

Running Scared: Therapists' Excessive Concerns About Following Rules

William Bernet, MD

Mental health professionals sometimes excessively follow rules and regulations to the point of neglecting or even injuring their clients. Five vignettes are presented that illustrate how this problem might occur in clinical or administrative decisions. The vignettes involve confidentiality, informed consent, reporting of sexual abuse, and other issues. Several specific recommendations are made that emphasize common sense and clinical reasoning, rather than relying merely on legal reasoning.

Our professional lives are constrained by many rules and regulations. These rules include practice guidelines, ethical standards, institutional procedures, corporate policies, criteria established by insurance companies, and both federal and state laws. Although the amount of regulation may be excessive, I am not questioning the need for some external structure to the practice of psychiatry. In fact, I believe clinicians should know the rules for their practice and follow them.

However, mental health professionals sometimes go so far overboard in following rules that they neglect or even injure their clients. Sometimes therapists make

up rules and regulations that do not actually exist; sometimes they extend the meaning or exaggerate the intent of a rule to a degree that does not make any sense; sometimes they take a rule out of context; sometimes, they say that they are concerned about a possible lawsuit. In using such "rules" as an excuse for their behavior, therapists are at risk of developing an uncaring attitude toward the client.

This article considers five clinical or administrative decisions, in which a therapist or hospital staff member thought that it was important to follow some rule to an excessive and unnecessary degree. In each case, the need of the clinician to follow the rule seemed more important than the needs of the client. These situations, which are all disguised in some way, occurred in several different hospitals, outpatient offices, and other settings. Each vignette is followed by a suggestion

Dr. Bernet is Director, Vanderbilt Forensic Psychiatry, and Medical Director, The Psychiatric Hospital at Vanderbilt, Nashville, TN. This paper was presented at the annual meeting of the American Academy of Psychiatry and the Law, San Antonio, TX, October 21-24, 1993. Address correspondence to Dr. Bernet at 1601 Twenty-Third Avenue South, Nashville, TN 37212.

as to how the situation could have been handled differently. Following the case illustrations, there are several recommendations for therapists to consider in order to avoid this kind of problem.

The Prodigal Adolescent

A 15-year-old boy, Alexis, was an inpatient on a locked adolescent unit. Alexis eloped from the hospital by bolting from the patient group when they were walking from the unit to the cafeteria. The absence-without-leave was properly reported to the attending psychiatrist and the boy's parents, who decided together to notify the local police. When the patient had not returned to the unit after 24 hours, he was discharged. Two hours later, however, Alexis walked in the front door of the hospital, took the elevator up to the adolescent unit, and announced his return. The nurse asked Alexis to have a seat, while she called his parents to get permission to readmit him to the hospital. Unfortunately, nobody was at home. The charge nurse thought that nonpatients were not allowed to sit around on the unit, and that the nursing staff should not take responsibility for Alexis without his parents' permission. Therefore, she told Alexis that he could not remain on the unit, and she suggested that he wait downstairs in the lobby. Of course, Alexis simply left the hospital and was not seen for several days. His parents were furious that the hospital had not kept him on the unit, and they threatened to sue. They later took Alexis to another treatment program.

Suggestion The nurse should have checked with the hospital administrator-

on-call and with the attending psychiatrist, who would have agreed that it was appropriate for Alexis to remain on the unit or in some other supervised location until his parents were contacted. In fact, the attending psychiatrist could have simply cancelled the discharge order, which would have enabled the nurse to keep Alexis on the unit.

Discussion This case illustrates the way in which legal advisors may influence hospital personnel to warp their clinical judgment. The problem is that when attorneys are consulted, they are trained to give the risks associated with a particular decision and not to weigh the clinical pros and cons. When asked their opinion regarding authorization to evaluate and treat patients, for example, attorneys usually take an extremely conservative position. They are apt to emphasize the fine points of the concept of informed consent and to remind us that only a child's custodial parent has the legal authority to authorize nonemergency medical care. The case of Alexis took place in Washington, DC, and the attorneys who advised the Washington Psychiatric Society had warned their membership that a physician might be sued for "perpetrating a battery" if he physically touched a child—even by simply shaking hands—without having the proper consent to treat.^{1,2} That kind of advice, which may have influenced the charge nurse to tell Alexis to wait in the lobby, is probably not accurate and is certainly not helpful.

The Spurned Referral Source

Rev. Burns, a pastoral counselor, had been counseling Mr. Cobb, age 27, for

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several weeks. Rev. Burns thought that Mr. Cobb was seriously disturbed and referred him for inpatient evaluation and treatment. Later that evening, Mr. Cobb was admitted to an inpatient program. The next morning, Rev. Burns was concerned about his client and wanted to make sure that he had followed through with the recommendation. Rev. Burns also wanted to give the treatment team clinical information about Mr. Cobb and his family. He telephoned the hospital and spoke to the unit secretary. The secretary explained that she could not give any information about a patient, including whether the patient was admitted to the unit, to any person unless that person's social security number was on the telephone list for that specific patient.

Rev. Burns was puzzled and disconcerted by this statement, because he was simply trying to be helpful to his client. Rev. Burns then called the intake office, and one of the staff gave him basically the same response. The intake staff did suggest that Rev. Burns call Mr. Cobb's attending psychiatrist, but could not tell Rev. Burns who that was because they were not allowed to indicate whether Mr. Cobb had been admitted to the hospital in the first place. Rev. Burns, who should be complimented for his persistence, called the medical director of the hospital and vented his frustration.

Suggestion The person who first answered the phone could have made a note of Rev. Burns's information, without acknowledging that Mr. Cobb was in the hospital. The unit staff could have assured Rev. Burns that Mr. Cobb's doctor would call him back, if Mr. Cobb actually

was in the hospital. Also, the unit staff could have simply put Rev. Burns on hold while he asked Mr. Cobb for permission to talk with Rev. Burns.

Discussion It is understood that respect for confidentiality is an extremely important value for mental health professionals. I am concerned, however, that commentaries regarding confidentiality (e.g., chapters by Appelbaum and Gutheil³ and Simon and Sadoff⁴) emphasize legal and ethical principles, but overlook common, real-life situations. Treatises on confidentiality in medicine do not emphasize that in actual practice it is necessary to balance the principle of confidentiality with the principle of clinical continuity. That is, it is extremely important for treatment personnel to communicate with each other when the patient has been referred from one clinician to the other. In fact, I would consider it unethical for them not to communicate with each other. In the context of a medical referral, physicians frequently do not obtain a written consent to communicate, because the caregivers and the patient all realize that the doctors are supposed to talk to each other. This is a principle of clinical practice that seems to get lost in the seminars and workshops on confidentiality, and misguided hospital personnel end up frustrating therapists like Rev. Burns.

The Stubborn Forensic Psychiatrist

Dr. Jones was a psychiatrist who provided medical services at a county jail. His primary duties were to perform psychiatric evaluations on inmates, who were

referred by the medical personnel of the jail, and to prescribe and monitor psychotropic medication. Dr. Jones did not enjoy his work, and sometimes he tried to avoid taking new patients. One of his methods was to refuse to prescribe any medication for female inmates until after the patient had agreed to a pregnancy test and Dr. Jones had verified that she was not pregnant. He insisted that this was standard psychiatric practice. In one case, the staff wanted him to treat a woman who was extremely disturbed and who caused self-injury by putting foreign objects in her vagina. The woman had a history of bipolar disorder and had always responded promptly to lithium. Dr. Jones refused to treat her until he saw a negative pregnancy test. The patient, however, refused to take the test, because she insisted that she already knew she was pregnant and that her baby was Jesus Christ. The stubborn psychiatrist and the manic patient came to an impasse—and the patient went untreated.

Suggestion Because it was extremely unlikely that the woman was pregnant, and because the staff knew that she responded readily to lithium, it would have made clinical sense to go ahead and treat her. Although she was not competent to offer informed consent, Dr. Jones could have obtained consent from a relative or from the administrative chief of the jail. In any case, he should have found a way to treat her mania.

Discussion It is known that lithium is associated with an increased incidence of birth defects, especially during the first trimester. Most authors would agree that “for potentially pregnant patients, a preg-

nancy test should be ordered to clarify the patient’s childbearing status” before starting lithium therapy.⁵ But it is also generally understood that it may still be appropriate to use lithium during a severe episode of mania during pregnancy, because of the possible consequences of leaving it untreated.⁶ It is always necessary to weigh the risks and benefits in making clinical decisions. Although the case of Dr. Jones was an extreme example, it is easy to see how therapists might use the fear of a malpractice suit as a reason to avoid taking on some kind of clinical responsibility.

The Suspicious Pediatrician

A pediatrician, Dr. Smith, had a very busy practice. In recent years, with the increased concern about sexual abuse, parents sometimes told Dr. Smith that they had reason to believe that their children may have been abused. Dr. Smith was an impatient person who did not want to get into any lengthy discussions with worried parents. He told his nurses and the parents of his patients that he would immediately call protective services regarding any situation in which any person raised the possibility of sexual abuse; of course, that promptly discouraged any further discussion of that topic.

Suggestion When a parent expresses concern that abuse may have occurred, the physician needs to sit down and listen to both the parent and the child. The pediatrician should consider the data that he has collected from both of them and determine whether he, himself, actually suspects that abuse occurred. If he has this suspicion, he should inform the par-

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ent and report the suspicion to protective services. But if, after collecting appropriate information, the physician is not suspicious that any abuse occurred, he should reassure the parent, and he is not required to notify anyone.

Discussion Although Dr. Smith's position seems almost irrational, his policy has been endorsed by mental health professionals. Wakefield and Underwager⁷ said that "... mandatory child abuse reporting laws mean that if a parent mentions suspicions to a health professional, the suspected abuse will have to be reported to the police and/or child protection services." I do not think that is a correct understanding, because I doubt that lawmakers intended for physicians to mindlessly pass on every single comment regarding child abuse that comes to their attention.

This widespread misconception is an overly rigid and overly legalistic interpretation of the child abuse reporting laws. For example, a school nurse wrote a letter that was published in the newspaper column "Dear Abby,"⁸ in which she stated that "all suspicious-looking injuries must be reported." I think both the nurse and Abigail Van Buren were mistaken. My position is that it is possible for a parent to have suspicions, but the health professional might not have any suspicion at all after assessing the patient. It is possible that a child would have a "suspicious-looking injury," but the school nurse could investigate the situation and not have any suspicion at all.

Child abuse reporting laws generally designate certain persons who are required to report "if they suspect or have

reason to believe that a child has been abused or neglected."⁹ That means that the person has reasonable cause to suspect child abuse based on the totality of the facts and circumstances actually known to the person. That does not mean that the person needs to become suspicious just because someone else happens to be suspicious. Basically, I think that medical personnel and mental health professionals should exercise some judgment in reporting cases to protective services. There are many variations in reporting laws, so it is important to know exactly how the law reads in your own community.

The Scrupulous Psychologist

A psychologist was asked to evaluate a college student named Donald. Although Donald was 20 years old and legally an adult, he lived with his parents and was brought to the first appointment by his mother. In fact, during part of the evaluation, the psychologist met with Donald and his mother together and told both of them his recommendation that Donald see him regularly for outpatient psychotherapy. The clinical problem was that Donald had threatened to kill his girlfriend Agnes, because she wanted to break up with him. The college authorities knew about the threats and said that they would not notify the police if Donald agreed to see the psychologist.

Donald met with the psychologist on two occasions and then announced at the end of the last meeting that he was fine and would not be returning for any more appointments. The psychologist told Donald that he needed to continue ther-

apy, but Donald did not agree. The psychologist did not take any further action. He said that he did not notify Donald's parents or school personnel that Donald had stopped his treatment prematurely, because it would have violated the patient's right to confidentiality. He said that his treatment plan provided that Donald should take more responsibility for his own behavior as an adult; therefore, the therapist thought that Donald himself would have to authorize the therapist to notify the mother that the treatment had ended.

The psychologist was stunned 10 days later when he learned that Donald had shot and killed Agnes and then killed himself. Donald's parents did not file a lawsuit against the psychologist, but they did pursue an ethics complaint. As non-clinicians, they were extremely confused and puzzled by the psychologist's failure to notify them that Donald had stopped treatment. Under the circumstances, they thought that the therapist's concern about Donald's right to confidentiality did not conform to "common sense"; I think the parents were correct.

Suggestion The overly scrupulous psychologist might have been able to avert the disaster of the murder-suicide by thinking ahead. In the initial conference with Donald and his mother, for instance, the psychologist could have explained that there are some circumstances in which he would contact the patient's mother, such as failure to keep appointments. Even without that understanding, the therapist should have realized that Donald's therapy was not totally voluntary. That is, he was seeing the psychol-

ogist in lieu of being charged with assault. It would certainly have been common sense to let the parents or school authorities know that Donald was not keeping up his end of the bargain.

Discussion At the time Donald prematurely terminated treatment the psychologist did not have reason to think that Donald was imminently dangerous to Agnes or to anyone else; the issue in this case was not the psychotherapist's duty to warn or to protect Agnes. The issue was that Donald had agreed to be in therapy, and everybody involved (Donald's parents, Agnes's parents, Agnes, and school authorities) was assuming that he was still in treatment. The question to consider is whether the therapist should have called Donald's mother without his permission.

Some therapists have ideas about confidentiality that are hypocritical. They may be comfortable going home and discussing therapy cases with friends and spouses over dinner, but they refuse to communicate basic information to their patients' family members when it is clinically indicated. Many therapists are overly rigid about confidentiality because that was how they were taught in classroom situations. Other therapists would agree that in real life therapists should be more flexible, and that confidentiality agreements should be actively discussed and negotiated. Petrila and Sadoff¹⁰ described how therapy with many patients can be improved by encouraging communication among the therapist, the patient, the family members, and the support system in the community. I believe

that confidentiality is very important, but that we should not use concerns about confidentiality as an excuse for avoiding appropriate communication with other parties.

Recommendations

1. There is currently a heightened awareness of the risks of professional liability and of general forensic issues. One frequently hears that you shouldn't do this or that because of the risk of getting sued. Practitioners and administrators should not react in a rote and automatic fashion every time the extremely remote risk of a lawsuit is mentioned. The psychiatrists and the attorneys who give seminars in risk management should emphasize that it is necessary to think through most clinical situations, not simply follow a list of rules. Along these lines, Slovenko¹¹ has suggested that "psychiatrists would fare better if they forgot about the law and endeavored to follow sound clinical practices and therapeutic precepts with diligence and purpose. The best protection from malpractice liability is not legal expertise, but clinical expertise."

2. The kinds of errors described in this paper seem to occur more frequently in work with children and adolescents. This is probably because the practice of child psychiatry involves more players (the patient, the parents, the teacher, the guidance counselor, the court), and because the rights, responsibilities, and competence of adolescent patients may fluctuate with the specific clinical situation. The teachers of social work, psychology, and psychiatry trainees should keep this in mind.

3. Practitioners and administrators frequently say that they would like to consult with an attorney to get the right answer for how to handle a tough clinical situation. Attorneys, however, are not trained to give a balanced view of a complex set of circumstances, but usually feel that it is their job simply to point out all the risks and pitfalls. In the case of the *Prodigal Adolescent*, for example, an attorney is likely to advise that the nurse who keeps the youngster on the unit is running a risk—albeit very small and remote—of being accused of false imprisonment or of being responsible if the patient were to injure himself while waiting on the unit. I urge attorneys to try to be sensitive to all the pros and cons in complicated situations, not simply the risk of being sued.

4. As a profession we need to acknowledge that there are common, appropriate, and acceptable practices that conflict with the letter of the law. In the case of the *Spurned Referral Source*, for example, it is generally understood that the clinician who makes a referral and the one who accepts a referral are supposed to talk to each other, even if the patient has not signed an authorization to do so. Another example of the same phenomenon—the conflict between common practice and the letter of the law—is that pediatricians and other clinicians commonly treat children who are brought by people who are not their legal guardians. That is, pediatricians treat children at the request of noncustodial parents, grandparents, and even baby sitters. To me, that is the way it should be, but strictly speaking, the pediatrician should not take that throat

culture until he has the permission of the person who has legal custody of the child.

5. Life is complex and we need to keep in mind that competing principles must be considered and balanced in many cases; for example, there may seem to be a conflict between the need for confidentiality and the need for clinical continuity. At times there may be a conflict between protecting the patient's interests and protecting the interests of third parties.

6. We should nurture common sense. In the case of the *Scrupulous Psychologist*, Donald's parents complained bitterly after his suicide that the therapist may have followed the letter of the law, but had failed to use common sense. It is hard to teach common sense; it is hard to give common sense to a nursing student or a medical student if they did not have it in the first place. I recommend that we avoid compromising the common sense that our students have to start out with by not teaching them to be preoccupied with following the letter of the law.

7. Many of the rules that apply to medical care are not made by doctors, but are formulated by nonphysician administrators, bureaucrats, and legislators. Whenever possible, physicians should participate in the rule-making process, so that the end result reflects realistic clinical practice.

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References

1. Kuder, Temple, Smollar, and Hellar. PC: Legal alert—treatment and consent. *Washington Psychiatric Society Newsletter*. Summer 1986
2. Washington Psychiatric Society: Legal update: evaluations in child custody cases. *Washington Psychiatric Society Newsletter*. March 1989
3. Appelbaum PS, Gutheil TG: *Clinical Handbook of Psychiatry and the Law* (ed 2). Baltimore: Williams & Wilkins, 1991
4. Simon RI, Sadoff RL: *Psychiatric Malpractice: Cases and Comments for Clinicians*. Washington, DC: American Psychiatric Press, 1992
5. Rosse RB, Morihisa JM: Laboratory and other diagnostic tests in psychiatry, in *Textbook of Psychiatry*. Edited by Talbott JA, Hales RE, Yudofsky SC. Washington, DC: American Psychiatric Press, 1988, p 259
6. Goodwin FK, Jamison KR: *Manic-Depressive Illness*. New York: Oxford University Press, 1990, p 607
7. Wakefield H, Underwager R: Sexual abuse allegations in divorce and custody disputes. *Behav Sci Law* 9:451–68, 1991
8. Van Buren A: Dear Abby: child's ugly bruise may hurt parent most. *The Tennessean*. July 22, 1993
9. Kramer DT (editor): *Legal Rights of Children* (ed 2, vol 2). Colorado Springs: Shepard's/McGraw-Hill, 1994, p 59
10. Petrila JP, Sadoff RL: Confidentiality and the family as caregivers. *Hosp Community Psychiatry* 43:136–9, 1992
11. Slovenko R: Misadventures of psychiatry with the law. *J Psychiatry Law* 17:115–56, 1989