Editorial

Will Psychotherapy Be Transformed in the 1980s?

by Barry R. Furrow, J.D.

The attractions of psychiatric mishaps are similar for the journalist and the lawyer — the perverse magnetism of sex and violence. A therapist engages in sex with his female patient; he fails to prevent a patient's suicide; or he releases a patient who then kills a third person. These are the themes of popular journalism, and of current highly publicized litigation involving psychotherapists. In this issue of *Law, Medicine & Health Care*, two articles look at the liability of the therapist. Michael D. Roth and Laurie J. Levin in *Dilemma of* Tarasoff: *Must Physiciains Protect the Public or Their Patients?* offer a careful look at the potential liability of the therapist, concerning the duty to warn others of a patient's threats, in light of the leading cases. The authors outline the parameters of the law, fuzzy as its current boundaries may be, in a useful attempt to offer the psychotherapist guidance through the minefield of tort liability. Sheila Taub, in a broader look at the subject, searches for threads which might link and rationalize the caselaw in these "hot" areas, particularly with regard to abuse of the therapeutic relationship.

Therapists are anxious about being sued; as one commentator recently wrote, the therapist risks ending up with a mind "cluttered with the trauma of litigation."[1] Indeed, the risk of being sued is high for the therapist who treats potentially violent patients or who has sex with a patient. In general, however, the risks of being sued for harm resulting from verbal psychotherapy are quite low. Suits are rarely brought, in part because the prodigious problems proving causation and damages make them unattractive to lawyers. The provider using verbal therapy continues to have the upper hand in the vast majority of malpractice situations.[2] Excessive professional anxiety about malpractice suits is not grounded in an accurate perception of legal reality. Roth/Levin and Taub clearly trace the risks of liability in the dramatic cases. But what about the role of tort suits in the great run of cases in which a patient deteriorates during the course of treatment, or experiences no benefit whatsoever, at substantial expense? Despite a variety of suggestions for legal reform, there is little settled case law.[3] One wonders whether more litigation in less dramatic areas of therapy might not serve a useful purpose in spurring some consolidation of the hundreds of treatment approaches, from Primal Scream therapy to traditional long-term psychoanalysis.

The outside observer (or government regulator) concerned with costs and quality of care would like to see a legal environment in which psychotherapists can steer a course between the Scylla of rigid defensive postures and the Charybdis of iatrogenic harms to patients. Malpractice is one force affecting current therapeutic practice, as Taub and Roth/Levin so clearly perceive. Other forces unrelated to tort suits are also at work, and they are more likely to transform the practice of psychotherapy. Three forces are currently at work: research into the underlying operation of mental illness and related studies into the efficacy of various treatment approaches; expanded third-party financing of therapies; and increasing practice of psychotherapy within corporate medicine. These forces deserve extended discussion and study because they will have a dramatic effect on the way therapy is practiced, and on the potential liability of the therapist.

Research on the organic bases of psychological illness and pharmacological treatment is accelerating.[4] A better understanding of the etiologies of mental illness offers the promise of more precise pharmacological handling, either alone or in combination with traditional psychotherapy. Simultaneously, efficacy studies suggest a need for research into the mechanisms of psychotherapy. A psychotherapist who continues to use a particular treatment mode, in the face of evidence of greater efficacy of other approaches, may be liable for his patient's deterioration or failure to improve. A recent commentator has written that "it behooves advocates of psychotherapy, whenever possible, to define with precision the active ingredients of psychotherapy, the conditions for their optimal administration, the minimum required training for the psychotherapist, the specific target symptoms for which therapy is indicated, and the groups of patients for whom psychotherapy is contraindicated."[5] Psychotherapy is under fire, and the ultimate consequence of research may be to put at risk the therapist who does not keep up with current findings.

Third-party reimbursement practices, research into psychological illness and treatment, and the increased presence of corporate medicine will eventually change the practice of medicine, and, indirectly, the shape of potential liability.

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41. N.Y. PUB. HEALTH LAW §230(11)(d) (McKinney Supp. 1982-1983).

42. N.Y. PUB. HEALTH LAW §230(11)(d)(i) (McKinney Supp. 1982-1983).

43. N.Y. PUB. HEALTH LAW §230(11)(d)(ii) (McKinney Supp. 1982-1983). A literal interpretation of this section suggests that the chairpersons of these committees have the responsibility of reporting this information to the Board, as they would fall into the category of those required to report under N.Y. PUB. LAW §230(11)(a) (McKinney Supp. 1982-1983). *See supra* note 37 and accompanying discussion.

44. N.Y. PUB. LAW §230(11)(d)(iii) (McKinney Supp. 1982-1983).

45. N.Y. PUB. LAW §230(11)(e) (McKinney Supp. 1982-1983).

46. At common law, a physician could be compelled to disclose information acquired while treating a patient. However, N.Y. CIV. PRAC. LAW §4504 (McKinney 1963) provides for a statutory privilege of nondisclosure, whereby medical information obtained by a physician in the course of, and necessary for, the treatment of a patient could not be disclosed without the patient's consent. There are additional statutory provisions which protect disclosure under these circumstances. They are closely related to N.Y. CIV. PRAC. LAW §4504 (McKinney 1963) and are cross-referenced to that rule. N.Y. PUB. HEALTH LAW §230(9) (McKinney Supp. 1982-1983); N.Y. EDUC. LAW §6527(3) (McKinney 1972).

47. The demonstration project (and the accompanying exemption) was in effect from April 1, 1980, until March 31, 1983. Because of the legislative emphasis on the importance of documenting the project's effectiveness, Section 230(ii)(g) provides for the submission of a written report to the Commission of the Department of Health and to the Director of the Division of Alcohol Abuse of the Department of Mental Hygiene. For a thorough discussion of the mechanics involved in the three-year demonstration project, see Nagy, B.R., *Help for the Impaired Physician*, NEW YORK STATE JOURNAL OF MEDICINE 81(10): 1531 (September 1981).

48. 1980 N.Y. LAWS, c. 343, §1.

49. N.Y. PUB. HEALTH LAW §2803-e (McKinney Supp. 1982-1983).

50. N.Y. PUB. HEALTH LAW §2803-e(3)(b) (McKinney Supp. 1982-1983). It should be remembered that hospital administrators who know of professional misconduct on the part of a physician must also report to the Board pursuant to Section 230(11)(1) of the Public Health Law.

51. Telephone interview with a Senior Medical Conduct Investigator, New York State Office of Professional Medical Conduct, Department of Health, Albany, New York (May 29, 1983).

52. The Office of Professional Medical Conduct must prove a "pattern" of poor medical practice in order to take strong disciplinary action. *Id.*

53. *See* Comment, *The Impaired Physician: An Old Problem Creates the Need for New Legislation*, ST. LOUIS UNIVERSITY LAW JOURNAL 26:727 (1982).

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Third-party reimbursement practices provide a second force converging on psychotherapists. The desire for reimbursement has led to an understandable clamor by subgroups — for example, psychologists and family therapists — as they demand recognition as independent providers. If such therapists are recognized, they are likely to be held to the higher standard of practice of the psychiatrist (whose reimbursement status they would have achieved). The possibility of obtaining third-party reimbursement and government funding places pressure on the profession to prove the efficacy of various treatments. The apparently "efficient" somatic modes of treatment, such as ECT and drugs, may eventually burden the talking therapies with justification of cost differentials. This will be a mixed blessing, if it happens. It may be that verbal therapies are ineffective or even harmful to some patients; it may also be that excessive reliance upon technological medicine produces pernicious side effects.

The third party payor's listing of approved billable treatments may prove to be a mixed blessing in other contexts, as it may be submitted as evidence in a malpractice action. If a defendant's treatment is listed, the list may present evidence of the propriety of that treatment. However, such a list may deny an evidentiary shield to the defendent who uses an effective but unlisted approach. Third-party reimbursement promises a complex and bewildering array of problems for practice, malpractice issues, and the status of practitioners in general.

A third transforming force is the expansion of private corporations into medical practice, what Paul Starr has referred to as "the coming of the corporation."[6] Large hospital management companies are moving into behavioral medicine, buying psychiatric hospitals, drug treatment facilities, and alcohol rehabilitation centers. Private corporate control of treatment for the mentally ill is likely to triple by the end of the 1980s.[7] Pressure toward short-term treatment may result; more therapists may work in group settings, rather than enter solo practice. This transition to practice in a corporate setting has significant malpractice implications. If the hospital will face liability for the acts of its agents, then it will tighten the controls over the therapist's practice. As Starr writes, "Under corporate management, there is also likely to be close scrutiny of mistakes, if only because of corporate liability for malpractice."[8] Patients may be more willing to sue once the doctor-patient relationship becomes imbedded in a corporate setting.

Tort law is only one of the many forces which affect the practice of medicine, and more particularly, psychotherapy. These other forces will eventually change therapeutic practices and settings, as well as, indirectly, the shape of potential liability. One can therefore expect some convergence of the splintering tendencies present in contemporary psychotherapy, and this may well be a change for the better.

References

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2. Watkins, Watkins, *Malpractice in Clinical Social Work: A Perspective on Civil Liability in the 1980's*, BEHAVIORAL SCIENCES & THE LAW 1: 55, 69 (1983).

3. *See, e.g.*, Feldman, Ward, *Psychotherapeutic Injury: Reshaping the Implied Contract as an Alternative to Malpractice*, NORTH CAROLINA LAW REVIEW 58: 63 (1979); Furrow, B., *Defective Mental Treatment: A Proposal for the Application of Strict Liability to Psychiatric Services*, BOSTON UNIVERSITY LAW REVIEW 58: 291 (1978).

4. *See, e.g.*, PSYCHOTHERAPY RESEARCH: METHODOLOGICAL AND EFFICACY ISSUES (American Psychiatric Association, Washington, D.C.) (1982).

5. Heinrichs, Carpenter, *The Psychotherapy of the Schizophrenic Disorders*, in PSYCHIATRY 1982 ANNUAL REVIEW (L. Grinspoon, ed.) (APA, Washington, D.C.) (American Psychiatric Press, Washington, D.C.) (1982) at 16.

6. P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (Basic Books, Inc., New York) (1982) at 420.

7. *A New Market for Hospital Chains*, Business Week, April 11, 1983, at 124a.

8. STARR, *supra* note 6, at 447.

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