Malpractice and Other Civil Liability in Psychedelic Psychiatry

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Psychedelics have the ability to fundamentally alter the consciousness of individuals who take them and thus pose unique legal risks for psychiatrists interested in incorporating them into their practice. Several issues related to malpractice may be relevant, including absence of standards of care, risk of harm, inappropriate treatment, and the doctrine of *respondeat superior*. In addition to malpractice, psychiatrists should be aware of other potential civil claims, including battery and the intentional or negligent infliction of emotional distress. Before providing psychedelic treatments to patients, psychiatrists should understand and mitigate their risk of malpractice and other civil claims.

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In 2020, a review of the research on psychedelics as psychiatric treatments reported that, at that point, evidence was insufficient to warrant Food and Drug Administration (FDA) approval of any psychedelic for the treatment of mental health conditions (1). More recently, a study showed that a two-dose course of psilocybin was equally effective as escitalopram in reducing self-reported depressive symptoms among patients with moderate to severe major depressive disorder (2). Researchers also found that two high-dose psilocybin sessions resulted in a significantly decreased percentage of heavy drinking days over 32 weeks among individuals diagnosed as having *DSM-IV*–defined alcohol dependence when compared with placebo (3).

Although psychedelics' therapeutic research base is growing, they remain on the Drug Enforcement Administration's Schedule I, rendering their prescription illegal under federal law. Despite this restriction, various jurisdictions in the United States have decriminalized the possession and sale of psychedelics. In 2020, Oregon established a new section of the Oregon Health Authority to oversee the establishment of psilocybin services in the state (4). Because psychedelics are consciousness-altering substances with unpredictable effects, psychiatrists should be responsible for supervising their provision (5). Psychiatrists recommending and prescribing psychedelic drugs face numerous legal risks, only some of which would be reduced should the FDA decide to approve psychedelics for the treatment of mental disorders. This column reviews malpractice and other civil legal considerations for psychiatrists interested in prescribing psychedelic drugs.

MALPRACTICE

Malpractice is a civil claim of a physician's negligence. To establish a psychiatrist's negligence, a patient must demonstrate that the psychiatrist had a duty to the patient through their established doctor-patient relationship; the psychiatrist fell below an acceptable standard of care, resulting in a dereliction of his or her duty to the patient; the psychiatrist's action or inaction led to damages experienced by the patient; and the dereliction directly led to these damages (6). The malpractice issues most relevant to psychiatrists interested in offering psychedelic treatments include absence of standards of care, risk of harm, inappropriate treatment, and the doctrine of *respondeat superior*. Currently, no established or accepted standards of care exist for the clinical use of psychedelic compounds, including psilocybin. Further research is needed to establish the effectiveness, dosing, and safety profile of and contraindications to treatment with psilocybin

HIGHLIGHTS

- Psychedelics' ability to radically alter human consciousness creates unique malpractice risks for psychiatrists who prescribe them or oversee their provision.
- Because no standards of care exist for psychedelic psychiatry, plaintiffs who receive psychedelics may accuse psychiatrists of inappropriate treatment.
- Psychiatrists who hire guides to conduct psychedelic-assisted psychotherapy risk facing malpractice claims related to the doctrine of *respondeat superior*.

and other psychedelics. Psychiatrists who choose to recommend or oversee the provision of psychedelic therapies in jurisdictions that have decriminalized such practices potentially open themselves to liability for negative outcomes because they are practicing outside the standard of care, even when they rely on currently available research protocols. FDA approval and the publication of clinical guidelines for psychedelics' indications, dosing, and administration would aid in establishing the standard of care in psychedelic treatment.

Because psychedelics can completely alter consciousness, they have the potential to cause harm to patients. Psychedelic experiences may range from mild perceptual abnormalities to the perceived dissolution of time, space, physical form, and self. An individual's interpretation of and emotional reaction to such experiences can be similarly broad, ranging from amusement to terror. Beginning with psychedelics' early use in the United States, much has been written about the mindset ("set") and external circumstances ("setting") in which psychedelics are taken and their importance in determining the type of experience that an individual has (7). Negative experiences, or "bad trips," are common in the context of naturalistic use (8) but less common in clinical research settings (1). In a survey of 1,993 individuals who used psilocybin mushrooms in a nonclinical setting and had a challenging experience, 8% reported that their most challenging experience led to a decrease in their sense of well-being or life satisfaction, 11% reported putting themselves or others at risk of physical harm, 3% reported being physically aggressive or violent toward themselves or others, and 3% reported receiving help at a hospital or emergency department (8). Moreover, 10% indicated that they experienced negative symptoms, such as fear, anxiety, depression, or paranoia, that persisted more than 12 months after using the psilocybin mushrooms, and 8% sought treatment for their symptoms. Those who had been treated for psychological symptoms prior to the bad trip were more than twice as likely to pursue treatment for their symptoms as were those with no history of treatment. Although these data come from individuals with a history of naturalistic use and likely overestimate the risk of negative outcomes posed to patients treated in clinical settings, they should be carefully considered by psychiatrists interested in providing psychedelic treatments to patients. Psychedelics' unpredictable effects make it highly likely that negative experiences will occur in clinical settings, even if only rarely. Individuals with persistent negative symptoms stemming from a psychedelic journey may reasonably argue that the psychiatrist's provision of psychedelics directly led to ongoing and distressing negative psychological symptoms.

A plaintiff pursuing a malpractice claim related to psychedelic treatment may allege that the psychiatrist provided inappropriate care for his or her condition. Psychedelics are not the standard of care for the treatment of any psychiatric disorder. Furthermore, psychiatrists should understand that clinical trials are extremely selective and that their participants do not reflect the patient population of a general psychiatric practice. One research protocol from Johns Hopkins University excluded participants with a history of psychotic disorders and bipolar I and bipolar II disorders, as well as those with first- and second-degree relatives with such diagnoses (9). Investigators in a study comparing psilocybin with escitalopram excluded patients with a history of psychosis, suicide attempts, and a "suspected or known" psychiatric condition, such as borderline personality disorder, that "could jeopardize rapport between the patient and their two mental health caregivers within the trial" (2). A study of psilocybin as a treatment for alcohol dependence excluded patients with any "major psychiatric and drug use disorders" (3). Such study populations are not representative of individuals who receive care in general psychiatric settings such as outpatient clinics. Psychiatrists interested in prescribing psychedelics run the risk of treating vulnerable patients, including those with a higher likelihood of having challenging or negative experiences that cause or exacerbate severe distress. Plaintiffs may therefore argue that they received treatment that was inappropriate for their psychiatric diagnosis and that the psychiatrist was negligent in recommending psychedelics. With further research and a better understanding of psychiatric contraindications, the risk of inappropriate treatment should decrease.

Because of the length of psychedelic journeys, which often last 6–8 hours, psychiatrists are unlikely to be directly responsible for guiding individuals through their sessions. Instead, psychiatrists more often oversee therapists who conduct psychedelic-assisted psychotherapy. These therapists should have mental health training and must have specialized training in working with psychedelics (5); psychologists and social workers may be best suited to this role. Delegating psychotherapy tasks to employees or supervisees renders a psychiatrist responsible for their actions under the doctrine of *respondeat superior*. A psychiatrist may be held liable for acts committed by an employee or supervisee in his or her scope of employment, regardless of whether the psychiatrist directly breached a duty (6). Oregon recently proposed that anybody with a high school diploma who has completed an "approved Psilocybin Facilitator education training program" (10) may be eligible to facilitate psilocybin sessions. By the doctrine of *respondeat superior*, a psychiatrist in Oregon who hires or contracts a high school–educated facilitator with no mental health training could be held liable for a negative outcome resulting from a decision that a facilitator makes during a psilocybin session.

OTHER CIVIL CLAIMS

Psychiatrists may face additional civil legal claims unrelated to malpractice, such as infliction of emotional distress and battery. A claim of intentional infliction of emotional distress (IIED) requires proof that a defendant intentionally or recklessly engaged in outrageous conduct that caused a plaintiff to experience severe emotional distress. Negligent

infliction of emotional distress (NIED), less widely recognized and more controversial than IIED, requires proof only that a breach of duty to a plaintiff was a substantial factor in causing that plaintiff's emotional distress. In California, emotional distress "includes suffering, anguish, fright, horror, nervousness, grief, anxiety, worry, shock, humiliation, and shame" (11). There is no question that psychedelic experiences may elicit serious anguish, fright, nervousness, anxiety, and worry, even when treatment is conducted in clinical research settings (12). In California and other jurisdictions that allow claims of NIED, a plaintiff could allege that a psychiatrist's negligent prescription of psychedelics or provision of psychedelic-assisted psychotherapy was a substantial factor in causing emotional distress.

I informally consulted with an individual who underwent psychedelic-assisted psychotherapy that could constitute IIED. During his third psilocybin session, he had the "realization" that his father had sexually abused him when he was a young child. Of note, no sensory memory was associated with the realization. As his cognitive faculties returned at the end of the session, the psychologist guide encouraged him to elaborate on his purported sexual abuse history. She even had the man call family members to share what he had discovered. The man subsequently went on medical leave to receive treatment for a history of sexual assault of which he had been unaware to that point and that could not be confirmed. California defines outrageous conduct, the standard for a claim of IIED, as "conduct so extreme that it goes beyond all possible bounds of decency" (11). Encouragement of a patient to believe and immediately share with family and friends the unverified thought that his father had sexually abused him—a thought that occurred during a psilocybin session, when suggestibility is enhanced—could potentially be considered outrageous conduct.

Another civil claim that psychiatrists may face is battery. Psychedelics may cause patients to become emotionally and physically agitated. Touching, restraining, or administering a sedative to a patient may be necessary, depending on the patient's degree of agitation. Most jurisdictions allow for civil claims of battery when an individual intentionally touches another individual without his or her consent and causes harm. Administering a medication to or restraining an agitated individual in the context of a psychedelic treatment session could be considered battery if the patient did not consent to such measures as part of the treatment. For this reason, psychiatrists planning to provide psychedelic treatment should discuss such risks with patients before sessions as part of an informed-consent procedure, and they should obtain consent for physical restraint or emergent treatment with a sedative that may be necessary during the session (5).

Finally, psychiatrists must consider the risk of allegations of sexual battery. Psychedelics may render patients more suggestible and vulnerable to inappropriate sexual behavior, ranging from sexual touching to rape. A recent podcast series (13) chronicled numerous victims' experiences with sexual abuse in the context of psychedelic journeys, including in a clinical trial sponsored by the advocacy and research organization Multidisciplinary Association for Psychedelic Studies. In one case, an unlicensed male "therapist" physically restrained a woman on a bed while his psychiatrist wife conducted the therapy session. In less egregious cases, efforts to calm or gently restrain an agitated patient may involve touching. Therapists must avoid acts that may be considered sexual. The use of a male-female therapist dyad is encouraged to reduce the risk of sexual abuse (1), although such a system does not eliminate the risk that therapist guides will engage in inappropriate sexual behavior with patients.

CONCLUSIONS

Psychedelics may represent a groundbreaking method of treating various psychiatric disorders in the future, but the currently available research base supporting this use of psychedelics is limited. Without FDA approval and the establishment of guidelines for use, psychiatrists hoping to incorporate psychedelics into clinical practice face significant malpractice risks because of the lack of standards of care, the possibility of causing a negative or harmful experience, and the risk of mistreatment of vulnerable patients. Even with FDA approval, civil litigation related to the doctrine of *respondeat superior*, IIED, NIED, and battery would likely remain salient. In the current context of advocacy organizations and influential podcasters touting psychedelics as a psychological panacea, psychiatrists should recognize these hazards and avoid riding the wave of popular support into a civil tort.

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