ORIGINAL

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

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.

REPLY BRIEF OF APPELLANT

Dennis P. Mulvihill (0063996)
Gregory S. Scott (0067255)
LOWE EKLUND WAKEFIELD & MULVIHILL CO., L.P.A.
610 Skylight Office Tower
1660 West 2nd Street
Cleveland, OH 44113-1454
Tel: (216) 781-2600
Fax: (216) 781-2610
E-mail: dmulvihill@lewm.com
gscott@lewm.com

Attorneys for Plaintiffs-Appellees

Irene C. Keyse-Walker (0013143)
(COUNSEL OF RECORD)
TUCKER ELLIS & WEST LLP
925 Euclid Avenue, Suite 1150
Cleveland, Ohio 44115-1414
Tel: (216) 592-5000
Fax: (216) 592-5009
E-mail: ikeyse-walker@tuckerellis.com

Attorney for Defendant-Appellant

Jonathan R. Stoudt (0083839)
Michael J. Rourke (0022950)
ROURKE & BLUMENTHAL, LLP
495 South High Street, Suite 450
Columbus, OH 43215
Tel: (614) 220-9200
Fax: (614) 220-7900
E-mail: jstoudt@randbllp.com
mrourke@randbllp.com

Attorneys for Amicus Curiae
Ohio Association for Justice

Patrick K. Adkinson (0016980)
ADKINSON LAW OFFICE
4244 Indian Ripple Road, Suite 150
Dayton, OH 45440
Tel: (937) 431-9660
Fax: (937) 228-0944
E-mail: pka.adklaw@bizwoh.rr.com

Additional Counsel for Defendant-Appellant

Anne Marie Sferra (0030855)
Bridget Purdue Riddell (0082502)
BRICKER & ECKLER LLP
100 South Third Street
Columbus, OH 43215
Tel: (614) 227-2300
Fax: (614) 227-2390
E-mail: asferra@bricker.com
bpurdue@bricker.com

Attorneys for Amici Curiae
Ohio Hospital Association,
Ohio State Medical Association,
American Medical Association, and
Ohio Osteopathic Association

John F. Haviland (0029599)
BIESER, GREER & LANDIS LLP
400 PNC Center
6 North Main Street
Dayton, OH 45402
Tel: (937) 223-3277
Fax: (937) 223-6339
E-mail: jfh@bgllaw.com

Attorney for Amicus Curiae
Ohio Association of Civil Trial Attorneys

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I. FACTUAL REBUTTAL

The bulk of the "facts" recited by Plaintiffs-Appellees Jeffrey Geesaman, et al. ("Plaintiffs") are incorrect, irrelevant, and/or inconsistent with the unanimous jury findings. Plaintiffs' claim that witnesses "discredited" the explanation of Defendant-Appellant John Cox, D.O. that the diffused weighted images were not sent with the rest of the MRI (Opposing Brief ("Opp. Br.") at 1), for example, is irrelevant, since Dr. Cox admitted he breached the applicable standard of care. It is also incorrect. In fact, hospital employees confirmed the technical problems with the computer system, including complaints from other radiologists regarding missing images. (Supp. 45-47; Tr. 457-459.)

Plaintiffs' claim that a series of measures other than aspirin "should have been implemented" during Mr. Geesaman's first hospital admission (Opp. Br. at 2) is misleading – those "other" measures were long-term measures (controlling diabetes, lowering cholesterol and blood pressure levels) that *were* implemented, but could have no effect on the second stroke that occurred just three days after his discharge. (Supp. 98-103; Tr. 937-942.) Plaintiffs' claim that "Jeffrey and Lori were **not** told that Jeffrey should take aspirin when discharged" (Opp. Br. at 2, emphasis in original) is contrary to the jury verdict. Plaintiffs' *allegation* that Dr. Almudallal did not orally instruct the Geesamans that Jeffrey should continue his aspirin was the primary basis for Plaintiffs' claim that Dr. Almudallal breached the standard of care. Dr. Almudallal agreed that the standard of care required him to instruct Mr. Geesaman to continue aspirin therapy, but

testified that he *did* so instruct Mr. Geesaman, in his wife's presence. (Supp. 49, 134; Tr. 556, 1337.) The jury necessarily must have believed Dr. Almudallal since they unanimously concluded that he did not breach the applicable standard of care. (Supp. 200; Tr. Vol. 8:127.)

What *is* relevant is the statement that Plaintiffs claimed that medical negligence "proximately caused" Mr. Geesaman's second stroke, and Plaintiffs "offered the expert witness testimony of Dr. David Thaler * * * that it was probable that had Jeffrey been diagnosed and treated appropriately, the disabling stroke of April 5, 2005, would have been avoided[.]" (Opp. Br. 3.) Like the plaintiff in *McMullen v. Ohio State University Hospital* (2000), 88 Ohio St.3d 332, the Plaintiffs in this case presented a prima facie, traditional malpractice claim. As in *McMullen*, "loss of chance" doctrines were irrelevant to that claim. The *only* difference between this case and *McMullen* is that the factfinder agreed with the plaintiff's expert in *McMullen* and did not agree with the Plaintiffs' expert in this case.

II. REBUTTAL ARGUMENT

After insisting that "loss of chance is not a befuddling area of Ohio law" and that Defendant-Appellant John Cox, D.O. has "manufacture[d] this purported confusion" (Opp. Br., p. 7), Plaintiffs proceed to generate the very confusion they deny by disassociating the "relaxed" causation burden unique to loss of chance from its precipitating justification – a medical malpractice claim based on a less than even chance of survival or recovery.

A. A Medical Malpractice Plaintiff's Causation Burden Is Necessarily Tethered to the Claim Asserted.

Plaintiffs take issue with the proposition that a medical malpractice proximate cause standard is defined by, and limited to, the type of claim asserted. See, e.g., Opp. Br. at 13-14, analogizing medical malpractice plaintiffs to tort plaintiffs who assert alternative theories of recovery. But tethering the proximate cause standard to the malpractice claim asserted is both justified and necessary for a simple reason – loss of chance medical malpractice plaintiffs are the *only* tort plaintiffs accorded a "relaxed" proximate cause burden of proof.

More specifically, the justification for this Court's adoption of a "relaxed" causation standard for medical malpractice plaintiffs with a less than even chance of survival or recovery was the unavailability of any remedy for such plaintiffs under traditional causation principles. Disassociating the rule from the claim asserted removes the justification for the rule. Further, assigning the appropriate burden of proof to the claim asserted is necessary to conduct a trial. Courts cannot rule on a defendant's motion for directed verdict on liability without knowing the nature of the plaintiff's causation burden of proof, and cannot rule on a motion for directed verdict on damages without knowing whether the plaintiff has the burden of presenting the *additional* expert statistical evidence required of loss-of-chance plaintiffs.

The confusion engendered by an attempt to sever the "relaxed" causation standard from the less-than-even-chance malpractice claim that spawned it is illustrated in Plaintiffs' own arguments. Plaintiffs claim, for example, that following Dr. Cox's

pretrial admission of a deviation from the standard of care, the "principle issue at trial" was "how to quantify" Mr. Geesaman's "lost chance." (Opp. Br., p. 5.) But "quantifying" a "lost chance" occurs only in loss-of-chance cases, and only *after* the jury has found proximate cause under the "relaxed" burden of proof. See *Roberts v. Ohio Permanente Med. Group, Inc.* (1996), 76 Ohio St.3d 483, syllabus.

"Quantifying" Mr. Geesaman's "lost chance" was not a part of the trial in this case because Plaintiffs pursued a traditional malpractice claim – i.e., they claimed that Mr. Geesaman had a better than even chance of avoiding a second stroke and that Dr. Cox's failure to diagnose the first stroke was the more probable than not cause of the second stroke. Because Plaintiffs did not assert a less than even chance of avoiding a second stroke and did not maintain a claim based on a "relaxed" causation standard, the jury was never presented with the question of "how to quantify" a "lost chance."

Similarly misplaced is Plaintiffs' argument that:

> Under Dr. Cox's logic, medical malpractice victims would be forced to choose between loss of chance and proximate causation at the time of filing the Complaint.

(Opp. Br. at 17.) Medical malpractice plaintiffs *never* choose between "loss of chance" and "proximate causation." *All* plaintiffs, including those asserting a less than even chance of recovery or survival, bear the burden of proof on proximate causation. Loss-of-chance plaintiffs simply have a "relaxed" standard. Identifying *which* proximate cause burden the plaintiff bears depends on the claim asserted by the plaintiff. As the trial court

correctly held in this case, a plaintiff "cannot elect to adhere to two different standards of proof in a jury trial." (Supp. 27; Tr. 260.)

The sole Ohio authority Plaintiffs cite to support their argument for multiple causation burdens in a single claim is a textbook example of courts "befuddled" (Opp. Br., p. 7) by loss of chance. See Opp. Br., pp. 14-15, discussing *Trevena v. Primehealth, Inc.* (2006), 171 Ohio App.3d 501. The *Trevena* trial court directed a verdict for two medical defendants on the grounds that "assuming" the plaintiffs had presented prima facie evidence of proximate cause, plaintiff's damage evidence was speculative. Id., ¶50. On appeal, the majority offers no insight into whether the plaintiff asserted a greater than even chance of survival or recovery claim (and thus shouldered a more probable than not causation burden) or a less than even chance of survival or recovery (as to which "relaxed" causation would apply). See id. at ¶13:

> Their theory of liability was that on June 2, 2002, Trevena had suffered a stroke; that on June 5, 2002, when Trevena presented to Dr. Mulcahy's office, and on June 11, 2002, when he was examined by Dr. Kotak, his doctors should have considered a diagnosis that he was having an evolving stroke. Had they done so, according to this theory, they would also have done adequate testing of his condition and would have ascertained that Trevena was having an evolving stroke at that time. The Trevenas further contend that had the doctors performed adequate testing, Trevena would have had some mild, residual disabilities instead of total and permanent disability.

The majority proceeds to recite the differing causation burdens in a traditional malpractice and loss-of-chance action (id., ¶¶52, 60), and recognizes that the trial court, in granting a directed verdict, "was really talking about the issue of proximate cause" as

opposed to damages (id., ¶70). But it then ignores the pivotal question of whether the plaintiff had presented sufficient proximate cause evidence for the claim asserted to withstand a motion for directed verdict. Instead, like the trial court, the majority simply *assumes* that sufficient, undefined proximate cause evidence was presented for the undefined claim, making the case appropriate for a jury determination of damages:

> Our reasons for applying the loss-of-chance theory are that the Trevenas' case-in-chief established a prima facie case of medical malpractice, and it also established that Trevena has a diminished chance of recovery as a result of that malpractice. In effect, he has established a prima facie case that he has lost his chance for any meaningful recovery as a result of the malpractice of Dr. Mulcahy. The jury should be permitted to decide the extent to which that malpractice reduced Trevena's likelihood of achieving a more favorable outcome.

Id., ¶72.[1] The proper analysis would have been for the court to determine whether the Trevenas presented a medical malpractice claim based on a less than even chance of avoiding a second stroke or a greater than even chance of avoiding a second stroke. See, e.g., *McMullen v. Ohio State Univ. Hosp.* (2000), 88 Ohio St.3d 332 (trial court erred when it unilaterally converted plaintiff's greater than even chance of survival claim to a less than even chance of survival claim). It is only through that analysis that the court can determine whether the plaintiff presented sufficient proximate cause evidence to establish a prima facie case.

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[1] Based on that same assumption, the dissent concludes that the trial court correctly held that the plaintiffs had failed to comply with their burden of providing the statistical expert evidence required to quantify the lost chance under the loss-of-chance doctrine. Id., ¶82.

B. Plaintiffs' Proposed Proposition of Law Is Unworkable and Unsound.

Plaintiffs propose the following proposition of law:

> The "loss of chance" doctrine applies in cases where doctors who admittedly breach their standard of care also offer evidence at trial that their breach caused their victim to lose a less-than-even chance of recovery.

Opp. Br. at 1. That proposition seeks to skirt the necessary connection between the nature of the medical malpractice claim asserted and the applicable causation burden by simply ignoring both. A more forthright articulation of the proposed rule of law might be:

> When a medical malpractice plaintiff offers expert opinion testimony that an injury or death was more probably than not caused by an alleged deviation from the standard of care, and the defendant offers expert testimony of less than probable causation, the jury must be instructed that if they find a breach of the standard of care, they must award *either* full damages *or* a portion of the full damages that accords with *the defendant's* causation evidence.

This fully revealed rule of law not only requires the simultaneous application of inconsistent causation burdens, but also provides *every* medical malpractice plaintiff the proverbial two bites at the apple.

Another technique employed by Plaintiffs to disguise the breadth and effect of their proposed rule of law is to seemingly limit the rule to defendants who "admittedly" breach the standard of care and defendants who "offer" loss-of-chance evidence at trial. Those qualifications, however, are both illusory and legally unsound.

The first limitation is illusory because if this Court were to hold that the second bite at the apple applies only to doctors who "admittedly" breach an applicable standard of care, the practical result would be that physicians would never admit error, since to do so would dramatically increase their liability exposure. More experts would have to be retained, and trials would be longer and more expensive. The limitation is unsound because negligence and causation are separate and independent elements of a cause of action and both must be proved to establish liability. "It is axiomatic that '* * * proof of negligence in the air, so to speak, will not do.'" *Sedar v. Knowlton Const. Co.* (1990), 49 Ohio St.3d 193, 197, quoting *Palsgraf v. Long Island R.R. Co.* (1928), 248 N.Y. 339, 341, 162 N.E. 99. Plaintiffs do not explain why the burden of proof for causation should change depending upon whether negligence is disputed or undisputed.

The limitation of a second bite at the apple to cases in which *defendants* offer loss-of-chance evidence "at trial" is illusory because defendants *always* present evidence that could be characterized as "loss-of-chance" evidence when they dispute causation at trial. Evidence that the alleged (or admitted) malpractice did *not* probably cause the injury or death for which damages are sought is evidence that the plaintiff had a less than even chance of avoiding the injury or death at the time of the alleged malpractice. Under Plaintiffs' proposition of law, physicians could never obtain a defense verdict based on causation because defendants themselves would create a second bite at the apple by defending against plaintiff's claim. The limitation is unsound because it creates two, mutually exclusive causation burdens for a single cause of action, and then foists one of

those burdens onto the *defendant*. Thus, plaintiff has the more probable than not burden for causation while the defendant assumes a "default" loss-of-chance burden. This is exactly the kind of sleight of hand condemned in *Snyder v. American Cigar Co.* (1908), 33 Ohio C.D. 440, 43 Ohio C.C. 440, aff'd (1910), 81 Ohio St. 568:[2]

> Where 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 the adversarial's position. This of course follows the rule that the burden of proof is on the plaintiff.

Finally, any such rule of law is illogical, unworkable, and unfair, as illustrated by the facts of this case. Here, Drs. Cox and Almudallal presented evidence that: 1) aspirin therapy has only a small chance of preventing recurrent strokes in the general population, considering all ages, overall health and types of strokes; 2) when the individual is, like Mr. Geesaman, an obese male with poorly controlled hypertension, high cholesterol, undiagnosed diabetes, and severe intracranial atherosclerosis, and when the individual's first stroke is, like Mr. Geesaman's, an evolving vertebral basilar stroke, such patients "progress to have other strokes no matter what we do"; and 3) aspirin therapy would not have prevented Mr. Geesaman's second stroke because he was given aspirin in the hospital, aspirin has an 8-10 day span of effectiveness, and his second stroke occurred

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[2] Plaintiffs incorrectly state (Opp. Br., p. 31) that "no court in Ohio has cited" *Synder*. See *Bush v. Harvey Transfer Co.* (1946), 146 Ohio St. 657, 670; *Bd. of Educ. v. Rhodes* (1959), 109 Ohio App. 415, 417; *Giovinale v. Rep. Steel Corp.* (1948), 51 Ohio Law Abs. 353, rev'd (1949), 151 Ohio St. 161; *Ohio Bell Tel. Co. v. Roy* (1932), 19 Law Abs. 294, all citing the case.

just three days after he was discharged from the hospital. (Supp. 102-103, 136, 171-172; Tr. 941-942, 1350, Vol. 7:87-88.)

Plaintiffs and the Third District Court of Appeals rely heavily on a single cross-examination question posed to Dr. Almudallal to conclude that the absence of an earlier diagnosis decreased Mr. Geesaman's chance of avoiding a second stroke:

> Q. * * * You would agree with me that with proper care in your own opinion he would have had a 25 to 33 percent chance at least of not having that second stroke; correct?
>
> A. As a relative risk, yes.

(Opp. Br., p. 3; App. Op., ¶¶13, 25.) But by referencing *relative* risk, Dr. Almudallal was necessarily addressing *general* populations – i.e., comparing the risk of recurrent strokes to aspirin users relative to non-aspirin users – not Mr. Geesaman's specific clinical condition. Further, "relative" risk does not mean that an individual has a 25 to 33% risk of recurrent strokes without aspirin therapy. If 9% of aspirin users have a second stroke and 12% of non-aspirin users have a second stroke, then the non-aspirin users have a 33% "relative" risk of a second stroke.

Most importantly, a review of the above quoted question and response in the context of the rest of the cross-examination reveals that Dr. Almudallal did *not* testify that Jeffrey Geesaman had *any* increased chance of avoiding a second stroke based on the missed diagnosis. (See Additional Supplement, 222-233; Tr. 569-580.) While Plaintiffs' counsel repeatedly attempted to get Dr. Almudallal to testify that his *treatment* of Mr. Geesaman would have changed had the MRI included a diagnosis of stroke, Dr.

Almudallal repeatedly testified only that he would have done more *diagnostic testing*. (Id. 222-224, 226-227; Tr. 569-571, 573-574.) When counsel attempted to elicit testimony that the second stroke would have been treated more aggressively if Mr. Geesaman were "sitting there in the hospital" when it occurred, Dr. Almudallal "totally disagree[d]." (Id. 227; Tr. 574.) When counsel attempted to elicit an admission that Mr. Geesaman would have had a better chance of avoiding a stroke being given aspirin in the hospital, as opposed to not taking aspirin at home, Dr. Almudallal reiterated that: 1) aspirin only affects the "relative" risk, and 2) "he missed the aspirin only two or three days when he left the hospital." (Id. 228; Tr. 575.) Finally, Dr. Almudallal rebuffed counsel's suggestion that an earlier diagnosis would have prompted him to prescribe "other blood thinning medication" by testifying that he would have prescribed such medication only after the *second* stroke. (Id. 228; Tr. 575.)

The overwhelming evidence that Mr. Geesaman's clinical circumstances would have led to a second stroke whether or not Dr. Cox evaluated the March 31 MRI as "normal," should have (and did) carry the day for Dr. Cox. In fact, such evidence would have carried the day in an "independent action" loss of chance jurisdiction as well. See, e.g., *Matsayuma v. Birnbaum* (Mass. 2008), 890 N.E.2d 819, 841 (explaining that under that state's "independent action" loss-of-chance doctrine, the plaintiff must present reliable statistical evidence that considers the "particular clinical circumstances of the patient"). Only under Plaintiffs' anomalous rule of law would evidence that aspirin therapy has *some* chance of preventing *some* recurring strokes in the *general population*

impose a mandatory duty on courts to instruct the jury to consider proportionate damages as an "alternative" theory of recovery.

In short, Plaintiffs' proposition of law creates a grossly expanded medical malpractice action in which the plaintiff's traditional burden of proof morphs into a "relaxed" causation standard whenever the defendant disputes causation. Instead of a narrow exception intended to apply when a plaintiff is unable to present a prima facie case of medical negligence, loss of chance would become a fallback position for every malpractice plaintiff. Insurance premiums would skyrocket to fund plaintiffs' two bites at the apple (assuming any insurers remained in the market at all), and the ensuing flight of physicians from the state would pose a grave threat to the continued availability of medical care in Ohio.

OAJ's proposed rule that plaintiffs be permitted to simultaneously pursue traditional and "relaxed causation" malpractice claims as alternative theories of recovery fares no better. The Connecticut and Massachusetts cases that Plaintiffs cite (Opp. Br., pp. 13-15) to support such a rule are "independent action" jurisdictions; they did not adopt loss of chance as a traditional malpractice action with a relaxed causation standard. In "independent action" jurisdictions, loss of chance must be pled, a prima facie case requires expert proof of more-probable-than-not causation and the injury compensated is the lost chance itself. *Matsuyama*, 890 N.E.2d at 822. Ohio loss of chance has none of those characteristics.

Further, Plaintiffs *did not seek* to plead or prove traditional malpractice and loss of chance as alternative theories of recovery. And for good reason. "Relaxed" and "more probable than not" causation burdens cannot simultaneously exist as "alternative theories" in a single cause of action, as the trial court correctly held in this case. (Supp. 27; Tr. 260.) As Plaintiffs' counsel conceded in response to pointed questions from the Third District appellate panel in this case, he did not seek to offer any evidence that Mr. Geesaman lost a less-than-even chance of avoiding the second stroke at trial, and he *would not have* sought to offer such evidence. To do so, Plaintiffs would have had to present contradictory expert evidence that the malpractice both did and did not probably cause the injury for which compensation was sought. OAJ's contrary suggestion does not jive with reality.

C. The Trial Court Properly Declined to Charge the Jury with the Incorrect and Inconsistent Instructions Proposed by Plaintiff.

The second portion of Plaintiffs' proposed proposition of law recites the rule that a trial court must instruct the jury on the law applicable to the issues framed by the pleadings and evidence. That is precisely what the trial court did here – it declined Plaintiffs' request that it instruct the jury on "two different standards of proof" for their single cause of action (Supp. 27; Tr. 260) and instructed the jury that they must decide, based upon all of the evidence, whether Plaintiffs had met their causation burden of proof.

Plaintiffs asked the court to instruct the jury *both* that they had the burden to prove negligence and proximate cause by a preponderance of the evidence (see Supp. at 9, 17) *and* on a *modified* loss of chance instruction (emphasis added):

Loss of Chance

> 1. GENERAL. **In the alternative, Defendants may claim that** Jeffery 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.

(Supp. at 18.) Compare OJI – CV 417.15 (emphasis added):

Loss of Less Than Even Chance of Survival

> 1. GENERAL. **The Plaintiff claims that** (insert name of decedent) lost a less than even chance of surviving from his/her pre-existing (condition) (disease) as a result of the Defendant's negligence.

Plaintiffs' proposed instruction, replacing "[t]he Plaintiff claims that" with "[i]in the alternative, Defendants may claim that," did not accord with the pleadings. The Defendants pled no counterclaim or any other form of affirmative "claim."

While Plaintiffs now argue that Dr. Cox's support of the trial court's decision constitutes an "unprecedented" request for "a rule that states the evidence the litigant admitted into evidence should not be given to the jury for its consideration" (Opp. Br. at 7), Dr. Cox makes no such request and the trial court's ruling set no such precedent. The trial court did not "withhold" "loss of chance" evidence from the jury's consideration; Plaintiffs did not assert a "loss of chance" claim and the Defendants did not present "loss of chance" evidence. Plaintiffs asserted a traditional malpractice claim and Defendants

presented evidence rebutting the traditional malpractice claim. The trial court charged the jury consistent with the evidence presented during trial.

For similar reasons, Plaintiffs' repeated claim (e.g., Opp. Br. at 11-12, 28) that Dr. Cox seeks to have this Court to overrule either *Roberts* or *Simko v. Miller* (1938), 133 Ohio St. 345, is misplaced. Dr. Cox seeks adherence to Ohio law, not its "evisceration" (Opp. Br. at 28). As OAJ's brief points out, *Roberts* adopted a "relaxed" causation standard for those situations where "'traditional notions of proximate causation may *unjustly* deprive a plaintiff of recovery * * *.'" (OAJ Br., p. 2, quoting *Roberts* at 845 (emphasis added).) If a plaintiff provides medical opinion testimony consistent with "traditional notions of proximate cause" and the jury agrees with the defense expert, the plaintiff has not been "unjustly" deprived of a recovery; like the plaintiff in any other tort action, he or she has simply failed to convince a jury of his or her peers. That is what occurred here.

This Court's clarification of loss of chance in *McMullen*, 88 Ohio St.3d 332, is equally consistent with the jury verdict in this case. *McMullen* held that a court acting as factfinder could not, upon finding as fact that the plaintiff had *proved* the traditional malpractice claim he had asserted, unilaterally transform that asserted and proven claim into a "loss of chance" claim. It is equally unjust to deprive a defendant of a jury's unanimous conclusion that plaintiff *did not prove* the traditional malpractice claim he had asserted. That is what the Third District did here. While Plaintiffs assert that "the Third District merely held that when parties introduce competing proximate cause evidence,

juries determine who carries the day" (Opp. Br. at 18), that is what the *trial court* held, not the Third District. The Third District held that "competing" evidence offered by a defendant *lessens the plaintiff's causation burden of proof*, providing a "fallback" opportunity to collect reduced damages.

D. This Court Should Reinstate the Unanimous Jury Verdict in Favor of Dr. Cox.

Finally, at pages 32 through 34 of his Opposing Brief, Plaintiffs suggest that this Court has somehow stripped itself of all power to reverse the Court of Appeals and reinstate the unanimous jury verdict in favor of Dr. Cox by declining to address Dr. Cox's second proposition of law. That is incorrect. This Court accepts jurisdiction of "cases," not parts of cases. See S.Ct.Prac.R. III, Section 6 (based on the jurisdictional memoranda filed, this Court determines whether to accept the appeal and decide "the case" on the merits); S.Ct.Prac.R. V (ordering the transmittal of the complete record of any case accepted). Simply because it chooses not to have all issues in the "case" briefed and argued does not affect this Court's jurisdiction.

Consistent with "reviewing court" jurisdiction, and regardless of the presence or absence of error by the court of appeals, this Court has the obligation to reinstate a vacated jury verdict when "substantial justice has been done" in the trial court. *Beard v. Meridia Huron Hosp.* (2005), 106 Ohio St.3d 237, ¶35 (reversing the court of appeals

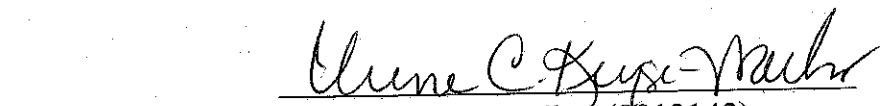
and reinstating the jury verdict; even assuming the trial court abused its discretion in the admission of certain testimony, reversal was "not * * * warranted"). Accord *Mikula v. Tailors* (1970), 24 Ohio St. 48 (reversing court of appeals and reinstating jury verdict when court of appeals erroneously concluded that trial court should have given a declined instruction and the remaining error did not warrant reversal of jury verdict). "Substantial justice has been done" when the jury "would probably have made the same decision even if the error had not occurred." *Beard*, ¶35.

In *Beard*, this Court held that whether or not the appellate court was correct in finding that the trial court had erroneously admitted certain expert opinion testimony, that "error" could not warrant a reversal of the jury verdict because the jury still "would have heard" the substance of the expert opinion from other witnesses. Id., ¶36. In this case, whether or not the Third District was correct in finding that the trial court had erroneously allowed Dr. Preston to respond to a hypothetical posed during cross-examination, that "error" could not warrant a reversal of the jury verdict because the jury still would have heard expert opinion testimony on Mr. Geesaman's April 15 and April 25 MRIs from other witnesses. See testimony of Charles Lanzieri, M.D. (Supp. at 208, 210, 214); testimony of Mark Delano, M.D. (Supp. at 115-122). Thus, "substantial justice has been done."

III. CONCLUSION

This Court should reverse the Court of Appeals and reinstate the unanimous verdict in favor of Dr. Cox.

Respectfully submitted,



Irene C. Keyse-Walker (0013143)
TUCKER ELLIS & WEST LLP
925 Euclid Avenue, Suite 1150
Cleveland, Ohio 44115-1414
Tel: (216) 592-5000
Fax: (216) 592-5009
E-mail: ikeyse-walker@tuckerellis.com

Patrick K. Adkinson (0016980)
ADKINSON LAW OFFICE
4244 Indian Ripple Road, Suite 150
Dayton, OH 45440
Tel: (937) 431-9660
Fax: (937) 228-0944
E-mail: pka.adklaw@bizwoh.rr.com

Attorneys for Defendant-Appellant

CERTIFICATE OF SERVICE

A copy of the foregoing has been served this 6th day of August, 2010, by U.S. Mail, postage prepaid, upon the following:

Dennis P. Mulvihill
Gregory S. Scott
Lowe Eklund Wakefield & Mulvihill Co., L.P.A.
610 Skylight Office Tower
1660 West 2nd Street
Cleveland, OH 44113-1454

Attorneys for Plaintiffs-Appellees

Anne Marie Sferra
Bridget Purdue Riddell
Bricker & Eckler LLP
100 South Third Street
Columbus, OH 43215

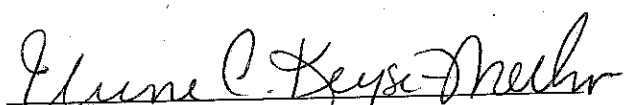
Attorneys for Amici Curiae Ohio Hospital Association, Ohio State Medical Association, American Medical Association, and Ohio Osteopathic Association

John F. Haviland
Bieser, Greer & Landis LLP
400 PNC Center
6 North Main Street
Dayton, OH 45402

Attorney for Amicus Curiae Ohio Association of Civil Trial Attorneys

Jonathan R. Stoudt
Michael J. Rourke
Rourke & Blumenthal, LLP
495 South High Street, Suite 450
Columbus, OH 43215

Attorneys for Amicus Curiae Ohio Association for Justice



One of the Attorneys for Defendant-Appellant