CASE OF THE QUARTER:
SWALLOWING A BITTER PILL

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The "Case of the Quarter" column is a sample case study that highlights best practices in actual scenarios encountered through PRMS' extensive experience in litigation and claims management. Specific names and references have been altered to protect clients' interests. This discussion is for informational and education purposes only and should not be relied upon as legal advice.

FACTS:

For three years, Dr. Smith has treated Mrs. Jones for major depressive disorder. Mrs. Jones is 38 years old, married, and has three minor children under the age of six. Mrs. Jones is a wealth management advisor and earns $500,000 plus per year. Her husband takes care of the children and does freelance writing, but Mrs. Jones is the main wage earner.

Mrs. Jones' primary care physician referred her to Dr. Smith for treatment of her depression. Dr. Smith obtained records from the primary care physician and found that he had prescribed Lexapro for six months prior to the referral with minimal improvement. Dr. Smith noted her review of prior records and what she found to be significant. Over the course of treatment, Dr. Smith prescribed two antidepressants before prescribing Zoloft. Mrs. Jones reported feeling best on the Zoloft and had been stable on the same dose for eight months. Each time she changed the medication, Dr. Smith documented the patient's report of effectiveness and the reasons for the change. At each visit, Dr. Smith performed and documented a suicide risk assessment using a rating scale that met the standard of care. Her notes indicated that Mrs. Jones did not have a history of suicidal gestures, attempts, or reported ideation. Dr. Smith documented her referral to a therapist and that Mrs. Jones was meeting with him regularly. Further, she documented that she had spoken to the therapist and asked for a call if the therapist had any concerns about Mrs. Jones' mental health.

Three days after the last visit with Dr. Smith, Mrs. Jones checked into a hotel and hung herself.

ALLEGATION:

Mr. Jones filed a wrongful death action against Dr. Smith. He alleged that she failed to adequately assess his wife's suicide risk and failed to appropriately monitor her medications thereby causing her death.

DEFENSE:

Dr. Smith's documentation was so thorough that finding a well-credentialed expert to support her care was easy. Dr. Smith made an excellent witness during her deposition. Mr. Jones was also an excellent and sympathetic witness. He testified of their loving relationship and the devastation his children felt at losing their mother. He also testified that his wife was crying and sleeping more in the last two weeks of her life. Neither Mr. or Mrs. Jones reported this to Dr. Smith or the therapist. Dr. Smith's attorney felt the case was very defensible on liability but had concerns about the potential damages. Defense counsel explained that the case would be tried in a liberal jurisdiction that would want to award this widower and his three young children a lot of money. He also said that the economic damages could be over $10 million dollars given her high earnings. Such an award would exceed Dr. Smith's policy limit of $1 million dollars

and expose her personal assets. Because of the potential exposure to Dr. Smith's personal assets and the liberal venue, defense counsel and the claims examiner advised Dr. Smith to consent to settling the case and suggested she was free to consult with personal counsel at her own expense, if desired. However, they also advised Dr. Smith that because the policy required her consent to settle, if she wanted to try the case, they would support her decision and do their best to win a defense verdict.

OUTCOME:

Dr. Smith felt she met the standard of care. The record and the expert supported that position. Defense counsel and the claims examiner felt the case was defensible; however, they knew that a trial always brings with it uncertainty. If the jury found for the plaintiff, an award would likely exceed the policy limits. As much as she wanted her day in court, Dr. Smith consented to settling the case thereby choosing the certainty of knowing her personal assets would not be exposed. The policy limit was offered and Mr. Jones accepted it.

TAKEAWAY:

Meeting the standard of care and documenting that care meticulously strengthen the ability to defend a provider. Consenting to settle in such situations is akin to swallowing a bitter pill. However, sometimes the potential damages or award, make settling the difficult, but prudent path to take. Defense counsel and the claims examiner consider many factors when advising an insured on settlement versus trial. Such factors may include the venue (plaintiff- or defense-friendly), recent awards in similar cases, the strength of expert support for the insured's care, and the insured's preference for the certainty of settlement versus the uncertainty of trial. Protecting an insured's personal assets is always a priority. Perhaps most important to note is that Dr. Smith retained control over the course of her case because her policy included a clause requiring her consent to settle. Further, she had a defense team ready to support her in whichever path she chose.

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