

Standard of Care and Patient Need

The other day I had a chance to talk with a medical director and an administrator of a psychiatric hospital, both good friends and highly competent professionals. The conversation turned to their ability to treat inpatients adequately, given payers' expectation of very short hospital stays. The medical director and administrator told me that the average length of stay for patients, including substance abuse patients, in their hospital was just over 3 days.

Please raise your hand if you have been taught that safe and lasting alleviation of schizophreniform psychosis and amelioration of major depressive episodes with suicidal danger take an average of 3 days. How about those of you whose clinical experience has taught you that seriously ill patients really don't need time-consuming assessment, close monitoring of early treatment response, and careful transition to outpatient care? C'mon, keep those hands up.

You get my point (or you have no feel for sarcasm).

Treating patients "adequately" is an important concept for forensic psychiatrists. Patients are entitled to "adequate" care—that is, care which meets a standard set by reasonable doctors and hospitals. On the other hand, civil (e.g., malpractice) law doesn't usually entitle them to "excellent" care unless someone has promised it (such as in a contract or advertisement). Caregivers are not expected to be perfect, and bad outcome doesn't mean malpractice.

I admit that in my forensic practice I tend to see the tragedies and not the successes. Defense and plaintiffs' lawyers don't call me unless someone has died or been seriously damaged. Nevertheless, we need to talk about the standard of care.

WHAT'S A STANDARD? WHAT'S NOT?

The "standard of care" (another term familiar to forensic clinicians, and to anyone who has been sued for malpractice) is determined by that which is good for patients. It is not determined by cost, "cost-effectiveness," or a committee far from the front lines of patient care.

The standard of care is usually highly correlated with professionally accepted clinical texts, clinical journal articles, clinical training programs, and what real doctors do across the country.

Documents such as the American Psychiatric Association *Practice Guidelines* come close but, in all their effort to be complete, APA acknowledges that they are guidelines, with exceptions in individual cases and allowances for future advances in our knowledge. Hospital policies and procedures may or may not define a standard of care. They are limited to one institution, and so may not reflect any broad standard (judges and juries use the latter in court), and they often (perhaps usually) reflect efforts at excellence, not adequacy (goals to be sought, not merely reasonable care). Hospitals and other clinical organizations often use policies, guidelines, and quality improvement procedures to exceed the standard and improve quality; one should not assume that the quality was substandard in the first place.

Reasonable clinicians can differ. One can remain within the standard of care without agreeing with the majority view, so long as a respected minority (but not a "fringe group") would have acted in the same way. Thus, quality psychoanalytic psychotherapy as accepted by properly trained and experienced psychoanalysts may be within the standard for a particular kind of patient, even if most therapists would recommend a different approach for that condition. This is tricky territory, however. The "respected minority" doctrine may fail if the evidence for the minority technique is scientifically weak (cf. a recent case of a physician treated with psychoanalytic psychotherapy for severe depression without adequate consideration of antidepressant medication).

Dr. Reid is a forensic psychiatrist in Horseshoe Bay, Texas, and a past president of the American Academy of Psychiatry and the Law. His most recent book, *The Treatment of Psychiatric Disorders, 3rd Edition*, will soon be followed by *Legal Issues for Psychotherapists*. His web page, Psychiatry and Law Updates, may be found at

<www.reidpsychiatry.com>

This column contains general clinical and clinical-forensic opinions which should not be construed as applying to any specific case, nor as any form of legal advice.

CONSIDERATION AND THOUGHTFUL JUDGEMENT

The standard of care usually relates to the *process* of the doctor's work and decisions, not always the decision itself, and rarely the clinical outcome alone.* When I review records and depositions in malpractice cases, I look for signs that the doctor and others carefully considered their actions (e.g., diagnosis, treatment, or discharge), using as much information as was reasonably available and considering most or all reasonable options. There's that vague word "reasonable" again. One doesn't have to be perfect, but one does have to cover the necessary clinical bases if it is reasonable to do so.

A man threatened to kill himself while drunk. He had no known history of psychiatric illness, serious domestic violence, or suicide attempt. His wife had recently left him after an argument in which both were apparently intoxicated, and he had called a faraway uncle to say he was thinking of shooting himself. The uncle called the man's father, who lived nearer the man, and recommended the father file commitment papers, which he did. The father came to the man's house and found him very angry, with loaded guns, saying that the police had better not try to take him to any "loony bin." The father talked him into allowing the police to take him to the local emergency room, from which he was referred to a state hospital for assessment.

The psychiatrist who saw him at the state hospital wrestled with the conflicting issues of possible illness and danger on the one hand, and the right not to be locked up on the other. He knew that the State had to show, to a legally "clear and convincing" degree, *both* mental illness and dangerousness in order to take away the man's freedom. The psychiatrist spent time with the patient (who was now considerably calmer and no longer drunk), talked with the mental health worker who had evaluated him in the local emergency room a couple of hours before and had talked with family members, and called both the man's father and his uncle for additional information. The wife was not available. After several hours, being unable to identify a mental illness, the psychiatrist acceded to the man's demand for release, and the police took the man home. About 6 hours later, he sought and found his wife,

*Occasionally, courts find that a decision and outcome is so far outside the norm that the plaintiff need not even call in an expert to discuss the standard of care (*res ipsa loquitur* cases such as amputating the wrong leg; translated literally, "the thing speaks for itself").

and then killed both her and himself in front of their children.

In the resulting lawsuit, the jury was shown photos of the bloody bodies and told about the orphaned children. Nevertheless, the jury came to understand that the doctor did all that was reasonable to assess the situation as he knew it, that he knew that commitment must not be taken lightly, and that he came to a reasonable and considered decision under the circumstances. They agreed, via their verdict, that not every tragedy is a malpractice.

I am concerned when clinicians seem to forget the assessment and treatment principles, documented in dozens of textbooks and training programs, that form the backbone of good care. For example, when one of my trainees says he hasn't called an acutely ill patient's family to corroborate the history, perhaps because the hospital policy is to have an overworked social worker do it or because the patient briefly suggested that he didn't want them to contact his family, I do my best to embarrass him in front of his peers.

A middle-aged, college-educated man presented to a private hospital emergency room with symptoms of severe depression and a clear suicide plan. He said he had serious financial problems, was in the middle of a rancorous divorce, and had been living in a motel since his wife kicked him out. A close friend had brought him to the hospital and was the "emergency contact" in the record. The psychiatrist diagnosed a major depressive episode, admitted the man, and ordered suicide precautions. The doctor elected not to contact relatives (or the close friend) for additional history, and didn't suggest to the patient that such contact might be important to his care. Four days later, after three days of treatment with an SSRI antidepressant and one day without overt suicidal wishes, the patient was discharged to his motel room. He killed himself within the week.

At a deposition in the malpractice suit a year later, the psychiatrist said the patient had asked him not to contact his family, but the doctor admitted he had not pressed the issue, never asked about contacting the close friend, and had not considered corroboration of the history important to the patient's assessment or treatment. He said he believed the patient was being truthful and complete because he was "well educated," and said clinical experience allowed him to tell when such patients were lying or unable to give accurate information.

Had the doctor contacted any family member or the close friend he would have learned that the patient, formerly a respected member of the community, had been acting irrationally for several

weeks, had a family history of severe mental illness and suicide, and was experiencing severe loss and humiliation. He might also have considered the fact that the clinical literature, standard texts, and professional training all agree that a day or two of superficial improvement during a hospital respite does not imply lasting change in middle-aged men with major depression, suicidal wishes, and great external stress.

DOES THE STANDARD APPLY EQUALLY TO ALL CLINICIANS?

One of the biggest misunderstandings in clinical practice is the notion that there are different standards for different professionals treating the same patient for the same condition. Don't you believe it (or, at least, don't rely on it). Primary care physicians and licensed clinical psychologists who treat depression, for example, must meet the same general standard of care as psychiatrists, *provided they assume responsibility for the patient's care and the patient has reason to expect the same clinical result*. That is, if the family doctor diagnoses and treats, the patient is entitled to expect that he or she is *competent* to diagnose and treat, and to expect that referral to a specialist will be offered if necessary.

The issue is not the clinician's training, but what the patient needs and is entitled to expect. The patient doesn't have the knowledge and experience necessary to know what's needed; he or she must rely on the doctor (M.D. or Ph.D.) for that. The doctor thus has a duty either to meet the standard of diagnosis and treatment for the patient's condition, or to recognize the need to refer to another clinician (and do so).

A young mother of several small children became depressed and sought treatment from a family doctor at her HMO (which advertised that it provided the best of care to its subscribers). Over the next several months, she exhibited—and the primary care physician documented—progressively worsening symptoms of a major mood disorder. The doctor prescribed low doses of imipramine (10 to 25 mg/day), saw her briefly every 2 or 3 weeks, reassured her and her husband that the medication would soon begin to work, and suggested they take a vacation. Months went by, with mounting sleep disturbance, weight loss, morbid withdrawal, inability to work or interact with her family, and signs of suicidal ideation. Eventually, her husband observed her acting oddly, “spinning around in the bedroom.” She couldn't explain why she did it, saying she just felt compelled to turn aimlessly.

At that point, her husband called the doctor in a panic. He saw the couple and scheduled a routine assessment by one of the clinic psychologists a few days later. The psychologist recognized a potentially grave situation and immediately referred the couple to one of the panel psychiatrists, to be seen the same day. The psychiatrist strongly recommended hospitalization; the husband and wife (with her husband's encouragement) declined. The psychiatrist considered civil commitment and various available outpatient measures, and decided the patient was not committable. He gave careful instructions to both husband and wife and arranged for them to come back the next day. She killed herself that evening.

In the lawsuit, the primary care physician alleged that he had met the standard for his profession. After all, he wasn't a specialist. He thought of antidepressants; he just got the dose wrong. He thought of depression; he just got the management mixed up. He thought of hospitalization; he just wasn't sure it was time to use those valuable health care resources and label the patient with the stigma of a psychiatric hospital stay. When he finally decided to ask for help, it was too little, too late.

The jury found for the plaintiff, and added that the HMO was also to blame. The standard required of the HMO was higher than usual because it had promised excellent, not merely reasonable, care. They weren't cited for malpractice, but for breach of that implied contract. The psychiatrist caught part of the plaintiff's wrath for not seeking involuntary hospitalization, but the fact that he carefully considered the various options, and came to a reasonably considered decision, kept him from liability.

LESSON

This month's take-home lesson has three parts:

1. Remember the things you were taught in training and have read in good clinical books and articles; they, far more than financial need or administrative convenience, define the standard of care.
2. Be sure your clinical decision-making process involves a consideration of the reasonable alternatives and that you make your decisions with the best information you can get.
3. Write down your decision process.

If you do all three, we'll probably never meet in court (and if we do, there's a good chance I'll be testifying for rather than against you).