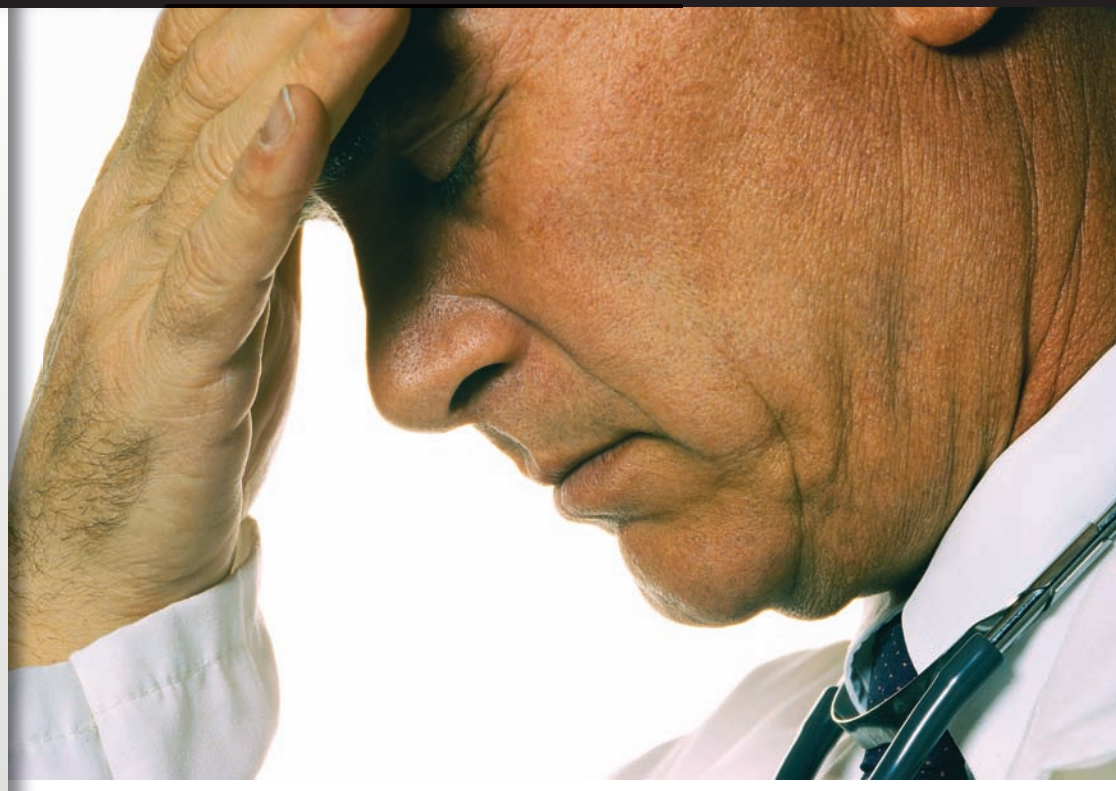
Burned-out Physicians in Litigation: Providing the Support They Need

By James W. Saxton, Esq., and Daniel Shapiro, PhD

The phone call was unsettling, because our preparation had been significant. We'd conducted multiple sessions, including videotaping and exhausting mock cross-examinations. Over time, the doctor's demeanor had improved. Before, he'd rocked nervously and answered with a halting cadence, his eyes down and looking away—now, he was sitting with his chin up, speaking clearly, and with that calm authority we knew the jury would appreciate.



To us, it seemed he had finally relaxed enough to tell the court his story effectively. He was ready, and not a moment too soon.

But then the call, and his reedy voice saying, "I just can't. I can't think about it anymore. I don't trust any of them, not the jury, not the judge. I can't sleep, I have headaches. You have to make this go away. Please."

All experienced defense attorneys have fielded this call; we know how to reassure and give a gentle push. But with a surprising finality, the doctor responded, "No, I can't take the stand. I will not."

Although we believed him, we thought that with some additional pressure we could get his cooperation, but we also knew that in his current state he'd be a terrible witness. So, another winnable case, or perhaps at least a compromise verdict or negotiated settlement in a more rea-

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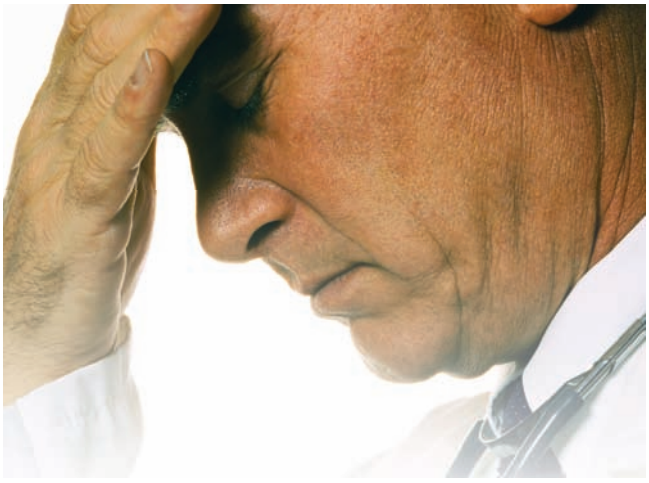
sonable range, was going to be settled at a number more in line with the plaintiff's demand.

This has to stop. Not only because of the financial repercussions, but because it isn't just. A physician who loses a winnable suit because he's frozen at the intersection of his psychological state and the arduous nature of litigation has revealed another flaw in our system. Not to mention that it encourages plaintiff's attorneys to pursue unjustifiable cases aggressively, just because they feel they can ultimately intimidate a physician.

In addition, the doctor may never be at peace about what has transpired. While in the short term it will doubtless feel good not to wake up thinking about the case, the long-term consequences, including the need to report the inflated settlement on credentialing applications and responding to the state board inquiry, will be bitter reminders. No: A win, well within our sights, would be much better.

Laurie C. Drill-Mellum, MD, was right in her comments in the Second Quarter 2016 issue of *Inside Medical Liability* ("The Evolution of the Chief Medical Officer Role in MPL," page 41). Physicians' health (both mental and physical) must assume a more prominent position in society and in our approach to litigation. Physician well-being impacts not only their productivity and liability; it also challenges this group of professionals we all need so badly, down to their very souls.



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Why the focus on physicians' health now? Not just because the statistics on it are so alarming, but also because healthcare is going through a period of transition, and with transition comes additional stress. So if anything, now is the time to focus on understanding better the root cause of physicians' stress and, equally important, learn how to support, manage, or defuse it.

Our firm has invested in understanding how to better recognize stress and help in light of this growing concern. We recently hired a Director of Physician Health, a noted national psychologist on the subject, Daniel Shapiro, PhD. The following summarizes some of the work Dr. Shapiro has done and highlights some statistics that show just how severe this problem has become.

Psychological status of physicians

By any occupational measure, physicians are a psychologically vulnerable population. Whereas status, economic power, job security, and education are typically protective factors against distress, physicians score at the very top of distress scales, including measures of burnout—the latest studies show that 54.4% of physicians have at least one symptom of burnout[1] and depending on specialty, upwards of 40% to 55% of physicians are severely burned-out,[2] demonstrating symptoms of fatigue, withdrawal, irritability, and depersonalization. And the rates are getting worse. A repeated Medscape survey of thousands of physicians have found that rates of burnout have increased by 16% in the last two years. In profound cases, physicians experience severe depression,[3] substance abuse,[4] and even commit suicide at higher rates than we see in professionals of equal status and economic power.[5]

Notably, burned-out physicians are more likely to be sued. They are less productive[6] and practice medicine less safely,[7] have significantly higher medical professional liability (MPL) claim rates,[8] and are at risk of leaving their practice abruptly.[9] Burnout worsens morale and can rapidly corrode a brand that may have taken decades to create. Recognizing the importance of burnout, healthcare enterprises around the world have called for the expansion of the Triple Aim to include health professional wellness as a fourth aim.[10] But progress in ameliorating burnout has been painfully slow and lags well behind the powerful forces that are exacerbating distress, including increased patient loads, time-consuming and frustrating electronic health records, reduced compensation, and the increasingly public nature of safety, quality, and satisfaction reports. In addition, mergers and acquisitions are upending the career trajectories of many physicians whose paychecks and work environments are quickly changing.

Put simply, today's physicians often feel that they are practicing high-stakes medicine in a public fishbowl with too many patients, too little support, and in systems in which they feel they have little input or control.

As a result, physicians are coming into the stressful MPL system with their psychological tanks already on "empty." And then, when we most need them to be able to advocate for themselves, we are doing a poor job in recognizing and addressing the psychological distress they experience.

Unlike attorneys, who have been professionally acculturated to litigation and are familiar with its feigns and parries, strategies and tactics, physicians often have surprisingly little familiarity with the system and are unaccustomed to being accused of negligence, ignoring

patients' pain, or recklessness. Nor have they had hundreds of hours to pore over every decision they've made on each of their many patients. The hot, and overly critical, magnifying glass of the plaintiff's attorney is typically unlike any review of care they've experienced at the hands of teachers and colleagues who naturally understand the realistic confines of care.

As a result, physicians often describe MPL litigation as among the worst experiences of their entire lives. A Medscape survey of 4,000 physicians revealed that 46% of men and 57% of women who were sued describe it as either one of the worst experiences of their lives or as a very bad, disruptive, and humiliating experience.[11] Unfortunately, many defense attorneys either don't recognize this distress or underappreciate it, preferring to focus on the challenging case at hand. Worse, some attorneys mistakenly believe that if a case is defensible, the physician must feel optimistic when, in reality, the majority of physicians are distressed during litigation and a significant percentage are so distressed that they are even considering abandoning the case, medicine, or both.

What can be done in the litigation arena?

The first step is identifying which doctors need greater support. This is not obvious. In colleges of medicine, we train physicians, often covertly, to ignore their own needs in the service of their patients. They learn during medical school and residency to grind out care even when they feel unwell, exhausted, or stressed. In fact, in recent surveys 83% of physicians and advanced practice clinicians admitted that they had worked at least once in the past year when they were too ill to work effectively.[12] They are taught not to complain and to meet the needs of their team as soon as they arrive at their practice setting. As a result, most physicians are not quick to share when they feel anxious, upset, or distressed.

One of us (D.S.), a psychologist who has treated physicians for many years, has noticed that they present for psychotherapy or even couples therapy at a significantly later point in their difficulty than others. Whereas other clients typically acknowledge the point when their discomfort has grown severe enough to prompt them to seek help, physicians tolerate that level of anguish and refuse to seek help until they approach a total loss of function or are referred because of aberrant behavior. As a result of this tendency to ignore discomfort until it has grown severe, it is usually impossible for attorneys to accurately assess the psychological states of their physician clients simply through observation.

For that reason, our team has developed two assessment tools. The first, a clinical effectiveness survey, is designed to detect and prevent specialty-specific, high-risk behaviors (for example, surgeons failing to routinely administer prophylactic antibiotics within one hour of skin incision) and general risk factors (such as burnout). This clinical effectiveness survey helps hospital administrators, practice managers, and other leaders identify their systematic medical-legal vulnerabilities.

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The second tool assesses physicians after they've been named in a suit. Dr. Shapiro developed the Witness Inventory for Health Professionals (WIP), a 10-question survey in three sections. The first assesses the physician's psychological response to being sued and provides a score that can be compared with that of other litigants. The second section is designed to assess their typical responses to stress, especially observable behaviors that might worsen their ability to serve as advocates for themselves as a witness. The final section assesses their routines for self-care, including activities that improve or worsen their sense of stress.

In our initial meetings with physician clients who have been named as defendants in MPL actions, our lawyers now provide each doctor with the WIP survey. The assessment enables our legal team to identify providers who are in need of additional psychological support and coaching during the litigation process. Many attorneys are hesitant to inquire prospectively about the psychological status of their clients out of respect and perhaps over concerns about the firm's resources. But it's our experience that physicians will readily acknowledge their psychological distress on the WIP and indeed, many are well accustomed to responding to burnout and engagement surveys that are ubiquitous in hospital systems. Unfortunately, insurers and lawyers have been too slow to embrace this scientific approach to assessing the well-being of physicians.

Developing a plan

Once we understand the psychological strengths and deficits facing our clients, we can begin to craft a personalized plan that improves their well-being and their ability to navigate the legal system as a witness. This may translate into seeing fewer patients for a while, improving self-care activities, and taking an honest look at their priorities. In the best situations, a suit can be a wake-up call that helps physicians transition to healthier lifestyles and practice patterns. This, in turn, can make them a more confident, capable witness.

Dr. Shapiro has brought into focus a number of issues at our firm. We can help identify at an earlier point when our healthcare professionals need help and actually support them in a fashion that works. There is science behind this, and privacy can and should be respected. Significantly, for the MPL industry, and certainly for defense counsel, we can develop more confident witnesses, who are ready and able to take the stand and tell their story. We know that when this happens the result is overwhelmingly positive.

First, it is what our doctors deserve. Second, it has the potential to transform a case from one in which the healthcare professional may refuse to testify, or at best looks hesitant or nervous (and jurors often misinterpret this as a lack of candor) to one in which the healthcare professional is truly engaged and a full contributor to the team. We need this counterbalance. Plaintiff's strategies around the country include adding punitive damages, asset discovery, and threatening attachment of personal property, all in an effort to intimidate. It is easy for us to say such findings are remote; we are not in the proverbial hot seat. Of course we need to continue to fight the legal and strategic battle aggressively, but, in addition, providing an additional level of scientifically based psychological support, along the lines Dr. Shapiro is suggesting, will make a difference. We have seen the results. Since bringing Dr. Shapiro aboard, we don't get calls like the one related in the opening sentences of this article. Our physicians are in a better position to endure litigation and are able to use the experience as a reminder that they need to make a greater investment in self-care and other protective activities.

For related information, see www.saxtonstump.com.

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