97-LW-3104 (10th)

Gary W. James, Plaintiff-Appellant,
v.
Albert W. VanFossen, M.D., Defendant-Appellee.

No. 96APE11-1609
10th District Court of Appeals of Ohio, Franklin County.
Decided on June 10, 1997.

APPEAL from the Franklin County Court of Common Pleas.

Ray, Alton & Kirstein Co., L.P.A., and John M. Alton, for appellant.

Reminger & Reminger, and Warren M. Enders, for appellee.

OPINION

TYACK, P.J.

On October 21, 1994, Gary W. James and his wife, Fran James,(fn1) filed a complaint in the Franklin County Court of Common Pleas, naming as the lone defendant Albert W. VanFossen, M.D., a physician practicing ophthalmology. The complaint alleged, inter alia, that Dr. VanFossen was negligent in his care and treatment of Mr. James; specifically, Dr. VanFossen failed to diagnose and treat in a timely manner a very serious eye condition, lattice degeneration, which ultimately resulted in retinal detachment.

As a result of the doctor's purported negligence, Mr. James suffered a retinal detachment in July 1993, endured eight surgical procedures, and ultimately lost most of the "useful" vision in his left eye.

A jury trial commenced on October 21, 1996. On October 24, the jury returned a verdict in favor of Dr. VanFossen. The jury's verdict was journalized pursuant to a judgment entry filed November 4, 1996.

Gary W. James (hereinafter "appellant") has timely appealed, assigning a single error for our consideration:

> "THE JURY'S FINDING THAT DEFENDANT-APPELLEE ALBERT W. VANFOSSEN, M.D.[,] WAS NOT NEGLIGENT WAS AGAINST THE MANIFEST WEIGHT OF THE EVIDENCE."

In addressing the assignment of error, we are guided by the well-established rule of C.E. Morris Co. v. Foley Construction Co. (1978), 54 Ohio St.2d 279, in which the Supreme Court of Ohio held, at the syllabus:

> "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."

See, also, Ross v. Ross (1980), 64 Ohio St.2d 203, 205; Vogel v. Wells (1991), 57 Ohio St.3d 91, 96.

Applying the above standard, we now examine the evidence adduced at trial to determine whether the jury's determination that Dr. VanFossen was not negligent was supported by "some competent, credible evidence."

Appellant, age 47 at the time of trial, had been a patient of Dr. VanFossen's since 1969, when appellant was 21. At the time of trial, Dr. VanFossen had been practicing ophthalmology for approximately 38 years.

Appellant's initial visit to Dr. VanFossen in 1969 was solely for a routine eye examination. Appellant had worn corrective eyeglasses since he was in the ninth grade; otherwise, his visual health history was unremarkable. Dr. VanFossen examined appellant's eyes, which included dilation of his eyes, and indicated no additional problems. (Tr. 12-14.) According to appellant, every eye examination conducted on him by Dr. VanFossen included dilation of his eyes. (Tr.

15.)

Appellant's next visit to Dr. VanFossen was some 10 years later in 1979. According to appellant, during those intervening 10 years, he had been examined by other optometrists and/or opthalmologists, primarily for purposes of trying contact lenses, which ultimately proved unsuccessful. Appellant decided to see Dr. VanFossen again because he needed new eyeglasses. The 1979 examination conducted by Dr. VanFossen revealed no new or additional problems with appellant's eyes. (Tr. 15.)

Appellant's next uneventful visit to Dr. VanFossen, again for updated eyeglasses, was four years later, in 1983. (Tr. 15.)

In February 1985, appellant saw Dr. VanFossen again. According to appellant, he informed the doctor that he had been taking flying lessons to become a licensed pilot. He also told the doctor that while flying, he had been noticing "floaters" in his vision. (Tr. 18.)

"Floaters," according to expert testimony in the record, are particles resulting from "collagen fiber condensation." Oftentimes, floaters are a harmless result of the aging process.

According to appellant, Dr. VanFossen indicated during the February 1985 examination that the floaters were common and nothing to be concerned about. (Tr. 18.) On cross-examination, appellant acknowledged that during a pre-trial deposition, he stated that he reported "nothing abnormal" to Dr. VanFossen during the February 1985 examination. (Tr. 267.)

Dr. VanFossen testified that he was "absolutely certain" that appellant said nothing to him about flying or experiencing floaters during the February 1985 examination. (Tr. 434.)

In July 1985, appellant obtained his pilot's license. The process required that he successfully complete a physical examination, which he did. He was required to repeat the physical every two years. (Tr. 277-279.) Details of pertinent physicals are discussed below.

Appellant's next visit to Dr. VanFossen was on November 1, 1988. According to appellant, when appellant informed the doctor that he was "still" flying airplanes and "still" seeing floaters, the doctor again responded that they were nothing to be concerned about. (Tr. 21.)

According to Dr. VanFossen, this November 1, 1988 examination was the first during which appellant mentioned experiencing floaters. Dr. VanFossen recalled informing appellant that "[t]here's no need to worry about them <u>so long as they do not change</u> significantly." (Tr. 358; 431-435; emphasis added.)

George E. Konold, D.O., an aviation medical examiner certified by the Federal Aviation Agency ("FAA"), testified on behalf of Dr. VanFossen. Dr. Konold performed the physical exams on appellant required by the FAA. Each physical included a direct examination of the retina. Following satisfactory completion of each physical, the doctor issued medical certificates for appellant, with the only limitation being that he wear his glasses while flying. (Tr. 378-385.)

Dr. Konold testified specifically regarding the physical he conducted on appellant on March 18, 1993. According to the medical history portion of the standard form completed by the patient, appellant responded "no" to the question "eye or vision trouble except glasses." (Tr. 391.) Dr. Konold testified that appellant's chart indicates that during this examination, appellant never mentioned seeing light flashes. (Tr. 394.)

Appellant's next and final visit to Dr. VanFossen occurred on April 29, 1993, when appellant scheduled another "routine" examination. Appellant thought that his vision had changed to the extent that he might need reading glasses. According to appellant, he told Dr. VanFossen that he continued to experience floaters. Appellant thought he recalled the doctor asking if there had been any "change" in the condition. Appellant believes he responded, "maybe a little." (Tr. 24-26; 307-308.)

Dr. VanFossen's recollection of the discussion about the floaters was essentially the same. The doctor did not note on appellant's chart the floaters because, in the doctor's opinion based upon what his patient told him, the floaters had

not changed significantly enough to warrant particular concern. (Tr. 366; 438-439.)

According to appellant, during the April 1993 examination, Dr. VanFossen shined a light in appellant's eyes as part of the "direct" examination. This led appellant to recall, and in turn to inform the doctor, that he had experienced "light flashes" four or five times since December 1992 or January 1993. (Tr. 26-27; 301-302.) According to appellant, Dr. VanFossen did not seem concerned with the light flashes, nor did he inform appellant of any warning signs which might signal a serious condition. Dr. VanFossen also testified that he did not inform appellant of the warning signs of retinal detachment. (Tr. 367.)

On cross-examination, appellant conceded that he did not seek immediate medical attention when the flashes and dark spots first occurred. (Tr. 313-314.)

Dr. VanFossen testified that he was "absolutely certain" that appellant did not inform him that he had experienced the alleged light flashes. (Tr. 439.) According to Dr. VanFossen, had appellant mentioned such flashes, the doctor would have conducted an indirect examination of the retina and, if necessary, referred his patient to a retinal specialist. (Tr. 440; 463.)

Appellant testified that in June 1993, he noticed a dark spot in the vision of his left eye, although it did not affect his vision and lasted only a few hours. (Tr. 33-34.) In July, he had a similar experience, although this time the dark spot did not disappear. (Tr. 36.) At first, the dark area affected only the vision in the periphery of his eye. However, the condition soon worsened to the extent that the vision in the center of his eye was affected as well. (Tr. 38-40.)

Appellant promptly consulted with another physician, who informed appellant that he had suffered a retinal detachment. (Tr. 40.) Appellant was referred to a retinal specialist, Dr. Rehmar, who recommended surgery, which was soon performed by another physician, Dr. Davidorf. (Tr. 41-43.)

On cross-examination, appellant acknowledged that prior to commencing the instant litigation, he filed a lawsuit against Dr. Davidorf, which was ultimately dismissed. (Tr. 332-333; 339.)

Appellant argues that the jury's finding that Dr. VanFossen was not negligent was against the manifest weight of the evidence because the record establishes that the doctor deviated from the appropriate standard of care. Specifically, appellant claims negligence on the part of Dr. VanFossen in not advising appellant of warning signs which could signal a potentially serious problem; and, in failing to perform an "indirect" examination in 1993 after appellant complained about the floaters during the "direct" examination.

Carl F. Asseff, M.D., appellant's expert ophthalmologist, explained that "indirect ophthalmoscopy" is an in-depth examination of the eyes involving special instruments which can detect serious conditions such as lattice degeneration, which can lead to retinal detachment. (Tr. 74.) Dr. Asseff testified that such an examination is indicated for "patients who give me a history of new floaters, first-time patient floaters, [and] flashes and floaters." (Tr. 85.)

Upon determining the cause of a floater, Dr. Asseff further testified about informing patients about warning signs of which they should be aware. The doctor testified as follows:

> "*** Once I find out why, I can tell a patient what it is and then make sure that there's no other diseases.
>
> "Then I have to tell them that *** this is a normal exam. You do have an aging floater, however... And then you give them all of the warnings because what you don't want them to do is walk away saying: Well, I've got a floater. Let's say they get another floater. The average person will probably assume it's the same thing, and it could very well be, but it may not be because the eye is subject to all these types of things.
>
> "So you give them the warnings: Well, if the floaters increase, if there's a change, if there's a change in vision, if you start to have a lot of little showery things coming down as floaters[,] you start to see some collapse of vision, call me right away. I want to see you as soon as possible to check it out to make sure nothing new has started." (Tr. 88-89.)

Based upon factual assumptions mirroring appellant's testimony and his review of appellant's medical records, Dr. Asseff opined that Dr. VanFossen deviated from the standard of care, which standard he set forth as follows:

> "It requires doing a dilated extended examination because the triggering event is the complaint of new floaters. And one has to look at the retinal tissue to look for *** various disease processes which we call retinal floaters. And then depending upon what one finds, you still have to give the appropriate warnings." (Tr. 102.)

Dr. Asseff concluded that appellant suffered the retinal detachment, and the consequent surgeries and loss of vision, as a direct result of Dr. VanFossen's deviation from the standard of care. Had appellant received the appropriate treatment and warnings, he likely would have received cryotherapy or laser surgery which could have prevented the detachment. (Tr. 114-116.)

On cross-examination, Dr. Asseff conceded that he had never personally examined appellant. (Tr. 133-138.) Significantly, Dr. Asseff agreed that if appellant had not actually informed Dr. VanFossen of the symptoms at his last appointment, as appellant testified, there was no breach of the standard of care by Dr. VanFossen. (Tr. 148.) Thus, the opinion of appellant's expert as to the appropriate standard of care does not actually differ from the opinion of Dr. VanFossen.

Essentially, the issue before the jury boiled down to one of credibility - whether or not appellant had indeed informed Dr. VanFossen about the alleged light flashes during his last appointment. The substance of appellant's argument before us is that his testimony was credible and Dr. VanFossen's was not. By its verdict, the jury of fact, resolved this issue in favor of the doctor. As the trier of fact, such a resolution of the evidence was clearly within the province of the jury.

Based upon our thorough review of the record, we cannot say that the jury's verdict was against the manifest weight of the evidence. Dr. VanFossen's testimony, as detailed above, constituted some competent, credible evidence which supported the jury's determination. Accordingly, the assignment of error is overruled.

Having overruled the sole assignment of error, the judgment of the trial court is affirmed.

Judgment affirmed.

BOWMAN and YOUNG, JJ., concur.

Pursuant to a notice filed October 18, 1996, Fran James voluntarily dismissed her claim "without prejudice and otherwise than on the merits."

Footnotes:

1. Pursuant to a notice filed October 18, 1996, Fran James voluntarily dismissed her claim "without prejudice and otherwise than on the merits."