Foundations of Emergency Medicine
Foundations III: Guided Small Group Experience

Session 25: "Medical Malpractice"
Unit: Non-Clinical Skills

- **Agenda and Learning Objectives**
  - Case Part I – Epidemiology of Malpractice Lawsuits and Basic Legal Terminology (10 min)
    - Outline basic statistics of medical malpractice in the United States
    - Outline basic legal terminology and concepts
  - Case Part II – Risk Mitigation (15 min)
    - Discuss the risk factors for being named in a medical malpractice lawsuit
    - Discuss ways to mitigate this risk
  - Case Part III – Anatomy of a Lawsuit (15 min)
    - Outline the basic steps of a lawsuit
  - Case Concludes (10 min)
    - Review Session Teaching Points

- **Note to Facilitators**

This session is meant to be a primer on medical law. It discusses some of the epidemiology of lawsuits, who is at risk for being named in a malpractice suit and the anatomy of a lawsuit. It is a 50-min large group question guided discussion. There is also an attachment with examples of the wording of some of the legal documents explained in Section III (Anatomy of a Lawsuit). Please print these out for each member of your group prior to facilitating this session. Finally, it may be useful to review any "I'm sorry" laws that protect apology in the setting of medical mistakes in your state.

- **Case Begins –** Epidemiology of Medical Malpractice and Basic Legal Terminology (10 min)

  - *You and a co-resident overhear that one of your faculty is getting sued. You tell your co-resident that you're worried about practicing in your home state because of the high malpractice incidence. Your co-resident says she has heard that things are getting better across the country. You wonder how many physicians are sued each year and how EM stands in relation to other specialties in terms of your legal risk.*

- **Discussion Questions with Teaching Points**

  - **What are the chances a claim brought against you goes to court? If it does go to court, how likely is it that the case will be settled against you? How long does this process usually take?**

- Emergency physicians are sued about once for every 20,000 patients seen → being sued is in large part, simply a numbers game as you see more patients (though there are some ways to protect yourself)
- The average EM doctor sees about 120,000 patients in a full career → therefore they will be "sued" about < 6 times in their career
- 40% of these suits will disappear with no effort → they get dismissed because the plaintiff's lawyer decides not to pursue the case after reviewing it more fully
- Of the remaining 60%, 2 might involve some evidence collection or deposition but are then dropped → only 1 (or less than 1) will involve litigation leading to a trial verdict
- Even of those suits that end in a trial verdict (4.5% of claims), over 75% of those verdicts will favor the physician
- Overall, an average EM physician is likely to get sued *successfully* less than once in their life
- However, the average time required to close a malpractice claim is 19 months, 11.6 for non-litigated and 25.1 months for litigated claims → this is where the true peril lies, in the emotional toll of the process **not** the outcome

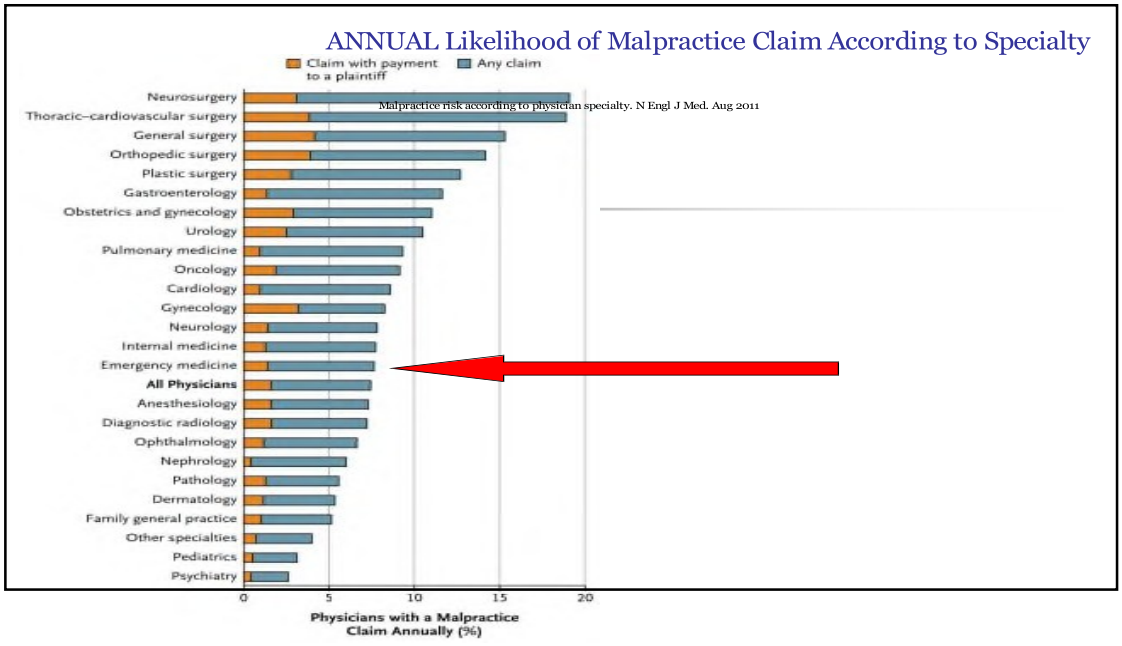
- **How many malpractice payouts are made per year in the US? Have malpractice payouts increased or decreased in the last 10 years? What is the most common reason for a claim being brought? What is the average payout?**
  - In 2013, 9,205 medical malpractice payouts were reported (out of nearly 12,000,000 ED visits)
  - This is down from 16,134 in 2001
  - Diagnostic errors were the most common claim (28% of cases) and led to the highest proportion of total payments (35%) → however, far and away, the most important driver of malpractice is not generally the medical care provided but instead the predicted size of damages
    - Think of it this way: a doctor who performs flagrant malpractice which doesn't result in any damages will not be sued; conversely, a doctor that performs perfect medicine but has a terrible and expensive outcome—brain injury in a child—will more likely be sued regardless of how good their medical practice was
  - The average payout depends on the injury reported
    - Brain damage/lifelong care: $808,000 (9% of claims)
    - Major injury: $569,000 (23% of claims)
    - Significant injury: $420,000 (27% of claims)
    - Death: $390,000 (40% of claims)

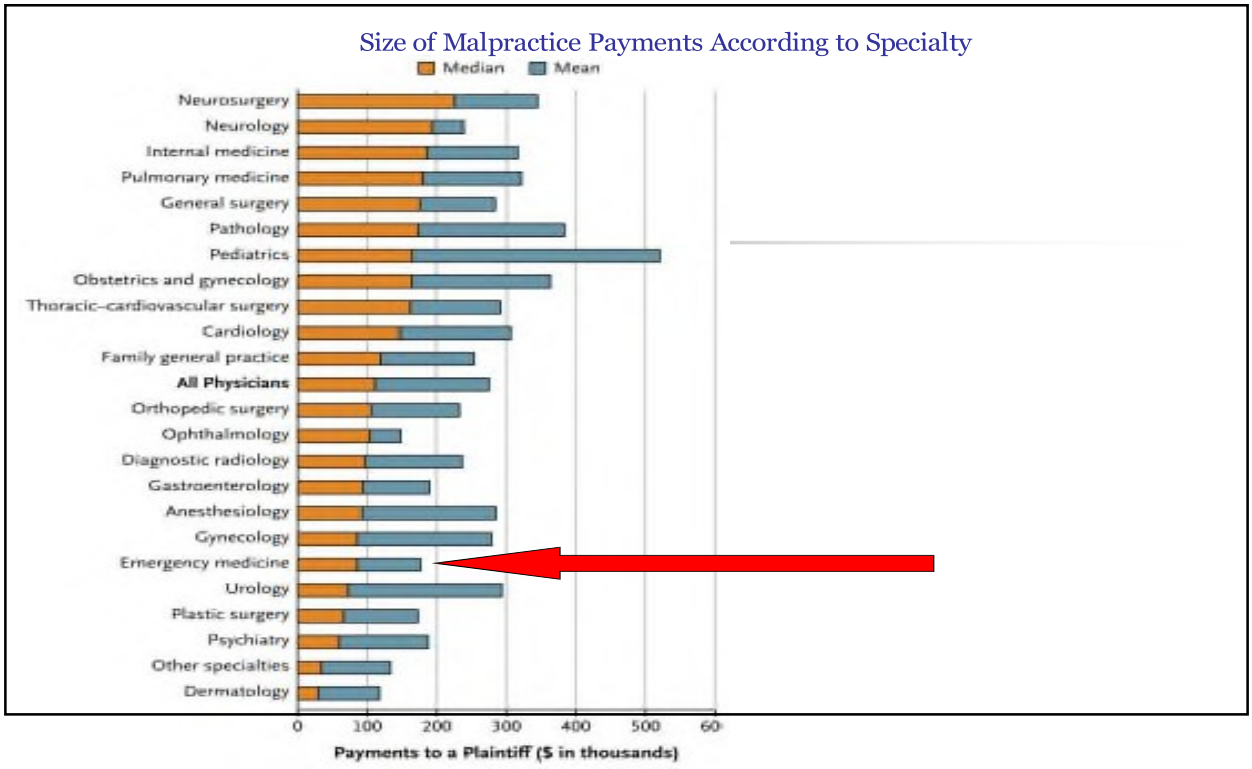
- **How are malpractice payouts tracked in the United States? What else is tracked? How many physicians are listed?**
  - The National Practitioner Data Bank is the federal repository for malpractice action (payouts only) as well as for adverse actions brought against a physician

- Reports are made to the NPDB when a payment > $11,000 is made on behalf of a physician in a malpractice action
- Reports are also made for certain adverse actions taken by a hospital, state licensing board or professional organization
- Hospitals must query the NPDB when giving a physician privileges and every 2 years after
- Other entities (ie state licensing boards, professional societies, plaintiff attorneys) can query the NPBD and physicians may self-query at any time
- 430,000 of the practicing 850,000 physicians are listed (310,000 due to malpractice and 120,000 for adverse actions)
- Though malpractice payouts have decreased over the last decade, reported state licensure actions are up 10x over the same time period
- *That being said, there are no real consequences to being listed in the NPDB → licensing violations (ie losing your license) almost never concern malpractice, rather they are usually about substance abuse, unlawful prescribing or sexual abuse of patients*

- **What about residents? How often are payouts made on their behalf?**
  - It is rare for residents to have malpractice payed out on their behalf (0.8% of all reports)
  - It is also rare for residents to have actions reported against them

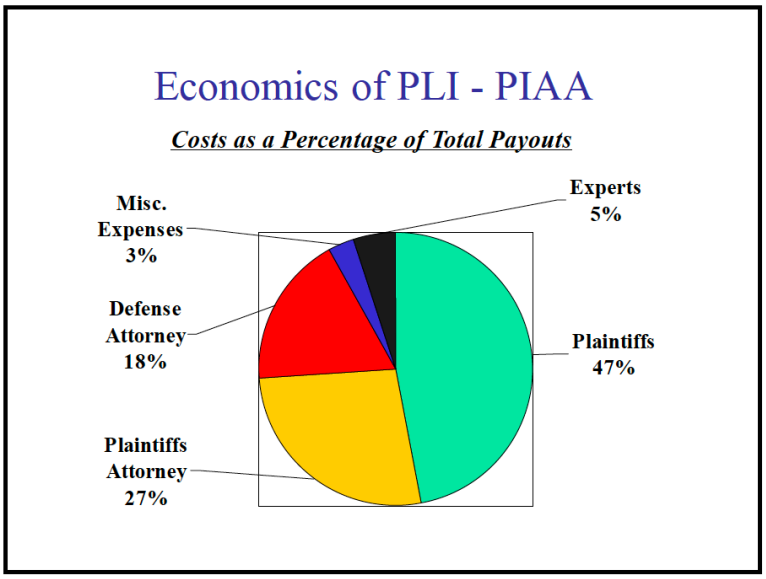
- **What is the annual likelihood of a malpractice claim in Emergency Medicine specifically? How does that compare to other specialties? How about our malpractice payments compared to other specialties?**
  - EM is about in the middle of specialties in terms of numbers of suits (7% per year) and lower than most in terms of the payout amounts





Malpractice risk according to physician specialty. N Engl J Med. Aug 2011.

- **Where does the money go when there is a medical malpractice payout?**



- Over 90% of malpractice claims result in no payout whatsoever
- The emotional cost to physicians who get sued is huge but unaccounted for
- There is also a large cost of what is called "defensive medicine" → it is estimated we spend about 60 billion dollars a year on our malpractice system → 7 billion goes to the injured patients, 7 billion to the legal system (lawyers, experts, etc.) and about 45 billion to defensive medicine (over-admitting/testing/ etc) **(**https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0807)

- **Let's spend a few minutes talking about definitions. Describe the legal hierarchy of courts in the United States. How are cases determined in the court system?**
  - Supreme Court > Appellate Court > Trial Court
  - Courts in one district or state don't have to follow decisions of those in other districts or states → this leads to large variation in the malpractice environment in various places in the country
    - ie Cook County, IL → 30% of trials resulted in plaintiff verdicts with a **1.1M** median verdict

- **What types of lawsuits exist in the United States (ie Criminal vs Tort)?**
  - Criminal Law → defendant against the government, must be guilty "beyond a reasonable doubt" and goal is to punish and deter (can be incarcerated)
  - Tort Law → plaintiff vs defendant, liable if more than 50% of the evidence (ie "tipping of the scale") and goal is to compensate and occasionally punish (cannot be incarcerated)
    - Malpractice suits are tort cases → hence attempts to mitigate malpractice is oftene referred to as "tort reform"
  - Other (tax, property, contracts, administrative)

- **What are the four requirements that have to be met for a physician to have a medical malpractice case levied against them?**
  - Malpractice litigation is based on negligence theory (ie you must act outside of what a *reasonable* physician would have done)
  - There are **four** elements of negligence which are required in order to successfully prosecute a malpractice case:
    - **Duty**: created by a patient-physician relationship (ie when they walk onto your hospital property seeking ED care defined by EMTALA (see Session 5: Rural EM and EMTALA))
    - **Breach of duty**: failure to uphold the "standard of care" → defined as exercising the skill, care and knowledge that a reasonably well-qualified practitioner in the same specialty would apply under the same or similar circumstances
      - The good news for physicians is that in more recent cases the courts have frequently upheld that the standard of care is what a *minimally competent* physician in the same field would do in the same situation, with the same resources (Using an "average" standard would mean half of

physicians are below the standard.) West J Emerg Med. 2011 Feb; 12(1): 109–112.

- "Standard of care" is defined by expert witnesses
- Bear in mind that this "standard" depends entirely on the "circumstances" → there are no objective standards
    - Ie it might be the standard of care to order a CXR on someone who you were somewhat worried might have a dissection → it would be foolish to order a CXR on the same patient if he was crashing
- This is the only time witnesses can offer opinion testimony in the US legal system
- Bad outcomes do **not** equal malpractice → you must violate the "standard of care"

- **Causation:** the act must have been the *actual* cause of injury as opposed to *proximal* cause (just related by time)
- **Damages:** the act must lead to compensable damages or injury to the plaintiff
    - Otherwise "no harm, no foul"
    - Damages must be the result of physician negligence (breach of duty)
    - Probably the most important aspect in determining whether or not an attorney will file a malpractice case against you!!!

- **What is the difference between a malpractice suit and an intentional tort suit?**
    - Intentional torts include assault, battery and false imprisonment
    - They are an attempt to prove that practitioners *intended* for the outcome to occur
    - Intentional torts do not require expert witnesses to establish standard of care
    - May subject defendant to both civil and criminal liability including punitive damages → though not incarceration (this goes through the criminal courts)
    - Can be found liable without physical injury to the patient
    - May not be covered by malpractice insurance
    - Accusations of intentional tort often suffices to terminate a physician's employment contracts → this is in stark contrast to medical malpractice suits which almost never end in termination
    - Examples of this include sexual assault while patients are sedated or surgical "branding" of patients (ie carving initials into patients during surgery)
    - These are often accompanied by criminal charges (ie sexual assault)

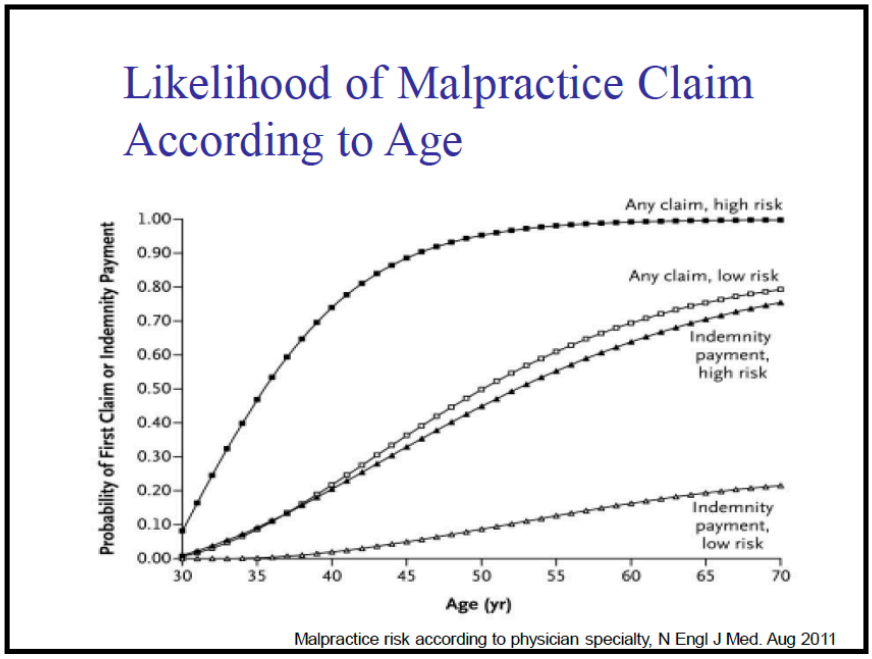
❖ **Case Part II –** Risk Mitigation (20 min)

- *You are taking care of a patient in the ED several weeks later. The patient is very angry throughout the encounter and when you tell him his CT is normal and he will be able to go*

home, he yells at you on the way out saying "You stupid docs here never get anything right. Watch out, I'm going to sue you all!"

❖ **Discussion Questions with Teaching Points**

- **What risk factors lead to increased risk of malpractice suits being levied against you?**
  - The biggest risk factor is simply the number of patients you see



  - That being said, there are still some things you can do to decrease your risk
  - Bad outcome **+** Bad feelings towards physicians = desire to sue
  - Patients don't usually sue physicians they like !!!
  - Survey of 227 patients suing health care providers showed some common themes (*Vincent et al.)*
    - Many malpractice suits are emotionally driven
    - Insensitive handling of care and poor communication were common
      - When an explanation of mistake or injury was made, only 15% were considered satisfactory
    - Four themes were recurrent when discussing reasons to sue:
      - Prevent similar occurrences in the future
      - Desire to know what happened and why
      - Compensation for losses
      - Belief that doctors and hospitals needed to be held responsible for their actions
  - Most patients who sue are more angry than injured

Why Do Patients Sue Physicians?

Why injured patients sued their doctors	Agree %
So that it would not happen to anyone else	91
I wanted an explanation	91
I wanted the doctors to realize what they had done	90
To get an admission of negligence	87
So that the doctor would know how I felt	68
My feelings were ignored	67
I wanted financial compensation	66
Because I was angry	65
So that the doctor did not get away with it	54
So that the doctor would be disciplined	48
Because it was the only way I could cope with my feelings	46
Because of the attitude of staff afterwards	43
To get back at the doctor involved	23

- **What things have been shown to decrease litigation risk?**
  - Explain mistakes and apologize → many states have "I'm sorry" laws that protect apology from being entered into evidence (see question below)
  - Correct mistakes and explain how you will mitigate this mistake so they don't occur again
  - Listen to your patients and practice good communication → 80% of malpractice claims are attributed to communication problems **not** the actual missed diagnosis or mistake!!!!!
  - People don't remember your medical knowledge but they will remember how you made them feel
  - Thoughtful patient follow-up is an area of systems improvement where we can decrease the size of damages (and show caring)
    - Always invite a patient back to your emergency department if they feel they are not getting better and especially if they are more worried
    - Keep follow up instructions subjective rather than objective (eg return if you are concerned about your childs vomiting rather than if the child throws up more than three times)
    - If the patient is worried, we want to see them back → make them feel welcome to come back → it is better to see them back for nothing than not see them back for something!

"I've learned that people will forget what you said, people will forget what you did but people will never forget how you made them feel."

Maya Angelou

- **What systematic steps have been taken to protect physicians from frivolous malpractice suits?**
  - Many states have enacted or are working to enact tort reform which limits the amount of payout that is available for malpractice suits
  - Some states have also convened boards of physicians to evaluate suits prior to allowing them through to a jury trial

- **What is meant by *"I'm Sorry"* laws?**
  - These laws protect physicians from statements of apology for an outcome → these statements are not admissible in court as evidence of malpractice
  - They help promote a culture of apology if medical mistakes occur
  - Apologizing has been shown to be good for both physicians, protecting them from second victim syndrome (see Session 15: Physician Errors and Second Victim Syndrome) as well as for patient in terms of dealing with emotions from a bad outcome or mistake → practice apologizing, it's a win-win for everyone!

❖ **Case Part III –** The Anatomy of a Malpractice Suite (10 min)

- *You are now a practicing EM physician 5 years out of residency. One day on your way out of shift a man approaches you and shoves a large envelope in your hands. With a sinking feeling you open the envelope and find that it is a complaint made against you for care rendered to a patient 2 years ago.*

❖ **Discussion Questions with Teaching Points**

- **What should I do if I'm served a complaint? What if they put a notice up on my door or call me on my cellphone?**
  - If you are served a complaint contact your malpractice insurer and attorney → it's a good idea to have an idea of who you might call before this happens
  - If you hear about a complaint, it is usually better just to let them serve you the complaint → they are paid to find you and if they can't find you easily, they can find you at home or another public place
  - Take a little time if you need it, most states give you between 30 and 90 days to respond so if you need a few days to process it, take them
  - You might want to consider securing a personal attorney → remember hospital attorneys protect the hospitals interests → these are usually in alignment with your interests but not always
  - You will often hear the advice, "don't talk about your lawsuit" because what you say might be discoverable in court → however, the psychological repercussions of isolating yourself can be much worse than the small risk of a friend being deposed and having to testify about what you said to them
  - We all worry about the professional and economic risks of malpractice but truly it is the psychological risks that are far and away the greatest!!! → being named in a malpractice

suit leads to burnout, worse patient care, depression, substance abuse, leaving medicine and can even precipitate suicide

- **What is the difference between a complaint and a summons?**
  - A complaint outlines a case against you while a summons is a request for you to come to court → they often come together but you can be summoned to give testimony when you are not being sued (ie a murder case where the state calls you to discuss your medical care of the murder victim)

- **What are the phases of a malpractice lawsuit?**
  - **Complaint (and Summons)**
    - Sets forth claims ***alleged*** by the patient paragraph by paragraph by the plaintiff (ie patient/family) against the defendant (ie physician/hospital)
    - Must be filed with the Court within a statute of limitations
      - This depends on the injury and the specialty → the statute of limitations in many states is **18 years**!
      - This leads to the complaint and summons being served to the defendants → this is generally required to be done in person (see below)
    - The summons requires your (ie your attorneys) response to the claim usually within 28-30 days → if you fail to meet this deadline the case could be settled against you by default!
  - **Answer**
    - Usually have 28-30 days to "answer or otherwise plead"
    - If you don't answer, they may find against you by default
    - Answer responds to each allegation paragraph by paragraph → "admitted, denied or lack knowledge to form belief" are the possible responses
  - **Motions (Round I)**
    - Motion to dismiss is often entered by the defendants → saying the complaint doesn't say enough, the defendant wasn't involved in the case or for other reasons
    - Burden of proof is heavily against the moving party (ie the defendant) to prove the case doesn't have merit
    - Defendant brings the motion, the plaintiff responds, defendant then replies
    - Judge reads through the submission and either decides to 1) grant the motion and dismisses the case (can be appealed by the plaintiff) or 2) deny the motion and the case then proceeds to discovery

- **Discovery**
    - **Interrogatories**
        - Written requests to other party regarding pertinent facts in the lawsuit
            - Ie "State the name, author, publisher, title, date of publication and specific provisions of all medical texts, books, journal or other medical literature which you or your attorney intend to use as authority or reference in defending any of the allegations set forth in the complaint"
        - Must be answered under oath → can be used against you in court
        - Your malpractice defense attorney should help you do these → they are voluminous and many of them are silly. Your attorney will tell you which to ignore
    - **Requests for Production**
        - Written requests for production of all documents related to issues in the lawsuit (ie medical records, notes, office schedules etc)
- **Depositions**
    - Questioning under oath by opposing attorney → answers can be used to discredit you during trial
    - Attorneys use these for three reasons:
        - Gather further facts
        - Lock deponent into certain fact patterns
        - See how the deponent will come across in court
            - This is a key moment → the plaintiff attorney isn't looking for you to explain why you didn't do anything wrong, they are looking to see how you would come across to a jury
            - Being defensive is not effective → showing sincerity and compassion is effective
        - Remember, you are there because something terrible happened to the patient
        - Showing compassion for the outcome does not signal weakness in your care
        - The opposite is true: compassion signals confidence in your care.
        - Performing well will make you much less of a target → **be prepared!!!**
        - You will be sitting in front of your chart (see below on charting)
            - It can discredit your medical care if there are multiple spelling, grammar or other errors in your chart
            - This can be a part of how easy a target you are for plaintiff attorneys (similar to your overall performance during the deposition)
            - There is significant disagreement on whether charting (or what kind of charting) protects you from being sued or from

having a suit be successful against you (discussed further below)

- **Motions (Part II)**
    - Motion for Summary Judgment is usually made by one side or the other
        - After evidence is presented the other side loses because 1) the plaintiff can't prove all aspects of case or 2) defendant has no/insufficient defense to the claims
    - This motion preserves the court's time by weeding out cases that don't have enough evidence
    - As before, the burden of proof lies with the moving party
    - Judge reads through the submissions and makes a ruling of 1) granted (case is dismissed though the ruling can be appealed) or 2) denied (case proceeds to trial)
- **Trial**
    - Parties present evidence
    - Plaintiff must prove the 4 elements of negligence discussed above (duty, breach, causation and damages)
    - Has the following structure
        - **Opening statements** → attorneys summary of what the facts will show (ie Cliff's notes), can't introduce arguments at this stage
        - **Party testimony**
            - Each side explains its version of events
            - Lawyers help guide witnesses through the story told
            - Opposing attorney may cross examine the other party in an attempt to discredit testimony
            - Can use fact witnesses as well as expert witnesses

                Fact Witnesses: testify about specific facts

                Expert Witnesses: testify about subjects outside the understanding of the jury to establish "standard of care" → must have some scientific basis and jury need not believe their testimony necessarily
        - **Closing Statements** → attorneys summarize what evidence showed and can introduce arguments to make their case
        - **Verdict** → judge defines the law for the jury and the jury renders a verdict
        - **Appeal to the Appellate Court** → generally may only involve issues of law *not* the facts of the case

- **What about charting? Does good charting protect me?**
  - Some argue that the medical record is incapable of capturing the complexity of medical decision making and that being specific in your charting (ie listing differentials) opens you to more risk than being more generally (ie "doubt worrisome causes of chest pain")
  - Much of what is communicated in a patient encounter is pre-cognitive, and therefore it *cannot* be recorded in the chart because it is non-verbal → the legal system loves to focus on the chart because it is all they know but we know that the chart can't possibly reflect the substance of the patient interaction
  - Some will argue that as we let charting become more important, we are giving away the power of what we do and conceding it to the legal system → medical care has almost nothing to do with the chart and everything to do with that complex and often non-verbal patient interaction
  - Further, time spent "buffing" a chart is likely better spent bedside where you are more likely to uncover a potential medical error that could protect you from a future lawsuit rather than working with your chart
    - At a rate of 1 lawsuit per 20,000 patient visits, if you spend 30 extra seconds on every chart, you will spend 170 extra hours (a week of 24-hour days) writing charts that will never be looked at by a lawyer
  - Others argue that a robust MDM (with clear discussion of the differential and *why* certain diagnoses are more or less likely) can make you a stronger defendant and increase the chances the plaintiff's lawyer will not pursue the case
    - Though as discussed above most of this is driven by the size of damages and not by any provider characteristics
  - There is also an argument that having a complete, well thought out chart in front of you during depositions will help you answer deposition questions better and make you less of a target
  - Finally, spending time writing a compelling MDM may decrease the chances of medical error as you spend additional time thinking through your decision making especially early on in your career
  - If you do decide to spend time charting, most will agree that the MDM is where you should focus the majority of your time → the rest of the chart is primarily a billing mechanism
  - Grammar and spelling errors can call into question your attention to detail to a jury
  - Make sure to explain your thinking if you choose to write a longer MDM, not just list a list of concerning differentials
  - Conversely, you can choose to be more general and write phrases such as "no red flags found" or "doubt concerning cause of symptoms"

- **What are some of the effects of being sued on the physician? What has been shown to help with these effects?**
  - Being sued has significant negative repercussions on physicians → this includes changes in practice patterns, isolation, depression, anxiety, burnout and can even precipitate leaving medicine or suicide
  - Can also have negative effects on the physician's personal life and relationships
  - Sharing experiences can help with these feelings → the benefits of this probably outweigh the risks of communications with trusted individuals being entered into court as evidence as stated above
  - Formal counseling can be helpful and is protected under HIPPA → also conversations with your spouse are almost always protected

❖ **Case Teaching Points Summary**

- Epidemiology and Basics of Malpractice
  - Though you are likely to get "sued" in your career, you are very unlikely to be found guilty of malpractice
  - The largest "risk" factor for getting sued is simply seeing more patients → that being said, good communication can help mitigate your risk
  - Overall, medical malpractice payouts are decreasing across the US though adverse actions are increasing
  - EM is in the middle of malpractice risk by specialty with a 7% risk per year
  - Must prove duty, breach of duty, causation and damages to successfully litigate a malpractice suit → damages are the biggest driver of the risk of being sued for a particular case
  - Most malpractice suits find in favor of the defendant (ie us)
- Risk Mitigation in Medical Malpractice
  - Bad outcome + bad feelings towards a doctor = malpractice suit
  - Most malpractice suites are based in poor communication not just the mistake or bad outcome
  - Practice apology → it's good for you and the patient!
- The Anatomy of a Trial
  - The steps of a trial include the complaint, the answer, motions I, discovery, depositions, motions II, trial with verdict and potentially an appeal
  - Don't be a target → prepare for your depositions and chart well! (and figure out what that means to you)

❖ **Facilitator Background Information**

Medical malpractice, and the fear surrounding it, is a source of significant stress for many practicing emergency physicians. This session attempts to demystify medical malpractice by laying out some statistics regarding malpractice as well as walking through the anatomy of a lawsuit. It gives the authors perspective on malpractice including what one can do help mitigate the risk of being sued. Most importantly, we hope that this session underscores that although being sued is an extremely difficult emotional experience, the true objective risks associated with being sued are much less than many believe. In the end, one's own assets, medical license or job is almost never threatened. These facts, however, do little to lessen the emotional impact and we cannot overemphasize the importance of discussing the emotional aspects of being sued with others. Among other impacts, being sued creates a second victim syndrome (a topic we discussed in further detail in Session 15: Physician Errors and Second Victim Syndrome).

Overview of Malpractice

Errors are **not** malpractice. Errors result from making complex decisions in situations of great uncertainty which is the fundamental basis of emergency medicine. If other reasonable emergency medicine doctors could have made a similar decision under similar circumstances then the error is not malpractice. Expect to make errors in your career. We cannot practice emergency medicine and not make errors.

The best defense to malpractice has nothing to do with anticipating the efforts of lawyers or documentation. Further, defensive medicine has never been shown to safeguard against malpractice but has been shown to increase medical costs and even cause patient harm with excessive testing and intervention. The best defense is to try to practice good medicine and to be kind and compassionate to each patient. The evidence is overwhelming that patients sue because they felt they were treated badly, not because the medicine was bad. Patients generally will not sue physicians they like, even if an error leading to harm is made.

Although physician behavior, namely practicing good medicine and being kind and compassionate to your patients, has some impact on your risk of being sued, the overwhelming proportion of risk comes simply from increasing patient exposure. Put another way, we can eliminate the risk of malpractice by not seeing any patients. The more patients you see, the higher your chances are of being sued. And, the more patients you see, the greater your opportunity to take care of them—which is exactly the reason you went into medicine. Don't let your anxiety about our out-of-control malpractice system detract from what you came to do.

Most emergency physicians will be sued at some point in their careers. Though we can, and should, continue to advocate for our profession and curtail excessive malpractice, we also need to accept that at this point in American history, being sued is unfortunately a job hazard. That being said, as stated above, the objective risks associated with malpractice are actually low. Even if filed, most lawsuits will not

picked up by the lawyers, dismissed by the judge or settled; rarely do they end in a trial. Only 1 in 4 EM physicians will ever see the inside of a courtroom (as a defendant) and the objective risks to the *individual* physician (ie loss of assets, job or license) are close to zero. Thus, the true toll malpractice has on us as physicians is largely a product of the mental toll it takes on us. We often feel a mix of sadness that a patient (or their family) feels we did them harm, anger at the process which often feels (and is) unfair, fear of the outcome and embarrassment that our medical care is being called into question. We begin to question ourselves as physicians even as we are expected to continue seeing patients and making complex medical decisions. This emotional toll may lead mental health issues including depression and anxiety, burnout, substance abuse and even suicide. It may also cause us to change our medical practice in ways that are not in the best interests of the patient, the physician or the medical system. It is this mental toll we need to discuss openly, freely and often, in order to help mitigate the effect malpractice is having on our profession.

The Anatomy of a Lawsuit

Being handed a legal complaint and summons can be an awful moment. Many of us don't know where to turn or what to do. First, ensure that the lawyer defending you is defending just you as the physician and not also the hospital or the system. Most EM groups have their own carrier and have some say in who defends them (also this lawyer is prepaid from insurance premiums) but make sure this lawyer isn't serving multiple parties. We also advocate, though we acknowledge this is controversial, finding a safe place to discuss your case with others as early as you feel comfortable. Though there is a very small risk that others can be supenoed to discuss what you told them, we believe the risk of holding in the feelings associated with being sued are much higher.

Once you are handed a summons the legal process goes as follows (though be aware you may alternately settle the case which would end the process). The complaint and summons you are handed, generally mandated to be done in person by a member of the prosecuting legal team, sets forth claims alleged by the patient (or their family). The attached summons usually requires a response within 28-30 days, this is why it's important to involve your legal team early. If you do not respond to the claim and summons, you may be found guilty by default. You then have a chance to respond to allegations. After you respond to the complaint, motions start which involve your team asking the judge to dismiss claims based on a variety of reasons. This is the first opportunity for your case to be dismissed. If your case is not dismissed, it enters the discovery phase where records are obtained and reviewed. This is followed by depositions where involved parties are interviewed by the lawyers under oath. This is a key time in the case as lawyers are often evaluating how you will appear to a jury and whether the case is worth pursuing. They are usually not looking for facts about the case itself but at your behavior. Be prepared, be kind, be compassionate and try not to be defensive! If you make yourself a difficult target by being a sympathetic witness, you increase the chances the lawyer drops your case. Also, remember that lawyers are not doctors. This is why many cases are dropped as the depositions and discovery phases progress and the plaintiff's lawyers realize they don't actually have a case.

We want to highlight one last time that most cases against physicians will never end in trial (only about 4%) and of those that do, most find in favor of the physician (>75%). Therefore, though the chances of having a complaint filed against you are quite high, the chances of being successfully sued are actually quite low. This is a very important fact to remember on the day you have a complaint handed to you. Finally, even if a guilty verdict is rendered, remember that your liability is actually quite low. Your personal assets are almost never in peril and it is extremely rare for a physician to lose their job or license unless there was truly gross negligence committed. The risks here are primarily psychological and can be devastating. We hope that an increased understanding of the legal process and a shift in our culture to one of openness and discussion surrounding litigation will help mitigate the emotional impact being sued has on us as EM physicians.

- **References**
  - **Author:** Dr. Natasha Wheaton (adapted by materials shared by Dr. William Sullivan)
  - **Expert Content provided by:** Dr. Jerome Hoffman and Dr. Mark Brown (MD/JD)
  - **References:**

Outcomes of Medical Malpractice Litigation Against US Physicians. Anupam B. Jena, MD, PhD; Amitabh Chandra, PhD; Darius Lakdawalla, PhD; et al

August 18, 2011. Malpractice Risk According to physician specialty. N Engl J Med 2011; 365:629-636

Appendix 1: Examples of Medical Malpractice Complaint

Complaint

CYNTHIA MONROE
v.
JOHNS HOPKINS HOSPITAL.
CASE NO.:
COMPLAINT

Cynthia Monroe, by her attorneys, Ronald V. Miller, Jr., Rodney M. Gaston and Miller & Zois, LLC, and brings this lawsuit against the Defendant Johns Hopkins Hospital and Johns Hopkins Community Physicians. In support of these allegations, Plaintiff states:
FACTS

1. That the Plaintiff is a resident of Anne Arundel County, Maryland.
2. That Defendant **Johns Hopkins Hospital** is a Maryland Corporation providing medical services to the citizens of Baltimore and has its principal place of business located in Baltimore City, Maryland.
3. That Defendant Johns Hopkins Community Physicians, Inc. is a Maryland Corporation providing medical care to the citizens of the State of Maryland with its principal place of business located at 3100 Wyman Park Drive in Baltimore City, Maryland and is wholly owned by Defendant Johns Hopkins Hospital.
4. That all remaining defendants are medical providers providing medical services in Maryland and at the time of the alleged medical malpractice were all employees/agents/servants of Defendants Johns Hopkins Hospital and Johns Hopkins Community Physician's Inc. and were acting within the scope of that employment/agency/servant relationship when they failed to follow the applicable standard of medical care during their treatment of the Plaintiff on or about May 29, 2017, and thereafter, at 1132 Odenton Road, Odenton, MD, which proximately resulted in a physical injury to the Plaintiff.
5. That the amount sought in this suit exceeds the jurisdiction limit of the District Court of Maryland. The venue that is a most appropriate venue in Baltimore City, Maryland as Defendants Johns Hopkins Hospital and Johns Hopkins Physicians Inc. maintain their principal place of business in Baltimore City, Maryland.
6. That these medical mistakes occurred on March 26, 2017, and after that, in the State of Maryland.
7. That on or about March 26, 2017, the Plaintiff underwent a CT scan of her abdomen, as recommended by the Defendants,
8. That following the Plaintiff's CT scan, the Defendants never informed the Plaintiff of the results of the CT scan, never informed the Plaintiff of the presence of the two ovarian cysts, never recommended that the Plaintiff have a follow-up sonogram, and never recommended that the Plaintiff have an OB/GYN consultation.
9. That the standard of medical care applicable to the Defendants after receiving the CT scan that revealed the presence of two ovarian cysts in the Plaintiff's body was to inform the Plaintiff of the presence of the cysts, to refer the Plaintiff for a sonogram, and to refer the Plaintiff for an OB/GYN consultation.
10. As a direct result of the Defendants breaching the applicable standard of medical care owed to the Plaintiff by failing to inform the Plaintiff of the results of the CT scan which revealed the presence of the ovarian cysts, by failing to recommend that the Plaintiff have a follow-up sonogram, and by failing to refer the Plaintiff for an OB/GYN consultation, the Plaintiff suffered a physical injury to her body.
11. That on May 29, 2017, and thereafter, Defendant Mary Carty, a physician's assistant, was required to be supervised by a licensed medical doctor during the occasions that she was providing medical care, treatment, and advice to the Plaintiff, and at all times that she provided medical care, treatment, and advice to the Plaintiff, she was under the direct supervision of Defendants Sidney McEnroe, M.D., David L. Fitzgerald, Jr., M.D., and Carol Chapman, M.D.
12. That Defendants Sidney McEnroe, M.D., David L. Fitzgerald, Jr., M.D., and Carol Chapman, M.D., all medical doctors, under the applicable standard of medical care owed a duty to the Plaintiff to supervise the medical care that Mary Carty, a physician's assistant, was providing to the Plaintiff. The defendant medical doctors breached this duty and standard of care by failing to adequately supervise Mary Simpson, on March 26, 2017, and thereafter, which resulted in the failure to inform the Plaintiff of the presence of the ovarian cysts as revealed by the CT scan, the failure to recommend that the Plaintiff have a follow-up sonogram, and the failure to refer the Plaintiff for an OB/GYN consultation. As a direct and proximate result of these failures, the Plaintiff suffered a physical injury to her body. All of these failures amounted to a breach of the applicable standard of medical care.
13. That as a direct and proximate result of the breach of the applicable standard of medical care by the Defendants, the Plaintiff has suffered harm. These harms include: 1) suffered conscious pain and suffering both in the past and, it is expected by her physicians, the future, 2) incurred medical expenses in the past

and will incur future medical expenses, 3) suffered mental and emotional sorrow and anguish, 4) suffered permanent physical injuries (enlargement of the ovarian cysts and a total hysterectomy) and disfigurement, and 5) was required to undergo additional medical procedures and has sustained other damages.

14. That all of the injuries and damages sustained by the Plaintiff were the direct and proximate result of the negligent actions and breaches of the applicable standards of medical care by all of the Defendants without any act or omission on the part of the Plaintiff directly thereunto contributing.
15. That the Plaintiff did not assume the risk of her injuries.
16. Plaintiff incorporates by reference herein the entire copy of the claim that she filed with the Health Claims Alternative Dispute Resolution Office on September 28, 2017 as Exhibit 1 which includes her Certificate of Qualified Expert from Dr. Kevin Phillips, M.D., Expert Report from Dr. Kevin Phillips, M.D., Certificate of Qualified Expert from Rochelle Ripple, RPA-C, and Expert Report from Rochelle Ripple, RPA-C, which further delineates the breaches of the applicable standards of medical care owed to the Plaintiff by all of the Defendants, which proximately caused a physical injury to the Plaintiff. Also attached hereto and incorporated by reference herein as Exhibit 2 is the Order of Transfer executed by Harry Chase, the Director of the Health Claims Alternative Dispute Resolution Office, directing that the claim be transferred to the Circuit Court for Baltimore City, demonstrating that the Plaintiff has complied with all of the statutory preconditions to filing the claim at bar.

COUNT I: Negligence – Medical Malpractice
(As to Defendant MARY CARTY)

17. The Plaintiff re-alleges and incorporates by reference herein all of the allegations contained in paragraphs 1-16 above.
18. That on or about March 26, 2017, Defendant Mary Carty breached the applicable standard of medical care owed to the Plaintiff, which directly caused a physical injury to the Plaintiff and was the direct and proximate cause of all of the Plaintiff's injuries and damages.

WHEREFORE: The Plaintiff claims monetary damages against Mary Carty individually in an amount to be determined at trial, plus costs, and for any further relief that this Honorable Court determines necessary and appropriate.

COUNT II: Negligence - Medical Malpractice
(As to Defendants SIDNEY MCENROE, M.D., DAVID L. FITZGERALD, JR., M.D., and CAROL CHAPMAN, M.D.)

19. The Plaintiff re-alleges and incorporates by reference herein all of the allegations contained in paragraphs 1-18 above.
20. That Defendants Sidney McEnroe, M.D., David L. Fitzgerald, Jr., M.D., and Carol Chapman, M.D. deviated from the acceptable standard of medical care during the care and treatment of the Plaintiff on or about March 26, 2017 and thereafter and that this deviation was the direct and proximate cause of a physical injury to the Plaintiff and the direct and proximate cause of all of the Plaintiff's injuries and damages.

WHEREFORE: Plaintiff claims money damages against Defendants Sidney McEnroe, M.D., David L. Fitzgerald, Jr., M.D., and Carol Chapman, M.D. in an amount to be determined at trial, plus costs, and for any further relief that this Honorable Court determines necessary and appropriate.

COUNT III: Negligence - Medical Malpractice
(As to Defendants SIDNEY MCENROE, M.D., DAVID L. FITZGERALD, JR., M.D., CAROL CHAPMAN, M.D., for failure to supervise)

21. The Plaintiff re-alleges and incorporates by reference herein all of the allegations contained in paragraphs 1-20 above.
22. That Defendants Sidney McEnroe, M.D., David L. Fitzgerald, Jr., M.D., and Carol Chapman, M.D., deviated from the acceptable standard of medical care during the care and treatment of the Plaintiff on or about March 26, 2017 and thereafter by failing to properly supervise the medical care and treatment that was being provided by Mary Carty to the Plaintiff and that this deviation was the direct and proximate cause of a physical injury to the Plaintiff and the direct and proximate cause of all of the Plaintiff's injuries and damages.

WHEREFORE: The Plaintiff claims monetary damages against Defendants Sidney McEnroe, M.D., David L. Fitzgerald, Jr., M.D., and Carol Chapman, M.D. in an amount to be determined at trial, plus costs, and for any further relief that this Honorable Court deems necessary and appropriate.

COUNT IV: Negligence/Medical Malpractice/Respondent Superior/Agency
(As to Defendants JOHNS HOPKINS HOSPITAL and JOHNS HOPKINSCOMMUNITY PHYSICIANS, INC.)

23. The Plaintiff re-alleges and incorporates by reference herein all of the allegations contained in paragraphs 1-22 above.
24. That during all of the times alleged herein that the Plaintiff was receiving medical care and treatment from Defendants Sidney McEnroe, M.D., David L. Fitzgerald, Jr., M.D., Carol Chapman, M.D., and Mary Carty, P.A.-C., these defendants were employed by Johns Hopkins Hospital and Johns Hopkins Community Physicians Inc. and they were acting within the scope of that employment.
25. That Defendants Johns Hopkins Hospital and Johns Hopkins Community Physicians. Inc. are responsible for the breach of applicable medical care occasioned by their employees, the defendants herein, which resulted in a physical injury to the Plaintiff.

WHEREFORE: The Plaintiff claims monetary damages against Defendants Johns Hopkins Hospital and Johns Hopkins Community Physicians. Inc. in an amount to be determined at trial, plus costs, and for any further relief that this Honorable Court deems necessary and appropriate.

Respectfully submitted,
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Sourced from: https://www.millerandzois.com/sample-hospital-medical-malpractice-complaint.html