Grievances and Law Suits Against Public Mental Health Professionals: Cost of Doing Business?

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Although there has been an increase in risk of malpractice for all physicians, general psychiatrists continue to have a relatively low risk of being sued. With the change in the nature of involuntary patient populations as a result of dangerousness criteria for commitment, and the advent of an activist mental health bar, however, psychiatrists who work in the public sector are significantly more likely than private psychiatrists to face grievances and law suits. While specific data providing direct comparisons of numbers of lawsuits between private and public psychiatrists are not available, a review of the existing literature supports this hypothesis, particularly with respect to grievances. The author suggests reasons for the increased risk of legal challenges faced by psychiatrists working with committed patients, and discusses various strategies for preparing ward staff as well as professional staff to reduce the risk of being challenged as well as the chance of losing grievances and law suits. While the article focuses on psychiatrists, most of its arguments are equally applicable to other mental health professionals, whose risk of being legally challenged is escalating rapidly.

Despite the current malpractice crisis,[1] psychiatrists continue to experience one of the lowest risks of being sued of any medical professionals; most of the suits that are filed are unsuccessful.[2] That of course does not minimize the traumatic effects of being sued, even unsuccessfully. There is a growing literature documenting these effects; they include practicing defensive medicine, experiencing a loss of nerve and lowered self-confidence, isolation, depression, pervasive anger, and increased incidence of physical illness and exacerbation of existing illnesses. A number of physicians in high-risk specialties have changed their practices.[3] On the positive side, physicians have reported keeping more meticulous records, studying the literature more carefully, and attending continuing education courses.[4]

The increase in risk for being challenged legally has occurred for all physicians, including psychiatrists in private practice. The reasons for the rise are complex, including the advent of the

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consumer movement, changes in malpractice law from local to national professional standards of care, the significant increase in the number of doctor-patient contacts, and the transition from personalized to technological medical care. The rise in lawsuits and other forms of legal challenge has caused physicians to suspect their patients, which in turn has damaged the trust between doctors and patients and has led to a further escalation in malpractice suits.[5] Paradoxically, the tremendous advances in psychiatric treatment over the past 30 years, particularly the advent of effective psychotropic medications, has raised expectations of successful care, and has also provided more objective standards against which professional practice can be measured, again resulting in more law suits.[6]

Psychiatrists working in the public sector have always been more at risk of being sued than those in private or academic practice. Psychiatry in the United States was born in state mental hospitals,[7] and conditions rapidly deteriorated in the 19th and early 20th centuries as admissions far outstripped discharges and staffing resources.[8] Even the President of the American Psychiatric Association called in 1958 for psychiatrists to stop practicing in a "bankrupt system."[9]

Public mental health facilities were responsible for significant abuse and neglect of patients, although in most cases their professional staffs were just attempting to do their best under impossible circumstances. With the rise of the civil rights movement in the 1960s, public mental hospitals were convenient targets.[10] They were large but circumscribed institutions, in which evidence of substandard conditions was easy to collect. The first landmark case attacking state hospitals for violating patients' rights to treatment[11] was actually initiated by hospital staff challenging working conditions that had been adversely affected by funding cuts; patients' rights to minimally adequate conditions was added almost as an afterthought.[12]

These early cases were generally class actions suits in federal court against high-ranking state officials, although staff psychiatrists at the facilities being sued often ended up spending long hours in depositions and testimony.[13] Such suits led to significant increases to state hospital resources, and were thus often at least partially welcomed by psychiatrists who ultimately benefitted from improved working conditions.[14] Several suits named individual psychiatrists as defendants, and sought monetary damages; while the suits have often been successful, appeals courts have not found psychiatrists liable for money damages, holding that expecting them to predict the finding of new constitutional rights would be unreasonable.[15] More recently, class action suits have shifted from focusing on conditions in inpatient facilities to demanding the creation of community-based treatment resources.[16]

If conditions at state hospitals improved, however, those improvements were outpaced by the growth of advocacy groups that often operated under the assumption that mental health

professionals in the public system were at best incompetent and at worst maleficent.[17] Although Brakel[18] reported that adversarial advocacy programs at state mental hospitals were less effective in advancing the rights of their clients than those that attempted to work collaboratively with staff, activist advocates continue to insist that aggressive adversarial tactics are necessary in order to obtain and protect patients' rights.[19] In a thought-provoking article, Wald and Friedman[20] distinguish between advocates whose goal is to obtain more effective treatment for their mentally disordered clients from those who wish to protect patients *from* treatment.

In addition to the attacks from professional and lay advocates, mental health professionals increasingly face organized challenges from patients as well. While Milner[21] argues that militant expatient groups prefer a direct action model to a litigation model, because the latter requires them to trade loss of autonomy to clinical professionals for loss to legal professionals, many such groups continue to use litigation as a major weapon against clinicians.

Beyond the establishment of new patient rights and a continuing rise in the level of scrutiny to which psychiatrists in the public system are subjected, many mental health professionals are also increasingly expected to serve as guarantors of the protection of the public from the acts of their patients. While the California *Tarasoff* decision in 1974–6[22] initiated a series of decisions across the country that held outpatient therapists potentially liable for the acts of their patients, suits against inpatient facilities alleging negligent release of patients who subsequently harm someone else have been common for many years.[23] The *Tarasoff* line of cases does not allege ordinary malpractice, but rather the failure of a therapist who has a "special relationship" to a patient to prevent that patient from doing harm.[24] More recent decisions have invoked professional malpractice standards in basing their findings of potential liability on negligent failure to prevent "foreseeable harm."[25]

For a number of years, however, mental health professionals in public facilities were protected from liability for such release decisions under the provisions of the immunity of the government that employed them. That immunity has been progressively eroded by courts and legislatures over the past 30 years, although some states continue to recognize it.[26] The resurrection of federal civil rights avenues through which to sue state employees (including clinicians), the reinterpretation of duties previously considered discretionary (and therefore protected from liability) as ministerial, the change from a malpractice basis for suits (which requires demonstration of deviation from professional standards) to a negligence theory (which does not necessarily require expert opinions), and judicial retreat from the position that individual liberty interests in the least restrictive environment justifies risk to public safety stemming from open wards and early releases[27] have all combined to place clinicians in a position uncomfortably close to strict liability for their

actions.[28] Although most state governments protect their employees from personal financial liability through tort claims act legislation, they cannot provide protection from the negative experience of being involved in a law suit, which can go on for years of conferences, depositions, and testimony.

Differences Between Public and Private Patients

In addition to these structural differences between private and public mental health practice, the patient populations involved are significantly different.[29] Public patients are much more likely to enter treatment under some form of coercion, particularly in the case of psychiatric hospitalization; the adversarial relationship thus established between patient and treaters would be expected to increase the likelihood of patient complaints in the form of either grievances or law suits.

There are other significant differences between private and public patients that contribute to the higher rates and different types of legal challenges experienced by public clinicians. The changes in civil commitment laws from need-for-treatment to dangerousness criteria have selected for a population that is not only more dangerous, but also that has much greater experience with the criminal justice system.[30] At the same time, clinicians' increasing liability for the violent actions of their patients[31] has forced evaluators to err on the side of commitment and delayed release when dangerousness is clear, regardless of the apparent probability of treatment success.[32]

These forces have combined to increase significantly the numbers of personality-disordered patients in public hospitals, particularly forensic hospitals.[33] These patients' criminal histories and ongoing contacts with attorneys have given them a familiarity with the adversarial, rights-oriented approach that often pervades their relationships with clinicians attempting to treat them. It has been reported that one reason for the lower incidence of malpractice suits against psychiatrists is the fact that the therapeutic relationship established in psychotherapy reduces the likelihood of patients suing their therapists[34]; but the higher proportion of psychotic and personality-disordered patients in involuntary populations reduces the proportion of those patients who are capable of developing such relationships,[35] and therefore removes a significant protection from public clinicians.

In addition to a predisposition toward adopting an adversarial relationship with their treaters, involuntary patients are increasingly provided with a system of protections that supports and often encourages such a posture. In addition to the provision of attorneys to represent them in commitment hearings and against criminal charges, the federal Patient Bill of Rights[36] has mandated the establishment of advocacy groups for involuntary patients. Most states have created their own advocacy or ombudsman system for involuntary patients, in addition to the independent advocacy systems already existing in many of them. While it is clear that the conditions in many public systems required

such protections, they have their side effects as well.[37]

Although Brakel[38] argues that patient advocates should concentrate on the complaints made by patients, many activist advocates counter that patients do not know what their rights are unless aggressively informed by knowledgeable advocates.[39] While it is certainly true that many facilities have not been exactly forward in their provision of information to patients, permitting the advocates to set the agenda allows them to be just as paternalistic as they accuse clinicians of being.[40]

Unfortunately, few advocates have received any clinical experience or training, and are thus unable to understand the multidetermined nature of patient motivations or actions.[41] Most, particularly attorneys, have been socialized in the criminal justice representation model, which has been explicitly extended to cover representation at civil commitment hearings by courts. This model often requires that the advocate go beyond the client's expressed wishes, and become an advocate for freedom, even without regard for the patient's own wishes.[42]

Such advocates are not only unable to appreciate patients' unconscious wishes for treatment, but may either manipulate patients into agreeing with their preconceived legal philosophies, or be manipulated by personality-disordered patients into using legal tactics to further their hidden agendas.

Patients with antisocial personalities, who make up a significant proportion of involuntary populations but are quite rare in private practice, do not conform to advocates' expectations.[43] They possess an unusually great need for ongoing stimulation, and as a result are process-oriented rather than goal-oriented. The excitement of the grievance or litigation process itself is what is desired, rather than achieving a particular end result. They use legal challenges (or the threat of such action) not so much to redress actual wrongs, but rather to use them as bargaining positions, or more directly to satisfy their need to challenge or inconvenience those in authority over them.

Such patients more closely resemble prison inmates than they do conventional psychiatric patients; and they have learned well how to win favor and influence over their peers through the art of jailhouse lawyering.[44] Since they use their challenges as ends in themselves, the last thing that many want is for the conditions about which they complain to improve, since they would then have nothing with which to harass their keepers.[45] In this respect, they are quite similar to some advocates who use allegations of rights violations to further their own personal ideological goals, whether or not they further their ostensible clients' true interests.[46]

Another aspect of the con mentality that causes friction between so-called patients and clinicians is the patients' demand that "the punishment fit the crime"[47] rather than the criminal. Prisoners expect, and are used to, voluminous rule books that spell out every possible infraction of the rules and specify an explicit punishment for each, regardless of the context of the behavior.[48]

Patients operating under such conceptual schemes have great difficulty in accepting the clinical (and legally mandated) framework of individualized treatment planning, which leads to different consequences for the same behavior because of differing capabilities of different patients.[49] Clinicians strive to maximize their patients' sense of responsibility,[50] while inmates typically attempt to abdicate such responsibility, aided by mechanical rules that seem to eliminate any realistic differences between persons.

While denial of illness is a major stumbling block to effective therapy with all types of mental patients,[51] antipsychotic and antidepressant medications exist for the majority of severely ill private patients, and are effective even when administered over their objections. The types of patients increasingly seen in public hospitals, particularly forensic hospitals, however, are frequently not responsive to medications, and do not admit that there is anything wrong with them that requires treatment, even though effective treatments are in fact available for many personality disorders.[52] This impasse effectively removes any possibility of developing therapeutic alliances, and converts treaters into jailers, further reinforcing the adversarial relationship.

Even when patients have their rights carefully explained to them, they often have difficulties in fully understanding them; they frequently hear what they want to hear. For example, state law in Wisconsin requires that patients be informed, both orally and in writing, of all their rights at the time of admission, including their rights to refuse treatment.[53] Even though they are informed that treatment may be administered involuntarily under emergency conditions,[54] and if they are found to be incompetent to make treatment decisions,[55] many hear only that they have the right to refuse, and some have filed grievances (and attempted to file law suits) when they have been forced to take appropriate medication under the legal exceptions to informed consent. Even when nonpsychotic patients do engage in meaningful therapy, their habit of dealing with the world through adversarial methods may carry over into the therapy as a form of resistance.[56]

Although the increasing availability of advocacy services is in general a benefit to both patients and staff, since many complaints are directed to issues outside the treatment facility, and others lead to improvements in treatment resources, the very responsiveness of advocates and ombudsmen (and of clinicians when threatened with grievances or litigation) may raise unrealistic expectations in patients. A major goal for clinicians working with long-term patients (and many forensic patients, particularly insanity acquittees and those committed under the remaining sex crimes laws, continue to spend years rather than weeks in public hospitals) is to prepare them for successful reentry into the community. This task is significantly complicated when patients learn to expect that their every need will be quickly addressed by advocates who are often ideologically prepared to accept their positions unques-

tioningly and clinically unprepared to understand the complex motivations underlying the complaints. They leave unprepared for the lack of instant response to their legal and medical complaints, and their unrealistic desires for immediate gratification are reinforced.[57]

Litigation has established a number of rights for prisoners, including access to attorneys and to a legal library.[58] Involuntary patients in a number of states have argued that their involuntary confinement, particularly if they have been committed through the criminal justice system, entitles them to the same rights as both prisoners and mental patients.[59] Since they reject treatment, they have an inordinate amount of time on their hands with which to pursue their litigious interests.[60]

Neither federal law nor most state law requires that indigent persons be provided with representation in civil cases. Representation can be provided through the contingency fee system whereby attorneys are reimbursed only if they prevail. This system is designed in part to provide a check on frivolous law suits, since attorneys are unlikely to take them on with little prospect of being paid. Unfortunately, long-term patients have little else to occupy their time, and often enjoy spending long hours preparing their cases, knowing that those they sue or grieve against will be forced to spend comparable time defending themselves. When they proceed *pro se*, attorneys for defendants and judges often allow them much more leeway than they would an attorney presenting the same case.[61]

Unlike ordinary medical malpractice suits, where the incidence of adverse verdicts against physicians is significant and rising,[62] the types of grievances, civil rights suits, and malpractice suits filed by forensic patients have a much lower success rate; they often serve chiefly to enable sociopathic "patients" to relieve the boredom of their commitments and to harass those in authority over them by forcing them to spend significant amounts of time responding to frivolous suits, with minimal risk of reprisals.

In contrast to malpractice suits against private practitioners, where suits against any one clinician are infrequent, public patients file large numbers of grievances[63] and law suits.[64] A national survey of forensic psychiatrists revealed a significant number of harassment suits filed against forensic evaluators.[65] It is interesting, however, that respondents to a 1985 national survey from psychiatrists working in public institutions did not list problems with litigation against them as a major problem, although a number did cite grievances and law suits as a problem.[66] As that pilot survey was sent to a small sample of institutional psychiatrists, and those working with forensic patients were not targeted, it is likely that these results were not representative of the population at risk. In addition, in 1985 (before the 1986 Protection and Advocacy for Mentally Ill Individuals Act) many states did not have formal advocacy systems in their public facilities, and thus the numbers of grievances (as well as law suits stimulated by access to legal advice) would be expected to be less. The advent of activist advocates has been demon-

strated to be correlated with a rise in legal challenges.[67]

Methods of Reducing Liability and Staff Fears of Liability

Although the problems faced by clinicians working with litigious patients are formidable, they are by no means insurmountable. Legal challenges are not only inevitable, but they may at times be helpful, by requiring the provision of more resources than would otherwise be provided.[68] There are a number of strategies that have proven effective in damage control when grievances and suits are filed.

MacCormack and Mandel[69] surveyed superintendents of 200 facilities for the developmentally disabled, who reported that their major training need was in legal issues, and that litigation was the third major problem, after funding and staff morale issues. They outline a number of suggestions for institutional administrators, including the necessity of maintaining communication with all staff, refraining from becoming defensive or antagonistic to plaintiffs (with whom the institution must often continue to work during the suit), being careful what is said to plaintiffs' attorneys, and attempting to develop channels of communication to local media to minimize one-sided coverage.[70]

In addition to these valuable suggestions, there are a number of ways in which clinical staff can help, both to reduce the number of grievances and suits filed, and to prepare themselves and their staffs better to deal with the ones that are. Prevention begins with the orientation of new staff, particularly if they will be working with forensic patients, who pose the highest risk of legal challenge.[71] Few line staff (nurses, social workers, aides, etc.) have worked with patients who have been charged with, or convicted of, serious crimes such as murder, rape, or serious child abuse, and both their realistic and their fantasy fears must be dealt with in training before they are required to deal with such patients. The use of group discussion, role playing, and videotaped interviews with patients, can help to desensitize staff sufficiently so that they can maintain professional objectivity while working with such patients. Those that cannot deal with their feelings should be assigned to duties in other programs; inappropriate behavior (rejection, punitive reactions, overzealous management of potentially aggressive behavior, etc.) disrupt the ward environment for patients and staff alike, and invite legal challenge.[72]

Staff also need to be trained in understanding the dynamics of litigious patients, so that they will not take their complaints personally and overreact to them—this is exactly what such patients want.[73] Grievances and litigation are major ways in which committed patients attempt to control their environments; if staff become too upset and defensive, they will have lost the ability to manage the ward as a whole. Patients have the advantage of being able to pick and choose their complaints: no staff is perfect, and when they make inevitable minor mistakes, litigious patients will be watching. It is crucial for staff to learn

when to "give up" in small matters without feeling that they have "lost" anything. This reduces feelings of inadequacy and impotence, and builds credibility when more serious allegations are made. It also removes much of the incentive for patients to file such nuisance complaints; if staff do not react, it takes much of the fun out of the activity for the patients.

Another way in which to reduce potential sources of misunderstanding and conflict, and also to minimize liability if challenged, is to improve the documentation in the medical records, and to encourage patients to review them. We teach our staff to write as if the patients would be reading over their shoulders. Our study with forensic patients[74] demonstrated that no patient became upset or filed grievances over information in the records, and that the majority said that they felt reassured by the very fact that they had the access, and felt no need to review their records.

As discussed above, patient advocates are important players in the system; they should not be treated (at least initially) as "the enemy," but rather attempts should be made to work collaboratively with them—after all, both clinicians and advocates are supposed to be working to improve conditions for the patients. We have found it effective to consult advocates proactively when questions arise about how to deal with problem patients; they are often capable of making suggestions on how to implement treatment plans that do not run afoul of patients' rights; and in the process, staff are building a working relationship that will pay off in the long run. It should be emphasized that this is not an effort to co-opt the advocates; but rather to work with them toward a common goal.

We have found that many advocates are educable in clinical matters, if the effort is made and they are willing to learn. As one example, the law school work study program that placed students in state hospitals and prisons in our state set up an experimental program in which the students were at two facilities, including our hospital. Under the program, students served as members of the ward treatment teams, and were required to abide by treatment team decisions concerning legal action.[75] While the program was ultimately abandoned when one of its supervisors became uncomfortable with the interference with limitations on the students' ability to represent their clients, the students themselves were very positive about their experiences, and felt that the increased familiarity with typical clinical decision-making provided them with information about both patients and the types of situations faced by the clinicians treating them that would be valuable in their subsequent careers. We have also worked with attorneys at the state level of the grievance adjudication system to educate them concerning the types of motivation and behavior to be expected from personality-disordered patients, particularly patients with borderline and antisocial personalities.[76]

If law suits are actually filed, it is crucial that those clinicians named as defendants demand to be actively involved in their defense. This is rarely a

time to "give up" gracefully, and it is important for the future management of the program that bureaucrats not be permitted to "cut their losses" by caving in to nonmeritorious allegations for expediency or to reduce defense costs. Only the line staff whose behavior has been challenged are in a position to provide defense attorneys with accurate information about what actually happened and to be an integral part of the decision-making process concerning defense tactics; and they should insist on being part of the ongoing development of the defense. Many attorneys are as uninformed about the patient's dynamics that led to filing of the suit as are patient advocates; such information may be crucial to the decision-making process.[77]

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51. See Wilson JD, Enoch MD: Estimation of drug refusal by schizophrenic in-patients, with analysis of clinical factors. Br J Psychiatry 113:209–11, 1967; Van Putten T: Why do schizophrenic patients refuse to take their drugs? Arch Gen Psychiatry 31:67–72, 1974; Appelbaum PS, Gutheil TG: Drug refusal: a study of psychiatric inpatients. Am J Psychiatry 137:340–6, 1980; and Miller RD, Bernstein MR, Van Rybroek GJ, Maier GJ: The impact of the right to refuse treatment in a forensic patient population: six-month review. Bull Am Acad Psychiatry Law 17:107–19, 1989
52. Miller, *supra* note 35
53. Wisconsin Stat. § 51.61(1)(a)
54. Wisconsin Stat. § 51.61(3)(g)
55. Jones v. Gerhardstein, 416 N.W.2d 883 (1987)
56. Gutheil has described the use of presentation of legal problems by psychiatric residents in supervision to avoid dealing with difficult problems; see Gutheil TG: Legal defense as ego defense: a special form of resistance to the therapeutic process. Psychiatr Q 51:251–6, 1979. Miller, Maier, Blancke and Doren, *supra* note 49, have discussed the case of a patient who used litigation as a means of resistance to dynamic psychotherapy
57. See Miller, Maier, Blancke and Doren, *supra* note 49
58. Bounds v. Smith, 430 U.S. 817 (1977)
59. Patients committed under Wisconsin's Sex Crimes Law (repealed as to new admissions in 1980) have been criminally convicted of sexual assault; they have brought suit to force the forensic hospital to which they were committed to furnish them with a full law library, as required by Bounds for prison inmates. See Skamfer v. Schnapp *et al.*, No. 88-C-412-S (W.D. Wis., Aug 22, 1988)
60. When a number of patients committed under Wisconsin's Sex Crimes Law refused to participate in any treatment, the Department of Health and Social Services attempted to transfer them to prison. They immediately filed suit to prevent the transfer, alleging violation of their right to treatment! Although the trial judge was quite aware of their motivation (they preferred living in a hospital rather than a prison), the statutory guarantee of a right to treatment for persons

so committed forced him to rule in the patients' favor. See Caldwell v. Percy, 314 N.W.2d 135 (Wis. Ct. App. 1981). In another case, when the state attempted to implement a new law by refusing to let another patient waive good time to avoid being sent back to prison (he was under a dual commitment, both to our hospital under the sex crimes law and to prison for other criminal convictions), he went to court to block the transfer. He was successful when the judge ruled that the new law did not apply to those who had been committed before its enactment. See Penzkover v. Torphy, No. 86 CV 1208 (Cir. Ct. Dane Cty., March 12, 1986).

61. Miller RD, Roach L, Maier GJ, Van Rybroek GJ: The re-minds of Billy Milligan. Paper presented at the 19th Annual Scientific Meeting of the American Academy of Psychiatry and the Law, San Francisco CA, October 20, 1988. The patient in this case has filed some 12 law suits against the Departments of Corrections and Health & Social Services, claiming that his rights have been violated because we did not accept his self-presented diagnosis of multiple personality disorder. In the four years that the suits have been before the courts to date, the author has personally responded to some 1100 interrogatories in the four suits in which the patient is a defendant.
62. See Lieberman, *supra* note 6
63. Data from the Wisconsin Division of Care & Treatment Facilities Client Advocacy Program indicate that patients at the Mendota Mental Health Institute (one of two state mental hospitals) filed 728 formal grievances in 1989 and 839 in 1990. Such grievances are first investigated by in-house advocates at the facilities. Those which can not be resolved at that level are appealed to the facility director (Stage 3), and then to the attorneys at the state Client Advocacy Program (Stage 4). Their decisions are advisory to the Administrator of the Division of Care & Treatment Facilities, although they are almost always accepted. Of the grievances filed, only 23 reached Stage 3 in 1989 and 65 in 1990. Of those, only two reached Stage 4 in 1989 and 13 in 1990. Of the total of 103 grievances that were resolved at Stage 3 or 4, only 16 were decided in favor of the patient. Thus, the patients did not have their grievances sustained in the great majority of cases; but they did have the satisfaction of forcing both the advocates and the clinicians involved to spend a significant amount of time in responding. By comparison, data from a 1986 national survey indicated that malpractice claims against psychiatrists were made on approximately 1.5% of malpractice policies.
64. A request for the number of suits filed against physicians and other clinicians in the current Wisconsin Department of Corrections was declined because (it was said) their record-keeping system did not permit accessing such data. Current litigation against the Wisconsin Department of Health & Social Services includes nine suits by patients against the Division of Care & Treatment Facilities, and seven against the Division of Community Services. Cumulative data were not available.
65. Miller RD: Harassment of forensic psychiatrists outside of court. Bull Am Acad Psychiatry Law 13:337–43, 1985
66. See Harry, Maier and Miller, *supra* note 48
67. See Schwartz and Fleischner, *supra* note 19; and Wald and Friedman, *supra* note 20
68. Rachlin S: Toward a definition of staff rights. Hosp Community Psychiatry 33:60–1, 1982
69. MacCormack and Mandel, *supra* note 13
70. Media coverage of law suits is one of the most difficult issues for clinicians and facility administrators to handle. When suits reach court, defendants are permitted to respond directly to accusations, and to cross-examine plaintiffs; but before trial, they are often hampered by confidentiality restrictions from making effective responses to allegations. Patient plaintiffs are under no such handicap, and make the most of their advantage. Perhaps the best protection against biased coverage is to have formed alliances with local media well before such allegations are made, thus preparing reporters to consider both sides of a question, and not to try the case in the media when only one side is permitted to make its case.
71. Miller RD, Maier GJ, Kaye M: Orienting the staff of a new maximum security forensic facility. Hosp Community Psychiatry 39:780–1, 1988
72. Maier GJ, Van Rybroek GJ, Doren DM, Musholt EA, Miller RD: A comprehensive model for understanding and managing aggressive inpatients. Am J Cont Ed Nurs 2(4):89–104, 1987
73. Examples from our experience include grievances filed when 13 medicated drops were delivered to one ear on one occasion instead of the prescribed 12, a staff nurse being five minutes late in administering scheduled medication, and taking two hours to provide paper and pencil to fill out another grievance.

A law suit that went all the way to trial before being rejected by a jury was based on staff failing to document 15-minute checks on a secluded patient twice over a three-day period

74. Miller RD, Morrow B, Kaye M, Maier GJ: Patient access to medical records in a forensic center: a review of the literature and a controlled study. Hosp Community Psychiatry 38:1081–5, 1987
75. Dickey W: The treatment team model of teaching law students in a work study program. Paper presented at the spring scientific meeting of the Midwestern Chapter of the American Academy of Psychiatry and the Law, Madison WI, April 15, 1989. This program was one of those reviewed favorably by Brakel, *supra* note 10
76. See Miller, Blancke, Doren and Maier, *supra* note 45
77. In the suits brought by the patient described in note 61, *supra*, the state's attorney had to be educated about the psychodynamics of antisocial patients before he could understand why attempting a settlement would only encourage the patient to file even more suits.