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You've Been Served, Now What? Malpractice tips and prevention for the acute care surgeon

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SUMMARY

Trauma and acute care surgeons commonly perform high acuity and emergent interventions on critically ill or injured patients. This often entails making life or death decisions rapidly and with incomplete and imperfect information, and in patients who may have a variety of comorbidities that contribute to the risk of adverse outcomes. In cases where there are real or perceived breaches of care, a medical malpractice claim may result. In the USA, approximately one-third to one-half of all physicians will be named in medical litigation at least once in their career. Among the various specialties, surgery remains among the highest risk for malpractice litigation, at an average of 10.6 defendants per 100 surgeons. These events can be extremely stressful, demoralizing, or even devastating to the career and well-being of the involved physicians. This can be made better or worse by the individual response and actions of the surgeon on notification of a real or potential claim, and the primary goal of this review is to highlight these key areas and optimal strategies in malpractice scenarios. This includes strategies to manage the initial receipt of a malpractice claim, subsequent courses of action, and advice for incorporating preventive measures into everyday practice.

INTRODUCTION

Trauma and acute care surgeons commonly perform high acuity and emergent interventions on critically ill or injured patients. This often entails making life or death decisions rapidly and with incomplete and imperfect information, and in patients who may have a variety of comorbidities that contribute to the risk of adverse outcomes. In cases where there are real or perceived breaches of care, a medical malpractice claim may result. In the USA, approximately one-third to one-half of all physicians will be named in medical litigation at least once in their career. Among the various specialties, surgery remains among the highest risk for malpractice litigation, at an average of 10.6 defendants per 100 surgeons (figure 1). These events can be extremely stressful, demoralizing, or even devastating to the career and well-being of the involved physicians. This can be made better or worse by the individual response and actions of the surgeon on notification of a real or potential claim, and the primary goal of this review is to highlight these key areas and optimal strategies in malpractice scenarios.

This review will be divided into two parts. The first relates to the professional aspects and the second will discuss the personal side of being sued. It is important to note that this should not be construed as offering 'legal advice,' as the optimal actions to take in a given scenario will vary greatly by the situation and also between the relevant local and state statutes. What we will attempt to offer in this review are insights into many aspects of being served with a notice of real or potential malpractice litigation that you may or may not be aware of. The standards and regulations for medical malpractice can differ between states. Always consult with an attorney that specializes in malpractice law for definitive answers and advice. The authors of this work have experience with being named in malpractice suits as primary or 'significantly involved' physicians, with assisting or leading groups where other surgeons have gone through this process, and in serving as medicolegal expert witness reviewers for both the plaintiff and defendant sides of litigation.

PART 1: PROFESSIONAL ASPECTS

Every surgeon's nightmare…you receive a notification of legal action, you are named as a defendant in a medical/surgical malpractice case, that is, you've been served. This is the first phase of a malpractice suit against you. From an AMA Benchmark Survey,[1] nearly one-third (31.2%) of US physicians in 2022 reported they had previously been sued. Note that being sued is not always related to a bad outcome or having committed malpractice. Poor communication with the patient/family, a misunderstanding of something discussed, or an unrealistic expectation of the surgical outcome are all potential non-procedural initiators of a lawsuit. A retained foreign body (sponge or instrument), wrong site surgery, failure to properly diagnose an injury that leads to death or disability, or incorrect procedure are all examples of typical and common initiators of a lawsuit. Of interest, there is little data that the severity of a complication or the impact on the patient is the primary driver of pursuing malpractice litigation. The most commonly cited factors are poor communication between the surgeon and patient, conflict or disagreements among the patient and family members and the managing surgeon, and the financial impact of the resultant disability.

Do's and don'ts

There are several issues related to 'being served' that you need to know about to best deal with the multiple processes and personal issues that will be initiated after 'being served.' Figure 2 provides a key list of 'do's and don'ts' for the physician who has received notification of a malpractice claim. Once you have been served, notify your employer

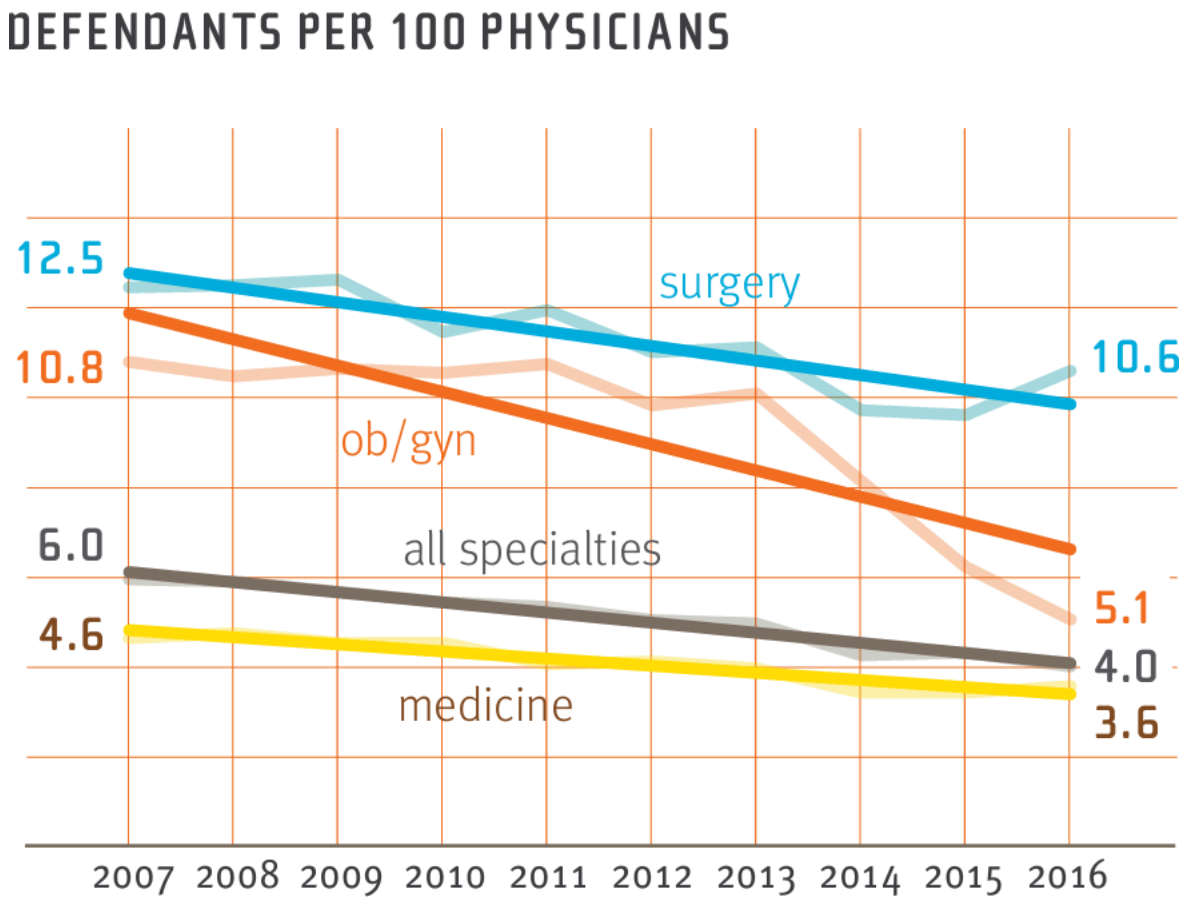

Figure 1 Rates of malpractice litigation by specialty highlighting the overall decrease in the rates but that surgery remains the highest risk specialty.[20]

or insurance carrier if in private practice. There are several 'do-nots':

- Do not discuss the case with colleagues or friends without first speaking to your attorney assigned to the case; you can discuss generalities with spouses (without any case specifics) but ask your attorney first.
- Do not review any medical records without your attorney present and in control of a copy of them.

Figure 2 List of things to do and key things not to do when served with a notice of malpractice litigation. *The advice to not contact the patient or family does not apply if the patient remains actively under your care. In that case, proceed with contact and interaction as you normally would, but do not directly discuss any aspect of the case with the patient or family.

- Do not edit/revise/add anything to the medical record once you have received notice or are aware of pending litigation (prior to receiving a subpoena).
- Do not feel like or believe you are in charge of all aspects of your legal defense, follow the lead and advice of your attorney. You will have and are entitled to your opinions and can assist in facilitating building your defense.
- Do not minimize the necessity of reading all details of the complaint against you, any and all depositions, expert witness statements, etc.

Definition of 'malpractice'

First, the definition of malpractice is appropriate to know. The plaintiff, the party bringing the suit against you (the defendant), must prove four elements of negligence under tort law:

1. There is a duty to the patient.
2. Once a duty has been established, the plaintiff must show that there was a breach of this duty; the standard of care (SOC) was not met.
3. There must be a direct and causal link between a failure to meet the SOC, and that this failure results in an injury to the patient; must prove that negligence caused injury or harm, and that, without the negligence, it would not have happened.
4. Last is damages; there must be injury to the patient due to the above elements that can include but are not limited to:

a. suffering;
b. enduring hardship;
c. constant pain;
d. considerable loss of income;
e. disability;
f. death.

Surgery (Medicine) involves risk, and not every negative outcome is grounds for a malpractice lawsuit. There is a term we use, 'Mal-Occurrence' that differentiates a negative/unexpected outcome or complication that had no negligence associated with it that is more common in our practices. Bad things (complications, death/disability) do happen in the field of trauma that can be due to factors not in our control, that is, the degree of injury, the degree of physiological decompensation/shock before they arrived to us, etc. Getting a wound infection when all appropriate pre-during-post procedure guidelines and standards of care were followed happens and is a mal-occurrence, not malpractice. A decapitated patient has no chance of survival regardless of what a family believes you did right or wrong and may blame you for a 'preventable' death. A medical malpractice lawsuit must demonstrate negligence on the physician's part. Negligence requires proving, based on the medical facts of the case, that the alleged deviation from the SOC and the patient's injury were cause and effect.

Discovery

The second phase of the malpractice litigation process is termed 'discovery.' This includes the requests for documents, depositions, and interrogatories.

- Any and all documents associated with the care of the patient, typically inpatient/outpatient hospital or clinic records, notes and/or letters you may have made outside of the medical record.
- Depositions involve providing testimony under oath to find out what you know about the case and to preserve your testimony for trial.
- Interrogatories are a written question(s) which is/are formally put to one party in a case by another party and *which must be answered.*

An integral part of this process is the naming of 'expert witnesses.' This is an area of contention when it comes to who and why another physician is deemed an 'expert.' It has been our collective experience that frequently the physicians proffered as 'experts' are actually anything but, and frequently have not even been practicing surgeons or even surgeons at all. This has improved somewhat over time as most states have adopted guidelines that require expert witnesses to at least be in the same specialty and to have held clinical privileges at the time of the act in question, although this is not universal. There are companies that advertise to attorneys to provide them with 'expert witnesses' as well as law firms that explain, online, how to find an expert and for purposes of this syllabus, an expert in Trauma Surgery.[2 3] Some of these people you may know professionally, socially or by name alone but what factors in their background make them a true 'expert'? Being in practice for 5 years vs 35 years, performing a few procedures 1000 times or hundreds of procedures 10–20 times or having your name on several medical journal articles are just some of the ways surgeons are identified as 'experts.' You have a responsibility/obligation to your defense, after careful review of an expert's opinion given during their deposition, to read, detail, take notes and discuss issues with your attorney. It is your opportunity to 'build a case' against the plaintiff and their experts; is there a conflict of interest with an expert, is the expert's opinion based on their practice or data that is challengeable and/or questionable, do they actively practice in the area they are giving an opinion, that is, experience. Is their expert witness a professional expert, that is, someone whose major portion of income is derived from legal cases. These questions can be answered and used by your attorney to challenge the integrity of the qualifications of an expert against you. Remember, the expert is basing an opinion on what the medical record tells them; retrospective reviews have biases that real-time experience may not have (hence why you need to document well!)

Standard of care

One key point of terminology that is critical to understand, and that is often applied incorrectly by both plaintiff's attorneys and their expert witnesses, is 'SOC.' The key determination of the plaintiff's expert that drives the pursuit of the malpractice claim is that there was a clear violation of the medical or surgical SOC. However, it is critical to understand the distinction between the legal definition of SOC and the commonly used medical characterization of SOC. The definitions for each are presented below, with the key aspects of the legal SOC highlighted in italics. As noted, the medical SOC can be thought of as the absolute optimal or ideal care delivered under normal circumstances (and that may or may not have been possible in a given situation). However, the legal definition of SOC requires care that is reasonable for the average provider in that specialty and under the same of similar circumstances. As an example in trauma care, while immediate CT scan for a high-risk patient is the SOC, in a mass casualty situation resulting in a significant delay to CT scan due to the large number of patients would still meet the legal SOC. This distinction often needs to be pointed out and highlighted to attorneys or expert witnesses who attempt to use the medical SOC rather than the legal SOC.

- Medical SOC: appropriate treatment based on scientific evidence or widely accepted guidelines and collaboration

between medical professionals involved in the treatment of a given condition.
- Legal SOC: care which an *ordinary, prudent professional* with the same level of training and experience in the *same or similar community* would practice *under the same or similar conditions*.

Expert witness guidelines

The American College of Surgeons has on its website, a *Statement on the Physician Acting as an Expert Witness* from April 1, 2011,[4] which contains recommended qualifications to act as an expert. We recommend reading and maintaining that reference as to check your experts against it. The American Medical Association (AMA) also has several policies regarding expert medical testimony as listed below[5–8]:

- Policy H-265.992 encourages peer review and discipline of unprofessional or fraudulent conduct from physician expert witnesses.
- Policy H-265.993 is an AMA declaration that providing medicolegal expert witness testimony is considered as the practice of medicine and should be subject to peer review.
- Policy H-265.994 encourages members to act as impartial experts and warns that it will assist medical societies in disciplining physicians who provide false testimony. This policy also seeks to ban expert contingency fees in personal injury legislation because such fees 'threaten the integrity and the compensation goals of the civil justice system.' Finally, this policy sets forth the AMA's minimum recommended requirements for qualification as an expert witness, which include that:

1. the witness must have comparable education, training, and occupational experience in the same field as the defendant;
2. the occupational experience of the witness must include active medical practice or teaching in the same field as the defendant;
3. the occupational experience must have been within 5 years of the date of the occurrence that gives rise to the claim.

Although these policies are not necessarily legally binding on physicians or on AMA members, they conceivably could be used as evidence against physicians deemed to have testified unprofessionally or unethically.

Legal liability for expert witness testimony

Because expert testimony has been deemed admissible does not mean that the testimony necessarily is appropriate or credible.[9] Courts have even acknowledged 'a judge's ruling that expert testimony is admissible should not be taken as conclusive evidence that [the testimony] is responsible.'[10] When a trial court is faced with a decision whether to allow questionable testimony, lawyers often argue that jurors should be the ones to determine whether to believe the expert and what weight to place on an expert's testimony. Unfortunately, when faced with contradictory expert opinions on the same issue, jurors may not have the ability to separate real science from pseudo-science, or to understand decisions when there is a lack of scientific evidence. Although medical experts still may testify about any opinions they wish, unsubstantiated opinions in medical malpractice cases are drawing closer scrutiny. In some cases, experts who provide unsubstantiated opinions are finding that they and their testimonies have become the targets of legal actions or professional sanctions by societies, licensing boards, or their local administrative leadership. This gives the defendant the opportunity to argue the opinions of the experts used against them. Doing your due diligence can pay huge dividends when arguing the reliability, validity, and strength of an opposing expert witness. Use the internet to search and explore each named expert to see their background, education, publications, and any other relevant information that is available that you and your attorney could potentially use to your advantage.

The authors suggest looking at this example website of 'experts for hire'; remember that experts are used by both the plaintiff and defendant: https://www.seakexperts.com/specialties/trauma-surgery-expert-witness

> Trauma Surgery Expert Witnesses
> The SEAK Expert Witness Directory contains a comprehensive list of trauma surgery expert witnesses who testify, consult and provide litigation support on trauma surgery and related issues. Trauma surgery expert witnesses and consultants on this page may form expert opinions, draft expert witness reports, and provide expert witness testimony at deposition and trial. The issues and subjects these trauma surgery expert witnesses testify regarding may include: Trauma Surgery, General Surgery, Surgical Critical Care, Sepsis, Surgical Complications, Abdominal Pain, Abdominal Surgery, Breast Cancer, Gallbladder Surgery, Laparoscopic Surgery, Shock, Traumatic Brain Injury, Wound Care, Acute Care Surgery, and Appendix Surgery.
> Use the search box above to further refine your search for trauma surgery expert witnesses by keyword and state. Attorneys contact the experts directly—with no middleman.

You may recognize names/faces and ask what makes them an expert; qualified in their field most likely, leaders in the field maybe?

Awards and monetary payouts

From an attorney website about malpractice awards[11]: many factors influence the amount of your payout. They include federal and state laws; some states have caps on awards:

- The type and gravity of negligence.
- The severity of the injury.
- How much of an impact your medical malpractice-related injuries have on your life.
- How much medical care you will need in the future.
- The amount of evidence you provide to prove your claim.
- The strength of your medical records and overall evidence.
- Economic and non-economic damages.
- Testimony from medical experts.
- Your age.
- The ability of your medical malpractice attorney.
- The medical malpractice laws and regulations in your jurisdiction.
- The quality of legal representation.
- Insurance coverage.
- Impact of your injury on partners/family members.

If you want to see what your state paid out in malpractice awards, reference these website articles.[11 12]

Documentation: friend or foe

Documentation is paramount to explain what you saw, what you were thinking and the status of the patient when assessed. This documentation will form the basis of your defense allowing for recognition of the circumstances that you encountered and that a non-participant (attorney/jury/expert witness) will read to form a basis of understanding of what went on without the ability to be there experiencing the episode 'real time.' Detailed documentation of the observed patient, the history provided (and from who/where it was obtained), pre-existing issues, presence or absence of risk factors based on mechanism of injury, past

medical history/surgical history/medications or allergies, etc, the physical examination, medical decision-making, and treatment plan is critical, as 58% of lawsuits are dropped before they get started.[13] The primary reason is that some cases have enough information within the chart that the plaintiff's attorney understands that a victory is unlikely, and the attorney will be unwilling to assume the time and financial risk of taking the case.

As expert medicolegal case reviewers and occasional medical experts called to testify in malpractice litigation, the number one cause for a recommendation to settle a claim (for the defendant) or to proceed with a claim (for the plaintiff) is the lack of adequate documentation by the responsible attending surgeon. This issue has been made even more difficult by the promulgation of electronic medical records that create voluminous notes with extraneous and often outdated data, that allow for copy/pasting progress notes forward from day to day with incorrect information, and the ability for attending surgeons to simply co-sign a note rather than write their own note or a clear addendum. *It is both of the authors' current practice to always write at least an attending addendum to all emergent trauma or surgical patients admitted and to all operative procedure notes that outlines WHAT happened, and WHY it happened or why we chose to pursue a particular management strategy*. In the absence of this kind of documentation, it is very difficult for a surgeon to offer a defense even for a clearly rational course of action when there is no cogent supporting documentation.

One commonly cited justification for a course of action or treatment/intervention decision is adherence to a published clinical guideline. While following clinical guidelines does not guarantee protection, and there is no clear standard at this time that specialty society or other guidelines clearly represent SOC at trial, the use of clinical guidelines is likely to significantly strengthen the defense and may even be able to prevent a trial in the first place. Always discuss questions, issues and anything related to your case with your attorney; you need to be the greatest advocate for yourself and your defense, do not 'rollover' and give up from frustration or anxiety about being sued, the odds are in your favor to come out of it with either a settlement and not going to court, a dropped case, or one found in your favor by a court. A recent article gives us hope (statistically): *"Our results could not confirm the often claimed increase in litigation procedures in the field of orthopedic and trauma surgery. Patients who underwent elective surgery were significantly more likely to file complaints than emergency patients*."[14]

PART 2: PERSONAL ASPECTS

An accusation of malpractice, regardless of whether or not substandard care was involved creates a cascade of responses in you that may have significant psychological, cognitive, spiritual, and physical effects, known collectively as '*litigation stress.*' This can often compound the already high levels of stress, depression, burnout, or moral injury that is increasingly prevalent among physicians and particularly surgeons. According to the American Psychological Association's topic of stress effects on the body, stress affects all systems of the body including the musculoskeletal, respiratory, cardiovascular, endocrine, gastrointestinal, nervous, and reproductive systems. There is a quote that we find helpful in our field of surgery/critical care with educating others as well as the authors' law enforcement and military endeavors: 'stress is a matter of perception and perceptions can be changed through the training process.'[15] How many of us have had formalized education and/or training either as a resident or attending on legal matters (malpractice)? We have found this to be an uncommon topic during residency training, fellowship, or at local and national conferences.

In one of the authors' (SV) residency program at Valleywise Health Medical Center/Creighton University-Phoenix, the students, residents, and staff were given an educational opportunity most had never experienced. It was published in the *ACS Bulletin* February 1, 2017: *The art of the deposition: teaching residents about medical liability*. We encourage you to read this and to potentially use at your institution. Preparation for dealing with the stressors experienced on notification of a malpractice suit can pay significant dividends. We also suggest reading this article:

A trauma surgeon on trial by Errington C. Thompson, MD, FACS, FCCM. ACS Bulletin January 6, 2018. This is from the introduction: "*It has been more than a year since I sat in the Buncombe County courthouse, Asheville, NC, with my career hanging in the balance. At the time, the unfairness of it all was overwhelming. Looking back now, I see it as a cautionary tale for other trauma surgeons*.' Several articles have been written by and for physicians and/or surgeons about surviving malpractice litigation. A company that provides medical professional liability insurance, education and support for physicians published a great article that we recommend reading.[16] Dr Baron states: I offer two common idioms to remember if you are sued for malpractice: "You are not alone," and "You will survive." He also writes: "Physicians often have an exaggerated sense of responsibility. We will overwork to clear our own conscience that everything has been done and done correctly. We also have an exaggerated sense of self-doubt that we missed something, so we check and recheck. These traits foster a compulsiveness that makes us good physicians but can backfire on us when we are accused and sued for malpractice. The loss or grief we feel is sometimes described as a loss of innocence." Of note, there are now an increasing number of successful legal actions brought by physicians for inappropriate or malicious prosecution, or for inept expert witness testimony brought against them in a malpractice lawsuit. The following are two recent articles from Medscape Medical News under the Business of Medicine heading that we recommend reviewing to highlight two of these successful cases[17]:

- Doc Sues Patient's Family and Attorney, Wins Case; Should a Physician Sue for Malicious Prosecution?
- Surgeon Beats $27 Million Malpractice Case After Contentious Trial

The emotional distress when served with a malpractice claim and during the often drawn-out proceedings are similar in many ways to the stages of the grief reaction first described by Kübler-Ross and shown in figure 3. The emotions described below do not always happen in a serial or linear manner. The processes of a malpractice lawsuit and our processing of emotions can cause us to cycle through these phases again and again. The psychological and physiological issues that we can experience are real and can lead to depression, traumatic events, substance abuses/impairment that can cause a cascade of events that can impact you and your family, friendships, and your career. In a striking survey of American College of Surgeons members by Balch *et al*, recent malpractice suits were associated with increased risks of burnout, depression, career dissatisfaction, and suicidal thoughts (figure 4).[18] Loss of confidence, self-esteem, and potential income all contribute to the vicious cycle that you need to break out of whether with colleague and or family assistance or professional help. As much as we try to rationalize this insult to our professionalism, it is not 'personal,' but professional and we must try and separate the two in order to begin to overcome the sense of 'grief' that we feel at being sued. There is also a

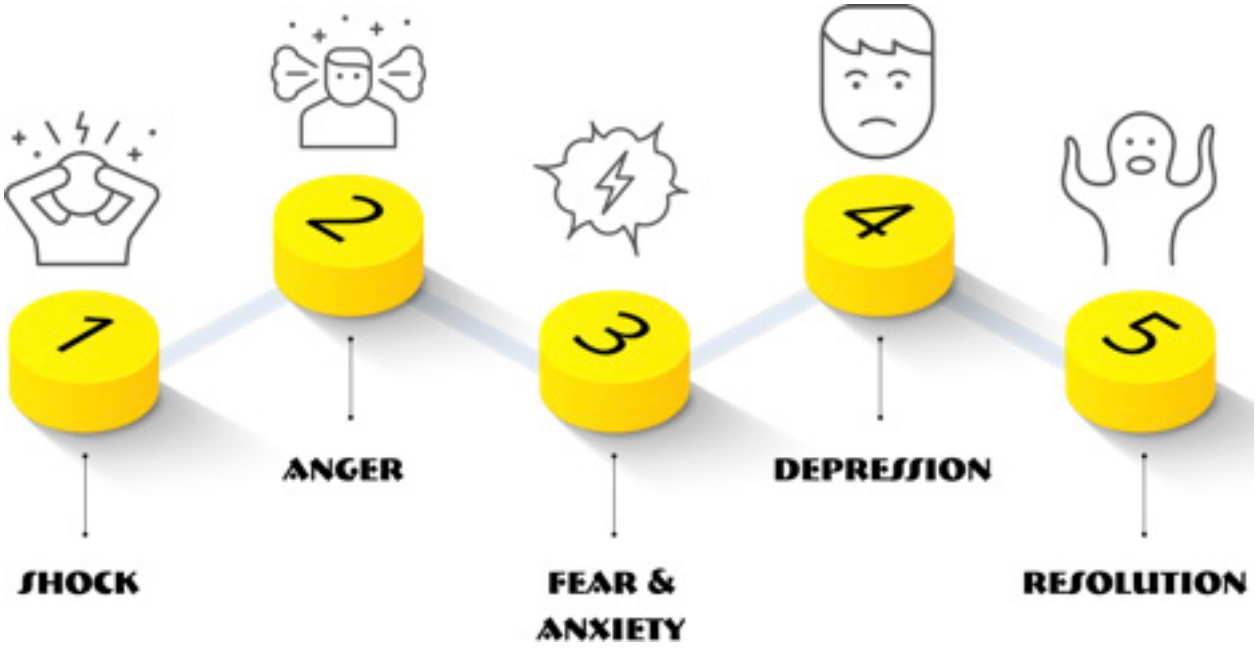

Figure 3 Common emotional responses by physicians who are served with a malpractice suit as described by Baron.[16]

common feeling of shame and isolation, particularly among more junior surgeons who have no prior experience with these issues and who feel like they will be viewed as incompetent by their colleagues. However, with the ubiquity of malpractice claims among surgeons in all specialties it is important to realize that your more senior colleagues have likely gone through the same or similar process, and can be a fantastic resource for advice and emotional support. Do not hesitate to go to a trusted colleague or senior partner (provided they are not involved in the claim or lawsuit) and ask for advice and guidance.

It is important to remember that the odds remain in your favor. Most malpractice cases never make it to the courtroom; only about 7% get to the point of a jury trial, according to medicalmalpractice.com. The energy that should be focused on your defense needs to be there to have the best chances of getting the suit behind you and not being on the wrong end of a jury decision. Another good article to refer to about the process and psychological aspects to expect to experience if you end up in court, with solid advice on how to approach the case is *The Verdict Is In: Surviving a Medical Malpractice Trial*, by Michael R. Canady, MD, MBA, CPE, FACS.[19] Many surgeons, based on our innate personalities find that mental efforts, time, energies and talents directed toward the planning your defense with your attorney helps mitigate some of the negative stressors that some dwell on and have a difficult time getting past once that subpoena is in your hand. Do think about speaking with a family member (spouse), therapist, or your attorney to help decompress and work through your frustrations, with the caveat that specifics of the case and particularly any patient-identifying information should never be discussed or disclosed. The better you remain mentally sharp, just like preparing and performing a complex surgical procedure, the better prepared your case will be and you will at least have the opportunity to feel like you did your true best.

CONCLUSIONS

Unfortunately, malpractice claims and litigation remain a common and likely event during a surgeon's career. These events can be extremely disruptive both personally and professionally,

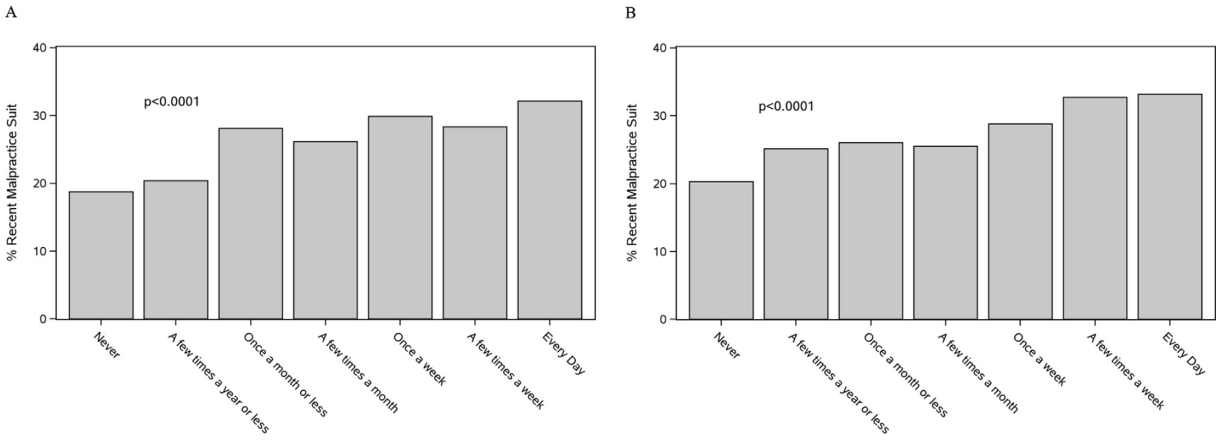

Figure 4 Survey results of American College of Surgeons members showing increased rates of emotional exhaustion (A) and feelings of depersonalization (B) among surgeons who were involved in a recent malpractice suit (with permission from Balch *et al*[18])

and can result in lasting adverse financial, career, and personal impacts. These can be minimized by following the principles discussed in this article, including the do's and don'ts of the initial response and actions, the close coordination with local leadership and legal advice, and the realization that your career can survive and thrive despite this setback. We believe that these issues should be much more commonly discussed during both surgical training and at our major medical and surgical conferences. Finally, we appreciate the opportunity to present and discuss these issues at the 2024 Trauma, Critical Care, and Acute Care Surgery Conference (aka 'the Mattox Meeting').

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