Psychiatric Malpractice Case Analysis: Striving For Objectivity

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Forensic psychiatrists, acting as expert witnesses, must be able to perform objective analyses of psychiatric malpractice cases. Accurate malpractice case analysis requires careful attention to relevant legal concepts and consideration of potential biasing influences. If forensic psychiatrists are to avoid a reliance on "experts policing experts," individual forensic psychiatrists must be fully prepared to police themselves by recognizing and avoiding certain errors in malpractice case analysis. Any effort to improve objectivity must include a clear understanding of the confounding variables. In this article, the authors discuss some potential impediments to objective analysis of malpractice cases such as the use of the wrong standard, causation, hindsight bias, and contributory negligence.

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Shortly after his last session with Dr. Liptzin, patient Wendall Williamson elected to stop taking his antipsychotic medication. Eight months later, his persecutory delusions returned in full force. Williamson then took to the streets of Chapel Hill, North Carolina, with an M-1 rifle. He was able to kill two strangers and wound a police officer before being shot by police.[1] In consideration of his persecutory delusions, a jury found him Not Guilty by Reason of Insanity for the shootings, and he was committed to a state hospital.

While in the confines of the state hospital, Williamson decided to sue Dr. Liptzin, alleging that it was Dr. Liptzin's negligent care that caused the tragedy. Williamson's attorney hired psychiatric experts who testified to several alleged flaws in Dr. Liptzin's treatment. In 1997, a jury found against Dr. Liptzin and awarded Williamson $500,000. Several years later, the North Carolina Court of Appeals reversed in favor of Dr. Liptzin, holding that the psychiatrist's "alleged negligence was not the proximate cause of plaintiff's injuries."[2]

After *Williamson v. Liptzin*[3] came to the attention of the psychiatric community, one scholar noted a shift among forensic psychiatrists toward emphasizing procedure over substance in their analyses of malpractice cases. Yet other than anecdotal experience, there are no data to use in analyzing this trend. The case and its implications for expert witnesses led to ardent discussion among psychiatrists. One theme seemed to have emerged strongly: Are forensic psychiatrists approaching malpractice cases competently and objectively? The question seems to be a timely one, given that expert witness liability is now a prominent concern. Both the medical profession and the courts have raised questions concerning "irresponsible" testimony, and the need for professional organizations to "police" expert testimony.[4] This recent trend has resulted in an increased scrutiny of medical expert testimony by medical associations, whose intent is to sanction physicians who provide irresponsible testimony.[5]

The intent of this article is not to analyze expert testimony in *Liptzin*. Instead, it seeks to use the controversy of the case's aftermath as an impetus for improving malpractice case analysis. It is not uncommon for malpractice case analyses to be rather complex and fraught with confusing circumstances that may be subject to personal bias. Even the most well-intended expert may be thwarted by subjectivity and cognitive illusions. The path toward objectivity must be cleared of such obstacles.

Forensic psychiatrists are crucial to both the plaintiff's and the defendant's cases. A skilled forensic psychiatrist can provide a thorough analysis of the case that will be helpful in establishing or refuting each of the four elements of negligence: (1) duty of care, (2)

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deviation from the standard of care, (3) damage to the patient as a (4) direct result of the deviation from the standard of care. At least in theory, the special knowledge and training possessed by forensic psychiatrists should involve a higher degree of accurate and well-reasoned analysis. The purpose of this article is to discuss some of the potential pitfalls that forensic experts may encounter when analyzing malpractice cases and to consider ways to avoid error.

Using the Wrong Standard

Even among forensic psychiatrists, there may be considerable confusion about what standard of care to use when analyzing a psychiatric malpractice case. Indeed, Stone[3] has pointed out that "the standard of care in psychiatric treatment, which is the central question in malpractice cases, is by no means the 'natural' province of the subspecialty of forensic psychiatrists" (Ref. 3, p 452). In an effort to seek current guidance from the literature, we performed a literature search on Medline with the search terms "medical malpractice" and "standard of care." The search resulted in 171 citations, with only two being directly relevant to forensic psychiatrists. One of these two references notes that the applicable standard in medical malpractice cases appears to be in the process of shifting and developing.[6] Confusion about the appropriate standard may lead the forensic expert to apply the wrong standard in certain circumstances. For this reason, it is critical to begin the analysis of a case with as clear an understanding of the prevailing standard as possible.

To clarify the concept of medical negligence, it is helpful to distinguish it from ordinary negligence. In ordinary negligence cases, a breach of duty is established by offering proof that the defendant did not use "reasonable care under the circumstances, that which an ordinarily prudent person would exercise in similar circumstances."[7] Establishing this standard does not require expert testimony, as a jury can determine on its own what an "ordinarily prudent person" would do. In contrast, medical negligence is traditionally defined as "that degree of skill and learning that is ordinarily possessed and exercised by members of that profession in good standing."[8] This standard emphasizes the physician's responsibility to take steps to ensure reasonable training and skills and to practice in a manner that is consistent with others in the field. This standard is also known as the "average practitioner" or "customary practice" standard. While standards of medical negligence are generally national in origin, some jurisdictions may apply a local or regional standard.[9]

The standard of care in malpractice cases usually cannot be proven without the testimony of an expert witness. The expert testifies as to the relevant standard, which is generally established by professionals in the field, learned treatises and statutes. This practice allows physicians to set their own standards for liability and, in effect, to police themselves. Several reasons for this special distinction have been offered, including the notion that peer review, professional boards, and organizations within the medical profession are already compelling doctors to practice safely and competently. However, as public faith in medicine has declined, the customary deference to physicians has begun to wane. This may be reflected in the move away from the "average practitioner" standard, and toward a "reasonably prudent practitioner" standard.[10]

Under the reasonably-prudent-practitioner standard, a physician can be held liable if a plaintiff proves that the physician failed to provide reasonable and prudent care in light of all the circumstances, even though the physician did, in fact, adhere to the customary practice of the average physician in the field. Consider a case in which a psychiatrist treats his patients with a new antipsychotic drug that has some risk of causing fatal arrhythmias in some patients with a history of heart disease. Prudent evaluation would include a review of the patient's cardiac history, along with an ECG and blood work. Suppose, however, that the customary practice in busy community clinics is to forgo a routine ECG, and evaluate risk based on patients' histories, accompanied by a review of any available medical records. If a patient in the community clinic died from a fatal arrhythmia after taking the medication and her family sued, the psychiatrist could be liable under the reasonably-prudent-physician standard, yet not under the average-practitioner standard.

According to one analysis of published malpractice cases and statutes, the average-practitioner standard is no longer clearly the majority rule.[11] In more than half the states, either through an explicit statutory change or through case law, malpractice law has moved away from a customary-practice standard, and toward a reasonably-prudent-physician standard. Note that the reasonably-prudent-physician standard still requires expert testimony to educate

the jury about appropriate practice. However, the experts do not *de facto* decide the standard as they do under the average-practitioner standard. Rather, it is the jury who ultimately determines the standard, based on their interpretation of what was reasonably prudent under the circumstances. Expert testimony about general custom would be relevant evidence of due care, but it would not be conclusive and could be overcome by expert testimony that the general custom itself is negligent.

In effect, juries will continue to "stand in the shoes of the physician but only to hold the defendant to the standard of care expected of a person with special skills, not to immunize physicians who follow the pack" (Ref. 11, p 163). Because the standard has changed in many jurisdictions, either by legislature or through case law, it is important to consult with the retaining attorney to clarify what standard is the prevailing one in the relevant jurisdiction before beginning the review of a malpractice case. In particular, experts should review the specific case law or statutory language that is determinative of the standard of care in the jurisdiction where the case occurred.[12]

When clarity surrounding the appropriate standard is lacking, experts may mistakenly apply a "standard of excellence," instead of a standard of average or reasonably prudent care. The use of an unreasonably high standard may be seen among experts who work primarily in an academic setting, or among those who have recently completed their training. Routine exposure to cutting-edge research, new treatment algorithms, and excellence in mental health care may have the effect of raising the expert's personal standards of care. In addition, trained forensic psychiatrists, who tend to be hypervigilant to risk and procedure, may mistake the standard of care for what they would have done in the same circumstances. The use of an unreasonably high standard may also occur when expert witnesses testify outside their area of expertise and thus have little understanding of how the average, reasonable psychiatrist in that area would practice.[13]

The use of an inappropriately high standard may also stem from a cognitive illusion called "egocentric bias." Egocentric bias is a well-researched psychological phenomenon in which people overestimate their own abilities and make self-serving judgments.[14] For example, people routinely estimate that they are above average in a variety of desirable characteristics, such as driving or having a successful marriage.[15,16] The expert who approaches a malpractice case with an exaggerated, unrealistic view of her own practice has an increased likelihood of performing an unreasonable or overly critical analysis. Therefore, forensic experts should not use their personal abilities and standards as a measuring stick for the standard of care.

The following case illustrates the error of using the wrong standard when analyzing a psychiatric malpractice case.

Case A

A patient was admitted to a psychiatric unit for treatment of acute psychosis. In addition, the patient had a history of diabetes insipidus, caused by neurosurgical trauma to the pituitary gland that occurred years earlier when a brain tumor was removed. As a result, the patient required daily doses of the hormone vasopressin to prevent dehydration. The attending psychiatrist had requested an endocrine consultation and carried out all of the consultant's recommendations. One week after the patient's admission, the hospital pharmacy ran out of vasopressin. Neither the pharmacy nor the nursing staff reported this to the attending psychiatrist. The patient quickly became dehydrated during the evening shift and died.

Plaintiff's expert, Dr. A., was an academic neuropsychiatrist who specialized in the area of neuroendocrine disorders. Dr. A. opined that the attending psychiatrist deviated from the standard of care by failing to educate hospital staff about diabetes insipidus, the action of antidiuretic hormone, and the mechanics of fluid and electrolyte balance. Dr. A. believed that if the attending psychiatrist had properly educated the hospital staff, they would have understood the seriousness of the medication shortage. Dr. A. concluded that once the staff had been armed with an adequate knowledge of the disease process, a timely response preventing the patient's dehydration would have been likely.

In this example, the expert applied a standard of excellence, as opposed to a standard of average or reasonably prudent care. Dr. A. believed that the defendant doctor should have personally ensured all hospital staff's knowledge of the neuroendocrine disorder. Dr. A.'s expertise in neuroendocrine disorders raised her own personal standards, leading her to have unrealistic expectations of the defendant doc-

tor. Her bias toward a standard of excellence in treating neuropsychiatric illness clouded her analysis, obscuring an objective consideration of causation. When experts use too high a standard in analyzing a malpractice case, they are vulnerable to attacks during cross-examination that are designed to expose bias and idiosyncratic beliefs. This type of error is best avoided by becoming familiar with the applicable standard (average practitioner or reasonably prudent practitioner), avoiding the use of a standard of excellence, and remaining sensitive to the effects of egocentric bias.

In the authors' experience, disregarding the standard is a less frequent, though not uncommon, variant of using the wrong standard. Experts who may harbor a biased agenda of "defending" the defendant doctor are susceptible to this error. The following case illustrates the error of disregarding the relevant standard of care.

Case B

Ms. B. drove herself to the emergency room (ER) of a large metropolitan hospital. She had taken the day off from her job as a schoolteacher because she was having difficulty organizing her lesson plans. She complained to the emergency room psychiatrist on duty that she felt exhausted and sleep deprived and was having trouble keeping her mind focused. She repeatedly expressed concern about her job performance, and asked, "Do you think I am losing my mind?" She reported that her symptoms had begun shortly after the death of her father approximately 4 months prior.

On evaluation, Ms. B. denied having any mental illness before her father's death. She denied feeling depressed and said she had never attempted suicide. The ER psychiatrist's mental status exam documented that Ms. B. was fully oriented. She was described as "moderately agitated and rather circumstantial." The ER psychiatrist diagnosed Ms. B.'s problem as "complicated bereavement" and gave her a referral to a therapist who specialized in grieving. Within an hour of her discharge, Ms. B. walked to the top of the six-floor hospital parking garage and jumped to her death. The ER psychiatrist's notes did not reflect an assessment of risk beyond the statement, "Denied suicidal ideation."

Ms. B.'s husband brought suit against the psychiatrist and the hospital. The plaintiff's expert opined that the ER psychiatrist deviated from the standard of care by failing to perform an adequate suicide risk assessment, in addition to failing to diagnose and treat Ms. B's psychiatric condition properly. The plaintiff alleged that had Ms. B.'s husband been contacted, the ER psychiatrist would have learned that over the past two weeks, Ms. B. had twice been rescued by her family after walking into heavy traffic and had paced erratically through her house during the night, sleeping little if at all.

The defense expert opined that Ms. B.'s suicide was not reasonably foreseeable by the ER psychiatrist and supported his opinion primarily with the ER psychiatrist's documentation that Ms. B. had denied having thoughts of suicide. On direct examination, the defense expert stressed the inability of psychiatrists to "predict" suicide, as well as the impracticality of calling family members of every patient admitted to a busy emergency room. On cross-examination, he refused to concede that Ms. B's previous dangerous behavior would be considered a significant risk factor. He acknowledged having testified as a defense expert in over two dozen malpractice cases and having never testified as a plaintiff's expert.

In this case, the defense expert focuses on one piece of documentation, to the exclusion of the broader matter of standard of care, which in this case calls for an adequate suicide risk assessment. While the standard of care does not require the psychiatrist to predict suicide, it does require an adequate assessment of suicide risk.[17] In essence, the defense expert disregarded the appropriate standard of care in an effort to defend the ER psychiatrist. Because the expert's usual motivation for disregarding the standard is a biased agenda, his testimony is likely to be vulnerable on cross-examination, and his opinion may lose credibility with the jury.

Failure to Address Causation

> "Proof of negligence in the air, so to speak, will not do."
> —Sir Frederick Pollock[18]

In approaching any forensic analysis, it is important that the expert connect psychiatric findings to the pertinent legal issues.[19] In cases of psychiatric malpractice, causation is perhaps the legal issue of greatest consequence. If forensic psychiatrists are to make objective and ethical use of their specialized knowledge, they must be familiar with the concept of causation. A forensic expert's neglect of the critical role of causation may either be deliberate or due to an

inadequate understanding of the concept. To prove causation in a negligence action, the plaintiff must prove that the defendant's act or omission was not merely the cause-in-fact of the harm, but the proximate (or legal) cause of the harm. Thus arises a common argument by defendants: that there was no legal cause linking the deviation from the standard of care to the plaintiff's damages. The cause-in-fact (also known as the "actual cause") is defined as the cause without which the event could not have occurred. It is the necessary antecedent to the injury. The cause-in-fact is sometimes articulated as the "but for" test: but for the defendant's act of negligence, the injury would not have occurred.[20]

Even when it is clear that the defendant's acts or omissions were the cause-in-fact of the injury, the plaintiff must prove that the acts or omissions were the proximate cause of the injury. Proximate cause or "legal cause" is a less concrete concept than the cause-in-fact and it constitutes a legal term of art, prone to considerable misunderstanding. Proximate cause is defined as "any original event, which in natural unbroken sequence, produces a particular foreseeable result, without which the result would not have occurred" (Ref. 21, p 17). For the purpose of conceptualizing proximate cause, the legal perspective views the causes of any given event as extending infinitely into the past, just as the results of any given event extend infinitely into the future. For reasons of practicality and societal fairness (the two may be the same or they may compete), the law must decide upon a dividing line along the continuum of cause and effect to come to a dispositive judgment.[1,9] Guided by notions of fairness, the law generally holds that a defendant should not be liable for far-reaching and improbable consequences of his or her acts or omissions.[22] Proximate cause, therefore, can be described as a policy determination that a defendant, even one who has behaved negligently, should not always be liable for his acts or omissions.

Two important concepts may support a defendant's claim that her acts or omissions were not the proximate cause of a plaintiff's damages: the presence of an intervening cause and the lack of foreseeability. Both intervening cause and foreseeability are elusive and complicated concepts. An intervening cause is an event that takes effect after the defendant's negligence, thus breaking the chain of causation. The intervening cause often rapidly precipitates the injury and may well supersede the defendant's negligence in causing the plaintiff's injury. For example, consider the case of a psychiatric inpatient with suicidal ideation who is slowly improving with treatment. He has improved to the point that he no longer has suicidal intent and no longer requires constant observation. During visiting hours one evening, his spouse unexpectedly takes the opportunity to tell him that she has decided to leave him. The patient promptly returns to his room, writes a brief note expressing anger toward his spouse, and commits suicide by hanging. In this example, the spouse's message of rejection was an intervening cause that rapidly precipitated the suicide. This intervening cause was not reasonably foreseeable by the patient's psychiatrist.

Cases involving foreseeability hold that defendants shall be liable only if the consequences of the act or omission were reasonably foreseeable. The concept of negligence requiring foreseeability has long been established, and, in the well known tort case *Palsgraf v. Long Island Railroad*,[23] it was given close scrutiny. In this case, a man who was running to board the defendant's train seemed as if he was about to fall. One of the railroad's employees attempted to push the man onto the train from behind to prevent the man from falling. As a result, a package was dislodged from the passenger's arms. The package contained fireworks (unbeknownst to the employee), which exploded when they fell. The shock of the explosion made scales at the other end of the railroad platform tip over and injure the plaintiff. In this case of an "unforeseeable plaintiff," the court held that negligence must be founded on the foreseeability of harm and ruled in favor of the Long Island Railroad.

In reviewing malpractice cases, the expert's analysis does not end with merely addressing deviations from the standard of care. The expert is then obligated to assess whether the deviations were the cause of the harm. This includes evaluations of both foreseeability and the presence of intervening causes. Establishing the causal link is a critical element in the analysis of any malpractice case. Psychiatric experts are not experts in proximate cause legal analysis. However, in malpractice cases, it is likely that they will be asked to opine on whether a deviation from the standard of care caused the plaintiff's damages as a medical matter. Clearly, focusing on causation would be likely to reduce the expert's emphasis on "procedural failings that have little to do" with substantive care, as some have alleged was involved in *Liptzin*.[3] The rigor involved in an analysis of causa-

tion necessarily forces the expert's attention beyond purely procedural failings, and toward causal deviations, where the essence of substantive care is more likely to reside.

Failure to consider causation may result in the expert's identifying a long list of deviations from the standard of care. In all likelihood, only a small number of the deviations can be causally connected to the outcome. Listing an excessive number of failures without causal connections may signal a plaintiff-oriented bias or, at the very least, a hasty, "shotgun" approach to the analysis. Another potential pitfall resulting from a failure to consider causation involves the expert's stressing a lack of documentation by the defendant doctor. An overly narrow focus on documentation is an example of a procedural failing that is only rarely causally connected to damages. While the standard of care requires documentation of important clinical assessments, the absence of documentation may or may not be the proximate cause of the damages.[13] Certainly, the lack of documentation may weaken the credibility of the defendant who claims that a critical procedure was done, but not documented. However, malpractice defense attorneys, familiar with the phrase, "the lack of documentation never harmed anyone," will be quick to note that discovery and depositions may later reveal the lack of documentation to be irrelevant. Unless the lack of documentation can be causally linked to the harm, stressing documentation to the exclusion of causation is likely to raise questions about the objectivity of the analysis.

The following two cases illustrate the importance of establishing a causal nexus between the deviation from the standard of care and the alleged damages.

Case C

Mr. C. was admitted to a psychiatric inpatient unit for depression and suicidal ideation. He was not started on medication and was discharged 48 hours later after he refused to answer questions about suicidality. At discharge, an outpatient appointment with a community doctor was made for the patient. At Mr. C.'s appointment, his psychiatrist prescribed an antidepressant. However, the psychiatrist did not take a complete history, and it was not discovered that the patient had a strong family history of bipolar disorder, in addition to a personal history of some mood cycling. After taking the antidepressant for several days, Mr. C. became frankly manic and drove his car erratically at high speeds, resulting in a traffic accident that caused severe head trauma from which he ultimately died. Mr. C.'s wife sued the hospital and the outpatient and inpatient doctors. The plaintiff's expert testified that the hospital was negligent in failing to assess and treat the patient's suicidality and discharging him prematurely from the hospital.

In this case, the expert overlooked the issues of intervening cause and foreseeability. Even though the hospital's treatment of the patient may have been negligent, the intervening event—prescription of an antidepressant by the community doctor—was the likely cause of Mr. C.'s mania. The outpatient doctor's actions had the effect of breaking the chain of causation between the hospital's negligence and the patient's death. In addition, it could be argued that the accident was not foreseeable by the hospital. For example, the probable consequences of premature hospital release for a suicidal patient do not include mania and a traffic accident.

Case D

Mr. D. was a man with depression and chronic, intermittent suicidal ideas. He was treated for depression as a psychiatric inpatient. At the time of his discharge, Mr. D. still had some symptoms of depression, but denied suicidal ideas. Upon discharge, Mr. D.'s psychiatrist scheduled him for a follow-up appointment approximately two months later. One day after discharge, Mr. D. committed suicide. The plaintiff's expert opined that Mr. D.'s psychiatrist fell below the standard of care by giving such a late follow-up appointment.

In this case, even if a two-month outpatient follow-up appointment is a clear departure from the relevant standard of care, there can be no liability unless the expert is willing to testify that failure to give a follow-up appointment less than 24 hours after discharge falls below the standard of care. Mr. D. killed himself the day after discharge, and so, hypothetically, the suicide could only have been prevented if he had been seen within that brief window of time. A more plausible deviation may exist in the area of premature discharge, and more analysis would be needed to determine whether it could be considered the proximate cause of Mr. D.'s suicide.

Hindsight Bias

An extremely powerful biasing influence that is pervasive in analyses of causation is known as the

"hindsight bias." The hindsight bias is another well-studied cognitive illusion, in which people overestimate and exaggerate what could have been predicted about past events.[24] Courts have long recognized this error in judgment, most notably the *Tarasoff* Court, which provided the cautionary warning that, ". . .proof aided by hindsight, that the therapist judges wrongly is insufficient to establish negligence."[25] In retrospect, everything becomes "foreseeable," and even improbable consequences seem reasonable.[26] Legal scholars are aware of the hindsight bias phenomenon and even recommend that defense lawyers use a "debiasing strategy" in the closing argument.[27] However, even when steps are taken to inform people about the bias, no practical methods have demonstrated significant success in reducing its influence.

Exposure to a known outcome causes people to update their beliefs without even realizing that their decision-making process has been affected. Indeed, ignoring a known outcome is an unnatural mental process, and few decisions in real life require true *ex ante* estimates of what care should have been exercised to avoid harm. Nevertheless, forensic experts are not entirely powerless against this cognitive illusion. There must necessarily be an attempt at mentally suppressing evidence that could not have been known beforehand by the defendant. The hindsight bias is most likely to impair forensic experts' ability to assess causation where foreseeability is at issue. The following case illustrates the importance of minimizing the hindsight bias.

Case E

Mr. E. was a man with paranoid schizophrenia who had been found not guilty by reason of insanity of murder. After 12 years of inpatient commitment and 5 years of clinical stability, he was discharged from a secure forensic hospital to a group home in the community. After six months of living in the group home, he wandered away, stopped taking his antipsychotic medication, and began using alcohol. Before his case manager could track him down, he obtained access to a public commercial target-shooting range where he began acting erratically. The police were dispatched, and Mr. E. was killed in a shoot-out with police.

Mr. E.'s family brought a lawsuit against the forensic hospital, the group home, and Mr. E.'s outpatient treatment providers. Plaintiff's expert was particularly critical of Mr. E.'s release from the forensic hospital. The expert opined that Mr. E.'s "premature discharge" played a causal role in his death and that his history of past violence placed him at high risk of just such an outcome.

Mr. E.'s past violent act and finding of insanity provide a powerful biasing influence, especially when combined with the fact that his release from the forensic hospital ultimately culminated in a tragic outcome. Though detailed analysis may indeed reveal deficits in such areas as outpatient treatment and supervision, a claim of premature discharge is dubious, given Mr. E.'s lengthy stay and clinical stability at the time of discharge.

To minimize hindsight bias, the forensic expert should use only the defendant doctor's pre-damages viewpoint in determining whether the doctor's actions fell below the standard of care. In a sense, this exercise requires looking through the defendant doctor's eyes, considering only data the doctor was aware of, or should have been aware of. It may be necessary to obscure purposely or remove the outcome from scrutiny, focusing only on preceding events. When the biasing influence of the tragedy is removed from the analysis, it is reasonable to conclude that there is no significant evidence to suggest that Mr. E., who demonstrated clinical stability for five years, was prematurely discharged. Taking such a viewpoint will reduce the effects of the hindsight bias and help the forensic expert more clearly examine the defendant doctor's compliance with the standard of care.

Contributory Negligence

The doctrines of contributory and comparative negligence allow courts to take into consideration the plaintiff's role in bringing about his own injury or harm. Under contributory negligence, if a plaintiff was himself negligent, recovery may be totally barred. In contrast, comparative negligence allows courts to offset a plaintiff's damages to the degree that he himself was negligent and contributed to the harm. Comparative negligence is the predominant doctrine nationwide, but individual state statutes should be consulted to determine the rule in a given jurisdiction.

Historically, the doctrines of comparative and contributory negligence have not been applied to malpractice actions involving suicide. Courts have ruled that it is inappropriate to hold patients responsible for suicide when they are under psychiatric care

for suicidal tendencies. The psychiatrist is said to be under a duty to "prevent precisely those actions."[28] From this viewpoint, patients are seen as incapable of taking responsibility for their actions because they are mentally ill. As stated by the New Jersey Supreme Court:

> The plaintiff's inability to adequately control her self-damaging behavior—which indeed was symptomatic of her mental disturbance—was known to the defendants, and the defendants were under a duty to prevent plaintiff's self-damaging acts. . . . Because [the defendant's] duty of care included the prevention of the kind of self-damaging acts that caused the plaintiff's injuries, the plaintiff's actions and capacity were subsumed within the defendant's scope of duty. Thus. . .the defense of contributory negligence was not available [Ref. 29, pp 166–7].

More recently, however, several states have ruled that the plaintiff's own contributions to the damages may be considered by the jury.[28,30] For example, in *Hobart v. Shin*,[28] the Illinois Supreme Court ruled that a jury instruction about contributory negligence was appropriate in a suicide malpractice case. That case involved a young woman treated for depression who took a lethal overdose of medication after registering into a hotel under a fictitious name. The court held that the issue of contributory negligence should be considered on a case-by-case basis, quoting a California court:

> The issue of contributory negligence of a mentally disturbed person is a question of fact; unless, of course, the evidence discloses that the person whose actions are being judged is completely devoid of reason. If he is so mentally ill that he is incapable of being contributorily negligent, he should be entitled to have the jury so instructed. . . [Ref. 28, p 911].

Defense attorneys, now increasingly aware of the importance of contributory negligence in psychiatric malpractice cases, may request that experts attend to it in their analyses. Alternatively, plaintiff's experts may be challenged by defense attorneys on issues involving the plaintiff's own contributions to the damages. Such cases typically involve suicide and require the expert to analyze the plaintiff's competence and autonomous decision-making capacity at the time in question.[28] Opinions on this issue are difficult to form for the conscientious, objective expert, given that the person on whose behalf the suit is filed is no longer alive to be interviewed. Exhaustive review of records and interviews with family and friends are likely to be necessary in this regard.

Conclusions

By virtue of their special knowledge and training, forensic psychiatrists should possess greater understanding of the subtleties of medical malpractice evaluations than their nonforensic psychiatric colleagues. The forensic psychiatrist should be more adept at focusing on the appropriate legal analysis and more vigilant for errors that preclude objective and accurate opinions. The rigor that the forensic psychiatrist brings to the malpractice case analysis should constrain examination to causal deviations, hopefully shifting the focus away from unrelated medical ritual. If forensic psychiatrists are to avoid a reliance on experts policing experts, individual forensic psychiatrists must be fully prepared to police themselves.

The impediments to objective analysis described herein may be prevented by careful attention to relevant legal concepts, use of the appropriate standards, and vigilant consideration of potential biasing influences. Opposing experts can be expected to come to different conclusions in psychiatric malpractice cases for a variety of reasons.[13] Nevertheless, it is the process by which forensic psychiatrists arrive at their conclusions that provides the greatest opportunity for improving accuracy of case analysis. It is hoped that this article will clarify essential concepts and stimulate discussion among forensic psychiatrists, which in turn will serve to improve the accuracy and objectivity of malpractice case analysis.

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