Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Professional Misconduct and Malpractice

Lisa Ramshaw, MD, DPhil, FRCPC[1]; Treena Wilkie, BScH, MD, FRCPC[1]; Sumeeta Chatterjee, MD, FRCPC[1]; Graham Glancy, MB, ChB, FRCPsych[1]

The authors would like to thank the National Working Group (Todd Tomita, Alberto Choy, Mansfield Mela, Jeff Waldman, Richard Schneider, Brad D. Booth, Jocelyne Brault, Mathieu Dufour, and Aileen Brunet) for their essential contributions. They would also like to thank their expert reviewers, Michael Colleton and John Bradford.

Reviewed and approved by the Canadian Academy of Psychiatry and the Law (CAPL) Board of Directors on June 28, 2022.

STATEMENT OF INTENT: CAPL Resource Guide for Reference and Training

This document is intended as a review of legal and psychiatric principles to offer practical guidance in the performance of forensic evaluations. This resource document was developed through the participation of forensic psychiatrists across Canada, who routinely conduct a variety of forensic assessments and who have expertise in conducting these evaluations in various practice settings. The development of the document incorporated a thorough review that integrated feedback and revisions into the final draft. This resource document was reviewed and approved by the Board of CAPL on June 28, 2022. It reflects a consensus among members and experts, regarding the principles and practices applicable to the conduct of forensic assessments. This document does not, however, necessarily represent the views of all members of CAPL. Further, this resource document should not be construed as dictating the standard for forensic evaluations. Although it is intended to inform practice, it does not present all currently acceptable ways of performing forensic psychiatry evaluations and following these guidelines does not lead to a guaranteed outcome. Differing facts, clinical factors, relevant statutes, administrative and case law, and the psychiatrist's clinical judgement determine how to proceed in any individual forensic assessment.

This resource document is for psychiatrists and other clinicians working in a forensic assessor role who conduct evaluations and provide opinions on legal and regulatory matters for the courts, tribunals, and other third parties. Any clinician who agrees to perform forensic assessments in any domain is expected to have the necessary qualifications according to the professional standards in the relevant jurisdiction and for the evaluation at hand.

See the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*, which applies to all of the guidelines and will not be repeated below. See also the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Overarching Principles for Civil Psychiatry Assessments* and the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Fitness to Work/Practise.*

OVERVIEW OF PROFESSIONAL MISCONDUCT AND MALPRACTICE

Professional misconduct is a failure to meet professional obligations involving any improper conduct, as set out by the profession's governing regulatory body. The regulatory body investigates misconduct complaints. This is a part of the administrative law governing the relationship between individuals and society. Professional malpractice involves an act by the defendant that has caused harm to the plaintiff.

Claims of professional malpractice, which include but aren't limited to medical or legal malpractice, are heard before civil courts.

Although the specific medicolegal questions arising in misconduct and malpractice may differ, there are many overlapping issues. Both misconduct and malpractice allegations and findings may trigger requests for third-party assessments, and both can involve fitness-to-practise concerns (i.e., health issues impairing the ability to practise; see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Fitness to Work/ Practise*). There are similar approaches to the evaluation and report and shared core concepts regarding individuals who fail to meet the expected norms of practice. Further, it is not uncommon for a malpractice complaint to result in a misconduct complaint, and vice versa.

This guideline focuses on the assessor's role in cases of medical misconduct and malpractice, although the principles are analogous for all regulated professions. The reader is referred to Bloom and Schneider (1) for a more extensive overview of professional conduct and professional malpractice, as well as the Canadian Medical Protective Association (CMPA) website (2) and the applicable provincial and territorial college websites for more information.

Professional Misconduct

Professional misconduct (referred to as *unprofessional conduct* or *conduct unbecoming,* in some jurisdictions) refers to any behaviour that does not meet the standards of the profession. Medical misconduct can involve any regulated health professional, including physicians, psychologists, nurses, dentists, chiropractors, and massage therapists, each dealt with by their respective colleges.

Complaints about physicians to provincial or territorial colleges may come from patients or their representatives, colleagues, or others, sometimes as a result of mandatory reporting. The extent of the college investigation and process depends on several factors, including the nature and severity of the allegations and the professional's response to the allegations. A finding of professional misconduct is the most serious outcome of such complaints. Examples of professional misconduct include fraudulent practice; incompetence; conflict of interest; boundary violations; substance abuse contributing to a failure to meet professional obligations; disruptive behaviours with team members, patients, or others; sexual improprieties or abuse; aggression; harmful or potentially harmful behaviour; or criminal behaviour. Actions that might lead to malpractice claims could also lead to misconduct allegations. Further, it is not uncommon for a potential plaintiff to start with an allegation of misconduct and then move to a malpractice claim. The regulating body will determine if there will be formal charges and a disciplinary (quasi-judicial) hearing whether to consider diversion to a capacity assessment. The outcome of a finding of professional misconduct can include reprimands, fines, remedial measures, restricted practice, suspension, and loss of licence. There may also be a loss of reputation resulting from public hearings and published outcomes by the governing body. Promoting professionalism has been reviewed by Hickson and colleagues. (3)

Each of the provinces and territories has legislation giving regulatory bodies the mandate and authority to regulate and discipline the medical profession, with a role to protect public health and safety. It is the assessor's responsibility to be aware of the relevant legislation applicable to the specific questions being posed.

The CMPA may provide advice and legal representation for member physicians undergoing a professional misconduct investigation. Requests for a third-party assessment can be made by the specific college(s) or legal representative assigned by the CMPA for their client under investigation, independent counsel, or hospitals. Further, according to the CMPA website, "If a physician's fitness to practice or competence is questioned [during a misconduct investigation], the College may order the physician to undergo a skills assessment, or medical or psychological examination."(2)

Professional Malpractice

Medical malpractice is a type of tort or civil suit in which one person (the plaintiff) alleges harm due to the wrongdoing of another (the defendant or tortfeasor). Medical malpractice involves a patient (referred to as the plaintiff) making a claim that a physician (the defendant) has engaged in a wrongful act that caused them injury or damage. Wrongful acts that constitute malpractice involve a breach of standard of care, which can be either intentional or unintentional. The most common form of medical malpractice is negligence. (4, 5) The constituents of any negligence case involve a duty of care, a breach of standard of care, causation, foreseeability, and subsequent damages. In all negligence cases, the onus is on the plaintiff to prove each element of the case on a balance of probabilities. (4) Although based in common law, some jurisdictions have codified certain torts, particularly in Quebec, where common law does not apply. In Quebec, there are three elements: fault—the doctor did not act as a reasonably prudent physician of similar training and experience would have under the circumstances; injury—bodily, moral, or material; cause—the doctor's fault caused the injury. (6)

As with misconduct allegations, the CMPA may provide advice and legal representation for member physicians undergoing professional malpractice investigations. Exceptions may include sexual abuse and other criminal acts.

Constituents of Negligence Cases

Duty of Care: Every treating physician owes a fiduciary duty to their patient, which involves acting in the patient's best interests. Although most third-party assessors do not owe a duty to the evaluee (as the evaluee is not their patient), there

are exceptions, such as when there are acute risk issues, where a duty may be owed to third parties (see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*).

Standard of Care: Standard of care is that which a competent and prudent physician of ordinary skill and training can reasonably be expected to deliver under similar circumstances (*Lapointe v. Hôpital Le Gardeur* [7]). This is an objective standard and, therefore, does not consider the personal circumstances of an individual physician. The courts give little credence to claims that local variations or lack of experience affect the standard of care. (5) Specialists are expected to have increased skills and knowledge commensurate with their qualifications beyond those of a generalist, and, therefore, they are expected to practise and are held to a higher standard than a generalist. The court is sensitive to the fact that sometimes errors in judgement or poor outcomes are not necessarily below the standard of care. It has also been noted that the court attempts to be careful not to rely on the obvious conclusion afforded by hindsight. (4) According to the CMPA website, the defendant physician is assessed according to the standards of practice applicable at the time of the event, (2) which might have been some years ago. In conclusion, the court will likely consider a contextualized assessment of the defendant's actions to consider standards of practice applicable at the time of the event and under similar circumstances.

Causation: As in any negligence claim where there has been a breach of standard of care, the plaintiff must prove the damages were caused by the physician not practising to the appropriate standard of care. This must be proven on the balance of probabilities and does not need to be proven with scientific precision (see *Snell v. Farrell* [8]) but, rather, to the court's satisfaction. The "but for" test is the gold standard in proving causation; in some cases, it is unworkable, and the "material contribution" test may be used (see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Personal Injury*). This is unlike intentional harm, where causation is assumed.

Foreseeability: The test of foreseeability requires an analysis by the court as to whether, in the case of this individual plaintiff patient with this particular history, it was reasonably foreseeable the damages would occur as a result of the defendant's actions. If the physician's conduct was commensurate with the standard of care, in that they took a reasonable history, did a reasonable examination, and instituted the same conditions and treatment that a prudent physician of ordinary skills and training would have instituted, then a sudden and unexpected outcome, such as a patient with no history of suicide attempts jumping out of a hospital window, could not have reasonably been foreseen. (5)

Damages: The burden is on the plaintiff to prove on the balance of probabilities that any alleged damages, such as physical or psychiatric injury, were caused by the physician's negligence. As in any tort action, damages are compensatory or restitutionary. They may include damages for pain and suffering, loss of future income, permanent disability, cost of future care, and other expenses. Rarely, the court will also give punitive damages in egregious cases, such as an intentional tort. It is likely the concepts of *thin skull plaintiff* and *crumbling skull plaintiff*, as discussed in the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Personal Injury*, are particularly relevant in psychiatric malpractice. The purpose of damages is to put the plaintiff where they would have been but for the wrongful act. Punitive damages are strictly intended to punish the tortfeasor or to send a message (e.g., for the purpose of deterrence) and have nothing to do with the plaintiff's losses.

Specific Types of Actions Leading to Medical Malpractice Claims

Lack of Informed Consent

It is standard practice for a physician to inform the patient about the risks and benefits of any type of treatment in order that the patient, assuming they have the requisite capacity, can make an informed decision. If the patient lacks the capacity to consent to treatment, the same information is given to a substitute decision-maker. It is part of the duty of care to obtain informed consent.

What constitutes informed consent has been a matter interpreted by the courts based on a societal paradigm shift. Over the last 50 years, patient rights have evolved in the form of the primacy of patient autonomy, which involves determining what happens to one's own body, including the right to informed consent to participate fully in medical decision-making. (9) The concept of the reasonable patient standard, as opposed to the reasonable physician standard, was affirmed in Canadian courts in an important case (*Reibl v. Hughes* [10]) This was explained when the Supreme Court ruled that the law now requires the patient be informed of all material risks. This implies a balance between informing the patient of any risks of both serious (even if rare) and common sequelae (see *Hopp v. Lepp* [11]).

Informed consent for treatment consists of providing the following information to the patient: the purpose or indication for the proposed treatment, potential benefits, potential risks and side effects, alternatives to the proposed treatment, and risks of not taking treatment. With this information, the patient with the capacity to consent can make an informed decision about whether to consent to treatment, which may include medication, engagement in psychotherapy, electroconvulsive therapy, or other interventions. It is helpful if the physician makes a note in the patient's chart that this has been discussed with them and that they understand. This is particularly relevant to a psychiatric patient who may have difficulty understanding due to cognitive problems, psychosis, or mania. Although anxiety might impact information processing at times,

it rarely results in incapacity. If the patient lacks capacity, this same information is explained to a substitute decision-maker. During assessments, all elements that satisfy the objective test of what information an ordinary person would require to make an informed decision are reviewed.

Inappropriate Prescribing Practices

In addition to the omission of informed consent, erroneous or inappropriate prescribing practices may also be a cause of action. Although there have been very few successful cases in Canada, it is more prevalent in the United States. (12) Litigation regarding inappropriate prescribing may involve a breach of the standard of care in the basic principles of psychiatric care. For instance, it could be argued that taking an inadequate history, and therefore not coming to a reasoned diagnosis, may lead to a prescribing error, which may subsequently constitute a cause of action. Prescribing without indication; failure to recognize, monitor, and treat side effects; and failure to prescribe the proper dose of medication might also lead to litigation. Inappropriate use of procedures may be subject to the same consequences.

Failure to Diagnose or Failure to Treat

Failure to diagnose, misdiagnosis, or failure to treat could result in litigation due to a breach of the standard of care.

Breach of Privacy

Breach of privacy of confidential medical records has become an increasing focus in Canada and can lead to medical malpractice claims. Each province and territory regulates how personal health information can be shared. There are also legal, regulatory, and ethical requirements with regard to the collection, use, and disclosure of personal information in the context of research. (13)

False Imprisonment

Civil law recognizes false imprisonment as a tort. False imprisonment requires the complete restriction of the plaintiff's physical liberty, directly and intentionally, by another person and requires the plaintiff to prove the imprisonment was unjustified because of a lack of consent or legal authority. (5) In psychiatry, this may arise when the patient is certified under the auspices of the provincial or territorial mental health act, with a claim that this was wrongful. This may involve various acts below the standard of care, such as the treating psychiatrist not carefully documenting their findings and, in particular, not taking the required procedural steps, including completing appropriate forms. Large claims in Canada have mainly been awarded where there has been lengthy detention over several years.

Breach of Duty

Increased legislative safety regulations and controls have decreased personal accidents in society over the course of the twentieth century. Osborne describes the complicated relationship between the use of negligence law and statutory regulatory schemas in increasing safety standards and how these strategies sometimes intersect. (5) Standards of conduct make it easier for the courts to decide on the standard of care, as is to be expected.

The case of *Barker v. Barker* involved actions against the two defendant psychiatrists (as well as the provincial government for direct and vicarious liability) for breach of fiduciary duty and the intentional torts of battery and assault. (14) Breach of fiduciary duty actions are sometimes used by the courts to serve as a deterrent related to public concern about infringements of fiduciary relations. (5) The physician-patient relationship is a fiduciary one that the courts would define as a duty to provide observation, care, and treatment. In *Barker*, it was ruled this was not negligence due to lack of informed consent for involvement in three experimental programs but a breach of fiduciary duty due to this lack of informed consent. The case involved experimental practices, and it was made clear in the judgement that these practices would engender even stricter ethical obligations because they were not commonly used elsewhere and were, in fact, unique. These programs were intended to break down the defences of the patients, all of whom were held involuntarily in a maximum-security hospital. This case highlights the need for rigorous oversight by ethics review boards regarding experimental treatments of psychiatric patients. (15)

Duty to Warn

Patient confidentiality is a core component of Canadian medical ethics. (16) Although this is approached somewhat differently in forensic assessments (see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*), as a treating psychiatrist, lawful authorization or consent is necessary to give information or a medical file to a third party. If information is shared without this consent, circumstances could lead to disciplinary action by a licensing body. Thus far, civil liability for breach of confidentiality has not been developed in Canadian common law. (4)

The concept of a duty to warn and protect others was enunciated in the US in the case of *Tarasoff v. Regents of the University of California*. (17) In this case, a student at the university told his treating psychologist who worked for the university that he intended to kill another student, Tatiana Tarasoff—a plan that he enacted sometime later. In Canada, common law has been developing in this area, including the case of a voluntarily admitted psychiatric patient who left his psychiatric hospital and drove his car in a dangerous manner, colliding with the victim (*Wenden v. Trikha* [18]). In this case, the Alberta Court of Appeal, while dismissing the particular case, did add that there may be a duty to warn and protect others if the requisite proximity (foreseeability) exists between them.

The Supreme Court of Canada ruled on this point in the case of *Smith v. Jones.* (19) This case involved an assessment by a forensic psychiatrist who was thought to be covered under the umbrella of solicitor-client privilege. The court clearly stated that the public safety exception to solicitor-client privilege, the highest privilege in the land, and doctor–patient confidentiality, applied in this case. The court noted that three factors should be considered in determining whether public safety outweighs solicitor-client privilege:

- Is there a clear risk to an identifiable person or group of persons?
- Is there a risk of serious bodily harm or death?
- Is the danger imminent? (19)

Based on this ruling, the Canadian Psychiatric Association produced a guideline that indicated a duty to warn and protect exists

- in the event that a risk to a clearly identifiable person or group of persons is determined;
- when the risk of harm includes severe bodily injury, death, or serious psychological harm; and
- when there is an element of imminence, creating a sense of urgency. (20)

In 2006, the Ontario Court of Appeal ruled that Dr. Stefaniu was liable for the murder committed by her patient, William Johannes. (21,22) After a lengthy stay in hospital, the patient was discharged and killed his sister some weeks later. The case was of particular interest to psychiatrists in that the psychiatrist was found to have fallen below the standard of care in changing the patient's status from involuntary to voluntary and that there was a failure to warn or protect the intended victim. This was despite the patient having visited two emergency rooms without being admitted during the period between being discharged and committing the murder, which highlights the complexity of interpreting causality and proximate cause.

Suicide

The suicide of a patient may lead to a civil action against a psychiatrist. Successful actions against psychiatrists in Canada are limited, given that the prediction of suicide is extremely difficult, (4) and the risk assessment of suicidality can change very quickly. As in other situations, negligence would be established if the doctor failed to practise up to the expected standard of care and the suicide was foreseeable. Regarding standard of care, if the psychiatrist has reason to believe the patient is currently at risk of suicide, then a suicide assessment is completed and documented, and the psychiatrist takes appropriate and reasonable steps to prevent the suicide of the patient. As in other cases, contemporaneous documentation may be an important part of the case. The expert will review this documentation and may be asked to give an opinion on whether it meets the standard of care. Stephenson describes several cases, noting that various factors, such as the unpredictability of suicide and the often impulsive actions of those who commit suicide, mean these cases rarely lead to successful litigation against psychiatrists. (4)

Death

Any death due to negligence or deliberate action by a health care provider can lead to malpractice litigation. Negligence would be established if the physician failed to meet the expected standard of care and death was foreseeable. Family members of the individual who died may sue the physician in these cases.

Assault, Battery, and Sexual Assault

In civil law, *battery* is a legal term defined by law and is codified in Quebec. (6) Although assault and sexual assault are codified under the Criminal Code, they can also be brought forward as a tort, where the standard of proof is the balance of probabilities rather than beyond a reasonable doubt (for example, the OJ Simpson case in the US, where he was not convicted of the criminal charge but liable in the civil suit). It involves direct, intellectual, and physical interference that is either harmful or offensive to a reasonable person. This wrongful action is considered "actionable per se," that is, without proof of damage. This recognizes the societal value put on a person's right to bodily integrity and personal security. A variety of physical assaults, from shooting someone to cutting a person's hair to pushing a person away to taking their fingerprints, could all be considered battery. In particular, a medical examination or any intimate or sexual contact without consent can also be considered battery. Actual body contact is not essential to establishing battery. (5) For instance, pulling a person by their clothing may qualify.

By some anomaly of legal history, in assault and battery cases the burden of proof is on the defendant to establish the conduct was not intentional or negligent. (5) Nowadays, it is more common to use negligence law in a case of battery, except in circumstances where the plaintiff might have difficulty proving negligence. Once proven, the defendant is liable for any consequences, even if they are not foreseeable. This type of action is becoming increasingly common among those who report having been sexually assaulted or are survivors of incest or child abuse. It is also becoming increasingly common among those who were abused in institutional or custodial settings. (5)

A sexual relationship between a physician and a patient is viewed as sexual assault due to the presence of a fiduciary relationship and the power imbalance in the relationship. It is generally held that patients cannot give free and voluntary consent to a sexual relationship due to the inherent nature of the relationship. These types of actions are usually litigated as negligence but could also be battery. In the case of such

a relationship, the psychiatrist may also be disciplined by their provincial or territorial licensing bodies and could also be charged criminally under the Criminal Code for sexual assault. Forensic psychiatrists may become involved as experts in these cases in civil courts, as well as the discipline committees of provincial or territorial licensing bodies in a number of roles. For instance, they may be asked to review records in order to help the court or tribunal decide whether the complainants' medical records should be produced. (23) Later in the process, they may also be involved in a risk assessment of the physician in criminal sentencing for licensing body disciplinary penalty purposes (see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Sexual Behaviour and Risk of Sexual Offending*).

ASSESSMENT OF PROFESSIONAL MISCONDUCT AND MALPRACTICE

A third-party assessment may be requested to aid in understanding whether there was a breach of standard of care and what might have contributed to the behaviour of concern. Alternatively, in a malpractice case, the assessment might be to assess foreseeability, causality, or actual damages to the plaintiff. The referring party may be a provincial or territorial licensing body, counsel representing the plaintiff or the defendant, the CMPA, provincial medical or territorial physician health programs (PHPs), or other counsel. The assessment might be limited to a file review or include an evaluation of the plaintiff or defendant.

Assessors are expected to be familiar with the various statutes, policies, and statements pertaining to professional misconduct and malpractice matters. (1) Assessments are like other types of forensic psychiatry assessments (see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles* and the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Overarching Principles for Civil Psychiatry Assessments*), and the focus is specific to the concerns raised and questions posed.

The assessor must determine if they have the requisite expertise to conduct the assessment and provide the necessary opinion(s), as well as licensing for the jurisdiction. Limitations to the assessment (such as, limited information, reliability, and being in a dual role) are disclosed. Further, as with all third-party assessments, the expert's role in assessing professionals with allegations of professional misconduct or malpractice is to be impartial and not to advocate for any party.

Although these are primarily conducted as a third-party assessment to reduce bias, there are situations where the evaluee's health care provider may be asked to provide an opinion about their patient (plaintiff or defendant). There may also be situations in which the assessor is familiar with the evaluee due to a small practice environment. In these circumstances, it is important for the assessor to acknowledge their dual role and the associated inherent therapeutic bias of such assessments. Failure to disclose a conflict of interest, be objective or nonpartisan, and/or work within the scope of practice or area of expertise can lead to allegations of misconduct or malpractice. Assessors must, of course, recuse themselves if they believe they cannot be unbiased.

As with any assessment, there are situations when the third-party assessor needs to exercise mandatory or discretionary reporting, such as involuntary hospitalization or invoking their duty to warn and protect (see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*).

In general, the more robust and complete the range of information provided to the assessor, the more confident the opinion. It is the assessor's responsibility to ensure they have adequate information to conduct an assessment and provide an opinion. This can be of particular concern when a defendant declines to consent to an interview or give consent for the assessor to obtain collateral information. There may also be times when counsel does not want the defence expert to access collateral sources. It is not uncommon for there to be some controversy about "the facts." In a misconduct case, for example, the assessor may not agree with the allegations in their entirety. Similarly, in a malpractice case, some important facts may be unclear. Clarifying this with the retaining party can help. In some cases, there may be an agreed statement of facts. Alternatively, the medicolegal questions may be posed as a hypothetical (e.g., "Assuming x, what would your opinion be?"). Oftentimes, a verbal opinion is given to the retaining party, who may then give direction on whether a report is required.

As with all forensic psychiatry assessments, the information obtained and reviewed is critically appraised, and it is important to understand any limitations to the assessment.

According to the CMPA, assessors are guided by what is perceived to be realistic standards and the usual or acceptable practice of colleagues in similar circumstances. (2) The standard is not one of excellence or perfection; rather, it is the level of care and skill that could reasonably be expected of a physician with similar training and in circumstances like those of the defendant physician. Experts must also ensure the work of the defendant physician is assessed according to the standards of practice applicable at the time of the event—recognizing that defining the standard of care is subject to the analysis of the court or tribunal. The courts will generally call experienced physicians who act as expert witnesses to help the court determine if there has been compliance with standard medical practice. This is often contested, and experts may be called by both sides, as this might not be a simple or obvious matter. In the final analysis, the standard of care is a matter for the trier of fact.

Table 1. Questions Addressing the Behaviour Leading to the Allegations of Misconduct

- What was the behaviour of concern, over what period, and in what context?
- Has there been similar behaviour before; if so, what were the associated factors?
- Does the evaluee think they did anything that could be deemed inappropriate, less than ideal, or of concern?
- What is the evaluee's perception of and rationale for the behaviour?
- Was the behaviour related to poor judgement, incompetence, personal circumstances, mental illness, environment, or willful wrongdoing?
- Does the evaluee have a lack of skill, knowledge, or judgement?
- Is there evidence of mental impairment (psychosis, mood, cognitive, personality)?
- Is there evidence of anger impacting the behaviour?
- Is there evidence of substance-related impairment impacting the behaviour?
- Are there evident cognitive distortions about the behaviour?
- Have there been any interventions/treatments to date; if so, what was the impact?
- Are others at risk of harm?
- Was the standard of care met?

Professional Misconduct

In assessing a physician accused of professional misconduct, the referring party might ask specific questions regarding the presence of mental illness; whether symptoms impacted the behaviour; prognosis; risk of recurrence or harm to others; mitigating factors; and treatment or other recommendations. The focus of the assessment could also be on whether the physician breached the standard of care. It is important to clarify these questions with the referring party at the outset.

A significant preliminary concern is if the assessing expert knows or has had dealings with the evaluee, as it is common for physicians to have crossed paths with each other, thereby creating a possible conflict of interest or apprehension of bias. The assessment will involve reviewing the collateral information provided by the retaining party, as deemed necessary to complete the assessment. This could include disclosure concerning the allegations, transcripts from examinations for discovery, surveillance footage, and all relevant physician's administrative records, medical records, and information about their practice setting. It can involve contacting collateral sources (i.e., colleagues and family), with permission from the referring party, assessing the individual when requested, and adjunctive testing if indicated. There are situations in which the assessor is asked to provide an opinion on the standard of care based only on the facts of the case.

When interviewing the physician of concern, a full psychiatric assessment is conducted (including background history and psychiatric, substance, and medical history); however, the assessment will focus on the specific behaviour of concern and associated factors. This includes an examination of any patterns of behaviour, motivation for the behaviour(s), and any associated mental disorder—and how this could have impacted the evaluee's behaviour, judgement, decision-making, and interactions. Concerns about sexual improprieties will require a full sexological and relationship history and a history of any boundary violations. Concerns about poor standard of care will require an understanding of the evaluee's knowledge, skills, competence, and attitudes, as well as the context and any changes over time. The assessment might include a review of treatment obtained thus far and an opinion regarding treatment potential and prognosis. It is important to assess the reliability of the evaluee's self-report. All the information obtained is critically appraised, and limitations, including conflict-of-interest concerns, are raised with the retaining party. Psychometric and medical testing may be requested. See Table 1 for additional questions that may be addressed.

Professional Malpractice

For these assessments, counsel may retain an expert for the defendant or the plaintiff. A malpractice assessment primarily focuses on the alleged behaviour of concern rather than the defendant physician's medical or psychiatric history (unless applicable) and whether they met the standard of care. Alternatively, if the plaintiff's counsel retained the assessment, then there may be an assessment of psychological harm and causality.

These professional malpractice assessments are related to negligence, such as lack of competence, failure to obtain informed consent, failure of mandatory reporting, poor provision of care and prescribing practices, wrongful detention, and treatment-related concerns for foreseeable situations regarding suicide, death, or another unintentional

Table 2. Example of a Report Template for Professional Misconduct

- Reason for assessment (specific questions to be answered) and referral source
- Summary of expertise and acknowledgement of duty to provide opinion evidence that is fair, objective, nonpartisan, and related only to matters within the assessor's area of expertise (wording will depend on the jurisdiction)
- Information sources
  - Date and place of interviews (if conducted)
  - Collateral interviews (e.g., colleagues, supervisors)
  - Collateral information (disclosure, including allegations, medical records, etc.)
  - Specify all documents received and reviewed
- Informed consent and confidentiality limits (when an interview is conducted)
  - If it is a file review only, then this and the rationale are stated
- Identifying information
- Behaviour of concern
  - From file review only and other collateral information
  - From self-report, including justification for the behaviour and view of concerns
  - History of the behaviour in question, circumstances, and factors leading to the current evaluation
  - History of similar behaviour or previous issues
- Personal history
  - Early history, conduct, education, employment, relationships
  - Course since medical school
- Psychiatric history and symptom review
- Medical history
- Family medical and psychiatric history
- Substance use history
- Sexological history (as applicable)
- Mental state examination, including reliability of self-report
- Adjunctive testing (as applicable)
- Summary of collateral Information
- Opinions (will depend on the specific questions posed by the retaining party)
  - Any assessment limitations
  - Diagnosis / symptoms and formulation
  - Motivation for behaviour and impact of any illness or psychological factors
  - Interventions to date
  - Problems related to standard of care (as applicable)
  - Alternate viable explanations
  - Prognosis (if requested)
- Risk assessment (if requested)
- Remediation and treatment recommendations, if requested (e.g., practice limitations, supervision, mentorship, personal coaching, anger management, urine drug screens, substance rehabilitation, other therapies)
- Other, such as any recommended testing or further assessment

Table 3. Example of a Report Template for Medical Malpractice of the Defendant

- Reason for assessment (specific questions to be answered) and referral source
- Summary of expertise and acknowledgement of duty to provide opinion evidence that is fair, objective, nonpartisan, and related only to matters within their area of expertise (wording will depend on the jurisdiction)
- Information sources
  - Date and place of interviews (as applicable)
  - Collateral interviews (e.g., colleagues, supervisors)
  - Collateral information (disclosure, including allegations by the plaintiff and medical records created by the defendant and plaintiff, as available)
  - All documents received and reviewed are specified
- Informed consent and limits of confidentiality (when an interview is conducted)
  - If it is a file review only, then this is stated, as is the assessor's rationale
- Identifying information and brief background history
- Collateral information (as applicable)
- Review of the file information and concerns identified (including a timeline, associated factors and behaviours, and context)
- Interview of the defendant (as applicable)
- Mental state examination
- Credibility and reliability of self-report
- Opinions
  - Any assessment limitations (these could also be placed earlier in the report)
  - Explanations for the behaviour, including alternate viable explanations
  - Rationale for how the physician did or did not meet the standards of care based on the information available

harm to self or others. They could also be related to inappropriate conduct, including breach of confidentiality, boundary violations (including sexual), and intentional harmful or offensive behaviour.

Assessments related to professional malpractice concerns might only involve a file review. If this limits the conclusions, then it should be stated. Certain circumstances might only involve a file review and interview with the defendant or plaintiff. An assessment of psychological harm and causality, for example, will likely require an assessment of the plaintiff. This will be conducted as discussed in the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Personal Injury*. Important sources of information include information about the allegations and circumstances leading to the behaviour of concern and the full medical records of the evaluee about the behaviour(s) in question. Other medical records might also be relevant.

If the assessor is asked only to review the defendant's file, then they review the various sources of information and conclude with an opinion based on the standard of reasonable care that a prudent physician of ordinary skill and training could reasonably have been expected to provide under similar circumstances. (7) The physician's specialty or subspecialty and qualifications are also considered. The defendant's potential motivation or contributing factors relevant to their behaviour might also be assessed (e.g., incompetence, poor judgement, mental illness, substance abuse, personal situation), if requested.

REPORT WRITING

The CMPA and most of the regulatory colleges in Canada have policies and statements about medicolegal reports, and assessors will likely be aware of these.

When a written report is requested, it follows the format described in the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles* for all forensic psychiatry reports. The report includes the referral source and purpose of the assessment, sources of information, assessment limitations, identifying data, the assessor's expertise, and summaries of information gathered from interviews and collateral sources. When the evaluee is interviewed, the report will also include informed consent and limits of confidentiality, a history from their perspective, a review of symptoms and mental status examination, and adjunctive testing as applicable. Opinions are limited to the questions posed by the retaining party.

At the beginning of the report, it is paramount the assessor clearly states when they have not done a direct assessment of the defendant and why they only conducted a file review.

Professional Misconduct

See Table 2 for an example of a report template for professional misconduct. See the section on Report Writing (above) for an overview of the report that applies to both professional misconduct and malpractice.

The assessor focuses on the questions posed by the retaining party, including any concerning behaviour and nexus between the behaviour and any psychiatric or medical issues that could be contributing factors.

Although psychiatrists focus on DSM-5 diagnoses, dealing with professional misconduct often involves the evaluation of high-functioning, highly intelligent individuals with strong compensatory mechanisms who are consciously and unconsciously motivated to appear in a certain way. They might not have a DSM diagnosis and may be minimizing their symptoms or psychologically unaware of their issues, making a DSM diagnosis less obvious. Whether or not the evaluee has a psychiatric disorder, it is important to have a comprehensive biopsychosocial understanding of the individual, including all factors relevant to the behaviour in question, their motivation, and the impact of the disorder or symptoms on their behaviour.

The assessor provides clear and reasoned opinions based on the background information in the report. If there are competing explanations for the behaviour in question, the assessor provides an opinion on which of the possibilities is viewed as most compelling and their rationale. The retaining party might also request opinions on prognosis or treatment, assessment of risk, and other recommendations. The latter might include a variety of measures, such as random urine testing for substance use, attendance with their physician at specified intervals, reporting to the college, and practice limitations. The expert might also suggest workplace monitoring, supervision, or mentoring.

Professional Malpractice

When a report is requested about the defendant, the focus is on whether the physician (or other professional) met the standard of care and the assessor's rationale for that opinion.

See Table 3 for an example of a report template for an assessment of a defendant in a medical negligence case. See the above section on report writing for an overview that applies to both professional misconduct and malpractice. If the report is an assessment of the plaintiff, the focus will be on the nature and degree of any psychiatric injury caused by the tort (see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Personal Injury*).

Regarding the standard of care by the defendant, the relevant background information and behaviour of concern are described, including time period(s), associated behaviours, and context. In commenting on the standard of care, the assessor must be aware it is according to the standard applicable at the time of the event—recognizing that defining the standard of care is subject to the analysis of the court or tribunal. Further, as indicated above, it is important to provide opinions about the standard of care as it relates to the level of care and skill that could reasonably be expected of a physician with similar training and in circumstances like those of the defendant physician.

AUTHOR AFFILIATIONS

[1]Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada.

REFERENCES

1. Bloom H, Schneider R. Law and mental disorder: a comprehensive and practical approach. Toronto (ON): Irwin Law; 2013.
2. Canadian Medical Protective Association. Understanding how colleges handle complaints or allegations of professional misconduct. Ottawa (ON): Author; 2021 [cited 2024 April 22]. Available from: https://bit.ly/476fTef.
3. Hickson GB, Pichert JW, Webb LE, et al. A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. Acad Med 2007;82(11):1040–1048.
4. Stephenson J. Psychiatric malpractice. In: Bloom H, editor. Law and mental disorder: a comprehensive and practical approach. Toronto (ON): Irwin Law; 2013. p 1147–1168.
5. Osborne PH. The law of torts. Toronto (ON): Irwin Law; 2011.
6. The Canadian Medical Protective Association. Medico-legal handbook for physicians in Canada. Ottawa (ON): Author; 2021/revised 2024 [cited 2024 April 22]. Available from: https://www.cmpa-acpm.ca/en/advice-publications/handbooks/medical-legal-handbook-for-physicians-in-canada
7. Lapointe v. Hôpital Le Gardeur, 1 SCR 351 (1992).
8. Snell v. Farrell, 2 SCR 311 (1990).
9. Halpern J. From detached concern to empathy: humanizing medical practice. New York (NY): Oxford University Press; 2001.
10. Reibl v. Hughes, 2 SCR 880 (1980).
11. Hopp v. Lepp, 2 SCR 192 (1980).
12. Wettstein R. Specific issues in psychiatric malpractice. In: Rosner R, editor. Principles and practice of forensic psychiatry. New York (NY): Chapman and Hall; 1994. p 325–336.
13. Mela M, Luther G, Gutheil TG. Forty-five years of civil litigation against Canadian psychiatrists: an empirical pilot study. Can J Psychiatry 2016;61(2):112–118.
14. Barker v. Barker, ONSC 3746 (2020).
15. Bradford JMW, Glancy G, Heintzman M. Psychiatric abuse of patients detained involuntarily by the state. Wiley Online Library; 2021. p 151–155.

16. Canadian Medical Association. CMA code of ethics and professionalism. Ottawa (ON): Author; 2018/rev. 2024 [cited 2024 April 22]. Available from: https://policybase.cma.ca/link/policy13937?_gl=1*w4gkbq*_ga*MjAxNzY4NTQ5Mi4xNzEzMjcyODUx*_ga_91NZ7HZZ51*MTcxMzI3Mjg1MS4xLjEuMTcxMzI3MzQzNC42MC4wLjA.
17. Tarasoff v. Regents of the University of California, 17 Cal. 3d 425 551 P.2d 334 131 Cal. Rptr. 114.
18. Wenden v. Trikha, 135 AR 382 (1993).
19. Smith v. Jones, SCR 455 (1999).
20. Chaimowitz G, Glancy G. The duty to protect. Can J Psychiatry 2002;47(7):Suppl 1–5.
21. Ahmed v. Stefaniu, OJ 4185 (2006).
22. Glancy D, Glancy G. The case that has psychiatrists running scared: Ahmed v. Stefaniu. J Am Acad Psychiatry Law 2009;37(2):250–256.
23. Glancy G, Patel M, Borooah M. Participation as an expert in cases involving the production of mental health records. International Journal of Risk and Recovery 2022;5(1):44–51.