American Handbook of Psychiatry

PSYCHIATRIC MALPRACTICE

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Table of Contents

Psychiatric Malpractice*

*In 1975, at the time that the second edition of the Handbook is being prepared, the increase in psychiatric malpractice suits gives cause for alarm. The factors leading to this rapid change are presented in Part B of this chapter.

However, the basic situation described in the chapter Psychiatric Malpractice in the first edition in 1966 still applies, and it is republished here unchanged as Part A. Footnotes, set in italics, have been added to unfinished cases or issues which have been terminated or stabilized in the meantime.

A Study of Twenty-eight Appellate Court Cases

While the occasional disagreements between medicine and law tend to make the headlines, cooperative efforts continue, quietly, toward improving the laws that govern medical practice and bringing them up to modern concepts of medicine. Both psychiatry and the law have made their contributions to these collaborations: the model commitment law drawn up by the National Institute of Mental Health (1951), or *The Mentally Disabled and the Law* (Lindman, 1961), drawn up by the American Bar Foundation, are but two examples. Many disciplines participate in these study groups, and broad benefits accrue to society, medicine, and law from continuing collaborations.[1]

The Law of Torts

Every professional practitioner carries certain legal duties of care; lacking violation of these, there can be no malpractice.

The law of torts[2] liability embraces three divisions; (1) negligent tort; (2) intentional tort; and (3) absolute liability. Only the first two apply to the practice of medicine.

1. Nearly all malpractice claims are tried under the law of negligent tort. Under this law the plaintiffs attorney must prove: (a) that a legal duty of care existed, (b) which the defendant (physician or hospital) fulfilled negligently, (c) as a result of which damages accrued to the plaintiff patient (or estate), and (d) that these damages were substantial.

Often, proving the claim is difficult. Year after year the defendant physicians win more cases than they lose, in spite of the fact that in most cases the jury feels sympathetic to the plaintiff (Harper, 1956). The pleas of plaintiffs' attorneys, stressing the difficulty of bearing the burden of proof, should be tempered with awareness that unmeritorious claims are also encountered.

The plaintiffs burden of proof is lessened when *res ipso loquitur*[3] is utilized. Objectively, when this principle is admitted and properly utilized by the court, it constitutes no more than circumstantial evidence, a "mere inference of negligence" (Prosser, 1955) which should be weighed along with

all the other evidence. Under these conditions, the medical profession has no objection to its use.

However, in recent years the principle has been misused as a *presumption* of negligence (rather than an *inference* of negligence) so that the burden of proof is shifted from the plaintiff to the physician. Unless the physician can come up with a factually convincing explanation of the cause of the damages to the patient, the physician may find himself held liable for an unusual complication, just because it is rare and not explainable. Prosser, former Dean of the University of California Law School, found the misuse of *res ipsa loquitur* sufficient to state:

> The Latin catchword is an obstacle to all clear thinking. . . . There is no case in which it has been anything but a hindrance. The present state of affairs in California, as elsewhere, is a reproach to the law. This, at least, speaks for itself (Prosser, 1953).

In addition, Harper has stressed that the doctrine is unfair to the physician, in view of the fact that the plaintiff wins most of the cases in which *res ipsa loquitur* is ruled admissible (Harper, 1956).

2. In rare instances, a malpractice claim will be tried under the law of intentional tort, implying an intent to touch injuriously, as in a fight, or as in administering electroshock therapy (EST).

A claim based upon *unenlightened consent* is a case in point. The

physician holds a legal duty of care to explain to the patient, relative, or guardian, the possible complications of EST, sufficient to form an *enlightened consent.* Without sufficient explanation, the consent is considered to be unenlightened, which amounts to signing no consent at all, and the physician has "assaulted" his patient.

Since witnesses usually are not present when the complications of EST are discussed, the case of alleged unenlightened consent boil down to the word of the patient against that of the physician. Thus, the plaintiff's attorney is relieved of the necessity to produce an expert witness of the same school of thought as the defendant-physician, willing to testify on behalf of the plaintiff. Understandably, plaintiff s attorneys base their claim upon unenlightened consent whenever possible.

Warranty of cure is somewhat similar to unenlightened consent. When a physician allegedly has said, "You accept this or that treatment and you will be all right," he has "promised a cure." Here, too, the case becomes the word of the patient against that of the physician, and no expert witness is needed on behalf of the patient. The physician who utters such a careless statement makes himself a warranter of cure—something the law would never do. Specifically, the law does not hold a medical service to be always safe. On the contrary, the law does hold the pharmaceutical manufacturer to be the warranter of a safe product, as exemplified by the $3,145,000 judgments

against Cutter Laboratories—with a few more minor suits still outstanding[4]—for manufacturing, admittedly nonnegligently, polio vaccines according to government specifications. It would have made as much sense for the plaintiff's attorneys to sue the federal government for faulty specifications as to sue the pharmaceutical manufacturing company which produced this highly complex attenuated vaccine product.

As an example of absolute liability, consider the owner of a reservoir, which overflows from a storm, and a neighbor suffers damage. The owner of the reservoir holds an absolute liability even though he maintained his reservoir nonnegligently. Absolute liability is not applicable in forensic medicine.

Legal Duty of Care

The existence of a legal duty of care is basic to all malpractice. As regards the practice of medicine, a legal duty can be formed either by law or by "common sense."

Our laws consist of both *statutory laic* (enacted by legislative bodies) and *case law* (precedent established via case decisions).[5] The judiciary are well aware of the danger of stultification of the law (Douglas, 1956), and it is quite appropriate for medicine and psychiatry to help in bringing about changes, via either statute or case law, so that the law may stay abreast of

modern psychiatric principles of diagnosis, treatment, and management of the mentally ill.

Statutory Law

Recently, in Connecticut, psychiatric interests were successful in uniting with the Bar Association in fostering enactment of a new psychiatric disclosure law dealing with privileged communication. By this law, psychotherapists in Connecticut now have greater protection in maintaining confidentiality, as well as precise delineation of the circumstances under which confidential communication from a client may, or shall, be broken for the benefit of society.[6]

To prepare the way for eventual enactment of the disclosure law, psychiatrists collected information, documented by case illustrations (Terhume, 1961), to demonstrate the need for confidentiality in psychotherapy, organized committees and study groups in collaboration with the Bar Association, and gave advance information to many members of the legislature as to the significance of the proposed bill (Goldstein, 1962). Proper preparation may save years of aimless discussion in the wrong committees, reaching the wrong ears.

Case Law

Modification of the law by establishing new precedents takes place constantly, but these changes generally occur over a longer period of time and are less spectacular than statutory changes. Also, modification by precedent can scarcely be planned, or debated in study groups, nor can forces be mobilized toward the intended goal. Nevertheless, by carefully defending all defensible malpractice claims, medicine and psychiatry can gradually mold the precedents thus established. An outstanding example of this is a suicide case presented below.

That "common sense" can also be used as a yardstick of reasonable duty of care may come as a surprise to some professional practitioners. We are more familiar with "the standard of practice in the community by practitioners of the same or similar school of thought"[7] so often used in malpractice cases. Actually, the measure of "what a man of reasonably prudent mind would do under circumstances" may be employed at the discretion of the judge and jury. Thus, in another case of suicide presented below, a plaintiff won a favorable verdict although the precautionary care provided the patient compared well with "standard practice" in psychiatric wards in that community.

The Vulnerability of the Psychiatric Profession

It is evident from the foregoing study of laws bearing on malpractice

that good laws facilitate good medicine. But there are limitations, and although psychiatry and the law have come a long way toward more humane handling of the mentally ill, malpractice claims cannot be eliminated entirely. First, discretionary powers must be allowed the professional practitioner or his activities cease to be professional and he becomes a tradesman. Thus, "good practice" cannot and should not be too rigidly codified, either by the law, or by medicine or psychiatry through too detailed codes of ethics or brochures delineating "standards of care."[8] Secondly, progress cannot be made without the occurrence of periods of flux. Changes, either in social attitude, legal maneuvers, or treatment concepts do affect malpractice claims, both as to incidence or outcome (for instance, size of award). It has taken time to work out the ground rules for adjudicating alleged damage to patients from innovations such as EST, introduced in 1938; the legal maneuver of alleged "unenlightened consent" which expanded rapidly in malpractice cases during the 1950's; or the current concepts of treatment by which the more serious forms of mental illness, such as suicidal tendencies, are being treated increasingly in the home, on open wards, or in day centers in the community closer to the patient's familiar surroundings, with admittedly greater risks, but with more patients getting well.

If malpractice claims cannot be eliminated, it is good preventive medicine to familiarize oneself with the nature of those risks that have been encountered.

The American Medical Association from time to time publishes accurate information on malpractice[9] (Hassard, 1957; Holloway, 1957; Morris, 1957; Sandor, 1957; Tucker, 1957). Psychiatry constitutes a low-risk group within the practice of medicine and consequently the American Medical Association has not given special attention to psychiatric risks. There are few papers dealing directly with psychiatric malpractice (Bellamy, 1962; Bellamy, 1965; Davidson, 1952; Louisell, 1960), although the subject arises tangentially in many publications.

A malpractice claim may be dropped by the plaintiff, weeded out as unmeritorious in pretrial hearing, settled out of court, or adjudicated in trial courts. Finally, a claim may be appealed; it is estimated that only about one out of every hundred claims reaches the appellate court (Sandor, 1957), and no reliable information is available about the other ninety-nine. However, all appellate court cases in the nation are abstracted and published as permanent documents, so they constitute one reliable source of information about the more serious primary malpractice risks in psychiatry. Out of 600 to 700 medical and surgical appellate court cases nationwide, twenty-eight were psychiatric cases in the eighteen years from 1946 to 1964.

Primary Psychiatric Malpractice Risks

The twenty-eight psychiatric cases that reached appellate courts

between 1946 and 1964 suggest five main areas of risk: (1) problems of treatment, twelve cases (43 percent); (2) problems of commitment, eight cases (29 percent); (3) problems of suicide, four cases (14 percent); (4) patient's assaultiveness, two cases (7 percent); and (5) problems of psychic injury ("mental anguish"), two cases (7 percent).

Problems of Treatment

Of the twelve cases based upon alleged negligent treatment, eight are concerned with shock therapies, and four with other forms of treatment.

Shock Therapies

Unauthorized Consent. The father of a schizophrenic patient signed consent for EST. The patient, after he improved, felt that he should have had the exclusive right to say whether or not he consented to the treatment. The psychiatrist was absolved of blame in this case, which occurred in California (Farber v. Olkon, 1953).

When mental competency is an issue, the signed authorization for treatment should be obtained from the legal guardian, if one has been appointed. Otherwise, it is better to obtain the signature of both the patient and the nearest relative, if possible, or to arrange to have a legal guardian appointed. It is fallacious for the psychiatrist to presume that if he proceeds

with EST and improvement follows that is gratifying to the patient, no malpractice claim will be filed.

Unenlightened Consent.[10] The law recognizes that if the physician were required by legal code to relate all the alarming details as to possible complications, the patients or relatives might refuse to sign their consent and useful treatment would be obstructed. Legal authorities advise the physician to inform the patient of potential hazards of the treatment "insofar as possible" (McCoid, 1957). Thus, discretionary powers are allowed the professional practitioner—which is as it should be.

The physician who conscientiously writes in the patient's record what complications were discussed and with whom (patient, relative, guardian), will have strong evidence that he fulfilled his legal duty of care to his patient. Of course, these notations must be made at the time of the discussions.

Alternatively, the patient or guardian may be asked to read a printed account of EST and its possible complications, and to sign to the effect that he has read and understands the contents of the account (Rodis, 1958). There is no foolproof method, however, of ensuring that consent is sufficient.

Three of the eight EST cases were tried on the basis of unenlightened consent; two were won by the defendant physician. In the third case (Woods v. Brumlop, 1962) a trial jury in New Mexico awarded $5,889.59, not against

the psychiatrist who administered EST which allegedly resulted in vertebral compression fracture and deafness, but against the diagnosing and referring psychiatrist who allegedly did not explain to the patient that complications might occur in connection with EST. The defendant referring psychiatrist appealed, and a new trial was held, and the psychiatrist was absolved.

Warranty of Cure.[11] Psychiatrists generally understand the insecurity that can be engendered by sickness. Wishful thinking, bolstered by distortions in perception and/or memory, may serve a useful, dynamic purpose in the insecure, or even in the mentally competent relative, guardian —or physician. The physician who reveals godlike attitudes is prone to malpractice (Blum, 1960).

There is no direct defense against an allegation of warranty of cure. The physician will not have written in the record, "I did not promise to cure this patient!" However, the presence of an accurate record, showing an overtone of due modesty in the healer, generally has been sufficient to win these cases. Such was the result in the two cases considered here.

Shock Therapy Negligently Administered. When a fracture or other significant complication of shock therapy occurs, the patient may claim that the shock was negligently administered, that the extremities were not held securely enough, or that they were held too securely, and so forth. The patient

needs a physician to testify to the alleged negligence. These cases were won by the defendant psychiatrist, except for two cases in which EST was continued after a fracture had occurred. In one case (Eisele v. Malone, 1956) a New York trial jury awarded $5000; the defendant appealed and retrial was granted. Before the second trial was held, the case was settled out of court for an undisclosed amount.

In the second case (Stone v. Proctor, 1963), a North Carolina trial judge ruled involuntary nonsuit. The plaintiff appealed, and a full trial was ordered by the appellate court. This trial ended in a mistrial due to a hung jury. The defendant then made an out-of-court settlement, amount held in confidence.

Plaintiffs' attorneys have attempted to introduce *res ipsa loquitur*—the contention being that fracture or other serious complication would not occur without the inference of negligence. However, the courts generally hold that if it is well known that complications frequently occur in connection with such procedures as shock therapies, then the fact that a complication did occur does not warrant an inference of negligence. Thus, *res ipsa loquitur* thus far has been ruled inadmissible in cases involving EST.

Other Treatment Situations

Wet Pack, Allegedly Cruelly Applied. In a Pennsylvania case (Powell v. Risser, 1953), the defendant psychiatrist and state hospital demonstrated

that the wet pack was applied in accordance with "standard practice in the community," as described in a military manual, and was not cruelly applied. Both were absolved.

Psychiatrist's Assault upon the Patient. In a New York case (Hammer v. Rosen, 1960), the mother of a schizophrenic patient brought suit because her daughter had been seen to emerge from treatment sessions with ecchymoses. The mother testified that the psychiatrist had claimed either (1) self-defense, or (2) that assault was part of the treatment. The mother also testified that the patient was not assaultive. However, the mother's own diary contained entries describing the daughter's assaults upon relatives or servants. The trial judge dismissed the case at the conclusion of the plaintiffs presentation.

Upon appeal, the appellate court in New York granted a full trial, on the basis that if the psychiatrist's alleged assaults were claimed to be part of the treatment, this would be prima-facie malpractice. Through failure to prosecute, this case now probably is as good as closed.[12]

Multiple Allegations. In another New York case (Gasperini v. Manganelli, 1949), a claim was filed naming several alleged acts of negligence, one of which was that the physician had given prolonged psychiatric treatment costing a few thousand dollars without obtaining a psychiatric

consultation. The physician was absolved of all allegations.

This case occurred in 1949, but it may still be important in view of the current trend toward encouraging the family physician to treat increasing numbers of the mentally ill in our nation. The law does not hold a physician to the same duty of care under all circumstances—for example, emergency treatment on the highway. On the other hand, some physicians tend to underestimate the value of psychiatric skill, and articles appearing in leading medical journals outline criteria for referral of a patient to a psychiatrist which are essentially the criteria of a psychotic episode! This would deprive a patient of earlier treatment by the specialist in psychiatry.

The emergency treatment of the mentally ill is an important trend by which the number of patients in some of our state hospitals is being decreased. As physicians are encouraged and trained to institute early treatment, they may also be informed of the value of psychiatric consultative and/or referral and treatment services, along with the potential jeopardy of a malpractice claim if they do not avail themselves of these services under proper circumstances. The benefits from early treatment of the mentally ill by the psychiatrist are too great to risk their being curtailed through faulty application of useful principles of treatment.

Wrongful Death. In a Pennsylvania case (Brown, v. Moore, 1956) a

patient was admitted to a private sanatorium for intermittent quadriplegia and other hysterical symptoms. About six or seven hours following the first EST, and after having had lunch and a nap, the patient fell down a flight of stairs. He was unattended at the time, and the fall was not observed. He immediately complained that his neck was broken. On the fourth day following the accident the patient died. During these four days there developed several typical signs of cervical cord injury, such as pain, distended abdomen, projectile vomiting, and quadriplegia. Diagnostic and treatment procedures customary in cases of spinal cord injury had not been instituted either by the psychiatrist or by his medical consultant. Post-mortem X-ray revealed an anterior dislocation of the fourth cervical vertebra, 8 mm., on the fifth cervical vertebra. The jury awarded $60,000 ($25,000 in wrongful death and $35,000 in survival action).

The above case is of further interest in that only the laymen hospital owners were named as defendants. The psychiatrist who was employed part-time by the hospital was not named as a defendant, nor was he called to testify as a witness. As a general medicolegal trend, owners of a hospital are assuming increased jeopardy because they are held responsible for the actions of their employees even though they may exercise no direct supervision.

In summary, of the twelve cases concerning problems of treatment, the

trial court rendered a judgment against the defendant in seven. Upon appeal, five of the judgments either were reversed or retrial granted. In the final result, a judgment for the plaintiff was won in three cases: (1) EST continued after a fracture had occurred, approximately $5000; (2) wrongful death, $60,000; and (3) EST "negligently administered," out-of-court settlement, amount held in confidence.

Problems of Commitment and Hospitalization

The most frequent basis for claims of illegal confinement is that the patient was *committed* on the basis of examination(s) performed perfunctorily or with ulterior motive—for example, to "dispose" of a patient who had proven refractory to treatment efforts (Bailey v. McGill, 1957).

In commitment cases the examining physician generally is exonerated. The courts hold that it is the judge, not the physician, who commits a patient, and that a witness must be free to testify as to his findings without fear of reprisal such as by suit for libel, or suit for negligent examination. It is a case of competing rights: the right of the individual witness to be protected against false statement, and the right of the public to be protected. The latter is considered the more important, according to an old legal principle worked out at the turn of the century.

However, for a physician to testify on the basis of cursory examination,

or no examination at all, always has been a criminal offense punishable by fine, imprisonment, or both. The law generally has not seen fit to prosecute in these infrequent instances.

In one case, the two examining physicians allegedly made no examination at all, but the district attorney did not prosecute. In a 1963 New York case (Kleber v. Stephens, 1963), the two examining physicians made twenty-minute examinations, allegedly negligently performed, and the trial judge allowed the defendants to be tried under the law of negligence; an award of $20,000 was made, upheld through two appeals to both appellate courts.

In both of these cases, the four physicians involved were not psychiatrists—but it is psychiatry that gets the "black eye" for these alleged felonies! In many jurisdictions the superior court holds the legal right to appoint medical examiners on the "lunacy commission." The psychiatric profession stands ready to advise the superior court as to reliable psychiatrists willing to serve as appointees of the courts within reasonable salary or fee schedules, and hopes that its advisory committees will be more fully utilized by the judiciary in connection with these appointments.

Hospitalization other than by commitment is exemplified by the following case. (Problems of hospitalization overlap with problems of suicide

discussed further in the next section.)

In a California case (Maben v. Rankin, 1961) a psychiatrist examined a patient who was acutely incompetent, obtained additional history from the patient's husband, administered sedative intravenously to the patient, and upon authorization signed by the husband for hospitalization and EST, had the patient taken to a hospital (of which the psychiatrist was part owner), and a course of EST was started. The patient made a very good recovery, but brought suit for assault and battery, claiming that when she "came to her senses" in the hospital and asked to leave, she was detained and, further, that EST was continued against her will. The psychiatrist would have been on safe ground had he followed any one of three or four legal codes for involuntary hospitalization. As one example, he could have filed a report of his examination to designated authorities within twenty-four hours, along with an examination and report by a second psychiatrist.

The trial court awarded $78,000 to the patient, and the defendant psychiatrist appealed. The appellate judges granted a new trial, but included, for consideration of the new trial court, the fact that the patient had benefited by hospitalization and treatment, and that such benefit could be given consideration in assessing damages as alleged. The case was retried, and $60,000 was the final judgment.

In summary, of eight cases, six were won by the defendant. In one case a judgment of $60,000 was awarded to the patient for false imprisonment, and in a second case a judgment of $20,000 for negligent mental examination was rendered.

Problems of Suicide

The referring physician, the treating physician-psychiatrist, or the hospital owners carry certain risks attendant to locked-ward and to open-ward types of treatment facilities.

In a Georgia case (Tisinger v. Wooley, 1948), a woman committed suicide by jumping from her unbarred window in a large university hospital. The referring physician was absolved. Evidently, back in 1948, if a hospital accepted mental patients it was considered to be reasonably prudent for the referring physician to admit a patient in that hospital. The hospital was absolved because the plaintiff made a general claim of inadequate attendance, but failed to show that the patient was not guarded at the critical moment.

In a Missouri case (Stallman v. Robinson, 1953), a woman committed suicide in her room on a locked ward by hanging herself with a rope fashioned from torn strips of nightgowns. The nurse had checked only one-half hour before the suicide and found the woman apparently sleeping comfortably on her bed with the safety belt presumably locked. The trial jury

awarded $9000 damages and the appellant court sustained this judgment, claiming that one-half hour was too long a period to leave a patient unattended.

Hospital costs surely would become astronomical if hospitals were required to maintain constant attendance upon patients presumably sleeping in locked safety belts! This precedent must be reversed in subsequent cases for the benefit of law, justice, and the mentally ill trying to recover.[13]

In a Spokane, Washington, case (Benjamin v. Havens, 1962), a woman sustained serious injuries from her dash for freedom or suicide from an open ward. On Christmas Eve the patient had tried to commit suicide by swallowing her nightgown and breaking off her toes. The family physician called in a physician-psychiatrist at once, but the psychiatrist was not told that the patient was actively suicidal either by the referring physician, the psychiatrist who had treated her three months earlier in a state hospital in a neighboring state, or by the husband—otherwise the open-ward facility would not have been selected as appropriate for this patient. The treating psychiatrist was absolved.

However, the trial jury awarded $11,226 against the hospital owners. A nurse testified that the patient alternated between periods of depression and moods in which she was cheerful and sociable. The patient, with permission,

had gone off the ward to the bathroom several times unattended during her five days in the hospital, and this time when the patient asked the nurse for permission to go to the bathroom she gave no telltale sign whatever of her intended dash for freedom, or suicide—otherwise, the nurse testified, she surely would have accompanied the patient to the bathroom.

The appellate court upheld absolution of the treating psychiatrist, but because nurses in this hospital customarily guarded the corridor leading outdoors, and because the nurse on duty in the nurse's station did not have unobstructed visibility up and down the corridor, a new trial against the defendant hospital was ordered. The case was then settled out of court at a figure slightly smaller than $11,226.

Evidently, if by custom an area has once been guarded, it must always thereafter be guarded. Furthermore, another nurse had talked to the patient immediately prior to the incident, and the patient gave no sign of her intention to flee or attempt suicide.

The open ward is too valuable a treatment method to be endangered through unjust litigation. Perhaps psychiatrists can (as anesthesiologists have) get across to judges and juries the complex nature of managing potentially or actively suicidal patients and get reasonable justice back into a very difficult field of professional treatment endeavors. Just this was done in

the next case.

In another Missouri case (Gregory v. Robinson, 1960), as a treating psychiatrist was leaving a locked door of a locked ward, a patient dashed from his bed fifteen feet distant, pushed through the door, and jumped through an unbarred window in a stairway and sustained serious injuries, miraculously short of death. This very complicated medicolegal case has been presented in detail elsewhere (Bellamy, 1962). It suffices here to demonstrate a proper way for psychiatrists, through their defense attorneys, to present their complex findings and philosophies of proper treatment to the judiciary. The trial jury had awarded $40,000 against the hospital, but the appellate court established a favorable precedent by absolving the hospital on the basis of the following deliberation, developed from court testimony:

The modern concept of treatment in such cases is to allow patients as much freedom as possible, to treat them as individuals, and to try to "resocialize" them; therein the physicians knowingly take a calculated risk; better safeguards could be afforded by strict confinement, but few patients would be cured; there is potential for suicide or for harming others in all acutely depressed mental cases, and in some patients this may increase when they begin to improve, but certainly not in all; patients such as plaintiff are being cured regularly by modern treatment; care in entering or leaving such a ward becomes a sort of automatic reflex and specifically, it was shown here, it

was a constant procedure for the doctors and attendants in this hospital to be careful on entering or leaving the ward. ... At the time of the trial he [plaintiff] had apparently recovered completely from his mental illness and he was working, though at a less remunerative position (Gregory v. Robinson, 1960).

Note the great clarity of the opinion expressed by the judiciary. This is an example of defending a difficult case, from which a favorable precedent was established for the benefit of law and medicine alike.

In summary, of four cases, the trial jury awarded judgments in three cases and appellate courts absolved the defendant hospital in one case but upheld the judgments against hospitals in the other two cases ($9000 in one case and less than $11,226 in the second case). Thus 50 percent of the suicidal cases were awarded judgments; the highest incidence of risk in psychiatry.

Problems of Patient's Assaultiveness

In these two cases, a patient suddenly became assaultive to relatives and attendants caring for the patient.

Both the physician and the psychiatrist defendants were acquitted in these two cases. However, the wording of the deliberations strongly suggests that if a physician does know that a patient has assaultive tendencies, he carries a legal duty of care to give warning of potential assaultiveness to those

persons who may be involved in custodial care of that patient, in the home or elsewhere. Also, the duty of care is higher for the psychiatrist than for the nonpsychiatric physician.

Problems of Psychic Injury

This is potentially a dangerous and unjust psychiatric risk. Thus far only one award has been sustained (against a treating roentgenologist). However, the judgment evidently rested largely upon psychiatric testimony, and consequently psychiatrists may well study the following two cases. In a New York case (Ferrara v. Galluchio, 1958), $25,000 was awarded against a roentgenologist of which a portion, $15,000, was for "mental anguish." X-ray treatment, administered to the shoulder for bursitis, was followed by a skin lesion that did not heal. After two years the patient's attorney directed the patient to a dermatologist who allegedly advised her to "have her shoulder checked every six months inasmuch as the area of burn might become cancerous." Whereupon, she asserted, she developed a fear of cancer. The psychiatrist testified that the patient had "cancerophobia."[14]

In their deliberations, the appellate judges spoke of (1) "autosuggestibility," and (2) "iatrogenic disease," as though these were a true explanation of the phobia. Thus, the deliberation: "It is common knowledge (from physical-culture lectures and newspaper articles) among laymen and

even more widely among laywomen that wounds which do not heal over long periods of time frequently become cancerous." Nevertheless, the dermatologist's statement "it might become cancerous" is held to be a form of "iatrogenic disease" and the damages accrue to the first "negligent person," the roentgenologist. This was a four-to-three split decision which carried a strongly worded minority opinion, but the $15,000 for "mental anguish" was sustained.

In other words, the roentgenologist is liable when the dermatologist tells the patient something she already knew from the newspapers. It would make as much sense to sue the newspapers for "newspaperogenic disease." It falls to the psychiatrist testifying in such a case to state clearly that (1) "suggestibility" is a universal function of every mind, normal or "neurotic," and (2) "cancerophobia" is a complex psychological mechanism not arising from any single cause but of necessity stemming from multiple causality. In any event, a start toward a dangerous precedent was made by the majority decision in this case.

In another New York case (Krause v. Spielburg, 1962), although the preceding case (Ferrara v. Galluchio, 1958) was cited as a reference, the defendant family physician was absolved from a charge of alleged "mental anguish" from "tuberculophobia." The trial judge believed the case was of little merit and, upon the conclusion of the plaintiff's testimony, gave a

directed verdict absolving the physician. The appellate court upheld the directed verdict of absolution.

Thus a dangerous precedent was reversed, but other cases in other jurisdictions surely will follow, and the psychiatrist had best be well prepared. We must remember that the judiciary are highly dependent upon expert medical testimony in order to formulate their deliberations in medical cases. Of course, the expert testimony must be accurate, well thought out in advance of appearance in court, and able to withstand the impeachment attempts allowed by law in the trial courts in the interest of discovering the truth—or falsity—of testimony rendered under oath.

In summary, these twenty-eight psychiatric malpractice cases comprise a low-risk group within the practice of medicine. Yet this low-risk group reflects nearly every important mediocolegal trend observed in high-risk groups.

Potential Psychiatric Risks

Reportable Diseases

Failure to report a reportable disease (epilepsy), which later figured in a serious auto accident, brought an out-of-court settlement of $230,000, of which $200,000 was against eight physicians who had failed to report their

knowledge that this patient had epilepsy.[15]

Drug-Induced Diseases[16]

Diseases attendant on the administration of drugs, such as agranulocytosis following psychopharmaceutical prescriptions, have brought awards in the quarter-million-dollar bracket. Psychiatrists are prescribing relatively new drugs to countless patients over prolonged periods of time. Although periodic physical and laboratory examinations are a notoriously poor preventive measure in cases of dyscrasia, nevertheless a patient should not continue on psychoactive drugs for years without an examination either by the psychiatrist or the family physician in the team on the case.

Treatment Innovations

In England, a psychiatrist had a judgment of £6000 brought against him for a new form of psychotherapy, namely, agreeing to innocent socializing with a female patient in a final effort to resolve a "transference love" that had resisted all usual psychoanalytic techniques for many months before the final socializing innovation was instituted. The patient finally committed suicide.

Research

Manufacture, testing, and research on new drugs now is carried on

under new rulings by the Food and Drug Administration. Atrocities to civilians perpetrated under the guise of "medical experiments" (for example, at the Buchenwald concentration camp) resulted in the Nuremberg laws, which are fairly adequate (Dragstedt, 1959.) Many physician-psychiatrists are unhappy with the restrictions passed. These laws have not yet been tested in our courts and we must reserve judgment. In the meantime, excellent articles have covered the anticipated pros and cons quite adequately[17] (Dragstedt, 1959; Furst, 1960; Gilder, 1960).

Preventive Measures

The Individual Psychiatric Practitioner

1. Know your laws. Know your rights as well as your duties under the law.

2. Purchase adequate malpractice insurance

3. coverage from an insurance carrier known to defend all defensible cases.

4. Do not overlook the value of a consultation under appropriate circumstances.

5. Keep adequate records, and keep them current.

6. If you repeatedly find yourself in trouble, consider obtaining psychiatric treatment.

The American Psychiatric Association

In one case, the plaintiff's attorney relied heavily upon the evidence of a statement from *Standards of Electroshock Treatment,* prepared by Committee on Therapy and approved by the Council of the American Psychiatric Association, May 1953: "If the patient should complain of pain or impairment of function, he should receive a physical examination, including X-rays, to ascertain whether he has suffered accidental damage" (Stone v. Proctor, 1963).

Even though in this particular case the clinical picture may have warranted taking X-rays, such a statement deprives the physician of his discretionary powers. Should every patient who complains of headache or backache following EST be X-rayed? Certainly not.

Consequently, the officials of the APA and other organizations of psychiatry and psychoanalysis should review their canons of ethics and their manuals of standard practice,[18] changing mandatory language to permissive language (or including a qualifying clause) whenever appropriate, and secondly, officials of all psychiatric organizations should make it their policy to screen all future official statements with that principle in mind.

Ethical Considerations

Since the professional practitioner must be granted discretionary powers in order that his activities may remain professional, and since good judgment cannot be legislated, it follows that ethics must pick up where the law leaves

off. To possess the highest ethical considerations is as important to the political and legal practitioner as it is to the medical practitioner.

Judge Jerome Frank said, in introducing Justice William O. Douglas: "Empathy constitutes his central virtue. He has discovered that the finest wisdom stems from emotionally understanding what one knows" (1956) Justice Douglas said, "The work of a court may send a whole economy in one direction, or help shape the manifest destiny of an era." Therefore, one must be ready to acknowledge his mistakes. Thus: "My convictions of yesterday I now see were wrong; to adhere to them, out of prideful consistency would be foolish, wicked. ... It is a healthy practice ... for a court to reexamine its own doctrines. . . . Responsible government should entail the undoing of wrongs" (1956).

Such is the high ethical awareness possessed by leaders of medicine and the judiciary. Ethical goals are like ideals that we strive toward but rarely, if ever, achieve. Yet we should be as unafraid to proclaim ideals as we would truths, and we should not be like those persons of whom Samuel Butler

wrote: “Some men love truth so much that they seem to be in constant fear that she should catch cold from overexposure.”

Consequently, to shirk our duty to speak our psychological truths by defending all defensible malpractice cases would be to foster stultification, rigidity, and injustice through case law. Equally, it is the duty of physicians, attorneys, judges, and political leaders to be worthy of the discriminatory powers bestowed upon them by tradition and by law.

In the vast majority of instances in the cases briefly reviewed above, the quality of performance of the medical witnesses, the attorneys, and the judges was of superbly high quality. (Those few exceptions have already been presented in greater detail.)

Turning briefly to another area, that of criminal law, physician-psychiatrists, when testifying as to the assumed mental status of a criminal at the time he performed the alleged crime, are of necessity testifying to opinions based upon a high degree of inference (Diamond, 1961). The public generally, and the judiciary occasionally, do not fully appreciate this fact and the image of psychiatry suffers accordingly, condemned by newspaper headlines.

On the other hand, in the above cases physician-psychiatrists were testifying to clinical observations and opinions carrying a much lower degree

of inference, and their testimony, now written into case law, was generally excellent. It is the latter area of testimony that resides on open library shelves as public documents—which, ironically, the public does not read!

The superb performance of the judiciary is the more remarkable considering that some degree of prejudice is universal, a fact that prompted Voltaire to say, "We must make intolerance intolerable, but we must respect prejudice," or, as Erikson put it, "The only unprejudiced person is one who is prejudiced against being prejudiced." I can perceive how the judiciary could have obtained such excellent empathy and understanding of the problems which physician-psychiatrists encounter in dealing with patients. But it is highly remarkable that the judiciary put aside their prejudices so well during their deliberations, which consequently stand up well under the test of time.

I should like to conclude with a statement of ethical principles for the professional practitioner, the law, and the social milieu, as forged by our professional statesmen.

1. Of the professional man (physician, attorney, statesman), it is reasonable to expect that he develop those arts and skills necessary to effectively carry out his professional duties; that he acquire that degree of knowledge necessary to have something to profess; that he profess it with discretion; and that he develop that degree of moral fiber necessary to

profess it with sincerity, integrity, and good conscience (ethics).

2. Of the law it is reasonable to expect that the lawmakers continue their search for better laws, toward our constitutional ideal of equal rights to everyone under the law, and that practitioners of the law strive toward the ideal of the "professional man" as delineated above, in order to better implement these laws in the interest of justice.

3. It is reasonable to expect society to provide an optimum social milieu for the ideals expressed under 1. and 2. and that the political leaders maintain that political climate in which what the professional man has to profess will be heeded as at least one of the multiple alternative choices in planning our social order.

Our late President John F. Kennedy said, "Give me multiple choices," operating under a sound psychological principle expressed by Macaulay, "Men are never so likely to settle a question rightly as when they discuss it freely."

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Notes

1 It is noteworthy that such outstanding jurists as professor Henry Weihofen and Judges John Biggs and David Bazelon have won the coveted Isaac Ray Award for distinction in the field of psychiatry and law.

2 In civil law, a tort is a wrongful action of commission or omission not involving breach of contract.

3 Literally, the thing or fact speaks for itself. If a bum on the skin appears at the site of a heating pad, it constitutes circumstantial evidence that someone was negligent—the patient, the doctor, the manufacturer, or others.

4 Mr. Edward Cutter stated that since 1966, two more cases have been completed for a total of $25,500 additional awards or $,3,170,000 liability as of the end of 1974.

There are two final cases outstanding which may not be determined for several years. For children, the statute of limitations may not begin to toll until the age of eighteen or twenty-one years; various states allow one to seven years after that. The “prayer” need not be declared at the time the claim is filed initially in twelve states, and this happens to apply in the two cases outstanding. However, Mr. Cutter stated that there was reason to believe that the prayer was moderate.

5 Probably we may now recognize law by a third process, administrative law (established by codes or regulations administratively created), which is discussed below (see p. 919).

6 By the time of the second edition of the Handbook, 1975, the Connecticut State Legislature already had weakened the formerly exemplary State Commitment Law.

7 Standard of practice in the community has been made to conform to the standard of practice in that state or in the nation. Thus the courts are ruling on admissible testimony of an expert witness from a distance of several hundred miles (Sinz v. Owens, 33 C2d 749, 1949; Huffman v. Lindquist, Cat S Ct, 1952.

As to "practitioner of the same school of thought,” this philosophy has been expanded (Brown v. Cohn, 11 Cal 3d 639, 1931). For example, a defendant surgeon had performed a rare and stipulatedly difficult surgical procedure many years before the case came to trial. The pathologist who testified for the plaintiff had done no surgery, but from countless autopsies performed in a distant community had presented himself as knowledgeable about the issue at bar. The appellate court sustained the admissibility of his testimony.

In a second case, a judge allowed testimony from an expert witness who had minimal experience but extensive reading on the issue at bar. If carried to a ridiculous extreme, a psychiatrist could find his testimony opposed by a professional assistant whom he was training in his clinic, if she had read the literature. More seriously, in Magit v. Board of Medical Examiners (57 C2d 74, 1961), an anesthetist was held liable for hiring an anesthetist

who did not yet have his license in California.

The philosophy "what a man of reasonable prudent mind would do under circumstances," is still not overly utilized. However, there is evidence of this philosophy being embraced covertly and juries seem to be getting the message.

8 See the section on Preventive Measures, p. 909.

9 By contrast, many popular magazines tend to sacrifice accuracy for sensationalism.

10 The courts have tightened up in this respect, as discussed in Part B. (see p. 916).

11 With the rapid expansion of new psychiatric methods—often discussed in popular magazines, complete with promises of cure—this may become a serious malpractice risk.

12 Case has been closed for this reason.

13 By 1974, the highly useful concept of ''dangerousness" has been developed, referable to suicide, murderousness, and the place of diagnosis. See references from Part B: Beck, 1973; Benjamin, 1974; Blackman, 1963; Danto, 1973; Goldzband, 1972; Hollister, 1974; Kiev, 1974; Klein, 1969; Klein, 1972; Leifer, 1969; Malmquist, 1971; Miller, 1973; Pasnau, 1974; Peer, 1974; Ross, 1973; Steadman, 1973; and Stoller, 1974.

14 I do not know what additional details the psychiatrist may have included in his testimony.

15 Battered child syndrome is now a legally reportable disease in several states (see Kolman, 1974, in Part B). This is almost certain to become a nation-wide legal duty of care for the psychiatrist.

16 This malpractice risk of potentially large monetary award is now compounded by questionable supervision of treatment regimes—e.g., who gives injections and cursorily signs prescriptions in some instances?—requires detailed appraisal (see Part B, pp. 918-919).

17 The FDA has tightened the conditions required in research such that it is difficult or impossible, especially in child research projects, for the researcher to feel secure that he has obtained an informed consent (see reference 50 from Part B). Furthermore, the Review

Boards passing judgment on proposed research projects have more members who are laymen—the latter sometimes holding a majority vote.

18 In 1959 the Board of Trustees of APA rescinded the manual on EST on the basis that it was a stabilized procedure.

B. New Malpractice Risks in Current Psychiatry[1]

The nine years elapsed since the first edition is too brief a span of time for basic psychiatric malpractice risks to have changed substantially with respect to case law. The basic findings presented there were gathered from appellate court cases which have been deliberated in depth and then published weekly in legal documents. Thus they "stand still," and since the appellate-court deliberations stood the test of time well, so did Part A of this chapter.

By contrast, the new risks are, indeed, too new to have been tried in trial court (unpublished), or to have gotten beyond a court settlement, or perhaps are looming only as a threat. Anecdotes, newspaper accounts, and assessments published but highly speculative, all leave much to be desired as source material and make this review highly speculative as well.

The new psychedelic vogue has brought many innovations. Treatment methods are tried without control studies. Innovations are to be encouraged, but control studies are difficult. Important dilemmas never have singular or simple solutions. However, the obvious malpractice risk mandates vigorous study for solutions.

Blum[2] analyzed the godlike attitude in the malpractice-prone physician.

More of the current indiscretions of psychiatrists and their professional assistant (PA) supervisees will be discussed in depth (see page 918).

From the point of view of the patient, a lawsuit is more likely if he is dissatisfied with the treatment results. Thus there are several forces at work, e.g. the cruel hoax of false promises which lead the mentally ill to disillusionment, frustration and perhaps mental depression (Posner, 1974). This source of increase in malpractice claims is obvious. Consequently, physicians have cautioned the legislators that it would be ill advised to enact laws that promise today what will take perhaps a decade or more of research to find; i.e., methods by which the professional practitioner reasonably will be able to deliver the desired benefits to the patient.[3]

Furthermore, within statutory law inequities exist. For example, in each of two California cases a patient discharged from a mental hospital committed murder shortly thereafter.

In one case the next of kin could not sue the doctor and/or the hospital because a statute proscribed this type of suit against a government facility. Had it been a public hospital or private practitioner (PP) what size award, if any, might have accrued?

In researching the second case, Tarasoff v. Regents of University of California the author found “publication delayed,” or words to that effect, on

an otherwise blank page. The law librarian advised that this meant the California Supreme Court was not entirely satisfied with the deliberation and/or decision of the California Appellate Court, and that in a few weeks or months the case might or might not be published. I consulted two attorneys who stated that the University of California physician involved stipulated that before being discharged the patient verbalized to him his active murderous intentions. The district attorney did not bring charges against this physician, basing his decision on a humanitarian principle—that should it become known that a physician could not protect the patient's privileged communication, then hardly any actively murderous or suicidal patient could be expected to disclose his inner thoughts in the psychotherapist-patient relationship. Thus, this district attorney showed more empathy with the critically mentally ill than did the Congress of the United States when in 1973 it voted down five rules of evidence dealing with privileged communication for relationships such as that of husband-wife, priest-penitent, psychotherapist-patient. In this action, Congress went against the recommendation of the United States Supreme Court (Rules of Evidence, 1973).The year before, however, the Supreme Court took a first step toward totalitarianism by reversing the privilege traditionally held by the newsman as to the source of his information.[4] (See Bellamy, unpublished, for a discussion in depth.)

It seems clear to this author that if we are to refute the allegation that

psychiatry is dying, we must learn to understand ourselves and our science of psychiatry; learn to cooperate in fruitful debate with all subspecialties within psychiatry; and collaborate with statesmen, legislators, the judiciary, attorneys, and all others interested in equal opportunity for good quality medical care for all. If so, then let us make public the charges brought against psychiatry to better enable us to refute them publicly.

Medical Malpractice Trends

Case-finding, Incidence, Rate of Change, and Size of Awards

It is common knowledge that, although it is hard to find "cases" in the "pre-appellate court" stages of inception of malpractice threats or claims filed, nevertheless the incidence is increasing at an escalating rate and bringing larger awards approaching geometrical progression.

A report of the Secretary's Commission of Health, Education and Welfare (HEW [Secretary's Commission on Medical Malpractice, 1973]) admits this—only to refute it:

> Magnitude and Impact of the Medical Malpractice
>
> Problem: Analysis of Claims Paid
>
> The total number of claims paid does not appear to be as important a factor in the overall problem as does the number that give rise to large

settlements or awards. These relatively few claims (the 6.1 percent above $40,000) appear to be the ones that most alarm health-care providers. As depicted in Table 7 [Table 45-1], more than half of the claimants who receive payment get less than $3,000, the other half receive more. Less than one out of every 1,000 claims paid is for $1 million or more, and there are probably not more than seven such payments each year. There is little doubt that the number of large awards or settlements has been increasing dramatically within the recent past [1973, page 10].

HEW refuted their above opinion by the following:

The Magnitude in Perspective

(1) Despite the publicity resulting from a few large malpractice cases, a medical malpractice incident is a relatively rare event; claims are even rarer and jury trials are rarer still.

(2) In 1970, a malpractice incident was alleged or reported for one out of every 158,000 patient visits to doctors.

(3) In 1970 a claim was asserted for one out of every 226,000 patient visits to doctors. . . .

(11) If the average person lives 70 years, he will have, based on 1970 data, approximately 400 contacts as a patient with doctors and dentists. The chances that he will assert a medical malpractice claim are one in 39,500 [1973, p. 12].

Table 45-1. Distribution of Amounts Paid on Medical Malpractice Claims Closed in 1970

TOTAL SETTLEMENT COSTS OF INCIDENTS, IN DOLLARS	PERCENT OF INCIDENTS	CUMULATIVE PERCENT OF INCIDENTS
1-499	21.1	21.1
500-999	l6.0	37.1

1,000-1,999	12.3	49.4
2,000-2,999	10.1	59.5
3,000-3,999	3.0	62.5
4,000-4,999	2.7	65.2
5,000-9,999	13.4	78.6
10,000-19,999	10.0	88.6
20,000-39,999	5.3	93.9
40,000-59,999	1.3	95.2
60,000-79,999	1.0	96.2
80,000-99,999	0.8	97.0
100,000 and up	3.0	100.0
	100.0	

Source: Commission Study of Claim Files Closed in 1970 (Secretary's Commission on Medical Malpractice, 1973, p. 11).

Physician-attorney Rubsamen (1974) presents the situation more concisely and informatively by the simple expedient of counting actual cases[5] rather than by extrapolating:

> This month a 5-year old Santa Clara County girl obtained a $1.1 million settlement for severe brain damage arising from a complication of her birth. This is the 12th million plus malpractice award in California's history and the seventh in the past 18 months.

What price *is* right for human life? Gates, as reported by Hoffer[6] in his government study, estimated that it cost about $400,000 to train a jet fighter

pilot and therefore it was considered uneconomical to exceed that value for safety devices on the plane. Would that the government place that ceiling on malpractice awards.

Geographical Distribution of Malpractice Claims

The Secretary's Commission of HEW calculates by extrapolation that the national average was 6.54 malpractice claims closed per 100 practicing physicians in 1970. Of three possible impressions—the figure is representative, is understated, or is overstated—it is noteworthy that HEW chose the latter:

The gross rate of 6.54 closed claims per 100 practicing physicians somewhat overstates the situation since some claims are made solely against hospitals, dentists, and others, but this gross rate does provide a fairly uniform comparison among the states. Only two of the western states are below the average, whereas the states with the highest rates are New Jersey, California, Montana, Arizona, Washington and Nevada. Although the average rate in some of the smaller states may be influenced by the fact that some carriers do not collect claims data for every state (Delaware may be mixed with some of Pennsylvania, for instance), the state groupings do suggest a western versus eastern bias in the number of claims per 100 practicing physicians (Secretary's Commission on Medical Malpractice, 1973, p. 8).

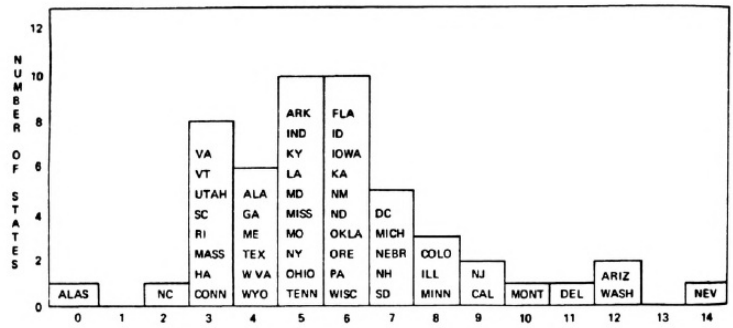
Figure 45-1 illustrates the geographic distribution of malpractice claims.

Cost of Medical Malpractice Insurance

HEW's report indicated that malpractice insurance premiums rose from $7,051 in i960 to $37,610 in 1972 (Secretary's Commission on Medical Malpractice, 1973, p. 13). Rubsamen (1971; 1972) and Hitchings (1974) reported that several insurance companies in California raised their premiums for malpractice insurance between 5 and 20 percent in the early 1970s; that some insurance companies have discontinued malpractice coverage because it is unfair to spread over the large group of insured physicians the very high awards granted against a few physicians; and that awards were increasing in size so rapidly as to render it impossible to actuarially appraise reasonable premium rates.

Physicians have had to form their own malpractice insurance companies to insure themselves against their own risks, which proves conclusively that the problem is substantial.

Figure 45-1.



State to state differences in number of claims closed in 1970 per 100 physicians providing patient care (U.S. average = 6.54).

Table 45-2. National Price and Index for Hospital Medical Malpractice Coverage, 1960, 1966, 1970, 1972

YEAR	Premium Cost For Constant Degree Of Coverage*	Index for Medical Malpractice Insurance (1966 = 100)	Medical Services Price Index
1960	$ 7,051	86.5	92.8
1966	8,153	100.0	100.0
1970	25,546	313.3	116.4
1972	37,610	461.3	n.a.

*The National Daily Average of occupied hospital beds was 217 in 1960, 207 in 1966, and 193 in 1970. Outpatient visits were 188, 226, and 322, respectively. The 1970 figures were used for 1972.

Sources: Insurance Services Office, New York (1960-1972), and Economic Report of the President (1971), p. 249.

Pharmaceutical Problems in Relation to Unenlightened Consent

The reader may recall from Part A that the manufacturers of pharmaceuticals have a legal duty of absolute warranty as to safety of their products. To make sure that the manufacturer will have no loophole, in some states this "warranty liability" has been expanded to the "strict liability" rule, which is a somewhat higher duty of care.

As a consequence of cases decided against them (Davis v. Wyeth, 1968; Gottsdanker v. Cutter, 1960), such as Gottsdanker v. Cutter, the pharmaceutical manufacturers are now listing every possible complication of a given drug in the annual *Physicians' Desk Reference* and circulating it to all physicians. This puts another burden on the physician. If he cannot impress on the jury that he adequately explained to the patient the potential risk in connection with the use of a given drug, he may be sued for "unenlightened consent." The discretionary powers mentioned in Part A (see p. 903) technically are still granted the physician, but recent court rulings indicate that the courts are demanding more discourse with the patient concerning the potential risks and have tightened up the need for "proof" that such discussion took place.

Awards obtained from negligence in medication tend to be very large. Although no cases involving psychiatrists have as yet come to this author's attention, the customary use of medications in the treatment of the mentally ill, often multiple and extended over long periods, makes psychiatrists

vulnerable. One or two large awards and insurance rates are certain to increase precipitously.

Informed consent has replaced *res ipsa loquitur* as the basis of claim to place the physician in jeopardy through legal ambiguity (Mills, 1974). This has implications for psychiatry because the syndromes of mental illness are less precise than those of most physical illnesses.

Cobbs v. Grant (1972) outlines the problem, and the California Medical Association (CMA, 1973) presents guidelines. Malpractice vulnerability is such as to prompt readers to study the case citations and law(s) governing informed consent in the state (s) in which they practice.

Psychiatric Malpractice Trends

So much for the above documentation of general trends. In the following we must revert to anecdotes. Certain categories of risk-inducing trends are suggested. There is considerable overlap among categories.

Phasing-Out of State Hospitals

Treatment in state mental hospitals has been called "warehousing." But now that these facilities are less available, we recall the usefulness of the state hospital for certain types of mentally ill who could not be managed as well in

local facilities. Two factors should be taken into consideration: (1) the overloading of local facilities; and (2) injudicious administrative practices. Details are presented by Robbins (1974) and Peszke (1974).

In any event, such patients are now being treated in outpatient facilities, e.g. clinics, or the offices of private practitioners. These are the patients who had been considered too sick for treatment outside of a hospital (Ozarin, 1974).

Hospitalization Difficulties

In California the Lanterman-Petris-Short Act has eliminated all commitment procedures. The patient is seen by a psychiatrist employed by a local mental-health facility, partly funded by the state.[7] The bases for holding a patient involuntarily are that the patient is dangerous to himself or others and/or that he is so disabled as to be incapable of feeding or clothing himself. The psychiatrist may then sign a hold order for three days, followed by fourteen-day hold periods, while informing the patient of his right of habeas corpus, which, if exercised, brings the patient to judicial review to see if his civil rights have been infringed. The difficulty with this procedure is that it makes the psychiatrist both judge and jury. Also, all full-time PP's have no say in these cases.

The intent of this provision for holding a patient is that mentally ill

persons can have voluntary admission to local facilities, such as community mental-health centers (CMHC). In actual practice, most local facilities—although fully funded (e.g., in California)—are overloaded. The police seem to know this, and refuse to take to a CHMC any but the nearly totally incapacitated so the more costly method of private ambulance often has to be utilized—round trip when there is no available bed—and the patient who knows by heart his way to his state hospital is turned away with "you aren't sick enough yet," or "your psychiatrist ought to know better," or words to that effect.

One result is that voluntary admissions are possible in theory but not in fact. The very ill must fall back on a hold order, so the hospital is *forced* to admit the patient. We have taken a giant step back to the Middle Ages, treating patients as prisoners rather than as sick people. Auerbach (1963) described the Anti-Mental Health Movement, led by Thomas Szasz, which has spread far. One wonders how people can be influenced to believe that mental illness does not exist except in the minds of psychiatrists, the motive of the myth being to protect the psychiatrist against loss of his occupation.

The Influence of the Community Mental Health Center

We turn now to undesirable practices found in some CMHC's. The private practitioner of psychiatry (PP) also is imprudent at times, but the

shortcomings and dangers are more readily detected in the former. In addition, some risks are peculiar to the CMHC, e.g., administrative problems and the increasing use of the professional assistant (PA)—an innovation too new to have the problems worked out as yet.

Problems of Hospital Administration

According to hearsay, in some CMHC's in California, a patient-client may be admitted, have his history taken, be examined, diagnosed, and have a treatment prescribed, the discharge conference may be conducted, and a follow-up plan of management of the patient undertaken without the patient-client ever seeing a licensed or certified person on the staff of the center, whether that person be the director of the center, or a leader assigned to direct a subgroup of patients (Bourne, 1974; DuMae, 1974).

The hospital's position on this management, and critiques and suggestions, are presented below.

hospital's position

1. The case load is too high.

2. Funding is insufficient.

3. Full time is committed to psychiatric administration:

a. to promote good will in the community, and

b. in the interest of economy, psychiatrists are competing to establish or continue their programs that may not fulfill psychiatric standards.

CRITIQUES AND SUGGESTIONS

More certified professional assistants (PA's) should be employed, authorized to establish a diagnosis.

Centers should be fully funded.

This applies only to very large centers.

Schedule luncheon and/or evening meetings.

It is false economy to institute substandard programs.

If under the circumstances of the management defended above, a patient should sustain substantial damages, e.g., loss of his estate through having been prevented the opportunity to adequately supervise and manage it, this would be *prima facie* malpractice.

The Professional Assistant

Community mental-health centers and other mental-health facilities are

increasingly using the professional assistant (PA). Training large numbers of PA's holds advantages, such as being able to treat more of the mentally ill (often in their homes, with their families), earlier case finding, and often at lower cost (Bourne, 1974; Karno, 1974; Lipowski, 1974; Morrison, 1973; Rogawski, 1974).

However, the laws regarding the PA are sketchy (Burton, 1972). The physician is the only person on the team who can sign a prescription. When a PA brings a prescription for him to sign, he has been known to sign without knowing about, or inquiring into, the patient's condition. Certified clinical psychologists in some states are authorized to make a diagnosis, yet they may leave this to a subordinate. Many PA's, both certified and uncertified,[8] oftentimes are uncertain as to what their respective duties and responsibilities are. Clinicians in charge of a clinic or a group of patients within the clinic, often assign work to their subordinates without having assessed what their particular talents, reliability and practical abilities are. These clinicians are highly vulnerable to malpractice claims if substantial damage to a patient or client accrues therefrom. For example, not infrequently the person carrying legal sanction to diagnose does not do so through inadvertence or refusal to "label" anyone. Upon discharge, however, the laws almost universally require an *official* diagnosis. To comply with the law, the clerk in the chart room, who sometimes has been known to graduate from school without the ability to read or write more than simple words,

"chooses" a diagnosis without asking anyone. Obviously such a claim would be *prima facie* malpractice. There are dozens of subtle applications of this principle. Don't underestimate the ability of attorney(s), jury, and/or judge to bring these out—under oath.[9]

The AMA code has been adopted by the APA (Branch, 1973).

In the above situation the prima facie malpractice rests on the legal principle *respondeat superior* (the superior is responsible for the negligence of his subordinates). Simonaitim (1974) wrote reassuringly to surgeons that the judiciary understood the complexity of surgery, that a surgeon could not reasonably be expected to supervise, e.g., the anesthesiologist, and so the surgeon is no longer held responsible—unless he *chose* his *surgical team negligently.* The psychiatrist or any PA in charge of a treatment team, let alone a chart room clerk, is *not* so taken up with infinite details (as is a surgeon performing an operation) and most likely the judge would rule *respondeat superior* applicable. To the best of my knowledge the way to remain on a sound legal and ethical basis is to: (1) recruit capable employees; (2) observe good business methods governing tables of organization as to lines of authority *and* responsibility, including definition of terms and job analysis (duties *expected* and job *limitations* [Leake, 1971; Bartemeier, 1970]). These rules should be followed with constant vigilance to prevent the inevitable relaxation that customarily follows any reorganization period (Dillon, 1973;

Frey, 1971; Hume, 1965; Hume, 1966; Selig, 1973; Steadman, 1973).

Finally, in-service training should include areas usually overlooked, e.g., laws, medical ethics, and the value of carrying individual malpractice liability insurance.[10] As to preventive measures, see Part A, p. 909.

Administrative Law

Some practices which may hold risk have become established as standard practice in community mental-health programs subsidized by local, state, or federal governments. The enabling legislation limits itself to defining services that are to be provided and the appropriation of public funds to pay for these services.

Enabling legislation, e.g., The National Mental Health Act of ig63 and The California Mental Health Act, spell out provisions for *establishing* mental-health programs. However, these acts do not spell out (1) a definition of terms, e.g., "psychiatrist," "psychologist," or "nurse"; (2) job qualifications; (3) job analyses; or (4) how to practice community psychiatry, counseling, etc.

In order to translate such enabling legislation into practice it is necessary to adopt, promulgate, and publish official guidelines. In California the guidelines are developed and then public hearings are held. The guidelines are finally adopted as part of the administrative code, which is a

part of the Statutory Laws of California. This concept of administrative law gives a form of legal sanction to practices in the field of psychiatry which are not necessarily consonant with traditional medical ethics or standards of practice of medicine. Thus what may be administratively sound may be malpractice. It is my opinion that once a practice is established on the basis of enabling legislation promoting mental-health programs, there results a set of precedents which, if unchallenged, become "established standard practice" in the community for CMHC's, while traditional standards still hold for PP's. Consider the PP who works mornings in a CMPIC and sees private patients in his own office afternoons. He well may be practicing a double standard, often supplying a lower level of care for the (usually) economically disadvantaged patient attending the clinic and applying a higher standard for the middle and upper class patient paying a full fee. If this be true, then would he be engaged in malpractice in the morning? Would it not be better for psychiatry to clarify these issues before they may be adjudicated in the courts? This is a dilemma of substantial proportion for the ethical psychiatrist.

Concluding Remarks

The author agrees with Talkington that (1973; 1973):

1. Our shortcomings notwithstanding, psychiatry in the United States has attained eminence and some world-wide recognition.

2. The belief prevalent today that “most anyone can do psychotherapy” is false, and that high quality psychiatric treatment requires years of vigorous training (Karno, 1974; Morrison, 1973).

3. Erosion of high quality clinical psychiatry already has lowered the quality of psychiatric efforts and shows no promise of subsiding in the foreseeable future;

4. Nevertheless psychiatry holds by far the best means of:

   a. Selection of the mentally stalwart;

   b. prevention of mental illnesses;

   c. evaluation of all aspects of each person including external forces, such as culture, environment, family constellation, and the like; and

   d. therefrom to formulate psychiatric and medical treatment plans best suited for each individual among the physically and mentally ill.

5. And that it is time that psychiatrists unite in concerted efforts to hold for psychiatry the position of eminence that we have won during the present century.

Malpractice suits are steadily on the increase in this country. High ethical standards are a good protection for the psychiatrist or physician, but he should carry insurance because patients have become more prone to sue for malpractice.

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Notes

1 I express my deep appreciation to C. Delos Puty, Dean of the School of Law, University of San Francisco, for allowing me to use the Kendrick Law Library for more than two decades.

2 See reference 31 of Part A of this chapter.

3 A patient is not a "consumer," as in the consumer-product relationship. The professional "provider" of a "service" does so to a "recipient," or "benefactor."

4 Bransburg v. Hayes, 92 S.C. Rep. 2646 (1972).

5 Another good source of early case reporting is "Citation," prepared by the Office of The General Counsel of the American Medical Association (1972).

6 W. Hoffer "What Price Is Right for Human Life," *PRISM* (published under the direction of the Board of

Trustees of The American Medical Association, August 1974.

7 Thus the private practitioners in psychiatry are totally disenfranchised, perhaps because psychiatrists seem to be increasingly under suspicion. Bazelon (1974) examines the issues; Szasz (1974) (leading the Anti-Mental-Health Movement) and anti-intellectuals (Sanville, 1974) also have been heard on this issue.

8 We should press for legislation to make PA training standards such that every graduate cannot practice until lie has been granted certification.

9 Consider the Nork Case, "Why the Lawyers Caught Nork and the Doctors Didn't" (Sheridan, 1974; Branch, 1973; Office of the General Council, 1972; Paxton, 1974; Paxton, 1974). The malpractice award totaled $3,710,447 of which 2 million dollars was punitive damages. Perhaps better peer review might have prevented this malpractice. Section 4 of the AMA Principles of Medical Ethics states:

> The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

10 Insurance varies with age, type of practice, size and age of family, and size of estate to be protected. For those of high risk, e.g., EST administrators, some professional risk underwriters offer a million dollar umbrella provided the basic coverage is $300,000/-$600,000 and there is no prior malpractice claim.