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MALPRACTICE IN PSYCHOTHERAPY: IS THERE A RELEVANT STANDARD OF CARE?*

The increased number of malpractice suits against psychotherapists poses a great difficulty for courts in their application of an appropriate standard of care. While the traditional medical malpractice standards of care are well defined, they are not applicable to every psychotherapeutic technique. Consequently, the courts have struggled in their attempts to formulate a standard of care for psychotherapists. In this Note, the author proposes a "dynamic" standard of care as a solution, arguing that such a standard would balance a mental health patient's right to quality care with the evolution of innovative psychotherapeutic practices.

INTRODUCTION

INCONSISTENT RESULTS in psychotherapy malpractice cases reflect the complex nature of mental health treatment and indicate the need for a uniform standard of care. Until very recently, legal action against mental health professionals was rare. Several factors explain the virtual absence of litigation. First, a psychotherapist may be able to prevent the patient's claim that the therapy

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1. "Psychotherapy is an undefined technique applied to unspecified cases with unpredictable results." V. Raimy, quoted in N. Finkel, Mental Illness and Health 73 (1976). Notwithstanding Raimy's incisive comment, other authorities have attempted to define this "undefined technique." One source defines psychotherapy as "[t]reatment designed to produce a response by mental rather than by physical effects, including the use of suggestion, persuasion, re-education, reassurance, and support, as well as the techniques of hypnosis, abreaction, and psychoanalysis which are employed in the so-called deep psychotherapy." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1092 (26th ed. 1981).

2. The term "mental health professional" is used in this Note interchangeably with the terms "therapist," "psychotherapist," and "practitioner." It encompasses a full range of professionals in the mental health care field, including psychiatrists, psychologists, psychiatric social workers, and other therapists. Cf. note 88. Each of these professionals practices some type of therapy or treatment the purpose of which is to relieve mental distress or illness. Where appropriate, the discussion in this Note refers to specific types of mental health professionals. The literature concerning mental health care makes frequent reference to the mental health professional as a "practitioner." Notwithstanding the identification of that term with a lawyer who engages in the practice of his profession, "practitioner" is used in this Note to refer solely to the mental health professional who is similarly engaged. See BLACK'S LAW DICTIONARY 1055 (rev. 5th ed. 1979).

injured him simply by convincing the patient that he is wrong. Second, the patient often has difficulty proving that the treatment caused the injury, particularly where verbal therapy is involved. Third, since the public traditionally has refused to accept either the existence of mental illness or its treatment, prospective litigants who were reluctant to expose their psychiatric histories in open court chose to avoid litigation altogether.

The first two factors continue to deter aggrieved patients from seeking judicial redress. But the stigma associated with mental health care is breaking down, and so is the reluctance to sue psychotherapists. At the same time, heightened expectations of consumers and third-party payors regarding the effectiveness of


Often a patient will not consider a lawsuit because he believes that the success of the therapy is a function of his own cooperation in the process. See Shapiro & Zimmerly, Current Medicolegal Issues in Psychiatry, LEGAL MED. ANN. 327, 329 (1977) (arguing that success or failure of therapy depends upon the patient to a much greater degree in psychiatry than in other medical specialties).

5. See infra text accompanying notes 76-77; see also Comment, supra note 4, at 108; Taub, supra note 3, at 97; Comment, Tort Liability of the Psychotherapist, 8 U.S.F.L. REV. 405, 418 (1973) (discussing the difficulties inherent in establishing causation in a psychotherapeutic malpractice action).

6. See infra text accompanying notes 76-77; see also Furrow, supra note 3, at 96. Deterioration in the patient's condition either during or after therapy may be a result of the patient's illness and not the therapist's treatment.


10. See Appleson, supra note 3, at 1353.

11. Taub, supra note 3, at 97. Consumer consciousness regarding the quality of goods and services is becoming an important factor in the dispensation of mental health care. For example, Ralph Nader's Mental Health Research Group conducted a survey to analyze consumer support for patient-therapist contracts which would define expectations about therapy. As a result, a number of psychiatrists in Washington, D.C. agreed to enter into such contracts. See S. ADAMS & M. ORGEL, THROUGH THE MENTAL HEALTH MAZE passim (1975); see also infra note 13.

12. See Furrow, supra note 3, at 117. Government agencies and corporations are frequently a source of such financing. See P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 477 (1982); see also infra note 13.
therapy\(^\text{13}\) have made psychotherapists more vulnerable to lawsuits.\(^\text{14}\) The rise of litigation has exposed psychotherapeutic techniques to increased judicial scrutiny.\(^\text{15}\) Courts have been hard-pressed, however, to formulate a definitive standard of care against which to measure the conduct of mental health professionals.\(^\text{16}\) What passes as a legitimate form of therapy in one jurisdiction may be found unacceptable in the next.\(^\text{17}\) Certainly one reason for the irresolution surrounding the standard of care issue is the large number of different and conflicting schools of therapy within the mental health profession itself.\(^\text{18}\) A profusion of new forms of treatment merely exacerbates the problem.\(^\text{19}\) Moreover, the very fact of change as a characteristic of psychotherapy would appear to defy the notion of a definitive standard of care.

Yet a rigid standard of care which fails to recognize the need for new techniques is not the solution. In an attempt to accommodate the evolutionary nature of psychotherapy, some courts have allowed psychotherapists who ascribe to minority schools of thought to practice within certain limits.\(^\text{20}\) This approach, however, is subject to wide variation in its application.\(^\text{21}\) As a result, a therapist

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14. Statistics showing the number of claims brought against psychotherapists are not available, according to Dr. Paul Slawson, Chairman of the Professional Liability Committee of the American Psychiatric Association (APA). Appleson, supra note 3, at 1353. A review of statistics compiled by the APA, which is the largest malpractice insurer of psychiatrists in the nation, indicates that the number of practitioners who are insured under the program has more than tripled since the program began in 1972. Id.

15. For a representative sampling of lawsuits against therapists, see 3 D. HOGAN, THE REGULATION OF PSYCHOTHERAPISTS 35-334 (1979) (synopses of 300 reported decisions).

16. See generally text accompanying notes infra 84-94 (discussing standard of care in the context of psychotherapy).

17. For example, in some jurisdictions the less restrictive “open door” approach is an acceptable method of treatment under certain circumstances. By contrast, practitioners in other jurisdictions are limited to the traditional and more restrictive “confinement” approach. See infra notes 155-61 and accompanying text.

18. See infra text accompanying notes 143-90.

19. See infra notes 152-54 and accompanying text.

20. See infra notes 149-51 and accompanying text.

21. See id.
who deviates from traditional approaches and who practices new or unconventional techniques cannot always predict whether his approach would survive a legal challenge. The extent to which such a therapist will be held liable for injuries flowing from his conduct remains very much an unsettled question.

The challenge for courts is twofold. They must apply a standard of care to techniques that are as antithetical to one another as classical Freudian psychoanalysis is to physical intimacy. Courts must also balance the right of practitioners to devise new treatments with the right of patients to obtain responsible health care.

This Note proposes a standard of care to address these concerns. Part I describes the plaintiff's most effective legal theory against his psychotherapist—a negligence claim similar to medical malpractice—and the steps that a patient must take to establish a prima facie case under this cause of action. Part II discusses the controversy surrounding the formulation of a standard of care in psychotherapeutic malpractice, with particular emphasis on the standard applied in cases that involve unconventional therapies. Part III outlines the major policy conflict behind reforming the standard of care: the need to encourage innovative psychotherapeutic techniques without denying patients their right to receive responsible mental health care. Part IV analyzes the elements of an appropriate standard of care and concludes that a "dynamic model" would

22. This challenge is illustrated by the ongoing debate between those adhering to traditional Freudian psychoanalysis and those who advocate physical intimacy as a means of psychotherapy. The conflict between these two schools dates back to at least the 1920's, when Sandor Ferenczi began to advocate physical affection as a means of counteracting emotional deprivation. Freud expressed grave misgivings about these innovations in a letter to Ferenczi:

Now picture what will be the result of publishing your technique. There is no revolutionary who is not driven out of the field by a still more radical one. A number of independent thinkers in matters of technique will say to themselves: why stop at a kiss? Certainly one gets further when one adopts 'pawing' as well, which after all doesn't make a baby. And then bolder ones will come along who will go further to peeping and showing—and soon we shall have accepted in the technique of analysis the whole repertoire of demiviergerie and petting parties, resulting in an enormous increase of interest in psychoanalysis among both analysts and patients.


23. See infra notes 170-211 and accompanying text.

24. See infra notes 31-77 and accompanying text.

25. See infra notes 39-57 and accompanying text.

26. See infra notes 78-190 and accompanying text.

27. See infra notes 142-90 and accompanying text.

28. See infra notes 191-211 and accompanying text.

29. See infra notes 212-22 and accompanying text.
best provide guidance to courts, practitioners, and patients.30

I. THE LEGAL SETTING FOR PSYCHOTHERAPEUTIC MALPRACTICE

A. The Basis for a Cause of Action in Psychotherapeutic Malpractice

Courts have applied medical malpractice principles to analogous issues involving mental health professionals.31 This is not surprising given that the inquiry in either instance concerns the "quality of services rendered in the name of treatment."32

A plaintiff alleging misfeasance by a psychotherapist may base his cause of action on any one of a number of theories. He may bring an action based on contract.33 Liability under this theory may arise as a result of the practitioner's breach of an express obligation to use proper skill and care.34 More typically, however, liability is based upon the practitioner's breach of an implied obligation of conduct.35 The plaintiff also may frame a complaint in fraud, as where the psychotherapist offers a proposed treatment to the patient for the purpose of deceiving him.36

Most plaintiffs, however, base their claims against psychotherapists on a tort theory.37 Under this cause of action courts must

30. See infra notes 223-24 and accompanying text.
32. See Slovenko, supra note 4, at 5 & n.l.
35. Breach of contract or warranty usually arises from the physician's failure to achieve satisfactory results which were warranted, failure to perform services in a specific manner, or failure to perform services personally. W. CURRAN & E. SHAPIRO, LAW, MEDICINE & FORENSIC SCIENCE 556 (2d ed. 1970); see also Johnston v. Rodis, 251 F.2d 917, 918 (D.C. Cir. 1958) (summary judgment for defendant reversed where defendant stated that particular treatment was "perfectly safe").
38. The facts of a given case may indicate liability under more than one theory. See, e.g., Zostautas v. St. Anthony De Padua Hosp., 23 Ill. 2d 326, 329, 178 N.E.2d 303, 304 (1961) (noting that the same transaction could give rise to both contractual and noncontractual duties and thereby create causes of action in either tort or contract).
define an appropriate standard of care and then determine whether the defendant-therapist's conduct meets that standard.\(^{38}\)

B. Establishing the Prima Facie Case in Tort

1. Requisite Elements

The plaintiff in a malpractice action based on tort must establish four elements to make out a prima facie case.\(^{39}\) He must show (1) that there was a legal duty which required the defendant's adherence to a certain standard of care in treating the plaintiff; (2) that the defendant breached this duty either through his action or his failure to act; (3) that the plaintiff suffered an injury; and (4) that the defendant's breach of duty directly and proximately caused the injury.\(^{40}\)

_Dinnerstein v. United States\(^{41}\) illustrates how the four requisite elements arise in the context of psychotherapeutic malpractice. There, the widow of a psychiatric patient sued the United States for its failure to prevent her husband's suicide. The patient had a six-year history of deepening depression and on one occasion had made a suicidal "gesture."\(^{42}\) On the advice of a private psychiatrist, he sought admission to a Veterans' Administration hospital as a precaution against suicide.\(^{43}\) He requested individual psychotherapy but the hospital could only offer him group therapy.\(^{44}\) Allegedly depressed by this denial, the patient refused to admit himself.\(^{45}\) The

\(^{38}\) See infra notes 39-53 and accompanying text.

\(^{39}\) See W. Prosser & W. Keeton, _Prosser and Keeton on the Law of Torts_ § 30, at 164-65 (5th ed. 1984). An exception to this requirement is found in the relatively narrow class of cases where courts have applied the res ipsa loquitur doctrine. The plaintiff in such a case need not prove the four elements because the defendant's conduct by itself creates a clear inference of negligence. See, e.g., Hammer v. Rosen, 7 A.D.2d 216, 181 N.Y.S. 805 (1959), modified, 7 N.Y.2d 376, 165 N.E.2d 756, 198 N.Y.S.2d 65 (1960) (psychiatrist's physical abuse of patient created prima facie case of malpractice).

The court in _Hammer_ implied that if the defendant-therapist in such a case is able to introduce expert evidence that the assault or other conduct was proper treatment, the burden of proof would shift back to the plaintiff to produce expert testimony in rebuttal. Comment, _Standard of Care in Administering Non-Traditional Psychotherapy_, 7 U.C.D. L. Rev. 56, 73 (1974).

\(^{40}\) See W. Prosser & W. Keeton, _supra_ note 39, § 30, at 164-65.

\(^{41}\) 486 F.2d 34 (2d Cir. 1973).

\(^{42}\) Id. at 37. The decedent had previously driven his car into a bridge in what he termed a suicide attempt. This incident resulted in only minimal damage to himself and his automobile. _Id._ at 35.

\(^{43}\) _Id._ at 36.

\(^{44}\) _Id._

\(^{45}\) _Id._
next day, however, he returned and again sought admission. 46 The
admitting psychiatrist on this occasion diagnosed the patient’s con-
dition as a “depressive reaction.” 47 Though aware of his history,
the psychiatrist did not consider the patient suicidal; 48 he assigned
him to a seventh-floor ward without any special supervision. 49 An-
tidepressant medication was discontinued to discern his true psy-
chological state. 50 Later that evening, the patient complained that
he had become even more depressed because of the inadequacy of
the group therapy program. 51 The psychiatrist neither issued any
additional orders regarding supervision of the patient nor pre-
scribed antidepressant medication. 52 The following day, the patient
jumped to his death from a seventh-floor unsecured lavatory
window. 53

The hospital’s duty to guard against the possibility of suicide
arose when the hospital, in full knowledge of the patient’s mental
health history, admitted the patient to its care. 54 By assigning him
to a seventh-floor ward and failing to restrict his movement, the
hospital breached its duty. 55 These acts and omissions directly and
proximately caused the injury. 56 Had the hospital’s psychiatrists
assigned the patient to a ground floor ward or adequately super-
vised and restricted his behavior, they could have prevented the fa-
tal jump. 57

46. Id.

47. Id. Psychotic depressive reaction refers to those “severely depressed patients with
gross interpretations of reality including delusions and hallucinations who do not have a
history of previous depressions or of marked mood swings but whose symptoms are reactive
(i.e., attributable to some identifiable experience) and of psychotic degree.” PSYCHIATRIC

48. 486 F.2d at 36.

49. Id.

50. Id.

51. Id.

52. Id.

53. Id.

54. See id. at 38.

55. Id. at 38-39.

56. Id. The Dinnerstein court applied a “but for” test of causation: but for certain acts
or omissions, the injury would not have occurred. See infra text accompanying note 57. In
addition to “but for” causation, a prevalent approach has been the “substantial factor” test.
Where two or more agents are involved in the injury and either one alone would have been
sufficient to cause the injury, the defendant will be held liable if his conduct was a “substan-
tial factor” in causing the injury. See, e.g., Anderson v. Minneapolis, St. P. & S. Ste. M. Ry.,
146 Minn. 430, 179 N.W. 45 (1920).

57. 486 F.2d at 37.
2. Establishing the Causation Element in a Psychotherapeutic Malpractice Case

Proof of causation may be more problematic in a psychotherapeutic malpractice case than in a typical medical malpractice case. Despite a close connection between physical and mental health, a physician's treatment methods may offer a much more readily discernible mode of conduct in which to pinpoint causation—whereas a psychotherapist's treatment may not. For instance, a physician may turn to physical or chemical agents to cure his patient's bodily ills. A psychotherapist also might use these techniques to treat certain mental disorders; for others, however, he might use nonphysical techniques such as persuasion or suggestion. These nonphysical forms of treatment can hinder a plaintiff's efforts to prove causation because the precise impact of the psychotherapist's conduct is not necessarily tangible or quantifiable.

During the course of psychotherapy, for example, a series of psychotic episodes of varying intensity and duration may punctuate an overall trend of improvement. However, a particularly prolonged or intense psychotic episode, if viewed in isolation, would suggest that the therapist's treatment is to blame for the patient's deterioration. It may not be clear, therefore, whether such episodes were induced by the therapy or whether they are just natural incidents of the healing process. In the absence of sufficient knowledge of the course of the illness, an allegation that the therapy caused the deterioration is purely speculative.

The ease with which a plaintiff can show causation also depends on whether the therapy in question is nonverbal or verbal. In non-

58. Both share a common purpose to alleviate pathological human disorders.
59. Not all psychotherapists are permitted to practice physical and chemical techniques. Psychiatrists may diagnose patients, prescribe drugs and medicine, and administer shock therapy, while psychologists may not. D. Dawidoff, The Malpractice of Psychiatrists 2 (1973); 18 Encyclopedia Britannica 718 (1968).
60. For a brief summary of psychotherapeutic techniques, see definition cited supra note 1.
61. A psychotic episode occurs when the subject has a "persistent misvaluation of perception not attributable to sensory defect of afferent abnormality and not accounted for on the basis of special social indoctrination or unusual life experience." D. Klein & J. Davis, Diagnosis and Drug Treatment of Psychiatric Disorders (1969).
62. See D. Dawidoff, supra note 59, at 72-73 (discussing a hypothetical case in which a patient sues the therapist even before any overall trend of improvement has had a chance to emerge).
63. Id.
64. Id. at 72.
65. Id. at 73 & n.48.
verbal therapy the practitioner's action is more likely to take an identifiable form that has identifiable effects. Perhaps the most clear-cut examples are somatic therapies\textsuperscript{66} such as psychotropic drug medication\textsuperscript{67} or electroconvulsive therapy.\textsuperscript{68} Actionable conduct in the nonverbal context takes many other forms as well, including breach of confidentiality,\textsuperscript{69} failure to obtain informed consent,\textsuperscript{70} negligent administration of drugs and mechanical therapies,\textsuperscript{71} negligent diagnosis,\textsuperscript{72} wrongful commitment,\textsuperscript{73} malpractice in psychosurgery,\textsuperscript{74} and sexual impropriety.\textsuperscript{75} The affirmative na-
ture of these acts stands in sharp contrast to the mere words of verbal therapy.

In verbal therapy, on the other hand, a therapist's "action" might consist of mere suggestion or, at most, a prescription of behavior that the patient might follow. It does not involve direct intervention. As a consequence, the therapist in this kind of suit typically will avoid liability.77

Thus, it may be difficult for the plaintiff to establish the causation element of his prima facie case. Establishing a breach of the standard of care is even more problematic because courts have not prescribed a single, definitive standard.

II. STANDARD OF CARE

In a typical case, the therapy-produced injury is only one element of the malpractice case.78 It is also necessary to determine whether the defendant's level of care deviated from the accepted standard.79

Courts have analyzed the question of standard of care in the context of both conventional and unconventional therapies by engaging in a number of subinquiries. Given that psychotherapy is a specialty profession, courts have had to determine the standard appropriate to specialists.80 They also have had to consider whether a local or a national standard is appropriate.81 Further, they have examined whether the patient's "informed consent" will serve as a defense for the therapist.82 Finally, in deciding the standard of care for unconventional therapies, courts have evaluated the applicability of the "respectable minority" principle.83

76. That plaintiffs have had difficulty in framing a malpractice complaint when verbal therapy is involved may be negatively inferred from statistics compiled by the American Psychiatric Association regarding the sources of psychiatric malpractice. Verbal therapy does not even appear in an APA listing of the eight most frequent kinds of claims. See Taub, supra note 3, at 97.

77. Watkins & Watkins, Malpractice in Clinical Social Work: A Perspective on Civil Liability in the 1980's, 1 BEHAV. SCI. & L. 55, 69 (1983). Given the near impossibility of success in establishing a prima facie case when verbal therapy is at issue, it would seem appropriate to lessen the plaintiff's burden of proof.

78. But see supra note 39 (res ipsa loquitur lessens plaintiff's burden of proof).

79. W. PROSSER & W. KEETON, supra note 39, § 37, at 236-38.

80. See infra notes 84-98 and accompanying text.

81. See infra notes 99-106 and accompanying text.

82. See infra notes 107-25 and accompanying text.

83. See infra notes 142-90 and accompanying text.
A. Formulations of the Standard of Care for Conventional Therapies

1. Reasonable Care Under the Circumstances

One of the few settled points of law regarding the standard of care in psychotherapy is the principle that a practitioner is not the insurer of a perfect cure.\footnote{84} Nor is a practitioner required to exercise the highest degree of skill possible or even extraordinary skill or care.\footnote{85} Rather, the requirement is that he exercise reasonable care under the circumstances.\footnote{86}

Courts look to the psychotherapist's special knowledge and skill when determining what is "reasonable under the circumstances."\footnote{87} As a specialist,\footnote{88} the psychotherapist is held to the standard of care exercised by other professionals in his field of expertise who are similarly situated.\footnote{89}

Once the court articulates an appropriate standard of care, the plaintiff usually must provide expert testimony from within the profession to prove his case. Of course, the defendant may bring in his own expert to rebut the testimony of the plaintiff's expert. Such

\footnotetext[84]{See, e.g., Nicholson v. Han, 12 Mich. App. 35, 162 N.W.2d 313 (1968). In Nicholson, the court noted that even where the parties enter into an express contract containing a warranty for a "cure," the contract will not be enforced unless the statements of the parties clearly show that a warranty was made at the time the contract was formed. \textit{Id.} at 41-42, 162 N.W.2d at 316; see also Carl v. Matzko, 213 Pa. Super. Ct. 446, 455, 249 A.2d 808, 812 (1968),\textit{ citing} Donaldson v. Maffucci, 397 Pa. 548, 553, 156 A.2d 835, 838 (1959) (physician neither warrants a cure nor guarantees results of treatments).}


testimony enables the court to decide what a reasonably qualified practitioner would do under like circumstances.\textsuperscript{90} It also enables the trier of fact to compare meaningfully the defendant's conduct with that of his peers\textsuperscript{91} to determine whether his conduct deviated from that of a reasonably qualified practitioner.

As a general rule, expert testimony is required where the subject matter is "sufficiently technical that a lay juror cannot be expected to be equally well qualified to form a worthwhile judgment."\textsuperscript{92} In some cases, however, courts have dispensed with the requirement of expert testimony because either the malpractice is so obvious that it falls within common knowledge\textsuperscript{93} or the defendant's conduct prompts a res ipsa loquitur inquiry.\textsuperscript{94}

The legal usefulness of professionally-prescribed standards is a potential point of debate in any malpractice suit. Not only may professionals be less than objective when proposing standards to govern their own conduct, but also competing disciplines within the profession may produce conflicting expert testimony. Consequently, the privilege that therapists, as professionals, enjoy in proposing legal standards of care may be subject to close judicial

\textsuperscript{90} See, e.g., Powell v. Risser, 375 Pa. 60, 99 A.2d 454 (1953) (plaintiff's own expert testified that the defendant's wetpack treatment method was in accordance with accepted practice).

\textsuperscript{91} See, e.g., Dimitrijevic v. Chicago Wesley Memorial Hosp., 92 Ill. App. 2d 251, 236 N.E.2d 309 (1968) (expert testimony required to prove negligence when there was no evidence of a prior suicide attempt by plaintiff); Farber v. Olkon, 40 Cal. 2d 503, 254 P.2d 520 (1953) (expert required to evaluate electroconvulsive therapy procedures and hazards when patient's legs were fractured during treatment).

Courts have experienced difficulty with the expert testimony requirement in the field of psychotherapy. One of the issues that has arisen concerns whether a nonmedical psychologist can testify as to the issues of mental condition or competency. See People ex rel. Wellington v. Wellington, 34 Ill. App. 3d 515, 340 N.E.2d 31 (1975). This issue has not received uniform treatment throughout the country. Id. at 517, 340 N.E.2d at 33-34. A similar issue is whether a medical professional from one state can qualify as an expert in another. See Kronke v. Danielson, 108 Ariz. 400, 403, 499 P.2d 156, 159 (1972) (out-of-state board-certified specialist can testify against in-state board-certified specialist). A final issue of controversy is whether an expert from one "school" of thought can provide background about another "school." Medical malpractice law permits this practice so long as the methods of treatment espoused by the two schools are generally the same. Wemmet v. Mount, 134 Or. 305, 313-14, 292 P. 93, 96 (1930). The extent to which courts will permit such crossing-over of expert testimony in psychotherapeutic malpractice cases is unclear at present.


\textsuperscript{93} See, e.g., Olson v. North, 276 Ill. App. 457 (1934); see also Olfe v. Gordon, 93 Wis. 2d 173, 286 N.W.2d 573, 577 (1980) (expert testimony not required where negligence is apparent and undisputed).

\textsuperscript{94} See, e.g., Hammer v. Rosen, 7 N.Y.2d 376, 380, 165 N.E.2d 756, 757, 198 N.Y.S.2d 65, 67 (1960) (expert testimony on issue of malpractice unnecessary where "the very nature of the acts complained of bespeaks . . . malpractice").
scrutiny. The case of *Helling v. Carey*\(^9\) illustrates how one court questioned and rejected a standard developed by professionals in a health care specialty. The court held that the ophthalmology profession’s standard regarding glaucoma testing did not provide adequate safeguards for eye patients.\(^9\) Quoting Justice Learned Hand in *The T.J. Hooper*,\(^7\) the court stated:

> [A] whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.\(^8\)

This same principle could surface in the context of psychotherapy: the therapist who follows the accepted and customary practice of his specialty may be held liable nonetheless.

2. *Local vs. National Standard*

Courts also evaluate standards of care through application of the traditional “locality rule” or, alternatively, a national standard.\(^9\) The locality rule holds a practitioner to the level of care used by members of the profession in the same line of practice in his own or a similar community.\(^10\) A national standard, in contrast, views the required level of care as a function of the common practice throughout the profession.\(^10\)

Courts recently have begun to discard the “locality rule” in favor of a national standard. This trend may be explained by the increasing accessibility of information available to members of the profession.\(^10\) Moreover, recognition of board certification and the

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95. 83 Wash. 2d 514, 519 P.2d 981 (1974).
96. Id. at 519, 519 P.2d at 983.
97. 60 F.2d 737 (2d Cir. 1932).
98. Id. at 740.
102. *See* Robbins v. Footer, 553 F.2d 123, 128 (D.C. Cir. 1977); Blair v. Eblen, 461
development of national organizations have eroded the community aspect of standard of care.\textsuperscript{103}

The judicial movement toward a national standard and away from the "locality rule" is beneficial to psychotherapists. Specialties are inherently amenable to national standards because the treatment methods of a given specialty are seldom, if ever, geographically oriented.\textsuperscript{104} A national standard would reduce some of the confusion that courts encounter in determining a standard of care. It also would be more responsive to developments in mental health care practice throughout the country.\textsuperscript{105} Most importantly, a national standard would lead to a consistent and more responsible application of the standard of care.

A single national standard does not necessarily imply a one-dimensional, procrustean rule. Instead, a single national standard could operate within a unified framework and yet be flexible enough to deal equitably with all fact situations.\textsuperscript{106}

\section*{B. Events Which Might Preclude a Court From Reaching the Standard of Care Issue}

\subsection*{1. Informed Consent}

The psychotherapist's use of informed consent as a defense to a malpractice claim may prevent courts from reaching the standard of care issue. In its traditional formulation, the informed consent

\begin{footnotesize}
\begin{itemize}
\setlength\itemsep{0em}
\item S.W.2d 370, 373 (Ky. 1970); \textit{see also} B. Schutz, \textit{Legal Liability in Psychotherapy} 4 (1982) (commenting on demise of locality rule).
\item Horan & Guerrini, \textit{supra} note 3, at 67; \textit{see also} Siirila \textit{v. Barrios}, 398 Mich. 576, 614-15, 248 N.W.2d 171, 186 (1976) (noting that the locality rule developed prior to accreditation of medical schools by the American Medical Association's Council of Medical Education in 1906).
\item Two commentators have discussed this concept in the context of the traditional physician. Their comments are equally applicable to psychotherapy:
\begin{itemize}
\item The comprehensive coverage of the Journal of the American Medical Association, the availability of numerous other journals, the ubiquitous "detail men" of the drug companies, closed-circuit television presentations of medical subjects, special radio networks for physicians, tape recorded digests of medical literature, and hundreds of widely available postgraduate courses all serve to keep physicians informed and increasingly to establish national standards. Medicine realizes this, so it is inevitable that the law will do likewise.
\end{itemize}
\item D. Lousse\textsc{e}ll & H. Williams, \textit{The Parenchyma of Law} 183-84 (1960).
\item Given the existence of subspecialties within the profession, a single national standard of care for all psychotherapists is arguably impossible—except, perhaps, under a strict liability theory. But this arrangement does not preclude the possibility of a national standard for each subspecialty.
\end{itemize}
\end{footnotesize}
doctrine requires a physician to disclose to the patient certain information about possible risks attendant to a contemplated treatment. He may proceed with the treatment only if the patient has voluntarily consented to it. The purpose of the informed consent doctrine is to protect a patient's ability to determine his own course of treatment, and courts have extended such protection to patients receiving mental health care.

Informed consent in the psychotherapeutic context presents very special problems for courts. The doctrine assumes that the patient is competent. Realistically, however, the patient's ability to make an informed, voluntary choice may be impaired by his illness, particularly in situations where he has become dependent on the therapist. In the gray area between competency and incompetency, courts must determine whether the patient had sufficient mental ability to understand the disclosed information and to make a rational choice based on the information given to him.

The extent of a psychotherapist's duty to disclose depends on the type of therapy involved. In the case of conventional psychotherapies, the professional need only disclose "those risks which a reasonable man would consider material to his decision whether or not to undergo treatment." This limitation relieves practitioners of the burden of having to explain every conceivable risk.

New or unconventional treatments, on the other hand, require that the therapist disclose the nature of the treatment and its collat-

107. See, e.g., Canterbury v. Spence, 464 F.2d 772, 781-82, 787-88 (D.C. Cir. 1972); see also Woods v. Brumlop, 71 N.M. 221, 228, 377 P.2d 520, 525 (1962) (full disclosure not required (1) in actual emergency where patient not in condition to consent or (2) where it might result in alarming the patient, thereby increasing the risk either through apprehension or through the patient's refusal of a treatment which carries only minimal risk).
111. See id. at 2064.
114. It has been observed that an evaluation of competency should address: (1) whether the patient evidences a choice; (2) whether that choice is a reasonable one; (3) whether the choice is based on rational reasons; (4) whether the patient has an ability to understand the information vital to the decision-making process; and (5) whether the patient has an actual understanding of that information. Roth, Meisel & Lidz, Tests of Competency to Consent to Treatment, 134 Am. J. Psychiatry 279, 280-82 (1977).
116. Id. at 85, 363 A.2d at 1176.
eral risks.\textsuperscript{117} To protect the patient in this situation, the law specifies a two-part duty of disclosure.\textsuperscript{118} The therapist must disclose all known collateral risks,\textsuperscript{119} and also make reasonable efforts to discover unknown collateral risks.\textsuperscript{120} Assuming that these requirements are met, and the patient has consented, liability will depend upon the reasonableness of the treatment itself.\textsuperscript{121} The treatment is "reasonable" if the therapist is able to conclude that enough is known about the procedure's collateral risks to justify its use.\textsuperscript{122}

While the informed consent doctrine may preclude a court from reaching the standard of care issue, it ensures a balance between the rights of patients and the development of therapeutic techniques.\textsuperscript{123} It protects patients by assigning liability where consent is invalidated either through a lack of competency on the part of the patient or because of faulty or insufficient information disclosure on the part of the therapist. As a further precaution, it assigns liability where the therapist has failed to meet the heightened disclosure duty that attaches to less conventional therapy. Even though informed consent does operate to restrict therapists, it also grants them a carefully circumscribed freedom\textsuperscript{124} to pursue unconventional, yet agreed-upon treatments.\textsuperscript{125}

2. Stringent Requirements for the Prima Facie Case: Topel v. Long Island Jewish Medical Center\textsuperscript{126}

The informed consent doctrine is not the only factor that may

\textsuperscript{117} D. LOUISELL & H. WILLIAMS, 2 MEDICAL MALPRACTICE ¶ 22.13 (1983). Those cases usually arise where (1) there is a collateral side effect to treatment; (2) the practitioner fails to warn the patient adequately of that possibility when securing the consent; or (3) the practitioner fails to advise the patient as to alternative modes of treatment.


\textsuperscript{120} See \textit{Restatement (Second) of Torts} § 300 (1965): "When an act is negligent if done without reasonable preparation, the actor, to avoid being negligent, is required to make the preparation which a reasonable man in his position would recognize as necessary to prevent the act from creating an unreasonable risk of harm to another."

\textsuperscript{121} See Waltz & Scheuneman, \textit{supra} note 118, at 633.

\textsuperscript{122} \textit{Id}.

\textsuperscript{123} See \textit{infra} note 125.

\textsuperscript{124} The license is not absolute. Aside from the limitation that the disclosure duty places on this freedom, courts have held that a patient's consent does not insulate a doctor from liability for negligence in the administration of the therapy. See, e.g., Valdez v. Percy, 35 Cal. 2d 338, 217 P.2d 422 (1950).

\textsuperscript{125} H.L.A. Hart perceives the unimpeded exercise of free choice as a doctrine that "enables individuals to experiment . . . and to discover things valuable both to themselves and to others." H. HART, LAW, LIBERTY, AND MORALITY 21-22 (1963).

preclude a court from reaching the standard of care issue. Recently, a doctrine has evolved which could conceivably make the standard of care irrelevant. In *Topel v. Long Island Jewish Medical Center*, the court held that expert testimony which fails to negate the factors underlying a psychiatrist's professional judgment is an insufficient basis for claiming negligence. This requirement stands in stark contrast to the conventional rule regarding burden of proof. The latter rule requires the plaintiff merely to produce expert testimony in support of his claim, not to negate his opponent's defense.

In *Topel*, a suicidal patient was admitted to a hospital for psychiatric treatment after having twice attempted suicide. The hospital's examining psychiatrist considered the patient's condition "life threatening," and ordered that the patient be observed at fifteen-minute intervals. Eventually, while left alone in his room, the patient committed suicide. Members of his family sued the hospital and the psychiatrist for malpractice. At trial, the plaintiff's expert testified that observation at fifteen-minute intervals constituted a deviation from the accepted medical practice. The defendant's expert maintained that the decision whether to keep the patient on constant observation, as opposed to observation at fifteen-minute intervals, was purely a matter of professional discretion. As such, the expert contended, the psychiatrist could not be held liable. The trial court agreed with the defendant and

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127. Id.
128. Id. at 684-85, 431 N.E.2d at 295, 446 N.Y.S.2d at 934.
129. See supra notes 87-92 and accompanying text.
131. Id. at 686-87, 431 N.E.2d at 296, 446 N.Y.S.2d at 936 (Fuchsberg, J., dissenting in part). The attending psychiatrist based his judgment upon the following factors: (1) the patient's adverse reaction to constant surveillance; (2) the possibility that his heart condition would be aggravated by continuing such surveillance; (3) the "gesture-like nature" of his previous suicidal tendencies; (4) the rehabilitative aspects of "open ward" treatment; and (5) the enhanced probability of obtaining the patient's consent to electroconvulsive therapy in the more relaxed open ward atmosphere. Id. at 685, 431 N.E.2d at 295, 446 N.Y.S.2d at 934.
132. Id. at 688, 431 N.E.2d at 297, 446 N.Y.S.2d at 936 (Fuchsberg, J., dissenting in part).
133. Id. at 685, 431 N.E.2d at 295, 446 N.Y.S.2d at 934. The court dismissed the claim against the hospital because the plaintiff failed to present evidence that it had improperly carried out the psychiatrist's fifteen-minute observation order. Id. at 684, 431 N.E.2d at 294, 446 N.Y.S.2d at 933.
134. Id. at 688-89, 431 N.E.2d at 297, 446 N.Y.S.2d at 936.
135. Id.
136. Id. at 684, 431 N.E.2d at 294-95, 446 N.Y.S.2d at 933-34.
overturned a jury verdict for the plaintiff.\textsuperscript{137} It dismissed the case on the grounds that the plaintiff had failed to establish a prima facie case.\textsuperscript{138}

The \textit{Topel} court's strict rule treats plaintiffs in psychotherapeutic malpractice suits harshly.\textsuperscript{139} It significantly raises the evidentiary threshold that such a plaintiff must meet to have his case submitted to the jury. Proponents of the \textit{Topel} rule may argue that it is beneficial because it acts to screen out ostensibly unwarranted claims. Realistically, however, the strict rule discourages even well-founded lawsuits against psychotherapists.\textsuperscript{140} Its result is to leave many deserving plaintiffs without a remedy against their psychotherapists.

3. \textit{Topel} in the Context of Unconventional Therapies

The litigation-deterrent effect of the \textit{Topel} rule is probably most pronounced in cases that involve unconventional therapies. Consider the following hypothetical example. A plaintiff alleges injuries resulting from his psychiatrist's use of an unconventional treatment. The defendant-psychiatrist developed the technique, and to date is the only person who practices it. Because no other practitioner of this technique is available, the plaintiff must resort to the use of an expert who is, at best, only vaguely familiar with it. At trial, the plaintiff's expert is unable to negate the factors underlying the defendant's technique, and the claim is summarily dismissed.

What is unacceptable here is that the expert testimony is labeled insufficient only because the evidentiary rule about what constitutes a prima facie showing has been tightened. Such testimony might have been sufficient under the traditional requirements for a prima facie case.\textsuperscript{141} Since it is futile for the hypothetical plaintiff to pursue his claim in a \textit{Topel} jurisdiction, he is effectively denied judicial redress. The \textit{Topel} rule severely undercuts the interests of the plaintiff.

\textsuperscript{137} \textit{Id.} The Court of Appeals of New York affirmed. \textit{Id.} at 682, 431 N.E.2d at 293-94, 446 N.Y.S.2d at 932-33.

\textsuperscript{138} \textit{Id.} at 684-85, 431 N.E.2d at 295, 446 N.Y.S.2d at 934 (affirming the result reached by the lower courts).

\textsuperscript{139} If the court had not applied such a difficult standard, the plaintiff might have won. As Judge Fuchsberg noted in dissent, the plaintiff raised a classic prima facie case. The plaintiff's expert testimony revealed that the defendant's treatment deviated from acceptable medical practice, and caused the patient to die. \textit{Id.} (Fuchsberg, J., dissenting in part).

\textsuperscript{140} \textit{See} 56 ST. JOHN'S L. REV. 763, 780-89 (1982) (arguing that \textit{Topel}'s rationale of discouraging psychiatric malpractice suits is unnecessary in light of legislative measures already in place which serve the same litigation-deterrent function).

\textsuperscript{141} \textit{See supra} text accompanying note 150.
in precisely the case where full judicial examination of the claim would seem imperative.

C. Unconventional Therapies and the Respectable Minority Rule

1. The Respectable Minority Rule: Underlying Theory

The "respectable minority" rule is a reflection of the courts' recognition that more than one school of thought may exist within a given discipline. Due to the distinctly different nature or scope of their techniques, the practitioners of different schools of thought may adhere to contrasting standards of conduct. Where this situation exists, it is possible that (1) no single school is necessarily best; and (2) the standard of conduct that applies to one school may not apply to the other. Medical malpractice law has taken these two possibilities into account by developing the doctrine that a doctor is to be judged by the school he professes to follow.

To qualify as a school which courts will recognize, the method or approach should fall roughly within the definition articulated by Dean Prosser. It must be "a recognized school with definite principles, and be the line of thought of at least a respectable minority of the profession."

2. How the Respectable Minority Rule Applies to Physician Malpractice

The respectable minority rule provides that the mere use of a minority approach in treating a patient is not an automatic breach
of the required standard of care. A physician will avoid liability for malpractice where his method of treatment is supported by a respectable minority of physicians. The respectable minority approach does not suggest, however, that a physician can practice medical treatments on an independent basis. Liability attaches when his treatment does not conform to the set standards of the minority school.

3. Application of the Respectable Minority Rule to Schools of Psychotherapy

The application of the respectable minority rule to psychotherapeutic malpractice is appropriate given the plethora of distinct therapeutic practices within the mental health field. Each “school” has its own method, emphasis, and goals. Courts have not been consistent in applying the respectable minority rule to “schools” of psychotherapy, but where they have applied the rule, the result has benefited the practitioner of an unconventional therapy.

Minority psychotherapeutic techniques such as the “open door” approach have been especially frequent subjects of litigation. In Johnson v. United States, the widow of a psychiatric patient challenged the permissibility of the “open door” policy and balancing test that the hospital’s doctors and psychiatrist had used. The

149. See, e.g., Leech v. Bralliar, 275 F. Supp. 897, 902 (D. Ariz. 1967) (holding that prolotherapy, as used by a respectable minority of physicians, was not an inappropriate method of treatment for the plaintiff’s whiplash injuries).

150. Hood v. Phillips, 537 S.W.2d 291, 294 (Tex. Civ. App. 1976), aff’d, 554 S.W.2d 160 (Tex. 1977); see also Hubbard v. Calvin, 83 Cal. App. 3d 529, 532-33, 147 Cal. Rptr. 905, 907 (1978) (jury instruction characterizing physician’s use of minority approach as inculpatory was reversible error); Meier v. Ross Gen. Hosp., 69 Cal. 2d 420, 445 P.2d 519, 71 Cal. Rptr. 903 (1968) (use of one of several alternative modes of treatment which is accepted by the profession held to be an exercise of proper care).


153. See N. FINKEL, supra note 1, at 62-70 (identifying twenty-two “individual” psychotherapies and six “group” therapies).

154. See supra note 101.

155. Advocates of the “open door” policy argue that psychiatric patients need not be isolated from normal human activities until every possible danger has passed. A traditional “confinement” approach, they argue, is faulty for two reasons. First, constant supervision and restriction often promote the very disorders which they are intended to control. Second, confinement results in prolonged incarceration for many patients who might otherwise become useful members of society. See Johnson v. United States, 409 F. Supp. 1283, 1293 (M.D. Fla. 1976).


157. Psychiatrists who practice an “open door” method must balance the therapeutic benefits of release against the possibility of self-inflicted harm or violence to others. If, in the
patient had committed suicide after having been treated and released from hospital confinement.\textsuperscript{159} Noting that other jurisdictions had recognized the validity of this technique, the court held that the defendant's "open door" policy was a permissible method of psychiatric treatment under applicable state law.\textsuperscript{160} Liability would not arise, said the court, "merely because a psychiatrist favors a newer [therapeutic] approach over an older one."\textsuperscript{161}

4. \textit{Determining a Respectable Minority}

The determination of whether practitioners of a "school of thought" constitute a respectable minority will often decide the permissibility of their therapies. It is clear that psychoanalysis, client-centered therapy, and other traditional forms of psychotherapy fit within the definition of a "school."\textsuperscript{162} Newer methods such as Gestalt therapy,\textsuperscript{163} rational-emotive therapy,\textsuperscript{164} and transactional anal-

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\textsuperscript{158} \textit{Id.} at 1293-95.
\textsuperscript{159} \textit{Id.} at 1290-92.
\textsuperscript{160} \textit{Id.} at 1293.

\textsuperscript{161} \textit{Id.; see also} Landau v. Werner, 105 SOL. J. 257, 23 THE TIMES (London), Nov. 23, 1961, at 5, col. 1 (psychiatrist held liable for grave deterioration in condition of patient with whom he had maintained a social relationship under the guise of "therapy"). The justice in Landau admonished courts to be cautious about finding a physician negligent merely because his treatment was unsuccessful or contrary to what a large majority of medical opinion would have recommended.

\textsuperscript{162} \textit{See} 3 D. HOGAN, \textit{supra} note 15, at 9. Both psychoanalysis and client-centered therapy have distinguished and relatively long histories. Freud developed and elaborated the first psychoanalytic method during the early years of this century. \textit{See generally} S. FREUD, \textit{THE INTERPRETATION OF DREAMS} (J. Strachey trans. 1965); S. FREUD, \textit{THREE ESSAYS ON SEXUALITY} (1905). Psychoanalysis investigates mental processes by means of free association, dream interpretation, and transference. N. FINKEL, \textit{supra} note 1, at 62; \textit{see infra} notes 184-87 and accompanying text (transference phenomenon).

\textsuperscript{163} According to Gestalt therapy, disturbed behavior is the manifestation of a painful polarization between two elements in a psychological process. The traditional treatment attempts to integrate the discordant elements through active participation by the therapist and
ysis also are arguably within the definition. The courts have been more hesitant, however, to classify techniques such as sexual intimacy or rage-reduction as "schools" of practice.

A court should consider several factors in determining whether a respectable minority supports a given therapy. These factors might include 1) the existence of a professional association which follows the method; 2) the existence of articulated standards of practice; and 3) the existence of ethical guidelines. These criteria represent an attempt at providing some indicia of whether the "school" designation should attach to the therapeutic technique in question.

5. Example: Should Physical Intimacy Be Accorded the Status of a "School of Thought"?

Physical intimacy between the psychotherapist and the patient can arise in two ways. First, the therapist might suggest that he and the patient engage in such conduct as a therapeutic measure. Second, the nature of the psychotherapeutic relationship itself can engender feelings of physical closeness which may lead to intimate

an emphasis on immediate behavior and feelings. See N. Finkel, supra note 1, at 65; Current Psychotherapies, supra note 162, at 251.

164. Rational-emotive therapy, which began in the 1950's, is based on the theory that irrational thinking causes emotional disturbances and that the patient can control or eliminate these disturbances through rational thinking. See N. Finkel, supra note 1, at 65-66.

165. Transactional analysis examines the ego structure of the patient (i.e., child, adult, and parent components) and then assesses single transactions in terms of this structure, with the result that the patient gains a level of awareness which enables him to make new decisions about his future behavior. See N. Finkel, supra note 1, at 66; Current Psychotherapies, supra note 162, at 353.

166. See 3 D. Hogan, supra note 15, at 9. These methods are not as well established as are psychoanalysis and client-centered therapy. Each has a sizeable following, however, and is generally recognized in the literature as a school of thought. See, e.g., N. Finkel, supra note 1, at 49-73.


168. See, e.g., Abraham v. Zaslow, a 1972 unreported California case cited in 3 D. Hogan, The Regulation of Psychotherapists 36 (1979). In Zaslow, the defendant-psychotherapist was held liable for use of an experimental "rage-reduction" therapy which resulted in physical and mental injuries to the patient. "The purpose of the therapy was to break down the patient's resistance through extensive use of tactile stimulation while the patient was immobilized." Id. This procedure would then allow repressed anger to escape. Id. But see, e.g., Hammer v. Rosen, 7 A.D.2d 216, 181 N.Y.S.2d 805 (1959) (psychiatrist held not liable for practice of "rage reduction" techniques).


bodily contact between patient and therapist. There is a special
quality of intimacy and intensity that defines the psychotherapeutic
relationship.\textsuperscript{171} A patient generally has frequent personal contact
with the therapist and may even regard him as a friend.\textsuperscript{172} The
process often creates powerful feelings which the patient may attach
or "transfer" to the therapist.\textsuperscript{173} In this "transference" phenome-
on, the patient imputes to the therapist the role of an oppressive
parent or other figure\textsuperscript{174} and learns, through seeing himself interact
with the therapist, to work through his problems.\textsuperscript{175}

While sexual contact is not uncommon in psychotherapy,\textsuperscript{176}
there are few therapists who openly advocate engaging in sex with
patients as a form of therapy.\textsuperscript{177} By indulging in the romantic as-
pect of the transference phenomenon, the therapist may prevent the
patient from actually working through his psychological
problems.\textsuperscript{178} Arguably, such conduct constitutes malpractice.

The codes of both the American Psychiatric Association and the
American Psychological Association state that it is unethical for
therapists to engage in intimate physical contact.\textsuperscript{179} Yet it is plausi-

\textsuperscript{172} Comment, \textit{supra} note 4, at 130.
\textsuperscript{173} T. Gutheil \& P. Appelbaum, \textit{supra} note 74, at 119.
\textsuperscript{174} \textit{Id.} The transference feelings may represent either realistic assessments of or delu-
sional perceptions about the object of the transference. \textit{Id.}
\textsuperscript{175} Taub, \textit{supra} note 3, at 101.
\textsuperscript{176} A 1973 study found that 5-7.2\% of a random sample of psychiatrists had had sexual
intercourse with their patients. The survey also showed that another 5-13\% had engaged in
sexual contact short of intercourse. Kardener, Fuller \& Mensh, \textit{A Survey of Physicians' Atti-
tudes and Practices Regarding Erotic and Nonerotic Contact with Patients}, 130 Am. J. Psy-
chiatry 1077, 1079-80 (1973). A similar study conducted four years later revealed that
6.1\% of licensed psychologists had had sexual intercourse with patients. Holroyd \& Brod-
sky, \textit{Psychologists' Attitudes and Practices Regarding Erotic and Nonerotic Contact with Pa-
\textsuperscript{177} Marmor, \textit{supra} note 171, at 11-14.
\textsuperscript{178} Taub, \textit{supra} note 3, at 101; see also T. Gutheil \& P. Appelbaum, \textit{supra} note 87, at
119 (arguing that patient may refuse to accept treatment on basis of transference of feelings).
\textsuperscript{179} In 1973, the American Psychiatric Association stated that such conduct was unethi-

cal. \textit{See The Principles of Medical Ethics, With Annotations Especially Applicable to Psychia-
followed suit in 1979:

Psychologists are continually cognizant of their own needs and of their inherently
powerful position vis-a-vis clients, in order to avoid exploiting their trust and depend-
cy. Psychologists make every effort to avoid dual relationships with clients
and/or relationships which might impair their professional judgment or increase
the risk of client exploitation. Examples of such dual relationships include treating
employees, supervisees, close friends or relatives. Sexual intimacies with clients are
unethical.

\textbf{American Psychological Association, Ethical Standards of Psychologists,}

ble that such a practice may constitute a "school." Those therapists who do advocate sexual activity as a mode of treatment have in fact formed a professional group known as the American Association of Sex Educators, Counselors and Therapists. This association has developed its own code of ethics and has articulated certain standards of conduct. At least superficially, then, this group would appear to have all the benchmarks necessary to qualify as a school of psychotherapy.

The courts have not recognized such conduct as a legitimate form of therapy; rather, they have consistently treated it as malpractice. In *Zipkin v. Freeman*, for example, the psychiatrist was held liable for "mishandling" the transference phenomenon when he induced the patient to become his mistress, took her to functions outside the consultation room (such as a nude swimming party), and suggested that she obtain a divorce and move in with him. In another case, *Roy v. Hartogs*, the plaintiff consulted the defendant-psychiatrist specifically for treatment of her sexual problems. At the suggestion of the psychiatrist, they had sexual relations over a period of thirteen months as part of her treatment program. The plaintiff's mental illness worsened, allegedly as a result of the defendant's actions, to the extent that she twice had to be confined to a mental hospital. The trial court held the psychiatrist liable for malpractice, citing the existence of a public policy to "protect the patient from a deliberate and malicious abuse of power and breach of trust by a psychiatrist when the patient entrusts to him her body and mind in the hope that he will use his best efforts to find a cure."

In the event that attitudes toward sex therapy become more permissive or the understanding of sexual needs changes significantly, courts perhaps may reexamine the prohibition against sex as a therapeutic technique. Absent such a change in the views of practitioners...
ers and society, however, courts will almost certainly continue to hold therapists liable for engaging in intimate physical contact with patients.\footnote{190}

III. THE NEED TO BALANCE EXPERIMENTATION AGAINST PATIENTS' RIGHTS IN REACHING AN APPROPRIATE STANDARD OF CARE

An accepted psychotherapeutic practice will pass through three stages. First it is experimental, then it is recognized as a "new" procedure, and finally it becomes commonly accepted.\footnote{191} In the experimental phase, the psychotherapist applies the technique at his peril.\footnote{192} But when a significant number of the profession begins to use it in ordinary practice, the technique should become a legally accepted practice.\footnote{193} An illustration of such an evolution is electroconvulsive therapy. When introduced in 1938 it was a dramatic experiment with unknown risks.\footnote{194} It has now become a conventional, though still controversial, procedure.\footnote{195} If courts were to reject this accepted form of therapy, they "would be penalizing in-

\footnote{190. Sex therapy has been the subject of increasing criticism by those who question its efficacy. \textit{See}, e.g., Sobel, \textit{Sex Therapy: As Popularity Grows, Critics Question Whether it Works}, N.Y. Times, Nov. 4, 1980, at Cl, col. 5, and Nov. 11, 1980, at Cl, col. 1.}

\footnote{191. Curran, \textit{Professional Negligence—Some General Comments}, 12 \textit{VAND. L. REV.} 535, 541 (1959); \textit{see}, e.g., Board of Medical Regis. & Exam. v. Kaadt, 225 Ind. 625, 76 N.E.2d 669 (1948). The \textit{Kaadt} decision states in relevant part: A physician is not limited to the most generally used of several approved modes of treatment and the use of another mode known and approved by the profession is proper, but every new method of treatment should pass through an experimental stage in its development and a physician is not authorized in trying untested experiments on his patients. \textit{Id.} at 634, 76 N.E.2d at 672.}

\footnote{192. \textit{Id}.}

\footnote{193. Curran, \textit{supra} note 191, at 541.}

\footnote{194. Although for many years the popular media has questioned the efficacy of electroconvulsive therapy, objective comments from within the profession attest to its clinical usefulness. It has been argued that the long-term side effects of electroconvulsive therapy are rare in modern practice, and that often it is "the only treatment that is likely to be effective (or sufficiently rapidly effective) in certain life-threatening situations." T. BUTHEIL & P. APPELBAUM, \textit{supra} note 87, at 96. \textit{See also} Sobel, \textit{Electroshock Treatment: Safer and Quicker Than Drugs?}, N.Y. Times, Dec. 21, 1979, at A16, col. 3 (discussing the conflicting views of former mental patients, public interest groups, and psychiatrists regarding use and abuse of electroconvulsive treatment); \textit{Comeback for Shock Therapy? Its Unsavory Reputation May Be Changing}, \textit{Time}, Nov. 19, 1979, at 76 (electroconvulsive therapy defended as an effective mode of treatment for some mental illnesses); Impastato, \textit{The Story of the First Electroshock Treatment}, 116 \textit{AM. J. PSYCHIATRY} 1113, 1113-14 (1960) (describing the original electroconvulsive experiment).}

\footnote{195. \textit{Id}.}
telligent advances" in psychotherapy.  

One commentator has argued that experimentation should be given greater deference and, accordingly, greater legal protection. The rationale in one court decision suggests such deference. In Saron v. State, the plaintiff claimed that the psychiatrist's use of an experimental drug in the treatment of schizophrenia constituted malpractice. An expert witness testified, however, that the alleged injury could have been caused by factors other than the drug. The testimony as to the then-known consequences of the drug was equivocal, and the court held for the defendant. The court thus indicated that, even when there are conflicting opinions about the efficacy of an experimental therapy, the use of such a therapy should not, as a matter of course, be categorized as malpractice.

Taking deference to experimental techniques one step further, it has been argued that ethical principles should be established through experimentation. Rules of conduct governing any professional activity must, according to this theory, be based upon knowledge of that activity's potential effects. If, to the contrary, policy precedes research, then it inhibits discovery of facts and relevant comparisons that are essential for a full scientific evaluation of issues in psychotherapy. In the context of principles governing psychotherapeutic research, this necessary factual basis would arise from experimentation itself.

This proposition has touched off a vociferous debate, and has

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196. Curran, supra note 191, at 541 (discussing the need for law to respect the mechanisms of advancement in all professions generally).
198. 24 A.D.2d 771, 263 N.Y.S.2d 591 (1965) (mem.).
199. Id. at 771, 263 N.Y.S.2d at 592.
200. Id.
201. Id.
203. Id.
204. Id. at 908.
205. See id. at 907-08. Gergen supports his thesis that researchers should be given more latitude in experimentation by arguing that strict rules are simply unwarranted. For several reasons, says Gergen, concern for the personal rights of individuals who are the subjects of research is misplaced:

If subjects are generally unconcerned about what is to happen to them, if they find experimental deceptions rather intriguing, if they do not care about the rationale of the research, and if their attitudes about life and themselves remain untouched regardless of whether the ethical principles [such as obtaining informed consent, avoiding deception, or allowing the patient freedom to withdraw] are experimentally realized, then establishing and reinforcing the principles simply pose unnecessary hardships for the scientist. The life of the research psychologist is difficult
come under attack as a "contravention of human rights and dignity." An opponent argues that while such an experimentation policy would expand understanding and knowledge of the psychotherapeutic process, it would also violate the personal rights of individual research participants. For this reason, he says, the policy is inadequate and is an improper reflection of the profession's equal concern for both the advancement of psychological science and protection of the patient's welfare.

In order to balance the need for experimentation against patients' rights, psychotherapists who use unconventional techniques must attempt to authenticate those methods which work and those which do not. Unless they do so, it is possible that the mental health profession might be viewed as a specialty concerned solely with "radical experimentation." For its part, the law must recognize that there is a place for innovation, and if psychotherapy is to evolve, courts must be wary of hindering necessary experimentation.

IV. ELEMENTS OF A RELEVANT STANDARD OF CARE

A. Interests Involved

The creation of an appropriate legal standard against which to measure psychotherapists' conduct must begin with an assessment of competing interests. Persons who sustain injuries flowing from the conduct of psychotherapists have an interest in obtaining some form of compensation for their suffering. The practitioner has an interest in his freedom to develop new methods of treatment to the fullest extent that his experience and ability permit. And society, by virtue of its role in providing for the health and welfare of its

enough without harnessing him with research restrictions that have few real-world consequences.

Id. at 907.


207. Gergen, supra note 197, at 911-12. The "accumulation of knowledge" is, for Gergen, an essential component in the continued efficacy of psychotherapy. See id.


209. Id.


211. Stone, supra note 210, at 225.
individual members, has a concomitant interest in fostering advancement within the field of psychotherapy.  

The purpose of a standard embodying these goals is twofold. As a practical matter, the legal standard must provide guidance to mental health professionals; as a policy matter, it must be flexible enough to ensure a fair disposition of the interests that are at stake.

B. Assumptions

1. The Nature of the Psychotherapeutic Process

The relationship between the therapist and patient is inherently susceptible to abuse. The patient suffers from a weakened ego or mental state and typically will seek a dependency relationship. Through "transference" and similar phenomena, the psychotherapeutic process offers an environment in which dependency can thrive. If the patient is injured and chooses to sue his psychiatrist, there are certain consequences that must be viewed in light of these conditions.

2. Consequences

a. Informed Consent. Given the nature of the psychotherapeutic process, the patient may be unable to give an "informed" consent. Even if he is able to do so, he is probably unable to render a completely objective consent. It would seem appropriate, then, for the courts to view a defense based on informed consent more critically in psychotherapeutic malpractice cases than they would in nonpsychotherapeutic circumstances.

b. Establishing the Validity or Invalidity of the Therapy. A plaintiff has the burden of demonstrating that a given therapy is unreasonable. The enormous diversity of psychotherapeutic techniques adds to this burden. Moreover, at least one jurisdiction has adopted a rule that increases this burden by requiring the

212. Cf. supra note 207 and accompanying text (explaining that the ability of psychotherapy to advance and thereby become more effective is largely a function of rules that are promulgated by forces such as professional associations, which are not overly restrictive or detrimental).

213. See supra notes 171-78 and accompanying text.

214. Id.

215. Id.

216. See supra notes 107-25 and accompanying text.

217. See R. Cohen, supra note 197, at 65-69.

218. See supra notes 39-40 and accompanying text.

219. See supra notes 152-54 and accompanying text.
plaintiff to negate the factors upon which the defendant-psychiatrist has based his judgment.\textsuperscript{220}

Given the dependency and potential for manipulation that emerge from the therapist-patient relationship, the plaintiff's burden should be lessened.\textsuperscript{221} One possibility is that the law might require the defendant-psychotherapist to prove that his conduct did not cause the injury.

One commentator has even suggested an absolute liability standard for psychotherapeutic malpractice.\textsuperscript{222} Such an extreme view would dispense with the notion of a standard of care as too inconvenient for the judicial system to administer. It does, however, focus needed attention on the desirability of a more uniform standard of care. But the uniformity that such an approach envisions is probably unrealistic given the evolutionary nature of and diversity inherent in mental health care.

\section*{C. Dynamic Model}

In formulating a standard of care to which the practitioner of a newer therapy should be held, a court should bear in mind the motives upon which a psychotherapist might base his conduct. Ideally, he would be motivated by a desire to render effective treatment—not by fear of a malpractice suit.\textsuperscript{223} A court must also recognize the dynamic relationship that exists between accepted current practice and advancement in the discipline. Where innovation and patients' rights clash, a court must be prepared to weigh all the interests against one another. Even the most legitimate claim must not obscure the importance of engaging in an objective evaluation of both the present risk and the future potential of an unconventional therapy.

Though courts should always make a careful inquiry, the legal standard need not keep pace with each and every innovation. Experimentation carries with it certain risks for which practitioners should remain liable, and an individual's conduct must fall within certain professionally-prescribed ethical limits. As a point of depa-

\textsuperscript{220} See supra notes 126-41 and accompanying text.

\textsuperscript{221} This is especially true when verbal therapy is at issue. See supra note 77.


\textsuperscript{223} This is not to suggest that psychotherapists should not contemplate the possibility of malpractice when devising and implementing new techniques. Rather, in the absence of other motivational forces, it might instill an attitude of undue precaution which could deprive individuals of psychotherapeutic treatment altogether.
ture, the court should make an effort to determine whether the challenged technique commands the support of a respectable minority. Sources to which a court could look in deciding this question might include standards and ethical guidelines articulated by "respectable" professional associations or similar authorities for the particular kind of conduct involved in the claim.224

The specific rule of law governing the standard of care in a given case should be a reflection of the tensions that exist between current psychotherapeutic practice and the current state of innovation. The standard also should be an intelligent reflection of this balance, recognizing that the law plays a significant role in creating or stifling an environment where psychotherapy might fully realize its potential. The evolution of psychotherapeutic practice over time—as in the emergence of a given therapy from the realm of the experimental to that of the commonplace—attests to the profession's dynamic characteristic.

In short, a dynamic model for standard of care requires the court in a psychotherapeutic malpractice case to make the following inquiry:

1) Whether the therapy is conventional or unconventional. If it is conventional, the parties must present expert testimony to establish the appropriate standard of care. To prevail, the plaintiff must prove that the defendant's conduct deviated from that standard.

2) If the therapy is unconventional, it must be advocated by a respectable minority of practitioners from which a representative may testify as to what is the appropriate standard and whether the defendant breached that standard.

3) If the therapy is both unconventional and experimental so as to fall outside of a respectable minority following, two matters must be resolved. First, it must be determined whether the therapy is ethical. There must also be experts available to testify as to whether the therapy is reasonable.

To insure a balance between the plaintiff's opportunity to find suitable experts and the therapist's opportunity to explain the benefits of innovative treatment, the burden of proof shifts under the dynamic model. If the therapy is conventional, the burden of proof should lie with the plaintiff. For an unconventional therapy followed by a respectable minority of practitioners and involving a tangible technique such as the administration of drugs, the plaintiff should have the burden. If the unconventional therapy involves an

intangible technique such as verbal therapy, the burden of proof should be placed upon the defendant. Likewise, if an unconventional therapy has no respectable minority following, the burden should rest with the defendant.

V. CONCLUSION

The level of care required of psychotherapists varies according to whether a particular jurisdiction follows local, national, or specialist standards of conduct. It also may depend on the burden of proof that a court allocates to the parties and on the weight that it assigns to respectable minorities. These factors are especially critical in assessing whether an unconventional therapy falls within the limits of acceptable practice. When viewed in its entirety, this jurisdictional variation reveals an underlying chaos in the law governing the conduct of psychotherapists. Moreover, the standard of care as it is currently applied is not a reliable guardian of all interests. It should provide therapists with clearer guidelines for patient care. It should also offer assurance to practitioners of new or unconventional therapies that the law will not reject their methods outright. Finally, it should be cognizant of not only patients' rights but also the crucial interplay between innovation and potentially more effective mental health care.

The unified framework embodied in the dynamic model attempts to build into its structure a proper respect for the dynamic characteristic of psychotherapy. Such an analysis is the most reasonable way of reaching a result that is at once intellectually defensible and individually tailored so as to achieve a rational disposition of competing interests.

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