Forensic Psychiatry and Malpractice

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This paper concerning the last 87 malpractice cases referred to the Department of Psychiatry and Law, Menninger Clinic, includes 57 suits against mental health practitioners and/or institutions, and 30 nonpsychiatric suits against general hospitals, surgeons, obstetricians, etc. A patient was available for interview in only 12 percent of the psychiatric cases; in 88 percent we reviewed medical records and consulted with attorneys. In the psychiatric cases the crucial question was whether a generally accepted standard of care was breached. The inherent problems of applying appropriate criteria to standards of care by practitioners and institutions are discussed. In half the psychiatric cases we found no significant deviation from acceptable clinical performance; in half we concluded that negligent practice had occurred. We did see a litigant for evaluation in 90 percent of the nonpsychiatric cases. The main issue involving them concerned harm or disability related to presumed negligence by medical personnel. How we evaluate such cases and apply disability criteria is discussed.

The steady increase in malpractice suits over the past decade has been documented, and among the medical practice specialties affected, psychiatry has not been spared.[1-4] However, only a minority of the malpractice suits filed are brought to the attention of forensic psychiatrists. This report describes and evaluates data derived from a review of the last 87 malpractice cases referred to the Department of Law and Psychiatry of the Menninger Clinic, a private practice group. The number of referrals to us is consonant over time with the national figures. During the first seven years of the 13-year period covered in this report (1976–1988), referrals to us averaged 3.7 per annum. During the final six years the average number more than doubled to 9.3 annually.

Our statistics are not readily comparable to those issued by the American Medical Association (AMA) or American Psychiatric Association (APA) in that their figures represent claims filed particularly against practitioners. Experience shows that one-third of such claims are dropped, and many are settled outside court for relatively modest sums.[2] It is the remaining contested claims concerning which attorneys are most likely to retain forensic psychiatrists.

Our data show that malpractice cases referred for a forensic psychiatrist's opinion have several distinguishing characteristics: (1) Because the referrals are made by attorneys, they in effect are first filtered through the legal system. We become involved in cases the lawyers elect to pursue. (2) Only two-thirds of our negligence cases represented claims

against mental health practitioners or institutions; one-third of the claims were nonpsychiatric cases involving general hospitals, surgeons, obstetricians, etc. (3) In contrast to the AMA/APA data concerning medical practitioners only, the majority of the defendants in our series were mental health or general medical institutions rather than individual practitioners. Also, our psychiatric cases included seven psychologists and two social workers. The nonpsychiatric cases included one chiropractor and one pharmacist. (4) In 63 percent of our 57 psychiatric cases, dangerousness was a crucial element of the claim (suicide, attempted suicide, homicide, and assault).

Case Material

The case material is drawn from a larger study reviewing all our forensic referrals, civil and criminal, for a 12-year period.[5] In that report the malpractice claims were not presented in detail. The figures in Table 1 illustrate the distribution of our 87 cases over time and in several categories, psychiatric/nonpsychiatric, and patients seen/records examined. The two subcolumns under "Psychiatric Cases" show that we interviewed seven patients. In the other 50 cases, we reviewed records only and functioned as consultants to attorneys. In contrast, we evaluated 90 percent of the patients involved in nonpsychiatric suits.

There are two primary explanations for this difference—patient availability and differing legal issues. In a majority of the 57 psychiatric cases, the defined patients were not available, 22 were suicidal deaths, six had sustained serious physical injury from suicide attempts, eight were incarcerated in institutions, and one was a class action suit. The other 10 cases were referred by defense attorneys, and the involved claimants refused to be examined by an expert for the defense. These claims included sexual misconduct with patients, negligent prescription of psychotropic drugs, incompetent physical diagnoses resulting in erroneous psychiatric treatment, and breach of confidentiality. The three nonpsychiatric case plaintiffs we did not examine included one suicide in a general hospital and two who claimed damage from psychotropic drugs.

A second explanation for the differing number of patients seen rests on the two different legal questions posed. In our 57 psychiatric cases the primary legal request was for a determination of negligence: did the practitioner or institution deviate significantly from a generally accepted standard of care? In the nonpsychiatric claims the main request was for a determination of mental/emotional harm and resulting disability from presumed negligent practice. The last column in Table 1 documents the remarkable increase in malpractice case referrals in recent years.

There was also a difference in referral sources between the two types of cases. Twenty-nine of the 57 psychiatric cases were referred to us by defense attorneys and 28 by plaintiffs' counsel. This 50–50 split is reassuring to us; it suggests that we have not been identified by the legal profession as leaning to one side or the other. That 90 percent of the non-

Table 1
Referred Malpractice Cases, 1976–1988, Claimants Evaluated

Year	Psychiatric Cases			Nonpsychiatric Cases			All Cases
	Patients	Records	Total	Patients	Records	Total	
1976		3	3				3
1977		3	3				3
1978	2		2	1		1	3
1979		1	1	3		3	4
1980		3	3	2		2	5
1981		2	2	2		2	4
1982	2	3	5	2		2	7
1983	1	3	4	6		6	10
1984	1	7	8	4		4	12
1985		8	8	4	2	6	14
1986		4	4	2		2	6
1987	1	6	7	1		1	8
1988		7	7		1	1	8
Totals	7	50	57	27	3	30	87

psychiatric cases were referred by plaintiffs' attorneys is understandable in that defense lawyers tend to deny that the claimants' disabilities, particularly of a mental/emotional nature, result from the defendants' actions. One defense attorney explained that if he retains a psychiatrist he automatically legitimizes the claim. This attitude may be changing; in the last four years defense and plaintiff referrals have been equal in number.

Calculation of demographic details was not usefully applicable to the psychiatric cases because we were able to interview only seven (12%). All of the 28 nonpsychiatric patients we evaluated were middle or upper class, and 26 were Caucasian. Only one was single and one unemployed (eight housewives). Twenty-five were between ages 25 and 49. Twenty (70%) were female. Although too numerically limited to be statistically significant, the seven psychiatric case patients corresponded demographically almost exactly to the nonpsychiatric.

This population is obviously not representative of the national distribution by race, age, socioeconomic status, gender, or marital state. The data confirm that all were relatively well educated, were supported by viable social systems, and possessed the knowledge and initiative to consult a lawyer. We assume this population to be representative of patients involved in malpractice litigation who will be examined by forensic psychiatrists.

Psychiatric Cases

In presenting statistical data from our survey, we found no consistent guidelines in the literature to assist us. Slawson, in summarizing the malpractice insurance experience, presented three groupings: procedures, injuries, diagnoses.[2] The APA Loss Control Commit-

tee applied a clinical orientation, listing drug reactions, suicide, diagnoses, restraints, confidentiality, etc.[1] Smith used a legal position for his three categories: body-related treatments, negligent care, and abuse of the therapeutic relationship.[4] Into the second category he lumped diagnoses, confidentiality, abandonment, informed consent, failure to obtain consultation, and third party interference.

We have elected to analyze our data from the perspectives of the three principals involved in malpractice actions: the complainant (patients or relatives), the practitioner or health institution, and the attorneys.

In the 57 psychiatric malpractice claims the precipitating events, or plaintiffs' primary complaints, were as follows: 22 suicide, five suicide attempt with resulting injury, one fall from hospital window with serious injury, eight homicide, one battery, one rape (of one patient by another), 10 sexual exploitation by therapeutic personnel, three deleterious effect of prescribed drugs, five harm or no benefit from treatment, and one breach of confidentiality.

In four of the 10 sexual exploitation cases, the immediate precipitating factor was the practitioners' decision to stop the relationship. The spurned female patients then vindictively complained. Of the five "no benefit from treatment" cases, three involved erroneous or missed diagnoses. One neurotic woman was diagnosed schizophrenic and treated accordingly. One patient was thought to have anorexia nervosa until her malfunctioning gastric shunt was repaired. One patient was given electroshock treatments with no benefit. When his pancreatic tumor was removed, his symptoms cleared. One patient claimed verbal abuse from her therapist. In the class action suit, a 23-year-old schizophrenic woman was discharged from a state hospital to its aftercare program. When she resumed her promiscuous sexual behavior, her father brought suit claiming negligent treatment. In contrast to the first four "no benefit" cases, we felt the fifth case was unfounded.

In the eight homicide tragedies the respective victims were two wives, one girlfriend, three mothers, one brother, and two strangers. In four cases the attorney was considering a "failure to warn" complaint but emphasized to us the issue of negligent discharge. In two cases the targeted relative had been warned. The two strangers were shot by the patient some months after hospital discharge.

The defendants included in the 57 psychiatric case suits were the following: 21 privately practicing psychiatrists, three state hospital psychiatrists, six clinical psychologists (psychotherapists), 17 psychiatric units in general hospitals, three substance abuse units in general hospitals, six Veterans Administration hospitals, five state hospitals, four community mental health centers, one private psychiatric hospital, and one private outpatient clinic.

In 10 cases the suit was filed against both a practitioner and an institution. Six suits against general hospital psychiatric units included the admitting psychiatrist, and four claims against psy-

chologists included the community mental health centers employing them. In two cases against separate psychiatrists, the primary targets were actually their social workers who had sexual relations with patients. Our involvement in these two instances was with an auxiliary claim, negligent supervision of the social workers by psychiatrists. The three state hospital psychiatrists were sued in that their employing institutions were statutorily protected.

By eliminating the six complaints against psychologists, our data illustrate that in the 51 cases involving psychiatrists and/or psychiatric institutions, 40 of the patients were hospitalized at the time of alleged negligence. This figure compares almost exactly with Tancredi's estimate that 80 percent of psychiatric malpractice claims involve hospital treatment.[6]

In the 57 psychiatric cases the legal theories pursued by plaintiffs' counsel were the following: 18 negligent hospital security, 13 negligent hospital discharge, four negligent professional supervision, three negligent diagnosis, 29 negligent treatment, eight negligent prescription of drugs, 10 sexual misconduct, 10 harm or no benefit from treatment, and one breach of confidentiality.

Nonpsychiatric Cases

In the 30 nonpsychiatric cases we evaluated, the defendants named were as follows: eight obstetrician/gynecologists, three plastic surgeons, three general surgeons, one ophthalmologist, one urologist, one neurosurgeon, two anesthesiologists, one internist, three family practitioners, four general hospitals, one chiropractor, and one pharmacist.

In these 10 cases, the legal claims being pressed by plaintiffs' attorneys were as follows: four diagnostic error, four negligent hospital supervision, three lack of informed consent, 11 negligent treatment (ineffective), five damaging effects of treatment, two breach of confidentiality, and one medication error by pharmacist.

In three patients the gynecologist failed to detect pregnancy and removed uteri containing fetuses. One surgeon missed colon cancer. Nine months later a second surgeon had to remove a sizable section of colon, make a colostomy, and begin chemotherapy. The three "lack of informed consent" charges involved an unauthorized tubal ligation, removal of a clitoris, and abortion in a 16-year-old girl. In this abortion case the girl's resentful mother was the complainant.

One of the four claims against general hospitals resulted from a very ill patient's suicide with a fruit knife given him by his wife. One patient suffered protracted vomiting and a food phobia after he identified rat droppings in cereal served him. One patient had a mastectomy for suspected cancer but the tissue was lost and never reached the pathology laboratory. Both patient and surgeon were in a quandary. Did she have cancer: should chemotherapy be started; should they await further developments? Two sisters accompanied their ill mother to a hospital. A deranged former patient burst into the lobby and started shooting. One sister and a doctor were killed. The surviving sister became the patient

we evaluated after she developed a classical posttraumatic stress disorder.

The 11 negligent treatment cases included charges of sexual exploitation, adverse psychotropic drug reactions, and dead or damaged babies at delivery. The three plastic surgeons were sued when repair failed to improve old, unsightly scars: tampering with the body image can be dangerous. One breach of confidentiality claim was instituted when a gynecologist removed a cervical condyloma from a young married woman then told the patient's mother-in-law, who began spreading rumors that her daughter-in-law had a venereal disease, presumably through sexual promiscuity, and was also sterile and could not have children. The pharmacist gave a patient thyroid extract instead of the prescribed drug and she developed hyperthyroidism including a generalized anxiety disorder with anxiety, tension, irritability, insomnia, and fatigue.

Our survey revealed that in seven of the 30 cases we estimated sustained disability as well as deviation from an acceptable standard of care. We were emboldened to render such opinions concerning nonpsychiatric practice because of unusual circumstances. Two female patients were sexually seduced. In five cases a diagnosis of psychiatric disorder had been established, and a charge of mismanagement was claimed. Two surgeons failed to obtain psychiatric consultation for two disturbed psychotic patients, two family physicians were accused of excessively prescribed psychotropic medication, and one patient committed suicide in a general hospital. In the suicide and the two drug cases, we concluded that the defendants had exercised proper care, but pinpointed a significant deviation in the other four.

Standard of Care

Of the 57 psychiatric cases, 29 were referred by defense attorneys and 28 by plaintiffs' attorneys. We agreed with the defense in 76 percent of their cases that no significant deviation from acceptable practice had occurred, and with the plaintiff in 78 percent of their cases that negligent practice was indeed present. These conclusions might suggest that we were unduly influenced by the referral sources. A more likely explanation relates to the legal contingency fee system: the observation that plaintiffs' attorneys avoid investing time and money in questionable cases. Only if liability is clear, negligence probable, and injury likely will they pursue cases to the point of retaining forensic psychiatrists. Defense attorneys employed by insurance companies have less leeway in accepting cases; but after a careful evaluation of a case, often including a deposition of the opposing expert, the attorney may advise the insurance company which cases to settle and which to contest. In the latter instance a forensic psychiatrist may be retained. In approximately one-fourth of the cases from each side, we informed the referring attorney that from our perspective he had no case. Generally speaking, we think attorneys tend to evaluate medical claims with sound judgment.

In determining whether a practitioner

or institution deviated significantly from a generally accepted standard of care in a given case, we have paid particular attention to the two modifying terms for standard of care—"significant" and "generally accepted." In regard to "significant," we have tried to identify average, acceptable knowledge, skill, and diligence in the defendants' professional behavior and have tried not to apply superior or ideal practice as the criteria for defining standard.[4] In concluding that a defendant did not "deviate significantly," we did note in several cases that the practitioner could have done better but his derelictions were not major and his lapses did not seriously reduce the efficacy of professional service rendered. Some attorneys are unhappy with such gray area views, preferring black or white, unequivocal conclusions. Usually we have been able to stand firm on our qualified judgments.

In determining a "generally accepted" standard, we have used our own professional experience and our firsthand knowledge of how others in our field practice. However, in forensic cases, in which our conclusions will be probed, questioned, and even attacked by attorneys, we have paid particular attention to the medical literature for evidence of what others think, do, and advise. Congruous with the rising number of malpractice suits, the literature has burgeoned with data, warnings, check lists, and many useful conclusions concerning psychiatric practice and malpractice. We have organized approved material from numerous contributions under several general headings:

1. Did the practitioner use all resources available to develop a careful clinical assessment of the patient—prior medical records, a report from the family physician, interviews with a family member?[4,6,7] In one of our cases the forthright psychiatrist-defendant stated that he seldom bothered to request prior medical records of his patients.

2. Did the practitioner file adequate clinical records documenting the basis for his diagnostic conclusions, treatment plan, risk benefit thinking, and discharge plan? Several of our informative sources indict inferior records as the major obstacle to a satisfactory malpractice defense.[6-8]

3. If the patient was hospitalized, did the practitioner consider using a risk management procedure, the hospital peer review committee, or a consultant, or did he go it alone? Tancredi,[6] Gutheil,[9] and Poythress,[10] among others, emphasize "Get help!"

4. Did he rely unduly on a nursing staff to practice psychiatry?[7,11]5. In suicide cases did he (1) use demographic, actuarial data to assess suicide risk,[4,7,12] (2) institute appropriate suicide precautions,[9] (3) leave too many decisions to the nurses, or (4) discharge the patient prematurely and with an inadequate treatment plan? Maltsburger has devised an excellent check list for assessing and managing suicide risk.[15] Halleck has observed that more malpractice cases are engendered by lack of diligence than by lack of skill.[18]

In the several cases involving psychologists, we did not presume to evaluate their competence as psychologists, only

as psychotherapists. Because in all but one instance sexual misconduct was claimed, we had little difficulty in expressing disapproval. In the exception the patient attempted suicide, and we determined that the therapist was remiss in not recognizing the seriousness of the patient's illness and in not procuring psychiatric consultation, which was readily available.

We observe that the average referring attorney assumes a forensic psychiatrist to be knowledgeable in all aspects of psychiatric practice. One must be skeptical of such implied flattery. We have had no difficulty accepting cases involving clinical behavior of privately practicing psychiatrists, but have paused to consider our expertise concerning some mental health institutions. They vary in patient population, staffing, funding, and professional functions.

Halleck has described the traditional, socially and politically condoned, perception of two standards—public and private.[16] There may be more.[17] What should the practice standard be of a community mental health center staffed by psychologists and social workers with a consulting psychiatrist weekly, or the psychiatric unit of a general hospital with no resident physician? In several instances we have refused a potential referral and have advised the attorney to seek instead, a hospital charge nurse, an expert on security and door locks, a public hospital administrator, a specialist in multiple personality, a child psychiatrist, or the medical director of a drug abuse program.

We have seldom compromised in judging the acceptability of standards if the case is within our areas of competence. We have leaned in the direction of traditional practice. We can hold that there is one incontrovertible standard — what is best for the patient, a standard the law generally supports. However, this position is currently under attack, and compromises are suggested using such concepts as risk benefit, cost effective, least restrictive treatment setting, and the patient's ability to pay.[19]

Disability

Of the 27 general medical, nonpsychiatric, patients interviewed, we saw 80 percent nine to 12 months after the negligence offense claimed. None was seen within four months of the offense. The diagnoses established at the time of examination were as follows: two no psychiatric disorder, 11 adjustment disorder, five dysthymic disorder, five generalized anxiety disorder (one with agoraphobia), four posttraumatic stress disorder (one with panic attacks), three organic mental disorder, and two multiple drug abuse.

The five patients with double diagnoses suffered from depression and/or anxiety, dysthymia, and generalized anxiety disorder, organic brain disorder with generalized anxiety disorder, and dysthymia with multiple drug abuse. Of the three organic patients one had an acute postoperative delirium with full recovery, one amphetamine delusional disorder with full recovery, and one chronic mild dementia of unknown etiology.

In determining and describing disabil-

ity for legal purposes, we have used the *Guides to the Evaluation of Permanent Impairment*, published by the American Medical Association.[20] Chapter 12, "Mental and Behavioral Disorders," provides definitions, explanations, and a table with which to evaluate disability by percentages. The guide is a general one and leaves much to the clinical judgment of the individual evaluator. It does provide a consistent frame of reference and encourages the forensic psychiatrist toward uniformity from patient to patient in his perceptions.

The table uses the loosely quantitative terms of none, slight, mild, moderate, and severe, defined by flexible percentages from zero to "over 75 percent." Using this vocabulary, we rated the disability in our patients at two points in time: (1) at or shortly after onset of impairment related to the negligent act, and (2) at the time of our examination six to 18 months later. The concordance or difference between the two ratings provides one basis for prognosis. If the disability after impact was "moderate" and now, nine months later, is "mild," these findings can support a conclusion in a given case of full recovery in another six months with no permanent disability.

In the 27 cases our disability ratings were the following: three no disability related to the malpractice claim; three mild disability, now recovered; five mild disability, no improvement; one moderate disability, now recovered; three moderate disability, now mild; seven moderate disability, no improvement; one severe disability, now mild; three severe disability, now moderate; and one severe disability, no improvement.

Of the five patients rated "severe," the diagnoses were posttraumatic stress disorder (n = 3), generalized anxiety disorder with agoraphobia (n = 1), generalized anxiety disorder with dysthymia (n = 1). In completing our ratings we considered the usual factors with which most psychiatrists are familiar personality, configuration, motivation, secondary gain, social support system and treatment possibilities.

Conclusions

When a forensic psychiatrist contemplates accepting a malpractice case referral, his first duty is to consider whether he feels comfortable and competent in judging his peers, a task less formidable today than in past years when the dictum "speak no evil of your colleagues" was a stated or implied principle of medical ethics. Over the past 15 years the American Medical Association has striven to break this "conspiracy of silence" with measurable success. The current Code of Medical Ethics mentions colleagues in only two brief phrases: "treat them honestly and respect their rights." Wide acceptance of peer review mechanisms has sanctioned doctors' looking over the shoulders of other doctors. However, just because a given action is labeled legitimate or legal does not mean it is invariably consonant with a person's moral perceptions.[22] The forensic psychiatrist is under no onus to accept a malpractice case unless he feels mentally and morally secure in doing so.

A second consideration promoting

reasonable comfort with malpractice litigation is a clear awareness of one's professional knowledge and experience in specific areas of practice, and one's limitations. The exercise of self-scrutiny is particularly important in forensic psychiatry because our opinions and conclusions are frequently subject to public scrutiny and criticism. The adversary system of legal practice can be seductive, and the unwary psychiatrist can be drawn into "helping" an attorney with a case in aspects beyond his area of defensible medical competence. An aphorism attributed to John Larsen states that the amateur knows what he can do; the professional knows what he cannot do.

As a concluding thought, our decision to continue accepting malpractice case referrals is bolstered by our manifest record. In half our cases we testified that no practice negligence occurred, and thus were able to serve our colleagues. In half the cases we did find significant deficits of competence, diligence, judgment or ethical conduct, and thus were able to serve society. Whichever way the case is resolved, we have an opportunity to contribute positively.

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