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## Mental Health Malpractice in the 1990s

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# LIABILITY

## MENTAL HEALTH MALPRACTICE IN THE 1990s

*Steven R. Smith\**

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## I. INTRODUCTION

Mental health professionals<sup>1</sup> have been telling a lot of lawyer jokes involving laboratory rats,<sup>2</sup> pitbulls,<sup>3</sup> skunks in the middle of the road,<sup>4</sup> and sharks.<sup>5</sup> Often, lawyer stories increase as a profession's malpractice claims rise, as has been the case with the mental health profession.<sup>6</sup> The last two decades have produced significant

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1. "Mental health professionals" is a somewhat uncertain term because a wide variety of people provide mental health services of some sort. Everyone would include psychiatrists and psychologists in the definition of mental health professionals. Even these professionals, however, may be difficult to identify. All physicians can practice psychiatry, and many of those physicians calling themselves psychiatrists are not board certified. Psychologists are licensed by all states, but in some states psychologists (without doctoral training) may not be eligible for full independent practice, so the term "psychologist" is applied to a range of professionals. Other professions that may fall in the category of mental health professions include social workers, counselors, and psychiatric nurses. A variety of other psychotherapists, including expressive therapists, sex therapists, and pastoral counselors, also may be considered mental health professionals. Even some bartenders claim to be mental health professionals. (They contend that they are more readily available than psychiatrists, less expensive, and much less likely to suggest that the "patients" give up drinking.) In this article, the term generally refers to psychiatrists and psychologists, and occasionally to social workers, psychiatric nurses, and counselors. "Patients" refers to the consumers of all mental health services. There is a debate concerning the proper name for these consumers. I will use the traditional term "patients" in this paper even though some mental health professionals do not use the term.

2. Some mental health professionals have suggested that psychological experiments be performed on attorneys rather than rats. Proponents claim that lawyers are more plentiful than lab animals, that torture or abuse of attorneys would cause no public outcry, and that lab assistants are less likely to become attached to attorneys than to rats. In addition, they claim, there are some things rats just won't do.

3. "What is brown and white and looks good on a lawyer?" "A pitbull."

4. Someone asked, "What is the difference between a dead skunk and a dead lawyer in the middle of the road?" The mental health professional replied, "There are skid marks in front of the skunk."

5. A minister, a mental health professional and a lawyer were adrift in a lifeboat in shark infested waters when they spotted land. The currents changed and they were being drawn back out to sea, and it was clear someone would have to jump in the water with a rope and swim to shore to pull the boat in. As the minister prayed, the lawyer volunteered for the dangerous mission and jumped in. The sharks did not attack. Indeed, they gave the lawyer a lift on their backs. "Our prayers have been answered," cried the minister. "Prayer had nothing to do with it," responded the mental health professional. "It was professional courtesy."

6. See, e.g., Bonnie, *Professional Liability and the Quality of Mental Health Care*, 16 L. MED. & HEALTH CARE 229, 229 (1988) (noting that a lawyer in a gathering of health professionals "can expect to be bombarded by complaints about the law of professional liability and the high cost of malpractice insurance").

changes in the malpractice liability of mental health professionals and the institutions in which they work. One commentator has described the increased frequency of lawsuits and settlements, the expansion of duties to nonpatient third parties, and the size of some awards as "an avalanche of claims" that "is a crisis in the making."<sup>7</sup>

Whether there will be a "crisis" may be debatable, but during the 1990s the liability of mental health professionals and institutions probably will expand.<sup>8</sup> Any malpractice reforms to limit liability most likely will be more than offset by an increase in claims. This increase will result from better definitions of mental health standards of care, greater willingness of patients to seek compensation for injuries, and expanded liability to third parties harmed by mental health patients.<sup>9</sup> Physical injuries (*e.g.*, suicides, homicides, and harm from medications) will continue to be important due to the size of damages in such cases. At the same time, patient expectations of successful treatment and concerns over confidentiality may increase liability for nonphysical injuries. Finally, the obligation of mental health institutions to supervise professionals practicing within the institutions, as well as expanded vicarious liability, will tend to increase malpractice claims against these institutions.<sup>10</sup> In the past, mental health practitioners have been protected from liability by a variety of legal rules and the stigma associated with being a mental patient. Those protections are beginning to disappear.

During the 1990s, the mental health and the legal professions ought to develop alternatives to the current civil trial system. The

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7. J. ROBERTSON, *PSYCHIATRIC MALPRACTICE: LIABILITY OF MENTAL HEALTH PROFESSIONALS* 5 (1988); *see also* 3 M. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* (1989) (providing an overview of the various types of mental health malpractice and concluding that the situation is worsening). For additional excellent, recent reviews of mental health malpractice, *see* R. COHEN, *MALPRACTICE: A GUIDE FOR MENTAL HEALTH PROFESSIONS* (1979); B. FURROW, *MALPRACTICE IN PSYCHOTHERAPY* (1980); B. SCHULTZ, *LEGAL LIABILITY IN PSYCHOTHERAPY* (1982); J. SMITH, *MEDICAL MALPRACTICE: PSYCHIATRIC CARE* (1986).

8. Although many factors will tend to increase mental health malpractice claims, I predict that the increase will be more gradual and not actually amount to a crisis. Refer to notes 304-54 *infra* and accompanying text.

9. Refer to notes 210-33 *infra* and accompanying text. *See generally* Tancredi & Weisstub, *Malpractice in America: Toward a Restructuring of the Psychiatrist-Patient Relationship*, in 2 *LAW AND MENTAL HEALTH: INTERNATIONAL PERSPECTIVES* 83 (D. Weisstub ed. 1984).

10. Malpractice claims against mental health institutions present especially difficult questions. Refer to notes 261-99 *infra* and accompanying text.

goal should be to compensate those injured in psychotherapy without requiring that they reveal publicly a tremendous amount of very private information from therapy. Reforms also should address the difficulty of demonstrating to lay jurors the appropriate standard of mental health care and proving causation and injury.

This article analyzes the current levels and kinds of mental health malpractice claims. It also discusses the direction of individual and institutional malpractice in the 1990s and considers potential reforms. Finally, the article argues that the current system is inadequate to deal with many mental health injuries and that patient plaintiffs should have the option of pursuing malpractice claims in a private, less threatening forum.<sup>11</sup>

## II. CURRENT LEVEL OF MALPRACTICE CLAIMS

Despite the increases in mental health malpractice claims described in this section, the number of claims remains low compared with many other health care specialties.<sup>12</sup> Obstetricians and neurosurgeons would give up weekday golf to have the malpractice premiums of mental health professionals.<sup>13</sup> During the first ten years (1961-71) of the malpractice insurance program of the American Psychological Association, no malpractice claims were paid; however, during the period 1976-1980, 122 claims were processed, with estimated payments totalling \$435,642.<sup>14</sup> For many years, malpractice actions against psychiatrists accounted for less than

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11. Refer to notes 304-37 *infra* and accompanying text.

12. Precise information about mental health malpractice claims is difficult to obtain for several reasons. First, some insurance carriers consider claim and loss information to be proprietary and, therefore, are reluctant to give information in a meaningful way. Also, insurance does not cover some types of claims (e.g., sexual contact with patients), making it difficult to obtain reliable data on these cases. Furthermore, mental health practitioners belong to several different professions (including medicine, psychology, social work) and possess various malpractice insurance plans and structures that vary from one discipline to another. Finally, a significant number of practitioners work in areas that are self-insured (e.g., state and federal agencies).

13. Cf. Slawson & Guggenheim, *Psychiatric Malpractice: A Review of the National Loss Experience*, 141 AM. J. PSYCHIATRY 979, 981 (1984) (noting that the statistics showing claims filed against psychiatrists for the reported period were probably understated because the data did not include claims brought against V.A. or public hospital patients). See generally Deardorff, Cross & Hupprich, *Malpractice Liability in Psychotherapy: Client and Practitioner Perspectives*, 15 PROF. PSYCHOLOGY: RES. & PRAC. 590 (1984) (discussing possible areas of liability for practicing psychotherapists); Watkins & Watkins, *Malpractice in Clinical Social Work*, 1 BEHAV. SCI. & L. 55 (1983) (discussing the enormous potential for malpractice suits against clinical social workers).

14. Slawson & Guggenheim, *supra* note 13, at 980.

one percent of the claims filed against all physicians.<sup>15</sup> In the mid-1970s, psychiatrists were sued at a rate of about 2.25 percent,<sup>16</sup> but by the 1980s that rate had nearly doubled to four percent.<sup>17</sup>

Only a small percentage of negligent events result in any claim being filed,<sup>18</sup> and only a small proportion of those claims result in any recovery.<sup>19</sup> Additionally, most recoveries are fairly small, totaling less than \$30,000, though jury verdicts may easily exceed that. The size of verdicts appears to be increasing: a 1985 study reported that psychiatric malpractice verdicts ranged from \$75,000 to \$766,000, with an average verdict of \$306,737.<sup>20</sup> As a result of the increased number and size of claims, psychiatric lawsuits and insurance premiums doubled between 1981 and 1986.<sup>21</sup> Other mental health disciplines are experiencing similar trends.<sup>22</sup>

Mental health malpractice claims traditionally have been low for a number of reasons: the elements of negligence—duty, causation, and injury—are often difficult to prove; technical legal doctrines sometimes interfere with potential claims; former patients are reluctant to expose their mental health problems to the public view of a civil trial; and the close relationship between patients and mental health professionals makes patients reluctant to file

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15. *Id.*

16. AMA, *MALPRACTICE IN FOCUS* (1975), quoted in J. ROBERTSON, *supra* note 7, at 5.

17. Perr, *Psychiatric Malpractice Issues*, in *LEGAL ENCROACHMENT ON PSYCHIATRIC PRACTICE* 47, 51 (S. Rachlin ed. 1983); see also Nye, Gifford, Webb & Dewar, *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 *GEO. L.J.* 1495, 1545-49 (1988) (discussing rise in claims and rise in malpractice insurance premiums).

18. See, e.g., P. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 19 (1985) (reporting that only 10% of persons with valid claims file suits for compensation); HARVARD MEDICAL PRACTICE STUDY, *PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK* (1990) (reporting that about one in eight of those injured through medical negligence filed suit and one in sixteen received a jury award or settlement).

19. Slawson & Guggenheim, *supra* note 13, at 980.

20. See, e.g., J. ROBERTSON, *supra* note 7, at 6 ("Million dollar verdicts have similarly been rendered in recent years against psychiatrists."); Personal Injury Verdict Reviews, Jan. 13, 1986, at 1 (reporting that one in 25 psychiatrists could expect to be sued, compared with one in 50 in 1979).

21. Personal Injury Verdict Reviews, *supra* note 20.

22. See, e.g., Andrade & Andrade, *Professional Liability of the Psychiatric Nurse*, 7 *J. PSYCHIATRY & L.* 141, 142 (1979) (commenting on the expanding liability of psychiatric nurses); Creighton, *The Malpractice Problem*, 9 *NURSING CLINICS N. AM.* 425, 426 (1974) (commenting on the increase of malpractice claims against nurses); Gerhart & Brooks, *Social Workers and Malpractice: Law, Attitudes, and Knowledge*, 66 *CASEWORK: J. CONTEMP. SOC. WORK* 413 (1985); Watkins & Watkins, *supra* note 13; Watkins & Watkins, *Negligent Endangerment: Malpractice in the Clinical Context*, 3 *J. INDEP. SOC. WORK* 35 (1989).

claims. Negligence requires a standard of professional care against which the actions of the defendant-professional can be measured. Liability exists only if the professional has failed to provide the same care as would a reasonably prudent professional.<sup>23</sup> The standard of practice for mental health professionals is not as clearly or precisely defined as it is in many areas of medicine.<sup>24</sup> For instance, the standard of practice for treatment of acute appendicitis is fairly uniform and clear; the standard of practice for treatment of schizophrenia is not.<sup>25</sup> The large number of "schools of thought" in psychotherapy complicates efforts to define a clear standard of care.<sup>26</sup> The absence of a clear "correct" treatment makes it difficult to assess the reasonableness of the therapist.<sup>27</sup>

Proving causation may be equally difficult.<sup>28</sup> The causes of emotional and psychological injuries are often difficult to identify

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23. See Federici & Doering, *Psychiatrists' Standard of Care*, 10 AM. J. FORENSIC PSYCHIATRY 5 (1989); see, e.g., *Rule v. Cheeseman*, 181 Kan. 957, 317 P.2d 472, 478 (1957) (requiring a higher standard of care for a surgeon holding himself out as a specialist); *McCarthy v. Boston City Hosp.*, 358 Mass. 639, 266 N.E.2d 292, 295 (1971) (requiring specialists to exercise the degree of skill of the average professional practicing that specialty).

24. Commentators have criticized the absence of clear standards. See, e.g., 3 D. HOGAN, *THE REGULATION OF PSYCHOTHERAPISTS: A REVIEW OF MALPRACTICE SUITS IN THE UNITED STATES* 27 (1979) ("As long as therapists restrict their practices to talk, interpretations, and advice, they will remain relatively immune from suit, no matter how poor their advice, how damaging their comments, or how incorrect their interpretations."); Knapp & VandeCreek, *Malpractice as a Regulator of Psychotherapy*, 18 PSYCHOTHERAPY: THEORY, RES. & PRAC. 354 (1981); Note, *Malpractice in Psychotherapy: Is There a Relevant Standard of Care?*, 35 CASE W. RES. L. REV. 251, 253 (1984) (concluding that the very fact of change as a characteristic of psychotherapy would appear to defy the notion of a *definitive* standard of care).

25. See, e.g., Note, *supra* note 24, at 253. The practical problem of applying a standard of care in psychiatric malpractice cases is noted in Modlin, *Forensic Psychiatry and Malpractice*, 18 BULL. AM. ACAD. PSYCHIATRY & L. 153 (1990) (reviewing malpractice cases).

26. See, e.g., *Hubbard v. Calvin*, 83 Cal. App. 3d 529, 147 Cal. Rptr. 905, 907 (1978) (defining standard of care for schools of neurosurgery); *Nelson v. Dahl*, 174 Minn. 574, 576, 219 N.W. 941, 942 (1928) (setting standards of care for schools of chiropractic); *Hansen v. Pock*, 57 Mont. 51, 187 P. 282, 284 (1920) (setting standard of care for Chinese herb doctor). See also 3 M. PERLIN, *supra* note 7, at 13-14 (identifying more than 200 forms of mental health "schools"); Paquin, *The Malpractice of Family Therapy: An Analysis of Two Schools*, 12 L. & PSYCHOLOGY REV. 21, 27, 33-48 (1988) (describing in detail the special legal problems that can arise from the family therapy "school of thought").

27. See Federici & Doering, *supra* note 23, at 6-7; Leesfield, *Negligence of Mental Health Professionals: What Conduct Breaches Standards of Care*, 23 TRIAL 57 (1987); Note, *supra* note 24, at 253.

28. See generally Paquin, *supra* note 26, at 50-52 (discussing three problems with proving causation: (1) differentiating between therapist's and patient's responsibility, (2) determining substantiality of therapist's actions as cause, and (3) presumptions of patient's defectiveness prior to treatment).

with certainty.<sup>29</sup> Therefore, a patient claiming therapy-related injury may not be able to demonstrate that the faulty therapy caused the harm.<sup>30</sup> Additionally, because patients generally suffer from mental problems before seeking therapy, any psychological injury may appear to be part of the pre-existing mental illness rather than the result of malpractice.<sup>31</sup>

Damages also may be hard to prove.<sup>32</sup> Emotional injuries are very real and painful, but to a jury, they are not generally so obvious or gruesome as physical injuries.<sup>33</sup> "A mangled limb or scarred body presents to a jury dramatic evidence of injury; a mangled psyche is much less evident."<sup>34</sup> Furthermore, the law traditionally has been reluctant to recognize emotional or mental injuries, except when they relate to physical harm.<sup>35</sup> Thus, the large verdict awards in mental health cases occur most often when clear physical injuries exist, such as in failure-to-prevent-suicide cases,<sup>36</sup> prescription drug cases,<sup>37</sup> and *Tarasoff* liability cases.<sup>38</sup>

In the past, a number of other traditional legal doctrines have helped reduce the number of mental health malpractice claims.

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29. S. SMITH & R. MEYER, *LAW, BEHAVIOR, AND MENTAL HEALTH: POLICY AND PRACTICE* 8 (1987).

30. *Id.*; see also 3 D. HOGAN, *supra* note 24, at 26 (proving that faulty therapy proximately caused patient's distress is enormous task).

31. Neiland, *Malpractice Liability of Psychiatric Professionals*, 1 *AM. J. FORENSIC PSYCHIATRY* 22 (1979).

32. See Paquin, *supra* note 26, at 52-57 (discussing unique problems associated with psychiatric malpractice damages).

33. S. SMITH & R. MEYER, *supra* note 29, at 8-9; see also 3 D. HOGAN, *supra* note 24, at 26 (emotional distress damages alone are particularly hard to prove); J. SMITH, *supra* note 7.

34. S. SMITH & R. MEYER, *supra* note 29, at 9.

35. *Id.*; W. KEETON, D. DOBBS, R. KEETON & D. OWEN, *PROSSER & KEETON ON THE LAW OF TORTS* § 12 (5th ed. 1984) [hereinafter *PROSSER & KEETON ON TORTS*]; see also Kineen & Locke, *Expanding the Horizons of Psychic Injury*, *TRIAL*, Feb. 1980, at 36, 37 (before a tortfeasor could be liable for infliction of emotionally related injuries, plaintiff had to show physical impact); Comment, *The Increasingly Disparate Standards of Recovery for Negligently Inflicted Emotional Injuries*, 52 *U. CIN. L. REV.* 1017, 1017 (1983) (noting that courts traditionally denied recovery absent physical injury to patient).

36. *Cf.* 3 D. HOGAN, *supra* note 24, at 406 (mean recovery in malpractice suits involving suicides through 1977 was \$27,126).

37. *Cf. id.* at 404 (mean recovery in cases through 1977 for negligent administration of drugs was \$170,000).

38. In *Tarasoff v. Regents of Univ. of Cal.*, 17 *Cal. 3d* 425, 435, 551 *P.2d* 334, 343, 131 *Cal. Rptr.* 14, 23 (1976), the California court imposed upon therapists a duty to take reasonable steps to protect the intended victims of psychiatric patients. See also *id.* at 21 (noting that cases involving diagnoses for lack of dangerousness produced recoveries at \$50,000-plus level). For a discussion of the *Tarasoff* case, refer to notes 212-33 *infra* and accompanying text.

Examples include the doctrine of limited duty as encompassed in the "rescue rule,"<sup>39</sup> suicide as a "superseding" cause,<sup>40</sup> and sovereign and charitable immunities.<sup>41</sup> These doctrines precluded liability even where a mental health professional acted carelessly.<sup>42</sup> The weakening of these defenses is partly responsible for the increase in mental health malpractice claims.

Several other factors limit the number of malpractice claims against mental health practitioners. One is the reluctance of patients to have their emotional problems and histories aired in a public forum.<sup>43</sup> By filing a malpractice lawsuit, plaintiffs lose any testimonial privilege covering their mental health care.<sup>44</sup> Public trials make patients' mental conditions matters of public record and expose friends and family to information previously held confidential.<sup>45</sup> Understandably, patients are generally more reluctant to

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39. See, e.g., PROSSER & KEETON ON TORTS, *supra* note 35, § 56 (rescue rule provides that one person is not obligated to rescue another person in danger of losing his life even if the rescue can be accomplished without risk to the potential rescuer). However, this rule does not apply to cases in which a special relationship exists between the parties. *Id.* For example, this relationship exists when the potential rescuer has caused the other party to be at risk or is the parent or caretaker of the other. *Id.*

40. See, e.g., *id.* § 44 (the common law considered the act of suicide to be an intentional act which broke the causal link between the negligence of the tortfeasor and the injury).

41. See *id.* § 133 (noting that virtually all states now reject complete charitable immunity); *id.* § 131 (noting that while sovereign immunity continues to exist in some form in most states, voluntary waiver and judicial decisions have substantially reduced its negative impact).

42. See, e.g., *Bellows v. State*, 37 A.D.2d 342, 325 N.Y.S.2d 225, 226-27 (1971) (even though former prisoner may have received inadequate psychiatric care for propensity to commit sex offenses while he was incarcerated, his suit against the state nonetheless failed because the state had not waived immunity).

43. S. SMITH & R. MEYER, *supra* note 29, at 9; see also Smith, *Constitutional Privacy in Psychotherapy*, 49 GEO. WASH. L. REV. 1, 29 n.176 (1980) (noting that patient's anxiety concerning the release of therapy information may result from psychotherapist's use of terms which have a negative connotation to the public).

44. See, e.g., Smith, *Medical and Psychotherapy Privileges and Confidentiality: On Giving With One Hand and Removing With the Other*, 75 KY. L.J. 473, 514-16 (1987) (the patient-litigant exception waives the testimonial privilege between psychotherapist and patient when the holder of the privilege brings mental condition or state into question). In a mental health malpractice action, the plaintiff patient would not only lose therapy privileges concerning the therapy on which the malpractice claim was based, but he might also lose privileges for any other therapy that is relevant to the malpractice case. In practical fact, the defendant could seek therapy-related information from the plaintiff with very little limitation. *Id.*; see also Slovenko, *Psychotherapist-Patient Testimonial Privilege: A Picture of Misguided Hope*, 23 CATH. U.L. REV. 649, 657 (1974) (noting that patient waives testimonial privilege by making a legal issue of his mental condition).

45. See Smith, *supra* note 43, at 30 (noting that psychotherapy patient has high expectation that information revealed in therapy will remain private due to ethics codes).

have their mental conditions discussed in public than their physical ailments.<sup>46</sup>

Relationships between therapists and patients also limit malpractice claims.<sup>47</sup> Such relationships are typically much closer in psychotherapy than they are in other health care contexts.<sup>48</sup> This closeness makes patients more reluctant to file suit against therapists than, for instance, against a surgeon whom the patient sees only briefly before and after surgery. Many psychotherapists see fewer patients than do other health care workers, thus reducing their exposure to liability.<sup>49</sup>

The increase in malpractice claims in the 1970s and 1980s reflects the erosion of several of these protections against mental health malpractice. The degree to which such erosion continues will determine the direction of mental health malpractice in the 1990s.

### III. TYPES AND AREAS OF MALPRACTICE CLAIMS

Malpractice claims may be divided in two ways: (1) by the legal causes of action underlying liability and (2) by the activity or therapy involved in the injury. Unfortunately, since courts and commentators have not always drawn this distinction clearly, some confusion has resulted. The malpractice matrix reproduced in the Appendix illustrates the interaction between types of liability and areas of practice.<sup>50</sup>

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46. See, e.g., Davidoff, *The Malpractice of Psychiatrists*, 1966 DUKE L.J. 696, 696 (citing natural reluctance of patients to reveal psychiatric history as reason for absence of case law on psychiatric malpractice); Comment, *The Liability of Psychiatrists for Malpractice*, 36 U. PITT. L. REV. 108, 131 (1974) (citing patient shame as reason for lack of malpractice actions against psychiatrists); Note, *Medical Malpractice: The Liability of Psychiatrists*, 48 NOTRE DAME L. REV. 693, 696-703 (1973) (scarcity of actions for negligently administered psychiatric therapy may be result of people's reluctance to expose psychiatric history).

47. See S. SMITH & R. MEYER, *supra* note 29, at 9; May & Stengel, *Who Sues Their Doctors? How Patients Handle Medical Grievances*, 24 L. & Soc'y REV. 105, 115-18 (1990) (noting a number of individual factors that relate to the decision to file suit in malpractice cases).

48. See, e.g., K. POPE & J. BOUHOUTSOS, *SEXUAL INTIMACY BETWEEN THERAPISTS AND PATIENTS* 22, 23 (1986) (noting that while a doctor may see a patient's most private body parts, a therapist may "see" a patient's deepest secrets); see also Pope, Keith-Spiegel & Tabachnick, *Sexual Attraction to Clients*, 41 AM. PSYCHOLOGIST 147, 155 (1986) (finding clear evidence that male and female psychologists are sexually attracted to patients).

49. For a discussion of other factors reducing the risk of malpractice claims, see S. SMITH & R. MEYER, *supra* note 29, at 8-9.

50. Refer to Appendix *infra*.

### A. *Legal Basis of Liability*

Negligence is the most common form of malpractice liability.<sup>51</sup> In negligence cases, the patient (or third party) claims that a mental health professional did not act as a reasonably prudent professional would under the circumstances, and as a consequence, the patient (or third party) suffered injury. However, not every bad outcome or mistake results in liability; negligence liability results only when unreasonable errors cause injuries.<sup>52</sup> The doctrine of informed consent is a special form of negligence liability.<sup>53</sup> Informed consent to medical treatment has received considerable attention in recent years,<sup>54</sup> but its application to psychotherapy has not been fully defined.<sup>55</sup> Additionally, malpractice claims may arise

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51. See, e.g., J. MALCOLM, *TREATMENT CHOICES AND INFORMED CONSENT: CURRENT CONTROVERSIES IN PSYCHIATRIC MALPRACTICE LITIGATION*, 5 (1988) (typical malpractice case involves physician negligence).

52. S. SMITH & R. MEYER, *supra* note 29, at 10; see also *In re Ballay*, 482 F.2d 648, 665 (D.C. Cir. 1973) (therapy regarding mental illness is not a perfect science); *Pike v. Honsinger*, 155 N.Y. 201, 209, 49 N.E. 760, 762 (1898) (law holds a physician liable for an injury to his or her patient *resulting* from his or her failure to exercise reasonable care) (emphasis added); *Carroll v. Richardson*, 201 Va. 157, 163, 110 S.E.2d 193, 197 (1959) (doctor not liable for lab technician's failure to advise patient, who subsequently fainted, not to stand up after his blood was drawn, because no evidence supported a custom among doctors to so advise).

53. See generally Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407, 408-17 (1980) (discussing history of and modern trends in the doctrine of informed consent); Note, *The Doctrine of Informed Consent Applied to Psychotherapy*, 72 GEO. L.J. 1637, 1641-42 (1984) (theories of recovery under doctrine of informed consent include: (1) battery, when patient did not give consent or was incompetent to give consent and (2) negligence when the doctor did not give the patient sufficient information).

Liability for the absence of consent, and the doctrine of consent to experimental treatment first arose in *Slater v. Baker & Stapleton*, 95 Eng. Rep. 860, 862 (K.B. 1767), in which the court held that "a patient should be told what is about to be done to him." Liability for the absence of informed consent is now firmly established by common law and statute. See Meisel & Kabnick, *supra*, at 408-09, 414. The doctrine applies to psychotherapy. See Note, *supra*, at 1637-38.

54. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 786-88 (D.C. Cir.) (to be legally effective, the physician must give the patient sufficient information to allow him to make a reasonably informed judgment on whether to accept treatment; such information includes: (1) the nature of the proposed treatment; (2) the major risks and benefits associated with the treatment; (3) reasonable alternative forms of treatment; (4) the consequences of no treatment), *cert. denied*, 409 U.S. 1064 (1972).

55. Cf. J. MALCOLM, *supra* note 51, at 58-60 (noting that while parameters of informed consent are well understood, defining the term in the context of psychiatric malpractice is difficult); Reamer, *Informed Consent in Social Work*, 32 Soc. WORK 425, 425 (1987) (noting that despite the commitment of social workers to the concept of self-determination, social work literature lacks research into the manner in which a client gives informed consent); see

from intentional torts such as battery,<sup>56</sup> intentional infliction of mental distress,<sup>57</sup> or false imprisonment.<sup>58</sup> However, these claims are infrequent.<sup>59</sup>

Under 42 U.S.C. section 1983, liability exists for those who act under color of state law to deprive someone of federal rights.<sup>60</sup> Mental health professionals working or consulting for a state entity<sup>61</sup> may incur liability if their conduct or deliberate indifference interferes with someone's federal rights.<sup>62</sup> *Zinermon v. Burch*,<sup>63</sup> a recent Supreme Court decision, illustrates the potential relevance of section 1983 claims. The Court held that section 1983 liability might be imposed if clearly incompetent patients are held under "voluntary" hospitalization.<sup>64</sup>

Contract liability infrequently arises from mental health care.<sup>65</sup> For example, a psychiatrist who warrants to a patient that electro convulsive therapy ("ECT") is perfectly safe may be making a contractual guarantee.<sup>66</sup> Such warranty cases, though not unknown, are unusual.<sup>67</sup> Common reassurances that are part of a

*also* Note, *supra* note 41, at 1663 (noting that doctrine of informed consent, which functions as a barrier against abuse in medical settings, has not generally arisen in context of psychotherapist-patient relationships).

56. Battery involves the intentional touching of someone in an offensive or harmful way without that person's consent. PROSSER & KEETON ON TORTS, *supra* note 35, § 9.

57. Intentional infliction of emotional stress occurs when (a) someone engages in outrageous conduct; (b) the actor intends the conduct to cause severe emotional pain; and (c) the conduct causes severe emotional pain. *Id.* § 12.

58. False imprisonment is the intentional restraining or confining of another without consent or legal authority. *Id.* § 12.

59. See 3 D. HOGAN, *supra* note 24, at 391 (during 1970-77, patients brought negligence actions almost 60% of the time, while battery actions, intentional infliction of emotional distress, and false imprisonment claims when combined constituted less than 15% of psychotherapist malpractice actions).

60. 42 U.S.C. § 1983 (1988) ("Every person, who, under color of any statute, ordinance [or] regulation . . . subjects . . . [anyone] to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured.").

61. *Cf.* *West v. Atkins*, 487 U.S. 42, 54 (1988) (holding that § 1983 applies to professionals who provide contract services but are not full-time state employees).

62. Refer to notes 139-49 and 335-37 *infra* and accompanying text. There are several good faith defenses available to therapists. For an excellent review of § 1983, including the important issues of § 1983 cases tried in state courts, see S. STEINGLASS, SECTION 1983 LITIGATION IN STATE COURTS (1989).

63. 110 S. Ct. 975 (1990).

64. *Id.* at 990.

65. See, e.g., J. SMITH, *supra* note 7, at 17-21, 28-31.

66. *Johnston v. Rodis*, 251 F.2d 917, 918 (1958) (psychiatrist's statement that shock treatment is "perfectly safe" may be a warranty).

67. See, e.g., *id.* (involving psychiatrist's warranty regarding shock treatment); *Rosenblum v. Cherner*, 219 A.2d 491, 491 (D.C. App. 1966); *Gould v. Concord Hosp.*, 126 N.H.

good professional manner ("bedside manner") are not contracts.<sup>68</sup> The issue is whether a reasonable person would have understood the assurances as a promise and an inducement to undertake a course of action or therapy.<sup>69</sup> The assurances may be particularly subject to liability if the professional attempts to persuade the client to agree to an unusual or experimental treatment.<sup>70</sup> "Treatment contracts," in which the patient agrees to certain undertakings as a part of therapy,<sup>71</sup> seldom are legally enforceable contracts because they generally do not contain one or more of the essential contractual elements.<sup>72</sup>

Other legal concepts relevant to malpractice liability include defamation,<sup>73</sup> the right of privacy (particularly public disclosure of private facts and false light),<sup>74</sup> and the antitrust laws.<sup>75</sup> Additionally, new legal problems continue to arise from mental health treatment. In at least two instances in recent years, formal actions have been taken against mental health professionals for insider

405, 493 A.2d 1193, 1195 (1985).

68. See *Cirañci v. Goffen*, 85 Ill. App. 3d 1102, 407 N.E.2d 633, 637 (1st Dist. 1980); *Stewart v. Rudner*, 349 Mich. 459, 84 N.W.2d 816, 823 (1957).

69. See, e.g., *Stewart*, 349 Mich. 459, 84 N.W.2d at 823.

70. See, e.g., *Hawkins v. McGee*, 84 N.H. 114, 146 A. 641, 642-43 (1929).

71. The patient-therapist or patient-hospital relationship is generally at least an implicit contract. Cf. *Barnhoff v. Aldridge*, 327 Mo. 767, 38 S.W.2d 1029, 1030 (1931) (surgeon's agreement with a patient can be called a contract).

72. See S. SMITH & R. MEYER, *supra* note 29, at 20; Cf. *Commonwealth v. Mayer*, 270 Pa. Super. 406, 411 A.2d 789 (1979) (involving revocation of probation because of violation of a mental health "treatment contract").

73. See, e.g., *Hoesl v. United States*, 451 F. Supp. 1170, 1179-81 (N.D. Cal. 1978) (qualified privilege to disclose employee information in psychiatric report), *aff'd*, 629 F.2d 586 (9th Cir. 1980); *Smith v. Di Cara*, 329 F. Supp. 439, 443 (E.D.N.Y. 1971) (government physician not immune from suit for defamation); *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814, 817-21 (1958) (psychiatrist's book detailing patient's therapy constituted an unlawful invasion of the common law right of privacy); see also PROSSER & KEETON ON TORTS, *supra* note 35, § 824-29.

74. *Doe v. Roe*, 93 Misc. 2d 201, 400 N.Y.S.2d 668, 674 (1977) (disclosure of information by psychiatrist to patient's fiancée); see also PROSSER & KEETON ON TORTS, *supra* note 35, § 63-64; *Egar, Psychotherapists' Liability for Extrajudicial Breaches of Confidentiality*, 18 ARIZ. L. REV. 1061, 1061 (1976).

75. See, e.g., *Virginia Academy of Clinical Psychologists v. Blue Shield*, 624 F.2d 476, 481-85, (4th Cir. 1980) (insurance carrier may require psychologist's fees to be billed through a physician), *cert. denied*, 450 U.S. 916 (1981); *Ohio v. Joint Comm'n on Accreditation of Hosps.* [Jan.-June], *Antitrust & Trade Reg. Rep. (BNA) No. 948*, at D-2 (Jan. 24, 1980); see also *McGuire & Moore, Private Regulation in Mental Health—The JCAH and Psychologists in Hospitals*, 7 L. & HUM. BEHAV. 235, 248-49 (1983); *Miller, Recent Developments in Antitrust: Challenges to Medical Autonomy*, 41 NEW DIRECTOR MENTAL HEALTH SERVICES 69 (1989).

trading securities violations.<sup>76</sup> The professionals in these cases received information from patients who were insiders, or their families, and traded in securities based on that information.<sup>77</sup>

Though not widely accepted, some commentators have suggested that malpractice should be based on strict liability.<sup>78</sup> It is not clear how such strict liability, in practice, would solve many of the problems of the current system. Although strict liability and no-fault systems may reduce the need to determine fault, they are still causation-based programs. As such, these systems rely on the courts' ability to determine when treatment caused an injury and when something else (e.g., a pre-existing condition) was the cause.<sup>79</sup> Therefore, mental health malpractice plaintiffs may encounter as much difficulty proving causation in strict liability as in negligence.

### B. Areas of Malpractice Liability

Activities that give rise to malpractice liability vary among mental health professions. Psychiatrists face liability resulting from the use of electroconvulsive therapy and drugs, risks that psychologists and social workers usually do not encounter.<sup>80</sup> On the other hand, psychiatrists do not often face liability related to test development and validation. Although commentators have focused attention on liability for physical interventions (e.g., ECT and drugs),<sup>81</sup> a substantial portion of the claims filed against mental health professionals arise from failure to prevent suicide; errors in diagnosis, treatment, and evaluation; breach of confidentiality; and

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76. See, e.g., *United States v. Willis*, 737 F. Supp. 269, 272 (S.D.N.Y. 1990) (psychiatrist traded on inside information received from a patient who was the wife of a business executive); *N.Y. Times*, June 1, 1986, § 12, at 47, col. 3 (Connecticut psychiatrist received information from a patient).

77. *Willis*, 737 F. Supp. at 272; *N.Y. Times*, *supra* note 76, § 12, at 47, col. 3.

78. E.g., B. FURROW, *supra* note 7, at 81-104 (1980); Furrow, *Defective Mental Treatment: A Proposal for the Application of Strict Liability to Psychiatric Services*, 58 B.U.L. REV. 391, 392 (1979); Comment, *Injuries Precipitated By Psychotherapy: Liability Without Fault as a Basis for Recovery*, 20 S.D.L. REV. 401, 401 (1975).

79. Refer to notes 371-79 *infra* and accompanying text.

80. Few claims have been filed against psychologists based on prescription drug use or ECT. Wright, *Psychologists and Professional Liability (Malpractice) Insurance*, 36 AM. PSYCHOLOGIST 1485, 1488-93 (1981).

81. E.g., Slawson & Guggenheim, *supra* note 13, at 979-81; Wright, *supra* note 80. But cf. Taub, *Psychiatric Malpractice in the 1980s: A Look at Some Areas of Concern*, 11 L. MED. & HEALTH CARE 97, 97 (1983) (cautioning that these data may be outdated or incomplete).

having sexual contact with, or otherwise taking unfair advantage of, patients.<sup>82</sup>

1. *Failure to prevent suicide.* Mental health professionals must act reasonably to diagnose and supervise patients who are at risk for suicide.<sup>83</sup> This duty arises out of the therapeutic relationship with the patient.<sup>84</sup> The negligence may result, for example, from unreasonable failure to do any of the following: Adequately examine the patient; recognize common indicia of potential suicide; or appropriately supervise, restrain, or treat the patient.<sup>85</sup> Hospitals and other institutions also have a duty to restrain and supervise potentially suicidal patients.<sup>86</sup>

Professionals are not required to prevent all suicides; they need only take reasonable steps to do so.<sup>87</sup> Courts increasingly recognize that the threat of suicide must be balanced against other risks and values, including freedom from restraint or the risks of some medications. As one court noted: "Calculated risks of necessity must be taken if the modern and enlightened treatment of the mentally ill is to be pursued intelligently and rationally. Neither the hospital nor the doctor are insurers of the patient's health and

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82. Various lists purport to enumerate the most common areas of mental health malpractice claims. See, e.g., Slawson, *The Clinical Dimension of Psychiatric Malpractice*, 14 *PSYCHIATRIC ANNALS* 358, 362 (1984) (listing the order of the most common claims as improper treatment, drug reactions, patient suicide, failure to restrain adequately, improper commitment, breach of confidentiality and libel). Another list ranks the claims as suicide, improper diagnosis, sexual misconduct, breach of confidentiality, death, fracture, attempted suicide, missed diagnosis and homicide. Private correspondence with Dr. Phillip Resnick and a malpractice carrier. A later version lists the order as negligent treatment, suicide, improper medications, misdiagnosis, negligent supervision, negligent confinement, undue familiarity, breach of confidentiality and lack of informed consent. *Id.* See also *APA Monitor*, Aug. 1987, at 39, col. 1 (listing sexual impropriety and incorrect treatment as the most common claims against psychologists).

83. See *Abille v. United States*, 482 F. Supp. 703, 706-08 (N.D. Cal. 1980); *Meier v. Ross Gen. Hosp.*, 69 Cal. 2d 420, 445 P.2d 519, 522-23, 71 Cal. Rptr. 903, 907 (1968); *Pisel v. Stamford Hosp.*, 180 Conn. 314, 430 A.2d 1, 10-16 (1980).

84. See, e.g., *Abille*, 482 F. Supp. at 706-08.

85. See, e.g., Slawson, *supra* note 82; Wright, *supra* note 80.

86. See *Vistica v. Presbyterian Hosp. & Medical Center, Inc.*, 67 Cal. 2d 465, 432 P.2d 193, 196, 62 Cal. Rptr. 577, 580 (1967); *Pisel*, 430 A.2d at 14-15. If a potentially suicidal mentally ill person commits suicide while incarcerated by the state, and the suicide is caused by the state's deliberate indifference to the need for treatment (e.g., withholding medicine), section 1983 liability may be imposed. *Greason v. Kemp*, 891 F.2d 829, 838-39 (11th Cir. 1990).

87. See Berman & Cohen, *Suicide and Malpractice: Expert Testimony and the Standard of Care*, 14 *PROF. PSYCHOLOGY: RES. & PRAC.* 6, 6 (1983); Kapp & Vandercreek, *Malpractice Risks with Suicidal Patients*, 20 *PSYCHOTHERAPY* 274, 274 (1983).

safety."<sup>88</sup> However, risks must be reasonable. The problem mental health professionals encounter is that in hindsight the risk of suicide often appears more "obvious" than it did before the event.<sup>89</sup>

2. *Electroconvulsive therapy.* In the past, ECT raised such malpractice concerns that some insurance companies applied surcharges specifically to cover it.<sup>90</sup> The current claims arising from ECT do not justify this fear.<sup>91</sup> Several theories of negligence provide the basis for ECT claims. Psychiatrists can incur liability because of failure to obtain proper informed consent, prescribing unnecessary ECT, or negligently administering it.<sup>92</sup>

When psychiatrists administer unneeded ECT, patients are subject to unnecessary risks, and psychiatrists may be liable for any injuries that result. For example, prescribing ECT to treat Alzheimer's disease would be negligent because it is not effective against that disease.<sup>93</sup> The use of ECT with patients for whom it is contraindicated (such as patients with some forms of organic brain damage) would also be negligent.<sup>94</sup> Furthermore, a therapist who does not administer ECT in a reasonably careful way will be subject to liability under usual negligence principles for any resulting

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88. *Baker v. United States*, 226 F. Supp. 129, 134-35 (S.D. Iowa 1964), *aff'd*, 343 F.2d 222 (8th Cir. 1965); *see also Johnson v. United States*, 409 F. Supp. 1283, 1292-96 (M.D. Fla. 1976), *rev'd*, 576 F.2d 606 (5th Cir. 1978), *later proceedings*, 631 F.2d 34 (5th Cir. 1980), *cert. denied*, 451 U.S. 1018 (1981); *Fiederlein v. New York Health & Hosps. Corp.*, 80 A.D.2d 821, 437 N.Y.S.2d 321, 323 (1981), *aff'd*, 56 N.Y.2d 573, 435 N.E.2d 393, 450 N.Y.S.2d 181 (1982).

89. Arkes, Guilmette, Faust & Hart, *Eliminating the Hindsight Bias*, 73 J. APPLIED PSYCHOLOGY 305, 305 (1988); Bursztajn, Gutheil, Brodsky & Swagerty, "Magical Thinking," *Suicide, and Malpractice Litigation*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 369, 369 (1988); Wexler & Schopp, *How and When to Correct for Juror Hindsight Bias in Mental Health Malpractice Litigation: Some Preliminary Observations*, 7 BEHAV. SCI. & L. 485 (1989).

90. *See Slawson & Guggenheim, supra note 13*, at 931.

91. *Id.*

92. *See Horan & Milligan, Recent Developments in Psychiatric Malpractice*, 1 BEHAV. SCI. & L. 23 (1983); Perr, *Liability and Electroshock Therapy*, 25 J. FORENSIC SCI. 503, 511 (1980); *see also Taub, Electroconvulsive Therapy, Malpractice, and Informed Consent*, 15 J. OF PSYCHIATRY & L. 7, 21 (1987) (discussing informed consent); Winslade, Liston, Roetz & Weber, *Medical, Judicial, and Statutory Regulation of ECT in the United States*, 141 AM. J. PSYCHIATRY 1349, 1352-53 (1984) (discussing competency and consent).

93. *Cf. S. SMITH & R. MEYER, supra note 29*, at 94-96 (suggesting that psychiatrists might use ECT on an experimental basis to treat certain conditions but should conduct such experimental use in strict conformity with the requirements for human experiments).

94. AMERICAN PSYCHIATRIC ASS'N, TASK FORCE REPORT NO. 14, ELECTROCONVULSIVE THERAPY (1978). *See generally* NATIONAL INST. OF MENTAL HEALTH, ELECTRO-CONVULSIVE THERAPY: CONSENSUS DEVELOPMENT CONFERENCE (1985) (general discussion on research advances and implications arising from the use of ECT).

injuries. For example, a therapist who neglects to give medication to protect a patient from harm due to extreme convulsions may be subject to liability if the patient suffers a fracture.<sup>95</sup>

3. *Prescribing drugs.* The use of psychoactive prescription drugs is a potential source of malpractice litigation because of the risk of harm to patients.<sup>96</sup> The bases of liability are similar to those described for ECT: failure of informed consent, inappropriate and unnecessary prescription, and negligent administration of drugs.<sup>97</sup> By definition, prescription drugs involve risks, and improperly prescribing them or failing to give adequate instruction poses an unnecessary risk to patients.<sup>98</sup>

4. *Psychosurgery.* Psychosurgery, once a controversial physical intervention of some importance, is less significant now because it is seldom performed. Presently, it exists as an experimental procedure and is, therefore, subject to special regulation.<sup>99</sup> Thus, if psychosurgery were undertaken now without extraordinarily complete informed consent, review, and care, the doctor would be subject to liability.<sup>100</sup>

95. See, e.g., *Stone v. Proctor*, 259 N.C. 633, 637, 131 S.E.2d 297, 300 (1963) (psychiatrist may be held liable for failing to discover a vertebra fracture resulting from the first of a series of electroshock therapy sessions); cf. Annotation, *Malpractice in Connection With Electroshock Treatment*, 94 A.L.R.3d 317 (1979) (discussing various bases of liability that may result from use of electroshock therapy).

96. Cf. Slawson & Guggenheim, *supra* note 13, at 980 (reporting that medication claims constitute more than one-third of malpractice claims arising from the major procedures employed in psychiatry).

97. See, e.g., *Ohligschlager v. Proctor Community Hosp.*, 55 Ill. 2d 411, 417, 303 N.E.2d 392, 396 (1973) (holding defendant liable for negligent administration of intravenous solution); *Clites v. State*, 322 N.W.2d 917, 921-23 (Iowa Ct. App. 1982) (holding defendant liable for failure to obtain informed consent); *Christy v. Saliterman*, 288 Minn. 144, 144, 179 N.W.2d 288, 291 (1970) (negligent instructions to family regarding how to administer drugs to discharged patient); Kramer, *Psychiatry, Psychology, and the Law*, 1988 PERS. INJ. REV. 150; Mills & Eth, *Legal Liability with Psychotropic Drug Use: Extrapyramidal Syndromes and Tardive Dyskinesia*, 48 J. CLINICAL PSYCHIATRY 28, 30-31 (1987) (informed consent); Tancredi, *Malpractice and Tardive Dyskinesia: Conceptual Dilemmas*, 8 J. CLINICAL PSYCHOPHARMACOLOGY 715, 735-45 (1988) (informed consent).

98. See Appleton, *Legal Problems in Psychiatric Drug Prescription*, 124 AM. J. PSYCHIATRY 877, 879-80 (1968); Wettstein, *Tardive Dyskinesia and Malpractice*, 1 BEHAV. SCI. & L. 85 (1983).

99. S. SMITH & R. MEYER, *supra* note 29, at 107-08; see also Comment, *Psychosurgery: The Rights of Patients*, 23 LOY. L. REV. 1007, 1017 (1987) (stating that institutional review boards may impose limitations on psychosurgery because of the potential for its misuse).

100. See S. SMITH & R. MEYER, *supra* note 29, at 105-08.

5. *Inadequate diagnosis.* Mental health malpractice may result from a therapist's failure to adequately test or diagnose patients.<sup>101</sup> This negligence may indirectly result in injury.<sup>102</sup> For instance, liability may be predicated on a negligently conducted examination which leads to the prescription of unnecessary medications that injure the patient. Additionally, negligent diagnosis may result from failure to perform an adequate examination; failure to understand the nature, limitations, and proper uses of tests; failure to draw conclusions reasonably arising from the examination; failure to properly administer tests; or failure to observe ethical limitations regarding tests.<sup>103</sup>

6. *Sexual contact and excessive force.* Liability may result from taking unfair advantage of a patient or from using excessive force. Unfair advantage is an ethical violation and commonly involves sexual contact between patient and professional.<sup>104</sup> One of

101. See Slawson & Guggenheim, *supra* note 13, at 979 (survey of 217 malpractice actions against psychiatrists from 1974 to 1978 indicates diagnostic errors were the major cause of liability); Wright, *supra* note 80, at 1485-93 (analyzing causes of action resulting in claims against insurance companies due to psychologists' malpractice); see Kahn & Taft, *The Application of the Standard of Care Doctrine to Psychological Testing*, 1 BEHAV. SCI. & L. 71, 74 (1983) (discussing standards for administration of commonly used tests).

102. Not every negligent diagnosis will result in liability. For example, most states provide some immunity for negligent diagnosis that results in wrongful civil commitment, so long as the professional acts in good faith or is not reckless.

103. See, e.g., Szimonisz v. United States, 537 F. Supp 147, 148 (D. Or. 1982) (finding liability for failure to diagnose growing tumor during patient's numerous stays at hospital); Naccarato v. Grob, 384 Mich. 248, 180 N.W.2d 788, 792 (1970) (two pediatricians independently treating plaintiff failed to administer tests for diagnosis of phenylketonuria); Welch v. Frisbie Memorial Hosp., 90 N.H. 337, 9 A.2d 761, 763 (1939) (psychiatrist, failing to diagnose thyroid problem, treated patient for depression for six months). See generally Busch & Cavanaugh, *Physical Examination of Psychiatric Outpatients: Medical and Legal Issues*, 36 HOSP. & COMMUNITY PSYCHIATRY 958, 959-60 (1985) (although psychiatric patients tend to be less healthy than the general population and examination of outpatients is important, psychiatrists rarely perform such examinations and only a small percentage initiate them); Modlin & Felthous, *Forensic Psychiatry in Private Practice*, 17 BULL. AM. ACAD. PSYCHIATRY 69 (1989) (suggesting that forensic psychiatrists need to be expert diagnosticians); Note, *Requiring Due Care in the Process of Patient Deinstitutionalization: Toward a Common Law Approach to Mental Health Care Reform*, 98 YALE L.J. 1153, 1161-67 (1989) (discussing the obligation of care and careful diagnosis in the release of patients).

104. See AMERICAN PSYCHOLOGICAL ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS (1981) (principles 6, 7); NATIONAL ASS'N OF SOC. WORKERS, CODE OF ETHICS, § IIF.5 (1979). See also Pope, Keith-Spiegel & Tabachnik, *supra* note 38, at 151-52 (noting that sexual attraction between therapist and patient is not uncommon). Sexual contact is often harmful to the patient. Bouhoutsos, Holroyd, Lerman, Forer & Greenberg, *Sexual Intimacy Between Psychotherapists and Patients*, 14 PROF. PSYCHOLOGY: RES. & PRAC. 185 (1983); Feldman-Summers & Jones, *Psychological Impacts of Sexual Contact Between Therapists or Other*

the most notorious cases, *Zipkin v. Freeman*,<sup>105</sup> involved a patient who was referred to a psychiatrist after a physician could discover no physical cause for her ailments.<sup>106</sup> At the psychiatrist's suggestion, she went on overnight trips with him and attended "group therapy" in the form of nude swimming parties.<sup>107</sup> The psychiatrist also advised her to leave her husband, sue her husband and brother, and rid herself of hostility by breaking into her husband's home.<sup>108</sup> The court found the psychiatrist liable for the injuries the patient sustained as a result of the psychiatrist's misconduct.<sup>109</sup>

This case undoubtedly represents an extreme example of the mishandling of the transference phenomenon.<sup>110</sup> Other courts, in less outrageous cases, have recognized that the nature of the therapist-patient relationship and the patient's great dependence on the therapist make it easy for the therapist to take advantage of the patient.<sup>111</sup> The therapist who does so is acting unethically and is subject to liability.<sup>112</sup> Indeed, sexual involvement with patients is

*Health Care Practitioners and Their Clients*, 52 J. CONSULTING & CLINICAL PSYCHOLOGY 1054, 1054 (1984).

105. 436 S.W.2d 753 (Mo. 1968) (en banc).

106. *Id.* at 756.

107. *Id.*

108. *Id.* at 758-59.

109. *Id.* at 762.

110. Transference, a common phenomenon in psychotherapy, is the process by which a patient's emotional feelings are transferred to the therapist from the true object of the patient's feelings. During this period, the patient often "falls in love" with the therapist for a time. See generally *Simmons v. United States*, 805 F.2d 1363, 1364-65 (9th Cir. 1986) (discussing the meaning of transference and judicial treatment of it in the context of malpractice).

111. See, e.g., *Nicholson v. Han*, 12 Mich. App. 35, 162 N.W.2d 313, 315 (1968) (during the period that psychiatrist provided marital counseling to couple, he seduced the wife); *Mazza v. Huffaker*, 61 N.C. App. 170, 300 S.E.2d 833, 837 (1983) (patient discovered his wife in bed with his psychiatrist after the patient disclosed their separation during a therapy session); *Roy v. Hartogs*, 85 Misc. 2d 891, 381 N.Y.S.2d 587, 588 (Sup. Ct. 1976) (psychiatrist induced patient to have sexual intercourse as part of her prescribed therapy). Institutions may also face liability claims as a result of therapist-patient sex. *Doe v. Samaritan Counseling Center*, 791 P.2d 344, 346-49 (Alaska 1990); see also Epstein, *The Exploitative Psychotherapist as a Defendant*, 25 TRIAL 53, 55 (1989) (asserting that if therapist has sex with one patient, he is likely to have sex with others); Stone, *The Legal Implications of Sexual Activity Between Psychiatrist and Patient*, 133 AM. J. PSYCHIATRY 1138, 1138 (1976) (arguing that because legal and professional sanctions against therapists who have had sex with their patients are either rare or extremely complicated, in the end, patients must depend on the decent moral character of their therapist).

112. A therapist may also be liable for alienation of affection when the therapist has been sexually involved with a married patient. In states still recognizing this cause of action, a spouse of a patient who has been enticed out of a marital relationship by a therapist may file suit. See, e.g., *Anclote Manor Found. v. Wilkinson*, 263 So. 2d 256, 257 (Fla. Dist. Ct.

among the most significant malpractice risks of the 1990s.

A few mental health professionals have suggested that, in specific instances, sexual contact between patients and therapists is proper or even desirable because it may provide the acceptance or affection a patient needs.<sup>113</sup> Although this position is rejected by most mental health professionals, it does represent a small "school of thought;" a troubling question is whether liability should be imposed on therapists who adhere to this school and engage in "therapeutic" sexual contact with patients.<sup>114</sup> Because this school of thought is rejected by much of the profession as being dangerous to the patient, such conduct is likely to be considered negligent (akin to curing cancer with copper bracelets) or, at best, experimental. Therefore, the therapist who engages in sexual relations with a patient is subject to liability if that conduct results in injury to the patient.<sup>115</sup> A patient probably cannot freely consent to en-

App. 1972) (psychiatrist's designs to wed married patient constituted breach of contract to provide professional care). See generally J. SMITH, *supra* note 7, at 286-338. A therapist may also be liable to the patient for sexual contact with a spouse or lover of a patient. *E.g.*, *Rowe v. Bennett*, 514 A.2d 802, 804 (Me. 1986); Note, *Negligent Infliction of Mental Distress in the Psychotherapist-Patient Relationship: A Case Analysis of Rowe v. Bennett*, 11 HAMLIN L. REV. 123 (1988).

113. See SHEPARD, *THE LOVE TREATMENT: SEXUAL INTIMACY BETWEEN PATIENTS AND PSYCHOTHERAPISTS* 15 (1971); see also MARIMOR, *Sexual Acting-Out in Psychotherapy*, 32 AM. J. PSYCHOANALYSIS 3 (1972) (discussing various rationalizations for therapist-patient sexual contact and concluding that it is detrimental to the therapeutic process).

114. The ethical standards of physicians and the mental health professions clearly prohibit sexual contact with patients. However, surveys repeatedly note that it is unusual for therapists to have sexual relations with present or former patients. About 90% of therapists report having been sexually attracted to patients, but less than 10% report having engaged in such behavior. See Pope, Keith-Spiegel & Tabachnick, *supra* note 48, at 147; Pope, Tabachnick & Keith-Spiegel, *Ethics of Practice: The Beliefs and Behaviors of Psychologists as Therapists*, 42 AM. PSYCHOLOGIST 993, 999 (1987); J. ROBERTSON, *supra* note 7, at 326-27.

115. *E.g.*, *Marlene F. v. Affiliated Psychiatric Med. Clinic, Inc.*, 48 Cal. 3d 583, 770 P.2d 278, 283, 257 Cal. Rptr. 98 (1989) (en banc) (holding therapist liable to both mothers and sons for molestation of the children because both suffered direct injury and severe emotional distress); *Roy v. Hartogs*, 85 Misc. 2d 891, 381 N.Y.S.2d 587, 588 (Sup. Ct. 1976) (patient so emotionally and mentally injured due to sex with therapist that she required hospitalization); see also Benetin & Wilder, *Sexual Exploitation and Psychotherapy*, 11 WOMEN'S RTS. L. REP. 121, 121-22 (1989) (emphasizing that harm to patient goes much deeper than tort or contract injury); Cope, *Psychotherapists Liable for Sexual Relations With Patients*, 25 TRIAL 135, 136 (1989) (discussing case in which therapist got patient addicted to barbiturates and valium, then used her addiction to force her to have sex with him over a 14-year period); Guthell, *Borderline Personality Disorder, Boundary Violations, and Patient-Therapist Sex: Medicolegal Pitfalls*, 146 AM. J. PSYCHIATRY 597, 597 (1989) (discussing the legal pitfalls therapists face when they become sexually involved); Note, *Psychiatric Malpractice: Exploitation of Women Patients*, 11 HARV. WOMEN'S L.J. 83, 84 (1988)

gage in therapist-patient sexual relations because of the nature of the relationship between patient and the therapist and the patient's emotional dependence on the therapist.<sup>116</sup>

Liability also may arise from the use of therapy that includes very painful or violent physical contact.<sup>117</sup> *Hammer v. Rosen*,<sup>118</sup> a notable excessive force case, involved a dramatic technique for treating schizophrenia. This technique required that communication be established between physician and patient "on the patient's level."<sup>119</sup> For some patients, this included substantial slapping and hitting as a means of opening up communication.<sup>120</sup> Although therapists typically obtained consent from next of kin or from a guardian, a patient ultimately sued for damages resulting from the slaps and abuses during the beating, and the doctor was subject to liability for injuries suffered as a result of this treatment.<sup>121</sup>

7. *Breach of confidentiality.* Mental health professionals have ethical and legal obligations to maintain the secrets of their

(asserting that a woman who seeks psychiatric treatment and subsequently becomes involved in sexual relations with her therapist is a victim of sex discrimination). *But cf.* Coleman, *Sex Between Psychiatrist and Former Patient: A Proposal for a "No Harm, No Foul" Rule*, 41 OKLA. L. REV. 1, 5 (1988) (suggesting that civil, rather than criminal sanctions are appropriate when a therapist has sex with a former patient).

116. See *Roy v. Hartogs*, 81 Misc. 2d 350, 352, 366 N.Y.S.2d 297, 299 (Civ. Ct. 1975) (a suit arising from a therapist's sexual relations with a patient is treated as a conventional action for seduction); Cummings & Sobel, *Malpractice Insurance: Update on Sex Claims*, 22 PSYCHOTHERAPY 186, 187 (1985) (sexual intimacy malpractice suit involves violation of a trust by the therapist to the patient); Morin, *Civil Remedies for Therapist-Patient Sexual Exploitation*, 19 GOLDEN GATE U.L. REV. 401, 417 (1989) (contending that patient's consent to therapy does not carry over to sexual acts, which are not considered proper therapy).

For a general discussion of possible criminal liability for therapist-patient sexual activity, see COLO. REV. STAT. § 18-3-405.5 (1989); MINN. STAT. ANN. § 609.344 (West 1989); N. D. CENT. CODE § 12.1-20-06.1 (1988); WIS. STAT. ANN. § 940.22 (West Supp. 1989); Appelbaum, *Statutes Regulating Patient-Therapist Sex*, 41 HOSP. & COMMUNITY PSYCHIATRY 15, 15-16 (1990); Leroy, *The Potential Criminal Liability of Human Sex Clinics and Their Patients*, 16 ST. LOUIS U.L.J. 586, 593-99 (1972); Stone, *The Legal Implications of Sexual Activities Between Psychiatrist and Patient*, 133 AM. J. PSYCHIATRY 1138, 1138-39 (1976).

117. Health care often involves some "violence" to the body, such as surgery, inoculations and the like. Psychiatry is no exception; ECT can be considered quite invasive. Therefore, the simple fact that painful physical contact occurred does not give rise to potential liability. Rather, liability will likely arise from the use of some form of physical invasion that is not widely accepted and is potentially harmful without offsetting potential benefits.

118. 7 N.Y.2d 376, 165 N.E.2d 756, 198 N.Y.S.2d 65 (1960).

119. *Hammer*, 165 N.E.2d at 757, 198 N.Y.S.2d at 66.

120. *Id.*

121. *Id.*

patients.<sup>122</sup> Failure to do so may result in liability for invasion of privacy,<sup>123</sup> for negligence,<sup>124</sup> or conceivably, for breach of contract.<sup>125</sup> The duty to protect confidentiality exists whether or not a testimonial privilege covers the communication.<sup>126</sup>

The duty of confidentiality is not absolute.<sup>127</sup> When competent, patients may waive confidentiality, for example, to release information needed for the therapist to receive payment for treatment.<sup>128</sup> However, patients' limited waivers do not permit an unlimited disclosure of the information by the therapist. For instance, permission to inform an insurance company of therapy

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122. For examples of ethical provisions concerning confidentiality, see AMERICAN PSYCHOLOGICAL ASS'N, *ETHICAL PRINCIPLES OF PSYCHOLOGISTS* (1981) (principle V); AMERICAN PSYCHIATRIC ASS'N, *THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY* § 4 (1981); NATIONAL ASS'N OF SOC. WORKERS, *CODE OF ETHICS* (1979) (provision II.H.); AMERICAN PERSONNEL AND GUIDANCE ASS'N, *ETHICAL STANDARDS* §§ 2, 5, 6, 7, 8 (1981). The relevant portions of these codes are reprinted in S. SMITH & R. MEYER, *supra* note 29, at 77-80.

123. The most likely form of privacy liability for revealing patient information is "false light." False light is publication of a misleading communication in a manner that would be highly offensive to a reasonable person. RESTATEMENT (SECOND) OF TORTS § 652D.

124. Therapists have a duty to maintain confidentiality. A reasonably prudent therapist would not reveal patient information (with certain exceptions) without patient consent. Therefore, unauthorized release of information is unreasonable and negligent. Refer to note 125 *infra*.

125. Some therapists expressly agree to maintain patient secrets. A therapist who violates this promise may be held liable for a breach of contract. Courts might also find an implied term in a treatment contract that the therapist would act ethically. The unauthorized release of information from therapy may be unethical conduct. For an excellent review of therapist liability for breach of confidentiality, see Eger, *Psychotherapists' Liability for Extrajudicial Breaches of Confidentiality*, 18 ARIZ. L. REV. 1061, 1065 (1976) (discussing the various theories of recovery available to a patient who has been harmed by a breach of confidentiality). See also Note, *Roe v. Doe: A Remedy for Disclosure of Psychiatric Confidences*, 29 RUTGERS L. REV. 190, 192 (1975) (discussing the contract, tort and constitutional issues raised by a therapist's breach of confidentiality); cf. Cooper, *The Physician's Dilemma: Protection of the Right to Privacy*, 22 ST. LOUIS U.L.J. 397, 397-99 (1978) (discussing medical information generally).

126. The obligation of confidentiality exists independently of the privilege. In the absence of a privilege, a court may order a therapist to release information, but the general duty to maintain the secrets of the client remains. Refer to note 125 *supra*. The therapist who wrongfully reveals information in documents related to a judicial proceeding may be subject to liability as well as discipline. *Mississippi Bd. of Psychological Examiners v. Hozford*, 508 So.2d 1049, 1053 (Miss. 1987) (psychologist was suspended from practice and settled a civil action for \$9000 after filing an affidavit about a patient in a divorce and custody case).

127. See Smith, *supra* note 44, at 513.

128. The patient "owns" the confidentiality and is free to waive the right. See *id.* at 541-42 (observing that patients commonly waive medical and psychotherapy confidentiality to ensure the payment of insurance claims).

does not include the right of the professional to write a book describing the patient and the therapy.<sup>129</sup> In some cases, therapists are obligated to breach confidentiality. For example, when therapists receive information concerning child abuse or a valid court order requiring release of information,<sup>130</sup> they may release such information without incurring liability.

8. *Referral to other practitioners.* Some clients present problems that a particular mental health professional cannot adequately address. For example, the patient may require sophisticated psychological testing that a psychiatrist does not feel competent to complete, or a patient being seen by a psychologist may need medical intervention. In such circumstances, the professional must refer the patient to another professional. If a therapist negligently fails to refer the patient, the therapist will be subject to liability.<sup>131</sup> This is consistent with ethical standards requiring that professionals not practice beyond their competence.<sup>132</sup>

When referral is necessary because of personal feelings or conflicts with patients, the professional must make arrangements for the patient to be transferred to another therapist. The therapist must not "dump" or suddenly stop seeing a patient. After treatment has begun, the professional's failure to attend to the patient or to make reasonable provision for the patient to see another competent professional may constitute "abandonment."<sup>133</sup>

9. *Involuntary civil commitment and detention.* Participation in the civil commitment process may subject mental health

129. See generally *Doe v. Roe*, 93 Misc. 2d 201, 400 N.Y.S.2d 668, 671 (1977) (invalidating patient's oral waiver of confidentiality obtained during the course of treatment).

130. See Smith & Meyer, *Child Abuse Reporting Laws and Psychotherapy: A Time for Reconsideration*, 7 INT'L J.L. & PSYCHIATRY 351, 352-53 (1984).

131. See Morreim, *Conflicts of Interest: Profits and Problems in Physician Referrals*, 262 J. A.M.A. 390 (1989). Referring a patient to another practitioner may also result in liability if the selection of the practitioner is negligent and the selected practitioner harms the patient. See e.g., *Cestone v. Harkavy*, 243 A.D. 732, 277 N.Y.S. 438, 439 (1935).

132. In mental health cases, it is often very difficult to determine when referral is required. The law defines the duty according to a reasonable practitioner standard: Would a reasonable practitioner with similar training and experience have made the referral? The desire to keep a client for economic reasons is not a legitimate reason not to refer. See PROSSER & KEETON ON TORTS, *supra* note 35, § 32, at 187.

133. See B. SCHULTZ, *LEGAL LIABILITY IN PSYCHOTHERAPY* 50-5 (1982); J. SMITH, *supra* note 7, at 47; Shapiro, *Medical Malpractice: History, Diagnosis and Prognosis*, 22 ST. LOUIS U.L.J. 469, 481 (1978); Weddington & Cavenar, *Termination Initiated by the Therapist: A Countertransference Storm*, 136 AM. J. PSYCHIATRY 1302 (1979).

professionals to liability. Although most states provide immunity so long as the professional acts in good faith,<sup>134</sup> significant misconduct may result in liability.<sup>135</sup> If the professional is not acting in good faith, efforts to detain or commit a patient involuntarily may result in liability for false imprisonment or for malicious prosecution.<sup>136</sup> In such circumstances, punitive damages are possible.<sup>137</sup>

In *O'Connor v. Donaldson*,<sup>138</sup> the United States Supreme Court addressed the applicability of section 1983 to the involuntary civil commitment process.<sup>139</sup> In that case, Donaldson claimed that, although he was not dangerous, he had been involuntarily held without treatment.<sup>140</sup> The trial court awarded him \$38,500 in damages from the state officials and psychiatrists involved in his lengthy confinement.<sup>141</sup> The Supreme Court held that a state cannot legally confine nondangerous individuals capable of surviving

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134. When psychotherapists testify in involuntary civil commitment hearings, their in court statements usually are protected by a "privilege" from successful defamation suits. See PROSSER & KEETON ON TORTS, *supra* note 35, § 114, at 816-17. Other work done for courts, or as part of the civil commitment process, will generally be exempt from defamation suits as long as therapists have acted in good faith. See *id.* § 114, at 818.

135. See, e.g., *Lanier v. Sallas*, 777 F.2d 321, 326 (5th Cir. 1985) (upholding a \$50,000 award to a person committed on the basis of false affidavits by doctors who never examined her); see also *Kleber v. Stevens*, 39 Misc. 2d 712, 241 N.Y.S.2d 497, 499 (Sup. Ct. 1963) (indicating that physician examining an allegedly mentally ill person has a duty to exercise ordinary care), *aff'd*, 20 A.D.2d 896, 249 N.Y.S.2d 668 (1964); Knapp & VandeCreek, *A Review of Tort Liability in Involuntary Civil Commitment*, 38 HOSP. & COMMUNITY PSYCHIATRY 648, 648-49 (1987) (discussing general bases of liability). But see *Rhiver v. Rietman*, 148 Ind. App., 265 N.E.2d 245, 249 (Ct. App. 1970) (indicating that physician may be held liable for performing test in a negligent manner).

In this section we consider liability for wrongfully committing a patient. Liability may also exist for negligently releasing a committed patient. Refer to note 211 *infra* and accompanying text.

136. As a practical matter, to sustain a malicious prosecution suit, the patient usually must demonstrate that the therapist acted in an outrageous fashion, either conspiring with others to commit the patient for ulterior motives, or attempting to detain the patient for the personal gain of the physician or out of hatred for the patient. See, e.g., *Maben v. Rankin*, 55 Cal. 2d 139, 358 P.2d 681, 682, 10 Cal. Rptr. 353, 354 (1961); *Whitree v. State*, 56 Misc. 2d 693, 290 N.Y.S.2d 486, 505 (Ct. Cl. 1968) (awarding \$300,000 damages to plaintiff who was wrongfully confined in a state hospital for 12 years); Note, *Tort Liability of the Psychotherapist*, 8 U.S.F. L. REV. 405, 415-16 (1973) (discussing the difficulty of proving lack of probable cause and malice).

137. See PROSSER & KEETON ON TORTS, *supra* note 35, § 2, at 11.

138. 422 U.S. 563 (1975).

139. *Id.* at 565. Section 1983 imposes liability on those who deprive others of the civil rights under color of state law. 42 U.S.C. § 1983 (1988).

140. *O'Conner*, 422 U.S. at 565.

141. *Id.* at 572.

safely in freedom unless it provides some form of treatment.<sup>143</sup> The Court did not decide whether a state may detain a dangerous person without treatment or whether a state may detain a nondangerous person if it provides treatment. According to the Court, although officials have "no duty to anticipate unforeseeable constitutional developments," persons held in violation of this constitutional rule could receive damages in the future.<sup>143</sup> However, in *Youngberg v. Romeo*,<sup>144</sup> the Court also has made it clear that professionals will not be individually liable for the state's failure to provide adequate funds and facilities for involuntary patients.<sup>145</sup> More recently, in *Zinermon v. Burch*,<sup>146</sup> the Court suggested that section 1983 liability may arise in an apparently "voluntary" admission to a mental hospital if a clearly incompetent patient is held in a hospital under his own "consent."<sup>147</sup> In that situation, the consent is legally ineffective and the decision to hold the patient without a judicial proceeding (*e.g.*, civil commitment or guardianship) may deprive him of freedom without due process.<sup>148</sup> Of course, the mistreatment of patients (*e.g.*, beatings or unreasonable restraint) or the unreasonable withholding of available treatment also may subject the professional to common-law or section 1983 liability.<sup>149</sup>

10. *Test construction and validation.* Mental health professionals have become increasingly involved in the development and validation of many forms of tests, particularly employment and ed-

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142. *Id.* at 576.

143. *Id.* at 577.

144. 457 U.S. 307 (1982).

145. *Id.* at 323.

146. 110 S. Ct. 975 (1990).

147. *Id.* at 987.

148. *Id.* at 987-88.

149. Severe beatings or treatment inflicted on a civil commitment patient constitute a violation of due process; if it were to occur to a prisoner, the cruel and unusual punishment prohibition of the eighth amendment would apply. The same activity directed towards a voluntary patient constitutes common law battery. See *Belger v. Arnot*, 344 Mass. 679, 183 N.E.2d 866, 869 (1962) (indicating that three attendants may have committed battery when they "grabbed" a patient and escorted her to a hospital ward); *Stowers v. Wolodzko*, 386 Mich. 119, 191 N.W.2d 355, 365 (1971) (holding psychiatrist liable for assault and battery for ordering that certain shots and medication be given to a patient who refused treatment); *Hammer v. Rosen*, 7 N.Y.2d 376, 379, 165 N.E.2d 756, 757, 198 N.Y.S.2d 65, 66 (1960) (holding that evidence indicating that psychiatrist beat patient established prima facie case of malpractice).

ucation tests.<sup>150</sup> Defective test design or defective validation may result in a test that does not do what it purports to do or that is illegally discriminatory. This may harm those relying on the test (e.g., an employer) as well as the test takers (e.g., a prospective employee). Traditionally, such defects did not result in significant liability partly because the doctrine of "limited duty" made it difficult for test takers to recover.<sup>151</sup> Mental health professionals cannot assume that this tradition will continue. In Cleveland, Ohio, a recent claim against a test developer was settled for a substantial amount in a case in which a psychologist developed a city employment test that had disparate impact on women.<sup>152</sup> The Title VII settlement went to those who had been disadvantaged by the test, not to the city organization that had paid to have the test developed.<sup>153</sup>

11. *Nontraditional therapy.* In recent years, therapists have developed a number of nontraditional and "pop" therapies.<sup>154</sup> Some of these claim to solve serious emotional problems and,

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150. See, e.g., S. SMITH & R. MEYER, *supra* note 29, at 173-88 (observing that the mental health professionals have become valuable in assisting courts with assessing the constitutional and statutory validity of educational and employment tests); cf. Bersoff, *Testing and the Law*, 36 AM. PSYCHOLOGIST 1047, 1047-48 (1981) (noting three benefits of increased legal involvement in psychological testing: (1) it makes society more aware of racial and cultural biases; (2) psychologists will be held responsible for their conduct, and (3) it will accelerate the search for better methods).

151. The limited duty rule prevents liability for negligent conduct by allowing for a determination that the defendant did not owe a duty to the injured plaintiff in certain circumstances. PROSSER & KEETON ON TORTS, *supra* note 35, § 53 at 356-59.

152. *Zamlen v. Cleveland*, 686 F. Supp. 631 (N.D. Ohio 1988) (concerning a test for prospective firefighters that discriminated against women applicants), *aff'd*, 906 F.2d 209 (6th Cir. 1990).

153. Personal conversation with Professor Jane Picker, Cleveland State University College of Law, an attorney representing the plaintiff in the litigation. The suit was settled with regard to the psychologist, but was dismissed with regard to the governmental entity. *Zamlen*, 686 F. Supp. at 634.

154. See, e.g., R. ROSEN, *PSYCHOBABBLE* (1977) (discussing the therapeutic trends of the 1970s including EST, rebirthing, co-counseling, and primal therapy); Glass, Kirah & Parris, *Psychiatric Disturbances Associated with Erhard Seminars Training: A Report of Cases*, 134 AM. J. PSYCHIATRY 245 (1977) (discussing five cases of psychiatric disturbance following EST participation); M. GROSS, *THE PSYCHOLOGICAL SOCIETY* 277-317 (1978) (comparing primal therapy to Freudian therapy); Keen, *Deliver Us From Shyness Clinics*, *PSYCHOLOGY TODAY*, Mar. 1978, at 18 (criticizing new therapies that promise to wipe out human emotions such as shyness); Shastrom, *Group Therapy: Let The Buyer Beware*, in *CLINICAL PSYCHOLOGY TODAY* 149 (B. Henker ed. 1967); Yalom & Lieberman, *A Study of Encounter Group Casualties*, 25 ARCHIVES GEN. PSYCHIATRY 16 (1971) (discussing 16 "casualties" of group therapy who experienced enduring, significant, and negative outcomes to therapy).

therefore, attract emotionally disturbed people.<sup>155</sup> The training available to or taken by the practitioners of these various forms of therapy varies widely. As a general matter, state licenses are not required in order to "practice" nontraditional therapies.<sup>156</sup>

A number of unsettled questions remain in this area. To what extent should the practitioners of "pop" therapies be held liable when the counseling results in injury (e.g., suicide)?<sup>157</sup> Should practitioners of nontraditional therapies be held to the standard of care of psychotherapists generally, or to a special standard of care defined by their own nontraditional therapy? Some commentators argue that, in order to protect patients from ineffective therapy and charlatans, practitioners of nontraditional therapies should be held to the same standard of care and charged with the same knowledge as more traditional psychotherapists.<sup>158</sup> According to the commentators, the application of a lesser standard would permit the absence of substantial training to be an advantage to avoid liability and would indirectly encourage the development of potentially harmful "pop" therapies.<sup>159</sup> On the other side, it is claimed that applying the standard of care of ordinary psychotherapy to nontraditional forms is unfair and will discourage the development of new, potentially effective, therapies.<sup>160</sup>

The law generally has defined a standard of care in terms of the "schools of thought" of the practitioner involved.<sup>161</sup> This principle suggests that practitioners of nontraditional therapy should be held to their own standard of care. However, those who "hold themselves out" as having special qualifications are expected to practice at a level consistent with those qualifications.<sup>162</sup> For instance, general practitioners who claim to be cardiologists should be held to that higher standard of care. These principles also should apply to the practitioners of "pop" therapies who present

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155. Keen, *supra* note 154, at 18-19.

156. S. SMITH & R. MEYER, *supra* note 29, at 128-33, 137-41.

157. 3 M. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* 66-69 (1989).

158. See, e.g., Note, *Standard of Care in Administering Non-Traditional Psychotherapy*, 7 U.C. DAVIS L. REV. 56, 82-3 (1974) (calling for legislative action to protect the public).

159. *Id.* at 83.

160. See Hogan, *Encounter Groups and Human Relations Training: The Case Against Applying Traditional Forms of Statutory Regulation*, 11 HARV. J. LEGIS. 659, 683-99 (1974) (taking the view that human relations training is a social invention like the family that tries to teach skills for living in modern society and should not be regulated).

161. See PROSSER & KEETON ON TORTS, *supra* note 35, § 32, at 185-93 (defining the standard of care for specialists).

162. *Id.* § 32, at 185-188.

themselves to the public as therapists or trained counselors.<sup>163</sup>

There is a strong argument that those practicing nontraditional forms of therapy should have a duty to recognize and refer to other professionals those clients who are suicidal and those with serious emotional problems who may be harmed by the nontraditional therapy.<sup>164</sup> Consider, for example, a "growth" group that uses highly emotional and aggressive techniques and does not screen applicants to eliminate those likely to be harmed by the sessions. If a participant commits suicide as a result of the emotional pressure and aggression generated by the session, liability is justified. By claiming to be counselors or therapists, the therapists hold themselves out as having sufficient training and skills to identify those with serious emotional problems.

A related issue arises when ministers, who may lack adequate training in pastoral counseling or psychotherapy, counsel seriously disturbed patients.<sup>165</sup> Ministers often combine therapy with religious counseling.<sup>166</sup> Thus, first amendment concerns arise because imposing liability for religious counseling may interfere with the

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163. B. SCHULTZ, *LEGAL LIABILITY IN PSYCHOTHERAPY* 3-4 (1982); Knapp, *A Primer on Malpractice for Psychologists*, 11 *PROF. PSYCHOLOGIST: RES. & PRAC.* 606, 607 (1980). *But cf. Nally v. Grace Community Church of the Valley*, 47 Cal. 3d 278, 299, 763 P.2d 948, 960-61, 253 Cal. Rptr. 97, 109-10 (1988) (holding that pastoral counselors have no duty to refer suicidal person to a psychotherapist).

164. Organizations that hold encounter group sessions without providing adequate supervision by professionals may be subject to liability because of the severe psychological harm that may result from such intense experiences. *Bingham v. Lifespring*, No. 82-5128 (E.D. Pa. July 31, 1984), reported in 28 *ATLA L. REP.* 139 (1985); *Cf. Suskind v. Lifespring*, No. 83-4370 (E.D. Pa. Nov. 1984) (significant settlement prior to trial), reported in 28 *ATLA L. REP.* 139 (1985). *But see Note, Nontherapist Counselors: No Duty to Refer Suicidal Patients to Licensed Psychotherapists*, 13 *L. & PSYCHOLOGY REV.* 91 (1989) (discussing the duty to refer, and agreeing with the court's analysis in *Nally*). Refer to notes 164-78 *infra* and accompanying text.

165. See generally Griffith, Adams & Young, *Further Clarification of Clergy Malpractice*, 39 *HOSP. & COMMUNITY PSYCHIATRY* 1041 (1988) (discussing the *Nally* case and the question of whether pastoral counseling is religious or secular); Griffith & Young, *Pastoral Counseling and the Concept of Malpractice*, 15 *BULL. AM. ACAD. PSYCHIATRY & L.* 257 (1987) (discussing the evolution of pastoral counseling and the *Nally* case); Young & Griffith, *The Development and Practice of Pastoral Counseling*, 40 *HOSP. & COMMUNITY PSYCHIATRY* 271, 274 (1989) (discussing the history of pastoral counseling and a typology of three major thrusts: religious counseling, pastoral mental health work, and pastoral psychotherapy); Note, *Clergy Malpractice: Bad News for the Good Samaritan or a Blessing in Disguise?*, 17 *U. TOL. L. REV.* 209, 210 (1985) (noting that the duty on clergy counselors is no greater than the ethical duty imposed by his own conscience and calling for more liability).

166. See Young & Griffith, *supra* note 165, at 271, 274 (describing pastoral mental health work as combining faith and mental health).

free exercise of religion.<sup>167</sup> The law should be reluctant to impose liability for religious malpractice since courts may have great difficulty determining where religious counseling ends and mental health therapy begins.<sup>168</sup> However, if ministers claim to be providing mental health services, they should at least be responsible for determining when patients are suicidal or otherwise at serious risk.

In *Nally v. Grace Community Church of the Valley*,<sup>169</sup> the California Supreme Court considered the question of whether a pastoral counselor could be liable for the negligent failure to diagnose and refer a suicidal client to a professional psychotherapist.<sup>170</sup> The court held that the pastoral counselors did not have a duty to refer a suicidal person to psychotherapists.<sup>171</sup> The court emphasized that pastoral counselors deal with a variety of problems, but are not "professional, medical or psychiatric counselors."<sup>172</sup> Therefore, they did not have a "special relationship" with the plaintiff that would have created a duty to prevent the suicide.<sup>173</sup>

The specific facts in *Nally* suggested that there was little need for referral; the plaintiff had seen five doctors and a psychiatrist and had been in a mental hospital for months before his suicide.<sup>174</sup> Furthermore, the court noted that the church had no "professional or clinical counseling ministry" and that its pastoral counseling "was essentially religious in nature."<sup>175</sup> Nevertheless, the court's holding went well beyond the facts of this case to suggest that liability should not "be extended to a nontherapist counselor who offers counseling to a potentially suicidal person on secular or spiritual matters."<sup>176</sup> In a footnote, however, the court noted that there

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167. *Id.* at 275 (noting that establishing a standard of care for pastoral counselors might create first amendment problems).

168. *Id.* (noting that the California Supreme Court in *Nalley* suggested that the state was not qualified to evaluate the quality of a religious counselor's work).

169. 47 Cal. 3d 278, 763 P.2d 948, 253 Cal. Rptr. 97 (1988).

170. *Id.* In addition to the negligence action, the case also contained a claim for intentional infliction of emotional distress that the court also dismissed. At least one commentator has concluded that this intentional tort cause of action has some promise. See Crane, *Clergy Malpractice After Nally v. Grace Community Church of the Valley*, 12 AM. J. TRIAL ADVOC. 381, 387-91 (1988) (noting that clergy have been held liable on theories of intentional infliction of emotional distress, alienation of affection, defamation, and breach of fiduciary relationship).

171. *Nally*, 47 Cal. 3d at 299, 763 P.2d at 960-61, 253 Cal. Rptr. at 109-10.

172. *Id.*

173. *Id.* at 299, 763 P.2d at 961, 253 Cal. Rptr. at 110.

174. *Id.* at 284, 763 P.2d at 951, 253 Cal. Rptr. at 100.

175. *Id.* at 283, 763 P.2d at 950, 253 Cal. Rptr. at 99.

176. *Id.* at 299-300, 763 P.2d at 961, 253 Cal. Rptr. at 110.

may be liability on "nontherapist counselors who hold themselves out as professionals" if their patients are injured.<sup>177</sup> The very fact that someone is called a "pastoral counselor" (rather than a "pastor") could lead many to believe that he is a professional with mental health skills.<sup>178</sup>

12. *Providing treatment without consent.* Informed consent issues appear repeatedly in discussions of malpractice claims.<sup>179</sup> In reality, however, failure of informed consent is probably not a significant source of liability unless there is also a physical injury and some form of misconduct (such as misrepresentation)<sup>180</sup> or negligence in providing the treatment.<sup>181</sup> For example, where a patient suffered a compression fracture of the spine as a result of ECT, but had not been informed prior to treatment of the risk of that injury, the court properly granted recovery based on a failure of informed consent.<sup>182</sup>

Other forms of treatment, such as aversive therapies, that involve substantial physical contact or manipulation ordinarily re-

177. *Id.*; see also Troyer, *Protecting the Flock from the Shepherd: A Duty of Care and Licensing Requirements for Clergy Counselors*, 30 B.C.L. REV. 1179, 1207 (1989) [hereinafter *Protecting the Flock*] (discussing the need for imposing liability on clergy counselors in order to protect the public); *Nontherapist Counselors—No Duty to Refer Suicidal Patients to Licensed Psychotherapists*, *supra* note 164, at 102 (discussing the footnote in *Nally* in which the court states that it may hold certain counselors liable).

178. See *Protecting of the Flock*, *supra* note 177, at 1207-20 (discussing how licensing would keep the public from being misled).

179. The failure of informed consent is, admittedly, more of a cause of action than an area of practice. However, it cuts across so many areas of practice that it merits separate consideration. For a table illustrating potential liability for various areas of mental health practice, refer to Appendix *infra*.

180. Any misrepresentation would destroy the voluntary assent that is critical to valid informed consent. See J. SMITH, *supra* note 7, at 175-77.

181. The need to prove that injury resulted from the mental health professional's failure to give adequate information, and that clear damages resulted from the lack of informed consent often make recovery difficult in informed consent cases. See *id.* In the past, when many valid medical malpractice claims were hard to pursue because expert witnesses for plaintiffs were not generally available, informed consent probably helped keep alive some cases that otherwise might have been dismissed. See *id.*; cf. R. FADEN & T. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 34-35 (1986) (noting that the plaintiff can show the required causal connection between failure to disclose and injury, if the patient would have still consented with a disclosure on a reasonable person standard).

182. *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962). The psychiatrist should also warn of dangers and discuss alternatives. See, e.g., *Mitchell v. Robinson*, 334 S.W.2d 11, 19 (Mo. 1960) (holding that doctor has a duty to inform patient of known hazards of insulin injections to treat emotional illness).

quire informed consent.<sup>183</sup> Prescription drugs should also include informed consent. Drug companies have an obligation to provide information about prescription drugs to physicians who, in turn, must inform their patients about the drugs.<sup>184</sup> For example, a patient should be informed about potential serious side effects such as tardive dyskinesia,<sup>185</sup> changes in mood, and addiction.<sup>186</sup> Therefore, psychiatrists who prescribe drugs should make reasonable efforts to inform patients of how to use the drugs and the consequences of using them.<sup>187</sup>

A patient who sees a psychotherapist has given implied consent to usual therapy.<sup>188</sup> Some commentators argue that patients have a right to know of certain risks that exist in nearly all therapy, such as the limits of confidentiality.<sup>189</sup> For example, because

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183. The level of risk and pain affects the importance of informed consent. It could be essential for some forms of aversive therapy. *See, e.g.*, *Knecht v. Gillman*, 488 F.2d 1136, 1139-40 (8th Cir. 1973) (giving mental patient a drug to induce vomiting as punishment requires knowing and intelligent consent); *Mackey v. Procnier*, 477 F.2d 877, 877-78 (9th Cir. 1973) (recognizing a cause of action for a patient who consented to shock treatment but not injection of "fright drug").

184. *See, e.g.*, *Sterling Drug, Inc. v. Yarrow*, 408 F.2d 978, 991-95 (8th Cir. 1969) (manufacturer of drug must use reasonably effective method to inform doctor of dangerous side effects of its drugs).

185. Tardive dyskinesia is an affliction characterized by involuntary movements of the head (notably the mouth or tongue) or arms or legs. These symptoms appear with varying intensity. Although the condition can occur after relatively short use of certain antipsychotic drugs, it is more commonly associated with long-term use. In the minority of cases, it is irreversible. More commonly, the condition subsides if the drug is discontinued. *Washington v. Harper*, 110 S. Ct. 1028, 1077 (1990).

186. Under limited circumstances, courts may presume that a patient consented to invasive procedures such as ECT if he fails to object to it. *E.g.*, *Wilson v. Lehman*, 379 S.W.2d 478, 479-80 (Ky. 1964) (finding that submitting to 11 shock treatments without any objection is evidence of consent). However, it would be a mistake to conclude that every patient who does not object to ECT has given informed consent to the procedure.

187. *See generally* Appleton, *Legal Problems in Psychiatric Drug Prescription*, 124 AM. J. PSYCHIATRY 877, 879-80 (1968) (concluding that a physician who does not warn a patient of potential drug toxicity must be prepared to justify the lack of warning); Merril, *Compensation for Prescription Drug Injuries*, 59 VA. L. REV. 1, 7-8 (1973) (asserting that the goal of fully informed patient participation in the selection and use of prescription drugs is illusory); Wettstein, *Tardive Dyskinesia and Malpractice*, 1 BEHAV. SCI. & L. 85, 99-102 (1983) (arguing against a return to written informed consent forms in favor of reminding the patient of possible risks as often as necessary).

188. Refer to note 56 *supra* and accompanying text. Consent to ordinary touching and the very minor invasions of treatment can be implied from the fact that the patient seeks therapy. Once something out of the usual or more invasive is undertaken, the practitioner should seek specific consent. This consent may be oral but many attorneys suggest written consent because it is easier to prove consent with a written document.

189. *See, e.g.*, Hare-Mustin, Marecek, Kaplan & Liss-Levinson, *Rights of Clients, Responsibilities of Therapists*, 34 AM. PSYCHOLOGIST 3, 7-10 (1979) (advocating the use of a

most patients presume that whatever they tell a therapist will remain confidential, a practitioner should perhaps inform them that some communications will not necessarily remain secret.<sup>190</sup> It is unlikely that significant liability exists for the failure of informed consent in most "talk therapy."<sup>191</sup> However, some forms of behavior modification should include informed consent if they involve treatment that patients will find uncomfortable, for example taking an acrophobic patient to an open, tall building. Such treatments are certain to inflict significant emotional distress and therefore should be accompanied by informed consent.<sup>192</sup>

In practice, mental health professionals frequently ignore the doctrine of informed consent.<sup>193</sup> Many factors may interfere with

contract to clarify the therapeutic relationship); Noll, *The Psychotherapist and Informed Consent*, 133 AM. J. PSYCHIATRY 1451, 1452 (1976) (discussing psychotherapists responsibility to inform patients of the potential limits of confidentiality for patients seeking therapy under the provisions of a health insurance policy); Smith, *supra* note 43, at 29; Smith, *Unfinished Business With Informed Consent Procedures*, 36 AM. PSYCHOLOGIST 22, 24-25 (1981) (advocating amendment of psychological standards to require informed consent before a client is diagnostically labeled or coded).

190. See, e.g., Meyer & Smith, *A Crisis in Group Therapy*, 32 AM. PSYCHOLOGIST 638, 643 (1977) (discussing the lack of certainty regarding the confidentiality of communications made in group therapy).

191. See S. SMITH & R. MEYER, *supra* note 29, at 625-26. An interesting debate between distinguished psychiatrists developed over whether it would be malpractice, without special informed consent, for a depressed patient to be treated with long-term traditional psychotherapy rather than biological treatments that have been shown to be effective. Compare Klerman, *The Psychiatric Patient's Right to Effective Treatment: Implications of Osheroff v. Chestnut Lodge*, 147 AM. J. PSYCHIATRY 409, 413-15 (1990) (suggesting psychotherapists may be liable for malpractice when they fail to use drugs and other biological treatments in the treatment of severe depression) with Stone, *Law, Science, and Psychiatric Malpractice: A Response to Klerman's Indictment of Psychoanalytic Psychiatry*, 147 AM. J. PSYCHIATRY 419, 424-26 (1990) (arguing that psychotherapists should be able to consider all forms of therapy, including traditional psychotherapy, without the threat of malpractice). The case that gave rise to this discussion was reported on a procedural basis without reaching the substance of the debate. *Osheroff v. Chestnut Lodge, Inc.*, 62 Md. App. 519, 525, 490 A.2d 720, 723 (Ct. Spec. App.), *cert. denied*, 304 Md. 163, 163, 497 A.2d 1163, 1163 (1985). The parties eventually settled. Stone, *supra*, at 419. See also J. MALCOLM, *supra* note 51, at 5-7 (examining the psychodynamic/biological treatment debate).

Liability should flow from the failure to inform a patient that he or she may not be offered the most effective treatment for a condition and to permit the patient to request the more effective treatment. The debate surrounding *Osheroff*, however, demonstrates how difficult it can be to define what is inappropriate in any given case even among distinguished mental health professionals of the same discipline.

192. Cf. PROSSER & KEETON ON TORTS, *supra* note 35, § 12 (discussing risk of liability for intentional infliction of emotional distress where there is no reasonable consent to treatment).

193. See generally C. LIDZ, A. MEISEL, E. ZERUBAVEL, M. CARTER, R. SESTAK & L. ROTH, *INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY*, 10-23 (1984) (reviewing in-

the consent process: the limited mental competency of some patients, the failure to provide sufficient information in an understandable form, a feeling of paternalism toward patients, and the patient's young age.<sup>194</sup> There is evidence that in mental health treatment, informed consent is often not very effective, either because professionals do not believe that patients are capable of participating in the decision or because of a concern that patients will not make decisions that are in their best interests.<sup>195</sup> In other instances, professionals go through the process in a very formal way that does not convey much information to the patient, or the information is presented in sophisticated medical jargon that the patient cannot understand.<sup>196</sup> Written consent is desirable because it provides a record of the transaction, for the therapist and the patient may take the process more seriously if there is a document to be signed.<sup>197</sup> The ultimate purpose, however, is to provide the patient sufficient information for making an informed treatment decision.

The competency of the patient is a critical issue in informed consent. Obtaining informed consent from patients presupposes that they are capable of making a reasoned decision, understanding the alternatives available for treatment, and selecting the treatment they desire.<sup>198</sup> Not all mental patients possess the capacity to make decisions.<sup>199</sup> In *Zinermon v. Burch*,<sup>200</sup> the Supreme Court noted that consent by an incompetent patient is not legally effective and that such consent may not be the legal basis for holding a patient in an institution.<sup>201</sup> Patients who have been formally adjudged incompetent will have guardians appointed who can legally provide consent.<sup>202</sup> Other patients may have impairments that do

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formed consent in an evaluation center, a research ward, and an outpatient clinic) [hereinafter INFORMED CONSENT].

194. *Id.* at 13, 303-06.

195. *Id.* at 316-18.

196. *Id.* at 13.

197. *But see* J. MALCOLM, *supra* note 51, at 75 (stating it is a mistake to equate the signing of a consent form with actual informed consent).

198. INFORMED CONSENT, *supra* note 193, at 20-22.

199. *See* Roth, Appelbaum, Sallee, Reynolds & Huber, *The Dilemma of Denial in the Assessment of Competency to Refuse Treatment*, 139 AM. J. PSYCHIATRY 910, 910-11 (1982) (using a case analysis to illustrate the difficulty in assessing competency when the patient denies illness).

200. 110 S. Ct. 975 (1990).

201. *Id.* at 987.

202. Guardianship requires a formal process to determine that a person cannot make

not justify a determination of incompetence, and in such cases, professionals should take special steps to obtain informed consent.<sup>203</sup> Those steps might include special or repetitious discussions (particularly if the patient has lucid moments) and, in some circumstances, informed consent from the next of kin.<sup>204</sup>

Informed consent for children has traditionally been provided by their parents.<sup>205</sup> In recent years, children have been playing a greater role in determining what treatment they will receive. However, the United States Supreme Court has recognized the right of parents to make important mental health treatment decisions for their children. In *Parham v. J.R.*,<sup>206</sup> the Court held that parents may constitutionally "voluntarily" admit their children to mental hospitals even over the objection of the children, subject to review by a disinterested third party at the hospital.<sup>207</sup> This involuntary mental hospital admission for a minor involves a significant loss of freedom. However, the Supreme Court has upheld the right of minors to make certain other important medical decisions (such as abortion) without parental consent.<sup>208</sup> The Court apparently sees

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or communicate decisions for herself. See S. BRAKEL, J. PARRY & B. WEINER, *THE MENTALLY DISABLED AND THE LAW*, 378-81 (3d ed. 1985); S. HERR, S. ARONS & R. WALLACE, *LEGAL RIGHTS AND MENTAL-HEALTH CARE* 128 (1983). See generally S. JORDAN, *DECISION MAKING FOR INCOMPETENT PERSONS: THE LAW AND MORALITY OF WHO SHALL DECIDE* 105-06 (1985) (noting that the state possesses an acknowledged responsibility for the incompetent and that the state has a system in place equipped to protect the incompetent individual).

Some patients are clearly incapable of making decisions for themselves even though guardianship proceedings have not been undertaken. Families or next of kin are usually permitted to make treatment decisions for these patients. See generally T. GRISSE, *EVALUATING COMPETENCIES* (1986); Green, *Proof of Mental Incompetency and the Unexpressed Major Premise*, 53 *YALE L.J.* 271, 306-07 (1944).

203. S. SMITH & R. MEYER, *supra* note 29, at 103 (arguing that the preferred approach is to tailor the consent process to the patient's condition).

204. *Id.*

205. See generally Ewald, *Medical Decision-Making for Children: An Analysis of Competing Interests*, 25 *ST. LOUIS U.L.J.* 689, 690-700 (1982) (tracing the history of the parental consent requirement).

206. 442 U.S. 584 (1979).

207. *Id.* at 606, 611-13; see also Comment, *Parents, Children and the Institutionalization Process—A Constitutional Analysis*, 83 *DICK. L. REV.* 261, 283-85 (1979) (suggesting that the Constitution does not require states to afford minors the full complement of due process protections).

208. See *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476, 490-93 (1983); *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 439-42 (1983). States may require, however, that parents be informed before an abortion is conducted, unless the minor demonstrates in court that she is sufficiently mature to make the decision without parental involvement. *Ohio v. Akron Center for Reproductive Health*, 110 S. Ct. 2972, 2979-80 (1990); *Hodgson v. Minnesota*, 110 S. Ct. 2926, 2947-48 (1990). See also *Carey v. Population Servs.*

the abortion decision as a more critically important personal decision than admission to a mental hospital. The extent to which parents may consent to particularly invasive therapy (for example, ECT or some aversive therapies) over the objection of their children is unclear. Inasmuch as these therapies may substantially change the thinking or "mentation" of children, a strong argument can be made that the children, particularly older children, have legal rights and, therefore, they should be included in the informed consent process.<sup>209</sup>

#### IV. PROTECTING THIRD PARTIES FROM DANGEROUS PATIENTS

The obligation of mental health professionals to protect third parties from dangerous patients is the most controversial recent malpractice development. This issue raises fundamental questions concerning the relationship among the patient, the mental health professional, and society. The two major forms of obligations to third parties are generally referred to as "the duty to protect (or to warn)" and "the duty to report."<sup>210</sup> Although examples are relatively rare, liability may be imposed for the negligent release of an involuntarily committed patient who is dangerous; such cases have resulted in substantial recovery.<sup>211</sup>

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Int'l, 431 U.S. 678, 693-94 (1977) (concluding that the abortion and contraception rights of minors are based on constitutional privacy).

209. The strongest argument for allowing minors to make or participate in making treatment decisions exists when treatment would invade a fundamental right of a minor. An example is permanent sterilization, when the treatment would make irreversible changes and the minor is close to the legal age of majority. It is highly unlikely that the law would permit parents to consent to sterilization of a minor. In situations in which the person is severely mentally retarded and will never have legal competency, there has been reluctance to permit the guardian to consent to sterilization. See Sherlock & Sherlock, *Sterilizing the Retarded: Constitutional, Statutory and Policy Alternatives*, 60 N.C.L. REV. 943, 977-78 (1982).

210. Refer to notes 212-33 and 246-60 *infra* and accompanying text. The duty to report, which emphasizes reporting to state authorities (such as a child protective services agency), is distinguished from the duty to protect or warn, which emphasizes the intended victim. The two concepts are related because protecting a potential victim may involve calling the police or other authorities.

211. *Perreira v. State*, 768 P.2d 1198 (Colo. 1989); *Wofford v. Eastern State Hosp.*, 795 P.2d 516 (Okla. 1990); Poythress, *Avoiding Negligent Release: Contemporary Clinical and Risk Management Strategies*, 147 AM. J. PSYCHIATRY 994, 994-95 (1990) (reporting verdicts ranging from \$6.75 million to \$25 million and suggesting that because of out-of-court settlements there are more negligent release cases than generally recognized). See generally Poythress, *Avoiding Negligent Release: A Risk Management Strategy*, 38 HOSP. & COMMUNITY PSYCHIATRY 1051 (1987) (suggesting ways of avoiding liability); Schwartz & Pinsker, *Mediating Retention or Release of the Potentially Dangerous Patient*, 38 HOSP. & COMMUNITY PSYCHIATRY 1051 (1987).

### A. *The Duty to Protect (or Warn)*

The landmark decision in *Tarasoff v. Regents of the University of California*<sup>212</sup> began to establish that therapists have a duty to take reasonable steps to protect potential victims from serious harm. Psychologists at the U.C.-Berkeley mental health clinic determined that one of their patients, Mr. Poddar, was dangerous and might kill a woman, Ms. Tarasoff, whom he thought was spurning his advances.<sup>213</sup> The clinic called the campus police who talked to Poddar and released him.<sup>214</sup> Poddar later killed Tarasoff, and her parents sued the university health service for failure to take appropriate action to protect Tarasoff from Poddar.<sup>215</sup> The California Supreme Court held that the clinic could be sued on the basis that it failed to take reasonable action to protect Ms. Tarasoff, such as warning her about Poddar's intention to kill her.<sup>216</sup> The court thus imposed an obligation on therapists to take

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NTY PSYCHIATRY 75, 75-76 (1987) (noting the difficulty and risk of release decisions).

212. 17 Cal. 3d 425, 431, 551 P.2d 334, 346, 131 Cal. Rptr. 14, 26 (1976).

213. *Id.* at 432, 551 P.2d at 341, 131 Cal. Rptr. at 21.

214. *Id.*

215. *Id.* at 431-32, 551 P.2d at 340-41, 131 Cal. Rptr. at 20-21.

216. *Id.* at 431, 551 P.2d at 343, 131 Cal. Rptr. at 23.

The arguments against imposing *Tarasoff*-type liability include the following: (1) the duty to warn is based on the ability of mental health professionals to predict dangerousness, and such predictions cannot be made with any degree of confidence; (2) warning intended victims will require that the confidences of therapy be revealed, and this breach of confidence will interfere with therapy among the very people whom we would like to have in therapy and will interfere with the privacy of those in therapy; (3) there are substantial overpredictions of dangerousness, so many people who are in fact not dangerous will have their therapy interrupted by unnecessary warnings to victims; (4) it is unusual and unfair to require "rescue" of third parties; (5) once patients who have aggressive feelings understand that there is a duty to warn, they will not reveal these feelings in therapy for fear of the disclosure, and therefore, over the long run, the duty to warn will largely be self-defeating by discouraging disclosure of aggression; and (6) even if some good can be accomplished by a duty to warn, the costs to therapy exceed the potential benefits of such disclosures.

Among the arguments in favor of imposing a *Tarasoff*-type duty to warn are the following: (1) the therapist should try to avoid unnecessary death or serious injury, because avoiding unnecessary death or injury is so important that interference with therapy or the right of privacy is comparatively trivial; (2) the duty imposed is not without precedent because professionals are sometimes required to act in the interest of society rather than a client or patient, e.g., the duty to isolate or report some serious, infectious diseases; (3) patients are not likely to refuse to disclose matters in therapy because of the threat that the therapist will warn potential victims; (4) although the prediction of dangerousness is not perfect, it is sufficiently accurate to be the basis of a warning when a patient is apparently dangerous; (5) if these predictions can be the basis for involuntary commitment, they surely are accurate enough to provide the basis for a warning; and (6) overpredictions of dangerousness resulting in some unnecessary warnings is a relatively small price to pay to avoid murders and

reasonable steps to protect the intended victim. Subsequent courts, however, emphasized the "duty to warn" the intended victim of the danger so the victim could take steps to protect herself. The several cases that followed the *Tarasoff* decision are commonly referred to collectively as *Tarasoff*.<sup>217</sup>

The *Tarasoff* decision was unusual in that it imposed on therapists a duty to the public arising out of the treatment of individual patients.<sup>218</sup> Some commentators have viewed *Tarasoff* as violating the principle that, absent special responsibility, one is not required to rescue persons from harm.<sup>219</sup> The court based this duty to protect or warn on the therapist-client relationship and a balance between the costs and benefits of such warnings.<sup>220</sup> By voluntarily entering the practice of therapy, the therapist assumed a responsibility to the public to avoid this public harm.<sup>221</sup> Although commonly called the "duty to warn," this phrase does not accurately describe the duty, since it requires reasonable steps to protect potential victims from dangerous patients.<sup>222</sup>

serious injury.

217. A number of excellent articles have considered this case. See, e.g., Roth & Meisel, *Dangerousness, Confidentiality, and the Duty to Warn*, 134 AM. J. PSYCHIATRY 508, 511 (1977) (suggesting action by psychiatrists that minimizes the undesirable consequences of *Tarasoff*); Stone, *The Tarasoff Decision: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358, 358 (1976) (asserting that if society introduces greater safeguards into involuntary civil commitment procedures, it must also accept the increased risk that potentially violent and mentally disturbed people will remain free); Note, *Imposing a Duty to Warn on Psychiatrists—A Judicial Threat to the Psychiatric Profession*, 48 U. COLO. L. REV. 283, 286 (1977) (criticizing the abandonment of the foreseeability test and the counter-productivity of the *Tarasoff* decision).

218. *Tarasoff*, 17 Cal. 3d 425, 446-47, 551 P.2d 334, 351, 131 Cal. Rptr. 14, 31 (1976).

219. There is ordinarily no legal duty to rescue another, even though the rescue may be accomplished without risk. See, e.g., *Hurley v. Eddingfield*, 156 Ind. 400, 400, 59 N.E. 1058, 1058 (1901) (physician not liable for failing, without any reason, to aid a violently ill person). One walking along a beach, and seeing someone drowning, is generally not legally obligated to throw a nearby lifesaver. A duty does exist, however, if the rescuer is in some way responsible for the victim—if, for example, the rescuer has pushed the victim into the water or there is a parent-child relationship. See, e.g., *Linder v. Bidner*, 50 Misc. 2d 320, 323, 270 N.Y.S.2d 427, 430 (Sup. Ct. 1966) (parents had duty to control obviously dangerous child). Some criticize the rule as being inefficient and rewarding immoral conduct, while others praise it as an important part of individual freedom. Some states have passed statutes requiring certain forms of rescue. For example, two states require people to render aid to others in grave danger when they can do so without peril. See MINN. STAT. ANN. § 604.05 (West 1988); VT. STAT. ANN. tit. 12, § 519 (1973).

220. *Tarasoff*, 17 Cal. 3d at 442, 551 P.2d at 347, 131 Cal. Rptr. at 25 (stating that "protective privilege ends where the public peril begins").

221. *Id.* at 438, 551 P.2d at 345, 131 Cal. Rptr. at 23.

222. *Id.* at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

The *Tarasoff* decision left many unanswered questions about the duty the court imposed.<sup>223</sup> Among the most discussed issues has been the "identifiable victim" issue—whether the duty applies only when a specific victim is identified.<sup>224</sup> The trend has been to require an identifiable victim.<sup>225</sup> Under this approach, the duty does not apply when a therapist fears that a patient is likely to hurt someone but does not know who may be harmed. Some decisions seem to have expanded the concept of the known victim. For example, the California Supreme Court indicated that the son of a woman who was the intended victim may also be an identifiable victim.<sup>226</sup> The son suffered emotional trauma when his mother was shot while attempting to protect him from injury.<sup>227</sup> The California Supreme Court held that the son was an identifiable victim to the therapist because it was foreseeable that the son might be present during the attack on the mother; therefore, the son could recover from the therapist.<sup>228</sup> However, not all courts have embraced this "known victim" approach.<sup>229</sup>

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223. What professionals have this duty? How much information may or must be revealed when a warning is given? What is the precise nature of the duty and how can the duty be fulfilled? When several people know of the dangerousness, who has the duty to act? What does dangerousness include (physical injury, property damage, emotional injury to others)? At what level of certainty concerning dangerousness does the duty to act exist? Most of these questions have not yet been fully answered by those states adopting the duty.

224. See, e.g., Carlson, Friedman & Riggert, *The Duty to Warn/Protect: Issues in Clinical Practice*, 15 BULL. AM. ACAD. PSYCHIATRY & L. 179, 185 (1987) (reasonable care must be taken to protect unnamed victims); Crocker, *Judicial Expansion of the Tarasoff Doctrine: Doctors Dilemma*, 13 J. PSYCHIATRY & L. 83, 83 (1988) (discussing how several cases have dealt with foreseeability issue); Gross, Southard, Lamb & Weinberger, *Assessing Dangerousness and Responding Appropriately: Hedlund Expands the Clinician's Liability Established by Tarasoff*, 48 J. CLINICAL PSYCHIATRY 9, 11 (1987) (discussing what clinicians should look for after hearing a patient make threats); Mills, Sullivan & Eth, *Protecting Third Parties: A Decade After Tarasoff*, 144 AM. J. PSYCHIATRY 68, 70 (1987) (reasoning that the circumstances may not require identifying the victim).

225. See, e.g., *Thompson v. County of Alameda*, 27 Cal. 3d 741, 748, 614 P.2d 728, 735, 167 Cal. Rptr. 70, 77 (1980) (no duty to warn of the release of an inmate who has made nonspecific threats of harm directed at nonspecific victims).

226. *Hedlund v. Superior Court*, 34 Cal. 3d 695, 700, 669 P.2d 41, 46, 194 Cal. Rptr. 805, 809 (1983); see also *Marlene F. v. Affiliated Psychiatric Medical Clinic*, 48 Cal. 3d 533, 585, 770 P.2d 278, 283, 257 Cal. Rptr. 98, 102 (1989) (concluding that the mother of a sexually assaulted child is a potential victim since mother and child were being counselled by psychologist guilty of sexual assault).

227. *Hedlund*, 34 Cal. 3d at 700, 669 P.2d at 46, 194 Cal. Rptr. at 809.

228. *Id.* at 700, 669 P.2d at 47, 194 Cal. Rptr. at 810.

229. See, e.g., *Bradley Center, Inc. v. Wessner*, 250 Ga. 199, 203, 296 S.E.2d 693, 697 (1982) (hospital liable to children of a woman murdered by her husband when hospital knew that husband intended to kill wife but released him anyway).

The identifiable victim issue is related to the question of how the duty may be discharged. If the duty is to "warn", there generally must be a known victim in order to issue the warning.<sup>230</sup> If, on the other hand, the therapist's duty focuses on taking reasonable steps to avoid injury, then an identifiable victim rule is not essential. When a therapist perceives a real threat to unspecified people, it is still possible to take action (civil commitment or notice to authorities) to avoid the injury.

Most state courts that have considered the question have adopted a duty to protect or warn rule,<sup>231</sup> and there has been only limited reluctance to impose liability.<sup>232</sup> *Tarasoff* is thus rapidly emerging as a generally accepted legal and ethical doctrine. Therapists usually take some action when faced with a dangerous patient, and many therapists identify a "duty to warn" as an ethical or moral duty as well as a legal duty.<sup>233</sup>

### B. *Tarasoff* Statutes

The adoption of *Tarasoff* statutes by more than a dozen states<sup>234</sup> is an unfortunate development. The mental health profes-

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230. *Jablonski v. United States*, 712 F.2d 391, 398 (9th Cir. 1983) (duty to warn arises if victim is foreseeable).

231. See, e.g., *Bradley Center*, 296 S.E.2d at 695 (Georgia law imposes duty to conform to a standard of conduct raised by the law for the protection of others against unreasonable risk of harm); *McIntosh v. Milano*, 168 N.J. Super. 466, 476, 403 A.2d 500, 511 (Law Div. 1979) (a therapist may have a duty to take steps reasonably necessary to protect an intended or potential victim of his patient when he determines or should determine that the victim is in danger); *Peck v. Counseling Serv. of Addison County*, 146 Vt. 61, 65, 499 A.2d 422, 426 (1985) (involving property damage rather than injury to persons).

232. See, e.g., *Furr v. Spring Grove State Hosp.*, 53 Md. App. 474, 480 454 A.2d 414, 420 (1983) (neither psychiatrist nor hospital's director of admissions liable when patient murdered a boy, absent identity of intended victim and a special relationship with victim). See generally Note, *The Scope of a Psychiatrist's Duty to Third Persons: The Protective Privilege Ends Where the Public Peril Begins*, 59 NOTRE DAME L. REV. 770, 772 (1984) (discussing scope of therapist's duty as determined by courts and public policy).

233. See Givelber, Bowers & Blitch, *Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action*, 1984 WIS. L. REV. 443, 475; Special Project, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 STAN. L. REV. 165, 183 (1978); Comment, *Psychotherapists' Duty to Warn: Ten Years After Tarasoff*, 15 GOLDEN GATE U.L. REV. 271, 293 (1985). For a review of the current practice of psychologists, see Pope, Tabachnick & Keith-Spiegel, *Ethics of Practice: The Beliefs and Behaviors of Psychologists as Therapists*, 42 AM. PSYCHOLOGIST 993, 995 (1987) (reporting that 41.9% of surveyed psychologists have broken confidentiality if a client was homicidal; another 16.2% said they sometimes did so; and 88% agreed that it was ethical to do so).

234. ALASKA STAT. § 08.86.200 (1988); CAL. CIV. CODE § 43.92 (West Supp. 1990); COLO. REV. STAT. § 13-21-117 (1987); FLA. STAT. ANN. § 490.0147 (West Supp. 1990); IND. CODE ANN.

sions generally promote these statutes, presumably as a way of reducing potential liability and clarifying the nature of any *Tarasoff*-type duty.<sup>235</sup> However, given the reality of the legislative process, other forces inevitably seek to modify the proposed statutes, and the resulting laws often do not clarify or limit liability. They may instead result in confusing the obligations of therapists when threats are made against third parties.

California, for example, has adopted a statute that provides for liability only if the patient has told the therapist of a "serious threat of physical violence against a reasonably identifiable victim or victims."<sup>236</sup> The duty is discharged by "reasonable efforts to communicate the threat to the victim or victims *and* to a law enforcement agency."<sup>237</sup> This statute broadly follows *Tarasoff*, but it emphasizes the duty to warn. Ironically, it may actually have somewhat expanded the duties of therapists by specifying a warning to both the victim and to the police.<sup>238</sup> The emphasis on warn-

§ 34-4-1112.4-1 to 4-4 (West Supp. 1988); KAN. STAT. ANN. § 5603 (Supp. 1989); KY. REV. STAT. ANN. §§ 202A.400, 645.270 (Michie/Bobbs-Merrill Supp. 1990); LA. REV. STAT. ANN. § 9:2800.2 (West Supp. 1990); MASS. GEN. LAWS ANN. ch. 112, § 129 (West Supp. 1990); MINN. STAT. ANN. §§ 148.975-.76 (West Supp. 1990); MONT. CODE ANN. §§ 27-1-1101 to 1-1102 (Supp. 1987); N.H. REV. STAT. ANN. §§ 329.31, 330-A:22 (Supp. 1989); OHIO REV. CODE ANN. § 5122.34 (Anderson Supp. 1989); UTAH CODE ANN. §§ 78-14a-101 to 14a-102 (Supp. 1989); WASH. REV. CODE ANN. § 71.05.120(2) (Supp. 1988).

235. Professional organizations have proposed model *Tarasoff* statutes, see, e.g., note 238 *infra*, and have actively lobbied for them in several states. See Slovenko, *Michigan's Duty to "Protect" Legislation: What Has MPS Wrought?*, 14 AAPL NEWSL. 109 (1989). In addition to the statute proposed by an arm of the American Psychiatric Association, the American Psychological Association has circulated a similar model. That proposal is reprinted in McCarty, *Patient Threats Against Third Parties: The Psychotherapist's Duty of Reasonable Care*, 5 CONTEMP. HEALTH L. & POL'Y 119, 135 (1989). Another proposal is contained in Note, *The Duty to Warn Third Parties: A Retrospective on Tarasoff*, 18 RUTGERS L.J. 145, 162-63 (1986).

236. CAL. CIV. CODE § 43.92 (West Supp. 1990).

237. *Id.* (emphasis added).

238. The Council on Psychiatry and Law of the American Psychiatric Association has proposed a model statute which avoids some of the ambiguity of several of the state statutes. The following is the text of the model statute.

Developed by the Council on Psychiatry and Law and approved by the Board of Trustees in June 1987, this resource document does not represent official APA policy but rather is offered as a guide to District Branches in those states in which case law has expanded the potential "duty to protect" liability of psychiatrists.

Section \_\_\_\_ Duty of [Physicians] to Take Precautions Against Patient Violence.

1. *Scope of cause of action.* Except as provided in paragraph 5, no cause of action shall lie against a [physician], nor shall legal liability be imposed, for breaching a duty to prevent harm to person or property caused by a patient unless a) the patient has communicated to the [physician] an explicit threat to kill or

ing is unfortunate because it may encourage therapists to warn potential victims without adequately considering other, possibly more effective, ways of protecting both the public and the therapists' patients.

Some states, where no case clearly establishes a *Tarasoff* duty, have adopted the duty by statute, apparently as a "preemptive strike" against the possibility of court-imposed liability. For example, Kentucky adopted a statute in 1986 that imposes obligations

seriously injure a clearly identified or reasonably identifiable victim or victims, or to destroy property under circumstances likely to lead to serious personal injury or death, and the patient has the apparent intent and ability to carry out the threat; and b) the [physician] fails to take such reasonable precautions to prevent the threatened harm as would be taken by a reasonably prudent [physician] under the same circumstances. Reasonable precautions include, but are not limited to, those specified in paragraph 2.

2. *Legally sufficient precautions.* Any duty owed by a [physician] to take reasonable precautions to prevent harm threatened by a patient is discharged, as a matter of law, if the [physician] either a) communicates the threat to any identified victim or victims; or b) notifies a law enforcement agency in the vicinity where the patient or any potential victim resides; or c) arranges for the patient to be hospitalized voluntarily; or d) takes legally appropriate steps to initiate proceedings for involuntary hospitalization.

3. *Immunity for disclosure.* Whenever a patient has explicitly threatened to cause serious harm to person or property, or a [physician] otherwise concludes that a patient is likely to do so, and the [physician], for the purpose of reducing the risk of harm, discloses any confidential communications made by or relating to the patient, no cause of action shall lie against the [physicians] for making such disclosure.

4. *Definitions.*

a. For purposes of this [section], "patient" means any person with whom a [physician] has established a [physician]-patient relationship.

b. For purposes of this [section], ["physician"] means a person licensed to practice medicine in this state.

5. *Limited applicability of this section.* This section does not modify any duty to take precautions to prevent harm by a patient that may arise if the patient is within the custodial responsibility of a hospital or other facility or is being discharged therefrom.

COUNCIL ON PSYCHIATRY AND LAW, AMERICAN PSYCHIATRIC ASS'N, MODEL STATUTE ON THE PHYSICIAN'S DUTY TO TAKE PRECAUTIONS AGAINST PATIENT VIOLENCE (1987), reprinted in Applebaum, Zonana, Bonnie & Roth, *Statutory Approaches to Limiting Psychiatrists' Liability for Their Patients' Violent Acts*, 146 AM. J. PSYCHIATRY 821, 827 (1989). The model, however, still creates uncertainty in this "pure" form. For example, by leaving an expansive definition of "reasonable precautions" at the end of paragraph 1, the model invites courts to determine that a physician *must* take additional precautions not listed in paragraph 2. Paragraph 1 of the model also requires action when there are "reasonably identifiable" victims, thus leaving open the fairly broad duty that many therapists have objected to. Furthermore, paragraph 1 implies that the identifiable victim requirement is eliminated when a patient threatens to "destroy property under circumstances likely to lead to serious personal injury or death." *Id.* For other model statutes, refer to note 235 *supra*.

on therapists beyond those required in California by apparently establishing a duty to take action even when no particular victim is identifiable.<sup>239</sup> That duty may be discharged by warning the police and/or (it is not clear which) by seeking civil commitment.<sup>240</sup> This statute is filled with ambiguities and contradictions that increase rather than decrease the level of confusion about the duty to protect.

On the other hand, Ohio contains a new statutory provision that appears to eliminate all *Tarasoff*-type liability.<sup>241</sup> This provision, however, is placed in the statutes dealing with civil commitment.<sup>242</sup> It may, therefore, apply only to a fairly narrow band of cases where a mental health professional has been involved in an involuntary civil commitment proceeding.

There are a number of problems with these statutes.<sup>243</sup> They are not well written. They often contain ambiguous and confusing language. The Kentucky statute, for example, is nearly unintelligible.<sup>244</sup> The sloppiness of the statutes has resulted in provisions that may lead courts to interpret them as expanding therapists' liability.<sup>245</sup> Furthermore, it is difficult to find a broad, consistent principle on which to base the *Tarasoff* statutes. If, for example, the reason for opposing *Tarasoff*-type liability is because confidentiality is essential to successful treatment, then a broader proposal (including liability for breach of confidentiality) to protect confidentiality should be part of the effort to adopt *Tarasoff* statutes because *Tarasoff* liability is not the primary threat to the confidentiality of therapy.<sup>246</sup> If therapists cannot predict dangerousness accurately enough to impose *Tarasoff* liability fairly, then little basis exists to rely on such predictions of dangerousness in areas such as civil commitment.<sup>247</sup> More than principled efforts to improve the

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239. See KY. REV. STAT. ANN. § 202A.400 (Michie/Bobb-Merrill Supp. 1990).

240. *Id.* at § 202A.400(2). The statute provides that "when . . . no particular victim is identifiable, the duty to warn has been discharged if reasonable efforts are made to communicate the threat to law enforcement authorities." *Id.*

241. OHIO REV. CODE ANN. § 5122.34 (Anderson Supp. 1989).

242. *Id.*

243. See Appelbaum, Zonana, Bonnie & Roth, *supra* note 238, at 822-27. But see Note, *Statutes Limiting Mental Health Professionals' Liability for the Violent Act of Their Patients*, 64 IND. L.J. 391, 401-20 (1989) (positively evaluating these statutes).

244. See KY. REV. STAT. ANN. § 202A.400 (Michie/Bobb-Merrill Supp. 1990).

245. Slovenko, *supra* note 235.

246. See generally Smith, *supra* note 44, at 549-56 (discussing an integrated approach to confidentiality).

247. Mental health professions have noted that predictions of dangerousness are not

law, these statutes appear to be an exercise of political power in an effort to avoid liability.

The current experience with *Tarasoff* statutes supports an argument against relying on legislative solutions to mental health malpractice issues. The medical malpractice reform movement in the last two decades has produced legislative reforms that are only partially effective and sometimes unconstitutional.<sup>248</sup> If mental health malpractice continues to increase in the 1990s, as many expect, the temptation to seek statutory reforms to eliminate some of the liability will be great. If the *Tarasoff* statutes are any indication, this temptation probably should be resisted.

### C. Reporting Obligations

States also try to protect third parties from injury by requiring that professionals report abuse that has occurred or is suspected. All states have child abuse reporting statutes,<sup>249</sup> and an increasing number have laws that require persons to report other forms of abuse, such as spouse or elder abuse.<sup>250</sup> By requiring reporting, the state can intervene to prevent further injury and may

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very reliable. See, e.g., *Barefoot v. Estelle*, 463 U.S. 880, 920-29 (1983) (Blackmun J., dissenting) (discussing reliability of dangerousness predictions). Nevertheless, mental health professionals continue to make these predictions in a variety of judicial proceedings, such as civil commitment hearings. The prediction of dangerousness argument in *Tarasoff*-type cases therefore loses some of its punch.

248. For examples of cases holding reform statutes unconstitutional, see *Kenyon v. Hammer*, 142 Ariz. 69, 87, 688 P.2d 961, 979 (1984); *McGuffey v. Hall*, 557 S.W.2d 401, 414 (Ky. 1977); *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825, 833-39 (1980); see also Smith, *Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws*, 38 OKLA. L. REV. 195, 208 (1985) (noting that state constitutional challenges to medical malpractice reforms are increasingly successful). Regarding the efficacy of reforms, see U.S. GOV'T GEN. ACCT. OFF., *MEDICAL MALPRACTICE: SIX STATE CASE STUDIES SHOW CLAIMS AND INSURANCE COSTS STILL RISE DESPITE REFORMS* (1986). But see Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 LAW. & CONTEMP. PROBS. 57, 78 (1986) (presenting empirical evidence that statutes mandating offset of collateral benefits or placing caps on awards have reduced claim severity, but that no other reform has had a significant impact on malpractice claims).

249. Besharov, *Child Protection: Past Progress, Present Problems and Future Directions*, 17 FAM. L.Q. 151, 153-55 (1983); Fraser, *A Glimpse at the Future: A Critical Analysis of the Development of Child Abuse Reporting Statutes*, 54 CHI.-[ ]KENT L. REV. 641, 649-86 (1978); Newberger, *The Helping Hand Strikes Again: Unintended Consequences of Child Abuse Reporting*, 12 J. CLINICAL CHILD PSYCHOLOGY 307, 307 (1983).

250. See Smith, *supra* note 44, at 511-12, 530-31; Note, *Mandatory Reporting of Elder Abuse: A Cheap But Ineffective Solution to the Problem*, 14 FORDHAM URB. L.J. 723, 735-53 (1986); Note, *Elder Abuse: The Merit of Mandatory Reporting Laws and the Minnesota Response*, 9 WM. MITCHELL L. REV. 365, 375-83 (1984).

decide whether or not to prosecute the abuser.

Many state abuse reporting laws require the reporting of known or suspected physical, sexual, or mental abuse, or neglect. Typically, abuse and neglect are very broadly defined in these statutes.<sup>251</sup> The obligation to report arises regardless of the source of the information.<sup>252</sup> Therefore, a mental health professional who learns of abuse from a patient seeking treatment to stop the abuse must report that abuse to the state.<sup>253</sup> The failure to file the required reports may result in criminal and civil liability.<sup>254</sup> Some states specifically provide civil liability for failure to report.<sup>255</sup> Even in states without statutory liability, it is likely that negligence liability would be imposed for the failure to report abuse.<sup>256</sup> Only a limited number of civil cases have resulted from the failure to report. If courts interpret reporting statutes as broadly as they are written, however, the failure to report abuse or neglect could one day become a more significant source of liability than *Tarasoff* cases.<sup>257</sup>

The U.S. Supreme Court in *DeShaney v. Winnebago County*<sup>258</sup> indicated that states are not liable under federal law for failure to take action to protect abused and neglected children.<sup>259</sup> This decision, however, would not protect individual practitioners or institutions from liability for their failure to report suspected child abuse or neglect as required by state law. Therefore, mental health professionals may face liability for the failure to report

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251. See Smith, *supra* note 44, at 510.

252. Appelbaum & Meisel, *Therapists' Obligations to Report Their Patients' Criminal Acts*, 14 BULL. AM. ACAD. PSYCHIATRY L. 221, 224-26 (1986); Miller & Weinstock, *Conflict of Interest Between Therapist-Patient Confidentiality and the Duty to Report Sexual Abuse of Children*, 5 BEHAV. SCI. & L. 161, 161-62 (1987); Weinstock & Weinstock, *Child Abuse Reporting Trends: An Unprecedented Threat to Confidentiality*, 33 J. FORENSIC SCI. 418, 419 (1988).

253. See Smith & Meyer, *supra* note 130, at 352-53.

254. *Id.* at 356-57.

255. Iowa and New York statutes provide that anyone required to report who fails to do so shall be "civilly liable for the damages proximately caused by such failure." See IOWA CODE ANN. § 232.75(2) (West 1989); N.Y. SOC. SERV. LAW § 420(2) (McKinney 1983).

256. See Isaacson, *Child Abuse Reporting Statutes: The Case for Holding Physicians Civilly Liable for Failing to Report*, 12 SAN DIEGO L. REV. 743, 755-62 (1975); Note, *Physician's Liability for Failure to Diagnose and Report Child Abuse*, 23 WAYNE L. REV. 1187, 1193-94 (1977).

257. See *Landeros v. Flood*, 17 Cal. 3d 399, 413-15, 551 P.2d 389, 396-98, 131 Cal. Rptr. 69, 76-78 (1976); Brown & Truitt, *Civil Liability in Child Abuse Cases*, 54 CHL. [-]KENT L. REV. 753, 760-64 (1978).

258. 489 U.S. 189 (1989).

259. *Id.* at 197.

abuse or neglect.<sup>260</sup>

## V. INSTITUTIONAL LIABILITY

Health care institutions have experienced increases in mental health malpractice liability at least as great as individual practitioners. Legal developments have weakened or eliminated some defenses once available to institutions.<sup>261</sup> Courts increasingly hold institutions responsible for the torts committed by individual practitioners within the institutions.<sup>262</sup> Thus, the increase in individual liability has a direct impact on institutions.<sup>263</sup> Also, new health care delivery arrangements are resulting in even greater liability for the malpractice of institutions' contract and employee professionals.<sup>264</sup>

Institutions and other principals incur liability for the torts of their employees and agents in two ways: negligence for failure to provide adequate care in selection and supervision, and vicarious liability.<sup>265</sup> Health institutions have a clear obligation to exercise care in selecting their employees and professional staff and in granting practice privileges to nonemployee professionals.<sup>266</sup> During the last two decades, health institutions have become responsi-

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260. Refer to notes 265-67 *infra* and accompanying text.

261. See, e.g., PROSSER & KEETON ON TORTS, *supra* note 35, §§ 131, 133 (demonstrating the near elimination of charitable immunity and the weakening of governmental immunities); Felthous, *Liability of Treators for Injuries to Others: Erosion of Three Immunities*, 15 BULL. AM. ACAD. PSYCHIATRY & L. 115, 115 (1987) (observing the decline of common law doctrines protecting mental health practitioners: non-responsibility, sovereign immunity, and the "honest error" rule); Note, *The Quality of Mercy: "Charitable Torts" and Their Continuing Immunity*, 100 HARV. L. REV. 1382, 1383-86 (1977) (describing the rise, fall and partial resurgence of charitable immunity).

262. Smith, *Hospital Liability for Physician Negligence*, 251 J. A.M.A. 447, 447 (1984).

263. Refer to notes 265-67 *infra* and accompanying text. The enlargement of the duty to supervise carefully and the more frequent imposition of vicarious liability, coupled with an increase in the level of individual malpractice exposure has resulted in significant liability changes for institutions. Nesterowicz, *Hospitals' Liability in American Law*, 6 MED. L. 553 (1987).

264. Smith, *supra* note 262, at 447.

265. See Lisko, *Hospital Liability Under Theories of Respondeat Superior and Corporate Negligence*, 47 UMKC L. REV. 171, 171 (1978); Southwick, *Hospital Liability: Two Theories Have Been Merged*, 4 J. LEGAL MED. 1, 2 (1983); see also Note, *Kirk v. Michael Reese Hospital: A Hospital's Liability as a Health Care Provider*, 19 LOY. U. CHI. L.J. 1261, 1263 (1988); Comment, *Evolving Theories of Malpractice Liability for HMOs*, 20 LOY. U. CHI. L.J. 841, 872 (1989).

266. Lisko, *supra* note 265, at 181-82; see also Copeland & Brown, *Hospital Medical Staff Privilege Issues: "Brother's Keeper" Revisited*, 17 N. KY. L. REV. 513, 513-17 (1990) (reviewing hospital corporate responsibility doctrine).

ble for providing an increasingly higher level of supervision<sup>267</sup> and for conducting periodic reviews to assess the quality of practice of professionals. Institutions may face liability if they fail to take minimal steps to ensure that professionals do not exceed the areas of authorized practice.

The professions themselves recognize the importance of this supervision in their accreditation requirements and professional standards.<sup>268</sup> As institutions become more complex and include a greater range of professionals, supervision becomes increasingly important. All institutions should have formal, periodic staff reviews to ensure that their mental health practitioners and other professionals are competent, have the necessary training for practice, have adequate supervision, and limit their practice to those areas in which they have demonstrated competence.

Because the law imposes vicarious liability on mental health institutions whether or not they have exercised all possible care,<sup>269</sup> the rules of agency have a significant impact on the level of institutional liability.<sup>270</sup> Traditionally, institutions were vicariously liable only for the torts of their agents.<sup>271</sup> Vicarious liability did not arise from the actions of other potential tortfeasors, for example physicians with staff privileges, because there was no employment relationship and the physician was merely an independent contractor.<sup>272</sup> That doctrine has significantly eroded in recent years.<sup>273</sup>

Courts increasingly find mental health institutions vicariously liable for the torts of independent professionals under the doctrine

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267. This trend was established by *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 329, 211 N.E.2d 253, 256 (1965) (holding hospital liable for failing to require doctor to update his skills and inadequately supervising the doctor's procedures), *cert. denied*, 383 U.S. 946 (1966).

268. See, e.g., JOINT COMM. ON THE ACCREDITATION OF HEALTHCARE ORGS., ACCREDITATION MANUAL FOR HOSPITALS (1990 ed.) (establishing detailed standards that include provisions for the careful evaluation and supervision of those practicing in hospitals); Roberts, Coale & Redman, *A History of the Joint Commission on Accreditation of Hospitals*, 258 J. A.M.A. 936, 938-40 (1987) (detailing the history of the Joint Commission's accreditation requirements).

269. See Southwick, *supra* note 265, at 3-4. The employees themselves are also directly responsible for their own negligence. *Id.*

270. See PROSSER & KEETON ON TORTS, *supra* note 35, § 70, at 460 (citing the Restatement of Agency when discussing implied negligence).

271. See Southwick, *supra* note 265, at 6-7.

272. Klages, *Medical Malpractice Liability from a Hospital's Perspective*, 77 ILL. B.J. 34, 34 (1988); Southwick, *supra* note 265, at 5.

273. Klages, *supra* note 272, at 34.

of "ostensible" or "apparent" agency.<sup>274</sup> This doctrine applies if the institution or professional gives the public the impression that the professional is an agent or employee of the institution.<sup>275</sup> Advertising, group practice, professional listings, and the like all may give the appearance of an agency relationship and set up ostensible agency vicarious liability.<sup>276</sup>

Like practitioners, institutions also face new duties to protect people other than their patients.<sup>277</sup> *Tarasoff* provides one prominent example.<sup>278</sup> That case arose in an institutional setting, a clinic at the University of California.<sup>279</sup> Child abuse reporting statutes may impose institutional liability as well.<sup>280</sup> Other similar obligations are not hard to imagine. For example, some states may impose an obligation to take steps to protect the spouse of an HIV-positive patient who continues to engage in conduct that may transmit the disease to her.<sup>281</sup> Such problems often involve very difficult conflicts between the ethical and legal duties to protect others and the confidentiality of patients.<sup>282</sup> Furthermore, these problems generally arise very quickly, allowing institutions little

274. See Southwick, *supra* note 265, at 10.

275. Firman, *Ostensible Agency: Another Malpractice Hazard*, 145 AM. J. PSYCHIATRY 510, 511 (1988); Note, *Hospital Vicarious Liability for the Negligence of Independent Contractors and Staff Physicians: Criticisms of the Ostensible Agency Doctrine in Ohio*, 56 U. CIN. L. REV. 711, 711 (1987); Brown, *Hospital Liability Law: Cost Containment, Marketing and Consumer Expectation*, 55 DEF. COUNS. J. 159, 164 (1988).

276. A. THOMPSON, GUIDE TO ETHICAL PRACTICE IN PSYCHOTHERAPY 26-30, 218-19 (1990).

277. Refer to notes 247-60 *supra* and accompanying text.

278. *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 442, 551 P.2d 334, 348, 131 Cal. Rptr. 14, 28 (1976).

279. *Id.* at 432, 551 P.2d at 341, 131 Cal. Rptr. at 21.

280. Refer to notes 249-60 *supra* and accompanying text. All states have reporting statutes, and in most states mental health institutions would have an obligation to report abuse. Smith & Meyer, *supra* note 130, at 351-53.

281. See, e.g., AMA, *Prevention and Control of Acquired Immunodeficiency Syndrome: An Interim Report*, 258 J. A.M.A. 2097, 2103 (1987) (recommending the drafting of statutes which require that public health officials, rather than physicians, inform individuals at risk); Labowitz, *Beyond Tarasoff: AIDS and the Obligation to Breach Confidentiality*, 9 ST. LOUIS J. PUB. L. REV. 495, 516 (1990) (counseling doctors that states may have a duty to warn spouses and known partners); Note, *AIDS: Establishing a Physician's Duty to Warn*, 21 RUTGERS L. J. 645, 657-64 (1990) (suggesting a physician's duty to warn based on *Tarasoff*); Comment, *Doctor-Patient Confidentiality Versus Duty to Warn in the Context of AIDS Patients and Their Partners*, 47 MD. L. REV. 675, 681 (1988) (observing that some jurisdictions require a doctor to warn other persons of a patient's illness).

282. See *Tarasoff*, 17 Cal. 3d at 438-43, 551 P.2d at 345-48, 131 Cal. Rptr. at 25-28 (discussing the conflicting interests of confidential psychotherapeutic communication and public safety).

time to consider fully the options and the conflicting duties. Therefore, institutions should have clear, written protocols for handling reports of abuse or patients' threats against third parties.

Liability may also arise from the research and teaching conducted in an institution.<sup>283</sup> Human research activities are now fairly well controlled in most institutions as a result of federal regulations, institutional review boards ("IRB"s), and ethics committees.<sup>284</sup> Institutions without these IRBs or ethics reviews should require express authorization for any human experimentation conducted in their facilities.<sup>285</sup>

Mental health professionals receive substantial clinical or practical experience during their training. Those still in training assess, counsel, and treat patients. Student practice raises legal issues regarding adequate supervision and review, methods of ensuring acceptable levels of care, and the adequacy of informed consent.<sup>286</sup> There are few reported legal cases involving injuries suffered because of inadequate treatment by those in training.<sup>287</sup> It may be that patients do not recognize most instances in which student malpractice has occurred.<sup>288</sup> Another possibility is that attorneys, many of whom received little formal clinical training in law

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283. When mental health professionals engage in research or teaching, they frequently involve their patients. Using patients for a purpose that is not solely directed toward helping the patient triggers special legal and ethical obligations to protect the patient from unnecessary risks and to ensure patient autonomy through the informed consent process. A. THOMPSON, *supra* note 276, at 47-52.

284. See generally S. SMITH & R. MEYER, *supra* note 29, at 189-227 (1987) (discussing issues related to experimentation).

285. Recent changes in federal law and some state laws also obligate institutions that undertake animal research to carefully review the research and the care given the animals. See, e.g., 9 C.F.R. §§ 1.1-3.142 (1990); 48 C.F.R. §§ 380.202-380.205 (1989). These regulations provide for the care and treatment of animals and require the formation of institutional committees to review the proposed use of animals in research. See Dresser, *Research on Animals: Values, Politics, and Regulatory Reform*, 58 S. CAL. L. REV. 1147, 1165-70 (1985).

286. See Kapp, *Supervising Professional Trainees: Legal Implications for Mental Health Institutions and Practitioners*, 35 HOSP. & COMMUNITY PSYCHIATRY 143, 143-45 (1984).

287. See, e.g., *McBride v. United States*, 462 F.2d 72, 73 (9th Cir. 1972) (young resident misdiagnosed an imminent heart attack as gastrointestinal disturbance); *Rush v. Akron Gen. Hosp.*, 84 Ohio App. 2d 292, 171 N.E.2d 378, 379 (1957) (intern failed to probe wound for pieces of glass before closing with stitches); cf. Kapp, *Legal Implications of Clinical Supervision of Medical Students and Residents*, 58 J. MED. EDUC. 293, 294 (1983) (demonstrating the lack of suits grounded on the clinical participation of a student despite patient objections).

288. Rich, *Malpractice Issues in the Academic Medical Center*, 36 DEP. L.J. 641, 646 (1987).

school, fail to notice or raise the possibility of training-related injuries in other disciplines.

Institutions must ensure that students work under supervision that is adequate to maintain the quality of treatment and that students do not extend themselves beyond their level of training or expertise.<sup>289</sup> This obligation goes beyond merely signing treatment or assessment reports and informing students when they make mistakes. Supervision should be sufficiently intense to protect patients from receiving inferior service. It would be unfair to hold students to the same standard of care as that expected of a fully trained professional.<sup>290</sup> It would be equally unfair for unsuspecting patients to bear the risk of inadequate care from those still in training. An institution should, therefore, provide supervision sufficient to guarantee that the services provided by students do not fall below the level of fully competent professional care.<sup>291</sup>

The use of patients in research or teaching presents special informed consent issues.<sup>292</sup> Deciding whether or not to participate in an experiment or to accept treatment by someone in training may be an important matter for some patients.<sup>293</sup> Receiving treatment from a student potentially may affect important legal rights of the patient, including the confidentiality of information revealed in therapy.<sup>294</sup> Human research subjects have benefitted from considerable legal protection in recent years.<sup>295</sup> Although similar mechanisms for protecting teaching subjects have not yet been developed, many of the considerations that cause concern for re-

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289. The amount of supervision required will vary with the student's level of education, the complexity of the treatment, and the risk and severity of potential harm to the patient. The greater the possibility or severity of harm to the patient, the more likely it is that the student requires full supervision.

290. *Rush*, 84 Ohio App. 2d at 292, 171 N.E.2d at 381.

291. See Slovenko, *Legal Issues in Psychotherapy Supervision*, in *PSYCHOTHERAPY SUPERVISION: THEORY, RESEARCH AND PRACTICE* 453, 462 (A. Hess ed. 1980).

292. See A. THOMPSON, *supra* note 276, at 47-52.

293. See Hirsh, *Which Physicians are Students?: The Patient Has a Right to Know*, *HOSP. MED. STAFF*, Dec. 1978, at 11, 11-13; Kapp, *supra* note 287, at 293-94.

294. The law should view students as assistants to their supervising faculty member. This view would protect confidences revealed to a student under the same psychotherapist-patient privilege that covers the supervising faculty member. It appears, however, that all states may not adopt this concept. One California appellate court held that the psychotherapist-patient privilege does not cover student interns. *People v. Gomez*, 134 Cal. App. 3d 874, 881-82, 185 Cal. Rptr. 155, 158-59 (1982). *But see* *Hall v. State*, 255 Ga. 267, 336 S.E.2d 812, 819-20 (1985) (hinting in dicta that if faced with the issue, the court would apply the privilege to student interns).

295. See S. SMITH & R. MEYER, *supra* note 29, at 190-94.

search subjects also arise with teaching subjects. By serving as teaching subjects, patients may be at increased risk, their privacy may be invaded more frequently, and their treatment needs may conflict with the teaching interests of the institution. These risks make informed consent particularly important in teaching as well as research. A patient's consent to participation in an experiment or to treatment by those in training should not be assumed; it should be explicit.

Institutions traditionally have benefited from a number of special immunities, including charitable immunity and governmental immunity.<sup>296</sup> Almost every jurisdiction has eliminated charitable immunity.<sup>297</sup> Sovereign immunity continues to be a viable defense, but statutes and court decisions continue to reduce its scope.<sup>298</sup> The federal government permits a wide range of liability suits against federal agencies (including VA hospitals), subject to a number of important limits.<sup>299</sup> The consequence of this waiver of immunity is that federal institutions face mental health malpractice liability that often approaches that faced by private institutions.

## VI. LIABILITY IN PERSPECTIVE

The extended discussion of current practitioner liability must be viewed against the background of the very small number of successful cases filed against mental health practitioners.<sup>300</sup> Malpractice liability does not represent a looming threat to most institutions or practitioners. Yet, the potential for increased liability certainly exists.

Institutions and practitioners can take several steps to mini-

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296. Refer to note 261 *supra*.

297. See PROSSER & KEETON ON TORTS, *supra* note 35, § 133, at 1070.

298. See, e.g., Frels & Horner, *The Interrelationship of Tort Liability, Governmental Immunity, and the Civil Rights Statutes*, 16 ST. MARY'S L.J. 851, 858-64 (1985) (pointing out the encroachment on sovereign immunity by the Civil Rights Acts in Texas); Note, *Lately "The King" Can Do Little Right: Idaho Governmental Immunity Doctrine in the Wake of Sterling v. Bloom*, 24 IDAHO L. REV. 291, 292-93 (1988) (discussing the degradation of sovereign liability caused by the Federal Tort Claims Act); Note, *The Life and Death of Governmental Immunity for Governmentally Owned or Operated Hospitals*, 1987 DET. C.L. REV. 565, 577-78 (demonstrating the exceptions to a case purportedly extending governmental immunity).

299. Federal Tort Claims Act of 1946, Pub. L. No 96-601, 60 Stat. 842 (1946) (codified as amended at 28 U.S.C. § 2674 and other scattered sections of 28 U.S.C. (1989)).

300. Refer to notes 12-22 *supra* and accompanying text.

mize the risks of malpractice.<sup>301</sup> They should (1) be particularly sensitive to maintaining the confidences of therapy and ensure that confidences are not breached without good reason; (2) obtain *informed* consent (preferably written) that includes a description of the hazards of treatment and the existence of alternative treatments; (3) maintain accurate records and not tamper with records to try to cover up mistakes; (4) be cautious of incomplete or sloppy testing, histories, and diagnoses; (5) refer the patient to another professional when the patient could benefit from the referral; (6) give particular attention to suicidal or dangerous patients and have sound reasons for any decision not to take action about such patients; (7) engage in ethical practice (unethical conduct is likely also to be illegal and subject to liability); (8) avoid engaging in or even suggesting sexual relationships with patients, former patients, or close relatives of patients; (9) accept only as many patients or other obligations as can be carefully and thoughtfully treated; (10) consider adopting "patient rights" advocates for all institutionalized patients to help identify potential problems;<sup>302</sup> (11) stay current with every area of practice in which work is undertaken; and (12) be up to date on drug information if drugs are prescribed.<sup>303</sup>

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301. For discussion of psychotherapist liability risk management, see generally R. SIMON, *PSYCHIATRIC INTERVENTIONS AND MALPRACTICE: A PRIMER FOR LIABILITY PREVENTION* (1982); Tan & McDonough, *Risk Management in Psychiatry*, 13 *PSYCHIATRIC CLIN. N. AM.* 135, 138-46 (1990); Shapiro, *A Clinician's Guide to Reducing the Risk of Malpractice*, 5 *PSYCHOTHERAPY PRIVATE PRAC.* 31 (1987); Horan & Guerrini, *Developing Legal Trends in Psychiatric Malpractice*, 9 *J. PSYCHIATRY & L.* 65, 69-85 (1981).

302. By permitting patient advocates to become an integral part of the ongoing treatment plan, they would be available to address the legal issues that frequently arise in mental health practice. Although patient advocacy is a crucial aspect of all mental health disciplines, conflicts will inevitably arise over what is in the patient's "best interest." Within this context, the patient advocate functions as a mediator between the caregiver and the patient to facilitate conflict resolution and to maintain the therapeutic relationship. Furthermore, the advocate could initiate and continually reevaluate written informed consent procedures for the therapeutic regime, including individual and group psychotherapy, psychotropic medication, behavioral therapy, and psychological testing. See generally Dobson, *Achieving Better Medical Outcomes and Reducing Malpractice Litigation Through the Healthcare Consumer's Right to Make Decisions*, 15 *J. CONTEMP. L.* 175, 201-04 (1989) (urging enforcing consumer rights as a way of reducing malpractice litigation).

303. See generally T. GUTHEIL & P. APPELBAUM, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* 178-203 (1982) (illustrating behavioral, documentational, technical, and consultative approaches to prevention of malpractice); Rothblatt & Leroy, *Avoiding Psychiatric Malpractice*, 9 *CAL. W.L. REV.* 260, 265-72 (1973) (discussing the development of various areas of psychiatric malpractice); Soisson, VandeCreek & Knapp, *Thorough Record Keeping: A Good Defense in a Litigious Era*, 18 *PROF. PSYCHOLOGY: RES. & PRAC.* 498 (1987) (exploring guidelines for thorough record keeping); Wills, *Preparation and Procedures for the Courtroom; Insight for the Licensed Professional Counselor*, 15 *T.A.C.D. J.* 91 (1987).

## VII. MALPRACTICE IN THE 1990s

Predicting the direction of mental health malpractice in the next decade is probably as "accurate" as long-term predictions of dangerousness.<sup>304</sup> Most predictions are based on the false assumption that current trends will continue unabated, but history seldom moves so simply. The best that can be done is to identify several factors that will probably affect the direction and extent of mental health malpractice in the 1990s. These factors suggest that the number of malpractice claims will increase, but that the growth will not be explosive.<sup>305</sup> Ironically, one conclusion that can be drawn from an analysis of such "malpractice factors" is that malpractice claims may increase with improvements in mental health research and rising public expectations about the efficacy of mental health care.

A. *Increasing Liability*

To the extent that mental health practice becomes more precise and standardized, it will be easier to establish a standard of care against which to evaluate professional practice. This precision will reduce the difficulty in defining what is inadequate practice, one of the significant protections against malpractice liability in the past. Better definitions of what constitutes appropriate treatment for mental conditions will result from several factors. First, research will continue to provide a more sophisticated understanding of the etiology and diagnosis of emotional conditions. It also promises to shed some light on what is and is not effective therapy.<sup>306</sup> In addition, reimbursement systems increasingly demand some method of determining what therapies are legitimate. Third-party payers, such as health insurance companies and Medicare, will reimburse mental health costs only to the extent that standard

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304. Such predictions, of course, are notoriously inaccurate. Cf. J. MONAHAN, PREDICTING VIOLENT BEHAVIOR: AN ASSESSMENT OF CLINICAL TECHNIQUES 26, 28 (1981) (concluding that mental health professionals are highly inaccurate at predicting violent behavior); Monahan, *Risk Assessment of Violence Among the Mentally Disordered: Generating Useful Knowledge*, 11 INT'L J.L. & PSYCHIATRY 249, 251 (1988) (recognizing the inconsistencies in recent risk assessment research).

305. However, the view of many mental health malpractice experts is that there will be very significant increases in malpractice liability. Refer to note 7 *supra* and accompanying text.

306. See S. SMITH & R. MEYER, *supra* note 29, at 152-55 (research concerning the efficacy of therapy). Refer to notes 23-28 *supra* and accompanying text.

care can be defined with reasonable certainty.<sup>307</sup> These developments, therefore, will exert pressure on the professions to define what is acceptable or effective therapy.<sup>308</sup> Such definitions, in turn, help establish that some treatment is negligent.

Research on the causes of emotional injuries may increase successful malpractice claims. Because demonstrating causation is often difficult in malpractice cases, this research should improve plaintiffs' ability to prove that element of negligence. Research may also help prove damages by establishing the presence of emotional injuries. Improvements in therapists' ability to detect patient malingering or falsification of psychic symptoms will not only help eliminate false claims of injuries, but will also help prove real claims of injury.<sup>309</sup> Even though no significant breakthroughs are likely to occur during the 1990s, this research should gradually begin to remove some of the de facto causation and injury defenses that mental health defendants have used in negligent diagnosis and treatment cases.

If the use of some physical therapies, notably drugs, increases, the potential number of physical injuries may also increase. Physical injuries tend to result in clearer liability than mental injuries because the injury is easier to prove. In addition, if the injury results from drug use, the standard of care for the use of prescription drugs is generally clearer than it is for other therapy.<sup>310</sup>

Public perceptions of a profession affect potential malpractice liability in inconsistent ways. The more the public perceives that a

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307. Smith, *A Crazy System: Mental Health Care Delivery in America*, 5 J. CONTEMP. HEALTH L. & POL'Y 75, 83-92, 112 (1989) (observing that increasing implementation of review mechanisms in the mental health delivery system is needed).

308. *Id.*; cf. T. BUTLER, MENTAL HEALTH, SOCIAL POLICY AND THE LAW 190-201 (1985) (examining the effects of the English Mental Health Act of 1959 on the administration of mental health care).

309. If it is possible to detect malingering, then the fact that it has not been detected in a plaintiff will suggest that the plaintiff is not malingering. See generally S. SMITH & R. MEYER, *supra* note 29, at 277-83 (discussing types of malingering and methods of assessment) Rogers, *Current Status of Clinical Methods*, in CLINICAL ASSESSMENT OF MALINGERING 293 (R. Rogers ed. 1988) (detailing current methods of detecting deception). A special issue on malingering is contained in *Malingering and Deception: An Update*, 8 BEHAV. SCI. & L. 1-104 (1990).

310. A new treatment for schizophrenia is much more likely to raise liability concerns if it is a drug than if it is a nonphysical therapy. When Clozaril (clozapine) was recently released by Sandoz Pharmaceuticals for schizophrenia, the company was so concerned about liability from the risk of blood abnormalities that it required weekly blood tests by a laboratory of its choosing. See N.Y. Times, May 15, 1990, at C2, col. 1. The cost of the drug, including the tests, will be about \$9,000 per patient. *Id.*

profession is effective in diagnosing or treating a condition, the higher are the expectations of good results. Consequently, the public may be more inclined to believe that a professional was negligent when treatment fails. On the other hand, the same public perception of a profession's effectiveness increases public esteem for it, and this esteem may tend to reduce liability. Currently, the public seems to have a cynical attitude about mental health professionals. The popular image is somewhat that of a personally troubled, ineffective therapist (if not charlatan) who can provide anyone an excuse for committing any crime.<sup>311</sup> If some version of this image dominates in the 1990s, mental health professionals will not make particularly sympathetic malpractice defendants.

Perhaps the worst malpractice position for a profession to be in is to have oversold its ability. The impression of professional competence may arise from direct claims the profession makes or from the implicit claim of competence that occurs when it regularly performs some task. Eventually, the public and the legal system will hold the profession responsible for accomplishing what it claims it can do or what it undertakes to do. In short, public expectations of ability create liability. Obstetricians created the expectation that with modern medicine they could safely deliver babies, and as a result, the public came to believe that if a baby was born with injuries someone must have made a mistake. Mental health professionals suffered similar liability from the perception that they were pretty good at predicting dangerousness. After all, they had been predicting dangerousness in and out of court for years. It should not have been too surprising that *Tarasoff* liability developed based on the theory that, if mental health professionals "know it when they see it," they ought to protect the rest of us from it.<sup>312</sup> This represents a kind of "petard liability" because the profession is hoisted on its own claims of expertise. To some degree, this has also occurred in the last couple of decades with suicide prevention: where courts and the public assume that therapists know when someone is at risk for suicide, they expect that therapists should take effective steps to prevent it.<sup>313</sup>

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311. In cartoons, television shows and movies, mental health professionals (especially psychiatrists) are now frequently pictured as buffoons, as obsessed with sex, or as California hottub therapists.

312. Refer to notes 235-66 *supra* and accompanying text.

313. Refer to notes 337-42 *infra* and accompanying text (examining professional liability for patient suicide). Like predictions of dangerousness to others, mental health experts

The potential exists for "petard liability" to arise in the 1990s. For example, expert testimony given by some professionals in rape, child abuse, and child custody is a possible source of such liability.<sup>314</sup> The assumption that mental health professionals have special expertise in constructing profiles of victims and perpetrators of such abuse obviously underlies this testimony.<sup>315</sup> Some mental health professionals also claim to be able to tell (and to testify) whether a parent is fit or not and even whether granting custody to one of two fit parents would be in the best interest of the child.<sup>316</sup> The public or the legal system may come to assume that mental health professionals really have the expertise to make these determinations. In this event, the 1990s may see malpractice claims advanced on the basis that professionals failed to detect or report sexual abuse while briefly treating a child, or failed to detect and report that a patient matched the "profile" a rapist, child abuser,

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testified in civil commitment hearings for years that potentially suicidal patients, because they were dangerous to themselves, should be committed. This, of course, eventually creates the impression that mental health experts can tell who is suicidal.

314. Smith, *Mental Health Expert Witnesses: Of Science and Crystal Balls*, 7 BEHAV. SCI. & L. 145, 158-61 (1989) (reviewing the use of psychological evidence regarding the battered wife syndrome, the rape trauma syndrome and the battering parent syndrome); cf. Buchele & Buchele, *Legal and Psychological Issues in the Use of Expert Testimony on Rape Trauma Syndrome*, 25 WASHBURN L.J. 26, 37-40 (1985) (describing the role of the expert and the advantages and disadvantages of using his testimony); Myers, Bays, Becker, Berliner, Corwin & Saywitz, *Expert Testimony in Child Sexual Abuse Litigation*, 68 NEB. L. REV. 1, 32-105 (1989) (detailing the scientific basis for identifying sexual abuse); Roe, *Expert Testimony in Child Sexual Abuse Cases*, 40 U. MIAMI L. REV. 97, 104-13 (1985) (warning against the use of expert psychiatric testimony to bolster the victim's credibility); Note, *Admissibility of Expert Testimony on Battered Wife Syndrome: An Evidentiary Analysis*, 77 Nw. U. L. REV. 348, 355-73 (1982) (suggesting that evidentiary safeguards are sufficient to prevent the improper use of battered wife syndrome testimony).

315. Courts will accept scientific evidence only if it has at least a fair acceptance in the scientific community and will assist the jury. See Ladd, *Expert Testimony*, 5 VAND. L. REV. 414, 417-21 (1952). Therefore, where "syndrome evidence" is admitted, it must mean that courts admitting such evidence have been convinced that mental health experts have special ability to determine who abusers are or are likely to be. See *id.*

316. Hirsch, *Expert Witnesses in Child Custody Cases*, 19 FAM. L.Q. 207, 215-17 (1985). See generally McCord, *Syndromes Profiles and Other Mental Exotica: A New Approach to the Admissibility of Nontraditional Psychological Evidence in Criminal Cases*, 66 OR. L. REV. 19, 27-35 (1987) (examining the characteristics and impact of non-traditional psychological evidence); Swann, *The Dangers of Using Court-Appointed Experts in Child Custody Cases*, 27 JUDGES' J. 16, 18-19 (1988) (recognizing the special problems faced by court-appointed experts in evaluating their subjects); Note, *The Syndrome Syndrome: Problems Concerning the Admissibility of Expert Testimony on Psychological Profiles*, 37 U. FLA. L. REV. 1035, 1054-57 (1985) (emphasizing the importance of evaluating the reliability of the testimony rather than determining whether its admission will usurp the role of the jury).

or unfit parent.

Some public advertising which portrays drug and alcohol treatment programs and juvenile hospitalization as a means of "straightening kids out" may also create unrealistic expectations. Even though these claims do not rise to the level of warranties, they may suggest a broad ability to provide treatment which probably cannot be delivered. This is likely to cause people to conclude that someone must have done something wrong if the programs do not work. This perception can expand liability in two ways. First, it can increase the possibility that the clients of these institutions will be dissatisfied and bring claims. Second, jurors will view mental health institutions and professionals with unrealistic expectations about what they should be able to do.

Mental health professionals also may face greater liability exposure in the 1990s because of an increase in the number of patients a typical therapist sees. Group and short-term therapy increases the patient count, compared with traditional approaches such as psychoanalysis. The trend has been toward these modes of therapy.<sup>317</sup> In addition, mental health professionals are increasingly involved in activities, for instance, test development and validation, that may affect dozens of people who are not directly their clients.<sup>318</sup> Those professionals who carelessly undertake these activities without thorough training face the possibility of legal exposure to many plaintiffs.

The continued expansion of a mental health bar may also have an impact. For the first time, there are a significant number of attorneys who have experience and training in mental health law and understand how to pursue mental health issues, including malpractice claims.<sup>319</sup> This group may also educate other plaintiffs' attorneys to the possibilities presented by mental health cases. At the same time, the mental health bar should help reduce malpractice claims by refusing to take weak cases, providing excellent defense work, and advising institutions and practitioners on ways of reducing the risks of malpractice.

On the other side of the interdisciplinary coin, a fair number of well-trained mental health professionals will be willing to act as

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317. See Smith, *supra* note 307.

318. Refer to notes 131-32 *supra* and accompanying text.

319. Mental health courses have been common in law schools only for a decade or two. As a result of these courses, a number of law graduates now have had formal exposure to, and training in, mental health law.

expert witnesses in malpractice cases. Because plaintiffs, rather than defendants, traditionally have had trouble securing experts to testify to questions of standard of care and causation, this development will tend to increase plaintiffs' ability to prove malpractice claims.

As the number of experienced forensic mental health experts increases, both sides should have access to better mental health evidence, and this should increase the number of correct malpractice verdicts. Further, a plaintiffs' bar better attuned to mental health issues should be able to reduce the number of frivolous claims. Neither result, however, is guaranteed. The mental health "any-testimony-for-a-buck hired guns" may use their expertise to make a very weak case seem unfairly strong to a lay jury,<sup>320</sup> and the mental health attorney may be able to use his understanding of mental health to take and make plausible even trivial cases.

A number of legal principles which have become fairly well accepted during the last fifteen or twenty years will undoubtedly continue to evolve into standard legal doctrine. This will tend to increase somewhat the level of malpractice claims. One of the significant developments includes the loss of immunities,<sup>321</sup> particularly charitable and governmental immunities. In addition, expanded concepts of vicarious liability and the duty to supervise have increased institutional liability.<sup>322</sup> Furthermore, the law is losing its traditional reluctance to recognize and compensate emotional and psychic injuries.<sup>323</sup> Also, the claim that suicide is a superseding cause no longer precludes recovery in most instances.<sup>324</sup> Finally, the concept that therapists owe duties to people other than their clients and the related weakening of the doctrine of limited duty gave rise to *Tarasoff*.<sup>325</sup> The full effect of that duty will be felt in several states during the 1990s.<sup>326</sup>

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320. Smith, *supra* note 314, at 150-51, 177-78.

321. Refer to note 261 *supra* and accompanying text.

322. Refer to notes 261-77 *supra* and accompanying text.

323. Refer to notes 33-38 *supra* and accompanying text.

324. Refer to note 40 *supra*.

325. Refer to notes 212-31 *supra* and accompanying text.

326. Although the *Tarasoff* duty to protect or warn seems to be a broadly accepted legal principle, many states have not formally adopted it because no case has reached their supreme courts. Because of the novelty of the theory, it is likely to be several years before the resulting level of malpractice liability can be judged.

### B. Reducing Liability

Some changes will tend to reduce the level of mental health malpractice liability. A number of states have enacted tort reform, or at least malpractice reform, and other states continue to consider such legislation.<sup>327</sup> Although these reform packages often are flawed, or even unconstitutional,<sup>328</sup> it is possible that some of them will have at least some impact on mental health malpractice.<sup>329</sup> For example, those statutes that put caps on the size of malpractice recovery could possibly limit verdicts in suicide, duty to protect (*Tarasoff*), and some medication cases. The *Tarasoff* statutes<sup>330</sup> might also limit malpractice liability somewhat if those statutes are interpreted as reducing the duty of therapists to protect the intended victims of their patients. Because most of these statutes are badly drafted, however, it is unlikely that they will ever have any significant effect on liability.<sup>331</sup>

It is also possible that mental health professionals will successfully seek specific statutory protection from liability during the decade. Some of the professions have demonstrated considerable lobbying strength in state legislatures, and if they made a concerted, unified effort to pass such limitations, they might well have some success. In the past, states have sometimes granted immunity from liability to mental health professionals, but this has generally been done to encourage participation in government or the legal system (e.g., civil commitment). If the experience with the *Tarasoff* statutes is any indication, however, other groups, such as trial lawyers, will match mental health lobbying efforts. In this event, the resulting statute would be so weak or muddled that few real changes in liability would occur.<sup>332</sup>

Common-law liability will probably not change dramatically during this decade. Courts will not plow significant new ground in establishing mental health liability as they have done in the last couple of decades; it is equally unlikely that there will be a dra-

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327. Refer to notes 370-81 *infra* and accompanying text.

328. Refer to note 248 *supra* and accompanying text.

329. Many of the general medical reforms may have somewhat limited impact on mental health professionals. For example, if the reform applies to claims against physicians, only psychiatrists among all mental health professionals would be affected.

330. Refer to note 234 *supra*.

331. Refer to notes 243-47 *supra* and accompanying text.

332. *Id.*

matic retreat from liability.<sup>333</sup> There has been sufficient reaction against the expansion of liability of the last twenty years that many courts now seem reluctant to continue to implement new theories of liability. At the same time, there is little evidence that courts are rejecting the liability doctrines developed in the last two decades. For example, it is highly unlikely that strict liability will be expanded to include services such as psychotherapy or to cover the prescription, as opposed to the manufacture, of drugs. The fact that states have formally adopted some generally accepted common-law doctrines (such as *Tarasoff*) may give the impression that the common-law liability is expanding. However, this represents a consolidation of principles developed in the 1970s and 1980s, not expansion of liability into new areas.

The Supreme Court has both expanded and contracted section 1983 liability in mental health law. It has applied that liability to areas of mental health practice,<sup>334</sup> while at the same time providing a broad range of defenses.<sup>335</sup> For example, the Court has tended to rely on the professional judgment of mental health professionals at least as long as they are operating within reasonable medical and mental health expertise.<sup>336</sup> The Court's current position makes it unlikely that section 1983 cases will significantly increase malpractice liability during the 1990s.

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333. The *Tarasoff*-type liability, increased recognition of mental distress as deserving compensation (even without physical injury), and the expanded vicarious liability of institutions are examples of tort law expansion that are not likely to be eliminated during the 1990s.

334. *E.g.*, *Zinerman v. Burch*, 110 S. Ct. 975, 987-90 (1990) (state facility's failure to ascertain competence of patient admitted as voluntary held sufficient to state a § 1983 claim); *City of Canton v. Harris*, 109 S. Ct. 1197, 1204-07 (1989) (recognizing the inadequacy of police training to deal with mentally ill prisoners as a basis for § 1983 municipal liability only where it amounts to deliberate indifference to constitutional rights); *O'Connor v. Donaldson*, 422 U. S. 563, 573-76 (1975) (holding that a state cannot constitutionally confine without treatment a non-dangerous individual who can survive safely in freedom).

335. *E.g.*, *Harlow v. Fitzgerald*, 457 U.S. 800, 818 (1982) (defendant must have violated a "clearly established statutory or constitutional right"); *Youngberg v. Romeo*, 457 U.S. 307, 321-23 (1982) (good faith exception to liability, defendant must have shown substantial departure from professional judgment); *Pierson v. Ray*, 386 U.S. 547, 555-57 (1967) (establishing good faith exception).

336. *Washington v. Harper*, 110 S. Ct. 1028, 1040-44 (1990) (using mental health professionals to decide whether to medicate a mentally ill prisoner held to comply with procedural due process); *Youngberg v. Romero*, 457 U.S. 307, 321-23 (1982) (holding that courts must defer to the judgment of qualified professionals in determining what level of training is reasonable for involuntarily committed patients); *Parham v. J.R.*, 442 U.S. 584, 607-13 (1979) (using a medical decision making process to determine whether children under 18 should be committed to state hospitals held to comply with due process).

Other changes may help to lower malpractice by reducing the incidence of harm from bad mental health practice. Insurance carriers and practitioners themselves will undoubtedly respond to increasing malpractice premiums by paying closer attention to the areas of practice and practitioners that account for the risk of liability. This will probably mean that many mental health institutions will begin more carefully to review the work of professional employees and those with practice privileges. Insurance carriers will increasingly offer educational and other risk-reduction programs. Malpractice insurance carriers will exclude professionally unacceptable activities from coverage, thereby providing an added incentive for practitioners to avoid these practices. It is possible, but unlikely, that increasing malpractice claims will encourage the mental health professions to use the licensure process more effectively in order to eliminate the incompetent or unethical practitioner.

As noted above, the development of standards of acceptable practice for treating emotional conditions may tend to increase liability by helping establish provable standards of care. The same process also clearly could inform practitioners of practices that they should avoid. In the end, treatment standards can help reduce the level of malpractice by discouraging the use of outdated, impractical, and useless therapies and techniques. These standards may thus reduce the level of malpractice by improving the overall quality of practice.

### C. *Malpractice Directions*

The factors that will contribute to increases in malpractice liability for mental health professionals and institutions during the 1990s are almost entirely unrelated to changes in the law. Indeed, any significant legal changes will most likely result from statutory efforts to reduce liability. It is changes in the nature of practice and, ironically, progress in mental health research that probably result in the increased liability.

By considering the factors working to change the level of malpractice during the 1990s, it is possible to predict which areas of mental health activity will be sources of increased liability.<sup>337</sup> I

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337. M. PERLIN, *supra* note 7, at 34, 47-48, 57, 69, 72, 84, 115 (suggesting a number of areas in which mental health liability is likely to increase, including sexual misconduct, ECT, suicide, unconventional therapy, wrongful confinement, informed consent and confi-

predict the following ten areas will have more malpractice claims by the end of the decade:<sup>338</sup> (1) Negligent diagnosis and treatment that deviates from accepted treatment patterns (unless there has been special informed consent to nonstandard treatment);<sup>339</sup> (2) failure to prevent suicide;<sup>340</sup> (3) inappropriate prescription of drugs and failure of informed consent;<sup>341</sup> (4) *Tarasoff*-type liability;<sup>342</sup> (5) inadequate test development and validation;<sup>343</sup> (6) institutional vicarious liability;<sup>344</sup> (7) breach of confidentiality;<sup>345</sup> (8) sexual exploitation of patients;<sup>346</sup> (9) failure of institutions to supervise professional staff and those in training;<sup>347</sup> and (10) failure to detect and report child and elder abuse.<sup>348</sup>

dentiality); J. ROBERTSON, *supra* note 7, at 5 (predicting an "avalanche" of claims and a resultant "crisis"); J. SMITH, *supra* note 7, at 12 (suggesting that "the days of relative immunity are definitely over").

338. Anyone can play the prediction game. Players may send entries to the author.

339. Refer to notes 93-95 *supra* and accompanying text. The development of more standard treatment may increase liability. Refer to notes 154-56 *supra* and accompanying text.

340. Refer to notes 83-89 *supra* and accompanying text.

341. The prescription of drugs may create physical injuries that are easily proved. Furthermore, it is likely that drugs will be used increasingly. Refer to notes 96-98 and 193 *supra* and accompanying text.

342. Refer to notes 212-48 *supra* and accompanying text. *Tarasoff* liability continues to be adopted by states. Refer to notes 231 and 234 *supra* and accompanying text. This increased acceptance of the duty to protect will probably lead to greater liability.

343. Refer to notes 150-53 and 283 *supra* and accompanying text. Federal laws regarding employment and educational testing have resulted in mental health professionals being significantly involved in test development. Refer to note 150 *supra* and accompanying text. Liability in this area is only beginning to develop. Refer to notes 151-53 *supra* and accompanying text.

344. Refer to notes 269-76 *supra* and accompanying text.

345. Refer to notes 122-30 *supra* and accompanying text. Although the mental health profession perceives confidentiality as essential for successful therapy, there are increasing pressures to release information obtained during therapy. Refer to note 231 *supra* and accompanying text. These conflicting requirements of confidentiality and the release of information from therapy will pose real dilemmas for therapists.

346. Refer to notes 104-16 *supra* and accompanying text. Sexual contact that causes injury subjects a therapist to liability. I expect that sexual contact liability will have a significant impact during the early years of the decade. Malpractice carriers increasingly refuse to cover sexual contact with patients. Refer to note 113 *supra* and accompanying text.

347. Refer to notes 265-68 *supra* and accompanying text. During the last two decades, a trend toward expecting health institutions to more carefully select and supervise their employees and others who work in the facilities has developed. Refer to notes 267-68 *supra* and accompanying text. Ostensible agency also imposes greater liability. Refer to notes 274-75 *supra* and accompanying text.

348. Refer to notes 249-60 *supra* and accompanying text. Both statutory and common law liability exist for failure to report child abuse. Refer to note 249 *supra* and accompanying text. This basis for liability has developed slowly, but given the amount of unreported

In contrast, there are several areas in which I do not predict increase in liability. These include (1) electroconvulsive therapy;<sup>349</sup> (2) wrongful involuntary commitment;<sup>350</sup> (3) defamation;<sup>351</sup> (4) section 1983 liability;<sup>352</sup> (5) testimony as expert witnesses,<sup>353</sup> and (6) forcible administration of medications.<sup>354</sup>

## VIII. AN AGENDA FOR MALPRACTICE REFORMS IN THE 1990s

### A. Problems with the Current System

Serious problems exist with the current mental health malpractice system. The system is slow, expensive, imprecise, immensely time consuming, threatening, and embarrassing; it creates great stress on plaintiffs and defendants alike and relies on lay juries to settle complex scientific questions and to define the standard of care.<sup>355</sup> Of course, many of these criticisms have been di-

abuse, it potentially represents a significant source of liability. Refer to note 258 *supra* and accompanying text.

349. Mental health professionals will probably use ECT less frequently and conduct it more safely. Moreover, institutions will monitor its use more closely. Refer to notes 90-95 *supra* and accompanying text.

350. States generally provide immunity for good faith participation in the involuntary commitment process. If anything, the Supreme Court is making it more likely that voluntary rather than involuntary treatment will be subject to liability. Refer to notes 134-49 *supra* and accompanying text.

351. The first amendment and common law protections make most mental health professionals' defamatory comments subject to at least a qualified privilege.

352. The expansion and contraction of § 1983 liability should make this source of liability a wash, with liability remaining at present levels. Refer to notes 138-41 *supra* and accompanying text.

353. Mental health professionals will appear with increased frequency in courts as expert witnesses during the 1990s. However, states generally grant immunity for such testimony, unless it is perjured. Refer to note 314 *supra* and accompanying text.

354. The right to refuse treatment is unlikely to expand during the 1990s. Furthermore, procedures for forcing medicine are increasingly well defined.

355. See, e.g., S. CHARLES & E. KENNEDY, DEFENDANT: A PSYCHIATRIST ON TRIAL FOR MEDICAL MALPRACTICE 210-24 (1985) (exploring the chilling effect on the practices of those physicians threatened by malpractice claims); Shapiro, Book Review, 31 N.Y.L. SCH. L. REV. 867, 867 (1986) (refusing to find the legal profession at fault for the medical malpractice crisis). See generally U.S. DEP'T. OF HEALTH & HUMAN SERVS., REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE (1987) (giving comprehensive analysis of medical liability and malpractice); P. DANZON, *supra* note 18, at 5 (giving an economic analysis of existing system and proposals for change); J. KARALIK & N. PACE, COSTS AND COMPENSATION PAID IN TORT LITIGATION vii-xii (1986) (setting forth empirical evidence regarding the costs of tort litigation); Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.C. DAVIS L. REV. 499, 506-07 (1989) (discussing defendants' complaints about tort reforms in medical malpractice); Robinson, *The Medical Malpractice Crisis of the 1970s: A Retrospective*, 49 L. & CONTEMP. PROBS. 5, 5-18 (1986)

rected at the tort system generally, and other problems are common to most health malpractice claims.<sup>355.1</sup> However, the malpractice system in mental health cases creates special problems.

Confidentiality and the obligation to maintain patient secrets have been hallmarks of the mental health professions. These professions have stressed that confidentiality is essential to successful therapy and to patient well being.<sup>356</sup> The spectacle of patient secrets being revealed publicly as a result of a malpractice case is inconsistent with the goals of the mental health professions. Psychotherapy requires that patients reveal the most sensitive information about themselves and their families.<sup>357</sup> Patients often disclose information that they would not tell anyone else. Therapy deals not only with factual information that can be embarrassing, but also with the most intimate fantasies, fears, and anxieties. In short, mental health malpractice cases will reveal information surrounding the most private details of the patient's life. In the debate over testimonial privileges, there has been broad agreement that a psychotherapist-patient privilege is justified<sup>358</sup> even though a general medical or health care privilege is not.<sup>359</sup>

The public nature of malpractice cases means that the patient's extremely personal information will not be revealed *in cam-*

(reviewing the causes of medical malpractice in the 1970s).

355.1 For a recent review of problems with the current medical malpractice system and the advantages of non-litigation resolution of injuries, see Hutkin, *Resolving the Medical Malpractice Crisis: Alternatives to Litigation*, 4 J.L. & HEALTH 21, 32-54 (1989-90).

356. See, e.g., GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, CONFIDENTIALITY AND PRIVILEGED COMMUNICATION IN THE PRACTICE OF PSYCHIATRY 92 (1960) ("There is wide agreement that confidentiality is a *sine qua non* for successful psychiatric treatment. . . . A threat to secrecy blocks successful treatment."). All mental health professions include in their code of ethics a confidentiality provision. Refer to note 100 *supra* (citations to various confidentiality provisions). Several studies have considered the importance of confidentiality from a utilitarian perspective with somewhat mixed results. See, e.g., Shuman & Weiner, *The Privilege Study: An Empirical Examination of Psychotherapist-Patient Privilege*, 60 N.C.L. Rev. 893, 926 (1982) (concluding that confidentiality is required for building trust); Smith, *supra* note 44, at 547-49 (asserting that current statutes do not adequately support confidentiality in psychotherapy).

357. Smith, *supra* note 43, at 25-30, 52.

358. See, e.g., Proposed Rules of Evidence, Rule 504, reprinted in 56 F.R.D. 183, 240-41 (1972) (providing for a psychotherapist-patient privilege); J. WIGMORE, WIGMORE ON EVIDENCE §§ 2285, 2380a (J. McNaughton ed. 1961 & Supp. 1988) (discussing general principles and policies behind privileges); Smith, *supra* note 44, at 546-49 (asserting the importance of protecting confidentiality through a privilege).

359. See Smith, *supra* note 44, at 546-49 (arguing that the psychotherapist-patient privilege is justified because psychotherapy information is more sensitive than medical information and psychotherapy usually relies more on free self disclosure).

era, but will be available to others. Not only will the information elicited at trial be disclosed, but considerably more information will be revealed during the discovery process. The breadth of discovery in civil cases leaves little information about the mental health of the patient beyond inspection.<sup>360</sup> Additionally, discovery is not limited to information held by the mental health professional against whom the malpractice case is filed. The plaintiff's mental condition before seeing the professional may be relevant to determine whether malpractice caused the injury. Therefore, much of the information from prior psychotherapy is probably relevant and discoverable. Furthermore, the mental health and treatment of the patient subsequent to any malpractice is usually relevant to the question of damages, so information from that subsequent treatment probably will be discoverable. Thus, virtually the entire mental health history of the plaintiff may be revealed during the mental health malpractice case.<sup>361</sup>

The foregoing discussion illustrates the difficulty facing an injured patient who has been harmed by a therapist's actionable breach of confidentiality. To pursue such legal claims, plaintiffs must undertake lawsuits which will inevitably require that they publicly reveal considerably more about their emotional conditions than their negligent therapists ever revealed. Thus, ironically, the patients' lawsuits probably will exacerbate the very harm for which they seek compensation.

Psychotherapist-patient privileges<sup>362</sup> will not protect the patient's sensitive information during a malpractice case. The patient-litigant exception<sup>363</sup> destroys the privilege because the plain-

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360. See Slovenko, *supra* note 44, at 649. The very nature of discovery is to allow fishing expeditions to determine what information may be relevant at trial. The discovery process, therefore, results in the examination of much more information than will be actually used at trial. See *id.* It is often very difficult to ensure that information requested in discovery is relevant until after it has been released to the opposing party. See *id.* Thus, the discovery exceptions to the privilege have left little or no protection for the psychotherapist-patient relationship. *Id.*

361. *Id.*; See Smith, *supra* note 43, at 52.

362. The psychotherapist-patient privilege allows patients to avoid judicial disclosure of their communications with psychotherapists. Smith, *supra* note 44, at 515. Almost all psychotherapist-patient privileges are statutory, although a few have constitutional or common law bases. Smith, *supra* note 314, at 158-61.

363. A patient waives the patient-litigant privilege when she brings her own mental condition into question. Smith, *supra* note 43, at 52-53. Courts have universally accepted the exception to avoid the unfairness of allowing a person who raises mental condition questions to hide behind the privilege in order to prevent opposing parties from obtaining the information necessary to challenge the claims. *Id.*

tiff brings his or her own mental conditions into question by filing the suit.<sup>364</sup> While there has been an interesting proposal to limit the patient-litigant exception to clearly relevant information revealed in therapy,<sup>365</sup> it has not been adopted. Thus, a potential malpractice plaintiff faces the unhappy choice of giving up a potentially legitimate claim for damages or agreeing to reveal large amounts of very sensitive personal information.

Plaintiffs who bring mental health malpractice claims often must relive publicly their most troubling experiences. Like the rape victim who is forced to confront the attacker, describe publicly the experience, and (in days past) disclose prior sexual history,<sup>366</sup> injured mental health malpractice plaintiffs must agree to have the most private aspects of their lives examined, explained, attacked, and viewed in public.<sup>367</sup> Furthermore, the plaintiffs who undertake this emotionally difficult process are people whose emotional difficulty and fragility probably caused them to seek psychotherapy in the first place.

Attorneys representing mental health plaintiffs often appear insensitive to the harm and pain that vigorously pursuing a mental health claim may cause the plaintiff. The plaintiff may be harmed by the emotional stress of prolonged proceedings, the release of private information, and the need to confront a formerly inti-

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364. In a few mental health malpractice situations the patient-litigant exception would not necessarily result in the waiver of the psychotherapist-patient privilege. Generally, waiver would not occur when someone other than the patient was injured, notably in *Tarasoff*-type cases. In those instances, the opposing party may still be able to obtain the therapy information, if, for example, the patient waived the privilege, or the state recognized a future crime exception to the privilege. See Note, *The Future Crime or Dangerousness Exceptions to Communications Privileges*, 77 HARV. L. REV. 730, 733 (1964); Note, *Psychiatrist-Patient Privilege: A Need for the Retention of the Future Crime Exception*, 52 IOWA L. REV. 1170, 1182-85 (1967).

365. See *Caesar v. Mountanos*, 542 F.2d 1064, 1075 (9th Cir. 1976) (Hufstedler, J. concurring and dissenting), cert. denied, 430 U.S. 954 (1977). Judge Hufstedler suggested that to avoid unnecessary invasions of privacy, the patient-litigant exception should be limited to permitting the opposing party to discover the time, length, cost and ultimate diagnosis of treatment. The discovering party could then obtain additional information only if by demonstrating a compelling need for it. *Id.*

366. See generally S. KATZ & M. MAZUR, UNDERSTANDING THE RAPE VICTIM 198-99 (1979); Berger, *Man's Trial, Woman's Tribulation: Rape Cases in the Courtroom*, 77 COLUM. L. REV. 1, 14-15 (1977); Tanford & Bocchino, *Rape Victim Shield Laws and the Sixth Amendment*, 128 U. PA. L. REV. 544, 548 (1980).

367. The patient will probably be required to confront the therapist, in whom great trust was placed and who had an emotional intimacy with the patient. The patient will have to reveal the details of that relationship. Furthermore, the patient may also be required to detail prior mental health history.

mately trusted mental health professional. The standard personal injury approach may promote the legal interests of the plaintiff in a technical sense while seriously harming the person's general welfare. In many cases, the overall interests of clients may be better served with a little less legal due process in exchange for a faster and less public resolution of mental health disputes. Mental health malpractice litigation does not produce a sense of justice and compassion, nor is it consistent with the goals and values of the mental health or legal professions.

In addition to the special problems of patient confidentiality, the mental health malpractice system poses a number of other difficulties. These include establishing the appropriate standard of care, determining causation, and accurately assessing damages.<sup>368</sup> These problems mean that a wide range of evidence may be relevant or necessary. In addition, expert testimony is a complication because the various approaches and schools of thought result in widely divergent expert opinions.<sup>369</sup> Lay juries, therefore, are asked to make extremely complex mental health decisions based on bewildering advice and testimony regarding the cause and extent of emotional harm.

### B. Reform Proposals

In addressing problems with the current system of health care malpractice, commentators have suggested creative reforms ranging from technical improvements in the current system<sup>370</sup> to major changes that include no fault.<sup>371</sup> Even major reforms would resolve

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368. Refer to notes 23-31 *supra* and accompanying text.

369. Smith, *supra* note 314, at 150.

370. See, e.g., Danzon, *Contingent Fees for Personal Injury Litigation*, 14 *BELL J. ECON.* 213 (1983); Wexler & Schopp, *How and When to Correct for Juror Hindsight Bias in Mental Health Malpractice Litigation: Some Preliminary Observations*, 7 *BEHAV. SCI. & L.* 485, 501-04 (1989) (suggesting changes to correct juror hindsight bias).

371. See, e.g., Epstein, *Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services*, 49 *LAW & CONTEMP. PROBS.* 201, 201 (1986) (discussing contractual allocation of medical malpractice risks between doctor and patient); Herzog, *The Reform of Medical Liability: Tort Law or Insurance?*, 38 *AM. J. COMP. L.* 99, 107-13 (1990) (reviewing "radical" proposals for change); O'Connell, *Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 *LAW & CONTEMP. PROBS.* 125, 127 (1986) (recommending a no fault system through legislative and contractual reform); Starr, *The No-Fault Alternative to Medical Malpractice Litigation: Compensation, Deterrence and Viability Aspects of a Patient Compensation Scheme*, 20 *TEX. TECH L. REV.* 803, 826-37 (modification of the current system is more desirable than a no-fault system); Tancredi, *Designing a No-Fault Alternative*, 49 *LAW & CONTEMP. PROBS.*

only some of the problems with the current system. Fault-based systems require some way of determining a standard of care as well as causation and damages.<sup>372</sup>

No fault, strict liability, and the like eliminate fault determinations, but they still are causation-based and therefore require that compensable events be identified.<sup>373</sup> Because the major advantage of these programs is the reduction in transaction costs, the compensable events must be capable of easy determination. Establishing causation, however, is a major problem in many mental health cases. Determining when injuries are caused by an automobile accident is relatively easy; when they are caused by medical care, more difficult; when they are caused by mental health care, extremely difficult. Since almost all reform proposals are causation-based, the substantial transaction costs in mental health cases would remain because of the difficulty in determining causation and damages.<sup>374</sup> Furthermore, most reforms would not protect plaintiff's privacy in a mental health malpractice action.

Other reform proposals regarding damages in personal injury (particularly malpractice) cases have included placing caps on total damages or noneconomic damages, establishing schedules of damages for specific injuries as in workers' compensation, and reducing damages by providing offsets against actual damages (*e.g.*, by elim-

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277, 285-86 (1986) (advocating a no-fault system).

372. Fault systems require that the trier of fact determine whether the party causing an injurious event was at fault. In negligence this determination is that of duty and breach.

373. No fault and strict liability relieve the trier of fact from determining whether one party or another breached a standard of care (*i.e.*, was at fault). However, the fact that someone did not come out of treatment "well" or "whole" does not mean that the patient should receive compensation. Only if the treatment *caused* the injury does the patient receive compensation. Thus, causation must be established to determine whether there has been a compensable event.

374. A no fault plan or other causation based system depends on the presence of some clear event that triggers payment. The purpose of such a system is to eliminate expensive arguments over whether the injury resulted from fault. However, it is meant to compensate injuries *caused* by an activity (*e.g.*, driving a car, medical treatment or psychotherapy). Compensation is intended not for every broken arm that someone who drives a car suffers, only those broken arms caused by car accidents. Similarly, a mental health no fault system is not designed to cover all neurotic reactions, only those that are caused by the therapy. The difficulty is determining whether therapy caused certain injuries. *See generally* Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 616 (1973) (arguing that no fault automobile insurance in the field of medical malpractice would not lower transaction costs). Although there have been a number of creative efforts to solve this it remains a problem. *See, e.g.*, ABA COMM'N ON MEDICAL PROFESSIONAL LIABILITY, *DESIGNED COMPENSABLE EVENT SYSTEM: A FEASIBILITY STUDY* (1979).

inating the collateral source rule).<sup>375</sup> Other reforms proposed by commentators aim to reduce malpractice claims by making it more difficult for plaintiffs to have the substance of their claims heard.<sup>376</sup> Still other proposals seek to eliminate *res ipsa loquitur* and redefine informed consent and are largely ineffective efforts to reduce successful claims under the mistaken belief that these legal doctrines are responsible for significant liability.<sup>377</sup>

Some reformers would change the decision maker in malpractice cases by replacing the jury with judges, administrative panels, "blue ribbon" (or expert) juries, or arbitrators.<sup>378</sup> These proposals differ from the other proposed reforms in that they do not necessarily seek to change the substantive law of liability and damages. The reforms reflect dissatisfaction in several areas: concern about asking lay jurors to resolve difficult medical, scientific, and professional questions; a feeling that jurors' sympathy for the plaintiff results in unfair findings of liability and excessive damages; and a fear that expert witnesses may easily mislead lay juries.<sup>379</sup> In mental health cases, such concerns are particularly great because the mental health sciences are so imprecise that jurors are left con-

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375. See generally Ingber, *Rethinking Intangible Injuries: A Focus on Remedy*, 73 CALIF. L. REV. 772, 809 (1985) (proposal for allowing general damages only to punish the morally blameworthy or to encourage primary cost avoidance); Johnson, Phillips, Orentlicher & Hatlie, *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1367 (1989) (discussing the AMA proposal for reforming malpractice also endorsed by the American Psychiatric Association and other groups).

376. See Robinson, *supra* note 355, at 21-23 (recommending that courts limit or eliminate the discovery rule to limit the statute of limitations).

377. See generally Bovbjerg, *supra* note 355, at 511-55 (reviewing the various reform efforts); U.S. GOV'T GEN. ACCT. OFF., *supra* note 248, at 2-5 (considering several reform efforts); Robinson, *supra* note 355, at 19-31 (reviewing what reforms of the 1970's accomplished).

378. See, e.g., Daughtrey & Smith, *Medical Malpractice Review Panels in Operation in Virginia*, 19 U. RICH. L. REV. 273, 274-75 (1985) (discussing medical screening panels in Virginia); Ladimer, Solomon & Mulvihill, *Experience in Medical Malpractice Arbitration*, 2 J. LEGAL MED. 433, 434-35 (1981) (analyzing arbitration of medical malpractice claims); Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 GEO. WASH. L. REV. 181, 239-52 (1990) (supporting modified panels and suggesting a statute to eliminate defects in existing plans); cf. Soble, *A Proposal for the Administrative Compensation of Victims of Toxic Substance Pollution: A Model Act*, 14 HARV. J. ON LEGIS. 683, 687 (1977) (proposing a Model Act to compensate victims of toxic pollution outside the present tort law system).

379. See U.S. DEP'T OF JUSTICE, REPORT OF THE POLICY WORKING GROUP ON THE CAUSES, EXTENT AND POLICY IMPLICATIONS OF THE CURRENT CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY 63 (1986); Franklin, *Replacing the Negligence Lottery: Compensation and Selective Reimbursement*, 53 VA. L. REV. 774, 778 (1967).

fused by the range of testimony.

### C. Reforms for the 1990s

A just and compassionate system to review mental health malpractice claims should strive to (1) increase protection of patient privacy; (2) conclude claims more quickly and efficiently; (3) promote consistent and predictable resolution of claims; (4) assure that decisions conform to announced legal principles and the best available science; and (5) encourage mental health practitioners to engage in high quality and ethical practice. The current system of public trials clearly does not succeed in meeting these goals in many cases. Because of the problems of the civil trial system in mental health malpractice cases, optional forums such as investigative panels and binding arbitration should be available to the injured mental health patient.<sup>380</sup>

Some potential malpractice claims could be handled more appropriately if the professions themselves took more active responsibility for helping to compensate those who are injured.<sup>380.1</sup> The professions might establish professional compensation funds to which those injured by the serious misconduct of a member of the profession could apply for assistance.<sup>381</sup> An interdisciplinary panel composed of mental health professionals, attorneys, and others would investigate cases and then determine what compensation or restitution was appropriate.<sup>382</sup> Such an approach is distinguished

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380. See, e.g., Franklin, *supra* note 379, at 778 (arguing that the current system amounts to an immoral lottery and suggesting a system of nonscheduled social insurance and selective reimbursement).

380.1 For a review of using alternatives to litigation to resolve health care malpractice, see Note, *Health Care Providers and Alternative Dispute Resolution: Needed Medicine to Combat Medical Malpractice Claims*, 4 J. DISPUTE RESOLUTION 65 (1988).

381. The AMA and American Psychiatric Association have endorsed a plan to move malpractice claims to an administrative agency somewhat like the panel this article proposes. See Johnson, Phillips, Orentlichner & Hattie, *supra* note 375, at 1367, 1379. A critical difference is the AMA proposal would preclude a patient from taking a claim to court. *Id.* The patient's option to choose the panel *instead* of the court is of central importance to the plan suggested in this article.

382. Each panel would have to have at least one mental health professional to help interpret the scientific data and an attorney to help ensure that the law is understood and followed by the panel. Obviously, creating a cadre of mental health professionals who would have the confidence of patients would be critical. Patients should be allowed to strike unacceptable professionals from the panel. A third member of the team might be a patient advocate to remove concern that the mental health professional would have a no-liability, low damages bias.

from other proposals that would make such panels mandatory.<sup>383</sup> This proposal is to use panels solely at the option of the plaintiff for the same reasons that the confidentiality of therapy exists at the option of the patient—it is the patient's personal information that requires protection.

Ideally, patients should not be required to have attorneys request that a panel undertake an investigation and payment of a legitimate claim. In addition, such claims and the information discovered in the investigations would remain confidential. This process would permit injured patients the option of seeing compensation without having to resort to the tort system. They could exercise this option any time before trial. Such professional compensation funds could operate as a voluntary function of the profession or, in the alternative, as a required part of the licensing process. Because mental health cases pose such great risks to personal privacy, a stronger argument exists for patients to have the option of choosing such panels in mental health cases than in any other area of litigation.

The funding for such programs could be established in several ways. A fee paid as part of licensure or membership in a professional organization would be one way. Another option would be to tie the compensation to the malpractice system and fund it through the malpractice carriers. Under this approach, the patient who opted to accept an award from the fund would do so in lieu of other malpractice recovery for the injury. Any recovery against a practitioner could be satisfied with insurance payments (or personal assets). The fund should also cover uninsured and judgment-proof practitioners.

Unless the profession voluntarily decided to permit a more generous standard for recovery, substantive tort law would be used. However, the method of investigating and proving negligence, causation, and damages would vary considerably from the current system. The system would protect patient confidentiality and, at the same time, work more quickly and efficiently. It should also be able to apply the best available science in resolving cases.

Mental health patients should also have binding arbitration available as an additional nonjudicial option with which to pursue mental health malpractice claims. Thus, as a matter of legal right,

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383. See, e.g., Johnson, Phillips, Orentlicher & Hattie, *supra* note 375, at 1379 (proposing mandatory panel for deciding malpractice claims).

injured patients would have the option (again, even over the objections of the mental health professional) of either binding arbitration or the special investigative panel described above as an alternative to a civil lawsuit against mental health professionals. No mental health professional or institution would be permitted to require that a patient agree, prior to an injury, to use the panel to resolve any claims or to enter into a binding contract limiting the patient's choice of forum. The arbitration panel would follow the rules of the American Arbitration Association (AAA) and apply substantive tort law;<sup>384</sup> the investigative panel would follow the approach outlined above. In either case, all parties would be required to maintain the confidentiality of the patient and of the proceedings. Arbitration is essentially an adversarial system, so most patients would need attorneys to represent them. Furthermore, presumably some limited discovery process would be required. Either approach should move comparably more quickly and efficiently and make better use of mental health science than does the current malpractice system.

Neither malpractice arbitration nor an investigative panel is an original concept,<sup>385</sup> but the argument for using them in mental health malpractice cases is particularly compelling because of the extraordinary need to protect patient privacy in those cases. The absolutely voluntary option given to the plaintiff to choose arbitration, investigative panel, or civil trial is a critical aspect of the proposal.

Despite the protection the proposal would give patient privacy, a number of objections could be raised to it. It removes cases from the sunshine of public view, bypasses the jury, compromises the right to appeal, and puts too much trust in the professions to "guard the hen house."<sup>386</sup> In addition, some commentators might

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384. Heintz, *Medical Malpractice Arbitration: A Viable Alternative*, 34 *ARB. J.* 12, 13-14 (1979) (reviewing Southern California Arbitration Project); Ladimer, Solomon & Mulvihill, *supra* note 378, at 444-47 (reviewing closed case analysis conducted by the Research Institute of the AAA); Note, *Arbitration: An Antidote to New York's Medical Malpractice Crisis* 11 *Vt. L. Rev.* 577, 585-86 (1986) (reviewing New York's Medical Malpractice Panel); Note, *Health Care Providers and Alternative Dispute Resolution: Needed Medicine to Combat Medical Malpractice Claims*, 4 *J. DISPUTE RES.* 65 (1988).

385. Refer to note 378 *supra* and accompanying text.

386. See S. GROSS, *OF FOXES AND HENHOUSES: LICENSING AND THE HEALTH PROFESSIONS* 14-15 (1984) (claiming that professional self-licensing has caused subversion of public interests). The same fear could be raised to the investigative and arbitration panels if they were controlled excessively by mental health professionals.

suggest the following: That the panels are less likely to be sympathetic to plaintiffs; that they would not work well for some mental health malpractice cases (such as faulty test development and *Tarasoff*-type cases in which the plaintiff is not the patient); that plaintiffs should have their days in court; that no plaintiff would choose these options; and that all of the options are the plaintiff's while the defendant has none.<sup>387</sup>

It is true that these proposals would remove some cases from public view. Indeed, the primary purpose is to resolve claims while protecting the privacy of the patient.<sup>388</sup> However, the usual civil trial remains available for the plaintiff who prefers to be heard in public. A large number of cases in the labor and commercial areas are considered confidentially in arbitration, and many other cases are negotiated to settlement outside public view and scrutiny. A narrow confidentiality exception legitimately should be made to allow reporting to licensing and credentialing authorities; this would help remove the incompetent and unethical therapists from practice.<sup>389</sup> The right to appeal is commonly limited in arbitration cases to help promote the goals of quick and confidential resolution of disputes, and this has not created impossible obstacles.

While the jury has many advantages, in the complex areas of establishing standards of mental health care, causation, and damages, experts may have considerable advantage over juries.<sup>390</sup> Additionally, plaintiffs who believe that their cases were not appropriate for an arbitration or investigation panel would utilize the usual civil jury system. At the same time, those plaintiffs who do not

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387. See, e.g., Interview with Thomas Demetrio (1988), reprinted in A.B.A. J, Mar. 1988, at 49 (comments by a noted trial lawyer discussing the reluctance of the plaintiffs' bar to embrace alternative malpractice approaches).

388. Refer to notes 43-46 *supra* and accompanying text.

389. Patients and patients' rights advocates increasingly have voiced concern about the need to identify and remove incompetent practitioners. Central registries of disciplinary actions by institutions, license suspensions and revocations, and malpractice claims may prove to be important tools for improving identification and removal efforts. The optional panels suggested here should have the authority to report the outcome of any hearing because the panels would use fault concepts. If the funds paid to plaintiffs were tied to malpractice insurance, those payments would certainly be reportable.

390. Experts are likely to be able to consider more carefully the content of scientific evidence, and as well as identify any claim or testimony that exceeds the bounds of good science. Experts, however, may be too sympathetic toward the fellow professional ("There, but for the grace of God, go I"). Moreover, the expert as decision maker may impose his own school of thought on any controversies. Selection of the experts who make up the panels, and clear statements of their obligations and of the law, therefore, would be critical. The presence of an attorney on the panels would also help with these problems.

want their "day in court" because it is too public should not be required to have it, they should have a less public option. The option may incidentally benefit mental health professionals who would prefer that any malpractice claims against them be handled as quietly and quickly as possible.

The conventional wisdom suggests that panels and arbitrators are less sympathetic to plaintiffs, or at least give lower awards, than juries. Although plaintiffs as a group have not done that well in jury trials in mental health cases,<sup>391</sup> it is probably true that in some cases (particularly where there has been outrageous conduct or grievous injury) juries may give higher awards. In those cases, plaintiffs could choose the usual civil jury trial. More importantly, however, plaintiffs could rationally choose a nonjury option even assuming it meant the possibility of a lower award. The benefits of maintaining the privacy of their mental health information and the ability to quickly conclude the claim in a less threatening environment may well outweigh the chance of a higher economic award. Furthermore, from the plaintiff's perspective, the efficiencies of the options may reduce the total costs of pursuing a claim and offset some of the possible economic disadvantages of the informal mechanism.

Conventional wisdom often causes plaintiffs' attorneys to object to nonjury determinations of liability and damages. They might, therefore, be expected to advise many plaintiffs not to opt for the arbitration or investigative panel. However, in mental health cases, this may be bad advice in light of the *total* interests of the plaintiff, as opposed to the plaintiff's interest in wringing every last dollar out of a case. As a sophisticated mental health bar develops, perhaps it will become more sensitive to the harm that mental health malpractice plaintiffs can suffer from the process of preparing for and going through a regular public trial.

The optional arbitration and investigative panels are important beyond the protection of confidentiality that they can provide. They also allow informal procedures and rules of evidence, more sophisticated use of expert witnesses (including experts not appointed by either party),<sup>392</sup> and the efficiency and speed noted

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391. See, e.g., J. ROBERTSON, *supra* note 7, at 5 (maintaining that the majority of mental health malpractice claims result in favorable verdicts for the defendant).

392. The more effective use of expert witnesses and the reduction in the use of marginal scientific evidence could be a very significant advantage for these panels. While federal courts may appoint "impartial" experts (FED. R. EVID. 706), they seldom exercise this power.

above. Because they are optional with the patient any time before trial, they should avoid many of the constitutional difficulties that have developed with medical malpractice reforms.<sup>393</sup>

In all likelihood, these optional forums would not effect significantly the goal of improving the quality of mental health practice. The deterrent effect of the tort law in malpractice cases probably would not be changed greatly.<sup>394</sup> Other efforts to improve the quality of professional services will be essential.<sup>395</sup> Like all professions, the mental health professions could reduce the number and severity of injuries if the licensing and credentialing processes were used more effectively to detect and eliminate the unethical and incompetent practitioners. Ultimately, significant reductions in injuries from therapy will depend on determining what kinds of therapy are effective for what conditions, and which practitioners are adequately trained and qualified to provide the services they render.

## IX. CONCLUSION

The last two decades have seen significant increases in numbers and size of malpractice claims against mental health practitioners and the institutions in which they work. Indications are that this trend will continue during the 1990s as the standard of care in the mental health professions is more carefully defined, as research helps identify the causes of some emotional harm, and as a sophisticated mental health bar develops.

The real challenge for the next decade is to find ways of avoiding the serious problems that the current torts system presents in considering mental health malpractice cases. Giving injured pa-

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T. WILLING, COURT-APPOINTED EXPERTS (1986) (Federal Judicial Center paper).

393. Refer to note 248 *supra*.

394. Obviously malpractice litigation affects professional practice. "Defensive medicine", for instance, is one such negative effect. Because the optional panels are based on the current fault concepts, they should not alter the deterrent effects of the present system. See generally Brown & Rayne, *Some Ethical Considerations in Defensive Psychiatry: A Case Study*, 59 AM. J. ORTHOPSYCHIATRY 534, 534 (1989) (discussing how professional self protection frequently motivates a psychiatrist's involuntary commitment decisions).

395. The current system of compensation is not sufficient by itself to significantly improve the quality of care. See Brook, Brutoco & Williams, *The Relationship Between Medical Malpractice and Quality of Care*, 1975 DUKE L.J. 1197, 1203; Pierce, *Encouraging Safety: The Limits of Tort Law and Government Regulation*, 33 VAND. L. REV. 1281, 1283 (1980); Shavell, *Theoretical Issues in Medical Malpractice*, in *THE ECONOMICS OF MEDICAL MALPRACTICE* 35, 49 (S. Rottenberg ed. 1978).

tients the options of using binding arbitration or an investigative panel instead of the current public civil trial would allow them to pursue legitimate claims while preserving the confidentiality of very private information from therapy. The panels would be composed of interdisciplinary teams of mental health professionals and attorneys. They would use substantive tort law, but be free to follow a more informal procedure. The optional panels would also provide the opportunity to more quickly review malpractice claims. Only if plaintiffs have the option to pursue mental health malpractice claims in a nonpublic forum will the confidentiality of patients, long a hallmark of the mental health professions, be ensured.

APPENDIX  
Forms of Liability for Various Activities of Mental Health Practitioner

	Negli- gence	Informed Consent	Battery	False Impris- onment	Intentional Emotional Distress	Strict Liability	Defama- tion	Privacy Rights	§ 1983 Liability
Failure to prevent suicide	*								
Drug prescription	*	*	o			?			
Failure to react to dangerous patient (Tarasoff)	*								
Breach of confidentiality	*	o					o	*	o
Sexual contact with patient	*	o	o						o
Careless diagnosis or treatment	*								
Treatment without consent	*	*	o	o	?	?		?	*
Faulty test development	*	o			?		*	o	o
Employment screening	*	o					*	o	o
ECT	*	*	*	?	?	?			o
Failure to report child abuse	*					?			?
Psychosurgery	*	*	*			o			
Expert witness testimony	*		?	?	?				?
Forcible administration of drugs	*	o	*	o	?	?	o		o
Termination of therapy relationship	*	o							
Referral of patient	*	o							
Experimentation	*	*	*	?	*	?		o	?
Faulty civil commitment		o		*	o				o

\* = Areas of liability  
o = Possible liability  
? = Remote possibility of liability in narrow areas