

Liability and Risk Management in Outpatient Psychotherapy Supervision

Patricia R. Recupero, JD, MD, and Samara E. Rainey, BA

Supervision of outpatient psychiatry residents plays the dual role of protecting the public by monitoring care and improving the educational experience of residents. The responsibility of supervisors may leave them vulnerable to liability under several legal theories. They may be vicariously liable for residents' negligence or may be directly liable for their own negligence in supervision or administration. Plaintiffs may bring claims alleging both vicarious and direct liability. There are particular risks with respect to residents' misconduct and liability to third parties, such as victims of a dangerous patient. Many of these legal issues are unsettled and may not apply to all situations. The authors discuss various risk-management techniques supervisors can use to mitigate risk.

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Supervisors of psychiatry residents play multiple roles in the improvement of mental health services: effective teaching of future psychiatrists; supervision of care; and protection of the public by ensuring that only qualified residents advance to positions of greater responsibility for patient care.¹ As one scholar has explained, “[I]nadequately trained persons are allowed to perform services on the theory that supervision will remedy any deficiencies” (Ref. 2, p 467). A patient harmed by a trainee or former trainee might sue the trainee's supervisor for actual or punitive damages.³ Other consequences of “negligent supervision” may include criminal charges or professional penalties, such as loss of employment or revocation of license. Such negative consequences, while uncommon, nonetheless provide strong incentives to reduce risk in outpatient psychotherapy supervision.

Plaintiffs in psychotherapy malpractice suits have several practical reasons to name supervisors as defendants in lawsuits arising out of resident negligence. Residents typically have limited assets with which to respond to a verdict against them.⁴ Similar to an award against a hospital, an award of damages against a supervisor may stand a better chance of reaching into deeper pockets. Supervisors' malprac-

tice insurance may cover supervision-related negligence, adding to what a plaintiff may recover from the resident's insurance. Residents' intentional torts or sexual misconduct may not be covered by their liability insurance,⁵ but a claim of supervisory error may access the supervisor's insurance coverage.

A nationwide survey by Schulte and colleagues⁶ of psychiatry residency training directors revealed that many training directors believe that supervisors are sufficiently aware of liability and accountability in supervision, but few training directors take steps to keep supervisors informed. The survey further revealed that patients are often unaware of a supervisor's identity. In response to these results, the authors of the survey offered practical suggestions for ways in which training programs could improve faculty awareness, documentation efforts, and trainee compliance. We propose additional suggestions for risk management in psychotherapy supervision, drawn from related case law, to help supervisors and training directors to develop their own risk-management practices.

Nearly all of the case law and scholarship on supervisor liability has occurred in the context of surgery, obstetrics, psychology, and social work. While there is a dearth of case law on supervisor liability in psychiatry, relevant cases from other mental health and medical fields may be instructive and can help underscore risks and elucidate theories of liability that might be used against outpatient psychotherapy supervisors of psychiatry residents. In this article, we

Dr. Recupero is Clinical Professor of Psychiatry, The Warren Alpert Medical School of Brown University, and President and Chief Executive Officer, Butler Hospital, Providence, RI. Ms. Rainey is a Paralegal and Research Assistant, Butler Hospital, Providence, RI. Address correspondence to: Patricia R. Recupero, JD, MD, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906. E-mail: patricia_recupero@brown.edu

draw on related research and case law from other treatment settings to help define legal theories of liability and relevant case law in the context of psychiatry, noting risks unique to supervisors of psychiatry residents. In the discussion, we also propose suggestions for minimizing risk in outpatient psychotherapy supervision.

Theories of Legal Liability

Vicarious Liability

Supervisors may be liable for residents' torts under the theory of *respondeat superior*. In a *respondeat superior* claim, a plaintiff is not required to establish the supervisor's direct involvement in the conduct that harmed the patient,⁷ but some type of employment or agency relationship is generally required. The owner of a practice may be held liable for the actions of an employee of the practice (such as a postdoctoral psychologist or a social worker providing therapy in a practice owned by the psychiatrist).² Liability associated with the supervision of psychology trainees and a full description of the principles of master/servant liability are well described by Dennis Saccuzzo in the *California Western Law Review*.³ However, a master/servant relationship is not typically the case for residents, and therefore, plaintiffs usually must prove something more than mere status as a supervisor *qua* employer, to hold the supervisor liable for the negligent treatment by the resident.

In outpatient psychotherapy supervision, the supervisor is not typically the resident's employer but provides supervision in the educational context. Supervision and clinical relationships can take many forms. The supervisor may be located at a remote site from the resident, providing instructional feedback and training without being directly involved in the administration of treatment. In such cases, the supervisor may be providing education without direct responsibility for actual clinical work and clinical decisions, while the administrators (not including the supervisor) of the practice at which the patient is registered have administrative responsibility. In such outpatient psychotherapy supervision, the primary doctor-patient relationship is between the resident and the patient, and a resident may decide to ignore the supervisor's recommendations. When such a dispute arises, the supervisor may not even have clinical privileges at the site where the patient is registered

and may bring concerns to the administrator of the practice where the patient is registered.

The risk of liability in outpatient psychotherapy supervision may also vary with the type of supervision in use. Indirect forms of supervision (e.g., video- and audiotape observation, chart review, and self-report) may carry less risk for supervisors than does direct supervision, such as contemporaneous or interactive supervision, because the supervisor has the immediate opportunity to intervene for the patient's well-being, as well as the ability to observe the actual nature of the exchange between the resident and the patient. In the self-report method, the supervisor's inability to monitor the therapy directly may limit the risks of the supervisor, who is removed from the situation. Conversely, the self-report method makes it easier for a trainee to conceal unethical conduct or to present negative experiences in a more positive light.² When self-report is the primary or only supervision technique used, supervisors may develop risk-management techniques, such as regular chart reviews for clinical and educational purposes. When it appears that a patient is not progressing, the supervision method may be supplemented or adjusted in type (e.g., readings, viewing master clinician tapes, developing skills by role playing, or escalating from indirect report to taped or live supervision).

When a tort is committed by a resident whose conduct the supervisor does not directly observe, a *respondeat superior* claim may still be possible under a claim of ostensible agency, if the patient reasonably believes that the resident is the employee or agent of the supervisor.⁶ Supervisors may educate patients and residents about the nature of the supervisory relationship and lack of agency. Although not required, a handout may be useful to inform patients about the supervisor's role and whom to contact if problems arise.⁸

Another factor courts may consider in determining vicarious liability is the existence of a financial arrangement. Enterprise liability may allow liability when a supervisor derives economic gain from the work of the resident. It may apply if the supervisor receives payment for the trainee's work. If a supervisor is employed by a hospital or by a medical school, vicarious liability may attach to the institution(s) rather than the supervisor, as the institution typically benefits directly from the supervision. However, if the supervisor is in private practice or receives payment for serving as an attending psychiatrist in a

resident clinic, enterprise liability may also apply, as the supervisor would be more likely to derive personal financial gain from the resident's services.

If a supervisor's name appears as the service provider on an invoice, the probability of liability is greater than if the supervisor receives payment indirectly, such as from a mutual employer. In addition, a supervisor who bills the patient or insurance company but fails to meet with the patient could face professional penalties, including suspension of his or her license.⁹ A bill for treatment should reflect the name of the individual who personally provided the treatment. Billing trainees for a portion of payments for supervised treatment could constitute fee-splitting and may be unethical, if not illegal.¹⁰

Direct Liability

Negligent Supervision

Supervisors may also be directly liable for their own negligent acts,¹¹ including negligent supervision. Negligent supervision includes failures such as not knowing what a resident is doing, not teaching, failing to meet with the resident as required, or failing to provide oversight. Direct liability claims against supervisors may be easier for plaintiffs to argue than is vicarious liability, as negligent supervision claims do not require an agency relationship. Supervisory negligence could be found if a supervisor: instructs a resident to do something that is contraindicated (e.g., inappropriately encourages prescription of addictive substances to a patient with a history of substance abuse); knows of a resident's error but fails to take corrective action; shows carelessness in monitoring the resident's work (e.g., neglects to review a patient's history to verify that a resident has taken a substance use history before prescribing potentially addictive substances); or fails to report concerns about a resident's conduct or competency to the appropriate administrative authority, such as the residency training director. Some patients may not be suitable for treatment by a resident, and some residents may be unfit to provide specific treatments. By allowing treatment by a resident only when clinically appropriate, the supervisor can improve care.

Negligent supervision and negligent education claims have been successful in other fields of medicine.¹² In *Morris v. Francisco*,¹³ a surgical resident seriously injured a young woman who subsequently sued the supervising physician for negligence “. . .in

failing to properly supervise [an inexperienced resident and]. . .in failing to properly identify and teach [the resident] the proper. . .method. . .” (Ref. 13, p 502). In psychotherapy supervision, a supervisor typically observes patient care, asks appropriate questions about the treatment, and follows up on resident reports. The Accreditation Council for Graduate Medical Education requires residents to maintain a record of clinical experience.¹⁴ Supervisors may consult this record to be sure that appropriate patients and experiences are noted. When a resident lacks appropriate training, the supervisor may compensate for any shortcomings in experience by filling in gaps in the resident's education. In treatments associated with increased risk, such as prescribing monoamine oxidase inhibitors (MAOIs), hypnosis, or amytal sodium interviews, supervisors should discuss and assess the resident's task-specific competence before the treatment.

Program directors, department chairs, and other supervising administrators often fulfill additional responsibilities to the institutions they serve, irrespective of personal legal liability. Negligent management of supervisory duties, such as a failure to investigate a complaint thoroughly, could result in hospital or clinic liability and significant losses, as occurred when a hospital administrator failed to respond appropriately to allegations of physician misconduct toward a psychiatric patient.¹⁵

Negligent Administration

Negligent administration relates to a supervisor's failure to follow statutory or program standards for supervision. Many residency training programs have rules regarding the required frequency, format, and duration of supervision sessions. Supervisors can ask for an official school or training program policy handbook to help clarify roles and responsibilities of supervisors (e.g., reporting concerns about misconduct). A supervisor may then communicate policies to the residents and follow through on their successful implementation. Documenting compliance with program standards may help reduce risk. Examples of administrative negligence could include failure to meet with the resident at the prescribed frequency, failure to review a resident's chart notes, or failure to use supervision time appropriately (e.g., discussing current events unrelated to the patient's care).

Supervisors may be responsible for knowing state laws and supervision requirements. While state laws

regulating the supervision of psychotherapists in training are often aimed at psychology³ and other mental health providers, the language of such legislation is often general and may in some cases apply to analogous supervisory relationships in psychiatry as well.² Similarly, actions taken by boards of psychology against psychotherapy supervisors, such as revocation¹⁶ or suspension⁹ of the supervisor's license, could be taken by state medical boards against psychiatrist supervisors. As one scholar has noted, supervisors can be "liable not only for their own negligence in failing to supervise adequately, but also for the actions of their supervisees" (Ref. 3, p 122). Guidance may be obtained through legal counsel, malpractice insurance companies, and regulatory authorities, such as licensing boards.¹⁷

Administrative negligence overlaps significantly with negligent supervision. Carelessness toward standards, such as a failure to be available, may constitute administrative or supervisory negligence. In *Mozingo v. Pitt County Memorial Hospital, Inc.*,¹⁸ a supervisor who was on call from home was found liable when he failed to arrive at the hospital within the required time frame to prevent injury to a newborn after supervisees called requesting assistance. Psychotherapy supervisors may owe a similar duty toward patients treated by residents. If the senior psychiatrist is unavailable when a crisis arises, he or she may be liable for a breach of duty to the patient or for a breach of policy for failing to respond in time. When unavailable, supervisors often arrange for "backup" coverage of their supervisory duties.

If a psychiatrist holds the administrative responsibility for supervision of residents (e.g., as a residency training director, service chief, or department chair), he or she could be held liable for failure to develop and enforce reasonable supervision policies. In *Maxwell v. Cole*,¹⁹ the court held that the duty to supervise and regulate supervision forms the basis for a patient's right to sue a department chair for ". . . his failure to adequately supervise the resident staff and to provide rules and regulations for the resident staff as to the necessity in certain circumstances to seek prompt consultation with attending physicians" (Ref. 19, p. 1001). If a resident deals improperly with a violent patient's escalating aggression and the patient seriously injures another, the residency training director may be liable, for example, for failing to ensure that residents are taught appropriate proce-

dures for de-escalation and management of dangerous situations.

Administrators may also be expected to develop written policies for supervision and to communicate these policies to individual supervisors. A written policy may also include requirements and standards for competency testing and supervision.²⁰ Because courts have held that evaluation reports of a resident's skills may guide the level of supervision appropriate for the resident,²¹ supervisors might consult residents' evaluations or confer with program directors when deciding on supervision methods. Policies often implement guidelines and recommendations made by professional organizations, such as the Accreditation Council for Graduate Medical Education (ACGME),¹⁴ the American Psychiatric Association (APA),¹⁰ and the American Medical Association (AMA). The ACGME calls for weekly meetings, and program directors are expected to notify supervisors and trainees of these requirements; a supervisor may be administratively negligent if he or she does not report that a resident failed to attend a scheduled meeting. A well-run program with structured supervision guidelines is likely to carry less risk than one characterized by unclear or poorly communicated standards. To minimize risk, policies should be well documented and agreed on by all who enter into supervisory relationships.

Sexual Misconduct Claims and Intentional Tort Liability

Many lawsuits brought by patients in mental health treatment are based on misconduct of caregivers.^{15,16,22,23} Most misconduct claims in psychotherapy will fall into one of two categories: claims for sexual misconduct and intentional torts. While sexual misconduct may seem a deliberate abuse of a patient or a conscious decision to transgress ethics boundaries and may therefore seem to be an intentional tort (and is sometimes argued as such), plaintiffs often characterize these claims as malpractice, arguing negligent mishandling of transference,^{22,24} boundary violations, or abandonment, to place the tort within the parameters of malpractice insurance.⁷ Some courts have held that employee therapists' sexual misconduct is a reasonably foreseeable risk of treatment or that it may be reasonably incidental to the course of treatment.²⁵ The Ninth Circuit, in *Simmons v. United States*,²⁶ upheld both a *respondeat superior* claim against the employer and a finding of

liability for negligent supervision against the social worker's supervisor for the social worker's sexual misconduct. The *respondeat superior* claim was predicated on the theory that the social worker had negligently mishandled transference. To lessen the likelihood of resident sexual misconduct, supervisors may instruct residents about appropriate treatment boundaries²⁷ and monitor for unusual circumstances, such as unusually long appointments and overly frequent appointments with a particular patient.

Supervisors monitor countertransference concerns and educate residents about appropriate boundaries and standards of professional conduct. Courts have cited a mishandling of transference when attempting to explain multiple egregious boundary violations by clinicians, including moving patients into the provider's home, inciting the patient to file spurious lawsuits, and encouraging the patient to steal from family members.²⁴ Such misconduct illuminates a wide range of unprofessional behavior that a supervisor might encounter in residents. Supervisors can explore why a resident behaves in a particular way with patients. In an *en banc* decision considering the employer's liability for the sexual misconduct of a psychologist, the Minnesota Supreme Court noted "that sexual relations between a psychologist and a patient is a well-known hazard. . ." (Ref. 28, p 311). The prudent supervisor, aware of this risk, may watch carefully for early-warning signs of boundary violations.^{29,30} Increased or unusual frequency of contact outside the usual therapy appointments (e.g., telephone calls and e-mails) is among the precursors to an unethical treatment relationship.

While sexual misconduct claims are among the most common torts in psychotherapy, intentional torts, such as battery³¹ and the tort of outrage,³² may also occur in a treatment setting. The tort of outrage, or intentional infliction of emotional distress,³³ refers to outrageous acts committed intentionally or recklessly, resulting in severe emotional distress to the victim. Courts have recognized that knowledge of an individual's particular vulnerability to emotional distress may factor into liability for intentional torts.³⁴ In *Anderson v. Prease*,³⁵ a physician was found liable for intentional infliction of emotional distress when he cursed at his patient and screamed at her to leave his office. In deciding *Anderson*, the court considered the fact that the physician must reason-

ably have known that his patient was emotionally vulnerable, as he had prescribed Valium for her on numerous occasions and had learned that she had a history of depression. A resident who insults or yells at a depressed, insecure patient may be sued for the tort of outrage, and the resident's supervisor might be found liable if he or she knows of the resident's countertransference problems or emotional lability and fails to take appropriate action. Court decisions on *respondeat superior* claims vary significantly with respect to intentional torts. Generally, intentional torts, such as assaults or torts of outrage, are not actionable under *respondeat superior*, because the very nature of the act is beyond the scope of the perpetrator's employment.³⁶⁻³⁸ However, when *respondeat superior* does not apply, a plaintiff might argue an alternate claim, such as direct liability for negligent supervision. Psychotherapy supervisors can lessen risk by helping residents understand standards of proper conduct for psychiatrists and by remaining vigilant for countertransference or conduct-related problems.

If a supervisor receives a complaint of resident misconduct, the supervisor should consider promptly reporting the complaint to the appropriate administrative authority. In *Andrews v. United States*,³⁹ the Fourth Circuit Court of Appeals held that while the sexual seduction of a patient by a physician's assistant (PA) did not constitute action within the scope of the PA's employment, the doctor who had primary responsibility for supervising the PA was acting within the scope of his employment and was liable for damages when he negligently failed to respond appropriately to a complaint of sexual misconduct.³⁹ A supervisor may report such complaints to a higher administrative authority (e.g., training director or hospital/clinic official). The official can then conduct a proper investigation.

Liability to Third Parties

Supervisors may be liable not only to their residents' patients but also to known and unknown third parties. In *Garamella v. New York Medical College*,⁴⁰ a sexual molestation victim brought a complaint against the perpetrator's prior training analyst who was also an assistant professor in the residency program. The resident had confessed pedophilic impulses, but the psychiatrist failed to notify the reviewing committee that the resident was unfit for child psychiatry and failed to prevent the resident from

progressing through the residency program. When the trainee subsequently molested a child, the court held that the victim was within a class of foreseeable victims and that a supervising psychiatrist may owe such victims a duty of care. Arguably, the supervisory failures in *Garamella* were fourfold: failure to report that the resident was no longer in analysis; failure to report to the training program that the resident was dangerous to children; failure to report the same to the licensing board; and failure to report suspected child abuse. Because the psychiatrist in *Garamella* was also the resident's supervisor, liability was predicated on the fact that he could have intervened to prevent future harm by notifying the training program of the resident's dangerous propensities.

Residents and supervisors often address the possibility of harm to third parties by patients, such as in *Tarasoff v. Regents of the University of California*,⁴¹ where a named defendant was the psychiatrist responsible for supervising a psychologist. The supervisory errors of the psychiatrist in *Tarasoff* were potentially threefold: the supervisor failed to instruct the therapist to take action; the supervisor instructed the therapist to destroy his notes; and the supervisor had his own nondelegable duty to protect the foreseeable victim of a dangerous patient. Although the therapist (employee) acted appropriately, the supervisor's liability can be seen as both administrative negligence and personal liability. Supervisors may encounter potentially dangerous residents (as in *Garamella*) and potentially dangerous patients (as in *Tarasoff*) under a resident's care. In either situation, the senior psychiatrist should be prepared to take prompt, decisive action toward resolving problems, by limiting the treatment privileges of unqualified or impaired residents, by reporting concerns to program administrators (administrative liability avoidance), or by personally reporting threats of harm to known potential victims and appropriate authorities (personal liability avoidance).

Risk Management for Supervision

Informed consent can be an ideal process for educating and involving the patient in the decision to receive treatment from a resident, as many states require informed consent from patients for treatment by supervision, at least in the context of psychology assistants.³ The informed-consent discussion affords a supervisor (directly, or through the resident, or in a clinic brochure) the opportunity to advise the patient

of the nature of the supervisory relationship and to tell the patient that if any problem arises during the course of therapy, the patient may notify the supervisor so that appropriate action can be taken before harm results. Supervisors may also engage residents in an informed-consent process, to ensure that they understand the terms of the relationship and the program's and supervisor's expectations. Supervisors can record the resident's as well as the patient's understanding and agreement to the supervisory relationship. During the informed-consent discussion, the supervisor or resident may also obtain the patient's consent to being supervised and can document the patient's agreement to the arrangement, including disclosure of the supervisor's identity.

Supervisors may familiarize themselves with common areas of risk in psychiatry and develop practices designed to address these risks specifically. Supervision can also address patient-specific areas of risk, such as dangerous patients (e.g., how to screen for and deal with potentially suicidal or homicidal patients) or patients who do not respond well to conventional treatments. Some suggestions for risk management are noted in the Appendix. A higher level of supervision may be indicated for situations in which risk may be greater. For example, a supervisor may ask a resident to notify the supervisor immediately upon learning of a patient's new suicidal or homicidal ideation so that they may discuss the treatment. Treatment-resistant patients may benefit from less-commonly practiced treatment methods (e.g., MAOIs for selective serotonin reuptake inhibitors [SSRI]-resistant depression), but less-common treatments may also warrant increased supervision, particularly when the resident has had only limited experience in the chosen method.

Conclusions

We have sought to present several ways in which a supervisor can lessen risk. While many of the arguments are derived from cases in psychology and other areas of medicine, and while our risk-management suggestions are only speculative and may not apply in all situations, supervisors may nonetheless find them helpful in developing their own risk-management practices. Supervision is designed not only to improve trainee skills but also to protect patients. When supervision in practice falls short of these goals, unrecognized or uncorrected negligence or misconduct may lead to subsequent lawsuits.⁴² Liability may in-

crease as a supervisor's contact with the resident's patients increases and with the supervisor's increasingly direct compensation for treatment. Plaintiffs harmed by residents may bring multiple-pronged claims against psychotherapy supervisors, alleging direct and vicarious liability. The potential for direct liability increases significantly when a supervisor overlooks residents' needs for further training, fails to respond to allegations or complaints, fails to report concerns to administrators, or fails to document compliance with supervision requirements.

To mitigate risk, supervision can be tailored to the individual situation of a particular resident as well as the needs of the individual patient. By providing consistent, responsible supervision, supervisors not only help patients but also improve the educational experience and may lessen the risk of residents. The more supervision trainees receive, the more likely they are to prefer frequent supervision.⁴³ If a supervisor detects and responds appropriately to warning signs, she might thereby reduce the risk of serious adverse events and subsequent legal action. The Appendix offers some practical suggestions for supervisors of residents. Additional suggestions for improving risk management in psychotherapy supervision may be found in another article.⁶ These suggestions represent preliminary ideas and are not intended to be used as practice guidelines. Further discussion within the profession may be useful in codifying practice guidelines for supervision.

Appendix: Risk Management Suggestions for Psychotherapy Supervision

1. Be familiar with residency training program guidelines for supervision. Consider developing supervision guidelines or a supervision contract to use with residents.
2. When assigned a new resident to supervise, inquire of the residency training program if there are any special concerns about the particular resident. Reporting all serious concerns to the residency training director may mitigate the risk.
3. Follow up on complaints or concerns about a resident promptly and thoroughly. Documenting the steps taken to resolve the problem may reduce further risk.
4. Consider establishing policies for resident conduct during treatment and supervision and consider ways to ensure that residents understand these policies. Develop an informed-consent form for residents to sign, indicating that they understand what is expected of them.
5. Establishing boundary expectations for the therapeutic relationship might be helpful. Consider distributing an information sheet or a sheet of frequently asked questions (FAQ) to the patients of residents.

6. Establish and maintain appropriate supervision boundaries. Set guidelines for appropriate and inappropriate behavior and assure that residents understand and agree to these boundaries.

7. When the resident is providing therapy associated with increased risk (e.g., prescribing MAOIs or conducting hypnosis or amytal sodium interviews), check that the resident is competent in the therapy by referring to performance reviews and past experience. The less training and experience a resident has in a particular treatment, the more intensive supervision may be appropriate.

8. Consider instructing residents to tell patients that they are being treated by a resident under supervision and to document in the record that patients understand who holds the primary responsibility for their care.

9. Review charts of patients in treatment by residents periodically. Consider developing a schedule for chart review.

10. Establish regular hours for supervision, and adhere to them. Supervisors who must be unavailable for any reason during scheduled supervision hours should check that appropriate coverage is provided and that residents know whom to contact in an emergency. During supervision, be available to manage difficult situations in treatment; a phone call may be an insufficient form of supervision if a patient becomes acutely suicidal.

11. Consider establishing routine guidelines for residents related to the management of suicidal or violent patients. These patients may require a higher level of supervision, and some may not be suitable for treatment by residents. Consider establishing a policy for intervention in the event that a patient requires treatment by a more experienced psychiatrist.

12. When billing occurs in the supervisor's name, more comprehensive supervision and actual attendance at treatment may be needed.

13. Documenting all supervision sessions may lessen risk. Take notes, and encourage residents to take notes as well. Ask residents to develop reports or to keep a residency journal.

14. Determine whether the current malpractice insurance policy covers liability for psychotherapy supervision. If it does not, consider informing patients treated by residents of insurance concerns.

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