"A" Is for "Airway" (and "Accountability")

A 3-month-old boy was diagnosed with severe respiratory syncytial virus infection at a North Carolina hospital in 2009. The infant was intubated, and a transfer to another hospital that had a pediatric ICU was ordered. The second hospital's emergency transport service facilitated the transfer.

The ambulance was staffed by an EMT-paramedic and a transport registered nurse, both certified in Pediatric Advanced Life Support (PALS). During transport, the infant was intubated and medically paralyzed with vecuronium. About 10 minutes prior to arrival, the infant's condition worsened, and he experienced cardiac arrest. Chest compressions and heart medications were provided.

Upon arrival at the second hospital, the infant was resuscitated. An emergency department physician, Dr S., ordered reintubation, and the infant again experienced cardiac arrest. For the next 10 minutes, Dr S. ordered chest compressions and heart medication; he eventually reintubated the infant, at which point cardiac arrest ceased with a spontaneous heartbeat.

After transfer to the pediatric ICU, the infant was diagnosed with permanent hypoxic ischemic brain injury caused by the cardiac episodes and low oxygen intake. At the time of trial, the child could not walk, talk, or hear very well and was fed via feeding tube. His vision and cognitive function were also impaired.

The plaintiff claimed that the intubation tube should have been adjusted or removed and re-inserted in the ambulance, but that did not happen. At trial, they called as an adverse witness the EMT-paramedic who had been in the ambulance with the plaintiff.

OUTCOME

During the plaintiff's presentation of evidence, the hospital agreed to a settlement of $13 million. The trial against Dr S. continued but ended in a mistrial. The plaintiffs were expected to re-try the claims against him.

COMMENT

This is a bad-airway case. Many medical malpractice cases are bad-airways cases: They are easy to bring and easy for jurors to understand, since hypoxic/anoxic injury is evident and plainly correlated with the airway missteps. These cases are also easy to prove, since the plaintiff can always hire an expert to testify that a reasonably prudent clinician would have been able to properly secure and monitor the airway—and the patient "would be standing here today," unscathed.

Of course, securing an airway is not a "given" and can be challenging. Factor in variables such as anatomy, age, body habitus, intoxication, combativeness, medical comorbidities, and a full stomach, and the risk swells. If your employment requires that you manage airways, you are practicing in a high-legal-risk environment.

Make sure your skills are up to par. Practice often. Have a plan, a backup plan, and rescue backup plan. Have working suction ready. Check your equipment regularly. Run practice codes—particularly if your practice does not manage cardiorespiratory emergencies often. Does your staff know how to open the crash cart? Are the meds expired? Is the oxygen cylinder empty? Are roles clearly defined? As clinicians, we sit through our share of useless meetings (discussing things like who left what in the break room fridge). We should find time to drill on cardiorespiratory emergencies, because there is no time to "reacquaint oneself" on the fly.

In the case report, we are told that the patient was monitored by O_2 saturation (SaO_2) and end tidal CO_2 ($ETCO_2$). The plaintiff alleges that the transport team (EMT-paramedic and RN) failed to address tube placement and rather focused their efforts on chest compressions and medications. As we know, most cases of pediatric cardiac arrest are not primarily cardiac but instead follow primary progressive respiratory failure. Despite the emphasis on "airway, breathing, circulation" covered by PALS, the airway appears to have been missed and tube placement unquestioned after the child began to decom-

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pensate. Tube placement wasn't reconsidered until 10 minutes after arrival at the second hospital, when the patient was reintubated and ventilatory status improved.

Airway cases—this one included—are "high damages" cases. A high damages case is one in which the injury is clear and expenses and costs to care for the patient are clear and immense. Such cases can be difficult to defend, because the enormity of the plaintiff's plight (the limitations, years of required rehabilitation, hospitalization, PT, OT, nutritional care, etc) can overwhelm the jury, who may infer negligence based on the plaintiff's condition. While jurors are required to consider damages only after negligence has been proven, lay jurors are human and many find it difficult to parse liability from damages. This is particularly true in airway cases involving a young, now-debilitated patient and an expert witness claiming an error that was preventable.

In this case, the plaintiff's attorney made an unusual move, by calling as a "hostile witness" the paramedic who treated the 3-month-old boy. The paramedic would generally be called by the defense and later cross-examined by the plaintiff. Instead, the plaintiff chose to examine him first. Under evidence rules in most states (including North Carolina,[1] where this case was heard), an adverse (or hostile) witness can be called by the opposing party.

Why is this important? Because during direct examination, you cannot lead the witness; during cross-examination, you can. Leading questions (if done correctly) generally produce the most effective and damaging moments during a trial. In this case, the plaintiffs were able to immediately examine one of the defendant's principal actors using leading questions. Shortly thereafter, when the plaintiff was directly examining his own paramedic expert witnesses, the defense relented and settled for $13 million, with further recovery against the emergency physician still available.

Interestingly, the attorney suing the medical personnel in this case was none other than John Edwards. Yes, that John Edwards—the former vice presidential candidate famous for his $500 haircuts, campaign finance tribulations, and ethical lapses. He originally became famous (and rich) suing clinicians. After his political fall from grace, he is back in business suing clinicians—and for him, business is good.

IN SUM

This case was unfortunate. Always use care in securing the airway, particularly during patient movement. Once it is established, monitor the airway using SaO_2, $ETCO_2$, and keen observation. Airways are not in the "set it and forget it" camp. An airway must be maintained, safeguarded, and protected. Be prepared to act quickly should the airway become dislodged, migrate, or otherwise fail. **—DML** **CR**

REFERENCE

1. North Carolina Rules of Evidence Rule 611 (1983, c. 701, s. 1.).

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