

## Risk assessment in a climate of litigation

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There has been a sea change in public attitudes toward the use of litigation in medicine over recent years. Mental health professionals are beginning to add an additional factor to their risk calculations when managing difficult patients: the assessment of risk (of a civil action) to *themselves* in the event of an untoward incident. This development must be recognised and anticipated if we are to assess fully the potential benefits, and the costs, of closer surveillance of vulnerable patients in the community.

In this paper I shall argue that recent guidelines concerning the care of mentally ill people will raise public expectations about the care of psychiatric patients and, in the event of a civil action, will assist a court in deciding whether care in the community has fallen short of an acceptable standard. While quality of care for those at greatest risk is bound to improve as a result of new guidelines, I will examine the prospects of an increase of defensive practice in community care and how this might impact adversely upon patients. In particular, we shall consider the threat of a new form of institutionalisation, where patients become entangled in webs of overcautious surveillance by mental health professionals and in walls of paper emanating from the new mental health bureaucracy.

Psychiatrists owe a duty of care towards their patients. That duty was spelt out most clearly in 1925 when a judge considered the case of a doctor accused of being under the influence of alcohol during the course of his duties. The court ruled that if a person advances himself as possessing special skill and knowledge, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relationship was considered to be necessary. The law requires a fair and reasonable standard of care and competence. This definition embraces the two main components of duty of care: adequate *knowledge* of the disease and appropriate treatments, and *due care* in the

application of that knowledge in the interests of the patient.

In psychiatry, and especially in 'community' psychiatry, the courts must wrestle with the problem of defining adequate knowledge and establishing a standard of reasonableness in the application of that knowledge in patient care. But what is adequate in terms of standards of knowledge and reasonable behaviour in community care? The benchmark was defined in *Bolam v. Friern Hospital* ([1957] 2 All ER 118; 1 WLR 582): "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art". This works well for relatively simple issues, such as whether one should be intoxicated while carrying out one's duties or whether a doctor should examine the fundi before carrying out a lumbar puncture. But in risk assessment, and especially with respect to defining reasonable standards of care in community settings, it is much more difficult to discern the consistent views of a "responsible body of medical men". Given the divergence of opinion within the profession regarding resource and policy matters in community care, neither a plaintiff alleging breach of duty of care, nor a defendant defending their clinical decisions, would have difficulty identifying expert witnesses who might support their particular view of the world. The extent to which such experts represent the views of "a responsible body of medical men" tests the judgements of the courts more than just a little; judges do not relish a parade of psychiatric expert witnesses competing to advance their professional credentials. The introduction of recent guidelines is therefore of considerable importance to patients alleging breach of duty of care, and for courts seeking standards against which to assess the reasonableness or otherwise of professional behaviour.

The most important policy initiative in recent years has been the introduction of the Care Programme Approach (Department of

Health, 1990). Subsequent guidelines, including those on the discharge of mentally ill patients from hospital and the introduction of supervision registers, will also be used by the courts in assessing liability.

Guidelines are relevant to the notion of duty of care in three domains. Firstly, they *clarify standards of reasonable care* in community care settings. It should be conceded that these policy initiatives have been expressed in the form of guidelines rather than treatment protocols. There can be little doubt, however, that courts will use these documents to guide their judgements as they are intended to guide the judgements and the behaviour of professionals. It would be advisable, therefore, for mental health professionals to treat verbal clarifications of these guidelines with great caution, whatever the source. It is the words written down which will be dissected by the courts rather than verbal clarifications of their intended meaning given from the conference podium. These guidelines effectively contain baseline service specifications and, in the absence of a consensus statement from a "responsible body of medical men skilled in that particular art" dissociating itself from them, they will be viewed as representing the standard for good practice. So patients treated by the psychiatric services must be entered into an explicit programme of care, be allocated a keyworker, and they must receive the quality and complexity of service appropriate to their assessed level of need. The highest standards of documentation and interprofessional communication are called for in these guidelines and will be required by a court considering a civil action.

Secondly, recent guidelines *potentially extend the boundaries of duty of care*. They do so only potentially because the boundaries of duty of care are not well defined and these matters will be decided by a court on a case-by-case basis. This view is summarised in the judge's dictum that the "categories of negligence are never closed". It is impossible, therefore, to compile a list of negligent acts and, in a rapidly changing world, it is not desirable that we should attempt to do so. The Secretary of State could therefore state that the introduction of supervision registers imposes "no new ethical or legal obligations" upon psychiatrists (Bottomley, 1994). Nevertheless, these guidelines will clarify several important issues when a court comes to consider a case of potential negligence. For example, they clearly extend the duty of care of mental health

professionals beyond the boundaries of the mental hospitals. It is no longer possible to take a relaxed view of one's duty of care toward a patient once they have been discharged safely into the hands of their general practitioner. If they are in the Care Programme Approach, that duty of care follows the patient into their community setting. In addition, guidelines make it clear that duty of care extends across professional boundaries. The consultant psychiatrist has traditionally felt a unique weight of responsibility for the safety and care of his/her patients, regardless of the involvement of other professional groups. This is probably not justified, as the Nodder Report (Department of Health and Social Security, 1980) concluded there is "no basis in law for the commonly expressed idea that a consultant may be held responsible for negligence on the part of others simply because he is the 'responsible medical officer'; or that, though personally blameless, he may be held accountable after the style of a military commander. A multidisciplinary team has no 'commander' in this sense." Onyett (1995) noted that there has been no subsequent body of case law to alter this conclusion substantially. Recent guidelines, however, add further weight to the view that key-workers have their own specific responsibilities for risk assessment, interdisciplinary communication, and for the highest standards of documentation. Regardless of interprofessional differences over respective roles and responsibilities in patient care, guidelines define the duties and responsibilities of the key-worker and carry important implications for the level of training required. There are also implications for the standards of training to be specified by purchasers.

The guidance accompanying the introduction of supervision registers also *extends duty of care beyond the patient's consent*. Traditionally the patient has been able to discharge him or herself from care unless detained under the Mental Health Act. That may or may not have been desirable, but it has been deemed an important civil right. Since the introduction of supervision registers, it is clear that mental health professionals are responsible for taking all reasonable steps to remain in contact with a patient who has been judged to be at risk in certain "foreseeable" circumstances, regardless of their consent. This duty extends until the patient becomes detainable or until the risk is no longer present. Unfortunately, given that the best predictor

of the future is the past, it is difficult to know how long the duty to supervise should extend, given that a particular risk factor will always remain in the patient's history. It is almost certain that this matter will be tested in court in the near future.

Thirdly, and finally, recent guidelines *create a climate of expectation* regarding standards of care and the obligations of mental health professionals in protecting the public from untoward incidents. In addition, the phenomenon of 'hindsight bias', which emerges during inquiries, further heightens expectations that untoward incidents can and should be avoided. It is likely that civil courts will reflect public concern in ruling upon liability. It is also probable in my view that advocacy groups will seek to use the new climate of litigation to secure better resourcing for patients by taking purchasers (and providers) to court. One or two expensive and high profile cases, testing the rights of patients and carers to reasonable standards of care defined in recent guidelines, will potentially have a major impact upon the resourcing of mental health care and increase targeting on the most vulnerable. This would prove a splendid development for patients (and professionals) in the longer term, but mental health professionals meanwhile will be caught in the crossfire.

The prospects of practising community psychiatry within an increasingly litigious atmosphere raises a number of important issues. The first is the likelihood of an increase in defensive practice. This will result in mental health professionals adopting a lower threshold for restrictive supervision and erring on the side of caution in risk assessment. Few could disagree with the overarching principle that resources must be targeted upon those with greatest need. Recent cases where supervision has clearly fallen well short of acceptable standards fully justify the introduction of the Care Programme Approach and additional measures to ensure the protection of particularly vulnerable individuals (Tyrer & Kennedy, 1995). The danger is that, given the low predictive validity of risk factors in relation to individual patients, large numbers may be drawn into supervision programmes having a custodial and coercive therapeutic focus. Tyrer *et al* (1995) reported the increased use of in-patient facilities following the introduction of key-workers in a community-orientated service. For many patients this represents an improved and more appropriate treatment programme. Many patients require intensive care, perhaps over long periods of

time. But there is a significant risk that mental health professionals will resort to in-patient care, or to over-restrictive styles of therapeutic care, because of risks not to their patient but to *themselves* should something go wrong. There is a danger that progress over recent decades in emphasising the individuality of patients and affirming their rights (and responsibilities) within a therapeutic relationship could be compromised by early resort to unnecessary in-patient supervision and coercive models of care.

The emphasis upon the rights of patients may well have gone too far and recent guidelines introduce an important correction. To repeat, we require a balance of facilities with sufficient in-patient beds, including for those requiring longer term care. But we should guard against the pendulum swinging too far, and too quickly, in the other direction. The Department of Health must be supported in resisting a "back to the asylum" (La Fond & Durham, 1992) mentality in the wake of recent incidents, and we must attempt to maintain a balance in risk assessment which defends against identifying large numbers of false positives for restrictive community supervision. If that is to be the case, key-workers must be offered every support and training in their almost impossible task. The risks of defensive practice should form an explicit component of training.

The prospect of an increase in defensive practice promises to recapitulate some of the excesses of institutional care in community treatment settings. The lessons of the 'three hospitals study' (Wing & Brown, 1970), emphasising the importance of humane and personalised treatment of our patients, are as relevant in the 'community' as in the old-style institutionalised setting. Key-workers and consultant psychiatrists face a unique challenge in attempting to balance the therapeutic needs of their patients against the risks of personal criticism in the present climate of public anxiety about community care.

There is a further danger of the frightening growth in bureaucracy and paperwork following the introduction of complex tiers of care programmes and convoluted flow diagrams governing the supervision process. Time which might previously have been expended upon therapeutic activities is being diverted to form-filling and attending reviews which may have the precision and atmosphere of a full mental health review tribunal. This threatens a new form of institutionalisation, located in the community. Patients will be

institutionalised within walls of paper unless local policy-makers take steps to simplify procedures as far as the guidelines will allow, and to recognise explicitly that some measure of risk-taking is essential to safeguard therapeutic work with patients.

So what is to be done if we are to avoid excessive defensive practice in community psychiatry? Essentially we must recognise that risk-taking is at the heart of community care and that inevitably there will be casualties. We must resist the temptation, under the influence of hindsight bias, to suggest that procedural tightening will eliminate all risk and ensure public safety. We could eliminate alcohol misuse by banning alcohol, and road traffic casualties by banishing cars from the roads. Similarly, adverse events in the community could be eliminated altogether by locking up everybody with a mental disorder. But in the interests of humane patient care we must strike a balance between the number of false negatives and false positives in coercive supervision. As the number of false negatives is reduced, inevitably the number of false positives increases dramatically.

Finally, I have called for much improved training of key-workers, which should be based upon a modularised curriculum and

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applicable to all professional groups. Lessons in risk management must be balanced by the dangers of over-coercive care and its adverse effects upon many psychiatric disorders. Training in risk assessment should include a recognition of the positive role of risk-taking in the optimum therapeutic care of patients within a basic framework of acceptable practice. The potentially noxious effects of fear on the part of mental health professionals can only be countered if the realities of defensive practice are recognised and understood. Properly challenged, our fears about the introduction of supervision registers may yet result in positive steps forward in community care.

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