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Medical Malpractice: The Liability of Psychiatrists

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MEDICAL MALPRACTICE: THE LIABILITY OF PSYCHIATRISTS

Introduction

The physician is in a unique position in our society. In a recent study physicians ranked second in occupational prestige, outranked only by United States Supreme Court Justices.[1] The dedicated, long-suffering physician is, perhaps, the most popular character in television programming today. At the same time, medical malpractice suits are on the rise.[2] One insurance company has estimated that there was a 400% increase in such suits from 1955 to 1966; another insurance company has estimated a 43% increase in suits between 1965 and 1970 with a 200% increase in costs per claim.[3]

This dramatic rise in malpractice litigation has been attributed to the growing impersonality of the doctor-patient relationship,[4] the lack of qualified physicians,[5] improper criticism by a physician of another physician's "work," and the unrealistic portrayal of physicians on television.[6] Whatever the explanation this rise in malpractice litigation reflects a shift in philosophy of both the courts and the public from an approach which places the financial burden of injury on the injured to a loss-spreading approach in which the injured no longer has to bear the full burden of his injury,[7] the loss being absorbed by malpractice insurance the cost of which is spread onto the entire patient population by higher doctors' fees.[8]

This shift in philosophy is best exemplified by the changing attitudes of the courts toward the liability of physicians for negligence. Courts have shifted from an approach favoring the physician to one allowing the injured plaintiff to be compensated by eliminating or modifying those rules of law which in the past had resulted in an almost complete insulation from liability. For example, courts developed the *locality rule* in order to prevent the rural doctor from being compared to his more sophisticated city based counterpart. The locality rule

1 Hodge, Siegel & Rossi, *Occupational Prestige in the United States: 1925-1963,* in CLASS, STATUS, AND POWER 324 (R. Bendix and S. Lipset eds. 1966).

2 Estimates of the rise of malpractice suits are elusive because there is no central data collection agency for such statistics. Brooke, *Medical Malpractice: A Socio-Economic Problem from a Doctor's View,* 6 WILLAMETTE L.J. 225, 227 (1970).

3 *Id.*

4 Mechanic, *Problems in the Future Organization of Medical Practice,* 35 LAW & CONTEMP. PROB. 233, 249 (1970); Note, *Restructuring Informed Consent: Legal Therapy For the Doctor-Patient Relationship,* 79 YALE L.J. 1533, 1533-55 (1970).

5 Ribicoff, *Medical Malpractice: The Patient vs. the Physician,* TRIAL, Feb.-Mar. 1970 at 11.

6 Auerbach, *Rx for Malpractice,* 19 CLEV. STATE L. REV. 20, 23-24 (1970).

7 *See,* Tribe, *Towards a New Technological Ethic: The Role of Legal Liability,* 21 IMPACT OF SCIENCE ON SOCIETY 215 (1971).

8 This philosophy is particularly well suited to the medical profession for society views medical care as indispensable.

> We can not say, as we would of a business enterprise, that if the accident costs are too high, the producer will be allowed to suspend production or produce something else.

Brown, *Social Resource Allocation Through Medical Malpractice,* 6 WILLAMETTE L.J. 235, 239 (1970).

At the same time the injured patient is most often truly "innocent"; because of lack of expertise and his emotional state when the need for care arises, he is rarely in a position to evaluate the treatment he is receiving.

requires an injured patient to prove with expert testimony that the physician failed to use the reasonable skill and care which is commonly exercised by a reputable, average physician in the same school of practice in the *same or similar locality*.[9] Today this rule is gradually disappearing.[10] The statute of limitations for malpractice was originally held to run from the time the negligent act was committed;[11] a number of courts have now held that the statute begins to run from the time of discovery of the damage.[12] A more significant change in judicial attitude towards physicians' liability has been the creation by the courts of the physician's *duty to inform* the patient of all material collateral risks involved in a recommended procedure. The doctrine of informed consent, which developed from battery cases in which no consent was given for treatment, is based on the theory that consent to treatment requires an understanding of the recommended procedure and its consequences.[13]

As may be noted from this brief review of judicial and social trends, physicians have become increasingly accountable for their acts. However, this accountability has not been extended to all medical specialties. Of particular interest for purposes of this Note is the fact that psychiatrists are rarely sued for malpractice.[14] Few cases directly deal with negligently administered psychotherapy.[15] This is particularly surprising since mental illness is one of the most widespread afflictions today.[16]

The purpose of this Note is to examine the nature of psychiatric practice

9 *E.g.*, Adkins v. Ropp, 105 Ind. App. 331, 14 N.E.2d 727 (1938); Nelson v. Nicollet Clinic, 201 Minn. 505, 276 N.W. 801 (1937); Teft v. Wilcox, 6 Kan. 46 (1870). Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 730 (1970).

10 *E.g.*, Blair v. Eblen, 461 S.W.2d 370 (Ky. 1970); Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968); Hundley v. Martinez, — W.Va. —, 158 S.E.2d 159 (1967).

11 *E.g.*, Albert v. Sherman, 167 Tenn. 133, 67 S.W.2d 140 (1934); Cappuci v. Barone, 266 Mass. 578, 165 N.E. 653 (1919).

12 *E.g.*, Frohs v. Green, 253 Ore. 1, 452 P.2d 564 (1969); Morgan v. Grace Hospital, 149 W. Va. 783, 144 S.E.2d 156 (1965). *See also*, ILL. ANN. STAT. ch. 83 § 22.1 (1966).

13 Fraser and Chadsey, *Informed Consent in Malpractice Cases*, 6 WILLAMETTE L.J. 183, 184 (1970).

Today, in many states the duty to inform requires the following:

> [W]here circumstances permit, the patient should be told (1) the diagnosis, (2) the general nature of the contemplated procedure, (3) the risks involved, (4) the prospects of success, (5) the prognosis if the procedure is not performed, and (6) alternative methods of treatment, if any.

2 D. Louisell and H. Williams, Medical Malpractice § 22.01 (1969). *See also*, Cooper v. Roberts 220 Pa. Super. 260, 286 A.2d 647 (1971); Di Rosse v. Wein 24 App. Div.2d 510, 261 N.Y.S.2d 623 (1965); Nathanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960).

14 The American Psychiatric Association estimates that only 400 suits were filed against psychiatrists between 1965 and 1968. B. FICARRA, SURGICAL AND ALLIED MALPRACTICE 509 (1968). These suits most likely involved actions for breach of the duty to inform, improper commitment, improperly administered electroshock or insulin therapy, and lack of proper patient supervision. *See* Dawidoff, *The Malpractice of Psychiatrists*, 1966 DUKE L.J. 696 (1966).

15 Psychotherapy, which will be discussed more fully below, refers to methods of treatment designed to produce changes in behavior through *verbal* and *symbolic* techniques within the context of a professional relationship between the psychiatrist and his patient. Psychotherapy is distinguished from *somatic therapy*, i.e., organic and biological therapies, which involve chemical, hormonal, and physical measures which affect the brain and, therefore, produce or inhibit behavior change. F. REDLICH & D. FREEDMAN, THE THEORY AND PRACTICE OF PSYCHIATRY 271-72 (1966).

16 While statistics on outpatient care for mental illness are unreliable, statistics on patients hospitalized for mental illness are available. On any day in 1966 over 525,000 patients resided in mental hospitals. In that year approximately 800,000 different individuals spent some time in mental institutions. R. STUART, TRICK OR TREATMENT 21 (1970).

and theory within the context of the contractual treatment relationship,[17] and to determine why in this age of the medical malpractice suit psychiatry has remained above the furor, and whether it would, in fact, be possible to establish malpractice in a psychotherapeutic setting. It is believed that an understanding of this problem will offer insight into medical malpractice theory in general.

I. The Nature of Medical Malpractice

The term "malpractice" denotes negligent misdeed and does not apply only to physicians. In the medical setting it refers to "an act or failure to act of a physician which is considered negligent according to the standard of medical procedure prevailing . . . and which results in injury to the patient."[18] The law generally permits the medical profession to establish its own standard of care; the physician can usually escape liability by showing conformity to accepted community practice.[19] Conversely, an injured patient must prove through expert testimony, in all but the extraordinary case,[20] that the physician failed to exercise the degree of care required of him.[21] In essence, then, some discernible standard of care is necessary to establish that a negligent act has been committed. Negligence in the case of medical malpractice means failure to act in a predetermined way. As a result, the effective malpractice action involves one of a recurring set of fact patterns[22] involving only narrow questions of medical judgment. Since medicine is a constantly changing science, certain areas of medicine exist in which a standard of care is impossible to determine. Courts have recognized this phenomenon, holding that a physician is not liable for a mistake of judgment when a matter is more or less unsettled or where physicians could reasonably differ.[23]

In addition to establishing a deviation from an established standard of care, an injured patient must show a causal connection between the negligent act and the injury[24] as well as the existence of a discernible harm.[25] While these three elements (standard of care, causal connection and harm) are easily established

17 See T. SZASZ, THE MANUFACTURE OF MADNESS at xxiii-xxvii (1970) for a discussion of the distinction between Institutional Psychiatry (i.e., involuntary treatment) and Contractual Psychiatry (i.e., voluntary treatment).

18 Morse, *The Tort Liability of the Psychiatrist,* 19 BAYLOR L. REV. 208 (1967).

19 *E.g.,* Toth v. Community Hosp., 22 NY.2d 255, 292 N.Y.S.2d 440, 239 N.E.2d 368 (1968).

20 See *e.g.,* Hammer v. Rosen 7 N.Y.2d 376, 198 N.Y.S.2d 65, 165 N.E.2d 756 (1960); Meiselman v. Crown Heights Hosp., 285 N.Y. 389, 34 N.E.2d 367 (1941).

21 *Id.*

22 The six most common reasons for suits are:

1. foreign objects left in the body during surgery
2. casts which are applied too tightly
3. technical surgical errors
4. failure to disclose sufficient information for informed consent
5. efforts of the hospital staff
6. adverse drug reactions

Morris, *Response to Ribicoff: Malpractice Suits vs. Patient Care,* 37 INS. COUN. J. 206, 218 (1970).

23 B. FICARRA, *supra* note 14, at 45-46; *see e.g.,* Hackworth v. Hart, 474 S.W.2d 377 (Ky. 1971); Loudon v. Scott, 58 Mont. 645, 194 P. 488 (1920).

24 *E.g.,* Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962); Mezullo v. Maletz, 331 Mass. 233, 118 N.E.2d 356 (1954).

25 Brooke, *supra* note 2.

by the plaintiff in an "ordinary" malpractice suit, they pose great difficulty for a plaintiff who does not have an "ordinary" illness. As will be seen below mental illness is an "extraordinary" illness which is not fully understood by the public or the professionals who attempt to treat it. Psychiatry, although approximately a hundred years old, has few, if any, universally accepted principles. Psychiatrists are encouraged to innovate and develop their own theories of, and therapies for, mental illness.[26]

II. The Nature of Mental Illness

A. *Diagnosis*

In order to understand psychotherapy and to ascertain whether there are discernible standards of care for psychotherapy it is necessary to understand what psychiatrists as physicians are supposed to treat.

According to most medical historians, the concept of mental illness evolved in Europe at a time when belief in witchcraft was disappearing. Witchcraft has been used to explain the behavior of individuals in society, whose noncriminal conduct deviated substantially from the societal norms.[27] In the Middle Ages witchcraft or madness was seen as evil, and people so "possessed" were believed to have chosen to lead evil lives.[28] The effect of substituting the concept of "mental illness" for witchcraft as the explanation for deviant behavior was to eliminate the need to punish such deviants.[29] Another effect was to place responsibility for their care and "rehabilitation" in the hands of the medical profession. As a result, mental illness has been viewed historically as merely a variant of organic disease, the root of disease being a "malfunction" in the mind.[30]

While many biological,[31] psychological,[32] and cultural[33] variables have been found to be correlated with the presence of mental disturbance, the causes of mental illness remain undiscovered. Psychiatrists treat individuals whose behavior ranges from mildly neurotic to severely psychotic, as in the case of schizophrenia. There are at least four different ideological orientations among mental health professionals toward mental illness: 1. the psychotherapeutic view;[34]

26 *See* R. HARPER, PSYCHOANALYSIS AND PSYCHOTHERAPY (1959) which discusses *thirty-six* basic systems of therapy upon which therapists are encouraged to build and modify.

27 [I]llness, as in "mental illness," was an illicit transformation of a metaphorical to a literal concept. To save unfortunate people from being labeled witches, it was useful to regard persons who exhibited misconduct of certain kinds as if they were ill.
Sarbin, *The Scientific Status of the Mental Illness Metaphor, in* CHANGING PERSPECTIVES IN MENTAL ILLNESS 15 (S. Plog & R. Edgerton eds. 1969).

28 *Id.* at 12.

29 *Id.* at 12-13.

30 London, *Morals and Mental Health,* in CHANGING PERSPECTIVES IN MENTAL ILLNESS 43-44 (S. Plog & R. Edgerton eds. 1969).

31 F. REDLICH & D. FREEDMAN, *supra* note 15, at 306-46, 403-95.

32 *Id.* at 121-54, 272-305.

33 CHANGING PERSPECTIVES IN MENTAL ILLNESS 73-479 (S. Plog & R. Edgerton eds. 1969).

34 The psychotherapeutic orientation towards mental illness is the most prevalent:
[It is] based upon the assumption that the observed problems are surface manifestations of underlying personality problems. Treatment would, in most instances, be oriented toward eliminating the pathogenic personality conditions or at least toward strengthening the defenses of the healthy portion of the personality against the

2. the somatotherapeutic view;[35] 3. the sociotherapeutic view;[36] 4. the behavior modification view.[37] Adherents to these orientations disagree over the causes of mental illness, the nature of the therapeutic process, and the appropriateness of different therapeutic procedures for different diagnostic groups.[38]

Despite the prevalence of mental illness, its cause remains a mystery. This fact tends to support the proposition that a standard of care for malpractice in psychotherapy is nonexistent. However, this indicator alone is not sufficient since there are many illnesses for which reliable diagnostic procedures and treatments exist even though the causes of the illness remain undetermined.[39]

Another indicator of the existence of a standard of care is the availability of generally accepted and reliable diagnostic procedures. Before an individual can be treated, it must be determined whether, in fact, he has an "illness" to

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destructive forces of the unhealthy elements.

. . .

> At the basis of the theories of psychotherapists . . . lies the so-called "medical model." This model assumes that an apparent problem of human behavior is a symptom of an underlying pathogenic condition in much the same way that elevations of fever or white corpuscle count are manifestations of infection in the body. . . . [I]t is assumed that unless the pathogen is removed, a greater number of possibly more severe symptomatic problems will result.

R. STUART, *supra* note 16, at 6-7.

35 The *somatotherapeutic* orientation is based on the assumption that certain forms of aberrant behavior are actually caused by organic malfunctions. This view is most commonly held by those who deal with schizophrenia although it is not the predominant view. Those who hold this view advocate chemical and physiological treatment strategies. Rabkin, *Opinions About Mental Illness,* 77 PSYCHOLOGICAL BULLETIN 153, 161 (1972); F. REDLICH & D. FREEDMAN, *supra* note 15, at 486-97; Rimland, *Psychogenesis versus Biogenesis: The Issues and the Evidence,* in CHANGING PERSPECTIVES IN MENTAL ILLNESS 702 (S. Plog & R. Edgerton eds. 1969).

36 The *sociotherapeutic* orientation is in many ways a reaction to the vagueness and failures of the *psychotherapeutic* orientation. Advocates question the appropriateness of a medical model when dealing with the problem of "improper" behavior. They argue that a person with a behavioral "defect" is not ill; since use of the term "mental illness" encourages the search for internal malfunctions which are, essentially, undiscoverable, the term is rejected in favor of terms such as "problems in living." Strengthened by research which shows that the nature and incidence of mental illness vary by social class, ethnic group, marital status and other demographic variables, they advocate a psychosociological model which looks at the social setting in which a person operates and has operated:

> The sociotherapeutic position is largely concerned with the network of people, places, and things constituting the ecology in which patients live; its adherents devote their therapeutic efforts to family and environment rather than the inner mental mechanisms analyzed by advocates of the psychotherapeutic position.

Rabkin, *supra* note 35, at 161; Almond & Astrachan, *Social System Training for Psychiatric Residents,* 32 PSYCHIATRY 277 (1969).

37 The *behavior modification* orientation is also an outgrowth of the failure of the psychotherapeutic orientation. It questions the use of the medical model:

> The explicit attitude or mental habit of viewing behavioral deviations as symptoms of some inner pathogenic element, which must be identified through accurate diagnosis in order to know how to treat it, reflects an assumption that organic disease and psychological disorder are structurally and etiologically isomorphic. Such an assumption is neither theoretically nor experimentally defensible.

Turner & Cummings, *Theoretical Malaise and Community Mental Health,* in EMERGENT APPROACHES TO MENTAL HEALTH PROBLEMS 43 (E. Cowen, E. Gardner, & M. Zax eds. 1967). Rather than searching for and asking the causes of problematic behavior, advocates of behavior modification seek to extinguish the behavior itself, through use of negative and positive reinforcement.

38 Rabkin, *supra* note 35, at 161.

39 For example, while the causes of cancer remain unknown, there are established diagnostic procedures in existence for detecting the presence of cancer. Once diagnosed, there are some well-established methods of treatment. *See* Ficarra, *supra* note 14, at 275, 404, 769.

treat. Diagnosis should also determine the nature of the treatment to be administered. Misdiagnosis or failure to diagnose is not a frequent basis for a malpractice action,[40] although several cases have predicated liability on such grounds.[41] Nevertheless, diagnosis is regarded as part of the treatment,[42] and therefore physicians are under a continuing duty throughout the period of care to use reasonable skill and care to arrive at a proper diagnosis.[43] The physician does not guarantee the exactness of his diagnosis. However, to prove malpractice for misdiagnosis the patient must show not only that the diagnosis was mistaken but also that it was arrived at negligently.[44] Mistake of judgment will be a defense if the physician can show:

1. the existence of reasonable doubt as to the nature of the condition involved; or
2. a split of medical authority as to the diagnostic procedure to be followed, and one of the conflicting procedures was, in fact, used; or
3. the diagnosis was made after a conscientious effort by the physician to inform himself about the patient's condition.[45]

Courts have granted leeway in cases involving misdiagnosis since diagnosis is, by its nature, inexact, and because the reliability of a diagnosis is dependent, in part, upon the adequacy of the communications made by the patient to the examining physician.[46] Therefore, for a patient to recover for misdiagnosis he must show an unreasonable departure by the physician from accepted procedure. If the patient has an illness for which there are no reliable diagnostic techniques, he cannot recover even though he may have spent considerable amounts of time and money for the treatment of an illness which he does not, in fact, have.

Actions for misdiagnosis in psychiatry usually arise when there has been an improper commitment to a mental hospital[47] or improper supervision of a patient while hospitalized.[48] It is difficult to generalize from these cases to cases involving misdiagnosis in a voluntary doctor-patient context. Most courts have held that an examining and committing psychiatrist is under no duty of care to the patient because he is acting as an agent of the state[49] or because the judge who com-

40 *See* note 22 *supra.*

41 *E.g.,* Ries v. Reinard, 47 Cal. App. 2d 116, 117 P.2d 386 (1941); Welch v. Frisbee Memorial Hospital 90 N.H. 337, 9 A.2d 761 (1939).

42 *Id.*

43 The physician is under a duty to use the following procedures:

> [He must] take an adequate history and make necessary examinations, laboratory tests and special studies, and . . . employ diagnostic instruments which the average physician of the same class . . . acting under similar circumstances and in the light of present scientific knowledge, would use to arrive at a proper diagnosis.

Ficarra, *supra* note 14, at 29.

44 *Id.*

45 Note, *An Evaluation of Changes in the Medical Standard of Care,* 23 VAND. L. REV. 729, 749 (1970).

46 *Id.* at 748.

47 *E.g.,* Rhiver v. Reitman, 24 Ind. Dec. 155, 265 N.E.2d 245 (1970); Schanbarger v. Kellog, 35 App. Div.2d 902, 315 N.Y.S.2d 1013 (1970); Gregoire v. Biddle, 177 F.2d 579 (2d Cir. 1949), *cert. denied,* 339 U.S. 949 (1950).

48 *E.g.,* Wright v. State, 300 N.Y.S.2d 153 31 App. Div. 2d 421, (1969); White v. United States, 317 F.2d 13 (4th Cir. 1963).

49 *E.g.,* Mezullo v. Maletz, 331 Mass. 233, 118 N.E.2d 356 (1954); Dunbar v. Greenlaw, 152 Me. 270, 128 A.2d 218 (1956); *but see* Kleber v. Stevens, 39 Misc. 2d 712, 241 N.Y.S.2d 497 (Sup. Ct. 1963), *aff'd,* 20 App. Div. 2d 896, 249 N.Y.S.2d 668 (1964).

mitted the patient, not the examining psychiatrist, is the proximate cause of the commitment.[50] Courts which have immunized the committing psychiatrist from liability for an erroneous commitment have done so because it is "better to leave unredressed the wrongs done by dishonest officers than to subject those who try to do their duty to the constant dread of retaliation."[51]

Improper supervision cases usually arise when there has been a failure by the hospital staff to restrain a suicidal patient.[52] Usually the state, which maintains the mental hospital, is sued rather than the supervising psychiatrist and staff. Here, again, liability is rarely found.[53] One court observed that "[t]he diagnosis of mental cases is not an exact science. As yet the mind cannot be x-rayed like a bone fracture. Diagnosis with absolute precision and certainty is impossible."[54]

Were a patient to sue a psychiatrist for misdiagnosis within the context of a contractual relationship, it is unlikely that the suit would be successful. Since the procedures used to diagnose mental disturbance are currently imprecise and unreliable, misdiagnosis is unlikely to be a result of negligence. The American Psychiatric Association has issued a nomenclature consisting of several hundred categories of adult psychopathology ranging from mild to severe disturbance.[55] These categories are not "natural" categories since they are dependent on a variety of theoretical assumptions.[56] Even among those psychiatrists who agree on these assumptions there is widespread disagreement as to the meaning of these diagnostic categories.[57] The categories name and describe those symptom sets which have been determined to constitute a type of disturbance.[58]

50 Rhiver v. Reitman, 24 Ind. Dec. 155, 265 N.E.2d 245 (1970). On the subject of improper commitment, see Morse, *The Tort Liability of the Psychiatrist,* 19 BAYLOR L. REV. 208 (1967).

51 Gregoire v. Biddle, 177 F.2d 579, 581 (2d Cir. 1949). This hesitation to hold psychiatrists liable for erroneous commitment may be due to the large volume of such cases which are handled. Ficarra, *supra* note 14, at 519-20.

52 *E.g.,* Wright v. State, 31 App. Div. 2d 421, 300 N.Y.S.2d 153 (1969); White v. United States, 317 F.2d 13 (4th Cir. 1963); Morse, *supra* note 50, at 228-40.

53 Morse, *supra* note 50, at 228-40. One case which differs significantly from the majority position is *Wright v. State.* In that case the court rejected the argument that the benefits to be derived from a permissive treatment of a suicidal patient outweighed the duty to restrain a patient bent on self-injury.

54 St. George v. State, 283 App. Div. 245, 248, 127 N.Y.S.2d 147, 150 (1954) *aff'd,* 308 N.Y. 681, 124 N.E.2d 320 (1954).

55 American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (1952).

In the case of *Stone v. Proctor,* 259 N.C. 633, 131 S.E.2d 297 (1963), the court admitted into evidence as proof of negligence the published "Standards of Electroshock Treatment" issued by the American Psychiatric Association.

The Group for the Advancement of Psychiatry has issued a system for classifying disorders found in children. Group for the Advancement of Psychiatry, *Psychopathological Disorders in Childhood: Theoretical Considerations and a Proposed Classification,* 6 Group for the Advancement of Psychiatry. Reports 173 (1966).

56 F. REDLICH & D. FREEDMAN, *supra* note 15, at 246.

The nomenclature published by the American Psychiatric Association is based upon an acceptance of the "psychotherapeutic" approach to mental disorders. It is rejected by those who take a "sociotherapeutic" or "behavior modification" approach. *See,* R. STUART, *supra* note 16, at 65-101.

57 F. REDLICH & D. FREEDMAN, *supra* note 15, at 248.

58 The classification scheme consists of eight major categories and their numerous subcategories. The three most well known major categories are psychotic disorders, psychoneurotic disorders, and personality disorders. The term *psychosis* is reserved for the most severe and disabling disturbances of mental functions, such as schizophrenia. *Neurosis* is used to describe

Diagnosis in a psychiatric setting involves generalizing from observed external behavior to unobserved, hypothetical internal states. For example, a paranoid individual is seen as one who manifests distrust of others (external behavior) and is also fearful and envious (internal state).[59] The difference between psychiatric diagnosis and other medical diagnosis is not to be found in this diagnostic approach[60] but in the reliability and validity of the procedures used to discern the internal "causes" of the external states.

Many studies have been conducted on the reliability of the psychiatric classificatory system.[61] Reliability in diagnosis can be measured in two different ways. The first type of reliability, termed inter-rater reliability, is determined by having more than one judge rate the same patient; the greater the agreement between judges, the higher the inter-rater reliability. The second type of reliability is test-retest reliability in which the same patient is seen repeatedly by the same physician for diagnostic purposes; a classification scheme is reliable for test-retest purposes if the patient's disorder is repeatedly given the same label.[62] Most studies of inter-rater reliability of psychiatric diagnosis indicate that clinicians tend to agree in which "gross" diagnostic category a particular patient should be placed; that is, clinicians will agree that a particular patient is, for example, either psychotic or neurotic. However, there is little agreement when the finer categories are employed.[63] It has also been found that reliability is low when a test-retest procedure is used.[64] In addition, a number of studies have shown that clinicians tend to be unsuccessful and disagree in the prediction

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milder disturbances which impair reality testing. *Personality disorders* refer to observable personality defects which seem to cause only minimal anxiety and distress in the patient. The accuracy and usefulness of the classification have been questioned:

> [T]he validity and usefulness of the concepts of neurosis and psychosis, and their differentiation [have been] questioned. . . . Clearly, severity of the disorder is not a completely satisfactory criterion. Some disorders we label neurosis . . . may be severe, socially disabling, and resistive to treatment. Some schizophrenic reactions, which we call psychosis, may be relatively mild and transient; others may not interfere too seriously with many aspects of everyday living. . . . The best and possibly only differentiating criterion is the fact that in psychosis the higher mental faculties, which permit us to recognize and evaluate the inner and outer world, are more deeply impaired than in neurosis. . . . The sharp boundary between neurosis and psychosis is undoubtedly spurious.

Id. at 252-53.

59 R. STUART, *supra* note 16, at 67; *see* Anderson & Whitman, *Control of Behavior Through Law: Theory and Practice,* 47 NOTRE DAME LAWYER 815, 848-49 (1972).

60 If a physician detects a lump of a certain mass and consistency in a woman's breast, he may conclude that the lump is possibly a malignant tumor. He then has procedures available to him which will enable him to examine the lump itself at close range. While he will not be able to determine the cause of the cancer if the lump is malignant, he will, at least, be able to suggest a therapy. He will also be able to predict the probable outcome of this treatment. He will, in effect, be able to verify his diagnosis with tangible, concrete evidence.

61 *E.g.,* Patrick, Overall, and Tupin, *Multiple Discriminant Analysis of Clinical Diagnostic Groups,* PROCEEDINGS OF THE 76TH ANNUAL CONVENTION OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION, 1968 at 465-466; Krutman, Sainsbury, Morrissey, Towers, and Scrivenet, *The Reliability of Psychiatric Assessment: An Analysis,* 107 J. OF MEDICAL SCIENCE 887 (1961); H. EYSENCK, THE SCIENTIFIC STUDY OF PERSONALITY (1952). Reliability refers to the extent to which a procedure is free from random error.

62 R. STUART, *supra* note 16, at 68.

63 *Id.* at 69. For a critique of the methodology used in studies which have found psychiatric diagnosis to be unreliable, see Beck, *Reliability of Psychiatric Diagnosis: 1. A Critique of Systematic Studies,* 119 AM. J. OF PSYCHIATRY 210 (1962).

64 Arthur and Gunderson, *The Prediction of Diagnosis and Disposition in Naval Hospitals,* 22 J. OF CLINICAL PSYCHOLOGY 259 (1966).

of the future course of mental illness[65] or in the effect of a particular mode of treatment.[66]

This high degree of unreliability of diagnosis inheres in the nature of the psychiatric diagnostic process. A psychiatric diagnosis is the result of a process of clinical judgment[67] which can be verified by concrete evidence only when dealing with behavioral disorders which have a demonstrable physical cause, i.e., "[t]hose [disorders] in which there is a disturbance of mental function resulting from, or precipitated by, a primary impairment of the function of the brain, generally due to diffuse impairment of brain tissue. . . ."[68]

The causes of judgment error can be found in the nature of the judgment situation itself. Such elements as the individual characteristics of both the clinician and the patient, the type of judgment demanded, and the context in which the judgment is made all influence the outcome of a diagnostic session and all can contribute to diagnostic error.[69] Studies have found that different therapists elicit varying responses from the same patient,[70] and that, based on their theoretical orientations and personal inclinations, different therapists will give different interpretations of the same patient behavior.[71] Since clinical judgments are the result of communications between the patient and the clinician, characteristics of the patient also affect the diagnosis. While diagnosis should be based only on observed patient behavior, there is evidence that factors other than patient behavior influence the diagnostic process. One study found that the social class of the patient influences the severity of the diagnosis of mental disorder.[72] Clinicians also tended to classify lower-class patients as more severely disturbed than middle- or upper-class patients when given written descriptions of clients which were identical except for social class.[73]

Psychiatric diagnosis is unreliable because so many extraneous factors enter into the diagnostic process that the possibility of error is quite high. It also has a high degree of invalidity. *Validity* refers to the extent to which a procedure actually measures what it is designed to measure.[74] While valid diagnosis is sup-

65 This inability to predict the future course of illness is particularly significant for the law since the fate of a criminal defendant or of an individual who faces psychiatric commitment is dependent on testimony concerning the nature and future course of the individual's "mental illness." Psychiatrists tend to overestimate the potential for violence as compared to psychologists, social workers, correction officials, and actuarial devices such as prediction or experience tables. Anderson & Whitman, *supra* note 59, at 848-50.

66 *Id.*

67 R. STUART, *supra* note 16, at 69.

68 AMERICAN PSYCHIATRIC ASSOCIATION STANDARD NOMENCLATURE ¶ 1 (1952).

69 R. STUART, *supra* note 16, at 69.

70 *Id.* at 70.

71 *Id.*

72 *Id.* at 73. It has also been found that social class plays a role in determining the type of patient to be given psychotherapy. When therapists have no choice in the selection of patients, as in an outpatient clinic setting, the duration of therapy is shorter for lower-class patients. Kandel, *Status Homophyly, Social Context and Participation in Psychotherapy*, 71 AM. J. OF SOCIOLOGY 640 (1966).

73 R. STUART, *supra* note 16, at 73.

74 *Id.* at 80-90. As a researcher at Mendota State Mental Hospital, Madison, Wisconsin, this author had the opportunity to take part in many diagnostic sessions which were designed to determine whether a particular patient was schizophrenic. The tests used in the diagnosis were supposed to determine the patient's contact with reality, as well as the ability of the patient to concentrate on performing certain mental tasks and the ability of the patient to abstract. Patients were asked, for example, to

posed to be used in determining the therapy to be offered, in reality it is not so used.[75]

As may be noted from this analysis, establishing a standard of care for diagnosis is quite difficult in the psychiatric setting, since it would be difficult to establish that the misdiagnosis is due to negligence rather than the nature of the diagnostic process itself. Physicians' liability is dependent upon the present state of scientific knowledge and on the extent to which this knowledge was used in arriving at a diagnosis and treatment plan.[76] The dangers inherent in the low reliability and validity of a diagnostic process are that an incorrect diagnosis will be made and, in addition, that an incorrect and unproductive treatment plan may be prescribed. The possible injury to a patient is more than monetary. Persons regarded as mentally ill or abnormal are not seen as merely sick; they are viewed as a separate class to be avoided and feared.[77] In addition, they are often regarded as incapable of personal responsibility.[78] The designation has certain legal implications as well. A person who is designated as mentally ill or mentally incompetent can be denied or released from a civil service job,[79] denied control over his property,[80] or if an attorney, can be disbarred.[81]

B. *Treatment*

The scarcity of cases dealing with negligently administered psychiatric therapy has been attributed to the skill of psychiatrists in dealing with negative feelings of their patients and to the reluctance of people to expose their psychiatric history.[82] In addition the vast majority of malpractice actions for mis-

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1. count down from 100 by sevens in two minutes (ability to concentrate);
2. name their governor or assemblyman (contact with reality);
3. interpret a proverb such as "people in glass houses shouldn't throw stones" (ability to abstract).

While many of the patients interviewed were severely disturbed, almost none of the patients could answer these questions. It is, in fact, doubtful whether many "normal" people could perform these tasks. Few people know who their assemblyman is; ability to interpret proverbs is more dependent on one's level of integration into the mass culture rather than on one's presumed level of mental illness. In addition, concentration may be more dependent on situational exigencies, such as number of observers, than on the presumed illness of the patient.

75 When the utility of the present system [of diagnosis] for practical purposes is considered, it might be regarded as self-evident that the clinician would be greatly handicapped by the variability of diagnosis. However, the extent of this handicap is related to the degree to which the psychiatrist depends on the diagnostic label in actual clinical decision-making. . . . Under such circumstances, he might simply regard the clinical diagnosis as an additional bit of information . . . which may support the therapeutic decisions made on the basis of the other factors.

Beck, *Reliability of Psychiatric Diagnosis: I. A Critique of Systematic Studies*, 119 AM. J. OF PSYCHIATRY 210, 213 (1962).

76 B. FIGARRA, *supra* note 14, at 29-30; Jensen v. Finley, 17 Cal. App. 536, 62 P.2d 430 (1937); Corr v. Moats, 121 Neb. 769, 238 N.W. 529 (1931).

77 *See*, Farina & Ring, *The Influence of Perceived Mental Illness on Interpersonal Relations*, 70 J. OF ABNORMAL AND SOCIAL PSYCH. 47 (1965).

78 Anderson & Whitman, *supra* note 59, at 849.

79 *See* Carr v. New Orleans Police Dept., 144 So. 2d 452 (La. 1962); Dew v. Halaby, 317 F.2d 582 (D.C. Cir. 1963).

80 *See* Davis v. Colorado Kenworth Corp., 155 Colo. 98, 396 P.2d 958 (1964); *In re* Nitschke's Guardianship, 113 Ohio App. 243, 177 N.E.2d 628 (1961); *see generally* Note, *The Disguised Oppression of Involuntary Guardianship: Have the Elderly Freedom to Spend?* 73 YALE L.J. 676 (1964).

81 *See In re* Sherman, 66 Wash. 2d 718, 404 P.2d 978 (1965).

82 Dawidoff, *The Malpractice of Psychiatrists*, 1966 DUKE L. J. 696 (1966).

treatment deal with acts of negligence which are either highly visible or easily discoverable.[83] This last factor may explain why so few actions for malpractice in psychiatric treatment are brought. Unless the negligence involved in psychotherapy is extreme or unless the injury is physical in nature, it may be impossible for a patient to associate the injury with the treatment.

1. Chemical-Mechanical Therapy

Psychiatric treatment methods can be classified into chemical-mechanical procedures and psychotherapy. Most actions for malpractice in treatment have involved negligent application of chemical-mechanical procedures. The most common of these procedures is known as "shock therapy." The "shock" is a convulsion in the brain produced by either the passage of electric current through the brain or by the injection of insulin into the body.[84] Shock therapy is used to strengthen the patient's "defenses and controls and self-confidence" in the case of electric-shock therapy and to relieve anxiety and "disturbance of mood" in the case of insulin therapy.[85] This form of therapy has been utilized in the past for treatment of schizophrenia and paranoia. Its use in the treatment of these disorders has decreased with the advent of tranquilizing drugs[86] and is confined today to the treatment of depression and for suicidal tendency.[87] Some common aftereffects are confusion and loss of memory.[88] A known risk is bone fractures caused by uncontrollable spasms induced by the convulsions.[89] Since these side effects are "uncontrollable," courts have refused to hold physicians absolutely liable for their occurrence.[90] Similarly, the doctrine of *res ipsa loquitur* has been held not to apply.[91]

Physicians have been held liable for injuries from shock treatment for failure to inform the patient of the potential injurious side effects.[92] The psychiatrist is expected to explain in nontechnical terms any unusual risk of injury that may inhere in the proposed therapy. If the patient is so disturbed that the explanation would not be understood or if the explanation would so upset the patient that it would cause further decline in his condition, then the situation should be discussed with a close family member or friend.[93] The psychiatrist cannot misrepresent the consequences simply because the patient might refuse to undergo the therapy.[94] While the physician does not have to inform the patient of remote

83 Brown, *Social Resource Allocation Through Medical Malpractice,* 6 Willamette L.J. 235, 247-48 (1970).
84 Dawidoff, *supra* note 82, at 699; *see* Morse, *The Tort Liability of the Psychiatrist,* 16 Buffalo L. Rev. 649, 654-56 (1967).
85 Dawidoff, *supra* note 82, at 698.
86 *Id.* at 698 n.11.
87 B. Ficarra, *supra* note 14, at 526.
88 *Id.*
89 Morse, *The Tort Liability of the Psychiatrist,* 16 Buffalo L. Rev. 649, 656 (1967).
90 Dawidoff, *supra* note 82, at 699.
91 *E.g.,* Osburn v. Saltz, 169 So. 2d 687 (La. 1964); Farber v. Olkon, 40 Cal. 2d 503, 254 P.2d 520 (1953).
92 *E.g.,* Lester v. Aetna Cas. & Sur. Co., 240 F.2d 676 (5th Cir. 1957); Woods v. Brumlop, 71 N.M. 221, 377 P.2d 550 (1962); Mitchell v. Robinson, 334 S.W.2d 11 (Mo. 1960).
93 Morse, *supra* note 90, at 650.
94 *Id.*

hazards,[95] known risks such as bone fracture are by no means remote.[96]

Psychiatrists have also been held liable for failure to follow established procedures for the administration of electric-shock therapy[97] and for failure to stop administering treatments after an injury has been sustained.[98] Since a patient is in a dazed condition after a shock treatment, psychiatrists have been held liable for improper supervision of patients who suffered injuries while in such a state.[99]

2. Psychotherapy

While psychiatrists have been held liable in the case of chemical-mechanical therapies, liability for psychotherapy is extremely rare and has occurred only in the exceptional case. Psychotherapy is a catchall phrase for those psychiatric treatment procedures which are designed to "produce behavior change largely through verbal and symbolic techniques in a professional relationship between a socially approved healer and a suffering person."[100] The goal of most psychotherapies is to enable the patient to gain insight into the causes of his pathological habits and to help him replace them with useful and socially acceptable behavior.[101] Doctor-patient interaction in psychotherapy may be divided in a number of ways: individual or group therapies,[102] analytic or directive-suppressive therapies,[103] and inner-directed or outer-directed therapies.[104] Some psychia-

95 *Id.*

96 *See,* Mitchell v. Robinson, 334 S.W.2d 11, 13-14 (Mo. 1960); Farber v. Olkon, 40 Cal. 2d 503, 511, 254 P.2d 520, 525 (1953).

97 Stone v. Proctor, 259 N.C. 633, 131 S.E.2d 297 (1963).

98 *Id.;* Eisele v. Malone, 2 App. Div. 2d 550, 157 N.Y.S.2d 155 (1956).

99 Brown v. Moore, 247 F.2d 711 (3d Cir. 1957); Quick v. Benedictine Sisters Hosp. Ass'n, 257 Minn. 470, 102 N.W.2d 36 (1960); Adams v. Ricks, 91 Ga. App. 494, 86 S.E.2d 329 (1955).

100 F. Redlich & D. Freedman, *supra* note 15, at 272.

101 *Id.*

102 *Individual therapy* is, perhaps, the predominant mode of therapy. It involves a one-to-one relationship between the therapist and the patient. *Group therapy* allows the therapist to reach a larger number of individuals at one time. B. Figarra, *supra* note 14, at 525. Group therapy can involve the use of psycho-drama. The therapist can exercise strong control over the group, or he can allow the group to determine the frequency, length, and content of group meetings. In other words, the structure of the group depends upon the therapeutic orientation of the therapist/group leader. Similarly, the group make-up depends on whether the therapist believes in the effectiveness of homogeneous or heterogeneous groupings. *See* R. Harper, Psychoanalysis and Psychotherapy 129-42 (1959).

103 In all *analytic* therapies the therapist allows the patient to set the tone of the session. The therapist's role is to listen to, reflect on, and interpret the patient's statements. In the *directive-suppressive* therapies the therapist takes a more active role. Systematic attempts are made to induce the patient to change his attitudes and behavior by accepting the assumptive systems of the therapist. The techniques used to induce behavior and attitude change are: (1) Direct suggestion, persuasion, advice and intellectual guidance. (2) Various verbal and nonverbal "magical" procedures . . . (3) Praise and exhortation, which reinforce or inhibit certain types of behavior . . . (4) Manipulation of the physical and social environment . . . F. Redlich & D. Freedman, *supra* note 15, at 286.

104 *Inner-directed therapies* are those therapies which look to the individual for the source of his problem, i.e., the patient's behavior is seen as an external manifestation of an internal problem. Inner-directed therapies are designed to get at this internal source. *Outer-directed therapies* are used by therapists who believe that the patient's behavior is a reaction to his environment. Their goal is to ascertain and modify those aspects of the patient's living situation which are responsible for his discomfort. *See* Sarbin, *The Scientific Status of the Mental Illness Metaphor,* in Changing Perspectives in Mental Illness 9 (S. Plog & R. Edgerton eds. 1969).

trists vary their therapeutic approach according to the nature of the patient's diagnosed illness and his personality.[105] Others adhere to only one particular mode of therapy[106] because they believe that it is the only effective one.[107] Moreover, the vast number of therapies available has induced some therapists to adhere to and to attempt to develop more fully only one method of treatment.[108]

3. Choice of Therapy

Even when chemical-mechanical therapy is involved in a suit, the issue is rarely whether the therapy actually used was necessary or appropriate for a patient suffering from plaintiff's disorder.[109] It is, in fact, unlikely that a psychiatrist could be held liable for negligently choosing a method of psychotherapy, since such a large number of possible therapies exist. For example, while there is widespread agreement that psychotherapy is appropriate for the treatment of neurosis, there is less agreement as to its appropriateness for the treatment of schizophrenia, manic-depressive reactions, and psychosomatic diseases.[110] Even so, there are many psychiatrists who use psychotherapy to treat such disorders.[111] Therefore, even if a patient were able to introduce expert testimony at trial to show that the therapy was inappropriate, the psychiatrist would be able to counter this testimony with experts of his own. Thus establishing that there is uncertainty[112] as to the procedure to be followed.

4. Proof of Failure to Cure

Proof of failure to recover from an illness or a degeneration of the patient's condition is insufficient to establish negligent treatment. No physician guarantees a cure simply by treating a patient.[113] In the case of psychotherapy it would be especially difficult for a patient to prove that his regression or failure to recover was due to negligence. Some forms of regression are, in fact, to be expected. When psychoanalysis is used:

> There is . . . a calculated risk involved at the basis of psychoanalytic treatment in which the patient is encouraged to develop a transitory form of neurosis which may, upon being unleashed, become unmasterable so that the "analysis must be broken off."[114]

Numerous studies have demonstrated that psychotherapy is unsuccessful in in-

105 F. Redlich & D. Freedman, *supra* note 15, at 275.
106 *Id.*
107 This is particularly true of psychoanalysts. *See* R. Stuart, *supra* note 16, at 51-58.
108 F. Redlich & D. Freedman, *supra* note 15, at 275.
109 *See,* Collins v. Hand, 431 Pa. 378, 246 A.2d 398 (1968). In that case the plaintiff questioned the appropriateness of electroshock therapy for one in her mental condition. The court ruled that negligence was not established because plaintiff failed to support her claim with expert testimony.
110 F. Redlich & D. Freedman, *supra* note 15, at 274.
111 *Id.*
112 B. Ficarra, *supra* note 14, at 45-46.
113 Wolfstone, *A Subjective Test of Professional Care,* in Medical Malpractice—the ATL Seminar 49 (L. Harolds & M. Block eds. 1966).
114 R. Stuart, *supra* note 16, at 56 (citation omitted).

ducing behavior change, that no form of psychotherapy is more successful than others, and that patients are either just as likely or more likely to improve their condition in the course of time without the benefit of psychotherapy.[115] While not unchallenged,[116] they do demonstrate that a patient would be unable to establish that his failure to improve was due to his therapist's negligence. Sigmund Freud himself recognized the uncertainty of results from psychotherapy:

> Our impression is that we must not be surprised if the difference between a person who has not and a person who has been analysed is, after all, not so radical as we endeavour to make it and expect and assert that it will be.[117]

5. Relationship between the Therapist's Conduct and Injury

A patient with nonphysical injuries would be hard-pressed to show that his injuries were due to the therapist's conduct during therapy, especially since the therapist's conduct varies significantly with the mode of therapy he chooses to utilize. Psychoanalysis, for example, requires that the therapist maintain an air of neutrality and detachment from the patient.[118] On the other hand, if the therapist uses a form of directive therapy, he is expected to become involved with the patient by showing his emotions, giving the patient directions, and manipulating the patient's environment.[119]

Two cases[120] in which the psychiatrist was held liable for malpractice involved therapists who used an *analytical* therapy, that is, one which requires neutrality. In both cases the plaintiffs introduced expert testimony to show that the therapists had incorrectly and negligently encouraged their patients to become excessively dependent upon them. In *Landau v. Werner,* the court held that since the therapist had used a novel technique in failing to control his patient's dependence, he could escape liability only by justifying this technique before the court:

> If his novel or exceptional treatment had failed disastrously he could not complain if it was held that he went beyond the bounds of due care and skill as recognized generally. Success was the best justification for unusual and unestablished treatment.[121]

C. *Establishing a Standard of Care—Expert Testimony*

It would be difficult for an injured patient to prove negligent treatment in the case of psychotherapy primarily because negligence in the context of medical

115 *Id.* at 43-50; Eysenck, *The Effects of Psychotherapy,* in Handbook of Abnormal Psychology 697 (H. Eysenck ed. 1960).
116 *E.g.,* Subotnik, *Spontaneous Remission: Fact or Artifact,* 77 Psychological Bulletin 32 (1972).
117 S. Freud, *Termination of Analysis,* in 5 Collected Papers 329 (1953).
118 *See* Newton, *Abstinence as a Role Requirement in Psychotherapy,* 34 Psychiatry 391 (1971).
119 F. Redlich & D. Freedman, *supra* note 15, at 286.
120 Zipkin v. Freeman, 436 S.W. 2d 753 (Mo. 1969); Landau v. Werner 105 Sol. J. 257 (Q.B. 1961), *aff'd* 105 Sol. J. 1008 (1961).
121 Landau v. Werner, 105 Sol. J. 1008, 1009 (1961).

malpractice means deviation from established custom in the field.[122] While "custom" is only one element of proof in an ordinary negligence case, it is almost the exclusive method for establishing the standard of care in malpractice cases.[123] Since so much debate and confusion exists within the profession, it is likely that a psychiatrist who is sued for negligently choosing or administering a therapy will always be able to find support from his colleagues for his actions. In such a case, an injured patient may be able to overcome this barrier only by proving that "the very nature of the acts complained of bespeaks improper treatment and malpractice."[124] For example, in *Hammer v. Rosen,*[125] a psychiatrist was held liable for the negligent treatment of his patient. He had used a form of aggressive psychoanalytic therapy which received the approval of many of his colleagues; the therapy involved striking the patient when "appropriate."[126] At trial, however, Doctor Rosen denied using beatings as part of his therapy. Even though the plaintiff introduced testimony to show that beatings had, in fact, occurred, the lower court ruled for the defendant because the plaintiff failed to produce expert testimony to show that such a mode of therapy was negligent.[127] The New York Court of Appeals reversed, holding that expert testimony was not necessary to establish negligence in such a case[128] since the treatment used "bespoke" of negligence. However, the court left open the possibility that such a therapy could be used without fear of liability if there was evidence which showed that the beatings constituted proper treatment.[129]

The court in the *Rosen* case still deferred to psychiatric expertise: it merely placed the burden on the physician to justify his behavior whenever an "extraordinary" form of therapy is used which on its face appears to be negligent. In a later case, however, the same court refused to defer to psychiatric judgment. In *Wright v. State,*[130] a psychiatrist was sued for negligent supervision of a suicidal patient who was allowed to remain in a room by himself after threatening suicide. While alone, the patient sustained injuries when he jumped out of an open window. The state argued that the permissive treatment of suicidal patients is an accepted therapeutic procedure. While the lower court refused to treat the psychiatrist as a layman and required the plaintiff to demonstrate by expert testimony that such a procedure was negligent,[131] the appellate court reversed and held, citing *Rosen,* that no expert testimony was required. The court rea-

122 B. FIGARRA, *supra* note 14, at 47; Note, *An Evaluation of Changes in the Medical Standard of Care,* 23 VAND. L. REV. 729, 742 (1970).

123 Note, *An Evaluation of Changes in the Medical Standard of Care, supra* note 122. A few courts have moved away from the "customary practice test" and have recognized that a customary procedure may itself be negligent. *See* Lundahl v. Rockford Mem. Hosp., 93 Ill. App. 2d 461, 235 N.E.2d 671 (1968); Toth v. Community Hosp., 22 N.Y.2d 255, 239 N.E.2d 368, 292 N.Y.2d 440 (1968); Favalora v. Aetna Cas. & Sur. Co., 144 So. 2d 544 (La. App. 1962).

124 Hammer v. Rosen, 7 N.Y.2d 376, 380, 165 N.E.2d 756, 198 N.Y.S.2d 65 (1960).

125 *Id.*

126 *See* Morse, *supra* note 90, at 663.

127 Hammer v. Rosen, 7 App. Div. 2d 216, 181 N.Y.S.2d 805, 806 (1959).

128 Hammer v. Rosen, 7 N.Y.2d 376, 379, 198 N.Y.S.2d 65, 165 N.E.2d 756 (1960). The Court, in effect, ruled that the jury was capable of determining whether the acts of Doctor Rosen were negligent even though there was no expert testimony to that effect.

129 *Id.* at 380, 198 N.Y.S.2d at 67.

130 31 App. Div. 2d 421, 300 N.Y.S.2d 153 (1969).

131 Wright v. State, 53 Misc. 2d 521, 297 N.Y.S.2d 215 (Ct. Cl. 1967).

soned that the jury was in a position to weigh the benefits to be derived from the treatment against the danger of injury to the patient.[132]

Cases awarding recovery for negligently administered therapy are exceptional. They involve situations where the therapists became deeply involved with their patients on a personal level, as well as situations such as *Rosen* and *Wright*. It is unlikely that a patient could recover for negligently administered psychotherapy unless such a dramatic fact pattern is involved; negligence in a medical context means an unreasonable deviation from a professionally established standard.[133] If there is no such standard, then there is no negligence. Psychiatry is not yet at the stage where it can provide the courts with such standards. Unless the psychiatrist's behavior is so exceptional that the court is willing to waive the requirement of expert testimony to establish negligence, a patient injured by psychiatric negligence in the execution of psychotherapy would most likely be without recourse. If courts were to relax the traditional standard of proof for malpractice cases when dealing with psychotherapy, they would, in effect, be shaping the future course of psychotherapy. Before courts will be able to deal effectively with psychiatric negligence, psychiatry will have to develop its theories and procedures so that courts will have some guidelines in setting standards of care. For a court to take a more active role at this point the court would have to be willing to pretend that there is more "order" in psychiatry than there actually exists, or the court would have to disregard psychiatric practice and treat the psychiatrist as it would treat any lay defendant in a negligence case.

III. Conclusion

Those authors who have dealt with psychiatric negligence have expressed surprise over the fact that there are so few cases dealing with diagnosis and therapy.[134] This scarcity can be attributed to both the lack of doctrinal footing for such an action and the inherent vagueness of psychiatric practice itself.[135] Unless the injury to the patient is physical or is the result of obvious misconduct, the patient is in no position to associate the injury with the treatment. Even if the patient does so, it is unlikely that he will be able to show negligence. The physician is protected when he can show some reputable support within his profession for his chosen course of conduct. Courts could not deny psychiatrists this defense unless they were willing to say that psychiatry is unlike any other medical specialty. They would, in effect, have to deny psychiatrists the privilege given the medical profession to establish its own standard of care.

Varda N. Fink

132 Wright v. State, 31 App. Div. 2d 421, 300 N.Y.S.2d 153, 155 (1969).
133 B. FIGARRA, *supra* note 14, at 46-47.
134 *See, e.g.*, Annot., 99 A.L.R.2d 599, 605 (1965); Dawidoff, *The Malpractice of Psychiatrists*, 1966 DUKE L.J. 696 (1966).
135 *See* Rosenhan, *On Being Sane in Insane Places*, 179 SCIENCE 250 (1973). This article presents an experiment which demonstrates the difficulty of distinguishing between sane and insane behavior.