HEARTACHES
MEDIATION

Confidential Information for
M. C. Trevor, Claims Representative
All-Med Insurance Company

You have worked for All-Med Insurance Company, an insurer exclusively in the medical market, for four years. While technically still a claims representative, you have earned the respect of peers and superiors for your hard work and insightful claims analysis. You have been told you are in line for a promotion when positions are juggled in the wake of an imminent senior staff retirement. "Just keep your nose clean and play it safe," advised your boss, "and you'll be tagged for a higher position in the pecking order."

Before All-Med, you worked in marketing research and then in middle management at a health product manufacturer, while earning an MBA at night. You have considered going to law school one day. You are 29 years old, not yet married, but recently engaged to your college sweetheart.

The working hours at the insurance company are not too taxing. The job is relatively easy, leaving plenty of time for sports and a social life. The only downside is that it forces you to become involved, often as the adversary, when terrible things have happened to people – either because of medical malpractice or unavoidable adverse results. Either way, the job requires you to read about people who were sick or injured before any medical practice issues or claims arose. You have learned the importance of distancing yourself from the injured claimants and from your insured physicians, who tend to be angry, defensive, and scared about their professional futures.

Your boss handed you the Fairday file several months ago, when All-Med was put on notice by its insured, Dr. Dellahunt, that a medical malpractice claim had been filed against him. The claim arose out of an unsuccessful Arterial Switch operation, performed at Farmington Hospital. The Arterial Switch, a pediatric cardiac surgical procedure, was intended to correct 6½ month old Joshua Fairday's congenital heart condition, known as "Transposition of the Great Arteries" ("TGA"). Joshua died shortly after surgery.

Dr. Dellahunt was informed that he should select an attorney on the All-Med approved list of local attorneys, and that you would work with the attorney to evaluate the claim. Since then, you have spoken with the attorney, Jan Carsen, reviewed the file, and took it to the All-Med internal committee, which put a $125,000 reserve on the claim. Dr. Dellahunt's policy limits are $2,000,000 per occurrence. You don't see an infant death as "worth" nearly that much in this business. Callous as it sounds, an infant death carries no economic loss and only minor loss of relationship. This infant would not have had suffered from the procedure. The attorney reported to you that the case was scheduled for mediation, but a magistrate had allowed informal discovery and exchange of expert reports before that.

You agreed to be in touch the week prior to the mediation, and the attorney recently provided you with the more detailed claim information set forth below.

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Three years ago, Dellahunt moved to Farmington from Little Rock, Arkansas, where he practiced some general surgery, but largely adult cardiac surgery. Dr. Dellahunt had completed residencies in both specialties, after medical school at the University of Arkansas. The Farmington Hospital was launching adult cardiac surgery and, shortly thereafter, pediatric cardiac surgery services. Farmington's Chief of Surgery, Dr. Knowles, told Dellahunt there would be plenty of time to be trained for the challenges of working on smaller hearts. Dellahunt was also told that the hospital was hiring Dr. Rasheesh, a surgeon with considerable training and experience in pediatric cardiac surgery, and that the two would be able to work together. Dellahunt accepted a job offer, with full clinical privileges.

Dr. Dellahunt's attended at least three formal training sessions in the first year at Farmington. Dellahunt learned that pediatric cardiac surgical procedures are entirely different from those typically done in adults. The small size of an infant's or a young child's heart is not the real challenge. In an adult, open heart surgery typically involves one or more by-pass attachments, clearing out arteries (basic plumbing), or repairing a ruptured aorta. In children, open heart surgery repairs a wide range of congenital defects rarely seen in adults. Even the occasional adult version is never severe as those seen in an infant. (Unless the defect has been repaired, people do not live to adulthood with defects like those found in neonates, infants, or young children.) Among the more challenging surgical procedures are the "Arterial Switch", designed to repair "Transposition of the Great Arteries" ("TGA"), and one designed to repair an "Atrio-Septal Ventricular Defect" ("AVSD"). Dr. Dellahunt's preparation included diligently studying and observing these and other procedures at Philadelphia Children's hospital. Once Farmington began to offer pediatric cardiology service, Dr. Dellahunt either observed or was assisted by Dr. Rasheesh a number of times in these surgeries.

Dellahunt's practice went reasonably well for in Farmington for the first eighteen months, including the first six months in pediatric cardiac surgery. While Dr. Dellahunt and Dr. Rasheesh both experienced somewhat higher than anticipated morbidity, they believed this was "par for the course" in open heart surgery.

Over time, Dr. Dellahunt's morbidity rate in pediatric surgery seemed to be slightly higher than Dr. Rasheesh's. Dr. Rasheesh told Dellahunt not to be alarmed, because they had both had a run of particularly difficult cases – children with unusually complex heart defects. Rasheesh noted that success rates can be misleading when taken from a small data pool, and there had been fewer than 15 Arterial Switch surgeries in the first year. There is an inevitable "learning curve" for this type of surgery, no matter how skillful the surgeon. It is generally thought that at least 30 of each type of complex surgery per surgeon, per year, is necessary for anyone to reach and maintain optimum skill.

After one unsuccessful Arterial Switch procedure last year, in which the neonate had presented the most challenging arterial characteristics Dellahunt had ever seen, Dr. Dellahunt took a week to travel back to Philadelphia, to observe the newest Arterial Switch techniques. Dr. Dellahunt was present in the operating room and also arranged for video recording of these surgeries. Dellahunt reviewed them carefully at home, found this

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training helpful, and incorporated some new techniques into the next few operations. These were successful.

Dr. Dellahunt described a real "downturn" as having begun eighteen months after arriving at Farmington. At about that time, Dr. Rasheesh informed Dr. Dellahunt confidentially that he was looking to phase out of pediatric cardiac surgery. Thus, more of the pediatric cardiac cases were referred to Dr. Dellahunt, and Dr. Rasheesh was rarely there to assist in the operating room. By then, Dr. Dellahunt felt well trained, and competent at applying the techniques learned. When two more infants died within hours after surgery, Dr. Rasheesh reviewed the files and assured Dellahunt he wouldn't have done anything differently. They were very difficult cases, requiring lengthy time to correct the full range of defects, and the babies were in poor condition.

In Dr. Dellahunt's words: "at about this time, one of the surgical team's anesthesiologists, Dr. Wilson, decided to appoint himself the master judge of surgeons." Dr. Wilson began questioning why Dellahunt's surgeries took so long and why Dellahunt's patients arrived at the ICU in difficult shape. He and at least one of the nurses began challenging your client's instructions and charting in the ICU. They went out of their way to congratulate Dellahunt on successful outcomes: "Hey, Dellahunt finally got a hit, never mind the batting average…" Obnoxious. Wilson also pushed Chief of Surgery Knowles, arguing for the purchase of newer heart lung machines for neonates and special neonatal ventilators, stating that the machines in use were "jerry-rigged." Dellahunt suspected Wilson was trying to cover anesthesia slip ups during surgery or lapses in care in the ICU. Dellahunt claims no expertise in the way those machines operate but did know that Knowles had paid large sums of money to have them retrofitted for infants.

Over time, Dr. Dellahunt came to believe there were other factors at Farmington affecting outcomes and morbidity statistics. The ICU was the number one suspect for contribution to the perceived problem. Acknowledging it is hard to put a finger on what was not being done well in there, Dellahunt does not think the nursing staff or the dedicated ICU physicians were all that sharp a group. Dellahunt's track record in adult cardiac surgery practice at Farmington has been mildly disappointing (though not to the same degree as pediatric). Yet Dellahunt's ability to perform adult cardiac surgery wouldn't have declined on the trip from Arkansas. Assuming Dellahunt's surgical abilities stayed the same, the cause either lay in an unlucky run of very bad hearts, or something else about the hospital care.

Dr Dellahunt felt subject to a negative campaign by Dr. Wilson. At every morbidity conference and, Dellahunt suspects, in various back-room conversation, Wilson was hyperbolically critical, arrogant, and "holier than thou." Wilson forced Dr. Dellahunt to discuss every twist, turn, and hole in each patient's heart defect to explain why the particular case was unusually difficult or how the patient's condition affected their ability to tolerate surgery and recovery. It's as if Wilson forgot that these were often very, very tiny neonates, or underweight infants weakened by their struggle to live with compromised hearts.

The struggle between Dr. Dellahunt and Dr. Wilson came to a head the evening before the Fairday surgery. Dr. Wilson marched into a morbidity conference on one of Dr. Dellahunt's

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recent Arterial Switch procedures, with a smug smile, waiving a report. "This does it," Wilson announced. "I hope the hard numbers will convince everyone that we are ethically and morally obligated to stop Dellahunt [pointing at you] from performing surgery here." Wilson passed the report around, and proudly explained they had gone through hospital files, and compiled statistics on morbidity in pediatric cardiac surgery over the past two years and compared it to the morbidity percentages in major pediatric cardiac surgery centers. According to Wilson, the national morbidity rate for Arterial Switch surgery is 20 – 21%, and as low as 15% in some centers within the past few years. Wilson's report stated the mortality rate at Farmington as 35-40%. In other major centers, the surgery lasts 4 to 4 ½ hours, while at Farmington, it averages 6-6 ½ hours, sometimes longer. Wilson also claimed not to see anything so unusual about the heart defects presented. Wilson stood up and dramatically made a formal proposal that the surgical team vote to stop Dr. Dellahunt from performing Arterial Switch operations, effective that minute.

Dr. Dellahunt was outraged by this ambush. It meant Wilson had broken into Dellahunt's files, Rasheesh's files, and those of other physicians. Moreover, Wilson's report threw Rasheesh's numbers and Dellahunt's early numbers together. There had been a learning curve, but Dellahunt's numbers had improved over the previous six months, since his second visit to Philadelphia. The most recent death was anomalous and completely explainable.

Fortunately, the rest of the team was equally outraged by Wilson's aggressive move. They basically told Wilson to sit down and be quiet and heard Dr. Dellahunt's explanation of the history and of the particular case. They voiced their respect for his decision to gain additional expertise through the trip to Philadelphia and noted that Dellahunt's statistics had improved within last year to six months. As Dellahunt explained, if one looked back at the six-month period, the numbers were about at the national average, including the recent unavoidable death. Wilson's proposal was defeated. The rest of the team voted not to bar Dr. Dellahunt from the Arterial Switch surgery. Dellahunt operated on a six and half month-old patient, Joshua Fairday, the next morning.

Joshua Fairday died in the ICU, despite Dr. Dellahunt's effort to use the utmost care during the Arterial Switch surgery. Once again, Joshua's heart condition was extreme.[1] In addition to classic TGA, the hole in his heart had enlarged, and the heart muscle and attachment point had several anomalies that were not discussed in the cardiologist's report (one could barely make out the details on the ultrasound). Dr. Dellahunt had met with Joshua's parents, the day

[1] Like most infants born with TGA, immediately after birth Joshua had been treated with Prostaglandin E to keep the arterial duct open. This is usually rapidly effective in improving the blood oxygenation by encouraging more blood flow to the lungs and more flow through the hole between the two atriums (which is common in hearts with TGA). At that point, Joshua received a cardiac catheter – a type of closed heart surgical procedure to help him survive prior to the open-heart Arterial Switch surgery that Joshua's condition required. The Arterial Switch is generally performed when a baby is three to four months old. However, the cardiologist had agreed with Joshua's mother that he seemed small and thin, and that it might be better for him to grow a bit before surgery. Surgery was finally when Joshua was 28 weeks – 6 ½ months old. In your mind, this was later than optimal, for it meant that Joshua's had been functioning for too long with a weak heart.

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before, and explained the Arterial Switch procedure as risky and delicate surgery. Dellahunt had told them that, despite the risks, it was the best hope for Joshua's becoming healthy.

Dr. Dellahunt acknowledged being very nervous during the surgery, concerned that Joshua might expire on the table. The surgery took much longer than Dellahunt would have liked. Dellahunt was very careful and had called for a cardiologist consult during surgery. Numerous subtle aspects of the defect required repair. Later, Dellahunt became angry when one of the ICU nurses challenged Dellahunt's chart notation of Joshua being "pink" and having "tolerated surgery well" when he entered the ICU. Joshua had looked so much better than Dellahunt would have expected when the surgery was finally finished. Dellahunt too was anguished upon learning that Joshua was failing in the ICU, about an hour after surgery. The nurse sounded an alarm. The anesthesiologist, Dr. Wilson, and various doctors and nurses rushed in, and began manipulating Joshua's chest, administering medication, and finally giving him electric shock treatment, to no avail. Dr. Dellahunt came in as the ICU team was working on Joshua, turned to his parents, and expressed great sorrow.

The next day, the entire surgical team announced that it would refuse to operate with Dr. Wilson as the anesthesiologist. Virtually no one in the hospital would speak to Wilson. One of the nurses, B.J. Stanton, a friend of Dr. Wilson's, announced that she would no longer work on pediatric ICU patients. Dr. Dellahunt notified the hospital's surgical director that he would like to stop doing Arterial Switch operations, but would still be willing to perform other, less complex pediatric cardiac procedures. A routine morbidity conference was held on the Fairday case shortly thereafter. Dr. Dellahunt reviewed the complexities of Joshua's heart condition with the team. They seemed to understand the difficulties of the case and did not argue with his conclusions.

In addition to conveying the details of Dellahunt's interview, Dellahunt's attorney sent along copies of the expert reports. You were relieved to see that your expert (whom you had recommended) concluded that the patient a serious TGA defect, with a seriously enlarged hole between the heart's chambers, and that his heart muscle appeared to have been in weakened condition prior to surgery. The expert indicated that the autopsy report included no evidence of surgical technique that fell below the standard of care.

As you fully expected, the plaintiff's experts, a pediatric cardiologist and a surgeon from Harvard Medical School and Boston Children's Hospital, disagreed. They stated that Joshua's TGA was not worse than most others, which are repaired in the Arterial Switch surgery by experienced surgeons. They also reviewed Joshua's vital signs and test results from doctor's visits in the months prior to surgery and on the morning of his admission. They disagreed with any notion that Joshua was in a "weakened condition" prior to surgery, though they noted that waiting 6 ½ months for the Arterial Switch is a bit long and can take its toll on the patient. They also disagreed Dellahunt's notation of Joshua being "pink" and having gone through surgery well, based upon his troubling vital signs in the ICU immediately after surgery. The experts dismissed any notion that the cardiologist's reports and tests had missed subtle aspects of Joshua's heart defect, making them unforeseeable. "Dr. Dellahunt may not have studied the reports or the ultrasound pictures carefully enough, but to an experienced reader of such documents, all of the necessary information was present."

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Finally, the surgeon criticized the length of the surgery as "excessive"– 7 hours under general anesthesia in the operating theater and 6 ½ hours on the heart-lung machine. He noted that the length of surgery indicates lack of surgical expertise and "falls below the current standard of care" barring unforeseeable or unusual characteristics of the TGA defect.

In preparation for the mediation, you also reviewed the complaints, accusing Dr. Dellahunt of "gross negligence" and "intentional harm" because Delahunt performed the surgery while aware of their own deficient qualification or competence. It is quite an aggressive complaint, more so than most. Still, you are not terribly worried about the outcome. You believe juries tend not to find against doctors in their community hospital. In any event, if the jury were to sock Dr. Dellahunt, finding liability for intentional harm, All-Med wouldn't have to pay any punitive damages. Its medical malpractice policy does not cover intentional torts. You have not raised this coverage issue, because the idea that Dellahunt acted "intentionally" is unlikely. But you will certainly raise it in negotiation if the facts develop in that direction.

You know mediators always want assurance that the insurance representative has "full settlement authority." In this case you have "full authority" up to the committee's $125,000 limit. Your boss could increase that *tentatively* by telephone, if necessary to close the deal. As a technical matter, your boss can only commit to recommending a final number beyond $125,000 to the All-Med committee. The committee would then formally re-review the claim. However, you've never known the committee to reject your boss's recommendations. It's also true that the hospital was named in the suit and will have its own insurance. You are not inclined to pay any more than the hospital's insurer unless convinced that liability or risk rests more heavily on Dr. Dellahunt. And, at this point, you don't see much risk or liability for either one. You also know you cannot authorize settlement without Dellahunt's approval, as this may affect the doctor's medical career.

Prior to the mediation, you may want to talk with Attorney Carsen (retained by All-Med for Dellahunt) and perhaps the hospital's insurer.

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