An Overview of Professional Liability in Occupational Therapy

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Key Words: malpractice • professional practice

Occupational therapists occasionally are sued for professional malpractice; thus, they need to be aware of the law of malpractice, those areas of practice that present the greatest legal challenges, and strategies to reduce client injury and liability risks. This article provides an overview of the law of professional malpractice, explains the impact of various employment relationships on liability risks, reviews specific malpractice actions against occupational therapists, and provides suggestions on how to reduce the risk of injuring a client in therapy. By increasing one's awareness of the legalities of professional malpractice and implementing certain strategies, therapists can improve quality of care and reduce their exposure to malpractice liability.

The purpose of this article is to introduce occupational therapists to the legal elements of a professional malpractice claim. It will identify those areas of practice that are potential trouble spots for litigation, discuss relevant case law that illustrates actual malpractice lawsuits, and suggest clinical management strategies to reduce the risk of incurring liability.

As clients' awareness about their health care increases and as our society becomes increasingly litigious, so does the possibility of litigation. Understanding the law of professional malpractice will help the practitioner increase his or her awareness of potential liability issues at the workplace so that risk management strategies can be implemented to protect the client from possible injury during a therapy session and to protect the therapist from being sued.

Literature Review

Few books or articles have been written about malpractice issues facing occupational therapists. Burghardt, Long, and Shanley & Fisher, PC (1996) described the law of negligence and actions an occupational therapist must take if sued by a client but did not identify specific incidents or lawsuits that have occurred in the clinic or the risk management strategies the therapist could implement to avoid such lawsuits.

Bailey and Schwartzberg (1995) outlined relevant ethical and legal dilemmas facing occupational therapy. They discussed at length the issues a therapist should review when using physical agent modalities. Specifically, occupational therapists need to be familiar with the practice acts or licensure law of the state in which they practice and must comply with the guidelines outlined by the American Occupational Therapy Association's (AOTA's) Physical Agent Modality Task Force (AOTA, 1992) to assure safe and appropriate use of modalities.

Some literature reviews the law of professional negligence as applied to physical therapists. This information is a resource for occupational therapists because the same legal principles apply to both disciplines, and certain practice areas overlap, allowing therapists to learn from the other's discipline. Most notably, Scott (1990) discerned that the frequency of claims filed against physical therapists rose significantly from 1985 to 1987 and that physical therapists could reduce their risk of exposure to malpractice liability through increased legal awareness and preventative risk management. He outlined the legal concepts of malpractice and briefly described relevant lawsuits filed against physical therapists. However, he did not identify specific areas of practice at risk of incurring liability and did not suggest risk management strategies.
to reduce claims of professional malpractice.

Professional Malpractice

To appreciate the risks involved in clinical practice and to be able to implement methods to reduce these risks, it is helpful to understand the law of professional malpractice or negligence. After defining the legal theory of negligence, we will discuss the various relevant employment relationships encountered by occupational therapists. These relationships ultimately determine who (the employer or the clinician) will be liable for the negligence of the therapist in the event the client is injured during a therapy session. This information can guide the selection of appropriate malpractice insurance coverage, without which the therapist is at risk of losing personal assets if sued.

What Is Negligence?

In the United States, we have two sets of laws that govern our behavior toward one another: criminal and civil. Professional liability cases are civil matters. According to civil law, everyone in society has the duty to exercise due care for his or her own safety and the safety of others. Failure to exercise this care is simple negligence. Negligence that causes another harm gives rise to a cause of action or lawsuit. A medical practitioner (i.e., physician, nurse, occupational therapist, physical therapist) is required to comply with what is called the standard of care. The practitioner must exercise the ordinary care that a reasonably prudent person in the same profession would exercise under the same or similar circumstances. In other words, there are certain explicit or implied rules of conduct in each medical specialty. The failure to follow these standards is a departure from standard of care and constitutes negligence. Falling below these reasonable practitioner standards is often referred to as medical negligence, professional negligence, or malpractice (Keeton, 1985).

For occupational therapists, negligence is doing, or not doing, something that an occupational therapist of ordinary skill, care, and knowledge should, or should not, do under similar circumstances. To prove negligence, the injured party (i.e., the client receiving services) must prove that the therapist deviated from the accepted standard of care, such deviation or treatment caused the injury, and the client was in fact injured (Keeton, 1985).

In most instances, one needs expert testimony, from either a therapist or physician, to prove the standard of care and deviation from the standard of care. In determining whether a therapist has deviated from the standard of care, an expert will review several important factors:

- How does an occupational therapist of ordinary care, skill, and knowledge perform a certain function?
- What rules or regulations does the hospital, employer, or rehabilitation department set forth, and have these been followed in the situation at hand?
- Is there occupational therapy literature or texts that provide certain standards of treatment?
- Does AOTA set forth guidelines or standards of practice?
- Is there a state licensure board that promulgates practice guidelines?

It is important to note that therapists are held to the standard of care that existed at the time of the alleged injury. In other words, therapists are judged by the degree of knowledge that they should have possessed at the time of the event or injury, not by what may become known later.

Employment Relationships and Liability

The type of relationship an occupational therapist has with an employer determines who will be held liable for the therapist’s negligence. The two most common relationships formed with an employer are the employer–employee and employer–independent contractor relationships.

Employee liability. A therapist who works directly for a hospital or clinic is in an employer–employee relationship defined by the law of agency. An agency relationship exists when one person (the principal) has authorized another person (the agent) to act on his or her behalf and subject to the principal’s control (Restatement, 1965). The employer is a principal who employs an agent–employee to perform services and who controls the physical conduct of the employee in the performance of the service (Restatement, 1965). When the employer–employee agency relationship exists, the employer may be held vicariously liable for the negligence of its employee if the negligence occurred during the course and within the scope of the employer’s business. Liability is extended to the employer under the doctrine of respondeat superior. The doctrine is based on the theory that an employer acts through its employee; “controls” the employee; and, therefore, should be held responsible for the employee’s actions (Keeton, 1985). The injured client may file a malpractice action directly against an employer for the alleged negligence of its therapist–employee without necessarily naming the therapist as an individual defendant.

Can the hospital (or employer) turn around and sue the therapist if it is held liable for that therapist’s negligence? Yes, the hospital can seek indemnification and reimbursement for damages resulting from the therapist’s negligence. Although such action is theoretically possible and legally proper, it rarely occurs in practice because (a) most hospitals are self-insured or purchase malpractice insurance that covers the negligent actions of its therapist–employees and (b) employers suing their employees
would be a labor relations nightmare.

Independent contractor liability. In an employer-independent contractor relationship, the employer is generally not held liable for the negligence of the independent contractor:

Since the employer has no right of control over the manner in which the work is to be done, it is to be regarded as the contractor's own enterprise, and he, rather than the employer, is the proper party to be charged with the responsibilities for preventing the risk of harm. (Keeton, 1985, p. 509)

However, liability for the negligence of an independent contractor can be extended to the employer in two ways. First, the question may arise whether the independent contractor is really an employee, even though the parties define the relationship as an employer-independent contractor arrangement. When the employer has the right to control physical details as to the manner of performance, it may become subject to liability for the physical conduct of the independent contractor under the theory of respondeat superior (Restatement, 1965). Whether someone is an employee or independent contractor is based on the following (Gilliland, 1990; Restatement, 1965):

- The extent of control the employer may exercise over the details of the work
- Whether the one employed is engaged in a distinct occupation
- Whether the work is usually done under the direction of an employer or by a specialist without supervision
- The skill required in the particular occupation
- Who supplies the instruments, tools, and the place of work for the person doing the work
- The method of payment, whether by the time or by the job
- Whether the work is a part of the employer's regular business
- Whether the parties believe that they are creating the relation of employer and employee
- Whether the principal is in business

If the independent contractor is found to be an employee, then the employer will be held liable for the negligence of that employee through the doctrine of respondeat superior because agency and employer-employee relationships exist, even though the term independent contractor is used by the parties. For example, when a facility, home health agency, or private practitioner hires a therapist as an independent contractor but provides equipment, instruments, or location for services; dictates policies and procedures; determines evaluation and treatment protocols; and controls all documentation, then the therapist may actually be an employee and the facility an employer. In this situation, the facility may be vicariously liable for the negligence of the therapist under the doctrine of respondeat superior.

The second way in which an employer may be held liable for the negligence of an independent contractor is through the doctrine of agency by estoppel. This theory prevents a health care provider from avoiding liability by simply saying that the negligent therapist was an independent contractor and not an employee. Agency by estoppel applies when the client looks to the institution rather than the therapist for care, and the hospital or facility "holds out" the therapist as its employee. If a client files a negligence action against the hospital or facility on the basis of this legal theory, the facility can be held vicariously liable for the negligence of the independent contracting therapist (Clark v. Southview Hospital & Family Health Center, 1994; Restatement, 1965). For example, assume the following facts: (a) a home health agency advertises that it provides occupational therapy services; (b) it hires an occupational therapist as an independent contractor; (c) the therapist identifies himself or herself as a therapist working for that agency, thus "holding himself or herself out" as an agent or employee of the agency; and (d) the client reasonably relies on these manifestations. If the client is injured by the therapist during a treatment session, the agency may be held liable for the therapist's negligence on the basis of the theory of agency by estoppel.

In the event the health care provider is held liable for the negligence of an independent contractor through the doctrine of agency by estoppel, the facility most likely will seek indemnification and reimbursement for damages from the independent contracting therapist or his or her malpractice insurer. Under these circumstances, the therapist (or the therapist's malpractice insurer) ultimately will be held responsible for his or her own negligence.

Currently, many occupational therapists independently contract their services to home care agencies, hospitals, or private practitioners, so they need to be aware of the impact of the employer-employee and employer-independent contractor relationships on liability. These practitioners must have appropriate malpractice insurance to protect themselves from incurring the loss of personal funds in the event they are sued by their clients for negligence.

Claims Filed Against Occupational Therapists and Physical Therapists

Claims submitted to a professional liability insurance company can take two forms: informal allegations made by clients that the therapist provided negligent care or a formal lawsuit. Simply looking at claims statistics and indemnity payments made to clients can be misleading. Indemnity payments are made for many reasons, some of
which are wholly unrelated to whether the therapist was actually at fault. For example, insurance companies and self-insured hospitals may pay claimants because they find this is substantially cheaper than fighting the claim in court. Or, a particular claim may be defensible theoretically, but the risk of financial loss or adverse publicity to the health care provider is too great. Sometimes the therapist’s documentation is inadequate to fully support a defense. However, claims information can help predict some areas in which more careful practice will reduce the risk of lawsuits and client injury. Thus, these claims data may reveal liability trends in the clinical practice of occupational therapy.

For this article, we reviewed limited information on several claims filed against occupational therapists and physical therapists. We included the claims against physical therapists because of the similarities in certain areas of practice between the physical therapy and occupational therapy professions. For example, both physical therapists and occupational therapists use physical agent modalities, transfer clients, use therapeutic equipment, and so forth. Additionally, the legal theories against physical therapists and occupational therapists are the same.

We reviewed 3 years of occupational therapy claims data and 4 years of physical therapy claims data. The occupational therapy data were secured from AOTA and the physical therapy data from an anonymous source. Although we had no control over the detail of the information or time periods reviewed, the data released did not contain identifying information.

The information provided was minimal: a brief description of the claim and the amount of indemnity paid (paid indemnity) or expected to be paid (unpaid indemnity) to the client for alleged injuries. There was no way to determine from the unpaid indemnity data whether the claim was open (still pending) or closed (resolved).

From the claims descriptions, we developed claims categories and placed each claim within one category and determined the total number of claims filed as well as the total number of paid and unpaid claims in each category. In addition, we calculated the maximum, minimum, and average paid indemnity for each category. Those claims that had insufficient descriptions were placed in “improper treatment” or “unknown” categories.

Seventy-six claims were filed against occupational therapists during a 3-year period, 44 of which fell within the five most common categories (see Table 1). Four hundred and fifty claims were filed against physical therapists during a 4-year period, 333 of which fell within the seven most commonly reported categories (see Table 2).

Relevance to practice. Although not extensive, these claims data allow us to predict some areas in which more careful practice will reduce the risk of lawsuits and losses:

- Burns from modality use implies that the therapist may have either incorrectly applied the modality or improperly supervised the client during application of the modality.
- Falls during therapy and injuries in a whirlpool or on equipment may indicate that the client was not properly supervised during therapy.
- Improper treatment claims or reinjury of a preexisting condition may suggest that the therapist did not adhere to the standard of care for that particular client or diagnosis.
- Injuries due to equipment malfunction may indicate that the therapeutic equipment was not properly maintained.
- Sexual misconduct allegations imply that the therapist may have violated ethical codes of professional conduct.

How can these risks be reduced? First, physical agent modalities, especially hot and cold packs and electrical stimulation, should be applied appropriately, and the client should be provided with adequate supervision during the application of a modality. If sued for an injury from a physical agent modality, an occupational therapist

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<tr>
<th>Table 1</th>
<th>Occupational Therapy Claims</th>
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<tbody>
<tr>
<td>Type</td>
<td>Number of Claims (Paid/Unpaid)</td>
</tr>
<tr>
<td>Improper treatment</td>
<td>11 (1/10)</td>
</tr>
<tr>
<td>Burns from hot pack</td>
<td>9 (4/5)</td>
</tr>
<tr>
<td>Fall</td>
<td>9 (2/7)</td>
</tr>
<tr>
<td>Sexual misconduct</td>
<td>2 (1/1)</td>
</tr>
<tr>
<td>Unknown</td>
<td>13 (0/13)</td>
</tr>
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</table>

Note. Between 1991 and 1994, 76 claims were filed against occupational therapists. The claims listed here had the highest frequency rates. Paid claims are those that have actually been relinquished to the client. Other categories of claims are not included because the incidence rates were nominal.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Physical Therapy Claims</th>
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<tbody>
<tr>
<td>Type</td>
<td>Number of Claims (Paid/Unpaid)</td>
</tr>
<tr>
<td>Burns from modalities (hot or cold packs, electrical stimulation)</td>
<td>58 (23/35)</td>
</tr>
<tr>
<td>Equipment malfunction</td>
<td>10 (4/6)</td>
</tr>
<tr>
<td>Fall</td>
<td>43 (22/21)</td>
</tr>
<tr>
<td>Improper treatment injured on or by equipment</td>
<td>133 (31/102)</td>
</tr>
<tr>
<td>Reinjury</td>
<td>34 (9/25)</td>
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<tr>
<td>Whoopool</td>
<td>10 (4/6)</td>
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Note. Between 1990 and 1994, 450 claims were filed against physical therapists. The claims listed here had the highest frequency rates. Other categories of claims are not included because the incidence rates were nominal.
will need to prove that he or she properly supervised the client during modality use and adhered to the standard of care for the particular treatment. Important evidence to prove standard of care is that the therapist followed the guidelines set forth by AOTA’s Physical Agent Modality Task Force, which in essence requires the practitioner to have proper training and competency in these modalities before applying them in treatment and that proper documentation exists to prove that such training has been received (AOTA, 1992). Other important evidence is that the therapist complied with the relevant state practice acts in effect at the time of the incident.

Second, claims for equipment failures, injuries on equipment, and falls during therapy are also, to some degree, avoidable. Equipment should be routinely inspected and maintained, and appropriate records of such kept. To the greatest extent possible, clients who are frail or unsteady should be supervised and assisted to prevent them from falling or injuring themselves on equipment.

Third, any plan designed or prescribed by a therapist should be done with thought, care, and awareness of the client’s overall medical condition. The therapist must accurately document preexisting conditions and clearly record client complaints, such as pain, discomfort, or loss of sensation, made during therapy.

Finally, therapists should be informed about the ethical and legal ramifications of sexual contact with clients. The AOTA states that an occupational therapist “shall maintain relationships that do not exploit the recipient of services sexually...and shall avoid those relationships...that interfere with professional judgment and objectivity” (AOTA, 1994, p. 1037). Employers should quote the AOTA guidelines in their policy and procedure manuals and review these with their therapists.

Overview of Important Case Law

When a therapist is sued, the action enters the judicial system. In other words, a client has filed a formal complaint with the court. Cases begin at the trial level and can continue on appeal to the higher state or federal appellate or supreme courts. Trial, appellate, and supreme court opinions all can be published, but the frequency and importance of publication increases with the higher level courts. An opinion of an appellate or supreme court holds higher precedential value in determining the outcome of later cases within the court’s jurisdiction.

The cases reviewed in this article mostly were decided at the state or federal appellate court level. The basic facts and final outcome of these cases are instructive because they help to identify clinical “hot spots” most often targeted by attorneys to prove that malpractice has occurred. In addition, the case law reveals strategies that therapists can use to reduce the chances of being sued.

Falls During a Therapy Session

In McAvenue v. Bryn Mawr Hospital (1976), the plaintiff, Ms. McAvenue, sustained a fracture of the left hip in May 1965. Her physician performed numerous corrective surgeries and ultimately referred her to physical therapy for gait training. During a physical therapy session conducted in the hospital’s physical therapy department, the plaintiff fell and fractured her left arm and leg. She sued the hospital, alleging that its physical therapist negligently provided treatment to her, which resulted in her injuries.

The testimony of the plaintiff and the physical therapist on the events of the fall conflicted. The plaintiff’s treating physician testified that in his opinion, her left leg fracture was a stress or spontaneous fracture due to the loss of calcium in her bones. In other words, the fall in physical therapy was not the cause of the plaintiff’s fractures. Interestingly, the plaintiff presented no other evidence at trial on the issue of causation.

The jury trial returned a verdict in favor of the hospital. The plaintiff unsuccessfully appealed the jury verdict. The Supreme Court of Pennsylvania affirmed the lower court’s decision and noted that not only did the plaintiff fail to prove that the fall in physical therapy caused her injuries, but also did not introduce evidence on the standard of care for a physical therapist who is performing gait training—an omission that could have resulted in an immediate dismissal of the case.

Relevance to practice. In McAvenue, as in many instances, factual accountings of the therapist and client conflicted, and the jury, finding in favor of the hospital and therapist, decided which version was most credible. In addition, the jury determined that the plaintiff failed to prove that the therapist caused the plaintiff’s injuries, a well-founded decision considering the plaintiff’s expert testified that her leg spontaneously fractured due to loss of calcium in her bones. Mindful of the factual conclusions drawn by a jury in a case such as this, a therapist must carefully supervise a client and accurately document the events of a therapy session (i.e., first-hand information only, such as what he or she observed, heard, felt; assumptions do not belong in a progress note). From a legal perspective, if the therapist does not document the important events of a therapy session, then it is very difficult to prove that he or she properly performed certain procedures during the evaluation or treatment. In sum, documentation is an important tool to preserve evidence that can help to prove that the therapist adhered to the standard of care.

Injury During a Therapeutic Exercise Program

In Flores v. Center for Spinal Evaluation and Rehabilitation
Although the plainriff exhibited proper body mechanics, the physical therapist instructed the plainriff as to the proper method for performing the test. Although the plaintiff exhibited proper body mechanics, he sustained an injury to his back during the test.

The plaintiff sued the physician and the center for negligence. The trial court, as affirmed by the appellate court, determined that the evidence indicated that the rehabilitation program, as prescribed, complied with the standard of care. Evidence also revealed that the occupational therapist properly implemented the program; that is, the therapist showed the plaintiff how to perform the exercise and supervised him while he performed it. Although the plaintiff was injured during the evaluation, he did not produce evidence that either the instructions or the execution of the test fell below the standard of care. Accordingly, the rehabilitation facility was not liable to the plaintiff.

Relevance to practice. An injury standing alone does not prove that malpractice occurred. The plaintiff must prove that the therapist provided care below the standard of practice at the time of the treatment. In Flores, adequate documentation helped to show that there was a rehabilitation plan and that the therapist properly implemented the treatment (i.e., the therapist instructed the client on how to perform the tests and exercises and supervised him while he performed them).

When Client Complains of Pain During a Therapy Session

In Bilderback v. Priestly (1986), the plaintiff, 63-year-old Ms. Priestly, slipped and fell at her job and injured her left knee. She consulted her physician, Dr. Bilderback (the defendant), to treat her injuries. The physician placed the plaintiff on a course of physical therapy and prescribed strengthening exercises with weights. During the physical therapy sessions, the plaintiff repeatedly complained to the therapists that her left leg was numb, that she had pain in the thigh, and that she had pain on the hip and back after lifting weights in therapy. The therapists documented these pain complaints in their progress notes. The plaintiff subsequently filed a medical malpractice action against Dr. Bilderback, contending that the physical therapy treatment for her injured knee aggravated a preexisting back injury. Dr. Bilderback stated that the plaintiff never told him that she suffered back pain during the exercises or at any time after the completion of the exercises. He further claimed that if the plaintiff had told him that she was suffering pain, he would have prescribed less weights in physical therapy.

At trial, the jury found that the defendant's prescribed treatment aggravated the plaintiff's preexisting condition of spinal stenosis and that such treatment constituted negligence and was the proximate cause of the condition at issue. In addition, the jury concluded that the defendant failed to diagnose and treat the condition of spinal stenosis (under the generally accepted standards in the community for treatment of a person in the same or similar physical condition of the plaintiff).

Dr. Bilderback appealed the jury's decision. However, the Texas Court of Appeals upheld the lower court's decision, concluding that the plaintiff's complaints of pain to the defendant's physical therapists and documented by the physical therapists in the plaintiff's medical record constituted notice to the defendant of such complaints. The defendant, therefore, was held solely liable for the plaintiff's injury.

In contrast, the physical therapist in Folta v. Bolton (1985) was found to be 15% negligent with regard to the plaintiff's neck injury because the therapist failed to inform the physician of the client's pain complaints. The plaintiff, Mr. Folta, was seriously injured in a motorcycle accident. The treating physicians misdiagnosed his hip injury and failed to diagnose a cervical spine fracture, despite the plaintiff's numerous pain complaints to the physical therapist. The therapist failed to document or otherwise notify the physicians of these complaints.

The plaintiff filed a medical malpractice action against the hospital, the emergency room physician, two general surgeons, and a radiologist. The claim against the hospital was premised on the theory of respondeat superior. Thus, the plaintiff argued that the hospital was vicariously liable for the alleged negligence of its physicians, nurses, and physical therapist. The jury determined that the hospital's physical therapist was partially negligent with regard to additional damage to the plaintiff's neck injury for his failure to inform the attending physicians of the plaintiff's complaints of neck pain.

Relevance to practice. Bilderback and Folta illustrate the need for a therapist to document and report to the attending physicians all pain complaints made by the client during therapy. This concept of thorough documentation of client complaints of pain can be extended to other
should write progress notes immediately after the treatment session, such as a fall. This is not good practice because the therapist's ability to recall important facts and details of a treatment session fades with time. Therefore, relevant facts may never be recorded in the client's medical chart. In addition, progress notes must be placed in the chart immediately, rather than days or weeks later. Documentation is a communication to the physician and places him or her on notice of the client's condition. In the event a progress note cannot be placed in the client's medical chart in a timely manner, the therapist must verbally report to the physician any major changes in the client's status and document in a progress note that such notification occurred. Absent proof of such communication to the physician, juries may find the therapist and employer at least partially liable for failure to diagnose an injury.

Injury Sustained When on a Field Trip

In Bramlette v. Charter-Medical-Columbia (1990), a psychiatric client committed suicide while on an occupational therapy field trip. Five days before the field trip, the client was voluntarily admitted to the hospital for treatment of suicidal–homicidal ideation and was immediately placed on suicidal precautions. His psychiatrist examined him soon after his admission, changed his status from suicidal precautions to active observation, and ordered assertiveness training and other therapy along with medication.

On the 5th day of admission, the psychiatrist permitted the client to leave hospital grounds on a recreational outing with a small group of fellow clients and an occupational therapist. On the return trip to the hospital, the client told the therapist that he was going to vomit and urged her to pull the hospital vehicle off the road to let him out. The therapist pulled the van to the edge of the road, and the client jumped out, ran to a highway overpass 20 ft away, climbed up on the ledge, and flung himself to his death.

The family of the deceased client subsequently asserted a medical malpractice action against the psychiatrist and the hospital. The court concluded that the occupational therapist was not liable for the client's death because the psychiatrist was the primary wrongdoer. The psychiatrist's failure to restrict the client to suicide precautions status proximately caused the client's death because it was foreseeable that he would attempt to commit suicide if taken off suicidal precautions. Thus, the occupational therapist's subsequent intervening negligence did not render the psychiatrist's negligence void.

Relevance to practice. Before allowing a client to participate in a field trip, therapists must make sure that the client's physician has authorized his or her release from hospital grounds. Failure to do so could result in a shift of liability to the supervising therapist if the client is injured while under the therapist's care. Furthermore, policies and procedures should be in place regarding field trips, transportation of clients, and when a client is permitted to exit a facility vehicle.

Sexual Misconduct With a Client

In Oslund v. United States (1988), the plaintiff, Mr. Oslund, a Vietnam veteran, sought and received psychiatric treatment for post-traumatic stress disorder (PTSD) from the Veterans Administration (VA) at various times since he returned from Vietnam. In 1979, the plaintiff suffered a traumatic flashback and entered psychiatric treatment at the VA. He alleged that after receiving treatment for several months, "he was drawn into an improper relationship" (p. 711) with an occupational therapy intern who was a member of his treatment team. He claimed that after the relationship ended, he relapsed into a severe recurrence of PTSD, resulting in "recurrent suicidal tendencies, self-destructive behavior, and near total withdrawal from society" (p. 711).

Five years later, the plaintiff filed this malpractice action against the VA under the Federal Tort Claims Act of 1981 (FTCA), claiming that his occupational therapist was negligent. The substantive issue in this case was whether the plaintiff asserted this lawsuit within the 2-year statute of limitations period. In general, malpractice claims must be filed within a 1-year or 2-year statutory period, which usually begins to run when the plaintiff has in fact discovered that he or she has suffered injury or, by the exercise of reasonable diligence, should have discovered it (Keeton, 1985). The tricky issue here is that the plaintiff claimed that he did not know whether he had a claim against the therapist because his psychiatric condition made it impossible for him to understand his injury and its cause. He claimed that he did not have this understanding until 5 years after the incident.

The court noted, as a general rule, that mental incompetence alone does not permit the FTCA statute of limitations to be tolled. Tolling of a statute of limitations means that the time period will not begin to run when the event occurred but at a later time, such as when the plaintiff knew that he or she had a claim. But when the plaintiff's mental incapacity is the result of the alleged negligence, and this injury impairs his or her ability to
understand the injury or its cause, then it may be appropriate to toll the limitations period. In this case, the court concluded that the jury must decide when the 2-year statutory period should begin to run.

Relevance to practice. Therapists who become sexually involved with clients must recognize that they are placing themselves at risk for being sued for sexual misconduct. If the client has a psychiatric history, such a lawsuit could arguably be asserted more than 2 years after the relationship. In addition, it is questionable whether an employer’s malpractice insurance would provide coverage for such conduct because the sexual encounters probably were not during the course and scope of employment. So, a therapist who has sexual involvement with a client opens himself or herself up to incurring personal financial losses.

Oslund also presents an interesting ethical issue: whether it is acceptable practice to become emotionally and sexually involved with a client. As previously discussed, the AOTA states that sexual relationships with a client should be avoided because they interfere with professional judgment and objectivity. In effect, a treating therapist should not have a sexual relationship with a client while the therapeutic relationship exists because professional judgment and objectivity could become tainted.

School-Based Therapists

In Greening v. School District of Millard (1986), the client, an 11-year-old boy, fractured his right upper femur while participating in a physical therapy program administered at an elementary school in the Millard school district. The client was born with a congenital deformity of the spinal column, known as myelodysplasia, resulting in some elements of paralysis of his legs. A common effect of this condition is osteoporosis, which is a loss or diminishment of mineral in the bone.

While enrolled in the Millard public school system, the client received physical therapy and occupational therapy. The therapists were employees of the State of Nebraska, paid by the state, and employed under the direction of the Nebraska Services for Crippled Children. Neither therapist regularly attended staff meetings convened in the school district, and both scheduled therapy sessions independent from the school district’s supervision.

The client’s physical therapist developed an exercise program designed to enable him to move out of his wheelchair and ambulate with the help of either a walker or special crutches. The physical therapist did not submit her program to a physician but did consult with the client’s orthopedist regarding general goals to be achieved. The occupational therapist developed an exercise program designed to increase strength in the client’s arms and thereby increase his independence to engage in activities of daily living. Both programs were developed without consultation with or direct contribution from the school district’s supervisory personnel.

Because the therapists had an increasing workload, they sometimes used a school district employee as an aide to work with the client. On the day of the incident, the client, as directed by the aide, performed the physical therapy exercises with his leg braces in place. While exercising, he complained about a popping sensation in his right leg and pain. The aide, who was unfamiliar with the client’s medical condition, ignored his complaint and instructed him to continue the exercises. Eventually, the occupational therapist arrived to conduct her exercise program with the client. After he again complained about pain in his leg, the therapist palpated the leg but failed to detect an injury and proceeded to put the client through the occupational therapy exercise program.

That evening, the client complained to his mother about his right leg pain. She noticed that his leg was positioned strangely and drove him to the hospital where X rays disclosed the right femur fracture.

In the lawsuit, the client and his parents claimed that the school district was vicariously liable for the actions of the aide, physical therapist, and occupational therapist. During trial, the client settled his claim against the occupational therapist. At trial, two experts testified that the physical therapy exercise program caused the fracture of the right upper femur because the brace acted as a focal point, thus placing stress on the weakened bone. Neither expert stated an opinion that the injury was in any way related to the aide’s supervision of the exercise program.

At the close of evidence, the court found in favor of the school district. The client and his parents appealed. Upon review of the case, the Supreme Court of Nebraska noted that there was ample evidence to support a finding that the physical therapist’s exercise program was negligently formulated or designed and such negligence caused the fracture. In addition, the court concluded that because no agency or employment relationship existed between the physical therapist and the school district, vicarious liability could not be imposed on the school district. The court further determined that there was no evidence to support a finding that alleged negligence on the aide’s part caused the client’s injury. Although the aide failed to act on the client’s complaints, such inaction was not the proximate cause of the particular injury alleged in the petition and established at trial.

Relevance to practice. Occupational therapists employed by a state or municipality must know that the school system in which they work will not be held vicariously liable for their negligent acts. A school system usually is a distinct legal entity from a state or city, and, therefore, no agency relationship exists between state-employed or city-employed
therapists and the school. Furthermore, therapists who use school-employed aides to implement their treatment programs may be held accountable for injuries sustained during those unsupervised sessions if it can be shown that the treatment program was improperly formulated. So, therapists need to design these treatment sessions carefully. First, the school-based therapist needs to review state practice guidelines to determine what duties are delegable to an unlicensed aide. Second, the therapist should carefully document exactly what the aide will perform, that the therapist demonstrated the program to the aide, and that the aide correctly performed the program with the client. This type of documentation can help guard against potential liability in the event the aide later performs the outlined program incorrectly.

Conclusion

Occupational therapists can reduce their risk of exposure to malpractice liability with increased legal awareness and preventative risk management. This also may increase the odds of winning the suits that are filed. By understanding the legal theories of negligence, respondeat superior, and agency by estoppel, the occupational therapist will be able to determine under what circumstances negligence may occur, how such malpractice can be prevented, who will be held liable for such negligent conduct, and when professional malpractice insurance is needed so that personal assets are protected in the event of a lawsuit.

By reviewing claims statistics, it is apparent that certain areas of practice are at higher risk for incurring liability. Therapists who use physical agent modalities or therapeutic equipment, who treat clients with complicated conditions and preexisting injuries, or who provide functional mobility training have a high chance of injuring clients and, therefore, of being sued.

However, clinicians can invoke certain strategies to reduce these risks. First, a clinician must adhere to the standard of care when treating a client. By using current evaluation and treatment methods and knowing the AOTA and state guidelines for particular therapeutic interventions, a therapist can prove that he or she adhered to such a standard. Second, a therapist must provide the client with proper supervision during the use of a physical agent modality and therapeutic equipment or while the client performs functional mobility tasks. Third, a therapist should not allow a client to use equipment that is not properly maintained or is broken. Finally, when developing a treatment plan, a therapist must be aware of the client’s entire medical condition and preexisting conditions by performing a thorough review of the medical record, by discussing the client’s case with the primary physician if questions arise, and by carefully documenting the events of the evaluation and treatment sessions.

The published case law illustrates several important points. Most importantly, documentation of therapy evaluation and treatment sessions needs to be accurate and made in a timely manner. From a legal perspective, if the therapist’s documentation does not enter the medical record, it is difficult to prove the facts of the therapeutic intervention. Documentation is critical to proving what transpired during a therapy session and is crucial evidence used to prove that the therapist adhered to the standard of care. In addition, documentation is the main method of communicating the events of therapy to the physician and other members of the health care team. Progress notes must be written immediately because important facts may be forgotten or recorded inaccurately if documented the next day.

Accurate and thorough documentation of treatment plans is also important when delegating tasks to unlicensed aides. The therapist must know which tasks may be delegated to aides and should properly instruct the aide in the performance of those activities in order to guard against possible liability for an aide’s negligent acts.

Therapists are at risk of being sued whenever they supervise clients on field trips. Ultimately, it is the physician’s responsibility to decide whether the client is medically stable to go on a field trip. So, clinicians must be sure that such an order exists. Moreover, facilities need to have policies and procedures in place that assure the safety of the clients while on field trips, and therapists should receive training regarding these policies and procedures.

Finally, sexual interaction with a client is not only a violation of the AOTA’s code of ethics, but also such involvement can possibly be the basis of a lawsuit. Therapists must know that such risks exist and that this type of conduct most likely will not be covered by an employer’s malpractice insurance because the actions were not in the course of employment or within the duties or scope of employment.

Ongoing awareness of malpractice claims can only help improve the quality of care provided by occupational therapists. Occupational therapists can learn from these examples and implement risk management strategies to assure that client safety will always be a priority. ▲

References


Bramlette v. Charter-Medical Columbia, 302 S.C. 68, 393
Folta v. Bolton, 758 F.2d 520, 522 (11th Cir. 1985).