Mitigating Malpractice Misery

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The medical malpractice experience has many adverse effects on physicians and on their practice community. Researchers report that more than 95% of sued physicians acknowledge some physical and/or emotional reactions. Given physician's general reluctance to admit emotional reactions, such prevalence is highly significant. The societal cost of defensive medicine has been estimated in the billions, and the resultant patient inconvenience or suffering due to false positives, iatrogenic complications, wasted trips to medical facilities, etc, is appalling. Our purpose in this article is to reduce the stress of litigation for physicians and their community.

The Impact of Suit

Sued-physician responses can include the onset or exacerbation of a physical illness, such as peptic ulcer disease, cardiogenic distress, or insomnia. Emotional responses may range from anger to profound depression and even suicidal ideation. A number of medical communities relate stories of physicians who attempted suicide in reaction to the receipt or continuing stress of a suit.

Throughout the course and even following resolution of a claim for medical malpractice, the stress of the experience has continuing adverse impact on a physician's life. Sued physicians are more likely to stop seeing patients who appear to have a risk for untoward outcomes or a propensity to initiate a suit. In the wake of a claim, some physicians consider early retirement and many discourage their children from entering medicine.

After being sued, most physicians obsessively document, order more tests and consultations, and stop performing procedures that may result in complications, even when the procedures are appropriate and are performed competently. A physician facing a medical malpractice suit frequently avoids speaking with colleagues, can be shunned by colleagues or hospital administrators, and many imagine the case will damage their practice permanently. These maladaptive coping mechanisms can easily spill over into the home environment.

Being named in a medical malpractice suit initiates a host of other consequences. Since 1990, an entity making payments in settlement of a claim, except the physician on his/her own behalf, must report the provider to the National Practitioner Data Bank (NPDB.) Hundreds of thousands of reports have been made to the NPDB; the vast majority are due to payments made to settle malpractice claims. Many of these settled claims were considered non-meritorious, but were settled by insurers due to the possibly greater cost of trying the case. In North Carolina payments by insurers and by those who are self-insured must be reported to the North Carolina Medical Board.

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Health care institutions are required by law to query the NPDB when considering the qualifications of an applicant for staff privileges and must check their staff lists with the NPDB every two years. State medical boards and other recognized credentialing bodies may also use the NPDB as a data resource. Such bodies invariably request information regarding previous malpractice cases of each physician in the application process. Although physicians are afforded an opportunity to provide details of malpractice claims, bias or prejudice is often present, and negative histories may result in denial of credentials or state licensure. Providing these agencies the details of a case long over is time consuming, sometimes impossible, and always stress provoking.

Many insurers retain the right to settle claims on behalf of their physician insureds without the consent of the insured physician. This practice often results in payment for non-meritorious claims because the nuisance value of litigating the case is greater to the insurance company than the settlement demand. Most physicians feel the exercise of such a right is a blatant violation of their trust and their professional autonomy. Since insurance companies vary in this practice, every physician should read and thoroughly understand the coverage contract to avoid this pitfall.

Prevention

Prevention is by far the most effective strategy in mitigating the effects of malpractice claims. Most risk management experts agree that besides knowing what situations invariably precipitate calls to an attorney, effective communication is the most crucial deterrent to malpractice litigation. Components of effective communication include the following:

- uninterrupted listening during the critical first 60 seconds of the physician-patient interaction;
- demonstrating acknowledgement of the patient by the physician;
- setting up realistic expectations for the interaction;
- sharing responsibility regarding the outcome with the patient, family, and other providers;
- providing time-and-action-specific discharge instructions, including the expected time frame for follow-up or recovery;
- providing an opportunity for the patient to ask questions, which provides a last chance to address the patient's concerns or to show an empathetic understanding of them.[1]

When you are communicating well, the behavior of the person with whom you are communicating changes. True communication always leads to new behavior, and often greater compliance. People are motivated to change behavior when they sense being acknowledged. To acknowledge is to deeply listen to what another person is saying. As Itoh writes, "Your ability to communicate well depends on your ability to get the other person to talk—and your ability to listen to what the other person is saying. Listening is only listening when you hear all of what another person is saying, without judging, or denying, or comparing that person to yourself." [2]

Additional actions that decrease the likelihood of a malpractice claim include the practice of complete, legible, and timely documentation; maintenance of continuing education and board certification requirements; reading current, practice-relevant journals; and participating in quality assurance activities.

Understanding the typical pattern of the generation of the typical suit can help to avoid it. People seek legal advice when:

- unexpected medical results and complications occur without warning (surprises);
- injuries are perceived by the patient (or close friends) as "catastrophic," or the patient is the primary provider in the home;
- the relationship with their physician is

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rocky, fleeting, or unsatisfying;
- communication is incomplete, disappointing or a "failure";
- subsequent providers make critical comments about received care;
- they perceive a lack of empathy shown by the physician or associated staff;
- the patient and/or family don't understand a bad outcome and cannot get an adequate explanation.

Mitigation

Despite the best preventive measures, litigation may nonetheless occur. Physicians preparing to defend themselves must recognize that they will inevitably experience emotional reactions. Individuals confronting the litigation process should expect they will feel angry, hurt, disappointed, disillusioned, isolated, vulnerable, violated, or unjustly singled out.

Guilt is a common response, even if the physician rendered faultless care. Defendant physicians may question their competence or persistence in their profession. They may become ill, stressed, withdrawn, or depressed.

Initially, support systems may appear to be scarce. Colleagues or associates may not offer empathy or understanding, particularly if they have not yet personally experienced a medical malpractice claim. The affected medical department or hospital administration may not offer support but, instead, may take an adversarial stance. Even family and friends may be incapable of providing support or understanding initially. All of these groups may harbor the mistaken belief that bad outcomes and malpractice suits happen when physicians make mistakes or are "bad doctors."

Several avenues in addition to legal counsel are available to assist physicians in sharing the burden of defending a medical malpractice claim. Sharing feelings and explaining the basics of similar types of medical cases to family members can help to ease the stress and gain their understanding, support, and empathy. Strong and intrusive negative feelings should be discussed with a professional counselor. Privileged communications are possible not only with attorneys but also with spouses, clergy, and mental or other treating health professionals, including state physician assistance programs.

The malpractice carrier should be notified promptly of any claim or threat of claim, of any contact by an attorney, or any request for records. Such notification often is a condition of insurability, as well as a mechanism for dating claims. Defendants should plan to participate actively in the case and provide the defense counsel with complete details as promptly as possible. No part of any medical record should ever be concealed or altered.

Defendants should inquire of their counsel about the opposition's deposition and trial tactics, insist on obtaining the best witnesses, assist in answering interrogatories, read the litigation documents, and carefully prepare for their testimony. They should prepare for the fact that the claim will intrude on regular life experience regardless of personal or professional schedules. It is wise to reduce non-essential professional obligations, and especially to eliminate overbooking or rigid schedules at this time. This is because there is some evidence that there is a higher likelihood of a second case being initiated in the wake of a first case.

Some physicians seek coaching from an advocate to better understand the malpractice process and prepare for deposition and possible trial. Hiring personal co-counsel (your own attorney to assist in the case and monitor the attorney hired by the insurer) may also be prudent if the insurer informs the physician that the award or settlement amount may exceed policy limits, or if the insurer's attorney does not appear skillful, or to represent the best interest of the physician.

After a trial, the physician defendant should prepare for each possible outcome before the verdict is given. He or she must understand and accept that settlement is not an admission of negligence. The amount of any settlement is not proportional to the degree of culpability (if any) in the case, but to the relative expense of litigating the case to its conclusion, the costs incurred by the medical outcome, and emotional or cultural factors weighed by the jury.

Unfortunately, even dismissal of a case does not completely remove the stigma or stress of litigation. Litigation stress may mimic post-traumatic stress and undermine personal ease for years. Litigating a malpractice case typically takes years, and the process may be even more stressful than the outcome if the defendant is not prepared, educated, and supported throughout the case. Since cases proceed by fits and starts, there will be recurrent painful reminders of the claim, which some have likened to vicarious re-traumatization.

Prior to settlement of a claim, the physician defendant and attorney should explore whether avoidance of NPDB reporting is possible under the circumstances of the case. Also, with the attorney's assistance, a summary of the claim should be created, which usually includes the terms of the judgment, settlement, or dismissal. This document, along with appropriate copies of the claim and settlement or dismissal, can be submitted for future credentialing and licensing application purposes.

Learning

Regardless of the outcome, successfully confronting a malpractice suit can provide a growth experience. The knowledge gained from researching and defending the case can often be used to help change the environment and circumstances that have contributed to the suit (for example, upgrading diagnostic or treatment services available at the institution). Neutral third parties, such as the defense attorney, counselor, or law clerks, may provide insight regarding demeanor or habits exhibited by the physician under stress, which may be similar to the behavior that prompted initiation of the claim! Better communication and coping skills can be learned from a coach who has been consulted because of the stress of the claim process. Analyzing and altering negative or abrasive behavior will improve all facets of life.

After the case is concluded, a sued physician may want to share the experience with others facing litigation or those facing similar stresses, such as disciplinary proceedings, divorce, serious illness, or practice dissolution, in a peer setting or a support group. Physician defendants can and are now motivated to educate the public regarding the limitations and constraints of medicine in general. The stress of dealing with medical malpractice litigation may additionally motivate society to look at alternative ways to manage errors, ambiguity, and the unavoidable risk associated with medical practice.

The practice of medicine includes the constant threat of medical malpractice litigation. When confronted with a malpractice claim, the physician should immediately begin building a personal support system including the best counsel available. Facing a medical malpractice suit is a tremendous challenge, but successfully negotiating the process enhances physicians' coping skills and may ultimately improve their practice of medicine.

References

1. The Bayer Institute for Health Care Communication offers a useful mnemonic for these components: "4E: we engage, empathize, educate, and enlist patients in management of their illness." For further information, call 800-800-5907.
2. Mamoru Itoh. *I Want to Tell You About My Feelings*. p 57. Morrow, 1992.

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