Psychiatric claims to the Danish Patient Insurance Association have low recognition percentages

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ABSTRACT

INTRODUCTION: Since 1992 the Danish Patient Insurance Association (DPIA) has been receiving claims from patients who had suffered an injury during examination or treatment in Danish healthcare. We have presently collected more than 85,000 patient cases in our database, which we make accessible to research that can promote patient safety. We now want to draw attention to conditions that mainly apply to patients with mental disorders.

MATERIAL AND METHODS: By searching the DPIA database over the past 15 years, we identified 1,278 patients with mental disorders. These patients were studied with respect to whether they had been treated within the psychiatric specialty or in a somatic specialty. During the study period, there was a change of opinion in the legal system after the Supreme Court ruled that surveillance of a psychiatric patient during admission, e.g. as anti-suicide precaution, should also be considered part of the treatment.

RESULTS: Of the registered claims, 742 had received specialised psychiatric treatment for their mental disorders, and 536 had been treated in one of the somatic specialties. Of the 1,278 patients, 16% had their claims accepted.
A marked difference was found in the acceptance rate of claims between these two groups: in psychiatry, 13% of the claims were accepted, whereas in the somatic specialties, the acceptance rate was 21%. Both of these numbers are well below the usual DPIA acceptance rate, which is 36% (p = 0.001). During the study period, there was a change in the Danish legal system after the Danish Supreme Court ruled that surveillance of a psychiatric patient during admission, e.g. as an anti-suicide precaution, should be considered part of the treatment.

CONCLUSION: The low acceptance rate for claims made by patients with mental disorders concerning treatment or examination may, in part, be due to the lodging of unqualified claims, but other causes may also have contributed to this. Psychiatric patients who are treated for somatic disease should receive special attention to avoid treatment-related injuries.

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In 1992, the Patient Insurance Act came into force, and the Danish Patient Insurance Association (DPIA) was founded to make decisions based on the Act. In 1996, the Patient Insurance Act was accompanied by the Act on Compensation for Medication-Related Injuries. Since 1996, the scope of application of the Patient Insurance Act has been extended repeatedly. For example, claims concerning psychical injuries were included as from 1 January 2004.

Today, both acts have been consolidated into the Danish Act on the Right to Complain and Receive Compensation within the Health Service [1]. DPIA decisions can be appealed to the National Agency for Patients' Rights and Complaints and further through the courts of law.

The DPIA operates on a no-fault basis. In general, compensation will be provided for injuries if they are caused by treatment (Act on the Right to Complain and Receive Compensation within the Health Service Section 19, Subsection 1) and if one of the following conditions are fulfilled (Section 20, Subsection 1, no. 1-4): 1) an experienced specialist would have acted differently, whereby the injury would have been avoided; 2) defects in or failure of the technical equipment were of major concern with respect to the incident; 3) the injury could have been avoided by using alternative treatments, techniques or methods which are considered equally safe and potentially offer the same benefits; and, finally, 4) the injury is rare, serious and more extensive than the patient should be expected to endure.

In Denmark, compensation can also be provided according to the ordinary compensation provision, i.e. the culpa rule (Act on the Right to Complain and Receive Compensation within the Health Service Section 21,

The Danish Patient Insurance Association in Copenhagen.

ORIGINAL ARTICLE

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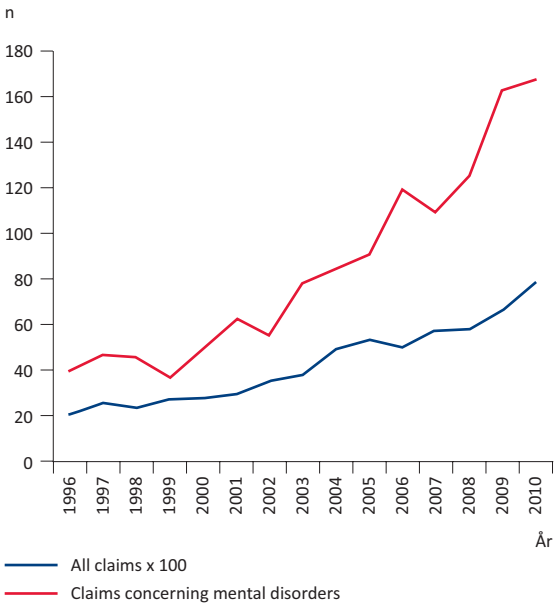
FIGURE 1

Increase in number of claims 1996-2010.



Subsection 2). This provision ensures compensation for some injuries that are not caused by treatment.

Calculation of compensation is made in pursuance of The Danish Liability for Damages Act.

Since 1992, the DPIA has received claims from patients who have suffered an injury during examination or treatment in Danish healthcare. We have presently collected more than 80,000 patient cases in our database, which is accessible to research that can promote patient safety. The aim of this study was to describe the low acceptance rate of claims from patients with mental disorders and to call attention to the need for special considerations when these patients are treated for somatic disease outside of the psychiatric specialty. We also describe a Supreme Court decision, which has changed the legal status concerning suicidal patients.

MATERIAL AND METHODS

This was a retrospective study. In the DPIA database, about 65,000 claims were made in the 1996-2010 period. These claims are registered by a primary diagnosis and two secondary diagnoses, three treatment codes and three complication codes. If necessary, the codes may be elaborated in a free-text field. The institution or person responsible for treatment and the medical specialty are also identified. A copy of the hospital records are kept electronically with the data. The DPIA database was searched for patients with mental disorders as the first, second or third diagnosis. The patients were divided into two groups: In one group, specialists in psychiatry were responsible for their treatment, whereas the patients in the other group had been treated outside of the psychiatric specialty.

Trial registration: not relevant.

RESULTS

During the 1996-2010 period, 742 claims were made to the DPIA in which a district psychiatric centre, a psychiatric hospital department or a private psychiatric specialist was identified as responsible for treatment. A total of 409 claims were made by women and 333 by men. The average applicant age was 39.4 years. Of the 742 claims, 96 (13%) were accepted. In the same period, 536 claims were made by patients with mental disorders who had been treated for somatic diseases within somatic departments in hospitals or by practicing medical doctors in various somatic specialties. Among these, 110 claims were recognised by the DPIA (21%). This group counted 262 women and 274 men. Their average age was 45.4 years, which is nearly equivalent to the overall average age for DPIA applicants.

The total sample thus included 1,278 patients: 671 women and 607 men with an average age of 43 years. The percentage of accepted claims from these patients was 16%, which was identical for women and men, but significantly lower than the usual DPIA acceptance rate, which is 36% ($p < 0.001$). The total amount of compensation was 7,179,743 Euro, which was paid out to a total of 201 patients; the average individual payment was 35.720 Euro.

Over the study period, the number of claims increased steadily (**Figure 1**) with a rise after 2001 and a further increase between 2008 and 2009. Currently, the annual number of claims from patients with mental disorders is approximately 160.

The majority of patients seen within psychiatry had a diagnosis of schizophrenia or mood (affective) disorders. Claims related to organic disorders were those that were most frequently accepted (**Table 1**). Outside of the psychiatric specialty, the majority of patients with mental disorders treated for somatic disease had a diagnosis of mental and behavioural disorders due to psychoactive substance use, but otherwise the two groups of patients were similar. The specialties responsible for treatment outside of the psychiatric speciality were mainly general medicine, internal medicine and orthopaedic surgery. There were few patients from gynaecology and obstetrics, neurosurgery and radiology, but these specialties had a high claim acceptance rate (**Table 2**).

The most common reason for acceptance in both groups was that the DPIA concluded that the treatment was below the standard of an experienced specialist.

The groups were very similar in this respect, except for two categories: "The patient suffered more than he should" and "Missed diagnosis". These two items were cited more frequently in the group treated outside of psychiatry (**Table 3**).

Some claims (10.1%) were rejected for the sole reason that there was no injury. For comparison, in surgery the number of such unfounded claims was 4.6%. Other reasons for rejection included complaints over side effects from drugs. Many antipsychotic drugs have troublesome side effects, e.g. dryness in the oral cavity, which causes decay of the teeth. Such injuries are too frequent to be recognized under the law, and these claims were often rejected. Of the 442 claims, which involved antipsychotic drugs, 381 were rejected.

Twenty-six deceased patients had their claims accepted because their deaths were caused by the fact that their treatment was not up to the standard of an experienced specialist. Among these, 12 were seen within psychiatry: One patient was strangled by a belt used to restrain him in his bed. In two other cases, the cause of death was a medication error. The remaining nine cases were suicides. Another two patients died due to their treatment, but these were not recognised by the DPIA. In one case, compensation was less than 1,500 Euro, which is the lower threshold for acceptance. In the other case, the Patient Complaint Board criticised the treatment, but the DPIA did not accept the claim. Outside of psychiatry, 14 deaths were related to treatment: two were suicides, and the rest were various unintentional incidents (**Table 4**).

DISCUSSION

It is unlikely that the frequency of claims for patients with mental disorders is higher than the frequency usually seen in the DPIA, which is assumed to be 5-20% [2, 3]. The approval rate for claims made by patients with mental disorders is significantly lower than the rate for somatic patients. This may be so for several reasons. In many cases, it is difficult to overcome the burden of proof because many decisions rely on estimations without the benefit of detailed clinical information. Relatively clear, objective standards exist in the assessment of the outcome of a hip alloplastic surgery, for example, but it is more difficult to evaluate the success of preventive treatment for a bipolar condition.

In mental disorders, it is easy to imagine that many patients or relatives may wish to make a claim because they disagree with the treatment provided, even in cases in which the treatment has followed lege artis. It would be desirable to limit these unfounded claims, but it is difficult to imagine how to accomplish such a case reduction without neglecting the patients' legal rights.

It is notable that when patients with mental disorders are treated for somatic diseases within various medical specialties, the percentage of accepted claims is significantly higher than in the rates observed when patients are treated by a psychiatric specialist. Nevertheless, this rate reaches only 60% of the acceptance

TABLE 1

Psychiatric diagnosis and recognition of claims in the two groups.

		Within the psychiatric specialty, n (%)		Outside of the psychiatric specialty, n (%)	
ICD-10 code	Text	total	recognized	total	recognized
DF00-09	Organic diseases	25	7 (28)	45	9 (20)
DF10-19	Mental and behavioural disorders due to psychoactive substance use	34	4 (12)	181	43 (24)
DF20-29	Schizophrenia and others	296	33 (11)	81	18 (22)
DF30-39	Mood (affective) mental disorders	216	32 (15)	111	19 (17)
DF40-48	Nervous disorders	45	4 (9)	40	8 (20)
DF50-59	Behavioural changes	5	0 (0)	4	2 (50)
DF60-69	Disturbances of personality structures	40	6 (15)	19	3 (16)
DF70-79	Mental retardation	2	0 (0)	6	1 (17)
DF80-89	Psychic development disorders	9	0 (0)	4	1 (25)
DF90-98	Behavioural disorders arising in childhood	57	10 (18)	42	5 (12)
DF99	Psychiatric diseases without specification	5	0 (0)	3	1 (33)
	Not coded (outside the law)	8	0 (0)	0	0 (0)
	Total	742	96 (13)	536	110 (21)

DF = the psychiatric chapters in the ICD-10 list; ICD = International Classification of Diseases.

TABLE 2

Somatic specialties responsible for treatment of the patients outside the psychiatric specialty.

Specialty	Total, n	Recognized, n (%)
General medicine	165	23 (14)
Internal medicine	110	25 (23)
Orthopaedic surgery	96	28 (29)
Surgery	55	10 (18)
Anaesthesiology	43	9 (21)
Neurology	21	4 (19)
Gynaecology and obstetrics	10	4 (40)
Pediatrics	5	0 (0)
Clinical biochemistry	4	1 (25)
Neurosurgery	4	3 (75)
Ear, nose and throat disease	5	0 (0)
Radiology	4	2 (50)
Pathology	2	0 (0)
Jaw surgery	2	1 (50)
Dermatology	2	0 (0)
Ophthalmology	1	0 (0)
Occupational medicine	1	0 (0)
Other	6	0 (0)
Total	536	110 (21)

TABLE 3

Reasons for recognition of claims in the two groups. The values are n.

	Within the psychiatric specialty	Outside of the psychiatric specialty
Treatment not up to the standard of the experienced specialist	54	43
Mechanical failure of apparatus	0	2
Alternative treatment would have been better	0	1
The patient suffered more than necessary	4	17
Missed diagnosis	6	26
Culpa	12	7
Medication-related injury	20	14
Total	96	110

TABLE 4

Cases where death was recognized as caused by treatment injuries. The values are n.

	Within the specialty	Outside of the specialty
Suicide	9	2
Medication errors	2	4
Falling in hospital and similar injuries	1	1
Perforation of internal organs	0	2
Other treatment not up to the standard of the experienced specialist	0	4
The patient suffered more than necessary	0	1
Total	12	14

rate for somatic patients treated within the somatic specialties. This finding seems to indicate that other factors are responsible for this difference, although the available data do not indicate what these factors could be.

In several of the reviewed cases treated outside of psychiatry, the patients seemed to have difficulties expressing their symptoms in a manner that was understandable to the staff. A bias against psychiatric patients hence seems to be present in the somatic specialties. In a recent Scandinavian study, Wallbeck and others showed that the average lifespan for psychiatric patients evaluated during the past 20 years has been 10-20 years below the average for the general population, although some improvements were seen within the period [4]. Part of this increased mortality may be explained by unfortunate patient flows. A Danish study on the diagnosis and treatment of cardiac disease in psychiatric patients demonstrated that the treatment was unsatisfactory, and that this partially explained the increased mortality [5].

Claims concerning the suicide or attempted suicide of a patient were previously judged according to the culpa rule and the rule about the standard for an experienced specialist (Section 20, Subsection 1, no. 1). The conditions for provision of compensation under the culpa rule are stricter than those of the standard for an experienced specialist, which is only used in decisions about injuries suffered during examination, treatment or similar conditions. Claims were considered under both rules because the evaluation of a patient's suicide risk and the prescription of various suicide-prevention measures (e.g. admission to a closed ward, antidepressant medication and surveillance) should be determined according to the rule concerning the standard for an experienced specialist. However, the execution of such preventive measures, such as the practical surveillance of the patient, should be determined in accordance with the culpa rule, because the execution itself was not considered as part of the treatment.

After a patient committed suicide while admitted to a psychiatric centre, a Danish Supreme Court ruling (U.2009.1835 H) established, however, that the surveillance of a psychiatric patient during an admission (i.e., the execution of the preventive measure itself) should be considered part of the treatment. The argument for this ruling was that the execution of the surveillance served a purpose in diagnosis and treatment, viz. to monitor the psychiatric condition of the patient in order to provide a continuous assessment of the patient's suicide risk. The DPIA therefore no longer evaluates the execution of prescribed security measures according to the culpa rule, but instead according to the rule of the experienced specialist. Cases are recognised according to this rule when action is deemed to be below the standard of the experienced specialist, and the suicide or attempted suicide could have been prevented if the standard of the experienced specialist had been followed. In cases in which the suicide or attempted suicide could not have been prevented regardless of whether the treatment was in accordance with the standard of the experienced specialist or not, the claim is rejected in pursuance of the rule of "no injury" (Section 19, Subsection 1) because the patient's suicide could not be considered a consequence of treatment, but rather a consequence of the patient's disease.

CONCLUSION

Patients with mental disorders generally seem to have a substantially lower claim acceptance rate than any other patient groups – especially when treated within the specialty of psychiatry, but also when treated within somatic specialties.

This is partly so because a large proportion of the claims from patients with mental disorders are unqualified. But there may be other reasons. The side effects of the antipsychotic drugs are so frequent that they will usually not be accepted as a patient injury within the

confines of the law, although it is obvious that the injury is caused by the drug.

The daily practice of a general physician or a specialist in psychiatry often involves patients who express suicidal plans or similar thoughts. As shown in this study, there is reason to take this information seriously whether it is the first time or the 40th time the person expresses these thoughts, even if it may be time-consuming to uncover them. Many rating scales in current practice can be useful if applied with empathy and discernment [6]. These may be of limited utility, however, if they are used mechanically.

It is regrettable that somatic diseases are underdiagnosed in psychiatric patients. The physical symptoms are often misjudged by the somatic physician as symptoms of the pre-existing psychiatric disease, such as delusions, hallucinations, depressive pain, aggravation, appealing and other symptoms. In rare cases, the patient does not want to talk about these issues or does not consider them important.

We also know that the treatment of somatic disease in psychiatric patients is less successful than it is in somatic patients. Some of the issues may be compliance, and in some cases psychotic patients suffer from delusions, e.g. that the staff is administering poisoning medications or that medicine must have a certain colour to be effective. However, under-diagnosis undoubtedly plays a major role.

Psychiatric patients who are treated for somatic disease should receive special attention to avoid treatment-related injuries.

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LITERATURE

1. Act no. 547 from june 24th 2005 on the Right to Complain and Receive Compensation within the Danish Health Service. www.patientforsikringen.dk/ (1 Sep 2012).
2. Petersen HØ, Rasmussen AH, Andersen LI et al. Mediastinitis in cardiac surgery – patient insurance reports. Ugeskr Læger 2008;170:1905-8.
3. Bock J, Hove LD, Andersen LI et al. Skader skal anmeldes. Ugeskr Læger 2011;173:1990.
4. Wahlbeck K, Westman J, Nordentoft M et al. Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders. BJP 2011;199:453-8.
5. Laursen TM, Munk-Olsen T, Agerbo E et al. Somatic hospital contacts, invasive cardiac procedures, and mortality from heart disease in patients with severe mental disorder. Arch Gen Psychiatry 2009;66:713-20.
6. Nordentoft M, Hjalsted B, Nielsen K et al. Vurdering og visitation af selvmordstruede. Copenhagen: Danish Health and Medicines Authority, 2004