

**IN THE COURT OF CLAIMS OF OHIO**

TERESA EDOJA, Admr.

Plaintiff

v.

THE OHIO STATE UNIVERSITY  
WEXNER MEDICAL CENTER

Defendant

Case No. 2022-00837JD

Judge Lisa L. Sadler

DECISION

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{¶1} Plaintiff brought this wrongful death and survivorship action after her daughter, Cecilia Edoja (Cecilia)<sup>1</sup>, died following a laparoscopic cholecystectomy (lap chole) performed by The Ohio State University Wexner Medical Center (OSUWMC) employees. At trial, Plaintiff presented four theories of medical negligence, including: (1) providing an inadequate preoperative evaluation; (2) performing the lap chole too soon after Cecilia underwent an endoscopic retrograde cholangiopancreatography (ERCP); (3) providing inadequate postoperative monitoring following the lap chole; and (4) failing to recognize an active hemorrhage. After careful consideration of the evidence and arguments presented at trial, the Court finds that Plaintiff failed to prove her claims by a preponderance of the evidence. For the following reasons, the Court enters judgment for OSUWMC.

**FINDINGS OF FACT**

{¶2} It is undisputed that Cecilia had a complex medical history. Soon after her birth on December 2, 1991, Cecilia was diagnosed with sickle cell disease (SCD). SCD is a hereditary form of anemia that causes red blood cells to form in a sickle shape instead of a disc. These abnormal cells can develop a blockage, which interferes with blood flow

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<sup>1</sup> Several names were used during trial, but the Court will refer to the decedent as “Cecilia” for consistency.

and oxygenation of the tissues in the body and can result in severe pain (commonly referred to as “a pain crisis”), organ dysfunction, and acute chest syndrome.

{¶3} When Cecilia experienced SCD pain crises as a child, Plaintiff would take her to the hospital where she would receive fluids and pain medication. At around nine years old, Cecilia needed her first blood transfusion, which introduced healthy blood cells to help prevent a blockage of abnormal cells. As an adult, Cecilia managed her own medical care. Often Cecilia could deal with SCD crises at home and would not need hospital care or assistance from her family. However, on March 11, 2022, Cecilia told Plaintiff she was experiencing pain in her abdomen and Plaintiff encouraged Cecilia to go to the hospital for treatment. Two days later, on March 13, 2022, Cecilia went to OSUWMC’s emergency department (ED). Sadly, in the early hours of March 17, 2022, Cecilia died at OSUWMC.

### **Preoperative Evaluation**

{¶4} Upon arrival at the ED on March 13, 2022, Cecilia complained of abdominal pain, vomiting, and chest pain. Defendant’s Exh. A, p. 416. Within two hours, Cecilia had been admitted to the ED and examined by attending physician Dr. Maegan Reynolds and physician assistant (PA) Jennifer Dickerson, who ordered blood labs, an abdominal CT scan, pain medications, an electrocardiogram (EKG), and a chest x-ray. Exh. A, p. 417, 423. Additionally, PA Dickerson noted a differential diagnosis<sup>2</sup> of acute chest syndrome, pneumonia, pleural effusion, appendicitis, diverticulitis, pancreatitis, cholecystitis (inflammation of the gallbladder), and SCD pain crisis. Exh. A, p. 423.

{¶5} In the afternoon on March 14, 2022, the results of the CT showed inflammation of the gallbladder and were “concerning for acute cholecystitis.” Exh. A, p. 424. As a result, Cecilia was examined by, among others, the attending physician for OSUWMC’s acute care surgery team—Dr. Sara Scarlet.

{¶6} From 2021 to 2023, Dr. Scarlet held the position of faculty member and attending physician at OSUWMC during which her duties included caring for trauma patients with emergency surgical concerns. Prior to her job at OSUWMC, Dr. Scarlet co-

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<sup>2</sup> A differential diagnosis is “the determination of which of two or more diseases with similar symptoms is the one from which the patient is suffering, by a systematic comparison and contrasting of the clinical findings.” (Cleaned up.) *Taylor v. Norfolk Southern Ry. Co.*, 2020-Ohio-2657, ¶ 36 (6th Dist).

authored an article proposing a management strategy to help reduce the likelihood of perioperative complications in patients with SCD. Dr. Scarlet followed that protocol in her practice at OSUWMC including in this case.

{¶7} In her years of practice, Dr. Scarlet treated approximately fifty patients with SCD, and operated on approximately fifteen to twenty of those patients. In Dr. Scarlet's experience, individuals with SCD are more likely to develop gallstones because there is an increased turnover of blood cells which increases bilirubin, and the increased bilirubin contributes to gallstone formation. Upon examination of Cecilia and her CT results, Dr. Scarlet recommended that Cecilia have her gallbladder surgically removed, which is done by performing a lap chole.

{¶8} When treating patients with SCD, Dr. Scarlet makes special efforts to avoid pain crises, including monitoring oxygen saturation, providing supplemental oxygen when needed, providing IV fluids, and ensuring pain management. Following her standard practice and in line with the article she co-authored, Dr. Scarlet noted in Cecilia's chart for all treatment providers to "be vigilant regarding hydration, oxygenation, and pain control" given Cecilia's "sickle cell and potential for acute chest syndrome and perioperative pain crisis." Exh. A, p. 477.

{¶9} Based on this evaluation, Dr. Reynolds updated the ED's treatment plan to include a diagnosis of acute cholecystitis and SCD pain crisis and reflect an upcoming transfer of care to OSUWMC's surgical service for a lap chole. Exh. A, p. 424. Cecilia remained in the ED until she could be admitted to the surgical service, during which time ED employees continued to take her vitals, examine her, perform tests, and provide pain medication. Exh. A, p. 446-471. At 11:24 p.m. on March 14, 2022, Cecilia was simultaneously discharged by the ED and admitted by the surgical service. Exh. A, p. 471.

### **Surgical Plan**

{¶10} Prior to the lap chole performed on Cecilia, Dr. Scarlet performed hundreds of other lap choles—it is one of the most common procedures she performs. A lap chole is a minimally invasive removal of the gallbladder through small incisions in the abdomen. Doctors insert several small plastic tubes (ports) into the abdominal incisions and use the

ports to puff up the abdominal wall by instilling gas, creating a working space. Next, doctors insert special tools into the ports to identify the gallbladder, dissect it from the liver, tie off the cystic artery and duct, and then remove the gallbladder from the body.

{¶11} When preparing for Cecilia's lap chole procedure, Dr. Scarlet discussed with her surgical team the preoperative protocol for treating surgical patients with SCD. Dr. Scarlet performed a preoperative exam on Cecilia and observed no particular cardiac risk factors. Dr. Scarlet converses with every patient she operates on about their comorbidities and risk factors for cardiovascular issues, which might cause problems with anesthesia. Dr. Scarlet's conversation with Cecilia did not suggest that she had any cardiovascular comorbidities or exertional symptoms that would suggest such comorbidities. The anesthesia department (anesthesia) also performed a preoperative evaluation on Cecilia and did not recommend further testing of Cecilia's heart function.

{¶12} As a part of Dr. Scarlet's preoperative protocol for treating surgical patients with SCD, Dr. Scarlet consulted with hematology on Cecilia's care. At approximately 1:29 p.m. on March 16, 2022, Dr. Jennifer Vaughn from OSUWMC's hematology service examined Cecilia. Exh. A, p. 111. Dr. Vaughn held the position of hematology section head at OSUWMC JamesCare East since January 2022. Exh. I, p. 2. As part of her practice at OSUWMC, Dr. Vaughn consults with surgeons who treat patients with SCD. These consults serve to optimize the patient's physical condition to prevent pain crises, infections, and clotting events.

{¶13} As part of her consultation with Cecilia, Dr. Vaughn listened to Cecilia's heart and lungs, checked for signs of red blood cell breakdown, performed an abdominal exam, and checked extremities for blood clots. Dr. Jinesh Gheeya, Dr. Vaughn's fellow, independently performed a similar exam on Cecilia. Dr. Vaughn also reviewed Cecilia's blood test results which showed that her hemoglobin was within her normal range and her platelet count was normal and did not indicate a high risk of bleeding.

{¶14} As a result of her examination and consultation, Dr. Vaughn noted in Cecilia's medical chart:

Prior to surgery, recommend simple transfusion to achieve a goal hemoglobin of > 8.5. Please transfuse 1 unit at a time as total hemoglobin should not exceed 11. She has no history of VTE [clotting] so standard

post-operative chemical prophylaxis should be utilized. Sickle cell disease patients have a high risk of SCD related complications post-operatively, so strict vigilance should be maintained for development of acute SCD crisis, acute chest syndrome (patient has a history of this in the past), infection and VTE [clotting]. Recommend pre and post operative incentive spirometry. Given her likely complex pain management needs, we have asked the surgery team to have her transferred to the benign hematology service for more intensive management and to continue as consultants for co-management.

Exh. A, p. 111.

{¶15} While Cecilia's hemoglobin was within her normal range at 7.5, a hemoglobin of 8.5 or higher is helpful when preparing for surgery. To achieve this, Dr. Vaughn recommended a blood transfusion. However, Dr. Vaughn recommended only one unit of blood at a time so that Cecilia's hemoglobin would not exceed 11 because a hemoglobin that high would increase her risk for stroke or other blood clotting. Finally, Dr. Vaughn recommended that Cecilia be transferred to the benign hematology service at some point after surgery for more specialized pain management.

{¶16} Finally, the gastroenterology (GI) surgery team evaluated Cecilia on March 15, 2022. Upon evaluation, GI recommended an ERCP procedure be performed in advance of the lap chole. An ERCP is an endoscopic procedure in which a scope is inserted through the mouth and stomach into the small intestine to evaluate the bile ducts. Doctors use this procedure for diagnostic procedures or therapeutic procedures such as removal of gallstones or to perform a biopsy. For Cecilia, an ERCP was recommended to remove sludge and stones in the gallbladder in preparation for the lap chole.

{¶17} Following these consultations, Dr. Scarlet determined that Cecilia was a good candidate for surgery. According to Dr. Scarlet, Cecilia needed both the ERCP and the lap chole in order to properly treat Cecilia's gallbladder inflammation. As a result, Dr. Scarlet updated the acute care surgical plan to perform the lap chole "[o]nce [an] ERCP [is] complete and she has stabilized and has no evidence of post-ERCP pancreatitis." Exh. A, p. 95.

### **Interval between ERCP and Lap Chole Procedures**

{¶18} At 12:47 p.m. on March 15, 2022, Dr. Richard Johnson performed the ERCP with Cecilia under general anesthesia. Exh. A, p. 156. Dr. Johnson found and removed one gallstone and swept sludge from the duct. Exh. A, p. 156. Following this procedure, OSUWMC staff continued to monitor Cecilia and provide pain medication until the lap chole. Exh. A, p. 178.

{¶19} At 4:18 p.m. on March 16, 2022, Dr. Scarlet began the lap chole procedure. Immediately prior to surgery, Dr. Scarlet routinely takes a “time out” to ensure everyone understands the treatment plan, identify staff, and confirm the patient’s identity and procedure details, which she did with Cecilia and “all were in agreement.” Exh. A, p. 120. Additionally, the blood transfusion began before surgery and continued throughout.

{¶20} During the lap chole, Dr. Scarlet noticed that Cecilia’s gallbladder was slightly more adherent and within the tissue of the liver than average. After removing Cecilia’s gallbladder from her liver, Dr. Scarlet noticed mild bleeding, which, according to Dr. Scarlet, is not unusual in patients with inflammation of the gallbladder. The surgical team used a surgical sponge to provide pressure to the bleeding, used electrocautery to stop the bleeding, and placed a clip on the bleeding vein. To ensure the area no longer bled, the surgical team irrigated the area with two liters of IV fluid. Then the team placed two sheets of absorbable, surgical gauze over the area to facilitate clotting. Dr. Scarlet checked her work after removing the gallbladder and she saw no signs of active bleeding. Dr. Scarlet placed a drain to allow for postoperative monitoring of possible bleeding or bile leakage. Dr. Scarlet completed the surgery at 7:34 p.m. Exh. A, p. 208.

### **Postoperative Monitoring**

{¶21} After surgery Dr. Scarlet took Cecilia to the post anesthesia care unit (PACU) and observed that her vitals were stable and her drain was properly placed. Dr. Scarlet’s shift ended and she verbally handed off care to the overnight attending surgeon. Dr. Scarlet planned for the overnight surgical team to monitor Cecilia throughout the night and for hematology to assume responsibility of monitoring her care once the immediate postoperative care was complete, as per OSUWMC’s usual practice. In particular, the surgical team planned to monitor Cecilia during the night following surgery and conduct

at least one postoperative evaluation of Cecilia prior to transferring her to hematology. Dr. Vaughn clarified at trial that her recommendation in Cecilia's chart referencing postoperative monitoring meant that Cecilia should be transferred to hematology after the surgical team completed their postoperative monitoring, not immediately following surgery. Further, Dr. Vaughn did not recommend postoperative monitoring in the intensive care unit (ICU). Additionally, Dr. Ayanna Jacobs—the surgical intern responsible for postoperative monitoring overnight of the surgical patients in the acute care unit in March 2022—testified that such a transfer typically occurs during the daytime, not in the evening immediately after surgery. Similarly, Dr. Scarlet testified that postoperative patients are usually observed on a surgical floor for a period of time to “ensure that there's no actionable surgical complication.”

{¶22} According to Dr. Scarlet, generally only patients with abnormal vital signs or who require very frequent monitoring are sent to the ICU immediately after surgery, other patients are sent to the regular surgical floor. Because Cecilia's vital signs were normal and stable, Dr. Scarlet saw no need for Cecilia to be in the ICU. After surgery, the PACU observed Cecilia and saw no need for her to go to the ICU. The PACU determined that Cecilia could safely go to the regular surgical floor. As a result, Cecilia went to the acute care unit for postoperative monitoring.

{¶23} While the attending surgeon on call for the overnight care of surgical patients assumed responsibility for Cecilia's needs, Dr. Jacobs was the surgical intern directly monitoring Cecilia overnight while she was in the acute care unit. Dr. Jacobs began her surgical internship at OSUWMC in July 2021, and her everyday duties included caring for postoperative patients. By March 2022, Dr. Jacobs cared for hundreds of postoperative patients, including many of whom underwent lap choles. Dr. Jacobs's usual practice included reviewing the patient's chart to see if there were any recommendations from the operating team regarding postoperative care or any notable postoperative labs and examining the patient prior to making the overnight treatment plan. On any given night, the acute care service maintained forty to fifty patients, but Dr. Jacobs generally only treated four to five of those patients because the majority sleep through the night and do not require her care.

{¶24} On March 16, 2022, Dr. Jacobs worked in the surgical department overnight with one other intern. When Dr. Jacobs began her shift that evening, the daytime resident doctor informed her that Cecilia might have difficulty with pain control after the lap chole due to her SCD and, therefore, Cecilia could receive more pain medication than typical to control her postoperative pain.

{¶25} Dr. Jacobs saw Cecilia around 10 p.m. on March 16, 2022, after the procedure, when a nurse alerted her to Cecilia's increased pain. During this visit, Cecilia told Dr. Jacobs that she had uncontrolled pain, trouble breathing, and felt like something was wrong. Exh. A, p. 103. Upon a physical examination of Cecilia, Dr. Jacobs did not observe any signs of postoperative bleeding, such as rebounding, guarding, or presence of frank (bright red) blood in Cecilia's drains. Exh. A, p. 103. Additionally, Dr. Jacobs noted Cecilia's vitals at that time were all within normal limits and appeared neither consistent with her complaints nor a postoperative bleed.

{¶26} Due to these inconsistencies, Dr. Jacobs also consulted her senior resident, who agreed that a bleed or other surgical complication was unlikely given the exam and Cecilia's vitals. Exh. A, p. 103. Instead, the doctors agreed that a differential diagnosis of poor pain control due to a high opioid tolerance was more likely. Dr. Jacobs ordered a chest x-ray, provided pain medication (both during the initial examination and through a patient-controlled pump), and ordered blood work. Exh. A, p. 103.

{¶27} Around 11:45 p.m. that night, Dr. Jacobs observed Cecilia looking more comfortable and in less pain. Based on Dr. Jacobs's observation, Cecilia did not have any ICU needs at that time, such as a need for breathing support. While this encounter was the last time Dr. Jacobs saw Cecilia until after she passed, Dr. Jacobs continued to participate in Cecilia's care and treatment. Specifically, Dr. Jacobs reviewed the results of Cecilia's blood work, which showed her hemoglobin level was similar to her preoperative level and her chest x-ray which came back normal, these results further supported the doctors' differential diagnosis of poor pain management.

{¶28} Additionally, Dr. Jacobs continued to communicate with the nursing staff in the acute care unit monitoring Cecilia throughout the night. At one point, the bedside nurse had concerns about Cecilia's heartrate and brought in specialized "stats" nurses to help assess Cecilia. Exh. M2, p. 4. Both Dr. Jacobs and the "stats" nurses attributed

Cecilia's increased heart rate<sup>3</sup> to uncontrolled pain due to her high opioid tolerance. Exh. M2, p. 4. Dr. Jacobs also consulted radiology after the bedside nurse raised concerns about Cecilia's chest x-ray, and radiology reported that the x-ray was normal. Exh. M2, p. 4. Dr. Jacobs and the bedside nurse discussed these concerns around 1:30 a.m. on March 17, 2022. Exh. M2, p. 3.

{¶29} An hour later, Cecilia's heart rate rose significantly at around 2:30 a.m. Exh. A, p. 104. Cecilia quickly developed low blood pressure, altered mental state, loss of peripheral pulses, and stopped breathing on her own. *Id.* A code blue was called at 3:12 a.m. *Id.* The OSUWMC team performed CPR for approximately one hour—which included giving Cecilia “multiple doses of epinephrine, anti-arrhythmics”, “2+ liters of IV [fluids] while awaiting blood products”, calcium, two units of platelets, glucose, and “2 coolers MTP”—before declaring time of death. *Id.*

### **After Death**

{¶30} After Cecilia's death, OSUWMC contacted Dr. Scarlet and she immediately went to the hospital. Once she arrived, Dr. Scarlet spoke with the on-call attending surgeon, the chief resident, nurses, and Cecilia's family. An autopsy was performed, which identified Cecilia's cause of death as a “postoperative hemorrhage due to acute cholecystitis requiring [lap chole], gallstones, and [SCD].” Plaintiff's Exh. 8.

{¶31} After consultation with the pathologist who performed the autopsy, Dr. Scarlet reviewed and signed Cecilia's death certificate. Plaintiff's Exh. 8. By speaking with the pathologist, Dr. Scarlet learned that the clips placed during surgery to control bleeding remained in place. However, there was a large blood clot located in Cecilia's abdomen—indicating a fatal hemorrhage. According to the pathologist another patient may have survived the amount of blood loss caused by the blood clot revealed by the autopsy. Additionally, Dr. Vaughn was shocked to hear of Cecilia's death because she

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<sup>3</sup> At 1:36 a.m., the nurse told Dr. Jacobs that Cecilia's heart rate was “135 – 142 for about 2-3 mins” and after Dr. Jacobs messaged the nurse asking if her heartrate was “still that high” the nurse reported that Cecilia's heartrate was “mostly in the 130's, and has been that way off and on for about a half hour.” Exh. M2, p. 3.

did not observe any signs upon her examination that would indicate Cecilia would not survive surgery.

## **EXPERT OPINIONS**

{¶32} With respect to establishing the standard of care, Plaintiff presented the expert opinion of Dr. Kenneth Brayman. In defense, Defendant presented the opinions of independent expert witnesses, Dr. Cheguevara Afaneh and Dr. Nirmish R. Shah, as well as the opinions of treating physicians, Dr. Jacobs and Dr. Scarlet.

### **Dr. Brayman**

{¶33} Dr. Brayman is board certified in general surgery, and practices general and transplant surgery at the University of Virginia. He has practiced medicine for approximately thirty-five years and spends approximately eighty percent of his time operating and treating patients. Most of the surgeries Dr. Brayman performs are transplant surgeries, but he estimates that he performs ten to twenty gallbladder surgeries a year, not all of which are lap choles.

{¶34} While Dr. Brayman has published research articles concerning transplant issues and diabetes, he has neither published articles about SCD nor did he specifically rely on any literature when forming his opinions regarding Cecilia's medical treatment. Instead, Dr. Brayman relied on his personal knowledge and "used [his experience] as a standard to which other physicians' activities and care should be measured." Prior to rendering an opinion, Dr. Brayman reviewed the portion of Cecilia's OSUWMC medical records limited to her March 2022 medical treatment.

{¶35} From this review, Dr. Brayman contends that OSUWMC breached the standard of care by: (1) providing an inadequate preoperative evaluation; (2) performing the lap chole too soon after Cecilia underwent an ERCP; (3) providing inadequate postoperative monitoring following the lap chole; and (4) failing to recognize an active hemorrhage.

### *Preoperative Evaluation*

{¶36} According to Dr. Brayman, the standard of care required OSUWMC to evaluate Cecilia's cardiac function and ejection fraction (the pumping ability of the heart) prior to surgery with tests such as an echocardiogram and a stress test. However, Dr. Brayman did not render an opinion as to whether this additional cardiac function testing would have made it more likely than not that OSUWMC could have sooner detected the post-operative hemorrhage that caused Cecilia's death.

{¶37} While Dr. Brayman opined that ejection fraction testing done approximately a year prior to surgery is insufficient to assess cardiac function at the time of surgery, he did not review any of the medical records containing Cecilia's prior cardiac testing prior to forming this opinion. Dr. Brayman nevertheless testified that he "would be comfortable performing a cholecystectomy on [Cecilia]" when asked if he would have performed the lap chole procedure without the additional cardiac function testing, despite this perceived lack of sufficient testing.

#### *Interval Between ERCP and Lap Chole*

{¶38} Although Dr. Brayman does not dispute that the ERCP procedure was necessary, he contends that OSUWMC should not have performed the lap chole within a day of the ERCP because the ERCP relieved Cecilia's pain. Specifically, Dr. Brayman asserted that the immediate removal of the gallbladder was not urgent because Cecilia rated her pain at a level of 10/10 prior to the ERCP and rated it at a level of 7/10 the morning after the ERCP. However, the medical records indicate that Cecilia rated her pain at a level of 7/10 both immediately prior to the ERCP and again at least four times after the ERCP but before the lap chole. Exh. A, p. 333. Instead of performing the lap chole when OSUWMC did, Dr. Brayman opined that a tube should have been placed in Cecilia's gallbladder to manage her gallbladder inflammation then doctors should have performed a lap chole once the inflammation had died down.

#### *Postoperative Monitoring*

{¶39} According to Dr. Brayman, postoperative surgical patients only get their vitals taken every four hours. Based on his general practice, Dr. Brayman opined that the standard of care includes placing patients such as Cecilia in a setting with a more

favorable nurse-to-patient ratio where nurses can check on patients every half hour and take their vitals every hour or two. To this end, Dr. Brayman asserted that OSUWMC failed to meet the standard of care by not placing Cecilia in a more intensive setting where her vital signs could be monitored on a more frequent basis. Despite Cecilia not being in a more intensive unit, Dr. Brayman also admitted that OSUWMC practiced good care when Cecilia was seen by nursing staff and her vitals were taken seventeen times in the five hours between Dr. Jacobs's initial assessment of her increased pain and when OSUWMC called the code blue.

{¶40} Additionally, Dr. Brayman opined that the standard of care for a patient with SCD requires monitoring coagulation factors perioperatively (during surgery) and postoperatively because SCD patients are at a higher risk of abnormal bleeding. Dr. Brayman explained that patients can encounter platelet or coagulation issues after receiving fluids or blood so this testing is necessary to ensure normal coagulation.

#### *Diagnosing Hemorrhage*

{¶41} According to Dr. Brayman, the standard of care required OSUWMC to perform a bedside ultrasound to see if she had an internal bleed as soon as Cecilia developed abdominal pain. Dr. Brayman explained that if doctors performed an ultrasound and recognized a bleed Cecilia could have been monitored more closely. To this end, Dr. Brayman opined that OSUWMC employees demonstrated a lack of concern about the fact Cecilia was a patient with advanced SCD. Dr. Brayman opined that OSUWMC failed to meet the standard of care which caused Cecilia's death.

#### **Dr. Scarlet**

{¶42} In addition to her testimony as a treating physician, Dr. Scarlet also provided expert opinion testimony. Dr. Scarlet is board certified in general surgery and surgical critical care. Prior to joining OSUWMC, Dr. Scarlet obtained her undergraduate and medical degrees at the University of Florida and completed a seven-year residency in general surgery and a one-year fellowship in surgical critical care at the University of North Carolina at Chapel Hill.

{¶43} Dr. Scarlet is published in many areas, including post-surgery care, medical ethics, emergency surgery, laparoscopic surgery, trauma surgery, and other topics related to her practice. Exh. H, p. 3. Specific to patients with SCD, Dr. Scarlet co-authored a publication titled “Interdisciplinary Perioperative Management Protocol for Patients with Sickle Cell Anemia” in 2018. Exh. H, p. 3. This article proposed a management strategy to help reduce the likelihood of perioperative complications in patients with SCD. Whenever feasible, Dr. Scarlet followed that protocol in her practice at OSUWMC. Importantly, Dr. Scarlet testified that she followed this protocol when treating Cecilia.

#### *Interval Between ERCP and Lap Chole*

{¶44} When patients present with acute gallbladder inflammation and gallstones, Dr. Scarlet opined that the standard of care requires performing a lap chole at the same time as or within a day or two of an ERCP. In forming this practice, Dr. Scarlet referred to recommendations from the Society of American Gastroenterologist and Surgeons (SAGES)—treatment standards to which many acute care surgeons refer for guidance. According to Dr. Scarlet, SAGES recommends this limited interval of time between performing an ERCP and a lap chole to prevent the inflammation of the gallbladder from worsening and causing the patient to become more symptomatic or to prevent the patient from developing more gallstones thereby creating the need for an additional ERCP prior to performing the lap chole. In either scenario, waiting a longer interval of time poses the risk of having to perform a more complex surgery to remove the gallbladder.

{¶45} With respect to whether placing a cholecystectomy tube was a plausible alternative in Cecilia’s case, Dr. Scarlet opined that a tube fails to properly drain the gallbladder when patients have numerous gallstones. Instead, it is the practice of Dr. Scarlet and her OSUWMC colleagues to reserve the placement of cholecystectomy tubes for those patients who, for various reasons, have difficulty tolerating general anesthesia.

#### *Perioperative and Postoperative Monitoring*

{¶46} With respect to further monitoring coagulation factors perioperatively and postoperatively was necessary in Cecilia’s case, Dr. Scarlet testified that she orders the testing of clotting factors when unusual bleeding happens in surgery and anesthesia can also request such testing if they observe unusual bleeding. During Cecilia’s lap chole, neither Dr. Scarlet nor the anesthesia team noticed unusual bleeding. Based on this information, Dr. Scarlet opined that further monitoring of Cecilia’s clotting factors was not indicated. Finally, Dr. Scarlet testified that, in her professional opinion, her care of Cecilia, including the preoperative care and the surgery, met the standard of care.

### **Dr. Jacobs**

{¶47} In addition to her testimony as a treating physician, Dr. Jacobs also provided expert opinion testimony. Dr. Jacobs graduated from Yale University with a bachelor’s degree in history and then obtained a post-baccalaureate certificate in pre-medicine studies from Bryn Mawr College. Dr. Jacobs obtained her medical degree from Columbia University. Dr. Jacobs completed one year of surgical residency at OSUWMC before transitioning to a radiology residency. Based on her education, training, and experience, and her treatment of Cecilia, Dr. Jacobs opined that she met the standard of care in her treatment of Cecilia because she “did the best that [she] could with the information that [she] had at the time, and there was nothing to indicate when [she] saw [Cecilia] that she was experiencing a postoperative bleed.”

### **Dr. Afaneh**

{¶48} Dr. Afaneh is board certified in general surgery, and spends approximately eighty to ninety percent of his time treating patients. Dr. Afaneh obtained his undergraduate degree from the University of Miami and his medical degree from the Chicago Medical School. Dr. Afaneh completed residency and a one-year fellowship in advanced GI and minimally invasive surgery at New York Presbyterian Hospital Weill Cornell Medical College. Currently, Dr. Afaneh practices at New York Presbyterian where he holds the position of chief of minimally invasive and GI metabolic surgery.

{¶49} Dr. Afaneh performs approximately 700 surgical procedures each year. Not only does Dr. Afaneh teach minimally invasive surgical procedures, he also lectures on

them at the regional, national, and international levels. Dr. Afaneh has written over eighty peer-reviewed publications on various topics including removal of the gallbladder, minimally invasive surgery, and robotic-assisted surgery. Dr. Afaneh performed approximately 1,500 lap choles prior to his testimony and followed up postoperatively with approximately 8,000 patients. Further, Dr. Afaneh testified that he has performed surgery on many patients with SCD.

{¶50} In preparing his opinion in this case, Dr. Afaneh reviewed the pertinent sections of the 12,000 pages of Cecilia’s OSUWMC chart, the depositions of Drs. Scarlet and Jacobs, and the report and deposition of Dr. Brayman. Dr. Afaneh asserted that OSUWMC appropriately evaluated Cecilia preoperatively, including the hematology consultation; OSUWMC properly found that Cecilia’s condition indicated surgery; and postoperatively Cecilia received frequent monitoring, and Dr. Jacobs appropriately determined differential diagnoses.

#### *Preoperative Evaluation*

{¶51} According to Afaneh, the mere fact that a patient has SCD does not make them a high-risk patient for surgery. Instead, the standard of care requires the doctor to establish a baseline of the patient’s pain and get a hematology consult when preparing a patient with SCD for surgery. Based on his review, Dr. Afaneh opined that OSUWMC properly assessed Cecilia for surgery.

{¶52} With respect to performing the lap chole without first performing further cardiac function testing, Dr. Afaneh testified that he would feel confident proceeding to surgery in light of the results of Cecilia’s prior cardiac function testing and her tolerance of the ERCP. Specifically, Cecilia had a “pretty significant stress test prior to the surgery with the ERCP” because she tolerated general anesthesia and a cut that was performed, and she had a history of an ejection fraction consistently over 50%. Dr. Afaneh also opined that it was reasonable for OSUWMC to perform a lap chole within twenty-four hours of Cecilia the ERCP in order to minimize complications from a lengthy hospital stay.

#### *Interval Between ERCP and Lap Chole*

{¶53} Dr. Afaneh opined that the standard of care for patients like Cecilia would be to remove the gallbladder in the same hospital admission as an ERCP is performed. With respect to delaying the lap chole and placing a cholecystectomy tube, Dr. Afaneh explained that placing a tube does not address the problem of gallstones and removal of the gallbladder is necessary to prevent more complications from arising. Further, Dr. Afaneh stated that if the gallbladder is not removed, the patient is at risk for repeated attacks that make later removal more difficult.

{¶54} According to Dr. Afaneh, OSUWMC properly timed the ERCP and lap chole to mitigate morbidity. Specifically, he opined that the fact that OSUWMC's surgical team "show[ed] some level of maturity" by first performing the ERCP to ensure that there were no issues prior to performing the lap chole. Based on his experience and knowledge of the literature, Dr. Afaneh testified that surgeons never recommend waiting multiple days between an ERCP and a lap chole due to an increased risk of bleeding.

#### *Postoperative Monitoring*

{¶55} As to monitoring coagulation factors in Cecilia's case, Dr. Afaneh opined that perioperative or postoperative testing was not indicated in this case because the GI doctors performed a cut during the ERCP and did not encounter abnormal bleeding. Further, Cecilia's normal platelet counts on pre- and postoperative blood work did not suggest a risk of bleeding.

{¶56} With respect to Cecilia being transferred to hematology for monitoring, Dr. Afaneh opined that such a transfer would occur "when the surgical team feels like everything is okay and stable from the surgery." According to Dr. Afaneh, transferring a surgical patient to hematology mere hours after surgery or calling hematology overnight after surgery would not be done because postoperative patients need to remain on the surgical floor to "assess for any issues with surgery overnight."

#### *Diagnosing Hemorrhage*

{¶57} Dr. Afaneh testified that the standard of care when making a differential diagnosis is to get a history, perform a physical exam, assess vital signs, lab results, and pertinent imaging, then "based on the information available, a best sort of prediction of

what could be going on is then made . . . [w]e typically list things from most common or most likely to least likely.” He explained that when a surgeon’s diagnosis turns out to be incorrect, that does not always mean that their care fell below the standard. Based on the information available to Dr. Jacobs, Dr. Afaneh opined that the differential diagnoses were appropriately determined.

{¶58} Specifically, Dr. Afaneh opined that Dr. Jacobs’s postoperative evaluation of Cecilia would not alert a doctor to a likely postoperative bleed. Based on the American College of Surgeons guidelines for mean arterial pressure, Dr. Afaneh explained that a drop in blood pressure, elevated pulse, weakness, shortness of breath, low urine output, and pale skin would be signs of bleeding. However, Cecilia did not have a mean arterial pressure that was concerning for a postoperative bleed. Moreover, Cecilia’s vitals, abdominal exam, urine output, pain, and drain output did not suggest a postoperative bleed. Therefore, Dr. Afaneh opined that a bedside ultrasound was not indicated. Additionally, Dr. Afaneh opined that the frequency of OSUWMC’s postoperative monitoring of Cecilia met the required standard of care.

#### **Dr. Shah**

{¶59} Dr. Shah is board certified in medicine, pediatrics, and pediatric hematology/oncology, and estimates that ninety-five percent of his job duties at Duke University include treating patients with SCD. Dr. Shah obtained his undergraduate degree at the University of Florida and obtained his medical degree from American University in the Caribbean. Dr. Shah completed a residency program in pediatric medicine at East Carolina University before completing fellowships in adult hematology/oncology and pediatric hematology/oncology at Duke University.

{¶60} Over the course of his career, Dr. Shah testified that he has treated approximately 2,000 patients with SCD, over 100 of whom underwent lap choles. Additionally, Dr. Shah authored over 128 publications with approximately ninety percent of which concern SCD and pain management.

{¶61} In preparing his opinion in this case, Dr. Shah reviewed the pertinent sections of Cecilia’s OSUWMC chart, the depositions of Drs. Scarlet and Jacobs, and the report and deposition of Dr. Brayman.

*Preoperative Evaluation*

{¶62} Dr. Shah disagreed with Dr. Brayman's assertion that OSUWMC failed to perform a proper preoperative assessment. Instead, Dr. Shah testified that OSUWMC met the standard of care when the surgical team consulted with hematology and followed their recommendations prior to surgery.

{¶63} With respect to further cardiac assessment prior to surgery, Dr. Shah opined that the standard of care in evaluating a patient with SCD for surgery does not include cardiac stress tests or pulmonary hypertension screenings unless the patient presents with a symptom or complication indicating further testing is necessary. Based on Cecilia's presentation of symptoms, Dr. Shah testified that he would not have ordered either of those diagnostics.

*Postoperative Monitoring*

{¶64} With respect to placement for postoperative monitoring, Dr. Shah opined that a patient having SCD alone does not require postoperative monitoring in the ICU. Furthermore, Dr. Shah testified that he, among other hematologists, would not be comfortable treating surgical patients mere hours after surgery and he would defer to the surgeons regarding when the patient is stable enough to be transferred to hematology.

{¶65} Regarding whether monitoring Cecilia's coagulation factors was necessary, Dr. Shah testified that there is no medical evidence to support that there would be any risk for abnormal bleeding from SCD. Instead, patients with SCD are generally at higher risk for developing blood clots given the abnormal shape of the blood cell. Furthermore, Dr. Shah testified that assessing a patient's blood clotting ability is appropriate when there is excessive bleeding in surgery, unstable vitals, or sepsis. However, Cecilia's medical records show she had none of these complications and "[s]he was hemodynamically stable" so there were no "hematologic reasons for coagulopathy."

{¶66} Finally, Dr. Shah opined that postoperative pain in a patient with SCD would likely indicate a SCD pain crisis. Moreover, Dr. Shah would regard complaints of pain at a level of "seven or eight out of 10 . . . as a sickle cell crisis." Even if internal bleeding was alternatively suspected of causing postoperative pain given it is an expected risk of

any surgery, Dr. Shah testified that a “CT scan is probably the quickest, fastest way to find if there is blood within the abdomen in particular” in comparison to an ultrasound, which “can pick up some blood, but it’s really not that effective depending on where the blood is located.”

## LAW

{¶67} Under Ohio law, Plaintiff must prove her civil claims by a preponderance of the evidence. See *Merrick v. Ditzler*, 91 Ohio St. 256, 260 (1915). A preponderance of the evidence “is defined as that measure of proof that convinces the judge or jury that the existence of the fact sought to be proved is more likely than its nonexistence.” *State ex rel. Doner v. Zody*, 2011-Ohio-6117, ¶ 54. It is well settled that the trier of facts determines the weight to be given the evidence and the credibility of the witnesses. *State v. DeHass*, 10 Ohio St.2d 230 (1967), paragraph one of the syllabus. As the trier of facts in this case, the Court is free to weigh the evidence and believe all, part, or none of the testimony of the witnesses, including the parties’ expert witnesses. See *State v. Green*, 2004-Ohio-3697, ¶ 24 (10th Dist.).

{¶68} Plaintiff’s claims are based upon a theory of medical malpractice. “In order to establish medical malpractice, a plaintiff must show: (1) the standard of care recognized by the medical community, (2) the failure of the defendant to meet the requisite standard of care, and (3) a direct causal connection between the medically negligent act and the injury sustained.” *Tobin v. Univ. Hosp. E.*, 2015-Ohio-3903, ¶ 14 (10th Dist.), citing *Stanley v. Ohio State Univ. Med. Ctr.*, 2013-Ohio-5140, ¶ 19 (10th Dist.). Under Ohio law, “[e]xpert testimony is required to establish the standard of care and to demonstrate the defendant’s alleged failure to conform to that standard.” *Reeves v. Healy*, 2011-Ohio-1487, ¶ 38 (10th Dist.). The test for evaluating whether a medical treatment provider failed to meet the requisite standard of care

is whether the physician, in the performance of his service, either did some particular thing or things that physicians and surgeons, in that medical community, of ordinary skill, care and diligence would not have done under the same or similar circumstances, or failed or omitted to do some particular thing or things which physicians and surgeons of ordinary skill, care and

diligence would have done under the same or similar circumstances. He is required to exercise the average degree of skill, care and diligence exercised by members of the same medical specialty community in similar situations.

*Bruni v. Tatsumi*, 46 Ohio St.2d 127, 129-130 (1976). A physician must exercise the average degree of skill, care, and diligence in the treatment of their patients, therefore, medical negligence does not occur merely because a patient did not receive the best treatment but only if a plaintiff proves that they received inadequate treatment. See *Buerger v. Ohio Dept. of Rehab. & Corr.*, 64 Ohio App. 3d 394, 400 (10th Dist. 1989)(“While plaintiff may argue that he did not receive the best treatment, it is his burden to show that he did not receive adequate treatment.”).

{¶69} In a medical negligence case where the parties present “a battle of the experts” regarding the applicable standard of care, it is up to the trier of fact to “weigh the medical testimony and to resolve the conflicting opinions.” *Gordon v. Ohio State Univ.*, 2011-Ohio-5057, ¶ 77 (10th Dist.). Conflicts in opinion testimony are generally resolved based on the quality of the evidence presented. See generally *Grieser v. Janis*, 2017-Ohio-8896, ¶ 36 (10th Dist.) (“Erosion of an expert opinion due to effective cross-examination does not negate that opinion; rather it only goes to weight and credibility.” Cleaned up.); see also *McRae v. State Med. Bd. of Ohio*, 2014-Ohio-667, ¶ 27 (10th Dist.) (“The fact that appellant had two expert witnesses does not mean she is entitled to prevail. As the lower court noted, ‘the quantity of the evidence does not always equate to quality.’”).

## **ANALYSIS**

{¶70} The Court has carefully considered and weighed all the expert testimony in this case. As a result, the Court finds that the testimony of Dr. Brayman carries less weight than the testimony of Drs. Scarlet, Afaneh, and Shah. Despite having more years of experience than the other doctors, Dr. Brayman practices in the field of transplant surgery and rarely performs lap choles. Comparatively, Drs. Scarlet and Afaneh perform this surgery on a weekly basis and have more experience in treating patients like Cecilia.

{¶71} Additionally, Dr. Brayman obtained no specialized training in treating patients with SCD unlike Dr. Shah, whose practice is almost exclusively dedicated to the treatment of such patients, and unlike Dr. Scarlet, who published a research article about treating surgical patients with SCD. Further, Drs. Afaneh and Scarlet relied on specific surgical guidelines that are adhered to in the surgical community in forming their opinions, while Dr. Brayman did not and relied solely on his own experience.

{¶72} Finally, Drs. Scarlet and Jacobs had personal experience with treating Cecilia that Dr. Brayman lacked. Moreover, Dr. Brayman admittedly reviewed only a portion of Cecilia's medical records prior to rendering his opinion.

### **Inadequate Preoperative Evaluation**

{¶73} Based on the expert testimony presented, the Court finds that the applicable standard of care for preoperative evaluation of a patient with SCD includes a physical exam, a hematology consultation, and gaining an understanding of the patient's pain. OSUWMC met this standard of care. Based on the testimony of Drs. Scarlet, Afaneh, and Shah, the Court further finds that the standard of care did not require additional testing of Cecilia's cardiac function and blood clotting ability based on her clinical presentation. Because the evidence demonstrates that a hematology consultation was obtained and discussed, the recommendations from hematology were followed, and proper pain prevention and management for patients with SCD were discussed prior to performing the lap chole, the Court finds that OSUWMC employees acted with the same skill, care and diligence that others in the same medical community would have done under the same or similar circumstances. Consequently, Plaintiff failed to establish a breach of the standard of care as it relates to preoperative evaluation.

### **Interval Between the ERCP and the Lap Chole**

{¶74} The Court finds that the testimony of Drs. Afaneh and Scarlet established that it is within the standard of care to perform a lap chole within twenty-four to forty-eight hours of an ERCP. Both doctors testified that this is the routine practice in their field. Additionally, the SAGES guidelines adhered to by surgeons in the field recommend that an ERCP be shortly followed by a lap chole. Comparatively, Dr. Brayman failed to cite

any specific authority supporting his assertion that OSUWMC doctors should have waited to perform the lap chole.

{¶75} Further, the Court is not persuaded by Dr. Brayman's assertion that the reduction in Cecilia's pain decreasing from a 10/10 to a 7/10 is medically significant, specifically in light of medical records indicating that Cecilia rated her pain as a 7/10 several times before and after the ERCP. Moreover, the Court is not persuaded by Dr. Brayman's suggestion that treating Cecilia's gallbladder inflammation by inserting a tube is a plausible alternative under the circumstances. Drs. Afaneh and Scarlet, who have more experience with gallbladder removal surgery than Dr. Brayman, testified that inserting a tube into Cecilia's gallbladder would not have helped the inflammation and is only indicated in patients who are not surgical candidates. Importantly, there are less complications during surgery when the gallbladder is removed quickly.

{¶76} Because the lap chole was performed within a day after Cecilia successfully tolerated the ERCP procedure, the Court finds that OSUWMC employees acted with the same skill, care and diligence that others in the same medical community would have done under the same or similar circumstances. Therefore, Plaintiff failed to demonstrate a breach of the standard of care as it relates to the interval of time between the ERCP and lap chole procedures.

### **Inadequate Postoperative Monitoring**

{¶77} Plaintiff asserts that OSUWMC breached the standard of care by failing to place Cecilia in the ICU for postoperative monitoring. To establish the standard of care, Plaintiff attempts to use Dr. Brayman's testimony that Cecilia would have received more frequent monitoring in the ICU and that as a patient with SCD she should have been in the ICU. However, Drs. Scarlet, Afaneh, and Shah credibly refuted this contention. Dr. Shah testified that simply having SCD is not a reason for a patient to be monitored in the ICU post-surgery. Further, Drs. Scarlet and Afaneh both testified that ICU Cecilia's condition post-surgery did not indicate ICU monitoring. While Dr. Brayman contends that the standard of care requires nurses to take Cecilia's vitals every hour or two and see patients every half hour, he also admitted that Cecilia's vitals were taken more frequently than this while in the acute care unit. Therefore, Plaintiff failed to establish that the

standard of care required OSUWMC employees to place Cecilia in the ICU postoperatively.

{¶78} Similarly, Plaintiff argues that the surgical team failed to follow hematology's recommendation that Cecilia be transferred to hematology for follow-up care after surgery and instead kept Cecilia on the surgical floor. However, Drs. Scarlet and Jacobs testified that such recommendation would typically mean that the patient should be transferred to the other service after postoperative monitoring was complete on the surgical floor. Further, Drs. Shah and Afaneh testified that a hematology department would not typically care for patients immediately after surgery. Therefore, the Court finds that the applicable standard of care would be to monitor Cecilia on the surgical floor unless her vitals suggested that she was unstable and to transfer her to hematology once the immediate postoperative monitoring and care was complete. Based on the evidence presented, the Court finds that OSUWMC met this standard of care. Accordingly, Plaintiff failed to demonstrate that OSUWMC breached the standard of care as to postoperative monitoring.

#### **Failure to Recognize a Hemorrhage**

{¶79} Plaintiff argues that Dr. Jacobs was overloaded with patients and breached the standard of care by dismissing Cecilia's pain and the concerns of a nurse regarding x-ray results. However, this assertion runs contrary to the facts proven at trial. First, Dr. Jacobs assessed Cecilia's pain, consulted with others to make a treatment plan, and ordered tests to investigate the cause of Cecilia's pain. Dr. Jacobs also addressed the nurse's concerns regarding the x-ray by consulting with radiology and reporting back to the nurse that the chest x-ray was normal. Furthermore, Dr. Jacobs only saw a few of the patients in the acute care unit on the night of March 16, 2022. The medical records show, and Plaintiff's own expert acknowledged, that Dr. Jacobs and OSUWMC employees actively cared for Cecilia. Therefore, Plaintiff failed to demonstrate a breach of the standard of care regarding responsiveness to Cecilia's complaints.

{¶80} Plaintiff asserts that OSUWMC failed to meet the standard of care when its staff failed to perform imaging to search for postoperative bleeding. Dr. Brayman opined that a bedside ultrasound or other imaging would have discovered an abdominal bleed if

performed. However, the Court finds that Dr. Afaneh refuted this opinion by explaining that Cecilia's physical exam, vitals, and overall presentation did not warrant such imaging because Dr. Jacobs's differential diagnosis of poor pain management was reasonable while she investigated other causes. While an ultrasound may have detected the bleed, the Court finds that the standard of care did not require OSUWMC to perform one. Thus, Plaintiff failed to demonstrate a breach of the standard of care as to recognizing a hemorrhage.

{¶81} In summation, the Court finds that the standard of care required that OSUWMC: (1) preoperatively evaluate Cecilia including a physical exam, a hematology consultation, and gaining an understanding of her pain; (2) perform a lap chole within twenty-four to forty-eight hours of the ERCP; (3) monitor Cecilia on the surgical floor unless her vitals suggested that she was unstable and to transfer her to hematology once the immediate postoperative monitoring and care was complete; and (4) perform tests to evaluate the cause of Cecilia's pain based on her symptoms. Based on the evidence presented at trial, Plaintiff failed to establish that OSUWMC failed to meet this standard of care. Consequently, OSUWMC is entitled to judgment in its favor.

### **Damages**

{¶82} Because Plaintiff failed to demonstrate that the medical treatment Cecilia received at OSUWMC did not meet the requisite standard of care, it is unnecessary for the Court to render an analysis of damages.

### **CONCLUSION**

{¶83} Having carefully considered all the evidence and the applicable law as set forth above, the Court finds that the medical care received by Cecilia at OSUWMC was within the standard of care. Therefore, the Court finds that Plaintiff has failed to prove by a preponderance of the evidence any of the alleged breaches set forth in the complaint. Accordingly, Defendant is entitled to a judgment in its favor.

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LISA L. SADLER

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Judge

[Cite as *Edoja v. Ohio State Univ. Wexner Med. Ctr.*, 2026-Ohio-880.]

TERESA EDOJA, Admr.

Plaintiff

v.

THE OHIO STATE UNIVERSITY  
WEXNER MEDICAL CENTER

Defendant

Case No. 2022-00837JD

Judge Lisa L. Sadler

JUDGMENT ENTRY

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**IN THE COURT OF CLAIMS OF OHIO**

{¶84} This case was tried to the court on the issues of liability and damages. 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.

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LISA L. SADLER  
Judge

Filed February 12, 2026  
Sent to S.C. Reporter 3/16/26