Original

Medical Professional Liability in Psychiatry

Carles Martin-Fumadó[1,2]
Esperanza L. Gómez-Durán[2,3,4]
Manuel Rodríguez-Pazos[5]
Josep Arimany-Manso[3,6]

[1]Institut de Medicina Legal de Catalunya, Departament de Justícia, Barcelona, Spain
[2]Departamento de Medicina. Facultad de Medicina. Universitat Internacional de Catalunya. Barcelona, Spain
[3]Servicio de Responsabilidad Profesional. Área de Praxis. Colegio de Médicos de Barcelona. Consejo de Colegios de Médicos de Cataluña. Barcelona, Spain
[4]Unidad de Psiquiatría. Fundació Sociosanitària de Barcelona. Barcelona, Spain
[5]Unidad de Medicina Legal y Forense. Departamento de Psiquiatría y Medicina Legal. Facultad de Medicina. Universidad Autónoma de Barcelona. Barcelona, Spain
[6]Unidad de Medicina Legal y Forense. Departamento de Salud Pública. Facultad de Medicina. Universidad de Barcelona. Barcelona, Spain

Introduction. The safety of patients and the risk of malpractice claims are overriding concerns in medicine and psychiatry.

Material and Methods. Claims for alleged malpractice in psychiatry managed by the Council of Colleges of Physicians of Catalonia between 1986 and 2009 were analyzed to evaluate their clinical and legal characteristics.

Results. Ninety-four malpractice claims were found in a 23-year period, mainly claims related to diagnosis (63.83%, including assessment of suicide risk) and the legal figure of serious professional negligence resulting in death (46.8%). Most claims were for hospital (62.77%), emergency (52.5%), and team (53.75%) care. The possible affected party was male (51.58%) with a mean age of 36.6 years. In one-half of the cases, the harm claimed was death. The cases involved 139 specialists, predominantly male (69.57%), with a mean age of 41 years, and of Spanish nationality (91.4%). The time between the medical act and the respective claim was 1.28 years and the time to resolution was 2.68 years. Most of the cases (77.66%) were processed through the courts. The outcome of the cases was filing or dismissal in 91 (95.77%), conviction in 2 (2.81%), and settlement in 1 (1.41%).

Conclusions. The cumulative incidence of 0.013 claims (1.35%) in 23 years suggests that there is a very low risk of lawsuits in psychiatry, with a similarly low rate of sentences of professional liability and awards for financial compensation. Specific actions could improve clinical safety, particularly in suicide risk assessment.

Correspondence:
Carles Martin-Fumadó
Institut de Medicina Legal de Catalunya (IMLC)
Ciutat de la Justícia de Barcelona i L'Hospitalet
Gran Via de les Corts Catalanes, 111 - Edifici G - 6a planta
08014 Barcelona (Spain)
Tel.: 935548278
Fax 935548259
E-mail: carles.martin@xij.gencat.cat

Keywords: Professional liability, Malpractice, Clinical safety, Suicide risk assessment

Actas Esp Psiquiatr 2015;43(6):205-12

Responsabilidad profesional médica en Psiquiatría

Introducción. La seguridad del paciente y el riesgo de reclamación por defecto de praxis son preocupaciones de primer orden en Medicina y en Psiquiatría.

Material y métodos. Se analizaron descriptivamente las reclamaciones por presunta mala praxis en Psiquiatría gestionadas en el Consejo de Colegios de Médicos de Cataluña entre 1986 y 2009 evaluando sus características clínicas y legales.

Resultados. Se hallaron 94 casos en 23 años, predominando las alegaciones relacionadas con el diagnóstico (63,83%, incluida la valoración de riesgo autolítico) y el supuesto legal de delito de homicidio por imprudencia profesional grave (46,8%). La mayoría de reclamaciones correspondieron a asistencia en atención hospitalaria (62,77%), urgente (52,5%) y prestada en equipo (53,75%). El eventual perjudicado tipo fue un varón (51,58%) con 36,6 años de edad media. En la mitad de los casos, la secuela alegada fue la muerte. Implicaron a 139 facultativos, predominantemente varones (69,57%) con una edad media de 41 años y de nacionalidad española (91,4%). El tiempo entre el acto médico reclamado y la reclamación fue de 1,28 años y el de resolución de 2,68 años. La mayoría de expedientes (77,66%) se tramitaron por vía judicial. Entre estos, se registraron un 95,77% de archivos o sobreseimientos, 2 condenas (2,81%) y 1 acuerdo (1,41%).

Conclusiones. La incidencia acumulada de 0,013 (1,35%) en 23 años sugiere que la Psiquiatría tiene un riesgo muy bajo de reclamación, con una tasa de responsabilidad profesional médica y cuantía en las indemnizaciones igualmente baja. Existen actuaciones específicas susceptibles de mejora en seguridad clínica resultando clave la valoración del riesgo autolítico.

Palabras clave: Responsabilidad profesional médica, Mala praxis, Seguridad clínica, Valoración del riesgo autolítico

INTRODUCTION

Concern for patient safety and the risk of malpractice claims are growing in the medical profession, with the risk of litigation weighing negatively on care.[1] Almost 75% of psychiatrists have recognized having practiced defensive medicine in the month before the survey, with recent graduates showing a greater tendency to do so.[2]

However, according to the national and international scientific literature, psychiatry is not one of the specialties with higher risk of litigation.[1,3,4] In the United States, Jena[3] recorded an annual probability of 2.6% of being sued in psychiatry, with only 0.5% of cases ending with an award of financial damages. In Spain, psychiatry ranks eighteenth among specialties in the frequency of litigation according to Arimany[1] (1.83% of 5246 claims analyzed), only 4.16% of cases concluding in the payment of financial damages, the mean compensation being 17,132 euros. In Spain, Perea-Pérez[4] ranked psychiatry in fourteenth place by the number of lawsuits (2.63%).

Different reasons for litigation in psychiatry have been reported internationally, most often related to the diagnosis and patients who commit suicide.[5,6] In Spain, Santiago-Saez[7] published a small analysis of 25 court cases involving psychiatrists, highlighting the relevance of suicide in medical professional liability (MPL) cases in psychiatry (the death of a patient was involved in 51.2% of claims and suicidal attempts in an additional 7.3%).

Although only a small proportion of adverse events in medicine leads to a claim and not all claims involve malpractice, claims for medical professional liability are one of the most visible, and potentially avoidable, manifestations of adverse events in health care.[8] The data on lawsuits for medical professional liability represent a potentially rich source for learning from mistakes and finding evidence and it has clearly been underexploited.[8,9] Understanding the main reasons why doctors are sued helps to reduce the risk of lawsuits and may improve clinical safety.[10]

In this study, the authors analyze 94 claims for alleged malpractice in psychiatry with the aim of identifying the clinical characteristics of the events that most frequently lead to claims in clinical psychiatric practice, as well as the characteristics and consequences of the claims. There has been no similar published analysis in our region. The detailed examination of the results aims to identify recurring problems and to justify recommendations for improving the clinical safety of patients and the legal security of psychiatry professionals.

MATERIAL AND METHODS

The Professional Liability Department (PLD) of the Council of Medical Colleges of Catalonia (CCMC, Spanish acronym) manages the primary professional liability policy of Catalonia; its operation has been previously described in recent publications.[11,12] Any out-of-court, civil, or criminal claim for professional liability brought against an insured member is managed directly by the PLD, which has a historical database of more than 8,000 lawsuits brought since 1986.[11,12] Physicians and lawyers specialized in professional liability use a standardized electronic form for recording information in the database[13] using the annotations and clinical records, reports, expert assessments, and reports of outcomes and cost as data sources.

After obtaining CCMC authorization, the records of claims involving psychiatrists contained in the database were identified and reviewed. For the purposes of analysis, the events that led to the lawsuit were classified into different categories based on clinical data and the alleged offense or law broken, and the characteristics of the patients and medical professionals were analyzed. Upon completion of this process, cases were separated into judicial and extrajudicial, depending on whether or not the court was involved in resolving the case, and into professional liability cases or not, depending on whether there was a financial award and the quantity of compensation (not including costs and legal fees).

A descriptive analysis was made of the most common events leading to a claim during the study period (from 1 January 1986 to 31 December 2009), together with the clinical, economic, and legal characteristics of these cases. Differences between groups were compared using Chi-square analysis and the Kruskal-Wallis test, with statistical significance set at $P<0.05$. The SPSS 12.0 statistical package was used for data analysis.

RESULTS

An incidence of 94 psychiatry claims was found, the cumulative incidence being 0.013 (1.35%) in 23 years (out of a total of 7237 claims made from 1986 to 2009). The alleged

reasons for the claims, the legal precepts allegedly violated, and the temporal distribution of the claims in the study period are shown in Tables 1 and 2 and in Figure 1.

Most of the claims involved hospital care (62.77%), followed by private practice (15.96%), and primary care (14.89%). The alleged malpractice occurred in a hospital ward in 30.85% of cases, in outpatient clinics in 29.79%, and in emergency services in 24.47%. The specific care cited in the claim was assessed by the authors of this study as urgent in 52.5% of cases and not urgent in 47.5% of cases. Care was given by an individual in 46.25% of cases and by a team in 53.75% of cases. The latter two conditions must be understood as independent of where the care was given.

Except for one case of alleged misdiagnosis of two sisters, in all the other cases the injured party was a single person. The patients were predominantly male (51.58%) and the mean age of the injured party was 36.6 years (SD 16.18 years). Psychiatric history was accredited in 93.68% of the injured parties. The alleged sequelae of the supposed malpractice was death in 50% of cases and was not objectified in 20.21% of cases.

A total of 139 professionals were involved in the 94 cases in the sample: a single practitioner was involved in 62 cases, two practitioners in 25 cases, three in 3 cases, four in 2 cases, and five in 2 cases. Five professionals were cited in two claims. The professionals sued were predominantly male (69.57%), mean age 41 years (SD 8.7 years), of Spanish nationality (91.4%), and with a mean time from graduation to the act motivating the claim of 15.1 years (SD 8.13 years). Among the professionals specialized in psychiatry (52.52% of claims), the mean time from specialization to the act motivating the claim was 12 years (SD 9.31 years).

The mean time between the medical act in question and filing a claim was 1.28 years (SD 1.4 years), and the mean time for resolution of the claim was 2.68 years (2.27 years).

Most of the claims were submitted through the courts (n=73, 77.66%). Among the 71 claims filed and completed, 68 (95.77%) were filed or dismissed, 2 (2.81%) resulted in sentences, and 1 (1.41%) resulted in an out-of-court settlement. The two claims that resulted in sentences were filed in the 1980s. The first sentence was for a nonreversible movement disorder resulting from a case of coma induced by lithium treatment, in which 8,800,000 pesetas ($60,000) in damages was awarded. The second sentence was dictated for the death of a patient due to delayed diagnosis of brain neoplastic disease, the working diagnosis being mood disorder, in which 10,000,000 pesetas ($68,000) in damages was awarded. A settlement for 8,500,000 pesetas ($58,000) was negotiated in the 1990s for a case of an error in supervision of a hospitalized patient that resulted in death. Among the extrajudicial cases, there were no cases of professional liability with payment of damages.

Tabla 1 **Alleged reasons for filing claims**

Presumptive errors in the established psychiatric diagnosis, coupled with an error in treatment (disconformity of the patient or family with the diagnosis and treatment received)	23	24.47%
Presumptive error in estimating the risk of suicide (defect in preventing suicidal behavior)	22	23.40%
Disconformity with the treatment established (presumptive error in prescribed treatment, dose, treatment discontinuation, or disconformity with side effects; includes claims by family members for legal abortion in the case of metal disorder)	15	15.96%
Presumptive error in the case of the established psychiatric diagnosis (disconformity of the patient or family with the diagnosis received)	7	7.45%
Disconformity with the refusal to provide/continue medical care (no response to attempts to contact the professional, refusal to give in to the demands of the patient/family, disconformity with discharge, and presumptive failure of the obligation to provide aid)	6	6.38%
Delayed diagnosis of organic disease (1 case of bronchoaspiration and 4 cases of meningioma)	5	5.31%
Incorrect legal processing of involuntary commitment (absence of the necessary communication and authorization of admission)	4	4.26%
Disconformity with the content of medical documentation (court-appointed legal opinion and medical records)	3	3.19%
Disconformity with administrative situations (assignment of professional and fees)	2	2.18%
Presumptive defect of due vigilance/supervision (deaths of patients while restrained)	2	2.18%
Unspecified reason	5	5.31%
Total	94	100%

Table 2 Laws presumably violated cited in the claims

Criminal manslaughter due to professional negligence	44	46.80%
Disconformity with medical practice not constituting a legal violation	12	12.77%
Criminal injury due to professional negligence	13	13.83%
Illegal abortion	7	7.45%
Illegal detention	4	4.26%
Criminal omission of professional duty to provide aid	4	4.26%
Falsification of an official document	1	1.06%
Violation of the Code of Ethics of the Organization of Medical Colleges of Spain	1	1.06%
Fraudulent representation of professional qualifications	1	1.06%
Violation of Organic Law 1/1982, on civil protection of the right to honor, personal and familial privacy, and to personal reputation	1	1.06%
No data	6	6.38%
Total	94	100%

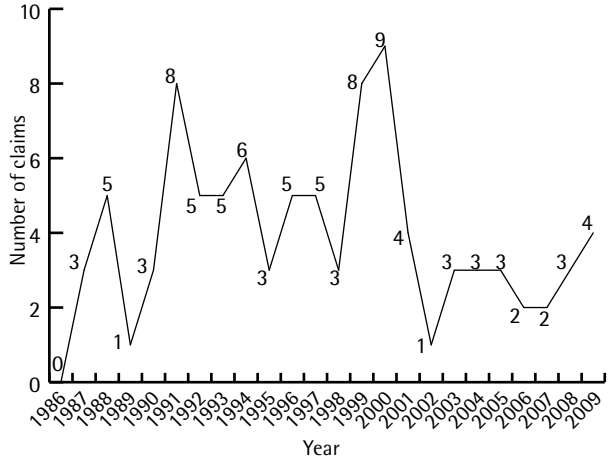

Figure 1 *Temporal distribution of the claims registered in the period between 1986 and 2009*

DISCUSSION

The data from this study, consisting of an incidence of 94 claims for alleged medical professional liability in psychiatry and a cumulative incidence of 0.013 (1.35%) in 23 years, suggest that psychiatry is a specialty with a very low risk of claims, which is reaffirmed by the scarcity of studies in Spain and internationally.[1,3] Despite the absence of reliable data on number of specialists in our region of Spain, considering that there was an estimated mean number of 600 psychiatrists in Catalonia during the study period,[14] it would mean that 0.9% of psychiatrists would be sued every year, yielding a figure well below the already low probability recorded by Jena in the United States.[3] Several authors suggest that this low incidence of complaints in psychiatry is related to the fact that psychiatric procedures rarely have consequences beyond emotional damage, so they are not reported in many cases.[5,6,15] The psychiatric pathology of those who sue is another factor to consider. It has been noted that people with mental health problems generally have poor access to legal services,[16] whereas the pathologies associated with paranoid symptoms or extrapunitive attitudes toward the therapist may be associated with more frequent lawsuits.[5]

Regarding the reasons for the claim, Slawson[5] indicated that lawsuits often arise from a possible misdiagnosis or poor therapeutic outcome. Slovenko[6] cited errors in the assessment of suicidal risk (17% for Simon[17]), errors in the consent, negligent hospital discharge, violation of confidentiality, and medication errors or electroconvulsive therapy as the most frequent reasons for filing claims. In Spain, earlier studies of legal data and assessments suggest that errors in follow-up (42.9%) and professional negligence (20.4%) are more common than cases of therapeutic error.[7] In said study, disagreement with the treatment or diagnosis, or with the diagnosis and treatment account for 76.59% of all reasons for suing rather than those reported by Meyer[5] and Slawson.[18] This predominance of disagreements with the diagnosis and treatment, which do not derive from a demonstration of professional malpractice, could be related to the difficulties in insight that patients with serious psychiatric

disorders usually have.[19] In our study, as in other international studies,[6] the group of claims in which there is a disagreement about the diagnosis of suicidal risk is noteworthy. It is irrefutable that assessment of the risk of suicide (an act not exclusive to psychiatry, but characteristic) is difficult and should always be performed. Both characteristics, coupled with the fact that the negative outcome is very serious regardless of whether the assessment was correct or not, makes suicide assessment a key intervention. Considering that the obligation of a professional is an obligation of means and not of results, it is recommended that this assessment always be performed in accordance with existing international guidelines (with or without using scales and based on a thorough clinical interview) and be explicitly documented in the patient's history. Such precautions usually cause the courts to dismiss liability.[20] Moreover, in addition to the claim itself, it should be noted that the suicide of a patient is one of the most traumatic events in a psychiatrist's professional life,[17,21] so suicide risk assessment is one of the core competencies of training.[22]

Slawson noted that cases related to suicide are usually due to a failure of supervision.[5] In our analysis, inadequate supervision was alleged in only two cases. Although professional liability was considered to be present in one of them, its importance is undeniable despite its relative rarity.[23] Similarly, it should be pointed out that according to our own data, claims about errors in supervision often are filed against the institution where the patient was admitted rather than against a specific professional and thus does not appear in the records of the Professional Liability Department of the CCMC.

Finally, although informed consent was generally not the main reason for the claim, breach of consent was a common cause of problems in the trial.[5] For some jurists, the informed consent document constitutes the golden rule used to measure the degree of liability that can be attributed to the professional.[24] Therefore, according to general recommendations,[25,26] strict compliance with the medico-legal provisions regarding patient autonomy, clinical information, and documentation is mandatory and complete documentation of every occurrence in the patient's records is important.[27,28]

Regarding the type of damage allegedly sustained by the patient, the crime of homicide and injury due to serious professional recklessness are highlighted, given that filing a claim is, a priori, a major alleged material injury. The cases recorded of the crime of abortion correspond to assumptions that depend on the legislative and cultural context, which makes it difficult to compare them with other studies and reflects specific and changing historical circumstances.

Probably due to the prolonged time period studied, the prevalence of court records (77.66%) for the sample do not reflect the current tendency for health care systems to resolve such claims out of court. By removing personal identities and fault, we obtain a contextual approach in which the focus is not only on compensation, but on actions that can improve the system by increasing the safety and confidence of patients and professionals.[29]

With regard to the existence or not of professional liability, it was found in three cases, corresponding to a conviction rate of 3.19% and awards for damages of 8,500,000, 8,800,000, and 10,000,000 pesetas.

Internationally,[5] more than one-third of claims are resolved without awarding financial damages, the mean compensation being $31,000 (between 1974 and 1978). In the cases that concluded with the payment of compensation, the amount exceeded $30,000 in 25% of cases and was less than $10,000 in 23% of cases. These data confirm that claims in psychiatry only infrequently confirm medical professional liability and the awards are small. Jena[3] also found that psychiatry is a specialty with one of the lowest rates of compensation, although the importance of claims in the practice of psychotherapy in the United States has been stressed[6,30] and the compensation for specific cases has been substantial.[31] Santiago-Sáez,[7] using a legal database, reported a conviction rate in excess of 50% of cases, the most common financial damages sought being €60,001 to €600,000 (67.7%). In cases resulting in conviction, the range of compensation in 45.8% of cases was between €18,001 and €60,000. More recently, Arimany[1] evaluated the psychiatry specialty in the CCMC sample for a shorter time period than was covered by our study, reporting 4.16% of cases awarded compensation (the mean percentage of cases awarded compensation being 17.32% for all the specialties). Thus, in the CCMC the mean compensation for such cases in psychiatry was € 17,132 (median €3,061 and maximum €60,101).[1]

Our results also showed a prolonged time between the act that motivated the claim and filing the claim, corresponding to a process of reflection by the injured party or the family in which mediation could be considered. In this sense, Slawson[5] attributed the low frequency of claims in psychiatry to the greater attention that psychiatrists assign to the doctor-patient relationship compared to other medical specialties, which may help to resolve conflicts arising from supervening adverse events.

As for the existence of sequelae derived from the alleged malpractice, it is noted that most claims in psychiatry internationally do not list sequelae and, when they do, they are of mild grade.[5] In Spain, Santiago Saez[7] recorded 58.3% of cases of patient deaths, predominantly by suicide, with a male:female ratio of more than 3:1. This coincides with the 50% of deaths in our local sample, which is relevant because the severity of the consequences of alleged malpractice in other specialties relates to a greater risk of conviction.[32]

In Spain, it has been reported that the affected party is female in 54% of cases considering all medical specialties,[33] whereas the sex of the affected party is male in 64.6% of professional liability claims in psychiatry[7] and in 51.58% of the claims in our study. Regarding the age of the injured party, the most common age range is between 18 and 40 years.[7] In our study, the mean age was 36.6 years, and in six cases the injured party was 15 years old or younger. In this regard, it should be mentioned that the progressive development of the Child and Adolescent Mental Health network in recent years might be accompanied by an increase in the number of claims involving injured minors,[34] especially when psychiatric disorders in minors and the circumstances of the minor's care may collide with parental expectations, as occurs in the field of obstetrics malpractice.[35]

In two of the three cases in which medical professional liability was thought to exist, the patient's pathology was serious (bipolar disorder and psychotic disorder). However, in other specialties it has been reported that the concurrence of professional liability is less likely in subjects with pathologies deemed severe because serious consequences can be expected due to the severity of the condition.[36]

Regarding the medical professionals involved in the cases under study, their mean age was 41 years. It could be assumed that as professional training and experience increase, the risk of professional liability claims would decrease. However, this does not coincide with what has been reported in the United States,[5] where the doctors against whom claims are filed are middle-aged and often highly qualified (which implies an older mean age), which may be related to experienced professionals assuming more responsibility over patients or attending patients with more complex conditions.

Regarding the predominance of men among the psychiatrists sued, it should be remembered that the number of women entering the medical profession in Spain has increased in recent years,[37,38] which may result in changes in the future. Lower rates of lawsuits have been reported for female professionals, as well as significantly lower professional liability claims.[39]

Finally, the existence of multiple incidents in which a single professional is involved and incidents in which more than one professional is involved emphasize the need for intensive training in forensic medicine for psychiatrists. Thus, in the context of involuntary commitment to psychiatric facilities, there are claims for alleged illegal detention. It is estimated that adherence to the correct protocols for interventions and attention to fundamental medical-legal aspects might help to avoid some of these claims.[40,41] This is a matter of maximum legal interest, given a recent judgment by the supreme court of Spain granting protection to a patient involuntarily admitted to a psychiatric facility, stating that the patient's fundamental right to personal liberty (art. 17.1, Spanish Constitution) had been violated and the patient was therefore entitled to the restoration of his/her full rights. Consequently, the proceeding was declared null and void, which had been initially presided by the Court of First Instance and the section of the Provincial Audience that resolved the respective appeal.[42]

CONCLUSIONS

Psychiatry is a specialty with a low frequency of claims and an extremely low incidence of professional liability sentences. The typical psychiatry lawsuit is brought before the courts by the family of the alleged injured party more than a year after adverse event has taken place and is resolved in approximately 2.5 years without legal consequences for the accused. It is usually related to disagreements regarding the diagnosis and/or treatment or to the assessment of suicidal risk, with the adverse event claimed often being the death of an affected party, who is about thirty years old and has a serious mental disorder. The professionals involved are generally men in their forties and of Spanish nationality.

Although the sample size did not allow statistically significant risk groups to be identified, the descriptive analysis pointed out a number of specific actions involving clinical safety and the prevention of claims that could be improved. Among the alleged reasons for claims, disagreements regarding the diagnosis of suicidal risk are relatively frequent, so it is concluded that risk assessment and communication with families about such risks should be emphasized as part of the core competencies in the training of psychiatrists. Similarly, according to the cases in which professional liability was cited, screening for organic pathology should be recommended in cases of atypical clinical manifestations, monitoring of drugs that require special pharmacovigilance, such as lithium or clozapine, and ensuring adequate supervision of patients at risk of suicide during admission.

Finally, extensive training of psychiatrists in forensic medicine is considered indispensable given the need for correct information management, medical documentation, and adherence to protocols for medical interventions. More attention to basic medical-legal aspects, such as those governing involuntary admissions, might avoid many claims for alleged malpractice.

LIMITATIONS

The content of this paper derives from an analysis of the database of the Professional Liability Department of CCMC and the extrapolation of results could be limited by the territorial limitations of the sample. This means that the results might differ from those of cases in regions in which claims are filed directed directly against the government rather than the professionals involved, and the predominance

of private practice among the policyholders might be a factor. Although it is the largest sample published in Spain, the relatively small sample size precluded obtaining significant results from the bivariate analysis.

REFERENCES

1. Arimany-Manso J, Gómez-Durán EL, Aubia-Marimon J. Las reclamaciones sobre responsabilidad profesional por especialidades en un escenario diferente al estadounidense. Gac Sanit. 2013;27:92-3.
2. Passmore K, Leung W-C. Defensive practice among psychiatrists: a questionnaire survey. Postgrad Med J. 2002;78:671-3.
3. Jena AB, Seabury S, Lakdawalla D, Chandra A. Malpractice risk according to physician specialty. N Engl J Med. 2011;365:629-36.
4. Perea Pérez B, Santiago Sáez A, Labajo González ME, Albarrán Juan ML, Sánchez Sánchez JA. Análisis de las consecuencias médico-legales de las reclamaciones judiciales de pacientes. Estudio comparativo de los casos de traumatología, ginecología y obstetricia, anestesia y reanimación y odontoestomatología. Trauma Fund MAPFRE. 2009;20264-8.
5. Slawson PF, Guggenheim FG. Psychiatric Malpractice: A review of the national loss experience. Am J Psychiatry. 1984;141:979-81.
6. Slovenko R. Malpractice in Psychotherapy. An overview. Psychiatr Clin N Am. 1999;22:1-15.
7. Santiago-Sáez A, Perea-Pérez B, Albarrán-Juan ME, Labajo-González E, Reneses-Prieto B. Análisis de las sentencias judiciales contra psiquiatras resueltas en segunda instancia en Spain entre 1992 y 2007. Actas Esp Psiquiatr. 2011;39:393-400.
8. Gómez-Durán EL, Martin-Fumadó C, Arimany-Manso J. Legal medicine contributions to patient safety. From ascertainment and evaluation to research in medical liability. Int J Legal Med. 2013;127:1051-3.
9. Gómez-Durán EL, Martin-Fumadó C, Arimany-Manso J. De la responsabilidad profesional médica a la seguridad clínica. Aten Primaria. 2014;46:110-1.
10. Wilson N, Strunck AL. Survey on professional liability. ACOG Clin Rev. 2006;12:13-6.
11. Arimany-Manso J, Gómez-Durán EL, Bruguera M, Aubía J. Un modelo integral y de gestión directa del aseguramiento de la responsabilidad profesional médica en Cataluña. Med Clin (Barc). 2013;141:300-4.
12. Arimany-Manso J, Gómez-Durán EL. La gestión de la responsabilidad profesional médica desde el colectivo de la profesión médica y enfocada a la seguridad clínica. Rev Esp Med Legal. 2013;39:142-8.
13. Gómez-Durán EL, Mulà-Rosías JA, Lailla-Vicens JM, Benet-Travé J, Arimany-Manso J. Analysis of obstetrics and gynecology professional liability claims in Catalonia, Spain (1986–2010). J Forensic Leg Med. 2013;20:442-6.
14. Solsona M, Treviño R, Merino M, Ferrer L. Demografia de les professions sanitàries a Catalunya: anàlisi dels estocs actuals de professionals sanitaris. Centre d'Estudis Demogràfics. Available in: http://www.gencat.cat/salut/ies/pdf/estudi_demografic.pdf
15. Conte HR, Karasu TB. Malpractice in Psychotherapy: An overview. American Journal of Psychotherapy. 1990;44:232-46.
16. Mind. Another assault. Mind's campaign for equal access to justice for people with mental health problems. 2007. Available in: http://www.mind.org.uk/assets/0000/4014/Anotherassault.pdf
17. Simon RI, Shuman DW. Therapeutic risk management of clinical-legal dilemmas: should it be a core competency. J Am Acad Psychiatry Law. 2009;37:155-61.
18. Meyer DJ. Psychiatry malpractice and administrative inquiries of alleged physician misconduct. Psychiatr Clin N Am. 2006;29:615-28.
19. Villagrána JM, Luque R. Psicopatología del insight. Psiquiatr Biol. 2000;7:202-15.
20. Sentencia del Tribunal Superior de Justicia de Madrid, sala de lo contencioso-administrativo, 336/2007, de 30 de marzo.
21. Gitlin MJ. A psychiatrist's reaction to a patient's suicide. Am J Psychiatry. 1990;156:1630-4.
22. Simon R, Shuman DW. The standard of care in suicide risk assessment: an elusive concept. CNS Spectr. 2006;11:442-5.
23. Gómez-Durán EL, Guija JA, Ortega-Monasterio L. Aspectos medicolegales de la contención física y farmacológica. Med Clin (Barc). 2014;142(Supl. 2):24-9.
24. Martín Pallín JA. Errores médicos. Rev Clin Esp. 2012;212:186-7.
25. Medallo Muñiz J, Pujol Robinat A, Arimany Manso J. Aspectos médico-legales de la responsabilidad profesional médica. Med Clin (Barc). 2006;126:152-6.
26. Pujol-Robinat A, Martin-Fumadó C, Giménez-Pérez D, Medallo-Muñiz J. Criterios medicolegales en la valoración de la responsabilidad profesional médica. Rev Esp Med Legal. 2013;39:135-41.
27. Quaderns de Bona Praxi. Praxi mèdica i reclamacions judicials. Maig 2011. COMB.
28. González Hernández E, Castellano Arroyo M. El consentimiento en las actuaciones médicas en las comunidades autónomas españolas: regulación actual. Rev Esp Med Legal. 2012;38:100-6.
29. Rodríguez Hornillo M, De la Riva Moreno C, Serratosa Sánchez-Ibargüen A. Responsabilidad sanitaria: responsabilidad personal del médico vs. responsabilidad del sistema sanitario. Cuad Med Forense. 2011;17:59-66.
30. Appelbaum PS. Law & psychiatry: Third-party suits against therapists in recovered-memory cases. Psychiatr Serv. 2001;52:27-8.
31. Ramona v Superior Court Ramona (judgement on jury veredict), n.61898 (Napa Cty Superior Ct, July 11, 1994). Available in: http://caselaw.findlaw.com/ca-court-of-appeal/1122202.html
32. Studdert DM, Mello MM, Brennan TA. Medical Malpractice. NEJM. 2004;350:283-9.
33. Álvarez González F, Hidalgo Salvador E, Sánchez del Castillo D, García Pérez H. Estudio retrospectivo de las denuncias por malpraxis médica en la provincia de Málaga. Cuad Med Forense. 2007;13:9-19.
34. Capellà Batista-Alentorn A. La reforma en Salud Mental en Cataluña: el modelo catalán. Rev Asoc Esp Neuropsiq. 2001;79:101-28.
35. Herczeg J. High-risk obstetrics, medicolegal problems. Eur J Obstet Gynecol Reprod Biol. 1997;71:181-5.
36. Roche E, Gómez-Durán EL, Benet-Travé J, Martin-Fumadó C, Arimany-Manso J. Professional liability claims in vascular surgery practice. Ann Vasc Surg. 2014;28:324-9.
37. Col·legi Oficial de Metges de Barcelona. Servei d'Informació. Informe Anual, 2010.
38. Arrizabalaga P, Bruguera M. Feminización y ejercicio de la medicina. Med Clin (Barc). 2009;4;133:184-6.
39. Bruguera M, Gómez-Durán EL, Arrizabalaga P, Arimany-Manso J. Reclamaciones por presunta malapraxis. ¿Existen diferencias entre médicos varones y mujeres? Med Clin (Barc). 2013. http://dx.doi.org/10.1016/j.medcli.2013.10.008
40. Martin Fumadó C, Barbería Marcalain E, Arimany Manso J. Motivos de reclamación en psiquiatría. Comunicación (póster) presentada en el XVIII Simposium de la Sociedad Española de Psiquiatría Forense. Barcelona. 2011.

41. Gómez-Durán EL, Martin-Fumadó C, Arimany-Manso J. Guía de práctica clínica sobre el trastorno bipolar: aspectos médico-legales. Med Clin (Barc). 2013 Nov 21. doi:pii: S0025-7753(13)00715-X. 10.1016/j.medcli.2013.10.004.
42. Sentencia del Tribunal Constitucional, sala Segunda, recurso de amparo 5.070/2.009, de 2 de julio de 2012.