

TYPE OF ACTION: Medical Malpractice, brain damage, cerebral palsy

ACTION: Proe\* v. Coe\*, et al. (names disguised pursuant to confidentiality agreement)

COURT: Superior Court of the District of Columbia

AMOUNT OF SETTLEMENT: \$4,200,000.00

ATTORNEY FOR PLAINTIFF: William E. Artz, Arlington, Virginia

CASE SUMMARY: The infant Plaintiff, age 20 months, was scheduled for an elective circumcision on 5/18/92. Upon arrival at the hospital, the infant Plaintiff presented with a fever of 100.4 degrees, runny nose, and a dry cough for one week. Rather than cancel surgery, the anesthesiologists cleared the patient. Upon induction of anesthesia, the infant Plaintiff went into laryngospasm and required a paralyzing drug and intubation. Concern arose that the infant had developed pulmonary edema and might need transfer to a tertiary level facility better able to manage the airway. After 2½ hours of observation in the operating room, a discussion ensued as to whether the infant Plaintiff needed transfer at all. The pulmonary edema was largely resolved, the arterial blood gases were dramatically improved, and the child's O<sub>2</sub> saturation levels and lung function were close to normal. Nevertheless, a decision was made to transfer.

Upon arrival at the second hospital, the child came under the largely unsupervised care of an anesthesiologist in his fellowship (one year after residency) on rotation from a neighboring hospital. The treatment plan called for continued intubation and periodic medication which both sedated and paralyzed the child. The arterial blood gases taken at 2:50 p.m. on 5/18 showed virtually normal lung function, making the child a candidate for extubation (tube removal). The anesthesiologist fellow nevertheless decided to continue with intubation and sedation. The sedation was being administered hourly, but the amount was effective for only 30 minutes. Thereafter, the child, by virtue of his agitation and thrashing about, self-extubated at

approximately 6:00 p.m. As a result, O<sub>2</sub> from the ventilator was delivered down the esophagus into the stomach, causing projectile vomiting at 6:10 p.m. With the tube out of the trachea and the child unседated, the infant Plaintiff was able to breathe on his own. At 6:20 p.m., the anesthesiologist fellow administered sedation and a paralyzing drug. At 6:25 p.m., the child's heart rate dropped to 47, and then into the 30's. Instead of removing the endotracheal tube and reinserting a new tube, the anesthesiologist fellow administered atropine and epinephrine pharmacologically, causing the heart rate to rise and then drop again. At 6:40 p.m., he finally removed the tube and reintubated the child. Ventilation improved dramatically, but the infant Plaintiff sustained severe hypoxic brain damage as a result of the 15 minute delay in correcting the airway. The infant remained hospitalized for two additional months and was eventually discharged home, where he is cared for by his parents and three sisters.

The infant Plaintiff's cognitive level will not develop beyond first grade level. He has cerebral palsy of the lower extremities, but is expected to be able to walk with tendon-lengthening surgery and a walker. As of age 4, he was not potty trained.

The medicals incurred as of settlement were \$175,000, and the lost wage claim totalled \$713,000. Cost of future care, were the infant to be placed in a full service school, exceeded \$5.6 million by projection, although defense experts felt the child's needs could be fully met with a present value annuity costing \$3 million.

The defendants were two hospitals and an anesthesia group, plus two individual anesthesiologists.