Liability Issues When Psychiatrists Supervise Other Practitioners and Professional Partners

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The landscape of the modern child and adolescent psychiatrist’s practice is vastly different from the simplistic physician-patient relationship represented in popular culture. More complex systems of healthcare, insurance, specialization, and provider shortages have generated a multi-tiered system of healthcare providers for any given patient. While physicians receive the most comprehensive training in both medicine and the sciences, nurse practitioners (“NP”), physician assistants (“PA”), psychologists and social workers receive varying degrees of clinical training and may participate in patient care along with psychiatrists. As such, today’s psychiatrists may find themselves working in a variety of roles and need to be aware of the medical, legal and ethical obligations pertinent to their particular situation.

Psychiatrists who supervise other providers may have a higher liability exposure because the psychiatrist remains legally and ethically responsible for the patient’s care, even when he or she may not be the one actually delivering the care. Under the legal doctrine of respondeat superior (translated to mean “let the master answer for the deeds of his servant”), a psychiatrist may be held liable for those he supervises and for those who provide the patient care. Therefore, psychiatrists
must be aware of their particular state regulations in these situations, along with their supervisee’s level of education, experience and training in order to determine the amount and type of supervision necessary.

When determining whether liability attaches when a psychiatrist is involved in a supervisory relationship, courts will often look to see whether the psychiatrist had the ability to alter the patient’s treatment or clinicians involved in the care.

The increase in non-physician care has yielded legal issues surrounding the specific duties of a psychiatrist when working with non-physician practitioners. When deciding whether to enter a supervisory arrangement, the psychiatrist should understand and address several issues beforehand. For example, what are the supervisory duties, if any, of a psychiatrist when practicing with non-physicians or resident physicians? What percentage of liability, if any, is attributable to a psychiatrist for the negligent acts of his/her professional partners? To what extent can a psychiatrist allow professional partners to exercise independent judgment? These questions are addressed by our legal system on a daily basis. The answers are important for psychiatrists to consider as other mental health providers are becoming increasingly prevalent in the behavioral health treatment model.

The Basic Psychiatric Malpractice Lawsuit and Applicable Standard of Care

As most of us are aware, to prevail in a suit for negligence against a psychiatrist, it is necessary to prove specific facts by a preponderance of the evidence. A plaintiff has the burden of proving:

1) That the psychiatrist owed a duty to conform to the applicable standard of care;

2) that the psychiatrist violated that duty;

3) that the plaintiff suffered actual injury or damage; and,

4) that the psychiatrist’s conduct was the legal cause of plaintiff’s injury or damage.

While not held to the highest possible degree of care, psychiatrists must conform to the degree of skill and care ordinarily employed, under the same or similar circumstances, by members of the psychiatric specialty using their best judgment in each particular case.

Again keep in mind that if you are the supervising physician, you may have no involvement with the care at issue but can be held liable for the acts of those you supervise. A psychiatrist can be sued directly for a breach of this standard of care or, indirectly, under one of several theories related to his supervision and/or liability for the acts of both physician and non-physician practitioners whom he is responsible for supervising. Such theories are negligent hiring and retention, negligent supervision, and vicarious liability. NOTE: The American Psychiatric Association has developed a resource document, entitled, “Guidelines for Psychiatrists in Consultative, Supervisory or Collaborative Relationships with Nonphysician Clinicians,” to help assist psychiatrists in these types of relationships.¹

A claim for negligent hiring or retention may occur where the physician employer knows, or should have known, that a particular provider whom they were supervising was incompetent or unfit to perform their professional duties. The psychiatrist may be found liable for failing to use reasonable care to discover whether or not the employee was competent. Thus, physician employers may be liable for failing to check their employee’s references, licensing and certifications or for failing to periodically evaluate their performance.

A claim for failure to supervise may occur when a psychiatrist fails to properly review or oversee the care and treatment of a provider for whom he supervises. In some jurisdictions, physicians are legislatively required to provide supervision. You should be familiar with the law of your state as it pertains to supervision of midlevel practitioners.

Psychiatrist employers may be vicariously liable for negligence if the midlevel practitioner whom they are supervising is acting at their direction. To prove liability, a plaintiff must generally show that an employer-employee relationship existed at the time of the alleged malpractice, that the midlevel practitioner was acting at the direction of a physician, and that the instructing physician had a right to control the practitioner’s actions. However, there may be variations within your state on this issue.

Note: non-physician providers may also be sued directly for professional malpractice.
Imputation of Negligent Acts versus Unprofessional Acts to Supervising Psychiatrists

It is important to recognize the distinction between negligent acts, for which civil liability can be imposed upon a supervising physician, and unprofessional acts, which cannot be similarly imputed. In certain circumstances, a supervising physician may not be held liable for his/her supervisee’s professional misconduct. Legal liability arises from the breach of a duty grounded in law, such as the standard of care. For such a breach, the law imposes a civil remedy and supplies legal theories which can be used to impute negligent acts to supervising physicians. Violations of professional obligations, on the other hand, arise from a set of professional ethics rules which regulate conduct within a given profession. The penalties for these violations impose professional discipline, rather than civil liability.

Working with Nurse Practitioners and Physician Assistants

Often, midlevel professionals such as physician assistants and nurse practitioners are required to practice medicine under the supervision of a licensed physician. Midlevel providers are being used in many psychiatric practice settings. In some states, however, NPs are legislatively authorized to practice their profession autonomously. A psychiatrist’s liability when working with PAs and NPs in a supervisory role is based upon the degree of control and supervision he has a duty to exercise.

Physician Assistants

In psychiatry, the PA scope of practice is to provide psychiatrist-supervised services that are legally authorized by the state in which she or he practices. Moreover, PAs may only provide services that are within the psychiatrist’s field of clinical expertise. In addition, they may prescribe controlled substances and medical treatment only as delegated by the supervising psychiatrist.

Nurse Practitioners

State qualifications for NPs vary extensively, from requiring as little as one additional year of academic training post-RN licensure, to requiring a masters degree level of education, certification by a national organization, continuing education, and training in pharmacology. In most states, once NPs have completed a certain number of hours of pharmacology education, they can prescribe controlled substances in the same way that a physician can prescribe controlled substances. Again, it is important that the supervising psychiatrist understand the extent of the NP’s education, experience and training, along with state regulations when deciding the appropriate level of supervision required.

PA services differ from physician and NP services due to the fact that PA services are delegated by the physician. Only physicians and, depending on jurisdiction, NPs, may use independent judgment when rendering professional services. Thus, when a psychiatrist supervises a PA or practices in a jurisdiction requiring that he or she supervise or collaborate with the NP, liability against the psychiatrist may be more easily established. This is because the law requires that the providers in these scenarios act under the supervision and control of the psychiatrist at all times.

Working with Psychiatric Residents and/or Child and Adolescent Fellows

Treatment provided by a resident is held to the same standard of care as treatment rendered by a physician with an unlimited license to practice medicine. However, residents and fellows are still in training and they may not have the skill and expertise of a supervising psychiatrist to whom ultimate responsibility for each patient lies. Psychiatrists, therefore, have a duty to supervise the care provided by a resident or fellow. Supervision does not require a physician’s physical presence. Rather, the supervising psychiatrist’s duty requires simultaneous or subsequent evaluation of each aspect of patient care, and approval or modification of the treatment plan initially developed by the resident.

When working in a hospital environment, the psychiatry resident is often required initially to use independent judgment and make preliminary treatment decisions. The ultimate review process by an attending or supervising psychiatrist eliminates the possibility that the independent medical judgment exercised by the resident will control patient care. As a result, so long as the review process actually occurs and the supervising physician either approves or modifies decisions made by the resident/fellow, he/she is unable to commit independent negligence for which the supervising physician may ultimately be liable. If the supervising physician fails to substantively supervise the practitioner, then liability may attach under a theory of negligent supervision or vicarious liability for negligent acts.
Working with Psychologists and Social Workers

The liability implications for psychiatrists when working alongside psychologists and social workers is similar to a psychiatrist’s obligations when working with other midlevel professionals - liability hinges upon the degree of control the physician can and does exercise. Since training and individual employment situations for psychologists and social workers vary widely, it is best to keep in mind the general framework regarding right to control and supervision in considering the liability implications for psychiatrists when working with either of these professionals.

If psychiatrists have a duty to control and delegate tasks to either psychologists or social workers, they have a corresponding duty to ensure that those tasks are not performed negligently. In jurisdictions which permit psychologists and/or social workers to practice autonomously, although psychiatrists may not have a duty to supervise them, the psychiatrist may still be liable for their negligent actions, depending on the nature of the relationship (i.e. working as a consultant or collaborator with a psychologist or social worker). For example, if a psychiatrist undertakes collaboration with a social worker or psychologist on a particular case, he may be held liable for his participation alongside that professional in the event of a negative outcome. As with other professional providers, it is important to know the degree of skill and experience of social worker and psychologist collaborators so that proper risk management decisions can be made.

Steps to Decrease Your Risk

There are several ways in which a supervisory psychiatrist can lessen risk when working with midlevel practitioners, residents, child and adolescent fellows, and other mental health providers. Consistent and responsible supervision is the key to helping supervisors ensure the best quality of care for patients, and improving the educational and training experience for their professional partners. A supervising physician should also make efforts to detect and take appropriate action when red flags arise. Performing checks to ensure that midlevel providers are competent and have sufficient training to perform delegated tasks will inform the level of supervision in which a psychiatrist must engage. For example, you may provide additional or closer supervision to a provider who has little/no experience versus someone you supervise with many years of experience.

Documenting supervision sessions may also minimize risk and may provide evidence of supervision if a lawsuit arises. In addition, if you are supervising another provider (be it a physician, midlevel provider or a mental health provider) and you are required to “sign off” on a document, such as a treatment plan, know what you are signing and review it.

Conclusion

As the law of each state varies the degree of independent practice in which midlevel professionals can engage and, thereby, your responsibility to supervise, you should be familiar with the law of the state(s) in which you practice. Make sure that you are familiar with the professionals who are permitted to make independent judgments and those who require your supervision. Implementation of these strategies may minimize the risk of adverse events and subsequent legal action by ensuring a proactive approach to supervision and, ultimately and importantly, a high-quality of patient care. Finally, be aware of your ethical and legal obligations. Should you have questions, consult an attorney or risk management professional.

About the Authors

Mario C. Ciano is a partner of Reminger Co., LPA, having served as Managing Partner from 1990 to 2005. Mario has defended medical providers, including behavioral health providers in addition to representing businesses and other professionals. Recognized among the ‘Best Lawyers in America’ for the last ten years, Mario is a faculty fellow for the National Institute of Trial Advocacy and a life delegate of the Eighth Ohio Judicial District.

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Ukrainian

Background: Ukraine’s official name is Ukrayina, which means “borderland.” Ukraine is located in southeastern Europe and is the second largest European country, with a population of approximately 44,573,205, making it comparable to France in both size and population. Ukraine is bordered by the Black Sea to the south, Hungary, Slovakia and Poland to the west, Belarus to the north and Russia to the northeast. Ukraine is one of fifteen countries that comprised the former Soviet Union. The citizens of these countries share many cultural qualities, and often are grouped together and referred to as “Eastern Europeans.”

Western Ukraine regions tend to bear a stronger European influence, while Eastern regions bear a stronger Russian influence. Ukraine is geographically diverse in terms of climate and terrain. A majority of Ukraine consists of fertile, grassy plains and plateaus suitable for farming, and is often referred to as the “bread-basket of Europe.” However, the vast majority of Ukrainian residents now live in urban centers.4

When immigrating to the United States, Ukrainians settled primarily in the larger urban areas of Pennsylvania, New York and New Jersey. Community organizations established by early Ukrainian immigrants remain very strong in these regions.5

History: Ukraine’s history reflects numerous conflicts and changes in political power. During the tenth and eleventh centuries, Ukraine was the center of the first eastern Slavic state, later known as Kyivan Rus. As a result, the direct ancestors of Ukraine’s population today are the Slavs. In the late eighteenth century, Russia annexed much of eastern Ukraine which resulted in orthodox religion now being practiced and with Russian as the official language. At roughly the same time, Austria gained possession of western Ukraine and controlled it until the end of World War I. Ukraine experienced a brief period of independence from 1917-20 before coming under the control of the Soviet Union. In 1990, the Ukrainian parliament passed a declaration of sovereignty, and in 1991 Ukraine gained its independence from the Soviet Union.6

Major Language/Dialects: Ukrainians have various languages due to the country’s history and geographical location. Beginning in 1991, when Ukraine gained its independence, the country’s official language became Ukrainian. The Ukrainian language is a Slavic dialect, similar to Belarusian, Polish and Russian languages. Today, the Russian language is the second most spoken language in the Ukraine.7

Nonverbal Communications: Generally, Ukrainians engage in direct eye contact and may use physical touch freely with family and close friends. Nodding is often considered a
gesture of approval. Ukrainian men will often shake hands when greeting others, particularly when it is their first encounter for the day. It is uncommon to greet a woman with a handshake. Younger Ukrainians may often greet others by exchanging kisses and hugs. Ukrainian culture is typically more relaxed than Western cultures in terms of discussing personal matters.\(^8\)

**Tone of Voice:** Ukrainians tend to exchange information at very short intervals, and closeness of relationships may often be gauged by the ability to understand each other without listening to the end of each statement.\(^9\)

**Religion:** Many Ukrainian Americans belong to either Catholic or Eastern Orthodox religions, although most are Catholic. In Ukraine, over fifty percent of Ukrainians declare themselves Orthodox Christians. However, the orthodox Christian church in Ukraine is not as dominant as it is in other European countries. Additional religious groups in Ukraine include Protestants and Jews.\(^10\)

**Consents:** Provided that informed consent is given, it is important to explain procedures, tests, etc. with the patient and, where indicated, with the parent/guardian present. Patients may often prefer to discuss the consent form with family members prior to signing.\(^11\) When treating children, this may be required and indicated.

**The Family Unit:** Early immigrants were mainly males who then brought over their wives and families later, and tended to marry within the Ukrainian culture. Today, there is a higher rate of marriage outside the Ukrainian culture.\(^12\) Extended families are common, and elders are highly respected members. In addition, elders often help raise grandchildren, particularly when both parents work outside of the home. Traditionally, Ukrainian women were responsible for maintaining language and culture in their households, specifically through holidays such as Christmas and Easter.\(^13\)

**Concept of Health:** Eastern European immigrants, such as those from Ukraine, may be unfamiliar with American medicine and as a result may be initially distrustful. Physical examinations in Eastern European medical culture may be different from those in American medical culture (i.e., often hospital gowns are not provided during examinations and patients are examined in their undergarments).\(^14\) Common diseases seen in immigrants from Ukraine and Eastern Europe include diabetes, hypertension, coronary disease, tuberculosis, mental illness, and alcohol and substance abuse.\(^15\) Family members are typically expected to visit sick relatives in order to provide support to the individual and immediate family. Family members may tend to keep negative health information from a person who is ill, as the family may not want the person to become anxious. It is commonly believed that the individual needs to be at peace so physical and emotional conditions do not worsen. As such, often the family prefers to receive the information first, and then decide whether or not to tell the patient of the condition and prognosis.\(^16\) Folk medicine is commonly used by Ukrainian Americans. As an example, physical illnesses may have been treated by attempting to drive them out by squeezing or sucking, or “frightening it away” by shouting or beating. Another belief is that diseases could also be “charmed away” by using magic incantations and prayers, or treated with medicinal plants or by using baths, bleeding (using leeches or cupping), or massages. These methods have lessened due to the assimilation into the western healthcare system. Traditionally, Ukrainians viewed the mentally ill to be “God’s people.”\(^17\)

Within Ukraine itself, about sixty percent of all deaths in the country are caused by cardiovascular disease, with heart disease being the single largest cause of death, and cancer accounting for about twelve percent of deaths.\(^18\) In addition, Ukrainian citizens currently experience one of the lowest vaccination rates of the fifteen former republics of the Soviet Union. As a result, only about half of Ukraine’s children are fully immunized against polio, measles, rubella and other diseases as compared with a rate of at least ninety percent in most Western European countries.\(^19\)

**Medications:** Ukrainians may typically rely upon self-care and often do not like to take excessive medications, believing all drugs can be harmful. Extra time should be spent with the patient and parents/guardians to explain rationales for prescribing medication.

**Mental Illness:** Ukraine has some of the highest rates of mental illness in the world, which may relate to its difficult social and political transitions. In addition, instances of cancer resulting from the Chernobyl incident have led to higher suicide rates among those affected. Ukrainian women have also experienced higher rates of suicide, depression and domestic violence incidents.\(^20\)

Prior to achieving independence from the Soviet Union in 1991, mental health treatment was not commonly available to Ukrainians. Mental health counseling as a separate field was virtually non-existent. Instead, many would seek treatment from “medicine women or men,” in order to treat a “bad or evil eye,” one of the commonly believed origins of mental illness.\(^21\)

Since the mid-1990’s there has been growing interest in progressive mental health treatments, with a shift away
from perceived authoritarian traditions and toward non-directive, insight-oriented therapies. Although great strides have been made in providing mental health services, challenges remain. In Ukraine, mental health training is unregulated, there is no accreditation process governing training programs, and no ethical/legal regulations in place governing practitioners. As a result, patients may have experienced abuses prior to immigrating to the West. In addition, counseling assistance is often only available to those able to afford the fees, as Ukraine does not have a system of third-party payments for health care.22

**Substance abuse:** The overall alcohol consumption in the Ukraine ranks among the top five percent of all countries worldwide. A WHO-coordinated national mental health survey found that Ukraine had the highest rates of alcohol abuse among men and major depression among women. The most common lifetime diagnoses among men are alcohol-related disorders and every year more than 40,000 Ukrainians die because of alcoholism.23, 24

**Suicide:** In 2009, Ukraine’s suicide rate ranked thirteenth in the world. The highest suicide rates occur in those aged 35–49, and the suicide risk is six times higher in men than women.25

### About Our Co-Author:

**Mike Yafa** was born in the Ukrainian town of Belaya Tserkov, which is about 40 miles from the capital city of Kiev. He received his Bachelor’s degree in Automation Computer Technology. Mike emigrated to the United State in 1992 with his wife and 2 year old daughter in search of the American Dream. When he first arrived in America, he worked in the construction industry; learning English and computer science in his spare time. Mike started his IT career at Saks Fifth Avenue’s corporate office in New York and has been with AWAC Services Company, a member company of Allied World since 2008. Mike currently works as a Senior System Administrator in our New York office.

### End Notes

**Liability Issues When Psychiatrists Supervise Other Practitioners and Professional Partners**


**Culture Corner: Ukrainian**

5. Id.
6. Id.
9. Id.
12. Countries and Their Cultures.
13. Id.
14. Id.
16. Id.
17. Culture and Their Cultures
22. Id.
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