[Cite as *Gordon v. Ohio State Univ.*, 2011-Ohio-5057.]

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Robert Gordon, Individually and as Administrator of the Estate of Lola McKinney et al.,	:	
Plaintiffs-Appellants,	:	No. 10AP-1058 (C.C. No. 2007-03471)
v.	:	(REGULAR CALENDAR)
Ohio State University et al.,	:	
Defendants-Appellees.	:	

D E C I S I O N

Rendered on September 30, 2011

Roger D. Staton, for appellants.

Michael DeWine, Attorney General, and *Jeffrey L. Maloon*, for appellee, The Ohio State University Medical Center.

Michael DeWine, Attorney General, and *Anne Strait*, for appellee, Ohio Department of Rehabilitation and Correction.

APPEAL from the Court of Claims of Ohio.

SADLER, J.

{¶1} Plaintiffs-appellants, Robert Gordon, individually and as administrator of the estate of Lola McKinney ("McKinney"), along with Heather McKinney and J.M. McKinney, Lola McKinney's children, appeal from the judgment of the Court of Claims of Ohio in

favor of defendants-appellees, Ohio State University Medical Center ("OSUMC") and Ohio Department of Rehabilitation and Correction ("ODRC"), on appellants' claims for medical malpractice, wrongful death, and loss of consortium. For the following reasons, we affirm.

{¶2} On October 18, 2005, McKinney began serving a prison sentence at the Ohio Reformatory for Women ("ORW") in Marysville. McKinney was 39 years old and suffered from end stage renal disease, hypertension, and a seizure disorder. McKinney's renal disease required her to undergo dialysis three times per week, and she did so for several years prior to her incarceration. While McKinney was in prison, ORW transported her to Frazier Health Center ("FHC")[1] for dialysis every Monday, Wednesday, and Friday.

{¶3} On November 6, 2005, McKinney experienced dizziness and fell twice at ORW, striking her head, right shoulder, arm, and wrist. On Monday, November 7, 2005, ORW transported McKinney to the emergency department at Union Memorial Hospital ("UMH") for evaluation. As a result, McKinney missed her regularly scheduled dialysis appointment at FHC.

{¶4} Dr. Matthew Sanders, the attending physician in the UMH emergency department, examined McKinney. McKinney informed Dr. Sanders she had fallen at ORW, but denied she had experienced any seizure activity preceding her falls. She further reported that she suffered from chronic renal failure requiring thrice-weekly dialysis and that she had missed her scheduled dialysis that day.

[1] Frazier Health Center is part of the Pickaway County Correctional Institution.

{¶5} Dr. Sanders ordered a CT scan of McKinney's head, x-rays, an EKG, and blood tests. The CT scan and x-rays produced no significant findings. However, a blood sample drawn at approximately 11:00 a.m. revealed an elevated[2] level of potassium in McKinney's blood serum, 7.4, a condition known as hyperkalemia. In addition, the EKG depicted abnormal T-waves, which indicated that McKinney's cardiac rhythm was adversely affected by her elevated blood serum potassium. Between 12:15 p.m. and 12:22 p.m., Dr. Sanders administered several medications, including albuterol, calcium gluconate, insulin, and sodium bicarbonate, to temporarily lower the elevated blood serum potassium.[3] A second EKG, performed at 1:00 p.m., revealed slightly less irregular T-waves.

{¶6} Dr. Sanders subsequently arranged to transfer McKinney to OSUMC under the care of Dr. Thomas Gavin, the attending physician in the OSUMC emergency department. Dr. Sanders testified that he spoke directly to Dr. Gavin to effectuate the transfer; however, he could not recall the specifics of the conversation. According to Dr. Sanders, he requested that the secretary or unit clerk send McKinney's medical chart, together with the results of her laboratory tests, to OSUMC and he assumed such was accomplished. The UMH transfer sheet, signed by Dr. Sanders, indicates that the purpose of the transfer was "further workup of [McKinney's] medical problems and possible dialysis." (Plaintiffs' Exhibit 5 at 20.) Dr. Sanders' emergency department report

[2] Dr. Sanders testified that the UMH laboratory defines a "normal" blood serum potassium level as 3.5 to 5.0. He further testified that patients with chronic renal disease often demonstrate elevated blood serum potassium.

[3] According to Dr. Sanders, these medications temporarily mobilize potassium from the blood serum to the surrounding cells. High levels of potassium in the blood serum can potentially cause life-threatening cardiac problems.

containing the pertinent information regarding McKinney's condition and treatment was not dictated or transcribed until after 6:00 p.m. on November 7.

{¶7} McKinney arrived at the OSUMC emergency room at approximately 2:13 p.m. on November 7. Dr. Gavin recalled the reason for McKinney's transfer as "possible elevated potassium," "reportedly treated," and "possibly needing dialysis." (Tr. 43, 64.) According to Dr. Gavin, he did not receive McKinney's medical records from UMH, nor was he made aware of McKinney's specific blood serum potassium level. He did not recall speaking with Dr. Sanders and did not know what, if any, medications Dr. Sanders had administered to McKinney.

{¶8} Dr. Gavin ordered a CT scan of McKinney's head. Because her blood serum potassium level was in question, he also ordered an EKG and blood work. McKinney's blood was drawn at 4:00 p.m., some four hours after McKinney's treatment at UMH. The blood test revealed that McKinney's blood serum potassium level was at 5.3,[4] and the EKG revealed no abnormality in the T-waves.

{¶9} According to Dr. Gavin, medications used to treat hyperkalemia are temporizing measures that remain effective for only one or two hours. He testified that had McKinney's blood serum potassium level been "truly elevated" at UMH, the temporizing effects of the medications would have worn off by 4:00 p.m. and her blood serum potassium level would have again been elevated. (Tr. 69.) Dr. Gavin also suggested that since McKinney's blood serum potassium level was at 5.3 approximately

[4] Dr. Gavin testified that a blood serum potassium level of 5.3 is "minimally elevated" but is not uncommon for dialysis patients. (Tr. 48, 51.)

four hours after the medications had allegedly been administered, it may "never really [have been] drastically elevated." (Tr. 69.)

{¶10} Dr. Gavin testified that McKinney did not meet the criteria for emergency dialysis because her blood serum potassium level was 5.3, which is in the normal range for a patient with end stage renal disease. Accordingly, he decided to transfer McKinney back to the custody of ODRC at its Corrections Medical Center ("CMC") to obtain dialysis the next day. Dr. Gavin did not feel that McKinney was a candidate for emergency dialysis because "[b]ased on her presentation, her potassium was essentially within normal range for a dialysis patient. She did not appear to be fluid overloaded. I don't recall her being acidotic. We felt she did not meet the need for dialysis. We felt we had time to get her dialyzed." (Tr. 58.)

{¶11} Dr. Gavin did not personally contact CMC. Rather, that task was performed by one of the OSUMC residents, Dr. William Jenkins. However, Dr. Gavin understood that McKinney "would be monitored [at CMC] to be sure the potassium was okay," and that CMC "would arrange for dialysis for her also." (Tr. 72.) Dr. Gavin stated that, pursuant to OSUMC protocol, Dr. Jenkins would have spoken directly to the physician at CMC and informed him or her of the specifics of McKinney's case. According to Dr. Gavin, this direct physician-to-physician communication allowed the CMC physician to assess whether CMC could manage McKinney's treatment and obviated the need for written orders. Dr. Gavin testified that the CMC physician could have refused to accept McKinney had he or she determined that CMC could not successfully manage McKinney's care.

{¶12} Dr. Jenkins, then a second-year resident in the OSUMC emergency room, testified that McKinney presented to OSUMC with elevated blood serum potassium levels. At the time, he was unaware that she had been transferred from UMH or that she had received any medications prior to her arrival at OSUMC. According to Dr. Jenkins, McKinney's blood serum potassium was monitored and an EKG was performed. Based on the results of those tests, Dr. Gavin determined that McKinney was not a candidate for emergency dialysis and could be transferred to CMC.

{¶13} Dr. Jenkins initiated the physician-to-physician call to CMC and prepared the transfer certificate for McKinney's move to CMC. He personally spoke to the on-call physician at CMC and reported the results of the blood test and EKG and noted that neither showed any abnormalities. He further reported that McKinney appeared to be stable but needed dialysis the next day. He could not recall whether he advised the CMC physician that McKinney required cardiac monitoring. He did not report that McKinney had a 7.4 potassium reading at UMH or provide documentation to that effect because OSUMC did not have the UMH records at the time he made the call. According to Dr. Jenkins, the CMC physician agreed to accept McKinney as a patient. He could not recall whether the CMC physician specifically stated that CMC would provide dialysis.

{¶14} The OSUMC transfer certificate, prepared at 5:26 p.m., states that the reason for the transfer was "hyperkalemia requiring dialysis, missed dialysis appointment today." (Plaintiff's Exhibit 2 at 146.) Dr. Jenkins testified that he "assumed" that McKinney's history of hyperkalemia and dialysis requirement would prompt CMC to follow up with repeat blood tests and cardiac monitoring and provide dialysis. (Tr. 122.) He admitted, however, that he did not specify those requirements on the transfer certificate.

He also admitted that he did not know whether CMC had the capability of providing further blood testing or cardiac monitoring. He averred, however, that he had provided the CMC physician with enough information regarding McKinney's condition to allow the physician to refuse the transfer if the physician felt that CMC could not provide McKinney with appropriate care.

{¶15} Dr. Martin Akusoba, CMC's chief medical officer, testified that CMC is not an acute care hospital; rather, it is a skilled nursing facility that provides step-down care for inmate patients who have been released from OSUMC. Dr. Akusoba testified that CMC does not provide dialysis, does not have a 24-hour laboratory, and does not have the type of telemetry equipment required to continuously monitor cardiac activity. Further, because CMC does not have acute care capabilities, it relies on OSUMC to transfer patients to CMC only when the patient is medically ready for the level of care CMC is able to provide. According to Dr. Akusoba, OSUMC physicians are aware that CMC is not an acute care facility.

{¶16} Dr. Akusoba testified that McKinney was sent to CMC because she was hyperkalemic, had end-stage renal disease, and had missed her regularly scheduled dialysis appointment that day. According to Dr. Akusoba, CMC was to observe McKinney throughout the evening and transport her to FHC for dialysis the next day. He stated that there was no need for CMC to obtain another blood serum potassium check of McKinney because the test run by OSUMC shortly before the transfer showed a 5.3 potassium level and she was scheduled for dialysis the next day.

{¶17} Dr. Nneka Ezeneke, the CMC physician who received the call from Dr. Jenkins, testified that she was advised that McKinney was an ORW inmate who had been

sent to OSUMC with hyperkalemia, that she had been treated and stabilized, and that she was being transferred to CMC for dialysis the next day. According to Dr. Ezeneke, the OSUMC physician did not inform her that McKinney would need further blood tests or continuous cardiac monitoring. Indeed, she would not have accepted the transfer under those conditions because CMC did not have the facilities to perform such functions. Dr. Ezeneke further averred that she did not receive all of the details regarding McKinney's prior treatment and test results when she accepted the transfer.

{¶18} McKinney arrived at CMC at approximately 6:45 p.m. The CMC intake note states that she was "[s]cheduled for dialysis in A.M." (Plaintiffs' Exhibit 2 at 152.) The first physician order at 7:15 p.m. states "admit to CMC, [diagnosis] hyperkalemia." (Plaintiffs' Exhibit 2 at 156.) The CMC medical admission record denotes McKinney's diagnosis was "hyperkalemia requiring dialysis." (Plaintiffs' Exhibit 2 at 151.)

{¶19} CMC's medical records indicate that McKinney was checked frequently by the nursing staff during the night and her vital signs were monitored. The record is unclear as to when, or if, McKinney was scheduled for transport to FHC, particularly because November 8 was a Tuesday and not her regularly scheduled dialysis day. There is no dispute, however, that McKinney was not taken to dialysis with the first group of patients on the morning of November 8.

{¶20} A CMC physician examined McKinney at approximately 10:00 a.m. on November 8. The physician noted that McKinney was alert and denied having any chest pain, shortness of breath or abdominal pain. At approximately 11:17 a.m., McKinney was found unconscious, cyanotic, and without a pulse. Resuscitation efforts were commenced immediately and a "code blue" was called at 11:19 a.m. Within two minutes,

at 11:21 a.m., a normal cardiac rhythm was restored. McKinney was given numerous drugs to increase blood pressure and maintain a heartbeat. She was transported back to OSUMC. McKinney's blood serum potassium level at approximately 1:00 p.m. on November 8 was 7.6, and she was thereafter treated with dialysis. McKinney never regained consciousness and died on November 14, 2005.

{¶21} The death certificate prepared by an OSUMC physician at the time of McKinney's death attributed the cause of death to "multi-system organ failure (hepatic, renal, respiratory)" due to "shock." (Plaintiffs' Exhibit 1 at Tab 7.) On November 14, the Franklin County Coroner's office conducted an abbreviated autopsy, which involved an external examination of the body, a toxicology study, and a review of McKinney's medical records. The coroner's report noted that McKinney's blood serum potassium, taken from the vitreous fluid in the eyeball, was 9.8. The coroner listed the cause of death as "[c]ardiovascular collapse due to acute cardiac arrhythmia (ventricular fibrillation or asystole) due to hyperkalemia due to chronic renal failure." The report also listed "[h]ypertensive cardiovascular disease" and "seizure disorder" as "[o]ther significant circumstances." (Plaintiffs' Exhibit 3.)

{¶22} On March 26, 2007, appellants filed a complaint against appellees asserting claims for wrongful death, medical malpractice, and loss of consortium. The trial court bifurcated the issues of liability and damages. Appellants' motion for summary judgment on the issue of liability was denied on July 2, 2008. Thereafter, the liability portion of the case proceeded to trial on September 22, 2008.

{¶23} In general, appellants' theory of the case against OSUMC was that Drs. Gavin and Jenkins were aware, or should have been aware, that McKinney's blood serum

potassium level at UMH was 7.4, that she had been given medications that would only temporarily lower that level, that her blood serum potassium would rise to life-threatening levels once those medications wore off, and that she was in need of emergency dialysis. Appellants contended that Drs. Gavin and Jenkins misconstrued the significance of both McKinney's 5.3 potassium level and the T-wave reading taken at OSUMC, and that their negligent care of her proximately caused her death.

{¶24} As to ODRC, appellants theorized that the medical staff at CMC was negligent in failing to obtain adequate information about McKinney's medical condition before accepting her as a transfer patient, in failing to monitor her blood serum potassium level and cardiac condition, and in failing to transport her to FHC for dialysis on the morning of November 8. Appellants maintained that ODRC's negligence was also a proximate cause of McKinney's death.[5]

{¶25} In support of their claims, appellants presented two expert witnesses via telephone deposition testimony: Dr. James E. Wood, III, a nephrologist employed by Southeast Renal Associates in Charlotte, North Carolina, and Dr. Joseph R. Yates, an emergency room physician at West Marion Community Hospital in Ocala, Florida.

{¶26} Dr. Wood was initially deposed on September 2, 2008. Dr. Wood opined that OSUMC's treatment of McKinney's hyperkalemia fell below the established standard of care in that it was inappropriate to discharge her to the care of CMC on November 7 without having provided her with dialysis. More specifically, Dr. Wood opined that Dr.

[5] Appellants did not allege that ORW's care and treatment of McKinney breached any standards of care.

Gavin deviated from the standard of care in interpreting the 5.3 blood serum potassium reading as an indication that McKinney did not need dialysis that day.

{¶27} Dr. Wood testified that the temporizing effects of the medications administered at UMH lasted four to six hours, which accounted for the 5.3 reading at 4:00 p.m.; however, by the end of that four-to-six hour period, McKinney's potassium level would have risen to at least 7.4, putting her at risk for cardiac arrhythmias that could lead to cardiac arrest. He further testified that an end stage renal disease patient with a 7.4 potassium level does not have the physical capability of reducing the level to 5.3 without the aid of medications; as such, the 5.3 level registered at 4:00 p.m. resulted solely from the medications. Dr. Wood opined that McKinney was a candidate for dialysis at the time she arrived at OSUMC, and, as such, OSUMC should have provided McKinney with dialysis at the "soonest possible time." Wood Deposition 31 (hereinafter "Wood Depo. __").

{¶28} Dr. Wood further opined that Dr. Gavin could have, and should have, obtained all of McKinney's records from UMH regarding her hyperkalemia, including her blood serum potassium level, the results of the EKG, and what medications UMH administered, and that his failure to do so constituted a deviation from the accepted standard of care. He further opined that had Dr. Gavin properly obtained this information, the accepted standard of care required that McKinney be provided dialysis "[a]s soon as possible," and, at the very latest, within six hours of the 12:20 p.m. administration of medications at UMH. Wood Depo. 43.

{¶29} With respect to ODRC, Dr. Wood opined that CMC breached the standard of care in failing to monitor McKinney's cardiac activity and blood serum potassium levels and in failing to schedule her for dialysis early in the morning on November 8.

{¶30} In addition, Dr. Wood opined that McKinney's cause of death was cardiac arrest resulting from hyperkalemia, and that there were no secondary causes of the cardiac arrest. He further opined that McKinney's cardiac arrest and subsequent death were directly and proximately caused by OSUMC's and ODRC's deviation from acceptable standards of care.

{¶31} Appellants' other expert, Dr. Yates, opined that McKinney was a candidate for dialysis at the time she was transferred from UMH to OSUMC because the medications administered at UMH only temporarily lowered her blood serum potassium level. Accordingly, OSUMC should have either dialyzed her within four to six hours of her arrival at OSUMC or more closely monitored both her cardiac activity and her blood serum potassium levels. Dr. Yates further averred that the 5.3 blood serum potassium reading at 4:00 p.m. resulted solely from the medications. He opined that OSUMC should have followed up with additional blood serum potassium testing and that the failure to do so constituted a deviation from the acceptable standard of care. Dr. Yates also agreed with Dr. Wood that Dr. Gavin's failure to obtain all relevant information regarding the care McKinney received at UMH, including her blood serum potassium level and what medications were administered, constituted a deviation from the accepted standard of care.

{¶32} Dr. Yates further opined that it was OSUMC's responsibility to ensure that instructions were communicated to CMC that McKinney be placed in a high priority so

that "[d]efinitive treatment of her hyperkalemia" would occur within a "reasonable time." Yates Deposition 85 (hereinafter "Yates Depo. __"). Dr. Yates defined "definitive treatment" as either dialysis or administration of medications to help the body excrete potassium. Yates Depo. 85. He defined "reasonable time" as the next morning, provided that her cardiac condition and potassium levels were monitored throughout the night. Dr. Yates opined that OSUMC's transfer of McKinney to a facility that was incapable of monitoring her and dialyzing her if her condition deteriorated violated accepted standards of care.

{¶33} Like Dr. Wood, Dr. Yates opined that McKinney's cause of death was cardiac arrest caused by hyperkalemia. When asked the basis for his opinion, he averred: "[t]here's no other real obvious explanation for why she would have that arrest, * * * her autopsy potassium and her body tissues was 9.8, [and] she had a potassium in excess of seven on arrival to the hospital." Yates Depo. 70. Dr. Yates opined that had McKinney received dialysis sometime before 11:00 a.m. on November 8, she would not have suffered the cardiac arrest that resulted in her death.

{¶34} Dr. Yates admitted, however, that patients with end stage renal disease are susceptible to electrolyte disturbances that cause dysrhythmias and weakened cardiac muscles. Dr. Yates also admitted that the coroner's conclusion that hyperkalemia was the cause of McKinney's cardiac arrest significantly influenced his own findings as to the cause of McKinney's cardiac arrest. Indeed, Dr. Yates testified that "if I didn't have the autopsy, I would have to put other things on the differential diagnosis, including obstruction of the coronary vessels and a heart attack." Yates Depo. 72. He further

stated, "[t]he pathologist felt like the arrhythmia was due to the hyperkalemia, so if I include the autopsy, then it narrows my differential quite a bit." Yates Depo. 73.

{¶35} In response to appellants' experts, OSUMC presented the videotaped deposition testimony of Dr. Michael E. Yaffe, an internal medicine physician employed by the OhioHealth McConnell Heart Health Center in Columbus, Ohio. Dr. Yaffe opined that the care and treatment provided to McKinney by OSUMC was proper and reasonable, and that such treatment was within established standards of care. Specifically, Dr. Yaffe opined that based on the 5.3 blood serum potassium level and normal EKG obtained at OSUMC, OSUMC did not fall below the standard of care in transferring McKinney to CMC rather than admitting her for dialysis at OSUMC on November 7 because McKinney did not meet the criteria for acute in-hospital dialysis. Dr. Yaffe explained the basis for his opinion as follows: "this is a woman who has chronic kidney failure, chronic kidney disease, and was being treated with dialysis, and she had missed dialysis that day. People with chronic renal failure on dialysis tolerate these electrolyte changes certainly much better than someone who has an acute change in their electrolyte balance. So the hyperkalemia that was identified would have been far better tolerated in the patient with chronic renal disease than one who didn't have chronic renal disease. * * * [S]he did not meet the criteria for acute dialysis. She wasn't in heart failure. She didn't have overwhelming metabolic acidosis. She didn't have overwhelming signs of pericarditis or other disturbances requiring acute dialysis. Therefore, delaying the dialysis to the next day after her potassium was re-measured and was found to be acceptable at 5.3, and in measuring her electrocardiogram as a mark of physiologic change of hyperkalemia, showing no T-wave abnormalities of hyperkalemia, that further supported that it was

acceptable to return this patient to the dialysis center where she is known and has her [usual] dialysis." Yaffe Deposition 28 (hereinafter "Yaffe Depo. __"). Dr. Yaffe further noted that at the time McKinney was transferred from OSUMC to CMC, she exhibited no signs of respiratory distress, which indicated that she did not require acute dialysis at OSUMC.

{¶36} Dr. Yaffe further stated that the effect of the medications administered to McKinney at UMH would have run their course by mid-afternoon. Accordingly, the 5.3 blood serum potassium reading at 4:00 p.m. did not reflect the effect of the medications; rather, it more likely reflected her current balance of potassium.

{¶37} As to the cause of McKinney's death, Dr. Yaffe testified that he was "unable to conclude that the cardiac arrest that occurred on the morning of November 8th was directly and proximately related to hyperkalemia." Yaffe Depo. 42. Dr. Yaffe explained his opinion as follows: "I have reason to believe that this patient's potassium problem had been mitigated and was under control on the night before, as evidenced by the blood test obtained with a potassium of 5.3, and the normal electrocardiogram that was obtained at OSU. So, * * * the facts are, entering into this next morning, the potassium count was under control. * * * [T]his woman has a number of co-morbid medical conditions, including heart disease with left ventricular hypertrophy, history of hypertension, past elicit drug use, including cocaine, diabetes. She had been a smoker, and therefore, other causes for an abrupt cardiac arrest as a primary cardiac arrhythmia, a cardiac arrhythmia related to heart disease, a possible myocardial infarction, all enter into the realm of possibilities, with none of these conditions reaching a greater than 51 percent probability, in my estimation." Yaffe Depo. 42-43. Dr. Yaffe noted that the coroner conducted only an

external examination of McKinney's body, which necessarily did not include an examination of McKinney's coronary arteries or heart.

{¶38} Dr. Yaffe further testified that the fact that McKinney's cardiac rhythm was restored within two minutes after resuscitation was begun supported his theory that the cause of her cardiac arrest was not due to hyperkalemia. According to Dr. Yaffe, had McKinney's cardiac arrest been caused by hyperkalemia, a normal cardiac rhythm could not have been restored within two minutes without the provision of either electrical shock or medication. Dr. Yaffe stated it was more likely that she suffered a primary cardiac arrhythmia unrelated to the hyperkalemia.

{¶39} Dr. Yaffe further stated that the blood serum potassium reading of 7.6 taken at OSUMC shortly after McKinney's cardiac arrest did not aid in determining what her blood serum potassium level would have been at the time of the cardiac arrest. He explained that the physiologic effect of McKinney's cardiac arrest would have raised the level of blood serum potassium; in addition, compressions of the chest during resuscitative efforts could have damaged muscle cells, resulting in a release of potassium. Dr. Yaffe also asserted that the coroner's finding of a 9.8 potassium level in the vitreous fluid of the eyeball had no bearing on the determination as to what her potassium level was immediately preceding her cardiac arrest.

{¶40} Regarding the allegations against CMC, ODRC presented the videotaped deposition testimony of Dr. Todd R. Wilcox, a board-certified urgent care physician and medical director of the Salt Lake County jail system in Salt Lake City, Utah. Dr. Wilcox opined that it was within established standards of care for CMC to accept McKinney as a transfer patient from OSUMC. Dr. Wilcox explained that the "transfer was done in

accordance with the rules for transferring patients. It was a physician to physician discussion. The treatment plan was laid out. The physician at the receiving facility was comfortable with the treatment plan and felt that they could meet the treatment plan goals, and there wasn't anything that was coercive about the treatment plan. There was no evidence of any sort of dumping of the patient." Wilcox Deposition 28 (hereinafter "Wilcox Depo. __").

{¶41} Dr. Wilcox specifically noted that the transfer instructions from OSUMC indicated that Dr. Jenkins had discussed McKinney's treatment plan with Dr. Ezeneke, including the fact that McKinney needed to receive dialysis the next day. Dr. Wilcox further noted that the transfer instructions indicated that McKinney's blood serum potassium level was 5.3 and the EKG exhibited no T-wave abnormalities. Dr. Wilcox testified that "we have to remember what everybody's role is here, [CMC is] a primary caregiver, and they are relying upon the specialists at the hospital to assist them with specialty care. So when you send a patient out, and they are evaluated by the hospital, you receive back the specialty recommendations from their wealth of physicians at the hospital who have collectively come up with a plan for the care of your patient. And so when you get a call from those physicians with the plan laid out - - and to be honest, this is the nicest discharge plan I have ever had. I wish they did this kind of discharge plan for my facility, because you rarely get that level of communication about a patient. And so this was done in an exemplary fashion with regard to the mechanics of the transfer." Wilcox Depo. 31-32. He continued: "[s]o when you have the physicians and the team at the hospital making the recommendation that the patient is safe to come back overnight and the dialysis can occur tomorrow, there is no reason in the world you would question

them, especially with the specifics of the case that were communicated that the potassium has decreased, * * * the peaked T waves have disappeared, and from really the workup standpoint, that is the management of the hyperkalemia." Wilcox Depo. 32. Dr. Wilcox further noted that OSUMC's transfer instructions did not indicate that McKinney should be provided continuous cardiac monitoring or repeat blood serum potassium tests.

{¶42} Dr. Wilcox also opined that there was no deviation from established standards of care in transferring McKinney from OSUMC to CMC without her first receiving dialysis. Dr. Wilcox stated that "given the circumstances at the time of her transfer and the knowledge that was obtained as part of that decision making process, the transfer was within medical guidelines, and she didn't at that point have any evidence that she needed to be d[i]alyzed imminently." Wilcox Depo. 29.

{¶43} In addition, Dr. Wilcox opined that CMC did not fall below the standard of care in failing to check McKinney's blood serum potassium levels. According to Dr. Wilcox, "it's not typical of a correctional facility to have the ability to check that, particularly after hours, and if there had been an indication as that being part of the discharge plan, then that would be something that would need to be scheduled and taken care of with the staff that received her at the facility. However, because she was scheduled to go to dialysis first in the morning, * * * the typical practice in dialysis is to draw labs prior to the dialysis, and then to create the dialysis plan based on those lab results, and then to draw labs afterwards to look at the impact of the dialysis. And so typically in a correctional facility, and in most health care facilities even, if you know the patient if being d[i]alyzed,

you don't run labs a few hours before that because you know they are going to draw labs at dialysis." Wilcox Depo. 100-01.

{¶44} With regard to whether CMC fell below the standard of care in failing to transport McKinney for dialysis early in the morning on November 8, Dr. Wilcox testified that he could not offer an opinion without having additional information. More specifically, Dr. Wilcox stated that "any time you're doing dialysis and any time you're having patient transports * * * there's a lot of coordination that has to occur. You have to schedule that with custody staff. There may be some barriers to care that would prevent that from happening. You don't just instantaneously order dialysis on a patient. You have to schedule and arrange that, and I don't know the circumstances that went into getting that done, but I know that, from working in a correctional facility, instantaneous outside appointments like that just don't happen." Wilcox Depo. 44. He further noted that the OSUMC transfer instructions indicated only that McKinney needed to be dialyzed the next day, and that no specific timeframe was identified.

{¶45} When asked to render an opinion as to the cause of McKinney's cardiac arrest, Dr. Wilcox testified that there was not "sufficient evidence in this medical record to make a call on the cause of her cardiac event." Wilcox Depo. 36. Dr. Wilcox noted that the medical records provided no indication that would lead to the conclusion that McKinney was imminently in danger of cardiac arrest. Indeed, Dr. Wilcox noted that a CMC physician examined McKinney at 10:00 a.m. on November 8 and found that she was not in acute distress requiring emergency treatment. Dr. Wilcox explained his reluctance to opine as to causation as follows: "the problem is that there are multiple causes of cardiac events, and there really is no medical evidence in the chart that you

can hang your hat on to talk about what the cause of that medical event would be. The types of evidence that you would need in order to come up with any sort of causality statement would be laboratory evidence, EKG tracing, something that is objective in the chart that would indicate what the cause of that is, or, if you don't have those, you would need to have an autopsy result that would hopefully give you a much more clear-cut picture of the cause of her event." Wilcox Depo. 36-37.

{¶46} Dr. Wilcox further explained that "[e]nd stage renal disease patients * * * face a lot of challenges. They are chronically ill. They exist really as a result of their dialysis because that's what keeps them alive. And they really have a lot of problems over time because of the metabolic changes that occur as a result of the dialysis and how hard that is on their system. Most of your end stage renal disease patients are very frail. They have limited physiologic reserve, and so stressors in their life can be much more significant for them than for many other patients. And you can even have very minor stressors such as [a] ground level fall, a small cold, things that don't tend to tip normal people over that can really be catastrophic for end stage renal disease patients because they just don't have the reserves physiologically to deal with that additional stress in their daily life." Wilcox Depo. 38-39.

{¶47} When asked to comment on Dr. Yates' conclusion that McKinney would have survived had she received dialysis in the early morning hours of November 8, Dr. Wilcox stated that "[b]ased on the dearth of evidence in the chart with regard to causality, I don't think that any physician can make that statement to the level of being medically certain. She is a dialysis patient. That is kind of her baseline care. But since we don't know the cause of her cardiac event, and since there are multiple causes that are likely

and happen all the time in patients that have cardiac events that are unrelated to dialysis, I don't think you can make that statement." Wilcox Depo. 40.

{¶48} Dr. Wilcox further stated that there was no way of discerning McKinney's blood serum potassium level immediately preceding her cardiac arrest. According to Dr. Wilcox, McKinney's blood serum potassium level at the time she arrived at OSUMC following her cardiac arrest was "almost guaranteed to be artificially high" because physiologic stress of the cardiac event and the trauma to the muscles during CPR cause "a phenomenal amount of potassium" to be released into the body. Wilcox Depo. 45-46.

{¶49} Following trial, and with the trial court's permission, Dr. Wood was again deposed. He disagreed with Dr. Yaffe's assertion that hyperkalemia could not have caused McKinney's cardiac arrest because a normal cardiac heart rhythm was restored within two minutes. In particular, Dr. Wood noted that following her cardiac arrest, McKinney was treated with medications which immediately counteracted the effects of hyperkalemia and restored a normal heart rhythm. On cross-examination, however, he admitted that McKinney was not administered any medications until after her cardiac rhythm was restored. This admission notwithstanding, Dr. Wood reiterated his opinion that hyperkalemia caused the cardiac arrest that resulted in McKinney's death.

{¶50} By decision filed on October 14, 2010, two years after the trial on liability only, the Court of Claims of Ohio concluded that appellants failed to prove, by a preponderance of the evidence, that either OSUMC or ODRC deviated from the required standard of care or that any care rendered by them proximately caused McKinney's death. More particularly, the court stated that it "[was] not persuaded that cardiac arrest as a result of hyperkalemia was the cause of McKinney's death and, thus, that OSUMC's

failure to dialyze her at its facility, or that any delay on the part of OSUMC or CMC in effecting her transport from CMC to [FHC] proximately resulted in her death." (Decision at 12-13.) Accordingly, the court entered judgment in favor of appellees.

{¶51} On appeal, appellants set forth the following four assignments of error:

> First Assignment of Error
>
> *R.C. 313.19* presents the exclusive procedure that must be followed if anyone in Ohio, including the State of Ohio, OSUMC, and DRC wants to change the findings of the Coroner as to the cause of death as set forth in the Coroner's Report: Findings of Facts and Verdict.
>
> Second Assignment of Error
>
> The Trial Court Erred by applying the incorrect standard of care to Appellant's medical malpractice claim.
>
> Third Assignment of Error
>
> THE TRIAL COURT ERRED TO THE PREJUDICE OF APPELLANTS BY REACHING A DECISION NOT SUPPORTED BY THE EVIDENCE AND AGAINST THE MANIFEST WEIGHT OF THE EVIDENCE.
>
> Fourth Assignment of Error
>
> THE TRIAL COURT ERRED TO THE PREJUDICE OF THE APPELLANTS BY STRIKING THE TESTIMONY OF DR. YATES AS TO THE FAILURE OF DRC AND CMC TO MEET THE STANDARD OF CARE.

{¶52} Appellants' first assignment of error contends that the trial court contravened R.C. 313.19 in allowing appellees to contest the coroner's findings as to the cause of McKinney's death without first challenging those findings in the Franklin County Court of Common Pleas. Appellants maintain that absent a proper challenge to the

coroner's findings, the trial court was obligated to find that McKinney's death was caused by hyperkalemia and, as such, erred in disregarding Dr. Yates' testimony to that effect.

{¶53} R.C. 313.19 provides that "[t]he cause of death and the manner and mode in which the death occurred, as delivered by the coroner and incorporated in the coroner's verdict and in the death certificate filed with the division of vital statistics, shall be the legally accepted manner and mode in which such death occurred, and the legally accepted cause of death, unless the court of common pleas of the county in which the death occurred, after a hearing, directs the coroner to change his decision as to such cause and manner and mode of death."

{¶54} Appellants contend that R.C. 313.19 provides the exclusive procedure for challenging a coroner's report. Appellants maintain that a litigant in a wrongful death action who seeks to contest a coroner's finding as to cause of death must first obtain from the common pleas court in the county where the death occurred an order directing the coroner to amend his or her decision as to the cause of death.

{¶55} This court recently considered this precise issue in *Melvin v. The Ohio State Univ. Med. Ctr.*, 10th Dist. No. 10AP-975, 2011-Ohio-3317. There, the decedent was diagnosed with a potentially cancerous polyp which required surgery. Following successful surgery at OSUMC, the hospital determined that the decedent was stable enough to be transferred to a long-term care facility. One day after the transfer, the decedent complained of abdominal pain and was admitted to a Dayton area hospital. Decedent's condition rapidly deteriorated and he died the next day.

{¶56} The Montgomery County coroner listed the cause of death as "[A]cute peritonitis due to surgical wound dehiscence." Id. at ¶6. The decedent's estate filed a

medical malpractice action against OSUMC alleging negligence in its failure to diagnose and treat the peritonitis. At trial before the Court of Claims of Ohio, OSUMC contested the coroner's report, asserting that the decedent died as a result of other medical problems, especially congestive heart failure. OSUMC also contested whether the decedent suffered peritonitis following the surgery. The trial court concluded that OSUMC's treatment of the decedent met the accepted standard of care.

{¶57} On appeal, the decedent's estate argued that, pursuant to R.C. 313.19, the trial court erred in permitting OSUMC to contest the coroner's findings without first challenging those findings in the Montgomery County Court of Common Pleas. Relying on *Vargo v. Travelers Ins. Co.* (1987), 34 Ohio St.3d 27, this court rejected that argument. In *Vargo,* the Supreme Court of Ohio, construing R.C. 313.19, held that "[t]he coroner's factual determinations concerning the manner, mode and cause of [the decedent's] death, as expressed in the coroner's report and death certificate, create a nonbinding rebuttable presumption concerning such facts in the absence of competent, credible evidence to the contrary." Id. at paragraph one of the syllabus. The court further held that "[t]he statute does not compel the fact-finder to accept, as a matter of law, the coroner's factual findings concerning the manner, mode and cause of decedent's death." Id. at paragraph two of the syllabus.

{¶58} In *Melvin,* we found that the matter was controlled by *Vargo's* clear holding that a coroner's report creates a nonbinding, rebuttable presumption that the factfinder is not compelled to accept, and that OSUMC had presented competent credible evidence of an alternative cause of death sufficient to rebut the presumption in the coroner's report. We further stated that had OSUMC sought to actually change the coroner's decision, it

would have been required to file such a request in Montgomery County pursuant to R.C. 313.19. We concluded, however, that OSUMC was not required to do so since it sought only to overcome the presumption of the coroner's report, not to change the coroner's decision.

{¶59} In the instant case, Dr. Bradley Lewis, the Franklin County Coroner at the time of trial, testified that a forensic pathologist in the coroner's office performed an autopsy on McKinney solely to rule out head trauma as a cause of death. According to Dr. Lewis, the autopsy involved a review of medical records, a toxicology study, and an external examination of the body; however, no internal examination was conducted. As such, there was no analysis of possible arterial blockages or other cardiac issues. Dr. Lewis identified the coroner's report, which, as noted above, listed cardiac arrest due to hyperkalemia as the immediate cause of death and as a consequence of chronic renal failure.

{¶60} Appellants' expert, Dr. Yates, admitted that but for the "findings" at the autopsy, an obstruction of a coronary artery in a patient like McKinney with hypertensive heart disease is "pretty close to hyperkalemia on the list of possibilities for this person to have a sudden cardiac arrest." Yates Depo. 75. However, Dr. Yates testified that he was persuaded by the autopsy that hyperkalemia was the cause of death because the coroner did not find an obstruction of a coronary vessel.

{¶61} In contrast, appellees' experts, Drs. Yaffe and Wilcox, disagreed with the coroner's verdict that hyperkalemia caused the cardiac arrest which resulted in McKinney's death. Dr. Yaffe ruled out hyperkalemia as the cause of McKinney's cardiac arrest because her blood serum potassium emergency had been mitigated by the time

she left OSUMC and no evidence suggested that her blood serum potassium was dangerously elevated as late as one hour before the cardiac arrest. Dr. Yaffe further opined that several factors other than hyperkalemia may have contributed to McKinney's cardiac arrest, including her history of heart disease and hypertension, her past elicit drug use, and the fact that she was a smoker. He also opined that the fact that McKinney's cardiac rhythm was restored by resuscitative efforts within two minutes of her cardiac arrest supported the theory that the cardiac arrest was not caused by hyperkalemia. Dr. Yaffe stated that it was more likely that McKinney suffered a primary cardiac arrhythmia unrelated to the hyperkalemia. In offering his opinions, Dr. Yaffe noted that the coroner did not conduct an internal examination of McKinney's body.

{¶62} Dr. Wilcox opined that the evidence in McKinney's medical records was insufficient to permit a conclusion as to the cause of McKinney's cardiac arrest. Dr. Wilcox noted, among other things, that the autopsy and coroner's findings did not provide a "clear-cut" picture of the cause of McKinney's cardiac arrest. Dr. Wilcox further opined that McKinney's cardiac arrest could have resulted from a myriad of factors, as end stage renal patients such as McKinney are chronically ill, suffer from debilitating metabolic changes resulting from long-term dialysis, and do not have the physiologic reserves to combat even minor stresses to the body, such as a fall or a cold.

{¶63} Appellees thus presented the trial court with competent, credible evidence that hyperkalemia was not the cause of death sufficient to rebut the coroner's finding that McKinney's death resulted in cardiac arrest caused by hyperkalemia. The trial court expressly found the opinions of Drs. Yaffe and Wilcox more persuasive than that of Dr. Yates. The court found that the results of the autopsy were neither determinative nor

persuasive and, as such, found Dr. Yates' opinions as to McKinney's cause of death flawed due to his deference to the autopsy results.

{¶64} As we stated in *Melvin*, appellants' argument might have merit if appellees had sought to change the coroner's verdict. Under those circumstances, appellees would be required to file an action in the Franklin County Court of Common Pleas. However, such was not appellees' objective. Rather, appellees sought to rebut the presumption created by the coroner's factual determinations regarding the cause of McKinney's death. Contrary to appellants' assertion, the trial court could weigh the evidence and determine whether the presumption had been rebutted and, as such, was free to reject Dr. Yates' opinion, which, by his own admission, was based on the coroner's findings. The first assignment of error is overruled.

{¶65} Appellants' second assignment of error contends the trial court erred in applying an incorrect standard of care to their medical malpractice claim. More specifically, appellants contend that the trial court applied a lesser standard of care than is required in a medical malpractice claim simply because McKinney was an inmate.

{¶66} To succeed on a medical malpractice claim, the plaintiff must establish: (1) the standard of care within the medical community; (2) the defendant's breach of that standard of care; and (3) proximate cause between the breach and the plaintiff's injuries. *Adams v. Kurz,* 10th Dist. No. 09AP-1081, 2010-Ohio-2776, ¶11. Proof of the recognized standards of the medical community must be provided through expert testimony. *Bruni v. Tatsumi* (1976), 46 Ohio St.2d 127, 131-32. In *Bruni,* the Supreme Court of Ohio established the legal standard for medical malpractice:

> In evaluating the conduct of a physician and surgeon charged with malpractice, the test is whether the physician, in the performance of his service, either did some particular thing or things that physicians and surgeons, in that medical community, of ordinary skill, care and diligence would not have done under the same or similar circumstances, or failed or omitted to do some particular thing or things which physicians and surgeons of ordinary skill, care and diligence would have done under the same or similar circumstances. He is required to exercise the average degree of skill, care and diligence exercised by members of the same medical specialty community in similar situations.

Id. at 129-30.

{¶67} The *Bruni* standard applies to an inmate's claim for medical malpractice. *Sloan v. Ohio Dept. of Rehab. & Corr.* (1997), 119 Ohio App.3d 331, 334, citing *Buerger v. Ohio Dept. of Rehab. & Corr.* (1989), 64 Ohio App.3d 394.

{¶68} As noted above, ODRC called Dr. Wilcox as its expert witness. Dr. Wilcox holds an accreditation with the National Commission on Correctional Healthcare and has been employed in the provision of healthcare services to the inmate population in Salt Lake City, Utah for a number of years. Dr. Wilcox testified that the manner in which healthcare services are provided to inmates is necessarily different than the manner in which healthcare services are delivered to patients in the private sector. Dr. Wilcox noted that the correctional community is faced with many challenges in its provision of healthcare services to the inmate population not attendant to the provision of healthcare services outside the prison system. Indeed, Dr. Wilcox testified that the prison system must ensure access to appropriate, medically necessary healthcare while also dealing with safety, security, and transportation issues.

{¶69} When specifically asked if the standard of care for inmates was different than the standard of care for non-inmate patients, Dr. Wilcox stated:

> Q[uestion]: Now, when you talk about the standard of care being a little bit different, I want to clarify that so that we all understand what you mean. Certainly when treatment is actually rendered to an inmate, the treatment that is rendered is expected to be at the community standard of care. In other words, medically the standard of care is no different for an inmate for treating their specific issues; is that right?
>
> A[nswer]: That's a correct statement.
>
> Q[uestion]: But the difference that you're talking about has to do with medical necessity and decisions as to whether or not an inmate is going to get care for a particular thing?
>
> [A]nswer: That's right. Many of the decisions that we make medically are framed in the context of medical necessity, as to whether something needs to be done or not and whether it is eligible for treatment or not. At the point that we actually treat the patient, we treat to community standards, but the administrative decision really has to do with the difference between whether something is necessary to treat or whether it is not considered necessary.

Wilcox Depo. 11.

{¶70} Following this testimony, Dr. Wilcox opined that "the care that was rendered to Ms. McKinney in the correctional facilities meets the standard of care for correctional health care." Wilcox Depo. 26. The trial court noted Dr. Wilcox's opinion in its decision. Appellants conclude, based upon the court's reliance on Dr. Wilcox's statement, that the trial court applied a different, and apparently lesser, standard of care because McKinney was an inmate in a correctional facility.

{¶71} Initially, we note that the trial court followed its allegedly objectionable assertion with a footnote stating that "[i]t is undisputed that the standard of care for

inmates is the same as that for non-inmate patients of health care facilities." (Decision at 11, fn.4.) Thus, the trial court specifically found that the standard of care for inmate patients is the same as that for non-inmate patients. Further, it is clear from the totality of Dr. Wilcox's testimony that he did not opine that correctional facilities are held to a lesser standard of care in the provision of medical services to inmates. Indeed, Dr. Wilcox clearly testified to the contrary.

{¶72} Upon review of the record in this case, we cannot find that the trial court applied a lesser standard of medical care to appellants' medical malpractice claim simply because McKinney was an inmate. To the contrary, the court accurately and expressly stated that the standard of medical care for inmate patients is identical to that for non-inmate patients. The second assignment of error is overruled.

{¶73} Appellants' third assignment of error contends that the trial court's judgment in favor of appellees was against the manifest weight of the evidence.

{¶74} In *Osgood v. Dzikowski,* 10th Dist. No. 08AP-105, 2008-Ohio-5065, ¶15-16, this court set forth the standard of review to be applied in civil cases in assessing whether a trial court's judgment is against the manifest weight of the evidence:

> "[W]here an appellant challenges a trial court's judgment in a civil action as being against the manifest weight of the evidence, the function of the appellate court is limited to an examination of the record to determine if there is any competent, credible evidence to support the underlying judgment." *Lee v. Mendel* (Aug. 24, 1999), Franklin App. No. 98AP-1404, 1999 Ohio App. LEXIS 3892, at *14. "Judgments supported by some competent, credible evidence going to all the essential elements of the case will not be reversed by a reviewing court as being against the manifest weight of the evidence." *Seasons Coal Co. v. Cleveland* (1984), 10 Ohio St.3d 77, 80, 10 OBR 408, 461 N.E.2d 1273.

> "A trial court's findings of fact are presumed to be correct and will not be reversed as being contrary to the manifest weight of the evidence if there is competent and credible evidence supporting the finding." *Eagle Land Title Agency v. Affiliated Mtge. Co.* (June 27, 1996), Franklin App. No. 95APG12-1617, 1996 Ohio App. LEXIS 2766, at *5, citing *Wisintainer v. Elcen Power Strut Co.* (1993), 67 Ohio St.3d 352, 355, 617 N.E.2d 1136. "Further, the weight to be given the evidence and the credibility of the witnesses are primarily for the trier of fact to decide." *Id.* at *6, 617 N.E.2d 1136; see, also, *State v. Wilson,* 113 Ohio St.3d 382, 2007-Ohio-2202, 865 N.E.2d 1264, ¶ 24, citing *Seasons Coal,* supra, at 80-81, 461 N.E.2d 1273. "This presumption arises because the trial judge had an opportunity 'to view the witnesses and observe their demeanor, gestures and voice inflections, and use these observations in weighing the credibility of the proffered testimony.' " *Wilson,* supra, at 387, 865 N.E.2d 1264, quoting *Seasons Coal,* supra, at 80, 461 N.E.2d 1273. Mere disagreement over the credibility of witnesses or evidence is not sufficient reason to reverse a judgment. *Id.*

{¶75} Appellants contend that the manifest weight of the evidence does not support the trial court's conclusion that neither OSUMC nor ODRC deviated from the accepted standard of care in treating McKinney. In support of their argument, appellants rely on the testimony of their expert witnesses. Both Drs. Wood and Yates opined that OSUMC breached the standard of care in failing to admit and dialyze McKinney on November 7. Dr. Wood also opined that CMC breached the standard of care in failing to monitor McKinney's cardiac condition and blood serum potassium levels and in failing to transport her to dialysis on the morning of November 8.

{¶76} However, appellees presented contrary testimony from their expert witnesses. OSUMC's expert, Dr. Yaffe, opined that OSUMC did not fall below the standard of care in transferring McKinney to CMC rather than admitting her for dialysis on November 7. ODRC's expert, Dr. Wilcox, opined that CMC did not violate accepted

standards of care in accepting McKinney as a transfer patient or in failing to conduct repeat blood serum potassium checks. Dr. Wilcox further opined that the medical records were not sufficiently comprehensive to permit a finding that CMC breached established standards of care in failing to transport her for dialysis on the morning of November 8.

{¶77} The instant case essentially presented for the trier of fact a battle of the experts. As noted above, a plaintiff in a medical malpractice case bears the burden of presenting sufficient evidence to allow the factfinder to conclude that the defendant breached the standard of care, and the issue of whether the defendant has employed the requisite care must be determined from the testimony of experts. *Bruni.* While appellants' experts provided opinion testimony that the care provided by appellees fell below the standard of care, there was also expert testimony provided by appellees' experts indicating that appellees met the standard of care. All four of the experts thoroughly explained the bases for their opinions, and the trial court carefully considered and outlined their testimony in its decision. It was within the province of the trier of fact to weigh the medical testimony and to resolve the conflicting opinions. The trial court expressly found the testimony of appellees' experts to be more credible and persuasive than the testimony of appellants' experts on the standard of care issue.

{¶78} Upon review of the record, we conclude that there was competent, credible evidence which, if believed, would support the trial court's finding that appellees did not breach the accepted standard of care in their treatment of McKinney. This court will not disturb such finding as being against the manifest weight of the evidence.

{¶79} Furthermore, even if appellants had proven that appellees breached their duty of care to McKinney, appellants also had the burden to prove that such breach was

the proximate cause of her death. While both of appellants' experts opined that untreated hyperkalemia caused the cardiac arrest that resulted in McKinney's death, appellees' experts disagreed. Both opined that McKinney's cardiac arrest could have been caused by a myriad of reasons other than hyperkalemia, including her general failing health due to her chronic renal disease, her other heart problems or her crack cocaine use. We reiterate that resolution of conflicting expert testimony is within the purview of the trial court. Upon review of the record, we conclude that there was competent, credible evidence which, if believed, would support the trial court's finding that appellants failed to establish that the care rendered by appellees proximately resulted in McKinney's death. We will not disturb such finding as being against the manifest weight of the evidence.

{¶80} Finally, although the trial court did not specifically address it, we note that appellants also asserted a claim for loss of consortium. "[A] claim for loss of consortium is derivative in that the claim is dependent upon the defendant's having committed a legally cognizable tort upon the [individual] who suffers bodily injury." *Bowen v. Kil-Kare, Inc.* (1992), 63 Ohio St.3d 84, 93. Since appellants have failed to prove their claims of medical malpractice and wrongful death, their loss of consortium claim also fails. The third assignment of error is overruled.

{¶81} Appellants' fourth assignment of error contends the trial court erred in granting ODRC's motion in limine excluding the testimony of Dr. Yates with regard to whether ODRC failed to comply with the applicable standards of care in its treatment of McKinney.

{¶82} A motion in limine is a request "that the court limit or exclude use of evidence which the movant believes to be improper, and is made in advance of the actual

presentation of the evidence to the trier of fact, usually prior to trial. The motion asks the court to exclude the evidence unless and until the court is first shown that the material is relevant and proper." *State v. Winston* (1991), 71 Ohio App.3d 154, 158. Thus, because a trial court's decision on a motion in limine is a ruling to admit or exclude evidence, our standard of review on appeal is whether the trial court committed an abuse of discretion that amounted to prejudicial error. *State v. Yohey* (1996), 3d Dist. No. 9-95-46, citing *State v. Graham* (1979), 58 Ohio St.2d 350, and *State v. Lundy* (1987), 41 Ohio App.3d 163. An abuse of discretion "connotes more than an error of law or judgment; it implies that the court's attitude is unreasonable, arbitrary or unconscionable." *Blakemore v. Blakemore* (1983), 5 Ohio St.3d 217, 219.

{¶83} On March 27 and June 9, 2008, respectively, appellants filed Dr. Yates' original and supplemental expert reports. In neither report did Dr. Yates provide an opinion as to the care and treatment rendered by ODRC to McKinney. However, during his trial deposition testimony taken by appellants' counsel on August 11, 2008, Dr. Yates for the first time opined that ODRC physicians deviated from acceptable standards of care in treating McKinney. ODRC objected on grounds that appellants' failure to comply with L.C.C.R. 7(E) precluded Dr. Yates from offering an opinion as to ODRC's alleged deviation from the standard of care. ODRC followed its oral objection with a written motion in limine filed on September 19, 2008. The trial court withheld ruling on the motion until after trial. By entry filed October 17, 2008, the trial court granted ODRC's motion and excluded Dr. Yates' testimony as to whether ODRC fell below the accepted standard of care.

{¶84} L.C.C.R. 7(E) provides, in relevant part:

> **Expert witnesses.** Each trial attorney shall exchange with all other trial attorneys, in advance of the trial, written reports of medical and expert witnesses expected to testify. The parties shall submit expert reports in accordance with the schedule established by the court.
>
> A party may not call an expert witness to testify unless a written report has been procured from said witness. It is the trial attorney's responsibility to take reasonable measures, including the procurement of supplemental reports, to insure that each such report adequately sets forth the expert's opinion. However, unless good cause is shown, all supplemental reports must be supplied no later than thirty days prior to trial. The report of an expert must reflect his opinions as to each issue on which the expert will testify. An expert will not be permitted to testify or provide opinions on issues not raised in his report.

{¶85} "L.C.C.R. 7(E) requires trial attorneys to exchange written reports of the expert witnesses they intend to call to testify at trial. An expert's report must reflect the expert's opinions as to each issue on which the expert will testify at trial, and the reports must be supplemented as necessary to insure that they comply with this requirement." *McMullen v. The Ohio State Univ. Hosps.* (Sept. 22, 1998), 10th Dist. No. 97API10-1301, citing *Longfellow v. Ohio Dept. of Transp.* (Dec. 24, 1992), 10th Dist. No. 92AP-549.

{¶86} Appellants urge that the trial court should have construed the opinion offered by Dr. Yates in his August 11, 2008 deposition as a supplement to his original and supplemental expert reports. Appellants note that the deposition was taken more than 30 days prior to the September 22, 2008 trial and well before ODRC took the deposition of its own expert, Dr. Wilcox, on September 17, 2008. Thus, appellants argue, ODRC would have suffered no prejudice in the admission of Dr. Yates' testimony because it had ample time to prepare Dr. Wilcox to respond to that testimony.

{¶87} We are not persuaded by appellants' contention that the trial court abused its discretion in failing to construe Dr. Yates' deposition testimony as a supplemental report as contemplated by L.C.C.R. 7(E). Appellants' counsel failed to comply with L.C.C.R. 7(E) in that he did not provide ODRC's counsel with a written report setting forth the opinion Dr. Yates intended to offer at trial regarding ODRC's alleged deviation from the standard care. Thus, we cannot find that the trial court abused its discretion in excluding Dr. Yates' testimony as to ODRC's alleged deviation from the standard of care.

{¶88} Moreover, even if the trial court erred in excluding Dr. Yates' testimony as to ODRC's alleged deviation from the standard of care, the trial court ultimately concluded that appellants failed to prove that any deviation in the standard of care provided by ODRC proximately caused McKinney's death. Thus, any error was harmless. The fourth assignment of error is overruled.

{¶89} Having overruled each of appellants' four assignments of error, we hereby affirm the judgment of the Court of Claims of Ohio.

Judgment affirmed.

DORRIAN, J., concurs.
BROWN, J., concurring separately.

BROWN, J., concurring separately.

{¶90} Under the third assignment of error, appellant argues that the trial court's decision is against the manifest weight of the evidence. A trial court's findings of fact are presumed correct, and "the weight to be given the evidence and the credibility of the witnesses are primarily for the trier of fact to decide." *Eagle Land Title Agency v. Affiliated Mtge. Co.* (June 27, 1996), 10th Dist. No. 95APG12-1617, citing *State v.*

Thomas (1982), 70 Ohio St.2d 79. This presumption arises because the trial judge "is best able to view the witnesses and observe their demeanor, gestures and voice inflections, and use these observations in weighing the credibility of the proffered testimony." *Seasons Coal Co. v. Cleveland* (1984), 10 Ohio St.3d 77, 80.

{¶91} I concur separately to note the potential for prejudice to litigants in cases such as the present where, as noted by the majority, more than two years have passed between the time of the trial and the court's rendering of its decision on liability. Such delay poses a danger of undermining the presumption that a trial court's finding of fact, based upon its ability to observe witnesses, recall testimony, and determine issues of credibility, are correct. In this case, however, the delay in rendering the decision was not prejudicial to the parties because pivotal testimony was presented through recorded depositions, rather than live testimony.
