Risk Matters: What to Keep Out of the Medical Record

By Jeffrey A. Woods, JD

At SVMIC, we stress the importance of accurate and timely documentation and for good reason – in the event of a claim or lawsuit, the medical record will be the most important piece of physical evidence. But, just as important as what to include in the medical record is what **not** to include.

Only clinically pertinent patient-care-related information should be entered in the patient's medical record. Documents that do not constitute the official medical record should be kept separate from the medical record and restricted from disclosure. Examples include incident reports, privileged documents, and correspondence with SVMIC.

Most communications with your attorney are legally privileged and, as such, are not subject to discovery. Similarly, communications with SVMIC relating to a lawsuit, claim, or even a potential claim may also be privileged. These communications should be kept separate from the patient's chart, thereby eliminating the possibility of being photocopied

or provided to the opposing party without a court order specifically compelling their production.

The record should contain only facts and objective clinical judgment. Remarks on a patient's personal characteristics are not appropriate. Examples of terms or phrases not to use in the record include "Drug-seeking," "Drunk," and "Liar/lying." Finally, billing records and peer review documents should also be kept out of the medical record.

Exciting New Risk Education Options for 2022

By Shelly Weatherly, JD

SVMIC is pleased to announce that beginning in January 2022, we are offering e-learning courses that provide 5% premium credit and 1 hour of CME (in addition to our traditional 10% premium credit/2-hour CME courses, which will still be offered). These easy-to-digest courses, being offered in response to policyholder requests for more diverse risk education options, will provide a greater variety of current and relevant risk topics.

SVMIC will continue to offer e-learning courses that qualify for 10% premium credit and 2 hours of CME. Additionally, we are hopeful that we will resume a live risk education program in 2022, focusing on physician wellness and burnout, that likewise will provide 10% premium credit and 2 CME hours.

The addition of the 5% courses is strictly intended to provide more options. Physician policyholders remain eligible to earn up to 10% premium credit, and may bank up to 10% premium credit, annually. In order to receive the maximum 10% premium credit, physician

policyholders may complete one 2-hour course or two 1-hour courses annually. The Vantage® education reporting will be updated on January 1, 2022 to display members' completion of both 5% and 10% courses.

We are also happy to announce that we will continue to offer all risk education courses free of charge in 2022 and beyond. This includes not only the e-learning courses but the live seminars as well.

Both of these initiatives serve to reinforce our dedication to supporting our members through education and resources that help improve patient safety and reduce malpractice claims.

Any policyholders or practice managers who have questions regarding the new 1-hour offerings can obtain more information through the Vantage portal, by calling SVMIC at 800.342.2239, or by email at ContactSVMIC@svmic.com.

Obligations of Medical Practices in Responding to Data Security Incidents (Not Just Data Breaches)

By Justin Joy, JD, CIPP

Physician offices, hospitals, banks and even pipeline companies; nearly every day, there is a story somewhere about a data breach impacting these types of organizations. What is not as well publicized, however, are the much more frequent security incidents that impact any organization that has an information system. Some of these security incidents may meet the legal definition of a data breach, while most others, although potentially bothersome, do not rise to such a level. There are no means of measuring the number of security incidents impacting organizations, especially attempted but unsuccessful efforts, as many security incidents may go undetected. By some estimates, however, these incidents total in the thousands each day.[1]

Physician practices need to be aware of their obligations in responding to a security

incident, regardless of whether or not the event meets the definition of a breach under the HIPAA Breach Notification Rule. By definition of the HIPAA Security Rule,

- a security incident is “the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.”[2]
- a breach is defined as “the acquisition, access, use, or disclosure of protected health information in a manner not permitted under [the HIPAA Privacy Rule] which compromises the security or privacy of the protected health information.”[3]

From a high level, the definition of security incident encompasses the definition of a data breach. In other words, every data breach is a security incident, however, every security incident is not a data breach. Whether or not a security incident constitutes a data breach, the HIPAA Security Rule requires that covered entities identify, investigate, respond to, and document security incidents. These incidents may come in a variety of forms, including the following:

- an unauthorized attempt to gain access to systems such as email and networks
- installation of malicious software (“malware”) such as ransomware
- the loss or theft of a device containing data
- the unauthorized or unintended disclosure of information

Fundamentally, in order to respond to a security incident, the event must be able to be identified. Medical practices have an obligation to have systems in place for detecting security incidents and alerting of their occurrence. Many of these detection systems may be technical in nature, such as intrusion detection systems and antivirus software that generates an alert when it discovers certain threats. However, even the most sophisticated and up-to-date systems and software are not capable of detecting all security incidents. Each member of a covered entity’s workforce must know how to identify a security incident and know his/her individual responsibilities in acting when they discover such an incident.

As noted above, even small organizations can be the target of hundreds or even thousands of potential or attempted security incidents daily. As part of a medical practice’s policies and procedures, it should define what type of event constitutes a security incident requiring investigation and other action. Fortunately, most events, although potentially malicious in intent, are automated and not specifically directed at the organization or any specific individual. It is likely reasonable for a medical practice to conclude, as a matter of policy, and that no formal investigation or other response is required for these random, automated, and likely frequent events.[4]

In contrast, for other more targeted attempts, whether successful or not, a practice’s incident response policy will require an investigation and other actions. An example here is an employee who is locked out because of an excessive number of failed login attempts, but it was a malicious actor, not the employee, attempting to login. Again, many security incidents, such as this example, may not meet the legal definition of a data breach, but nonetheless require some level of prompt response to confirm there has not been a

breach, mitigate any harmful effects of the incident, and document the incident along with the outcome of the investigation.

It is important for medical practices to be mindful that, under the HIPAA Breach Notification Rule, a data breach is considered discovered from the day the breach was discovered by the covered entity, or the date, in exercising reasonable diligence, the breach should have been discovered. Many security incident investigations are complex and require considerable examination before a legal determination can be made as to whether a breach has occurred. Some leeway may be provided in certain circumstances when reasonable efforts have been made to investigate a security incident, but given the action covered entities are required to complete within 60 days (and in some cases, even sooner) of discovery of a breach, security incidents must be promptly investigated. Relatedly, agreements with business associates must contain a provision requiring the business associate to report breaches to the covered entity when discovered by the business associate. While the HIPAA regulations provide a default of up to 60 days for the business associate to report a breach to the covered entity, it is typically advisable that a contract with a business associate contain a much shorter period in which to report discovery of a security incident.

Developing and implementing a security incident policy and procedure is one of the best ways for a medical practice to prepare itself to take the necessary actions when it finds itself faced with a security incident. Like nearly every other policy and procedure for a medical practice, a security incident policy and procedure needs to be developed and implemented specifically for the unique operations of the practice. This often takes the form of a security incident response plan. While each incident plan document needs to be specifically developed and implemented, there are several common components that most plans need in order to be effective and comprehensive.

- The plan needs to provide the specific definition of a security incident, which should be based in substantive part—if not verbatim—on the definition found in the HIPAA Security Rule.
- The plan may also specify types of events that do not require an immediate investigation response because of their minimal or nonexistent risk.
- The plan also needs to identify the individual, who can be the HIPAA security and/or privacy officer, within the organization that workforce members should notify upon discovery of a security incident.
- Relatedly, the plan document should also identify the members, either by position (such as IT, HR, marketing/PR and legal counsel) or by name with contact information, of a team or committee of individuals who will be activated in the event a response is required. External resources, such as SVMIC, should also be included in the plan.
- Finally, requirements related to documentation should be included as well, perhaps providing sample reporting forms upon which the information to be collected about the event is to be provided.

Once the plan has been developed and implemented, it should be reviewed periodically, preferably by the members of the incident response team, with changes made as needed. Those involved in handling incident responses for an organization should be familiar with the general steps of the plan. The midst of a security incident response, which can often be chaotic and complex, is not the time to realize there are areas of the plan that are confusing and incomplete.

While it is no longer a matter of if, but when, a medical practice will experience a data breach, it is only a matter of hours, if not minutes, before a practice may experience another security incident. While most security incidents do not meet the legal definition of a data breach, some security incidents will require a prompt and diligent response. Promptly contact SVMIC if an incident is discovered and there is any question or concern about how your practice should respond. Addressing security incidents has unfortunately become a routine requirement for medical practices. Be sure that your practice is adequately prepared to fulfill its obligations regarding these events when they occur.

[1]. One of the first known efforts to quantify hacking attempts against computers connected to the internet revealed such an attempt on average every 39 seconds or 2,244 times a day. "Hackers Attack Every 39 Seconds," Security (Feb. 10, 2017), https://www.securitymagazine.com/articles/87787-hackers-attack-every-39-seconds.

[2]. 45 C.F.R. § 164.304.

[3]. 45 C.F.R. § 164.402.

[4]. Many of the events that fall in this random, automatic category are technical in nature, necessitating some technical knowledge for assessment as to whether an investigation should be categorically required as a matter of policy. HHS gives the example here of an automated "pinging" application to determine whether a computer is accessible at a specific IP address, which is often done for malicious surveillance efforts. U.S. Department of Health and Human Services, "What does the Security Rule require a covered entity to do to comply with the Security Incidents Procedures standard?", HIPAA FAQs for Professionals (July 26, 2013), https://www.hhs.gov/hipaa/for-professionals/faq/2002/what-does-the-security-rule-require-a-covered-entity-to-do-to-comply/index.html.

A Cautionary Tale

By Jeff Williams, JD

Smart phones and other handheld devices are ubiquitous in our society. They are used in the medical community for professional and personal purposes continuously throughout the day. With the increasing use of these devices to communicate about patients, the line can be crossed not only as to liability concerns, but also privacy concerns.

Susan Dunbar[1] was a forty-four-year-old married mother of one. She lived with her adult daughter, Mattie, and second husband, Matt Dunbar. As a result of a severe beating at the hands of her biological father when she was an infant, Mattie was left with permanent, severe mental and physical deficits. While Mattie's biological father spent many years in prison, Susan remarried to Matt, who was by all accounts a good man. The two undertook the responsibility of caring for Mattie, a non-verbal, partially blind adult with severe mental deficits.

Susan lived with persistent lower lumbar pain for several years. She finally decided to seek treatment for this issue from her primary care physician. An MRI was subsequently scheduled to diagnose the problem. Other than the back pain, she had a history of obesity,

prior stroke, hypertension, and suspected sleep apnea.

On the day that the MRI was scheduled, Susan became very anxious about the prospect of undergoing the MRI. Upon her arrival at the hospital for the MRI, Susan told a staff member that she was claustrophobic and was experiencing a heightened level of anxiety about the process. Anesthesiologist Dr. Amanda Means evaluated Susan and noted her to be a suitable candidate for monitored anesthesia care. She also spoke to Susan about her anxiety and decided it was safe to perform the MRI while Susan was sedated. The sedation was 150 mg of propofol. Additionally, one milliliter of fentanyl was administered by IV due to her complaints of back discomfort. Certified Registered Nurse Anesthetist Joseph Gardner administered the anesthesia and would accompany Mrs. Dunbar into the MRI room to physically monitor the patient. An MRI tech would also be in the room.

Just prior to the MRI, Susan took a selfie with her cellphone and sent two consecutive text messages to her husband:

Susan: ***"I love you!"***

Matt: ***"Love you, what's going on?"***

Susan: ***"I.V. and wait."***

Additionally, before the MRI she posted a picture of her daughter and husband on Facebook with the caption:

"Getting an MRI – family here to support me! They are putting me to sleep. I'm really nervous."

Also, just prior to the MRI the following text message exchange took place between Dr. Means and CRNA Gardner:

Dr. Means: ***"They're just getting her ready now. She's extremely nervous"***

CRNA Gardner: ***"Total overreaction"***

Dr. Means: ***"HA HA. Typical"***

Mrs. Dunbar entered the MRI room accompanied by CRNA Gardner and was placed in the MRI scanner. Mr. Gardner was monitoring her oxygen levels with an O_2 sensor and was also observing her on an MRI-compatible monitor. Although capnography to monitor her end-tidal CO_2 was available for purposes of monitoring, it was not used. Capnography would have offered reliable, real-time feedback about the status of the patient's condition.

After the MRI had begun, Mrs. Dunbar's oxygen saturation levels ("sats") appeared irregular. CRNA Gardner had access to the patient's head and performed a jaw thrust procedure, which appeared to stabilize her oxygen saturation levels momentarily. Just

minutes later her sat levels again fell to a concerning level in the upper 80s. CRNA Gardner asked the MRI tech to stop the MRI scan and bring the patient out. To increase the oxygen levels, he retrieved a nasal trumpet and oxygen mask that was located outside of the MRI room. Mrs. Dunbar's sats again stabilized. Approximately four minutes later, her sats began to drop again, this time into the mid-80s. CRNA Gardner then retrieved and placed a laryngeal mask airway ("LMA"). The patient was struggling. The MRI tech brought CRNA Gardner an Ambu bag (manual resuscitator), so that oxygen could be provided to the patient in a more forceful manner. As Susan Dunbar's condition continued to deteriorate, she was removed from the MRI room. CRNA Gardner then used his cell phone to call Dr. Means, who responded immediately. Another nurse had become involved and observed that the patient was no longer breathing. A code was called.

CPR was started. To be sure the patient was not experiencing an adverse reaction to Fentanyl, an IV-push of Narcan was administered. Although initial attempts at establishing an airway were unsuccessful, Dr. Means was eventually able to do so. The patient was successfully resuscitated. Later, the records would indicate that from the time the MRI scan started to the time when she was resuscitated, thirty minutes passed. Susan Dunbar had suffered an anoxic brain injury. With the consent of the family, life support was removed a few days later.

The family filed a lawsuit against Dr. Means, CRNA Gardner, and the hospital alleging wrongful death. The allegations against Dr. Means were failure on her part to appropriately evaluate the patient, failure to be physically present during anesthesia, failure to assure the patient's oxygenation, failure to appropriately monitor, and failure to ensure timely and appropriate resuscitative efforts. The allegations against CRNA Gardner included failure to ensure the patient's oxygenation, failure to appropriately monitor the patient, and failure to recognize and timely respond to a medical emergency.

In every case in which there is an allegation of medical negligence, the plaintiff must put forth competent experts in the same field that the defendants were practicing at the time the alleged negligence occurred. Here, the plaintiff produced an anesthesiologist and a certified registered nurse anesthetist to testify that there were deviations from the standard of care. It became clear as the case developed that the primary target of the case was CRNA Gardner.

The evidence would show that capnography to monitor the patient's end-tidal $C0_2$ was readily available for use during the MRI. Choosing not to use capnography became a major issue in the case. Further, there appeared to be an appreciable delay from the time Mrs. Dunbar's condition was deteriorating in the MRI, to the time she was removed from the machine.

Plaintiff's experts were going to testify that the standard of care required better monitoring of the patient during the MRI. The two criticisms that became the focus of the case were that CRNA Gardner should have chosen to utilize the available capnography to monitor the patient's end-tidal CO_2 and should have responded in a more timely manner to the patient's respiratory distress. Both experts would testify that the standard of care required

the use of capnography to monitor her end-tidal CO_2.

As to the lack of monitoring with capnography, the Plaintiff's experts zeroed in on the patient's comorbidities, especially sleep apnea. The comorbidities, they argued, combined with the use of fentanyl and propofol, proved to be a fatal combination. The Plaintiff's theme in the case was that Mrs. Dunbar's condition was fragile, and, therefore, she should have been monitored more closely.

During the pendency of the suit, Plaintiff's counsel requested all text messages exchanged between any of the patient's medical caregivers to be produced. This is a common request in civil litigation. The text messages were produced, and Dr. Means and CRNA Gardner were questioned about them during their depositions. Did the text messages have an adverse effect on the patient's care or condition? No. Did the text messages have an adverse effect on the defense of the case? Absolutely. At a minimum, the text messages were an unnecessary distraction in a wrongful death case. All medical professionals should assume that text messages, e-mails, and any other recorded communications could become the focus of litigation. Plaintiff's counsel would certainly attempt to use the text messages against them.

In addition to the wrongful death damages that the family was allowed to recover in the suit, state law allowed the family to recover damages related to the continuing care of Mrs. Dunbar's daughter, Mattie, for the rest of her life. This caused the potential damages recoverable to multiply. This unusual wrinkle in the case provided for a challenging defense which was fraught with peril if tried before a jury.

At its most basic level, this case involved a 44-year-old patient who underwent an outpatient MRI and ended up dying due to complications of the sedation used during the procedure, which would be difficult for a jury to reconcile. Given the nature of this case, all parties agreed to mediate the matter. Ultimately, it settled without the necessity of trial.

This story is a cautionary tale. Medical practitioners should assume communications through text messaging, e-mail, and posts on social networks can be used against you in court. Here, Plaintiff's counsel intended to use Mrs. Dunbar's own social media posts just before her death to evoke the jurors' sympathetic emotions. Conversely, it was anticipated that plaintiff's counsel was also going to try to use the text messages between Dr. Means and CRNA Gardner to arouse negative sentiment amongst the jury.

In cases like this one, a healthcare provider's attorney will make arguments to the judge in an attempt to exclude such text messages from being seen and heard by the jury on the basis that the messages are overly prejudicial and lack relevance. A judge, however, is considered the "gatekeeper" of evidence and may or may not allow the text messages into evidence based on certain evidentiary rules and laws. In other words, there is no guarantee that this kind of evidence will be excluded from the jury's consideration.

Many medical practitioners do not use a secure messaging system to send text messages regarding their patients. They simply use their phone to send the messages like everyone

else. Be forewarned, this might constitute a breach of HIPAA and various state laws regarding patient confidentiality. Although text messaging is not specifically prohibited by HIPAA, all patient's PHI (Protected Health Information) must be appropriately safeguarded.

For more on this evolving topic, a video presentation by SVMIC's Director of Risk Education, Jeff Woods, J.D., titled "Practicing in the Age of Electronics" can be viewed in the Resources section of the Vantage® policyholder portal.

[1] Names have been altered.

Malpractice Litigation Stress: You Will Survive

By Michael Baron, MD, MPH, FASAM

A wise attorney once told me, “The road to serenity is not paved with litigation.” How true that is. Unfortunately, litigation is a familiar experience for those of us who practice medicine -- most of us will find our serenity traumatized by a lawsuit during our career. The stress can be overwhelming and even debilitating, but it doesn’t have to be. In this article we will discuss the sources of that stress and the ways to cope. I offer two common idioms to remember if you are sued for malpractice: “You are not alone,” and “You will survive.”

Fight or Flight

Physicians, like all humans, will respond to an external threat, even a non-violent threat, with a sympathetically mediated response. Although helpful in certain situations, it can be detrimental in others, especially when it involves a prolonged nonphysical threat, like the threat physicians experience when they are named in a malpractice lawsuit. Being named as a defendant in a malpractice lawsuit carries the same amount of grief and stress as the loss of a loved one.

Seeing your name on the initial complaint associated with alarming legal terms like gross negligence, below the standard of care, compensation, duty, patient injury and litigation causes a severe visceral reaction. The news that a lawsuit is forthcoming is perceived as a threat and feels like being kicked in the gut. Unfortunately, that feeling is re-experienced or may just never recede throughout the litigation process, which can take years. Just when the visceral reaction and emotions begin to settle down, they are brought right back up to the surface with the same gut-punch with every new message or document about the lawsuit. Just seeing the sender's name on the envelope or email can cause a Pavlovian response of sorts.

Every time a physician gets a new communication from their attorney, they start to relive the case. They go over and over it in their mind. The physician begins to second-guess themselves and have self-doubt. They are told not to talk about the case by their defense attorney so they can't even discuss it or ask a colleague or friend about it. For that reason and others, they become more isolated. They have guilt and may even experience toxic shame. In a diagnostic sense the physician is experiencing a trauma reaction, also called Malpractice Stress Syndrome. We will discuss this later.

Unfortunately, medical malpractice lawsuits are relatively common in the United States. Greater than 85 percent of physicians will face a malpractice claim during a 40-year career. The legal system is unfamiliar to physicians; it's not our turf. We don't know the rules, the language, the process or the procedures. We are not in charge. This is very difficult for many physicians. The good news is that almost half of malpractice claims are dropped, and another 25 percent are dismissed with no award or settlement. Overall only about 15 percent of malpractice claims are settled with a payment.

The Odds

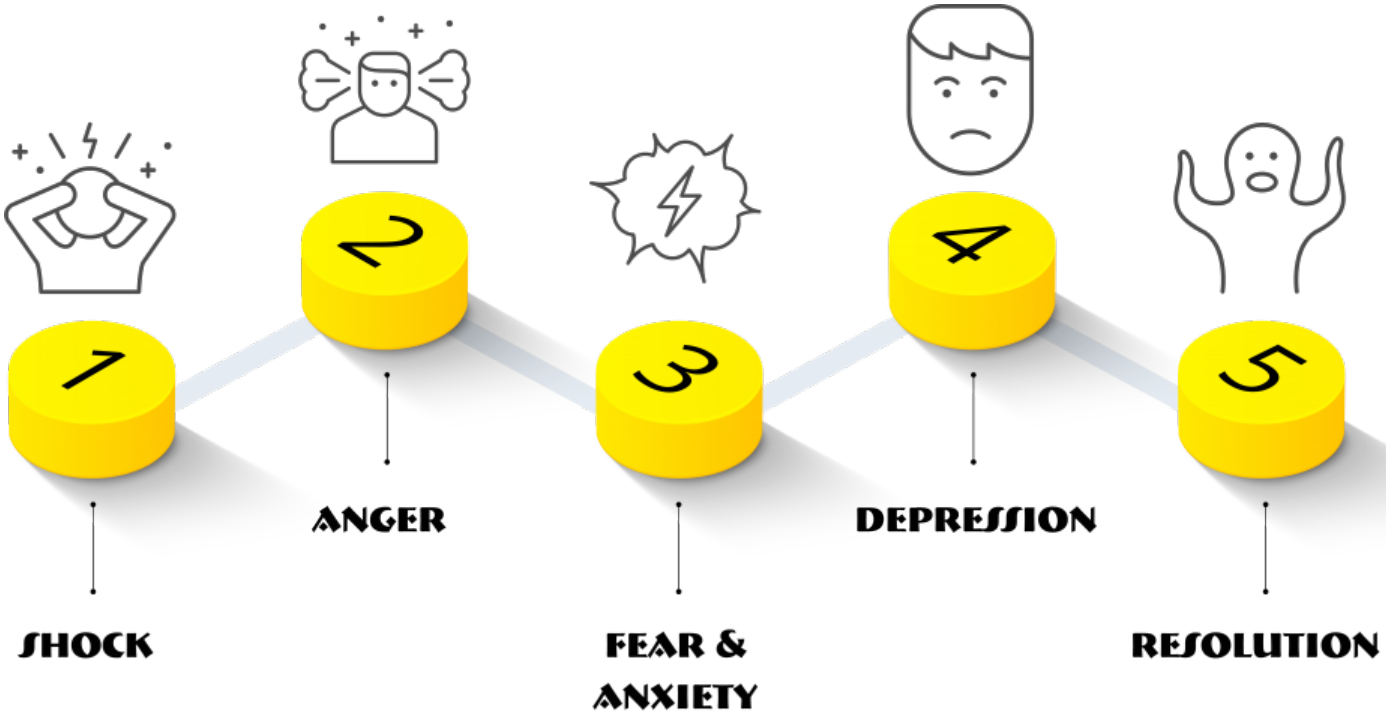
Although not every physician sued for malpractice experiences the trauma reaction described above, studies have shown that about 95 percent of us do report significant emotional or physical reactions when named as a defendant in such a case. About 40 percent of physicians who go through the complete malpractice litigation process will experience at least one episode of a Major Depressive Disorder.

Physicians have an exaggerated sense of responsibility. We will overwork to clear our own conscience that everything has been done and done correctly. We also have an exaggerated sense of self-doubt that we missed something, so we check and recheck. These traits foster a compulsiveness that makes us good physicians but can backfire on

us when we are accused and sued for malpractice. The loss or grief we feel is sometimes described as a loss of innocence.

These feelings are similar in many ways to the stages of the grief reaction first described by Kübler-Ross. The emotions described below do not always happen in a serial or linear manner. The processes of a malpractice lawsuit and our processing of emotions can cause us to cycle through these phases again and again.

Grief Emotions



Shock
The initial phase of a malpractice lawsuit is called the “Service of Process.” This is when the initial Summons signed by a judge and the written Complaint prepared by the plaintiff’s attorney are delivered together to the physician defendant. When the physician defendant receives and first reads the Service of Process, they enter the Shock phase. Most physicians have difficulty comprehending what they are reading. They feel terrible seeing their name associated with such inflammatory accusations and experience the visceral reaction described above. The inflammatory wording is purposeful; it raises uncomfortable emotions the plaintiffs hope will trigger the will for a quick settlement. Other symptoms associated with this initial stage are numbness, confusion, and easy distraction. The defendant physician may make self-soothing statements such as, “It’s fine” or “I’m fine.” Many physicians get their self-identity from being a physician and for many, it’s where their self-worth is realized. They have considerable difficulty with the defendant identification. Not only is it unfamiliar, it can be denigrating. All this is made worse when it’s unexpected

and the physician cannot remember the patient or the particulars of the case.

Anger
The Shock is quickly followed and often intermingled with Anger. The Anger phase is driven by frustration, resentment, embarrassment, feeling out of control, and shame. Physicians may begin to exhibit cynicism or detachment (symptoms of burnout). They may become sarcastic and irritable. Those prone to passive-aggressive behavior may start leaning more towardaggression. The physician's self-confidence may suffer. They may begin to question their own judgment and may assume that others are questioning their judgment as well. The physician will feel betrayed and may begin to distrust their own patients.

Fear and Anxiety
The Anger phase is followed by Fear and Anxiety. Paramount in this is the fear of financial insecurity. In this phase physicians will discuss with their malpractice insurance carrier the limits of their policy. They will want to know what happens if the plaintiff wins and the amount exceeds the limits of their individual policy. They may talk with their financial planner or personal attorney to try to protect personal assets. There is also fear about what other physicians will think, and what their own patients think when they hear that their doctor was named in a malpractice lawsuit. Catastrophizing - predicting the worst possible outcome - is common in this phase, as is ruminating on the past or future – anything but the present.

Depression
Depression is generally the next phase. As mentioned previously around 40 percent of physicians who go through a malpractice lawsuit will meet the DSM-5 criteria for a Major Depressive Disorder. Many physicians will just have subclinical symptoms of Depression such as reduced energy, decreased social interest, decreased motivation, crying, and changes in constitutional habits. The Depression phase may be expressed as feelings of hopelessness or helplessness, feeling overwhelmed and disappointed. Some physicians will self-medicate with alcohol or prescription drugs which will lead to its own set of problems. Some physicians will contemplate or fantasize about suicide.

Resolution
The final emotional phase to being named as a defendant in a malpractice lawsuit is Resolution. This phase can be experienced as emotional neutrality or acceptance. If the physician does not get to this phase, then they are fighting or avoiding the reality of the malpractice lawsuit.

Resolution doesn't mean they are not experiencing some distress – rather, it means the physician has learned how to live with or accept the malpractice lawsuit for what it is, or perhaps the malpractice lawsuit has been adjudicated and is no longer a threat. Resolution can feel like self-validation, self-compassion, wisdom, and pride. The physician was able to be vulnerable and tolerated their emotions. The physician is engaging with reality as it is and not how they want it to be.

The stop-and-go nature of litigation is foreign and frustrating to physicians. Physicians are trained to deal with a medical problem until it is resolved or at least stabilized. Malpractice litigation will begin with a tsunami of emotions when the Service of Process is received by the physician. Then there will be a decrescendo effect that may go on for months at a time when there is no activity. Another wave hits with interrogatories and depositions followed by yet another period of little activity. Every part of the litigation process triggers the emotional series. When that part of the process is completed, the emotional series may wind down as well, even to resolution. The emotional series process may dissipate a little quicker with each subsequent wave of activity, especially if the events bring promising news. Overall this is a very individualized process. With some physicians the emotional series only reaches resolution after there is a settlement or the case is closed. As you can imagine, some physicians feel like they are on an emotional roller coaster whereas other physicians just feel the high stress of the unknown.

Malpractice-Related Disorders
This emotional series of Shock, Anger, Fear/Anxiety, Depression and Resolution are experienced by most physicians named in a malpractice lawsuit. These stages are normal, just as grief is a normal emotional reaction to the loss of a loved one. However, just as grief can become complicated and lead to other disorders, the emotions caused by a malpractice lawsuit can become complicated and lead to other disorders such as Major Depressive Disorder and Trauma Related Disorders.

Depressive Disorder
As stated earlier, many physicians involved in malpractice litigation will experience a Depressive Disorder. The symptoms needed to make a diagnosis of a Major Depressive Disorder include five or more of the following criteria within a two-week period and they need to cause clinically significant distress or impairment:

- Subjective feeling of being sad, empty or hopeless
- A diminished interest and pleasure
- Significant weight loss
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt
- Decreased ability to think or concentrate
- Recurrent thoughts of death or dying including suicidal ideation

Trauma
Another set of disorders that can manifest during a malpractice lawsuit are the Trauma and Stressor-Related Disorders -- the classic ones being Acute Stress Disorder and Posttraumatic Stress Disorder. The symptoms of these trauma-related disorders include:

- Recurrent involuntary and intrusive memories of the case or complaint
- Recurrent distressing dreams of the case or complaint

- Dissociative reactions
- Intense or prolonged psychological distress to cues that resemble an aspect of the traumatic event. The physician may recoil when faced by a patient with the same presentation or disease process or who even looks like the patient involved in the litigation.
- Avoidance of thoughts or feelings closely associated with the traumatic event
- Inability to remember important aspects of the event, persistent or exaggerated negative beliefs or expectations, distorted cognitions about the cause or consequences of the event, persistent negative emotional state, diminished interest or participation in significant activities
- Irritable behavior and angry outbursts, self-destructive behavior, hypervigilance, exaggerated startle response, problems with concentration and sleep

The symptoms of Acute Stress Disorder begin immediately after the traumatic event and need to persist for at least three days and up to one month. When the symptoms persist more than one month, which they invariably do as the lawsuit may take years, the diagnosis changes to posttraumatic stress disorder.

Impairment

The symptoms of depression and trauma carry over into the physician's home and social life. They can cause impairment, which presents another set of problems. The physician's spouse or significant other and family are subjected to these symptoms, putting a strain on the relationship. They are the ones exposed to the distressed behavior. Family members are generally the first to suggest there is a problem and that the physician should seek help. When the physician doesn't talk about the lawsuit at home, either because of shame or other reasons, the connection between the malpractice lawsuit and the physician's symptoms is not well appreciated. This disconnect sets up a cognitive dissonance experienced by the physician's family who will then try to search for other causes for the behavior.

Physicians are not good at asking for help for their own medical or mental health problems. Unfortunately, they learn in residency that asking for help is a sign of weakness, and that getting help can have licensure and hospital privilege repercussions. This misinformation only adds to the stigma physicians face when needing help. So, physicians go un-helped and untreated until disaster happens. Many physicians do not have their own primary care provider and get substandard healthcare by using "hallway consults" or by treating themselves. A physician who treats themself is on a very slippery slope to self-medicating with alcohol or mood-altering drugs. This scenario only makes matters worse.

Defense Mechanisms

Physicians are goal-oriented; when they are stressed, they react by working harder, which may be contrary to what a distressed physician actually needs. This is a form of sublimation, a defense mechanism to combat the feelings caused by a malpractice lawsuit. These unacceptable feelings are transformed into the socially acceptable action of throwing themselves into their work. Another defense mechanism is suppression.

Physicians can often “suppress” the unwanted and unpleasant emotions attached to the lawsuit while they are working. Unfortunately, many are unable to successfully suppress or compartmentalize these emotions at other times, including their off-hours, family time, or on a much-needed vacation. When they are away from work the emotions caused by the malpractice lawsuit can come spewing out in all directions, causing family members to recoil.

It’s Not Personal

Being named a defendant in a malpractice lawsuit is a difficult process, but there are ways to successfully maneuver through this minefield. Even though it feels like a personal attack -- especially when reading the inflammatory words on the initial complaint -- it’s important for the physician to realize this is a business decision for the attorney and many times for the patient. When working with a physician who is in the midst of a lawsuit, I often quote from Mario Puzo’s *The Godfather*, “It’s not personal, it’s business.” It is simplistic, but it’s true. Removing the personal assault tends to lighten the emotional response.

Help

There are other “treatment modalities” that can help a physician successfully navigate this process. The first place to turn is their own family. Physicians need to share their emotions with their spouse or significant other. It is amazing how simple this process is and how well it works. The embarrassment can create resistance to talking about the lawsuit but discussing the feelings caused by the lawsuit does reduce the emotional energy it can have over the physician. While they are under legal advice not to discuss details, they can share the emotional experience of the lawsuit.

Other helpful options include practicing a Mindfulness-based meditation program. Mindfulness is an excellent form of meditation that has been shown to promote gray matter changes for the better – and it can help a physician to calm the emotional reaction.

Seeking individual psychotherapy is another solid approach to dealing with the emotions brought on by a malpractice lawsuit. Many therapists are now using telehealth which makes this process even easier to utilize. When starting with a new therapist, I advise giving the therapist three appointments; if by the third appointment there is no trust, comfort, or a therapeutic alliance formed, then go to the next therapist on your list. Your health insurance provider will have a panel of therapists; the TMF also has lists of vetted therapists in Tennessee’s major metropolitan areas.

Another very effective strategy is joining a support group, whether it’s malpractice-focused or one offering general support. There are many types of support groups including gender-specific, trauma-focused, substance use-focused and time-limited, to name a few. Therapy support groups have the same protection as other forms of therapy, meaning what is said in the group is confidential and protected. And it is much more therapeutic for the physician to talk about the emotions they are having, rather than the specifics of the clinical case.

Trust the Experts

It is important to remember when named as a defendant in a malpractice lawsuit that you will be represented by a competent defense attorney retained by SVMIC. Your attorney understands and knows the law and the litigation process, just as you understand your practice of medicine. When discussing the lawsuit with your attorney you may experience a flood of emotions; please remember the heightened emotions are caused by the lawsuit itself and generally not by your attorney. Trust your attorney's expertise, the same way you want your patients to trust yours.

I Will Survive

Being named as a defendant in a malpractice lawsuit is a unique experience that we as physicians are not trained or prepared for. When this happens to you, please reach out for help. Reach out to loved ones, friends, therapists, and to our staff at the Tennessee Medical Foundation – all of whom are here to help and support you through this arduous process. Keep in mind that in Tennessee, a physician does not have to report to the licensing board that they reached out to the TMF for emotional support. The TMF is here for you, and will help you through this process that, believe it or not, you will survive.
