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## MEDICAL MALPRACTICE

**Childbirth - OB-GYN**

# Brain Damage from Botched Intubation

**VERDICT:** **$114,869,533.00**

**CASE:** Elizabeth Evans and Mark McCord, as co-g.a.l. for Michelle McCord v. St. Mary's, No. 4038/91

**VENUE:** Kings Supreme, NY

**JUDGE:** Richard A. Goldberg

**DATE:** 11-09-2001

**PLAINTIFF(S) ATTORNEY:** **Stephen E. Erickson;** Pegalis & Erickson; Lake Success, NY, for Elizabeth Evans and Mark McCord, as co-g.a.l. for Michelle McCord.

**FACTS:** At 2:30 AM on 5/9/88, Pltf., a 28-year-old telephone operator who was 8 months pregnant at the time, was brought by ambulance to the emergency room of Deft. St. Mary's Hospital in respiratory distress. She had a recent history of tonsillitis, for which she had been taking antibiotics until 2 days before going to the emergency room. Additionally, she had a history that the onset of breathing difficulties occurred when she had smoked crack and inhaled heroin several days earlier. Upon arrival to the emergency room, her respiratory symptoms worsened and her heart rate slowed. Initial attempts at intubation were unsuccessful, and an incision was made in Pltf.'s neck in preparation for the performance of a tracheotomy. Pltf. was eventually successfully orally intubated by emergency room personnel, and she was admitted to the hospital and taken to the intensive care unit where she was under the care of obstetrical, pulmonology, and intensive care personnel. Four chest X-rays taken that day showed progressive worsening of Pltf.'s lungs. According to the Hospital's radiology report, the final X-ray, taken at 9 PM, showed acute respiratory distress syndrome. Deft. contended that the next day, on 5/10, the pulmonology service read the X-rays from the previous day as showing some improvement, and observed Pltf. to be clinically stable and doing well on a T piece off of the respirator. Defts. began the process of attempting to wean Pltf. from the respirator. She remained off of the respirator for more than 3 hours before the actual extubation. It was noted that during this process, Pltf.'s blood oxygen level began to drop, and she was given increased oxygen. Approximately 1 hour after increasing the level of oxygen, and after approval by the ICU chief, hospital residents removed the endotracheal tube. Within 3 minutes, Pltf. began wheezing and became short of breath. An anesthesiologist was called to attempt to reintubate her, but the attempt was unsuccessful. A surgeon was then called to perform a tracheotomy. By the time that procedure was performed, Pltf. was in respiratory and cardiac arrest and began having seizures. She underwent an emergency Caesarean section later that evening because of concerns of maternal brain death with a viable fetus.

Pltf. remained in the hospital for 8 months and was then transferred to a long-term care facility. She suffered extensive brain damage, and although she is able to walk, talk, and feed herself, she requires constant supervision because of extreme disorientation and frequent aggressive outbursts. Pltf. contended that she will require institutional care for the rest of her life.

Pltf. claimed that according to the hospital chart, Deft. Dr. Bajaj recommended that the endotracheal tube be removed. Deft. Dr. Bajaj testified that the decision to remove the tube was discussed among the various medical services including the chief of ICU, and that he would not have made the decision to extubate on his own. Pltf.'s experts testified that it was a departure from good and accepted medical practice to have removed the endotracheal tube when Pltf.'s X-rays showed that her lung problems were worsening and she required supplemental oxygen during the attempts at weaning. Pltf. also contended that Defts. should have anticipated that she would develop further swelling and obstruction of the upper airway during the extubation, because it was performed less than 36 hours after the traumatic intubation, she had been difficult to intubate in the emergency room, she was receiving antibiotics for tonsillitis before arriving at the emergency room, and she had exhibited upper airway obstruction in the emergency room. Pltf. also contended that it was a departure not to have evaluated her upper airway for swelling under these circumstances before the extubation, but that if extubation was going to be done, the standard of care required that a qualified doctor who was capable of performing an emergency tracheotomy be present at her bedside.

Defts. contended that the decision to remove the endotracheal tube was a reasonable exercise of judgment, given the evaluations of the pulmonologist, who believed that the X-rays showed some improvement; in light of the fact that she was described as being clinically stable by several physicians; that she had tolerated 3

hours on a T piece off the respirator; and that the weaning criteria had been performed and found to be satisfactory. The Hospital also contended that its personnel had responded promptly to Pltf.'s needs after the extubation had been performed while she was in ICU. Defts. contended that Pltf.'s condition was compromised by the fact that she had smoked crack 8-9 hours before arriving at the emergency room on 5/9/88. They also argued that the type of brain damage from which she now suffers, including impairment of function of memory, cognition, and behavior, are the types of brain damage caused by chronic use of crack cocaine. They contended that her brain damage was due to a combination of chronic crack use in conjunction with anoxic brain damage, from which she had suffered before she came into the emergency room in respiratory distress, and the additional insult of lack of oxygen to the brain following the extubation on 5/10.

Pltf. had undergone drug rehabilitation for 28 days in 1986 and 1987. Deft. contended that there was proof of some impaired brain function at that time, and that it was likely secondary to the chronic use of crack cocaine. Pltf. argued that Deft.'s own hospital records, as well as all subsequent records, stated that her brain damage was due to lack of oxygen at the time of her respiratory arrest, and that no medical personnel had ever attributed her brain damage to drug use.

Pltf., age 28 at the time of the alleged malpractice, suffers from extreme confusion and frequent aggressive outbursts. She has required care at a long-term residential facility since her discharge from the hospital in January 1989. She is not married, and her child is being cared for by the guardian and paternal grandmother.

**VERDICT INFORMATION:** $114,869,533 6/0. Breakdown: $30,000,000 for past pain and suffering; $2,000,000 for past medical expenses; $383,161 for past lost earnings; $70,000,000 for future pain and suffering; $11,528,676 for future medical expenses; $957,696 for future lost earnings.