[Cite as *Blue v. Med. Univ. of Ohio at Toledo,* 2009-Ohio-1995.]

Court of Claims of Ohio
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TONY AND IRENE BLUE, etc., et al.

Plaintiffs

v.

MEDICAL UNIVERSITY OF OHIO AT TOLEDO

Defendant
Case No. 2005-07763

Judge J. Craig Wright

DECISION

{¶ 1} Plaintiffs brought this action alleging medical negligence. The issues of liability and damages were bifurcated and the case proceeded to trial on the issue of liability.

{¶ 2} In 2003, plaintiff[1] sought medical treatment for her first pregnancy. Her treating physician, Angelina Gangestad, M.D., was an assistant professor in defendant's department of obstetrics and gynecology. During plaintiff's prenatal care, an ultrasound examination revealed the presence of two fibroid tumors inside her uterus: one tumor was located on the anterior wall of the uterus and the other was located on the posterior wall near the top or fundus of the uterus. Plaintiff also informed Dr. Gangestad that in 1999, she had undergone a myomectomy which involved the surgical removal of fibroid tumors from her uterus. Based upon these conditions, plaintiff's pregnancy was classified as "high risk." Plaintiff's history of myomectomy placed her at risk of uterine

[1]The term "plaintiff" shall be used to refer to Irene Blue throughout this decision.

rupture if a vaginal delivery were attempted. In addition, because the myomectomy was an abdominal surgery, it posed a risk of scar tissue in the abdominal cavity. Dr. Gangestad scheduled plaintiff for a low, transverse cesarean-section (c-section) whereby the incision would be below both the anterior fibroid tumor and the placenta, which also was located anteriorly.

{¶ 3} On January 2, 2004, at 8:27 a.m., Dr. Gangestad made the first skin incision of the c-section. Typically, during a c-section cuts are made through multiple layers of tissue beginning with the skin, then fatty tissue, then the fascia which is a tough layer of tissue that overlies the muscle, then the rectus muscle, then the peritoneum. In a routine c-section, the individual layers of tissue are quickly identified, cut through, and held open using retractors to isolate the uterus. However, in this case, when Dr. Gangestad reached the layer of fascia, she discovered that plaintiff's abdominal tissues were adhered to one another, making it impossible to identify the "tissue planes." Plaintiff's abdomen was filled with scar tissue or "adhesions" that had to be cut away or "lysed" to clear an adequate passageway for delivery. Although Dr. Gangestad testified that scar tissue from the myomectomy was a foreseeable risk prior to the c-section, she stated that both the abundance and the density of plaintiff's scar tissue were unusual.

{¶ 4} Dr. Gangestad lysed adhesions while a first-year resident, Dr. Jarrett Sutton, assisted with retraction from 8:27 to 8:58 a.m. Dr. Gangestad described the adhesions beginning at the fascia level as being very dense and that the tissue was thick and firm, "almost like cement." She also testified that the peritoneum, the lining of the abdominal cavity, is usually thin and stretchy but that the texture of plaintiff's peritoneum was not normal.

{¶ 5} Dr. Gangestad made an incision into the uterus at 8:58 a.m. and then ruptured the membranes. Typically in a c-section delivery, the time needed to cut the uterus, rupture the membranes and deliver the baby is less than two minutes. However, in this instance, the time that passed from uterine incision to delivery was 41 minutes. From 8:58 to 9:18 a.m., Dr. Gangestad attempted various maneuvers using her hands, a vacuum extractor multiple times, and making multiple additional cuts to facilitate delivery, but without success. At 9:18 a.m., Dr. Gangestad realized how much time had

passed and paged Dr. Robert Blair for assistance. Although there is a discrepancy in the medical records, Dr. Blair arrived in the operating room at some time between 9:20 and 9:30 a.m. Plaintiff's baby boy was delivered at 9:39 a.m. and was taken to the neonatal intensive care unit for treatment due to hypoxic ischemic encephalopathy.

{¶ 6} Plaintiffs contend that Dr. Gangestad failed to meet the applicable standard of care in the following instances. First, plaintiffs contend that it was foreseeable that plaintiff's c-section would be difficult based upon her medical history and, accordingly, that Dr. Gangestad should not have chosen a first-year resident to assist her; second, that neither she nor her assistant were trained in the use of forceps; third, that she should have called for Dr. Blair's assistance when she first realized how extensive plaintiff's scar tissue was before she made the uterine incision; and fourth, that she should have called for Dr. Blair's assistance shortly after she had made the uterine incision but was continuing to experience difficulty delivering the baby.

ANGELINA GANGESTAD, M.D.

{¶ 7} Dr. Gangestad testified that she attained her board certification from the American Board of Obstetrics and Gynecology in December 2003, shortly before the delivery at issue. Dr. Gangestad explained that after she made the uterine incision and ruptured the membranes, she reached into the uterus with her hands and felt for the baby's head. She attempted to bring the baby's head to the incision but could not. She used the vacuum and was able to bring the head near the incision but not through it. Then she released the suction on the vacuum and repositioned the baby's head to keep it flexed, with the chin down. Fundal pressure was placed on the abdomen but something that she could not see was holding the baby's head back.

{¶ 8} She then made an incision on the fascia downwards, because the fascia is usually the most resistant layer of tissue. She again attempted to deliver the head with the vacuum. After three additional attempts, which resulted in "pop-offs," she stopped.[2] She then extended the uterine incision and attempted delivery again with the vacuum. After that, she made a muscle cut to the left to gain a few inches of space. At that point, she looked at the clock and realized how much time had passed. At 9:18 a.m., she

called for Dr. Blair. When Dr. Blair arrived he attempted a vacuum extraction and two different sets of forceps. Then a cut was made on the muscle to the right. A cut was made on what felt like a tight band of tissue that Dr. Gangestad believed to be an adhesion. She described it as "quite lateral, outside of the normal surgical field." Then the baby was delivered. Dr. Gangestad testified that in her opinion, extending the uterine cut vertically up the uterus to resemble an upside-down "T" would not have been possible because of the location of the anterior fibroid tumor and the placenta.

{¶ 9} Dr. Gangestad testified that she had never encountered adhesions of this density or magnitude before, but she felt that she had achieved adequate visualization to deliver the baby before she made the uterine incision. She also testified that she did not lyse additional adhesions prior to making the uterine incision due to the proximity of the anterior fibroid tumor, which if cut, would present an increased risk of blood loss.

{¶ 10} On cross-examination, Dr. Gangestad stated that before she began the operation, she was aware of: plaintiff's history of myomectomy; the presence and location of two uterine fibroid tumors; the anterior location of the placenta; and the possibility of abdominal adhesions. She also testified that from 8:27 to 8:58, both plaintiff and the baby were hemodynamically stable. She acknowledged that the uterine wall feeds the placenta, and that once the uterine wall is cut, blood is taken away from the placenta. She admitted that it was her decision not to call Dr. Blair from 8:27 to 8:58 a.m. when she was experiencing difficulties with the tissue planes that were adhered to one another. She also stated that once she made the uterine cut, she expected to deliver the baby in approximately two minutes. She agreed that the risk to the baby increases as the length of time increases between the uterine cut and delivery. Dr. Gangestad conceded that the baby's encephalopathy was due to the delay in his delivery and that there was no reason to believe that the baby's health was compromised from 8:27 to 8:58 a.m.

ROBERT BLAIR, M.D.

{¶ 11} Robert Blair, M.D., who has practiced obstetrics for more than 40 years, testified that on the day of plaintiff's surgery he was employed by the hospital as a

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[2]Dr. Gangestad explained that the vacuum is designed to "pop off" the baby's head after too

laborist and was available to help attending physicians as needed. Dr. Blair testified that after receiving a phone call that he was needed in the delivery room, he went to the delivery room, assessed the situation and then scrubbed in. He made one attempt with the vacuum and was not successful because the baby's head remained high in the uterus. He felt that the resistance was higher up in the uterus, above the incision. He used Tucker-McLean forceps to attempt to get an application on the fetal head and bring it through the incision; however, he could not get an application with those forceps. He then tried Simpsons forceps but was unable to get an application. He stated that the baby's head was in an unusual position, looking up, which made it difficult to apply forceps. Dr. Blair explained that the dense adhesions made the procedure technically difficult; that while Dr. Gangestad was informing him of the situation they were both working to surgically make more room by snipping bands of adhesions; and that it was a combination of surgical manipulations that allowed the baby's head to be freed and then be delivered.

LAW

{¶ 12} "In order to establish medical malpractice, it must be shown by a preponderance of the evidence that the injury complained of was caused by the doing of some particular thing or things that a physician or surgeon of ordinary skill, care and diligence would not have done under like or similar conditions or circumstances, or by the failure or omission to do some particular thing or things that such a physician or surgeon would have done under like or similar conditions and circumstances, and that the injury complained of was the direct result of such doing or failing to do some one or more of such particular things." *Bruni v. Tatsumi* (1976), 46 Ohio St.2d 127, 131, paragraph 1 of the syllabus.

MARTIN GUBERNICK, M.D.

{¶ 13} Plaintiff's expert, Martin Gubernick, M.D., testified that he is board-certified in Obstetrics and Gynecology (OBGYN) and that he practices medicine at New York Presbyterian Hospital. Dr. Gubernick testified that myomas are benign tumors that form on the walls of the uterus. Dr. Gubernick testified that for a patient with a history of

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much resistance is encountered.

myomectomy, the standard of care is to recommend a c-section because the myomectomy causes the uterine walls to weaken and the forces of labor may result in a rupture. He stated that fibroid tumors can cause an abnormal presentation of the baby. He added that if an extension of the abdominal incision needs to be made, a fibroid may be in the way. He opined that the anterior fibroid in plaintiff's uterus affected the location of the baby, in that the baby was off to plaintiff's right side and in the "occiput posterior" position with his head turned facing up.

{¶ 14} Dr. Gubernick opined that it is foreseeable that a myomectomy can form dense adhesions in the abdomen. He explained that a low transverse incision was reasonable in this case. However, he opined that for this patient, with two fibroid tumors and a previous myomectomy, a reasonable and prudent physician should have had a primary plan and a "back-up plan" for the mode of delivery. He stated that this was a complicated case that warranted both an OBGYN and a skilled assistant for delivery.

{¶ 15} Dr. Gubernick stated that he was not critical of the amount of time that Dr. Gangestad took to lyse adhesions from 8:27 to 8:58 a.m., but opined that she should have paged Dr. Blair prior to making the uterine cut once she became aware of the unusual amount and density of the adhesions. He added that once Dr. Gangestad saw the unusual amount and density of the abdominal adhesions, she should have realized that her assistant, a first-year intern, would not be qualified to help her lyse additional adhesions if the need arose. Dr. Gubernick explained that once the uterine cut is made, "the clock begins to run" on the health of a baby because the blood flow to the baby is compromised. He stated that two minutes is a reasonable time after the uterus is cut to deliver a baby. He added that the uterus should not be cut until the physician is sure that there is an adequate surgical field for delivery.

{¶ 16} Dr. Gubernick further opined that if Dr. Gangestad could not get the baby out within seven minutes after the uterine incision, she should have then called Dr. Blair for help. He further opined that she did not meet the standard of care when she failed to remain cognizant of the amount of time that was passing after the uterine cut was made. According to Dr. Gubernick, at 9:05 a.m. "bells and whistles" should have been going off for Dr. Gangestad and that her failure to call for assistance until 9:18 a.m. was a breach of the standard of care. He added that it was "inexcusable" for her not to know

how many minutes had passed since the uterine cut was made. He stated that at 9:05, she should have called for assistance from an attending physician, and that the next option was to "T" the uterus by either going around or through the fibroid tumor. He stated to a reasonable degree of medical probability that the hypoxic injury to the baby occurred due to the prolonged period of time from the uterine incision to delivery.

{¶ 17} Dr. Gubernick also opined that it was "ridiculous" for Dr. Gangestad to use the vacuum more than three times during a c-section. He stated that there is no medical literature on the use of a vacuum in c-sections because vacuums are intended for use in vaginal births, but a publication by The American College of Obstetricians and Gynecologists recommends that a vacuum should not be used more than three times for the safety of the baby. Dr. Gubernick disagreed with the assertion that the adhesions were not foreseeable inasmuch as Dr. Gangestad encountered the adhesions before the uterine cut was made.

JOHN P. ELLIOTT, M.D.

{¶ 18} Defendant's expert, John P. Elliott, M.D., testified that he was director of the maternal-fetal medicine department at Good Samaritan Regional Medical Center in Phoenix, Arizona. Dr. Elliott opined to a reasonable degree of medical probability that Dr. Gangestad met the standard of care in this case.

{¶ 19} Dr. Elliott agreed that based upon plaintiff's history of myomectomy the decision to perform a scheduled c-section was within the standard of care. He testified that plaintiff's history of myomectomy put her in the same category of risk for scar tissue in the abdomen as a patient with a history of a classical c-section with a vertical incision in the higher muscle tissue.

{¶ 20} Dr. Elliott opined that Dr. Gangestad's lack of training in using forceps was not relevant. He explained that the medical community has experienced a major movement away from the use of forceps and toward the use of the vacuum, and he noted that forceps training is not required for board certification. He added that it would be extraordinarily rare to use forceps in a c-section delivery.

{¶ 21} Dr. Elliott testified that Dr. Gangestad needed to cut enough adhesions to establish a clear path for the baby, and that it would have been a violation of the

standard of care to cut all of the adhesions in her abdomen because they may have been attached to other organs and could have caused additional bleeding. He further opined that the degree of adhesions in plaintiff's abdomen was both abnormal and unforeseeable. He stated that in his 30 years of experience he has seen a uterus completely adhered to other layers of tissue only one or two times. He also opined that it was not below the standard of care for a first year resident to assist Dr. Gangestad.

{¶ 22} Dr. Elliott testified that the standard of care during a c-section calls for a doctor to think the situation through and deal with it in steps if problems arise. He opined that it was within the standard of care to attempt the vacuum, then extend the fascial incision inferiorly downward, then attempt the vacuum three more times. He stated that medical literature dictates that as long as progress is made with each attempt and the fetal heart rate tracing remains stable, the vacuum may be used repeatedly.

{¶ 23} Dr. Elliott stated that once the uterine incision was made, Dr. Gangestad needed to focus on getting the baby out of the uterus. He also stated that it would have been below the standard of care for her to have made a "T" incision in this case because she would have cut into the fibroid and the placenta: cutting the fibroid would have made plaintiff hemorrhage; cutting the placenta would have further hurt the baby's blood supply.

{¶ 24} Dr. Elliott explained that time is a factor once a uterine incision is made, and that the average time from incision to delivery is one to one and one-half minutes. He stated that the longest amount of time from uterine cut to delivery that he has experienced in his 30-year career was 15 minutes. Dr. Elliott stated that if the baby had been born within eight minutes after the uterine incision, it was highly unlikely that there would have been any injury. He further stated that even a baby with complete umbilical cord occlusion would probably not suffer injury if it took eight minutes for delivery, and that there was no cord occlusion in this case. He stated that he did not know whether plaintiff's baby would have not sustained injury if he had been delivered by 9:18 a.m., but that the goal is to get the baby out as soon as possible. Dr. Elliott conceded that although the unusual density and amount of adhesions were not foreseeable prior to

surgery, Dr. Gangestad was aware of the adhesions before she made the uterine incision.

FINDINGS

{¶ 25} The court notes that the medical records show that Dr. Blair was paged at 9:18 a.m. The labor and delivery intra-operative record states that Dr. Blair was "in room scrubbed in for assist" at 9:20 a.m. The anesthesia note states that "Dr. Blair scrubbed in" at 9:30 a.m. Both records show that the baby was delivered at 9:39 a.m. Dr. Blair testified that he was at least 60 yards away from the delivery room when he was paged and that two minutes would not have been enough time to arrive and be scrubbed in to assist with the surgery. He stated that nine minutes was probably enough time to perform the procedures that he described. Although there is a discrepancy in the medical records, the court notes that it is not contested that Dr. Blair was not paged until 9:18 a.m.

{¶ 26} Upon review of all of the evidence submitted, the court finds that the expert testimony of Dr. Gubernick was the most persuasive. The court finds that Dr. Gangestad became aware of the unusual amount and density of plaintiff's abdominal adhesions prior to making the uterine incision. The court further finds that during the 30 minutes that she spent lysing adhesions, Dr. Gangestad knew or should have known that Dr. Sutton, a first-year resident, was not authorized or qualified to assist her by either lysing additional adhesions or by making additional cuts to the abdominal tissue should the need arise. In addition, all of the physicians in this case testified that a reasonable expectation of delivery in a c-section following uterine incision is one to two minutes. The court finds that a physician of ordinary skill, care and diligence would be cognizant both of the passage of time after the uterine incision was made and the increased risk of hypoxic injury to the baby. The court further finds that Dr. Gangestad's failure to remain cognizant of the passage of time, and to allow 20 minutes to pass before calling Dr. Blair after the uterine incision had been made, was a breach of the standard of care. The court finds that Dr. Gangestad's failure to call Dr. Blair for assistance by 9:05 a.m. after having encountered such difficulty in lysing adhesions which she described as "like cement" was also a breach of the standard of care. The

court finds that it was foreseeable that the adhesions in plaintiff's abdomen, combined with the fibroid tumors in plaintiff's uterus, would more likely than not complicate the baby's delivery. Defendant's contention that the amount and density of plaintiff's adhesions was not foreseeable is not credible inasmuch as Dr. Gangestad was aware of the unusual condition of plaintiff's abdomen before she made the uterine incision. The court finds that after encountering the adhesions, Dr. Gangestad knew or should have known by 9:05 a.m. that she needed the assistance of a skilled OBGYN to deliver plaintiff's baby.

{¶ 27} The court further finds that the delay caused by Dr. Gangestad's failure to timely call for assistance was the proximate cause of the baby's injuries. Dr. Gubernick testified that the delay in the delivery was a proximate cause of the baby's injuries. Even Dr. Gangestad admitted that the hypoxic event was a result of the delay in delivery. Dr. Elliott opined that it was more probable than not that if the baby had been born eight minutes after the uterine incision, the baby would not have sustained hypoxic injury. For the foregoing reasons, the court finds that plaintiffs have proven by a preponderance of the evidence that the injury to the baby was the direct result of Dr. Gangestad's failure to timely call for assistance and, accordingly, judgment shall be rendered in favor of plaintiffs.

TONY AND IRENE BLUE, etc., et al.

Plaintiffs

v.

MEDICAL UNIVERSITY OF OHIO AT TOLEDO

Defendant
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Judge J. Craig Wright

JUDGMENT ENTRY

This case was tried to the court on the issue of liability. The court has considered the evidence and, for the reasons set forth in the decision filed concurrently herewith, judgment is rendered in favor of plaintiffs. The case will be set for trial on the issue of damages.

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J. CRAIG WRIGHT
Judge

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HTS/cmd
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