

RISK MANAGEMENT

Most Doctors Win: What to Do If Sued for Medical Malpractice

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All gastroenterologists are at risk of being accused of medical malpractice; few have received much training about what to do should a lawsuit occur. This article details what one can expect in a typical medical malpractice negligence claim and reviews basic relevant legal terminology. The timeline of a lawsuit is described, particularly noting the physician's role in discovery and trial. Cautions and suggestions for successful navigation of this unfamiliar and uncomfortable world are dispensed.

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INTRODUCTION

Even the most conscientious, well-trained, and competent gastroenterologist is at risk to become a defendant in a lawsuit. Although most doctors—approximately 80%—will eventually prevail, a malpractice suit can be relatively easily initiated, with low evidentiary requirement in most states. Many suits occur as a result of a bad outcome rather than medical negligence (1,2). A lawsuit is a stressful process regardless of the outcome (3). The landmark large Harvard study of malpractice claims filed over a period of time in New York informed us that there are more episodes of medical negligence than there are medical lawsuits (1). However, more lawsuits result from non-negligent bad outcomes than from physician negligence (2) (see **Table 1**). Indeed, although many suits are said to reflect a desire for understanding of the event and restitution in the face of poor physician–patient communication regarding perceived bad treatment (4,5), some legal suits may be perceived by the financially impaired plaintiff as the only available avenue toward financial restitution and recovery (see **Table 2**).

The fear of being subject to a lawsuit is pervasive in medicine and may affect how one practices (i.e., defensive medicine) (3,6). The angst is perhaps more proportionate to the perception of the pain and humiliation associated with the process and character of a lawsuit than to the frequency of occurrence. The consequences of being sued are not merely the time spent in defense preparation but may involve personal loss of self-esteem, depression, family stress, credentialing issues, and financial worry. Fortunately, gastroenterology has fewer suits than many specialties (7,8). Further, some bad outcomes (i.e., perforation) occur within the acceptable standard of care and are highly amenable to successful defense.

Physicians receive relatively little legal training during our long education process; and much of what we do receive is designed to protect the institutions within which we work and train. Thus we receive relentless (and often incomprehensible) fraud, abuse, and billing training from our employers, and training about informed consent from our medical insurers. Little training is given about the process of a medical (negligence) lawsuit. This article is meant to be a brief travel guide to the land of the lawsuit. This will hopefully reduce the stress of anticipation of a lawsuit and provide instruction, suggestions, and medical legal pearls for dealing with an actual suit.

PREVENTION

Although the main purpose of this article is the description of a lawsuit, malpractice education begins with prevention. The principle behind risk management is that the identification of areas of legal risk will allow development strategies to reduce that risk. The implementation of those strategies will hopefully prevent lawsuits. A full discourse on lawsuit prevention would be an article in itself; however, a few tips and examples will suffice to guide the practitioner.

1. Guidelines are used by the plaintiff's attorney to describe standard of care. Be knowledgeable about major gastroenterology society guidelines, and document reasons for your exceptions to the guidelines (such as patient frailty and patient refusal) (9).
2. Although it is a very valuable and widely practiced model, there is less of a physician–patient relationship in open-access endoscopy. Be careful regarding your open-access

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process to ensure appropriate informed consent, assessment of significant family history, and prescreening for major illnesses and anticoagulation (10).

3. Complications are a risk area. Do not ignore post-complication care out of embarrassment, fear, or concern that your answers to questions may later be quoted in a suit. Make certain the patient is well cared for by your medical and surgical colleagues, as well as by you. Engage your clinic or hospital risk management team if appropriate.
4. E-mails are discoverable. Remember the old saying: never e-mail anything you would not want on the front page of your newspaper.
5. The electronic medical record (EMR) may become a fertile area for the plaintiff's attorneys. EMR policies regarding timing of response and completeness for staff-to-staff and patient-to-staff communications may prevent challenges about poor follow-up (11).
6. Vicarious liability pertains to your responsibility for your subordinates. Ensure adequate training and policies for office staff.
7. Your duty to your patients involves appropriate office wait time and routing of the emergent call received by your office staff. You may be vicariously liable for the emergent call taken by your staff, even though you never received the message (12).
8. Endoscopic sedation of frail patients for prolonged and complicated procedures requires care; consider anesthesiology support where appropriate (13–15).
9. Consider the risks and benefits of endoscopic retrograde cholangiopancreatography, and whether magnetic resonance cholangiopancreatography may be more appropriate, especially for diagnostic procedures (16).
10. Carefully document informed consent for the use of high-risk medications, such as those often needed for control of inflammatory bowel disease (17).

EVENT WITH LAWSUIT POTENTIAL

Many gastroenterologists have risk management personnel available through their clinic, hospital, or insurer. Many physicians are concerned that notifying their risk management personnel of a risk event will engender a negative perception of them, and they prefer to hope that the lawsuit will not materialize (the head-in-the-sand approach). Actually, you should consider notifying your risk management personnel, who can then help to be sure steps are taken in your defense, such as

flushing out the defense strategy before much is forgotten, being especially careful to preserve evidentiary materials, and, sometimes, helping waive certain bills, particularly for post-complication care.

APOLOGY

There is increased interest in and literature about discussing harmful medical errors with patients, and apologizing for them. Some authors and proponents of disclosure believe that error disclosure will restore trust and integrity to health care, increase effective communication, decrease patient anger, allow patients a sense of physician accountability, and reduce lawsuits, particularly if coupled with a compensation program (4,18,19). From a strictly legal point of view, it has also been pointed out that there are substantial holes in many state apology laws. For instance, two-thirds of state apology laws protect only expression of regret, not information regarding causality or fault; further, an apology provides useful information to a plaintiff's attorneys as they decide whether to take the case, even if the apology can't be presented at trial (3). There are some data on reduction in claims experience related to the establishment of apology programs, but definitive data are not yet available (3,4). Many institutions have personnel who can help the physician understand and craft an apology, and one can review the issue with a risk manager regarding an event with malpractice potential.

A physician may also express empathy regarding a bad outcome, but be careful not to label it a medical error. For instance, a colon perforation is a bad outcome, unless there was standard technique or another issue that would make it a medical error. Even a "missed" colon cancer may be a bad outcome rather than a negligent medical error (20).

TIMELINE AND STRUCTURE OF THE LAWSUIT

Overview

The initial phase of a lawsuit begins with service to the physician of a summons or complaint, which alleges medical malpractice. The physician's attorney, after review with the physician, will seek dismissal of the suit, or answer it, rebutting the claims, i.e., denying malpractice. The second phase is discovery, in which the attorneys for both parties attempt to determine the facts, seek expert opinions, and develop their sides of the case. This will generally last at least one year, usually much more (occasionally almost a decade!). As the discovery progresses, one party may obtain sufficient information to propose a settlement. If there is no settlement, the case goes to trial and a verdict is reached. If the physician loses (or settles at amounts above a triggering limit), the claim is paid, and a report will be filed with the National Practitioner Databank (NPDB); this will be reportable during medical credentialing processes. Although NPDB reportability has been of most concern to physicians, most credentialing processes request that the physician report information on any malpractice action, loss of privileges, and a host of other adverse events (21,22).

Table 1. Legal terminology relevant to a malpractice lawsuit

Claim: Assertion of wrongdoing that forms the basis for the suit.

Deposition: The questioning under oath of the plaintiff, defendant, and witnesses during the discovery phase of the lawsuit.

Discovery: The period after a lawsuit is filed when both sides have a right to discover as much information as possible about the events in question, by requesting documents (medical records), by questioning witnesses and experts (during depositions), and by posing written questions to the defendant doctor (interrogatories).

Expert witness: A physician or other provider who specializes in the care and treatment of the illness or injury at issue. They are meant to be objective purveyors of knowledge and the current standard of care, but in practice the experts chosen by each side generally believe and support that side of the argument.

Interrogatories: Written questions to which the defendant or plaintiff must respond, generally guided by his or her attorney.

Negligence: A physician's failure to meet standard of care, the care that a reasonable physician would deliver under similar circumstances.

Res ipsa loquitur: "The thing speaks for itself," referring to something an ordinary citizen may understand, which therefore does not require expert testimony. The classic example is the operative sponge left in the body at surgery.

Service: Legal method for delivery of the summons, notifying the recipient that a lawsuit has commenced.

Subpoena: A judicial requirement that a witness appear before the court.

Summons: A legal document identifying the plaintiff and defendant, with court identifiers, notifying the defendant that a lawsuit has been filed.

Notice

After you have been served (i.e., received the summons, or notice of lawsuit), you should contact your risk management personnel, and/or your malpractice insurer.

Do not discuss the case with your colleagues, who can be subpoenaed and deposed to reveal the content of that discussion.

Do not contact the plaintiff's attorney to try to convince him or her of the merits of your opinion and the fruitlessness of pursuing the case. He or she has already decided there is enough merit to at least begin the process. You will not persuade the opposing attorneys; all you will have done is to provide useful information to them.

Contacting your attorney

Meet with your attorney. Meeting with your attorney is important and should be accomplished early. It is often reassuring, as it gives you an opportunity to ask detailed questions and allows you to understand the process that will unfold. It enables you to present your case in protected fashion, and to understand how you may help by guiding or assisting the choice of expert witnesses, participating in research and discovery, and learning what contacts and mistakes to avoid. It allows you to develop a rapport with the attorney, which will become important—and, in the uncommon instance of poor rapport, to request other counsel. It will be important to present background information that may not be in the chart

notes, to translate from medical-speak into plain English, and to alert your attorney to any treatment decisions and actions you perceive to be areas of weakness in your case. Your attorney is representing you and needs the information to prepare an answer, or to understand whether to push for a settlement, even if a high amount. Not discussing negative information with your attorney doesn't make it likely that the information won't eventually come out. It merely makes it likely that when the information surfaces, your attorney won't be prepared for it, and your case may be damaged.

Again, do not contact the plaintiff's attorney to discuss the case.

Assess potential conflict of interest on the part of your attorney. This is an aspect of analysis of the physician's risk from the lawsuit that may not be readily apparent and may not be mentioned by one's attorneys. It involves whom the attorney is hired to represent. Most physicians assume the attorney is exclusively representing them. Some institutions are self-insured and hire their own attorneys, with the insurer's attorney becoming involved only if the reinsurance is threatened. However, the attorney is hired by the institution or insurer and owes allegiance to the institution or insurer, which is in fact the attorney's client. In most cases, the needs of the physician and those of the institution and insurer are synchronous. Thus, vigorous defense of the physician is the goal of the institution, the insurance company, and the attorney.

However, there are some situations in which those interests may diverge. Say the physician has coverage of \$1 million per claim. An offer of settlement for \$1 million, if accepted, prevents the potential of a higher jury verdict—say, \$2 million, half of which would be the financial responsibility of the physician. Thus, settlement within coverage limits of a legally risky or uncertain case is often in the physician's best interest. However, the insurer has nothing (other than court costs) to lose by a jury trial and excess verdict, since the \$1 million the insurer would pay in settlement is the insurer's coverage maximum, no matter how high the verdict. (In general, the insurer's attorney is obligated to discuss this with you.) Also, if it were unclear how the claims of a lawsuit were to be structured, it could be in the insurer's financial best interest if the physician were accused of a non-covered claim—battery (which is not covered by insurance) rather than lack of informed consent (medical negligence, which is covered). A loss on the claim of battery (fortunately that claim is rare in modern malpractice suits) is not paid by the insurance and falls to the personal resources of the insured. Sexual impropriety is also not covered by insurance. In these cases, the lawyer has an ethical duty to inform the physician that a potential conflict exists; and many insurers will accept the need to hire another attorney whose sole client is the physician. If not, the physician is advised to hire counsel to review or supervise the insurance company-provided attorney and to be sure the physician's interests are paramount as the case proceeds (23,24).

Discovery

Discovery is quite a long phase of trial (or settlement) preparation. In this phase, the attorneys develop the case by finding the important facts, building hypotheses about what went wrong, and whether any fault exists.

Courts are quite interested in the development of the facts and give wide latitude to these requests, and they expect compliance from the physician and expert witnesses, with forthright, honest, and direct answers. The process will include requests for production of documents (mostly chart materials), interrogatories (lists of relevant questions your attorney will answer with your assistance), and depositions. Your attorney will benefit from your help in explaining the medical aspects of the case, and perhaps in guiding the attorney's research. In many nonmedical trials, e-mails regarding the case under review provide relevant information and are requested. If your e-mail contains relevant data about your case, it could be requested. It would be best not to use e-mail for discussion or transmission of relevant material about your case for several reasons, but particularly the difficulty of having to provide the relevant e-mails as part of discovery.

Usually, burden of production, i.e., the argument that some records and data are hard to find, is not an acceptable excuse. You will be required to go to significant effort and expense to produce documents the judge concurs has potential merit for understanding the case.

Table 2. Legal malpractice pearls in brief (see article for full explanations)

1. Never alter the medical record. It is unethical and against your interest, and the record has already been copied for the plaintiff's attorney.
2. Do not discuss the case with your colleagues, who may be subpoenaed to testify as to the content of your conversation.
3. Do consider, and ask your insurance company-provided attorney, whether there are any conflicts of interest in that attorney's representation of you.
4. Your demeanor is very important; do not appear arrogant, demeaning, or unprepared.
5. Deposition tips: Be well prepared: reread the medical record thoroughly, research the medical problem at issue, and have it down cold. Don't rush.
6. If asked whether certain texts, journals, or guidelines are the accepted authorities in the field, be sure to qualify any affirmative answer.

Peer-review data are usually protected from discovery, as long as the peer-review process is scrupulously followed. If you emerge from a peer-review session and then, over lunch with your colleagues, reveal the entire discussion, you have just lost that peer-review protection. Further, when you are asked whom you discussed the case with (and you will be asked), you will need to disclose that luncheon and those lunch buddies, who will then be deposed to testify regarding your statements.

It is likely you will be asked to appear at a deposition, where the plaintiff's attorneys will question you in advance of trial. Be well prepared: reread the medical record thoroughly, research the medical problem at issue, and have it down cold. Don't rush: take your time before answering each question. The plaintiff's attorney will probably ask for some of the same information repeatedly, looking for divergent answers and perspective; keep your story straight. Answer honestly but concisely; do not volunteer information, and try not to elaborate. Remember, you are not trying to convince the plaintiff's attorney of your point of view—only the plaintiff's experts and research can do that. The plaintiff's attorney is trying to get enough rope to hang you, quoting your words within a context that he or she will present; you are trying to fulfill your legal obligations to honestly answer questions put to you, while giving out as little rope as possible. Ask your attorney to have a practice deposition with you. If asked whether certain texts, journals, or guidelines are the accepted authorities in the field, be sure to qualify any affirmative answer, noting that the state of the art changes, and that no text is universally accurate or universally applicable—each specific citation needs to be examined in the context of the particular patient and problem.

The expert witnesses

Medical malpractice attorneys are quite knowledgeable about how to develop the case, and about many common aspects of

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medicine. However, they will rely on the opinions of experts to assess whether your actions fall within the standard of care, and to understand how best to defend you. You may be requested to help the attorney by suggesting knowledgeable and personable local and national experts.

Your attorney will also be familiar with the “hired gun,” and knowledgeable in questions that get to the amount of income earned in witnessing, and the proportion of plaintiff representation before the jury. There is a code of conduct for the expert witness in gastroenterology, promulgated by the *American College of Gastroenterology* (25,26).

Settlement

Most cases are settled. After discovery, experienced attorneys will have a sense of which case is stronger, which witnesses and experts will appear more credible or sympathetic, which side has the lowest risk tolerance for uncertainty (a jury trial victory is never fully predictable), how soon the money may be needed by the plaintiff, and what are ballpark financial-verdict expectations. It often behooves both sides to settle for an agreed amount (within the physician’s coverage limits) rather than for the plaintiff to risk receiving nothing, or for the physician to risk a verdict above coverage limits, requiring expenditure of personal resources (22).

Trial

If you do get to trial, remember, the jury is not a group of medical epidemiologists. Scientific proof is not the sole determinant of victory. Be present and visible at the whole trial—which generally will last several days—demonstrating your belief that the trial and its verdict are important. Keep your demeanor appropriate, as you would in a medical office visit. The jury needs to trust you and to believe you are a caring physician (27).

EMOTIONAL ASPECTS OF BEING THE DEFENDANT

Experienced malpractice attorneys attest to the emotional difficulty of being a defendant. The physician’s world may feel surreal. Instead of receiving respect, there is a characterization as incompetent and perhaps uncaring. Instead of moving on, there is repeated replaying of the events leading to the claimed injury. There may be physician guilt or anger over the situation. The process is unfamiliar and stressful. Understand that there is a game being played, and those damaging characterizations are part of it; attempt to establish some distance despite the intensely personal nature of the attacks. The angst is perhaps more proportionate to the perception of the pain and humiliation associated with the process and character of a lawsuit than to the frequency of lawsuit occurrence. The consequences of being sued are not merely the time spent in defense preparation but may involve personal loss of self-esteem, depression, family stress, credentialing issues, and financial worry (22,27). Take care to address and ameliorate the emotional issues and to be attentive to family stressors, and do not be embarrassed to use supportive resources.

SUMMARY

Any gastroenterologist can become a defendant in a lawsuit. A suit can easily be initiated with low evidentiary requirement in most states, and many suits occur as a result of a bad outcome rather than medical negligence. The fear of being subject to a lawsuit is pervasive in medicine and may affect how one practices. The uncertainty of how to respond heightens that fear. The knowledge that physicians most often win, the knowledge of what to expect regarding a suit, and the knowledge of time frames and of how to participate in one’s own defense, may help reduce that fear and uncertainty.

CONFLICT OF INTEREST

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