HEARTACHES
MEDIATION

Confidential Information for Jan Carsen, Esq.
Attorney for Dr. Dellahunt

You are a partner in a small litigation firm, specializing in professional malpractice defense of all types, including medical malpractice. You are listed as an approved attorney by most of the medical malpractice insurers in the area. In exchange for a place on their list, you agree to defend cases for those carriers and their insureds at slightly below market rates. You are also an elected member of the Farmington City Council, a decidedly part time position that pays very modestly.

Your new client is Dr. Dellahunt, a surgeon at Farmington Hospital. Several months ago, Dr. Dellahunt contacted you to defend them in a medical malpractice suit filed by the Fairdays, parents of his deceased patient, Joshua Fairday. Dr. Dellahunt said that Farmington Hospital's Chief of Surgery, Dr. Knowles, had recommended you from among the lawyers listed by his malpractice carrier – All Med Insurance, Inc. You were pleased by the referral. You had successfully defended a lawsuit claiming negligence in nursing care several years ago, and you know Dr. Knowles through community activities.

Dr. Dellahunt is a personable and caring doctor who lies awake at night regretting two decisions: to leave Arkansas and to undertake pediatric cardiac surgery. Dellahunt had always wanted to be a physician. Once at University of Arkansas's Medical School, surgery's excitement and dramatic curative impact were irresistible. An Ohio native, Dellahunt enjoyed Arkansas's slower lifestyle and mild winters and stayed on for general surgery and cardiac surgery residencies in Little Rock. Dellahunt's first years as a surgeon were spent performing some general surgery but largely adult cardiac surgery at Little Rock's hospital. Dr. Dellahunt is married with three children, between the ages of 16 and 10.

Three years ago, Dr. Dellahunt began looking into a move back to Ohio and was delighted to learn of an opening in Farmington, Ohio, where Dellahunt had gone to high school. The hospital was intent on launching adult cardiac surgery and then pediatric cardiac surgery. Farmington Hospital's Chief of Surgery, Dr. Knowles said the hospital would ramp 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 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.

Within their first year at Farmington, Dellahunt was indeed 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 only 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

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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 "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 a number of times before performing these surgeries solo.

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 that first six months but later 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 –babies 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 a number of 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 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

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more infants died within hours after surgery, Dr. Rasheesh reviewed their files and said 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, why the infants arrived at the ICU in difficult shape. Wilson and at least one of the nurses began challenging Dellahunt'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. 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 to any suggestion they weren't working as fast as possible. Dr. Wilson also pushed Dr. Knowles to purchase newer heart lung machines for neonates and special neonatal 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 believe other factors at Farmington Hospital were affecting outcomes and morbidity statistics. The ICU was Dellahunt's number one suspect. Acknowledging it is hard to put a finger on what was not being done well there, Dellahunt does not think Farmington's nursing staff or ICU physicians are too sharp. In fact, 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. Wilson appears to have initiated a campaign against Dr. Dellahunt. 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 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 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 hid explanations of what had occurred in surgery, and why morbidity was unavoidable in particular cases. Dellahunt was grateful for their professional courtesy and personal loyalty.

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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 your client] 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 report 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 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 your client from performing Arterial Switch operations, effective that minute.

Dr. Dellahunt was "outraged by this ambush." It meant that Wilson had broken into 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 patient's history and surgery. 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-month period, 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 six-and-half month-old Joshua Fairday the next morning.

Dr. Dellahunt reflected: "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. Once again, Joshua's heart condition was extreme.[1] In

[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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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.

Your client admitted to being 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 called for a cardiologist consult in surgery, which took time. Numerous subtle aspects of the heart defect required repair. Later, Dellahunt was angry when an ICU nurse challenged their chart notation of Joshua being "pink" and having "tolerated surgery well" when Joshua entered the ICU. Joshua 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 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 procedures. A routine morbidity conference was held on the Fairday case shortly thereafter. Dr. Dellahunt reviewed the complexities of Joshua's heart condition. They seemed to understand the difficulties of his case, and did not challenge Dellahunt, perhaps because they understood Dellahunt would no longer do Arterial Switch surgery.

Eight months ago, five months after Joshua's death, Dellahunt noticed a column 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 had 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

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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."

A while later, the paper published a letter by Joshua Fairday's parents, purporting to "warn the community of danger at Farmington," alleging incompetence in pediatric cardiac surgery, and notifying parents that mortality percentages were "worse at Farmington than in other quality hospitals."

Shortly after that, the hospital's public relations director fielded a call from a local reporter indicating they were considering a more thorough investigation. Fortunately, hospital's public relations director 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. The same can be said of a terminated, disgruntled, former employee.
She noted that the story in this case (and any others) was in technical physiology and surgical details, which would not make interesting newspaper copy. The reporter backed off. You are not aware of any further reporting.

Still, Dr. Dellahunt was not surprised at being served with the complaint in a medical malpractice wrongful death suit, filed by Joshua Fairday's parents. Dellahunt was horrified by the words in the complaint, describing Dellahunt as incompetent, unqualified, grossly negligent, and having intentionally caused the death. Dr. Dellahunt couldn't bear to read it through. Distraught, Dellahunt went immediately to Dr. Knowles, who said that notice of the complaint had also been served on the hospital. Dr. Knowles advised Dr. Dellahunt to notify their medical malpractice insurance carrier and recommended you as a defense attorney from among those on the insurer's list.

A few months ago, you met with Dr. Dellahunt to review the terms of the insurance policy and obtain information needed to draft an answer to the complaint. You explained that you represent both Dellahunt and the insurance carrier. However, under the policy terms, the case cannot be settled without Dellahunt's approval. You said if there were a coverage issue, Dellahunt might need independent counsel. Fortunately, Dr. Dellahunt's medical malpractice policy seemed to cover all claims made at this point. The policy limits are $2 million "per occurrence," which could be needed in cases of brain damage or debilitating physical injuries. However, you explained that wrongful death claims on behalf of deceased children are typically settled for far, far less than that. You also know that All-Med Insurance will NEVER authorize anything close to $2 million or even $1 million to settle this claim.
Dr. Dellahunt seemed worried about settling because of the national registry on which settlements or liability verdicts are reported.

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In a later meeting, Dr. Dellahunt reviewed with you the details of Joshua Fairday's case as well as their medical training and experience [described earlier in this document].

Not long after that, you attended an early magistrate's case conference where the magistrate suggested mediation. Based on your advice, Dr. Dellahunt agreed to mediate and authorized you to approve any mediator who would be fair and not biased toward the plaintiffs.

You also explained the magistrate had permitted some preliminary, informal discovery in preparation for the mediation, including various medical and hospital records and information concerning the defendants' insurance coverage and policy limits. As you explained, you and the hospital's counsel had initially objected, but plaintiff's counsel made an oral "offer of proof" to the magistrate, describing Dr. Wilson's statistical study and the meeting on the evening before Joshua's surgery. The magistrate advised you both to provide the requested information, because "information produced for mediation is covered by the mediation privilege, unless otherwise discoverable. Besides counsel, let me tell you right now that if I were ruling on a formal motion for discovery in this litigation, I'd allow it."

Dr. Dellahunt expressed concern that the magistrate appears to have been impressed by mention of Wilson's statistics. As Dellahunt explained, "one must understand that statistics work in funny ways. When absolute numbers of surgeries performed are small, a short run of bad luck and a small number of difficult cases can dramatically affect percentages." You made no comment.

The mediation was scheduled for a few months later, to give both sides time to select a mediator and to have Joshua's medical records and other documents reviewed by independent experts. (You later suggested and Dellahunt agreed that, for the purposes of the mediation only, you and the hospital might retain the same expert.) The lawyers agreed to exchange expert reports a week prior to the mediation. Everyone agreed that parties and party-representative with full settlement authority would attend the mediation.

Last week, you received and sent copies of the expert reports to your client. You were relieved to see that your expert, a semi-retired cardiologist from Columbus (recommended by the insurance company) concluded that the patient had a difficult 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, stating that Joshua's TGA was not worse than most others 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.

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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. The experts dismissed the claim 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." 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 expertise by the surgeon or surgical team, and "falls below the current standard of care barring unforeseeable or unusual characteristics of the TGA defect."

Dr. Dellahunt called after seeing the reports and was clearly distraught by phrases in the report such as "below the standard of care" and words in the complaint such as "intentional" and "negligent.". You explained that is the usual language: parents are emotional, often looking to blame someone else for their son's congenital defect, and it becomes a battle of the experts. You also said any case has risk and acknowledged Wilson's statistics do not look great. Still, you tried to reassure your client by saying that juries tend not to find against doctors in their community.

In fact, after Dellahunt's phone call, you realized the complaint raises a remote coverage issue, because the standard medical malpractice policy (including his) does not cover intentional torts. You decided not to raise it at this point, given the lack of formal discovery. 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. You do not see this as the type of intentionality excluded from coverage. If the case does not settle and facts develop to make this a serious issue, Dellahunt might need separate counsel.

You advised Dr. Dellahunt to prepare for the mediation by thinking carefully about their interests, whether settlement would be preferable to trial, and if so, on what terms. While you doubt Dr. Dellahunt would ever want to do an Arterial Switch again, you understand the doctor's fear of losing their medical license or of not being granted clinical privileges to conduct surgery anywhere.

As counsel, you will prepare for the mediation by thinking through the plaintiffs' possible theories and your client's defenses and considering applicable law. While you did not want to alarm Dr. Dellahunt, you see a significant risk of liability here, even though juries generally tend to favor doctors. You are concerned that a trial or the mediation could turn into a finger pointing session between the hospital and Dellahunt, which would make both of them look bad. If they come into evidence, 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 you would never say it, based upon what you now know, you would hate to learn that a friend's child was scheduled for cardiac surgery with Dr. Dellahunt or at Farmington Hospital. You might reach a different conclusion if the defense expert's report were stronger. Frankly, you were

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underwhelmed by the credentials of the defense expert (retained by the insurers) and by the report's lack of thoroughness. The plaintiffs' expert report was predictable but sure sounds solid. If there is to be a credible expert defense, it will have to be stronger than what you have now.

Prepare to participate in the mediation, scheduled to take place soon. Prior to the mediation, you may want to talk with your client (again), the representative of All-Med Insurance, and perhaps the hospital's attorney.

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