months after the statute of limitations expired on July 20, 2009. Therefore, the wrongful death savings provision does not apply here.

THEREFORE, IT IS ORDERED that Defendant's *Motion for Summary Disposition* is **GRANTED**, pursuant to MCR 2.116(C)(7). In compliance with MCR 2.602(A)(3), this Court finds that this decision resolves the last pending claims and closes the case.

IT IS SO ORDERED.

Hon. Rosemarie E. Aquilina (P37670)
Court of Claims Judge

PROOF OF SERVICE

I hereby certify I served a copy of the above Order upon Plaintiff and upon Defendant by placing the Order in sealed envelopes addressed to the attorney of each party and deposited them for mailing with the United States Mail at Lansing, Michigan, on December 6, 2011.

Luke A. Goodrich (P72090)
Law Clerk

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Dr. Umashankar's Motion for Summary Disposition (9/26/2013)

Dr. Vellaiah Durai UMASHANKAR
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Email: umashankar@hotmail.co.uk

PERSONAL INFORMATION

Sex	Male
DOB	25th October 1966
Nationality	Indian
Tamilnadu Medical Council	Registration number 49491
General Medical Council, London	Full Registration no: 5195355
Royal College of Anaesthetists London, England	Fellow
Association of Cardio thoracic Anaesthetists, United Kingdom	Associate member
Indian Association of Cardio thoracic Anaesthetists	Associate member

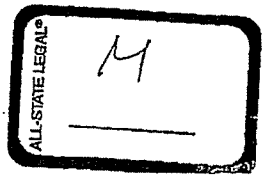
EDUCATION & QUALIFICATIONS

Primary Degree	M.B., B.S. University of Madras, Sri Ramachandra Medical College and Research Institute, Madras, India June 1991
Postgraduate Certification	F.R.C.A. Royal College of Anaesthetists, London, June 2003 CCST September 2006
Further Certification	ALS Provider, Resuscitation council UK, May 1999 A.T.L.S. Provider, Resuscitation council UK, Nov 2000 P.L.A.B. General Medical Council, Oct 1998 BSE Certification for Trans Esophageal Echocardiography
Academic achievements	Distinction in Pharmacology, June 1988 Distinction in General Medicine, May 1990

CAREER STATEMENT

To serve as a Consultant Anesthesiologist and Intensivist with a lead roll in the speciality of Cardiac anesthesia and Cardio Thoracic Intensive Care.

To actively involve in teaching and research activities in the speciality.



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iversity of Michigan
Health System

UMHS Risk Management
300 North Ingalls, Room 8A06
Ann Arbor, MI 48109-5478
(734) 763-5456
(734) 763-5300 fax

Ann Blackwell
(734) 647-8524

July 22, 2009

Thomas C. Miller, Esq.
P.O. Box 785
Southfield, MI 48037

Re: Sandra D. Marquardt

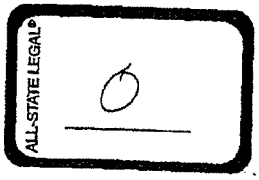
Dear Mr. Miller:

I am in receipt of your Notice of Intent dated July 20, 2009. Please forward all future correspondence concerning this matter to my attention at the address indicated above.

In an effort to timely investigate this matter, please provide us with copies of all non-University of Michigan medical records in your possession, and we will reimburse you for any duplication expense. In the event that it is necessary for us to obtain these records ourselves, we have enclosed several Authorization to Request Patient Information from Another Organization forms for your client's signature. Please indicate on these authorization forms the identity of the hospital, physician or medical facility (other than the University of Michigan), wherein your client has received treatment in the five (5) years preceding the incident in question, and all treatment since the date of the incident until the present. Please return these authorization forms and medical records to my attention within the next three (3) weeks.

This request is submitted to you in accordance with MCLA 600.2912 b(5). If there are records concerning our care of the patient to which you have not yet been given access, kindly advise us so that arrangements can be made to make them available to you. Our Medical Records Department will honor a valid medical authorization, and they can be reached by mail at UMHS Health Information Management, Release of Information, 2901 Hubbard Road, Room 2722, Ann Arbor, Michigan 48109-2435 (734) 936-5490 or by phone at (734) 936-5490. Requests for x-rays can be made by mail to the UMHS Radiology Department, 1500 E. Medical Center Drive, Ann Arbor, Michigan 48109-0030.

The submission of this letter does not waive any defenses as to the adequacy or the timing of your Notice of Intent or any defects that may be present therein.



Thank you for your attention to these matters. Please feel free to call me should you have any questions or wish to discuss this matter.

Sincerely,

Kelly A. Saran
Healthcare Risk Management
Consultant

KAS/shb

Enclosures

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

◄ Previous Volume 354:353-365 January 26, 2006 Number 4 Next ►

The Risk Associated with Aprotinin in Cardiac Surgery

Dennis T. Mangano, Ph.D., M.D., Julia C. Tudor, Ph.D., Cynthia Dietzel, M.D., for the Multicenter Study of Perioperative Ischemia Research Group and the Ischemia Research and Education Foundation

ABSTRACT

Background The majority of patients undergoing surgical treatment for ST-elevation myocardial infarction receive antifibrinolytic therapy to limit blood loss. This approach appears counterintuitive to the accepted medical treatment of the same condition — namely, fibrinolysis to limit thrombosis. Despite this concern, no independent, large-scale safety assessment has been undertaken.

Methods In this observational study involving 4374 patients undergoing revascularization, we prospectively assessed three agents (aprotinin [1295 patients], aminocaproic acid [883], and tranexamic acid [822]) as compared with no agent (1374 patients) with regard to serious outcomes by propensity and multivariable methods. (Although aprotinin is a serine protease inhibitor, here we use the term antifibrinolytic therapy to include all three agents.)

Results In propensity-adjusted, multivariable logistic regression (C-index, 0.72), use of aprotinin was associated with a doubling in the risk of renal failure requiring dialysis among patients undergoing complex coronary-artery surgery (odds ratio, 2.59; 95 percent confidence interval, 1.36 to 4.95) or primary surgery (odds ratio, 2.34; 95 percent confidence interval, 1.27 to 4.31). Similarly, use of aprotinin in the latter group was associated with a 55 percent increase in the risk of myocardial infarction or heart failure ($P<0.001$) and a 181 percent increase in the risk of stroke or encephalopathy ($P=0.001$). Neither aminocaproic acid nor tranexamic acid was associated with an increased risk of renal, cardiac, or cerebral events. Adjustment according to propensity score for the use of any one of the three agents as compared with no agent yielded nearly identical findings. All the agents reduced blood loss.

Conclusions The association between aprotinin and serious end-organ damage indicates that continued use is not prudent. In contrast, the less expensive generic medications aminocaproic acid and tranexamic acid are safe alternatives.

THIS ARTICLE
- Abstract
- PDF
- PDA Full Text
- PowerPoint Slide Set

COMMENTARY
- Perspective by Hunter, D.
- Editorial by Vlahakes, G. J.
- Letters

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The mainstay of medical therapy for patients with an acute coronary syndrome — when accompanied by myocardial infarction with ST-segment elevation — includes fibrinolytic and antiplatelet agents to mitigate thrombosis-related events.[1] However, if surgical therapy (coronary-artery surgery) is elected, fibrinolytic agents are not used before, during, or after surgery because of concerns regarding excessive bleeding. In fact, these bleeding-related concerns have given rise to the testing, regulatory approval, and widespread use of two classes of agents, both proven to mitigate bleeding: the lysine analogues (aminocaproic acid and tranexamic acid) and the serine protease inhibitors (aprotinin). Consequently, the majority of patients now routinely receive one or more of these agents during and after invasive cardiovascular procedures, including coronary-artery surgery.[2,3,4] Thus, at least for patients with ST-elevation myocardial infarction, the surgical approach (with the use of antifibrinolytic agents) is in stark contrast, and may seem counterintuitive, to the medical approach (with fibrinolytic therapy as a mainstay) for thrombosis-related events. (Although aprotinin is a serine protease inhibitor, here we use the term antifibrinolytic therapy to include all three agents.)

The question of the safety of serine protease inhibitors or lysine analogues for thrombosis-related events — though noted in a handful of early case reports and small, single-center experiences involving graft thrombosis[5,6,7] and creatinine elevation[5,8,9] — has largely been contested by a number of published secondary analyses that have nearly always concluded that antifibrinolytic therapy, as defined here, is safe.[10] Unfortunately, however, this "safety evidence" has three important limitations: no prior investigation was adequately powered to assess relatively infrequent, but clinically serious, safety events[10]; the comparative safety of the three agents has not been assessed within one study — an important consideration, given the large cost differential among agents (aprotinin being far more costly than either aminocaproic acid or tranexamic acid); and nearly all investigations were sponsor-supported[10] and therefore carried unavoidable bias.

Addressing these considerations, however, is not straightforward. After a decade of use, antifibrinolytic practice now is embedded and dictated by guidelines,[2,3,11] such that safety assessment in independent, placebo-controlled clinical trials with unselected recruitment becomes difficult, if not impossible. In addition, regulatory approval for use of these agents differs among countries, making a large-scale, multicountry, comparative study challenging. Therefore, to address the safety of antifibrinolytic therapy for thrombosis-related cardiac, cerebral, and renal events, we conducted a non–sponsor-supported, prospective,

FDA News

FOR IMMEDIATE RELEASE
P06-19
February 8, 2006

Media Inquiries:
Susan Cruzan, 301-827-6242
Consumer Inquiries:
888-INFO-FDA

FDA Issues Public Health Advisory for Trasylol

The Food and Drug Administration today issued a Public Health Advisory alerting doctors who perform heart bypass surgery, and their patients, that Trasylol (aprotinin injection), a drug used to prevent blood loss during surgery, has been linked in two scientific publications to higher risks of serious side effects including kidney problems, heart attacks and strokes in patients who undergo artery bypass graft surgery.

"FDA is conducting a thorough evaluation of the safety profile for this drug in light of the recent publications," said Dr. Steven Galson, Director of FDA's Center for Drug Evaluation and Research. "We're working to evaluate the potential risks and determine whether there is a need for further action. In the meantime, we advise providers to carefully assess the benefits and risks of the drug for their patients."

FDA advises health care providers to be aware of the following:

- Physicians who use Trasylol should carefully monitor patients for the occurrence of toxicity, particularly to the kidneys, heart or central nervous system and promptly report adverse event information to Bayer, the drug manufacturer, or through the FDA Medwatch program.
- Physicians should consider limiting Trasylol use to those situations in which the clinical benefit of reduced blood loss is essential to medical management of the patient and outweighs the potential risks.
- FDA is working with the manufacturer to examine the safety and benefits of Trasylol in light of the recent data and the evolving practice of medicine.
- Patients should discuss all major risks for heart bypass surgery with their healthcare providers. These include the risks for bleeding and the available ways to lessen the risk for bleeding.

Trasylol (aprotinin injection) is the only product approved by FDA for the prevention of peri-operative blood loss and the need for blood transfusion among patients undergoing coronary artery bypass graft surgery. The drug aids the body's ability to stop bleeding and is used to lessen the bleeding risk during this surgical procedure. This surgery is done to bypass clogged arteries.

FDA is evaluating the studies more closely, along with other scientific literature and reports submitted to the FDA through the MedWatch program, to determine if labeling changes or other actions are warranted. One study, published in the New England Journal of Medicine, reported that patients who received Trasylol had higher rates of serious kidney problems, heart attacks, and stroke compared to treatment with other drugs to prevent bleeding or to no treatment; the second study, reported in Transfusion, reported more cases of decreased kidney function in patients treated with Trasylol compared to another treatment to prevent bleeding. A limitation of both studies was that doctors chose which patients were to receive Trasylol or another treatment. It is possible that patients treated with Trasylol may have been

sicker than other patients. The studies used complex statistical methods to adjust for possible differences in patient risk factors.

The agency also anticipates convening an advisory committee meeting in 2006 to discuss the existing data about the risks and benefits of Trasylol, and if additional safety measures need to be taken. The FDA will notify health care providers and patients in a timely manner following further scientific investigation of adverse event reports.

FDA also urges health care providers and patients to report adverse event information to FDA via the MedWatch program by phone (1800-FDA-1088), by fax (1-800-FDA-1078) or internet.

The Public Health Advisory is available on line at http://www.fda.gov/cder/drug/advisory/aprotinin.htm.

For more information please visit http://www.fda.gov/cder/drug/infopage/aprotinin/default.htm,

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TRASYLOL®
(aprotinin injection)

~~01298181~~ 11/06

Trasylol® administration may cause fatal anaphylactic or anaphylactoid reactions. Fatal reactions have occurred with an initial (test) dose as well as with any of the components of the dose regimen. Fatal reactions have also occurred in situations where the initial (test) dose was tolerated. The risk for anaphylactic or anaphylactoid reactions is increased among patients with prior aprotinin exposure and a history of any prior aprotinin exposure must be sought prior to Trasylol® administration. The risk for a fatal reaction appears to be greater upon re-exposure within 12 months of the most recent prior aprotinin exposure. Trasylol® should be administered only in operative settings where cardiopulmonary bypass can be rapidly initiated. The benefit of Trasylol® to patients undergoing primary CABG surgery should be weighed against the risk of anaphylaxis associated with any subsequent exposure to aprotinin. (See CONTRAINDICATIONS, WARNINGS and PRECAUTIONS).

DESCRIPTION

Trasylol® (aprotinin injection), $C_{284}H_{432}N_{84}O_{79}S_7$, is a natural proteinase inhibitor obtained from bovine lung. Aprotinin (molecular weight of 6512 daltons), consists of 58 amino acid residues that are arranged in a single polypeptide chain, cross-linked by three disulfide bridges. It is supplied as a clear, colorless, sterile isotonic solution for intravenous administration. Each milliliter contains 10,000 KIU (Kallikrein Inhibitor Units) (1.4 mg/mL) and 9 mg sodium chloride in water for injection. Hydrochloric acid and/or sodium hydroxide is used to adjust the pH to 4.5-6.5.

CLINICAL PHARMACOLOGY

Mechanism of Action: Aprotinin is a broad spectrum protease inhibitor which modulates the systemic inflammatory response (SIR) associated with cardiopulmonary bypass (CPB) surgery. SIR results in the interrelated activation of the hemostatic, fibrinolytic, cellular and humoral inflammatory systems. Aprotinin, through its inhibition of multiple mediators [e.g., kallikrein, plasmin] results in the attenuation of inflammatory responses, fibrinolysis, and thrombin generation.

Aprotinin inhibits pro-inflammatory cytokine release and maintains glycoprotein homeostasis. In platelets, aprotinin reduces glycoprotein loss (e.g., GpIb, GpIIb/IIIa), while in granulocytes it prevents the expression of pro-inflammatory adhesive glycoproteins (e.g., CD11b).

The effects of aprotinin use in CPB involves a reduction in inflammatory response which translates into a decreased need for allogeneic blood transfusions, reduced bleeding, and decreased mediastinal re-exploration for bleeding.

Pharmacokinetics: The studies comparing the pharmacokinetics of aprotinin in healthy volunteers, cardiac patients undergoing surgery with cardiopulmonary bypass, and women

† The pump prime regimen was evaluated in only one study in patients undergoing primary CABG surgery. Note: The pump prime only regimen is not an approved dosage regimen.

* Significantly different from placebo, $p<0.05$
(Transfusion variables analyzed via ANOVA on ranks)

** Differences between Regimen A (high dose) and Regimen B (low dose) in efficacy and safety are not statistically significant.

Additional subgroup analyses showed no diminution in benefit with increasing age. Male and female patients benefited from Trasylol® with a reduction in the average number of units of donor blood transfused. Although male patients did better than female patients in terms of the percentage of patients who required any donor blood transfusions, the number of female patients studied was small.

A double-blind, randomized, Canadian study compared Trasylol® Regimen A (n=28) and placebo (n=23) in primary cardiac surgery patients (mainly CABG) requiring cardiopulmonary bypass who were treated with aspirin within 48 hours of surgery. The mean total blood loss (1209.7 mL vs. 2532.3 mL) and the mean number of units of packed red blood cells transfused (1.6 units vs 4.3 units) were significantly less ($p<0.008$) in the Trasylol® group compared to the placebo group.

In a U.S. randomized study of Trasylol® Regimen A and Regimen B versus the placebo regimen in 212 patients undergoing primary aortic and/or mitral valve replacement or repair, no benefit was found for Trasylol® in terms of the need for transfusion or the number of units of blood required.

INDICATIONS AND USAGE

Trasylol® is indicated for prophylactic use to reduce perioperative blood loss and the need for blood transfusion in patients undergoing cardiopulmonary bypass in the course of coronary artery bypass graft surgery who are at an increased risk for blood loss and blood transfusion.

CONTRAINDICATIONS

Hypersensitivity to aprotinin.

Administration of Trasylol® to patients with a known or suspected previous aprotinin exposure during the last 12 months is contraindicated. For patients with known or suspected history of exposure to aprotinin greater than 12 months previously, see **WARNINGS.** Aprotinin may also be a component of some fibrin sealant products and the use of these products should be included in the patient history.

WARNINGS

Anaphylactic or anaphylactoid reactions have occurred with Trasylol® administration, including fatal reactions in association with the initial (test) dose. The initial (test) dose does not fully predict a patient's risk for a hypersensitivity reaction, including a fatal reaction. Fatal hypersensitivity reactions have occurred among patients who tolerated an initial (test) dose.

Hypersensitivity reactions often manifest as anaphylactic/anaphylactoid reactions with hypotension the most frequently reported sign of the hypersensitivity reaction. The hypersensitivity reaction can progress to anaphylactic shock with circulatory failure. If a hypersensitivity reaction occurs during injection or infusion of Trasylol®, administration should be stopped immediately and emergency treatment should be initiated. Even when a

Bayer HealthCare

IMPORTANT DRUG WARNING
Regarding Trasylol® (aprotinin injection)

December 2006

Dear U.S. Healthcare Professional,

Bayer would like to inform you of developments related to Trasylol® (aprotinin injection) including: recent changes to the U.S. prescribing information, including a change in indication and the need to have cardiopulmonary bypass equipment available during surgery.

U.S. Label Modifications
Bayer has been in ongoing discussions with the Food and Drug Administration (FDA) regarding prescribing information on Trasylol. On December 15, 2006 agreement was reached with the agency and is being communicated through a "Dear Healthcare Professional" letter, a copy of which is attached.

This letter includes the following language:

Revised **INDICATIONS AND USAGE** section:

- Trasylol® is indicated for prophylactic use to reduce perioperative blood loss and the need for blood transfusion in patients undergoing cardiopulmonary bypass in the course of coronary artery bypass graft surgery ***who are at an increased risk for blood loss and blood transfusion.***

"Trasylol administration increases the risk for renal dysfunction and may increase the need for dialysis in the perioperative period." Other Trasylol safety issues include the risk for serious hypersensitivity reactions, including fatal reactions. These safety issues have resulted in an important revision of the prescribing information to:

- Contraindicate the "administration of Trasylol to any patients with a known or suspected prior exposure to Trasylol or other aprotinin-containing products within the previous 12 months."
- Provide additional information on the management and prevention of hypersensitivity reactions, including the administration of Trasylol **"only in an operative setting where cardiopulmonary bypass may be rapidly initiated."**
- Highlight the "risk for kidney dysfunction."

For more information, a copy of the complete revised label is attached. Additionally, the current U.S. Prescribing Information for Trasylol is available on www.trasylol.com. If you wish to request further information, please contact Bayer Pharmaceuticals Corporation Clinical Communications at 1-800-288-8371.

Sincerely,

Paul Mac Carthy

Paul Mac Carthy, MD, FRCPI
Vice President, Medical Affairs
Bayer Pharmaceuticals Corporation

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ADDENDUM

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FDA News

FOR IMMEDIATE RELEASE
P06-203
December 15, 2006

Media Inquiries:
Megan Moynahan, 301-827-6242
Consumer Inquiries:
888-INFO-FDA

FDA Revises Labeling for Trasylol (Aprotinin Injection) to Strengthen Safety Warnings and Limit Usage of Drug to Specific Situations

The U.S. Food and Drug Administration (FDA) today approved revised labeling for Trasylol (aprotinin injection) to strengthen its safety warnings and to limit its approved usage to specific situations. Trasylol is given to patients before heart surgery to reduce bleeding and the need for blood transfusions. Trasylol is marketed by Bayer Pharmaceuticals Corporation, Leverkusen, Germany.

"The purpose of the label change is to inform physicians and patients about the risks associated with Trasylol and to ensure they understand the new warnings and use the product as directed by the label," said Steven Galson, M.D., MPH, Director of FDA's Center for Drug Evaluation and Research.

The new labeling specifies that Trasylol should only be given to patients who are at an increased risk for blood loss and blood transfusion in the setting of coronary bypass graft surgery (a procedure used to improve blood flow to the heart) when patients undergo cardiopulmonary bypass (a procedure that allows a machine to take over the heart's functions when it is stopped during surgery). The changes also include a warning that Trasylol increases the possible risk for kidney damage, and suggest ways to manage and reduce the patient's risk for hypersensitivity (exaggerated immune) reactions.

The labeling changes follow an FDA-conducted review of safety information that FDA became aware of after the product was introduced to the market. FDA began this safety review of Trasylol in January 2006. The review was triggered by the results of two published research studies. One study reported an increase in the possibility of kidney failure, heart attack and stroke in patients treated with Trasylol compared to those treated with other drugs. The other study reported an increase in the possibility of kidney damage compared to other drugs, but did not show an increased risk of heart attack or stroke. On February 8, 2006, FDA issued a Public Health Advisory regarding these new findings with Trasylol. On September 21, 2006, FDA held a public meeting of the Cardiovascular and Renal Drugs Advisory Committee to discuss the safety and overall risk-benefit profile for Trasylol. At that meeting, the committee discussed the findings from the two published observational studies, a Bayer worldwide safety review, and the FDA review of its own post-marketing database, and made recommendations for labeling changes. The labeling changes for Trasylol are based upon the recommendations of that advisory committee.

FDA announced on September 29, 2006, that Bayer informed the agency of an additional safety study on September 27, 2006. The preliminary results from that study suggest that in addition to serous kidney damage, Trasylol may increase the chance for death, congestive heart failure (a weakening of the heart), and strokes. The FDA review of this additional Trasylol safety information is continuing and it may result in other actions, including additional changes to the labeling. For additional information about Trasylol, see www.fda.gov/cder/drug/infopage/aprotinin/default.htm.

http://www.fda.gov/bbs/topics/NEWS/2006/NEW01529.html

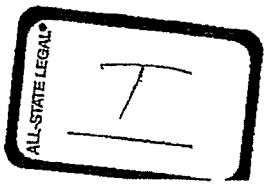

Exhibit 13

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of the Estate of Sandra D. Marquardt,

Plaintiff,

v.

VELLAIAH DURAI UMASHANKAR, M.D.

Defendants.

Case No. 12-621-NH

Honorable David S. Swartz

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REPLY IN SUPPORT OF DEFENDANT VELLAIAH DURAI UMASHANKAR, M.D.'S MOTION FOR SUMMARY DISPOSITION

The first nearly three pages of Mr. Marquardt's response to the motion for summary disposition have nothing to do with the basis for this motion. Perhaps for sympathy, possibly to prejudice, Mr. Marquardt recounts the legal hurdles he has faced in asserting claims against the University of Michigan, Board of Regents and Dr. Jonathan Haft. Those claims were dismissed on legal grounds.[1] The claim against the Regents failed because Mrs. Marquardt, who commenced the action against the Regents before she died, failed to give the notice required by the Court of Claims Act (a notice requirement that, as Mr. Marquardt acknowledges, has been explicitly enforced by the Michigan Supreme Court). The claim against Dr. Haft failed because Mr. Marquardt did not file an Affidavit of Merit with the complaint (or at any time thereafter) signed by a board certified physician in Dr. Haft's medical specialty. The claim against Dr. Umashankar must fail because it was not timely filed and is now barred by the applicable statute of limitations.

This statute of limitations argument was before the Court when Dr. Haft moved for summary disposition, but this Court did not address it. The pivotal question is the effect of a notice of intent ("NOI") directed to the University of Michigan Health System ("UMHS") – but not Dr. Umashankar - on July 20, 2009 and whether it tolled the statute of limitations as to Dr. Umashankar. Although, in response to Dr. Haft's statute of limitations motion, Mr. Marquardt admitted that "Counsel for Sandra Marquardt served a notice of intent ***upon the University of Michigan Health System*** pursuant to MCL 600.2912b (Pl.'s Resp. to Haft's SD Mot. at 3) (emphasis added), Mr. Marquardt now states that "Counsel for Sandra Marquardt served a notice of intent ***upon Defendant Umashankar by sending it to the University of***

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[1] Mr. Marquardt also complains in those first three pages that he was required to serve Dr. Umashankar in accordance with the Hague Convention. That also was a legal requirement which this Court itself enforced.

Michigan Health System pursuant to MCL 600.2912b(2)" (Pl.'s Resp. to Umashankar's SD Mot. at 6) (emphasis added). Inexplicably, Mr. Marquardt argues that it was proper to send Dr. Umashankar's NOI to the U of M Health System at that time because Dr. Umashankar was no longer there. See Pl.'s Resp. at 6 ("That meant that Defendant Umashankar was not at the University of Michigan when the notice of intent was served on July 20, 2009; therefore, pursuant to MCL 600.2912b(2) his notice of intent was properly served by sending it to the University of Michigan Health System, Inc."). Common sense would seem to dictate the opposite.

Mr. Marquardt misstates the effect of MCL 600.2912b(2). It is not intended to provide a convenient after-the-fact justification for failing to direct the NOI to an intended defendant. To properly invoke the alternative afforded by MCL 600.2912b(2), a plaintiff must make some effort to "reasonably ascertain[] the last known professional business or residential address" of the intended recipient. Mr. Marquardt was likely not concerned with making this inquiry because he did not intend to direct the NOI to Dr. Umashankar, just as he did not intend to sue Dr. Umashankar (and did not in fact sue him) when the 182-day tolling period expired.[2]

Mr. Marquardt's failure to inquire as to a reasonably ascertainable address is tacitly acknowledged in the assertion that "[i]t would have been extremely unlikely that counsel for claimant could have found a current address for Defendant Umashankar in 2009 after he had

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[2] As Mr. Marquardt admitted in response to Dr. Haft's motion for summary disposition, "It was only when the University of Michigan decided to file a motion for summary disposition based upon a technical requirement regarding the filing of a claim with the Court of Claims that it became necessary to file this action against the individual doctors …" Pl's Resp. to Haft's Mot. at 12. Mr. Marquardt also states that "counsel for Plaintiff anticipated that Sandra Marquardt's claim could have been resolved through the Court of Claims litigation without actually naming the individual doctors in Washtenaw County." Pl.'s Resp. to Haft's Mot. at 13. This explains why the July 20, 2009 NOI was not directed to Dr. Umashankar. Practically speaking, the only intended action was against the Hospital.

returned to India" and "[s]erving the University of Michigan with the notice was thought to have been the best way to advise Defendant of the pending claim." Pl.'s Resp. at 12-13. Further, Mr. Marquardt confuses the address to which the NOI is directed with the person or entity to whom it is to be directed. Nothing in the statute permits a plaintiff to direct notice intended for a physician to the risk manager of the hospital. The notice must still be directed to the physician.

Dr. Umashankar does not dispute the fact that he is mentioned in the NOI directed to the UMHS Risk Manager. So were others. However, as explained in Dr. Umashankar's brief in support of the motion for summary disposition, the Michigan Supreme Court has expressly stated that "[w]hen a claimant files an NOI with time remaining on the applicable statute of limitations, that NOI tolls the statute of limitations for up to 182 days *with regard to the recipients of the NOI*." *Driver v Naini*, 490 Mich 239, 249; 802 NW2d 311 (2011) (emphasis in original). See also, *Burton v Reed City Hosp Corp*, 471 Mich 745, 753; 691 NW2d 424 (2005) (stating that compliance with MCLA 600.2912b is mandatory before tolling may occur and that this clear, unambiguous statute requires full compliance with its provisions as written", citing *Roberts v Mecosta Co Gen Hosp*, 466 Mich 57, 65-67; 642 NW2d 663 (2002) (*Roberts I*)). In *Atkins v Suburban Mobility Authority for Regional Transportation*, 492 Mich 707; 822 NW2d 522 (2012), the Michigan Supreme Court explained that a claim is "not merely an occurrence; it is a demand for payment pursuant to a legal right as a result of that occurrence" and "[k]nowledge of operative facts is not equivalent to written notice of a claim." *Id.* at 720-721. Mentioning Dr. Umashankar in the text of the NOI is not the same as directing the NOI to him.

Mr. Marquardt argues that his counsel was advised by UMHS Risk Management office that "they had received the notice of intent" and "[n]owhere in that letter does Karen A. Saran indicate that the University of Michigan was not accepting the notice of intent on behalf of

Defendant Umashankar." Pl.'s Resp. at 6. While there would have been no reason to disavow acceptance on behalf of Dr. Umashankar when the NOI was clearly not directed to Dr. Umashankar, Ms. Saran did clearly state in the letter that "[t]he submission of this letter does not waive any defenses as to the adequacy or the timing of your Notice of Intent or any defects that may be present therein." See Pl.'s Resp., Exhibit 12. Further, Mr. Marquardt should not presume that UMHS was empowered to accept the NOI on behalf of a physician who had departed from the hospital two years earlier.

Mr. Marquardt argues that if the NOI had been directed to Dr. Umashankar at UMHS it would have been returned to sender "so no one would have gotten the notice of intent." Pl.'s Resp. at 14. Mr. Marquardt, obviously still intending to sue the UofM Board of Regents, would have still directed a NOI to UMHS. Each intended defendant must receive a NOI, and a NOI intended to one defendant cannot be sent to another. *See e.g., Fournier v Mercy Community Health Care System*, 254 Mich App 461; 657 NW2d 550 (2002),

Without discussion or legal authority, Mr. Marquardt blithely refers to a statute of limitations defense asserted on behalf of the University of Michigan, Board of Regents in the Court of Claims case before Judge Aquilina. That statute of limitations decision has no bearing on the issue before this Court. Judge Aquilina did not decide whether the July 20, 2009 NOI tolled the statute of limitations as to Dr. Umashankar. The issue in the Court of Claims case was whether the Complaint was timely filed on January 19, 2010, the day after the 182-day notice period expired, when notice was given on the last day of the limitations period and there was thus no time after the notice period expired within which to commence the action.

CONCLUSION

Under the statute of limitations period applicable to medical malpractice claims and the concomitant accrual, notice, tolling and savings provisions, the statute of limitations which

governs the claims against Dr. Umashankar expired on July 20, 2009. The requisite pre-suit notice of intent was not directed to Dr. Umashankar until September 2, 2011 – over two years after the statute of limitations expired.[3] Consequently, the notice-tolling provision had no effect and did not extend the statute of limitations beyond the July 20, 2009 expiration date. Likewise, the wrongful death savings provision does not extend the time for suit against Dr. Umashankar because Sandra Marquardt died on January 27, 2010, more than 30 days after the statute of limitations expired on July 20, 2009. For these reasons, summary disposition for Dr. Umashankar is required.

KERR, RUSSEL AND WEBER, PLC

By: Joanne Geha Swanson
Patrick McLain (P25458)
Joanne Geha Swanson (P33594)
Attorneys for Defendant Jonathan Haft, M.D.
500 Woodward Avenue, Suite 2500
Detroit, MI 48226-3427
(313) 961-0200
(313) 961-0388 (Facsimile)

Dated: October 28, 2013

[3] The Complaint erroneously asserts that Dr. Umashankar was served with a notice of intent "on or about November 14, 2011." The date discrepancy is irrelevant to the analysis. Irrespective of whether the NOI was served on September 2, 2011 or November 14, 2011, the limitations period had long since expired and was not subject to tolling.

STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR WASHTENAW COUNTY

SARON E. MARQUARDT, Personal representative of the estate of SANDRA MARQUARDT, Deceased,

Plaintiff,

v.

VELLAIAH DURAI UMASHANKAR, M.D., and JONATHAN HAFT, M.D.,

Defendant.

Case No. 12-621-NH

PROOF OF SERVICE

STATE OF MICHIGAN)
) ss
COUNTY OF WAYNE)

Cynthia J. Villeneuve, being duly sworn, deposes and says that on Monday, October 28, 2013 she served a copy of Reply in Support of Defendant Vellaiah Durai Umashankar, M.D.'s Motion for Summary Disposition, and this Proof of Service upon Thomas C. Miller, Esq., P.O. Box 785, Southfield, MI 48037 by First Class Mail and by electronic mail at millertc@comcast.net.

Cynthia J. Villeneuve

Subscribed and sworn to before
me this 28th day of October, 2013

Angela E. Hincks
Notary Public, Wayne County, MI
My Commission expires: 4-10-20
Acting in Wayne County, MI

ANGELA E. HINCKS
Notary Public, Wayne County, MI
My Commission Expires April 10, 2020
Acting in the County of Wayne

{34784/15/DT692152.DOCX;4}

Exhibit 14

Saron Marquardt, et al v Vellaiah D. Umashankar

STATE OF MICHIGAN

IN THE COURT OF APPEALS

SARON E. MARQUARDT, Personal Representative of the Estate of SANDRA MARQUARDT (Dec.),

Plaintiff-Appellant,

vs.

VELLAIAH DURAI UMASHANKAR, M.D.,

Defendant-Appellee.
_____/

Case No. 12-621-NH

Court of Appeals No. 319615

Honorable

David S. Swartz

TRANSCRIPTION OF AUDIOTAPE

Wednesday, October 30, 2013

- - -

On The Record Reporting & Video
313.274.2800

COURT CLERK: Number 11 on the docket, Marquardt versus Umashankar, Case Number 12-621-NH.

MR. MILLER: Good afternoon, Your Honor. Thomas Miller on behalf of the Plaintiff.

MRS. SWANSON: Joanne Geha Swanson on behalf of the Defendant Umashankar.

THE COURT: You may proceed.

MRS. SWANSON: Your Honor, this is an action for medical malpractice that was commenced by the personal representative of Mrs. Marquardt's estate on June 2nd, 2012, following the dismissal of that action she had filed against the University of Michigan Board of Regents arising out of the same set of facts. The earlier action was dismissed by the Court of Claims for failure to give notice and that was affirmed by the Court of Appeals.

The present motion before you is based upon the statute of limitations leaving aside the question of whether or not there is any time left within the statute of limitations period within which to file an action after an NOI expires when that NOI is filed on the very last day of the statute of limitations.

The question before this Court really depends upon whether the notice of intent that was directed to the University of Michigan Health System Risk Manager on July 20th, 2009, was, in fact, a notice of intent to Dr. Umashankar that tolled the

period of limitations against him. Dr. Umashankar was, in fact, mentioned in that NOI but it was not addressed to him, and when the tolling period expired in January 2012, he was not named as a Defendant in that action.

Mrs. Marquardt admits that -- or Mr. Marquardt admits that he didn't decide to sue Dr. Umashankar when he filed the Court of Claims action and, in fact, it wasn't until that Court of Claims action was dismissed that he decided to sue Dr. Umashankar, along with another physician Dr. Haft, who has since been dismissed from this action as well. When Mr. Marquardt made the decision that he was going to sue Dr. Haft and Dr. Umashankar, he served new notices of intent upon them. Those notices of intent were directed expressly to the physicians and Dr. Umashankar's was addressed to him, not at the Risk Management Office of the University of Michigan Health System but at the Department of -- Cardiovascular Department at University of Michigan Hospital Anesthesia Department.

So the parties agree that the statute of limitations or the claim accrued on July 20, 2007, and that the statute of limitations is for two years and that that period would have been extended for 182 days if that notice had been filed as to Dr. Umashankar.

The real issue for this Court is what was the effect of that notice, and that's significant, Your Honor, because as

personal representative of Mrs. Marquardt's estate, if Mrs. Marquardt died within 30 days of expiration of the statute of limitations, the personal representative would have another two years within which to file suit. Mrs. Marquardt died on January 27th, 2010. The statute of limitations without the NOI would have expired on July 20, 2009. If the NOI was effective as to Dr. Umashankar, then she would have died within the 30 days of the expiration of the statute of limitations, which would have been around January 18th, 2010.

Mr. Marquardt's theory or basis for arguing that the NOI against Dr. Umashankar was effective is MCL -- as far as I can tell, Your Honor, is MCL 600.2912b, and Plaintiff argues that the notice of intent sent to the Risk Manager at University of Michigan Health System was good enough because that provision allows the NOI to be mailed to the health facility if the Doctor's last known address cannot be found, but Your Honor, this statute is not intended to provide a convenient after the fact justification for failing to direct the NOI to the particular Defendant physician.

To properly invoke the alternative afforded by this statute, the Plaintiff has to make some reasonable effort to ascertain the last known address of the intended Defendant. Mr. Marquardt was likely not concerned with making this inquiry, Your Honor, because he did not intend to direct the NOI to Dr. Umashankar because he did not intend to bring suit

against Dr. Umashankar at that time. So Mr. Marquardt's failure to make that reasonable inquiry is basically constantly acknowledged in the response to our motion where Mr. Marquardt says that it would have been extremely unlikely that counsel for claimant could have found a current address and that serving the University of Michigan with the notice was thought to have been the best way to advise the Defendant of the pending claim.

Nothing in the statute, Your Honor, permits a Plaintiff to direct notice intended for a particular physician to the Risk Manager of the hospital at which the surgery was performed. The notice still has to be directed to the physician, and if Dr. Umashankar was the intended Defendant, it should have been directed to him. In fact, that is how the NOI was addressed when it was served in September 2011 after the case against the Board of Regents has been dismissed.

Mr. Marquardt seems to argue that University of Michigan Health System would have notified Dr. Umashankar of the notice of intent that they received and that that should have been sufficient, but again there is no authority whatsoever for the proposition that the NOI statute can be satisfied by directing the NOI to someone who will tell the Defendant or who should tell the Defendant or who might tell the Defendant about the claim. The statute itself is inconsistent with that proposition because it states that proof of the mailing

constitutes prima facie evidence of compliance with this section.

The clear meaning of this provision, Your Honor, is that compliance requires a specified physical mailing to the Defendant and nothing less and the date of mailing is obviously important because that is the date upon which the tolling period begins, and if you just mail the notice of intent directed to one Defendant to another Defendant and are relying on that Defendant to tell them, there would really be no way to be able to ascertain precisely when the tolling period begins and when it ends.

So because, Your Honor, no notice of intent was directed to Dr. Umashankar on July 20, 2009, Mrs. Marquardt did not die within 30 days of expiration of the statute of limitations and her personal representative could not take advantage of the two year savings provision within which to file a claim, and for that reason, Your Honor, we are requesting that summary disposition be granted.

MR. MILLER: In somewhat of an inverse order, Your Honor, let me just address a few things that counsel mentioned. The cases that Defendant's cite for the proposition that you cannot serve one Defendant by serving another Defendant is part of MCL 2912b(1) and that's the authority cited in those decisions.

The provision that is relevant here is 600.2912b(2), which

reads as follows, Your Honor, "If no last known professional business or residential address can reasonably be ascertained, notice may be mailed to the health facility where the care that is the basis of the claim was rendered". There is basically two things in that provision, Your Honor. Reasonably ascertained, I will indicate to the Court that in subsequent discoveries in the Court of Claims action we learned that Dr. Umashankar had returned to India while the Plaintiff was still in the hospital in 2009.

Subsequent when we made efforts to try to find Dr. Umashankar in 2011 and 2012, there was nothing on the internet about Dr. Umashankar as far as his professional address. We had an address on his curriculum vitae but we didn't have a curriculum vitae in 2011 -- I mean, excuse me, in 2009. Mrs. Marquardt was in the hospital in 2007. I misstated and said 2009. The notice of intent was sent in 2009. There would have been no way that we could have ascertained a last known address for Dr. Umashankar when the notice of intent was sent in 2009.

When we tried -- Your Honor will recall all the problems we had with serving Dr. Umashankar. It took over a year to effectuate service -- not over a year but up to a year. I contacted the two professional organizations to which he claimed to have belonged in his curriculum vitae. Neither of those organizations would give us his last known address.

Those same organizations two years earlier would not have had his last known address.

So there is no case law cited by Defendant that requires, as she points out, Plaintiff has a duty to exercise reasonable effort. The statute doesn't say that. There's no case law to support that proposition cited by Defendants. It simply says, if no last known professional address or residential address can be reasonably ascertained. It doesn't say that Plaintiff must demonstrate that reasonable effort has been made to find him somewhere in India. It just simply says that it could not have been reasonably obtained, and based upon the subsequent work incident of serving process in this case, it was clearly evident that we would not have been able to ascertain the last known address.

The other thing is counsel says that it was not addressed to Dr. Umashankar. There is nothing in the statute that requires that it be addressed or sent -- or that the addressee be part of the notice. It simply says, notice may be mailed to the health facility, not to the Defendant care of the healthcare facility. It says, mailed to the facility, and we did mail it to the facility.

Defendant argues, well, you should have addressed it to Dr. Umashankar at the University of Michigan, and if I could approach, Your Honor, I can show you the two letters that we did send in 2011, one by regular mail and one by certified, and

they were addressed to Dr. Umashankar at the University of Michigan. You can make out the address under that white part that's covered up. Both of them were returned by the University of Michigan indicating that he was no longer there.

So what Defendant seems to be arguing is that the statute would be complied with if we had done the same thing in 2009. The statute infers that by sending it to the facility that the best -- it represents the best chance that this notice is going to get to the effected person. Dr. Umashankar is mentioned I think five times in the notice of intent. There is no dispute about that.

Plaintiff has complied with the provisions of 2912b(2). Part of it may have been inadvertent notice but he was served by reason of this 2912b(2) because we did mail it to the health facility, and again there's no authority cited by Defendant that says Plaintiff has to make reasonably effort. It simply says, a determination made as to -- as it says, no last known address can be reasonably ascertained, and we couldn't at that time, Your Honor.

THE COURT: Thank you.

MRS. SWANSON: Thank you, Your Honor. Just a couple of quick points, it says -- yes, the statute says it may be mailed to the facility but it says the notice of intent to file a claim required under subsection one and that is a notice of intent directed to the particular intended Defendant, Your

Honor.

And I also would like to point out, there is a difference between mentioning Dr. Umashankar in the notice of intent and directing it to him, and in Atkins versus Suburban Mobility, the case decided -- one of the notice cases decided by the Michigan Supreme Court last year, the Court emphasized that a claim is not nearly an occurrence. It's a demand for payment pursuant to a legal right.

And there is no notice of intent within the statute of limitations that was served upon or sent to or directed to Dr. Umashankar where a claim was specifically indicated intended to be made against him at all. There is nothing that demand payment from him. There's nothing that says this claim is being asserted against you, and so while he has been mentioned in the notice of intent, it certainly was not a claim for an exercise of legal right against him.

MR. MILLER: Could I address just one issue?

THE COURT: Sure.

MR. MILLER: Counsel points out the fact that subsection two refers back to subsection one. There's no dispute that this notice of intent complied with the provisions in part one. Subsection two creates an exception for how to serve that notice of intent and it says it can be sent to the health facility if no reasonable address. We had a compliant NOI. If Your Honor reads it, you will see it complied with all

of the provisions of section one but it gave an exception on how service was to be made in section two.

THE COURT: Defendant's motion for summary disposition is based on the expiration of the statute of limitations. The history of the case includes a Court of Claims case that was dismissed on other grounds and a dismissal of another Defendant in this action on other grounds. Defendant argues that the wrongful death savings clause MCL 600.5852 does not apply. In the absence of a savings clause, the complaint filed on June 6th, 2012, was untimely.

Defendant relies primarily on the Court of Claims opinion in this case that held, quote, "MCL 600.5852 is also inapplicable because the statute applies where a potential Plaintiff dies within 30 days of the expiration of the statute of limitations. Here Mrs. Marquardt died on January 27, 2010, more than six months after the statute of limitations expired on July 20, 2009. Therefore, the wrongful death savings provision does not apply here", unquote.

In the absence of a savings provision, the Defendant asserts that there is no time remaining in the period of limitations that closed on July 20th, 2009, in which Plaintiff could have filed suit. Therefore, the complaint is properly dismissed with prejudice. Plaintiff correctly concedes that absent tolling the medical malpractice statute would have expired on July 20th, 2009, and Plaintiff would have been

prohibited from filing the Court of Claims case on January 19th, 2010, MCL 600.5856(b).

Plaintiff also acknowledges that the notice of intent had to be filed no later than July 20th, 2009, when the two year medical malpractice statute of limitations statute expired. Plaintiff asserts that despite dismissal of the Court of Claims case the claims against Defendant are viable because Defendant was not a party in the Court of Claims case or any companion case and the original notice of intent filed included Defendant and was served on him.

Further, contrary to the Court of Claims opinion and Defendant's argument, Plaintiff asserts that pursuant to the savings provision Plaintiff's complaint was timely filed on June 6th, 2010, prior to the June 14th, 2010, when the PR's two-year period was closed and within the three-year savings period that closed on either July 20th, 2012, or July 18th, 2013.

In support, Plaintiff submits the following analysis, quote, "Once a notice of intent has been mailed, the statute of limitations is tolled for 182 days pursuant to MCL 600.5856(c). That meant that the tolling period in the instant case would have started on July 20th, 2009, and ended on January 18, 2010, which was determined by adding 182 days to the original statute of limitations date. Since the provisions of MCL 600.5856(c) established a tolling provision rather than a savings

provision, the clock applicable to the existing statute of limitations was stopped during the tolling period which meant that the clock resumed again at the end of that tolling period. As such, the new statute of limitations date became January 18th, 2010.

In the instant case, January 18th, 2010, was Martin Luther King Day and the Courts were closed by order. Therefore, the next day when the Courts were open was January 19th, 2010. According to MCL 1.108(1), Plaintiff was permitted to timely file the complaint on January 19, 2010".

The Court finds that Plaintiff's analysis is flawed. Plaintiff's error is in the assumption that the statute of limitations date of July 20, 2009, was, quote, "extended", unquote, by the 182-day tolling provision of MCL 600.2912b(1) and that consequently, quote, "The new statute of limitations date became January 18th, 2010", unquote.

The reason Plaintiff is in error is because tolling does not operate to extend or expand the statute of limitations. Tolling merely extends the time during which a claim can be brought by temporarily suspending the running of the statute of limitations, Bush versus Shabahang, 484 Mich 156;189. As one Court has explained, quote, "The two-year statute of limitations for Plaintiff's medical malpractice action expired on June 4th, 2004, absent tolling. MCL 600.5805(6); MCL 1.108(3). Plaintiff served the notice of intent on

June 4th, 2004. Plaintiff was required to wait the entire 182-day period before filing suit. See Burton versus Reed City Hospital, 471 Mich 745. When the 182-day period ended, the statute of limitations did not resume running, period. The Plaintiff had no time remaining in which to file the suit. See Dewan versus Khoury, 2006 West Law 7853891, Michigan Court of Appeals 2006, unquote".

The above analysis readily applies here. The filing of the notice of intent on July 20th, 2009, merely suspended for 182 days the running of the two-year medical malpractice statute that accrued on July 20th, 2007, and expired on July 20th, 2009. MCL 600.2912b. See Maricle versus Shapiro 2001 West Law 7725313, Mich Ap 2001. When the 182-day period ended on January 18th, 2010, the statute of limitations did not resume running because Plaintiff had no time remaining in the period of limitations in which to file suit absent the savings provision.

The savings provision is not a statute of limitations or a repose and is only an exception to the statute of limitations. Miller versus Mercy Memorial Hospital, 466 Mich 196;202. In other words, the savings provision, such as MCL 600.5852, merely allows commencement of an action after the statute of limitations period has run. Quote, "If a person dies before the period of limitations has run or within 30 days after the period of limitations has run, an action which survives by law

may be commenced by the personal representative of the deceased person at anytime within the two years after the letters of authority are issued, although the period of limitations has run, but an action shall not be brought under this provision unless the personal representative commences it within three years after the period of limitations has run", unquote.

Contrary to Plaintiff's argument and analysis and as the Court of Claims correctly found, decedent's death on January 27, 2010, was more than 30 days after July 20th, 2009. Therefore, MCL 600.5852 does not apply to save the Plaintiff's case against Defendant. For the reasons stated by the Court of Claims and by the Defendant, Defendant's motion for summary disposition is granted. Plaintiff's complaint is dismissed with prejudice. This is a final order that resolves the last pending claim and closes the case.

MRS. SWANSON: Thank you, Your Honor.

MR. MILLER: Thank you.

- - -

STATE OF MICHIGAN)
) SS.
COUNTY OF SAGINAW)

CERTIFICATE OF NOTARY PUBLIC

I, Natalie A. Gilbert, a duly commissioned and qualified Notary Public for the County of Saginaw, State of Michigan, do hereby certify that I have transcribed, via stenographic means to the best of my ability, the taped proceedings conducted on Wednesday, October 30, 2013, before the Honorable David S. Swartz.

I do further certify that I have delivered the original transcript into the possession of THOMAS C. MILLER, ESQ.

I do further certify that I am not connected by blood or marriage with any of the parties or their attorneys; that I am not an employee of any of them nor interested directly or indirectly in the matter in controversy, as counsel, attorney, or otherwise.

IN WITNESS WHEREOF, I have hereunto set my hand at Saginaw, County of Saginaw, State of Michigan, this 19th day of February, 2014.

Natalie A. Gilbert, CSR-4607
Certified Shorthand Reporter
Registered Professional Reporter
Notary Public, Saginaw County, Michigan
My Commission expires: August 10, 2020

- - -

Exhibit 15

501 Mich. 870
Supreme Court of Michigan.

Saron E. MARQUARDT, Personal Representative for the Estate of Sandra Marquardt, Plaintiff-Appellant,
v.
Vellaiah Durai UMASHANKAR, MD, Defendant-Appellee,
and
Jonathan Haft, Defendant.

SC: 151555
|
COA: 319615
|
September 27, 2017

Washtenaw CC: 12-000621-NH

Order

By order of November 23, 2016, the application for leave to appeal the March *855 26, 2015 judgment of the Court of Appeals was held in abeyance pending the decision in *Haksluoto v. Mt. Clemens Regional Medical Center*, 500 Mich. 892, 886 N.W.2d 718 (2017). On order of the Court, the case having been decided on June 27, 2017, 500 Mich. 304, 901 N.W.2d 577 (2017), the application is again considered. Pursuant to MCR 7.305(H)(1), in lieu of granting leave to appeal, we VACATE the judgment of the Court of Appeals and REMAND this case to the Washtenaw Circuit Court for reconsideration in light of *Haksluoto*.

We do not retain jurisdiction.

Wilder, J., did not participate because he was on the Court of Appeals panel.

All Citations

501 Mich. 870, 901 N.W.2d 854 (Mem)

End of Document

Exhibit 16

886 N.W.2d 722 (Mem)
Supreme Court of Michigan.

Saron E. MARQUARDT, Personal Representative for the Estate of Sandra Marquardt,
Plaintiff–Appellant,
v.
Vellaiah Durai UMASHANKAR, MD,
Defendant–Appellee,
and
Jonathan Haft, Defendant.

Docket No. 151555.
|
COA No. 319615.
|
Nov. 23, 2016.

Order

On order of the Court, the application for leave to appeal the March 26, 2015 judgment of the Court of Appeals is considered and, it appearing to this Court that the case of *Haksluoto v. Mt. Clemens Regional Medical Center* (Docket No. 153723) is pending on appeal before this Court and that the decision in that case may resolve an issue raised in the present application for leave to appeal, we ORDER that the application be held in ABEYANCE pending the decision in that case.

All Citations

886 N.W.2d 722 (Mem)

STATE OF MICHIGAN

IN THE SUPREME COURT

SARON E. MARQUARDT, Personal Representative of the ESTATE OF SANDRA MARQUARDT (Dec.)	Supreme Court Case No. 160772
Plaintiff-Appellant,	Court of Appeals Case No. 343248
v.	Washtenaw County Case No. 12-621-NH
VELLAIAH DURAI UMASHANKAR, M.D.,	Hon. David S. Swartz
Defendant-Appellee.	

APPENDIX OF EXHIBITS IN SUPPORT OF DEFENDANT-APPELLEE VELLAIAH DURAI UMASHANKAR, M.D.'S SUPPLEMENTAL BRIEF

Volume II

Exhibit 17

STATE OF MICHIGAN WASHTENAW COUNTY TRIAL COURT	**NOTICE OF MOTION HEARING** AND PROOF OF SERVICE	Case No: 12-621-NH

101 E Huron St., P.O. Box 8645, Ann Arbor, Michigan 48107 (734)222-3001

Plaintiff Name:	v	Defendant Name:
Saron E. Marquardt, Personal Representative of the Estate of Sandra D. Marquardt		Vellaiah Durai Umashankar, M.D>

*** FAILURE TO FILL IN ALL BLANKS ON THIS NOTICE OF MOTION HEARING FORM MAY RESULT IN THE COURT DECIDING NOT TO HEAR YOUR MOTION.***

1. Motion title(s): Defendant's Post-Remand Motion for Summary Dispositoin

2. Moving Party: Defendant

   Attorney for Moving Party: Joanne Geha Swanson (P 33594)

   Phone Number of Attorney/Moving Party: (313) 961-0200

3. Responding parties/attorneys (include Bar No.(s))

   Thomas C. Miller (P 17786) (P) (P)

   (P) (P)

4. ☑ I have contacted opposing attorney/party and have been informed that this motion will / will not (CIRCLE ONE) be contested.

   ☐ I have not contacted opposing attorney/party for the following reason:

5. **NOTICE OF HEARING:** The above motion(s) will be heard as follows:

Judge	Date	Time
David S. Swartz	January 10, 2018	1:30 p.m.

(P75841)
Signature of moving attorney or party — December 15, 2017 Date

6. **PROOF OF SERVICE:**

I certify that I served a copy of this document and the motion(s) referred to in this notice and exhibits :

☑ by regular mail at least 9 days before this hearing, or
☐ personally at least 7 days before this hearing

to the attorneys or parties (CIRCLE ONE OR BOTH) of record to their last known addresses as defined by MCR 2.107.

I declare that the statements above are true to the best of my information, knowledge, and belief.

Cynthia J Villeneuve
Signature of person serving document — December 15, 2017 Date

(10/17)

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

SARON E. MARQUARDT, Personal Representation of The Estate of SANDRA D. MARQUARDT,

Plaintiff,

v.

VELLAIAH DURAI UMASHANKAR, M.D.,

Defendant.

Case No. 12-621-NH

Hon. David S. Swartz

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DEFENDANT VELLAIAH DURAI UMASHANKAR, M.D.'S
POST-REMAND MOTION FOR SUMMARY DISPOSITION

Defendant Vellaiah Durai Umashankar, M.D., through his undersigned counsel, moves for summary disposition in his favor pursuant to MCR 2.116(C)(7) because the action is barred by the statute of limitations. After vacating the Michigan Court of Appeals' decision affirming this Court's grant of summary disposition, the Michigan Supreme Court remanded this case for reconsideration in light of the Supreme Court's decision in *Haksluoto v Mt. Clemens Regional Med Ctr*, 500 Mich 304; 901 NW2d 577 (2017). See *Marquardt v Umashankar*, 501 Mich. 870; 901 NW2d 854 (Mem). Because *Haksluoto* affects only one of multiple grounds relied upon by this Court and the Court of Appeals in granting summary disposition to Dr. Umashankar, and does not address the other independent grounds, *Haksluoto* does not change the result.

BRIEF IN SUPPORT OF POST-REMAND MOTION FOR SUMMARY DISPOSITION

STATEMENT OF FACTS AND PROCEEDINGS

Plaintiff Saron E. Marquardt, Personal Representative of the Estate of Sandra D. Marquardt, filed this action on June 6, 2012, asserting that Dr. Jonathan Haft and Dr. Vellaiah Durai Umashankar breached the standard of care in administering the drug Trasylol to Sandra Marquardt during surgery performed on July 20, 2007. *See* Complaint (Ex. 1, ¶s 7, 9. The Complaint alleges that "Defendants were initially served with notices of intent pursuant to MCL 600.2912b on July 20, 2009" and again on November 14, 2011. Complaint, ¶6. But the July 20, 2009 notice, given on the very last day of the limitations period, was not directed to Dr. Haft or Dr. Umashankar; it was directed to "Risk Manager University of Michigan Health System." *See* July 20, 2009 NOI (Ex. 2). Further, the Regents of the University of Michigan was the only named defendant when, on January 19, 2010, after the notice period expired, Mrs. Marquardt filed an action in the Court of Claims. *See* Complaint against UM Regents (Ex. 3). Neither Dr. Haft nor Dr. Umashankar were named as defendants in that action.

Mrs. Marquardt died on January 27, 2010, while the Court of Claims action remained pending. Complaint (Ex. 1), ¶12. Her husband, Saron Marquardt, was appointed personal representative on June 14, 2010 and continued the suit on behalf of her estate. *See* Letters of Authority (Ex. 4). On August 31, 2011, the U of M Regents moved for summary disposition asserting (1) that the applicable statute of limitations expired before the Court of Claims complaint was filed; and (2) that plaintiff's failure to comply with the Court of Claims notice requirement barred the action. While that motion was pending, Mr. Marquardt sent individual notices of intent to Dr. Haft and Dr. Umashankar. *See* Haft NOI (Ex. 5) and Umashankar NOI (Ex. 6). Unlike the July 20, 2009 NOI, which was directed to:

Risk Manager
University of Michigan Health System
1500 E. Medical Center Drive
Ann Arbor, MI 48109-5912

the September 2, 2011 NOI to Dr. Haft was expressly addressed to:

Jonathan W. Haft, M.D.
University of Michigan Cardiovascular Center
Section of Cardiac Surgery
1500 E. Medical Center Drive, Floor 3
Ann Arbor, MI 48109-5853

and the NOI to Dr. Umashankar was addressed to:

Vellaiah Durai Umashankar, M.D.
c/o University of Michigan Cardiovascular Center
Department of Anesthesia
1500 E. Medical Center Drive, SPC 5861
Ann Arbor, MI 48109

(Exhibits 5 and 6).[1]

Summary disposition was granted to the University of Michigan in the Court of Claims action on December 6, 2011, due to Mrs. Marquardt's failure to file the requisite notice. *See* Court of Claims 12/6/2011 Opinion and Order (Ex. 7). That order was affirmed by the Court of Appeals, *see Marquardt v University of Michigan Board of Regents*, unpublished opinion per curiam of the Court of Appeals, issued November 27, 2012 (Docket No. 307917), 2012 Mich App LEXIS 2359 (Ex. 8). Thereafter, on June 6, 2012, Mr. Marquardt commenced this action against Dr. Haft and Dr. Umashankar. Dr. Haft was immediately served through counsel and later dismissed due to Mr. Marquardt's failure to file the requisite affidavit of merit as to Dr. Haft. See 2/13/13 Order (Ex. 9).

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[1] The Complaint erroneously asserts that Dr. Umashankar was served with a notice of intent "on or about November 14, 2011." The date discrepancy is irrelevant to the analysis. Irrespective of whether the NOI was served on September 2, 2011 or November 14, 2011, the limitations period had long since expired and was not subject to tolling.

Dr. Umashankar also moved for summary disposition because the complaint was barred by the statute of limitations. The motion argued, among other things, that the statute of limitations expired on July 20, 2009, and because Mrs. Marquardt died more than 30 days after the statute of limitations expired, the wrongful death savings provision did not extend the time within which her personal representative could file suit.

The motion was argued on October 30, 2013 and in a bench ruling, this Court granted summary disposition for Dr. Umashankar. *See* 10/30/2013 Tr. (Ex. 10). In addition to expressly granting the motion "for the reasons stated in defendant's motion," this Court held that because notice was given on the last day of the limitations period, there was no time left in the limitations period after the NOI tolling ended within which to file suit (even assuming the NOI was timely directed to Dr. Umashankar). This Court also concluded that the NOI merely "suspends," but does not extend, the running of the statute of limitations for purposes of filing a claim. Thus, the statute of limitations expired more than 30 days before Mrs. Marquardt died, and the personal representative savings provision did not apply. As to this point, this Court explained:

> The Court finds that Plaintiff's analysis is flawed. Plaintiff's error is in the assumption that the statute of limitations date of July 20, 2009, was, quote, "extended", unquote, by the 182-day tolling provision of MCL 600.2912b(1) and that consequently, quote, "The new statute of limitations date became January 18th, 2010", unquote.
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> * * *
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> The savings provision is not a statute of limitations or a repose and is only an exception to the statute of limitations. Miller versus Mercy Memorial Hospital, 466 Mich 196; 202. In other words, the savings provision, such as MCL 600.5852, merely allows commencement of an action after the statute of limitations period has run. Quote, "If a person dies before the period of limitations has run ***or within 30 days after the period of limitations has run***, an action which survives by law may be commenced by the personal representative of the deceased person at anytime within the two years after the letters of authority are issued, ***although the period of limitations has run***, but an action shall not be brought under this provision unless the personal representative commences it within three years ***after the period of limitation has run***", unquote.

> Contrary to Plaintiff's argument and analysis and as the Court of Claims correctly found, decedent's death on January 27, 2010, was more than 30 days after July 20th, 2009. Therefore, MCL 600.5852 does not apply to save the Plaintiff's case against Defendant. For the reasons stated by the Court of Claims and by the Defendant, Defendant's motion for summary disposition is granted. [*Id.* at 12-15 (emphasis added)].

See also 11/19/13 Order (Ex. 11).

Mr. Marquardt subsequently appealed and the Court of Appeals affirmed on several bases. One ground for affirmance was the Court's conclusion that giving notice on the last day of the limitations period did not leave any time in the limitations period within which to file suit after the notice period expired. Noting that Mrs. Marquardt's claim accrued on July 20, 2007, the date Marquardt alleges that his wife was negligently administered the drug Trasylol, the Court of Appeals observed that the limitations period was set to expire on July 20, 2009. Although Marquardt filed the initial notice of intent on July 20, 2009, the last day of the limitations period, the 182-tolling period provided for in MCL 600.5856 did not start ***until the following day***, July 21, 2009, one day after the limitations period had expired. Thus, the statute of limitations had expired by the time NOI tolling commenced. *Marquardt v Umashankar*, unpublished opinion per curiam of the Court of Appeals dated March 26, 2015 (Docket No. 319615) at *2-3 (Ex. 12). This is the issue as to which the Supreme Court reached a contrary result in *Haksuloto*.

But the Court of Appeals also articulated two other grounds for affirming summary disposition in Dr. Umashankar's favor, and these holdings were not addressed or impacted by *Hakslouto*. First, the Court of Appeals held that the claim was not saved by the wrongful death savings provision because Mrs. Marquardt did not die before the statute of limitations had run or within 30 days after it expired. In other words, the Court of Appeals agreed with this Court that notice-tolling did not extend the statute of limitations for purposes of determining whether the

decedent died within 30 days after expiration of the statute of limitations for purposes of the wrongful death tolling statute.

The Court of Appeals also held that the NOI directed to the Risk Manager at U of M Health Service, although indicating an intent to assert a claim against Dr. Umashankar, was not proper notice to Dr. Umashankar and did not toll the limitations period as to him because "*in order to effectuate notice, the NOI must be directed to or addressed to the defendant professional to whom the NOI is intended to provide notice.*" *Marquardt*, at *4. The NOI did not toll the limitations period as to Dr. Umashankar because it was not directed or addressed to him. *Id.*

Mr. Marquardt subsequently sought leave to appeal to the Michigan Supreme Court. On November 23, 2016, the Court entered an order holding the application in abeyance because it appeared to the Court that a decision in *Haksluoto* might "resolve ***an*** issue raised in the present application for leave to appeal." See Supreme Court Order (Ex. 13) (emphasis added). The Court issued its decision in *Haksluoto* on June 27, 2017. See *Haksluoto,* 500 Mich 304; 901 NW2d 577 (2017) (Ex. 14). On September 27, 2017, the Supreme Court issued an order vacating the Court of Appeals' *Marquardt* decision and remanded the case to this Court "for reconsideration in light of *Haksluoto*." See Order (Ex. 15).

Dr. Umashankar now again moves for summary disposition to demonstrate that *Haksluoto* does not alter this Court's proper grant of summary disposition on statute of limitations grounds because other grounds articulated by the Court of Appeals in affirming this Court's grant of summary disposition were not addressed by or even raised in *Haksluoto,* and thus remain a valid basis for dismissal.

ARGUMENT

I. Summary Disposition for Dr. Umashankar is Required Because This Action is Barred by the Applicable Statute of Limitations.

Under the statute of limitations period applicable to medical malpractice claims and the concomitant accrual, notice, tolling, and savings provisions, the statute of limitations as to the claims against Dr. Umashankar expired on July 20, 2009. The wrongful death savings provision did not allow additional time for suit against Dr. Umashankar because Sandra Marquardt died on January 27, 2010, more than 30 days after the statute of limitations expired.

The notice of intent provision did not extend the limitations period beyond the July 20, 2009 expiration date because: *first*, the NOI tolling provision does not "extend" the limitations period for the purpose of determining whether death occurred before the statute of limitations expired or within 30 days thereafter; and *second*, the NOI directed to the Risk Manager at the University of Michigan Health Center was not effective as to Dr. Umashankar and did not toll claims against Dr. Umashankar.

Haksuloto did not decide whether summary disposition was proper on these grounds. It only addressed the third basis for Dr. Umashankar's summary disposition motion, holding that when an NOI is sent on the last day of the statute of limitations period, suit is timely if filed on the business day immediately after the notice period expires. Here, because notice was directed to the risk manager at UMHS rather than to Dr. Umashankar, and because the notice-tolling provision does not ***extend*** the statute of limitations, Mr. Marquardt's claim is barred.

A. The Statute of Limitations Expired on July 20, 2009.

By statute, a claim for medical malpractice accrues at the time of the act or omission giving rise to the claim. MCL 600.5838a(1). Once a claim accrues, a medical malpractice plaintiff has two years within which to commence an action. MCL 600.5805(6). In this case, the

basis for the claim against Dr. Umashankar is the administration of Trasylol during surgery performed on July 20, 2007. *See* Complaint, ¶s 7-12. Consequently, the claim accrued on July 20, 2007, and expired on July 20, 2009. The Complaint filed on June 6, 2012 is time-barred.

B. The Wrongful Death Savings Provision Does Not Apply.

The time within which Mr. Marquardt was required to sue Dr. Umashankar is not extended by the additional time sometimes afforded to personal representatives under the wrongful death savings provision. MCL 600.5852 states:

> If a person dies ***before the period of limitations has run or within 30 days after the period of limitations has run***, an action which survives by law may be commenced by the personal representative of the deceased person at any time within 2 years after letters of authority are issued although the period of limitations has run. But an action shall not be brought under this provision unless the personal representative commences it within 3 years after the period of limitations has run (emphasis added).

Here, the statute of limitations expired on Mrs. Marquardt's claim on July 20, 2009, and Mrs. Marquardt died on January 27, 2010, more than 30 days after the period of limitations expired. As a result, MCL 600.5852 does not apply.

This analysis is not altered by the notice-tolling provision. First, NOI tolling does not "extend" the statute of limitations and does not toll a savings provision. Further, notice sent to the risk manager at UM Health System was not proper notice to Dr. Umashankar.

1. The NOI Provision Does Not *Extend* the Statute of Limitations.

Haksluoto is not a wrongful death action and does not address the impact of NOI tolling on the calculation of the personal representative savings provision. Thus, it does not affect this Court's proper determination that MCL 600.5852 did not afford Mr. Marquardt additional time for suit because Mrs. Marquardt died ***more than 30 days*** after the statute of limitations expired. As this Court concluded, the NOI merely triggers tolling and "tolling does not operate to extend

or expand the statute of limitations" but rather, "extends the time during which a claim can be brought by temporarily suspending the running of the statute of limitations." 10/30/13 Tr. at 13. Thus, the notice-tolling period could not extend the limitations period for the purpose of determining whether death occurred within 30 days of its expiration.

This Court's decision is well-supported by the jurisprudence of this State. The notice-tolling provision is not a statute of limitations; it is a savings provision that merely suspends the statute of limitations to save a claim that might otherwise expire.[2] And more particularly in this context, our law firmly holds that the medical malpractice notice-tolling provision does not apply to MCL 600.5852. In *Waltz v Wyse*, 469 Mich 642; 677 NW2d 813 (2004), the Michigan Supreme Court held that MCL 600.5856(d) [now MCL 600.5856(c)] does not toll the additional period afforded to personal representatives for filing wrongful death claims. The Court explained:

> Section 5856(d), by its express terms, tolls only the applicable "statute of limitations or repose." As we recently stated in *Miller*, *supra* at 202, the wrongful death provision, § 5852, "is a saving statute, not a statute of limitations." (Emphasis supplied.) See also *Lindsey v Harper Hosp*, in which we explained that § 5852, as "the statute of limitations saving provision" and an "exception to the statute of limitations," operated "to suspend the running of the statute until a personal representative is appointed to represent the interests of the estate." [*Id.* at 650 (citing *Miller v Mercy Mem Hosp*, 466 Mich 196; 644 NW2d 730 (2002) and *Lindsey v Harper Hosp*, 455 Mich 56, 61, 65; 564 NW2d 861 (1997)) (footnotes omitted)].

The Court thus concluded that Section 5852

> is a saving provision designed "to preserve actions that survive death in order that the representative of the estate may have a reasonable time to pursue such

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[2] The notice-tolling provision provides that at least 182 days prior to commencing an action for medical malpractice, a plaintiff must give the health professional written notice of intent to file the claim. MCL 600.2912b(1). The statute of limitations is then tolled for a period "not longer than the number of days equal to the number of days remaining in the applicable notice period after the date notice is given" ***if during that period a claim would be barred by the statute of limitations***. MCL 600.5856(c) (emphasis added).

> actions." *Lindsey, supra* at 66. It is not a "statute of limitations" or a "statute of repose." Thus, the notice tolling provision, § 5856(d) which explicitly applies only to "the statute of limitations or repose" does not operate to toll the additional period permitted under § 5852 for filing wrongful death actions. [*Id.* at 655].

If notice-tolling does not apply to the savings provision of MCL 600.5852, it also cannot apply to that portion of MCL 600.5852 which requires death to have occurred within 30 days of expiration of the statute of limitations. In other words, notice-tolling does not extend the statute of limitations for purposes of computing whether death occurred within 30 days of the statute of limitations' expiration. This is supported by the analysis in *Maricle v Shapiro*, unpublished opinion per curiam of the Court of Appeals, issued January 23, 2001 (Docket No. 217533), 2001 WL 772531, where the Court of Appeals explained:

> Contrary to both parties' assertions on appeal, the two-year statute of limitations is not "extended" 182 days when a plaintiff files a notice of intent to sue in accordance with MCL 600.2912b; MSA 27A.2912(2). Instead, the limitations period is only tolled where the statute of limitations will expire during the 182-day notice period that the plaintiff is prohibited from filing a lawsuit. MCL 600.5856(d); MSA 27A.5856(d). [2001 WL 772531, at *3, n1].[3]

Further, the NOI provision does not trigger tolling for just any reason. The statute of limitations is only tolled if the limitations period will expire ***during the notice tolling period.*** *See, e.g.*, *Mayberry v Gen Orthopedics, PC,* 474 Mich 1, 5; 704 NW2d 69 (2005) ("As we have previously explained, if the mandatory notice of intent to sue is given in such a manner that the period of limitations would expire during the 182-day notice period, §5856(d) operates to toll the limitations period for 182 days from the date notice is given"). In *Hoffman v Boonsiri*, 290 Mich App 34, 42; 801 NW2d 385 (2010), the Court of Appeals explained:

> Caselaw interpreting former MCL 600.5856(d) indicated that the tolling from the filing of an NOI applied only when the limitations period would otherwise expire during the notice period. In *Omelenchuk*, 461 Mich at 574, our Supreme Court concluded that the phrase "[i]f, during the applicable notice period under [MCL

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[3] *Maricle* (Ex. 16) is cited to illustrate that the NOI does not extend the statute of limitations.

> 600.2912b], a claim would be barred by the statute of limitations or repose" in former MCL 600.5856(d) indicated that former MCL 600.5856(d) was not applicable if the interval during which a potential plaintiff was not allowed to sue ended before the limitations period expired ... The current version essentially reordered the pertinent phrases from the former version. Therefore, we conclude that this particular holding in *Omelenchuk* is still valid.

See also, *Maricle*, 2001 WL 772531, at *3 n1 ("Because the notice was given more than 182 days before the end of the limitations period, the two-year limitations period was not tolled during the notice period"). Thus, the notice-tolling provision cannot be used to bring the statute of limitations expiration date to within 30 days of Mrs. Marquardt's death.

2. Notice Was Not Given to Dr. Umashankar Until After the Limitations Period Expired.

This Court also granted summary disposition to Dr. Umashankar for the reasons asserted in Dr. Umashankar's motion for summary disposition. There, Dr. Umashankar argued that the pre-suit notice of intent addressed to the University of Michigan Health System Risk Manager on July 20, 2009, did not toll the statute of limitations with respect to the claims against Dr. Umashankar because it was not directed to Dr. Umashankar. The Court of Appeals properly agreed with this analysis. See *Marquardt*, slip op. at *3-4. *Haksluoto* did not address this issue.

In *Driver v Naini*, 490 Mich 239, 249; 802 NW2d 311 (2011), the Michigan Supreme Court expressly stated that "[w]hen a claimant files an NOI with time remaining on the applicable statute of limitations, that NOI tolls the statute of limitations for up to 182 days *with regard to the recipients of the NOI*" (emphasis in original). In *Driver*, the NOI was directed to a doctor and his professional corporation but was not directed to a second professional corporation with which the doctor was associated during the period of treatment. The Court explained:

> There is no dispute that plaintiff timely filed suit within this six-month period with respect to Dr. Naini and MCA. Plaintiff provided those defendants an NOI in April 2006 and then waited 182 days before filing his complaint in October 2006. Plaintiff, however, first provided CCA an NOI in February 2007 and filed a complaint against CCA in March 2007, long after the six-month discovery

> period expired in May 2006. Because a medical malpractice plaintiff must provide *every* defendant a timely NOI in order to toll the limitations period applicable to the recipient of the NOI, plaintiff failed to toll the limitations period applicable to CCA. Hence plaintiff's complaint was time-barred with regard to CCA, and the Court of Appeals properly remanded the case for entry of summary disposition in CCA's favor. [*Id.* at 251 (emphasis in original) (footnotes omitted)].

See also Burton v Reed City Hosp Corp, 471 Mich 745, 753; 691 NW2d 424 (2005) (stating that compliance with MCL 600.2912b is mandatory before tolling may occur and "that this clear, unambiguous statute requires full compliance with its provisions as written," citing *Roberts v Mecosta Co Gen Hosp*, 466 Mich 57, 65-67; 642 NW2d 663 (2002) (*Roberts I*)); *Griesbach v Ross*, 291 Mich App 295; 804 NW2d 921 (2010) (NOI pertaining to two defendants did not toll the limitations period as to a third defendant to whom no notice of intent was sent).

Mr. Marquardt admits that the July 20, 2009 NOI was addressed to the Risk Manager at University of Michigan Health System, not to Dr. Umashankar. *See* Pl's Sup Ct App at 1 ("First notice of intent (NOI) was served pursuant to MCL 600.2912b(2) on the University of Michigan not Defendant Umashankar …") (capitalization omitted); Pl's Sup Ct App at ("There was also no dispute that the NOI was sent to the University of Michigan rather than to Defendant Umashankar"). *See also*, Pl's Court of Appeals' Br at 2 ("Counsel for Sandra Marquardt served a notice of intent upon Defendant Umashankar by sending it to the University of Michigan Health System's Risk Manager …"). Mr. Marquardt further admits that Dr. Umashankar was not at the University of Michigan Health System at that time and was not in the United States when the notice of intent was served. Pl's Sup Ct App at 1, 7. This was not proper notice to Dr. Umashankar. Thus, the NOI did not toll the limitations period as to Mr. Marquardt's claims.

This result is not altered by the pre-suit notice provision which permits an NOI to be mailed to the health facility if the doctor's last known address cannot be determined. *See* MCL 600.2912b. Even when MCL 600.2912b permits the pre-suit notice to be mailed to the hospital

because the physician-defendant's address is unknown, the pre-suit notice must still be directed to the physician-defendant. In other words, one must not confuse the address to which the NOI is mailed with the person or entity to whom it is given. Nothing in the statute permits a plaintiff to direct notice intended for a physician to the risk manager of the hospital. The pre-suit notice must still be "given" to the physician although under certain circumstances (not present here), it may be "mailed" to the physician at the hospital. MCL 600.2912b states in part:

> Sec. 2912b. (1) Except as otherwise provided in this section, ***a person shall not commence an action alleging medical malpractice against a health professional*** or health facility ***unless the person has given the health professional*** or health facility ***written notice under this section*** not less than 182 days before the action is commenced.
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> (2) The notice of intent to file a claim required under subsection (1) ***shall be mailed to the last known professional business address or residential address of the health professional*** or health facility ***who is the subject of the claim***. Proof of the mailing constitutes prima facie evidence of compliance with this section. ***If no last known professional business or residential address can reasonably be ascertained, notice may be mailed to the health facility where the care that is the basis for the claim was rendered*** [emphasis added].

And in fact, when the pre-suit NOI intended for Dr. Umashankar was directed to him on September 2, 2011, it was specifically addressed to Dr. Umashankar at the hospital in the following manner:

> Vellaiah Durai Umashankar, M.D.
> c/o University of Michigan Cardiovascular Center
> Department of Anesthesia
> 1500 E. Medical Center Drive, SPC 5861
> Ann Arbor, MI 48109

(Ex. 6), unlike the July 20, 2009 NOI, which was directed to "Risk Manager, University of Michigan Health System, 1500 E. Medical Center Drive, Ann Arbor, MI 48109-5912." (Ex. 2). The facility at 1500 E. Medical Center Drive is a huge complex where thousands of people maintain offices. The variations in departments, floors, and zip codes belie any assertion that directing the NOI to the Risk Manager at 1500 E. Medical Center Drive is the same as directing

the NOI to Dr. Umashankar c/o University of Michigan Cardiovascular Center, Department of Anesthesia, 1500 Medical Center Drive, SPC 5861.[4]

MCL 600.2912b(2) is not intended to provide a convenient after-the-fact justification for failing to direct the NOI to an intended defendant. To properly invoke the alternative afforded by MCL 600.2912b(2), a plaintiff must make some effort to "reasonably ascertain[] the last known professional business or residential address" of the intended recipient. Mr. Marquardt was likely not concerned with making this inquiry because he did not intend to direct the NOI to Dr. Umashankar, just as he did not intend to sue Dr. Umashankar (and did not in fact sue him) when the tolling period expired.[5]

Mr. Marquardt's failure to inquire as to a reasonably ascertainable address is tacitly acknowledged in the assertion that "[i]t would have been extremely unlikely that counsel for claimant could have found a current address for Defendant Umashankar in 2009 after he had returned to India" and "[s]erving the University of Michigan with the notice was thought to have been the best way to advise Defendant of the pending claim," Pl.'s Resp. (Ex. 17) at 12-13, and "it would have been difficult if not impossible for counsel to have found him in 2009." Pl.'s

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[4] Mr. Marquardt has argued that the intent to sue Dr. Umashankar along with the University Health System and other physicians was expressed in the body of the July 20, 2009 NOI. That is not something Dr. Umashankar would know if the NOI was not directed to him in the first instance. Nothing in MCL 600.2912b permits a plaintiff to direct notice intended for a physician to another defendant. Expressing an intent to sue a non-recipient physician in the body of a NOI directed to another defendant does not comply with the statute. Further, Dr. Umashankar was not named as a defendant when the suit against the Regents was filed after the notice period expired.

[5] As Mr. Marquardt admitted in response to Dr. Haft's first motion for summary disposition, "It was only when the University of Michigan decided to file a motion for summary disposition based upon a technical requirement regarding the filing of a claim with the Court of Claims that it became necessary to file this action against the individual doctors ..." Pl's Resp. (Ex. 17) at 12. Mr. Marquardt also states that "counsel for Plaintiff anticipated that Sandra Marquardt's claim could have been resolved through the Court of Claims litigation without actually naming the individual doctors in Washtenaw County." *Id.* at 13. This explains why the July 2009 NOI was not directed to Dr. Umashankar; the only intended action was against the Hospital.

COA Br. at 14. No efforts to obtain an address are described. But beyond that, nothing in the statute permits a plaintiff to direct notice intended for a physician to the risk manager of the hospital. The notice must still be directed to the physician.

In appellate briefing, Mr. Marquardt has proffered a series of rhetorical questions and speculative assumptions regarding whether and when Dr. Umashankar might have learned of the NOI directed to the Hospital's Risk Manager, and whether there is a difference between sending notice directly to the individual doctors or relying upon the Risk Manager to notify them of the claim. The difference is, in fact, significant: the first method complies with the statute, while the second method does not. There is no authority for the proposition that the NOI requirement can be disregarded if the defendant had actual notice of the claim. The statute itself belies any such supposition, stating in pertinent part that "Proof of the mailing constitutes prima facie evidence of compliance with this section." MCL 600.2912b(2). The clear thrust of this provision is that compliance requires the specified physical mailing to the named individual, and nothing less.[6] See also, *Fournier v Mercy Community Health Care Sys*, 254 Mich App 461; 657 NW2d 550 (2002).

McCahan v Brennan, 492 Mich 730; 822 NW2d 747 (2012), and *Atkins v Suburban Mobility Auth for Reg'l Transp*, 492 Mich 707; 822 NW2d 522 (2012), support Dr. Umashankar's argument that the pre-suit NOI directed to the "Risk Manager University of Michigan Health System" on July 20, 2009 did not toll the statute of limitations as to

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[6] The date of mailing is obviously important because it is the date after which the tolling period begins. That date would not be as easily defined if "actual notice" were sufficient to trigger the tolling period. One can only imagine the multiplication of proceedings that would become necessary to pinpoint the actual notice-tolling date including, as Mr. Marquardt suggested in response to Dr. Haft's motion, extensive discovery and depositions as to "exactly how Defendant Haft learned about the July 20, 2009 notice of intent." Pl.'s Resp. (Ex. 17) at 14.

Dr. Umashankar because it was not directed to Dr. Umashankar in conformity with the statutory requirements of MCL 600.2912b, irrespective of whether Dr. Umashankar at some point received ***actual notice*** of the claim. In *McCahan*, despite plaintiff's failure to effectuate notice as required by the applicable Court of Claims notice statute, defendant had actual notice of plaintiff's intent to pursue a lawsuit, was fully apprised of relevant details regarding the claim, and had communicated with plaintiff and her counsel within the six-month notice period. Nonetheless, the Michigan Supreme Court concluded that plaintiff's failure to file the required notice barred her action "regardless of whether the university was otherwise put on notice of plaintiff's apparent intent to pursue a claim," 492 Mich at 732-33, and irrespective of whether actual prejudice (resulting from the failure of notice) could be shown. *Id.* at 746-47.[7] The Supreme Court confirmed that statutory notice requirements must be interpreted and enforced as plainly written, and courts may not require a showing of actual prejudice as a condition to enforcement or otherwise diminish the claimant's obligation to fully comply. The Supreme Court thus concluded that McCahan's failure to timely file the required notice in the Court of Claims barred her action against the University regardless of whether the University was informed in some other manner of McCahan's intent to pursue a claim.

Similarly, in *Atkins*, the Supreme Court held that a common carrier's presumed institutional knowledge of an injury or occurrence does not relieve the claimant of the obligation to formally give the required statutory notice. 492 Mich at 711-12.[8] In *Atkins*, the Court of Appeals concluded that the carrier's knowledge of plaintiff's no-fault claim and the aggregate

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[7] The required notice was prescribed by MCL 600.6431.

[8] The notice was required by the Metropolitan Transportation Authorities Act, MCL 124.419.

information plaintiff provided were sufficient notice of the subsequently filed third-party tort claim. ***Rejecting*** that conclusion, the Supreme Court in part explained:

> By providing that the accumulated information obtained by SMART from other sources, in addition to a no-fault application, substantially met the requirement that plaintiff provide written notice of her tort claims, the Court of Appeals replaced a simple and clear statutory test with a test based on apparent or imputed knowledge. The Court of Appeals' holding would require SMART and its counterparts to *anticipate* when a tort claim is likely to be filed on the basis of the underlying facts. In short, it would require a governmental agency to divine the intentions of an injured or potentially injured person and then notify itself that the person may file a suit in tort. This approach entirely subverts the notice process instituted by the Legislature. [*Id.* at 721].

Here, MCL 600.5856(c) tolls the statute of limitations only with respect to claims against persons to whom notice is given. Because no notice of intent was directed to Dr. Umashankar on July 20, 2009, the statute of limitations as to claims against Dr. Umashankar was not tolled. Rhetorical questions and speculative assumptions regarding whether and when Dr. Umashankar might have learned of the NOI directed to the Health System's Risk Manager have no bearing on the tolling issue as to Dr. Umashankar. This is particularly so given the fact that ***no claim was in fact asserted against Dr. Umashankar when the July 20, 2009 notice period expired.*** The subsequently-filed complaint was against the University of Michigan Board of Regents.

In *Atkins*, the Supreme Court concluded that "[t]he claim asserted in plaintiff's application for no-fault benefits was qualitatively different from a claim for recovery in tort and could not reasonably apprise SMART that plaintiff would pursue a tort action," explaining:

> Plaintiff's interpretation, and that of the Court of Appeals, essentially rewrites the statutory text to provide that notice of any one claim – however distinct – suffices as notice of any other claim that plaintiff may pursue even when the statute plainly requires "written notice …"

Id. at 720. The Supreme Court further explained that a claim is "not merely an occurrence; it is a demand for payment pursuant to a legal right as a result of that occurrence" and "[k]nowledge of operative facts is not equivalent to written notice of a claim." *Id.* at 720-21. Similarly,

identifying Dr. Umashankar in the NOI as "one of the individuals that had breached the applicable standards of care resulting in Plaintiff's injury" (Pl.'s COA Br. at 12) is not the same as putting Dr. Umashankar on notice of Mr. Marquardt's intent to assert a claim ***against him***. In the same vein, notice of a claim directed to the Risk Manager is not notice of a claim directed to and against Dr. Umashankar, particularly when the complaint filed when the notice period expired did not name Dr. Umashankar as a defendant. As Mr. Marquardt admits, "It was only when the University of Michigan decided to file a motion for summary disposition based upon a technical requirement regarding the filing of a claim with the Court of Claims that it became necessary to file this action against the individual doctors rather than finish the litigation directly against the University of Michigan." Pl's Resp. to Dr. Haft's Mot. (Exhibit N) at 12. See also Pl.'s Resp. to Dr. Haft's Mot. at 13 ("counsel for Plaintiff anticipated that Sandra Marquardt's claim could have been resolved through the Court of Claims litigation without actually naming the individual doctors in Washtenaw County"); *id.* at 14 ("the interests of justice would be served by ignoring the technical error that occurred when counsel for Plaintiff, while acting in good faith, attempted to litigate this claim directly against the University without the necessity of filing two separate lawsuits in two different venues"). This explains why the July 20, 2009 NOI was not directed to Dr. Umashankar. The only intended action was against the Hospital and consequently, the July 20, 2009 NOI was only directed to the Hospital.

C. *Haksluoto* Does Not Address the Above Grounds for Summary Disposition.

For the reasons stated above, the complaint against Dr. Umashankar is barred by the statute of limitations. *Hakslouto* did not address, and has no effect, on this Court's grant of summary disposition on these grounds. The *Haksluoto* opinion is an explication of how half-days are to be counted. As Justice Markman said in the unanimous decision, the issue the Court considered was "whether the limitations period is tolled when the NOI is filed on the last day of

the limitations period, leaving no whole days of the limitations period to toll." 500 Mich 304, 901 NW2d at 579.

Hakslouto concluded that "the limitations period *is* tolled under such circumstances" and "plaintiff's complaint, which was filed the day after the notice period ended, was timely." *Id.* (emphasis in original). In reaching this conclusion, the Court explained that "[b]ecause it is undisputed that the notice here was filed on the final day of the limitations period (but before that final day ended,) MCL 600.5856(c) [the notice tolling provision] has ostensibly been satisfied so as to trigger tolling." *Id.* at 582. The Court noted, however, that "[o]ur law rejects fractions of a day…" and to know whether there is any time left to toll, the Court must determine whether to round up the time remaining in the day to "a whole day remaining, or round down to no days remaining." *Id.* The resulting fundamental question is "whether less than a whole day remaining in the limitations period qualifies as 'time remaining on the applicable statute of limitations' as required … to trigger tolling." The Court concluded that it did.

In the Court's view, it did not matter what time in the day the NOI was filed because the common law disregards fractions of a day and treats the act and the day as co-extensive. But for purposes of NOI tolling, the Court had to determine whether to "'round down' and treat the NOI filed on the final day as ineffective at tolling for want of any time left to toll, or … 'round up' and treat the NOI as having tolled, and preserved, the date on which the NOI was filed for use once the notice period ended." *Id.* at 585-86. The Court rounded up, stating:

> We hold, therefore, that applying our common-law jurisprudence of fractional days produces a conclusion that a timely NOI preserves the day the NOI is filed as a day to be used once the limitations period begins running after the notice period ends. Notably, this applies to any NOI that triggers tolling under MCL 600.5856(c), whether filed on the final day of the limitations period or on some earlier day. The rule is that once the notice period ends and the time for the plaintiff to bring a claim once again begins to run, it will run for the number of whole days remaining in the limitations period when the NOI was filed, plus one

> day to reflect the fractional day remaining when the NOI itself was filed. There is no principled reason to treat the last day differently from any other—the abacus bead does not slide over until the day is over, and that applies with equal force to the ultimate and penultimate days of the limitations period [*Id.* at 587].

The rule endorsed by the Court in *Hakslouto* is this: "when an NOI is filed on the final day of the limitations period, the next business day after the notice period expires is an eligible day to file suit." *Id.* Thus, while *Haksluoto* affects a prior argument as to whether there were any days left in the statute of limitations within which to file suit when Mrs. Marquardt gave notice on the last day of the limitations period, it has no bearing on the grounds for summary disposition described above.

Haksluoto is not a wrongful death case and did not decide whether notice tolling applied to a statute of limitations calculation made to determine whether the wrongful death savings provision could be invoked. Nor did it decide whether an NOI directed to a hospital is proper notice to an individual doctor. But the Court did note in describing the statutory scheme for "limitations periods, times of accrual, and tolling for civil cases" that the Legislature intended "the scheme to be comprehensive and exclusive" and that "***any deviation due to tolling from the two-year limitations period for malpractice actions is only as provided by statute***..." *Id.* at 581 (emphasis added). Neither NOI tolling nor any other statute extends the limitations period in this case. Summary disposition is required.

KERR, RUSSELL AND WEBER, PLC

By: _____ (By permission) P75842
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December 15, 2017

INDEX OF EXHIBITS TO DEFENDANT VELLAIAH DURAI UMASHANKAR, M.D. POST-REMAND MOTION FOR SUMMARY DISPOSITION

Exhibit 1

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of
the Estate of Sandra D. Marquardt

Plaintiff

VS.

Civil Action No. 12-621 NH

David S. Swartz

VELLAIAH DURAI UMASHANKAR, M.D.
AND JONATHAN HAFT, M.D.

Defendants

/

THOMAS C. MILLER (P17786)
Attorney for Plaintiff
P.O. Box 785
Southfield, MI 48037
(248) 210-3211
millertc@comcast.net

/

COMPLAINT AND AFFIDAVIT OF MERIT

There is no other civil action between these parties arising out of the same transaction or occurrence as alleged in this Complaint pending in this Court, nor has any such action been previously filed and dismissed or transferred after having been assigned to a judge, nor do I know of any other civil action, not between these parties, arising out of the same transaction or occurrence as alleged in this Complaint that is either pending or was previously filed and dismissed, transferred, or otherwise disposed of after having been assigned to a judge in this Court.

NOW COMES Plaintiff Saron E. Marquardt, Personal Representative of the Estate of Sandra Marquardt, by and through his attorney Thomas C. Miller, and states:

1. Decedent resided in Jackson County at all times relevant to this litigation.

2. Defendants maintained their professional practices of medicine and/or surgery in Washtenaw County at all times relevant to this litigation.

3. Defendants were employees of the University of Michigan Health System at all times relevant to this litigation.

4. Plaintiff claims an exemption from governmental immunity pursuant to MCL 691.1407 (4).

6. Defendants were initially served with notices of intent pursuant to MCL 600.2912b on July 20, 2009, and they were again served with notices of intent on or about November 14, 2011.

7. Decedent Sandra D. Marquardt was a patient at the University of Michigan Hospital from July 17, 2007 through December 4, 2007. During that admission Decedent underwent mitral valve replacement surgery on July 20, 2007.

8. Defendants had a duty to provide medical and surgical care consistent with applicable standards of care for anesthesiologists or consistent with applicable standards of care for cardiac surgeons. Those standards of care required that Trasylol not be used during mitral valve surgery given the changes made by the manufacturer regarding the indications for the use of the drug before Decedent's surgery, and given the cautionary warnings issued by the FDA and the manufacturer prior to Decedent's surgery. The manufacturer's changes to its insert and the FDA advisories regarding the indications for the use of Trasylol clearly stated that the drug was to be used only for patients with a high risk of bleeding ***and*** who were undergoing coronary

artery bypass graft surgery. Decedent surgery did not meet both of those indications. In addition to the published warnings detailed above, the standards of care prohibited the use of Trasylol in a patient that had evidence of possible preoperative renal insufficiency. In addition Ms. Marquardt's history of other drug allergies was also a contraindication for the use of Trasylol. Once the decision was reached to administer the Trasylol, the standards of care required that a test dose be administered ten minutes before the loading dose, and that the administration of the loading dose be accomplished over a 20-30 minute time period before the sternotomy and before the infusing of the drug began during the actual surgery. The standards of care for both anesthesiologists and cardiac surgeons are more clearly set forth in the attached affidavit of merit and incorporated by reference into this Complaint. Both Defendants have testified that the decision to use Trasylol during Decedent's valve replacement surgery was a joint decision, and therefore, the standard of care detailed in the attached affidavit of merit is applicable to both Defendants even though they are engaged in different specialties.

9. Defendants breached the applicable standards of care, as they relate to the use of Trasylol, in the following ways:

a. They used Trasylol before and during mitral valve replacement surgery, despite the revised indications and warnings published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current regarding the indications and warnings regarding Trasylol, and used the drug during off-label surgery.

b. They used Trasylol during off-label mitral valve replacement surgery, when the FDA and the manufacturer, who were aware of such off-label uses for the drug, cautioned against using the drug for any procedure other than a CABG procedure where the

patient was at an increased risk of bleeding, until the drug's safety could be fully reviewed.

c. They also ignored Decedent's preoperative history of other drug allergies and possible renal insufficiency, which placed her at an increased risk of a reaction to Trasylol and/or at an increased risk of further renal disease from the drug.

d. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.

e. They failed to take the requisite 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, before the sternotomy was performed and before the infusion of the drug was commenced, as recommended by the manufacturer.

11. As a direct and proximate result of Decedent being given Trasylol during her mitral valve replacement procedure on July 20, 2007, she developed a significant pre-renal condition complicated by an obstructive kidney condition. She also suffered from a coagulopathy that was caused by the Trasylol, and aggravated by the lack of effective treatment in the postoperative period of time. Her renal disease, coagulopathy, multi-organ dysfunction, acidosis and significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long period of time. The lack of effective treatment and an accurate diagnosis led to a series of iatrogenic complications due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Decedent's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, and severe depression during her lengthy hospitalization and extreme debilitation. She remained

hospitalized for four and one-half months. Upon discharge she was on hemodialysis; she was oxygen due to changes in her lungs from ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis; and she was discharged suffering from an end-stage renal disease, ongoing liver disease, and heart problems that required an extensive array of drug therapies and continue to cause severe debilitation. Decedent went from an independent person, who was able to perform all ADL's except when her mitral valve failed, to a person totally dependent on her husband and others. Those problems were more likely than not directly related to complications from the use of Trasylol during her valve replacement surgery. As a result of her chronic kidney and pulmonary complications, Decedent passed away on January 27, 2010 from those medical complications.

12. As a result of the above injuries, Decedent suffered considerable pain, suffering, mental anguish, disability and medical expense before her death. Those same injuries resulted in her death on January 27, 2010.

13. Saron E. Marquardt was appointed the Personal Representative of the Estate of Sandra Marquardt by the Jackson County Probate Court under # 10011754-DE. His letters of authority were issued on June 14, 2010.

14. Decedent was survived by a son, several sisters and a spouse.

15. As a result of the death of Sandra Marquardt, her son, her sisters and her husband were denied her love, society and companionship.

14. As a result of her death the Estate of Sandra Marquardt has become obligated for the costs of her funeral, burial and last illness.

WHEREFORE, Plaintiff Saron E. Marquardt, the Personal Representative of the Estate of Sandra Marquardt, requests that this Court grant the Estate of Sandra Marquardt a judgment that

fairly, reasonably and adequately compensates Decedent for the pain, suffering, mental anguish, disability and denial of social pleasures and enjoyment she sustained before her death. Additionally, Plaintiff requests that the Estate be compensated for the losses suffered by her heirs at law and for the funeral, burial and last illness expenses incurred.

Respectfully submitted,

Thomas C. Miller (P17786)

6-4-12

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of
the Estate of Sandra D. Marquardt

Plaintiff

VS. Civil Action No. NH

VELLAIAH DURAI UMASHANKAR, M.D.
AND JONATHAN HAFT, M.D.

Defendants

/

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/

AFFIDAVIT OF MERIT
(Previously filed in the Court of Claims # 10-4 NH)

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

SANDRA D. MARQUARDT

PLAINTIFFS

VS. CIVIL ACTION NO. NH

THE UNIVERSITY OF MICHIGAN BOARD OF REGENTS
(UNIVERSITY OF MICHIGAN HOSPITALS AND
HEALTH CENTERS)

DEFENDANT

AFFIDAVIT OF MERIT

I, Javier H. Campos, M.D., having been duly sworn, state:

1. I am licensed to practice medicine in the State of Iowa, and I was so licensed at all times relevant to this litigation.

2. I am a professor in anesthesiology and director of cardiothoracic anesthesia at the University of Iowa Healthcare

3. I am engaged in the full time clinical practice of anesthesia/cardiothoracic anesthesia, and I was so engaged at all times relevant to this litigation.

4. I have received and reviewed the notice of intent provided to me by counsel for Ms. Marquardt.

5. I have received and reviewed medical records from counsel for Ms. Marquardt.

6. I am familiar with the standards of care for anesthesiologists, as they relate to the indications for the use of Trasylol (after November 2006) during mitral valve replacement surgery.

7. The standards of care for anesthesiologists, who are involved with cardiothoracic surgery to replace a mitral valve (after November 2006), require that Trasylol not be used during such surgery given the changes made by the manufacturer regarding the indications for the use of the drug, and given the cautionary

warnings issued by the FDA and the manufacturer prior to that date. The manufacturer's changes to its insert and the FDA advisories regarding the indications for the use of Trasylol clearly indicated that the drug was to be used exclusively for patients with a risk of bleeding ***and*** who were undergoing coronary artery bypass graft surgery. In addition to the published warnings detailed above, the standards of care would prohibit the use of Trasylol in a patient that had evidence of possible preoperative renal insufficiency. Once the decision was reached to administer the Trasylol, the standards of care required that a test dose be administered ten minutes before the loading dose, and that the administration of the loading dose be accomplished over a 20-30 minute time period before the sternotomy and before the infusing of the drug began.

8. The anesthesiologists, who were involved with the subject mitral valve replacement procedure, breached the applicable standards of care, as they relate to the use of Trasylol, in the following ways:

   a. They used Trasylol before and during mitral valve replacement surgery, despite the revised indications and warnings published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current regarding the indications and warnings regarding Trasylol, and used the drug during off-label surgery.
   b. They used Trasylol during off-label mitral valve replacement surgery, when the FDA and the manufacturer, who were aware of such off-label uses for the drug, cautioned against using the drug for any procedure other than a CABG procedure where the patient was at an increased risk of bleeding, until the drug's safety could be fully reviewed.
   c. They also ignored Ms. Marquardt's preoperative history of other drug allergies and possible renal insufficiency, which placed her at an increased risk of a reaction to Trasylol and/or at an increased risk of further renal disease from the drug.
   d. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.
   e. They failed to take the requisite 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, as recommended by the manufacturer.

9. The anesthesiologists that participated in the mitral valve replacement surgery on Ms. Marquardt would have complied with applicable standards of care, if they had insisted that Trasylol not be used, in light of the FDA warnings and the changes made by the manufacturer regarding the indications for use of the drug. Additionally, an alternative drug should have been used due to the patient's preoperative evidence of possible renal insufficiency and the patient's history of other drug allergies.

10. As a direct and proximate result of Ms. Marquardt being given Trasylol during her mitral valve replacement procedure on July 20, 2007, Ms. Marquardt

developed a significant renal condition complicated by an obstructive condition of the kidneys. Her renal disease, coagulopathy, multi-organ dysfunction, acidosis and significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, and severe depression during her lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months. Upon discharge she was on hemodialysis; she was oxygen dependent upon discharge due to changes in he lungs from ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis; and she was discharged still suffering from renal disease, ongoing liver disease, and heart problems that must be treated with an extensive array of drug therapies and continue to cause severe debilitation. Ms. Marquardt went from an independent person, who was able to perform all ADL's, except when her mitral valve failed, to a person totally dependent on her husband and others. These problems are more likely than not directly related to complications from the use of Trasylol during her cardiothoracic surgery.

Respectfully submitted,

Javier H. Campos, M.D.

STATE OF IOWA)
§
COUNTY OF)

On the 15 day of January, 2010, Javier H. Campos, M.D. appeared before me, a Notary Public, personally and being duly sworn, acknowledged signing this Affidavit of Merit as her/his free act and deed.

, Notary Public
Johnson County, Iowa
My Commission Expires: 4/7/12

Exhibit 2

LAW OFFICES
OF
THOMAS C. MILLER
P.O. BOX 785
SOUTHFIELD, MICHIGAN 48037
248-210-3211

July 20, 2009

Risk Manager
University of Michigan Health System
1500 E. Medical Center Drive
Ann Arbor, MI 48109-5912

Re: Sandra D. Marquardt

Dear Risk Manager:

You are hereby notified that Sandra D. Marquardt intends to file suit against Jonathan Haft, M.D., Umashankar Vellaiah, M.D., Ranjiv Saran, M.D. and the University of Michigan Health System, Inc. (University of Michigan Hospitals and Health Centers), upon the expiration of 182 days from the above date. This notice is being provided pursuant to MCL 600.2912b. This same statute places certain obligations upon each of you as well. One of those obligations is to provide the undersigned with a copy of all medical records covering the care and treatment of Ms. Marquardt. The undersigned has already received the full hospital chart covering Ms. Marquardt's inpatient stay from July 17, 2007 to December 4, 2007; however, the clinical records covering her pre-admission assessments and her post-operative care have not been supplied, so a specific request is made for these records.

Drs. Haft, Vellaiah and Saran, together with their associates, residents and fellows, were all agents/employees of the University of Michigan Health System, Inc, and the University of Michigan Health System, Inc is responsible for their actions under principles of *respondeat superior*.

Ms. Marquardt's medical history is well documented in the University of Michigan Hospitals and Medical Centers' chart covering the above admission. Ms. Marquardt agrees that it contains the relevant medical history necessary for this notice of intent. In addition, all of the relevant medical treatment regarding this notice of intent is contained in that hospital chart. Certain portions of the care and treatment provided to Ms. Marquardt should be highlighted below, so that there is sufficient context to explain the claims being made below.

Ms. Marquardt was known to have suffered drug reactions to penicillin and ceftriaxone. Her baseline or pre-operative renal function studies revealed some degree of renal insufficiency. Specifically, her pre-operative creatinine level was reported to be 1.4 (on two occasions), her pre-operative BUN level was reported to be 21 (on two occasions) and there was evidence of significant levels of blood in her pre-operative urinalysis.

Dr. Haft admitted Ms. Marquardt in order to stabilize her cardiovascular status before performing a mitral valve replacement procedure. He was particularly interested in getting her off her Coumadin and onto IV Heparin, so that her coagulation could be more closely controlled during and after the surgery. He wanted the INR to be equal to or less than 2.0 and he wanted her PTT levels to be between 50 and 70 before proceeding with the surgery. Her INR was 2.8 on admission and had fallen to 1.6 by July 19th. Her PTT was 42.9 on admission and fell to 33.7 by July 19th. He initially planned on surgery for July 24th; however, that date was subsequently moved up to July 20th.

The Anesthesia Record, which was prepared incident to the mitral valve replacement procedure performed on July 20th, established the following timeline:

1. The anesthesia was started at 0645.
2. The patient was brought to the operating room at 0702.
3. The anesthesia induction ended at 0801.
4. The patient was placed in the left lateral decubitus position at 0804.
5. The baseline ACT was drawn at 0804 and reported to be 157 (the exact equipment used is not reflected on the chart).
6. The surgical incision was made at 0839. [No test dose or loading dose of Trasylol was administered before the incision and thoracotomy as required by the manufacturer in its insert.]
7. The 200 ml loading dose of Trasylol was given at 0909. [No test dose was given before the loading dose, as required by the manufacturer in its insert.]
8. The first ACT level obtained after the loading dose of Trasylol was reported as 999, which was apparently the highest level that could be digitally displayed by the equipment, at about 0915.
9. The Trasylol infusion dose of 50 ml/hr was begun at 0918.
10. The first dose of Heparin was administered at 0930. [There was confusion in the record as to the exact dosage given at that time. The written chronology indicates that 25,000 units were given. The graphic summary indicates that 2,500 units were given; however, the total on the graphic summary indicates that 35,000 total units were given during the procedure, which would have included 10,000 units at 1230. Dr. Haft indicates in his operative report that she was "systemically heparinized with 3 mg/kg sodium heparin", which would mean that she was given about 250 mg. given her known weight of 77.1 kg.]
11. Full cardiopulmonary bypass was initiated at 0942.
12. The first ACT level obtained after the Trasylol and Heparin were given reflected a continuing level of 999 at 1015.
13. The ACT level obtained at about 1115 revealed a level of 545.
14. The ACT level obtained at about 1215 revealed a level of 499.

15. The second dose of Heparin containing 10,000 or 1,000 units was given at 1230.
16. The ACT level obtained at about 1300 revealed a level of 387.
17. The cardiopulmonary bypass was terminated at 1311. **[The total time spent on the bypass equipment was reported by Dr. Haft to have been 209 minutes.]**
18. The ACT level obtained at about 1315 revealed a level of 590.
19. A 250 mg dose of Protamine was given at about 1330.
20. A 50 mg dose of Protamine was given at about 1400.
21. The ACT level obtained at about 1400 revealed a level of 158.
22. The surgical dressing was completed at 1445.
23. The patient was transferred to the TICU at 1501.
24. The anesthesia was ended at 1515.
25. The Trasylol infusion was terminated at about 1530.

In January 2006 a group of physicians and research experts published the results of an extensive study comparing the drug Trasylol with two other similar acting drugs. Their findings were accepted for publication in the prestigious *New England Journal of Medicine*. That article, together with a similar smaller study published in the March 2006 issue of *Transfusion*, began to raise serious questions about the safety of Trasylol. The FDA apparently became aware of those two studies and responded by publishing a "Public Health Advisory for Trasylol" dated February 8, 2006. In that advisory they informed the medical profession, particularly the cardiac surgeons and anesthesiologists, that they were aware of two studies that were reporting an increased risk of death and serious injury due to renal and heart disease incident to the use of Trasylol, when compared to the incidence of such results in patients who received two similar acting drugs. Following the FDA investigation and following consultations with the drug's manufacturer, the FDA adopted a revised insert to be distributed to all physicians who were the end users of the drug. That new insert was published and made available to the relevant physicians in November 2006. In that publication the manufacturer added additional information and cautionary content regarding the risk of renal, cardiac and vascular risks with the use of the drug. Of particular note was the manufacturer's "Indications and Usage" section. Trasylol was indicated for prophylactic use to reduce perioperative blood loss and the need for blood transfusion in **patients undergoing cardiopulmonary bypass in the course of coronary artery bypass graft surgery who are at an increased risk for blood loss and blood transfusion.**

It should be noted that the earlier insert also limited the indications to patients undergoing coronary artery bypass graft procedures in which cardiopulmonary bypass equipment was used; however, both the medical specialists involved and the manufacturer itself were aware that the drug was being used for off-label surgeries including cardiac valve replacements. In December 2006 the FDA again advised the medical community that it was very concerned about Trasylol; however, it wanted more information before making a decision regarding the safety of the drug. The FDA requested and Bayer agreed to inform its customers that the drug was to be used in strict compliance with the insert. Specifically, the manufacturer told its users to adhere strictly to the indications contained in the old and new insert, i.e. it was to be used only in CABG procedures. The FDA issued a press release regarding the new insert in December 2006,

and Bayer drafted a form letter, which it sent to each of its customers in the same month. The FDA indicated that it wanted the physicians to "understand the new warnings and use the product as directed by the [insert]". The new insert specifically stated that the drug was to be used only during CABG procedures. In the December letter the company also made it very clear to the physicians that the drug was to be used incident to CABG procedures only. They also advised the physicians of the renal and cardiac risks raised in the literature. The letter highlighted the changes in the new insert, which had been published in November 2006. It is believed that the information from the FDA and from Bayer was communicated directly to Dr. Hafi, Dr. Vellaiah and/or the University of Michigan Hospitals and Medical Centers in late 2006.

The revised 2006 insert made many critical points relevant to the facts in this matter. First, the use of the drug was to be restricted to CABG procedures, and was not to be used for valve replacement procedures. Second, patients with pre-existing renal insufficiency were at an increased risk of developing renal complications from the use of Trasylol. Third, patients with other drug allergies were more likely to have a reaction to Trasylol. Fourth, a test dose of Trasylol was to be given at least ten minutes before the loading dose of the drug. Fifth, the loading dose was to be given over a 20-30 minute time period before infusion of the drug. Sixth, the patient was to be placed in a supine position during administration of the test dose and the loading dose. Seventh, the patient was to be closely monitored closely for possible coagulopathy when Trasylol and Heparin were administered concurrently. An elevated ACT level might not reflect a high therapeutic level of Heparin, when Heparin was administered concurrently with Trasylol. Eighth, Protamine titration should be used to establish the adequacy of Heparin levels before any Trasylol is given, so that the anti-coagulation effects of the two drugs can be separated, and so that the results of that titration could be used to determine the effect of the Heparin therapy throughout the operative and post-operative phases. Ninth, the therapeutic level of Heparin must be kept above certain levels during the procedure (reflected by careful monitoring of coagulation studies) independent of the anti-coagulation effect created by the Trasylol given concurrently with Heparin.

The medical records of Ms. Marquardt reflect that no test dose of Trasylol was administered ten minutes before the loading dose. The patient was not in a supine position when she was given the loading dose of Trasylol. The loading dose was not given slowly over a 20-30 minute period of time (only nine minutes separated the loading dose from the start of the infusion of Traslol). Ms. Marquardt had a history of two different drug allergies. The procedure was a valve replacement procedure and not a CABG procedure. Ms. Marquardt did have evidence of pre-operative kidney dysfunction. Lastly, she was not closely monitored after the administration of Trasylol and Heparin to determine the anti-coagulation effect of Heparin alone versus the synergistic anti-coagulation effect of the two drugs in combination.

Following the surgery, during which Ms. Marquardt received Heparin and Trasylol, she began to manifest significant clinical signs and symptoms of renal disease, which led to multiple other organ system problems. The lack of attention to her renal complications from the Trasylol resulted in other iatrogenic complications and nosocomial infections. Despite numerous medical diagnoses formulated by the numerous physicians who treated Ms. Marquardt over the four months of post-operative care, the diagnosis of Trasylol induced pathology never appeared. It was not even mentioned as

part of anyone's differential diagnoses. The various treating physicians did proffer opinions regarding the etiology of her renal disease, specifically that they were post-op complications and that may have been related to the lengthy period of time spent on the bypass equipment; however, they never once mentioned the drug Trasylol as a possible factor.

During the time Ms. Marquardt was an inpatient at the University of Michigan Hospital, the following diagnoses were made and repeated often by the various physicians charged with providing her with care for her post-operative complications:

1. Various nosocomial infections, bacteremia and sepsis.
2. Hyperglycemia secondary to surgical stress requiring Tight Glycemic Control
3. Oliguric
4. Diminished Coronary Output/Coronary Index
5. Hemolysis secondary to long coronary bypass machine time
6. Fluid overload
7. Renal Hypoperfusion
8. Polyuric Renal Failure secondary to prolonged pump time
9. Acute Tubular Necrosis (ATN)
10. Hyperphosphatemia
11. Acute Kidney Injury (AKI) secondary to ATN
12. Hypotension
13. Pulmonary Edema
14. Non-oliguric Renal Failure
15. Acute Respiratory Distress Syndrome (ARDS)
16. Systemic Inflammatory Response Syndrome (SIRS)
17. Prolonged Respiratory Failure
18. Hematuria
19. Metabolic Acidosis
20. Pleural Effusion
21. Swallowing Dysfunction
22. Hypothyroidism
23. Hypercarbia
24. Hypoxemia
25. Clinical Depression
26. Peri-operative vascular leak
27. Respiratory Acidosis
28. Anemia
29. Atrial Fibrillation
30. Sick Euthyroid Syndrome
31. Prerenal Azotemia
32. Moderate Differentiated Encephalopathy
33. End Stage Renal Disease
34. Pulmonary Vein Stenosis
35. Urinary Tract Infection (UTI)
36. Adrenal Insufficiency
37. Cholecystitis

38. Wound Dehiscence
39. Extracellular Fluid Volume Depletion

Each of the above diagnoses appear to be related to Ms. Marquardt's underlying renal disease, the iatrogenic efforts made by the medical staff to diagnose and treat the underlying renal disease, the nosocomial infections resulting from her long hospital stay, problems caused by the inability of the medical staff to correct the fluid imbalance situation caused by her renal dysfunction, or from the effects of the long-term hospital stay and the decompensation caused by the overwhelming medical and emotional conditions.

Ms. Marquardt has been followed by her primary care physician Raymond Cole, D.O. 107 W. Chicago, Brooklyn, MI 49230, her nephrologists R.V. Nagesh, M.D., 205 N. East Avenue, Jackson, MI 49201, her pulmonologist Robert D. Albertson, M.D., 900 E. Michigan Avenue, Jackson, MI 49201, and her cardiologist Bishan Hassunizadeh, M.D., 205 Page Avenue, Suite B, Jackson, MI 49201.

The standards of care for anesthesiologists assisting in cardiac surgeries involving the use of cardiopulmonary bypass equipment and cardiac surgeons require that Trasylol not be used during cardiac valve procedures performed after November 2006, given the advisories issued by the FDA and Bayer. The standards of care for both specialties also require that Trasylol induced renal disease should be ruled out as soon as possible, if renal disease is diagnosed or suspected following a surgical procedure in which Trasylol was used. These same standards require the appropriate use of Heparin in conjunction with the concurrent use of Trasylol. The anti-coagulation effect of Heparin must be isolated from the overall anti-coagulation effect of Heparin and Trasylol in combination. Trasylol should not be used as a Heparin sparing agent. Additional Heparin therapy may be needed even if ACT levels are elevated. Protamine titration to measure Heparin therapeutic levels must be performed before the administration of Trasylol and that baseline level must be used to determine if Heparin is needed to maintain anti-coagulation therapy intra-operatively and post-operatively, given that the Trasylol in a renal insufficient patient might be long-lasting and affect anti-coagulation test results, leading to reduced Heparin therapy post-operatively. These standards of care also require the physician to identify, carefully monitor and effectively treat fluid levels to avoid cardiopulmonary complications due to fluid overload or due to extracellular fluid volume depletion. If diagnosed, Trasylol induced renal disease must be aggressively treated with appropriate anti-thrombotic drug therapy, and therapeutic Heparin levels must be implemented to counter the Trasylol induced coagulopathy. If Trasylol is indicated, the applicable standards of care require that a test dose of 1 ml be given at least ten minutes before the loading dose. Then the loading dose should be given slowly over a 20-30 minute time period after induction of anesthesia and before the sternotomy, while the patient is in a supine position. Then the constant infusion of the drug is begun and continued until the surgery is completed and the patient leaves the operating room.

The standards of care for nephrologists require that Trasylol be considered as a possible cause for acute prerenal kidney disease, when a patient in 2007 undergoes a mitral valve replacement and develops ARF within hours of that procedure. Trasylol induced kidney disease must be ruled out in such circumstances. If Heparin and Trasylol were both given during the procedure, then the standards of care require that the consulting nephrologist assess abnormal coagulation studies to determine whether or not

the abnormality is related to the anti-coagulation effect of Heparin or the anti-coagulation effect of Trasylol, and then treat the patient accordingly. These same standards require that the patient's fluid imbalance be assessed and treated appropriately. If the abnormal fluid level condition cannot be resolved effectively with diuretics and the patient has evidence of ARF, then the patient must be placed on some form of temporary dialysis to manage the fluid abnormality, especially if the fluid fluctuations are causing generalized edema, pulmonary edema and/or cardiac dysfunction. The fluid level fluctuations and renal function test results should not be treated symptomatically; instead, a cause must be established for the renal dysfunction and treated in a timely manner. The anti-coagulation effect of Heparin must be isolated from the overall anti-coagulation effect of Heparin and Trasylol in combination. Trasylol should not be used as a Heparin sparing agent. Additional Heparin therapy may be needed, even if ACT levels and other measures of hypocoagulation are elevated. If diagnosed, Trasylol induced renal disease must be aggressively treated with appropriate anti-thrombotic drug therapy, and therapeutic Heparin levels must be implemented to counter the Trasylol induced coagulopathy.

Drs. Haft and Vellaiah, together with their associates, residents and fellows, breached applicable standards of care for cardiac surgeons and/or anesthesiologists assisting in cardiac procedures in the following ways:

1. They used Trasylol incident to a mitral valve replacement procedure, despite the indications published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current on the indications for the drug and used the drug during an off-label procedure.
2. They used Trasylol for an off-label purpose, when the FDA and the manufacturer, who were aware of the off-label uses of the drug, cautioned against using the drug for any procedure other than a CABG procedure, until the drug's safety could be fully reviewed.
3. They ignored Ms. Marquardt's preoperative history of other drug allergies and renal insufficiency, which placed her at an increased risk of an allergic reaction to Trasylol and/or at an increased risk of further renal disease from the drug.
4. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.
5. They failed to take 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, before the sternotomy was performed and before the infusion of the drug was commenced.
6. They failed to adequately separate any coagulopathy caused by the Trasylol from any coagulopathy caused by Heparin therapy or the lack of that therapy, and, in so doing, they decreased or withheld Heparin therapy from the patient when she actually needed the therapy to counteract the Trasylol effects on the kidneys.
7. The failed to recognize the connection between Trasylol (thrombosis) and the hypocoagulopathy demonstrated in the laboratory results.
8. They failed to institute dialysis and/or appropriate diuretic therapy in a timely manner to maintain an appropriate fluid balance.

9. They failed to diagnose Trasylol induced renal disease, and treat it appropriately in a timely manner.
10. They failed to diagnose the prerenal disease caused by the Trasylol and recognize that the problems they were encountering in regards to pulmonary edema, cardiac dysfunction and other organ system failures were directly related to the renal disease, iatrogenic consequences of the inappropriate treatment protocols, nosocomial infections and/or from long periods of ventilation, decompensation and debilitation.

Drs. Haft and Vellaiah, together with their associates, residents and fellows, would have complied with applicable standards of care, if they had decided not to use Trasylol during Ms. Marquardt's mitral valve repair procedure on July 20, 2007, given the FDA and manufacturer warnings against using it for such procedures. If they felt that the procedure and patient warranted the use of Trasylol, then they needed to recognize the other risk factors presented by her prior drug allergies and pre-existing renal insufficiency. They also had to use the drug as indicated in the insert regarding a test dose, the loading dose and coagulation assessments during and after the procedure. They also had to rule out Trasylol induced renal disease given the problems that presented in the immediate postoperative period. Then they needed to treat the Trasylol induced renal disease, the coagulopathy, the fluid imbalance and the effects of the renal disease on other organ systems in a timely manner.

Dr. Saran, his associates, fellows and residents breached applicable standards of care in the following ways:

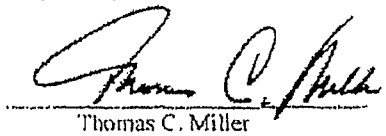
1. They failed to diagnose and treat Trasylol induced acute renal failure in a timely manner. In fact, the diagnosis was not mentioned at all in the various progress notes prepared by Nephrology over the many months that the department under the initial leadership of Dr. Saran.
2. They failed to institute timely dialysis to address an abnormal fluid level problem that was a major problem for many weeks. Instead, the problems were addressed with varying attempts at diuresis, which provided only temporary relief at best. Despite numerous suggestions to implement dialysis, the process was not started for more than one month following the onset of ARF.
3. They failed to appreciate that the obstructive prerenal kidney disease that appeared evident was caused by Trasylol, and that the patient needed to be placed on dialysis.
4. They failed to appreciate that despite the hypocoagulable the Trasylol related kidney disease needed to be treated with aggressive anti-coagulation therapy and anti-thombotic agents.

Dr. Saran, his associates, residents and fellows would have complied with applicable standards of care for nephrologists if they had diagnosed and treated the Trasylol induced renal failure in a timely manner. They also had to treat the fluid level problems with a temporary form of dialysis in a timely manner, given the significant problems in the pulmonary and cardiac systems that the fluid or lack of fluid was causing. The fluid levels, which were directly related to the underlying renal disease, needed to be treated by diagnosing the underlying disease process and by treating that disease process, not by using diuretics to try to remove the fluids. During the early treatment process, the

patient should have been placed on temporary dialysis to more effectively remove excess fluid to reduce the fluid overload or to increase fluid levels to force renal perfusion.

As a direct and proximate result of the above negligent acts by Drs. Haft, Saran, and Vellaiah (together with their associates, residents and fellows), Ms. Marquardt was given a contraindicated drug during her mitral valve repair procedure on July 20, 2007. This drug then caused a prerenal condition complicated by an obstructive condition of the kidneys. She also was suffering from a coagulopathy that was caused by the Trasylol, and aggravated by the lack of effective treatment in the postoperative period of time. Her renal disease, coagulopathy, multi-organ dysfunction, acidosis and a significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, severe depression, as she tried to cope with the lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months, was discharged on hemodialysis, is oxygen dependent due to changes in he lungs from the ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis, ongoing renal disease, ongoing liver disease, heart problems that must be treated with medication and severely debilitated. She went from an independent person who was able to perform all of her ADL's, except when her mitral valve failed, to a person totally dependent on he husband and others to perform her ADL's. She is also completely oxygen dependent and severely disabled due to the poor care and treatment she received during her four and one-half months of hospitalization. These problems are directly related to the complications from a drug she should not have been given and directly related to the ineffective care and treatment she was given thereafter.

Respectfully submitted,



Thomas C. Miller

TCM:mls

Exhibit 3

Approved, SCAO | Original - Court, 1st copy - Defendant | 2nd copy - Plaintiff, 3rd copy - Return

STATE OF MICHIGAN
JUDICIAL DISTRICT
Jud. of Cedars JUDICIAL CIRCUIT
COUNTY PROBATE

SUMMONS AND COMPLAINT

CASE NO. 10-444

Court address

Court telephone no.

ROSEMARIE E. AQUILINA

Plaintiff's name(s), address(es), and telephone no(s).	v	Defendant's name(s), address(es), and telephone no(s).
SANDRA D. MARQUARDT 3049 VILLAGE LANE BROOKLYN, MI 48230		THE UNIVERSITY OF MICHIGAN BOARD OF REGENTS (UNIVERSITY OF MICHIGAN HOSPITAL) ED REYNOLDS (ASST. GENERAL COUNSEL) 300 N. INGALLS #~~2108~~ 3B04 ANN ARBOR, MI ~~48109-0478~~
Plaintiff's attorney, bar no., address, and telephone no. THOMAS C. MILLER (P17786) P.O. BOX 785 SOUTHFIELD, MI 48037		RECEIVED BY JAN 22 2010 HEALTH SYSTEM LEGAL OFFICE

SUMMONS **NOTICE TO THE DEFENDANT:** In the name of the people of the State of Michigan you are notified:

1. You are being sued.
2. **YOU HAVE 21 DAYS** after receiving this summons to **file a written answer with the court** and serve a copy on the other party or **take other lawful action with the court** (28 days if you were served by mail or you were served outside this state). (MCR 2.111[C])
3. If you do not answer or take other action within the time allowed, judgment may be entered against you for the relief demanded in the complaint.

Issued	This summons expires*	Court clerk
JAN 19 2010	APR 20 2010	MIKE BRYANTON

*This summons is invalid unless served on or before its expiration date. This document must be sealed by the seal of the court.

COMPLAINT ***Instruction: The following is information that is required to be in the caption of every complaint and is to be completed by the plaintiff. Actual allegations and the claim for relief must be stated on additional complaint pages and attached to this form.***

Family Division Cases

☐ There is no other pending or resolved action within the jurisdiction of the family division of circuit court involving the family or family members of the parties.

☐ An action within the jurisdiction of the family division of the circuit court involving the family or family members of the parties has been previously filed in _____ Court.
The action ☐ remains ☐ is no longer pending. The docket number and the judge assigned to the action are:

Docket no.	Judge	Bar no.

General Civil Cases

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

☐ A civil action between these parties or other parties arising out of the transaction or occurrence alleged in the complaint has been previously filed in _____ Court.
The action ☐ remains ☐ is no longer pending. The docket number and the judge assigned to the action are:

Docket no.	Judge	Bar no.

VENUE

Plaintiff(s) residence (include city, township, or village)	Defendant(s) residence (include city, township, or village)
JACKSON COUNTY	WASHTENAW COUNTY

Place where action arose or business conducted
WASHTENAW COUNTY

01/19/2010
Date

Signature of attorney/plaintiff

If you require special accommodations to use the court because of a disability or if you require a foreign language interpreter to help you fully participate in court proceedings, please contact the court immediately to make arrangements.

MC 01 (3/08) **SUMMONS AND COMPLAINT** MCR 2.102(B)(11), MCR 2.104, MCR 2.105, MCR 2.107, MCR 2.113(C)(2)(a), (b), MCR 3.206(A)

1/19

PROOF OF SERVICE

SUMMONS AND COMPLAINT
Case No.

TO PROCESS SERVER: You are to serve the summons and complaint not later than 91 days from the date of filing or the date of expiration on the order for second summons. You must make and file your return with the court clerk. If you are unable to complete service you must return this original and all copies to the court clerk.

CERTIFICATE/AFFIDAVIT OF SERVICE/NONSERVICE

☐ **OFFICER CERTIFICATE**
I certify that I am a sheriff, deputy sheriff, bailiff, appointed court officer, or attorney for a party (MCR 2.104[A][2]), and that: (notarization not required)

OR

☐ **AFFIDAVIT OF PROCESS SERVER**
Being first duly sworn, I state that I am a legally competent adult who is not a party or an officer of a corporate party, and that: (notarization required)

☐ I served personally a copy of the summons and complaint,
☐ I served by registered or certified mail (copy of return receipt attached) a copy of the summons and complaint,
together with _____
List all documents served with the Summons and Complaint

_____ on the defendant(s):

Defendant's name	Complete address(es) of service	Day, date, time

☐ I have personally attempted to serve the summons and complaint, together with any attachments, on the following defendant(s) and have been unable to complete service.

Defendant's name	Complete address(es) of service	Day, date, time

I declare that the statements above are true to the best of my information, knowledge, and belief.

Service fee	Miles traveled	Mileage fee	Total fee
$		$	$

_____
Signature

_____
Name (type or print)

_____
Title

Subscribed and sworn to before me on _____ (Date), _____ County, Michigan.

My commission expires: _____ (Date) Signature: _____ (Deputy court clerk/Notary public)

Notary public, State of Michigan, County of _____

ACKNOWLEDGMENT OF SERVICE

I acknowledge that I have received service of the summons and complaint, together with _____ (Attachments)

_____ on _____ (Day, date, time)

_____ on behalf of _____
Signature

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

SANDRA D. MARQUARDT

PLAINTIFF

VS. CIVIL ACTION NO. 10-4 ~~MH~~ MK

ROSEMARIE E. AQUILINA

THE UNIVERSITY OF MICHIGAN BOARD OF REGENTS
(UNIVERSITY OF MICHIGAN HOSPITALS AND
HEALTH CENTERS)

DEFENDANT

/

THOMAS C. MILLER (P17786)
ATTORNEY FOR PLAINTIFF
P.O. BOX 785
SOUTHFIELD, MICHIGAN 48037
(248) 210-3211

/

COMPLAINT AND AFFIDAVIT OF MERIT

[There is no other pending or resolved civil action arising out of the same transaction or occurrence as alleged in the complaint.]

NOW COMES Plaintiff Sandra Marquardt, by and through their attorney Thomas C. Miller, and states:

1. Plaintiff resides in Jackson County.

2. Defendant maintains numerous health care facilities in Washtenaw County.

3. Defendant is the duly elected governing board for the University of Michigan, which operates the University of Michigan Hospitals and Health Centers.

4. Plaintiff claims an exemption from governmental immunity pursuant to MCL 691.1413.

5. The anesthesiologists and anesthesiology residents and fellows, who participated in the subject mitral valve surgery, were all employees and/or agents of Defendant.

6. The University of Michigan Hospitals and Health Centers was served with a notice of intent to sue on or about July 20, 2009, pursuant to MCL 600.2912b.

7. Plaintiff Sandra D. Marquardt was a patient at the University of Michigan Hospitals and Health Centers from July 17, 2007 through December 4, 2007. During that admission Ms. Marquardt underwent mitral valve replacement surgery on July 20, 2007.

8. Defendant, though its agents and employees, had a duty to provide medical and surgical care consistent with applicable standards of care for anesthesiologists. The standards of care for anesthesiologists, who are involved with cardiothoracic surgery to replace a mitral valve (after November 2006), require that the drug Trasylol not be used during such surgery given the changes made by the manufacturer regarding the indications for the use of the drug, and given the cautionary warnings issued by the FDA and the manufacturer prior to that date. The manufacturer's changes to its insert and the FDA advisories regarding the indications for the use of Trasylol clearly stated that the drug was to be used exclusively for patients with a risk of bleeding ***and*** who were undergoing coronary artery bypass graft surgery. Ms. Marquardt met neither of these indications. In addition to the published warnings detailed above, the standards of care would prohibit the use of Trasylol in a patient that had evidence of possible preoperative renal insufficiency. In addition Ms. Marquardt's history of other

d. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.

e. They failed to take the requisite 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, before the sternotomy was performed and before the infusion of the drug was commenced, as recommended by the manufacturer.

11. As a direct and proximate result of Ms. Marquardt being given Trasylol during her mitral valve replacement procedure on July 20, 2007, Ms. Marquardt developed a significant pre-renal condition complicated by an obstructive condition of the kidneys. She also was suffered from a coagulopathy that was caused by the Trasylol, and aggravated by the lack of effective treatment in the postoperative period of time. Her renal disease, coagulopathy, multi-organ dysfunction, acidosis and significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, and severe depression during her lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months. Upon discharge she was on hemodialysis; she was oxygen dependent upon discharge due to changes in he lungs from ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis; and she was discharged still suffering from renal disease, ongoing liver

disease, and heart problems that must be treated with an extensive array of drug therapies and continue to cause severe debilitation. Ms. Marquardt went from an independent person, who was able to perform all ADL's, except when her mitral valve failed, to a person totally dependent on he husband and others. These problems are more likely than not directly related to complications from the use of Trasylol during her cardiothoracic surgery.

12. As a result of the above injuries, Plaintiff Sandra D. Marquardt has suffered considerable pain, suffering, mental anguish, disability, lost income, and medical expenses. The injuries are likely permanent in nature, and the above damages will continue.

WHEREFORE, Plaintiff Sandra D. Marquardt request that this Court grant them a judgment that fairly, reasonably and adequately compensates them for their injuries and damages.

Respectfully submitted,

Thomas C. Miller (P17786)

Dated: January 18, 2010

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

SANDRA D. MARQUARDT

PLAINTIFFS

VS. CIVIL ACTION NO. NH

THE UNIVERSITY OF MICHIGAN BOARD OF REGENTS
(UNIVERSITY OF MICHIGAN HOSPITALS AND
HEALTH CENTERS)

DEFENDANT

AFFIDAVIT OF MERIT

I, Javier H. Campos, M.D., having been duly sworn, state:

1. I am licensed to practice medicine in the State of Iowa, and I was so licensed at all times relevant to this litigation.

2. I am a professor in anesthesiology and director of cardiothoracic anesthesia at the University of Iowa Healthcare

3. I am engaged in the full time clinical practice of anesthesia/cardiothoracic anesthesia, and I was so engaged at all times relevant to this litigation.

4. I have received and reviewed the notice of intent provided to me by counsel for Ms. Marquardt.

5. I have received and reviewed medical records from counsel for Ms. Marquardt.

6. I am familiar with the standards of care for anesthesiologists, as they relate to the indications for the use of Trasylol (after November 2006) during mitral valve replacement surgery.

7. The standards of care for anesthesiologists, who are involved with cardiothoracic surgery to replace a mitral valve (after November 2006), require that Trasylol not be used during such surgery given the changes made by the manufacturer regarding the indications for the use of the drug, and given the cautionary

warnings issued by the FDA and the manufacturer prior to that date. The manufacturer's changes to its insert and the FDA advisories regarding the indications for the use of Trasylol clearly indicated that the drug was to be used exclusively for patients with a risk of bleeding ***and*** who were undergoing coronary artery bypass graft surgery. In addition to the published warnings detailed above, the standards of care would prohibit the use of Trasylol in a patient that had evidence of possible preoperative renal insufficiency. Once the decision was reached to administer the Trasylol, the standards of care required that a test dose be administered ten minutes before the loading dose, and that the administration of the loading dose be accomplished over a 20-30 minute time period before the sternotomy and before the infusing of the drug began.

8. The anesthesiologists, who were involved with the subject mitral valve replacement procedure, breached the applicable standards of care, as they relate to the use of Trasylol, in the following ways:

   a. They used Trasylol before and during mitral valve replacement surgery, despite the revised indications and warnings published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current regarding the indications and warnings regarding Trasylol, and used the drug during off-label surgery.
   b. They used Trasylol during off-label mitral valve replacement surgery, when the FDA and the manufacturer, who were aware of such off-label uses for the drug, cautioned against using the drug for any procedure other than a CABG procedure where the patient was at an increased risk of bleeding, until the drug's safety could be fully reviewed.
   c. They also ignored Ms. Marquardt's preoperative history of other drug allergies and possible renal insufficiency, which placed her at an increased risk of a reaction to Trasylol and/or at an increased risk of further renal disease from the drug.
   d. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.
   e. They failed to take the requisite 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, as recommended by the manufacturer.

9. The anesthesiologists that participated in the mitral valve replacement surgery on Ms. Marquardt would have complied with applicable standards of care, if they had insisted that Trasylol not be used, in light of the FDA warnings and the changes made by the manufacturer regarding the indications for use of the drug. Additionally, an alternative drug should have been used due to the patient's preoperative evidence of possible renal insufficiency and the patient's history of other drug allergies.

10. As a direct and proximate result of Ms. Marquardt being given Trasylol during her mitral valve replacement procedure on July 20, 2007, Ms. Marquardt

developed a significant renal condition complicated by an obstructive condition of the kidneys. Her renal disease, coagulopathy, multi-organ dysfunction, acidosis and significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, and severe depression during her lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months. Upon discharge she was on hemodialysis; she was oxygen dependent upon discharge due to changes in he lungs from ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis; and she was discharged still suffering from renal disease, ongoing liver disease, and heart problems that must be treated with an extensive array of drug therapies and continue to cause severe debilitation. Ms. Marquardt went from an independent person, who was able to perform all ADL's, except when her mitral valve failed, to a person totally dependent on her husband and others. These problems are more likely than not directly related to complications from the use of Trasylol during her cardiothoracic surgery.

Respectfully submitted,

Javier H. Campos, M.D.

STATE OF IOWA)
§
COUNTY OF)

On the 15 day of January, 2010, Javier H. Campos, M.D. appeared before me, a Notary Public, personally and being duly sworn, acknowledged signing this Affidavit of Merit as her/his free act and deed.

, Notary Public
Johnson County, Iowa
My Commission Expires: 4/7/12

Exhibit 4

Approved, SCAO

JIS CODE: LET

STATE OF MICHIGAN PROBATE COURT COUNTY OF JACKSON	LETTERS OF AUTHORITY FOR PERSONAL REPRESENTATIVE	FILE NO. 10011754 -DE

Estate of SANDRA D. MARQUARDT (DEC)

TO:

Name and address	Telephone no.
SARON E. MARQUARDT 3049 VILLAGE LANE BROOKLYN, MI 49230	(517) 917-5889

You have been appointed and qualified as personal representative of the estate on 06/14/2010 (Date). You are authorized to perform all acts authorized by law unless exceptions are specified below.

☐ Your authority is limited in the following way:

☐ You have no authority over the estate's real estate or ownership interests in a business entity that you identified on your acceptance of appointment.

☐ Other restrictions or limitations are:

☐ These letters expire: _____ (Date)

06/14/2010
Date

Judge (formal proceedings)/Register (informal proceedings) Bar no.

SEE NOTICE OF DUTIES ON SECOND PAGE

THOMAS C. MILLER (P17786)
Attorney name (type or print) Bar no.

P.O. BOX 785
Address

SOUTHFIELD, MI 48037 (248) 210-3211
City, state, zip Telephone no.

I certify that I have compared this copy with the original on file and that it is a correct copy of the original, and on this date, these letters are in full force and effect.

JUN 23 2010
Date

Deputy register

Do not write below this line - For court use only

FILED
JUN 14 2010
Jackson County Probate Court

TRUE COPY
of the original on file
in said Proceedings.
JUN 23 2010
Jackson County Probate Court

The following provisions are mandatory reporting duties specified in Michigan law and Michigan court rules and are not the only duties required of you. See MCL 700.3701 through MCL 700.3722 for other duties. Your failure to comply may result in the court suspending your powers and appointing a special fiduciary in your place. It may also result in your removal as fiduciary.

CONTINUED ADMINISTRATION: If the estate is not settled within 1 year after the first personal representative's appointment, you must file with the court and send to each interested person a notice that the estate remains under administration, specifying the reasons for the continued administration. You must give this notice within 28 days of the first anniversary of the first personal representative's appointment and all subsequent anniversaries during which the administration remains uncompleted. If such a notice is not received, an interested person may petition the court for a hearing on the necessity for continued administration or for closure of the estate. [MCL 700.3703(4), MCL 700.3951(3), MCR 5.144, MCR 5.307, MCR 5.310]

DUTY TO COMPLETE ADMINISTRATION OF ESTATE: You must complete the administration of the estate and file appropriate closing papers with the court. Failure to do so may result in personal assessment of costs. [MCR 5.310]

CHANGE OF ADDRESS: You are required to inform the court and all interested persons of any change in your address within 7 days of the change.

Additional Duties for Supervised Administration

If this is a supervised administration, in addition to the above reporting duties, you are also required to prepare and file with this court the following written reports or information.

INVENTORY: You are required to file with the probate court an inventory of the assets of the estate within 91 days of the date your letters of authority are issued or as ordered by the court. You must send a copy of the inventory to all presumptive distributees and all other interested persons who request it. The inventory must list in reasonable detail all the property owned by the decedent at the time of death. Each listed item must indicate the fair market value at the time of the decedent's death and the type and amount of any encumbrance. If the value of any item has been obtained through an appraiser, the inventory should include the appraiser's name and address with the item or items appraised by that appraiser. You must also provide the name and address of each financial institution listed on your inventory at the time the inventory is presented to the court. The address for a financial institution shall be either that of the institution's main headquarters or the branch used most frequently by the personal representative. [MCL 700.3706, MCR 5.307, MCR 5.310(E)]

ACCOUNTS: You are required to file with this court once a year, either on the anniversary date that your letters of authority were issued or on another date you choose (you must notify the court of this date) or more often if the court directs, a complete itemized accounting of your administration of the estate. This itemized accounting must show in detail all income and disbursements and the remaining property, together with the form of the property. Subsequent annual and final accountings must be filed within 56 days following the close of the accounting period. When the estate is ready for closing, you are also required to file a final account with a description of property remaining in the estate. All accounts must be served on the required persons at the same time they are filed with the court, along with proof of service.

ESTATE (OR INHERITANCE) TAX INFORMATION: You are required to submit to the court proof that no estate (or inheritance) taxes are due or that the estate (or inheritance) taxes have been paid. Note: The estate may be subject to inheritance tax.

Additional Duties for Unsupervised Administration

If this is an unsupervised administration, in addition to the above reporting duties, you are also required to prepare and provide to all interested persons the following written reports or information.

INVENTORY: You are required to prepare an inventory of the assets of the estate within 91 days from the date your letters of authority are issued and to send a copy of the inventory to all presumptive distributees and all other interested persons who request it. You are also required within 91 days from the date your letters of authority are issued, to submit to the court the information necessary to calculate the probate inventory fee that you must pay to the probate court. You may use the original inventory for this purpose. [MCL 700.3706, MCR 5.307]

ESTATE (OR INHERITANCE) TAX INFORMATION: You may be required to submit to the court proof that no estate (or inheritance) taxes are due or that the estate (or inheritance) taxes have been paid. Note: The estate may be subject to inheritance tax.

Exhibit 5

LAW OFFICES
OF
THOMAS C. MILLER
P.O. BOX 785
SOUTHFIELD, MICHIGAN 48037
248-210-3211

September 2, 2011

Jonathan W. Haft, M.D.
University of Michigan Cardiovascular Center
Section of Cardiac Surgery
1500 E. Medical Center Drive, Floor 3
Ann Arbor, MI 48109-5853

Re: Sandra D. Marquardt

Dear Dr. Haft:

You are hereby notified that Sandra D. Marquardt intends to file suit against Jonathan Haft, M.D., and Vellaiah Durai Umashankar, M.D. upon the expiration of 182 days from the above date. This notice is being provided pursuant to MCL 600.2912b. This same statute places certain requirements upon each of you as well. One of those obligations is to provide the undersigned with a notice of meritorious defense, which must be provided within 154 days from the date above.

Ms. Marquardt's medical history is well documented in the University of Michigan Hospitals and Medical Centers' chart covering the above admission. Ms. Marquardt agrees that it contains the relevant medical history necessary for this notice of intent. In addition, all of the relevant medical treatment regarding this notice of intent is contained in that hospital chart. Certain portions of the care and treatment provided to Ms. Marquardt should be highlighted below, so that there is sufficient context to explain the claims being made below.

Ms. Marquardt was known to have suffered drug reactions to penicillin and ceftriaxone. Her baseline or pre-operative renal function studies revealed some degree of renal insufficiency. Specifically, her pre-operative creatinine level was reported to be 1.4 (on two occasions), her pre-operative BUN level was reported to be 21 (on two

9/2

occasions) and there was evidence of significant levels of blood in her pre-operative urinalysis.

Dr. Haft admitted Ms. Marquardt in order to stabilize her cardiovascular status before performing a mitral valve replacement procedure. He was particularly interested in getting her off her Coumadin and onto IV Heparin, so that her coagulation could be more closely controlled during and after the surgery. He wanted the INR to be equal to or less than 2.0 and he wanted her PTT levels to be between 50 and 70 before proceeding with the surgery. Her INR was 2.8 on admission and had fallen to 1.6 by July 19th. Her PTT was 42.9 on admission and fell to 33.7 by July 19th. He initially planned on surgery for July 24th; however, that date was subsequently moved up to July 20th.

The Anesthesia Record, which was prepared incident to the mitral valve replacement procedure performed on July 20th, established the following timeline:

1. The anesthesia was started at 0645.
2. The patient was brought to the operating room at 0702.
3. The anesthesia induction ended at 0801.
4. The patient was placed in the left lateral decubitus position at 0804.
5. The baseline ACT was drawn at 0804 and reported to be 157 (the exact equipment used is not reflected on the chart).
6. The surgical incision was made at 0839. [**No test dose or loading dose of Trasylol was administered before the incision and thoracotomy as required by the manufacturer in its insert.**]
7. The 200 ml loading dose of Trasylol was given at 0909. [**No test dose was given before the loading dose, as required by the manufacturer in its insert.**]
8. The first ACT level obtained after the loading dose of Trasylol was reported as 999, which was apparently the highest level that could be digitally displayed by the equipment, at about 0915.
9. The Trasylol infusion dose of 50 ml/hr was begun at 0918.
10. The first dose of Heparin was administered at 0930. [There was confusion in the record as to the exact dosage given at that time. The written chronology indicates that 25,000 units were given. The graphic summary indicates that 2,500 units were given; however, the total on the graphic summary indicates that 35,000 total units were given during the procedure, which would have included 10,000 units at 1230. Dr. Haft indicates in his operative report that she was "systemically heparinized with 3 mg/kg sodium heparin", which would mean that she was given about 250 mg. given her known weight of 77.1 kg.]
11. Full cardiopulmonary bypass was initiated at 0942.
12. The first ACT level obtained after the Trasylol and Heparin were given reflected a continuing level of 999 at 1015.
13. The ACT level obtained at about 1115 revealed a level of 545.
14. The ACT level obtained at about 1215 revealed a level of 499.
15. The second dose of Heparin containing 10,000 or 1,000 units was given at 1230.
16. The ACT level obtained at about 1300 revealed a level of 387.

17. The cardiopulmonary bypass was terminated at 1311. [**The total time spent on the bypass equipment was reported by Dr. Haft to have been 209 minutes.**]
18. The ACT level obtained at about 1315 revealed a level of 590.
19. A 250 mg dose of Protamine was given at about 1330.
20. A 50 mg dose of Protamine was given at about 1400.
21. The ACT level obtained at about 1400 revealed a level of 158.
22. The surgical dressing was completed at 1445.
23. The patient was transferred to the TICU at 1501.
24. The anesthesia was ended at 1515.
25. The Trasylol infusion was terminated at about 1530.

In January 2006 a group of physicians and research experts published the results of an extensive study comparing the drug Trasylol with two other similar acting drugs. Their findings were accepted for publication in the prestigious *New England Journal of Medicine*. That article, together with a similar smaller study published in the March 2006 issue of *Transfusion*, began to raise serious questions about the safety of Trasylol. The FDA apparently became aware of those two studies and responded by publishing a "Public Health Advisory for Trasylol" dated February 8, 2006. In that advisory they informed the medical profession, particularly the cardiac surgeons and anesthesiologists, that they were aware of two studies that were reporting an increased risk of death and serious injury due to renal and heart disease incident to the use of Trasylol, when compared to the incidence of such results in patients who received two similar acting drugs. Following the FDA investigation and following consultations with the drug's manufacturer, the FDA adopted a revised insert to be distributed to all physicians who were the end users of the drug. That new insert was published and made available to the relevant physicians in November 2006. In that publication the manufacturer added additional information and cautionary content regarding the risk of renal, cardiac and vascular risks with the use of the drug. Of particular note was the manufacturer's "Indications and Usage" section. Trasylol was indicated for prophylactic use to reduce perioperative blood loss and the need for blood transfusion in **patients undergoing cardiopulmonary bypass in the course of coronary artery bypass graft surgery who are at an increased risk for blood loss and blood transfusion.**

It should be noted that the earlier insert also limited the indications to patients undergoing coronary artery bypass graft procedures in which cardiopulmonary bypass equipment was used; however, both the medical specialists involved and the manufacturer itself were aware that the drug was being used for off-label surgeries including cardiac valve replacements. In December 2006 the FDA again advised the medical community that it was very concerned about Trasylol; however, it wanted more information before making a decision regarding the safety of the drug. The FDA requested and Bayer agreed to inform its customers that the drug was to be used in strict compliance with the insert. Specifically, the manufacturer told its users to adhere strictly to the indications contained in the old and new insert, i.e. it was to be used only in CABG procedures. The FDA issued a press release regarding the new insert in December 2006, and Bayer drafted a form letter, which it sent to each of its customers in the same month. The FDA indicated that it wanted the physicians to "understand the new warnings and use the product as directed by the [insert]". The new insert specifically stated that the

drug was to be used only during CABG procedures. In the December letter the company also made it very clear to the physicians that the drug was to be used incident to CABG procedures only. They also advised the physicians of the renal and cardiac risks raised in the literature. The letter highlighted the changes in the new insert, which had been published in November 2006. It is believed that the information from the FDA and from Bayer was communicated directly to Dr. Haft, Dr. Umashankar and/or the University of Michigan Hospitals and Medical Centers in late 2006.

The revised 2006 insert made many critical points relevant to the facts in this matter. First, the use of the drug was to be restricted to CABG procedures, and was not to be used for valve replacement procedures. Second, patients with pre-existing renal insufficiency were at an increased risk of developing renal complications from the use of Trasylol. Third, patients with other drug allergies were more likely to have a reaction to Trasylol. Fourth, a test dose of Trasylol was to be given at least ten minutes before the loading dose of the drug. Fifth, the loading dose was to be given over a 20-30 minute time period before infusion of the drug. Sixth, the patient was to be placed in a supine position during administration of the test dose and the loading dose. Seventh, the patient was to be closely monitored closely for possible coagulopathy when Trasylol and Heparin were administered concurrently. An elevated ACT level might not reflect a high therapeutic level of Heparin, when Heparin was administered concurrently with Trasylol. Eighth, Protamine titration should be used to establish the adequacy of Heparin levels before any Trasylol is given, so that the anti-coagulation effects of the two drugs can be separated, and so that the results of that titration could be used to determine the effect of the Heparin therapy throughout the operative and post-operative phases. Ninth, the therapeutic level of Heparin must be kept above certain levels during the procedure (reflected by careful monitoring of coagulation studies) independent of the anti-coagulation effect created by the Trasylol given concurrently with Heparin.

The medical records of Ms. Marquardt reflect that no test dose of Trasylol was administered ten minutes before the loading dose. The patient was not in a supine position when she was given the loading dose of Trasylol. The loading dose was not given slowly over a 20-30 minute period of time (only nine minutes separated the loading dose from the start of the infusion of Trasylol). Ms. Marquardt had a history of two different drug allergies. The procedure was a valve replacement procedure and not a CABG procedure. Ms. Marquardt did have evidence of pre-operative kidney dysfunction. Lastly, she was not closely monitored after the administration of Trasylol and Heparin to determine the anti-coagulation effect of Heparin alone versus the synergistic anti-coagulation effect of the two drugs in combination.

Following the surgery, during which Ms. Marquardt received Heparin and Trasylol, she began to manifest significant clinical signs and symptoms of renal disease, which led to multiple other organ system problems. The lack of attention to her renal complications from the Trasylol resulted in other iatrogenic complications and nosocomial infections. Despite numerous medical diagnoses formulated by the numerous physicians who treated Ms. Marquardt over the four months of post-operative care, the diagnosis of Trasylol induced pathology never appeared. It was not even mentioned as part of anyone's differential diagnoses. The various treating physicians did proffer opinions regarding the etiology of her renal disease specifically that they were post-op complications and that may have been related to the lengthy period of time spent on the

bypass equipment; however, they never once mentioned the drug Trasylol as a possible factor.

During the time Ms. Marquardt was an inpatient at the University of Michigan Hospital; the following diagnoses were made and repeated often by the various physicians charged with providing her with care for her post-operative complications:

1. Various nosocomial infections, bacteremia and sepsis.
2. Hyperglycemia secondary to surgical stress requiring Tight Glycemic Control
3. Oliguric
4. Diminished Coronary Output/Coronary Index
5. Hemolysis secondary to long coronary bypass machine time
6. Fluid overload
7. Renal Hypoperfusion
8. Polyuric Renal Failure secondary to prolonged pump time
9. Acute Tubular Necrosis (ATN)
10. Hyperphosphatemia
11. Acute Kidney Injury (AKI) secondary to ATN
12. Hypotension
13. Pulmonary Edema
14. Non-oliguric Renal Failure
15. Acute Respiratory Distress Syndrome (ARDS)
16. Systemic Inflammatory Response Syndrome (SIRS)
17. Prolonged Respiratory Failure
18. Hematuria
19. Metabolic Acidosis
20. Pleural Effusion
21. Swallowing Dysfunction
22. Hypothyroidism
23. Hypercarbia
24. Hypoxemia
25. Clinical Depression
26. Peri-operative vascular leak
27. Respiratory Acidosis
28. Anemia
29. Atrial Fibrillation
30. Sick Euthyroid Syndrome
31. Prerenal Azotemia
32. Moderate Differentiated Encephalopathy
33. End Stage Renal Disease
34. Pulmonary Vein Stenosis
35. Urinary Tract Infection (UTI)
36. Adrenal Insufficiency
37. Cholecystitis
38. Wound Dehiscence
39. Extracellular Fluid Volume Depletion

Each of the above diagnoses appear to be related to Ms. Marquardt's underlying

renal disease, the iatrogenic efforts made by the medical staff to diagnose and treat the underlying renal disease, the nosocomial infections resulting from her long hospital stay, problems caused by the inability of the medical staff to correct the fluid imbalance situation caused by her renal dysfunction, or from the effects of the long-term hospital stay and the decompensation caused by the overwhelming medical and emotional conditions.

Ms. Marquardt has been followed by her primary care physician Raymond Cole, D.O, 107 W. Chicago, Brooklyn, MI 49230, her nephrologists R.V. Nagesh, M.D., 205 N. East Avenue, Jackson, MI 49201, her pulmonologist Robert D. Albertson, M.D., 900 E. Michigan Avenue, Jackson, MI 49201, and her cardiologist Bischan Hassunizadeh, M.D., 205 Page Avenue, Suite B, Jackson, MI 49201.

The standards of care for anesthesiologists and cardio-thoracic surgeons assisting in cardiac surgeries involving the use of cardiopulmonary bypass equipment require that Trasylol not be used during cardiac valve procedures performed after November 2006, given the advisories issued by the FDA and Bayer. The standards of care for both specialties also require that Trasylol induced renal disease should be ruled out as soon as possible, if renal disease is diagnosed or suspected following a surgical procedure in which Trasylol was used. These same standards require the appropriate use of Heparin in conjunction with the concurrent use of Trasylol. The anti-coagulation effect of Heparin must be isolated from the overall anti-coagulation effect of Heparin and Trasylol in combination. Trasylol should not be used as a Heparin sparing agent. Additional Heparin therapy may be needed even if ACT levels are elevated. Protamine titration to measure Heparin therapeutic levels must be performed before the administration of Trasylol and that baseline level must be used to determine if Heparin is needed to maintain anti-coagulation therapy intra-operatively and post-operatively, given that the Trasylol in a renal insufficient patient might be long-lasting and affect anti-coagulation test results, leading to reduced Heparin therapy post-operatively. These standards of care also require the physician to identify, carefully monitor and effectively treat fluid levels to avoid cardiopulmonary complications due to fluid overload or due to extracellular fluid volume depletion. If diagnosed, Trasylol induced renal disease must be aggressively treated with appropriate anti-thrombotic drug therapy, and therapeutic Heparin levels must be implemented to counter the Trasylol induced coagulopathy. If Trasylol is indicated, the applicable standards of care require that a test dose of 1 ml be given at least ten minutes before the loading dose. Then the loading dose should be given slowly over a 20-30 minute time period after induction of anesthesia and before the sternotomy, while the patient is in a supine position. Then the constant infusion of the drug is begun and continued until the surgery is completed and the patient leaves the operating room.

Drs. Haft and Umashankar, together with their associates, residents and fellows, breached applicable standards of care for cardiac surgeons and/or anesthesiologists assisting in cardiac procedures in the following ways:

1. They used Trasylol incident to a mitral valve replacement procedure, despite the indications published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current on the indications for the drug and used the drug during an off-label procedure.
2. They used Trasylol for an off-label purpose, when the FDA and the manufacturer, who were aware of the off-label uses of the drug, cautioned

against using the drug for any procedure other than a CABG procedure, until the drug's safety could be fully reviewed.

3. They ignored Ms. Marquardt's preoperative history of other drug allergies and renal insufficiency, which placed her at an increased risk of an allergic reaction to Trasylol and/or at an increased risk of further renal disease from the drug.
4. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.
5. They failed to take 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, before the sternotomy was performed and before the infusion of the drug was commenced.
6. They failed to adequately separate any coagulopathy caused by the Trasylol from any coagulopathy caused by Heparin therapy or the lack of that therapy, and, in so doing, they decreased or withheld Heparin therapy from the patient when she actually needed the therapy to counteract the Trasylol effects on the kidneys.
7. The failed to recognize the connection between Trasylol (thrombosis) and the hypocoagulopathy demonstrated in the laboratory results.
8. They failed to institute dialysis and/or appropriate diuretic therapy in a timely manner to maintain an appropriate fluid balance.
9. They failed to diagnose Trasylol induced renal disease, and treat it appropriately in a timely manner.
10. They failed to diagnose the prerenal disease caused by the Trasylol and recognize that the problems they were encountering in regards to pulmonary edema, cardiac dysfunction and other organ system failures were directly related to the renal disease, iatrogenic consequences of the inappropriate treatment protocols, nosocomial infections and/or from long periods of ventilation, decompensation and debilitation.

Drs. Haft and Umashankar, together with their associates, residents and fellows, would have complied with applicable standards of care, if they had decided not to use Trasylol during Ms. Marquardt's mitral valve repair procedure on July 20, 2007, given the FDA and manufacturer warnings against using it for such procedures. If they felt that the procedure and patient warranted the use of Trasylol, then they needed to recognize the other risk factors presented by her prior drug allergies and pre-existing renal insufficiency. They also had to use the drug as indicated in the insert regarding a test dose, the loading dose and coagulation assessments during and after the procedure. They also had to rule out Trasylol induced renal disease given the problems that presented in the immediate postoperative period. Then they needed to treat the Trasylol induced renal disease, the coagulopathy, the fluid imbalance and the effects of the renal disease on other organ systems in a timely manner.

As a direct and proximate result of the above negligent acts by Drs. Haft and Umashankar (together with their associates, residents and fellows), Ms. Marquardt was given a contraindicated drug during her mitral valve repair procedure on July 20, 2007. This drug then caused a prerenal condition complicated by an obstructive condition of the kidneys. She also was suffering from a coagulopathy that was caused by the Trasylol, and aggravated by the lack of effective treatment in the postoperative period of time. Her

renal disease, coagulopathy, multi-organ dysfunction, acidosis and a significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, severe depression, as she tried to cope with the lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months, was discharged on hemodialysis, is oxygen dependent due to changes in he lungs from the ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis, ongoing renal disease, ongoing liver disease, heart problems that must be treated with medication and severely debilitated. Her multiple medical problems that began following the above surgery and post-operative complications eventually led to her death on January 27, 2010. She went from an independent person who was able to perform all of her ADL's, except when her mitral valve failed, to a person totally dependent on he husband and others to perform her ADL's and eventually death from renal failure complications. She was also completely oxygen dependent and severely disabled due to the poor care and treatment she received during her four and one-half months of hospitalization. These problems were directly related to the complications from a drug she should not have been given and directly related to the ineffective care and treatment she was given thereafter.

Respectfully submitted,

Thomas C. Miller

TCM:mls

Exhibit 6

LAW OFFICES
OF
THOMAS C. MILLER
P.O. BOX 785
SOUTHFIELD, MICHIGAN 48037
248-210-3211

September 2, 2011

Vellaiah Durai Umashankar, M.D.
c/o University of Michigan Cardiovascular Center
Department of Anesthesia
1500 E. Medical Center Drive, SPC 5861
Ann Arbor, MI 48109

Re: Sandra D. Marquardt

Dear Dr. Umashankar:

You are hereby notified that Sandra D. Marquardt intends to file suit against Jonathan Haft, M.D., and Vellaiah Durai Umashankar, M.D. upon the expiration of 182 days from the above date. This notice is being provided pursuant to MCL 600.2912b. This same statute places certain requirements upon each of you as well. One of those obligations is to provide the undersigned with a notice of meritorious defense, which must be provided within 154 days from the date above.

Ms. Marquardt's medical history is well documented in the University of Michigan Hospitals and Medical Centers' chart covering the above admission. Ms. Marquardt agrees that it contains the relevant medical history necessary for this notice of intent. In addition, all of the relevant medical treatment regarding this notice of intent is contained in that hospital chart. Certain portions of the care and treatment provided to Ms. Marquardt should be highlighted below, so that there is sufficient context to explain the claims being made below.

Ms. Marquardt was known to have suffered drug reactions to penicillin and ceftriaxone. Her baseline or pre-operative renal function studies revealed some degree of renal insufficiency. Specifically, her pre-operative creatinine level was reported to be 1.4 (on two occasions), her pre-operative BUN level was reported to be 21 (on two

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occasions) and there was evidence of significant levels of blood in her pre-operative urinalysis.

Dr. Haft admitted Ms. Marquardt in order to stabilize her cardiovascular status before performing a mitral valve replacement procedure. He was particularly interested in getting her off her Coumadin and onto IV Heparin, so that her coagulation could be more closely controlled during and after the surgery. He wanted the INR to be equal to or less than 2.0 and he wanted her PTT levels to be between 50 and 70 before proceeding with the surgery. Her INR was 2.8 on admission and had fallen to 1.6 by July 19th. Her PTT was 42.9 on admission and fell to 33.7 by July 19th. He initially planned on surgery for July 24th; however, that date was subsequently moved up to July 20th.

The Anesthesia Record, which was prepared incident to the mitral valve replacement procedure performed on July 20th, established the following timeline:

1. The anesthesia was started at 0645.
2. The patient was brought to the operating room at 0702.
3. The anesthesia induction ended at 0801.
4. The patient was placed in the left lateral decubitus position at 0804.
5. The baseline ACT was drawn at 0804 and reported to be 157 (the exact equipment used is not reflected on the chart).
6. The surgical incision was made at 0839. [**No test dose or loading dose of Trasylol was administered before the incision and thoracotomy as required by the manufacturer in its insert.**]
7. The 200 ml loading dose of Trasylol was given at 0909. [**No test dose was given before the loading dose, as required by the manufacturer in its insert.**]
8. The first ACT level obtained after the loading dose of Trasylol was reported as 999, which was apparently the highest level that could be digitally displayed by the equipment, at about 0915.
9. The Trasylol infusion dose of 50 ml/hr was begun at 0918.
10. The first dose of Heparin was administered at 0930. [There was confusion in the record as to the exact dosage given at that time. The written chronology indicates that 25,000 units were given. The graphic summary indicates that 2,500 units were given; however, the total on the graphic summary indicates that 35,000 total units were given during the procedure, which would have included 10,000 units at 1230. Dr. Haft indicates in his operative report that she was "systemically heparinized with 3 mg/kg sodium heparin", which would mean that she was given about 250 mg. given her known weight of 77.1 kg.]
11. Full cardiopulmonary bypass was initiated at 0942.
12. The first ACT level obtained after the Trasylol and Heparin were given reflected a continuing level of 999 at 1015.
13. The ACT level obtained at about 1115 revealed a level of 545.
14. The ACT level obtained at about 1215 revealed a level of 499.
15. The second dose of Heparin containing 10,000 or 1,000 units was given at 1230.
16. The ACT level obtained at about 1300 revealed a level of 387.

17. The cardiopulmonary bypass was terminated at 1311. [**The total time spent on the bypass equipment was reported by Dr. Haft to have been 209 minutes.**]
18. The ACT level obtained at about 1315 revealed a level of 590.
19. A 250 mg dose of Protamine was given at about 1330.
20. A 50 mg dose of Protamine was given at about 1400.
21. The ACT level obtained at about 1400 revealed a level of 158.
22. The surgical dressing was completed at 1445.
23. The patient was transferred to the TICU at 1501.
24. The anesthesia was ended at 1515.
25. The Trasylol infusion was terminated at about 1530.

In January 2006 a group of physicians and research experts published the results of an extensive study comparing the drug Trasylol with two other similar acting drugs. Their findings were accepted for publication in the prestigious *New England Journal of Medicine*. That article, together with a similar smaller study published in the March 2006 issue of *Transfusion*, began to raise serious questions about the safety of Trasylol. The FDA apparently became aware of those two studies and responded by publishing a "Public Health Advisory for Trasylol" dated February 8, 2006. In that advisory they informed the medical profession, particularly the cardiac surgeons and anesthesiologists, that they were aware of two studies that were reporting an increased risk of death and serious injury due to renal and heart disease incident to the use of Trasylol, when compared to the incidence of such results in patients who received two similar acting drugs. Following the FDA investigation and following consultations with the drug's manufacturer, the FDA adopted a revised insert to be distributed to all physicians who were the end users of the drug. That new insert was published and made available to the relevant physicians in November 2006. In that publication the manufacturer added additional information and cautionary content regarding the risk of renal, cardiac and vascular risks with the use of the drug. Of particular note was the manufacturer's "Indications and Usage" section. Trasylol was indicated for prophylactic use to reduce perioperative blood loss and the need for blood transfusion in **patients undergoing cardiopulmonary bypass in the course of coronary artery bypass graft surgery who are at an increased risk for blood loss and blood transfusion.**

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drug was to be used only during CABG procedures. In the December letter the company also made it very clear to the physicians that the drug was to be used incident to CABG procedures only. They also advised the physicians of the renal and cardiac risks raised in the literature. The letter highlighted the changes in the new insert, which had been published in November 2006. It is believed that the information from the FDA and from Bayer was communicated directly to Dr. Haft, Dr. Umashankar and/or the University of Michigan Hospitals and Medical Centers in late 2006.

The revised 2006 insert made many critical points relevant to the facts in this matter. First, the use of the drug was to be restricted to CABG procedures, and was not to be used for valve replacement procedures. Second, patients with pre-existing renal insufficiency were at an increased risk of developing renal complications from the use of Trasylol. Third, patients with other drug allergies were more likely to have a reaction to Trasylol. Fourth, a test dose of Trasylol was to be given at least ten minutes before the loading dose of the drug. Fifth, the loading dose was to be given over a 20-30 minute time period before infusion of the drug. Sixth, the patient was to be placed in a supine position during administration of the test dose and the loading dose. Seventh, the patient was to be closely monitored closely for possible coagulopathy when Trasylol and Heparin were administered concurrently. An elevated ACT level might not reflect a high therapeutic level of Heparin, when Heparin was administered concurrently with Trasylol. Eighth, Protamine titration should be used to establish the adequacy of Heparin levels before any Trasylol is given, so that the anti-coagulation effects of the two drugs can be separated, and so that the results of that titration could be used to determine the effect of the Heparin therapy throughout the operative and post-operative phases. Ninth, the therapeutic level of Heparin must be kept above certain levels during the procedure (reflected by careful monitoring of coagulation studies) independent of the anti-coagulation effect created by the Trasylol given concurrently with Heparin.

The medical records of Ms. Marquardt reflect that no test dose of Trasylol was administered ten minutes before the loading dose. The patient was not in a supine position when she was given the loading dose of Trasylol. The loading dose was not given slowly over a 20-30 minute period of time (only nine minutes separated the loading dose from the start of the infusion of Trasylol). Ms. Marquardt had a history of two different drug allergies. The procedure was a valve replacement procedure and not a CABG procedure. Ms. Marquardt did have evidence of pre-operative kidney dysfunction. Lastly, she was not closely monitored after the administration of Trasylol and Heparin to determine the anti-coagulation effect of Heparin alone versus the synergistic anti-coagulation effect of the two drugs in combination.

Following the surgery, during which Ms. Marquardt received Heparin and Trasylol, she began to manifest significant clinical signs and symptoms of renal disease, which led to multiple other organ system problems. The lack of attention to her renal complications from the Trasylol resulted in other iatrogenic complications and nosocomial infections. Despite numerous medical diagnoses formulated by the numerous physicians who treated Ms. Marquardt over the four months of post-operative care, the diagnosis of Trasylol induced pathology never appeared. It was not even mentioned as part of anyone's differential diagnoses. The various treating physicians did proffer opinions regarding the etiology of her renal disease specifically that they were post-op complications and that may have been related to the lengthy period of time spent on the

bypass equipment; however, they never once mentioned the drug Trasylol as a possible factor.

During the time Ms. Marquardt was an inpatient at the University of Michigan Hospital, the following diagnoses were made and repeated often by the various physicians charged with providing her with care for her post-operative complications:

1. Various nosocomial infections, bacteremia and sepsis.
2. Hyperglycemia secondary to surgical stress requiring Tight Glycemic Control
3. Oliguric
4. Diminished Coronary Output/Coronary Index
5. Hemolysis secondary to long coronary bypass machine time
6. Fluid overload
7. Renal Hypoperfusion
8. Polyuric Renal Failure secondary to prolonged pump time
9. Acute Tubular Necrosis (ATN)
10. Hyperphosphatemia
11. Acute Kidney Injury (AKI) secondary to ATN
12. Hypotension
13. Pulmonary Edema
14. Non-oliguric Renal Failure
15. Acute Respiratory Distress Syndrome (ARDS)
16. Systemic Inflammatory Response Syndrome (SIRS)
17. Prolonged Respiratory Failure
18. Hematuria
19. Metabolic Acidosis
20. Pleural Effusion
21. Swallowing Dysfunction
22. Hypothyroidism
23. Hypercarbia
24. Hypoxemia
25. Clinical Depression
26. Peri-operative vascular leak
27. Respiratory Acidosis
28. Anemia
29. Atrial Fibrillation
30. Sick Euthyroid Syndrome
31. Prerenal Azotemia
32. Moderate Differentiated Encephalopathy
33. End Stage Renal Disease
34. Pulmonary Vein Stenosis
35. Urinary Tract Infection (UTI)
36. Adrenal Insufficiency
37. Cholecystitis
38. Wound Dehiscence
39. Extracellular Fluid Volume Depletion

Each of the above diagnoses appear to be related to Ms. Marquardt's underlying

renal disease, the iatrogenic efforts made by the medical staff to diagnose and treat the underlying renal disease, the nosocomial infections resulting from her long hospital stay, problems caused by the inability of the medical staff to correct the fluid imbalance situation caused by her renal dysfunction, or from the effects of the long-term hospital stay and the decompensation caused by the overwhelming medical and emotional conditions.

Ms. Marquardt has been followed by her primary care physician Raymond Cole, D.O, 107 W. Chicago, Brooklyn, MI 49230, her nephrologists R.V. Nagesh, M.D., 205 N. East Avenue, Jackson, MI 49201, her pulmonologist Robert D. Albertson, M.D., 900 E. Michigan Avenue, Jackson, MI 49201, and her cardiologist Bischan Hassunizadeh, M.D., 205 Page Avenue, Suite B, Jackson, MI 49201.

The standards of care for anesthesiologists and cardio-thoracic surgeons assisting in cardiac surgeries involving the use of cardiopulmonary bypass equipment require that Trasylol not be used during cardiac valve procedures performed after November 2006, given the advisories issued by the FDA and Bayer. The standards of care for both specialties also require that Trasylol induced renal disease should be ruled out as soon as possible, if renal disease is diagnosed or suspected following a surgical procedure in which Trasylol was used. These same standards require the appropriate use of Heparin in conjunction with the concurrent use of Trasylol. The anti-coagulation effect of Heparin must be isolated from the overall anti-coagulation effect of Heparin and Trasylol in combination. Trasylol should not be used as a Heparin sparing agent. Additional Heparin therapy may be needed even if ACT levels are elevated. Protamine titration to measure Heparin therapeutic levels must be performed before the administration of Trasylol and that baseline level must be used to determine if Heparin is needed to maintain anti-coagulation therapy intra-operatively and post-operatively, given that the Trasylol in a renal insufficient patient might be long-lasting and affect anti-coagulation test results, leading to reduced Heparin therapy post-operatively. These standards of care also require the physician to identify, carefully monitor and effectively treat fluid levels to avoid cardiopulmonary complications due to fluid overload or due to extracellular fluid volume depletion. If diagnosed, Trasylol induced renal disease must be aggressively treated with appropriate anti-thrombotic drug therapy, and therapeutic Heparin levels must be implemented to counter the Trasylol induced coagulopathy. If Trasylol is indicated, the applicable standards of care require that a test dose of 1 ml be given at least ten minutes before the loading dose. Then the loading dose should be given slowly over a 20-30 minute time period after induction of anesthesia and before the sternotomy, while the patient is in a supine position. Then the constant infusion of the drug is begun and continued until the surgery is completed and the patient leaves the operating room.

Drs. Haft and Umashankar, together with their associates, residents and fellows, breached applicable standards of care for cardiac surgeons and/or anesthesiologists assisting in cardiac procedures in the following ways:

1. They used Trasylol incident to a mitral valve replacement procedure, despite the indications published by the FDA and the manufacturer Bayer; or, in the alternative, they failed to remain current on the indications for the drug and used the drug during an off-label procedure.
2. They used Trasylol for an off-label purpose, when the FDA and the manufacturer, who were aware of the off-label uses of the drug, cautioned

against using the drug for any procedure other than a CABG procedure, until the drug's safety could be fully reviewed.

3. They ignored Ms. Marquardt's preoperative history of other drug allergies and renal insufficiency, which placed her at an increased risk of an allergic reaction to Trasylol and/or at an increased risk of further renal disease from the drug.
4. They failed to administer a test dose of Trasylol ten minutes before they began the loading dose.
5. They failed to take 20-30 minutes to administer the loading dose of Trasylol while the patient was in a supine position, before the sternotomy was performed and before the infusion of the drug was commenced.
6. They failed to adequately separate any coagulopathy caused by the Trasylol from any coagulopathy caused by Heparin therapy or the lack of that therapy, and, in so doing, they decreased or withheld Heparin therapy from the patient when she actually needed the therapy to counteract the Trasylol effects on the kidneys.
7. The failed to recognize the connection between Trasylol (thrombosis) and the hypocoagulopathy demonstrated in the laboratory results.
8. They failed to institute dialysis and/or appropriate diuretic therapy in a timely manner to maintain an appropriate fluid balance.
9. They failed to diagnose Trasylol induced renal disease, and treat it appropriately in a timely manner.
10. They failed to diagnose the prerenal disease caused by the Trasylol and recognize that the problems they were encountering in regards to pulmonary edema, cardiac dysfunction and other organ system failures were directly related to the renal disease, iatrogenic consequences of the inappropriate treatment protocols, nosocomial infections and/or from long periods of ventilation, decompensation and debilitation.

Drs. Haft and Umashankar, together with their associates, residents and fellows, would have complied with applicable standards of care, if they had decided not to use Trasylol during Ms. Marquardt's mitral valve repair procedure on July 20, 2007, given the FDA and manufacturer warnings against using it for such procedures. If they felt that the procedure and patient warranted the use of Trasylol, then they needed to recognize the other risk factors presented by her prior drug allergies and pre-existing renal insufficiency. They also had to use the drug as indicated in the insert regarding a test dose, the loading dose and coagulation assessments during and after the procedure. They also had to rule out Trasylol induced renal disease given the problems that presented in the immediate postoperative period. Then they needed to treat the Trasylol induced renal disease, the coagulopathy, the fluid imbalance and the effects of the renal disease on other organ systems in a timely manner.

As a direct and proximate result of the above negligent acts by Drs. Haft and Umashankar (together with their associates, residents and fellows), Ms. Marquardt was given a contraindicated drug during her mitral valve repair procedure on July 20, 2007. This drug then caused a prerenal condition complicated by an obstructive condition of the kidneys. She also was suffering from a coagulopathy that was caused by the Trasylol, and aggravated by the lack of effective treatment in the postoperative period of time. Her

renal disease, coagulopathy, multi-organ dysfunction, acidosis and a significant fluid imbalance resulted in a constellation of problems that went untreated or maltreated for a long time. The lack of effective treatment and accurate diagnoses led to a series of iatrogenic injuries due to a prolonged and ineffective treatment phase following the operative complications. The fluid imbalance, the coagulopathy, the renal dysfunction, the iatrogenic injuries and the nosocomial infections prolonged Ms. Marquardt's recovery phase. She was forced to endure long-term ventilation, hemodialysis, poly-drug therapy, severe depression, as she tried to cope with the lengthy hospitalization and extreme debilitation. She remained hospitalized for four and one-half months, was discharged on hemodialysis, is oxygen dependent due to changes in he lungs from the ARDS, SIRS, pulmonary edema, nosocomial pneumonia, pleural effusion, and atelectasis, ongoing renal disease, ongoing liver disease, heart problems that must be treated with medication and severely debilitated. Her multiple medical problems that began following the above surgery and post-operative complications eventually led to her death on January 27, 2010. She went from an independent person who was able to perform all of her ADL's, except when her mitral valve failed, to a person totally dependent on he husband and others to perform her ADL's and eventually death from renal failure complications. She was also completely oxygen dependent and severely disabled due to the poor care and treatment she received during her four and one-half months of hospitalization. These problems were directly related to the complications from a drug she should not have been given and directly related to the ineffective care and treatment she was given thereafter.

Respectfully submitted,

Thomas C. Miller

TCM:mls

Exhibit 7

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

SARON E. MARQUARDT, Personal Representative of the Estate of SANDRA D. MARQUARDT,

Plaintiff,

v

UNIVERSITY OF MICHIGAN BOARD OF REGENTS,

Defendant.

OPINION AND ORDER

HON. ROSEMARIE E. AQUILINA

Docket No. 10-4-MH

At a session of said Court held in the City of Lansing, County of Ingham, State of Michigan this 6th day of December, 2011

PRESENT: The Honorable Rosemarie E. Aquilina
Court of Claims Judge

This matter comes before the Court on Defendant University of Michigan Board of Regent's ("Defendant") *Motion for Summary Disposition*. This Court, having reviewed Defendant's brief in support and Plaintiff's response; having reviewed all supporting documents and correspondence; having heard oral argument; and being fully apprised of the issues, states the following:

BACKGROUND FACTS

On July 20, 2007, open heart surgery was performed on Sandra D. Marquardt ("Ms. Marquardt") to replace a valve at the University of Michigan Health System by their surgical and anesthesia staffs. During the procedure, the drug Trasylol was used to control bleeding. Ms. Marquardt spent the next four months in the hospital dealing with significant complications from the surgery. On December 31, 2007, Ms. Marquardt retained counsel to investigate the case

against the University of Michigan Health System's surgical and anesthesia staff, which are answerable to the University of Michigan Board of Regents, Defendant. On February 8, 2008, a request for medical records was sent to Defendant. On May 8, 2008, Defendant produced the medical records.

On January 15, 2009, the Federal Drug Administration documents and medical journal articles regarding the drug Trasylol were reviewed by Plaintiff's counsel. Plaintiff's counsel and Ms. Marquardt decided liability rested with Bayer and not with Defendant. A letter was sent to Bayer informing them that Ms. Marquardt wished to make a claim for damages. About four or five months later, Plaintiff's counsel received a call from a representative of Bayer in which it was revealed that the various advisories and revised package inserts had been sent to Defendant in a timely manner. The revised package inserts had advised using the drug for coronary artery bypass grafts procedures only.

On July 20, 2009, the two year statute for medical malpractice claims approached, and Plaintiff's counsel advised the Ms. Marquardt that a notice of intent should be sent to Defendant, just in case the claim against Bayer could not be settled. The notice of intent would permit counsel time to obtain a consultation from a specialist regarding whether or not this was malpractice. On July 20, 2009, the notice of intent was sent to Defendant. On January 19, 2010, the first day the Court of Claims was open for business following the expiration of the tolling period, Plaintiff's counsel filed the complaint. On January 27, 2010, Ms. Marquardt died allegedly as a result of injuries she had sustained following surgery on July 20, 2007. On May 20, 2010, this Court entered an order substituting the Estate of Sandra Marquardt in place of the individual Sandra Marquardt, after a petition for commencement proceedings had been filed with the Jackson County Probate Court. On June 14, 2010, letters of authority were issued to Saron

Marquardt ("Plaintiff") by the Jackson County Probate Court.

DEFENDANT'S ARGUMENT

The claims against Defendant are barred as a matter of law based on the expiration of the statute of limitations, pursuant to MCR 2.116(C)(7). A complete reading of the plain language of MCL 600.5658(c) confirms that the tolling period does not begin to run until the day after the notice of intent is served. Only the remaining days in the statutory period remain at the end of the notice period. In this case, there are no days left remaining in the statutory period after the date Plaintiff gave notice.

Since the notice of intent was served on July 20, 2009, the tolling period began to run on July 21, 2009, with zero days remaining on the statute of limitations. When the tolling period ended, the statute of limitations had already expired and there was no time left to file a complaint. *Dewan v Khoury* 2006 Mich App LEXIS 884 is directly on point in this case. *Dewan* provides that if the notice of intent is served on the last day of the statute of limitations, the tolling period does not apply.

Plaintiff improperly relies on *Omelenchuk v City of Warren* 461 Mich 567 (2000), *Decosta v Gossage,* 486 Mich 116 (2010), *Dunlap v Sheffield,* 193 Mich App 313 (1992), and *Buscaino v Rhodes,* 385 Mich 474 (1971), in support of his claim. Neither *Decosta* nor *Dunlap* provide support for Plaintiff's claim. *Decosta* merely stands for the proposition that a notice of intent is determined filed on the day it is served, and *Dunlap* supports Defendant's position that the tolling period began the day after the notice is served. Plaintiff's reliance on *Omelenchuk* is inapplicable to this case because the *Omelenhuck* case deals with a notice of intent filed well within the statute of limitations and did not address the issue in this case where the statute of limitations had expired.

MCL 600.5856(c) and MCR 1.108(1) clearly contradict Plaintiff's arguments based on *Omelenchuk*, and state that the tolling period begins the day after the notice of intent is filed. The statutes are to be followed as written and following the statutes as written, as well as the interpretation in *Dewan*, the statute of limitations in this case expired before the tolling period began and summary disposition is appropriate.

Plaintiff has failed to comply with MCL 600.6431(3), which provides that in all actions for personal injuries against a State institution, the claimant shall file with the Clerk of the Court of Claims a notice of intention to file a claim, or file the claim itself, within 6 months following the occurrence that gives rise to the potential cause of action. The Court of Appeals in *McCahan* specifically stated that the MCL 600.6431(3) filing requirement is a condition precedent to sue the state in a personal injury action. *McCahan v Brennan, et al*, 2011 Mich App LEXIS 210 (Mich Ct. App, Feb 1, 2011). The *McCahan* court also stated that substantial compliance does not satisfy the requirements of MCL 600.6431(3). *Id.* The July 20, 2009 notice of intent, which was not filed with the Clerk, was provided for two years after the event giving rise to the cause of action. MCL 600.6431(3) clearly requires that a plaintiff with a personal injury claim against the state must file with the clerk of the Court of Claims a notice of intent to sue or an actual claim within six months of the date of the events giving rise to the claim. Plaintiff failed to do so because the surgery took place on July 20, 2007, and Plaintiff filed on July 20, 2009.

Finally, MCL 600.6431 does not require that the defendant demonstrate prejudice when a plaintiff fails to comply with a statutory requirement. *Id.* The Court of Appeals reaffirmed the controlling nature of *McCahan* in *Kline v Department of Transportation*, 2011 Mich App LEXIS 411, even though the panel disagreed with the ruling of *McCahan*.

The death savings provision of MCL 600.582 does not apply in this case.

PLAINTIFF'S ARGUMENT

Defendant relies principally upon dictum contained in the unpublished decision in *Dewan v Khoury* 2006 Mich App LEXIS 884, which was decided in March 2006. The dictum contained in *Dewan* and relied upon by Defendant is actually inconsistent with the holding in the case, and that dictum was inconsistent with the Michigan Supreme Court decision in *Omelenchuk v City of Warren*, 461 Mich 567 (2000).

In *Dewan*, the claimed negligence occurred on June 4, 2002. The plaintiff in *Dewan* filed a notice of intent on June 4, 2004, which was the last day of the statute of limitations. The Court of Appeals found that the 182 day tolling period ended on December 3, 2004. The plaintiff in the *Dewan* matter did not file her complaint until December 6, 2004, which was Monday. Defendant mistakenly relies on dictum in *Dewan*. The *Dewan* court, in affirming the trial court's granting of summary disposition, stated, in dictum, that "[t]he 182 day tolling period began running on June 5, 2004, MCR 1.108(1) and expired on Friday, December 3, 2004." The Court also stated that since the entire 182 days had to be allowed to run, the complaint could not be filed on December 3, 2004. That finding was inconsistent with the Court's decision affirming summary disposition because the complaint was not timely filed on December 3, 2004, but rather December 6, 2004.

In contrast, the Court of Appeals in *Zwiers v Growney*, 286 Mich App 38, 40-41 (2009), stated plaintiff could have timely filed her complaint 182 days from the date of filing notice of intent. The plaintiff in *Zwiers* suffered injuries on September 2, 2005. On August 30, 2007, plaintiff served her notice of intent on defendants. On February 27, 2008, 181 days after serving notice of intent on the defendant, plaintiff filed her complaint. The *Zwiers* court stated that "[t]o be in compliance with MCL 600.2912b(1), the complaint and affidavit needed to be filed on or

after February 28, 2008," 182 days after the filing the notice of intent. The Court specifically identified that a plaintiff may file a complaint on or after 182 days after notice of intent was sent.

If this claim against the Defendant actually accrued on July 20, 2007, the statute of limitations would have expired at the end of the day on July 20, 2009, pursuant to MCR 1.108(1) and MCL 600.5838a(1), unless the applicable statute of limitations was tolled. *Dunlap v Sheffield*, 193 Mich App 313, 314 (1992). Plaintiff relies upon the unambiguous language contained in MCL 600.5658(c), which contains the tolling provision relevant to this litigation. That statute clearly states that the tolling begins at the time notice is given, which in this case was July 20, 2009. The statute of limitations had not expired on July 20, 2009 when the notice of intent was served upon Defendant.

The Michigan Supreme Court addressed this very issue in *Decosta*. *Decosta* at 118. The Court held that if the notice of intent was timely filed, then the statute of limitations was tolled pursuant to MCL 600.5856(c). Once the statute of limitations was tolled pursuant to MCL 600.5856(c), it remained tolled for the full 182 days permitted by MCL 600.2912b(1), even if Defendant failed to provide a notice of meritorious defense within 154 days. The Court of Appeals in *Decker v Rochowiak*, 287 Mich App 666, 667 (2010), citing the Supreme Court's decision in *Bush*, stated quite unambiguously that once notice of intent is given, the applicable statute of limitations is tolled by MCL 600.5856. In *Omelenchuk*, the Supreme Court was confronted with facts that revealed that the notice of intent was mailed to the defendant on December 11, 1995. The Court clearly stated that the tolling period of 182 days ran from December 11, 1995 until June 10, 1996 (182 days).

In contrast, in *Buscaino v Rhodes*, 385 Mich 474, 481-82 (1971), the Supreme Court clearly stated the tolling occurred the moment the complaint was filed. Plaintiff asserts that that

holding can easily be used to hold that the moment the notice of intent was mailed the applicable statute of limitations was tolled. Defendant has relied on an unpublished decision, *Lancaster v Wease*, 2010 Mich App LEXIS 1819, and *Dewan*, both of which used date calculations which were clearly inconsistent with those proffered by the Supreme Court in *Omelenchuk*.

In addition, the notice provisions contained in MCL 600.6431(3) were met. The notice requirements contained in MCL 600.6431(3) were not activated until a claim actually accrued. *Oak Construction Co. v Highway Department*, 33 Mich App 561, 565-67 (1971) and *Cooke v Highway Department #1*, 55 Mich App 336, 338-39 (1974) support the proposition that a claim does not accrue, pursuant to MCL 600.6431(1), until the state has rejected the administrative claim, and the time limits imposed by that statute did not begin to run until the administrative efforts had been denied. Plaintiff did not appreciate that there was a potential claim against Defendant until its letter to Bayer, sent on January 15, 2009, generated a call from Bayer regarding the nature and extent of the notice that Bayer had provided to Defendant regarding the restricted use of Trasylol in the middle of 2009. This is when he first became aware of a possible claim against Defendant. Then on July 20, 2009, an administrative claim was filed with Defendant, pursuant to MCL 600.2912b, which was consistent with the requirements contained in MCL 600.6431(3), and the claim was filed within 6 months of when the claim accrued. When Defendant failed to settle the matter administratively by January 18, 2010, it became evident that Defendant had no intention of settling the case and a lawsuit would be required. This became the happening of the event giving rise to the cause of action as set forth in MCL 600.6431(3), which then required Plaintiff to file a notice of intention to file a claim or the claim itself.

In addition, a significant number of appellate decisions have long established that the state must show actual prejudice in order to move for summary disposition based upon a

plaintiff's failure to comply with the notice requirements contained in MCL 600.6431(3). The Michigan Supreme Court in *Rowland* did not address whether or not the notice requirements contained in MCL 600.6431 were affected by its decision, nor did it hold that all statutorily created notice requirements were to be treated in the same manner. The decision in *May v Department of Natural Resources*, 140 Mich App 730, (1985), should remain the controlling authority of showing actual prejudice.

Lastly, MCL 600.6452 establishes a three year statue of limitations for claims filed against the State of Michigan which is controlling in this case. In addition, MCL 600.5852 provides "the claim possessed by decedent would have been saved for up to three years from the date the statute of limitations would have expired, provided Decedent died within the applicable statute of limitations period, or, Decedent died within 30 days after the statute of limitations had expired." Therefore, Plaintiff could have timely filed the complaint on or before June 14, 2012, two years after the letters of authority were issued on June 14, 2010.

CONCLUSIONS OF LAW

Summary disposition is available, pursuant to MCR 2.116(C)(7), when a claim is barred by the statute of limitations. A defendant who files a *Motion for Summary Disposition*, pursuant to MCR 2.116(C)(7), may, but is not required to file supportive material such as affidavits, depositions, admissions, or other documentary evidence. *Turner v Meray Hospitals & Health Services of Detroit*, 210 Mich App 345, 348 (1995). When reviewing a motion pursuant to MCR 2.116(C)(7), a court must consider all affidavits, pleadings, and other documentary evidence submitted by the parties and construe the pleadings and evidence in favor of the nonmoving party. *Doe v Roman Catholic Archbishop of the Archdiocese of Detroit*, 264 Mich App 632, 638 (2004).

MCL 600.5838a(1) provides "a medical malpractice action accrues at the time of the act or omission that is the basis for the claim of medical malpractice, regardless of the time the plaintiff discovers or otherwise has knowledge of the claim." The Court of Appeals in *McKiney v Clayman*, 237 Mich App 198, 204 (1999) held that the accrual date of medical malpractice claims is on the occasion of the act or omission complained of. In this case, it is July 20, 2007, the date of surgery. Plaintiff claims that the accrual date was when Defendant failed to settle the matter administratively by January 18, 2010. Plaintiff relies on *Oak v Construction Co. v Highway Department*, 33 Mich App 561, 565-67 (1971) and *Cooke v Highway Department #1*, 55 Mich App 336, 338-39 (1974), for support of the principle that the accrual date did not begin until the exhaustion of administrative remedies. However, the cases relied on by Plaintiff dealt specifically with state employers who had contracts providing that in order to file a complaint or sue, the employee must pursue all administrative remedies first. There is nothing of the sort in this case and the cases are not applicable. Therefore, the date of accrual is not when Plaintiff found there was a potential claim against Defendant when receiving a response from Bayer, it is the date of surgery, July 20, 2007.

Mailing of a notice of intent before the statute of limitations expires is a prima face case for compliance with MCL 600.2912b. *Decosta* at 118. Here, Plaintiff mailed the notice of intent on the last day of the statute of limitations, July 20, 2009, and therefore complied with MCL 600.2912b. If Plaintiff had filed the notice of intent on July 21, 2009, then the mailing would not be in compliance with MCL 600.2912b because the statute of limitations would have expired.

MCL 600.2912b states in relevant part:

> (1) Except as otherwise provided in this section, a person shall not commence an action alleging medical malpractice against a health professional or health facility unless the person has given the health professional or health facility written notice under this section not less than

182 days before the action is commenced.

...

(7) Within 154 days after receipt of notice under this section, the health professional or health facility against whom the claim is made shall furnish to the claimant or his or her authorized representative a written response that contains the information required by MCL 600.6912b(7) (a)-(d);

(8) If the claimant does not receive the written response required under subsection (7) within the required 154-day time period, the claimant may commence an action alleging medical malpractice upon the expiration of the 154-day period.

(9) If at any time during the applicable notice period under this section a health professional or health facility receiving notice under this section informs the claimant in writing that the health professional or health facility does not intend to settle the claim within the applicable notice period, the claimant may commence an action alleging medical malpractice against the health professional or health facility, so long as the claim is not barred by the statute of limitations.

These subsections set forth a number of requirements. A plaintiff cannot file suit without giving the notice required by subsection (1). No suit can be filed for 182 days after notice is given. The interval of 182 days during which a suit cannot be filed can be reduced to 154 days if the health professional or health facility fails to respond to the notice. The interval can also be reduced if the health professional or health facility responds that it will not settle.

Plaintiff timely filed her complaint 182 days from the date of filing notice of intent. In *Zwiers*, the Court of Appeals stated that "[t]o be in compliance with MCL 600.2912b(1), the complaint and affidavit needed to be filed on or after February 28, 2008," 182 days after the filing of the notice of intent. *Zwiers* at 40-41. The Court specifically identified that a plaintiff may file a complaint on or after 182 days after notice of intent was sent. In this case, 182 days ended on January 18, 2010. However, this Court was closed in observance of Martin Luther King Day. Plaintiff filed the complaint on January 19, 2010, which was 182 days after the notice of intent was sent, when the Court resumed. Therefore, it was timely pursuant to MCL

600.2912b.

However, MCL 600.6431(3) provides "in all actions for property damage or personal injuries, claimant shall file with the clerk of the court of claims giving a notice of intention to file a claim or the claim itself within 6 months following the happening of the event giving rise to the cause of action." Section (3) clearly states that a "claimant *shall* file with the clerk of the Court of Claims. . . . within 6 months following the happening of the event." The word "shall" designates a mandatory provision. *Walters v Nadell*, 481 Mich 377, 383 (2008). Clear statutory language must be enforced as written. *Flour-Enterprises, Inc v Dep't of Treas*, 477 Mich 170, 174 (2007). It is clear Plaintiff has failed to comply with MCL 600.6431(3). Plaintiff filed the notice of intent two years after the date of accrual on July 20, 2007. Therefore, Plaintiff has not timely filed the claim against Defendant, pursuant to MCL 600.6431(3).

Prejudice does not have to be shown when a plaintiff does not comply with a statutory filing requirement. In *Rowland*, the Michigan Supreme Court overturned several cases that had required the state to show actual prejudice when a plaintiff failed to comply with a statutory filing requirement. *Rowland v Washtenaw County Rd Comm'n*, 477 Mich 197, 219 (2007). The Supreme Court in *Rowland* stated that because the language of the statute was clear on the filing requirement, the Supreme Court would not give the statute any judicial construction. The filing requirement was strictly applied. *Id.* The filing requirement must be applied as it is written without a reading of prejudice into the statute.

The Court of Appeals recently addressed the notice requirements in MCL 600.6431 in *McCahan v Brennan, et al*, 2011 Mich App Lexis 210 (Mich Ct. App, Feb 1, 2011). The *McCahan* court, relying on *Rowland*, reasoned that the notice requirements contained in MCL 600.6431(3) should be treated the same way that the Supreme Court treated the notice

requirements in *Rowland*. Furthermore, the Court of Appeals reaffirmed the principle in *Kline v Department*, 2011 WL 711042. Thus, the notice requirement of MCL 600.6431(3) cannot have prejudice read into the statute as was held in *Rowland*.

MCL 600.5852 is also inapplicable because the statute applies where a potential plaintiff dies within 30 days of the expiration of the statute of limitations. Here, Ms. Marquardt died on January 27, 2010 more than six months after the statute of limitations expired on July 20, 2009. Therefore, the wrongful death savings provision does not apply here.

THEREFORE, IT IS ORDERED that Defendant's *Motion for Summary Disposition* is **GRANTED**, pursuant to MCR 2.116(C)(7). In compliance with MCR 2.602(A)(3), this Court finds that this decision resolves the last pending claims and closes the case.

IT IS SO ORDERED.

Hon. Rosemarie E. Aquilina (P37670)
Court of Claims Judge

PROOF OF SERVICE

I hereby certify I served a copy of the above Order upon Plaintiff and upon Defendant by placing the Order in sealed envelopes addressed to the attorney of each party and deposited them for mailing with the United States Mail at Lansing, Michigan, on December 6, 2011.

Luke A. Goodrich (P72090)
Law Clerk

Exhibit 8

STATE OF MICHIGAN

COURT OF APPEALS

In re Estate of SANDRA D. MARQUARDT.

SARON E. MARQUARDT, Personal Representative of the Estate of SANDRA D. MARQUARDT,

Plaintiff-Appellant,

v

UNIVERSITY OF MICHIGAN BOARD OF REGENTS,

Defendant-Appellee.

UNPUBLISHED
November 27, 2012

No. 307917
Court of Claims
LC No. 10-000004-MH

Before: BORRELLO, P.J., and FITZGERALD and OWENS, JJ.

PER CURIAM.

In this medical malpractice action, plaintiff appeals as of right the order granting summary disposition in favor of defendant on the ground that plaintiff failed to comply with the notice provision of MCL 600.6431(3). We affirm.

On July 20, 2007, Sandra Marquardt underwent mitral valve replacement surgery at the University of Michigan Hospital and Health Center. Defendant University of Michigan Board of Regents governs the hospital, MCL 390.3, and may sue and be sued on behalf of the hospital. MCL 390.4. According to plaintiff's complaint, during the surgery the hospital negligently administered to Marquardt the drug Trasylol. Marquardt died on January 27, 2010, allegedly as a result of complications resulting from administration of the Trasylol.

On July 20, 2009, counsel sent a notice of intent to file a medical malpractice claim pursuant to MCL 600.2912b to defendant and three doctors who performed the surgery. On January 19, 2010, Marquardt filed a complaint alleging medical malpractice in the Court of Claims. After Marquardt's death, plaintiff was appointed personal representative of Marquardt's estate and the estate was substituted as plaintiff in this action.

Defendant moved for summary disposition on the grounds that plaintiff failed to file her cause of action within the statute of limitations and that she failed to satisfy the notice provision

of MCL 600.6431(3). The trial court granted summary disposition in favor of defendant on the ground that plaintiff failed to satisfy the notice provision in MCL 600.6431(3).

We review de novo a trial court's ruling on a motion for summary disposition. *Jimkoski v Shupe*, 282 Mich App 1, 4; 763 NW2d 1 (2008). We also review de novo issues of statutory interpretation. *Driver v Naini*, 490 Mich 239, 246; 802 NW2d 311 (2011).

There is no dispute that the Court of Claims has jurisdiction over this personal injury claim. MCL 600.6419(1)(a). Cases brought in the Court of Claims are subject to the notice provisions of MCL 600.6431. MCL 600.6431(3) provides:

> In all actions for property damage or personal injuries, claimant shall file with the clerk of the court of claims a notice of intention to file a claim or the claim itself within 6 months following the happening of the event giving rise to the cause of action.

"A claim based on the medical malpractice . . . accrues at the time of the act or omission that is the basis for the claim of medical malpractice, regardless of the time the plaintiff discovers or otherwise has knowledge of the claim." MCL 600.5838a(1); see also *McKiney v Clayman*, 237 Mich App 198, 203-204; 602 NW2d 612 (1999). Thus, the "happening of the event giving rise to the cause of action" in this case was the allegedly negligent administration of Trasylol during Marquardt's surgery on July 20, 2007. MCL 600.6431(3). In order to pursue her claim against defendant, Marquardt was required to file "a notice of intention to file a claim or the claim itself" in the Court of Claims within six months of July 20, 2007. *Id.* The claim was not filed until January 19, 2010. Thus, summary disposition in favor of defendant was appropriate.

Plaintiff argues on behalf of the estate that MCL 600.6431's notice provision is inapplicable because it conflicts with the medical malpractice notice provision of MCL 600.2912b. The two statutory notice provisions do not conflict and both can be met by a medical malpractice plaintiff. MCL 600.6431(3) requires that notice of intent to file a claim must be filed with the clerk of the Court of Claims within six months after the conduct giving rise to the claim. The notice must state "the time when and the place where such claim arose and in detail the nature of the same and of the items of damage alleged or claimed to have been sustained." MCL 600.6431(1). MCL 600.2912b(1) requires that notice of the claim be provided to the medical malpractice defendant not less than 182 days before the action is commenced. That notice must state the "factual basis for the claim," the "applicable standard of practice or care," the manner in which the defendant breached the standard of care, how the defendant could have avoided the breach, how the breach caused the plaintiff's injury, and the "names of all health professionals and health facilities" being notified. MCL 600.2912b(4). Nothing prevents a plaintiff from complying with both statutory notice provisions. There simply is no conflict entitling the estate to avoid strict compliance.

Plaintiff argues that, despite her failure to comply with MCL 600.6431(3), the trial court should not have dismissed the action without a showing of actual prejudice by defendant. This argument was considered and rejected in *McCahan v Brennan*, ___ Mich ___; ___ NW2d ___ (Docket No. 142765, decided August 20, 2012), slip op at 16-17 ("when the Legislature

specifically qualifies the ability to bring a claim against the state or its subdivisions on a plaintiff's meeting certain requirements that the plaintiff fails to meet, no saving construction—such as requiring a defendant to prove actual prejudice—is allowed"). Thus, the trial court did not err in ruling that defendant was not required to prove actual prejudice and dismissing plaintiff's claim.

We decline to address plaintiff's unpreserved argument that the application of MCL 600.6431(3) to medical malpractice cases has no "rational basis." The "interest of justice and judicial economy" do not dictate that we disregard the preservation requirements in this case. See *STC, Inc v Dep't of Treasury*, 257 Mich App 528, 538; 669 NW2d 594 (2003). Further, decisions of our Supreme Court and this Court have repeatedly upheld the constitutionality of notice provisions and rejected the idea that such provisions unconstitutionally favor government defendants. See, e.g., *Rowland v Washtenaw Co Rd Comm*, 477 Mich 197, 210; 731 NW2d 41 (2007); *Gleason v Dep't of Transp*, 256 Mich App 1, 2-3; 662 NW2d 822 (2003).

Affirmed.

/s/ Stephen L. Borrello
/s/ E. Thomas Fitzgerald
/s/ Donald S. Owens

Exhibit 9

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of the Estate of SANDRA MARQUARDT, Deceased,

Plaintiff,

Case No. 12-621-NH
Honorable David S. Swartz

v

VELLAIAH DURAI UMASHANKAR, M.D., and JONATHAN HAFT, M.D.,

Defendants.

Thomas C. Miller (P17786)
Attorney for Plaintiff
P.O. Box 785
Southfield, MI 48037
(248) 210-3211

Patrick McLain (P25458)
Attorney for Defendant Haft
600 Woodward Avenue, Suite 2500
Detroit, MI 48226-3427
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ORDER GRANTING DEFENDANT HAFT'S MOTION FOR SUMMARY DISPOSITION AND DISMISSING PLAINTIFF'S CLAIMS AGAINST DEFENDANT HAFT ONLY WITH PREJUDICE

At a Session of Court held in the
Washtenaw County Trial Court
City of Ann Arbor, on February 13, 2013.

PRESENT: HONORABLE DAVID S. SWARTZ, Circuit Court Judge

Defendant Haft (Defendant) filed a motion for summary disposition seeking dismissal with prejudice of Plaintiff's medical malpractice claims. The

Court reviewed the respective briefs and attached exhibits, heard oral argument and took the matter under advisement before issuing its opinion.

The Court finds determinative Defendant's argument that Plaintiff's claim is subject to dismissal because the affidavit of merit (AOM) is invalid. Defendant argues that because Defendant is a specialist who is board certified, Plaintiff's expert must also be a specialist who is board certified in the same specialty. Defendant's specialty is surgery and he is board certified in thoracic surgery. Plaintiff's expert is not board certified in surgery and his specialty is anesthesia. In the absence of an identical "match" of specialties and board certifications, Defendant submits that Plaintiff's expert is not qualified to sign an AOM or render standard-of-care testimony against Defendant.

Further, Defendant submits that, "[D]ismissal with prejudice should be ordered." While acknowledging that Section MCL 600.2301 applies, and that MCR 2.112(L)(2)(b) specifically provides for retroactive amendment of an AOM, Defendant asserts that relief is barred because: "In this case, given the knowledge possessed from the litigation against U of M, justice does not warrant that an amendment be allowed. Plaintiff is well aware of Dr. Haft's area of specialization and could have easily determined his board certifications. Plaintiff's failure to comply with the affidavit of merit requirement is blatant and wholly unjustified. One can only conclude that Plaintiff does not have a cardiac surgery expert supportive of the claims against Dr. Haft, and should never have filed this Complaint against Dr. Haft."

Plaintiff states in response that Defendant's motion is a "gotcha exercise" that raises "technical" defects and errors and "insignificant procedural matters" rather than the merits of Plaintiff's medical malpractice claims against Defendant. Addressing the AOM challenge only "in passing", Plaintiff characterizes the argument as "absurd" and asserts that the standards of care "relating to the use of Trasylol" are the same for cardiothoracic surgeons and cardiothoracic anesthesiologists. The standards of care "cannot be different" because, Plaintiff posits, the Defendants, represented by the same counsel, "have all testified that the decision to use Trasylol was a joint decision made by the anesthesia and cardiac physicians" who "jointly decided to disregard the FDA and manufacturer on July 20, 2007 and use Trasylol during a valve replacement procedure."

Plaintiff does not offer an amended or replacement AOM pursuant to MCR 2.118 and, in particular, MCR 2.112(L)(2)(b) which provides in part:

> (2) In a medical malpractice action, unless the court allows a later challenge for good cause:
>
> * * *
>
> (b) all challenges to an affidavit of merit or affidavit of meritorious defense, including challenges to the qualifications of the signer, must be made by motion, filed pursuant to MCR 2.119, within 63 days of service of the affidavit on the opposing party. An affidavit of merit or meritorious defense may be amended in accordance with the terms and conditions set forth in MCR 2.118 and MCL 600.2301.

Instead, Plaintiff asserts that the Court may properly "disregard" errors or defects in the pleadings and grant a waiver of the statutory requirements. Section 2301 provides:

> The court in which any action or proceeding is pending, has power to amend any process, pleading or proceeding in such action or proceeding, either in form or substance, for the furtherance of justice, on such terms as are just, at any time before judgment rendered therein. The court at every stage of the action or

proceeding shall disregard any error or defect in the proceedings which do not affect the substantial rights of the parties.

Plaintiff advises that the Legislature "envisioned such relief" for medical malpractice plaintiffs when it enacted Section 2301 and "decided to give the judiciary the statutory authority to halt such efforts before the system completely evolves into a system where procedure trumps substance."

It is well-established that an AOM is presumed valid when filed. *Jackson v. Detroit Medical Center*, 278 Mich.App. 532, 541-542 (2008). However, when challenged, a plaintiff must demonstrate that the AOM meets the requirements set forth in the statutes. *Kirkaldy v. Rim*, 478 Mich. 581 (2007). MCL 600.2912d provides as follows:

(1) Subject to subsection (2), the plaintiff in an action alleging medical malpractice or, if the plaintiff is represented by an attorney, the plaintiff's attorney shall file with the complaint an affidavit of merit signed by a health professional who the plaintiff's attorney reasonably believes meets the requirements for an expert witness under section 2169.

MCL 600.2169 provides:

Sec. 2169. (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:

If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

The statute mandates that plaintiff's counsel must possess a "reasonable belief" that the health professional signing the AOM meets the expert witness requirements set forth in MCL 600.2169. *Geralds v. Munson Healthcare*, 259

Mich.App. 225, 233 (2009) The "reasonableness" of the belief is determined by the medical records and information available to the plaintiff's attorney before or at commencement of the case. *Grossman v. Brown*, 470 Mich. 593, 599-600 (2004). A trial court is not required to conduct mini-trials concerning the ultimate validity of the contents of the AOM. *Sturgis Bank & Trust Co. v. Hillsdale Community Health Ctr.*, 268 Mich.App. 484, 493 (2005). Rather, the inquiry is limited to whether, on its face, the AOM reflects the necessary "reasonable belief." *Kalaj v. Khan*, 295 Mich.App. 420, 428-429 (2012).

Plaintiff's AOM is signed by an expert who is not board certified in cardiothoracic surgery, the "specialty engaged in by the defendant physician during the course of the alleged malpractice." *Gonzalez v. St. John Hosp. & Med. Ctr.* (*On Reconsideration*), 275 Mich.App. 290, 302–303 (2007). Based on the blatant lack of "matching" qualifications, Plaintiff's counsel could not have reasonably believed that the health professional signing the AOM met the requirements of MCL 600.2169. *Grossman, supra, at* 600. Because the AOM, on its face, does not comply with the statutory requirements, the Court finds, as a matter of law, that Plaintiff's AOM is invalid.

Section 2301 clearly states that the Court may not disregard defects and errors in the proceedings that affect a party's substantial rights. Further, Plaintiff has presented no authority in support of a waiver of the statutory requirements pertaining to submission of AOMs. Thus, despite the uncontroverted "joint decision", Plaintiff was required to file an AOM signed by an expert engaged in the "specialty engaged in by the defendant physician during the course of the

alleged malpractice" and "board certified in that specialty." *Hoffman v. Barrett* (On Remand), 295 Mich.App. 649, 663-664 (2012). There is no dispute that Plaintiff failed to comply with those mandates.

Considering that Plaintiff does not offer an amended or replacement AOM and that no time remains in the limitations period within which Plaintiff could file a new complaint against Defendant with a conforming AOM, the Court GRANTS Plaintiff's request for dismissal of the claims with prejudice.

Defendant's Motion for Summary Disposition is GRANTED. Plaintiff's claims against Defendant Haft only are DISMISSED WITH PREJUDICE.

This is not a final order.

IT IS SO ORDERED.

PROOF OF SERVICE
The undersigned certifies that the foregoing instrument was served upon all parties to the above cause to each of the attorneys of record herein at their respective addresses disclosed on the pleadings on 8/12/2020
By U.S. Mail ___ Express Mail ___
Hand Delivered ___ Fax ___ Inter Office
Signature

David S. Swartz,
Circuit Court Judge

Exhibit 10

Saron Marquardt, et al v Vellaiah D. Umashankar

STATE OF MICHIGAN

IN THE COURT OF APPEALS

SARON E. MARQUARDT, Personal Representative of the Estate of SANDRA MARQUARDT (Dec.),

Plaintiff-Appellant,

vs.

VELLAIAH DURAI UMASHANKAR, M.D.,

Defendant-Appellee.
_____/

Case No. 12-621-NH

Court of Appeals No. 319615

Honorable

David S. Swartz

TRANSCRIPTION OF AUDIOTAPE

Wednesday, October 30, 2013

- - -

COURT CLERK: Number 11 on the docket, Marquardt versus Umashankar, Case Number 12-621-NH.

MR. MILLER: Good afternoon, Your Honor. Thomas Miller on behalf of the Plaintiff.

MRS. SWANSON: Joanne Geha Swanson on behalf of the Defendant Umashankar.

THE COURT: You may proceed.

MRS. SWANSON: Your Honor, this is an action for medical malpractice that was commenced by the personal representative of Mrs. Marquardt's estate on June 2nd, 2012, following the dismissal of that action she had filed against the University of Michigan Board of Regents arising out of the same set of facts. The earlier action was dismissed by the Court of Claims for failure to give notice and that was affirmed by the Court of Appeals.

The present motion before you is based upon the statute of limitations leaving aside the question of whether or not there is any time left within the statute of limitations period within which to file an action after an NOI expires when that NOI is filed on the very last day of the statute of limitations.

The question before this Court really depends upon whether the notice of intent that was directed to the University of Michigan Health System Risk Manager on July 20th, 2009, was, in fact, a notice of intent to Dr. Umashankar that tolled the

period of limitations against him. Dr. Umashankar was, in fact, mentioned in that NOI but it was not addressed to him, and when the tolling period expired in January 2012, he was not named as a Defendant in that action.

Mrs. Marquardt admits that -- or Mr. Marquardt admits that he didn't decide to sue Dr. Umashankar when he filed the Court of Claims action and, in fact, it wasn't until that Court of Claims action was dismissed that he decided to sue Dr. Umashankar, along with another physician Dr. Haft, who has since been dismissed from this action as well. When Mr. Marquardt made the decision that he was going to sue Dr. Haft and Dr. Umashankar, he served new notices of intent upon them. Those notices of intent were directed expressly to the physicians and Dr. Umashankar's was addressed to him, not at the Risk Management Office of the University of Michigan Health System but at the Department of -- Cardiovascular Department at University of Michigan Hospital Anesthesia Department.

So the parties agree that the statute of limitations or the claim accrued on July 20, 2007, and that the statute of limitations is for two years and that that period would have been extended for 182 days if that notice had been filed as to Dr. Umashankar.

The real issue for this Court is what was the effect of that notice, and that's significant, Your Honor, because as

personal representative of Mrs. Marquardt's estate, if Mrs. Marquardt died within 30 days of expiration of the statute of limitations, the personal representative would have another two years within which to file suit. Mrs. Marquardt died on January 27th, 2010. The statute of limitations without the NOI would have expired on July 20, 2009. If the NOI was effective as to Dr. Umashankar, then she would have died within the 30 days of the expiration of the statute of limitations, which would have been around January 18th, 2010.

Mr. Marquardt's theory or basis for arguing that the NOI against Dr. Umashankar was effective is MCL -- as far as I can tell, Your Honor, is MCL 600.2912b, and Plaintiff argues that the notice of intent sent to the Risk Manager at University of Michigan Health System was good enough because that provision allows the NOI to be mailed to the health facility if the Doctor's last known address cannot be found, but Your Honor, this statute is not intended to provide a convenient after the fact justification for failing to direct the NOI to the particular Defendant physician.

To properly invoke the alternative afforded by this statute, the Plaintiff has to make some reasonable effort to ascertain the last known address of the intended Defendant. Mr. Marquardt was likely not concerned with making this inquiry, Your Honor, because he did not intend to direct the NOI to Dr. Umashankar because he did not intend to bring suit

against Dr. Umashankar at that time. So Mr. Marquardt's failure to make that reasonable inquiry is basically constantly acknowledged in the response to our motion where Mr. Marquardt says that it would have been extremely unlikely that counsel for claimant could have found a current address and that serving the University of Michigan with the notice was thought to have been the best way to advise the Defendant of the pending claim.

Nothing in the statute, Your Honor, permits a Plaintiff to direct notice intended for a particular physician to the Risk Manager of the hospital at which the surgery was performed. The notice still has to be directed to the physician, and if Dr. Umashankar was the intended Defendant, it should have been directed to him. In fact, that is how the NOI was addressed when it was served in September 2011 after the case against the Board of Regents has been dismissed.

Mr. Marquardt seems to argue that University of Michigan Health System would have notified Dr. Umashankar of the notice of intent that they received and that that should have been sufficient, but again there is no authority whatsoever for the proposition that the NOI statute can be satisfied by directing the NOI to someone who will tell the Defendant or who should tell the Defendant or who might tell the Defendant about the claim. The statute itself is inconsistent with that proposition because it states that proof of the mailing

constitutes prima facie evidence of compliance with this section.

The clear meaning of this provision, Your Honor, is that compliance requires a specified physical mailing to the Defendant and nothing less and the date of mailing is obviously important because that is the date upon which the tolling period begins, and if you just mail the notice of intent directed to one Defendant to another Defendant and are relying on that Defendant to tell them, there would really be no way to be able to ascertain precisely when the tolling period begins and when it ends.

So because, Your Honor, no notice of intent was directed to Dr. Umashankar on July 20, 2009, Mrs. Marquardt did not die within 30 days of expiration of the statute of limitations and her personal representative could not take advantage of the two year savings provision within which to file a claim, and for that reason, Your Honor, we are requesting that summary disposition be granted.

MR. MILLER: In somewhat of an inverse order, Your Honor, let me just address a few things that counsel mentioned. The cases that Defendant's cite for the proposition that you cannot serve one Defendant by serving another Defendant is part of MCL 2912b(1) and that's the authority cited in those decisions.

The provision that is relevant here is 600.2912b(2), which

reads as follows, Your Honor, "If no last known professional business or residential address can reasonably be ascertained, notice may be mailed to the health facility where the care that is the basis of the claim was rendered". There is basically two things in that provision, Your Honor. Reasonably ascertained, I will indicate to the Court that in subsequent discoveries in the Court of Claims action we learned that Dr. Umashankar had returned to India while the Plaintiff was still in the hospital in 2009.

Subsequent when we made efforts to try to find Dr. Umashankar in 2011 and 2012, there was nothing on the internet about Dr. Umashankar as far as his professional address. We had an address on his curriculum vitae but we didn't have a curriculum vitae in 2011 -- I mean, excuse me, in 2009. Mrs. Marquardt was in the hospital in 2007. I misstated and said 2009. The notice of intent was sent in 2009. There would have been no way that we could have ascertained a last known address for Dr. Umashankar when the notice of intent was sent in 2009.

When we tried -- Your Honor will recall all the problems we had with serving Dr. Umashankar. It took over a year to effectuate service -- not over a year but up to a year. I contacted the two professional organizations to which he claimed to have belonged in his curriculum vitae. Neither of those organizations would give us his last known address.

Those same organizations two years earlier would not have had his last known address.

So there is no case law cited by Defendant that requires, as she points out, Plaintiff has a duty to exercise reasonable effort. The statute doesn't say that. There's no case law to support that proposition cited by Defendants. It simply says, if no last known professional address or residential address can be reasonably ascertained. It doesn't say that Plaintiff must demonstrate that reasonable effort has been made to find him somewhere in India. It just simply says that it could not have been reasonably obtained, and based upon the subsequent work incident of serving process in this case, it was clearly evident that we would not have been able to ascertain the last known address.

The other thing is counsel says that it was not addressed to Dr. Umashankar. There is nothing in the statute that requires that it be addressed or sent -- or that the addressee be part of the notice. It simply says, notice may be mailed to the health facility, not to the Defendant care of the healthcare facility. It says, mailed to the facility, and we did mail it to the facility.

Defendant argues, well, you should have addressed it to Dr. Umashankar at the University of Michigan, and if I could approach, Your Honor, I can show you the two letters that we did send in 2011, one by regular mail and one by certified, and

they were addressed to Dr. Umashankar at the University of Michigan. You can make out the address under that white part that's covered up. Both of them were returned by the University of Michigan indicating that he was no longer there.

So what Defendant seems to be arguing is that the statute would be complied with if we had done the same thing in 2009. The statute infers that by sending it to the facility that the best -- it represents the best chance that this notice is going to get to the effected person. Dr. Umashankar is mentioned I think five times in the notice of intent. There is no dispute about that.

Plaintiff has complied with the provisions of 2912b(2). Part of it may have been inadvertent notice but he was served by reason of this 2912b(2) because we did mail it to the health facility, and again there's no authority cited by Defendant that says Plaintiff has to make reasonably effort. It simply says, a determination made as to -- as it says, no last known address can be reasonably ascertained, and we couldn't at that time, Your Honor.

THE COURT: Thank you.

MRS. SWANSON: Thank you, Your Honor. Just a couple of quick points, it says -- yes, the statute says it may be mailed to the facility but it says the notice of intent to file a claim required under subsection one and that is a notice of intent directed to the particular intended Defendant, Your

Honor.

And I also would like to point out, there is a difference between mentioning Dr. Umashankar in the notice of intent and directing it to him, and in Atkins versus Suburban Mobility, the case decided -- one of the notice cases decided by the Michigan Supreme Court last year, the Court emphasized that a claim is not nearly an occurrence. It's a demand for payment pursuant to a legal right.

And there is no notice of intent within the statute of limitations that was served upon or sent to or directed to Dr. Umashankar where a claim was specifically indicated intended to be made against him at all. There is nothing that demand payment from him. There's nothing that says this claim is being asserted against you, and so while he has been mentioned in the notice of intent, it certainly was not a claim for an exercise of legal right against him.

MR. MILLER: Could I address just one issue?

THE COURT: Sure.

MR. MILLER: Counsel points out the fact that subsection two refers back to subsection one. There's no dispute that this notice of intent complied with the provisions in part one. Subsection two creates an exception for how to serve that notice of intent and it says it can be sent to the health facility if no reasonable address. We had a compliant NOI. If Your Honor reads it, you will see it complied with all

of the provisions of section one but it gave an exception on how service was to be made in section two.

THE COURT: Defendant's motion for summary disposition is based on the expiration of the statute of limitations. The history of the case includes a Court of Claims case that was dismissed on other grounds and a dismissal of another Defendant in this action on other grounds. Defendant argues that the wrongful death savings clause MCL 600.5852 does not apply. In the absence of a savings clause, the complaint filed on June 6th, 2012, was untimely.

Defendant relies primarily on the Court of Claims opinion in this case that held, quote, "MCL 600.5852 is also inapplicable because the statute applies where a potential Plaintiff dies within 30 days of the expiration of the statute of limitations. Here Mrs. Marquardt died on January 27, 2010, more than six months after the statute of limitations expired on July 20, 2009. Therefore, the wrongful death savings provision does not apply here", unquote.

In the absence of a savings provision, the Defendant asserts that there is no time remaining in the period of limitations that closed on July 20th, 2009, in which Plaintiff could have filed suit. Therefore, the complaint is properly dismissed with prejudice. Plaintiff correctly concedes that absent tolling the medical malpractice statute would have expired on July 20th, 2009, and Plaintiff would have been

prohibited from filing the Court of Claims case on January 19th, 2010, MCL 600.5856(b).

Plaintiff also acknowledges that the notice of intent had to be filed no later than July 20th, 2009, when the two year medical malpractice statute of limitations statute expired. Plaintiff asserts that despite dismissal of the Court of Claims case the claims against Defendant are viable because Defendant was not a party in the Court of Claims case or any companion case and the original notice of intent filed included Defendant and was served on him.

Further, contrary to the Court of Claims opinion and Defendant's argument, Plaintiff asserts that pursuant to the savings provision Plaintiff's complaint was timely filed on June 6th, 2010, prior to the June 14th, 2010, when the PR's two-year period was closed and within the three-year savings period that closed on either July 20th, 2012, or July 18th, 2013.

In support, Plaintiff submits the following analysis, quote, "Once a notice of intent has been mailed, the statute of limitations is tolled for 182 days pursuant to MCL 600.5856(c). That meant that the tolling period in the instant case would have started on July 20th, 2009, and ended on January 18, 2010, which was determined by adding 182 days to the original statute of limitations date. Since the provisions of MCL 600.5856(c) established a tolling provision rather than a savings

provision, the clock applicable to the existing statute of limitations was stopped during the tolling period which meant that the clock resumed again at the end of that tolling period. As such, the new statute of limitations date became January 18th, 2010.

In the instant case, January 18th, 2010, was Martin Luther King Day and the Courts were closed by order. Therefore, the next day when the Courts were open was January 19th, 2010. According to MCL 1.108(1), Plaintiff was permitted to timely file the complaint on January 19, 2010".

The Court finds that Plaintiff's analysis is flawed. Plaintiff's error is in the assumption that the statute of limitations date of July 20, 2009, was, quote, "extended", unquote, by the 182-day tolling provision of MCL 600.2912b(1) and that consequently, quote, "The new statute of limitations date became January 18th, 2010", unquote.

The reason Plaintiff is in error is because tolling does not operate to extend or expand the statute of limitations. Tolling merely extends the time during which a claim can be brought by temporarily suspending the running of the statute of limitations, Bush versus Shabahang, 484 Mich 156;189. As one Court has explained, quote, "The two-year statute of limitations for Plaintiff's medical malpractice action expired on June 4th, 2004, absent tolling. MCL 600.5805(6); MCL 1.108(3). Plaintiff served the notice of intent on

June 4th, 2004. Plaintiff was required to wait the entire 182-day period before filing suit. See Burton versus Reed City Hospital, 471 Mich 745. When the 182-day period ended, the statute of limitations did not resume running, period. The Plaintiff had no time remaining in which to file the suit. See Dewan versus Khoury, 2006 West Law 7853891, Michigan Court of Appeals 2006, unquote".

The above analysis readily applies here. The filing of the notice of intent on July 20th, 2009, merely suspended for 182 days the running of the two-year medical malpractice statute that accrued on July 20th, 2007, and expired on July 20th, 2009. MCL 600.2912b. See Maricle versus Shapiro 2001 West Law 7725313, Mich Ap 2001. When the 182-day period ended on January 18th, 2010, the statute of limitations did not resume running because Plaintiff had no time remaining in the period of limitations in which to file suit absent the savings provision.

The savings provision is not a statute of limitations or a repose and is only an exception to the statute of limitations. Miller versus Mercy Memorial Hospital, 466 Mich 196;202. In other words, the savings provision, such as MCL 600.5852, merely allows commencement of an action after the statute of limitations period has run. Quote, "If a person dies before the period of limitations has run or within 30 days after the period of limitations has run, an action which survives by law

may be commenced by the personal representative of the deceased person at anytime within the two years after the letters of authority are issued, although the period of limitations has run, but an action shall not be brought under this provision unless the personal representative commences it within three years after the period of limitations has run", unquote.

Contrary to Plaintiff's argument and analysis and as the Court of Claims correctly found, decedent's death on January 27, 2010, was more than 30 days after July 20th, 2009. Therefore, MCL 600.5852 does not apply to save the Plaintiff's case against Defendant. For the reasons stated by the Court of Claims and by the Defendant, Defendant's motion for summary disposition is granted. Plaintiff's complaint is dismissed with prejudice. This is a final order that resolves the last pending claim and closes the case.

MRS. SWANSON: Thank you, Your Honor.

MR. MILLER: Thank you.

- - -

STATE OF MICHIGAN)
) SS.
COUNTY OF SAGINAW)

CERTIFICATE OF NOTARY PUBLIC

I, Natalie A. Gilbert, a duly commissioned and qualified Notary Public for the County of Saginaw, State of Michigan, do hereby certify that I have transcribed, via stenographic means to the best of my ability, the taped proceedings conducted on Wednesday, October 30, 2013, before the Honorable David S. Swartz.

I do further certify that I have delivered the original transcript into the possession of THOMAS C. MILLER, ESQ.

I do further certify that I am not connected by blood or marriage with any of the parties or their attorneys; that I am not an employee of any of them nor interested directly or indirectly in the matter in controversy, as counsel, attorney, or otherwise.

IN WITNESS WHEREOF, I have hereunto set my hand at Saginaw, County of Saginaw, State of Michigan, this 19th day of February, 2014.

Natalie A. Gilbert, CSR-4607
Certified Shorthand Reporter
Registered Professional Reporter
Notary Public, Saginaw County, Michigan
My Commission expires: August 10, 2020

- - -

Exhibit 11

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of the Estate of Sandra D. Marquardt,

Plaintiff,

v.

VELLAIAH DURAI UMASHANKAR, M.D.

Defendants.

Case No. 12-621-NH

Honorable David S. Swartz

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ORDER GRANTING DEFENDANT VELLAIAH DURAI UMASHANKAR, M.D.'S MOTION FOR SUMMARY DISPOSITION AND DISMISSING THE CASE WITH PREJUDICE

At a session of said Court, held in the City of Ann Arbor, Washtenaw County, State of Michigan, on

NOV 19 2013, 2013

Present: Hon. _____
Circuit Court Judge

This matter having come before the Court upon the filing of Defendant Vellaiah Durai Umashankar, M.D.'s Motion for Summary Disposition; the Court having reviewed the parties' briefs and a hearing having been held on Wednesday, October 30, 2013;

NOW, THEREFORE, for the reasons stated by the Court on the record at the hearing;

IT IS ORDERED that summary disposition be and the same is hereby granted in favor of Defendant Vellaiah Durai Umashankar, M.D., and all claims against Defendant Vellaiah Durai Umashankar, M.D., are hereby dismissed with prejudice.

This Order resolves the last pending claim and closes the case.

IT IS SO ORDERED.

David S Swartz
Circuit Court Judge

Order prepared by:

Joanne Geha Swanson (P33594)
Attorney for Defendant
Vellaiah Durai Umashankar, M.D.

{34784/15/DT809284.DOC;1}

Exhibit 12

STATE OF MICHIGAN

COURT OF APPEALS

SARON E. MARQUARDT, Personal Representative for the Estate of SANDRA MARQUARDT,

Plaintiff-Appellant,

v

VELLAIAH DURAI UMASHANKAR, MD,

Defendant-Appellee,

and

JONATHAN HAFT,

Defendant.

UNPUBLISHED
March 26, 2015

No. 319615
Washtenaw Circuit Court
LC No. 12-000621-NH

Before: WILDER, P.J., AND SERVITTO, AND STEPHENS, JJ.

PER CURIAM.

In this medical malpractice action, plaintiff appeals as of right from an order of the trial court granting summary disposition in favor of defendant Vellaiah Durai Umashankar, M.D., on the ground that plaintiff's claim is barred by the statute of limitations. We affirm.

On July 20, 2007, the decedent, Sandra Marquardt, underwent mitral valve replacement surgery at the University of Michigan Hospital. Plaintiff claims that during the surgery, the deceased was negligently administered the drug Trasylol. On July 20, 2009, a notice of intent (NOI) to file a medical malpractice claim pursuant to MCL 600.2912b was sent. The NOI was addressed to the risk manager of the University of Michigan Health System. In the body of the NOI, plaintiff expressly stated that decedent "Marquardt intends to file suit against Jonathan Haft, M.D., Umashankar Vellaiah, M.D., Ranjiv Saran, M.D., and the University of Michigan Health System, Inc." In January 2010, the decedent filed suit against the University of Michigan Board of Regents, but did not name defendant Umashankar as a defendant. The decedent died on January 27, 2010, allegedly as a result of complications resulting from the administration of the Trasylol. Plaintiff was appointed personal representative of the estate, which was substituted as plaintiff.

> Defendant moved for summary disposition on the grounds that plaintiff failed to file her cause of action within the statute of limitations and that she failed to satisfy the notice provision of MCL 600.6431(3). The trial court granted summary disposition in favor of defendant on the ground that plaintiff failed to satisfy the notice provision in MCL 600.6431(3). [*In re Estate of Marquardt*, unpublished opinion per curiam of the Court of Appeals, issued November 27, 2012 (Docket No 307917), pp 1-2.]

This Court affirmed the Court of Claims' dismissal of that claim because plaintiff failed to comply with the notice provision of MCL 600.6431(3). *Id.*, unpub op at 2-3.

Plaintiff served defendant Umashankar with a new NOI on September 2, 2011, and filed suit against him on June 7, 2012.[1] Defendant Umashankar moved for summary disposition, which the trial court granted on the ground that plaintiff's claim against Umashankar was barred by the statute of limitations. On appeal, plaintiff challenges the dismissal, arguing that the statute of limitations tolling provision extended the time period in which she could file suit until January 18, 2010, and that the wrongful-death savings provision in MCL 600.5852 saved the claim until June 14, 2012, because the decedent died within 30 days of the January 18, 2010 expiration of the statute of limitations.

The circuit court's grant of summary disposition is reviewed de novo. *Hinkle v Wayne Co Clerk*, 467 Mich 337, 340; 654 NW2d 315 (2002). Summary disposition is properly granted under MCR 2.116(C)(7) when the plaintiff's complaint is barred by the applicable statute of limitations. *Sills v Oakland Gen Hosp*, 220 Mich App 303, 307; 559 NW2d 348 (1996). "In reviewing a motion under MCR 2.116(C)(7), this Court accepts as true the plaintiff's well-pleaded allegations, construing them in the plaintiff's favor." *Hanley v Mazda Motor Corp*, 239 Mich App 596, 600; 609 NW2d 203 (2000). "If the facts are not in dispute, whether the statute bars the claim is a question of law for the court." *Sills*, 220 Mich App at 307.

Absent tolling, the statute of limitations for medical malpractice is two years. MCL 600.5805(6). Accordingly, because plaintiff's claim accrued on July 20, 2007,[2] the limitations period was set to expire on July 20, 2009. The statute of limitations, however, could be tolled for

---

[1] Jonathan Haft, M.D., was also named as a defendant. The trial court granted summary disposition as to Haft, concluding that the affidavit of merit submitted was nonconforming and that there was no time remaining in the limitations period within which plaintiff could refile against him.

[2] MCL 600.5838a(1) provides in pertinent part:

> For purposes of this act, a claim based on the medical malpractice of a person or entity who is or who holds himself or herself out to be a licensed health care professional . . . accrues at the time of the act or omission that is the basis for the claim of medical malpractice, regardless of the time the plaintiff discovers or otherwise has knowledge of the claim.

up to 182 days pursuant to MCL 600.2912b(1), which requires a plaintiff to provide a NOI to file a medical malpractice action and then wait up to 182 days before filing suit. See MCL 600.5856. Here, plaintiff filed the initial NOI on July 20, 2009, the last day in the two-year limitations period. However, MCR 1.108(1) provides:

> (1) *The day of the act, event, or default after which the designated period of time begins to run is not included.* The last day of the period is included unless it is a Saturday, Sunday, legal holiday, or day on which the court is closed pursuant to court order; in that event the period runs until the end of the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is closed pursuant to court order. [Emphasis added.]

Thus, the 182 tolling period did not start until July 21, 2009, which was one day *after* the limitations period had expired. Moreover, the decedent's death on January 27, 2010, was not within the time limits provided in the wrongful-death savings provision in MCL 600.5852

MCL 600.5852(1) provides:

> If a person dies before the period of limitations has run or within 30 days after the period of limitations has run, an action that survives by law may be commenced by the personal representative of the deceased person at any time within 2 years after letters of authority are issued although the period of limitations has run.

Again, the two year limitations period expired on July 20, 2009. Thus, the decedent's death on January 27, 2010, did not occur before the period of limitations had run or within 30 days after that date.

The parties also dispute whether the July 20, 2009, NOI did or would have tolled the statute of limitations with respect to defendant Umashankar at all, regardless of the timeliness. MCL 600.2912b provides in pertinent part as follows:

> (1) Except as otherwise provided in this section, a person shall not commence an action alleging medical malpractice against a health professional or health facility unless the person has given the health professional or health facility written notice under this section not less than 182 days before the action is commenced.
>
> (2) The notice of intent to file a claim required under subsection (1) shall be mailed to the last known professional business address or residential address of the health professional or health facility who is the subject of the claim. Proof of the mailing constitutes prima facie evidence of compliance with this section. If no last known professional business or residential address can reasonably be ascertained, notice may be mailed to the health facility where the care that is the basis for the claim was rendered.

Subsection (1) makes it clear that a plaintiff cannot commence an action unless he or she first gives the party against whom relief is sought (the health professional or health facility)

written notice. Subsection (2) makes it clear that the plaintiff can mail the NOI to either the last known professional business address or residential address of the responding party. The parallel construction of the two provisions makes it clear that the written notice in subsection (1) must be sent to subject party of the notice. That is, if the responding party is a health professional, the NOI must be sent to the professional business or residential address of that professional. If neither address "can reasonably be ascertained," then the NOI can be sent to the healthcare facility where the care rendered by that professional was rendered. However, in order to effectuate the required notice, the NOI must be directed to or addressed to the defendant professional to whom the NOI is intended to provide notice.

The July 20, 2009, NOI was addressed and mailed to the risk manager for University of Michigan Health System. Though the body of the NOI indicated the decedent's intent to file suit against Umashankar, "a medical malpractice plaintiff must provide *every* defendant a timely NOI in order to toll the limitations period applicable to the recipient of the NOI . . . ." *Driver v Naini*, 490 Mich 239, 251; 802 NW2d 311 (2011). Our Supreme Court explicitly stated that it has interpreted MCL 600.2912b:

> as containing a dual requirement: A plaintiff must (1) submit an NOI to *every* health professional or health facility before filing a complaint and (2) wait the applicable notice waiting period with respect to each defendant before he or she can commence an action. [*Driver*, 490 Mich at 255](emphasis in original).

Accordingly, the NOI did not toll the statute of limitations with regard to defendant Umashankar because it was not directed or addressed to him.

Affirmed.

/s/ Kurtis T. Wilder
/s/ Deborah A. Servitto
/s/ Cynthia Diane Stephens

Exhibit 13

Order

November 23, 2016

151555

SARON E. MARQUARDT, Personal Representative for the Estate of SANDRA MARQUARDT,
Plaintiff-Appellant,

v

SC: 151555
COA: 319615
Washtenaw CC: 12-000621-NH

VELLAIAH DURAI UMASHANKAR, MD,
Defendant-Appellee,

and

JONATHAN HAFT,
Defendant.
_____/

On order of the Court, the application for leave to appeal the March 26, 2015 judgment of the Court of Appeals is considered and, it appearing to this Court that the case of *Haksluoto v Mt. Clemens Regional Medical Center* (Docket No. 153723) is pending on appeal before this Court and that the decision in that case may resolve an issue raised in the present application for leave to appeal, we ORDER that the application be held in ABEYANCE pending the decision in that case.

a1116

I, Larry S. Royster, Clerk of the Michigan Supreme Court, certify that the foregoing is a true and complete copy of the order entered at the direction of the Court.

November 23, 2016

Clerk

Exhibit 14

500 Mich. 304
Supreme Court of Michigan.

Jeffrey HAKSLUOTO and Carol Haksluoto, Plaintiffs–Appellants,
v.
MT. CLEMENS REGIONAL MEDICAL CENTER, a/k/a McLaren Macomb, General Radiology Associates, PC, and Eli Shapiro, D.O., Defendants–Appellees.

Docket No. 153723
|
Calendar No. 1
|
Argued April 12, 2017
|
Decided June 27, 2017

Synopsis

Background: Patient filed medical malpractice claim against health care providers for injuries allegedly resulting from a misdiagnosis in an emergency room. The Macomb Circuit Court, Peter J. Maceroni, J., denied providers' motion for summary disposition on statute of limitations grounds. Providers' interlocutory application for leave to appeal was granted. The Court of Appeals, 314 Mich.App. 424, 886 N.W.2d 920, reversed. Patient's motion for leave to appeal was granted.

Holdings: The Supreme Court, Markman, C.J., held that:

[1] as matter of first impression, patient's notice of intent (NOI) to file his medical malpractice claim, which was filed on the final day of the two-year statute of limitations period for medical malpractice actions, tolled the limitations period, abrogating *Lancaster v. Wease*, 2010 WL 3767569, and

[2] patient was required to file his medical malpractice complaint after the 182-day notice period expired, and thus, patient's complaint, which was filed one day after the notice period expired, was timely.

Reversed and remanded.

West Headnotes (17)

[1] **Health**
⇦ Notice
Limitation of Actions
⇦ Pendency of Action or Other Proceeding

The Revised Judicature Act (RJA) requires that a prospective medical malpractice plaintiff provide a potential defendant at least 182 days of notice prior to filing suit; if a plaintiff files a notice of intent (NOI) to file a claim before the limitations period for the malpractice action expires, but the limitations period for the malpractice action would otherwise expire during the 182–day notice period, the statute of limitations for the malpractice action is tolled for the duration of the notice period. Mich. Comp. Laws Ann. §§ 600.2912b(1), 600.5805(6).

Cases that cite this headnote

[2] **Appeal and Error**
⇦ Cases Triable in Appellate Court

The Supreme Court reviews motions for summary disposition de novo.

Cases that cite this headnote

[3] **Appeal and Error**
⇦ Judgment

When a motion for summary disposition is brought based on statute of limitations grounds, all well-pleaded allegations are viewed in the light most favorable to the nonmoving party unless documentary evidence is provided that contradicts them. Mich. Ct. R. 2.116(C)(7).

1 Cases that cite this headnote

[4] **Appeal and Error**
⇦ Cases Triable in Appellate Court

The meaning of statutes and court rules are reviewed de novo by the Supreme Court.

Cases that cite this headnote

[5] **Appeal and Error**
⇦ Cases Triable in Appellate Court
Trial
⇦ Questions of Law or Fact in General

The applicability of a legal doctrine constitutes a question of law; the Supreme Court reviews questions of law de novo.

Cases that cite this headnote

[6] **Limitation of Actions**
⇦ Constitutional and Statutory Provisions

As a general matter, the relevant sections of the Revised Judicature Act (RJA) comprehensively establish limitations periods, times of accrual, and tolling for civil cases; the Legislature intended the scheme to be comprehensive and exclusive. Mich. Comp. Laws Ann. § 600.101 et seq.

Cases that cite this headnote

[7] **Time**
⇦ Fractions of day

As a general proposition, state law rejects fractions of a day; to reject—or disregard—the remaining fraction of a day means courts must either round up to a whole day remaining, or round down to no days remaining when determining whether a statute of limitation period has elapsed.

Cases that cite this headnote

[8] **Limitation of Actions**
⇦ Causes of action in general

In measuring a statute of limitations period, only whole days are counted so as to ensure that the amount of time being provided to the user of the time consists of the entire amount of time the law allows for, which the user of the time essentially receives in addition to the fractional day that initiates the time period.

Cases that cite this headnote

[9] **Health**
⇦ Notice

In reckoning the end of the 182–day notice period for medical malpractice claims, courts exclude the day on which the notice of intent (NOI) to file a claim was served to ensure that defendants receive 182 whole days of notice before the plaintiff files the action. Mich. Comp. Laws Ann. § 600.2912b(1).

Cases that cite this headnote

[10] **Limitation of Actions**
⇦ Causes of action in general

In measuring a statute of limitations period, any act done in the compass of a day is no more referable to any one, than to any other portion of it, but the act and the day are co-extensive.

Cases that cite this headnote

[11] **Limitation of Actions**
⇦ Causes of action in general

The touchstone of the common law is that in measuring a statute of limitations period fractional days must be rounded off in a way that accords with common understanding and is consistent with prevailing social customs, practices, and expectations.

Cases that cite this headnote

[12] **Limitation of Actions**
⇦ Pendency of Action or Other Proceeding

Under the common-law jurisprudence of fractional days, a timely notice of intent (NOI) to file a medical malpractice claim preserves the day the NOI is filed as a day to be used once the two-year statute of limitations period for the medical malpractice claim begins running after the notice period ends; notably, this applies to any NOI that triggers tolling under statutory provision, which tolls the limitations period at the time notice is

given in compliance with the notice period for medical malpractice claims, whether filed on the final day of the limitations period or on some earlier day. Mich. Comp. Laws Ann. §§ 600.2912b(1), 600.5805(6), 600.5856(c).

Cases that cite this headnote

[13] **Limitation of Actions**
⇦ Pendency of Action or Other Proceeding

Once the notice period for a medical malpractice claim ends and the time for the plaintiff to bring a claim once again begins to run, it will run for the number of whole days remaining in the two-year statute of limitations period for medical malpractice actions when the notice of intent (NOI) to file a claim was filed, plus one day to reflect the fractional day remaining when the NOI itself was filed; abrogating *Lancaster v. Wease*, 2010 WL 3767569. Mich. Comp. Laws Ann. §§ 600.2912b(1), 600.5805(6), 600.5856(c).

Cases that cite this headnote

[14] **Limitation of Actions**
⇦ Pendency of Action or Other Proceeding

When a notice of intent (NOI) to file a medical malpractice claim is filed on the final day of the two-year statute of limitations period for medical malpractice claims, the next business day after the notice period expires is an eligible day to file suit. Mich. Comp. Laws Ann. §§ 600.2912b(1), 600.5805(6), 600.5856(c).

Cases that cite this headnote

[15] **Limitation of Actions**
⇦ Pendency of Action or Other Proceeding

Patient's notice of intent (NOI) to file his medical malpractice claim against health care providers for injuries allegedly resulting from misdiagnosis in emergency room tolled two-year statute of limitations period for patient's medical malpractice action, where patient filed his NOI on the final day of the limitations period. Mich. Comp. Laws Ann. §§ 600.2912b(1), 600.5805(6).

Cases that cite this headnote

[16] **Limitation of Actions**
⇦ Negligence in performance of professional services

Limitation of Actions
⇦ Filing pleadings

Patient was required to file his medical malpractice complaint after the 182-day notice period for his medical malpractice claim expired, and thus, patient's complaint, which was filed one day after the notice period expired, was timely and legally sufficient to commence his action against health care providers for injuries allegedly resulting from misdiagnosis in emergency room; Revised Judicature Act (RJA) required patient to wait 182 days after filing his notice of intent (NOI) to file his claim before filing suit, which meant that if patient had filed suit on the last day of the 182-day period, his complaint would have been untimely. Mich. Comp. Laws Ann. § 600.2912b(1); Mich. Ct. R. 1.108(1).

Cases that cite this headnote

[17] **Courts**
⇦ Highest appellate court

The Supreme Court is not bound by decisions of the Court of Appeals.

1 Cases that cite this headnote

Attorneys and Law Firms

*579 Hertz Schram PC (by Steve J. Weiss and Daniel W. Rucker) for plaintiffs.

Giarmarco, Mullins & Horton, PC (by LeRoy H. Wulfmeier, III, and Jared M. Trust), for defendants.

Charfoos & Christensen, PC (by David R. Parker), for the Michigan Association for Justice. Hewson & Van Hellemont, PC (by Nicholas S. Ayoub), Amici Curiae, for Michigan Defense Trial Counsel.

BEFORE THE ENTIRE BENCH

Opinion

OPINION

Markman, C.J.

[1] The Revised Judicature Act (RJA), MCL 600.101 *et seq.*, requires that a prospective medical malpractice plaintiff provide a potential defendant at least 182 days of notice prior to filing suit. If a plaintiff files a notice of intent (NOI) to file a claim before the limitations period for the malpractice action expires, but the limitations period for the malpractice action would otherwise expire during the 182–day notice period, the statute of limitations for the malpractice action is tolled for the duration of the notice period. In this case, we consider whether the limitations period is tolled when the NOI is filed on the last day of the limitations period, leaving no whole days of the limitations period to toll. We conclude that the limitations period *is* tolled under such circumstances. As a result, we further conclude that plaintiff's complaint, which was filed the day after the notice period ended, was timely, and we reverse the contrary decision of the Court of Appeals.

I. FACTS AND HISTORY

On December 26, 2011, plaintiff Jeffrey Haksluoto [1] went to the emergency room at defendant Mt. Clemens Regional Medical *580 Center, complaining of abdominal pain and various forms of gastrointestinal distress. He was given a CT scan that was interpreted by defendant Dr. Eli Shapiro as being unremarkable, and plaintiff was sent home. Plaintiff went back to the emergency room on January 6, 2012, at which time, he asserts, he was correctly diagnosed, prompting emergency surgery. Plaintiff now alleges that Dr. Shapiro misinterpreted the CT scan on December 26 and that if it had been properly interpreted, his condition would have been detected sooner and addressed rather than worsening.

It is undisputed that the end of the limitations period for plaintiff's medical malpractice claim was December 26, 2013. Plaintiff served his NOI on that very date, the final day of the limitations period. After waiting 182 days from December 26, 2013, plaintiff then filed his complaint on the "183rd day," June 27, 2014. Shortly after he filed his complaint, defendants filed a motion for summary disposition, arguing that the suit was time-barred, but the trial court denied the motion.

The Court of Appeals reversed. *Haksluoto v. Mt. Clemens Regional Med. Ctr.*, 314 Mich.App. 424, 886 N.W.2d 920 (2016). The panel held that MCR 1.108—the rule concerning the calculation of time—is best understood to signify that "the 182–day notice period began on December 27, 2013—the day *after* plaintiffs served the NOI on December 26, 2013—and expired on June 26, 2014." *Id.* at 432, 886 N.W.2d 920. Because this meant that "the notice period did not commence until one day *after* the limitations period had expired," the Court felt "constrained to conclude that filing the NOI on the last day of the limitations period was not sufficient to toll the statute of limitations...." *Id.* at 432–433, 886 N.W.2d 920. The Court acknowledged "that [its] analysis means that a plaintiff who serves an NOI on the last day of the limitations period is legally incapable of filing a timely complaint and is, in effect, deadlocked from timely filing a suit in compliance with both the statutory notice period and the statute of limitations." *Id.* at 433, 886 N.W.2d 920. We granted leave to appeal to consider whether plaintiff's NOI tolled the statute of limitations and whether the instant complaint filed the day after the notice period ended was therefore timely. *Haksluoto v. Mt. Clemens Regional Med. Ctr.*, 500 Mich. 892, 886 N.W.2d 718 (2016).

II. STANDARD OF REVIEW

[2] [3] [4] [5] This Court reviews motions for summary disposition de novo. *Maiden v. Rozwood*, 461 Mich. 109, 118, 597 N.W.2d 817 (1999). Defendants' motion for summary disposition in the trial court was brought under MCR 2.116(C)(7). All well-pleaded allegations are viewed in the light most favorable to the nonmoving party unless documentary evidence is provided that contradicts them. *Patterson v. Kleiman*, 447 Mich. 429, 434, 526 N.W.2d 879 (1994). Substantively, this case requires us to interpret the meaning of statutes and court rules, which are reviewed de novo. See *McAuley v. Gen. Motors Corp.*, 457 Mich. 513, 518, 578 N.W.2d 282 (1998). Similarly, "[t]he applicability of a legal doctrine [constitutes] a question of law. This Court reviews questions of law de novo." *James v. Alberts*, 464 Mich. 12, 14, 626 N.W.2d 158 (2001). See also *Tkachik*

v. Mandeville, 487 Mich. 38, 45, 790 N.W.2d 260 (2010) ("The interpretation and applicability of a common-law doctrine is also a question that is reviewed de novo.").

III. ANALYSIS

A. LEGAL BACKGROUND

The parties' arguments and the Court of Appeals' decision both draw upon certain *581 provisions of the RJA and upon our court rule on calculating time periods. The limitations period for a medical malpractice action is two years. MCL 600.5805(6). The RJA also imposes a notice requirement on prospective medical malpractice plaintiffs:

> [A] person shall not commence an action alleging medical malpractice against a health professional or health facility unless the person has given the health professional or health facility written notice under this section not less than 182 days before the action is commenced. [MCL 600.2912b(1).]

Michigan employs a "mailbox rule" for providing this notice of intent. See MCL 600.2912b(2) ("Proof of the mailing constitutes prima facie evidence of compliance" with the NOI requirement.). The RJA also provides that mailing an NOI tolls the statute of limitations

> [a]t the time notice is given in compliance with the applicable notice period under [MCL 600.2912b], if during that period a claim would be barred by the statute of limitations.... [MCL 600.5856(c).]

Plaintiff here mailed the required NOI on the final day of the limitations period: December 26, 2013. Plaintiff argues that, because MCL 600.5856(c) provides that the limitations period is tolled "[a]t the time notice is given," the limitations period was tolled at that point. Because there was some time remaining on the clock (that portion of December 26 that had not yet elapsed), plaintiff argues that we must "round up" and afford him a whole day on which to file his complaint after the notice period has ended. Defendants and the Court of Appeals, by contrast, point to MCR 1.108(1), which provides that in computing periods of time, "[t]he day of the act, [or] event, ... after which the designated period of time begins to run is not included." Defendants argue that because the day of the act or event "is not included," the notice period did not begin until December 27, 2013, the day after the limitations period ended. Since the limitations period is tolled under MCL 600.5856(c) only when the limitations period is going to expire *during* the notice period, that notice period did not begin until *after* the limitations period ended, and therefore "there was nothing left to toll," *Ligons v. Crittenton Hosp.*, 490 Mich. 61, 90, 803 N.W.2d 271 (2011), rendering plaintiff's complaint untimely. [2]

[6] As a general matter, "the relevant sections of the Revised Judicature Act comprehensively establish limitations periods, times of accrual, and tolling for civil cases." *Trentadue v. Buckler Automatic Lawn Sprinkler Co.*, 479 Mich. 378, 390, 738 N.W.2d 664 (2007). "[T]he Legislature intended the scheme to be comprehensive and exclusive." *Id.* at 391, 738 N.W.2d 664. Consequently, any deviation due to tolling from the two-year limitations period for malpractice actions is only as provided by statute, such as in MCL 600.5856(c). That tolling provision states that tolling begins "[a]t the time notice is given," so long as the limitations period would otherwise expire during the notice period. Thus, we *582 stated in *Driver v. Naini*, 490 Mich. 239, 249, 802 N.W.2d 311 (2011), that "[w]hen a claimant files an NOI with time remaining on the applicable statute of limitations, that NOI tolls the statute of limitations...." Because it is undisputed that the notice here was filed on the final day of the limitations period (but before that final day ended), MCL 600.5856(c) has ostensibly been satisfied so as to trigger tolling.

[7] However, as a general proposition, "[o]ur law rejects fractions of a day...." *Warren v. Slade*, 23 Mich. 1, 3 (1871). To "reject"—or disregard—the remaining fraction of a day means we must either round up to a whole day remaining, or round down to no days remaining. *Driver* makes clear that tolling is contingent on there being time left to toll. Given that the instant NOI was filed on the final day of the limitations period, if we were to round down, the NOI would not trigger tolling because there would be no time left to toll. Therefore, to know whether there was any time left to toll and hence whether tolling was triggered, we must determine whether we round up or round down. While the Legislature certainly has the power

to abrogate the common-law rule disregarding fractions of a day, see *Cohen v. Supreme Sitting of the Order of the Iron Hall*, 105 Mich. 283, 288, 63 N.W. 304 (1895) ("In the *absence* of any statute recognizing fractions of days, it has been held that all judgments entered on the same day will be regarded as if entered at the same time.") (emphasis added), MCL 500.5856(c) does not do so. Therefore, the fundamental question we confront here is whether less than a whole day remaining in the limitations period qualifies as "time remaining on the applicable statute of limitations" as required by *Driver* to trigger tolling. In other words, while MCL 600.5856(c) provides that the limitations period is tolled "[a]t the time notice is given," if the NOI is served on the final day of the limitations period and only a fraction of a day is left, can that fractional day be tolled? This is surprisingly a question of first impression in this state. None of our caselaw squarely answers the question. [3] Rather, we must turn to the law of fractional days.

*583 B. LAW OF FRACTIONAL DAYS

While it is well established that fractional days are to be disregarded, to assert this affords little insight as to how to go about *implementing* such disregard. We must determine whether this disregard is or is not consistent with recognizing that the instant NOI was filed before the end of the day on December 26, 2013, and if we do take such note, what effect the unexpired portion of the day had on plaintiff's subsequent filing options. The parties spend considerable effort disputing the significance of MCR 1.108(1) on this case, but that rule deals with only a single aspect of how fractional days are regarded—how time periods are *counted* in relation to fractional days. The law of fractional days, however, has two relevant strands of analysis—how time periods are counted and how fractional days are rounded off.

1. COUNTING TIME

The law regarding how time is counted is currently codified in two overlapping provisions. Among our statutes, MCL 8.6 provides that, "[i]n computing a period of days, the first day is excluded and the last day is included." Relatedly, MCR 1.108(1) provides that, "[i]n computing a period of time prescribed or allowed by these rules, by court order, or by statute ... [t]he day of the act, [or] event, ... after which the designated period of time begins to run is not included," but "[t]he last day of the period is included...." [4] This method of excluding the first day and including the last day has been codified within our court rules in some version since Michigan's origins. Our current court rule is essentially a restatement of its predecessor, GCR 1963, 108.6, which, in turn, was a broadened version of *its* predecessor, Court Rule No. 9, § 1 (1945). [5] Court Rule No. 9, § 1 (1945) applied this method of excluding the first day and including the last to time periods that ran from the service of various court documents; however, the same method was used for time periods under statutes as a matter of common law. See, e.g., *Gorham v. Wing*, 10 Mich. 486, 496 (1862) ("When time is to be computed *from* the time of an act done, we think the more reasonable rule is that the day on which the act is done is to be excluded from the computation [.]"). Thus, although the method of excluding the first day and including the last was not *codified* as to statutory time periods until the 1963 court rules, it nonetheless has consistently been applied in all contexts because it "best accords with the common understanding and is least likely to lead to mistakes in the application of statutory provisions." *Griffin v. Forrest*, 49 Mich. 309, 312, 13 N.W. 603 (1882). The fact that the same method prevails whether implemented by court rule or as simply a matter of historical practice suggests that the rule excluding the first day and *584 including the last is tantamount to a common-law principle. [6]

The rationale for this method of excluding the first day and including the last in calculating a period of time is to ensure that parties receive the entire amount of time to which they are entitled. Consider, for example, *Dousman v. O'Malley*, 1 Doug. 450 (Mich., 1844), which applied a statutory ancestor of MCL 8.6. Under 1838 R.S. pt. 1, tit. 1, ch. 1, § 3, ¶ 11, "[a]ny specified number of days [was to be] construed to mean entire days, excluding any fraction of a day[.]" [7] *Dousman* applied the method to 1840 P.A. 45, § 3, which required that a certain "citation ... be served three days at least, before the return day thereof...." In *Dousman*, the citation had been served on March 29, 1843, with a return date of April 1, and we said that this was insufficient because the statutory "rule of construction would exclude the day of service, that being but the fraction of a day; and, but two entire days having intervened, between the day of service and the return day of the citation, the service was clearly insufficient." 1

Doug. at 451. In other words, when a party is afforded a certain number of days, that period is construed as a certain number of whole days, excluding the day which triggered the running of the period, to ensure that the party receives all of the time to which he or she is entitled. We apply a similar principle in the medical malpractice realm, requiring that a plaintiff wait the entire 182–day notice period before filing a complaint. See *Tyra v. Organ Procurement Agency of Mich.*, 498 Mich. 68, 94, 869 N.W.2d 213 (2015).

[8] Defendants argue that because our method of counting days excludes the first day, the notice period does not begin until the day after the notice was served, which was "day one" of the notice period under our counting rule. However, investing this much significance into identifying "day one" is inconsistent with *Dunlap v. Sheffield*, 442 Mich. 195, 200 n. 5, 500 N.W.2d 739 (1993), in which we noted that "if the period was measured in days, *it would begin on the date of the accident*" because MCR 1.108(1) "only indicates that the 'day counter' will not register a '[one]' until the day after the accident." (Emphasis added.) *Dunlap* thus establishes that "day one" is not the same as the day that the period begins running. The day counter is a method by which we ensure that the party afforded a particular amount of time is provided that *entire* amount of time. As we held in *Dousman*, only whole days are counted so as to ensure that the amount of time being provided to the "user" of the *585 time consists of the entire amount of time the law allows for, which the user of the time essentially receives in *addition* to the fractional day that initiates the time period. In the context of this case, once the NOI was filed on December 26, 2013, "day 182" was June 26, 2014. Because Michigan uses a mailbox rule for NOIs, MCL 600.2912b(2), the notice period ran for 182 whole days *plus* whatever fraction of the day was left on December 26, 2013, at which time the NOI was placed in the mail.

[9] In sum, the law of counting time indicates that the first fractional day—i.e., the day that triggers the running of the time period—is excluded, while the last day is included, based on common-law notions of fairness. After all,

> [i]f a man is given a certain number of days after an event in which to perform an act or claim a right, he is likely to understand that he is allowed so many *full* days, and would be surprised if told that the fragment of the day on which the event took place was to be taken into the account against him. [*Griffin*, 49 Mich. at 312, 13 N.W. 603] (emphasis added).]

Thus, in reckoning the end of the 182–day notice period, we exclude the day on which the NOI was served to ensure that *defendants* receive 182 whole days of notice. The law of counting time tells us how long plaintiff had to wait before filing his complaint to ensure that defendants received every moment of the notice to which they were entitled. What the law of counting time does *not* explain is the legal consequence of the NOI filed on the final day of the limitations period and the effect of the unexpired fraction of the day on plaintiff's options once the notice period ended. In other words, the law of counting time provides no answer as to whether the NOI, which was filed with less than an entire day remaining in the limitations period, tolled that period, in that it provides no answer as to whether the limitations period should be treated as having any time left to toll if there is only a *fraction* of a day remaining. To resolve this, we must look to our law relating to the rounding off of fractional days.

2. ROUNDING FRACTIONAL DAYS

[10] As already noted, our law disregards fractions of a day. *Warren*, 23 Mich. at 3. This concept is not specific to Michigan but is instead a general feature of the common law. See, e.g., *McGill v. Bank of U.S.*, 25 U.S. (12 Wheat.) 511, 514, 6 L.Ed. 711 (1827) ("[T]he law makes no fractions of a day."). Indeed, this proposition predates even American independence. Blackstone provided "a short explanation of the division and calculation of time by the English law," in which he observed that "[i]n the space of a day all the twenty four hours are usually reckoned; the law generally rejecting all fractions of a day, in order to avoid disputes." 2 Blackstone, Commentaries on the Laws of England, pp. **140–141. As we have expressed the principle, "[A]ny act done in the compass of [a day] is no more referable to any one, than to any other portion of it, but the act and the day are co-extensive[.]" *Warren*, 23 Mich. at 3. This establishes that there is no need to inquire into precisely *when* on December 26, 2013, plaintiff filed his NOI. Instead, the fact that it was filed at some point or another on that day is all that matters, with the legal consequence of that action being the same

regardless of the precise point in the day when it occurred. But what consequence, if any, should attach to the act of filing the NOI on the final day of the limitations period? Should we "round *down*" and treat the NOI filed on the final day as ineffective at tolling for want of any time left to toll, or should we "round *up*" and treat the NOI as having *586 tolled, and preserved, the date on which the NOI was filed for use once the notice period ended?

A system that disregards fractions of a day and trades only in whole days—a system in which fractional days are rounded off in some fashion—will necessarily result in parties getting somewhat more, or somewhat less, time than they would have received if the calculation of time had taken notice of hours and minutes. This effect has caused some confusion as to how "edge" cases such as the instant one should be treated.

> Now, in several of these cases, the actual result of the rule ... may be, under given circumstances, to give the party one day more than the statute time in which to bring suit, inasmuch as he would be legally entitled to act on the very day of the event from which the time is computed, if that event took place at an hour of the day which, would permit of action; but, on the other hand, the opposite rule ... would, under other circumstances, give him one day less than the statute time, and if that time was one day only, would give him no time at all. There is good reason, therefore, in the rule ... of treating the day of the act or event as a point of time only, and excluding it altogether from the computation. [*Id.* at 5.]

We ultimately decided in *Warren* to err on the side of affording parties somewhat *more* time rather than somewhat *less*—to "round up" rather than "round down"—because this was consistent with "the preponderance of American authority," which "harmonize[d] with the mode of computing time under rules of practice," making it "less likely [that] those who are to act ... [are] deceived and misled in their action." *Id.* at 6.

[11] The touchstone of the common law, therefore, is that fractional days must be rounded off in a way that accords with common understanding and is consistent with prevailing social customs, practices, and expectations. We recently reaffirmed this principle in *People v. Woolfolk*, 497 Mich. 23, 857 N.W.2d 524 (2014). The common-law rule that fractions of a day were disregarded was traditionally applied to mean that a day was considered over as soon as it began; accordingly, a person was considered to have arrived at a particular age on the day before his or her birthday. We rejected this rule as inconsistent with "the prevailing customs and practices of the people" to conclude that a person did not advance to their next year of age until his or her actual birthday. *Id.* at 26–27, 857 N.W.2d 524. This establishes an altogether sensible rule that, in disregarding fractions of a day, we do not consider a day to be over until it is *entirely* over.

If, as we said in *Warren*, "any act done in the compass of [the day] is no more referable to any one, than to any other portion of it," we can just as easily say that, in disregarding fractions of a day, an act taken on a particular day can be construed as though either the day had not yet begun or was entirely over. If our rule is that a day is not over until it is *entirely over*, then we have effectively decided to construe our disregarding of fractional days, at least in this context, as though the day had *not yet begun*—to, in effect, "round up" rather than down. If we were to analogize days to beads on an abacus, in disregarding fractions of a day, we keep the beads on one end of the wire or the other rather than measuring intermediate locations, and we do not move the bead from one end of the wire to the other until the day is *completely* over. But this does not mean that we are incapable of identifying when a bead has been shifted over and when it has not; it is not inconsistent with our disregard of fractional days to take *587 note that December 26, 2013, was only partially exhausted when the NOI was mailed. But with the day not yet over, the bead was not yet advanced. Thus, we first take notice of the fact that the day was not yet over when the NOI was filed, and second, that the NOI filed on that day preserved that *entire* day for use when the 182–day notice period finally expired.

In reaching a contrary conclusion, the Court of Appeals acknowledged that its resolution of the case meant that a plaintiff who filed an NOI on the final day of the limitations period was "deadlocked." *Haksluoto*, 314 Mich.App. at 433, 886 N.W.2d 920. It is hard to see how

a conclusion that a plaintiff could end up "deadlocked" before the limitations period expires accords with "common understanding," which we expressed as the governing standard in *Griffin*. Indeed, this Court has specifically acknowledged this concern when it stated that "[t]he Legislature surely did not intend its tolling provision as a trap for the unwary...." *Omelenchuk v. City of Warren*, 461 Mich. 567, 576 n. 19, 609 N.W.2d 177 (2000), overruled in part on other grounds by *Waltz v. Wyse*, 469 Mich. 642, 677 N.W.2d 813 (2004). Leaving a plaintiff "deadlocked" when that plaintiff files an NOI before the limitations period expires seems as if it is the epitome of a "trap for the unwary," and it cannot be countenanced here.

[12] [13] We hold, therefore, that applying our common-law jurisprudence of fractional days produces a conclusion that a timely NOI preserves the day the NOI is filed as a day to be used once the limitations period begins running after the notice period ends. Notably, this applies to any NOI that triggers tolling under MCL 600.5856(c), whether filed on the final day of the limitations period or on some earlier day. The rule is that once the notice period ends and the time for the plaintiff to bring a claim once again begins to run, it will run for the number of *whole days* remaining in the limitations period when the NOI was filed, *plus* one day to reflect the fractional day remaining when the NOI itself was filed. There is no principled reason to treat the last day differently from any other—the abacus bead does not slide over until the day is over, and that applies with equal force to the ultimate and penultimate days of the limitations period.

[14] The rule we adopt here has been used in Michigan before. In *Crockett v. Fieger Fieger Kenney & Johnson, P.C.*, unpublished per curiam opinion of the Court of Appeals, issued October 28, 2003 (Docket No. 240863), 2003 WL 22439718, the claim accrued on April 10, 1996. The Court stated:

> Assuming *arguendo* the notice of intent had been sent on April 10, 1998 [the last day of the limitations period], the limitations period would have been tolled until Friday, October 9, 1998 ..., and *suit would have [had to have] been filed by the following Monday....* [*Id.* at 2, 2003 WL 22439718 (emphasis added).]

This is precisely the result we endorse here—when an NOI is filed on the final day of the limitations period, the next business day after the notice period expires is an eligible day to file suit. [8]

*588 As noted, this rule applies whether the NOI is filed on the final day of the limitations period or some day before the final day. Either way, if it is filed at a point at which tolling will occur, the remaining period preserved for plaintiff to use once the notice period ends comprises the number of whole days remaining in the period of limitations when the NOI was filed, *plus* one day to reflect the fractional day remaining when the NOI is filed. Consider, in this light, the example of *Lancaster v. Wease*, unpublished per curiam opinion of the Court of Appeals, issued September 28, 2010 (Docket No. 291931), 2010 WL 3767569. There, the plaintiff filed her NOI the day before the limitations period expired and, after the notice period ended, filed her complaint not on the day immediately following the 182–day notice period ("day 183" after the NOI), but instead the day after that ("day 184" after the NOI). The Court held that her complaint was untimely. Under the rule we adopt here, that is the wrong conclusion—the plaintiff's complaint should have been deemed timely because the one whole day remaining in the limitations period was preserved *plus* the day on which the NOI was filed.

C. APPLICATION

[15] As applied to the instant case, the rule is simple to implement. Plaintiff filed his NOI on the final day of the limitations period—December 26, 2013. Because it was filed before the end of the day on December 26, 2013, some fraction of that day remained. We take notice of that fraction of the day only to the extent that we recognize that it was not yet over, and not yet having ended, our metaphorical abacus bead was not yet shifted from one end of the wire to the other. Consequently, the NOI tolled the limitations period, leaving one day for plaintiff to file his complaint after the notice period ended.

D. PRESERVED DAY

[16] [17] Defendants also argue that even if plaintiff's NOI served on the final day of the limitations period successfully tolled the running of the statute of limitations, plaintiff's *complaint* was still untimely. They argue that plaintiff was required to file his complaint on "day 182"—the final day of the 182–day notice period—rather than on "day 183," the following day, on which he did file.[9] The RJA requires a plaintiff to wait 182 days after filing an NOI *before* filing suit. See MCL 600.2912b(1) ("[A] person shall not commence an action alleging medical malpractice ... unless the person has given ... written notice ... not less than 182 days *before* the action is commenced.") (emphasis added). We have made clear that a plaintiff must wait the *entire* 182 days before filing a complaint. In *Burton v. Reed City Hosp. Corp.*, 471 Mich. 745, 754, 691 N.W.2d 424 (2005), we said that "the failure to comply with the statutory [notice] requirement renders the complaint insufficient to commence the action." In *Tyra*, 498 Mich. at 76–77, 869 N.W.2d 213, the plaintiff's action accrued on April 4, ***589** 2008, and the limitations period therefore expired on April 4, 2010. The NOI, dated April 1, 2010, was placed in the mail on April 4, 2010. The complaint was then filed on September 30, 2010, which was 179 days after the NOI. We held that the complaint was premature and therefore legally insufficient. In doing so, we observed that "[e]ven assuming that the NOI had been sent on April 1, 2010, ... the complaint was filed at least one day prematurely." *Id.* at 77 n. 5, 869 N.W.2d 213. Under MCR 1.108(1), September 30, 2010—the day the complaint in *Tyra* was filed—was "day 182" after April 1, 2010. Our conclusion that a complaint on "day 182" was untimely only further emphasizes that the *entire* 182–day notice period must be over *before* a plaintiff can file a complaint. Indeed, this is precisely the rule of *Dousman*, in which the plaintiff had to wait three *whole* days *plus* the day of service before hailing the defendant into court.

In much the same fashion here, had plaintiff filed his complaint on June 26, 2013—"day 182"—the complaint would have been untimely and legally insufficient. Instead, he had to wait 182 days *as calculated by MCR 1.108(1)*, meaning that he had to wait until June 26, 2013, was over before using whatever time remained of the period of limitations—in this case, one day, June 27, 2013, on which he filed the complaint. Therefore, his complaint was timely filed and was legally sufficient to commence his suit.

IV. CONCLUSION

This Court has not hesitated in the past to enforce the various notice and filing requirements related to medical malpractice actions as they are written. Where, as here, plaintiff's NOI was timely filed and he filed his complaint on the day that he preserved from the limitations period, he cannot be denied his day in court. Consequently, the decision of the Court of Appeals is reversed, and the matter is remanded to the trial court for further proceedings consistent with this opinion.

Brian K. Zahra, Bridget M. McCormack, David F. Viviano, Richard H. Bernstein, Joan L. Larsen, Kurtis T. Wilder

All Citations

500 Mich. 304, 901 N.W.2d 577

Footnotes

1 His wife, Carol Haksluoto, is also a named plaintiff, claiming loss of consortium. For ease of reference, this opinion will refer to plaintiff in the singular form.

2 Both parties essentially assume the conclusion of their respective arguments. It is undoubtedly true that the NOI was filed at some point before the end of December 26, 2013, and that December 27, 2013, was "day one" for purposes of the 182–day notice/tolling period. However, contrary to defendants' argument and the position of the Court of Appeals, identifying "day one" offers little illumination as to the legal consequences of the unexpired portion of December 26 that remained when plaintiff filed his NOI. By the same token, while it is true that the RJA provides that tolling begins "[a]t the time notice is given," plaintiff also begs the question when he argues that this language necessarily rendered timely his complaint filed on "day 183."

3 Both parties invite us to look to passing remarks in our prior opinions that are consistent with either plaintiff's or defendants' arguments. For example, plaintiff points to *Tyra v. Organ Procurement Agency of Mich.*, 498 Mich. 68, 76, 869 N.W.2d 213 (2015), in which we characterized an NOI sent on the final day of the limitations period as "timely"; while the plaintiff's complaint there was ultimately disallowed as having been filed before the notice period had ended, plaintiff notes that we

raised no concerns that the plaintiff would have been "deadlocked" had she not waited for the end of the notice period. However, this is nonbinding dicta. See *People v. Peltola*, 489 Mich. 174, 190 n. 32, 803 N.W.2d 140 (2011) ("Obiter dicta are not binding precedent."). The issue in *Tyra* was whether the complaint was filed *prematurely*, not whether the NOI filed on the final day of the limitations period succeeded in tolling the running of the statute of limitations.

Defendants point us, for example, to our order denying leave in *Dewan v. Khoury*, 477 Mich. 888, 722 N.W.2d 215 (2006). There, the plaintiff filed the NOI on the final day of the limitations period, waited 182 days, which ended on a Friday, and then filed suit on the following Monday. The Court of Appeals held that the complaint was untimely because the notice period did not begin until the day after the NOI was served, signifying that the notice period did not begin during the limitations period and thus there was no limitations period left to toll. We denied leave to appeal. However, denials of leave to appeal do not establish a precedent. See MCR 7.301(E) ("The reasons for denying leave to appeal ... are not to be regarded as precedent."); *Tebo v. Havlik*, 418 Mich. 350, 363 n. 2, 343 N.W.2d 181 (1984) (opinion by BRICKLEY, J.) ("A denial of leave to appeal has no precedential value."); *Frishett v. State Farm Mut. Auto. Ins. Co.*, 378 Mich. 733, 734 (1966) (When denying leave to appeal, "the Supreme Court expresses no present view with respect to the legal questions dealt with in the opinion of the Court of Appeals.").

4 The apparent overlap of the statute with the court rule was previously recognized in *Beaudry v. Beaudry*, 20 Mich.App. 287, 288, 174 N.W.2d 28 (1969).

5 "The day on which any rule shall be entered, claim of appeal filed, or order, notice, pleading or papers served shall be excluded in the computation of the time for complying with the exigency of such rule, order or notice, pleading or paper, and the day on which a compliance therewith is required shall be included...." A version of the rule has been in continuous effect since Michigan's origins as a state. See Court Rule No. 9 (1933); Court Rule No. 9 (1931); Supreme Court Rule No. 25 (1916); Circuit Court Rule No. 5 (1916); Supreme Court Rule No. 25 (1897); Circuit Court Rule No. 36(a) (1897); Supreme Court Rule No. 7 (1858); Circuit Court Rule No. 15 (1858); Supreme Court Rule No. 7 (1853); Circuit Court Law Rule No. 14 (1853); Supreme Court Rule No. 7 (1843); Circuit Court Law Rule No. 9 (1843); Court Rule No. 21 (1834).

6 Cases applying the method without recourse to any positive law authority include *Wesbrook Lane Realty Corp. v. Pokorny*, 250 Mich. 548, 550, 231 N.W. 66 (1930) ("The general rule ... is to exclude the day from which the notice begins to run and include that of performance."), *Gantz v. Toles*, 40 Mich. 725, 728 (1879) ("The general rule in regard to notices which has always prevailed in this State includes the day of performance and excludes the day from which notice begins to run."), and *Gorham*, 10 Mich. at 496 (applying rule excluding first day and including last day to redemption period). On the other hand, in *Anderson v. Baughman*, 6 Mich. 298 (1859), we looked to Supreme Court Rule No. 7 (1858) rather than more generally invoking the "practice" of the Court. See also Computation of Time, 9 Opinions of the U.S. Attorney General 131, 132–133 (March 10, 1858) ("It is the universal rule, in the computation of time for legal purposes, not to notice fractions of a day....").

7 This requirement was not retained in the Revised Statutes of 1846, and an analogous requirement was not reintroduced to our statutory law until the Legislature adopted MCL 8.6 in 1966. As this history makes clear, however, the same requirement has been in our court rules, and enforced as a matter of practice in our caselaw, the entire time.

8 Maine has reached the same conclusion with its similar notice scheme, concluding that "the day of serving notice of claim ... does not count in either the calculation of the period of limitations or in the calculation of the 90–day notice period," leaving the day on which notice is served as a preserved day of the limitations period once the notice period ends. *Gilbert v. Maine Med. Ctr.*, 483 A.2d 1237, 1239 (Me. 1984). See also *Woods v. Young*, 53 Cal.3d 315, 326 n. 3, 279 Cal.Rptr. 613, 807 P.2d 455 (1991) ("A plaintiff who serves the notice of intent to sue on the last day of the limitations period has one day after the ninety-day waiting period to file the complaint.").

9 Defendants point to dicta in *Kincaid v. Cardwell*, 300 Mich. App. 513, 524, 834 N.W.2d 122 (2013), in support of their argument. "This Court, of course, is not bound by Court of Appeals decisions." *Catalina Mktg. Sales Corp. v. Dep't of Treasury*, 470 Mich. 13, 23, 678 N.W.2d 619 (2004). Moreover, the statement in *Kincaid* that an act of malpractice must have occurred within two years and 182 days of the filing of the complaint (rather than, as we hold here, two years and 183 days) constituted dicta when the act of malpractice occurred two years and 207 days before the filing of the complaint. The distinction pertinent in the instant case was not relevant.

End of Document

Exhibit 15

Order

Michigan Supreme Court
Lansing, Michigan

Stephen J. Markman,
Chief Justice

Brian K. Zahra
Bridget M. McCormack
David F. Viviano
Richard H. Bernstein
Joan L. Larsen
Kurtis T. Wilder,
Justices

September 27, 2017

151555

SARON E. MARQUARDT, Personal Representative for the Estate of SANDRA MARQUARDT,
Plaintiff-Appellant,

v

SC: 151555
COA: 319615
Washtenaw CC: 12-000621-NH

VELLAIAH DURAI UMASHANKAR, MD,
Defendant-Appellee,

and

JONATHAN HAFT,
Defendant.
_____/

By order of November 23, 2016, the application for leave to appeal the March 26, 2015 judgment of the Court of Appeals was held in abeyance pending the decision in *Haksluoto v Mt Clemens Regional Medical Center* (Docket No. 153723). On order of the Court, the case having been decided on June 27, 2017, 500 Mich ___ (2017), the application is again considered. Pursuant to MCR 7.305(H)(1), in lieu of granting leave to appeal, we VACATE the judgment of the Court of Appeals and REMAND this case to the Washtenaw Circuit Court for reconsideration in light of *Haksluoto*.

We do not retain jurisdiction.

WILDER, J., did not participate because he was on the Court of Appeals panel.

a0920

I, Larry S. Royster, Clerk of the Michigan Supreme Court, certify that the foregoing is a true and complete copy of the order entered at the direction of the Court.

September 27, 2017

Clerk

Exhibit 16

2001 WL 772531
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Court of Appeals of Michigan.

Susan MARICLE, Plaintiff-Appellant,
v.
Dr. Brian SHAPIRO and General Surgeons of Flint, P.C., Defendants-Appellees.

No. 217533.
|
Jan. 23, 2001.

Before: SAAD, P.J., and GRIFFIN and R.B. BURNS,* JJ.

Opinion

PER CURIAM.

*1 Plaintiff appeals as of right from the trial court's order granting defendants' motion for summary disposition pursuant to MCR 2.116(C)(7) based on the statute of limitations. We affirm.

This medical malpractice action arose from the surgery performed by defendant Dr. Brian Shapiro, who is a general surgeon, on May 8, 1996. Dr. Shapiro removed two lymph nodes from plaintiff's neck. Plaintiff alleges that during the procedure, the right spinal accessory nerve was injured, which resulted in severe pain and partial paralysis of her right arm.

Plaintiff apparently requested a general surgeon, Dr. Raymond Ippolito, to review her medical records and to determine if she had a possible claim for medical malpractice against Dr. Shapiro and his employer, defendant General Surgeons of Flint, P.C. On July 31, 1997, Dr. Ippolito sent a two-page letter to plaintiff's counsel, indicating that he had reviewed plaintiff's medical records and the medical care rendered by Dr. Shapiro in 1996. Dr. Ippolito opined that plaintiff suffered an injury to her right spinal accessory nerve as a result of the biopsy performed by Dr. Shapiro and that the injury to the nerve deviated from the standard of care. The letter was signed by Dr. Ippolito and a notary signed below his signature.

Apparently, counsel for plaintiff sent a notice of intent to file a claim to defendants pursuant to M.C.L. § 600.2912b; MSA 27A.2912(2) on September 2, 1997. After the 182-day period expired with apparently no response from defendants, plaintiff filed her complaint on March 24, 1998. However, plaintiff did not file an affidavit of merit with the complaint in accordance with M.C.L. § 600.2912d; MSA 27A.2912(4).

The summons and complaint were served by registered mail on March 30, 1998. Although the answer was due twenty-eight days later, MCR 2 .108(A)(2), counsel for defendants requested a thirty-day extension for filing an answer. Counsel for plaintiff agreed to an extension and the joint answer was sent on May 15, 1998, and filed on May 19, 1998. In their affirmative defenses, defendants asserted that plaintiff failed to file an affidavit of merit with the complaint and that the claim "may be" barred by the statute of limitations.

According to the parties, defendants sent interrogatories requesting plaintiff to identify her experts and to indicate whether any reports had been rendered by the experts. In July 1998, plaintiff sent the answers to the interrogatories and included a copy of Dr. Ippolito's report.

On November 30, 1998, defendants filed a motion for summary disposition pursuant to MCR 2.116(C)(7), arguing that the statute of limitations expired before the action was properly commenced. Defendants pointed out that the affidavit of merit was not attached to the complaint, that plaintiff did not request a twenty-eight-day extension to file one, and that plaintiff to date had not yet filed an affidavit of merit. Defendants argued that they were entitled to summary disposition pursuant to *Scarsella v. Pollak*, 232 Mich.App 61; 591 NW2d 257 (1998), aff'd. 461 Mich. 547; 607 NW2d 711 (2000).

*2 In response to the motion, plaintiff claimed the affidavit of merit inadvertently was not attached to the complaint when it was filed and that counsel intended to use Dr. Ippolito's report as the affidavit of merit. Plaintiff asserted that counsel for defendants participated in unconscionable conduct by requesting an extension to file an answer to the complaint, and that without the extension, plaintiff's counsel would have learned of the

mistake and then filed the affidavit before the statute of limitations expired. Plaintiff also claimed that the affidavit was eventually provided in answers to interrogatories and argued that dismissal of the action was improper pursuant to *VandenBerg v. VandenBerg*, 231 Mich.App 497; 586 NW2d 570 (1998). At oral argument before the trial court, plaintiff further argued that M.C.L. § 600.2912d; MSA 27A.2912(4) was unconstitutional because the Legislature improperly interfered with the power of the Supreme Court regarding practice and procedure.

Ultimately, the trial court ruled that *Scarsella* required dismissal of the action for failure to comply with § 2912d. The trial court also indicated the report of Dr. Ippolito was not a proper affidavit of merit.

On appeal, plaintiff first argues that § 2912d is unconstitutional because it violates the separation of powers clause, Const 1963, art 3, § 2, by infringing upon the exclusive power of the Supreme Court to establish practice and procedure in the courts of this state. Although this argument was only orally made below and the trial court did not render a ruling on this point, the constitutionality of § 2912d presents a question of law, which this Court reviews de novo. *McDougall v. Schanz*, 461 Mich. 15, 24; 597 NW2d 148 (1999). This Court should also presume that § 2912d is constitutional "unless its unconstitutionality is clearly apparent." *Id.*

The authority to determine the rules of practice and procedures rests exclusively with the Supreme Court. Const 1963, art 6, § 5. "This exclusive rule-making authority in matters of practice and procedure is further reinforced by separation of powers principles. See Const 1963, art 3, § 2." *Id.* at 27. However, rules of practice set forth in any statute, if not in conflict with any court rule, are effective until superseded by rules adopted by the Supreme Court. MCR 1.104; *Neal v. Oakwood Hosp Corp*, 226 Mich.App 701, 722; 575 NW2d 68 (1997).

In *Neal*, this Court examined whether § 2912b, which provides that a plaintiff shall not commence a medical malpractice action unless the plaintiff has given written notice not less than 182 days before the action is commenced, was a rule of procedure that directly contradicted MCR 2.101(B), which provides that "[a] civil action is commenced by the filing of a complaint with a court." In ruling that there was no conflict, this Court stated:

> In this case, we conclude that § 2912b(1) does not change the manner in which or how a civil action is commenced in medical malpractice cases. Rather, § 2912b(1) imposes a temporal requirement with which a plaintiff must comply before the plaintiff can commence a civil action in accordance with MCR 2.101(B). Accordingly, we find no conflict between § 2912b(1) and MCR 2.101(B). Thus, if procedural, § 2912b(1) is effective until superseded by rules adopted by our Supreme Court. MCR 1.104. [*Id.* at 723.]

*3 Plaintiff asserts that this Court in *Neal* implied that if legislation did change the manner in which civil actions were commenced, then it would infringe upon the Supreme Court's rule-making power in matters of practice and procedure. Plaintiff argues that because § 2912d changes the manner in which to commence a medical malpractice action, it violates the separation of powers clause. Section 2912d provides, in relevant part:

> Subject to subsection (2), the plaintiff in an action alleging medical malpractice or, if the plaintiff is represented by an attorney, the plaintiff's attorney shall file with the complaint an affidavit of merit signed by a health professional who the plaintiff's attorney reasonably believes meets the requirements for an expert witness under section 2169. [MCL 600.2912d(1); MSA 27A.2912(4)(1).]

On the other hand, defendants argue that § 2912d merely imposes an additional requirement without directly conflicting with MCR 2.101(B).

We believe that the Supreme Court's subsequent promulgation of MCR 2.112(L), which adopts the Legislature's procedural requirement for filing an affidavit of merit with the complaint, sufficiently disposes of plaintiff's argument. MCR 2.112(L) provides:

In an action alleging medical malpractice filed on or after October 1, 1993, each party must file an affidavit as

provided in M.C.L. § 600.2912d; 600.2912e, M.S.A. § 27A.2912(4); 27A.2912(5). Notice of filing the affidavit must be promptly served on the opposing party. If the opposing party has appeared in the action, the notice may be served in the manner provided by MCR 2.107. If the opposing party has not appeared, the notice must be served in the manner provided by MCR 2.105. Proof of service of the notice must be promptly filed with the court. [Emphasis added.]

While MCR 2.112(L) went into effect April 1, 1998, one week after plaintiff filed her complaint, it is clear from the above emphasized language that the Supreme Court intended retroactive application to plaintiff's medical malpractice action. Accordingly, § 2912d is not unconstitutional as proposed by plaintiff.

Next, plaintiff contends that the trial court erred in granting defendants' motion for summary disposition and in dismissing her complaint where she failed to file an affidavit of merit with the complaint. This Court reviews decisions on motions for summary disposition under MCR 2.116(C)(7) de novo to determine if the moving party is entitled to judgment as a matter of law. *Rheaume v. Vandenberg*, 232 Mich.App 417, 420-421; 591 NW2d 331 (1998). In reviewing a motion granted pursuant to MCR 2.116(C)(7), this Court considers all affidavits, pleadings, and other documentary evidence submitted by the parties and construes the pleadings in favor of the plaintiff. *Id.* at 421.

In this case, the alleged malpractice occurred on May 8, 1996. The period of limitations for malpractice claims is two years, M.C.L. § 600.5805(4); MSA 27A.5805(4). Plaintiff filed her complaint on March 24, 1998, but did not file the affidavit of merit before the statute of limitations expired on May 8, 1998. [1]

*4 In *Scarsella, supra,* this Court held that, "for statute of limitations purposes" in a medical malpractice case, the mere tendering of a complaint without an affidavit of merit is insufficient to commence the lawsuit and therefore, the trial court did not err in ruling that the plaintiff's claim was time-barred. *Id.* at 64. The Supreme Court adopted the opinion in its entirety, reaffirming that dismissal is the appropriate remedy for failing to comply with § 2912d. *Scarsella v. Pollak*, 461 Mich. 547, 548-550; 607 NW2d 711 (2000). Contrary to plaintiff's argument, *Vandenberg* and *Scarsella* do not conflict. Unlike *Vandenberg*, where the plaintiff filed the affidavit of merit only a few weeks after the complaint was filed and before the statute of limitations ran, the plaintiff in *Scarsella* failed to file an affidavit of merit with the complaint and did not do so until after the statute of limitations expired. It is clear that the facts of this case fall squarely under *Scarsella* since plaintiff failed to file an affidavit of merit before the statute of limitations expired. Accordingly, we find that the trial court did not err in granting the motion for summary disposition and dismissing plaintiff's claim with prejudice.

While plaintiff argues that the failure to file the affidavit of merit was inadvertent, we find it significant that plaintiff made no attempt to remedy the problem after defendants' answer to the complaint pointed out that no affidavit was attached to the complaint. Certainly, the trial court may have estopped any attempt by defendants to argue that the statute of limitations had already expired in light of their request for an extension to file their answer. However, given plaintiff's failure to immediately request an extension pursuant to M.C.L. § 600.2912d(2); MSA 27A.2912(4)(2), we cannot excuse the running of the limitations period based on plaintiff's claim of inadvertence or preclude defendants from asserting that plaintiff's claim was barred.

Plaintiff further argues that no prejudice occurred from the failure to attach the affidavit since defendants had previously received a detailed notice of intent and thus were fully aware of the merits of her claim. However, this Court has noted that substantial compliance with the statutory procedural requirements is not sufficient to toll the statute of limitations. See *Rheaume, supra* at 422-423. Clearly, the fact that defendants were sent a notice of intent to sue in accordance with § 2912b does not excuse plaintiff's failure to comply with § 2912d.

Affirmed.

All Citations

Not Reported in N.W.2d, 2001 WL 772531

Footnotes

* Former Court of Appeals judge, sitting on the Court of Appeals by assignment.

1 Contrary to both parties' assertions on appeal, the two-year statute of limitations is not "extended" 182 days when a plaintiff files notice of intent to sue in accordance with M.C.L. § 600.2912b; MSA 27A.2912(2). Instead, the limitations period is only tolled where the statute of limitations will expire during the 182-day notice period that the plaintiff is prohibited from filing a lawsuit. MCL 600.5856(d); MSA 27A.5856(d). Here, plaintiff sent her notice of intent to sue on September 2, 1997. Because the notice was given more than 182 days before the end of the limitations period, the two-year limitations period was not tolled during the notice period. See *Omelenchuk v. City of Warren*, 461 Mich. 567, 574; 609 NW2d 177 (2000). Therefore, the statute of limitations did not expire on November 7, 1998, as the parties contend.

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Exhibit 17

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of
the Estate of SANDRA D. MARQUARDT

Plaintiff

VS. Civil Action No. 12-621 NH

VELLAIAH DURAI UMASHANKAR, M.D.
AND JONATHAN HAFT, M.D.

Defendants
_____/

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PLAINTIFF'S BRIEF IN SUPPORT OF PLAINTIFF'S ANSWER TO DEFENDANT HAFT'S MOTION FOR SUMMARY DISPOSITION

of the internet in 2011failed to provide counsel with a current address for Defendant Umashankar, and it was also impossible to find a current address in 2009; as a result, counsel was clearly in compliance with MCL 600.2912b (2) when the notice of intent was sent to the risk manager for the University of Michigan Health System on behalf of Defendant Umashankar.

MCL 600.2301 was enacted in 1963 by the Legislature to provide the judges in this state with the authority to ignore certain procedural and substantive errors or defects, when justice would be served by ignoring such errors or defects that might result in a party losing their right to have the merits of their claim heard within the legal system simply because a "t" was not crossed or an "i" was not dotted. The Michigan Supreme Court in *Bush* found that MCL 600.2301 afforded the trial courts an opportunity to overlook minor procedural errors or defects if a party had made those errors despite acting in good faith. In the instant case, the notice of intent clearly identified Defendants by their name, by their specialty and by the actions that they undertook to cause Sandra Marquardt to suffer significant injuries and damages. Counsel for Sandra Marquardt made a good faith effort to identify the responsible individuals in the July 20, 2009 notice of intent, and the employer of those individuals was notified in a timely manner. The notice of intent provided the risk manager with all of the necessary information to investigate the claim fully. It was only when the University of Michigan decided to file a motion for summary disposition based upon a technical requirement regarding the filing of a claim with the Court of Claims that it became necessary to file this action against the individual doctors rather than finish the litigation directly against the University of Michigan. There is no doubt that any judgment that is rendered against the individual doctors in this litigation will be paid by the University of Michigan Health System, and there is no doubt that the defense costs for

defending the individual doctors is being paid by the University of Michigan Health System or its carrier. Counsel for Sandra Marquardt acted in good faith when the July 20, 2009 notice of intent was drafted and sent to the University of Michigan Health System. At that time, based upon more than 40 years of *stare decisis*, a lawsuit could have been filed against the University of Michigan Health System in the Court of Claims without having previously filed a notice of claim with that court. Counsel for Plaintiff relied upon that well established case law that required that the University of Michigan Hospital show actual prejudice in order to move for summary disposition, and counsel for Plaintiff anticipated that Sandra Marquardt's claim could have been resolved through the Court of Claims litigation without actually naming the individual doctors in Washtenaw County. Counsel for Plaintiff acted in good faith when the individuals were identified in the July 20, 2009 notice of intent, and when the notice of intent was sent to the risk manager for the University of Michigan Health System. No one could have anticipated that almost two years into the litigation in the Court of Claims and after more than fifteen depositions had been taken or scheduled, counsel for the University of Michigan would file a motion for summary disposition based upon Plaintiff's failure to file a worthless claim form with the Court of Claims within six months of the negligence. In the instant case, that claim would have had to be filed in the Court of Claims approximately one and one-half months after Sandra Gordon was discharged from the hospital and while she was still recovering at home. MCL 600.2301 is the appropriate statutory safety valve for this type of miscarriage of justice. Counsel for Plaintiff acted in good faith when he sent the notice of intent on July 20, 2009, and counsel for Plaintiff acted appropriately when he filed this litigation against the individual doctors. The facts exposed in the instant case demonstrate the hardship that is caused when the legal system evolves into a "gotcha" exercise.

In the case of Defendant Umashankar, the notice of intent was served in strict compliance with MCL 699.2912b (2), because Dr. Umashankar was residing in India when the notice of intent was served, and the health facility where the care was provided was correctly notified. In the case of Defendant Haft, the notice was served appropriately given that his office and one of the risk management offices were both situated in the same building when the July 20, 2009 notice of intent was served. In addition, Defendant Haft has not proffered any evidence that would establish that he was not made aware of the notice of intent in July 2009. Plaintiff asserts that the notice of intent that was served upon the risk manager for the University of Michigan complied with the provisions of MCL 600.2012b (1) and (2). If, however, this Court determines that Defendant Haft was not notified directly, as opposed to indirectly through the office of the risk manager for the University of Michigan Health System, then Plaintiff would suggest that MCL 600.2301, as interpreted by the Michigan Supreme Court in *Bush*, should be used to avoid having to grant summary disposition as to Defendant Haft, because the interests of justice would be served by ignoring the technical error that occurred when counsel for Plaintiff, while acting in good faith, attempted to litigate this claim directly against the University of Michigan Health System without the necessity of filing two separate lawsuits in two different venues.

If this Court wishes to know exactly how Defendant Haft learned about the July 20, 2009 notice of intent, Plaintiff's counsel would suggest that this motion be denied without prejudice. Then counsel would also suggest that he be permitted to depose the risk management staff and Defendant Haft to address the notice issues, which would be beneficial in determining whether or not MCL 600.2301 should be used to permit Plaintiff to proceed with this litigation.

STATE OF MICHIGAN

IN THE SUPREME COURT

SARON E. MARQUARDT, Personal Representative of the ESTATE OF SANDRA MARQUARDT (Dec.)

Plaintiff-Appellant,

v.

VELLAIAH DURAI UMASHANKAR, M.D.,

Defendant-Appellee.

Supreme Court Case No. 160772

Court of Appeals Case No. 343248

Washtenaw County Case No. 12-621-NH

Hon. David S. Swartz

APPENDIX OF EXHIBITS IN SUPPORT OF DEFENDANT-APPELLEE VELLAIAH DURAI UMASHANKAR, M.D.'S SUPPLEMENTAL BRIEF

Volume III

Exhibit 18

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of
the Estate of SANDRA D. MARQUARDT

Plaintiff

VS.

Civil Action No. 12-621 NH
Hon. David S. Swartz

VELLAIAH DURAI UMASHANKAR, M.D.

Defendant

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PLAINTIFF'S ANSWER TO DEFENDANT VELLAIAH DURAI UMASHANKAR, M.D.'S POST-REMAND MOTION FOR SUMMARY DISPOSITION

NOW COMES Plaintiff Saron E. Marquardt, Personal Representative of the Estate of Sandra D. Marquardt, by and through his attorney Thomas C. Miller and asserts that the statute

of limitations had not expired when he filed this Complaint in the above entitled action on June 8, 2012. Defendant has stated in his motion for summary disposition that "***this Court*** and the Court of Appeals" (emphasis added) granted summary disposition and affirmed that grant of summary disposition respectively on grounds independent of the holding in the recent Michigan Supreme Court decision in *Haksluoto v Mt. Clemens General Regional Medical Center,* 500 Mich 304, 324 (2017). (Defendant's motion for summary disposition page 1.) In fact, ***this Court's*** grant of summary disposition was based entirely on the rationale struck down by the Michigan Supreme Court in its unanimous decision in *Haksluoto*. Specifically, ***this Court*** granted summary disposition based entirely upon the fact, i.e. that Plaintiff Sandra D. Marquardt had filed her notice of intent on the last day of the statute of limitations period. ***This Court*** held since the notice of intent was filed on the last day of the statute of limitations period, the statute of limitations period could not be tolled because there were no days left in the statute of limitations period to save; therefore, Plaintiff was unable to take advantage of the tolling provisions contained in MCL 600.5856 (c). ***This Court*** further held that since the statute of limitations period was not tolled during the pendency of the notice of intent Plaintiff's death on January 27, 2010, did not save her cause of action pursuant to MCL 600.5852 (1). (Defendant's Exhibit 10 pages 11-15.) Those holdings reached by ***this Court*** were identical to the holdings reached by the Court of Appeals in *Haksluoto,* 314 Mich App 424 (2016) and reversed by a unanimous Supreme Court.

Plaintiff concedes that Defendant raised other issues before this Court on October 30, 2013; however, ***this Court*** did not address those issues in its opinion from the bench. In fact, counsel for Defendant, in her motion and oral arguments, tried to ***ignore the issue of tolling*** and

address the issue regarding how the notice of intent had been mailed instead. (Defendant's Exhibit 10, pages 2-6, and 9-10.)

A unanimous Michigan Supreme Court in *Haksluoto* unequivocally held that if a notice of intent was filed on the last day of the statute of limitations period, then the filing of that notice of intent still saved one day of the limitations period allowing the plaintiff to take advantage of the tolling provisions found in MCL 600.5856 (c); therefore, the Supreme Court's decision in *Haksluoto* clearly reversed ***this Court's*** decision completely. The facts in *Haksluoto* are identical to the facts in the instant case, as they relate to the issues of tolling. (Defendant's Exhibit 14.) Based upon that decision, Plaintiff Sandra D. Marquardt did in fact save one day from her statute of limitations period when she filed her notice of intent on July 20, 2009. As such, the statute of limitations period was extended to January 19, 2010. (One day after the 182-day notice of intent expired.) As a result, Plaintiff Sandra D. Marquardt could have filed her lawsuit against Defendant Umashankar on January 19, 2010, and it would have been timely filed. Since she died within 30 days of that date, her cause of action against Defendant Umashankar was saved pursuant to the provisions of MCL 600.5852 (1). Since her Estate was opened on June 14, 2010, the Estate had until June 14, 2012, to file a timely complaint against Defendant Umashankar. (Defendant's Exhibit 4.) The complaint in this matter was filed on June 8, 2012; therefore, the complaint filed against Defendant Umashankar was filed in a timely manner, based solely upon the issues ***this Court*** used to grant summary disposition on November 19,2013. (Defendant's Exhibit 11.) By statute the complaint had to be filed within three years of when the statute of limitations would have expired. Pursuant to the Supreme Court decision in *Haksluoto* the statute of limitations period would have expired on January 19, 2010; therefore, the Estate

had to have filed its complaint on or before January 19, 2013. Again, the complaint in this matter was filed June 8, 2012, which was timely under those statutory restrictions.

Plaintiff concedes that the Court of Appeals favorably ruled on Defendant's arguments regarding the mailing of the notice of intent issue; however, a unanimous Michigan Supreme Court entered an order in the instant case dated September 27, 2017, in which it ***vacated*** that Court of Appeals decision and remanded this matter back to the trial court to reconsider its earlier grant of summary disposition "in light of *Haksluoto*". (Defendant's Exhibit 15.)

Counsel for Defendant decided that it would ***not*** ask for a clarification or rehearing in the Supreme Court to address its issue regarding the mailing of the notice of intent. Given that the Court of Appeals was the only court that had given any weight to Defendant's argument regarding the mailing of the notice of intent issue, Defendant's decision not to ask for clarification or reconsideration by the Supreme Court was curious at best. Defendant, instead, decided to file a second motion for summary disposition raising the issue again that had not been addressed by this Court originally. It should be noted that a unanimous Supreme Court vacated the entire decision by the Court of Appeals in the instant case, which means that it has no precedential value. It should also be noted that the Supreme Court would have been aware of the Court of Appeals decision regarding the mailing of the notice of intent issue, since it was raised in his brief in opposition to Plaintiff's application for leave to appeal. It should also be noted that the Supreme Court did not remand the matter to the Court of Appeals to reconsider its decision in light of *Haksluoto*, which would have been the normal remand order in such situations. Instead, it remanded it back to this Court for reconsideration, which had granted summary disposition ***based solely*** upon the fact that the notice of intent had been filed on the last

day of the statute of limitations period; and had ignored Defendant's arguments that the mailing of the notice of intent was deficient.

PLAINTIFF'S BRIEF IN SUPPORT OF ITS ANSWER TO DEFENDANT'S MOTION FOR SUMMARY DISPOSITION

OVERVIEW

Now that the issue regarding when a notice of intent can be filed and still take advantage of the tolling provisions found in MCL 600.5856 (c) has been resolved favorably for Plaintiff by the unanimous Michigan Supreme Court decision in *Haksluoto v Mt. Clemens Regional Medical Center,* 500 Mich 304 (2017), Defendant is again raising an argument that this Court chose not to address at the time Defendant's first motion for summary disposition was heard and decided.

Given that the Supreme Court by order vacated the entire Court of Appeals decision in the instant case, Plaintiff would argue that the issue being addressed by Defendant at this time was in fact decided by the Supreme Court. In support of that position, Plaintiff would point to the fact that Defendant ***opted not to ask*** for a clarification or reconsideration of that order. Discussions were held between this Court's judicial attorney, counsel for Defendant, and counsel for Plaintiff regarding how to proceed with this matter after the Supreme Court had entered its remand order. Those discussions ended with an agreement that counsel for Defendant would decide whether or not she would file a motion for reconsideration with the Supreme Court or file a new motion in this Court. A few days after those discussions, counsel for Defendant informed the undersigned that she had decided not to file a motion for reconsideration with the Supreme

Court to address the issue regarding how the notice of intent had been mailed, which had been addressed by the Court of Appeals.

Plaintiff would argue further that the language used in the unanimous Supreme Court order dated September 27, 2017, in which the Court "[VACATED]" the decision of the Court of Appeals and remanded this matter to this Court for reconsideration in light of *Haksluoto.* (Defendant's Exhibit 15.) The Supreme Court was certainly aware of the fact that the parties wanted the Court to consider the issue now being re-addressed in this Court, since both Plaintiff and Defendant raised that issue in their briefs filed with the application for leave to appeal. If the Supreme Court had wanted to let the Court of Appeals decision to stand regarding the mailing of the notice of intent issue, all they had to do in their order was to state that in lieu of granting leave to appeal we remand this case to the Court of Appeals for reconsideration in light of *Haksluoto.* ***Instead***, the unanimous Supreme Court Order contained the following language: "in lieu of granting leave to appeal, we VACATE the judgment of the Court of Appeals and REMAND this case to the Washtenaw County Circuit Court for reconsideration in light of *Haksluoto."* (Emphasis added by the Court. Defendant's Exhibit 15.) It is also significant that Justice Wilder chose not participate in the decision to issue the remand order, because he had been on the Court of Appeals panel that had ruled on the issue regarding the manner in which the notice of intent was mailed in the instant case. This decision by Justice Wilder to not participate in the Order was supportive of the position being taken by Plaintiff in this matter, because Justice Wilder did participate in the unanimous decision by the Court in *Haksluoto;* therefore, the Order must have involved a substantive issue that had been addressed in the earlier Court of Appeals decision, since he had no problems participating in the *Haksluoto* deliberations and decision, which certainly involved the same issues he had addressed while sitting on the Court of Appeals.

(Defendant's Exhibit 14 page 10 and Defendant's Exhibit 15.) Once Justice Wilder participated in the decision-making in *Haksluoto*, why did he feel had had to recuse himself from considering the remand order, unless the whole bench was considering an issue that was not raised in *Haksluoto*. That fact alone probably swayed Defendant's decision to forego requesting a reconsideration of the Supreme Court's Order, which certainly would have been the easiest route.

There is no dispute in the instant case that Plaintiff Sandra D. Marquardt's cause of action accrued on July 20, 2007. (Defendant's Exhibit 1, paragraph #7.) There is also no dispute that Plaintiff's notice of intent was mailed on July 20, 2009, to the University of Michigan Health System, who was Defendant's employer on July 20, 2007. (Defendant's Exhibit 2.) There is also no dispute that Defendant was identified by name as an individual that Plaintiff intended to sue. There is also no dispute that his name appeared in the body of the notice of intent five times. There is also no dispute that he was identified by name in each of the critical paragraphs of that notice of intent, as required by MCL 600.2912b (4). (Defendant's Exhibit 2.) There is also no dispute that the last day of the 182-day notice of intent period was January 18, 2010, at which time the tolling of the statute of limitations would have ended and Plaintiff Sandra D. Marquardt would have had one day saved from the applicable statute of limitations period. (Defendant's Exhibit 14, *Haksluoto,* pages 9-10.) There is also no dispute that Plaintiff filed her complaint on January 19, 2010, in the Court of Claims against the University of Michigan Health System. (Defendant's Exhibit 3.) So, under the *Haksluoto* decision, the complaint was filed in a timely manner; and a complaint could have been filed against Defendant Umashankar. There is also no dispute that Plaintiff Sandra D. Marquardt died on January 27, 2010, which was within 30 days of when the statute of limitations applicable Defendant Umashankar expired on January

19, 2010. There is also no dispute that MCL 600.5852 (1) provides that if "a person dies before the period of limitations has run or within 30 days after the period of limitations has run, an action that survives by law may be commenced by the personal representative if the deceased person at any time within 2 years after the letters of authority are issued although the period of limitations has run." There is also no dispute that Saran Marquardt was appointed the Personal Representative of the Estate of Sandra D. Marquardt on June 14, 2010, by the Jackson County Probate Court. (Defendant's Exhibit 4.) There is also no dispute that this cause of action was filed on June 8, 2012. (Defendant's Exhibit 1.)

ARGUMENT

Plaintiff has ***always*** conceded that if this Court decides, contrary to the Supreme Court's Order, that the notice of intent sent to the University of Michigan Health System's Risk Manager on July 20, 2009, in which Defendant Umashankar was clearly identified as one of the potential defendants, does not comply with the provisions of MCL 600.2912b (2), then the subject notice of intent does not toll the statute of limitations and the Estate of Sandra D. Marquardt cannot take advantage of the savings provisions found in MCL 600.5852 (1). However, if this Court determines that the subject notice of intent did satisfy the requirements of set forth in MCL 600.2912b (2) as to Defendant Umashankar, then the statute of limitations period was tolled for 182 days on July 20, 2009; the statute of limitations period was extended until January 19, 2010; Plaintiff died within 30 days after the statute of limitations had expired; Plaintiff's cause of action against Defendant Umashankar was saved by MCL 600.5852 (1); and Plaintiff's complaint against Defendant Umashankar was timely filed on June 8, 2012.

There is no question that MCL 600.2912b (1) and (2) were intended to insure that any potential defendants were given notice of a possible claim being asserted against them. There are many relevant facts that need to be highlighted before attempting to decide whether or not Defendant Umashankar was given notice of a potential claim pursuant to MCL 600.2912b (2):

1. There is no dispute that Defendant Umashankar was ***not*** in the United States when the subject notice of intent was sent to the University of Michigan Risk Management Department on July 20, 2009. He testified during a discovery deposition in the Court of Claims action that he had returned to India after a one-year assignment at the University of Michigan ended on September 30, 2007, which was three and one-half months before Plaintiff Sandra Marquardt was released from the hospital. There is no dispute that at all times relevant to this litigation, Defendant Umashankar was an employee of the University of Michigan Health System. (See Exhibit A pages 3-4.)

2. His current address in India was not known and could not have been reasonably ascertained on July 20, 2009, because he was not deposed until August 2, 2011, and his *curriculum vitae* had not been made available to counsel for Plaintiff until that date. (Exhibits A and B.)

3. An online search failed to provide any information regarding Defendant Umashankar's last known address when the first notice of intent was given on July 20, 2009.

4. There is no dispute that Defendant Umashankar was identified in the July 20, 2009 notice of intent as one of the individuals that had breached the applicable standards of care resulting in Plaintiff's injury. Defendant Umashankar was identified by name (even though his first and second names were reversed in the medical records and in the notice of intent) on at

least five occasions. His name was clearly identified in the notice of intent at all critical points. (Defendant's Exhibit 2.)

5. The University of Michigan Risk Management Department acknowledged receipt of the notice of intent in a letter dated July 22, 2009. Nowhere in that letter does the risk manager indicate that the University of Michigan would not represent Dr. Umashankar's interests. (See Exhibit C.)

6. The University of Michigan through their counsel arranged for Defendant Umashankar to be deposed in the Court of Claims action. In fact, they brought him to Ann Arbor from India for that deposition. (See Exhibit A.)

7. When the second notice of intent was sent to Defendant Umashankar c/o the University of Michigan Health System on September 2, 2011,it was returned to counsel for Plaintiff marked "Return to Sender no longer here". (Exhibit D.) However, counsel for Defendant Umashankar filed a notice of meritorious defense on his behalf pursuant to MCL 600.2912b. (See Exhibit E.)

8. On November 12, 2011, the undersigned emailed Defendant Umashankar, with a copy of the second notice of intent attached, requesting that he contact the University of Michigan Health System. (Exhibit I.)

9. On December 10, 2011, the undersigned emailed Defendant Umashankar another note regarding the notice of intent. (Exhibit J.)

10. The undersigned followed up the earlier emails with additional email messages on March 28, 2012, March 29, 2012, and March 30, 2012. (Exhibit K.)

11. When the complaint and summons were sent by registered mail August 3, 2012, to

Defendant Umashankar in India at the address listed on his *curriculum vitae*, it was returned to sender. (Exhibit F.)

12. On August 9, 2012, an email was sent to Defendant's email address requesting that he cooperate by accepting service by email or by providing an address where the pleadings could be mailed by registered mail. No notification of non-delivery was ever received back on the many emails sent to Defendant. (Exhibit G.)

13. The complaint and summons were then sent to the Indian government for service pursuant to the Hague Convention on August 14, 2012. (See Exhibit H.)

14. On January 14, 2013, the local courts in India acknowledged having received the pleadings pursuant to the Hague Convention protocol and that they had attempted to serve Defendant Umashankar; however, their efforts proved to be unsuccessful and they returned the documents in September 2013. (Exhibit L.)

15. With no real results from the Indian government, the undersigned retained an investigator in India to confirm the address that appeared on Defendant Umashankar's *curriculum vitae,* and to personally serve him with the pleadings. Defendant was finally served on September 11, 2013. (Exhibit M.)

MCL 600.2912b (2) clearly states that the notice of intent "shall be mailed to the last known professional address or residential address of the health professional or health facility, who is the subject of the claim." The same subsection goes on to state, "proof of mailing constitutes *prima facie* evidence of compliance with this section." The same subsection continues, "If no last known professional business or residential address can reasonably be ascertained, notice may be mailed to the health facility where the care that is the basis for the claim was rendered."

In that subsection there are two options given to the claimant for effectuating service on the health professional. The first allows for the notice of intent to be sent to the last known professional address or residential address. Clearly, in 2009 the last known professional address for Defendant Umashankar would have been the University of Michigan Health System, since we now know that he had returned to India in the fall of 2007, before Decedent was actually discharged from the University of Michigan Medical Center. There is no dispute that the first notice of intent dated July 20, 2009, was in fact sent to the University of Michigan Health System's Risk Manager; and there is no dispute that it was received by that entity. The second option mentioned in the relevant subsection of the notice of intent statute provides that if no last known address is known, the notice can be sent to the institution where the negligent care was provided. If that option was exercised, it too would have called for sending the notice of intent to the University of Michigan Health System, Defendant's employer.

In July 2009 Defendant Umashankar had returned to his native India. A review of the efforts that were expended by counsel for Plaintiff to serve him with the second notice of intent and complaint in this matter during the years 2011-2013 serves to illustrate how difficult, if not impossible, it would have been for counsel to have identified Defendant's last known address in 2009. (See Exhibit E.) The University of Michigan Health System was in the best position to locate Defendant Umashankar in 2009. They had far more ways to find his last known address or current address in 2009. At no time did the risk manager advise counsel for Plaintiff that they were unable to inform him of the pending claim.

More importantly, given that the notice of intent had been mailed to the University of Michigan Health System on July 20, 2009, Plaintiff had certainly complied with both the first ad the second options permitted by statute. Defendant will likely argue that the notice of intent

mailed to the University of Michigan Health System on July 20, 2009, was not addressed to Defendant Umashankar; and, therefore, it was not actually mailed to him. That position is weak at best. First, the statute does not say that the notice of intent has to be addressed to the potential defendant when there is no last known business or residential address. It simply says in such cases the notice of intent "may be mailed to the health facility where the care that is the basis of the claim was rendered." The care was rendered at the University of Michigan Health System in this case, and the notice of intent was "mailed" to the University of Michigan Health System's Risk Manager.

If the notice of intent had been addressed to Defendant Umashankar c/o the University of Michigan Health System on July 20, 2009, would it likely have been forwarded to Defendant Umashankar by an employee at the University of Michigan Health System? Would the addition of the name Dr. Umashankar as the specific addressee have resulted in him getting the notice of intent? Both of those questions can be answered by reviewing what happened in 2011 when a second notice of intent was sent by regular mail and by certified mail addressed to "Vellaiah Durai Umashankar, M.D. c/o University of Michigan Cardiovascular Center, 1500 E. Medical Center Drive SPC 5861, Ann Arbor, MI 48109". The certified letter was signed for and the return receipt was returned to counsel for Plaintiff. The letter sent by regular mail was also accepted by the staff. Then, the regular letter was opened and returned to counsel for Plaintiff with a handwritten note indicating that it was to be returned to sender because addressee no longer worked there. The same occurred with the certified letter, except that it was not opened. (See Exhibit D.) It is clear that if the July 20, 2009 notice of intent had been mailed with Defendant Umashankar identified as the addressee on the envelope, it would not have ultimately been accepted. On the other hand, when it was simply sent to the University of Michigan Health

System's Risk Manager, it was accepted and processed in a timely manner. (Exhibit C.) It appears that the Legislature realized that simply sending the notice to the hospital, when there was no last known address for the health professional, had the greatest chance of getting to the health professional rather than being returned to sender because the physician was no longer at the institution. Based upon what occurred in this case, Defendant Umashankar was in fact informed of the litigation by the risk management staff; he participated in the Court of Claims litigation; and he participate in the Washtenaw County litigation after he was finally served with the complaint.

Remarkably, Defendant argues that if the 2009 notice of intent had been addressed in the same manner as the 2011 notice of intent Plaintiff would have satisfied the notice provisions found in MCL 600.2912b (2); however, since the addressee was not Dr. Umashankar in 2009 the notice provisions were not satisfied. The absurdity of that argument is patently obvious. We know that Dr. Umashankar was likely notified regarding the 2009 notice of intent assertions being made against him, since the University of Michigan Risk Management staff acknowledged receipt of the notice. (Exhibit C.) We also know that the 2011 notices of intent sent by regular mail and by certified mail were both returned to sender. (Exhibit D.) Given those two critical facts, which process was more likely to have resulted in Defendant being informed in a timely manner regarding the potential claim being made against him.

Very simply, when all of the irrelevant citations proffered by Defendant are stripped way, Defendant asserts that Plaintiff's addressing and mailing the 2009 notice of intent to the University of Michigan Health System's Risk Manager was not sufficient to satisfy the provisions of MCL 600.2912b (1) and (2). On the other hand, Plaintiff asserts that mailing the 2009 notice of intent to the University of Michigan Health System's Risk Manger did satisfy the

provisions of MCL 600.2912b (1) and (2) based upon the facts detailed above, which clearly indicate that Plaintiff could not have reasonably ascertained Dr. Umashankar's last known address; or his last known address was, in fact, the University of Michigan Health System.

It is essential, however, to address some of the irrelevant citations that are found in Defendant's extensive brief. The citation of *Waltz v Wyse,* 469 Mich 642 (2010) is clearly not applicable to the issues being addressed in the instant case. The Supreme Court in *Waltz* was confronted with a situation in which the plaintiff wanted to extend the five years permitted to file a claim that was saved by MCL 600.5852 (1). In *Waltz* the cause of action accrued in April 1994, and the notice of intent was filed in January 1999 and the lawsuit was not filed until June 1999. Plaintiff sought to use MCL 600.5856 (c) to extend the provisions of MCL 600.5852 (1), which clearly state that the savings provisions expire three years after the statute of limitations would have expired. In *Waltz* the savings provisions would have ended in April 1999; therefore, the Supreme Court held that MCL 600.5856 (c) could not be used to extend the savings provisions in MCL 600.5852 (1), because that statute was not a statute of limitations nor was it stature of repose. In the instant case, the statute of limitations was extended until January 19, 2010, pursuant to MCL 600.5856 (c) and the Supreme Court's decision in *Haksluoto;* therefore, Plaintiff's death occurred within 30 days of when the statute of limitations had expired on her claim against Defendant Umashankar. Plaintiff is not requesting that the savings provisions found in MCL 600.5852 (1) be extended. Plaintiff filed her complaint on June 8, 2012, which was within three years of when the statute of limitations expired would have expired on January 19, 2013.

Defendant also cited two additional cases that are totally irrelevant to the issues being presented in the instant case. *McCahan v Brennan,* 492 Mich 730 (2012) and *Atkins v Suburban*

Mobility Authority for Regional Transportation, 492 Mich 707 (2012) were cited by Defendant in support of his claim that service must be made on a specific entity identified by statute and the notice statutes cannot be satisfied by indirect service on some other individual or entity. Those cases are not relevant to the instant case, because one of them deals with the notice provision contained in MCL 600.6431 (3) and the other one deals with the notice provision found in MCL 124.419. Both of those relevant statutes are very clear as to whom pre-suit notices are to be served. In the instant case, the claimant is offered two possible options for serving the potential defendant with the notice of intent. There are no such alternatives contained in the statutes addressed by the two cases cited by Defendant.

The last irrelevant case that needs to be addressed is *Fournier v Mercy Community Health Care System,* 254 Mich App 461 (2002). The facts in that case are clearly distinguishable from the facts in the instant case. In *Fournier* the Court of Appeals was faced with a factual situation in which several notices of intent were addressed to various health care professionals and health care facilities, but they were all mistakenly put in one package and sent to an individual that was not identified in any of the notices of intent. By the time they reached the individuals or entities named, the two-year anniversary had passed in regards to the appointment of the personal representative. In the instant case, the 2009 notice of intent clearly identified Defendant as one of the culpable parties and it was sent to either Defendant's last known address; to the health care facility where the negligence occurred; or to Defendant's employer at the time of the negligence. Those facts clearly distinguish the instant case from the facts in *Fournier.*

If this Court finds that MCL 600.2912b (1) and (2) specifically require that a notice of intent must be ***addressed*** to the health professional, as opposed to the manner in which it was

sent to Dr. Umashankar in the instant situation, then Plaintiff would direct this Court's attention to the Michigan Supreme Court's decisions in *Bush v Shabahang,* 484 Mich 156 (2009) and *De Costa v Gossage,* 486 Mich 116 (2010). The Supreme Court in *Bush* held that defects in the notice of intent may be amended or disregarded pursuant to MCR 600.2301, if the substantial rights of the parties are not affected, provided the cure is in the furtherance of justice and has terms that are just. *Supra* page 185. The above facts that are not in dispute certainly would support this Court's reliance on MCL 600.2301 in order to find that the mailing of a notice of intent addressed to the University of Michigan Health System's Risk Manager, who acknowledged receipt of that notice in 2009, did not affect the substantial rights of the parties and would be in furtherance of justice in this case. The Supreme Court noted in *Bush* the Legislature considered and rejected a mandatory dismissal clause for failures to strictly follow the notice requirements. *Supra* 172-174. The Court also reviewed the changes in MCL 600.5856 (c) from the original version found in the prior statute MCL 600.5856 (d). The Supreme Court found that the earlier language contained in MCL 600.5856 (d), i.e. "If, during the applicable notice period under section 2912b, a claim would be barred, the statute of limitations or repose…[would be tolled] ***after notice is given in compliance with section 2912b***" was different from the language adopted in the revised MCL 600.5856 (c), i.e. "***At the time notice is given in compliance with the applicable notice period under section 2912b***". The Court reasoned that the only thing that was essential was that the notice needed to be given in a timely manner, and no longer required that the notice be in compliance with each of the provisions of MCL 600.2912b. *Supra* pages 168-170.

Two years later the Michigan Supreme Court again was called upon to rule on technical problems with a notice of intent that were being cited as a basis for summary disposition of the

plaintiff's cause of action. In *De Costa* the Court was asked to affirm the trial court and Court of Appeals' decisions to grant summary disposition when plaintiff had not sent the notice of intent to the defendant's last known address. There was no dispute that plaintiff knew that defendant had moved to a new address, but the notice of intent was sent to defendant's old address. The Supreme Court reversed the prior decisions in part based upon its decision in *Bush* and in part based upon on MCL 600.2301. They again found that the decision was in the furtherance of justice and did not substantially affect the rights of the parties. They again reiterated that the changes in the tolling statute indicated that the tolling occurred when the notice was sent, not whether or not the notice complied with all of the provisions contained in MCL 600.2912b.

CONCLUSION

In the instant case, Defendant Umashankar's last known address could not have been "reasonably ascertained" in 2009 or it was the University of Michigan Health System; therefore, Plaintiff was allowed to send the notice to the University of Michigan Health System pursuant to MCL 600.2912b (2).

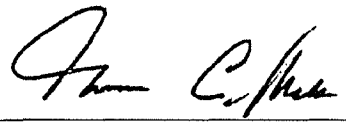
Plaintiff mailed her notice of intent pursuant to MCL 600.2912b (2) within the applicable statute of limitations period, and the applicable statute of limitations period was tolled for 182 days pursuant to MCL 600.5856 (c).

There is no dispute that Plaintiff Sandra Marquardt passed away on January 27, 2010. Therefore, according to MCL 600.5852 (1), which provides that if a person dies within the statute of limitations period or within 30 days after the statute of limitations would have expired, the cause of action was saved for two years after the letters of authority were issued, but not to

exceed three years from when the statute of limitations would have expired. That meant that Sandra Marquardt's cause of action against Defendant Umashankar remained viable, provided the lawsuit naming Defendant Umashankar was filed within two years after letters of authority were issued to Saron E. Marquardt and within three years from when the statute of limitations would have expired, since the letters of authority were issued to Saron E. Marquardt on June 14, 2010, Sandra Marquardt's claims against Defendant Umashankar could have been brought at any time before June 14, 2012.

Finally, Defendant has ***never*** asserted that he was not timely informed by the University of Michigan Health System's personnel about the claims being made against him in the 2009 notice of intent. Curious?

Respectfully submitted,



Thomas C. Miller (P17786)
Attorney for Plaintiff

Dated: January 4, 2018

EXHIBIT A

Vellaiah Durai Umashankar

STATE OF MICHIGAN

IN THE COURT OF CLAIMS

SARON E. MARQUARDT, PERSONAL REPRESENTATIVE OF THE ESTATE OF SANDRA D. MARQUARDT,

Plaintiff,

vs.

THE UNIVERSITY OF MICHIGAN BOARD OF REGENTS (UNIVERSITY OF MICHIGAN HOSPITAL AND HEALTH CENTERS),

Defendant.
_____/

Civil Action No. 10-4 MH

The Deposition of Vellaiah Durai Umashankar, M.D., a Witness herein, taken pursuant to Notice of Taking Deposition before Sharon Julian, CSR-3915, Registered Professional Reporter and Notary Public for the County of Wayne, acting in the County of Washtenaw, at 300 North Ingalls, Ann Arbor, Michigan, on Tuesday, August 2, 2011, commencing at about 11:50 a.m.

APPEARANCES:

THOMAS C. MILLER, ESQ., P17786
P. O. Box 785
Southfield, Michigan 48037
(248)210-3211

GERARD J. ANDREE, ESQ. P25497
Sullivan, Ward, Asher & Patton, P.C.
25800 Northwestern Highway, Suite 1000
Southfield, Michigan 48075-8412
(248)746-0700

For the Defendant.

- - -

Vellaiah Durai Umashankar

Page 2

INDEX

WITNESS: VELLAIAH DURAI UMASHANKAR, M.D. PAGE

EXHIBITS

(Attached)

Deposition Exhibit	Description	Page Marked
1	Curriculum Vitae	3

Page 3

Ann Arbor, Michigan
Tuesday, August 2, 2011
About 11:50 a.m.

(Exhibit 1 was marked for identification.)

MR. MILLER: Let the record reflect that this is the deposition of —

And, again, the Curriculum Vitae has Umashankar as the last name, for our purposes, so I'll use it that way —

THE WITNESS: Yes.

MR. MILLER: — just to avoid some confusion. It's the deposition of Dr. Umashankar being taken pursuant to Notice for all purposes contained in the Michigan Court Rules.

VELLAIAH DURAI UMASHANKAR, M.D., a Witness herein, having been first duly sworn, testified as follows:

EXAMINATION

BY MR. MILLER:

Q Dr. Umashankar, when did you come to the University of Michigan?

Have you been here more than one — I'm not talking about visiting, but were you in the anesthesia department?

A For a year. From 2006, October 1st — October 2006 to 30th of September 2007.

Q Okay. And during that time you were an attending anesthesiologist?

MR. ANDREE: You mean 2007?

A That's right.

MR. ANDREE: October of '06 to —

BY MR. MILLER:

Q September '07.

A '07.

MR. ANDREE: Okay.

MR. MILLER: All right. I must have misheard it, too.

BY MR. MILLER:

Q During that time you were what we term an attending anesthesiologist?

A Yeah.

Q And as such you had both clinical and education responsibilities within the department?

A True.

Q And were you assigned, during your clinical assignments, to cardiothoracic anesthesia or all areas of anesthesia?

A Assigned to all areas of anesthesia with importance to cardiothoracic, which means at least two days in the week I'd be doing cardiothoracic anesthesia.

Q And you provided us with a Curriculum Vitae that recites your professional education and experience; correct?

A Yes.

Q And is that, essentially, accurate to the present time?

A Yes.

Q Now, when you came to the University of Michigan, did you come from another institution within the United States or did you come from India?

A From UK.

Q Okay. And where in the UK were you before you came to the University of Michigan?

A University Hospital of South Hampton.

Q And did you work in cardiothoracic anesthesia at that institution?

A Yeah.

Q Were you aware, in early 2006, of the articles published by Dr. Mangano?

A Yeah.

Q Were you also aware of the article published in transfusion about Aprotinin around almost the same time?

A Not at that time, but then I read the article at a later period.

Q Okay. Was your knowledge of Dr. Mangano's article contemporaneous with its publication? In other words,

EXHIBIT B

Dr. Vellaiah Durai UMASHANKAR
MBBS FRCA(Lon) CCST(UK)
7 Vivekananda Road,Chetpet, Chennai 600 031
Tel: 044 28364586 Mobile: 89399 64586
Email: umashankar@hotmail.co.uk

PERSONAL INFORMATION

Sex	Male
DOB	25th October 1966
Nationality	Indian
Tamilnadu Medical Council	Registration number 49491
General Medical Council, London	Full Registration no: 5195355
Royal College of Anaesthetists London, England	Fellow
Association of Cardio thoracic Anaesthetists, United Kingdom	Associate member
Indian Association of Cardio thoracic Anaesthetists	Associate member

EDUCATION & QUALIFICATIONS

Primary Degree	M.B., B.S. University of Madras, Sri Ramachandra Medical College and Research Institute, Madras, India June 1991
Postgraduate Certification	F.R.C.A. Royal College of Anaesthetists, London, June 2003 CCST September 2006
Further Certification	ALS Provider, Resuscitation council UK, May 1999 A.T.L.S. Provider, Resuscitation council UK, Nov 2000 P.L.A.B. General Medical Council, Oct 1998 BSE Certification for Trans Esophageal Echocardiography
Academic achievements	Distinction in Pharmacology, June 1988 Distinction in General Medicine, May 1990

CAREER STATEMENT

To serve as a Consultant Anesthesiologist and Intensivist with a lead roll in the speciality of Cardiac anesthesia and Cardio Thoracic Intensive Care.

To actively involve in teaching and research activities in the speciality.

EXHIBIT C

University of Michigan
Health System

UMHS Risk Management
300 North Ingalls, Room 8A06
Ann Arbor, MI 48109-5478
(734) 763-5456
(734) 763-5300 fax

Amy Blackwell
(734) 647-8528

July 22, 2009

Thomas C. Miller, Esq.
P.O. Box 785
Southfield, MI 48037

Re: Sandra D. Marquardt

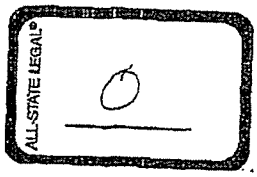
Dear Mr. Miller:

I am in receipt of your Notice of Intent dated July 20, 2009. Please forward all future correspondence concerning this matter to my attention at the address indicated above.

In an effort to timely investigate this matter, please provide us with copies of all non-University of Michigan medical records in your possession, and we will reimburse you for any duplication expense. In the event that it is necessary for us to obtain these records ourselves, we have enclosed several Authorization to Request Patient Information from Another Organization forms for your client's signature. Please indicate on these authorization forms the identity of the hospital, physician or medical facility (other than the University of Michigan), wherein your client has received treatment in the five (5) years preceding the incident in question, and all treatment since the date of the incident until the present. Please return these authorization forms and medical records to my attention within the next three (3) weeks.

This request is submitted to you in accordance with MCLA 600.2912 b(5). If there are records concerning our care of the patient to which you have not yet been given access, kindly advise us so that arrangements can be made to make them available to you. Our Medical Records Department will honor a valid medical authorization, and they can be reached by mail at UMHS Health Information Management, Release of Information, 2901 Hubbard Road, Room 2722, Ann Arbor, Michigan 48109-2435 (734) 936-5490 or by phone at (734) 936-5490. Requests for x-rays can be made by mail to the UMHS Radiology Department, 1500 E. Medical Center Drive, Ann Arbor, Michigan 48109-0030.

The submission of this letter does not waive any defenses as to the adequacy or the timing of your Notice of Intent or any defects that may be present therein.



Thank you for your attention to these matters. Please feel free to call me should you have any questions or wish to discuss this matter.

Sincerely,

Kelly A. Saran
Healthcare Risk Management
Consultant

KAS/shb

Enclosures

EXHIBIT D

Plaintiff's Answer to Dr. Umashankar's Post-Remand Motion for Summary Disposition

C. MILLER
IEY AT LAW
K 785
IELD, MI 48037

Vellaiah Durai Umashankar, M.D.

Return to sender no longer

NIXIE 482 SE 1 09/09/20
RETURN TO SENDER
UNDELIVERABLE AS ADDRESSED
UNABLE TO FORWARD
BC: 48037070565 *0653-00700-10-13

48037@0795

CJE 24

THOMAS C. MILLER
ATTORNEY AT LAW
P.O. BOX 785
SOUTHFIELD, MI 48037

CERTIFIED MAIL

7010 0290 0000 [illegible] 7811

9-13-11

9-28-11

U.S. POSTAGE
PAID
HIGHLAND, MI
48356
SEP 02 11
AMOUNT
$5.79
00047248-06

1000

48109

RETURN RECEIPT REQUESTED

Vellaiah Durai Umashankar. M.D.

Return To Sender
Refuser Here
M.D.

[redacted]

48097@0785

NIXIE 482 DE 1 08/30/11
RETURN TO SENDER
UNDELIVERABLE AS ADDRESSED
UNABLE TO FORWARD
BC: 48097078585 *0653-00707-10-19

EXHIBIT E

SULLIVAN, WARD, ASHER & PATTON, P.C.
ATTORNEYS AND COUNSELORS AT LAW

1000 MACCABEES CENTER
25800 NORTHWESTERN HIGHWAY
SOUTHFIELD, MICHIGAN 48075-8412

TELEPHONE: (248) 746-0700
FAX: (248) 746-2760
WEB SITE: www.swappc.com

ROBERT E. SULLIVAN, SR. (1922-1998)
DAVID M. TYLER (1930-2002)
RICHARD G. WARD (RETIRED)

NICOLE K. NUGENT
nnugent@swappc.com
(248) 746-2763

February 3, 2012

By E-Mail and U.S. Mail

Thomas Miller, Esq.
Law Offices of Thomas C. Miller
P.O. Box 785
Southfield, MI 48037

Re: Marquardt, Sandra, The Estate of v. Jonathan Haft, MD and Vellaiah Umashankar, MD, et al
Our File No. UMH-124222

Dear Mr. Miller:

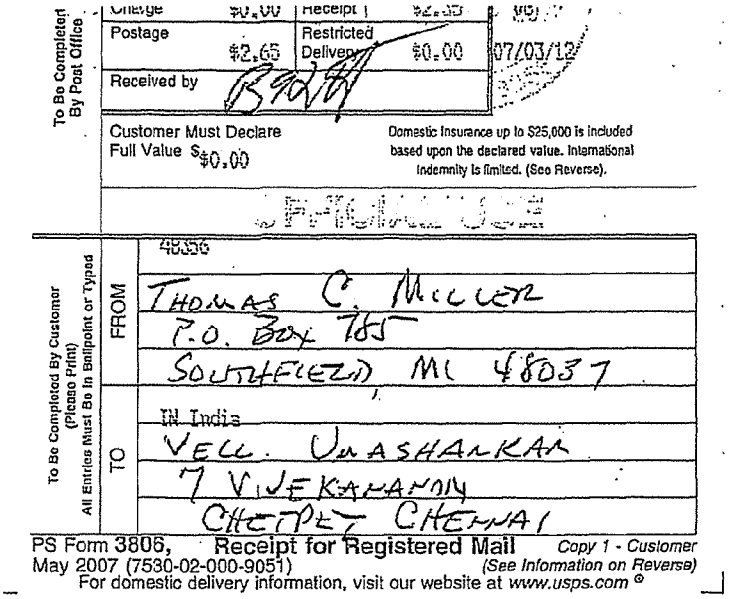
This letter is in response to the Notices of Intent to pursue a medical malpractice action you prepared on behalf of The Estate of Sandra Marquardt. We are responding on behalf of Dr. Jonathan Haft and Dr. Vellaiah Umashankar without waiving any legal defenses, factual defenses or defects of form or service. The Board of Regents, University of Michigan and all healthcare providers involved in Mrs. Marquardt's care and treatment maintain the position that the statute of limitations has expired on these potential claims rendering the Notices of Intent and any subsequent lawsuits in the Circuit Court improper and in violation of controlling statutes and rules.

RESPONSE TO NOTICE OF INTENT TO FILE CLAIM

Factual Basis for the Defense

Sandra Marquardt was initially admitted to the University of Michigan on May 13, 2007, from an outside hospital, where she had been admitted three weeks prior with left leg cellulitis and dyspnea on exertion. During that hospitalization, she was diagnosed with severe mitral stenosis and pulmonary hypertension. Her medical history included: single vessel coronary artery disease, congestive heart failure, valvular heart disease, pulmonary hypertension, diabetes, hypothyroidism, dyslipidemia, obesity, left lower

EXHIBIT F



To Be Completed By Post Office

Postage	$2.65	Restricted Delivery	$0.00
Received by			07/03/12

Customer Must Declare Full Value $0.00

Domestic Insurance up to $25,000 is included based upon the declared value. International indemnity is limited. (See Reverse).

FOR DOMESTIC USE

To Be Completed By Customer (Please Print) All Entries Must Be In Ballpoint or Typed

FROM
48356
THOMAS C. MILLER
P.O. BOX 785
SOUTHFIELD MI 48037

TO
IN India
VELL. UMASHANKAR
7 VIJEKANANTH
CHETPET CHENNAI

PS Form 3806, Receipt for Registered Mail Copy 1 - Customer
May 2007 (7530-02-000-9051) (See Information on Reverse)
For domestic delivery information, visit our website at www.usps.com ®

HIGHLAND
376 BEACH FARM CIRCLE
HIGHLAND, MI 48356-9998

08/03/2012 01:47:53 PM

Track & Confirm Delivery Status

You entered RE27 6076 720U S

ATTEMPTED DELIVERY - SCHEDULED FOR
ANOTHER DELIVERY ATTEMPT TODAY, INDIA,
July 14, 2012, 3:41 pm.

For additional information, visit our
Track & Confirm website at USPS.com,
or call us at 1-800-222-1811.

Thanks.
It's a pleasure to serve you.

EXHIBIT G

XFINITY Connect

millertc@comcast.net

± Font Size -

Service of Process

From : millertc@comcast.net

Subject : Service of Process

To : umashankar@hotmail.co.uk

Thu, Aug 09, 2012 12:35 PM

1 attachment

Dr. Umashankar:

I am the attorney that deposed you on August 2, 2011, in Ann Arbor in connection with the lawsuit filed by Sandra Marquardt against the University of Michigan. You may or may not know that that case has been dismissed, and that decision to dismiss the case is on appeal.

I then sent you a notice of intent soon after your deposition, in which I indicated that the Estate of Sandra Marquardt intended to sue you individually, since the case against the University of Michigan had been dismissed.

On June 2, 2012, I filed that lawsuit naming both you and Dr. Haft. That case is pending in Washtenaw County. I asked the attorneys representing the University of Michigan to accept service on your behalf and they have refused.

I then sent a copy of the complant and summons to you by registered mail. According to the Indian Postal authorities service of that registered mail was attempted on at least one occasion; however, I would assume that they have tried to deliver the letter to you on more than one occasion.

Both the United States and India are signatories on the Hague Convention, which permits me to send the summons and complaint to The Ministry of Law and Justice-Department of Legal Affairs in New Delhi, and they then must serve you with the documents under international law.

I expect that the forwarding of these documents to The Ministry of Law and Justice together with the actual service of the documents on you at your home or professional address will take some time and will likely result in some inconvenience for you and for my client due to the delay. If this process is initiated you will eventually be served, so there is no benefit for you to prolong or complicate this matter by involoving the Indian Ministry of Law and Justice.

I am attaching a copy fo the complaint, the summons, and the affidavit of merit for your review. If you are willing to accept service of these documents, you can simpy send me a e-mail note to that effect and i will explain how you can formalize your decision to accept service.

If I do not hear from you in the next seven days, I will assume that you are not willing to accept service voluntarily and I will begin the process of having you served by Indian authorities in the manner prescribed by international law.

Thomas C. Miller (Attorney for the Estate of Sandra Marquardt)

Marquardt E-Mail to Dr. U.pdf
4 MB

EXHIBIT H

WARNING
AVERTISSEMENT

Identity and address of the addressee
Identité et adresse du destinataire

DR. VELLAIAH DURAI UMASHANKAR
7 VIVEKANANDA ROAD
CHETPET, CHENNAI 600031
INDIA

IMPORTANT

THE ENCLOSED DOCUMENT IS OF A LEGAL NATURE AND MAY AFFECT YOUR RIGHTS AND OBLIGATIONS. THE 'SUMMARY OF THE DOCUMENT TO BE SERVED' WILL GIVE YOU SOME INFORMATION ABOUT ITS NATURE AND PURPOSE. YOU SHOULD HOWEVER READ THE DOCUMENT ITSELF CAREFULLY. IT MAY BE NECESSARY TO SEEK LEGAL ADVICE.

IF YOUR FINANCIAL RESOURCES ARE INSUFFICIENT YOU SHOULD SEEK INFORMATION ON THE POSSIBILITY OF OBTAINING LEGAL AID OR ADVICE EITHER IN THE COUNTRY WHERE YOU LIVE OR IN THE COUNTRY WHERE THE DOCUMENT WAS ISSUED.

ENQUIRIES ABOUT THE AVAILABILITY OF LEGAL AID OR ADVICE IN THE COUNTRY WHERE THE DOCUMENT WAS ISSUED MAY BE DIRECTED TO:

TRÈS IMPORTANT

LE DOCUMENT CI-JOINT EST DE NATURE JURIDIQUE ET PEUT AFFECTER VOS DROITS ET OBLIGATIONS. LES « ÉLÉMENTS ESSENTIELS DE L'ACTE » VOUS DONNENT QUELQUES INFORMATIONS SUR SA NATURE ET SON OBJET. IL EST TOUTEFOIS INDISPENSABLE DE LIRE ATTENTIVEMENT LE TEXTE MÊME DU DOCUMENT. IL PEUT ÊTRE NÉCESSAIRE DE DEMANDER UN AVIS JURIDIQUE.

SI VOS RESSOURCES SONT INSUFFISANTES, RENSEIGNEZ-VOUS SUR LA POSSIBILITÉ D'OBTENIR L'ASSISTANCE JUDICIAIRE ET LA CONSULTATION JURIDIQUE, SOIT DANS VOTRE PAYS, SOIT DANS LE PAYS D'ORIGINE DU DOCUMENT.

LES DEMANDES DE RENSEIGNEMENTS SUR LES POSSIBILITÉS D'OBTENIR L'ASSISTANCE JUDICIAIRE OU LA CONSULTATION JURIDIQUE DANS LE PAYS D'ORIGINE DU DOCUMENT PEUVENT ÊTRE ADRESSÉES À :

UNIVERSITY OF MICHIGAN HEALTH SYSTEM
LEGAL AFFAIRS
ANN ARBOR, MI 48109
UNITED STATES OF AMERICA

It is recommended that the standard terms in the notice be written in English and French and where appropriate also in the official language, or in one of the official languages of the State in which the document originated. The blanks could be completed either in the language of the State to which the document is to be sent, or in English or French.

Il est recommandé que les mentions imprimées dans cette note soient rédigées en langue française et en langue anglaise et le cas échéant, en outre, dans la langue ou l'une des langues officielles de l'État d'origine de l'acte. Les blancs pourraient être remplis, soit dans la langue de l'État où le document doit être adressé, soit en langue française, soit en langue anglaise.

Permanent Bureau September 2011

SUMMARY OF THE DOCUMENT TO BE SERVED
ÉLÉMENTS ESSENTIELS DE L'ACTE

Convention on the Service Abroad of Judicial and Extrajudicial Documents in Civil or Commercial Matters, signed at The Hague, the 15th of November 1965 (Article 5, fourth paragraph).
Convention relative à la signification et à la notification à l'étranger des actes judiciaires ou extrajudiciaires en matière civile ou commerciale, signée à La Haye le 15 novembre 1965 *(article 5, alinéa 4).*

Name and address of the requesting authority: Nom et adresse de l'autorité requérante :	THOMAS C. MILLER-ATTORNEY P.O. BOX 785 SOUTHFIELD, MI 48037 UNITED STATES OF AMERICA

Particulars of the parties*: Identité des parties* :	ESTATE OF SANDRA MARQUARDT V. VELLAIAH DURAI UMASHANKAR

* If appropriate, identity and address of the person interested in the transmission of the document
S'il y a lieu, identité et adresse de la personne intéressée à la transmission de l'acte

☑ JUDICIAL DOCUMENT**
ACTE JUDICIAIRE**

Nature and purpose of the document: Nature et objet de l'acte :	COMPLAINT, AFFIDAVIT OF MERIT AND SUMMONS
Nature and purpose of the proceedings and, when appropriate, the amount in dispute: Nature et objet de l'instance, le cas échéant, le montant du litige :	CIVIL ACTION FOR DAMAGES DUE TO PROFFESSIONAL NEGLIGENCE-THE AMOUNT IN DISPUTE IS LIKELY TO EXCEED TWENTY FIVE THOUSAND DOLLARS
Date and Place for entering appearance**: Date et lieu de la comparution** :	WASHTENAW COUNTY CIRCUIT COURT, ANN ARBOR, MI USA
Court which has given judgment**: Juridiction qui a rendu la décision** :	N/A
Date of judgment**: Date de la décision** :	N/A
Time limits stated in the document**: Indication des délais figurant dans l'acte** :	IF PERSONALLY SERVED PERSONALLY 21 DAYS; IF SERVED OTHER BY OTHER MEANS-28 DAYS

** if appropriate / s'il y a lieu

☐ EXTRAJUDICIAL DOCUMENT**
ACTE EXTRAJUDICIAIRE**

Nature and purpose of the document: Nature et objet de l'acte :	
Time-limits stated in the document**: Indication des délais figurant dans l'acte** :	

** if appropriate / s'il y a lieu

Permanent Bureau September 2011

CERTIFICATE
ATTESTATION

The undersigned authority has the honour to certify, in conformity with Article 6 of the Convention,
L'autorité soussignée a l'honneur d'attester conformément à l'article 6 de ladite Convention,

☐ 1. that the document has been served*
que la demande a été exécutée*

– the (date) / le (date):	
– at (place, street, number): à (localité, rue, numéro) :	

– in one of the following methods authorised by Article 5:
dans une des formes suivantes prévues à l'article 5 :

☐ a) in accordance with the provisions of sub-paragraph a) of the first paragraph of Article 5 of the Convention*
selon les formes légales (article 5, alinéa premier, lettre a)*

☐ b) in accordance with the following particular method*:
selon la forme particulière suivante* :

☐ c) by delivery to the addressee, if he accepts it voluntarily*
par remise simple*

The documents referred to in the request have been delivered to:
Les documents mentionnés dans la demande ont été remis à :

Identity and description of person: Identité et qualité de la personne :	
Relationship to the addressee (family, business or other): Liens de parenté, de subordination ou autres, avec le destinataire de l'acte :	

☐ 2. that the document has not been served, by reason of the following facts*:
que la demande n'a pas été exécutée, en raison des faits suivants*:

☐ In conformity with the second paragraph of Article 12 of the Convention, the applicant is requested to pay or reimburse the expenses detailed in the attached statement*.
Conformément à l'article 12, alinéa 2, de ladite Convention, le requérant est prié de payer ou de rembourser les frais dont le détail figure au mémoire ci-joint*.

Annexes / Annexes

Documents returned: Pièces renvoyées :	
In appropriate cases, documents establishing the service: Le cas échéant, les documents justificatifs de l'exécution :	

* if appropriate / s'il y a lieu

Done at / Fait à The / le	Signature and/or stamp Signature et / ou cachet

Permanent Bureau September 2011

REQUEST FOR SERVICE ABROAD OF JUDICIAL OR EXTRAJUDICIAL DOCUMENTS

DEMANDE AUX FINS DE SIGNIFICATION OU DE NOTIFICATION À L'ÉTRANGER D'UN ACTE JUDICIAIRE OU EXTRAJUDICIAIRE

Convention on the Service Abroad of Judicial and Extrajudicial Documents in Civil or Commercial Matters, signed at The Hague, the 15th of November 1965.
Convention relative à la signification et à la notification à l'étranger des actes judiciaires ou extrajudiciaires en matière civile ou commerciale, signée à La Haye le 15 novembre 1965.

Identity and address of the applicant Identité et adresse du requérant	Address of receiving authority Adresse de l'autorité destinataire
THOMAS C. MILLER P.O. BOX 785 SOUTHFIELD, MI 48037 UNITED STATES OF AMERICA	CENTRAL AUTHORITY THE MINISTRY OF LAW AND JUSTICE DEPARTMENT OF LEGAL AFFAIRS ROOM NO. 4304, 4TH FLOOR A WING, SHASTRI BHAWAN, NEW DELHI-110001 INDIA

The undersigned applicant has the honour to transmit – in duplicate – the documents listed below and, in conformity with Article 5 of the above-mentioned Convention, requests prompt service of one copy thereof on the addressee, i.e.:
Le requérant soussigné a l'honneur de faire parvenir – en double exemplaire – à l'autorité destinataire les documents ci-dessous énumérés, en la priant, conformément à l'article 5 de la Convention précitée, d'en faire remettre sans retard un exemplaire au destinataire, à savoir :

(identity and address)
(identité et adresse)

DR. VELLAIAH DURAI UMASHANKAR
7 VIVEKANANDA ROAD
CHETPET, CHENNAI 600031
INDIA

☑	*a)*	in accordance with the provisions of sub-paragraph *a)* of the first paragraph of Article 5 of the Convention* selon les formes légales (article 5, alinéa premier, lettre *a*)*
☐	*b)*	in accordance with the following particular method (sub-paragraph *b*) of the first paragraph of Article 5)*: selon la forme particulière suivante (article 5, alinéa premier, lettre *b*)* :
☐	*c)*	by delivery to the addressee, if he accepts it voluntarily (second paragraph of Article 5)* le cas échéant, par remise simple (article 5, alinéa 2)*

The authority is requested to return or to have returned to the applicant a copy of the documents - and of the annexes* - with the attached certificate.
Cette autorité est priée de renvoyer ou de faire renvoyer au requérant un exemplaire de l'acte - et de ses annexes* - avec l'attestation ci-jointe.

List of documents / Énumération des pièces

(1) COMPLAINT-THE ESTATE OF SANDRA MARQUARDT V. VELLAIAH DURAI UMASHANAR, M.D. AND JONATHAN HAFT, M.D.
(2)AFFIDAVIT OF MERIT
(3)SUMMONS

* if appropriate / s'il y a lieu

Done at / Fait à	SOUTHFIELD, MI 48037	Signature and/or stamp Signature et / ou cachet
The / le	14 AUGUST 2012	

Permanent Bureau September 2011

EXHIBIT I

XFINITY Connect millertc@comcast.ne

± Font Size -

Notice of Intent

From : millertc@comcast.net Sat, Nov 12, 2011 04:05 PM

Subject : Notice of Intent 1 attachment

To : umashankar@hotmail.co.uk

Dear Dr. Umashankar:

I have attached a copy of the notice of intent that was sent to the University of Michigan Department of Anesthesiology In September 2011. I am not sure that you were advised of this because I believe you are back in in India.

I am sending you another copy by e-mail, so that you have notice of the claim. I would suggest that you contact Ms. Nugent as soon as you receive this e-mail.

Thomas C. Miller

Marquardt Notice of intent # 2.doc
51 KB

EXHIBIT J

XFINITY Connect millertc@comcast.ne

± Font Size -

Notice of Intent

From : millertc@comcast.net Sat, Dec 10, 2011 02:31 PM
Subject : Notice of Intent 1 attachment
To : umashankar@hotmail.co.uk

Dear Dr. Umashankar:

I am enclosing another notice of intent for your records. I have not heard from Ms. Nugent as to whether or not you have received the notice.

Thomas C. Miller

Marquardt Notice of intent # 2.doc
51 KB

EXHIBIT K

millertc@comcast.net

Re: Legal Proceedings

From : millertc@comcast.net Sat, Mar 30, 2013 07:23 AM

Subject : Re: Legal Proceedings

To : umashankar@hotmail.co.uk

I am again following up on the e-mail correspondence below. I would again repeat that time is critical, so I would appreciate if you could respond to my requests.

From: millertc@comcast.net
To: umashankar@hotmail.co.uk
Sent: Friday, March 29, 2013 5:44:43 AM
Subject: Re: Legal Proceedings

I am following up on the e-mail correspondence below. Time is critical, could you please take the time to provide me with an answer?

From: millertc@comcast.net
To: umashankar@hotmail.co.uk
Sent: Thursday, March 28, 2013 6:26:19 AM
Subject: Legal Proceedings

Dear Dr. Umashankar:

I am contacting you regarding the lawsuit that is pending against you in Washtenaw County (Ann Arbor, MI). I represent the Estate of Sandra Marquardt. You will recall that your deposition was taken in 2011 regarding this matter, when the litigation was pending in the Michigan Court of Claims. Since that time it has been necessary to file directly against you in Washtenaw County.

I am corresponding with you in hopes that you will either accept service of process by e-mail, or that you will confirm your address, so that the pleadings can be sent directly to you in India.

Please e-mail me back with either your consent to accept service by e-mail or with a confirmation that the following address is still your address: 7 Vivekananda Road, Chepet, Chennai, India 6000031.

If you do not wish to communicate with me, please e-mail the requested information to the attorney that is representing the University of Michigan in this matter. Her name is Joanne Geha Swanson and she can be reached at jgs@krwlaw.com.

Thomas C. Miller, Esq.
Attorney at Law

EXHIBIT L

RTS-4482/2012/B 12 (590/13-J
FTS/R41/2374/2012

No.12(80)/2012-Judl
Department of Legal Affairs
Judicial Section

Date:14. 1..2013.

The Documents/summons/notices received for service under the provision of ' The Hague Convention of 1965- Service Abroad of Judicial and Extra-judicial Documents / Mutual Legal Assistance Treaties/ Reciprocal arrangements with foreign countries in Civil and Commercial Matters' are returned herewith for the reasons as mentioned below:-

Sl. No.	Particulars of information	
1.	Various Central Authorities of Foreign Countries have been returning the request sent by this Department for legal assistance . if the date of appearance of respondents/hearing of case are less than three months. Due to large number of such requests received from courts all over the India and lack of sufficient resources, this Department also needs at least one month time for processing the request Summons/Notices are therefore returned with the request to issue fresh summons/notices providing 4 months time in advance so that it could be effectively served to the concerned party.	
2.	Summons/Notices should be in original and in duplicate for sending a request for legal assistance to foreign Central Authority.	
3.	Full address of the party and translation of the documents in the official language of requesting country wherever necessary may be provided in the summon/notice.	
4	Ministry of Home Affairs is the nodal ministry and Central Authority for seeking and providing the legal assistance in criminal law matters. Ministry of Home Affairs receives all kind of such requests examines and takes appropriate action(as per circular no T 4410/14/2006 dated 30.04.2010 of Ministry of External Affairs).	
5.	Summon/notice is the photocopy of the original. Original court Notice/Summons in duplicate may be sent	✓
6	Documents may be sent in the prescribed request form. The details available at hcch.net.	

Submitted for approval before we may return the documents to the court/_____ for taking further necessary action at their end

14/1/2013
ALA(Judl)

15.01.13 S.O. (J.)

14/1/13

To.

THOAS C. MILLER
P. O BOX 785
SOUTHFIELD. MI 48037
UNITED STATES OF AMERICA.

State of michigan
Court for the County of
SMALL CAUSES COURT, CHENNAI
Washtenaw
I.A. No. CA 4300 / 12 - 821 NH
OS/OP No: / 200 . 62 NH
Bailiff Name GS
Hg dt
Return Date 8/8
22/7/13
DEPUTY NAZAR
MADRAS-600 104

287
H
15857

Received the notes
and Petion coppy
VELLAIAH DURAI UMASHANKAR M.D
wife of
REVATHI Revathi

6 - 8 - 2013
(DEFENDENT'S WIFE)

SERVED

I, G. Selvaraj, Jr. Bailiff, Court of Small causes, Chennai-104 have solemnly affirmed that: On 6/8/13 I went to the Defendants address, since defendants has gone out I served notice to her wife, got acknowledgment and I humbly submit to hnible court.

Solemnly
affirmed

Deputy Nazar
Small Causes Court
/8/13

F. No. ...Judl.

भारत सरकार सेवार्थ
ON INDIA GOVERNMENT SERVICE

Identity and address of the applicant
Identité et adresse du requérant
THOMAS C. MILLER
P.O. BOX 785
SOUTHFIELD, MI 48037
UNITED STATES OF AMERICA

EMS ED 072765

stice
Affairs
ion
Delhi-110 001

EXHIBIT M

CORPORATE RISK INVESTIGATORS
GREVESGROUP

Dear Mr. Miller,

Pursuant to your instructions vide email dated April 18, 2013; we conducted skip trace investigation of **Dr. Uma Shankar**, at **7th Vivekananda Road, Chetpet, Chennai, India.**

Details of the investigation are appended below:

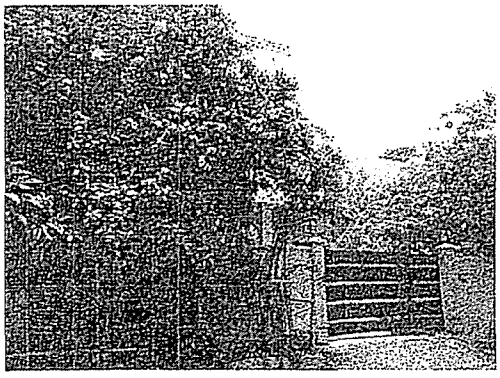
Site Visit: Vivekananda Road, Chetpet, Chennai

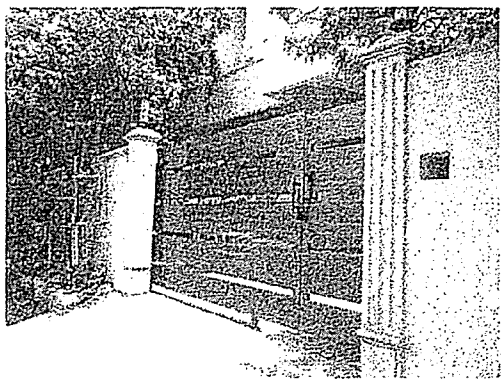
On visiting the provided address, it was observed that it was a residential building. There was a nameplate outside the house bearing the name Dr. T R Muthurangam.

At the premises, the investigator met Dr. T R Muthurangam, father of Dr. Uma Shankar. During discreet conversation with Mr. Muthurangam, it was learnt that the residence belonged to Dr. Uma Shankar where he was residing with his father, wife and a maid.

Dr. Uma Shankar was however not available at the residence during visit as he was at the hospital. No details about the hospital could be obtained during discreet conversation. A few photographs of the house and another of Dr. Muthurangam are appended below:

Residence





CORPORATE RISK INVESTIGATORS
GREVESGROUP

Mr. Muthurangam – Father of the subject

CORPORATE RISK INVESTIGATORS GREVESGROUP

A sign-board displaying the name of the street is furnished below:

Conclusion:

From the investigation and enquiries, it is confirmed that the subject Dr. Uma Shankar resides at the given address.

We report accordingly,

Rakesh Sharma
Director

CORPORATE RISK INVESTIGATORS
GREVESGROUP

From: millertc@comcast.net [mailto:millertc@comcast.net]
Sent: Tuesday, April 23, 2013 4:39 PM
To: Greves Group
Subject: Re: skip/trace Dr. Umashankar

I wired $525 U.S. to make sure that the charges at your end were covered.

From: "Greves Group" <info@grevesgroup.com>
To: millertc@comcast.net
Cc: rakesh@grevesgroup.com, ceo@grevesgroup.com
Sent: Tuesday, April 23, 2013 4:53:49 AM
Subject: RE: skip/trace Dr. Umashankar

Dear Tom,

Thank you for the confirmation. But we are still waiting for the amount to reflect in our bank account. We will let you know as soon as we get the confirmation from our bank.

Regards,

Response Team
Email: info@grevesgroup.com
Website: www.grevesgroup.com

CORPORATE RISK INVESTIGATORS
GREVESGROUP

From: millertc@comcast.net [mailto:millertc@comcast.net]
Sent: Monday, April 22, 2013 8:19 PM
To: Greves Group
Subject: Re: skip/trace Dr. Umashankar

Funds wired, conformation # 68404162032-0001
Transaction ref # 3935000112ES

From: millertc@comcast.net
To: "Greves Group" <info@grevesgroup.com>
Sent: Monday, April 22, 2013 5:15:01 AM

Subject: Re: skip/trace Dr. Umashankar

I did receive the details, and I will be at the bank within the next five to six hours. I will notify you as soon as the transfer has been made. I appreciate your attention to this matter, and I hope that you are able to confirm the address as quickly, because I have to give the Indian authorities as much time as possible to serve him with the papers once I confirm the address.

From: "Greves Group" <info@grevesgroup.com>
To: millertc@comcast.net
Cc: "'Rajeev George" <rajeev@grevesgroup.com>, ceo@grevesgroup.com
Sent: Monday, April 22, 2013 1:27:46 AM
Subject: RE: skip/trace Dr. Umashankar

Dear Tom

Greetings. I am sure you must have received the bank details form our office. Please do let me know once the transfer is through so that we can get the assignment initiated.

Regards,

Response Team
Email: info@grevesgroup.com
Website: www.grevesgroup.com

CORPORATE RISK INVESTIGATORS
GREVES GROUP

From: millertc@comcast.net [mailto:millertc@comcast.net]
Sent: Saturday, April 20, 2013 6:40 PM
To: Greves Group
Subject: Re: skip/trace Dr. Umashankar

Sorry for the delay in getting back to you. I do want you to undertake the investigation. Please let me know how to make payment. I was given your information by Process Forwarding International (the US State Department's process service under the Hague Convention. I believe that Dr. Umashankar is still at the address on his CV, so I would like to pay this fee initially and then discuss any subsequent fees later.

Tom Miller

From: "Greves Group" <info@grevesgroup.com>
To: millertc@comcast.net
Cc: rakesh@grevesgroup.com, ceo@grevesgroup.com
Sent: Saturday, April 20, 2013 5:29:09 AM
Subject: skip/trace Dr. Umashankar

Dear Tom,

This has reference to your recent query. Please let us know if you have duly received our response in that regard. You are requested to let us have the acknowledgment of this mail even if you have dropped the idea of continuing with the desired investigation at this point of time.

Please feel free to write to us at any point of time for any assistance.

PROOF OF SERVICE | Case No.

TO PROCESS SERVER: You are to serve the summons and complaint not later than 91 days from the date of filing or the date of expiration on the order for second summons. You must make and file your return with the court clerk. If you are unable to complete service you must return this original and all copies to the court clerk.

CERTIFICATE/AFFIDAVIT OF SERVICE/NONSERVICE

☐ OFFICER CERTIFICATE

I certify that I am a sheriff, deputy sheriff, bailiff, appointed court officer, or attorney for a party (MCR 2. 104[A][2]), and that: (notarization not required)

OR

☒ AFFIDAVIT OF PROCESS SERVER

Being first duly sworn, I state that I am a legally competent adult who is not a party or an officer of a corporate party, and that: (notarization required)

☒ I served personally a copy of the summons and complaint,

☐ I served by registered or certified mail (copy of return receipt attached) a copy of the summons and complaint, together _____

List all documents served with the Summons and Complaint

_____

_____ on the defendant(s):

Defendant's name	Complete address(es) of service	Day, date, time
Dr. Vellaiah Durai Umashankar, M.D.	7 Vivekananda Road, Chetpet, Chennai, India 600031	September 11, 2013 12:15 P.M.

☐ I have personally attempted to serve the summons and complaint, together with any attachments, on the following defendant(s) and have been unable to complete service.

Defendant's name	Complete address(es) of service	Day, date, time

I declare that the statements above are true to the best of my information, knowledge and belief.

Service fee	Miles traveled	Mileage fee	Total fee
$		$	$

Signature

Manjunath Umasutha

Name (type or print)

Process Server

Title

Subscribed and sworn to before me on 16 September 2013, Bangalore, Karnataka, India

My commission expires: MY TERM EXPIRES ON 1.12.2016 Signature: _____

Date

Deputy court clerk/Notary public

Notary public, State of Karnataka, Bangalore, India

GOVT. OF KARNATAKA

ACKNOWLEDGEMENT OF SERVICE

SWORN TO BEFORE ME

I acknowledge that I have received service of the summons and complaint, together with _____ on _____

day, date, time

_____ on behalf of _____

Signature

S. VENKATASUBBA REDDY
Advocate & Notary
No. 111, Doddathogur,
Electronics C ty Post,
BANGALORE - 560 100.

Sl. No. 108 Page 36
Vol. I Date 16/9/13

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of
the Estate of SANDRA D. MARQUARDT

Plaintiff

VS. Civil Action No. 12-621 NH

VELLAIAH DURAI UMASHANKAR, M.D.
AND JONATHAN HAFT, M.D.

Defendants

_____/

THOMAS C. MILLER (P17786)
Attorney for Plaintiff
P.O. Box 785
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_____/

PROOF OF SERVICE

The undersigned certifies that a copy of Plaintiff's Answer to Defendant Umashankar's Motion for Summary Disposition and Plaintiff's Brief in Support of Plaintiff's

Answer to Defendant Shankar's Motion for Summary Disposition were served upon counsel for Defendant Haft at the above address on January 4, 2018, by regular mail.

Respectfully submitted

Thomas C. Miller (P17786)
Attorney for Plaintiff

Dated: January 4, 2018

Exhibit 19

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

SARON E. MARQUARDT, Personal Representation of The Estate of SANDRA D. MARQUARDT,

Plaintiff,

v.

VELLAIAH DURAI UMASHANKAR, M.D.,

Defendant.

Case No. 12-621-NH

Hon. David S. Swartz

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DEFENDANT VELLAIAH DURAI UMASHANKAR, M.D.'S
REPLY IN SUPPORT OF POST-REMAND MOTION FOR SUMMARY DISPOSITION

I. *Haksluoto* Does Not Affect the Alternate Grounds for Summary Disposition.

Haksuloto decided only one of the three grounds raised in support of summary disposition. *Haksluoto* held that the complaint in that case was timely when notice was given on the last day of the statute of limitations period and suit was filed the day after the notice period expired. *Haksuloto* did not decide whether a notice of intent directed to a hospital satisfies the pre-suit notice requirement for a physician. Nor did *Haksluoto* decide whether a notice of intent ***extends*** the statute of limitations for purposes of determining the timeliness of a claim under the personal representative savings provision. These are the alternate grounds upon which this Court granted summary disposition to Dr. Umashankar, either by express analysis or by granting the motion "for the reasons stated in defendant's motion." [10/30/2013 Tr. (Ex. 10) at pp 12-15]. The Supreme Court order vacating the Court of Appeals' decision does not disturb or vacate this Court's grant of summary disposition for Dr. Umashankar and there is no reason to depart from that ruling.

Nothing in the Supreme Court's remand order prohibits this Court from adhering to its prior decision on these alternate grounds. The remand order does not command a particular result from this Court with respect to any issue, let alone issues that were not addressed in *Haksluoto*. It merely directs "reconsideration in light of *Haksluoto*." Mr. Marquardt's assertion that "the issue being addressed by Defendant at this time was in fact decided by the Supreme Court" is disingenuous and completely unsupported. Dr. Umashankar was not obligated to seek reconsideration of the remand order, which the Court would have likely deemed premature prior to a remand ruling. Further, a Supreme Court order vacating a Court of Appeals decision does not reverse that decision. In *Hill v Ford Motor Co*, 183 Mich App 208, 212; 454 NW2d 125, 127 (1989), the Court explained (with emphasis added):

> First, leave to appeal was never granted by the Supreme Court. Instead, it vacated our prior decision in lieu of granting leave. ***Thus, there was never any decision by the Supreme Court and no law of the case established there***. Second, the order of the Supreme Court ***did not reverse our prior order*** as apparently contended by plaintiff, but merely vacated it with directions to reconsider plaintiff's claims in light of *Teper*. Accordingly, the law of the case doctrine does not apply in this case.

Nor should this Court deem Justice Wilder's non-participation in the *Marquardt* order as evidence that the Supreme Court substantively considered the non-*Haksluoto* issues raised here. Justice Wilder did not participate because he was on the *Marquardt* Court of Appeals' panel. Non-participation is customary when a justice previously decided the case.[1]

II. Pre-Suit Notice Tolling Does Not *Extend* the Statute of Limitations.

Mr. Marquardt misconstrues the purpose of notice tolling. By the express words of the statute [MCL 600.5856(c)], tolling only occurs "if ***during the [applicable notice] period a claim***

[1] Michigan Supreme Court case law is replete with matters in which a justice sat aside due to earlier participation, with 18 such recusals in the last 30 days and more than 250 in the last calendar year. See, e.g., *Dawley v Hall*, No. 155991, 2018 WL 285007, at *6 (Mich January 3, 2018); *JP Morgan Chase Bank, NA v Ellis,* 902 NW2d 895 (Mich Nov 9, 2017). Indeed, the Michigan Court of Appeals IOPs contemplate recusals where a judge participated in a matter at the trial level. See Michigan Court of Appeals Internal Operating Procedure 7.213(D)-(3).

would be barred by the statute of limitations or repose." Mr. Marquardt's use of tolling in this case is not to permit the assertion of a claim that would have been barred during the July 20, 2009 notice period. Indeed, Dr. Umashankar was not named as a defendant in the lawsuit Mr. Marquardt's counsel filed when the July 20, 2009 notice-tolling period expired. Rather, contrary to the limiting statutory language recited above, Mr. Marquardt seeks to give notice-tolling the effect of permanently ***extending*** the statute of limitations so he can argue that Mrs. Marquardt died "within 30 days after the period of limitations has run" as required by the personal representative savings provision of MCL 600.5852.[2] Mr. Marquardt offers no authority for extending the statute of limitations in this manner. Mr. Marquardt is asking this Court to be the first to construe the statute in this manner. This Court previously declined that invitation, stating:

> The Court finds that Plaintiff's analysis is flawed. ***Plaintiff's error is in the assumption that the statute of limitations date of July 20, 2009, was, quote, "extended", unquote, by the 182-day tolling provision of MCL 600.2912b(1) and that consequently, quote, "The new statute of limitations date became January 18th, 2010", unquote.***
>
> The reason Plaintiff is in error is because tolling does not operate to extend or expand the statute of limitations. Tolling merely extends the time during which a claim can be brought by temporarily suspending the running of the statute of limitations. [10/30/2013 Tr (Exhibit 10) at 12 (citation omitted; emphasis added)].

There is no reason to depart from this conclusion.[3]

---

[2] Mr. Marquardt argues that with the filing of the NOI on July 20, 2009, "the statute of limitations period was extended to January 19, 2010" and because Mrs. Marquardt "died within 30 days of that date, her cause of action against Defendant Umashankar was saved pursuant to the provisions of MCL 600.5852(1)." Resp. at 3.

[3] Inexplicably, Mr. Marquardt ignores this basis for this Court's original grant of summary disposition, stating "***this Court's*** grant of summary disposition was based entirely on the rationale struck down by the Michigan Supreme Court in its unanimous decision in Haksuloto" and "[s]pecifically, ***this Court*** granted summary disposition based entirely upon the fact, i.e. that Plaintiff Sandra D. Marquardt had filed her notice of intent on the last day of the statute of limitations period." Resp. at 2 (emphasis in original). This is an inaccurate representation of the Court's opinion, which speaks for itself.

III. The July 20, 2009 Pre-suit Notice Is Not Effective Notice As to Dr. Umashankar.

Mr. Marquardt urges this Court to hold that notice addressed to one party is proper notice to an unaddressed party as long as the other party is mentioned in the body of the notice. This is contrary to binding precedent in this state. See e.g., *Driver v Naini*, 490 Mich 239, 249; 802 NW2d 311 (2011) (NOI directed to a doctor and his professional corporation was not effective as to a second professional corporation with which the doctor was associated during the period of treatment because tolling only applies "with regard to the recipients of the NOI"); *Griesbach v Ross*, 291 Mich App 295; 804 NW2d 921 (2010) (NOI pertaining to two defendants did not toll the limitations period as to a third defendant to whom no notice of intent was sent); *Fournier v Mercy Community Health*, 254 Mich App 461; 657 NW2d 550 (2002).

This requirement is not altered by *Bush v Shabahang*, 484 Mich 156; 772 NW2d 272 (2009), which Mr. Marquardt relies upon for the proposition that this Court should disregard his failure to direct an NOI to Dr. Umashankar because "defects in the notice of intent may be amended or disregarded pursuant to MCR [sic] 600.2301, if the substantial rights of the parties are not affected, provided the cure is in the furtherance of justice and has terms that are just." Marquardt's Resp. at 17. In *Driver*, the Supreme Court reached the contrary conclusion, distinguishing between the defects in the content of the NOI at issue in *Bush*, and the outright failure to serve an NOI to a defendant in *Driver*. The Supreme Court explained that "[t]he *Bush* majority held that when an NOI fails to meet all of the *content* requirements under MCL 600.2912b(4), MCL 600.2301 allows a plaintiff to amend the NOI and preserve tolling unless the plaintiff failed to make a good-faith effort to comply with MCL 600.2912b(4)." *Id.* at 252-253 (footnotes omitted; emphasis in original). However, in *Driver*, as in the present case, content wasn't the issue; defendant "never received a timely, albeit defective, NOI." And beyond that, the *Driver* court held that "by its plain language, MCL 600.2301 only applies to actions or proceedings that are *pending*." *Id.* at 254. The

action in *Driver*, as is true of the action here, was not timely commenced and hence was not pending. *Id.* at 254. MCL 600.2301 was therefore inapplicable. *Id.*

The *Driver* court additionally concluded that allowing the original NOI to be amended under MCL 600.2301 to add a defendant would not be "for the furtherance of justice" and would affect that defendant's "substantial rights," including the defendant's right to receive a timely NOI and to assert its statute of limitations defense. *Id.* at 254-255. The Court concluded:

> We have construed this provision [MCL 600.2912b(1)] as containing a dual requirement: A plaintiff must (1) submit an NOI to *every* health professional or health facility before filing a complaint and (2) wait the applicable notice waiting period with respect to each defendant before he or she can commence an action. A plaintiff has the burden of ensuring compliance with these mandates. With regard to the requirement that a plaintiff provide every defendant an NOI during the applicable limitations period before filing a complaint, nothing in *Bush* eliminates this requirement. [Id. at 255 (footnotes omitted; emphasis in original)]

Further, MCL 600.2912(2) does not cure the failure to address the NOI to Dr. Umashankar. While the provision permits ***mailing*** to the last known address or where the care was rendered, the NOI must nonetheless be directed to Dr. Umashankar. Dr. Umashankar wasn't named because Mr. Marquardt didn't intend to name him in the subsequently filed action [and didn't name him]. Further, Mr. Marquardt admits he knew Dr. Umashankar was in India but describes no effort to reasonably ascertain Dr. Umashankar's address at the time the July 2009 NOI was sent, relying instead on efforts between 2011-2013. Resp. at 12.[4] Summary disposition is required.

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Dated: January 5, 2018

[4] Contrary to Mr. Marquardt's representation, Dr. Umashankar does not admit that the second NOI was sufficient. Among other reasons, the NOI was sent after the statute of limitations expired.

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

SARON E. MARQUARDT, Personal Representation of The Estate of SANDRA D. MARQUARDT,

Plaintiff,

v.

VELLAIAH DURAI UMASHANKAR, M.D.,

Defendant.

Case No. 12-621-NH

Hon. David S. Swartz

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PROOF OF SERVICE

Cynthia J. Villeneuve, being duly sworn, deposes and says that on Friday, January 5, 2018 she served a copy of Defendant Vellaiah Durai Umashankar, M.D.'s Reply in Support of Post-Remand Motion for Summary Disposition and this Proof of Service by electronic and First Class Mail upon Thomas C. Miller, P.O. Box 785, Southfield, MI 48037.

Cynthia J. Villeneuve

Subscribed and sworn to before
me this 5th day of January, 2018

Angela E. Hincks
Notary Public, Wayne County, MI
My Commission expires: 4-10-20
Acting in Wayne County, MI

ANGELA E. HINCKS
Notary Public, Wayne County, MI
My Commission Expires April 10, 2020
Acting in the County of Wayne

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Exhibit 20

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of the Estate of SANDRA MARQUARDT, deceased,

Plaintiff,

v Case No. 12-621-NH

VELLAIAH DURAI UMASHANKAR, M.D.,

Defendant./

MOTION HEARING

BEFORE THE HONORABLE DAVID S. SWARTZ, CIRCUIT JUDGE

Ann Arbor, Michigan - Wednesday, January 10, 2018

APPEARANCES:

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Transcribed by:	Lisa Beam, CER #8647

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Ann Arbor, Michigan

Wednesday, January 10, 2018 - 2:03 p.m.

* * * * * *

THE CLERK: Marquardt v Umashankar, case number 12-621-NH.

MR. MILLER: Ready your Honor. Thomas Miller on behalf of the Plaintiff your Honor.

MS. SWANSON: And Joanne Geha Swanson on behalf of the Defendant your Honor.

THE COURT: You may proceed.

MS. SWANSON: This is um -- Dr. Umashankar's motion for summary disposition post-remand. Um -- this is an action for medical malpractice. The allegation is that Dr. Umashankar breached the standard of care by prescribing Aprotinin to control bleeding during surgery. We were before you a couple of years ago on a motion for summary disposition based upon the statute of limitations. At that time you granted the motion. The Court of Appeals affirmed. Mr. Marquardt filed an application for leave to appeal to the Supreme Court and the Supreme Court vacated the Court of Appeals decision and remanded it to this Court for reconsideration in light of the Supreme Court's opinion in Haksluoto. Importantly, while the court vacated the court of -- the Supreme Court vacated the Court of Appeals opinion it did not vacate this Court's

opinion, it merely remanded for reconsideration of that opinion which is why we are here today.

Haksluoto held that the complaint in that case was not -- was timely when the Notice of Intent was filed on the last day of the statute of limitations period and the action was commenced the day after the Notice period expired. The untimeliness of a claim under those circumstances was one of the reasons that this Court granted summary disposition but it was not the only reason. There were two other grounds for summary disposition that formed the basis for this Court's initial grant that Haksluoto did not address because they were not at issue in Haksluoto and one of the grounds is whether the Notice tolling provision extends the statute of limitations or merely tolls it for purposes of filing an action as this Court concluded and the other ground was whether a Notice of Intent, that is directed to the risk manager of a hospital, can in fact be effective Notice as to the doctor. These alternate grounds were not disturbed by the Haksluoto decision um -- and this Court has expressly already concluded that both of these grounds um -- are -- are viable bases for summary disposition.

So we are today with our post-remand motion for summary dispose -- disposition asking you to affirm the alternate grounds for summary disposition upon which this

Court's initial decision was based and I will briefly address those grounds now.

Um -- the first ground is -- is that the statute of limitations is not extended by the Notice tolling provision. By the express words of the Notice tolling statute, tolling only occurs if during the applicable Notice period a claim would be barred by the statute of limitations or repose. Mr. Marquardt's use of tolling in this case is not to file a lawsuit that would be barred during the applicable Notice period. When the Notice was given on July 20, 2009, and the lawsuit was filed after that Notice period expired mister -- or Dr. Umashankar was not named as a Defendant by mis -- Mrs. Marquardt. So contrary to the limited scope of tolling allowed by the statute, Mr. Marquardt now wants to allege that that Notice in July 20, 2009, didn't merely toll the statute of limitations it extended it to allow for him to argue that Mrs. Marquardt died within 30 days of the expiration of the statute of limitations.

Mr. Marquardt offers no authority for extending the statute of limitations in this matter. The Court of Appeals in the case of Miracle v Shapiro specifically rejected that notion stating, and I'll quote, contrary to both parties assertions on appeal the two year statute of limitations is not extended 182 days when a plaintiff

files Notice of Intent to sue in accordance with MCL 6002912b (sic), instead the limitations period is only tolled where the statute of limitations will expire during the 182 Notice period that the plaintiff is prohibited from filing a lawsuit.

This Court reached that very conclusion in your earlier summary disposition motion. The Court said, and I'll quote, the Court finds that Plaintiff's analysis is flawed. Plaintiff's error is in the assumption that the statute of limitations date of July 20, 2009, was "extended" by the 182 day tolling provision of MCL 600292 -- 2912b1 and that consequently "the new statute of limitations date became January 18th, 2010." The reason Plaintiff is in error is because tolling does not operate to extend or expand the statute of limitations, tolling merely extends the time where -- during which a claim can be brought by temporarily suspending the running of the statute of limitations. This Court also noted that the savings provision in MCL 6005852 is not a statute of limitations of repose but merely an exception to the statute of limitations and the Court said that it allows commencement of an action after the statute of limitations has run. This Court went on to say um -- that Mr. Marquardt's claim was untimely um -- because it did not fall within 30 days of the expiration of the statute of

limitations and we are asking this Court to confirm that basis for summary disposition continues to apply, it is not altered by the Haksluoto decision.

In addition to the argument that the statute of limitations was not extended, the July 20, 2009, Notice of Intent that Mr. Marquardt relies upon was not even sent or directed to Dr. Umashankar. It was sent to the risk manager at the University of Michigan Health System and the University of Michigan Regents were the only -- or was the only Defendant that was sued when the tolling period expired. Although Dr. Umashankar was mentioned in the body of the NOI it wasn't directed to him because Plaintiff was not planning to sue Dr. Umashankar. Mr. Marquardt's lawyer admits that he didn't decide to sue Dr. Umashankar until the Regents moved for summary disposition in 2011 in the Court of Claims action and that at that time another NOI was addressed to Dr. Umashankar by then the statute of limitations had expired.

Now Plaintiff is arguing to this Court that the Notice of Intent sent to the risk manager at U of M is effective as to Dr. Umashankar because it was sent to um -- the doctor's lan -- or because the doctor's last known address could not be reasonably ascertained. But that does not satisfy the statute for several reasons. First of all your Honor, in order to properly invoke the

provision that you can send it to the facility where the care was rendered Plaintiff has to make some effort to ascertain Dr. Umashankar's last known professional address. Mr. Marquardt's lawyer wasn't concerned with doing that in 2009 when that Notice of Intent was sent because he didn't intend to sue Dr. Umashankar um -- and Mr. Marquardt's failure to inquire as to the -- a reasonably ascertain -- ascertainable address is acknowledged in his response to our motion for summary disposition where he states "it would've been extremely unlikely that counsel for claimant could have found a current address for Dr. Umashankar in 2009 after he had returned to India" and further states quote, serving the University of Michigan with the Notice was thought to have been the best way to advise Defendant of the pending claim. But University of Michigan had no relationship with Dr. Umashankar in July of 2009. Dr. Umashankar's tenure as a visiting physician at the Hospital lasted less than a year and terminated in October of 2007. At that -- at that point, as Mr. Marquardt's lawyer admits to knowing -- Dr. Umashankar returned to India. His response makes no effort to describe any effort made to ascertain Dr. Umashankar's address in 2009. He describes efforts that he made between the period of two, oh, oh -- two hun -- 2011 and 2013 which was two years later and the time at

which he was making the determination that he would have to file another lawsuit based on the Court of Claims dismissal.

Secondly your Honor, nothing in the Notice tolling statute permits a Plaintiff to direct Notice intended for a physician to the risk manager at the Hospital. The Notice still has to be given to the intended defendant and if Dr. Umashankar was the intended defendant it should've been sent to him but the Notice itself makes no pretense that this was supposed to be noticed to Dr. Umashankar. It's not addressed to him and the first sentence of the Notice tells the risk manager "you are hereby notified" and then goes on to describe the Hospital's liability based upon vicarious liability. In his Supreme Court application Mr. Marquardt admits that the Notice was not served on Dr. Umashankar, stating at page one "first Notice of Intent was served pursuant to MCL 6002912b2 on the University of Michigan not Defendant Umashankar" and -- and Mr. Marquardt states again in the application "there was also no dispute that the NOI was sent to the University of Michigan rather than to Defendant Umashankar."

Although the Court of Appeals opinion in this case affirming your decision was vacated um -- in the Supreme Court's remand order the Court of Appeals reached

that same conclusion stating that in order to infectuate -- effectuate notice the NOI must be directed to or addressed to the Defendant professional to whom the NOI is intended to provide notice and this is in fact your Honor the settled law of the Supreme Court. In Driver v Naini the NOI was directed to his do -- to a doctor and his professional corporation but was not directed to another second professional corporation with which he was affiliated during the period of treatment and the Michigan Supreme Court expressly stated that the NOI tolls the statute of limitations with regard to the recipients of the Notice. In -- in Fournier v Mercy Community Health System one day before the statute of limitations expired Plaintiff prepared six Notices of Intent and inadvertently placed them in a single envelope and mailed them to one of the Defendants. When that Defendant returned three days later from his vacation he delivered them to the risk manager at the hospital. The Court of Appeals held that that was not service um -- that was not effective Notice as to the other five Defendants who did not receive the Notices of Intent within the statute of limitations period.

In Greisbach (ph) v Ross the Court of Appeals also held that an NOI pertaining to two Defendants did not apply or effectuate Notice as to a third defendant to whom

no Notice was sent. It's not sufficient to argue, as Mr. Marquardt does, that Dr. Umashankar was mentioned in the body of the letter. Um -- there's no authority -- and that he thought that the risk manager would have conveyed Notice to Dr. Umashankar -- there's no authority whatsoever for the proposition that the NOI statute can be satisfied by sending Notice to a third party who you then think will -- will notify the intended defendant. The statute is inconsistent with any such notion in that it states that proof of mailing constitutes prima facie evidence of compliance with this section. The clear meaning of the provision is that compliance requires that the specified physical mailing be to the defendant and -- and nothing less than that. The date of mailing is obviously important because that's the day that the Notice period begins -- the tolling period begins and you wouldn't be able to determine when tolling begins if you mailed the Notice to a third party who you thought would then tell the intended defendant.

We've cited two Michigan Supreme Court cases which enforced other Notice requirements despite allegations that actual notice was received which is another argument that Mr. Marquardt makes to this Court. In McCahan despite the Plaintiff's failure to give Notice required by the Court of Claims Notice statute the

plaintiff argued that defendant had actual Notice of the intent to pursue a lawsuit, was fully apprised of all the relevant details and in fact had communicated with the plaintiff during that Notice period; nonetheless, the Supreme Court concluded that plaintiff's failure to file the required Notice barred her action regardless of whether the University was somehow put on notice by some other means. Similarly in another Supreme Court case -- both of these are cited in our brief -- in the Adkins case the Supreme Court held that a common carrier's presumed institutional knowledge of an injury or occurrence doesn't relieve the claimant of the obligation to give the required statutory Notice.

In this case your Honor, Dr. Umashankar would not know he was going to be sued if he is not the one receiving Notice and in fact he was not sued when this Notice period expired so this is really an after the fact retrospective attempt to fit the new claim Mr. Marquardt is asserting under the wrongful death savings provision into the statute of limitations for filing -- or the statute of limitations savings provision for filing that claim. Plaintiff argues that Bush versus Shoeving (ph) and MCL 6002301 permits the Court to disregard his failure to send the Notice of Intent to Dr. Umashankar and that simply is not so. This very issue was addressed by the

Supreme Court in Driver where the Supreme Court distinguished between defects in the content of Notice which was the issue in Bush v Shoeving and a complete failure to send the notice which was the issue in Driver and the issue in our case and Driver held that MCL 6002301 could not apply to a failure to send Notice because that would circumvent the purpose and intent of this statute. Um -- also 6002301 only applies to pending actions and when a Notice of Intent is not timely sent there is no pending action to which the statute can apply. And the court in Driver further concluded that -- that the um -- statute didn't apply because the failure to serve the NOI would not be in the furtherance of justice and it would affect the substantial rights of the Defendant.

So for these reasons your Honor, while it is true that Haksluoto affects one basis for this Court's grant of summary disposition there are two other grounds that are unaffected and unaddressed by Haksluoto and on that basis we ask this Court to reaffirm its grant of summary disposition and or grant --

THE COURT: Thank you.

MS. SWANSON: -- summary disposition again.

MR. MILLER: This -- this Court granted summary disposition in October of 2013, more than four years ago. Prior to that there had been over a year of effort made to

serve Dr. Umashankar in India um -- personally and under the Hague Convention. When this Court decided, the appeal was taken, the application was essentially granted, in lieu of it it was remanded and -- and then this new motion was filed. At no time, your Honor, has Defendant ever -- ever submitted an affidavit by Dr. Umashankar saying that he did not receive the Notice that was sent to the University of Michigan and there's one reason that they've never submitted that affidavit your Honor, because he did receive it.

The 2912b2 provisions are intended to do whatever is necessary to ensure that the potential defendant is given notice of the possible claim being made against him. There are two sections of 2912b2, one says that the defendant -- potential defendant could be served at his last known address or at the health care facility that the negligence occurred. Dr. Umashankar came to the United States strictly to work at the University of Michigan for a period of approximately 11 months. During that time and as soon as he completed that assignment at the University of Michigan he left the country. The last known address that Plaintiff had at that time for Dr. Umashankar was the University of Michigan. Counsel says, well the Notice of Intent mentioned Dr. Umashankar in the body of the Notice. The body of the Notice says that it

was Plaintiff's intention to sue Dr. Umashankar and Dr. Happ (ph) as well as the University of Michigan Hospital. Twenty-nine 12, two, b, 12 -- b, two -- excuse me -- or four -- b, four, requires specific allegations be made against the potential defendants in each and every one of those requirements, i.e., what were the factual issues, two, what was the applicable standard of care, three, how was the standard of care breached, four, what could have been done to be in compliance with the standard of care, and five, what's the proximate cause between the claimed negligence and the claimed injuries. Dr. Umashankar was referred to in each and every one of those paragraphs by name.

Defendant says that this was served on the third party, 2912b provided two options for service and both of 'em involved the University of Michigan. In addition, Counsel states that this Court essentially decided this issue back in 2013 which is absolutely not true. This Court entered a detailed opinion in which it said that since the Plaintiff filed the Notice of Intent on the last day of the statute of limitations period there could be no tolling because there was no time on the statute of limitations to be saved for 182 days. The Court then went on to say, as a result -- since the statute was not tolled -- then 5852 which was the savings provision, when a

person dies within 30 days of when the statute would've expired -- then that also cannot be used to save this litigation. That is the entire extent of this Court's opinion on October 30th, of 2013. There was no -- there -- this Court did not address the issue of whether or not the Notice of Intent had to be addressed to Dr. Umashankar as opposed to sent to his last known address or to the Hospital in the case of the last known address not being determinable. Um -- the Court of Appeals affirmed -- or excuse me -- the Court of Appeals de novo considered both issues, the one that this Court had addressed as well as the addressee issue and found that the Court was correct to grant summary disposition on the basis that it had been filed the last day of the statute of limitations and that -- that the -- it had to be sent to the addressee. That decision has been vacated by the Michigan Supreme Court. It has no -- no precedential value by definition once it's vacated.

The law of the case your Honor -- the Supreme Court in Plaintiff's application to the court of -- Supreme Court and in Defendant's response to that application both issues were thoroughly briefed -- the Supreme Court put -- even though my application was filed before Haksluoto they put mine -- they held my claim in abeyance pending the decision in Haksluoto. Once

Haksluoto was decided it then issued an order and in that order it said in light of -- that the Court of Appeals decision is vacated and the matter is remanded to the trial court. The Supreme Court could have, as they typically do when there are multiple issues involved and they don't intend to address one of those issues, is to remand it to the Court of Appeals. They chose not to do that. As such, they were ruling on the merits that were presented to them and they wanted to remand it to the trial court.

In my brief to this Court on this motion I indicated that the law of the case applies. Defendant in her reply brief -- or Counsel for Defendant in her reply brief cited a case of Hill v Ford Motor Company for the proposition that since the decision was vacated that it had no law of -- of the case ramifications. Unfortunately, what the Defendant did not indicate in the reply brief was that Hill the Supreme Court remanded to the Court of Appeals that had issued the decision. The Supreme Court in Johnson v White at 430 Mich 47, page 52, 53, held as a general rule an adjudication on an issue in the first appeal is the law of the case in all subsequent appeals in which the facts are substant -- substantially the same. The reason for the rule is the need for finality of judgment and the want of a jurisdiction of

appellate court we don't -- excuse me -- and the want of a jurisdiction in the appellate court to modify its own judgment except on rehearing. That's the law of the case was the order by the Supreme Court. Counsel for Defendant, as I set forth in my brief, we had discussions with your judicial attorney and both Counsel as to how to proceed on the remand. Counsel for Defendant was going to elect whether she wanted to file a motion for rehearing with the Supreme Court to clarify the issue of addressee. She chose not to do that your Honor. This becomes the law of the case.

She um -- and if we -- if you examine -- go behind the scenes, judge -- Justice Wilder who sat on our case in the Court of Appeals and then was elevated to the Supreme Court -- did not recuse himself from the Haksluoto decision. He was part of the seven justice ma -- unanimous opinion; however, when it came time to issuing the order of remand he exc -- he recused himself from that deliberation. Counsel says that the Bush decisions had to do with the contents of the Notice of Intent. That is not true. In the Bush case the issue was Plaintiff had ser -- had filed their complaint short of 182 days. I think 181 days and the Supreme Court said we are going to permit that error but if they had not the statute of limitations would've expired. The Supreme Court in Driver was

confronted with the prior decision in Bush and in DeCosta (ph) and they chose not to overrule either of those decisions and both of them are on similar grounds with the present case.

Counsel references these two decisions that had to do with Notice provisions having to do with highways and having to do with transportation in neither of those statutes is there any option as to how to serve -- how to give Notice; however, in 2912b2 there is an option. Plaintiff is entitled to either send it to the last known address or to send it to the Hospital. Those options are not available in those statutes. They specifically identify the gov -- governmental entity that must receive the Notice. Thank you, your Honor.

MS. SWANSON: Your Honor.

THE COURT: Brief rebuttal. Might be the longest oral argument I've had in this Court in five years between the two of you so let's keep it brief.

MS. SWANSON: Your Honor we are under no obligation to submit an affidavit from Dr. Umashankar as to whether he did or did not receive the NOI. It's Plaintiff's burden to show that Notice was proper. Um -- I'm not going to argue or repeat again what you said in your opinion. You issued a five page opinion. You did more than what Mr. Miller indicated, you said when I said

Again, Justice Wilder recusing himself or not recusing himself from Haksluoto but recusing himself from our -- that has nothing to do with the substance of this case your Honor, that is normal practice for a Supreme Court justice who has sat on a panel of a Court of Appeals to recuse himself. Thank you.

THE COURT: Take the mot -- matter under advisement, issue a written opinion.

MR. MILLER: Thank you, your Honor.

MS. SWANSON: Thank you.

(At 2:36 p.m., proceeding concluded)

* * * * * *

STATE OF MICHIGAN)
COUNTY OF WASHTENAW)ss.

I certify that this transcript, consisting of 22 pages, is a true and accurate transcription to the best of my ability of the proceeding in this case before the Honorable David S. Swartz, as recorded by the clerk.

Proceedings were recorded and provided to this transcriptionist by the Circuit Court and this certified reporter accepts no responsibility for any events that occurred during the above proceedings, for any inaudible and/or indiscernible responses by any person or party involved in the proceeding or for the content of the recording provided.

Dated: August 14, 2018

/S/ Lisa Beam
Lisa Beam, CER #8647

Exhibit 21

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WASHTENAW

SARON E. MARQUARDT, Personal Representative of
the Estate of SANDRA D. MARQUARDT

Plaintiff

VS. Civil Action No. 12-621 NH

VELLAIAH DURAI UMASHANKAR, M.D.
AND JONATHAN HAFT, M.D.

Defendants

/

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/

PLAINTIFF'S BRIEF IN SUPPORT OF PLAINTIFF'S ANSWER TO DEFENDANT HAFT'S MOTION FOR SUMMARY DISPOSITION

of the internet in 2011failed to provide counsel with a current address for Defendant Umashankar, and it was also impossible to find a current address in 2009; as a result, counsel was clearly in compliance with MCL 600.2912b (2) when the notice of intent was sent to the risk manager for the University of Michigan Health System on behalf of Defendant Umashankar.

MCL 600.2301 was enacted in 1963 by the Legislature to provide the judges in this state with the authority to ignore certain procedural and substantive errors or defects, when justice would be served by ignoring such errors or defects that might result in a party losing their right to have the merits of their claim heard within the legal system simply because a "t" was not crossed or an "i" was not dotted. The Michigan Supreme Court in *Bush* found that MCL 600.2301 afforded the trial courts an opportunity to overlook minor procedural errors or defects if a party had made those errors despite acting in good faith. In the instant case, the notice of intent clearly identified Defendants by their name, by their specialty and by the actions that they undertook to cause Sandra Marquardt to suffer significant injuries and damages. Counsel for Sandra Marquardt made a good faith effort to identify the responsible individuals in the July 20, 2009 notice of intent, and the employer of those individuals was notified in a timely manner. The notice of intent provided the risk manager with all of the necessary information to investigate the claim fully. It was only when the University of Michigan decided to file a motion for summary disposition based upon a technical requirement regarding the filing of a claim with the Court of Claims that it became necessary to file this action against the individual doctors rather than finish the litigation directly against the University of Michigan. There is no doubt that any judgment that is rendered against the individual doctors in this litigation will be paid by the University of Michigan Health System, and there is no doubt that the defense costs for

defending the individual doctors is being paid by the University of Michigan Health System or its carrier. Counsel for Sandra Marquardt acted in good faith when the July 20, 2009 notice of intent was drafted and sent to the University of Michigan Health System. At that time, based upon more than 40 years of *stare decisis*, a lawsuit could have been filed against the University of Michigan Health System in the Court of Claims without having previously filed a notice of claim with that court. Counsel for Plaintiff relied upon that well established case law that required that the University of Michigan Hospital show actual prejudice in order to move for summary disposition, and counsel for Plaintiff anticipated that Sandra Marquardt's claim could have been resolved through the Court of Claims litigation without actually naming the individual doctors in Washtenaw County. Counsel for Plaintiff acted in good faith when the individuals were identified in the July 20, 2009 notice of intent, and when the notice of intent was sent to the risk manager for the University of Michigan Health System. No one could have anticipated that almost two years into the litigation in the Court of Claims and after more than fifteen depositions had been taken or scheduled, counsel for the University of Michigan would file a motion for summary disposition based upon Plaintiff's failure to file a worthless claim form with the Court of Claims within six months of the negligence. In the instant case, that claim would have had to be filed in the Court of Claims approximately one and one-half months after Sandra Gordon was discharged from the hospital and while she was still recovering at home. MCL 600.2301 is the appropriate statutory safety valve for this type of miscarriage of justice. Counsel for Plaintiff acted in good faith when he sent the notice of intent on July 20, 2009, and counsel for Plaintiff acted appropriately when he filed this litigation against the individual doctors. The facts exposed in the instant case demonstrate the hardship that is caused when the legal system evolves into a "gotcha" exercise.

In the case of Defendant Umashankar, the notice of intent was served in strict compliance with MCL 699.2912b (2), because Dr. Umashankar was residing in India when the notice of intent was served, and the health facility where the care was provided was correctly notified. In the case of Defendant Haft, the notice was served appropriately given that his office and one of the risk management offices were both situated in the same building when the July 20, 2009 notice of intent was served. In addition, Defendant Haft has not proffered any evidence that would establish that he was not made aware of the notice of intent in July 2009. Plaintiff asserts that the notice of intent that was served upon the risk manager for the University of Michigan complied with the provisions of MCL 600.2012b (1) and (2). If, however, this Court determines that Defendant Haft was not notified directly, as opposed to indirectly through the office of the risk manager for the University of Michigan Health System, then Plaintiff would suggest that MCL 600.2301, as interpreted by the Michigan Supreme Court in *Bush*, should be used to avoid having to grant summary disposition as to Defendant Haft, because the interests of justice would be served by ignoring the technical error that occurred when counsel for Plaintiff, while acting in good faith, attempted to litigate this claim directly against the University of Michigan Health System without the necessity of filing two separate lawsuits in two different venues.

If this Court wishes to know exactly how Defendant Haft learned about the July 20, 2009 notice of intent, Plaintiff's counsel would suggest that this motion be denied without prejudice. Then counsel would also suggest that he be permitted to depose the risk management staff and Defendant Haft to address the notice issues, which would be beneficial in determining whether or not MCL 600.2301 should be used to permit Plaintiff to proceed with this litigation.

Exhibit 22

STATE OF MICHIGAN

IN THE SUPREME COURT

SARON E. MARQUARDT, Personal Representative of the Estate of SANDRA MARQUARDT (Dec.)

Plaintiff-Appellant

v

Washtenaw County Circuit Court No. 12-621-NH
Court of Appeals No. 319615

VELLAIAH DURAI UMASHANKAR, M.D.

Defendant-Appellee

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APPLELLANT'S APPLICATION FOR LEAVE TO APPEAL

INTRODUCTION

The following chronology should provide all of the relevant information needed to address the issues relevant to this Application for Leave to Appeal:

JULY 20, 2007—THE RELEVANT SURGERY WAS PERFORMED.

SEPTEMBER 30, 2007—DEFENDANT UMASHANKAR LEFT THE COUNTRY. (See Appellant's Exhibit 7, page 4, attached to Appellant's Court of Appeals Brief.)

JULY 19, 2009—SUNDAY (See Exhibit C-Attached to this Application for Leave to Appeal.)

JULY 20, 2009—FIRST NOTICE OF INTENT (NOI) WAS SERVED PURSUANT TO MCL 600.2912b (2) ON THE UNIVERSITY OF MICHIGAN NOT DEFENDANT UMASHANKAR, WHO HAD RETURNED TO INDIA ALMOST TWO YEARS EARLIER. (THE SURGERY HAD BEEN PERFORMED AT THE UNIVERSITY OF MICHIGAN MEDICAL CENTER.) MCL 600.5856 (c) TOLLED THE STATUTE OF LIMITATIONS FOR A PERIOD OF 182 DAYS. (See Appellant's Exhibit 9 attached to Appellant's Court of Appeals Brief.)

JULY 22, 2009—UNIVERSITY OF MICHIGAN ACKNOWLEGED RECEIPT OF THE NOI. (See Appellant's Exhibit 10 attached to Appellant's Court of Appeals Brief.)

DECEMBER 21, 2009—A COMPLAINT COULD HAVE BEEN FILED PURSUANT TO MCL 600.2912b (7) AND (8), SINCE NEITHER DEFENDANT UMASHANKAR NOR THE UNIVERSITY OF MICHIGAN FILED A NOTICE OF MERITORIOUS DEFENSE WITHIN 154 DAYS AFTER BEING SERVED WITH THE NOI.

JANUARY 17, 2009—STATUTE OF LIMITATIONS WOULD HAVE BEGUN TO RUN AGAIN, IF THE NOI HAD BEEN ABLE TO BE FILED ON JULY 19, 2009 AND THE STATUTE OF LIMITATIONS WOULD HAVE EXPIRED ON JANUARY 18, 2010, GIVEN THAT ONE DAY WOULD HAVE BEEN SAVED WHEN THE NOI WAS FILED ON JULY 19TH.

JANUARY 19, 2010—FIRST COMPLAINT WAS FILED. THE COMPLAINT COULD NOT BE FILED ON JANUARY 18, 2010, SINCE IT WAS MARTIN LUTHER KING DAY AND THE COURTS WERE CLOSED. (See Appellant's Exhibit 11 attached to Appellant's Court of Appeals Brief.)

JANUARY 27, 2010—PLAINTIFF DIED. EVEN IF THE CASE HAD NOT BEEN TIMELY FILED ON JANUARY 19, 2010, THE CAUSE OF ACTION WOULD HAVE BEEN

health professionals that she believed contributed to her injuries and damages. His name was mentioned several times in the body of the NOI. There was also no dispute that the NOI was sent to the University of Michigan rather than to Defendant Umashankar. There was also no dispute that Defendant Umashankar had left the United States in September of 2007, while Sandra Marquardt was still hospitalized at the University of Michigan, to return to his native India. There was no way that counsel for Sandra Marquardt could have reasonably obtained a last known address for Defendant Umashankar in 2009 in India when the NOI was being prepared and sent out.

Recognizing that such situations might arise, the Michigan Legislature was careful to tailor their statutory language in a way that allowed health professionals to be served with a NOI when claimants were unable to find a last known address for a health professional. Specifically, the Legislature drafted MCL 600.2912b (2) in a way that would ensure that claimants could still meet the notice provisions of subsection (1) where the health professional had no last known address.

The trial court in the instant case did not address that issue even though it was the only issue actually raised by Defendant in his motion for summary disposition. The Court of Appeals decided to address the issue even though it had had already affirmed the trial court's grant of summary disposition. Unfortunately, the Court of Appeals chose to ignore the clear and unambiguous language of MCL 600.2912b (2). It chose instead to add to the clear and unambiguous language of that section by stating that in the instant case, claimant did not address or direct the NOI to Defendant Umashankar while mailing it to the health facility's address. Nothing in the provisions of subsection (2) required that the NOI be addressed or directed to the health professional care of the health facility, if reasonable efforts failed to identify a last known

Exhibit 23

STATE OF MICHIGAN

IN THE COURT OF APPEALS

SARON E. MARQUARDT, Personal Representative of the Estate of SANDRA MARQUARDT (Dec.)

Plaintiff-Appellant

v

Washtenaw County Circuit Court No. 12-621-NH
Court of Appeals No. 319615

VELLAIAH DURAI UMASHANKAR, M.D.

Defendant-Appellee

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APPELLANT'S BRIEF

(ORAL ARGUMENT REQUESTED)

December 15, 2006—The FDA issued its own advisory letter to physicians that repeated and reinforced the steps that had been taken by the manufacturer to restrict the use of Trasylol to CABG procedures. (See Exhibit 5.)

July 20, 2007—Sandra Marquardt underwent open heart surgery at the University of Michigan. The surgery involved the removal of her damaged aortic valve and the placement of a synthetic aortic valve. That surgery did ***not*** involve a CABG procedure; however, during that surgery she ***was*** given the drug Trasylol to control bleeding both intra-operatively and post-operatively. The use of Trasylol during aortic valve replacement procedures was contrary to the FDA advisory and the manufacturer's warnings. Defendant Umashankar, Dr. Haft, and Defendant Umashankar's fellow Dr. Chang jointly decided to administer Trasylol to Sandra Marquardt before the drug was actually administered by Defendant Umashankar. (See Plaintiff's Exhibit 6 page 25; Exhibit 7 page 22; and Exhibit 8 pages 16 and 35.) Defendant Umashankar was an employee of the University of Michigan Health System, Inc. at the time of the surgery.

July 20, 2009—Counsel for Sandra Marquardt served a notice of intent upon Defendant Umashankar by sending it to the University of Michigan Health System's Risk Manager pursuant to MCL 600.2912b (2). (See Exhibit 9.) In that document counsel for Plaintiff clearly identified Defendant Umashankar as one of the subjects of that notice. During the deposition of Defendant Umashankar, which was taken as part of the Court of Claims discovery process, it was learned that Defendant Umashankar had returned to India in late 2007, before Sandra Marquardt had left the University of Michigan Medical Center. Defendant Umashankar also testified that he had been at the University of Michigan for only one year; specifically, he was part of the University of Michigan medical staff from October 1, 2006 through September 30, 2007. (See Exhibit 7, pages 3-4.) That meant that Defendant Umashankar was not at the

that he could not have been given a timely notice of intent on July 20, 2009. Plaintiff could not possibly have anticipated that the trial court would go off script and decide that summary disposition was appropriate for a reason not advanced by Defendant Umashankar.

Based upon the changes enacted by the Legislature in 2004, the statute of limitations was tolled on July 20, 2009, for up to 182 days, provided Defendant was given notice of Plaintiff's intent to sue pursuant to MCL 600.2912b (2). Whether or not Defendant Umashankar was given notice of a claim on July 20, 2009, was the actual issue raised by Defendant in his motion for summary disposition, which was not addressed by the trial court when it *sua sponte* decided to dismiss the case for other reasons that were not applicable to this litigation given that cause of action had accrued in 2007.

DEFENDANT UMASHANKAR WAS PROPERLY GIVEN A NOTICE OF INTENT PURSUANT TO MCL 600.2912B (2) WHEN THAT NOTICE OF INTENT WAS SENT TO THE UNIVERSITY OF MICHIGAN HEALTH SYSTEM'S RISK MANAGEMENT DEPARTMENT

There are many relevant facts that need to be highlighted before attempting to decide whether or not Defendant was properly given notice of a potential claim pursuant to MCL 600.2912b (2):

1. Defendant Umashankar was not in the United States when the notice of intent was sent to the University of Michigan Risk Management Department on July 20, 2009. He testified during a discovery deposition in the Court of Claims action that he had returned to India after his one year assignment at the University of Michigan ended on September 30, 2007, which was

8. After the complaint was filed in Washtenaw County, counsel for Defendant Umashankar appeared multiple times in opposition to substituted service and in regards to Plaintiff's efforts to have the summons extended.

9. When the second notice of intent was sent to Defendant Umashankar in India, it was not returned to sender.

10. When the second notice of intent was sent to the Defendant Umashankar c/o the University of Michigan by regular mail and by certified mail the letters were initially accepted and then returned with a note: "Return to sender no longer works here." (See Exhibit 15.)

MCL 600.2912b (2) clearly states that the notice of intent "shall be mailed to the last known professional address or residential address of the health professional or health facility, who is the subject of the claim." The same subsection goes on to state, "proof of mailing constitutes *prima facie* evidence of compliance with this section." The same subsection continues, "If no last known professional business or residential address can reasonably be ascertained, notice may be mailed to the health facility where the care that is the basis for the claim was rendered."

In that subsection there are two options given to the claimant for effectuating service on the health professional. The first allows for the notice of intent to be sent to last known professional address or residential address. Clearly, in 2009 the last known professional address for Defendant Umashankar was the University of Michigan Health System, since we now know that he had returned to India in the fall of 2007, before Decedent had been discharged from the University of Michigan Hospital. There is no dispute that the first notice of intent dated July 20, 2009, was in fact sent to the University of Michigan Health System's Risk Manager; and there is no dispute that it was received by that entity. The second option mentioned in the relevant

subsection of the notice of intent statute provides that if no last known address is known, the notice can be sent to the institution where the negligent care was provided.

There can be little doubt that in July 2009 Defendant Umashankar had returned to his native India, and his last known address was the University of Michigan Health System, since he had returned to India. A review of the efforts that were expended by counsel for Plaintiff to serve him with the complaint in this matter during 2012 and 2013 should demonstrate that it would have been difficult if not impossible for counsel to have found him in 2009. (See Exhibit 18.) The University of Michigan Health System was in the best position to locate Defendant Umashankar in 2009. They had far more ways to find his last known address or current address in 2009. At no time did the risk manager advise counsel for Plaintiff that they were unable to inform him of the pending claim.

More importantly, giving the notice of intent to the University of Michigan Health System on July 20, 2009, certainly complied with the second option permitted by statute. Defendant will likely argue that the notice of intent mailed to the University of Michigan Health System on July 20, 2009, was not addressed to Defendant Umashankar; and, therefore, was not actually given to him. That position is weak at best. First, the statute does not say that the notice of intent has to be addressed to the potential defendant when there is no last known business or residential address. It simply says in such cases the notice of intent "may be mailed to the health facility where the care that is the basis of the claim was rendered." The care was rendered at the University of Michigan Health System in this case, and the notice of intent was sent to the University of Michigan Health System's Risk Manager.

If the notice of intent had been addressed to Defendant Umashankar c/o the University of Michigan Health System on July 20, 2009, would it likely been forwarded to Defendant

Exhibit 24

STATE OF MICHIGAN

IN THE COURT OF APPEALS

SARON E. MARQUARDT, Personal Representative of the
ESTATE OF SANDRA MARQUARDT (Dec.)

Plaintiff-Appellant

V

Washtenaw County Circuit Court No. 12-621-NH
Court of Appeals No. 343248

VELLAIAH DURAI UMASHANKAR, M.D.

Defendant-Appellee

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APPELLANT'S BRIEF

ORAL ARGUMENTS REQUESTED

December 2006—The manufacturer followed its publication of a new package insert with an advisory letter to physicians in which it reiterated that Trasylol was ***to be used only during CABG procedures***. (Exhibit 4.)

December 15, 2006—The FDA issued its own advisory letter to physicians that repeated and reinforced the steps that had been taken by the manufacturer ***to restrict the use of Trasylol to CABG procedures.*** (Exhibit 5.)

July 20, 2007—Sandra Marquardt underwent open heart surgery at the University of Michigan Medical Center. The surgery involved the removal of her damaged aortic valve; and the placement of a synthetic aortic valve. That surgery did ***not*** involve a CABG procedure; however, during that surgery she ***was*** given the drug Trasylol to control bleeding both intraoperatively and postoperatively. ***The use of Trasylol during an aortic valve replacement procedure was contrary to the FDA advisory and the manufacturer's warnings to physicians***. Dr. Umashankar, Dr. Haft, and Dr. Umashankar's fellow Dr. Chang jointly decided to use that drug, prior to it being administered by Dr. Umashankar. (Exhibit 6 page 25; Exhibit 7 page 22; and Exhibit 8 pages 16 and 35.) ***Dr. Umashankar was an employee of the University of Michigan Health System, Inc. (hereinafter referred to as UMHS)*** at the time of the surgery.

July 20, 2009—Counsel for Sandra Marquardt served a notice of intent (hereinafter referred to as a NOI) upon Dr. Umashankar by sending it to the UMHS's Risk Manager pursuant to MCL 600.2912b(2). (Exhibit 9.) In that document counsel for Plaintiff, on multiple occasions, clearly identified Dr. Umashankar as a potential defendant (he was identified as Dr. Vellaiah due to confusion regarding his given name and surname). (Exhibit 9, pages 1, 4, 7, 8, 9.) During Dr. Umashankar's deposition, which was taken as part of the Court of Claims discovery process, ***it***

ARGUMENT

THE TRIAL COURT ERRED WHEN IT CONCLUDED THAT DEFENDANT UMASHANKAR HAD NOT BEEN GIVEN TIMELY NOTICE OF PLAINTIFF'S CLAIM AGAINST HIM PURSUANT TO MCL 600.2912b(2).

Appellant asserts that Sandra Marquardt strictly complied with the notice requirements set forth in MCL 600.2912b(2), when a NOI was mailed to the UMHS's Risk Manager on July 20, 2009. That NOI clearly and unmistakably referenced Vellaiah Durai Umashankar, M.D. repeatedly as an individual that breached the applicable standards of care for anesthesiologists. (Exhibit 9.) He was mistakenly identified as Umashankar Vellaiah, M.D. and Dr. Vellaiah in that NOI due to an error in recognizing his given name from his surname; however, that error was not a factor in any of the issues raised in this appeal. The UMHS's Risk Manager acknowledged receipt of the NOI in a letter dated July 22, 2009; and she did not raise any questions as to the claims being made against Dr. Umashankar. (Exhibit 10.)

If the NOI mailed to the UMHS on July 20, 2009, fully complied with the requirements set forth in MCL 600.2912b(2), then the applicable statute of limitations was tolled for up to 182 days pursuant to MCL 600.5856(c). Since the statute of limitations was to have expired on July 20, 2009, MCL 600.5856(c) tolled the statute of limitations until January 18, 2010, which meant that a complaint needed to have been filed no later than that date to have been timely filed; however, since January 18, 2010, was a court holiday (Martin Luther King's birthday celebration) the complaint could be filed on January 19, 2010. Sandra Marquardt filed her complaint in the Court of Claims January 19, 2010. Again, if Appellant's NOI had fully complied with the provisions of MCL 600.2912b(2), then the applicable statute of limitations would have barred any complaint filed after January 19, 2010; however, Sandra Marquardt died

not applicable, because the prior grant of summary disposition was really based upon Plaintiff's failure to comply with the requirements of MCL 600.2912b(2) and not based upon the fact that the NOI was filed on the last day of the statute of limitations period. That assertion was strange at best, given the trial court's earlier pronouncement from the bench following oral arguments presented in connection with Defendant's first motion for summary disposition. (Exhibit 29.) That having been said, the trial court held that Plaintiff had not fully complied with the notice requirements detailed in MCL 600.2912b(2), because Plaintiff had not "addressed" the NOI to Dr. Umashankar. (Exhibit 27.)

Appellant acknowledges that the NOI addressed to the UMHS's Risk Manager needed to comply with the requirements of MCL 600.2912b(2) in order to take advantage of the tolling provisions found in MCL 600.5856(c). Appellant further acknowledges that if the NOI was not properly served on Dr. Umashankar, then Sandra Marquardt's cause of action was not saved by MCL 600.5852, when she died on January 27, 2010. ***In other words, the only issue to be resolved by this Court is whether or not the subject NOI was served on Dr. Umashankar on July 20, 2009, when it was sent to the UMHS's Risk Manager pursuant to MCL 600.2912b(2).***

When the Legislature initially passed and later amended the various notice requirements found in MCL 600.2912a-600.2912f, its intent was to provide a pre-suit procedure for resolving medical malpractice claims without the necessity of litigation. It reasoned that if the potential adversaries were required to provide notice of the potential claim and defense and required to provide access to the relevant information possessed by each of the parties, lengthy and costly litigation might be avoided. Without getting into a discussion regarding whether or not such a goal was really desired by the parties in interest, it is clear that the Legislature had that goal in mind when it crafted and amended the notice requirements contained in MCL 600.2912a-2912f.

The Michigan Supreme Court's first real chance to examine the notice provisions of MCL 600.2912b(2) came in *Roberts v Mecosta General Hospital I* 466 Mich 57 (2002), when it was asked to determine whether or not a deficient NOI could still toll the applicable statute of limitations pursuant to MCL 600.5856. In considering whether or not a party was required to strictly comply with all of the requirements contained in MCL 600.2912b, before that party could take advantage of the tolling provisions of MCL 600.5856, the Supreme Court held that it was necessary to address how the provisions of MCL 600.2912b(2) would be interpreted. In so doing, it set forth in detail exactly how legislation would be reviewed by the Court:

> "An anchoring rule of jurisprudence, and the foremost rule of statutory construction, is that courts are to effect the intent of the Legislature. *People v Wager* 460 Mich 118, 123 (1999). To do so, we begin with an examination of the language of the statute. *Wickens v Oakwood Healthcare System, Inc.* 465 Mich 53, 60 (2001). If the statute's language is clear and unambiguous, then we assume that the Legislature intended its plain meaning and the statute is enforced as written. *People v Stone* 463 Mich 558, 562 (2001). A necessary corollary of these principles is that a court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature and derived from the words of the statute itself. *Omne Financial, Inc. v Shacks, Inc.* 460 Mich 305, 311 (1999). *Supra p. 61.*

There is no dispute that Sandra Marquardt's cause of action accrued on July 20, 2007. There is also no dispute that Plaintiff's NOI was mailed on July 20, 2009, and that the NOI was addressed to the UNHS's Risk Manager. (Exhibit 9.) There is also no dispute that Dr. Umashankar was an employee of the UMHS at all times relevant to this litigation. There is also no dispute that Dr. Umashankar's name appeared in the NOI on at least five occasions, in which it was claimed that he breached the applicable standards of care for anesthesiologists. (Exhibit 9.) There is also no dispute that January 18, 2010 was the last day of 182-day tolling period. There is also no dispute that Plaintiff Sandra Marquardt filed her Complaint in the Court of Claims on January 19, 2010, due to the court holiday on January 18th; therefore, according to the unanimous Supreme Court opinion in *Haksluoto,* Plaintiff's first Complaint was timely filed.

Exhibit 25

STATE OF MICHIGAN

IN THE SUPREME COURT

(ON APPEAL FROM THE COURT OF APPEALS)

SARON E. MARQUARDT, Personal Representative of the
ESTATE OF SANDRA MARQUARDT (Dec.)

Plaintiff-Appellant

V

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PLAINTIFF/APPELLANT'S APPLICATION FOR LEAVE TO APPEAL

December 15, 2006—The FDA issued an advisory letter to physicians that repeated and reinforced the steps that had been taken by the manufacturer ***to restrict the use of Trasylol to CABG procedures.*** (Exhibit 5)

July 20, 2007—Sandra Marquardt underwent open heart surgery at the University of Michigan Medical Center. The surgery involved the removal of her damaged aortic valve; and the placement of a synthetic aortic valve. ***That surgery did not involve a CABG procedure***; however, during that surgery she ***was*** given the drug Trasylol to control bleeding both intraoperatively and postoperatively. ***The use of Trasylol during an aortic valve replacement procedure was contrary to the FDA advisory and contrary to the manufacturer's warnings to physicians***. Dr. Umashankar, Dr. Haft, and Dr. Umashankar's fellow Dr. Chang jointly decided to use that drug prior to it being administered by Dr. Umashankar. (Exhibit 6 page 25; Exhibit 7 page 22; and Exhibit 8 pages 16 and 35) ***Dr. Umashankar was an employee of the University of Michigan Health System, Inc. (hereinafter referred to as UMHS)*** at the time of the surgery.

July 20, 2009—The undersigned served a notice of intent (hereinafter referred to as NOI) upon Dr. Umashankar by mailing it to the UMHS pursuant to MCL 600.2912b(2). (Exhibit 9) In that document the undersigned, on multiple occasions, clearly identified Dr. Umashankar as a potential defendant (he was identified as Dr. Vellaiah due to confusion regarding his given name and surname). (Exhibit 9, pages 1, 4, 7, 8, 9) During Dr. Umashankar's deposition, which was taken as part of the Court of Claims discovery process, ***it was learned that Dr. Umashankar had returned to India in late 2007, before Sandra Marquardt was actually released from the University of Michigan Medical Center due to multiple organ failures.*** Dr. Umashankar also testified that ***he had been at UMHS for only one year***; specifically, he was part of the University of Michigan's medical staff from October 1, 2006 through September 30, 2007. (Exhibit 7, pages 3-4) ***That meant that Dr. Umashankar was not at UMHS or anywhere else within the United States when the NOI was mailed to UMHS on July 20, 2009, given that no last known address could have reasonably been ascertained and the claimed negligence occurred at that facility.***

July 22, 2009—The undersigned was advised by the UMHS's Risk Management office that they had received the NOI by mail. ***Nowhere in that letter did Karen A. Saran indicate that UMHS was not accepting the NOI on behalf of Dr. Umashankar; nor did it indicate that they were unable to contact Dr. Umashankar.*** (Exhibit 10)

January 19, 2010—The undersigned filed a complaint in the Court of Claims naming the University of Michigan Board of Regents as the only defendant. (Exhibit 11) ***Sandra Marquardt was still alive when that complaint was filed.*** It should be noted at this point that the University of Michigan Board of Regents filed a motion for summary disposition in August 2011, which was filed more than one and one-half years after the complaint was filed. In that motion the University of Michigan Board of Regents asserted that Plaintiff had failed to file a notice of claim with the Court of Appeals within six months of the claimed medical malpractice. The Court of Claims granted summary disposition.

January 27, 2010—Sandra Marquardt passed away. An appropriate Suggestion of Death was filed. Probate proceedings were initiated in the Jackson County Probate Court, and Letters of Authority were issued to Saron E. Marquardt on June 14, 2010. (Exhibit 13) Since Sandra Marquardt passed away within 30 days of the expiration of the statute of limitations (the statute of limitations would have expired on January 18, 2010, which was 182 days after the NOI was mailed pursuant to MCL 600.2912b) her cause of action was saved for an additional two years following the appointment of a personal representative pursuant to MCL 600.5852, which meant that the Estate of Sandra Marquardt had until June 14, 2012, to initiate legal proceedings against Dr. Umashankar, since Saron Marquardt was appointed the personal representative of the Estate of Sandra Marquardt on June 14, 2010. (Exhibit 13)

September 2, 2011—***The undersigned attempted to serve a second NOI upon Dr. Umashankar shortly after the University of Michigan filed its motion for summary disposition in the Court of Claims litigation***. (Exhibit 14) It should be noted that undersigned ***sent that second NOI "addressed to" Dr. Umashankar by regular mail and by certified mail (c/o the University of Michigan Cardiovascular Center located at 1500 E. Medical Center Drive SPC 5861, Ann Arbor, MI 48109) pursuant to MCL 600.2912b(2); and each of those notices were returned with a note "return to sender no longer works***

here". (Exhibit 15) ***A third and fourth copy of the second NOI was sent by e-mail and by regular mail to Dr. Umashankar's address in India, which was found in Defendant's curriculum vitae, which had been provided to the undersigned during his deposition.*** (Exhibit 16) The second NOI, which was sent to Dr. Umashankar in September 2011, contained a new allegation that had not been included in the July 20, 2009 NOI; specifically, that the negligence and the postoperative complications had caused the death of Sandra Marquardt. The undersigned decided to prepare and mail multiple copies of the second NOI to avoid a later motion for summary disposition claiming that there had been no claim filed by the Personal Representative of the Estate of Sandra Marquardt indicating that her death was caused by the negligence of Dr. Umashankar. Since there was time to serve a second NOI on Dr. Umashankar before the savings provisions contained in MCL 600.5852 expired on June 14, 2012, it seemed only prudent to mail multiple copies of the second NOI, in light of this Court's decision in *Waltz v Wyse*, 469 Mich 642 (2004).

December 6, 2011—Summary disposition was formally granted in the Court of Claims action based upon Plaintiff's failure to file a timely notice of claim against the State of Michigan in the Court of Claims. (Exhibit 12)

December 27, 2011—Plaintiff filed his Claim of Appeal in the Court of Appeals. (Court of Appeals #307917-Exhibit 19)

February 3, 2012—Counsel for Dr. Umashankar filed a notice of meritorious defense on his behalf pursuant to MCL 600.2912b after receipt of the second NOI. (Exhibit 18)

June 8, 2012—The undersigned filed this action against Defendant Umashankar in the Washtenaw County Circuit Court. The complaint was timely filed, because MCL 600.5852 had saved the cause of action until June 14, 2012, which was two years after the Letters of Authority were issued to Saron E. Marquardt, Personal Representative of the Estate of Sandra Marquardt. In addition, it was filed within three years of when the original statute of limitations would have expired on January 18, 2010. (Exhibit 21)

July 3, 2012— During a phone conference with counsel for Defendant Umashankar, the undersigned was informed that the General Counsel for the UMHS would accept service on behalf of

This Court's first real chance to examine the notice provisions of MCL 600.2912b(2) came in *Roberts v Mecosta General Hospital I* 466 Mich 57 (2002), when it was asked to determine whether or not a deficient NOI could still toll the applicable statute of limitations pursuant to MCL 600.5856(c). In considering whether or not a party was required to strictly comply with all of the requirements contained in MCL 600.2912b, before that party could take advantage of the tolling provisions of MCL 600.5856(c), this Court held that it was necessary to address how the provisions of MCL 600.2912b(2) would be interpreted. In so doing, it set forth in detail exactly how legislation was be reviewed by this Court:

> "This case again calls into question the authority of courts to create terms and conditions at variance with those unambiguously and mandatorily stated in a statute. We reaffirm that the duty of the courts of this state is to apply the actual terms of an unambiguous statute." *Supra,* p. 58.

This Court went on to expound further upon those general principles:

> "An anchoring rule of jurisprudence, and the foremost rule of statutory construction is that courts are to affect the intent of the Legislature. *People v Wager,* 460 Mich 118, 123 (1999). To do so, we begin with an examination of the language of the statute. *Wickens v Oakwood Healthcare System,* 465 Mich 53, 60 (2001). ***If the statute's language is clear and unambiguous, then we assume that the Legislature intended its plain meaning and the statute is enforced as written.*** *People v Stone,* 463 Mich 558, 562 (2001). A necessary corollary of these principles is that ***a court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statue itself.*** *Omni Financial v Shacks,* 460 Mich 305, 311 (1999). *Supra,* p.63. (Emphasis added.)

There is no dispute that Sandra Marquardt's cause of action accrued on July 20, 2007. There is also no dispute that Plaintiff's NOI was "mailed to" UMHS on July 20, 2009. (Exhibit 9) There is also no dispute that Dr. Umashankar was an employee of the UMHS at all times relevant to this litigation. There is also no dispute that Dr. Umashankar's name appeared in the first NOI on at least five occasions, in which it was claimed that he breached the applicable standards of care for anesthesiologists. (Exhibit 9) There is no dispute that an agent of UMHS

to or addressed to" Dr. Umashankar; instead, it was addressed to the Risk Manager. (Exhibits 24, page 4; 27, pages 4-5; and 30, page 6.)

One need only examine what happened when the September 2, 2011 NOI was addressed to Dr. Umashankar c/o the University of Michigan Health System, Inc., to see what would have likely happened in 2009, if the first NOI had been addressed to Dr. Umashankar c/o the University of Michigan Health System, Inc. (Exhibit 15) Instead of a letter acknowledging receipt of the first NOI on July 22, 2009 (Exhibit 10), the September 2, 2011 NOI "addressed to" Dr. Umashankar was returned with a handwritten note on both the NOI sent by regular mail and the NOI sent by certified mail: "Return to sender no longer works here." (Exhibit 15)

It should also be noted that the third sentence ***does not*** say the NOI "mailed to" the health care facility must be "directed to or addressed to" the physician, it simply states: "notice may be ***mailed to*** the health facility." Appellant would return to Justice Young's comments in *Roberts* cited above, in which he stated: "…***a court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature or derived from the words of the statute itself." There is a clear difference between the phrases "mailed to" and "directed to or addressed to".*** *Supra,* 63. (Emphasis added.)

The undersigned is able to demonstrate what would likely have occurred in 2009 if the NOI had been "directed to or addressed to" Dr. Umashankar. (Exhibit 15) Appellant challenges Appellee to demonstrate that the manner in which the September 2, 2011 NOI addressed to Dr. Umashankar was handled would have been different in 2009, if the first NOI had been addressed to Dr. Umashankar. Appellant would ask this Court to decide whether "mailed to" UMHS or "directed to or addressed to" Dr. Umashankar would have more likely informed Dr. Umashankar of the possible claims being made against him? In the absence of any proof that Dr. Umashankar

did not receive contemporaneous notice of the July 20, 2009 NOI, Appellant would assert that the distinction between "mailed to" and "directed to or addressed to" are irrelevant, since he likely did receive contemporaneous information regarding the substance of the claims being made against him.

THE COURT OF APPEALS ERRED WHEN IT HELD THAT DEFENDANT WAS NOT GIVEN TIMELY NOTICE OF PLAINTIFF'S CLAIMS AGAINST HIM PURSUANT TO MCL 600.2912b(2).

Despite numerous opportunities Defendant Umashankar has never provided an affidavit indicating that he did not receive timely notice from UMHS in July 2009, that he had been identified in Plaintiff's initial NOI. So far, counsel for Defendants have filed the following pleadings addressing the same issues raised in this application for leave to appeal:

1. Defendant's motion for summary disposition dated September 26, 2013;
2. Defendant's reply to Plaintiff's answer to Defendant's motion for summary disposition dated October 28, 2013;
3. Defendant-Appellee's brief on appeal dated July 24, 2014;
4. Defendant-Appellee's Response to Application for Leave dated June 1, 2015;
5. Defendant's Post-Remand Motion for Summary Disposition dated December 15, 2017;
6. Defendant's reply brief to Plaintiff's answer to summary disposition motion dated January 5, 2018; and
7. Defendant-Appellee's Brief on Appeal dated February 5, 2019.

In none of those pleadings did counsel for Defendant-Appellee ever provide an affidavit executed by Defendant Umashankar or executed by an employee of UMHS that asserted that Defendant did not receive notice of the pending claims detailed in the July 20,

Exhibit 26

2001 WL 772531
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Court of Appeals of Michigan.

Susan MARICLE, Plaintiff-Appellant,
v.
Dr. Brian SHAPIRO and General Surgeons of Flint, P.C., Defendants-Appellees.

No. 217533.
|
Jan. 23, 2001.

Before: SAAD, P.J., and GRIFFIN and R.B. BURNS,* JJ.

Opinion

PER CURIAM.

*1 Plaintiff appeals as of right from the trial court's order granting defendants' motion for summary disposition pursuant to MCR 2.116(C)(7) based on the statute of limitations. We affirm.

This medical malpractice action arose from the surgery performed by defendant Dr. Brian Shapiro, who is a general surgeon, on May 8, 1996. Dr. Shapiro removed two lymph nodes from plaintiff's neck. Plaintiff alleges that during the procedure, the right spinal accessory nerve was injured, which resulted in severe pain and partial paralysis of her right arm.

Plaintiff apparently requested a general surgeon, Dr. Raymond Ippolito, to review her medical records and to determine if she had a possible claim for medical malpractice against Dr. Shapiro and his employer, defendant General Surgeons of Flint, P.C. On July 31, 1997, Dr. Ippolito sent a two-page letter to plaintiff's counsel, indicating that he had reviewed plaintiff's medical records and the medical care rendered by Dr. Shapiro in 1996. Dr. Ippolito opined that plaintiff suffered an injury to her right spinal accessory nerve as a result of the biopsy performed by Dr. Shapiro and that the injury to the nerve deviated from the standard of care. The letter was signed by Dr. Ippolito and a notary signed below his signature.

Apparently, counsel for plaintiff sent a notice of intent to file a claim to defendants pursuant to M.C.L. § 600.2912b; MSA 27A.2912(2) on September 2, 1997. After the 182-day period expired with apparently no response from defendants, plaintiff filed her complaint on March 24, 1998. However, plaintiff did not file an affidavit of merit with the complaint in accordance with M.C.L. § 600.2912d; MSA 27A.2912(4).

The summons and complaint were served by registered mail on March 30, 1998. Although the answer was due twenty-eight days later, MCR 2 .108(A)(2), counsel for defendants requested a thirty-day extension for filing an answer. Counsel for plaintiff agreed to an extension and the joint answer was sent on May 15, 1998, and filed on May 19, 1998. In their affirmative defenses, defendants asserted that plaintiff failed to file an affidavit of merit with the complaint and that the claim "may be" barred by the statute of limitations.

According to the parties, defendants sent interrogatories requesting plaintiff to identify her experts and to indicate whether any reports had been rendered by the experts. In July 1998, plaintiff sent the answers to the interrogatories and included a copy of Dr. Ippolito's report.

On November 30, 1998, defendants filed a motion for summary disposition pursuant to MCR 2.116(C)(7), arguing that the statute of limitations expired before the action was properly commenced. Defendants pointed out that the affidavit of merit was not attached to the complaint, that plaintiff did not request a twenty-eight-day extension to file one, and that plaintiff to date had not yet filed an affidavit of merit. Defendants argued that they were entitled to summary disposition pursuant to *Scarsella v. Pollak*, 232 Mich.App 61; 591 NW2d 257 (1998), aff'd. 461 Mich. 547; 607 NW2d 711 (2000).

*2 In response to the motion, plaintiff claimed the affidavit of merit inadvertently was not attached to the complaint when it was filed and that counsel intended to use Dr. Ippolito's report as the affidavit of merit. Plaintiff asserted that counsel for defendants participated in unconscionable conduct by requesting an extension to file an answer to the complaint, and that without the extension, plaintiff's counsel would have learned of the

mistake and then filed the affidavit before the statute of limitations expired. Plaintiff also claimed that the affidavit was eventually provided in answers to interrogatories and argued that dismissal of the action was improper pursuant to *VandenBerg v. VandenBerg*, 231 Mich.App 497; 586 NW2d 570 (1998). At oral argument before the trial court, plaintiff further argued that M.C.L. § 600.2912d; MSA 27A.2912(4) was unconstitutional because the Legislature improperly interfered with the power of the Supreme Court regarding practice and procedure.

Ultimately, the trial court ruled that *Scarsella* required dismissal of the action for failure to comply with § 2912d. The trial court also indicated the report of Dr. Ippolito was not a proper affidavit of merit.

On appeal, plaintiff first argues that § 2912d is unconstitutional because it violates the separation of powers clause, Const 1963, art 3, § 2, by infringing upon the exclusive power of the Supreme Court to establish practice and procedure in the courts of this state. Although this argument was only orally made below and the trial court did not render a ruling on this point, the constitutionality of § 2912d presents a question of law, which this Court reviews de novo. *McDougall v. Schanz*, 461 Mich. 15, 24; 597 NW2d 148 (1999). This Court should also presume that § 2912d is constitutional "unless its unconstitutionality is clearly apparent." *Id.*

The authority to determine the rules of practice and procedures rests exclusively with the Supreme Court. Const 1963, art 6, § 5. "This exclusive rule-making authority in matters of practice and procedure is further reinforced by separation of powers principles. See Const 1963, art 3, § 2." *Id.* at 27. However, rules of practice set forth in any statute, if not in conflict with any court rule, are effective until superseded by rules adopted by the Supreme Court. MCR 1.104; *Neal v. Oakwood Hosp Corp*, 226 Mich.App 701, 722; 575 NW2d 68 (1997).

In *Neal*, this Court examined whether § 2912b, which provides that a plaintiff shall not commence a medical malpractice action unless the plaintiff has given written notice not less than 182 days before the action is commenced, was a rule of procedure that directly contradicted MCR 2.101(B), which provides that "[a] civil action is commenced by the filing of a complaint with a court." In ruling that there was no conflict, this Court stated:

> In this case, we conclude that § 2912b(1) does not change the manner in which or how a civil action is commenced in medical malpractice cases. Rather, § 2912b(1) imposes a temporal requirement with which a plaintiff must comply before the plaintiff can commence a civil action in accordance with MCR 2.101(B). Accordingly, we find no conflict between § 2912b(1) and MCR 2.101(B). Thus, if procedural, § 2912b(1) is effective until superseded by rules adopted by our Supreme Court. MCR 1.104. [*Id.* at 723.]

*3 Plaintiff asserts that this Court in *Neal* implied that if legislation did change the manner in which civil actions were commenced, then it would infringe upon the Supreme Court's rule-making power in matters of practice and procedure. Plaintiff argues that because § 2912d changes the manner in which to commence a medical malpractice action, it violates the separation of powers clause. Section 2912d provides, in relevant part:

> Subject to subsection (2), the plaintiff in an action alleging medical malpractice or, if the plaintiff is represented by an attorney, the plaintiff's attorney shall file with the complaint an affidavit of merit signed by a health professional who the plaintiff's attorney reasonably believes meets the requirements for an expert witness under section 2169. [MCL 600.2912d(1); MSA 27A.2912(4)(1).]

On the other hand, defendants argue that § 2912d merely imposes an additional requirement without directly conflicting with MCR 2.101(B).

We believe that the Supreme Court's subsequent promulgation of MCR 2.112(L), which adopts the Legislature's procedural requirement for filing an affidavit of merit with the complaint, sufficiently disposes of plaintiff's argument. MCR 2.112(L) provides:

In an action alleging medical malpractice filed on or after October 1, 1993, each party must file an affidavit as

provided in M.C.L. § 600.2912d; 600.2912e, M.S.A. § 27A.2912(4); 27A.2912(5). Notice of filing the affidavit must be promptly served on the opposing party. If the opposing party has appeared in the action, the notice may be served in the manner provided by MCR 2.107. If the opposing party has not appeared, the notice must be served in the manner provided by MCR 2.105. Proof of service of the notice must be promptly filed with the court. [Emphasis added.]

While MCR 2.112(L) went into effect April 1, 1998, one week after plaintiff filed her complaint, it is clear from the above emphasized language that the Supreme Court intended retroactive application to plaintiff's medical malpractice action. Accordingly, § 2912d is not unconstitutional as proposed by plaintiff.

Next, plaintiff contends that the trial court erred in granting defendants' motion for summary disposition and in dismissing her complaint where she failed to file an affidavit of merit with the complaint. This Court reviews decisions on motions for summary disposition under MCR 2.116(C)(7) de novo to determine if the moving party is entitled to judgment as a matter of law. *Rheaume v. Vandenberg,* 232 Mich.App 417, 420-421; 591 NW2d 331 (1998). In reviewing a motion granted pursuant to MCR 2.116(C)(7), this Court considers all affidavits, pleadings, and other documentary evidence submitted by the parties and construes the pleadings in favor of the plaintiff. *Id.* at 421.

In this case, the alleged malpractice occurred on May 8, 1996. The period of limitations for malpractice claims is two years, M.C.L. § 600.5805(4); MSA 27A.5805(4). Plaintiff filed her complaint on March 24, 1998, but did not file the affidavit of merit before the statute of limitations expired on May 8, 1998.[1]

*4 In *Scarsella, supra,* this Court held that, "for statute of limitations purposes" in a medical malpractice case, the mere tendering of a complaint without an affidavit of merit is insufficient to commence the lawsuit and therefore, the trial court did not err in ruling that the plaintiff's claim was time-barred. *Id.* at 64. The Supreme Court adopted the opinion in its entirety, reaffirming that dismissal is the appropriate remedy for failing to comply with § 2912d. *Scarsella v. Pollak,* 461 Mich. 547, 548-550; 607 NW2d 711 (2000). Contrary to plaintiff's argument, *Vandenberg* and *Scarsella* do not conflict. Unlike *Vandenberg,* where the plaintiff filed the affidavit of merit only a few weeks after the complaint was filed and before the statute of limitations ran, the plaintiff in *Scarsella* failed to file an affidavit of merit with the complaint and did not do so until after the statute of limitations expired. It is clear that the facts of this case fall squarely under *Scarsella* since plaintiff failed to file an affidavit of merit before the statute of limitations expired. Accordingly, we find that the trial court did not err in granting the motion for summary disposition and dismissing plaintiff's claim with prejudice.

While plaintiff argues that the failure to file the affidavit of merit was inadvertent, we find it significant that plaintiff made no attempt to remedy the problem after defendants' answer to the complaint pointed out that no affidavit was attached to the complaint. Certainly, the trial court may have estopped any attempt by defendants to argue that the statute of limitations had already expired in light of their request for an extension to file their answer. However, given plaintiff's failure to immediately request an extension pursuant to M.C.L. § 600.2912d(2); MSA 27A.2912(4)(2), we cannot excuse the running of the limitations period based on plaintiff's claim of inadvertence or preclude defendants from asserting that plaintiff's claim was barred.

Plaintiff further argues that no prejudice occurred from the failure to attach the affidavit since defendants had previously received a detailed notice of intent and thus were fully aware of the merits of her claim. However, this Court has noted that substantial compliance with the statutory procedural requirements is not sufficient to toll the statute of limitations. See *Rheaume, supra* at 422-423. Clearly, the fact that defendants were sent a notice of intent to sue in accordance with § 2912b does not excuse plaintiff's failure to comply with § 2912d.

Affirmed.

All Citations

Not Reported in N.W.2d, 2001 WL 772531

Footnotes

* Former Court of Appeals judge, sitting on the Court of Appeals by assignment.

1 Contrary to both parties' assertions on appeal, the two-year statute of limitations is not "extended" 182 days when a plaintiff files notice of intent to sue in accordance with M.C.L. § 600.2912b; MSA 27A.2912(2). Instead, the limitations period is only tolled where the statute of limitations will expire during the 182-day notice period that the plaintiff is prohibited from filing a lawsuit. MCL 600.5856(d); MSA 27A.5856(d). Here, plaintiff sent her notice of intent to sue on September 2, 1997. Because the notice was given more than 182 days before the end of the limitations period, the two-year limitations period was not tolled during the notice period. See *Omelenchuk v. City of Warren*, 461 Mich. 567, 574; 609 NW2d 177 (2000). Therefore, the statute of limitations did not expire on November 7, 1998, as the parties contend.

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