HEARTACHES
TWO INDEPENDENT PHASES
INTERVIEWING AND COUNSELING & MEDIATION

Overview Teaching Note

Deep background in a true story

This simulation draws from a documentary describing the tragic consequences of substandard care – surgeons inexperienced and unskilled in Arterial Switch Surgery, inadequate equipment, and shoddy procedures for the care of infants with heart defects – in a hospital in northern England, operated by its National Health Service. My colleague at the University of Cincinnati College of Law, health law professor Elizabeth Malloy, became aware of the documentary in approximately 2002. She obtained a copy and, with the assistance of our library staff, we were able to obtain boxes of documents from the British government's investigation. In 2003, we co-taught a class on "Health Law Practice" and first used the medical malpractice mediation simulation in that course. If memory serves, the mediation was scheduled as a double or extended class session. In the next week's class – the last class of the semester – we played the documentary. There wasn't a dry eye in the house. The students had not known the case was anything but fiction dreamed up by their professor. The emotional impact of realizing it was true, and that many babies had died unnecessarily, was the point. We wanted them to know that consequences are real, and to see how actions or inactions matter: ignoring or punishing a whistleblower, willingness to accept justifications, falling in behind explanations, without questioning, failure to insist on real investigation and immediate action (particularly inside the hospital). In the documentary, the cover-ups or collegial blindness were primarily by doctors and hospital administrators/government officials, not by lawyers. We wanted to teach the students that, as lawyers, they may be in a position to see, investigate, and make it so that the legal system/settlement can prevent future tragedies.

By the time this teaching note has been published, I will make every effort to re-locate the video documentary.

We used this case a second time in an "Advanced Health Care Practice class" approximately twelve years later. By then, a basic client counseling course was required for 2Ls at UC Law. Seeking to build on that, I wrote the simulation roles for the simulation's interview phase.

Note about the two phases

While both "phases" draw from the same factual context, they are independent. Each can certainly be taught without the other.

The interviewing and counseling phase, raises important (and discussion-worthy) questions around attorney-client privilege and disclosure obligations and conflict issues, as well as an attorney's obligation to question a witness/client representative's version of the facts – for

the benefit of the corporate client and public health and safety. The main purpose of the exercise is effective interviewing (trust, rapport, eliciting essential facts, considering the interviewees' credibility, determining where skepticism or further investigation would be essential) as well as recognizing and handling lawyer's ethics issues. The counseling challenges are largely focused on communicating regarding conflicts and ethical issues, though for the deceased parents, the lawyer must also communicate regarding current choices and strategic trade-offs (as described more fully in this Teaching Note).

The mediation phase – four parties, each represented by counsel – does not rely on having previously done the interviewing & counseling phase. I wrote and taught with the mediation simulation many years earlier. Between the parties and the lawyers, it contains all of the information and motivation necessary for a simulated mediation. (That doesn't make it easy, just complete on its own.)

Having said that, the two phases do work well together pedagogically – even if you were to use them many class sessions apart. In other words, if you are teaching a course that involves interviewing and counseling, and then moves on to negotiation and dispute resolution, you could easily use the two Heartache phases in different course stages. The way the facts and parties' roles are further developed in the mediation phase may, or perhaps should, prompt participants to revisit their perspectives on the lawyers' ethical obligations in the initial interviews and chosen courses of action.

Factual overview for both phases

This case involves allegations of medical malpractice/negligence against Farmington Hospital and one of its surgeons, Dr. Dellahunt, arising from the death of 6 ½-month-old Joshua Fairday, following Arterial Switch surgery to repair his heart condition. Joshua had been born with the heart defect known as "Transposition of the Great Arteries" and Arterial Switch surgery is designed to correct it.

By way of background: Three years ago, Farmington Hospital hatched a business plan to stay competitive by expanding ob-gyn, surgery (including cardiac surgery), and pediatrics, it obtained JCAHO's tentative approval of the concept. JCAHO agreed that the community would be well served by the expansion of those practice areas. JCAHO is a bit behind schedule in its review inspections, so its last full review at Farmington was approximately 2 ½ years ago. At that time, while the hospital had begun its expanded operations in, ob-gyn, surgery, and pediatrics, it had not yet undertaken pediatric cardiac surgery. Just before Farmington officially began performing pediatric cardiac surgery, JCAHO came in to inspect the facilities and staffing and gave tentative approval. JCAHO was due to come in for a regular accreditation review within the next few months after the tragic event leading to this claim.

Farmington Hospital hired Drs Dellahunt and Rasheesh. Dr. Dellahunt had experience in adult cardiac surgery, but not pediatric surgery. Dr. Rasheesh was a surgeon with considerable training and experience in pediatric cardiac surgery. The plan was for the two of them to work together. The hospital ramped up its adult heart surgery service well before

pediatrics, leaving Dellahunt plenty of time to be trained for the challenges of working on smaller hearts. Knowles also said the hospital was.

Within their first year at Farmington, Dellahunt was sent to at least three training sessions at Philadelphia Children's Hospital in Philadelphia. Dellahunt soon realized that pediatric cardiac surgical procedures were entirely different from those typically done in adults. The small size of an infant's or a young child's heart was not the major challenge. In an adult, open heart surgery typically involves one or more bypass 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, and never as severe as those seen in an infant. (People do not live to adulthood with defects of the kind you find in neonates, infants, or young children.) The more difficult procedures include one designed to repair the "Transposition of the Great Arteries" ("TGA") – the Arterial Switch – and one designed to repair an "Atrio-Septal Ventricular Defect" ("AVSD"). Dr. Dellahunt studied these procedures diligently and observed them in Philadelphia. Once the pediatric cardiology service began at Farmington Hospital, Dellahunt either observed or was assisted by Dr. Rasheesh several times before performing these surgeries solo.

In the meanwhile, the hospital also hired a new anesthesiologist, Dr. Wilson, who had completed a year-long fellowship in pediatric anesthesiology at Children's Hospital in Philadelphia, after medical at Tufts University, an internship at Hopkins, and a general anesthesiology residency at the Brigham in Boston. Thus, Dr. Wilson brought considerable prior experience with the Arterial Switch operation, having witnessed many as an anesthesiologist in these prestigious hospitals.

As explained by Dr. Wilson, the Arterial Switch surgery performed by Dr. Dellahunt on Joshua was first used approximately 10 years earlier, replacing another surgical sequence that was less surgically difficult, but less effective for patients. When the Arterial Switch surgery was first performed, the operations tended to be lengthy, as long as 6 or 7 and even up to 8 hours, and a large number of patients failed to survive. Surgical techniques aside, the length of surgery alone contributed to mortality rates. During open-heart surgery, patients are hooked up to a heart-lung machine. It is hard on the body and its vital organs to be on that machine for a lengthy period. This is particularly true for infants and small children. After four or five years of experience with the Arterial Switch surgery, average times were drastically reduced – to no more than 4 or 4 ½ hours, barring unforeseeable circumstances. These times were reduced at pediatric cardiac surgical centers in London, Australia, Boston, Chicago, Seattle, Philadelphia, and the City, due to refined surgical techniques and better coordinated surgical teams. Thus, within 5 years after this surgery was pioneered, the mortality rate for infants was less than 20-21% in most major centers, and very recently as low as 15% in some centers. According to Dr. Wilson, the mortality rate at Farmington Hospital during his short tenure there was 35-40%.

Dr. Wilson had become alarmed at the number of infants dying during or shortly after Arterial Switch surgery and in Atrio-Ventricular Septal Defect ("AVSD") surgery, performed by Dr. Dellahunt and Dr. Rasheesh. Wilson talked to BJ Stanton, a nurse colleague in the ICU,

who had also moved recently to Farmington Hospital. The nurse agreed with Wilson's observation that too many infants were dying when these doctors operated, more than in other hospitals and that the surgery seemed to take much longer. The nurse commented that Dr. Dellahunt had a habit of telling parents that their deceased baby had been "so very sick and weakened," when they had been relatively robust before surgery. The nurse had also observed Dellahunt record on patients' post-operative charts in the ICU that they were "pink and tolerated surgery well," when that wasn't true. The nurse suspected Dellahunt was trying to shift blame, to make it look like the surgery had been successful, but post-operative care would be to blame if the patient did not survive.

These observations caused Dr. Wilson to raise concerns within the surgical team and at the morbidity conferences held by the surgical team in the wake of a death or "adverse outcome." Each time, Dr. Rasheesh or Dr. Dellahunt would describe the case as very difficult or unusual and launch into technical discussions of the presenting arteries or the size of the hole in the patient's heart. Occasionally, they would complain that the cardiologist's reports and tests had failed to reveal an aspect of the patient's heart defect, which came as a surprise and took additional time in surgery. With every death, the surgical team would nod and accept their explanations.

Dr. Wilson was not nodding and was disturbed enough about the situation to speak to the Chief Physician, Dr. Knowles. However, Knowles fully accepted the surgeon's explanations. Wilson then spoke on a confidential basis to a former medical professor at a conference, who recognized a potentially serious problem and advised Wilson to gather the evidence.

Dr. Wilson began to investigate, gaining access to the surgeons' files through central file archives, and compiled statistics for the last few years, since Dellahunt's and Rasheesh's arrival and the beginning of pediatric cardiac surgery at Farmington. Wilson prepared a report summarizing the findings: for the previous two years, the mortality rates for Arterial Switch surgery at Farmington were 35-40%, compared to rates of 20 – 21% percent at most major pediatric surgery centers, and 15% in some centers. Also, the time elapsed in average surgery was far longer, 6 – 6 1/2 hours at Farmington, vs. 4 hours or less elsewhere. Dr. Wilson's report questioned the experience and qualifications of Dr. Dellahunt, whose major training was in adult cardiac surgery and who had limited exposure to pediatrics. Finally, Dr. Wilson also noted Farmington's lack of dedicated surgical teams, operating rooms, and ICU facilities for neo-natal and surgery on very young children compromised the quality of care.

As has been explained to the Fairdays, it is important to understand that statistics work in funny ways. When the absolute number of surgeries performed is small, a short run of bad luck and difficult cases can dramatically affect percentages. If surgery is skillfully performed, these things will "even out" over time, and a small hospital's mortality rate should be no higher than any other. However, if the numbers do not even out, the statistical variation would be strong evidence that the standard of care was not being met, either in surgery or in post-operative care.

The evening before Joshua's surgery, Dr. Wilson presented their report and findings to the surgical team and to Dr. Knowles, during a morbidity conference scheduled to discuss the death of two other infant patients of Dr. Dellahunt. The surgical team was outraged and berated Dr. Wilson for invading other doctors' files, told Wilson not to be naïve about statistics when the absolute numbers are small, and noted that a run of difficult cases can make numbers misleading. Dr. Wilson argued strongly that Dr. Dellahunt should not be permitted to perform Arterial Switch surgery again, that the next day's surgery should be delayed, and that a specialist brought in from the City or elsewhere. Dr. Wilson pressed Dr. Dellahunt to review the circumstances leading to prior adverse outcomes. Dr. Dellahunt again maintained that the infants' heart conditions had presented unusual and difficult challenges, not foreseeable from the cardiologist's reports or prior tests, and the infants were terribly weak. The matter was put to a vote, and all but Dr. Wilson voted in favor of permitting Joshua's surgery to go forward.

The next morning, when the Fairdays brought Joshua in for his "pre-op" preparation, no one mentioned the previous evening's controversy to them, or suggested that they consider bringing Joshua to another pediatric cardiac surgeon. The surgery went ahead as scheduled. Joshua died that day.

The next day, the surgical team announced they would refuse to operate with Dr. Wilson as an anesthesiologist. Members of the surgical and medical staff avoided Wilson in the hallways, treating Wilson like a traitor. Only a few sympathetic nurses appeared willing to speak with Wilson at all. One of those nurses, B.J. Stanton, announced that they would no longer work on pediatric ICU patients. Dr. Dellahunt gave notice to Dr. Knowles that they would no longer perform the Arterial Switch, though willing to perform other, less complex pediatric cardiac procedures. Dr. Wilson does not know if the surgical team conducted a morbidity conference to review the causes of Joshua's death. If so, Wilson was not invited.

The next week, Dr. Wilson was summoned to the office of Pat Burns, the hospital's Medical Director, to review issues relating to their clinical privileges at Farmington Hospital. (Dr. Wilson had technically been employed by GAS- General Anesthesiology Services – but that employment relied upon having clinical privileges at Farmington.) Without officially terminating Wilson's privileges, Burns reported the Farmington surgeons all refused to operate with Wilson as an anesthesiologist (giving Wilson no income) and that Burns would not interfere on Wilson's behalf. Burns left the clear impression that Wilson's privileges would be terminated in the near term unless they chose to resign. Wilson did so.

From Dr. Dellahunt's perspective: Dr. Dellahunt's surgical practice seemed to go reasonably well in Farmington for the first eighteen months, including the first six months in pediatric cardiac surgery. Dr. Rasheesh was easy to work with and a gracious teacher. They were both experiencing somewhat higher than anticipated morbidity, but this is "par for the course" in open heart surgery. Dellahunt explained that is why heart surgeons must remain detached from patients' families and emotions: they cannot afford to be distracted.

Dr. Dellahunt hadn't kept track of Dr. Rasheesh's precise numbers during those six months but began to suspect that their own morbidity rate in pediatric surgery was slightly higher than Dr. Rasheesh's. Dr. Rasheesh reassured Dellahunt, saying they had both had a "run" of particularly difficult cases – children with unusually complex heart defects. He 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. He also acknowledged an inevitable "learning curve" for this type of surgery, no matter how well-studied 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 maintain optimum mastery.

After one unsuccessful Arterial Switch procedure last year, in which the neonate had presented highly challenging arterial characteristics, Dellahunt sent an email seeking guidance from a Philadelphia surgeon who had provided the earlier training. The surgeon wrote that he had several extremely difficult cases scheduled that week and invited Dellahunt to observe. Dellahunt went back to Philadelphia for the week, witnessed these newest Arterial Switch techniques in the operating room, and later reviewed video recordings of the surgeries at home. This training seemed helpful. Dellahunt was able to incorporate new techniques into the next few operations, which were successful.

The downturn for Dellahunt began eighteen months after arriving at Farmington. Dr. Rasheesh informed Dellahunt confidentially that he was looking to "phase out" of pediatric cardiac surgery. Rasheesh and his wife were having some trouble trying to start a family, after having lost a nearly full-term baby in utero, several months earlier. For him, open heart surgery on newborns with severe heart defects was becoming emotionally overwhelming; he could no longer distance himself from the families' anguish. Dellahunt suspected he was suffering from depression. Thus, more of the pediatric cardiac cases were referred to Dellahunt, and Dr. Rasheesh was rarely there to assist in the operating room. By then, 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 concluded 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. Stephen Wilson decided to self-appoint as master judge of surgeons." Dr. Wilson began questioning why Dellahunt's surgeries took too long, and why the infants arrived at the ICU in difficult shape. Wilson and at least one of the nurses began challenging your 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. At routine surgical staff meetings, Dr. Wilson started suggesting that the attending nurse mind the clock and call out "time elapsed" at fifteen-minute intervals, to speed surgery along. Dellahunt objected strenuously, for it suggested that they weren't working as fast as possible. Dr. Wilson also pushed Dr. Knowles to purchase newer heart-lung machines for neonates and special neo-natal ventilators, stating the machines in use were "jerry-rigged." Dr. Dellahunt immediately suspected that was a way for Wilson to cover anesthesia slip-ups during surgery or lapses in care in the ICU. Dellahunt claims no expertise in the operation of

those machines but knows the hospital paid a great deal to have them upgraded and retrofitted for infants.

Over time, Dr. Dellahunt began to think other factors at Farmington Hospital were affecting outcomes and morbidity statistics. The ICU was Dellahunt's number one suspect. Acknowledging that it is hard to put a finger on what was not being done well in there, Dellahunt does not think Farmington's nursing staff or ICU physicians are too sharp. Dellahunt had mildly disappointing success rates in *adult* cardiac surgery at Farmington compared to Arkansas. Yet Dellahunt's ability to perform adult cardiac surgery wouldn't have declined on the trip from Arkansas. Dellahunt's surgical abilities are the same. So, the cause was either an unlucky run of very bad adult hearts, or something different about care at Farmington Hospital. One or both may be true.

Dr. Dellahunt believes Dr. Wilson initiated a campaign against them. At every morbidity conference and, most likely, in various back-room conversations, Wilson was hyperbolically critical, arrogant, and "holier than thou." Wilson forced Dellahunt to discuss every twist, turn, and hole in each patient's heart defect to explain in detail why the particular case was unusually difficult or how the patient's condition affected his tolerance for the procedure and recovery. It's as if Wilson forgot these were often very, very tiny neonates or underweight infants weakened by their struggle to live with compromised hearts.

Dr. Dellahunt remarked that the only bright spot in all of this was the other surgical team colleagues, including Chief of Surgery, Dr. Knowles, who pushed back against Dr. Wilson (and nurse Stanton, who took Wilson's side). Even though Dellahunt had not been there long, the team listened and accepted the surgeon's explanations of what had occurred in surgery, and why morbidity was unavoidable in some cases. Dellahunt was grateful for their professional courtesy and personal loyalty.

As described earlier, 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 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 this one [pointing at Dellahunt] from performing surgery here." Wilson passed the report around and proudly explained that they had gone through hospital files, compiled statistics on morbidity in pediatric cardiac surgery over the past two years and compared these to morbidity percentages in major pediatric cardiac surgery centers. According to Wilson, the morbidity rate for Arterial Switch surgery in most major medical centers is 20 – 21%, and as low as 15% in some centers within the past few years. Wilson's reported the mortality rate at Farmington Hospital as 35-40%, during their tenure. In other major centers, the surgery lasts 4 to 4 ½ hours; 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 Dellahunt from performing Arterial Switch operations, effective that minute.

Dr. Dellahunt was "outraged by this ambush." It meant that Wilson had broken into the files of Dellahunt, Rasheesh, and other physicians. Outrageous! And who appointed Wilson judge of what was a difficult case and what was not?" 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 that second visit to Philadelphia. The most recent morbidity was anomalous and completely explainable.

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

Dr. Dellahunt reflected to their lawyer: "Perhaps I should have known that the stars would not line up on my side that day." Joshua Fairday died in the ICU, despite Dellahunt's effort to use utmost care during the Arterial Switch surgery. According to Dellahunt, 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). In a meeting with Joshua's parents, the day before, Dellahunt had explained the Arterial Switch procedure, and that the surgery is risky and delicate. Dellahunt had told them that, despite the risks, it was the best hope for Joshua's becoming healthy.

To their lawyer, Dellahunt admitted to 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 wanted to be careful and had even called for a cardiologist consult in surgery, which took some time. Numerous subtle aspects of the heart defect required repair. Later, Dellahunt was angry when one of the ICU nurses challenged their chart notation of Joshua being "pink" and having "tolerated surgery well" when Joshua entered the ICU. Joshua

[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.

had looked so much better than Dellahunt would have expected when the surgery was finally finished. Dellahunt 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 their refusal to operate with Dr. Wilson as an anesthesiologist. Nurse B.J. Stanton, Dr. Wilson's only friend there, announced they would no longer work on pediatric ICU patients. Virtually no one else in the hospital would speak to Wilson. Dr. Dellahunt gave notice to the hospital's surgical director, Dr. Knowles, that they would stop doing the Arterial Switch operation, while open to performing 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 his case and did not challenge Dellahunt's conclusions, perhaps because they understood Dellahunt would no longer do Arterial Switch surgery.

Eight months ago, five months after Joshua's death, a column was published in the local paper called "Comings and goings down at Farmington Hospital." The columnist noted that the pediatric anesthesiologist, Dr. Wilson, resigned after only a short time.

Wilson also filed suit against the hospital for effectively terminating or forcing Wilson's resignation after Wilson uncovered "just how down on the farm and backward in time" the practice was at Farmington. Colleagues accused Wilson of being difficult for calling them on their botch-ups. Wilson claimed to have evidence that the surgeons at Farmington Hospital performing heart surgery on babies had much higher mortality rates than surgeons in "quality" hospitals elsewhere. Wilson noted as proof that one of the surgeons had finally admitted being unable to handle neo-natal heart surgery, and was giving it up, but "not before they decided to sack me because secrets are more important than patients in this terribly chummy backwater town." Hardly an in-depth report, the article also cited an anonymous nurse who stated that it was not responsible to use the same ICU and the same surgeons for tiny babies as for adults and that they were constantly depressed from seeing so many babies die on the operating table. "Yes, it's part of the risk you take when you work in the ICU she said, but there seems to be a curse on Farmington." The balance of the article quoted the Medical Staff Director and other hospital officials who asserted that, while they couldn't comment on particulars, "It should be obvious to the public that Dr. Wilson is a bitter and justly terminated former employee, pointing fingers at everyone else."

Not long after that column's publication, Joshua Fairday's parents published a letter in the same paper, "alerting parents in town to the danger of taking their children for surgery at Farmington Hospital."

Shortly after that, Joshua Fairday's parents sued Dr. Dellahunt and the hospital. The complaint described Dellahunt as incompetent, unqualified, and grossly negligent, and claimed they intentionally caused the death.

I hereby confess that NOT all of this information would be known before the interviewing and counseling phase of this simulation, and not all of it would necessarily come out in that phase. However, it does constitute the factual context. This could serve as useful prompts for questions to participants in the lawyers' roles: what if this is true – what if this is what happened – would your interview have elicited the information? Would it have led you to investigate further? Should you be skeptical, or at least willing to test the conclusions your clients have drawn?

Some additional information specific to each phase of the simulation is contained within the two segments of this Teaching Note.

PHASE 1 – INTERVIEWING & [SOME] COUNSELING

This phase involves three potential parties or witnesses and their initial meeting with a lawyer.

1) Attorney Heath and Dr. Wilson
   Attorney Heath is a partner in a mid-sized law firm. The attorney has represented the hospital in three or four cases and was brought in on a claim involving a possible allegation of an anesthesia overdose – though no suit was filed. The law firm currently represents the hospital in a case involving claims of defamation against a nurse.

   This interview sets up a clear conflict of interest: Dr. Wilson approached Attorney Heath because Heath had interviewed Wilson in connection with the anesthesia overdose and seemed to listen to Wilson's medical explanations.

   When Dr. Wilson reached out to Heath on this matter, the communication did not raise obvious conflict flags. Wilson's email had asked "to discuss some issues of importance to Farmington Hospital."

   Clearly, those in the attorney's role would be well advised to explain to Dr. Wilson, at the outset, that they cannot represent the doctor's interest against the hospital's because the hospital is a client of the firm and has been a direct client of this lawyer. If the attorney fails to do so at the outside, they surely should as soon as they get wind of the fact that Dr. Wilson's interests are not aligned with the hospital's.

   The question becomes: once the conflict is clear and has been disclosed, should the attorney permit an eager Dr. Wilson to provide information about a problem and potential legal claim against the hospital? At that point in the conversation, it's clear

that Dr. Wilson will need representation, and the attorney should not be eager to speak with them until they are represented.

What if Wilson says, "I really don't care about being legally protected right now. I want you to know what's going on at Farmington Hospital because infants' lives are being lost needlessly and someone has to do something!"?

What could and should the lawyer do? Can the lawyer listen to what Wilson has to say?

Should the lawyer inform the Hospital's GC or CEO? How quickly? Can or should the lawyer make arrangements for another competent med-mal defense attorney to represent Dr. Wilson, at least temporarily, in a meeting where Wilson would provide information about the "issues of importance to Farmington Hospital."

Assume that, one way or another, the attorney learns what Wilson has to say. Then what are the attorney's obligations? Note: This attorney does not owe Dr. Wilson confidentiality because there's no attorney-client relationship. Presumably, the attorney would have made that clear.

Okay, let's take the hypothetical further: what if Wilson does get separate counsel? What would that lawyer's obligation be concerning Wilson's analysis of the statistics and substandard care for infants requiring Arterial Switch surgery at Farmington?

For those of us in Ohio, the Ohio Rule for Professional Conduct, 1.6 provides:

"(a) A lawyer shall not reveal information relating to the representation of a client, including information protected by the attorney-client privilege under applicable law unless the client gives informed consent, the disclosure is impliedly authorized to carry out the representation, or the disclosure is permitted by division (b) or required by division (d) of this rule.

(b)A lawyer may reveal information relating to the representation of a client, including information protected by the attorney-client privilege under applicable law, to the extent the lawyer *reasonably believes* necessary for any of the following purposes:

(1) to prevent reasonably certain death or substantial bodily harm;…."

The generic ABA Model Rule 1.6 is substantially similar, stating "A lawyer may reveal information relating to representation of a client to the extent the lawyer reasonably believes necessary to prevent reasonably certain death or substantial bodily harm;"

Dr. Wilson has some pretty alarming statistics about the comparatively high rate of infant deaths from Arterial Switch surgery at Farmington. Wilson presents with some credibility given his impressive background and experience at other prestigious

hospitals. While I suspect that this Dr. Wilson would want their attorney to inform the hospital higher-ups of what is occurring in the pediatric cardiac surgery unit, what if they wouldn't? Is Wilson's presentation of data and observation sufficient for the lawyer to "reasonably believe" it necessary to disclose the information "to prevent reasonably certain death…"

How would you feel about it if you were the parents of the next infant who died after Arterial Switch surgery at Farmington?

2) Employment Law Attorney Keene and BJ Stanton

The lawyer doesn't have any potential conflicts that would preclude representation of BJ Stanton, but the information received from BJ does raise both ethical and strategic concerns. BJ's case presents as an employment matter: BJ is (justifiably) concerned that their employer, Farmington Hospital, is setting up to terminate them. The lawyer needs to learn BJ's interests: whether they prefer to stay at Farmington or an alternative hospital employer and how the lawyer can assist BJ to "land on their feet."

From an ethical perspective (both legal ethics and human ethics), the question is what the lawyer can and should do with the information provided by BJ. Of course, it is covered by the attorney-client privilege and cannot be disclosed without the client's permission. On the other hand, if BJ's observations are correct, more infants may die unnecessarily if no action is taken at Farmington.

If BJ agrees, then the lawyer can approach the hospital. However, should the lawyer suggest to BJ that they approach Farmington Hospital's CEO, GC, or Board Chair with BJ's concerns? Will that jeopardize BJ's employment prospects, now and in the future?

What if the hospital were to demand BJ's silence as a condition of retaining them on staff or of a favorable recommendation or settlement? That's an ethical question for BJ and the lawyer.

Looking to Rule 1.6: Do the facts relayed by BJ give rise to a "reasonable belief" that disclosure is "necessary to prevent reasonably certain death."

BJ's observations do not include Dr. Wilson's gathered statistics, and she was not privy to the evening morbidity conference presentation and confrontation. Still, should BJ's story prompt the lawyer to investigate further? To what extent?

3) **General Counsel, Farmington Hospital and Pat Burns, M.D. Medical Director, Farmington Hospital**

Pat Burns approached the General Counsel for advice about terminating a physician's employment contract. Theoretically, the General Counsel could listen to Burns' story, highlight grounds for dismissal under the contract, point out any gray areas, etc. The GC might point out the risks of the physician publicizing their observations about Farmington Hospital, and express concern about the effect on their pediatric (and adult) cardiac surgery reputation and business. Perhaps the physician could be counseled, or given a warning, contingent on an agreement not to make public disclosures.

However, this author hopes these choices remain theoretical and that the attorney takes a different path: at minimum, immediately undertaking further investigation to protect the hospital and its patients. And, subject to confirmation of Dr. Wilson's statistics (whether or not they should have been gathered), the GC might go so far as to require temporary cessation of Arterial Switch surgery (at least) at Farmington.

To recognize the wisdom of immediate investigation and action, the GC must have sufficient wisdom to be skeptical of Dr. Burns' motivations and biases., as well as those of Dr. Knowles (who reported the situation to Burns.) While it's possible that Dr. Burns' downplaying of the problem and his deference to Dr. Knowles is appropriate, it's equally possible that they are not. Who is the villain and who is the hero? Dr. Burns has relayed the "narrative" of the head of a surgical unit accused of medical malpractice and the unnecessary death of infants in the hospital's care. Their solution is to banish the accuser- Dr. Wilson. But what would motivate Dr. Wilson to jeopardize their career at Farmington? Yes, Wilson may have something to hide. But it's also possible that Wilson is speaking the truth – Wilson's credentials surely suggest it would be unwise to dismiss these allegations out of hand.

The GC's obligation is to the hospital, and the hospital's obligation is to its patients.

Going back to the interview: at a minimum, the GC should advise Dr. Burns that the GC represents the hospital and not Dr. Burns (or Dr. Knowles). If that wasn't done at the outset, when the GC had no reason to know Wilson's potentially serious allegations, the GC should raise it when these are known. Given that Burns is a senior officer and has similar obligations (and no apparent conflicts at the moment), the GC would and should be able to elicit what Burns knows about what has happened – why Knowles seeks to terminate Dr. Wilson, and what Dr. Wilson has alleged about pediatric cardiac surgery at Farmington. At that point, the GC is obligated to investigate thoroughly. And, in my view, if the hospital CEO or Burns tries to block immediate investigation and corrective action, if necessary, the GC must report on this to the Chair of the Board of Directors.

A note about the client role players:

Because our class was small, we were able to recruit professionals to play the client roles, including a member of the law school's financial administration staff and his wife, whose background was in nursing and (later) health care administration. We conducted interviews,

fishbowl style, rotating in the students who had been assigned that lawyer's role. I surely don't believe that would be the only way to use the simulation. Particularly in a larger class, it would be fine to assign some students to the lawyers' roles, others to client roles, etc. However, at some point, I do see value in having students see a client with some life experience (okay, older) and/or who understood health care if you can swing it. You might want to have students conduct these interviews with each other, debrief a bit, and then have a demo with non-students in the client (or the lawyers') roles.

PHASE TWO – MEDIATION

Post-interview developments and information, known to all parties and counsel

After discussing their interests and options, Fairdays authorized their lawyer to draft a strong letter to the hospital's General Counsel and CEO but received no response other than to the lawyer, expressing sorrow at Joshua's "unavoidable death due to a congenital heart defect" and directing future correspondence and discussions to the hospital's outside counsel. They then authorized the lawyer to file a lawsuit against the hospital and the surgeon and to commence the legal process against Farmington Hospital and Dr. Dellahunt.

The Fairdays also wrote a letter to the local paper, even though their lawyer advised waiting because the "threat" to write a letter would provide leverage. They didn't care about leverage. They wanted to alert parents in town to the danger of taking their children for surgery at Farmington Hospital. The paper published their letter.

After suit was filed, a scheduling conference as convened by a magistrate who suggested mediation. Because formal discovery had not yet begun, the Fairdays' lawyer insisted on the voluntary exchange of certain information: Joshua's full medical record, including the cardiologist's, surgeon's, anesthesiologist's, and nursing files and all charts, and records of mortality and other adverse outcomes (such as brain damage) in pediatric cardiac surgeries performed by Dr. Dellahunt. When the defense attorneys objected to the scope of the request, the plaintiff's attorney made an oral "offer of proof" describing Dr. Wilson's statistics and the meeting on the evening before Joshua's surgery. The magistrate strongly advised the defense counsel to provide the information and they agreed.

The mediation was scheduled for a few months later, to give both sides time to agree upon a mediator and to have Joshua's medical records and other documents reviewed by independent experts. The lawyers agreed to exchange expert reports a week prior to the mediation. Defense counsel agreed to make sure that necessary insurance carriers were put on notice, and that party-representative with full settlement authority would attend the mediation.

Not surprisingly, the defense expert, a semi-retired cardiologist from Columbus, reviewed only Joshua's medical record. He concluded that Joshua's was a serious TGA defect, with a seriously enlarged hole between the heart's chambers, and his heart muscle appeared to

have been in weakened condition prior to surgery. The expert concluded there was no evidence of surgical technique that fell below the standard of care.

The plaintiffs' experts, a pediatric cardiologist and a surgeon from Harvard Medical School and Children's Hospital in Boston agreed that TGA is a serious heart defect and that Joshua's case was not uncomplicated. However, they observed that Joshua's TGA was not "worse" than most others, which were repaired in the Arterial Switch surgery by experienced surgeons. They 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 the assertion 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 with Dr. 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. Finally, these experts dismissed Dellahunt's assertion 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 the necessary information was present." Finally, the surgeon was particularly troubled by the excessive length of the surgery – 7 hours under general anesthesia in the operating theater and 6 ½ hours on the heart-lung machine. He asserted the surgery's duration indicates a lack of expertise by the surgeon or surgical team, and "falls below the current standard of care" barring unforeseeable or unusual characteristics of the TGA defect.

Mediator challenges: Parties' interests, emotions, concerns, and constraints

You may notice that this folder does not contain any overview or general information for the mediator. That's because we've used it to challenge students to initiate contact with a mediator (either a mediation student or a pre-selected volunteer), and then work with the mediator to decide how and when the mediator should learn the substance of the case: will there be preliminary written submissions? A joint conference call with counsel? Any preliminary separate meetings with the lawyers and the parties? In other words, the students and the mediators (even student mediators) should handle those questions from the beginning, as in a real case.

Plaintiffs Ellen and Elliot Fairday (parents of the deceased) and Attorney

- The Fairdays

It should never happen again. In addition to anger, outrage, grief, and no doubt some unspoken feelings of guilt, the Fairdays primary goal is to make sure this never happens to another patient. In the narrow sense, they do not want another infant born with a heart defect to be subject to surgery at the hands or Dr. Dellahunt (or Dr. Rasheesh, or another less than highly skilled pediatric cardiac surgeon). More broadly, Farmington should not subject any patient to a substandard surgeon. The Fairdays want "to make sure that incompetent

surgeons are not permitted to wield a scalpel, that doctors don't defer to their self-serving buddies when they should know it puts a child at risk." If ANY concerns are raised about a surgeon's skill, the hospital should take immediate action: putting surgeries on hold or referring them out, investigating thoroughly and objectively – preferably with outsiders.

They strongly believe the hospital administrators, doctors, nurses, and everyone who knew what was going on should be punished for trying to cover up, for hiding information, trying to silence the doctor who brought forth the data, for failing to stop Joshua's surgery on the morning of his death.

Redress for financial hardship. While Elliot has continued in his job, both Fairdays have suffered from depression, which has also taken a toll on their marriage. The Fairdays have paid for psychological counseling and some short-term marriage counseling (They describe their marriage as now stronger than ever, thanks to that). But Ellen has been unable to shake her depression. She found it impossible to walk into the elementary school building and work with children. She had taken a six-month leave after Joshua was born because you knew his medical condition would require her care. After he died, her leave was extended for an additional six months, and she returned as a "teacher's assistant" at 2/3 of her former teacher's salary. Ellen has also given up all responsibilities for the enrichment curriculum. Before Joshua's death, she was earning $52,000 a year - $48,000 as a first-grade teacher and $4,000 for the curriculum responsibilities. When she returned as a teacher's assistant, her salary dropped to $32,000. The Fairdays do not know how long Ellen will have to remain in that position, or whether she will be able to overcome depression enough to maintain it. The Fairdays' psychological and other counseling has cost at least $10,000, and will likely require an additional $6,000 a year in counseling and prescription drugs. Of course, money cannot compensate for their loss, or for their inability to enjoy life on a day-to-day basis.

One small note on the financial side: while the attorney has taken the case on a contingency fee basis, that does not include the direct costs of expert witnesses, etc. While it's not a large hurdle, that would be a strain for the Fairdays if the case isn't settled in mediation.

There is a potential tension between individual settlement and allegiance. The Fairdays feel strong allegiance to the families of other children who might not have died, had they had heart surgery at City Children's Hospital instead of Farmington Hospital. They feel these lost children and their parents should be represented too. On the one hand, you believe it right to reach out to these families and let them know what you have learned about Dellahunt and Rasheesh and Farmington Hospital. The Fairdays wonder if itis more ethical to spare them the information. For, now knowing the truth, they suffer additionally from guilt because Joshua might be alive had they made different choices.

The role information does set up a possible "diplomatic and logistical" issue for the mediator. When their attorney asks if the Fairdays are comfortable being in the same room as Dr. Dellahunt, they are uncertain. The attorney suggests they think about prior to the mediation. If some in the Fairday roles take this up, they (or their lawyer) may decide that they do NOT wish to be in a joint session with Dr. Dellahunt. (This assumes they would not have the same

feelings regarding the hospital CEO, but that should not be taken for granted.) This is understandable and creates potential challenges for the mediation process. What if the Dr. wants to apologize, or express sincere sympathy, or just explain what this has felt like? Assuming the Dr. is sincere, that might be effective. On the other side, will the Fairdays feel ready to settle if they are not able to tell their story directly – at least to the hospital CEO? Then again, if opposing parties are in the same room, will their intense emotions render them unable to think rationally, to absorb complexity?

What process options might the mediator suggest to avoid harm and increase the likelihood of settlement in the parties' interests (including their emotional interests)?

- The Attorney

Their attorney is aware of everything the Fairdays know and has informed them of everything learned in the litigation thus far.

The attorney has not attempted to steer them toward any settlement range or terms. While advising them of choices available and strategic issues, the attorney has encouraged the Fairdays to make decisions based on what feels right to them. For example, the Fairdays' attorney anticipates that the hospital would be more willing to settle (or more generously) if the Fairdays agree not to speak or write about what happened to Joshua, and the damning statistics on pediatric cardiac surgery there. Based upon their strong interests, the attorney understands Fairdays are unlikely to agree to such a term. Some in the real Fairdays' role might decide to reach out to the parents of other infants who died following Arterial Switch Surgery at Farmington and bring them into the lawsuit. It's likely the hospital and the doctor (and their insurers) would not embrace such action. From the Fairday's and their lawyer's perspectives, that would take time and delay settlement. On the other hand, assuming some of those families would also retain the Fairdays' lawyer, joining them might be in the lawyer's long-term financial interest.

Defendant - Dr. Dellahunt, Attorney, and Insurer's Claims Representative

- Dr. Dellahunt

Dr. Dellahunt was not surprised at being sued by Joshua Fairday's parents. The doctor found it hard to read through the complaint, which accused them of being incompetent, unqualified, grossly negligent, and even intentionally causing the death.

Dellahunt's attorney, Jan Carsen, explained that they represent the doctor and the insurance carrier. However, under the policy terms, the case cannot be settled without the doctor's approval. The doctor's policy limits are $2 million "per occurrence."

The attorney told the doctor that wrongful death claims on behalf of deceased children are typically settled for far, far less than that. However, Dellahunt is very worried about the national registry on which settlements or liability verdicts are reported. Never having faced a malpractice claim before, Dellahunt doesn't know exactly how the system works.

Regarding Wilson's statistics (based on inexcusable searching through your files), Dr. Dellahunt emphasized to the attorney that statistics work in funny ways. When the absolute number of surgeries performed is small, a short run of bad luck and a small number of difficult cases can dramatically affect percentages**.**

Of course, Dellahunt was aware of both sides' experts' findings and conclusions prior to the mediation. Dellahunt was relieved that the defense expert concluded that Joshua Fairday's was 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, a semi-retired cardiologist from Columbus, stated that the autopsy report included no evidence of surgical technique that fell below the standard of care.

Unsurprisingly, Dellahunt was not pleased by the plaintiff's experts' report. Still, Dellahunt does acknowledge that their credentials are topflight. Since reading that report, the words "below the standard of care" and the words in the complaint, "intentional" and "negligent" have been ringing in Dr. Dellahunt's head. They have barely slept. The attorney told Dellahunt this is the usual medical malpractice language, and the parents are emotional, wanting to blame someone else for their son's congenital defect, but this provided little comfort. The attorney acknowledged any case has risk and Wilson's statistics do not look great but also reassured you that juries tend not to find against doctors in their community.

Unbeknownst to the plaintiffs, Dellahunt does not plan to do another Arterial Switch again because of the trauma this has caused. However, Dellahunt is terribly afraid of losing their license to practice medicine, or of not being granted clinical privileges to conduct surgery anywhere.

- The Attorney

While the facts and perspectives contained in Dr. Dellahunt's role information are almost identical, there are a few small differences. Dr. Dellahunt was told there shouldn't be an insurance coverage issue. However, after their meeting, the attorney realized the complaint raises a remote coverage issue, because the standard medical malpractice policy (including his) does not cover intentional torts. The complaint accuses Dellahunt of "knowing" their own lack of competence to perform the surgery and thus acting intentionally to cause the patient's death. The attorney didn't see this as the type of intentionality excluded from coverage. However, there's an open question as to whether, at least by the time of Joshua Fairday's surgery, Dellahunt recognized their own lack of competence – at least on that day, in light the previous evening's meeting and Dellahunt's acknowledged nervousness. Would a mediator want to be alert to this potential issue? What ethical question does it raise for the attorney, who also represents the insurer? Depending on what Dellahunt acknowledges in the mediation, what role does the mediation privilege play?

On the overall liability front, the lawyer does see a significant risk of liability here and is concerned that a trial or the mediation could turn into a finger-pointing session between the hospital and Dellahunt, which would make both look bad. The attorney recognizes those statistics (or anything close gathered in formal discovery) are quite damaging. If you were a parent of a child scheduled for surgery, you'd want to know the doctor's and the hospital's success rates. Although the attorney would not say it, they would hate to learn that a friend's child was scheduled for cardiac surgery with Dr. Dellahunt or at Farmington Hospital. The attorney was underwhelmed by their own defense expert's credentials (and the report's lack of thoroughness. The plaintiffs' expert report was predictable but sounded solid. The attorney sees that any expert defense would have to be stronger to be credible.

Neither the doctor's nor their attorney's role information contains hard dollar limits on settlement, other than the policy limits and the lawyer's assertion that wrongful death cases for children are generally settled for much less. It's an entirely open question as to whether the attorney (on behalf of the doctor or the insurer) would support an effort to bring in other plaintiffs (parents of deceased infants on whom Dellahunt or Rasheesh) performed the surgery. On the one hand, the insurer would be loath to encourage more claims. But what would the lawyer's incentive be? And on the other hand, whether the Fairdays alert other parents to the action, and encourage joinder, is not within this attorney's or their clients' control. If others were brought into a global settlement (assuming they would have sued separately), that may be more efficient for the insurance client who would be footing the bill, and for Dr. Dellahunt who would be served by moving past this.

- The Dr's Insurer's Claims Representative

The claims representative believes the complaint in this case is quite aggressive, more so than most. Still, they are not terribly worried about the outcome, believing juries tend not to find against doctors in their community hospital. They know if the jury were to "sock" Dr. Dellahunt, finding liability for intentional harm, All-Med wouldn't have to pay any punitive damages and its medical malpractice policy does not cover intentional torts. The claims rep

has not raised this coverage issue, because the idea that Dellahunt acted "intentionally" is unlikely. But they will raise it in negotiation if the facts develop in that direction.

While aware that mediators always want assurance that the insurance representative has "full settlement authority," this claims rep has "full authority" ONLY up to the committee's $125,000 limit. Their boss could increase that *tentatively* by telephone, if necessary to close the deal. As a technical matter, the 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, they have never known the committee to reject your boss's recommendations.

Of course, the claims rep is aware that the hospital will have its own insurance. They 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, they don't see much risk or liability for either one. The claims rep is aware they can't authorize settlement without Dellahunt's approval, as this may affect the doctor's medical career.

Oh, settlement authority! The bane of mediators! And then there's the occasional blindness of insurance claims people (especially at lower levels). This claims adjuster's role information sets up three challenges for a mediator and for the process.

First, they do not have full settlement authority; the limits set by the reserve and the committee are likely unrealistic. Even if these can be moved, the process would take time and doesn't allow for back and forth. So, assuming $125,000 will not be sufficient, the mediator will have to try to get a "final" number that will be needed. It would be best if the mediator could learn these constraints early. In a real mediation, when dealing with a younger claims representative with a not-so-senior title, the mediator might be more likely to see the authority issue. (With a law school class or other simulation format, the signs will be less clear.) It does allow the professor to make the point that inquiring into authority – early – is always a good idea. Without asking for the $ limit, the mediator should learn that there is one, and just as important, what internal insurer processes may be required. In my experience, it's best to alert the other parties to this possibility when it appears the negotiations are going to bump into the reserve limits.

Second, back to the persuasion/evaluation issue: this claims rep somehow doesn't quite see risk or liability for Dellahunt or the hospital. Sigh! If this is sincere blindness, some eyesight will have to be corrected. The mediator may have to set up a discussion of the merits/the realities, leaning heavily on the experts' reports and Dr. Wilson's statistics. This might be most effectively done through the hospital's counsel or (more senior) claims VP, if they've been candid with the mediator about their recognition of the risks. If not, some mediator evaluation might be helpful, if agreed to (and done well). That would give the claims representative something to lean on with their boss and the committee.

Third is the ethical/coverage issue and how that influences the persuasive "narrative" presented to the adjuster. After all, the more the hospital's attorney or claims VP leans on

Dellahunt's culpability as outrageous – that Dellahunt should have known, did know their own incompetence, especially after Wilson's findings, or when so nervous that morning – the more the claims adjuster can take up the characterization of an intentional tort. The insurer would be off the financial hook; the Dr. would have no coverage. This raises an ethical problem for the lawyer, and a lawyer-mediator should also be aware of the jeopardy posed to the doctor. Who should inform the doctor of the risk and the exposure? I'd argue that the lawyer (representing Dellahunt and the insurer) is obligated to do so, but what if the lawyer resists? What if the mediator observes the "narrative" in the mediation – in caucus with the Dellahunt "side" as shifting to the risk of a jury finding of an intentional tort? Can the mediator find an opportunity to speak with the lawyer, outside the presence of the claims representative? In the interest of settlement, is it okay for the mediator to speak with Dellahunt and the lawyer without the claims adjuster?

The Hospital's CEO, Outside Counsel, and Insurer Claims Representative

- The CEO

Unsurprisingly, the Hospital's CEO is less positively inclined toward Dr. Wilson and less inclined to blame the hospital's medical staff. The CEO first learned of the death of Joshua Fairday through an aggressive letter from a plaintiff's attorney, threatening a malpractice suit against the hospital and several of its nurses and physicians, and describing how the parents of a deceased child were suffering due to their alleged incompetence. At that point, the CEO asked an assistant to investigate. She spoke to the Chief of Surgery, Dr. Knowles, who was familiar with the case. Knowles explained that an infant, Joshua Fairday, had suffered from a serious congenital heart defect, was in terrible shape before surgery, and that some risks could not be avoided. The CEO referred the letter to the hospital's outside counsel for litigation and put the hospital's insurance carrier on notice. The CEO had also received a letter full of angry accusations from the Fairday parents, requesting a private meeting, However, the CEO had no desire to be subjected to angry accusations by grieving parents and knew any lawyer would advise against speaking directly to a potential plaintiff. Instead, the CEO sent a brief but polite letter expressing sorrow at the death of their child, but requesting they communicate with the hospital's outside counsel regarding any legal claims.

The CEO initially heard the story of Dr. Wilson's actions from the medical staff leadership. On their recommendation, the CEO had approved the termination of Wilson's clinical privileges at Farmington Hospital and their contract with General Anesthesiology Services (GAS), the corporate entity that provides anesthesiologists on the hospital's medical staff. The CEO understood Wilson might have claimed whistleblower status but was already under a cloud for questionable judgments as an anesthesiologist. The CEO knows Wilson was advised to resign and did so.

When alerted to the article in the local paper, the CEO asked the hospital's P.R. Director to handle it. She contacted the reporter and tactfully suggested that grieving parents of a child who had died from a serious heart congenital heart defect might understandably not be

objective sources of information. She noted that the complete story of the medical case involved extremely technical physiology and surgical details. The reporter backed off, and the hospital's public relations person invited her to call if there were any more rumors. The letter also led to half a dozen or so calls from parents of children scheduled for cardiac surgery within the next few months. The CEO instructed all hospital staff to recommend these parents talk to their cardiologists and surgeons and make their own decisions, but also to assure them that the hospital was committed to caring for its patients, particularly young patients with heart problems.

Unsurprised when served with notice of the lawsuit, the CEO retained a well-respected attorney at a larger firm in the city and notified the hospital's insurance carrier. (Later, because there appeared to be no coverage issues, the insurance carrier agreed that it and the hospital would jointly retain E.F. Adams, to save on defense costs.) The CEO is aware that their surgical expert recommended by the insurance company, a semi-retired cardiologist from Columbus, concluded there was no evidence of surgical technique that fell below the standard of care. However, the CEO is skeptical. The CEO suspects their expert is less than highly credentialed and that the Fairdays will be using, directly or indirectly, information gathered by Dr. Wilson regarding the mortality percentages for Arterial Switch and AVSD surgery performed at Farmington Hospital, particularly by Dr. Dellahunt. The CEO can see the numbers look bad: the mortality rates at Farmington for the past 2 years in Arterial Switch surgery have been 35 - 40%, compared to rates in most larger centers of 20-21% and, recently, as low as 15% in some centers. The CEO also knows from the complaint that Dr. Wilson presented these statistics to others on the surgical team in the context of a morbidity conference, following the death of an infant in Arterial Switch back surgery.

The attorney agrees and advises the CEO that these numbers did not look good for Farmington Hospital. When pressed, the Chief of Surgery continued to stand with the surgeons and the argument that these were unusually difficult cases. Not entirely satisfied with this explanation, the CEO and the attorney decided to look further.

Unbeknownst to the plaintiffs or Dellahunt, they retained a statistics professor from the local college to review the likelihood that this discrepancy could have been due to random variation, given the smaller number of these surgeries performed at Farmington and the larger numbers in the general statistics. The professor was not asked for a formal report, just a review and discussion of the data, on a confidential basis. The professor reported that, based on a rough-cut analysis, it is 85% likely that the differences in rates would not have occurred without cause. In short, chances are that *something* was not going well at Farmington Hospital.

In addition, the CEO decided to try, very quietly, to get an internal confidential assessment of the quality of care in the hospital, particularly pediatrics, surgery, and the ICU. The CEO set up small boxes near various bulletin boards in the hospital with a small sign that asked: "How are we doing? If you are a doctor, nurse, or patient, please tell us if you have any concerns about the hospital. Of course, we like nice comments too! You need not sign your name – all comments will remain confidential." The CEO was surprised by the number of

negative comments received. Several respondents, identifying themselves as nurses, provided detailed critiques of ICU operations, and condemnations of various surgeons. Some of the medical staff indicated concerns with people operating "beyond the range of their competence", and a "slipshod, chummy review procedure where excuses are tolerated, and bad practice continues without concern for patients." The CEO was shocked by these comments because they were articulated by current staff, not just a disgruntled former employee. **The CEO has not told the lawyer about this informal information-gathering exercise.**

Despite the many concerns, the Hospital's lawyer told the CEO that the hospital has a good chance of winning on the Fairdays' claims and that juries are loathe to find against community hospitals. Any mistake made, or substandard care (the length of the surgery is a bit troubling) rests with Dr. Dellahunt in this case.

The CEO knows the hospital's policy limits to be in excess of $3 million per event. While they wouldn't want the insurer to pay too much (the hospital would be penalized in next year's premiums), and doesn't to admit liability or invite more lawsuits, the insurer should know not to block a reasonable settlement. Any funds contributed directly by the hospital (in addition to insurance) would have to be approved by the hospital's board. The hospital's budget is always tight, but the CEO would be able to fund a reasonable settlement, if absolutely necessary. Though the CEO believes the board would ultimately follow their recommendation, various board members would strongly question a decision to let the insurer off the hook for any of the settlements.

The CEO recognizes the hospital would suffer if the insurer failed to put up reasonable funds. They can think of nothing worse than this case going to trial or hitting the papers, particularly with Dr. Wilson's statistics. Fear or even uncertainty about the quality of care for their children will send parents searching far away from Farmington for pediatric surgery. It can be predicted to affect all non-emergency admissions, especially for pediatric care and obstetrics. The CEO sees that a prospective mother won't choose to give birth when there is a question about the quality of care for her newborn. In short, win or lose, this case and the bad press it creates could completely derail Farmington Hospital's strategic plan. (While the hospital had not quite met the strategic plan's projected numbers in pediatric surgery, its obstetrical practice and general pediatric practices had been on target. Without those revenues, the hospital's future would be directly and quickly threatened.)

The CEO does believe settling creates a risk that more claims will follow – claims by the parents of other children who died after complex heart surgery at Farmington Hospital. It would be in the hospital's interest to discourage any more filings, or at least to know who's planning to sue, and to reduce publicity and consequent financial damage.

Business aside, if the plaintiff's allegations were even partially true, it would trouble the CEO greatly. They did not go into a not-for-profit hospital business instead of a corporate job to bring about unnecessary infant deaths. If there is something wrong with the way Farmington Hospital is caring for patients, the CEO is committing to fixing it.

- The hospital's outside counsel

Except as noted for the internal anonymous information gathering exercise, the hospital's attorney is aware of everything contained in the CEO's role information.

In fact, the attorney has a critical view of the CEO's and the hospital's performance. The attorney's role information states:

> *You chose not to lecture the CEO on issues of management, negligent credentialling, and clubby peer review, which fails to learn what is going on in the operating theatre and fails to correct it. You will wait to see what additional information develops in the mediation. You are also aware that your responsibility is to the hospital entity, to see that the claims are appropriately analyzed, and risk realistically assessed on its behalf – not on behalf of the CEO or Medical Director. For now, given that it's the CEO who hired you, you are not going to criticize the hospital. You'll let them hear it from the other side, or from the mediator.*

Despite the tragedy of the death of an infant, the attorney does not believe these are high-dollar verdicts, because there would be no economic loss and no pain and suffering. They have not yet done jury verdict research on the range of possible awards, and to track recent changes in Ohio's law relating to medical malpractice recoveries but recognize the need to do so if the case fails to settle in mediation.

Neither the CEO's nor the attorney's role information sets a cap (other than polity limits) on what they would be willing to pay or actions they would agree to take to resolve the case.

- Associate VP of Claims

The Associate VP of Claims for the hospital's insurance company is aware of the basic facts in the case but, at least prior to the mediation, unaware of the CEO's and the attorney's informal retention of a statistics professor to review the data gathered by Dr. Wilson.

The Claims VP does anticipate the plaintiff will attack their defense expert's credentials as less "blue chip" but doesn't believe that should invalidate his findings. The Claims VP believes the hospital has a good chance of winning on the claims made against it. They see any mistake or substandard care (the length of the surgery is a bit troubling) as resting with Dr. Dellahunt.

The Claims VP is aware their attorney expressed concern the hospital might be on the hook for negligent credentialing, or for Dr. Knowles's failure to restrict Dr. Dellahunt's surgical privileges based upon mortality rates (reflected in the numbers), or at least for the vote permitting Dellahunt to operate on Fairday. However, the Claims VP suspects the attorney

is just trying to soften them up before mediation. They are skeptical that good faith, discretionary management decisions would lead to a malpractice liability verdict.

The Claims VP confirms insurance coverage up to the policy limits of $3 million per occurrence. However, they are determined not to overpay, "indeed, not to pay much at all unless someone can articulate a plausible theory of liability against the hospital or its staff." However, AHIC does want to keep Farmington as an insured, premium-paying client. Moreover, the Claims VP is aware that hospitals talk; AHIC could lose other hospital accounts if it stands in the way of a favorable settlement for Farmington.

While this Claims VP has a great deal of authority, they will have to justify any settlement to an AHIC claims committee. They initially set a reserve of $50,000 on the claim, on the theory that it was worth no more than $150,000 and that the hospital should not pay more than 1/3. Their role information provides that, **if persuaded in mediation that the hospital's share should be higher or the total adjusted**, they have the discretion to change these parameters. But the higher they go, the more forceful a presentation you will have to make to the committee. Whether or not it's technically needed, they may want to get formal approval before agreeing to any settlement far from these numbers.

Note that the Claims VP's role information thus sets up a need for some form of persuasion or evaluation on the merits for there to be significant movement and chance of settlement. The mediator will be challenged to recognize this. It can be addressed by setting up an exchange on the merits of the hospital's defenses. Counsel might be given the opportunity to make persuasive arguments as to why the hospital's share is more significant, and that the total should be higher (in light of the risks and the hospital's objectives). If agreed upon and if the mediator will undertake it, a mediator evaluation – timed and delivered well – might also be helpful. Thus, this case invites discussion and practice on how to set up productive merits discussion and persuasion, as well as the question of mediator evaluation.

Final Words

Yes, this is an excessively long teaching note. It seeks to lay out all pertinent facts and perspectives – what's known to all and what's not – so that the professor does not have to read all the rather long roles. This is a realistic and difficult mediation. There are no real pre-set limits. Even if insurers have set initial reserves and instructions, these should be subject to adjustment as they would be in a real case. (To be sure students understand this, the professor would be wise to flag the issue: observe that some have instructions regarding settlement value and ranges, but these reflect thinking and analysis prior to the mediation. The role player can do any research about settlements and verdicts they like (or not); they could consider their real interest beyond litigation and legal issues; they can be influenced and adjust or expand their thinking within and by the mediation process. Interests are far beyond monetary compensation; parties can consider and agree on any number of ways to address the Fairday's, the community's, the hospitals (and yes, even the insurers') desire to prevent needless infant deaths and to provide the highest quality of care at Farmington Hospital.