[Cite as *Courtney v. Ohio State Univ. Wexner Med. Ctr.*, 2025-Ohio-1824.]

IN THE COURT OF CLAIMS OF OHIO

FRED COURTNEY, et al. Plaintiffs v. THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER Defendant	Case No. 2020-00532JD Judge Lisa L. Sadler DECISION

{¶1} In a refiled lawsuit filed in September 2020, Plaintiffs Fred Courtney and Jamie Courtney brought an original civil action against Defendant The Ohio State University Wexner Medical Center in which Plaintiffs asserted claims of medical negligence and loss of consortium.[1] The case proceeded to a bench trial on issues of liability and damages. Plaintiffs' loss-of-consortium claim was dismissed during trial with the consent of both Plaintiffs and without objection. After the dismissal of Plaintiffs' loss-of-consortium claim, trial continued on Plaintiffs' claim of medical negligence.[2]

{¶2} Upon careful consideration of the evidence, and for reasons explained below, the Court holds that Plaintiffs have not proven their claims of medical negligence by a preponderance of the evidence. The Court further determines that a judgment in Defendant's favor should be entered.

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[1] *Fred Courtney, III, D.O., et al. v. The Ohio State Univ. Wexner Med. Ctr.*, Ct. of Cl. No. 2019-00722JD, was dismissed without prejudice, on September 9, 2019, pursuant to Civ.R. 41.

As noted in the caption of Ct. of Cl. No. 2019-00722JD, Plaintiff Fred Courtney, III is a doctor of osteopathic medicine. Dr. Courtney formerly practiced as an obstetrician and gynecologist in southern Ohio. The Court shall hereafter refer to Plaintiff Fred Courtney as Plaintiff Dr. Fred Courtney or Plaintiff Dr. Courtney in this Decision.

[2] Tr. Vol. 2, 194-196; Tr. Vol.3, p. 752-755.

I. Background

{¶3} On September 3, 2020, Plaintiffs sued Defendant, asserting claims of medical negligence and loss of consortium. Plaintiffs allege that, on or about December 21, 2017, Plaintiff Dr. Fred Courtney presented to Highland District Hospital's emergency department with complaints of flu-like symptoms and a sensation of pins and needles in his hands and feet. (Complaint, ¶ 11.)[3] After receiving treatment at Highland District Hospital, Plaintiff Dr. Fred Courtney was transferred to the emergency department at The Ohio State University Wexner Medical Center (OSUWMC), and he was later transferred to OSUWMC's intensive care unit (ICU). (Complaint, ¶ 17-18.)

{¶4} Plaintiffs allege that Plaintiff Dr. Fred Courtney remained at OSUWMC until January 10, 2018, with digital ischemia on his fingers and toes and that he was discharged with plans to allow the ischemia to demarcate for future surgical intervention. (Complaint, ¶ 24.) Plaintiffs further allege that, on or about March 28, 2018, Plaintiff Dr. Fred Courtney underwent amputation of all his fingers and toes. (Complaint, ¶ 25.) Plaintiffs maintain that Defendant, through its medical providers, failed to meet the accepted standard of care, skill, and diligence by (1) failing to timely initiate steroids; (2) failing to timely obtain appropriate medical or surgical consultations, or both, and (3) failing to formulate an appropriate differential diagnosis. Plaintiffs seek an award of compensatory, consequential, incidental, special, and medical damages in an amount greater than Twenty-Five Thousand Dollars ($25,000.00) together with costs and such other relief as may be just and appropriate in this case.

{¶5} Defendant denies liability in this matter. Defendant admits, however, that, at all times relevant, it was an entity of the state of Ohio that employed physicians, nurses and other personnel to evaluate, care for, and treat patients at its hospitals, clinics and outpatient facilities; Defendant also admits that it provided medical training and education

[3] Plaintiff Dr. Fred Courtney presented to the emergency room with a history of smoking cigarettes. Plaintiff Dr. Courtney testified that he began smoking cigarettes when he was about ten or eleven years-old, quit smoking after undergraduate college, but resumed smoking during approximately his third year of medical school. (Tr. 692). Plaintiff Dr. Courtney smoked about a pack a day until he was hospitalized at The Ohio State University Wexner Medical Center. (Tr. 692, 694.) According to Defendant's expert witness, Robert Goitz, M.D., smoking is a known risk factor for developing dysvascularity in a smoker's fingers and toes.

to matriculating students and retained physicians and other medical care personnel to provide supervision and instruction to medical students, interns, residents, and others. (Answer, ¶ 2.)

II. Positions of the Parties.

{¶6} Plaintiffs essentially maintain in their medical negligence claim that Defendant's medical providers committed medical malpractice by failing to diagnose Plaintiff Dr. Fred Courtney with hemophagocytic lymphohistiocytosis (HLH) sooner and by delaying treatment with steroids. Plaintiffs maintain that Defendant's first negligent act was Defendant's failure to act upon the values of laboratory tests, which were ordered by Joshua Peck, M.D. (a "moonlighter" in OSUWMC's ICU) that came back at 00:36 on December 25, 2017.[4] Plaintiff urges that, if Dr. Peck did not understand the significance of the values, such as a high level of ferritin, he should have called Spero Cataland, M.D., a hematologist who was providing care to Plaintiff Dr. Fred Courtney. Plaintiffs further maintain that lab values should have been discussed at the handoff of Plaintiff Dr. Fred Courtney's care to Naeem Ali, M.D. the next day. Plaintiffs also maintain that the audit trail shows that Natasha Jain, M.D., a fellow in hematology, saw the ferritin level for 4 seconds, yet there is no evidence that she communicated the results to Dr. Cataland. Plaintiffs maintain that there is no evidence that Dr. Cataland was aware of the ferritin level, which an expert witness of Plaintiffs, Amit Mehta, M.D. describes as a red flag.

{¶7} Plaintiffs state in their written closing arguments, "The above shows a massive lack of communication, all occurring on Christmas Day. This lack of communication on Christmas Day included the high Ferritin level, elevated triglycerides, fever and low platelets. At this point, HLH should have shot to the top of the differential list yet no discussion, no review, no action taken. This delay of at least 36 hours in getting steroids resulted in the loss of all of Dr. Courtney's fingers and toes."

[4] "Moonlighters" have been described in this trial as "either advanced practitioners, either nurse practitioners or physician's assistants that have a license to practice and then -- or physicians, either medical residents, fellows or attendings that also have a license to practice medicine. And it's -- you take shifts where there's not someone already assigned to them." (Deposition of Kristin Koenig, M.D., 12-13.)

{¶8} With respect to non-economic damages (e.g., pain, suffering, inability to perform usual functions, and disfigurement), Plaintiffs represent that under Ohio law non-economic damages are currently capped at $250,000 in actions against the State, but Plaintiffs maintain that Plaintiff Dr. Fred Courtney's non-economic damages exceed $5,000,000.00. Plaintiffs represent that Plaintiff Dr. Fred Courtney receives Medicaid and Defendant is therefore not liable for medical expenses that have been paid by Medicaid. Plaintiffs also seek damages for lost wages and lost earning capacity.

{¶9} Defendant disputes Plaintiffs' allegations. Defendant contends that Plaintiff Dr. Fred Courtney presented to both Highland District Hospital's emergency department and Defendant's emergency department with several highly concerning, nonspecific symptoms, which resulted in an initial diagnosis of presumed septic shock.[5] Defendant also contends that now, with the benefit of hindsight, Plaintiffs argue that the results of a single nonspecific laboratory test should have sent Defendant's medical providers in search of a diagnosis of hemophagocytic lymphohistiocytosis (HLH)—a rare condition that typically affects children, not adults. Defendant further contends that its medical providers followed the fundamental medical principle that a clinician should first consider the most common explanation for a patient's symptoms, which in this instance was septic shock—a diagnosis for which Plaintiff Dr. Fred Courtney satisfied all of the diagnostic criteria. Defendant urges that later, on December 26, 2017, after the condition of Plaintiff Dr. Fred Courtney's extremities continued to worsen, Defendant's medical providers began treatment with high dose steroids for treatment of suspected vasculitis. Plaintiff Dr. Fred Courtney was later able to be extubated, stabilized and discharged, although Plaintiff Dr. Fred Courtney would later require amputation of his toes and significant portions of all of his fingers.

{¶10} With respect to damages, Defendant does not dispute that Plaintiff Dr. Fred Courtney is unable to return to work in the same capacity as he did before his illness and amputations. Defendant contends, however, that Plaintiff Dr. Fred Courtney is able to work in some capacity and that Plaintiff Dr. Fred Courtney has a duty to mitigate his

[5] Kristin Koenig, M.D. testified in a deposition that "shock is a general term that means the patient's blood pressure is low, and they're having trouble perfusing, getting blood -- getting blood to their organs. And then septic shock is what's causing the shock. So septic -- septic means infection, so infectious etiology of the shock." (Koenig Deposition, 19.)

damages by availing himself of vocational therapy and the use of possible hand prosthetics and that any award of damages should be offset by disability payments that Plaintiff Dr. Fred Courtney receives and is anticipated to receive.

III. Law and Analysis

A. Legal Standards

{¶11} Plaintiffs are required to establish their civil claim of medical negligence by a preponderance of the evidence. *See Merrick v. Ditzler*, 91 Ohio St. 256, 260 (1915) ("[i]n the ordinary civil case the degree of proof, or the quality of persuasion as some text-writers characterize it, is a mere preponderance of the evidence"); *Weishaar v. Strimbu*, 76 Ohio App.3d 276, 282 (8th Dist.1991). A preponderance of the evidence "is defined as that measure of proof that convinces the judge or jury that the existence of the fact sought to be proved is more likely than its nonexistence." *State ex rel. Doner v. Zody*, 2011-Ohio-6117, ¶ 54.

{¶12} On the trial of a civil case, the weight to be given the evidence and the credibility of the witnesses are primarily for the trier of the facts to determine. *State v. DeHass*, 10 Ohio St.2d 230 (1967), paragraph one of the syllabus. Here, the Court is the trier of the facts. The Court, as the trier of the facts, is required to give weight to the evidence presented, as it reviews and evaluates the evidence. The Court is free to believe all, part, or none of the testimony of any witnesses, including expert witnesses who have testified in this trial. *See State v. Green*, 2004-Ohio-3697, ¶ 24 (10th Dist.).

{¶13} The Ohio Supreme Court has recognized that, in the medical context, "because only individuals practice medicine, only individuals can commit medical malpractice." *Natl. Union Fire Ins. Co. v. Wuerth*, 2009-Ohio-3601, ¶ 14. However, the Ohio Supreme Court also has recognized that, under the doctrine of respondeat superior, a hospital "is liable for the negligent acts of its employees." *Berdyck v. Shinde*, 66 Ohio St.3d 573, 577 (1993), citing *Klema v. St. Elizabeth's Hosp. of Youngstown*, 170 Ohio St. 519 (1960).

{¶14} The Ohio Supreme Court has identified elements to establish negligence of a hospital employee. *See Berdyck*, *supra*. In *Berdyck* the Ohio Supreme Court stated: "To establish the negligence of a hospital employee, an injured party must demonstrate

that a duty of care was owed to the injured party by the employee, that the employee breached that duty, and that the injuries concerned were the proximate result of the breach." *Berdyck*, 66 Ohio St.3d at 577.[6] In *Berdyck* the Ohio Supreme Court also stated:

> In negligence cases the duty is always the same: to conform to the legal standard of reasonable conduct in the light of apparent risk. What a defendant must do, or must not do, is a question of the *standard of conduct* reasonably required to satisfy the defendant's duty. See Prosser & Keeton on Torts (5 Ed.1984) 356, Section 53.
>
> In general, a standard of "reasonable" conduct implies a minimum standard of care. But, if a condition by its nature requires the application of knowledge and skill superior to that of the ordinary person, one who possesses that superior knowledge and skill and who fails to employ it for the benefit of another when their relation requires it will be held liable for injuries proximately resulting from that failure. Such persons must use the care and skill reasonable in the light of their superior learning and experience, not simply a minimum standard of care. For those persons the relevant standard of conduct is "good practice." See *id.* at 185, 189, Section 32.

Berdyck, 66 Ohio St.3d at 577-579 (1993).

{¶15} In *Cromer v. Children's Hosp. Med. Ctr. of Akron*, 2015-Ohio-229, ¶ 27, the Ohio Supreme Court stated,

> In the physician-patient relationship . . . the scope of the duty owed includes an augmented expectation that physicians will exercise the degree of care that is reasonable in light of the physician's superior training and knowledge.

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[6] Under Ohio law, cause in fact and proximate cause are distinct. *See Ackison v. Anchor Packing Co*., 2008-Ohio-5243, ¶ 48. The standard test for establishing cause in fact is "but for" causation. *Ackison* at ¶ 48. In *Anderson v. St. Francis-St. George Hosp., Inc*., 77 Ohio St.3d 82, 84-85 (1996), the Ohio Supreme Court explained that "a defendant's conduct is a cause of the event (or harm) if the event (or harm) would not have occurred *but for* that conduct; conversely, the defendant's conduct is not the cause of the event (or harm) if the event (or harm) would have occurred regardless of the conduct." (Emphasis sic). And in *Ackison* the Ohio Supreme Court stated, "Once cause in fact is established, a plaintiff then must establish proximate cause in order to hold a defendant liable." *Ackison* at ¶ 48. In *Clinger v. Duncan*, 166 Ohio St. 216, 223 (1957), the Ohio Supreme Court noted: "Ordinarily, the existence of both negligence and proximate cause are, in a jury trial, questions of fact for the determination of the jury under proper instructions from the court."

> *Berdyck* at 579. Thus, the standard of care applicable to medical professionals is to exercise the degree of care that a medical professional of ordinary skill, care, and diligence would exercise under similar circumstances. *Bruni v. Tatsumi*, 46 Ohio St.2d 127, 346 N.E.2d 673 (1976), at paragraph one of the syllabus.

{¶16} Whether a standard of care articulated by an expert witness governs a duty of care is a question of fact, determined from all relevant facts and circumstances. *See Berdyck*, *supra*, at 584; *Burton v. Elsea*, 1999 Ohio App. LEXIS 6401, at *32 (4th Dist. Dec. 27, 1999), citing *Strother v. Hutchinson*, 67 Ohio St. 2d 282 (1981) ("disputes as to both the conduct of the parties and the standard of care are questions for the jury"). The Tenth District Court of Appeals has explained:

> With few exceptions, the trier of fact must determine the applicable standard of care in a medical malpractice case from the testimony of expert witnesses. In *Turner v. Children's Hosp., Inc.* (1991), 76 Ohio App. 3d 541, 602 N.E.2d 423, we explained:
>
> > Ordinarily, the issue of whether the physician has employed the requisite care must be determined from the testimony of experts, unless the standard of care is sufficiently obvious that laymen could reasonably evaluate the physician's conduct. . . . Such expert testimony serves to aid the trier of fact in determining if there was malpractice. For, although customary practice is evidence of what a reasonably prudent physician would do under like or similar circumstances, it is not conclusive in determining the applicable standard required. *Id.* at 548.

Wheeler v. Wise, 133 Ohio App.3d 564, 569 (10th Dist.1999).

B. Defendant's medical providers did not act negligently by failing to diagnose hemophagocytic lymphohistiocytosis (HLH) sooner or by delaying treatment with steroids.[7]

{¶17} At least one state court of last resort has remarked, "'Even with all the advances of medical science, the practice of medicine remains an art.'" *Easum v. Miller*, 92 P.3d 794, 803 (Wyoming 2004), quoting *Coastal Tankships, U.S. A., Inc.. v. Anderson*, 87 S.W. 3d 591, 604 (Tex. App. 2002). The Court agrees with this sentiment in *Easum*. The practice of medicine is both science and art because it relies on science to understand diseases of the human body and to develop effective treatments, while at the same time it requires a medical practitioner to apply this understanding in the treatment of a person's presenting illness.

{¶18} In *Easum* the Supreme Court of Wyoming stated,

> "'Differential diagnosis' refers to the process by which a physician 'rules in' all scientifically plausible causes of the plaintiff's injury. The physician then 'rules out' the least plausible causes of injury until the most likely cause remains. The remaining cause is the expert's conclusion." *Hollander v. Sandoz Pharmaceuticals*, 289 F.3d 1193, 1209 (10th Cir. 2002) (citation omitted). The Fourth Circuit describes it this way:
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> > Differential diagnosis, or differential etiology, is a standard scientific technique of identifying the cause of a medical problem by eliminating the likely causes until the most probable one is isolated. A reliable differential diagnosis typically, though not invariably, is performed after physical examinations, the taking of medical histories, and the review of clinical tests, including laboratory tests, and generally is accomplished by determining the possible causes for the

[7] Plaintiffs' expert witness, Amit Mehta, M.D. (a board-certified hematologist and oncologist) described hemophagocytic lymphohistiocytosis (HLH) as follows: "HLH fundamentally is a condition that features severe, systemwide inflammation where tissues, blood vessels have severe inflammation." (Tr., 263.) Dr. Mehta testified that HLH·was first recognized in the medical literature "roughly about 80 years ago" (Tr., 261), and "since the early '90s, there's been significant advance in terms of understanding how to diagnose and how to treat in a way that the majority of patients will be able to successfully be treated if recognized in a prompt fashion." (Tr., 261-262.)

> patient's symptoms and then eliminating each of these potential causes until reaching one that cannot be ruled out or determining which of those that cannot be excluded is the most likely.
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> *Westberry v. Gislaved Gummi AB*, 178 F.3d 257, 262 (4th Cir. 1999) (internal quotation marks omitted). Most physicians use the term differential diagnosis to describe the process of determining which of several diseases is causing a patient's symptoms while courts use the term more generally to describe the process by which causes of the patient's condition are identified. *Clausen*, 339 F.3d at 1057 n. 4; *see, e.g., Westberry*, 178 F.3d at 262.

Easum, 92 P.3d at 802 (Wyoming 2004).

{¶19} Upon careful consideration, the Court concludes that Defendant's medical providers' assessment of Plaintiff Dr. Fred Courtney's condition as septic shock, upon transfer, and Defendant's medical providers' treatment with broad spectrum antibiotics following admission to the OSUWMC intensive care unit, with consideration given to consulting the hematology service about Plaintiff Dr. Fred Courtney's thrombocytopenia and anemia after admission, did not deviate from "good practice," *see Berdyck*, *supra*, and conformed with the standard of care. Even Plaintiffs' expert witness, Amit Mehta, M.D. (hematologist/oncologist) testified: "So when [Plaintiff Dr. Fred Courtney] was initially seen in the emergency department at Highland Park [sic] before being -- and then also when he was transferred to Ohio State on December 23rd, 2017, he had a number of investigations to look for infection, which I thought were appropriate and comprehensive to look for a source of infection." (Tr. 265.) Dr. Mehta testified, "I believe that that hypothesis as far as the chief leading diagnosis was the appropriate course of action. Likely septic shock, treat for infection and they started antibiotics and ordered the appropriate lab tests as well." (Tr., 269.) And Dr. Mehta testified: "I feel the initial workup was reasonable given that they saw the patient upon being called. The patient had critical lab values that were life threatening lab values. And so a hematology investigation was appropriate and done reasonably, I feel, on the December 24th, 2017, initial consultation." (Tr., 274.) Additionally, Dr. Mehta, testified:

> On the morning of December 24th, I believe that HLH would not have been considered a likely diagnosis early on the 24th. Because there were other working diagnoses, such as septic shock, that were reasonable, in my view, for Dr. Courtney's case. So I'm not critical that during the rounding process between the ICU teams, hematology, et cetera, that – I'm not critical that HLH was not discussed, such as in Dr. Jain's 24 note on December 24th.

(Tr., 279.)

{¶20} However, according to Dr. Mehta, if a physician held a view that a high ferritin level does not have any indication about HLH in this case, then this would be below the standard of care and that, in view of a severely elevated ferritin level, a hematologist should begin to think about diseases that could have such an elevated finding. (Tr., 304.) Dr. Mehta further testified that he felt that Dr. Cataland and Dr. Jain, as consulting physicians, should have seen Plaintiff Dr. Fred Courtney on December 25, 2017. (Tr., 311.) Dr. Mehta testified, "I suppose the disagreement I have is that I feel that he should have seen the patient, even if there was not a high likelihood of the exam and whatnot making a difference to his clinical impression." (Tr., 400.)

{¶21} Notwithstanding Dr. Mehta's opinion, the Court is not persuaded that the presence of certain laboratory values—such as a high ferritin level, elevated triglycerides, fever, and low platelet count—required Defendant's medical providers to place HLH atop a list of differential diagnoses for consideration shortly after Plaintiff Dr. Fred Courtney's admission to the OSUWMC intensive care unit, especially given that, according to the evidence, HLH is not commonly found in adults, and that, according to the evidence, results from certain laboratory tests were still pending when Plaintiffs contend that a diagnosis of HLH should have been made.[8] Plaintiffs' critical care expert witness, Amit

[8] Evidence adduced at trial illustrates the rarity of HLH. On direct examination, when Dr. Mehta (Plaintiffs' expert witness who previously served as a faculty member at Duke University and who has been engaged in private practice since 2016) was asked about how many patients with HLH Dr. Mehta had been involved with, Dr. Mehta testified, "My -- of my own patients, it's been four of my own patients" (Tr. 263.). Dr. Mehta added, "And I've been indirectly involved, back when I was at the university, where in the department, there were other colleagues of mine who had an HLH case." (Tr., 263.) On cross-examination, Dr. Mehta clarified that the four patients that he treated for HLH occurred during his time at Duke University. (Tr., 363).

Uppal, M.D. (a board-certified physician in internal medicine, pulmonary medicine, and critical care), conceded that HLH is not the most common of conditions—even though, according to Dr. Uppal, it should have been on a list of differential diagnoses. Also, Dr. Mehta described HLH as "uncommon diagnosis." (Tr., 262.)

{¶22} The Court also is not persuaded by Dr. Mehta's view that a failure of the hematology service to physically evaluate Plaintiff Dr. Fred Courtney on Christmas breached the standard of care, since, according to Dr. Cataland, Dr. Cataland was reviewing Plaintiff Dr. Fred Courtney's laboratory values and, according to the evidence, Plaintiff Dr. Fred Courtney's care was monitored by Defendant's ICU staff.

{¶23} The Court acknowledges Dr. Mehta's expert testimony that, in his opinion, if a physician held a view that a high ferritin level does not have any indication about HLH in this case, then this would be below the standard of care and that, in view of a severely elevated ferritin level, a hematologist should begin to think about diseases that could have such an elevated finding. (Tr., 304.) Here, however, according to Spero Cataland, M.D., a hematologist at The Ohio State University Wexner Medical who was involved in Plaintiff Dr. Fred Courtney's care, HLH is a diagnosis that crosses his "radar screen" about 5 to 10 times a week during an eight-week period, depending on the amount of consultation requests that he receives during that period (Tr., 86) and, according to Dr. Cataland, the criteria used to diagnosis HLH are seen in sepsis. (Tr., 89-90.) Thus, it does not appear to the Court that Dr. Cataland was blind to the possibility of HLH as a potential diagnosis.

{¶24} The Court finds Dr. Cataland and Naeem Ali, M.D. (critical care physician) were credible when testifying about the differential diagnoses that could have been causing Plaintiff Dr. Fred Courtney's presenting symptoms during his admission and the management of Plaintiff Dr. Fred Courtney's care during Plaintiff Dr. Fred Courtney's ICU hospitalization. Dr. Cataland testified that, in Plaintiff Dr. Fred Courtney's case, among the differential diagnoses considered when Plaintiff Dr. Fred Courtney first presented to OSUWMC were sepsis, septic shock, but also of concern was digital ischemia, including things that could affect the small vessels, vasculitis, and prior globulinemia, as well as possible exposure to hepatitis C because Plaintiff Dr. Fred Courtney had practiced as a surgeon as part of his medical practice. (Tr., 139.) Dr. Cataland also referenced a study in UpToDate by Nancy Berliner, M.D., an expert regarding HLH and an editor of a medical

journal, that ferritin is a better marker of HLH in children, but hyperferritinemia does not predict HLH in adults because of other comorbid medical conditions and other issues. (Tr., 148.) Dr. Ali noted that unexplained multiple organ failure has multiple causes, which may require referral to different medical specialists.

{¶25} Plaintiffs' claims about a "massive lack of communication, all occurring on Christmas Day" fails to, in part, persuade because it is premised on Plaintiffs' unconvincing contention that certain laboratory values and symptoms (e.g., ferritin level, elevated triglycerides, fever, and low platelets) demanded that HLH—a rare condition—should have been placed atop Defendant's medical providers' list of differential diagnoses for consideration, even while certain lab results were still pending. Further, after reviewing Defendant's witnesses' testimony about their review of Plaintiff Dr. Fred Courtney's electronic medical record and information contained within it (including, among other things, notes about Plaintiff Dr. Fred Courtney's condition, Plaintiff Dr. Fred Courtney's multiple organ failure, vitals, laboratory values, and consultations by medical specialties) the Court disagrees with the characterization of Defendant's processes as a "massive failure of communication."

{¶26} Based on the Court's weighing of the experts' testimony and medical providers' testimony, and the Court's consideration of the evidence, this case does not present a situation where Defendant's medical providers failed to exercise the degree of care that medical professionals of ordinary skill, care, and diligence would have exercised under similar circumstances. The Court finds that Plaintiffs have failed to prove by a preponderance of the evidence that Defendant's medical providers breached a duty of care owed to Plaintiff Dr. Fred Courtney. Because Plaintiffs have failed to prove a breach of a duty care, Plaintiffs cannot prevail on their claim of medical negligence. *See Whiting v. State Dept. of Mental Health*, 141 Ohio App.3d 198, 202 (10th Dist.2001) ("[a]ll of the elements of negligence must be demonstrated for a plaintiff to recover under a theory of negligence"). Also, since Plaintiffs have failed to prove a breach of a duty of care, the Court need not determine whether Plaintiffs have satisfactorily established other elements

of their medical negligence claim, including the element of proximate cause.[9] *See PDK Laboratories, Inc. v. United States Drug Enforcement Administration*, 362 F.3d 786, 799 (D.C.Cir.2004) (Roberts, J., concurring in part and concurring in judgment) (expressing "the cardinal principle of judicial restraint," *i.e.*, "if it is not necessary to decide more, it is necessary not to decide more"); *State ex rel. Karmasu v. Tate*, 83 Ohio App.3d 199, 205 (4th Dist.1992), citing *Coulverson v. Ohio Adult Parole Auth*., 1992 WL 97805 (4th Dist. May 11, 1992) (a trial court "is not required to consider any legal theory, or argument, beyond that which will adequately dispose of the case at hand").

IV. Conclusion

{¶27} Accordingly, after careful consideration of the evidence, including documentary evidence and testimonial evidence, and for reasons explained above, the Court holds that Plaintiffs have not proven by a preponderance of the evidence their claims of medical negligence against Defendant. The Court therefore need not address the issue of damages. Judgment shall be rendered in favor of Defendant.

LISA L. SADLER
Judge

[9] "[P]roximate cause is an element of a tort action and is "[a] cause that is legally sufficient to result in liability; an act or omission that is considered in law to result in a consequence, so that liability can be imposed on the actor." *Black's Law Dictionary* 265 (10th Ed.2014).

> "[W]here an original act is wrongful or negligent and in a natural and continuous sequence produces a result which would not have taken place without the act, proximate cause is established, and the fact that some other act unites with the original act to cause injury does not relieve the initial offender from liability." One is thus liable for the natural and probable consequences of his negligent acts.
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> *Strother v. Hutchinson*, 67 Ohio St.2d 282, 287, 423 N.E.2d 467 (1981), quoting *Clinger v. Duncan*, 166 Ohio St. 216, 222, 141 N.E.2d 156 (1957). An injury may be the result of more than one proximate cause. *Taylor v. Webster*, 12 Ohio St.2d 53, 57, 231 N.E.2d 870 (1967).

Argabrite v. Neer, 2016-Ohio-8374, ¶ 40.

[Cite as *Courtney v. Ohio State Univ. Wexner Med. Ctr.*, 2025-Ohio-1824.]

IN THE COURT OF CLAIMS OF OHIO

FRED COURTNEY, et al. Plaintiffs v. THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER Defendant	Case No. 2020-00532JD Judge Lisa L. Sadler JUDGMENT ENTRY

{¶28} For reasons explained in the Decision filed concurrently herewith, judgment is rendered in favor of Defendant. Court costs are assessed against Plaintiffs. The Clerk shall serve upon all parties notice of this judgment and its date of entry upon the journal.

LISA L. SADLER
Judge

Filed April 2, 2025
Sent to S.C. Reporter 5/22/25