Current PSYCHIATRY

Practice, not malpractice

3 clinical habits to reduce liability risk

Psychiatrists face legal risk not only when patients are harmed but also when they harm others.

Jeffrey M. Watabe, MD
Fellow in forensic psychiatry
University Hospitals of Cleveland
Case Western Reserve University
Cleveland, OH

Daniel K. Hall-Flavin, MD
Assistant professor of psychiatry
Mayo Medical School
Consultant, department of psychiatry and psychology
Mayo Clinic
Rochester, MN

Psychiatrists' risk of malpractice liability[1] is broadening as courts consider the uncertainties of off-label prescribing, telemedicine, and confidentiality. Juries are holding mental health practitioners responsible for harm done both to and by psychiatric patients.

How you keep medical records, communicate with patients and colleagues, and arrange consultations can reduce your malpractice risk *(Box 1)*.[4-9] We offer recommendations based on court decisions and other evidence for managing:

- traditional risks—such as patient violence and suicide, adverse drug reactions, sex with

Box 1

Want to reduce malpractice risk? Cultivate 3 clinical habits

1. Keep thorough medical records

The most powerful defense against a malpractice suit is a well-documented chart. It can often prevent a malpractice suit by providing evidence that the physician adequately evaluated the available information and made good-faith efforts with his or her best judgment. Juries are typically forgiving of mistakes made in this context.[4,5]

Write legibly, and sign and date all entries. Try to think out loud in the chart. By outlining your thoughts about differential diagnosis, risks and benefits, and treatment options, you can help a jury understand your decision-making process and show that you carefully evaluated the situation. When documenting difficult cases, for example, imagine a plaintiff's attorney reading your notes to a jury.[6]

2. Communicate freely with patients

Careful interaction with patients and their families can also prevent lawsuits. Communicating includes preparing patients for what to expect during treatment sessions, encouraging feedback, and even using humor.[7] Freely sharing treatment information with patients can build a sense of mutual decision-making and responsibility.[8] Acknowledging treatment limitations and deflating unrealistic expectations can also protect you.

Patients who file malpractice suits are often seeking an apology or expression of regret from their physicians. It is appropriate and prudent to admit and apologize for minor errors. It is also appropriate to express condolence over what both sides agree is a severe, negative outcome.[9] Expressing sympathy is not equivalent to admitting wrongdoing.

3. Seek consultation as needed

Discussing difficult or ambiguous cases with peers, supervisors, or legal staff can help shield you from liability. For example:

- Second opinions may help you make difficult clinical decisions.
- Peers and supervisors may provide useful suggestions to improve patient care.
- Legal staff can give advice regarding liability.

The fact that you sought consultation can be used in court as evidence against negligence, as it shows you tried to ensure appropriate care for your patient.[9]

patients, faulty termination of treatment, and supervisory and consultative relationships[4]

- newer risks—such as recovered memory, off-label prescribing, practice guidelines, and e-mail and confidentiality.

This article describes general guidelines and is not intended to constitute legal advice. All practitioners have a responsibility to know the laws of the jurisdictions in which they practice.

PREVENTING PATIENT VIOLENCE

The case that opened Pandora's box. Prosenjit Poddar, a student at the University of California at Berkeley, was infatuated with coed Tanya Tarasoff and told his psychologist he intended to kill her. The psychologist notified his psychiatric supervisor and called campus police.

The psychologist told police Poddar was dangerous to himself and others. He stated that he would sign an emergency hold if they would bring Poddar to the hospital.

The police apprehended Poddar but released him. Poddar dropped out of therapy and 2 months later fatally stabbed Ms. Tarasoff.

Ms. Tarasoff's parents sued those who treated Poddar and the University of California.[2] After a

continued on page 20

continued from page 18

complicated legal course, the California Supreme Court ruled that once a therapist determines—or should have determined—that a patient poses a serious danger of violence to others, "he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger."[3]

The 1976 Tarasoff ruling has become a national standard of practice, leading to numerous other patient violence lawsuits. In these cases, psychiatrists are most likely to be found liable when recently released inpatients commit violent acts, particularly if the physician had reason to know the patient was dangerous and failed to take adequate precautions or appropriately assess the patient.[4]

Wider interpretations. Cases in several states have extended the Tarasoff ruling. In at least two cases, this standard has been applied when the patient threatened no specific victim before committing violence:

- A New Jersey court *(McIntosh v. Milano, 1979)* found a psychiatrist liable for malpractice on grounds that a therapist has a duty to protect society, just as a doctor must protect society by reporting carriers of dangerous diseases.
- A Nebraska court *(Lipari v. Sears, Roebuck, and Co., 1980)* held that physicians have a duty to protect—even if the specific identity of victims is unknown—so long as the physician should know that the patient presents an unreasonable risk of harm to others.[2]

Auto accidents. Tarasoff liability also has been extended to auto accidents. In Washington state *(Petersen v. Washington, 1983)*, a psychiatrist was held liable for injuries to victims of an accident caused by a psychiatric patient. The court ruled that the psychiatrist had a duty to take reasonable precautions to protect any foreseeable persons from being endangered by the patient.

In a similar case in Wisconsin *(Schuster and Schuster v. Altenberg, et al., 1988)*, the court ruled that damages could be awarded to anyone whose harm could have been prevented had the physician practiced according to professional standards.[2]

Other extensions include cases such as *Naidu v. Laird, 1988,* in which patient violence occurred more than 5 months after hospitalization.[2] Vermont has extended the Tarasoff precedent to property destruction by psychiatric patients.[10]

Recommendation. Most states require a psychiatrist to protect against only specific threats to identifiable victims.[10] To defend yourself against a Tarasoff-type suit, you must show that you:

- carefully assessed the patient's risk for violence
- provided appropriate care
- and took appropriate precautions.

The most protective evidence is a medical record documenting that you thoroughly assessed a patient for risk of violence *(Table)*.[4,11]

Tardive dyskinesia alone is not grounds for malpractice; negligence also must be established

If you are unsure about how to manage a patient you believe may be dangerous to himself or others, consult with supervisors, peers, and legal advisors. Many states have Tarasoff-like statutes that specify the conditions that require action and the appropriate actions.

In states without specific statutes, options that generally satisfy Tarasoff requirements include hospitalizing the patient, notifying authorities, and/or warning the potential victim.[10] As the Tarasoff case demonstrated, notifying authorities may not substitute for warning or hospitalizing.[2]

SUICIDE RISK? DOCUMENT CAREFULLY

Patient suicide accounts for one-fifth of claims covered by the American Psychiatric Association (APA) insurance plan.

In court, key points of challenge to a physician's judgment in a suicide case include the admission evaluation and any status changes. Thorough risk assessment includes carefully reviewing existing records, evaluating risk factors for suicide, and seeking advice from colleagues or supervisors when appropriate.[4]

Recommendation. Document for every inpatient admission, discharge, or status change that the patient's risk for suicide was assessed. List risk factors, protective factors, and risk for self-harm.

Explicitly address in the patient's chart any comments about suicidality (such as heard by nursing staff).[9] Document your rationale for medical decisions and orders, consistently follow unit policies, and explain risks and benefits of hospitalization to patients and their families.

Before discharge, schedule appropriate follow-up and make reasonable efforts to ensure medication adherence.[4]

Table

Is this patient dangerous? Risk factors for violence

Psychiatric	• Delusions of persecution, mind-control, or thought insertion • Command hallucinations • Impulsivity and low frustration tolerance • Current thoughts of violence • Past violent behavior • Evidence of aggression and hostility • Current intoxication, history of substance abuse
Demographic	• Male gender • Age late teens to early twenties • Low IQ • Access to and proficiency with weapons
Socioeconomic	• Employment instability • Residential instability • Low socioeconomic status • Recent losses, stressors, and conflicts

SEX WITH PATIENTS IS UNPROTECTED

Sexual involvement with patients is indefensible and uncontestable in malpractice cases. Even so, up to 9% of male therapists and 3% of female therapists report in surveys that they have had sexual interaction with their patients.[4]

In 1985 the APA excluded sex with patients from its malpractice insurance coverage. Courts generally consider a treatment to be within the standard of care if a respectable minority of physicians consider it to be appropriate. Sex with patients is considered an absolute deviation from the standard of care, and no respectable minority of practitioners supports this practice. Because patients are substantially harmed, sex with patients is considered prima facie malpractice.[12]

WHEN MEDICATIONS CAUSE HARM

Adverse drug reactions—particularly tardive dyskinesia (TD)—are a source of significant losses in malpractice cases. Multimillion-dollar awards have been granted, especially when neuroleptic antipsychotics have been given in excessive dosages without proper monitoring.[13]

Informed consent has been a particularly difficult issue with the use of neuroleptic medications. Many doctors worry that patients who fear developing TD will not take prescribed neuroleptics. A study of North Carolina psychiatrists in the 1980s revealed that only 30% mentioned TD when telling their patients about neuroleptics' possible side effects.[13]

The fact that a patient develops TD while taking an antipsychotic does not establish grounds for

continued on page 24

continued from page 21

malpractice; a valid malpractice suit must also establish negligence. Negligence could include failing to obtain appropriate informed consent or continuing to prescribe an antipsychotic without adequately examining the patient.[4]

Informed consent does not require a patient to fully understand everything about a medication. The patient must understand the information a reasonable patient would want to know. Obvious misunderstandings must be corrected.

Recommendation. Consider informed consent a process, rather than one event—especially when you give neuroleptics for acute psychotic episodes. You can establish, review, and refresh consent in follow-up visits as medications help patients become more coherent and organized.

If you doubt a patient's capacity to provide informed consent, a court determination may be necessary. In emergencies, however, treatment becomes a priority, even if the patient's capacity to make rational decisions has not been established.[13]

TERMINATE TREATMENT WITH CAUTION

Terminating treatment can lead to malpractice, particularly if a patient becomes suicidal or violent. Psychiatrists have the right to choose their patients but cannot terminate care if a patient is acutely ill or requires emergency care.

Ensuring appropriate follow-up for patients at risk for decompensation often requires more than providing a referral or phone number. With the patient's permission, for example, you could contact his subsequent psychiatrist or work with his support network to ensure that he receives follow-up care.[14]

Recommendation. With stable patients, send a written notice of termination and specify a reasonable period, usually 30 days. Send the letter by certified mail, and request a return receipt. Offer to help the patient find a new doctor, and say that you will forward the patient's records to the new doctor when you receive appropriate release-of-information paperwork.[15]

LET THE SUPERVISOR BEWARE

Under the legal concept of respondeat superior ("let the master reply"), liability for the actions of subordinates may be transferred upward to the supervisor.[4] For psychiatrists, supervisory liability obviously applies to teaching residents but may also apply in joint care, as with psychologists or social workers.

Recommendation. As a co-treating psychiatrist, you may be liable for other therapists' actions unless you formally distinguish your role as a prescriber and not as a supervisor.[9]

When you prescribe medications for patients of nonphysician therapists, be sure you, the therapist, and patient understand the nature of your collaboration. Document the type of relationship and your discussion with the patient in the patient's chart.

A 'curbside' consult—if sufficiently detailed—may be adequate to establish a duty to care and corresponding liability

WATCH OUT FOR 'CURBSIDE' CONSULTS

Consult-liaison psychiatrists typically face a lower malpractice risk than do those who provide primary treatment. Duty to care for the patient is usually established by a formal consult request, after which the psychiatrist examines the patient and recommends treatment to the primary team.

You can, however, establish duty without meeting a patient. If sufficiently detailed, an informal "curbside" consult may establish a duty and corresponding liability[16] *(Box 2)*.[4,5,9,17,18]

Liability is usually shared with the primary team but may be related to how much responsibility you assume in the patient's care. Any direct treatment—electroconvulsive therapy, psychotherapy, prescribing, writing orders in the chart—

continued on page 27

continued from page 24

can elevate your risk to the primary level. Similarly, if the patient is harmed because the primary treater followed a consulting psychiatrist's negligent advice, the psychiatrist can be found solely liable.

When you recommend a treatment, you share a portion of liability for informed consent. If neither you nor the provider obtains appropriate informed consent, you may both share liability for adverse outcomes. Both teams also share the duty to report child and elder abuse.[16]

Recommendation. Establish an explicit division of responsibilities with the primary team, including who writes orders and manages medications and who provides follow-up and discharge planning.

For curbside consults, inform the primary physician that you are providing general information and not a specific treatment recommendation. If the case is too complicated for general information to be useful, a formal consultation would serve the patient better. In written consultations, specify:

- the reason for the consult
- the issues addressed
- and the parties responsible for follow-up.[16]

RECOVERED MEMORY? FORGET PROSECUTION

In 1994, a father successfully sued his daughter's therapists for implanting false memories of incest. A California court awarded him $500,000 on grounds that the therapists owed a duty of care to the patient's parents as well as to the patient. Since then, multimillion-dollar cases have been litigated on grounds of false recovered memories, and some insurers exclude coverage for "revival of memory."[12]

Most therapists who have been found liable have strongly supported the accuracy of their patients' memories. These memories have usually contained bizarre features, including satanic abuse, baby breeding, human sacrifice, and cannibalism. Therapists in these cases have often recommended that their patients press charges or file lawsuits against their alleged abusers.

Lawsuits against therapists have been won on grounds that they used unorthodox procedures without informed consent, negligently or recklessly implanted memories of abuse, negligently reinforced such memories, and failed to sufficiently investigate the memories' accuracy.[19]

Recommendation. Patients in therapy sometimes report newly found memories. To reduce your risk:

- obtain informed consent from patients before you begin any psychotherapy
- carefully document therapy session details when patients divulge new memories—particularly of abuse

continued on page 29

Box 2

When does practice become malpractice?

Malpractice requires four conditions:

- A doctor-patient relationship was established.
- The physician practiced below the standard of care.
- The patient was harmed.
- The patient's harm was a direct result of the physician's failure to practice at the standard of care.[4]

Standard of care. A treatment may be considered within the standard of care so long as a "respectable minority" of practitioners considers it appropriate.[17] Standard of care may be established by expert testimony, published texts, or practice guidelines[18] and tends to be flexible in medical specialties—such as mental health—that allow for multiple treatment options.

Preponderance of evidence. In court proceedings, the plaintiff must establish malpractice by a preponderance of the evidence, which means "more likely than not." This is a much less-stringent level of proof than beyond a reasonable doubt, as is required in criminal cases.[9]

Although a preponderance of the evidence may seem disturbingly easy to establish, courts are often forgiving of adverse outcomes caused by judgment errors if the physician acted in good faith and followed professional standards.[4,5]

continued from page 27

- avoid encouraging patients to act on recovered memories.[19]

OFF-LABEL DRUG USE: KNOW THE LITERATURE

Off-label prescribing is both common and legal but may increase a physician's liability risk if adverse events occur. Cases in Minnesota, Texas, and Louisiana have established precedents for using the *Physician's Desk Reference* or package inserts to establish a standard of care.

In 1970 the Minnesota Supreme Court held that deviating from the package insert constituted prima facie evidence of negligence. This interpretation shifts the burden of proof from the plaintiff to the physician, who must then prove that he or she was not negligent when prescribing the drug.[20]

Recommendation. Off-label prescribing is an important component of modern psychiatric care. Research supports most accepted off-label prescribing, at least to the point of establishing a respectable minority for a standard of care (*Box 2*).

When prescribing, know which indications are FDA-approved and which are off-label. For off-label prescribing, know the literature supporting that use and notify patients of off-label status as you document informed consent.[20]

PROS AND CONS OF PRACTICE GUIDELINES

Clinical practice guidelines developed by professional organizations to assist physicians have also acquired legal ramifications. Difficult questions about guidelines include:

- Do they set the standard of care, or are they merely suggestions?
- Do they provide a defense against liability?
- How does a practitioner select between conflicting guidelines?

On the other hand, following clinical guidelines can protect you in cases with adverse outcomes. In a study of insurance company claims, approximately one-fourth of plaintiff's attorneys who were surveyed said they had refused cases because the physician had followed practice guidelines. Conversely, one-fourth of defense attorneys said they had been influenced to settle cases because the physicians they represented had not followed practice guidelines.[21]

Liability cases involving practice guidelines have produced varying decisions. As a rule of thumb, courts tend to find that more-specific guidelines constitute a standard of care, whereas more-general guidelines are flexible suggestions.

E-mail with patients is considered part of the medical record and is subject to discovery in legal proceedings

Recommendation. If the court finds that existing guidelines establish the standard of care and your care has deviated from the guidelines with adverse consequences, the burden of proof shifts to you to prove that you were not negligent.[18] When guidelines exist, know them and be prepared to defend decisions that deviate from them.

TELEMEDICINE: DANGERS IN CYBERSPACE

Unauthorized use or disclosure of patients' electronic information can leave physicians liable for invasion of privacy and breach of confidentiality.[22]

E-mail communication with a patient may also be sufficient to establish a duty of care, especially if the patient presents diagnostic information and the physician provides medical advice. Once duty to care is established, the physician is responsible for ongoing care or may face charges of abandonment.

Establishing duty to patients through e-mail is particularly troublesome, as patients may be writing from another state where you are not licensed to practice. Several states have explicitly forbidden unlicensed telemedicine; others have offered limited licenses for telemedicine practice.[22]

Using e-mail to communicate with established

continued on page 33

continued from page 29

patients introduces other liabilities. E-mail is legally considered part of the medical record and is subject to discovery in legal proceedings. Failure to preserve important patient e-mail may be evidence of negligence, especially in cases involving the medical record.

On the other hand, e-mail can be surprisingly permanent; it is virtually impossible to definitively delete e-mail that contains sensitive or embarrassing information. Deleted e-mail frequently can be recovered, and every e-mail exists in multiple copies, including the sender's, the receiver's, and at least one in a centralized server.[23]

Recommendation. Reduce liability risks with informed consent if you use e-mail to communicate with existing patients. Minimize e-mail contact with nonestablished patients, and make sure the confidentiality of patients' communications is secure.[22]

References

1. Slawson PF, Guggenheim FG. Psychiatric malpractice: a review of the national loss experience. *Am J Psychiatry* 1984;141:979-81.
2. Buckner F, Firestone M. Where the public peril begins: 25 years after Tarasoff. *J Legal Med* 2000;21(2):187-222.
3. Tarasoff v. Regents of the University of California, 551 P.2d 334 (California 1976).
4. Menninger WW. The impact of litigation and court decisions on clinical practice. *Bull Menninger Clin* 1989;53:203-14.
5. Davenport J. Documenting high-risk cases to avoid malpractice liability. *Fam Pract Manag* 2000;7(9):33-6.
6. Rice B. How plaintiffs' lawyers pick their targets. *Medical Economics* 2000;8:94-110.

continued

Malpractice risk in mental health is expanding to new practice areas. Keeping thorough medical records, communicating with patients and colleagues, and seeking consultation as needed are the keys to reducing liability.

Bottom Line

Malpractice

Related resources

- Gutheil TG, Appelbaum PS. *Clinical handbook of psychiatry and the law (3rd ed)*. Philadelphia: Lippincott Williams & Wilkins, 2000.
- American Psychiatric Association. Practice guidelines. http://www.psych.org/clin_res/prac_guide.cfm

7. Levinson W, Roter DL, Mullooly JP, et al. Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. *JAMA* 1997;277(7)553-9.
8. Condon JT. Medical litigation: the aetiological role of psychological and interpersonal factors. *Med J Aust* 1992;157:768-70.
9. Gutheil TG, Appelbaum PS. *Clinical handbook of psychiatry and the law (3rd ed)*. Philadelphia: Lippincott Williams & Wilkins; 2000.
10. Resnick PJ, Scott CL. Legal issues in treating perpetrators and victims of violence. *Psychiatr Clin North Am* 1997;20(2):473-87.
11. Resnick PJ. *Risk assessment for violence (lecture)*. Cleveland, OH: Case Western Reserve University, June 26, 2003.
12. Slovenko R. Malpractice in psychotherapy. *Psychiatr Clin North Am* 1999;22(1):1-15.
13. Mills MJ, Eth S. Legal liability with psychotropic drug use: extrapyramidal syndromes and tardive dyskinesia. *J Clin Psychiatry* 1987;48(9S):28-33.
14. Appelbaum PS. Can a psychiatrist be held responsible when a patient commits murder? *Law Psychiatry* 2002;53(1):27-9.
15. Tan MW, McDonough WJ. Risk management in psychiatry. *Psychiatr Clin North Am* 1990;13(1):135-47.
16. Garrick TR, Weinstock R. Liability of psychiatric consultants. *Psychosomatics* 1994;35:474-84.
17. Bradford GE. The "respectable minority" doctrine in Missouri medical negligence law. *J Missouri Bar* 2000;56(6):326-34.
18. Jacobson PD. Legal and policy considerations in using clinical practice guidelines. *Am J Cardiol* 1997;30(8B):74H-79H.
19. Scheflin AW, Spiegel D. From courtroom to couch: working with repressed memory and avoiding lawsuits. *Psychiatr Clin North Am* 1998;21(4):847-67.
20. Bradford GE, Elben CC. The drug package insert and the PDR as establishing the standard of care in prescription drug liability cases. *J Missouri Bar* 2001;57(5):233-42.
21. Hyams AL, Brandenburg JA, Lipsitz SR, et al. Practice guidelines and malpractice litigation: a two-way street. *Ann Intern Med* 1995;122(6):450-5.
22. Jones J. MD liability for electronic medical communications. *Physician's News Digest* [serial online] 2000;(5).
23. Spielberg AR. Online without a net: physician-patient communication by electronic mail. *Am J Law Med* 1999;25:267-95.