Information

Physicians on Trial—Self-Reported Reactions to Malpractice Trials

SARA C. CHARLES, MD
CHARLENE E. PYSKOTY, MA
AMY NELSON
Chicago

A MAJOR MEDICAL INSURER reported that the frequency of malpractice claims increased from 10.5 claims per 100 physicians in 1980 to 17.8 claims per 100 in 1986.[1] Not all claims involved litigation, and the number of cases that eventually went to trial was very small. As an example, the Illinois State Medical Inter-Insurance Exchange, a physician-owned insurer, since its inception in 1976 has tried to verdict less than 4% of its 8,965 closed claims, 96% of which involved a malpractice suit.[2]

In a literature review, no reports were given on the psychological reaction to being on trial for any cause. Our previous studies indicated that being sued for malpractice was stressful for most physicians and resulted in a number of physical, emotional, and behavioral responses. Few of these cases, however, had progressed to trial. We studied a group of physicians whose malpractice actions did result in trial in order to compare their responses with those of both sued and nonsued physicians previously studied.[3,4]

Physicians and Methods

A mail survey was sent to those physicians who were listed in the 1985 Cook County Jury Verdict Reporter summary and index of malpractice trials for northern Illinois.[5] Valid addresses were obtained for 107 of the 122 physicians who went to trial during that year. A total of 64 questionnaires were completed, for a response rate of 60%. The questionnaire was based on an instrument used previously, with questions added to request specific information about the trial.[3,4]

Statistical analysis included the use of the difference-of-proportions test to evaluate the significance of the differences between sued and nonsued physicians and between samples over time.[6(pp234-236)]

Results

Most of the responding physicians were men (N = 62, 97%), with a mean age of 50.6 years. The most frequently reported specialties were surgery (N = 25, 39%), internal medicine (N = 16, 25%), general practice or family practice (N = 11, 17%), and obstetrics and gynecology (N = 9, 14%). Most were board certified (N = 50, 78%), and 25% (N = 16) had been recertified. The most commonly mentioned types of practice were solo (44% [28]) and partnership or corporation (39% [25]). Locations of practices were suburban (52% [33]), urban (38% [24]), and rural (8% [5]). Age, sex, specialty, and certification percentages were comparable to our previous studies.[3,4]

The percentage of physicians (72% [46]) who won favorable verdicts is comparable to that noted in other reports.[7(p22),8(p51)] Almost 45% (28) had known the plaintiff-patient one month or less, while about 17% (11) had known the patient for more than five years. In all, 47 (73%) physicians, compared with only 34 (53%) in our first study, reported additional malpractice suits filed against them. Of these, 11 reported five or more suits.

Symptomatic Reactions

Most (97%) of these physicians acknowledged some physical or emotional reactions, or both, in response to being sued for malpractice. Ten (16%) said that the trial was the single most stressful stage of litigation. Most (52% [33]) indicated that the entire period or a combination of stages was most stressful (Table 1). Feelings of inner tension (86% [55]), depressed mood (80% [51]), frustration (78% [50]), and anger (70% [45]) were commonly reported (Table 2).

About 58% (37) of all respondents acknowledged either one or both of the symptom clusters that we described in earlier studies.[3,4] Of these, 53% (34) reported the anger cluster of symptoms (with or without the depressive cluster), which is characterized by feelings of anger accompanied by at least four of the following symptoms: depressed mood, inner tension, frustration, irritability, insomnia, fatigue, headache, or gastrointestinal symptoms. This percentage included 67% who lost at trial and 48% of those who won. Only 5% (3), including both those who won and those who lost, reported the depression cluster alone (exclusive of the anger cluster), which is characterized by a depressed mood accompanied by at least four of the symptoms from the criteria list for affective disorder in the *Diagnostic and Statistical Manual of Mental Disorders,* revised third edition.[9] The differences in self-reported symptoms and symptom clusters between those who won and those who lost were not significant.

Although the majority (88% [56]) of the total sample believed that a plaintiff's case was not justified, the physicians who lost were significantly more likely than those who won to feel that the plaintiff's case was indeed justified ($\chi^2 = 5.89$, degrees of freedom 1, $P = .015$). Those who lost also tended to report more feelings of guilt ($\chi^2 = 2.98$, df 1, $P = .086$) and were significantly more likely to report a lack of adequate social support ($\chi^2 = 5.45$, df 1, $P = .019$).

There was notably less physical illness but more insomnia reported by physicians in this study compared with the sued groups previously studied. On almost every variable there were significant differences between the groups of sued physicians and the one group who had not been sued (Table 2).

Changes in Practice Behavior

Physicians in this study, compared with sued physicians in previous studies, reported similar changes in their daily medical practice (Table 2). Furthermore, the number of practice changes that were initiated was significantly and positively correlated with the number of symptoms reported ($r = .4952$,

(Charles SC, Pyskoty CE, Nelson A: Physicians on trial—Self-reported reactions to malpractice trials. West J Med 1988 Mar; 358-360)

From the Department of Psychiatry, University of Illinois School of Medicine (Dr Charles and Ms Pyskoty), and the Department of Psychology, Loyola University (Ms Nelson), Chicago.

This research was sponsored by a grant from the Doctors' Company, Santa Monica, California.

Reprint requests to Sara C. Charles, MD, Department of Psychiatry, University of Illinois at Chicago, 912 S Wood St, Chicago, IL 60612.

$P < .001$). Nearly 90% (57) of those studied indicated that the current climate of litigation has eroded the quality of the physician-patient relationship. More of them were likely to question their competence as a result of litigation than the sued physicians in the first study, but compared with nonsued physicians, they were less likely to do so. Almost two thirds reported a decreased satisfaction with their careers.

Discussion

The results of this study indicate that, in terms of symptomatic and behavioral responses to malpractice litigation, it does not matter whether a physician goes to trial or even whether he or she is vindicated by a favorable trial outcome. In addition, as shown by comparing these results with our previous studies, those who have been sued, regardless of the phase of litigation or the outcome of the suit, generally report significantly more adverse symptoms and changes in behavior than nonsued physicians.

Compared with our earlier studies, a smaller percentage of physicians reported that they have stopped seeing certain types of patients, and significantly fewer reported that they stopped doing certain high-risk procedures and had changed their record-keeping as a result of litigation. This may simply represent a function of time. The process of litigation is lengthy—the average length of time in this study from complaint to trial was 37.5 months. These physicians may have initiated changes in practice early in the process that they may no longer perceive as changes. On the other hand, this decrease may represent a certain attitude, not clearly measured, that is unique to physicians who experienced the entire litigation process, even though most won their cases. They may feel, for example, that engaging in such behavior has no relationship to the risk of being sued. Although fewer than in previous studies reported making changes in their practices, the total number of physicians who report defensive practice behavior remains quite high.

Among current study subjects there was a dramatic increase in the anger cluster of symptoms, whereas the depression cluster was significantly lower than in our previous studies. These changes may be due to a number of factors. In the 1982 study, for example, 64% of respondents were sole defendants; in the current study, only 28% were. Being accused as one of a group or in conjunction with a hospital may dilute the feelings of isolation so commonly reported in our earlier studies. This may generate more anger but less depression.

There also have been changes in the attitude of physicians regarding the commonly accepted notion that a malpractice suit represents a judgment on one's competence. As shown in Table 2, the nonsued in one of our earlier studies were significantly more likely than all three groups of sued physicians to feel that, given the threat of being sued for malpractice, litigation is both an affront to and a reflection of one's professional competence. This attitude, similarly held by the lay public, implies that a malpractice suit is directly related to negligence or lack of competence and is, therefore, the physician's "fault." On the other hand, once a physician is sued, these feelings about the relationship between competence and malpractice suits may change, often because in the incident in question, the physician felt that he or she had exercised good judgment and behaved in a competent manner. This change in attitude may set the stage for more feelings of anger and frustration that are externally directed toward a system in which highly competent physicians are the ordinary subjects of malpractice suits. At the same time, fewer physicians would experience the internally directed feelings of depression,

TABLE 1.—*Most Stressful Stage of Litigation Process*

Stressor	Physician Response, N=64 No. (%)
Notification	13 (20)
Period of discovery	2 (3)
Trial	10 (16)
Entire period	21 (33)
Combination of stages	13 (20)
No particular stage mentioned	5 (8)

TABLE 2.—*Symptomatic and Behavioral Responses to Malpractice Litigation—Comparison of Three Studies*

	1982*	1983†		1986‡
	N=154, %	Sued N=194, %	Nonsued N=152, %	N=64, %
Did unnecessary tests	62	68	60	67§
Changed record keeping	69§	75	79	56§‖
Stopped seeing certain patients	48§	49§	30	41
Stopped doing high-risk procedures	28	43§	33	14§‖
Questioned own competence	15§	39§	59	31§‖
Talked with peers	10§	..	..	70‖
Inner tension	74§	83§	57	86§
Depressed mood	72§	79§	51	80§
Frustration	70§	77§	48	78§
Anger	88§	86§	46	70§‖
Insomnia	47§	56§	43	56§‖
Onset of physical illness	8	5	6	2‖
Exacerbation of physical illness	7	10	9	2§‖
Depression cluster	39§	35§	27	27‖
Anger cluster	20	31§	14	53§‖

*From Charles et al.[3]
†From Charles et al.[4]
‡This study.
§$z > 1.65$, $P < .05$; sued physicians differ significantly from nonsued.
‖$z > 1.65$; $P < .05$; data from this study differ significantly from those of Charles and co-workers.[3]

guilt, and shame that commonly accompany the accusation of being a "bad doctor."

Social support may also play a role in the expression of symptoms. In our 1982 study, only 10% of those responding said that they talked about the emotional impact of litigation with one of their peers, compared with more than 70% of the current study subjects. The forming of medical and specialty society support groups that provide a resource of understanding for those involved in litigation reflects this development.[10] Sharing the emotional impact of this event with a colleague allows for a greater expression of anger and may at the same time diminish the potential for turning the anger inward, a classic explanation for the development of symptoms of depression.[11(p400)] Although this study showed no significant differences in symptoms between physicians who won and those who lost their trials, the latter clearly felt they had less social support. A legal judgment of malpractice, irrespective of one's real level of competence, may set in motion self-generated behaviors that disrupt these physicians' perception of their own social roles and status. This may also alter their feelings of community with other medical professionals. This finding may give added direction to support groups by identifying a particularly vulnerable group—those who lost at trial—who may profit from active interventions even though they evince no more symptoms than their vindicated counterparts.

Some researchers have suggested that a feeling of well-being is an important variable in determining the quality of care delivered by a physician.[12] As noted earlier, an increasing number of practicing physicians have become subjects of litigation. If, as the findings of this study suggest, the major impact of the litigation experience—in terms of physical, emotional, and behavioral changes—is a function of the allegation rather than the outcome of the suit, and because the number of practice changes initiated was significantly and positively correlated with the number of symptoms reported, then this increase in allegations may have important implications for the quality of medical care. We plan further studies to quantify the specific effects that litigation has on a physician's feeling of well-being and its subsequent effect on patient care.

REFERENCES

1. Physicians' and Surgeons' Update: A Special Report—Vol 3. St Paul Fire and Marine Insurance Company, St Paul, Minn, 1986

2. Loss Analysis, Claim and Suit Status by Policy Year, December 31, 1986. Chicago, Illinois State Medical Inter-Insurance Exchange, 1986

3. Charles SC, Wilbert JR, Kennedy EC: Physicians' self-reports of reactions to malpractice litigation. Am J Psychiatry 1984; 141:563-565

4. Charles SC, Wilbert JR, Franke KJ: Sued and nonsued physicians' self-reported reactions to malpractice litigation. Am J Psychiatry 1985; 142:437-440

5. 1985 Calendar Year Summary and Index of Malpractice Trials. Chicago, Cook County Jury Verdict Reporter, January 1986

6. Blalock HM: Social Statistics, 2nd Ed. New York, McGraw-Hill, 1979

7. Professional Liability Insurance and Its Effect: Report of a Survey of ACOG's Membership. Washington, DC, American College of Obstetricians and Gynecologists, 1985

8. Chin A, Peterson MA: Deep Pockets, Empty Pockets: Who Wins in Cook County Jury Trials, Rand Study R-3249-ICJ. Santa Monica, Calif, Rand Corp, 1985

9. Diagnostic and Statistical Manual of Mental Disorders, Revised 3rd Ed. Washington, DC, American Psychiatric Association, 1987

10. Charles SC: A response to the malpractice crisis: Physician support group formed. IMJ 1985; 167:454-455

11. Meissner WW: Theories of personality and psychopathology: Classical psychoanalysis, *In* Kaplan HI, Sadock BJ (Eds): Comprehensive Textbook of Psychiatry—Vol 4, 4th Ed. Baltimore/London, Williams & Wilkins, 1984

12. Quantity versus quality: Is stress the link? (Editorial). Fam Pract 1985; 2:125-126