ANNALS OF CLINICAL PSYCHIATRY 2014;26(1):XXX-XXX

REVIEW ARTICLE

An empirical data comparison of regulatory agency and malpractice legal problems for psychiatrists

James Reich, MD
Department of Psychiatry
University of California, San Francisco
San Francisco, California, USA

Alan Schatzberg, MD
Department of Psychiatry
and Behavioral Health
Stanford Medical School
Stanford, California, USA

BACKGROUND: Our objective is to compare legal difficulties that psychiatrists encounter in regulatory agency and malpractice (insurance) settings.

METHODS: Data sources included a literature search of malpractice and medical board discipline from 1990 to 2009 (rates and types of discipline); publicly available insurance data (malpractice frequency and type); and data from the National Practitioner Data Bank (NPDB) (required reports of malpractice settlements and hospital discipline).

RESULTS: Medical board discipline findings indicate that psychiatrists are at increased risk of disciplinary action compared with other specialties. NPDB data indicated relatively infrequent problems for psychiatrists. In malpractice, psychiatry accounted for a small percentage of overall claims and settlements. Overall, more years in practice and a lack of board certification increased the risk of legal difficulties.

CONCLUSIONS: There are shared and separate risk factors in the malpractice and regulatory agency areas, but there is evidence that these 2 legal areas are distinct from each other.

KEYWORDS: forensic psychiatry, malpractice, review of literature

CORRESPONDENCE
James Reich, MD
1988 Greenwich Street
San Francisco, CA 94123 USA

E-MAIL
james.reich@ucsf.edu

INTRODUCTION

Physicians encounter potential legal risks with both regulators and in the malpractice setting. We chose to examine empirical data in this report because it might have higher generalizability than literature that is not data-based and therefore might be more replicable in future studies. We are not aware of any reports comparing empirical data from malpractice

TABLE 1
Data from National Practitioner Data Base on Psychiatrist difficulties

Year	Number of psychiatrists[a]	One or more malpractice claims[b]	License revocation[b]	Loss of clinical privileges[b]	Medical Society expulsions[b]	Mean dollar amount settlement
2004	47,140	0.827	0.212	0.085	0	$203,666.67
2005	48,832	0.881	0.225	0.082	0.020	$331,162.79
2006	48,645	1.090	0.411	0.062	0.041	$230,826.42
2007	48,940	1.43	0.368	0.122	0.061	$190,571.43
2008	48,262	0.559	0.083	0.021	0	$369,907.41
2009	48,054	0.645	0.125	0.083	0	$340,629.03
Trend *P*[c]		0.18	0.12	0.70	0.80	0.31

[a]This indicates number of physicians indicating they practice in the area of psychiatry from the AMA national database.

[b]Rates are per 1000 psychiatrists per year.

[c]P for amount of settlement was based on analysis of variance other P values were based on the Jonckheere-Terpstra test.

and state regulatory board settings. Our goal with this report is to compare the risk factors for these 2 settings.

METHODS

A literature search using PubMed was performed to identify studies of malpractice lawsuits or medical discipline of psychiatrists between 1990 and 2009. Search terms used were *physicians*, *discipline*, *psychiatrists*, and *malpractice*. We selected studies that had a representative sample base and empirical measures. We also used data from the insurance industry that was created for industry use but is available to the public.

Information from the National Practitioner web site is public record and was accessed online. The number of behavioral health disciplinary actions for physicians each year was divided by the number of physicians who indicated psychiatry as their primary area of practice in the American Medical Association tabulations of physicians.[1] Trends for the National Practitioner Data Bank (NPDB) data in **TABLE 1** are calculated by analysis of variance for amount of settlement and the remaining factors on **TABLE 1** by the Jonckheere-Terpstra test.

RESULTS

Seven reports of medical board discipline in different states in the United States were identified and one from the United Kingdom. Information was available from 4 insurance companies, an arbitration board, and 2 sets of aggregated insurance company data. NPDB information was tabulated for 2004 to 2009 (2004 was chosen as a starting point because it was the first year the NPDB used behavioral health as a variable).

Results from regulatory agencies

Medical boards.

COMPARISONS OF PSYCHIATRISTS BEING DISCIPLINED COMPARED WITH OTHER SPECIALTIES. There are 3 reports about actions of the California Medical Board. These indicate psychiatrists have an increased rate of discipline compared with other specialties. The first found an odds ratio (OR) = 1.47.[2] The second found an OR = 1.87.[3] The third found that psychiatrists appear twice as frequently in the disciplined group as the non-disciplined group.[4]

A report based on the Ohio medical board describes a trend toward a more psychiatrists being disciplined by the medical board (OR = 0.73), however this did not reach statistical significance.[5] The Oklahoma medical board report finds an increased risk of disciplinary actions against psychiatrists ($P < .001$).[6] A report based on the Texas medical board finds that psychiatrists were among the specialties at highest risk of license revocation (OR = 2.68)[7] (anesthesiologists and general practitioners also were among high-risk specialties).

A report based on the North Carolina medical board finds physicians with infractions against their licenses also have difficulty with substance abuse. The rate of impairment by substance abuse among psychiatrists is second only to that among anesthesiologists.[8]

A review on physicians in the United Kingdom with disciplinary problems finds psychiatrists represented the largest group of problem doctors (22%).[9]

EFFECT OF SEX. There may be a trend for males to have more disciplinary actions although this finding is not statistically significant in all studies. Morrison and Wickersham[2] find an increased incidence of disciplinary action among males; the OR for females being disciplined is 0.44. Kohatsu et al[3] find that males had an elevated risk of disciplinary action (OR = 2.76). Morrison and Morrison[4] find increased risk of males being disciplined by the medical board (P = .0002 by binomial proportions test).

Clay and Canatser[5] found a nonsignificant trend towards males having more disciplinary actions against them. Khaliq et al[3] found a nonsignificant trend (after Bonferroni correction) for more males being disciplined by the medical board.

EFFECTS YEARS IN PRACTICE. The 4 reports that discuss this issue have similar findings. Clay and Conatser[5] found that physicians who had been in practice ≥20 years were more likely to be subject to disciplinary action (OR = 1.51). Khaliq et al[6] reported that the proportion of physicians disciplined significantly increased with each successive 10-year interval since their first licensure. Kohatsu et al[3] find increasing age is a risk factor for disciplinary action (OR = 1.64). Cardarelli et al[7] find the longer a physician has been in practice the greater the risk that he or she would have a license revocation (OR = 2.68).

EFFECTS OF MEDICAL TRAINING. Clay and Conatser[5] found that psychiatrists who were disciplined were significantly less likely to be board certified (OR = 0.65). Morrison and Wickersham[2] found that board certification was negatively associated with the probability of discipline (OR = 0.42). Kohatsu et al[3] found increased chance of disciplinary action for graduates of international medical schools (OR = 1.36).

AREAS OF MOST FREQUENT CLINICAL DIFFICULTY. Morrison and Wickersham[2] find 34% of cases involved negligence or incompetence, 14% alcohol or substance abuse, 11% inappropriate prescribing, and 10% involved inappropriate contact with a patient. Morrison and Morrison[4] found 27% involved inappropriate conduct (sexual and nonsexual), 19% fraud, 17% negligence, 17% drug or alcohol impairment, 16% selling drugs, and 13% incompetence.

Substance abuse or inappropriate substance prescriptions are other problem areas. Morrison and Wickersham[2] reported that physicians' alcohol or drug problems accounted for 14% of complaints; inappropriate prescribing accounted for 11%. Clay and Conatser[5] reported that impairment due to drugs or alcohol (21%) and inappropriate prescribing (14%) are among the most common complaints. Nanton et al[8] find that among the most common infractions are alcohol/substance abuse (26%) and improper prescribing (22%).

OTHER PERTINENT VARIABLES. In general, these findings indicate that the more severe the patients' illness, the higher likelihood of legal action. However, this is not absolute. Slawson[10] found relatively few problems for psychiatrists performing electroconvulsive therapy (ECT) (also see Slawson and Guggenheim[11]).

Khaliq et al[6] report that patients found out about problems with their treatment from the general public (66%), other physicians (5%), and staff (4%).

Data from the NPDB. Data from the NPDB is in **TABLE 1**. The frequency of malpractice claims, license revocation and medical society expulsions is low in absolute terms. These rates do not show any significant change by year. Mean dollar settlement amounts were in the $200,000 to $300,000 range and did not vary by year.

Data related to malpractice

Data from individual insurance companies.

AMERICAN PSYCHIATRIC ASSOCIATION (APA) INSURANCE. We have 3 reports based on the APA insurance program. In a study of closed claims, Slawson[12] found areas of complaint are: ineffective or incorrect treatment (50% of cases; often involving medication use); incorrect diagnosis (10%); and improper detention in the hospital (9%). Patients who sued tended to have significant psychiatric illness. Complaints were filed in two-thirds of the cases; of these 21% settled; there was a summary judgment in 6% of cases; and only 2% were tried. The most costly claims were undue familiarity (highest) followed by suicide.

Meyer[13] reports loss information from the APA. Causes of loss are reported as: incorrect treatment (31%); suicide/attempted suicide (15%); other (15%); drug reaction (9%); incorrect diagnosis (9%); unnecessary commitment (6%); and improper supervision (6%).

The authors contacted the APA's insurance agency, which provided claim loss information for claims from Jan 1, 2007 to Dec 31, 2007 (policy years 1998 to 2007). Causes of loss are: incorrect treatment (25.28%); suicide/attempted suicide (21.06%); other (19.36%); confidentiality breach (17.32%); and drug reaction (9.62%).

PROMUTUAL INSURANCE GROUP. Meyer[13] reports loss information from the Promutual Insurance Group from 1996 to 2005. The causes of loss are: negligent treatment (27%); medication related (26%); failure to prevent suicide/homicide (14%); sexual misconduct (12%); other (10%); and failure to diagnose (6%).

NEW JERSEY INTER-INSURANCE EXCHANGE. Taragin et al[14] report the malpractice experience of physicians practicing in New Jersey. Male physicians were 3 times as likely to be in the high-claims group as female physicians (relative risk, 3.1). Specialty was strongly associated with claims rate and psychiatry had the fewest claims. The rate of claims varied with age ($P < .001$) and peaked at approximately age 40.

STATE OF MARYLAND ARBITRATION BOARD. Morlock et al[15] report on malpractice claims in Maryland. They find 27% of claims were dismissed, 35% settled privately, and 38% required a formal hearing; 47% of the claims at formal hearing were found in favor of the plaintiff. The most expensive case is a suicide followed by failure to diagnose and treat medical problems. Areas specific to psychiatrists are: suicide or attempted suicide (43%) and sexual relations with a patient (20%).

WARSCHAW INSURANCE AGENCY. Schwartz and Mendelson[16] report on the Warschaw Insurance Agency, which provides insurance for physicians who have difficulty getting insurance elsewhere (surplus insurance). Physicians age 45 to 54 were over represented but there was no difference in board certification or percentage of foreign medical graduates. Psychiatrists were under represented in this group.

Data from aggregated insurance company information.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 1974 TO 1978. Slawson and Guggenheim[11] report data from the National Association of Insurance Commissioners. This was a nationwide study reporting on the outcome of 217 malpractice actions against psychiatrists. Claims against psychiatrists represented 0.3% of the claims against all physicians although the percentage of physicians who were psychiatrists is not given (this could be estimated at 8%). Ten psychiatric procedures accounted for 50% of the psychiatric claims. The primary procedure categories associated with a malpractice suit were: use of medication (mainly psychoactive medication; 16%); patient examination (13.4%); psychotherapy (7.4%); and ECT (6%). The most frequent injuries found in psychiatric claims are diagnostic errors, followed by suicide and self-injury.

PHYSICIANS INSURERS ASSOCIATION OF AMERICA (PIAA) RISK MANAGEMENT REVIEW PSYCHIATRY 2006. The PIAA[17] pools data from the insurance industry to help members control risk. The data they report does not include APA insurance. Only claims are reported therefore percentage of problems by total number of insured cannot be calculated. This report included 1,513 psychiatric physicians. Only 1% of claims and 0.3% of indemnity dollars were attributable to psychiatry claims. In order of frequency, the most common "misadventures" of claims are "none" (no physician negligence; 36%), failure to supervise (16%), medication errors (15%), and errors in diagnosis (11%). Of the 2,121 psychiatry claims closed between 1985 and 2006, 43.1% involved performance of a psychological or psychiatric evaluation or psychotherapy.

The disorders with the highest average claims are bipolar disorder ($420,802), personality disorder ($130,385), major depression ($137,053), and neurotic disorder ($118,226). For 2001, the average indemnity payment for psychiatrists—$595,000—is 2-times higher than the overall average of $295,885. In 2006, the average indemnity paid on behalf of psychiatrists is $506,250. This payment value is 1.55 more than the overall average indemnity paid for all physician specialties ($317,239).

A summary of the key empirical findings can be found in **TABLE 2**.

DISCUSSION

Overall, in spite of higher payouts, psychiatrists do not appear to be a major driver of malpractice costs. Paradoxically, they do seem to have more complaints at the state board level.

Examining the data for regulatory agencies provides some significant contradictions. In medical board discipline, psychiatrists appear to have more legal difficulties than their numbers would warrant. However, when examining the NPDB data, there appears to be a reverse finding. This raises the question as to whether there is a bias as to which doctors and specialties are reviewed by each agency.

One data analysis indicates there may be a bias. Levine et al[19] found that less than one-half of doctors disciplined by medical societies or hospitals and are reported to the NPDB also are reported to state medical

TABLE 2
Summary of findings from Empirical Studies of Psychiatrists Legal Difficulties

Findings from regulatory agencies
A. Medical board findings
1. Psychiatrists are more likely to be disciplined by medical boards than other specialties.
2. Women psychiatrists had fewer medical boards disciplinary problems than men.
3. Drug and alcohol problems were major causes of discipline followed by negligence and incompetence. (quality of care and medication were often issues.)
4. Board-certified physicians had fewer medical board problems.
5. Longer time in practice was correlated with greater medical board problems.
6. Prior discipline by a medical board predicted future discipline.
B. Findings related to the National Practitioner Data Bank
1. Psychiatrists have a relatively low frequency of legal problems and this frequency does not appear to be changing over time.
Findings related to malpractice
1. Among physicians psychiatrists accounted for a small amount of insurance premiums paid out and most cases were dismissed or settled. However, payment could be above average for successful cases against psychiatrists.
2. Severity of injury was associated with malpractice suits with suicide attempt or completion leading causes.
3. Other high frequency causes of problems were incorrect diagnosis, incorrect or ineffective treatment (including medication errors), improper detention and inappropriate sexual behavior.
4. Physicians in practice longer had a greater chance of difficulty with malpractice suits.
5. Board-certified physicians had fewer malpractice actions.

boards. If this was correct, the lack of full reporting of incidents to state medical boards and to the NPDB creates the possibility of bias. This could lead to certain types of cases being over-represented at the state level and others being under-represented. What form these biases may take would have to be determined by future research. In addition to a bias in reporting, there is the possibility is that some actions by psychiatrists (sexual relations with a patient) are legal problem areas but are not for non-psychiatrists. This also would cause over-representation of psychiatrists at the state level.

Our best guess is that the disparity between board discipline and NPDB information is because of a combination of the above factors. This would be differential reporting of cases to the medical board and NPDB, the possibility that some actions of psychiatrists with patients are problematic in ways that would not be a problem for other physicians (ie, social or sexual patient contact) and perhaps the emotional nature of the claims creating a greater sense of urgency to report them. Possibly if all of the above were accounted for we would have to consider that psychiatry, being a highly stressful specialty, might have increased rates of burnout with attendant performance and legal difficulties.

Psychiatrists tend to be responsible for a relatively small amount of malpractice claims, which is consistent with the NPDB data (occasionally there are high payouts). Generally, in malpractice, the greater the patient disability, the greater chance of insurance payout.

There are common areas of difficulty in both the regulatory board and malpractice settings that deserve discussion. In both settings not being board certified and being longer in practice led to greater legal difficulties. Board certification seems straightforward. This represents a degree of advanced study or training necessary to pass the boards. It is likely that board certification is a proxy for a higher level of training. One possible conclusion is that policies that encourage advanced training or continuing education might reduce the profession's legal problems (in the PIAA data 71% of psychiatrists were board certified compared with 78.7% of other specialties).

The issue of physicians being at higher risk for legal problems the longer they are in practice is an interesting one. Because most studies that report more legal difficulties for physicians who have been in practice longer compare these physicians with their colleagues during a set time period, not for the duration of their career, it appears that this is a valid finding. The cause of this finding is not known. It could be that there is a decrease in continuing education over time. The rapid change in the psychiatric field going from psychoanalysis to empirically based medicine also could be a factor. Possibly there is some form of physician "burn out" that occurs after many years of practice. This is an area that would need to be clarified in future research.

There also are differences in the different settings: medical board, NPDB, and malpractice. In medical board findings, there is a trend for fewer discipline problems for females and more for international medical graduates. These findings do not appear consistently in the malpractice data.

The available data show the need for psychiatry to collect and periodically report comparable empirical data that would allow the field to determine areas of weakness, areas of strength, and significant practice trends. Ideally similar data for different specialties should be collected in ways that could be compared directly, perhaps over set intervals. For now we should be careful in the conclusions we draw because of the possibility of bias.

There are other possible areas of investigation suggested by the data. One is to examine the amount of money received by psychiatrists from pharmaceutical firms to see if it is higher than other specialties. One report indicates this may be the case.[18] In addition, how the patient finds out about the problem may have significant implications for legal outcomes. The report from Khaliq et al[6] indicates that this often is not the treating physician. One study where the physicians quickly informed the patient of medical errors finds this creates fewer malpractice problems.[20]

Overall, it appears that we have enough information to see possible problem areas the field will need to address.

Limitations of this report include data taken from groups of potentially differing in demographic or other components such as years surveyed. These differences prevent the various studies from being directly compared and they cannot be analyzed by a meta-analysis. The data from medical boards, NPDB, insurance companies also are different. Because of the variations of methods within each group as well as differences between the medical board and insurance company data there could be no overall statistical analysis, only a descriptive review of the empirical literature was possible. Space limitations prevented extensive discussion of individual studies cited from the literature, but the information is contained in a previous report.[21] Overall, it appears that we have enough information to see possible problem areas the field will need to address. ■

DISCLOSURE: The authors report no financial relationships with any company whose products are mentioned in this article or with manufacturers of competing products

ACKNOWLEDGEMENT: The authors would like to acknowledge the help of Elizabeth Stickman, MSW, MPH Research Associate, Practice Research Network Program Manager, Office of International Activities American Psychiatric Association.

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