Organization Liability: Beyond *Respondeat Superior*

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Respondeat superior is the legal principle that an employer is generally responsible for the mistakes of his or her employees. This month's column discusses a few issues involving facilities, clinics, groups, agencies, and other mental health provider organizations that I have encountered in forensic consultations. We won't cover the entire waterfront; I've boiled it down to a sort of "top ten" list—well, maybe seven.

CONFLUENCE OF EVENTS

Tragedies, and the lawsuits and expensive settlements that sometimes follow, often arise from a confluence of errors rather than just one thing. Facilities and other healthcare organizations have evolved a number of "layered" protocols and safeguards that serve to protect patients from errors in care. For example, nurses double-check prescription labels before administering medications. If there is a failure at one level, it is likely to be corrected at the next. A *series* of errors, however, or a flaw in the layered system, often creates a danger.

> *A young inpatient on 15-minute checks for suicide prevention asked an aide to let him into an exercise room. The aide took him there, closed the self-locking door leaving him alone, and went to lunch without telling anyone where he was. The room had one observation window, which faced an empty day room. The patient covered it with a curtain. About 20 minutes later, a staff person searching for the patient was told he might be in the exercise room. She went there, found the door locked, and had to retrieve the key from the nurses' station. The patient was found hanging by the neck from a weight machine cable, in respiratory arrest. He was resuscitated, but was left with permanent quadriplegia. The hospital was sued and settled for a very large amount of money.*

Let's look at several apparently negligent events discovered in this case, many of which might not by themselves have led to such a devastating suicide attempt.

First, unit staff were not consistently documenting (and thus perhaps not carrying out) the 15-minute checks. Deposition testimony revealed that they often completed the required checklist at the end of each shift rather than initialing it at each check. The aide had not been given a report about the patient at the beginning of her shift, then failed to check with her supervisor about his exercise room request, left him there unsupervised, and failed to tell anyone where he was. The exercise room itself was located in an out-of-the-way area, inconvenient for staff observation, with a window that could be easily covered. The self-locking nature of the door was not a problem in itself, but the lack of emergency access caused a crucial delay.

Thus one or more initial hospital errors created a danger for the patient. Those problems combined with others to increase the patient's risk, quickly allowing a serious adverse event to occur. Still other deficits made the event worse, increasing the damage to the patient.

LIABILITY FOR EMPLOYED, CONTRACTED, OR ADMINISTRATIVE CLINICIANS

Take Titles Seriously

It is very important that clinicians understand their contracts, job descriptions, and potential liabilities. Many organizations try to slough liability to contract physicians, medical directors, or unit directors in order to shield themselves. In other cases, particularly in smaller clinics and practice groups, "medical director" or

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a similar title is used to flatter the psychiatrist—we all love titles—who may not realize that *the title alone can create duties that he or she is not aware of and may not be in a position to fulfill*. If there is no job description for the title and a tragedy occurs, a lawyer or jury may infer duties and standards after the fact.

A psychiatrist was happy to accept the title of medical director for a group of nonmedical counselors that operated and advertised as an organized mental health center. He didn't pay much attention to any "medical director" responsibilities (there was no official job description in clinic policies) and spent his office time doing brief medication checks and occasional evaluations.

The psychiatrist was surprised to learn that he was named in a lawsuit that arose from a clinic patient's suicide. The suit alleged that the psychiatrist had some responsibility for the care provided to the patient by a counselor in the mental health center, even though the psychiatrist had only briefly seen the patient several months previously. At deposition, he agreed that he was the medical director, but also had to admit that he had not instituted procedures for credentialing counselors, quality improvement, clinician oversight, psychiatrist-counselor communication, or peer review.

Discretionary Duties

Even clinicians who believe they are fully indemnified by their employment status (i.e., financially protected from malpractice claims) should note that if they do or oversee clinical work, much of their activity may be construed as "discretionary." That word refers to the fact that doctors and other independently licensed clinicians aren't always as bound to employer rules and procedures as other employees. They often have an additional duty to practice adequate medicine or therapy, regardless of administrative rules. That duty is important to good patient care, to licensure and ethics requirements, and to the possibility that one will be sued personally, separately from the organization, if there is a tragedy.

Informal Clinical Work

Another common, but sometimes unexpected, source of duty and potential liability comes from performing clinical services for staff outside one's employment or administrative role. Prescribing or even simply counseling a staff person is likely to create a separate doctor-patient relationship, establishing in turn the professional duties and liabilities associated with treating a patient. I recommend that clinicians make "informal" consultations "formal," or refer staff members to an appropriate colleague (see below).

SUICIDE

The column by Simpson and Stacy in the May 2004 issue of this journal[1] discussed a number of issues related to suicide, but the topic deserves further comment. Wrongful death or injury is the most common cause of action (i.e., reason for a lawsuit) brought against mental health facilities. What is likely to attract a lawyer's attention when he or she reviews patient records after a suicide or suicide attempt?

- *Failure to admit* a patient when clearly indicated, to properly recommend admission to a refusing patient, or to adequately consider pursuing involuntary admission when necessary. The critical decisions usually rest with a physician, but sometimes undertrained or poorly credentialed staff are given responsibility for admissions triage.

A psychiatric hospital "admissions counselor" was presented with a severely depressed patient who was brought in by police when most of the psychiatrists were off duty. The patient was threatening suicide and had a history of severe mood and behavioral instability, a diagnosed psychotic disorder with recent self-destructive command hallucinations, recent hospitalizations for serious suicide attempts, and an increase in symptoms over the previous few days.

The counselor spent about half an hour with the patient. She did not review easily available prior records, nor did she try to contact the patient's current psychiatrist (who was on the hospital staff). The counselor spoke with an on-call psychiatrist by telephone for 5 or 10 minutes, apparently never mentioning many of the ominous symptoms and risk factors that were obvious in the patient's presentation. She told the psychiatrist that the patient had changed her mind and said she wouldn't kill herself. The psychiatrist listened briefly to the hospital counselor's evaluation and interpretation but chose not to see the patient in person, nor did he ask to speak with the patient or her husband. He ordered an outpatient referral. The patient killed herself the next day.

A lawsuit was eventually filed by the patient's relatives. Information acquired during the lawsuit "discovery" process revealed that the counselor was unlicensed and had no mental health experience prior to coming to work for the hospital a couple of years before this event. Her deposition suggested a number of deficits in her knowledge and understanding of suicidal patients. The on-call psychiatrist said at deposition that he had relied on the counselor's skill and experience for his decision not to admit the patient and believed she was qualified to evaluate such patients. The case was settled out of court for a substantial sum.

- *Improper assessment or inadequate documentation* of assessments and conclusions.[1] Note that adequate assessment has little to do with rote checklists, brief statements such as "No S.I./H.I.," or that old bugaboo "Contract for safety." They won't prevent a lawsuit when the care or documentation of care is sloppy.
- *Failure to get collateral information* (and/or unreasonably relying on the patient's own statements or promises about things such as suicidality).
- *Premature discharge, passes, or privileges.* Please don't rely on saying that you were "forced" to discharge a patient because a payer wouldn't certify further care, or that you did not attempt involuntary hospitalization when you believed the patient needed it because you thought the judge would probably turn you down. Juries don't like that attitude, and it should ring hollow to you, too. If a voluntary patient demands premature discharge, be certain to document sincere efforts to encourage the patient to stay.
- *Failure to allow adequate inpatient time for treatment response.* Short stays are often clinically appropriate when treatment can be continued safely in a less restrictive setting. Be aware, however, that a period of patient observation, including monitoring for medication response and side effects, is an important part of treatment.
- *Too much time between appointments* for patients who are new, deteriorating, or whose treatment has been changed. The currently popular *average* period between maintenance medication checks is not always a *clinically appropriate* period. Try asking yourself, "would a return appointment in 6 or 8 weeks seem reasonable if the patient were my own close relative?"
- *Relying on organization policies and procedures (P&P) as if they were the only relevant guidelines or standards.* Organization P&P are not "standards of care" (although lawyers often use them if doing so serves their purposes). They may be interpreted as promises or as quasi-standards that the organization has volunteered to meet. P&P are important to organization operations, but they often reflect either efforts to exceed suggested standards (not merely meet them) or, on the other hand, rules that are limited to the idiosyncratic needs of the facility.*

BOUNDARY ISSUES, SEX WITH PATIENTS

It is difficult to prevent lawsuits against an organization when one of its clinical associates is accused of inappropriate intimacy with a patient, even if the clinician is not an employee. Malpractice policies often forbid or severely limit financial recovery for (especially sexual) boundary violations, so plaintiffs' lawyers routinely look to organizations for a source of blame and compensation. Some potential areas of vulnerability include:

- Negligent credentialing (e.g., failure to perform relevant background checks, contact references, or verify experience).
- Knowingly providing an incomplete reference to another organization or employer (for example, failing to notify a future employer or medical staff organization of significant problems with a clinician).
- Inadequate supervision or monitoring, or failure to document same, especially of new employees or clinicians or those reasonably known to have a blemished reputation.
- Not reasonably noticing that something is wrong or not acting on reasonable signs of abuse or clinician impairment.†
- Inadequate staff training in recognizing the above, and in recognizing warning signs and countertransference in oneself.
- Inadequate policies and procedures about recognition and reporting of boundary issues, abuse, or clinician impairment.

SETTING-RELATED SAFETY ISSUES

Physical setting, staffing, and staff procedures are all relevant to both patient care and liability. For example,

*For example, some psychiatric hospitals have admission criteria which fit payer or administration requirements but are quite different from broadly accepted criteria based on patient need. The standard of care is much more closely related to the latter than the former.

†"Reasonable" is difficult to define, of course. For additional discussion of impaired clinicians, see Reid 2001.[2,3]

physical appointments and staffing of a unit are sometimes not commensurate with patient acuity (especially in smaller facilities). When there are only one or two inpatient units to choose from, or a single small partial hospitalization program, a setting may be used for many patients with different needs and symptoms—but one size doesn't fit all. The facility has some duty to match the patient to the available services (and to the patient mix that the patient will encounter while in the program).

Staff Credentialing

When staff provide clinical services, such as evaluations, screening for symptoms or suicide risk, or counseling, staff credentialing for individualized assessment and treatment becomes an important issue. Generic group counseling or education is not sufficient for patients who need focused antidepressant programs, for example, nor is the documenting of rote-sounding questions and answers by an aide with little training often adequate for routine suicide risk assessment.

Seclusion and Restraint Settings and Procedures

Settings and procedures related to the use of seclusion and restraint are a common source of potential problems. Adequate monitoring is particularly important. I am concerned about some facilities' increasing reliance on video cameras. Although efficient, video often does not take the place of in-person observation. Monitors in nurses' stations are frequently unattended, with no one specifically assigned to pay attention to the patient on the screen. In addition, one may not be able to see patient details well (e.g., to check the patient's breathing or expression), and it takes time to get to the patient if a problem is recognized. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) offers publications and accreditation requirements that are a good resource for guidance in this area, with references to the physical characteristics of seclusion rooms and restraint settings, staff training and procedures, and similar topics.[4]

Facility and Unit Security

Issues related to facility/unit security are sometimes cited in lawsuits in which a patient has eloped, attempted suicide on the unit, been injured in some sort of disaster (such as a fire), or been injured by an intruder (such as an angry former patient). Each of these categories suggests a different set of precautions, with the overriding principle being environmental safety with respect to both staffing and architecture.

Protection from Other Patients

Patients are hospitalized in order to increase the probability that they will improve and decrease the risk that they will experience harm. We tell patients and their families that the hospital is a safe place; patients have what lawyers call a "reasonable expectation" of safety while there. Nevertheless, many are concerned about being injured by other patients.

Patient-on-patient assault is uncommon, but not rare. Serious injury from such assaults is rare, but not unknown. Protection of patients is much more a staffing issue than an architectural one. In lawsuits concerning patient-to-patient injury, the allegation is rarely that the patients should have been locked away from each other, but usually that there were insufficient staff to monitor the unit and/or manage an allegedly known risk (or that the unit was inappropriate for one or both patients).

Think of it this way: Would you be comfortable spending a couple of days (and nights) on one of your hospital's acute care units? Consider actually doing so. I've done it and recommended it to trainees for years.

DUTIES ASSOCIATED WITH CO-THERAPY AND REFERRALS TO OTHER CLINICIANS

Co-therapy (co-treatment, split therapy) is (in this context) the sharing of mental health treatment by two or more professionals. It often consists of a psychiatrist or other physician who prescribes medication for a patient who is receiving counseling from a nonmedical professional. The plan may be for the psychiatrist to provide medication, to share clinical responsibility, or to provide supervision.

The word "plan" in the last sentence is important. The law often views the psychiatrist as having more duty to the patient than the doctor realizes. Those who accept jobs or roles in which they naively write prescriptions for a counselor's clients every 2 or 3 months, believing they are not really involved in the patient's week-to-week treatment, are likely to be wrong. If a treatment-related tragedy occurs, they may find it difficult to explain their lack of knowledge of, or involvement in, the patient's overall care.

Dr. Thomas Gutheil has published important recommendations for psychiatrists engaging in joint treatment, the "8 Cs of Collaborative Treatment," which are

summarized in a recent article co-authored with Robert Simon.[5] Co-treaters should:

- Assure *clarity* between themselves about what each will do (e.g., whether the relationship is supervisory or complementary, vacation coverage).
- Create a *contract* or other clear understanding spelling out the above. In the absence of a written agreement, later reviewers may assume that the psychiatrist had a substantial duty, responsibility, and/or supervisory role.
- *Communicate* regularly.
- Have routine *contact* (not just during crises).
- Tell the patient about the treaters' roles and open communication, so he or she can *consent* to them.
- Share a *comprehensive view* of the patient, particularly when the psychiatrist sees the patient only infrequently (neither party should view the psychiatrist as merely a prescription writer).
- *Credential* each other, reasonably verifying the other's professional background (especially important when the two have little experience with each other; it need not reach the level of hospital credentialing).
- Feel free to instigate *consultation* when there are disagreements about patient care or any of the above.

Referring patients to other clinicians demands some of the same care. One should be aware of the colleague's qualifications and suitability for the patient's needs. If you must refer through a list of psychiatrists or therapists with whom you have no personal experience (such as to clinicians who are simply on a patient's managed care panel), consider adding a disclaimer to the patient about your lack of knowledge. Any comment such as "Mr. X is a fine counselor" may be viewed as an indication that you know and trust that clinician.

EMPLOYEE HARASSMENT AND EEO ACTIONS THAT BECOME MALPRACTICE

Alleged harassment or violation of Equal Employment Opportunity Commission regulations does not usually raise questions related to malpractice. I have seen several cases, however, in which the plaintiff's best cause of action against the organization—and the most likely path to individual or organization insurance money—was in trying to establish a clinician-patient relationship between a clinician and an employee.

For example, under many circumstances, an employee's or trainee's allegation of sexual activity with a staff member might be viewed by a court as consensual. If, however, she alleges that a clinician-patient relationship exists, the alleged sexual behavior could become a matter of clinical boundaries, and thus more likely to establish a credible cause of action for which the organization may have some responsibility. In addition, informal counseling or prescribing for an employee or associate is often carried out without very much examination, record keeping, or follow-up, all of which could suggest practice below the standard of care.

Lots of things can (but don't necessarily) create the clinician-patient relationship that is important to implying a legal "duty of care." Prescribing for employees or associates is probably the most common one, but performing a brief examination (such as looking into someone's throat or ear) or offering clinical advice may also raise a question about whether or not a doctor-patient relationship exists. One should note that we clinicians are viewed differently from nonprofessionals in this regard. Our training and licensure, sometimes coupled with the setting (such as a healthcare workplace) and an expectation of care, may give our actions special legal meaning.

THE LAST WORD

Independently licensed clinicians who work for, or otherwise practice in, healthcare organizations often have duties of care that extend beyond the simple concept of *respondeat superior*. This affects the liability of both the individual practitioner and the organization. Know your duties and responsibilities.

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