[Cite as *Brown v. Delliquadri*, 2010-Ohio-5182.]

IN THE COURT OF APPEALS

ELEVENTH APPELLATE DISTRICT

TRUMBULL COUNTY, OHIO

JEREMY BROWN, INDIVIDUALLY AND ON BEHALF OF MINORS JEREMY D. BROWN AND EMILY BROWN,	:	**O P I N I O N**
Plaintiff-Appellant,	:	**CASE NO. 2009-T-0094**
- vs -	:	
JOHN AND DAVID DELLIQUADRI, D.O., INC., et al.,	:	
Defendants-Appellees.	:	

Civil Appeal from the Trumbull County Court of Common Pleas, Case No. 2005 CV 01397.

Judgment: Affirmed

Scott R. Cochran, Atway & Cochran, L.L.C., 19 East Front Street, #1, Youngstown, OH 44503 (For Plaintiff-Appellant).

Douglas G. Leak, Roetzel & Andress, L.P.A., 900 One Cleveland Center, 1375 East Ninth Street, Cleveland, OH 44114 (For Defendants-Appellees).

Michael J. Hudak, Roetzel & Andress, L.P.A., 222 South Main Street, Akron, OH 44308 (For Defendants-Appellees).

DIANE V. GRENDELL, J.

{¶1} Plaintiff-appellant Jeremy Brown, individually and on behalf of the minors, Jeremy D. Brown and Emily Brown, appeals the Judgment Entry of the Trumbull County Court of Common Pleas, denying his Motion for Judgment Notwithstanding the Verdict

and/or Motion for New Trial. Brown had brought suit against defendant-appellee, John P. Delliquadri, D.O., alleging medical malpractice. For the following reasons, we affirm the decision of the court below.

{¶2} On December 20, 2001, Brown was working as a machine operator at HM Steel in Niles, Ohio. On that date, Brown was electrocuted when he inadvertently grabbed the bottom rail of an overhead crane with his left hand.

{¶3} Brown was taken by ambulance to Tod Minor ER Center in Warren, Ohio. An EKG revealed a right bundle branch block and Brown complained of pain and weakness in the left shoulder. Brown described the pain as a "10" on a scale of one to ten. Brown was admitted to St. Joseph Health Center under the care of Dr. Douglas A. Dunlap. Brown was initially administered Toradol for pain and, subsequently, Vicodin.

{¶4} Brown was released on December 21, 2001. According to the discharge summary: "The patient stated he was feeling better, but he was still having some weakness in his left shoulder and still felt like there were some knots in there." Brown testified that he could "barely move the arm" and kept it in a sling.

{¶5} On December 28, 2001, Brown met with his personal physician, Dr. Delliquadri. According to Delliquadri's records, Brown showed a "marked amount of weakness in the left hand left elbow to flexion and extension against resistance," "literally no range of motion or strength in his shoulder joint," and "pain throughout the shoulder joint and the left arm." Delliquadri entered a diagnosis of "left shoulder sprain." Delliquadri had Brown keep the arm in a sling and prescribed Vicodin for the pain. Brown was referred to physical therapy.

{¶6} On January 10, 2002, Brown was evaluated by physical therapist, Larry Bradley, of Banyan Tree Rehabilitation. Bradley's evaluation revealed weakness and decreased range of motion in the left upper extremities and pain in the left shoulder. Bradley noted his "[f]indings [were] consistent with diagnosis." Brown underwent physical therapy at Banyan Tree three times a week from January 10 to February 8, 2002. During this time, Dr. Delliquadri continued to see Brown approximately every other week.

{¶7} On January 11, 2002, Dr. Delliquadri determined that an "EMG with nerve conduction evaluation" should be performed on Brown. As of February 15, 2002, Delliquadri was still awaiting approval for the EMG.

{¶8} At the conclusion of the physical therapy, Bradley re-evaluated Brown, finding that none of the goals were met with respect to weakness, range of motion, and pain. Bradley noted that "slow progress" was being made and that Brown would "benefit from additional therapy to restore functional use with left upper extremity."

{¶9} On February 15, 2002, according to Dr. Delliquadri's records, Brown stated that "his strength and range of motion in his left arm is improving, neck pain and upper back pain improving," although "he has continued discomfort and pain." Delliquadri prescribed Brown non-narcotic Ketoprofen for pain.

{¶10} On February 28, 2002, Dr. Delliquadri examined Brown and noted continued discomfort and pain and decreased strength and range of motion. Delliquadri began performing osteopathic manipulation on Brown and continued to do so approximately every other week through September 2002. Delliquadri prescribed Brown Ultram for pain as needed.

{¶11} On March 8, 2002, Dr. Delliquadri saw Brown and found "some improvement regarding left shoulder range of motion and strength," and that Brown claimed "the Ultram is helping." It was observed that osteopathic manipulation was providing "some relief." Delliquadri noted that they were awaiting approval from the Bureau of Workers' Compensation for additional physical therapy.

{¶12} On March 25, 2002, Dr. Delliquadri's records report that Brown returned to "light duty" work at the plant.

{¶13} Subsequent visits record the persistence of pain, weakness, and limited range of motion, with periods of improvement as well as regress.

{¶14} At the end of June 2002, the HM Steel plant closed and Brown ceased working.

{¶15} On August 21, 2002, the Bureau of Workers' Compensation, through the health management firm, CorVel Corporation, denied the request for additional physical therapy. The letter of denial stated: "IW [injured worker] has had continued PT [physical therapy] with persistent but limited diagnostics to assess source of difficulties. Prior to pursuing additional PT, which has been of limited objective benefit by treatment documentation, it would be prudent to pursue diagnostic testing, i.e. EMG/NCV LUE, possible MRI."

{¶16} On September 5, 2002, following a peer review/appeal of the prior denial, physical therapy was authorized three times a week for a four week period. The authorization letter stated: "The services of the physical therapy are related to the claim. This etiology is much different than what would be considered a typical muscle sprain/strain injury, considerable muscle break down can occur during electrical injury

sometimes necessitating surgical intervention. **Recommendations: Further consideration should be given to additional diagnostic testing if the continuation of physical medicine modalities provides no sustained objective benefits.**" (Emphasis sic.)

{¶17} From September 9 to October 14, 2002, Brown was evaluated by physical therapist, Robert A. Farr, and underwent further therapy at Banyan Tree Rehabilitation. At the conclusion of therapy, Farr reported that Brown's goals were partially met. There was progress in shoulder strength, range of motion, and functional use, although these indications, including pain, persisted.

{¶18} On November 8, 2002, Dr. Delliquadri's records indicated decreased shoulder strength and range of motion and increased pain. The records also noted that Brown had "numbness [and] tingling throughout the left arm and hand region." Delliquadri ordered Brown to undergo an EMG with nerve conduction.

{¶19} On December 3, 2002, Dr. Joseph Cerimele performed an EMG with nerve conduction which detected a slight ulnar motor nerve problem at the wrist, but was otherwise normal with respect to the shoulder.

{¶20} On December 6, 2002, Dr. Delliquadri ordered an x-ray of the left shoulder.

{¶21} On December 12, 2002, an x-ray was taken of Brown's left shoulder. The results indicated a "complete anterior dislocation of the humeral head," and a "Hill-Sach's deformity of the greater tuberosity region of the humerus."

{¶22} On December 16, 2002, Dr. Delliquadri noted the results of the x-ray. Delliquadri was of the opinion that Brown "has had a chronically subluxating left

shoulder joint or humeral head which will indeed need surgically [sic] corrected after the MRI to assess the rotator cuff and ligament damage." Delliquadri noted "the patient does state there are times that it feels like it pops in or out and he is having chronic problems with this."

{¶23} On January 3, 2003, Dr. Delliquadri noted that Brown feels the shoulder is "chronically out presently," and that they are awaiting approval for an MRI from the Bureau of Workers' Compensation.

{¶24} On February 12, 2003, Brown underwent a left-shoulder MRI. The results indicated the "apparent dislocation of left shoulder which is most likely chronic in nature," a "hatchet-head deformity involving the humeral head also consistent with chronic dislocation," some tearing of the rotator cuff, and tearing of the glenoid labrum.

{¶25} The results of the MRI were reviewed by Edward J. Uberti, D.O., who reported: "The MRI shows what appears to be a rotator cuff tear and an obviously dislocated shoulder with a large Hill-Sachs lesion on the posterior aspect of the humeral head. *** Physical exam shows obvious deformity of the left shoulder. The acromion shows a sharp edge and a significant drop of[f] with squaring of the shoulder as compared to the right shoulder which is normally rounded by the deltoid. The palpation shows that the humeral head is in deed anterior and inferior to the glenoid. Palpation in the subacromial space shows a wide defect."

{¶26} On April 7, 2003, Brown was seen by Dr. John H. Wilber, an orthopedic surgeon.

{¶27} On December 19, 2003, Dr. Wilber operated on Brown to reduce the dislocation. Wilber noted that the humeral head was wedged in against the rim of the

glenoid cup and that this area was densely scarred. Contrary to earlier expectations, the rotator cuff was intact.

{¶28} Post-operative, Brown continues to suffer from decreased functional use/range of motion in his left arm and pain, for which he is prescribed Vicodin.

{¶29} On June 16, 2005, Brown filed a Complaint for medical negligence against Dr. Delliquadri, David Delliquadri, D.O., John and David Delliquadri, D.O., Inc., and Humility of Mary Health Partners, Inc. David Delliquadri and Humility of Mary Health Partners were subsequently voluntarily dismissed, pursuant to Civil Rule 41(A).

{¶30} The case was tried before a jury for 8 days between June 23 and July 2, 2009.

{¶31} Brown testified that during the whole period in which he was under Dr. Delliquadri's care he suffered pain, weakness, and a decreased range of motion in his left arm. Physical therapy provided some relief for the pain, but it was aggravated by physical activity. Brown denied telling Delliquadri that the shoulder was popping in and out of joint. Rather, after the second course of physical therapy, he felt a "popping sensation" in the area of the collar bond, "like something was rubbing up against something else which caused like a popping sound."

{¶32} Brown testified that Dr. Delliquadri never advised him that his shoulder was dislocated, although he met with Delliquadri several times in December 2002 and January 2003. According to Brown, he was first advised of the shoulder dislocation by Dr. Uberti in March 2003.

{¶33} Lawrence Bradley, the physical therapist who worked with Brown from January to February 2002, testified that there were visible differences in the appearance

of Brown's left and right shoulders. In particular, there was a "sulcus sign" in the left shoulder, i.e. an indentation caused by a separation of the humeral head from the acromion. Bradley also observed "laxity" or looseness in the shoulder joint and muscle atrophy. Although these are indicators of dislocation, Bradley believed Brown's shoulder was "subluxed," i.e. not in its normal position, rather than totally dislocated.

{¶34} Dr. Michael P. McGonigal, a practitioner of family medicine from Bethel Park, Pennsylvania, testified as an expert on Brown's behalf. McGonigal testified that the standard of care for a family physician, when a patient has suffered electrical shock and has symptoms of pain, weakness, and decreased range of motion, is to consult an orthopedic specialist and/or perform a diagnostic test (such as an x-ray) within sixty days. Shoulder dislocation is a common consequence of electric shock injury. The consultation and diagnostic testing is important because "the potential for serious injury is so high." Moreover, only by diagnostic testing is it possible to determine whether a shoulder is dislocated, subluxed, or fractured. Given Brown's symptoms, Dr. Delliquadri breached the standard of care by not consulting a specialist or ordering diagnostic testing, especially after the minimal progress made in physical therapy.

{¶35} Dr. Wilber, the orthopedic surgeon who reduced Brown's shoulder in December 2003, testified that he believed the shoulder had been totally dislocated since the electric insult in December 2001. He based his opinion on the large size of the Hill-Sachs lesion found on the humeral head and the scarring of the ligature. Wilber opined that the longer the head remained wedged against the rim of the glenoid, the larger the legion will be. Wilber was unable to quantify how much of the lesion was caused by the

original dislocation and how much of it was due to the passage of time. Wilber testified that the scarring he observed could have developed within a year of the dislocation.

{¶36} Dr. Steven E. Kahn, an orthopedic surgeon from Pittsburgh, Pennsylvania, testified as an expert on Brown's behalf. Kahn testified that joint dislocation is a known complication of electrical shock injury. The common signs of dislocation - pain, weakness, and loss of range of motion - were present in Brown immediately after the electric insult. Accordingly, Kahn believed that Brown's shoulder dislocated in December 2001. Kahn's opinion was also supported by the size of the Hill-Sachs lesion, the adhesion of the humeral head to the glenoid, and scar tissue around the glenoid.

{¶37} Dr. Kahn testified that the longer the humeral head remained against the glenoid, the deformity of the humeral head would be larger. Performing physical therapy with the head dislocated in this position would cause further damage and pain as it ground against the harder bone of the glenoid. Over time, one could see improvement in the range of motion as the humeral head was drawn ("telescoped") back toward its proper location although, in fact, the head was becoming further embedded in the glenoid. As the head became further embedded, the dislocation would become less visibly and palpably observable.

{¶38} Dr. Kahn testified that a dislocation was not always observable, particularly in muscular individuals, and noted that Dr. Wilber described Brown as muscular.

{¶39} Dr. Kahn disagreed with the opinion that the shoulder had been subluxating since the original injury, only becoming fully dislocated at the end of 2002.

If the shoulder had been subluxating, popping in and out of joint, there would have been fragments of cartilage in the joint. Dr. Wilber's post-operative report, however, did not indicate any fragmentation of the cartilage.

{¶40} Finally, Dr. Kahn testified that tearing in the labrum could allow a shoulder to subluxate and, unless corrected, could lead to a permanent dislocation. Moreover, some labral tears may be treated by physical therapy while others require surgery. Diagnostic testing, such as an MRI, would be necessary to make that diagnosis.

{¶41} Farr, a physical therapist who evaluated Brown during the second course of therapy in September and October 2002, testified that as part of the evaluation he observed, palpated, and manipulated Brown's shoulder. Farr testified that during therapy Brown demonstrated increased strength and some improvement to the range of motion, although the pain persisted. He noted atrophy and laxity. Farr did not find indications of dislocation and did not believe Brown's shoulder was dislocated during therapy: "there was the quality of movement, there was the range of movement that he had and some of his abilities to perform exercises or activities of daily living that was indicative of [it] not being dislocated." Nor did Farr observe subluxation, in which case the patient reports the sensation of the joint popping in and out.

{¶42} Dr. Michael Yaffe, an internal medicine physician practicing in Columbus, Ohio, testified as an expert on behalf of Dr. Delliquadri. Yaffe opined that Delliquadri's treatment of Brown met the standard of care. Yaffe opined that the initial electrical shock weakened "the support structures of the shoulder and the muscles that allowed this shoulder to eventually dislocate ***[;] if he had a dislocation from the beginning, he would not have experienced the popping sound" reported in December 2002. Yaffe

explained that Brown's muscles weakened over time resulting in a progression from laxity (play or movement in the joint) to subluxation to dislocation: "the muscles weakened from the electrical injury, and weakened to the point where they could no longer hold the shoulder joint in and it began to creak *** and eventually began to pop out to the point where it didn't go back in."

{¶43} Dr. Yaffe testified that Brown would not have been able to participate in physical therapy had his shoulder been fully dislocated at the time of the initial injury. While pain, weakness, and a decreased range of motion are indicative of dislocation, they are also indicative of other conditions such as muscle damage or laxity or subluxation. Accordingly, Brown's condition did not warrant diagnostic testing during 2002 and the treatment of his condition through physical therapy was reasonable.

{¶44} Arthur Nitz, a physical therapist from Frankfort, Kentucky, testified as an expert on behalf of Dr. Delliquadri. Nitz testified that the "classic position" for a dislocation caused by electrocution is a posterior dislocation, rather than an anterior dislocation as in Brown's case. Nitz did not believe that Brown's shoulder dislocated as a result of the initial electric insult. It was "virtually impossible" that "an individual could have the kind of deformity that occurs with an anterior dislocation and be able to tolerate the motion, strength assessment, physical therapy that then ensued on two separate occasions for a month each and have a shoulder dislocation."

{¶45} Nitz also testified that it was unlikely that two physical therapists would have failed to notice an anterior dislocation given the prominence of the deformity. When a shoulder dislocates, the deltoid muscle, forming the curve of the shoulder, loses its contour without the humeral head to support it. The normally rounded shoulder

becomes squared and the acromion becomes its most prominent feature. It is unlikely that therapists, who are constantly palpating the patient, would fail to notice such indicators.

{¶46} In the absence of prominent physical deformity and given that some progress occurred in therapy, Nitz opined it was not necessary to obtain an orthopedic consult or diagnostic testing in Brown's case prior to December 2002.

{¶47} Dr. Delliquadri testified that at no time prior to December 2002 did his physical examinations or osteopathic manipulations of Brown's shoulder reveal "any gross deformity or bony abnormalities." His initial impression of Brown's condition was shoulder sprain and/or strain and he presupposed some damage to the supporting structures, i.e., the ligaments and musculature, of the shoulder. He saw Brown approximately every two weeks throughout 2002 and noted overall progress, despite relative setbacks. On his initial visit, Brown had no range of motion; by February 2002, he had limited range of motion. Delliquadri testified that persons with musculoskeletal injuries often showed a pattern of progress and regress. Brown appeared to be feeling better over time and his pain was managed with Tramadol, a "pretty mild" analgesic.

{¶48} Dr. Delliquadri did not observe any physical signs of dislocation during this time. He repeatedly examined Brown's shoulder and the humeral head was never palpable underneath the coracoid process. Delliquadri did not believe Brown to be so muscular as to mask an anterior dislocation. Nor did Delliquadri observe a loss of contour in the deltoids.

{¶49} Dr. Delliquadri also performed osteopathic manipulation on Brown, a cross-armed thrust technique, throughout 2002 prior to December. Usually, Brown felt

better after such manipulation. For these reasons, Delliquadri did not consider an orthopedic consult or diagnostic procedures necessary.

{¶50} On November 8, 2002, Brown reported a numbness and tingling in his arm. As these were new indications, Dr. Delliquadri ordered an EMG. On December 6, 2002, Delliquadri noticed changes in the bony structure around the shoulder joint, with the humeral head appearing anteriorly. Delliquadri did not record these observations in his medical records, but testified that because of them he ordered Brown to be x-rayed. At subsequent appointments, Brown related that he felt the shoulder popping in and out of joint.

{¶51} Dr. Delliquadri testified that he believed that, at the time of the electric insult, the shoulder dislocated but immediately self-reduced. The supporting structures, however, were damaged at this time which made the subsequent dislocation possible.

{¶52} Dr. Dunlap, an internal medicine specialist and Brown's treating physician at St. Joseph Health Center, testified that he did not find indications of dislocation in Brown's shoulder while Brown was at the hospital.

{¶53} Dr. Lisa DeStefano, a specialist in family medicine and neuro-musculoskeletal medicine at the Michigan State University College of Osteopathic Medicine, testified as an expert on behalf of Dr. Delliquadri. She testified that osteopathic manipulation was an appropriate treatment in Brown's case and that "the type of osteopathic manipulation that was used [by Delliquadri] would have been very difficult, if not impossible to do in light of a dislocated shoulder." Performing such techniques on a patient with a dislocated shoulder would increase the pain, rather than provide relief.

{¶54} Dr. Cerimele, who performed the EMG on Brown in December 2002, testified that there was a "very good possibility" of detecting an anterior dislocation during the EMG, although that test is not appropriate for that purpose. Had he suspected that Brown had a dislocated shoulder, he would have noted it in his report.

{¶55} On July 2, 2009, six members of the jury returned a Verdict for the Defendant. The jury responded in the negative to the following interrogatory: "Have plaintiffs proven by the greater weight of the evidence that defendant Dr. John Delliquadri was negligent?"

{¶56} On July 16, 2009, Brown filed a Motion for Judgment Notwithstanding the Verdict and/or Motion for New Trial.

{¶57} On August 27, 2009, the trial court entered a Judgment Entry, overruling Brown's Motion.

{¶58} On September 24, 2009, Brown filed a Notice of Appeal. On appeal, Brown raises the following assignments of error:

{¶59} "[1.] The jury's verdict in favor of Defendant-Appellee was contrary to the manifest weight of the evidence, and the trial court abused its discretion in denying Plaintiff-Appellant's motion for a new trial."

{¶60} "[2.] The trial court erred in denying the Plaintiff-Appellant's motion for judgment notwithstanding the verdict."

{¶61} "[N]ot later than fourteen days after entry of judgment [following a jury trial], a party may move to have the verdict and any judgment entered thereon set aside and to have judgment entered in accordance with his motion; or if a verdict was not returned, such party, within fourteen days after the jury has been discharged, may move

for judgment in accordance with his motion." Civ.R. 50(B); *Freeman v. Wilkinson* (1992), 65 Ohio St.3d 307, 309 (Civ.R. 50(B) "only applies in cases tried by jury").

{¶62} "A motion for a new trial may be joined with this motion, or a new trial may be prayed for in the alternative." Civ.R. 50(B).

{¶63} "A new trial may be granted to all or any of the parties and on all or part of the issues," where "[t]he judgment is not sustained by the weight of the evidence." Civ.R 59(A)(6).

{¶64} When considering a motion for judgment notwithstanding the verdict, "[t]he evidence adduced at trial and the facts established by admissions in the pleadings and in the record must be construed most strongly in favor of the party against whom the motion is made, and, where there is substantial evidence to support his side of the case, upon which reasonable minds may reach different conclusions, the motion must be denied." *Posin v. A.B.C. Motor Court Hotel, Inc.* (1976), 45 Ohio St.2d 271, 275. "In considering a motion for judgment notwithstanding the verdict, a court does not weigh the evidence or test the credibility of the witnesses." *Osler v. Lorain* (1986), 28 Ohio St.3d 345, at syllabus; *Posin*, 45 Ohio St.2d at 275 ("[n]either the weight of the evidence nor the credibility of the witnesses is for the court's determination"). Thus, the question is whether there is sufficient evidence regarding a particular issue for the trial court to submit the issue to the jury for determination. *O'Day v. Webb* (1972), 29 Ohio St.2d 215, at paragraph four of the syllabus.

{¶65} "In evaluating the propriety of the trial court's decision premised on the weight of the evidence," however, "a reviewing court can reverse such an order for a new trial only upon a finding of an abuse of discretion." *Malone v. Courtyard by Marriott*

Ltd. Partnership, 74 Ohio St.3d 440, 448, 1996-Ohio-311. When reviewing such a judgment, the court is "guided by the principle that judgments supported by competent, credible evidence going to all the material elements of the case must not be reversed, as being against the manifest weight of the evidence." *Karches v. Cincinnati* (1988), 38 Ohio St.3d 12, 19, citing *C.E. Morris Co. v. Foley Constr. Co.* (1978), 54 Ohio St.2d 279, at syllabus.

{¶66} "There is a basic difference between the duty of a trial court to submit a case to the jury where 'reasonable minds' could differ and the right of a trial court to grant a new trial on the basis of its conclusion that the verdict is not 'sustained by sufficient evidence.' The former does not involve any *weighing* of evidence by the court; nor is the court concerned therein with the question of credibility of witnesses. However, in ruling on a motion for new trial upon the basis of a claim that the judgment 'is not sustained by sufficient evidence,' the court must weigh the evidence and pass upon the credibility of the witnesses, not in the substantially unlimited sense that such weight and credibility are passed on originally by the jury but in the more restricted sense of whether it appears to the trial court that manifest injustice has been done and that the verdict is against the manifest weight of the evidence." *Rohde v. Farmer* (1970), 23 Ohio St.2d 82, at paragraph three of the syllabus (emphasis sic).

{¶67} In the present case, the question of whether the trial court properly denied Brown's Motion depends on whether the jury's verdict is against the weight of the evidence. Cf. *State v. Robinson* (1976), 47 Ohio St.2d 103, 107 ("[i]n a civil case, the plaintiff normally has the burden of producing evidence to support his case"). The Ohio Supreme Court has recognized that the standard set forth in *C.E. Morris* "tends to

merge the concepts of weight and sufficiency," so that "a judgment supported by 'some competent, credible evidence going to all the essential elements of the case' must be affirmed." *State v. Wilson*, 113 Ohio St.3d 382, 2007-Ohio-2202, at ¶26; cf. *Poske v. Mergl* (1959), 169 Ohio St. 70, 73 ("where there is a motion for a new trial upon the ground that the judgment is not sustained by sufficient evidence, a duty devolves upon the trial court to review the evidence adduced during the trial and to itself pass upon the credibility of the witnesses and the evidence in general"). Accordingly, our standard of review is abuse of discretion. *Rohde*, 23 Ohio St.2d 82, at paragraph one of the syllabus.

{¶68} Brown's arguments rely upon the applicability of the "physical facts rule" in the present case.

{¶69} The Ohio Supreme Court has stated various formulations of the physical facts rule. "[T]he testimony of a witness which is opposed to the laws of nature, or which is clearly in conflict with principles established by the laws of science, is of no probative value and a jury is not permitted to rest its verdict thereon." *McDonald v. Ford Motor Co.* (1975), 42 Ohio St.2d 8, 12 (citation omitted). Similarly, "[t]he testimony of a witness which is positively contradicted by the physical facts cannot be given probative value by the court." Id. (citation omitted). Any application of the doctrine must strive to strike "a balance between, on the one hand, the common sense notion that physical facts and evidence can be so conclusive and demonstrative that no reasonable person could accept the truth of contrary testimony, and, on the other hand, the need for courts to be wary of treating a party's theory of a case as 'fact,' when a different theory is also possible in the case." Id. at 13.

{¶70} Brown maintains that the testimony at trial established two incontrovertible facts: 1) "[t]here was a large, 'hatchet head' sized deformity in Jeremy Brown's left humeral head"; and (2) "the cartilage surrounding the humeral head was intact"/"there was no loose cartilage found during Dr. Wilber's operation." According to Brown, these two facts, combined with Dr. Kahn's and Dr. Wilber's testimony, compel the conclusion that his "shoulder had been dislocated for a long time prior to the December 12, 2002 X-ray and had remained continuously dislocated."

{¶71} We disagree that the existence of a large Hill-Sachs lesion as of December 2002 and the absence of loose cartilage in the shoulder as of December 2003 establish the dislocation of Brown's shoulder in December 2001 as incontrovertible fact. Given that the existence of a large deformity and the absence of loose cartilage are facts, the belief that the shoulder had been dislocated for a year is only a conclusion inferred from those facts. This conclusion is not incontrovertible.

{¶72} Dr. Kahn testified that it was his opinion that the size of the deformity was caused by the length of time the shoulder had been dislocated. He did not testify that the only possible cause of a large deformity is an extended period of dislocation. Kahn testified that the initial dislocation could cause a large deformity in an elderly female, but one "would anticipate a healthy male in his 20's to have just a small divot initially." This testimony demonstrates that Kahn's conclusion about the length of time the shoulder was dislocated is his opinion based on available facts, not a "physical fact" itself. It is also significant that Dr. Wilber testified that he was unable to quantify how much of the Hill-Sachs lesion was due to the initial dislocation and how much of it was due to "chronicity."

{¶73} With respect to the cartilage issue, Dr. Kahn testified that if the shoulder was popping in and out, as suggested by defense witnesses, there would be fragments of cartilage in the joint: "every time it dislocates you tend to sheer off cartilage, so you get fragments, loose bodies in the joint." Kahn noted, however, that Dr. Wilber reported "that the cartilage looked fine," and "inter-operatively [he] did not note any cartilage shavings." Again, these facts merely support the conclusion that the shoulder had been dislocated since the time of electrocution; they do not establish it as fact.

{¶74} Other testimony demonstrates that Dr. Kahn's conclusion is not inescapable. While Kahn testified, at one point, the cartilage was intact, when testifying in regards to Brown's traumatic arthritis, he stated there was an absence of any cartilage in the ball and socket: "there is no longer cartilage covering the bones."

{¶75} Dr. Kahn's ultimate conclusion about the significance of the absence of cartilage fragments is also contradicted by the witnesses testifying on behalf of Dr. Delliquadri. Drs. Yaffe and DiStefano and professor Nitz proffered the opinion that Brown's shoulder did not dislocate prior to December 2002 based on the physical therapy and osteopathic manipulations he underwent during this time. Physical therapists Bradley and Farr and Drs. Dunlap and Cerimele physically examined Brown's shoulder prior to December 2002 and none of them found reason to believe that it was dislocated.[1] Finally, Delliquadri examined Brown twenty-four times in 2002 prior to the x-ray. Yet, he did not believe the shoulder dislocated until sometime between November and December.

1. We acknowledge that many of the professionals who examined Brown found symptoms that could be indicative of dislocation, but none of them drew this conclusion.

{¶76} Brown dismisses all the evidence offered by Dr. Delliquadri as being "discredited through the application of the physical facts rule." Contrary to the requirements of *McDonald*, Delliquadri's evidence is not self-contradictory, not inherently false, and not inconsistent with undisputed physical facts. 42 Ohio St.2d at 12. It is not possible to establish with absolute certainty the condition of Brown's shoulder in December 2001. Brown's witnesses claim it was dislocated based on its condition in December 2002. Delliquadri's witnesses claim it was not dislocated based on its functional use and the lack of palpable injury. Brown's witnesses may provide explanations as to why Brown was able to undergo therapy and why the dislocation may not have been palpable, but they do not conclusively exclude the possibility that the dislocation did not occur until the end of the year.

{¶77} In this respect, the present case is similar to other medical malpractice actions where the appellate courts have declined to apply the physical facts rule. In *Ellinger v. Ho*, 10th Dist. No. 08AP-1079, 2010-Ohio-553, the defendant-physician diagnosed the plaintiff as having bladder cancer in the clinical stage; the plaintiff's expert testified, based on information learned post-operatively, that the plaintiff's cancer was in the pathologic stage. On appeal, the plaintiff argued the application of the physical facts rule precluded the jury from giving any weight to the physician's testimony. The court of appeals disagreed: "Although post-surgery pathological testing showed that the cancer had invaded the prostate, Ho did not know that when he conducted the clinical staging. Thus, the post-surgery results of pathological testing do not contradict Ho's testimony that, given what he knew prior to surgery, the correct clinical stage diagnosis was T3 bladder cancer." Id. at ¶77.

{¶78} In *Bedard v. Gardner*, 2nd Dist. No. 20430, 2005-Ohio-4196, the plaintiff filed suit when she developed a fistula between the rectum and vagina following colo-rectal surgery. The plaintiff's witnesses testified the fistula occurred as a result of the rectum and vagina being negligently stapled together during surgery. The defendant-physician claimed the location of the staples observed by plaintiffs' experts was the result of post-operative inflammation. The plaintiff countered there was no evidence of infection, inasmuch as her white blood cell count was normal. The court of appeals acknowledged that the plaintiff's arguments, "while persuasive," were not conclusive. Id. at ¶¶36-38. "Plaintiff's theory contended facts, but the facts contended were subject to dispute, and not so conclusive as to make the trial court's finding that the verdict was not against the weight of the evidence one which is an abuse of the discretion conferred on the court by Civ.R. 59(A)(6)." Id. at ¶39.

{¶79} Finally, assuming arguendo that Brown's shoulder permanently dislocated in December 2001, this fact would not require this court to reverse the jury's verdict. That verdict was based on the jury's determination that Brown had failed to prove "by the greater weight of the evidence that defendant Dr. John Delliquadri was negligent." The answer to this question turned on whether Delliquadri violated his duty of care toward Brown by not obtaining an orthopedic consult or ordering diagnostic testing within the first two months of treatment. Whether Brown's arm was actually dislocated is not absolutely determinative of this issue.

{¶80} Dr. McGonigal testified that given the circumstances of the injury, i.e. electric insult, and the symptoms consistently displayed by Brown, i.e. weakness, pain, and limited range of motion, a reasonable practitioner of family medicine would have

consulted a specialist or performed diagnostic testing. Dr. Yaffe testified, on the contrary, that Dr. Delliquadri's diagnosis and treatment of Brown's shoulder through physical therapy and osteopathic manipulation was appropriate and within the standard of care. Dr. DiStefano proffered a similar opinion. We further note that Brown's expert, Dr. Kahn, testified to the essential plausibility of these opinions. He stated that, if Brown had only suffered a torn labrum initially, it would allow the humeral head to pop in and out of place before becoming completely dislocated. Kahn also acknowledged that, in some instances, it is appropriate to treat labral tears through physical therapy.

{¶81} Brown's two assignments of error are without merit.

{¶82} For the foregoing reasons, the judgment of the Trumbull County Court of Common Pleas, denying Brown's Motion for Judgment Notwithstanding the Verdict and/or Motion for New Trial, is affirmed. Costs to be taxed against appellant.

CYNTHIA WESTCOTT RICE, J.,

COLLEEN MARY O'TOOLE, J.,

concur.