Psychiatric Malpractice: Basic Issues in Evolving Contexts

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This article focuses on 4 issues in psychiatric malpractice: prescribing, liability for suicide, informed consent, and duty to protect under the Tarasoff v Regents of the University of California ruling. Malpractice is a civil wrong actionable by law. There are 2 goals of malpractice suits: the first is to make an injured plaintiff whole by an award of money, and the second is to inform the profession how courts will decide similar cases in the future.

Since there is no malpractice unless there is a physician-patient relationship, it is critical that psychiatrists know how the relationship comes into existence. A jury may seize on relatively small acts performed by the psychiatrist to construe that a reasonable person would think a professional relationship had formed. It is equally important to know when the relationship ends. So long as it exists, the psychiatrist owes the patient a duty to practice with the skill and competence that is possessed by the reasonable and prudent psychiatrist under similar circumstances.

Although courts rely on the profession to determine standards of care, this reliance is not absolute. As one judge put it, "Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission." Informed consent and the Tarasoff duty are examples of judge-made duties. Today, this doctrine, though limited in application, suggests that psychiatrists keep a careful eye on emerging technologies.

Before proceeding, we recognize that psychiatric malpractice is as emotionally devastating as it is a fact of life for the practitioner. A recent New Yorker cartoon showed Hippocrates addressing medical students. The caption read, "First. Treat no lawyers!" Why such negativity? It may be because a call from a patient's lawyer or from a lawyer working for a state licensing agency can be terrifying. Law is a negative contact sport and psychiatrists are ill-equipped by their nature to play. Lawyers, on the other hand, are by nature adversarial. You can anticipate that a lawyer going against you will be more logic-driven than scientific and will hold considerable skepticism concerning your expertise.

Prescribing drugs
Any drug requiring a prescription is by law "dangerous" (California Business and Professions Code §4022) and the act of prescribing a drug establishes the existence of the psychiatrist-patient relationship. Therefore, the act of prescribing gives rise to legal duties. The discharge of these duties requires not only our expertise but also our time. These duties cannot be accomplished by a quick review of a chief complaint and a brief mental status examination.

The traditional dyadic psychiatrist-patient relationship now often includes a variety of others relationships, such as nonmedical therapists, clinical laboratories, institutional administrators, and fiscal intermediaries. In shared-care situations, a physician may think he or she is the only member of the team, but a judge may consider the psychiatrist to be the "captain of the ship." In O'Reata v Yusuf (2006), the Court reversed a judge who refused to instruct the jury on the captain-of-the-ship doctrine. In finding that the captain-of-the-ship doctrine was applicable, the court focused on the doctor's "temporary special relationship" with a nurse and his overall authority and responsibility and not on any right to exercise control over the how and when. Consider the psychiatrist in a community mental health center who is responsible for making the diagnosis and developing, or signing off on, a treatment plan that delegates therapeutic issues to a psychiatric nurse, a clinical social worker, and a family therapist. Although the doctrine may not extend to a coprovider psychologist, it is arguable that it applies to all the others.

The psychiatrist must resist pressure to take prescribing shortcuts. The psychiatrist should have a
basis to believe that all coinvolved parties are competent and acting within their scope of practice. Psychiatrists who ignore these issues of competency risk direct liability for uninformed decisions as well as indirect or vicarious liability for the wrong acts of others. Divisions of responsibility should be made clear to all, including the patient.

Good practice and common sense are excellent risk-management tools to lessen liability exposure when prescribing medications. At minimum, follow these basic tenets:

- Do a thorough examination.
- Determine a valid diagnosis.
- Decide on an appropriate course of treatment.
- See your patients long enough and frequently enough to do a good job.
- Stay current with evolving standards and new technologies.
- Order appropriate lab tests and act on the results in a timely manner.
- Respond to lack of progress.
- Do not hesitate to seek consultation.
- Obtain second opinions: a second opinion is good practice and better risk management.
- Be sure your instructions are appropriate and understood when obtaining consent. Proper consent with bad instructions could be considered “constructive abandonment.” Constructive abandonment occurs when the psychiatrist leaves the patient in the lurch—constructively abandons the patient—at a critical moment. Consider the psychiatrist who warns the patient about a potentially serious side effect but fails to tell the patient what to do if it occurs.
- Do not take on more cases than you can handle.
- Do not deviate from ordinary practice without a very good, articulable reason.
- Do not err by prescribing the right drug in the wrong dose or to the wrong patient.
- Do not rely on a pharmacist to catch mistakes or decipher bad penmanship.
- Never prescribe to nonpatients; if you do, you risk both civil liability and disciplinary action by your state licensing agency.
- Attend to the therapeutic alliance: patients who like their doctors are far less likely to sue them.

Liability for suicide

Patient suicide is the most frequent source of malpractice claims against psychiatrists. Yet, according to Robert Simon, MD, "Suicide risk can vary from minute to minute, hour to hour, day to day. This makes any prediction about the imminence of suicide illusory." If psychiatry cannot reliably predict suicide, how can a psychiatrist be found negligent for patient suicide? The answer involves differentiating suicide prediction from suicide risk assessment. Although it is difficult to predict suicide, there is an evolving standard of care for suicide risk assessment. Thus, prediction may be illusory but risk assessment is not.

The key to an adequate suicide risk assessment is to gather necessary clinical data and identify unique risk factors. This may require a detailed interview, a review of the patient's past psychiatric records, and obtaining collateral information from the patient's family. In order to provide appropriate treatment and to minimize potential liability, it may be necessary to conduct this evaluation in a psychiatric emergency room or arrange for hospitalization of the patient. If a patient does not meet criteria for involuntary treatment, the psychiatrist may consider voluntary hospitalization, partial hospitalization, or more frequent office visits.

In judging acute risk, it is best to rely on objective data and not exclusively on clinical intuition based solely on experience. Modifiable and treatable risk factors need to be identified. Risk factors for suicide include expressed intent; active mental illness; and clinical symptoms such as depression, anxiety, insomnia, impulsivity, agitation, and a history of past suicide attempts. The psychiatrist should also address psychosocial factors, such as access to firearms, substance abuse, and situational stresses (eg, recent loss of a relationship, job, or housing). Protective factors, such as family support, religious commitment, and access to mental health treatment, should also be considered.

Psychiatrists should not exclusively rely on a patient's statements to avoid the pitfall of being reassured when a patient denies suicidal ideation or agrees to a no-suicide contract; such statements may be misleading. High-risk patients motivated to end their lives may tell the psychiatrist what they believe the psychiatrist wants to hear.

After the threat has been assessed and a risk has been determined, a plan of action should be designed and implemented. The plan should address identified risk factors. For example, if risk
factors include insomnia, access to firearms, and the need for ongoing mental health treatment, the treatment plan might include insomnia treatment, removal of the firearm from the home, and arrangements for appropriate mental health treatment. To avoid a finding of negligence, proper documentation is crucial; juries may conclude that if it wasn't documented, it wasn't done. Finally, psychiatrists should attend to inconsistent documentation. A malpractice attorney will have a field day if a psychiatrist's last note indicates that the patient's anxiety and suicidal ideation have abated, while the nurse or other coinvolved clinicians contemporaneously state that the patient does not sleep, paces, and continues to endorse suicidal thoughts.

Informed consent
Informed consent flows from the principle that competent individuals have the right to make their own treatment decisions. Informed consent respects patient autonomy, optimizes the doctor-patient relationship, and reduces liability by eliminating surprises from the care. Proper informed consent involves discussions with the patient on the condition and proposed treatment, including discussion of the risks and benefits of the proposed intervention as well as reasonable alternatives. This requires a focus not only on what a reasonable physician would say and what a reasonable patient would want to know but also on the quality of physician-patient communication. Physicians are not obliged to review all possible outcomes, only reasonably foreseeable outcomes. The burden to inform is higher, however, in situations where a poorly informed refusal would place the patient at substantial risk. The psychiatrist should be aware that liability may attach to outcomes that were not due to negligence but were foreseeable, yet not covered by the informed consent process. In practice, physicians often use a consent form that patients are asked to sign in lieu of substantive discussion. Doing so places more emphasis on the disclosure of facts than on the patient's understanding of those facts. Informed decision making is best achieved when, through a dialogue with his physician, an individual receives enough information to meaningfully weigh the risks and benefits of treatment and then uses this understanding to make treatment decisions. Documentation of the consent discussion is critical for liability protection.

Optimal informed consent procedures involve a dynamic process of informing and updating, rather than a singular event at the initiation of a treatment. When "consenting" occurs throughout treatment, the patient has the opportunity to reaffirm or withdraw consent at any point, based on information received or new alternatives identified. The patient also shares the therapeutic uncertainty and accepts an "owner's interest" in the outcome. Since symptoms of illness often fluctuate, treatment often occurs in phases. This suggests informed consent ought to be approached in phases as well. Phase-specific informed consent involves consideration of the patient's capacity to comprehend increasingly sophisticated information, new information a patient would want to know at various points during treatment and recovery, and how to most effectively present this information. This may be summarized by the following inquiry:

- Has the mental status of my patient changed?
- Would my patient wish to alter the treatment decision based on better understanding or more information?

In addition to being a good risk management strategy, the informed consent doctrine is essential to ethical medical care. The goal and emphasis must not be simply to obtain consent but to engage patients in an ongoing dialogue that provides information and ensures voluntary compliance with recommended treatments. This is not achieved by a one-time consent event. The psychiatrist's liability is reduced by the implementation and documentation of consent procedures that reinform and reconsent throughout treatment, accompanied by adequate documentation.

Duty to protect
One of the most complicated duties of the psychiatrist is the duty to protect third parties from a potentially harmful patient when the patient has expressed a viable threat to that third party. Before 1970, this was not a legal issue for psychiatrists. However, with the Tarasoff ruling in 1976, a responsibility was confirmed for therapists, and subsequently all psychiatrists, to protect certain individuals who were not their patients. Many jurisdictions beyond California have adopted this ruling, holding psychiatrists to a similar standard. The difficulty for psychiatrists lies in understanding exactly which third parties need to be protected and how the psychiatrist is supposed to protect them. All psychiatrists practicing in a Tarasoff jurisdiction should know what that means for their clinical behavior.

A common misunderstanding is that the Tarasoff duty, as defined in California and other
jurisdictions, is a duty to warn, rather than a duty to protect. However, the duty is not to warn; it is a duty to protect. This misunderstanding is not limited to psychiatrists. As recently as 2001, a California court incorrectly defined it as a duty to warn in its jury instructions prompting a petition to amend the California Civil Code to more explicitly define a duty to protect. The California Supreme Court had, in fact, held:

The discharge of this duty may require the therapist to take . . . various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

Warning an intended victim is only one of several ways to protect the person at risk. Informing the police is another. Sometimes these are the only actions available. However, neither of these actions may be sufficient to protect the psychiatrist against suit if negligent treatment rather than failure to warn is held to be the proximate cause of injury to the third party. To determine this, the court will ask if the treatment should have been changed or if the patient should have been seen more frequently or hospitalized. Some clinicians remain concerned about warning third parties (even when legally required) because of confidentiality issues, potential reactions from the person being warned, and so forth. These concerns can be managed clinically. It must be kept in mind that the court clearly stated, “In this risk-infested society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal.”

Because jurisdictions in the United States are different, the first step is to find out whether your jurisdiction has a duty to protect third parties requirement and whether there are guidelines for informing psychiatrists how that duty is to be discharged. When faced with a situation in which a patient has expressed a viable threat to harm an identifiable victim, the psychiatrist must take the following steps to ensure the duty to protect is performed:

- Assess the threat for imminence and likelihood.
- If the threat is determined to be imminent and likely, establish a method of protecting the victim.
- Execute the method of protection.
- Follow up with the method to ensure it was effective.

There are several sources that are helpful for guidance on each of these steps. In performing a stepwise assessment and execution of a method of protection, psychiatrists will be able to treat their patients effectively, protect the third parties as mandated by law, and minimize risk of liability.

**Conclusion**

Not all negligent acts cause injuries and not all injuries result in lawsuits. However, many untoward outcomes of treatment, both medical and legal, are avoidable by focusing on evidence-based care and applying the principles outlined in this article. We accomplish this by practicing psychiatric medicine with compassion and competence, with an eye on evolving legal and medical standards. Although society has delegated health care delivery to us, it has delegated the resolution of disputes over the results of health care delivery to the law.

**References:**

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