

Psychiatric Malpractice: A California State-Wide Survey

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Introduction

Few psychiatrists have ever been accused of malpractice. Claims of improper or bad treatment have in the past been most frequent in those areas of specialty practice involving the management of immediate threats to life, the clinical application of new medical technology, and elective cosmetic surgery. During the last few years there has been a substantial increase in the number of lawsuits brought against doctors, and the law court has become a new forum for the expression of patient dissatisfaction. Redress in the form of substantial judgments has become commonplace. The impact on the insurance industry has been sufficient to disrupt a once orderly market, put some casualty carriers out of the professional liability business and cause others to respond with sharp premium increases. The result, termed a malpractice crisis, has received broad media coverage and evoked much popular concern.

While premium escalation could eventually be offset by higher professional fees, the effect on practitioners was immediate. Marginal practices, some long established but serving a special and often lower-fee population, were forced out of business. Doctors who had just completed their training were unprepared to pay the high premium required for the privilege of entering practice.

The effect on psychiatrists was less marked than on most other physicians. Psychiatric malpractice rates, when compared with those of other forms of specialty practice, have always been low. The increase, while substantial, did not close many clinics or put psychiatrists out of work. However, the increases have raised some reasonable questions, and justification of the higher rates seems warranted. While parity with non-surgical medicine was tenable when malpractice premiums were but a small fraction of usual office expense, the higher rates clearly justify a more selective accounting of type of practice and a harder look at attendant loss experience.

For many years the California courts have been a liberal vanguard in the area of tort liability. Large judgments and broad, freeswinging, consumer-oriented interpretations have set a pattern often followed in other jurisdictions. It is not surprising that professional liability premiums for California psychiatrists are the highest in the nation. In response, the insurance committees of the California Psychiatric Association (CPA)

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decided to conduct a state-wide survey of their membership. The intent was to get information concerning current insurance coverage, claims experience and certain other factors considered relevant. What follows is a description of the survey, a tabulation of some of the findings and a discussion of their significance.

Survey Design

A single-page, multiple-choice questionnaire was mailed to all California psychiatrists who were members of one of the four American Psychiatric Association (APA) district branches in the state. The mailing went to just over 3100 psychiatrists and included a self-addressed and stamped envelope to facilitate return. The questionnaire was printed on official CPA letterhead and the respondents were asked, but not required, to identify themselves. All responses were returned to the CPA central administrative office for initial tabulation and subsequent data processing. An interval of sixty (60) days was allowed from the time of the mailing to the close of sample. No effort was made to follow up non-responders.

Survey Results

A. General

A total of 1537 psychiatrists responded within the allotted time. About 80% identified themselves with respect to name and address. Twenty per cent made additional comments in the area provided on the questionnaire. A number of these were detailed notes reflecting both technical sophistication and genuine concern. Others were pure affect.

B. Demographic

1. Type of practice:

Just over 50% of respondent psychiatrists were in full-time private practice. Almost 11% were exclusively salaried. About 40% had both a private practice and a salaried position. Within this group there was about equal dominance of the private and salaried sectors.

2. Need for coverage:

Over 95% of respondents have and pay for malpractice insurance. Only 70 psychiatrists out of a total of 1531 do not.

3. Coverage provider:

Only 12% of insured psychiatrists were covered by the current official APA professional liability plan. Almost 67% obtain their coverage through the former APA plan management firm and its underwriter. Other commercial carriers account for the remaining 20% of coverage.

4. Liability limits purchased:

Almost 44% of insured psychiatrists carried liability limits in excess of 200,000/600,000 dollars. About 30% had limits of 100,000/300,000, and 25% carried 200,000/600,000. One per cent had limits below 100,000/300,000.

5. Business practice:

Only 23% of respondent psychiatrists were incorporated, and less than 30% had one or more employees.

6. Clinical practice:

a. Medication

Almost 48% of respondents prescribed drugs frequently, and 50% used them occasionally. Only 44 of 1530 respondents (less than 3%) claimed never to give medication.

b. Electroconvulsive therapy (ECT)

Just over 9% of the psychiatrists carried a professional liability policy which covered treatment by ECT.

c. Hospital treatment

About 54% of respondents averaged a zero hospital caseload, and 28% averaged one or two hospital patients. Only 18% had an average hospital census of greater than three patients.

C. Claims Experience:

1. Occurrence:

Of 1504 respondent psychiatrists, 166 had notified their company of a claim or potential claim during the preceding five years. This means that in a given year, only about 2% of the insured psychiatrists had any claims activity.

2. Rate:

Over 88% of the respondents had made no claims or notification of potential claims in the preceding five years. Less than 9% made one claim notification during that period, and fewer than 2% made more than one such notification. Interpolation of these frequency categories would suggest a five-year total of about 230 claims or notifications from almost 1500 California psychiatrists, for an average of three claims or notifications of potential claims per 100 practitioners per year at risk.

D. Statistical Correlations

One purpose of the survey was to obtain information about the risks to which psychiatrists may be exposed and to determine their effect on claims incidence. The sample proved to be large enough to yield statistically significant results.

1. Claims experience as a function of type of practice: Of 166 psychiatrists who notified their companies of a claim or potential claim, 107 were in full-time private practice, and only 5 were fully salaried. While there is some blending among those who are both salaried and do private practice, there is a significant correlation between doing private practice and claims notification. ($\chi^2 = 16.6$, 3 df, $p < .01$)
2. Claims experience as a function of medications prescribed: Of 166 claimant psychiatrists, 111 prescribe drugs frequently and 55 do so occasionally. There is a significant correlation between prescribing medication and claims notification. ($\chi^2 = 35.5$, 2 df, $p < .01$)
3. Claims experience as a function of giving ECT: Only 25 of the 166 claimant doctors were covered for ECT. There is a significant correlation between the use of ECT and claims notification. ($\chi^2 = 10.0$, $p < .01$)
4. Claims experience as a function of hospital practice: While a majority of psychiatrists would appear to have no hospital practice, 97 of the 166 claimants averaged a hospital caseload of between one and five patients. There is a significant correlation between claims notification and hospital practice. ($\chi^2 = 33.7$, $p < .01$)

Discussion

Systematic studies of psychiatric malpractice remain scarce. Bellamy¹ reported on cases which had reached the level of the appellate courts prior to 1962. However, experience has shown that the vast majority of such cases are settled before trial and only rarely go on to appeal. In 1969 a study² of psychiatric malpractice claims in Southern California showed a stable claims rate during the period from 1958 through 1967. The average rate was estimated at 1.5 claims per 100 psychiatrists per year. Most cases were settled at modest cost without going to trial. In 1976 Trent³ reported early claims experience with the APA professional liability program. This program has been operative since 1972 and now insures approximately 6,800 psychiatrists nationally. From its inception in October 1972 to September 1977, the program generated 260 claims. The claims rate has increased with new year's experience and is now approaching 2.0 claims per 100 psychiatrists per year. Trent points out that this increasing claims rate reflects, as one of the responsible factors, the "long tail" seen in malpractice as a result of a claim being filed long after the event complained of has occurred. As the program matures, this phenomenon will exert less effect, and the rate should stabilize unless skewed by other factors. Trent's data are valuable because they are derived from a large group of psychiatrists at risk and reflect national trends. They are especially welcome since loss experience and other data from the long-standing former APA program are not available.

The data from this survey provide information on psychiatric practice and claims experience in California and may not accurately reflect other localities. The practice characteristics inquired of were those felt most relevant to risk assessment and estimation of apparent coverage needs. Most psychiatrists spent most of their time doing private practice. Only 10% had a full salary and saw no private patients. Almost all psychiatrists have and pay for malpractice insurance. Only 5% do not. Most California psychiatrists are insured through the former APA plan management firm. Only 12% have joined the new APA plan. Almost half the psychiatrists carry liability limits in excess of 200,000/500,000 and practically none carries less than 100,000/300,000. About one-quarter of the psychiatrists are incorporated and one-third have one or more employees. Almost all prescribe medication on either a frequent or an occasional basis. Less than 3% of the psychiatrists never prescribe medication. Only one psychiatrist in ten gives ECT and over one-half do no hospital practice. Less than 20% averaged a hospital caseload of greater than three patients.

The vast majority of psychiatrists have never filed a claim. In a given year only one psychiatrist in fifty would have any form of new claim activity. The likelihood of a second claim or notification, in a given year, is less than one in three hundred. The responding California psychiatrists accounted for about 230 claims or notifications during a five-year period, for an average of three claims or potential claims per 100 psychiatrists at risk per year.

The respondent sample was large enough to provide adequate information for a statistical correlation of claims and practice data. A valid correlation was found between being in private practice and the probability of making a claim notification. Psychiatrists who frequently prescribe medication are

more likely to notify of a claim than psychiatrists who do not. This correlation is stable, and psychiatrists who prescribe occasionally have fewer claims than those who prescribe more often. The small group of psychiatrists who never prescribe medication made no claims notification. Although the number of psychiatrists giving ECT was small, there was a significant correlation between use of ECT and claims frequency. Hospital practice also showed a correlation with claims notification. However, the number of psychiatrists with a hospital caseload greater than three was too small to demonstrate a relationship between size of average caseload and claims frequency.

Conclusions

The survey provides no information about the practice characteristics or claims experience of non-respondents. This is an inherent limitation of the technique. Personal follow-up of a random sample of recipients would be required to demonstrate that the respondents were representative of the population under study.

Given this limitation, these data suggest that psychiatrists who prescribe medication frequently, who hospitalize patients and who use ECT are a greater malpractice risk than those who do not. Statistical analysis of the claims frequencies derived from the drug, hospital and ECT practice categories failed to show significant differences among these specific aspects of exposure. Using a binomial probability distribution, the claims frequency for ECT practitioners was compared with that of doctors who hospitalize and those who frequently prescribe drugs. The obtained z scores were not significant at the .05 level. Since almost all the respondent psychiatrists prescribe drugs, that risk is best covered in the basic premium. ECT is already surcharged. If there is need for further risk refinement, a surcharge for hospital practice would make sense.

The survey data confirm prior and more limited studies. In the absence of contrary information, these findings strongly suggest that psychiatry presents a low order of malpractice risk when compared to other medical specialties. Only 2% of psychiatrists notify of or file a claim in a given year, and the annual total of such notifications does not exceed 3% of the doctors insured. This is an inflated yet modest rate.

It is inflated because it includes both notices of patient dissatisfaction, *i.e.*, potential claims, and actual claims filed in response to an already initiated legal process. From this total, the number of viable claims for whom dollar reserves are set aside is possibly less than half. This would bring the actual claim rate down to 1.5 claims/100 doctors/year. This is the same claims frequency reported in an earlier California study.⁴ The study was based on a count of claims in the insurer's office and reflected the practice risk of more than a decade ago.

The 3% rate is modest when compared to that of other areas of medical practice. An estimate⁵ of the national average is 17%, and surgical specialists can go as high as 50%, *i.e.*, one malpractice action per doctor every two years.

These figures are of more than academic interest. Malpractice premium escalation has caused physicians and their medical societies to press for

legislative relief. State-run insurance proposals have attracted wide interest. In an effort to control premium cost for high-risk specialists, some of these programs have devised a constricted range of premiums which reduces the cost for the high-risk specialist by requiring a premium disproportionate to risk from a larger body of low risk practitioners. While some well-intentioned legislators are convinced that this form of risk-sharing within the body of medicine is in the public interest, others may not agree. Premiums for psychiatrists based on experience derived from other forms of medical practice are likely to be excessive. State-mandated refinement of claims data offers the best basis for argument to support equitable distribution of premium costs for medical liability programs.

References

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