

{¶4} Plaintiff was initially transported to the local Madison City Hospital where x-rays confirmed plaintiff's hip was broken. Arrangements were made to transfer plaintiff to The Ohio State Medical Center (OSU) in Columbus for treatment. Plaintiff testified that while his injury was being diagnosed at Madison City Hospital and during his transfer to OSU he was in severe pain. Upon his arrival at the OSU emergency room the decision was made to admit him for surgery. While awaiting a bed in the prison ward, plaintiff testified that he was secured in a hospital mop closet, still without the benefit of pain medication. Plaintiff estimated that he was in the mop closet awaiting a bed for two hours. Eventually, he was taken to the prison ward and assigned a bed. Next, an intern laced plaintiff's leg into a sheepskin boot and placed it in traction with 15 to 20 pounds of weight. Plaintiff testified that he did not receive any pain medication until an intern started a morphine infusion after beginning traction and that his pain was intense for the several hours prior to his receiving the pain medication.

{¶5} The morning after plaintiff was admitted to OSU, plaintiff underwent surgery to repair his broken hip. During surgery, a ten inch incision was made in plaintiff's right thigh and a metal plate was screwed to the broken femur to hold the bone together. The surgery was completed without complications.

{¶6} On December 26, 1995, plaintiff was discharged from OSU to the Correctional Medical Center (CMC) in Columbus to recuperate. Plaintiff testified that the only pain medication that he received while at CMC was nonprescription-strength Tylenol and that he was in constant "heavy pain" during his recuperation. However, plaintiff's medical records contradict his testimony. (Joint Exhibit A.) The records indicate that for the first two weeks after surgery he was prescribed Tylenol 3 and Ultram for pain, and Motrin thereafter. The pain medications were available to plaintiff at both OSU and CMC. Daily entries in the medical records further indicate that plaintiff often denied that he was in pain or that he had any unusual discomfort. By February 3, 1996, plaintiff refused Motrin for the first time and told medical personnel that he had "no complaints of pain or discomfort" and that "he feels much better."

{¶7} During the course of plaintiff's recovery he initially ambulated with a wheelchair. On the fourth day after surgery he began to use a walker and on February 5, 1996, he used crutches for the first time. On December 29, 1995, plaintiff began a regime of approximately 18 physical therapy sessions to help him strengthen his leg and walk on it again. He also did prescribed exercises in his room to strengthen his leg.

{¶8} On January 8, 1996, a nurse at CMC removed 38 staples from plaintiff's incision. Plaintiff testified that the nurse uses a pliers-type device to remove the staples one at a time. He described the pain caused by removing the staples as a six or seven on a scale of one to ten.

{¶9} On February 20, 1996, plaintiff was discharged from CMC and returned to LCI. He was initially placed on medical idle and remained in the dorm except to go to meals. Plaintiff progressed to performing light duty work in the dorm. He used crutches for another one and one-half months, then used a cane. According to plaintiff, he was able to return to his job in the garment factory in May or June 1996.

{¶10} Plaintiff testified that although his pain has diminished over time, he continues to have some pain as a result of the fracture. He described his pain on warm days as a level two or three on a scale of one to ten. He claimed that on cold or rainy days, his pain intensifies. However, during a medical examination on April 4, 1996, plaintiff described his pain as "minimal." A notation in plaintiff's medical record made on June 6, 1996, states that he is "doing well" and has "no pain."

{¶11} On November 9, 2001, Edwin H. Season, M.D., conducted an independent medical examination of plaintiff. After examining plaintiff and reviewing his medical records, Dr. Season concluded that the subtrochanteric fracture was healed well and that plaintiff has returned to "fairly normal functional capacity." Dr. Season determined that "there were no significant complications associated with his treatment" and he "did not identify a significant permanent impairment." However, Dr. Season confirmed that such a fracture would "produce substantial pain and discomfort" and that it would take three to six months to return to doing all activities.

{¶12} Based on the testimony and evidence, the court finds that plaintiff was 52 years old when he fell on ice as he walked to work at LCI; he suffered a right subtrochanteric fracture of the hip which was surgically repaired at OSU without complications; he initially suffered substantial pain and discomfort which gradually dissipated over a six month period of recovery; he had no significant complications during his treatment which included adequate pain medication and physical therapy; and, finally, he has no significant permanent impairment and will not likely need future medical care for his injury.

{¶13} Therefore, judgment is recommended in the amount of \$22,525, which includes the \$25 filing fee paid by plaintiff.

STEVEN A. LARSON
Magistrate

Entry cc:

Jeffrey A. Rich
Mark H. Gillis
Jeffrey A. Dittmer
300 East Broad Street, Suite 300
Columbus, Ohio 43215

Attorneys for Plaintiff

Lisa M. Eschbacher
65 East State St., 16th Fl.
Columbus, Ohio 43215

Assistant Attorney General