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Chapter 41

Psychiatric Malpractice

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The development and emergence of malpractice lawsuits against psychiatrists have been very gradual and seemingly of recent occurrence. Malpractice actions against psychiatrists have steadily increased since the early 1970s. In 1970, Slawson noted that defendant psychiatrists try to avoid publicity, and many cases escape notice. A survey of psychiatric malpractice claims in southern California between 1958 and 1967 showed no increase in claims rate and an average of 1.5 claims per 100 psychiatrists per year. Most claims were settled for a modest fee before trial.[1] In 1993, the low frequency risks of psychiatric malpractice were reported again, based on the American Psychiatric Association professional liability insurance program which had insured an average of 10,000 psychiatrists each year since 1984. Two thousand malpractice insurance cases had been entered into a purpose configured relational database to permit analysis of clinical, demographic and economic variables. The results indicated low frequency risks of psychiatric malpractice.[2]

CASE PRESENTATIONS

Case 1

In 1976, *Tarasoff v. Regents of Univ. of California*[3] was the first case to find that a mental health professional may have a duty to protect others from possible harm by their patients. In Tarasoff, a lawsuit was filed against, among others, psychotherapists employed by the Regents of the University of California to recover for the death of the plaintiffs' daughter, Tatiana Tarasoff, who was killed by a psychiatric outpatient. Two months prior to the killing, the patient had expressly informed his therapist that he was going to kill an unnamed girl (who

was readily identifiable as the plaintiffs' daughter) when she returned home from spending the summer in Brazil.

The therapist, with the concurrence of two colleagues, decided to commit the patient for observation. The campus police detained the patient at the oral and written request of the therapist, but released him after satisfying themselves that he was rational and exacting his promise to stay away from Ms. Tarasoff. The therapist's superior directed that no further action be taken to confine or otherwise restrain the patient. No one warned either Ms. Tarasoff or her parents of the patient's dangerousness.

Upon her return from Brazil, Ms. Tarasoff was killed by the patient. After the patient murdered Ms. Tarasoff, her parents filed suit alleging, among other things, that the therapists involved had failed either to warn them of the threat to their daughter or to confine the patient.

The California Supreme Court, while recognizing the general rule that a person owes no duty to control the conduct of another, determined that there is an exception to this general rule where the defendant stands in a special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct. The court made an analogy to cases which have imposed a duty upon physicians to diagnose and warn about a patient's contagious disease and concluded that by entering into a doctor-patient relationship the therapist becomes sufficiently involved to assume some responsibility for the safety, not only of the patient, but also for any third person whom the doctor knows to be threatened by the patient.

The court also considered various public policy interests determining that the public interest in safety from violent assault outweighed countervailing interests of the confidentiality of patient therapist communications and the difficulty in predicting dangerousness. The California Supreme Court held: When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.

Case 2

On June 27, 1991, at 9:25 a.m., Gad Joseph telephoned his mental health counselor to tell him that he was going to kill his ex-girlfriend, Teresa Hausler. The counselor immediately had him come in for therapy, which began at 11:00 a.m. and ended at noon, that same day. Gad

promised his counselor that he would not hurt Teresa. Fifteen minutes later, Teresa telephoned the counselor to tell him that she was going to Gad's apartment to pick up her clothing. The counselor advised her not to go to the apartment but to return to her new home in Reading. Teresa ignored the counselor's advice and continued onto Gad's apartment. At 12:30 p.m. Gad arrived and, in a fit of rage, fatally shot Teresa six times in the head and abdomen.

Subsequently, Teresa Hausler's family filed a lawsuit against the mental health counselor and his employer, Albert Einstein Medical Center in Philadelphia, alleging failure to warn Teresa.[4] At that time, the law in Pennsylvania was unclear regarding what duty a medical professional owed to a third party who is not the patient. The plaintiff cited *Tarasoff v. Regents of the University of California (1976)*. The facts of *Tarasoff* were eerily similar to the facts in the Teresa Hausler case. In 1998, because of the actions of Gad and Teresa, the Supreme Court of Pennsylvania expressly adopted *Tarasoff* as law.

ISSUES

Along with the incidence of malpractice actions, the variety of claims against psychiatrists has also increased. Some causes of action reflect acts of negligence or substandard care for which any physician may be found liable. These malpractice areas include negligent diagnosis, abandonment from treatment, various intentional and quasi-intentional torts (assault and battery, fraud, defamation, invasion of privacy), failure to obtain informed consent, and breach of contract. Areas of liability specific to psychiatry include harm caused by organic therapies (electroconvulsive therapy [ECT], psychotropic medication), breach of confidentiality, sexual exploitation of patients, failure to control or supervise a dangerous patient or negligent release, failure to protect third parties from potentially dangerous patients, false imprisonment, and negligent infliction of mental distress. These claims represent the major causes of action that may be brought against a psychiatrist.

Malpractice actions based on a psychiatrist's use of psychotropic drugs have been fairly infrequent considering the widespread use of this form of treatment during the past 20 years. With managed care, more frequent utilization of the psychiatrist as the prescriber of medication with the psychotherapy, and primary care parceled out to psychologists and other nonmedical therapists, more actions based on medication can be expected.

Negligence is more likely to be found in high-risk situations in which either the psychiatrist's choice of intervention or manner of supervision was unreasonable under the circumstances. The *Clites v. Iowa* case is one of the first decisions specifically dealing with TD and aptly illustrates some of the liability considerations.[5] The court ruled that the defendants were negligent because they deviated from the standards of the "industry." Specifically, the court cited a failure to administer regular physical examinations and tests; failure to intervene at the first sign of TD; the inappropriate use of drugs in combinations, in light of the patient's particular condition and the drugs used; the use of drugs for the convenience of controlling behavior rather than therapy; and the failure to obtain informed consent.

Breach of confidentiality

The duty to safeguard the confidentiality of any communication in the course of psychiatric treatment is the cornerstone of the profession. This obligation of confidentiality is fundamental, but none is more keenly sensitive to its importance than mental health professionals. This point is aptly reflected in the ethical codes of the various mental health organizations.

Confidentiality in a psychiatric perspective embodies two fundamental rationales. First, a patient has a right to privacy that should not be violated except in certain legally prescribed circumstances. Second, physicians have historically been enjoined (on an ethical basis) to maintain the confidences of their patients. In doing so, patients should feel more comfortable revealing information, which would enhance their treatment.

Psychiatrists have always been susceptible to ethical sanctions if they breach patient confidentiality, but liability for monetary damages is a relatively recent development. Several legal theories allow a patient plaintiff recovery for breach of confidentiality. Besides statutory bases, some courts have upheld a cause of action based on breach of confidentiality on a contract theory. Accordingly, a psychiatrist is considered to have implicitly agreed to keep any information received from a patient confidential, and when he or she has failed to do so, there is a breach of that implied contract term by the psychiatrist. In cases based on this theory, damages typically have been restricted to economic losses flowing directly from the breach, but compensation based on any residual harm (e.g., emotional distress, marital discord, loss of employment) is precluded.

Theories based on invasion of privacy have supported recovery involving breach of confidentiality. The law defines invasion of privacy as an "unwarranted publication of a person's private affairs with which the public has no legitimate concern, such as to cause outrage, mental suffering, shame, or humiliation to a person of ordinary sensibilities."[6]

In many states the legal duty to maintain patient confidentiality is governed by mental health confidentiality statutes. These statutes outline the legal requirements covering confidentiality.

Failure to warn or protect

Confidentiality was considered sacrosanct by the psychiatric profession until the Supreme Court of California heard the case *Tarasoff v. Regents of the University of California* in 1976, (Case 1 presented above). The response by the courts following the 1976 California decision has been inconsistent and at times, confusing. Several courts have followed the holding of *Tarasoff,* concluding that a therapist was liable for not warning an identifiable victim. A slightly broader but analogous limitation has been fashioned by decisions where the courts have recognized a duty to warn only when the victim is "foreseeable." Cases to date involving some form of the duty-to-warn theory can be viewed as falling somewhere on a continuum based on two common factors: (1) a threat (or potential for harm) and (2) a potential victim. At one end is the "specific threat specific victim" rule, [7] and at the other end is "foreseeable violence" created a duty to protect "others," regardless of whether the victim was identified or specified. [8] At present, most courts have held that in the absence of a foreseeable victim, no duty to warn or protect will be found. Reviewing the cases, a few facts stand out. Most notable is the relative absence of litigation that most commentators thought would occur after the *Tarasoff* decision.[9]

The liability considerations that underlie the treatment and care of the dangerous patient generally differ according to the amount of control a psychiatrist, therapist, or institution has over the patient. As a general rule, psychiatrists who treat dangerous or potentially dangerous patients have a duty of care, which includes controlling that individual from harming other persons inside and outside the facility as well as himself or herself. On the other hand, the outpatient who presents a possible risk of danger to others creates a duty of care, which may include warning or somehow protecting potential third-party victims.

Whatever the extent of the duty imposed by the *Tarasoff* decision and its progeny, a psychiatrist or therapist cannot be held liable for a patient's violent acts unless it is found that (1) the psychiatrist determined (or by professional standards reasonably should have determined) that the patient posed a danger to a third party (identified or unidentified) and that (2) the psychiatrist failed to take reasonable steps to prevent the violence.

Sexual exploitation

From a legal standpoint, the courts have consistently held that a physician or therapist who engages in sexual activity with a patient is subject to civil liability and in some cases to criminal sanctions. The reason for this overwhelming condemnation rests in the exploitative and often deceptive practice that sex between a health care professional (e.g., psychiatrist, physician, therapist) and patient represents. The fundamental basis of the psychiatrist-patient relationship is the unconditional trust and confidence patients have in the therapist. This trust permits patients to share their most intimate secrets, thoughts, and feelings.

Abandonment

Once an agreement (explicit or implicit) to provide medical services has been established, the physician is legally and ethically bound to render those services until the relationship has been appropriately terminated. If a physician terminates treatment prematurely and the patient is harmed by the termination, a cause of action based on "abandonment of treatment" may be brought. Generally, in the absence of an emergency or crisis situation, treatment can be concluded safely if a patient is provided reasonable notice of the termination and is assisted in transferring the care to a new physician. Proper transfer of care typically implies that the original psychiatrist prepares and makes available the patient's records as needed by the new psychiatrist. It is also prudent for the original care provider to give the patient written and verbal notice to avoid any possible questions regarding the nature, timing, or extent of the announcement of termination.

The issue of abandonment frequently arises when either no notice of termination has been given or the extent of this notice has been insufficient in some way. Although there are no rules or guidelines *per se* regarding sufficiency of the notice, a therapist who decides to terminate treatment is expected to act reasonably.

Patient control and supervision

The treatment of patients who pose a risk of danger to themselves or others presents a unique clinical and legal challenge to the mental health profession. A lawsuit for patient suicide or attempted suicide is often brought by a patient's family or relatives claiming that the attending psychiatrist, therapist, or facility was negligent in some aspect of the treatment process. Specifically, there are three broad categories of claims that encompass actions stemming from patient suicide. The first is when an outpatient commits suicide or is injured in a suicide attempt. Plaintiffs in this situation claim that the psychiatrist or therapist was negligent in failing to diagnose the patient's suicidal condition and provide adequate treatment, which is typically hospitalization. The second situation is when an inpatient is given inadequate treatment and commits or attempts suicide. Typically, the essence of a negligence claim involving inadequate treatment is that the patient was suicidal and the psychiatrist failed to provide adequate supervision. The last general situation is when a patient is discharged from the hospital and shortly thereafter attempts or commits suicide. Family members, or the injured patient, frequently claim that the decision to release the patient was negligent.

The treatment of suicidal or potentially suicidal patients inherently requires a psychiatrist or other practitioner to make predictions regarding future behavior. The mental health profession has frequently disclaimed ability to predict future behavior with any degree of accuracy. As a result, the law has tempered its expectation of clinicians in identifying future dangerous behavior. Instead of a strict standard requiring 100% accuracy, the law requires professionals to exercise reasonable care in their diagnosis and treatment of patients at risk.[10] Accordingly, a court will not hold a practitioner liable for a patient's death or injury resulting from suicide if the treatment or discharge decision was reasonably based on the information available.

As in cases involving suicide, a treating psychiatrist or other practitioner cannot be held liable for harms committed after a patient's discharge (e.g., negligent release) unless the court determines (1) that the psychiatrist knew or should have known that the patient was likely to commit a dangerous or violent act and (2) that in light of this knowledge, the psychiatrist failed to take adequate steps to evaluate the patient when considering discharge. Similarly, in cases involving third parties injured by a dangerous patient who has escaped, the court evaluates (1) whether the psychiatrist knew or should have known that the patient presented a risk of

elopement and (2) in light of that knowledge, whether the psychiatrist took reasonable steps to supervise or control the patient. The actions of a psychiatrist in a negligent discharge or negligent control or supervision claim are scrutinized based on the reasonableness of the actions and the standards of the profession.

SURVIVAL STRATEGIES

1. All psychiatric patients should be medically evaluated, in addition to the psychiatric evaluation. Medical conditions, such as subdural hematoma, encephalitis, and AIDS sometimes present primarily psychiatric symptoms. Psychiatrics patients may have associated medical problems, including diabetes and other metabolic disorders, hormonal imbalance and abuse or failure to conform to their medications.

2. Appropriate psychiatric, neurologic, neuropsychological, laboratory and radiologic testing should be performed and documented; genetic testing may be indicated in some patients.

3. Psychiatrists must conform to good psychiatric (medical) community standards and act like "reasonable individuals" under like circumstances.

4. Careful and scrupulous documentation is indicated in the care of all psychiatric patients, but the psychiatric record should include only clinical data, and never legal opinions or derogatory comments. Good record keeping is a must because it is the strongest defense against a lawsuit, or in support of a contention.

5. Psychiatric patients share the same substantive constitutional rights as other patients. Compulsory medication may be regarded by the courts as an intrusion on the patient's liberty interest, a deprivation of the freedom of thought, and cruel and unusual punishment.

6. A psychiatric patient may not be confined involuntarily if he or she is not dangerous to anyone and can live safely in freedom.

7. It is permissible for a psychiatrist to confine a patient involuntarily after a proper evaluation determines that a mental disorder exists, without being liable for malpractice, under the following circumstances:

    a. When the patient actually injures himself or others;

    b. When the patient can be expected in the near future to injure himself or others;

c. When the patient has engaged in recent overt acts or made significant recent threats that substantially support those expectations; and

d. When the patient is unable to attend to his or her basic needs (gravely disabled).

Mere acts of destruction of property by the mentally ill patient are usually insufficient to justify involuntary commitment.

8. Psychiatrists should respect the rights of hospitalized patients to refuse medication unless there is evidence that the individual is determined to be incompetent after a hearing before an independent trier of fact who provides consent on behalf of the patient. This applies equally to the voluntarily and the involuntarily hospitalized individuals. The psychiatrist often has to decide whether the patient is truly competent to refuse the medication offered. If the refusal is based on a delusional system of the patient's illness, he or she may not be competent to refuse treatment. If the situation becomes an emergency, and medication is required, the physician may administer a temporary dose of medication to handle the emergency, and then reassess the patient's condition and the situation. A physician should not give long acting psychotropic medication in an emergency situation.

9. Psychiatric patients who are placed in seclusion and/or restraint should be observed regularly. Failure to do so could lead to a malpractice lawsuit. In addition to regulations regarding seclusion and restraint, hospitals should have specific policies and procedures regarding observation of suicidal patients and elopement precautions.

10. Psychiatric patients should be treated in the least restrictive environment necessary for the clinical needs of the patient. For example, it would be improper to place a homicidal or suicidal patient in a situation where he or she may act out the destructive behavior.

11. Psychiatric patients most commonly become the source of malpractice actions if they injure themselves or others. Psychiatrists may be found liable for damages if psychiatric patients injure themselves, commit suicide, injure others, elope, prove false imprisonment, or prove sexual abuse. Psychiatrists should take appropriate steps to avoid such allegations. At all times, they should use good clinical judgment, and adequately document the risks and benefits of treatment.

12. In psychiatry, the most common reasons for malpractice include improper diagnosis and treatment, suicide, violence to others, mishandling the transference (sexual exploitation of the patient), and violation of the patient's rights.

CONCLUSION

The issue of reasonableness, whether involving the diagnosis, supervision, or treatment of a patient, is usually measured in terms of the accepted standards of the profession. Expert testimony is needed to establish or disprove that the defendant psychiatrist failed to exercise the reasonable care other psychiatrists would have used in that or similar circumstances. The risk of liability is greatly enhanced when it can be demonstrated that a practitioner or institution failed to follow its own usual practices and procedures for treating a patient.

GOLDEN RULES

1. Diagnose psychiatric patients only after doing a competent assessment.
2. Obtain and thoroughly document informed consent, especially before utilizing physical therapies, such as electroconvulsive therapy and psychotropic medication.
3. Avoid even the appearance of sexual exploitation of a patient.
4. Control or supervise a dangerous patient with great care and document such care.
5. Warn and protect third parties from potentially dangerous patients.
6. Use the least intrusive alternative to commit or restrain a psychiatric patient.

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