[Cite as *Pond v. Ohio Dept. of Rehab. & Corr.*, 2006-Ohio-622.]

IN THE COURT OF CLAIMS OF OHIO
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ROBERT POND	:	
Plaintiff	:	CASE NO. 2004-05686 Judge Joseph T. Clark
v.	:	Magistrate Anderson M. Renick
DEPARTMENT OF REHABILITATION AND CORRECTION	:	MAGISTRATE DECISION
Defendant	:	

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{¶ 1} Plaintiff brought this action against defendant alleging negligence. The issues of liability and damages were bifurcated and the case was tried to a magistrate of the court on the issue of liability.

{¶ 2} At all times relevant to this action, plaintiff was an inmate in the custody and control of defendant pursuant to R.C. 5120.16. On November 22, 2003, plaintiff was incarcerated in "B" dormitory at the Southeastern Correctional Institution (SCI) where he became involved in a physical altercation with another inmate. Plaintiff testified that he was sitting on a bench when another inmate approached him and pushed him onto the floor. Plaintiff further testified that he heard his right arm "crack" when it struck the floor and that his wrist became disfigured and started to swell after he was pushed a second time.

{¶ 3} Nurse Willoughby examined plaintiff at SCI and noted his complaint of right wrist pain and an "obvious physical deformity." (Defendant's Exhibit B.) According to Willoughby's examination report, plaintiff was transported to the emergency department at the Fairfield Medical Center (FMC) soon after the incident.

Plaintiff's medical records show that the FMC staff took several x-rays of his wrist, which revealed fractures of both his right ulna and radius. The testimony and evidence established that plaintiff's wrist was immobilized with a splint and that he was provided with pain medication. Plaintiff was subsequently released by the attending physician with instructions to follow up with an orthopedic surgeon.

{¶ 4} After his return to SCI, plaintiff was placed in a segregation unit pending an investigation of the altercation. In her December 3, 2003, incident report, Earlaena Schorr, the B dormitory unit manager, recommended that plaintiff be released from segregation because the investigation revealed that plaintiff was not the aggressor in the altercation. Plaintiff testified that he was transferred to the institution infirmary upon his release.

{¶ 5} Toni Basse, a health information technician at SCI, testified that plaintiff was scheduled for an appointment on December 4, 2003, the earliest date available at the orthopedic clinic at the Corrections Medical Center (CMC). Basse explained that she was responsible for scheduling orthopedic appointments at CMC and that she would do so after the institution medical director had noted a referral in an inmate's medical record. According to Basse, the only day of the week that the CMC orthopedic clinic accepted inmate patients was Thursday. Bassse testified that December 4, 2003, was the first available date because the clinic was closed on November 27, 2003, for the Thanksgiving holiday.

{¶ 6} As a result of the December 4, 2003, orthopedic examination, plaintiff was scheduled for surgery on December 10, 2003, to place surgical pins to aid in correct bone alignment

during healing. The surgical report in plaintiff's medical record notes that "excellent alignment" was achieved during the surgery.

{¶ 7} Plaintiff asserts that he was not treated in a timely manner due to defendant's negligence and that the delay in setting his fractured wrist resulted in complications that caused him pain and limited range of motion in his right hand. Plaintiff also asserts that he did not need expert medical testimony to prove his claim of negligence because defendant's negligence was obvious and a matter of "common sense." Plaintiff maintains that the medical records and his testimony are sufficient to establish his negligence claim. Defendant contends that plaintiff failed to show that the medical treatment rendered to him fell below the required standard of care.

{¶ 8} In order to prevail on a claim of medical malpractice or professional negligence, plaintiff must first prove: 1) the standard of care recognized by the medical community; 2) the failure of defendant to meet the requisite standard of care; and, 3) a direct causal connection between the medically negligent act and the injury sustained. *Bruni v. Tatsumi* (1976), 46 Ohio St.2d 127. The appropriate standard of care must be proven by expert testimony. Id. at 130. That expert testimony must explain what a medical professional of ordinary skill, care, and diligence in the same medical specialty would do in similar circumstances. Id. The exception to that rule is "in cases where the nature of the case is such that the lack of skill or care of the physician and surgeon is so apparent as to be within the comprehension of laymen and requires only common knowledge and experience to understand and judge it ***." Id.

{¶ 9} The Tenth District Court of Appeals has observed that this exception has a limited scope in a world of increasing medical complexity. *Buerger v. Ohio Dept. of Rehab. & Corr.* (1989), 64 Ohio App.3d 394, 399. Furthermore, "[r]elatively few courts in Ohio have found the common knowledge exception applicable so as to obviate the need for expert witness testimony on the malpractice issue." Id.

{¶ 10} Plaintiff's medical records include a detailed medical history of examination and treatment. He was initially treated by an emergency department physician who consulted with another physician and determined that it was appropriate to stabilize plaintiff's fractured wrist with a splint and refer him to an orthopedic surgeon. The Ohio State University Medical Center physician who performed the surgery on plaintiff also prepared an extensive report which stated that "the fracture was in excellent alignment" after the surgical pins were placed. The surgical report also noted that there were no complications. Additionally, plaintiff failed to identify any statements in the medical records that either suggest inadequate treatment or otherwise support his claim of negligence.

{¶ 11} Plaintiff's allegations of negligence involve a physician's decision to refer him for further treatment to an orthopedic specialist and the length of time between the treatment that was provided by the hospital emergency department staff and the orthopedic specialists. The court finds that plaintiff's allegations pertain to matters that are not within the common knowledge and experience of laymen. Rather, plaintiff's allegations concern the professional skill and judgment used by the medical staff who treated him. Therefore, expert testimony was

required both to establish the requisite standard of care and to show that defendant's employees deviated from that standard of care.

{¶ 12} During the trial, plaintiff referenced medical journal articles that addressed the treatment of bone fractures. However, plaintiff failed to present any expert testimony to support his claim that defendant's medical staff deviated from the appropriate standard of care. Without expert testimony regarding standard of care, the court is unable to determine the nature of plaintiff's medical needs. *Buerger*, supra, at 400. "Plaintiff's situation, although more acute due to his incarceration and indigency, is not unlike the difficulty which all plaintiffs have in securing competent and credible expert testimony to meet the burden of proof required by law to show medical malpractice." *Buerger*, supra, at 400.

{¶ 13} The court concludes that plaintiff has failed to prove his claim of negligence by a preponderance of the evidence. Accordingly, judgment is recommended in favor of defendant.

{¶ 14} *A party may file written objections to the magistrate's decision within 14 days of the filing of the decision. A party shall not assign as error on appeal the court's adoption of any finding or conclusion of law contained in the magistrate's decision unless the party timely and specifically objects to that finding or conclusion as required by Civ.R. 53(E)(3).*

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ANDERSON M. RENICK
Magistrate

Entry cc:

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AMR/cmd
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