**Medical Malpractice Stress Syndrome**

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**P**hysicians and other health care providers who are confronted with professional liability litigation develop a medical disorder called ***Medical Malpractice Stress Syndrome (MMSS)***. This syndrome takes a significant toll on the physician as well as the immediate family, staff, and other patients. The syndrome is similar to ***Post-Traumatic Stress Disorder (PTSD)***.

**Medical Malpractice Statistics**

**A**ccording to an [American Medical Association survey](https://www.ama-assn.org/media/21976/download), 34% of all American physicians have been sued over allegations of medical malpractice. About 17% of physicians have faced two or more lawsuits, and 32% of [malpractice suits](https://www.rmf.harvard.edu/-/media/Files/Strategies/Reports/Benchmarking-Medication-Report.pdf) related to medication problems involve patient death.

By the age of 65, over 75% of physicians in lower-risk specialties and 99% in higher-risk areas of medicine, such as neurosurgery and obstetrics and gynecology, will have been sued.

* One of five patients experience medical error.
* Half of the medication errors are due to ordering or prescribing medications.
* Some 4,000 surgical errors occur annually in the U.S.
* A third of medical malpractice claims in the U.S. are misdiagnosis errors.

In 2020, safety experts estimated that approximately 22, 000 preventable deaths due to medical errors occur each year in the U.S.

In 2021, the States with the most lawsuit medical malpractice payment reports were: (1) Florida, (2) California, (3) Bew York, (4) Texas, and (5) Pennsylvania.

**Outcome of Medical Malpractice Claims**

**A**bout two thirds of malpractice claims are withdrawn, dismissed, or dropped.

One third of lawsuits end up with medical malpractice payments, of which 96.5% are the [result of settlements](https://www.leveragerx.com/malpractice-insurance/2019-medical-malpractice-report/).

Less than 10% of malpractice claims end up in court with a full-blown trial, where the defendant doctors prevail in 88% of the verdicts. The total payouts are close to $4 billion.

**Medical Malpractice Payouts**

The largest cases were plaintiffs who had become quadriplegic or brain-damaged, or required lifelong care, averaging $961,185.

Major permanent injury cases resulted in an average payment of more than $610,000, followed by significant permanent injury at $450,000, and wrongful death at more than $386,000.

A medical malpractice payout for an insignificant injury averaged slightly more than $40,000.

Payment amounts were greatest for those in the 50-59 age group and were also greater for females at 55.5% of the amount paid compared to 44.2% for males.

**Medical Malpractice Statistics in the U.S.**

**Ten (10) %** of all deaths in the U.S. result from medical errors.

* **In 2019, the** [members of the armed services](https://about.bgov.com/news/pentagon-has-2-billion-in-unresolved-medical-malpractice-claims/) filed **$2.16 billion** in medical malpractice claims.
* **5% to 10%** of all physicians have had [sexual contact](https://www.aaos.org/contentassets/6507ec63e5ac4ea48375ad96d154daac/1208-sexual-misconduct.pdf) with patients.
* **68**liability claims have been filed per 100 physicians.
* **49.2%** of physicians age 55 and older have been sued.
* **39.4%** of male physicians have been sued.
* **22.8%** of female physicians have been sued.
* **12,000-13,000** medical malpractice lawsuits, [filed each year](https://nationaltriallaw.com/medical-malpractice-statistics/)  are paid medical claims.
* In 2020, however, the paid medical claims were the lowest in a decade, about 9,300.
* Over**30%** of physicians pay [more than $10,000](https://www.malpracticeteam.com/blog/2014/december/some-interesting-facts-about-medical-malpractice/) for medical malpractice insurance annually.

**Medical Malpractice Claims by Specialty**

**I**n 2020, about 20,000 malpractice claims were filed against nurses. RNs were sued the most, >13,000 claims, followed by MDs at nearly 12,000, and third, Practical Nurses, nearly 6,500 claims.

Other health care providers sued include DOs, technicians, medical assistants, therapists, dentists, pharmacists, and social workers.

**About 16%**of psychiatrists have been sued, the lowest of any specialty.

**Medical Malpractice Stress Syndrome (MMSS)**

**R**egardless which party prevails, more than 95% of defendant physicians report that the litigation had a major psychological and/or physical effect on them. Many physicians describe their feelings about malpractice litigation as the most stressful occurrence of their lives.

Indeed, that happened to Sara C. Charles, MD, who is a psychiatrist and now professor emerita at the University of Illinois College of Medicine at Chicago. In 1976, Dr. Charles endured a 6-week trial for medical malpractice in federal court; she prevailed. But her experience at trial affected her profoundly, and she began studying, researching and publishing on the mental, emotional and physical effects of malpractice litigation on physician defendants. Among her many publications two books: ***Defendant, A*** ***Psychiatrist on Trial for Medical Malpractice*** (written with her husband, Dr. Eugene Kennedy), and ***Adverse Events, Stress and Litigation*** (written with attorney Paul Frisch).

In 1985, Dr. Sara Charles and co-authors[[1]](#endnote-1) described the ***Medical Malpractice Stress Syndrome (MMSS)***. The authors assessed the impact of malpractice litigation on physicians' personal and professional lives. They surveyed random samples of sued and non-sued physicians who were members of the Chicago Medical Society. Both groups reported changes in professional behavior and emotional reactions to both the threat and actuality of litigation. But the physicians who were sued reported significantly more symptoms and they were likely to stop seeing certain types of patients, thought of retiring early, and discouraged their children from entering medicine.

**Effect on Health Care Delivery**

**D**r. Charles and co-authors noted that malpractice litigation might affect not only physicians' personal and professional lives but also the delivery of health care. Some physicians who develop a MMSS may consider leaving the field of medicine, but they rarely do so. That is generally not a viable or reasonable option for most.

In 2009, the turnover rate among physicians was 5.9% and in 2013 it rose to 6.8%.[[2]](#endnote-2) This turnover rate is relatively low compared to other professions. For example, the turnover rate for nurses is 18% in the first year, and 30-60% in retail, hospitality and food service.

**Malpractice Case # 1**

**D**r. Ray Sunshine is a 43-year-old second-generation family physician. While in medical school, he met and fell in love with his classmate, Angela. They got married the same month they graduated from medical school. The couple have two daughters and a son.

After Dr. Ray and his wife graduated from medical school at the University of Florida, he completed a residency training program in Family Medicine; Angela also trained at the University of Florida as an Emergency Physician. Both of them have been practicing medicine for 12 years, working with Ray’s father, Christopher Sunshine, at the Family Medical Clinic, in Sun City, Florida.

On January 13, 2001, at approximately 1:00 P.M., Dr. Ray returned from lunch to resume his work at the Clinic. His nurse informed him that the ***Sheriff*** (a patient treated by his father) was here to see him. The Sheriff was ushered into Dr. Ray’s office. The two of them exchanged greetings. Apologetically, but in a business-like manner, the Sheriff served Dr. Ray with a ***summons and complaint***, alleging ***medical malpractice***. The Sheriff told Dr. Ray that he was being sued by one of his patients. The Sheriff said goodbye and walked out of the office.

Dr. Ray was stunned, shocked and dismayed. He could not believe that he was being sued by one of his patients. He had never been sued before. He could not think of having done wrong to his patients. He thought to himself:

“All my patients love me. Who would do such a horrible thing?”

He had flash backs of many patients that he had treated in the last few of years. He gently placed the petition on his desk without opening it, and he stepped away from his desk, all the time staring at the petition.

***Symptoms and signs developed acutely.*** His forehead became sweaty, as did the palms of his hands. His hands were shaking and his body felt like it was trembling all over. His chest felt tight and he could not breathe deeply enough. He had goose bumps all over. He became weak and nauseated. His lunch-filled stomach felt heavy, and he was afraid he might vomit any time. He felt momentarily unstable on his feet and dizzy.

Dr. Ray could not believe what was happening to him.

Nurse Susan knocked at his door and entered the office to inform Dr. Ray that his first afternoon patient has been waiting to see him. The doctor, now visibly pale and diaphoretic, did not look back to acknowledge the nurse’s presence. Instead, he walked two steps and sat in a nearby chair, with his head bent forward.

He felt ashamed and did not want to tell his nurse what happened. He took his handkerchief out of his back pocket and wiped his forehead.

The nurse, realizing that there was something wrong, asked the doctor if he felt well. The doctor did not answer at first, but then he told the nurse to cancel all his patients for the rest of the day because he was not feeling well.

The nurse promptly informed Dr. Angela, Dr. Ray’s wife, that he was not feeling well and that the Sheriff had visited him at his office.

Angela excused herself and ran to her husband’s office. He was still sitting in the chair, staring at his desk. “Honey,” she said, “What is the matter? What is bothering you? Are you hurting anywhere?” Dr. Ray could not talk. He felt lonely even in his wife’s presence. Guilt feelings were running through his mind. Angela asked him what the Sheriff was doing here.

Dr. Ray stared at the ***petition*** on his desk and nodded ever so slightly. Angela walked toward the desk, picked up the envelope, opened it and slowly read ***allegations of negligence and gross negligent acts*** by her husband. She was shocked herself, but she quickly realized that her husband was suffering from an ***acute stress disorder***.

Angela called her father-in-law, Dr. Christopher, who was in his office, and informed him about Dr. Ray. He rushed to Dr. Ray’s office. He had a flash back at the time when he was served with his malpractice lawsuit many years previously. He told his son that when he was sued by one of his patients for medical malpractice, he likewise suffered symptoms of distress throughout the five years of litigation, until the lawsuit ended in his favor.

Dr. Ray’s malpractice litigation lasted three years, during which time both his wife and father were extremely sympathetic and supportive. Nevertheless, Dr. Ray suffered distress symptoms throughout the course of the litigation. The trial ended with a defense verdict. Dr. Ray was relieved, but continued to suffer from ***MMSS*** symptoms similar to those who have ***post-traumatic stress disorder***.

**Malpractice Case # 2**

**I**n March 2008, prominent Denver business owner Leslie Fishbein suffered cardiac arrest and died after receiving trigger point injections with bupivacaine for chronic neck pain.[[3]](#endnote-3)  The 55-year-old sought treatment because she had chronic back pain from a horse-riding accident. Fishbein, the face of Kacey Fine Furniture’s television ads, died after a series of painkiller injections in her lower back that were administered by Dr. Daniel Brookoff at Presbyterian/St. Luke’s pain-management clinic.

Ms. Fishbein owned a chain of high-end furniture stores.  She was well known within the community because of her starring role in television commercials promoting her business.  Her death drew tremendous media attention and heavy scrutiny for the physician who treated her.

Dr. Brookoff who treated Kacey Fine Furniture president Leslie Fishbein was sued for wrongful death.  He lived in Memphis with his family. He was licensed to practice medicine in Tennessee and Colorado. He had treated chronic-pain patients for many years. He cared very deeply for his patients, and he also did a lot of good for a lot of people that had severe, intractable pain.

He practiced competently with good risk-management hospital procedures. He was well-trained, with adequate self-knowledge, a balanced personal and professional life and had a good relationship with patients, their families, and other health professionals.

Licensing Board Records showed that no disciplinary action were ever taken against Brookoff’s medical license in Colorado or Tennessee.

In April 2001, the 56-year-old doctor was reported missing. On April 14, 2001, Dr. Brookoff was found by a security guard in Mud Island Park in Memphis, Tennessee. The guard called police in the early- morning hours. They forced their way into the Camry and discovered his body under the blanket; he was dead. He had a self-inflicted gunshot wound to the head.  The day he killed himself was the very day that the lawsuit filed against him by Leslie’s family settled out of court.

Leslie’s husband, Sam, filed the lawsuit in Denver District Court claiming his wife received 30 trigger-point painkiller injections into her back within a five-minute period, which stopped her heart. At a previous appointment, she received 15 pinpoint injections that left her so woozy she had to call her husband to drive her home. HCA-HealthOne LLC, which owns Presbyterian/St. Luke’s Medical Center, settled the lawsuit on behalf of everyone, including Dr. Brookoff.

Four other Colorado patients who were treated by Brookoff also sued the doctor for malpractice or negligence. Three of the four lawsuits claim Brookoff administered too much of the anesthetic Marcaine, causing his patients’ respiratory systems to shut down and sending them to the hospital. The fourth lawsuit involved the death of a patient allegedly for improperly managing the patient and the medications. The terms of all the settlements, including Fishbein’s, were confidential.

***The following two cases[[4]](#endnote-4) sustained catastrophic cardiovascular complications associated with malpractice litigation and medical malpractice stress syndrome.***

**Malpractice Case # 3**

**A** 57-year-old male spine surgeon was sued for a failed anterior cervical discectomy and fusion. After 5 years of depositions, interrogatories, pretrial motions, and delays, the trial was finally scheduled.

About 36 hours before the trial began, the surgeon met with one of his closest friends. At that time, he was visibly distressed, anxious, apprehensive and depressed. He admitted to insomnia, lack of appetite, and anger at the whole experience.

After prolonged sitting for 5 days in court during jury selection and preliminary motions, he developed mild nonspecific chest discomfort, which he attributed to stress. He was on no medications, had no history of cardiac or pulmonary disease risk factors for clotting disorders, and was in general excellent health. He had not smoked or used alcohol.

On the morning of the first day of trial he walked to his car and suddenly fell to the ground and died. The autopsy revealed multiple pulmonary thrombo-emboli, well organized and occluding the pulmonary arteries. There was also a large non-adherence saddle embolus occluding the main pulmonary arteries that resulted in the sudden death.

**Malpractice Case # 4**

**I**n 2012, a 72-year-old male neurosurgeon was sued for a failed anterior cervical fusion performed in 2009. The complaint included 27 allegations of ***negligence and gross negligence***. ***Punitive damages,*** which are not covered by insurance, were sought because of ***wanton disregard and/or reckless intentional conduct.***

In May 2018, the final court date was selected after numerous depositions, motions and failed attempts at settlement.

Beginning 4 weeks before trial commencement, the neurosurgeon embarked on an intense all-consuming preparation reviewing medical records, depositions, complaints, and expert witness testimony. Pretrial and post-trial meetings averaged 12 to 14 hours per day with long sitting throughout it all. He was a competitive Ironman triathlete, but all meaningful physical activity came to a halt. He was stressed and obsessed with the details of the case. He was inactive and anorexic. He lost 12 lbs., was insomniac, anxious, depressed and angry for being confined and having to cancel needed surgery for many patients.

During trial, he was on the witness stand testifying for three on direct and cross-examination. The trial lasted three weeks before the jury deliberation began. While the jury was deliberating, the physician experienced discomfort of the lower sternum and xiphoid area and had tachycardia. He was extremely apprehensive about the outcome.

His past medical history included a coronary artery bypass graft to the anterior descending artery. He had no history of smoking, hypertension or other medical problems. He presented to the emergency room at the local hospital. He had an electrocardiogram, followed by a stress test and cardiac catheterization via the radial artery. That demonstrated a high-grade occlusion of the circumflex artery which was successfully stented.

While on the catheterization table he was told of the ***verdict for the defense***.

Twelve 12 days later while walking up a hill with a 6% grade he experienced excruciating pain in the left gluteal muscle that felt like a muscle strain or sprain but without antecedent trauma. Arteriography revealed stenosis and a large thrombus in the left iliac artery which was stented.

He was later able to resume his vigorous daily exercise routine and neurosurgical practice. And he was able to complete the Ironman distance triathlon in 2017.

**Litigation Stress**

**M**edical malpractice is a predictable hazard of medical practice for which professional insurance is necessary. But it leads to MMSS with potentially devastating consequences. Physicians are ill-prepared to deal with MMSS. **TO BE FOREWARNED IS TO BE FOREARMED.**

Time hardened experience has proven that to be forewarned is to be forearmed. This dictum is applicable to medical malpractice prevention.

***Prophylaxis indeed beats malpractice***. Medical malpractice is preventable. Prophylactic awareness by physicians of malpractice liability, coupled with the adoption of preventive programs, should minimize allegations of malpractice. Victory is achievable when preventative alertness diminishes the need for aggressive legal defense.

Competently trained, experienced physicians and surgeons are mindful of legal liability. They follow a course of medical and surgical care that is commensurate and consistent with their skill, knowledge, ability and experience. Such physicians and surgeons, when accused of medical malpractice, rarely lose in a court of law. On the other hand, medical and surgical errors, mistakes, major judgmental miscalculations, and obvious negligence are difficult to defend. The quintessential physician and surgeon must pursue professional actions that are in the best interests of the patient. This prevails even if it demands personal inconvenience.

One of the most potent and proven methods of prevention of medical malpractice is to educate physicians about the medical and legal ramifications of medical malpractice lawsuits. Physicians should be educated about malpractice litigation stress, how to react when confronted with a medical malpractice lawsuit, how to communicate with the defense attorney, and they should have a good grasp of the legal process. ***Active physician participation in the defense of a medical malpractice lawsuit is the key to a successful outcome.***

**Stress of Medical Malpractice Litigation**

**M**edical malpractice lawsuits are extremely stressful. They are predictable hazards of medical practice. Some medical professionals view malpractice lawsuits as an inherent part of providing medical care. Indeed, no individual physician is immune from medical malpractice, and the majority of physicians are affected, directly or indirectly, by patients alleging negligent professional care as the cause for their injuries.

It is known that litigation distress may affect any individual who is involved in litigation. There are predictable effects of medical malpractice lawsuits on the defendant physicians characterized by the medical malpractice stress syndrome, a unique variation of the well-accepted litigation stress syndrome.

Even though medical malpractice lawsuits are common, most physicians are ill-prepared to deal with the devastating psychological effects of medical malpractice litigation on the physicians, their families, and their medical practices.

The stress of medical malpractice litigation may directly contribute to physical illness of the physician, as well as dissatisfaction with medical practice leading to burnout and early retirement. Tragically, if the reaction of the physician is extreme, depression may lead to suicide.

**Manifestations of MMSS**

**A**n allegation of medical malpractice (or charges of unprofessional or unethical conduct by a physician’s peers) may be extremely traumatic to the accused physician, regardless of whether or not the allegation has merit. The emotional turmoil that results can be debilitating.

The primary manifestations of medical malpractice stress syndrome are listed. They include:

* Psychological symptoms (acute or chronic anxiety and depression), and
* Physical symptoms which may be manifestations of a new disorder or may represent an aggravation of a pre-existing disorder, such as peptic ulcer, asthma and angina due to coronary artery disease.

The accused physician may develop excessive worry, which would occupy over 50% of waking hours. The physician may have difficulty controlling the worry. When such worry symptoms last over six months, it is characterized as persistent or chronic.

The physician may complain of restlessness, tiredness, difficulty concentrating, irritability, tense muscles, and/or insomnia. Such anxiety symptoms interfere with the physician’s daily life both at work and at home.

Some physicians develop feelings of anger, bitterness, shock, dismay, guilt, shame, irritability, frustration, distrust, loneliness, and diminished self-esteem; and the physician may manifest hyperactivity.

The accused physician may react by emotionally distancing himself/herself from family members, friends and professional colleagues. Interest in work, food, recreation, and sex may be diminished. The accused physician may become insecure, may develop concerns about ability and competency to make decisions, may compulsively order unnecessary tests on patients, and may have thoughts of changing careers.

The physician may resort to alcohol, or self-medication, in an attempt to self-medicate many of the uncomfortable symptoms.

The accused physician, who is already suffering from a pre-existing medical illness, such as coronary artery disease, diabetes, hypertension, or gastro-intestinal disease, may exacerbate or aggravate those disorders thereby causing more physical symptoms and signs related to those disorders.

Consultation with Treating Physician

**T**he accused physician must acknowledge that he or she may be suffering from a medical malpractice stress syndrome. It is sometimes difficult for the physician to formally seek medical or psychiatric attention from a colleague. Especially when the symptoms of anxiety and depression are severe, or where there are thoughts of suicide, the distressed physician should seek prompt psychiatric assistance.

Management and control of the symptoms of MMSS under the supervision of a treating physician should never be underestimated. The amelioration of the stress symptoms will lead to a feeling of well-being, confidence and behavioral control thereby reversing the agonizing mental turmoil. Reduction of stress symptoms will also allow the physician to think and act with greater objectivity, to remain focused, and to maintain a healthier perspective on the litigation process.

**Discussions with Family, Close Friends & Colleagues**

**A** friend in need is without question a friend indeed. The distressed physician should seek support, understanding and comfort from immediate family members, close friends, and professional colleagues. In particular, open and candid discussions with one’s spouse, and maybe even the children, may reassure all the family members. This can lead to greater support and understanding of any unusual behavior.

Discussions with physician colleagues, particularly those who have been through malpractice litigation, can be helpful. Reaching out to family, friends, and professional colleagues for emotional support should not be construed as a sign of Strong person, one that is not afraid to confront reality, no matter how harsh it may seem.

**Meeting with Defense Counsel**

**T**he meeting(s) between the accused physician and the defense counsel can be extremely helpful in educating the physician about the legal system and addressing fears and concerns about the litigation. The physician who develops rapport and trust with the attorney, who gains a thorough understanding of the legal process, and who assists the legal counsel to understand the factual issues related to the alleged negligence claim, will benefit immensely by gaining confidence, thereby reducing the stress of litigation.

**Management of MMSS**

**I**n March 2005, at the 45th Annual Conference of the American College of Legal Medicine, in Las Vegas, Dr. Louise B. Andrew, MD, JD, who is an expert in MMSS, presented the S. Sandy Sanbar Lecture, which dealt with this personal, sensitive and difficult subject of malpractice litigation stress. The following discussion is derived in part from that excellent lecture, as well as from the selected references at the end of this chapter.

Andrew noted the following four essentials of management of the MMSS:

1. Replace mystery with knowledge;
2. Replace shame with confidence;
3. Provide insight into the players and drama while being enacted;
4. Provide tools and strategies for combating the emotional and physical stress of litigation.

Andrew pointed out that charging the physician with malpractice is perceived as a “***wound to the heart***.” In every known bad medical treatment outcome, the physician blames self-long before the patient begins to blame. Hence, the physician already has a wound to self-esteem by the time the legal claim is made.

Every step in the legal process, while ostensibly designed to reveal the truth and serve justice is perceived by the physician as an attempt to prove intentional wrongdoing by the physician. This is related to the psychological vulnerabilities of the accused physicians and the lack of understanding of the legal process.

The physician needs help to acknowledge and address the fears of medical malpractice stress, all of which are appropriate to the situation. These include:

1. Loss of control;
2. The loss of livelihood;
3. Loss of reputation;
4. Loss of assets;
5. Loss of significant supporters;
6. Lack of knowledge about the process and potential outcomes.

Education is the key to dealing with fear. The physician should be encouraged to:

1. Attend supportive educational meetings;
2. Read available materials on litigation stress support;
3. Seek advice from experienced colleagues, malpractice and estates lawyers, counselors, or consultants;
4. Ask questions, and acknowledge that this is not the physicians’ sphere of expertise.

The physician can do a number of things including:

1. Begin to transform one’s personal definitions;
2. Pay more attention to one’s own needs;
3. Assemble a personal survival kit:
4. Pay more attention to the needs of one’s principal supporters; and
5. Reframe the case as a “Passion Play”, and hone one’s acting skills for the court drama.

According to Dr. Andrew, the physician should recognize that he or she is an actor involved in a malpractice lawsuit “drama” which is not of the physician’s own making nor under his/her control. The arcane script is written by people who have long been dead, by morbid “poets”, and by modern day pirates. Indeed, only part of the physician’s professional persona is involuntarily involved in the “Passion Play.”

It is important, according to Dr. Andrew, to arm the physician with psychological armor. The physician should be taught that, to the extent that he or she forgets the actual goal of the plaintiff (money), and accepts the stated goal (justice), he or she can and will be disempowered. Therefore, to the extent possible, the physician should ignore what the other side says or does and focus on the fact that the plaintiff is only entitled to money.

The physician must remember that knowledge is power and must be acquired. The physician should be encouraged to access resources, including counselors, consultants in litigation stress, witness preparation, talk to close colleagues and attend support groups. Physicians who have been involved in malpractice litigation should share their experiences and their successes with their colleagues.

The accused physician must continually be reminded that being sued for medical negligence is a predictable hazard of medical practice in our times. Medical malpractice litigation is one of the most stressful events of the life of any physician. But it is survivable and surmountable. It can be an experience from which the physician can actually become a better doctor. Nietzsche said, “What does not destroy me, makes me stronger.”

**MMSS Pearls**

**T**he Physician can derive MMSS therapeutic benefit from the following:

1. Being actively involved with the defense attorney team;
2. Participating in official discovery requests;
3. Assisting in identifying qualified experts;
4. Performing medical literature research to determine nuances of medical care;
5. Attending as many depositions and as much of the trial as feasible;
6. Preparing diligently for appearances by thoroughly knowing the medical records and the medical literature;
7. Becoming educated and comfortable in dealing with the tactics of the plaintiff’s attorney and the time and scheduling difficulties required by legal proceedings;
8. Becoming educated about medical malpractice stress and its effects on the Physician;
9. Recognizing that there are inherent conflicts of interest between the insurer and the physician;
10. Being prepared to seek counsel by a private attorney if conflicts are perceived with being represented by an insurance company appointed attorney or if claims are not covered or if an excess judgment beyond coverage is possible.

In 2014, anesthesiologist Dianne Ansari-Winn, MD, MPH[[5]](#endnote-5) and founder of[*Transitions Coaching*](http://careercoachfordoctors.com/)stated that, “The primary cause of this stress is the perception of a malpractice suit as an attack on our sense of personal integrity — our honor as a physician. For this reason, MMSS can be triggered by a formal complaint or investigation even if it does not result in a lawsuit.”

Dr. Ansari-Winn recommended four keys to managing malpractice-related stress:

1. Reach out for support including consulting with a mental health professional and support groups;
2. Engage in the legal process;
3. Make time for hobbies and activities that you enjoy, exercise, eat a healthy diet, and spend time with friends and family. Self-care is critical during this time; and
4. Take time to review the successes in one’s career; it helps to see the incident that occurred more clearly.

Malpractice-related stress is practically inevitable. Fortunately, if you understand that stress is part of the process and take active steps to manage it, you will be able to weather the emotional storm that can come with being sued.

**Summary**

**M**edical malpractice lawsuits are extremely stressful. The allegation of medical malpractice may be extremely traumatic to the accused physician.

* The primary manifestations of medical malpractice stress syndrome are psychological symptoms (e.g., acute or chronic anxiety and depression), and the secondary manifestations are physical symptoms. The accused physician must acknowledge that he or she may be suffering from a medical malpractice stress syndrome. The distressed physician should seek support, understanding and comfort from immediate family members, close friends, defense counsel and professional colleagues.
* The physician needs help to acknowledge and address the fears of medical malpractice stress. The accused physician must continually be reminded that being sued for medical negligence is a predictable hazard of medical practice in our times. Education of the sued physician about medical malpractice stress is the key to dealing with the fear of litigation.
* Stress and Litigation Summary

|  |
| --- |
| 1. A certain amount of stress can be healthy and challenging; however, when coping resources are not available, stress can be harmful and may lead to burnout and impairment. |
| 2. To continue providing quality care to their patients, physicians must learn to effectively manage daily stressors. |
| 3. Physical, psychological, familial, spiritual, social, and occupational stressors may affect a professional’s level of functioning. |
| 4. Burnout is a process that usually occurs sequentially, progressing through stages and giving a person an opportunity to recognize symptoms and take necessary steps to prevent it. |
|  |
| 6. Intrusive thoughts or compulsions, feeling helpless or hopeless to change the course of events, and impulse to do something drastic or dangerous are ominous symptoms that require immediate attention. |
| 7. The average length of time from injury to notice of claim is approximately two years, and it takes an average of more than three years to disposition date. |
| 8. Ninety-six percent of physicians who are sued suffer physically and emotionally regardless of the outcome in court. |
| 9. The most traumatic moment in the litigation process appears to be when the plaintiff’s expert witness makes a deposition criticizing the physician’s treatment or action. |
| 10. Physicians who are sued experience a range of negative emotions that can have a paralyzing effect personally and professionally. |
| 11. Malpractice litigation changes the physician-patient interaction significantly. |
| 12. It is important to share feelings generated by the litigation process even though specific facts should not be discussed. |
| 13. Response patterns are similar to the grieving process (denial, anger/blame, bargaining, depression, acceptance). |
| 14. Coping successfully with malpractice litigation often requires learning more about the legal process, accepting that litigation may take years to resolve, and making use of support systems, such as colleagues, family members, and friends. |
| 15. Resilience involves maintaining flexibility and balance in your life as you deal with stressful circumstances and traumatic events. |
| 16. The tolls of unmanaged stress are addictive behaviors, relationship distress, emotional/behavioral problems, and professional consequences. |
| 17. Government regulations and demands from insurance companies are considered the most stressful aspects of being a physician. |
| 18. The key is not to try to avoid stress altogether, but to manage the stress in our lives in such a way that we avoid the negative consequences of stress. |

**Appendix A:** **Medical Malpractice Stress Syndrome Self-Assessment for *Physicians Adapted from Louise B. Andrew, M.D., J.D., 2005 (revised by S. Sandy Sanbar, MD, PhD, JD) http://www.mdmentor.com/SelfTestforMalpracticeStressSyndrome.html***

**Answer “YES” if you experience or feel any of the following**:

1. Anger or irritability affecting your satisfaction with life………………………. YES

2. Reduction or loss of control in life or at work …………………………............ YES

3. Singled out, isolated or distanced from your peers …………………..………... YES

4. Altered activity relative to your usual pattern ………………...……………….. YES

5. Symptoms of anxiety or depression...………………………………………….. YES

6. Changes in appetite or eating habits…………………………………………… YES

7. Insomnia or poor-quality sleep…………………………………………………. YES

8. Changes in libido (particularly reduction)……………………………………… YES

9. Emotional distancing from patients or office staff……………………………… YES

10. Tendency towards withdrawal from family, friends, group activities………… YES

11. Concerns about your competence or ability to make decisions……………….. YES

12. Hesitation to take on difficult problems or demanding patients……..………... YES

13. Compulsion to order more testing of patients…………………………………. YES

14. Less willingness to take on administrative decisions or activities…………….. YES

15. Thoughts about changing careers or limiting practice………………………… YES

16. Physical symptoms which are different or worse from normal……………….. YES

17. Fatigue, or reduced energy levels……………………………………………... YES

18. Loss of enjoyment in practice…………………………………………………. YES

19. Loss of interest in recreation…………………………………………………... YES

20. Drawn towards mindless pursuits, e.g. television, internet……………………. YES

21. Frustration that no end is in sight……………………………………………… YES

22. Stymied by the system from dealing directly with the problem………………. YES

23. Questions about value of persisting in medicine……………………………… YES

The defendant physician in a medical malpractice case who answers ‘YES’ to five or more of the above is stressed and should consider seeking experienced professional, supportive intervention.

***24. Intrusive thoughts or compulsions………………………………………….... YES***

***25. Alone in efforts to vindicate yourself from an unfair accusation…………… YES***

***26. Helpless or hopeless to change the course of events………….……………… YES***

***27. Impulse to do something drastic or dangerous………….…………………… YES***

***28. Thoughts about benefit of ending it all………………………..……………... YES***

**The defendant physician in a medical malpractice case, who feels any one of the last five items, must seek professional help *immediately.***

**Appendix B**

**Medical Malpractice Stress Syndrome Exam Questions**

1. What advice would you give to a Physician who is suffering from medical malpractice stress syndrome?
2. A certain amount of stress can be healthy and challenging.
3. When coping resources are not available, stress can be harmful and may lead to burnout and impairment.
4. To continue providing quality care to their patients, physicians must learn to effectively manage daily stressors.
5. All the above three answers (a, b, and c),
6. With respect to the Physician who is suffering from medical malpractice stress syndrome, one of the following answers is FALSE?

	1. Physical, psychological, familial, spiritual, social, and occupational stressors may affect a professional’s level of functioning.
	2. Burnout is a process that usually occurs sequentially, progressing through stages and giving a person an opportunity to recognize symptoms and take necessary steps to prevent it.
	3. Intrusive thoughts or compulsions, feeling helpless or hopeless to change the course of events, and impulse to do something drastic or dangerous are ominous symptoms that require immediate attention.
	4. Approximately 50 percent of physicians who are sued suffer physically and emotionally regardless of the outcome in court,
7. In a medical malpractice lawsuit, the most traumatic moment in the litigation process appears to be:

	1. When the plaintiff’s expert witness makes a deposition criticizing the physician’s treatment or action,
	2. When the lawsuit is filed.
	3. When the trial begins.
	4. When the Jury is deliberating behind closed doors.
8. Which of the following answers is FALSE with regard to Physicians who are suffering from medical malpractice stress syndrome?

	1. Physicians who are sued experience a range of negative emotions that can have a paralyzing effect personally and professionally.
	2. Response patterns are not similar to the grieving process (denial, anger/blame, bargaining, depression, and acceptance),
	3. Malpractice litigation changes the physician-patient interaction significantly.
	4. It is important for defendant Physicians to share feelings generated by the litigation process even though specific facts should not be discussed.
9. Coping successfully with malpractice litigation often requires:

	1. Learning more about the legal process.
	2. Accepting that litigation may take years to resolve.
	3. Making use of support systems, such as colleagues, family members, and friends.
	4. All the above answers (a, b, and c),
10. Which of the following answers is FALSE with regard to Physicians who are suffering from medical litigation stress?

	1. The key to treating litigation stress is to try to avoid it altogether,
	2. Resilience involves maintaining flexibility and balance in your life as you deal with stressful circumstances and traumatic events.
	3. The tolls of unmanaged stress are addictive behaviors, relationship distress, emotional/behavioral problems, and professional consequences.
	4. Government regulations and demands from insurance companies are considered the most stressful aspects of being a physician.

**SELECTED REFERENCES**

* Andrew, Louise; Litigation stress, 2006. http://www.mdmentor.com/resources/eMedicine+Litigation+Stress.pdf
* Andrew, Louise, Managing Medical Malpractice Stress, 2003. <http://www.magmutual.com/risk/malpractice-stress1.html>
* Charles SC, Wilbert JR, Kennedy EC. Physicians' self-reports of reactions to malpractice litigation. Am J Psychiatry 1984;141: 563-565. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/6703136)] [[Google Scholar](https://scholar.google.com/scholar_lookup?journal=Am+J+Psychiatry&volume=141&publication_year=1984&pages=563&pmid=6703136&)]
* Charles SC, Wilbert JR, Franke KJ. Sued and nonsued physicians' self-reported reactions to malpractice litigation. Am J Psychiatry 1985;142: 437-440. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/3976916)] [[Google Scholar](https://scholar.google.com/scholar_lookup?journal=Am+J+Psychiatry&volume=142&publication_year=1985&pages=437&pmid=3976916&)]
* Charles SC, Warnecke RB, Wilbert JR, Lichtenberg R, DeJesus C. Sued and nonsued physicians: satisfactions, dissatisfactions and sources of stress. Psychosomatics 1987;28: 462-468. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/3432549)] [[Google Scholar](https://scholar.google.com/scholar_lookup?journal=Psychosomatics&volume=28&publication_year=1987&pages=462&pmid=3432549&)]
* Charles SC, Psykoty CE, Nelson A. Physicians on trial: self-reported reactions to malpractice trials. West J Med 1988;148: 358-360. [[PMC free article](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1026123/)] [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/3363970)] [[Google Scholar](https://scholar.google.com/scholar_lookup?journal=West+J+Med&volume=148&publication_year=1988&pages=358&pmid=3363970&)]
* Charles SC, Warnecke RB, Nelson A, Pyskoty CE. Appraisal of the event as a factor in coping with malpractice litigation. Behav Med 1988;14: 148-155. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/3256367)] [[Google Scholar](https://scholar.google.com/scholar_lookup?journal=Behav+Med&volume=14&publication_year=1988&pages=148&pmid=3256367&)]
* Charles SC, How to handle the stress of litigation. Clin Plast Surg (United States), Jan 1999, 26(1) p69-77, vii
* Charles SC, Coping with a medical malpractice suit. West J Med (United States), Jan 2001, 174(1) p55-8
* Frisch PR, Charles SC, Gibbons RD, Hedeker D. Role of previous claims and specialty on the effectiveness of risk management education for office-based physicians. West J Med 1995;163: 346-350. [[PMC free article](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1303128/)] [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/7483591)] [[Google Scholar](https://scholar.google.com/scholar_lookup?journal=West+J+Med&volume=163&publication_year=1995&pages=346&pmid=7483591&)]
* Gabbard GO. The role of compulsiveness in the normal physician. JAMA 1985;254: 2926-2929. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/4057513)] [[Google Scholar](https://scholar.google.com/scholar_lookup?journal=JAMA&volume=254&publication_year=1985&pages=2926&pmid=4057513&)]
* Horowitz MJ. Stress Response Syndromes. 2nd ed. Northvale, NJ: Jason Aronson; 1986.
* Reading EG, Malpractice stress syndrome: a new diagnosis? Md Med J (United States), Mar 1987, 36(3) p256-7
* Reading EG, The malpractice stress syndrome. N J Med (United States), May 1986, 83(5) p289-90
* Schwartz, Shelly K.; Malpractice: Navigating a Lawsuit: Roughly two-thirds of U.S. physicians will be sued at least once during their careers. How can you prepare yourself? Physicians Practice, October 2008. http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/1233.htm
* Sorrel, Amy Lynn; Litigation stress: Being sued is personal as well as professional - Some programs are helping physicians cope. *Posted Nov. 2, 2009. Last visited Dec. 14, 2009.* http://www.ama-assn.org/amednews/2009/11/02/prsa1102.htm
* Troxel, David B., Jenkins, Paula, Dixon, Laura A.; Coping with Depositions, 2007. http://www.thedoctors.com/KnowledgeCenter/PatientSafety/articles/CON\_ID\_000329
1. <https://www.ncbi.nlm.nih.gov/pubmed/3976916/>, Charles SC, Wilbert JR, Franke KJ, Sued and nonsued physicians' self-reported reactions to malpractice litigation. [Am J Psychiatry.](https://www.ncbi.nlm.nih.gov/pubmed/3976916/) 1985 Apr;142(4):437-40 [↑](#endnote-ref-1)
2. <https://www.gilmanbedigian.com/what-is-medical-malpractice-stress-syndrome> [↑](#endnote-ref-2)
3. <https://www.kevinmd.com/blog/2013/03/medical-malpractice-stress-syndrome-side-litigation.html> [↑](#endnote-ref-3)
4. <https://opmed.doximity.com/articles/medical-malpractice-stress-syndrome-and-catastrophic-vascular-complications?_csrf_attempted=yes> [↑](#endnote-ref-4)
5. <https://www.kevinmd.com/blog/2014/03/4-keys-manage-medical-malpractice-stress-syndrome.html> [↑](#endnote-ref-5)