The Remarkable Case of Dr. Christopher Duntsch

On Aug. 28, 2013, the Texas Observer broke the story about young Dr. Christopher Duntsch, who, fresh from completing his residency in Tennessee, had breezed into Dallas in late 2010. An M.D. *and* a Ph.D., Dr. Duntsch opened the Texas Neurological Institute, hired a marketing firm and nurses, put up a website, started seeing patients, and in November 2011 obtained surgical privileges at Baylor Regional Medical Center in Plano.[i]

Two months later, in January 2012, he performed a spinal fusion, a procedure of medium-level complexity, in which two vertebrae are joined and held together with a metal plate. During the procedure, Dr. Duntsch nicked the patient's vertebral artery, causing the space he was working in to fill up with blood. His patient woke up with no feeling in his left arm and suffered extreme pain for months. Later scans showed bone fragments lodged in the nerves of his back. A more experienced doctor later observed Dr. Duntsch had a hard time moving organs and blood vessels out of the way.

Three weeks later, Dr. Duntsch performed another spinal fusion, this time on a childhood friend. He cut into one of the arteries that runs along the spine, causing massive bleeding. To stanch the flow of blood, he packed coagulants around the cut, and in the process seriously damaged the patient's spinal cord. He failed to order tests and re-operate to fix the damage so that as of the date of this writing, his childhood friend and patient can no longer move his arms and legs.

The next month, on March 12, 2012, he performed a microlaminectomy, a fairly straightforward procedure, in which part of the spine is removed to relieve pressure on the nerves. The 55-year-old patient and her husband both found Dr. Duntsch impressive, even eloquent, and very self-confident.

For the third time, Dr. Duntsch cut one of the arteries next to the spine. This time, he didn't notice it in time, and his patient bled to death.

Dr. Duntsch resigned from Baylor Regional that month. (We have to ask ourselves, was he asked to? The Observer doesn't say.) Dr. Duntsch retained his full clinical privileges, which meant there was no discipline, no public record. He was free to continue seeing patients. Because it did not suspend Dr. Duntsch, the medical center was not legally required to report him to the National Practitioner Data Bank.

By July 2012, Dr. Duntsch was granted temporary surgical privileges at another hospital, the Dallas Medical Center. Of course, the Dallas Medical Center did a reference check as a part of the credentialing process. Another neurosurgeon at the Dallas Medical Center said that Baylor Regional reported to the effect that there were no issues with Dr. Duntsch's performance, that he'd been on staff and had voluntarily resigned. In other words, they confirmed his employment and offered nothing else. A subsequent lawsuit by

some of Dr. Duntsch's patients revealed that Baylor Hospital had given Dr. Duntsch a letter asserting he had no outstanding investigations or restrictions at Baylor.

This same neurosurgeon from Dallas Memorial says that Dr. Duntsch mentioned his last two surgical misadventures to the folks at Dallas Medical Center, but claimed they weren't his fault. According to Duntsch the first was a bad drug reaction, the second was complications from anesthesia.

The Dallas Medical Center gave Dr. Duntsch provisional privileges to perform five surgeries. The first three took place on three consecutive days in July 2012.

The first surgery was uneventful.

During the second surgery, Dr. Duntsch damaged the patient's vertebral artery. The patient suffered significant blood loss and a stroke, and lay dying while Dr. Duntsch moved on to his third surgery, another spinal fusion.

This third patient woke up from surgery in horrible pain that continued for months and eventually required remedial surgery by another neurosurgeon, whose postoperative comment was: "He (Dr. Duntsch) had amputated a nerve root. It was just gone. And in its place is where he had placed the fusion. He'd made multiple screw holes on the left everywhere but where he had needed to be. On the right side, there was a screw through a portion of the S1 nerve root. ... He just had no recognition of the proper anatomy." His third patient is a partial paraplegic.

Dr. Duntsch was reported to the Texas Medical Board, but continued to practice neurosurgery. In December 2012, he did a cervical fusion that left his patient with paralyzed vocal cords. In January 2013, a patient became paraplegic.

In May 2013, University General Hospital arranged for a special dinner at an expensive uptown restaurant to celebrate the new addition to their medical staff, one Dr. Christopher Duntsch.

In June 2013, Dr. Duntsch cut into the vertebral artery of yet another patient, and left a surgical sponge in his neck wound. On June 26, 2013, Dr. Duntsch's license was suspended. Up until June 26, 2013, as far as the public knew, he was a neurosurgeon in good standing.

Doctors can be expected to do whatever it takes to avoid accountability. It's never their fault. They are highly motivated and can be convincing.

Medical boards will discipline for behavioral problems like drug or alcohol abuse, sexual harassment or unauthorized disclosure of a medical record, but they are extremely reluctant to act on a performance issue and challenge the competence or possible negligence of a doctor. The first reason is simple: liability. Any such attempt would be

met by legal action against the board by the doctor and his attorneys. The dispute could last for years.

A second reason could be a reluctance to publicly admit to the possibility of physician incompetence. The medical establishment does not tolerate the slightest hole in the dam of public confidence in their profession.

In Texas, complaints about doctors are reviewed by medical licensing board staff. Only one out of four is sent to a panel of two (in this case, neurosurgeons) for expert review. The work and time of these two experts is volunteered, and as a result, there are few candidates for the thankless job. First of all, you have to pass critical judgment on the performance of a colleague, which is usually a conflict of interest and loyalties; secondly, there is no compensation; and thirdly, the process can go on for a very long time — years. Finally, there is the question of liability for both the board and its volunteer experts. This stands in contrast to malpractice lawyers, who will pay dearly for the necessary expert analyses. The attorneys' willingness to pay colleagues is the primary reason they are able to get frank, unbiased evaluations of the defendant doctor's work. Successful doctors would rather be practicing and seeing patients and making money.

The results of the credentialing process, including checking the references when a physician seeks clinical or surgical privileges at a new hospital, are privileged information. Suspensions and other disciplinary actions are also privileged. Information is shared on a need-to-know basis. And as far as the medical system is concerned, patients don't need to know. It seems that everything that might help patients is privileged and unavailable to the people who need it most.

Policing the doctors is left to the hospitals, and it can be very difficult to sue a hospital. In Texas, or anywhere else for that matter, to obtain privileged credentialing information to determine if the hospital complied with all the standards related to granting practice privileges is well-nigh impossible.

One of the doctors who reported Dr. Duntsch to the medical board concluded that Dr. Duntsch's patient-harm spree was "a one-in-a-generation occurrence." He felt the physicians serving on the medical board could not be faulted for taking so long to act; after all, they're not surgeons. "They just can't comprehend that an M.D.-Ph.D. neurosurgeon could do what Christopher Duntsch was doing," the doctor said.[ii] This is nonsense, akin to saying cops who fail to capture criminals can't be blamed because they're not criminals themselves, and therefore, don't understand what criminals do.

No one wants to break ranks. No one dares to offend the gatekeepers of the profession.

Hospitals that provide safe haven for marginal or incompetent doctors become a magnet for more of the same. Word gets around. The same goes for states that build walls of secrecy and protection around their health care providers. Incompetent physicians know where to go.

Even when physicians face malpractice litigation, there's little way future patients could ever find out. Almost invariably everything gets a gag order to protect the physician's reputation.

Is it that only physicians know the real story about patient safety, and how much is hidden that can never be exposed to public scrutiny? Everyone seems terrified of malpractice litigation, and yet the numbers don't justify the panic. Is it about what we are not allowed to see or know that goes on in every hospital in America?

Thanks to subsequent litigation, more has been learned about Dr. Duntsch's tragic trail of tears. The lawsuits allege that he was in treatment for drug abuse at the University of Tennessee, that he was abusing prescription drugs at Baylor and that he skipped out five times on drug tests there without penalty. The lawsuits contend that Dr. Duntsch kept a bottle of vodka under his desk, "that a bag of white powder showed up in his private bathroom, and that he took off for Vegas immediately after a surgery, leaving his patient unattended." In spite of numerous complaints about his surgeries, the hospital continued not only to allow him to continue practicing, but actively encouraged other doctors in the network to refer patients to him. Why was Baylor so blind? They weren't. According to the lawsuits, the hospital had advanced Dr. Duntsch $600,000, and if he didn't continue to practice, the hospital wasn't going to get repaid.[iii]

Texas laws give hospitals almost total immunity in malpractice cases. After all, medical associations, hospital associations and insurance groups are the ones with millions of dollars to spend on financing political campaigns. Who stands up for the patients? As they like to say in Texas, patient-safety advocates are all hat and no cattle. No money, no connections, no clout. Injured patients who are nothing more than fodder for the medical money machine have no recourse to justice except through people like me, plaintiffs' counsel, the lawyers everyone loves to hate.

Dr. Duntsch's case is an extreme example of the how the medical industry protects its own — even the worst offenders — at the expense of patient safety. The systemwide refusal to submit to transparency or accountability, or even to conduct meaningful internal reviews and reforms, differentiate it from virtually every other industry, especially any other industry so influential in matters of life and death.

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[i] Elbein, S. (2013, Aug. 28). Anatomy of a Tragedy: Dr. Christopher Duntsch's patients ended up maimed and dead, but the real tragedy is that the Texas Medical Board couldn't stop him. *The Texas Observer*. The details of the Duntsch narrative are all drawn from The Texas Observer article.

[ii] Ibid.

[iii] Elbein, S. (2014, May 2). Licensed to kill: Lawsuit seeks to overturn Texas hospital shield law. *The Texas Observer*. Retrieved from http://www.theguardian.com/world/2014/may/02/texas-legal-doctor-lawsuit-christopher-duntsch.