No. 08-0392

In the Supreme Court of Ohio

ON APPEAL FROM THE COURT OF APPEALS
FIFTH APPELLATE DISTRICT
RICHLAND COUNTY, OHIO
CASE NO. 2006CA0095

ESTATE OF DONALD STEVIC, by Betty A. Stevic, Executrix,

Plaintiff-Appellee,

v.

BIO-MEDICAL APPLICATION OF OHIO, INC., d/b/a FMC RICHLAND COUNTY DIALYSIS SERVICES, et al.,

Defendants-Appellants.

BRIEF OF APPELLANT BIO-MEDICAL APPLICATIONS OF OHIO, INC. d/b/a FMC DIALYSIS SERVICES OF RICHLAND COUNTY

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I. STATEMENT OF THE FACTS

This case is before the Court as a result of a judgment entered by the Fifth Appellate District reversing the trial court's order granting judgment on the pleadings in favor of the Appellant Bio-Medical Applications of Ohio, Inc. d/b/a FMC Dialysis Services of Richland County ("FMC Dialysis"). The trial court had granted FMC Dialysis judgment because Appellee Betty Stevic failed to file her complaint within the one-year statute of limitations for "medical claims" as that term is defined by R.C. 2305.113(E)(3)(b)—a brand new statutory provision enacted as part of Am.Sub.S.B. No. 281, Ohio's tort-reform legislation.

In reversing the trial court, the Fifth District found that Stevic's complaint did not present a "medical claim" because the claim against FMC Dialysis did not fall within one of the enumerated categories set forth in R.C. 2305.113(E)(3). But the Fifth District ignored the definition of "medical claim" plainly and unambiguously contained in subsections (b)(i) and (ii) of that statute, and in doing so, thwarted the very purpose of tort-reform legislation.

A. The legislative history behind S.B. 281

Beginning in 2002, the General Assembly undertook an exhaustive study of the costs associated with health-care delivery after increasing concerns about the availability and affordability of health care in Ohio. It found as part of this study that medical-malpractice litigation represented "an increasing danger to the availability and quality of health care in Ohio." Section 3(A)(1), Am.Sub.S.B. No. 281 (R.C. 2305.113 and 2323.43, uncodifed law), Appx. at 28, 39. Although the number of medical-malpractice claims remained relatively constant, the number of jury awards in excess of one million dollars "doubled in the past three years." Section 3(A)(2), Am.Sub.S.B. No. 281 (R.C. 2305.113 and 2323.43, uncodifed law), Appx. at 28-29, 39. The effect of this dramatic increase in litigation costs resulted in an increase

in the costs of medical-malpractice insurance state-wide, which, in turn, had the unprecedented effect of causing medical-malpractice insurers and practitioners to leave the state. Section 3(A)(3)(c), Am.Sub.S.B. No. 281 (R.C. 2305.113 and 2323.43, uncodifed law), Appx. at 29, 39. "Some health care practitioners, including a large number of specialists, have been forced out of the practice of medicine altogether as a consequence." Id.

The General Assembly enacted S.B. 281 to confront this crisis and stabilize the continued availability and cost of health-care delivery. Effective April 11, 2003, the legislation's express purpose is to strike a balance between a patient's to seek legal redress for medical malpractice while at the same time "stem the exodus of medical malpractice insurers from the Ohio market" and "ensure the availability of quality health care" for Ohio citizens. Section 3(B), Am.Sub.S.B. No. 281 (R.C. 2305.113 and 2323.43, uncodifed law), Appx. at 30-31, 40. The General Assembly sought to achieve this balance by amending or enacting several statutes: R.C. 2305.11, 2305.113, and 2323.43, among others.

1. S.B. 281 amends R.C. 2305.11 and codifies R.C. 2305.113(E).

Before S.B. 281, R.C. 2305.11 set forth the statutes of limitations that applied to claims for "malpractice" and "medical claims." A claim for malpractice based on a "medical claim" was to be—as it still is—commenced within one year after a cause of action accrued. Former R.C. 2305.11(B), Appx. at 44; cf. R.C. 2305.113(A), Appx. at 25.

Section (D)(3) of the former statute also contained a definition for "medical claim." This section provided:

> "Medical claim" means any claim that is asserted in any civil action against a physician, podiatrist, or hospital, against any employee or agent of a physician, podiatrist or hospital, or against a registered nurse or physical therapist, and that arises out of the medical diagnosis, care, or treatment of any person. Medical claim

> includes derivative claims for relief that arise from the medical diagnosis, care or treatment of a person.

Former R.C. 2305.11(D)(3), Appx. at 45.

In passing S.B. 281, the General Assembly repealed all of the statutory provisions contained in R.C. 2305.11 that concerned "medical claims" and reenacted them in R.C. 2305.113, a brand new statute that in relevant part provides:

> Except as otherwise provided in this section, an action upon a medical *** claim shall be commenced within one year after the cause of action accrued.

R.C. 2305.113(A), Appx. at 25.

The new definition for "medical claim" is set forth at R.C. 2305.113(E)(3), which provides:

> [A]ny claim that is asserted in any civil action against a physician, podiatrist, hospital, home, or residential facility, against any employee or agent of a physician, podiatrist, hospital, home or residential facility, or against a licensed practical nurse, registered nurse, advanced practice nurse, physical therapist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, emergency medical technician-paramedic, and that arises out of the medical diagnosis, care, or treatment of any person. 'Medical claims' include the following:
>
> (a) Derivative claims for relief that arise from the medical diagnosis, care, or treatment of a person;
>
> (b) Claims that arise out of the medical diagnosis, care or treatment of any person and to which either of the following applies:
>
> (i) The claim results from acts or omissions in providing medical care.
>
> (ii) The claim results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment.

> (c) Claims that arise out of the medical diagnosis, care, or treatment of any person and that are brought under section 3721.17 of the Revised Code.

R.C. 2305.113(E)(3), Appx. at 26.

In enacting R.C. 2305.113, the General Assembly removed all reference to the word "malpractice," a term that previously limited this Court's construction of the statute, and expanded the definition of "medical claim" to "include" those claims that can be defined under subsections (b) and (c).

2. S.B. 281 codifies R.C. 2323.43, which applies to "medical claims."

To effectuate its express purpose, the General Assembly also codified R.C. 2323.43 when it enacted S.B. 281. This statute limits non-economic damages that a plaintiff asserting a medical claim can recover to "the greater of two-hundred fifty thousand dollars, or three times the plaintiff's economic loss to a maximum of five hundred thousand dollars." R.C. 2323.43(A)(2), Appx. at 36. If the plaintiff sustains a catastrophic injury, such as the loss of the use of a limb, the limit is much higher—one million dollars per occurrence. R.C. 2323.43(A)(3), Appx. at 36. It was the General Assembly's intent to strike a balance between a patient's right to seek legal recourse for medical negligence and a health-care provider's ability to continue to provide affordable health care. See Section 3(B), Am.Sub.S.B. No. 281 (R.C. 2323.43, uncodifed law), Appx. at 41.

B. Plaintiff Betty Stevic sues FMC Dialysis for injuries allegedly sustained while her husband was receiving a kidney dialysis treatment.

FMC Dialysis is a free-standing kidney dialysis center in Mansfield, Ohio. Am. Compl. at ¶3, 6, Supp. at 7. On October 4, 2003—six months after the enactment of S.B. 281—Donald Stevic was seen at FMC Dialysis for his scheduled dialysis treatment. Confined to a wheelchair,

he required the use of a "Hoyer" lift[1] to be transferred from his wheelchair to the dialysis treatment chair. Id. at ¶9-15, Supp. at 7-8. Donald Stevic allegedly fell from the lift while being transferred. Id. He died several months later from unrelated causes.

Almost two years later—on October 3, 2005—Donald Stevic's wife Betty Stevic—in her individual capacity and as executor of his estate—filed a two-count complaint alleging that FMC Dialysis employees acted negligently as they positioned her husband for dialysis. Compl., Supp. at 2-5. She alleged that FMC Dialysis "employees or persons under their control" failed to (1) "secure the decedent safely and properly in the Hoyer device"; (2) "ensure the safety of the [decedent] during the transfer process"; (3) "supervise and properly see that decedent was transferred safely using the Hoyer device into a proper position for dialysis"; (4) "properly apply the harness straps and other parts of the Hoyer lift before raising decedent from his wheelchair." Compl. at ¶9-12, Supp. at 3. The complaint included a claim for loss of consortium. Id. at ¶21-22, Supp. at 4. Stevic filed an amended complaint the next day—on October 4, 2005—to correct a clerical error. All material allegations, however, remained unchanged. See, generally, Am. Compl., Supp. at 6-9.

FMC Dialysis answered Stevic's amended complaint. It admitted that Donald Stevic was a dialysis patient and that he had received dialysis treatment on October 4, 2003, but denied any negligence. Answer, ¶3, Supp. at 10. FMC Dialysis also asserted that Stevic's claims were "barred by the applicable statute of limitations." Id. at ¶24, Supp. at 12.

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[1] A Hoyer lift is a type of mechanical device used to lift and transfer patients with limited, physical mobility.

1. The trial court grants FMC Dialysis judgment on the pleadings.

Because Stevic's claims arose out of medical care or treatment of a person, FMC Dialysis argued in a subsequently-filed motion for judgment on the pleadings that Stevic's claims presented a "medical claim" under *Rome v. Flower Mem. Hosp.* (1994), 70 Ohio St. 3d 14. Defs.' Mot. for Judgment on the Pleadings, Supp. at 16; see, also, Civ.R. 12(C), Appx. at 15. FMC Dialysis argued that, when the General Assembly amended R.C. 2305.11 and codified R.C. 2305.113 as part of S.B. 281, it understood that "modern medical care is delivered at a wide variety of outpatient and/or specialty clinics." Id., Supp. at 27. As such, the broad language used at section (E)(3)(b) emphasized the *types* of services delivered and received (i.e., medical care) and not the *place* where medical care is delivered. Id., Supp. at 27-28. Thus, because Stevic had alleged that the Donald Stevic's injuries occurred as a result of acts or omissions in providing medical care, any claim against FMC Dialysis was barred by the one-year limitations period, which had expired on October 4, 2004. Id., Supp. at 29.

Stevic argued in response that a kidney dialysis center is not a specifically-listed health-care provider under R.C. 2305.113(E)(3), and further that is unknown if any of employees of FMC Dialysis are any of the enumerated health-care providers. Mem. in Opp., Supp. at 52-54.

The trial court granted FMC Dialysis judgment on the pleadings without an opinion. See 10/16/06 J. Entry, Appx. at 14.

2. The Fifth Appellate District reverses.

In a two-to-one decision, the Fifth Appellate District reversed. See 1/8/08 Op., Appx. at 4. It concluded that there was insufficient information on the face of the complaint to determine whether Stevic's claim was a "medical claim." Id. at ¶20, 22-23, Appx. at 9, 10-11. In reaching this conclusion, however, the majority looked only at R.C. 2305.113(E)(3)—without regard to

subsection (b) of R.C. 2305.113(E)(3), and held that it "must look to whether [FMC Dialysis] falls under the categories designated in R.C. 2305.113(E)." Id. at ¶18, Appx. at 8. It found that Stevic did not assert any claims against any of the enumerated individuals or against a home or residential facility. Id. Nor was it clear from the face of the amended complaint whether FMC Dialysis satisfied the definition of "hospital." Id. at ¶20, Appx. at 9. In the end, the majority concluded that it was "unclear from the complaint whether [FMC Dialysis'] employees were any of the types of persons identified in R.C. 2305.113(E)(3)" and found that the trial court erred in granting judgment on the pleadings. Id. at ¶23, Appx. at 11.

The dissenting judge disagreed. She found that Donald Stevic's alleged fall from the Hoyer lift during the course of kidney dialysis treatment was within the clear and unambiguous definition of "medical claim" under R.C. 2305.113(E)(3). Id. at ¶27, Appx. at 12.

II. LAW AND ARGUMENT

Proposition of Law

> **Under R.C. 2305.113(E)(3)(b), medical claims include claims that arise out of the medical diagnosis, care or treatment of any person and results from acts or omissions in providing medical care, or results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment. R.C. 2305.113(E)(3)(b) does not require claims to be filed against one of the classes or categories of individuals or entities identified in R.C. 2305.113(E)(3) to be considered a "medical claim."**

A. R.C. 2305.113(E)(3)(b) is clear and unambiguous and must be applied as written.

This Court has held on numerous occasions that "if the meaning of the statute is clear on its face, it must be applied as written." *Lake Hosp. Sys., Inc. v. Ohio Ins. Guar. Assn.* (1994), 69 Ohio St.3d 521, 524, citing, *Provident Bank v. Wood* (1973), 36 Ohio St.2d 101. This is so because a clearly-written statute "expresses plainly, clearly and distinctly, the sense of the law-

making body." *State v. Hairston*, 101 Ohio St.3d 308, 2004-Ohio-969, at ¶11. "To construe or interpret what is already plain is not interpretation but legislation, which is not the function of the courts." *Lake Hosp. Sys., Inc.*, 69 Ohio St.3d at 524.

The definition of medical claim under R.C. 2305.113(E)(3)(b) plainly "includes" claims "that arise out of the medical diagnosis, care or treatment of any person *** [that] results from acts or omissions in providing medical care." R.C. 2305.113 (E)(3)(b), Appx. at 26. In applying these plain and unambiguous terms, this Court must do what the Fifth District failed to do—give effect to the term "include."

Under R.C. 1.42, words and phrases are to be read in context and "construed according to the rules of grammar and common usage." R.C. 1.42, Appx. at 18. The common meaning of "include" is "to take in or comprise as a part of a whole or group." See http://www.merriam-webster.com/dictionary/include. To "'[i]nclude' suggests the containment of something as a constituent, component, or subordinate part of a larger whole." Id.; see, also, The Merriam-Webster Dictionary (1997) 378. Thus, by "including" subsection (b) in R.C. 2305.113(E)(3), the General Assembly evidenced its intent to bring claims that "arise out of the medical diagnosis, care or treatment of any person *** [that] result from acts or omissions in providing medical care," or "from the hiring, training, supervision, retention or termination of caregivers providing medical diagnosis, care, or treatment" within the larger group of claims known as "medical claims."

There is nothing in the plain language of R.C. 2305.113(E)(3)(b) that is ambiguous. Nor is there any language that requires a claim that meets either of the express requirements in (i) or (ii) to be filed against one of the categories enumerated in R.C. 2305.113(E)(3). Instead, the Fifth District simply read the statute as if subsection (b) did not exist. But a court cannot delete

words, or treat any part of the statute as superfluous. *Judy v. Ohio Bur. of Motor Vehicles*, 100 Ohio St.3d 122, 2003-Ohio-5277, at ¶19. As the Tenth Appellate District explained:

> [S]tatutory language must be construed as a whole and given such interpretation as will give effect to every word and clause in it. No part should be treated as superfluous unless that is manifestly required, and the court should avoid that construction which renders a provision meaningless or inoperative.

Penrod v. Ohio Dept. of Adm. Serv., 10th Dist. No. 04AP-1118, 2005-Ohio-5836, ¶13, citing *State ex rel. Myers v. Spencer Twp. Rural School Dist. Bd. of Edn.* (1917), 95 Ohio St. 367, 372-373.

For this Court to affirm the Fifth District's opinion, it would have to do as the Fifth District did and delete the word "include" from operation of the statute, or add words that are not there to limit categories of health-care providers that the statute plainly does not. In short, to uphold the Fifth District would completely eviscerate subsection (b) and render it meaningless.

1. A narrow construction of "medical claim" would result in an absurdity.

Any construction of "medical claim" as defined by R.C. 2305.113(E)(3)(b) also must be in keeping with the maxim that statutory construction cannot result in an absurdity. See *State ex rel. Ohio Gen. Assembly v. Brunner*, 114 Ohio St.3d 386, 2007-Ohio-3780, at ¶114. ("It is a cardinal rule of statutory construction that a statute should not be interpreted to yield an absurd result"). Yet, to adopt the Fifth District's reasoning would cause absurdities in the uniform administration of tort-reform legislation.

There are various types of health-care providers that are not "specifically enumerated" in R.C. 2305.113(E)(3), such as home health care agencies, visiting nurse services, freestanding dialysis centers, vision centers, dental centers, and mobile x-ray centers to name a few. See, generally, R.C. 2305.113(E)(3), Appx. at 26. There is no dispute that these entities employ

various health-care providers, including doctors, nurses, nurses' aides, assistants, and technicians who provide medical diagnosis, care, or treatment that can potentially result in a claim for negligence. An absurdity results when these providers are able to avail themselves of tort-reform protections—such as the one-year statute of limitations and caps on non-economic damages—for care rendered by providers in the enumerated categories, but not for care by non-enumerated providers, such as aides or technicians.

For instance, consider the situation in which a visiting nurse agency sends a state-tested nursing assistant (STNA) to the home of "Patient A," an elderly patient with a spine injury. During a bed bath, the STNA improperly turns the patient, aggravating the spinal injury and causing permanent paralysis of the patient's lower extremities. Under the Fifth District's reasoning, Patient A has a claim for bodily injury (with a two-year statute of limitations under R.C. 2305.10) against the visiting nurse agency and the potential for unlimited damage recovery[2] simply because neither the visiting nurse agency nor the STNA fall within one of the enumerated categories in R.C. 2305.113(E)(3). See R.C. 2305.113(E)(3), Appx. at 26; see, also R.C. 2305.10, Appx. at 19.

Patient B, however, has the same injury as patient A, but this time, the same visiting nurse agency dispatches a nurse to perform the patient's bed bath. Just like the STNA, the nurse improperly turns the patient aggravating the spinal injury that results in permanent paralysis. Now, the claim against the visiting nurse agency—under the Fifth District's reasoning—presents a medical claim with a one-year statute of limitations period and limited non-economic damages;

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[2] Under R.C. 2315.18(B)(3)(a) or (b), a patient who sustains a catastrophic injury is not subject to any limitation on non-economic damages. R.C. 2315.18(B)(3), Appx. at 34. This Court upheld the constitutionality of R.C. 2315.18 against a facial challenge in *Arbino v. Johnson & Johnson*, 116 Ohio St.3d 468, 2007-Ohio-6948, at ¶8, 40.

not because treatment differed, but because the nurse whose actions occasioned the injury falls within one of the categories enumerated in R.C. 2305.113(E)(3). Id.

More absurd is the situation in which an enumerated category member and non-enumerated category member both were negligent. For example, imagine the visiting nurse agency employing both a nurse and an STNA who work together to turn a patient. As a result of the combined efforts of both, the patient sustains a catastrophic injury. Two years after sustaining injury, the patient files a claim against the visiting nurse agency. Although the claim against the visiting nurse agency would be barred by the one-year statute of limitations for medical claims based upon the nurse's actions, using the Fifth District's reasoning, the plaintiff still could proceed against the visiting nurse agency based upon the actions of the nurse's aide-and possibly gain greater damages. Thus, the visiting nurse agency still loses its tort-reform protection. The General Assembly did not intend this absurd result.

Yet, this is precisely what is happening in the Fifth District. See *Sliger v. Stark Cty. Visiting Nurses Serv. & Hospice,* 5th Dist. No. 2005CA00207, 2006-Ohio-852 (*Sliger I*). At issue in *Sliger I* was whether the plaintiff's claim presented a medical claim as defined in R.C. 2305.113 or a claim for bodily injury. If it was a claim for bodily injury, the two-year statute of limitations applied (and arguably the potential for unlimited damages as permitted in R.C. 2315.18). Id. at ¶14. The plaintiff alleged that an employee of the Stark County Visiting Nurse Service (VNS) was negligent in the manner in which she performed a post-operative dressing change. Id. at ¶12. The plaintiff did not allege, however, that the employee was within one of the enumerated categories in R.C. 2305.113(E)(3). Id. Nevertheless, the VNS moved for summary judgment arguing that the complaint was barred by the one-year statute of limitations for medical claims. Id. at ¶3. The trial court agreed and granted summary judgment.

On appeal, the plaintiff argued that her complaint did not present a medical claim because the VNS was not one of the specifically-enumerated categories of medical providers contained in R.C. 2305.113(E)(3). Id. at ¶10. The Fifth District agreed to the extent that the VNS would be liable under the theory of respondeat superior for the care rendered by its employees. Id. at ¶14. Thus, if a nurse performed the allegedly negligent dressing change (which the Fifth District held as a matter of law constituted "medical treatment"), the plaintiff's complaint was barred as a medical claim. Id. at ¶13. But, since the record did not disclose whether the negligent employee was a "licensed practical nurse, registered nurse, advanced practice nurse, physical therapist, [or] physician assistant," the Fifth District concluded that summary judgment was premature. Id. at ¶15. Regardless of whether the plaintiff's complaint "arose from acts or omissions in providing medical care," and without regard to the definition of "medical claim" as set forth in R.C. 2305.113(E)(3)(b), the Fifth District held that the plaintiff's complaint would only present "a medical claim" if the care was rendered by one of the specifically-enumerated health-care providers in R.C. 2305.113(E)(3). Id. at ¶15.

On remand, the VNS produced an affidavit from the employee who performed the dressing change as proof that she was a registered nurse. See *Sliger v. Stark Cty. Visiting Nurses Serv. & Hospice*, 5th Dist. No. 2006-CA-00202, 2007-Ohio-645, at ¶9. The plaintiff nonetheless still argued that her claim was not a medical claim because the VNS is not one of the specifically-enumerated categories listed in R.C. 2305.113(E)(3). This time, however, the Fifth District held that, under the doctrine of respondeat superior, a corporation is liable for the negligent acts of its employees, and since the negligent employee was one of the persons enumerated in R.C. 2305.113(E)(3), the claim against the VNS constituted a medical claim. Id. at ¶8.

The Fifth District was unconcerned that *Sliger I* unquestionably arose from acts or omissions that occurred while providing medical care. It plainly ignored the statute's broad definition of "medical claim" and, instead, looked only at the first part of the statutory definition and found it categorically limited. To the Fifth District, if the allegedly negligent VNS employee would not have been within one of the specifically-enumerated categories, it would have denied the VNS the very tort-reform protections that the General Assembly enacted—protections that were enacted to ensure the continued quality and affordability of health-care services.

The Fifth District's reasoning is equally absurd here. As pleaded, Donald Stevic was allegedly injured during a procedure that was "ancillary to and inherently necessary" to the care and treatment of his kidney disease. Under *Rome*, Stevic's amended complaint presents a medical claim. But, under the Fifth District's reasoning, it does not matter how Donald Stevic was injured. To the Fifth District, Stevic only asserts a medical claim if (1) a nurse or other specifically-enumerated health-care provider caused the injury; or (2) FMC Dialysis qualifies as a "hospital." Under either scenario, FMC Dialysis would be entitled to the one-year statute for medical claims and accompanying limitations on damages. If, however, a dialysis technician was responsible for transferring Donald Stevic using the Hoyer lift, then the claim—at least according to the Fifth District—is one for bodily injury, and not a medical claim.

Thus, a dialysis center like FMC Dialysis here—a center that provides life-saving medical care—is only afforded tort reform protection if its nurses (or other specifically-enumerated health-care providers)—not dialysis technicians—cause a medical injury. As such, it potentially remains subject to unlimited damage exposure and a longer limitations period despite the fact that the costs and availability of medical care are the same under either scenario.

See Section 3(A)(3), Am.Sub.S.B. No. 281 (R.C. 2305.113 and 2323.43, uncodifed law), Appx. at 29, 39-40.

2. The definition of medical claim in R.C. 2305.113(E) is statutorily different from the common law meaning of "malpractice."

This Court is not constrained by its prior decisions to construe R.C. 2305.113(E)(3)(b) narrowly. Over the last thirty-plus years, the General Assembly has had to redefine what constitutes a "medical claim" to bring causes of action against various health-care providers that arose from acts and omissions in providing medical diagnosis, care or treatment within the one-year statute of limitations. Until the enactment of S.B. 281, however, the operative limitation provision—former R.C. 2305.11(A)—always contained the term "malpractice," which at common law referred only to attorneys and physicians. See *Richardson v. Doe* (1964), 176 Ohio St. 370, 372-73. The legislature's use of the term "malpractice" constrained this Court from expanding the definition of "medical claim" beyond its common-law meaning unless the General Assembly specifically enumerated a given health-care provider within the statute.

In *Lombardi v. Good Samaritan Medical Center* (1982), 69 Ohio St.2d, 471, for example, the defendants argued for an expansive meaning of the term "medical claim" to include hospital employees such as nurses and laboratory technicians. Because former R.C. 2305.11(A) referred to "malpractice," however, this Court declined to extend the definition of medical claim beyond the class of individuals expressly enumerated, stating:

> The term malpractice has a limited definition. Today, the term, malpractice, is sometimes used loosely to refer to the negligence of a member of any professional group. *However, legally and technically, it is still subject to the limited common law definition.* (Emphasis added.)

Id. at 473. Because "the operative limitation provision of R.C. 2305.11(A)" expressly mentioned malpractice, this Court was constrained in its ability to expand the definition of "medical claims"

to include other professionals without some indication from the legislature that it meant to broaden the definition. Id. at 474.

But, when the General Assembly amended R.C. 2305.11(A) as part of S.B. 281, it excluded "medical claims" from malpractice actions. R.C. 2305.11(A), Appx. at 23. Instead, the General Assembly enacted R.C. 2305.113, an entirely new statute that sets forth not only the statute of limitation that applies to medical claims, but the definition of "medical claim." R.C. 2305.113(E)(3), Appx. at 26. Because the term "malpractice" is removed from the statutory text,[3] this Court is no longer constrained to construe the definition of medical claim in accordance with common-law.

Not only did the General Assembly remove the last vestiges of common-law malpractice from the definition of "medical claim," it also "expanded the definition" of "medical claim" by expressly including subsection (b) and (c) in R.C. 2305.113. This action is exactly what this Court recommended to the General Assembly in *Whitt v. Columbus Coop. Ent.* (1980), 64 Ohio St.2d 355. In *Whitt*, the plaintiff filed a negligence action against her optometrists and their professional corporation for the failure to diagnose a detached retina. The defendants moved to

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[3] FMC Dialysis acknowledges that the world "malpractice" is included in the title of the R.C. 2305.113, but the title, chapter, and section headings do not constitute any part of the law as contained in the revised code. See R.C. 1.01, Appx. at 17. As noted by now-retired Justice Resnick in *Cosgrove v. Williamsburg of Cincinnati Mgt. Co., Inc.* (1994), 70 Ohio St.3d 281, 286:

> [H]eadings are publisher's aids to the user of the code. [They are not] part of the code; [they are not] official. In Ohio, the General Assembly does not assign official Revised Code headings, or taglines; they are written by the Publisher's editorial staff *** .

Id. at 286 (Resnick, J., concurring). Thus, the mere reference to "malpractice" in the heading is of no import to this appeal.

dismiss, arguing that the plaintiff failed to file her claim within the one-year statute of limitations for "malpractice" as set forth in then-applicable R.C. 2305.11(A). Id. at 356.

The trial court dismissed the action. The Tenth Appellate District affirmed the trial court's decision with respect to the optometrists, but reversed as to the professional corporation. Finding its decision in conflict with *Ruble v. Nupuf* (Feb. 14, 1979), Stark App. No. 4934, the appellate court certified the record to this Court. The sole issue before this Court was whether negligence by an optometrist constituted "malpractice" within the meaning of R.C. 2305.11(A)." Id. at 356-357.

This Court held that, despite the 1975 and 1976 amendments, the General Assembly retained the term "malpractice" in R.C. 2305.11(A), and therefore, "the statute of limitations is limited to the areas specifically enumerated therein and to the common-law definition." Id. at 358. In reaching this conclusion, this Court explained:

> If the General Assembly has wished to protect groups which are not traditionally associated with malpractice *** it would have listed them under R.C. 2305.11(A) *** or included them in an expanded definition of physician under R.C. 2305.11(D).

Id. at 358.

In passing S.B. 281, and enacting R.C. 2305.113, the General Assembly responded to this Court's instruction to "expand the definition" of "medical claim" by "including" claims against health-care providers that previously had not been protected. As a result, a claim is a "medical claim" within the meaning of R.C. 2305.113(E)(3)(b) when it "arise[s] out of the medical diagnosis, care or treatment of any person and *** either *** (i) *** results from acts or omissions in providing medical care" or (ii) *** results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment." R.C.

2305.113E)(3)(b), Appx. at 26. No prior constraints preclude this Court from applying this statute as it is plainly written.

3. Ejusdem generis does not restrict the definition of "medical claim."

Ejusdem generis is a principle of statutory construction that applies when terms in a statute "are first *** confined to a particular class of objects having well-known and definite features and characteristics, and then afterwards 'a term' having perhaps a broader signification is conjoined." *State v. Aspell* (1967), 10 Ohio St.2d 1, paragraph two of the syllabus.

Ejusdem generis does not apply here. The enumerated categories do not share any well-known and defining features, nor are they followed by any "conjoining" terms that limit the broadly-defined "medical claim" to the specifically-enumerated categories of health-care providers. To the contrary, the broadly-inclusive "medical claim" definition is its own sentence and begins "Medical claims include *** " and each subsequent subsection is a separate statutory provision that is not conjoined in any manner to the specifically-enumerated categories of health-care providers. Ejusdem generis simply does not apply.

4. The goal of statutory construction is to effectuate legislative intent.

Even if this Court determines that the plain language of R.C. 2305.113(E)(3)(b) is ambiguous, it should refer to the legislative history of S.B. 281 to ascertain the General Assembly's reason for enacting R.C. 2305.113(E)(3). See *Family Medicine Found, Inc. v. Bright*, 96 Ohio St.3d 183, 2002-Ohio-4034, at ¶9. In determining intent, the "court may consider a host of factors, including the object sought to be attained by the statute." Id.

The objective behind S.B. 281 could not be any clearer. The General Assembly recognized that medical malpractice litigation and awards exceeding one million dollars increased the cost of health care and the cost of insurance premiums paid by health-care

providers, which in turn threatened the availability and affordability of health care in Ohio. See Section 3(A)(1), Am.Sub.S.B. No. 281 (R.C. 2305.113 and 2323.43, uncodifed law), Appx. at 28, 39. The General Assembly enacted S.B. 281 to strike a proper balance in stabilizing the cost of health care and insurance premiums, while at the same time allowing plaintiffs to "hold negligent health care providers" accountable for their actions. Section 3(B), Am.Sub.S.B. No. 281 (R.C. 2305.113 and 2323.43, uncodifed law), Appx. at 30-31, 41.

One of the steps the General Assembly took towards achieving this objective was to limit the time in which a plaintiff has to file a medical claim. The General Assembly determined that the availability of relevant evidence pertaining to an incident deteriorates over time, as does the availability of witnesses knowledgeable about the plaintiff's diagnosis, care or treatment. Id. at Section 3(A)(6)(b), Am.Sub.S.B. No. 281 (R.C. 2305.113 and 2323.43, uncodifed law), Appx. at 30, 40. Like hospitals, health-care providers such as dialysis centers are burdened by the need to maintain records for long periods of time. Id. at Section 3(A)(6)(c), Am.Sub.S.B. No. 281 (R.C. 2305.113 and 2323.43, uncodifed law), Appx. at 30, 40. A one-year statute of limitations for medical claims addresses these issues and advances the General Assembly's balance-of-interests objective.

The General Assembly also achieved this objective by enacting R.C. 2323.43, which limits the amount of non-economic damages that a plaintiff asserting a "medical claim" can recover. See R.C. 2323.43, Appx. at 36-43. As of April 2003, the amount of non-economic damages a plaintiff asserting a medical claim can recover is limited to "the greater of two hundred fifty thousand dollars, or three times the plaintiff's economic loss to a maximum of five hundred thousand dollars." Id. If the plaintiff sustains a catastrophic injury, however, the plaintiff may recover as much as one million dollars in non-economic damages. Id. Claims for

non-catastrophic bodily injury not occasioned by medical negligence are subject to limitations on damages as well, but claims for catastrophic bodily injury are not subject to any limit on non-economic damages. See R.C. 2315.18(B)(3), Appx. at 34. Thus, the potential exposure for catastrophic injuries in a claim for bodily injury far exceeds that available in a medical claim. As such, a health-care provider that is not protected by tort reform remains subject to unlimited financial exposure and its attendant consequences of increased health-care costs, increased insurance premiums, and decreased affordability and availability of health-care services.

Any construction of R.C. 2305.113(E)(3) that attempts to narrow the definition of a "medical claim" thwarts the legislature's objectives by destroying the ability of health-care providers—especially facilities or entities that employ health-care providers not specifically enumerated in the statute—to avail themselves of tort reform protections, including the one-year limitations period in R.C. 2305.113(A) and the damage caps in R.C. 2323.43, when those claims involve negligent medical diagnosis, care, or treatment. The reasons for imposing time and non-economic damages limitations have nothing to do with the category of providers who allegedly commit a negligent act and everything to do with protecting the availability and affordability of health care. If health-care providers are not afforded the protection of the one-year limitations period or statutory limits on damages simply because it is not specifically mentioned in R.C. 2305.113(E)(3), then there is a negative impact upon that health-care provider's ability to continue to provide affordable health-care services and secure reasonable insurance premiums. Neither health-care providers nor their patients will realize the laudable benefits of tort reform—affordable health care and stable insurance premiums.

The General Assembly enacted S.B. 281 because it had good reason to believe it to be a necessary step in limiting the deleterious effects that malpractice litigation and excessive jury

verdicts have on the cost and continued availability of much-needed health-care services. If this Court construes R.C. 2305.113(E)(3)(b) as requiring a medical claim to be filed against one of the specifically-enumerated categories of health-care providers listed in R.C. 2305.113(E)(3), then it will thwart the very goals of tort reform legislation. By enacting R.C. 2305.113(E)(3)(b), the General Assembly provided a means to protect *all* health-care providers providing medical care or treatment. To decide otherwise is to read R.C. 2305.113(E)(3)(b) out of the statute.

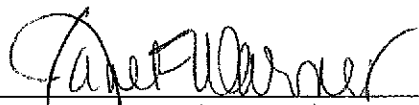
III. CONCLUSION

R.C. 2305.113(E)(3)(b) plainly and unambiguously broadens the definition of "medical claim" to include claims that arise from acts and omissions in providing medical care, or from the hiring, training, supervision, or retention of caregivers who provide medical diagnosis, care, or treatment of any person. Nothing in the plain language requires a claim meeting either of theses express requirements to be filed against one of the specifically-enumerated categories of health-care providers listed in R.C. 2305.113(E)(3). For this Court to conclude otherwise, would violate well-established principles of statutory construction and render subsection (b) entirely meaningless.

Appellant Bio-Medical Applications of Ohio, Inc. d/b/a FMC Dialysis Services of Richland County respectfully asks this Court to reverse the decision by the Fifth Appellate

District and reinstate the order of the trial court granting judgment on the pleadings because Appellee Betty Stevic's failure to file her medical claim within the one-year statute of limitations.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing has been served by regular U.S. Mail, postage prepaid, this 29th day of July, 2008, on the following:

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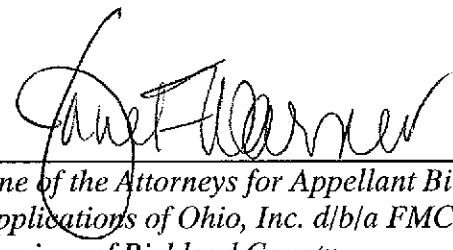

One of the Attorneys for Appellant Bio-Medical Applications of Ohio, Inc. d/b/a FMC Dialysis Services of Richland County

APPENDIX

No. 08-0392

IN THE SUPREME COURT OF OHIO

ESTATE OF DONALD R. STEVIC,
by Betty A. Stevic, Executrix,

Plaintiff-Appellee,

v.

BIO-MEDICAL APPLICATION OF OHIO, INC.,
d/b/a RICHLAND COUNTY DIALYSIS SERVICES, et al.

Defendant-Appellant

ON DISCRETIONARY APPEAL FROM THE
COURT OF APPEALS FOR RICHLAND COUNTY, OHIO,
FIFTH APPELLATE DISTRICT
CASE NO. 2006CA0095

NOTICE OF APPEAL OF APPELLANT BIO-MEDICAL APPLICATION OF OHIO, INC. d/b/a RICHLAND COUNTY DIALYSIS SERVICES, et al.

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NOTICE OF APPEAL OF BIO-MEDICAL APPLICATION OF OHIO, INC.

Appellant Bio-Medical Application of Ohio, Inc., hereby gives notice of appeal to the Supreme Court of Ohio from the judgment of the Richland County Court of Appeals, Fifth Appellate District, entered in Court of Appeals Case No. 2006-CA-0095, 2008-Ohio-33, entered January 7, 2008.

This case is one of public or great general interest.

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On February 20 2008, a copy of the foregoing Notice of Appeal was served by U.S. Mail, postage pre-paid, on the following:

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COURT OF APPEALS
RICHLAND COUNTY, OHIO
FIFTH APPELLATE DISTRICT

ESTATE OF DONALD R. STEVIC BY BETTY A. STEVIC, EXEC.	:	JUDGES:
	:	William B. Hoffman, P.J.
Plaintiff-Appellant	:	Sheila G. Farmer, J.
	:	Julie A. Edwards, J.
-vs-	:	
	:	Case No. 2006 CA 0095
BIO-MEDICAL APPLICATION OF OHIO, INC.	:	
Defendant-Appellee	:	OPINION

CHARACTER OF PROCEEDING: Civil Appeal From Richland County Court Of Common Pleas, Case No. 05CV1008

JUDGMENT: Reversed and Remanded

DATE OF JUDGMENT ENTRY:

APPEARANCES:

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Edwards, J.

{¶1} Plaintiff-appellant Betty A. Stevic, Executrix of the Estate of Donald Stevic, appeals from the October 16, 2006, Judgment Entry of the Richland County Court of Common Pleas granting the Motion for Judgment on the Pleadings filed by defendant-appellee Bio-Medical Application of Ohio, Inc., dba FMC Dialysis Services of Richland County.

STATEMENT OF THE FACTS AND CASE

{¶2} On October 4, 2003, Donald Stevic went to the Richland County Kidney Dialysis Center for dialysis treatment. While at the center, employees of the center dropped Donald Stevic [hereinafter "the decedent"] or otherwise allowed him to fall from a Hoyer lift, which is a mechanical lift device that was being used to move him into position for dialysis. As a result, the decedent suffered a fractured hip, abrasions and other injuries and, in February of 2004, died.

{¶3} Subsequently, on October 3, 2005, appellant Betty A. Stevic, as Executrix of the Estate of Donald Stevic, filed a complaint for personal injuries and other tort damages against appellant Bio-Medical Application of Ohio, Inc., dba FMC Dialysis Services of Richland County, which appellant alleged owned or operated the Kidney Dialysis Center.[1] The complaint set forth a survival claim and also a derivative claim for loss of consortium. A first amended complaint was filed on October 4, 2005.

{¶4} On August 14, 2006, appellee filed a Motion for Judgment on the Pleadings pursuant to Civ.R. 12(C). Appellee, in its motion, argued that appellant had failed to file her complaint within the one year statute of limitations set forth in R.C.

[1] While other defendants were named in appellant's complaint, they were voluntarily dismissed without prejudice on October 28, 2005.

2305.113 for medical claims. Appellant, in her memorandum in opposition, argued that the two year statute of limitations set forth in R.C. 2305.10 for bodily injury applied and that, therefore, the complaint was timely filed.

{¶5} Pursuant to a Judgment Entry filed on October 16, 2006, the trial court granted appellee's motion and dismissed appellant's complaint.

{¶6} Appellant now raises the following assignment of error on appeal:

{¶7} "THE TRIAL COURT COMMITTED REVERSIBLE ERROR IN GRANTING APPELLEE'S MOTION FOR JUDGMENT ON THE PLEADINGS."

I

{¶8} Appellant, in her sole assignment of error, argues that the trial court erred in granting appellee's Motion for Judgment on the Pleadings pursuant to Civ.R. 12(C). We agree.

{¶9} Motions for judgment on the pleadings are governed by Civ.R. 12(C), which states: "After the pleadings are closed but within such time as not to delay the trial, any party may move for judgment on the pleadings." Pursuant to Civ.R. 12(C), "dismissal is [only] appropriate where a court (1) construes the material allegations in the complaint, with all reasonable inferences to be drawn therefrom, in favor of the nonmoving party as true, and (2) finds beyond doubt that the plaintiff could prove no set of facts in support of his claim that would entitle him to relief." *State ex rel. Midwest Pride IV, Inc. v. Pontious,* 75 Ohio St.3d 565, 570, 1996-Ohio-459, 664 N.E.2d 931. The very nature of a Civ.R. 12(C) motion is specifically designed for resolving solely questions of law. *Peterson v. Teodosio* (1973), 34 Ohio St.2d 161, 166, 297 N.E.2d 113, 117. Reviewing courts will reverse a judgment on the pleadings if plaintiffs can prove

any set of facts that would entitle them to relief. *Flanagan v. Williams* (1993), 87 Ohio App.3d 768, 772, 623 N.E.2d 185, 188. The review will be done independent of the trial court's analysis to determine whether the moving party was entitled to judgment as a matter of law. Id.

{¶10} At issue in the case sub judice is whether appellant's complaint is barred by the one year statute of limitations for medical malpractice claims set forth in R.C. 2305.113(A). Appellant contends that the claims contained in the complaint are not medical malpractice claims because appellee does not qualify under any of the enumerated categories for medical providers contained in R.C. 2305.113(E)(3).

{¶11} R.C. 2305.113(A) states as follows: "...[A]n action upon a medical, dental, optometric, or chiropractic claim shall be commenced within one year after the cause of action accrued."

{¶12} In turn, R.C. 2305.113(E)(3) defines a "medical claim" as meaning "any claim that is asserted in any civil action against a physician, podiatrist, hospital, home, or residential facility, against any employee or agent of a physician, podiatrist, hospital, home, or residential facility, or against a licensed practical nurse, registered nurse, advanced practice nurse, physical therapist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, and that arises out of the medical diagnosis, care, or treatment of any person. 'Medical claim' includes the following:

{¶13} "(a) Derivative claims for relief that arise from the medical diagnosis, care, or treatment of a person;

{¶14} "(b) Claims that arise out of the medical diagnosis, care, or treatment of any person and to which either of the following applies:

{¶15} "(i) The claim results from acts or omissions in providing medical care.

{¶16} "(ii) The claim results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment.

{¶17} "(c) Claims that arise out of the medical diagnosis, care, or treatment of any person and that are brought under section 3721.17 of the Revised Code."

{¶18} As noted by this Court in *Sliger v. Stark Cty. Visiting Nurses Serv. & Hospice*, Stark App. No. 2005CA00207, 2006-Ohio-852, in order to determine whether appellant's claims are medical claims, we must look to whether appellee falls under the categories designated in R.C. 2305.113(E)(3). In the case sub judice, appellant, in her complaint, did not assert any claims against any individuals such as a physician or a podiatrist or any employee or agent of the same.[2] Nor did appellant assert any claims against a home or residential facility as such terms are defined in R.C. 2305.113. The issue thus becomes whether appellant asserted a medical claim against a hospital.

{¶19} R.C. 2305.113 states, in relevant part, as follows: "(E) As used in this section: (1) 'Hospital' includes any person, corporation, association, board, or authority that is responsible for the operation of any hospital licensed or registered in the state, including, but not limited to, those that are owned or operated by the state, political subdivisions, any person, any corporation, or any combination of the state, political subdivisions, persons, and corporations. 'Hospital' also includes any person,

[2] In *Johnson v. Ohio Dept. of Rehab. And Corr.*, Franklin App. No. 06AP-196, 2006-Ohio-6432, the Tenth District Court of Appeals looked only at the named defendant in determining whether or not the action constituted a medical claim and the one year statute of limitations for medical claims applied. In such case, the court held that the evidence did not support the trial court's determination that the ODRC was a hospital for purposes of former R.C. 2305.11(D)(1).

corporation, association, board, entity, or authority that is responsible for the operation of any clinic that employs a full-time staff of physicians practicing in more than one recognized medical specialty and rendering advice, diagnosis, care, and treatment to individuals. 'Hospital' does not include any hospital operated by the government of the United States or any of its branches."

{¶20} In the case sub judice, the complaint alleges that the decedent fell while he was being positioned for kidney dialysis treatment at the Richland County Kidney Center in Mansfield, Ohio. The complaint further alleges that appellee owns or operates the center where the decedent fell. It is unclear from the allegations in the complaint whether or not appellee falls within the definition of a "hospital". It is unclear whether or not appellee is a corporation and, if so, whether appellee "employs a full-time staff of physicians practicing in more than one recognized medical specialty and rendering advice, diagnosis, care, and treatment to individuals." See R.C. 2305.113(E)(1). Based on the foregoing, we cannot determine, based on the face of the complaint, whether appellant's claim is a medical malpractice claim or not.

{¶21} Even assuming, arguendo, that the trial court dismissed the complaint because it found the allegations of negligence made against the employees of Richland County Kidney Center constituted a medical claim governed by the one year statute of limitations, we do not agree with that dismissal. We do not agree with that dismissal even though we concede that an employer may not be held to be vicariously liable for the negligence of its employees or agents under the doctrine of respondeat superior, if the employee or agent cannot be liable due to the expiration of the statute of limitations. See *Comer v. Risko*, 106 Ohio St.3d 185, 2005-Ohio-4559, 833 N.E.2d 712. An

employer such as appellee is only secondarily liable if its employee is primarily liable. See *Comer*, supra. We also concede that the employee may not need to be a named party in the lawsuit against the employer. See *Comer*, supra. Thus, the issue becomes whether or not appellee's employees were primarily liable in this case. If appellee's employees cannot be held to be primarily liable because of the expiration of the statute of limitations, then appellee cannot be held secondarily liable under the theory of respondeat superior. See *Comer*, supra.

{¶22} In the case sub judice, appellant alleged in the complaint that appellee's employees were negligent in, among other matters, failing to secure the decedent in the Hoyer device, dropping the decedent or allowing him to fall, and failing to properly apply the harness straps and other parts of the Hoyer lift. However, it is unclear from the language in the complaint whether or not the employees were employees of a hospital or were nurses, physical therapists, physician assistants or emergency medical technicians. See R.C. 2305.113(E)(3). Nowhere in the complaint are the employees identified in any manner or by any title. If the employees are nurses, physical therapists, emergency medical technicians, or physicians assistants or employees of a hospital and, assuming that the activities they were involved in arise out of medical diagnosis care, or treatment, then appellant's claims against them are medical claims under R.C. 2305.113 and the one year statute of limitations set forth in R.C. 2305.113(A) applies. Because appellant's claims against such employees would be barred by the one year statue of limitations set forth in R.C. 2305.113(A), appellant's claim against appellee, as an employer of such employees, would fail because the

employer can only be secondarily liable if the employee can be primarily liable. See *Comer*, supra.

{¶23} However, because, as is stated above, it is unclear from the complaint whether appellee's employees were any of the types of persons identified in R.C. 2305.113(E)(3), we find that the trial court erred in granting appellant's Motion for Judgment on the Pleadings pursuant to Civ. R. 12(C).

{¶24} For the above reasons, we find that the trial court erred in granting appellant's Motion for Judgment on the Pleadings pursuant to Civ.R. 12(C).

{¶25} Appellant's sole assignment of error is, therefore, sustained.

{¶26} Accordingly, the judgment of the Richland County Court of Common Pleas is reversed and this matter is remanded to the trial court for further proceedings.

By: Edwards, J.

Hoffman, P.J. concurs and

Farmer, J. dissents

Julie A. Edwards

William B. Hoffman

JUDGES

JAE/0702

Farmer, J., dissenting

{¶27} I respectfully dissent from the majority's view that the one year statute of limitations does not apply sub judice. Based upon the clear and unambiguous language of R.C. 2305.113(E)(3), I would find the fall from the Hoyer lift during the course of treatment while at the Richland County Kidney Dialysis Center to be a medical claim.

{¶28} The incident arose out of and during the course of the decedent's medical treatment. Therefore, the one year statute of limitations requires a dismissal of appellant's claims.

{¶29} I would affirm the trial court's decision.

JUDGE SHEILA FARMER

IN THE COURT OF APPEALS FOR RICHLAND COUNTY, OHIO

FIFTH APPELLATE DISTRICT

ESTATE OF DONALD R. STEVIC BY BETTY A. STEVIC, EXEC. Plaintiff-Appellant	:	
-vs-	:	JUDGMENT ENTRY
BIO-MEDICAL APPLICATION OF OHIO, INC. Defendant-Appellee	:	CASE NO. 2006 CA 0095

For the reasons stated in our accompanying Memorandum-Opinion on file, the judgment of the Richland County Court of Common Pleas is reversed and this matter is remanded to the trial court for further proceedings. Costs assessed to appellee.

Julie A. Edwards

William B. Hoffman

JUDGES

4

COURT OF COMMON PLEAS
RICHLAND COUNTY, OHIO

BETTY A. STEVIC, Executrix of the Estate of Donald R. Stevic, et al.	)	CASE NO. 2005 CV 1008
Plaintiffs	)	JUDGE JAMES D. HENSON
v.	)	
BIO-MEDICAL APPLICATIONS OF OHIO, INC., et al.	)	PROPOSED JUDGMENT ENTRY
Defendants	)	

Defendant Bio-Medical Applications of Ohio, Inc. d/b/a Richland County Dialysis Services' Motion for Judgment on the Pleadings is hereby granted. Plaintiffs' Complaint is dismissed.

IT IS SO ORDERED.

JUDGE JAMES D. HENSON

1593480.1

cc: Jeffrey Ream
Jane Warner
Jeffrey VanWagner
Frank Benham

SERVED BY Deputy Clerk:_____

On the___day of_____, _____

Civ. R. Rule 12

RULES OF CIVIL PROCEDURE
Rules of Civil Procedure (Refs & Annos)
TITLE III. PLEADINGS AND MOTIONS
Title III. Pleadings and Motions

→Civ R 12 Defenses and objections--when and how presented--by pleading or motion--motion for judgment on the pleadings

(A) When answer presented

(1) Generally. The defendant shall serve his answer within twenty-eight days after service of the summons and complaint upon him; if service of notice has been made by publication, he shall serve his answer within twenty-eight days after the completion of service by publication.

(2) Other responses and motions. A party served with a pleading stating a cross-claim against him shall serve an answer thereto within twenty-eight days after the service upon him. The plaintiff shall serve his reply to a counterclaim in the answer within twenty-eight days after service of the answer or, if a reply is ordered by the court, within twenty-eight days after service of the order, unless the order otherwise directs. The service of a motion permitted under this rule alters these periods of time as follows, unless a different time is fixed by order of the court: (a) if the court denies the motion, a responsive pleading, delayed because of service of the motion, shall be served within fourteen days after notice of the court's action; (b) if the court grants a motion, a responsive pleading, delayed because of service of the motion, shall be served within fourteen days after service of the pleading which complies with the court's order.

(B) How presented

Every defense, in law or fact, to a claim for relief in any pleading, whether a claim, counterclaim, cross-claim, or third-party claim, shall be asserted in the responsive pleading thereto if one is required, except that the following defenses may at the option of the pleader be made by motion: (1) lack of jurisdiction over the subject matter, (2) lack of jurisdiction over the person, (3) improper venue, (4) insufficiency of process, (5) insufficiency of service of process, (6) failure to state a claim upon which relief can be granted, (7) failure to join a party under Rule 19 or Rule 19.1. A motion making any of these defenses shall be made before pleading if a further pleading is permitted. No defense or objection is waived by being joined with one or more other defenses or objections in a responsive pleading or motion. If a pleading sets forth a claim for relief to which the adverse party is not required to serve a responsive pleading, he may assert at the trial any defense in law or fact to that claim for relief. When a motion to dismiss for failure to state a claim upon which relief can be granted presents matters outside the pleading and such matters are not excluded by the court, the motion shall be treated as a motion for summary judgment and disposed of as provided in Rule 56. Provided however, that the court shall consider only such matters outside the pleadings as are specifically enumerated in Rule 56. All parties shall be given reasonable opportunity to present all materials made pertinent to such a motion by Rule 56.

(C) Motion for judgment on the pleadings

After the pleadings are closed but within such time as not to delay the trial, any party may move for judgment on the pleadings.

(D) Preliminary hearings

Civ. R. Rule 12

The defenses specifically enumerated (1) to (7) in subdivision (B) of this rule, whether made in a pleading or by motion, and the motion for judgment mentioned in subdivision (C) of this rule shall be heard and determined before trial on application of any party.

(E) Motion for definite statement

If a pleading to which a responsive pleading is permitted is so vague or ambiguous that a party cannot reasonably be required to frame a responsive pleading, he may move for a definite statement before interposing his responsive pleading. The motion shall point out the defects complained of and the details desired. If the motion is granted and the order of the court is not obeyed within fourteen days after notice of the order or within such other time as the court may fix, the court may strike the pleading to which the motion was directed or make such order as it deems just.

(F) Motion to strike

Upon motion made by a party before responding to a pleading, or if no responsive pleading is permitted by these rules, upon motion made by a party within twenty-eight days after the service of the pleading upon him or upon the court's own initiative at any time, the court may order stricken from any pleading any insufficient claim or defense or any redundant, immaterial, impertinent, or scandalous matter.

(G) Consolidation of defenses and objections

A party who makes a motion under this rule must join with it the other motions herein provided for and then available to him. If a party makes a motion under this rule and does not include therein all defenses and objections then available to him which this rule permits to be raised by motion, he shall not thereafter assert by motion or responsive pleading, any of the defenses or objections so omitted, except as provided in subdivision (H) of this rule.

(H) Waiver of defenses and objections

(1) A defense of lack of jurisdiction over the person, improper venue, insufficiency of process, or insufficiency of service of process is waived (a) if omitted from a motion in the circumstances described in subdivision (G), or (b) if it is neither made by motion under this rule nor included in a responsive pleading or an amendment thereof permitted by Rule 15(A) to be made as a matter of course.

(2) A defense of failure to state a claim upon which relief can be granted, a defense of failure to join a party indispensable under Rule 19, and an objection of failure to state a legal defense to a claim may be made in any pleading permitted or ordered under Rule 7(A), or by motion for judgment on the pleadings, or at the trial on the merits.

(3) Whenever it appears by suggestion of the parties or otherwise that the court lacks jurisdiction on the subject matter, the court shall dismiss the action.

(Adopted eff. 7-1-70; amended eff. 7-1-83)

Current with amendments received through 7/15/08

END OF DOCUMENT

R.C. § 1.01

Baldwin's Ohio Revised Code Annotated Currentness
General Provisions
Chapter 1. Definitions; Rules of Construction (Refs & Annos)
Definitions

→1.01 "Revised Code"

All statutes of a permanent and general nature of the state as revised and consolidated into general provisions, titles, chapters, and sections shall be known and designated as the "Revised Code," for which designation "R. C." may be substituted. Title, Chapter, and section headings and marginal General Code section numbers do not constitute any part of the law as contained in the "Revised Code."

The enactment of the Revised Code shall not be construed to affect a right or liability accrued or incurred under any section of the General Code prior to the effective date of such enactment, or an action or proceeding for the enforcement of such right or liability. Such enactment shall not be construed to relieve any person from punishment for an act committed in violation of any section of the General Code, nor to affect an indictment or prosecution therefor. For such purposes, any such section of the General Code shall continue in full force notwithstanding its repeal for the purpose of revision.

(1953 H 1, eff. 10-1-53)

R.C. § 1.01, OH ST § 1.01

Current through 2008 File 129 of the 127th GA (2007-2008), apv. by 7/24/08, and filed with the Secretary of State by 7/24/08.

END OF DOCUMENT

Baldwin's Ohio Revised Code Annotated Currentness
General Provisions
Chapter 1. Definitions; Rules of Construction (Refs & Annos)
Statutory Provisions (Refs & Annos)

➡1.42 Common and technical usage

Words and phrases shall be read in context and construed according to the rules of grammar and common usage. Words and phrases that have acquired a technical or particular meaning, whether by legislative definition or otherwise, shall be construed accordingly.

(1971 H 607, eff. 1-3-72)

R.C. § 1.42, OH ST § 1.42

Current through 2008 File 129 of the 127th GA (2007-2008), apv. by 7/24/08, and filed with the Secretary of State by 7/24/08.

END OF DOCUMENT

R.C. § 2305.10

BALDWIN'S OHIO REVISED CODE ANNOTATED
Baldwin's Ohio Revised Code Annotated Currentness
TITLE XXIII. COURTS--COMMON PLEAS
Title XXIII. Courts--Common Pleas
CHAPTER 2305. JURISDICTION; LIMITATION OF ACTIONS
Chapter 2305. Jurisdiction; Limitation of Actions (Refs & Annos)
LIMITATIONS--TORTS
Limitations--Torts

→2305.10 Product liability, bodily injury or injury to personal property; when certain causes of action arise

(A) Except as provided in division (C) or (E) of this section, an action based on a product liability claim and an action for bodily injury or injuring personal property shall be brought within two years after the cause of action accrues. Except as provided in divisions (B)(1), (2), (3), (4), and (5) of this section, a cause of action accrues under this division when the injury or loss to person or property occurs.

(B)(1) For purposes of division (A) of this section, a cause of action for bodily injury that is not described in division (B)(2), (3), (4), or (5) of this section and that is caused by exposure to hazardous or toxic chemicals, ethical drugs, or ethical medical devices accrues upon the date on which the plaintiff is informed by competent medical authority that the plaintiff has an injury that is related to the exposure, or upon the date on which by the exercise of reasonable diligence the plaintiff should have known that the plaintiff has an injury that is related to the exposure, whichever date occurs first.

(2) For purposes of division (A) of this section, a cause of action for bodily injury caused by exposure to chromium in any of its chemical forms accrues upon the date on which the plaintiff is informed by competent medical authority that the plaintiff has an injury that is related to the exposure, or upon the date on which by the exercise of reasonable diligence the plaintiff should have known that the plaintiff has an injury that is related to the exposure, whichever date occurs first.

(3) For purposes of division (A) of this section, a cause of action for bodily injury incurred by a veteran through exposure to chemical defoliants or herbicides or other causative agents, including agent orange, accrues upon the date on which the plaintiff is informed by competent medical authority that the plaintiff has an injury that is related to the exposure, or upon the date on which by the exercise of reasonable diligence the plaintiff should have known that the plaintiff has an injury that is related to the exposure, whichever date occurs first.

(4) For purposes of division (A) of this section, a cause of action for bodily injury caused by exposure to diethylstilbestrol or other nonsteroidal synthetic estrogens, including exposure before birth, accrues upon the date on which the plaintiff is informed by competent medical authority that the plaintiff has an injury that is related to the exposure, or upon the date on which by the exercise of reasonable diligence the plaintiff should have known that the plaintiff has an injury that is related to the exposure, whichever date occurs first.

(5) For purposes of division (A) of this section, a cause of action for bodily injury caused by exposure to asbestos accrues upon the date on which the plaintiff is informed by competent medical authority that the plaintiff has an injury that is related to the exposure, or upon the date on which by the exercise of reasonable diligence the plaintiff should have known that the plaintiff has an injury that is related to the exposure, whichever date occurs first.

(C)(1) Except as otherwise provided in divisions (C)(2), (3), (4), (5), (6), and (7) of this section or in section 2305.19 of the Revised Code, no cause of action based on a product liability claim shall accrue against the manufacturer or supplier of a product later than ten years from the date that the product was delivered to its first purchaser or first lessee who was not engaged in a business in which the product was used as a component in the production, construction, creation, assembly, or rebuilding of another product.

(2) Division (C)(1) of this section does not apply if the manufacturer or supplier of a product engaged in fraud in regard to information about the product and the fraud contributed to the harm that is alleged in a product liability claim involving that product.

(3) Division (C)(1) of this section does not bar an action based on a product liability claim against a manufacturer or supplier of a product who made an express, written warranty as to the safety of the product that was for a period longer than ten years and that, at the time of the accrual of the cause of action, has not expired in accordance with the terms of that warranty.

(4) If the cause of action relative to a product liability claim accrues during the ten-year period described in division (C)(1) of this section but less than two years prior to the expiration of that period, an action based on the product liability claim may be commenced within two years after the cause of action accrues.

(5) If a cause of action relative to a product liability claim accrues during the ten-year period described in division (C)(1) of this section and the claimant cannot commence an action during that period due to a disability described in section 2305.16 of the Revised Code, an action based on the product liability claim may be commenced within two years after the disability is removed.

(6) Division (C)(1) of this section does not bar an action for bodily injury caused by exposure to asbestos if the cause of action that is the basis of the action accrues upon the date on which the plaintiff is informed by competent medical authority that the plaintiff has an injury that is related to the exposure, or upon the date on which by the exercise of reasonable diligence the plaintiff should have known that the plaintiff has an injury that is related to the exposure, whichever date occurs first.

(7)(a) Division (C)(1) of this section does not bar an action based on a product liability claim against a manufacturer or supplier of a product if all of the following apply:

(i) The action is for bodily injury.

(ii) The product involved is a substance or device described in division (B)(1), (2), (3), or (4) of this section.

(iii) The bodily injury results from exposure to the product during the ten-year period described in division (C)(1) of this section.

(b) If division (C)(7)(a) of this section applies regarding an action, the cause of action accrues upon the date on which the claimant is informed by competent medical authority that the bodily injury was related to the exposure to the product, or upon the date on which by the exercise of reasonable diligence the claimant should have known that the bodily injury was related to the exposure to the product, whichever date occurs first. The action based on the product liability claim shall be commenced within two years after the cause of action accrues and shall not be commenced more than two years after the cause of action accrues.

(D) This section does not create a new cause of action or substantive legal right against any person involving a

product liability claim.

(E) An action brought by a victim of childhood sexual abuse asserting any claim resulting from childhood sexual abuse, as defined in section 2305.111 of the Revised Code, shall be brought as provided in division (C) of that section.

(F) As used in this section:

(1) "Agent orange," "causative agent," and "veteran" have the same meanings as in section 5903.21 of the Revised Code.

(2) "Ethical drug," "ethical medical device," "manufacturer," "product," "product liability claim," and "supplier" have the same meanings as in section 2307.71 of the Revised Code.

(3) "Harm" means injury, death, or loss to person or property.

Harm

(G) This section shall be considered to be purely remedial in operation and shall be applied in a remedial manner in any civil action commenced on or after April 7, 2005, in which this section is relevant, regardless of when the cause of action accrued and notwithstanding any other section of the Revised Code or prior rule of law of this state, but shall not be construed to apply to any civil action pending prior to April 7, 2005.

(2006 S 17, eff. 8-3-06;2004 S 80, eff. 4-7-05;2001 S 108, § 2.01, eff. 7-6-01;2001 S 108, § 2.02, eff. 7-6-01;1996 H 350, eff. 1-27-97 (See Historical and Statutory Notes); 1984 H 72, eff. 5-31-84; 1982 S 406; 1980 H 716; 1953 H 1; GC 11224-1)

UNCODIFIED LAW

2006 S 17, § 5, eff. 8-3-06, reads:

If any provision of a section of the Revised Code as amended or enacted by this act or the application of the provision to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the section or related sections that can be given effect without the invalid provision or application, and to this end the provisions are severable.

2004 S 80, § 3(B): See Uncodified Law under RC 2305.131.

2004 S 80, § 3(C): See Uncodified Law under RC 2305.09.

2001 S 108, § 1: See Uncodified Law under RC 2305.251.

2001 S 108, § 3, eff. 7-6-01, reads, in part:

(A) In Section 2.01 of this act:

(3) Sections 109.36, 2117.06, 2125.01, 2125.02, 2125.04, 2305.10, 2305.16, 2305.27, 2305.38, 2307.31, 2307.32, 2307.75, 2307.80, 2315.01, 2315.19, 2501.02, 2744.06, 3722.08, 4112.14, 4113.52, 4171.10, and 4399.18 of the

Revised Code are revived and amended, supersede the versions of the same sections that are repealed by Section 2.02 of this act, and include amendments that gender neutralize the language of the sections (as contemplated by section 1.31 of the Revised Code) and that correct apparent error.

R.C. § 2305.10, OH ST § 2305.10

Current through 2008 File 129 of the 127th GA (2007-2008), apv. by 7/24/08, and filed with the Secretary of State by 7/24/08.

END OF DOCUMENT

R.C. § 2305.11

Baldwin's Ohio Revised Code Annotated Currentness
Title XXIII. Courts--Common Pleas
Chapter 2305. Jurisdiction; Limitation of Actions (Refs & Annos)
Limitations--Miscellaneous

→2305.11 Time limitations for bringing certain actions

(A) An action for libel, slander, malicious prosecution, or false imprisonment, an action for malpractice other than an action upon a medical, dental, optometric, or chiropractic claim, or an action upon a statute for a penalty or forfeiture shall be commenced within one year after the cause of action accrued, provided that an action by an employee for the payment of unpaid minimum wages, unpaid overtime compensation, or liquidated damages by reason of the nonpayment of minimum wages or overtime compensation shall be commenced within two years after the cause of action accrued.

(B) A civil action for unlawful abortion pursuant to section 2919.12 of the Revised Code, a civil action authorized by division (H) of section 2317.56 of the Revised Code, a civil action pursuant to division (B)(1) or (2) of section 2307.51 of the Revised Code for performing a dilation and extraction procedure or attempting to perform a dilation and extraction procedure in violation of section 2919.15 of the Revised Code, and a civil action pursuant to division (B)(1) or (2) of section 2307.52 of the Revised Code for terminating or attempting to terminate a human pregnancy after viability in violation of division (A) or (B) of section 2919.17 of the Revised Code shall be commenced within one year after the performance or inducement of the abortion, within one year after the attempt to perform or induce the abortion in violation of division (A) or (B) of section 2919.17 of the Revised Code, within one year after the performance of the dilation and extraction procedure, or, in the case of a civil action pursuant to division (B)(2) of section 2307.51 of the Revised Code, within one year after the attempt to perform the dilation and extraction procedure.

(C) As used in this section, "medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

(2002 S 281, eff. 4-11-03;2002 H 412, eff. 11-7-02;2001 S 108, § 2.01, eff. 7-6-01;2001 S 108, § 2.02, eff. 7-6-01;1996 H 350, eff. 1-27-97 (See Historical and Statutory Notes); 1995 H 135, eff. 11-15-95; 1992 S 124, eff. 4-16-93;1991 H 108;1990 S 125, S 80; 1987 H 327; 1985 H 319; 1984 S 183; 1981 H 243; 1976 H 1426; 1975 H 682; 1974 H 989; 1953 H 1; GC 11225)

UNCODIFIED LAW

2002 S 281, § 6 through 8, eff. 4-11-03, read:

Section 6. (A) Sections 1751.67, 2117.06, 2305.11, 2305.15, 2305.234, 2317.02, 2317.54, 2323.56, 2711.21, 2711.22, 2711.23, 2711.24, 2743.02, 2743.43, 2919.16, 3923.63, 3923.64, 3929.71, and 5111.018 of the Revised Code, as amended by this act, and sections 2303.23, 2305.113, 2323.41, 2323.42, 2323.43, and 2323.55 of the Revised Code, as enacted by this act, apply to civil actions upon a medical claim, dental claim, optometric claim, or chiropractic claim in which the act or omission that constitutes the alleged basis of the claim occurs on or after the effective date of this act.

(B) As used in this section, "medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the

same meanings as in section 2305.113 of the Revised Code.

Section 7. If any item of law that constitutes the whole or part of a section of law contained in this act, or if any application of any item of law that constitutes the whole or part of a section of law contained in this act, is held invalid, the invalidity does not affect other items of law or applications of items of law that can be given effect without the invalid item of law or application. To this end, the items of law of which the sections contained in this act are composed, and their applications, are independent and severable.

Section 8. If any item of law that constitutes the whole or part of a section of law contained in this act, or if any application of any item of law contained in this act, is held to be preempted by federal law, the preemption of the item of law or its application does not affect other items of law or applications that can be given affect. The items of law of which the sections of this act are composed, and their applications, are independent and severable.

2002 H 412, § 3, eff. 11-7-02, reads:

Nothing in this act applies to proceedings or appeals involving workers' compensation claims under Chapter 4121. or 4123. of the Revised Code.

2002 H 412, § 4, eff. 11-7-02, reads:

If any provision of section 2305.11, 2315.21, 3721.02, or 3721.17 of the Revised Code, as amended by this act, any provision of section 5111.411 of the Revised Code, as enacted by this act, or the application of any provision of those sections to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the particular section or related sections that can be given effect without the invalid provision or application, and to this end the provisions of the particular section are severable.

2001 S 108, § 1: See Uncodified Law under 2305.251.

2001 S 108, § 3: See Uncodified Law under 2305.01.

1995 H 135, § 3, eff. 11-15-95, reads: The General Assembly declares that its intent in enacting sections 2307.51 and 2919.15 and in amending section 2305.11 of the Revised Code in this act is to prevent the unnecessary use of a specific procedure used in performing an abortion. This intent is based on a state interest in preventing unnecessary cruelty to the human fetus.

1990 S 125, § 4, eff. 7-13-90, reads: Sections 2305.04, 2305.11, 2305.16, and 2743.16 of the Revised Code, as amended by this act, shall apply only to causes of action that accrue on or after the date specified in Section 3 of this act, which is six months after the effective date of this act.

R.C. § 2305.11, OH ST § 2305.11

Current through 2008 File 129 of the 127th GA (2007-2008), apv. by 7/24/08, and filed with the Secretary of State by 7/24/08.

END OF DOCUMENT

R.C. § 2305.113

Baldwin's Ohio Revised Code Annotated Currentness
Title XXIII. Courts--Common Pleas
Chapter 2305. Jurisdiction; Limitation of Actions (Refs & Annos)
Limitations--Miscellaneous

➞2305.113 Time limitations for bringing medical, dental, optometric, or chiropractic claims

(A) Except as otherwise provided in this section, an action upon a medical, dental, optometric, or chiropractic claim shall be commenced within one year after the cause of action accrued.

(B)(1) If prior to the expiration of the one-year period specified in division (A) of this section, a claimant who allegedly possesses a medical, dental, optometric, or chiropractic claim gives to the person who is the subject of that claim written notice that the claimant is considering bringing an action upon that claim, that action may be commenced against the person notified at any time within one hundred eighty days after the notice is so given.

(2) An insurance company shall not consider the existence or nonexistence of a written notice described in division (B)(1) of this section in setting the liability insurance premium rates that the company may charge the company's insured person who is notified by that written notice.

(C) Except as to persons within the age of minority or of unsound mind as provided by section 2305.16 of the Revised Code, and except as provided in division (D) of this section, both of the following apply:

(1) No action upon a medical, dental, optometric, or chiropractic claim shall be commenced more than four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim.

(2) If an action upon a medical, dental, optometric, or chiropractic claim is not commenced within four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim, then, any action upon that claim is barred.

(D)(1) If a person making a medical claim, dental claim, optometric claim, or chiropractic claim, in the exercise of reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within three years after the occurrence of the act or omission, but, in the exercise of reasonable care and diligence, discovers the injury resulting from that act or omission before the expiration of the four-year period specified in division (C)(1) of this section, the person may commence an action upon the claim not later than one year after the person discovers the injury resulting from that act or omission.

(2) If the alleged basis of a medical claim, dental claim, optometric claim, or chiropractic claim is the occurrence of an act or omission that involves a foreign object that is left in the body of the person making the claim, the person may commence an action upon the claim not later than one year after the person discovered the foreign object or not later than one year after the person, with reasonable care and diligence, should have discovered the foreign object.

(3) A person who commences an action upon a medical claim, dental claim, optometric claim, or chiropractic claim under the circumstances described in division (D)(1) or (2) of this section has the affirmative burden of proving, by clear and convincing evidence, that the person, with reasonable care and diligence, could not have discovered the

injury resulting from the act or omission constituting the alleged basis of the claim within the three-year period described in division (D)(1) of this section or within the one-year period described in division (D)(2) of this section, whichever is applicable.

(E) As used in this section:

(1) "Hospital" includes any person, corporation, association, board, or authority that is responsible for the operation of any hospital licensed or registered in the state, including, but not limited to, those that are owned or operated by the state, political subdivisions, any person, any corporation, or any combination of the state, political subdivisions, persons, and corporations. "Hospital" also includes any person, corporation, association, board, entity, or authority that is responsible for the operation of any clinic that employs a full-time staff of physicians practicing in more than one recognized medical specialty and rendering advice, diagnosis, care, and treatment to individuals. "Hospital" does not include any hospital operated by the government of the United States or any of its branches.

(2) "Physician" means a person who is licensed to practice medicine and surgery or osteopathic medicine and surgery by the state medical board or a person who otherwise is authorized to practice medicine and surgery or osteopathic medicine and surgery in this state.

(3) "Medical claim" means any claim that is asserted in any civil action against a physician, podiatrist, hospital, home, or residential facility, against any employee or agent of a physician, podiatrist, hospital, home, or residential facility, or against a licensed practical nurse, registered nurse, advanced practice nurse, physical therapist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, and that arises out of the medical diagnosis, care, or treatment of any person. "Medical claim" includes the following:

(a) Derivative claims for relief that arise from the medical diagnosis, care, or treatment of a person;

(b) Claims that arise out of the medical diagnosis, care, or treatment of any person and to which either of the following applies:

(i) The claim results from acts or omissions in providing medical care.

(ii) The claim results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment.

(c) Claims that arise out of the medical diagnosis, care, or treatment of any person and that are brought under section 3721.17 of the Revised Code.

(4) "Podiatrist" means any person who is licensed to practice podiatric medicine and surgery by the state medical board.

(5) "Dentist" means any person who is licensed to practice dentistry by the state dental board.

(6) "Dental claim" means any claim that is asserted in any civil action against a dentist, or against any employee or agent of a dentist, and that arises out of a dental operation or the dental diagnosis, care, or treatment of any person. "Dental claim" includes derivative claims for relief that arise from a dental operation or the dental diagnosis, care, or treatment of a person.

(7) "Derivative claims for relief" include, but are not limited to, claims of a parent, guardian, custodian, or spouse of

an individual who was the subject of any medical diagnosis, care, or treatment, dental diagnosis, care, or treatment, dental operation, optometric diagnosis, care, or treatment, or chiropractic diagnosis, care, or treatment, that arise from that diagnosis, care, treatment, or operation, and that seek the recovery of damages for any of the following:

(a) Loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, or any other intangible loss that was sustained by the parent, guardian, custodian, or spouse;

(b) Expenditures of the parent, guardian, custodian, or spouse for medical, dental, optometric, or chiropractic care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations provided to the individual who was the subject of the medical diagnosis, care, or treatment, the dental diagnosis, care, or treatment, the dental operation, the optometric diagnosis, care, or treatment, or the chiropractic diagnosis, care, or treatment.

(8) "Registered nurse" means any person who is licensed to practice nursing as a registered nurse by the board of nursing.

(9) "Chiropractic claim" means any claim that is asserted in any civil action against a chiropractor, or against any employee or agent of a chiropractor, and that arises out of the chiropractic diagnosis, care, or treatment of any person. "Chiropractic claim" includes derivative claims for relief that arise from the chiropractic diagnosis, care, or treatment of a person.

(10) "Chiropractor" means any person who is licensed to practice chiropractic by the state chiropractic board.

(11) "Optometric claim" means any claim that is asserted in any civil action against an optometrist, or against any employee or agent of an optometrist, and that arises out of the optometric diagnosis, care, or treatment of any person. "Optometric claim" includes derivative claims for relief that arise from the optometric diagnosis, care, or treatment of a person.

(12) "Optometrist" means any person licensed to practice optometry by the state board of optometry.

(13) "Physical therapist" means any person who is licensed to practice physical therapy under Chapter 4755. of the Revised Code.

(14) "Home" has the same meaning as in section 3721.10 of the Revised Code.

(15) "Residential facility" means a facility licensed under section 5123.19 of the Revised Code.

(16) "Advanced practice nurse" means any certified nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, or certified nurse-midwife who holds a certificate of authority issued by the board of nursing under Chapter 4723. of the Revised Code.

(17) "Licensed practical nurse" means any person who is licensed to practice nursing as a licensed practical nurse by the board of nursing pursuant to Chapter 4723. of the Revised Code.

(18) "Physician assistant" means any person who holds a valid certificate to practice issued pursuant to Chapter 4730. of the Revised Code.

(19) "Emergency medical technician-basic," "emergency medical technician-intermediate," and "emergency medical

technician-paramedic" means any person who is certified under Chapter 4765. of the Revised Code as an emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, whichever is applicable.

(2006 S 154, eff. 5-17-06;2004 S 80, eff. 4-7-05;2002 S 281, eff. 4-11-03)

UNCODIFIED LAW

2003 S 86, § 3, eff. 7-12-04, reads:

(A) As used in this section, "health care professional," "health care worker," "indigent and uninsured person," "nonprofit health care referral organization," and "volunteer" have the same meanings as in section 2305.234 of the Revised Code, as amended by this act.

(B) The Ohio Medical Malpractice Commission created by Section 4 of Am. Sub. S.B. 281 of the 124th General Assembly shall have the following duties, in addition to the other duties provided by law for the Commission:

(1) To study the affordability and availability of medical malpractice insurance for health care professionals and health care workers who are volunteers and for nonprofit health care referral organizations;

(2) To study the feasibility of whether the state of Ohio should provide catastrophic claims coverage, or an insurance pool of any kind, for health care professionals and health care workers to utilize as volunteers in providing medical, dental, or other health-related diagnosis, care, or treatment to indigent and uninsured persons;

(3) To study the feasibility of whether the state of Ohio should create a fund to provide compensation to indigent and uninsured persons who receive medical, dental, or other health-related diagnosis, care, or treatment from health care professionals or health care workers who are volunteers, for any injury, death, or loss to person or property as a result of the negligence or other misconduct by those health care professionals or workers;

(4) To study whether the Good Samaritan laws of other states offer approaches that are materially different from the Ohio Good Samaritan Law as amended by this act, as contained in section 2305.234 of the Revised Code.

(C) The Commission shall submit a report of its findings regarding all of the matters provided in division (B) of this section to the members of the General Assembly not later than two years after the effective date of this act.

(D) The Department of Insurance shall provide any technical, professional, and clerical employees that are necessary for the Commission to perform its duties under this section.

2002 S 281, § 3, eff. 4-11-03, reads:

The General Assembly makes the following statement of findings and intent:

(A) The General Assembly finds:

(1) Medical malpractice litigation represents an increasing danger to the availability and quality of health care in Ohio.

(2) The number of medical malpractice claims resulting in payments to plaintiffs has remained relatively constant. However, the average award to plaintiffs has risen dramatically. Payments to plaintiffs at or exceeding one million

dollars have doubled in the past three years.

(3) This state has a rational and legitimate state interest in stabilizing the cost of health care delivery by limiting the amount of compensatory damages representing noneconomic loss awards in medical malpractice actions. The overall cost of health care to the consumer has been driven up by the fact that malpractice litigation causes health care providers to over prescribe, over treat, and over test their patients. The General Assembly bases its finding on this state interest upon the following evidence:

(a) The Superintendent of Insurance has stated that medical malpractice insurers' investments are not to blame for the increase in medical malpractice insurance premiums. The vast majority of these insurers' assets are invested in bonds and other fixed income investments, not in stocks. Investment income declined by less than one per cent from 1996 to 2001.

(b) Many medical malpractice insurers left the Ohio market as they faced increasing losses, largely as a consequence of rapidly rising compensatory damages and noneconomic loss awards in medical malpractice actions. The Department of Insurance reports that only six admitted carriers continue to actively write coverage in Ohio at this time.

(c) As insurers have left the market, physicians, hospitals, and other health care practitioners have had an increasingly difficult time finding affordable medical malpractice insurance. Some health care practitioners, including a large number of specialists, have been forced out of the practice of medicine altogether as a consequence. The Ohio State Medical Association reports fifteen per cent of Ohio's physicians are considering or have already relocated their practices due to rising medical malpractice insurance costs.

(d) As stated in testimony provided by Lawrence E. Smarr, President of the Physician Insurers Association of America, medical malpractice costs have increased even while sixty-one per cent of all claims filed against individual practitioners are dropped or dismissed by the court and even while the defendants win eighty per cent of all claims that are continued through trial to verdict.

(e) The U.S. Department of Health and Human Services published a report in 2002 stating that health care practitioners in states with effective caps on noneconomic damages are experiencing premium increases in the twelve to fifteen per cent range, as compared to an average forty-four per cent increase in states that do not cap noneconomic damage awards.

(4)(a) The distinction among claimants with a permanent physical functional loss strikes a reasonable balance between potential plaintiffs and defendants in consideration of the intent of an award for noneconomic losses, while treating similar plaintiffs equally, acknowledging that such distinctions do not limit the award of actual economic damages.

(b) The limits on compensatory damages representing noneconomic loss as specified in section 2323.43 of the Revised Code, as enacted by this act, are based on testimony asking the members of the General Assembly to recognize these distinctions and stating that the cap amounts are similar to caps on awards adopted by other states.

(c) In *Evans v. State* (Sup. Ct. Alaska, August 30, 2002), No. 5618, 2002 Alas. LEXIS 135, one of the issues addressed by the Alaska Supreme Court is whether the caps on noneconomic and punitive damages constitute a violation of the right to a trial by jury granted by the Alaska Constitution and the Seventh Amendment to the United States Constitution. The Court held that the damages caps do not violate the constitutional right to a trial by jury and agreed with the reasoning by the Third Circuit Court of Appeals in *Davis v. Omitowoju* (3d Cir. 1989), 883 F.2d 1155, which interpreted the Seventh Amendment to the United States Constitution to allow damages caps. The Alaska Supreme Court relied on the *Davis* holding that a damages cap did not intrude on the jury's fact-finding

function, because the cap was a "policy decision" applied after the jury's determination and did not constitute a re-examination of the factual question of damages. *Evans v. State, supra,* at pp. 11-12.

It is the intent of the General Assembly that as a matter of policy, the limits on compensatory damages for noneconomic loss are applied after a jury's determination of the factual question of damages.

(d) A report from the U.S. Department of Health and Human Services, *Update on the Medical Litigation Crisis: Not the Result of the Insurance Cycle* (Sept. 25, 2002), states that among states that have adopted a two hundred fifty thousand dollar cap on noneconomic damages are: Indiana, Colorado, California, Nebraska, Utah, and Montana. These states, as well as others that have imposed meaningful caps on noneconomic damages, report significantly lower increases in average premium rates than those states without caps. Limits on damages have been upheld by other state supreme courts, as in *Fein v. Permanente Medical Group* (1985), 38 Cal.3d 137, 695 P.2d 665, *Johnson v. St. Vincent Hospital, Inc.* (1980), 273 Ind. 374, 404 N.E.2d 585, and *Evans v. State, supra.*

(5) This legislation does not affect the award of economic damages, such as for lost wages and medical care.

(6)(a) That a statute of repose on medical, dental, optometric, and chiropractic claims strikes a rational balance between the rights of prospective claimants and the rights of hospitals and health care practitioners;

(b) Over time, the availability of relevant evidence pertaining to an incident and the availability of witnesses knowledgeable with respect to the diagnosis, care, or treatment of a prospective claimant becomes problematic.

(c) The maintenance of records and other documentation related to the delivery of medical services, for a period of time in excess of the time period presented in the statute of repose, presents an unacceptable burden to hospitals and health care practitioners.

(d) Over time, the standards of care pertaining to various health care services may change dramatically due to advances being made in health care, science, and technology, thereby making it difficult for expert witnesses and triers of fact to discern the standard of care relevant to the point in time when the relevant health care services were delivered.

(e) This legislation precludes unfair and unconstitutional aspects of state litigation but does not affect timely medical malpractice actions brought to redress legitimate grievances.

(f) This legislation addresses the aspects of current division (B) of section 2305.11 of the Revised Code, the application of which was found by the Ohio Supreme Court to be unconstitutional in *Gaines v. Preterm-Cleveland, Inc.* (1987), 33 Ohio St.3d 54. In *Dunn v. St. Francis Hospital, Inc.* (Del. 1982), 401 Atl.2d 77, the Delaware Supreme Court found the Delaware three-year statute of repose constitutional as not violative of the Delaware Constitution's open courts provision.

(B) In consideration of these findings, the General Assembly declares its intent to accomplish all of the following by the enactment of this act:

(1) To stem the exodus of medical malpractice insurers from the Ohio market;

(2) To increase the availability of medical malpractice insurance to Ohio's hospitals, physicians, and other health care practitioners, thus ensuring the availability of quality health care for the citizens of this state;

(3) To continue to hold negligent health care providers accountable for their actions;

(4) To preserve the right of patients to seek legal recourse for medical malpractice.

(5)(a) To abrogate the common law collateral source rules as adopted by the Ohio Supreme Court in *Pryor v. Webber* (1970), 23 Ohio St.2d 104, and reaffirmed in *Sorrell v. Thevenir* (1994), 69 Ohio St.3d 415;

(b) To address the aspects of former section 2317.45 of the Revised Code that the Supreme Court found in *Sorrell v. Thevenir* (1994), 69 Ohio St.3d 415, *May v. Tandy Corp.* (1994), 69 Ohio St.3d 415, and *DePew v. Ogella* (1994), 69 Ohio St.3d 610, to be unconstitutional as being violative of the equal protection provision of Section 2, the right to a trial by jury provision of Section 5, and the due course of law, right to a remedy, and open court provision of Section 16 of Article I of the Ohio Constitution.

(C)(1) The Ohio General Assembly respectfully requests the Ohio Supreme Court to uphold this intent in the courts of Ohio, to reconsider its holding on damage caps in *State v. Sheward* (1999), Ohio St.3d 451, to reconsider its holding on the deductibility of collateral source benefits in *Sorrel v. Thevenir* (1994), 69 Ohio St.3d 415, and to reconsider its holding on statutes of repose in *Sedar v. Knowlton Constr. Co.* (1990), 49 Ohio St.3d 193, thereby providing health care practitioners with access to affordable medical malpractice insurance and maintaining the provision of quality health care in Ohio.

(2) The General Assembly acknowledges the Court's authority in prescribing rules governing practice and procedure in the courts of this state as provided by Section 5 of Article IV of the Ohio Constitution.

2002 S 281, § 4, eff. 4-11-03, reads:

(A) There is hereby created the Ohio Medical Malpractice Commission consisting of nine members. The President of the Senate shall appoint three of the members, and the Speaker of the House of Representatives shall appoint three of the members. The minority leader of the Senate shall appoint one member and the minority leader of the House of Representatives shall appoint one member. The Director of the Department of Insurance or the Director's designee shall be the ninth member of the Commission. Of the six members appointed by the President of the Senate and the Speaker of the House of Representatives, one shall represent the Ohio State Bar Association, one shall represent the Ohio State Medical Association, and one shall represent the insurance companies in Ohio, and all of them shall have expertise in medical malpractice insurance issues.

(B) The Commission shall do all of the following:

(1) Study the effects of this act;

(2) Investigate the problems posed by, and the issues surrounding, medical malpractice;

(3) Submit a report of its findings to the members of the General Assembly not later than two years after the effective date of this act.

(C) Any vacancy in the membership of the Commission shall be filled in the same manner in which the original appointment was made.

(D) The members of the Commission shall by majority vote elect a chairperson from among themselves.

(E) The Department of Insurance shall provide any technical, professional, and clerical employees that are necessary for the Commission to perform its duties.

2002 S 281, § 6 through 8: See Uncodified Law under 2305.11.

HISTORICAL AND STATUTORY NOTES

Ed. Note: Former 2305.113 repealed by 2001 S 108, eff. 7-6-01; 1996 H 350, eff. 1-27-97[FN1].

[FN1] See Notes of Decisions, *State ex rel. Ohio Academy of Trial Lawyers v. Sheward* (Ohio 1999), 86 Ohio St.3d 451, 715 N.E.2d 1062.

Amendment Note: 2006 S 154 substituted "to practice" for "of registration or temporary certificate of registration" in division (E)(18).

Amendment Note: 2004 S 80 deleted "state" in subdivision (E)(8); inserted "state" and deleted "examining" in subdivision (E)(10); deleted "or", substituted "who holds a certificate of authority issued" for "certified" and substituted "Chapter 4723" for "section 4723.41" in subdivision (E)(16); and deleted "state" in subdivision (E)(17).

R.C. § 2305.113, OH ST § 2305.113

Current through 2008 File 129 of the 127th GA (2007-2008), apv. by 7/24/08, and filed with the Secretary of State by 7/24/08.

END OF DOCUMENT

R.C. § 2315.18

Baldwin's Ohio Revised Code Annotated Currentness
Title XXIII. Courts--Common Pleas
Chapter 2315. Trial Procedure (Refs & Annos)
Determination of Amount of Recovery; Contributory Negligence and Assumption of Risk; Damages

→2315.18 Amount of recovery to be determined

(A) As used in this section and in section 2315.19 of the Revised Code:

(1) "Asbestos claim" has the same meaning as in section 2307.91 of the Revised Code.

(2) "Economic loss" means any of the following types of pecuniary harm:

(a) All wages, salaries, or other compensation lost as a result of an injury or loss to person or property that is a subject of a tort action;

(b) All expenditures for medical care or treatment, rehabilitation services, or other care, treatment, services, products, or accommodations as a result of an injury or loss to person or property that is a subject of a tort action;

(c) Any other expenditures incurred as a result of an injury or loss to person or property that is a subject of a tort action, other than attorney's fees incurred in connection with that action.

(3) "Medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

(4) "Noneconomic loss" means nonpecuniary harm that results from an injury or loss to person or property that is a subject of a tort action, including, but not limited to, pain and suffering, loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, disfigurement, mental anguish, and any other intangible loss.

(5) "Occurrence" means all claims resulting from or arising out of any one person's bodily injury.

(6) "Product liability claim" has the same meaning as in section 2307.71 of the Revised Code.

(7) "Tort action" means a civil action for damages for injury or loss to person or property. "Tort action" includes a civil action upon a product liability claim or an asbestos claim. "Tort action" does not include a civil action upon a medical claim, dental claim, optometric claim, or chiropractic claim or a civil action for damages for a breach of contract or another agreement between persons.

(8) "Trier of fact" means the jury or, in a nonjury action, the court.

(B) In a tort action to recover damages for injury or loss to person or property, all of the following apply:

(1) There shall not be any limitation on the amount of compensatory damages that represents the economic loss of the person who is awarded the damages in the tort action.

(2) Except as otherwise provided in division (B)(3) of this section, the amount of compensatory damages that represents damages for noneconomic loss that is recoverable in a tort action under this section to recover damages

for injury or loss to person or property shall not exceed the greater of two hundred fifty thousand dollars or an amount that is equal to three times the economic loss, as determined by the trier of fact, of the plaintiff in that tort action to a maximum of three hundred fifty thousand dollars for each plaintiff in that tort action or a maximum of five hundred thousand dollars for each occurrence that is the basis of that tort action.

(3) There shall not be any limitation on the amount of compensatory damages that represents damages for noneconomic loss that is recoverable in a tort action to recover damages for injury or loss to person or property if the noneconomic losses of the plaintiff are for either of the following:

(a) Permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system;

(b) Permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and perform life-sustaining activities.

(C) In determining an award of compensatory damages for noneconomic loss in a tort action, the trier of fact shall not consider any of the following:

(1) Evidence of a defendant's alleged wrongdoing, misconduct, or guilt;

(2) Evidence of the defendant's wealth or financial resources;

(3) All other evidence that is offered for the purpose of punishing the defendant, rather than offered for a compensatory purpose.

(D) If a trial is conducted in a tort action to recover damages for injury or loss to person or property and a plaintiff prevails in that action, the court in a nonjury trial shall make findings of fact, and the jury in a jury trial shall return a general verdict accompanied by answers to interrogatories, that shall specify all of the following:

(1) The total compensatory damages recoverable by the plaintiff;

(2) The portion of the total compensatory damages that represents damages for economic loss;

(3) The portion of the total compensatory damages that represents damages for noneconomic loss.

(E)(1) After the trier of fact in a tort action to recover damages for injury or loss to person or property complies with division (D) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for economic loss in the amount determined pursuant to division (D)(2) of this section, and, subject to division (F)(1) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for noneconomic loss. Except as provided in division (B)(3) of this section, in no event shall a judgment for compensatory damages for noneconomic loss exceed the maximum recoverable amount that represents damages for noneconomic loss as provided in division (B)(2) of this section. Division (B) of this section shall be applied in a jury trial only after the jury has made its factual findings and determination as to the damages.

(2) Prior to the trial in the tort action described in division (D) of this section, any party may seek summary judgment with respect to the nature of the alleged injury or loss to person or property, seeking a determination of the damages as described in division (B)(2) of this section.

(F)(1) A court of common pleas has no jurisdiction to enter judgment on an award of compensatory damages for noneconomic loss in excess of the limits set forth in this section.

(2) If the trier of fact is a jury, the court shall not instruct the jury with respect to the limit on compensatory damages for noneconomic loss described in division (B)(2) of this section, and neither counsel for any party nor a witness shall inform the jury or potential jurors of that limit.

(G) With respect to a tort action to which division (B)(2) of this section applies, any excess amount of compensatory damages for noneconomic loss that is greater than the applicable amount specified in division (B)(2) of this section shall not be reallocated to any other tortfeasor beyond the amount of compensatory damages that the tortfeasor would otherwise be responsible for under the laws of this state.

(H) This section does not apply to any of the following:

(1) Tort actions that are brought against the state in the court of claims, including, but not limited to, those actions in which a state university or college is a defendant and to which division (B)(3) of section 3345.40 of the Revised Code applies;

(2) Tort actions that are brought against political subdivisions of this state and that are commenced under or are subject to Chapter 2744. of the Revised Code. Division (C) of section 2744.05 of the Revised Code applies to recoverable damages in those actions.

(3) Wrongful death actions brought pursuant to Chapter 2125. of the Revised Code.

(I) If the provisions regarding the limits on compensatory damages for noneconomic loss set forth in division (B)(2) of this section have been determined to be unconstitutional, then division (C) of this section and section 2315.19 of the Revised Code shall govern the determination of an award of compensatory damages for noneconomic loss in a tort action.

(2004 S 80, eff. 4-7-05)

UNCODIFIED LAW

2001 S 108, § 1: See Uncodified Law under 2315.01.

2001 S 108, § 3, eff. 7-6-01, reads, in part:

(A) In Section 2.01 of this act:

(7) Section 2315.18 of the Revised Code is revived, supersedes the version of the same section that is repealed by Section 2.02 of this act, includes an amendment to respond to division (C)(2) of section 2315.21 of the Revised Code having been held unconstitutional by the Supreme Court of Ohio in *Zoppo v. Homestead Ins. Co.* (1994), 71 Ohio St.3rd 552, and includes an amendment to change its number to section 2315.07 of the Revised Code.

R.C. § 2315.18, OH ST § 2315.18

Current through 2008 File 129 of the 127th GA (2007-2008), apv. by 7/24/08, and filed with the Secretary of State by 7/24/08.

END OF DOCUMENT

R.C. § 2323.43

Baldwin's Ohio Revised Code Annotated Currentness
Title XXIII. Courts--Common Pleas
Chapter 2323. Judgment (Refs & Annos)
Miscellaneous Provisions

→2323.43 Compensatory damages for economic and noneconomic loss

(A) In a civil action upon a medical, dental, optometric, or chiropractic claim to recover damages for injury, death, or loss to person or property, all of the following apply:

(1) There shall not be any limitation on compensatory damages that represent the economic loss of the person who is awarded the damages in the civil action.

(2) Except as otherwise provided in division (A)(3) of this section, the amount of compensatory damages that represents damages for noneconomic loss that is recoverable in a civil action under this section to recover damages for injury, death, or loss to person or property shall not exceed the greater of two hundred fifty thousand dollars or an amount that is equal to three times the plaintiff's economic loss, as determined by the trier of fact, to a maximum of three hundred fifty thousand dollars for each plaintiff or a maximum of five hundred thousand dollars for each occurrence.

(3) The amount recoverable for noneconomic loss in a civil action under this section may exceed the amount described in division (A)(2) of this section but shall not exceed five hundred thousand dollars for each plaintiff or one million dollars for each occurrence if the noneconomic losses of the plaintiff are for either of the following:

(a) Permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system;

(b) Permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and perform life sustaining activities.

(B) If a trial is conducted in a civil action upon a medical, dental, optometric, or chiropractic claim to recover damages for injury, death, or loss to person or property and a plaintiff prevails with respect to that claim, the court in a nonjury trial shall make findings of fact, and the jury in a jury trial shall return a general verdict accompanied by answers to interrogatories, that shall specify all of the following:

(1) The total compensatory damages recoverable by the plaintiff;

(2) The portion of the total compensatory damages that represents damages for economic loss;

(3) The portion of the total compensatory damages that represents damages for noneconomic loss.

(C)(1) After the trier of fact in a civil action upon a medical, dental, optometric, or chiropractic claim to recover damages for injury, death, or loss to person or property complies with division (B) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for economic loss in the amount determined pursuant to division (B)(2) of this section, and, subject to division (D)(1) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for noneconomic loss. In no event shall a judgment for compensatory damages for noneconomic loss exceed the maximum recoverable amount that represents damages for noneconomic loss as provided in divisions (A)(2) and (3) of this section. Division (A) of this section shall be applied in a jury trial only after the jury has made its factual findings and determination as to the damages.

(2) Prior to the trial in the civil action, any party may seek summary judgment with respect to the nature of the alleged injury or loss to person or property, seeking a determination of the damages as described in division (A)(2) or (3) of this section.

(D)(1) A court of common pleas has no jurisdiction to enter judgment on an award of compensatory damages for noneconomic loss in excess of the limits set forth in this section.

(2) If the trier of fact is a jury, the court shall not instruct the jury with respect to the limit on compensatory damages for noneconomic loss described in divisions (A)(2) and (3) of this section, and neither counsel for any party nor a witness shall inform the jury or potential jurors of that limit.

(E) Any excess amount of compensatory damages for noneconomic loss that is greater than the applicable amount specified in division (A)(2) or (3) of this section shall not be reallocated to any other tortfeasor beyond the amount of compensatory damages that that tortfeasor would otherwise be responsible for under the laws of this state.

(F)(1) If pursuant to a contingency fee agreement between an attorney and a plaintiff in a civil action upon a medical claim, dental claim, optometric claim, or chiropractic claim, the amount of the attorney's fees exceed the applicable amount of the limits on compensatory damages for noneconomic loss as provided in division (A)(2) or (3) of this section, the attorney shall make an application in the probate court of the county in which the civil action was commenced or in which the settlement was entered. The application shall contain a statement of facts, including the amount to be allocated to the settlement of the claim, the amount of the settlement or judgment that represents the compensatory damages for economic loss and noneconomic loss, the relevant provision in the contingency fee agreement, and the dollar amount of the attorney's fees under the contingency fee agreement. The application shall include the proposed distribution of the amount of the judgment or settlement.

(2) The attorney shall give written notice of the hearing and a copy of the application to all interested persons who have not waived notice of the hearing. Notwithstanding the waivers and consents of the interested persons, the probate court shall retain jurisdiction over the settlement, allocation, and distribution of the claim.

(3) The application shall state the arrangements, if any, that have been made with respect to the attorney's fees. The attorney's fees shall be subject to the approval of the probate court.

(G) This section does not apply to any of the following:

(1) Civil actions upon a medical, dental, optometric, or chiropractic claim that are brought against the state in the court of claims, including, but not limited to, those actions in which a state university or college is a defendant and to which division (B)(3) of section 3345.40 of the Revised Code applies;

(2) Civil actions upon a medical, dental, optometric, or chiropractic claim that are brought against political subdivisions of this state and that are commenced under or are subject to Chapter 2744. of the Revised Code. Division (C) of section 2744.05 of the Revised Code applies to recoverable damages in those actions;

(3) Wrongful death actions brought pursuant to Chapter 2125. of the Revised Code.

(H) As used in this section:

(1) "Economic loss" means any of the following types of pecuniary harm:

R.C. § 2323.43

(a) All wages, salaries, or other compensation lost as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim;

(b) All expenditures for medical care or treatment, rehabilitation services, or other care, treatment, services, products, or accommodations as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim;

(c) Any other expenditures incurred as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim, other than attorney's fees incurred in connection with that action.

(2) "Medical claim, dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

(3) "Noneconomic loss" means nonpecuniary harm that results from an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim, including, but not limited to, pain and suffering, loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, disfigurement, mental anguish, and any other intangible loss.

(4) "Trier of fact" means the jury or, in a nonjury action, the court.

(2002 S 281, eff. 4-11-03)

UNCODIFIED LAW

2003 S 86, § 3, eff. 7-12-04, reads:

(A) As used in this section, "health care professional," "health care worker," "indigent and uninsured person," "nonprofit health care referral organization," and "volunteer" have the same meanings as in section 2305.234 of the Revised Code, as amended by this act.

(B) The Ohio Medical Malpractice Commission created by Section 4 of Am. Sub. S.B. 281 of the 124th General Assembly shall have the following duties, in addition to the other duties provided by law for the Commission:

(1) To study the affordability and availability of medical malpractice insurance for health care professionals and health care workers who are volunteers and for nonprofit health care referral organizations;

(2) To study the feasibility of whether the state of Ohio should provide catastrophic claims coverage, or an insurance pool of any kind, for health care professionals and health care workers to utilize as volunteers in providing medical, dental, or other health-related diagnosis, care, or treatment to indigent and uninsured persons;

(3) To study the feasibility of whether the state of Ohio should create a fund to provide compensation to indigent and uninsured persons who receive medical, dental, or other health-related diagnosis, care, or treatment from health care professionals or health care workers who are volunteers, for any injury, death, or loss to person or property as a result of the negligence or other misconduct by those health care professionals or workers;

(4) To study whether the Good Samaritan laws of other states offer approaches that are materially different from the Ohio Good Samaritan Law as amended by this act, as contained in section 2305.234 of the Revised Code.

(C) The Commission shall submit a report of its findings regarding all of the matters provided in division (B) of this section to the members of the General Assembly not later than two years after the effective date of this act.

(D) The Department of Insurance shall provide any technical, professional, and clerical employees that are necessary for the Commission to perform its duties under this section.

2002 S 281, § 3, eff. 4-11-03, reads:

The General Assembly makes the following statement of findings and intent:

(A) The General Assembly finds:

(1) Medical malpractice litigation represents an increasing danger to the availability and quality of health care in Ohio.

(2) The number of medical malpractice claims resulting in payments to plaintiffs has remained relatively constant. However, the average award to plaintiffs has risen dramatically. Payments to plaintiffs at or exceeding one million dollars have doubled in the past three years.

(3) This state has a rational and legitimate state interest in stabilizing the cost of health care delivery by limiting the amount of compensatory damages representing noneconomic loss awards in medical malpractice actions. The overall cost of health care to the consumer has been driven up by the fact that malpractice litigation causes health care providers to over prescribe, over treat, and over test their patients. The General Assembly bases its finding on this state interest upon the following evidence:

(a) The Superintendent of Insurance has stated that medical malpractice insurers' investments are not to blame for the increase in medical malpractice insurance premiums. The vast majority of these insurers' assets are invested in bonds and other fixed income investments, not in stocks. Investment income declined by less than one per cent from 1996 to 2001.

(b) Many medical malpractice insurers left the Ohio market as they faced increasing losses, largely as a consequence of rapidly rising compensatory damages and noneconomic loss awards in medical malpractice actions. The Department of Insurance reports that only six admitted carriers continue to actively write coverage in Ohio at this time.

(c) As insurers have left the market, physicians, hospitals, and other health care practitioners have had an increasingly difficult time finding affordable medical malpractice insurance. Some health care practitioners, including a large number of specialists, have been forced out of the practice of medicine altogether as a consequence. The Ohio State Medical Association reports fifteen per cent of Ohio's physicians are considering or have already relocated their practices due to rising medical malpractice insurance costs.

(d) As stated in testimony provided by Lawrence E. Smarr, President of the Physician Insurers Association of America, medical malpractice costs have increased even while sixty-one per cent of all claims filed against individual practitioners are dropped or dismissed by the court and even while the defendants win eighty per cent of all claims that are continued through trial to verdict.

(e) The U.S. Department of Health and Human Services published a report in 2002 stating that health care practitioners in states with effective caps on noneconomic damages are experiencing premium increases in the twelve to fifteen per cent range, as compared to an average forty-four per cent increase in states that do not cap

noneconomic damage awards.

(4)(a) The distinction among claimants with a permanent physical functional loss strikes a reasonable balance between potential plaintiffs and defendants in consideration of the intent of an award for noneconomic losses, while treating similar plaintiffs equally, acknowledging that such distinctions do not limit the award of actual economic damages.

(b) The limits on compensatory damages representing noneconomic loss as specified in section 2323.43 of the Revised Code, as enacted by this act, are based on testimony asking the members of the General Assembly to recognize these distinctions and stating that the cap amounts are similar to caps on awards adopted by other states.

(c) In *Evans v. State* (Sup. Ct. Alaska, August 30, 2002), No. 5618, 2002 Alas. LEXIS 135, one of the issues addressed by the Alaska Supreme Court is whether the caps on noneconomic and punitive damages constitute a violation of the right to a trial by jury granted by the Alaska Constitution and the Seventh Amendment to the United States Constitution. The Court held that the damages caps do not violate the constitutional right to a trial by jury and agreed with the reasoning by the Third Circuit Court of Appeals in *Davis v. Omitowoju* (3d Cir. 1989), 883 F.2d 1155, which interpreted the Seventh Amendment to the United States Constitution to allow damages caps. The Alaska Supreme Court relied on the *Davis* holding that a damages cap did not intrude on the jury's fact-finding function, because the cap was a "policy decision" applied after the jury's determination and did not constitute a re-examination of the factual question of damages. *Evans v. State, supra*, at pp. 11-12.

It is the intent of the General Assembly that as a matter of policy, the limits on compensatory damages for noneconomic loss are applied after a jury's determination of the factual question of damages.

(d) A report from the U.S. Department of Health and Human Services, *Update on the Medical Litigation Crisis: Not the Result of the Insurance Cycle* (Sept. 25, 2002), states that among states that have adopted a two hundred fifty thousand dollar cap on noneconomic damages are: Indiana, Colorado, California, Nebraska, Utah, and Montana. These states, as well as others that have imposed meaningful caps on noneconomic damages, report significantly lower increases in average premium rates than those states without caps. Limits on damages have been upheld by other state supreme courts, as in *Fein v. Permanente Medical Group* (1985), 38 Cal.3d 137, 695 P.2d 665, *Johnson v. St. Vincent Hospital, Inc.* (1980), 273 Ind. 374, 404 N.E.2d 585, and *Evans v. State, supra.*

(5) This legislation does not affect the award of economic damages, such as for lost wages and medical care.

(6)(a) That a statute of repose on medical, dental, optometric, and chiropractic claims strikes a rational balance between the rights of prospective claimants and the rights of hospitals and health care practitioners;

(b) Over time, the availability of relevant evidence pertaining to an incident and the availability of witnesses knowledgeable with respect to the diagnosis, care, or treatment of a prospective claimant becomes problematic.

(c) The maintenance of records and other documentation related to the delivery of medical services, for a period of time in excess of the time period presented in the statute of repose, presents an unacceptable burden to hospitals and health care practitioners.

(d) Over time, the standards of care pertaining to various health care services may change dramatically due to advances being made in health care, science, and technology, thereby making it difficult for expert witnesses and triers of fact to discern the standard of care relevant to the point in time when the relevant health care services were delivered.

(e) This legislation precludes unfair and unconstitutional aspects of state litigation but does not affect timely

medical malpractice actions brought to redress legitimate grievances.

(f) This legislation addresses the aspects of current division (B) of section 2305.11 of the Revised Code, the application of which was found by the Ohio Supreme Court to be unconstitutional in *Gaines v. Preterm-Cleveland, Inc.* (1987), 33 Ohio St.3d 54. In *Dunn v. St. Francis Hospital, Inc.* (Del. 1982), 401 Atl.2d 77, the Delaware Supreme Court found the Delaware three-year statute of repose constitutional as not violative of the Delaware Constitution's open courts provision.

(B) In consideration of these findings, the General Assembly declares its intent to accomplish all of the following by the enactment of this act:

(1) To stem the exodus of medical malpractice insurers from the Ohio market;

(2) To increase the availability of medical malpractice insurance to Ohio's hospitals, physicians, and other health care practitioners, thus ensuring the availability of quality health care for the citizens of this state;

(3) To continue to hold negligent health care providers accountable for their actions;

(4) To preserve the right of patients to seek legal recourse for medical malpractice.

(5)(a) To abrogate the common law collateral source rules as adopted by the Ohio Supreme Court in *Pryor v. Webber* (1970), 23 Ohio St.2d 104, and reaffirmed in *Sorrell v. Thevenir* (1994), 69 Ohio St.3d 415;

(b) To address the aspects of former section 2317.45 of the Revised Code that the Supreme Court found in *Sorrell v. Thevenir* (1994), 69 Ohio St.3d 415, *May v. Tandy Corp.* (1994), 69 Ohio St.3d 415, and *DePew v. Ogella* (1994), 69 Ohio St.3d 610, to be unconstitutional as being violative of the equal protection provision of Section 2, the right to a trial by jury provision of Section 5, and the due course of law, right to a remedy, and open court provision of Section 16 of Article I of the Ohio Constitution.

(C)(1) The Ohio General Assembly respectfully requests the Ohio Supreme Court to uphold this intent in the courts of Ohio, to reconsider its holding on damage caps in *State v. Sheward* (1999), Ohio St.3d 451, to reconsider its holding on the deductibility of collateral source benefits in *Sorrel v. Thevenir* (1994), 69 Ohio St.3d 415, and to reconsider its holding on statutes of repose in *Sedar v. Knowlton Constr. Co.* (1990), 49 Ohio St.3d 193, thereby providing health care practitioners with access to affordable medical malpractice insurance and maintaining the provision of quality health care in Ohio.

(2) The General Assembly acknowledges the Court's authority in prescribing rules governing practice and procedure in the courts of this state as provided by Section 5 of Article IV of the Ohio Constitution.

2002 S 281, § 4, eff. 4-11-03, reads:

(A) There is hereby created the Ohio Medical Malpractice Commission consisting of nine members. The President of the Senate shall appoint three of the members, and the Speaker of the House of Representatives shall appoint three of the members. The minority leader of the Senate shall appoint one member and the minority leader of the House of Representatives shall appoint one member. The Director of the Department of Insurance or the Director's designee shall be the ninth member of the Commission. Of the six members appointed by the President of the Senate and the Speaker of the House of Representatives, one shall represent the Ohio State Bar Association, one shall represent the Ohio State Medical Association, and one shall represent the insurance companies in Ohio, and all of them shall have expertise in medical malpractice insurance issues.

(B) The Commission shall do all of the following:

(1) Study the effects of this act;

(2) Investigate the problems posed by, and the issues surrounding, medical malpractice;

(3) Submit a report of its findings to the members of the General Assembly not later than two years after the effective date of this act.

(C) Any vacancy in the membership of the Commission shall be filled in the same manner in which the original appointment was made.

(D) The members of the Commission shall by majority vote elect a chairperson from among themselves.

(E) The Department of Insurance shall provide any technical, professional, and clerical employees that are necessary for the Commission to perform its duties.

2002 S 281, § 5, eff. 4-11-03, reads:

(A)(1) In recognition of the statewide concern over the rising cost of medical malpractice insurance and the difficulty that health care practitioners have in locating affordable medical malpractice insurance, the Superintendent of Insurance shall study the feasibility of a Patient Compensation Fund to cover medical malpractice claims, including, but not limited to the following:

(a) The financial responsibility limits for providers that are covered in Am. Sub. Senate Bill 281 of the 124th General Assembly, and the Patient Compensation Fund;

(b) The identification of methods of funding, excluding any tax on consumers;

(c) The operation and administration of such a fund;

(d) The participation requirements.

(2) The Superintendent shall submit a copy of a preliminary report by March 3, 2003, with a final report by May 1, 2003, to the Governor, the Speaker of the Ohio House of Representatives, the President of the Ohio Senate, and the chairpersons of the committees of the General Assembly with jurisdiction over issues relating to medical malpractice liability. The final report shall include the Superintendent's recommendations for implementing the Patient's Compensation Fund.

(B) The Superintendent of Insurance shall make recommendations for the operation of a Patient's Compensation Fund designed to assist health care practitioners in satisfying medical malpractice awards above designated amounts. The purpose of the study shall be to consider the feasibility of the Fund satisfying that portion of the awards for damages for noneconomic loss under division (A)(2) of section 2323.43 of the Revised Code resulting from medical malpractice claims against hospitals, physicians, and other health care practitioners in excess of three hundred fifty thousand dollars to a maximum of five hundred thousand dollars. The recommendations shall also provide for the satisfaction of the awards for damages for noneconomic loss under division (A)(3) of section 2323.43 of the Revised Code resulting from medical malpractice claims against hospitals, physicians, and other health care practitioners in excess of five hundred thousand dollars to a maximum of one million dollars.

(C) The Superintendent's recommendations shall include sources of revenues for the Fund and a mechanism for making, and the assessment of, claims against the Fund.

2002 S 281, § 6 through 8, eff. 4-11-03, read:

Section 6. (A) Sections 1751.67, 2117.06, 2305.11, 2305.15, 2305.234, 2317.02, 2317.54, 2323.56, 2711.21, 2711.22, 2711.23, 2711.24, 2743.02, 2743.43, 2919.16, 3923.63, 3923.64, 3929.71, and 5111.018 of the Revised Code, as amended by this act, and sections 2303.23, 2305.113, 2323.41, 2323.42, 2323.43, and 2323.55 of the Revised Code, as enacted by this act, apply to civil actions upon a medical claim, dental claim, optometric claim, or chiropractic claim in which the act or omission that constitutes the alleged basis of the claim occurs on or after the effective date of this act.

(B) As used in this section, "medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

Section 7. If any item of law that constitutes the whole or part of a section of law contained in this act, or if any application of any item of law that constitutes the whole or part of a section of law contained in this act, is held invalid, the invalidity does not affect other items of law or applications of items of law that can be given effect without the invalid item of law or application. To this end, the items of law of which the sections contained in this act are composed, and their applications, are independent and severable.

Section 8. If any item of law that constitutes the whole or part of a section of law contained in this act, or if any application of any item of law contained in this act, is held to be preempted by federal law, the preemption of the item of law or its application does not affect other items of law or applications that can be given affect. The items of law of which the sections of this act are composed, and their applications, are independent and severable.

HISTORICAL AND STATUTORY NOTES

Ed. Note: Former 2323.43 repealed by 1970 H 1201, eff. 7-1-71; 125 v 903; 1953 H 1; GC 11627.

Ed. Note: Former 2323.43 was in conflict with Civil Rule 54(D).

Pre-1953 H 1 Amendments: RS 5350

R.C. § 2323.43, OH ST § 2323.43

Current through 2008 File 129 of the 127th GA (2007-2008), apv. by 7/24/08, and filed with the Secretary of State by 7/24/08.

END OF DOCUMENT

BALDWIN'S OHIO REVISED CODE ANNOTATED
TITLE XXIII. COURTS--COMMON PLEAS
CHAPTER 2305. JURISDICTION; LIMITATION OF ACTIONS
LIMITATIONS--MISCELLANEOUS

2305.11 TIME LIMITATIONS FOR BRINGING CERTAIN ACTIONS; EXTENSIONS; EFFECT OF LEGAL DISABILITY

<Note: See also following version of this section, eff. 4-11-03>

(A) An action for libel, slander, malicious prosecution, or false imprisonment, an action for malpractice other than an action upon a medical, dental, optometric, or chiropractic claim, or an action upon a statute for a penalty or forfeiture shall be commenced within one year after the cause of action accrued, provided that an action by an employee for the payment of unpaid minimum wages, unpaid overtime compensation, or liquidated damages by reason of the nonpayment of minimum wages or overtime compensation shall be commenced within two years after the cause of action accrued.

(B)(1) Subject to division (B)(2) of this section, an action upon a medical, dental, optometric, or chiropractic claim shall be commenced within one year after the cause of action accrued, except that, if prior to the expiration of that one-year period, a claimant who allegedly possesses a medical, dental, optometric, or chiropractic claim gives to the person who is the subject of that claim written notice that the claimant is considering bringing an action upon that claim, that action may be commenced against the person notified at any time within one hundred eighty days after the notice is so given.

(2) Except as to persons within the age of minority or of unsound mind, as provided by section 2305.16 of the Revised Code:

(a) In no event shall any action upon a medical, dental, optometric, or chiropractic claim be commenced more than four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim.

(b) If an action upon a medical, dental, optometric, or chiropractic claim is not commenced within four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim, then, notwithstanding the time when the action is determined to accrue under division (B)(1) of this section, any action upon that claim is barred.

(C) A civil action for unlawful abortion pursuant to section 2919.12 of the Revised Code, a civil action authorized by division (H) of section 2317.56 of the

Revised Code, a civil action pursuant to division (B)(1) or (2) of section 2307.51 of the Revised Code for performing a dilation and extraction procedure or attempting to perform a dilation and extraction procedure in violation of section 2919.15 of the Revised Code, and a civil action pursuant to division (B)(1) or (2) of section 2307.52 of the Revised Code for terminating or attempting to terminate a human pregnancy after viability in violation of division (A) or (B) of section 2919.17 of the Revised Code shall be commenced within one year after the performance or inducement of the abortion, within one year after the attempt to perform or induce the abortion in violation of division (A) or (B) of section 2919.17 of the Revised Code, within one year after the performance of the dilation and extraction procedure, or, in the case of a civil action pursuant to division (B)(2) of section 2307.51 of the Revised Code, within one year after the attempt to perform the dilation and extraction procedure.

(D) As used in this section:

(1) "Hospital" includes any person, corporation, association, board, or authority that is responsible for the operation of any hospital licensed or registered in the state, including, but not limited to, those that are owned or operated by the state, political subdivisions, any person, any corporation, or any combination thereof. "Hospital" also includes any person, corporation, association, board, entity, or authority that is responsible for the operation of any clinic that employs a full-time staff of physicians practicing in more than one recognized medical specialty and rendering advice, diagnosis, care, and treatment to individuals. "Hospital" does not include any hospital operated by the government of the United States or any of its branches.

(2) "Physician" means a person who is licensed to practice medicine and surgery or osteopathic medicine and surgery by the state medical board or a person who otherwise is authorized to practice medicine and surgery or osteopathic medicine and surgery in this state.

(3) "Medical claim" means any claim that is asserted in any civil action against a physician, podiatrist, hospital, home, or residential facility, against any employee or agent of a physician, podiatrist, hospital, home, or residential facility, or against a registered nurse or physical therapist, and that arises out of the medical diagnosis, care, or treatment of any person. "Medical claim" includes the following:

(a) Derivative claims for relief that arise from the medical diagnosis, care, or treatment of a person;

(b) Claims that arise out of the medical diagnosis, care, or treatment of any person and to which either of the following apply:

(i) The claim results from acts or omissions in providing medical care.

(ii) The claim results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment.

(c) Claims that arise out of the medical diagnosis, care, or treatment of any

person and that are brought under section 3721.17 of the Revised Code.

(4) "Podiatrist" means any person who is licensed to practice podiatric medicine and surgery by the state medical board.

(5) "Dentist" means any person who is licensed to practice dentistry by the state dental board.

(6) "Dental claim" means any claim that is asserted in any civil action against a dentist, or against any employee or agent of a dentist, and that arises out of a dental operation or the dental diagnosis, care, or treatment of any person. "Dental claim" includes derivative claims for relief that arise from a dental operation or the dental diagnosis, care, or treatment of a person.

(7) "Derivative claims for relief" include, but are not limited to, claims of a parent, guardian, custodian, or spouse of an individual who was the subject of any medical diagnosis, care, or treatment, dental diagnosis, care, or treatment, dental operation, optometric diagnosis, care, or treatment, or chiropractic diagnosis, care, or treatment, that arise from that diagnosis, care, treatment, or operation, and that seek the recovery of damages for any of the following:

(a) Loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, or any other intangible loss that was sustained by the parent, guardian, custodian, or spouse;

(b) Expenditures of the parent, guardian, custodian, or spouse for medical, dental, optometric, or chiropractic care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations provided to the individual who was the subject of the medical diagnosis, care, or treatment, the dental diagnosis, care, or treatment, the dental operation, the optometric diagnosis, care, or treatment, or the chiropractic diagnosis, care, or treatment.

(8) "Registered nurse" means any person who is licensed to practice nursing as a registered nurse by the state board of nursing.

(9) "Chiropractic claim" means any claim that is asserted in any civil action against a chiropractor, or against any employee or agent of a chiropractor, and that arises out of the chiropractic diagnosis, care, or treatment of any person. "Chiropractic claim" includes derivative claims for relief that arise from the chiropractic diagnosis, care, or treatment of a person.

(10) "Chiropractor" means any person who is licensed to practice chiropractic by the chiropractic examining board.

(11) "Optometric claim" means any claim that is asserted in any civil action against an optometrist, or against any employee or agent of an optometrist, and that arises out of the optometric diagnosis, care, or treatment of any person. "Optometric claim" includes derivative claims for relief that arise from the optometric diagnosis, care, or treatment of a person.

(12) "Optometrist" means any person licensed to practice optometry by the state board of optometry.

(13) "Physical therapist" means any person who is licensed to practice physical therapy under Chapter 4755. of the Revised Code.

(14) "Home" has the same meaning as in section 3721.10 of the Revised Code.

(15) "Residential facility" means a facility licensed under section 5123.19 of the Revised Code.

CREDIT(S)

(2002 H 412, eff. 11-7-02; 2001 S 108, § 2.01, eff. 7-6-01; 2001 S 108, § 2.02, eff. 7-6-01; 1996 H 350, eff. 1-27-97) [FN1]; 1995 H 135, eff. 11-15-95; 1992 S 124, eff. 4-16-93; 1991 H 108; 1990 S 125, S 80; 1987 H 327; 1985 H 319; 1984 S 183; 1981 H 243; 1976 H 1426; 1975 H 682; 1974 H 989; 1953 H 1; GC 11225

[FN1] See Notes of Decisions and Opinions, State ex rel. Ohio Academy of Trial Lawyers v. Sheward (Ohio 1999), 86 Ohio St.3d 451, 715 N.E.2d 1062.

<Note: See also following version of this section, eff. 4-11-03>

R.C. § 2305.11

OH ST § 2305.11

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