

# Malpractice Claims against Psychiatrists Related to Psychopharmacologic Agents: File series

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## ÖZET:

Psikiyatristlere psikofarmakolojik ajanlarla ilişkili açılan malpraktis davaları: Dosya serileri

**Amaç:** Psikiyatristlerin diğer uzmanlıklara göre en az dava edildikleri düşünülmektedir. Yirmisekiz tıp uzmanlığı içinde psikiyatri açılan malpraktis dava sayısı açısından 22. sırada gelmektedir. Biz, Türkiye’de psikofarmakoloji ile ilişkili psikiyatristlere açılan malpraktis dava konularını araştırmayı amaçladık.

**Yöntem:** Olgular Adli Tıp Kurumu’na psikiyatrik ve adli tıbbi bilirkişilik için mahkeme tarafından gönderilen 2003-2012 yılları arasındaki dosyalardan seçildi. Çalışmaya yalnızca psikofarmakolojik ajanlarla ilişkili dava dosyaları alındı.

**Bulgular:** Çalışmaya dahil etme ölçütlerine göre sekiz malpraktis davası saptandı. Dava dosyalarının üçü kadın ve beşi erkek hastaya aitti ve dördünde depresyon ve geri kalan dördünde ise şizofreni tanıları vardı. Reçete edilen ilaçlarla ilgili dördünde yanlış tedavi, birinde ihmal ve yanlış tedavi, birinde ciddi ilaç yan etkisi, birinde ölümden sorumlu tutulma ve birinde kötülük görme yakınması saptandı.

**Sonuç:** Psikiyatristlere karşı malpraktis davaları artmaktadır ve bu konunun psikiyatristler üzerine negatif etkileri olabilecektir. Bu nedenle, psikiyatristler malpraktis konuları hakkındaki farkındalıklarını artırmalıdır.

**Anahtar sözcükler:** malpraktis konuları, psikiyatri, tazminat davaları, dava

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## ABSTRACT:

Malpractice claims against psychiatrists related to psychopharmacologic agents: file series

**Objective:** Psychiatrists are considered to be the least frequently sued among other medical specialties. Of the 28 medical specialties, psychiatry ranked 22<sup>nd</sup> in terms of number of malpractice claims. We aimed to investigate psychopharmacotherapeutic malpractice claims against psychiatrists in Turkey.

**Methods:** Data from claim files were extracted between the years of 2003 and 2012 in which expert witness testimony of psychiatrist and forensic specialists in the Council of Forensic Medicine were requested by the court. Only, claim files about psychopharmacotherapeutic issues were included in the study.

**Results:** There were eight malpractice claim files selected according to the inclusion criteria. There were 3 female and 5 male patients in the related claims; four of them had a diagnosis of depression while the remaining four had schizophrenia. Four wrong treatments, one neglect and wrong treatment, one severe adverse effect, one accountability for death, one persecutory complaint about the prescribed drugs were cited in the claims.

**Conclusion:** Malpractice claims against psychiatrists have been rising and this issue might have some negative influences on interrelations between psychiatrists. Therefore, psychiatrists should improve their awareness about malpractice subjects.

**Keywords:** malpractice issues, psychiatry, indemnity payment, claim

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## INTRODUCTION

The injury rate caused by physicians of all medical specialties has been reported to be 20 times more than the number of malpractice suits in New York, in a study conducted by Harvard

University in 1991 (1). However, this ratio might be less, since there is a tremendous interest in medical malpractice throughout the world. The data about the proportion of clinicians who are sued for malpractice, the amount of settlements based on practice specialty and the incidence of

being sued during the course practicing a specific specialty is lacking (2). In a 15 year follow up study, 7.4% of all clinicians were reported to have a malpractice claim every year and the proportion of physicians exposed to a claim in each year ranged between 19.1% in neurosurgery, 18.9% in thoracic-cardiovascular surgery, 5.2% in family medicine and 2.6% in psychiatry (2). Nevertheless, during the study period, only 22% of those claims led to payments annually (2). Strikingly, specialties in which clinicians were most likely to face claims were often not specialties in which indemnity claims were most prevalent. For example, the average settlement for neurosurgeons who were sued for malpractice was found to be less than the average payment for pathologists or pediatricians who were infrequent subjects of malpractice claims (2).

Psychiatrists are considered to be the least frequently sued among other medical specialties. In a comprehensive review, of 28 medical specialties, psychiatry ranked 22<sup>nd</sup> according to number of malpractice claims and 24<sup>th</sup> in amount of paid; monetary settlements were calculated to be 35% less than indemnity payments calculated for other specialties (3). However, in recent years, malpractice claims against psychiatrists have been increasing in number. The annual number of respondents was 1 in 25 psychiatrists twenty years ago, while this ratio has increased to 1 in 12 psychiatrists five years ago (3). Some possible causes of actions against psychiatrists include: suicide (4), medication adverse effects (3), electroconvulsive therapy-related adverse effects (5), sexual misconduct (6), lack of informed consent (7), negligent psychotherapy (8), false imprisonment, breach of confidentiality and negligent supervision (9). In Turkey, there have been no studies about malpractice issues (i.e., frequency of claims, amount of payment, causes of claims etc.) in psychiatry. Thus, in the current study, we aimed to investigate the content of malpractice claims against psychiatrists related to psychopharmacotherapeutic issues in Turkey.

## METHODS

The data were extracted from filed claims dated between the years of 2003 and 2012 in which expert witness testimony by psychiatrist and forensic specialists in the Council of Forensic Medicine have been requested by the court. Only, filed claims about psychopharmacotherapeutic issues were included in the study and the malpractice claims which were not relevant to direct psychopharmacotherapeutic outcomes or consequences were excluded. There were eight malpractice claim files according to the inclusion criteria. The local ethics committee of the Council of Forensic Medicine approved the study.

## DISCUSSION

Placing all-encompassing responsibility on the psychiatrist and reducing the personal responsibility of the patient can force the therapist to make defensive medical decisions, consequently limiting the range of appropriate and correct interventions (10) and significantly influencing career satisfaction (11). Furthermore, although physicians may insure against indemnity payments through malpractice insurance, they are unable to insure against the indirect costs of litigation, such as time, stress, added work, and reputational damage (2).

As abovementioned, the most frequent psychiatric malpractice claim is reported to be completed suicide and the highest amount of judicially appraised indemnity payments are for completed suicide or suicide attempts which leave the patient severely injured (3). Thus, the risk of a further suicide attempt, even when appropriate treatment is under way, remains the greatest fear for psychiatrists. In this study, the issue of a claim against a psychiatrist was completed suicide by jumping in which this act was linked to the use of an antidepressant drug that made the patient more liable to such an attempt during the course. Although suicide is more prevalent in psychiatric disorders such as schizophrenia or affective disorder, in human beings, suicide is universally

## RESULTS

| No. | Characteristics of the case   | Event   | Subject of the claim   | Drug  |
|-----|---|---|--|---|
| 1   | 20 year old, female, diagnosis of depression,   | Antidepressant prescription and manic shift within three weeks  | Wrong treatment  | Fluoxetine  |
| 2   | 57 year old, male, complaining of anxiety, uneasiness, insomnia   | Beneficial adverse sedative effect of antidepressant, transient ischemic attack after 2 days , aortic stenosis was detected and no permanent injury was found   | Wrong treatment  | Mirtazapine   |
| 3   | 18 year old, female, diagnosis of depression, no report of follow up visits, no report of treatment adherence | Completed suicide after 4 months by jumping   | "The liability to suicide attempt is mentioned in the prospectus of this drug, thus wrong treatment" | Specific serotonin reuptake inhibitor   |
| 4   | 35 year old, female, obese, diagnosis of schizophrenia, acute excitation,                                     | Intra muscular (IM) antipsychotic drugs administered twice in 45 minutes. Death in the way home in ambulance.   | Wrong treatment  | Haloperidol and biperiden   |
| 5   | 45 year old, male, diagnosis of schizophrenia   | Death after a few days of hospitalization while receiving IM antipsychotic drugs. Cardiac arrest due to adverse effect of drugs?  | Wrong treatment and neglect of other health issues   | Haloperidol and biperiden   |
| 6   | 41 year old, male, diagnosis of resistant depression,   | Titrating up the drugs during 4 week hospitalization. A few days after discharge, sore throat, itching, xerophthalmia, oral apthae, severe skin rash and diagnose of Stevens Johnson Syndrome. No sequelae were detected after recovery | The severe adverse effect of treatment   | Fluoxetine and lamotrigine  |
| 7   | 24 year old, male, single, diagnosis of schizophrenia with paranoid features                                  | Prescription of antipsychotic drugs,  | "purposing to impotence by prescribing such drugs" congruent with thought content                    | Haloperidol and biperiden   |
| 8   | Diagnose of schizophrenia, hospitalization,   | Deaths of 5 cases due to use of concurrent polypharmacy and 6 suspicious deaths due to such polypharmacy  | "doctor is responsible for deaths"   | Concomitant use of haloperidol + biperiden + chlorpromazine, olanzapine 10mg 3x1 IM, olanzapine 20 mg/day, amisulpride 1200mg/day, and ECT sessions |

independent from psychiatric morbidity (10). Even in the legal system suicide is accepted as an irrational act by an individual who is not responsible for their actions. Thus, the status of suicidality is believed to be dichotomous; either the person is suicidal or not, rather than a

continuous spectrum (10). In addition, there is no model for assessment of suicide risk that has been proven to be more effective than others. Thus the assessment should include the following: i) clarification of various suicidal expressions such as thought, intention, plans; ii) assessment of risk

factors such as prior suicidal behaviors, psychotic features or disorders, stressful events; iii) protective factors such as loved ones, therapeutic relationship (10). Usually, claims against a psychiatrist for suicide occurring outside the healthcare establishment appear to be less likely. It is difficult to establish liability for inadequate supervision of a patient no longer in one's care as was the statement in this malpractice case. If psychiatric assessment of the patient at admission conforms to standard medical practice, it would be difficult to uphold a claim of misdiagnosis given the multiple and intricately linked factors that can lead to self-aggressive behavior (12).

In the judicial system, psychiatrists are determined to be either accountable or not for injury to patients resulting from medical error. Psychiatrists may not be accused for some errors because their knowledge of a particular patient is understandably limited. Each patient has a unique history and has specifically different physiology than others (3). In the current study, there were three cases related to the unknown physiology of those particular patients. Here we report a patient who had a history of transient ischemic attack that was misattributed to mirtazapine use in which undetermined aortic stenosis was responsible. Haloperidol and biperiden IM that are known to have a wide therapeutic range were accused for the deaths of two schizophrenic patients (1 female / 1 male). However, reviewing the possible predictive factors of QTc prolongation such as female gender, old age, and treatment with clozapine, chlorpromazine or thioridazine (13), performing an ECG and measuring electrolytes should be done in patients taking psychotropic drugs when additional risk factors are present (14). Nevertheless, complete knowledge about the patient is impossible. Thus, if an unwanted result occurs in one of these contexts, the fault is not thought to be due to any knowledge defect or clinical misstep on the part of the psychiatrist but rather to the unavoidable vagaries of the treatment context.

Furthermore, psychiatrists may not be considered responsible for errors that result from

unavailable information because of limited scientific knowledge. Nowadays, the etiologies of and optimal treatments for many disorders in psychiatry are still undiscovered. The best known treatments in psychiatry sometimes may cause significant adverse effects, and may be partially effective or may be a failure. In this study, a manic shift due to antidepressant use was also the subject of a malpractice claim. In the bipolar literature, the frequency of type I and II bipolar disorders (BD-I/BD-II) is accepted as being significantly underestimated (15) because patients with BD are frequently misdiagnosed with major depressive disorder (MDD) and may receive inadequate or inappropriate treatment as a consequence (16). Despite some differences (i.e., greater severity, more atypical symptomatology, more previous depressive episodes, early onset of depression age, more psychotic symptoms in bipolar depression) a cross sectional categorical distinction between bipolar and unipolar depression is impossible according to our current scientific knowledge level (17). Although tricyclic antidepressants and venlafaxine have been reported to be more likely to lead a manic switch than serotonin reuptake inhibitors (17), fluoxetine was blamed for the manic switch in the current case report. Thus, although a manic switch due to antidepressant use is a well-known state, unfortunately the etiology, prevention or ability to predict such a state is not well clarified due to the limitations of scientific knowledge. Secondly, one patient developed a skin rash that was diagnosed as Stevens Johnson Syndrome which is an infrequent and well described adverse effect of lamotrigine. However, dosing (slow titration as in the index case), prompt recognition, and patient education are crucial for preventing morbidity and mortality associated with the development of serious cutaneous reactions (18). In the light of evidence, a psychiatrist could not be expected to do more than what is recognized by health authorities.

In the judicial system, sources of reliable and authoritative statements on clinical care, available for reference including leaflets of pharmaceutical products and warnings, the Physicians' Desk

Reference???, textbooks, research articles, and clinical practice guidelines (3). In this study, a malpractice claim against a psychiatrist was found who had an unusual approach of polypharmacy to the psychiatrically ill patients and whose deaths (n=5) and suspected deaths (n=6) were attributed to concomitant use of multiple drugs plus electroconvulsive therapy. In the literature, serotonin reuptake inhibitors and both atypical and typical antipsychotic drugs have been suggested to be strongly related to an raised risk of sudden death due to prolonging of the QT interval (19). In addition, the use of different psychotropic drugs in combination or concomitant use with other medical drugs may have unpredicted interactions and may result arrhythmia (20). Clinical practice guidelines are “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances”, although the American Psychiatric Association (APA) has explained in a Statement of Intent for its clinical practice guidelines in 2007 that “The APA Practice Guidelines are not intended to be construed or to serve as a standard of medical care ... The ultimate

judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available” (21). In addition, one may refer to evidence based medicine while treating the patient. Nevertheless, relying on a particular medical text in forming an opinion should be carefully considered, as the selection or use of an unreliable or untrustworthy text may undermine the credibility of the expert’s testimony (22). However, in the malpractice claim against that psychiatrist, it is clear that he had departed from the acceptable standard treatment practice according to psychopharmacologic treatment guidelines or evidence based medicine.

In conclusion, malpractice claims against psychiatrists are rising and this issue might have some negative influences on relationships between psychiatrists and patients. Therefore, psychiatrists should be aware about malpractice subjects and should have more detailed knowledge of facts (i.e., history taking, physical examination, laboratory assessment etc.) about the patient even when prescribing conventional drugs.

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