Commentary: Delving Further Into Liability for Psychotherapy Supervision

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In their article, "Liability and Risk Management in Outpatient Psychotherapy Supervision," Recupero and Rainey discuss some of the difficult matters related to outpatient psychotherapy supervision. We offer this commentary to make observations about their article and to further the discussion of liability and risk management. We believe there is a need to include this type of information in the orientation of supervisors and supervisees and to make discussions of liability and risk management a part of outpatient psychotherapy supervision.

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In their article, "Liability and Risk Management in Outpatient Psychotherapy Supervision," our colleagues Recupero and Rainey[1] discuss the difficulties clinical supervisors may encounter as they attempt to maintain the balance between training supervisees and treating patients, without losing sight of the need to protect themselves legally as supervisors. To that end, Recupero and Rainey discuss the relevant legal theories of direct and vicarious liability, highlight several high-risk areas in supervision, and offer useful risk-management suggestions to help mitigate the risk that supervisors may face when working with supervisees. As they point out, many of the liability and risk-management concerns regarding outpatient psychotherapy supervision flow from legal principles involving other medical and paramedical specialties (e.g., surgery and psychology). It can be difficult to apply to psychiatry supervision the legal principles involved in other specialties because of the unique nature of psychiatric practice which blends medical and psychological theories. Psychiatrists work in a field with some known hard-science risks and benefits, such as those involved in pharmacotherapy, and with other less tangible factors such as character structure. In short, supervision of outpatient psychotherapy may often be more challenging than supervision in other medical disciplines because the treatments and outcomes are as varied as the patients themselves.

In many cases, the supervisee/psychiatry resident is the patient's primary clinician, while the supervisor is limited to reading reports from the resident, listening to tape recordings of sessions, or viewing the patient through a one-way mirror. The field of psychiatry lends itself to many treatment approaches, styles, and beliefs about how one should manage a patient. This complicates the supervision further. In no other field of medicine do practitioners discuss whether they should approach a case from a biologic, behavioral, supportive, psychoanalytic, cognitive behavioral, insight-oriented, or eclectic point of view. Other elements that may affect supervision of psychiatry residents include the limited time for supervision, the fact that supervision does not take place in a vacuum (e.g., multiple supervisors), and financial and billing pressures.

A reality of many residency training programs is that faculty members are limited in the amount of time they can devote to the supervision of residents because of the pressures of teaching, writing, taking care of their own patients, and tending to administrative duties. These pressures often lead to a resident's having many supervisors simultaneously directing him or her in different parts of the training program. It is common practice for psychiatry residency training programs to provide residents with multiple supervisors to increase the exposure to various forms of psychotherapy and to broaden resi-

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dents' perspectives on treating patients. Obviously, liability and risk increase when several supervisors give differing advice about the same patient.

According to Recupero and Rainey,[1] a supervisor's reviewing a psychiatry resident's outpatient psychotherapy case without seeing the patient may lower the supervisor's risk of liability, presumably due to there being no direct contact with the patient and therefore a limited opportunity to control the supervisee and the clinical situation. However, in our opinion, the supervisor's duty to monitor the resident's management of the case is not necessarily decreased by the supervisor's remoteness from the situation. Recupero and Rainey also state that "Liability may increase as a supervisor's contact with the resident's patients increases . . ." (Ref. 1, pp 193–4). That risk of liability increases with contact may be true, but in our opinion the converse is not true. In other words, a supervisor's liability does not necessarily decrease as the supervisor's contact with the resident's patients decreases. Having said that, we acknowledge the general legal principle that the more control a supervisor exerts over a supervisee, the greater the risk of liability to the supervisor.[2]

Another matter to consider is that the degree of supervision may be dictated by economic factors such as Medicare reimbursement policies.[3] It is important for academic faculty supervisors to know whether they are supervising in a hospital clinic or a university clinic. This distinction is important because the degree of personal supervision, documentation, and responsibility varies, depending on the setting. The setting of the treatment also affects whether the attending psychiatrist generates the bill (university clinic) or the resident physician generates the bill through the hospital (hospital clinic). The Medicare legislation does not specifically address psychiatric clinics, which again leaves psychiatry training programs to interpret laws written with other medical specialties in mind. Individuals who supervise residents in university clinics may have a greater degree of liability, since Medicare billing regulations consider the teaching attending of record to be the primary physician. Medicare requires the teaching attending to see the patient personally at the time of service and to generate documentation that verifies parts of the history and examination. Individuals who supervise residents in hospital clinics are not required to be present at the time of service, but are required to be available, which creates the potential for liability if they cannot be reached. As discussed by Recupero and Rainey,[1] hospital clinic supervisors may still be liable under a *respondeat superior* claim.

Financial matters also raise questions of liability in situations in which psychiatrists pay for additional supervision after the completion of residency training. In such contexts, the potential liability of a privately retained supervisor is unclear. The treating psychiatrist who hires a private supervisor presumably has the ultimate responsibility for the care of the patient. However, a privately retained supervisor may also be found to have assumed liability for his or her supervisee's patients, since he or she is compensated for the supervision. It could be argued that the privately retained supervisor who accepts money to provide guidance to a less experienced psychiatrist shares the responsibility for the care of the patient.

Another area that has received relatively little attention in the psychiatric literature is that of dual relationships in psychotherapy supervision. Examples include supervisor-trainee sexual relations, business relations, and cases in which the supervision itself is allowed to become psychotherapy for either the supervisor or the trainee. Dual relationships in supervision may be exploitative and harmful for the trainee and may have a negative impact on patient care.

In a nationwide survey of members of the American Psychological Association, 10 percent of respondents reported that as trainees, they had sexual relations with educators; 13 percent reported entering sexual relationships with their students.[4] A similar survey of female members of the Clinical Services Division of the American Psychological Association found that 17 percent of respondents reported intimate sexual contact with at least one psychology educator during graduate training.[5] Findings in a nationwide survey of 548 psychiatry residents revealed that 4.9 percent had some form of sexual involvement with a psychiatric educator during their training.[6] Both the American Psychiatric Association and the American Psychological Association have taken positions against sexual intimacy between supervisors and trainees.[7,8]

Although the ethics-related implications of sexual contact between supervisors and trainees are clear, less is known about the legal implications of such behavior. In a 1989 report of the Council on Ethical and Judicial Affairs of the American Medical Association, sexual harassment and/or sexual exploitation

by faculty supervisors was described as ". . . obviously unethical and may also be illegal under employment discrimination laws."[9] Some courts have held academic institutions liable for sexual relationships between faculty and students.[10] Since residents in postgraduate medical training programs are considered employees of the institutions that provide them with training, they may have legal standing to file sexual harassment claims under Title VII of the Civil Rights Act of 1964.

As noted in a study by Riess and Fishel in 2000,[11] one of the greatest challenges for outpatient supervisors is the lack of information provided by the training program about where to turn in a supervisory dilemma. They also found that supervisors often lack formal training in supervision. These findings are consistent with the 1997 study by Shulte *et al.*,[12] cited by Recupero and Rainey, which revealed that 87 percent of the training directors who responded to the survey reported that their psychotherapy supervisors receive no formal training in the risk of liability related to outpatient psychotherapy supervision. Shulte and her colleagues concluded that ". . . the vast majority of psychotherapy supervisors may be teaching without clear guidelines from their academic institutions with reference to the extent and limits of their liability or about how to conduct supervision in a manner that minimizes potential lawsuits (and hopefully also minimizes risk of inadequate therapy and patient harm)" (Ref. 12, p 137). To the helpful risk management suggestions offered by Recupero and Rainey[1] in their Appendix we would add a suggestion that residency training programs document the training of outpatient supervisors in legal and risk-management areas.

Some psychiatry residency training programs, especially those within large university-based medical schools, use clinical psychology faculty members to provide psychotherapy supervision for psychiatry residents. This arrangement calls attention to ethics-related problems, as the American Psychological Association's ethics code requires that, as part of informed consent, trainees must make known to their patients that their work is being done under supervision. The American Psychological Association's Code of Conduct specifically states, "When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor" (Ref. 8, p 1072). One author has commented that failure to inform a patient of the status of the trainee may expose the trainee and the supervisor to lawsuits alleging breach of confidentiality and lack of informed consent, as well as fraud, deceit, misrepresentation, and invasion of privacy.[13] As an addendum to Recupero and Rainey's risk management suggestion number 8, we recommend that the patient give written informed consent for the supervisee to discuss confidential information with the supervisor.[2]

In discussing supervisors' potential liability to third parties, Recupero and Rainey[1] cite the well-known case of *Tarasoff v. Regents of the University of California*, 551 P.2d 334 (Cal. 1976), in which the supervising psychiatrist was found to have failed to warn an identified victim of a threat by a violent patient. The question of whether to break confidentiality to warn or protect a third party from potential harm is particularly troublesome for supervisors. We agree with the position of Recupero and Rainey, who advise that when a supervisor encounters a potentially dangerous patient under a trainee's care, the supervisor should be prepared to take prompt action and to make a personal report of threats of harm to the appropriate persons.

However, psychotherapy supervisors should be aware that not all states have a *Tarasoff*-type duty to warn and/or protect third parties,[14] and that in some states a supervisor may be liable for a supervisee's failure to discharge his or her duty to take action when a patient makes a threat against property.[15] These concerns are likely to be prevalent in outpatient settings in which trainees provide psychotherapy services to patients in high-risk groups such as domestic violence perpetrators and patients in anger management courses who are court-ordered for treatment.

Although there are probably many psychotherapy supervisors who are vigilant about the risk of liability and regularly include discussion of the problems in their supervision sessions, such wisdom may frequently go undocumented. We find the risk management suggestion of Recupero and Rainey[1] that supervisory sessions be documented to be useful advice, since lawyers are fond of making the claim that not documented means not done.

In summary, we commend Recupero and Rainey[1] for calling attention to the legal risks involved in

outpatient psychotherapy supervision. We submit that when supervisors are aware of the risk management concerns raised by Recupero and Rainey, the interests of the supervisor, the supervisee, the patient, and any potential third-party victim will be better protected. In addition, supervisors who are vigilant about psychotherapy supervision liability and risk management serve as role models in emphasizing the importance of such concerns to trainees who one day may become clinical supervisors themselves. We believe that the present article by Recupero and Rainey makes a significant step toward increasing the awareness of the need for risk management in outpatient psychotherapy supervision and represents a substantial contribution to the literature on this topic. We join them in calling for further discussion of this subject and for more guidance in risk management for psychotherapy supervisors and their trainees.

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