STATE OF MICHIGAN

COURT OF APPEALS

ZAINAB AL-MOHSIN,

Plaintiff-Appellant,

v

ANDREA LAVERA DAVIDSON a/k/a ANDREA LAVERA McCALL, DAVID McCALL, and LANA KAY McCALL,

Defendants-Appellees.

UNPUBLISHED
August 20, 2020

No. 350893
Wayne Circuit Court
LC No. 18-005829-NI

Before: RONAYNE KRAUSE, P.J., and SAWYER and BOONSTRA, JJ.

PER CURIAM.

Plaintiff, Zainab Al-Mohsin, appeals by right the trial court's grant of summary disposition in favor of defendants, Andrea Davidson, Lana McCall, and David McCall. This matter arises out of a three-car accident that occurred on May 23, 2015, at approximately 6:20 p.m., on a service road adjacent to M-39 in Detroit. Plaintiff was stopped at a yield sign, waiting for traffic to clear, when she was rear-ended by Davidson; and shortly thereafter Lana McCall (Lana), who was following Davidson in a separate vehicle, rear-ended Davidson, causing a second impact to plaintiff's vehicle.[1] Plaintiff contends that as a result of the accident, she suffered long-term debilitating pain and permanent damage to her spine and neck. We affirm.

I. FACTUAL BACKGROUND

There is no dispute that the accident described above actually occurred. According to the traffic crash report created by a responding police officer, none of the vehicles' airbags deployed, plaintiff's vehicle was drivable after the accident, and neither of defendants' vehicles were drivable after the accident. Plaintiff was apparently driving a rental vehicle at the time, although at one

[1] David McCall (David) was not personally involved in the accident, but rather owned Lana's vehicle. Davidson is the daughter of David and Lana.

point she apparently indicated that her vehicle had been totaled. Plaintiff's statements have also been inconsistent whether she was properly wearing a seat belt. Lana and Davidson testified that plaintiff approached them, "very angry and yelling and screaming." Plaintiff testified that she injured her wrist in the first impact, and then the second impact caused her head to strike the steering wheel and her headrest. Plaintiff also sustained a bruise to her forehead.[2]

Plaintiff initially declined medical attention at the scene, but later that day was taken to the Garden City Hospital ER by her mother. The doctor who saw plaintiff noted that plaintiff had tenderness and swelling on her forehead, wrist, left lower ribs, and midline thoracic spine. Plaintiff also vomited. The hospital conducted a CT scan of plaintiff's brain and cervical spine, and x-rayed her chest, lumbar spine, and wrist; all were "negative for any acute process." According to the medical notes, the doctor addressed plaintiff's concerns, plaintiff "agrees with the plan," and plaintiff was "discharged home with Tylenol with codeine and instructions to followup with PCP within one to 2 days."

Plaintiff returned to the Garden City ER the next day, complaining of a headache, full-body numbness, lightheadedness, dizziness, and blindness. She also claimed that her pain intensity was 10 out of 10. However, she had not filled her previous day's prescription, she was observed to be walking normally, resting comfortably, playing on her phone, and joking with her family. She was extremely uncooperative and even combative with medical personnel, and she refused to give more than one-word answers. She swore and yelled at medical personnel, and she insisted that she would "not leave this hospital until [her] headache and pain are completely gone." When told that it was normal to be in some amount of pain after a motor vehicle accident, especially because she did not take her prescribed medications, and confronted about her abusive conduct toward staff, she demanded her "fucking papers." She was given her discharge paperwork and a prescription for a single 5mg dose of Norco,[3] whereupon she jumped out of bed with no apparent distress and walked out of the hospital with no apparent complication.

The record is unclear about what medical treatment plaintiff had after she left the Garden City ER. It is obvious from reviewing the record that plaintiff has not provided all of her medical records, and at her deposition, she explained that she "had like a lot of doctors since the accident." She was given disability certificates covering portions of August through November of 2015. Also during the period of August through November of 2015, plaintiff received physical therapy from Relief Rehab. Plaintiff provided fifteen "Relief" receipts, each of which states a "diagnosis" of cervicalgia[4] and lumbago[5], and a few of them also indicate shoulder or hand pain. The only

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[2] Plaintiff contends that she also received "a very light cut," but neither the police officer nor defendants noticed any such injury, and medical notes made later that day reflect only a bruise and do not mention a cut.

[3] Norco is a brand name for a combination of hydrocodone, an opioid, and acetaminophen.

[4] This simply means "neck pain." See < https://healthprovidersdata.com/hipaa/codes/ICD10-M54.2 > and < https://en.wiktionary.org/wiki/cervicalgia >.

[5] This means "lower back pain." See < https://healthprovidersdata.com/hipaa/codes/ICD10-M54.5 > and < https://en.wiktionary.org/wiki/lumbago >.

medical professionals who signed those receipts were a physical therapist assistant (PTA) and a registered play therapist (RPT).

In November of 2015, she underwent an MRI scan of her lumbar and cervical spine. Both were found to be normal or unremarkable under than "a broad-based 7 mm central disc herniation . . . which encroaches mildly the anterior epidural space" at C5-C6, a reversal of her mid lordotic curve, and possible disc herniations in her thoracic spine. The report suggested that "Thoracic spine MR imaging should be considered." Plaintiff later underwent an MRI of her left shoulder in March of 2016, which found "mild diffuse attenuation of the rotator cuff and some narrowing of the acromial humeral interval," but the results were otherwise normal. An MRI of plaintiff's thoracic spine was finally performed in April of 2016, which revealed disc herniation or protrusion compressing the thecal sac at several points, but no neuroforaminal compromise or spinal canal stenosis, and apparently no other concerns.

In January of 2016, plaintiff was seen by Wayne Neurology "for headaches, cognitive problems, neck pain, lower back pain, blurry vision, dizziness and balance problems sustained from a motor vehicle accident on May 23, 2015." The Wayne Neurology notes reflected that plaintiff was complaining of headaches, neck pain, and back pain radiating to her left elbow and left hip, and that plaintiff reported the intensity of her pain to be 8 or 9 out of 10. Plaintiff further reported that she had previously experienced migraines two to three times a month but was now experiencing them most days of the week. Plaintiff was taking "Norco 7.5/325 two to three times a day," as well as various other pain medications. The Wayne Neurology notes contain no opinion as to the veracity of any of plaintiff's statement, but rather simply records what plaintiff reported at face value. Plaintiff also reported that she was on disability and had been in physical therapy "since August." Notwithstanding the Wayne Neurology Notes, plaintiff testified that she never made any claim for Social Security Disability Benefits.

Wayne Neurology conducted a physical examination of plaintiff, which was found to be normal; including her gait, coordinated movements, reflexes, muscle strength, attention and concentration, memory and speech, and pupillary response. The only exception was "tenderness throughout entire spine." The examining physician recommended that plaintiff continue with physical therapy, provided some further analgesic prescriptions, and recommended further testing. Specifically, the doctor recommended an electroencephalogram (EEG) test, a videonystagmography (VNG) test, and an electromyography (EMG) test.[6] In addition, a "visual evoked responses" test was performed on January 11, 2016, the results of which were normal.

The VNG test was conducted on January 26, 2016, which was incomplete because plaintiff refused to undergo a portion of the test; it found that plaintiff "could not control her eye movements and blinking during the recording," but she was otherwise normal. Plaintiff's EEG test was performed on January 11, 2016, which did reveal abnormal results. According to the report:

[6] Respectively, these tests monitor certain electrical signals in the brain, check for involuntary eye movements, and measure electrical activity generated by skeletal muscle movements.

> ABNORMALITY: No definitive epileptiform discharges seen. Occasional slow sharp waves from the right temporal area seen and more slow sharp waves from left temporoparietal area seen.
>
> * * *
>
> IMPRESSION: This is an abnormal EEG. The waveforms described from the left temporoparietal area are not clearly epileptiform in nature and could be seen with structural or functional abnormality of the brain and seizure tendencies. There is also concern for mild structural or functional abnormality from the left temporal parietal area.
>
> Clinical correlation is required.

There is nothing in the record to indicate whether plaintiff followed up on the above or obtained the required clinical correlation. Furthermore, there is nothing in the record resembling any medical opinion explaining the above "abnormality," which we are otherwise at a loss to comprehend.

At some point, plaintiff's physical therapy provider referred plaintiff to Summit Medical Group. It is not clear from the record when this occurred. Plaintiff has provided a tome of documentation from Summit Medical Group dated from June 2016 through July 2017. However, plaintiff was apparently treated by Summit Medical Group long before the earliest date documented. For example, plaintiff testified that Summit Medical prescribed a back brace, which she used "on and off until about a year after the accident." Furthermore, as will be discussed immediately below, plaintiff underwent an independent medical examination in early February of 2016 that entailed reviewing at least one note from Summit Medical Group dated in 2015; however, the records plaintiff provided from Summit Medical Group do not begin until June of 2016. Furthermore, it appears that some of the notes from Summit Medical Group are missing pages.

As noted immediately above, in February 10, 2016, plaintiff underwent an independent medical examination (IME) with Dr. Steve R. Geiringer. There is nothing in the record explaining why, nor can we even propose a guess. At her deposition, plaintiff stated that the only independent medical examination to which she was sent was conducted by a Dr. Khansa or Khasa, her primary doctor,[7] at the behest of an employer for hiring purposes. She did not mention Dr. Geiringer. Plaintiff implies that that Dr. Geiringer was retained by defendants, which makes no sense because plaintiff's complaint was not filed until more than two years after Dr. Geiringer's IME. We have not been able to determine anything about the referrer to whom Dr. Geiringer's report is addressed. Neither party explains why plaintiff was sent to Dr. Geiringer. Nevertheless, although plaintiff strenuously argues that Dr. Geiringer should be regarded as utterly devoid of any credibility whatsoever, neither party disputes that the IME occurred.

[7] Plaintiff has not provided any records from Dr. Khansa, or from Dr. Faraz Zouabi, her primary doctor at the time of the accident.

Dr. Geiringer concluded that it was "clear with 100% medical certainty that no symptoms or impairment either arose or certainly persisted after [the date of the accident]." Irrespective of whether it is proper to accept Dr. Geiringer's ultimate conclusion, we find the specific observations and tests that he conducted to be the *only* meaningful medical analysis of plaintiff found in the record after her departure from the Garden City ER. Therefore, although brevity is ordinarily a virtue, we feel it necessary to include Dr. Geiringer's report in full:

> To Whom It May Concern:
>
> As you know, Ms. Al-Mohsin did not present to a previously scheduled evaluation appointment. That has been rescheduled for later today and I have reviewed additional records in anticipation of this visit. Prior record review found no justification for any treatment, no documentation of any impairment arising on 5/23/15, and the only probable diagnosis of malingering.
>
> UPDATED RECORD REVIEW
>
> There are additional therapy notes from Relief PT through 12/31/15. As with their earlier notes, the documentation does not satisfy the basic PT standards in virtually every aspect this entire time, and the treatment continued to be ineffective. After their entire four months plus of treatment, her pain had "improved" from 7 to 5.
>
> There is one PA note from Summit Medical on 11/16/15[8] with no physician oversight. Ms. Al-Mohsin mentioned a rear impact at 10mph and brief LOC [loss of consciousness]. That is a false statement, as there is clear documentation that did not occur, both in the ER and the next day. She also reported her head was bleeding, another false statement. She told them that there was no EMS at the scene, although documentation is that she refused such treatment. Her pain was said to have arisen two days later and was now the worst imaginable in the low back at 10 and left leg, and severe at 8 in the neck and left arm. Norco 7.5mg was not helping and there was a history of depression and anxiety.
>
> The PA found distal lumber and left S1 joint tenderness, pain with lumbar ROM [range of motion], SLR [straight leg raise test] was negative, and the lower limb neurologic was normal. There was neck tenderness with reduced ROM, and the left shoulder was tender with reduced motion. He did not test for the pattern of pain with ROM, palpation for spine tenderness, muscle tone, or muscle texture, Spurling [a test to evaluate nerve root pain], upper limb reflexes, sensation, strength, atrophy, [illegible] or gait. Despite these shortcomings, the diagnosis was

[8] As alluded to above, no such document appears to exist in the lower court record, and this tends to indicate that plaintiff was treating with Summit Medical Group well before the commencement of the records she provided.

soft tissue pain and the recommendations were for psychology evaluation for possible TBI [traumatic brain injury], Soma,[9] Mobic,[10] and the Norco dose was increased to 10mg. Suffice it to say that exactly none of this treatment was justified from his own input.

HISTORY

When she arrived for today's appointment, Ms. Al-Mohsin was told that no treatment would be provided and that the report would be sent only to you. She understood these points and proceeded. She also furnished several reports from Dr. Nisar, including a possibly abnormal EEG on 1/11/16. That was done for closed head injury, which never occurred. There was normal central testing on 1/26/16. She reports 50% improvement that she attributes to therapy that has occurred since about one month after the accident. There is midline and bilateral low back pain equal from right to left, and it is worse with either prolonged sitting or standing more than 15 minutes. There is extension of a tingling feeling, as if the leg is asleep, from the left gluteal area to just above the left knee, never on the right. The spine is more troubling to her than the thigh. There is a similar pattern of midline and bilateral neck and upper trapezius pain, more on the left, with extension of sharp pain to above the left elbow; she is right handed. She cannot recall the name of the physician at Summit who is treating her, and by description she has had the same passive modalities the entire time but at no point has she ever performed a regular home exercise program. Ms. Al-Mohsin has been told to be generally active as much as possible and she also says her time schedule with taking classes does not allow her to do exercises on a regular basis. By itself, that point of history means the [sic] none of this "therapy" has been warranted since it began, and of course her "improvement" is many times slower than would be expected simply from time passing, even if there is an impairment present. By prescription she takes Norco for pain and Xanax at night to help her sleep. There have been no spine injections.

Past history for similar problems is negative. Before 5/23/15 there were no such symptoms requiring medical tests, treatment, or limitation of work or other activities. Otherwise, she had migraine headaches before the accident but does not have any currently. Ms. Al-Mohsin is taking online classes toward her high school diploma.

PHYSICAL EXAMINATION

Physical examination shows a healthy appearing, thin but otherwise normally muscled young woman. There are no operative scars in examined areas.

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[9] Soma is a brand name for carisoprodol, a potentially addictive Schedule IV muscle relaxant with a potentiating effect on opioids. See < https://en.wikipedia.org/wiki/Carisoprodol >.

[10] Mobic is a brand name for meloxicam, a nonsteroidal anti-inflammatory pain medication. See < https://en.wikipedia.org/wiki/Meloxicam >.

Of the six lumber motions, only flexion and extension cause substantial low back pain, the other four minimal if any. That is a pattern not pointing to disc or muscle origin of symptoms. No leg pain is produced and there is no asymmetry with flexion or when she is supine, judging from palpation of bony landmarks. Supine SLR is negative on both sides but on each side causes sharp lateral and anterior hip pain, 5° on the left and 5-10° on the right. Seated SLR is negative on both sides to 90° for pain in any location. There is prominent tenderness over the lumber spine, the mid to low lumber muscles, the right iliac crest more than left, and less so over the right sciatic notch. All of the lumber muscles have normal tone and texture. Lower limb neurologic exam is normal. Reflexes are 1+ and symmetric at the knees, ankles, and hamstrings, without clonus. Strength is normal to resistance and the calves each measure 29.5cm. Light touch sensation is "tingly" in all areas except one throughout the entire left lower limb, a nonorganic pattern. Gait is normal.

Neck ROM is normal in all directions although with left neck pain. She indicates the left upper trapezius and there is prominent tenderness with light pressure palpation over that same region. However, all the neck and shoulder muscles have normal tone and texture and the two sides feel identical. Spurling maneuver is negative on both sides, with no symptoms on the left and when done to the right causing pain at the vertex and to the left side of her head, nonorganic. Left rotator cuff and the impingement maneuvers are negative, causing pain from below the elbow in a line straight up the arm to the side of the neck. Upper limb neurologic exam is objectively normal. Reflexes are 1+ and symmetric at the biceps, triceps, and brachioradialis. Strength is normal throughout where she gives full effort, although does not do so with either grip; there is no atrophy. Light touch sensation is "completely numb" in the entire left upper limb in all areas tested, as she said she could not feel my finger whatsoever, again a nonphysiologic pattern.

UPDATED DIAGNOSIS/DISCUSSION

Combining the record reviews and today's examination, I can now finalize my opinions pertaining to Ms. Al-Mohsin. It is clear with 100% medical certainty that no symptoms or impairment either arose or certainly persisted after 5/23/15. There is no credible documentation anywhere in the file of an impairment and today's examination is not only normal objectively, the only findings are inconsistent and/or nonorganic. When there is no impairment, no diagnosis can be assigned and the concepts of causation, prognosis, and MMI [maximum medical improvement] never did pertain. At no point, therefore, has there been the medical need for formal treatment of any type including office visits, diagnostic testing, treatment of any sort, or any disability status. For the latter, there has never been support for replacement services, attendant care, transportation assistance, or work restrictions.

I mentioned earlier that none of the so-called physical therapy has been warranted since it began, this for two reasons. First, there is no impairment documented by any practitioner, so no formal therapy was never [sic] needed.

> Next, at no point has Ms. Al-Mohsin done anything resembling a proper home exercise program, meaning that even if an impairment had been present to begin with, not documented here, that treatment would have no possibility of working toward or achieving MMI. Feel free to contact me again with any remaining questions.

Again, plaintiff contends that Dr. Geiringer's report should be afforded no credence whatsoever. We are concerned that we lack any explained context for the IME, but given the obviously incomplete medical records provided by plaintiff, we are not inclined to discard Dr. Geiringer's report as worthless.

As discussed above, plaintiff continued to make visits to Summit Medical Group, but plaintiff's documentation begins in June of 2016. Throughout plaintiff's visits to Summit Medical Group, she repeatedly reported her pain as "constant" 9 or 10 out of 10, generally in her neck, shoulder, or lower back. At each of those visits, plaintiff was observed to have a normal gait and stance, or to be alert and oriented with no apparent distress, or otherwise similarly in drastically less apparent discomfort than a 9-out-of-10 or 10-out-of-10 would indicate. As also noted above, plaintiff reported the intensity of her pain as 10 out of 10 when she returned to the Garden City Hospital ER the day after the accident, despite being observed to be in no real distress.

Additionally, at her deposition, plaintiff stated that she "tried" marijuana, but she denied otherwise using it for any reason. However, urinalyses were performed during at least some of plaintiff's documented visits to Summit Medical Group. THC was found in her urine at two visits, and she admitted to using marijuana at a third visit. Opioids were found in plaintiff's urine on numerous occasions. Opioids would be expected if plaintiff was taking prescribed Norco, but her medications are very poorly documented. The notes from plaintiff's January 16, 2017, appointment indicate that plaintiff was to "cease out" her Norco after two months. Plaintiff continued to have opioids in her urine thereafter. On one occasion, also thereafter, oxycodone was found in plaintiff's urine. We have not found any evidence that plaintiff was ever prescribed oxycodone.[11]

Plaintiff denied having been in any car accidents since May of 2015. However, defendants provided records from the Oakwood Hospital Emergency Department indicating that on July 25, 2016, plaintiff was transported by EMS to the emergency department after another automobile accident in which she was, again, rear-ended by another car. The emergency department notes state that plaintiff arrived wearing a C-collar and complaining of pain in her neck and right knee, but plaintiff was not in acute distress. Almost exactly two hours later, the notes state,

[11] We emphasize that plaintiff's drug use is *only* relevant in this matter to the internal consistency of plaintiff's testimony and to the possibility that she was suffering from a condition other than the aftereffects of an injury. Although there is little to no evidence in the record indicating what medications plaintiff was prescribed, that could easily be an outcome of the obvious incompleteness of plaintiff's medical records. We therefore presume, for purposes of resolving this matter, that any and all medications plaintiff took were legal or pursuant to a valid prescription.

> Pt reports that she is leaving at this time she is feeling fine. Family at bedside. Pt ambulatory with a steady gait to lobby. NAD noted.

The Oakwood Hospital notes state that plaintiff left after being triaged but before being seen by a doctor.

The Summit Medical Group notes from plaintiff's next visit on August 11, 2016, do not mention plaintiff having been in a second car accident. The Summit Medical Group notes are inconsistent about what information is logged at each visit, but the next time any possible cause for plaintiff's concerns is mentioned is several visits later and only states "auto accident" on May 23, 2015. Out of the thirteen visits to Summit Medical Group documented by plaintiff, she was seen by a physician assistant (PA) on ten of those occasions, and an osteopathic physician[12] (DO) on only three of those occasions. None of the notes from the times plaintiff was seen by a DO contain any affirmative statement of medical opinion, beyond simply including a diagnostic code, linking the car accident to plaintiff's symptoms. Summit Medical Group issued several more disability certificates for plaintiff, covering most of the period between November 9, 2016, and June 15, 2017, with a few gaps. Summit Medical Group also prescribed twice-weekly physical therapy for plaintiff, covering approximately the same time period.

As of the date of her deposition, plaintiff testified that she was no longer prescribed any medications other than for her migraines. She was employed as a caregiver at a nursing home, which hired her in 2016, and she obtained some kind of medical assistant certification in 2018. She also worked at an urgent care and at a doctor's office, and she was to begin working at another urgent care shortly. Her nursing home employment was full-time, but with flexible hours. She described her injury, as of that date, as neck and back pain if she remained in one position for too long.

Plaintiff was not under any doctor-imposed restrictions at the time of her deposition, but she stated that she was not able to take cases at her job that involved lifting or transferring. She stated that she recently started going to a gym, but she was no longer able to take her younger family members to playgrounds or help carry them, and she was no longer able to go to movies because she could not stay seated for more than about 30 minutes. She also was no longer able to go swimming, which was a hobby she had previously enjoyed. She sometimes had difficulty sleeping due to her migraines. Her wrist healed on its own after a few weeks in a wrap. The accident interfered with plaintiff's ability to obtain her GED, but she was ultimately able to do so.

II. PROCEDURAL BACKGROUND

In her complaint, plaintiff alleged that the accident caused her "to suffer serious and disabling injuries to her skeletal system, nervous systems, and the muscles, tendons, ligaments, nerves, and tissue of her back, neck, head, shoulders, arms, hands, legs, feet, knees, and other parts of her body, as well as other serious and disabling injuries, including closed head injuries requiring surgical intervention, the nature and extent of which are unknown at this time." Discovery was

[12] Modern osteopathic physicians are considered the equivalent of Doctors of Medicine (MDs), see MCL 333.16265(1) and MCL 333.17501.

closed on April 3, 2019. Defendants moved for summary disposition, arguing that the medical evidence showed that, at the most, she had some disc degeneration in her spine. Defendants argued that plaintiff had not shown any impairment to her ability to lead her normal life, her medical documentation showed no evidence of a traumatic injury, and plaintiff failed to provide any concrete evidence contradicting Dr. Geiringer's findings or conclusion that she was unimpaired and probably malingering.

Plaintiff argued that her MRIs did indeed show objective evidence of an impairment, especially given that she was young and had no previous health conditions. She argued that, in effect, doctors performing IMEs were intrinsically biased and should not be relied upon. Plaintiff also argued that "her treating doctors will, again, testify to this causation and it is clearly a question of fact" whether the accident caused her injuries. She further asserted that it was "common knowledge in this case," that plaintiff's injuries were caused by the accident, and "[t]he treating physicians will testify to it." Plaintiff asserted that Dr. Geiringer's opinion was contradicted by "every other doctor that [plaintiff] saw, the radiologist, the neuroradiologist, the treating physicians, everybody." However, even on appeal, plaintiff has provided no actual evidence, such as an affidavit, that any doctors could or would provide such testimony. As defendant pointed out, "we haven't been presented with any doctor's opinions and nowhere within the medical records" linking plaintiff's injuries to the accident other than plaintiff's own subjective history recited to the doctors.

The trial court recounted the basic facts of the case and specifically recognized that Dr. Geiringer was a defense expert witness. The trial court observed that the IME was nevertheless evidence, so plaintiff had the burden of establishing a question of fact, "and, frankly, there is simply no evidence provided as part of plaintiff's response" that would do so. The trial court did not make any findings whether plaintiff's life had been affected, but concluded that there was "nothing to connect" any injuries to the accident. It therefore granted summary disposition in favor of defendants. The trial court then denied plaintiff's motion for reconsideration, which largely reiterated arguments she previously made. This appeal followed.

III. STANDARD OF REVIEW

All arguments made by plaintiff on appeal were at least generally raised in the trial court, so they are preserved for appellate review. *Peterman v Dep't of Natural Resources*, 446 Mich 177, 183; 521 NW2d 499 (1994); *Steward v Panek*, 251 Mich App 546, 554; 652 NW2d 232 (2002). However, because plaintiff failed to provide any statement of questions presented, MCR 7.212(C)(5), all of plaintiff's issues are technically abandoned. *Ypsilanti Fire Marshal v Kircher*, 273 Mich App 496, 543; 730 NW2d 481 (2007). Nevertheless, because plaintiff does substantively argue her issues, we choose to exercise our discretion to consider them. See *Mack v Detroit*, 467 Mich 186, 207; 649 NW2d 47 (2002); cf. *Mitcham v City of Detroit*, 355 Mich 182, 203; 94 NW2d 388 (1959).

A grant or denial of summary disposition is reviewed de novo on the basis of the entire record to determine if the moving party is entitled to judgment as a matter of law. *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999). When reviewing a motion under MCR 2.116(C)(10), which tests the factual sufficiency of the complaint, this Court considers all evidence submitted by the parties in the light most favorable to the non-moving party and grants summary

disposition only where the evidence fails to establish a genuine issue regarding any material fact. *Id*. at 120. Generally, courts may not weigh the evidence, and summary disposition is especially inappropriate where the resolution of a matter turns on the credibility of a witness. *Lytle v Malady*, 458 Mich 153, 176; 579 NW2d 906 (1998); *Nichol v Billot*, 406 Mich 284, 301-302; 279 NW2d 761 (1979). However, a limited exception may exist if a witness's testimony is irreconcilably contrary to unassailably clear and objective record evidence, or if a witness's testimony is intrinsically impossible or totally unbelievable. *Scott v Harris*, 550 US 372, 378-381; 127 S Ct 1769; 167 L Ed 2d 686 (2007); *People v Lemmon*, 456 Mich 625, 643-646; 576 NW2d 129 (1998); see also, *Anderson v City of Bessemer City, NC*, 470 US 564, 575; 105 S Ct 1504; 84 L Ed 2d 518 (1985) ("a witness's "story itself may be so internally inconsistent or implausible on its face that a reasonable factfinder would not credit it").

IV. PROOF OF CAUSATION AND INJURY

Under the no-fault insurance act, MCL 500.3101 *et seq*., tort liability for non-economic loss arising out of a motor vehicle accident is curtailed, and in relevant part limited to situations in which the allegedly injured person can establish a "serious impairment of body function." MCL 500.3135(1); *McCormick v Carrier*, 487 Mich 180, 189-190, 200-203; 795 NW2d 517 (2010). For purposes of the no-fault act,

> "serious impairment of body function" means an impairment that satisfies all of the following requirements:
>
> (a) It is objectively manifested, meaning it is observable or perceivable from actual symptoms or conditions by someone other than the injured person.
>
> (b) It is an impairment of an important body function, which is a body function of great value, significance, or consequence to the injured person.
>
> (c) It affects the injured person's general ability to lead his or her normal life, meaning it has had an influence on some of the person's capacity to live in his or her normal manner of living. Although temporal considerations may be relevant, there is no temporal requirement for how long an impairment must last. This examination is inherently fact and circumstance specific to each injured person, must be conducted on a case-by-case basis, and requires comparison of the injured person's life before and after the incident. [MCL 500.3135(5).]

At issue in this appeal is whether plaintiff has established a genuine question of material fact whether she sustained a "serious impairment of body function" as a result of the May 23, 2015, motor vehicle accident.

The evidence only barely suggests that plaintiff was even seriously injured. Plaintiff clearly sustained a bruise to her forehead, and possibly a cut. By her own testimony, she needed her wrist "wrapped" for a few weeks, but it healed on its own. On the day of the accident, plaintiff received several diagnostic scans that revealed nothing wrong. It is certainly possible for symptoms to make a delayed appearance. However, when plaintiff returned to the ER the next day, she complained of 10-out-of-10 pain, whole body numbness, and being blind; despite being in no apparent distress, playing on her phone, and joking with her family. The only possible

assessment is the same one arrived at by Dr. Geiringer: malingering, or possibly drug-seeking. Plaintiff continued to complain of pain at a level of 9 or 10 out of 10, which should have left her incoherent and wholly nonfunctional but clearly did not. Even accepting plaintiff's argument that Dr. Geiringer had an extrinsic motive to find plaintiff not disabled, and thereby disregarding Dr. Geiringer's conclusions; plaintiff has not provided anything contradicting Dr. Geiringer's specific and objective observations, such as a lack of muscle atrophy or a nonsensical set of reported symptoms.

Plaintiff argues that the Wayne Neurology records show that she was "diagnosed with" post-traumatic headache, cognitive impairment, cervicalgia, lumbago, and blurred vision. The Wayne Neurology records show nothing of the sort. Plaintiff refers to a section of the Wayne Neurology notes from January 5, 2016, labeled "A/P." However, "A/P" actually stands for "Assessment & Plan."[13] Reading the record as a whole, it is clearly just applying a diagnostic code to plaintiff's self-reported symptoms, not a medical determination that they were real or were caused by anything in particular. Plaintiff provides a further list of diagnoses she allegedly received from Summit Medical. These are, indeed, found in various "diagnosis" sections of the Summit Medical documentation. However, it is unclear from any of the notes whether those diagnoses were based on anything more than plaintiff's self-reports. Some of the notes indicate that various treatments were applied, but nowhere is there any affirmative statement from a medical practitioner to the effect that they found anything wrong with plaintiff beyond her self-reported pain and, possibly, some joint displacement. Plaintiff has not provided any materials from her primary doctor.

Notwithstanding plaintiff's contention that doctors could testify that there was a link between the accident and injuries plaintiff suffered, plaintiff has not provided any actual statements from any actual doctors to that effect. The only evidence plaintiff provides that is not just a record of plaintiff's own self-reporting is (1) the MRI of her thoracic spine indicating that she has several herniated discs, (2) the "abnormal" EEG, and (3) some possible joint displacement. This is clearly objective evidence of a medical abnormality, and defendants provide no support for their seemingly lay dismissal of the MRI as chronic or degenerative. However, plaintiff provides no expert opinion explaining the significance of the herniations or abnormal EEG. For example, there is simply no evidence of whether her disc herniations *are* unusual, or likely to cause noticeable symptoms, or likely to cause damage, or likely to interfere with any physical abilities she might otherwise have. Likewise, the Summit Medical Group notes do not discuss the significance or cause of the joint displacements it found. A party may not withstand summary disposition by merely promising to provide better evidence at trial. *Maiden*, 461 Mich at 121.

Plaintiff's argument appears to be, in effect, that because she was treated for pain, she must, *ipso facto*, have had an underlying injury. Supposing that to be a reasonable inference, it does not follow that she was injured as a result of the accident. The various notes in the Summit Medical Group files to the effect that plaintiff was injured in a motor vehicle accident on May 23, 2015, are clearly based on plaintiff's self-reporting. There are no statements from any medical provider

[13] See, for example, < https://meded.ucsd.edu/clinicalmed/abbreviation.html >, and see also < https://en.wikipedia.org/wiki/List_of_medical_abbreviations:_A >.

stating a *finding* (or analogous medical opinion) that there was a link between the accident and plaintiff's self-reported symptoms. Notably, plaintiff totally ignores the evidence that she was involved in another motor vehicle accident just over a year after the accident at issue, in which she was again rear-ended and this time was taken to the ER by EMS wearing a C-collar. She complained of pain, but nevertheless left on her own, in no apparent distress. This accident was, disturbingly, never reported to Summit Medical Group.

Accepting that the MRI and EEG pre-date the second accident and show abnormalities that *could* have been caused by trauma; plaintiff nevertheless has not provided anything resembling a medical opinion linking those abnormalities to the first accident. Indeed, despite the numerous doctors with whom plaintiff treated, plaintiff has not provided any medical opinion whatsoever to the effect that her injuries are real, let alone what might have caused them. Plaintiff has likewise not provided any medical opinion explaining what significance, if any, the MRI and EEG abnormalities might have. Critically, "a temporal connection" or "a coincidence in time" are not, standing alone, generally sufficient to establish causation. *West v General Motors Corp*, 469 Mich 177, 186, 186 n 12; 665 NW2d 468 (2003).

Pursuant to MCL 500.3135(5)(a), a "serious impairment of body function" must, *inter alia*, be "observable or perceivable from actual symptoms or conditions by someone other than the injured person." Plaintiff has provided objective evidence tending to suggest that she may have some kind of injury. However, plaintiff has provided no evidence of an observable *impairment*. Specifically, plaintiff has provided no evidence, nor can any be inferred from the evidence, showing (1) that any of her documented medical abnormalities could possibly be causing her alleged symptoms, or (2) that any of her documented medical abnormalities could possibly have been caused by the May 23, 2015, motor vehicle accident. Pain certainly can be an impairment. However, to survive summary disposition, the non-moving party must provide more than just a plausible conjecture. *Skinner v Square D Co*, 445 Mich 153, 164-167; 516 NW2d 475 (1994). Here, plaintiff has provided only guesswork by a layperson, not an expert opinion setting forth a biological model supporting the existence or cause of plaintiff's reported symptoms. Rather, the evidence strongly suggests that if plaintiff is indeed suffering from a medical problem, it is more likely to be a drug addiction or something psychological.

We also note that some of plaintiff's argument is disingenuous. For example, plaintiff argues that Dr. Nisar at Wayne Neurology "directly correlated her findings of injury in [plaintiff] to motor [sic] vehicle accident." Dr. Nisar did the exact opposite: Dr. Nisar observed "multiple blink artifacts" but otherwise found plaintiff's results completely normal, and stated that "[a] correlation with patient history and examination *is recommended* and evaluation for other causes of dizziness . . . should be considered" (emphasis added). Similarly, the EEG report specifically states that "Clinical correlation is required," but there is no evidence that plaintiff obtained that clinical correlation. Plaintiff asserts that her medical documentation establishes that the onset of her various symptoms was the date of the car accident, but it is clear that is merely the date reported by plaintiff. The fact that plaintiff did not report the second accident to any of her medical providers is further concerning.

In short, the only medical opinion in the record squarely and directly addressing whether plaintiff's reported symptoms are real or have any underlying biological cause is Dr. Geiringer's IME. Plaintiff could have solicited an affidavit or other statement from any of her treating

physicians, but she did not. Even if the conclusions in Dr. Geiringer's report are ignored, plaintiff has presented nothing more than self-reports and conjecture. Plaintiff therefore cannot establish a serious impairment of body function or that any impairment was caused by the car accident on May 23, 2015. We therefore need not address whether plaintiff's reported symptoms would meet the threshold for a serious impairment under MCL 500.3135(5)(c).

Affirmed. Defendants, being the prevailing parties, may tax costs. MCR 7.219(A).

/s/ Amy Ronayne Krause
/s/ David H. Sawyer
/s/ Mark T. Boonstra