

# **HOW I DECIDED TO SUE YOU: MISADVENTURES IN PSYCHIATRY**

**By**

**Jeffrey C. Anderson  
LAW OFFICE OF JEFFREY C. ANDERSON  
9801 McAllister Freeway, Suite 1250  
San Antonio, Texas 78216**

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by  
Charles E. Moody  
Mark T. Smith  
Bryan J. Maedgen  
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## **TABLE OF CONTENTS**

	<b><u>PAGE</u></b>
I. INTRODUCTION	1
II. WHAT IS PSYCHIATRIC MALPRACTICE?	1
III. THE TOP 10 REASONS YOU GET SUED	2
A. Failure to Prevent Suicides or Self Inflicted Injuries	3
B. Sex with the Sick	7
C. Informed Consent	9
D. Inappropriate Administration of Electro Convulsive Therapy	11
E. Inappropriate Use or Non Use of Physical or Chemical Restraints	11
F. Liability for Locking Them Up	12
G. Injuries Resulting From Escapes or Elopements	14
H. Medication Errors	15
I. Failure to Diagnose Intracranial Lesions	17
J. The Psychiatrist Duty to Warn Third Persons	17
IV. CONCLUSION	21

# **HOW I DECIDED TO SUE YOU: MISADVENTURES IN PSYCHIATRY**

## **I. INTRODUCTION**

Let me start off by saying that I did not choose the title for this topic. This paper will not specifically address the process of determining how a decision is made to sue a physician for a cause of action based on the negligent practice of psychiatry. Rather, the focus of this paper will be to identify and discuss areas and events in the practice of psychiatry that are commonly seen in psychiatric malpractice cases.

Claims and lawsuits arising out of the practice of psychiatry commonly involve issues and potential defendants which include not only psychiatrists and psychologists but also their support staff which may include nurses, mental health technicians, counselors and other healthcare providers. Psychiatric negligent claims also commonly involve State and private hospitals and outpatient care clinics. Having said that, let me reassure you that the practice of psychiatry is not considered a high risk medical specialty, at least in regard to the risk of being sued based on a cause of action for medical negligence. There was a period of time in the mid to late 1980's where lawsuits against psychiatrists and psychologists appeared to be rapidly increasing, both in numbers and theories of liability. For a time, it was thought there would be numerous cases against psychiatrists arising out of the use or misuse of anti psychotic medications. The increase in patients who are developing Tardive Dyskinesia secondary to the overuse of anti psychotic/neuroleptic medications was for a time thought to be the onset of an epidemic. This did not prove to be the case.<sup>1</sup>

Even though the practice of psychiatry is not one commonly associated with a high risk of being sued for medical negligence, psychiatrists, like other professionals, make mistakes, resulting from the failure of the physician to exercise ordinary care.

## **II. WHAT IS PSYCHIATRIC MALPRACTICE?**

Psychiatric malpractice? There is no such thing. Under Texas law, the term "malpractice" has no legal definition. When a lawsuit is filed based upon allegations of a medical mistake, the jury (or finder of fact) is not asked to determine whether or not the Defendant physician committed "malpractice". The jury in a medical liability case is asked to determine whether or not the physician or healthcare provider's acts or omissions constituted negligence as that term is defined by Texas law. In a jury trial, the Court instructs the jury in regard to the following definitions:

- (1) "Negligence", when used with respect to the conduct of the Defendant means the failure to exercise ordinary care that is, failing to do that which a physician of

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<sup>1</sup> "Preparing for the Tardive Dyskinesia Epidemic" *Tex. Personal Inj. Law Rpt.* Vol. 3, No. 4, (Nov. 1985) and others.

ordinary prudence would have done under the same or similar circumstances or doing that which a physician of ordinary prudence would not have done under the same or similar circumstances.

- (2) "Ordinary care" when used with respect to the conduct of the Defendant means that degree of care that a physician of ordinary prudence would use under the same or similar circumstances.
- (3) "Proximate cause" when used with respect to the conduct of the Defendant means that cause which, in a natural and continuous sequence, produces an event, and without which cause, such event would not have occurred. In order to be a proximate cause, the act or omission complained of must be such that a physician using ordinary care would have foreseen that the event, or some similar event, might reasonably result therefrom. There may be more than one proximate cause of an event.<sup>2</sup>

The Court will also instruct the jury if requested that:

- (1) "A finding of negligence may not be based solely on evidence of a bad result to a patient in question, but such a bad result may be considered by you, along with other evidence, in determining the issue of negligence; you shall be the sole judge of the weight, if any, to be given any such evidence."<sup>3</sup>

With these definitions, the Court then instructs the jury to answer the following simple question:

- (1) "Did the negligence, if any, of the Defendant proximately cause the occurrence or injury in question? Answer "yes" or "no"."

Therefore, in accordance with Texas Law, in order to find a psychiatrist liable for a patient's injury or death, the jury must determine, from a preponderance of the evidence, that the psychiatrist's negligent acts or omissions resulted from a failure to exercise ordinary care. Sometimes, this concept is referred to during a trial as a physician's failure to practice his profession "within the standard of care". The words are different, but the legal standard is the same. Before you can be held liable for a patient's injuries or death, the jury must find that the care provided to that patient was not reasonable and prudent.

### **III. THE TOP 10 REASONS YOU GET SUED**

At this point in the paper I would like to address some of the more common causes of action alleging psychiatric negligence which appear on the reported cases or that I recall from my own docket. Borrowing a format from David Letterman, I have prepared a top

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<sup>2</sup> PJC 50.1, Texas Pattern Jury Charge (2002).

<sup>3</sup> Article 4590i Section 7.02(a) of the Texas Civil Practices and Remedies Code (2002).

10 list of reasons that psychiatrists are sued. Unlike David Letterman's top 10 list, however, these do not appear in any particular order:

**A. Failure to Prevent Suicides or Self Inflicted Injuries**

Suicides or self-inflicted injuries by psychiatric patients are probably the most frequent sources of claim brought against healthcare providers. Such cases typically arise in one or two treatment settings:

- (1) The patient is hospitalized or confined in a psychiatric hospital or other mental healthcare facility; or
- (2) Suicide occurs away from the mental health facility after the psychiatric patient has been discharged or has commenced treatment as an outpatient.<sup>4</sup>

Most cases involving suicide in a psychiatric hospital include allegations against the patient's treating psychiatrist, the hospital, and often various members of the treatment team, such as nurses, therapists, or mental health technicians. Typical allegations include the contention that healthcare providers fail to recognize the patient's suicidal ideations or tendencies and institute appropriate orders or precautions to prevent the suicide. For example, the allegations of negligence against a psychiatrist often assail assignment of a suicidal patient to an open, unlocked or insecure unit or area; failure to confine the suicidal patient to a unit where sufficient nursing supervision can be provided; and/or failure to order closer supervision or observation. Typical allegations against the hospital staff include assertions that the staff failed to appropriately supervise or monitor the suicidal patient, failed to follow the physician's orders or hospital policy, failed to report significant events to the treating doctor, failed to properly staff the psychiatric unit with appropriately treated personnel or allowed unsafe conditions to contribute to the suicide and/or failed to maintain appropriate treatment. For example, in January of 1993, the family of a Dallas woman who committed suicide at a County mental health facility reached a \$250,000.00 settlement with Dallas County, Parkland Memorial Hospital, and the Dallas County Mental Health and Mental Retardation Center. The woman was one of five patients who died at the Dallas County Mental Diagnostic Center in 1991.

In another example, at least one Court in Texas has stated that Texas psychiatric hospitals have:

- (1) "The duty to exercise reasonable care to safeguard a patient from any known or reasonably appreciable danger from himself or to exercise such reasonable care for his safety as the patient's mental and physical

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<sup>4</sup> See Liability of Mental Care Facilities for Suicide of Patient or Former Patient, 19 A.L.R. 4<sup>th</sup> 7 (1983); Liability of Doctor, Psychiatrist or Psychologist for Failure to Take Steps to Prevent Patient Suicide, 17 A.L.R. 4<sup>th</sup> 1128 (1982); see also Druggist Civil Liability for Suicide Consummated With Drugs Furnished by Him, 58 A.L.R. 3d 8 (1974) and others.

condition, if known, may require. Liability exists only if the suicide proximately results from the negligence of the hospital or its employees. *The most import single factor in determining the liability of a hospital for failing to prevent a suicide of a patient is whether the hospital authorities in the circumstances could reasonably anticipated that the patient might harm himself.*"<sup>5</sup>

In *Bornmann*, the patient, an R.N. who had been employed at the Defendant hospital for seven months, was admitted to the hospital on June 11, 1968, with a diagnosis of "possible Pheno<sup>l</sup>arbital or Dilantin reaction." The patient had been taking such medications to control epileptic seizures for a number of years and according to her husband had not exhibited any indications of potential suicide during the hospitalization. The patient however, had been admitted to the Defendant hospital approximately one month earlier with a preliminary diagnosis of "dilantin overdose." She had also been known to have difficulty with drugs having been sent home by both the hospital administrator and her co-workers due to inability to perform her duties because of the effects of the medication.

At 7:30 a.m. on June 14, nurses found the patient dead in her room with the cause of death ultimately determined to be "Phenobarbital intoxication" resulting from ingestion of over 300 pills. The source of the drug was not determined. The medical records reflected vital signs were last documented at 4:00 p.m. on June 13 the previous day.

The jury eventually found the hospital negligent but failed to find such negligence to be the proximate cause of the patient's death. The jury further found that Mrs. Bornmann was contributorily negligent in that, as an R.N., she understood the danger presented by taking an overdose of barbiturates and voluntarily exposed herself to such appreciable danger as a result of an intelligent choice.

On appeal, the Court pointed out that the issue of a patient's contributory negligence was immaterial, since the jury did not find causation. The Court discussed but did not decide whether the contributory negligence defense is unavailable, especially when the Defendant "is on notice of the suicidal danger or has specifically undertaken a duty to prevent suicide." Finally, the Court discussed without deciding, whether suicide can constitute:

"New and independent cause and upheld submission of the affirmative defense of "volenti non fit injuria" which relieved the Defendant of liability for negligence when the Plaintiff knew of the existence of danger caused by the Defendant's negligence involuntarily and intelligently exposed himself to that danger. While the Texas legislature has since recognized that suicide can be an affirmative defense in civil actions for damages for a personal injury or death, such offense does not apply **if the**

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<sup>5</sup> See *Bornmann v. Great Southwest General Hospital, Inc.*, 453 F.2d 616, 621(5<sup>th</sup> Cir. 1971) emphasis added.

**suicide or attempted suicide was caused in whole or in part by a failure on the part of any Defendant to comply with an applicable legal standard (which will obviously be an issue in a psychiatric malpractice case).** (See Section 93.001 of the Texas Civil Practices and Remedies Code, 2002).

In another early psychiatric negligence case, a Texas hospital was held to have the duty to guard against a patient's propensities and desires, exercising ordinary care and watching, caring for and treating a patient where it had knowledge of a patient's suicidal tendencies or propensity to escape. Because the sanitarium negligently permitted the patient to escape it was liable for all damages resulting from such negligence.<sup>6</sup>

In a more recent case of *Texarkana Memorial Hospital, Inc., v. Firth*,<sup>7</sup> a hospital was found negligent and grossly negligent for failing to monitor a known suicidal patient, failing to properly maintain windows to prevent the patient from jumping through the windows and failing to adequately staff the psychiatric unit with properly trained nursing personnel. In *Firth*, the patient was admitted through an emergency room with symptoms of depression, possible suicidal ideation, inability to sleep and hallucinations. After consultation by the emergency room physician with a staff psychiatrist, the patient was placed in the hospital's open psychiatric unit, which was unlocked and where patients could freely come and go. Although the patient's psychiatrist attempted to transfer her to a secure closed psychiatric unit, such unit was fully occupied and no doctor with a closed unit patient would agree to move his patient to an open unit to make room for the Plaintiff.

The evidence also showed that on two occasions prior to the incident the patient threatened to jump out of her hospital window. Although the windows in the open unit allegedly could not be raised more than 4 inches, they were not protectively screened as compared to the windows in the closed unit, which were protected by screens designed to prevent patients "elopement." There was also testimony that the patient told the nurse that she felt someone was trying to kill her and shortly thereafter had attempted to leave the hospital.

The nurse reported the patient's condition to the treating psychiatrist, who increased her dosage and frequency of the patient's medications. The open unit nurse, who was going off duty at 7 p.m., recognized the need for additional help and requested assistance to help monitor the patient. Although the house supervisor initially refused the request, he eventually sent a "floater" R.N. to the unit at approximately 7:10 p.m. By 7:30 p.m., the medications began to take effect, and the patient's two daughters, who had been staying with her, went home. At 11:00 p.m., the floater nurse advised the house supervisor that the patient was asleep and sedated and requested permission to leave, which was granted, but no replacement was sent. From 11:00 p.m. until 6:50 a.m. the following morning, the

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<sup>6</sup> *Arlington Heights Sanitarium v. Deaderick*, 272 S.W.2d 497 (Tex.App.-San Antonio, 1925, no writ).

<sup>7</sup> 746 S.W.2d 494 (Tex.App.-Texarkana, 1988, no writ).

patient was apparently checked every two hours by nurses who had little psychiatric experience. The two-hour checks were done despite testimony by both nurses and physicians that the hospital policies and procedures required 15-minute checks on the night shift. The last charting entry was 6:00 a.m. and at approximately 6:50 a.m. the patient jumped to her death from the fourth floor window. In affirming the jury's award of \$467,985.82 in compensatory damages and \$500,000.00 in punitive damages, the Court indicated that there was sufficient evidence to support a jury's belief that the nurses in charge of the open psychiatric unit were vice-principals of the hospital.

It should be noted that in cases where suicide is not a known risk and/or the healthcare provider is not able to exercise a reasonable degree of control that can be administered over a hospitalized patient, the rationales of the *Bornmann* case would not apply. Such a distinction with respect to the ability to control was recognized in another case, *Speer v. United States*.<sup>8</sup> Recognizing that the danger of self-inflicted injury is one risk a psychiatrist is trained to prevent, the Court observed that a psychiatrist might be liable for the voluntary suicide of a **unconfined patient** where:

- (1) He writes a prescription ordering a number of pills which could be fatal if taken in one dose;
- (2) The risk of suicide is great; and
- (3) The patient uses the pills to commit suicide.

Because however, there was an absence of any persuasive indication of a known risk of suicide, the Court in *Speer*, in a non-jury trial found that the psychiatrist, who is treating the patient's depression on an outpatient basis, was not negligent. Furthermore, the Court found that since the patient's death was not reasonably foreseeable, the patient's suicide by ingestion of medication was an intentional act that constituted a new and independent cause. The Court similarly reasoned in finding no liability of the pharmacist who dispensed the drug and noted that the majority of Courts considering the issue felt voluntary ingestion of a drug with knowledge of its effects amounted to an independent intervening cause. Although the pharmacist violated the standard the care in refilling the decedent's prescriptions, such negligence was not a proximate cause of her death.

For another interesting Texas suicide case, see *Weeks v. Harris County Hospital District*,<sup>9</sup> in which a summary judgment on behalf of the hospital was affirmed on appeal. In *Weeks*, the decedent was ordered by the probate court to be detained for her own welfare and protection at an inpatient mental health facility at Ben Taub Hospital however, Ben Taub had no such facility. Although the patient was taken to Ben Taub, there was no evidence that she was officially registered into the hospital for care and the hospital took no measures to restrain or confine her while awaiting her transfer to another facility. Several hours later the patient voluntarily left Ben Taub and returned home by taxi. Within an hour she committed suicide by self-inflicted gunshot. The Appellate Court

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<sup>8</sup> 512 Fed. Supp. 670 (N.D. text, 1981).

<sup>9</sup> 785 S.W.2d (Tex.App.-Houston [14<sup>th</sup> Dist.] 1990, error denied).



noted that the patient's family had no intentions of admitting her into Ben Taub and there was no reliance on either their part or the decedent's part on the hospital to provide services. The Court further noted that Ben Taub could not have reasonably anticipated the decedent's self-destructive act and that the suicide was too remote to attribute to the hospital's negligence.

## **B. Sex with the Sick**

### **Don't do it!**

The duty to refrain from sexual relations with patients undergoing psychiatric or psychological treatment by health care providers has long been recognized by the psychiatric profession in the legal system.<sup>10</sup> Several reasons have been advanced for avoiding sexual relations with psychiatric patients, including:

- (a) Loss of objectivity by the therapist;
- (b) Possibility of exploitation of a patient who is in a dependent and vulnerable state by a therapist who enjoys a position of power and influence over the patient; and
- (c) Confusion of fact and fantasy in the mind of the patient.<sup>11</sup>

Not only is engaging in sexual relations with a patient unethical for a psychiatrist, most cases have held that such conduct constitutes professional negligence. Furthermore, psychoanalytic theory supports this position.<sup>12</sup>

The principle elements supporting such psychoanalytic theory is the "transference phenomena" which develops from the intensity of the therapist stage patient relationship, resulting in a process by which the patient invests the psychiatrist with many of the traits of a person who was of critical importance to the patient in early life. As the patient develops feeling of fondness and appreciation when helped or understood by the psychiatrist, such feeling naturally are often misinterpreted by the patient, who frequently believes he or she is falling in love with the therapist. Only by exploring the transference phenomena can the patient's psychological problems be effectively treated. Sexual relationships with the patient however, indulge the romantic ideations created by the transference phenomena and prevent the patient from working through his or her faulty methods of relating to others, including the psychiatrist.

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<sup>10</sup> See *J.J. Martinez M.D. v. Texas State Board of Medical Examiners*, 476 S.W.2d 400 (Tex. App.-San Antonio 1973, Refused N.R.E.) [Upholding Board of Medical Examiner's decision to revoke licenses of a physician accused of having sex with patients and others.]

<sup>11</sup> See R.: N.W. Mariano, *Legal Guidebook in Mental Health*, 252(1982); Marmor, *The Seductive Psychotherapist*, 3 *Psych Digest* 10(1970) and others.

<sup>12</sup> Taub, *Psychiatric Malpractice* pg. 101.

Such relationships were alleged to have occurred in a recent case that drew national attention involving a Harvard psychiatrist who was investigated by the Massachusetts Medical Board for her therapy sessions with a Harvard medical student who died of a cocaine overdose. As a result, the psychiatrist surrendered her license and paid a one million dollar settlement in the civil suit filed by her former patient's family.

Where a therapist mishandles transference and engages in sexual relations with the patient, Texas Courts have found actions to constitute professional negligence.<sup>13</sup> Recognizing that mishandling of the transference phenomena constitutes negligence, but holding that the Plaintiff's claims against her psychologist for professional negligence in engaging in sexual relations after allegedly and intentionally or negligently gaining complete emotional control over her by use of the "transference phenomena were barred by limitations".<sup>14</sup>

Whether or not a physician-patient's sexual relationships results in a civil negligence action against the physician therapist, such conduct may also result in license revocation or criminal prosecution for rape.<sup>15</sup>

While a psychiatrist or psychologist may be liable for malpractice of other torts for engaging in sexual relations with patients during the course of treatment, the Texas Supreme Court has held that a psychiatrist is not liable for the breach of implied warranty to abide by the ethical commandments of the medical profession when he sexually assaults his patient.<sup>16</sup>

Recently, the Texas Supreme Court has held that because Plaintiff patient had other adequate remedies to address wrongs committed during the treatment, it was not necessary to impose an implied warranty theory as a matter of public policy. The Court also noted that although the issue had not been specifically addressed in Texas, other States have recognized the causes of action for medical negligence or assault and battery for patients sexually assaulted or beaten by their psychiatrist.

Since the Court specifically rejected the implied warranty for good and workman like performance of a purely professional service, several Texas Appellate Courts have refused to expand such implied warranties to healthcare liability claims.

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<sup>13</sup> See *Lenhard v. Butler*, 745 S.W.2d 101, 103 (Tex.App.-Ft. Worth, 9aa, writ denied).

<sup>14</sup> See also, *Simons v. United States*, 805 S.W.2d 1363(\_\_\_\_? 1986);

See *Walters v. Bourhis*, 709p.2<sup>d</sup> 469(1985) and others.

<sup>15</sup> See *Jacoby v. Texas State Board of Medical Examiners*, 308 S.W.2d 261(Tex.App.-Waco 1957, Writ refused N.R.E.); See also Tob, Psychiatric Malpractice at 101, 58-59; Civil Liability of a Doctor or a Psychologist for Having Sexual Relations with a Patient, 33 A.P.L.R. 3d 1393 (1970) and others.

<sup>16</sup> See *Dennis v. Allison*, 698 S.W.2d 94 (Tex. 1985).

In addition to the individual liability by a psychiatrist or psychologist for sexual contact with patients, hospitals may also be exposed to liability for direct negligence in hiring or supervising employees who engage in improper sexual conduct or vicarious liability under a theory of respondeat superior. Such conduct may, however, be outside the course of scope of employment. Although no Texas Appellate decision has addressed the hospital's vicarious liability for sexual relations with patients by hospital employees, it is likely that Texas Courts would side with the majority of jurisdictions in finding that the actions certainly fall outside the course of scope of employment. That would not mean however, that the individual employee would be liable for his own acts of misconduct.

Finally, it may seem somewhat unfair that psychologists and psychotherapists may be held liable for having sex with their patients where other medical specialties would not, but the basis of such liability is associated with the patient's psychological dependence and illness for which he has turned to the physician or psychologist for help. Sex between patients and physicians practicing in other medical specialties enjoy the presumption that the patient suffers from no identifiable mental impairment and that therefore the sex has occurred as a result of a consensual act between adults.

### **C. Informed Consent**

Most healthcare providers, including psychiatrists and psychologists, are overly concerned about the issue of informed consent. While the failure to obtain a patient's informed consent for medical or surgical care can and does form the basis of professional negligence lawsuits, it is not a cause of action that is commonly asserted. That having been said, Article 4590(i), Section 6.02 of the Texas Civil Revised Civil Statutes provides that negligence is the only theory of recovery available in a suit against a physician or healthcare provider based upon a failure to disclose or adequately disclose the risks and hazards involved in the medical or surgical procedure rendered by a physician or healthcare provider. In order to determine which risks and hazards related to medical care or surgical procedures must be disclosed by healthcare providers or physicians to their patients or persons authorized to consent for their patients and to establish a general form or substance of such disclosure, the Texas Medical Disclosure Panel was created.

Pursuant to provisions of §6.04 of Article 4590(i) of the Texas Civil Practice and Remedies Code, the Texas Medical Disclosure Panel has prepared lists of risks and hazards for certain enumerated medical treatments and surgical procedures which physicians and healthcare providers are required to disclose or not disclose to their patients. Such statutory scheme of informed consent shifts the focus of an informed consent case from a subjective standard to an objective standard of what information would influence a reasonably prudent patient in making a decision to give or withhold consent for particular medical procedure.

Don't bother to look up §6.04 for a list of hazards and risks associated with psychiatric care because no psychiatric treatments or procedures are contained in the list prepared by

the Texas Medical Disclosure Panel. Therefore as a psychiatrist, you are under the “duty otherwise imposed by law,” to disclose the risks and hazard associated with your medical care. This duty has been held by the Texas Supreme Court to require a physician “to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent.”<sup>17</sup>

In the case of *Barclay v. Campbell*,<sup>18</sup> the issue concerned the risks and hazards to be disclosed in conjunction with the administration of narcoleptic drugs. A psychiatrist had treated a schizophrenic patient with anti psychotic medications, which in a significant percentage of cases were known to produce a condition known as Tardive Dyskinesia. The psychiatrist acknowledged that he did not warn the patient of the risk of Tardive Dyskinesia.

Since neuroleptic drug ingestion was not included in the medical procedures found in list A, the Court held that the Plaintiff must establish by expert testimony that the medical condition complained of was a risk inherent to the medical procedure performed. The expert testimony was also required from a psychiatrist regarding “all other facts concerning the risks which show that the knowledge of the risk could influence a reasonable person in making a decision to consent to the procedure”. In further elaborating, the Texas Supreme Court went on to note that expert testimony demonstrated Tardive Dyskinesia was an inherent risk associated with neuroleptic drugs. Therefore, having met the first prong of the legal test, the Court went on to determine if the Plaintiff had met the material requirements set out in previous decisions, the Plaintiff should have been entitled to the submission of the jury of an informed consent issue.

Although observing that the probabilities of contracting Tardive Dyskinesia were unknown but probably “extremely small,” the Court nevertheless held that such testimony was some evidence that the risk was material enough to influence a reasonable person in a decision to give or withhold consent. The Texas Supreme Court noted that other evidence bearing on the materiality of the risks included how the condition manifests itself; permanency of the condition caused by the risks; known cures for the condition; seriousness of the condition; and the overall effect of the condition on the body. Thus, the Texas Supreme Court concluded that the patient had met the threshold requirements of earlier decisions and was entitled to have the issue of informed consent submitted to the jury.

The Court emphatically rejected arguments that the physician was excused from a medically infeasible disclosure since a schizophrenic patient would not have the reactions of a reasonable person. The expert testimony also conceded that had the patient known of the risks of side effects like Tardive Dyskinesia, he probably would have refused the treatment no matter how minimal the risk or how great the countervailing risk of refusing the medication. While recognizing the psychiatrist’s dilemma in such circumstances the

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<sup>17</sup> See *Peterson v. Shields*, 652 S.W.2d 929 (Tex.1983).

<sup>18</sup> See *Barclay v. Campbell*, 704 S.W. 2d 8 (Tex.1986).

Court nevertheless held that it was not the legislative intent to take away the individual's right to make such decisions for himself just because his psychiatrist did not believe this patient is reasonable. The Texas Supreme Court further found that the right to make a medical decision for oneself was encompassed within the constitutional right to privacy, which is not lost because of mental illness. The Texas Supreme Court also stated that the right to make one's own mental decisions was expressly recognized by the Texas Mental Health Code in Article 5547-80(a) of the Texas Revised Civil Statutes which provides that a person suffering from mental illness is guaranteed all rights, benefits and privileges afforded by the laws of the United States and Texas.

When faced with the dilemma of informing a patient of risk and benefits of a particular procedure, including the risks associated with a particular medicine regimen, the psychiatrist is still under a duty to obtain his patient's informed consent even if the psychiatrist believes that his patient is not capable of reasonably conducting a risk benefit analysis. In that circumstance, this psychiatrist should obtain the assistance of family members or guardians or seek to have the patient adjudicated as being incapable of making treatment decisions. Under those circumstances a Court will appoint a guardian who will then make an informed decision after analyzing the risks and benefits to the client of a particular medical or surgical procedure.

#### **D. Inappropriate Administration of Electro Convulsive Therapy**

Several theories of potential liability have been asserted regarding the administration of the electroconvulsive or electro shock therapy, commonly referred to "ECT" which, although not used nearly as frequently in the past, is still utilized by some psychiatrists to treat certain forms of depression and other psychiatric diagnoses. Some theories espoused in various cases involving ECT administration include the following:

- (1) Failure to provide informed consent;
- (2) Negligence in pre-ECT examination and diagnosis by the psychiatrist;
- (3) Negligence in the use of medications associated with ECT;
- (4) Method of administering shock treatments;
- (5) Negligence by a physician in examination and diagnosis after occurrence of injury. Such cases generally deal with the failure to diagnose or properly treat fractures after administration of ECT; and
- (6) Negligence post-ECT care and supervision. An example would be failure to properly restrain or supervise a patient after ECT.

Currently, the Texas Mental Health Code governs conditions under which ECT could be performed in Texas. I am not aware of any current cases within the last several years associated with the negligent selection, use or post-ECT care in cases published in the Texas Reporter system.

#### **E. Inappropriate Use or Non Use of Physical or Chemical Restraints**

At the present time the use of restraints is an extremely controversial area of medicine. Physical restraints are intended to deter psychiatric patients from injuring themselves or others help the patients regain physical or emotional control or for a variety of other purposes; but under no circumstances are restraints intended to be used as a form of punishment. The use of physical restraints however, has also been associated with increased risks of injury or death from patients who are inadequately supervised following administration of the restraints.

The application of physical restraints is addressed in the Texas Health and Safety Code, §576.024, which provides:

- (1) A physical restraint may not be applied to a patient unless a physician prescribes the restraint.
- (2) A physician restraint shall be removed as soon as possible.
- (3) Each physical restraint and the reason for the use shall be part of the patient's clinical record.
- (4) The physician who prescribed the patient's restraint shall sign the record.

An increasing number of cases are reported in which patients have sued hospitals and physicians for alleged assault and battery, false imprisonment, negligence, etc., alleging bodily injury and suffering, mental anguish and other forms of damage caused by the application or non-application of restraint.<sup>19</sup> The JCAHO Consolidated Standards Manual also contains standards for application of restraints in private psychiatric hospitals.

The use of restraints for hospitalized patients remains controversial. Contrary to common perception, the use of restraints requires more frequent monitoring of the patient that is restrained than those who are not. Because of its controversial nature the potential success of a lawsuit based upon the use or misuse of physical restraints is questionable. That is of little comfort however, to a physician who has been sued by a patient or his family because of injury or death suffered as a result of the use of those restraints.

#### **F. Liability for Locking Them Up**

The Texas Mental Health Code, Texas Health and Safety Code Chapters 573-74 govern the provision of involuntary mental health services. In connection with psychiatric examinations and other actions required or authorized by the Texas Mental Health Code, Texas Health and Safety Code §571.019 provides a limitation of liability and healthcare providers and certain circumstances, stating:

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<sup>19</sup> Hospital's Liability for Injuries Sustained by a Patient as a Result of Restraints Imposed on Movement, 25 A.L.R. 1439 (1969); Malpractice Liability with Respect to the Diagnosis Treatment of Mental Disease, 99A.L.R. 2d 599 (1965); Liability of a Doctor or Dentist Using Force to Restrain or Discipline Patient, 89 A.L.R. 2d 983 (1963).

- (1) “A person who participates in the examination, certification, apprehension, custody, transportation, detention, treatment, or discharge of any person or in any performance of any act required or authorized by this subtitle and who acts in good faith, reasonably and without negligence is not criminally or civilly liable for the action.”

The Texas Health and Safety Codes §571.019 also provides potential affirmative defenses to psychiatrists, physicians and inpatient healthcare facilities in the following situations:

- (1) “A physician performing a medical examination and providing information to a Court in a Court proceeding held under the mental health code or providing information to a peace officer to demonstrate the necessity to apprehend a person under Chapter 573 (emergency detention) is considered an officer of the Court and is not liable for the examination or testimony when acting without malice.”
- (2) “A physician or inpatient mental health facility that discharges a voluntary patient is not liable for the discharge if:
  - (a) A written request for the patient’s release was filed and not withdrawn; and
  - (b) The person who filed the written request for discharge is notified that the person assumes all responsibility for the patient on discharge.”

The issue of civil liability for negligent diagnosis by a psychiatrist who testified in a criminal proceeding was recently addressed by the Court in *Clark v. Grigson*.<sup>20</sup> Without citing to the statute, the Appellate Court in Dallas held that no civil liability existed on the part of the psychiatrist who formed an opinion that was rendered in a judicial proceeding, even though the psychiatrist was found to be negligent in making his diagnosis.

The comfort afforded psychiatrists by the *Clark* decision was short lived, however, when in *James v. Brown*,<sup>21</sup> the Texas Supreme Court disapproved of the language of *Clark* inasmuch as it extended to psychiatrists testifying in mental health proceedings blanket immunity from all civil liability. While noting that the psychiatrist communications to the Court in a due course of judicial proceedings could not serve as a basis for a defamation action, the Court stated that the diagnoses was made by the psychiatrist could be actionable under other grounds. Thus, the Texas Supreme Court held that a patient was not precluded from recovering from a psychiatrist for negligent diagnosis or medical malpractice in a context of civil commitment, concluding that the plain implication of the statute was that “persons acting in bad faith and unreasonably and negligently in connection with mental health proceedings are not free from liability.”

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<sup>20</sup> See *Texas v. Grison*, 579 S.W.2d 263 (Tex.App.-Dallas 1978) (Writ refused N.R.E.)

<sup>21</sup> *James v. Brown* 637 S.W.2d 914 (1982).

Similar issues were raised in a different context in *W.C.W. v. Bird*,<sup>22</sup> wherein a divorced father sued a psychologist for erroneously concluding that he had sexually abused his child, leading to filing of criminal charges. The Court in Houston reversed the summary judgment from the psychologist, finding that a fact question existed with respect to breach of duty and holding that it was foreseeable that a misdiagnosis of sexual abuse could harm a parent accused of the same, and termination of custody rights and criminal charges could result from that misdiagnosis.

The touchstone for causes of action based upon a wrongful civil commitment require that the psychiatrists conduct be found to be unreasonable and negligent. In other words, the safety net provided by the Texas Mental Health Code still require that a psychiatrist diagnosis of a patients threat to harm himself or others be a reasonable and prudent one. It cannot be based on a medical determination that a patient's underlying mental illness would be better treated in an inpatient setting. Psychiatrists should be cautious of the underlying motives of well meaning family members and relatives.

### **G. Injuries Resulting From Escapes or Elopements**

The principles that are applicable to suicide cases also apply when a psychiatric patient causes self-inflicted injury or death to himself or others while hospitalized or while escaping or attempting to escape from a mental health facility.<sup>23</sup> In a well publicized case occurring in Houston, a patient was admitted to a psychiatric unit for observation and treatment of acute schizophrenic reaction. He injured himself after knocking out plexiglass windows on the ward's entrance doors and then running to another wing of the hospital and climbing through an outside window to the roof from which he fell three floors to the ground. The Appellate Court in Houston in upholding the jury's verdict declining to find the hospital negligent for the failure to maintain the plexiglass windows in such a condition as to prevent the patient's escape, pointed out that in determining whether the hospital was negligent, it was appropriate to consider not only the physical custodian surrounding for psychiatric patients but also the patient's mental status. The Court elaborated stating that the psychiatric hospital was only required to "guard against those dangers which it should have anticipated from a particular circumstance at hand and the fact that a patient suffered some mental incapacity would not, under every circumstance, have constituted notice to the hospital that the patient would likely harm himself unless restrained by maximum security measures." Because the evidence did

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<sup>22</sup> 840 S.W.2d 50 (Tex.App.-Houston [1<sup>st</sup> Dist.] 1992, writ req'd).

<sup>23</sup> *Harris v. Harris County Hospice Hospital District*, 557 S.W.2d 353(Tex.App.-Houston [1<sup>st</sup> Dist.] 1977, no writ); *Harris v. Pope*, 520 S.W.2<sup>d</sup> 813 (Tex.App.-Ft. Worth, 1975 writ refused NRA); and see Hospital's Liability for Patient's Injury or Death Resulting from Escape or Attempted Escape 37 A.L.R. 4<sup>th</sup> 200 (1985); and Hospital's Liability for Mentally Deranged Patients Self Inflicted Injuries, 36 A.L.R. 4<sup>th</sup> 117 (1985).



not indicate that the hospital knew or should have known that a patient would likely take radical steps to escape from the psychiatric floor or attempt to afflict injury upon himself, the jury was free to decide that the patient's known mental condition was not such as to indicate his potential for escape.

In a more recent case arising out of a military medical facility in San Antonio, Texas, a patient was able to elope from a locked ward by merely walking out the door. During her confinement, the patient was able to observe that a button located under the desk at the nurse's station, if pressed, deactivated the lock on the door leading into the unit. When it was observed that the nurses station was unoccupied the female patient had another patient go to the nurses station and deactivate the lock, and enabled both of the patients to elope from the unit. Subsequently, a claim was filed against the military pursuant to the provisions of the Federal Tort Claims Act while alleging negligent supervision of the locked facility. Although the case was settled without a specific finding of negligence, the act of settlement itself acknowledged some degree of litigation risk recognized by the military authorities.

Once an elopement or escape occurs the psychiatrist is under a continuing duty to act reasonably and prudently in apprehending the patient. The physician's duty includes notifying medical authorities, family members and law enforcement agencies in a timely manner. In the case of patients who pose a danger to identifiable third-parties, the physicians duties include making a reasonable attempt to notify those third-parties of the dangerous patient's escape. A psychiatrist's duty to identifiable third-parties will be discussed in greater detail in a later portion of this paper.

#### **H. Medication Errors**

In addition to claims and lawsuits filed against psychiatrists and psychiatric facilities arising out of escapes and elopements, numerous lawsuits have been filed against psychiatrists for the inappropriate or misuse of medications associated with psychiatric illnesses. For example, hundreds of lawsuits have been filed against psychiatrists for the misuse of Prozac, the current anti depressant *de jour*. Among other things, Plaintiffs in such cases generally contend that the psychiatrist failed to warn them of adverse side effects, such as impulsive, violent, homicidal or suicidal behavior. In cases, too numerous to mention, Prozac has been found by juries to cause or contribute to cause a worsening of a patients depression, self inflicted injuries, and suicides. In other cases, also too numerous to mention, Prozac has found to be unrelated, violent, or injurious behavior.

In addition to litigation concerning Prozac there has also been Halcion, a popular sleeping pill. Warnings now exist concerning Halcion's chronic use. Such cases associated with Halcion typically allege that the physicians fail to warn a patient of the numerous adverse side effects including amnesia, fainting, or violent behavior. Recently, Dallas County jury rendered a verdict in the amount of \$1.8 million dollars of a claim of the family of a former Dallas police officer who said the side effects of Halcion caused him to kill his friend. The allegations during the trial included charges that the packaging insert did not

adequately warn the officer, (who was subsequently convicted and sent to prison for murder) of the possibility of psychosis, paranoia and homicidal tendencies.

In March of 1993, a jury in San Antonio, Texas found a drug company UpJohn was not liable for a fatal stabbing.

Even though many of the cases involving allegations of adverse medication side effects are directed primarily at the drug companies, physicians and psychiatrists are also sued for prescribing the medications, as venue defendants. In other words, a psychiatrist may be sued for his prescribing a dangerous medication primarily to obtain a choice of forum favorable to the patient.

The use or overuse of anti psychotic/neuroleptic medication has given rise to numerous lawsuits resulting from a patient's contracting Tardive Dyskinesia. Drugs associated with the development of Tardive Dyskinesia include Thorazine, Sparine, Vesprin, Prolixin, Trilafon, Compazine, Stelazine, Mellaril, Haldol, Taractan, Navane, Moban, Serentil, and others.

A particularly tragic case of the misuse of anti psychotic drugs occurred in the case of a patient named Nancy Purdue. Nancy began showing symptoms of a schizo-effective disorder in her early twenties. As the suggestion of schizophrenia became more pronounced, her doctor undertook drug therapy to control the disorder by prescribing 400 milligrams of Thorazine. Even at that time, this dosage was certainly questionable, since Nancy's "psychotic" episodes were infrequent and non-violent. When Nancy's condition did not readily improve on the initial treatment, the dosage of Thorazine was increased. Nancy was maintained on ever increasing dosages of Thorazine over the next several years, during that time Nancy's "psychotic" episodes became more frequent and prolonged. In response to this worsening of her condition, her psychiatrist increased her daily intake of Thorazine, which at times during her treatment amount to more than 1300 mg a day. From time to time her physician would also prescribe Stelazine or Mellaril in addition to or as a substitute for Thorazine. For several years Nancy was continuously kept on Thorazine or alternate neuroleptic medications, with no breaks or prolonged drug free periods. Subsequently, Nancy developed some minor involuntary repetitive movements of her orafacial, buccal and lingual musculature, and one physician noted that she showed movements characteristics of the early stages of Parkinson's Disease. In view of her continuing diagnosis as an undifferentiated schizophrenic, however, she was maintained on heavy dosage of anti psychotic medications. These Parkinsonian-like movements increased in severity and spread to her trunk and limbs. By this time, it was too late, Nancy had developed Tardive Dyskinesia.

The real tragedy in this case was that Nancy did not suffer from a schizoaffective disorder for which she was originally treated in the first place. Her condition was later correctly diagnosed as temporal lobe epilepsy: a condition from which neuroleptic medication is not only contraindicated, but may actually worsen a seizure disorder. As a result of despondency over her worsening Parkinson-like movements, Nancy committed suicide by dousing herself with gasoline and setting herself on fire.

In a suit against the United States under the provisions of the Federal Tort Claims Act, a verdict was returned against the United States for over \$300,000.00. In his findings of fact, the Court concluded that the psychiatrists involved in Nancy's care not only misdiagnosed her underlying mental illness, but were not reasonable or prudent in the administration and use of the anti psychotic neuroleptic medications.

Today, much more is known about the risks associated with antipsychotic medication, specifically in regard to the development of Tardive Dyskinesia. While Tardive Dyskinesia can occur in patients receiving low dosages for short periods of time, the disorder still primarily occurs as the result of prolonged or chronic administration of heavy doses of anti psychotic or neuroleptic medications.

### **I. Failure to Diagnose Intracranial Lesions**

Most psychologists who are board certified by the American Board of Medical Specialties are also tested in neurology. A psychiatrist's knowledge of neurology is essential to psychiatry practice. Some of the most devastating injuries occurred to patients who are treated for psychiatric disorder, which is in fact caused by an intracranial lesion. Malignant or non-malignant lesions in the frontal or temporal lobes frequently produce psychotic or epileptic symptoms.

In a case occurring at the naval air station in Corpus Christi, Texas, an older Hispanic woman was treated by Navy physicians as a mental health patient for many years. The woman's mental health symptoms included depression, anger, and paranoia. At times she appeared confused. Her husband and family members reported significant changes in her personality and fluctuating moods unrelated to her environment or family situation. During her care by the Navy she was diagnosed as psychothymic, manicdepressive, schizoaffective, schizophrenic and demented secondary to early on set Alzheimer's disease. When her condition deteriorated to a point where she began demonstrating epileptic symptoms and strange facial tics a cranial CT scan was performed which identified a large pituitary adenoma. Upon diagnosing her pituitary adenoma the woman was sent to Pittsburgh where she underwent extensive and complicated neurosurgery. Because of the delay in the recognition and diagnosis of her intracranial lesion the patient suffered from profound brain damage, which not only left her impaired but disfigured. Subsequently, a claim and lawsuit was filed against the United States pursuant to the provisions of the Federal Tort Claims Act and was subsequently settled for a significant sum, which remains subject to a confidentiality agreement.

### **J. The Psychiatrist Duty to Warn Third Persons**

One controversial theory of liability regards the conduct of psychiatrists and other psychiatry health providers regarding the issue of whether a duty should be imposed upon physicians to warn third persons of their patients intent to commit violence against specific third persons. As I am sure all psychiatrists are now aware, such a duty was found to exist in the landmark case of *Tarasoff v. The Regents of the University of*

California.<sup>24</sup> *Tarasoff I* stems from the murder of a college coed, Tatinna Tarasoff by Prosenjit Podder a voluntary outpatient at the Crowell Memorial Hospital which was affiliated with The University of the California Healthcare System. Two months before the murder, Podder had confided his intention to kill Tarasoff to his treating psychiatrist Dr. Laurence Moore. Dr. Moore contacted the campus police and requested that Podder be detained, and he was apprehended, but released after he appeared rational and campus police obtained a promise from Podder to stay away from Tarasoff. Dr. Moore's supervisor then directed that no further action be taken to detain Podder. Neither Tarasoff nor her family were warned of Podder's homicidal threats. Two months later, Podder went to Tarasoff's home and murdered her.

Finding that the psychotherapist-patient relationship constituted a type of "special relationship", the Court in *Tarasoff I* held "that the psychotherapist had a duty to use reasonable care to give the threatened person such warning as are essential to avert foreseeable danger arising from his patient's conditions or treatment."

Distressed by *Tarasoff I*, Defendants and the APA, who were fearful of the impact of such a ruling on mental healthcare profession, petitioned the Court for a rehearing, which was granted. The subsequent ruling, which was handed down in *Tarasoff II*, however, resulted in an even more expansive duty for psychiatrists. Specifically, the *Tarasoff II* Court held:

- (1) "When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of his duty may require the therapists to take one or more various steps depending upon the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police or take whatever other steps are reasonably necessary under the circumstances."

It goes without saying, but the court in *Tarasoff II* set off an avalanche of critical responses in both the medical and legal communities with critics arguing that the therapist's professional obligation to his patients to keep his disclosures confidential and the inability of the psychiatric profession to accurately predict dangerous behavior created an unreasonable burden on the psychiatric profession.<sup>25</sup> Since *Tarasoff II*,

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<sup>24</sup> *Tarasoff v. The Regents of the University of California*, 529 P 2<sup>d</sup> 553(1974)(hereinafter "*Tarasoff I*"), reargued, 551 P 2d 334(1976) hereinafter referred to as "*Tarasoff II*").

<sup>25</sup> See Patient's Threats Against Third Parties: The Psychotherapist Duty of Reasonable Care, 5 J. Contemp. Health L and Poll-y 119, 120 note 8-9 (1989); Applebon, Zonatti, Bonnie & Roth, Statutory Approaches to Limiting Psychiatrist Liability for Their Patient's Violent Acts, 146 M.J. Psychiatry, 821 (1989); Roth & Levine, Delema of Tarasoff; Must Physicians Protect the Public or Their Patients?, Eleven Law, Med and Healthcare, 104 (1983); and others.

numerous cases have considered the issue of a psychotherapist's duty to warn. Two distinctive qualifications were quickly added to the Tarasoff doctrine. First, the doctrine was held not to require parents of suicidal patients to be warned of a patient's suicidal ideation.<sup>26</sup> More importantly, the psychotherapist duty to warn was limited to cases involving a prior threat to a specifically identifiable victim.<sup>27</sup> Courts have considered a psychotherapist duty to warn third persons have basically followed a three pronged test:

- (1) Whether a special relationship exists;
- (2) Whether specific threats were made or whether there was the presence of danger; and
- (3) The requirement of a specific or readily identifiable victim.

Numerous Courts have since applied the three-prong test in determining whether a psychiatrist had a duty to warn a specific third party of a patient's intent to commit violence. In one specific case, James Brady, President Reagan's Press Secretary, sued John Henkley's psychiatrist for injuries resulting from Henkley's assassination attempt of the President and Brady's subsequent injury.<sup>28</sup>

A vast majority of Courts acknowledge that the psychotherapist-patient relationship is a "special relationship" as required by *Tarasoff*. The second prong of the post-*Tarasoff* decision has not however, been applied consistently in judicial decisions addressing a psychotherapist's duty to warn. While some Courts have favored a more expansive interpretation of the specific threat requirement, a majority of Courts have favored a more narrow construction of specific threats in an effort to limit the scope of the therapist duty.<sup>29</sup> The third prong, foreseeability of a readily identifiable victim, has been narrowly construed by almost all courts considering the issue. Policy arguments in favor of narrow interpretation of the readily identifiable victim requirement include inadequacy of warning to the general public, failure of the public to take defensive measures in response to vague warnings, cost prohibitiveness, stigmatization of patients and the negative effects of rehabilitative efforts. In a recent Iowa case, the Court held that a psychiatrist whose discharged patient who committed an assault owed no duty of care to the general public for decisions regarding the treatment and release of mentally ill persons absent a reason to believe some particular person would be at risk.

At least one court has also dealt with the failure to institute civil commitment proceedings as an independent theory of liability that may arise from the failure to warn case. In a recent Wisconsin Supreme Court case, the Court held that civil commitment proceedings were less disruptive to the therapist-patient relationship than warnings to third parties, and warnings alone were frequently ineffective to satisfy the duty to protect a potential

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<sup>26</sup> *Bellah v. Greenson*, 81 Cal.App. 3d 614 (1975).

<sup>27</sup> *Thompson v. County of Alameda*, 27 Cal. 3d 71, 758 (1980).

<sup>28</sup> See *Brady v. Hopper*, 751 F.2d 329 C.A. Colo., 1984.

<sup>29</sup> See McCarthy, Patient Threats Against Third Parties: The Psychotherapist Duty of Reasonable Care, 5 J. Contempt Health L. and Pol-y 119, 130-321.

victim. The failure to institute civil commitment proceedings have resulted in psychiatrists being held liable for the injuries sustained to a victim of his patient. Other Courts have refused to recognize a duty of a psychiatrist to seek involuntary commitment.<sup>30</sup> Two Texas Appellate Courts have addressed the issue of *Tarasoff* – type liability, although under somewhat different circumstances. The first Texas case to consider the issue of a physician or other health care provider’s duty to warn third persons was *Gooden v. Tipps*.<sup>31</sup> The Gooden Court was presented with the following issue:

- (1) “When a physician prescribes a drug for his patient which the physician knows or should know has an intoxicating effect, does a physician have a duty to warn the public to warn that patient not to drive while under the influence of said drug? Or stated another way, is a physician under a duty to take whatever steps are reasonable under the circumstances to reduce the likelihood of injury to third parties who may be injured by the patient because said patient is under the influence of intoxicating drugs prescribed by a physician?”

The *Gooden* litigation originated as a personal injury suit involving an automobile collision. During the course of discovery Plaintiffs learned that the Defendant driver was under the influence of a drug, Quaalud, which had been prescribed by the Defendant’s psychiatrist. Plaintiff’s then amended their petition to add Dr. Tipps as an additional Defendant contending that he was negligent in prescribing the medication to his patient and in failing to warn her not to drive an automobile while under the influence of the drug. Dr. Tipps filed a Motion for Summary Judgment asserting that since there was no physician-patient relationship between himself and the Plaintiff, he owed no duty to the Plaintiff. The Court granted Dr. Tipps’ Motion for Summary Judgment, and the Plaintiff’s appealed, arguing genuine issues of material facts existed to preclude Summary Judgment.

Concluding that Summary Judgment was inappropriate, the Appellate Court found that a physician can owe a duty to use reasonable care to protect the driving public. The Court also found that the harm resulting to Plaintiffs was a reasonably foreseeable consequence of the physician’s failure to warn his patient not to drive. Because a physician knew or should have known that his patient’s condition could seriously impair the patient’s ability to drive, the Court held the harm was in the general field of danger, which should have been reasonably foreseen by the physician when he administered the medication. Thus, the psychiatrist had a duty to take whatever steps were reasonable under the circumstances to reduce the likelihood of injury to other motorists. However, the Court then limited its holding, noting only that Dr. Tipps may have had a duty to warn his patient not to drive, but the physician did not have a duty to prevent her from driving, if she so desired.

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<sup>30</sup> *Currie v. United States*, 836 F.2d 209, 210 (no writ 1987).

<sup>31</sup> *Gooden v. Tipps*, 651 S.W. 2d (Tex.App.-Tyler, 1983 no writ).

The Court specifically pointed out that its holding did not require the physician to control the conduct of his patients, as was imposed in *Tarasoff* and its progeny. The Court stated that the *Tarasoff*-type cases were grounded on the fact that the doctor had “taken charge” of a third person whom he knows or should have known was likely to cause bodily injury to others if not controlled and thus was under a duty to exercise reasonable care to control the third person to prevent such harm. It should also be noted that the Court pointed out that the case was not controlled by provisions of the Medical Liability Insurance Improvement Act, Article 4590i of the Texas Revised Civil Statutes, since the injury was to one other than the patient.

The issue of *Tarasoff*-type liability was also considered in *Williams v. Sun Valley Hospital*.<sup>32</sup> In *Williams*, Plaintiff sued the hospital alleging she sustained injuries when her automobile struck a patient who had escaped from the hospital psychiatric unit and jumped in front of the Plaintiff’s car, more than one mile from the hospital. The patient was a voluntary admission, who had the right to sign himself out of the hospital.

Based upon *Tarasoff* and the line of cases that followed, the *Williams* court held that there was no allegation of a threat or danger to a readily identifiable person, it was unwilling to impose blanket liability on all hospitals and therapists for the unpredictable conduct of their patients with a mental disorder. The court also noted that there was no allegation of failure to seek a valid involuntary commitment order, and there can be no breach of duty to confine a person against his will without a valid commitment order. The court left open the question of potential liability for failure to institute commitment proceedings under the appropriate circumstances.

Today the duty owed third persons by psychiatrists whose patients had advocated violence against specific third persons still exists and require psychiatrists to make reasonable and prudent efforts to warn and/or protect those third persons from harm. The duty identified in the *Tarasoff*-type decisions are still alive and well in Texas.

#### IV. CONCLUSION

Delivery of psychiatric care and treatment is, like other medical specialties, a rapidly evolving area of medicine. Although claims against psychiatrists and other mental health care professionals have increased, this increase has been far less than most other medical specialties. To the extent that a psychiatrist’s risk of being sued is thought to be reflected by the increase in medical liability insurance premiums, this correlation is grossly inaccurate. From a review of recent verdicts arising out of psychiatric negligence cases, there is no justification for the substantial increase in medical liability insurance premiums associated with current litigation risks.

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<sup>32</sup> *Williams v. Sun Valley Hospital*, 723 S.W.2d 783 (Tex.App.-El Paso 1987, writ refused N.R.E.).

In summary, lawsuits claiming liability for the mismanagement of psychiatric patients can present interesting issues from both the Plaintiff and Defense perspectives. Psychiatric illnesses and psychiatric treatments are becoming more accepted in society. The stigma associated with patients seeking psychiatric care is decreasing resulting in an increase of patients seeking psychiatric care, including treatment for substance and alcohol abuse. Furthermore, both Federal and State legislative bodies have enacted and will be enacting statutes and regulations dramatically changing the care, treatment and rights given both private patients and patients of State operated facilities, whether voluntarily admitted or involuntarily committed. Along with increased public awareness of the need for mental health services comes an increased demand that psychiatrists and other medical health professionals conform their treatment decisions to those required of a reasonable and prudent physician.