October's True or False Answers - Part 2

Avoiding Liability Bulletin - December 2019

NOTE*: In the** October 2019 issue ***of this Bulletin, I asked twenty-five questions regarding various areas of practice (and the law) that may be encountered by practitioners during the course of their careers. While the discussions below cannot address the law in every state and are primarily based upon California law, the reader should determine whether the law in their state of practice is consistent with the answers and content appearing below. (Fourteen of the questions were answered in the** November 2019 issue ***of this Bulletin.)

CONVICTION OF CRIME (Question 14 in the October 2019 Bulletin)

Most if not all licensing laws for mental health professionals contain provisions that allow licensing boards to revoke or suspend a license due to the fact that the licensee has been convicted of a crime, whether a felony or misdemeanor. The crime typically has to be substantially related to the qualifications, functions, or duties of the particular type of license held, but there need not be any evidence or proof of patient harm. A conviction of petty theft, for example, might indicate that the licensee has a problem with honesty and integrity – crucial characteristics regarding a licensee's fitness to safely work with the public. Recent legislation in California imposes some limitations on licensing boards in order to control the overzealous use of criminal convictions in order to discipline licensees.

PARTNERSHIPS (Question 16 in the October 2019 Bulletin)

There are several ways for licensed mental health practitioners to structure their practices. Many simply practice as sole proprietorships, while some form professional corporations or other entities that state law allows. Partnerships are another option, but state law typically prevents, for example, a licensee from forming a partnership and conducting business with an unlicensed person (perhaps one's spouse) or a licensee of a different profession. If a licensed marriage and family therapist or licensed professional clinical counselor formed a partnership with a physician (perhaps a psychiatrist) or a psychologist, the partnership, and thus the LMFT or LCPP, would be receiving money for the practice of medicine or psychology, which licensing boards would likely assert is both unlawful and illegal.

ADVERTISING (Question 18 in the October 2019 Bulletin)

Most if not all state laws applicable to licensed mental health professionals make it a crime for the practitioner to advertise in a manner that is false, fraudulent, misleading or deceptive. If such a law is violated, the licensing authority in the state can take disciplinary action against the licensee. Whether or not a particular advertisement violates the applicable state law is not always easy to determine, and licensing boards and licensees may each have reasonable arguments in support of

their position. It should be remembered that the omission of material information could properly be considered to be misleading and to constitute a deception of the consumer (these advertising statutes are consumer protection laws).

In question 18, I believe the better argument is that the advertisement is misleading and deceptive because of the failure to disclose that forty percent of the years of clinical experience in treating patients was gained as a pre-licensed person. The consumer may be looking for a “seasoned practitioner” and the reference to ten years of clinical experience in treating patients may give the consumer the impression that the practitioner has been a licensed practitioner for ten years. Why didn’t the practitioner disclose that 40% of the experience was gained as a student, intern, associate, or other pre-licensed status? In some cases, such a disclosure could be advantageous. First and foremost it is truthful, accurate, and complete. Secondly, the fact that the experience was gained under the supervision of a licensed clinician, perhaps of a different licensure and perhaps with an excellent reputation in the community, can be useful.

RECORDKEEPING (Questions 19 and 20 in the October 2019 Bulletin)

One aspect of recordkeeping that a licensed mental health practitioner may encounter is when prospective patients insist that minimal records be kept in order to protect their privacy. Under such a circumstance, the practitioner might want to explain how the laws of confidentiality and privilege protect patient privacy as well as the practitioner’s reasons for keeping more than minimal records. These reasons may be because of laws or regulations related to recordkeeping or the practitioner’s desire to deliver quality care and to document that care for purposes of continued treatment and for limiting the practitioner’s liability. If the prospective patient nevertheless insists that minimal records be kept, the practitioner may properly refuse to treat under such a circumstance.

There may be circumstances, however, where the practitioner will be agreeable to keep minimal records when the patient makes such a request. Of course, the practitioner will want to refer to state laws or regulations regarding recordkeeping to see if they would prevent the practitioner from complying with a patient’s reasonable request. California law provides that it is unprofessional conduct for the practitioner to fail “...to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services rendered.” This reasonable standard would seemingly allow for a decision with regard to keeping “minimal records” (whatever that term means) to be properly implemented. Finally, the agreement to keep minimal records should be understood by the practitioner and patient to be an agreement to keep minimal records consistent with applicable law.

REFUSAL TO TREAT PATIENT (Question 21 in the October 2019 Bulletin)

There are many reasons why a practitioner may refuse to treat a prospective patient. One of the best reasons to refuse to treat a patient is where the patient insists that the practitioner not contact

or communicate with any other health care practitioners or health facilities (current or past) about the patient's mental or physical health. This attempted limitation upon the statutory right of the practitioner (in California, and hopefully elsewhere) to break confidentiality by making disclosures to or receiving information from other health care practitioners or facilities for the purpose of diagnosis or treatment of the patient could expose the practitioner to liability. Practitioners need not accept such limitations upon their duty to provide competent care and need not subject themselves to possible claims of negligence or other wrongdoing.

DUAL OR MULTIPLE RELATIONSHIPS (Question 23 in the October 2019 Bulletin)

Dual or multiple relationships are neither unlawful nor unethical, and they need not be avoided. Professional association ethical standards have for a long time addressed this boundary issue, and they all make clear, in one way or another, that it is only those dual relationships that are reasonably likely to lead to exploitation or harm or to impair the practitioner's judgment, effectiveness, or objectivity that must or should be avoided. Some standards expressly state that dual or multiple relationships that would not reasonably be expected to cause impairment of judgment or lead to exploitation or harm are not unethical.

Other standards make clear that not all dual relationships are unethical and that some dual relationships cannot be avoided. Licensing boards typically use expert witnesses to opine on the appropriateness of a particular dual relationship, and they may have a tendency to brand many dual relationships as a violation of the licensing law provisions related to unprofessional conduct. Practitioners who find themselves in such a relationship should be familiar with their professional association's ethical standards regarding dual or multiple relationships, with any law or regulation that addresses the subject, and with the practitioner's duty once a problematic dual relationship arises.

***NOTE*: Next month, I will address question 17, 22, 24, and 25 from the October 2019 issue of this Bulletin/blog, which deal with termination and duty to patient, avoidance of involvement with litigation, and the question of when the psychotherapist-patient relationship begins.**