STATE OF MICHIGAN

COURT OF APPEALS

DAVID RAMMELOO and JANICE RAMMELOO,

Plaintiffs-Appellants,

v

TARZZA KENT WILLIAMS and GELCO CORPORATION,

Defendants-Appellees,

and

ALFONS KAREL RIGOLE, RACHEL MARIA RIGOLE, and CRAIG STEVEN HARRISON,

Defendants.

UNPUBLISHED
November 25, 2003

No. 242602
Macomb Circuit Court
LC No. 2000-001812-NI

Before: Fort Hood, P.J., and Murphy and Neff, JJ.

PER CURIAM.

Plaintiffs appeal as of right from a judgment granting summary disposition to defendants Williams and Gelco Corporation pursuant to MCR 2.116(C)(8) and (10). This case arises out of a motor vehicle accident involving plaintiff David Rammeloo (hereinafter "plaintiff") and defendant Williams, in which plaintiff's vehicle was rear-ended by a vehicle operated by Williams and owned by the Gelco Corporation.[1] Plaintiff claimed that he suffered a serious impairment of body function, MCL 500.3135, in an attempt to recover noneconomic losses. On

[1] The remaining defendants not subject to this appeal were sued on the basis of two subsequent automobile accidents involving plaintiff. Those claims were settled but play a part in our analysis here. Our reference to "defendants" in this opinion regards Williams and Gelco Corporation, and we shall refer to the other defendants specifically by name. Additionally, in order to avoid any confusion in the remainder of this opinion, we shall simply make reference to "plaintiff" in the singular despite there being two plaintiffs; Janice Rammeloo's claim was predicated on loss of consortium.

appeal, plaintiff maintains that the trial court erred in rejecting his position that post-traumatic stress disorder (PTSD) constituted a serious impairment of body function. Plaintiff argues that there remains a genuine issue of material fact with respect to the PTSD claim. We affirm.

I. COMPLAINT

There is no dispute that plaintiff was involved in three motor vehicle accidents, all of which formed the basis of the complaint. Plaintiff's first accident, the subject of this appeal, occurred on December 31, 1997, and involved defendants. The second accident occurred three weeks later on January 20, 1998, and involved Alfons Rigole. The third accident occurred on July 24, 1998, involving Craig Harrison. There is also no dispute that before any of these accidents, in August 1997, plaintiff's brother died in a motor vehicle accident that did not involve plaintiff. His brother's fatal accident was not referenced in plaintiff's complaint.

Plaintiff alleged that in the first accident, Williams violently rear-ended his vehicle near an intersection. With respect to the second accident, plaintiff alleged that a vehicle operated by Alfons Rigole, and owned by Rachel Rigole, violently rear-ended his vehicle. As to the third accident, plaintiff alleged that a motor vehicle owned and operated by Craig Harrison violently rear-ended his vehicle. Plaintiff alleged negligence on the part of Williams, Rigole, and Harrison, and liability for the remaining defendants predicated on vehicle ownership.

Plaintiff alleged that, as a result of the accidents, he suffered serious impairment of body function and serious permanent disfigurement, including a closed-head injury, dizziness, headaches, a herniated cervical disk, blurred vision, extreme shock to the nervous system, great physical pain, and mental anguish. There is no specific reference to PTSD in the complaint. Plaintiff allegedly incurred extensive medical bills, a loss of earnings and earning capacity, and has been rendered disabled and unable to attend to his usual, ordinary affairs.

II. MOTION FOR SUMMARY DISPOSITION

A. Defendants' Arguments

Defendants filed a motion for summary disposition pursuant to MCR 2.116(C)(8) and (10). They maintained that plaintiff did not suffer a serious impairment of body function and failed to show any injuries resulting from the first accident. Defendants argued that there was no genuine issue of material fact that plaintiff did not have an objectively manifested impairment of an important body function that affected his general ability to lead his normal life. According to defendants, any alleged injuries suffered by plaintiff, or any alleged serious impairment, was the result of the second and third accidents.

B. Evidence Presented at Summary Disposition

Plaintiff's Deposition

Plaintiff was deposed in this action, and his deposition forms the basis for some of the parties' arguments below and on appeal. Plaintiff was thirty-three years old at the time of the first accident and married. He was employed as a superintendent for GTR, a construction company, but is now unemployed. Plaintiff testified that he was no longer employed because he

suffered from dizziness, numbness, bad headaches, nausea, and eye pain, along with ear, neck, and shoulder problems. He stated that before his motor vehicle accidents, he had no medical problems or conditions.

At the time of the first accident, plaintiff was driving a full-size Ford pickup truck, which was struck from behind as plaintiff was slowing down to navigate a right-hand turn at an intersection. The accident shook plaintiff and tossed him back and forth; he thought his head hit the headrest, but he was not one-hundred percent certain. No other part of plaintiff's body struck anything within the truck when the impact occurred, and he did not detect any bleeding. The only damage to the truck was to the rear bumper, and the truck remained driveable. Plaintiff indicated that he told a responding police officer that he was shaken, that he had back and shoulder pain, and that his head hurt. However, plaintiff refused medical treatment, drove to his nearby home, went to bed, and eventually went back to work that same day. Plaintiff could not recall when he first sought medical treatment or whether he received treatment after that first accident and before the second accident; he only remembered that at some point in time he started going to the emergency room often because of dizziness and related problems. Plaintiff testified that the first accident did not result in any cuts, abrasions, fractures, or broken bones.[2]

Plaintiff continued to go to work during the period of time between the first and second accidents; however, much of the time at work was spent laying on a couch, and he was able to delegate work to others. Plaintiff testified that, after the first accident and before the second accident, he had dizzy spells, his eyes would flutter, everything would shake, his ears would ring, he had many headaches, and lots of naps were taken. He asserted that within a few days of the first accident, he developed vision problems and eye pain. Plaintiff subsequently went to the emergency room for the eye-related problems, but he could not remember when he went to the emergency room. He testified that he eventually stopped driving because of the vision problems following back surgery in December 1998. But he had continued driving following each of the three accidents. Plaintiff maintained that after the first accident, he had arm problems, in that he would wake up at night and not be able to feel his arms.

In the second accident, plaintiff was again rear-ended, and afterward he felt pain in his shoulders and chest, along with the same problems he experienced after the first accident, except they were now aggravated. Plaintiff was also driving a pick-up truck in the second accident,[3] which incurred some damage to the bumper, and plaintiff drove himself, in the truck, to the hospital for treatment. Plaintiff was in the hospital for only about an hour, and he was given something for dizziness; no x-rays were taken. Subsequently, plaintiff made numerous visits to hospital emergency room because of shoulder, neck, and vision problems, eye pain, ringing and pressure in the ears, dizziness to the point of falling to the ground, confusion, sleep difficulties,

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[2] We note that plaintiff failed to present any documentary evidence, such as a medical record, medical bill, or insurance document, that showed that he went for medical treatment on a date falling before the second accident.

[3] This appears to be a different truck than that driven by plaintiff in the first accident.

light and movement sensitivity, and mood swings. These emergency room visits did not result in plaintiff ever being admitted, nor in any resolution of his problems.

Plaintiff was then involved in the third accident while he was driving the same truck from the second accident. Plaintiff was again rear-ended as he sat stopped at a traffic light. This accident caused a little more damage to the bumper than already existed from the previous accident. Once again, the truck could still be driven. Plaintiff told responding police that he was not injured as a result of the crash. He stated that he suffered no new pain or problems as a result of the third accident, but the previous problems persisted. Plaintiff did not seek medical attention, and he drove himself home from the accident.

According to plaintiff, his condition continued to deteriorate,[4] and he often went to emergency rooms and started seeing doctors outside the ER, including specialists. Eventually plaintiff underwent back surgery in December 1998. Medical documents reveal that the preoperative diagnosis was "[c]ervical myelopathy due to cervical spondylosis at C5-C6 and also spinal stenosis at C5-C6." Plaintiff testified that his condition did not improve after the surgery, and he continued to visit the ER and see other doctors outside the ER who conducted a variety of medical tests. The results of these tests, as evidenced by medical records, are discussed below.

Plaintiff has taken a variety of medications for his health and psychiatric problems, including Serzone, Xanax, Effexor, Antivert, and Darvocet, and he has undergone psychiatric counseling with Dr. Malachy Browne. At the time of the deposition, plaintiff was being treated on a regular basis by numerous medical specialists without success. Plaintiff testified that the doctors acknowledged that something was wrong; however, they could not pinpoint or identify the source of the problem.

Plaintiff indicated that he stays at home most of the time and rests, and that his activity around the home, such as playing with the children, is severely limited because of his medical problems. He has stopped most activities outside of the home due mainly to his problems with dizziness and light sensitivity. Before the first accident, plaintiff engaged in numerous activities, including working around the house, going to the beach, restaurants, and movies, and rollerblading. These activities have stopped.

Dr. Frank Ochberg

The documentary evidence relevant to this appeal relates to plaintiff's claim that he suffers from chronic PTSD as a result of the first accident and in connection with the accident that killed his brother. Plaintiff relied heavily on a psychiatric opinion and evaluation provided by Dr. Frank M. Ochberg. Dr. Ochberg is a clinical professor of psychiatry at Michigan State University and the former director of the Michigan Department of Mental Health. In his evaluation, that was based on a two-hour and fifteen-minute interview with plaintiff and review of a file provided by counsel, Dr. Ochberg stated in pertinent part:

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[4] Plaintiff claimed that he was now also feeling numbness and burning in his legs.

Mr. Rammeloo suffers from Chronic Post-traumatic Stress Disorder caused by a compound trauma: the experience of the death of his brother in a motor vehicle accident in August, 1997, followed by his own series of automobile injuries in the succeeding eleven months. His flashbacks, nightmares and associated disabling symptoms incorporate elements of his brother's fatal injuries (for which he irrationally blames himself) and his own injuries to his head, neck and nervous system. He experiences his brother's neck snapping as he re-experiences his own shock and pain.

* * *

PTSD is a well recognized medical syndrome consisting of episodic, harrowing bouts of unwanted memory – sometimes so vivid that it has the quality of a hallucination and causes the sufferer to fear he is "going crazy." Additionally, the person feels emotionally numb without capacity for joy or hope. Finally, the person has anxious arousal that interferes with sleep, concentration and a sense of security. In Mr. Rammeloo's case, all of these elements have been present since his first car accident in December, 1997.

* * *

After this accident [first accident], but before the next one on January 20, 1998, David lost his temper, frequently withdrew from his wife (causing a brief separation), experienced numerous physical symptoms such as headache, dizziness, visual distortion, and "I got psychotic almost." At first he explained this in purely physical terms, such as getting up at night and sleeping on the floor in a fetal position. Later, toward the end of our time together, he noted how he seemed to feel his brother's neck snapping when his own neck hurt and how his sudden, unwanted memories of his own accident became confused with his fantasy of his brother's fatal crash.

* * *

I went through every PTSD marker in the DSM with David and his wife, inquiring about quality, quantity and duration of symptoms. He has them all. Some were present in August, 1997; all were present in 1998.

* * *

He is embarrassed by psychological symptoms, and therefore minimizes them, while emphasizing his visual and vestibular disabilities. PTSD fully explains his neuropsychological testing (non-organic impairment).

* * *

Had David not been struck from the rear in December, 1997, he would have progressed with his bereavement and self blame. He may have had PTSD symptoms, but not chronic, severe, incapacitating PTSD. His first car crash gave

him compounding physical symptoms and turned pathological grief into PTSD. His second and third crashes added an element of fatalism and inevitably to his downward course. . . .

* * *

In sum, Mr. Rammeloo has an unusual but not unique form of PTSD caused by multiple traumas, primarily the death of his brother and his own vehicular crash. Together, these events cause a "fused" traumatic memory which has been avoided, suppressed, and insufficiently explored and understood. Additionally, Mr. Rammeloo has the other hallmarks of PTSD: numbing, avoidance, detachment, insomnia, concentration deficit, hypervigilance and startle reaction. He has a history of neurologic impairment and neurosurgery and the common subjective sequellae of head injury with minimal brain damage. . . .

The evaluation indicates that, when Dr. Ochberg asked plaintiff how he felt in December 1997, before the first accident, plaintiff responded that he was healthy and everything was fine.[5]

Medical Records

Numerous medical records, reports, and letters were submitted to the trial court by both parties for purposes of the summary disposition motion. We shall reference relevant portions of these records.[6] A December 1998 report by Dr. Browne provided:

He [plaintiff] states he did not have any particular problems after the first accident in January. However, on the second accident where he slammed his head into the back of the seat of his car, he has had these symptoms predominantly and are getting progressively worse.

* * *

The patient presents with a lot of anxiety symptoms precipitated by dizziness, blurring of vision and tingling, all of which could possibly be related to panic. However, these symptoms do not seem to come together nor does he seem

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[5] Dr. Ochberg's evaluation indicates that the fatal accident that killed plaintiff's brother occurred in Canada during a visit by plaintiff and his wife to his brother's home. Plaintiff's brother, a passenger in a vehicle driven by a third person, died when his neck was broken in the accident. The driver had been drinking, and plaintiff blamed himself for not stopping his brother from going out for a drive.

[6] We note that the parties failed to present evidence explaining the medical terminology contained in the medical records and the medical significance of the language used. We also note that the medical records do not necessarily constitute admissible evidence; however, the parties apparently do not dispute the records, nor argue against the consideration and use of the records for purposes of analyzing the summary disposition arguments.

to have at any one time all the [symptoms] of a panic disorder. His difficulties in large buildings seem to suggest some agoraphobia. However, he feels it is a visual perceptual difficulty, which indeed it might be, that is accounting for these symptoms. The patient's background of unmet dependency needs leaves him vulnerable to having difficulty with his disability and tolerating and dependent rolls.

FINAL DIAGNOSIS:

AXIS I: Adjustment disorder with anxiety, rule out panic disorder with agoraphobia.

AXIS II: Deferred.

AXIS III: Possible herniated disc, inner ear dysfunction, visual perceptual dysfunction.

A January 1999 radiology report from St. Joseph's Mercy of Macomb Hospital indicated that plaintiff underwent a cervical and lumbar myelogram – a CT scan of the cervical spine, and a CT scan of the lumbar spine. The results of the CT scan of the lumbar spine was normal. The conclusion noted on the radiology report with respect to the CT scan of the cervical spine stated:

> Post operative changes C5-C6, small amount of spurring on the right at C5-6. Some effacement of the right anterior subarachnoid space. No other significant abnormality.

The record contains a report by Dr. Douglas J. Gelb, a member of the Department of Neurology, University of Michigan Medical Center (February 26, 1999), which provided in pertinent part:

> He [plaintiff] told me that he was fine until January 1998, when he was involved in two car accidents.[7] He did not think he lost consciousness in either accident, although he may have lost consciousness very briefly in the second one. He does not remember any specific symptoms after the first accident, but after the second one he started getting pain in both of his shoulders. He also started having headaches, dizzy spells, and a pressure behind his eyes.
>
> * * *
>
> His neurologic examination today was essentially normal. He responded appropriately to questions and instructions. His cranial nerves were intact to detailed testing, with full visual fields; equal and normal reactive pupils; intact

[7] We believe that it is quite evident that plaintiff's reference to two accidents in January 1998 included the first accident which actually occurred on the last day of December 1997.

> extraocular movements; normal facial sensation and strength; intact hearing to finger rub; and symmetric palate, neck, and tongue movements. His gait and coordination were intact to detailed testing. He had normal muscle, bulk, and tone throughout, with no pronator drift, and his strength was full throughout. He had normal reflexes throughout the upper extremities, and they were symmetric except for slight reduction of the right biceps jerk relative to the left. He had normal and symmetric reflexes at his knees and ankles. Both of his plantar responses were flexor. He reported mild reduction of vibration sense at the toes, but his sensation was otherwise intact to all primary modalities, with no extinction on double-simultaneous stimulation.
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> * * *
>
> In summary, he has diffuse symptoms with a nearly normal neurologic examination, and no findings on his MRI scans or CT scans to explain his symptoms. All of his symptoms are similar to the ones that have been described by other patients after head trauma, and often labeled the "post concussion syndrome" or the "post traumatic syndrome."

Dr. Akemi Takekoshi, who consulted with plaintiff's attending physician, Dr. Manouchehr Nikpour, stated in a March 1999 medical report:

> After the second motor vehicle accident, he had constant headaches, which were generalized, dizzy spells and constant ringing in his ears, varying in intensity and pitch. Following the third motor vehicle accident, along with these symptoms, which were worsened, he has had blurred vision and periods of difficulty concentrating and thinking.
>
> * * *
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> Neurological examination appears normal at this time. . . . He did suffer cervical injury, requiring cervical fusion at C5-C6 last year (1998 surgery) and has had persistent headaches, dizziness with tinnitus and recently photophobia, he states he has been wearing sunglasses most of the time. He was found to have elevated spinal fluid pressure, apparently. The results of the spinal fluid are not known to the patient. He was started on Diamox. . . . He is having another lumbar puncture today and MRI of the brain. Apparently, Dr. Jankowski found some inner dysfunction, which could be from head injury. However, these records are not available.

Dr. Jonathan D. Trobe examined plaintiff in April 1999, and he indicated that plaintiff's neuro-ophthalmic examination was completely normal. Dr. Trobe also opined that plaintiff was suffering an anxiety disorder, and that there was no connection between plaintiff's symptoms and any organic neurologic disease.

The record contains four letters, dates ranging from February to August 1999, from Dr. Thomas C. Spoor, who treated plaintiff during that period of time. The following are relevant excerpts from those letters:

[Plaintiff's] visual acuity is equal and normal. There is a trace of an afferent pupillary defect and a trace of pallor of the right disc. This may be related to his trauma. His photophobia is due to the mild iritis which we are treating with a steroid drop. His other symptoms are related to convergence insufficiency and are being treated with orthoptic exercises.

* * *

His positive findings include convergence insufficiency with decreased convergence amplitudes. We could not find a vertical. He does have a trace iritis in the left side and 1+ iritis in the right side. This may well account for his photophobia. There is a hint of pallor of his right disc . . . .

Such photophobia is not uncommon in patients with head injury. It can sometimes be explained by a little iritis, and sometimes it can't. Hopefully, we will resolve his problems for him.

* * *

I was somewhat suspicious that he had elevated intracranial pressure. He subsequently underwent a floureseein angiogram to look for leakage of his optic disc compatible with papilledema. None was found; however no spontaneous venous pulsations were evident. I did have a lumbar puncture performed, and his intracranial pressure was 320mm CSF. This is approximately twice what it should be and is definitely abnormal. My diagnosis is that Mr. Rammeloo has pseudotumor cerebri. This may well be posttraumatic in etiology.

* * *

Positive findings, I repeat, are markedly decreased convergence amplitudes and elevated intracranial pressure. These are both possibly sequelae of a closed head injury and subsequently I suggested treatment for both. Neither of these would obviate against him driving or, for that matter, working.

An August 20, 1999, letter from psychologist Diane K. Klisz Karle, who examined and tested plaintiff, stated that plaintiff had a psychological profile indicating strong histrionic characteristics. She opined that "[s]imilar people are highly suggestible, develop physical symptoms when under emotional distress or use physical symptoms to manipulate others."

In a letter to plaintiff from Dr. Edward M. Cohn, dated September 7, 1999, Dr. Cohn warned plaintiff not to drive, and he opined:

You have an internuclear ophthalmolplegia that is bilateral. This means that your eye muscle coordinating center in the brainstem (that part of the central nervous system connecting the spinal cord and brain) is not functioning normally.

The result is that rapid eye movements tend to result in blurred and double vision. Therefore, when trying to drive, a quick glance to one side or the other

> leaves you dizzy with double vision. You are not a safe driver with this condition, and anyone asking you to drive is responsible and liable for any resulting accident, injury, or difficulty.

An October 22, 1999, letter from neurologist Dr. Paul A. Cullis stated that he evaluated plaintiff, and that plaintiff indicated that he did not hit his head or pass out in the first accident but his head did impact the steel above the rear window in the second accident, causing a severe headache, pain in the back of the head, chest pressure, and terrible dizziness. Plaintiff informed Dr. Cullis that he experienced more severe headache, along with neck and shoulder pain, following the third accident. Dr. Cullis opined that "this patient is suffering from the sequelae of a traumatic brain injury and cervical myelopathy caused by a motor vehicle accident in which he was involved on the second of January, 1998."

A December 19, 2000, report by neurologist Dr. Richard A. Lewis reflected that plaintiff was referred to him by Dr. Cullis for a neuromuscular evaluation. Dr. Lewis indicated that plaintiff's EEG was normal, that plaintiff had some phobias, that plaintiff had hysterical aspects to his personality, that an MRI scan of plaintiff's brain was negative, that his spinal fluid did not reveal any changes, that internuclear ophthalmoplegia was unlikely, and that there was no clear neurologic abnormality.

C. Trial Court's Ruling

The trial court granted defendants' motion for summary disposition from the bench at oral argument, without any discussion whatsoever, after entertaining the parties' arguments. A curt order granting the motion was entered thereafter.

III. MOTION FOR RECONSIDERATION

A. Plaintiff's Arguments

Plaintiff argued that the trial court palpably erred in failing to consider his serious impairment of body function as it related to the first accident. Plaintiff submitted the deposition testimony of Dr. Ochberg, maintaining that it had not been available at the time plaintiff filed a response to defendants' motion for summary disposition. Additionally, plaintiff requested the trial court to consider the affidavit of Dr. Malachy Browne, which affidavit was also allegedly not available at the time plaintiff responded to defendants' motion for summary disposition.

B. Evidence Presented in Support of Motion

Dr. Browne's affidavit indicated that he is a Diplomat of the American Board of Psychiatry and Neurology, and that plaintiff was his patient. The affidavit averred that Dr. Browne was treating plaintiff, and that plaintiff was "severely impaired in his capacity to meet his own needs within his own home as the result of [PTSD]." Dr. Browne continued by stating that "[i]t is my opinion that the [PTSD] was precipitated by the inseparable events of his brother's death and the three car accidents."

In Dr. Ochberg's deposition, he testified consistently with his prior evaluation of plaintiff but went into much greater elaboration than was possible in the evaluation. The deposition

reflected Dr. Ochberg's opinion that plaintiff suffered symptoms of PTSD. The deposition also provided details on Dr. Ochberg's background and qualifications to render an opinion on PTSD.

C. Trial Court's Ruling

The trial court, denying plaintiff's motion for reconsideration, issued a ruling which provided in pertinent part:

> In the instant matter, any dispute concerning the nature and extent of plaintiff David Rammeloo's injuries was not material to determining whether he suffered a serious impairment of body function.
>
> Plaintiff David Rammeloo's asserted vision problems, dizziness, pain, headaches, ringing in the ears and difficulties functioning following the first accident were clearly subjective articulations of his condition. . . . The record was devoid of any evidence of medical testing, examination or other assessment before the second accident suggesting and/or confirming an objective physical basis of his claimed injuries from the first accident.
>
> Consequently, plaintiff David Rammeloo failed to proffer evidence suggesting he suffered an objectively manifested impairment of an important body function because of the first accident. Accordingly, there was no palpable error in dismissing plaintiffs' complaint.

IV. ANALYSIS

A. Appellate Arguments

Plaintiff acknowledges that an injury must be objectively manifested and medically identifiable, along with having a physical basis. Plaintiff argues that the first accident compounded with the accident that killed his brother resulted in PTSD, which is a medically identifiable and recognized psychiatric injury with debilitating symptoms. Plaintiff maintains that case law and the Michigan Civil Jury Instructions (M Civ JI) support the position that a mental or psychiatric injury can constitute a serious impairment of body function, where the mental injury is caused by physical injury, or where the mental injury is not caused by physical injury but which results in physical symptoms. According to plaintiff, there is a physical basis here in light of the evidence that, between the first and second accidents, he suffered sleep interference, concentration problems, headaches, dizziness, shoulder and neck pain, visual distortion, eye fluttering, numbing, insomnia, and startle reaction. Minimally, there is an issue of fact on these matters.

With respect to the fatal accident that took the life of plaintiff's brother, plaintiff asserts, based on Dr. Ochberg's evaluation, that chronic and severe PTSD occurred only after the first accident, not before, and regardless, there can be recovery where there is a combination of causes with an aggravation of a preexisting injury. Plaintiff argues that defendants have the burden to separate damages as between those arising from the first accident and his brother's fatal accident, and that if it cannot be done, defendants are liable for the full amount of damages. Although not reached by the trial court, plaintiff argues that PTSD regards an important body function, i.e.,

operation of the brain or mind and nervous system, and that there was sufficient evidence to create a factual issue as to whether the first accident impaired plaintiff's ability to lead his normal life. Finally, plaintiff argues that the trial court erred in denying the motion for reconsideration because there was new evidence, previously unavailable, that supported a finding that a genuine issue of fact existed with regard to whether plaintiff suffered a serious impairment of body function. Plaintiff does maintain, however, that the trial court had sufficient documentary evidence to find a factual issue at the time the summary disposition motion was heard even without the additional evidence submitted with the motion for reconsideration.

Defendants first assert that, under MCL 500.3135, the issue whether a threshold injury is present is a question of law for the court to decide, absent an outcome-determinative factual dispute. According to defendants, plaintiff failed to show that an outcome-determinative factual dispute existed, and failed to show that the trial court erred in its ruling. Defendants argue that there was no evidence that plaintiff suffered a physiological injury as a result of the first accident. Moreover, with respect to the PTSD claim, plaintiff failed to submit objective evidence of a medically identifiable injury. Relying on *Garris v VanderLaan*, 146 Mich App 619; 381 NW2d 412 (1985), defendants maintain that even if there is a factual issue in regard to PTSD, it was not an outcome-determinative factual dispute because PTSD is not recognized as an objectively manifested injury that is sufficiently serious to rise to the level of a threshold injury, it does not involve an important body function, and there was insufficient proof that it affected plaintiff's general ability to lead his normal life.[8] Defendants focus on the point that plaintiff failed to produce any evidence establishing that plaintiff received medical treatment or psychiatric care after the first accident and before the second accident, and that Dr. Ochberg did not conduct a physical examination but instead relied on plaintiff's subjective complaints of pain and physical problems. Defendants argue that plaintiff has abandoned on appeal any claim of serious impairment predicated solely on physiological symptoms, outside the context of PTSD, because plaintiff only presents a PTSD argument on appeal. Because PTSD is not identified in plaintiff's complaint, defendants conclude that summary disposition would also be proper under MCR 2.116(C)(8).

With respect to plaintiff's motion for reconsideration, defendants argue that there was no legitimate excuse for not providing Dr. Browne's affidavit and Dr. Ochberg's deposition transcript prior to summary disposition given that both doctors started their professional relationship with plaintiff long before the motion was decided. Defendants argue that any delay was plaintiff's fault, not defendants or the trial court; therefore, the motion for reconsideration lacked a proper basis and was rightfully denied. Moreover, according to defendants, the additional evidence, even if considered, had no impact on the trial court's proper resolution of the case.

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[8] Defendants reach the conclusion that PTSD, assuming its validity, did not affect plaintiff's general ability to lead his normal life because he kept working between the first and second accidents.

B. Standard of Review

This Court reviews de novo a trial court's decision on a motion for summary disposition. *Koenig v City of South Haven,* 460 Mich 667, 674; 597 NW2d 99 (1999). Issues of law are also reviewed de novo. *Mahaffey v Attorney General,* 222 Mich App 325, 334; 564 NW2d 104 (1997).

C. Tests for Summary Disposition – MCR 2.116(C)(8) and (10)

MCR 2.116(C)(8) provides for summary disposition where "[t]he opposing party has failed to state a claim on which relief can be granted." A motion for summary disposition under MCR 2.116(C)(8) tests the legal sufficiency of a complaint. *Beaudrie v Henderson,* 465 Mich 124, 129; 631 NW2d 308 (2001). The trial court may only consider the pleadings in rendering its decision. *Id.* All factual allegations in the pleadings must be accepted as true. *Dolan v Continental Airlines/Continental Express,* 454 Mich 373, 380-381; 563 NW2d 23 (1997).

MCR 2.116(C)(10) provides for summary disposition where there is no genuine issue as to any material fact, and the moving party is entitled to judgment or partial judgment as a matter of law. Our Supreme Court has ruled that a trial court may grant a motion for summary disposition under MCR 2.116(C)(10) if the affidavits or other documentary evidence show that there is no genuine issue in respect to any material fact, and the moving party is entitled to judgment as a matter of law. *Smith v Globe Life Ins Co,* 460 Mich 446, 454; 597 NW2d 28 (1999). In addition, all affidavits, pleadings, depositions, admissions, and other documentary evidence filed in the action or submitted by the parties are viewed in a light most favorable to the party opposing the motion. *Id*. Where the burden of proof on a dispositive issue rests on a nonmoving party, the nonmoving party may not rely on mere allegations or denials in the pleadings, but must go beyond the pleadings to set forth specific facts showing that a genuine issue of material fact exists. *Quinto v Cross & Peters Co,* 451 Mich 358, 362; 547 NW2d 314 (1996). Where the opposing party fails to present documentary evidence establishing the existence of a material factual dispute, the motion is properly granted. *Id.* at 363.

D. Serious Impairment of Body Function, Discussion, and Conclusion

Under the no-fault act, a plaintiff may recover noneconomic losses only where the plaintiff has suffered "death, serious impairment of body function, or permanent serious disfigurement." MCL 500.3135(1); *Kreiner v Fischer (On Remand),* 256 Mich App 680, 682; __ NW2d __ (2003). The issue whether a person has suffered a serious impairment of body function is a question of law for the trial court to decide if the court finds that there is no factual dispute concerning the nature and extent of the person's injuries, or there is a factual dispute concerning the nature and extent of the person's injuries, but the dispute is not material to the determination as to whether the person has suffered a serious impairment of body function. MCL 500.3135(2)(a); *Kreiner, supra* at 682-683. In other words, MCL 500.3135(2) requires a trial court to determine, as a matter of law, whether a plaintiff has suffered serious impairment of body function where there is no factual dispute, or, where the facts are in dispute, but the disputed facts are not outcome-determinative with respect to a proper resolution of determining serious impairment. *Kern v Blethen-Coluni,* 240 Mich App 333, 341-342; 612 NW2d 838 (2000).

MCL 500.3135(7) provides that serious impairment of body function "means an objectively manifested impairment of an important body function that affects the person's general ability to lead his or her normal life." The *Kreiner* panel stated:

> The statutory definition of serious impairment in MCL 500.3135(7) can be broken down into three requirements that must be established in order to find a serious impairment of body function. First, there must be an objectively manifested impairment. Second, the impairment must be of an important body function. Third, the impairment must affect a person's general ability to lead his or her normal life. [*Kreiner, supra* at 684.]

For an impairment to be objectively manifested, there must be a medically identifiable injury or condition that has a physical basis. *Jackson v Nelson*, 252 Mich App 643, 653; 654 NW2d 604 (2002); M Civ JI 36.11.

Here, a major thrust of defendants' position and that of the trial court is plaintiff's failure to show an objectively manifested impairment that is medically identifiable with a physical basis. This position is predicated on the arguments that plaintiff failed to prove that he went to a doctor after the first injury but before the second injury, and that plaintiff's deposition, in and of itself, cannot establish a threshold injury because the testimony reflected purely subjective complaints. We initially hold that there is no legal basis to support the proposition that plaintiff was required to obtain medical or psychiatric treatment between the first and second accidents in order to establish serious impairment of body function. The medical and psychiatric care given to plaintiff subsequent to the second accident could establish an outcome-determinative factual issue on serious impairment, when considered in relation to plaintiff's deposition, if this evidence can be shown to relate to plaintiff's alleged symptoms arising directly after the first accident and if supportive of a finding of serious impairment.

Next, and importantly, plaintiff's appellate argument relates solely to the claim that PTSD constituted serious impairment of body function, and that the trial court erred in rejecting the claim. On appeal, plaintiff makes no argument that the trial court erred in dismissing any claim of serious impairment based on physiological injuries unrelated to PTSD. Therefore, our focus is on PTSD; a mental or psychiatric injury. We thus start by reviewing case law addressing mental or psychiatric injury in the context of MCL 500.3135.

In *Luce v Gerow*, 89 Mich App 546, 547; 280 NW2d 592 (1979), the plaintiff was not physically injured in a car accident, but her husband sustained a serious permanent head injury. The plaintiff suffered an emotional shock and mental injury from witnessing the injury to her husband and his subsequent continuing poor condition, and the shock resulted in physical symptoms. *Id.* at 547-548. The *Luce* panel, addressing the threshold inquiry of serious impairment of body function, stated:

> We reject defendant's contention that the section [MCL 500.3135] retaining tort liability on a showing of a certain threshold is limited to physical injuries. An injury to mental well being can be as much an injury to a "body function" as an injury to an arm or a leg. Once it is accepted that mental injuries, with physical consequences, are "real" injuries, defendant's position becomes unsupportable either in law or in logic. It is clear that under present medical and

> legal theory, mental injuries are considered just as real as physical injuries. We therefore hold, as a matter of law, that the Legislature did not intend to exclude the possibility of recovering for mental injuries resulting in physical symptoms by using the term "body function" in § 3135(1). [*Luce, supra* at 549-550.]

The principles enunciated in *Luce* are similarly found in the present version of the Michigan Model Civil Jury Instructions, wherein it is stated:

> The operation of the mind and of the nervous system are body functions. Mental or emotional injury which is caused by physical injury or mental or emotional injury not caused by physical injury but which results in physical symptoms may be a serious impairment of body function. [M Civ JI 36.02.][9]

We note that any reliance on *Luce* must be considered cautiously because *Luce* was decided before the 1995 amendment to MCL 500.3135, which added the definition of serious impairment of body function, including the language requiring an objectively manifested impairment. Additionally, *Luce* was decided before our Supreme Court decided *Cassidy v McGovern*, 415 Mich 483; 330 NW2d 22 (1982), in which the Court ruled, as a precursor to the amendment of § 3135, that serious impairment of body function required an objectively manifested injury. See *Jackson, supra* at 648, citing *Cassidy*, *supra* at 505. Moreover, the judicially-created requirement that the impairment be medically identifiable had not been established at the time *Luce* was decided. See *Jackson*, *supra* at 649-650, citing *DiFranco v Pickard*, 427 Mich 32, 74-75; 398 NW2d 896 (1986).[10]

Defendants rely on *Garris, supra,* for the proposition that even if there is a factual issue in regard to PTSD, it was not an outcome-determinative factual dispute because PTSD is not recognized as an objectively manifested injury that is sufficiently serious to rise to the level of a threshold injury. In *Garris, supra* at 622, the plaintiff was injured in an automobile accident and alleged serious impairment of body function on the basis that she suffered a back injury and was psychiatrically disabled as a result of the accident. The *Garris* panel stated:

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[9] This instruction references *Luce*, and *Luce* only, as support for the language contained in the instruction.

[10] The *DiFranco* Court stated:

> We disapprove of those cases which have automatically disregarded certain types of evidence merely because it was based upon the plaintiff's subjective complaints or the symptoms of an injury. An expert's diagnosis and the basis for it (e.g., the plaintiff's complaints, the physician's observations, and test results) can be adequately challenged at trial through cross-examination and the presentation of contrary medical evidence. The "serious impairment of body function" threshold requires the plaintiff to prove that his noneconomic losses arose out of a medically identifiable injury which seriously impaired a body function. [*DiFranco, supra* at 75.]

> On September 29, 1983, plaintiff was examined by defendant's consulting psychiatrist, Charles Brosius, M.D. His deposition testimony indicated that plaintiff complained of anxiety, tension and anger. He found no evidence of psychosis, a mental illness arising in the mind itself, but instead diagnosed plaintiff's condition as post-traumatic neurosis, which is characterized by depression, anxiety, confusion, isolation and may be associated with some type of bodily injury or mental injury. The post-traumatic neurosis may have been related to the November 24, 1979, automobile accident. Dr. Brosius believed that the neurosis was temporary and would subside in a short period of time if plaintiff received psychiatric treatment. [*Id.* at 623.]

The *Garris* panel then noted that Dr. Brosius was unable to establish a relationship between the plaintiff's back problem and the car accident, and that another doctor found no objective evidence of traumatic or orthopedic pathology to account for her physical complaints. *Id.* This Court concluded:

> Under the facts of this case, while plaintiff's post-traumatic neurosis allegedly resulted in anxiety, nervousness and feelings of anger, such symptoms did not constitute an objectively manifested injury. Plaintiff's alleged symptoms are purely subjective. It cannot be said that plaintiff's post-traumatic neurosis surpasses the significant barrier imposed by the Legislature in requiring a "serious impairment of body function" for recovery of noneconomic losses. See *Luce* v *Gerow*, 89 Mich App 546; 280 NW2d 592 (1979), a pre-*Cassidy* interpretation of serious impairment of body function regarding a mental "injury." [*Id.* at 624 (citations omitted).]

The *Garris* panel also found that, assuming objectively manifested impairments, there was a failure to establish that such injuries significantly interfered with the plaintiff's normal activities. *Id.* at 625.

We choose today not to address the current status of mental or psychiatric injury, standing alone, in the context whether such an injury can constitute a serious impairment of body function under the statutory and judicially-created definitions that now control. It is unnecessary because, assuming that a mental or psychiatric injury such as PTSD is cognizable under MCL 500.3135, it would require, as acknowledged by plaintiff, a physical injury causing the psychiatric injury, a physical basis, or physical symptoms arising out of the psychiatric injury. See *Jackson* and *Luce*, *supra*; M Civ JI 36.02. Here, all of the available medical records, reports, and letters indicate that plaintiff confided that he had no physical problems or pain directly after the first accident. Plaintiff told each of the doctors that he first developed the physical symptoms and pain complained of after hitting his head in the second accident. This is supported by the evidence that plaintiff did not go for medical care after the first accident, yet sought medical attention at an emergency room after the second accident. Although plaintiff testified to the contrary at his deposition, his testimony revealed much uncertainty as to times and dates in connection with his injuries and medical treatment. We conclude that the deposition testimony was insufficient to create a genuine factual issue in the face of the overwhelming medical documents indicating a lack of physical problems resulting from the first accident.

Moreover, as argued by defendants, there is no reference whatsoever in the complaint to PTSD or the fatal accident involving plaintiff's brother, which formed the underlying basis for the PTSD argument. Accordingly, plaintiff failed to state a claim for serious impairment of body function predicated on PTSD, thereby making dismissal proper under MCR 2.116(C)(8).

Finally, in light of our ruling above, the trial court did not err in denying plaintiff's motion for reconsideration.

Affirmed.

/s/ Karen M. Fort Hood
/s/ William B. Murphy
/s/ Janet T. Neff