The Tort Liability of the Psychiatrist

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Psychiatry is defined as "a branch of medicine that deals with mental, emotional, or behavioral disorders."[1] Due to its very nature, psychiatric practice differs from that of other medical specialties, which minister primarily to bodily ills and discomforts. Consequently, the tort liability of the psychiatrist, as might be expected, is in many ways different from that of other practitioners.[2]

The psychiatrist must deal not only with psychiatric disorders of an organic nature, but also with the emotions and feelings of his patients. To a great degree, success in treatment is dependent upon the effective interaction between practitioner and patient.[3] Psychiatric patients often institute litigation against their doctors during periods of temporary setback, when the relationship with the physician is far from optimal.[4]

This paper will survey the areas of tort liability encountered by the psychiatrist, examining past and present trends, and suggesting guidelines to be followed which may minimize the risks involved.

The broad range of a psychiatrist's contacts with patients exposes him to an equally wide spectrum of potential tort liability—from invasion of privacy actions to suits for the failure to restrain or supervise dangerous patients; from actions for fractures sustained during shock therapy, to those for negligent psychotherapy. This study will deal with the following areas:

1. Negligent diagnosis
2. The shock therapies and informed consent
3. Drug therapy
4. Miscellaneous somatic treatment
5. Suicide
6. Injuries to third parties
7. Privilege and breach of confidentiality
8. Duty to warn
9. Commitment
10. Negligent psychotherapy
11. Miscellaneous areas of liability

In past decades, suits against psychiatrists have been relatively scarce, compared with litigation involving other medical specialists.[5] Various reasons have been advanced; they may be summarized as follows:

1. The diagnosis of mental and emotional disorders is imprecise. Psychiatrists often disagree about the very definition of a mental illness.[6]
2. As knowledge of psychiatric causation is limited, there is difficulty in establishing proximate cause of damages.[7]
3. The diversity of acceptable therapeutic techniques makes it difficult, if not impossible, to establish definite standards for psychiatric judgment in clinical situations.[8]
4. As some stigma has been attached to psychiatric disorders, patients are often reluctant to bring their histories to light.[9]

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5. Due to the transference phenomenon (whereby the patient develops strong emotional ties to his therapist), many patients see the psychiatrist as a friend, and are therefore understandably reluctant to institute legal proceedings.[10]

6. Psychiatrists are trained to handle their patients' negative reactions and are skilled in dispelling hostility.[11]

7. Often, during the occurrence of alleged malpractice, the patient is alone with his therapist. Problems of proving the facts of a practitioner-patient interaction are therefore rampant.[12]

8. Psychiatrists perform no surgery and rarely perform inherently risky diagnostic studies.[13]

Nonetheless, claims against psychiatrists in recent years have demonstrated an alarming upswing, both in frequency of litigation and in the amounts of damages awarded. In part, the increase can be attributed to the greater exposure of the American public to the practice of psychiatry. A study published in 1969 estimated that more than two million Americans undergo psychiatric treatment each year and that about twenty million in the United States suffer from mild to severe psychiatric problems.[14] No doubt these figures are even more dramatic today. Psychiatry therefore is becoming a more significant and prominent medical specialty.[15]

Unfortunately, with increased recognition has come a concomitant surge of claims against psychiatrists[16] and judicial expectations of higher duties of care.[17] Bellamy expects the trend to continue.[18]

Many psychiatric patients are angry and/or frustrated, and may institute legal proceedings against their doctors with or without reasonable cause to do so. Moreover, there is often familial involvement with which to contend. Attorneys must be alert to claims which are without foundation and discourage such litigation.[19,20]

Whatever the reasons, suits against psychiatrists for hundreds of thousands of dollars are no longer uncommon, and the range of liability is ever increasing. A New York jury recently awarded $350,000 to a woman whose therapist had sexual relations with her,[21] although an appellate court has more recently reduced the judgment to $25,000.

Rothblatt has pointed out that this "ominous trend" of major malpractice liability has threatened to remove psychiatrists from the "most favorable risk" category, and has caused malpractice insurance premiums to increase drastically.[22]

The foregoing takes on even more serious aspects when one considers that plaintiffs are overcoming many inherent difficulties in sustaining psychiatric malpractice actions.[23] A comprehensive definition of psychiatric malpractice (negligence) has been offered by Krouner:

> an act or omission by a psychiatrist in the treatment of a patient which is inconsistent with such reasonable care and skill as is usually exercised by psychiatrists of good standing of the same school or system or practice in the nation, and which results in or aggravates an injury to the patient.[24]

As a general rule, such negligence must not be presumed from the fact of a mistake in judgment;[25] plaintiff must prove the following elements of malpractice by a preponderance of the evidence:

1. That the psychiatrist owed him a duty to conform to a particular standard of conduct.
2. That the psychiatrist was remiss in the breach of that duty by some act of commission or omission.
3. That because of the dereliction, the patient suffered actual damage.
4. That the psychiatrist's conduct was the direct or proximate cause of such damage.[26]

Difficulties inhere in each. Let us consider first the establishment of a standard of conduct. This must be documented by expert testimony.[27,28] In addition to the reluctance of experts to testify (the so-called "conspiracy of silence"),[29,30] the plaintiff

often faces a mélange of acceptable practice in the field of psychiatry. If there are various accepted methods of treatment, the psychiatrist may use any which is acceptable to some practitioners, even though its use is not general.[31] In the past, a community or locality rule was applied; the standard being increasingly used at present is that of all psychiatrists.[32]

Once a standard of care has been established, the plaintiff must prove its breach, usually by expert testimony with its attendant problems.[33] "[W]hat one doctor would or could do is not the test. It must be testified to unequivocally by a doctor that the . . . defendant doctor was negligent." *Daniels v. Finney*, 262 SW 2d 431, 434 (Tex. Civ. App. 1953). Such a determination is frequently not an easy one, particularly since the reaction of a psychiatrist to his patient may vary with the situation and with the type and stage of illness.[34]

Next, plaintiff must prove actual damages. As probably the most common claim is that of a deterioration in the patient's emotional and/or mental state,[35] the allegation is hard to substantiate. Such a decline is usually intangible,[36] unlike physical damage (*e.g.*, a fracture from electroshock therapy), and may involve more than a monetary loss (*e.g.*, stigmatization, harm to reputation, etc.).[37] A differentiation must be made of new from prior damage.[38] Moreover, so-called "psychic injuries" are considered easier to simulate than physical ones,[39] making courts wary of "vexatious suits and fictitious claims."[40]

Finally, assuming a proven act of negligence, there is no liability for any injury which has not been proximately caused by the psychiatrist's act or omission. Since knowledge of psychiatric processes is limited, such a link is difficult to establish under the clearest conditions, and impossible under the murkiest.[41]

Expert testimony is required in this area with two exceptions: (1) matters which are within the common knowledge of any layman, and (2) negligence and injury which are "so gross and readily apparent" that the injury must have been caused by the negligence. (Cassidy points out that, due to the intricate nature of psychiatry and its therapeutic processes, the first exception is rarely invoked.)[42,43]

It should be apparent from the foregoing discussion that the field of psychiatric malpractice is rife with problems for both plaintiff and defendant. As in any litigation, there are equities on both sides. Overlitigiousness in patients and their families is often counterbalanced by difficulties of proof. The lack of standardized psychiatric treatment can cut both ways. Dawidoff has observed that "neither sympathy for the patient nor the exalted position of the psychiatrist should determine the matter."[44] Messinger finds the odds still to be heavily in favor of the psychiatrist—particularly when he has reached a well-reasoned diagnosis and has followed a regimen of treatment which is "reasonably grounded in his professional training and experience."[45]

Nevertheless, psychiatric malpractice suits are and will continue to be successfully prosecuted. There are some specific recommendations for psychiatric practitioners who wish to protect themselves against unfavorable legal and financial outcomes.

A general and pervasive concept is that the psychiatrist maintain the integrity of the doctor-patient relationship, possibly the single most important factor in the prevention of malpractice claims.[46] Bellamy has stated the situation well: "There is a constant need for the [psychiatrist] to be thoughtful of his patient's individual needs, to exercise his best skill, good judgment, and fine discrimination at all times." He should also exercise tact and consideration toward each patient and his family.[47]

Should litigation be instituted despite all precautions, the psychiatrist must defend himself and his practices. It is felt by many that good clinical records are vital to a successful defense,[48] particularly if suit has been filed where the allegations are patently false but nonetheless maintained by "an angry or paranoid patient."[49] Suggested inclusions in the record are outlined as follows:

1. Symptomatology
2. Diagnosis

3. Treatment
4. All aspects of consent, including any explanations made to the patient and/or relatives, guardian
5. Prescriptions
6. Notes of cognitive ability and extent of perceptive capacities and disorders
7. Consultations and their outcomes
8. Descriptions and documentation of any significant events which occurred in private practice supervision or hospital management
9. Follow-up[50]

Additionally, every psychiatrist must familiarize himself with the basic concepts of negligence and adjust his own practices accordingly.[51]

Finally, as a strictly economic measure, Bellamy advises that the psychiatrist periodically review his malpractice insurance. He feels that the inadequately insured or uninsured physician tends to become alarmed, and thus is more likely to agree to out-of-court settlements. This encourages nuisance suits and consequently aggravates malpractice problems.[52]

Slawson has summarized the aforesaid considerations succinctly, though somewhat over-optimistically:

> A conscientious practitioner who listens to his patient, keeps good records, and pays his insurance premiums has little to fear from the impressive legal resources that may at any time, and without apparent justification, be mobilized against him.[53]

Careful perusal of the following material will substantiate the author's assertion of Slawson's over-optimism: while precautions may mitigate damages, the psychiatrist can never be certain of victory.

I. Negligent Diagnosis

Reaching a correct diagnosis is of great importance in psychiatry, as well as other medical specialties, for it often sets the stage for all that is to follow. Unfortunately, accuracy of diagnosis is much more difficult to achieve in psychiatry;[54] rarely can a psychiatrist fall back upon the relatively unambiguous results of a blood test or electrocardiogram. Courts have recognized the problem,[55] and have put heavy burdens on plaintiffs, who must prove both that the diagnosis was mistaken and that it was arrived at negligently. There is no liability for a mere mistake in judgment.[56] Harris recommends that the psychiatrist "cut his losses" by periodically reviewing his diagnoses.[57]

Most of the negligent diagnosis cases fall into the areas of suicide or wrongful commitment. The author found three exceptions.

In *Warner v. Packer*, 139 A.D. 207, 123 N.Y.S. 735 (1910), the plaintiff sued for gross and culpable negligence in the "alienists'" failure to "exercise reasonable or ordinary care, skill, and diligence" to ascertain plaintiff's "true mental condition." 123 N.Y.S. at 726-727. As plaintiff introduced no expert testimony, the Appellate Division found the evidence insufficient to support a verdict of negligence.

In *Morris v. Rousos*, 397 S.W. 2d 504 (Tex. Civ. App. 1965), *cert. den.* 385 US 858 (1966), a former student sued a university psychiatrist, alleging that the psychiatrist had improperly diagnosed the patient's condition in a letter retained in the school files. The court found the complaint insufficient in its failure to allege any intent to injure the student, or willfulness or malice in placing false information in the student's file.

Finally, the plaintiff in *Hendry v. U.S.*, 418 F. 2d 774 (2nd Cir. 1969), alleged that a psychiatrist and a psychologist in the United States Public Health Service had negligently labelled him "paranoid schizophrenic" and caused him humiliation and distress. The court found that the diagnosis had been arrived at with due care and that the term had not been negligently applied.

II. The Shock Therapies: Informed Consent

Electroshock therapy represents the first really modern incidence of actions against psychiatrists for the mistreatment of their patients.[58] Shock therapies—electric, insulin, or Metrazol—are forms of treatment in which one of the foregoing agents introduces a convulsive state in the body.[59] Although the mechanisms are still somewhat uncertain, it is thought by most that the shock induces chemical changes in the body which will have a beneficial effect on abnormal behavior patterns.[60] Some illnesses do not respond to shock therapy;[61] it is used primarily to treat affective disorders, schizophrenia, psychoneuroses, anxiety states, and conversion hysteria. Krouner finds that it has been most valuable in alleviating the symptoms of affective disorders on a permanent basis.[62]

Generally, the goal of *electroshock therapy*, which originated in Italy in 1938,[63] has been to build up the patient's defenses, controls, and self-confidence.[64]

Insulin shock therapy was devised by Dr. Manfred Sakel. Coma is induced by the administration of insulin, and is terminated by the introduction of sugar. During the coma period, convulsions occur.[65] Insulin therapy, as opposed to electroshock, is indicated for the relief of basic anxiety and mood disturbance, so as to facilitate psychotherapeutic interactions.[66] At present, however, insulin shock is rarely used:

1. The death rate is more than ten times that associated with electroshock therapy (EST).
2. It may cause prolonged coma, indicating possibly irreversible damage to brain cells.
3. It is difficult to determine in advance how far the patient's sugar level is likely to fall.
4. Not all patients promptly regain normal brain function after the administration of sugar.[67]

A third form of shock therapy, the use of pentylenetetrazol (Metrazol), is less popular than EST but preferred to insulin—the risk of brain injury is less. While the drug was once thought to subsume a higher risk of fractures and dislocations than either electroshock therapy or insulin shock therapy, that danger has largely been eliminated by the widespread use of muscle relaxants.[68]

Although in many cases shock therapy proves to be effective, its administration is not without risks. Complications of the shock therapies include the following:

1. Fractures and dislocations;
2. Cardiovascular and respiratory complications (usually associated with the use of muscle relaxants and anesthesia);
3. "Mental" complications:
   a. Post-convulsion restlessness
   b. Confusion
   c. Psychotic episodes
   d. "Startle" reaction
   e. Memory impairment[69]

The risks of the above must be carefully balanced against the likelihood of improvement, before a final decision is made to go ahead with shock therapy.

The cases in this area may be loosely grouped into four categories—informed consent, premedication, negligent administration of shock therapy, and negligent management after treatment.

1. *Informed Consent**

Generally, the shock therapies represent the only significant area in which the issue of informed consent to treatment has been raised against psychiatrists.[70] With certain

* Sample consents to shock therapy may be found in Appendix A.

exceptions, to be delineated shortly, the physician-patient relationship is *consensual.*[71] As such, it requires *consent* to treatment, lest the psychiatrist be faced with an action for negligently providing inadequate disclosure, or assault and battery, the offensive or harmful and unauthorized touching of another.[72]

The psychiatrist is obligated to explain, in relatively comprehensible and nontechnical language:

1. The diagnosis and prognosis;
2. Any danger or risk of complications which may inhere in the proposed therapy; and
3. The results which are reasonably to be anticipated, particularly if there is only a limited chance for improvement of the patient's condition.[73]

There must be no false assurances of safety or guarantees of cure made.[74]

The standard for *what* should be disclosed is what a reasonable psychiatrist would make known in similar circumstances,[75] taking into account such factors as the emotional condition of the patient and his ability to understand an explanation. Should the patient's illness render him incompetent to comprehend the situation, or where the psychiatrist feels that disclosure would be ill-advised in the patient's present emotional state, full explanation should be made to a relative or guardian.[76,77] Wherever possible, consent should be documented by a signed form.[78,79]

There are three situations in which the requirement of informed consent has been relaxed (although to maximize his protection, the psychiatrist should *still* consider speaking with a relative or guardian). The following scenarios are considered exceptions to the general rule:

1. Emergencies, where the patient is in no condition to exercise independent judgment;
2. A situation in which the explanation of every risk is likely to cause undue alarm and possible refusal, against the patient's best interests; and
3. A situation in which complete disclosure is likely to increase the risks of treatment by making the patient overly apprehensive.[80,81]

Adherence to the requirement of informed consent to shock therapy will lend additional protection to the psychiatrist administering the treatment and will provide necessary information to the individual consenting. Informed consent is therefore both a legal necessity and a practical desirability,[82] as the following cases will illustrate.

In *Farber v. Olkon*, 40 Cal. 2d 503, 254 P. 2d 520 (1953), plaintiff sustained fractures of both legs during an electroshock treatment to which her father alone had consented. The patient was incapable of understanding at the time of the treatment and had no court-appointed guardian; it was therefore contended that the therapy constituted unlawful assault and battery. The court held that, as plaintiff's father was legally required to maintain and care for her as a mentally incompetent adult dependent, his consent was sufficient.

Other cases involved similar fact patterns. In *Anonymous v. State of New York*, 17 A.D. 2d 495, 236 N.Y.S. 2d 88 (1963), a parent gave consent for EST on a mentally ill adult dependent, for whom no committee of the person had been appointed. An analogy was made to consent to emergency surgery on a minor child and the parent's consent was deemed sufficient. *Lester v. Aetna Casualty and Surety Co.*, 240 F. 2d 676 (5th Cir. 1957), *cert. den.* 354 U.S. 923 (1957), upheld a wife's consent to EST on her husband, since it was the judgment of both psychiatrist and wife that it would be "unsafe and unwise to require [the patient] to undergo the strain and shock of discussing and considering possible, though not probable hazards." *Supra* at 678. *Maben v. Rankin*, 55 Cal. 2d 139, 10 Cal. R. 353, 358 P. 2d 681 (1961) involved a husband's consent to shock therapy on his wife. The court held that either of two defenses—a good-faith consent by the husband, or the emergency doctrine—would suffice, and that plaintiff assumed the burden of disproving either.

Wilson v. Lehman, 379 S.W. 2d 478 (Ky. 1964), spoke to the issue of *implied consent.*

Plaintiff was unable to recall the events surrounding her treatment. Since she voluntarily submitted, and her husband did not request discontinuation, consent was presumed.

In *Johnston v. Rodis*, 251 F. 2d 917 (D.C. Cir. 1958), statements were made by a psychiatrist to the effect that shock treatments were "perfectly safe." *Supra* at 917. The court held that such promises could be properly found to be a warranty, thus exposing the psychiatrist to liability.

A similar fact pattern was presented in *Woods v. Brumlop*, 71 N.M. 221, 377 P. 2d 520 (1962). Plaintiff alleged that the defendant psychiatrist had assured her that no harmful risks could occur. The court considered that the evidence warranted submitting to the jury the issue of a negligent failure to disclose.

Finally, *Mitchell v. Robinson*, 334 S.W. 2d 11 (Mo. 1960), and *Aiken v. Clary*, 396 S.W. 2d 668 (Mo. 1965), both involve informed consent with regard to insulin therapy. In *Mitchell*, the issue of whether plaintiff had been sufficiently informed was held to be a submissible factual issue of negligence, primarily because it concerned a "new, radical procedure with a rather high incidence of serious and permanent injury." *Supra* at 19. In *Aiken*, the court reiterated the importance of informed consent, adding the requirement of expert testimony to establish what a "reasonably prudent practitioner" would disclose. *Supra* at 673.

2. *Premedication*

Two cases are concerned with the administration of premedication (sedatives, muscle relaxants) before shock therapy. In the first, *Foxluger v. State*, 23 Misc. 2d 933, 203 N.Y.S. 2d 985 (Ct. Cl. 1960), plaintiff alleged negligence in the failure to administer muscle relaxants prior to EST. Since at the time of treatment (1956) there were two schools of thought about the safety of such premedication, the state was not held responsible for an "honest error of professional judgment made by qualified and competent doctors." 203 N.Y.S. 2d at 985.[83]

In *Kosberg v. Washington Hospital Center*, 394 F. 2d 947 (D.C. Cir. 1968), a patient's death allegedly resulted from the negligent administration of a tranquilizer (Thorazine) before and after EST. Sufficient evidence was presented to warrant submitting the case to the jury.

3. *Injury During the Administration of Shock Therapy*

There are several cases which speak to the issue of negligence in the administration of shock therapy. The author will elaborate upon those two which predominate in the literature.[84]

In *Collins v. Hand*, 431 Pa. 378, 246 A. 2d 398 (1968), plaintiff alleged that the psychiatrist's failure to take or read X-rays to determine the existence of her osteoporotic (fragile-boned) condition caused her to sustain bilateral acetabular fractures during EST. No causation was proved.

In a relatively early case, *Quinley v. Cocke*, 183 Tenn. App. 428, 192 S.W. 2d 992 (1946), plaintiff charged "negligent, careless, and reckless use of instrumentalities and negligent administration of [electroshock] treatment." 192 S.W. 2d at 993-994. The sole question on appeal was the applicability of *res ipsa loquitur*. As expert testimony established that fractures can occur without negligence and despite all precautions, relevance of the doctrine was denied and the judgment for defendant upheld.[85]

4. *Negligent Care After the Administration of Shock Therapy*

By far the largest number of cases in this group centers around falls occurring after EST. All affirm the duty of the psychiatrist to provide for supervision of the patient after shock therapy—as mental confusion often follows treatment.[86]

Brown v. Moore, 247 F. 2d 711 (3rd Cir. 1957), *cert. den.* 355 U.S. 882 (1957), represented the first major award in the psychiatric malpractice field. A judgment of

$60,000 was given to a patient who fell down a flight of stairs after electroshock therapy. It was held that the defendants—hospital and psychiatrist—did not use reasonable care to protect the patient after treatment. In *Meynier v. De Paul Hospital*, 218 So. 2d 98 (La. App. 1969), parallel facts led the court to a similar decision.

In *Quick v. Benedictine Sisters Hospital Association*, 257 Minn. 470, 102 N.W. 2d 36 (1960), plaintiff sustained an injury when he fell from his bed after EST. Sufficient evidence of negligent supervision presented a jury question. *Adams v. State*, 71 Wash. 2d 414, 429 P. 2d 109 (1967), reached the same conclusion on similar facts.

Constant v. Howe, 436 S.W. 2d 115 (Tex. 1968), reversed a plaintiff's verdict. Although the court did find that a psychiatrist is obligated to supply a reasonable form of restraint, there is no liability if the patient nonetheless manages to escape and injure himself.[87]

Christy v. Saliterman, 288 Minn. 144, 179 N.W. 2d 288 (1970), involved a somewhat different situation.[88] A psychiatrist ordered the discharge of a patient when he learned of the termination of the patient's credit. The man had received an electroshock treatment on the morning of discharge. The psychiatrist prescribed paraldehyde over the telephone; he did not warn the patient of its sleep-inducing qualities. The patient fell asleep in his chair and set himself on fire, suffering serious injuries. The court stated that there was evidence that the psychiatrist's negligence as to the discharge of the patient was the direct cause of the injury sustained.

Three cases allege negligence in the administration of shock therapy after fractures had been sustained in prior treatments—*i.e.*, the negligent failure to diagnose a shock-related injury. In *Eisele v. Malone*, 2 A.D. 2d 550, 157 N.Y.S. 2d 155 (1956), plaintiff was awarded $5000 against the psychiatrist involved and $25,000 against the hospital. Both appealed and the case was settled for an undisclosed amount.[89] In *Stone v. Proctor*, 259 N.C. 633, 131 S.E. 2d 297 (1963), standards of the American Psychiatric Association (1953) were admitted as evidence of the defendant psychiatrist's negligence. (See note 85, *supra*.) The reader is also referred to *Collins v. Hand*, 431 Pa. 378, 246 A. 2d 398 (1968), discussed *supra*, p. 197.

In general, psychiatrists and hospitals are held to an affirmative duty of surveillance after the administration of shock therapy.

With the increased use of muscle relaxants, lawsuits regarding the shock therapies are on the wane. There are, however, potential areas of liability which remain; psychiatrists must not relax their vigilance:

1. Shock therapy without informed consent;
2. The failure to have available facilities to manage cardiorespiratory emergencies which occur during shock treatment;[90]
3. The failure to diagnose and/or treat shock-related injuries;[91]
4. The failure to manage the patient properly after shock therapy.

III. Drug Therapy (Psychopharmacology)

Much more than in the past, growing concern has been evinced recently among psychiatrists about careful drug practices. Appleton has delineated four major reasons for the extending vigilance:

1. The increasing use of more potent major tranquilizers and tricyclic antidepressant drugs for out-patients;
2. Attempts to prescribe an adequate dosage (where precise reactions might not be known), thus increasing the danger of side-effects;
3. The ever-increasing incidence of medical malpractice suits; and
4. Increased monitoring and regulation by the Food and Drug Administration.[92]

In addition, Saxe finds significant the increased use of drugs as diagnostic tools (*e.g.*, sodium pentothal) and as forms of treatment.[93]

As psychopharmacology is a relatively new science, there is little legal precedent

directly pertinent to drug usage in the office practice of psychotherapy.[94] Generally, however, the use of drugs by psychiatric patients is similar to other areas of psychiatric practice. The psychiatrist must use care in prescribing medication and heed any cautionary instructions of the manufacturer. He must give adequate advice on the use of the drug and warning of side-effects and possible hazardous consequences. Otherwise, the psychiatrist risks liability to the patient or a third party for consequential injury.[95,96]

Psychiatric drug therapy is yet a somewhat inexact field; and there are many variables to be considered in prescribing medication—amount, idiosyncratic reactions, and individual tolerance, to name but a few. Although it is therefore often difficult to determine whether a patient received the "correct" dose, as a professional the psychiatrist will be held to the possession of reasonable knowledge and the practice of a reasonable standard of care.[97]

Appleton has segregated five major areas of concern about drug practice—adherence to manufacturers' directions; disclosure; physical examination of the patient; suicidal patients; and the use of investigatory drugs.[98]

1. *Adherence to Manufacturer's Instructions*

Although it has been asserted that courts consider package inserts as only one factor,[99] Appleton feels strongly that the insert has far too much legal standing.[100] In some states, the manufacturer's brochure may be introduced into evidence to support a malpractice claim.[101] As it is in the best interests of the drug company to protect itself, the manufacturer's insert tends to shift responsibility to the prescribing physician—the producer having disclosed all he knows.[102] Moreover, the brochures are often outdated, as they may have been written before all known uses and dangers came to light.[103] Two alternative possibilities have been suggested: (a) reducing the insert to an "advisory" status and giving major legal weight to another body of experts (*e.g.*, the American College of Neuropharmacology); or (b) requiring periodic revision of the inserts.[104] Nonetheless, as the package insert is now the chief reference point of attorneys and judges, the psychiatrist would do well to pay careful heed to its suggestions and admonitions.

2. *Disclosure*

In general, a patient must be informed at least to some extent about the possible side effects of prescribed medication. Preferably, any consent obtained should be written. The only exceptions to the rule just enunciated are (1) belief by the psychiatrist that full disclosure will cause the patient to forego needed treatment; and (2) cases where the patient is afflicted by mental impairment or major psychiatric illness. In such situations, the psychiatrist should attempt to convey the relevant information to a relative or guardian.[105] Disclosure is particularly vital if the patient is to engage in activity such as driving a vehicle or operating machinery and the drug is likely to affect his functional ability.

Two cases are on point in this area. The first, *Christy v. Saliterman*, 288 Minn. 144, 179 N.W. 2d 288 (1970), has already been discussed (*supra*, p. 198). In the second, a physician had prescribed a drug known as tranyl cypromine to alleviate a patient's depression. The drug has the potential to cause a sudden and dangerous elevation in blood pressure if a patient ingests a substance known as tyramine. The victim in the case at bar ate cheddar cheese (a source of tyramine) and died of the resultant hypertension. Although plaintiff alleged the failure of the physician to inform his patient of the risk, the doctor insisted that he had made disclosure and thus successfully defended himself.[106]

3. *Physical Examination*

Theoretically, all psychiatrists should take a comprehensive medical history from and perform a thorough physical examination upon any patient for whom they are prescrib-

ing medications. In reality, few do—primarily because they lack proper equipment and assistance. Although to date most psychiatrists usually get away with this laxity, if sued they are in difficulty. First, courts tend to adopt the position that the standard of care of all psychiatrists should be elevated. Moreover, sufficient support could be garnered from psychiatrists who would testify that administering drugs without medical supervision is an unwise practice.[107]

The author therefore recommends that the psychiatrist at least take a careful history, and insist upon close medical supervision (if not by himself, then by an internist or other specialist) for any patient not in excellent health.

4. *Suicidal Patients*

A psychiatrist may be chargeable with poor judgment should he administer potentially dangerous drugs to a patient known to be suicidal.[108] Whenever possible, if the patient's emotional or mental stability is at all doubtful, the psychiatrist should try to ascertain whether more than one doctor is being consulted to enable the patient to stockpile lethal medication.[109]

Only one appellate case has come to light in this area. In *Runyon v. Reid*, 510 P. 2d 943 (Okla. 1973), a decedent's widow sued a psychiatrist and others for her husband's wrongful death from an overdose of sleeping medication (which the court found must have been suicide). The court noted that the decedent had been an out-patient over whom his psychiatrist and physician had little control. Since a "reasonably skillful psychiatrist using customary methods" would not have seen the patient as a suicidal risk (510 P. 2d at 944), defendant was not held liable.

In part *because* of the lack of extensive legal precedent, it would behoove the psychiatrist to make a thorough evaluation of suicide potential (particularly in out-patients) before prescribing any possibly lethal medication.

5. *Investigational Drugs*

In this area, as with all human experimentation, informed consent is absolutely mandatory. It should be in writing if at all possible; if the patient is a minor, from his parent(s); if the patient is acutely disturbed, from a legally appointed guardian. Appleton notes that malpractice insurance does not cover the use of investigational drugs.[110]

In *Saron v. State*, 24 A.D. 2d 771, 263 N.Y.S. 2d 591 (1965), an experimental drug known as "Compound 100" (isonicotinic acid hydrazide or INH) was administered to plaintiff's intestate. It was alleged that the medication caused organic brain damage with resultant pain and suffering. The court held that the treatment with Compound 100 was neither negligent nor the cause of plaintiff's pain and suffering, as the testimony about the side effects was "equivocal at best." 263 N.Y.S. 2d at 592.

Finally, the author would like to cite two other cases relevant to drug therapy. In *Cox v. Hecker*, 218 F. Supp. 749 (E.D. Pa. 1963), *aff'd* 330 F. 2d 958 (3rd Cir. 1964), *cert. den.* 379 U.S. 823 (1964), *reh. den.* 379 U.S. 917 (1964), plaintiff alleged that the negligent administration of chlorpromazine (Thorazine) to the patient caused a state of confusion which progressed until he died. No expert testimony was introduced that the administration of the drug was improper under the circumstances or that Thorazine caused permanent brain damage.

In *Rosenfeld v. Coleman*, 19 Pa. D. & C. 2d 635, 35 North Co. R. 206 (1959), very questionable behavior by the defendant psychiatrist was at issue. Plaintiff alleged that the physician negligently caused him to become a narcotics addict.

The defendant testified that he had prescribed the use of Demerol, a morphine-like drug, because it was "not dangerous," and, though it was habit-forming, withdrawal was relatively simple.[111] He was apparently trying to make the plaintiff (*not* addicted before

his first visit to the defendant) understand why he had the characteristics of a habitual user. Then the psychiatrist could allegedly cure the patient's mental illness; with such a cure would come the removal of the addiction. The defendant admitted that by continually renewing plaintiff's prescriptions, he was trying to gain goodwill and so effect transference.

The court found sufficient evidence for jury consideration that the defendant was in violation of the Anti-Narcotic Act (an expressed intent of which was to control the use of narcotics by known users and to prevent self-administration). If there *was* violation, there was sufficient evidence of negligence to support a verdict for plaintiff.

The lesson of *Rosenfeld* should be obvious—among other things, a psychiatrist must never instigate behavior which could place his patient in legal jeopardy.[112]

Comparatively speaking, there are few cases in the area of psychopharmacology, or drug therapy. The increase in use of medications by psychiatrists, however, may well be accompanied by a concomitant increase in litigation. In this as in other areas, therefore, the psychiatrist must adhere to the strictest professional standards of skill, care, and diligence.

IV. Miscellaneous Somatic Treatment

This section will be devoted to the discussion of two cases involving somatic treatment other than shock therapy or psychopharmacology. The earliest, *Bellandi v. Park Sanitarium Association*, 214 Cal. 472, 6 P. 2d 508 (1931), is shocking in its unenlightenment. Plaintiff's decedent, in a state of relative excitation, was admitted to a private hospital and sanitarium. In his strenuous attempts to escape and return home, the patient broke out of the hospital's "strong room" and was then pursued by hospital personnel. He was tripped at the request of defendant physician and subdued with large quantities of ether and the application of a tourniquet around his neck. The patient died, evidence being strong that he was etherized or strangled to death.

The court held that institutions in the business of treating patients with mental disease should have on hand reasonable devices of restraint which pose the minimum danger to the patient. There was sufficient evidence to support a finding of negligent and improper treatment of the decedent.

Powell v. Risser, 375 Pa. 60, 99 A. 2d 454 (1953), involved the administration of wetpack therapy, a standard procedure at the time. The patient sustained severe blistering of the hand with subsequent problems. The court held that, inasmuch as the treatment was one routinely left to the nursing staff, the psychiatrist would be liable only if he had been negligent in ordering the treatment.

V. Suicide

Most suits for suicide are directed against hospitals.[113] Nonetheless, relatively detailed attention will be paid to the issue for two reasons:

1. Suicides account for a very large proportion of the total litigation involving psychiatric patients; and
2. Psychiatrists are often named as co-defendants or their negligence is cited as a basis for hospital liability.

Suicides and attempted suicides constitute a major mental health problem in this country; and suicide is now considered a leading cause of death among Americans.[114] "[I]t can be expected [,therefore,] that even more tort claims will be brought by parties attempting to fix civil responsibility on someone other than their beloved decedent."[115]

In general, the basic theory concerning institutional liability is that when suicidal tendencies are known to exist, reasonable care must be taken to prevent the patient from succeeding in his self-destructive attempts.[116] The rule is usually stated as follows:

A hospital must exercise such reasonable care and attention for the safety of its patients as their mental and physical condition, if it was known or should be known, may require. Obviously pertinent is the judgment as to what is good hospital practice in handling certain types of situations.[117]

As regards psychiatrists, the rules are less easy to draw and involve many more variables. For one thing, many people who are seen in a private psychiatric practice are treated on an out-patient basis. The psychiatrist *de facto* exerts less control over such patients than over those confined in institutions. With the growing proliferation of crisis therapy centers, and the emphasis even in hospitals on open wards and short-term stays, psychiatrists are facing an ever-increasing responsibility for suicidal patients in settings geared for maximum freedom as part of the therapeutic scenario.[118]

Generally, the psychiatrist's duties in this area are based on his underlying responsibility as a physician to exercise that degree of skill and care ordinarily employed under like circumstances by specialists in his field.[119] The psychiatrist must arrange for the observation and/or restraint of those patients whose mental or emotional state makes them a threat to their lives or well-being.[120] Moreover, the psychiatrist is expected to re-evaluate the likelihood of suicide at certain key points in treatment (*e.g.*, admission to or discharge from a psychiatric hospital).[121]

Many studies, says Schwartz, suggest that the psychiatrist should not be subject to liability unless the patient is under hospital supervision at the time the suicide occurs. He sees three exceptions to that theory.

First, liability could and perhaps should be imposed upon a psychiatrist who has made a gross error in judgment concerning the advisability of confinement. Schwartz suggests the following as symptoms so apparent that a psychiatrist of reasonable skill would order confinement in their presence: previous serious attempt(s) at suicide; deep depression; loss of sleep; loss of appetite; near inability to function in society.[122]

Schwartz next has proposed that a psychiatrist should be responsible if he negligently prescribes a large quantity of dangerous medication, or refills a small prescription, for a potentially suicidal patient.[123] This issue has been discussed in greater depth, *supra*, pp. 199–200.

Finally, Schwartz suggests the possibility of liability predicated on a psychiatrist's negligent or intentional disclosure of confidential communications—a breach of confidentiality which might cause sufficient stress to precipitate a suicide.[124]

The author suggests that liability might also be founded upon the therapist's negative handling of his own reactions toward the patient. This issue will be discussed further in Section X, NEGLIGENT PSYCHOTHERAPY.

With negligible exceptions, the cases in the area of suicide center about (1) the foreseeability of the suicide potential, or (2) precautions taken to prevent the suicide once the risk was acknowledged.[125]

1. *Foreseeability*

Words that recur over and over in the case law on suicide are "preventable," "controllable," "reasonable," "anticipated," "foreseeable."[126] Virtually all investigators agree that it is impossible to predict suicidal risk with complete accuracy.[127] Even previous attempts are not necessarily a reliable guide.[128] Sauer differentiates between suicidal risk and suicidal thoughts. A suicidal *risk*, he indicates, is a "medical determination which balances a patient's suicidal thoughts against his clearness of mind, how he relates to those around him, his articulateness in describing emotional problems, whether he is delusional, hallucinatory, agitated, or cooperative."[129]

Murphy has observed that the most common communication of suicidal intent is a direct statement of such. A patient with a specific, potentially lethal suicide scheme, with the means to carry it out, is obviously a grave risk; but, beyond a clear emergency, the serious often cannot be distinguished from the non-serious. It is best, he recommends,

to err on the side of caution, and confine and/or restrain the questionably serious patient.[130]

Because of the extreme difficulty of accurate prediction, it will be seen that courts rarely mete out liability absent a *clear* suicidal risk.[131]

In *Baker v. U.S.*, 226 F. Supp. 129 (S.D. Iowa 1964), *aff'd* 343 F. 2d 222 (8th Cir. 1965),[132] a patient was seriously injured when he attempted to commit suicide by jumping into a concrete window well on the grounds of a Veterans Administration Hospital. Plaintiff charged negligence by the acting chief of the neuropsychiatric service in failing to exercise the required standard of care.

Although the certificate accompanying plaintiff's written application for admission indicated depression and suicidal content, and plaintiff's wife claimed to have confirmed this to the chief, the latter did not consider the patient a suicidal risk and admitted him to an open ward. A few days later, the patient made his leap. The court took notice of the fact that diagnosing suicidal proclivity with precision is impossible. Moreover, the goal of the V.A. facility was acknowledged to be treatment, and not merely incarceration. It was found that the doctor's interview and lengthy examination of the patient were sufficient and that there was no negligence.

In *White v. U.S.*, 244 F. Supp. 127 (E.D. Va. 1965), *aff'd* 359 F. 2d 989 (4th Cir. 1966), the administrator of a decedent's estate charged that insufficient care had been taken for the patient's safety while he was at the Roanoke Veterans Administration Hospital. The veteran had wandered off and stood in front of a train. The patient had attempted suicide four times previously. The day before his death, he told the doctor he feared he would run away and kill himself. Nevertheless, the court held that at most, the failure of the V.A. psychiatrist to curtail the patient's freedom was a "mere error of judgment," 244 F. Supp. at 127, insufficient to hold the defendant liable.

Notice was taken of the policy of allowing the maximum possible liberty, and of the fact of the psychiatrist's judgment that on the day of the patient's death, he did not appear depressed or self-destructive.

Decedent in *Dimitrijevic v. Chicago Wesley Memorial Hospital*, 92 Ill. App. 2d 251, 236 N.E. 2d 309 (1968), jumped to his death from an unguarded hospital window. The court held that, *despite* the patient's having entertained "suicidal thoughts," and the fact that he was to be transferred to a locked ward as soon as space became available, there was no liability.

In *Fernandez v. Baruch*, 52 N.J. 127, 244 A. 2d 109 (1968), plaintiff alleged malpractice of the defendant psychiatrists as the cause of the decedent's suicide. It was claimed that the psychiatrists negligently failed to tell the police of the decedent's suicidal tendencies. Therefore, no precautions were taken and the decedent hanged himself in jail. The psychiatrists were not held responsible, as none of the evidence tended to prove that the suicide should have been anticipated.

In a recent case, *Dillmann v. Hellman*, 283 So. 2d 388 (Fla. App. 1973), a patient jumped from an open window in a wing to which she had been transferred with her psychiatrist's approval. Suit was brought over the injuries sustained. The court found that the psychiatrist could not be held liable for "honest errors of judgment made while pursuing methods, causes, procedures and practices recognized as acceptable by the profession." 283 So. 2d at 388-389. It was pointed out that doctors need to be assured of a wide range of action in the exercise of their discretion and judgment.

Finally, *Meier v. Ross General Hospital*, 69 Cal. 2d 420, 71 Cal. Rptr. 903, 445 P. 2d 519 (1968), represents one case in which the hospital and physician *were* found negligent. A wrongful death action was brought against a hospital and doctor. Following a suicide attempt by the decedent, a hospital physician located him in a second story room with a fully openable window. The court held that, *without expert testimony*,[133] the jury could more probably than not find that the hospital and doctor breached the duty of care owed the patient. "If those charged with the care and treatment of a

mentally disturbed patient know of facts from which they could reasonably conclude that the patient would be likely to harm himself in the absence of preclusive measures, then they must use reasonable care under the circumstances to prevent such harm." 445 P. 2d at 522-523.

2. *Precautions*

The second group of cases deals with the precautions to be taken once there is an acknowledged risk of suicide. Unfortunately, either too much or too little restraint is considered malpractice.[134] Moreover, it is acknowledged that on occasion people have committed suicide despite all precautions.[135]

It is also now recognized that very close observation, often accompanied by restraint and imposing restrictions, can actually be anti-therapeutic, causing rage, panic, and a drive to escape, and possibly aggravating feelings of self-loathing and worthlessness.[136] Present trends therefore favor a removal of as many as possible of the prison-like features of psychiatric hospitals and the institution of the "open-door policy."[137] This practice advocates extending as much freedom as possible to patients, and encouraging self-reliance and a return to normal living conditions.

The problem attendant upon such a situation is the need to balance the therapeutic value of freedom against the risk of potential injury;[138] nonetheless, those who have studied the policies involved find that the open door approach is a most valuable tool, and have expressed concern lest the courts limit its use.[139,140]

Schwartz does caution that the therapeutic value of the open door policy should not excuse negligence in its administration and should not provide an "absolute shield" against liability.[141]

The cases are less skewed in this group. Once the likelihood of suicide is an established fact, courts have less difficulty in determining whether supervision was negligent than they do in deciding whether or not a risk existed.

a. *Liability Found*

In *Stallman v. Robinson*, 364 Mo. 275, 260 S.W. 2d 743 (1953), plaintiff sued defendant psychiatrists for the death of his wife. She had attempted suicide twice before entering defendants' hospital, where she subsequently hanged herself. A $9000 judgment was sustained by the appellate court, on the grounds that under the circumstances, closer observation should have been given.

Four years later, a patient who survived a jump sued the hospital and doctors for the injuries he sustained, and was awarded a judgment of $39,380. The court in *Mounds Park Hospital v. Von Eye*, 245 F. 2d 756 (8th Cir. 1957), sustained the finding of liability against the hospital (but not the physicians) and remarked on the duty of a hospital to take precautions in the face of a suicidal tendency which is or should be known.

Benjamin v. Havens, Inc., 60 Wash. 2d 196, 373 P. 2d 109 (1962), was a similar action. A patient escaped from her ward and fled, leaping or falling to her injury. The court again exonerated the psychiatrist, but found that the insufficient attention paid by the nurses was properly a jury question.

In *Vistica v. Presbyterian Hospital and Medical Center*, 67 Cal. 2d 465, 62 Cal. R. 577, 432 P. 2d 193 (1967), decedent had been admitted to the psychiatric ward after attempting suicide at home. After a hospital stay of a few months, she jumped out of a window—not without prior indications of her intent. The hospital was held liable.

Finally, the court in *Wright v. State*, 31 A.D. 2d 421, 300 N.Y.S. 2d 153 (1969), found the state of New York liable for a patient's suicide without requiring expert testimony (see note 133, *supra*). It considered the requirement obviated by the "patient's suicidal tendencies, his conceded mental illness, his impulsive and bizarre behavior following his entry into hospital, and the immediate danger of an opened unscreened window fifteen feet above the ground coupled with his threat to jump." 300 N.Y.S. 2d at 154.

b. *No Liability Found*

In *James v. Turner*, 184 Tenn. 563, 201 S.W. 2d 691 (1941), the plaintiff's husband drowned himself in a water tank on the grounds of the sanitarium in which he was a patient. Although hospital personnel were aware of decedent's suicidal tendencies, it was noted that his condition had improved. Since his suicide was considered to be a *possibility* rather than a *likelihood*, the hospital was not negligent.

Gregory v. Robinson, 338 S.W. 2d 88 (Mo. 1960), was a suit against two psychiatrists who were hospital owners, for the plaintiff's injuries after he leaped from an unbarred window. The patient had escaped on the heels of a departing doctor, despite the physician's careful scrutiny and attempt to restrain the escapee. After citing with commendation the modern trend toward freedom and "resocialization," the court found that the doctor was not required to anticipate such a "precipitous bolt," and hence was not negligent. *Supra* at 90, 93. A judgment of $40,000 for the plaintiff was set aside as unwarranted by the weight of the evidence.

Finally, in *Hirsh v. State*, 8 N.Y. 2d 125, 202 N.Y.S. 2d 296, 168 N.E. 2d 372 (1960), it was alleged that a state hospital had been negligent in failing to prevent a patient with known suicidal intent from committing suicide. The patient was in a closely supervised, confined ward—yet somehow he had hoarded sufficient Seconal tablets with which to overdose. Since no negligence was found in the State's precautions, liability was precluded.[142]

In summary, there are several factors for hospitals to consider with regard to the care of suicidal patients:[143]

1. No precise level of patient behavior requires a corresponding level of vigilance. The passage of time dilutes the significance of prior attempts; moreover, there is a somewhat questionable distinction between threats and actual attempts.
2. Watchfulness may be relaxed if the patient's condition improves—but not merely for the sake of expediency.
3. The hospital must maintain its facilities and equipment so that hazards are not created.
4. Staffing ratios, if insufficient, are from time to time determinative of negligence.
5. Courts will find negligence where it can be proved that the hospital violated its own precautionary rule.
6. If a mistake is found to be an honest error of judgment within a physician's discretion, liability will usually not be assigned.[144]

VI. Injuries to Third Parties

The rationale applied in cases where a mental patient has caused harm to the person or property of another is an extension of that found in the suicide cases.[145] Consequently, a brief discussion and citation of the leading cases will suffice for purposes of this study. Those desiring additional case citations should consult Appendix C.

If anything, courts have established a greater duty upon a hospital to protect third parties than to protect the mentally disturbed from self-destruction, probably because of public policy considerations and the need to safeguard the community.[146] Patients who kill or injure others constitute an increasingly serious problem. In California alone, at least seventy murders in two years were committed by the mentally ill.[147]

Difficulties are similar to those regarding suicide risks—the prediction of dangerousness is rarely a matter of textbook simplicity and accuracy. Nonetheless, once a harmful propensity has been demonstrated, it is clearly the duty of psychiatrists and hospital staffs to maintain a reasonable level of watchfulness and/or restraint.

In *Weihs v. State*, 267 A.D. 233, 45 N.Y.S. 2d 542 (1943), an escaped inmate of Kings Park State Hospital seriously injured the plaintiff. The patient had been classified as assaultive and dangerous and was known as an eloper, or escaper. The court held that

his escape should have been reasonably anticipated and steps taken to prevent it. It was noted that there were but three guards for sixty-nine such patients.

A decade later, in *St. George v. State*, 283 A.D. 245, 127 N.Y.S. 2d 147 (1954), *aff'd* 308 N.Y. 681, 124 N.E. 2d 320 (1954), decedent was killed without provocation by a former state inmate who had been discharged as recovered. The court took note of the imprecision inherent in the diagnosis of mental illness: "As yet, the mind cannot be x-rayed like a bone fracture." 127 N.Y.S. 2d at 150. Moreover, it pointed out the goal of eventually returning patients to society; the court did not want to discourage releases by making the state liable for all ex-patients' actions after discharge. Since at most the doctors had made a "mere error of professional judgment," the state was not negligent.

A contrary result was reached in two recent cases. In *Hicks v. U.S.*, 357 F. Supp. 434 (D.D.C. 1973), *aff'd* 511 F. 2d 407 (D.C. Cir. 1975), a former mental patient killed his wife less than two months after his discharge from the hospital. The patient had assaulted his wife previously and threatened to kill her; he was arrested. A general hospital found him incompetent to stand trial. The patient was then committed to St. Elizabeth's Hospital and the superintendent informed the trial court that he had recovered. It was then that the murder occurred.

The District Court found that St. Elizabeth's had been negligent in its diagnosis and had rendered a negligent competency report to the trial court—and thus was the proximate cause of the wife's death. A judgment of $100,000 was upheld.

In an unreported White Plains case, a former mental patient bit off the nose of his wife's attorney during an apparently routine conference about a support order. The attorney brought suit against Halcyon Rest (the place of confinement), the patient's private psychiatrist there, and a previous place of confinement, for $250,000—for the alleged failure to confine and supervise a dangerous patient. The jury exonerated the original place of confinement, but awarded plaintiff $200,000—half to be paid by Halcyon Rest, and the other half by the psychiatrist, Dr. Alexander Carlen. The trial judge refused to set aside the verdict and neither defendant appealed.

Although there is precedent for the duty of hospitals to restrain dangerous inmates, the instant case was the first time a private practitioner had ever been held liable for an injury inflicted by a mental patient.[148]

Even more than in cases of suicide, courts appear ready to impose strict standards in third party cases. Hospitals and private psychiatrists must be aware of this propensity and gauge their actions accordingly. As with suicide, it is probably true that it is better to err on the side of caution.[149]

VII. Confidentiality and Privilege

Confidentiality in medical practice is founded upon three underlying assumptions:

1. The right of every patient to privacy;
2. The need of the patient's complete candor in his interaction with a physician, so that the goals of proper diagnosis and treatment may be optimally served;
3. The interest of both the medical and lay sectors of society in preserving the physician-patient relationship.[150]

Apart from the obvious, there are basic differences between psychiatry and other medical specialties which affect the area of confidentiality. Information about physical ailments, while dependent to an extent upon information from the patient, can nonetheless be garnered largely from examinations and laboratory tests. Quite to the contrary, the psychiatrist must rely almost completely upon what the patient is willing to tell him (except in the case of certain extreme psychotic disorders).[151]

> The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins and his shames.[152]

Moreover, as mental ill health still causes more embarrassment than physical problems, many people still perceive the need for psychiatric care as something of a social stigma.[153,154] It can thus be inferred that the patient's stake in confidentiality is of much greater significance in a psychotherapist-patient relationship than in an ordinary physician-patient relationship.[155]

The psychotherapeutic relationship depends for its very existence upon complete privacy. Judge Alverson, of the Superior Court of Atlanta, recognized this when he stated:

> Psychotherapy by its very nature is worthless unless the patient feels assured from the outset that whatever he may say will forever be kept confidential. Without a promise of secrecy from the therapist, buttressed by a legal privilege, a patient would not be prone to reveal personal data which he fears might evoke social disapproval.[156]

Virtually all who have commented on the nature of the psychotherapist-patient relationship have been in accord with Judge Alverson's point of view.[157]

It is also assumed that when a patient seeks psychiatric care, he *expects* that what he discloses will be held in confidence.[158] Consequently, it has been suggested that, should the profession's reputation for secrecy be undermined (even by one or two publicized cases of disclosure), many people will be deterred from seeking needed psychiatric care. In addition, it is feared that those patients already in therapy would be inhibited from making those candid revelations which are essential to effective diagnosis and treatment.[159,160] Guttmacher feels that the patient might be subject even to unwitting blocks of information, should he begin to feel insecure.[161]

The principle of confidentiality is well-grounded in medical ethics, beginning with the Hippocratic Oath:

> Whatsoever I shall see or hear in the course of my profession as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.[162]

and achieving continuing recognition by the American Medical Association:

> A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.[163]

and the American Psychiatric Association:

> The principle (of confidentiality) has governed physician-patient relationships since time immemorial and is as sound today as ever. In the case of psychiatry, *it is absolutely essential to the practice of psychotherapy* since, obviously, patients would not reveal their thoughts and feelings if it were not observed.[164]

In addition to the grounding of confidentiality in ethical principles, it has received recognition in legislation as legal privilege—which allows a patient to prevent a physician from testifying in a legal proceeding as to any confidence revealed in the physician-patient relationship.

Privilege applies only to courtroom proceedings and is held by the *patient*.[165] Moreover, it is strictly statutory in nature; there is no common law back-up.[166] The singular exception to this principle is *Binder v. Ruvell*, Civil Docket 52 *C* 2535 (Circ. Ct. Cook Co., Ill., June 24, 1952). In that situation, the trial judge upheld a psychiatrist-patient evidentiary privilege, based upon the intimate nature of disclosures by patients to their therapists.

More than thirty states have privilege statutes to cover physician-patient communications.[167] In 1961, Connecticut enacted the first *psychotherapist*-patient privilege statute;[168] at least six states have followed suit (California, Florida, Georgia, Illinois, Kentucky, and Maryland).[169]

Wigmore has set forth four criteria by which to test the validity of a privilege:

1. The communication to be protected must originate in a confidence.
2. The inviolability of the confidence must be vital to the purposes of the relationship.
3. The relationship must be one which should be fostered.
4. The expected injury to the relationship through fear of later disclosure must exceed the expected benefit for justice in obtaining the testimony.[170]

Brief analysis will indicate that the psychotherapist-patient relationship easily fulfills the first three standards. As to the fourth, it has been repeatedly pointed out that therapist-patient communications are rarely factual in nature; they may contain dreams, fantasies, and other material of a highly subjective and often prejudicial nature.[171]

It must be emphasized, however, that the privilege, even where it exists, is subject to limitations. For example, a psychiatric examination for an involuntary commitment procedure is not privileged—as no doctor-patient relationship is considered to have been established. Moreover, many statutes retain a future crime and/or patient-litigant exception.

While the ethical psychiatrist can do much to protect a patient's confidences, there are occasions when he can and must reveal information, or face an action for contempt of court.[172,173]

The cases in the confidentiality area cover a wide range of situations, from defamation to claims of emotional harm resulting from disclosure. It should be noted that, apart from the sanctions of litigation, in many states a physician may be subject to the loss of his license for unauthorized disclosures.[174]

Three of the cases speak to the issue of libel and/or slander.[175] The earliest was *Gasperini v. Manginelli*, 196 Misc. 547, 92 N.Y.S. 2d 575 (Sup. Ct. 1949). A psychiatrist was treating a man whose name was the same as his father's, except for a "Junior." During the course of therapy, the physician had occasion to produce a writing diagnosing the illness of his patient and requesting his admission into a hospital for observation. The psychiatrist inadvertently failed to write "Junior" after the son's name; the father brought suit for libel. The court held that any statements made in the context at issue were absolutely privileged.

In *Berry v. Moench*, 8 Utah 2d 191, 331 P. 2d 814 (1958), a patient brought suit for libel, alleging that his psychiatrist had published false and derogatory information acquired in connection with treatment. The psychiatrist had replied to a letter from another physician, inquiring on behalf of people whose daughter contemplated marriage to the plaintiff (a former patient of defendant).

The court found sufficient evidence of a breach of duty to constitute a jury issue. It pointed out that any privilege applying would be conditional, and its exercise governed by certain limits:

1. The statement must have been made in good faith, with reasonable regard for the truth.
2. The information must have been reported fairly.
3. Only such information must be disclosed to
4. Only such people as necessary to the purpose at hand.

The court found the fulfillment of the criteria to be a jury question.

Hammer v. Polsky, 36 Misc. 2d 482, 233 N.Y.S. 2d 110 (Sup. Ct. 1962), spoke to the allegation that a defendant psychiatrist gave defamatory testimony about the plaintiff in a custody proceeding. The court held that the disclosure was absolutely privileged.[176]

In *Schaffer v. Spicer*, 215 N.W. 2d 134 (S. Dak. 1974), a mother sued a psychiatrist for breach of the physician-patient privacy relationship, allegedly occurring when the psychiatrist gave an affidavit concerning the mother's mental health to the father's attorney. The court found insufficient evidence that the mother had waived her right to

confidentiality and held that a summary judgment for defendant constituted reversible error.

Furniss v. Fitchett, [1958] N.Z.L.R. 396, was a New Zealand case with issues closely related to those under scrutiny. The court held a psychiatrist liable for damages incurred when he issued an unauthorized report on the patient's condition to her husband. The husband later used the disclosure in public legal proceedings. The physician was held responsible primarily because he should have foreseen that his disclosure would be harmful to the plaintiff (his patient). Implicit in the judgment was that liability was grounded not only in the *fact*, but also in the *manner* of the communication.[177]

In *Clark v. Geraci*, 29 Misc. 2d 791, 208 N.Y.S. 2d 564 (Sup. Ct. 1960), a patient sued a physician for allegedly causing the Air Force to dismiss him (a civilian employee) and for causing him to be unable to find other employment. The doctor had apparently stated in a letter that the plaintiff's absences from work were due to alcoholism. The court held that where the patient requested and permitted the doctor to make *any* disclosure to the Air Force about his illness, he was estopped from preventing any further disclosure about alcoholism.

The final case in the group is rather unusual. *Doe v. Roe*, 42 A.D. 2d 559, 345 N.Y.S. 2d 560 (1973), was an action brought by a former patient to enjoin her analyst's disclosure (*per* a commercial book) of the case histories of plaintiff and her family. The plaintiff asserted that the publication of the near-verbatim record of her psychotherapeutic treatment constituted a breach of confidentiality and violation of her right of privacy. The Supreme Court of New York held that enjoining publication would not be invalid prior restraint, and that injunctions of this sort were not limited to publications reaching the general public.[178]

It should now be apparent that before a psychiatrist makes any disclosure, he must ascertain that he is within the protection of a privilege (*e.g.*, as a witness in a judicial proceeding), or that he has the express consent of his patient to reveal the information in question. Otherwise, he faces severe penalties for unauthorized disclosure, including suits for damages, professional sanctions, and conceivably the loss of his license.

VIII. Duty to Warn

Diametrically opposed to the duty of the psychiatrist to remain silent is the question of his duty to warn the potential victims of dangerous patients. There now appears to be ample authority to support the proposition that, by entering into a physician-patient relationship, the therapist becomes sufficiently involved to be responsible for the safety and well-being not only of his patient but of any other parties the doctor knows to be threatened by his patient.[179]

In traditional common law tort theory, there is no affirmative duty to act or to control the conduct of a third person to protect others. However, once a special relationship has been established, which gives rise to a duty of care, affirmative obligations (including a duty to warn) may then be imposed.[180]

The benefits of warning third parties who have been threatened are apparent. Unfortunately, such advantages are neither easily nor cheaply attained.

First, the prediction of violent behavior against others poses problems analogous to those extant in the prediction of suicides. Moreover, "dangerousness" is not so glibly definable as, *e.g.*, "contagious" or "infectious." The diagnosis of dangerousness is an elusive and complex determination.[181]

Second, as *per* the discussion in Section VII, important confidentiality considerations are at stake. It is a delicate balance indeed to choose between the importance of disclosure to third parties in danger and maintaining the confidentiality which is vital to the therapeutic relationship. The fear has been expressed that the threat of disclosure might keep murderous or destructive impulses from being revealed, and thus actually be counterproductive.[182]

There is a brief line-up of cases in this area, culminating explosively with *Tarasoff v. Regents of University of California* in 1974.

In the earliest case, *Fair v. U.S.*, 234 F. 2d 288 (5th Cir. 1956), three people were shot by an Air Force officer after his release from a hospital. He had previously threatened the life of one decedent; the other two had been hired for her protection. As the Air Force doctors (and provost-marshal) knew of the threats, and did *not* supply the previously promised warning when the patient was released, the court held that the evidence was sufficient to entitle plaintiffs to a trial on the merits.

A similar situation was presented in *Underwood v. U.S.*, 356 F. 2d 93 (5th Cir. 1966). There, a United States airman killed his ex-wife. The complaint alleged the negligent release of the hospitalized patient to a tour of duty giving him access to weapons, and the negligent grant to him of permission to withdraw the gun and ammunition with which he shot his victim.

The patient had previously assaulted his ex-wife and had made threats against her life. An officer on duty when the patient was admitted to the hospital conveyed that information to the psychiatrist—who promised to inform the doctor taking over the case. He did not keep his word.

The court found the first doctor negligent in not reporting the information received from the ex-wife, or the admitting officer's fears on the woman's behalf. The case is significant as regards the point at issue in that, in the face of overt threats to her life, the United States completely disavowed any responsibility to the ex-wife.

The decedent in *Merchants Nat. Bank & Trust Co. of Fargo v. U.S.*, 272 F. Supp. 409 (D.N.D. 1967), was killed by her husband, a mental patient on a leave of absence from a V.A. hospital. He had been sent to a ranch for convalescence; however, no notice was given the owners as to the nature of the patient's illness; nor were instructions given in case the patient left the ranch.

The patient had previously threatened to kill his wife; this was known to V.A. personnel. The man's psychiatrist had been personally acquainted with the wife's apprehensions of danger.

The court upheld an award of $200,000 to the plaintiff. It remarked that the government undertook the custody, care, and treatment of this patient with the knowledge of his homicidal tendencies, and that the V.A.'s "inexcusable negligence" was the proximate cause of the wife's death. *Supra* at 417.

Thus was the stage set for *Tarasoff*.

On October 27, 1969, Prosenjit Poddar killed Tatiana Tarasoff.[183] Her parents sued the regents of the University of California, several doctors, and the campus police to recover for the death of their daughter.[184]

The plaintiffs alleged that Poddar had confided his intention to Dr. Lawrence Moore, a university psychologist. At Moore's request, Poddar was briefly detained by the campus police, but was released when he seemed rational and stated that he would attempt to keep away from Tatiana. The claim was made that Dr. Harvey Powelson, Moore's superior, then instructed that no further action be taken to detain Poddar. No one warned Tatiana.

The complaint predicated liability on two grounds:

1. The failure to bring about Poddar's confinement;
2. The failure to warn Tatiana Tarasoff of the threat to her life.

The court held that immunity protected the defendants *vis à vis* their duty to confine Poddar; that issue will not be considered. However, the court also held that merely because the victim was not their patient, the psychotherapists could not avoid liability for failing to exercise due care to warn the victim or those who could reasonably have been expected to tell her; and that moreover, as to the issue of warning, neither the campus police nor the doctors were protected by the cloak of statutory immunity.

The court reasoned that the relationship between the therapists and Poddar imposed the duty to warn a third party, and that "a second basis for liability lies in the fact that defendants' bungled attempt to confine Poddar may have deterred him from seeking further therapy and aggravated the danger to Tatiana; having thus contributed to and partially created the danger, defendants incur the ensuing obligation to give the warning." 529 P. 2d at 555. Moreover, once the therapist has undertaken to control behavior, he must do so with reasonable care.

The court noted the strong public interest in safety from assault, and the "dangerous patient" exception to the psychotherapist-patient privilege statute.[185] After concluding that plaintiffs could assert the elements necessary to a cause of action for breach of duty to warn, the court remanded the case for further factual determination.

Tarasoff was met with great trepidation by psychologists, psychiatrists, and other medical practitioners. Most feared the inroads that became possible into the patient-physician tradition of strict confidentiality, with the attendant potential of deterring the kinds of disclosures necessary for treatment. Also, it is recognized that predicting violence with a significant degree of accuracy is often all but impossible. William Curran, a leader in the field of medical jurisprudence, spoke for many of his colleagues when he asked:

> Does this case mean that every time a patient makes a threat against an unnamed person, the therapist must take steps to find out who it is and warn him (of anything at all, from vague threats to murder) or suffer money damages in the thousands or tens of thousands if the threat, or an aspect of the threat, is carried out?[186]

Fleming, responding to the threat of such a situation, has proposed a compromise formula. It includes the following provisions:

1. The requirement of a second independent opinion of dangerousness;
2. A rule of waiting until the danger is truly imminent before action is taken;
3. Selective intervention only, with the least harmful impact on the patient's interests;
4. Informed consent—i.e., telling patients at the inception of therapy of the limits to be placed upon confidentiality.[187]

The scheme is a good one. It speaks to both the interest of the community in protection and that of the patient in confidentiality. It is to be hoped that, if and when another *Tarasoff* reaches the judicial process, such a rationale as Fleming's will be applied. For in an area so rife with competing concerns, and with uncertainty, imposition of an absolute duty is a price too high for any of us to pay.

IX. Commitment

The psychiatrist's watchwords in the area of commitment must always be "prudence" and "caution."[188] A psychiatrist is obligated to diagnose any patient with the ordinary care and skill expected of his profession.[189,190] A psychiatrist acting as a court witness may be accorded judicial immunity, even in cases of gross negligence (*Niven v. Boland*, 177 Mass. 11, 58 N.E. 282 (1900), *Bailey v. McGill*, 247 N.C. 286, 100 S.E. 2d 860 (1957)); nevertheless, ethical considerations and professional obligations dictate that reasonable care be taken.

Another reason alleged in support of the frequent verdicts for defendant doctors is that no duty is owed the patient in a commitment proceeding because no genuine physician-patient relationship ever arose. The argument was rejected, however, in *Kleber v. Stevens*, 39 Misc. 2d 712, 241 N.Y.S. 2d 497 (Sup. Ct. 1963), *aff'd* 20 A.D. 2d 896, 249 N.Y.S. 2d 668 (1964). Plaintiff alleged that a negligent examination had been made. The court rejected the contention of "no duty" and noted that "it is conceivable that a doctor examining for purposes of confinement may comply mechanically with the requirement of the law and without malice and yet fail to utilize the minimal skill

required to effectuate this process." 241 N.Y.S. 2d at 499. The argument of judicial immunity was not accepted.

The most common causes of action brought in the involuntary commitment cases are those for malicious prosecution, false imprisonment, assault and battery, and lately, civil rights actions. The leading cases in each group will be examined.[191]

1. *Malicious Prosecution*

In addition to actual confinement, a finding of malicious prosecution requires both lack of probable cause and malice.[192] In the earliest case, *Daniels v. Finney*, 262 S.W. 2d 431 (Tex. Civ. App. 1953), the court held that the burden was on the plaintiff affirmatively to establish that the defendant psychiatrist did not have reasonable cause to believe plaintiff was mentally ill. It moreover found that there was insufficient evidence presented in expert testimony to establish that the defendant's diagnosis was negligent.

The next year, in *Mezullo v. Maletz*, 331 Mass. 233, 118 N.E. 2d 356 (1954), the court held that *even if* the defendant psychiatrist had acted with malice and bad faith, as a court witness he was protected by absolute privilege. Notice was taken of the judges' need for frank medical testimony.

2. *False Imprisonment*

A cause of action for false imprisonment is probably a more useful and accurate legal weapon than a suit for malicious prosecution; expert testimony is usually not required, and plaintiff need prove only falseness (not malice).[193]

In *Dunbar v. Greenlaw*, 152 Me. 270, 128 A. 2d 218 (1956), plaintiff's charge of gross negligence in his certification as insane fell before a finding of absolute privilege for the physician involved. The court pointed to the dearth of psychiatrists available for certification examinations and held that participation as a court officer lent the doctor the cloak of judicial immunity. The court also noted that provisions in the criminal law against conspiracy, perjury and the like provide ample protection for the public against intentionally false certification. For a similar reason, the same result was reached in *Blitz v. Boog*, 328 F. 2d 596 (2nd Cir. 1964), *cert. den.* 379 U.S. 855 (1967).

In *Maben v. Rankin*, 55 Cal. 2d 139, 10 Cal. R. 353, 358 P. 2d 681 (1961), the plaintiff was forcibly sedated, taken to a hospital, and given electroshock therapy, on the word of her husband and without her consent. On appeal of a judgment for plaintiff for $78,000, the court held that while it was not negligent for the psychiatrist to accept a relative's word in good faith, there was nevertheless a legal duty to comply with the commitment laws. The case was remanded because of faulty jury instructions; plaintiff was awarded $60,000 after a new trial.[194]

In *Stowers v. Ardmore Acres Hospital*, 19 Mich. App. 115, 172 N.W. 2d 497 (1969), the plaintiff was committed on a court order to a private psychiatric hospital. By her psychiatrist's orders, she was prevented from having any communication with the people "outside," including her attorney; she was given medication without her consent. The court held that such a manner of detention was out of line with that contemplated by the commitment order and constituted false imprisonment. Plaintiff was awarded $40,000.

In a case closely related to the false imprisonment issue, the claimant in *Whitree v. State*, 56 Misc. 2d 693, 290 N.Y.S. 2d 486 (Ct. Cl. 1968), alleged wrongful confinement for a period of twelve years and four months in a state hospital. The court upheld a verdict for the plaintiff (in the amount of $300,000), finding that a careful examination was lacking, and that no competent professional judgment had ever been made.

3. *Assault and Battery*

Those cases involving assault and battery in false imprisonment actions are *Maben v. Rankin*, 55 Cal. 2d 139, 10 Cal. R. 353, 358 P. 2d 681 (1961), and *Stowers v. Ardmore*

Acres Hospital, 19 Mich. App. 115, 172 N.W. 2d 497 (1969), discussed *supra*, p. 212. Plaintiffs were awarded judgments in both instances.

4. *Civil Rights Actions*

Campbell v. Glenwood Hills Hospital, Inc., 224 F. Supp. 27 (D. Minn. 1963), and *Duzynski v. Nosal*, 324 F. 2d 924 (7th Cir. 1963), both denied causes of action under the Civil Rights Act for wrongful commitment. However, a more recent case, *Beaumont v. Morgan*, 427 F. 2d 667 (1st Cir. 1970), *cert. den.* 400 US 882 (1970), did not consider the Civil Rights Act inapplicable to involuntary commitment. At least one commentator feels that more such actions will now occur.[195]

To summarize, in many cases involving involuntary commitment, psychiatrists are accorded judicial immunity. Nonetheless, it is legally, medically, and ethically advisable for psychiatrists in such circumstances to conduct careful examinations based on probable cause.

X. Negligent Psychotherapy

Until the very recent past, suits for improper and/or negligent psychotherapy were few and far between. Lately, there has been a somewhat alarming upswing.

Black's Law Dictionary (4th ed. 1971, p. 1392) defines psychotherapy as follows:

> a method or system of alleviating or curing certain forms of disease, particularly diseases of the nervous system, or such as are traceable to nervous disorders, by suggestion and persuasion, encouragement, the inspiration of hope or confidence, the discouragement of morbid memories, associations, or beliefs, and other similar means addressed to the mental state of the patient . . .

Causes of action for malpractice in psychotherapy, therefore, usually speak either to a breach of the doctor-patient relationship by the psychiatrist or an unusually faulty approach to the patient's problems.[196]

Essentially, the foundation of the relationship between patient and therapist is trust.[197] Upon this, the patient will hopefully build a positive transference reaction with his therapist, which should then guide him toward the establishment of healthy relationships with others in his life.

The psychiatrist must not take advantage of the trust relationship thus nurtured. Moreover, it is essential that the therapist control his own reactions to the patient, or countertransference. Should any conflict arise, the psychiatrist's first duty must be to the patient and his best interests.[198,199]

Despite the inherent possibilities, there has been a relative dearth of suits against practitioners for the mishandling of psychotherapy.

First, there is still much uncertainty about what is acceptable therapy. There is a wide range of treatment extant; and a psychiatrist is not obligated to have the unanimous backing of his professional peers, provided his viewpoint is legitimately recognized even by a minority. Expert testimony can usually be obtained, no matter what the therapeutic approach.[200]

The second major difficulty a plaintiff must hurdle is that of proving the damages sustained from what was usually a non-physical injury. Psychotherapy is still a sufficiently growing science that results, be they good or bad, may not be easily attributable to therapeutic methods.[201]

The cases in the area of negligent psychotherapy will be loosely grouped into only two categories, depending upon whether they deal with social and/or sexual relations between therapist and patient.

The earliest and one of the most well-known cases is *Hammer v. Rosen*, 7 N.Y. 2d 376, 165 N.E. 2d 756 (1960). The cause of action asserted in *Hammer* was malpractice (alleged beatings) in the course of treatment. The patient was a young schizophrenic

girl, who had had more than one hundred and fifty shock treatments (without apparent benefit) before becoming a patient of Dr. Rosen. Several witnesses (including the patient's mother) testified that they had seen the girl emerge black and blue from the psychiatrist's office, often with torn clothing. The psychiatrist was never seen assaulting the patient.

The court held that "testimony given by three of patient's witnesses, indicating that psychiatrist had beaten patient on a number of occasions, made out a prima facie case of malpractice." 165 N.E. 2d at 756. As such, *Hammer* was the first case to hold that a psychiatrist's actions could be intrinsically negligent, and that plaintiff was not required to produce expert testimony in order to recover.[202] The case no doubt reflects the view that courts are rather uneasy about radically innovative forms of treatment.[203]

An unreported case, *Abraham v. Zaslow*, Docket No. 245862 (Sup. Ct., Santa Clara Co., Oct. 26, 1970), was also predicated upon alleged physical abuse. Defendant, a certified psychologist, practiced Rage Reduction or Z-Therapy, a form of treatment designed for autistic children in which the patient is restrained while being questioned by the therapist. If the answer is considered unsatisfactory, volunteer assistants tickle and poke the patient until a satisfactory reply is elicited. A twenty-two-year-old graduate student agreed to undergo the treatment experimentally. She was grilled and abused for ten to twelve hours continuously and suffered extensive bruising and acute renal failure. Ms. Abraham was awarded damages of $170,000.[204,205,206]

In general, psychiatrists have taken a relatively strong stand against direct sexual involvement with their patients.[207] The American Psychiatric Association has taken a very strong stand on the matter:

> The APA in its statement on 1 (of the principles of ethics of the American Medical Association) affirms the following:
> The patient may place his trust in his psychiatrist knowing that the psychiatrist's ethics and professional responsibilities preclude him from gratifying his own needs by exploiting the patient. This becomes particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationships established with the psychiatrist.
> The requirement that the physician 'conduct himself with propriety in his profession and in all the actions of his life' is especially important in the case of the psychiatrist because the patient tends to model his behavior after that of his therapist by identification. Further, the necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and therapist, while weakening the objectivity necessary for control. *Sexual activity with a patient is unethical.*[208]

While at least one practitioner (Shepard—*The Love Treatment: Sexual Intimacy between Patients and Psychotherapists*) advocates sex as a valuable therapeutic process, even he nonetheless cautions as to its potential for abuse.[209] And the majority of other investigators warn against direct sexual involvement, indicating that should the therapist fall in love with or become sexually attached to his or her patient, treatment should be discontinued at once and the patient referred elsewhere.[210] Certainly in a case where the treatment was questioned, the burden of justification would rest with the practitioner.[211]

Several cases will be discussed in the area of sexual and/or social involvement.[212]

Landau v. Werner, 105 Sol. J. 257, 105 Sol. J. 1008 (1961), was a British case. A psychiatrist undertook treatment of a middle-aged single woman in a state of anxiety. After several months, she allegedly felt much better but believed that she had fallen in love with her therapist and discontinued treatment.

Dr. Werner, feeling that an abrupt discontinuation of their relationship would be harmful to the plaintiff, saw her socially many times over the next several months; there was allegedly some talk of a joint vacation. Plaintiff's condition again deteriorated and Dr. Werner resumed treatment, but to no avail. The plaintiff was unable to work and

brought suit against Dr. Werner, alleging professional misconduct and negligence. Plaintiff was awarded £6000 and the doctor appealed. The judgment was upheld. Although the court found Werner not without good intentions, it determined that the defendant had not sufficiently justified his departure from traditional practice.

Like *Hammer v. Rosen, Landau* is indicative of the court's uneasiness as regards innovative forms of therapy. It also suggests that a therapist might well be held responsible for every aspect of his relationship with a patient.[213]

Zipkin v. Freeman, 436 S.W. 2d 753 (Mo. 1968), involved a psychiatrist with more questionable motives than Dr. Werner's. During the course of treating the plaintiff for a nervous condition, the defendant psychiatrist induced her to leave her husband, move in with him, give him sums of money, and take property from her home for his use, among other acts of misconduct.[214]

The court held that "the damage to the plaintiff was the result of [defendant's] mishandling of the transference phenomenon." 436 S.W. 2d at 762. Expert testimony supported the conclusion. A concurring opinion condemned Freeman even further, to wit:

> Regardless of all psychiatric theories, whether of transference, withdrawal, or otherwise, this relationship (and the doctor's acts) passed the point at which anyone could logically believe that they had any reasonable connection with professional services, or that they were being performed in the course of any legitimate treatment. In other words, the "treatment" ceased, and an ordinary, person-to-person, invasion of plaintiff's rights, civil or criminal or both, began. As an illustration of this, one of the expert witnesses said, according to the opinion: " * * * that a psychiatrist should no more take an overnight trip with a patient than shoot her"; and, so far as I am concerned, a similar conclusion may well be applied to many of the doctor's other acts. 436 S.W. 2d at 764-765.

The most recent case, *Roy v. Hartogs*, 81 Misc. 2d 350, 366 N.Y.S. 2d 297 (Civ. Ct. of N.Y. Trial Term 1975), upheld a $350,000 award to a plaintiff whose psychiatrist had sexual relations with her as a part of treatment for sexual problems. In a brief opinion, the court pointed out that the psychiatrist-patient relationship is a fiduciary one, and that "there is a public policy to protect a patient from the deliberate and malicious abuse of power and breach of trust by a psychiatrist when that patient entrusts to him her body and mind in the hope that he will use his best efforts to effect a cure." 366 N.Y.S. 2d at 301.[215]

The final two cases are not suits by patients, but nonetheless involve inappropriate psychotherapy. In *People v. Bernstein*, 171 Cal. App. 2d 279, 340 P. 2d 299 (Dist. Ct. App. 1959), a psychiatrist was convicted of the statutory rape of his sixteen-year-old patient. The girl had been brought to him because of her sexual promiscuity. In a later action, *Bernstein v. Board of Medical Examiners*, 204 Cal. App. 2d 378, 22 Cal. R. 419 (1962), the court upheld the revocation of Bernstein's license because of his conviction of a crime involving moral turpitude.

Morra v. State Board of Examiners of Psychologists, 212 Kan. 103, 510 P. 2d 614 (1973), also involved a license revocation. The court held that the evidence supported findings that the defendant had "wrongfully ignored his basic duty to avoid sexual intimacies with patients . . . and had neglected to consider the well-being of patients." 510 P. 2d at 614. The court noted Morra's violation of the code of ethics of the American Psychological Association.

In summary, the following cautions must be considered by psychotherapists:

1. The therapist must never take advantage of his patient's transference and must exert control over his own countertransference.
2. The therapist must be prepared to justify any treatment which is a radical or innovative form of therapy.
3. The therapist should be prepared for serious consequences (legal, professional, and

financial) should he become sexually or socially involved with a patient, whether or not in the name of therapy.

XI. Miscellaneous Areas of Liability

Other possible areas of liability faced by the psychiatrist are abandonment suits,[216] fee disputes,[217] breach of warranty action,[218] actions involving the physical plant of a hospital facility,[219] and suits involving research and experimentation.[220]

XII. Summary

It is indisputable that claims against psychiatrists are now reaching a new level of significance. Verdicts are being returned against more defendants, in a widening circle of liability, and for amounts which are ever increasing.

The following *caveats* should be observed by all psychiatrists:

1. *Diagnosis*

The psychiatrist must act with that degree of skill and care common to others in his specialty when diagnosing a patient. The diagnosis should be periodically reviewed.

2. *Shock therapies*
   a. The psychiatrist must obtain informed consent before proceeding. If the patient is incapable of consent for any reason, efforts should be made to communicate with a close relative or guardian.
   b. Proper premedication must be administered.
   c. Equipment and personnel to handle cardiorespiratory emergencies must be immediately available.
   d. Diligent care and observation must be supplied for a reasonable period of time after the treatment.

3. *Drug therapy*
   a. The psychiatrist must obtain informed consent (see 2-a above).
   b. Close attention should be paid to the manufacturer's package insert.
   c. Extreme caution must be observed in prescribing dangerous drugs for a potentially suicidal patient.

4. *Suicides*

Reasonable skill and diligence must be applied
   a. to determine the likelihood of a patient's committing suicide, and
   b. to protect the patient once suicidal tendencies have been diagnosed.

5. *Injuries to third parties*

The same considerations apply as were noted in "Suicides."

6. *Confidentiality: duty to warn*
   a. Before making any disclosures as to the mental state of his patient, a psychiatrist should be certain that he is protected by privilege (e.g., judicial immunity) or by the prior consent of the patient.
   b. However, *Tarasoff* (supra, p. 210 ff.) may impose on the psychiatrist an affirmative duty to warn a party whose life or safety has been threatened in a disclosure to the psychiatrist.

Competing interests must be carefully balanced.

7. *Commitment*

The psychiatrist must exercise due care and diligence in examining patients for commitment proceedings, taking care to see that there is probable cause.

8. *Psychotherapy*
   a. In addition to ordinary care and skill, the psychiatrist owes his patient the duty of maintaining the trust established in the therapist-patient relationship.
   b. The psychiatrist bears the burden of establishing the justification of any innovative therapy, particularly should he become sexually or socially involved with the patient.

While adherence to the above admonitions will not guarantee verdicts for defendant psychiatrists, it will hopefully reduce the professional, financial, and emotional costs of litigation.

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4. ibid
5. Dawidoff has estimated 1.5 claims/100 psychiatrists/year, as opposed to 1 claim/4 physicians/year for other practitioners. Dawidoff DJ: The Malpractice of Psychiatrists: Malpractice in Psychoanalysis, Psychotherapy, and Psychiatry. Springfield, Charles C Thomas, 1973, p viii
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9. Cassidy PS: The liability of psychiatrists for malpractice. 36 U Pitt L Rev 108 (1974), pp 130–1; Fink, op cit p 702; Tarshis, op cit p 96
10. Cassidy, op cit pp 130–1
11. ibid; Heller, op cit pp 401–2; Tarshis, op cit p 96
12. Dawidoff, op cit p 66
13. Beresford, op cit p 123
14. Kennedy CA: Injuries precipitated by psychotherapy: Liability without fault as a basis for recovery. 20 S Dak L Rev 401 (1975), p 401
15. Dawidoff DJ: The malpractice of psychiatrists. 1966 Duke LJ 696 (1966), p 696; Harris, op cit p 405; Rappeport JR: Psychiatrist-patient privilege. 23 Md L Rev 39 (1963), p 45; Sauer JG: Psychiatric malpractice—a survey. 11 Washburn LJ 461 (1972), p. 470; Saxe DB: Psychiatric treatment and malpractice. 37 Med-Leg J 187 (1969), p 187
16. Messinger, op cit p 21; Rothblatt, op cit p 261
17. Bellamy WA: Malpractice risks confronting the psychiatrist: A nationwide fifteen-year study of appellate court cases, 1946 to 1961. 118 Am J Psychiatry 769 (1962), p 778
18. ibid p 770
19. Beresford, op cit p 124; Dawidoff (book), pp 72–3; Heller, op cit p 401; Rodis I and Groh RH: One aspect of the medicolegal implications of shock therapy, 51 So Med J 219 (1958), p 219
20. Lesse, however, has little faith in attorneys' likelihood to do so: "The legal profession in general does not hold psychiatrists in great respect. Many are viewed as mumbling philosophers who cannot express themselves in a comprehensible fashion." Lesse, op cit pp 183–4

* For the sake of brevity, the works of multiple authors in "op cit" citations will generally be referred to by the last name of the first listed author only.

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22. Rothblatt, op cit p 262
23. Note that the present discussion is confined to psychiatric *malpractice*, and does not include other areas of psychiatric tort liability (false imprisonment, duty to warn, etc.).
24. Krouner LW: Shock therapy and psychiatric malpractice: The legal accommodation to a controversial treatment, 2 For Sci 397 (1973), p 404
25. Dawidoff (book), p 71; Perr IN: Liability of hospital and psychiatrist in suicide, 122 Am J Psychiatry 631 (1965), p 633
26. Dawidoff (book), pp 70–71; Harris, op cit pp 411–2; Kennedy, op cit p 405; Messinger, op cit pp 21–2; Rothblatt, op cit p 263
27. Cassidy, op cit pp 132–3; Dawidoff (book), p 61; Glenn, RD: Standard of care in administering non-traditional psychotherapy, 7 UCD L Rev 56 (1974), p 68
28. The common rule has been stated as follows: "[U]nder the present law a plaintiff cannot avoid a directed verdict for the defendant physician unless he produced expert testimony in regard to the applicable standard of medical practice except in rare cases of *res ipsa loquitur*, or where common lay knowledge is enough to judge the defendant's conduct as malpractice." Dawidoff (book), p 65, quoting Curran
29. Cassidy, op cit pp 132–3
30. Dawidoff cites the following as reasons for experts' reluctance to testify: the belief that such an appearance would be unethical, time, financial loss, fear of reprisal, and reticence to come forth from a "realm of privacy and confidence." (book) p 62.
31. Harris, op cit p 419; Messinger, op cit p 22; Perr, op cit p 633
32. Tancredi, op cit p 25
33. Dawidoff (book), pp 61, 66; Kennedy, op cit p 408
34. Dawidoff (book), p 15
35. Kennedy, op cit pp 405–6
36. Cassidy, op cit pp 134–5; Kennedy, op cit pp 405–6; Rothblatt, op cit p 264
37. Fink, op cit p 702
38. Heller, op cit p 402
39. Rothblatt, op cit pp 405–6
40. Prosser, Law of Torts (4th ed), Sec 54 at p 328
41. Cassidy, op cit p 135; Harris, op cit p 418; Kennedy, op cit p 406; Messinger, op cit p 22; Rothblatt, op cit p 264; Tarshis, op cit p 94
42. Cassidy, op cit p 135
43. Rothblatt has suggested that, in addition to proving the aforementioned elements of negligence, the plaintiff may also have to demonstrate that he neither assumed the risk of injury nor contributed in a negligent way to the damages he claims to have sustained. If he is unable to do so, plaintiff may be denied recovery. Rothblatt, op cit p 265
44. Dawidoff (book), p 67
45. Messinger, op cit p 29
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49. Dawidoff, Some suggestions . . ., p 701
50. Bellamy, op cit p 776; Dawidoff, Some suggestions . . ., p 699; Hamilton, op cit p 71
51. Rothblatt, op cit p 272
52. Bellamy WA: Malpractice in psychiatry. 26 Dis Nerv Syst 312 (1965), p 319
53. Slawson, op cit p 1305
54. Cassidy, op cit pp 127–8; Harris, op cit p 409
55. Dawidoff (book), pp 22–3
56. Messinger, op cit p 23
57. Harris, op cit p 410
58. Dawidoff (book), p 135
59. Krouner, op cit p 398
60. ibid p 400; Krouner LW: Shock therapy and psychiatric malpractice: The legal accommodation to a controversial treatment, 20 J For Scis 404 (1975), pp 404–5
61. Beresford, op cit p 129
62. Krouner, 20 J For Scis at 406
63. Morse HN: The tort liability of the psychiatrist. 16 Buff L Rev 649 (1966–7), p 656
64. Dawidoff (book), p 136; Fink, op cit p 703; Sauer, op cit p 468

65. Morse, op cit pp 654–5
66. Dawidoff (book), p 136; Fink, op cit p 703; Sauer, op cit p 468
67. Beresford, op cit pp 132–3
68. ibid p 134
69. ibid p 124; Krouner, 2 For Sci at 402–3
70. However, at least one investigator believes that all prospective mental patients are entitled to informed consent about the "extremely high failure, injury, and death rates under psychiatric hospital care, of the extinction of civil rights, of the true extent of discrimination which permanently handicaps the ex-mental hospital patient." Kimmel M: Patterns and consequences of psychiatric hospital treatment, 21 Brook Bar 186 (1969–70), p 187
71. Cassidy, op cit p 118
72. Bellamy, op cit p 778; Cassidy, op cit p 119; Krouner, 2 For Sci at 415–6; Morse, op cit p 652
73. Cassidy, op cit pp 118–9; Morse, op cit pp 649–50; Rothblatt, op cit p 268; Tarshis, op cit pp 88–92
74. Beresford, op cit p 124; Sauer, op cit p 145
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76. Beresford, op cit pp 128–9; Krouner, 2 For Sci at 405; Morse, op cit 650; Sauer, op cit p 462; Tancredi, op cit p 22
77. When it is difficult or impossible to locate a relative or guardian, *implied* consent (e.g. voluntary submission to treatment) may protect the psychiatrist.
78. Messinger, op cit 23; Rodis, op cit p 220; Rothblatt, op cit p 268
79. Suggested consent forms may be found in Appendix A
80. Cassidy, op cit pp 118–9; Fink, op cit p 703; Krouner, 2 For Sci at 406, 409; Margulies, op cit pp 643–4; Messinger, op cit p 22; Morse, op cit pp 650, 651; Sauer, op cit p 462; Tancredi, op cit p 123
81. It may be of interest to note that the attorneys-general of two states (Vermont in 1944–46 and Pennsylvania in 1947–48) have at one time determined that electroshock therapy is valid without consent as regards patients hospitalized under involuntary commitment orders. Beresford, op cit p 127; Krouner, 2 For Sci at 405–6; See also Advisory opinion upholding legality of administering electric shock treatments to patients of state mental hospitals without consent. 97 U Penna L Rev 436 (1949)
82. Krouner, 2 For Sci at 416
83. A similar result was reached in an English case. Bolam v Friern Hospital Committee (1957), 2 All Eng L Rev 118. Krouner, 2 For Sci at 417
84. Other cases are: O'Rourke v Halcyon Rest, 281 AD 838, 118 NYS 2d 693 (1953) and Bailey v Dept of Mental Health, 2 NC App 645, 163 SE 2d 652 (1968)
85. The elements of res ipsa loquitur are as follows: 1. The event must be of a kind which ordinarily does not occur in the absence of someone's negligence; 2. It must be caused by an agency or instrumentality within the exclusive control of the defendant; 3. It must not have been due to any voluntary action or contribution on the part of the plaintiff. Prosser, Law of Torts (4th ed), p 214. As the condition in (1) can rarely be fulfilled, res ipsa loquitur is usually rejected in the shock therapy cases. Quinley v Cocke, 183 Tenn App 428, 192 SW 2d 992 (1946); Farber v Olkon, 40 Cal 2d 503, 254 P 2d 520 (1953); Johnston v Rodis, 251 F 2d 917 (DC Cir 1958); Mitchell v Robinson, 334 SW 2d 11 (Mo 1960); Collins v Hand, 431 Pa 378, 246 A 2d 398 (1968)

Stone v Proctor, 259 NC 633, 131 SE 2d 297 (1963) represents a minority view—the admission into evidence of the published standards (1953) of the American Psychiatric Association's Commission on Therapy, to establish the negligence of the defendants. Since 1959, the more general standards make it harder for plaintiffs to set forth a specific standard of care without expert testimony (Krouner, 2 For Sci at 418). Expert testimony was required in Howe v State, 33 Misc 2d 143, 226 NYS 2d 933 (Ct Cl 1962).

86. Krouner, 2 For Sci at 411.
87. The only case which might seem to support a somewhat laxer standard is Roth v Havens, Inc, 56 Wash 2d 393, 353 P 2d 159 (1960). It is distinguishable, however, since the patient fell from his bed more than twenty-four hours after his last shock treatment, much longer than the usual period of confusion, and much longer than any previous period of confusion suffered by this individual.
88. The case was actually a malpractice suit against an attorney for failing to bring an action within the period of the statute of limitations. However, the opinion rendered sufficient conclusions on the medical issues to make the case a relevant one for the purposes of this study.
89. Bellamy, 118 Am J Psych at 772
90. For example, cardiac arrest, arrhythmias, and respiratory distress. Moreover, if the patient is insufficiently oxygenated during EST, while he is anesthetized and/or paralyzed, or during

the post-convulsive state, during which respiration is often depressed, hypoxic brain injury might occur, causing permanent neurological deficits. The author has found no cases in this area. Beresford, op cit p 132

91. 1-3 are from Beresford HR: Legal issues relating to electroconvulsive therapy. 25 Arch Gen Psychiatry 100 (1971), p 100

92. Appleton WS: Legal problems in psychiatric drug prescription. 124 Am J Psychiatry 877 (1968), p 877

93. Saxe DB: Psychotherapeutic treatment and malpractice liability. 58 Ky LJ 467 (1969–70), p 468

94. Appleton, op cit p 877

95. Dawidoff (book), p 97

96. In this context, see Christy v Saliterman, discussed supra, p 198

97. Beresford, 21 Def LJ at 135–7

98. Appleton, op cit passim

99. Beresford, op cit p 138

100. Appleton, op cit p 881

101. Appleton WS: Psychotherapist prescribes a drug in his office; medicolegal risks. 16 Med Tr Tech Q 33 (9/69) and 51 (12/69), p 52

102. Appleton, 124 Am J Psych at 881; Beresford, op cit pp 134–5

103. Appleton, 124 Am J Psych at 881

104. ibid

105. ibid at 879–90; Appleton, 16 Med Tr Tech Q at 52, 55; Beresford, op cit pp 140–141; The reader is also referred to informed consent in the area of shock therapy, discussed supra, pp 195–197

106. Medicolegal—cheese and tranylcypromine, 3 Br Med J 354 (1970), cited in Beresford, op cit p 140

107. Appleton, 124 Am J Psych at 876; Appleton, 16 Med Tr Tech Q at 36

108. Appleton, 124 Am J Psych at 880

109. Dawidoff, 29 Arch Gen Psych at 699–700

110. Appleton, 124 Am J Psych at 881

111. The plaintiff had complained of headaches.

112. Dawidoff (book), p 84

113. At first blush, one might assume that psychiatric hospitals would be involved in all such litigation. However, Veterans hospitals, for example, are frequently named as defendants; and in De Martini v Alexander Sanitarium, Inc, 192 Cal App 2d 442, 13 Cal R 564 (1961), a California court held that general *and* psychiatric hospitals entitle mental patients to the same degree of care.

114. Chayet NL: Psychiatric emergencies. 1969 Leg Med Ann 91 (1969), p 93; Harris, op cit p 422; Perr, op cit p 631

115. Schwartz VE: Civil liability for causing suicide: A synthesis of law and psychiatry, 24 Van L Rev 217 (1971), p 217

116. Perr IN: Suicide responsibility of hospital and psychiatrist, 9 Clev-Mar L Rev 427 (1960), p 428; Saxe, 58 Ky LJ at 480

117. Perr, 122 Am J Psych at 632

118. Litman RE: Medical-legal aspects of suicide, 6 Washburn LJ 395 (1967), pp 397–8

119. Schwartz, op cit p 245

120. Krouner, 2 For Sci at 411; Margulies, op cit p 644

121. Litman, op cit p 401

122. Schwartz, op cit p 246

123. ibid pp 246–7

124. ibid pp 247–8; See Section VII: Confidentiality and Privilege, for a more detailed description of the issues involved.

125. The most well-known and illustrative cases will be dealt with in this study. The reader is referred to a more extensive source of cases in Appendix B.

126. Perr, 122 Am J Psych at 633

127. Beresford, 21 Def LJ at 156–7; Dawidoff (book), p 131; Harris, op cit p 421; Messinger, op cit p 25; Perr, 122 Am J Psych, passim; Saxe, 58 Ky LJ at 481; Tarshis, op cit p 87

128. Tarshis, op cit p 87

129. Sauer, op cit p 463

130. Murphy GE: Recognition of suicidal risk: The physician's responsibility, 62 So Med J 723 (1969), pp 725, 727

131. Beresford, 21 Def LJ at 162–3; Dawidoff (book), p 131; Messinger, op cit p 25; Sauer, op cit p 463. Note that the cases discussed may involve attempts as well as successful suicides; the principles are identical.

132. In suits against government hospitals (state or federal), government immunity is often at issue. That area of the law will not be surveyed in this study.

133. The determination of negligence in suicide cases is usually thought to require expert testimony. Harris, op cit pp 424–5. In some cases, however, the requirement was obviated; see e.g. Bennett v Punton Sanitarium Association, 213 Mo App 363, 249 SW 666 (1923); US v Gray, 199 F 2d 239 (10th Cir 1952); De Martini v Alexander Sanitarium, Inc, 192 Cal App 2d 442, 13 Cal R 564 (1961); Vistica v Presbyterian Hospital and Medical Center, 67 Cal 2d 465, 62 Cal R 577, 432 P 2d 193 (1967); Wright v State, 31 AD 2d 421, 300 NYS 2d 153 (1969)
134. Messinger, op cit p 24; Sauer, op cit p 466
135. Harris, op cit p 421; Litman, op cit p 401; Perr, 9 Clev-Mar L Rev at 433; Schwartz, op cit pp 249–50
136. Liability of mental hospitals for acts of their patients under the open door policy. 57 Va L Rev 156 (1971), p 158 (Henceforth Liability . . .); Perr, 9 Clev-Mar at 439–40
137. Dawidoff (book), p 3; *Liability* . . ., op cit p 159; Litman, op cit p 398; Perr, 9 Clev-Mar at 430; Saxe, 58 Ky LJ at 481
138. Cooper TR: Medical treatment facility liability for patient suicide and other self-destruction. 3 J Leg Med 8 (Jan 1975), p. 8; *Liability* . . ., op cit p 162
139. Bellamy, 26 Dis Nerv Syst at 313; Perr, 122 Am J Psych at 637; Saxe, 58 Ky LJ at 481
140. The open door policy has found recognition in the courts. See for example Hirsh v State, 8 NY 2d 125, 202 NYS 2d 296, 168 NE 2d 372 (1960); Gregory v Robinson, 338 SW 2d 88 (Mo 1960); Dimitrijevic v Chicago Wesley Memorial Hospital, 92 Ill App 2d 251, 236 NE 2d 309 (1968); Lucy Webb Hayes National Train Sch for D & M v Perotti, 419 F 2d 704 (DC Cir 1969)
141. Schwartz, op cit pp 250–1
142. The dissent pointed out that a previous suicide attempt had been made in a similar fashion. Nonetheless, all conceivable precautions *were* taken, hence the finding of no liability.
143. Note: A psychiatrist in private practice whose patient is hospitalized as a suicidal risk should make all records available to the hospital psychiatrists. He should also make continual checks to ensure proper supervision. Hospital personnel are then less likely to be negligent and the referring psychiatrist less likely to be a target of litigation. Messinger, op cit p 24
144. Cooper, op cit pp 14–5
145. Cassidy, op cit pp 111–2. See n 132 for the author's policy on the immunity issue.
146. Krouner, 2 For Sci at 411; Liability . . ., op cit p 164–5
147. Harris, op cit p 421
148. $200,000 award points up widening malpractice liability. 7 Med World News 170 (Oct 14, 1966) (Henceforth $200,000 . . .)
149. However, in cases of the voluntarily hospitalized patient, the psychiatrist and hospital may find themselves caught between the Scylla of liability to the public and the Charybdis of a false imprisonment action should the patient be held in the hosptial against his will. $200,000 . . ., op cit p 171
150. Lerner J: Confidentiality of psychiatric reports used in evaluating social security disability claims. 120 Am J Psychiatry 992 (1964), p 992; Modlin HK: How private is privacy? 30 Psychiatry Dig 13 (Feb 1969), p 14
151. Hollender MH: The psychiatrist and the release of patient information. 116 Am J Psychiatry 828 (1960), p 830
152. Guttmacher MS and Weihofen H: Psychiatry and the Law, NY: W.W. Norton & Co, Inc, 1952, p 272
153. Fisher RM: The psychotherapeutic professions and the law of privileged communications. 10 Wayne L Rev 609 (1964), p 622; Freedman AM: Looking over the doctor's shoulder, 11 Trial 29 (Jan-Feb 1975), p 29; Guttmacher & Weihofen, op cit p 271; Psychiatrist-patient privilege—a need for retention of the future crime exception. 52 Iowa L Rev 1170, 1967, p 1179 (Henceforth Privilege)
154. The reader will recall that after his psychiatric treatment came to light, Senator Thomas Eagleton was rejected as a Vice-Presidential candidate.
155. Fleming, op cit p 1033
156. Slovenko R and Usdin GL: The psychiatrist and privileged communication. 4 Arch Gen Psychiatry 431 (1961), p 436
157. Davis DG: Evidence—privileged communications—a psychiatrist has no constitutional right to assert an absolute privilege against disclosure of psychotherapeutic communications. In re Lifschutz 49 Tex L Rev 929 (1971), pp 935–6; Dawidoff (book), p 10; Fisher, op cit p 620; Guttmacher & Weihofen, op cit p 272; Heller, op cit p 406; Hollender, op cit p 829; Kennedy C: The psychotherapist's privilege. 12 Washburn LJ 297 (1973), p. 314; Lebensohn ZM: Psychiatry and national security. 175 JAMA 1001 (1961), p 1001; Louisell DW: The psychologist in today's legal world. Part III. 41 Minn L Rev 731 (1957), p 750; Love, op cit p 426; Marmor J: The seductive psychotherapist. 31 Psychiatry Dig 10 (Oct 1970), pp 10–1; Menninger WW and English JT: Confidentiality and the request for psychiatric information for nontherapeutic purposes. 122 Am J Psychiatry 638 (1965), p 640; Plaut EA: A perspective on confidentiality. 131 Am J Psychiatry 1021 (1974), p 1021; Privilege, op cit p 1180; Psychoanalysts subpoenaed (letter),

2 Lancet 785 (1965), p 785; Slawson PF: Patient-litigant exception: A hazard to psychotherapy. 21 Arch Gen Psychiatry 347 (1969), p 352; Slovenko R: Psychiatry and a second look at the medical privilege. 6 Wayne L Rev 175 (1960), p 199; Suarez JM and Balcanoff EJ: Massachusetts psychiatry and privileged communication. 15 Arch Gen Psychiatry 619 (1966), p 619; Tancredi op cit p 50; Tarshis op cit p 92; Vidakovich J: Are the records of mental hospitals privileged in mental incompetency adjudications? 19 Wyo LJ 59 (1964–65), p 61

158. Goldstein AS and Katz J: Psychiatrist-patient privilege: The GAP proposal and the Connecticut statute. 36 Conn B J 175 (1962), p 178; Psychoanalyst subpoenaed, op cit p 786; Rappeport op cit p 45; Tancredi op cit p 56

159. Closson WG, Hall RA and Mason BS: Confidentiality in psychiatry and psychotherapy. 113 Cal Med 12 (Oct 1970), p 13; Daley DW: Tarasoff and the psychotherapist's duty to warn. 12 San Diego L Rev 932 (1975), p 948; Fisher op cit p 611; Freedman op cit p 33; Goldstein op cit pp 178–9; Guttmacher MS and Weihofen H: Privileged communications between psychiatrist and patient. 28 Ind L J 32 (1952–3), p 34; Heller op cit p 407; Hollender op cit p 832; Kennedy, 12 Washburn LJ at 300; Malcolm JJ: Negligence—physicians and surgeons—duty imposed on psychotherapists to exercise reasonable care to warn potential victims of foreseeably imminent danger posed by mentally ill patients—Tarasoff, 6 Set Hall L Rev 536 (1975), p 546; Privilege, op cit pp 1178–9; Slovenko R: Psychotherapist-patient testimonial privilege: A picture of misguided hope. 23 Cath U L Rev 649 (1974), p 649; Tancredi, op cit p 141

160. Guttmacher & Weihofen (book), p 273

161. Note, Functional overlap between the lawyer and other professionals: its implications for the privileged communications doctrine. 71 Yale LJ 1226 (1962), p 1255

162. Slovenko and Usdin op cit p 431

163. Section 9, Principles of Medical Ethics of the American Medical Association, The principles of medical ethics with annotations especially applicable to psychiatry. 130 Am J Psychiatry 1058 (1973), p 1059 (Henceforth Principles)

164. 1962 Statement of American Psychiatric Association, cited in Closson, op cit p 12

165. It has been suggested that the privilege be jointly held, by the patient to protect himself and by the therapist to protect the practice of psychotherapy. Hollender MH: Privileged communication and confidentiality. 26 Dis Nerv Syst 169 (1965), p 169; Suarez op cit pp 18–19

166. Beresford, 21 Def L J at 153; Chayet op cit p 104; Daley op cit pp 945–6; Guttmacher & Weihofen (book), p 279; Lebensohn op cit p 1001; Menninger op cit p 647; Plaut, op cit p 1021; Privilege, op cit pp 1170–1; Suarez op cit 622; Tancredi op cit p 52; Vidakovich op cit 62; Watson AS: Communication between psychiatrists and lawyers. 1 Internat'l Psychiatry Clin 185 (#1, 1964), p 195

167. Tancredi op cit p 52

168. Slovenko, 23 Cath U L Rev at 655

169. Cal Evid Code §1014 (West 1966); Conn Gen Stat Rev §52–146d (1974); Fla Stat Ann §90.242 (Supp 1966); Ga Code Ann §38–418 (Supp 1966); Ill Rev Stat ch 51, §5.2 (1965); Ky Acts 1966, ch 121 at 569; Md Ann Code art 35, §13A (Supp 1966); Malcolm op cit p 545; Privilege, op cit p 1180

170. Slovenko & Usdin op cit p 436

171. Beresford, 21 Def L J at 153; Fisher op cit p 631; Kennedy, 12 Washburn LJ at 304; Psychoanalyst subpoenaed, op cit p 786; Slawson, 21 Arch Gen Psych at 351–2; Slovenko & Usdin op cit p 439

172. See In re Lifschutz, 2 Cal 3d 415, 85 Cal R 829, 467 P 2d 557 (1970)

173. At this point, brief notice should be taken of other threats to confidentiality—requests for information by third party payers, computer data bank storage of records, multistate record systems—to mention a few of the most prominent. For further information, the reader is referred to Freedman A.M: Looking over the doctor's shoulder. 11 Trial 29 (Jan-Feb 1975), and the Tancredi book, supra, note 6, p 22 ff

174. Zenoff E: Confidentiality and privileged communications, 182 JAMA 656 (1962), p 662

175. An additional case is Hager v Major, 353 Mo 1166, 186 SW 2d 564 (1945)

176. A claim made for invasion of privacy was dismissed.

177. Inglis BD: Furniss v Fitchett: A footnote, 34 NZLJ 235 (1958), p 235.

178. For a more detailed analysis of the case, see Freedman, op cit pp 28–9

179. Daley, op cit p 937; Fleming op cit pp 1029–31; Malcolm op cit pp 540–1

180. Daley op cit 937; Fleming op cit p 1029; Glassman M.S.: Torts—confidential communications—privileged communications—psychiatry. . . . *Tarasoff v. Regents of Univ. of Calif.* 44 Cin L Rev 368 (1975), p 371; Latham JA: Torts—duty to act for protection of another—liability of psychotherapist for failure to warn of homicide threatened by patient, 28 Vand L Rev 631 (1975), pp 632–3; Malcolm, op cit pp 538–9. See also: Wojcik v Aluminum Co of America, 18 Misc 2d 740, 183 NYS 2d 351 (Sup Ct 1959); Kaiser v Suburban Transportation System, 65 Wash 2d 461, 398 P 2d 14, mod 401 P 2d 350 (1965)

181. Beresford, 21 Def L J at 163; Chayet op cit p 95; Daley op cit pp 940–2; Glassman op cit p

371; Latham op cit pp 639–40; McGarry AL: Psychiatry and the dangerous offender. 272 NEJM 684 (1965), p 684; Pendley WP: Torts—the dangerous psychiatric patient—the doctor's duty to warn. Tarasoff. 10 Land and Water L Rev 593 (1975), pp 599–600; Privilege, op cit p 1185

182. Chayet op cit p 104; Daley op cit p 949; Fleming op cit pp 1034–40; Glassman op cit p 373; Latham op cit p 639; Messinger, op cit p 23

183. People v Poddar, 10 Cal 3d 350, 111 Cal R 910, 518 P 2d 342 (1974)

184. Tarasoff v Regents of University of California, 13 Cal 3d 177, 118 Cal R 129, 529 P 2d 553 (1974). See also Tarasoff v Regents of University of California, 33 Cal App 3d 275, 108 Cal R 878 (1973)

185. Cal Evid Code Section 1024

186. Curran WJ: Confidentiality and the prediction of dangerousness in psychiatry, 293 NEJM 285 (1975), p 286

187. Fleming op cit pp 1064–6

188. Dawidoff, 29 Arch Gen Psych at 700

189. Curran WJ: Malpractice by psychiatrists in a private hospital. 60 Am J Pub Health 1528 (1970), p 1529; Messinger op cit p 25; Rothblatt op cit pp 270–1; Sauer op cit pp 463–4

190. The Principles of Medical Ethics of the American Medical Association also speak to the issue. See Section 10, Principles, op cit p 1063

191. For additional commitment cases, see Appendix D.

192. Beresford, 21 Def LJ at 150; Dawidoff (book), pp 99–100; Harris op cit p 416

193. Dawidoff (book), p 101; Harris op cit p 415

194. Bellamy, 26 Dis Nerv Syst at 316

195. Beresford, 21 Def LJ at 152

196. Heller op cit p 406

197. Dawidoff (book), p 43; Guttmacher & Weihofen (book), p 270; Marmor op cit p 14; Sauer op cit p 469

198. Beresford, 21 Def LJ at 147; Dawidoff (book), p 52; Glenn op cit p 69; Messinger op cit p 26; Saxe, 37 Med-Leg J at 191; Tarshis op cit pp 84–85

199. At least two separate studies have concluded that psychotherapy can play a causal role in patients' suicides. Negative countertransference may cause a therapist unconsciously to permit a suicide to rid himself of a source of irritation. Therefore, the psychotherapist must be particularly cautious in handling his countertransference vis à vis an already depressed or despondent patient. Bloom V: An analysis of suicide at a training center. 123 Am J Psychiatry 918 (1967), pp 918, 922; Dawidoff (book), p 57; Kennedy, 20 S Dak L Rev at 403; Saxe, 37 Med-Leg J at 194; Stone AA: Suicide precipitated by psychotherapy. A clinical contribution. 25 Am J Psychotherapy 18 (1971), p 19

200. Beresford, 21 Def LJ at 145; Dawidoff (book), p 83; Fink op cit p 705; Harris op cit p 435; Heller op cit pp 404–5; Tancredi op cit p 122; Tarshis op cit p 86

201. Beresford, 21 Def LJ at 142–4, 148; Fink op cit p 708; Glenn op cit p 65; Harris op cit p 417; Kennedy 20 S Dak L Rev at 402–3; Saxe, 58 Ky LJ at 479

202. Messinger op cit p 26

203. Dawidoff (book), p 68; Morse op cit pp 664–5; Saxe, 58 Ky LJ at 479

204. Glenn op cit pp 66–7

205. The state was successful in its revocation of the defendant's license, but he is apparently still practicing and training other therapists in New York, Massachusetts, Colorado, and New Jersey. Glenn op cit pp 66–7

206. A third case, Hess v Frank, 47 AD 2d 889, 367 NYS 2d 30 (1975); concerned allegedly abusive statements made by a psychiatrist.

207. Perr IN: Legal aspects of sexual therapies, 3 J Leg Med 23 (Jan 1975), p 24

208. ibid p 23

209. Messinger op cit p 29

210. For example, Marmor op cit p 15, and Perr, 3 J Leg Med at 28

211. Beresford, 21 Def LJ at 145–6; Marmor, op cit p 14; Perr, 3 J Leg Med at 28

212. Additional cases in the area are: Nicholson v Han, 12 Mich App 35, 162 NW 2d 313 (1968); Anclote Manor Foundation v Wilkinson, 263 So 2d 256 (Fla App 1972); and Whitesell v Green, Docket No 38745 (Haw Dist Ct, Honolulu, Nov 19, 1973), reported in 28 Citation 172, cited by Perr in 3 J Leg Med at 27

213. Dawidoff (book), p 41

214. Although the facts are too detailed to be discussed in depth, they are quite interesting; the author recommends a full reading of the case.

215. An appellate court has recently reduced the judgment to $25,000. The defendant now faces investigation by the New York County Medical Society's Board of Censors, the State Education Department's Division of Professional Conduct, and the American Psychiatric Association Com-

mittee on Ethics and Discipline. For further details of the case, see Stimeling G: A Case in Point, 3 J Leg Med 28 (April, 1975).

216. Cassidy op cit pp 129–30; Dawidoff (book), pp. 12–13, 38, 57, 74; Tancredi op cit pp 118–9, 121; Tarshis op cit pp 87–8

217. Cassidy op cit pp 117–8; Dawidoff (book), pp 74–5; Gasperini v Manginelli, 196 Misc 547, 92 NYS 2d 575 (Sup Ct 1949); Hess v Frank, 47 AD 2d 889, 367 NYS 2d 30 (1975)

218. Bellamy, 118 Am J Psych at 778; Dawidoff (book), p 21

219. Morse op cit p 673; Gallachicco v State, 43 NYS 2d 439 (Ct Cl 1943)

220. Butler RN: Privileged communication and confidentiality in research. 8 Arch Gen Psychiatry 139 (1963), pp 139–40; Davidson HA: Legal and ethical aspects of psychiatric research, 126 Am J Psychiatry 237 (1969), p 238

221. Psychiatrists in the states of New York and California represent a disproportionately large number of defendants. As judgments in those jurisdictions also tend to be high, psychiatrists in the two areas should be even more cautious.

Appendix A

Consents to Shock Therapy

Details of Electroshock Therapy

Electroshock therapy is an accepted form of treatment for certain types of nervous and mental illness. It has been used successfully in thousands of cases since its introduction in 1938. It is one of the most effective ways of treating depressed patients with suicidal tendencies or patients who might otherwise require prolonged hospitalization.

The psychiatrist himself gives the treatment, using a specially designed electronic instrument. The treatment consists of passing a controlled electric current between two electrodes applied to the patient's temples. In some instances the patient may be given medication prior to treatment to reduce tension and produce muscular relaxation. The patient experiences no discomfort or pain during the treatment; he does not feel the electric current and has no memory of the treatment. When the treatment is given, the patient becomes immediately unconscious and has strong muscular contractions of a convulsive nature. These contractions last 35 to 50 seconds. Complete relaxation follows and several minutes later the patient gradually regains consciousness. His condition is similar to that of a patient emerging from brief anesthesia. Within 15 to 60 minutes, the confusion clears and the patient is able to recognize his surroundings. Following this, the patient is permitted to get up and about. Headache and nausea sometimes occur, but these are infrequent and usually respond rapidly to simple treatment.

The number of treatments in any given case will vary with the condition being treated, and the individual response to treatment. The frequency of treatment will also vary with each case. As the treatments progress (usually after the 3rd and 4th treatment), a certain amount of haziness of memory and confusion develops. This memory impairment is transitory and clears up within several weeks following the last treatment.

Electroshock therapy, like any other medical or surgical procedure, involves a certain amount of calculated risk. Complications are infrequent, the most common being fractures and/or dislocations of the extremities, or fractures of the vertebrae. These may sometimes occur in spite of all precautions and must be looked upon as a recognized hazard of the treatment. Should such an injury occur, the patient and his family will be notified and urged to call in a physician competent to treat the complication.

During the hospital treatment, the patient's general care is provided by the hospital personnel. On discharge from the hospital, the patient begins a "convalescent period" of several weeks duration during which he must be under strict supervision of some member of the family or some responsible person selected by the family. This precaution is necessary because of the temporary mental confusion and impairment of memory. During this entire period, the patient is not permitted to drive an automobile, to transact any business or to carry on his usual employment until the doctor gives his permission. He should not be permitted to leave the house unless accompanied by a responsible companion because of the possibility that he may wander off and get lost. Supervision is very important and must be provided by a responsible person.

Finally, a word about the results of treatment. Although the results in most cases are gratifying, not all cases will respond equally well. As in all forms of medical treatment in general, some patients will recover promptly; others will recover only to relapse again and require further treatment; still others may fail to respond at all.

The above information has been prepared to answer some of the most frequently asked questions concerning electroshock therapy. The treating psychiatrist will be glad to answer any further questions which may occur to the patient or his family.

When the patient is treated by the ambulatory or outpatient method the family, or someone designated by the family, has definite and real responsibility for the patient's

care. The patient is escorted to the hospital or the doctor's office. The responsible person stays with the patient until he reacts from the treatment and then escorts him back home. During the approximately two-week period of treatment and for at least two or three weeks following termination of treatment the patient must be under the strict supervision and companionship of the family.

Date:_____

I, _____, hereby acknowledge receipt and understanding of this information sheet which contains details relative to the care, risks, and treatment to be received by

_____

Witness:_____Signed: _____

Consent for Electroshock and/or Insulin Treatment

INSULIN

I, John Doe, a patient in the George Washington University Hospital, Washington, D.C., and I, Mary Doe, of 4444 West North Street, being the wife, and nearest relative of John Doe, do hereby authorize and direct Dr. Blank or his designee, to administer

electroshock
insulin } treatment, having been fully informed of its nature and purpose. I also agree to hold the George Washington University Hospital, all of its officers and employees, and the attending physician free from liability for any injury which may result from such treatment.

_____
Witness

_____
Patient's Signature

_____
Date

_____
Witness

_____
Relative's Signature

_____
Date

Rodis, Isadore and Robert H. Groh. *One Aspect of the Medicolegal Implications of Shock Therapy*, 51 So. Med. J. 219 (1958), p. 220.

Consent to Shock Therapy

A.M.
Date _____ Time _____ P.M.

1. I (We) authorize Dr. _____ and assistants of his choice, to administer _____ shock treatment,
(insulin and/or electric)
and relaxant drugs and other medication to _____;
(name of patient)
and to continue such treatment at such intervals as he and his assistants may deem advisable.

2. The effect and nature of this treatment and possible alternative methods of treatment have been explained. I (We) understand that shock therapy, like medical and surgical procedures, involves an element of risk despite precautions, and the possibility of complications such as dislocations and fractures of the limbs and vertebrae.

3. In addition to the foregoing, the strict care which will be required immediately following treatment and during convalescence has been fully explained to me (us).

4. No guarantee or assurance has been given by anyone as to the results that may be obtained.

Signed _____

Signed _____

Witness _____

Morse, Howard Newcomb. *The Tort Liability of the Psychiatrist*, 16 Buff. L Rev. 649 (1966–7), p. 687.

Appendix B

Suicide Cases

Adams v State, 71 Wash 2d 414, 429 P 2d 109 (1967)
Apicella v State of New York, 207 Misc 743, 140 NYS 2d 634 (Ct Cl 1955)
Arlington Heights Sanitarium v Deaderick, 272 SW 497 (Tex Civ App 1925)
Bannon v US, 293 F Supp 1050 (D RI 1968)
Brawner v Bussell, 50 Ga App 840, 179 SE 228 (1935)
Brigante v State, 33 NYS 2d 354 (Ct Cl 1942)
Broz v Omaha Maternity and General Hospital Ass'n, 96 Neb 648, 148 NW 575 (1914)
Callahan v State, 179 Misc 781, 40 NYS 2d 109 (Ct Cl 1943), aff'd 266 AD 1054, 46 NYS 2d 104 (1943)
Carlino v State, 30 AD 2d 987, 294 NYS 2d 30 (1968)
Clements v Swedish Hospital, 252 Minn 1, 89 NW 2d 162 (1958)
Crowe v State, 48 Misc, 2d 174, 264 NYS 2d 459 (Ct Cl 1965)
Dahlberg v Jones, 232 Wis 6, 285 NW 841 (1939)
Daley v State, 273 AD 552, 78 NYS 2d 584 (1948), aff'd without opin 298 NY 880, 84 NE 2d 801 (1949)
Dalton v State, 34 AD 2d 605, 308 NYS 2d 441 (1970)
Davis v Springfield Hospital, 204 Mo App 626, 218 SW 696 (1920)
Dimitroff v State, 171 Misc 635, 13 NYS 2d 458 (Ct Cl 1939)
Eaby v US, 298 F Supp 959 (DDC 1969)
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Appendix C

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