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Malpractice Arising From Negligent Psychotherapy: Ethical, Legal, and Clinical Implications of *Osheroff v. Chestnut Lodge*

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Traditionally, there have been few legal actions brought against psychotherapists that allege negligent psychotherapy and negligent treatment of psychiatric disorders. However, in the case of *Osheroff v. Chestnut Lodge,* a patient–physician (Dr. Osheroff) sued Chestnut Lodge, a private psychiatric facility, for negligence based on the staff's decision to apply a psychodynamic model of treatment (through psychotherapy) and not a biological model. The case sparked a heated debate between adherents of the psychodynamic model and those of the biological model. This article explores the implications of the *Osheroff* litigation for mental health professionals. It is proposed that an interactive informed consent process be used to protect psychotherapists against *Osheroff*-type litigation.

Key words: *Osheroff v. Chestnut Lodge,* negligent treatment, psychotherapy, ethics

PSYCHOTHERAPISTS' LIABILITY FOR INJURIES TO PATIENTS

Theories of Liability

What are the primary social functions of law? Clearly, one major function is adjudicative dispute settling; another is maintaining order (Mermin, 1973). However, there is more to our legal system than settling disputes and maintaining order. The system constitutes a framework within which certain common

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expectations about the transactions, planned happenings, and accidents of daily life can be met. It is expected that those who have made promises will be held to their promises under the laws of contract, and those who have suffered personal injuries will be compensated for their injuries under the laws of tort (Mermin, 1973).

A *tort* is a civil wrong committed by one individual, known as the defendant, who has caused harm to another individual, known as the plaintiff (Simon, 1992). Most liabilities in tort are founded on the "infliction of harm which the defendant had a reasonable opportunity to avoid at the time of the acts or omissions which were its proximate cause" (Holmes, 1963, p. 116). Malpractice is classified in legal terms as a tort action. In the common law, there is a set of torts—assault, battery, and false imprisonment—to cover cases of intentional injury (Pound, 1978). Negligence, another ground of tort liability, is a principle of duty to answer for injuries that result from failure to meet a legal standard of conduct governing affirmative courses of action (Pound, 1978). In malpractice litigation, negligence is the predominant theory of liability. Malpractice is a negligent act committed by a professional that harms another (Malcolm, 1987).

This article focuses on the liability of psychotherapists for injuries arising from negligent therapy. The term *psychotherapist,* as used in this article, includes psychiatrists, psychologists, or other mental health practitioners who are either licensed by the state or members of professions sanctioned by the state. Thus, qualified and licensed practitioners of psychotherapy are included. In cases involving a professional psychotherapist, an action clearly may be based on a theory of malpractice.

Proving Psychotherapeutic Malpractice

Allegations of malpractice are a startling reality in modern psychiatric and psychological practice. Common forms of malpractice include failure to obtain informed consent, breach of confidentiality, abandonment, improper or negligent diagnosis, negligent use of somatic therapy, physical contact and sexual relations with patients, and negligent supervision or referral. In a cause of action based on malpractice against a psychotherapist, the elements of proof are the same as in other medical and malpractice actions generally.[1] The plaintiff must establish four elements: (a) that a duty of care was owed by the psychotherapist to the plaintiff; (b) that the psychotherapist violated the applicable standard of care (breach of duty); (c) that the plaintiff suffered a compen-

[1]Most of the reported cases and legal articles have involved actions brought against psychiatrists alleging liability for injuries sustained as a result of a psychiatrist's negligent conduct. From a legal perspective, these cases are typically considered under the more general heading of medical or psychiatric malpractice.

sable injury; and (d) causation—that is, that the plaintiff's injury was caused in fact and was proximately caused by the defendant's substandard conduct (Prosser, 1971). However, there are particular problems of proof encountered in proving psychotherapeutic malpractice. A major difficulty includes determining the applicable standard of care. The legal ambiguity of the respectable minority rule further adds to the problem of determining the applicable standard of care (Furrow, 1980).

Standard of care. In the courtroom, mental health professionals are generally held to their respective standards of care, as determined by expert witnesses. Psychiatrists are held to the provision of the skill and care of a professionally qualified psychiatrist, and psychologists to the provision of the skill and care of a professionally qualified psychologist. Thus, in malpractice cases, the customary practices of the specialty within the profession generally set the standard of care (Furrow, 1980). The weight accorded professional standards is a central question. Should conformity to the professional standard conclusively establish the defendant's due care, or should it simply constitute evidence of due care that the finder of fact may accept or reject (Furrow, 1980; King, 1986)? The majority of courts seem to treat professional standards as conclusively establishing the standard of care for negligence (see *Chiero v. Chicago,* 1979; Prosser, 1971). The medical and mental health professions are allowed to set their own standards of care largely because of the court's perceived lack of expertise in judging another profession, and the fear of imposing liability based on an uninformed judgment (Furrow, 1980; Prosser, 1971).

At least one landmark case has rejected the conclusiveness of the professional standard. In *Helling v. Carey* (1974), the plaintiff sued defendant opthalmologists for failing to diagnose glaucoma in time to prevent serious impairment of her vision. The defendants had treated the plaintiff for nearsightedness for a number of years. Because there was no indication that the plaintiff's symptoms required a glaucoma test significantly sooner than the date on which it was finally administered—she was tested approximately 1 month after the onset of the relevant symptoms—the issue for the court was whether the physicians should have routinely tested the plaintiff's intraocular eye pressure years earlier. Expert testimony established that the standards of the medical specialty of opthalmology did not then require routine glaucoma testing for persons under 40 years old. For such persons, the incidence of glaucoma was estimated as 1 in 25,000. But the Washington Supreme Court held the defendants negligent as a matter of law for not having routinely administered the glaucoma test to this plaintiff at an earlier stage, presumably years earlier. The court based its decision on its perception of the relative cost, safety, simplicity, and definitiveness of the pressure test as compared with the seriousness of the untreated disease. Thus, it rejected the conclusiveness of the

standard of the profession as applied to the facts of that case. Not only did the *Helling* court reject the conclusiveness of professional standards, it also found negligence as a matter of law, rather than leaving that question to the jury. Despite *Helling,* the trend from case law and statutes appears to be in the direction of affording greater weight to professional standards (Malcolm, 1987).

Respectable minority. A large stumbling block that the plaintiff must overcome in a medical malpractice action is the respectable minority rule. In fields as complex as medicine, psychiatry, and psychology, there will seldom be complete agreement on the proper therapeutic approach for a particular medical or psychological condition. Courts have recognized that they are ordinarily not in the best position to decide among competing regimens of diagnosis and treatment (King, 1986). The majority of courts agree that a practitioner should not be penalized for following a course approved by at least a respectable segment of his or her profession (King, 1986).

In response to the need to accommodate differing medical approaches and points of view, courts developed the respectable minority rule. The rule allows defendant–physicians to defend against a negligence suit by showing that their conduct conformed to a minority school within the profession. Such conduct is usually held to be nonnegligent even though most professionals would not follow it (Furrow, 1980; Prosser, 1971). In the view of one court, "physicians do not incur liability merely by electing to pursue one of several recognized courses of treatment" (*Downer v. Veilleux,* 1974, p. 87). Similarly, in *Chumbler v. McClure* (1974), the court noted that "the test for malpractice . . . is not to be determined solely by a plebiscite" (p. 492). Accordingly, a professional who follows a particular school of thought is judged by the standards of that school. A "school" must be a recognized one with definite principles (Prosser, 1971). In order to profit from this protection, the defendant's school must have the support of a body of competent medical opinion (Furrow, 1980). The traditional concern of the law has been to prevent a quack or charlatan from setting himself or herself up as a "school" and applying his or her individual ideas without liability. Thus, a school must be grounded in sound scientific principles that are attested to by professional expert witnesses (Furrow, 1980; Prosser, 1971).

Courts have not yet resolved the question of what constitutes a respectable minority or acceptable support for a particular approach (King, 1986). It is unclear whether the answer depends on the sheer number of practitioners endorsing a specific practice or on some other criteria such as the professional standing of those supporting such an approach (King, 1986; Malcolm, 1987). On occasion, courts have adopted relaxed standards, finding that a respectable minority can be quite a small number. For example, in a malpractice action against a surgeon (*Hood v. Phillips,* 1976), the court found the defendant not

liable of malpractice for performing an unnecessary and highly controversial surgical procedure. The court reasoned that there was evidence that this procedure was used by six other physicians in the world. The court arrived at this decision even though the majority of the medical community considered the surgical procedure to be below minimum standards of medical treatment, have no medical justification, and be potentially quite dangerous. In another case involving a controversial procedure (*Leach v. Bralliar,* 1967), a physician was found negligent because his procedure varied from the accepted procedure of a respectable minority. Importantly, the court implied that had the defendant's procedure been in accord with the respectable minority, liability would not have been imposed even though the respectable minority consisted of 65 physicians throughout the United States.

Innovative Treatments and Therapies

The aforementioned cases raise additional concerns. If there is to be medical progress, professional standards must be defined broadly enough to accommodate sound innovation (King, 1986). On the other hand, patients deserve protection against ill-considered, untested medical procedures, especially when traditional acceptable therapies exist. With respect to therapeutic innovation, some authorities advocate liability for any departure from well-established practices and have implied that a physician should be held strictly liable for employing "experimental" procedures (King, 1986). A rule requiring conformity to a narrowly defined professional standard (or to an approach sanctioned by at least a respectable minority) could conceivably impose liability for any departure from the medical mainstream.

Under a more flexible approach, there would not automatically be a finding of liability, even if one's diagnostic or therapeutic approach did not fall within either the prevailing medical practice or that of a respectable minority (King, 1986). Rather, liability for a practitioner's choice of medical procedure would depend more on whether the defendant undertook a treatment approach that a "reasonable and prudent member of the [particular] profession would undertake under . . . similar circumstances" (*Hood v. Phillips,* 1976, p. 291). Relevant factors might include the effectiveness, availability, and relative safety of more traditional alternatives; the level of the patient's understanding of the risks, benefits, and alternatives to the procedure; and the quality and extent of research that preceded the use of the procedure in question. In short, although professional standards should be accorded conclusive weight when the defendant conforms to them, the defendant who departs from the customary practices should be afforded the opportunity to prove that his or her decision was reasonable (King, 1986). Under appropriate circumstances, reasonable innovation might be consistent with acceptable medical practice, particularly under a liberal interpretation of the respectable minority rule (King, 1986).

Legal Considerations and Strategies

From a legal perspective, depending on the case, the expert witness will attempt to put the defendant in the mainstream of practitioners. A fall-back position suffices that fits the practitioner into a respectable minority of the field (McDonald, 1992). In unusual cases, an attorney may have no choice but to argue that the defendant acted far ahead of what passed as good practice among orthodox peers (McDonald, 1992). As McDonald stated, the political concept that the majority is always right does not fit very well in the dynamics and controversy of medicine and psychotherapy. Today's reputable minority may well supplant the others and become tomorrow's prevailing majority. For example, Dr. Christiaan Barnard no doubt at one point constituted a minority of only a handful of physicians who believed that heart transplantation could work. Moreover, "in the 19th Century, Oliver Wendell Holmes (the elder), in America, and Ignaz Semmelweis (in Austria), counted as a minority of two in the whole world, to the hoots of about everybody else, who advocated handwashing before surgery" (p. 259). Virtually every malpractice matter that goes to trial illustrates the fact that the art of medicine rarely can proceed by blueprint.

REVIEW OF MALPRACTICE ACTIONS BROUGHT AGAINST PSYCHOTHERAPISTS

Actions Subject to Legal Action

The law considers psychotherapy to be inexact, evolving, and based on principles difficult to measure and quantify (Simon, 1992). Thus, malpractice lawsuits for negligent psychotherapy, misdiagnosis, and negligent treatment are infrequent and typically unsuccessful (Simon, 1992).[2] In theory, establishing a breach of the defendant psychotherapist's duty of care is much more difficult in an action for alleged malpractice in the administration of a particular mode of psychotherapy than it is in an action for malpractice in the administration of a somatic type of therapy, such as electroshock therapy, chemotherapy, or psychosurgery. In somatic therapy, the body itself is physically affected. This makes alleged malpractice in the use of such therapy similar to that of the typical medical malpractice action. In the handful of reported decisions that

[2]One study found that psychiatric claims accounted for only a small percentage (0.3%) of the total claims against physicians (Slawson & Guggenheim, 1984). The incidence of malpractice claims against psychiatrists has risen from 0.6 claims per 100 in 1980 to 4 claims per 100 in the latest studies (Kull, 1991). The overall rate of malpractice suits against psychologists is relatively low. In the past 14 years, only 0.5% of all psychologists insured by the American Psychological Association Insurance Trust have been sued for any reason. Pope (1989) found that 13.2% of the total claims and 8.4% of the total cost of malpractice actions involving psychologists were for claims alleging incorrect treatment.

actually involve malpractice in psychotherapy, proof of the defendant clinician's breach of his or her duty of care was demonstrated with little difficulty because he or she had been engaged in extremely unprofessional conduct.

For example, in *Zipkin v. Freeman* (1968) the defendant–psychiatrist was sued for negligent psychotherapy due to his mishandling of the transference phenomenon. The plaintiff went to see the defendant, as recommended by her family physician, for the treatment of severe headaches of unknown etiology. After 2 months of psychotherapy, which consisted of conversations about her family life and feelings toward her husband, the plaintiff sought to terminate because her symptoms had been alleviated. The defendant persuaded her to remain in treatment. As the treatment progressed, the plaintiff described intense feelings of love for the defendant. As a result, she was willing to comply with anything he asked. At the defendant's direction, the plaintiff left her husband and became the defendant's mistress. The plaintiff filed spurious lawsuits against her husband and brother because the defendant told her it would help release her hostility. The defendant also persuaded her to invest in the defendant's farm, turn over child support money to him, and take trips with him. The court awarded the plaintiff damages for, among other things, remorse, humiliation, mental anguish, and nervousness. In rendering its decision the court referred to defendant's behavior as negligence in mishandling the transference phenomenon.

Another malpractice suit, *Hammer v. Rosen* (1960), involved an action against a psychiatrist who had beaten his schizophrenic patient on several occasions during 7 years of psychotherapy. The defendant's psychoanalytic theory involved striking patients on occasion. Although the therapy was novel, it was respected by some of his colleagues and believed to be beneficial. The New York Court of Appeals held that the lower court should have submitted the case to the jury, and that, on the evidence presented, a jury would have been warranted in finding that the defendant's acts had caused the plaintiff pain and suffering. Although the defendant argued that there was no expert testimony to support the malpractice claim, the court noted, "the very nature of the acts complained of bespeaks malpractice" (p. 757) and improper treatment. Moreover, if the defendant chose to justify those acts as proper treatment, he had to offer evidence to that effect. That is, the psychotherapist had the burden of proving that his unusual theories of treatment conformed to the professional standard of care.

In electroshock therapy and insulin shock therapy litigation, the plaintiff ordinarily seeks damages for a fracture that he or she sustained during the defendant's administration of the therapy. In such litigation, however, the defendant's negligence is difficult to prove because such fractures are a commonly known consequence of undergoing the therapy, even when it is properly administered (*Farber v. Olkon,* 1953). Therefore, instead of attempting to prove negligence in the administration of the therapy, the plaintiff often bases the suit on the defendant's alleged negligence in failing to obtain the plaintiff's

informed consent to treatment. Nevertheless, in some cases, courts have indicated that the defendant psychiatrist can be held liable for negligence in causing the plaintiff's injuries. This is especially true where the plaintiff proves that the defendant—despite the plaintiff's complaints of pain and injury following the first treatment—continues to administer further treatments without properly investigating the plaintiff's complaints or symptoms of injury (*Eisele v. Malone,* 1956). In one case, the court held that the plaintiff's evidence would have permitted the jury to infer (a) that the plaintiff had suffered an injury as a result of the first of a series of shock treatments; (b) that the plaintiff had immediately complained of this injury to the defendant; (c) that the defendant had known about the plaintiff's persistent suffering; (d) that the indications of injury were sufficient to put the defendant on notice of a potential fracture; and (e) that notwithstanding this notice, which x-rays would have confirmed, the defendant made insufficient efforts to discover whether a fracture had in fact occurred (*Stone v. Proctor,* 1963).

In sum, courts have found certain abuses—exploiting the transference relationship, physical beatings, and shock therapy—subject to legal action. As detailed in the following section, a cause of action for alleged negligent treatment and misdiagnosis also exists where a psychiatric disorder is treated exclusively by psychotherapy when proven effective biological treatments exist (Simon, 1992).

Osheroff v. Chestnut Lodge: Wave of the Future

In a well-known treatise, Gutheil and Appelbaum (1982) commented that misdiagnosis of psychiatric conditions "is a ripe area for future litigation and for consciousness raising" (p. 151) in the mental health profession. *Misdiagnosis* refers to a negligent failure to recognize the nature of the patient's condition and then to implement proper measures before harm occurs. In our view, clinicians at high risk are those who rely entirely on psychotherapeutic approaches for all patients and who do not refer patients for whom pharmacotherapy might be appropriate to more biologically oriented colleagues.

In a case of first impression, *Osheroff v. Chestnut Lodge* (1985), a patient, who was also a physician, sued a private psychiatric facility for negligence because the staff had failed to prescribe medication and had instead treated him according to the psychodynamic model.[3] The patient's psychiatric experts

[3]In the lawsuit, an arbitration panel found in the plaintiff's favor and issued an award in the amount of $250,000. Both parties appealed the arbitration findings to court. Before trial, the case was settled for an undisclosed amount (*Osheroff v. Chestnut Lodge,* Simon, 1992; 1985). Although the case has no precedential value and is not a binding decision, the arbitration panel's award should give serious pause to mental health professionals who rely exclusively on the psychodynamic treatment model (Stone, 1984).

diagnosed him as having a biologic depression. The private psychiatric hospital contended that the patient was properly diagnosed as having a narcissistic personality disorder.

Factual history. The patient, Dr. Raphael Osheroff, was a 42-year-old White male physician.[4] He was admitted to Chestnut Lodge in January 1979. Osheroff had completed medical school, residency, and internship and had become a subspecialist in nephrology. He was married and had three children. Osheroff was married three times before his hospitalization.

Dr. Osheroff's first marriage began while he was in college and ended in divorce after 21 months because his wife had allegedly been unfaithful. He thought of leaving medical school but saw a psychiatrist who convinced him to return. During internship, Osheroff met and married a nurse. That second marriage lasted much longer but deteriorated after the birth of two children. Osheroff saw a psychiatrist again during these years while he was establishing his practice. According to Osheroff,

> All during the early years of my second marriage, I had been rather immature and insensitive and my energies seemed to be so devoted to and focused on my career, that I perhaps was not listening and if I was listening, perhaps I wasn't hearing. I was seemingly oblivious to the stresses that were developing in my marriage. (Stone, 1990, p. 421)

Psychotherapy for Osheroff and marital therapy for the couple did not save the marriage. His second wife eventually left the children with him and went off with another man. Though not overweight, Dr. Osheroff claimed to have lost 40 pounds during this time, living "a life that was almost devoid of the usual types of satisfaction" (p. 422). His nephrology practice nonetheless grew and prospered. He then met his third wife, a medical student, and married her after a whirlwind romance. This was at first a happy and successful marriage, and symptoms of depression apparently disappeared. There were continuing conflicts with his second wife, who now wanted custody of their two children. Conflict also began with his third wife. According to her, the conflicts were precipitated by his seemingly inconsiderate behavior during the birth of their first child and his lack of attention to the baby and to her.

Dr. Osheroff also began to have serious disagreements with his professional associates in practice. Because of these conflicts and the deterioration of his marriage, he saw at least three different psychiatrists, two of whom prescribed antidepressants, which were not successful. Apparently Osheroff was reluctant to use this medication. His condition worsened. Osheroff admitted himself into Chestnut Lodge in January 1979.

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[4]Factual history and legal arguments are supplied by Klerman (1990), Malcolm (1987), and Stone (1984, 1990).

Osheroff was hospitalized at Chestnut Lodge for approximately 7 months. During this time, he was treated with individual psychotherapy four times a week. He lost 35 lb, experienced severe insomnia, and had marked psychomotor agitation. His agitation was manifested by incessant pacing and was so extreme that his feet became swollen and blistered.

The patient's family (mother and stepfather) became distressed by the length of the hospitalization and by his lack of improvement. They consulted a psychiatrist, who spoke to the hospital leadership on the patient's behalf. In response, the Chestnut Lodge staff held a case conference to review the patient's treatment. They decided against making any major changes—specifically, not to institute any medication but to continue the intensive individual psychotherapy. Dr. Osheroff's condition continued to worsen. At the end of 7 months, his family had him discharged and admitted to Silver Hill Foundation.

On admission to Silver Hill, Dr. Osheroff was diagnosed as having a psychotic depressive reaction. Although one of his treating physicians considered the diagnosis of personality disorder, she did not put this diagnosis in the admitting chart because it (personality disorder) was not preeminent at the time. His treating physician began treatment with a combination of phenothiazines and tricyclic antidepressants. Osheroff showed improvement within 3 weeks and was discharged within 3 months. His final diagnosis was manic-depressive illness, depressed type. One of the Silver Hill physicians later testified that she did not find evidence of a narcissistic personality disorder in Dr. Osheroff and that the correct diagnosis according to terminology used in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed. [*DSM–III*]; American Psychiatric Association, 1980) would be major depressive episode with psychotic features.

Following discharge from Silver Hill in the summer of 1979, Osheroff resumed his practice. He was in outpatient treatment, receiving psychotherapy and medication. Sources (Klerman, 1990; Malcolm, 1987; Stone, 1984, 1990) indicate he has not been hospitalized and has not experienced any episodes of depressive symptoms severe enough to interfere with his professional or social functioning. He has resumed contact with his children and become active socially.

Initiation of malpractice action. In 1982, Osheroff initiated a malpractice suit against Chestnut Lodge. He alleged, among other things, that the defendant was negligent in the following ways: (a) Chestnut Lodge failed to diagnose by appropriate means a biologic depression, (b) Chestnut Lodge negligently failed to treat this biologic depression by appropriate biological means, and (c) Chestnut Lodge failed to obtain the informed consent of the patient by failing to disclose to and discuss with him alternative therapeutic modalities and the costs and benefits of each of these alternatives.

Chestnut Lodge responded to the suit primarily by defending its original diagnosis of narcissistic personality disorder.

Parties' legal arguments. The *Osheroff* litigation became a source of an intense debate concerning biologic versus psychodynamic treatment of psychiatric disorders (Klerman, 1990; Stone, 1990).[5]

In his suit against Chestnut Lodge, the plaintiff alleged that the defendant had failed to diagnose a biologic depression. With respect to the standard of care for negligent diagnosis, Dr. Gerald Klerman (one of the plaintiff's retained expert witnesses) pointed out that narcissistic personality disorder was not listed in the *Diagnostic and Statistical Manual of Mental Disorders* (2nd ed. [*DSM–II*]; American Psychiatric Association, 1968). Therefore, Chestnut Lodge had been negligent in using a diagnosis not listed in psychiatry's official nomenclature. He also stated that the psychiatric experts did not agree on the validity of the diagnosis. One expert who did not accept the diagnosis of narcissistic personality disorder noted the patient's successful life achievements before the onset of the illness, including his professional success and his loving and sensitive relationship with his children.

Dr. Alan Stone (one of the defendant's retained expert witnesses), pointed out that the *DSM–II* was not regarded with the same authority as its successors. Psychodynamic etiological diagnoses are common even if they are not in the *DSM–II.* The defendant's diagnosis of narcissistic personality disorder was not evidence of negligence, especially because a diagnosis of affective disorder was also made.

The plaintiff also alleged that not only had Chestnut Lodge negligently failed to diagnose biologic depression, but they failed to treat it appropriately. The plaintiff directly challenged advocates of the psychodynamic model by claiming that the law should regard as negligence per se the treatment of serious mental disorders through psychotherapy alone. In Dr. Klerman's view, the most scientifically valid evidence as to safety and efficacy of a treatment comes from randomized controlled trials. As for the plaintiff's narcissistic personality disorder, there were no reports of controlled trials of any pharmacological or psychotherapeutic treatment for this condition. With regard to the psychotic depressive reaction, there was good evidence for the efficacy of two biological treatments—electroconvulsive therapy and the combination of phenothiazines and tricyclics. No clinical trials supported the claims for efficacy of psychoanalysis or intensive individual psychotherapy based on psychoanalytic theory for any form of depression. According to Dr. Klerman, Osheroff's remarkable cure at Silver Hill is attributed to the combination of phenothiazines and tricyclic antidepressants.

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[5]The alleged malpractice took place in 1979. Therefore, the applicable legal standard of care is the accepted practice of the psychiatric profession at that time.

The defendant's psychiatric experts claimed that they chose not to treat Osheroff's depression through medications because they believed it would be deleterious to their primary goal—treatment of the narcissistic personality disorder. They also feared that medication might increase the plaintiff's resistance to psychotherapy. Dr. Stone stated that the initial treatment program was acceptable given Osheroff's history of previous unsuccessful drug treatment. In addition, the breakdown of Osheroff's third marriage and his professional conflicts that precipitated hospitalization were examples of psychosocial crises that destroy the balance of the narcissistic personality disorder.

The defendant offered a different explanation for Osheroff's marked improvement when he changed hospitals. At Chestnut Lodge, Osheroff developed a negative therapeutic reaction and negative transference to the hospital and therapist. Osheroff was in revolt against his treatment. According to Dr. Stone (1990), Dr. Osheroff's response to the second hospitalization, as described in his autobiography, "suggests that other equally important psychodynamic factors were involved. He had escaped, if not narcissistically triumphed over Chestnut Lodge and his therapist. His negative transference had been vindicated" (p. 423).

In another cause of action, Dr. Osheroff alleged that Chestnut Lodge had failed to obtain his informed consent to treatment, that is, Chestnut Lodge had failed to discuss the pros and cons of alternative treatment modalities with him, and their negligence had caused him harm. Chestnut Lodge claimed therapeutic privilege. This privilege allows clinicians to withhold information they would otherwise have to disclose if the effect of disclosure would be "harmful" to the patient (Malcolm, 1987). Chestnut Lodge argued that given Dr. Osheroff's narcissistic personality disorder, the disclosure of the required information might have interfered with the treatment process offered by Chestnut Lodge or might have led Dr. Osheroff to refuse consent to the proposed treatment altogether (Malcolm, 1987).

Respectable minority of psychotherapists. Traditionally, psychotherapists have been able to defend their actions against a negligence cause of action by showing that, given the patient's condition, their diagnosis and proposed treatment accorded with the practices of a respectable minority (Malcolm, 1987). In psychotherapy, the "custom" defense (i.e., customary practice of a profession) assumes a broad scope because of the respectable minority rule. Indeed, in psychotherapy, respected minorities are legion (Harris, 1973).

> Statistically, [psychiatrists and psychologists] can be expected to agree only 54 percent of the time. (Ziskin). That rate of agreement is only slightly better than the law of averages.
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> Disagreement is so common because the opinions of psychiatrists and psychologists are determined as much by their own personal biases and values as

they are by any fixed body of psychiatric or psychological knowledge. *Id.* at 286. Ennis, "Trial Techniques," in Ennis & Siegel, *The Rights of Mental Patients* (ACLU Handbook, 1973)

In this litigation, Chestnut Lodge's experts argued that a respectable minority of the profession would have treated Dr. Osheroff as Chestnut Lodge had, through psychotherapy alone. Dr. Stone (1990) noted that the respectable minority concept was "intended to protect scientific innovation and the diversity of reasonably prudent professional opinion and different approaches to the practice of the healing arts" (p. 425) against rigid orthodoxy in the standard of care.

On the other hand, the plaintiff's experts contended that the treatment rendered the defendant was no longer defensible by even a respectable minority of the mental health profession. Dr. Klerman stated that *Osheroff v. Chestnut Lodge* prompted a reevaluation of the respectable minority doctrine (Klerman, 1990). He proposed that the respectable minority doctrine no longer holds if there is a body of evidence supporting the efficacy of a particular treatment and agreement within the profession that this is the proper treatment of a given condition. Dr. Klerman was ready to discard the respectable minority rule on scientific grounds: In the absence of new efficacy studies, exclusive use of psychodynamic therapy or other therapies that are not scientifically substantiated is improper (Stone, 1990).

Courts have traditionally not questioned the practice of a respectable minority of mental health professionals in a medical malpractice action (Malcolm, 1987). In *Osheroff,* however, the plaintiff's biologically oriented psychiatric experts were arguing that it should be considered negligence per se to treat serious mental disorders exclusively within the psychodynamic model, even though a respectable minority of psychotherapists might support the use of such treatment (Malcolm, 1987).

Psychotherapists offer a wide variety of theoretical approaches in the treatment of mental disorders.[6] Lazare (1973) described contemporary psychiatry as operating under four different conceptual models: biological, behavioral, psychodynamic, and sociocultural (Stone, 1984). Under the relaxed standards of the *Hood* and *Leach* cases, it would be extremely difficult to impose liability on clinicians who practiced a variation of the four conceptual models (Malcolm, 1987; Simon, 1987). In fact, Dr. Klerman acknowledged that a rather large minority—if not majority—of clinicians use psychotherapeutic techniques and avoid biological treatment for treating personality disorders (Malcolm, 1987). On the other hand, a court following and extending the reasoning of the *Helling* court could choose to hold the use of an outdated psychotherapeutic procedure negligent as a matter of law, even though it was es-

[6]Currently, over 450 schools of psychotherapy exist (Simon, 1992).

poused by a respected minority or a majority of psychotherapists within the mental health field.

Ramifications of Osheroff. In light of the *Osheroff* litigation, Dr. Klerman (1990) set forth five specific recommendations for mental health professionals:

1. The clinician has a responsibility to make a comprehensive assessment including a proper diagnosis. The formulation should be in accord with the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., rev. [*DSM–III–R*]; American Psychiatric Association, 1987).
2. The clinician has a responsibility to inform the patient as to his or her diagnosis. This should be communicated in a manner consistent with *DSM–III–R* criteria.
3. The clinician has a responsibility to provide information as to alternative treatments. The patient has the right to be informed as to the alternatives available, their efficacy, and their likely outcomes. This is a special requirement for the respectable minority in that they should inform the patient that their treatment is not the one most widely held within the profession.
4. The clinician has a responsibility to provide proper treatment. Proper treatment involves those treatments for which there is substantial evidence.
5. The clinician has a responsibility to modify treatment plans or seek consultation if the patient does not improve.

In Dr. Stone's (1990) view, the first responsibility forces the traditional mental health professional into the scientific paradigm urged by Klerman. With regard to the second recommendation, Stone valued *DSM–III–R* as a basis for reliable communication among clinicians. However, he did not hold that the *DSM–III–R* formulation should necessarily be shared with patients—a psychodynamic formulation may be more helpful to them. He further contended that one of a clinician's professional responsibilities is to help patients understand their problems. Accordingly, informed consent is an essential principle of psychotherapy. "But informed consent is a process, not an immediate one-time recitation of a formula regardless of the actual situation" (p. 425).

Stone noted that the responsibility to describe alternative treatments is heaviest on traditional psychotherapists, whom Klerman relegated to a respectable minority. They were to familiarize themselves with the claims of scientific efficacy put forth by all other therapies, present them to the patient, and inform the patient that their traditional psychotherapy has no demonstrated efficacy. According to Stone, Klerman's approach repudiates the traditional commitment of both psychiatry and the law to diversity (Stone, 1990).

Klerman's fourth recommendation concerns proper treatment. In his view,

proper treatment includes those treatments for which there is substantial evidence. He believed that there is no such substantial evidence for traditional psychotherapy in the treatment of any *DSM–III–R* disorder. Stone (1990) pointed out that, under Klerman's recommendation, clinicians who apply traditional psychotherapy cannot claim to provide effective treatment. "This criterion might raise the specter of malpractice not for a respectable minority but for the majority" of psychotherapists "who . . . in some of their clinical practice provide such treatments to patients with *DSM–III–R* diagnoses" (p. 426).

Stone and Klerman agreed on the final recommendation—to consult and refer. This is a well-established legal and ethical principle in the mental health profession. It is especially important to consult colleagues and experts when a patient's condition is obviously deteriorating on a given regimen of treatment (Stone, 1990).

Perhaps the most important concept that Klerman and Stone addressed is the notion of informed consent. A patient who is properly informed of the risks and benefits of specific psychotherapies is less likely to launch subsequent litigation.

INFORMED CONSENT: SHARING AUTHORITY

The number of medical malpractice claims against psychotherapists has traditionally been substantially lower than against other medical practitioners (Malcolm, 1987). Psychoanalysts and psychodynamic therapists have, to this point, been practically immune from lawsuits because of legal and technical reasons (Furrow, 1980; Stone, 1990). However, disgruntled plaintiffs–patients who are dissatisfied with their lack of improvement after long-term psychodynamic therapy may have found a legal avenue to redress their grievances. Like Dr. Osheroff, these patients may now be able to sue their psychotherapists for malpractice because biological treatments were not administered (Stone, 1990).[7] They may also argue that the informed consent doctrine requires that patients be fully informed of alternative, available treatments.

Malcolm (1987) argued that a likely response to an increase in malpractice litigation would be the practice of defensive medicine. Thus, it is feasible that *Osheroff*-type lawsuits would induce psychodynamic professionals to act de-

[7]The psychodynamic therapist who refers the patient to alternative treatments, such as medication, is not immune from liability. Other areas of liability could be derived from the general heading of negligence in exercising the duty of care, including failure to make a referral when it was necessary to do so or referring the patient to the wrong treatment modality or wrong person. Each of these negligent acts demonstrates a mental health professional's general breach of the duty of care and can be considered malpractice if it proximately causes a patient harm.

fensively: namely, to institute drug therapy the moment a patient displayed any behavioral signs that could arguably call for biological treatments. Drug therapy would be instituted even if it was against the therapist's best clinical judgment. The psychotherapist might see prescribing medication as the lesser of two evils, more favorable than facing a malpractice action. The therapist might fear that at some future date one of his or her "more biologically oriented peers may testify that failure to institute drug therapy under such circumstances was negligent" (p. 71). Under these circumstances, Malcolm stated the psychodynamic psychotherapist would be substituting the clinical judgment of a reasonably prudent biologically oriented psychotherapist for his or her own clinical judgment. Patients would benefit if the biological techniques proved efficacious. However, if biological techniques caused harmful side effects, many patients might be worse off (physically and mentally) in the long run. The harm might have been avoided if the patients had been treated exclusively through psychodynamic techniques.

Harm to patients and malpractice harm to psychotherapists may be avoided if the psychotherapist integrates informed consent into treatment. The practice of presenting patients with information about alternative treatment modalities warrants serious consideration by psychodynamic therapists (Stone, 1990). Indeed, the legal doctrine of informed consent is consistent with the provision of good clinical care by all mental health professionals (Simon, 1992).

Standards and Exceptions of Informed Consent

The doctrine of informed consent is a main source of tension between the medical and legal professions (Malcolm, 1987). Before 1950, courts did not really concern themselves with the information doctors gave to patients. All that was required was that doctors not provide any information that they should have known was false (Malcolm, 1987). This general expectation gradually developed into an affirmative duty on the physician to disclose certain information to the patient (*Hunt v. Bradshaw,* 1955). Generally, courts adhering to a professional standard of disclosure reason that, given the complexities of medicine, the determination of what risks warrant disclosure is best left to the judgment of members of the medical profession (King, 1986). A new lay standard was enunciated in the landmark case of *Canterbury v. Spence* (1972). There, the court discarded the professional standard of disclosure, rejecting the view that a "physician's obligation to disclose is either germinated or limited by medical practice" (p. 783). Instead, under a new lay standard, the physician was required to disclose any information about a proposed treatment or its alternatives that a reasonable person in the patient's circumstances would find material to his or her decision either to undergo or to forgo treatment. Significantly, the court feared that arrogating to the medical profession the decision concerning what information to disclose might be in derogation of the patient's

right of self-determination (King, 1986; Malcolm, 1987). The court also noted that what risks are material represents a nonmedical judgment (*Canterbury v. Spence,* 1972).

A number of jurisdictions have adopted *Canterbury* in whole or in part (see generally Pegalis & Wachsman, 1992, which discusses the lay standard). A leading California case, *Cobbs v. Grant* (1972), applied a test that provides that "the scope of the physician's communications to the patient . . . must be measured by the patient's need, and that need is whatever information is material to the decision" (p. 515). Courts following the reasonable patient standard set forth in *Canterbury* and *Cobbs* have essentially enunciated a doctrine that the clinician is required to disclose those risks that are material to the patient's decision. In those jurisdictions, the physician's duty to disclose is judged against a lay standard of reasonableness, not a medical standard (Pegalis & Wachsman, 1992). Although the *Canterbury* decision attracted significant support from the courts and a few legislatures, a trend favoring the lay standard has been checked by a proliferation of medical malpractice statutes, most of which have adopted a professional standard of disclosure (King, 1986).

As noted in the aforementioned cases, traditionally the primary emphasis in informed consent cases has been on assuring adequate disclosure of the risks and alternatives of a contemplated medical procedure. A few decisions have expanded the clinician's potential liability by expressly recognizing a duty to disclose the risks of refusing a recommended medical procedure (King, 1986). In a somewhat controversial decision, the California Supreme Court in *Truman v. Thomas* (1980) rendered an opinion that has been described by some as "informed refusal." The defendant, a family physician engaged in general practice, acted as the primary physician for the plaintiff (Mrs. Truman) during a 6-year period of time. During that time, she not only sought medical advice but also discussed personal matters with him. On several occasions, the defendant recommended to his patient that she have a Pap smear. The physician acknowledged, however, that he never specifically informed the patient of the risk of not having the test. The Pap test itself was virtually a risk-free procedure. The patient declined the test, stating that she could not afford the cost. Subsequently, it was discovered that the patient had cancer of the cervix, which had advanced to such a degree as to claim her life shortly thereafter. A wrongful death action was brought against the defendant alleging failure to perform a Pap test on the plaintiff during the 6-year period. The court held that a physician owed a duty to inform his or her patient of the material risks not only of accepting but also of rejecting a recommended procedure. In the court's view, *material information* is that which "the physician knows or should know would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject the recommended medical procedure" (p. 311). Thus, if a patient indicates that he or she is going to decline a

risk-free test or treatment, the clinician has a duty to disclose all material information.

Viewed in perspective, the *Truman* decision does not impose an onerous burden on physicians or mental health professionals. When a therapist–patient relationship exists, clearly the clinician must conform to certain standards of care with respect to recommending therapeutic procedures or diagnostic tests. The *Truman* decision applies to the uncommon situation in which the patient refuses the recommended test or treatment. Under these limited circumstances, it is not unreasonable to impose on the clinician a duty to explain to the patient the reason for the recommended medical therapy and the risk of failing to follow the clinician's advice (Pegalis & Wachsman, 1992). This is especially compelling where the recommended test is virtually risk free (as with a Pap smear) and the risk to the patient of not having the test is potentially fatal.

In the area of informed consent, the parameters for the extent of the information to be disclosed, as well as considerations that influence disclosure, continue to be shaped and defined by case law. Generally speaking, regardless of the standard of disclosure, a mental health professional is only expected to know of risks and other information that a similarly situated reasonable practitioner would be expected to know (King, 1986).

In the debate over informed consent, physicians and mental health professionals usually present the greatest opposition to the doctrine, whereas legal professionals strongly support it. Supporters view the relationship between clinician and patient as one between unequal bargaining partners and feel that the inequality is due to the clinician's special knowledge (Malcolm, 1987). The clinician should be made to disclose his or her special knowledge to the patient so that they will become equal bargaining partners. An increased feeling of participation by the patient in the decision-making process may engender a feeling of trust in the clinician and strengthen the therapeutic alliance (Stone, 1990). Opponents of the informed consent doctrine argue that the inequality of knowledge is impossible to overcome. Unless the patient is a physician or mental health professional, the patient will never be able to give a consent that is truly informed (Malcolm, 1987).

This debate has led to a confusing resolution in the courts. In an attempt to balance individualism (i.e., an individual's status as an autonomous human being) with paternalistic instincts, courts have affirmed the autonomy interests by adopting the general rule of the doctrine of informed consent (Malcolm, 1987). They have accommodated the paternalistic interests by coming up with a series of judicially developed exceptions to the informed consent doctrine (King, 1986; Simon, 1987). The four exceptions to informed consent include (a) emergency, (b) incompetency of the patient, (c) waiver, and (d) therapeutic privilege. These exceptions to informed consent constitute a viable defense from charges of improper treatment. On each of these affirmative defenses, the

clinician must introduce sufficient evidence for the trier of fact to find that the exception applies. If the clinician fails to do so, these matters of defense cannot be considered by the jury (Appelbaum, Lidz, & Meisel, 1987).

Informed Consent for Psychotherapy: Recommendations for Clinicians

It is important to emphasize that consent is an interactive process (Rozovsky, 1990; Stone, 1990). Many mental health professionals think of informed consent as a form to be signed—that is, a static, one-time event. Consent is an ongoing dialogue between the patient and mental health professional in which both parties exchange information, ask questions, and come to an agreement on the course of psychotherapy (Rozovsky, 1990). Both parties must be active participants. A document cannot replace this important process. The emphasis is on communication, not the form (Wallace, 1991).[8] Decision making in psychotherapy must become a joint undertaking in order to safeguard the autonomy of both parties (Katz, 1984).

The process of gathering and divulging information regarding the pros and cons of various treatments may encourage mental health professionals to scrutinize the relative merits of various treatments (Malcolm, 1987). This would be an especially fruitful endeavor in psychotherapy, where 450 schools of therapy abound (Simon, 1987).

Simon (1987) recommended that a mental health professional consider disclosing the following type of information to persons considering psychotherapy:

1. *Proposed treatment:* First, there should be an initial period of evaluation. This gives the patient time to assess the therapist, the psychotherapeutic technique, and the interactional process between therapist and patient. This evaluation period allows the therapist time to make a reasonable diagnostic assessment. The patient's difficulties can be described in plain language using descriptive terms.
2. *Anticipated benefits:* Depending on the patient's situation, the anticipated benefits should be discussed in terms of altering maladaptive defenses and resolution of underlying conflict, or symptomatic relief. If treatment outcome studies are available, the information can be shared with patients.
3. *Risks:* If the evaluation reveals past regressive episodes, one may consider with the patient whether such a recurrence might happen in the course of long-term therapy. Additionally, a history of, for example, intense transference reactions toward others should alert the therapist to a possible similar recurrence in the psychotherapeutic arena.

[8]The form may be necessary in the legal system to memorialize the consent process. However, rarely is the form enough to withstand legal scrutiny (Wallace, 1990).

4. *Prognosis and expected outcome:* Prognostic statements should be made with great caution. The expected outcome of a particular mental disorder without treatment may be difficult to determine. However, certain mental conditions such as schizophrenias or phobias have recurrent or chronic courses.

5. *Available alternative treatments:* Alternative therapeutic modalities must be discussed with patients. Clinicians can no longer recommend only one form of treatment. Psychotherapists may not be competent in using more than a few treatment approaches; however, they should be up to date in their knowledge of the standard treatments used by competent, ethical therapists. Further, they should be able to intelligently explain these options to the patient. The psychodynamic therapists should be reasonably knowledgeable about the methods, indications, and contraindications of other therapies (behavioral, cognitive, etc.). "Patients have a right to know about alternative therapies that may be reasonably expected to help their condition" (Simon, 1987, p. 113).

Simon (1987) noted that the therapeutic alliance can be enhanced by discussing with patients the length of sessions, cost, frequency of visits, missed appointment policies, and confidentiality issues. He also points out that patients should be given the opportunity to ask and receive answers to questions about psychotherapy. Some psychotherapists continue to express concern that consent procedures may negatively affect the therapeutic relationship and hinder treatment (Simon, 1987). Psychoanalytic or psychodynamic therapists may feel that detailed information about therapy and the therapist's qualifications distorts the therapeutic process and weakens the transference relationship (Wolberg, 1967).[9] Recent empirical evidence has not supported these negative expectations (Handelsman, 1990). In fact, a study by Sullivan, Martin, and Handelsman (1993) suggests that patients may be more favorably disposed to therapists who provide information. Participants rated professional therapists who used informed consent as more trustworthy and expert than those who did not (Sullivan, Martin, & Handelsman, 1993).

Significantly, Simon (1987) underscored that informed consent is not a solitary event that occurs only at the beginning of treatment. Rather, it is a continuous process throughout therapy. In a related vein, Gutheil (1984) noted that informed consent is more than a legal formality. Indeed, it can become a focal point for establishing the therapeutic alliance. Informed consent becomes a powerful clinical tool; it allows the patient's helplessness to be supplanted by a degree of control as the patient becomes a participant with the therapist in the treatment process (Simon, 1987). "The therapeutic use of informed consent enlists the patient in an active alliance that discourages simplistic blaming, and

[9]The potential distorting effect of consent procedures on the psychotherapy process is beyond the purview of this article, but it is discussed elsewhere by Epstein (1978) and Robitscher (1978).

reduces the alienation towards the clinician that often produces malpractice claims" (p. 126).

CONCLUSION

Given the current legal climate, negligent psychotherapy, negligent treatment, and misdiagnosis of psychiatric conditions are likely to constitute a ripe area for future lawsuits against psychotherapists. Psychodynamic psychotherapists may be particularly vulnerable to such lawsuits. How can today's respectable, reputable minority—which may become tomorrow's prevailing majority—protect itself against *Osheroff*-type litigation? Moreover, how can the fields of law and psychiatry maintain their traditional commitments to diversity and innovation? It is proposed that the most effective way of protecting against potential *Osheroff* causes of action is through an interactive informed consent process.

Informed consent is more than reading and signing a form. It is the beginning of a process, and an opportunity to ask questions and to gain knowledge that is explained in terms the patient can understand. A patient must be properly informed of the proposed treatment, the risks and anticipated benefits, a cautious prognostic assessment, available alternative procedures (including risks and benefits), and the expected outcome with and without treatment (Simon, 1992). Both the patient and psychotherapist must be active participants. It is important that risk information be presented in a way that does not unduly alarm the patient. This open communication and ongoing dialogue protects the patient's right to self-determination. A patient who is properly informed is less likely to launch subsequent litigation over undisclosed risks that become manifest (Wallace, 1991). However, an informed plaintiff is not precluded, as a plaintiff, from winning a malpractice action. Informed consent per se does not govern the outcome of a lawsuit; that outcome is, ultimately, in the hands of the trier of fact.

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