Commentary: Bringing Order to Chaos—How Psychiatrists Know the Standard of Care

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In this commentary, we explore the clinical and educational implications of the study by Recupero and Harms on the standard of care (SOC) as it pertains to obtaining psychiatric outpatient clinical records of prior treatment. We discuss differences between the legal and clinical SOCs and make recommendations to incorporate risk management training and education about the medicolegal aspects of SOC in psychiatry residency curricula.

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We are delighted to have the opportunity to provide commentary on the timely study by Recupero and Harms on outpatient psychiatrists' standard practices for requesting records of prior treatment.[1] As they made clear in their article, there is little published research on the topic of standard of care (SOC) in general, and specifically, there has been a lack of investigation and empirical data detailing the customary practices of psychiatrists in regard to records requests. The lack of clearly defined customary practices within the psychiatric field leaves experts, courts, and juries involved in malpractice cases with inadequate guidance for their SOC determinations. This, in our view, is what happened in *Jablonski v. United States*.[2] Empiric data delineating the extant customary practices were unavailable to the court at the time, and the court was therefore left to rely on the opinion of one expert witness to help inform its SOC determination. This precedent, in our opinion, is a dangerous one, because poorly informed SOC determinations run the risk of being overly broad and clinically impractical. For example, in light of *Jablonski*, were outpatient psychiatrists subsequently expected to obtain old treatment records for everyone they evaluated, even for those who were evasive and not forthcoming about where they were treated in the past? After all, violence risk assessment is part of all initial psychiatric evaluations. Psychiatric thought since 1983, when *Jablonski* was settled, has provided little additional guidance on the matter. This deficiency is what makes the Recupero and Harms study significant and most welcome. Empiric data from their study on the customary practices of outpatient psychiatrists' records requests will provide better guidance for experts, courts, and juries in their SOC determinations. We echo the authors' sentiment that more studies of this kind should follow in the psychiatric field.

Recupero and Harms not only provide useful empiric data, they also call attention to a surprisingly simple, but salient problem: how psychiatrists know the SOC. Over a quarter of the psychiatrists surveyed in their study, many of whom were fresh out of residency, responded "did not know" or "guessed" when asked how they knew the SOC. This result is alarming from a risk management perspective.[1] Simply being aware of best practices in one's field is not enough, especially given the stark reality that many psychiatrists are likely to encounter a malpractice claim against them at some point in their careers. Knowing the legally defined concept of SOC is important to practicing psychiatrists because it is the millstone on which

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their professional fate is ground when the scourge of a malpractice suit descends.

In our commentary, we take a closer look into to how psychiatrists know the SOC. We begin by expounding more on *Jablonski v. United States* and why it is important for the psychiatric field to delineate the customary practices of psychiatrists with empiric data. We then examine the SOC from an epistemological perspective in hopes of explaining the confusion among psychiatrists when asked how they know the SOC. We conclude by offering some observations and a recommendation for residency training curricula revisions based on the findings of this study and trends in the medical liability literature and courts.

Jablonski v. United States

Jablonski highlights the legal expectation that psychiatrists are responsible for obtaining prior medical records when performing violence risk assessments. The case also exemplifies how subjectively the SOC can be determined, especially when the customary practices of psychiatrists are not known. Let us summarize the case.

> On July 10, 1978 Philip Carl Jablonski agreed to a psychiatric examination upon the recommendation of the police and encouragement from his family. A few days prior, Mr. Jablonski had threatened Isobel Pahls with a sharp object and attempted to rape her. Ms. Pahls had also been the target of recent obscene phone calls and other malicious acts, which were thought to have originated from Mr. Jablonski. Ms. Pahls was the mother of Mr. Jablonski's partner, Melinda Kimball. The police became involved but Ms. Pahls declined to press charges. She did assert that Mr. Jablonski would benefit from psychiatric care. After discussion with police, Mr. Jablonski agreed to a voluntary psychiatric examination at the Loma Linda Veterans Administration Hospital in California. Before the scheduled evaluation by the psychiatrist Dr. George Kopiloff, the police called the hospital and informed Dr. Berman, the head of psychiatric services, of Mr. Jablonski's prior criminal record, recent history of harassment and malicious damage toward Pahls, and the police officer's opinion that Mr. Jablonski needed inpatient psychiatric hospitalization. This information never reached Dr. Kopiloff.[2]
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> Ms. Kimball drove Mr. Jablonski to the VA and participated in his initial psychiatric evaluation by Dr. Kopiloff. During that visit, Dr. Kopiloff learned that Mr. Jablonski had served a five-year prison term for raping his previous wife and had threatened Ms. Kimball's mother with a sharp object four days prior and attempted to rape her. Dr. Kopiloff also learned that Mr. Jablonski had mental health treatment in the past, but Mr. Jablonski refused to state where. He was noted to be vague and unwilling to disclose his history. It was determined that Mr. Jablonski did not meet criteria for involuntary commitment because of his presentation during the evaluation; it was recommended, however, that he be voluntarily admitted for inpatient care, as he could benefit from it. He refused. In a private conversation after the psychiatric examination, Kimball expressed her fear and worry about Mr. Jablonski, especially in light of his unusual behaviors. Dr. Kopiloff advised her to leave Mr. Jablonski until he received some stabilizing treatment. She declined to do so, stating that she loved him. Dr. Kopiloff's diagnosis for Mr. Jablonski was anti-social personality disorder, and he labeled Mr. Jablonski potentially dangerous. A follow-up appointment was made for two weeks. Other than Dr. Kopiloff's questioning of where Mr. Jablonski had received treatment, no further efforts were made to obtain his medical records. Around July 11, Ms. Pahls called Dr. Kopiloff to complain that the two week follow-up window was too long. There was some discussion about whether Ms. Pahls should call the police again, given her concern about Mr. Jablonski. Dr. Kopiloff instead encouraged Mr. Jablonski to come to the hospital for an earlier appointment at the end of the week, July 14. On July 12, Ms. Kimball and Meghan (Ms. Kimball and Mr. Jablonski's baby), moved out of Mr. Jablonski's apartment and into Ms. Pahls' apartment. Ms. Kimball remained involved with Mr. Jablonski, however, and drove him to the clinic appointment with Dr. Kopiloff. Again, she voiced her concern about safety to Dr. Kopiloff. Again, Mr. Jablonski was found not to be homicidal or suicidal, nor did he meet involuntary hospitalization criteria. Voluntary hospitalization was again offered but refused. On July 16, Ms. Kimball went to Mr. Jablonski's apartment to pick up some diapers for Meghan. She encountered Mr. Jablonski, who attacked her and murdered her.[2]
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> A wrongful death suit was filed on behalf of Ms. Kimball's daughter, Meghan Jablonski, against the U.S. Government, claiming that the physicians should have sought collateral information from prior police and medical records that would have informed them of his history of schizophrenia and prior attempts to murder his ex-wife. Meghan charged ". . . that psychiatrists at the Loma Linda Veterans Administration Hospital . . . committed malpractice proximately resulting in her mother's death," which the district court ruled in favor of, despite the absence of specific threats made toward Ms. Kimball at the time. The district judge confirmed several findings of malpractice, including "malpractice for failure to record and transmit the information from the police, for failure to obtain the past medical records, and for failure adequately to warn Ms. Kimball." Further, the district judge agreed with the plaintiff's expert witness, who opined "that the failure to obtain Mr. Jablonski's records was negligent in light of accepted community standards." Under appeal, the Ninth Circuit Court of Appeals upheld the district court decision.[2]

In regard to the SOC determination, we see that the district court agreed with the testimony of the plaintiffs' expert witness, who said "the failure to obtain Mr. Jablonski's records was negligent in light of accepted community standards."[2] That is the extent of the court's SOC determination, a simple parroting back of the opinion of one expert witness. The matter is almost completely glossed over. No learned treatises or clinical practice guidelines (CPGs) were

consulted; the specifics of how the expert came to his opinion were not fleshed out. To the court, the appropriate SOC seemed fairly self-evident and comported nicely with the opinions of the expert witness. So, the SOC was determined by one judge who heard the opinion of one expert. Were outpatient psychiatrists now expected to obtain treatment records for everyone they evaluated, even for those who were evasive and not forthcoming about where they had been treated? After all, violence risk assessment is part of all initial psychiatric evaluations. Further, any patient has the potential to commit a future violent act. If psychiatrists' actions are going to be examined by experts, courts, and juries through the lens of hindsight bias, it probably makes sense from a risk management perspective to mandate that all records for all patients be obtained.

Fulfilling such a mandate, however, is problematic. After all, is it possible to obtain records from patients who are not forthcoming? Do psychiatrists have time to sift through hundreds of pages of documents of patients' medical records? Do psychiatrists need to obtain records from 1 year ago, 5, 10, or 20? Should just mental health records be obtained? What about from a patient's primary care provider? What are the limits of this duty?

Subsequent psychiatric thought has not been helpful on the matter. Fast forward to the latest edition of the American Psychiatric Association (APA) Practice Guideline for Psychiatric Evaluation of Adults (revised in 2006), we see reflected in the document a lack of research and guidance on the question of requesting treatment records. It explicitly states that "When past medical records are available and readily accessible, it is important that they be consulted for ancillary information" (Ref. 3, p 19). This statement is fairly nonspecific. There is no careful description of when and under what circumstances records should be requested, from whom, or for how far back; no empiric evidence is referred to or cited. Everything appears to be left to the realm of clinical judgment. This statement appears to put psychiatrists on the hook legally. It is fairly prescriptive in tone.

So, the study by Recupero and Harms is most welcome and helps to clarify the SOC regarding records requests. The empiric data provided helps the field in understanding what psychiatrists' thoughts and practices actually are in regard to records requests. The hope is that available customary practice evidence will help guide and inform fact finders' SOC determinations. Courts and jurors will have to rely less on their own personal experience to make sense of the clinical practice in question; in addition, the fact finders become less reliant on and more discerning of the opinions of expert witnesses.

"What is the Standard of Care, Doctor?"

Let us now turn our attention to one of the more troubling findings of the study: that more than a quarter of surveyed psychiatrists expressed confusion on how they know the SOC.[1] First, in defense of the young doctors, the very term SOC has differing meanings, depending on the profession defining it. In the legal profession, SOC, in essence, is a concept that has evolved with time and has been influenced by case law. Further, the exact wording of the legal standard can vary depending on jurisdiction and statute. When the appropriate statute, jurisdiction, and professional arena are specified, the words used for legally defined SOC tend to be overly broad and general: what an "average physician" (Ref. 4, p 8), "reasonable, prudent practitioner" (Ref. 4, p 10), or "minimally competent physician" (Ref. 5, p 112) in the same field would do in a particular clinical circumstance. This nonspecific standard must then be applied to the individual facts of a specific legal case. This process would be confusing enough.

In the medical profession, the use of the term is less abstract and more direct; it more often means the "best clinical practice" in a particular clinical situation. To use a hypothetical scenario, suppose Dr. X, when trying to decide how to care for a particular patient, consults Dr. Y and asks, "What's the standard of care here?" In this scenario, Dr. X is trying to determine the best thing to do for the patient. He is not using the legally defined meaning of SOC. If so, he would in essence be trying to figure out what a minimally competent physician would do in that situation. Indulging more in this absurd hypothetical, imagine, just for a moment, that the words "average," "prudent," or "minimally competent" were found in the mission statements of hospitals or the program requirements of residencies. Clearly, as most are well aware, the medical field strives for optimal care, and the legal field strives to define clearly the terms and thresholds. These unaligned forces naturally introduce confusion into the shared lexicon.

So, when a doctor hears the question, "What is the standard of care?" or "How do you know the stan-

dard of care?", and he says he does not know, it does not mean that he is not aware of the best clinical practice or how to find the clinical practice guideline for a given situation. The confusion is more reflective of his not knowing exactly what the question is asking. He probably knows just enough about SOC to know it is a complicated answer, not lending itself to a succinct, direct response. Having him recite "it is the caution that a reasonable person in similar circumstances would exercise in providing care to a patient (Ref. 6, p e192)," or, similarly, having him say "I learned it in my education and training" sounds stilted, vague, and wholly nonmeaningful. Indeed, as Simon points out in his 2005 article, "There is no stock answer to the question: what is the standard of care?" (Ref. 4, p 9). We further contend that there is no stock answer to the question: how do you know the standard of care?

The Medicolegal Aspects of SOC Must Become Part of All Residency Curricula

The likelihood that a physician will be sued at some point in his career is substantial. According to the American Medical Association's Physician Practice Information Survey for 2007–2008, to which nearly 6,000 physicians responded, the average physician has a 61 percent chance of being sued at least once by the time he reaches age 55 or older, and for psychiatrists, it is 35 percent.[7] In another study,[8] that examined closed malpractice claim data from 1991 through 2005 for 41,000 physicians who were covered by a nationwide professional liability insurer, the annual risk of a malpractice claim for psychiatrists was 2.6 percent. Thus, per this study's findings, a psychiatrist who practices for 20 years will more likely than not face at least one malpractice claim during that time. These are unsettling numbers.

The authors in the present study point out that the SOC can be considered "the core of any malpractice case" (Ref. 9, p 664, cited in Ref. 1, p 445). Indeed, SOC is not uncommonly one of the first terms to be brought up by attorneys when discussing a malpractice action with an expert witness consultant. Forensic psychiatrists generally understand the legal aspects of SOC because of their specialty training, but the typical clinician may not. This latter assertion is supported by Recupero and Harm,[1] who found that over a quarter of respondents did not know or guessed when asked how they knew the SOC. Playing this out, it is disconcerting to imagine that a not-inconsequential proportion of psychiatrists, when sued and asked during a deposition under oath, "What is the SOC doctor?" would respond truthfully but not necessarily harmlessly by saying, "I don't know."

As stated by Moffitt and Moore, ". . . it is important to know how the legal system defines the standard of care, and to what standards we as physicians are being held." (Ref. 5, p 109). Recupero and Harms noted that, since a large proportion of their sample was within 10 years of residency completion, the finding that more than one quarter of them did not know how they knew the SOC "is surprising and suggests an important target for improvement in both residency and continuing medical education" (Ref. 1, p 448). We wholeheartedly agree and believe no resident should leave training without being forearmed with this knowledge. As it now stands, however, the 38-page Accreditation Council for Graduate Medical Education (ACGME) Program Requirements for Graduate Medical Education in Psychiatry does not mention even once the terms "SOC," "malpractice," or "risk management" (Ref. 10). Under Curriculum Organization and Resident Experiences for Forensic Psychiatry, the Requirements state:

> This experience must expose residents to the evaluation of forensic issues such as patients facing criminal charges, establishing competency to stand trial, criminal responsibility, commitment, and an assessment of their potential to harm themselves or others. This experience should include writing a forensic report. Where feasible, giving testimony in court is highly desirable [Ref. 10, § IV.A.6.c., p 21].

Yet, in its introduction, the Program Requirements explain, "Residency is an essential dimension of the transformation of the medical student to the independent practitioner" (Ref. 10, p 1). There is a serious gap, though, when psychiatry residency programs do not provide dedicated, focused risk management education and experiences, yet bless their graduates as independent to practice. Our military does not send soldiers into the field without some degree of body armor, and we should not send physicians into a risk-filled practice environment without the necessary protections. In light of today's litigious medical practice environment, graduating newly fledged psychiatrists from residency without specific education and training about malpractice and the standard of care is in our view educational malpractice.

The number of risk management curricula in graduate medical education programs is believed to be insufficient.[11] Nissen *et al.*[12] have declared that risk management education is "a crucial bridge between educational and practical domains" (Ref. 12, p 589). They developed a curriculum at the University of Connecticut that teaches residents basic principles of risk management with the aims of reducing malpractice exposure and improving patient safety, and noted, "Residents need to understand the medical-legal events that may be set into motion as a result of their decisions and actions" (Ref. 12, p 589). Their multimodal risk management curriculum, spread out over two years, consists of "4 pillars of risk management: informed consent, documentation, patient relations, and standard of care" (Ref. 12, p 590). In our opinion, residency training programs across the nation would be well served to incorporate similar educational programs.

Conclusions

When the customary practices of psychiatrists are defined by empiric evidence and less by opinion, the experts, courts, and juries are better informed, which results in more thoughtful, clinically meaningful SOC determinations, and both the medical and legal fields benefit. The psychiatric field should continue this trend, and promote further investigations into the customary practices of psychiatrists.

In terms of psychiatric residents' education, we assert that greater attention be paid to the curricula that improve resident psychiatrists' knowledge and practical skills in risk management. The teaching should include an appropriate review of the legal history of the standard of care, how the meaning of the term differs depending on setting, and how it is distinguished from best clinical practice. Incorporating these educational elements into residency training programs will serve future practicing psychiatrists well.

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