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Tristan Serri

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COMMENT: AN EXAMINATION OF THE IMPACT OF MALPRACTICE LAW ON TELEPSYCHIATRY CLINICIANS & CLIENTS WITH SUICIDAL IDEATIONS

*Tristan Serri**

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I. INTRODUCTION

Ten years ago, psychiatrist Steve Bauer spent four hours every two weeks driving round trip to see his patients.[1] His main office was at the

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Duluth-based Human Development Center.[2] Due to the rural nature of Minnesota, the Human Development Center developed an out-post clinic in Grand Marais.[3] To effectively treat his patients, Dr. Bauer made this drive to treat only a few individuals.[4]

In 2004, Dr. Steve Bauer received a grant to purchase equipment for telemental health visits.[5] Because of this grant, Bauer has been able to assess his patients and provide necessary consultations without leaving his office.[6] The four hours that he does not spend driving has allowed him to increase the number of patients he is able to see and help.[7] Dr. Bauer's situation is but one of many examples of a nationwide problem facing mental health practitioners trying to provide accessible, readily-available mental health care to underserved populations of rural patients.

Telepsychiatry, one of the most effective means of overcoming the obstacles which frustrate full mental healthcare justice for rural populations, has been defined as "the delivery of health care and the exchange of health information for purposes of providing psychiatric services across distances."[8] Modern technological advancements (which have rendered the equipment essential to the provision of telepsychiatry less costly) could provide a solution to the issue that Dr. Bauer and many others health professionals are encountering.[9] However, even with suitable solutions, there are still many legal roadblocks preventing the widespread implementation of telepsychiatry.

In the United States, there are an estimated fifteen million rural residents who suffer from some type of mental health illness.[10] These individuals have significant healthcare demands but obstacles prevent

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1. Jeanne Mettner, *The Doctor is In. . . Another Town: Telepsychiatry Brings Care to People in Rural Minnesota*, 96 MINN. MED. 22, 23 (2013).

2. *Id.*

3. *Id.*

4. *Id.* The lack of patients is not due to a deficit of individuals with mental illness, but is instead attributable to a dearth of knowledge and the negative stigma in rural areas concerning mental illness.

5. *Id.*

6. *Id.*

7. *Id.*

8. Marta Valdagno et al., *Telepsychiatry: New Perspectives and Open Issues*, 19 CNS SPECTRUMS 479, 479 (2014).

9. *Id.*

10. Laura Weiss Roberts et al., *Frontier Ethics: Mental Health Care Needs and Ethical Dilemmas in Rural Communities*, 50 PSYCHIATRIC SERVS. 497, 497 (1999).

them from receiving needed care.[11] These obstacles include, but are not limited to, insufficient access to multidisciplinary clinicians, crisis services, mental health and general medical clinics, in-patient and out-patient hospitals, and innovative medicines and other therapies.[12] These obstacles are amplified in rural areas by deficiencies in basic services like transportation, communication systems, and education.[13]

The mental health needs in rural areas are immense.[14] Currently, suicide rates in rural communities far surpass urban communities.[15] One of the leading causes of suicide is an untreated or mismanaged mental health disorder.[16] To combat suicide, psychiatrists use various techniques. One of the most prevalent treatments for suicidal ideations is Cognitive Behavioral Therapy (CBT).[17]

One recurring issue in this field is the uncertainty of malpractice liability. This comment presents a potential solution that serves to bring clarity to one aspect of this conundrum. This comment addresses liability for psychiatric medical malpractice with a focus on the application of CBT through telepsychiatry in the context of patients with suicidal ideations. Due to the nature of psychiatry and the difficulties inherent in the field, psychiatric medical malpractice law suits are still a prominent concern,[18] especially in actions against mental health professionals which frequently arise out of patient suicides.[19]

Under current law, the standard of care is the same for all psychiatrists regardless of if one practices traditional psychiatry or

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11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.* at 502.

15. *Id.* at 498; *see also* Jay H. Shore et al., *Emergency Management Guidelines for Telepsychiatry*, 29 GEN. HOSP. PSYCHIATRY 199, 199 (2007).

16. *See* Joel L. Young, *Untreated Mental Illness: Understanding the Effects*, PSYCHOL. TODAY (Dec. 30, 2015), https://www.psychologytoday.com/blog/when-your-adult-child-breaks-your-heart/201512/untreated-mental-illness; *Not Another Life to Lose: Suicide in America*, OKLA. DEP'T MENTAL HEALTH & SUBSTANCE ABUSE SERVS., https://www.ok.gov/odmhsas/documents/suicide%20infographic.pdf (last visited July 3, 2017).

17. *See generally* Barbara Stanley et al., *Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP): Treatment Model, Feasibility, and Acceptability*, 48 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 1005 (2009).

18. Mark A. Rothstein, *Health Care Reform and Medical Malpractice Claims*, 38 J.L. MED. & ETHICS 871, 873 (2010) ("There are no readily accessible national statistics on medical malpractice case filings, but there are several types of data from which national trends may be derived. All of the available data clearly suggest the number of cases filed has dropped significantly in the last decade.").

19. Carol I. Tsao & Joseph B. Layde, *A Basic Review of Psychiatric Medical Malpractice Law in the United States*, 48 COMPREHENSIVE PSYCHIATRY 309, 309 (2007).

practices through telepsychiatry.[20] This should not be the case. Due to the lack of personal contact with the patient and other contributing factors, mental health providers should be held to a heightened standard of care when performing their duties using telepsychiatry.

Part II of this comment provides a brief history of the evolution of telehealth. It also furnishes a background on the medical principles pertinent to this comment, especially serious mental trauma with an emphasis on suicidal ideations. An understanding of the process of CBT for suicide prevention (CBT-SP) and internet based CBT (I-CBT) is necessary in demonstrating that the traditional standard of care is preferable over a less rigorous standard.

Part III consists of an extensive outlook on psychiatric medical malpractice law. This Part is structured around the three elements of a psychiatric medical malpractice claim: (1) duty, (2) breach of that duty, and (3) causation. Notably, this part examines psychiatric medical malpractice claims in light of the growing field of telepsychiatry.

Part IV discusses a new approach for handling psychiatric medical malpractice claims when the practitioner is implementing telepsychiatry. This Part provides a recommendation on a new standard of care that should be implemented for all practicing telepsychiatrists. This Part also provides additional recommendations on how to prevent psychiatric medical malpractice with more robust medical protocols, policies, and standards for telepsychiatry.

II. HISTORY AND MEDICAL BACKGROUND

This Part begins with a general overview of the history of telehealth and telepsychiatry. Additionally, this Part provides background information on the medical aspects of psychiatry in general—information which is essential to a full understanding of the issues and themes addressed in this comment.

A. *The History of Telehealth*

Telehealth is defined as the use of electronic information and telecommunications technologies to support long-distance clinical healthcare, patient and professional health-related education and training, public health, and health administration.[21] Recently, there has

20. *See* Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med., 865 N.W.2d 252, 255 (Iowa 2015); *see also* Charles D. Cash, *Telepsychiatry and Risk Management*, 8 INNOVATIONS CLINICAL NEUROSCIENCE 26, 28 (2011).

21. LuAnn E. White et al., *Technology Meets Healthcare: Distance Learning and Telehealth*,

been increased acceptance of and interest in all forms of telehealth.[22] Due to the increasing costs of healthcare, many medical professionals are searching for new ways of providing affordable, yet high-quality, healthcare.

The concept of telehealth has been around for centuries. Even though there is not a definitive date for the creation of telehealth, its origins can arguably be traced back to the Dark Ages.[23] During this time, medical professionals would transport information about the bubonic plague across Europe.[24] By the twentieth century, the telephone became a mainstay of telehealth, providing physicians and other health professionals with a tool to accurately communicate and transfer medical information.[25] One of the earliest purposes of telehealth—the delivery of healthcare to individuals in remote areas—is still one of its premier objectives.[26]

With respect to telepsychiatry, the invention of the television contributed more to the development of telepsychiatry than any other factor.[27] In the late 1960s and early 1970s, mental health professions conducted consultations over two-way, closed-circuit televisions which allowed mental health professionals to help and educate patients and other physicians.[28] Televisions also allowed mental health care professionals to treat individuals who were in remote and less populated regions; this aspect of telehealth is implemented today through the use of internet-based communication devices.[29] These aspects are crucial to provide basic mental health treatment for individuals in rural areas, especially concerning individuals with suicidal ideations.

B. Medical Background

This subpart provides a brief synopsis of the underlying medical background, first discussing mental health trauma and the concept of suicidal ideations. These mental health issues are then examined through the lens of CBT and I-CBT. The use of telepsychiatry in implementing these therapies can help combat many issues within the rural mental

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3 OCHSNER J. 22, 23 (2001).

22. *See* Valdagno et al., *supra* note 8, at 479.

23. *See* Karen M. Zundel, *Telemedicine: History, Applications, and Impact on Librarianship*, 84 BULL. MED. LIBR. ASS'N 71, 72 (1996).

24. *Id.*

25. *Id.*

26. *Id.* at 73.

27. *Id.* at 75.

28. *Id.*

29. *Id.*

health community.

1. Mental Health Trauma and Suicidal Ideations

In 2013, suicide was the tenth leading cause of death in America—over 40,000 deaths were attributable to suicide.[30] While there are many triggering factors that mental health practitioners look to in assessing suicide risk, one of the most salient factors is previous mental health issues. Patients with previous mental health issues have been shown to be at greater risk for suicide.[31] Other risk factors include: (i) depression and other mental disorders, or a substance-abuse disorder (often in combination with other mental disorders); (ii) prior suicide attempts; (iii) a family history of mental disorder or substance abuse; (iv) family history of suicide; (v) family violence, including physical or sexual abuse; (vi) firearms in the home;[32] (vii) incarceration; and (viii) exposure to the suicidal behavior of others, such as family members, peers, or celebrities.[33]

One of the most prevalent methods used to combat suicide and suicidal ideations is CBT. CBT aims to use therapeutic relationships to identify and facilitate a change in an individual's cognitions,[34] through the use of cognitive and behavioral interventions.[35] Cognitive theory shows an individual that emotions, psychological responses, and behaviors are a product of an individual's present thoughts.[36] Another

30. *Suicide: Facts at a Glance 2015*, CDC, https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf (last visited May 28, 2017). 2013 is the most recent year for which all data is available.

31. Jay H. Shore et al., *supra* note 15, at 199-200.

32. This risk factor is more prevalent in the United States. *See* Erin Grinshteyn & David Hemenway, *Violent Death Rates: The U.S. Compared with Other High-Income OECD Countries, 2010*, 129 AM. J. MED. 266 (2016).

33. *See* Stephen J. Tripodi & Kimberly Bender, *Inmate Suicide: Prevalence, Assessment, and Protocols*, 7 BRIEF TREATMENT & CRISIS INTERVENTION 40 (2007), *available at* http://btci.edina.clockss.org/cgi/content/full/7/1/40/; *Risk Factors and Warning Signs*, AM. FOUND. FOR SUICIDE PREVENTION, https://afsp.org/about-suicide/risk-factors-and-warning-signs/ (last visited May 28, 2017).

34. Cognitions consist of, but are not limited to, negative automatic thoughts, dysfunctional assumptions, and core beliefs. *See* FRANK WILLS & DIANA SANDERS, COGNITIVE BEHAVIOUR THERAPY 229 (3rd ed. 2013).

35. Georgia Konstantinou, *The Relationship of Counselling Psychology Training with CBT: Implications for Research and Practices*, 29 COUNSELLING PSYCHOL. REV. 43, 43 (2014).

36. John D. Matthews, *Cognitive Behavioral Therapy Approach for Suicidal Thinking and Behaviors in Depression*, *in* MENTAL DISORDERS: THEORETICAL AND EMPIRICAL PERSPECTIVES 24 (Robert Woolfolk & Lesley Allen eds., 2013), *available at* http://www.intechopen.com/books/mental-disorders-theoretical-and-empirical-perspectives/cognitive-behavioral-therapy-approach-for-suicidal-thinking-and-behaviors-in-depression.

function of CBT is to reduce the subject's negative emotional reactions, distressing physiological responses, and self-defeating behaviors.[37]

The "father" of CBT, A. T. Beck, found that depressed patients with suicidal ideations view themselves as defective, inadequate, diseased, or deprived and thus worthless or undesirable.[38] Additionally, the focus of CBT for a suicidal patient is to "identify the perceived unsolvable problem; reduce cognitive distortions and errors in logic with regards to his or her views of self, others, and future; improve problem solving skills; increase motivation to problem solve; reduce perceived emotional pain; and encourage acceptance of emotional pain as part of everyday life."[39]

The aims of treatment for CBT should be directed toward addressing specific cognitive biases and distortions, developing problem solving techniques, accepting and tolerating emotional pain, improving communications, reducing stress, and developing a support system.[40] Studies and examinations of the use of CBT with suicidal patients point to the effectiveness of CBT in suicide prevention.[41]

2. Internet-Based Cognitive Behavioral Therapy

Internet-based cognitive behavioral therapy (I-CBT) is the delivery of treatment components and ongoing support systems using electronic mail, webpages, and video conferencing.[42] Use of I-CBT as a therapeutic device is relatively new and research on I-CBT is still somewhat undeveloped (although rapidly growing),[43] but from the existing scholarship, it is clear that human interaction between the patient and the health care provider cannot be completely absent.[44]

Patients who may benefit most from receiving this type of treatment are those located in rural areas without access to traditional face-to-face psychiatry.[45] However, many of the obstacles which prevent individuals from accessing traditional psychiatric care also hinder implementation of this type of therapy. Internet-based CBT requires individuals to use self-

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37. *Id.* at 25.
38. *Id.* at 27.
39. *Id.* at 29.
40. *Id.* at 33.
41. *Id.* at 38-40.
42. Gerhard Andersson, *Using the Internet to Provide Cognitive Behaviour Therapy*, 47 BEHAV. RES. & THERAPY 175, 175 (2009).
43. *See id.*
44. *Id.* at 177.
45. *See* Brian Grady, *Promises and Limitations of Telepsychiatry in Rural Adult Mental Health Care*, 11 WORLD PSYCHIATRY 199, 199 (2012).

guided self-help materials presented via the internet; the psychiatrist provides the patients with encouragement and occasionally directs therapeutic activities, such as face-to-face consultations and medication therapy.[46] However, geographical barriers, along with a lack of education and communication systems, can still be troublesome.[47] Statistically, persons living in rural areas are under-educated, with many discontinuing their education following high school graduation.[48] This limitation must be taken into account when developing the self-help materials, maneuvering the Internet and internet-based services, and providing health care education regarding diagnosis and treatment options.

As discussed above, the field of psychiatry has undergone tremendous growth in recent years, perhaps most in regards to the new and varied means of providing treatment. However, this growth has not been matched by a commensurate change in the law. As such, medical malpractice laws, insofar as they apply to the implementation of telemedicine, have become somewhat outdated.

III. LEGAL BACKGROUND

A medical malpractice action is a particular type of negligence action.[49] As a particular type of negligence action, medical malpractice, in its simplest form, consists of a medical diagnosis or treatment which falls below the standard of care established by law for the protection of another against unreasonable risk of harm.[50] The elements that are needed for a successful claim of medical malpractice are: (i) duty, (ii) breach of duty, (iii) causation, and (iv) injury.[51]

A. *Duty/Duty to Treat*

Absent a doctor-patient relationship, physicians have no general

46. *See* Andersson, *supra* note 42, at 175.

47. *See* Roberts et al., *supra* note 10.

48. NATIONAL CENTER FOR EDUCATION STATISTICS, THE STATUS OF RURAL EDUCATION 64, 88 (2007), *available at* https://nces.ed.gov/pubs2007/2007040.pdf.

49. *See* Day v. Johnson, 255 P.3d 1064, 1068 (Colo. 2011).

50. RESTATEMENT (SECOND) OF TORTS § 282 (1965).

51. *See, e.g.*, Winn v. Posades, 913 A.2d 407, 411 (Conn. 2007); Durham v. HTH Corp., 870 A.2d 577, 579 (Me. 2005); Brown v. Brown, 739 N.W.2d 313, 316-17 (Mich. 2007); Paz v. Brush Engineered Materials, Inc., 949 So. 2d 1, 4 (Miss. 2007); Barr v. Great Falls Int'l Airport Auth., 107 P.3d 471, 477 (Mont. 2005); Avery v. Diedrich, 734 N.W.2d 159, 164 (Wis. 2007). For purposes of this article, injury is defined as a personal or bodily injury, including death, affecting an individual's health. *See Personal Injury*, BALLENTINE'S LAW DICTIONARY (3rd ed. 1969).

obligation to undertake the treatment of a patient.[52] This issue was first addressed in *Hurley v. Eddingfield*, wherein the only available physician refused to see an ill patient who subsequently died.[53] The *Hurley* court rejected an argument that the doctor had a duty similar to innkeepers and common carriers and found that a doctor has no affirmative duty to treat someone who he has not taken on as a patient.[54] The duty to treat has been viewed as the threshold element when examining a medical malpractice claim.[55] This duty will only arise from either an express or implied physician-patient relationship.[56] An express physician-patient relationship is established when the patient has sought out the physician's services and the doctor provides them to the individual directly.[57] An implied physician-patient relationship will be found by the courts where there is an affirmative action to treat the patient or prescribe a course of treatment.[58]

Due to the hybrid nature of medical malpractice lawsuits (i.e., a fusion of contract and tort law), the need for a physician-patient relationship at the time of the injury is a must and if there is not a contractual relationship, there cannot be liability on the physician.[59] This assertion is derived from principles of contract law, where the physician has a fiduciary responsibility to the patient but retains the right to enter into a contract with the patient that will be mutually beneficial.[60] Without this relationship, there is an absence of duty on the part of the physician to provide any medical services, and therefore, the physician would not be capable of breaching a duty to the patient.

Another element of duty is the informed consent process, and the

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52. *See* Harper v. Hippensteel, 994 N.E.2d 1233, 1237 (Ind. Ct. App. 2013).

53. 59 N.E. 1058, 1058 (Ind. 1901).

54. *See id.*; *see also* RESTATEMENT (SECOND) OF TORTS § 314A (1965) (stating that an innkeeper has a duty to his guests to protect them from unreasonable risk of harm).

55. Sterling v. Johns Hopkins Hosp., 802 A.2d 440, 444 (Md. Ct. Spec. App. 2002).

56. *See id.* at 445-46; J. Gregory Lennon, *Easing the Medical Malpractice Crisis: Restricting the Creation of Duty Through an Implied Doctor-Patient Relationship*, 7 J. HEALTH CARE L. & POL'Y 363, 367 (2004).

57. *See* Lennon, *supra* note 56, at 367.

58. *Id.*; *Sterling*, 802 A.2d at 455 (noting that a physician-patient relationship may be implied "where the doctor takes affirmative action to participate in the care and treatment of a patient"); *see also* Mozingo v. Pitt Cnty. Mem'l Hosp., Inc., 415 S.E.2d 341, 345-46 (N.C. 1992) (holding that because the defendant knew the residents at the hospital were actually treating patients when he undertook the duty to supervise the residents as an on-call supervising physician the defendant owed a duty to the patients under his residents' care); *but see* Irvin v. Smith, 31 P.3d 934, 943 (Kan. 2001) (holding that an agreement to give a consultation the next day did not create a physician-patient relationship because of a lack of meaningful contact with the patient).

59. *Id*. at 364.

60. *Id.* at 364-65; *see* Moore v. Regents of the Univ. of Cal., 793 P.2d 479, 483 (Cal. 1990).

duty of disclosure in providing patients with comprehensive medical information that is understandable to the patient. In recognizing the dignity of persons and basic human freedoms, patients have the right to be fully informed and to make informed decisions on matters concerning their health and treatment.[61] Most often, questions about whether a patient gave informed consent revolve around the amount and type of information that the healthcare professional was required to give to the patient and what information was actually communicated. Courts have found that, for informed consent to be valid, the physician must provide all material facts.[62] The definition of "material fact" is the subject of great debate.

There are two competing legal theories concerning what type of information must be disclosed to satisfy the informed consent requirement. The first is what a reasonable medical practitioner would disclose. This legal standard if often locality-based, in that the standard is what a reasonably prudent medical practitioner, in good standing in the jurisdiction of the evaluating court, would do in the same situation.[63] A slight majority of states have adopted this standard.[64] The second legal standard is that of the reasonable prudent patient standard, or what a reasonable prudent patient would want to know under the same situation.[65] This theory focuses on patient autonomy over medical paternalism.[66] Without informed consent, healthcare providers can be held liable for medical malpractice unless they can prove that they were acting within the bounds of an exception.

In most jurisdictions, the duty of informed consent is subject to certain exceptions.[67] The first exception, known as therapeutic privilege, applies when a health care provider makes a clinical decision to withhold information from the patient believing that providing such information would be harmful, especially if it is likely to cause a great deal of mental stress and impair the patient's decisional capacity.[68] The

61. *See* Schloendorff v. Soc'y of N.Y. Hosps., 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body.").

62. *See Moore*, 793 P.2d at 483.

63. Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 916 (1994); *see also* Natanson v. Kline, 354 P.2d 670, 672 (Kan. 1960).

64. Schuck, *supra* note 63, at 916.

65. *See generally* Marjorie M. Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985); *see also* Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972).

66. Schuck, *supra* note 63, at 916.

67. *Id.* at 919.

68. *See Canterbury*, 464 F.2d at 789; Schuck, *supra* note 63, at 919.

second exception applies when the patient lacks clinical competency (i.e., mental disability or infancy).[69] There is also an exception for emergency situations.[70] Another exception is in situations where the risk is either known to the patient or is so obvious as to justify a presumption on the part of the physician that the patient has knowledge of the risk.[71] The final exception is in situations where the physician does not know of an otherwise material risk, does not have reason to know of the otherwise material risk, and could not have been aware of it in the exercise of ordinary care.[72] When these exceptions are applicable, the doctor will not be held liable for the nondisclosure.

B. Breach of Duty

The standard for breach of duty has been succinctly phrased as follows: "[i]n the law of negligence, the standard of care is the degree of care that a reasonable person should exercise."[73] In an action for medical malpractice, the medical professional will be held to a specialized standard of care, that of a reasonable, competent medical professional. In these actions, the trier of fact must determine if the defendant's conduct (i.e., the medical professional's diagnosis or treatment) conformed to the medical standard or customs.[74] Unlike other negligence cases, in medical malpractice, the standard of care must be established by expert testimony.[75] The use of expert testimony is needed because the proper exercise of professional medical judgment, or the lack thereof, is not usually apparent to the average lay juror.[76]

After the plaintiff has established the standard of care, the plaintiff will have to show that the medical practitioner has breached the standard of care.[77] To breach a standard of care, the plaintiff must show that the healthcare provider's care fell beneath the level of care that a reasonably prudent healthcare provider would have given in a similar situation.[78] To

69. Schuck, *supra* note 63, at 919.

70. *Id.*; *Canterbury*, 464 F.2d at 788-89.

71. Pauscher v. Iowa Methodist Med. Ctr., 408 N.W.2d 355, 360 (Iowa 1987).

72. *Id.*

73. John C. Drapp III, *The National Standard of Care in Medical Malpractice Actions: Does Small Area Analysis Make it Another Legal Fiction?*, 6 QUINNIPIAC HEALTH L.J. 95, 97 (2003) (quoting Black's Law Dictionary).

74. *Id.*

75. *Id.*

76. *Id.* at 97-98.

77. *Id.* at 98.

78. Vergara v. Doan, 593 N.E.2d 185, 186 (Ind. 1992); *see also* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 309 (7th ed. 2013) ("[I]n a professional

do so, the plaintiff must use expert testimony to show that the defendant deviated from the acceptable norm.[79]

To establish the accepted norm, the plaintiff's expert will rely on one of two legal standards. The first is commonly called the "locality rule"; the second is termed the "national standard of care." The locality rule defines the standard of care as the degree of care, skill, and proficiency which is commonly expected by a prudent physician, at the time care was given and in similar localities.[80] In contrast, the national standard of care requires that a medical professional provide her patients with care comparable to the care provided to patients anywhere in the United States, regardless of the skill and knowledge of the particular professional and the area in which the care is provided.[81] The national standard of care has garnered wide support and is now the majority rule.[82] This movement is largely based on the nationalization of medical education and the accessibility to professional and scientific journals by electronic databases.[83]

When examining the standard of care, there are a few limited exceptions. The first exception is that of respectable minority. This exception allows for variation in clinical judgment.[84] The second exception is the "two schools of thought" doctrine. The "two schools of thought" doctrine poses that a health care professional will not be held liable to a plaintiff merely for exercising judgment in applying a treatment that is supported by other medical professionals.[85] This doctrine goes further in that the health care provider will not be liable in

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negligence cause of action, the standard of care that the plaintiff must prove is that the professional failed to conform to the generally recognized and accepted practices in his profession. If the plaintiff is unable to demonstrate that the professional failed to conform to the generally recognized and accepted practices in his profession, then the professional cannot be found liable as a matter of law.").

79. FURROW ET AL., *supra* note 78, at 309.

80. *Vergara*, 593 N.E.2d at 186 (quoting Burke v. Capello, 520 N.E. 2d 439, 441 (Ind. 1988)).

81. *See* Hall v. Hilbun, 466 So. 2d 856, 867 (Miss. 1985).

82. *See* FURROW ET AL., *supra* note 78, at 360; Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice at the Millennium*, 57 WASH. & LEE L. REV. 163, 166, n. 15 (2000).

83. *Id.* at 870-71; *see also* FURROW ET AL., *supra* note 78, at 310 (stating that most states have moved away from the locality rule due to worries about a "conspiracy of silence" (i.e., local physicians are likely unwilling to testify against one another) which would limit the availability of experts).

84. *See* Downer v. Veilleux, 322 A.2d 82, 87 (Me. 1974) ("Even if the evidence could be construed to suggest that an alternative treatment would have been feasible, a physician does not incur liability merely by electing to pursue one of several recognized courses of treatment.").

85. Jones v. Chidester, 610 A.2d 964, 966 (Pa. 1992).

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applying such a treatment even if the other experts would have favored a different course of treatment.[86] The final exception is clinical innovation. Clinical innovation involves the health care provider modifying ordinary procedures in hopes of serving his individual patient better.[87]

C. Causation

Causation refers to any act or omission inconsistent with an existing standard of care that is a substantial factor in bringing about an injury.[88] For the most part, the issue of causation arises in medical malpractice suits when the plaintiff has a preexisting condition, and it is questionable whether the negligent act of the health care provider was the cause of the bad outcome or if the event would have happened anyways.[89] Causation is satisfied by a showing that the injury was the natural and probable consequence of the defendant's actions.[90]

The element of causation can become increasing difficult to establish as the number of individuals providing care to the patient increases.[91] However, where there are multiple individuals who act in concert to commit a wrong, the multiple parties will be considered joint tortfeasors.[92] Due to the adoption of comparative fault in the majority of jurisdictions,[93] the trier of fact may be required to apportion the damage

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86. *Id.*

87. E. Haavi Morreim, *Medical Research Litigation and Malpractice Tort Doctrines: Courts on a Learning Curve*, 4 HOUS. J. HEALTH L. & POL'Y 1, 14-15 (2003); *see also* Brook v. St. John's Hickey Mem'l Hosp., 380 N.E.2d 72, 75 (Ind. 1978) (holding that a physician's choice to use a different injection site was not a breach of the standard of care due to the physician's knowledge of anatomy, and the extensive literature on the subject). This is a controversial issue in the realm of psychiatry as there are significant inconsistencies in clinical practice. For example, not all psychiatrists value psychotherapy and instead choose to treat only with pharmaceuticals and management of medications.

88. Steven E. Pegalis, *Proximate Cause*, 1 AM. LAW MED. MALP. § 5:1 (2016); RESTATEMENT (SECOND) OF TORTS § 431 (1965). In the context of suicide and suicidal ideations, an injury can be death, injury from an unsuccessful attempt, injury or death to another, and further mental health injuries.

89. *See* FURROW ET AL., *supra* note 78, at 400.

90. *Id.*

91. *See id.* at 401.

92. *Id.*; *see also* Martin J. McMahon, Annotation, *Joint and Several Liability of Physicians Whose Independent Negligence in Treatment of Patient Causes Indivisible Injury*, 9 A.L.R.5th 746 (2011) ("Multiple physicians have been held jointly and severally liable with each other for injuries negligently inflicted, in the absence of evidence delineating the aspects of the injury caused by the respective negligence of the individual physicians, even though they did not act in concert or concurrently.").

93. *See* RESTATEMENT (SECOND) OF TORTS § 886A (1979) (stating when two or more individuals are liable in a tort action, there is a right of contribution among the tortfeasors).

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amount among the joint tortfeasors.[94]

Additionally, the doctrine of *res ipsa loquitur* ("the thing speaks for itself") [95] has been implemented in situations where several defendants could have caused injury to the plaintiff.[96] Finally, in the seminal case of *Ybarra v. Spangard*, the court found that when there is uncertainty as to which defendant caused the injury, the burden is shifted to the joint tortfeasors to prove that they were not the cause of the injury.[97]

IV. MEDICAL MALPRACTICE WITHIN TELEPSYCHIATRY FOR CBT TREATMENT FOR PATIENTS WITH SUICIDAL IDEATIONS

This section examines the general principles of medical malpractice discussed above in connection with telepsychiatry. This section begins by discussing where a medical malpractice action could be brought and what law should govern. Secondly, this part discusses common bases for medical malpractice suits. When an action for medical malpractice is brought against a mental health professional, the plaintiff must prove all the elements of the cause of action.[98] As in any other type of medical malpractice action, the standard of care must be distinguished from the quality of the care that is provided.[99] Two of the most prevalent wrongs that lead to a cause of action are a mental health professional's failure to consider a medical condition as the cause of the patient's mental or emotional pain and the failure to take action when a patient threatens violence against him or herself or against others.[100] The standard of care must be established by expert testimony, practice guidelines, psychiatric literature, hospital policies and procedures, or state and federal guidelines.[101]

94. *See* FURROW ET AL., *supra* note 78, at 401. Note, however, that if a physician fails to diagnose a patient's underlying medical condition, the physician might be liable to the injured plaintiff for all foreseeable injuries resulting from the later negligent medical treatment. *Id.*

95. *See* RESTATEMENT (SECOND) OF TORTS § 328D (1965) (stating that the trier of fact may draw inferences that the harm was caused by the defendant because the type of action normally does not occur without a negligent action).

96. *See* Ashland v. Ling-Temco-Vought, Inc., 711 F.2d 1431, 1439 (9th Cir. 1983).

97. Ybarra v. Spangard, 154 P.2d 687, 691 (Cal. 1944) ("[W]here a plaintiff receives unusual injuries while unconscious and in the course of medical treatment, all those defendants who had any control over his body or the instrumentalities which might have caused the injuries may properly be called upon to meet the inference of negligence by giving an explanation of their conduct.").

98. To reiterate, these elements are: (i) duty; (ii) breach of that duty; (iii) causation; and (iv) injury.

99. LEE S. GOLDSMITH, 5 MEDICAL MALPRACTICE: A GUIDE TO MEDICAL ISSUES § 79.01 (Matthew Bender, Rev. Ed. 2017).

100. *Id.*; *see generally* Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334 (Cal. 1976).

101. GOLDSMITH, *supra* note 99.

A. *Jurisdiction and Choice of Law*

The first issue that must be addressed concerning telepsychiatry is where an individual can bring suit (i.e., the state where the patient is located or the state where the psychiatrist is located) and what law should apply when adopting a standard of care (i.e., the law of the patient's state or the law of the practitioner's state).[102] The United States Supreme Court has held that to be subject to personal jurisdiction in the courts of a state, an individual must have minimum contacts with that state.[103] Minimum contacts are established when an individual "purposefully avails [herself] of the privilege of conducting activities within the forum State, thus invoking the benefits and protections of its law."[104] While the issue of personal jurisdiction is easily resolved where a potential defendant had or has a physical presence in a state, modern technologies complicate the determination of minimum contacts.

Through use of the internet, it is possible to connect with individuals around the world at the touch of a button. This being so, some courts have implemented a sliding scale test to measure personal contacts when a defendant's only contacts with a state were through cyberspace.[105] At one end of the scale are cases where the defendant clearly conducts business over the internet in an active manner; here, it is clear that if the defendant enters into contracts over the internet, they have availed themselves of the protection of the states, and therefore, personal jurisdiction is proper.[106] At the other end of the scale, in cases where a website does little more than make information available to the public, personal jurisdiction does not lie.[107] Finally, in cases in the middle ground (interactive), information can be exchanged with the host computer; jurisdiction is determined by focusing on the level of interactivity and the commercial nature of the exchanged information.[108] In applying these tests to telepsychiatry, it is clear that in many instances, there will be jurisdiction over the defendant. This is because a medical professional who provides medical care to a person located

102. *See* LYNN D. FLEISHER & JAMES C. DECHENE, TELEMEDICINE AND E-HEALTH LAW § 1.04 (2017).

103. *See generally* Int'l Shoe Co. v. Washington, 326 U.S. 310 (1945); Burger King Corp. v. Rudzewicz, 471 U.S. 462 (1985).

104. Hanson v. Denckla, 357 U.S. 235, 253 (1958). Note that, even if a person has sufficient minimum contacts with a state such that jurisdiction is constitutionally permissible, jurisdiction will not lie unless the state's long-arm statute applies to the person's activities.

105. *See* Zippo Mfg. Co. v. Zippo Dot Com, Inc., 952 F. Supp. 1119, 1124 (W.D. Pa. 1997).

106. *Id.*

107. *Id.*

108. *Id.*

within the boundaries of a state will likely be held to have actively availed himself of the laws and jurisdiction of that State.[109]

When looking at choice of law, the subject of medical malpractice is extremely important and complex.[110] The complexities arise from the significant differences in state policies regarding medical malpractice.[111] The choice of law doctrine is normally governed by legal precedent in the jurisdiction hearing the case.[112] The governing jurisdiction will also determine the factors determining the choice of law. Some factors that could be examined by the courts are: (i) the relevant policies of the forum state; (ii) the relevant policies of other interested states in the determination of the particular issue; (iii) the protection of justified expectations; (iv) the basic policies underlying the particular field of law; (v) certainty, predictability, and uniformity of result; and (vi) the ease of determination and application of the law to be applied.[113] Other general principles that apply when determining the law that is to govern a tort action are: (i) the place where the injury occurred; (ii) the place where the conduct causing the injury occurred; (iii) the domicile, residence, nationality, place of incorporation and place of business of the parties; and (iv) the place where the relationship, if any, between the parties is centered.[114]

There are two notable suggestions for resolving the choice of law issue concerning telepsychiatry. One suggestion involves the idea that the patient is "electronically transported" to the jurisdiction where the physician is located.[115] The other is that the physician might be deemed to have personally availed himself of the patient's jurisdiction.[116] This is because the jurisdiction where the patient suffered the injury will have such a strong interest in adjudicating the matter and protecting its

109. 225 ILL. COMP. STAT. ANN. 60/49.5(e) (LexisNexis 2016) (stating any physician practicing telemedicine within the State subjects him or herself to the jurisdiction of Illinois); *but see generally* Bradley v. Mayo Found., 1999 U.S. Dist. LEXIS 17505 (E.D. Ky. 1999).

110. Jeffrey L. Rensberger, *Choice of Law, Medical Malpractice, and Telemedicine: The Present Diagnosis with a Prescription for the Future*, 55 U. MIAMI L. REV. 31, 31 (2000).

111. *Id.*

112. *See* FLEISHER & DECHENE, *supra* note 102.

113. RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 6(2) (1971); *but see* RESTATEMENT (FIRST) OF CONFLICT OF LAWS § 377 (1934) (stating courts should only look at where the harm occurs).

114. RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 145(2) (1971).

115. Shannon S. Venable, Comment, *A Call to Action: Georgia Must Adopt New Standard of Care, Licensure, Reimbursement, and Privacy Laws for Telemedicine*, 54 EMORY L.J. 1183, 1192-93 (2005).

116. *See id.*

citizens.[117]

These jurisdictional issues are further complicated by the different ethical and professional implications posed by telepsychiatry. These patients are in a vulnerable state, and policy should dictate that these patients are afforded several protections by virtue of their vulnerability and their roles as patients in the fiduciary therapeutic relationship. With these factors in mind, the most likely outcome of this issue is that the law applied will be the law where the treatment was received.[118] If we apply the law of the jurisdiction where the treatment was received, this will afford the patient more protections, which are needed. Furthermore, jurisdictions will be able to better regulate the physicians who act locally, which will allow for better patient autonomy and safeguards, such as the informed consent process.[119]

B. Practitioner-Patient Relationship and Informed Consent

Like traditional medical malpractice law suits, a practitioner-patient relationship must exist between the medical professional practicing telepsychiatry and a patient in order for the patient to sustain a malpractice suit. In traditional psychiatry, the practitioner-patient relationship is temporal, as each session lasts for a specific period of time, but in telepsychiatry, this relationship is more fluid, as telepsychiatry requires the patient to engage in other activities assigned by the therapist outside of each session.[120] This fluidity causes additional stress on the courts because whether a practitioner-patient relationship exists is a question of law.[121] In determining whether a physician-patient relationship existed, the courts will consider the relationship between the parties, the nature of risk (foreseeability), and public policy.[122] The main inquiry concerns whether the doctor was in a unique position to prevent harm, the burden of preventing harm, and the patient's reliance on the physician.[123]

Before beginning any type of mental health relationship, the physician must obtain the patient's informed consent. As in any other

117. *See* Christopher J. Caryl, Note, *Malpractice and Other Legal Issues Preventing the Development of Telemedicine,* 12 J.L. & HEALTH 173, 203 (1997).

118. *See generally* Rensberger, *supra* note 110.

119. *See id.* at 78-79.

120. Patricia C. Kuszler, *Telemedicine and Integrated Health Care Delivery: Compounding Malpractice Liability*, 25 AM. J.L. & MED. 297, 308 (1999).

121. *See* Doe v. Bradley, 58 A.3d 429, 447 (Del. Super. Ct. 2012).

122. White v. Harris, 36 A.3d 203, 205 (Vt. 2011).

123. *See id.* at 205-07 (holding that a single ninety-minute consultation was enough to establish a physician-patient relationship).

physician-patient relationship, this disclosure needs to consist of all material facts.[124] Additionally, the risks and benefits telepsychiatry can provide will vary from patient to patient, and the mental health professional must tailor the informed consent process to each patient.[125]

In a normal therapeutic session, a mental health professional will be face-to-face with the patient. Medical professionals are trained to use all of their senses in the examination of a patient. Through the use of telepsychiatry, the use of all the human senses is hindered. The first hindrances concern the senses of hearing, touch (e.g., taking vitals), and sight. Mental health professionals need to gauge many non-verbal cues, such as facial expressions and micro expressions.[126] These senses are paramount in a face-to-face situation as anywhere from seven to thirty-five percent of communication is accomplished verbally, while the remaining communication is conducted through non-verbal cues.[127] One useful tool that could be implemented to limit these issues is emotion-capture technology.[128] This technology applies acute analysis to the data by recording patients' facial expressions, analyzing videos, and developing a tracking algorithm which will help clinicians interpret the different emotions during a therapeutic session.[129]

The main sense that is restricted through the use of telepsychiatry is smell. Many individuals who have mental health issues self-treat by using narcotics and alcohol.[130] A lack of face-to-face interaction prevents a treating mental health professional from gauging whether the individual is under the use of narcotics and/or alcohol. These hindrances could lead to misunderstandings and misdiagnoses that could create risks of further exacerbating the underlying mental health issues.[131]

In addition to these issues, the practice of telepsychiatry is still relatively new and uncertain. The uncertainty and lack of empirical

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124. *See* Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92 (N.Y. 1914); White v. Leimbach, 959 N.E.2d 1033, 1038-39 (Ohio 2011).

125. Patricia R. Recupero & Samara E. Rainey, *Informed Consent to E-Therapy,* 59 AM. J. PSYCHOTHERAPY 319, 322 (2005).

126. *Id.*

127. WALLACE V. SCHMIDT ET AL., COMMUNICATING GLOBALLY: INTERCULTURAL COMMUNICATION AND INTERNATIONAL BUSINESS 95 (2007).

128. Rebecca Calhoun, *Emotion-Capture Video Takes Tele-Psych to Deeper Levels*, 2 TELEMEDICINE 1, 8 (2015).

129. *Id.* As with any technology, there is always the chance of error (e.g., false positives and negatives). Another possible issue is the financial burden this technology could impose on rural communities.

130. Marie Bussing-Birks, *Mental Illness and Substance Abuse*, NAT'L BUREAU ECON. RES., http://www.nber.org/digest/apr02/w8699.html (last visited July 1, 2017).

131. Recupero & Rainey, *supra* note 126, at 322.

research concerning telepsychiatry might cause courts to view this type of practice as experimental.[132] Any medical procedure (e.g., testing or treatment) that is being used to diagnosis or treat will be considered experimental (i.e., not established medical practice) until there is medical evidence regarding the risks, benefits, and safety and efficiency of the procedures.[133] If this type of therapy is defined as experimental, the health care provider must divulge the experimental nature of the treatment and all foreseeable consequences of the treatment.[134]

In the field of telepsychiatry, this duty will most likely be established when the psychiatrist either agrees to treat the patient,[135] or if there is not an expressed agreement, when the first therapeutic session takes place.[136] Additionally, mental health professionals must divulge all material risks and should provide the patient with the possible experimental nature of this type of therapy.

C. Establishing the Standard of Care in Telepsychiatry

When examining the breach of duty, the most important factor will be the establishment of the standard and the deviation from that standard. The science and art of psychiatry is ever-changing. Advances in modern technology and research have resulted in a rapid growth in psychiatry. In the new age of the internet, all medical professionals have the power to inform themselves about the newest technologies and studies. This accessibility needs to be reflected in the standard of care.

It has been said there are two types of psychiatrists, "those who have had patients commit suicide and those who will."[137] In the field of psychiatry, suicide is the most common occurrence underlying a claim

132. *Id.* at 327.

133. Am. Soc'y for Reprod. Med., *Definition of Experimental Procedures: A Committee Opinion*, 99 FERTILITY & STERILITY 1197, 1197 (2013).

134. Ahern v. Veterans Admin., 537 F.2d 1098, 1102 (10th Cir. 1976). This type of technology has not been subjected to extensive studies, which even furthers the likelihood of being considered experimental.

135. *See* Millard v. Corrado, 14 S.W.3d 42, 49 (Mo. Ct. App. 1999) ("The law defines a physician-patient relationship as a consensual relationship where the patient or someone acting on the patient's behalf knowingly employs a physician who consents to treat the patient."); St. John v. Pope, 901 S.W.2d 420, 424 (Tex. 1995) (noting that a formal written contract is not necessary to create a physician-patient relationship).

136. Irvin v. Smith, 31 P.3d 934, 941 (Kan. 2001) (holding that, generally, a physician-patient relationship is created only when the patient is examined); McKinney v. Schlatter, 692 N.E.2d 1045, 1050 (Ohio 1997) (finding that a lack of contract between the patient and the physician does not preclude the finding of a relationship).

137. Robert I. Simon, *Suicide Risk Assessment: What is the Standard of Care?*, 30 J. AM. ACAD. PSYCHIATRY & LAW 340, 340 (2002).

for medical malpractice.[138] The rarity of suicide and the complexities of its causes have not allowed for a professional standard of care.[139] Due to the lack of a professional standard of care, this standard must be assessed through expert testimony.

Some mental health care professionals find that the standard of care lies with a systematic suicide risk assessment, where the mental health care provider must consider the risk and protective factors.[140] The American Psychiatric Association (APA) has developed extensive guidelines concerning the standard of care for suicide assessment.[141] Under the APA's guidelines, the most important aspect of suicide prevention is the initial psychiatric evaluation and assessment.[142] If the initial assessment is conducted correctly, this will provide the mental health care professional with specific factors and features that can be targeted for specific intervention.[143] The APA also notes that, due to differing beliefs about suicide and death, simply asking about suicidal ideations might not give the mental health care professional an accurate or complete description of the issues.[144]

One of the more common practices is the use of "no-harm contracts"—normally oral contracts between the patient and the mental health care provider whereby the patient agrees not to harm themselves or others for a certain period of time.[145] These contracts are established when the mental health care provider feels that the patient is at a heightened risk for self-destructive behavior.[146] The rationale for using these types of contracts is to reduce the client's self-destructive behavior and minimize liability to the mental health care professionals.[147] However, there is little, if any, empirical evidence showing that these contracts are effective.[148] Additionally, the idea that the patient might not be of sound mind to enter into this type of contract, or cannot grasp

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138. *Id.*

139. *Id.*

140. *Id.*

141. AM. PSYCHIATRIC ASS'N, PRACTICE GUIDELINE FOR THE ASSESSMENT AND TREATMENT OF PATIENTS WITH SUICIDAL BEHAVIORS (2003).

142. *Id.* at 10; *see* Perez v. United States, 883 F. Supp. 2d 1257, 1285 (S.D. Fla. 2012).

143. S*ee* AM. PSYCHIATRIC ASS'N, *supra* note 142, at 10.

144. *Id.*

145. *See generally* Rebecca S. Hyldahl & Brent Richardson, *Key Considerations for Using No-Harm Contracts with Clients Who Self-Injure*, 89 J. COUNSELING & DEV. 121 (2011).

146. *Id.*

147. *Id.* at 122.

148. *Id.* ("Clients who self-injure may not be able or willing to stop what has been an effective, albeit destructive, coping strategy until they have addressed some of their underlying issues and acquired effective replacement skills.").

the consequences of their actions, makes these types of contracts all the more insufficient.

Disagreement over the standard of care between mental health professionals has made defining it almost impossible for the legal system. In *Perez v. United States*, the standard of care was established by expert testimony, and the court held that the standard was breached due to the mental health professional's failure to make a proper diagnosis after ascertaining a medical history and regular assessment of the patient over several sessions.[149] The court noted that even though there was conflicting testimony on whether the standard of care was breached, the court found the testimony of the plaintiff's expert more persuasive.[150] This decision shows that the question of standard of care is unique and subjective and can only be established on a case-by-case basis using expert testimony.[151]

This issue is further complicated by the different ethical considerations that are posed by telepsychiatry. The most important issue is the appropriateness of telepsychiatry as concerning suicidal ideations.[152] Due to the severity of this condition, safeguards must be taken to ensure the safety of the patients and others. In traditional psychiatry, the mental health provider conducts treatment with the patient present. During these sessions, the patient may become agitated, requiring the mental health professional to take steps to prevent any injury.[153] The mental health professional must be able to take substantial steps to protect the patient and third parties, even if this means involuntary hospitalization.[154] In *Bell v. New York City Health & Hospitals Corporations*, the court held that a treating psychiatrist could be held liable for releasing a patient without a careful and competent examination.[155]

Even when a careful and competent examination is performed, issues can arise. The field of psychiatry is not an exact science, and there is much disagreement among mental health professionals regarding

149. 883 F. Supp. 2d 1257, 1285-87 (S.D. Fla. 2012).

150. *Id.* at 1288.

151. Stanley v. McCarver, 92 P.3d 849, 854 (Ariz. 2004) ("what is necessary to satisfy the standard will depend upon the facts of each case.").

152. *See* Monique Manhal-Baugus, *E-Therapy: Practical, Ethical, and Legal Issues*, 4 CYBERPSYCHOLOGY & BEHAV. 551, 558-60 (2001).

153. Such interventions range from speaking to the patient to having the patient hospitalized.

154. *See* Patricia C. Kussmann, Annotation, *Liability of Doctor, Psychiatrist, or Psychologist for Failure to Take Steps to Prevent Patient's Suicide*, 81 A.L.R.5th 167, *9 (2000).

155. *See* Bell v. N.Y. City Health & Hosps. Corp., 456 N.Y.S.2d 787, 794 (N.Y. App. Div. 1982).

diagnostic categories, treatments, and prognoses.[156] This causes mental health professionals to make predictions of what would constitute the best form of treatment, which in some circumstances involves a calculated risk.[157] Many courts have held that a medical professional will not be held liable for a bad result if the physician acts with due care in pursuit of a course of treatment that is within an acceptable norm.[158] This issue is further exacerbated when applied to telepsychiatry.

D. Liability for Suicide

As with any type of negligence, for liability to exist in a medical malpractice action, there must be a causal connection between the breach of duty and the injury that resulted.[159] Causation is established when the evidence proves that the negligence was the probable cause of the injury.[160] This means that a verdict cannot be based on speculation or conjecture as to the element of causation.[161] Under traditional tort law, a person is not liable for actions committed by another person and is not under any duty to protect a person from harm.[162] However, if there is a "special relationship," an affirmative duty may arise.[163]

In the context of suicide, the element of causation has elicited differing views in the judicial system. Until recently, the common law held that an individual could not be held liable for another's suicidal actions.[164] Under the common law, suicide is often a superseding act[165]

156. Wulbrecht v. Jehle, 902 N.Y.S.2d 910, 919 (N.Y. Sup. Ct. 2010).

157. *Id.* at 917.

158. *See, e.g.*, Joseph H. King, Jr., *Reconciling the Exercise of Judgment and the Objective Standard of Care in Medical Malpractice*, 52 OKLA. L. REV. 49, 57-58 (1999); Hirahara v. Tanaka, 959 P.2d 830, 835 (Haw. 1998); Morlino v. Med. Ctr., 706 A.2d 721, 732 (N.J. 1998) ("Doctors may exercise reasonable care and still produce a bad result."); Frakes v. Cardiology Consultants, P.C., No. 1-A-01-9702-CV-00069, 1997 Tenn. App. LEXIS 597, at *2 (Tenn. Ct. App. Aug. 29, 1997); Nowatske v. Osterloh, 543 N.W.2d 265, 274-75 (Wis. 1996); Ouellette v. Subak, 391 N.W.2d 810, 816 (Minn. 1986).

159. W.E. Shipley, Annotation, *Proximate Cause in Malpractice Cases,* 13 A.L.R.2d 11, *2 (1950); Granicz v. Chirillo, 147 So. 3d 544, 547-48 (Fla. Dist. Ct. App. 2014) ("[T]he proximate cause element of negligence [focuses] on 'whether and to what extent the defendant's conduct foreseeably and substantially caused the specific injury that actually occurred.'").

160. Pappa v. Bonner, 105 So. 2d 87, 90 (Ala. 1958).

161. *See* Shipley, *supra* note 160, at *3.

162. Kockelman v. Segal, 71 Cal. Rptr. 2d 552, 557 (Cal. Dist. Ct. App. 1998).

163. *Id.* ("Such a special relationship is typically where the plaintiff is particularly vulnerable and dependent upon the defendant who, correspondingly, has some control over the plaintiff's welfare.") (citing Prosser & Keeton, Torts (5th ed. 1984) § 56, p. 374); *see generally* Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334 (1976). The relationship between a mental health professional and their patient satisfies this special relationship.

164. C.T. Drechsler, Annotation, *Civil Liability for Death by Suicide*, 11 A.L.R.2d 751, **2-3 (1950).

that absolves an individual from liability.[166] While most jurisdictions have abolished this rule, some have made exceptions.[167] Some jurisdictions require a special relationship for liability to exist, while other jurisdictions take it further and require that special relationship to be custodial in nature.[168] Under this view, liability would not exist for a telepsychiatrist. In the context of telepsychiatry, individual patients would most likely be considered outpatients.[169] Liability is rarely imposed in situations concerning outpatients.[170]

The more modern view focuses mainly on the aspect of foreseeability.[171] In *Foster v. Charter Medical Corporation*, the Alabama Supreme Court held that the question of causation will most always hinge on the foreseeability of the patient's suicidal ideation.[172] The court held that "[f]oreseeability of a decedent's suicide is legally sufficient . . . if the deceased had a history of suicidal proclivities, or manifested suicidal proclivities in the presence of the defendant, or was admitted to the facility of the defendant because of a suicide attempt."[173]

165. *See, e.g.*, 22A AM. JUR. 2D Death § 43 (1988); Watters v. TSR, Inc., 904 F.2d 378, 383 (6th Cir.1990); Gilmore v. Shell Oil Co., 613 So. 2d 1272, 1276-78 (Ala. 1993); Pompeneo v. Verde Valley Guidance Clinic, Inc., 249 P.3d 1112, 1114 (Ariz. Ct. App. 2011) ("Intervening causes become superseding causes when the 'intervening force was unforeseeable and may be described, with the benefit of hindsight, as extraordinary.'"); Eidson v. Reprod. Health Servs., 863 S.W.2d 621, 626-27 (Mo. Ct. App. 1993); Krieg v. Massey, 781 P.2d 277, 279 (Mont. 1989); R.D. v. W.H., 875 P.2d 26, 28 (Wyo. 1994).

166. *See* McLaughlin v. Sullivan, 461 A.2d 123, 124 (N.H. 1983) ("As a general rule, negligence actions seeking damages for the suicide of another will not lie because the act of suicide is considered a deliberate, intentional and intervening act which precludes a finding that a given defendant, in fact, is responsible for the harm."); *see also* Winger v. Franciscan Med. Ctr., 701 N.E.2d 813, 816 (Ill. App. Ct. 1998); *but see* Edwards v. Tardif, 692 A.2d 1266, 1269 (Conn. 1997) (stating that if suicide is a foreseeable result of a defendant's tortious act, the suicide will not break the chain of causation).

167. *See, e.g.*, Lee v. Corregedore, 925 P.2d 324, 330-31 (Haw. 1996).

168. *See id.*; RESTATEMENT (SECOND) OF TORTS § 314A(4) (1965); Nally v. Grace Cmty. Church, 763 P.2d 948, 956 (Cal. 1988) (holding that nontherapist counselors did not have a duty to prevent the suicide of a person who was not in their custody); Krieg, 781 P.2d at 279 (holding a landlord-tenant relationship is not custodial in nature).

169. *See generally* Mark Olfson & Harold Alan Pincus, *Measuring Outpatient Mental Health Care in the United States*, 13 HEALTH AFFAIRS 172 (1994) (stating there is not a standard definition of what constitutes an outpatient, but does give input).

170. *See* Eisel v. Bd. of Educ., 597 A.2d 447, 450 (Md. 1991) ("Liability against therapists for outpatient suicides is rarely imposed . . . ."); *but see* Kockelman v. Segal, 71 Cal. Rptr. 2d 552, 558 (Cal. Dist. Ct. App. 1998) ("[W]e believe California courts have recognized that psychiatrists owe a duty of care, consistent with standards in the professional community, to provide appropriate treatment for potentially suicidal patients, whether the patient is hospitalized or not.").

171. *See* Kussmann, *supra* note 155, at *4; Patton v. Thompson, 958 So. 2d 303, 307 (Ala. 2006).

172. Foster v. Charter Med. Corp., 601 So. 2d 435, 440 (Ala. 1992).

173. *See id.* (quoting Keeton v. Fayette County, 558 So. 2d 884, 887 (Ala. 1989)).

This idea of foreseeability does not depend on the mental capacity of the deceased at the time the suicide occurred, but rather the negligent conduct of the mental health professional that led to or made it reasonably foreseeable that the suicidal action would occur.[174]

In addition to the foreseeability aspect of liability for an individual's suicide, the Supreme Court of Mississippi adds a further element for liability.[175] Mississippi provides a rebuttable presumption concerning suicide—the "irresistible impulse"—under which a person's suicide is presumed to not be a foreseeable result of another's potential negligence.[176] Under the Second Restatement of Torts:

> If the actor's negligent conduct so brings about the delirium or insanity of another as to make the actor liable for it, the actor is also liable for harm done by the other to himself while delirious or insane, if his delirium or insanity . . . makes it impossible for him to resist an impulse caused by his insanity which deprives him of his capacity to govern his conduct in accordance with reason.[177]

Under this view, the plaintiff must show more than that the defendant breached a duty of care which set off a chain of events leading to the individual's suicide.[178] The plaintiff is required to prove that the defendant's actions caused a mental issue, which resulted in an "irresistible impulse" to commit suicide "in the sense that the decedent could not have decided against and refrained from killing himself, and because of such uncontrollable impulse, the decedent committed suicide."[179]

In *Truddle v. Baptist Memorial Hospital*, the court reaffirmed a two part "irresistible impulse" test for determining if a plaintiff is capable of recovering from a defendant for a third party's suicide.[180] To recover, the plaintiff must prove (1) the decedent was under an "irresistible impulse" rendering him or her unable to discern the nature or consequences of suicide, and (2) the "irresistible impulse" was

174. *See* White v. Lawrence, 975 S.W.2d 525, 530 (Tenn. 1998).

175. The Mississippi Supreme Court has limited this to wrongful death actions, not medical malpractice. *See* Truddle v. Baptist Mem'l Hosp.-Desoto, Inc., 150 So. 3d 692, 696 (Miss. 2014).

176. Mississippi *ex rel* Richardson v. Edgeworth, 214 So. 2d 579, 585 (Miss. 1968) ("[T]he presumption that a person will not destroy himself by suicide is rebuttable. . . . [and] the presumption against suicide does not exist where it appears that decedent was insane."); RESTATEMENT (SECOND) OF TORTS § 455 (1977).

177. RESTATEMENT (SECOND) OF TORTS § 455 (1977).

178. District of Columbia v. Peters, 527 A.2d 1269, 1276 (D.C. 1987).

179. *Id.* (quoting Orcutt v. Spokane Cnty., 364 P.2d 1102, 1104-05 (Wash. 1961) (en banc)).

180. 150 So. 3d 692, 696 (Miss. 2014).

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proximately caused by the defendant's intentional conduct.[181] Under the "irresistible impulse" test, ordinary negligence will not suffice for liability to attach; the act must be intentional.[182]

Foreseeability is the key point courts should focus on when dealing with the issue of liability for suicidal patients. The unyielding, harsh rule which holds that suicide is a superseding act under all situations cannot be retained. In some situations, the act of suicide is due to different diseases[183] and without exceptions, the courts would be punishing individuals for actions over which they have little, if any, control. The "irresistible impulse" exception is needed and should be implemented nation-wide. The application of this test, in the context used by the Mississippi Supreme Court, should be the norm. In this context, an individual should not be liable for another's death due to a negligent act. Liability for another's suicide should be limited to those instances where the defendant acted with the intent to harm his patient and the patient later committed suicide as a result.

In regard to medical care, it is important to determine what constitutes an intentional act. Individuals within the health care field should be held to a higher standard. With this in mind, an "intentional act" in the context of a health care professional should be different than for a lay individual. In the assessment and treatment of an individual in traditional psychiatry or telepsychiatry, the health care professional needs to be aware of the possibility that the patient is experiencing suicidal ideations. If the mental health provider finds that there is a relative probability[184] that an individual may cause harm to a third-party or to themselves, the mental health provider has a duty to take additional steps to prevent such harm from occurring. The inability or unwillingness of a mental health professional to take affirmative steps to prevent the patient from harming himself or others should suffice to allow liability to attach, even if the traditional foreseeability standard has not been met.

E. Recommendation

The discipline of psychiatry relies on the observation of human behavior and human interaction.[185] The use of telepsychiatry might

181. *Id.*

182. *See id.*

183. These diseases include, but are not limited to, depression, alcoholism, and schizophrenia.

184. While there is no discernible way to test for relative probability, the mental health professional must have more than an idea that harm will occur.

185. Savita Malhotra et al., *Telepsychiatry: Promise, Potential, and Challenges*, 55 INDIAN J.

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create a false sense of human interaction which could ultimately hinder the practitioner-patient relationship.[186] This relationship is central to the assessment and treatment of all patients. A strong practitioner-patient relationship is absolutely essential when treating unstable patients using I-CBT. When using this type of therapy, the involvement of highly structured lessons and homework assignments, coupled with regular practitioner-patient communication, is of the utmost importance.[187]

Individuals in rural areas often have substandard access to mental health practitioners. While the need for telepsychiatry is unquestionable, certain policies and regulations need to be put in place to protect the patients before the practice becomes more widespread and pervasive. These policies and recommendations need to start with the informed consent process.

1. Informed Consent

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body."[188] This is the basic principle of informed consent. We, as a society, find that patient autonomy is paramount and that autonomous decisions about an individual's health care need to be afforded the most stringent protections. The goal of informed consent is to allow the patient to make an informed decision about their medical treatment.[189] Therefore, informed consent should consist of all material facts. But, what if all material facts are unknown?

Recent developments have allowed telepsychiatry to grow rapidly. Due to this rapid growth, state and federal legislatures have not been able to keep pace. With very few laws and regulations set in place,[190] mental health care professionals are using a variety of different methods in conducting the informed consent process.[191] Currently, six states have general informed consent laws for the practice of telemedicine.[192] Six

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PSYCHIATRY 3, 6 (2013).

186. *Id.*

187. *Id.*

188. Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).

189. CLINICAL VIDEOCONFERENCING IN TELEHEALTH: PROGRAM DEVELOPMENT AND PRACTICE 134 (Peter W. Tuerk & Peter Shore eds., 2015) [hereinafter Tuerk & Shore].

190. *See* Jennifer M. Little, *Into the Future: The Statutory Implications of North Carolina's Telepsychiatry Program*, 93 N.C. L. REV. 864, 878-84 (2015); *see also* CAL. BUS. & PROF. CODE § 2290.5(c) (West 2001).

191. Tuerk & Shore, *supra* note 190, at 135.

192. Little, *supra* note 191, at 882. These states are Arizona, California, Kentucky, Maryland, Missouri, and Texas.

other states have implemented statutes that require that specific information be provided.[193] This information ranges from potential risks and benefits of telemedicine to how the patient can access medical records.[194] While these informed consent laws will better protect patients, they are not without flaws. Primarily, these laws only direct mental health care providers to inform patients of certain issues pertaining to telepsychiatry. While the disclosure of specific information concerning telepsychiatry better informs the patient of the treatment they will receive, this could also infringe upon the treating physician's judgment and affect the patient's care.[195] While the specific information approach is well founded, this approach needs to be expanded.

In addition to the information a practitioner is required to disclose under traditional informed consent principles, additional information must be provided for an individual to fully consent because telepsychiatry is highly technical and a relatively novel practice. The informed consent process must be continually on-going and consistent throughout the course of treatment.

First, the mental health care professional should disclose all information that is traditionally required for informed consent. Additionally, the patient should be aware of the following factors: (1) all potential risks and benefits of telepsychiatry;[196] (2) safeguards to protect against any risks associated with telepsychiaty; (3) privacy and confidentiality; (4) how this treatment can differ from traditional therapy; (5) legal rights, in the case of adverse events; (6) the structure of the treatment; (7) safety protocols; (8) termination procedures; (9) potential risks concerning electronic transmission, such as distortions, delays, and the possibility of unauthorized interception of medical data transmission;[197]and (10) any other information that a reasonably prudent mental health professional would disclose under similar circumstances.[198] These ten factors should be discussed by the mental health professional with the patient so that they can ask questions or relate any concerns to the practitioner. Furthermore, these ten factors should also be presented to the patient in writing so that the practitioner has a clear record of the information which informed the patient's

193. *Id.* These states are Alabama, Colorado, Louisiana, Mississippi, Nebraska, and Oklahoma.

194. *Id.* at 882-83.

195. *Id.* at 884, n. 155.

196. This includes the possible "experimental" nature of telepsychiatry.

197. Kip Poe, *Telemedicine Liability: Texas and Other States Delve Into the Uncertainties of Health Care Delivery Via Advanced Communications Technology*, 20 REV. LITIG. 681, 687 (2001).

198. Tuerk & Shore, *supra* note 190, at 135.

consent and so that the patient can easily refer back to this information at a later date.

This proposed rule will afford the patient all the protection that is necessary to make a fully informed decision. This rule will also allow the mental health professional to use her professional judgment in informing the patient.

2. Standard of Care

Another pressing issue in the implementation of telepsychiatry is determining the appropriate standard of care. Currently, the extent of potential liability for practicing telepsychiatry across state lines is uncertain.[199] Traditionally, states dictate policy regarding the health and safety of their citizens.[200] This police power allows an individual state to implement regulations and laws which are uniquely tailored to meet the particular health and safety needs of its own citizens.[201]

Predictably, one state's exercise of its police powers frequently puts its laws in conflict with the tort laws of other states. Historically, the standard of care for medical professionals was geographically limited; this limitation was expressed through the locality rule.[202] The locality rule was based on the rationale that there was a disparity in medical knowledge and treatment between large urban areas and rural areas.[203] But the advancement of modern technology, the internet, and modern medicine has made the locality rule mostly obsolete.[204]

The differences and changes in the field of medicine occur temporally (i.e., because of changes in technology and access to

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199. Caryl, *supra* note 117, at 192.

200. *Id.* This power is reserved to the states through the Tenth Amendment. U.S. CONST. amend. X. ("The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.").

201. Lambert v. Yellowley, 272 U.S. 581, 596 (1926) ("[T]here is no right to practice medicine which is not subordinate to the police power of the States."); Crane v. Johnson, 242 U.S. 339 (1917); Collins v. Texas, 223 U.S. 288 (1912); Dent v. West Virginia, 129 U.S. 114 (1889); La. State Bd. of Med. Exam'rs v. Fife, 111 So. 58 (La. 1926), aff'd 274 U.S. 720 (1927); Ross D. Silverman, *Regulating Medical Practice in the Cyber Age: Issues and Challenges For State Medical Boards*, 26 AM. J.L. & MED. 255, 256 (2000).

202. *See* Kuszler, *supra* note 121, at 315 ("Under this standard, the physician or other provider must abide by the standard of care in the local geographic area.").

203. Orcutt v. Miller, 595 P.2d 1191, 1194 (Nev. 1979).

204. *See, e.g.*, Kronke v. Danielson, 499 P.2d 156 (Ariz. 1972); Blair v. Eblen, 461 S.W.2d 370 (Ky. 1970); Shilkret v. Annapolis Emergency Hosp. Ass'n, 349 A.2d 245 (Md. 1975); Naccarato v. Grob, 180 N.W.2d 788 (Mich. 1970); Belk v. Schweizer, 149 S.E.2d 565 (N.C. 1966); Pederson v. Dumouchel, 431 P.2d 973 (Wash. 1967); Shier v. Freedman, 206 N.W.2d 166 (Wis. 1973).

information over time), not geographically.[205] At a touch of a button, medical students and medical professionals have access to the latest literature, videos on the latest procedures, and the like.[206] The adoption of a national standard is a must for telepsychiatry to prevail. The resources that are now readily available to medical professionals make it clear that the obstacles which once prevented the easy exchange of medical knowledge and techniques (and thus supported the locality rule) have been toppled. A psychiatrist in rural Montana now has access to the exact same information as a psychiatrist in New York City.

Traditionally, the standard of care for medical professionals can be phrased as the degree of care which a reasonably prudent medical professional would exercise under the same or similar circumstances.[207] In medicine, psychiatry is considered a specialty.[208] The fact that psychiatry is considered a specialty heightens the standard of care, requiring that the degree of care is not that of a reasonably prudent physician, but that of a reasonably prudent psychiatrist under similar circumstances.[209]

As to practitioners of telepsychiatry, the standard of care should be even more demanding than that applicable to psychiatrists generally. The practice of telepsychiatry should be considered a sub-specialty of psychiatry. The differences between traditional psychiatry and telepsychiatry are too great to allow for the same standard of care. Practitioners of telepsychiatry have all the skills of a traditional psychiatrist, but more should be required of them. As noted above, the lack of face-to-face contact can create many issues. While some of these issues can be easily resolved during a face-to-face therapeutic session, an individual practicing telepsychiatry will need to take additional precautions or have an additional individual present. The differences between traditional psychiatry and telepsychiatry warrant a different standard of care.

3. Miscellaneous Issues

When traditional therapy is conducted, the mental health professional has the ability to recognize different non-verbal cues and make a determination on whether or not the patient will act on their

205. Hall v. Hilbun, 466 So. 2d 856, 870 (Miss. 1985).
206. *Id.*
207. Morrison v. MacNamara, 407 A.2d 555, 560 (D.C. 1979).
208. *See* Richardson v. Perales, 402 U.S. 389, 404 (1971).
209. *See* Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 345 (1976).

impulses and attempt to commit suicide. The traditional mental health professional is better equipped to handle these situations by contacting local police departments or other medical practitioners if she feels the patient needs to be committed to a hospital due to risk that the patient will harm himself or others. This might not be the case for telepsychiatry. Because of the need for mental health practitioners in rural areas, this deficiency must be weighed against the benefits of telepsychiatry. The principle of non-maleficence is instilled in all medical professionals. But the issue that arises is whether the obligation to do no harm is more stringent than the obligation to help.[210]

The only discernable way to prevent this harm is by requiring that some sort of medical professional be present with the patient during any treatment sessions. These medical professionals should have some experience dealing with mental health issues.[211] Additionally, these medical health professionals should be familiar with local law enforcement and emergency services, in case of adverse events. The treating mental health professional should also contact local law enforcement and hospitals and emergency services about treatment being conducted in the area.[212]

Finally, the treating physician and the patient should establish and implement an emergency plan.[213] First, the mental health professional should try to convince the patient to have a family member or a close friend nearby during treatment sessions.[214] Additionally, as stated above, local law enforcement agencies should be notified. During the general notification, the treating medical professional should inform law enforcement of the current situation, the condition the patient is or could be in and the impact of the patient's condition on the interaction with law enforcement, and information on mental health follow-up, resources, and support for patients.[215] Next, the practitioner should have a frank discussion with the patient. The patient needs to be aware that there are plans set in place to prevent any harm to the patient or anyone else. In

210. Raanan Gillon, *"Primum non Nocere" and the Principle of Non-Maleficence*, 291 BRIT. MED. J. 130, 130 (1985).

211. Individuals without previous mental health experience should be trained and shadow other professionals during assessments.

212. The only concern is the potential HIPAA violations and privacy. These concerns could be alleviated so long as the treating mental health professional does not divulge any personal identifiable information to individuals whom should be notified.

213. Jay H. Shore et al., *supra* note 15, at 200, tbl. 1 (sample emergency guidelines for telepsychiatry).

214. *See id.* at 204 (involving family members can be extremely helpful).

215. *Id.* at 203-04.

this discussion, the patient must be made fully aware of the emergency plan that has been established. The mental health professional should also explain the reasoning for the notifications to the law enforcement agency and the hospitals. Last, this emergency plan should be discussed with any party that might be affected by the emergency plan.[216]

V. CONCLUSION

Mental illness affects a significant number of individuals in both urban and rural settings alike. Suicide is becoming more prevalent, especially in rural areas in America. This is mainly due the issue of accessibility. The rural community is at a substantial disadvantage when it comes to accessibility. Telepsychiatry is mostly aimed at solving this disadvantage. Telepsychiatry is unquestionably needed. But, without proper legal and ethical consideration, it is bound to have many issues.

In the context of medical malpractice, it is clear the law needs to evolve. Individuals with mental illnesses need to be afforded more protection than what they are currently given. First, when a mental health professional is implementing telepsychiatry, the patient must be fully informed. This includes the experimental nature of telepsychiatry along with all associated risks—even if all the risks are unknown. Secondly, the duty that a practitioner owes to a patient when practicing telepsychiatry should be assessed by a national standard of care. Technological advancements have eroded all barriers to the collection of knowledge. The easy access to the latest research and theories further shows that the "locality" rule is outmoded; the only logical step is to implement a national standard.

Legally, there is not a difference between traditional, face-to-face therapy, and telepsychiatry. This also needs to be addressed. The standard of care should be that of a specialist. Mental health professionals who use telepsychiatry should be held to the standard of a prudent mental health professional who is using telepsychiatry.

Finally, legislatures must implement laws and regulations setting up emergency plans for individuals who are receiving treatment. This is a protective measure that is not extensive but is capable of preventing many issues. Additionally, a mental health professional should always be present with an individual receiving treatment through telepsychiatry. These individuals should have experience dealing with mental illness or should have training. Finally, local first responders should be notified

216. Such parties may include hospitals, law enforcement, family members who might be present, and the medical professional present during the therapy sessions.

that there is an individual who is receiving treatment for suicidal ideations, and should be given the patient's condition, information on the impact that interaction with first responders could have on the patient, and information on mental health follow-up, resources and support for this individual.

Telepsychiatry is needed in rural America. It is a great tool that should be used. With these recommendations, many issues concerning medical malpractice in the context of telepsychiatry will be minimized if not completely resolved.