

Medical liability litigation as a disruptive life event

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Litigation is predictably stressful for surgeons. Our natural responses often compromise all aspects of our lives as well as our performance in the litigation process. To assist us in avoiding these consequences, Sara Charles, MD, professor of psychiatry (emerita) at the University of Illinois at Chicago College of Medicine, and Paul R. Frisch, JD, general counsel for the Oregon Medical Association, provide us with insight and direction for dealing with these complex emotions in a recent publication, *Adverse Events, Stress, and Litigation: A Physician's Guide*. The article by Dr. Charles that follows is a glimpse into the content of this important book. For comprehensive information on this subject, surgeons may also access the Physician Litigation Stress Resource Center at <http://physicianlitigationstress.org>.

—F. Dean Griffen, MD, FACS,
Chair, ACS Patient Safety and
Professional Liability Committee

“This was the most disruptive experience of my life. I feel I am better after it but only because I decided I could be bitter or better, and I chose the latter...”
—Anonymous surgeon

Disruptive:
to upset the order of; throw into confusion or disorder; from the German *rupja*, meaning “to rip” or “to snatch.”¹

The disruption physicians feel under the impact of an adverse event or being sued motivates us to unearth the roots of these feelings so that we may examine them carefully. What we learn tells us what we can and cannot control to clear our heads and restore order in our lives. The experienced surgeon quoted at left had tried unsuccessfully to save a six-year-old boy who had sustained head trauma after an automobile accident. He was subsequently sued, along with the driver of the automobile, and charged with “wrongful death.” This surgeon offers a model for responding to an event that he not only experienced as traumatic but which he transformed, by his decision to be “better” rather than “bitter,” into a life-changing opportunity.

Adverse Events, Stress and Litigation: A Physician’s Guide (Oxford University Press, 2005. ISBN 0195171489) advocates this approach by exploring the human reactions to serious adverse medical events and the lawsuits that may result from them. Through a series of interviews with physicians and patients, this book tracks the emotional and legal impact of these experiences and offers practical and supportive advice to those similarly affected.

Paralleling these goals of the surgeon, the book encourages physicians to take an active role in their defense and supports their efforts to become informed and to avail themselves of the support of family members and colleagues during the lengthy litigation process. Its guidelines help physicians cooperate more fully with their legal and insurance counsel in order to become more effective and, hopefully, more successful defendants.

The roots of disruptive feelings

Two key factors contribute to physicians’ feelings prompted by the litigation experience: the impersonal nature of tort law and the highly personal, obsessive-compulsive personality features most physicians demonstrate.² A tort, in contrast to a criminal complaint, is a perceived wrong in which the plaintiff must allege and prove negligence in order to obtain compensation. Obsessive-compulsive personality features include a preoccupation with orderliness, perfectionism, and mental and interpersonal control, along with an excessive devotion to work and productivity. These two factors converge in medical liability

cases when a charge of negligence is made. The interplay between these factors profoundly affects physicians' thinking and behavior. As stated in *Adverse Events*:

Under the impact of a lawsuit, these characteristics may morph into exaggerated and destructive tendencies: Where we once appropriately considered options, we are now obsessed with immobilizing doubts; where we once felt guilty over falling even slightly short of a standard, we are now morbidly self-critical; where we once exercised an exaggerated but controlled sense of responsibility, we now condemn ourselves for not managing circumstances well beyond our control. By eroding our self-confidence these distortions make us miserable. Such a state of mind on our part is exactly what the plaintiff attorneys hope for and depend on: they want us to doubt our competence and to feel guilty and personally responsible, even if we are not, for whatever happened.

Understanding the sued physician

The key to mastering any traumatic experience is readiness to explore the emotions associated with it, to organize it intellectually to deepen understanding of it, and to correct any possible distortions about it that may be harbored.

Physicians' personality characteristics and individual life history strongly influence their reactions to a bad outcome or a lawsuit. Even if a physician has multiple experiences with lawsuits, each one remains unique and demands a different response. Most physicians experience the accusation of fault as an assault on their sense of integrity. When physicians pride themselves on competence and dedication, this painful allegation of failure to meet the standard of care is profoundly disruptive. One cannot begin to address and control these feelings until identifying their roots, naming them correctly, and acknowledging the threat they pose.

Sued for the first time near the end of his career, an internist experienced his first episode of atrial fibrillation the day after the complaint was filed and poignantly describes his feelings in *Adverse Events*:

I had guilt about being involved in a case like this. An individual prides himself on his clinical

acumen and his attention to detail. It's a blow to the image I had of myself, my code of behavior that I tried to live up to. I'm sure I didn't always do it but I tried to live up to that word (honor) in that the patient who came to me could put his trust in me and I would be his advocate and always try to act in his or her best interest. That was the image that I wanted to convey and also the image that I wanted not only my patients to come away with but also my colleagues that I worked with in the community. It was my impression that I was generally thought of as an honorable person upon whom you could rely and who tried to do a good job.

His lawsuit disrupted his self-concept and prompted him to review objectively his competence and motivations. The lawsuit challenged his healthy narcissism and his self-ideal—that he was a good, caring, and beneficent person who placed the care of patients above his own self-interest. He felt offended and misunderstood. The feelings of guilt, shame, and humiliation with which physicians often react may prompt them to protect themselves by avoiding contact with their colleagues and withdrawing from some of their routine activities. Instead of wallowing in negative feelings and avoiding others, this internist reevaluated his practice, actively rededicated himself to his work, and made changes in his work environment that restored some feelings of control.

Litigation also probes the need for self-preservation. Physicians ordinarily feel devastated both by the patient's terrible outcome and by the charge of negligence that follows. After being accused of allegedly having made discriminatory remarks, CBS commentator Andy Rooney uttered words with which many physicians can identify: "It is not clear to me whether I have been destroyed or not, but I know that a denial from anyone does not carry anywhere near the same weight as an accusation."³ A lawsuit threatens physicians with many potential losses—loss of reputation, time, patient base, affordable liability insurance—and the potential of financial uncertainties that may lead to closing one's practice or retiring prematurely.

"The loss of trust in others" is identified by psychiatrist Jonathan Shay, MD, PhD, as the "deepest danger" associated with any traumatic event.⁴ An

adverse event or lawsuit may disrupt relationships with formerly trustworthy patients⁵ along with those colleagues, staff, and even family members who do not understand one's reaction. A formerly satisfied patient may become accusatory; once trustworthy colleagues may become mildly suspicious and distance themselves; and the system that accepted the physician and in which he or she fit well may become blaming and withdraw support. Physicians who experience this outcome must recognize and acknowledge these feelings of isolation and loneliness if they are to mend these relationships so central to productive work.

Putting the experience into perspective

Bad outcomes regularly occur in the human condition and often in medical practice in particular. Physicians recognize that, despite their best efforts, unexpected complications and even errors can occur, and it is normal to react emotionally to them. Their transformation into lawsuits, in the words of an obstetrician-gynecologist quoted in *Adverse Events*, "just prolongs the agony."

How many of these adverse events actually precipitate a lawsuit? Sometimes those that seem to bristle with the threat do not; sometimes those events that seem minimally dangerous become major lawsuits. Localio and his group estimate that there are 7.6 adverse events caused by negligence to every liability claim.⁶ Matching medical records and medical liability claims, however, revealed that the number of adverse events caused by negligence that actually led to claims was 1.53 percent. This difference is explained by the fact that most events for which claims were made in this study did not meet the researchers' criteria for negligence. The work of Brennan and the earlier work of Danzon suggest that the severity of injury, rather than any suggestion of negligence, is a central factor in filing a liability claim.^{7,8} This explains why specialty looms large in the claims vulnerability of physicians: surgeons and obstetrician-gynecologists are far more likely to work with patients who sustain serious permanent injuries and death than are pathologists and psychiatrists.^{9,10}

The popular culture readily assumes that physicians involved in catastrophic medical events and/or those sued for medical liability are bad

or negligent doctors. Two data sources put the results of this perception into perspective. According to an American College of Obstetrician Gynecologists 2003 survey, 76.3 percent of its members had been sued at least once and can expect an average 2.64 medical liability claims during their careers.¹¹ The Physicians Insurers Association of America's national claims database of more than 40 member physician-owned insurance companies—which closed 184,950 claims between 1985 and 2003—found that 69.9 percent were closed in the defendant's favor (63.3% were closed without payment; 5.4%, in a defendant's verdict at trial; and 0.2%, a defendant's favor at mediation).¹²

The primary goals of the medical liability system are compensation for those injured in the health care system and the deterrence of poor medical care. Few critics of the tort system believe that these goals are currently being achieved.¹³ As noted above, the vast majority of claims are closed without any payment to the injured patient—and often it is not the worst but the best physicians who are sued in liability claims. Lawyers, patients, insurers, health policy makers, patient safety experts, and medical experts all have varying interests in and views on the system and its usefulness to society. As a result, change in the system is slow and subject to widely divergent interests. Because emotions among the participants run high, compromise and resolution are not easy to achieve. Despite the fact that physicians are only one of many participants in the medical liability system, they remain the primary focus of the litigation that engenders emotional disruption that is sometimes life-changing for them.

Disclosure of adverse events

Many physicians believe that straightforward honesty about their role in a bad outcome increases their chances of being sued. They are also wary that, if a claim is made against them, any expression of regret or sympathy may be translated into a legally binding admission of fault. Furthermore, disclosure means different things to different people. For many physicians, disclosure carries the connotation of an acknowledgment that implies the disclosure of something that has been or might be concealed.

Will acknowledging that a mistake has occurred and that the physician is truly sorry this has happened imply something physicians do not intend—that is, are physicians actually stating responsibility for the event? Can empathy be expressed without a possibly ambiguous apology?

Increasingly, state legislatures are writing laws that protect physicians' statements of sympathy from being admitted as evidence in a medical liability case. But the devil is found, as usual, in the details. In California, for example, apologies are protected but specific admissions of fault are not.¹⁴

Although most physicians believe in full disclosure, they also know the realities of medical liability litigation and the law that governs it. Most institutions and liability insurers support the disclosure of mistakes while cautioning physicians about how candid this disclosure should be. Most companies suggest that physicians should never speculate about fault and that they contact the insurer before assuming any culpability for the outcome. The insurability of the physician who fails to do so may be questioned. But, whereas some insurers caution physicians, others allow them to use the word "sorry" to express regret for an incident. Physicians are responsible for becoming familiar with the specific disclosure policy of their insurers and health care institutions as well as the parameters of any disclosure law applicable within their jurisdiction.

Mastering the experience

Three major strategies are used buffer the impact of any stressful life event: restoring feelings of control, social support, and changing the meaning of the event (see box on this page). Because litigation disrupts the usual order of life, measures aimed at restoring feelings of control are useful; and because litigation leaves a physician feeling isolated and in the spotlight as negligent, he or she may feel alone when facing the charges, shunned by colleagues or abandoned by the institution. Support from those who respect and cherish a person restores feelings of equilibrium. The charge of negligence brands a physician as a "bad doctor" or negligent or incompetent. To repair the sense of self as a "good" physician in a bad situation, such perceptions must be reviewed objectively and revised accordingly.

Reestablishing control

The need to be in control is a prime professional and personal characteristic of physicians. This dynamic, which is both a strength and a need, must be understood if physicians are to monitor their reactions and responses to the pressure of litigation. In the service of both their personal comfort and their professional competence, they must experience a degree of mastery over and certainty about the decisions they make and know that these decisions may alter quickly when the unexpected happens. This professional freedom depends on their observing and managing the ever-present tension of fallibility and vulnerability, being human and so capable of making mistakes and incapable of knowing everything.

The pressure associated with clinical decision-

Useful strategies for coping with litigation

Obtaining social support

- Discuss feelings about the case with a trusted confidant

Regaining control

- Become informed about the legal process
- During periods of increased stress, rearrange office and surgery schedules
- Avoid situations that generate anxiety and increase risk
- Reevaluate time commitments
- Seek consultation on financial and estate planning
- Participate in leisure time activities such as active sports and exercise
- Schedule the necessary time to participate in the defense of the case

Changing the meaning of the event

- Nourish the conviction of being a "good" physician rather than "bad doctor," as portrayed in the complaint

Adapted from *Adverse Events, Stress, and Litigation: A Physician's Guide*, Table 8-1, page 127.

making is also a function of patients' expectations and demands that physicians be both infallible and omnipotent, that they be gods instead of mortals. If physicians cannot make a healthy distinction between the reality in which they are immersed and the impossible ideal in which they are draped, they may lose their balance and become anxious and indecisive, almost certainly increasing their risk of making an error.

Physicians' long training period teaches what they must do, even below the level of consciousness, to maintain sufficiently good control in their daily work. Despite their training and experience, this tension, according to medical sociologist Renee Fox, may be a lifelong companion for doctors because the "basic human-associated stresses and dilemma...cannot be eliminated."¹⁵

Being sued shatters the delicate balance of these factors, forcing physicians to work diligently to preserve it. Determining who in the incident was in control and, therefore, responsible for the "bad outcome" is the subject and object of litigation and its draining protocol of depositions, motions, and trials. This issue of who exercised control preys on physicians' feelings of fallibility and vulnerability and the demand—partly internal and partly external—that they should be in absolute control over every event. Physicians are suddenly forced to question how much control they actually had over the incident and to wonder about all their past and future choices.

Physicians can deal with feeling a loss of control by taking control of those controllable aspects of their lives. One may not be able to determine how other defendants or experts will testify, which judge is assigned to the case, or the pace at which the case proceeds. One can, however, attend to the spiritual side of his or her life as a physician by rededicating his or her self to the profession and by reaffirming the commitment to patients. The strategies that other physicians have found helpful (see box, page 21) may also be of use to others.

Adverse Events, Stress, and Litigation: A Physician's Guide helps physicians to prepare for deposition and trial testimony and how to evaluate the ramifications of settlement or going to trial. Feelings of control and self-esteem are restored by taking the case seriously, preparing

well, and working closely with attorneys throughout the entire process.

Obtaining social support

The single greatest help in any traumatic life event is the availability of other persons who can be understanding and offer support. Bolstered by such support, people regain equilibrium more quickly and are less likely to sustain long-term symptomatic disturbances.

Sued physicians, however, face a dilemma when the need for support is thwarted by the advice of lawyers. After any serious or catastrophic event, it is healthy and human to want to talk about it. Yet, lawyers caution to "not talk to anybody" about the event. They do not want a physician with pending litigation to say anything that might suggest culpability and therefore jeopardize the defense of the case. This book encourages physicians to talk directly about their feelings in a way that respects the concern of the lawyers. One can talk about personal feelings with a trusted confidant while restricting discussions of the technical details of the case to conversations with legal counsel, claims professionals, or other persons whose relationship with a litigant is protected by law. If, like others subjected to major life events, we act humanly and feel understood by others, a better perspective about the experience is gained and physicians become better defendants. Suppressing the need to talk about feelings increases the risk of becoming emotionally isolated and more vulnerable to lingering effects of the experience.

Controlling thoughts

A legal charge of negligence profoundly disrupts thinking. Physicians' obsessive personality traits render them vulnerable to repeated mental reviews of what has happened and ruminations about whether there was negligence, if there were some other approach that might have been taken in caring for the patient, or if some other decision could have been made based on the facts present at the time. People are sometimes their own harshest critics, and only concerted effort controls such thoughts—but they can be mastered in various ways.


Viewing the lawsuit within the totality of a career reinforces the belief, "I am a good

physician.” All physicians have had less than satisfactory outcomes on occasion or have made decisions they later regret or would reconsider. Most physicians experience only one medical liability lawsuit during an entire career. There is a need for realistic comparison of the relative frequency of patients’ good outcomes and the relative infrequency of medical liability suits. One case does not make a physician “bad.” The reality of the situation is this: Good physicians find themselves in a bad situation or in one that is perceived as bad, whether it truly is or not.

Physicians help themselves by realizing that the current medical liability system is widely considered as an inefficient mode of compensation and that it does little to deter negligent medical care.¹³ Understanding the system’s function and the role of physicians in it may not be comforting but it puts the charge of negligence into perspective.

Conclusion

In *Adverse Events*, Mary Santos, an obstetrician-gynecologist, describes her mindset during a liability suit that spanned nine years and a trial of more than two weeks that led to a defense verdict: “I treated it like an adventure. I would not let it interfere with my love of medicine and my patients. I would be a better doctor. I would meet amazing people. It was a terrific challenge. Not allowing the negative distractions associated with the case to interfere with my focus and taking time away from patient care during the trial were important lessons.”

Like the surgeon who chose to be “better” rather than “bitter,” Dr. Santos viewed her litigation experience as an intensely human and deeply challenging experience. By participating actively and assertively, both physicians mastered the experience that enhanced, rather than diminished, their pride in their work and their good feelings about themselves. 

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