

Essential Tips for Malpractice Risk Management

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Disclosures

Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose.

Vignette #1

- **Dr. D**, a psychiatrist, is treating **Mr. E**, a 38-year-old man with a history of bipolar I disorder.
- Over the course of several outpatient visits, Mr. E begins to exhibit signs of emerging mania, including elevated mood, decreased need for sleep, rapid speech, and impulsive spending.

- Despite these symptoms, Dr. D continues Mr. E's antidepressant regimen without initiating or adjusting mood stabilizers and does not document any clinical rationale for this decision.

- Within two weeks, Mr. E experiences a full manic episode with behaviors including exorbitant spending and culminating in a physical altercation that leads to emergency hospitalization.
- A subsequent chart review reveals minimal documentation of symptom progression and no evidence of risk assessment or treatment modification in response to the evolving clinical picture.

Goals For Today

- Discuss the Standard of Care required for the practice of psychiatry
- Present common practice pitfalls that expose practitioners to increased risk & potential liability, including:
 - Failure to properly diagnose and treat
 - Failure to maintain confidentiality
 - Failure to obtain informed consent

The Frame: Legal Risk

Discuss Today:

- Negligence (Tort) Law
- Malpractice Risk in Psychiatry

Excluded:

- Constitutional Law Violations
- Administrative Board Sanctions
- Criminal Charges

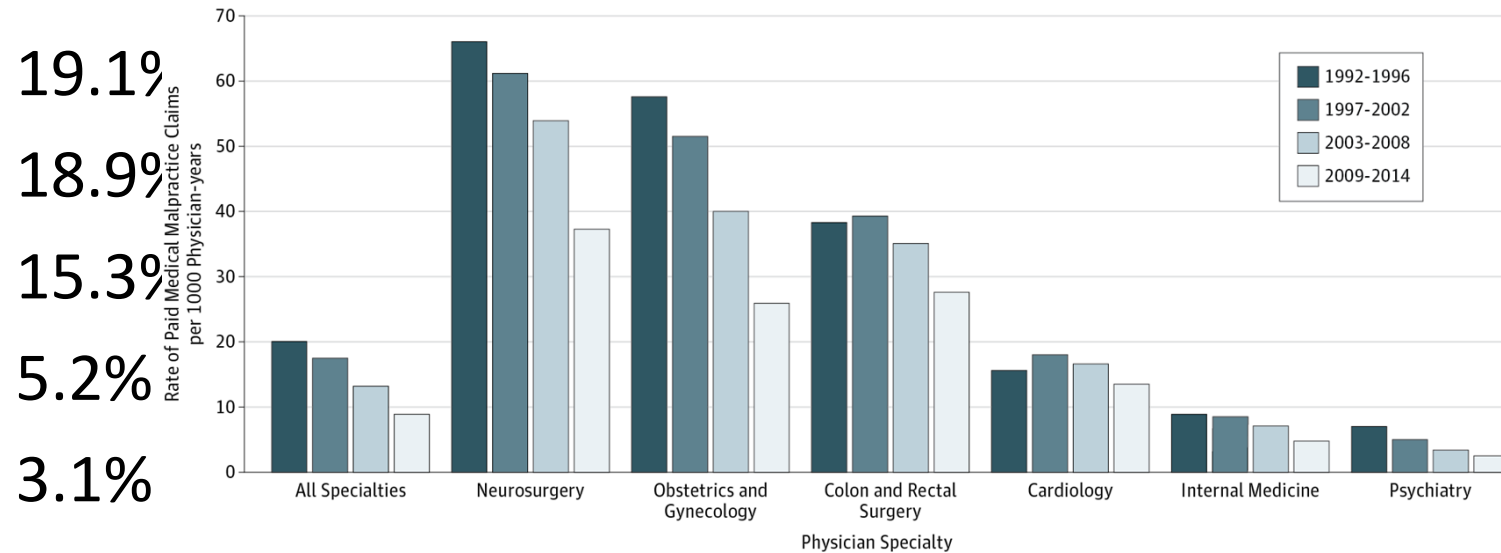
Paid Malpractice Claims by Specialty, 1992-2014

(JAMA Intern Med. 2017;177(5):710-718.)

Annually 7.4% of all physicians face a malpractice claim

Ranked By Specialty (NEJM 2011)

- Neurosurgery
- Cardiothoracic Surgery
- General Surgery
- Family Medicine
- Pediatrics
- Psychiatry



Outcomes? 78% of claims result in no payments.

2026 AMA Report on 2024 Data

- 2024: 1.8% of physicians were sued in the previous year
- 28.7% of physicians said they were sued at least once in their career
- Represents a moderate decline from 2016, when 2.3% of physicians were sued in the previous year and 34.0% reported they were sued at least once in their career.
- Variation in claim frequency by age, gender and specialty.
 - Increased exposure to risk the longer physicians are in practice
 - 45.2% of physicians aged 55 and over were sued at least once in their career
 - 22.2% of physicians aged 45–54 and 11.0% of physicians under the age of 45.
 - When looking at differences across specialties, obstetricians-gynecologists and general surgeons were at the highest risk.
 - About 60% of obstetricians-gynecologists were sued at least once in their career, followed by 53.1% of general surgeons.
 - 75% of obstetricians-gynecologists and general surgeons aged 55 and over were sued at least once in their career.
 - Male physicians faced higher liability risk than female physicians in both the short and long terms, although part of this gap is explained by differences in age and specialty.

<https://www.ama-assn.org/about/ama-research/medical-liability-market-research>

Psychiatric Malpractice Suits by Claim Type

1. Suicide
2. Boundary Violations
3. Split Treatment Dislocations
4. Unavailability/Abandonment
5. Failure to Protect Third Parties
6. Mismanagement of Medications
7. Failure to Obtain Informed Consent

What is Malpractice?

Where does Malpractice sit in the legal landscape?

- A “tort” or non-criminal harm (Civil Law)
 - Within torts, a “negligent tort”
 - Negligent tort committed by a professional.

The 4 D's

What must a plaintiff in a malpractice action assert to have a valid claim?

- Duty
- Dereliction
- Directly
- Damages

#1 : Duty

The plaintiff must show that he or she was your patient....that a duty of care existed.

- When is this in dispute?
 - Curbside consultations
 - Supervision of residents
 - Consultation to teams
 - Good Samaritan contexts

#2 Dereliction

A professional negligence tort (malpractice) means that a professional failed to live up to the “Standard of Care”

Psychiatrists have the duty to possess that degree of skill and learning ordinarily possessed and used by members of the profession in good standing, and who are engaged in the prescribing, dispensing and administering of medications in the same or similar circumstances.

#2 Dereliction continued

What lives up to the standard of care?

- Reasonable care, not extraordinary or perfect care;
- Based on the sub-specialty which you purport to offer;
- Proved by a preponderance of the evidence.

#3 Directly:

Proximate or legal causation

- Mechanical or direct causation: But-for the allegedly negligent act, the harm would not have occurred
- Proximate or legal cause = foreseeability: the actor knew or reasonably should have known that negligence would result in injury
- Without intervening acts or omissions

#4 Damages

The dereliction of your professional duty must have directly caused Damages:

- Measurable physical damage
- Measurable psychological damage
- Measurable social/occupational/reputational or economic damage

Dereliction: Breaching the Standard of Care

The Duty to Treat Properly:

- Negligent Diagnosis:
 - Suicidality
 - Homicidality
 - Treatable Conditions
- Generally Negligent or Poor Care:
 - Failure to offer indicated medications
 - Failure to treat with adequate doses
 - Failure to hospitalize when indicated
 - Failure to Report Abuse or Neglect
 - Failure to Protect Third Parties
 - Failure to Provide Coverage/Abandonment

Suicidality

Liability for Suicidal Acts to patient survivor, family members, third parties

- Failure to offer proper treatment
- Failure to offer appropriate safety

Where should you turn?

- Professional Practice Guidelines
- Hospital Risk Management Guidelines
- Authoritative Texts
- Consultation: Never worry alone.

Dereliction: Breaching the Standard of Care

Negligent Use of Somatic Treatments

- Poor Record Keeping
- Fragmented Care
- Failure to Monitor Side Effects
- Disregard of Treatment Guidelines

Vignette #2

- **Dr. F**, a mental health clinician, begins meeting with **G**, a young adult patient, outside of scheduled sessions, including for coffee and personal outings.
- Over time, **Dr. V** develops a dual relationship and shares confidential details about **G**'s case with a mutual acquaintance—without consent.
- The situation escalates when **G** feels confused and distressed by the blurred boundaries and loss of privacy.
- A colleague reports the behavior, prompting an ethics review. **Dr. V** is removed from the case, and the incident is formally reported to the licensing board for investigation.

Failure to Maintain Boundaries

Models of Boundary Violations – a well-known progression with disastrous results:

- Erosion of therapist neutrality
- Therapy as a social hour
- The patient is treated as special
- The therapist talks about other patients
- The therapist talks about herself
- Extra-therapeutic contact
- Extended therapy sessions
- Evening therapy sessions
- Therapist stops billing
- Therapist patient romantic/sexual contact

The Legal Consequences of Boundary Violations

- Civil Law Suits
 - Negligence
 - Intentional Torts
 - Loss of Consortium
- Breach of Contract
- Ethical Sanctions
- Loss of License
- Criminal Charges

Breach of Confidentiality

- “You must keep confidential the communications of your patients made in the course of treatment”
- Says who?
 - State common law
 - State statutes
 - Federal law
 - Ethical principles

Who Can You Tell?

Paul Appelbaum and the Circle of Knowing

Inside

The Patient
The Treatment Team
Some Consultants
Nursing / Caregivers
Custodial Parents
Guardians

Outside

Attorneys
Referring Therapists
Previous Treaters
Emancipated Minor Parents
Police

Breach of the Duty to Obtain Informed Consent

- *“Patients have the right to full disclosure concerning a proposed treatment, including a description of risks and benefits of the treatment, side effects and sequelae, and alternative treatments”*

Vignette #3

- **Dr. H**, a psychiatrist, is treating **Ms. I**, a 29-year-old woman with a history of borderline personality disorder and recurrent depression.
- During a routine visit, **Ms. I** reports experiencing intermittent auditory hallucinations—non-commanding and vague in nature.
- She denies substance use and reports no major mood changes.

- Uncertain whether these symptoms reflect a transient stress response, an emerging psychotic process, or a feature of her underlying condition, **Dr. H** carefully documents the clinical presentation and **Ms. I's** account.
- Recognizing the complexity, **Dr. H** consults with a senior colleague and a psychologist involved in **Ms. I's** care to explore diagnostic and treatment options.

- **Dr. H** discusses the uncertainty openly with **Ms. I**, explaining the risks and rationale for a cautious approach.
- Together, they agree to monitor symptoms closely, defer medication changes, and reassess at the next visit.
- The collaborative process and clinical reasoning are documented reasonably thoroughly.

Failures of Documentation:

The Most Common Pitfalls

- If you didn't write it down, it didn't happen
- What should you document?
 - The service provided, when and by whom;
 - The informed consent process;
 - Your own reasoning about the decision;
 - Whom you consulted.
- Do Not Alter Past Records!

The Bottom Line:

- The best way to avoid liability is to practice up to the highest standards, obtain consultation where indicated, document process and reasoning, and maintain respectful boundaries and patient confidentiality.

Thank you!