Commentary: Lawyer Phobia

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Fear of being involved in a malpractice lawsuit has spawned various defensive attitudes and behaviors in physicians. Despite the relative low rate of malpractice suits against psychiatrists, they too engage in defensive medicine. Simon's and Shuman's paper reviews the hidden danger to clinical care that defensive psychiatric practices can pose to both patients and doctors. This commentary further endorses the paper's position that the study of defensive medicine should be included in psychiatric residency training much like the study of countertransference.

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By the time psychiatric residents reach their third or fourth training year, their lawyer phobia is well established. A phobia is an irrational or excessive fear of an object or situation. The residents' fears of lawyers and legal matters are largely irrational and well out of proportion to their experiences. They fret about being sued, or worse, incarcerated, for some clinical stumble. Pulses rise with the mention of *Tarasoff* warnings. They lay awake obsessing over clinical decisions that might lead to a bad outcome. They engage in antiphobic behavior. They vigorously talk patients into signing voluntary admission agreements to avoid having to go to commitment hearings. They pack seminars on malpractice prevention. They order every test on every patient.

Some dread their forensic rotations, fearing that they may encounter attorneys. They fear that in any encounter a lawyer may second-guess their decisions or uncover their hidden negligence. When asked to write reports for lawyers or judges, they burrow into medical jargon, holding onto obscure medical phrasing like transitional objects. They fear the scrutiny of attorneys. They fear having to defend their opinions or literally themselves against attorney inquiries. When attorneys give lectures in our teaching program, the residents pepper them with anecdotes about patients, in an apparent attempt to gain reassurance about their malpractice fears.

For some it is not a phobia *per se*, but amorphous anxiety. Some call it hate, as in "I just hate lawyers," although it is not really hate at this stage of their medical development. The hate is a cover for or displacement of the fear, as in people who say they hate spiders, or snakes. For many, however, it is simply an inexplicable runaway fear. Whatever it is called, it can be pernicious and paralyzing.

I am not referring to physicians who have been sued. Over the years, I have evaluated or treated many physicians who have been sued. They are another group altogether. They have genuine, or reality-based dread, anger, and perhaps, hate, particularly if they are found liable in a trial.[1] But this group of psychiatrists is relatively small, and residents are rarely exposed to them.

Where does all this turmoil in the residents come from? I have rarely encountered a resident who has had much personal interaction with the legal system, including those who may be retraining after a career in another specialty. A few have been sued, but for a rent dispute or a car accident, not for malpractice. They have not been the recipients of registered letters from law firms or sat in the hot seat in a deposition or trial. Some may have testified in commitment hearings, but those proceedings are often geared to their level and focused on the health and safety of the patient as opposed to any shortcomings in treatment. They have little or no contact with lawyers from the hospital. When they do, it is generally in the setting of risk management training, in which lawyers present as their advocates.

Nevertheless, the phobia is instilled in them in various ways. Partly, it is our society, which is at once hyperlitigious and lawyer-bashing. Like spouses in a dysfunctional marriage, we can't live with lawyers, but we can't live without them. The residents have

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witnessed societal changes blamed on lawyers, such as swings removed from playgrounds or absurdly long warning signs on coffee cups. They may have patients who have been involved in personal injury or other lawsuits. These generic or vicarious experiences may explain the residents' anti-lawyer attitudes to some extent, but does not account for these physicians' visceral emotions and unreasonable fear.

Their training plants the real seeds of the phobia. The junior residents hear whispered stories from their senior residents, generally about some unfortunate trainee of years past who was sued over a case in which circumstances were not under their control. They hear the dire pronouncements of their attendings. They hear, "It's not *if* you will be sued, it's *when* you will be sued." They hear this from attendings who most likely have never been sued themselves. Residents are required to attend onerous risk-management sessions. Despite being run by nonthreatening hospital attorneys, these sessions are also full of horrific anecdotes of treatment gone wrong, generally from other medical specialties. The attorneys recount tales of doctors pounced on by shady malpractice attorneys representing greedy claimants. The residents end up believing they are but one patient removed from their own medicolegal train wreck.

As with other phobias or panic disorders, the anticipatory lawyer anxiety is generally worse than actually interacting with attorneys. The anxiety leads to the development of defense mechanisms such as avoidance, indecisiveness, restriction of practice activities, or overcompensation. In a 2005 study, Studdert *et al.*[2] surveyed over 800 physicians in specialities with high malpractice risk and found that 90 percent engaged in defensive medicine. They categorized defensive actions into assurance behaviors and avoidance behaviors. Assurance maneuvers included such activities as ordering excessive tests or referrals or overprescribing. Avoidance included restricting practice scope to perceived lower risk activities or restricting the types of patients seen. For instance, patients on workers' compensation or with medical assistance were regarded as potentially more litigious and were thus shunned.

One of the most interesting findings of the Studdert study was that objective measures of liability exposure did not correlate with individual physicians' defensive practices. The doctors did not practice defensively because they had been sued, they were defensive because they feared being sued. They referenced a prior study with similar results by Glassman *et al.*,[3] who commented that defensive practices may have come about not just from individual experience but from collective anxiety. Studdert *et al.*, posited, "Personal anxiety may also overshadow actual experience" (Ref. 2, p 2615).

The anticipatory anxiety and accompanying defense mechanisms may lead to clinical apprehension. The avoidance and assurance behaviors Studdert *et al.* outlined for other medical specialties are also seen in psychiatric practice. For instance, some psychiatrists limit themselves to non-inpatient work or may not perform ECT. They may limit the type of patients they see, particularly avoiding higher risk patients such as those with borderline or antisocial personality disorders. They may be too eager to commit patients who would otherwise be reasonably managed as outpatients. They may get excessive laboratory work or imaging scans, encourage medications for patients who would do well with therapy alone, or shy away from prescribing life-changing medications, such as Clozaril, for fear of litigation over side effects.

Lawsuit phobia has produced other oddities and clinical misadventures. For example, form consent has in some ways replaced truly informed consent. Many facilities and doctors use lengthy small-print forms that describe extensive risks of taking medications. Psychiatrically ill patients may not have the ability to read, much less consider, the information on these forms, which take the place of ongoing interactive discussions with the physician. Check-off progress notes take the place of concise, well-written descriptive treatment notes. Inpatient treatment plan meetings are more akin to real estate closings with flurries of forms to be filled out and signed and little time spent actually talking with the patient. These sorts of forms or check-off sheets can be very useful. They may help structure practice and thereby reduce anxiety. Such forms, however, may also engender a false sense of security in the treatment, or worse, a false sense of the doctor's competence.

In this defensive environment, it was refreshing to read the thought-provoking paper by Simon and Shuman.[4] They put forth the notion that risk management education should be incorporated fully and deliberately into clinical training. Even though risk management is considered legal information, they thought that it should be integrated into clinical

training and not presented as a separate or ancillary topic. Simon and Shuman make a case for improving quality of care by promoting legal knowledge.

Their paper outlines three case examples in the specific setting of the suicidal patient. In one example, the psychiatrist's concern about potential litigation leads to a crucial delay in care. The other examples demonstrate how an understanding of the law and legal process can inform and to some extent enhance psychiatric treatment. These latter two cases describe how the treating psychiatrists' healthy appreciation of malpractice defensiveness leads to a better outcome for their patients.

Simon and Shuman note that malpractice risk is usually best managed by focusing on providing good care, as opposed to focusing on avoiding a lawsuit. They believe that adequate legal knowledge provides a more comprehensive understanding of therapeutic options. An enhanced medicolegal knowledge base will reduce inappropriate defensive practices. They suggest that this body of knowledge become a core competency in residency training.

In residency training, the core competencies include patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.[5] Simon and Shuman[4] do not explain how they would go about incorporating medicolegal education into the existing curriculum—whether they would make it a separate core competency or insert it or therapeutic risk management into existing categories. They do comment that in the specific arena of suicide prevention, "Suicide risk assessment is a core competency that a psychiatrist must possess, informing the treatment and management of all patients" (Ref. 4, p 157).

I believe that in residency training programs, suicide risk assessment and management are studied as intensively as are other areas of pathology and practice. What I found more interesting about this article is what they leave less specifically stated. They present an excellent case for including the study of defensive medicine in the residency curriculum. They call it avoiding harmful defensive practices. I would call it understanding and managing medicolegal anxiety and defense mechanisms.

Residents learn about countertransference when they learn about psychotherapy. They study it, hear about it from attending psychiatrists, experience it with their own patients, work through it, and then use it productively in providing treatment. Similarly, they should learn about how they may have a variety of unconscious responses to legal intrusions in their medical practice. Just as with countertransference or other personal feelings, they should learn how to look for it, recognize it when it happens, and not let it interfere with good care.

As in Simon's and Shuman's examples, residents need to work with their emotional responses to promote better care for their patients. Training programs should be required to provide residents with the tools to address and manage their anxieties about working with attorneys rather than fostering the development of lawyer phobia.

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