Psychiatrists and other medical specialties difficulties with regulators and the law.

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Conflict of Interest.

- **I have no conflicts of interest related to this presentation.**
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Goals.

- **We are going to look at what the empirical literature says about medical legal risks with an emphasis on psychiatry.**
- **A hypothetical medical student “Joe” thinking about going into psychiatry will ask us questions.**

Fellows.

- **But first we will ask the fellows about some sample cases.**

Stanford talk (1).

- **Joe asks,**
- **“What might legal difficulties look like for a physician?”**

Stanford talk (2).

- **Here are some sample cases.**

Cases (1a).

- **Case 1.**
- **Physician with a bad marriage.**
- **Drinks at home and has arguments with wife.**
- **Decides to spend night at office.**
- **Fellows: Is this a professional medical issue. If so, why?**

Cases (1b).

- **Case 1.**
- **Forgets wallet and toiletries.**
- **Puts items in pocket at store, arrested.**
- **Fellows: Is this now a professional medical issue? Why?**
- **Is this just a private civil issue?**

Cases (1c).

- **Case 1.**
- **This doctor has never had a patient medical complaint or finding of substandard care.**
- **Fellows: Is this now a professional issue?**
- **How would the authorities find out? Is there a system of informers?**

Cases (2).

- **<u>Case 2.</u>**
- **Female physician, drinking, invites in ex partner with a restraining order.**
- **After both drink a bit she beats him unconscious and puts a three inch knife gash on his face.**
- **Dumps his unconscious body in the apartment stairwell.**

Cases (2a).

- **Case 2.**
- **Question for Fellows;**
- **Is this a medical professionalism issue or just a relationship issue?**

Cases (2b).

- **<u>Case 2.</u>**
- **Pretends not to be home when police arrive.**
- **Not charged legally – she claimed he assaulted her.**
- **Someone informed the medical board.**

Cases (2c).

- **<u>Case 2.</u>**
- **Questions for Fellows;**
- **Is this of professional concern here?; There are no legal charges or patient issues presented.**

Cases (3a).

- **<u>Case 3</u>.**
- **Top level surgeon.**
- **Insulted both staff under him and patients.**
- **Eventually a patient reported him to the medical board.**

Cases (3b).

- **<u>Case 3</u>.**
- **His patients did remarkably well from surgery.**
- **Question for Fellows;**
- **Do we have a problem here or just a talented quirky person who need to be accommodated due his skills?**

Cases (4a).

- **Case 4.**
- **Psychiatrist sometimes discusses real estate with a patient.**
- **To Fellows: A problem?**

Cases (4b).

- **<u>Case 4</u>.**
- **Psychiatrist and patient make three real estate investments together which earn both money.**
- **To Fellows: A problem? If so, why?**

Cases (4c).

- **Case 4.**
- **Psychiatrist and patient make a real estate investment which loses both of them money. Patient sues.**
- **To Fellows: Now a problem, but what kind?**

Stanford talk (3).

- **Joe, “I am a medical student I would imagine students don’t have legal problems because they are students and supervised.”**

Stanford talk (4).

- **There are regular problems with <u>medical student and residents</u>.**
- **These are generally of two types:**
- **Failure to responsibly carry out duties.**
- **Lack of professional skill.**
- **These are usually remediable.**

Stanford talk (5).

- **Joe, “What processes get triggered to deal with problems in physicians?”**

Stanford talk (6).

- **<u>There are three common ways</u>:**
- **Fitness for duty evaluations**
- **Malpractice lawsuits**
- **Medical Board or peer review complaints**

Stanford talk (7).

- **Fitness for duty**
- **Approximately 1% of physicians a year have a serious issue and fitness for duty exam.**
- **Surgery and psychiatry are at highest risk.**
- **Issues usually involve education, personality, culture and emotional illness.**

Stanford talk (8).

- **Fitness for duty**
- **Over 70% have one of more DSM disorders.**
- **Most cases respond to intervention.**
- **The most problematic cases are violence or overt hostility towards others which have a poorer outcome.**

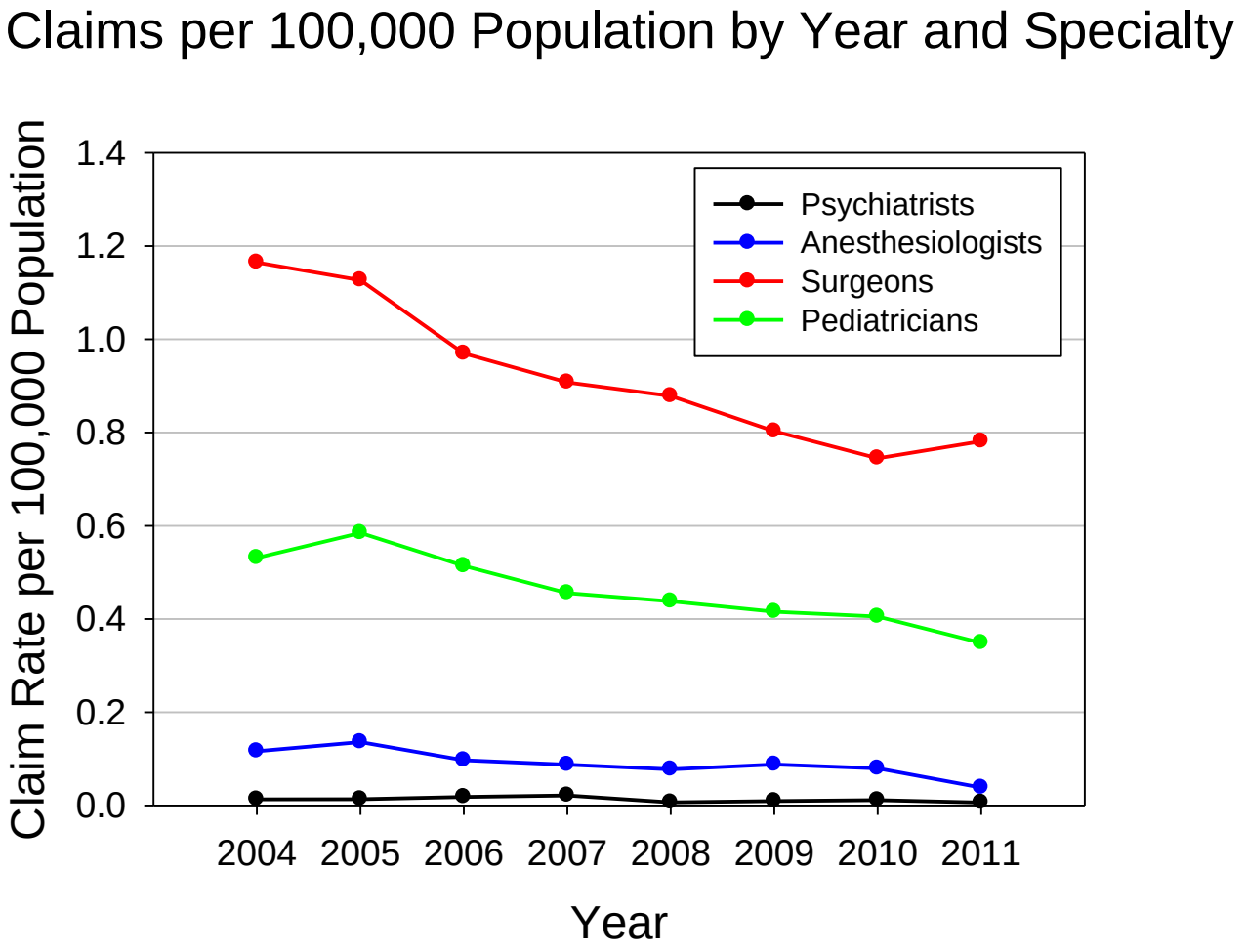
Stanford talk (9).

- **Joe, “Do psychiatrists have much malpractice risk compared to other specialties?”**

Stanford talk (10).

- **If you divide specialties into high and low risk, psychiatry is in the low risk group.**
- **There are different groupings of high and low risk but surgical specialties and OBGYN are often considered high risk. Psychiatry is always considered low risk.**

Stanford talk (11)



Stanford talk (12).

- **Causes of risk for psychiatrists are more likely administrative than malpractice.**

Stanford talk (13).

- **Joe, “So I don’t have to worry about a malpractice suit?”**

Stanford talk (14).

- **Well, not exactly.**
- **Risk of career lawsuit in high risk specialties: 99%**
- **Risk of career lawsuit in low risk specialites: 75%**

Stanford talk (15).

- **Joe, “If I do get sued what are the risks of a finding against me.”**

Stanford talk (16).

- **In general low.**

Stanford talk (17)

- **Morlach found in a health claims arbitration office:**
- **27% dismissed**
- **35% settled privately**
- **38% formal hearing**
- **47% of formal hearings found in favor of plaintiff (about 18% of total).**

Stanford talk (18)

- **PRMS claims data for 2022 indicate that 75% of claims and lawsuits were resolved without payment.**

Stanford talk (19)

- **Joe, “Are psychiatrist lawsuit payouts high compared to other specialties?”**

Stanford talk (20)

- **In aggregate the insurance industry considers them “rounding error,” relatively low.**

Stanford talk (21)

- **Joe, “So party on?”**

Stanford talk (22)

- **Not exactly, when a claim does go against a psychiatrist the cost can be higher than other specialties.**
- **The most costly claims were undue familiarity and suicide.**

Stanford talk (23)

- **Many high cost claims are those involving permanent physical or neurologic injury.**
- **An example would be a suicide attempt resulting in neurologic injury or SJS from lamotragine.**
- **High cost injuries often require lifelong care.**

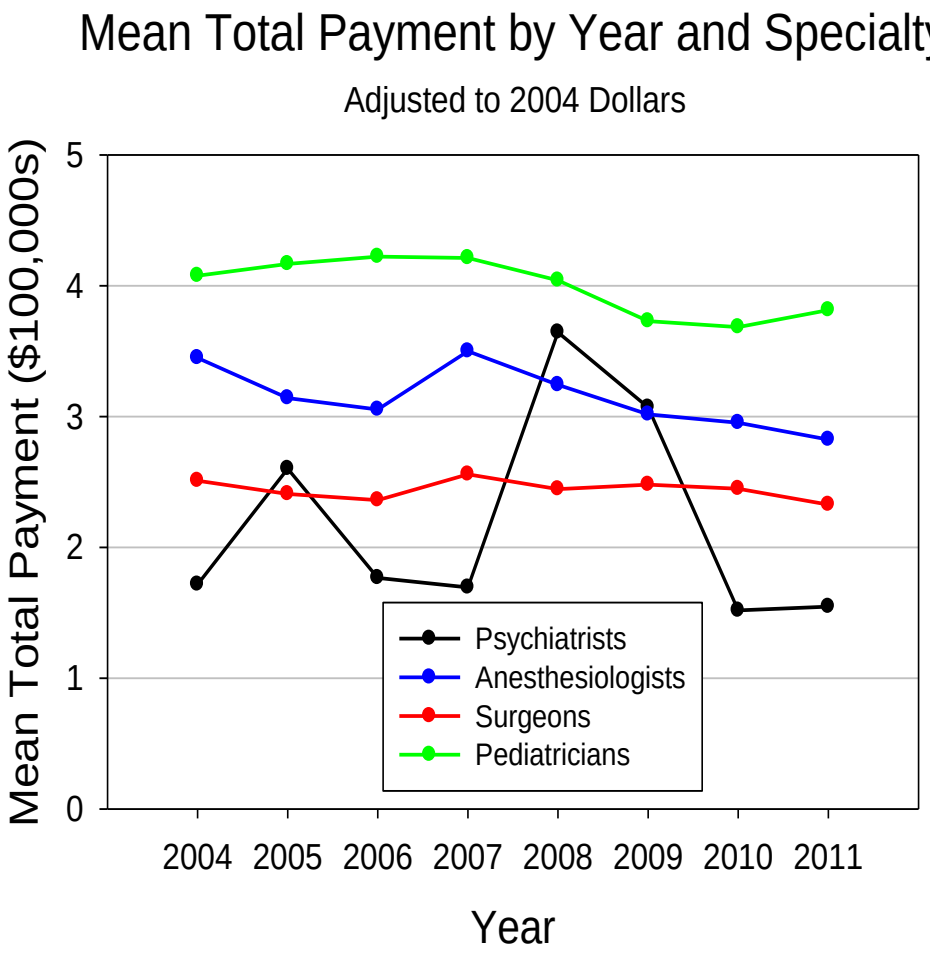
Stanford talk (24)

- **Undue familiarity is a risk area for psychiatrists.**
- **Most insurance policies limit their coverage greatly (if they cover it at all.)**

Stanford talk (25)

- **Sexual boundary crossing in these cases is what usually leads to problems.**
- **Key case is Roy vs. Hartogs (1976)**
- **Punishable by fine and or prison in California.**

Stanford talk (26)



Stanford talk (27)

- **PRMS data in 2022 indicated an average indemnity of $284,873.**
- **The most common problems in PRMS data are suicide and medication errors.**

Stanford talk (28)

- **There is also Medical Malpractice Stress Syndrome (MMSS) which is similar to a mild form of PTSD. Sometimes the physician can be considered a second victim to a bad outcome.**
- **Also, it is estimated a physician can spend 11% of his career dealing with a malpractice claim.**

Stanford talk (29)

- **Joe, “What kinds of things get us in malpractice trouble?”**

Stanford talk (30)

- **PRMS lawsuits and claims only for 2013 to 2022.**

Primary Allegation	All Aged Patients
Incorrect Treatment	27%
Medication Issues	22%
Suicide/Attempted Suicide	13%
Other	11%
Incorrect Diagnosis	6%
Hospital Commitment / Discharge	7%
Breach of Confidentiality	6%

Stanford talk (31)

- **However, when we add in administrative actions it changes a bit.**

Stanford talk (32)

- **PRMS cause of loss, claims and admin actions 1986 to 2022**

Allegation	All States	CA
Suicide/ attempted suicide	28%	24%
Incorrect treatment	22%	25%
Breach of confidentiality	14%	10%
Other	12%	10%
Medication issues	8%	5%
Incorrect diagnosis	5%	6%
Unnecessary Commitment	3%	3%

Stanford talk (33)

- **When we look at only administrative actions it is a bit confusing.**

Stanford talk (34)

- **PRMS cause of loss: administrative actions 1986 to 2022**

Allegation	All States
Suicide/ attempted suicide	<1%
Incorrect treatment	5%
Breach of confidentiality	1%
Other	82%
Medication issues	8%

Stanford talk (35)

- **The “incorrect treatment” and “other” are catch all phrase that lawyers use before they have a more definitive case.**
- **In the end the difficulties for psychiatrists are usually medication management and suicide but also can include conflict of interest.**

Stanford talk (36)

- **An additional important area is <u>conflict of interest</u>.**
- **In short, this is gaining an advantage from a patient that you would not get unless you are a treater.**
- **This is a broad category which includes sexual exploitation but covers more ground.**

Stanford talk (37)

- **<u>Conflict of interest</u>: If the physician uses his relationship with the patient to gain a benefit for himself/herself that would not have happened if there was not a patient relationship.**

Stanford talk (38)

- **Joe, “What kind of problems do psychiatrists get into administrativelty?”**

Stanford talk (39)

- **A <u>medical board case</u> can be for anything.**
- **Practice of medicine not required.**
- **Damages not required.**
- **There is no due process for the physician.**

Stanford talk (40)

- **Issues around patient commitment, poor patient supervision or patient violence often come up.**
- **Not infrequently the legal problem arises from an initial evaluation.**

Stanford talk (41)

- **Joe, “Does a lawsuit or administrative action mean the psychiatrist did something wrong?”**

Stanford talk (42)

- **Not necessarily, but for a patient to get compensation in the US the doctor must be found at fault.**
- **This is not the case in other countries with different systems where there is less risk for the physician when good care is given but there is a bad outcome.**

Stanford talk (43)

- **In countries that have a separate payment system for medical bad outcome from doctor complaints the bad outcome route is 3:1 more popular.**
- **People are more interested in replacing lost income rather than placing blame.**

Stanford talk (44)

- **In the United States system someone has to be found at fault for payment to be made.**
- **So, in the United States if there is a bad outcome they need a fall guy to collect.**
- **Who is the fall guy: look in the mirror.**

Stanford talk (45)

- **It is important to remember that bad outcomes can occur even with excellent care.**
- **So a bad outcome is not necessarily malpractice.**
- **Most courts recognize this.**

Stanford talk (46)

- **Joe, “Are there just a few doctors who are responsible for most claims?”**

Stanford talk (47)

- **The evidence here is mixed.**
- **There is no evidence that having a previous malpractice claim indicates a high risk doctor.**
- **However, some studies indicate that there is a small group of high repeat offenders.**

Stanford talk (48)

- **NPDB data indicates the more previous malpractice claims the higher the likelihood of another.**
- **The dollar amount of the claims is a better predictor than the number of claims.**

Stanford talk (49)

- **Joe, “Is overwork or high volume a source of medical errors or malpractice suits?”**

Stanford talk (50)

- **The literature indicates a volume sweet spot.**
- **Up to a certain volume the risk of malpractice per patient seen goes down although the absolute number of cases goes up.**
- **After that sweet spot the frequency of malpractice claims goes up quickly.**

Stanford talk (51)

- **Joe, “How much control does a physician have over malpractice suits?”**

Stanford talk (52)

- **There are systemic and individual factors to physician risks: You can only control the individual factors.**

Stanford talk (53)

- **Examples of systemic factors.**
- **Legal: Statute of limitations, malpractice caps for pain and suffering.**
- **Interest rates: the lower the interest rates the less money insurance companies have for defense.**

Stanford talk (54)

- **Scope of practice of nurse practitioners or other assistants.**
- **The size of your state medical board and its independence from the legislature.**
- **Your specific state laws.**

Stanford talk (55)

- **Institutional pressures for high patient volume.**
- **The presence and availability of physician support programs.**
- **Your state board's attitude toward physician mental health.**
- **Your board's attitude towards rehabilitation**

Stanford talk (56)

- **There is some evidence that merely monitoring adverse outcomes can reduce malpractice claims about 15%.**
- **This is just feedback with no punitive component.**

Stanford talk (57)

- **<u>Individual factors a doctor can control.</u>**
- **The most important thing to do after an adverse event is patient care – take care of the patient.**
- **If the event precludes your treating further you can refer to another physician.**

Stanford talk (58)

- **Before a complaint is filed: address the problem.**
- **You do not have to admit fault.**
- **After the complaint is filed: contact your malpractice carrier and risk management officers immediately.**

Stanford talk (59)

- **<u>Individual factors a doctor can control.</u>**
- **Documentation.**
  - **Identify what is being treated.**
  - **Identify a reasonable rationale for your course of action.**
  - **Describe actions taken**
  - **Need not be a novel**

Stanford talk (60)

- **Never change your documentation or write a self serving addendum after an allegation has been made.**

Stanford talk (61)

- **<u>Other issues</u>:**
- **Give and document informed consent.**
  - **Key case Clites vs State of Iowa 1982**
- **Evaluate the specific risks of your practice.**
- **Be careful not to create the impression of conflict of interest.**

Stanford talk (62)

- **<u>Joe, “What is the standard of care required?”</u>:**
- **This varies by jurisdiction but,**
- **Physicians are held “to such reasonable care and skill as exercised by the ordinary physician of good standing under like circumstances.” (Clites v. Iowa, 1982)**

Stanford talk (63)

- **If treatment provided is acceptable to a respectable minority of practitioners, it should not be considered negligent (Hood v. Phillips, 1977).**

Stanford talk (64)

- **Joe, “What if I take extra steps in my patient care just to avoid a malpractice suit?”**

Stanford talk (65)

- **That is called defensive medicine. It is not uncommon but moves made to prevent malpractice suits that don't benefit patient care are not considered a best practice and add to the already high cost of medical care.**

Stanford talk (66)

- **Joe, “So what happens if there is a settlement against me.”**

Stanford talk (67)

- **There is a clearinghouse for all adverse actions against physicians called the National Practitioner Data Bank.**
- **Any amount of payment to settle a claim is reported.**
- **Peer review, state boards and other board findings are also reported.**

Stanford talk (68)

- **The NPDB is consulted by organizations before hiring and as needed.**
- **The reports never drop off your record.**
- **In addition it is likely your malpractice premiums will go up.**

Stanford talk (69)

- **Joe, “So is a malpractice lawsuits the only legal risk we need to worry about?”**

Stanford talk (70)

- **No, two thirds of psychiatrists legal difficulties are with the medical board or other administrative boards, not malpractice lawsuits.**
- **The rate of psychiatrists' difficulties with medical boards is increasing.**

Stanford talk (71)

PRMS/YEAR	Claims and Lawsuits	Administrative
2019	39%	62%
2020	41%	59%
2021	28%	72%
2022	20%	80%

Stanford talk (72)

- **Joe, “Are psychiatrists more at risk than other specialties for medical board discipline?”**

Stanford talk (73)

- **Several studies in the United States indicate an OR of about 2 or greater for discipline of psychiatrists.**
- **In England one study indicated that 22% of problem doctors were psychiatrists.**
- **<u>Psychiatrists are at higher risk</u>.**

Stanford talk (74)

- **Joe, “What gets us in trouble with medical boards?”**

Stanford talk (75)

- **Suicide or attempted suicide.**
- **Sexual relations or inappropriate contact with a patient.**
- **Inappropriate prescribing or treatment.**
- **Exploitation of a patient (conflict of interest.)**

Stanford talk (76)

- **Physician substance abuse.**
- **Falling below the standard of care.**
- **But <u>could be anything</u>. There are no lower limits to what the board can review related to professional behavior.**

Stanford talk (77)

- **PRMS told me there was one case initiated because a patient saw a used McDonalds bag in the trash can in the doctors office. So it *could* be anything.**

Stanford talk (78)

- **Joe, “I guess when I have been in practice a while these problems will be reduced as I have more experience.”**

Stanford talk (79)

- **Not exactly.**
- **There were four studies in this area. They found:**
- **The longer time in practice the increased odds of medical board discipline and license revocation.**

Stanford talk (80)

- **Joe, “Well wouldn’t that just be due to longer time in practice allowing more claims to be filed?”**

Stanford talk (81)

- **No.**
- **These studies adjusted for years in practice in the comparisons – it was not just that being in practice longer that allowed for more problems to develop due to duration of time.**
- **<u>The longer you are in practice the higher the risk each year.</u>**

Stanford talk (82)

- **Joe, “Well I expect my electronic medical records will organize me and protect me from lawsuits and discipline.”**

Stanford talk (83)

- **Not really.**
- **Kim et al. (2015) found that spending on IT (electronic medical records) did not reduce overall malpractice lawsuits, it just created different ones.**

Stanford talk (84)

- **Joe, “What helps?”**

Stanford talk (85)

- **The strongest finding is that board certified physicians have fewer discipline problems.**
- **This may reflect either better initial training or maintenance of skills.**
- **Best practices and APA guidelines (A separate lecture.)**

Stanford talk (86)

- **There is evidence that consultation is highly protective.**
- **The same is true of good documentation.**

Stanford talk (87)

- **Comments on curbside consults.**
- **Not a problem in most jurisdictions.**
- **If asked, provide an answer for a similar hypothetical patient, not the specific patient.**
- **Ask that your name not be entered in the chart.**

Stanford talk (88)

- **Joe, “Are there other things to remember?”**

Stanford talk (89)

- **In general the more severe the patient's damage the greater the chance of legal action.**
- **75% of patients discovered problems from other than the treating physician.**

Stanford talk (90)

- **Duration of stress for the physician with medical legal issues can be long. Psychological effect of administrative procedures / malpractice on a physician are significant.**
- **Preparation is better than defense.**

Stanford talk (91)

- **The relationship may be important to who gets sued (how patients find out about medical errors is important.)**

Stanford talk (92)

- **The risk of malpractice may be more due to the match of precautions and risk rather than absolute risk.**

Stanford talk (93)

- **Joe, “Could you make a list of things that could help me stay out of trouble?”**

Stanford talk (94)

- **<u>Suggested precautions</u>.**
- **1. Document assessment and reasoning, the more risk the more complete the documentation should be.**
  - **Appropriate issues need to be identified, action taken indicated and justification of action given. Does not have to be long.**

Stanford talk (95)

- **<u>Suggested precautions</u>.**
- **2. Clinicians must recognize the destructiveness and strong sanctions about patient/therapist sexual contact/exploitation and other forms of exploitation.**

Stanford talk (96)

- **3. Be aware of high risk situations.**
- **4. Make use of consultations.**
- **5. Make use of APA or other guidelines.**

Stanford talk (97)

- **6. Remember that if you start off with a wrong diagnosis problems can follow.**
- **7.Level of precautions should match the level of risk.**

Stanford talk (98)

- **8. Consider discussing bad outcomes with the patient yourself in a timely manner (prior to any legal action).**
- **9. In joint treatment situations be aware of what is expected to be your legal responsibility.**
- **10. Keep up with your field by CME.**

Stanford talk (99)

- **11. Good clinical care is always protective.**

Return to Cases (1)

- **Returning to our cases.**

Return to Cases (2)

- **If you had to boil it down, three things get physicians in trouble.**
- **Problems of competence.**
- **Problems of integrity.**
- **Problems of professionalism which can include conflict of interest.**

Return to Cases (3)

- **In our first case there were emotional problems:**
- **Depression, alcohol abuse**
- **These caused a severe error in judgment on one occasion.**
- **So there is a problem affecting judgement of concern to the medical board. (Problem of competence.)**

Return to Cases (4)

- **This doctors problems were remediable.**
- **Probationary license during marital counseling, divorce, individual counseling and substance abuse counseling.**
- **Eventually returned to full practice and full license without problems.**

Return to Cases (5)

- **<u>Case 2</u> represented a different problem.**
- **Multiple statements she made were not in accord with established facts.**
- **In addition she would tell different stories to different people depending on what she perceived as her best interest in the moment.**

Return to Cases (6)

- **This was found to be a problem on integrity which was not remediable.**
- **License revoked.**

Return to Cases (7)

- **<u>Case 3</u>.**
- **This was a long term problem of professional behavior although medically highly competent.**
- **Rehabilitation only partly successful and ultimately he moved to a smaller less demanding hospital where he fit in better.**

Return to Cases (8)

- **<u>Case 4</u>.**
- **This case has the appearance of conflict of interest.**
- **The board did not find against the psychiatrist, likely because he shared the investment risks.**
- **However, it could easily have gone the other way.**

Thank you.

- **Thank you for you attention.**

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