

2019

Experience is Treacherous: An Intimate View of the Physician's Experience of Adverse Patient Outcomes and Malpractice Litigation

M. Stacia Dearmin

Follow this and additional works at: <https://scholarlycommons.law.case.edu/healthmatrix>

Part of the [Health Law and Policy Commons](#)

Recommended Citation

M. Stacia Dearmin, *Experience is Treacherous: An Intimate View of the Physician's Experience of Adverse Patient Outcomes and Malpractice Litigation*, 29 Health Matrix 357 (2019)
Available at: <https://scholarlycommons.law.case.edu/healthmatrix/vol29/iss1/9>

This Article is brought to you for free and open access by the Student Journals at Case Western Reserve University School of Law Scholarly Commons. It has been accepted for inclusion in Health Matrix: The Journal of Law-Medicine by an authorized administrator of Case Western Reserve University School of Law Scholarly Commons.

EXPERIENCE IS TREACHEROUS: AN INTIMATE VIEW OF THE PHYSICIAN'S EXPERIENCE OF ADVERSE PATIENT OUTCOMES AND MALPRACTICE LITIGATION

M. Stacia Dearmin[†]

Not long ago, I heard a story told by Doctor Adam Grant, award-winning professor of organizational psychology at the Wharton School of Business. Via his WorkLife podcast, he captures an experience he had with the facilitator of a retreat.¹ She presents participants with the image of an everyday object and asks each member of the group to quickly jot a list, describing what they saw. The variety of their responses is both astonishing and humorous. With this simple exercise, the facilitator beautifully makes two points: 1) that what you see is as much a product of who you are as what you are looking at, but also, 2) that we all gain so much from seeing what someone else sees.

I would like for us to take that everyday object as a symbol for the complex experience of an unforeseen adverse patient outcome and medical malpractice litigation. Clearly, those of you who study and practice law could describe features of that experience which I, who have lived it, cannot begin to fathom. I, on the other hand, want you to know that there are things hidden there which you might never have imagined. Essentially, I am here to enrich your understanding of an everyday experience which is in no way ordinary.

Why would I do this? It is rare for physicians who have been litigated against to speak openly about it, much less in such a public forum. Let me give you an analogy. In the early 1970s, when I was just a girl, Betty Ford, who was then our First Lady in the United States, moved the world. At that time, women – people in general, really – simply did not talk about breast cancer in polite company. It felt shameful to them. Because it was not an acceptable topic for conversation, women's lives were needlessly lost.

[†] Dr. Stacia Dearmin is a practicing physician, speaker, coach, and writer with a passion for supporting physicians recovering from adverse patient outcomes and surviving malpractice litigation. She is a member of the Division of Emergency Services, Akron Children's Hospital, Akron, OH, and the founder of Thrive: Insight, Education, Support.

1. *Your Hidden Personality*, WORKLIFE WITH ADAM GRANT (Mar. 2018), https://www.ted.com/talks/worklife_with_adam_grant_is_your_personality_more_flexible_than_you_think.

Betty Ford, however, broke the mold. After finding a lump, she was diagnosed with breast cancer, and underwent a total mastectomy in the days before breast reconstruction.² She could have been private about that; no one would have faulted her. In that time, though, following so closely upon Watergate and Nixon's resignation,³ I think she sensed that the nation yearned for honesty from the White House. Thanks in no small part to her openness and her willingness to promote mammograms, the world for the one in eight women, and the smaller number of men with breast cancer,⁴ has never been the same.

Among physicians, even though we may not realize it, far more than one in eight face litigation. The best study I have found estimates that seventy five percent of American physicians in "low-risk" specialties (specialties like psychiatry, pediatrics, family medicine) and ninety-nine percent in "high-risk" specialties (largely surgical or heavily procedure-oriented specialties) will be sued by the age of sixty-five.⁵ If you ask me, it sounds like we are all "high risk."

The fact that it happens to most of us does not make litigation any easier for us than a diagnosis of cancer would be. Most physicians who have been there – and I am among them – will tell you that being sued is the hardest thing they have ever done, bar none.

And in fact, in some specialties, physicians are sued on average once every five to eight years. This is not hypothetical. I personally know physicians – excellent physicians – out there taking risks daily to manage our collective emergencies or childbirths or to perform challenging surgeries, whose life experience is exactly that.

In the world of emergency medicine, we are very aware of the heroics performed by the trauma teams who responded to the Boston Marathon bombing,⁶ the Pulse Nightclub tragedy,⁷ and the Las Vegas

-
2. Corinna Wu, *A Leading Lady*, CANCER TODAY (Sept. 27, 2012), <https://www.cancertodaymag.org/pages/Fall2012/betty-ford-yesterday-and-today.aspx>.
 3. *Id.*
 4. U.S. Breast Cancer Statistics, BREAST CANCER, https://www.breastcancer.org/symptoms/understand_bc/statistics?gclid=EA1aIQobChMI35qln7Sv4AIVycDACh2g2Q1wEAAAYAyAAEgIDLfD_BwE (last updated Feb. 13, 2019).
 5. Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty*, 7 NEW ENG. J. MED. 629, 636 (2011).
 6. See Atul Gawande, *Why Boston's Hospitals Were Ready*, NEW YORKER (Apr. 17, 2013), <https://www.newyorker.com/news/news-desk/why-bostons-hospitals-were-ready>.
 7. See Gary A. Parrish et al., *The Orlando Nightclub Shooting: Firsthand Accounts and Lessons Learned*, 48 EMERGENCY MED. 348 (2016).

shooting.⁸ We are aware of the toll those events must have taken on them, we are dazzled by their skill and creativity in a crisis, and we are proud to call them our own. On another day of the week, though, I promise you, those very emergency physicians, surgeons, and residents are being sued. And, believe it or not, that takes an equally large, or larger, toll on them, their health, and their capacity to practice their vocation.

As with the Betty Ford story, we physicians and other healers have a taboo against discussing our experiences with medical malpractice litigation, even amongst ourselves. It feels shameful to us, and we worry that our colleagues will not trust us to take good care of their patients. Consequently, many physicians cannot tell you who among their colleagues shares this deeply personal experience. I believe that this taboo harms us as physicians, and in turn, the community we serve.

Like cancer, this experience has the potential to take physicians and other healers' professional and personal lives from them and their communities, figuratively and literally. The experience of adverse or near-adverse outcomes and litigation is widely known to result in post-traumatic stress disorder in practice.⁹ It drives some physicians to retire early – even pursue an alternative career and go into something like real estate – or leave the operating room which they had loved and pursue an administrative role, often at the midpoint of their career.¹⁰ Given that we face physician shortages projected to reach up to 120,000 by the year 2030,¹¹ the loss of their accumulated years of clinical experience should concern us all.

-
8. Kevin Menes et al., *How One Las Vegas ED Saved Hundreds of Lives After the Worst Mass Shooting in U.S. History*. EMERGENCY PHYSICIANS MONTHLY (Nov. 3, 2017), <http://epmonthly.com/article/not-heroes-wear-capes-one-las-vegas-ed-saved-hundreds-lives-worst-mass-shooting-u-s-history/>.
 9. Alisa G. Woods, *When the Psychiatrist Has PTSD*, PSYCHIATRIC TIMES (Nov. 24, 2015), <https://www.psychiatrictimes.com/ptsd/when-psychiatrist-has-ptsd>.
 10. Charles M. Balch et al., *Personal Consequences of Malpractice Lawsuits on American Surgeons*, 213 J. AM. COLL. SURGEONS 657, 662 (2011).
 11. *The Complexities of Physician Supply and Demand: Projections from 2016 to 2030*, ASS'N OF AM. MED. C. (2018), https://aamc-black.global.ssl.fastly.net/production/media/filer_public/85/d7/85d7b689-f417-4ef0-97fb-ecc129836829/aamc_2018_workforce_projections_update_april_11_2018.pdf.

Physicians affected by painful patient outcomes and litigation may do things like give up obstetrics and practice gynecology alone.¹² It affects their physical health and no small number experience depression and even suicide.¹³ In fact, it was in the midst of my own trial a few years ago when I stumbled quite by chance upon a TED talk on the topic of physician suicide¹⁴ that life set me on the path that has brought me here today.

There are other parallels to Betty Ford's experience. Her diagnosis of cancer had to be very challenging. The loss of a breast touches very deeply on many women's sense of their fundamental identity and cancer shakes a person's confidence that they are safe in the world. Likewise, the loss my patient had – *my own patient* – and the medical malpractice litigation which ensued was very difficult for me. Not unlike many cancer diagnoses, it felt like a state of emergency which sustained itself over years.

For many physicians, as the old U.S. Navy advertisement says, our work is “Not Just A Job, It’s An Adventure.”¹⁵ The very distinct set of sacrifices required to learn our craft and the intense life experiences met along the way often weave our identity as a healer into our very fiber. For most of us, it is not “what we do,” it is “who we are,” and we would not have it any other way. My patient’s loss and the subsequent litigation challenged fundamental aspects of my sense of identity as someone who protects children, who is intelligent and insightful, who is endowed with significant clinical acumen accumulated over years, and it shook my confidence that I was safe in a world I love.

In order to capture in words for you what the experience of a major adverse outcome and litigation meant to me, I need to clarify that these sorts of events actually comprise two stories; one of the patient’s loss and our response to that, and the other of the experience of litigation. Not every healer who has one experience has the other, but when they

-
12. See *Medscape Ob/Gyn Malpractice Report 2017: Real Physicians. Real Lawsuits.*, MEDSCAPE (Mar. 22, 2019), <https://www.medscape.com/slideshow/2017-obgyn-malpractice-report-6009316#18>; Comm. On Prof'l Liability, *Coping With the Stress of Medical Professional Liability Litigation*, AM. C. OBSTETRICIANS & GYNECOLOGISTS (Jan. 2013), <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Professional-Liability/Coping-With-the-Stress-of-Medical-Professional-Liability-Litigation?IsMobileSet=false>.
 13. Balch et al., *supra* note 10, at 665.
 14. TEDx Talks, *How to Get Naked With Your Doctor – Dr. Pamela Wible – TEDxSalem*, YOUTUBE (Jan. 31, 2014), <https://www.youtube.com/watch?v=5cvHgGM-cRI>.
 15. *The Navy’s Slogans: The Words Set the Tone*, NAVCYBERSPACE, <https://www.navycs.com/blogs/2010/06/27/navy-recruiting-slogans> (last updated August 9, 2018).

co-occur, the two interlock and intensify one another. Fundamentally, however, they are two stories and make different demands upon us.

My personal experience involved a young woman I met in early March some years ago. At that time, I was the Assistant Medical Director of the Pediatric Emergency Department. I was not at the large children's hospital where I now practice, but at a community hospital in the region where I live. I loved it. The team of nurses was tremendous, and thanks to them, the department ran like a top. In that setting, we see patients under twenty-one- years of age for every imaginable injury or illness of every possible degree of severity. As you might imagine, teamwork reigns supreme.

Like all medical specialties, pediatric emergency medicine comes with a unique set of pleasures and stressors. We have a lot of fun with our young patients, relishing their tales of mischief run amok thereby resulting in a visit to the Emergency Room. I find it to be an unadulterated joy to relieve their pain and see their physiology respond to our first steps to address life-threatening injuries or illness. On the other hand, it has fallen to me more than once over the years to tell parents that their three-year-old is stumbling due to a brain tumor or that their pale eight-year-old has leukemia. I have held the weeping mother who has lost her baby to sudden infant death syndrome or the father whose two children have just died in a housefire. It is hard work, but I am committed. I take pride in what we do and how we do it.

On the particular Friday I want to tell you about, I was the doctor on duty from 9:00 AM to 5:00 PM. Around midday, a young woman around eighteen or nineteen years old came in. It was a busy, late winter day all around, and she was in one of two ambulances which rolled in at once. My nurse-colleagues quickly sized things up and rightly directed me to the other patient, who worried them. He was a really big, strong guy, and his thinking was deteriorating in such a way that he rapidly presented a real danger to his own safety as well as that of some amazing nurses, all of whom were much smaller than he. By the time I got to see the young woman – we will call her Emily¹⁶ – a medical student had been in to interview and examine her, thirty minutes or so had passed, and the rest of the department had simmered back down just a bit.

I learned from the medical student that Emily had been seen by another physician elsewhere the day before, something which always piques our curiosity. The student candidly said that she could not quite piece together what Emily and her mother were trying to tell her, so we went in together. Now, I consider myself to be pretty good at getting to the bottom of whatever is bothering families, and I am proud of that aspect of my bedside manner. So, I sat down to listen and question.

16. The patient's name and other identifying details have been altered to protect her and her family's privacy.

Little by little, I sifted through their concerns, all the while thinking that this would be a good opportunity for the student to observe that skill at work. Although Emily had past medical problems, the symptoms that brought her in, while a little convoluted, fit a clear, known pattern.

Over the course of about six hours, we did some thorough testing and observed her, while she and I intermittently chatted along the way. She was a sweet young woman and her parents were very nice. At the end of the day, we reviewed everything and made a decision together that it made sense for her to go home and follow up with her doctor on Monday. After finishing my charts at the close of such a busy day, I got out a couple of hours late that night.

On Saturday, I returned at 5:00 PM for an evening shift. No sooner had I settled in than a specialist from another area of the hospital came by. He wanted me to know that one of the patients I had seen the day before was now in the Intensive Care Unit (ICU). Honestly, I could not imagine who, but I thought about the young man. He told me that it was Emily.

She had arrested – stopped breathing – while in the community that afternoon. Ambulance personnel had tried in vain to intubate her, in order to do her breathing for her, as had the skilled team at an ED near her home. She was helicopter-lifted to our ICU, where this specialist had managed the airway problem quite some time after she had originally stopped breathing.

It is hard to convey to you how very stunned I felt upon hearing this news. I felt dizzy, and I had the out-of-body sensation many of us get when we learn that someone we love has died. One of our most important roles in the Emergency Room is to make the best choices we can about who needs to be in the hospital and who does not. At that moment, it felt patently obvious to me that I had made the wrong choice, although I could not figure out how or why. I felt sick. I knew with certainty that Emily's prognosis was not good at all, and I felt that I had failed her and her parents. Nearly twenty years out of medical school, I deeply doubted my competence. And none of that changed the fact that my colleague and I had a late-winter, Saturday-night pediatric Emergency Room to run for the next eight hours.

At my trial three and a half years later, records revealed that over the next few days, I repeatedly looked at Emily's electronic medical record. I had no desire to alter it and I am grateful that I stayed late to complete my charting right after our visit. The only thing I wanted to alter was the past, Emily's and mine. And if I could not alter it, I needed at least to understand it for the next patient. No understanding came, however, even a month later after an autopsy was complete. To this day, I do not know why she died. As far as I can tell, no one truly does, including the numerous experts who testified at trial.

Right away, I spoke with my medical director. After all, I was his right-hand woman, he had a responsibility to know, and I wanted him to hear it from me. I also called my favorite colleague and mentor, with whom I had worked closely for years. They are both smart physicians, and I needed to ask what they each thought had happened -- they did not know -- and whether they would have done anything more -- they said no, more likely they would have done less. This brought me a little relief, but not much. I felt that, having been there, with the patient before me, I should have somehow figured it out.

Nurses and a social worker sensed my distress and surrounded me over the days to come with warmth and support, reminders of how highly they thought of me and of their concern for me. I continued to do my work, but they knew me well and could read my confusion and my heartache, even through a stoic exterior. One nurse, a religious person, took me aside and tenderly asked, "You remember that you don't get to choose who lives and dies, right?" That took me aback and set me down in that tiny little place we each actually inhabit. My mentor-friend, after hearing the whole story, said, "Stacia, you know that you are an excellent doctor, don't you?" At that moment I genuinely did not know that, but it helped that she thought so.

At a later time, in my effort to heal, I did a little math. For a long time, it felt to me that Emily was the only patient who mattered, but I began to remind myself that in the course of my career, prior to seeing Emily, I had cared for roughly 50,000 babies, children, and teens. She was 1 in 50,000, and yet she was occupying much of my mental and spiritual space. My struggle lay in making peace with the events that surrounded Emily's care and returning my heart and mind to those children whose future I *did* have the opportunity to impact. It was an uphill climb.

I now know that the intense questions and emotions I experienced represent a known phenomenon, which is actually deeply embedded in the work of all healers, no matter how excellent or exceptional. Nearly 2400 years ago, Hippocrates hinted at this when he wrote, "[l]ife is short, the art long, opportunity fleeting, experience treacherous, judgment difficult."¹⁷ The use of the word "treacherous" to describe clinical experience is so poignant to me now. When you see marble busts of Hippocrates, his brow is furrowed, just like mine is at times. This experience is as old as humanity. Even Hippocrates knew what I now know.

Much more recently, this aspect of a healer's life has been more clearly defined and given a name. Almost a year after Emily died, while I was still recovering from our shared loss and hoping against hope that

17. HIPPOCRATES, APHORISMS, Section I: 1; See George A. Antoniou et. al., *A Contemporary Perspective of the First Aphorism of Hippocrates*, 56 J. VASCULAR SURGERY 866, 867 (2012).

the statute of limitations would elapse uneventfully, I stumbled upon a brief but beautiful essay written in the year 2000 by Doctor Albert Wu,¹⁸ a physician at Johns Hopkins, in response to a major report on medical errors from the Institute of Medicine.¹⁹ This essay began to illuminate my experience in a very personal way, and to relieve me of harsh self-criticism on the grounds that if I were a better and stronger physician, I would be over this already.

He wrote, “although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.”²⁰ Claiming that “virtually every practitioner knows” some of the elements of this experience, he said, “[i]n the long run, some physicians are deeply wounded, lose their nerve, burn out, or seek solace in alcohol or drugs. My observation is that . . . some of our most reflective . . . colleagues [are] perhaps most susceptible to injury from their own mistakes.”²¹

“Eureka!” I thought, “I’m not weak, I’m reflective.” I know that to be true for me and I know that it would be a huge loss for society if the most reflective physicians abandoned our beautiful calling. Once that door opened for me, the healing process did not become a foregone conclusion, but it did move slightly more steadily forward.

I was not the only member of the medical community ready to hear what Doctor Wu had to say. Once my trial was behind me some years later and my commitment was firm to teach physicians, especially the young ones, about this aspect of our work, I discovered an explosion of research into the experience of the “second victim,”²² though we in healthcare continue to struggle to apply its lessons. The proper use of the term “second victim” is not limited to physicians, nurses, and other healers.²³ As it turns out, second victims may be firefighters, police officers, members of the military, and business owners. Those in aviation and the aerospace industry are at risk. In fact, the leading international expert is a Dutch pilot named Sidney Dekker, now living

-
18. Albert W. Wu, *Medical Error: The Second Victim*, 320 BRIT. MED. J. 726, 726-727.
 19. See generally LINDA T. KOHN ET. AL., INST. MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (2000).
 20. Wu, *supra* note 18.
 21. *Id.*
 22. Susan D. Scott, *The Second Victim Phenomenon: A Harsh Reality of Healthcare Professions*, PATIENT SAFETY NETWORK (May, 2011), <https://psnet.ahrq.gov/perspectives/perspective/102/the-second-victim-phenomenon-a-harsh-reality-of-health-care-professions>.
 23. See Hanan Edrees et al., *Implementing the RISE Second Victim Support Programme at John Hopkins Hospital: A Case Study*, 6 BMJ OPEN 1, 9 (2016).

in Australia, teaching safety science.²⁴ He and others have identified that “[a]ll second victims have two things in common: 1 [a] deep, personal commitment to the welfare of others; and 2. [w]ork where safety is generally critical, characterized by high levels of complexity, frequently involving rapid-fire decision making in the face of limited knowledge and significant unknowns.”²⁵

What better way to describe the work we do in healthcare? Those of us who do it well, often those “most reflective colleagues,” have a profound commitment to the welfare of others. But the fact of the matter is that, apart from the complexity of the systems we operate in, the human body – even a healthy one – is full of secrets and may surprise us abruptly. Meanwhile, we ourselves are flawed human beings attempting to take care of other flawed human beings. Given that our compassion is the most healing thing we bring to the bedside, there is no substitute for the human presence. However, the nature of the work is that we often engage in rapid-fire decision-making in the face of limited knowledge and significant unknowns. In fact, on the day in question, there were many more irons in the fire than just one. Is it any surprise then that something may or may not occasionally get past us?

And here is the interesting thing: a full-fledged error need not occur for a healer to become a second victim. Even a near-miss, such as a wrong drug dose never administered or, as in Emily’s and my case, a perceived possible error, is adequate to create this firestorm in the second victim.

Sully, the pilot who successfully brought a jet down on the Hudson in 2001, became a classic second victim,²⁶ as did the air traffic controller who thought the airliner had been lost.²⁷ The Superintendent of Schools in Parkland, FL, where the Marjorie Stoneman Douglas High School shooting occurred,²⁸ is a likely candidate. In “Hamilton,” Lin-Manuel

-
24. SIDNEY DEKKER, *Introduction to SECOND VICTIM: ERROR, GUILT, TRAUMA, AND RESILIENCE* (2013).
 25. M. Stacia Dearmin, *Living Among Heroes: Who Becomes a Second Victim?*, THRIVE (May 4, 2018), <https://www.thrivephysician.com/blog/2018/5/4/living-among-heroes-who-becomes-second-victim>.
 26. Marjorie P. Stiegler, *What I Learned About Adverse Events From Captain Scully: It's Not What You Think*, 313 JAMA 361 (2015).
 27. See Nancy Pelosi, *Air Traffic Control Specialist Patrick Harten Testifies*, YOUTUBE, (Feb. 24, 2009), <https://www.youtube.com/watch?v=X9hKGXvb4sc>; Ian Spanier, *Right Next Door: Patrick Harten, Air-Traffic Controller “Miracle on the Hudson,”* YOUTUBE, (Sept. 8, 2016), <https://www.youtube.com/watch?v=YlvZkkPHtpI>.
 28. Elizabeth Chuck et al., *17 Killed in Mass Shooting at High School in Parkland, Florida*, NBC NEWS (Feb 15, 2018), <https://www.nbcnews.com/news/us-news/police-respond-shooting-parkland-florida-high-school-n848101>.

Miranda tenderly gives the second victim in George Washington a voice when he sings:

I was younger than you are now
when I was given my first command.
I led my men straight into a massacre,
I witnessed their deaths firsthand.
I made every mistake,
And felt the shame rise in me.
And even now I lie awake,
knowing history has its eyes on me.²⁹

Sensations of fear, shame, and guilt; lost sleep; reliving the event whilst repeatedly searching for answers; prolonged grief – I did it all. And all are typical of a second victim.³⁰ None are signs of weakness; in fact, as I see it now, this phenomenon uniformly occurs in people engaged in what I would call heroic pursuits out of a deep commitment to humanity. A risky but beautiful way to live, and a group of people worth protecting and preserving.

I knew in my heart as soon as I learned that Emily had arrested that I would be perceived as the weak link in the chain and that I would be sued. A lawsuit is something most physicians dread,³¹ and I was no exception. Emily had seen other physicians for her symptoms as it turned out – more physicians than I was able to know at the time of my visit with her – but I was the last in line. I knew that I would be perceived and portrayed as the person who sent her home to die.

And honestly, while I did not like the idea of being sued, at some level, I understood it. I know from my work that when a child dies, even when a miscarriage occurs, many parents cannot avoid blaming themselves. They look endlessly for their error. They grieve, lose sleep, feel guilty and ashamed. They become second victims in their own right.

My experience and compassion told me that Emily's parents had three options: to blame themselves, blame God, or blame me. If they were going to survive the incomparable loss of their only child, they were going to need to hold tight to God if they had one and they were going to need each other. That left me.

-
29. LIN-MANUEL MIRANDA, *History Has Its Eyes On You*, on HAMILTON: AN AMERICAN MUSICAL (Original Cast Recording 2015).
 30. S.D. Scott et al., *The Natural History of Recovery for the Healthcare Provider 'Second Victim' After Adverse Patient Events*, 18 QUALITY & SAFETY IN HEALTH CARE 325, 328 (2009).
 31. See Emily R. Carrier et al., *Physicians' Fears of Malpractice Lawsuits Are Not Assuaged by Tort Reforms*, 29 HEALTH AFF. 1585, 1585, 1590 (2010).

There are omnipresent forces in American society encouraging citizens to believe that they will get some relief from this type of loss by suing one another, particularly by suing their doctor. I doubt the efficacy of lawsuits for providing relief from grief; I think they prolong it and stunt its resolution. But I could see that from Emily's parents' perspective, I was the logical target for their blame.

About a year after Emily died, I received a letter informing me that I was now a defendant and directing me to make an appointment with my newly designated defense attorney. I could not know at that moment that another two and a half years would elapse before the legal process came to a close. For me too, the lawsuit prolonged my grief and stunted my growth and healing.

It was scary to have to go meet my own personal defense attorney, but also a relief. He was clearly knowledgeable, confident, and a person of integrity. Over time, I grew to respect him enormously.

As funny as it may sound, I have often compared that time, especially the three weeks we spent at trial, to the moment in *Star Wars* when Luke Skywalker, Princess Leia, Han Solo, and Chewbacca find themselves in a giant trash compactor on the Death Star.³² When you are twelve, as I was when I first saw it, you really believe they might be crushed to death, right there and then, surrounded by garbage, unless, of course, they find some way out by dint of their wits and tenacity. The pressure of trial was crushing, quite unlike anything I have experienced before or since. I do not exaggerate when I say that it felt like my personal and professional survival were at risk.

The process of medical malpractice litigation is much harder for physicians than I think most people imagine, especially given that we bring to it our habit of stoicism in the face of difficulty in our professional environment. The stress is enormous, and difficult to compartmentalize at times, in part because we continue to see patients – in my case another 5000 or 6000 over that two and a half years – usually in the very environment where the original incident occurred.

A similar situation or procedure can bring out a fight-or-flight response together with a racing heart and sweaty palms, not exactly the ideal state of flow required for the excellent practice of medicine. Regardless of whether we believe we met the standard of care or not, many physicians cannot work as efficiently and effectively as usual during that time, even though colleagues may not be aware of what is transpiring. Most worry about our license, our insurability, our reputation, and our credentialing, all of which are the foundation of our livelihood.

Malpractice litigation was stressful and difficult for me in such innumerable ways that I cannot possibly lay them all out for you. With the passage of time, though, I have come to see that, apart from the

32. STAR WARS EPISODE IV: A NEW HOPE (Twentieth Century Fox 1977).

factors I have already described, many of the challenges stemmed from a profound culture clash between the environment of litigation and the environment in which I work. I felt like a fish out of water. What I know how to do when in my professional role is swim, but I was being asked to travel through the air. Not only did I not know what I was doing, I felt like I could not breathe while I was doing it. Among those challenges, I will elaborate on three.

First, I experienced a profound mismatch between my role at work and my role as a defendant. At work, I am a competent and fun team leader. I took charge of my education for years and still do, and in the Emergency Room, it falls to me to take charge and lead when the chips are down. Some days I do a better job than others, but even on a bad day, at least I know my role. I cannot tell you how challenging it was as a physician-defendant to know that the chips were down for me and not to know where to begin to do my part to help myself.

All of this confusion can be complicated by the fact that a physician's professional role is not confined to the office or hospital. More than once while I have been on vacation, I have stepped up when strangers got hurt. Twice I have seen a motorcyclist thrown by a car and have stepped in to stabilize their cervical spine or hold their scalp on while help arrived. A story went viral recently about an OB/GYN-defendant in California who took swift action when a juror at his own trial collapsed, requiring him and his medical assistant to perform CPR and use the courthouse's automated external defibrillator.³³ The juror was stabilized, which is excellent, but the plaintiff's lawyer called for a mistrial, which was granted. The poor physician-defendant had to wait and start all over again.

Although that story is very recent, given my history on vacations, I really feared something like that myself. When Emily's father did not look so well, I felt very tense. Not only did I feel terrible for him, but I also worried about whether he would collapse, which would put me in quite a quandary. I am who I am, and I have the skills I have, so I could never just not respond, but I knew enough to realize that that would cause the whole thing to veer off the rails and drag on longer.

The second cluster of challenges lies in the fact that healthcare occurs in what should be, and often is, a collaborative environment. We physicians discuss odd cases with each other on a daily basis. That is how we learn. The first thing I wanted to do after Emily arrested was to reach out to my colleagues and hear what they thought and what they knew.

Knowing I was likely to be sued, I kept those conversations to an absolute minimum. What a shame! If I had not had that worry, I would

33. Dorothy Atkins, *Punk Rock OB-Gyn Gives Juror CPR: Gets Med Mal Mistrial*, LAW360 (Mar. 27, 2018), <https://www.law360.com/articles/1026730/punk-rock-ob-gyn-gives-juror-cpr-gets-med-mal-mistrial>.

have informally sought out the physicians who cared for Emily in the ICU and the pathologist who did the autopsy. I would have described what she told me and what I saw in detail, and heard what they perceived, and maybe we would have reached conclusions any single one of us could not. Those conversations, however, were not an option.

Litigation took me from a collaborative work environment into the world of a hostile proceeding, just when I was most vulnerable. Many physicians will tell you that the hardest part of the process is the isolation. Physicians undergoing litigation are often second victims struggling to recover while litigation, which can hinder the process, moves excruciatingly slowly. Understandably, excellent defense attorneys generally advise their clients to “speak to no one,” lest those people be subpoenaed. For second victims, however, their human connections are life-giving, sometimes life-saving. I had a primal need to talk with those who love and respect me for who I am – not just colleagues, but family and friends. Squashing that drive is destructive.

Do you remember my saying I saw 50,000 patients before meeting Emily and another 5000 or so from the day I saw her until the verdict came in? The best thing for all concerned was for me to heal and be at my best.

While it may sound silly to you who know the legal model, for many physicians, the rules of litigation are not at all intuitively obvious. Consequently, to us, it does not always feel like a search for right and wrong; it feels like gamesmanship. And gamesmanship, when we are dealing with my license, my insurability, my capacity to care for children and even my former patient, is not a model adequate to the magnitude of the problem at hand.

As a simple example, in my daily work, I am accustomed to answering people’s questions fully, giving them the information they asked for, and often the information they did not know to ask for. That is what I see as professional, helpful, and courteous. It took me a while to get it, but I now understand that in a deposition or under cross-examination, while I have to project that I am professional, helpful, and courteous, I am only to answer exactly the question the plaintiff’s attorney is smart enough to ask. I cannot tell you how many times during our preparations and even during breaks in a day-long deposition, my defense counsel reminded me to be brief. To me, that felt like withholding information, and certainly we were never going to get to the truth of the matter if I withheld information. We would not in my world; why would we in yours? As it turns out, of course, the plaintiff’s attorney may or may not be all that interested in the truth of the matter. Their interest may solely be in winning.

Furthermore, and I am sure I need not elaborate much here, plaintiff’s attorneys sometimes exhibit behavior which verges on mean and certainly would not be considered professional or ethical in my world. I found my trial grueling, but have since learned that some

attorneys engage in behavior far exceeding that of the attorneys I confronted. They ambush defendants or cozy up to them and then deliberately try to make them lose their cool before the jury. If they cannot win their case on purely medical grounds, many attempt to win by destroying the physician's confidence or impugning his or her character, even when there is no true reason to suspect that a flaw of character was at work in the original incident.

Laypersons rightly expect physicians to be diligent, compassionate, humble, and intelligent, and in a courtroom, it is expected that we will somehow demonstrate those qualities despite deep fear and distress. Given that context, nothing offended me more deeply than attempts to portray me as dishonest, unconscientious, uncaring, or self-serving when it came to Emily's medical care. As the ten-year-old son of a fellow defendant said, "What motive could you possibly have to kill your patient, Mom?" This goes for all of us who are legitimate physicians. The limits of medicine are enormous and I am certainly human. I can accept someone claiming I made a mistake, but do not defame my integrity or bedside manner!

Third, it is disorienting to go from being a patient's ally to their adversary. It is painful to hear them speak ill of us in deposition or from the witness stand, and sometimes in ways that have, over intervening years, drifted far from the truth. I was horrified at times, and found myself saying to my attorney, "I would NEVER do that!" I am thankful that he presumed as much.

Looking back, although trial was very difficult, I am proud of the way I handled myself. I moved through those days very slowly, putting one foot in front of the other. My defense team gave me excellent leadership and fought our fight in a way I could feel good about. For that, I am deeply grateful. Ultimately, though, what stays with me most is that they helped me to find a way to be the strong, compassionate physician I know myself to be, even under duress. The jury's attention to my testimony was touching, and I felt good about being able to be myself for them.

One of the most important moments for me in the course of the trial occurred at the very end, after the verdict was read. With their permission, as everyone else was leaving the courtroom, I approached Emily's parents. I embraced the opportunity to tell them how sorry I was that they had lost their daughter and that I was sad that I had not been able to foresee what would happen. I told them how many times I had thought of them over the years and that I wished them continued healing. By that point, the verdict had come back in our favor, and for that I am very thankful, but honestly, I think it was Emily's parents' openness to that message – particularly her mother – which finally allowed me to feel that the work I started at a visit years prior had finally come to its close.