$15 Million Settlement In Suit Alleging Negligent Anesthesia Induction

John Doe was born with a heart defect requiring surgical repair. His third operation at the age of 21 months was on April 10, 1996. He received excessive Versed, a premedication. Despite being limp, and having a depressed cardiac reserve, he was given Halothane, which acts as a further cardiac depressant. During the anesthesia induction, he suffered a cardiac arrest. As a consequence of the arrest and a prolonged period of inadequate resuscitation, he was deprived of oxygen and he suffered severe and irreversible brain injury. He has spastic quadriplegia.

The anesthesia record began at noon, the time of the induction. The record reflected a very brief amount of time during which the heart rate fell. The anesthesiologist therefore claimed that the incident did not cause harm to the child, but rather his brain damage was caused by the surgery, which proceeded at 1:55 p.m. He also claimed that no chest compressions were required.

The surgeon testified that when he was called emergently the child was pulseless and blue and that vigorous resuscitation was necessary. The surgeon could not say how long the "incident" lasted. According to him, no injury occurred during the surgery. He subsequently caused the anesthesiologist to be removed from the pediatric cardiac service.

The surgical resident who the Defendant claimed they could not find was located in Israel and returned to testify that the incident lasted at least 15 minutes.

According to the record an initial blood gas was done at 12:05 p.m. reflecting a PH of 7.04.

Records obtained shortly before trial revealed 3 abnormal blood gases taken at 11:28, 11:35 and 11:55 a.m., times suggesting that the operation actually began earlier and therefore, the "incident" lasted much longer than the anesthesiologist and the anesthesia resident had testified to.

The Defendant claimed that these ABG's were "prime numbers", that is results due to "priming" the heart bypass machine and therefore donor blood and not John Doe's. The ABG machine times however had not been changed from daylight savings time, which had occurred on April 8, 1996. Therefore, the 12:04 ABG time for the 7.04 PH was really 1:04 p.m. Since all of the testimony was that the event occurred on induction at 12:00, the incident lasted for over an hour.

Injury: Spastic quadriplegia.

Result: $15,000,000.00 settlement.

Plaintiff's Expert Witnesses: Alvin Hackel, M.D., Pediatric Anesthesia, Stanford, CA; Max Wiznitzer, M.D., Pediatric Neurology, Cleveland, Ohio; John F. Burke, Jr., Ph.D., Economist, Cleveland, Ohio

Defendant's Expert Witnesses: John H. Menkes, M.D., Pediatric Neurology, Beverly Hills, CA; William J. Greeley, M.D., Pediatric Anesthesia, Philadelphia, PA

Plaintiff's Attorneys: Charles Kampinski, Christopher M. Mellino and Laurel A. Matthews of Kampinski & Mellino Co., L.P.A., Cleveland, Ohio.

Doe v. XYZ Hospital, (Cuyahoga County Ct. of Common Pleas, Cleveland, Ohio 1999)