Medical Malpractice Stress Syndrome: A “Forme Fruste” of Posttraumatic Stress Disorder

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Physicians practicing medicine face many challenges in today’s healthcare arena. The stress of practicing medicine is increasing exponentially as new medical information is exploding on a daily basis and new stresses to practicing are occurring in a burgeoning telecommunication world. The impact of rapidly increasing medical information and the era of electronic medical records allowing physicians to communicate with patients and physicians electronically, without the benefit of observing body language or clarifying misunderstandings, has had a huge impact on practicing physician-patient risk for misinterpretation of the electronically transmitted medical information. The risk of malpractice allegations is real even under the best circumstances. The potential risk to physicians alleged to be negligent has resulted in a clinical entity called medical malpractice stress syndrome; it is a “forme fruste” of posttraumatic stress disorder.

KEY WORDS: Posttraumatic stress disorder; medical malpractice stress syndrome; standard of care; clinical guidelines; liability; levels of evidence; class of recommendations.

Posttraumatic stress disorder (PTSD) is well described and extensively written about in the literature. Stress is a well-defined feature of acute and chronic illness. PTSD may develop in some people who have experienced a shocking or dangerous event. It is natural to feel terrified and anxious during and after a traumatic event. Fear triggers many split-second changes in the body to help defend against danger or to avoid it. This “fight-or-flight” response originating in the thalamus is meant to protect a person from harm. Everyone experiences a range of reactions after trauma, yet most people recover from initial symptoms naturally. Those who continue to experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened even when they are not in danger.

Traumatized people may or may not develop chronic or even short-term PTSD, and PTSD can occur even though a person has not been through a dangerous event. Some experiences that can precipitate PTSD include the sudden, unexpected death of a loved one a wartime experience; or an observation of a fatal event. Symptoms usually begin early, within three months after the traumatic incident, but may begin years after the initial emotional trauma. Symptoms must last more than a month and be severe enough to interfere with human relationships or work. The course of the illness varies. Some people recover within six months, whereas others have symptoms that last much longer. In a subset of people, the condition becomes chronic.

Not everyone who lives through a dangerous event develops PTSD.

Cognition and mood symptoms can begin, or become exacerbated, after the shocking event. These symptoms can make the person feel alienated or isolated from friends or family members. It is natural to have some of these symptoms after a dangerous event. Sometimes people have very serious symptoms that go away after a few weeks. This is called acute stress disorder. When the symptoms last more than a month, seriously affect one’s ability to function, and are not due to substance use, medical or mental illness, or anything except the event itself, they might indicate PTSD. Some people with PTSD do not show any symptoms for
weeks or months. Depression, substance abuse, and anxiety disorders often accompany PTSD.

PTSD can develop at any age, and may occur in war veterans, children, and people who have been through a physical or sexual assault, abuse, accident, disaster, or many other serious events. Women are more likely to develop PTSD than men, and genetic predisposition may make some people more likely to develop PTSD.

Not everyone who lives through a dangerous event develops PTSD. In fact, most people will not develop the disorder. Many factors play a part in whether a person will develop PTSD. Risk factors can make a person more likely to develop PTSD, whereas other factors, called resilience factors, can help reduce the risk of the disorder.

### RISK FACTORS AND RESILIENCE FACTORS FOR POSTTRAUMATIC STRESS DISORDER

Factors that increase risk for PTSD include:
- Living through dangerous events and traumas;
- Getting injured emotionally or physically;
- Seeing another person hurt, or seeing a dead body;
- Childhood trauma;
- Feeling horror, helplessness, or extreme fear;
- Having little or no social support after the event;
- Dealing with extra stress after the event, such as loss of a loved one, pain and injury, or loss of a job or home; and
- Having a history of mental illness or substance abuse.

Some resilience factors that may reduce the risk of PTSD include:
- Seeking out support from other people, such as friends and family;
- Finding a support group after a traumatic event;
- Learning to feel good about one’s own actions in the face of danger;
- Having a positive coping strategy, or a way of getting through the bad event and learning from it; and
- Being able to act and respond effectively despite feeling fear.

### CASE PRESENTATION

A 51-year-old male physician presented to the emergency department with chest pain, dyspnea, and an electrocardiogram suggestive of a myocardial infarction—ST elevation across the precordial leads of the electrocardiogram. Biomarkers for myocardial injury were elevated.

A short history revealed that the patient was recently served notice of a pending malpractice allegation for the death of one of his young patients. The notice stated he was being sued for $10 million. He had been experiencing severe anxiety and suicidal ideation for the last five days and had been using antianxiety agents and alcohol to suppress symptoms.

The echocardiogram revealed apical hypokinesis with depressed left ventricular function. Coronary angiography revealed normal coronary arteries. The diagnosis was Takotsubo cardiomyopathy or “broken heart syndrome.” The exact cause of broken heart syndrome is unclear. It is thought that a surge of stress hormones, such as adrenaline, might temporarily, or, in some cases, permanently, damage the hearts of some people.

This patient had experienced severe stress and emotional chaos after receiving notice of a pending malpractice action. The patient’s cardiac function returned to normal, but he had persistent restless, anxiety, depression, fatigue, difficulty concentrating, irritability, insomnia, and temptation to commit suicide.

His psychiatrist diagnosed the patient with medical malpractice stress syndrome (MMSS) manifesting as a myocardial infarction with persistent emotional and psychological stress.

### MEDICAL MALPRACTICE STRESS SYNDROME

MMSS is a “forme fruste” of PTSD. It is a common disorder with a spectrum of presentations, manifestation, and long-term health effects. It is rarely discussed and often is concealed by the physician experiencing the traumatic syndrome.

**Most physicians will at some point be affected, directly or indirectly, by an allegation of medical negligence.**

Medical malpractice suits are emotionally traumatic. Although they are a hazard of medical practice, physicians rarely consider their potential impact—because that is something that happens to other physicians. Unfortunately, no physician is immune from an allegation of medical negligence, and most physicians will at some point be affected, directly or indirectly, by an allegation of medical negligence. Consequently, it is important to discuss the syndrome so every physician is aware of its presentation, works proactively to prevent allegations of malpractice, and, if faced with such an allegation, is prepared to cope with the psychological and physical effects. It is important to remember that most malpractice suits are decided in favor of the defendant physician.

Even though medical malpractice lawsuits are common, most physicians are ill equipped to deal with the devastating and demoralizing psychological trauma they
experience. They also fail to anticipate the impact such a suit will have on their family and friends, and their medical practice. This stress-type syndrome can escalate to severe depression, which may even lead to suicide.

The primary manifestations of MMSS are emotional symptoms; a secondary manifestation may be physical findings such as the “broken heart syndrome,” as seen in the case example. The emotional and physical manifestations of MMSS may represent a new disorder, or the aggravation of a preceding disorder.

Physicians may develop feeling of shame, guilt, irritability, distrust, loneliness, and diminished self-esteem. Physicians often react by emotionally detaching themselves from family, friends, and medical colleagues. Often an emotionally damaged physician becomes insecure, concerned about his or her knowledge and skills, and finds it difficult to make medical decisions. Sadly, the accused may remedy the situation by resorting to alcohol and self-medication.

He or she also may experience deterioration in any preexisting medical conditions, such as coronary artery disease, diabetes, or gastrointestinal disease.

The physician experiencing MMSS must first acknowledge this fact and then seek medical and psychiatric medical care. This can be difficult, because the physician often is severely depressed and ashamed. The affected physician must act to ameliorate the psychological and physical manifestations in an attempt to reverse the agonizing mental turbulence. Diminution of the stress symptoms and physical manifestations allows the physician to think and act with greater objectivity, permitting focus and a healthy perspective on the approaching litigation process. Additionally, the physician must reestablish normal relations with family, close friends, and medical colleagues.

**PREVENTION OF MEDICAL MALPRACTICE STRESS SYNDROME**

Prevention of MMSS requires due diligence. What solutions are available to help physicians prevent MMSS? Understanding and dealing with the pervasive presence of standards and guidelines is a requirement for 21st-century healthcare delivery. Evidence that applicable standards of practice were followed is the key to preventing a successful legal challenge after a suboptimal patient outcome. If the physician deviated at all from the practice standards or guidelines, there should be a carefully documented discussion of the rationale and reasoning for this variation.

Since this is a medical-legal analysis, it must start with the legal definition of what constitutes a proper medical standard of care. Negligence in regard to the conduct of a physician means the failure to use ordinary and customary medical care, which is defined as failing to do that which a physician of ordinary prudence would have done under the same or similar circumstances. Ordinary care, when used with respect to the conduct of a physician, means that degree of care that a physician of ordinary prudence would use under the same or similar circumstances.

Juries decide whether the healthcare provider followed the standard of care as defined by expert witnesses. The “strictest medical scrutiny” is for avoiding common human failings: being careless, forgetful, inattentive, or indolent. Sound judgment, reasonable caution, and evidence of caring are the key factors woven into evaluating the standards of care.

**Prudent Physicians Understand Clinical Guidelines**

What could be more compelling to establish the proper standards of medical care than the criteria used to license every healthcare facility or to determine what level of medical care should be reimbursed for millions of American citizens? Enter the Joint Commission (JCAHO) and CMS.
By adopting the standards purportedly developed using evidence-based medicine, the private accreditation arm of healthcare facilities and the reimbursement services of the federal government may have taken over the definition of proper medical care.

Prudent Physicians Know the Levels of Evidence and Class of Recommendations

It is left to the trial judge to evaluate the admissibility of evidence-based clinical guidelines based on their proven integrity, as scored using level-of-evidence and class-of-recommendation parameters. The court hears “evidence of the evidence” to determine whether conflicts in clinical guidelines actually identify the proper standard of care. Evidence is categorized into different levels:

- Level A: recommendation based on evidence from multiple randomized trials or meta-analyses;
- Level B: recommendation based on evidence from a single randomized trial or nonrandomized studies;
- Level C: recommendation based on expert opinion, case studies, or standards of care.

After the level of evidence is valued, the relative strength of the recommendation must be quantified, using a risk/benefit analysis and an evaluation of the conflicting findings that may be present in different studies. A class of recommendations is thus established:

- Class I: conditions exhibiting evidence or general agreement that a given procedure or treatment is useful and effective;
- Class II: conditions exhibiting conflicting evidence or a divergence of opinion about the usefulness/efficacy of a procedure or treatment;
- Class IIa: weight of evidence is in favor of usefulness/efficacy;
- Class IIb: usefulness/efficacy is less well established by evidence or opinion;
- Class III: exhibiting evidence or general agreement that the procedure is not useful or effective, and in some cases, may be harmful.

Of the Class I recommendations, only approximately 20% are based on Level A evidence. Most of the recommendations are Class II, and they are most commonly supported by Level C evidence. Clearly, practitioners are not limiting their medical decisions to criteria derived from Class I recommendations and Level A evidence. For example, 30% of percutaneous coronary interventions and 39% of cardiac catheterizations were recently performed under Class II indications.

Physicians must recognize that if there is no documentation in the electronic medical record (EMR), it is assumed to not have occurred.

One fact persists about evidence-based medical care—there must be some evidence that it was utilized. Thus the emphasis shifts onto what some say is the foremost medical advancement of the 21st century—EMRs.

Rarely has there been such excitement about the virtues of a technology for information transfer. By initial accounts, EMRs should speed medical care, stop pharmacy errors, provide real-time access to medical advancements, improve quality of care, enforce clinical guidelines, encourage best practices, ensure proper billing and reimbursement, eliminate fraud and coding abuse, and provide administrators and credentialing bodies with immediate access to the data required to ensure regulatory compliance and to effect certification for an operation.

In fact, there is anecdotal evidence that all of these goals, and more, may be realized by the creation of a universal medical database that is interoperable among practitioners, facilities, and allied healthcare providers. EMRs will be very important in avoiding medical negligence claims once the constraints, both fiscal and physical, have been worked out.

Physicians Must Avoid “Never Events”

A “never event” is one of a list of serious medical errors or adverse events (e.g., wrong-site surgery or hospital-acquired pressure ulcers) that should never happen to a patient. CMS defines never events as “serious, preventable, and costly medical errors.” It is the place where medical invoices go that are filed for certain surgical mistakes, medical errors, and preventable complications—labeled “never events” or “reportable adverse events” by CMS. Refusal to pay for such occurrences will inevitably lead to medical–legal questions as to whether proper standards of care were employed in the treatment that led up to the events.

Being on the provider end of any of the following CMS-provided categories will almost certainly be followed by the dreaded certified letter with notice of intent to file suit for medical negligence:

- Surgery performed on the wrong patient;
- Surgery performed on the wrong body part;
- Invasive surgery scheduled but wrong procedure performed;
- Objects left in the patient’s body after surgery;
- Air embolisms;
- Blood incompatibility;
- Pressure ulcers;
- Falls in the hospital;
- Catheter-associated urinary tract infections;
- Catheter-associated vascular infections;
- Mediastinitis after coronary artery bypass graft;
- Inadequate glycemic control;
- Surgical site infections;
- Deep vein thrombophlebitis and pulmonary embolism; and
- Drug-induced delirium.
Defense against liability for any of these events may be possible only if written guidelines for preventive measures are documented in the patient’s medical records. Compliance with relevant clinical guidelines seems to be the only meaningful defense when charged with the occurrence of a never event with one of your patients.

**FINAL THOUGHTS**

Physicians must have patient connection based on mutual respect and trust.

If you are the target of a medical negligence challenge, what can you do to increase your chances of prevailing? More importantly, what could you **have done** before the litigation process began to lessen the chances of being sued in the first place?

- The primary criterion for determining whether a jury of his or her peers might find a defendant negligent often is whether he or she is *likeable*. If the practitioner is amiable, remorseful, sincere, and articulate in offering his or her feelings, a jury is less likely to find that his or her care was negligent. This is the case even if the medical error was relatively unmistakable.

- The key is that a practitioner or facility administrator cannot hope to “turn on the charm” after a bad outcome has occurred. In other words, genuine compassion and caring go a long way in communicating that even failed efforts to achieve optimum results are, nonetheless, our profession’s best efforts.

- The best place to begin evaluating your personal malpractice risk is with close personal scrutiny. Do you **care**, without qualifications? Are you positive, upbeat, and encouraging about your patients’ health? Are you honest, both in demanding your own best efforts, and in holding your patients accountable for a substantial portion of their own well-being?

This is a time of patients’ rights and of shared healthcare information, but also of shared responsibility between providers and patients. The threat of medical negligence claims will persist for a long time to come. Being informed about the source of complaints and remaining vigilant in following the proven standards of our specialties and subspecialties offer the surest form of insurance against liability claims. Prevention is the key element in preventing MMSS.

Physicians must empower themselves through awareness of the emotional symptoms and physical manifestations of stress and can prepare themselves to handle stress through participation in wellness training programs. **Wellness** is defined as a dynamic process involving self-awareness and healthy choices resulting in a successful, balanced lifestyle. Wellness incorporates balance between the physical, emotional, and intellectual realms of daily living. The result of wellness is a sense of accomplishment, satisfaction, and belonging. The importance of connectedness cannot be overemphasized. This wellness community offers protection from the unique demands of medical training and defines a lifestyle that offers protection throughout life against the many stressors of daily living. Maintaining wellness requires feelings of empowerment and engagement by physicians.

Awareness of the MMSS allows physicians to adapt their practice patterns in such manner that the risk of an allegation of negligence will be reduced. Prevention is the best approach to any risk. The ultimate answer to the question of how to avoid medical negligence claims lies in **prevention**. Ideally each physician should carefully document his or her rationale in all decision-making and clinical care. Any deviations from medical standards or guidelines should be carefully documented, explaining the rationale for the deviation. This strategy will reduce the likelihood of allegations of negligence and the potential for MMSS.

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