Back to Basics: Law and Mental Health

WILLIAM H. REID, MD, MPH

It's good to review the basics every once in a while. Many psychiatrists, especially international medical graduates and trainees, have little experience with U.S. jurisprudence and its foundations. This month we'll review some foundations of U.S. law and a few basic principles that are relevant to clinicians and mental health.

Where Do Our Laws Come From?

U.S. laws are created by representatives of the people, whether on a federal or state level (in Congress or a state legislature) or a local one (such as a city council). Local laws are subordinate to state ones, which are in turn subordinate to federal statute. Congress cannot simply run roughshod over states' interests, however. The Constitution and federal law give broad authority to the states for managing their own affairs, including most mental health matters.

Federal law steps in when legal issues *extend beyond* state borders (such as transportation and other matters of interstate or national interest) or *transcend* state interests (such as civil rights and other rights and protections guaranteed by the U.S. Constitution). Every law in every part of the United States, no matter what the source, must conform to the federal Constitution.

Two additional sources of law are particularly relevant to clinicians and patients: Case law and rules that have the force of law.

Case law is created by appellate court decisions. It is really an affirmation of existing or potential law by means of a legal decision that creates *precedent* in one or more jurisdictions. The U.S. Supreme Court interprets the Constitution and federal law. Its decisions establish interpretations that must be followed by all other courts. Lower (but still appellate) court decisions, such as those of state supreme courts and federal and state appeals courts, affect limited geographic areas, such as states or federal districts. Appeals courts deal with the law itself, not with the "facts" of cases. They do not second-guess juries, but decide whether or not a trial-court judge followed the law during an initial proceeding. Trial courts do not create legal precedent; that role is reserved for appeals courts and state and U.S. supreme courts.

Rules that have the force of law are created by, for example, state or federal agencies to whom a legislature has given the authority to regulate or enforce some relatively narrow area (such as clinician licensure or health insurance). Congress and state legislatures often lack the time and expertise to deal with specialty issues and administrative minutiae, so detailed rules governing such things are made and modified—within the restrictions of applicable law—by administrative entities like departments of health, state medical boards, and the federal Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA).

Jurisdiction. We have already mentioned a geographic hierarchy and distribution of lawmakers (federal, state, county, city). The same concept applies to courts themselves, which have boundaries and hierarchies of *jurisdiction* that define when a particular court is appropriate for a case of one kind or another. Geographic distribution is one kind of jurisdiction. Laws and cases in one area generally have no formal effect on those of another area unless the former is contained within the latter. That is, California *state* laws and statewide appellate legal decisions govern the behavior of those in Los Angeles, San Francisco, and Fresno, but have no effect on people or cases in other states. Fresno's *municipal* laws don't apply in Sacramento. Federal appeals decisions in the Seventh Federal Circuit—a specific geographic area in the upper Midwest—become case law in Illinois, Indiana,

WILLIAM H. REID, MD, MPH is a forensic and clinical psychiatrist from Horseshoe Bay, Texas, and a past president of the American Academy of Psychiatry and the Law. He maintains an educational website, *Psychiatry and Law Updates*, at www.reidpsychiatry.com. His most recent book is *Handbook of Mental Health Administration and Management* (edited with Stuart B. Silver, M.D.), New York: Brunner-Routledge, 2003. This column contains general information which should not be construed as applying to any specific case, nor as any form of legal advice.

and Wisconsin (all of which are in the Seventh Circuit), but not in Tennessee or New Jersey (which are in the Sixth and Third Circuits, respectively). Federal law supercedes all state and local law when properly applied to a given case. U.S. Supreme Court decisions interpret the U.S. Constitution and federal law, and create precedent (case law that must be followed) for all U.S. courts and legislatures.

The Adversary System of Justice. You've heard of the adversary system, but you may not understand the crucial role it plays in our judicial process. In litigation, we choose special representatives (lawyers, mostly) to work for us against the opposing side. There is a bloodless fight between the disagreeing parties to see who prevails. It is the responsibility of the *opposing parties,* not of the judge or jury, to bring and use the weapons (e.g., evidence, experts, persuasiveness). That's what makes it "adversarial": the judge is an umpire who makes sure the rules of fairness are being followed (a "trier of law"). He or she does not get involved in the fight itself and may not even decide who is right and who is wrong (that's usually, but not always, a jury's role, to be the "trier of fact," except in very small cases).

Much of U.S. law, which is largely derived from European legal and religious principles, relies on the philosophical concept of right and wrong and the idea that in a fair fight, "right" will triumph over "wrong." *Much of the U.S. judicial process is devoted to making the "fight" a fair one.* For example, criminal defendants, who are in jeopardy of losing their liberty (see below), are given great procedural advantages over State prosecutors, in part to make up for the formers' weaknesses (e.g., fewer resources, less experience) and level the judicial playing field. Civil defendants, too, have some advantages, but not to the same extent (their liberty is not in jeopardy, only their money; see below).

Who Does the Proving? One of the most important means of leveling the adversarial playing field and decreasing the potential for unfair harm to defendants (criminal and civil) is the fact that *the defendant does not have to prove he is innocent* (or, in civil cases, that he is entitled to prevail). The prosecution in criminal trials, or the plaintiff in civil actions, must prove that the defendant deserves to lose. In a sense, all the defendant has to do is show up, and if the other side doesn't meet its burden of proof, the defendant wins.

In practice, of course, defendants almost always present evidence of their innocence or lack of wrongdoing, but it is not unusual for a judge to listen to the prosecutor's or plaintiff's arguments (either at trial or in a pretrial hearing), decide that the prosecutor's/plaintiff's case has not been proved to the extent required, and simply terminate the proceedings in the defendant's favor.

Comparing Criminal and Civil Matters

Criminal matters involve crimes. That's a simple statement, but it conveys several important differences between criminal and civil law (the latter is more relevant in most clinical situations). Accusations of criminal behavior place the defendant at risk of losing his or her liberty (that is, of going to jail or prison). That *liberty interest* means that criminal defendants have a great many protections in the judicial process—more than they have in civil matters (see below). For example, criminal defendants are guaranteed competent legal counsel; the procedural rules for the most part favor them; and guilt must be determined beyond reasonable doubt (roughly 95%–98% certainty in each juror's mind).

Civil matters are not crimes or alleged crimes, and their resolution doesn't involve loss of liberty. People accused of civil breaches such as negligence (the main allegation in most malpractice lawsuits) do not go to jail or prison, even if they lose the case. In a lawsuit, for example, if the plaintiff (the person who brings the lawsuit) prevails, the resolution is designed to alleviate the plaintiff's damages by making him or her "whole" again. This is routinely accomplished with money (a damage award, for example, to pay for medical costs, lost wages, other losses, or pain, or to punish the defendant). Civil judgments occasionally require a defendant to do something else; for example, in a class-action settlement, one might see a decree requiring a state hospital to increase its staffing levels or offer a particular kind of treatment. Note that the defendant cannot be required to do anything unless the plaintiff prevails in court, or unless the defendant agrees to do something as part of a voluntary settlement (an agreement reached by the parties without, and in lieu of, a trial).

The lack of any *liberty interest* (i.e., there is no danger that the civil defendant will go to jail or prison) allows the rules in civil matters to be significantly different from those of criminal matters and to provide fewer protections and guarantees for civil defendants. Retaining and paying for legal counsel, for example, is the litigant's responsibility; the defendant's rights in the legal process are fairly similar to the plaintiff's (and less than those of a criminal defendant); and the plaintiff need

only prevail by a "preponderance" of the evidence (roughly 51% certainty in most or all jurors' views).*

Dr. A., a private psychotherapist, was accused of sexual improprieties with a minor patient. The various allegations led to three kinds of legal procedures.

A local district attorney filed criminal *charges of sexual assault on a minor. In that action, Dr. A. was formally arraigned, the charges were clarified, and he faced trial in a state criminal court. He was convicted and sentenced to several years in prison.*

The state licensing agency for his profession notified him that his professional license was summarily suspended pending administrative action to determine whether or not it should be revoked. This civil administrative action *was based on authority given to the agency by the state legislature, to be exercised for the health and protection of state citizens. Dr. A. had certain rights in the process, similar but not identical to his rights in the civil lawsuit (see below). The agency held an investigation, received information and evidence from his attorney, and eventually had a hearing at which Dr. A. had a right to appear and present a defense to the license-related charges and rules. His license was revoked.*

The child's parents filed a civil lawsuit *on behalf of the patient, claiming that Dr. A.'s behavior had been negligent and had substantially damaged the child. They alleged malpractice and also sued on other grounds. The lawsuit process took over 2 years, far longer than either the criminal or licensure matter, and was settled out of court for an undisclosed amount of money, paid partially (but not entirely) by Dr. A.'s malpractice carrier.*

There are a few areas of mental health law that don't seem to fit the brief descriptions of criminal and civil concepts presented above. We won't discuss those in detail (and I'm not a lawyer, after all), but let's mention a couple.

Civil commitment is a process by which states are allowed, under carefully defined circumstances, to admit certain patients to hospitals against their will.† Patients are not vulnerable to criminal punishments in the process, but nevertheless may lose their liberty. The U.S. Supreme Court decided many years ago that, because hospitals and psychiatric care offer something more than simply confinement, with genuine effort to treat and/or protect the patient, this loss of liberty is different from criminal incarceration. Thus states need not provide the same level of protection for the rights of patients considered for commitment as they do for criminal defendants. In most states, for example, the level of certainty (burden of proof) required that a patient meets commitment criteria is not "beyond reasonable doubt," but a level called "clear and convincing," which lies between the criminal and civil burdens. No state may use the lower civil threshold (preponderance of the evidence; see above); a few use beyond reasonable doubt.

Child custody is another civil process that affects liberty (i.e., where the child will live). The purpose is not punishment, however, and the intent is to serve the interests of the child. Those interests, and secondarily parents' rights to retain custody of their children, are more important than mere monetary civil matters, and various judicial procedures reflect that fact.

Civil Matters in Mental Health

Malpractice and the Standard of Care. When it comes to the civil law and mental health, everyone wants to talk about malpractice. Malpractice is a wrong (or *tort*) that involves *negligence*. Note that negligence is not the same as an accident. Negligent acts are those that one should reasonably have been able to avoid. In order to commit malpractice, a clinician must first have a duty to someone (usually a patient), then negligently fail in that duty, causing damage to the patient. Each of these elements must be proved in court before malpractice exists.

The negligence part of malpractice is often defined in terms of clinical practice "below the standard of care." The standard of care is defined slightly differently in different jurisdictions, but is usually considered to be that level of care employed by reasonable clinicians of similar training in situations similar to the one being discussed. One does not have to practice exemplary care, or do what every other professional does; however, the level of care must be adequate and consistent with that of a legitimate subgroup of clinicians.

Confidentiality. The right of patients or clients to control the release of information about them is a mainstay of psychotherapy and psychiatric practice. However, the patient's right, and the clinician's obligation to preserve that right, is not absolute. There are

*Cf. the O.J. Simpson criminal and civil trials, in which Mr. Simpson's rights as a *criminal* defendant strengthened his case in the criminal trial (in which he was not convicted), while the absence of many of those defendant protections in the *civil* lawsuit contributed to his losing in that litigation.

†We will ignore outpatient commitments in this discussion.

many circumstances in which information about a patient can and/or should be divulged, most commonly with authorization by the patient although this may be affected by considerations such the patient's age or level of competence, safety, and clinical need. Almost all laws regarding confidentiality are state laws, with the exception of laws related to substance abuse, the recent Health Insurance Portability and Accountability Act of 1996 (HIPAA), and federal jurisdictions (such as the military and Veterans Administration, federal prisons, U.S. territories, and the District of Columbia).

Competence and Consent. *Competence*, similar to the legal concept of *capacity*, is the ability to do something. The most relevant question in competency discussions is "competence to do what?" The threshold for legal competence varies with the complexity and importance of the task. Competence to carry out simple, benign activities may require only the ability to indicate a preference (e.g., how to spend a small allowance or whether to have chicken or fish for dinner). At the other end of the spectrum, competence to engage in activities that require complex decision-making and/or have serious consequences (e.g., spending large amounts of money or choosing between complicated surgical alternatives) calls for much more sophisticated information processing ability.

Consent has three elements, each of which must be present for the consent to be valid. First, the consentor must have sufficient *information* with which to weigh the advisability of the act (e.g., authorizing release of information, accepting or refusing a treatment procedure). Second, the person must possess the mental *capacity* to adequately use that information (more complex consents, and those with more serious consequences, require higher levels of capacity). Third, the consent must be *voluntary* rather than forced or extorted. Manipulations such as "We'll commit you if you don't sign in voluntarily" threaten voluntariness and thus the validity of the consent.

Note that the phrase "informed consent" didn't enter into the above discussion. That's because "informed" reflects only one of the three required elements—information.

Do consents have to be in writing? No, unless there is some rule (such as a hospital regulation) that specifically requires written consent. People may consent or refuse orally, by a nod or shake of the head, or simply by voluntarily participating in a procedure (such as routinely happens when having one's blood drawn). Written forms and signatures are convenient ways of documenting the process, but not the only ones.

The fact that complexity and consequences affect the level of mental capacity necessary for valid consent raises an important point: *The mental competence criteria for* consenting to *something are often different from those for* refusing *it.* That is, a patient doesn't need to know every nuance of the pros and cons of accepting hospital admission or psychotropic medication in order to be competent to accept either.

The risk-benefit ratio of, say, hospital admission or antipsychotic medication is likely to be very favorable for an acutely ill patient. The potential for benefit is substantial and very few patients are significantly harmed by coming into the hospital or taking a prescribed psychotropic medication. Thus, the level of competence required to accept such measures is (or should be) fairly low.

On the other hand, refusing admission or antipsychotic medication is likely to have serious adverse consequences for the patient. The potential benefits of refusal are far fewer than those of acceptance, and the risks associated with refusal are substantial. Thus the competency threshold for appreciating the consequences of refusing such treatment is much higher than the threshold for accepting it.

Danger to Self or Others. Mental health professionals often assess risk in the care of their patients. Our first objective is the safety of the patient and others. The second is therapeutic benefit. Our potential liability for negligently assessing risk is significant. Alleged "wrongful death," usually from self-harm, is the most common cause of action in malpractice litigation against psychiatrists, psychologists, and psychiatric hospitals. (See my January 2003 column on "Risk Assessment, Prediction, and Foreseeability"[1]).

Several states limit, through statute or case law, clinicians' responsibility for injuries to parties other than patients themselves (so-called "third parties"). In others, psychiatrists and therapists who believe third parties are in danger are either obligated or allowed (i.e., shielded from accusations of breaching confidentiality) to do something to protect the third parties.[‡] Sometimes the protective concept is limited to specifically named

[‡] "Protect" is not the same as "warn." Warning potential victims is often insufficient and may be useless. The appropriate protective clinician behavior varies with the situation and may include such things as warning potential victims, acute treatment, efforts to hospitalize the patient, or notifying law enforcement agencies or other responsible entities.

potential victims. In some states, however, even a vague (but serious) threat to the public requires the clinician to act (e.g., in the case of a severely paranoid patient who is known to carry a gun, or a teacher with pedophilic impulses).

Regulation of Clinical Practice and Practitioners

The public are sometimes frustrated because they view doctors as individuals who can do anything they want, and for whom complaints to licensing boards and professional organizations seem meaningless. Nothing could be farther from the truth.

Psychiatrists and other independently licensed mental health professionals are regulated in a number of ways—by laws and rules that have the force of law; relatively informal restrictions of employment, credentialing, and payers; the potential ramifications of malpractice actions; and organizational ethics. We know that our ability to practice is a privilege, not a right. The *quid pro quo* for permission to exercise that privilege includes proper training and other qualifications, practicing within the standard of care, and openness to review by licensing and privileging bodies.

Professionals with fewer credentials than psychiatrists or licensed psychologists often endure less oversight and offer fewer avenues of redress for the public. Those who aren't licensed at all have few restrictions except those related to ordinary business (e.g., laws against fraud or assault), and routinely lack insurance against civil liability or vulnerability to professional sanctions. At that level, "buyer beware" becomes more than a mere catch-phrase.

The Last Word

Psychiatrists and other mental health professionals should be aware of the laws that affect their practices and of the basic legal concepts and processes they entail.

References

1. Reid WH. Risk assessment, prediction, and foreseeability. Journal of Psychiatric Practice 2003;9:82–6.