

IN THE SUPREME COURT OF OHIO

ROBERT N. WHITE, et al.	:	
	:	Case No. 10-0988
Plaintiffs/Appellees,	:	
	:	On Appeal from the
v.	:	Franklin County Court
	:	of Appeals, Tenth Appellate
WARREN H. LEIMBACH, II, M.D.,	:	District, Case No. 09AP-000674
	:	
Defendant/Appellant.	:	

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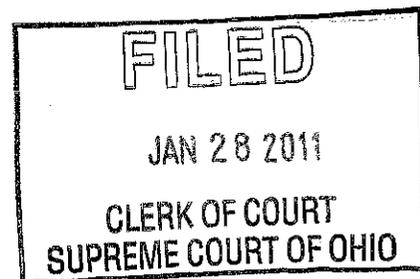


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PROCEDURAL HISTORY

In 1998 appellant, Dr. Warren H. Leimbach II, performed two back surgeries on appellee Robert White, both at the L5-S1 level. Mr. White healed perfectly from the first surgery but re-injured his back when he slipped in the rain a few months after returning to work. At Dr. Leimbach's suggestion, Mr. White agreed to a second surgery. Dr. Leimbach called the second surgery a "re-do" surgery and indicated it would simply be a repeat of the first, successful, surgery. The second surgery left Mr. White with permanent, intractable pain. This lack-of-informed-consent case ensued because Dr. Leimbach never disclosed to Mr. White that the second surgery had a much greater risk of a poor outcome than the first surgery.

The case was tried to a Franklin County jury. At the close of all of the evidence, the trial court granted a directed verdict against Robert and Mary White. From the bench, the trial court stated: "[T]he fact of the situation is that there just hasn't been sufficient testimony to meet the second element of the Nickel [sic] requirements."¹ (Supp. 003, Tr. 702.) Through its Final Judgment Entry, the trial court provided additional explanation: "Specifically, the Court finds that reasonable minds could come to but one conclusion based upon the evidence submitted and that conclusion was adverse to Plaintiff's burden to establish the determinative issue that the alleged failure of Defendant to advise the Plaintiff of the risks that subsequently materialized were the proximate cause of Plaintiff's injury." (Appx. 048.)

¹ In *Nickell v. Gonzalez* (1985), 17 Ohio St.3d 136, 477 N.E.2d 1145, this Court held that the tort of lack of informed consent is established when:

- (1) 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;
- (2) 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
- (3) a reasonable person in the position of the plaintiff 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.

The court of appeals reversed. Finding that "the record is replete with evidence that Mr. White's condition was made worse because of the second surgery, and the presence of scar tissue," (Appx. 030), the court concluded that "the evidence was sufficient to withstand Dr. Leimbach's directed verdict motion[.]" (Appx. 032.)

Appellant filed a memorandum in support of jurisdiction with two propositions of law. By a 4-3 vote, the Court accepted jurisdiction, limited to the following proposition of law:

Proposition of Law: A plaintiff must present expert testimony as to all of the elements of a claim for lack of informed consent arising out of the performance of a medical procedure, including expert testimony as to what the claimed undisclosed material risks are, and, if disputed, as to whether those risks did in fact materialize.

The proposition of law extends far beyond the narrow holdings of the trial court and the court of appeals. The courts below merely addressed whether the Whites produced sufficient evidence of proximate cause under the second part of the *Nickell* test. The proposition of law, however, (and the merit briefs of appellant Leimbach and his amicus) would require this Court to determine whether "expert testimony" is required "as to all of the elements of a claim for lack of informed consent" (emphasis added) "including expert testimony as to what the claimed undisclosed material risks are, and, if disputed, as to whether those risks did in fact materialize," even though that issue was not the basis for the trial court's decision or the subsequent appeal. Accordingly, appellees respectfully submit that jurisdiction was improvidently granted and that this cause should be dismissed.

SUMMARY OF ARGUMENT

If this Court limits its review to the issue upon which the trial court and the court of appeals based their decisions – i.e., whether appellees presented evidence of proximate cause sufficient to overcome appellant's motion for a directed verdict – the issue can be quickly addressed. The court of appeals correctly found that "the record is replete with evidence that Mr. White's condition was made worse because of the second surgery." The appellate court based this conclusion on the evidence that:

- Before the first surgery, Dr. Leimbach informed the Whites that the risk of a poor outcome was less than 1% [Tr. 186:12-18];
- According to Dr. Leimbach and Dr. Michael Miner, the risk of a poor outcome with the second surgery was much greater than the first surgery [Tr. 204:1-3, 645:5-9] and the increased risk is something that should be disclosed [Tr. 218:21–219:4, 648:14-19];
- Dr. Leimbach never disclosed the increased risk [Tr. 252:9-19];
- There was no urgent need for the surgery. Mr. White's low back pain was being relieved by heat and Percocet [Tr. 255:10-19];
- Mr. White woke up from the second surgery with a raw, burning (and permanent) pain in his foot that did not exist before the surgery [Tr. 269:4-16]
- Before Mr. White could tell Dr. Leimbach about the new pain, Dr. Leimbach asked Mr. White whether he was now experiencing any pain in his foot [Tr. 266:12-20];
- After examining Mr. White immediately following the surgery, appellant, Dr. Leimbach, expressed concern that as a result of the second surgery Mr. White was developing "causalgia," an intense, burning pain that results from a nerve injury. [Tr. 215:3-20, 649:18-23];
- Dr. Gary Rea testified that the second surgery was the "most likely cause" of the raw, burning pain in Mr. White's foot [Tr. 521:25 – 532:8];
- Dr. Leimbach, admitted in his post-surgical notes that "**That is what I was afraid of with the scar tissue and the second operation and we just made it worse.**"[Plaintiffs' Trial Exh. 11, p. 3].

From this evidence a jury easily could have found proximate cause, i.e., (a) that a reasonable person in Mr. White's condition would not have agreed to the "re-do" surgery if the material risks had been disclosed, and (b) Mr. White was harmed as a result of the surgery. Indeed, it would have been difficult for the jury *not* to have found proximate cause. Accordingly, this Court should affirm the Tenth District's decision and remand the case for a second trial.

If the Court elects to go beyond the narrow "proximate cause" issue presented below and instead undertakes a more expansive review of the elements of informed consent to determine when expert testimony is required and whether sufficient testimony supporting each element was presented at trial, the analysis will be longer but the result will be the same. Through the Whites' testimony, admissions by Dr. Leimbach, and the testimony of Dr. Leimbach's own experts, appellees presented evidence that established each element of a claim for lack of informed consent:

- **Dr. Leimbach admitted, and Dr. Miner confirmed, that the risk of a poor outcome significantly increases with a "re-do" surgery.** Appellant states at page 7 of his brief that "[f]urthermore, it is simply not the case that Dr. Leimbach (or anyone else) 'knew that the second surgery carried a much greater risk of a poor outcome than the first.'" The opposite is true. Dr. Leimbach testified at trial as follows:

Q: The second surgery, the redo, had a much greater risk of a poor outcome, isn't that true?

A: That's correct.

[Tr. 203:1-3.] Appellant's expert, Dr. Michael Miner, testified the same way:

Q: And, doctor, those – the risks that patient's pain will actually get worse as a result of surgery, those risks change with a redo surgery, true?

A: In general, that's true.

Q: In fact, they change significantly, don't they?

A: In general, I think they do and – but – but, yes.

Q: There is a much greater risk of a bad outcome in a redo surgery, isn't there?

A: Well, there is a much greater risk that – well, the relief of pain is much less with a second operation, that's true.

[Tr. 644:17 – 645:4.]

• **Dr. Leimbach admitted, and Dr. Miner confirmed, that a surgeon should disclose the increased risk.** Dr. Leimbach admitted at trial that a surgeon should disclose the fact that the risks increase with a "re-do" surgery. [Tr. 219:1-220:24.] Dr. Miner testified the same way:

Q: Well, it's important for the patient to know whether there is a chance that his pain will likely get worse as a result of the surgery, true?

A: Sure.

Q: The patient has to know that in order to make an informed decision, right?

A: Certainly.

Q: And, doctor, those – the risks that a patient's pain will actually get worse as a result of surgery, those risks change with a redo surgery, true?

A: In general, that's true.

* * *

Q: All right. And, doctor, would you agree with me that it would be appropriate and important even to inform patients that the outcome of a – of a redo surgery is substantially different than the outcome of a first surgery?

A: Yes.

[Tr. 644:10-21, 648:14-19.]

- **Dr. Leimbach did not disclose the increased risk.** Appellant states at p. 7 of his brief "[i]t is also not true that Dr. Leimbach failed to disclose the enhanced risk of the second surgery." Both Mr. White and his wife (who accompanied him on his visits with Dr. Leimbach) testified that Dr. Leimbach **never** explained that the "re-do" surgery was much riskier than the first surgery. [Tr. 252:9-19, 408:4-25.] And, Dr. Leimbach admitted at trial that he does not recall telling Mr. White about the increased risk associated with the "re-do" surgery. [Tr. 221:25 – 222:4.]

- **Dr. Leimbach admitted, and Drs. Miner and Rea confirmed, that the risk materialized.** Appellant states at page 8 of his brief that "it is simply not the case that 'Mr. White's condition was significantly worse after the second surgery.'" This representation is flatly false. After the "re-do" surgery Dr. Leimbach **admitted** that the surgery made Mr. White worse:

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.***

[Plaintiffs' Trial Exh. 11, p. 3 (emphasis added).]

Before the surgery, Mr. White had low back pain that was relieved with heat and Percocet. [Tr. 198:14 – 199:11, 254:14-18, 255:16-23.] **After** the "re-do" surgery, Mr. White suffered from an intense and permanent raw burning pain in his foot. [Tr. 269:4-16, 270:4-9.] Mr. White testified that he had never experienced this before the "re-do" surgery. [Tr. 269:4-16.] And, Dr. Miner, who conducted a "second opinion" examination of Mr. White before the second surgery, conceded at trial that Mr. White had none of these symptoms before the "re-do" surgery. [Tr. 653:18-23, 654:2-25.]

Expert witness Dr. Gary Rea also testified that the "re-do" surgery is the most likely cause of Mr. White's permanent nerve injury:

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.**

[Tr. 521:25 – 532:8 (emphasis added).] As a result of the second surgery, Mr. White must now take heavy pain narcotics for the rest of his life. It is ludicrous for appellant to suggest that Mr. White's condition was not significantly worse after the second surgery.

STATEMENT OF FACTS

In early 1998 Robert White developed low back pain that radiated down to his knee. [Tr. 237:3-9.] He was referred to appellant, Dr. Warren H. Leimbach, II, a board-certified neurosurgeon. [Tr. 160:1-7, 239:4-9.]

Mr. White explained to Dr. Leimbach that he wanted to proceed conservatively because he was "really leery of surgery." [Tr. 239:18-23, 241:12-15.] Dr. Leimbach's office notes confirm that "Mr. White would like to be as conservative as possible[.]" [Tr. 175:9-13; Plaintiffs' Trial Exhibit 1.] As a result, Mr. White underwent six weeks of physical therapy in an effort to see if surgery could be avoided. [Tr. 241:16 - 242:2.]

Following physical therapy, Mr. White elected to undergo surgery after Dr. Leimbach described the surgery – a discectomy at the L5-S1 level – as a "common surgery, something routine actually." [Tr. 243:1-8.] The surgery took place March 10, 1998 ("the first surgery").

The surgery immediately eliminated the pain, [Tr. 245:12-24], and within three months Mr. White returned to his heavy-labor job without any restrictions whatsoever. [Tr. 246:13 - 247:9.]

Informed Consent Prior To The First Surgery

Dr. 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. [Tr. 174:12-15.] According to Dr. Leimbach, before the first surgery he told Mr. White 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. [Tr. 186:12-18.]

To document this "informed consent" discussion before the first surgery, Dr. Leimbach did the following:

1. He stated in his office notes that he had informed Mr. White of the risks of surgery.
2. He completed a Grant Hospital pre-surgical form in which he:
 - specifically checked a box indicating that "the expected results and reasonably known risks have been explained;"
 - dated the form "3-10-98;"
 - described in his own handwriting the type of surgery to be performed; and
 - signed the form.
3. He stated in the surgical "Operative Report" that Mr. White had provided informed consent to the surgery.

[Tr. 186:19-22, 187:10-188:8, 188:16-189:12; Plaintiffs' Trial Ex. 1; Plaintiffs' Trial Ex. 9; Plaintiffs' Trial Ex. 10.] As discussed below, Dr. Leimbach did none of these in connection with the second surgery he performed on Mr. White. A jury could conclude from this that Dr. Leimbach did not discuss risks with Mr. White prior to the second surgery.

Mr. White Re-injures His Back

Two and a half months after returning to work, Mr. White slipped in the rain and felt the same type of pain he had felt before the first surgery. [Tr. 248:1-23.] He returned to Dr. Leimbach, who told him that he had herniated the same L5-S1 disk. [Tr. 249:21-24, 250:22-251:2.] As a result, Dr. Leimbach suggested performing the same surgery, which he called a "redo" surgery. [Tr. 251:2-5.] He never indicated the second surgery would be different in any way from the first surgery.

Dr. Leimbach recommended surgery even though Mr. White reported that pain medicine and heat were relieving the pain. [Tr. 196:20-22, 197:11-25, 198:14-199:11.] Moreover, he recommended surgery without explaining the benefits of alternative approaches such as physical therapy; indeed, he never even discussed the option. [Tr. 252:20-253:5.] Mr. White agreed to the "redo" surgery because of the way Dr. Leimbach described it to him. The "redo" surgery took place October 23, 1998.

The Risk Of A Poor Outcome Is Significantly Higher With A "Re-do" Surgery When Compared To A First Surgery

Dr. Leimbach admitted at trial that the risk of a poor outcome is much greater with a "redo" surgery as compared to a first surgery. [Tr. 204:1-3 ("Q: The second surgery, the redo, had a much greater risk of a poor outcome, isn't that true? A: That's correct.")]. In particular, Dr. Leimbach testified that the reason a "re-do" surgery carries a much greater risk that the patient will be left with chronic pain and complications is because the second surgery is complicated by internal scar tissue created by the first surgery. [Tr. 204:4-10.]

Dr. Michael Miner agreed that the risks are substantially greater. [Tr. 645:5-9 ("Q: And not just the relief of pain, but the chance of a – of a poor outcome substantially increases with a redo, doesn't it? A: Yes; but that's why it is important to decide what success is in the first

place.".)] The fact that "re-do" surgeries have a much higher risk of failure was known to medical professionals before Dr. Leimbach performed the second surgery. Dr. Miner testified that before Dr. Leimbach performed the second surgery it was well-documented in peer-reviewed medical journals that the chances of a poor outcome substantially increase with a "re-do" surgery. [Tr. 644:25 – 645:17.] For example, a 1989 article from the Journal of Neurosurgery noted that although complete or significant pain relief occurs 87-91% of the time with a first surgery (consistent with the statistics Dr. Leimbach gave to Mr. White), *complete or significant pain relief is achieved only 52% of the time following reoperation.* [Tr. 647:8-19.] More important, with a "re-do" surgery the number of surgical "failures" increases to **19 %**. [Tr. 645:19 – 646:18.] The risk of a poor outcome increases even more – to **21%** – when, as in Mr. White's case, an MRI taken before the second surgery reveals the presence of "fibrosis" (scar tissue). [Tr. at pp. 647:19 – 648:13.] This is a material increase over the "less than 1% chance" of a poor outcome that Dr. Leimbach says exists with a first surgery.

**When The Risk Of A Poor Outcome Is Substantially Different
Between A First Surgery And A Second Surgery, The Surgeon
Must Inform The Patient Of The Increased Risk**

There is no dispute that the increased risk should have been disclosed. Dr. Leimbach admitted at trial that before the second surgery it was important to make clear to Mr. White that the risk was greater than the first time around. [Tr. 218:21 – 219:4.] Dr. Miner also testified 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. [Tr. 648:14-19.]

**Dr. Leimbach Did Not Obtain Informed Consent
Prior To The Second Surgery**

Instead of informing Mr. White that the risk of a poor outcome was materially different, Dr. 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." [Tr. 251:23-25.] Dr. Leimbach did not provide any literature about the second surgery. [Tr. 252:3-6.] He did not mention anything about the likelihood of success with a "re-do" surgery or provide percentages about the possible outcomes. [Tr. 252:9-15.] Most important, Dr. Leimbach did not indicate in any way that a "re-do" surgery was riskier than a first surgery, [Tr. 252:16-19], even though he admits that it clearly was.

Before the second surgery an MRI was conducted to determine the cause of Mr. White's pain. Dr. Leimbach claims he reviewed the MRI before telling Mr. and Mrs. White that Mr. White "did indeed herniate a disc at the L5-S1 level." [Tr. 198:1-6; Plaintiffs' Trial Exh. 11 at p. 2.] According to the MRI report, however, the radiologist who performed the MRI observed scar tissue but could not definitively conclude that there was a herniated disc. [Tr. 208:1-3; Plaintiffs' Trial Exh. 14.] Yet Dr. Leimbach never shared the radiologist's MRI report with the Whites and never told Mr. White that there was only a *possible* disc herniation. [Tr. 259:12-25, 411:7-25.] Moreover, plaintiffs' expert Dr. Bruce Massau testified that he reviewed the MRI and "I really didn't see any recurrent injury that would forsake [sic] an operative procedure at that point in time." [Tr. 376:1-4.]

Most important of all, Dr. Leimbach never discussed the fact that the presence of scar tissue in a "re-do" surgery created a much greater risk that Mr. White would have a poor outcome. The topic of "scar tissue" came up in a conversation with Dr. Leimbach, but it was raised by Mary White. Mary White – who had heard from a friend that "scar tissue" could be an issue with back surgeries – asked Dr. Leimbach about the subject, believing that the "scar tissue" to which her friend was referring was the incision scar that forms on the surface of the skin following surgery. [Tr. 408:7-20.]

In response to Mrs. White's general question about scar tissue, Dr. Leimbach told Mr. and Mrs. White that during surgery he would not remove scar tissue because it would only "come back twice as bad." [Tr. 258:1 – 259:4, 408:7-12.] Dr. Leimbach did not refute this testimony at trial. When he conducted the "re-do" surgery, however, Dr. Leimbach did not find a herniated disk and – contrary to what he had told the Whites before surgery – he proceeded to dissect scar tissue. [Plaintiff's Trial Exhibit 11, p. 3.]

Dr. Leimbach conceded that he does not recall telling Mr. White about the increased risk associated with the "re-do" surgery. [Tr. 221:25 – 222:4.]² Although he claimed it was "routine" for him to have such a conversation with his patients, there is absolutely no indication that Dr. Leimbach discussed the risks of the second surgery. In contrast with the first surgery:

- Dr. Leimbach's office notes do not indicate that he ever discussed with Mr. White the risks of a second surgery [compare Plaintiffs' Exh. 1 at p. 3 with Plaintiffs' Trial Exh. 11];
- Dr. Leimbach did not complete the Grant Hospital "Documentation of Informed Consent" form. He scrawled his initials across a form without completing the form as required [compare Plaintiffs' Trial Exh. 9 with Plaintiffs' Trial Exh. 17]; and
- Dr. Leimbach's "Operative Report" for the second surgery does not indicate that he obtained informed consent before performing the surgery [compare Plaintiffs' Trial Exh. 10 at p. 1 with Plaintiffs' Trial Exh. 18].

² During the course of this litigation, Dr. Leimbach suffered a mild stroke. The stroke occurred after he had already provided deposition testimony during discovery but before the case went to trial. While appellate counsel now states at page 3 of appellant's brief that the stroke "placed significant limitations on Dr. Leimbach's cognitive functioning," there was no indication at trial that Dr. Leimbach's *memory* was impaired. Rather, he claimed his ability to *read* had been impacted, and therefore was permitted to have trial counsel stand right next to him throughout his testimony to confirm that plaintiff's counsel had accurately read various exhibits and/or deposition testimony. [Tr. 157, 158:22-159:4, 168:25-169:15.] At trial, when Dr. Leimbach indicated he could not recall a fact, he attributed it to the passage of time, not his stroke. [Tr. 193:19-24, 195:4-10.]

Both Mr. White and his wife (who accompanied him on his visits with Dr. Leimbach) testified that Dr. Leimbach **never** explained that the "re-do" surgery was much riskier than the first surgery. [Tr. 252:9-19.] Both testified that Dr. Leimbach repeatedly described the second surgery as "the same surgery," "routine," and a "re-do" surgery. [Tr. 251:6-11, 406:4-8.] Mrs. White testified that she asked Dr. Leimbach whether there were any risks with the second surgery and he assured her that the risks were "minimal." [Tr. 406:11-25.] This is consistent with Dr. Leimbach's own testimony that never expressed to the Whites any hesitation whatsoever about performing the second surgery. [Tr. 205:23 – 207:3.]

**Mr. White Would Not Have Agree To The Second Surgery Had He Known
That The Risks Of A Poor Outcome Were Significantly Higher**

Mr. White's surgery was not an emergency. [Tr. 635:8-15.] The low back pain he was experiencing before the second surgery was relieved through mere heat and Percocet, [Tr. 255:10-19], and Mr. White was able to participate in events with his children and engage in social activities. [Tr. 256:21-257:5.] In short, "the pain medicine was taking care of it." [Tr. 257:12.]

Dr. Leimbach admitted that before the second surgery he knew that pain medicine and heat were providing Mr. White relief from his back pain. [Tr. 198:14 – 199:20, 254:14-18, 255:16-23.] Dr. Leimbach also admitted at trial that Mr. White had insisted on proceeding conservatively before the first surgery and there were conservative alternatives to a second surgery. [Tr. 174:23-175:21, 202:22 – 203:2.] He further admitted that medication, therapy or simply the passage of time can eliminate the pain of a person who has reinjured a disk. [Tr. 203:3-13.]

Mr. White was never told that the "re-do" surgery could result in greater pain. [Tr. 257:13-17.] Had Mr. White been told that a "re-do" surgery had a much greater risk of a poor

outcome than the first surgery and that conservative alternatives might eliminate his low back pain, he would not have gone through with the second surgery. [Tr. 254:7-11.] This is especially true because, as Dr. Leimbach stated at trial (but did not tell Mr. White prior to surgery) – "surgery is always a last resort" [Tr. 165:9] and "[y]ou try not to redo for any reason." [Tr. 162:7-8.]

The Increased Risks Associated With A "Re-Do" Surgery Materialized

When Mr. White woke up from the first surgery, he was free of all pain. In sharp contrast, when Mr. White woke up from the "re-do" surgery he felt intense pain that he had not felt before the surgery:

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

* * *

Have you ever got like a little metal splinter in your hand and you can't see it. If you rub it, you feel it. Imagine 10,000 of those side-by-side all over the top of your foot. I couldn't sleep with a sheet over the top of my foot. To this day I can't wear a sock or put a regular shoe on. In the wintertime I am walking in a foot of snow with a sandal. It is still like this.

[Tr. 265:20 – 266:2; 269:4-12.]

Although appellant suggests that Mr. White was no worse off after the second surgery than before, Mr. White testified unequivocally that he had never experienced anything like this before the "re-do" surgery. [Tr. 269:13-16, 271:23-25.]

Dr. Leimbach apparently expected something to be amiss after the "re-do" surgery. When he came into Mr. White's hospital room after Mr. White woke up from the anesthesia, and before Mr. or Mrs. White said anything, Dr. Leimbach asked Mr. White whether he was now

experiencing pain in his foot. [Tr. 266:12-20.] According to Mr. White, Dr. Leimbach "was different. He had a sense of urgency it seemed like." [Tr. 268:5-6.]

As noted above, the pre-surgery radiology report that Dr. Leimbach never shared with the Whites identified scar tissue but did not definitively identify a herniated disc. When Dr. Leimbach operated, he did not find a herniated disc. In his notes Dr. Leimbach wrote:

I was very disappointed with the second surgery because when I got in there I really ***found no herniated disk.***

[Plaintiff's Trial Exh. 11, p. 3 (emphasis added).] Although Dr. Leimbach speculated that perhaps he had "sucked it out" when he began the surgery, based on Dr. Leimbach's observations Dr. Miner believes that there was no herniated disk. [Tr. 660:13-22.] Moreover, although Dr. Leimbach had promised the Whites that he would not remove scar tissue because "it only comes back twice as bad," he did, in fact, remove scar tissue during the second surgery:

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.***

[Plaintiffs' Trial Exh. 11, p. 3 (emphasis added).]

As noted above, Dr. Leimbach never discussed with Mr. White that the risk of a poor surgical outcome substantially increases during a "re-do" surgery because of the presence of internal scar tissue at the site. Yet Dr. Leimbach's own notes reveal (a) that he was aware of this risk before conducting the surgery, and (b) that the undisclosed risk materialized:

That is what I was afraid of with the scar tissue and the second operation and ***we just made it worse.***

[Plaintiffs' Trial Exh. 11, p. 3 (emphasis added).]

**Mr. White Is Left With Chronic Pain And Permanent Injury
As A Result Of The Second Surgery**

After the second surgery Dr. Leimbach worried that Mr. White had developed "causalgia" as a result of the "re-do" surgery. [Plaintiffs' Trial Exh. 11, p. 3; Tr. 214:23 – 215:2.] Causalgia is an intense, burning pain that results from a nerve injury. [Tr. 215:3-8, 649:18-23.]

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. [Tr. 650:2 – 651:1.] According to Dr. Miner and medical literature, causalgia pain develops quickly after injury to a nerve. [Tr. 652:10 – 653:5.] The symptoms Mr. White experienced immediately after the "re-do" surgery fit the clinical definition of causalgia to a "T":

- Soon after the second surgery Mr. White began experiencing a pain that is "raw to the touch" [Tr. 270:4-9];
- He began experiencing an intense pain when anything brushes up against his foot [Tr. 269:4-16];
- His leg swelled "really big" from his knee to his foot [Tr. 271:13-15];
- His leg became discolored, such that "sometimes it would be a dull, gray-looking color" and "other times it would come up a bright red[.] [Tr. 271: 15-20].

There is no dispute that Mr. White had never experienced any of these symptoms before the "re-do" surgery. [Tr. 269:15-16, 271:23-25.] Dr. Miner concedes that these are classic signs of causalgia and that the symptoms suggest nerve damage. [Tr. 651:6-15, 655:1-8.] Because causalgia occurs very soon after injury to a nerve, Dr. Miner agreed that Mr. White's symptoms could not be attributed to a remote incident such as the one that caused Mr. White to experience pain and return to Dr. Leimbach after he had recovered from the first surgery (i.e., the incident in which he slipped in the rain and fell on his buttocks two months before the "re-do" surgery). [Tr. 656:9-13.]

Dr. Rea was also called as an expert by Dr. Leimbach. After completing his direct examination live before the jury, Dr. Rea informed the Court at the end of the day that he could not return the following day (or thereafter) to testify under cross-examination. Instead of striking the witness' testimony, however, the Court required the Whites' counsel to cross-examine Dr. Rea on the record after the jury left for the day and then *read* the cross-examination to the jury the following day. The court of appeals observed that this was "highly irregular." 2010-Ohio-1726 at ¶21. Indeed, this was highly prejudicial to the Whites; the jury was given the opportunity to see the defense expert testify live with respect to all of the information that favored the defense but was deprived of the opportunity to observe the witness' demeanor when he changed his opinion under cross-examination.

Significantly, under cross-examination Dr. Rea supported the Mr. White's claims. When pressed, Dr. Rea initially equivocated but then 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.**

[Tr. 521:25 – 532:8 (emphasis added).]

Despite the testimony by Robert and Mary White, the admissions by Dr. Leimbach, and the testimony of Dr. Miner and Dr. Rea, at the conclusion of all of the evidence the trial court entered a directed verdict against the Whites. The trial court did not find a lack of evidence about a failure of informed consent. Rather, the trial court entered a directed verdict on a narrow

ground: that "[T]here just hasn't been sufficient testimony to meet the second element of [Nickell]." [Tr. 702.] The second element in *Nickell v. Gonzalez* (1985), 17 Ohio St.3d 136, 477 N.E.2d 1145, is whether the undisclosed risks actually materialized and caused injury to the patient.

The Tenth District Court of Appeals reversed, concluding at paragraph 16 of its decision that "[t]he evidence before the trial court was more than sufficient to create a question of fact for the jury; in fact, Dr. Leimbach's office notes from two weeks after the surgery were sufficient to establish the second prong of *Nickell*." (Citing and quoting from Plaintiff's Trial Exhibit 11.) This Court subsequently accepted jurisdiction.

ARGUMENT

A. Appellees Provided Sufficient Evidence of Proximate Cause

1. Expert testimony was not needed to establish "causation" in appellees' informed consent case

The essence of a claim for lack of informed consent is that a reasonable person in Mr. White's position would have decided against the surgery had the material risks been disclosed to him. Therefore, causation occurs if the patient proceeds with a surgery to which he would not otherwise have consented and the surgery makes him worse than before. See, e.g., *Frost v. Brenner*, 300 N.J. Super. 394, 406, 693 A.2d 149 ("Causation is established if a prudent person in Frost's position would have declined treatment if he had been informed of the risk that resulted in post-surgical harm").

Expert testimony may not be necessary to establish this. Expert testimony is certainly not required for the first part, i.e., whether a reasonable person in the plaintiff's position would have decided against the medical procedure. See *Nickell v. Gonzalez* (1985), 17 Ohio St.3d 136, 139, 477 N.E.2d 1145 (adopting the "reasonable patient" standard). And, if the evidence is clear to a

layperson that the medical procedure (which a reasonable person in the plaintiff's position would have decided against had the material risks been disclosed) has left the plaintiff worse off than before, expert testimony is not necessary. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, at 791, 795 (C.A.D.C. 1972) ("If adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown," and "[t]he jury's power to draw the inference that the aggravation of petitioner's tubercular condition, evident so shortly after the accident, was in fact caused by that accident, was not impaired by the failure of any medical witness to testify that it was in fact the cause.")

In short, "causation" in an informed consent case is established by proof that (a) a reasonable person in the plaintiff's position would have decided against the medical procedure had the material risks been disclosed to him or her prior to the procedure, and (b) the procedure leaves the plaintiff worse off than before. The Whites presented evidence of this at trial.

2. Appellees' evidence established causation

The Whites presented evidence from which a jury could conclude that a reasonable person in Mr. White's position would have decided against the surgery had the material risks been disclosed to him.

First, Mr. White's surgery was not an emergency. [Tr. 635:8-15.] The low back pain he was experiencing was relieved through mere heat and Percocet. [Tr. 255:10-19.] Mr. White was able to participate in events with his children and engage in social activities. [Tr. 256:21-257:5.] In short, "the pain medicine was taking care of it." [Tr. 257:12.]

Second, Dr. Leimbach admitted that the risk of a poor outcome is much greater with a "re-do" surgery. [Tr. 204:1-10.] Dr. Miner agreed. [Tr. 645:5-9.] Both Dr. Leimbach and Dr.

Miner agreed that this significantly increased risk should be disclosed prior to surgery. [Tr. 218:21 – 219:4; 648:14-19.]

Based on the foregoing, a jury could conclude that (a) the significantly increased risk is a "material" risk that should be disclosed, and (b) a reasonable person in Mr. White's position would have decided against the surgery had this material risk been disclosed, especially since – as Dr. Leimbach put it – "surgery is always a last resort" [Tr. 165:9] and "[y]ou try not to redo for any reason." [Tr. 162:7-8.]

The Whites also presented evidence from which a jury could conclude that the "re-do" surgery (which a reasonable person in Mr. White's position would have declined) left Mr. White worse off. Mr. White woke up from the "re-do" surgery with a burning pain that he had never experienced before (either in terms of location or intensity). [Tr. 265:20- 266:8, 269:4--16, 271:23-25.] From this evidence alone the jury could have concluded that the "re-do" surgery left Mr. White worse off.

Additionally, however, the jury heard testimony that after the surgery, and before Mr. White said anything at all, Dr. Leimbach asked Mr. White whether he was now experiencing pain in his foot. [Tr. 266:12-20.] This question is odd when one considers that before the "re-do" surgery Mr. White was merely experiencing low back pain that radiated down to his knee. And, according to Mr. White, Dr. Leimbach "was different. He had a sense of urgency it seemed like." [Tr. 268:5-6.] Moreover, in his own office notes Dr. Leimbach acknowledged that the "re-do" surgery made Mr. White worse. See Plaintiff's Trial Exhibit 11, p. 3 ("That is what I was afraid of with the scar tissue and the second operation and *we just made it worse.*")

Finally, Dr. Rea testified that the burning pain Mr. White experienced for the first time when he woke up from the "re-do" surgery was 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.**

[Tr. 521:25 – 532:8 (emphasis added).]

Based on the foregoing, a jury easily could have concluded that the second surgery made Mr. White worse off, thus establishing causation. Accordingly, the trial court erred in entering a directed verdict on the issue of proximate cause.

B. The Proposition Of Law Would Require This Court To Abandon Precedent

Proposition of Law: A plaintiff must present expert testimony as to all of the elements of a claim for lack of informed consent arising out of the performance of a medical procedure, including expert testimony as to what the claimed undisclosed material risks are, and, if disputed, as to whether those risks did in fact materialize.

The proposition of law is contrary to precedent. This Court recognized in *Nickell v. Gonzalez* (1985), 17 Ohio St.3d 136, 477 N.E.2d 1145 that expert testimony is not required as to "all" of the elements of an informed consent claim when it adopted the "reasonable person" standard. Moreover, appellant's proposition of law creates two problems. First, it blurs the distinction between medical malpractice claims – which involve "standard of care" issues that generally require expert testimony – and informed consent claims, which do not. Second, it suggests that the need for expert testimony depends on the nature of the *claim*, rather than the nature of the *evidence*.

1. The tort of lack of informed consent

The doctrine of informed consent is rooted in the "concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine

what shall be done with his own body. . . .' True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each." *Canterbury v. Spence*, 464 F.2d 772, 780 (C.A.D.C. 1972). See also *Turner v. Children's Hospital, Inc.* (1991), 76 Ohio App.3d 541, 554, 602 N.E.2d 423 (informed consent is "predicated on notions of patient sovereignty and serves to safeguard the patient's right of choice.")

"The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision." *Canterbury*, 464 F.2d at 780. As a result, a physician has a duty "to warn of the dangers lurking in the proposed treatment" and a duty "to impart information which the patient has every right to expect." *Id.* at 782. A patient places a deep trust in his or her physician and "[h]is dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject." *Id.*

Canterbury was one of the first cases to recognize that although a physician may violate a local standard of care in failing to provide his patient with important information, a cause of action for lack of informed consent does not depend upon the existence and nonperformance of a professional tradition. *Id.* at 783. Rather, "[r]espect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves." *Id.* at 784 (citations omitted). As a result, the court established an objective "reasonable patient" standard to determine which risks must be disclosed, holding that a risk is "material," and a physician must disclose it, when "a reasonable person, in what the physician knows or should know to be the patient's position, would be likely

to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy." *Id.* at 787 (citation omitted).

Canterbury also addressed the issue of causation, noting that "a causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it. The patient obviously has no complaint if he would have submitted to the therapy notwithstanding awareness that the risk was one of its perils. On the other hand, the very purpose of the disclosure rule is to protect the patient against consequences which, if known, he would have avoided by foregoing the treatment." *Id.* at 790. Once again, the court rejected a subjective test, electing instead to "resolve the causality issue on an objective basis: in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance." *Id.* at 791. The court fashioned the following test: "[i]f adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown, but otherwise not." *Id.*

The principles set out in *Canterbury* in 1972 were adopted by this Court in 1985. In *Nickell v. Gonzalez* (1985), 17 Ohio St.3d 136, 139, 477 N.E.2d 1145, the Court held that 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 plaintiff 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.

Like *Canterbury*, the Court expressly adopted the "reasonable patient" standard to determine the risks that must be disclosed. *Id.* at 139. In doing so, Ohio followed a clear trend among the states. Although some states still clung to a "professional standard" test, requiring the plaintiff to present expert "standard of care" testimony, most jurisdictions had begun to adopt the "reasonable patient" standard under which the physician's disclosure duty is measured by the patient's need for information rather than by the standards of the medical profession. The distinction and trend were aptly described by the Supreme Court of Maine in *Woolley v. Henderson* (1980), 418 A.2d 1123, 1129:

Many courts hold that the duty of a physician to make adequate disclosure is, as in other cases of medical malpractice, measured by the standard of the reasonable medical practitioner under the same or similar circumstances. Under this "professional" disclosure standard, therefore, whether and to what extent a physician has an obligation to disclose a particular risk must in most cases be determined by expert medical testimony establishing the prevailing standard of practice and the defendant's departure therefrom.

On the other hand, an increasing number of courts hold that because a physician's obligation to disclose therapeutic risks and alternatives arises from the patient's right of physical self-determination, the disclosure duty should be measured by the patient's need for information rather than by the standards of the medical profession. These courts reason that physicians have a legal obligation adequately to disclose risk and option information that is material to the patient's decision to undergo treatment and that expert testimony as to medical standards is not required to establish this duty. Under this "material-risk" standard, although expert medical testimony may be necessary to establish the undisclosed risk as a known danger of the procedure, the jury can decide without the necessity of a medical expert whether a reasonable person in the patient's position would have considered the risk significant in making his decision.

(Citations omitted.)

2. The role of expert testimony in lack-of-informed-consent cases

Lower courts have occasionally misunderstood *Nickell* to require expert "standard of care" testimony. See, e.g., *Badger v. McGregor*, Franklin App. No. 03AP-167, 2004-Ohio-4036, at ¶27 (Petree, J., dissenting)("Ohio appellate cases, including at least one from this court,

finding that, in order for a plaintiff to establish the tort of lack of informed consent, the plaintiff must present expert testimony stating that the physician deviated from the accepted standard of care, have misstated and misapplied the law in Ohio.") One justice of this Court has noted that the notion of "standard of care" does not apply to an informed consent case. See *Badger v. McGregor*, 107 Ohio St.3d 1210, 2006-Ohio-3, 839 N.E.2d 398 (Pfeifer, J. dissenting from dismissal of cause)(explaining that "[p]roof of deviation from the standard of care is not a part of a tort claim for lack of informed consent. Nor is it relevant to any of the three elements of a successful claim.") This is consistent with the view held by other states. See, e.g., *Howard v. University of Medicine and Dentistry of New Jersey* (2002), 172 N.J. 537, 547, 800 A.2d 73 (standard of care testimony is important in medical malpractice cases to determine what a doctor in the defendant's position should have done but it is not necessary in informed consent cases because the jury decides what risks were material (and thus should have been disclosed) and "the physician's negligence is in the inadequate disclosure[.]").

Nonetheless, appellant Leimbach makes this mistake, injecting "standard of care" language in his brief. See, e.g., Appellant's Brief at pp. 5-6 ("Where a plaintiff has failed to offer expert medical testimony to prove that the injury was caused by the deviation from the standard of care, a directed verdict for the defense is proper.") Appellant made the same mistake at trial, asking Mr. White's pain management doctor if he knew what the "standard of care" was for neurosurgeons and asking the defense experts to confirm that appellant had performed the surgery according to standards.

Expert "standard of care" testimony is unnecessary because jurors are entrusted with the role of determining whether a risk is "material" and therefore required to be disclosed. See *Nickell*, supra, at p. 139 ("[T]he jury was properly instructed that 'a risk is material when a

reasonable person . . . would be likely to attach significance to the risk . . . in deciding whether or not to forego the proposed treatment.") Similarly, expert testimony is unnecessary with respect to certain other aspects of a claim for lack of informed consent:

It is evident that many of the issues typically involved in nondisclosure cases do not reside peculiarly within the medical domain. Lay witness testimony can competently establish a physician's failure to disclose particular risk information, the patient's lack of knowledge of the risk, and the adverse consequences following the treatment. Experts are unnecessary to a showing of the materiality of a risk to a patient's decision on treatment, or to the reasonably, expectable effect of risk disclosure on the decision. These conspicuous examples of permissible uses of nonexpert testimony illustrate the relative freedom of broad areas of the legal problem of risk nondisclosure from the demands for expert testimony that shackle plaintiffs' other types of medical malpractice litigation.

Canterbury, 464 F.2d at 792.

As *Canterbury* indicates, it is overly broad to suggest that expert is always required to establish every element of an informed consent claim. Such an approach leads to absurd arguments, such as appellant's argument that a directed verdict was appropriate because the Whites failed to present expert testimony "to support the conclusion [] that 1) the potential for scar tissue aggravation was not sufficiently discussed in advance of the second surgery." Appellant's Brief, p. 8. Obviously, "expert testimony" is not required for a jury to decide whether a risk was "sufficiently discussed." The jury must decide whether a risk was "sufficiently discussed."

Appellees do not suggest that expert testimony is never required to establish a claim for lack of informed consent. For example, expert testimony is typically required to assist the jury in understanding the nature and magnitude of the risks inherent in a procedure so that the jury can decide which risks are "material." However, it is plainly inaccurate to state, as the proposition of law does, that "a plaintiff must present expert testimony as to all of the elements of a claim for

lack of informed consent arising out of the performance of a medical procedure." (Emphasis added.)

In sum, the need for expert testimony does not depend upon the label placed on a cause of action; it depends upon whether the issue to be established – regardless of the cause of action or the elements of a claim – requires specialized information beyond the knowledge of a layperson. When special knowledge is required, it can be provided by experts or by admissions from the defendant.

3. **Robert White was not required to present expert testimony to establish a claim for lack of informed consent**

Under *Nickell*, Robert White was required to present evidence of the following to establish his claim:

1. The risks associated with a "re-do" surgery.
2. The likelihood of the risk(s) and potential affect(s) if the risk(s) materialized.
3. That Dr. Leimbach did not disclose and discuss the risk(s).
4. The alternatives to the procedure that existed.
5. That a reasonable person in Mr. White's position would have decided against the procedure if the risk(s) associated with a "re-do" surgery had been disclosed.
6. That the risk(s) Dr. Leimbach should have disclosed materialized.
7. That Mr. White has suffered injury.

Although certain information – such as the types and magnitude of risks associated with a "re-do" surgery – are beyond the knowledge of jurors, in medical case a defendant's admissions can supply this information. See, e.g., *Hubach v. Coyle* (1938), 133 Ohio St. 137, 142, 12 N.E.2d 283 (expert testimony "ordinarily" required in a medical malpractice action "[b]ut the statements and acts of the defendant physician . . . may be given by nonexpert witnesses. And such

testimony by lay witnesses may show a course of conduct with ensuing results of such a character as to warrant the inference of want of care.") See also *Miller v. Marrocco* (1989), 63 Ohio App.3d 293, 578 N.E.2d 834 (defendant physician's stipulation of "liability" constituted admission of duty, breach of duty and proximate cause, leaving damages as sole remaining issue for trial); *Kennedy v. University of Cincinnati Hosp.* (March 30, 1995), Franklin App. No. 94API09-1333 at *5 ("Appellants finally argue that appellee failed to establish proximate cause due to her failure to offer the testimony of an expert. However, as stated above, appellee was relieved of presenting such evidence due to appellants' admission of liability.")

Indeed, as the Court implied in *Nickell*, a defendant physician can admit facts that establish proximate cause in an informed consent case: "Moreover, there is also some question as to whether the procedure even caused the brachial plexus palsy. Certainly, Dr. Gonzalez, contrary to appellants' protestations, never admitted such proximate causation[.]" *Nickell*, 17 Ohio St.3d at 139.

In the instant case, Dr. Leimbach made the following admissions:

- He admitted that with respect to the first surgery he told Mr. White 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. [Tr. 186:12-18.]
- He admitted that a "re-do" surgery has a "much greater risk of a poor outcome" than the first surgery. [Tr. 203:1-3.]
- He admitted that a surgeon should disclose the fact that the risks increase with a "re-do" surgery. [Tr. 219:1-220:24.]
- Although he testified that it would have been his "standard" practice to disclose such risks to his patients, he admitted that he does not recall specifically telling Mr. White about the increased risk associated with the "re-do" surgery. [Tr. 221:25 – 222:4.] And, he admitted that he did not complete the "informed consent" documentation for the "re-do" surgery as he did with the first surgery. [Tr. 222:7 – 224:5.]

- He admitted that his medical chart indicated that Percocet and heat were relieving Mr. White's pain prior to the second surgery. [Tr. 199:12-20.]
- He admitted that the second operation made Mr. White worse. [Plaintiff's Trial Exhibit 11, p. 3 ("That is what I was afraid of with the scar tissue and the second operation and we just made it worse.").]
- He admitted that immediately after the "re-do" surgery Mr. White developed a raw, burning pain in his foot, a pain that did not exist before the surgery. [Tr. 215:16 - 216:2.]

In sum, Dr. Leimbach admitted that the risks of poor outcome were substantially greater with a "re-do" surgery. He admitted that this risk should be disclosed. And, he admitted that the "re-do" surgery made Mr. White worse. The remaining elements of the informed consent claim – whether the risks were disclosed, and whether a reasonable person in Mr. White's position would have decided against the surgery had the risks been disclosed – did not require expert testimony. Accordingly, appellees provided evidence to establish all elements of the informed consent claim, and the jury should have been allowed to decide the case.

4. **Expert testimony regarding "causation" is not necessary in every informed consent case**

As discussed above, causation is established in an informed consent case if the patient proceeds with a surgery to which a reasonable person would not otherwise have consented and the surgery makes him worse than before. See, e.g., *Canterbury*, 464 F.2d at 791, 795 ("If adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown," and "[t]he jury's power to draw the inference that the aggravation of petitioner's tubercular condition, evident so shortly after the accident, was in fact caused by that accident, was not impaired by the failure of any medical witness to testify that it was in fact the cause.") See also *Frost v. Brenner*, 300 N.J. Super. 394, 406, 693 A.2d 149 ("Causation is established if a

prudent person in Frost's position would have declined treatment if he had been informed of the risk that resulted in post-surgical harm").

When, as here, (a) a patient has some low back pain (that is of the same quality as the pain that was completely eliminated by a first surgery, and that is relieved by medicine and heat), (b) the patient is not informed that there is a substantial risk that a second surgery will result in a poor outcome, (c) patient proceeds with surgery, and (d) the patient wakes up from the second surgery with an intense and permanent pain that did not exist before the surgery, the jury can find proximate cause; the jury can easily conclude that a reasonable person in the plaintiff's condition would not have agreed to the surgery and that the patient therefore would have avoided the intense and permanent pain.

5. **Although expert testimony was not required, such testimony was, in fact, presented**

a. **Dr. Leimbach**

To avoid the effect of his admissions, appellant argues at page 3 of his brief that "at the time of trial Dr. Leimbach was not qualified to provide expert testimony." It was not necessary for appellees to "qualify" Dr. Leimbach as an expert witness in order to gain the benefit of his admissions. Expert testimony is required when knowledge beyond that of a layperson is needed to resolve a factual dispute. When a defendant admits certain facts – whether through his answer to the complaint, through responses to discovery requests, or through trial testimony – the need for expert testimony is eliminated as to those facts. See *Miller v. Marrocco* (1989), 63 Ohio App.3d 293, 578 N.E.2d 834 (defendant physician's stipulation of "liability" constituted admission of duty, breach of duty and proximate cause, leaving damages as sole remaining issue for trial).

Moreover, Dr. Leimbach was a board-certified neurosurgeon. [Tr. 160:1-7.] Having performed two surgeries on Mr. White, it seems a bit disingenuous for him to now assert that he does not possess enough special knowledge or experience that differentiates him from a layperson in matters pertaining to neurosurgery. Appellant's effort to disqualify himself under Evid.R. 601(D) places form over substance. The purpose of Evid.R. 601(D) is to prohibit the testimony of a physician who makes his living as a professional witness from providing standard of care testimony against other physicians. See *Celmer v. Rodgers*, 114 Ohio St.3d 221, 226, 2007-Ohio-3697, 871 N.E.2d 557, at ¶23. An argument similar to appellant's was rejected by the Second District Court of Appeals in *Crosswhite v. Desai* (1989), 64 Ohio App.3d 170, 580 N.E.2d 1119, 1124 – 1125, where the defendant in a medical malpractice case attempted to prevent the testimony of an medical expert who had retired:

A literal and strict interpretation of the statute focusing only on the present ignores the historical nature of the inquiry and the true purpose of the statute. It might even permit the testimony of a novice currently in practice yet exclude the testimony of an experienced clinical practitioner who is not. It would not serve the purposes of the statute or the ends of justice to exclude the assistance of the experienced specialist whose clinical practice spanned decades, because he is now retired. The true purpose of the statute is to ensure competency, and a strict application of the text in its literal sense fails to do that.

Id. at 178. Moreover, whether Dr. Leimbach was, at the time of trial, an "expert" misses the point. As a defendant, Dr. Leimbach's statements constitute admissions that obviate the need for expert testimony.

b. Dr. Michael Miner

Dr. Miner testified that the risks inherent in a "re-do" surgery change significantly as compared to a "first" surgery. [Tr. 644:17 – 645:4.] He also testified that in order to make an informed decision a patient has to know whether there is a significant chance that his pain will get worse as a result of the surgery. [Tr. 644:10-21, 648:14-19.]

Right after the "re-do" surgery, Dr. Leimbach noted that Mr. White was experiencing a raw, burning pain in his foot, a pain that did not exist before the surgery. [Tr. 215:16-23.] As a result, he expressed fear that Mr. White had developed "causalgia." [Tr. 214:23 – 215:20.] Dr. Miner testified that causalgia is a pain syndrome that results from nerve injury. [Tr. 649:18-23.] He further testified that the "raw, burning pain" that defines causalgia occurs very soon after injury to a nerve occurs. [Tr. 652:10 – 653:17.] According to Dr. Miner, Mr. White's slip-and-fall that occurred in August 1998 – two months before the October "re-do" surgery – was too remote in time to be considered the cause of the causalgia symptoms. [Tr. 656:9-13.]

Dr. Miner also testified that based on his own examination of Mr. White before the "re-do" surgery, as well as his review of the medical records, Mr. White's "causalgia" symptoms did not exist before the "re-do" surgery. [Tr. 653:18 – 654:25.] Indeed, although appellant now says in his brief that Mr. White was "no worse off after the surgery than before the surgery," it is undisputed that when he woke up from the "re-do" surgery Mr. White was experiencing an intense, raw, burning pain that he had never experienced before the surgery. [Tr. 265:20-266:8, 269:2-16.]

i. Whether Dr. Miner discussed the risks of the "re-do" surgery is irrelevant to this appeal

Appellant contends at pages 9 and 30 of his brief that Dr. Miner informed Mr. White of the risks associated with the "re-do" surgery. The contention is irrelevant to this appeal; the trial court's decision to grant a directed verdict was based not on whether Mr. White was informed of the risks, but rather on the issue of proximate cause. Indeed, as the appellate court observed, "[t]he trial court did not find a lack of evidence about a failure of informed consent." (Supp. 12.) Moreover, clearly a factual dispute existed that precluded a directed verdict; both Robert and

Mary White (who accompanied her husband on his medical visits) testified they were not informed of the increased risks associated with a "re-do" surgery.

- ii. Dr. Miner did not disclose the increased risks of the "re-do" surgery

In addition, appellant mischaracterizes Dr. Miner's testimony. Dr. Miner did not testify that he informed the Whites that the risks increased with a "re-do" surgery. He testified that (a) his records do not reflect any discussions with the Whites about the risks of surgery and he does not specifically recall any such discussions with the Whites [Tr. 659:8-17], and (b) he would have told the Whites that the risks regarding the "re-do" surgery would have been "pretty much the same risks as [the first surgery]." [Tr. 606:20 – 607:20.] In short, if Dr. Miner in fact spoke with the Whites about the risks associated with the "re-do" surgery, he made the same mistake that Dr. Leimbach did – he failed to inform Mr. White of the admittedly "much greater" risk of a poor outcome! Moreover, Mr. White adamantly denied that Dr. Miner discussed the risks of surgery. [Tr. 245:4-5, 261:6-22.] After examining Mr. White, Dr. Miner simply said he concurred with Dr. Leimbach that a second surgery "is something I should consider." [Tr. 261:11-16.]

- iii. The duty to disclose the increased risks of the "re-do" surgery was a duty owed by the surgeon, Dr. Leimbach, not the "second opinion" doctor

Finally, from a legal standpoint, Dr. Leimbach cannot use Dr. Miner to avoid his own responsibility to inform his patient. The *Nickell* test makes clear that the tort of lack of informed consent is established when "the physician" fails to disclose to the patient and discuss the material risks. The obligation to inform the patient about the risks of surgery is properly placed on the surgeon, in part because different physicians may have different personal rates of success with respect to a particular surgical procedure. See, e.g., *McNabb v. Louisiana Medical Mutual*

Ins. Co. (2004), 858 So.2d 808, 818 (La. App.)("Furthermore, the surgery by Dr. Harper was, in fact, canceled, arguably due to the disclosure of the risks. We do not conclude that Dr. Harper's fulfillment of his own obligation to the plaintiff can be found to have relieved Dr. Hart of his obligation to obtain informed consent for the surgery that he ultimately performed.")

c. **Dr. Gary Rea**

Dr. Rea admitted under cross-examination that the "re-do" surgery is the most likely cause of Mr. White's "raw, burning pain" and other symptoms. [Tr. 521:25 – 532:8.] He initially attempted to attribute all of Mr. White's pain after the "re-do" surgery to the incident in which Mr. White fell in the rain. But Mr. White fell more than two months before the "re-do" surgery, and, as Dr. Miner explained, the raw, burning pain in Mr. White's foot cannot be attributed to the fall. [Tr. 656:9-13.] Moreover, after being forced to concede that Mr. White experienced a different degree of pain after the "re-do" surgery, Dr. Rea back-pedaled. [Tr. 531:5-24.] Dr. Rea then attributed Mr. White's pain to one of two causes: the "re-do" surgery or "continued pain from the other issue." [Tr. 531:19-532:4.] When compelled to choose between the two, Dr. Rea admitted that the raw, burning pain Mr. White experienced when he woke up from surgery was most likely caused by the surgery. [Tr. 532:2-8.]

CONCLUSION

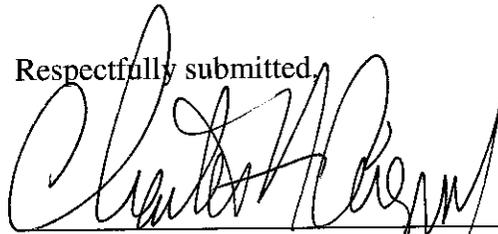
As to the narrow question raised by the trial court's decision to grant a directed verdict – was there sufficient evidence of proximate cause? – the answer is an undeniable "yes." Through the testimony of Robert and Mary White, the testimony of Dr. Leimbach, and the testimony of Drs. Miner and Rea, the jury had enough evidence to find proximate cause.

The proposition of law is flawed inasmuch as it states that expert testimony is required for all elements of an informed consent claim. The proposition is contrary to *Nickell*. It is also

contrary to how this Court has historically viewed the need for expert testimony; the need to establish certain facts through expert testimony depends on whether the facts are within the knowledge of laymen. In contrast, the proposition of law would indicate that the need for expert testimony turns on the elements of a claim. The point, however, is moot in this case, because, as to each fact requiring specialized knowledge or experience, appellees presented admissions and/or expert testimony.

For the foregoing reasons, the decision by the Tenth District Court of Appeals should be affirmed.

Respectfully submitted,



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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing Merit Brief of Appellees Robert and Mary White was served upon the following counsel of record, by ordinary U.S. mail, postage prepaid, this 28th day of January, 2011:

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