
HEARTACHES INTERVIEW

Confidential Information for Dr. Wilson Anesthesiologist, Farmington Hospital

For the last two years, you have served as anesthesiologist at Farmington Hospital. You were hired at Farmington as part of an initiative to expand its cardiac surgical unit, particularly its pediatric cardiac surgery. You completed a year-long fellowship in pediatric anesthesiology at Children's Hospital in Philadelphia, after medical school at Tufts University, an internship at Hopkins, and a general anesthesiology residency at the Brigham Hospital in Boston. You began your anesthesiology practice in Boston at the Brigham, but after 3 years, decided to move back to the Midwest, to be closer to family and enjoy an easier and less expensive lifestyle.

Background

You know Farmington Hospital sought to increase its cardiac surgery capacity a few years ago. The Hospital's larger plan included expansion in other profitable areas such as ob-gyn and pediatrics.

Medical insurers generally reimburse ob-gyn, pediatrics, and complex surgery services at higher rates. Obstetrics often involves in-hospital monitoring or tests (inspired by nervous prospective mothers) and caesarian section operations. Women anticipating labor and delivery often opt to pay for more expensive options, such as private or semi-private rooms. Once a woman has had a baby at a hospital, she is more likely to choose that hospital for her children, when necessary. Pediatric hospital care tends to be profitable because insurance companies are much less strict about guidelines for hospital stays, medical tests, and other discretionary diagnostic and treatment decisions for children than for adults. Insurers appear to have recognized the political folly of stinting on acute pediatric care, or that a mistake on a child leads to enormous damages. Thus, pediatric hospital care can generate real profits. You wish physicians did not need to be aware of such things, but they are today's medical practice realities.

The hospital's investments toward its strategic plan were evident and real: state-of-the-art equipment for labor and delivery and pediatric care, rooms and amenities upgrades in labor and delivery, and play apparatus and decorations in children's areas. The hospital advertised heavily. The plan worked. Farmington Hospital's numbers for newborn deliveries and pediatric care began to rise.

Farmington hired a new surgical team, including two anesthesiologists (you were the more junior, with only three years in post-fellowship practice), and three older, experienced surgeons, including one general surgeon and two with cardiac specialties, one who had done a fellowship in pediatric cardiology. All the hospital's clinical physicians as well as



Farmington area internists, obstetricians, and pediatricians knew of the new team hired, and came to a lavish reception to “meet the new docs.”

That was two years ago. You are told that, before they began at Farmington General, all three surgeons were sent to training sessions to learn the newest procedures for cardiac surgery in neonatal infants and young babies and children (under a year old, or one to two years old). Slowly, the hospital’s case load in cardiac surgery has been growing as local physicians have referred area residents to the new surgeons in the hospital. However, the pediatric segment of Farmington’s cardiac surgical practice has not grown as rapidly as projected. From your perspective, that is fortunate, for the reasons set forth below.

The Current Problem

You are extremely concerned – really, distraught - over the number of deaths among neonatal patients and young children (one to two years of age) undergoing cardiac surgery at Farmington. Your internship, residency, and fellowship in pediatric cardiology has kept you up to date on developments in pediatric cardiology and cardiac surgery. You are familiar with the success rates at the Cleveland Clinic and at Children’s Hospital in Philadelphia in pediatric cardiac surgeries; these are far, far better than Farmington’s success rates. For example, in Cleveland, approximately 15% of neonates fail to survive a “Arterial Switch” surgery. This “Switch” procedure corrects a heart defect in which the “Great Arteries of the Heart” - the left ventricle and the right ventricle - develop connected to the wrong side of the circulatory system. The surgery “switches the left ventricle “back” to the aorta and the right ventricle “back” to the pulmonary artery, their correct positions. Your observations indicate that, at Farmington, between 40% and 50% of these surgeries result in death.

You are also greatly concerned about Farmington’s record for surgeries to correct “Atrio-Ventricular Septal Defect (“AVSD”). The hearts of patients with ASVD have a hole between the lower portion of the atriums, and the upper or “inlet” portion of the ventricles. This is a significant abnormality of the valves separating the atriums from the ventricles; the valves almost become a common atrio-ventricular valve. The AVSD surgery is complex, involving closure of the defects between the atriums and the ventricles, and separation of the common atrio-ventricular valve into two separate valves. In Philadelphia and Cleveland, you know that AVSD surgical success rate was close to 90% when you left, and your rough count of surgical results at Farmington in the first year, indicated a success rate of only 60% - 65%. Moreover, for some children who required multiple surgeries, you suspect the Cleveland or Philadelphia surgeons would have corrected the problem in the first surgery.

In your first six months on the job, while noticing that fewer infants seemed to survive surgery at Farmington, you gave your colleagues the benefit of the doubt. After all, the absolute number of Arterial Switches was small, and you understand statistics can look very good or bad in a small sample, but then even out over time. Moreover, you had heard the surgeon describe some of the deceased children’s cases as having been very complex.



After a particularly rough week in which two neonatal Arterial Switch operations resulted in death, you decided to pay more attention to the details. You observed that the surgery took a long time - sometimes 7 hours or more - yet the surgeons in Philadelphia had the same procedure down to 3 hours. It is simply difficult for anyone, but particularly a newborn, to survive so long a time in open heart surgery. You also noticed that the way the Farmington surgeons went about the Arterial procedures was different - clumsier and less precise than you have seen it done, though you cannot point to particular surgical techniques or "mistakes." While a professor of surgery might be able to name the problem, you simply observed that the Farmington surgeons didn't seem to be as skilled.

After approximately nine months, you began raising questions within the medical team, during meetings convened after a death or "adverse medical result" (likelihood of brain damage). While hesitant to call your colleagues clumsy, you did raise the issue of surgery durations being longer than in other hospitals. Not surprisingly, the surgeons reacted defensively, maintaining that seven or eight hours was "within the acceptable range, even if longer than we would have liked." Dr. Dellahunt, the older of the two surgeons, is consistently in this longer range. They vehemently disputed your statistical estimates as exaggerated due to failure to account for unusual difficulty of the patient's heart defect in particular cases, and inclusion of deaths occurring several days or up to a month or more after surgery. The surgeons objected to being saddled with statistics when they did not control all of the care decisions: "You just don't know the real problems. Sometimes, the cardiologist misses defects in the diagnosis, and we have to make up for that. Besides, who knows what their incompetent mothers or others do with these patients, after our surgery."

The last comment angered you, because it was intended as a not-so-subtle attack on your post-operative care decisions. Within the medical profession, anesthesiologists have taken on increasing responsibility for coordinating post-operative medical care in the ICU - formerly the surgeons' sole domain. Many times, you and the surgeons have disagreed about treatment in the ICU, and you found your instructions overruled by the surgeons. You know it angered the surgeons when you voiced your disagreement in front of the nursing staff (and, it later turned out, the parents), but you felt it imperative that the reasons for your care recommendations be heard. You tend to keep newborns on ventilators for longer than one of the surgeons, even though it bothers you that the ICU ventilator equipment was not designed for newborns. Two of the units have been "retrofitted" - jerry-rigged would be more accurate - for these smallest patients. You do not think this is optimal.

Since you first raised this issue after nine months at Farmington (fifteen months ago), you have returned to it in several post-mortem discussions within the medical team. Dr. Knowles, the Chief Physician, who generally facilitates these discussions, was initially attentive to and alarmed by your information, and questioned the surgeons about their results. However, Knowles has been mollified by the surgeons' explanations of particular cases being extremely complex (and the young patients' frailties), and willing to defer to surgeons' judgments regarding post-operative care. You suspect Dr. Knowles or Dr. Dellahunt recognize the length of their surgeries as problematic; Knowles let you know that



Dr. Dellahunt will be moving away from pediatric cardiac cases, to focus on more adult surgery. However, Dellahunt will continue with patients one year of age or more, until a replacement can be found. You suspect that, for financial reasons, the hospital and the medical team will not be eager to replace Dellahunt until the pediatric case load increases.

It is true that relationships within the medical team have become increasingly strained, as are the medical team's relationships with the nurses who handle post-operative care and front-line contact with pediatric patients' families. You have had several discussions with BJ Stanton, the best pediatric ICU nurse in the unit, in your opinion. Stanton was emotionally distraught by a number of the neonatal and young children's deaths during or immediately after Arterial Switch surgeries. Stanton had expressed the belief to you that this "did not have to happen." You did not disagree. You know Stanton recently refused to work a shift covering one of Dr. Dellahunt's neonatal Arterial Switch surgeries and has taken some heat for that. You can't really blame Stanton; if you could, you would opt out of serving as the anesthesiologist for these surgeries. As it stands, the other surgeons have barely been on speaking terms with you or with Stanton, and you are in constant fear of sabotage by members of the team.

While Dr. Knowles seemed satisfied with the surgeons' explanations and propping up their statistics, you were not. You decided to undertake an unofficial "audit" of pediatric cardiac surgeries performed, prior to and since your arrival at Farmington. On several evenings over the last two months, you went through Farmington Hospital's central files, and the surgeons' office files. No doors were locked, and the surgeons' secretaries were willing to let you review their case files. You looked carefully at autopsies, and at notations regarding neonates or young children's condition just prior to surgery. In many instances, you found no evidence of particularly difficult or unusual defects, or frailties prior to surgery. You also failed to find indications of errors or risks taken in post-operative care - even where it was not your case. Your review confirmed that the death rate for Arterial Switches - counting 30 days after surgery - at Farmington was 42%, compared to 15% - 20% in other highly regarded medical centers. The death rate for AVSD procedures at Farmington was 35%, compared to 10% in other centers. Farmington's figures improved somewhat in children one to three years of age, though still fell below the current levels in a top rate pediatric surgical center.

Your research indicates that, in other medical centers, when these operations were first performed, in the late '80's and into the mid '90's, the survival rates were not great. However, as surgeons gained more experience, survival rates improved dramatically. This was due in significant part to surgical teams' success in reducing the average length of time their patients were on the operating table. It is essential that the surgeon, nurses, and cardiologist in the operating room function flawlessly, as an efficient, coordinated team. The medical literature indicates there is an inevitable "learning curve" for a medical center to gain real expertise and experience in these and other complex procedures. A surgeon generally requires 30 to 40 operations per year to achieve the highest skill level. At Farmington, there have been only 30 surgeries per year, total, between the two surgeons. Of course, to cite the learning curve problem to parents of a newborn or young child facing



surgery is not acceptable. You do not want to be part of a medical team unless the surgeons are on top of the curve before they operate.

A week ago, you presented the results of your “audit” to Dr. Knowles and the rest of the medical team at their regular monthly meeting, and, based upon your results, demanded they stop performing pediatric cardiac surgery. The surgeons were outraged that you would question their medical judgments or descriptions of the cases reviewed, and the team’s consensus regarding unavoidable causes of death. They insinuated your goal was to cover for post-operative botch-ups. Dr. Dellahunt was pointed in noting that your performance as an anesthesiologist is under review, as a result of unnecessarily high dosage of anesthesia on an older adult, resulting in near death and possibly brain damage. “The best defense is a good offense, hey Wilson?” he shouted. You were incensed, as the dosage was within guidelines, and the adult appeared to have suffered from dementia prior to surgery. Merits aside, it has nothing to do with the tragedies occurring in pediatric cardiac surgery, and they know it.

The day after the meeting, you checked the schedule board, and found you were not listed as the anesthesiologist for any surgery that week. You went to see Dr. Knowles, who said, “Don’t tell me you’re surprised. None of the rest of the medical team will agree to operate with you as an anesthesiologist. That does create a problem for the hospital and its patients, now doesn’t it?” A stroll through the hospital confirmed that no one is speaking to you except a few of the nurses and the secretarial staff.

You decided to seek the advice of counsel, because you do not believe pediatric cardiac surgery should be performed at Farmington Hospital, and or that your contract should be terminated. You suspect that will be Dr. Knowles’ next step.

You called Attorney Heath, the partner at the hospital’s outside law firm, Finn, Tucker & Wesley. Heath interviewed you a while ago in connection with a potential medical malpractice claim arising out of the anesthesiology incident. No case has been filed, but because the hospital’s patient representative had received some angry accusations from the patient’s son, they decided to involve outside counsel. The hospital has stood with you in that matter, agreeing that you followed the standard of care.

You do not trust the hospital’s General Counsel. You assume they are too friendly with Pat Burns, Chief of Staff, who is probably a golfing buddy of Dr. Knowles. You were concerned the General Counsel would want to cover things up.

You chose to call Attorney Heath, who had seemed ethical, smart, and understanding – someone you could trust to do the right thing.