RISK MATTERS

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Helping our clients manage liability exposure with proactive Risk Management strategies.

THE RISK FACTOR

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Coping with Litigation Stress

By Peter Brandt, JD
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A study by Dr. Sara Charles of the University of Illinois – Chicago School of Medicine, in conjunction with the Department of Psychiatry, showed that of the 107 physicians who had been through a malpractice case from the date of the misadventure through trial to verdict:

1. 97% had some physical or emotional reaction to being sued,
2. 86% had feelings of inner tension,
3. 80% had bouts of depression,
4. 78% reported frustration,
5. 70% reported anger, and
6. 2/3's reported dissatisfaction with their careers.

The most important point of the study was that these emotions were experienced by care providers regardless of whether they won or lost at trial.

The stress of a malpractice suit on care providers, physicians and nurses alike, can be monumental. Risk managers are often involved in helping the care provider deal with this stress because the risk manager is at the front line of dealing with claims, misadventures and untoward or unexpected outcomes. The stress of a malpractice suit can manifest itself in depression, denial and even departure from the practice of medicine.

Bill Kanasky, Jr., PhD, Senior Litigation Consultant for Courtroom Services, Inc., has written about how litigation stress is additive to the inherent stress of a medical career. A career in medicine involves long hours, pressure from insurance companies, governments and hospital administration, stress inherent in providing effective medical care for complex patients, constantly dealing with disease, illness, disability and death. When litigation is added to those stressors, the result is intense physical, mental, emotional and behavioral responses. These stressors can endanger the health professionals' mental, physical and emotional wellbeing. By their nature, health professionals are self-critical. They have difficulty with feelings of guilt and an exaggerated sense of

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responsibility. Care providers are acutely sensitive to any suggestion that they have failed to meet the standard of care. They believe their honor is at issue and the threat of its loss is devastating.

The stress responses to litigation are many. From a physical standpoint, care providers can experience sleep disturbance, low appetite, nausea, fatigue, headaches, insomnia, muscle aches and stiffness, and heart palpitations. From a mental health perspective, care providers have been seen to have ruminating thoughts, low concentration, low confidence, confusion, memory problems, over-thinking and second-guessing. From an emotional standpoint, care providers can experience fear, guilt, anger, depression, anxiety, worry, irritability, and impatience. Socially, care providers can become withdrawn and isolated. Their behaviors can change. They can manifest with substance abuse and a cessation of healthy behaviors.

Risk managers are often involved in helping the care provider deal with this stress because the risk manager is at the front line of dealing with claims misadventures and untoward or unexpected outcomes.

How the Risk Manager Can Help

1. **Be available to the care provider.** This means providing the care provider with your cell phone number and indicating a call at any time is perfectly acceptable. The risk manager, in essence, becomes a lifeline to the care provider who is being sued. The discussions can be held in confidence in most circumstances. Allowing care providers to have access to you 24 hours a day can mean many hours on the phone. Often the risk manager is the only individual who the care provider believes will understand the concerns involved with being sued. However, the risk manager will actually find this is one of the most rewarding aspects of the position.

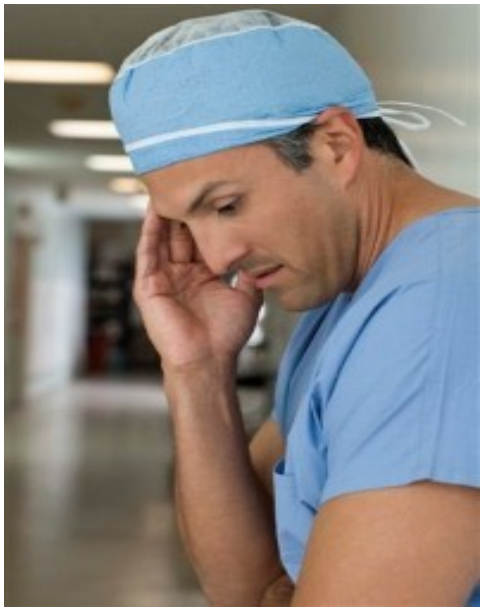
2. **Strongly encourage care providers sued for malpractice to communicate their emotions with their trusted friends and colleagues.** Staying in communication with friends and colleagues, except those colleagues who may also be involved in the lawsuit, talking about the stress of malpractice, helps the care provider keep perspective. It nourishes resiliency. It helps provide insight.

3. **Provide a contact to another care provider who has made it through the litigation process and who has come through intact.** These individuals are typically willing to consult with the care provider who is having any of the many problems dealing with litigation stress. Encourage a discussion about recognizing symptoms – physical, mental, emotional and behavioral – as simply a part of the litigation process. Once the care provider understands the manifestations of stress related to being a defendant, dealing with those symptoms when they occur becomes much more manageable.

4. **Remind the care provider that there are things in life they can control and those they cannot.** Care providers cannot control all medical errors. They cannot stop lawsuits from being filed. Remind the care provider that exerting energy over things that one cannot control is a waste of energy.

   One thing the care provider sued in malpractice can control is their perspective of patients. Once sued, the care provider may start to look at each patient as a potential plaintiff in a medical negligence claim. The care provider can control this by looking at each patient as essentially someone who is good and needs help. This will increase the care providers' sense of their own worth.

   Discuss with the care provider the values and honor he or she has held throughout their career. Those values and honor can never be taken away by any jury or any legal process. Emotion over the lawsuit can clearly affect one's belief in oneself and one's abilities. As noted above, care providers are typically self-critical. Add to that a



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Updated Policy on Board Eligibility for Physicians Seeking Board Certification

On May 30, 2012 the American Board of Medical Specialists (ABMS) updated its policy on Board Eligibility for physicians seeking Board Certification. Board Eligibility is limited to the period of time that may elapse between the completion of residency training and achievement of Board Certification. Depending on the medical specialty, a physician has 5-7 years after completion of residency to achieve Board Certification. Any physician who has not achieved Board Certification in the designated timeframe is considered ineligible until he/she completes the requirements for re-entry into the certification program.

Physicians may no longer declare themselves Board Eligible if they have not met the certification requirements within the designated timeframe, or by the transition date specified by the individual Medical Board – for those individuals who had not achieved Board Certification at the time the ABMS policy became effective on 1/1/2012.

Example #1: An emergency physician who completed training residency in 2001 has until the American Board of Emergency Medicine transition date of 1/1/2019 to claim that he is Board Eligible. However, an emergency physician who completed training residency in July 2013 has only until July 2018 to be considered Board Eligible.

Example #2: An internal medicine physician who completed residency training in 1993 has until the American Board of Internal Medicine transition date of 1/1/2019 to complete certification and consider herself Board Eligible. An internal medicine physician who completes residency training in July 2013 has until July 2020 to claim that she is Board Eligible.

To view the ABMS policy and individual ABMS Board eligibility periods and transitions dates, please visit http://www.abms.org/News_and_Events/downloads/ABMS_Board_Eligibility_Fact_sheet-updated05302012.pdf http://www.abms.org/News_and_Events/downloads/ABMS_Board_Eligibility_Policy_by_Board_100912.pdf

For risk management questions on board certification contact Mary Stankos at (630) 276-5565 or mstankos@ihastaff.org.■

MAIC/IRMS Education Sessions

Up-coming Education Programs

Feb 21 **Risk Management Meeting**
Grand Magnuson Hotel, Carlinville

Feb 28 **Risk Management Meeting**
Illinois Hospital Association, Naperville

May 2 **OB Risk Management Meeting**
IHA, Naperville & Springfield

June 13 **ED Risk Management Meeting**
Illinois Hospital Association, Naperville

June 19 **ED Risk Management Meeting**
Southern Illinois Location, TBD

Oct 2-4 **IRMS 29th Annual Risk Management Meeting**
Embassy Suites, East Peoria

Visit www.maicinsurance.com to obtain an agenda, driving directions, and registration form or contact Lisa Galvan at 630/276-5694 or lgalvan@ihastaff.org for additional information.

On-line Education Sessions

MAIC Risk Advantage on-line education sessions are available for MAIC insured physicians at www.maicinsurance.com. For additional information contact Lisa Galvan at (630) 276-5694 or lgalvan@ihastaff.org.

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malpractice suit and self-criticism can overwhelm the values and honor associated with the careful exercise of medical judgment.

As risk manager, remind the care provider that he or she has always had and will continue to have values and honor associated with their own practice of medicine. Just saying those words can bring perspective back to the care provider.

5. **Express to the care provider early on what to expect.** Litigation is a rollercoaster and the care provider does not have control of the brakes. Emotions will ebb and flow. One day the care provider will want the case to be settled at all costs; the next day, the care provider will want the case litigated to the highest court in the world. Tell them they might experience manifestations of the stress of litigation. Encourage the care provider to seek medical help the moment any stress-related symptoms develop or manifest.

6. **Restore confidence in mastery.** Remind care providers that it is the very best in their respective fields who are sued because they are the few who treat high risk patients.

7. **Shrink the litigation.** Care providers are self-critical, but they are also good at compartmentalization. Discuss envisioning the litigation as a file box placed in the corner of the office. The care provider will need to open the "box" from time to time, but it has a "lid" which can be used to keep the "box" closed during those long periods of time when little activity is taking place in the litigation. Compartmentalization of the litigation helps shrink its importance.

8. **Encourage the care provider to be involved in the litigation.** This allows for the assertion of control that is otherwise lost. It also has the ancillary benefit of increasing the chances of success.

9. **Make clear to the care provider that malpractice litigation is not about competency.** It is about compensation. This fact becomes clear when, on many occasions, plaintiffs at deposition indicate they have absolutely no criticism of the defendant care provider. This underscores that malpractice litigation is all about compensation and not about the care provided.

10. **Remind care providers sued in malpractice that most are vindicated.** Nationwide, there is an approximately eighty-six percent (86%) success rate in cases that move to trial. Most people (jurors) appreciate that outcomes in medicine cannot always be controlled even when all of the care is appropriate.

11. **Organize stress management.** In a study noted in the Journal of Applied Psychology (2007), hospitals that implemented an organization wide stress management program had significantly fewer claims of medical error compared with an equal number of hospitals that had not initiated such a program. This study showed that the over twenty-two hospitals that implemented organization-wide stress management programs also reduced turnover and increased satisfaction of staff.

A tremendous resource for helping care providers deal with the stress of litigation can be found at www.physicianlitigationstress.org. This webpage provides sources of support and information on traversing the legal process.

For additional information on this topic contact Mary Stankos at (630)276-5565 or mstankos@ihastaff.org.■

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Case Study

Documentation of Patient Communication

A 34 y/o patient had laparoscopic surgery for pelvic pain and endometritis. On the first day post-op, the patient called the surgeon's office requesting discharge information and complained of abdominal pain. The surgeon advised the patient that abdominal pain was expected post-op and she would be fine. The patient was not instructed by the surgeon to go to the ED if the pain worsened or did not improve. The following day, the patient stated she called and left a message with the surgeon's answering service that she was still having abdominal pain and fever, but she never heard back from the surgeon. She saw the surgeon on post-op day 4 for scheduled follow up. A CT scan was performed and the patient was diagnosed with a bowel perforation. Surgery was performed to repair the injury, and the patient had an extended recovery period with IV antibiotics and temporary ostomy placement. Another procedure was performed 6 months later to close the temporary ostomy.

The patient filed a lawsuit alleging the failure of the surgeon to take action on post-op day 1 or 2, which resulted in a prolonged recovery period and unnecessary complications. The surgeon testified in her deposition that the patient's complaints of pain were expected, and she saw no need to instruct the patient on emergency care. Further, she did not recall being contacted by her answering service on post-op day 2 and doubted that the patient called since she would have responded to any patient calls, and there was no documentation in the medical record concerning the call.■

Risk Management Issues:

1. Can the surgeon rely upon the lack of her recollection and documentation of the patient communication to support her claim that the patient never called?
   Yes or No
2. Should a physician and/or his/her office document all patient phone calls and responses?
   Yes or No
3. Should the surgeon have provided the patient with instructions on follow-up, including going to the ED if her condition did not improve or worsened?
   Yes or No

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New Study—Zolpidem and Risk of Falls in Hospitalized Patients, and New FDA Recommendations on Zolpidem Use/Prescribing

A new study from the Mayo Clinic suggests that zolpidem (Ambien) may increase the risk of falls in inpatients. The authors concluded that the rate of falls was four times higher in those administered zolpidem as compared to those who were prescribed but did not receive zolpidem. The study suggests that changing hospital based physician order sets so that zolpidem use is not encouraged, and consideration for alternate medications could potentially reduce fall rates in hospitalized patients. (*J Hosp Med* published online Nov. 19, 2012. http://onlinelibrary.wiley.com/doi/10.1002/jhm.1985/abstract)

In addition, the FDA recently posted public information on its MeDWatch Safety Information and Adverse Event Reporting Program for healthcare providers and patients on zolpidem, indicating "the bedtime dose be lowered because new data show that blood levels in some patients may be high enough the morning after use to impair activities that require alertness, including driving." The FDA is requiring the manufacturers of Ambien, Ambien CR, Edluar, and Zolpimist to lower the recommended dose.

The FDA is asking that health care professionals caution all patients (men and women) who use these products about the risks of next-morning impairment for activities that require complete mental alertness, including driving. Further, it recommends:

- The recommended dose of zolpidem for women should be lowered from 10 mg to 5 mg for immediate-release products (Ambien, Edluar, and Zolpimist) and from 12.5 mg to 6.25 mg for extended-release products (Ambien CR).
- For zolpidem and other insomnia drugs, prescribe the lowest dose that treats the patient's symptoms.
- Inform patients that impairment from sleep drugs can be present despite feeling fully awake.
- The recommended doses of Intermezzo, a lower dose zolpidem product approved for middle-of-the-night awakenings, are not changing. At the time of Intermezzo's approval in November 2011, the label already recommended a lower dosage for women than for men.

You can read the complete MeDWatch alert, at: http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm334738.htm

For risk management questions or comments about this information, please contact Mary Stankos, RN, MJ, Director, Risk Management.■

Case Study: Documentation of Patient Communication

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Risk Management Answers and Discussion

No. The lack of physician documentation of the patient call could not be used as definitive evidence by the surgeon that the patient did not call on post-op day #2, because the surgeon admitted she did not routinely document after hour patient calls. The first telephone encounter on post-op day #1 was not documented by the surgeon, but both the surgeon and the patient had an independent recollection of the conversation, and as such the call was not in contention, just the content that was shared during the call. Defense counsel can suggest the surgeon's non-response to complaints of abdominal pain and fever, and absent documentation is proof that no such call was made by the patient, but it would be up to a jury to decide whether or not they believe it to be true. Phone records from the patient's cell phone and records from the answering service could have served as evidence in support of whether or not the call was made; however, by the time the issue came to light years later, these records had been purged. Moreover, it would have only shown that a call was made, not specify the content of the conversation.

The lack of physician documentation of the patient call could not be used as definitive evidence by the surgeon that the patient did not call on post-op day #2, because the surgeon admitted she did not routinely document after hour patient calls.

No. From a risk management perspective, it is neither feasible nor necessary to document all patient conversations that occur during the course of a day. Nevertheless, physicians and their office staff should attempt to document all patient communications involving patient care. Afterhours physicians should document all communications with patients that instruct the patient to take certain action(s), such as an order for a new or changed medication, or instructions to call the office in the morning, or to go to the ED. An electronic medical record (EMR) system makes the process of afterhours documentation easier, because it allows for ready/immediate access to the EMR from anywhere the physician has access to a computer and can result in improved afterhours documentation.

Yes. While the surgeon did not believe the patient needed immediate attention at the time of the first call, a patient should always be advised/instructed that visiting the emergency department for care is an option to be considered, if the condition that resulted in the call does not improve or worsens. Too frequently, patients rely upon the reassuring words of a physician to guide their decisions concerning follow up care, and may be hesitant to go to the ED for care if not instructed to do so by the treating physician. Failure to instruct patients to go to the ED if the condition does not improve or worsens can result in potential liability exposure, as was seen in this case. The patient did not consider going to the ED because she was told that she would be fine, and patient alleged the surgeon did not return her call the following day. Having advised the patient to seek emergency care during the first call may have resulted in early care and mitigation of damages.

For additional information on this case study contact Mary Stankos at (630)276-5565 or mstankos@ihastaff.org.■