Medical Malpractice: Coming Changes and Their Impact on Psychiatry

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In 2024, the American Law Institute revised its influential Restatement of the Law for medical malpractice. The most important change is an updated standard for determining when a clinician is negligent, which emphasizes the failure to provide reasonable care, replacing the traditional standard of customary care. Determinations of reasonable care can consider evidence from the medical literature and practice guidelines, even if they have not yet generally been adopted in ordinary practice, as well as contextual factors. Although not yet incorporated into law, the new standard underscores the importance of clinicians staying current with changes in evidence-based practice.

Psychiatric Services in Advance (doi: 10.1176/appi.ps.20250230)

Medical malpractice is a legal cause of action that occurs when a physician or other health care professional, through a negligent act or omission, is alleged to have deviated from accepted standards of professional care, thereby causing injury or death to a patient (1). Historically, the standard of care to which a health professional needed to conform to avoid being found negligent was what a similarly trained and experienced practitioner would do in similar circumstances, in the same or a similar locale (2). As technology, training, and communication allowed for more uniform access to medical knowledge and practices, however, the "locality rule" was rejected in favor of national standards of care.

Rules governing malpractice law, as with other areas of tort law, generally have been developed by the courts, although judicial decisions could always be modified by legislative action. One of the sources to which courts may look to help them frame such rules is the American Law Institute (ALI), a private, independent, nonprofit organization. Among other initiatives, the ALI publishes restatements of the law, which are extensive summaries of existing case law with proposed standards for adjudicating cases (3). Although the impact of ALI's restatements is persuasive and not controlling, they are frequently cited in judicial opinions and are often used to aid interpretation of the law and to provide a basis for legislation. In 2024, the ALI revised its proposed legal standards for assessing medical malpractice (4). Clinicians and forensic experts must understand and appreciate these changes and their potential effects on medical malpractice litigation in psychiatry. Our goal is to highlight some of the key changes in the revised standards.

THE STANDARD OF REASONABLE MEDICAL CARE

The previous edition of the ALI's Restatement of Torts, of which the medical malpractice restatement is a part, defined the standard of care as "the skill and knowledge normally possessed by members of [the relevant] profession" (5). In contrast, the new Restatement calls for the application of a "standard of reasonable medical care," which it characterizes as "the care, skill, and knowledge regarded as competent among similar medical providers in the same or similar circumstances" (4). In describing what may be relevant to determining whether a treatment decision was reasonable, the authors of the Restatement highlight the patient's medical condition, the state of medical knowledge and available treatment options, the resources available to the provider, differences in standards among different

HIGHLIGHTS

- A new set of proposed rules for judging medical malpractice from the American Law Institute will alter clinicians' responsibilities with regard to patient care.
- Rather than determining acceptable standards of care based on customary practice in the profession, the new approach asks whether the decisions made by the clinician were reasonable in light of current knowledge.
- Hence, the new rules underscore the importance of staying up to date on advances in research and authoritative practice guidelines.

groups of providers, and, interestingly, "any representations the provider made to the patient or public about the provider's level of care, skill, knowledge, experience, or scope of practice" (4). Although the change from the previous standard may appear to be subtle, its impact could be substantial.

The biggest change embedded in the new standard is a move away from primary reliance on "customary practice" and national, or even local, standards of care to reliance on a more evidence-based model. Given the well-known lag between the publication of definitive evidence of the value of a new treatment approach and its adoption by the medical profession—the gap is typically said to be 17 years (6)—the skill and knowledge possessed by one's colleagues may not reflect the most reasonable approach to care. Rather than looking to what other practitioners would do in a similar situation, the new standard will encourage judges and juries to consider existing research and published practice guidelines, among other sources, to determine what would be considered reasonable. But the legal finders of fact in a malpractice case will still need to judge whether other professionals would consider the care rendered to have been competent—typically with aid of expert testimony—in light of the available medical evidence.

For this new standard to take effect, it must be adopted by courts or legislatures in each state. Nonetheless, given the influence of ALI restatements in general, ultimate adoption should be anticipated, and practitioners will need to prepare for that eventuality.

APPLYING THE NEW STANDARD

Although the precise details of how the new reasonableness standard is applied will have to be worked out in the courts, the Restatement itself notes four situations in which what is reasonable may differ from what is customary in the profession. One such circumstance is when "prevailing professional practice may fall short of what medical professionals themselves regard as competent; in these circumstances, it should be no defense that many other providers render similarly deficient care" (4). When many psychiatrists, for example, fail to adopt evidence-based approaches to treatment, an appeal to customary practice will no longer constitute an adequate defense. The famous case of *Osheroff v. Chestnut Lodge* (7), though brought under the previous standard, illustrates this situation. Dr. Osheroff, who was severely depressed, was treated for months with psychoanalytically oriented psychotherapy, without effect, and allegedly was never offered psychopharmacological treatment despite extensive evidence of its efficacy. He sued his treaters, alleging inadequate care. After a favorable finding for the plaintiff in arbitration, the case was settled out of court. Regardless of whether exclusive use of psychotherapy in such a situation was a common practice at the time, the case is typically taken to show that clinicians who fail to conform to existing evidence regarding the treatment of patients' psychiatric disorders can be held liable for their care—an outcome that is likely to be more common under the new standard.

Two additional examples are closely related. In some cases, an established standard of treatment may not exist, perhaps because of unique or unusual features of the patient's symptoms. Or despite claims of an existing standard, the court may have difficulty ascertaining the content of the standard, which may occur when members of a profession hold strongly opposing views. In both cases, the finder of fact (often the jury, but sometimes the judge) will look instead to evidence of what would have constituted reasonable care in those situations, based on "what similar professionals—nationally—believe *would be* competent to do in the same or similar circumstances" (4). Exigent circumstances may also render existing standards moot, as occurred at the peak of the COVID-19 pandemic, when psychiatric units scrambled to provide care consistent with public health guidelines aimed at reducing the spread of the virus, and outpatient psychiatry moved in large measure to videoconferencing platforms.

Finally, circumstances may occur in which a standard of care exists and was not met by the clinician, but the treatment that was provided was nonetheless reasonable. For instance, a highly promising experimental treatment, even though not yet incorporated into general standards of care, might be a reasonable approach to use when existing treatments are limited in their efficacy. As an example, given the poor response rate of treatment-resistant depression to standard approaches, use of innovative brain stimulation techniques or intravenous ketamine, both of which have data supporting their efficacy (8, 9) but neither of which is yet standard treatment, might be reasonable in a particular case, assuming patient consent.

Two other facets of how the new reasonableness standard is likely to be applied may be reassuring to mental health professionals. First, the Restatement is quite clear that in defining reasonable care as reflecting "the care, skill, and knowledge regarded as competent" (4) by other members of the profession, practitioners are not required to have above-average or even average levels of skill. The authors cite the previous Restatement, which this document replaces, as indicating that "those who have less than median or average skill [by definition half the profession] may still be competent and qualified" (5). Second, practice guidelines can be invoked by a clinician-defendant as evidence of reasonable care, but deviation from a set of guidelines will not be taken as conclusive evidence of a failure to provide reasonable care. Guidelines become outdated, vary in their authoritativeness, and, because they often address typical symptoms, may not be relevant to every clinical context (10). Hence, they will be of limited utility to plaintiffs but, when they support the treatment that was provided, may bolster a clinician's defense.

INFORMED CONSENT TO PSYCHIATRIC TREATMENT

The Restatement's approach to informed consent also introduces a reasonableness standard as part of the determination of whether a failure to disclose relevant information should result in liability for the treater. As has been the case for many years, the standard calls for disclosure of "the general nature of and reasons for the proposed treatment; the proposed treatment's material risks and benefits; and material and substantially different alternatives to the proposed treatment" (4). In addition, "the provider must also supply other relevant information that the provider is aware the patient reasonably wants to know" (4), including providing truthful answers to the patient's questions. However, to prove liability for a failure to disclose information, a patient-plaintiff must prove that they suffered an injury that was not disclosed as a risk, and that if they had received the information in question, they would have chosen a different course of treatment that would not have resulted in injury. Moreover, under the new Restatement, a plaintiff must also show that their decision not to receive the proposed treatment would have been reasonable under the circumstances that they faced.

Patients who claim that their physician failed to disclose a risk that later materialized—and for which they seek compensation—have always needed to persuade a jury that, had the risk been revealed to them, they would not have undergone the treatment (11). However, the Restatement adopts the approach of some courts that also require that a decision to decline the treatment would have been objectively reasonable at the time that it was made. As the authors note, although this requirement "runs counter to informed consent's autonomy-promoting goals" (4), it was adopted to limit the ability of an embittered plaintiff who suffered an unfortunate outcome to argue, with the benefit of hindsight, that disclosure of the risk would have led the patient to choose another course of care. Clinicians will find this provision protective against a successful claim of failure to obtain consent.

Although the judicial formulation of the doctrine of informed consent originated in response to cases involving surgical procedures, the Restatement is quite clear that these rules also apply to noninvasive treatment. This expansion is particularly relevant to psychiatry, in which treatment with medication is common. The Restatement does not specifically address the role of informed consent in psychotherapy, although it does note that "when treatment decisions are less invasive . . . their risks may require less discussion" (4). In addition, the requirement to respond to a patient's questions is always operative, and any affirmative statements by the practitioner regarding their credentials and experience, or the likelihood of success of the treatment, must be accurate. Even in the absence of a direct comment regarding psychotherapy, one can reasonably assume that the principles of informed consent laid out by the Restatement apply—at least to some extent—to psychotherapeutic treatment as well.

Finally, with regard to obtaining informed consent, the Restatement is quite clear that the duty belongs to the practitioner primarily responsible for the patient's treatment, who will usually be the physician. Although the primary treater can delegate the task of obtaining consent, the treater will be held liable for any shortcomings in the consent process.

CONCLUSIONS

Medicine and the law both evolve continuously. As the new ALI Restatement demonstrates, with its emphasis on providing reasonable care, clinicians must stay abreast of the changes in their profession, especially as they relate to current treatment options, treatment guidelines, and evidence-based practice. Psychiatrists and other clinicians will want to track the extent to which the Restatement is incorporated into law in their jurisdiction—and how it might be modified in the process—to have a clear understanding of their obligations to their patients and the situations that could result in adverse outcomes of malpractice claims.

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The authors report no financial relationships with commercial interests.

Accepted April 30, 2025; published online May 28, 2025.

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