Presented by HPSO and CNA

Counselors Medical Malpractice Case Study with Risk Management Strategies

Case Study: Failure to protect the client from harming himself, failure take aggressive actions and warn the client's family and/or authorities about a client's suicidal thoughts, failure to maintain appropriate boundaries

Indemnity Payment: Greater than $45,000
Legal Expenses: Less than $25,000
Licensing Protection Defense Cost: Greater than $3,000

Medical malpractice claims can be asserted against any healthcare provider, including counselors. In fact, over $14 million was paid in indemnity and expenses for malpractice claims involving counselors, according to the most recent CNA HealthPro 10-year study.*

This case study involves a counselor working in an adult intensive out-patient therapy program.

Summary

(Monetary amounts represent only the payments made on behalf of the insured counselor.)

Our insured counselor (defendant) was working in adult intensive out-patient therapy program that treated clients with dual diagnoses of mental health disorders and substance abuse. She had Masters of Education degree in Counseling, was a licensed mental health counselor and certified as an addiction professional with 10-years of experience working with clients with dual diagnoses and chemical dependency. Our counsel felt she was called to work with substance abusing adult because of own her personal battle with alcoholism and depression. Due to her past alcohol dependency, for the last 12 years she regularly attended Alcoholics Anonymous (AA) meetings. Many of her prior clients from the adult intensive out-patient therapy program would also attend the same AA meetings and she would socially speak with them, but she was never in charge or worked in a counseling capacity during the meetings.

The client was a single, 40 year-old successful trauma surgeon. He had a long history of abusing alcohol, which began in his teenage years. His wish after college was to join the military, but due to medical reasons, he was unable. His inability to be in the military devastated him as this had been a lifelong dream. His parents pressured him to attend medical school to become a physician and while in medical school he became engaged. After graduating medical school and accepting a job in his fiancée's home town, she broke off their engagement. The breakup was very difficult for the client as he had moved several states away from his family and did not have a good support system. He began drinking heavily after the breakup to combat his loneliness which began his addiction to alcohol.

A year later, the client had been on a drinking binge when he texted a fellow colleague/business partner stating that he was going to kill himself. As a result, the police were called to the client's home and he was taken to emergency department to be evaluated. He was found to be severely depressed and had a blood alcohol level of over 300 ml/dl. He was involuntarily admitted into a behavioral health unit due to being deemed a risk to himself and others. After spending one-week in the involuntarily unit, the client was required to attend an adult intensive out-patient therapy program for two weeks as part of his treatment plan. The treatment plan also required that once the out-patient program was successfully completed, the client was expected to abstain from drinking any alcohol, get a sponsor and attend an AA meeting on a weekly basis.

Our insured counselor was leading a group meeting in the adult intensive out-patient therapy program when she met the client. During her deposition, she stated that he was a loner and did not want anyone to know that he was a physician, so he barely spoke during any of the group therapy sessions. He attended group sessions led by our insured counselor as well as three other counselors and successfully attended the requirements of his treatment plan. The client made good progress, but kept to himself during most of the sessions as he had a hard time opening up to people.

As part of his treatment plan, the client began attending AA meetings which happened to be the same one our insured counselor attended. After the meetings, our insured counselor and several of the meeting attendees made a habit of going to dinner and at some point the client began coming along. Eventually, this evolved to only the insured counselor and client going to dinner together. The client confided in the insured counselor by telling her that he was supporting his parents due to their overwhelming debt and was currently living in squalor. He resented the fact that he had to help pay off his dad's credit cards, but loved his family and felt obligated to help them. During one of the dinners, the two traded telephone numbers and began calling and texting each other. Initially it was strictly platonic and friendly, but at some point it became flirtatious. The two would talk and exchange numerous texts several times a day and during the week they would meet for breakfast and lunch. The relationship eventually became physical and at one point the client told the insured counselor he loved her.

The physical relationship went on for several months, despite the insured counselor being married with two children. The client continued with his sobriety initially, but at some time during their relationship he began drinking. He sank into depression and without consulting his physician and despite pleas from the insured counselor, stopped taking his antidepressant. Often, he would send text messages asking the insured counselor vague questions and statements about suicide. These messages were worrisome, but because he was vague about his comments she didn't feel she could or should contact the police. Several times after he would text her stating he was depressed or considering suicide, she would go to his house to talk with him until he seemed better.

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His drinking escalated and his depression worsened when the insured counselor told him she was going to spend the holidays with her husband and children instead of traveling with him to his family several states away. On her way out of town she tried to call him, but he would not answer the phone or return her text messages, despite her pleas. The counselor contacted his fellow colleague/business partner requesting that he check on the client as she was concerned that something may have happened. When the fellow colleague/business partner arrived at the client's house the client had shot himself and had been dead for several hours.

Licensing Protection Comments

A board compliant was made by the client's father (plaintiff) after the client's suicide. The compliant focused around the counselor committing an act upon a client which constitutes sexual misconduct as defined by her state board. Upon investigation, the state board found that the treating counselor's conduct was unprofessional and included boundary violations. The licensing board sent a letter of reprimand and mandated disciplinary actions against the counselor including relinquishment of her license to practice mental health counseling. The insured counselor voluntarily relinquished her license to avoid further administrative actions, attorney's fees and costs related to the prosecution or defense in the matter.

Risk Management Comments

Soon after the board action was made against the treating counselor, the father filed a malpractice claim against our insured counselor. In the malpractice claim, the plaintiff's experts alleged that the treating counselor was negligent in the following aspects:

1. The counselor owed a duty to the client to not abuse her position of authority by engaging in an inappropriate intimate or sexual relationship with him. The insured counselor breached this duty resulting in the client's suicide and causing damage and loss of a relationship with the survivors of the client.
2. The counselor committed medical negligence by breaching her duties to abide by the rules of her profession (according to her state statue) when she engaged in, an inappropriate relationship with the insured counselor. As a result of this negligence, the client committed suicide.
3. The counselor had a duty to protect the client and warn authorities about the client's comments concerning suicide and his increased depression.

The plaintiff's attorney subpoenaed the insured counselors cellular phone records, texted messages, emails and written letters to the client. This request was to prove that the insured counselor was in an inappropriate relationship, had knowledge that the client was contemplating suicide and was still providing counseling services even after his discharge from the adult intensive out-patient therapy program.

Resolution

The possibility of a defense verdict was deemed to be 15 percent.

Experts assessed the potential exposure/claim value of the case for all defendants as being between $50,000 and $75,000 with our insured counselor identified as having the majority of the liability.

The counselor understood the charges against her would be difficult to defend based on the board complaint and her voluntarily relinquishment of her license to practice mental health counseling. She was working on rebuilding her marriage and requested the malpractice claim be resolved as soon as possible.

The defense experts felt that the insured counselor had a duty to protect the client from harm and should have acted on the vague suicide comments made by the client. They reported that if the insured counselor counselor had been more proactive in her duty to protect, the outcome might not have ended in the client's suicide.

Risk Management Recommendations

- ***Understand all laws or regulations that govern client interactions.*** Ignorance of the law, employer policy or professional ethics does not absolve the counselor of the responsibility to act within established clinical, ethical and regulatory guidelines.
- ***At lease annually, review the American Counselor Association Code of Ethics, and understand the professional obligations to uphold the code.***
- ***Practice in accordance with the standard of care, limits of one's license/certification, and all regulations and ethical guidelines.*** Seek peer review and /or clinical supervision as needed, and actively participate in continuing education programs relating to evolving ethical issues.
- ***Prohibit and prevent any sexual activity with a current client.*** The *ACA Code of Ethics* clearly states that such relationships are never ethically appropriate. Client consent to sexual relations or romantic relationships /activities of any kind does not waive the counselor's responsibility to prevent any such activity from occurring. The counselor will be deemed solely responsible and liable for any sexual or romantic relationship with a client, a client's significant other and/or a client's family member.
- ***Manage transference and/ or counter-transference with appropriate clinical techniques, obtaining clinical supervision and/or consultation as needed.*** If the transference/countertransference cannot be successfully managed, the counselor should cease treatment, explaining the reasons for termination to the client and referring the client to another professional. Consult with the ACA and/or a healthcare attorney for additional assistance, if needed.
- ***Terminating the client does not cancel the prohibition against a sexual romantic relationship.*** Cease written and verbal contact with the client upon termination and document any client communication attempts.
- ***Do not engage in sexual activity or a romantic relationship with a prior or current client's significant other or family member.*** The *ACA Code of Ethics*, states that such a relationship should not be entertained until at least five years from the last treatment date. Again, simply terminating treatment does not exempt the counselor from the responsibility for waiting the recommended period of time before considering a sexual/romantic relationship with a former client or anyone closely associated with the client. Even after the five-year waiting period has elapsed, consider whether such a relationship would be beneficial or potentially harmful to the client.
- ***Avoid multiple relationships with clients, their significant others and their family members.*** This may involve declining invitations to participate in social/personal/family activities with the client or others outside of the treatment setting. Document all such invitations in the client's clinical record, as well as the response given and consequent communication. Occasionally, participation in such events may be beneficial to the client; refer to the *ACA Code of Ethics* for guidance. If the decision is made to participate, document the potential benefit to the client, the clinical decision-making process and the client's response.

Guide to Sample Risk Management Plan

Risk Management is an integral part of a healthcare professional's standard business practice. Risk Management activities include identifying and evaluating risks, followed by implementing the most advantageous methods of reducing or eliminating these risks – a good Risk Management Plan will help you perform these steps quickly and easily!

Visit **www.hpso.com/risktemplate** to access the Risk Management Plan created by HPSO and CNA. We encourage you to use this as a guide to develop your own Risk Management Plan to meet the specific needs of your healthcare practice.

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*CNA HealthPro Understanding Counselor Liability Risks, CNA Insurance Company, March 2014. To read the complete study along with risk management recommendations, visit http://www.hpso.com/counselorclaimreport.

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