Nos. 2009-1715, 2009-2094
(Consolidated)

ORIGINAL

In the Supreme Court of Ohio

APPEAL FROM THE COURT OF APPEALS
THIRD APPELLATE DISTRICT
ALLEN COUNTY, OHIO
CASE NO. 01-08-065

JEFFREY GEESAMAN, et al.,
Plaintiffs-Appellees,

v.

ST. RITA'S MEDICAL CENTER, et al.,
Defendants,

and

JOHN COX, D.O.,
Defendant-Appellant.

MERIT BRIEF OF APPELLANT

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I. STATEMENT OF FACTS

This medical malpractice action arose out of Plaintiffs-Appellees' claim that had Jeffrey Geesaman's stroke been appropriately diagnosed and treated when he presented at the emergency room of St. Rita's Medical Center (St. Rita's") on March 31, 2005, he would not have suffered a further stroke on April 5, 2005. (Supp. 3, Compl., ¶¶11-12.)

A. Mr. Geesaman's Severe Intracranial Atherosclerosis and Vertebral Basilar Strokes.

When he presented at St. Rita's on March 31, Mr. Geesaman was obese, and had poorly controlled hypertension, high cholesterol, undiagnosed diabetes, and severe intracranial atherosclerosis. (Supp. 56-57, 93, 94, Tr. 640-641, 932, 933.[1]) His symptoms were evaluated and he was admitted for further tests and observation under the care of neurologist Ali Almudallal, M.D. (Supp. 29-30, 31, 128-129, Tr. 392-393, 395, 1319-1320.) Dr. Almudallal ordered a carotid ultrasound and MRI, among other tests. (Supp. 61, Tr. 659.)

According to Plaintiffs' expert, the carotid ultrasound showed an abnormality in the right vertebral artery, but the unknown reviewer reported "normal study." (Supp. 62-

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[1] The Trial Transcript is comprised of eight volumes. Volume 6 ends at page 1385, while Volume 7 contains pages 1-212 and Volume 8 contains pages 1-130. Transcript citations from Volumes 1-6 are denoted as "Tr.," and appear at pages 24-137 of the Supplement. Transcript citations from Volume 7 are denoted as "Tr. Vol. 7," and appear at pages 138-189 of the Supplement. Transcript citations from Volume 8 are denoted as "Tr. Vol. 8," and appear at pages 190-203 of the Supplement. In addition, the deposition of Charles Lanzieri, M.D. was read to the jury (Supp. 126, Tr. 1297), but not recorded. Cited portions of the deposition testimony read to the jury are denoted "Lanzieri Dep.," and appear at pages 204-220 of the Supplement.

63, 75-76, Tr. 660-661, 798-799.) The MRI was read by Defendant-Appellant neuroradiologist John Cox, D.O. on the afternoon of April 1. (Supp. 34, 131, Tr. 412, 1326.) Because the diffusion weighted images did not appear when Dr. Cox accessed Mr. Geesaman's MRI on the computer,[2] Dr. Cox did not review those images, and concluded that the MRI was also "normal." (Supp. 38-39, Tr. 416-417.). Mr. Geesaman received aspirin during his three-day hospital stay and was discharged on April 2, 2005, with oral instructions to continue the aspirin. (Supp. 49-52, 134, Tr. 556-559, 1337.)

Mr. Geesaman returned to St. Rita's Emergency Room on April 5. (Supp. 136, Tr. 1350.) After an MRI revealed a stroke, the diffusion-weighted images missing from the April 1 MRI were retrieved and examined. (Supp. 144, Tr. 422.) Upon inspection, the April 1 images showed 2 to 3 infarcts (dead tissue caused by a stroke) in the pons and the cerebellum of Mr. Geesaman's brain. The April 6 MRI showed additional damage in the pons and right cerebellum and new infarcts in the left cerebellum. (Supp. 91, 151, 153-154, 161-163, Tr. 930; Tr. Vol. 7: 53, 55-56, 63-65.)

Medical expert testimony explained that the April 1 and April 6 MRIs revealed an evolving vertebral basilar stroke – a particularly serious form of stroke with a poor prognosis.[3] It was also apparent that the arteries critical to the proper nourishment of Mr.

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[2] The testimony of hospital employees offered by Plaintiffs confirmed technical problems with the computer system, including complaints from other radiologists regarding missing images. (Supp. 45-47, Tr. 457-459.)

[3] The pons and cerebellum are located above and to the side of the brain stem and receive blood through the brain stem. The brain stem, in turn, receives blood from the basilar artery, which is fed by the left and right vertebral arteries. In the case of Mr. Geesaman,

Geesaman's brain stem were already compromised by severe atherosclerosis by the time he presented at St. Rita's on March 31 – a condition that could not be alleviated in the short term by medication or surgery. (Supp. 165-167, Tr. Vol. 7: 81-83.) Long-term treatment would be aimed at lowering glucose levels, blood pressure, and cholesterol, along with some type of antithrombotic medication such as aspirin. (Supp. 96-97, Tr. 935-936.)

Had Mr. Geesaman's evolving vertebral basilar stroke been diagnosed on April 1 instead of April 5, the appropriate treatment would have been exactly what he received – aspirin. (Supp. 165, Tr. Vol. 7: 81.) In fact, the aspirin Mr. Geesaman took during his March 31-April 2 hospital stay would have continued its blood-thinning propensities for 5-10 days, but did not prevent the second stroke which brought Mr. Geesaman to St. Rita's on April 5. (Supp. 102, 167, Tr. 941; Tr. Vol. 7: 83.) And, even though he was again placed on aspirin during his April 5 hospitalization, the aspirin did not prevent additional infarcts, which were evidenced in MRIs taken on April 15 and 25. (Supp. 116-117, 120, 122, 123, Tr. 1230-1231, 1238, 1281-1282; Supp. 208, 210, 214, Lanzieri Dep. 83, 85, 89.)

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severe atherosclerosis had caused a narrowing of the left and right vertebral arteries. The right vertebral artery had blockage on April 1, the left vertebral artery had restricted blood flow, and there was likely some clot in the basilar artery. Blockages of these critical arteries caused "vertebral basilar strokes" – a particularly serious form of stroke with a poor prognosis. (Supp. 89, 104, 111-112, 119-120, 136, 150-151, 159-162, Tr. 927, 987, 1201-1202, 1237-1238, 1350; Tr. Vol. 7: 52-53, 61-64.)

As Dr. Almudallal explained, regardless of treatment the outcome for a vertebral basilar stroke "is typically poor," and his own experience is that patients suffering such strokes "progress to have other strokes no matter what we do." (Supp. 136, Tr. 1350.) See, also, Supp. 101, 104, Tr. 940, 987 (any risk reduction from aspirin "would be less" for Mr. Geesaman "because he has a serious problem in the thrombus and his basilar artery"). Neurologist David Preston, M.D. summarized Mr. Geesaman's condition as follows:

> This atherosclerosis is something you develop over a lifetime and it's exacerbated by certain risk factors. It works out that in Mr. Geesaman's case * * * there was no option which could have prevented his subsequent strokes to a reasonable degree of medical certainty. And indeed, it's far from any reasonable degree of medical certainty that anything could have helped.
>
> For instance, in his situation, where his atherosclerosis was there was no surgical alternative. You cannot do surgery on the vertebral and vascular arteries.
>
> * * *
>
> As far as treating someone with a blood thinning medicine * * * the typical drug that's used there is aspirin. * * * However, the amount of improvement or reduction in risk of taking aspirin is extremely small and nowhere does it come to a reasonable degree of medical certainty that this would have prevented Mr. Geesaman's subsequent strokes.

(Supp. 165-167, Tr. Vol. 7: 81-83.)

Not only was aspirin ineffective to prevent Mr. Geesaman's recurrent strokes, but its effectiveness in preventing recurrent strokes in the general population is statistically remote. Dr. Preston testified regarding the results of 13 different studies conducted to

determine the effectiveness of aspirin to prevent a second stroke. Of the combined 5,061 patients studied, those who took aspirin had an 8.3% chance of having a second stroke, while those who did not take aspirin had a 10% chance of having a second stroke. "So the difference of taking aspirin is 10% versus 8.3%" or 1.7%. (Supp. 171-172, Tr. Vol. 7: 87-88.) Dr. Preston then explained why some physicians refer to a number higher than 1.7% to describe aspirin's effectiveness – they confuse "absolute" risk reduction and "relative" risk reduction:

> As opposed to the absolute risk reduction which is 10 minus 8.3, 1.7, they take that 1.7 and say well 1.7 is how much of 8.3. And works out – that's works out to be 17%. * * * This is the so-called relative risk reduction. So, the doctor says to you, well if you take an aspirin, there's a 17% chance you're going to do better. But it's relatively better because it's actually the difference between 8 and 10 – actually the difference between 8 and 10 is 20% difference.
>
> So * * * this is somewhat misleading. This exaggerates the effect.

(Id.; see, also, Supp. 105-108, Tr. 998-1001.)

B. A Unanimous Jury Concludes that Dr. Cox's Failure to Locate Missing Diffusion Images Did Not Proximately Cause Mr. Geesaman's Recurring Strokes.

On September 13, 2006, Jeffrey and Lori Geesaman filed a medical malpractice suit against St. Rita's Medical Center, Dr. Cox, Dr. Cox's employer (Lima Radiology Associates ("LRA")), Dr. Almudallal, and three other physicians, alleging that as "a direct and proximate cause" of the defendants' violation of the standard of care during his March 31-April 2, 2005 admission, Jeffrey Geesaman suffered a second stroke on April

5. (Supp. 3, Compl., ¶¶12-13.) The case went to trial against Dr. Cox, LRA, and Dr. Almudallal.

1. The evidence.

Prior to and during trial, Dr. Cox conceded that he deviated from the applicable standard of care when he neglected to locate the missing images before concluding that the April 1 MRI was "normal" (Supp. 43, Tr. 421), but disputed Plaintiffs' claim that the deviation proximately caused Mr. Geesaman's April 5 stroke. (E.g., Supp. 101, Tr. 940.)

Prior to and during trial, Plaintiffs presented expert testimony that Dr. Almudallal, as well as Dr. Cox, deviated from the applicable standard of care, and that both deviations more probably than not caused Mr. Geesaman's April 5 stroke. (Supp. 59, 65-66, 68, 69-70, Tr. 653, 676-677, 694, 719-720.) Based on that evidence, the trial court agreed with Defendant's motion in limine regarding the inapplicability of any "loss of chance" theory to Plaintiffs' claim. (Supp. 25-28, Tr. 258-261.)

Dr. Almudallal and other defense witnesses testified that any causal link between Mr. Geesaman's medical treatment March 31 to April 2 and his April 5 stroke was far less than probable. (See, e.g., Supp. 55, 98, 136, 167, Tr. 577, 937, 1350; Tr. Vol. 7: 83.) Witnesses for both sides discussed articles and studies on the effect of aspirin in preventing recurrent strokes and various "relative" and "absolute" rates of risk reduction for various types of strokes. (See, e.g., Supp. 67, 71-74, 77-86, 87-88, 97-98, 109-110, 168-177, 181-183, Tr. 678, 746-749, 811-820, 828-829, 936-937, 1004-1005; Tr. Vol. 7: 84-93, 97-99.)

2. Plaintiffs' proposed jury instructions.

Plaintiffs submitted a proposed jury charge with internally inconsistent instructions on both a traditional malpractice claim and a loss-of-chance malpractice claim. (Supp. 5-23, Pls.' Proposed Jury Instructions.) Plaintiffs' proposed instruction No. 2, for example, described the correct burden of proof for *any* medical malpractice claim:

> The burden of proof is on the Plaintiff to prove the facts necessary for his case by a preponderance of the evidence.

(Supp. 9.) Similarly, following a definition of the standard of care, Plaintiffs' proposed instruction No. 10 correctly instructed that a party "who seeks to recover for his injury must prove" proximate cause as well as negligence, and defined proximate cause as "an act or failure to act which * * * directly produces the injury, and without which it would not have occurred." (Supp. 17.)

The very next instruction (No. 11), however, presented a definition of causation based on an inapplicable loss-of-chance theory that not only conflicted with instruction No. 10, but also shifted the burden of proof away from Plaintiffs (emphasis added):

> In the alternative, *Defendants may claim* that Jeffrey Geesaman lost a less than even chance of avoiding a stroke from his pre-existing vulnerability to stroke. Plaintiffs claim that if this occurred, it was a result of Defendants' negligence. The law recognizes that even though avoidance from a pre-existing vulnerability to stroke was likely, the Plaintiff may be entitled to compensation for the loss of any remaining chance of avoidance proximately caused by the defendant's negligence.

(Supp. at 18.)

Plaintiffs proposed equally conflicting damage instructions. Proposed instruction No. 11 included an equation for calculating loss-of-chance proportional damages ("the percentage of lost chance of avoidance that was proximately caused by the defendant's negligence"), while proposed instruction No. 12 instructed the jury that "[i]f you find for the plaintiff," they are to compensate Plaintiffs for *all* of their damages "proximately and directly caused" by malpractice. (Supp. 18, 19.)

The trial judge correctly rejected the Plaintiffs' proposed loss-of-chance instructions,[4] based on its earlier ruling that: 1) the injection of loss of chance would confuse the jury; and 2) Plaintiffs could not pursue the two theories simultaneously, as held in *Haney v. Barringer*, 7th Dist. No. 06MA141, 2007-Ohio-7214. (Supp. 26-27, 191-192, Tr. 259-260; Tr. Vol. 8: 8-9.)

3. The unanimous defense verdict.

A unanimous jury returned defense verdicts, concluding that Dr. Almudallal did not breach the applicable standard of care and that Dr. Cox's deviation from the standard of care did not proximately cause Mr. Geesaman's claimed injuries. (Supp. 200, Tr. Vol. 8: 127; Appx. 16, App. Op. ¶16.) Plaintiffs appealed.

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[4] The trial court inadvertently included one paragraph of the Plaintiff's "loss of chance" instruction when he read the charge to the jury. (Supp. 194, Tr. Vol. 8: 111.) After the jury retired, the parties agreed to address the inadvertent error by simply removing the paragraph from the written instructions provided to the jury. (Supp. 197-198, Tr. Vol. 8: 124-125.)

C. The Third District Reverses.

The Third District Court of Appeals reversed and remanded as to Dr. Cox and LRA only, concluding that the trial court was *required* to give the conflicting instructions proposed by Plaintiffs. (Appx. 17-18, App. Op., ¶34.) The Court also held that Dr. Cox's counsel had presented an improper hypothetical regarding the April 12 and April 15 MRIs during his cross-examination of Dr. Preston, even though those MRIs had already been discussed in the prior testimony of Drs. Lanzieri and Delano. (Appx. 38, App. Op., ¶61.) Dr. Cox and LRA separately appealed to this Court, which consolidated the appeals and accepted jurisdiction on Dr. Cox's first proposition of law.

II. ARGUMENT

Proposition of Law

> **The "loss-of-chance" doctrine is inapplicable when a plaintiff maintains a medical malpractice claim that seeks full damages for harm directly and proximately caused by medical negligence.**

The above legal proposition may also be articulated as:

> The "loss-of-chance" doctrine applies only to patients who had a less-than-even chance of recovery or survival that was diminished even further by a defendant's medical negligence.

Dobran v. Franciscan Medical Center (2004), 102 Ohio St.3d 54, ¶8, fn. 1.

A. Introduction and Summary of the Argument.

The 22 jurisdictions that have adopted some form of "loss of chance" over the past quarter of a century have struggled to develop a coherent doctrine that is equitable, rational, and capable of consistent application by courts and juries. This Court's

jurisprudence, however, has been cited as a rare example of courts' ability "to control the doctrine's spread and to prevent plaintiffs from using the doctrine to skirt the rules of evidence." Steven R. Koch, Whose Loss Is It Anyway? Effects of the "Lost-Chance" Doctrine on Civil Litigation and Medical Malpractice Insurance (Jan. 2010), 88 N.C.L.Rev. 595, 632 (hereinafter "Koch"). Ohio has avoided unworkable and inconsistent applications of "loss of chance" in part because it limits the doctrine's applicability "to cases in which the plaintiff's odds of recovery prior to the defendant doctor's negligence were already less than 50%." Id. at 632-633.

The Third District Court of Appeals leaped those reasonable boundaries when it concluded that trial courts can and *must* instruct a jury on "loss of chance" in medical malpractice cases when: 1) a plaintiff seeks full damages and presents expert opinion testimony that the claimed injury was "more probably than not" caused by medical negligence; and 2) *the defendant* presents expert opinion testimony that the claimed injury was *not* more probably than not caused by medical negligence. This Court should reverse the Third District's extraordinary expansion of Ohio's loss-of-chance doctrine and reinstate the unanimous jury verdict in favor of Dr. Cox.

In order to explain the analytical error in the Third District opinion – and the Pandora's box opened by its misinterpretation of Ohio law – it is first necessary to understand the two forms of "loss of chance" recognized by various jurisdictions. This brief will therefore first look at the distinct "relaxed causation" and "independent action"

theories established via statute or court decision in 22 jurisdictions, as well as the uneven development of both theories in those jurisdictions.

The brief then describes this Court's adoption of the "relaxed causation" version of loss of chance, and application of proportional damages to a doctrine that is "limited in scope." *Roberts v. Ohio Permanente Medical Group, Inc.* (1996), 76 Ohio St.3d 43, 49.

Finally, Defendant-Appellant will explain why the Third District's reversal of the unanimous jury verdict in this case misinterprets Ohio law, distorts fundamental tort law, and establishes an unfair and unworkable rule of law applicable only to healthcare providers.

B. The Origins and Two-Track Development of the "Loss of Chance" Doctrine in Medical Negligence Cases.

Broadly speaking, the "loss-of-chance" or "lost-chance" doctrine permits some form of recovery "for the destruction or reduction of prospects for achieving a more favorable outcome" as a result of medical negligence. Tori A. Weigand, Loss of Chance in Medical Malpractice: The Need for Caution (2002), 87 Mass.L.Rev. 3, 4 ("Weingand"). As of January of this year, 22 states have adopted a version of the doctrine, either in case law or through statutes, and a roughly equal number of states have either rejected it or deferred deciding the issue. Koch, 88 N.C.L.Rev. at 606-609, 614.

The 22 states recognizing the doctrine fall into two camps. They either: 1) allow loss of chance through a "relaxation" of the proximate cause element of a traditional medical malpractice claim ("relaxed causation"); or 2) recognize a new and independent tort, which may only be asserted against healthcare providers, and which redefines the

"damage" or "harm" to be evaluated and awarded as the lost chance itself ("independent action").

1. Loss of chance as a traditional medical malpractice claim with "relaxed" causation.

The doctrinal origins of "relaxed causation" loss of chance are somewhat obscure. Those courts seeking a common law basis for adopting the theory most often cite to the "increased risk of harm" language in Section 323 of the Restatement (Second) of Torts, or dicta in *Hicks v. United States* (4th Cir. 1966), 368 F.2d 626. Neither supports the doctrine. See Restatement (Third) of Torts: Liab. Physical Harm (2005) §26, Reporter's Notes to Comment *n* (reliance on Section 323 to adopt a "relaxed causation" loss-of-chance doctrine is "misplaced"; Section 323 is under the topic of "Duties of Affirmative Action" and does not address "causal matters"); *Hurley v. U.S.* (4th Cir. 1991), 923 F.2d 1091, 1095 ("*Hicks* made no change to the law that requires a plaintiff to establish proximate cause by a preponderance of the evidence in order to prove medical malpractice negligence").

"Relaxed causation" jurisdictions do not recognize loss of chance as a new or different cause of action. The "harm" to be evaluated and compensated remains the same as in a traditional medical malpractice action – that is, a patient may recover damages for a materialized death or injury. Weingand at 5-6. But because patients with a less-than-even-chance of survival or recovery can *never*, by definition, prove that that harm is more probably than not the result of malpractice, courts "relax" the causation requirement in

those instances in which the patient's chances of survival or recovery are less than 50% at the time of the malpractice. Id.

2. Loss of chance as a separate, independent cause of action that redefines the harm to be compensated.

Jurisdictions that decline to single out healthcare practitioners for a unique deviation from fundamental tort causation standards, nevertheless adopt an equally dubious theory – they create a new, independent "lost chance" tort that may only be asserted against healthcare practitioners. The tort recharacterizes the *harm* for which compensation is sought, as proposed in a 1981 Yale Law Review article.[5] In those jurisdictions, the lost chance itself is the harm to be evaluated and compensated; the plaintiff still must prove that the recharacterized harm was more probably than not caused by malpractice. Weingand at 9; *Matsuyama v. Birnbaum* (Mass. 2008), 890 N.E.2d 819, 822 (the loss-of-chance doctrine does not change the causation burden; "the plaintiff must prove by a preponderance of the evidence that the physician's negligence caused the plaintiff's injury, where the injury consists of the diminished likelihood of achieving a more favorable medical outcome").

This form of loss of chance compensates an inherently speculative harm; when "harm" is redefined as the lost or reduced "chance," the doctrine logically applies even though the ultimate harm has yet to materialize. See, e.g., Fischer, Tort Recovery for Loss of a Chance (2001), 36 Wake Forest L.Rev. 605, 618 ("characterizing the damage as

[5] King, Causation, Valuation and Chance in Personal Injury Torts Involving Preexisting Injuries and Future Consequences (1981), 90 Yale L.J. 1353.

the loss of a chance of avoiding harm (or gaining a benefit) relieves the plaintiff of the burden of proving that the harm itself (or lost benefit itself) occurred"). Even when the ultimate harm has materialized, no consistent method for quantifying and compensating the "lost chance" has evolved. See, e.g., *Jorgenson v. Vener* (S.D.2000), 616 N.W.2d 366, 371 ("the key to a successful application of the [loss-of-chance] doctrine is recognizing and valuing the lost chance as a compensable injury"). Generally, courts allow "proportional" damages, supported by expert statistical testimony, as compensation for the "lost chance" harm. See, e.g., *Matsuyama*, 890 N.E.2d at 841 (cautioning that courts must require reliable statistical evidence for loss of chance, including evidence that considers the "particular clinical circumstances of the patient").

C. Courts' Inability to Fashion a Uniform Rule of Application for Loss of Chance Favors a Narrow Construction of the Doctrine.

The 22 jurisdictions that have adopted a "relaxed causation" or "independent action" form of loss of chance have faced numerous difficulties in its application to case specific facts and allegations.

First, as the authors of the Third Restatement note, each jurisdiction must answer, on a case-by-case basis, the innumerable corollary questions that arise by virtue of the infinite variety of facts presented in medical malpractice actions – i.e.:

> (1) whether [loss of chance] is limited to only those whose lost opportunity is fifty percent or less, or also extends to those with a greater than fifty percent but less than one hundred percent chance, awarding the latter less than a full recovery; (2) whether persons with a lost opportunity to avoid harm who have not yet suffered any harm can recover before

> the harm occurs; (3) whether persons deprived of an opportunity of avoiding harm who nevertheless do not suffer the harm may recover for the lost opportunity; and (4) whether to impose a threshold percentage of lost opportunity before plaintiff may recover any damages.

Restatement (Third) of Torts: Liab. Physical Harm, §26, Reporter's Note on Comment *n*. And the rarity of supreme court review in most states has resulted in unpredictable and arbitrary answers to those questions. Id. Such inconsistency is evident in the encyclopaedic categorization of cases in American Law Reports. See 54 A.L.R.4th 10, Medical Malpractice: "Loss of Chance" Causality, Summary and Comment (describing courts' "diverging opinions," "different perspectives," "varied rationales," and their internally conflicting decisions).

Second, the loss-of-chance doctrine's heavy dependence upon statistical evidence has led to "mathematical blunders." Lars Noah, "An Inventory of Mathematical Blunders in Applying the Loss-of-a-Chance Doctrine" (2005), 24 Rev.Litig. 369, 370 (the "track record among judges, lawyers, and commentators in addressing loss-of-a-chance claim evinces a number of fairly serious blunders," such that one is left to wonder whether the mathematical concept "may pose too great of a challenge for litigants and decisionmakers"). Notably, one example of a "basic mathematical error" offered in the Noah article is an error made by the Third District in this case – confusion between a

"relative" increase of risk of harm and an "absolute" increase in risk of harm. Compare id. at 400 and Appx. 15-16, App. Op., ¶¶13-15.[6]

The difficulties courts have experienced attempting to interpret and apply the loss-of-chance doctrine are not surprising, given the doctrine's uncertain pedigree and deviation from causation requirements that form the "bedrock" of tort jurisprudence. See, e.g., *Weymers v. Khera* (Mich. 1997), 563 N.W.2d 647, 653 (declining to "scrap[]" causation, "the bedrock of our tort law," by adopting of loss of chance); *Jones v. Owings* (S.C. 1995), 456 S.E.2d at 374 (approving this Court's decision in *Cooper* and rejecting loss of chance as "contrary to the most basic standards of proof which undergird the tort system"). The fact that it singles out healthcare providers for this expanded liability is equally troubling. Compare *Kramer v. Lewisville Mem'l Hosp.* (Tex. 1993), 858 S.W.2d 397, 408:

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[6] The article criticizes the Kansas Supreme Court for describing an "absolute" increase in mortality of 6% (the patient's risk of death had increased from 19% to 25%) as "an increase of over 30%[,]" which was the "*relative*" increase in risk (i.e., 25 is 30% higher than 19). In this case, the Third District holds that the jury should have been given a "loss-of-chance" instruction based on defense testimony that Mr. Geesaman had a 25-33% or 13-20% or 17% or 1.7% chance of avoiding recurrent strokes with aspirin therapy. (Appx. 15-16, App. Op., ¶¶13-15.) But the transcript demonstrates that the higher figures represent testimony of *relative* risk (Supp. 55, 71, 73, Tr. 577, 746, 748) while the 1.7% figure is *absolute* risk (Supp. 171-172, Tr. Vol. 7: 87-88). Under the Third District statistical analysis, the jury would have virtually unlimited discretion in awarding loss-of-chance damages, even though the only accurate mathematical principle – absolute risk reduction – was 1.7%, and even though Mr. Geesaman's severe intracranial atherosclerosis and vertebral basilar stroke made his likelihood of avoiding recurrent strokes even more remote.

> We see nothing unique about the healing arts which should make its practitioners more responsible for possible but not probable consequences than any other negligent actor.

Perhaps for those reasons, and as explained below, this Court emphasized that the loss-of-chance doctrine it adopted in 1996 was "limited in scope." *Roberts v. Ohio Permanente Medical Group, Inc.* (1996), 76 Ohio St.3d 43, 49. This case presents the need and opportunity for this Court's further explanation of those limitations.

D. This Court Adopted a Limited "Relaxed Causation" Loss of Chance for Patients Who Could Not Assert a Traditional Medical Negligence Claim Due to Their Less-than-Even Chance of Recovery or Survival at the Time of the Alleged Malpractice.

1. *Roberts* adopted a "relaxed causation" form of loss of chance.

Prior to *Roberts*, this Court required all tort plaintiffs, including medical malpractice plaintiffs, to prove more-probable-than-not causation as an essential element of their claim. See *Cooper v. Sisters of Charity of Cincinnati, Inc.* (1971), 27 Ohio St.2d 242, syllabus:

> In an action for wrongful death, where medical malpractice is alleged as a proximate cause of death, and plaintiff's evidence indicates that a failure to diagnose the injury prevented the patient from an opportunity to be operated on, which failure eliminated any chance of the patient's survival, the issue of proximate cause can be submitted to a jury only if there is sufficient evidence showing that with proper diagnosis, treatment and surgery the patient probably would have survived.

The plaintiff in *Roberts*, like the plaintiff in *Cooper*, presented expert testimony that the plaintiff's decedent had a less-than-even chance of survival even if proper and

timely care had been rendered. *Roberts*, 76 Ohio St.3d at 484. In *Roberts*, however, this Court overturned *Cooper* and concluded that a "relaxed causation" standard based on the "increased risk of harm" theory in Section 323 of the Restatement (Second) of Torts would apply. See 76 Ohio St.3d at 488 (adopting "the approach set forth in Section 323, Restatement of Torts"); id. at 485, 487 ("[T]he requirement of proving causation is relaxed to permit recovery" and "the jury, rather than the medical expert, is given the task of balancing probabilities"). The new rule of law set forth in the *Roberts* syllabus specifies that the doctrine applies to patients who would otherwise be unable to maintain a medical malpractice claim – i.e., those with a "less-than-even chance of recovery or survival" at the time of the alleged malpractice:

> In order to maintain an action for the loss of a less-than-even chance of recovery or survival, the plaintiff must present expert medical testimony showing that the healthcare provider's negligent act or omission increased the risk of harm to the plaintiff. It then becomes a jury question as to whether the defendant's negligence was a cause of the plaintiff's injury or death.

Roberts, syllabus at para. 1.

The damages allowed for loss of chance under *Roberts* are the "proportional" damages suggested in Prof. King's 1981 law review article. *Roberts*, syllabus at para. 3. That is, damages are to be measured according to "the total sum of damages for the underlying injury or death assessed from the date of the negligent act or omission multiplied by the percentage of the lost chance." Id. at 484. Expert testimony must be presented regarding the statistical "percentage." Id.

Although the measure of damages is the same used for the "independent action" loss of chance, this Court did *not* adopt the form of loss of chance where the injury to be evaluated and compensated is the lost chance itself. Rather, *Roberts* maintains the traditional characterization of the harm being compensated – the ultimate and materialized death or injury caused by malpractice. See *Roberts*, syllabus at para. 2 (describing recoverable damages as a portion of the damages "for the underlying injury or death"). See, also, 76 Ohio St.3d at 491 (dissent) (the loss of chance adopted by the *Roberts* majority is *not* the loss-of-chance theory "recognized in some jurisdictions, [where] the injury suffered and the basis of the claim are the reduced possibility of survival, and not the death itself"); *Southwick v. University Hospital, Inc.*, 1st Dist. No. C-050247, 2006-Ohio-1376, ¶¶16-24 (*Roberts* does not create an "independent cause of action" that "would permit recovery for the loss-of-chance itself").

The *Southwick* decision explains why *Roberts* both maintains the traditional definition of harm and limits the doctrine's availability to patients with a less-than-even chance of survival or recovery:

> Although mental suffering and related injuries are compensable in other contexts, damages would be particularly hard to calculate in a case where the chance of recovery does not fall below fifty percent. Damages in such a case would be subject to especially imprecise calculations concerning the actual decrease in the probability of recovery as well as the value to be placed on the resulting anguish or distress.

Id. at ¶24.

In short, Ohio's loss-of-chance doctrine "relaxes" the proximate cause burden of a traditional medical malpractice action for plaintiffs with a less-than-even chance of survival or recovery at the time of the alleged malpractice. All other elements of the traditional claim – including a materialized harm – remain the same. Proportional damages are awarded based on expert medical statistical evidence of the individual patient's chances of survival or recovery at the time of the malpractice.

2. Ohio's loss-of-chance doctrine does not compromise traditional evidentiary requirements or shift the burden of proof.

This Court adopted a loss-of-chance doctrine that modifies only one element of a traditional malpractice action, and only applies to patients with a less-than-even chance of survival or recovery. The evidentiary requirements and burden of proof for a plaintiff's malpractice action have not changed; only the proximate cause requirement has been modified, and only in those cases in which a pre-existing condition or disease renders it impossible for the patient to prove "more probable than not" causation.

A recent law review article cites Ohio's loss-of-chance jurisprudence as an example of how, if a jurisdiction decides to deviate from fundamental causation requirements, it can do so in a manner that maintains traditional evidentiary requirements and the proper burden of proof. Koch, 88 N.C.L.Rev. at 633-634. The article cites to *Roberts, Dobran v. Franciscan Medical Center* (2004), 102 Ohio St.3d 54, and the appellate decision in *Haney v. Barringer*, 7th Dist. No. 06MA141, 2007-Ohio-7214 as examples of the properly narrowed construction of loss of chance.

In *Dobran*, this Court clarified that loss of chance does not apply to a claim seeking damages for an unmaterialized injury:

> *Roberts* contemplates those plaintiffs who had a "less-than-even chance of recovery or survival" that was diminished even further by the defendant's negligence. * * * Dobran has not been diagnosed with metastatic cancer, and consequently cannot claim that his chance of survival is less than fifty percent.

102 Ohio St.3d at 56, ¶18, fn.1. As the Koch article points out, this clarification also "illustrates the fact that the lost-chance doctrine is, by its own nature, limited in applicability to cases in which the plaintiff's odds of recovery prior to the defendant doctor's negligence were already less than fifty percent," and "exemplifies the fact that the lost-chance doctrine does not compromise and traditional evidentiary requirements[.]" 88 N.C. L. Rev. at 632.

Haney v. Barringer (which was also cited by the trial court in this case (Supp. 26, 27, Tr. 259-260)), establishes that loss of chance was not adopted as a "fallback position" for medical malpractice plaintiffs. *Haney* arose out of the alleged failure of emergency room personnel to timely diagnose the decedent's aneurysm. Although the estate's expert testified in deposition that the decedent would have survived but for the defendants' medical negligence, the trial court concluded that the expert was not qualified to provide causation opinion testimony and granted defendants' motion for summary judgment.

On appeal, the estate argued that even without the unqualified opinion testimony, the jury should be permitted to consider her wrongful death claim under the "relaxed"

causation of loss of chance. Id. at ¶9. The defendants countered that the estate "cannot pursue a medical malpractice claim and a loss-of-chance claim because the two claims are mutually exclusive." Id. at ¶11. The court of appeals agreed with the defendants:

> Although Appellant is correct that the loss-of-chance theory of recovery relaxes, to some extent, the traditional requirements for proving proximate cause, it is clear that the loss-of-chance doctrine is not simply a fallback position when a plaintiff cannot establish proximate cause or has simply failed to address the issue. * * * Ohio case law does not permit the application of the loss-of-chance doctrine in a case where the injured patient had a greater-than-even chance of recovery at the time of the alleged negligence.

Id., ¶14. Because the estate "based her proof of liability solely on traditional medical malpractice and traditional notions of proximate cause," she could not premise trial court error on the "loss-of-chance" doctrine. Id., ¶15.

The Koch article notes that *Haney*, in conjunction with *Roberts* and *Dobran*:

> * * * effectively address the concerns that the lost-chance doctrine might circumvent traditional evidentiary requirements for bringing a malpractice action. The doctrine does not allow a plaintiff with a lack of evidence regarding causation to recover under a "fallback" cause of action. When applied appropriately, it merely enables the plaintiff who has reliable statistical evidence of some causal connection in the generality of similar cases to get to the jury when the plaintiff's pre-negligence odds of recovery were already less than fifty percent.

88 N.C. L. Rev. at 633-634 (footnotes omitted).

Other Ohio appellate decisions also correctly interpret *Roberts* and *Dobran* to limit loss of chance to malpractice plaintiffs who are unable to offer expert testimony of more-probable-than-not causation. See *Fehrenbach v. O'Malley* (2005), 164 Ohio

App.3d 80, ¶43 (affirming that a "loss-of-chance" instruction "is not applicable when the plaintiff demonstrates a more than even chance of a full recovery with proper diagnosis and treatment"); *McDermott v. Tweel* (2003), 151 Ohio App.3d 763, ¶43 (loss-of-chance doctrine does not apply to a case "in which the injured patient had an even or greater-than-even chance of recovery at the time of the alleged negligence"); *Liotta v. Rainey* (Nov. 22, 2000), 8th Dist. No. 77396, 2000 WL 1738355 (trial court correctly directed a verdict on "loss of chance" where plaintiff's expert "[a]t no time" testified that the plaintiff had a less than even chance of recovery at the time of the alleged malpractice).

E. The Third District's Misinterpretation of *McMullen v. Ohio State Univ. Hosps.* Drastically Expands Ohio's Loss-of-Chance Doctrine.

The Third District Court of Appeals deviated from this long line of cases limiting *Roberts'* loss-of-chance doctrine to patients *unable* to present more-probable-than-not causation evidence. In so doing, the Court misinterpreted another decision of this Court – *McMullen v. Ohio State Univ. Hosps.* (2000), 88 Ohio St.3d 332 – and "the entire premise" of *Roberts*. (Appx. 24-26, App. Op. ¶¶32-34.)

1. *McMullen* is consistent with Ohio law that "loss of chance" only applies to a malpractice claim that is founded on a less-than-even chance of recovery or survival.

The medical negligence alleged in *McMullen* was a 20-minute delay in the re-establishment of the plaintiff's decedent's endotracheal tube. 88 Ohio St.3d at 333. Although the decedent (Mrs. McMullen) had severe underlying medical problems that likely would have caused her death within 30 days absent malpractice, and had developed

hypoxia (oxygen deprivation) prior to the alleged malpractice, the specific negligent act of failing to re-establish an airway caused her oxygen saturation level to fall to a level that was "inconsistent with life." Id. at 334.

As is evident from the majority and dissenting opinions in *McMullen*, the facts leading to the ultimate harm (Mrs. McMullen's death) could be characterized in a manner consistent with either of two equally plausible legal theories. They could be offered as evidence that the misplaced endotracheal tube was the "direct" and more-probable-than-not cause of Mrs. McMullen's demise – a traditional malpractice claim. Id. at 334. Alternatively, those same facts could be offered as evidence of the defendants' failure to "arrest" Mrs. McMullen's pre-existing hypoxia, thereby reducing her 25% chance of surviving hypoxia to zero. Id. at 345, 347 (Moyer, C.J., dissent).

Mrs. McMullen's estate asserted a traditional malpractice claim and presented expert testimony that the malpractice constituted the direct and more-probable-than-not cause of Mrs. McMullen's death. The court of claims found in favor of the plaintiff, but applied the "proportional damages" of *Roberts*' loss-of-chance doctrine to reduce the full damages the estate was entitled to receive. Id. at 335. This Court reversed.

The issue presented was whether the court of claims could "force" the loss-of-chance doctrine on a plaintiff "who could otherwise prove that specific negligent acts of the defendant caused the ultimate harm." 88 Ohio St.3d at 337. It is questionable whether loss of chance *could* apply to a plaintiff who is *able* to present more-probable-than-not causation evidence. But this Court concluded that whether or not Mrs.

McMullen's estate *could have* framed and pursued a claim based on Mrs. McMullen's less-than-even chance of recovery prior to the alleged malpractice, that was not the claim presented and proved. A plaintiff able to present a traditional malpractice claim is permitted to seek full damages for that claim. Such plaintiffs are not required to "involuntarily use an increased-risk theory of recovery, with its attendant formula for reducing damages." Id. at 337.

Of course, the "full damages" claimed by the plaintiff would be affected by the expert testimony regarding Mrs. McMullen's prognosis. For that reason, this Court remanded *McMullen* to the trial court for an assessment of damages "based on decedent's life expectancy, taking into account decedent's condition at the time of her death, as in any other malpractice case[.]" Id. at 344. But it was plaintiff's right to elect to pursue those "full" damages.

McMullen confirms the hornbook law that a plaintiff is the master of his or her claim. The decision in no way modifies this Court's holding that the loss-of-chance doctrine applies only to plaintiffs seeking proportional damages for a diminution of the plaintiff's less-than-even chance of recovery or survival. It is not a "fallback" claim for plaintiffs seeking full damages for an injury they claim to be the direct and more-probable-than-not result of medical negligence.

2. The Third District misinterpreted *McMullen*.

In its analysis of *McMullen*, the Third District first concluded that the facts of this case were more "akin to" the loss-of-chance cases "reviewed" in *McMullen* – i.e., cases

"wherein a medical provider's negligence combined with" a pre-existing condition "to lead to the injury" – than to the facts of *McMullen*. (Appx. 24, App. Op., ¶32.) Second, the Third District characterized "the entire premise" of *Roberts* as: "doctors and other medical personnel should not be allowed to benefit from the uncertainty of recovery/survival that their negligence has created." (Appx. 25, App. Op., ¶33.) Based on those two premises, the Court concluded that "the jury should have been instructed on the loss of less-than-even chance theory of recovery" and proportional damages *in addition to* traditional causation and full damages. (Appx. 25-26, App. Op., ¶¶33-34.) Specifically:

> [I]f the jury did not find proximate cause, the evidence warranted instructing them to consider loss of chance, not as a fallback position * * * but based upon the evidence before it.

(Appx. 25-26, App. Op., ¶34.) The Third District's conclusion, and the two premises upon which the conclusion is based, are flawed.

First, this case *is* factually akin to *McMullen*. Like the facts in *McMullen*, the facts leading to the ultimate harm in this case (which Plaintiffs characterize as a "second" stroke) are consistent with two different theories. One is a claim for *full* damages for the physical effects of Mr. Geesaman's second stroke, based upon an assertion that the Defendants' alleged failure to timely diagnose and treat the March 31 symptoms more probably than not caused a second stroke. The other is a claim for *proportional* damages based upon an assertion that Mr. Geesaman had a less-than-even chance of avoiding further strokes at the time of the alleged malpractice, and the Defendants' negligence

combined with the underlying evolving stroke to cause additional damage on April 5. Like the plaintiff in *McMullen*, the Plaintiffs in this case chose to pursue full damages under a traditional malpractice theory. That was the claim presented and the claim defended. No court "forced" Plaintiffs to pursue one theory or the other. The Third District, however, unilaterally relieved Plaintiffs of their chosen burden of proof by holding that the trial court was *required* to instruct the jury that they could find for plaintiff *even if he did not carry his burden of proof upon which his claim is founded.*

Second, the Third District erroneously concluded that the "entire premise" of *Roberts* supported its holding that Plaintiffs are entitled to *both* a traditional proximate cause instruction *and* a loss-of-chance instruction. (Appx. 25, App. Op., ¶33.) The "premise" of *Roberts* is that patients who have been injured by medical negligence, but who *cannot present a prima facie case of malpractice* due to an underlying medical condition, should be compensated for that portion of ultimate harm caused by the malpractice. That is, absent the availability of loss of chance, the physician whose negligence reduces a less-than-even chance of survival would be "insulated from liability." *Roberts*, 76 Ohio St.3d at 488. Here, the Defendants were not "insulated from liability" as a result of traditional rules of causation. To the contrary, Plaintiffs were given a full opportunity to present their evidence to a jury and the jury was instructed to award full damages if they believed Plaintiffs' experts. A jury of Mr. Geesaman's peers – not a rule of law – determined that Defendants were not responsible for his April 5

stroke. Neither *McMullen* nor any other decision of this Court even remotely suggests that traditional proximate cause operates in tandem with "relaxed" causation.

Third, based on those two faulty premises, the Third District erroneously concluded that juries must be instructed on both traditional and relaxed proximate cause, full and proportionate damages any time a defendant disputes proximate cause. Loss of chance is neither an "add on" to, nor a "fallback" for, a traditional malpractice claim. Nothing in *Roberts* or its loss-of-chance doctrine supports such an illogical and unfair expansion of physicians' tort liability.

The new rule of law imposed by the Third District goes far beyond *Roberts'* rule allowing "relaxed" proximate cause in limited circumstances. By mandating instructions on two inconsistent theories – one based on the plaintiff's claim and the second based upon evidence offered to refute the plaintiff's claim – the court effectively relieves the plaintiff of his burden of proof, contrary to 100 years of Ohio law.

In 1910, this Court affirmed the holding in *Snyder v. American Cigar Co.* (1908), 33 Ohio C.D. 440, 43 Ohio C.C. 440, aff'd (1910), 81 Ohio St. 568, that under "the rule that the burden of proof is upon the plaintiff," when "two antagonistic theories of the case are presented * * * the plaintiff must recover, if at all, upon the merits of his own theory and the sufficiency of his own allegations and proof, not upon any weakness in his adversary's position." Here, "two antagonistic theories of the case" were presented – the Plaintiffs alleged and presented evidence that Mr. Geesaman's second stroke was the direct and probable result of insufficient intervention between the March 31 and April 5

hospitalizations, while Defendants alleged and presented evidence that additional therapies would not have affected the evolving stroke or Mr. Geesaman's severe intracranial atherosclerosis. Plaintiffs had the burden of proof and were required to recover, "if at all, upon the merits of [their] own theory and the sufficiency of [their] own allegations * * *." Here, Plaintiffs did not even seek to latch onto a "weakness" in the Defendants' position to make up for their own inability to persuade the jury. Instead, they claimed that Defendants' *refutation* of Plaintiffs' expert causation testimony created a "fallback" position for the Plaintiffs that otherwise would not exist. More specifically, rather than trying to prove *their* theory through an adversary's evidence, Plaintiffs attempted to prove an *unasserted* theory through an adversary's evidence. See, e.g., Plaintiffs' Proposed instruction 11 ("Defendants may claim" loss of chance and "[t]he law recognizes" that a plaintiff "may be entitled to compensation for the loss of any remaining chance of avoidance proximately caused by the defendant's negligence"). (Supp. 18.)

Such an extraordinary departure from fundamental tort law is unsupported by law or policy. The trial court correctly presented Plaintiffs' malpractice claim to the jury and the Third District Court of Appeals' finding of instructional error should be reversed.

F. This Court Should Reinstate the Trial Court's Entry of Judgment on the Unanimous Jury Verdict in Favor of Dr. Cox.

In addition to the alleged instructional error, the Third District held that Plaintiffs' "sixth assignment of error is well taken[.]" (Appx. 38, App. Op., ¶61.) If this Court concludes that the trial court correctly refused the Plaintiffs' "loss of chance" instructions, it may either: 1) remand to the Court of Appeals for further consideration; or 2) "exercise our authority to finally resolve this cause" based upon the record before it. *Myocare Nursing Home, Inc. v. Fifth Third Bank* (2003), 98 Ohio St.3d 545, 551, ¶48. Accord *Willis v. Baker* (1906), 75 Ohio St. 291, 307; *Bridges v. National Engineering and Contracting Co.* (1990), 49 Ohio St.3d 108, 114. It is respectfully submitted that the evidence before this Court is wholly sufficient to enter a final judgment and no remand is necessary.

Plaintiffs' sixth assignment of error alleged that the trial court had "erred" when it overruled Plaintiffs' objection to a hypothetical asked by counsel for Dr. Cox during his cross-examination of a neurologist expert testifying on behalf of Dr. Almudallal. More specifically, Plaintiffs alleged that the hypothetical elicited a "new" opinion from Robert Preston, M.D. "in contravention of" the trial court's ruling restricting Dr. Almudallal's counsel's *direct* examination of Dr. Preston. (Appx. 17, App. Op., ¶17.)

The appellate court's conclusion that the assigned error was "well taken" appears to be nothing more than guidance offered for the presumed retrial. First, the Court does not state that the trial court abused its discretion in overruling Plaintiffs' objection to the

hypothetical question; it does not even say that the trial court's ruling constituted "error." And it does not even suggest that any such error or abuse of discretion, standing alone, would require reversal of the unanimous jury verdict in Dr. Cox's favor. Compare Civ.R. 61 (no error in the admission of evidence constitutes grounds for granting a new trial "unless refusal to take such action appears to the court to be inconsistent with substantial justice").

Further, the Court neither discusses nor analyzes the Civil Rule governing what constitutes "new" opinion testimony at trial (Civ.R. 26(E)). Finally, although it concludes that Plaintiffs' counsel "did not have the opportunity to prepare for this portion of Dr. Preston's testimony" (Appx. 37, App. Op. at ¶60), the decision does not explain how Plaintiffs were "surprised" by the cross-examination question or answer, or how Plaintiffs were prejudiced. In fact, the record conclusively establishes that the response could not possibly have caused *any* "surprise," much less affect the substantial right of any party.

The allegedly "new" opinion in Dr. Preston's cross-examination response was that new infarcts in the MRIs from April 15 and April 25 (ten days after Mr. Geesaman's second stroke), indicated that the aspirin and other medication instituted April 5 "wasn't working." (Supp. 188, Tr. Vol. 7: 181.) Virtually identical testimony was elicited in the deposition of an expert *retained by Plaintiffs*, taken *three months before trial*. At that deposition, neuroradiologist Charles Lanzieri, M.D. not only testified that the April 15 and 25 MRIs showed "additional infarcts in both cerebellar peduncles" and the pons, but

testified that the additional infarcts proved that aspirin therapy was ineffective in the prevention of Mr. Geesaman's recurrent strokes: "[I]f we're still having infarcts, then the medicine ain't working, Doc." (Supp. at 208, 210, 214, Lanzieri Dep. at 83, 85, 89.)

Further, before Dr. Preston took the stand, Dr. Lanzieri's deposition was read to the jury (Supp. 126, Tr. 1297); neuroradiologist Mark Delano, M.D., opined that the April 15 and April 25 MRIs showed "new areas" of infarcts (Supp. 115, 116, 117, 120, 122, Tr. 1207, 1230, 1231, 1238, 1281); and counsel for Dr. Cox announced in open court that he intended to cross-examine Dr. Preston with a hypothetical based on the April 15 and April 25 images that had already been discussed by Drs. Lanzieri and Delano. (Supp. 146, Tr. Vol. 7: 8.)

Finally, after counsel for Dr. Almudallal conducted his direct examination of Dr. Preston and counsel for Plaintiffs conducted his cross-examination, the Court took a *two-hour recess*. (Supp. 184-185, Tr. Vol. 7: 168-169.) After the recess, Dr. Cox conducted the cross-examination in which he presented the previously announced hypothetical to Dr. Preston. (Supp. 188, Tr. Vol. 7: 181.) Plaintiffs' objection was overruled and Dr. Preston confirmed that the additional infarcts on the two MRIs would support the position that "the treatment that the patient was receiving wasn't resolving his neurologic problems." (Supp. 188-189, Tr. Vol. 7: 181-182.)

Under the record presented in this case, no remand is necessary for further consideration of whether the trial court's discretionary ruling, standing alone, constitutes

a manifest injustice requiring a new trial. This Court can and should enter final judgment in the cause.

III. CONCLUSION

If "loss of chance" were an issue of first impression for this Court, it might well choose to follow those jurisdictions which have declined to adopt the loss-of-chance doctrine. See, e.g., *Kemper v. Gordon* (Ky. 2008), 272 S.W.3d 146, 152, which is particularly relevant to the facts of this case:

> [W]e see many difficulties in adopting the lost or diminished chance doctrine. For instance, what is a "late diagnosis"? Does a diagnosis missed this week, but made next week, rise to the level of diminished chance? A whole new and expensive industry of experts could conceivably be marched through our courts, providing evidence for juries that an MRI misread on Monday, but accurately discerned on Friday, perhaps gives rise to an infinitesimal loss of a chance to recover.

Having adopted it, however, it is respectfully submitted that this Court should provide the further guidance appellate courts need by confirming the narrow parameters of *Roberts'* loss-of-chance doctrine. More specifically, this Court should clarify that loss of chance is not a "fallback" claim for plaintiffs presenting a traditional malpractice claim based on more-probable-than-not causation.

For all of the reasons stated more fully above, Defendant-Appellant John Cox, D.O. respectfully requests reversal of the appellate decision in this case and reinstatement of the trial court's judgment on the unanimous jury verdict in his favor.

Respectfully submitted,

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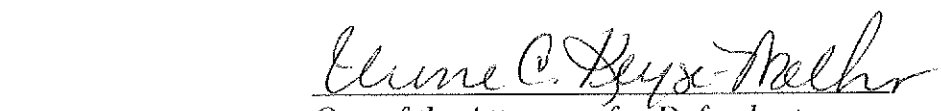

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APPENDIX

No. 09-1715

In the Supreme Court of Ohio

APPEAL FROM THE COURT OF APPEALS
THIRD APPELLATE DISTRICT
ALLEN COUNTY, OHIO
CASE NO. 01-08-065

JEFFREY GEESAMAN, et al.,
Plaintiffs-Appellees,

v.

ST. RITA'S MEDICAL CENTER, et al.,
Defendant-Appellees,

and

JOHN COX, D.O.,
Defendant-Appellant.

NOTICE OF APPEAL OF APPELLANT JOHN COX, D.O.

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NOTICE OF APPEAL OF APPELLANT JOHN COX, D.O.

Appellant John Cox, D.O. hereby gives notice of appeal to the Supreme Court of Ohio from the judgment of the Allen County Court of Appeals, Third Appellate District, entered in Court of Appeals Case No. 01-08-065 on August 10, 2009. This case is one of public or great general interest.

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No. 2009-2094

In the Supreme Court of Ohio

APPEAL FROM THE COURT OF APPEALS
THIRD APPELLATE DISTRICT
ALLEN COUNTY, OHIO
CASE NO. 01-08-065

JEFFREY GEESAMAN, et al.,
Plaintiffs-Appellees,

v.

ST. RITA'S MEDICAL CENTER, et al.,
Defendants,

and

JOHN COX, D.O.,
Defendant-Appellant.

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Appellant John Cox, D.O. hereby gives notice of appeal to the Supreme Court of Ohio from the judgment of the Allen County Court of Appeals, Third Appellate District, entered in Court of Appeals Case No. 01-08-65 on August 10, 2009, and the opinion issued that same date, as clarified in the Court's Judgment Entry and Erratum to Opinion, both of which were filed October 21, 2009. Dr. Cox's appeal from the August 10, 2009 judgment is already pending before this Court in S.Ct. No. 2009-1715. Neither the clarifying Judgment Entry nor the Erratum to Opinion filed October 21, 2009 modifies or makes any substantive change to either the August 10, 2009 judgment or opinion, and no additional notice of appeal was necessary. However, since Defendant-Appellant Lima Radiology Associates, Inc. (also a party to S.Ct. No. 2009-1715), filed a second notice of appeal, and this Court assigned a separate appeal number to the second notice, Dr. Cox now files this additional notice of appeal out of an abundance of caution. This case presents a matter of great and general public interest.

Respectfully submitted,

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CERTIFICATE OF SERVICE

A copy of the foregoing has been served this 4th day of December, 2009, by U.S. Mail, postage prepaid, upon the following:

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IN THE COURT OF APPEALS OF OHIO
THIRD APPELLATE DISTRICT
ALLEN COUNTY

JEFFREY GEESAMAN, ET AL.,

PLAINTIFFS-APPELLANTS, **CASE NO. 1-08-65**

v.

ST. RITA'S MEDICAL CENTER, ET AL., **O P I N I O N**

DEFENDANTS-APPELLEES.

Appeal from Allen County Common Pleas Court
Trial Court No. CV2006 0914

Judgment Affirmed in Part, Reversed in Part, and Cause Remanded

Date of Decision: August 10, 2009

APPEARANCES:

Dennis P. Mulvihill **for Appellants**

James F. Nooney **for Appellee, Ali Almudallal, M.D.**

Patrick K. Adkinson **for Appellees, John Cox, M.D. and Lima Radiology**

SHAW, J.

{¶1} Plaintiffs-appellants Jeffrey and Lori Geesaman appeal the October 1, 2008 judgment of the Common Pleas Court of Allen County, Ohio, entering a judgment for the defendants-appellees, Dr. John Cox, Lima Radiology Associates, and Dr. Ali Almudallal, and dismissing the Gessamans' complaint following a jury verdict in favor of the appellees.

{¶2} The facts relevant to this appeal are as follows. On March 31, 2005, Jeffrey Geesaman went to the emergency room at St. Rita's Medical Center where he saw Dr. Gary Beasley. Mr. Geesaman reported that he was experiencing dizziness, balance issues, slurred speech, problems with his vision, and had vomited three times throughout the day. His blood pressure was taken at the time, and it was 171/111 and later reached 184/117. His weight was 280 pounds, and he was 6' 1" tall. Mr. Geesaman also provided a history to medical personnel, which included poorly controlled hypertension, smoking, and alcohol consumption. Mr. Geesaman further stated that he quit smoking and consuming alcohol a number of years prior. In addition, he reported that his mother had a stroke at age forty-five.

{¶3} Dr. Beasley conducted a physical exam of Mr. Geesaman in order to determine the cause of his symptoms and found no signs of trauma to his head. Dr. Beasley did not have Mr. Geesaman stand up or walk because of his size and complaints of dizziness and balance problems. Mr. Geesaman was placed on a

heart monitor, and a chest x-ray and CT scan of his head were taken, as well as other tests. The chest x-ray and physical examination were negative for any cardiac problems. The CT scan did not show any kind of bleed or tumor that could explain the symptoms. However, Mr. Geesaman's sugar level was elevated at 224.

{¶4} After reviewing the various tests and conducting his own examination, Dr. Beasley was concerned that Mr. Geesaman might have had a stroke or was experiencing a transient ischemic attack ("TIA"). As a result, Dr. Beasley, who is an emergency medicine physician, contacted neurologist, Dr. Ali Almudallal, to discuss the case and his concerns. After discussing the case, the decision was made to have Mr. Geesaman admitted to internal medicine and Dr. Almudallal would provide a neurological consult.

{¶5} That evening, Mr. Geesaman was admitted to the hospital and placed on a number of different medications, including aspirin. The following day, Dr. Almudallal ordered several tests for Mr. Geesaman, including magnetic resonance imaging ("MRI") of his brain, in order to determine if he had a stroke. An MRI of the brain involves the taking of hundreds of images in various sequences, including diffusion weighted images. The MRI was reviewed by Dr. John Cox, a neuroradiologist. Dr. Cox concluded that the MRI was normal and wrote that conclusion in his report. After reading the conclusion of Dr. Cox, as well as the results of the other tests, Dr. Almudallal ruled out a stroke.

{¶6} Mr. Geesaman's condition seemed to improve, and Dr. Almudallal determined that his neurological problems were possibly caused by either a complicated migraine or labyrinthitis, an inflammation in the inner ear. Therefore, Dr. Almudallal discharged Mr. Geesaman from his neurological care. Prior to discharging Mr. Geesaman from neurology, Dr. Almudallal spoke with him and his wife about his conclusions and decided to see him on an outpatient basis to provide additional workup for these possible conditions. In addition, Dr. Almudallal testified that he told Mr. Geesaman to continue taking aspirin every day. However, the Geesamans testified that he never gave that instruction.

{¶7} Mr. Geesaman remained in the hospital for another day because of other issues, including his hypertension and his newly discovered diabetes, which were being treated by the internal medicine physicians. On April 2, 2005, Mr. Geesaman was discharged from the hospital. Prior to that discharge, he was given discharge instructions and five prescriptions, neither of which involved him taking aspirin. Upon leaving the hospital, Mr. Geesaman did not take any additional aspirin.

{¶8} For the next three days, Mr. Geesaman seemed to be improving. However, on April 5, 2005, Mr. Geesaman returned to St. Rita's emergency room. This time he and his wife reported that his slurred speech had increased, he was off balance, had difficulty walking, was confused, had right sided weakness, loss of appetite, and was very tired. Once again, Mr. Geesaman was admitted to the

hospital, and another MRI of his brain was ordered in addition to other tests. Included in the other tests was a magnetic resonance angiogram ("MRA"). An MRA uses a magnetic field to provide pictures of blood vessels inside the body. In this case, the MRA was utilized to determine if any abnormalities in Mr. Geesaman's vessels, such as a blood clot, existed that could explain his symptoms.

{¶9} This second MRI revealed that Mr. Geesaman had suffered a stroke. In addition, the doctors treating Mr. Geesaman realized that his first MRI had shown that he had a stroke. In fact, two to three infarcts, dead tissue caused by a stroke, were visible in the April 1, 2005 MRI. However, those infarcts went unnoticed because Dr. Cox failed to view the diffusion weighted images of the MRI. Diffusion weighted images are helpful to identify an area of acute ischemia in the brain, i.e. a restriction in blood supply, which would indicate a recent stroke. In this case, these images showed damage to the portions of the brain located in the back of the head, known as the pons and the cerebellum. Problems in these parts of the brain were consistent with the symptoms Mr. Geesaman was experiencing when he came to the hospital the first time.

{¶10} Mr. Geesaman remained in the hospital until April 13, 2005, when he was transferred to the rehabilitation facility at St. Rita's. He remained in rehabilitation until he was discharged to his home on May 11, 2005. As a result of the strokes, he suffered brain damage, leaving him permanently disabled and unable to care for himself.

{¶11} The Geesamans filed a complaint for medical malpractice and loss of consortium against Dr. Almudallal, Dr. Cox, and several others on September 13, 2006. The case proceeded through the discovery phase with the parties deposing several doctors on behalf of each and various parties being dismissed. Among those deposed was Dr. Charles Lanzieri, a neuroradiologist. Dr. Lanzieri was listed as an expert witness for the Geesamans.

{¶12} During discovery, Dr. Cox admitted that he breached the standard of care by failing to review the diffusion weighted images of the MRI.[1] Ultimately, the case proceeded to trial against Dr. Almudallal, Dr. Cox, and Lima Radiology Associates.[2] Prior to the trial, the Geesamans filed a motion in limine, asking the court to exclude any evidence of Mr. Geesaman's prior drug and alcohol usage. The court overruled this motion. Additionally, Dr. Cox filed a motion in limine, requesting that the Geesamans not be permitted to introduce any evidence or make any argument to the jury as to loss of a less-than-even chance of recovery. The trial court granted this request and ordered that the Geesamans were "foreclosed from bringing forth any evidence with a focus on Loss of Chance."

[1] The parties dispute the reason for Dr. Cox's breach of duty. Dr. Cox maintained that the images did not appear when he accessed Mr. Geesaman's MRI in the computer due to some problem with the system. However, witnesses for the plaintiffs testified that the system was working properly and the images were available for review when Dr. Cox accessed Mr. Geesaman's MRI. In any event, Dr. Cox admitted that he should have reviewed these images and that his failure to recognize that the images were not available and to examine them prior to determining the MRI was normal was a breach of the standard of care.

[2] The complaint names Lima Radiology Associates ("LRA") under the doctrine of respondeat superior as the employer of Dr. Cox or that Dr. Cox was the owner of LRA. The judgment entry on the jury's verdict indicates that LRA was dismissed pursuant to the verdict. However, LRA's involvement was not mentioned during the trial nor was there a finding by the jury in regards to LRA. Rather, all parties acted as if the case were solely against Dr. Cox and Dr. Almudallal.

{¶13} On September 15, 2008, the trial in this matter began. Over the next several days, the parties presented their respective cases. One of the experts utilized by the Geesamans was Dr. David Thaler, a neurologist. He testified, inter alia, that had the stroke that Mr. Geesaman suffered on March 31, 2005, been recognized, the condition that caused that stroke identified, and Mr. Geesaman properly treated, he more likely than not would not have suffered the second stroke on April 5, 2005, which left him disabled. Counsel for the Geesamans also called Dr. Almudallal to testify as upon cross-examination. During this testimony, Dr. Almudallal opined that with proper care during Mr. Geesaman's first admission, he would have had a 25-33% chance of avoiding the second stroke.

{¶14} Dr. Cox's expert in neurology, Dr. Howard Kirshner, testified that even if the first stroke would have been detected, the condition that caused the stroke identified, and Mr. Geesaman properly treated, he more likely than not would have suffered the second stroke. However, he also testified that there are studies that have shown with proper treatment, particularly utilizing aspirin, there is a 13-20% chance to avoid a second stroke.

{¶15} Dr. Almudallal also presented the expert testimony of Dr. David Preston, a neurologist. In respect to causation, Dr. Preston testified that no treatment option would have prevented Mr. Geesaman's second stroke to a reasonable degree of medical certainty. This testimony was based, in part, upon a meta-analysis of thirteen clinical trials involving stroke treatment utilizing aspirin.

That analysis found that patients who were treated with aspirin had an 8.3% chance of having another stroke, whereas patients who were not treated had a 10% chance of having another stroke. These numbers correlated to a 17% relative risk reduction for a second stroke in patients who were treated with aspirin and an absolute risk reduction of 1.7%.

{¶16} At the conclusion of all the evidence, the trial court provided the jury with instructions, interrogatories, and verdict forms. Included in the instructions was an instruction about comparative negligence. After deliberations, the jury answered the necessary interrogatories and returned verdicts in favor of Dr. Almudallal and Dr. Cox. Specifically, the jury found that Dr. Almudallal was not negligent. It also found that Dr. Cox's negligence, which was conceded at trial, did not proximately cause injury to Mr. Geesaman. In accordance with these verdicts, the trial court rendered judgment in favor of the doctors and dismissed the Geesamans' complaint.

{¶17} The Geesamans now appeal, asserting six assignments of error.

ASSIGNMENT OF ERROR NO. 1

THE TRIAL COURT ERRED WHEN IT EXCLUDED APPELLANTS' LOSS-OF-CHANCE THEORY OF RECOVERY FROM TRIAL.

ASSIGNMENT OF ERROR NO. 2

THE TRIAL COURT ERRED WHEN IT REFUSED TO CHARGE THE JURY ON THE LOSS-OF-CHANCE THEORY OF RECOVERY.

ASSIGNMENT OF ERROR NO. 3

THE TRIAL COURT ERRED WHEN IT CHARGED THE JURY ON APPELLANT JEFFREY GEESAMAN'S COMPARATIVE NEGLIGENCE.

ASSIGNMENT OF ERROR NO. 4

THE TRIAL COURT ERRED WHEN IT ADMITTED EVIDENCE OF APPELLANT JEFFREY GEESAMAN'S PRIOR DRUG USE.

ASSIGNMENT OF ERROR NO. 5

THE TRIAL COURT ERRED WHEN IT ADMITTED DR. LANZIERI'S DEPOSITION INTO EVIDENCE AT TRIAL.

ASSIGNMENT OF ERROR NO. 6

THE TRIAL COURT ERRED WHEN IT ADMITTED TESTIMONY FROM DR. PRESTON IN CONTRAVENTION OF ITS OWN ORDER REGARDING TWO MRIS TAKEN OF JEFFREY GEESAMAN'S BRAIN.

{¶18} For ease of discussion, we elect to address the assignments of error out of order.

Second Assignment of Error

{¶19} In their second assignment of error, the Geesamans maintain that the trial court erred when it failed to instruct the jury on the issue of loss-of-chance. Initially, we note that this assignment or error involves the causation element of a medical malpractice action, not issues of duty and a breach thereof, i.e. negligence. The jury found that Dr. Almudallal was not negligent and,

accordingly, never proceeded to the causation inquiry. Therefore, this assignment of error does not apply to the verdict rendered in favor of Dr. Almudallal, and we address this issue only as it applies to Dr. Cox.

{¶20} In general, requested instructions should be given if they are correct statements of the law applicable to the facts in the case and reasonable minds might reach the conclusion sought by the instruction. *Murphy v. Carrolton Mfg. Co.* (1991), 61 Ohio St.3d 585, 591, 575 N.E. 2d 828. "In reviewing a record to ascertain the presence of sufficient evidence to support the giving of a[n] ... instruction, an appellate court should determine whether the record contains evidence from which reasonable minds might reach the conclusion sought by the instruction." *Id.*, citing *Feterle v. Huettner* (1971), 28 Ohio St.2d 54, 275 N.E.2d 340 at syllabus. In reviewing the sufficiency of jury instructions given by a trial court, the proper standard of review for an appellate court is whether the trial court's refusal to give a requested jury instruction constituted an abuse of discretion under the facts and circumstances of the case. *State v. Wolons* (1989), 44 Ohio St.3d 64, 68, 541 N.E.2d 443. The term "abuse of discretion" implies that the court's attitude is unreasonable, arbitrary or unconscionable. *Blakemore v. Blakemore* (1983), 5 Ohio St.3d 217, 219, 450 N.E.2d 1140.

{¶21} Here, the issue is whether the evidence warranted an instruction on loss-of-chance. The loss-of-chance theory, more appropriately referred to as "loss of a less-than-even chance," was first recognized as a method of recovery in a

medical malpractice action in Ohio in 1996. See *Roberts v. Ohio Permanente Medical Group, Inc.*, 76 Ohio St.3d 483, 668 N.E.2d 480, 1996-Ohio-375. The plaintiff in *Roberts* was the executor of the estate of a patient who died from lung cancer. *Id.* at 484. The defendants failed to diagnose and properly treat the patient's lung cancer for seventeen months. *Id.* The plaintiff presented evidence that the decedent would have had a 28% percent chance of survival had proper and timely care been rendered but that the defendants' negligence decreased that chance of survival to zero. *Id.* After reviewing the loss-of-chance theory and Ohio's prior treatment of this theory, the Court held:

> **In order to maintain an action for loss of a less-than-even chance of recovery or survival, the plaintiff must present expert medical testimony showing that the health care provider's negligent act or omission increased the risk of harm to the plaintiff. It then becomes a jury question as to whether the defendant's negligence was a cause of the plaintiff's injury or death. Once that burden is met, the trier of fact may then assess the degree to which the plaintiff's chances of recovery or survival have been decreased and calculate the appropriate measure of damages. The plaintiff is not required to establish the lost chance of recovery or survival in an exact percentage in order for the matter to be submitted to the jury.**

Id. at 488, 668 N.E.2d at 484. In so holding, the Ohio Supreme Court expressly overruled its prior holding in *Cooper v. Sisters of Charity of Cincinnati, Inc.* (1971), 27 Ohio St.2d 242, 251-252, 272 N.E.2d 97. *Id.*

{¶22} In *Cooper*, the decedent, a sixteen-year-old boy, was struck by a truck while riding a bicycle and hit his head. *Cooper*, 27 Ohio St.2d 242. The

emergency room physician failed to conduct a proper examination, thus missing his skull fracture and welling of the tissues in the back of his head. *Id.* at 243-245. The doctor sent him home, and the boy died early the next morning from his injuries. *Id.*

{¶23} The executor of the boy's estate brought suit and presented two experts. *Id.* at 245-248. One doctor, who performed the decedent's autopsy, stated that it was difficult to ascertain with any degree of certainty whether the decedent would have survived or died with proper treatment. *Id.* at 247. The other doctor testified that proper diagnosis and surgery would have placed the boy's chances for survival around 50%. *Id.* The trial court granted the defendants a directed verdict, finding that the plaintiff failed to establish proximate cause between the defendants' negligence and the boy's death. *Id.* at 248-249. In affirming this decision, the Supreme Court of Ohio rejected the loss-of-chance theory and only permitted recovery in a medical malpractice action under a traditional proximate cause standard, i.e. when the plaintiff could prove that the negligence of the tortfeasor was more probably than not the proximate cause of the death and/or injury of the patient. *Id.* at syllabus.

{¶24} In *Roberts*, the Court re-examined the loss-of-chance theory and the views expressed in *Cooper*. *Roberts*, 76 Ohio St.3d at 487. The Court then found that it could "no longer condone this view" and overruled *Cooper*. *Id.* at 488. In explaining its decision, the Court stated: "Rarely does the law present so clear an

opportunity to correct an unfair situation as does this case before us. The time has come to discard the traditionally harsh view we previously followed[.]" *Id.* The Court also declared that "[a] patient who seeks medical assistance from a professional caregiver has the right to expect proper care and should be compensated for any injury caused by the caregiver's negligence which has reduced his or her chance of survival." *Id.* The Court went on to discuss the advancements seen in the medical field and the importance of early intervention and held that "a health care provider should not be insulated from liability where there is expert medical testimony showing that he or she reduced the patient's chances of survival." *Id.*

{¶25} During the trial in this case, the Geesamans presented the testimony of Dr. David Thaler, who concluded that Mr. Geesaman's second, more devastating stroke and its attendant injuries more likely than not could have been avoided but for the errors made in failing to identify the first stroke and treating him properly. Dr. Almudallal testified as upon cross-examination that Mr. Geesaman's chances of avoiding that second stroke were 25-33% if he had been properly treated after his first stroke. Dr. Kirshner, in testifying for Dr. Cox, acknowledged that some studies have shown that with proper treatment, such as the use of aspirin, there is a 13-20% chance to avoid a second stroke. Lastly, Dr. Preston, in testifying for Dr. Almudallal, stated that a meta-analysis of thirteen

different studies involving stroke treatment with aspirin demonstrated a 17% relative risk reduction and 1.7 absolute risk reduction for having a second stroke.

{¶26} On these facts, the evidence before the jury was sufficient that reasonable minds might reach the conclusion sought by a loss of less-than-even chance of recovery instruction. This evidence was introduced initially by the Geesamans through the use of cross-examination of Dr. Almudallal in their case-in-chief and was further brought about during the presentation of expert witnesses for the respective defenses. Although Dr. Thaler provided testimony to establish proximate causation, witnesses for the two defendant doctors and Dr. Almudallal himself provided the evidence which warranted a loss of less-than-even chance instruction.

{¶27} Nevertheless, Dr. Cox maintains that the loss of less-than-even chance theory should not be forced upon the defense because the Geesamans proceeded under a proximate cause theory of their case in their complaint. In support, Dr. Cox relies upon another Ohio Supreme Court case, *McMullen v. Ohio State Univ. Hospitals*, 88 Ohio St.3d 332, 725 N.E.2d 1117, 2000-Ohio-342. In *McMullen*, the plaintiff's decedent suffered from cancer, had a bone marrow transplant, and later returned to the hospital with high fevers and a possible viral infection. *Id.* at 333. The decedent's lungs had fluid buildup and she experienced shortness of breath, leading to the placement of an endotracheal ("ET") tube through her mouth and throat in order to maintain her oxygenation level. *Id.*

Three days later, on October 14, 1990, her oxygen saturation level dropped to a critical point, and when other efforts failed to improve this level, the nurses removed her ET tube. *Id.* It took the responding doctors several different attempts in excess of twenty minutes before the ET tube was successfully re-established. *Id.* During this time, the decedent's oxygen saturation level fell below that consistent with life, causing the decedent irreversible damage to her brain, lungs, and heart. *Id.* She died seven days later. *Id.*

{¶28} During a trial to the court, the plaintiff presented evidence that this event was the direct cause of all the underlying causes of the decedent's death. *McMullen*, 88 Ohio St.3d at 334. The defendants presented evidence that prior to the October 14, 1990 incident, the decedent's chances of survival were less than fifty percent given her overall condition and that she would have died within thirty days, notwithstanding the events on October 14th. *Id.* at 335.

{¶29} The trial court found that the decedent had a chance of surviving prior to October 14, 1990, but that the negligent medical treatment decreased her chance of survival to zero. *Id.* The court found in favor of the decedent's estate but then conducted a trial on the issue of damages and applied the formula for the calculation of damages based upon a lost chance of survival rather than a total amount of damages. *Id.*

{¶30} The Supreme Court found that the trial court should never have proceeded to assess damages under a loss of chance theory given the trial court's

conclusion that the cause of death was the October 14, 1990 anoxic or hypoxic event, attributed solely to the defendants' negligence. *Id.* at 337. Specifically, the Court held that it "never intended to force this theory on a plaintiff who could otherwise prove that specific negligent acts of the defendant caused the ultimate harm."

{¶31} Further, the Court noted that a review of the many cases on loss of less-than-even chance revealed a particular factual situation involved:

> **the plaintiff or the plaintiff's decedent [was] already suffering from some injury, condition, or disease when a medical provider negligently diagnoses the condition, fails to render proper aid, or provides treatment that actually aggravates the condition. As a result, the underlying condition is allowed to progress, or is hastened, to the point where its inevitable consequences become manifest.**

Id. The Court then found that the case before it was different in that the ultimate harm was directly caused by the defendants' negligence rather than by their negligence combining with the decedent's pre-existing condition. *Id.* at 341. Thus, the Court concluded that the trial court should not have applied the loss of less-than-even chance theory.

{¶32} The situation before us is akin to the cases reviewed by the Supreme Court in *McMullen,* wherein a medical provider's negligence combined with Mr. Geesaman's pre-existing condition to lead to the injury, rather than the actual facts of *McMullen.* The holding in *McMullen* was designed to prevent a tortfeasor from escaping full liability when the person the tortfeasor negligently injured happened

to also suffer from some pre-existing condition. However, in this case, no one alleged that Dr. Cox did something to directly cause Mr. Geesaman to have a stroke, but instead, that he failed to recognize the first stroke, which led to a lack of proper treatment to prevent the second stroke.

{¶33} Once again, the entire premise of the loss of less-than-even chance of recovery/survival is that doctors and other medical personnel should not be allowed to benefit from the uncertainty of recovery/survival that their negligence has created. See *Roberts*, 76 Ohio St.3d at 486-487. Moreover, "'[w]hen those preexisting conditions have not absolutely preordained an adverse outcome, however, the chance of avoiding it should be appropriately compensated even if that chance is not better than even.'" *Roberts*, 76 Ohio St.3d at 487, quoting King, Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences (1981), 90 Yale L.J. 1353, 1354.

{¶34} For these reasons, the jury should have been instructed on the loss of less-than-even chance theory of recovery. Although the Geesamans presented testimony that Mr. Geesaman's chance to avoid the second stroke and resultant injuries was more probable than not with proper diagnosis and treatment, other evidence could have led a reasonable juror to conclude that Mr. Geesaman had a less-than-even chance to avoid the second stroke and resultant injuries. Therefore, if the jury did not find proximate cause, the evidence warranted instructing them to consider loss of chance, not as a fallback position for the Geesamans, as Dr. Cox

asserts, but based upon the evidence before it. Thus, the trial court abused its discretion in unreasonably refusing to instruct the jury on this issue when the evidence clearly supported it. For these reasons, the second assignment of error is sustained.

First Assignment of Error

{¶35} The Geesamans assert in their first assignment of error that the trial court erred in excluding the loss of less-than-even chance of recovery during their case-in-chief. Although we fail to find any legal obstacle in Ohio law for the Geesamans to have pursued both the traditional notion of proximate causation and the relaxed causation standard of loss of less-than-even chance, especially in light of the Supreme Court's decision in *Roberts* to expressly overrule *Cooper*, we need not decide this issue here given the actual development of the evidence at trial, which clearly warranted the requested jury instruction on loss of less-than-even chance in any event as discussed in the determination of the second assignment of error. Therefore, the first assignment of error is moot and, consequently, overruled.

Third Assignment of Error

{¶36} In their third assignment of error, the Geesamans contend that the trial court abused it discretion when it gave the jury an instruction on comparative negligence. The jury was given eight interrogatories by the trial court at the conclusion of its instructions. The fourth and fifth interrogatories addressed the

issue of comparative negligence. However, the jury was to answer these interrogatories only if it found Dr. Almudallal negligent and that his negligence proximately caused injury to Mr. Geesaman or if it found Dr. Cox's admitted negligence proximately caused injury to Mr. Geesaman. Because the jury did not find Dr. Almudallal negligent and did not find that Dr. Cox's negligence proximately caused injury to Mr. Geesaman, the issue of whether Mr. Geesaman was comparatively negligent was never reached. Therefore, this assignment of error is moot and, consequently, overruled.

Fourth Assignment of Error

{¶37} The Geesamans next maintain that the trial court erred in permitting evidence of Mr. Geesaman's prior drug use to be introduced at trial. In reviewing this assignment of error, we first note that "[t]he admission of evidence is generally within the sound discretion of the trial court, and a reviewing court may reverse only upon the showing of an abuse of that discretion." *Peters v. Ohio State Lottery Comm.* (1992), 63 Ohio St.3d 296, 299, 587 N.E.2d 290. As previously noted, the term "abuse of discretion" connotes a judgment that is rendered with an unreasonable, arbitrary, or unconscionable attitude. *Blakemore*, 5 Ohio St.3d at 219, 450 N.E.2d 1140.

{¶38} In the case sub judice, the medical records of Mr. Geesaman included a reference to prior drug use. One such reference was included in a letter to Dr. Stephen Sandy, Mr. Geesaman's primary physician, from Matthew P.

Ziccardi, Psy.D. Dr. Ziccardi conducted a neuropsychological consult on Mr. Geesaman on June 7, 2005, and wrote a letter to Dr. Sandy regarding his examination, impression, and recommendations. Included in this letter was the following statement: "His medical and psychiatric histories are notable for an extensive history of polysubstance abuse, including alcohol, barbiturates, injected drugs, and inhalants."

{¶39} Prior to trial, the Geesamans filed a motion in limine to exclude any reference to prior drug use by Mr. Geesaman. The trial court overruled this motion, stating that

> **It's common knowledge the effect of these particular items. * * * You don't start with, okay, he had a stroke. It has to do with everything; if there is any link or how a person conducted their life. It didn't start at that event. And if a person had taken drugs once or twice that's one thing. But if they've taken it for a number of times over a number of years the court believes that it does have probative value and it is not prejudicial and would allow reference to the same.**

After this ruling, counsel for Dr. Cox commented in opening statement that Mr. Geesaman had a fairly lengthy history of substance abuse. In response, Lori Geesaman testified that she had known her husband since 1992, that they were married in 1996, and that she had never known him to have taken any illegal drugs.

{¶40} The trial court admitted the letter from Dr. Ziccardi as a part of Dr. Almudallal's Exhibit A.[3] During closing statements, counsel for Dr. Almudallal placed several items on a screen in his discussion of damages to show the jurors regarding Mr. Geesaman's failure to follow through with medical advice, the number of risk factors that he had and ignored, and his overall failure to attend to his own health. In these images, he included the letter from Dr. Ziccardi. He directed the jurors' attention to a portion of the letter, which he highlighted, involving Mr. Geesaman's denial of any cognitive or emotional changes related to his stroke. However, immediately preceding this sentence was the sentence concerning Mr. Geesaman's history of polysubstance abuse, which was also underlined.

{¶41} Evidence Rule 402 provides that "[a]ll relevant evidence is admissible, except as otherwise provided[.]" Relevant evidence is defined as "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." Evid.R. 401. Relevant evidence is not admissible "if its probative value is substantially outweighed by the danger of unfair prejudice, of confusion of the issues, or of misleading the jury." Evid.R. 403.

[3] Although the Geesamans did not object to the admission of this exhibit as a whole, they did object to any references to prior drug usage, preserving this issue for appeal.

{¶42} Here, there was no evidence that any drug use, if shown, was relevant to the issues before the jury. There was no testimony showing any causal connection between Mr. Geesaman's drug use, his stroke, and the resultant damages. Thus, this topic did not have any tendency to make the existence of any fact of consequence more or less probable. Moreover, even assuming arguendo that there was some relevance to past drug use, its probative value was substantially outweighed by the danger of unfair prejudice, confusion of the issues, and of misleading the juror. In fact, the trial court's own statement, noted above, evidences these problems as it appears to have been misled by the evidence of prior drug use and confused as to the issue. Thus, the trial court should not have allowed this evidence and abused its discretion in so doing.

{¶43} However, while the trial court erred in admitting evidence of prior drug use, we cannot find that the trial court's decision, given the limited nature and reference to this evidence by the parties, affected the outcome of the trial so as to rise to the level of reversible error. Therefore, this assignment of error is overruled.

Fifth Assignment of Error

{¶44} The Geesamans assert in their fifth assignment of error that the trial court erred when it admitted the deposition of Dr. Charles Lanzieri, a neuroradiologist, into evidence during the trial. As an initial matter, we note that the testimony of Dr. Lanzieri involved the standard of care of radiologists and

causation. Given the jury's finding that Dr. Almudallal was not negligent, this assignment of error does not apply to the verdict rendered in favor of him. Thus, we address this issue only as it applies to Dr. Cox.

{¶45} During the discovery phase of this case, the Geesamans listed Dr. Lanzieri as one of their experts. As a result, a deposition of Dr. Lanzieri was conducted on June 23, 2008, and all counsel present questioned Dr. Lanzieri to varying degrees.[4] At trial, the Geesamans elected not to present Dr. Lanzieri as a witness in their case-in-chief. However, counsel for Dr. Cox introduced the deposition of Dr. Lanzieri during the presentation of Dr. Cox's case. The Geesamans objected to the use of the deposition for a number of reasons. The trial court overruled these objections, and the deposition in its entirety was then read into the record.

{¶46} The use of depositions at trial is governed by Civ.R. 32. This rule states, in relevant part:

> **At the trial * * * any part or all of a deposition, *so far as admissible under the rules of evidence* applied as though the witness were then present and testifying, may be used against any party who was present or represented at the taking of the deposition * * * in accordance with any one of the following provisions * * *
>
> The deposition of a witness, whether or not a party, may be used by any party for any purpose if the court finds: * * * (e) that the witness is an attending physician or medical expert, although**

[4] At this point in the litigation, St. Rita's Medical Center was a defendant. Counsel for the hospital was present at Dr. Lanzieri's deposition and also questioned him. The hospital was later dismissed prior to trial.

> **residing within the county in which the action is heard * * * or (g) upon application and notice, that such exceptional circumstances exist as to make it desirable, in the interest of justice and with due regard to the importance of presenting the testimony of witnesses orally in open court, to allow the deposition to be used.**

Civ.R 32(A)(3). In cases involving medical malpractice, a person giving expert testimony on the issue of liability must be licensed to practice medicine by the licensing authority of any state and devote at least fifty percent of his/her professional time to active clinical practice in his/her licensed field or to teaching it at an accredited school. Evid.R. 601(D).

{¶47} In this case, Dr. Lanzieri qualified as a medical expert in radiology. Therefore, Civ.R. 32(A)(3) was satisfied. Further, he was a professor of radiology and neurosurgery at University Hospitals of Cleveland/Case Western Reserve University School of Medicine at the time of his deposition in June of 2008. Additionally, when he was deposed, he had recently stepped down as chairman of the department of radiology and resumed being a full-time radiologist. Thus, he was competent to testify pursuant to Evid.R. 601(D).

{¶48} However, our analysis does not end there. Rather, Civ.R. 32 only permits the use of depositions "so far as admissible under the rules of evidence." Civ.R. 32(A). That rule also provides that "[t]he introduction in evidence of the deposition or any part thereof for any purpose other than that of contradicting or

impeaching the deponent makes the deponent the witness of the party introducing the deposition[.]" Civ.R. 32(C).

{¶49} Evidence Rule 611 governs the mode and order of interrogation and presentation of evidence. Included in this rule is that "[l]eading questions should not be used on the direct examination of a witness except as may be necessary to develop the witness' testimony." Evid.R. 611(C). However, despite this limitation, "'[t]he allowing or refusing of leading questions in the examination of a witness must very largely be subject to the control of the court, in the exercise of a sound discretion.'" *Ramage v. Central Ohio Emergency Serv., Inc.* (1992), 64 Ohio St.3d 97, 111, 592 N.E.2d 828, quoting *Seley v. G.D. Searle & Co.* (1981), 67 Ohio St.2d 192, 204, 423 N.E.2d 831. In addition, the Rules of Evidence provide that "[c]ross-examination shall be permitted on all relevant matters and matters affecting credibility." Evid.R. 611(B).

{¶50} A trial court's ruling on these issues will stand absent an abuse of discretion. *Lambert v. Shearer* (1992), 84 Ohio App.3d 266, 275, 616 N.E.2d 965. As previously stated, an abuse of discretion "connotes more than an error of law or judgment; it implies that the court's attitude is unreasonable, arbitrary, or unconscionable." *Blakemore*, 5 Ohio St.3d at 219, 450 N.E.2d 1140.

{¶51} In the case sub judice, the Geesamans assert that Dr. Cox made Dr. Lanzieri his witness when Dr. Cox introduced the deposition at trial. Thus, they maintain that leading questions by counsel for Dr. Cox should not have been

permitted at the trial. They further contend that by allowing this deposition to be introduced, the trial court denied them the right to cross-examine Dr. Lanzieri pursuant to Evid.R. 611(B).

{¶52} A review of Dr. Cox's counsel's examination of Dr. Lanzieri during the deposition indicates that he asked many leading questions in attempting to discover the facts upon which Dr. Lanzieri based his opinions. By doing so, he was clearly cross-examining Dr. Lanzieri, who at the time of the deposition was not Dr. Cox's witness. The problem arose when Dr. Cox subsequently decided to present the deposition of Dr. Lanzieri in effect as his own witness in Dr. Cox's case-in-chief.

{¶53} In this particular deposition, however, Dr. Lanzieri was repeatedly allowed to elaborate on his answers, often times providing great detail and in depth explanations. In addition, many questions were also asked by counsel for the two other remaining defendants, Dr. Almudallal and St. Rita's Medical Center, both of whom also permitted Dr. Lanzieri to expound upon his responses. Accordingly, on the record before this Court, we cannot conclude that the trial court acted in an unreasonable, arbitrary, or unconscionable manner in permitting the use of the deposition at trial or that any prejudice resulted therefrom based upon the use of leading questions.

{¶54} As to the contention that the Geesamans had no opportunity to cross-examine Dr. Lanzieri, this assertion is without merit. During the deposition of Dr.

Lanzieri, counsel for the Geesamans did ask questions of him. Although we note that counsel for Dr. Almudallal objected to the Geesamans questioning their own witness at the deposition, counsel for the Geesamans stated: "I disagree, obviously. It's a witness, and anybody can ask questions." Counsel then proceeded to ask questions of Dr. Lanzieri. Thus, the Geesamans did have an opportunity to question the witness, including through the use of their own leading questions. Furthermore, Dr. Lanzieri was a listed witness for the Geesamans. As such, their counsel had ample opportunity to fully discover the opinion(s) of Dr. Lanzieri prior to the deposition and to fully question him on those at the deposition if he so chose. Therefore, the fifth assignment of error is overruled.

Sixth Assignment of Error

{¶55} In their sixth assignment of error, the Geesamans assert that the trial court erred when it permitted Dr. David Preston, the neurologist who testified on behalf of Dr. Almudallal, to render an opinion concerning two MRI's taken of Mr. Geesaman during his rehabilitation on April 15, 2005, and April 25, 2005.

{¶56} During the presentation of Dr. Almudallal's defense, counsel for the doctor called Dr. Preston to the stand. Prior to his testimony, the Geesamans' attorney made an oral motion in limine, requesting that Dr. Preston not be permitted to testify about the aforementioned MRI's. These two MRI's showed additional infarcts in Mr. Geesaman's brain.

{¶57} Counsel's concern was that Dr. Preston would use those images to show that Mr. Geesaman was suffering additional strokes despite proper medical intervention since the April 5, 2005 stroke, thus bolstering the defense theory that nothing would have prevented the second stroke. They maintained that the problem with this sort of testimony was that during his deposition, taken a number of months before trial, Dr. Preston did not recall those images and rendered no opinions based on those images. Therefore, any testimony concerning those MRI's in support of Dr. Preston's opinions on causation was a surprise and would be unfairly prejudicial.

{¶58} The trial court agreed with the Geesamans and informed counsel for Dr. Almudallal that he could not elicit any testimony from Dr. Preston that involved those two MRI's. Counsel for Dr. Almudallal followed this decision and did not elicit any such testimony. However, during cross-examination by counsel for Dr. Cox, counsel proposed hypothetical questions to Dr. Preston using those two MRI's. Specifically, counsel for Dr. Cox asked him to assume that two other doctors testified that an MRI on April 15th and on April 25th revealed new infarcts, both occurring several days after Mr. Geesaman was readmitted to the hospital and started on aspirin and other medications/treatments. He then asked Dr. Preston if this would indicate that the medication was not working to defeat Mr. Geesaman's atherosclerotic disease, which was causing his strokes. Over the repeated objections by the Geesamans, Dr. Preston was permitted to answer. He answered

that the subsequent strokes did indicate that the medicine was not working at that point.

{¶59} The Rules of Civil Procedure allow the discovery of opinions of experts retained by the opposing party. See Civ.R. 26(B)(5). This Court has previously noted that the purpose of this rule is "to prevent surprise when dealing with expert witnesses." *Vance v. Marion Gen. Hosp.*, 165 Ohio App.3d 615, 847 N.E.2d 1229, 2006-Ohio-146, at ¶ 12, citing *Vaught v. The Cleveland Clinic Foundation* (Sept. 6, 2001), 8th Dist. No. 79026, 2001 WL 1034705, at *3. Moreover, "[a] litigant is not only entitled to know an opposing expert's opinion on a matter, but the basis for that opinion as well * * * so that opposing counsel may make adequate trial preparations." *Vaught*, 8th Dist. No. 79026, 2001 WL 1034705, at *3.

{¶60} Here, the opinion rendered by Dr. Preston that evidence of new infarcts in the April 15th and April 25th MRI's would indicate that the medication was not working to defeat Mr. Geesaman's atherosclerotic disease, which was causing his strokes, was an opinion not previously disclosed during his deposition. Because Dr. Preston did not recall those images and offered no opinion regarding anything seen on those images, counsel for the Geesamans did not have the opportunity to adequately prepare for this portion of Dr. Preston's testimony. This is true regardless of who asked the questions.

{¶61} Although this would not be regarded as a direct discovery violation by counsel for Dr. Cox, who did not call Dr. Preston to the stand, it nonetheless amounts to unfair surprise and defeats the spirit of the discovery rules, particularly in light of the fact that counsel for Dr. Cox was present at the taking of the deposition of Dr. Preston and during the argument and ruling on the motion in limine. For these reasons, the sixth assignment of error is well taken as to Dr. Cox.

{¶62} However, the subject-matter of this assignment of error involves the issue of causation, not standard of care. As previously noted, given the jury's finding that Dr. Almudallal was not negligent, this assignment of error does not affect the verdict in favor of Dr. Almudallal and is overruled as to him.

{¶63} Based on all of the foregoing, the judgment of the trial court in favor of Dr. Almudallal is affirmed, the judgment in favor of Dr. Cox is reversed, and the cause remanded to the trial court for further proceedings consistent with this opinion.

Judgment Affirmed in Part,
Reversed in Part, and
Cause Remanded

ROGERS and BROGAN, J.J., concur.

(2nd District Court of Appeals Judge James Austin Brogan, sitting by Assignment)

/jlr

IN THE COURT OF APPEALS OF OHIO
THIRD APPELLATE DISTRICT
ALLEN COUNTY

JEFFREY GEESAMAN, ET AL.,

PLAINTIFFS-APPELLANTS, **CASE NO. 1-08-65**

v.

ST. RITA'S MEDICAL CENTER, ET AL., **J U D G M E N T E N T R Y**

DEFENDANTS-APPELLEES.

For the reasons stated in the opinion of this Court, it is the judgment and order of this Court that the judgment of the trial court is affirmed in part and reversed in part with costs assessed equally between Appellants and Appellees for which judgment is hereby rendered. The cause is hereby remanded to the trial court for further proceedings and for execution of the judgment for costs.

It is further ordered that the Clerk of this Court certify a copy of this Court's judgment entry and opinion to the trial court as the mandate prescribed by App.R. 27; and serve a copy of this Court's judgment entry and opinion on each party to the proceedings and note the date of service in the docket. See App.R. 30.

JUDGES

DATED: August 10, 2009

IN THE COURT OF APPEALS OF OHIO
THIRD APPELLATE DISTRICT
ALLEN COUNTY

JEFFREY GEESAMAN, ET AL.,

PLAINTIFFS-APPELLANTS, **CASE NO. 1-08-65**

v.

ST. RITA'S MEDICAL CENTER, ET AL., **E R R A T U M**
T O
DEFENDANTS-APPELLEES. **O P I N I O N**

Appeal from Allen County Common Pleas Court
Trial Court No. CV2006 0914

Judgment Affirmed in Part, Reversed in Part, and Cause Remanded

Date of Decision: August 10, 2009

Footnote 2 in Paragraph #12 filed on August 10, 2009 incorrectly reads:

The complaint names Lima Radiology Associates ("LRA") under the doctrine of respondeat superior as the employer of Dr. Cox or that Dr. Cox was the owner of LRA. The judgment entry on the jury's verdict indicates that LRA was dismissed pursuant to the verdict. However, LRA's involvement was not mentioned during the trial nor was there a finding by the jury in regards to LRA. Rather, all parties acted as if the case were solely against Dr. Cox and Dr. Almudallal.

Footnote 2 in Paragraph #12 filed on August 10, 2009 is hereby corrected to read:

The complaint names Lima Radiology Associates ("LRA") under the doctrine of respondeat superior as the employer of Dr. Cox or that Dr. Cox was the owner of LRA. However, LRA's liability under the doctrine of respondeat superior was not a question before the jury because LRA admitted in its answer to the plaintiffs' complaint that Dr. Cox was its employee at the time of Mr. Geesaman's injury and was acting

within the scope of that employment when he examined Mr. Geesaman's MRI and concluded that the MRI was normal. LRA denied, however, that Dr. Cox was negligent and/or that he caused the plaintiffs' injuries. Given these admissions and denials, LRA's liability was dependent upon the jury's verdict as to Dr. Cox. In accordance with the jury's verdict as to Dr. Cox, the judgment entry on the jury's verdict indicates that both Dr. Cox and LRA were dismissed pursuant to the verdict. Because LRA's liability is dependent solely upon the liability of Dr. Cox, throughout this opinion our rulings on the assignments of error as to Dr. Cox also apply to LRA.

Paragraph #63 filed on August 10, 2009 incorrectly reads; "Based on all of the foregoing, the judgment of the trial court in favor of Dr. Almudallal is affirmed, the judgment in favor of Dr. Cox is reversed, and the cause remanded to the trial court for further proceedings consistent with this opinion."

Paragraph #63 filed on August 10, 2009 is hereby corrected to read; "Based on all of the foregoing, the judgment of the trial court in favor of Dr. Almudallal is affirmed, the judgment in favor of Dr. Cox and Lima Radiological Associates is reversed, and the cause remanded to the trial court for further proceedings consistent with this opinion."

SHAW, ROGERS and BROGAN, J.J., concur.

(2nd District Court of Appeals Judge James Austin Brogan, sitting by Assignment)

/jlr

COURT OF APPEALS
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[illegible] STALEY-BURLE
CLERK OF COURTS
ALLEN COUNTY, OHIO

IN THE COURT OF APPEALS OF OHIO
THIRD APPELLATE DISTRICT
ALLEN COUNTY

JEFFREY GEESAMAN, ET AL.,

PLAINTIFFS-APPELLANTS, **CASE NO. 1-08-65**

v.

ST. RITA'S MEDICAL CENTER, ET AL., **JUDGMENT ENTRY**

DEFENDANTS-APPELLEES.

This cause comes on for determination of the application for reconsideration and application to certify a conflict filed by Appellee John Cox, D.O., with response briefs in opposition, and the motion for clarification and/or reconsideration filed by Appellee Lima Radiology Associates, Inc., with response briefs in opposition.

Upon consideration of same, the court finds that the application for reconsideration filed by Dr. Cox fails to call to the attention of the court an obvious error in the decision or raise an issue not properly considered in the first instance. *Garfield Hts. City School Dist. v. State Bd. of Edn.* (1992), 85 Ohio App.3d 117; *Columbus v. Hodge* (1987), 37 Ohio App.3d 68. The application sets forth the same arguments that were considered and decided properly in the first instance.

The court further finds that there is no true and actual conflict on a rule of law between the decision in the instant case and the decisions in *Haney v. Barringer*, 7th

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Dist.No. 06MA141, 2007-Ohio-7214; *McDermott v. Tweel*, 151 Ohio App.3d 763; *Liotta v. Rainey*, (Nov. 22, 2000), 8th Dist.No. 77396; *Wright v. Suzuki Motor Corp.*, 4th Dist.No. 03CA2, 03CA3, 03CA4, 2005-Ohio-3494; and *Faulk v. Internatl. Bus. Mach. Corp.*, (Sept. 7, 2001), 1st Dist.Nos. C-000765, C-000778. The factual distinctions in these cases result in a rule of law that is not in conflict with the instant case. See *Whitelock v. Gilbane Bldg. Co.* (1993), 66 Ohio St.3d 594. Accordingly, the applications of Appellee Cox are not well taken.

In regard to the motion for clarification and/or reconsideration of Lima Radiology Associates, the court finds that it is not necessary to grant reconsideration and vacate the entire opinion. However, there does appear to be a misstatement in "Footnote 2" and, although it should be evident to the parties, an ambiguity in the concluding paragraph of the opinion, Paragraph #63, that is worthy of clarification to remove any doubt. For this reason the request for clarification is well taken and an Erratum to the opinion shall issue contemporaneously herewith.

It is therefore **ORDERED** that the application for reconsideration and application to certify a conflict filed by Appellee John Cox, D.O., be, and the same hereby are, overruled.

It is further **ORDERED** that the motion for clarification and/or reconsideration filed by Appellee Lima Radiology Associates, Inc. be, and hereby is, granted to the

extent that an erratum to the opinion shall issue correcting "Footnote 2" in Paragraph #12, and Paragraph #63.

JUDGES

DATED: October 21, 2009
/jlr

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