

No. 2012-2134

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In the Supreme Court of Ohio

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APPEAL FROM THE COURT OF APPEALS  
NINTH APPELLATE DISTRICT  
SUMMIT COUNTY, OHIO  
CASE NO. 25632

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SETH NILES CROMER, Minor Child, Deceased, et al.  
Plaintiffs-Appellees,

v.

CHILDREN'S HOSPITAL MEDICAL CENTER OF AKRON,  
Defendant-Appellant.

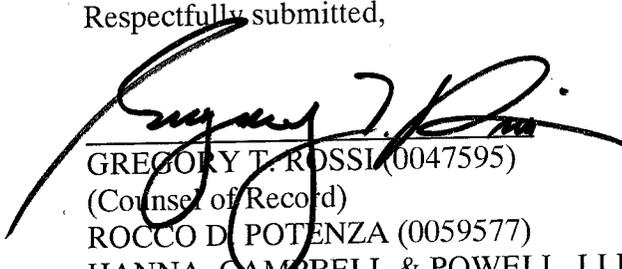
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**MERIT BRIEF OF DEFENDANT-APPELLANT  
CHILDREN'S HOSPITAL MEDICAL CENTER OF AKRON**

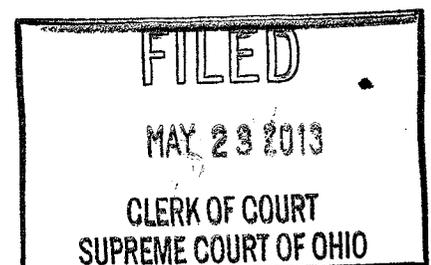
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Respectfully submitted,

Jack Morrison, Jr., Esq. (0014939)  
Thomas R. Houlihan, Esq. (0070067)  
Vicki L. DeSantis, Esq. (0075716)  
159 South Main Street  
Suite 1100 Key Building  
Akron, Ohio 44308  
Counsel for Plaintiffs-Appellees



GREGORY T. ROSSI (0047595)  
(Counsel of Record)  
ROCCO D. POTENZA (0059577)  
HANNA, CAMPBELL & POWELL, LLP  
3737 Embassy Parkway, Suite 100  
Akron, Ohio 44333  
Phone: 330-670-7600  
Fax: 330-670-7478  
E-mail: [GRossi@hcplaw.net](mailto:GRossi@hcplaw.net)  
[RPotenza@hcplaw.net](mailto:RPotenza@hcplaw.net)  
Counsel for Defendant-Appellant  
Children's Hospital Medical Center of Akron



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## I. INTRODUCTION

The Ninth District Court of Appeals has erroneously created a dangerous and problematic precedent, removing foreseeability from a jury's consideration in medical malpractice actions. Foreseeability is one of the most longstanding and deeply rooted principles in negligence law. By so holding, the Ninth District prohibits trial courts from giving appropriate guidance to jurors on how they are to go about assessing whether a medical defendant has acted negligently – i.e. whether the defendant has failed to act reasonably under the same or similar circumstances. Such a decision, result-oriented to be sure, runs contrary to the very foundations upon which negligence law has been built, is inconsistent with this Court's precedents, and directly conflicts with the position of the First, Sixth, and Eighth District Courts of Appeals.

By eliminating a fundamental principle of negligence law, specifically foreseeability, the Ninth District has created a vacuum in the jury instructions in medical malpractice actions. If the court's decision were to stand, future juries will no longer be instructed to take into consideration foreseeability when making the critical determination of whether a defendant has acted with *reasonable care*. Contrary to the Ninth District's decision, the trial court's jury instruction in this case was a correct statement of the law, consistent with this Court's previous decisions regarding foreseeability, the Second and Third Restatement of Torts, and OJI. The instruction has undoubtedly been given to countless juries in the State of Ohio in medical malpractice cases over many years. This Court should reverse the Ninth District's legally and logically flawed decision to confirm that foreseeability is necessary in determining whether a healthcare provider's actions met the standard of care.

## II. STATEMENT OF THE CASE

On January 14, 2007, five-year-old Seth Cromer tragically passed away from a rare disorder known as viral myocarditis, despite receiving all appropriate care during a five-hour stay at Children's Hospital Medical Center of Akron (hereinafter "Children's Hospital"). Seth was treated primarily by pediatric emergency medicine physician Brett Luxmore, D.O., pediatric intensive care physician, Richard Wendorf, M.D., and the nursing staff. In addition to the myocarditis, Seth had developed a 60 to 70% blockage of his left main coronary artery. The combination of these two rare problems caused Seth's heart to fail, leading to cardiogenic shock and death.

On or about July 3, 2008, Plaintiffs-Appellees, Melinda and Roderick Cromer, filed this medical malpractice action naming a number of Defendants, including Children's Hospital and Dr. Wendorf. Plaintiffs did not specifically name Dr. Luxmore but ultimately asserted a claim that as his employer, Children's Hospital was vicariously liable for his allegedly negligent conduct. The Defendants herein timely filed an answer to Plaintiffs' complaint denying all essential allegations of negligence and proximate cause.

Thereafter, discovery ensued with depositions of relevant fact witnesses. Pursuant to order of the trial court, both sides produced reports from expert witnesses. Plaintiffs produced a report from Margaret Parker, M.D., a pediatric intensive care physician. Children's Hospital produced reports from several experts, including the two experts who ultimately testified at trial, Robert Kennedy, M.D. (pediatric emergency medicine) and Douglas Willson, M.D. (pediatric critical care medicine). Subsequently, discovery depositions of these expert witnesses were taken.

Trial commenced before the Honorable Judge Lynne Callahan in the Summit County Court of Common Pleas on June 16, 2010. Just prior to trial, Plaintiffs dismissed Dr. Wendorf as a named defendant but continued to pursue their claim related to his conduct against Children's Hospital based on a vicarious liability theory. Evidence and testimony was presented over the next seven days. At the conclusion of the case, Judge Callahan instructed the jury and the case was submitted to the jury on June 24, 2010. After four hours of deliberation, the jury returned a verdict in favor of Children's Hospital, finding that the care and treatment provided to Seth was within the standard of care and not negligent.

On July 6, 2010, Plaintiffs filed a motion for a new trial raising several arguments, including that the verdict was against the manifest weight of the evidence. Noticeably absent was any argument that the court had erred by instructing the jury regarding foreseeability. On September 24, 2010, the court denied plaintiff's motion concluding that there was competent, credible evidence supporting the jury's verdict in favor of Children's Hospital.

Thereafter, Plaintiffs instituted an appeal to the Ninth District Court of Appeals arguing, among other things, that the trial court had erred in instructing the jury on foreseeability with respect to the standard of care. On November 7, 2012, the Ninth District issued an order invalidating the jury's verdict on the grounds that the trial court had erroneously delivered the foreseeability instruction with respect to the standard of care. The court concluded that such an instruction should never be given in a medical malpractice action because foreseeability only goes to the question of duty, which is a matter of law for the court. Not only did the court conclude the instruction was erroneous, the court also concluded that it was reversible error to give the instruction. Accordingly, it reversed the judgment of the trial court and ordered a new trial.

Children's Hospital, thereafter, instituted the instant appeal to this Court. In an order dated March 13, 2013, this Court accepted Defendants' Proposition of Law I for review.

### **III. STATEMENT OF FACTS:**

On January 13, 2007, Seth Cromer's parents brought him to the emergency room at Children's Hospital at approximately 10:44 p.m. (Tr. 207). Seth had been ill for several days with what was thought to be an ear infection. He had been under the care of his primary care physician who had been treating Seth with oral antibiotics for the ear infection. (Tr. 656-657). On January 13, 2007, as the day progressed, Seth became progressively more ill, he was less active, and appeared to be having some difficulty breathing. As a result, his parents brought him to the emergency room. (Tr. 748-752).

Upon arrival to the emergency room, Seth was immediately triaged by nurse Richelle Brown, R.N., who designated Seth as urgent. (Tr. 208). While Plaintiffs argued that it was nearly one hour later before Seth was taken back to an exam room, Mrs. Cromer admitted that it was a very short time following their arrival. (Tr. 776-778). Moreover, according to the testimony and records, it appeared that Seth was seen within 10 to 15 minutes of his arrival by Luz Natal, M.D., an emergency room resident. (Tr. 961-981). Dr. Natal performed an extensive history and physical examination of Seth. (Tr. 864-865). Immediately upon the conclusion of her evaluation, Dr. Natal consulted with Dr. Luxmore, a board certified pediatric emergency medicine physician.

Dr. Luxmore came to Seth's room at approximately 11:15-11:20 pm. (Tr. 967). After discussing Dr. Natal's findings, Dr. Luxmore performed his own evaluation of Seth. Once he arrived in Seth's room, both Dr. Luxmore and Dr. Natal remained with Seth during his entire

stay in the ER until his transfer to the pediatric intensive care unit ("PICU"). (Tr. 1015 and Dr. Natal Video Tr. 50-51). Dr. Luxmore determined that Seth had low blood pressure, low oxygenation, and findings consistent with poor blood perfusion. (Tr. 984). Based on these evaluations, Dr. Luxmore suspected that Seth was suffering from shock, potentially related to an infection. (Tr. 984). Dr. Luxmore ordered a number of interventions for Seth, including oxygen, IV fluids, and epinephrine to address the low blood pressure and poor perfusion. (Tr. 985, 989, 996-997). He ordered an IV antibiotic, Vancomycin, to address a potential bacterial infection. (Tr. 1013). He also ordered that Seth be transferred to ER room 3, which had the facilities for constant cardiovascular monitoring. (Tr. 989-990).

Dr. Luxmore had also ordered various blood testing. One of the tests was an arterial blood gas ("ABG"). The results of the ABG indicated that Seth was suffering from metabolic acidosis, which is a condition that results when there is diminished blood flow to the body's tissues. (Tr. 1108-1111). However, the results showed that Seth was not experiencing respiratory acidosis, which occurs when there is a retention of carbon dioxide. (Tr. 388). The significance is that where respiratory acidosis exists, there may be an issue with how the patient is oxygenating his blood through ventilation. (Tr. 1108-1111).

At approximately 12:13 a.m., Seth was moved to "treatment room 1." (Tr. 999-1002). During his care of Seth, Dr. Luxmore considered whether Seth should be intubated (a significantly invasive procedure for the insertion of a breathing tube so the patient can be placed on a ventilator). (Tr. 1010). However, while in treatment room 1, Seth's condition began showing considerable improvement. (Tr. 1010-1014). His blood pressure was stabilizing and his color was much better. (Tr. 721, 1014). Both were indications of improved blood perfusion to Seth's tissues. (Tr. 1104, 1260). Moreover, clinically, Seth's activity level had improved.

According to the testimony of his parents, Seth was laughing, joking, and flirting with the nurses. In their view “Seth was being Seth.” (Tr. 721-722, 786).

When weighing the risks and benefits of the procedure at that time, Dr. Luxmore decided not to intubate Seth. (Tr. 1010-1011). As will be discussed more fully below, Seth had shown signs of improvement, including that his oxygen saturation was being maintained at 99%, he was much more alert, his clinical condition had improved, his blood pressure had normalized, and his color had improved. *Id.* While Dr. Luxmore was still concerned about Seth’s condition because his blood pressure was being maintained on a relatively high dose of epinephrine, Seth was more stable and able to be transferred to the PICU. Dr. Luxmore believed if Seth ultimately needed to be intubated, it could be done more safely in the intensive care unit. (Tr. 1010).

At 1:15 a.m., Seth was transported to the PICU where he was immediately seen by Dr. Wendorf, a board-certified pediatric intensive care physician. (Tr. 1176). After his evaluation, Dr. Wendorf went about three specific interventions, the placement of a central line, the placement of an arterial line, and intubation. (Tr. 1172). Dr. Wendorf indicated that he placed the central line and an arterial line before intubation in order to make the intubation procedure safer. During the process of intubation, there is a significant risk that a patient who is suffering from shock can have a precipitous worsening of their condition. (Tr. 1172-1175). The central line and arterial line allow for very precise monitoring during the intubation procedure and venous access to ensure that, if needed, medication and treatment can be effectively delivered in a timely fashion. (Tr. 1177-1178).

Dr. Wendorf completed all three procedures by approximately 2:15 a.m., within an hour of Seth’s arrival to the PICU. (Tr. 1196). Over the next 45 minutes, Seth’s condition remained stable. (Tr. 1198). However, beginning at approximately 3:00 am, Seth’s condition deteriorated

and while Seth was undergoing an echocardiogram at 3:45 a.m. to assess his heart function, Seth went into cardiac arrest and a code blue was called. (Tr. 589). Efforts to resuscitate Seth were attempted but Seth ultimately expired.

The Summit County Coroner's office was notified of Seth's death but declined jurisdiction. (Tr. 544, 1207). Thereafter, an autopsy was performed by Mark Steele, M.D., a pediatric pathologist employed at Children's Hospital. (Tr. 592). Dr. Steele concluded that Seth's death was a result of cardiogenic shock precipitated by viral myocarditis and ischemia due to a 60 to 70% narrowing of the left main coronary artery in Seth's heart. (Tr. 613-616). Dr. Steele's microscopic examination of Seth's heart tissue revealed that there was evidence of tissue necrosis as part of the viral infection. (Tr. 614). Viral myocarditis is a rare condition. (Tr. 853). The narrowing in Seth's coronary artery is an extraordinarily unusual condition for any young person. (Tr. 1266). Dr. Steele, Dr. Kennedy, and Dr. Willson explained that the injury to Seth's heart from the viral myocarditis reduced the heart's ability to pump blood throughout his body. (Tr. 612-616, 1112-1113, and 1266-1267). The diminished blood flow, in turn, caused Seth to develop a type of shock known as cardiogenic shock. Ultimately, the combination of the cardiogenic shock and the narrowing of Seth's coronary artery caused Seth's arrest and death. (Tr. 613, 1112-1113).

### **Plaintiffs' Claims Of Negligence**

Plaintiffs asserted a number of theories of negligence against Dr. Luxmore, Dr. Wendorf, and the nursing staff at Children's Hospital. The primary contentions included the following:

1. Seth was not seen in the emergency room in a timely manner by Dr. Luxmore;
2. The ER nursing staff initially administered the wrong type of IV fluids;

3. The nursing staff failed to administer the antibiotic (Vancomycin) ordered by Dr. Luxmore; and
4. Both Dr. Luxmore and Dr. Wendorf failed to timely intubate Seth to reduce the workload on his heart at an earlier point in time.

During the course of trial, it became evident that Plaintiffs' trial strategy was to try to assert as many theories of negligence as possible and hope the jury would conclude that, based on the sheer number of claims, Children's must have done something negligently to cause Seth's death. However, it became clear that this strategy backfired and likely had a negative impact on the jury. In particular, it was evident that Dr. Parker, Plaintiffs' own expert, did not support the viability of most of these claims yet Plaintiffs continued to pursue them. The following examples serve to illustrate.

Throughout trial, Plaintiffs repeatedly pursued a claim that Dr. Luxmore did not see Seth in a timely fashion in the emergency room. At the time Dr. Parker issued her report and at the time of her deposition, Dr. Parker supported this claim. However, Dr. Parker was under the mistaken belief that Dr. Luxmore did not see Seth until 12:13 a.m., nearly one and a half hours after Seth's arrival to the ER. (Tr. 859-861). On cross-examination, Dr. Parker conceded that when she originally offered the opinion she was wrong about this timing and she was now aware that Dr. Luxmore had seen Seth nearly an hour sooner than she originally thought. (Tr. 861-865). Dr. Parker also reluctantly admitted that Dr. Luxmore had indeed met the standard of care by seeing Seth in the first hour of his arrival to the emergency room:

Q. On the portion of whether or not he complied with the standard of care in the first hour, you agree that he does, right?

MR. MORRISON: Objection.

A. He sees him in the first hour.

THE COURT: Hang on. Overruled. You can answer that.

A. Yes.

(Tr. 867-868).

In regards to the theory that the nursing staff was negligent for giving Seth different fluids than those ordered by Dr. Luxmore, Dr. Parker admitted that after the fluids were given, Seth improved clinically, and that the fluid issue had nothing to do with Seth's outcome:

Q. So to make sure we all understand your opinion, you would agree with me that there were no ill-effects in this child from the administration of D 5-and-a-half normal saline, true?

A. No apparent clinical ill-effects. Having your blood sugar go over 300, having your sodium go over are not necessarily good for you. No long-term ill-effects, no apparent clinical change.

(Tr. 882).

Similarly, with respect to the issue of the alleged failure to administer Vancomycin, Dr. Parker clearly established that the fact that Vancomycin was not administered had nothing to do with the Seth's outcome. In fact, she did not render any criticism for the failure to give the Vancomycin:

Q. The Vancomycin, there has been some questioning about that, you are aware that Vancomycin was ordered but in all likelihood not given to this child.

A. Yes.

Q. You are not critical of anyone for not providing this child with Vancomycin, correct?

A. In general, but it is not a good idea not to deliver a drug that is ordered, *but I don't believe it would have changed the outcome.*

(Tr. 873) (emphasis added).

The questionable credibility of Dr. Parker's testimony was further highlighted by Dr. Parker's complete change in opinion on the cause of death and proximate causation. As noted

above, Dr. Steele, the pathologist, concluded that Seth's death was due to cardiogenic shock resulting from viral myocarditis and coronary ischemia, i.e. the 60-70% blockage. Dr. Kennedy and Dr. Willson testified that even had Seth been treated differently, as argued by Plaintiffs, Seth would still have succumbed to the viral myocarditis. (Tr. 1114, 1267).

During the course of her discovery deposition in this case, Dr. Parker testified that she too believed Seth died of cardiogenic shock secondary to viral myocarditis and blockage of the coronary artery. She further testified in deposition that even had the care been delivered as she claimed it should have been Seth chances of survival were less than 50%. However, at trial, she dramatically, and without notice to Children's Hospital's attorneys, changed her opinion on both accounts.

At trial, Dr. Parker testified that Seth died of septic shock, not cardiogenic shock. (Tr. 877). She also testified that viral myocarditis did not play a role in causing Seth's death. (Tr. 880). On cross-examination, Dr. Parker admitted that she was changing her opinion on both counts (Tr. 877, 899-900), that these were brand-new opinions that she formed only within the several weeks leading up to trial (Tr. 879), and admitted that these new opinions were "pretty significant." (Tr. 879). She disingenuously claimed that the reason she came to the wrong opinions after being involved in the case for several years was that somehow Children's Hospital's counsel misled her as to the underlying facts pertaining to the myocarditis at the time of her deposition (Tr. 880). However, Dr. Parker had the records, including the autopsy report, from the very beginning of her involvement in this case.

Dr. Parker also admitted, when taking into consideration the narrowing of the left main coronary artery, that at best, even had the treatment she alleged should have taken place occurred, Seth had a less than 50% chance of surviving:

Q. You would agree me that, doctor, to a reasonable degree of medical probability that the cause of death in this case was probably related to acute myocarditis?

A. *Well, that is what I said in my deposition, but I would not agree with that at this point.*

Q. Can we agree that in your opinion in this case, if everything had been done exactly as you say it should have been, this child had a less than 50 percent chance of survival from this illness, true?

A. I don't think I agree with that. It is always hard to give percentages, but I think it is more likely than not that had he been promptly intubated, had he received fluid resuscitation an hour before he did, which clearly could have happened from the time that he presented, that there is a better, more likely than not he could have survived.

Q. Can you turn in your deposition to page 82, line 13?

Question: "As I understand what you are saying, you can't say to a reasonable degree of medical probability even if those things had happened earlier from the moment he arrived it would have changed the outcome; is that fair?"

Answer: "I think if he had received aggressive support in that first, you know, hour, rather than having another hour-and-a-half to go into further shock, I think there is a reasonable chance that he might have survived."

Question: "Can you put a percentage on that?"

Answer: "Even odds."

Is that what you said at that time?

A. That is what I said.

Q. So are you changing your opinion?

A. It is hard. It is hard to give exact percentages on something like this, but I think that there is a significant chance that he could have survived. *Is it 50-50, is it 51-49, I can't answer that.*

Q. Can we agree that once the 60 to 70 percent occlusion of the left main coronary artery is - is put into this, as well, that further reduces any chance of survival from this child -- for this child in this condition, true?

- A. Well, it certainly has the potential to decrease his ability to compensate, and decreases his reserves, *so it might reduce the chance of survival*. It's hard to know how much.

(Tr. 901-903) (emphasis added).

### **Intubation/Foreseeability and Standard of Care**

In the end, it was apparent that the only theory of negligence that remained was Dr. Parker's opinion that both Dr. Luxmore and Dr. Wendorf should have intubated Seth earlier. It was the issue of intubation that clearly implicated concerns of foreseeability. Dr. Parker was of the opinion that intubation was necessary to treat Seth's shock to decrease the workload on Seth's heart which was beating at an elevated rate due to the effects of shock. She indicated that Seth should have been intubated no later than 12:15 a.m.

It was Dr. Parker's opinion that Seth was suffering from respiratory acidosis and intubation is required to treat respiratory acidosis. (Tr. 834-840). Accordingly, it was her opinion that Dr. Luxmore deviated from the standard of care by not intubating Seth at that time. Moreover, it was her opinion that Dr. Wendorf deviated from the standard of care by choosing to place a central line and arterial line before intubating Seth upon his arrival to the PICU. Again, on cross-examination, Dr. Parker backpedaled on this opinion, giving the jury yet another reason to look unfavorably on her testimony. In this regard, she indicated that Dr. Wendorf engaged in a thoughtful risk-benefit analysis about the order in which one would perform these procedures, that it was a very reasonable approach, and an approach that many of her well-respected colleagues would have followed. (Tr. 892-893).

## Children's Hospital's Evidence on Foreseeability/Standard of Care

During its case, Children's Hospital presented testimony demonstrating that Dr. Luxmore and Dr. Wendorf met the standard of care in all respects. There was a significant amount of testimony about the well-reasoned thought processes of Dr. Luxmore and Dr. Wendorf as to the factors they considered in reaching the decisions pertaining to intubation. In particular, the testimony at length discussed the foreseeable risks and benefits of the alternative courses of action.

Dr. Luxmore testified that he had considered the possibility of intubating Seth but, in his judgment, the foreseeable benefits of doing so at that time were outweighed by the foreseeable risks of doing so:

Q. At some point in this process then, did you consider intubation for this child?

A. I did. That is why I brought him down to the treatment room, because he was requiring so much support or requiring to start an epi. I did very much consider it. In looking to see how he responded to something like IV attempts, and going through the process of intubation, I had -- I was very concerned that he may drop his blood pressure and not ever return. I didn't feel it was safe at that time. I felt him to be improving clinically; and I thought if he did need intubation, the intensive care unit would be the appropriate place for him. We had him on epi drip with peripheral lines, and it is -- it's a long distance to get to that heart. It is dangerous. I don't want to do any harm. I like procedures, that is one of the reasons why I went to the emergency room, but based on my experience it is important to do no harm and not just do a procedure that can potentially be fatal.

Q. Is that why you decided not to do an intubation?

A. That's correct.

(Tr. 1010-1011).

On cross-exam, Dr. Luxmore again discussed the risk-benefit analysis, i.e. assessing the foreseeable probabilities of varying courses of action:

Q. You heard doctor Parker say that she does respect clinical judgment, but in this case, the decision not to intubate Seth when he lost consciousness in the emergency room was a departure from accepted standards of care, I assume you disagree with that?

A. I disagree because I think I showed restraint in not taking unnecessary risks and giving him a chance as long as possible.

Q. Wasn't his chances better if you were relieving his acidosis, his heart work, his lung work, giving him oxygen, getting rid of that PCO<sub>2</sub> you were talking about?

A. Getting rid of PCO<sub>2</sub>, PCOs is normal --

Q. Don't you think his --

A. -- and I don't know what the clinical effect is going, all I see is an improving patient in my treatment room. I can't predict what is happening there. All I can do is the best IV fluids and support while he has metabolic acidosis, and put him in a safer place where he can get central lines in case he has a drop in his blood pressure and -- and he becomes completely unstable with the process of intubation.

(Tr. 1058-1059).

Similarly, Dr. Wendorf addressed the allegation that he should have intubated Seth immediately upon Seth's arrival to the PICU. Dr. Wendorf explained that in his estimation, it was more important to place the central line and arterial line before intubating Seth because intubation has the potential to cause a precipitous decline and potentially could cause a cardiac arrest:

Q. Why did you decide to start with the central venous line for Seth?

A. There was a number of reasons why I chose the central venous line first. In assessing Seth, again, people mentioned before, you go through the A B Cs, so Seth's airway was patent. He was moving air through his airway. And so for that reason I didn't feel that he needed to be intubated immediately. . . .

I did think he was going to be -- needed to be intubated because I was not sure what his trajectory was going to be and I didn't want to wait. But I

wanted to make sure that when I get back it was in a most controlled fashion as possible, the safest for him.

So I chose to place the central line first because he was receiving a significant dose of epinephrine through an IV. I don't remember if it was going through his hand or going through the one in his arm, peripheral IV, and those did not work.

Sometimes those can go bad. Some infiltrate, get swollen, they come out, doesn't continue to work. If he needs a dose of epinephrine to maintain his cardiac output, blood pressure, I didn't want to lose that. If that is what was keeping him, you know, doing his -- you know, he was not doing well but at least doing as well as he was doing, I didn't want to lose that, I didn't want to take the risk I would not have a place to give that.

(Tr. 1172-1174).

Dr. Wendorf's answer clearly illustrates the role of foreseeability in medical decision making that requires weighing the foreseeable risks and benefits for choosing one course of action over another. Dr. Wendorf continued:

Now the other reason -- sorry -- the other reason is that in a patient that has significant shock, especially if they have cardiogenic shock where their heart doesn't work very well, during the process of intubating there are things that, physiologic changes as you are doing that that can actually make that patient much worse, and similar to what doctor Kennedy had mentioned, can actually cause the blood pressure to go lower faster, or so, quite frankly, cause their death during intubation.

So if you -- if that was a possibility, and if he was going to have any instability with me intubating him, I wanted to make sure that I had stable access to give him medication, to give him fluids, to give him what I needed if that event was going to happen. So that is why I chose to place the central venous line first.

(Tr. 1174-1175).

Dr. Wendorf then explained why he placed the arterial line before intubation:

A. . . . What I can do with [an arterial line] is two things. You know, one is I can know, instead of having a blood pressure cuff and we blow it up every few minutes to get a blood pressure monitoring, I know second to second what somebody's blood pressure is, because it is in the artery which is where you feel the pulse is. It is your blood pressure. So I will know

second to second what his blood pressure is. I can look that up on a monitor, I can see every second what his blood pressure is.

Q. I just want to interrupt you there. Why is it important to know what Seth's blood pressure is while you are intubating?

A. Again, the reason I just mentioned, the -- while intubation itself is not -- if you're trained is not difficult to do, it can cause some physiologic changes as you are taking away somebody's breathing. By doing it, that can cause instabilities, that can cause blood pressure to get quite low. And as I mentioned especially in a patient in severe shock, especially -- even more especially so in a patient whose heart is not working very well, that can cause them to be very unstable. And this way I would know moment to moment if that was happening. That was one of -- that was my thought process on placing this before I went ahead and intubated Seth.

(Tr. 1177-1178).

Children's also presented testimony from two experts, Robert Kennedy, M.D., a board certified pediatric emergency medicine physician at St. Louis Children's Hospital, and Douglas Willson, M.D., a board certified pediatric critical care specialist from the University of Virginia. Dr. Kennedy and Dr. Willson spent considerable time on the witness stand explaining the risks and benefits regarding the timing of intubation, emphasizing that in making the decision the physician assesses the future probability of harm in choosing one course of action over another. Dr. Kennedy's testimony in this regard was as follows:

A. I think doctor Luxmore made the right decision. The major advantage of the emergency department of intubating somebody is if they are not breathing adequately, and I think that it was pretty clear, particularly by the time that Seth was in room 1, in the third treatment room, that his color was improving, his saturation was 100 percent throughout. So he was getting plenty of oxygen. He was talking, as I already mentioned, and interacting with the staff. His blood pressure was coming up. And he was not having any problems with ventilation. It was more a problem with perfusion, and he was ventilating effectively.

So I think with him still not completely volume resuscitated in terms of his hypertension, if you give a patient like that the drugs that are necessary to intubate, drugs that sedate him, that paralyze him to be able to do the intubation, *there is a fair likelihood that that would cause him to*

*deteriorate dramatically, that the blood pressure could bottom out completely, and that his heart would stop and he would have died right there.* And so I think with him improving and ventilating and oxygenating well, there is -- there is no reason to intubate him in the emergency department.

(Tr. 1106-1107) (emphasis added).

Dr. Kennedy confirmed that the PICU is a safer environment for intubation. Under these circumstances, the foreseeable of risk of harm in the emergency department is much greater than in the PICU:

Q. Did you take those kinds of things into consideration, along with everything else you have discussed in terms of your decision on whether or not to intubate?

A. Eventually, I think in the intensive care unit, in a critical care setting, that is more than an issue because they are thinking long-term, they are thinking over the next 24, 48 hours, and, there, it may be important to take some of the work of breathing, you know, off the patient, if you will. But in the emergency department, we are really focused on getting him stabilized enough to get him up to the intensive care unit and to make sure that he is breathing adequately. And in the emergency department, we often don't have all of the extra staff and everything that we need and the central lines and everything that we need to be prepared to vigorously resuscitate the patient if he does crash, so to speak, when he is paralyzed and sedated for intubation. So it is a matter of being in a more controlled environment in the ICU, and I think most importantly, though, Seth had no indication that he needed that done in the emergency department, that it was safer to do it in the intensive care unit.

(Tr. 1111-1112).

Dr. Willson testified that Dr. Wendorf's care and treatment of Seth was very appropriate and within the standard of care. During his testimony, Dr. Willson discussed in detail the difficulty and complexity in treating a patient like Seth Cromer and the need for central line placement:

Q. The first procedure that was done for Seth in the intensive care unit was to place a central venous line. Do you know why doctor Wendorf decided to do that?

A. Well, I know why it should be done. I think that at that point Seth had come up two peripheral IVs, they resuscitated him in the emergency room giving him fluids, albeit IV, and also giving him a fairly high dose of epinephrine.

. . . [O]ne reason to do it, is to assure a way to give [epinephrine] that obviously he needed and seemed to be benefiting from.

Another dilemma that [Dr. Wendorf] faces at that point is he needs a way to draw blood, to measure things like electrolytes, coagulation factors. He had no way to do that short of repeatedly sticking the -- trying to get blood peripherally from a child who is in early shock.

And then finally I think that at that point it is not at all clear, at least wouldn't have been to me, why this child came in looking the way he did, who seemed to respond to the therapy in the emergency department, he is now looking bad again, what's going on. I mean, they have fluid resuscitated him, and they gave him epinephrine, it seems the blood pressure is back up, and now he is very desperately ill again.

So getting a central venous pressure measurement at that point in time would tell them a lot about his volume status; that is, have they given him enough fluid in order to resuscitate him, is this potentially his heart, rather than sepsis at this point? And so I think there were at least three reasons that I would have done exactly what he did, which was to access the child that is otherwise okay, to do it as quickly as you can and try to get central access.

(Tr. 1252-1253).

Dr. Willson then addressed Dr. Wendorf's decision to proceed to arterial line placement prior to intubation. Dr. Willson testified that judgment must guide one's decision making process. Clearly, foreseeability is an integral part in this process as one is considering the risk of harm versus the desirability of "moment to moment" blood pressure recordings:

Q. The next procedure was an arterial line, and I think this is where the jury has heard criticism of doctor Wendorf. Do you have any criticisms of doctor Wendorf for following the central line with an arterial line prior to intubating him?

A. No. I mean, I think that is a judgment as to how do you proceed a long this. Clearly this child needs to have monitoring, including arterial pressure monitoring. Whether you do intubation first, the central line first,

the arterial line first, I think it is a judgment based on what you are seeing in the child.

Certainly it is ideal to have an arterial line when you are doing intubation, because in the process of giving the agents that you use to sedate the child to intubate him, and the process of changing from spontaneous breathing to positive pressure breathing, blood pressure can drop precipitously and so having literally moment to moment tracings that you can follow to look at blood pressure.

I think it is ideal, and certainly would be something that I would want. In my judgment, I thought the child was stable enough, I would do the procedure with the arterial line.

(Tr. 1254-1255).

Dr. Willson summarized the physician's need to weigh the foreseeable risks in exercising his or her judgment:

Q. Was it appropriate for doctor Wendorf to place a central line first, the arterial line second and intubate Seth third?

A. Well, again, this is certainly a matter of judgment here. The pluses and minuses of this are -- are a little complicated. If you'll give me just one minute to explain it.

The advantage to intubating a child who has marginal cardiac function or in early shock or that you take over the work of breathing, and so you relieve the heart of that -- that oxygen consumption, if you will. About a third of your oxygen consumption goes to breathing.

On the other side of that, if you take and you intervene in an airway in a child who is hypotensive, who has low blood pressure, in shock, you can abruptly decrease blood pressure. The reason for that is that because when you breathe, spontaneously you literally suck blood into your chest. When I intubate, I develop negative pressure, it pulls air in and it also pulls blood out from the periphery, and your heart needs that preload, it needs that volume to come into the chest in order to inject it.

If you are dry, or dehydrated or cardiac function is such that you are barely ejecting enough blood, when you stop that spontaneous breathing, instead of sucking blood into your chest, you are pushing air into your chest. The pressure of the chest becomes positive, and it takes greater pressure to get blood back into the heart. You have a transient decrease in

blood return to the heart. *And that's a real risk. And, yes, I have seen children arrest in that situation.*

So there is a judgment to be made here about timing of intubation. And in my judgment, looking through this record, I personally think he made the right choice. *I think doctor Luxmore made the right choice. I think doctor Wendorf made the right choice, knowing that these were the risks and benefits.*

And I think frankly the fact that he -- that Seth tolerated the intubation, was stable after the intubation, speaks to that. You cannot do that better than that.

So I think, again, in my judgment it's the best -- it was the best choice. There are certainly people who would choose to do it a different way using the same information I just gave you, where I think is a very reasonable choice, and the sequence of events I would have followed resuscitating and caring for this child.

(Tr. 1257 -1260).

It was clear from the above testimony that foreseeability was a significant issue in the case, and one that the jury would ultimately need to decide. In closing argument, Plaintiffs' counsel addressed the issue of foreseeability:

Ladies and gentlemen, what doctor Parker told you is that she is very critical that doctor Luxmore did not intubate. She has limited criticisms of doctor Wendorf, because she views doctor Wendorf as Seth's last chance, and that last chance was not at 2:25 or 2:20 or 2:15, that last chance was when he arrived in the PIC unit so that you could avoid getting into an acidosis of 6.99.

There was a failure to intubate by doctor Luxmore. There was a failure to timely intubate by doctor Wendorf. As a result, Seth's clinical course progressively got worse, which would not be -- which would not be unexpected. *That is very foreseeable* if you don't intubate and you don't address this increasing acidosis, which is causing tissue damage, not just to the heart, but throughout the body.

(Tr. 1342-1343).

In addition to the foregoing evidence that was presented on the issues of the standard of care and demonstrating the analysis of evaluating the foreseeable risks versus the foreseeable benefits of one course of action over another, Children's Hospital also presented evidence that

the alleged negligence did not proximately cause Seth's death. Dr. Kennedy and Dr. Willson testified that even had Seth been treated differently, Seth would not have survived due to the damage that he had suffered to his heart. (Tr. 1114, 1267). Furthermore, as noted above, Dr. Parker, Plaintiffs' expert, admitted that at best he had a 50% chance of survival and when factoring in the 60 to 70% narrowing of his left main coronary artery, it was somewhat less than that number. (Tr. 901-903).

### **Trial Court's Charge to the Jury**

At the close of evidence, the trial court instructed the jury on the law applicable to the case to aid the jury in its deliberations. In regards to negligence and the standard of care, the court provided extensive instructions that spanned 22 paragraphs. The court's instruction related to the physicians standard of care were as follows:

Plaintiffs further claim that the negligence of the defendants caused the death of their son, Seth Cromer. Plaintiffs seek to recover damages for Seth Cromer's death.

Plaintiffs must prove to you by the greater weight of the evidence that the defendant was negligent, that the defendant's negligence proximately caused Seth Cromer's death and that plaintiffs were damaged by the defendant's negligence. The defendant denies that any of its employees were negligent in causing or contributing to the death of Seth Cromer.

....

I will now define for you the standard of care that applies to a physician. The existence of a physician-patient relationship places upon the physician the duty to act as a physician of reasonable skill, care and diligence under like or similar conditions or circumstances. This is known as the standard of care.

The standard of care is to do those things which a reasonably careful physician would do, and to refrain from doing those things which a reasonably careful physician would not do. The required standard of care is the same throughout the United States.

If you find by the greater weight of the evidence that the defendant by and through its employees, doctor Richard Wendorf and doctor Brett Luxmore, failed to meet the standard of care, then you shall find the defendant was negligent.

A specialist is a physician who holds himself or herself out as specially trained, skilled and qualified in a particular branch of medicine. The standard of care for a physician in a practice of a specialty is that of a reasonable specialist practicing medicine, exercising reasonable skill, care and diligence under like and similar circumstances regardless of where he or she practices. A specialist in any branch has the same standard of care as all other specialist in that branch.

Doctor Luxmore is a specialist in pediatric emergency medicine and doctor Wendorf is a specialist in pediatric critical care medicine. If you find by the greater weight of the evidence that doctor Luxmore failed to meet the standard of care for a pediatric emergency medicine physician, and/or doctor Wendorf failed to meet the standard of care for a pediatric critical care physician, then you shall find the defendant was negligent.

Although some other physician might have used a procedure different from that used by the defendant, this circumstance will not by itself prove that the defendant was negligent. You shall decide whether the procedure used by defendant was in accordance with the required standard of care.

The customary or routine method of treatment may be considered by you, along with all of the other facts and circumstances in evidence. Although a particular method may be customary, usual or routine, this circumstance will not by itself prove that method to be within the standard of care.

You shall decide whether the method of treatment used by defendant was in accordance with the required standard of care. The mere fact that an unexpected or bad result followed does not in itself require you to find the physician failed in the duty he owed to the patient. If the physician exercised that degree of care and skill that the law requires of him, he cannot be found to have failed in his duty simply on the basis of the results that followed.

.....

Under the law, in order to prove medical negligence in this case, plaintiffs must show by a preponderance of the evidence and you, the jury, must find that defendant did some particular thing or things that hospitals, physicians and/or nurses of ordinary skill, care and diligence would not have done under the same or similar circumstances, or in the alternative, that the defendant failed or omitted to do some particular thing or things that hospitals, physicians and/or nurses of ordinary skill, care and diligence would have done under the same or similar circumstances.

So hospitals, physicians and/or nurses are not negligent if they use for the treatment of their patient that degree of knowledge, skill and care ordinarily used by reasonable hospitals, physicians and nurses practicing under the same or similar circumstances and conditions in the same medical specialty.

(Tr. 1402-1408).

The trial court then instructed the jury on foreseeability, modeling its instruction after that set forth in OJI:

I will now discuss foreseeability. In deciding whether ordinary care was used, you will consider whether the defendant should have foreseen under the attending circumstances that the natural and probable result of an act or failure to act would cause Seth Cromer's death.

The test for foreseeability is not whether the defendant should have foreseen the death of Seth Cromer precisely as it happened. The test is whether under all the circumstances a reasonably cautious, careful, prudent person would have anticipated that death was likely to result to someone from the act or failure to act.

If the defendant by the use of ordinary care should have foreseen the death and should not have acted, or if they did act, should have taken precautions to avoid the result, the performance of the act or the failure to act to take such precautions is negligence.

(Tr. 1408-1409).

The court concluded its standard of care instruction as follows:

In a case such as this, the issue of whether the hospital, physicians and/or nurses have exercised ordinary care in the practice of medicine requires of the plaintiffs, who have the burden of proof, to produce the testimony of an expert witness who can establish the recognized standard of care in the medical community under the circumstances shown in evidence, and any departure from the standard that constitutes a failure to exercise ordinary care.

(Tr. 1409).

After receiving the court's instruction, the jury retired to deliberate. Despite the fact that the jury was presented with seven days of complex medical testimony, the jury returned its verdict after only four hours of deliberation. After carefully considering all of the evidence, listening to the details of the testimony and observing the witnesses' demeanor, the jurors, being

in the best position to assess the credibility of the witnesses and parties, concluded that Children's Hospital's position was more credible. The jurors answered interrogatories finding that Children's Hospital was not negligent and further finding that the alleged negligence was not the proximate cause of Seth's death.

In its ruling, the Ninth District Court of Appeals invalidated the jury's assessment of the evidence and findings. The court, in a troublesome and logically flawed decision, dramatically altering fundamental concepts of negligence law, concluded that foreseeability should never be a part of a jury's consideration in medical malpractice cases and that it was *reversible* error to have so instructed the jury. The court did so without considering whether the jury charge as a whole fairly set forth the applicable law or whether the error was so egregious as to have probably resulted in an erroneous verdict.

As demonstrated in the following sections, the Ninth District's opinion is contrary to the very foundations upon which negligence law is based. Foreseeability is one of the crucial considerations a factfinder must take into account in assessing whether a defendant accused of negligence has failed to act in a reasonable manner. It is important for this Court to ensure that jurors in medical malpractice cases are properly instructed on the issue of foreseeability. Since the Ninth District usurped the jury's role as a factfinder, and since it has erroneously removed foreseeability from consideration in all future medical malpractice cases, Children's Hospital respectfully requests this Court overturn that Ninth District's decision and reinstate the verdict in favor of Children's Hospital.

### III. LAW AND ARGUMENT

**Proposition of Law: Foreseeability is a vital and important factor for a jury to consider in determining whether a medical defendant has acted as a reasonably prudent medical provider under the same or similar circumstances. Thus, a trial court should instruct jurors in medical malpractice cases on the issue of foreseeability.**

It is rudimentary that in order to establish actionable negligence, one must show the existence of a duty, a breach of the duty, and an injury resulting proximately therefrom. *Di Gildo v. Caponi*, 18 Ohio St.2d 125, 247 N.E.2d 732 (1969). A medical malpractice action is nothing more than an ordinary negligence claim against a medical professional. *Kurzner v. Sanders*, 89 Ohio App.3d 674, 627 N.E.2d 564 (1st Dist. 1993); *Littleton v. Good Samaritan Hosp. & Health Ctr.*, 39 Ohio St.3d 86, 92, 529 N.E.2d 449 (1988) (“the same three elements must be shown to establish a negligence action generally, including a survivorship action predicated upon ordinary negligence or medical malpractice.”).

This Court has repeatedly held that foreseeability is one of the most important considerations in determining whether a defendant’s actions were negligent and that it is appropriate to provide instructions to the jury on foreseeability. However, using faulty logic, the Ninth District Court of Appeals concluded that foreseeability is totally irrelevant in determining whether a medical defendant is negligent and that any instruction on foreseeability in a medical malpractice action constitutes *reversible error*.

The following excerpt sets forth the Ninth District’s logic:

“[T]he duty of the physician is established simply by the existence of a physician-patient relationship, not by questions of foreseeability.” *Oiler v. Willke*, 95 Ohio App.3d 404, 409, 642 N.E.2d 667 (4th Dist.1994). “[P]hysicians are said to owe patients a legal duty to use recognized standards of professional knowledge and skill.” *Ryne v. Garvey*, 87 Ohio App.3d 145, 155, 621 N.E.2d 1320 (2d Dist. 1993). A plaintiff proves a breach of duty by showing that the physician failed to act in accordance with those established norms. *Id.* Consequently, evidence that the physician could have foreseen the patient’s injury is irrelevant because

“[f]oreseeability is not determinative of a physician’s legal duties.” *Id.* at 154–155, 621 N.E.2d 1320.

The Ninth District’s opinion in this case was based on the premise that foreseeability goes to duty, that duty is a matter of law for the court, and that once duty has been established, foreseeability is not a proper consideration for a jury. If that were true, then foreseeability should never be part of any instructions to a jury in any negligence action. That is, if a negligence action survives a summary judgment on the duty issue, or it is conceded that a duty of care exists, then foreseeability should never be a question. However, this is a myopic view of the role of foreseeability in negligence actions and is contrary to this Court’s decisions, the Restatement of Torts, and the position of commentators.

There is no doubt, pursuant to this Court’s decisions, foreseeability is a factor in determining whether a duty of care exists. *Menifee v. Ohio Welding Prods., Inc.*, 15 Ohio St.3d 75, 472 N.E.2d 707 (1984). However, simply because foreseeability is relevant to the determination of duty does not mean that it is irrelevant to the issue of whether a defendant breached the duty of care. To the contrary, foreseeability has always been a fundamental consideration for the jury in assessing whether a defendant’s actions were negligent.

In 1893, this Court, in *Lakeshore & M.S. Ry. Co. v. Murphy*, 50 Ohio St. 135, 33 N.E. 403 (1893), clearly held that a standard of care instruction that included foreseeability was properly submitted to the jury. In rejecting the appellant’s challenge to the instruction regarding foreseeability, the Court explained:

Whether if, under the circumstances of this case, a rule providing for warning was necessary, and by the exercise of reasonable care on the part of the company that necessity could have been foreseen, it was the duty of the company to prescribe such rule. Whether it ought to have so provided or not was a question for the jury.

*Id.* at paragraph two of the syllabus.

Fault is found [by the defendant] also with what the court said as to ordinary care, and especially with the statement that “no general rule can be given as to what in law constitutes ordinary care.” The court added this: “A general definition of ‘ordinary care’ is such care and vigilance as a person of ordinary prudence and *foresight* would usually exercise under the same or similar circumstances.” Taken as a whole, we see no valid objection to this part of the charge.

*Id.* at 144.

The reason foreseeability is an important factor for a jury’s determination is that it goes to the assessment of the reasonableness of the defendant’s actions under the same or similar circumstances. Whether one has acted as a reasonably prudent person depends on the foreseeable risks involved in the conduct. In *Thompson v. Ohio Fuel Gas Co.*, 9 Ohio St.2d 116, 224 N.E.2d 131 (1967), this Court explained this importance as follows:

In determining in any given case whether a defendant exercised that care which an ordinarily and reasonably prudent man would have exercised under the same or similar circumstances, *one of the most important of the circumstances* is ‘the potential danger *apparently* involved.’ *Schwer, Admx., v. New York, Chicago & St. Louis Rd. Co.*, 161 Ohio St. 15, 21, 117 N.E.2d 696, 43 A.L.R.2d 606 [1954].

The danger here, as evidenced by the seriousness of the occurrence itself, was great. The remaining question was whether it was apparent. *That is to say, should the defendant have foreseen this danger?*

*Id.* at 119 (Emphasis added).

The fundamental nature of foreseeability’s role was noted by this Court in *Weaver v. Columbus, S. & H. Ry. Co.*, 76 Ohio St. 164, 81 N.E. 180 (1907), where this Court stated: “*the elementary rule [is] that the degree of care to be exercised is determined by the danger to be apprehended.*” *Id.* at 176 (Emphasis added).

In *DiGildo, supra*, this Court again upheld the propriety of a jury charge on foreseeability in a negligence action:

Appellant contends further that the following instruction to the jury was erroneous: ‘the test is whether in light of all of the attending circumstances, all of them, a reasonably prudent person *would have anticipated* the injury was likely to

result to someone from the performance of the act in question.’

The trial court’s charge here was a correct statement of the law of foreseeability as announced in *Neff Lumber Co. v. First National Bank*, 122 Ohio St. 302, 171 N.E. 327 [1930], and followed in *Mudrich v. Standard Oil Co.*, 153 Ohio St. 31, 39, 90 N.E.2d 859, 863 [1950]: ‘It is not necessary that the defendant should have anticipated the particular injury. It is sufficient that his act is likely to result in an injury to someone.’ See, also, *Miller v. B. & O. Southwestern Rd. Co.*, 78 Ohio St. 309, 325, 85 N.E. 499, 18 L.R.A., N.S., 949 [1908]; *Gedeon v. East Ohio Gas Co.*, 128 Ohio St. 335, 190 N.E. 924 [1934].

*Id.* at 130 (emphasis added).

In *Delta Fuels, Inc. v. Consol. Environmental Servs., Inc.*, 969 N.E.2d 800 (6th Dist. 2012), the Sixth District Court of Appeals explained the significance of foreseeability:

There is also a calculus of what constitutes a reasonable risk that dictates the degree of caution an individual is bound to exercise. This involves a balance between the probability that an untoward event will occur, the gravity of the harm that will result and the burden of taking adequate precaution to prevent the harm. *Benlehr v. Shell Oil Co.*, 62 Ohio App.2d 1, 9, 402 N.E.2d 1203 (1st Dist.1978), *Keeton*, *Prosser and Keeton on Torts*, Section 31, 171 (5th Ed. 1984), 1 Dobbs, Hayden and Bublick, *The Law of Torts*, *supra*, at 501 [2d Ed 2011].

*Id.* at 806.

It must be remembered that a medical malpractice action is nothing more than a negligence case involving professionals. *Kurzner*, *supra*; *Littleton*, *supra*. Simply stated, the only difference is that a layperson cannot determine what a reasonable professional would do under the same or similar circumstances since the layperson does not have the specialized training of the professional. However, the ultimate issue that the jury must decide is the same as in any other negligence case -- whether the defendant failed to act as would a reasonably prudent person under the same or similar circumstances. *Bruni v. Tatsumi*, 46 Ohio St.2d 127, 346 N.E.2d 673 (1976), paragraph one of the syllabus. According to the above decisions, clearly foreseeability of harm is not only an acceptable consideration for the jury, it is “elemental” and

“one of the most important” considerations for determining the issue of negligence. *Weaver, supra; Thompson, supra.*

Physicians are called upon on a daily basis to make choices between competing courses of action. In deciding, a physician must take into consideration the potential risks involved with each course of action. Whether a given course of action is in fact negligent or a deviation from the standard of care will necessarily involve questions as to the foreseeable risks of harm, including the likelihood of harm occurring in choosing one course of action over another, as well as the foreseeable magnitude of harm posed by either choice.

This is precisely the scenario Dr. Luxmore and Dr. Wendorf faced in this case. Their choices involved the weighing of the foreseeable risks of two scenarios. First, they could intubate Seth sooner and expose him to the risk of a precipitous decline, cardiac arrest, and death, without having the lines in place to administer emergent treatment and perform continuous monitoring, where Seth had experienced significant improvement in his status. Second, and alternatively, they could transfer Seth to the PICU, a safer environment for performing intubation, insert a central line and arterial line so second to second monitoring and interventions were available should Seth suffer a precipitous change in his condition during intubation.

Recently, David G. Owen, Carolina Distinguished Professor of Law, University of South Carolina, wrote an extensive article regarding foreseeability in the law of negligence. Dr. Owen discussed the concept that choice and foreseeability were at the heart of negligence law:

Notwithstanding its elusive nature, foreseeability so deeply permeates tort, especially negligence, that it cannot and should not be excised. For a person's actions to be wrongful, the person must have had a choice between alternative courses of action and also must have chosen, by some standard, incorrectly. If an actor chooses to act in a manner that violates some community norm of proper behavior, tort law holds the actor accountable for harmful consequences that result from that choice. Thus, tort responsibility normally implies that the actor ought to have considered and chosen to avoid the kind of harm he caused--that he

or she wrongfully failed to avoid the harm. So, ascribing moral character (blame or praise) to a choice to risk or avoid the risk of harm implies the actor's ability to conceive ("foresee") its consequences. Foreseeability thus is bound up, inextricably, in notions of both wrongfulness and how far responsibility for wrongfulness should extend.

Owen, DG, *Figuring Foreseeability*, 44 Wake Forest L. Rev. 1277, 1280 (2009).

Contrary to the Ninth District's analysis that foreseeability is solely relevant to whether a duty of care exists and not relevant to the jury's evaluation of whether there was a breach of duty, this Court has historically and consistently stated that foreseeability is an important consideration in the factfinder's assessment of whether a defendant has failed to use reasonable care. This view is consistent with the position taken by commentators and the Second and Third Restatement of Torts.

In his article, Dr. Owen explains that of all the negligence elements, the least controversial place for foreseeability is with respect to breach.

Now that we have examined why negligence law is normatively bounded by the concept of foreseeability, we may turn to a consideration of where in negligence--in which elements--foreseeability properly belongs. Among the five elements of which negligence is comprised,<sup>65</sup> most scholars agree that foreseeability is implicated significantly in three: duty, breach, and proximate cause.<sup>66</sup> ***Breach and proximate cause may be the most important, and, because the role of foreseeability in them is least controversial,*** how foreseeability fits in breach and proximate cause is addressed first, followed by an examination of foreseeability's role in duty.

\* \* \*

The *Restatement (Second) of Torts* defines negligent conduct as "an act which the actor as a reasonable man should recognize as involving an unreasonable risk of causing an invasion of an interest of another." This standard is explained as whether "a reasonable man should have expected that" his conduct "might cause harm to persons" like the plaintiff. The *Second Restatement* further provides: "Where an act is one which a reasonable man would recognize as involving a risk of harm to another, the risk is unreasonable and the act is negligent if the risk is of such magnitude as to outweigh what the law regards as the utility of the act or of the particular manner in which it is done." While this standard of *what a reasonable man should expect or recognize* embraces the idea of foreseeable risk,

the *Restatement (Third) of Torts* locates foreseeability more prominently at the heart of negligence, defining negligence in section 3 explicitly in terms of foreseeable risk:

A person acts negligently if the person does not exercise reasonable care under all the circumstances. ***Primary factors to consider in ascertaining whether the person's conduct lacks reasonable care are the foreseeable likelihood that the person's conduct will result in harm, the foreseeable severity of any harm that may ensue, and the burden of precautions to eliminate or reduce the risk of harm.***

W. Jonathan Cardi, Assistant Professor of Law, University of Kentucky similarly noted:

Perhaps foreseeability's most uncontroversial function in negligence law lies in aiding the factfinder to determine breach. The breach inquiry is the core of the negligence cause of action because it calls for a decision regarding the defendant's blameworthiness, or culpability. Where the judge has determined that the defendant owed a duty and has delineated the broad contours of that duty in a statement of the "standard of care," the jury must then decide, in the context of breach, whether the defendant's conduct failed to conform to that standard. . . .

The near-universal standard of care in negligence cases is the duty to act as would a reasonable person under the circumstances. Foreseeability makes its entrance in the application of this reasonable person standard.

W. Jonathan Cardi, *Purging Foreseeability*, 58 Vand. L.R. 739, 744 (2005).

In the Restatement (Third) of Torts, the Drafters addressed the role of foreseeability as follows:

*j. The proper role for foreseeability.* Foreseeable risk is an element in the determination of negligence. In order to determine whether appropriate care was exercised, ***the factfinder must assess the foreseeable risk at the time of the defendant's alleged negligence.*** The extent of foreseeable risk depends on the specific facts of the case and cannot be usefully assessed for a category of cases; small changes in the facts may make a dramatic change in how much risk is foreseeable. Thus, for reasons explained in Comment i, ***courts should leave such determinations to juries*** unless no reasonable person could differ on the matter.

*Restatement of the Law 3d, Torts, Section 7, Comment j (2012) (Emphasis added).*

The Drafters also explained that the fact finder's determination of negligence must necessarily take into consideration the foreseeable risks versus the foreseeable benefits of an actor's conduct. To this end, they explained:

*e. Balancing risks and benefits.* Insofar as this Section identifies primary factors for ascertaining negligence, it can be said to suggest a "risk-benefit test" for negligence, where the "risk" is the overall level of the foreseeable risk created by the actor's conduct and the "benefit" is the advantages that the actor or others gain if the actor refrains from taking precautions. (Hence this benefit is the same as the burdens that the precautions, if adopted, would entail.) The test can also be called a "cost-benefit test," where "cost" signifies the cost of precautions and the "benefit" is the reduction in risk those precautions would achieve. Overall, this Section can be referred to as supporting a "balancing approach" to negligence.

The balancing approach rests on and expresses a simple idea. Conduct is negligent if its disadvantages outweigh its advantages, while conduct is not negligent if its advantages outweigh its disadvantages. The disadvantage in question is the magnitude of risk that the conduct occasions; as noted, the phrase "magnitude of the risk" includes both the foreseeable likelihood of harm and the foreseeable severity of harm that might ensue. The "advantages" of the conduct relate to the burden of risk prevention that is avoided when the actor declines to incorporate some precaution. The actor's conduct is hence negligent if the magnitude of the risk outweighs the burden of risk prevention. The burden of precautions can take a very wide variety of forms.

*Restatement of the Law 3d, Torts, Section 3, Comment e (2012).*

Accordingly, there can be no doubt that, contrary to the Ninth District's opinion, foreseeability is an indispensable factor to be considered by a jury in determining the issue of breach, i.e. whether the defendant failed to act in a reasonable manner under the circumstances.

In the last five years, excluding the present case, six other appellate decisions have been issued in which the propriety of the foreseeability instruction in medical malpractice cases has been challenged (four in the last one and one half years). In each of these cases, the court upheld the propriety of the foreseeability instruction. *See Cox v. MetroHealth Med. Ctr. Bd. Of Trustees*, 2012-Ohio-2383, 971 N.E.2d 1026 (8th Dist.); *Ratliff v. Mikol*, 8th Dist. No. 94930, 2011-Ohio-2147; *Peffer v. Cleveland Clinic Found.*, 8th Dist. No. 94356, 2011-Ohio-450;

*Clements v. Lima Memorial Hosp.*, 3d Dist. No. 1-09-24, 2010-Ohio-602; *Joiner v. Simon*, 1st Dist. No. C-050718, 2007-Ohio-425; *Miller v. Defiance Regional Med. Ctr.*, 6th Dist. No. L-06-1111, 2007-Ohio-7101.

In *Ratliff, supra*, the Eighth District Court of Appeals rejected the precise argument adopted by the Ninth District in the present case, stating:

Moreover, [plaintiff's] only argument as to whether the trial court should have omitted the foreseeability instruction altogether is ***that since foreseeability is a factor for duty, an issue of law for the court, the jury should not be charged with foreseeability.*** The parties presented dueling evidence on the standard of care. It was in the province of the trier of fact to determine whether, based on the evidence presented, the standard of care owed to Baker included performing an emergency Caesarean section, as Baker argued. We therefore cannot say that the trial court erred in including or with regard to the language of the foreseeability instruction. We agree with Dr. Mikol that the foreseeability instruction given is a correct statement of law, is required by the issues of the case, and is clear in setting out the general rule. *Id.* at ¶11. (Emphasis added).

Similarly, in *Peffer, supra*, the Eight District reasoned: “these cases contradict [plaintiff's] arguments that a foreseeability instruction is not warranted in medical malpractice cases.” *Id.* at ¶56. In *Miller, supra*, the Sixth District Court Appeals held: “[o]ur reading of the court's instruction on foreseeability reveals that it is patterned, almost word for word, on the language set forth in 1 Ohio Jury Instructions Sections 1.99 and 7.13. Therefore, we find that the common pleas court did not abuse its discretion in giving this particular foreseeability instruction.” *Id.* at ¶52.

The foreseeability instruction has been part of standard OJI instructions since the inception of these instructions more than 50 years ago. *See Ohio Jury Instructions*, Section 7.13 (1963); *Ohio Jury Instructions*, Section 401.07 (2010). While OJI are not binding law, they are a consensus of Ohio jurists on certain issues commonly presented in certain types of action. Thus, this instruction has been given to juries considering whether a defendant's actions have been

negligent, including medical defendants, in countless negligence actions.

Despite the repeated acknowledgement from the above noted courts of appeals as to the propriety of the foreseeability instruction, plaintiffs have not been deterred from challenging the instruction as evidenced by the challenge in this case. Because the Ninth District has issued a ruling directly in conflict with these decisions, it is necessary that this Court make clear that an instruction on foreseeability is appropriate in medical malpractice actions.

Finally, it is important to note that this Court has repeatedly reminded lower courts that an erroneous instruction is a basis for reversal only if it is clearly established that the erroneous instruction, when taken as a whole, probably misled the jury to an incorrect result. *Ohio Farmers Ins. Co. v. Cochran*, 104 Ohio St. 427, 428, 135 N.E. 537 (1922). Thus, only an egregious error that leaves little doubt that the outcome was indeed erroneously arrived at warrants a reversal. *See Centrello v. Basky*, 164 Ohio St. 41, 52-53, 128 N.E.2d 80 (1955) (reversible error only occurs where the error is “pernicious, misleading and confusing character”).

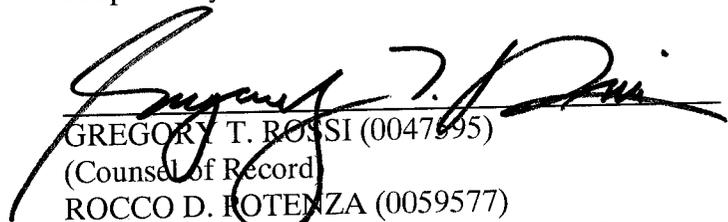
In the present case, not only did the trial court appropriately instruct the jury in regards to the issue of foreseeability, even assuming *arguendo* that the instruction somehow was improper, when taken as a whole, the trial court's extensive instructions on the standard of care could in no way have misled the jury. Moreover, there is no evidence to support the contention that the jury was misled in any way. The fact that the Ninth District used a proper foreseeability instruction as a basis for reversal, contrary to the above-noted rule, demonstrates that the court's decision was clearly a result-oriented decision.

## CONCLUSION

The Ninth District's decision in this case prohibits juries from considering one of the most basic and fundamental tenants of negligence: foreseeability. Not only is this position contrary to this Court's holdings, it is in direct conflict with other Ohio courts of appeals. It is also contrary to the approach set forth in both the Second and Third Restatement of Torts. Finally, the Ninth District's decision, by failing to apply the proper standard, allows a court of appeals to invalidate a jury's verdict no matter how insignificant the alleged error in a jury charge.

This Court should reverse the decision of the Ninth District Court of Appeals and reinstate the jury verdict in this case.

Respectfully submitted:



GREGORY T. ROSSI (0047595)

(Counsel of Record)

ROCCO D. POTENZA (0059577)

HANNA, CAMPBELL & POWELL, LLP

3737 Embassy Parkway, Suite 100

Akron, Ohio 44333

Phone: 330-670-7600

Fax: 330-670-7478

E-mail: [GRossi@hcplaw.net](mailto:GRossi@hcplaw.net)

[RPotenza@hcplaw.net](mailto:RPotenza@hcplaw.net)

Counsel for Defendant-Appellant

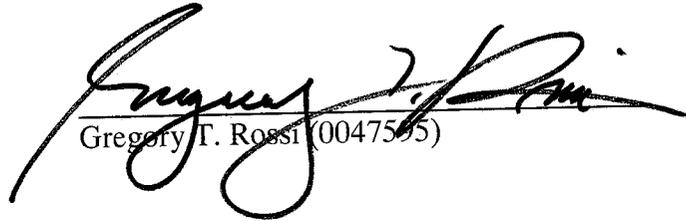
Children's Hospital Medical Center of Akron

**CERTIFICATE OF SERVICE**

A true copy of the foregoing *MERIT BRIEF OF DEFENDANT-APPELLANT CHILDREN'S HOSPITAL MEDICAL CENTER OF AKRON* was served by regular U.S. mail on the 23<sup>rd</sup> day of May 2013 upon:

Jack Morrison, Jr., Esq. (0014939)  
Thomas R. Houlihan, Esq. (0070067)  
Vicki L. DeSantis, Esq. (0075716)  
159 South Main Street  
Suite 1100 Key Building  
Akron, Ohio 44308

Counsel for Appellees

  
Gregory T. Rossi (0047595)

<<HCP #678336-v1>>

NO. 12-2134

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In the Supreme Court of Ohio

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APPEAL FROM THE COURT OF APPEALS  
NINTH APPELLATE DISTRICT  
SUMMIT COUNTY, OHIO  
CASE NO. 25632

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SETH NILES CROMER, Minor Child, Deceased, et al.  
Plaintiffs-Appellees,

v.

CHILDREN'S HOSPITAL MEDICAL CENTER OF AKRON,  
Defendant-Appellant.

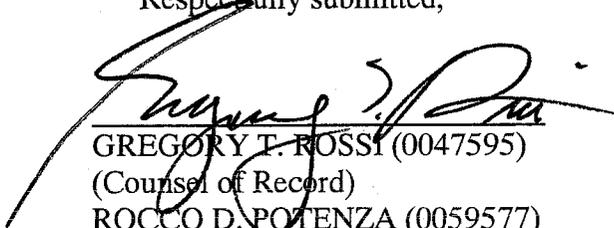
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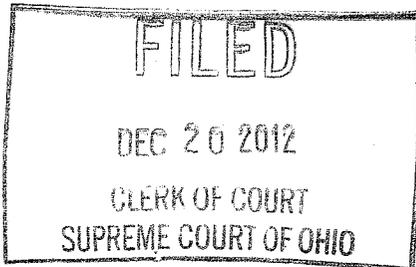
**NOTICE OF APPEAL OF DEFENDANT-APPELLANT  
CHILDREN'S HOSPITAL MEDICAL CENTER OF AKRON**

---

Respectfully submitted,

Jack Morrison, Jr., Esq. (0014939)  
Thomas R. Houlihan, Esq. (0070067)  
Vicki L. DeSantis, Esq. (0075716)  
159 South Main Street  
Suite 1100 Key Building  
Akron, Ohio 44308  
Counsel for Plaintiffs-Appellees

  
GREGORY T. ROSSI (0047595)  
(Counsel of Record)  
ROCCO D. POTENZA (0059577)  
HANNA, CAMPBELL & POWELL, LLP  
3737 Embassy Parkway, Suite 100  
Akron, Ohio 44334  
Phone: 330-670-7600  
Fax: 330-670-7478  
E-mail: [GRossi@hcplaw.net](mailto:GRossi@hcplaw.net)  
[RPotenza@hcplaw.net](mailto:RPotenza@hcplaw.net)  
Counsel for Defendant-Appellant  
Children's Hospital Medical Center of Akron

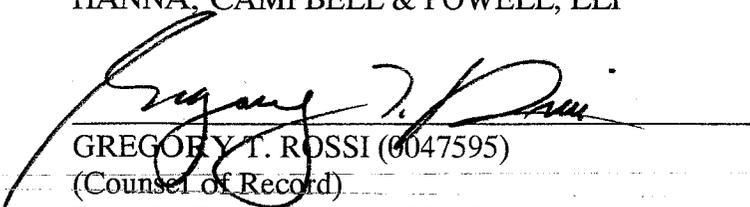


**NOTICE OF APPEAL OF DEFENDANT-APPELLANT**  
**CHILDREN'S HOSPITAL MEDICAL CENTER OF AKRON**

Defendant-Appellant, Children's Hospital Medical Center of Akron, gives notice of its appeal to the Supreme Court of Ohio from the judgment of the Summit County Court of Common Pleas, Ninth Appellate District, entered in Case No. CA-25632 on November 7, 2012.

This case presents issues of public and great general interest.

HANNA, CAMPBELL & POWELL, LLP



GREGORY T. ROSSI (0047595)

(Counsel of Record)

ROCCO D. POTENZA (0059577)

HANNA, CAMPBELL & POWELL, LLP

3737 Embassy Parkway, Suite 100

Akron, Ohio 44334

Phone: 330-670-7600

Fax: 330-670-7478

E-mail: [GRossi@hcplaw.net](mailto:GRossi@hcplaw.net)

[RPotenza@hcplaw.net](mailto:RPotenza@hcplaw.net)

Counsel for Defendant-Appellant

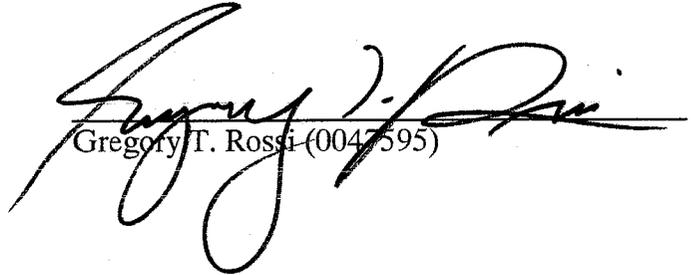
Children's Hospital Medical Center of Akron

CERTIFICATE OF SERVICE

A true copy of the foregoing **NOTICE OF APPEAL OF DEFENDANT-APPELLANT CHILDREN'S HOSPITAL MEDICAL CENTER OF AKRON** was served by regular U.S. mail on the 20<sup>th</sup> day of December, 2012 upon:

Jack Morrison, Jr., Esq. (0014939)  
Thomas R. Houlihan, Esq. (0070067)  
Vicki L. DeSantis, Esq. (0075716)  
159 South Main Street  
Suite 1100 Key Building  
Akron, Ohio 44308

Counsel for Appellees

  
Gregory T. Rossi (0047595)

<<HCP #652209-v1>>

STATE OF OHIO  
COUNTY OF SUMMIT

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IN THE COURT OF APPEALS  
NINTH JUDICIAL DISTRICT

SETH NILES CROMER, et al.

C.A. No. 25632

Appellants

v.

CHILDREN'S HOSPITAL MEDICAL  
CENTER OF AKRON

Appellee

APPEAL FROM JUDGMENT  
ENTERED IN THE  
COURT OF COMMON PLEAS  
COUNTY OF SUMMIT, OHIO  
CASE No. CV 2008 07 4775

DECISION AND JOURNAL ENTRY

Dated: November 7, 2012

CARR, Presiding Judge.

{¶1} Appellants, Melinda Cromer, individually; and Roderick Cromer, Jr., individually and on behalf of their late son Seth; appeal from a judgment entered on a jury verdict for Children's Hospital Medical Center of Akron on the Cromers' claims against it, which alleged that their son's death was caused by medical negligence of the hospital's employees. Because the trial court incorrectly stated the law when it instructed the jury about the hospital's standard of care, this Court reverses and remands for a new trial.

I.

{¶2} This case involves the death of five-year-old Seth Cromer during the early morning hours of January 14, 2007, while he was being treated as a patient in the pediatric intensive care unit ("PICU") at Children's Hospital. Seth had been diagnosed with an ear infection by his pediatrician several days earlier and, although he had been taking antibiotics and had shown signs of improvement initially, his condition worsened after several days. Seth's

parents brought him to the hospital emergency room because he had developed a stomach ache and fever, and was clammy, cold, and listless.

{¶3} Because many of the specific details about Seth's treatment at the hospital are disputed by the parties, this Court will confine its recitation of facts primarily to those that are not disputed. Due to an unexplained failure of the hospital to document what transpired in the first exam room, an error in which another patient's information was noted on Seth's medical records, and apparently because the hospital staff became too busy with the hands-on treatment of Seth, Seth's hospital records include incomplete details about the progression of his symptoms and the treatment he received while in the emergency room. Therefore, most of the evidence about the time Seth spent in the emergency room came from the conflicting recollections of witnesses.

{¶4} It is not disputed that, at approximately 10:44 p.m., shortly after his arrival at the hospital emergency room, Seth was assessed by a triage nurse, who noted that he was pale, had a tender abdomen, and had a fast heart rate. Although Seth had no fever at that time, his parents stated that they had given him Advil a few hours earlier. The nurse assigned Seth a triage level of "urgent," which indicated that he needed to be seen by a physician quickly.

{¶5} Seth was initially assigned to exam room 18 and remained in that room for approximately 30 minutes. At some point, a doctor assessed Seth and concluded that he was in shock because he was dehydrated, had an elevated heart rate and elevated respiratory levels, and his blood pressure was decreasing. At approximately 11:20 or 11:30, the doctor ordered that Seth be moved to exam room 3, which had more equipment to monitor his vital signs and was closer to the nurses' station.

{¶6} The doctor ordered that Seth be given normal saline fluids intravenously. Due to an error by one of the nurses, however, Seth was given D5 ½ normal saline, which was not the correct or optimal fluid to treat his dehydration. The evidence is disputed, however, about how much of that incorrect fluid Seth received and what, if any, negative impact it had on his condition. When the emergency room doctor realized the error, he ensured that Seth began receiving normal saline solution through his IV. At some point, epinephrine was added to Seth's intravenous fluids, in an attempt to increase his blood pressure. The epinephrine was later increased to a high dose, although the exact dosage is disputed. The negative or positive impact of the epinephrine was also disputed by the parties.

{¶7} Shortly after midnight, Seth was transferred to treatment room 1. While in that room, Seth seemed to show some signs of improvement because he was more alert and was talking. In hindsight, however, given some of his other symptoms, experts agreed that Seth was actually in compensated shock, meaning that his body was attempting to compensate for the shock. Although his physical condition might have appeared in some ways to be improving, it was actually getting worse. Because the emergency room doctor apparently recognized that Seth was in compensated shock and believed that he was in critical condition, Seth was transferred to the pediatric intensive care unit ("PICU") at approximately 1:14 a.m.

{¶8} Shortly after Seth arrived in the PICU, the critical care doctor assessed him and also determined that he was in shock. Suspecting that Seth's shock had progressed to the point that he had acidosis, the doctor believed that he would probably need to intubate Seth and place him on a ventilator. Ventilation would help reduce the acidosis by decreasing the carbon dioxide levels in the blood. The doctor first placed a central venous line to establish stable intravenous access to continue administering the epinephrine and other medications, if needed. He then

placed an arterial line to draw blood for testing, which revealed that Seth was suffering from significant acidosis. The doctor intubated Seth at approximately 2:15 - 2:25 a.m., and then ordered an echocardiogram. During the echocardiogram procedure, at approximately 3:45, Seth went into cardiac arrest and a code blue was called. Cardiopulmonary resuscitation was not successful and Seth was pronounced dead at 4:05 a.m.

{¶9} The Cromers filed this action against the hospital and several individual defendants, alleging that Seth's death was caused by the negligent medical care that he received at the hospital. The individual defendants were later dismissed and case proceeded to trial against the hospital. At trial, although there was disputed evidence about some of the treatment that Seth received, particularly while in the emergency room, the primary dispute between the parties was the cause of Seth's death. All experts agreed that Seth died due to coronary failure. The dispute involved whether his heart failure was caused by an unknown, pre-existing heart defect or the hospitals' failure to properly treat the septic shock that had developed from his viral infection.

{¶10} The Cromers' medical expert, Dr. Margaret Parker, testified that, although Seth's autopsy revealed that he had a pre-existing narrowing of his left coronary artery, that condition did not cause his death. Instead, she opined that Seth died due to septic shock that had not been appropriately and timely treated at the hospital but was allowed to progress to severe cardiac and respiratory failure. She explained that, when Seth arrived at the hospital, he was suffering from septic shock, which, if not quickly treated and reversed, can lead to cardiac shock. She further explained that untreated shock can lead to acidosis, which if not treated will ultimately cause death. Dr. Parker pointed to evidence that Seth developed both respiratory and metabolic acidosis while in the emergency room. She further explained that the primary method of treating

acidosis is to intubate the patient and put him on a ventilator. Intubation and ventilation help to decrease the patient's respiratory rate and the stress on his heart and allow carbon dioxide to be released and oxygen to be increased in the blood.

{¶11} Dr. Parker testified that the hospital departed from the standard of care by not intubating Seth sooner, or no later than 12:15 a.m., when his blood gas levels indicated that he was suffering from severe acidosis. She explained that, by the time Seth was actually intubated after 2:00 a.m., he had already "fallen off the cliff" and it was too late to save his life. Dr. Parker further testified that the hospital departed from the standard of care by not treating Seth within 30 minutes of his arrival at the hospital, by not giving him intravenous fluids sooner, and by giving him the wrong intravenous fluids.

{¶12} According to the results of the autopsy performed by a pediatric pathologist at the hospital, Seth died of heart failure that was the combined result of a pre-existing narrowing of his left coronary artery and a viral infection that had spread to his heart. The hospital's experts testified that Seth's pre-existing heart problem caused his acidosis and his eventual death because his heart could not pump effectively. They testified that there was nothing more that the treating physicians could have done to save Seth's life.

{¶13} During Dr. Parker's testimony, the hospital objected and later moved to strike her testimony, asserting that she was not qualified as a medical expert pursuant to Evid.R. 601(D) because she did not devote at least half of her professional time to active clinical practice. The hospital then moved for a directed verdict on that basis, arguing that, without the expert's testimony, the Cromers had not presented a prima facie claim of medical malpractice. The trial court denied both motions.

{¶14} Following the presentation of evidence, over the Cromers' objection, the trial court instructed the jury that, in determining whether the hospital exercised its duty of care, the jury was required to consider whether the treating professionals should have foreseen that Seth Cromer's death was a natural and probable result of their actions or inactions.

{¶15} The jury returned a general verdict in favor of the hospital. In response to its first interrogatory, the jury indicated that the plaintiffs had not proven that the hospital was negligent. The trial court entered judgment for the hospital. The Cromers moved for a new trial, but the trial court denied their motion.

{¶16} The Cromers appeal and raise three assignments of error. The hospital raises one assignment of error, in the event this Court finds merit in any of the Cromers' assignments of error and reverses the judgment.

## II.

### APPELLANT'S ASSIGNMENT OF ERROR I

#### THE COURT ERRED IN INSTRUCTING THE JURY.

{¶17} Through their first assignment of error, the Cromers argue that the trial court committed reversible error by improperly instructing the jury on the hospital's standard of care. Specifically, over their objection, the trial court instructed the jury that, in determining whether the hospital exercised ordinary care, it was required to consider "whether the defendant should have foreseen under the attending circumstances that the natural and probable result of an act or failure to act would cause Seth Cromer's death." The Cromers argue that the trial court's instruction that defined the hospital's standard of care as requiring it to consider the foreseeability of Seth's death was an incorrect statement of law and constituted reversible error in this case. We agree.

{¶18} Generally, to establish a claim of negligence, the plaintiff must prove the existence of a duty by the defendant, breach of that duty, and an injury proximately caused by that breach of duty. *Menifee v. Ohio Welding Products, Inc.* 15 Ohio St.3d 75, 77 (1984). A fundamental aspect of proving negligence is determining whether the defendant owed the plaintiff a duty. *Jeffers v. Olexo*, 43 Ohio St.3d 140, 142 (1989). It is well established that the existence of a duty will depend, in part, on the foreseeability of injury to the plaintiff. *Menifee* at 142.

{¶19} The defendant's duty to exercise due care to protect the plaintiff does not arise unless the risk of injury is foreseeable:

In delimiting the scope of duty to exercise care, regard must be had for the probability that injury may result from the act complained of. No one is bound to take care to prevent consequences which, in the light of human experience, are beyond the range of probability. Only when the injured person comes within the circle of those to whom injury may reasonably be anticipated does the defendant owe him a duty of care.

*Gedeon v. E. Ohio Gas Co.*, 128 Ohio St. 335, 338 (1934).

{¶20} In addition to the foreseeability of injury, the existence and scope of a tort duty will depend upon the relationship between the parties. *Simmers v. Bentley Constr. Co.*, 64 Ohio St.3d 642, 645 (1992). "Duty, as used in Ohio tort law, refers to the relationship between the plaintiff and the defendant from which arises an obligation on the part of the defendant to exercise due care toward the plaintiff." *Commerce & Industry Ins. Co. v. Toledo*, 45 Ohio St.3d 96, 98 (1989), citing *Baltimore & Ohio Southwestern Ry. Co. v. Cox*, 66 Ohio St. 3d 276, 278 (1902).

{¶21} Certain relationships, by their very nature, impose a duty on the part of one person to act for the benefit of another. *Berdyck v. Shinde*, 66 Ohio St.3d 573, 578 (1993). The defendant's duty is imposed by law in those relationships specifically due to the "risks and

dangers inherent in the relationship.” *Id.* at 579. In other words, the law has recognized that a duty will be imposed in those relationships because there is always some foreseeability of injury. “The most frequently applied example of persons of superior knowledge and skill who are held to a standard of good practice is that of physicians.” *Id.* “The law imposes on physicians engaged in the practice of medicine a duty to employ that degree of skill, care and diligence that a physician or surgeon of the same medical specialty would employ in like circumstances.” *Id.*, citing *Bruni v. Tatsumi*, 46 Ohio St.2d 127, 130 (1976). Unless the allegations that the defendant deviated from the standard of care are obvious to a lay person, “[p]roof of the recognized standards must necessarily be provided through expert testimony.” *Bruni* at 131-132. The expert testimony establishes the standard of care. “A negligent failure to discharge that duty constitutes ‘medical malpractice’ if it proximately results in an injury to the patient.” *Berdyck* at 579, citing *Bruni* at 134-135.

{¶22} Under Ohio law, in order to present a prima facie claim of medical malpractice, a plaintiff must establish: (1) the standard of care, as generally shown through expert testimony; (2) the failure of defendant to meet the requisite standard of care; and (3) a direct causal connection between the medically negligent act and the injury sustained. *Bruni v. Tatsumi*, 46 Ohio St.2d at paragraph one of the syllabus. “[T]he duty of the physician is established simply by the existence of a physician-patient relationship, not by questions of foreseeability.” *Oiler v. Willke*, 95 Ohio App.3d 404, 409, fn.2 (4th Dist. 1994). “[P]hysicians are said to owe patients a legal duty to use recognized standards of professional knowledge and skill.” *Ryne v. Garvey*, 87 Ohio App.3d 145, 155 (2d Dist.1993). A plaintiff proves a breach of duty by showing that the physician failed to act in accordance with those established norms. *Id.* Consequently, evidence

that the physician could have foreseen the patient's injury is irrelevant because "[f]oreseeability is not determinative of a physician's legal duties." *Id.* at 154-155.

{¶23} The hospital cites *Littleton v. Good Samaritan Hosp. & Health Ctr.*, 39 Ohio St.3d 86 (1988), to support its position that foreseeability of injury was relevant to its duty in this case, but that case has no application here. Although the *Littleton* plaintiffs brought claims alleging medical malpractice, they did not allege that injuries to a patient had resulted from the quality of medical care provided by the defendant. Instead, the *Littleton* plaintiffs sought to recover for the wrongful death of a third party, who had been killed by her mother, based on the alleged negligence of the mother's psychiatrist in failing to control her actions and prevent her from harming her child. *Id.* at 91-92. The alleged duty by the psychiatrist was not to his patient, but to her daughter, with whom he had no physician-patient relationship. Foreseeability of injury was relevant in that medical malpractice case because the plaintiffs sought to establish the existence of a new duty by the treating physician, as Ohio law did not recognize a duty on the part of a psychiatrist to control the conduct of his patient to protect third parties from injury. *Id.* at 92.

{¶24} In this case, the Cromers' only allegations of medical malpractice by the hospital pertained directly to the quality of medical treatment that Seth received while a patient there. There was no question in this case that the hospital and its treating professionals owed a duty of care to Seth, that the existence of the hospital's duty was imposed by law, and that the scope of its duty would be established at trial solely through expert testimony about the applicable standard of care. The risks inherent in treating patients in the emergency room and intensive care unit of the hospital had already been taken into account in establishing the professional standard of care. The Cromers were not required to prove actual foreseeability of Seth's death

by the treating professionals in this case. Therefore, instructing the jury to that effect was an incorrect statement of law and constituted reversible error.

{¶25} We cannot conclude that this error was harmless because, although the jury also found that the Cromers failed to prove causation in this case, the jury's causation finding was not that the hospital's actions or inactions did not cause Seth's death but that the hospital's "negligence" did not cause his death. The jury indicated in its answer to the first jury interrogatory that the Cromers failed to prove that the hospital was negligent. Given that finding, it was instructed not to answer the remaining interrogatories. Nevertheless, the jury answered "No" to the third interrogatory, which asked:

Do you find that the Plaintiffs \*\*\* have proven by a preponderance of the evidence that the negligence of Defendant CHILDREN'S HOSPITAL MEDICAL CENTER OF AKRON was a direct and proximate cause of Seth Cromer's death?

{¶26} The proximate cause finding was directly tied to the jury's finding that the hospital was not negligent. The jury had no choice but to find that the hospital's negligence was not the proximate cause of Seth's death because it had already found that there was no negligence by the hospital. Consequently, we cannot conclude that the trial court's improper instruction on the hospital's standard of care did not affect the ultimate outcome in this case.

{¶27} Because the hospital's standard of care did not involve a jury question about whether the treating professionals in this case could have foreseen Seth's death due to their actions or inactions, the trial court committed reversible error by so instructing the jury. The Cromers' first assignment of error is sustained.

#### APPELLANT'S ASSIGNMENT OF ERROR II

THE JURY'S VERDICT IN THIS MATTER WAS AGAINST THE MANIFEST WEIGHT OF THE EVIDENCE.

**APPELLANT'S ASSIGNMENT OF ERROR III**

THE COURT ERRED IN FAILING TO GRANT APPELLANTS' MOTION FOR A NEW TRIAL.

{¶28} Because this Court has reversed and remanded the trial court's judgment based on the improper jury instruction, the Cromers' second and third assignments of error have been rendered moot and will not be addressed. App.R. 12(A)(1)(c).

**THE HOSPITAL'S ASSIGNMENT OF ERROR**

PLAINTIFFS' ONLY EXPERT WITNESS WAS NOT COMPETENT TO TESTIFY BECAUSE SHE DOES NOT DEVOTE AT LEAST 50% OF HER PROFESSIONAL TIME TO THE ACTIVE CLINICAL PRACTICE OF MEDICINE. HER TESTIMONY ON THE STANDARD OF CARE SHOULD HAVE BEEN STRICKEN AND A DIRECTED VERDICT IN FAVOR OF CHILDREN'S HOSPITAL SHOULD HAVE BEEN RENDERED.

{¶29} Next, because this Court reverses the trial court's judgment, it will address the hospital's assignment of error. The hospital challenges the trial court's denial of its motion to strike the testimony of the Cromers' medical expert, Dr. Margaret Parker, because she was not competent to testify. It further asserts that, without Dr. Parker's testimony, which was essential to the Cromers' claim, it would have been entitled to a directed verdict.

{¶30} The hospital objected to the testimony of Dr. Parker and, at the close of the Cromers' case, argued that she was not competent to testify pursuant to Evid.R. 601(D). Although the hospital also now challenges the qualifications Dr. Parker to testify about the field of emergency medicine, it did not raise that challenge in the trial court when it moved to disqualify her testimony and has therefore forfeited the issue on appeal. *E.g., State v. Tibbetts*, 92 Ohio St.3d 146, 161 (2001).

{¶31} Consequently, the challenge on appeal is limited to whether Dr. Parker was competent to testify as a medical expert pursuant to Evid.R. 601(D), which requires that, to be

competent to give expert testimony in this case on the issue of the hospital's liability, the expert must hold a state license to practice medicine and "devote[] at least one-half of his or her professional time to the active clinical practice in his or her field of licensure, or to its instruction in an accredited school." See also R.C. 2743.43(A)(2)(although superseded by Evid.R. 601(D), it includes the same "active clinical practice" language that has been construed by the Ohio Supreme Court); *Celmer v. Rodgers*, 114 Ohio St.3d 221, 2007-Ohio-3697, ¶ 17.

{¶32} The sole dispute here is whether Dr. Parker devoted at least half of her professional time to "active clinical practice" in her field of pediatric critical care or "instruction in an accredited school." The term "active clinical practice" is not defined in the Ohio Rules of Evidence, nor is it defined in R.C. Chapter 2743. Consequently, it has been judicially construed according to common usage, with an understanding that the purpose of this competency requirement is to preclude testimony by professional witnesses, or those who spend much of their professional time testifying against fellow professionals rather than gaining practical experience in the field they seek to judge. *McCrary v. State*, 67 Ohio St.2d 99, 103-104 (1981). The *McCrary* court further stressed that, although the phrase primarily includes the work of physicians treating their patients, it must also encompass the work done by physicians away from the patient's bedside "assisting, directing, or advising" the care provided by the treating physician, as they are also directly involved in the care of the patient and are aware of the progress and ultimate result of the treatment. *Id.* at 103. Therefore, the *McCrary* court construed the term "active clinical practice" to include "the physician-specialist whose work is so related or adjunctive to patient care as to be necessarily included in that definition for the purpose of determining fault or liability in a medical claim." *Id.* at syllabus.

{¶33} In *Celmer v. Rodgers*, 2007-Ohio-3697, ¶ 23, the Ohio Supreme Court “reiterate[d] that the purpose of Evid.R. 601(D) is to prohibit a physician who makes his living as a professional witness from testifying on the liability of physicians who devote their professional time to the treatment of patients.” Moreover, a trial court has discretion to determine whether a witness is competent as an expert under Evid.R. 601(D) and the court’s decision will not be reversed “absent a clear showing that the court abused its discretion.” *Id.* at ¶ 19.

{¶34} In this case, the hospital argues that Dr. Parker failed to satisfy the competency threshold that half of her professional time was devoted to the active clinical practice of critical care medicine. It focuses its argument on the following testimony that it elicited during its cross-examination of her:

- Q. \* \* \* [Y]ou agree with me that only 25 percent of your time is clinical care, right?
- A. Yes.
- Q. Seventy-five percent of your time is administrative care or administrative function, true?
- A. Administrative and teaching. I have some teaching responsibilities outside of the clinical arena, but, yes, pretty much.
- Q. Would you agree with me now, doctor, as you sit on the witness stand right now that less than half of your time is clinical care and teaching?
- A. Yes.

{¶35} Through her other testimony, Dr. Parker had the opportunity to explain the 75/25 percent allocation of her professional time in more detail. She testified that, like most pediatric intensive care specialists, she rotates direct patient care with other physicians assigned to the unit. Each physician is on 24-hour call in the PICU for one week and then off-call for three weeks because the round-the-clock work is “too stressful” and “too fatiguing” to maintain that

schedule every week. Because she was directly responsible for patient care in the PICU 24 hours a day during her one week on call, she testified that she worked 168 hours each month in direct patient care in the PICU. Given that she would work much shorter days during her three weeks outside the PICU, she actually devoted close to half of her professional time each month to direct patient care in the PICU. She also testified that she sometimes assisted her colleagues in the PICU during the weeks that she was not on call.

{¶36} Moreover, although the hospital suggests that Dr. Parker's "administrative" time could not qualify as active clinical practice, we do not agree. Dr. Parker explained that, during the weeks that she was not actively treating patients in the PICU, she devoted much of her professional time to oversight of intensive care treatment at the hospital. She had been the director of the PICU at Stony Brook University for seventeen years. Although she did not explain her oversight duties in detail, overseeing the work of other medical professionals in their treatment of patients involves the type of "assisting, directing, or advising," that was contemplated by the *McCrary* court as "so related or adjunctive to patient care" that it falls within the definition of "active clinical practice." 67 Ohio St.2d at 103-104.

{¶37} Dr. Parker further testified that she taught pediatrics at the university, although she did not indicate how much of her time was devoted to her teaching duties. In addition to her other professional responsibilities, Dr. Parker had been nationally recognized as a leader in the critical care field and was actively involved with scholarly publications. Dr. Parker was an associate editor of *Critical Care Magazine*, which required her to evaluate and screen peer reviews of all medical literature submitted for publication. She was also on the editorial board of *Pediatric Critical Care Magazine*. In addition to editorial responsibilities, Dr. Parker had written many of her own scholarly articles in the field of pediatric critical care medicine, particularly on

the topic of septic shock and its association with myocarditis and cardiogenic shock, which was directly related to the substance of her expert testimony in this case.

{¶38} The record demonstrates that Dr. Parker was not a professional witness but was actively involved in the clinical practice of pediatric critical care medicine. Given the evidence before the trial court about Dr. Parker's extensive experience, which was directly related to the substance of her testimony in this case, this Court cannot conclude that the trial court abused its discretion by determining that she was competent to testify as a medical expert under Evid.R. 601(D). Therefore, the hospital's assignment of error is overruled.

### III.

{¶39} The Cromers' first assignment of error is sustained, which renders moot their remaining assignments of error. Consequently, the Cromers' second and third assignments of error were not addressed. The hospital's assignment of error is overruled. The judgment of the Summit County Court of Common Pleas is reversed and remanded for a new trial.

Judgment reversed  
and cause remanded.

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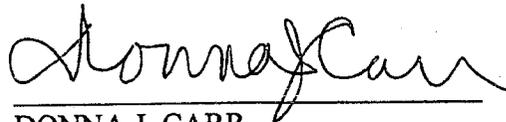
There were reasonable grounds for this appeal.

We order that a special mandate issue out of this Court, directing the Court of Common Pleas, County of Summit, State of Ohio, to carry this judgment into execution. A certified copy of this journal entry shall constitute the mandate, pursuant to App.R. 27.

Immediately upon the filing hereof, this document shall constitute the journal entry of judgment, and it shall be file stamped by the Clerk of the Court of Appeals at which time the period for review shall begin to run. App.R. 22(C). The Clerk of the Court of Appeals is

instructed to mail a notice of entry of this judgment to the parties and to make a notation of the mailing in the docket, pursuant to App.R. 30.

Costs taxed to Appellee.



\_\_\_\_\_  
DONNA J. CARR  
FOR THE COURT

DICKINSON, J.  
BELFANCE, J.  
CONCUR.

APPEARANCES:

JACK MORRISON, JR., THOMAS R. HOULIHAN, and VICKI L. DESANTIS, Attorneys at Law, for Appellant.

GREGORY R. ROSSI and GREGG A. PEUGEOT, Attorneys at Law, for Appellee.

DANIEL M. HORRIGAN

2010 JUN 24 PM 4:01

SUMMIT COUNTY  
CLERK OF COURTS

IN THE COURT OF COMMON PLEAS  
SUMMIT COUNTY, OHIO

SETH NILES CROMER, et al.,	)	CASE NO.: CV 2008 07 4775
	)	
Plaintiffs,	)	JUDGE CALLAHAN
	)	
v.	)	
	)	<u>JUDGMENT ENTRY</u>
CHILDREN'S HOSPITAL MEDICAL	)	
CENTER OF AKRON,	)	
	)	
Defendant.	)	

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This matter came before the Court for a Jury Trial on Plaintiffs' Complaint on June 16, 2010. On June 16, 2010, while on the record, Plaintiffs dismissed without prejudice Defendants John Does 1-10 and Jane Does 1-10. Additionally, on June 17, 2010, while on the record, Plaintiffs dismissed without prejudice Defendant Dr. Richard Wendorf. Further, Plaintiffs had previously dismissed without prejudice Defendants Drs. Richard Dom Dera and Kelli Sabin and Ohio Family Practice Centers, Inc. on October 10, 2008 and Defendant Dr. Tsun-Hsin-Lin on January 28, 2009.

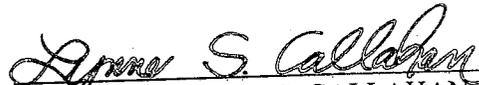
The Jury Trial proceeded solely on Plaintiffs' claims against Defendant Children's Hospital Medical Center of Akron. The Jury was sworn and impaneled on June 16, 2010. The Jury returned a general verdict on June 24, 2010, in favor of Defendant Children's Hospital Medical Center of Akron.

The Jury having returned its verdict in favor of Defendant Children's Hospital Medical Center of Akron on all counts of Plaintiffs' Complaint, the Court hereby adopts the verdict of the Jury and finds the issues in this case in favor of Defendant Children's Hospital Medical Center of Akron.

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that judgment is rendered in favor of Defendant Children's Hospital Medical Center of Akron and against the Plaintiffs the estate of Seth Cromer, and his parents, Roderick Cromer, Jr. and Melinda Cromer. Costs taxed to Plaintiffs.

Pursuant to Civ.R. 54(B), there is no just reason for delay.

IT IS SO ORDERED.

  
JUDGE LYNNE S. CALLAHAN

cc: Attorneys Vicki DeSantis / Jack Morrison, Jr.  
Attorneys Gregory T. Rossi / Gregg A. Peugeot

DANIEL M. HARRIGAN

2010 SEP 24 AM 11:50

SUMMIT COUNTY  
CLERK OF COURTS

IN THE COURT OF COMMON PLEAS  
SUMMIT COUNTY, OHIO

122

SETH NILES CROMER, et al.,

Plaintiffs,

v.

CHILDREN'S HOSPITAL MEDICAL  
CENTER OF AKRON, et al.,

Defendants.

) CASE NO.: CV 2008 07 4775

)

) JUDGE CALLAHAN

)

)

) ORDER

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This matter is before the Court upon Plaintiffs' Motion for New Trial filed on July 6, 2010. Defendant Children's Hospital Medical Center of Akron filed a brief in opposition on July 13, 2010. Upon leave of Court, Plaintiffs filed a reply brief on August 3, 2010. The Court deems all matters submitted. Upon consideration of the three grounds set forth by Plaintiffs, the briefs, and the trial testimony, the Court finds Plaintiffs have not shown good cause for a new trial. Plaintiffs' Motion for New Trial is DENIED.

1. Manifest Weight of the Evidence

When a trial court reviews a motion for new trial based on the sufficiency of the evidence, it must weigh the evidence and pass on the credibility of the witnesses. *Jones v. Olcese* (1991), 75 Ohio App.3d 34, 37. The trial court's weighing of the evidence is different from the jury's weighing of the evidence in that the trial court only determines "whether manifest injustice has been done and whether the verdict is \*\*\* manifestly against the weight of the evidence." *Id.* The court, however, may not set aside a verdict on the weight of the

evidence due to a difference of opinion between it and the jury. *Id.* citing, *Poske v. Mergl* (1959), 169 Ohio St. 70, 73-4.

Plaintiffs first argue that the jury lost its way by not finding negligence against the manifest weight of the evidence as to Defendant's administration of the "wrong" IV fluids to Seth Cromer. Civ.R. 59(A)(6). Plaintiffs ask the Court to weigh the evidence regarding whether the Defendant giving Seth Cromer D5 ½ Normal Saline was a breach of the standard of care. Plaintiffs assert that three of the hospital's employees and its expert, Dr. Kennedy, all admitted it was a departure from the standard of care to give Seth Cromer the wrong IV fluids. Plaintiffs then make the leap that Defendant conceded to this being negligence by their decision to not put forth testimony to the contrary. According to Plaintiffs, the jury lost its way by not finding negligence despite the Defendant's "admission" of negligence.

Defendant points out that at no time during the six days of testimony did any of its employees or experts "admit" negligence in hanging the D5 ½ Normal Saline. The Court agrees. Defendant did not concede negligence. Instead, it conceded to the use of an alternative medicine, which was not the optimal option. The ER nurses and Dr. Luxmore testified that Seth Cromer received D5 ½ Normal Saline. While they conceded this was not the optimal fluid to administer to Seth Cromer, it was not a deviation from the standard of care to give it to him. Further, Defendant's expert, Dr. Kennedy, confirmed the ER nurses and Dr. Luxmore's opinions through his own testimony that D5 ½ Normal Saline is the second fluid he prescribes to a patient experiencing shock. Moreover, Plaintiffs' own expert, Dr. Parker, conceded that the D5 ½ Normal Saline was not the cause of Seth Cromer's death.

In weighing the evidence, the Court finds that there was substantial evidence presented at trial by Defendant that the administration of the D5 ½ Normal Saline to Seth Cromer was not a deviation from the standard of care. Further, the record contained competent and credible evidence supporting the Defendant's defense. Upon weighing the evidence, the Court does not find that a manifest injustice has occurred or that the jury's verdict is against the manifest weight of the evidence.

2. **Inconsistent Interrogatory Answers**

Plaintiffs seek a new trial based upon the jury's inconsistent answers to Interrogatory Nos. 1 and 3. Plaintiffs argue that the jury misunderstood the jury instructions when it answered Interrogatory No. 1 regarding negligence in the negative and then went on to answer Interrogatory No. 3 regarding proximate cause also in the negative. It is Plaintiffs' position that these inconsistencies rise to the level of irregularity in court proceedings and errors of law to justify a new trial. Civ.R. 59(A)(1) and (9).

Defendant correctly notes that the jury's answers to Interrogatory Nos. 1 and 3 were not inconsistent. From the face of the Interrogatories, it is clear that the jury did not follow the instructions on the bottom of the page on how to proceed. This simply was a failure of the jury to follow unambiguous instructions.

The answering of both interrogatories, however, does not automatically equate to the interrogatory answers being inconsistent. The jury found that the Defendant was not negligent (Interrogatory No. 1) and that the Defendant did not proximately cause Seth Cromer's death (Interrogatory No. 3). While it was not necessary for the jury to go to the second issue, the jury was consistent in its findings on the issue of negligence and proximate cause. Further, the jury's

findings under both of these interrogatories are consistent with their general verdict for Defendant. Accordingly, there was no irregularity in the proceedings or error of law by the jury answering both interrogatories.

3. **Irregularities and Errors in the Jury Instructions**

Lastly, Plaintiffs assert that there were irregularities in the proceedings and error of law by the inclusion of jury instructions for physician specialist and different methods. Civ.R. 59(A)(1) and (9). Plaintiffs claim the inclusion of these unnecessary instructions improperly influenced the jury's consideration on the issue of negligence.

It is Plaintiffs' position that the physician specialist instruction was inappropriate because Drs. Luxmore and Wendorf, while board-certified in specific fields, were treating a basis case of dehydration and shock and not utilizing any of their specialty training and expertise. Defendant counters that Drs. Luxmore and Wendorf were practicing within their specialties when they treated Seth Cromer.

It is important to note that Mr. and Mrs. Cromer took their five-year old son, Seth, to the emergency room of Defendant's medical facility, which specializes in the treatment of children. While Seth Cromer's initial presentation to the emergency appeared to be for basic dehydration and shock, his condition worsened while in the emergency room and the PICU unit, ultimately leading to his unfortunate death. Seth Cromer's presentation at the emergency room of Children's Hospital, subsequent treatment and extraordinary measures taken to save his life, all necessitated the use of Dr. Luxmore's specialized training in pediatric emergency medicine and Dr. Wendorf's specialized training in pediatric critical care medicine. Therefore, the physician specialist jury instruction was properly given to the jury.

As for the different methods instruction, Plaintiffs allege that Defendant interjected a red herring and confused the jury as to what the true issue of negligence was in this matter. Plaintiffs attempt to clarify the negligence issue post-trial in their Reply brief as being a delay in intubating Seth Cromer and not the order of which Defendant placed an arterial line and intubated Seth Cromer.

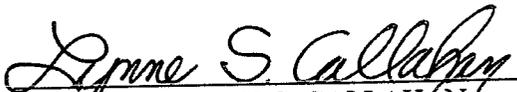
Plaintiffs' attempt to limit and / or narrow the negligence issues post-trial is untimely. Throughout the six-day trial Plaintiffs put forth a multitude of criticisms of Defendant's actions and had a laundry list of theories as to how and why Seth Cromer died. Accordingly, the different methods jury instruction was warranted based on Plaintiffs' presentation of the issues at trial.

Based on the evidence produced at trial, the physician specialist and different methods jury instructions were appropriately given to the jury. Further, both of these instructions were taken directly from the Ohio Jury Instructions and are correct statements of law to be applied in this case. Thus, no irregularity in the proceedings or errors of law occurred by the reading of these jury instructions.

4. Conclusion

Based upon the foregoing, Plaintiffs' Motion for New Trial is DENIED.

IT IS SO ORDERED.

  
JUDGE LYNNE S. CALLAHAN

cc: Attorneys Jack Morrison, Jr. / Vicki L. DeSantis  
Attorneys Gregory T. Rossi / Gregg A. Peugeot