Managing After Bad Outcomes

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Like many of you, I am engaged in the practice of pediatric anesthesia at a tertiary, academic children's hospital. I have been in practice for 11 years and have had my share of critical events and adverse outcomes, one in particular that resulted in a lengthy litigation process. It is through my personal difficulty in dealing with that event and the ensuing litigation that this topic became relevant to me. I am certain that there are others here today, or your colleagues, who have also experienced an adverse outcome. While I am not an accomplished researcher, published author, or medical-legal expert, it is my hope that the information shared today will help you in several ways; (1) to prepare you for the personal and professional stress reactions common to physicians who have had an adverse outcome and/or litigation, (2) outline steps you can take to facilitate coping with the stressor(s), (3) outline risk management principles to incorporate into your practice and thereby minimize your exposure to adverse events and their sequelae.

The case, *my case*, happened in my sixth year in practice. I was on-call with a CA-1 and an experienced CRNA. The patient was a 16-year-old male who had been struck by a car 6 hours earlier. He was billed as an ORIF of the right femur with fasciotomies for compartment syndrome of the thigh. After reviewing the chart from the emergency room, information was sketchy. There were large blocks of time unaccounted for, labs missing or not obtained and no thorough evaluation to rule out multiple trauma i.e.; closed head injury, internal organ damage, or angiography of the injured extremity. After a cursory exam, the patient was found to be in extreme pain but otherwise appeared to be hemodynamically stable. His aunt accompanied him. His mother had gone home after signing the surgical consent because she had not been feeling well.

There was much that was unclear. Was I going to delay the case to sort out what might amount to a paperwork snafu or wait to reach the mother for separate anesthesia consent before proceeding? A call to the ER failed to locate the nurse, resident, or attending that had treated the patient. The orthopedic resident was not able to answer the questions regarding lab work and fluid administration because "that was the ER's job." The orthopedic surgeon swore there was blood available even though the patient had no blood bands and I saw no order for a type and cross. Meanwhile, the patient's foot and lower extremity were at risk.

I elected to proceed with fluid resuscitation, "gentle" induction of general anesthesia and to send for the blood that the surgeon had emphatically stated was available. The case was complicated by persistent hypotension, profuse bleeding from the surgical wound, and the onset of massive pulmonary edema within 15 minutes of opening the compartments. This resulted in an inability to effectively oxygenate, and ventilate the patient, ultimately culminating in cardiac arrest. He failed to effectively respond to all resuscitative measures, developing a brief tachyarrhythmia on high dose epinephrine. He never regained consciousness and died in the early morning hours.

I was devastated after losing an otherwise healthy patient with a femur fracture. Even though I *thought* that I did nothing wrong in his management and that the choices I made were justified, I couldn't be certain. I was filled with sadness, anger, guilt and shame. The mother had returned to the hospital and was present when her son expired, overwhelmed with grief and surrounded by a large contingent of friends and relatives. I couldn't bring myself to intrude on her grief, introduce myself and try to explain to her what happened. I was afraid of what her reaction to me would be, having never met me. I allowed my fear and shame to prevent me from speaking with her.

During the intra-operative events I tried desperately to remember what I was supposed to do beside save the patient's life. I believe I followed the **APSF Guidelines for Response to an Adverse Anesthesia Event**[1] as closely as I could. (1) I called for help. Additional nurses and the PICU fellow responded. My back-up attending came in from home. (2) I assigned my resident the task of meticulously documenting the record and a nurse to keep a hospital code sheet once the ACLS protocols started as a back-up. (3) I documented a post-op note stating the facts of the intra-op events, my treatments and my differential diagnosis for the patient's failure to respond to those measures. (4) The surgeon had left the case multiple times to talk with the family and make them aware of the events that were transpiring while I stayed with the patient. (5) I notified the PICU attending and described the events as well as my thoughts and stayed with the patient until he was pronounced. (6) The orthopedic surgeon notified the hospital risk manager on-call. (7) My department chief was made aware of the events and in turn, alerted the group malpractice carrier.

The next day I obtained copies of the entire chart and chronologically reconstructed the events of that evening, concentrating very specifically on every detail of the case I could remember. At the behest of my chief, I dictated a comprehensive note, sealed it in an envelope marked "Personal and Confidential", and filed it away hoping it would never be necessary to look at again.

I was instructed not to talk to anybody, even my chief, about the details of the case. I felt very isolated and continued to be overwhelmed by feelings of anger, shame and guilt. I experienced a lack of confidence in decision-making particularly regarding patients' fitness for surgery. Anxiety and stress over routine healthy ASA 1 patients grew exponentially when I was on-call, encountered a femur fracture, or passed the orthopedic surgeon in the hallway. I wondered if colleagues blamed me, perceived deficiencies in my abilities, or if surgeons questioned my ability to care for their patients.

I felt certain that a massive fat embolus contributed to my patient's demise. While the results of the autopsy seemed to confirm my suspicions, the anxiety and feelings of uncertainty remained.

I participated in the QA process for anesthesia and the hospital-wide trauma committee.

Hospital systems were changed as a result of the case. I endeavored to learn all I could about fat emboli and the fat embolus syndrome, presenting a grand rounds lecture on the topic.

As time passed, the feelings of anxiety, shame and guilt grew less intense. But I was often pre- occupied and tended to worry excessively. My interactions with families became more involved. I frequently mentioned death as a complication of anesthesia, being careful to document it on the anesthesia consent. I tried to call parents more often, documenting my efforts, the time and telephone number I called. I delayed non-emergent cases to wait for a parent's arrival even if there was a signed consent on the chart. I worked hard to clear up any questions about in-hospital care before undertaking an anesthetic, thus delaying cases, and disrupting the day.

Three days after the anniversary of *the case*, I received a certified letter containing the complaint….

> "Plaintiff further states that Defendants, X, Y, Z, Retzack and Doe acting individually, or by and through their agents and /or employees were **professionally negligent** and **did fall below the accepted standards of medical care expected of competent medical practitioners** and provided under the same or similar circumstances, when the patient, _____, died as a result of massive blood loss while undergoing a routine surgical procedure.
>
> As a further **direct and proximate result of the negligence** of the defendants, decedent has suffered bodily injury, experienced much pain, suffering, and mental anguish prior to his wrongful death."

Physician Reactions

Being named in a lawsuit is one of the most traumatic events in a physician's professional life. Many times the events that led to the suit, an unexpected complication resulting in patient injury or worse, is already the source of emotional pain and concern for the physician. The formal complaint begins anew the emotional rollercoaster of stress, fear, shame, anxiety, isolation, uncertainty, anger and depression that can last years after the suit is concluded.

Doctors get sued everyday. In fact, more than 50% of physicians will be sued at least once in their lifetimes.[2] Why do we react so personally to this event? Our reactions are related to two major factors: the personality characteristics of physicians and the nature of tort law.

We are well-educated, highly-accomplished individuals with a compulsive, controlling, critical nature, demanding of ourselves and others, dedicated to the pursuit of excellence in our field, often at the expense of personal and family life. We are utterly unprepared for the accusatory language of a claim. A charge of *negligence* directly assaults a physician's sense of self; attacking our integrity, eroding self-confidence and our sense of competency. Even when we know we did nothing wrong, lingering feelings of shame and guilt remain.

The nature of tort law involves the finding of fault in order to award compensation. The accusation of failure to meet the standard of care is the central psychological event affecting a physician's honor and personal integrity. Physicians also experience a loss of control. Being in the legal arena is unfamiliar territory. The language, rules, and unpredictably lengthy process are all new to the uninitiated defendant and beyond the normal scope of medical knowledge.

Dr. Sara C. Charles, MD, a professor of psychiatry at the University of Illinois, has published a book[3] about her personal reactions to being sued as well as a large body of work looking at physicians' stress responses to litigation. She has found that more than 95% of physicians react to being sued by experiencing periods of emotional distress during all or portions of the lengthy litigation process.[4] Feelings of intense anger, frustration, inner tension, and insomnia are frequent throughout the initial period of emotional disequilibrium following notification of a suit.[4] Symptoms of major depressive disorder (prevalence, 27-39%), adjustment disorder (20-53%), and the onset of physical illness (2-15%) occur, although fewer than 2% acknowledge drug or alcohol misuse. More than 25% report feelings of aloneness.[4,5,6]

The extent to which a suit affects a doctor also depends on their coping capacity and psychological and social support systems. Dr. Charles again identified two groups of physicians in response to being sued.[7] Group one identified litigation as their most stressful life event and experienced significantly more symptoms, acknowledging the depression cluster more often and was less able to cope in a problem-focused fashion. Group two physicians had experienced other life stressors i.e. divorce, death of a family member, and were more able to cope by putting litigation experience into perspective, relying on problem-focused strategies to attack areas of anxiety.

The stress and emotions accompanying an adverse outcome and/or litigation may wax and wane for years. Symptoms can be exacerbated by similar clinical circumstances, a phone call or letter from an attorney, not to mention upcoming depositions or trial dates. How well we cope will determine whether or not we can continue to be healthy and productive members of our specialty. If we fail to manage our personal and professional stress, we are more likely to be frustrated and distracted at work, less empathetic to patients and their families, more prone to burn-out and more likely to get sued. Risk for an additional claim doubles for physicians who have had a claim in the previous year.[8]

Coping Strategies

There are three main areas of focus which may enhance a physician's ability to cope with the stress of an adverse outcome and/or litigation. They are (1) seeking adequate social support, (2) restoring mastery and self-esteem, and (3) changing the meaning of the event.[9]

Seeking Support

The common instruction after an adverse event or upon receipt of a summons is to not discuss the case with anyone, as it might make them eligible to be called as a witness in the future. While this is good legal advice, it only adds to the sense of isolation and aloneness a physician might be feeling. Support, especially from other physicians, tempers these ideas and help to restore feelings of belonging to the professional community. The goal of support is not to obtain testimony but to share feelings of fear, loss, anger and frustration with someone who understands, and perhaps, has been through similar circumstances. It is important to discuss these feelings with a trusted person; your lawyer, another physician, family member or close friend.

If you have a colleague that is in this situation, ask how they're doing. You don't have to have any answers; just asking will let them know you're concerned. Support your colleague to other staff and patients when appropriate. Do not remind them that this is a risk all physicians face. Refrain from encouraging a countersuit. Attempting to blame others only makes the situation worse.

Many state medical societies,[10] malpractice insurance carriers,[11] and professional organizations[12] have a physician support program in place specifically to assist physicians and their families cope with the stress of an adverse outcome or litigation. Perhaps a professional therapist may be beneficial in providing a safe, confidential, non-judgmental environment to work through the stress of the event. Pursue the help of a professional if needed and avoid the temptation to self-medicate.

Restoring Mastery and Self-Esteem

The analysis following an adverse outcome challenges a physician's sense of competence as it seeks to establish who was in control, and therefore, responsible for the event. As physicians, our self-esteem is closely linked to our sense of competence. Having a case proceed to litigation further enhances the loss of control one may experience as you get thrown into the unfamiliar legal arena and find yourself dependent on an unknown attorney for advice and representation during a process that could last years. It is important to reassert control personally and professionally to restore feelings of control and self-esteem.

Personally, it is important to seek a balanced lifestyle. It may be necessary to reduce some responsibilities at work. Obtain a personal physician if you are experiencing any physical effects of stress i.e., hypertension, indigestion, headaches, chest pain, palpitations, etc. Set aside time for family and friends. Pursue leisure activities; take a long-awaited vacation, get a massage, practice yoga, schedule sleep. Regularly pursue aerobic or racquet sports to have a defined time to workout your tension, frustrations, and stress. In the year following my adverse outcome I trained and completed a marathon. I used the time during my runs to compartmentalize my thoughts and feelings regarding the lawsuit. Get involved in your faith community or a service organization. It helps to focus on helping others. Consider your financial vulnerability to a large verdict and restructure your finances or obtain an umbrella policy. Take one day at a time. Worrying about the future causes anxiety and ruminating about the past creates sadness and regret.

Professionally, identify areas of practice that cause anxiety and find ways to diminish them. Don't participate in practice situations that demand compromises in professional standards. Engage in activities that will increase your competence. Perform a literature search on the topic(s) in the case and become an expert in the possible mechanisms leading to the adverse event. Take CME courses and teach others (residents, students, nurse, etc.) what you're learning.

If the adverse outcome leads to litigation learn about the process (summons, discovery, mediation, and trial/settlement). Recognize that it may take from two to eight years to completion. Get to know your carrier-appointed attorney. Ask about their training, experience with malpractice litigation, cases tried, won and lost. Inquire what other physicians they've represented and call them. Participate actively in your defense. Teach your attorney the medicine of your case. Determine whether or not you need a second opinion or a personal attorney to represent your interests in the case.

Change the Meaning of the Event

It is necessary to change the perception that only negligence or incompetence lead to adverse outcomes and litigation. As Dr. Berry states in his ASA Refresher Course, "bad outcomes do occur when good doctors practice good medicine and there is no negligence."[13] Those who are sued are often the best in their field, working with the sickest patients.[14]

It helps to recognize that litigation is about compensation not competence. In the ASA Closed Claims analysis, Cheney, et, al. found that more than 40% of patients were provided appropriate non-negligent care and still collected payments.[15] Brennan, et.al. reviewed 51 malpractice claims over 10 years in New York state and found that there was no association between an adverse event of any type ($p=0.03$) or an adverse event due to negligence ($p=0.32$) and payment on a claim.[16]

These facts may be reassuring, but how do we make them personal? Review your career objectively; most physicians function well and with competence. Reflect on the input of legal and insurance counsel regarding the 'defensibility' of your case. Work to acknowledge the truth about the events in question. If there was an error or negligence did occur, admit it and seek to rectify the situation as quickly as possible through an early settlement agreement. Recognize that the vast majority of claims are dismissed in favor of the defendant physician or settled before going to trial. Of the 7-10% of claims that go to trial only one in four will find for the plaintiff.

The coping strategies outlined above are designed to restore a stress-impaired physician to personal and professional health and well-being. Failure to effectively address the stress-impaired physician makes them vulnerable to future adverse events and claims of malpractice.[16,17,18] Having successfully dealt with the stress of an adverse event and/or litigation makes them an invaluable member of their department. They can use their unique experiences to the benefit of others and serve as a resource to similarly troubled physicians.

Risk Management Strategies

The next step, then, is to give attention to preventive measures of risk management to enhance the quality of patient care and minimize concern about additional adverse events and liability exposure. Frisch, et.al. determined that anesthesiologists and OB-GYN physicians in Oregon were among the specialties most likely to benefit from risk management education with a reduction in claims incidence (18.8% to 9.1%) and reduction in payout (from 14.6% to 5%).[8]

Risk management focuses on several areas of vulnerability; education, informed consent, documentation and communication.

Educate yourself and adhere to the published ASA standards of care, guidelines and practice parameters. Read the Anesthesia Patient Safety Foundation newsletter and the conclusions of the ASA closed claims studies to identify problem areas. Be familiar with your departmental and hospital-wide policies and procedures for anesthesia-related areas such as criteria for PACU discharge, sedation guidelines, and equipment maintenance. Pursue CME in all relevant areas of your specialty.

Informed consent involves a frank and open discussion with the patient/family regarding the real risks of the procedure as well as the documentation of the results of the discussion. In pediatrics, there is much discussion about the benefits of informed *assent* by minors to enhance their feelings of control, relieve anxiety, and increase participation in their care. To the degree that it is developmentally possible, attempt to enlist patient cooperation.

Documentation tends to focus on the anesthetic record, but the preoperative evaluation, informed consent and recovery notes are all legal documents. As such, they will be looked at critically in the event of litigation. They should be legible, accurate, complete, and timely. Unusual or adverse events need to be described in factual detail. Never alter the medical record, particularly in the case of an adverse event. Have a colleague look over the record and notes objectively to identify errors or questions so that corrections can be made or clarified at that time. If changes need to be made they should be done in a fresh note, timed, and dated at the time of the writing. The reason for the 'late entry' should also be noted.

Communicate effectively to establish rapport with patients and their families and to avoid misunderstanding. Anesthesiologists are particularly vulnerable in this area as we often may be meeting patients and their families for the first time in the holding area just prior to going into the operating room. In a busy day filled with ENT procedures the pre-op interview may last five to ten minutes at most. In this brief time a physician's attitude of impatience coupled with patient/family anxiety can increase the potential for misunderstanding, dissatisfaction, disappointment, and anger, particularly if the case proceeds to an adverse outcome. Failure to communicate effectively, administer appropriate care, and establish rapport are all related to the risk of a future malpractice claim.[19]

A few extra minutes taken now may save you years of unrest in the long run. So sit down; get to know the patient by reviewing the chart thoroughly, listening and addressing their concerns. Educate them regarding the risks of different anesthetic and/or analgesic options. Encourage their questions and enlist their participation, ask how they'd like you to proceed. Don't write while they're speaking, make eye contact, and refrain from interrupting them.

An unfavorable outcome can evoke feelings of despair and helplessness that quickly turns to hostility.[20] When faced with an angry patient it is especially important to seek them out and allow them to express their anger. It is best to remain silent until the patient or family member has calmed down and then request additional information or explanation and listen attentively in silence. The request for information or further explanation reinforces the importance you have attached to the patient's message. Remain accessible, particularly after a bad outcome. I've learned the hard way how important it is to seek families out after an unexpected outcome so that they have an opportunity to continue to express their concerns. This is not the time to defend your actions but to answer questions and provide an empathetic understanding presence.

While it is clear that the practice of anesthesia is safer today than ever before in our history, adverse outcomes will continue to occur. It is my sincere hope that the information contained here will help you to deal with the sequelae of the event, restore you to a rewarding profession and minimize the chances of it happening to you.

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