

Whom Do You Trust? Patient Care and Professional Relationships

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Patient care often involves relationships with other clinicians and, sometimes, relevant laypersons or organizations such as employers. Many relationships create a duty of some sort and thus have some potential for liability. Sometimes that's good news (as when an employer takes some of your risk). This column is about what you should know or do with respect to the other professionals with whom you work.

Employer or Employee

Many readers of this journal work for a healthcare agency or facility. Healthcare organizations, even government ones, take on additional potential for liability when they employ clinicians rather than contracting with them (see below) or entering into non-contract voluntary arrangements (such as one sees in a private hospital professional staff).

A longstanding legal doctrine called *respondeat superior* makes employers generally responsible for the negligent acts of their employees. Thus when an employee with few personal resources damages a patient, the patient may be able to recover from the employer. There are exceptions, such as for actions that are outside one's job parameters and some "discretionary" activities (i.e., those not completely under employer control, like clinical decisions) in many settings.

It is important to remember that employee-clinicians do not give up their near-fiduciary* relationship with their patients, despite the doctrine of *respondeat superior*. Professionals such as doctors and therapists, who are qualified and empowered to make independent decisions, often retain some independent liability as well. It is difficult to sue military clinicians and some other government doctors and therapists (federal, state, and local governments can often limit their vulnerability), but one should not be completely reassured that his or her employer absorbs all of the potential liability for clinical acts.

The patient is entitled to rely on the healthcare employer to provide licensed, qualified professionals and to monitor them from time to time to be sure they are doing a good job. Since employers and supervisors don't often directly observe clinical care, they should exercise

"reasonable care" (or some similar term) when they hire, privilege, and evaluate clinicians, and when they censure and terminate them. It is not enough for the employer to claim it didn't know about a clinician's problematic background; the organization must take acceptable steps to discover problems and sometimes to anticipate future potential for negligence.

A hospital therapist was accused of abusing several patients, and both therapist and hospital were sued. Since the abusive acts were clearly outside his professional assignment, the hospital attempted to deny any liability. The plaintiff's expert reviewed the hospital's personnel and credentialing files and found that there was no information from the therapist's last place of employment and no explanation for a period of several years in which he listed no professional activities. Further research revealed that if the hospital had inquired, it would have discovered that the therapist had been unable to practice for some time because of a suspended license. The information was likely to have established liability for the hospital, which settled out of court.

On the other hand, employers should not unfairly suspect the professionals who work for them. For clinicians, censure or termination that affects one's reputation is far more damaging than merely losing one's job.

A clinician dated a nonclinical staff member. The woman involved was unmarried and was not his employee, employer, supervisor, or supervisee. After several weeks, the staff person filed a complaint alleging that he had harassed her. The evidence for harassment was quite vague and inconclusive, but the employer terminated him within a few hours of the complaint and filed a derogatory report with his

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* Remember "fiduciary" from an earlier column? It describes your duty to give your patient's interests very high priority, generally above your own and your employer's interests.

licensing board and a monitoring agency. All of this was baffling to the clinician-employee, who readily admitted the relationship but denied doing anything non-consensual.

The clinician appealed and obtained legal counsel. An administrative law judge found that he had been terminated without "due process." The employer offered to reinstate him while they re-processed his termination using the appropriate administrative procedures. The clinician did not accept the reinstatement. He sued the employer for wrongful termination and damage to his career, alleging that the employer overreacted to the possibility of a sexual harassment lawsuit and attempted to sacrifice him to decrease its exposure.†

Clinicians in management positions should be cautious about developing conflicting relationships with employees, especially those over whom they have some authority. There is an adage that bosses and supervisors may be "friendly," but should not be the employee's "friend." Sometimes apparently benevolent acts can be construed as legally inappropriate and damaging.

A senior mental health professional in a large agency was showing increasingly poor performance and was in danger of termination. An agency executive, also a clinician, noted symptoms of emotional impairment and quietly began to intervene with informal talks and occasional counseling. The executive believed he was just trying to be helpful and that there was no therapist-patient relationship. When the employee-professional divulged bizarre thoughts and behavior, only some of which were obvious to others, he feared patients (or the employee herself) might be in danger; and contacted the agency director and the employee's husband. The husband was grateful for the call, saying he had been very worried and that the employee had "fooled her psychiatrist" in a recent evaluation.

The employee was eventually terminated. She then sued the clinician-executive for breach of privilege, misrepresenting his role, and slander. She alleged that a therapist-patient relationship had been created and that calling her husband and the director amounted to breach of a clinician's obligation to maintain confidentiality. She claimed the executive described her inaccurately, assumed a dual role of "counselor" and management representative, unfairly caused the agency director to doubt her performance, and damaged her marriage.

† Wrongful termination suits tend to be cheaper to defend than sexual harassment ones.

Independent Contractor

Clinicians are commonly retained as "independent contractors" who agree to provide clinical services, under conditions specified by the contractee, for some kind of payment. By contracting with, rather than employing, the clinician, the organization or person offering the contract ("contractee") can limit or eliminate many, but not all, "employer" responsibilities.

The organization retaining the clinician is entitled to expect that he or she is properly licensed and qualified and will work within applicable law and ethical guidelines, but the contractee should not rely solely on the contractor's own assurances. Some form of verification of important qualifications and performance is usual. This is routinely done by such measures as demanding proof of qualifications, checking references, recredentialing from time to time, and perhaps peer and performance review.

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Since the patient is not the contractee (as would be the case when the patient or patient's insurance pays the clinician directly), a conflict of interest is created whenever the contract's purpose differs from the purpose of the clinical relationship (for example, when a managed care agreement limits resource use). The clinician's duty to the patient takes priority over any contract that tends to limit care, although disclosure of the conflict to a competent and consenting patient may modify that priority. Thus, telling the patient that the contracting organization won't authorize certain treatment may not remove any therapist duties, but the patient's agreement to participate under those conditions—as long as all relevant information is provided—can modify one's responsibility to go beyond the agreement. Note, however, that *the patient doesn't necessarily give up the right to adequate care merely by agreeing to accept less.*

What's in the contract? Clinicians should enter clinical contracts with both knowledge and caution. It is impossible to provide a complete discussion of contract issues here; however, I will highlight several principles.

1. Be aware of duties and responsibilities that you cannot change merely by signing a contract.
2. Be certain about what is demanded in exchange for your compensation. Do not accept any contract that is

not completely filled in and be particularly wary of items that refer to materials which are not supplied for your review. References to documents such as organization policies or rules should provide the complete wording from those sources; otherwise, you are agreeing to provisions you have never seen.

3. Do not accept any requirement to keep business (“proprietary”) data confidential when such confidentiality might interfere with the best interests of your patients. In some states, it is illegal for healthcare organizations to prohibit disclosures to patients about limitations on care, treatment alternatives, or conflicts of interest (e.g., financial incentives). It is usually unethical and/or below the standard of care to deprive the patient of information likely to significantly affect clinical outcome.
4. Some third party contracts require the clinician to indemnify the contractee against claims arising from care. Sometimes this is subtle, such as requiring the clinician to carry malpractice insurance (and that the clinician’s insurance must be exhausted before the contractee accepts any liability). Others blatantly say that patient care is entirely the contracting clinician’s responsibility and that the organization will not accept any liability for adverse outcomes. Such wording exposes the clinician to more trouble than necessary; agree to it at your peril.
5. Whenever possible, contracts should be reviewed by your own attorney and malpractice carrier. The malpractice carrier understands legal duty and standard of care and can help determine whether or not the contract exposes you to unusual, or non-covered, liability.
6. It is foolish to sign a contract hurriedly, or just because it is “our standard agreement.” The value of the contract goes beyond the dollar value of the agreement and includes protecting your assets and professional reputation.

Being a Clinical Supervisor

Supervisory responsibility should not be taken lightly. The relationship may seem to be with the supervisee alone, but it is wise to act as if it is also with his or her patient(s). Supervisors should meet regularly with supervisees and make some effort to get relevant patient information (e.g., by reviewing the chart, reading the supervisee’s notes, or listening to parts of therapy session tapes).

A supervisor who has control or direct influence over patient care assumes many of the same risks as a treating clinician. It is important for supervisor and supervisee (and third parties such as training programs or

employers) to have a clear, perhaps written, understanding of supervisory parameters and expectations. In clinical team oversight, for example, the supervisor is often expected to see the patient and, perhaps, to perform certain evaluations or treatments in person. At the other end of the spectrum, privately arranged psychotherapy supervision does not generally require personal interaction with the patient and may not create much duty to the person receiving psychotherapy.

Sharing information with one’s supervisor is not a breach of privilege or confidentiality.

The patient should be made generally (but not obsessively) aware that a highly trustworthy and qualified third person will have access to clinical information. No matter what the style of supervision, the supervisee must not hold back information from the supervisor, and should never promise a patient that some bit of information will be kept “just between us.” *Sharing information with one’s supervisor is not a breach of privilege or confidentiality.* The temptation to censor patient or therapist material for one’s supervisor, no matter what the conscious reason, suggests countertransference or other problems that, conversely, need discussion.

Using a Consultant

Both the primary clinician and the consultant should know that *unlike supervision, consultation is not a binding process.* The standard of care generally requires that the primary clinician be competent to weigh the consultant’s advice in the patient’s interest, but consultative relationships—unless they involve treatment by the consultant—are generally with the primary clinician, not the patient, and the clinician may take or leave the consultant’s advice.

The consultant has a duty to do his or her job properly. That means being competent and complete and communicating promptly with the referring clinician, but not making final decisions. On the other hand, a consultant who recognizes, or should recognize, an emergency or other acute condition requiring immediate attention to prevent damage to the patient or others probably has a duty to take some form of protective action. The action should be proportional to the patient’s need and might not involve direct clinical intervention (promptly notifying the primary clinician, for example, may be sufficient).

“Co-Treaters”

As used here, “co-treatment” implies a situation in which more than one clinician is treating a patient, but neither is the other’s supervisor (nor primarily a consultant, although consultation may occur). It is very easy for the concept of co-treatment to overlap with some duty to supervise, protect, or monitor the other clinician’s care, particularly for psychiatrists. In any event, co-treaters are responsible for knowing something about the care, treatment style, credentials, and even ethics of those with whom they share treatment or to whom they refer patients. For example, a psychiatrist should not automatically accept a discharge plan that assigns his or her patient to a psychotherapist with whom he or she is unfamiliar. Co-treaters should know about each other, understand each other’s roles, and communicate.

Communication is especially important, but is often overlooked. For example, when a physician prescribes medications and a counselor provides psychotherapy, each clinician should be aware of the other’s activities and findings with regard to the patient. In most cases, this goes beyond merely sharing information “as needed” (such as when significant medication changes or suicidal thoughts occur). I recommend routine periodic communication through the patient’s written record, conferences, phone calls, letters, e-mail, and/or some other appropriate medium.

Many clinicians assume they need a release to talk with a patient’s psychiatrist, therapist, or family doctor about relevant clinical matters. I have never seen any reliable legal information suggesting that patient authorization is truly necessary or that the patient can invoke privilege to prevent important clinician-to-clinician interchange. You may wish to check for yourself in your state or jurisdiction, but I cringe when I hear therapists say they couldn’t tell a patient’s psychiatrist or primary care physician about an important change in symptoms, prescription noncompliance, or medication abuse simply because they didn’t have the patient’s permission.

Coverage and Substitute Clinicians

The rule is simple: Be sure you have adequate, competent after-hours coverage. The corollary is simple, too: Determine, to a reasonable extent, whether any clinician associated with your professional practice or on-call roster lacks the ability, experience, or character necessary to meet his or her obligations to your patients. If so, avoid placing your patients in that person’s care. You may rely on such things as acceptable credentialing procedures, professional references, and/or your personal experience with the clinician.

Professional or Employee References

Health care employers, licensing and certification agencies, and clinical staff organizations rely on professional

references to help determine clinicians’ or employees’ fitness to care for (or have access to) patients. We all want to help friends, and no one wants to be the one to keep a colleague from working, but *be honest* if asked for a reference. If you knowingly mislead an employer, clinic, licensing agency, or credentialing body about a clinician’s suitability and the clinician later causes some tragedy, you may be partially liable.

Of course, both positive and adverse comments must be based on personal knowledge or reliable evidence. Rumor and innuendo do not constitute “good faith” and, in addition to being unfair, leave one open to charges of libel or slander. If you don’t know the facts, say so and decline to provide a reference.

Many organizations have policies against providing detailed references for former employees or associates. In my opinion, organizational policy limitations should not apply in these matters. It’s not fair to future patients, and it doesn’t meet the clinician’s ethical obligation to protect them from incompetent or unsafe clinicians. If you are asked for a reference and you have knowledge that is important to patient care, don’t withhold it.

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In Your Own Office

When you employ nonprofessionals such as secretaries, receptionists, or even cleaning people, you have a duty to be aware (e.g., through background or reference checks) of indications that they may harm your patients. You should also have clear rules about issues such as confidentiality, train staff appropriately, monitor employee behavior, and take suitable action if problems arise. Many of the same concerns apply when you are not the employer but such people have access to your patients and their records. Even when you are not directly responsible for hiring, training, or monitoring, you should satisfy yourself that your patients are reasonably protected.

The Final Word

Know the people with whom you work and on whom your patients depend.