Medical Liability Claims and Lawsuits Filed Against the University of Texas System Involving Adult Psychiatric Patients

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A survey was conducted to investigate medical liability claims filed against the University of Texas System (the U.T. System), physicians, and/or institutions concerning care of adult psychiatric patients. There were 34 such claims filed between 1978 and 1991 that had closed by December 1991. In many of these cases, medical record documentation was determined to be inadequate. Of the 34 claims filed, only seven were settled on behalf of U.T. personnel or U.T. institutions. Of these seven settlements, the mean monetary amount paid per case on behalf of U.T. System and non-U.T. System parties was $98,678.57. The two categories with the largest number of claims were 1) cases involving suicides, and 2) cases involving adverse reactions to medication. The largest award was $350,000, paid on behalf of U.T. physicians, a private physician, and non-U.T. institutions for alleged negligent failure to diagnose Cushing's disease. Of this amount, only $150,000 was paid on behalf of U.T. physicians. Risk management strategies should be implemented to address areas of liability in psychiatry residency programs.

Malpractice litigation in psychiatry has increased in recent years. Frequently cited areas of liability in psychiatry are patient suicides, patient violent acts, misdiagnosis, negligent treatment, abandonment, wrongful commitment, and violation of confidentiality.[1-4] In response to this growth of malpractice litigation, risk management strategies must be developed and implemented. It is important for psychiatrists, as well as psychiatry residents, to be aware of the nature of malpractice claims in their respective geographic regions, so that risk management strategies can be developed and incorporated by hospitals and psychiatry training programs.

This study is a survey of professional

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liability claims against the University of Texas (U.T.) System concerning care of adult psychiatric patients filed and closed between 1978 and 1991.

Method

The University of Texas Office of Health Care Quality and Risk Management (M.S.) completed questionnaires that inquired about closed medical liability claims concerning the care of adult psychiatric patients filed against the University of Texas System physicians and/or institutions. The questionnaire requested the year each claim was filed, the allegation made, type(s) of defendant(s) named, (e.g., institution, faculty, resident, private practitioner), status of claimant(s), disposition of claim, and amount of monetary award, if any. Information requested about each patient included gender, diagnosis, age, time of incident, inpatient or outpatient status, and whether the claimant had health insurance coverage. A brief summary of the case was requested, as well as suggestions for risk management strategies.

Results

There were 34 claims concerning adult psychiatric patients against U.T. System physicians filed and closed between 1978 and 1991. The categories of these claims are summarized in Table 1. The summary is based on only 31 claims because the allegations were not identified in three cases.

Homicide/Suicide The largest category of claims studied was the group of cases related to suicide, attempted suicide, and homicide followed by suicide (26% of the 34 cases reviewed). In the six cases of suicide, four were committed by men ranging in age from 27 to 54, with diagnoses of depression, schizophrenia, steroid-induced psychosis, or bipolar disorder. One woman who committed suicide had a diagnosis of depression, and in the other case, the diagnosis was unknown.

Table 1
Summary of Allegations Made by Claimants

Patient Management
6 negligent failure to prevent suicide; 1 negligent failure to prevent attempted suicide
2 negligent failure to prevent homicide/suicide
1 negligent failure to diagnose
2 inappropriate treatment
2 inadequate supervision
3 medical negligence
Medication
5 negligent failure to warn of and/or prevent adverse reactions (methysergide, imipramine, amitriptyline, fluphenazine, physostigmine)
Other
4 false imprisonment
2 breach of confidentiality
2 negligent failure to warn or protect third party
1 negligent failure to admit

Most suicides occurred in the outpatient setting. In two cases, the patients committed suicide following an emergency room evaluation. One man presented to the emergency room after cutting his wrists in a suicide attempt. Following surgical repair of the lacerations, he was evaluated by a psychiatrist and was determined not to be suicidal. He was discharged from the emergency room, and two days later he committed suicide. In another case, a patient with a history of schizophrenia presented to the emergency room for evaluation of tonic-clonic seizures. He was treated with phenobarbital and phenytoin and received a psychiatric evaluation. He admitted to

suicidal feelings but denied suicidal plans. He agreed to the psychiatrist's recommendation for voluntary hospitalization but killed himself several hours after being discharged from the emergency room.

The circumstances of the other suicide cases varied. In one instance, a woman who was referred for counseling missed her appointment. After several attempts by clinic personnel to contact her by letter and telephone, the patient called and declined treatment. She later committed suicide. In another case, a patient with a history of depression was evaluated in the emergency room and prescribed a low dose of imipramine with three refills. Two months later, he was brought to the emergency room dead-on-arrival after an overdose with imipramine that had been prescribed by another physician.

One suicide occurred while a depressed patient was hospitalized on a medical unit for treatment of diabetes. He acknowledged suicidal ideation but no suicidal plan. The patient was not placed on suicide precautions because the consulting psychiatrist did not believe the patient was an imminent risk for suicide. The plan was to transfer the patient to a psychiatric unit on completion of his medical treatment. Before transfer, the patient committed suicide by jumping out of a hospital window.

In one case of attempted suicide, the patient had a diagnosis of major depression and a family history notable for a sibling who had committed suicide. The patient was prescribed desipramine for treatment of depression. Three weeks later she called her psychiatrist to discuss the occurrence of medication side-effects, but she claimed that she was not allowed to speak with the psychiatrist. The psychiatrist called the pharmacy to renew the prescription of desipramine for an additional 30 days at the same dosage. Within one week, the patient attempted suicide by overdose with desipramine and was admitted to the cardiac intensive care unit with drug induced cardiac arrhythmias.

Two cases involved suicide, along with homicide. In one case, a woman had a history of depression, multiple psychiatric hospitalizations, significant marital discord, and previous threats to kill her husband, her children, and herself. During her last psychiatric admission, it was reported that the patient vacillated on the issue of suicide, but there was no documentation in the chart of intent to hurt anyone. Following discharge, she failed to keep her outpatient appointments. Within two weeks, the patient killed her husband, her two children, and herself. In the other case, a man with a six-month history of marital and financial difficulties presented to the emergency room with a complaint of depression. Three weeks before this evaluation, his wife had left him, and he had made two suicide gestures involving firearms. The patient reported that he had no current suicidal plans. He was transferred to another hospital emergency room where antidepressant medications were prescribed and outpatient treatment was recommended. Two days later, the patient killed his wife and commit-

ted suicide.

Alleged Negligent Failure to Diagnose Negligent failure to diagnose was alleged in one case. A man developed acute psychosis characterized by paranoia, ritualistic behavior, depression, hallucinations, and suicidal tendencies. He was fired from his job and his wife divorced him. Over the next three years, he received psychiatric treatment including electroconvulsive therapy. He was then diagnosed with Cushing's disease by a local physician. The patient's physical symptoms included a moon face, osteoporosis, diabetes, truncal obesity, hypertension, wasting of the extremities, and hypokalemia.

Alleged Inappropriate Treatment Allegations of inappropriate treatment were made in two cases. In one case, a patient admitted to a psychiatric facility received more than 200 electroconvulsive therapy treatments combined with insulin shock and Indaklon gas treatments over a period of 18 months. The patient alleged the treatments were negligently administered and resulted in permanent damage and disability.

In another case, a woman was admitted to a geriatric psychiatric unit with a diagnosis of organic brain syndrome. The treatment plan included behavior modification to increase her physical activity and to prevent further social withdrawal. The patient was locked out of her room for 30 minutes after meals to encourage socializing with other patients. During the hospitalization, the patient suffered several falls resulting in a fractured finger and fractured arms. The patient alleged that her injuries were the result of punishment imposed by the behavior modification plan.

Alleged Inadequate Supervision Two cases involved allegations of inadequate supervision. In one instance, an elderly patient with depression was admitted for electroconvulsive therapy. Following treatment, she was transferred to the recovery area. When the patient appeared to be asleep, the nurse allegedly turned her back away from the patient. The patient awoke suddenly and attempted to get out of the bed, and sustained fractures to the hip requiring surgical repair.

The second case involved an allegation of failure to adequately observe a patient in seclusion and alleged unnecessary use of force. A man who was involuntarily admitted to a psychiatric facility became combative and attempted to leave the unit. Technicians tried to lead him away from the exit door, but he fell to the ground. He was then carried to the seclusion room while twisting and kicking. Following the incident, he complained of hip pain, although there was no evidence of injury on examination. The patient was monitored and assessed every 15 minutes. Approximately five hours after the incident, he complained of severe hip pain. His hip appeared swollen and tender. X-rays revealed a fracture to the head of the femur necessitating internal fixation.

Alleged Medical Negligence One case involved a nonspecific claim of medical negligence in the treatment of a psychiatric patient who alleged he was raped by his roommate while in the hospital. In another case, psychiatric

evaluation was conducted to determine the need for appointing a relative as guardian for the patient. The psychiatrist concluded that the patient required mental health treatment for her psychiatric disorder and recommended guardianship. The patient alleged that the psychiatrist's opinion was based upon insufficient data.

One case involved 60 allegations. The patient alleged abandonment, libel, and inadequate, substandard, and negligent treatment resulting from the birth of her son. The patient alleged grievous injuries due to hospital personnel allegedly forcing her husband to make false and libelous statements.

Adverse Reaction to Medication Approximately 15 percent of the cases involved an adverse reaction to medication. In four of the cases, plaintiffs alleged failure to obtain adequate informed consent regarding medication side effects. In one of these cases, a woman with idiopathic central nervous system hypersomnolence was prescribed methysergide. Within a few months, she developed respiratory problems, and she later died from acute interstitial pneumonia complicating pulmonary fibrosis. The patient's family alleged she was not informed of possible pulmonary fibrosis as a side effect of methysergide. They further alleged negligent overprescription of methysergide that was not approved by the Food and Drug Administration for the treatment of hypersomnolence. In the second case, a patient was administered fluphenazine and alleged that he suffered tremors and convulsions for three months that resulted in loss of work. He claimed he was not warned of dangerous medication side effects. In the third case, a woman died of a drug and alcohol overdose while receiving amitriptyline for the treatment of depression. Her family alleged that she did not receive adequate warning about the dangers of combining amitriptyline with alcohol. The fourth case involved a patient who was prescribed 400 mg of imipramine per day for the treatment of depression. He alleged that this dose resulted in the development of seizures and subsequent mental anguish.

One case of alleged failure to inform the patient of medication side effects also included allegations of failure to diagnose, improper medical care and treatment, and failure to provide adequate facilities and equipment to treat the patient. This case concerned a woman with probable pre-senile dementia who was administered an experimental protocol of physostigmine. She became anxious when the study was completed. The medication was not continued because of her minimal response and the need for the medication to be administered every two hours.

Alleged False Imprisonment False imprisonment was alleged in 11 percent of the cases. All but one of these patients suffered from psychosis. In two cases, the patients were brought to the emergency room by the police. Following psychiatric evaluation, the patients were hospitalized involuntarily. In the other cases, the patients requested to leave the hospital, but were determined to require continued involuntary hospitalization.

Alleged Breach of Confidentiality

Breach of confidentiality was alleged in two cases. One case involved a woman with a history of depression and paranoid delusions who was admitted to a psychiatric unit. After two weeks of hospitalization, she requested to be discharged. She sent a letter to the hospital administration rescinding the waiver of confidentiality of her medical record, except for herself, her attorney, and her doctors. Commitment proceedings were initiated, and a psychiatrist who had not evaluated the patient signed the certificate for commitment in lieu of the treating resident. The patient alleged that her confidentiality was breached when the application for involuntary commitment was filed.

In the other case, a woman in outpatient treatment for multiple personality disorder and depression was treated by a psychiatry resident who became personally involved with her. During the course of treatment, she allegedly requested that the resident not present her case at grand rounds. Nonetheless, the resident presented her case at grand rounds and identified her by name. One week after the presentation, the patient's psychiatric condition deteriorated, and she was hospitalized for two weeks for major depression with suicidal ideation.

Alleged Negligent Failure to Warn or Protect a Third Party Negligent failure to warn or protect a third party was alleged in two cases. In one case, the plaintiff alleged that he suffered permanent mental and physical injuries from a gunshot wound inflicted by a psychiatric patient. He alleged negligence and failure of the psychiatrist to commit the patient to a mental health facility as indicated. In the second case, a man with a diagnosis of atypical psychosis, cocaine abuse, and a history of five-year incarceration for physical assault of a woman was hospitalized in a psychiatric facility. During the hospitalization, he reported that in the past he had been dating a woman who became a prostitute, and that when he went to her apartment, a man who answered the door threw acid on his face. The patient blamed the woman for this event. Following treatment of his psychiatric disorder, he was discharged from the hospital. Medication was prescribed and outpatient follow-up recommended. One month after discharge, he broke into the woman's home and assaulted her and her boyfriend and threatened their children.

Alleged Negligent Failure to Admit In this case, the patient was brought to the hospital emergency room and diagnosed as having atypical organic brain syndrome. His mother requested that the patient be hospitalized. There was no evidence on the basis of a psychiatric examination that the patient was dangerous to himself or others, and therefore it was determined he did not require hospitalization. After discharge from the emergency room, the patient had a seizure that rendered him unconscious. During this period, the patient was assaulted and abused. His mother alleged failure to admit to a psychiatric unit as the cause of his injuries.

Other No data were available about the basis of claims in three cases. In one of these cases, a paranoid schizophrenic

man filed a claim but refused to specify the allegations.

All 34 of the claims were filed within three years of the respective incidents, with an average period between the date of incident and date of filing of one year. The claims were filed by the patient in 15 cases, the patient's parents in six cases, the patient's spouse in four cases, other family members in two cases, the patient's guardian in two cases, the patient's estate in three cases, and an injured third party in two cases. For the 11 cases in which information about the patient's health insurance payment status was available, six patients had private insurance, and five patients had no insurance.

The institution was named as a defendant in 23 cases, and of these, seven times as the sole defendant. In 17 claims, faculty were named as defendants, and a faculty member was the sole defendant in four cases. Residents were named in 11 cases, and a resident was the sole defendant in three of these cases. Private physicians were named in seven cases, but never as sole defendants. Medical students were not defendants in any of the 34 claims reviewed.

Out of the 34 claims involving adult psychiatric patients filed against U.T. System physicians and/or U.T. System institutions that had closed by December 1991, 21 evolved into lawsuits. Of the 13 claims that never became lawsuits, one was determined not to involve an allegation of professional negligence by a health care professional, nine were dropped, and three were settled. Of the 21 claims that did become lawsuits, five were later dropped, nine were dismissed, five resulted in summary judgments in favor of U.T. System defendants, two went to trial, and five were settled. Both cases that went to trial were won by the U.T. System. Figure 1 summarizes the final outcome of these 34 claims.

Of the cases settled on behalf of U.T. System defendants, the total monetary awards paid to the plaintiffs by all settling defendant parties (including U.T. System and non-U.T. System defendants) ranged from $750 to $350,000, with a mean award of $98,678.57. The highest amount was an out-of-court settlement for alleged negligent failure to diagnose Cushing's disease.

Discussion

This survey of psychiatry programs within the University of Texas System revealed that 34 malpractice claims involving adult psychiatric patients had been filed and closed between 1978 and 1991. Given the explosion of malpractice claims in the medical field, this fig-

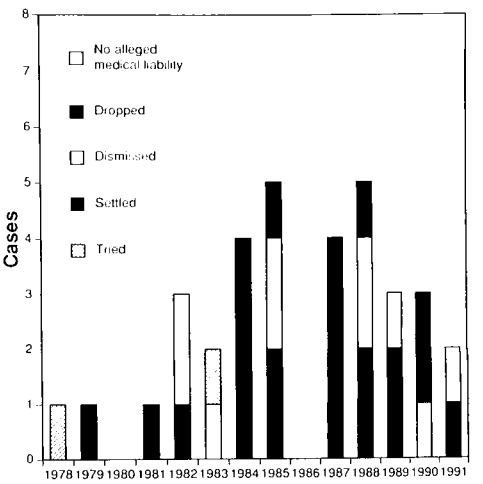

Figure 1.

ure represents a modest number of claims.

Suicide, attempted suicide, and homicide followed by suicide accounted for the most claims (26% of the cases reviewed). This percentage is higher than the percentage reported by the American Psychiatric Association's Professional liability insurance program.[5] Most suicides occurred following outpatient visits; a few of these patients had been evaluated in an emergency room shortly before they committed suicide. In some cases, the patient was known to have suicidal ideation, whereas in others the patient had no known suicidal intent. More men than women committed suicide; this is consistent with epidemiological data.

It is difficult for psychiatrists to predict with any degree of certainty the patients who will commit suicide. Appelbaum and Gutheil[6] emphasized the importance of assessing suicidality in order to avoid future claims of negligence. Risk factors critical to obtain during the assessment are personal issues, especially older age, psychological isolation, and Protestant religion; family history of affective disorder; suicide or alcoholism; previous suicide attempts; current stressors such as physical illness, deaths, or job loss; psychiatric disorders, especially depression, bipolar disorder, panic disorder, schizophrenia, and personality disorders; and substance abuse and suicidal acts, particularly those that involve advance preparation such as giving away possessions. They make an important point: that empathy may lead a clinician to an erroneous conclusion regarding suicide potential. Some patients who plan to commit suicide have isolated their affect from their cognition. The clinician then perceives that the patient appears to be okay and not in great distress. In these cases, assessment of risk factors and information obtained from outside sources would be vital to the evaluation. Also, a patient who is judged to be a significant suicidal risk should not be left unobserved.

Weisman and Worden[7] provide guidelines for assessment of the lethality potential of suicide attempts. The most lethal act is high risk, low rescue (puts rope on neck and home alone), followed by high risk, high rescue (puts rope on neck in crowded room), low risk, low rescue (takes some acetaminophen while home alone), low risk, high rescue (takes some acetaminophen and immediately informs a family member).

In the assessment of suicidality and suicidal acts, well-documented notes about the patient's evaluation and the psychiatrist's clinical judgement can avoid malpractice settlements and monetary awards.[8] It is important for psychiatrists to document the medical rationale for treatment decisions with which other reasonable psychiatrists could differ (e.g., explanation of decision not to order suicide precautions or to dismiss a chronically suicidal patient from the emergency room). Efforts should be made to follow up on patients who were assessed for suicidality and who do not keep outpatient appointments. Documentation of serial assessments of an inpatient's suicide potential is another

means to avoid claims of negligent evaluation and treatment.

Adverse reaction to medications accounted for the second most frequent source of claims (14% of the cases reviewed). These claims illustrate the importance of obtaining informed consent before the initiation of any psychotropic medication. The doctrine of informed consent involves three elements: information, voluntariness, and competency.[6] The amount of information revealed to a patient may be held to the standard of either the usual amount of information given by most psychiatrists, or all the information a reasonable person would need in order to adequately consider a treatment. Voluntariness implies that the patient gave consent with his or her own free will and was not coerced into treatment. Competency means that the patient has adequate mental faculties to participate in the process of informed consent.

In the cases involving adverse reaction to medication, the patients alleged that they were not given information about the side effects of the prescribed medication. The process of informed consent involves a discussion with the patient about the purpose of treatment (benefits), description of treatment process, risks of treatment, and alternative treatments, including nontreatment, risks, and benefits.[9] It is important that there is documentation in the medical record that informed consent was obtained from the patient and/or persons authorized to consent on the patient's behalf. Some psychiatrists use a written consent form, whereas others write a note in the record that reviews the elements discussed in the consent process. When patients are prescribed medication, the presence or absence of side effects should be documented in progress notes. It is recommended that when a patient experiences side effects of medication, the patient should be evaluated prior to renewal of the prescription.

An alleged negligent failure to diagnose a physical illness with psychiatric manifestations resulted in the largest monetary award. It is vital for psychiatrists to consider organic disorders within a differential diagnosis in order to provide appropriate medical treatment and avoid this type of malpractice litigation. It is reasonable to obtain consultation from primary care physicians for patients who exhibit physical symptoms. This consultation should be documented in the medical record.

The case of the resident who was personally involved with a patient and identified her by name at a grand rounds presentation argues for more careful supervision of residents. The legal doctrine of *respondeat superior*[10] could make faculty (supervisors) vicariously liable for the negligent actions of residents they supervise. Patients' names and identifying data should be omitted during case presentation at grand rounds and other presentations in order to protect patient confidentiality. This case was further complicated by the personal involvement between the resident and the patient. Beyond the issue of confidentiality in the therapeutic relationship, the patient may have felt personally betrayed by the resident. Personal involvement

with a patient is a fertile ground for allegations of malpractice.

In this survey, two cases involved negligent failure to warn or protect a third party. The duty to protect occurs in those cases in which a psychiatrist becomes aware of the probability that a patient poses a foreseeable threat of harm. Beck[11] lists three factors that are important to establish foreseeability: history of violence, threat to a clearly identifiable victim, and plausible motive. Usually courts find that violence was foreseeable if at least two of these factors are present. In addition to foreseeability of violence, the psychiatrist must be in a position to exercise control over the patient's behavior. Courts find that psychiatrists have sufficient control over patients to prevent violence in most cases involving release of hospitalized patients, whereas the duty to control is found in only one-half of outpatient cases.[11] The decision to release a psychiatric patient, especially one who was admitted for violent behavior, is a critical one. Allegations of negligence in this decisionmaking that resulted in harm to others provides grounds for malpractice suits. Poythress[12] outlined detailed hospital release procedures to lessen the likelihood of negligent release of a dangerous patient. Specific release policies, documentation of a violence assessment, independent review of the release decision, and videotaped exit interviews of patients are some of his recommendations.

The cases in this survey involved release of a hospitalized patient and an outpatient, both of whom committed violent acts but who did not make threats before the acts. In both cases, the claims against the U.T. System were dropped. In cases involving potentially violent patients, it is critical for psychiatrists to document findings and provide an explanation for the taken course of action.

Two cases involved allegations of inappropriate treatment. These claims may be avoided by thorough evaluation of the patient's condition and implementation of an individual treatment plan. The treatment plan should follow a biopsychosocial model and address the particular patient's needs.

False imprisonment was alleged in four cases. In cases where patients are hospitalized involuntarily or refused discharge from the hospital, it is critical for psychiatrists to document that the hospital is the least restrictive alternative given the patient's psychiatric condition.

In this survey, the institution was named as a defendant in a majority of cases, whereas faculty were named in half of the cases. Psychiatry residents were named in one-third of the cases and as a sole defendant in three. The finding that psychiatry residents were sued contrasts with other reports in the literature concerning malpractice litigation against residents. In national surveys of residency training programs, no child and adolescent psychiatry residents[13] or dermatology residents[14] were named as sole defendants.

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