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Michael A. Karson

REGULATING MEDICAL PSYCHOTHERAPISTS IN ILLINOIS: A QUESTION OF BALANCE

INTRODUCTION

Vocational regulation by the state is the price paid by professionals whose business is affected with a public interest.[1] The greater the impact that an occupational group has on society through the normal exercise of its specialty, the greater the need for the group to be privileged,[2] and the specialty to be regulated by the state.[3] Society has traditionally sought to inhibit professional dereliction by three methods: the state's licensing or certification process, the self-regulatory action of professional associations, and the always present threat of malpractice suits.[4] Each of these measures performs its prophylactic function of preventing harm to the public with varying degrees of success depending on the group to be regulated and the danger to be avoided. It follows that where one of these measures proves to be less than fully effective, the other two must be made more capable of shouldering the additional burden if a balanced protection is to be achieved.

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1. Munn v. Illinois, 94 U.S. 113 (1877) (property becomes clothed with a public interest when used in such a manner as to make it of significant public consequence). As a general rule, the state has plenary power to regulate *any* enterprise, professional or otherwise, in order to promote the general welfare, as long as the means used are reasonably adapted to accomplish a legitimate goal. People v. Witte, 315 Ill. 282, 146 N.E. 178 (1924) (state regulation of physicians and surgeons); People v. Elerding, 254 Ill. 579, 98 N.E. 982 (1912) (regulation of hours for female employees); Landberg v. Chicago, 237 Ill. 112, 86 N.E. 638 (1908) (restrictions on the collection, shipping, and sale of manure). According to one author, the balance is struck with the recognition that "every individual [has] the right to select his own calling, subject only to certain regulations for the protection of the public interest." Graves, *Professional and Occupational Restrictions*, 13 TEMP. L.Q. 334, 336 (1939).

2. An occupational group is "privileged" when persons deficient in the requisite skills and learning are denied an opportunity to pursue that occupation. *See* People v. Love, 298 Ill. 304, 131 N.E. 809 (1921) (minimum standards for physicians and surgeons).

3. It has been suggested that, apart from the matter of protecting society from harm at the hands of incompetent professionals, the need to protect individual market participants from excessive competition provides an economic rationale for specialty regulation. *See* Barron, *Business and Professional Licensing—California, A Representative Example*, 18 STAN. L. REV. 640 (1966). In light of this economic model of specialty regulation, it is interesting to note that acceptance of a fee for services rendered is a primary vehicle for determining the applicability of certain statutes regulating health services. *See, e.g.*, ILL. REV. STAT. ch. 111, § 5302(5) (1977) (applicability of the Psychologist Registration Act).

4. Langsley, *Peer Review: Prospects and Problems*, 130 AM. J. PSYCHIATRY 301, 302 (1973).

Psychiatrists[5] are among the professional groups to which this protective triad is applicable.[6] However, the protection afforded is marginal when the threat to be guarded against is negligent[7] psychotherapy.[8] The "social engineering"[9] function of tort liability is especially inadequate to protect the public from the negligent practice of psychotherapy, because, given the nebulous nature of the psychotherapeutic process, a standard of care is all but impossible to define.[10] In addition, uncertainty within the discipline makes the likelihood of establishing proximate causation minimal.[11] When combined with the problems inherent in assessing non-physical damages,[12] it is not surprising that as late as 1965, no psychiatrist had been found liable by an American appellate court for the negligent practice of psychotherapy.[13]

What was an absence of litigation in 1965 is now a "curious

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5. A "psychiatrist" is a physician who specializes in psychiatry, or "that branch of medicine which deals with the study, treatment, and prevention of mental illness." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1281 (25th ed. 1974). For purposes of this paper, the terms "psychiatrist," "psychotherapist," and "therapist" are used interchangably.

6. Speaking of the need to prevent negligent psychotherapy, the trial judge in Landau v. Werner, 105 Sol. J. 257, 258, *aff'd*, 105 Sol. J. 1008 (1961), noted that "[a] psychiatrist [has] explosive forces under his control and if a mistake [is] made the consequences might be disastrous and irrevocable."

7. "Negligent psychotherapy" is defined as "[t]he liability of the psychiatrist to his patient . . . for the breach of a duty to the patient to bring to their relationship the skill and care of a professionally qualified psychiatrist practicing in that community." Dawidoff, *The Malpractice of Psychiatrists*, 1966 DUKE L.J. 696, 700-01 [hereinafter cited as Dawidoff]. *See also* notes 39-101 and accompanying text *infra*.

8. "Psychotherapy" is defined as:

> [a] method or system of alleviating or curing certain forms of disease, particularly diseases of the nervous system or such as are traceable to nervous disorders by suggestion, persuasion, encouragement, the inspiration of hope or confidence, the discouragement of morbid memories, associations, or beliefs, and other similar means addressed to the mental state of the patient, without (or sometimes in conjunction with) the administration of drugs or other physical remedies.

BLACK'S LAW DICTIONARY 1392 (4th rev. ed. 1968).

Psychotherapeutic treatment is "designed to produce a response by mental rather than by physical effects, including the use of suggestion, persuasion, reeducation, reassurance, and support, as well as the techniques of hypnosis, abreaction, and psychoanalysis which are employed in the so-called deep psychotherapy." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1284 (25th ed. 1974). *See also* notes 23-28 and accompanying text *infra*. For a thorough discussion of a psychiatrist's liability for negligence in the use of chemical or mechanical therapy see Annot., 99 A.L.R.2d 599 (1965).

9. W. PROSSER, LAW OF TORTS 14 (4th ed. 1971) [hereinafter cited as PROSSER].

10. *See* notes 118-27 and accompanying text *infra*.

11. *See* notes 128-34 and accompanying text *infra*.

12. *See* notes 135-40 and accompanying text *infra*.

13. Annot., 99 A.L.R.2d 599, 620 (1965).

scarcity" of cases dealing with the liability of psychiatrists[14] for negligent psychotherapy. Despite the sharp rise of medical malpractice suits generally,[15] in only one American appellate court case has a psychiatrist been held liable for negligent psychotherapy.[16] There are several plausible explanations for the scarcity of case law on the subject. One theory is that psychiatrists are especially well-trained to deal with the negative feelings of their patients and, as such, are able to deflect the hostility which serves as the driving force in many malpractice actions.[17] Another possibility is that there has been no negligent practice of psychotherapy. This theory seems unlikely, however, and was rejected by a Michigan Supreme Court Justice who commented that "[a]ll professions . . . contain unscrupulous individuals who use their position to injure others."[18]

Various authors have intimated another explanation—that traditional tort theory renders the successful prosecution of a suit for negligent psychotherapy a functional improbability.[19] Central to their thesis is the contention that the lack of litigation in this area is due to the uniqueness of psychotherapy and the resulting conceptual difficulty in defining the duties that should

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14. If it is true that "anyone engaging in psychotherapy is subject to the same duties and liabilities," Tarshis, *Liability for Psychotherapy*, 30 FACULTY L. REV. 75, 75 (1972) [hereinafter cited as Tarshis], then a clinical psychologist, "a doctorate, other than medical, who specializes in the mental phenomena of consciousness and behavior or mental activity," Appleton, *Psychotherapist Prescribes a Drug in His Office: Medicolegal Risks*, 1970 MED. TRIAL TECH. Q. 207, 209, is exposed to the same legal risks for his negligent practice.

15. *See, e.g.*, Brooke, *Medical Malpractice: A Socio-Economic Problem from a Doctor's View*, 6 WILLAMETTE L.J. 225, 227 (1970) (wherein author reports a 43% increase over a five-year period). *See also* Sandor, *The History of Professional Liability Suits in the United States*, 163 J.A.M.A. 459 (1957).

16. Zipkin v. Freeman, 436 S.W.2d 753 (Mo. 1969) (psychiatrist held liable for a gross breach of his fiduciary duties by intentional mismanagement of the transfer phenomenon).

In Roy v. Hartogs, 85 Misc. 2d 891, 381 N.Y.S.2d 587 (1976), the plaintiff brought an action against her psychiatrist, alleging that he adversely affected her mental and emotional status by engaging in sexual intercourse with her over a period of 13 months as part of her prescribed treatment. The majority based the defendant's liability on his failure to treat the plaintiff with professionally acceptable procedures.

17. *See* Heller, *Some Comments to Lawyers on the Practice of Psychiatry*, 30 TEMP. L.Q. 401 (1957) [hereinafter cited as Heller].

18. Stowers v. Wolodzko, 386 Mich. 119, 135, 191 N.W.2d 355, 363 (1971) (suit by patient against psychiatrist for false imprisonment, assault and battery, and malpractice).

19. *See* Dawidoff, *supra* note 7, at 696; Tarshis, *supra* note 14, at 75; Comment, *Medical Malpractice: The Liability of Psychiatrists*, 48 NOTRE DAME LAW. 693 (1973) [hereinafter cited as *Medical Malpractice*]; Comment, *Tort Liability of the Psychotherapist*, 8 U.S.F. 405 (1973) [hereinafter cited as *Tort Liability*].

be required of the therapist. These authors report that in the few cases where liability has been imposed, the courts have been able to formulate standards which delineate only the extremes of acceptable psychotherapeutic practice.[20]

If the negligence standard is impossible to implement effectively, other existing sources of control over the psychiatrist who practices psychotherapy must be re-evaluated in light of the unavailability of a tort alternative. The importance of this re-evaluation becomes apparent in view of the number of patients who are likely candidates for psychotherapeutic treatment. One out of every twelve Americans will be hospitalized for mental illness during his lifetime, while, at the present time, more than one-half of our hospital beds are occupied by patients suffering from mental illness.[21] It has been estimated that 16% of all Americans suffer from some form of mental disability with 15,000,000 affected by serious personality disturbances.[22] Many, presumably, undergo psychotherapy.

To understand why the tort sanction ineffectively deters negligent psychotherapy, one must first become familiar with the nature of the relationship that exists between the psychotherapist and his patient, for it is the negligent manipulation of this relationship that serves as a basis for liability in the cases that will be examined. Yet the cases are few in number; it will therefore be necessary to depict how a psychotherapist might be negligent by means of analogies drawn from other medical specialities. After the tort alternative and its inadequacies are discussed, the sources and shortcomings of regulatory control over psychiatrists who practice psychotherapy in Illinois will be examined, and reform measures will be suggested.

THE NATURE OF PSYCHOTHERAPY: ITS USE AND ABUSE

Nature of the Practice

Just as the relationship between a physician and his patient is based on a fiduciary trust, so is the relationship between the therapist and his patient.[23] Although both relationships are grounded in confidence, the respective roles played by physician and psychotherapist during the course of the healing process differ considerably. Should a patient have a personal dislike for the surgeon who will operate on his broken leg, the friction between the two will not likely interfere with the doctor's func-

20. *See* cases cited in note 150 *infra*.
21. N. KITTRIE, THE RIGHT TO BE DIFFERENT 54-55 (1971).
22. *Id.*
23. Dawidoff, *supra* note 7, at 702-03; Tarshis, *supra* note 14, at 88.

tion nor the patient's recovery. In the case of psychotherapy, on the other hand, the relationship between the patient and his therapist is of critical importance since "[t]he relationship is the medium for treatment and (one hopes) cure."[24] In this respect, the practice of psychotherapy is unlike any other medical specialty, and as such, demands special attention.

Donald J. Dawidoff was perhaps the first legal scholar to note the importance of this relationship on the entire psychotherapeutic process:

> Central to psychotherapeutic treatment is the establishment of a relationship with the psychiatrist to which the patient can bring past experience and emotions, and in which he can establish the model for a new method of dealing with his environment. Through the establishment of a transference with the psychiatrist, the patient reacts towards him with the emotional responses he had learned and used with his parents and siblings, thus experiencing again the emotions of the past. Through such a reliving, and the interpretation of the experience, the patient learns to understand his reactive patterns and through them to grow to new and more mature behavior. The center of the growth is often an identification with the therapist, where the patient sees in the therapist the image of the healthy person, and comes to make healthy patterns of response his own.[25]

Thus, the relationship between the therapist and his patient is as necessary as and equivalent to the hands of the hypothetical surgeon who operates on his patient's broken leg. Without the relationship, there is no effective therapy.[26]

Non-involvement on the part of the patient will prevent the development of this necessary relationship. In other words, the patient must try to interact with his therapist for the therapy to have any success. Although the psychiatrist brings to this relationship a professional expertise for which the patient is expected to pay, the bond between the parties is not unlike a close friendship.[27] In essence, then, the psychiatrist is "agreeing to provide a situation, the psychotherapeutic situation—a secluded environment, a readiness to listen and talk to the patient, and to allow a relationship to develop."[28] It is through this relationship that treatment is offered to the patient.

The treatment offered will depend on the nature of the problem and the professional orientation of the psychiatrist. The pa-

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24. Tarshis, *supra* note 14, at 78.

25. Dawidoff, *supra* note 7, at 697-98.

26. Unless the patient can form a trusting relationship with the psychiatrist, psychotherapy becomes an "ineffective and intellectual exercise." Heller, *supra* note 17, at 406.

27. Tarshis, *supra* note 14, at 78.

28. *Id.* at 80.

tient's illness may range from schizophrenia to a mild, transient neurosis.[29] If the psychotherapist is of the somatotherapeutic orientation,[30] he may offer some variety of drug therapy. If he ascribes to the sociotherapeutic view,[31] supportive therapy may be employed.[32] Practitioners of the behavior modification school[33] may try to "re-educate"[34] their patients, while those who maintain a psychotherapeutic view[35] will make use of the more aggressive reconstructive therapy.[36] Some therapists make use of all of these approaches, or some combination of those applicable in a given situation.[37] No matter what the approach, however, the goal is the same: to allow the patient to live a more healthy and productive life.[38]

The Case Law

Landau v. Werner,[39] an English decision, is the leading case[40] concerning the negligent practice of psychotherapy. In *Landau*, the plaintiff was referred to the defendant psychiatrist by her physician because of acute symptoms of anxiety neurosis. Due to the transference phenomenon[41] that arose during the

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29. Dawidoff, *supra* note 7, at 697.

30. Proponents of this orientation maintain that certain forms of aberrant behavior are caused by organic malfunctions. *See Medical Malpractice, supra* note 19, at 697 n.35.

31. Advocates of this view suggest that aberrant behavior is the result of "problems in living." *Id.* at 697 n.36.

32. Supportive therapy is used to strengthen existing psychic defenses to better enable the patient to cope with his environment. *See* Tarshis, *supra* note 14, at 79.

33. Rather than seeking the cause of the aberrant behavior, the advocate of this school will help the patient "extinguish" the behavior itself. *See Medical Malpractice, supra* note 19, at 697 n.37.

34. Re-educative therapy does not seek to re-build the patient's psyche, but rather aims to "re-condition" his behavior. Tarshis, *supra* note 14, at 79.

35. This is the most traditional of the approaches, and its use is thought to enable the therapist to uncover the actual cause of the aberrant behavior. *See Medical Malpractice, supra* note 19, at 696 n.34.

36. The aim of this type of therapy is a general alteration of the patient's personality. Tarshis, *supra* note 14, at 79.

37. *Id.*

38. *Medical Malpractice, supra* note 19, at 704.

39. 105 Sol. J. 257, *aff'd*, 105 Sol. J. 1008 (1961).

40. Apart from being the leading case, it was for some time the *only* case in the area of negligent psychotherapy. *See* text accompanying note 13 *supra*.

41. Defined as "[t]he shifting of an effect from one person to another or from one idea to another, especially the transfer by the patient to the analyst of emotional tones, either of affection or of hostility, based on unconscious identification," DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1630 (25th ed. 1974), transference results from the psychiatrist's manipulation of the psychotherapeutic relationship in order to achieve certain mental states in his patient. *See generally* Tarshis, *supra* note 14, at 78.

course of her treatment, the plaintiff fell in love with the defendant. After a few months, the plaintiff began feeling better and the treatment was ended. What followed can best be described as a "series of social contacts"[42] between the parties which lasted approximately six months and which, according to the defendant, constituted the most therapeutic way to disengage from their professional association. When the defendant sought to terminate these social encounters altogether, the plaintiff attempted suicide and never fully recovered from her worsened mental condition.[43]

Liability in *Landau* was based on the social contacts which were introduced by the defendant psychiatrist. Although the defendant was acquitted of having sexual relations with his patient and absolved of anything which could be regarded as professional misconduct or unethical practice,[44] the English court noted that there was not a body of opinion which would have thought it desirable to take out a woman in a highly emotional state and already in love with the doctor.[45] Cognizant of the uncertainty within the science, the appellate court ruled that although "a doctor might not be negligent if he tried a new technique . . . he must justify it before the court."[46]

Lack of justification for use of a rather novel technique led an American court to impose liability for conduct that bordered on assault and battery. In *Hammer v. Rosen*,[47] while various theories to support liability were alleged on appeal,[48] the court found evidence that physical beatings which were used to treat schizophrenia constituted a *prima facie* case of malpractice, and, unless justified, would result in judgment against the psychiatrist.[49] By shifting the burden of proving reasonable care to

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42. Annot., 99 A.L.R.2d 599, 620 (1965).

43. Plaintiff's £6000 award was based on her inability to work after the traumatic experience for which Dr. Werner was held to have been responsible. Landau v. Werner, 105 Sol. J. 257, *aff'd*, 105 Sol. J. 1008 (1961).

44. Tarshis, *supra* note 14, at 85; Annot., 99 A.L.R.2d 599, 620 (1965).

45. Landau v. Werner, 105 Sol. J. 257, 258, *aff'd*, 105 Sol. J. 1008 (1961).

46. Landau v. Werner, 105 Sol. J. 1008, *aff'g*, 105 Sol. J. 257 (1961).

47. 7 App. Div. 2d 216, 181 N.Y.S. 805 (1959), *modified*, 7 N.Y.2d 376, 165 N.E.2d 756, 198 N.Y.S.2d 65 (1960).

48. (Specifically, malpractice, breach of contract, and fraud). 7 N.Y.2d 376, 379, 165 N.E.2d 756, 757, 198 N.Y.S.2d 65, 66 (1960).

49. Speaking to the appropriateness of such "physical therapy," the appellate court held that "the very nature of the acts complained of bespeaks improper treatment and malpractice and that if the defendant chooses to justify those acts as proper treatment, he is under the necessity of offering evidence to that effect." 7 N.Y.2d 376, 379, 165 N.E.2d 756, 757, 198 N.Y.S.2d 65, 67 (1960).

In Zipkin v. Freeman, 436 S.W.2d 753 (Mo. 1969), a physician's insurance company argued unsuccessfully that its insured was acting outside the scope of the malpractice policy coverage when he intentionally mishandled

the therapist, the plaintiff was able to sustain her case without the use of expert testimony.[50]

Other reported instances of professional misconduct in the course of the psychotherapeutic process have been disposed of either by statute[51] or through settlement,[52] and it is "not possible" to get information about unprofessional conduct that is brought to the attention of the American Psychiatric Association because all such cases are "handled confidentially."[53] Therefore, it is necessary to analogize from the general doctor-patient relationship to illustrate the various forms of malpractice in a psychotherapeutic setting.

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the transference phenomenon in a calculated effort to defraud the plaintiff out of her savings and her honor. However, the issue in the case was one of coverage, and did not concern the standard of care for the practice of psychotherapy. *But see* Roy v. Hartogs, 85 Misc. 2d 891, 381 N.Y.S.2d 587 (1976) (psychiatrist who had engaged in sexual intercourse with his patient held liable for his failure to use professionally acceptable procedures).

50. *See generally* PROSSER, *supra* note 9, at 227.

51. In Nicholson v. Han, 12 Mich. App. 35, 162 N.W.2d 313 (1968), the plaintiff sued a psychiatrist who was "intimately" treating his wife, but the court summarily dismissed the complaint for criminal conversation and alienation of affections, the actions having been abolished by statute. *But see* Roy v. Hartogs, 85 Misc. 2d 891, 381 N.Y.S.2d 587 (1976) (wherein the court held that an action against a psychiatrist based on allegations that the psychiatrist had sexual intercourse with the plaintiff as part of her therapy was not barred by legislation eliminating actions for seduction).

A case brought by a drug-addict patient against his former psychiatrist for mismanagement of the transference phenomenon was resolved against the defendant, but the sufficiency of the evidence sustaining liability was based on a violation of an anti-narcotics statute. Rosenfeld v. Coleman, 19 Pa. D. & C.2d 635, 35 North Co. R. 206 (1959), cited in Annot., 99 A.L.R.2d 599, 606-07 n.20 (1965). This is not to say, however, that the same result could not be achieved by means of a malpractice action. *See* King v. Solomon, 323 Mass. 326, 81 N.E.2d 838 (1948) (physician liable in malpractice for his patient's morphine addiction).

52. Lawsuits are expensive, time-consuming, and often produce adverse publicity that can jeopardize a physician's medical practice. Doubtless these considerations influenced the psychiatrist in the following unreported case:

> A dapper 32-year-old psychiatrist was sued by his patient, a young woman of 24, after more than two years of intensive psychotherapy. The allegation: "improper medical care, treatment, acts and conduct resulting in permanent mental injuries." She testified that his conduct toward her while she was ill made her "more upset and nervous." The doctor said she was "lonely and frightened. . . . I helped her, brought her various gifts, let her do routine work in the office and helped her find an apartment." He denied dates or sexual involvement. He had trouble finding his records and asked the insurance company to settle promptly and at any cost. They did. The settlement cost $3,500 plus legal fees.

Slawson, *Psychiatric Malpractice: A Regional Incidence Study*, 126 AM. J. PSYCHIATRY 1302, 1305 (1970).

53. Letter from Henry H. Work, Deputy Medical Director, American Psychiatric Association, to Michael J. Karson (February 11, 1975).

Beyond The Cases

Malpractice suits involving psychiatrists are rare,[54] and, as reported, actions grounded on the negligence of a psychotherapist are all but non-existent.[55] As a result, depicting how a patient undergoing psychotherapy might incur compensable damage at the hands of a negligent psychiatrist is difficult.[56] This is not to say, however, that there are no theoretical constructs into which instances of psychotherapeutic malpractice can be placed. The categories below represent phases of the physician-patient relationship during which a psychiatrist might later be held to have acted negligently.[57] In each instance, the basis for liability would be the psychiatrist's failure to cure or the worsening of the patient's condition.[58]

Pre-Diagnostic Negligence

Not unlike other medical specialists, psychotherapists can be negligent in their selection of prospective patients.[59] Thus, the newly-licensed psychiatrist would be ill-advised to begin psychotherapeutic treatment of a severely troubled patient who would be better served by an experienced specialist.[60] In this regard, ignorance of or disregard for the psychiatrist's professional limitations could provide the foundation for litigation.[61]

Unique to psychiatrists is the way in which personalities can operate as a limitation on the types of patients the psychia-

54. *See generally Medical Malpractice, supra* note 19, at 694.

55. *See* note 16 and accompanying text *supra*.

56. *See* Tarshis, *supra* note 14, at 96, where the author suggests that the "development of legal theory" in this area has been restricted in part because "the conceptual tools (of the science) are underdeveloped."

57. *See generally* Dawidoff, *supra* note 7, at 700-11; Tarshis, *supra* note 14, at 82-92; *Medical Malpractice, supra* note 19, at 704-06; *Tort Liability, supra* note 19, at 411-14.

58. Tarshis, *supra* note 14, at 75; *Tort Liability, supra* note 19, at 411. Of course, negligent treatment is not *necessarily* established by proving a failure to recover or a worsening of the patient's mental condition. *See* notes 130, 131 *infra*.

59. When a physician takes a case, he represents that he has professional learning and skill common to similarly situated practitioners and that he will exercise reasonable care in the application of those skills to his patient's case. *See, e.g.*, Custodio v. Bauer, 251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (1967); Stone v. Proctor, 259 N.C. 633, 131 S.E.2d 297 (1963).

60. If the patient's condition requires the services of a specialist, the physician has a duty to advise his patient accordingly and to make the referral. *See, e.g.*, King v. Flamm, 442 S.W.2d 679 (Tex. 1969).

61. In addition, "[r]egardless of his legal obligation, a professional man demonstrates a high degree of ethical conduct by recognizing the limitations upon his own ability and by associating with . . . or referring the patient to, a man more skilled in the treatment of the particular ailment." J. MIRZA & J. APPLEMAN, ILLINOIS TORT LAW AND PRACTICE 314 (1974).

trist can treat.[62] If the therapist has consistently been unable to develop an effective working relationship with persons exhibiting certain personality patterns, it would be necessary for him to refuse to treat persons with those personality traits.[63] Should he direct the patient to another specialist with the same limitation, a duty to avoid negligent referrals would be breached.[64]

Diagnostic Negligence

Improper diagnosis is a common source of medical malpractice.[65] In the case of a psychiatrist engaged in the practice of psychotherapy, the problem is twofold. It first must be determined whether the patient is suffering from a physical or mental disorder.[66] Secondly, if the psychiatrist determines that the problem is mental, the proper diagnostic category must be found.[67] Even when the therapist has determined that "symptom treatment"[68] is the most prudent course of treatment, basic diagnostic determinations would still be in order.[69]

Misdiagnosis may be the result of the psychiatrist's failure to consult.[70] Although similar to the physician's disregard for his

62. *See* notes 23-28 and accompanying text *supra*.

63. Tarshis, *supra* note 14, at 79, 85.

64. *See, e.g.*, Strum v. Green, 398 P.2d 799 (Okla. 1965) (liability predicated on defendant's failure to exercise reasonable care in selecting a substitute physician).

65. *See, e.g.*, Huff v. Condell Memorial Hosp., 4 Ill. App. 3d 352, 280 N.E.2d 495 (1972) (improper diagnosis due to inadequate number of x-rays); Pugh v. Swiontek, 115 Ill. App. 2d 26, 253 N.E.2d 3 (1969) (failure to diagnose complications during pregnancy).

Some courts have found the diagnosis of organic disease to be an inexact science (because accuracy depends on information supplied by the patient) and have therefore applied a less rigid standard in affixing liability for misdiagnosis. Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 749 (1970). Yet, because the psychotherapeutic process is even more inexact, "the diagnosis is not given to the level of precision expected in other fields." Tarshis, *supra* note 14, at 78.

66. Tarshis, *supra* note 14, at 79.

67. This basic determination can prove to be difficult because there are "several hundred categories of adult psychopathology" from which the physician may select. *Medical Malpractice, supra* note 19, at 699. Perhaps as a result, psychiatric diagnosis has been labeled "unreliable" and deserving of "very serious question when classifying, treating, and studying patients' behavior and outcomes." Pasamanick, Dinitz & Lefton, *Psychiatric Orientation and Its Relation to Diagnosis and Treatment in a Mental Hospital*, 116 AM. J. PSYCHIATRY 127 (1959).

68. Practitioners of the behavior modification school, *see* notes 33-34 and accompanying text *supra*, simply treat their patients' symptoms rather than probe for the underlying cause of the symptoms.

69. *See generally* B. FICARRA, SURGICAL AND ALLIED MALPRACTICE 29 (1968) (basic diagnostic procedures outlined).

70. Senseris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955) (breach of this duty must be shown by expert testimony).

professional limitations when accepting a new case,[71] it is suggested that a greater duty to the patient exists after a fiduciary relationship has been established.[72] Since the duties of proper diagnosis and consultation when necessary are ones that continue throughout the psychotherapeutic process, the therapist could be negligent in failing to re-evaluate the original diagnosis, or in failing to consult when a re-evaluation has been undertaken.[73]

Negligent Treatment

Once the psychiatrist correctly "labels" his patient's illness, he is ready to plan the treatment strategy.[74] The first step in this process in which the therapist might be negligent is in his choice of treatment,[75] since certain types of therapy are wholly inappropriate for persons with certain personality traits. For example, the patient with a fragile psyche who could probably be helped with supportive therapy[76] might be devastated by a reconstructive approach.[77] To "reconstruct" a patient exhibiting only mild, transient neurotic symptoms might be to negligently prolong his treatment.

After the choice of treatment has been made, the psychiatrist is confronted with the question of how fully to inform his patient about the decision.[78] The dilemma is difficult because

71. *See* notes 59-61 and accompanying text *supra*.

72. It is not until the physician accepts a case that the fiduciary relationship is created and representations of competency are made. *See* notes 23, 59 and accompanying text *supra*.

73. If, after a reasonable amount of time, the patient shows no signs of progress, the physician has a duty to investigate the nature of the problem and to take steps to rectify it. Tarshis, *supra* note 14, at 88.

74. Some courts have held the diagnostic stage to be a part of the treatment. *See, e.g.*, Ries v. Reinard, 47 Cal. App. 2d 116, 117 P.2d 386 (1941); Welsh v. Frisbee Memorial Hosp., 90 N.H. 337, 9 A.2d 761 (1939).

The treatment strategy might entail nothing more than some advice on how to handle a domestic problem. For example, if a psychiatrist were to identify his patient's depression with the habitual nagging of his recently arrived mother-in-law, he might recommend ways to facilitate her early departure. Should the patient's wife bring suit for divorce because of her mother's eviction from the homestead, an action by the patient against the psychiatrist for negligent advice might be pursued, although it is doubtful that liability would be imposed on the basis of inaccurate advice that is otherwise reasonable. Tarshis, *supra* note 14, at 95.

75. *See* notes 30-36 and accompanying text *supra*. Showing negligence in choice of treatment will be especially difficult, given both the inherently nebulous nature of the psychotherapeutic process, *see* notes 23-28 and accompanying text *supra*, and the number of respected minorities that have evolved as a result of discord within the discipline. *See Tort Liability, supra* note 19, at 49.

76. *See* note 32 and accompanying text *supra*.

77. Tarshis, *supra* note 14, at 85.

78. The doctrine of informed consent requires that the attending physi-

the psychotherapist is forced to balance his duty to protect the patient from counterproductive distress against his patient's right to full and complete information about the treatment.[79] Since the patient's mental condition may inhibit his propensity to question the therapist about the treatment,[80] the balance is delicate at best. And, of course, the duty to disclose is a continuing one which becomes more compelling as the therapy strengthens the patient's tolerance for "bearing" the prognosis.[81]

Another balance that may prove difficult for the psychiatrist to maintain is that between detachment and diligence. The therapist must remain somewhat distant from his patient if he is to maintain the objectivity that is critical to a successful resolution of the patient's problem.[82] For example, by encouraging social

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cian disclose to the patient the risks incident to the treatment so as to enable the patient to decide whether he should accept the treatment. *E.g.*, Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906). The legal sufficiency of the information provided by the physician must be proven by expert testimony. Green v. Hussey, 127 Ill. App. 2d 174, 262 N.E.2d 156 (1970).

Lack of informed consent by a patient to certain kinds of physical therapy may result in an actionable violation of his bodily integrity. Paulsen v. Gendersen, 218 Wis. 578, 260 N.W. 448 (1935). However, the courts have been hesitant in allowing recovery for interference solely with a person's peace of mind, particularly when such interference was the result of the defendant's *negligent* conduct. *See* PROSSER, *supra* note 9, at 327. Thus, a court might be reluctant to hold that a physician who was guilty of unauthorized psychotherapy was liable for negligent infliction of emotional distress.

79. As noted in Gault v. Sideman, 42 Ill. App. 2d 96, 109-10, 191 N.E.2d 436, 443 (1963), "the physician cannot, and should not, so terrify the patient by pointing out to him the manifest dangers which are present at any time the slightest surgical operation is performed. To do so might present a psychic reaction which would seriously retard the success of the physician's treatment." Therefore, if a detailed explanation of the patient's illness would worsen his condition or impede further progress, full disclosure might itself be negligent. *See* Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965); Wilson v. Scott, 412 S.W.2d 299 (Tex. 1967). However, a psychotherapist is not justified in withholding from his patient pertinent information concerning the treatment simply because the patient would elect to forego therapy if full disclosure was made. *Medical Malpractice, supra* note 19, at 703. *See also* Smith, *Therapeutic Privilege to Withhold Specific Diagnosis From Patient Sick With Serious or Fatal Illness*, 19 TENN. L. REV. 349 (1946).

80. For the effect of the patient's mental condition on his willingness to bring suit against his psychotherapist, *see* note 114 and accompanying text *infra*.

81. Tarshis, *supra* note 14, at 91.

82. *See* Landau v. Werner, 105 Sol. J. 257, *aff'd*, 105 Sol. J. 1008 (1961) (wherein liability of psychiatrist for mishandling the transference phenomenon resulted from lack of detachment).

It is generally recognized that the therapist is best able to bring to bear his skill on the patient's problem when he is detached from emotional involvement. Dawidoff writes that a therapist "must maintain his emotional stability if only because without it his capacity to empathize and participate in the therapy by infusing it with his own energy might be lost." Dawidoff, *supra* note 7, at 709.

contacts with his patient, the psychiatrist may confuse his personal goals with his professional obligations.[83] Since affection can be perceived on a variety of different levels, consideration must be given to the possibility of a patient's distorted perception of an otherwise neutral act.[84]

There is also a duty of diligence that the therapist must meet.[85] This duty will necessarily be fulfilled if the psychiatrist is to inspire the confidence of his patient that is essential to a healthy psychotherapeutic relationship.[86] However, apart from the basic attention necessary to maintain the relationship, a therapist may have a duty to be available during a crisis.[87] Should the patient's worsened condition be traced to a lack of care at this time, the therapist can be held responsible.[88]

An extension of the psychotherapist's duty to be diligent is a duty to monitor his patient's activity. This supervision may be incident to the treatment itself and as such, might require only

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83. In Landau v. Werner, 105 Sol. J. 257, 258, *aff'd*, 105 Sol. J. 1008 (1961), the trial court noted that it was highly undesirable for a psychiatrist to interact socially with an unstable patient who was already very much in love with him and, as such, was in a highly suggestive state. One author suggests that "there is professional medical opinion to the effect that, in the transference relationship, it is not possible clearly to separate social and professional conduct." Dawidoff, *supra* note 7, at 704-05. Of course, the propensity of a therapist to become emotionally involved with certain personality types must be recognized at the time he accepts the patient's case. *See* notes 62-64 and accompanying text *supra*.

84. However, a psychiatrist is not bound to remain emotionally flat when treating his patients. "His every action need not be drive reduced and free of neurotic motive, nor need it be uniformly recognized or accepted as drive reduced by the psychiatric community." Dawidoff, *supra* note 7, at 709. Indeed, without some psychological involvement on the part of the therapist, it is doubtful that the requisite relationship—the medium for cure—could develop between the physician and patient. *See* notes 23-28 and accompanying text *supra*. Yet to contend that the "standard practice of the medical profession" must guide the point at which a therapist is held liable for failure to control his own feelings, Dawidoff, *supra* note 7, at 710-11, is to presuppose that a single standard of care is available. *But see* note 124 and accompanying text *infra* .

85. Church v. Adler, 350 Ill. App. 471, 113 N.E.2d 327 (1953) (a doctor has a duty to treat his patient as long as treatment is required).

86. *See* notes 23-28 and accompanying text *supra*.

87. It is important to determine whether the therapist has contracted to be available only for scheduled appointments or whether he has contracted to treat a disease, an obligation which may not be accommodated by an inflexible appointment schedule. Both views are represented in practice, *see* Tarshis, *supra* note 14, at 87, and are subject to prior agreement between the particular parties. *See generally* Annot., 57 A.L.R.2d 432 (1958).

88. Johnson v. Vaughn, 370 S.W.2d 591 (Ky. 1963) (physician cannot leave patient at critical stage without giving reasonable notice or making arrangements for a qualified substitute). In this regard, the duty of care should be strictly construed for if the lack of diligence destroys the patient's basic sense of trust, another psychotherapist may not be able to "pick up where the last left off." Tarshis, *supra* note 14, at 88.

that the patient make a regular report of his emotional response to certain of life's events. An extreme would be the requirement of institutional supervision when the patient's violent behavior poses a threat to himself,[89] or others.[90] While suicide is difficult to predict,[91] a therapist might be liable for disregarding evidence of his patient's violent tendencies.[92]

The converse of the psychiatrist's obligation to exercise reasonable diligence in caring for his patient is his duty to terminate the physician-patient relationship when treatment is no longer required or when it ceases to be effective. In both instances the therapist must determine to what degree the treatment has been successful. If the patient is "cured," there is no need for further treatment.[93] If nothing more can be done by the psychiatrist to help the patient, there is no reason to continue the relationship.[94] In either case, continuing a course of unnecessary treatment could render the psychiatrist liable for malpractice.[95] Yet if the therapist is in error about the success of the treatment or underestimates his own ability to offer additional help to the patient, he may be negligent in discharging him prematurely.[96] Where there is reasonable doubt about the patient's "cure" or the utility of the therapist's role, the psychiatrist might be held liable for failing to consult with another specialist if the

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89. Suicide among patients in therapy is not uncommon, Litman, *When Patients Commit Suicide*, 19 AM. J. PSYCHOTHERAPY 570, 572 (1965), and ranks as a major cause of death generally. *See* Peer, *Liability of Hospital and Psychiatrist in Suicide*, 122 AM. J. PSYCHIATRY 631 (1965). *See generally Tort Liability, supra* note 19, at 422.

90. Apart from his duty to supervise a potentially dangerous patient, the psychotherapist may now have a duty to warn an endangered victim whose peril was disclosed during a privileged communication between the therapist and patient. *See* Tarasoff v. Regents of the Univ. of Calif., 33 Cal. App. 3d 275, 108 Cal. Rptr. 878 (1973). *See generally Tort Liability, supra* note 19, at 425.

91. Perr, *Suicide Responsibility of Hospital and Psychiatrist*, CLEV.-MAR. L. REV. 427, 437 (1960) (even previous attempt is of little value in predicting suicidal tendencies).

92. *See* Tarshis, *supra* note 14, at 87.

93. "If treatment is no longer required, then of course the doctor has not abandoned the patient." *Tarshis*, supra note 14, at 88.

94. Thus, "there may be a duty upon a psychiatrist whose continued application has borne no visible fruit to abandon the case or seek consultation." Dawidoff, *supra* note 7, at 713. *See* note 73 and accompanying text *supra*.

95. However, it may be impossible to determine whether or not the treatment is unnecessary since there is little agreement among clinicians when secondary diagnostic categories are employed. *Medical Malpractice, supra* note 19, at 699-702. Thus, "[i]f the patient has an illness for which there are no reliable diagnostic techniques, he cannot recover even though he may have spent considerable amounts of time and money for the treatment of an illness which he does not, in fact have." *Id.* at 698.

96. *See* note 85 and accompanying text *supra*.

discharge later proves to have been premature.[97]

Post-Discharge Negligence

The key to a successful psychotherapeutic process is the relationship between therapist and patient.[98] This relationship may or may not extend beyond the "official" discharge of the patient from treatment. If it does, a question arises over whether the psychiatrist may be held liable to the patient or third persons for damages that result from events which occur subsequent to the discharge. Presumably, a person cannot be held accountable for the acts of another solely on the basis of the friendship that exists between them.[99] With fiduciaries, however, a stronger case can be argued in support of *some* continuing obligation during the period *immediately* following discharge.[100] This would be true particularly when the discharge resulted from the patient's unilateral act which was later determined to be only a symptom of the emotional problem that first gave rise to the consultation.[101]

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97. *See* note 70 and accompanying text *supra*.

98. *See* notes 23-28 and accompanying text *supra*.

99. Prosser notes that "the law has persistently refused to recognize the moral obligation of common decency . . . to come to the aid of another human being who is in danger," but he then lists the special relations between parties which might give rise to such affirmative duties, concluding that there are "undoubtedly other relations [which call] for the same [duty]." PROSSER, *supra* note 9, at 341.

100. The duty of a treating physician to exercise due care is not founded in contract but rather, "is predicated by the law on the *relation* which exists between physician and patient . . . ." 61 AM. JUR. 2d *Physicians and Surgeons* § 106 (1972) (emphasis added). Thus, where the psychological bond between the therapist and patient continues after discharge, some duty of care might be imposed on the psychotherapist despite the gratitutous nature of the relationship. *See* Stevens v. Stevens, 355 Mich. 363, 370, 94 N.W.2d 858, 862 (1959), in which the court, in construing the applicability of a guest statute, noted that:

> [I]t has been our boast that when one entrusts another with life or property relying upon a relationship of trust and confidence, rather than the weapons and guarantees of the business world, a performance of duty the most exacting will be demanded, a conformity not with the arm's length standards of the market but rather the infinitely nicer standards of the hearth and the heart.

101. While the psychiatrist cannot force a patient to continue therapy, he would be obligated to deal appropriately with a patient's unilateral termination of the relationship when the act was symptomatic of the psychological problem which the psychiatrist *did contract to treat*. Yet, there are those who feel that the patient should nevertheless be given the responsibility of deciding whether to submit to, or discontinue treatment. Tarshis, *supra* note 14, at 90.

THE INADEQUACIES OF A TORT ALTERNATIVE

When a physician assumes to treat a patient, he represents himself as having the skills and knowledge common to the class of practitioners to which he belongs.[102] As an incident of the physician-patient relationship,[103] the law imposes on the doctor a duty to employ the requisite care[104] in the performance of his professional responsibilities. If the physician lacks ordinary skills or neglects to apply those which he does possess, he may be liable to his injured patient in a malpractice action.[105] Due, in part, to an increase in the wealth of scientific information available to plaintiffs seeking to impose liability on physicians for negligent treatment of physical illnesses,[106] the number of malpractice suits against these practitioners has increased dramatically.[107] This influx of litigation has generated new and clearer guidelines to the medical profession for avoiding negligent practice.

In general, the duties of care imposed on medical practitioners are equally applicable to psychiatrists[108] who, being no more perfect than other medical specialists,[109] should also be vulnerable to malpractice claims. However, such has not been the case. Instead, psychiatrists engaged in the practice of psychotherapy

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102. *E.g.*, Church v. Adler, 350 Ill. App. 471, 113 N.E.2d 327 (1953).

103. It is not required that a psychiatrist expressly represent his professional qualifications to his patient before a duty to care for him arises since an implicit representation of competence is made by reason of the physician holding himself out as being a member of the psychiatric community. *See* Ayers v. Russell, 50 Hun. 282, 289, 3 N.Y.S. 338, 341 (Sup. Ct. 1888). Where an express representation is made, the resulting contractual relationship between the parties may provide the basis for the duty. *See* Nicholson v. Han, 12 Mich. App. 35, 162 N.W.2d 313 (1968).

104. The practitioner is required to display the ordinary training and skill possessed by physicians and surgeons practicing in the same or similar communities. *See, e.g.*, Church v. Adler, 350 Ill. App. 471, 113 N.E.2d 327 (1953).

105. While lack of the requisite knowledge or skills and negligent application of that knowledge or those skills are separate forms of malpractice, Newport v. Hyde, 244 Miss. 870, 147 So. 2d 113 (1962), the courts occasionally fail to make the distinction when there would be no difference in result. *See, e.g.*, Copeland v. Robertson, 236 Miss. 95, 112 So. 2d 236 (1959); Wilson v. Martin Memorial Hosp., 232 N.C. 362, 61 S.E.2d 102 (1950).

Apart from liability for malpractice, the physician may be held accountable for breach of contract. *See, e.g.*, Doerr v. Villate, 74 Ill. App. 2d 332, 220 N.E.2d 767 (1966) (physician guaranteed sterility). *But see* Gault v. Sideman, 42 Ill. App. 2d 96, 191 N.E.2d 436 (1963) (in suit for breach of specific contract, representation that operation could cure plaintiff was not a warranty that defendant physician would cure plaintiff).

106. J. MIRZA & J. APPLEMAN, ILLINOIS TORT LAW AND PRACTICE 311 (1974).

107. *See* note 15 and accompanying text *supra*.

108. *See* Annot., 99 A.L.R.2d 599, 619 (1965).

109. Tarshis, *supra* note 14, at 96.

have been relatively immune from suits resulting from negligent practice.[110] While this lack of litigation may be due in part to the psychiatrist's ability to displace the negative feelings of his patient and thus reduce his propensity to sue,[111] it may be due primarily to the difficulty in implementing traditional tort theories within the unique context of the psychotherapeutic relationship.

General Problems With the Tort Alternative

A malpractice action becomes a viable option for an injured patient only after he associates the damage he suffered with the therapy offered by the negligent psychotherapist.[112] This connection is tenuous at best and may be overlooked when the patient's unstable mental condition impairs his ability to reason. Subsequent therapy might help bring to light the negligence of a previously consulted psychiatrist and may provide the moral support necessary for the patient to bring an action against a former confidant; however, the patient who has been severely traumatized by the aborted treatment may be reluctant to seek this additional help.[113]

Even when the patient is cognizant of his worsened mental state and can associate that condition with the negligence of a particular therapist, he still may be unwilling to pursue a remedy in the courts. If the patient is distrustful as a result of his former treatment, it is unlikely that he will initiate litigation the result of which is highly speculative. This reluctance would be especially pronounced when the patient knows that it may be necessary for him to bare his soul before a judge and jury whose members are selected from his community. Moreover, while such testimony would be essential to the successful resolution of the patient's suit, by no means would it insure favorable results at trial since the "diseased" witness no doubt will face credibility problems when testifying against an articulate professional whose public esteem is somewhat greater than that of his former patient.[114]

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110. *See* text accompanying note 16 *supra*.

111. One author has observed that "[l]itigation of this type—a patient against his doctor—is often a product of hostility that the doctor has engendered in the patient and that has not been worked out." Tarshis, *supra* note 14, at 96.

112. Unless the therapist's negligence is extreme, or results in physical injury, the association between the injury and the treatment may be impossible to make. *Medical Malpractice, supra* note 19, at 703.

113. In cases where the patient does seek additional help, the negative feelings caused by his deteriorated sense of trust may carry over into the new psychotherapeutic situation, thereby inhibiting further progress. *See* note 88 *supra*.

114. In one study, physicians were ranked among the most prestigious

Problems With Specific Elements of the Cause of Action

The problems involved in proving a tort case against a negligent psychiatrist can be traced directly to the nebulous nature of the psychotherapeutic process itself.[115] At times characterized as "clandestine and mystical,"[116] the process is highly individual and, as such, defies the quantification that is necessary for a standard of psychotherapeutic care to evolve. Thus, "[t]he price of recognizing a cause of action for psychiatric malpractice is some judicial ordering of psychiatric behavior."[117] It remains to be seen whether the courts will be able (or willing) to do what the psychiatric community itself has not yet been able to accomplish.

Defining the Duty

Actionable negligence is based on the breach of a legal duty[118] of one person to exercise the requisite care for the protection of the person injured as a result of the breach.[119] The psychiatrist's duty to protect his patient from harm arises out of their physician-patient relationship.[120] Apart from the basic duty imposed on the psychiatrist because of his professional status,[121] the degree to which he must care for individual patients depends on the particular circumstances of their relationship. In other words, "[t]he greater the risk that a course of

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of all occupational groups, second only to Justices of the United States Supreme Court. Hodge, Siegel & Rossi, *Occupational Prestige in the United States: 1925-1963*, in CLASS, STATUS, AND POWER 324 (R. Bendix and S. Lipset eds. 1966). Conversely, the public stigma associated with mental disease was powerful enough to cause the resignation of the Democratic vice-presidential nominee in the 1972 national elections. One author suggests that transference, "as well as the character of the neurosis itself, makes some testimony of the psychiatric patients questionable." Heller, *supra* note 17, at 406. *See also* Farina & Ring, *The Influence of Perceived Mental Illness on Interpersonal Relations*, 70 J. ABNORMAL SOC. PSYCH. 47 (1965).

115. *Medical Malpractice, supra* note 19, at 708.

116. Tarshis, *supra* note 14, at 96.

117. Dawidoff, *supra* note 7, at 714.

118. Whether or not a duty of care exists in a particular circumstance is a legal question. *See, e.g.*, Palsgraf v. Long Island R. Co., 248 N.Y. 339, 162 N.E. 99 (1928).

119. *See* Cunis v. Brennan, 56 Ill. 2d 372, 308 N.E.2d 617 (1974) (no duty to guard against "freakish or fantastic" occurrence); Lance v. Senior, 36 Ill. 2d 516, 224 N.E.2d 231 (1967) (no duty to prevent a hemophiliac from playing with a needle).

120. Alternatively, the contractual relationship between the physician and patient can form the basis for liability when the physician's negligence is in breach of a contractual duty. *See, e.g.*, Colton v. Foulkes, 259 Wis. 142, 47 N.W.2d 901 (1951) (complaint stated a cause of action in tort even though the duty alleged to have been breached arose out of a contractual obligation to repair plaintiff's porch).

121. *See* note 103 and accompanying text *supra*.

treatment or an aspect of the relationship may harm the patient, and the greater the harm might be, the greater care the psychotherapist must take."[122] Thus, a psychiatrist who possesses and properly applies the basic skills of his profession can exercise varying *degrees* of care towards individual patients.[123]

Individualized degrees of care have led to the application of various standards for quantifying psychiatric negligence.[124] This inconsistency may be the result of the judiciary's reluctance "to establish legal standards of care in the murky area where schools of thought proliferate—and disintegrate—at an alarming rate."[125] Due to this uncertainty within the science, the courts have been able to do little more than "outline the extreme limit of acceptable psychotherapeutic treatment."[126] In the absence of litigation defining the points within this outer limit at which the courts will hold a psychotherapist liable, uncertainty over acceptable standards of practice will persist. Yet, until the practice of psychotherapy becomes more definite, the courts will not be able to establish narrower standards of care, and the injured patient will continue to face the prospect of dismissal for failure to state a cause of action in his complaint.[127]

Proximate Cause

The literature is rich with studies which indicate that the exacting science of psychiatry is anything but exact.[128] In one,

122. Tarshis, *supra* note 14, at 83.

123. While the *standard* of care does not vary from case to case, the *measure* of care may vary depending on the factors incident to the treatment. Dawidoff, *supra* note 7, at 701, 703. Of course, where the psychotherapist makes use of a new or somewhat novel technique, he must justify that treatment before the court. Landau v. Werner, 105 Sol. J. 1008, *aff'g* 105 Sol. J. 257 (1961).

124. *E.g.*, Ayers v. Russell, 50 Hun. 282, 289, 3 N.Y.S. 338, 341 (1888) (ordinary care); McCandless v. McWha, 22 Pa. 261, 268 (1863) (reasonable diligence); Wood v. Clapp, 36 Tenn. 26, 28 (1856) ("reasonable" degree of skill and care as opposed to "highest" degree); Landau v. Werner, 105 Sol. J. 257, *aff'd*, 105 Sol. J. 1008 (1961) ("very greatest care").

125. *Tort Liability, supra* note 19, at 409. Dawidoff reports that the measure of care required depends on the "tractability of the forces being controlled: their danger, the skill necessary to control them or the interest at stake." Dawidoff, *supra* note 7, at 702.

Application of inconsistent standards may also be the result of the judiciary's attempt to acknowledge the limitations of a newly developing science by restricting the formulation of duties for which a psychotherapist might be held liable, much like the restrictions placed on the level of precision expected in the diagnosis of mental illness. Tarshis, *supra* note 14, at 78. *See also* note 65 *supra*.

126. Tarshis, *supra* note 14, at 85. *See* note 150 and accompanying text *infra*.

127. *See generally* PROSSER, *supra* note 9, at 289.

128. *See Medical Malpractice, supra* note 18, at 700-02.

the authors report that, on the average, psychiatrists can be expected to agree only 54% of the time.[129] This uncertainty within the profession generally is equally applicable to the practice of psychotherapy.[130] Thus it is likely that a medical psychotherapist who is sued for malpractice will always be able to find colleagues who will testify that the plaintiff's condition was the result of factors beyond the defendant's control,[131] and that the treatment did not proximately cause the damage complained of.[132] If it can be proven that the plaintiff's injuries did result from the psychiatrist's tortious conduct, the patient must still show that a different treatment would not have caused the injury.[133] Such a showing will be difficult to make given the underdeveloped state of the science and the reluctance of psychotherapists to predict the success of any one method of

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129. B. ENNIS & L. SIEGEL, THE RIGHTS OF MENTAL PATIENTS 286 (1973). The authors go on to report that this figure compares unfavorably with the 90% agreement rate among ballistics experts and the 75% agreement rate among polygraph specialists. The 54% general figure is surprisingly high when compared with the agreement rate among psychiatrists who relate psychiatric categories to a patient's present mental condition. *See* note 141 *infra*. For a further discussion of agreement rates among psychiatric experts, *compare* Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693 (1974), *with* Beck, *Reliability of Psychiatric Diagnosis: A Critique of Systematic Studies*, 119 AM. J. PSYCHIATRY 210 (1962) (reviewing the methodology employed by some researchers who have concluded that psychiatric diagnosis is unreliable).

130. "Numerous studies have demonstrated that psychotherapy is unsuccessful in inducing behavior change, that no form of psychotherapy is more successful than others, and that patients are either just as likely or more likely to improve their condition in the course of time without the benefit of psychotherapy." *Medical Malpractice, supra* note 19, at 706-07. *Contra*, Subotnik, *Spontaneous Remission: Fact or Artifact*, 77 PSYCHOLOGICAL BULL. 32 (1972).

131. Since the psychotherapeutic relationship works only when both physician and patient try to interact, the patient's worsened condition may be the result of his own contributory negligence or peculiar sensitivities. *Cf.* Braun v. Craven, 175 Ill. 401, 51 N.E. 657 (1898) (defendant having no knowledge of plaintiff's particular sensitivities not liable for intentional infliction of mental distress). Experts may even be justified in testifying that the injury (or some portion of it) was the natural result of the illness itself. *Tort Liability, supra* note 19, at 412. This division of responsibility between the parties would preclude the injured patient from invoking the doctrine of res ipsa loquitur. *See* Kerby v. Chicago Motor Coach Co., 28 Ill. App. 2d 259, 171 N.E.2d 412 (1960); Kirchner v. Kuhlman, 334 Ill. App. 339, 79 N.E.2d 628 (1948).

132. In a field "where there is so little agreement on diagnosis and treatment, it is no mean task to establish the necessary causal chain." *Tort Liability, supra* note 19, at 412.

133. *Cf.* Milano v. State, 44 Misc. 2d 290, 253 N.Y.S.2d 662 (1964) (because there was no showing that Rorschach test would have revealed homicidal tendencies, state mental health authority was not negligent in failing to predict a homicidal assault by an untested mental patient).

therapy.[134]

Assessing the Damages

Among the legal burdens imposed on the plaintiff whose pleadings have survived the demurrer stage in his suit against a negligent psychotherapist is the requisite showing that a deteriorated (or unimproved) mental condition resulted from the psychiatrist's negligent conduct.[135] In other words, proof of damages is an essential part of the plaintiff's case.[136] However, because of the unique nature of the psychotherapeutic process, the assessment of an injured patient's damages may be nearly impossible. The difficulty encountered by courts when evaluating the symptoms of psychic injury is illustrative of this damage assessment problem.[137] Unlike other specialty branches where the damages suffered by the patient are manifestations of the physician's negligence, symptoms associated with psychic injury may ironically be indicative of the psychotherapist's success. For example, if two years of therapy have done nothing for the patient except increase his anxiety, a condition which has caused his loss of employment, the psychiatrist can defend by showing that what his former patient considers an injury was really the first sign of progress in unearthing the plaintiff's problem.[138] Alternatively, should anxiety decrease, success may be

134. While it is generally agreed that psychotherapy is appropriate treatment for neurosis, its usefulness in treating schizophrenia, manic depression, and psychosomatic diseases remains uncertain. *See Medical Malpractice, supra* note 19, at 705.

135. In Landau v. Werner, 105 Sol. J. 257, *aff'd*, 105 Sol. J. 1008 (1961), the plaintiff recovered for her severe neurosis as well as for the damages incurred as a result of her inability to work. Normally, the extent of liability resulting from psychic injury is uncertain, *see* note 137 and accompanying text *infra*, but is more easily measurable when accompanied by bodily injury. *See* PROSSER, *supra* note 9, at 330.

136. The importance of proving damages is illustrated by a New York judge who intimated that where damages are unascertainable, the plaintiff's cause will fail. *See* Williams v. State, 18 N.Y.2d 481, 484, 223 N.E.2d 343, 345, 276 N.Y.S.2d 885, 888 (1966) (Keating, J., concurring). *But cf.* Illinois Power Co. v. Champaign Asphalt Co., 19 Ill. App. 3d 74, 310 N.E.2d 463 (1974) (damages may be established on the basis of reasonable probability).

137. Mental pain has not always been compensable. *See, e.g.*, Cleveland, C.,C. & St. L. Ry. v. Stewart, 24 Ind. App. 374, 56 N.E. 917 (1900); Mitchell v. Rochester Ry., 151 N.Y. 107, 45 N.E. 354 (1896). In Illinois, mental pain which results from physical pain is recoverable, Werner v. Illinois Cent. R. Co., 309 Ill. App. 292, 33 N.E.2d 121 (1941), *rev'd. on other grounds*, 379 Ill. 559, 42 N.E.2d 82 (1942), because a neurosis is as much an injury as the loss of a limb. Postal Tel. Cable Co. v. Industrial Comm'n, 345 Ill. 349, 178 N.E. 187 (1931).

138. Dawidoff reports that:

> [S]uch intensity of feelings is not only the mark of some therapeutic success, but the prelude to insight on the part of the patient. Such a resurrection of the repressed feelings of childhood allows the intellec-

claimed for alleviating painful symptoms. Where this temporary but requisite regression is found to constitute sufficient damage to impose liability, a court would be somewhat reluctant to "fix liability upon the downside of a curve before its future path upward has had a chance to emerge."[139] Thus, the valuation even of acknowledged damages might prove difficult when they are transitory in nature. Should the damages be permanent, they may prove difficult to apportion if they are caused in part by the plaintiff's refusal to seek the additional help necessary for his "turning the corner" in the psychotherapeutic process.[140]

Problems of Proof

The injured patient willing to bring suit against a negligent psychiatrist faces serious problems in assembling proof to support his cause of action.[141] Psychotherapy is practiced, for the most part, in private, with only the therapist and patient present.[142] It is necessary, therefore, to resolve the question of negligence on the basis of the parties' conflicting testimony about what was said and done during the course of the treatment.[143]

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tual and emotional examination of feelings not previously understood or dealt with. Through such re-examination the emotional learning of psychotherapy occurs.

Dawidoff, *supra* note 7, at 714. Thus, where some form of regression is to be expected, it is doubtful that those symptoms which surface constitute adequate damage. *See generally Medical Malpractice, supra* note 19, at 705.

139. Dawidoff, *supra* note 7, at 712.

140. *See* notes 88, 113 *supra*. If the negligent psychiatrist is responsible for his former patient's incredulous disposition, then the patient's refusal to seek additional help is not in breach of a duty to mitigate damages. Should the responsibility for his former patient's disposition be traced to an inadequacy in the psychiatrist's initial explanations of what was to be expected during therapy, the patient may be able to avoid numerous pitfalls by showing lack of informed consent. *See* Tarshis, *supra* note 14, at 89. *See also* notes 78-79 and accompanying text *supra*.

141. The problems of proof are most acute when the plaintiff alleges diagnostic negligence, for when attempting to relate psychiatric categories to a patient's present mental condition, the rate of agreement among the experts was reportedly less than 25%. Goldsmith & Mandell, *The Psychodynamic Formulation: A Critique of a Psychiatric Ritual*, 125 AM. J. PSYCHIATRY 1738 (1969). *See also* Ash, *The Reliability of Psychiatric Diagnosis*, 44 J. ABNORMAL SOC. PSYCH. 272, 276 (1949). Thus, "[s]ince so much debate and confusion exists within the profession, it is likely that a psychiatrist who is sued for negligently choosing or administering a therapy will always be able to find support from his colleagues for his actions." *Medical Malpractice, supra* note 19, at 707.

142. This "private" dimension of psychotherapy also limits the effectiveness of peer control. *See* Tarshis, *supra* note 14, at 77.

143. Wise counsel would not allow plaintiff's case to assume the posture of the psychiatrist's word against that of his former patient, for the psychiatrist would be viewed as more credible by the jury. *See* note 114 and accompanying text *supra*.

Records of sessions kept by the psychotherapist may help bolster the patient's quantum of proof, and sloppy or incomplete records will weigh heavily against the therapist.[144] However, the sufficiency of detail in these records will be judged in light of the standard in the community,[145] which may be difficult to ascertain given the general reluctance of physicians to testify in malpractice actions.[146] When a general standard can be established on the basis of learned treatises, professional journal articles, or association guidelines, the same "conspiracy of silence" will hamper the plaintiff's showing that the defendant's records were inadequate when viewed against a specific standard, the terms of which are defined by the pecularities of his particular treatment.[147] Of course, even where complete records show deviation from some standard practice in the relevant psychiatric community, the psychiatrist will seek to justify the treatment by characterizing it as acceptable to a "respected minority" of the profession.[148] "[S]ince psychiatry is one field where the traditional, conservative approach has been repudiated by many practitioners,"[149] the psychotherapist will encounter little difficulty in legitimizing all but the most extraordinary forms of treatment,[150] particularly when the therapy has been successful

144. Slawson, *Psychiatric Malpractice: A Regional Incidence Study*, 126 AM. J. PSYCHIATRY 1302, 1305 (1970).

145. *See* Whitree v. State, 56 Misc. 2d 693, 701, 290 N.Y.S.2d 486, 495-96 (Ct. Cl. 1968).

146. *See* Note, *Malpractice and Medical Testimony*, 77 HARV. L. REV. 333, 336-38 (1963). "The reluctance of the members of the medical profession to testify against a fellow disciple of Aesculapius makes the search for a medical expert very difficult in most cases and well nigh impossible in some cases." Sanders v. Frost, 112 Ill. App. 2d 234, 241, 251 N.E.2d 105, 108 (1969).

147. It might be argued that once the plaintiff shows any deviation from established recordkeeping practices, it is incumbent upon the psychiatrist to come forth with an adequate explanation. *See Tort Liability, supra* note 19, at 419-20.

148. PROSSER, *supra* note 9, at 163.

> It is, in fact, unlikely that a psychiatrist could be held liable for negligently choosing a method of psychotherapy, since such a large number of possible therapies exist. . . . Therefore, even if a patient were able to introduce expert testimony at trial to show that the therapy was inappropriate, the psychiatrist would be able to counter this testimony with experts of his own.

Medical Malpractice, supra note 19, at 705.

149. *Tort Liability, supra* note 19, at 419.

150. Roy v. Hartogs, 85 Misc. 2d 891, 381 N.Y.S.2d 587 (1976) (sexual psychotherapy); Zipkin v. Freeman, 436 S.W.2d 753 (Mo. 1969) (intentional mismanagement of transfer phenomenon in order to commit fraud); Hammer v. Rosen, 7 App. Div. 2d 216, 181 N.Y.S.2d 805 (1959), *modified*, 7 N.Y.2d 376, 165 N.E.2d 756, 198 N.Y.S.2d 65 (1960) (therapy bordering on assault and battery).

In Landau v. Werner, 105 Sol. J. 257, *aff'd*, 105 Sol. J. 1008 (1961), the psychotherapist who had initiated social contacts with his patient was

in the past.[151]

Thus, despite the conceptual ease with which one can illustrate various forms of psychotherapeutic malpractice, recovery for all but the most outrageous conduct on the part of the therapist is unlikely. Duties of the psychotherapist are difficult to formulate. Injuries are hard to identify and difficult to trace to the responsible psychiatrist. If a causal connection can be made, damages may prove unmeasurable. Yet, the tort sanction is only one of three methods used by society to inhibit professional dereliction. Perhaps the state's certification process or the self-regulatory action of the psychiatric community can be used to minimize the risk of psychotherapeutic malpractice.

REGULATION OF PSYCHOTHERAPISTS

The Existing Controls

Negligent psychotherapists are a legitimate public concern.[152] Given the potentiality for abuse, there is little doubt that statutes providing for the regulation of psychotherapists can be grounded in the Constitution[153] and the states' police

found guilty of negligence, but only because there was no proof offered into evidence which showed acceptance of this type of treatment by a respected minority of his peers. *See* Dawidoff, *supra* note 7, at 715, wherein the author refers to this case as an "accident of proof."

151. *See* Tarshis, *supra* note 14, at 85, where the author notes that "success is the best justification for unestablished treatment." In view of the manner in which ordinarily adverse symptoms can be characterized as favorable, *see* note 138 and accompanying text *supra*, a showing of successful results in the past would seem to pose little difficulty. Yet the use of some novel techniques which have succeeded in cases where more established methods have failed still may result in liability for the innovative therapist. *See* Hammer v. Rosen, 7 App. Div. 2d 216, 181 N.Y.S.2d 805 (1959), *modified*, 7 N.Y.2d 376, 165 N.E.2d 756, 198 N.Y.S.2d 65 (1960) (physical beatings made out a *prima facie* case of malpractice despite evidence elicited at the trial court that schizophrenic patient, who had undergone radical psychiatric care at various institutions without success, was initially aided by the beatings).

152. *See* note 6 *supra*.

153. Included within a citizen's constitutional right to liberty and the pursuit of happiness is his right to pursue the calling of his choice. Frazer v. Shelton, 320 Ill. 253, 150 N.E. 696 (1926); People v. Love, 298 Ill. 304, 131 N.E. 809 (1921). However, the citizen's occupational prerogative is subordinate to the right of the state to impose such reasonable restrictions and regulations on that field as may be necessary to protect the public interest. Bessette v. People, 193 Ill. 334, 62 N.E. 215 (1901). Thus, where the character or extent of operation of an enterprise causes it to affect other persons or their property, the state can impose conditions on entry into the field, and may prescribe terms under which the calling may be pursued. Chicago v. R. & X. Restaurant, 369 Ill. 65, 15 N.E.2d 725 (1938). In this regard, the Constitution offers no protection to one who conducts his business in disregard for the public health, safety or morals. Nebbia v. New York, 291 U.S. 502 (1934); Broadnax v. Missouri, 219 U.S. 285 (1911).

power.[154] Of course, regulation of psychotherapy, designed to inhibit negligent practice generally, should include all practitioners whether medical or non-medical personnel. In addition to formal state regulations governing those who practice psychotherapy, there are professional associations which possess regulatory and disciplinary powers over their membership. Their principal powers are certification of members and accreditation of training programs in which members receive their professional education.

Role of the State

Non-Medical Practitioners

Psychiatrists are not alone in the practice of psychotherapy but share the discipline with non-medical practitioners. Psychologists,[155] armed with either a masters or doctoral degree in psychology, advise and counsel clients on matters of mental health and treat their mental illness. During the course of this treatment, psychologists may practice psychotherapy.[156]

Recognizing the danger to the health and welfare of its citizens which results from the rendition of psychological services by unskilled psychologists, many states have passed legislation providing for the licensing or certification of practitioners of psychology.[157] The courts generally have found these statutes to be within the states' police powers and have upheld those rea-

154. The states are charged with the responsibility of protecting the general welfare and thus it is within their police power to regulate the practice of medicine and any of its related branches. *E.g.*, Mann v. Board of Medical Examiners, 31 Cal. 2d 30, 187 P.2d 1 (1947). State regulation is justified because the practice of medicine requires special skills and qualifications that the public is generally unable to acquire. *See* People v. Witte, 315 Ill. 282, 146 N.E. 178 (1925). Apparently, this right of the public to preserve professionalism within medical ranks and to protect itself from incompetence was recognized as early as the Code of Hammurabi. *See* Hughes v. State Medical Examiners, 162 Ga. 246, 134 S.E. 42 (1926).

A limitation on this power is that the regulations must bear a reasonable relation to the public welfare and cannot be arbitrary. State v. Borah, 51 Ariz. 318, 76 P.2d 757 (1938); Lowman v. Kuecker, 246 Iowa 1227, 71 N.W.2d 586 (1955). Those regulations found to be both necessary and appropriate are proper exercises of the state's plenary power and as such, violate no constitutional rights of liberty or property, Laughney v. Maybury, 145 Wash. 146, 259 P. 17 (1927), nor any privilege or immunity of national citizenship. Madden v. Kentucky, 309 U.S. 83 (1940).

155. *See* note 14 *supra*.

156. *See* H. LIEBENSON & J. WEPMAN, THE PSYCHOLOGIST AS A WITNESS 81 (1964). *See also* W. VANHOOSE & J. KOTTLER, ETHICAL AND LEGAL ISSUES IN COUNSELING AND PSYCHOTHERAPY 109-11 (1977) (approximately 10,000 psychologists practice psychotherapy).

157. Forty-seven states have statutes regulating the practice of psychology. W. VANHOOSE & J. KOTTLER, ETHICAL AND LEGAL ISSUES IN COUNSELING AND PSYCHOTHERAPY 121 (1977).

sonably calculated to achieve a legitimate public interest goal.[158]

Psychologists practicing[159] in Illinois are regulated through the Psychologist Registration Act.[160] The Act regulates persons holding themselves out as "psychologists"[161] and those rendering "psychological services"[162] by prohibiting the use of the title and rendition of the services by persons without a certificate.[163] The Act further requires that before a certificate can be issued the applicant must have received a doctoral degree in psychology from an approved institution,[164] completed two years of satisfactory professional experience,[165] and passed the Department of Registration and Education's examination.[166] Usually, only a fee is required for renewal, reinstatement or restoration of a certificate,[167] however, "where the circumstances so indicate," the Department may require an examination prior to restoring any certificate of registration.[168] Grounds for refusal or revocation of a practitioner's certificate generally reflect a concern for either the applicant's moral turpitude or his mental health.[169] The penalty for violating the Act is a Class B misdemeanor for the first offense [170] and a Class A misdemeanor for second and subsequent violations.[171] Since the Act defines unlawful practice as a public nuisance,[172] uncertified practitioners can be enjoined from performing such unlawful acts and can be held in contempt

158. *See, e.g.*, Pitts v. State Board of Examiners, 222 Md. 224, 160 A.2d 200 (1960); National Psychological Ass'n v. Univ. of N.Y., 8 N.Y.2d 197, 168 N.E.2d 649, 203 N.Y.S.2d 821, *appeal dismissed*, 365 U.S. 298 (1960).

159. The practice of psychology is defined in ILL. REV. STAT. ch. 111, § 5304 (1977).

160. *Id.* § 5301 (1977).

161.

> A person represents himself to be a "psychologist" within the meaning of this Act when he holds himself out to the public by any title or description of services incorporating the words "psychological," "psychologic," "psychologist," or "psychology," and under such title or description offers to render or renders services to individuals, corporations or the public for remuneration.

Id. § 5302(5) (1977).

162. " 'Psychological services' refers to any services if the words 'psychological,' 'psychologic,' or 'psychology' are used to describe such services by the person or organization offering to render or rendering them." *Id.* § 5302(6) (1977).

163. *Id.* § 5303 (1977).

164. *Id.* § 5311(d) (1977).

165. *Id.* § 5311(e) (1977).

166. *Id.* § 5311(f) (1977).

167. *Id.* § 5315 (1977).

168. *Id.*

169. *Id.* § 5316(1) to (7) (1977).

170. *Id.* § 5326 (1977).

171. *Id.*

172. *Id.* § 5327 (1977).

of court for violating the injunction.[173]

Medical Practitioners

Since the general practice of medicine is a qualified right,[174] the state may regulate branches of the medical art and prescribe rules and regulations for those practicing in a medical specialty.[175] Presumably, then, a state has the right to regulate persons who hold themselves out as "psychiatrists," or those who render "psychiatric services" the same as psychologists. However, no such regulation exists in Illinois despite the functional overlap of psychiatry with psychology.[176]

Illinois has defined "psychiatrist" in a number of ways,[177] but all commonly refer to a physician[178] "who devotes a substantial portion of his time to the practice of psychiatry."[179] Time in practice requirements are found in several statutes,[180] and special qualifications are required for psychiatrists seeking admin-

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173. *Id.*

174. At common law, the right was unqualified and the practice of medicine open to all with the only check on incompetency being the tort sanction. *See generally* State v. Borah, 51 Ariz. 318, 76 P.2d 757 (1938); Vest v. Cobb, 138 W. Va. 660, 76 S.E.2d 885 (1953).

175. Barsky v. Board of Regents of N.Y., 347 U.S. 442 (1954). Among the related branches regulated in Illinois are dental surgery, nursing, optometry, pharmacy, physical therapy, and veterinary medicine. *See generally* ILL. REV. STAT. ch. 111, §§ 2202, 3401, 3801, 4001, 4201, 6901 (1977).

176. "Psychiatry . . . is by and large, in its function and its subject matter, nearly identical to the field of clinical psychology. . . ." with the only difference being that the psychiatrist can prescribe drugs and shock therapy while the psychologist cannot. J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 259 (2d ed. 1975) [hereinafter cited as ZISKIN]. One author reports that psychiatrists have become quite dependent on psychologists for valuable and almost indispensable diagnostic services without which no formulation of the personality problems of the patient would be complete. Kirkpatrick, *Training For Psychotherapy with Special Reference to Non-Medical Fields*, 19 AM. J. ORTHOPSYCHIATRY 1, 3 (1949).

177. *See* notes 178-81 and accompanying text *infra*.

178. " 'Physician,' means any person licensed by the State of Illinois to practice medicine in all its branches, and includes any person holding a State Hospital Permit or Temporary Certificate of Registration, as provided in the Medical Practice Act." ILL. REV. STAT. ch. 91 ½, § 1-14 (1977).

179. This language is found in the Mental Health Code, ILL. REV. STAT. ch. 91½, § 1-15 (1977), as well as the statute which defines the psychiatrist-patient relationship and the evidentiary privilege resulting therefrom. ILL. REV. STAT. ch. 51, § 5.2 (1977). *See also* ILL. REV. STAT. ch. 38, § 105-4.01 (1977) and ILL. REV. STAT. ch. 23, § 2403 (1977) (reputable physician who specializes in the diagnosis and treatment of mental and nervous disorders).

180. One year in practice is required of the certifying psychiatrist immediately preceeding his certification of any patient in commitment proceedings. ILL. REV. STAT. ch. 91½, § 1-15 (1977) and five years in practice is required for psychiatrists appointed by a court to examine sexually dangerous persons. ILL. REV. STAT. ch. 38, § 105-4 (1977) and ILL. REV. STAT. ch. 23, § 2403 (1977).

istrative positions in state departments.[181] But for the physician who seeks to enter private psychiatric practice and specialize in psychotherapy, *nothing beyond a medical license is required by the State of Illinois.*

Internal Control of Psychiatrists

Primary control of the practice of psychotherapy by psychiatrists comes from within the psychiatric community itself.[182] The American Board of Psychiatry and Neurology,[183] the specialty organization of the American Psychiatric Association, controls the certification in psychiatry of licensed physicians, while the Joint Residency Review Committee sets the academic requirements for medical students who enter a certified psychiatric practice after graduation.[184] The American Board of Psychiatry and Neurology maintains strict certification requirements including three years of specialty training in an accredited psychiatric training program and two years of post-residency experience.[185] This insures that certified practitioners exhibit an advanced proficiency in the diagnosis and treatment of mental diseases. Presumably, this expertise sets them apart from their collegues whose minimal exposure to the mental healing arts came during their basic medical school training.[186]

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181. ILL. REV. STAT. ch. 127, § 7.07 (1977).

182. Tarshis, *supra* note 14, at 76.

Hospital by-laws and peer review panels can provide some informal control over its staff psychiatrists, *see* Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253, *cert. denied*, 383 U.S. 946 (1965), however, "peer control can only have limited effectiveness, since the psychotherapist's professional activity takes place in the privacy of his interviews, in which none of his peers participates." Tarshis, *supra* note 14, at 77.

It might be argued the complaints and discipline committees of psychiatric associations constitute a primary source of control over the practice of psychiatry, however, professional misconduct is not necessarily negligence but perhaps only unethical practice. *See* Tarshis, *supra* note 14, at 76. Of course, that ethical and professional conduct is no defense to a malpractice suit was made clear in Landau v. Werner, 105 Sol. J. 257, 258, *aff'd*, 105 Sol. J. 1008 (1961). *See* text accompanying note 44 *supra*.

183. For an interesting discussion of the background, history and function of the American Board of Psychiatry and Neurology, *see* Freeman, Ebaugh & Boyd, *The Founding of the American Board of Psychiatry and Neurology, Inc.*, 115 AM. J. PSYCHIATRY 769 (1959).

184. Taylor & Torrey, *The Pseudo-Regulation of American Psychiatry*, 129 AM. J. PSYCHIATRY 658, 659 (1972) [hereinafter cited as Taylor & Torrey]. The substance of Taylor & Torrey's critical article was reaffirmed in W. VANHOOSE & J. KOTTLER, ETHICAL AND LEGAL ISSUES IN COUNSELING AND PSYCHOTHERAPY 114-16 (1977).

185. Taylor & Torrey, *supra* note 184, at 659.

186. Medical students study the basic sciences such as bio-chemistry, anatomy, pharmacology, and physiology and receive clinical training and experience in surgery, internal medicine, pediatrics, gynecology and obstet-

The regulatory mechanism of the Joint Residency Review Committee is more basic than that of the Board. By controlling the accreditation of psychiatric training programs in the medical schools, the Committee insures its direct and immediate role in the education of psychiatric residents by "regulating" the size of the medical staff, the hours of supervision, the number of patients in the hospital, and the number of volumes in the library.[187]

While the Board and the Committee are charged with the primary responsibility of insuring that psychiatrists are competent, both are said to operate with a "structural bias that has a way of changing regulation into protectionism."[188] A brief examination of the certification and accreditation processes will illuminate this criticism.

Certification of Psychiatrists

Psychiatrists enjoy voluntary certification.[189] As a result, approximately two-thirds of all psychiatrists practice in America without Board certification.[190] This is not to say, however, that "premature" practice of psychiatry is the norm. On the contrary, 98% of all "self-designated" psychiatrists have entered a residency training program.[191] However, only 58% registered for the written examination of the American Board of Psychiatry and Neurology.[192] An extension of these figures show that if all who registered actually take the Board's certification examination, then approximately 20% of those tested are practicing psychia-

rics, neurology, developmental psychology, psychiatry and other areas of medical practice. ZISKIN, *supra* note 176, at 275.

187. Taylor & Torrey, *supra* note 184, at 661.

188. *Id.* at 658. *But see* Frazier, *A Commentary on "The Pseudo-Regulation of American Psychiatry"*, 129 AM. J. PSYCHIATRY 664 (1972). This structural bias has lead one author to suggest that the Board review its goals and functions in order to maintain a higher degree of professional competence among practicing psychiatrists. Morganstern, *A Criticism of Psychiatry's Board of Examiners*, 127 AM. J. PSYCHIATRY 1, 33 (1970).

189. Taylor & Torrey, *supra* note 184, at 658.

190. *Id.* This figure compares with the following specialty board rates: surgery (89%), pediatrics (87%), internal medicine (61%). Levit, Sabshin & Mueller, *Trends in Graduate Medical Education and Specialty Certification*, 290 N. ENG. J. MED. 545-49 (1974).

191. Levit, Sabshin & Mueller, *Trends in Graduate Medical Education and Specialty Certification*, 290 N. ENG. J. MED. 545-49 (1974). Conversely, two percent have had no specialty training of any kind.

The authors note that the percentage of psychiatrists entering training programs compares favorably with other medical specialities, e.g., surgery (96%), pediatrics (91%), and internal medicine (84%).

192. *Id.* For a lesson on the options available to those wishing to take the Board examination, *see* Patterson, *How to Avoid Taking the Boards but Save Face*, 132 AM. J. PSYCHIATRY 79 (1975).

try after receiving a failing grade in the test that presumably measures professional expertise.[193]

Ancillary to the problem of voluntary certification is the absence of a recertification process.[194] Currently, "a man could pass the Board examination at age 31, enter the field of engineering for the next 30 years, and return to psychiatry at age 61 as a full-fledged, Board-certified psychiatrist."[195] When one considers the dramatic changes that have occurred over the last 20 years in drug therapy alone,[196] the dangers posed by lack of periodic recertification become evident.

Accreditation of Psychiatric Training Programs

The second vehicle through which the psychiatric profession regulates its membership is the Joint Residency Review Committee which controls the curriculum offered to the psychiatrist during residency training.[197] If the psychiatric residency program offered is satisfactory, the school is accredited and becomes eligible to send its graduates to the American Board of Psychiatry and Neurology certification examination.[198]

Little is known about the mechanics of this review committee because its semi-annual meetings are held in secret.[199] Most unusual, however, is the lack of evidence to substantiate the effectiveness of the criteria used by the Review Committee in accrediting residency programs. No statistical correlation has been made to determine the strength of the accrediting criteria with the competence of those who have undergone advanced psychiatric training at schools accredited by the Review Committee.[200] This lack of supportive data is due to the absence of specialty orientations within accredited residency programs. Apart from time spent studying electives, psychiatrists planning on careers in research receive the same training as psychiatric consultants to industry.[201] Since subspecialists are trained in like fashion, it

193. Even a passing score on the examination does not allay the suspicion in some minds because the Board has failed to establish "performance criteria that correlate with psychiatric competence," thus rendering the test a less than meaningful basis for certification. Taylor & Torrey, *supra* note 184, at 659.

194. Taylor & Torrey, *supra* note 184, at 659.

195. *Id.*

196. *See generally* LAWYERS' MEDICAL CYCLOPEDIA, MALPRACTICE AND PRODUCT LIABILITY ACTIONS INVOLVING DRUGS(1976).

197. Taylor & Torrey, *supra* note 184, at 660.

198. *Id.* at 659, 660.

199. *Id.* at 660.

200. *Id.* at 659.

201. Also receiving the same training are "future community psychia-

would be difficult to measure how the training influences the psychiatrist's general competence.

FINDINGS AND RECOMMENDATIONS

Formal regulation of psychiatrists who practice psychotherapy in Illinois is currently inadequate to insure an acceptable level of professional competence.[202] Presently in Illinois, any licensed physician may practice psychiatry, including psychotherapy, since no additional training or demonstrable proficiency in psychiatry is required.[203] The reluctance of the psychiatric community to police its own ranks is illustrated by the absence of mandatory certification or periodic recertification[204] and the uniform training programs offered all psychiatric residents regardless of their subspeciality. Yet, the more complex the activity of a professional group, the more society

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trists, behavioral researchers, psychotherapists, mental health administrators and psychiatric educators . . . ." *Id.*

202. The magnitude of the problem in Illinois was illustrated in an early 1977 news article which reported that "half of the psychiatrists employed by the Illinois Department of Mental Health . . . flunked a special medical-licensing examination . . . ." The test was

> [M]ade up of questions on psychiatry, neurology and internal medicine taken from a national medical-licensing exam administrated in every state. To make the special Illinois exam easier, the [Registration and Education Department] included only questions that 92 percent of doctors taking the complete test recently had got correct. . . . Passing scores for the two main sections of the test were about 520 of 800 possible points. According to the official sheets for the test [the grades were tabulated by the respected National Board of Medical Examiners] . . . the 127 doctors [who flunked] averaged only 227.4 and 244.8 points. The majority of them scored far less than half the number of points required.

The Illinois Mental Health Agency employs about 330 psychiatrists, but many are engaged in *private practice* and work for the state on a part-time basis. Chicago Sunday Sun-Times, Feb. 27, 1977, at 4, col. 1.

203. Apparently, this training and field demonstration of competence is thought by some experts to be important since both are now a part of the Board of Psychiatry and Neurology certification requirement. *See* note 185 and accompanying text *supra*. Similar mandatory requirements are imposed on the "nearly identical" field of psychology. *See* note 165 and accompanying text *supra*.

However, applicants for the Board's certification examination having "two years of training in any medical or surgical specialty may substitute this experience for a year of psychiatric experience. This means that two years of training in colon and rectal surgery may count as a year of experience in psychiatry." W. VANHOOSE & J. KOTTLER, ETHICAL AND LEGAL ISSUES IN COUNSELING AND PSYCHOTHERAPY 115 (1977).

204. One author addressing this point notes that "[a]lthough certification, as distinguished from licensure, is not a legal requirement to practice a specialty, it does infer a willingness to be evaluated by one's peers on matters of clinical safety and competence." Small, *Recertification For Psychiatrists: The Time to Act is Now*, 132 AM. J. PSYCHIATRY 291, 292 (1975).

must depend on the group to regulate itself.[205] Therefore, some catalyst (other than the illusory threat of a tort sanction) will have to motivate the psychiatric community to take a more active and meaningful role in the production of qualified psychiatrists if a public oriented system of professional regulation is to be achieved.

The Illinois Psychologists Registration Act has had this catalytic effect on those rendering psychological services,[206] and so might similar legislation which vests mandatory specialty certification authority for psychiatrists with either the American Board of Psychiatry and Neurology or another similarly situated public panel. Despite arguments to the contrary,[207] a "Psychiatrist Registration Act" would seem to be as valid an exercise of Illinois' police power as the Psychologists Registration Act which regulates the "nearly identical" field of psychology.[208] Indeed, since psychiatrists have become quite dependent on psychologists for indispensable diagnostic services,[209] it would be inconsistent for the state to insist on a higher level of competence for the assisting psychologist than for the referring psychiatrist.

Besides being a necessary exercise of the state's police power, registration would be both reasonable and appropriate.

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205. The inability of patients to evalute the qualifications of physicians on an individual basis necessitates the licensing process. *See* People v. Witte, 315 Ill. 282, 146 N.E. 178 (1925). Yet, presumably, government is in no better position to pass judgment on individual practitioners. It follows, then, that after the legislature decides to invoke its police power to license members of a professional group, the licensing power should be passed to respected members of that profession who would proscribe qualifications to be met before a license is granted. *See* Barron, *Business and Professional Licensing—California, A Representative Example*, 18 STAN. L. REV. 640, 649 (1965).

206. Beginning in 1953, the American Psychological Association developed standards for training psychologists which were used as guidelines for certification and licensure laws enacted in many states during the 1950s and 1960s. In later years, the more comprehensive and definitive standards which emerged to stabilize the qualifications and functions of psychologists had considerable impact on the educational institutions that members, by statute, were required to attend. *See generally* W. VANHOOSE & J. KOTTLER, ETHICAL AND LEGAL ISSUES IN COUNSELING AND PSYCHOTHERAPY 109-14 (1977).

207. Frazier, *Commentary on "The Pseudo-Regulation of American Psychiatry,"* 129 AM. J. PSYCHIATRY 664, 666 (1972) ("it seems abundantly clear to those in the area of civil liberties that the individual rights of citizens and physicians, as well as the right of the individual states to grant licensure for practice, would stand in the way [of mandatory certification]").

208. *See* notes 153-54 and accompanying text *supra*. *See also* Rios v. Jones, 63 Ill. 2d 488, 348 N.E.2d 825 (1976) (the states' interest in promoting the general welfare by licensing physicians is of great importance).

209. *See* note 176 and accompanying text *supra*.

In the past, neglect of the Board of Psychiatry and Neurology concerning the certification process has been defended on the ground that the Board had no authority to act,[210] a position that has not been without its critics.[211] By formalizing the certification requirement through legislation, the state can utilize an authoritative board of medical personnel, academicians, and representatives of the public to better insure quality psychotherapeutic practice. This legislation would have the additional effect of centralizing the responsibility for patient care through improvement in the psychiatrist's medical school training.[212] As officers of the state, Board members would have the authority to insure that "deficient" professionals enroll in various educational programs conducted by peer review committees,[213] and would be better able to exercise the authority since their livelihood would not depend on the marketplace.[214]

Admittedly, mandatory certification for psychiatrists is no panacea. It will not eliminate negligence within the psychotherapeutic relationship. However, it will insure that psychiatrists are at least minimally qualified to practice psychotherapy. Since it is unlikely that the judiciary can adequately redress a patient injured while undergoing psychotherapy, the legislature must demand that a psychiatrist have minimal qualifications in order to reduce the risk of the injury ever occurring.

CONCLUSION

The unique nature of psychotherapy raises special problems for an injured patient who sues his psychiatrist for malpractice. Authors addressing the problems have intimated

210. *See* Frazier, *A Commentary on "The Pseudo-Regulation of American Psychiatry,"* 129 AM. J. PSYCHIATRY 664, 666 (1972).

211. *See* Morganstern, *A Criticism of Psychiatry's Board of Examiners*, 127 AM. J. PSYCHIATRY 33 (1970) (wherein the author suggests that it may be necessary to re-examine the functions and goals of the Board).

212. This improvement in the educational process is especially important in light of a study which has shown that a college student whose only exposure to formal psychology was a 17 hour program of study, could get a higher grade on an exam in psychiatry than medical students who received a minimum of 250 hours of classroom instruction in psychiatry. Pierce, Mathis & Pishkin, *Basic Psychiatry in Twelve Hours: An Experiment in Programmed Learning*, 29 DISEASES NERVOUS SYS. 533-35 (1968). This result is consistent with the sentiments of one psychiatrist who stated that his medical school education was irrelevant to the work that he does. Mariner, *A Critical Look at Professional Education in the Mental Health Field*, 22 AM. PSYCHOLOGIST 271, 274 (1967).

213. *See* Newman & Luft, *The Peer Review Process: Education versus Control*, 131 AM. J. PSYCHIATRY 1363-85 (1974).

214. *See* Barron, *Business and Professional Licensing—California, A Representative Example*, 18 STAN. L. REV. 640, 644 (1966).

that as the science becomes more defined, the resulting increase of litigation will help define standards for psychotherapeutic care which will accommodate both the capabilities of the psychiatrist and society's need to protect its citizens from negligent treatment.[215] Yet, if the nature of the psychotherapeutic relationship renders the tort option a functional impossibility in all but the most extreme circumstances, the case law will remain stagnant. If the tort alternative is unavailable, other sources of professional regulation must be re-evaluated.[216] Mandatory certification will serve to minimize the malpractice threat by insuring a high level of professional competence among psychiatrists through minimum training and field practice.[217] Until such time as the legislature moves in this direction, the psychiatric regulatory scheme will be in a state of imbalance.

Michael J. Karson

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215. *See* Tarshis, *supra* note 14, at 96.

216. This assumes that it is undesirable to upgrade the standard of care to one of strict liability in order to strengthen the tort option against those who wished to practice in a still-developing field. *See* Tarshis, *supra* note 14, at 83.

217. Greater peer review among medical psychotherapists could facilitate the same goals. *See, e.g.*, Langsley, *Peer Review: Prospects and Problems*, 130 AM. J. PSYCHIATRY 301 (1973). Yet, inadequate records, lack of agreement on diagnosis, and the limited usefulness of psychiatric diagnosis make peer review in psychiatry very difficult. Liptzin, *Quality Assurance and Psychiatric Practice: A Review*, 131 AM. J. PSYCHIATRY 1374 (1974). However, the difficulty with "self-policing" may not be impossible to overcome given adequate statistics and follow-up studies. *Cf.* Schmideberg, *The Promise of Psychiatry: Hopes and Disillusionment*, 57 NW. U.L. REV. 19, 21 (1962) (adequate statistics and follow-up studies are regarded by other medical doctors as their "scientific duty").