Reviewing Medical Malpractice and Risk Management Issues

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Psychiatric Times August 2000, Vol. XVII, Issue 8

The practice of medicine has changed dramatically. Physicians find themselves working under financial and time constraints; in fewer personal, one-on-one doctor/patient relationships; and in more contractual arrangements with other physicians, health maintenance organizations and the public. The demands and realities of managed care have altered the traditional role of the physician. Communication has become more complex. The modern system of health care delivery often consists of a team of direct caregivers (including physicians, nurses and clinical support personnel), "physician-extenders," health care administrators, utilization reviewers, insurance organizations, and even researchers or public health officials. As a result, it is more difficult to guard the confidentiality of information. Further, record-keeping has changed with increased legislative and judicial regulation of the practice of medicine and rapid development in technology.

Yet, while doctors are increasingly burdened and find it harder to practice their craft, medical malpractice litigation has skyrocketed. Jury awards have become larger and, in many states, are easier to attain. Correspondingly, fees paid by most physicians for malpractice insurance have become excessive, forcing many to retreat from self-employment into solo or small group practices, or from the practice altogether.

The field of psychiatry has always been fraught with litigation danger, as evidenced by simply looking at the population that is served. Clearly, when a physician prescribes medication or performs invasive procedures, there is risk. This is especially true when dealing with suicidal or confused patients. Inevitably, a substantial number of affronted and/or injured patients find their way through the legal system in pursuit of redress. Moreover, the American public continues to view the health care system as overpriced, inefficient and in dire need of complete reform. Americans have also become frustrated with the often chaotic and seemingly irrational rules and regulations of managed care. These hostilities also find their way through the judicial system.

In this health care environment, proactive risk management is essential and is no longer a discourse for insurance professionals and hospital administrators. The identification of potential risk, its appropriate evaluation and strategic management is critical to a healthy medical practice. As the psychiatrist walks the high-wire in the practice of medicine today, risk management strategies must be applied (Melonas, 1999). Once a psychiatrist becomes a defendant in a malpractice lawsuit or receives a letter requesting treatment records from a plaintiff's attorney, it is usually too late to adequately prepare a proper response.

This article will attempt to touch upon the most common and widespread psychiatric malpractice liability concerns in everyday practice: standard of care, record-keeping, confidentiality versus the duty to warn and shared treatment. (*The prominence of these issues is taken from the experience of Mr. Rychik, a New York attorney specializing in the defense of psychiatric malpractice claims-Ed.*)

The Standard of Care

A physician's duty of care is the level acceptable in the professional community in which they practice (*Schrempf v State of New York*, 1985). A physician is not required to achieve success in every case and cannot be held liable for mere errors in professional judgment (*Schrempf v State of New York*, 1985). Courts have recognized this professional judgment rule and have applied it more commonly in cases involving psychiatric treatment (*Topel v Long Island Jewish Med. Center*, 1981). *Schrempf v State of New York* (1985) stated: "Psychiatry is not an exact science, decisions with respect to the proper course of treatment often involve a calculated risk and disagreement among experts as to whether the risk was warranted or in accord with accepted principles." Thus, if a "psychiatrist chooses a course of treatment, within a range of medically accepted choices, for a patient after a proper

examination and evaluation, the doctrine of professional medical judgment will insulate such psychiatrists from liability [*O'Sullivan v Presbyterian Hospital*, 1995]."

To impose liability, a plaintiff must show that a psychiatrist's decision was "something less than a professional medical determination" (*Darren v Safier*, 1994; *Vera v Beth Israel Medical Center*, 1990; *Wilson v State*, 1985). Just because experts disagree with a psychiatrist's conclusions does not necessarily mean there is enough to find liability. At most, this represents a difference of opinion, not culpability for the patient's injuries (*Darren v Safier*, 1994; *Mohan v Westchester County Medical Center*, 1988).

A physician has always been allowed to refuse to accept a patient for any reason; once a patient is accepted, however, the physician owes the patient the same standard of care irrespective of financial resources (*Frank v Kizer*, 1989; *Tunkl v Regents of University of California*, 1963). Physicians must deliver the same degree of skill and care irrespective of managed care constraints (*Milano v Freed*, 1995; Packer, 1996; *Wickline v State*, 1986). As in a general negligence claim, a plaintiff in a medical malpractice action must prove the elements of duty, breach of duty, causation and damages (*Bleiler v Bodnar*, 1985; *Milano v Freed*, 1995).

Keeping Records

The duty to keep records regarding patients' treatments is well-grounded in tradition and law. Indeed, where patients are seen by many different providers, the quality of care is enhanced by thorough notes contained in the charts, providing a basis for future treatment (*MacDonald v Clinger*, 1982).

State regulations require medical records to be maintained; the failure to comply may result in disciplinary measures such as suspension or revocation of the license to practice medicine. (For example, see Mass. Gen. Laws Ch. 111 §70 [1994]; 8 NYCRR §29.2: records must "accurately reflect the evaluation and treatment of the patients"; *Schwartz v Board of Regents of the University of the State of New York*, 1982, 89 A.D.2d 711, 453 N.Y.S.2d 836 [3d Dep't 1982]; Fla.Stat.Ann. §395.3015: "each hospitalýshall require the use of a system of problem-oriented medical records for its patients, which system shall include the following elements: basic client data collection; a listing of the patients' problems, the initial plan with therapeutic and diagnostic orders as appropriate for each problem identified and progress notes, including a discharge summary.")

In suicide cases in particular, the failure to record notes, observations and decisions may result in an inference that the treatment fell below the applicable standard of care (*Eaglin v Cook County Hospital*, 1992; *McNamara v Honeyman*, 1989; *Stepakoff v Kantar*, 1985). Therefore, it is important that diagnoses and a corresponding treatment plan be included for all patients (8 NYCRR §29.2; *Schwartz*, 1982).

For example, the standard for records in New York is whether the records are "objectively meaningful" (8 NYCRR §29.2; *Suslovich v New York State Education Department*, 1991). If not, the psychiatrist may be disciplined by the State Board and may also be subject to a medical malpractice suit (*Clausen v New York State Department of Health*, 1996; *DePaula v Sobol*, 1993).

Confidentiality

It is generally accepted that the relationship between the patient and a psychiatrist or psychotherapist is confidential, since confidentiality is vital to treatment efficacy. The legal duty to keep information confidential has been codified by statute and is applicable under federal law as well.

There are variations across states and exceptions to the rule regarding testimony (see District of Columbia Medical Health Information Act, D.C. Code Ann. §6-2001 *et seq.* [1989]; N.Y. Civ Prac. L. & R. §4504 as cited in McKinney's, 2000; Rule 501, Fed. R. Evid.: Illinois Mental Health & Developmental Disabilities Confidentiality Act, ILCS §740 ¶ 110 [1993]). Even outside the courtroom, there are circumstances under which a physician has a duty to disclose information about a patient. When a physician knows that the patient intends to commit a crime, the physician may have a duty to warn the intended victim. (See Mental Hygiene Law §33.13 [c][6]: providing that confidence can be breached to an endangered

individual and law enforcement agency when...[it] has determined that a patient or client presents a serious and imminent danger to that individual; *Tarasoff v Regents of the University of California*, 1976; *Cf MacDonald*, 446 N.Y.S.2d at 801: breach of confidence was not justified were there was no danger to spouse.) Similarly, in most states, a physician has a duty to report child abuse (e.g., *Hope v Landau*, 1986; *Storch v Silverman*, 1986).

Record-keeping has changed in recent years as a result of the shift toward managed care, increased legislative and judicial regulations of the practice of medicine, and technology developments. Often, there is more than one doctor treating a patient; similarly, teams are often responsible for the delivery of health care. There are quality reviews of medical decisions conducted by managed care personnel. Therefore, a patient's records may be accessed by many people. Computer technology has changed the way records are kept and transmitted to others as well. Information may be furnished to third-party preparers only when it is necessary and is strictly limited to the purpose involved.

A physician who agrees to treat a patient also agrees to keep in confidence all information divulged by the patient concerning the patient's mental and physical condition, as well as information learned by the physician in the course of treatment (*MacDonald v Clinger*, 1982; *Doe v Roe*, 1977). A patient's communication with a psychiatrist is deemed privileged and can only be waived by the patient (see Mental Health Hygiene Law §33.13 [c][6]). The duty to maintain confidence is not absolute, however, and there are situations where confidences can and should be breached. As already noted, where a psychiatrist believes that a patient poses a threat to another individual, the physician has a duty to warn that individual (*Tarasoff; MacDonald*).

The *Tarasoff* duty to warn the intended victim, notify the police or take steps necessary under the circumstances has not been uniformly applied across the states. Initially, the *Tarasoff* duty was held to be inapplicable where the victim was not identifiable; where there was reasonable belief that the patient would not pose a danger to the victim; and where the victim was already aware of the dangerous patient (*Wagshall v Wagshall*, 1989). If the identity of the intended victim was reasonably discoverable, however, liability has been found in the context of a psychotherapist-patient relationship. (For example, *Durflinger v Artiles*, 1983: family members were reasonably foreseeable targets of patient's violence; *Evans v Morehead Clinic*, 1988: potential victim identified only as "young man" but patient's family would have provided the identity if asked.)

The more recent trend is the imposition of liability in the absence of identifiable victims. For example, in *Schuster v Altenberg* (1988), the Wisconsin court held that a psychotherapist could be liable to unforeseen plaintiffs for failing to warn of the potentially harmful acts of the patient. In that case, the patient committed suicide in an automobile accident that injured members of his family. The court emphasized that the standard imposed on a psychotherapist is not one of omniscience, but the degree of skill that is exercised by the average practitioner in the field. The *Tarasoff* duty was recognized as a duty to protect, which may include such things as reassessment, medication change or hospitalization and is clearly not limited to the duty to warn (*Turner v Jordan*, 1987).

Under certain circumstances there are other exceptions to the privileges and confidential nature of treatment records: the patient has provided consent for disclosure of information (N.Y. Civ. Prac L & R §4504 [McKinney's, 1999]; American Psychiatric Association, 1993; New York Public Health Law §18); the patient has placed their physical or mental condition at issue in a litigation (*Arena v Saphier*, 1985; Cal Evid. Code §996, §1016); and mandatory state reporting statutes (e.g., New York Public Health Law §2782 as cited in McKinney's, 1999; Cal Evid. Code §1006-1026). These statutes deal with such concerns as AIDS/HIV-related information.

Shared Treatment

The numerous relationships in the provision of mental health care subject the psychiatrist to liability concerns. The relationships and the arrangements must be made crystal clear. Knowing the relative responsibilities and expectations, as well as ongoing communication among all parties, is critical for successful shared treatment that meets the standard of care (Sederer et al., 1998).

Generally, it is the physician who is considered to be the primary clinician in every conceivable shared relationship (*Connell v Hayden*, 1981; *Thomas v Intermedics Orthopedics Inc*., 1996). This assumption is buttressed by requirements that psychiatrists "sign-off" on cases, whether this refers to treatment plan, insurance claims or hospital discharge documents.

The legal system demands greater specificity than occurs in most clinical situations. The casual arrangement is ripe for liability risk. State licensing boards demarcate areas of responsibility and limitations of activities for professional disciplines (New York Education Law §6530, §33, 1999; New Jersey Statute, 1999; Cal. Bus. & Prof §3502; Illinois Medical Practice Act of 1987). Even though responsibilities are clearly stated in such licensing requirements, judges and juries are not always sufficiently persuaded by job descriptions and licensing requirements to forgive physicians involved in court cases.

Formal contractual relationships best serve those involved in shared treatment responsibilities. Consultation with an attorney who specializes in hold-harmless/indemnification and insurance-liability requirements is usually recommended.

Conclusion

The guiding principles for the psychiatric practitioner involve strict scrutiny of professional shared relationships, standard of care and confidential state statutes, careful records, and overall proactive risk management to avoid liability. Careful risk management today will help clinicians avoid the malpractice defense of tomorrow. Psychiatrists and other mental health care professionals should consult with an attorney and/or malpractice insurance professional at their earliest concern.

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