Psychotherapeutic Treatment and Malpractice

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By DAVID B. Saxe

I. Introduction

The problems relating to malpractice of psychiatrists and psychoanalysts differ in many respects from the malpractice problems of medical doctors. Psychiatrists deal with the feelings and emotions of their patients. Their methods and instruments of treatment, although often similar to those of medical practitioners, include for the most part exposure through dream analysis, free-association, and direct discussion of the patients' feelings and emotions.

In comparison with other medical specialists, psychiatrists are not often defendants in malpractice cases.¹ Most of the litigation involving psychiatrists has resulted from physical injury to a patient received during the course of treatment. A few recent cases² raise the possibility of malpractice liability in the context of what may be referred to as defective psychotherapeutic or analytical technique. One of the cases³ involved no physical injury to the patient, but involved instead a deterioration of mental condition apparently produced by the arousal of deeply-hidden psychic conflicts.

With the increased availability of psychiatric and psychoanalytical treatment and its increased acceptance, not only as therapy but as an intellectual growth process, we may anticipate an increase in psychiatric malpractice suits before the courts.

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II. PROBLEMS OF TREATMENT

A. Chemical Treatment

Chemical procedure for the treatment of psychiatric disorders involves the use of drugs, and it is anticipated their use will be greatly increased. Drugs may be utilized as diagnostic aids (e.g., sodium pentothal), for the treatment of the psychiatric problem itself (e.g., chlorpromazine or reserpine) or for treating disorders closely connected with the psychiatric problem (e.g., antihistamines for treatment of allergies). Generally, any drug taken on the prescription of the patient’s physician or on the patient’s own initiative should be carefully reviewed by the psychiatrist.

Insulin shock therapy for schizophrenia and other behavioral abnormalities is a widely accepted chemical treatment. The injection places the patient into a coma state of short duration from which he is brought out by the administration of sugar. It is thought while the patient has entered into the coma stage, he is more receptive to effective psychotherapy.

There are certain hazards inherent in shock therapy well illustrated in the case of *Mitchell v. Robinson*, a malpractice action against a physician for convulsive fractures alleged to have been sustained by the plaintiff while undergoing insulin therapy for the treatment of emotional illness. The plaintiff, although mentally competent, was suffering from severe schizophrenia accompanied by profound depression and anxiety. The plaintiff had been told by his physician that the best course of treatment would combine electroshock and insulin sub-coma therapy. The general purpose behind electroshock therapy is to build up the patient’s defenses, controls, and self-confidences. Insulin shock therapy, as noted before, induces a sub-coma state, but it is neither intended nor desired, as it is with electroshock therapy, that the patient suffer convulsions. Convulsions sometimes occur, however, and one product of such convulsions is fractured vertebrae. On his seventh insulin treatment the plaintiff

4 See generally L. Williams, *Trial of Medical Malpractice Cases* § 3.10 (1968).
6 334 S.W.2d 11 (Mo. 1960).
had a grand mal seizure which resulted in a compression fracture of the fifth, sixth and seventh dorsal vertebrae. The main question before the court was whether the defendant was under a duty to inform the plaintiff that one of the hazards of insulin treatment is the fracturing of bones not involved in either the illness or treatment. The court held that the defendant should have informed the plaintiff of the possible serious collateral risks of combined electroshock and insulin sub-coma therapy. The question of whether or not there was a failure to inform was a submissible fact issue for the jury to decide. The Mitchell case stands for the proposition that a patient must give an informed consent before the psychiatrist is protected from malpractice litigation. A psychiatrist must disclose all risks inherent in the chemical treatment and a failure to inform may result in liability.°

The case of Saron v. State° is another important decision in the area of chemical treatment. The patient, a diabetic, entered a state mental hospital diagnosed as a schizophrenic. He was administered the experimental psychiatric drug Isoniazid, called Compound 100, allegedly in excessive doses causing fatal organic brain damage. The court found that administration of the drug did not constitute negligence. There was testimony as to the possible side effects of Isoniazid, but no definite findings were made. The contentions of the claimant's intestate regarding the harmful side effects of Isoniazid were based on an article in a 1952 English journal reporting a single case of the possible harmful side effects of the drug. The court concluded that the organic brain damage could have occurred without the use of Compound 100, namely as a result of the patient's diabetes.

Bellandi v. Park Sanitarium Association° was a wrongful death action against a hospital and an attending psychiatrist. The

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° There, of course, are instances where full disclosure is not necessary. Certainly, an emergency situation where the patient is not able to determine or consent to a course of treatment is a recognized exception. Also, there are those instances where a disclosure of all risks attendant upon a treatment procedure may result in alarming an already apprehensive patient who may as a result refuse to undertake surgery or a treatment in which there is a minimal risk or where such disclosure may result in actually increasing the risk by reason of the psychological effects of the apprehension itself. See generally Macaulay v. Booth, 53 Cal. App. 2d 757, 123 P.2d 386 (1942); Los Alamos Medical Center v. Coe, 58 N.M. 686, 275 P.2d 175 (1954).


° 214 Cal. 472, 6 P.2d 508 (1931).
decendent, an Italian immigrant, had been planning a trip back
to his native Italy for some time. As the preparations for the
voyage became more numerous, he became overly excited, al-
though not violent. His private doctor diagnosed the case as
acute neurasthenia. He was extremely upset and volatile and was
finally transferred to the Park Sanitarium where the nurse on duty
was informed by his relative that the patient had a remarkable
diffidence to women. He was assigned a room with a male nurse
in charge and was attired in hospital gown. After sleeping for
some time, the patient decided it was time to go home and began
wandering up and down the halls in search of his clothing. He
confronted a female nurse in the hall and demanded his clothing.
When the nurse reached for an emergency bell, the patient
grabbed her hand. At this time Dr. Mulligan was called and a
battle ensued which lasted nearly forty-five minutes. The doctor,
an attendant and six nurses finally subdued the decendent. Straps
and other restraining apparatus commonly used in mental hos-
pitals were available but not used. A choke tourniquet was im-
provised with the aid of a towel and a pound can of ether
was applied to gauze and administered to the patient. A few
minutes after the struggle was over, another doctor observed
the patient and found him dead. The court upheld the jury's
award based on the negligence of the hospital and its personnel
in improperly treating the decendent in view of the fact he was
not violent, but merely excitable with sudden outbursts often
yielding to rest and treatment.

B. Electroshock Treatment

The tort liability problems involving electroshock treatment
are vividly illustrated by the following cases.

Faber v. Olkon was an action for damages brought by a
mentally incompetent patient who sustained fractures of both
femur bones while undergoing electroshock therapy. The plaintiff
had been mentally ill for twelve years, suffering from chronic
schizophrenia with hebephrenic-paranoid features with general
progressive mental deterioration. In 1948, a lobotomy was per-
duced by a Dr. Seletz. The history given by Dr. Seletz stated:

10 40 Cal. 2d 503, 254 P.2d 520 (1953).
[T]hat the patient has stereotyped behavior—will not answer questions. He has no discipline and continues to ramble in his speech . . . his thoughts are disjointed . . . . He refuses to use water to wash with since he states it is too costly. He will not bathe, and will not use the toilet . . . . He has had some eighty shock therapy treatments both in private hospitals and at Camarillo State Hospital.¹¹

The plaintiff's condition deteriorated and he was referred to the defendants for shock therapy treatment. The father of the patient signed a written consent for administration of the therapy. On September 1, 1948, a second shock treatment was administered, a day intervening between the first shock treatment because, according to the testimony of Dr. Wayne, one of the defendants:

There seems to be evidence of a favorable response, and ordinarily we have found it good practice to skip a day in between each treatment . . . to observe the reaction to the individual treatment . . . .¹²

During the second treatment, five to ten seconds after the current was applied and while the plaintiff was in a convulsive state, a snapping or "crunching" sound was heard by the attending doctors and nurses. The result was a fracture of both femur bones for which the plaintiff was hospitalized. Following the fracture, the plaintiff's hip became permanently deformed.

The plaintiff contended that since he was incompetent at the time of treatment and had no court appointed guardian, the treatment without his consent constituted an assault as a matter of law. The court rejected this contention because the father of the patient had given his written consent. The court also rejected the plaintiff's contention that the case should have gone to the jury on the issue of res ipsa loquitur instead of the verdict being directed for the defendant.¹³ The court, in rejecting the res ipsa loquitur contention, distinguished the case of Ybarra v. Spangard.¹⁴ In Ybarra, the plaintiff, while unconscious on the operating table, received injuries to healthy parts of his body,

¹¹ Id. at —, 254 P.2d at 522.
¹² Id.
¹³ Id.
neither subject to the treatment nor within the area covered by the operation, from instruments used in the treatment. The evidence presented in Farber, however, seemed to show that a certain percentage of fractures will occur regardless of the degree of precaution or care exercised to prevent it:

[T]he over-all incidence of fractures in shock treatment varies anywhere from perhaps one-half to about three and a half per cent. If one considers fractures of the spine . . . the incidence is between ten and forty per cent.\(^{15}\)

The court noted that the doctrine of *res ipsa loquitur* applies in malpractice cases only where a layman is able to say as a matter of common knowledge and observation, or from evidence can draw an inference, that the consequence of professional treatment was not such as ordinarily would have followed if due care had been exercised.\(^{16}\) Here, the court found that these consequences might follow this treatment even if all reasonable precautions were taken.

The plaintiff had also contended that the defendants were negligent in failing to restrain him properly during the shock treatment. This contention was also rejected since it was not shown that administration of shock therapy with three nurses present constituted a failure to conform to the applicable standard of care. Testimony showed that some practitioners felt that a great deal of restraint was needed, while others believed a lesser degree of restraint was required. The defendants here, according to the court, adopted a middle position.\(^{17}\) The court concluded that the use of three nurses in the administration of the therapy, one placed at the extremities, and the other two at the shoulders, was in accord with accepted standards of practice. No inference of negligence could be drawn because the plaintiff's ankles were not restrained.

Another leading case in the general area of negligent electroshock therapy is *Stone v. Proctor*.\(^{18}\) The plaintiff alleged that the electroshock therapy caused a compressed fracture of his ninth

\(^{15}\) Farber v. Olkin, 40 Cal. 2d 503, 254 P.2d 520, 524 (1953).

\(^{16}\) Id.

\(^{17}\) Id. at 526.

thoracic vertebra. The court held over the objection of the defendant that the question of malpractice was one for jury determination. Apparently this defendant, a Fellow in the American Psychiatric Association and familiar with its "standards of electroshock treatment" prepared by the Committee on Therapy and approved by the Council of the Association, did not fulfill the requirements of section "E" which states, "If the patient should complain of pain or impairment of function, he should receive a physical examination, including X-rays to ascertain whether he suffered accidental damage."\(^\text{19}\)

The Stone v. Proctor decision represents a view not fully accepted by most states: i.e., if a psychiatrist is alleged to have failed to fulfill accepted published standards for the administering of electroshock therapy, these standards are material evidence for submission to a jury.

The doctrine of *res ipsa loquitur*, considered by the court in Farber, has been examined by courts in other cases alleging malpractice in electroshock therapy. In Johnson v. Rodis,\(^\text{20}\) the plaintiff sustained a fracture during electroshock therapy, and it was stated that the alleged breach of safety of the treatment administered by the physician could be grounds for recovery. The court held, however, that the negligence count failed since *res ipsa loquitur* was inapplicable. The United States Court of Appeals for the District of Columbia, ruling that the doctrine of *res ipsa loquitur* did not apply, adopted without quoting, the reasoning of the trial court. The district court had said:

This doctrine (*res ipsa loquitur*) is, however, generally restricted to cases of injuries inflicted by a mechanical apparatus or some other inanimate object within the defendant's exclusive control. It does not ordinarily apply to cases of injuries caused by the careless act or thoughtless omission of a human being. It follows, hence that there is no sound basis for extending it to actions for negligence against a member of a learned profession. To do otherwise would practically require him to guarantee success in every case. Such a course would be contrary to the principles of fairness to the profes-

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\(^{19}\) American Psychiatric Association, Standards of Electroshock Treatment § E (1953).

\(^{20}\) 251 F.2d 917 (D.C. Cir. 1958).
sions and against the best interests of the public. It would cast an undue burden on the medical profession and might place every doctor on the defensive against any disgruntled patient whom he has failed to cure. Consequently, the doctrine of res ipsa loquitur may not be invoked in an action for malpractice against a physician or surgeon.\(^1\)

In Quinley v. Cooke,\(^2\) the court rejected the res ipsa loquitur contention because fractures are part of the "calculated risk of the treatment."\(^3\)

Currently, most psychiatrists utilizing electroshock therapy first administer a sedative\(^4\) to the patient and then a depressant-paralyzing drug.\(^5\) Both drugs are administered intravenously prior to the administration of the electrical shock. The combined effects of the two drugs are almost complete elimination of fractures through the reduction in convulsions and muscle contraction. The use of such procedures in electroshock therapy should virtually eliminate malpractice litigation in this area. For those not using such precautions, malpractice litigation would seem to be almost a certainty if injuries occur, but the number of physicians failing to use available precautions will certainly be minimal at best.

With the use of these drug precautions in electroshock therapy, malpractice litigation in this area will most probably be strictly limited to those instances in which such precautions were not carefully observed.

C. Defective Analytical Technique

This sub-section deals with the legal problems that might arise in psychotherapeutic or psychoanalytical relationships. Normally, analytical therapy is conducted without the added feature of mechanical or chemical agents, although in some instances, electroshock therapy will enable the psychiatrist to aid the patient in discovering new and valuable insights that may ameliorate the patient's emotional difficulties. Our discussion will focus on the one-to-one relationship that normally exists in analytical work

\(^2\) 183 Tenn. 428, 192 S.W.2d 992 (1946).
\(^3\) Id. at 439, 192 S.W.2d at 996-97.
\(^4\) The sedative generally used is a curare-like drug, e.g., sucinyleholine.
\(^5\) I.e. pentothal (a short-acting barbituate).
and which may in the future give rise to legal problems for the psychiatrist.

Effective psychoanalytical treatment depends to a great degree on the relationship between the analyst and the patient, to which the patient can bring past emotions and experiences in order to develop more emotionally mature standards for dealing with his present environmental situation. This phenomenon of transference is important in the technique of psychoanalysis:

It (transference) is the automatic tendency of the patient to transfer to the analyst feelings which he has had in his childhood years toward important figures in his environment, particularly his parents. For instance, the man who comes from a home where his father was a brutal, sadistic, demanding person is stirred from early childhood to rebellion against this type of treatment . . . . Soon in the analytic situation he becomes rebellious toward the analyst, finding all sorts of faults with the treatment situation, feeling the analyst is unkind to him and even resentful of him. Thus he transfers hostile feelings of the type that he originally had toward his father to the analyst and accuses the latter of the same unfair, cruel treatment as he has suffered at the hands of his father. Meantime, of course, the analyst's attitude remains friendly and understanding so that eventually the patient can be helped to see the unreality in his feelings and behavior. Previously in his life when he has become hostile to authoritarian figures they have reacted with hostility toward him, which in turn has prevented him from recognizing his original neurotic reaction. However, in the treatment situations he has the opportunity to trace the pattern back to its origin and develop a more mature solution.26

The phenomenon of transference is affected by the so-called "countertransference"27 which refers to the emotional responses of the psychiatrist during the course of treatment. The psychiatrist who understands his own motivations and needs will best be able to serve his patient's emotional needs. Conversely, the psychiatrist with little or faulty understanding of his own personality

27 Id. at 555. See also Balint, On the Transference and Countertransference, 20 Int'l J. Psycho-Analysis 223 (1939); Berman, Countertransference and Attitudes of the Analyst in the Therapeutic Process, 12 Psychiatry 159 (1949).
will interfere with and possibly lessen the effectiveness of his patient’s treatment. Psychiatric practitioners are not required by law to have undergone successful psychoanalysis themselves so that their actions and drives are free from neurotic motivation. Yet the psychiatrist should have some degree of insight into his own motivations in order to control the countertransference. The interest being served in the analytical setting is the patient’s emotional well-being and that interest may be impeded by a lack of insight by the psychiatrist into his own unconscious motivations. In analyzing analytical malpractice litigation, the degree of skill exercised by the psychiatrist in controlling and understanding the countertransference should be a measuring stick for a malpractice defense. As one writer has stated:

The question in each case should be whether the doctor has taken undue advantage of the relationship for the pursuit of personal gain; whether he has demonstrated a control of his own motives which falls below the standard of the relevant psychiatric community, not alone whether his treatment was an expression of his unconscious hostility toward the patient.

The boundaries of psychiatric-patient involvement have been explored in relatively few cases and have never been defined. Landau v. Werner was a successful malpractice action brought against a psychiatrist who began a social relationship with a patient who had “fallen in love” with him. The plaintiff had been referred to the psychiatrist in a highly emotional and nervous condition in March, 1949. He treated her by “transference” and after twenty-four sessions, the plaintiff had become.

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28 See generally S. Freud, The Dynamics of the Transference, 2 Collected Papers 312 (1912); S. Freud, Further Recommendations in the Technique of Psychoanalysis: Observation on Transference—Love, 2 Collected Papers 377 (1915).

29 Dawidoff, The Malpractice of Psychiatrists, 1966 Duke L.J. 696, 711. A considerable number of malpractice suits stem from faulty doctor-patient relationships, and from feelings of resentment which the patient develops toward the physician. Mr. Dawidoff likens the duty of the psychiatrist to a patient to that of a fiduciary to his beneficiary. Id. at 702-03. See also Heller, Some Comments to Lawyers on the Practice of Psychiatry, 30 Temp. L.Q. 401 (1957). See especially Shankor, Strict Tort Theory of Products Liability and the Uniform Commercial Code: A Commentary on Jurisprudential Eclipses, Pigeonholes and Communication Barriers, 17 W. Res. L. Rev. 5 (1965). New theories are often pigeonholed into safe areas of law, a common but unfortunate aspect of legal thinking.

sexually and emotionally aroused by the intimate conversation with the defendant. She discussed these feelings with the defendant and her shame about them. The defendant advised her to continue with the therapy and assured her that the feelings of love and attachment would cease. The plaintiff, in August, 1949, contemplated the ending of the relationship, but the defendant thought that the plaintiff was not wholly recovered and, fearing a relapse to her former anxiety state, he advised against discontinuing the relationship. Instead, he began a series of social visits with the plaintiff outside his office. They visited restaurants together, rode in taxicabs, spoke of a vacation together and on one occasion visited the plaintiff’s sitting room. The defendant never made any improper advances. The plaintiff failed to recover and as a probable consequence of these further visits experienced a setback in her progress. The treatment resumed in March, 1950, with electroshock therapy, but this did not produce any change. In April, 1951, the plaintiff attempted suicide. The psychiatrist made one final unsuccessful attempt with therapy. The Court of Appeals affirmed the Queen’s Bench verdict for the plaintiff holding that a good cause of action in negligence was made out by the testimony of other physicians condemning social visits in the course of treatment by a psychiatrist of a patient who is aroused towards him by transference and which are the probable cause for a serious decline in condition from an improved level.

*Hammer v. Rosen*31 deals with a somewhat unorthodox method of psychiatric treatment, but does not involve the faulty handling of the countertransference. The plaintiff, a schizophrenic, became the patient of the defendant after having undergone over one hundred and fifty electroshock treatments with another therapist. Applying a therapy that he labeled “direct psychoanalysis,”32 Dr. Rosen’s treatment allegedly included physical

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32 See generally J. Rosen, Direct Psychoanalytic Psychiatry (1961); J. Rosen, A Method of Resolving Acute Catatonic Excitement, 20 Psych. Q. XI (1946), describing Rosen’s efforts to apply Freudian techniques to psychotic patients. “The governing principle of direct psychoanalysis [is] that the psychiatrist shall be, in effect, a foster-parent to the psychotic individual who has regressed to infancy, and who must be brought up all over again.” See Stone, Two Avenues of Approach to the Schizophrenic Patient, 3 J. Am. Psychoanalytic Assoc. 126 (1955).
beatings of his patients. Some initial improvement in the plaintiff's condition occurred, but after seven years of treatment, the initial improvement did not last, a phenomenon of "complex causation." The Court of Appeals held inter alia that the trial court erred in dismissing a cause of action for malpractice. The court held that expert testimony of malpractice was not necessary where "the very nature of the acts complained of bespeaks malpractice;" and consequently, the testimony of three witnesses to the alleged assaults made out a prima facie case.

The professional guidelines adhered to by the court in Landau are that a psychiatrist fulfills his duty when the method of therapy he employs is accepted by his profession. Nevertheless, the psychiatrist should not be found negligent solely on the ground that the treatment was unsuccessful or that it was contrary to a majority viewpoint among physicians. As long as the treatment he pursues is recognized to some degree in the profession, the psychiatrist need not strictly adhere to "standard procedures." Yet, the Court of Appeals in Landau felt that the course which the defendant should have followed upon discovering that his patient had fallen in love with him was to abandon the therapy rather than to encourage social visits. The court's inclination appears psychiatrically unsound. The occurrence of the feelings experienced by the plaintiff was certainly not the point at which the relationship should have been terminated. The intensity of Miss Landau's feelings probably pointed to analytical success and to a beginning of insight on the part of the patient. Once the repressed feelings of childhood are liberated, the patient may emotionally examine such feelings which gave rise to the psychic conflicts that are the roots of anxiety states. The emotional learning that follows the re-examination and liberation of such feelings is the core of psychotherapy. The court in Landau could not countenance the defendant's social visits as a therapeutic solution to the plaintiff's dependency problems. Termination of the relationship, rather than the continued but somewhat innovative and less frequent therapy of Dr. Werner was the correct procedure to be followed.

Hammer v. Rosen and Landau v. Werner reflect the uneasy attitude concerning psychiatric methodology that afflicts courts unfamiliar with the dynamic strides taken in the development of modern psychiatric techniques. Both are unfortunate decisions. Hammer v. Rosen, although conventionally incorporating the traditional law of assault and battery into a psychiatric malpractice situation, refused to view or comprehend this type of treatment in its proper perspective, thereby undermining the trust existing between the legal and psychiatric professions. Landau v. Werner reflects the legal attitude of discomfort with innovative psychiatric-medical procedure. Here, unlike the Hammer v. Rosen situation, there was no battery, but instead an unsuccessful attempt to deal with a patient’s emotional problems culminating in an abortive suicide attempt by the patient. A psychiatrist should be responsible for controlling the countertransference toward the patient, although defining and proving the relevant standards of control will be difficult. Moreover, the failure to control the countertransference must be the causative factor in the plaintiff’s emotional decline. The difficulty here begins not so much with the degree to which the therapist controls and understands his own feelings of anger and hostility toward the patient as it does with the court’s disinclination to accept the notion that successful analytical work often encounters serious setbacks and barriers in the form of psychic resistances. Often the patient in the progress of incorporating new levels of independence and ego strengths may have a temporary loss in the form of a psychotic episode when emotionally charged areas are explored. This factor deserves keen attention by a court, especially when a patient, unhappy by the necessarily slow and often tortuous path of therapy, decides to terminate the relationship and initiate litigation. Will a court be justified in fixing liability when the patient falls below the pre-therapy level of his condition? Is this point the base-line for the determination of damages? Although case-by-case evaluation is necessary, even declines from a pre-therapy level may be therapeutically unchangeable due to the necessity of uncovering layers of resistance erected by the patient prior to therapy. Therefore, it seems necessary to require more than a mere breach of duty when a patient fails to improve or even suffers some decline in progress.
D. Tort Liability for Suicide

The rule of law applicable to suicides committed in hospitals and other institutions requires that where suicidal tendencies are known to exist, reasonable care must be taken to protect the possible victim from himself. The most important single factor to consider in determining whether a hospital or physician is negligent in failing to prevent the suicide of a patient is whether the hospital authorities, under the circumstances, could reasonably have anticipated that the patient might harm himself. The hospital through its attending staff is under a positive duty to use reasonable care to protect the patient from a known or reasonably-apprehended danger of suicide.34

The basic issue involved in all the cases dealing with tort liability for a patient's suicide is the foreseeability or predictability of the suicide. Certain difficulties are encountered when considering the implications of foreseeability. Statistical complications do not often reflect the true incidence of suicide because of a variety of social and medical factors, including the difficulty of detection or identification and the social opprobrium often attached to suicide.35 The notion that suicide is predictable in a majority of cases is often fallacious. It is well known that an individual can commit suicide despite most precautions. Clothing, cutlery, glass and other sharp objects, access to heights or vehicles, all can provide the mode of self-destruction. As one leading lay science writer has pointed out:

In any given case, the psychiatrist deals with the possibilities of a remote and unpredictable but ever-present nature. He never deals with probabilities—only possibilities of unmeasurable degrees. Unlike the situation elsewhere where a disaster occurs because of an act by the physician—for example, leaving scissors in the abdomen during surgery, here the disaster arises from the act of the individual patient. Not only can the disaster not be accurately anticipated, but the patient himself changes from day to day, week to week, and month to month.36

35 Perr, supra note 34, at 431.
36 Id. at 438.
We must accept the fact that suicide is a problem characterized by marked limitation in predictability and prevention, not only in hospitals but throughout our society. It is quite clear that the hospital aspect represents only a single element. Hopefully, courts will not feel shackled by past decisions which proclaim the wisdom of close observation and strict patient surveillance. Current trends in psychiatry clearly show that these psychiatric methods are not effective in rehabilitating patients and enabling them to return to a normal life. The "open-door" technique whereby patients are encouraged to resume a normal existence, the increased liberal trends in psychiatric hospitals and the unforeseeability of suicide in many instances should provide guidelines for judges and juries so that judicial decisions in this area may reflect the trends and developments of modern dynamic psychiatry. This does not mean that plaintiffs' verdicts are too frequent. Certainly there are numerous instances where the warning was clear and the precautions inadequate or nonexistence. Furthermore, a faulty handling of the countertransference as a result of the therapist's hostility or anxiety toward the patient may crystallize feelings of rejection and depression within an already concerned patient.

III. Conclusion

The psychiatrist may appear as defendant in cases alleging wrongful commitment to an institution, false imprisonment, malicious persecution or improper disclosure of privileged communications. These situations are not covered here because they do not deal primarily with areas of psychiatric treatment.

The responsibility of the psychotherapist to his patient will be established under the usual test of malpractice liability, i.e. whether the physician departed significantly from the professional standards of other physicians conducting a similar practice in the same geographical area. But these standards of malpractice must incorporate knowledge of relevant psychiatric standards regarding countertransference so that emerging litigation in the area of analytical technique may be decided properly.

37 See, e.g., Lexington Hospital, Inc. v. White, 245 S.W.2d 927 (Ky. 1952).