

**THIS CASE DOES NOT PRESENT AN ISSUE OF
PUBLIC OR GREAT GENERAL INTEREST**

Section 2, Article IV of the Ohio Constitution instructs that a judgment of an Ohio Court of Appeals shall serve as the ultimate and final adjudication of cases except those involving constitutional questions, conflict cases, felony cases, cases in which the Court of Appeals has original jurisdiction, and cases of public or great general interest. "Except in these exceptional circumstances, it is abundantly clear that in this jurisdiction a party to litigation has a right to but one appellate review of his cause." *Williamson v. Rubich* (1960), 171 Ohio St. 253, 253-254 (emphasis added). A case does not present a question of public or great general interest if the issue is merely of interest primarily to the parties. *Id.* at p. 254. In short, this Court is not intended to be just another appellate court.

Here, the trial judge – without the benefit of a transcript – granted a directed verdict in this "informed consent" case because he mistakenly believed that plaintiffs had not presented evidence regarding the second prong of the "*Nickell*" test. Upon reviewing the transcript, the court of appeals saw that sufficient evidence had been presented and reversed. In short, this civil case is not one of public or great general interest. There is no novel issue of law or procedure, and neither the facts nor the legal issues require guidance by this Court. Accordingly, there is no reason to review the appellate court's decision.

STATEMENT OF THE CASE AND FACTS

In early 1998 Bob White developed radiating pain in his hip and lower back. His family physician referred him to defendant-appellant Warren H. Leimbach, II, a neurosurgeon. Mr. White met with Dr. Leimbach for the first time in January 1998.

Mr. White explained that he wanted to be conservative because he was "really leery of surgery." And, Leimbach's office notes specifically note that "Mr. White would like to be as

conservative as possible[.]” As a result, and at Mr. White's request, Mr. White underwent six weeks of physical therapy in an effort to see if surgery could be avoided.

Eventually, Mr. White elected to undergo surgery after Leimbach described the surgery – a discectomy at the L5-S1 level – as a “common surgery, something routine actually.” The surgery took place March 10, 1998 (“the first surgery”). When Mr. White woke up from the first surgery, the pain was gone. Within three months, Mr. White returned to his heavy-labor job without any restrictions whatsoever.

Before the first surgery, Leimbach did not discuss the likelihood of a successful outcome but described the surgery as “common” and “routine.” Leimbach testified that there is a “very high” success rate with a “first time” surgery to repair a herniated disk at the L5-S1 level, and that there was a 90-95% chance that Mr. White would get better as a result of surgery, a 4-5% chance that he would stay the same, and less than a 1% chance that he would be worse following surgery.

Two and a half months after returning to work, Mr. White slipped in the rain and began to experience the same type of pain he had felt before the first surgery. He returned to Leimbach, who told him that he had herniated the same L5-S1 disk that had been the subject of the first surgery. As a result, Leimbach suggested performing the same surgery, which he called a “re-do” surgery.

This time, Leimbach did not recommend any physical therapy and never discussed it as an option. Even though Mr. White reported that pain medicine and heat were relieving the pain, Leimbach recommended surgery. Surgery took place October 23, 1998 (“the second surgery”).

Although he never said so to the Whites, Leimbach admitted at trial that the risk of a poor outcome is much greater with a “re-do” surgery when compared to a first surgery. In particular,

according to Leimbach a "re-do" surgery carries much greater risk of chronic pain and complications because of the scar tissue created by the first surgery:

Q: In fact, the risk of chronic pain and complications was much higher with the second surgery than the first surgery, correct?

A: It is higher with the second surgery, yes.

Q: And there was much more risk because of the scar tissue created by the first surgery, correct?

A: Yes.

Leimbach never disclosed this to Mr. White and never told him that there was a substantial risk that a "re-do" surgery would leave him in much greater pain.

The fact that "re-do" surgeries have a much higher risk of failure was known to medical professionals before Leimbach performed the second surgery. According to Dr. Michael Miner, who testified for the defense, the fact that the chances of a poor outcome substantially increases with a "re-do" surgery was well documented in peer-reviewed medical journals before the second surgery. Indeed, a 1989 article from the Journal of Neurosurgery noted that the number of surgical "failures" more than doubled – from 8% with a first surgery to 19% with a "re-do" surgery. The medical literature further states that although complete or significant pain relief occurs 87-91% of the time with a first surgery, complete or significant pain relief is achieved only 52% of the time with a "re-do" surgery.

Dr. Miner testified at trial that it is important to inform patients that the outcome of a "re-do" surgery is substantially different than the outcome of a first surgery, and Leimbach admitted at trial that this risk should be disclosed. Instead, however, Leimbach told Mr. White that the second surgery would be "exactly the same thing we just went through back in the beginning of the year." Dr. Leimbach did not provide any literature about the second surgery. He did not

mention anything about the likelihood of success with a "re-do" surgery or provide percentages about the possible outcomes. And, he never indicated in any way that a "re-do" surgery was riskier than the first surgery. Mr. White testified that had he been told of this, he would not have gone through with the second surgery.

Unlike the first surgery, when Mr. White woke up from the "re-do" surgery he felt intense pain. Mr. White testified as follows:

The pain was completely different. It was not in the same place as it was the first time. . . . It was a constant, sharp throb from the top of my hip all the way down. Plus, now it did not stop at my knee. Now it goes all the way to my toes and my foot. It felt like someone took a knife and peeled all the skin off of it

When Leimbach came into the hospital room, and before Mr. or Mrs. White said anything, Leimbach asked Mr. White whether he was now experiencing pain in his foot. According to Mr. White, Leimbach "was different. He had a sense of urgency it seemed like."

Although Leimbach had conducted the second surgery to remove a herniated disc, according to the post-surgery notes he did not find a herniated disc. In his notes Leimbach wrote:

I was very disappointed with the second surgery because when I got in there I really found no herniated disk. Everything was flush on the floor of the canal and there is a lot of scar tissue which I had to dissect off the root That is what I was afraid of with the scar tissue and the second operation and *we just made it worse.*

Leimbach worried that Mr. White was developing "causalgia" as a result of the second surgery. Causalgia is an intense, burning pain that results from a nerve injury. Dr. Miner testified that the symptoms of causalgia include burning pain, allodynia (pain in response to a non-painful stimulus), swelling and discoloration of the affected limb. There is no dispute that Mr. White possessed none of these symptoms before the "re-do" surgery and possessed all of them after the "re-do" surgery.

Dr. Miner conceded that Mr. White's symptoms following the "re-do" surgery are classic signs of causalgia. He also concedes that according to the medical literature, in 72% and 90% of the time, the time from injury to the nerve to the onset of causalgia pain is within one week and one month, respectively.

Dr. Miner admitted that the immediate onset of the "raw, burning pain" that Mr. White experienced after the "re-do" surgery suggests nerve damage. He also admitted that in light of the timing of the onset of causalgia, the "raw burning pain" in Mr. White's foot could not be attributed to the incident in which he fell on his buttocks in the rain two months before surgery.

The testimony of Dr. Gary Rea also supported the plaintiffs' claims. When pressed during cross-examination, Dr. Rea admitted that the symptoms Mr. White began experiencing after the "re-do" surgery were "most likely" caused by the surgery:

Q: So, it is fair to attribute that raw burning pain to the surgery is it not?

A: It could be. It could also be a combination of the continued pain from the other issue. But, yes, it could be from the surgery.

Q: That is the most likely cause, true, because we didn't have that symptomatology prior to the surgery?

A: Correct.

Despite Dr. Rea's testimony that the second surgery performed by Dr. Leimbach was the most likely cause of Bob White's injuries, the trial court granted a directed verdict at the close of all the evidence, concluding – incorrectly – that there had been no testimony that established the second prong of the test enunciated in *Nickell v. Gonzalez* (1985), 17 Ohio St.3d 136.

The Tenth District Court of Appeals reversed, finding as follows:

The relevant evidence at trial revealed the following: (a) Dr. Leimbach knew that the second surgery carried a much greater risk of a poor outcome than the first;

(b) based on the documentary evidence and the testimony of Mr. White and his wife – who were both present at all medical appointments – Dr. Leimbach did not mention the greater risk(s) associated with the second surgery; (c) Mr. White's condition was significantly worse after the second surgery; and (d) the second surgery was the most likely cause of Mr. White's deteriorated condition.

This evidence, according to the appellate court, was sufficient to create a jury question. As a result, the court reversed and remanded.

RESPONSE TO APPELLANT'S PROPOSITIONS OF LAW

Proposition No. 1. Appellant asks for a "bright line" requirement that expert testimony is always required in every aspect of every informed consent case. Setting aside the fact that this is simply not true - expert testimony is not required in situations where (a) the defendant's admissions obviate the need for such testimony, or (b) an issue is such that a lay person can make a determination without the need for explanation or validation from an expert - the proposition of law is moot because the Whites provided expert testimony as to each element of their claim. Dr. Leimbach and Dr. Miner – both neurosurgeons – testified that the risks of a "re-do" surgery as significantly higher and should be disclosed. And, Dr. Rea testified that Mr. White's current condition was "most likely" caused by the second surgery. Thus, even if the Court were inclined to consider such a proposition of law, this case does not present facts upon which such a proposition of law would turn, because in this case there is expert testimony supporting each element.

Proposition No. 2. In his second proposition of law, Leimbach asks the Court to address an issue that is not central to this case. In brief, appellant asks the Court to conclude that a surgeon does not need to inform his patient of the material risks of the surgery so long as the patient has picked up the information elsewhere along the way. In this case, it is clear that Leimbach failed to inform Bob White of the material risks of a "re-do" surgery. At trial,

Leimbach attempted to overcome this deficiency by arguing that Dr. Miner – who, for insurance purposes, provided a second opinion regarding the need for surgery – informed Mr. White of the risks. Dr. Miner, however, testified as follows:

Q: Okay. Doctor, the – can you show me in any of your records where it's indicated that you discussed the risks and benefits and outcomes of surgery with the Whites?

A: No.

Q: It's not anywhere to be found in writing, true?

A: No, I didn't – no, that's – that is true.

Q: And you don't recall any specific conversation with the Whites, do you?

A: No.

[Miner Depos., p. 73:8-18.]

More important, however, the tort of lack of informed consent "is established when:

(a) the physician fails to disclose to the patient and discuss the material risks and dangers inherently and potentially involved with respect to the proposed therapy, if any;

(b) the unrevealed risks and dangers which should have been disclosed by the physician actually materialize and are the proximate cause of the injury to the patient; and

(c) a reasonable person in the position of the patient would have decided against the therapy had the material risks and dangers inherent and incidental to treatment been disclosed to him or her prior to the therapy." *Nickell v. Gonzales* (1985), 17 Ohio St.3d 136 at syllabus (emphasis added). The test places the burden on the surgeon to inform his patient of the risks; it does not permit the surgeon to shift his responsibilities to someone else. Appellant contends that the phrase "the physician" in paragraphs (a) and (b) above refers to *any* physician. Both the model Ohio Jury Instructions and Ohio case law make clear that the phrase "the physician" refers to the

defendant. Ohio Jury Instruction CV 417.05, titled "Common law lack of informed consent: physician/surgeon," states as follows:

1. GENERAL. Plaintiff claims that defendant failed to inform the plaintiff about the material risks in the (*describe therapy, treatment, surgery, or procedure*) which caused (injury)(harm) to the plaintiff. The plaintiff must prove by the greater weight of the evidence that

(A) the **defendant** failed to disclose to and discuss with the plaintiff the material risks and dangers inherently and potentially involved with respect to the proposed (*describe therapy, treatment, surgery, or procedure*); and

(B) the risks and dangers that should have been disclosed by the **defendant** actually occurred and were a (proximate)(direct) cause of (injury)(harm) to the plaintiff; and

(C) a reasonable person in the plaintiff's position would have decided against the (*describe therapy, treatment, surgery, or procedure*) if the material risks and dangers inherent and incidental to it had been disclosed to him/her prior to the (*describe therapy, treatment, surgery, or procedure*).

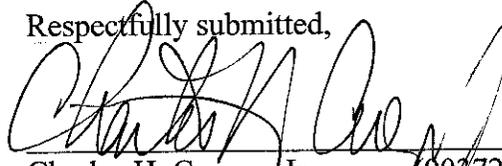
(Emphasis added.)

The model instructions accurately reflect Ohio case law. Appellant's proposition of law, which would reverse this requirement, should not be accepted.

CONCLUSION

For the foregoing reasons, Appellees Bob and Mary White respectfully submit that this case does not present a matter of public or great general interest. Appellant's memorandum in support of jurisdiction merely reargues the points argued below and asks this Court to come to a different conclusion in this run-of-the-mill informed consent case. In short, the issue presented is of interest only to the parties.

Respectfully submitted,



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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing Appellees' Response to Appellant's Memorandum in Support of Jurisdiction was served on the following counsel, by regular U.S. mail, postage prepaid, this 2nd day of July, 2010:

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