

STATE OF MICHIGAN
COURT OF APPEALS

MICHAEL SCHUTZ,

Plaintiff/Appellant/Cross-Appellee,

v

INGHAM REGIONAL MEDICAL CENTER, a
Michigan non-profit corporation; RICHARD
McCLAIN, D.O.; PETER VASIU, D.O.; and
DELORES VANDERHOOF, CRNA, jointly and
severally,

Defendants/Appellees/Cross-
Appellants,

and

JOHN A. SAUCHAK, D.O., ROBERT E.
TUBBEN, D.O., and ESTATE OF KEITH
EVANS, CRNA,

Defendants/Appellees.

Before: Smolenski, P.J., and Owens and Donofrio, JJ.

PER CURIAM.

Plaintiff appeals as of right the trial court's directed verdict with respect to certified registered nurse anesthetist (CRNA) Keith Evans, as well as the jury's verdict of no cause of action in favor of all remaining defendants. The hospital cross-appeals as of right the trial court's denial of its summary disposition motion and its directed verdict motion with respect to agency, and the trial court's denial of its summary disposition motion, its motion in limine, and its directed verdict motion with respect to plaintiff's claim of a lost opportunity for an NFL career. This case arose when plaintiff developed deep vein thrombosis and compartment

UNPUBLISHED

May 25, 2006

No. 259594

Ingham Circuit Court

LC No. 01-93668-NH

syndrome¹ in his right leg while in the hospital for surgery on his left knee. We reverse in part and remand.

Plaintiff testified that he grew up in Canada and began playing football in ninth grade. By the time he was in tenth grade, several United States colleges were recruiting him to play football. He started at Michigan State University in January 1996. In spring 1998, he was moved to first string offense in the green and white game, during which he injured his left knee. A first arthroscopic procedure was performed on the left knee June 26, 1998; because plaintiff continued to have problems with the left knee, a second surgery was performed August 26, 1998. Plaintiff re-injured the left knee on October 3, 1998. A third arthroscopic surgery was performed by a doctor in Pennsylvania on October 22, 1998. Plaintiff was introduced to orthopedic surgeon John Sauchak in December 1998. Sauchak testified that plaintiff had completely torn his posterior cruciate ligament (PCL) in the left knee and described the injury as a grade two or three.² Sauchak intended to perform a PCL reconstruction and a meniscal allograft in the same surgery.

The surgery was performed January 18, 1999, and lasted about ten hours. Registered nurse Sylvia Crouch³ was the circulating nurse. Peter Vasiu and Mitchell Copeland were the assisting residents. Anesthesiologist Robert Tubben and CRNA Keith Evans administered plaintiff's anesthesia. After surgery, he was attended by registered nurse Virginia Maguire. He complained throughout the night about pain in his non-operative right calf. About 2:30 a.m., on January 19, 1999, orthopedic resident Richard McClain evaluated plaintiff's calf; his differential diagnosis was either a muscle spasm or deep vein thrombosis. At 7:45 a.m., plaintiff was evaluated by Vasiu, who ordered that a Doppler test be performed to determine whether plaintiff had deep vein thrombosis. Sometime between 12:30 p.m. and 1:30 p.m., Sauchak evaluated plaintiff and determined that compartment syndrome had developed in the right calf. A fasciotomy was performed shortly thereafter.

Plaintiff suffered permanent nerve damage. He was required to wear a brace for awhile, and he finally realized he would never play football again. He claimed he was so depressed that he was put on anti-depressants and referred to a psychologist. He did poorly in school, and his relationship with his girlfriend fell apart. On May 25, 2001, plaintiff filed a complaint against

¹ If a compartment in the leg becomes over-compressed, the blood supply to the muscles and nerves will be reduced, and both can die. This is called compartment syndrome. The five "P's" of compartment syndrome are pain out of proportion (unbelievable excruciating pain), pallor (indicating poor circulation), pulselessness, paresthesia (a funny bone feeling), and paresis (paralysis or inability to move the limb). Generally, to avoid permanent injury, a fasciotomy should be performed within six hours to relieve the pressure of the compartment.

² Orthopedic surgeon Herbert Ross testified that PCL injuries were graded zero through four – four required reconstruction, three was borderline, while two did not require reconstruction.

³ Sylvia Crouch subsequently became Sylvia Crouch Kirgis. At the time of the surgery, she was known as Sylvia Crouch; she was referred to as Sylvia Crouch throughout the testimony, and she will be referred to as Sylvia Crouch on appeal to avoid confusion.

the hospital, Sauchak, McClain, Vasiu, Tubben, Evans, and another CRNA Delores Vanderhoof. At the close of plaintiff's proofs, various motions for directed verdict were made. The court denied most of the motions, but directed a verdict for the various CRNAs. The jury found no cause of action with respect to all remaining defendants.

Plaintiff first claims the court erred in granting a directed verdict to CRNA Evans because he presented expert testimony establishing that the CRNAs were responsible for ensuring that the patient, including the non-operative leg, was properly positioned, and this obligation required that the leg be periodically removed from its holder and exercised.⁴ We agree.

We review de novo a trial court's grant of a directed verdict. *Sniecinski v Blue Cross & Blue Shield*, 469 Mich 124, 131; 666 NW2d 186 (2003). In determining whether a question of fact existed that would preclude a directed verdict, we draw every reasonable inference in favor of the nonmoving party, *Elezovic v Ford Motor Co*, 472 Mich 408, 418; 697 NW2d 851 (2005), while recognizing the trial court's superior opportunity to observe witnesses, *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003). To prevail in a medical malpractice action, a plaintiff must prove (a) the applicable standard of care, (b) the defendant breached the standard, (c) an injury, and (d) the breach proximately caused the injury. *Wiley, supra* at 492. To survive a directed verdict motion, a plaintiff must make a prima facie showing of each element. *Tobin v Providence Hosp*, 244 Mich App 626, 643; 624 NW2d 548 (2001). A directed verdict is appropriately granted when all the evidence, viewed in a light most favorable to the nonmoving party, fails to establish a question upon which reasonable minds could differ. *Smith v Foerster-Bolser Constr Inc*, 269 Mich App 424, 427-428; 711 NW2d 421 (2006).

The standard of care required of a nurse must be established by expert testimony. *Wiley, supra* at 492. With respect to positioning and movement of the non-operative leg, plaintiff's expert Jay Beebe testified that the CRNA's duty was to ensure that range of motion exercises on

⁴ Ordinarily, we will not consider a point that is not set forth in the statement of questions presented. *Caldwell v Chapman*, 240 Mich App 124, 132; 610 NW2d 264 (2000). Plaintiff's stated issue only alleges error with respect to the directed verdict for Evans. His argument, however, refers to the other CRNAs involved in the surgery. Mary Beth Kinney, a CRNA employed by the hospital and involved in plaintiff's surgery but not a named defendant, determined from the anesthesia record that she relieved Evans at 3:00 p.m. She was relieved for a short period between 4:35 p.m., and 4:50 p.m., by CRNA Delores Vanderhoof, and was relieved again at 5:50 p.m., by a CRNA with a last name of Coe. Coe also was not a named defendant. While Vanderhoof was a named defendant, and her deposition testimony was read into the record at trial, her deposition testimony was not provided to this Court on appeal. An appellant must provide this Court with all transcripts in the trial court file, MCR 7.210(B)(1)(a); *Nye v Gable, Nelson & Murphy*, 169 Mich App 411, 414; 425 NW2d 797 (1988), as well as all exhibits in his possession, MCR 7.210(C). This Court will refuse to consider issues for which the appellant failed to produce the transcript. *PT Today, Inc v Comm'r of Financial & Ins Services*, ___ Mich App ___, ___; ___ NW2d ___ (#259964, rel'd 2/28/06) slip op p 22. Because plaintiff failed to properly present the issue with respect to the remaining CRNAs, we address this issue only with respect to CRNA Evans.

the non-operative leg were performed every two or three hours and to assist the circulating nurse with their performance. Although Evans points to an abundance of testimony indicating the CRNAs did not have a duty to position the non-operative leg, conflicting evidence may not be considered when deciding a directed verdict motion.

In passing on a motion for directed verdict, a trial judge must consider the evidence in plaintiff's favor *unqualified* by any conflicting evidence. The trial judge is not prohibited from considering evidence presented by a defense witness per se; rather, the judge may not consider evidence from *any* witness to the extent that it conflicts with evidence in plaintiff's favor. [*Locke v Pachtman*, 446 Mich 216, 226 n 8; 521 NW2d 786 (1994).]

Hence, Beebe's testimony, unqualified by conflicting evidence, established a duty. Evans testified that he did not see anyone performing range of motion exercises on the non-operative leg, and he did not perform them. Therefore, Evans' testimony established that he breached the duty to ensure the periodic performance of range of motion exercises on the non-operative leg. To demonstrate causation in a medical malpractice action, the plaintiff must show that the defendant or defendants more probably than not proximately caused the plaintiff's injuries. *Dykes v William Beaumont Hosp*, 246 Mich App 471, 477; 633 NW2d 440 (2001). Taffet testified that well leg compartment syndrome was directly linked to the duration that the leg was elevated. While Taffet testified that CRNA Evans was relieved before the six-hour window when compartment syndrome developed, testimony indicated that the onset of compartment syndrome was gradual, and Evans was the responsible CRNA during six of the ten hours in surgery. Thus, a question of fact existed whether Evans' breach more probably than not caused plaintiff's injuries, *id.*, and a directed verdict was not appropriate, *Smith, supra* at 427-428.

Plaintiff also argues that the court erred in granting the CRNAs a directed verdict because Beebe testified that the type of injury plaintiff suffered was not the type that occurred in the absence of negligence, and the trial court found that whether the positioning of plaintiff in the operating room resulted in plaintiff's injuries was a question for the jury. To maintain a medical malpractice case under the theory of *res ipsa loquitur*, a plaintiff must demonstrate the event (1) was the type that ordinarily did not occur unless someone was negligent, (2) was caused by an agency or instrumentality within the exclusive control of a defendant, and (3) was not the result of any action or contribution by the plaintiff. *Wischmeyer v Schanz*, 449 Mich 469, 484; 536 NW2d 760 (1995). Here, although Beebe testified that plaintiff's injuries were not the type that would occur in the absence of negligence, and plaintiff could not have contributed to his injuries because he was under anesthesia, plaintiff failed to present any testimony that his non-operative leg or the well leg holder was within the exclusive control of the CRNAs. Hence, a directed verdict was properly granted on plaintiff's *res ipsa loquitur* claim.

Plaintiff next argues the court abused its discretion when it admitted evidence relating to the personal protection order (PPO) obtained against plaintiff by his former girlfriend. We disagree.

We review for an abuse of discretion a trial court's decision to admit evidence. *Elezovic, supra* at 419. When reviewing the trial court's decision, appellate courts do not assess the weight and value of the evidence, but only determine whether it was the type that should have been considered by the jury. *Cole v Eckstein*, 202 Mich App 111, 113-114; 507 NW2d 792

(1993). Reversal is only required if a substantial right was affected by the evidentiary ruling. MRE 103(a); *Craig v Oakwood Hosp*, 471 Mich 67, 76; 684 NW2d 296 (2004).

Unless precluded by law, all relevant evidence is admissible under MRE 402. *Waknin v Chamberlain*, 467 Mich 329, 333; 653 NW2d 176 (2002). Relevant evidence tends to make the existence of a fact significant to a determination of the case more or less probable than it would be without the evidence. *Id.* A fact is of consequence to an action if it is truly in issue; it need not be an element of a cause of action but must be within the range of litigated matters. *People v Mills*, 450 Mich 61, 67-68; 537 NW2d 909, mod 450 Mich 1212 (1995). In the instant case, defendants argued that the evidence surrounding the PPO would be relevant to disprove plaintiff's claim that his emotional distress resulted from the surgical complication, and to show plaintiff was unable to handle the stress of playing professional football in order to rebut damages. Because plaintiff claimed mental anguish and loss of earnings and earning capacity as damages, the circumstances surround the issuance of the PPO, to the extent they affected or disproved damages, were relevant. *Waknin, supra; Mills, supra.*

Even though relevant, evidence may be precluded if its probative effect is substantially outweighed by the danger of unfair prejudice. MRE 403. The trial court initially indicated it found the evidence relevant and was inclined to find the evidence more probative than prejudicial; nevertheless, it reserved its ruling until it was able to review the proffered evidence. A trial court best determines the prejudicial effect of evidence by contemporaneously assessing its presentation, credibility, and effect. *People v Bahoda*, 448 Mich 261, 291; 531 NW2d 659 (1995). The trial court rendered a thoughtful and appropriately discretionary decision with respect to the admissibility of the evidence at that point in the trial. When it later assessed the prejudicial effect of the proffered evidence, the trial court properly exercised its discretion by limiting the prejudicial effect of the evidence.

Nevertheless, plaintiff argues he suffered unfair prejudice because defendants used the evidence to portray his character in the worst possible light. Having reviewed the challenged questions, we find that they merely indicated an attempt to establish an alternative source for plaintiff's depression, or to establish that the breakup with the former girlfriend was not caused by plaintiff's inability to play football. Thus, they were properly probative. While this evidence may have been somewhat prejudicial, relevant evidence is inherently prejudicial. *Waknin, supra* at 334. MRE 403 only precludes evidence that is unfairly prejudicial; unfair prejudice exists when there is a danger that marginally probative evidence will be given preemptive weight by a jury. *Lewis v Legrow*, 258 Mich App 175, 199; 670 NW2d 675 (2003). Given that the challenged questioning consisted of thirteen questions out of more than three thousand pages of transcripts, it is unlikely that the evidence was given preemptive weight. Even if this were considered a close evidentiary question, a court's decision on a close evidentiary question generally cannot be considered an abuse of discretion. *Lewis, supra* at 200.

Plaintiff next argues the court abused its discretion in denying plaintiff's motion for a new trial. We disagree.

We review for an abuse of discretion a trial court's denial of a motion for a new trial premised on the ground that the verdict was against the great weight of the evidence. *Morinelli v Provident Life & Accident Ins Co*, 242 Mich App 255, 261; 617 NW2d 777 (2000). Given the trial court's opportunity to observe witnesses and assess credibility, we give great deference to

its decision that the verdict was not against the great weight of the evidence. *Id.* A new trial should only be granted when the evidence preponderated so heavily against the verdict that allowing the verdict to stand would result in a miscarriage of justice. *Campbell v Sullins*, 257 Mich App 179, 193; 667 NW2d 887 (2003). When there is competent evidence to support the verdict, a court may not substitute its judgment for that of the jury. *Ellsworth v Hotel Corp of America*, 236 Mich App 185, 194; 600 NW2d 129 (1999).

Interoperative negligence:

Plaintiff's only claim of interoperative negligence on appeal is the failure to ensure that the non-operative leg was safely positioned and periodically exercised. Beebe testified that the duty to ensure that a patient was safely positioned was a collaborative effort. Tubben testified that it was not the anesthesiologist's responsibility to check the positioning of the lower extremities. Vaughn testified that an anesthesiologist's responsibility toward a patient's lower extremities was secondary to that of the surgeon's. Sauchak said he personally positioned plaintiff for surgery, including padding and positioning the right non-operative leg in the well leg holder. The purpose of the padding was to prevent deep vein thrombosis or compartment syndrome and to protect nerves and bony prominences. Protective hose and sequential pressure devices were used on the non-operative leg to promote circulation and prevent blood clots. He stated that given the precautions that were taken, the chances of developing compartment syndrome were extremely rare. He could not have foreseen that plaintiff would develop compartment syndrome and could have done nothing to prevent it.

Tubben and Vasiu agreed that plaintiff's injuries were very unusual. Endress opined that positioning of the well leg did not cause plaintiff's subsequent compartment syndrome; pressure from the well leg holder would have caused pressure to the muscles in the back of the calf, while plaintiff's highest pressures occurred in front muscles of the leg. In contrast, Taffet testified that the duration of leg elevation was linked to development of compartment syndrome. Hence, evidence was presented to support and to rebut the theory that positioning of the leg resulted in compartment syndrome.

Crouch testified that she twice performed range of motion exercises on the non-operative leg during the surgery. Although Beebe testified that range of motion exercises should have been performed every two or three hours, and Winkleman testified that they should have been performed four times during the surgery, both acknowledged there was no written standard with respect to the frequency in which the exercises should be performed. In contrast, Taffet testified the exercises should have been performed every three or four hours, which coincided with Sauchak's testimony that exercises were usually performed two or three times during a ten-hour surgery, and supported a finding that the exercises in the instant case were performed with the frequency required by the standard of care. Moreover, Tubben, Evans, Endress, and Reich testified that no standard of care required range of motion exercises in the operating room to prevent injury; they were simply performed for the patient's comfort.

Thus, six people essentially testified that there was no specific written standard with respect to the frequency of the exercises. Crouch testified that she exercised the leg twice, which corresponded with Taffet's and Sauchak's estimate on how often the exercises should have occurred. In addition, Copeland corroborated Crouch's testimony when he stated he vaguely recalled someone doing something with the leg underneath the drape, and he assumed it would

have been the circulating nurse. Evidence both supported and rebutted plaintiff's theory that failure to perform range of motion exercises to the non-operative leg resulted in compartment syndrome. Because competent evidence supported the verdict, the court properly denied the motion for a new trial premised on interoperative negligence. *Ellsworth, supra* at 194.

Post-operative negligence:

Plaintiff's post-operative negligence theory was essentially that Sauchak, Vasuu, and McClain failed to diagnose his compartment syndrome in time to correct it before plaintiff suffered permanent injury. Sauchak stated he checked plaintiff's circulation in both legs with a Doppler device and his hands while plaintiff was in recovery; at that time, circulation was intact. The chart entry at the time plaintiff was transferred to a regular bed indicated plaintiff complained of severe aching in his arms and right leg. Endress testified that patients typically complain of aching all over their body after long procedures. Maguire contacted Sauchak again at 9:30 p.m., because plaintiff's urine was tea-colored, which could indicate the presence of blood. According to Taffet, tea-colored urine could also indicate muscle damage from applied pressure, which could indicate that compartment syndrome was developing, and Sauchak should have ordered the urine be tested for myoglobin or muscle protein. In contrast, Endress testified that the order for the hemoglobin and hematocrit test was an appropriate response.

According to Maguire, plaintiff did not localize pain to the knee until 10:00 p.m., and he first indicated his calf was cramped at 11:45 p.m. Plaintiff's leg felt firm and tense, but she could not perform a Homans test⁵ because plaintiff could not stand to be touched. When she paged Sauchak, he ordered Vicodin and pneumatic compression hose and, if there was no significant improvement to the calf in sixty minutes, to call the resident. Taffet testified that a reasonably prudent surgeon, upon hearing that a patient had tea-colored urine, centralized pain in his calf, and a feeling like the calf would explode, would have come in to evaluate the patient personally or ordered a resident to evaluate the patient. In contrast, Endress testified that calling the resident in sixty minutes was an appropriate backup plan if the first orders did not work. At 12:10 a.m., Maguire evaluated both legs; the evaluation indicated good capillary refill and positive pedal pulse. Winkleman acknowledged that good blood flow to the foot was inconsistent with compartment syndrome. At 1:00 a.m., plaintiff was dozing. Plaintiff's girlfriend told Maguire that plaintiff had a history of leg cramps that took hours to relieve. McClain arrived at about 2:20 a.m. He examined the right calf and found plaintiff had pain with both passive and active dorsiflexion, which could either indicate a muscle spasm or deep vein thrombosis. Plaintiff was alert, and did not appear to be in acute distress. His capillary refill was less than two seconds, and there was no pallor or blue color. From the way plaintiff was acting, compartment syndrome would have been low on the list of potential diagnoses.

⁵ A Homans test involves flexing of the foot toward the patient's head and then pointing the toes— if this test causes pain, it is an indication that the patient may have deep vein thrombosis, which is a blood clot. Deep vein thrombosis can be very serious because a blood clot could break free and cause a pulmonary embolism in the brain or lungs.

According to Taffet, McClain violated the standard of care required of a resident because orthopedic residents learn early on about compartment syndrome; he believed compartment syndrome could have been diagnosed at 2:00 a.m. However, Taffet acknowledged that compartment syndrome was harder to diagnose in a muscled patient, and deep vein thrombosis also had symptoms of pain and leg swelling although not usually as intense. Sauchak, on the other hand, testified that he did not believe compartment syndrome existed at 2:30 a.m. Endress noted that the findings of the nurses and McClain were the same – the pulses, temperature, and sensation in plaintiff’s leg were normal throughout the evening. He found McClain’s plan to conduct a Doppler exam in the morning to be appropriate because it demonstrated McClain was trying to differentiate between a muscle cramp and a blood clot; he would not have expected the doctors to look for compartment syndrome at this point because it occurred so rarely.

According to Maguire, plaintiff was still complaining of tightness at 5:00 a.m., but the color and pulse in his leg were still good. Licensed Practical Nurse Ronnie Ann Pixley testified that when she met plaintiff at 7:45 a.m., he was crying and very upset. His right calf and lower leg were hard to the touch. Vasuu saw plaintiff at 7:45 a.m. The right calf was tender and tested positive for Homans’ sign. He ordered an ultrasound to rule out deep vein thrombosis. He also ordered heparin, a blood thinner, in case plaintiff had deep vein thrombosis. He noted that plaintiff did not appear to be in acute distress at the time. Vasuu stated he did not think plaintiff’s pain was out of proportion – one of the signs of compartment syndrome – because the pain could be controlled with medication. He claimed he would not have been able to palpitate the muscles if plaintiff had had compartment syndrome, and the fact that plaintiff had sensation and vasculature or pulse in the right leg was inconsistent with compartment syndrome. He explained that compartment syndrome in a non-operative leg was very rare, deep vein thrombosis would be a more probable post-operation finding, and doctors try to consider the most obvious things first.

Sauchak testified that Vasuu’s notes did not correlate with compartment syndrome but were more consistent with deep vein thrombosis, which is rarely associated with compartment syndrome. Endress stated that compartment syndrome was not a likely diagnosis at 7:45 a.m., because plaintiff’s response to medications, the positive Homans test, and swelling all indicated a blood clot. He found the plan to start the anticoagulant and confirm with a Doppler test to be an appropriate response. Taffet testified that Vasuu violated the standard of care because he should have entertained compartment syndrome as a co-existing diagnosis, and Sauchak violated the standard of care by not measuring compartment pressure or operating at 7:45 a.m. Pixley testified that the deep vein thrombosis diagnosis was consistent with the pain and hardness, so there was no reason to question the diagnosis.

Pixley stated that the condition of the leg remained the same when she checked it at 10:15 a.m., and 11:00 a.m.. Sauchak testified that the Doppler performed two hours later came back positive for deep vein thrombosis. Registered Nurse Julia Munoz testified that plaintiff was dozing off and appeared comfortable at 12:30 p.m.. She did not observe a sudden deterioration in plaintiff’s condition. Sauchak’s note at 1:30 p.m. indicated he found plaintiff in acute distress; and he believed the dramatic increase in plaintiff’s condition occurred within thirty minutes before he arrived. Vasuu and McClain joined him and confirmed that the examination results had changed since 2:30 a.m., and 7:45 a.m.

Taffet stated that the level of CPK enzymes in the bloodstream likely demonstrated significant muscle damage or muscle death. However, Sauchak said that if plaintiff had

sustained pressure for many, many hours, there would have been extensive tissue death, which did not occur. Endress confirmed that the surgery likely was performed soon after the relatively recent onset of compartment syndrome because there was no dead muscle found during the fasciotomy or when the fasciotomy was closed. The evidence both supported and refuted a finding of negligence. Because competent evidence supported the verdict, the court properly denied the motion for a new trial. *Ellsworth, supra* at 194.

Plaintiff next argues the court erred when it gave the standard medical uncertainties instruction, M Civ JI 30.04. However, plaintiff waived this issue when he agreed to the instruction before it was given, and did not object after it was given. A party may not raise on appeal a claim of error to which the party contributed at trial. *Phinney v Perlmutter*, 222 Mich App 513, 538-539; 564 NW2d 532 (1997).

On cross-appeal, the hospital argues the trial court erred in denying its summary disposition motion and its directed verdict motion with respect to agency.⁶ We disagree.

A hospital may be held indirectly responsible for the acts of its agents. *Cox v Flint Bd of Hosp Mgrs*, 467 Mich 1, 11; 651 NW2d 356 (2002). To establish ostensible agency, a plaintiff must demonstrate (1) a reasonable belief that the individual was an agent of the hospital, (2) the belief was the result of an act or neglect by the hospital, and (3) the plaintiff was not negligent. *Zdrojewski v Murphy*, 254 Mich App 50, 66; 657 NW2d 721 (2002). Ostensible agency generally is precluded by an independent doctor-patient relationship that existed before the patient's admission to the hospital; however, the hospital's actions can override the notions created by the independent relationship and establish a reasonable belief that the individual is the hospital's agent. *Id.* A question of material fact exists, and a motion for summary disposition is properly denied with respect to ostensible agency, when a defendant fails to present evidence of a pre-existing relationship, and the plaintiff presents evidence he was unaware of the medical professional's existence until after the surgery. *Id.* at 67. Here, plaintiff testified at his deposition and swore by affidavit that before surgery he did not meet Evans and was unaware what function Evans performed. Because the hospital failed to present evidence of a pre-existing relationship between plaintiff and Evans, the trial court properly denied the hospital's summary disposition motion. *Id.*

The hospital next argues the court erred in failing to exclude plaintiff's claim of a lost opportunity for an NFL career. We briefly address this issue because it is likely to recur on remand. Citing MCL 600.2912a(2), the hospital argues plaintiff was required to prove that the

⁶ Because Sauchak and Tubben prevailed at trial, and the hospital has not indicated on appeal a collateral reason why this issue should be addressed with respect to these defendants, the issue is moot. An issue is moot when circumstances have occurred that make it impossible to grant relief. *Bayati v Bayati*, 264 Mich App 595, 602; 691 NW2d 812 (2004); *People v Cathey*, 261 Mich App 506, 510; 681 NW2d 661 (2004), citing *In re Dodge Estate*, 162 Mich App 573, 583-584; 413 NW2d 449 (1987) (an issue is not considered moot if it will continue to affect a party in a collateral manner). However, the issue is not moot with respect to Evans, and we address it accordingly.

alleged malpractice reduced his opportunity to obtain an NFL career by more than fifty percent. We find that the hospital misapprehends the plain meaning of MCL 600.2912a(2). The opportunity to achieve a better result refers to the actual injury the plaintiff suffered. In the instant case, the actual injury was the nerve and muscle impairment suffered by plaintiff. Damages, however, generally refer to pecuniary compensation that may be recovered in court by a person who has suffered injury. *Universal Underwriters Ins Co v Kneeland*, 464 Mich 491, 497; 628 NW2d 491 (2001).

Once a plaintiff proves an injury, recovery of damages is not precluded merely because the amount of damages is not precise. *Severn v Sperry Corp*, 212 Mich App 406, 415; 538 NW2d 50 (1995). On the other hand, damages predicated on conjecture and speculation may not be recovered. *Health Call v Atrium Health Care*, 268 Mich App 83, 96; 706 NW2d 843 (2005). Relevant evidence is admissible unless more prejudicial than probative, MRE 401, 403, and a trial court has discretion whether to admit evidence, *Elezovic, supra* at 419. “Questions regarding what damages may be reasonably anticipated are issues better left to the trier of fact.” *Id.* at 97, citing *Wendt v Auto-Owners Ins Co*, 156 Mich App 19, 26; 401 NW2d 375 (1986). Because the hospital’s argument to preclude evidence of damages is inapposite, we decline to address the issue further. We leave it to the trial court’s discretion should the issue arise on remand.

Reversed in part and remanded for proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Michael R. Smolenski
/s/ Donald S. Owens
/s/ Pat M. Donofrio