[Cite as *Williams v. Ohio State Univ. Med. Ctr.*, 2015-Ohio-5566.]

Court of Claims of Ohio
The Ohio Judicial Center
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Columbus, OH 43215
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www.cco.state.oh.us

NADA WILLIAMS, Admx., etc.

Plaintiff

v.

OHIO STATE UNIVERSITY MEDICAL CENTER

Defendant

Case No. 2012-07269

Judge Patrick M. McGrath

DECISION

{¶1} Plaintiff filed this action alleging medical negligence based upon treatment provided to plaintiff's decedent, James Williams, at The Ohio State University Medical Center (OSUMC). The court previously bifurcated the issues of liability and damages for trial; however, on September 5, 2014, the parties agreed that the initial trial shall only pertain to whether OSUMC breached the standard of care with respect to the medical treatment it provided to James Williams. The case then proceeded to trial.

{¶2} Plaintiff, Nada Williams, testified that she and her husband, James Williams (herein after Williams) have lived in Kentucky their entire lives. In July 2009, Williams went to see a dentist regarding pain in his mouth. The dentist subsequently referred Williams to an oral surgeon whereupon on August 11, 2009, a biopsy was performed, which revealed that Williams had a malignant sarcoma in his mouth. Thereafter, Williams was referred to Joseph Valentino, M.D., in Lexington, Kentucky, for further evaluation. After consulting with Dr. Valentino regarding treatment options, Williams sought a second opinion with Theodoros Teknos, M.D., an otolaryngologist at OSUMC.

{¶3} In October 2009, plaintiff and Williams met with Dr. Teknos for an initial consultation. Dr. Teknos testified that at the time of the consultation, Williams' maxillofacial sarcoma, or myofibroblastic sarcoma, located on his left cheek was the

size of a softball, eroding through his upper jaw. Due to the size, growth rate, and aggressive nature of the cancer, Dr. Teknos staged Williams' cancer to be a four out of four. Dr. Teknos then discussed treatment options with plaintiff and Williams. Dr. Teknos testified that for Williams' tumor, surgery was the best option. Williams subsequently elected to proceed with surgery at OSUMC.

{¶4} Prior to surgery, Harrison Weed, M.D., examined Williams to determine the medical risk of surgery. During a stress test performed as a part of a cardiac evaluation, it was discovered that Williams had ischemia, indicating a possible blockage of an artery. As a result, Dr. Weed determined that Williams needed a more comprehensive cardiac evaluation prior to surgery. Williams subsequently underwent a cardiac catheterization to evaluate the blood flow to his heart. Plaintiff explained that Williams had a history of cardiac problems, including coronary artery disease, which previously necessitated the placement of stents. Following the cardiac catheterization, a bare metal stent was placed in an occluded left coronary artery. Dr. Teknos testified that he would typically wait six months after placement of a bare metal stent before proceeding with a surgery inasmuch as the risk of a thrombosis is greater for the first six months after placement of the stent. However, given the rapid growth and type of tumor that Williams had, Dr. Teknos determined that it was important to proceed with surgery to remove the tumor. In order to reduce the risk of a thrombosis or blood clot, Williams was placed on two blood thinners prior to the surgery: aspirin and Plavix.

{¶5} Shortly before surgery, Dr. Teknos met with the surgical team to discuss the preoperative plan. Dr. Teknos testified that the surgical team consisted of Jonathon Grischkan, M.D., the chief resident on the day of the procedure, Dr. Ristev, an anesthesiologist, and a certified registered nurse anesthetist (CRNA). As a part of the discussion, the surgical team considered the potential difficulties surrounding the breathing tube including a discussion about both intubation and extubation. Dr. Teknos testified that the surgical team decided that after the tumor is successfully removed, the breathing tube would be removed at the completion of the case inasmuch as Williams will have a wider, more open airway.

{¶6} Immediately prior to surgery, Williams was given a mallampati score of 4, meaning the least visual when the mouth is fully opened. Such a score is given to the airway of a patient to assess the ease of the intubation and indicates what can be seen by a physician when viewing a patient whose mouth is open. After multiple failed

attempts to intubate, Williams was successfully intubated with a nasotracheal tube. For the procedure, Williams was positioned supine with his head slightly elevated. The surgery began at about 3:20 p.m. on October 27, 2009. Dr. Teknos, with the assistance of Dr. Grischkan, removed the tumor and the affected lymph nodes through incisions in the face and in the mouth. After the removal of the tumor, a skin graft was placed inside Williams' mouth and a custom obturator, or prosthetic, was screwed into place and attached to the roof of his mouth. The obturator filled the space where the tumor was removed giving Williams facial structure and providing him the ability to eat once he recovered. Dr. Teknos testified that at the end of the procedure, after tying off the blood vessels, Williams' surgical bed was dry despite the presence of blood thinners.

{¶7} Prior to the conclusion of the surgery, anesthesiologist Joshua Lumbley, M.D., entered the operating room at 7:05 p.m. and replaced Dr. Dalton, who had previously replaced Dr. Ristev as the on call attending anesthesiologist responsible for Williams' care. According to Dr. Lumbley, OSUMC sets forth a procedure for anesthesiologists to follow when one anesthesiologist replaces another while a surgery is ongoing. Such a procedure includes a list of items that the two anesthesiologists should discuss prior to the subsequent anesthesiologist proceeding with the surgery. Dr. Lumbley testified that he received a personal report from Dr. Dalton about the case, which included information about the patient's height, weight, past medical history, allergies, antibiotics administered, how the case had proceeded and what the plan was going forward. Additionally, Dr. Lumbley learned that Williams had a recently placed coronary stent prior to surgery and had been administered aspirin and Plavix. Finally, Dr. Lumbley learned that the preoperative plan was to extubate Williams after the procedure.

{¶8} Dr. Lumbley testified that toward the end of the procedure, Williams was monitored by the electrocardiogram (EKG or ECG), pulse oximeter, blood pressure cuff, and a catheter in an artery in Williams' wrist. Additionally, the anesthesia machine continued to monitor Williams' exhaled gas concentration and the concentration of the anesthetic. Dr. Lumbley described Williams' vital signs as smooth as the case concluded.

{¶9} According to Drs. Teknos and Lumbley, the preoperative plan to extubate Williams after the procedure was revisited during the surgery. Drs. Teknos and

Grischkan reported no complications with the surgical procedure itself. At the conclusion of the procedure, Dr. Teknos left the operating room to speak with Williams' family. Dr. Grischkan proceeded to the computer in the operating room to commence post-operative paperwork. The procedure concluded at approximately 7:50 p.m.

{¶10} Dr. Lumbley testified that as the anesthetic began to wear off and Williams began breathing on his own, the breathing machine commenced supporting Williams' breathing with extra pressure or pressure support rather than breathing for Williams through controlled ventilation as had been the case during the procedure. Dr. Lumbley testified that Williams remained intubated and remained breathing with pressure support for approximately 15 minutes following the conclusion of the procedure. The operating bed was then flipped so Williams' head was closer to the anesthesia machine, and Dr. Lumbley assessed whether Williams had adequate strength by applying a stimulator to a nerve. Dr. Lumbley then prepared Williams for extubation. Dr. Lumbley asserted that he looked in Williams' mouth and saw no swelling, edema or excessive blood. Additionally, Dr. Lumbley testified that he performed an indirect laryngoscopy to assess Williams' airway rather than a direct laryngoscopy, which involves the use of a laryngoscope to view the airway. However, Dr. Lumbley admitted that he did not mention in his deposition or note in the medical records that he performed such a procedure prior to extubation. Nevertheless, Dr. Lumbley asserted that he was able to visualize the posterior portion of the tracheal inlet up to the vocal cords but did not look below the vocal cords to the base of the endotracheal tube.

{¶11} At some point prior to extubation, Williams was moved to the hospital bed, or transport bed, enabling Dr. Lumbley to raise Williams' back and legs. Dr. Lumbley explained that because of Williams' morbid obesity, positioning him in such a way would allow gravity to pull his abdomen down, helping him breathe. Dr. Lumbley testified that he continued to test Williams' muscular, respiratory, and neurological levels and responses. Dr. Lumbley asserted that at this point, Williams had proper muscular response, had the ability to squeeze his hand with sufficient strength, and had the strength necessary to inhale. Additionally, Dr. Lumbley asserted that Williams was able to follow two-step commands indicating that Williams was neurologically prepared for extubation. Dr. Lumbley testified that he continued to monitor Williams' tidal volumes, oxygen saturation rate, carbon dioxide level, and respiratory status. Dr.

Lumbley asserted that Williams' oxygen saturation rate remained at 100 percent throughout this process.

{¶12} Dr. Lumbley testified that the endotracheal tube was subsequently removed and a mask delivering constant positive airway pressure to assist in breathing was immediately placed on Williams' face. Dr. Lumbley asserted that for approximately 15-30 seconds, Williams successfully breathed on his own. According to Dr. Lumbley, Williams subsequently swung his arm up at the mask. The CRNA removed and subsequently repositioned the mask. Dr. Lumbley testified that immediately thereafter, Williams' arms stiffened and rotated inward. Dr. Lumbley testified that he then became concerned that there may be decreased profusion of the blood to the brain. Dr. Lumbley asserted that Williams' oxygen saturation was still 100 percent, although it was not recorded in the medical chart. Nevertheless, Dr. Lumbley testified that Williams' breathing pattern subsequently switched to an agonal breathing pattern. Such a breathing pattern was noted in the chart by the CRNA to be an obstructed breathing pattern accompanied by breath holding. Dr. Lumbley asserted that the pattern was not such that it appeared to be obstructed, but rather, an irregular breathing pattern, which he asserted is consistent with a cardiac event. Additionally, Dr. Lumbley did not report the presence of either stridor or stertor, which are sounds made by an obstructed airway. Williams was then returned to the operating table and the monitors were reconnected.

{¶13} Dr. Grischkan became aware that Williams was "fighting" the remaining surgical team and returned to assist. Dr. Grischkan testified that attempts to reintubate Williams were unsuccessful and that the medical staff was unable to open Williams' mouth. However, Dr. Lumbley testified that he placed a laryngeal mask airway (LMA), although he was unable to get air past Williams' vocal cords into his lungs. After he removed the LMA, Dr. Lumbley noticed blood on the LMA, which he attributed to his forceful placement of the LMA. At some point Dr. Lumbley called a code and instructed Dr. Grischkan to ask Dr. Teknos to return to the operating room. Dr. Lumbley testified that once the monitors, arterial line waveform, and pulse oximeter were reattached, the monitors displayed that Williams had a wide complex ventricular tachycardia, which Dr. Lumbley asserted is consistent with ventricular fibrillation. Drs. Grischkan and Lumbley testified that Williams had no femoral pulse.

{¶14} Dr. Grischkan commenced chest compressions and Dr. Lumbley began administering drugs to restart Williams' heart. Dr. Teknos subsequently returned to the operating room and placed an emergency tracheostomy tube in a procedure known as a cricothyrotomy. There was noted to be a rent or tear in the back of the trachea, which Dr. Grischkan attributed to the scalpel used during the emergency cricothyrotomy. After resuscitative efforts and the emergency cricothyrotomy, Williams' was eventually stabilized. Williams, however, had been deprived of oxygen for approximately 4 to 6 minutes. In the days following the arrest, Williams was subsequently noted to have increased levels of troponin, which is an enzyme released in the blood by dying heart tissue. Williams suffered a profound brain injury as a result of the incident and subsequently died.

{¶15} Plaintiff alleges that the medical care and treatment provided to Williams fell below the standard of care. Plaintiff argues that the standard of care required Dr. Lumbley to perform a direct laryngoscopy prior to removing Williams' breathing tube and that such a failure was a breach of the standard of care. Plaintiff argues that Williams should have remained intubated and transferred to the ICU where he would spend the night and extubated at some later point. Finally, plaintiff argues that seconds after removal of the breathing tube, Williams suffered an obstructed airway that led to a respiratory arrest followed by a cardiac arrest. Defendant argues that the medical care that Dr. Lumbley provided to Williams complied with the applicable standard. Specifically, defendant argues that the preoperative plan to extubate Williams at the completion of the procedure met the standard of care and that the surgical team properly reevaluated Williams for extubation prior to the conclusion of the procedure. Finally, defendant argues that subsequent to extubation, Williams suffered an unpreventable cardiac arrest.

{¶16} "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 and proximate result of such doing or failing to do some one or more of such particular things." *Bruni v. Tatsumi*, 46 Ohio St.2d 127

(1976), paragraph one of the syllabus. The appropriate standard of care must be proven by expert testimony. *Id*. at 130.

{¶17} Plaintiff presented the expert testimony of anesthesiologist and critical care physician Thomas James Gallagher, M.D. Dr. Gallagher, formerly the Chairman of Critical Care Medicine in the Department of Anesthesiology at the University of Florida, is board certified in anesthesiology with a specialization in critical care medicine where he spends approximately 50 percent of his professional time. Dr. Gallagher testified that he reviewed the medical records and the treating physicians' depositions. According to Dr. Gallagher, the standard of care required Dr. Lumbley to perform a direct laryngoscopy with a laryngoscope prior to deciding whether to perform an extubation. Dr. Gallagher explained that Dr. Lumbley should have examined Williams' airway to check for any obstructions and determine whether any swelling and bleeding would improve over the next several hours. Dr. Gallagher asserted that because of the positioning of Williams' body during surgery, blood would collect in the back of the throat. Dr. Gallagher opined that if Dr. Lumbley would have performed a direct laryngoscopy, he might have seen lots of redundant tissue, swelling, and an obstructed airway.

{¶18} Dr. Gallagher testified that Williams was a difficult intubation due to his large size, body mass index of 40, and mallampati score of 4. Dr. Gallagher explained that a mallampati score of 4 means that when a patient opens his or her mouth, a physician cannot see the pharynx. Additionally, Dr. Gallagher testified that the presence of the tumor in combination with Williams' obesity and his redundant soft tissue in the back of his throat made any attempt at visualization of the vocal cords more difficult; however, Dr. Gallagher admitted that he did not know Williams' mallampati score after removal of the tumor. Nevertheless, Dr. Gallagher concluded that Dr. Lumbley should have performed a direct laryngoscopy with a laryngoscope prior to deciding whether to extubate Williams.

{¶19} Dr. Gallagher testified that after performing such a procedure, Dr. Lumbley should have evaluated the risks and benefits of transporting Williams to the intensive care unit (ICU) where he would remain until extubation could safely be performed at some later point. According to Dr. Gallagher, there were minimal risks associated with taking Williams to the ICU compared with a greater risk of prematurely extubating Williams immediately after the procedure. Dr. Gallagher explained that in the ICU,

Williams would have remained sedated overnight and remained connected to a breathing machine. Dr. Gallagher testified that there was no increased risk of pneumonia or vocal cord injury and a minimal risk that the breathing tube would have become disconnected. Accordingly, Dr. Gallagher concluded that it was safer for Williams to be sent to the ICU rather than extubated immediately after the procedure.

{¶20} Dr. Gallagher opined that Williams suffered a primary respiratory event followed by a cardiac event. Dr. Gallagher based such an opinion upon the sequence of events immediately after extubation. Dr. Gallagher explained that the CRNA noted that Williams demonstrated an obstructed breathing pattern and that Williams swung his arm at the breathing mask subsequent to extubation. Williams was thereafter noted to have an abnormal heart rhythm, which Dr. Gallagher asserted is consistent with a primary respiratory event. Dr. Gallagher testified that Williams' heart rhythm returned only after Williams' airway was reestablished through a cricothyrotomy. Additionally, Dr. Gallagher testified that if Williams' had suffered a primary cardiac event caused by a thrombosis or blood clot at the site of the bare metal stent, he would expect blood pressure medications for 24 hours after the event and that such treatment did not occur in this case. Finally, Dr. Gallagher noted that a rise in troponin in the blood does not indicate which event occurred first. Accordingly, Dr. Gallagher concluded that Williams suffered a primary respiratory event followed by a cardiac event.

{¶21} Defendant presented the expert testimony of Robert Caplan, M.D., Medical Director of Quality at Virginia Mason Medical Center in Seattle, Washington. Dr. Caplan is board certified in both anesthesiology and internal medicine. Additionally, Dr. Caplan is a member of the American Society of Anesthesiologists Committee on Standards and Practice Parameters and has published various anesthesiology practice standards and peer reviewed medical articles. Dr. Caplan reviewed the medical records and the depositions of the care providers in this case. Dr. Caplan testified that the preoperative plan to remove the breathing tube at the conclusion of the procedure complied with the standard of care. Additionally, Dr. Caplan testified that nothing happened in the surgery that would cause Dr. Lumbley to alter such a plan. According to Dr. Caplan, Dr. Lumbley's evaluation of Williams' airway prior to extubation met the standard of care. Dr. Caplan explained that Dr. Lumbley properly evaluated Williams to determine whether he was ready for extubation. Dr. Caplan noted that Williams'

vitals were stable, his muscles were strong enough to support respiration, and he was awake such that he was able to follow a two-step command. Accordingly, Dr. Caplan concluded that Williams' met all criteria for extubation.

{¶22} Regarding whether the standard of care required a direct laryngoscopy, Dr. Caplan testified that such a direct visualization of the airway by a laryngoscope is not required by the standard of care and that such a procedure would have been problematic. Dr. Caplan explained that the proposed maneuver could have caused bleeding or disturbed the newly-placed obturator; however, Dr. Caplan admitted that such a procedure could be safely performed by the oral surgeon. Regarding Dr. Lumbley's indirect laryngoscopy, Dr. Caplan testified that after removal of the tumor, Williams' mallampati score would have improved, although he was unable to determine a new score. Furthermore, Dr. Caplan testified that there are risks associated with keeping a patient intubated overnight in the ICU. Dr. Caplan explained that such risks include mechanical respiration pneumonia and dislodgment of the breathing tube; however, he admitted that the risk of pneumonia was about 1-5 percent and that the risk of an accidental extubation was about 1-5 percent. Accordingly, Dr. Caplan concluded that the care and treatment provided by Dr. Lumbley met the standard of care.

{¶23} Finally, Dr. Caplan opined that Williams first suffered a cardiac arrest followed by a respiratory arrest. Dr. Caplan explained that a respiratory arrest typically occurs incrementally whereas a cardiac arrest occurs suddenly. Dr. Caplan concluded that Williams' arrest occurred suddenly, shortly after extubation. Additionally, Dr. Caplan testified that Williams met all the criteria for extubation and was 100 percent oxygenated prior to the arrest. Lastly, Dr. Caplan testified that when a patient experiences a respiratory arrest, there is an audible signal from one of the machines in the operating room and that none of the caretakers reported such a signal. Accordingly, Dr. Caplan concluded that Williams suffered a cardiac event followed by a respiratory event.

{¶24} Additionally, defendant presented the expert testimony of Rod Rezaee, M.D., the Director of Microvascular Head and Neck Reconstructive Surgery in the Department of Otolaryngology at University Hospitals, Case Medical Center, and Seidman Cancer Center in Cleveland, Ohio. Dr. Rezaee is board certified in otolaryngology, head and neck surgery. Dr. Rezaee reviewed the medical records

from OSUMC and the depositions of the treating physicians. Dr. Rezaee testified that Dr. Teknos' preoperative plan to extubate at the conclusion of the procedure met the standard of care. Dr. Rezaee explained that the surgery was in the mouth and upper jaw and that removing the tumor improved airway access. Dr. Rezaee testified that there was no need for Williams to remain intubated after the surgery inasmuch as the surgery did not structurally alter the airway. Additionally, Dr. Rezaee testified that nothing occurred during the surgery to alter the original plan to extubate at the conclusion of the procedure. Dr. Rezaee testified that there were no indications to perform a direct laryngoscopy prior to extubation. As a result, Dr. Rezaee concluded that extubation at the conclusion of the procedure met the standard of care.

{¶25} Dr. Rezaee opined that Williams suffered a cardiac arrest before suffering a respiratory arrest. Dr. Rezaee explained that Williams' oxygen levels were reasonable after extubation and that the arrest occurred suddenly. However, Dr. Rezaee was under the mistaken belief that Williams breathed on his own for two minutes after extubation. Additionally, Dr. Rezaee stated that the CRNA's contemporaneous note describing breath holding and obstructed breathing patterns after extubation did not alter his opinion inasmuch as a CRNA is not a clinically trained physician. Dr. Rezaee added that the airway was not altered during the surgery and that Williams' bare metal stent placed six days prior to surgery created an increased risk of a cardiac event. Accordingly, Dr. Rezaee concluded that Williams suffered a primary cardiac event.

{¶26} Finally, defendant presented the testimony of Theodore Fraker, M.D., a cardiologist at OSUMC. Dr. Fraker was the attending cardiologist for Williams' procedure and provided care to Williams after the procedure. Dr. Fraker learned of the events surrounding extubation, saw the patient the following morning, and reviewed and signed the dictation of the consultation written by Brian Birnbaum, M.D., a resident at OSUMC. Dr. Fraker's signed dictation noted that subsequent to the surgery to remove the tumor and after extubation, Williams developed a respiratory arrest followed by a cardiac arrest. Dr. Fraker also noted a modest rise in troponin and that there was no evidence of an acute myocardial infarction. Subsequently, in a progress note, Dr. Fraker wrote that Williams suffered a respiratory arrest following his operation.

{¶27} Additionally, Dr. Fraker wrote that he reviewed "the available ECGs which show no new or acute ischemic changes." (Defendant's Exhibit T.) Dr. Fraker

asserted that the EKG he reviewed was not the EKG taken the night of the arrest during the code. However, Dr. Fraker could not recall which EKGs he reviewed and who informed him that Williams suffered a respiratory arrest following the surgery. Nevertheless, Dr. Fraker testified that on or about October 29 or 30, 2009, he reviewed the EKG taken during the arrest and that such an EKG showed changes consistent with an acute lateral wall myocardial infarction accompanied by ventricular fibrillation post extubation. Dr. Fraker explained that the EKG taken during the code event differs from the EKG taken preoperatively, in that the EKG taken during the code demonstrates changes consistent with a lateral infarct. Dr. Fraker testified that in the days following the surgery, Williams' troponin levels elevated dramatically from 0.91 to 67, which Dr. Fraker asserted is consistent with a myocardial infarction. Dr. Fraker testified that at that point he then became convinced that Williams suffered a primary cardiac event.

{¶28} Dr. Fraker opined that Williams suffered an acute myocardial infarction primary to a respiratory event. Dr. Fraker testified that the troponin rise and the EKGs are consistent with a primary cardiac event rather than a primary respiratory event. Additionally, Dr. Fraker testified that a primary cardiac event is consistent with the risks associated with placement of a stent six days prior to the surgery; however, Dr. Fraker admitted that it would be speculation to conclude that the stent caused a clot. Dr. Fraker testified that he did not perform a cardiac catheterization to identify a thrombosis at the stent site because the course of treatment would have been the exact same as had already been prescribed. Accordingly, Dr. Fraker concluded that Williams suffered a primary cardiac event.

{¶29} Based upon the foregoing, the court concludes that plaintiff has failed to establish her claim by a preponderance of the evidence. Dr. Gallagher believed that Williams should have remained intubated and spent time in the ICU prior to extubation, which would have occurred at some later point. However, the court finds that the anesthesiology team's preoperative plan to extubate Williams immediately after surgery met the standard of care. Dr. Caplan credibly testified that such a preoperative plan met the standard of care. Indeed, such a plan is consistent with the surgical care that both Drs. Teknos and Rezaee provide at their respective hospitals.

{¶30} The court notes that Dr. Gallagher spends 50 percent of his professional time in critical care medicine rather than surgery whereas Drs. Teknos and Rezaee are very familiar with this type of a surgery. Indeed, Dr. Teknos testified that Dr.

Gallagher's proposed plan of treatment would not typically occur in this type of a case. Dr. Caplan credibly testified that the extubation following Williams' surgery is the expected plan and the right decision. Furthermore, nothing unusual occurred during the surgery that would have altered the surgical team's preoperative plan to perform extubation following the surgery. Moreover, Dr. Gallagher's proposed plan was not without increased risks such as pneumonia or inadvertent dislodgment of the breathing tube. Additionally, while intubated and under sedation in the ICU, Williams would not have been able to communicate with hospital staff if he experienced any increased chest pain. There is no dispute that following placement of the bare metal stent, Williams remained at an increased risk of a cardiac event.

{¶31} Regarding the care that Dr. Lumbley provided, the court finds that Dr. Lumbley appropriately evaluated Williams' airway prior to extubation. There is no dispute that Dr. Lumbley assessed Williams' muscular, neurological, and respiratory (MRN) abilities prior to extubation. Indeed, there is no dispute that Williams was able to follow two-step commands and that Williams met the MRN criteria prior to extubation.

{¶32} Dr. Gallagher, however, criticized Dr. Lumbley's decision not to perform a direct laryngoscopy. However, the court finds that there were no indications to perform a direct laryngoscopy in this case. Dr. Lumbley believed that such an examination would have been deleterious. Additionally, Dr. Teknos cautioned that such a procedure could dislodge the newly-placed obturator. Indeed, Dr. Caplan agreed that such a proposed procedure may have disturbed the newly-placed obturator or caused bleeding. Neither Dr. Teknos nor Dr. Rezaee believed such a procedure was required by the standard of care in this case. The court further finds that a direct laryngoscopy was not necessary inasmuch as the airway had not been structurally altered during the surgery and the surgical team had not encountered excessive bleeding. Furthermore, Dr. Gallagher could not definitively say what Dr. Lumbley would have seen had he performed a direct laryngoscopy. Moreover, Dr. Lumbley was able to perform an indirect laryngoscopy in order to evaluate Williams' airway prior to extubation. As a part of the indirect laryngoscopy, Dr. Lumbley did not see any swelling or pooling of blood. In short, the court finds that plaintiff has failed to prove by a preponderance of the evidence that the care and treatment Dr. Lumbley provided to Williams fell below the standard of care.

{¶33} Lastly, the court notes that, with the exception of Dr. Gallagher, all of the doctors testified that Williams suffered a cardiac event followed by a respiratory event. Dr. Gallagher, however, was adamant that a respiratory event occurred first. While objective medical signs exist supporting the occurrence of a primary cardiac event (i.e. troponin levels, lack of stridor or stertor, EKG readings at the time of the event), the court believes that resolving such an issue is not necessary for a determination as to whether the care and treatment provided to Williams fell below the applicable standard. Having found that plaintiff failed to prove a breach of the standard of care, the court need not address whether Williams suffered a primary cardiac event or a primary respiratory event. Accordingly, the court finds that plaintiff failed to prove her claim by a preponderance of the evidence. Given that plaintiff cannot prevail on her claim of medical negligence, the derivative claim for loss of consortium must fail as well. *Bowen v. Kil-Kare, Inc.*, 63 Ohio St.3d 84, 93 (1992).

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PATRICK M. MCGRATH
Judge

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NADA WILLIAMS, Admx., etc.

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v.

OHIO STATE UNIVERSITY MEDICAL CENTER

Defendant

Case No. 2012-07269

Judge Patrick M. McGrath

JUDGMENT ENTRY

{¶34} This case was tried on plaintiff's claim of medical malpractice. The court has considered the evidence and, for the reasons set forth in the decision filed concurrently herewith, judgment is rendered in favor of defendant. Court costs are assessed against plaintiff. The clerk shall serve upon all parties notice of this judgment and its date of entry upon the journal.

_____
PATRICK M. MCGRATH
Judge

cc:

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Filed February 24, 2015
Sent To S.C. Reporter 12/31/15