$6,500,000 SETTLEMENT IN ANESTHESIA CASE RESULTING IN BRAIN DAMAGE* (Structured Settlement payout of $45,000,000)

Medical Malpractice Trial Report

ANESTHESIA Medical Malpractice Lawsuit: Failure to Monitor Anesthesia Results in Brain Damage.

The Plaintiff, age 7, was admitted to the Hospital for the performance of a tonsillectomy and adenoidectomy.

The morning of the surgery the Plaintiff's father met with the Anesthesiologist briefly. The Anesthesiologist never told the family that the Nurse Anesthetist would actually be inducing anesthesia and monitoring the Plaintiff during the surgery, and that he, the Anesthesiologist would not be physically in the operating room for the majority of the time. After intubation and induction, the Anesthesiologist left the operating room leaving the Plaintiff to be monitored by Nurse Anesthetist.

The Hospital had five working operating rooms. On the date in question four operating rooms were in use. Nurse-anesthetists manned three of the operating rooms with the fourth room manned by an anesthesiologist other than the Defendant Anesthesiologist. The Defendant Anesthesiologist's sole responsibility that day, pursuant to the guidelines of the Hospital, was to be the director and supervisor of the Nurse-Anesthetists in the three operating rooms.

Following intubation the Plaintiff underwent anesthesia induction with the drug Halothane through the endotracheal tube. Anesthesia is the practice of rendering someone unconscious so that they will not feel pain. Halothane does this by affecting the central nervous system. When given in too high of a dose, the central nervous system will shut down to too large of a degree affecting the transfer of oxygen in the body. This failure of the body to transfer oxygen and oxygenate the blood leads to a condition as know hypoxia. Hypoxia is defined as a decrease below normal levels of oxygen in arterial blood or tissue. When the body is faced with hypoxia it attempts to protect itself from damage. This is done by autoregulation of the blood flow. The brain shunts blood away from the periphery and increases flow to the brain and heart to insure that they are not damaged. Unfortunately, the body can only autoregulate itself for a period of time. Eventually, if the hypoxia continues, there is cardiovascular- collapse and brain damage. One sign of hypoxia is a lowering of the blood pressure and an increase in the pulse rate. The low blood pressure is due to the shunting of the blood; the high pulse rate is the bodies attempt to counteract the decreased oxygen content by increasing the amount of heartbeats. In effect, by having additional beats of low oxygenated blood the body hopes to maintain the same tissue oxygenation that was being supplied by fewer beats of properly oxygenated blood.

The Plaintiff was started with an induction dose of O-3.O percent. The standard of care then calls for a tapering of the induction dose to a smaller maintenance dose during surgery. During surgery the Plaintiff was monitored at a dose

of 2.5 percent. It was the opinion of the Plaintiff's various medical experts that Defendants Anesthesiologist and Nurse Anesthetist fell below the standard in the administration and maintenance of the Halothane in that the Plaintiff was overdosed on Halothane. The Plaintiffs expert testified in deposition that the loading dose of 3.O percent and the maintenance dose of 2.5 percent were too high. Also, the anesthesia record for the Plaintiff indicates that during surgery the Plaintiff's pulse became tachycardic (very fast) and his blood pressure was dropping. These symptoms were apparently ignored by the Nurse Anesthetist.

Another manner of confirming the patients well being during surgery is through the use of a pulse oximiter. This is a process by which a machine determines the oxygen saturation of blood. This is done through a clip or wrap piece that is placed on a patients finger. Pulse Oximitry was used on the Plaintiff. The pulse oximitry will provide a reading of the percentage of oxygen content. Clearly the percentage should be high in a normal person, 98-100 percent. The Plaintiff was receiving oxygenate during surgery through the intubation tube and therefore his oximitry reading should have been 100%. During surgery the oximitry reading was only 97%. Further, during surgery the pulse oximitry actually dropped on two occasions from 97 to 0. This was a sign of lack of oxygenation that was also ignored by the Nurse Anesthetist. Nurse Anesthetist who simply asked that the clip for the oximitry be replaced did not aggressively investigate this situation. The clip was replaced and again showed readings that went from 97 to 0. Again the Nurse Anesthetist asked for the clip to be replaced. The Nurse Anesthetist did not consider that the oximitry reading might actually be evidence of the Plaintiff becoming hypoxic, which was the case. The Nurse Anesthetists simply assumed that the machinery was not working, and did not confirm the Plaintiffs well being. had the Nurse Anesthetist done so it would have been evident that the Plaintiff was hypoxic, and would have taken action to reverse the hypoxia, well before cardiovascular collapse and brain damage. The pulse oximetry equipment was later checked and found to be properly working without any difficulty. Therefore, the drop in the pulse oximetry from 97 to 0 was not caused by a machine malfunction, as was at one point suggested by the Defendants, but was an indication of hypoxia.

Either because of concern due to the abnormal oximetry readings or because it was the conclusion of the surgery, depending upon which deponent was to be believed, the surgical table was turned so that the Plaintiff's head was away from the surgeon and in front of the Nurse Anesthetists. At that time the Plaintiff was found to be severely cyanotic. Cyanosis is a bluish coloration of the skin due to deficient oxygenation content of the blood. Cyanosis is one of the indications of hypoxia. The bluish color of the child's sin was not noticed earlier by the surgeon or the Nurse Anesthetist because the child was draped for surgery.

Faced with what was now a medical emergency, the Nurse Anesthetist called for a code blue. The supervising Anesthesiologist responded with another Anesthesiologist and CPR was begun. At that time the Plaintiff had no pulse. The second anesthesiologist managed the care of the Plaintiff during the code. This second anesthesiologist stated that he saw a wide QRS rhythm on the EKG. This wide complex rhythm is evidence of a long standing duration of hypoxia rather than an acute event.

Due to the long-standing delay in recognizing the Plaintiff's hypoxia, his condition had deteriorated so badly that it was extremely difficult to regain a pulse. By this time, extensive brain damage had already occurred. Eventually the Plaintiff did regain a pulse and was transferred to another facility.

Following the events in question the Plaintiff was diagnosed as being significantly and profoundly brain damaged. The actual diagnosis is anoxic encephalopathy. Apart form the brain damage, he is otherwise physically healthy. The Plaintiff has little cognitive function but does smile appropriately, laughs when tickled and responds to his mother's voice. The Plaintiff will now be cared for at home with his family.

Following the close of discovery, the case was settled at mediation for the amount of Six Million Five Hundred Thousand ($6,500,000.00) Dollars. A portion of the settlement amount was structured. Should the child live for a normal life expectancy, which it is expected he will, the payout for the structure will be in the amount of Forty Five Million ($45,000,000.00) Dollars.