Duty to the Patient – When Does It Begin?

written by Richard Leslie | February 1, 2021

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NOTE: The articles below were first published on the CPH Insurance's website in September 2010. They appear below with minor changes. The topics addressed can be encountered unexpectedly and they can have significant impact on the practitioner's liability. Because state laws vary, often in fine nuance, practitioners must be aware of how and whether their state laws and regulations (and case law) address the legal issues raised below.

DUTY TO THE PATIENT – WHEN DOES IT BEGIN?

…Licensed mental health practitioners often discuss the issue and process of termination of treatment, including the question of when the termination becomes effective, but not as much discussion occurs with respect to the question of when the therapist-patient relationship begins. When I write about this topic I do have a bias in thinking about the consumer of mental health services as the "patient," and not as the "client." Lawyers have clients. Retail establishments have consumers. Practitioners who provide mental health services, or who seek to diagnose and treat mental or emotional conditions or disorders, do so, in my view, with patients. The psychotherapist-patient privilege is granted to patients, not clients. "Patient," for purposes of the privilege, may be defined, as in California, as a person who consults a psychotherapist or submits to an examination by a psychotherapist for the purpose of securing a diagnosis or preventive, palliative, or curative treatment of his or her mental or emotional condition. Thus, I discuss the duty to the *patient* below!

Some may think that the relationship with the patient begins when the first session begins, or perhaps when it ends. Others may peg the beginning of the relationship to when the patient pays for the first session. Others may argue that the relationship begins when there is an oral (or written) agreement to provide services at an agreed upon fee, or after the patient receives the therapist's disclosure or "informed consent" form. While this is a rather technical question and usually not of great significance, I am reminded of the situation where a therapist receives a telephone call from a prospective patient who was referred by a former patient of the therapist. The prospective patient tells the therapist that his wife has just informed him of her desire for a divorce, that he needs some help during this trying period of time, and that the therapist was highly recommended. The therapist tells him that there is an opening on Friday afternoon and that the fee is $125 per hour. The prospective patient makes an appointment for Friday, some four days later.

On Wednesday, before the scheduled session, the "prospective" patient calls in crisis – talking about his anger and hinting of possible violence aimed at his wife and her new companion. Perhaps the therapist has second thoughts about taking on such a difficult case and thinks about telling the "prospective"

patient" of the reluctance to proceed and the desire to make a referral to a therapist who deals with this kind of acute problem. However, the "prospective" patient insists upon seeing the therapist as soon as possible and offers to pay an additional fee for an "emergency" session. What is the duty, if any, of the therapist? Should the therapist take the position that the therapist-patient relationship has not legally begun and that the patient will have to look elsewhere for immediate assistance?

My view is that the therapist is under a duty to see the new patient, to assess the situation, and by doing this, to thereby commence "treatment" (hold a first session). Referral for appropriate reasons may soon be necessary and can be discussed with the patient. However, the failure to see the patient for the initial visit, for which an appointment was made (it might not be wise to make the patient wait until the appointment date and time, but that may be possible in some cases), could result in liability for the therapist – depending, of course, upon the facts and circumstances that ensue. An effort to refer the patient prior to the first session, under these facts, would be risky and might create a liability problem for the therapist in the event that the patient was to cause harm to himself or to his wife or her companion. Perhaps a clinical or legal consultation may be needed.

CHILD ABUSE – DOES A STATUTE OF LIMITATIONS EXIST?

I have written extensively about child abuse and child abuse reporting requirements in prior issues of this Bulletin. Those articles can be found in the Archives (Legal Resources) on this website under the category "Child Abuse." One area that I have not written about is the misunderstanding amongst some mandated reporters regarding the issue of an applicable "statute of limitations." Suppose that a nineteen year-old patient tells a therapist that she was molested by an uncle ten years earlier. Or, suppose that a seventeen year old patient tells his therapist that he was molested by his uncle seven years earlier. What are the reporting requirements and what role, if any, does a statute of limitations play with respect to reporting in each of these examples? As I have written here before, state laws vary, sometimes in fine nuance, so my remarks below are based upon California law.

In the first scenario, there is no duty to report child abuse because the nineteen year old is not a child, but rather, an adult. Generally, there is no duty in California to report child abuse when an adult patient tells the therapist of abuse that occurred when the patient was a child. There is an exception to this general rule, but that is a topic for another article. If a thirty year old patient reveals that she was sexually molested when she was thirteen, there is no duty to report. The patient, whether thirty or nineteen years of age, may choose to report the prior abuse if it is their desire. There may be an applicable statute of limitations that will prevent the perpetrator from being criminally prosecuted. The determination as to the existence of a statute of limitations affecting the prosecution, and the precise calculation thereof, is typically made by the District Attorney's office or other-titled local prosecutor. Statutes of limitations are sometimes tolled (the clock does not tick) during certain periods of time or under certain circumstances.

In the second scenario, the therapist must report child abuse because a child (the seventeen year old) was abused (I of course assume that the child's report to the therapist is credible and that reasonable suspicion exists). In California, and elsewhere, there is no statute of limitations applicable to the reporting of child abuse by a therapist. In other words, even if the abuse is old, and even if the criminal prosecution of the perpetrator were barred by an applicable statute of limitations (some states have lengthened their statutes of limitation by action of state legislatures), the child abuse reporting law likely requires a report to be made – provided that the information conveyed to the practitioner is about a *child*, and not an adult who was abused as a child. As to the statute of limitations that may apply to the criminal prosecution, and as stated above, that determination is typically made by the prosecuting authorities.

Are the laws in your state similar to what I have described here? You should not fail to make a child abuse report that is required by law. Similarly, you should not make a report when no report is required or authorized by law. To do so will likely constitute a violation of law for breach of confidentiality that can result in disciplinary action by the state licensing authority and monetary liability in a civil lawsuit by the patient.

CHILD ABUSE – REFUSAL TO TAKE A REPORT

… One problem that has arisen for mandated reporters of child abuse is the occasional refusal or failure (due to unavailability) of the local child protective services agency (or the police or sheriff) to take a telephone report of child abuse from the mandated reporter. This problem would typically occur in a state that requires both a telephone report and a written report. California is such a state, and practitioners there have been met with the problem of refusals or unavailability when they call to report the suspected abuse.

There are a few situations that can arise where there can be some ambiguity as to whether a report should or must be made. Licensed mental health practitioners want to protect themselves in these situations so that they can demonstrate that they did what the law required – reported by telephone *and* in writing. When child protective services representatives say that a report is not warranted and when they refuse to take the telephone report, or they advise that a written report should not be made, the mandated reporter is often confused as to what should be done. For example, perhaps a therapist is under the impression that a report must be made even though the abuse took place in another state, while the representative on the phone is under the mistaken impression that the report must be made with the other state.

More common than the above scenario is the situation where the reporting practitioner is unable to complete the call because the line is busy, because the practitioner is kept on hold for an inordinate period of time, or because the phone is answered with a recorded message. In California, the child abuse reporting law provides that if a mandated reporter is unable to submit an initial report by

telephone (after making reasonable efforts), he or she must immediately or as soon as practically possible, by fax or electronic transmission, make a one-time automated written report, and must also be available to respond to a telephone follow-up call from the agency where the report was filed. Under these circumstances, a written follow-up report would not be required.

Are you aware of a similar problem in your state? If practitioners are required to report, usually immediately or as soon as practically possible, it ought to be easy to do so!