The Devil's Advocate

Press reports of a recent California decision[1] raise some important issues regarding confidentiality. Does a psychotherapist have a legal obligation to take appropriate action if his patient reveals a fixed intention to commit a serious crime? And if he does, what constitutes "appropriate action"?

At the outset, it should be noted that the *Principles of Medical Ethics* provide that "A physician may not reveal the confidence entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community."[2] In addition, apparently the California Evidence Code lists a specific exception to the rule of confidentiality when disclosure is necessary to avert serious danger. In other words, both professional ethics and the applicable statute impose an ethical and legal duty to communicate rather than to maintain confidence where the danger to an individual or the community outweighs the value of the general principle of protecting the confidential relationship.

Those who assert that the integrity of the psychotherapist-patient relationship should be maintained at all costs in effect argue that confidentiality should be absolute, rather than qualified. Such an assertion runs counter to the jurisprudential propensity of courts to weigh and balance even fundamental constitutional rights, such as freedom of speech, of the press, and of religion. Judges, like butchers, by occupation are weighers and balancers, and the most we can hope for is that they will keep their thumbs off the scales.

There also is a psychological dimension to the problem. Courts are unlikely to extend the physician-patient, psychotherapist-patient, or other relationship that entails confidentiality beyond the ambit of the attorney-client rules as to confidentiality, unless statutory language clearly calls for such construction. It is clear that the general principle is that professional communications are not privileged when they are made for an unlawful purpose or have as their object the commission of a crime.[3] When a client discloses that he is about to commit a serious crime or fraud, "it is not only lawful to divulge such communications, but under certain circumstances it might become the duty of the attorney to do so."[4] The notion is that an attorney cannot be properly consulted for professional advice to aid in the perpetration of a crime or a fraud. Such a situation partakes of conspiracy.[5]

The distinction is that between the revelation of past crimes or frauds, where the harm has already been done, and the disclosure of a fixed intention to commit a future crime or fraud, where the social harm has not yet occurred, and steps may be taken to prevent it. However, just as the general principle of confidentiality is subject to the future crime exception, so too the latter may be qualified by various circumstances. The weighing and balancing process is continual. Little fleas have lesser fleas, on their backs to bite 'em, and littler fleas have littlest fleas, and so on *ad infinitum*.

Qualifications to the exception to the general principle may be drawn with regard to both the likelihood that the future crime or fraud will be perpetrated and the seriousness of the offense. The duty to communicate the confidence is predicated upon the existence of a real danger. Talk is cheap, except when you converse with a psychiatrist or a lawyer. Threats and fantasies may be idle or seen as pipe dreams. It all depends upon the circumstances and ultimately upon whether or not a reasonable professional person would have appreciated the risk and acted accordingly. Where there is a manifest threat to human life or an obvious risk of substantial social harm, the professional's duty as a citizen takes over.

So there must be a real danger, appreciated as such, or apparent to a reasonable professional, to trigger off the exception to the rule of confidentiality. The greater the

potential harm, the more likely it is that a duty to disclose will be imposed. Perhaps some proposed offenses or crimes may be deemed to be relatively innocuous and not to require disclosure.[6] For example, a psychotherapist treating a drug addict may know full well that his patient will resort to illicit activities (theft or prostitution) to obtain funds to supply the habit and to pay the psychotherapist. General as distinguished from specific knowledge regarding a future crime probably would not give rise to a duty to disclose,[7] aside from statutes and regulations requiring the reporting of addicts for a registry.

When the California case goes to trial on the damage issue, the plaintiffs will have to prove that the university health service and its doctors were negligent and that but for such negligence the patient would not have killed the victim who had jilted him.[8] Would a reasonable professional so situated have appreciated that the victim's life was in danger? Probably, expert psychiatric testimony will be offered by each side on this issue. Since generally we are entitled to assume that crimes will not be perpetrated (regardless of the crime rate),[9] there may be difficulties in proving that a reasonable psychiatrist would have acted on the information divulged by the patient. Depending upon the circumstances, it may have been reasonable to regard the revelation as fantasy.

Even if it is found that a reasonable psychiatrist would have appreciated the serious danger, the question remains as to whether or not his duty to divulge the danger was discharged. Apparently, the doctor who examined the student-patient notified the campus police, who briefly detained the patient, then released him when he appeared rational. However, a hospital supervisor ordered no further action against the patient. The administrative decision of the campus police, assuming a full and accurate report was made to them by the health service, should insulate the psychiatrist from individual liability, although the university may be as responsible for police errors as for the medical errors of its employees. Although the police may have rightly opted against preventive detention, in turn they may have had a duty to warn the potential victim or to take measures for her protection, depending upon the circumstances. With reference to the psychiatrist, however, again assuming a full and accurate report, disclosure to the police was perhaps the most reasonable alternative, unless he knew that the campus police were incompetent or ineffectual, and that reporting to them was an exercise in futility.

Those who have been quoted as deploring the California decision adopt an absolutist position and predict that patients will drop out of therapy if there is a duty to disclose a patient's intention to commit a crime, including murder.[10] On their scales, retention of the patient in therapy is more important than human life. Would such critics feel the same way if there was reason to know that the patient firmly intended to plant a bomb in a public place?[11] Continuation in therapy may or may not be important for a given individual, but at most it is but a factor to be considered. Moreover, it should be noted that the patient's own welfare may require disclosure of a contemplated crime and that if it is attempted or committed, the course of treatment will be imperiled in any event. Thus, on balance, the interests of society, the potential victim, and the patient, combine to favor the exceptional duty of disclosure.

All of this is nothing new. Statutes in most if not all states impose a duty of disclosure regarding gunshot wounds, venereal disease, child abuse, drug addiction, and other matters of legitimate public concern. There is no proof that such statutory obligations have posed a threat to sound medical practice or have been destructive to confidential relationships. We agree that the psychotherapist-patient relationship deserves the fullest protection accorded by law and urge that it receive statutory recognition and implementation.[12] We insist, however, that it be viewed in its social context, and when that is done, we recognize that there must be exceptions and qualifications so that other important social values are unimpaired. A doctrinal approach by doctors to these problems is a delusion. The golden mean still has meaning.

References

1. The New York Times, December 25, 1974, p 15, cols 1–2
2. American Medical Association: Principles of Medical Ethics § 9 (1957)

3. The American Bar Association's Canons of Ethics No. 37 provides in part: ". . . The announced intention of a client to commit a crime is not included within the confidences he (the attorney) is bound to respect. He may properly make such disclosures as to prevent the act or protect those against whom it is threatened." See also, Queen v Cox, 14 QBD 153, 167 (1884) (Stephen, J); Matthews v Hoagland, 48 NJ Eq 455, 469, 21 A 1054, 1059 (1891); and People v Van Alstine, 57 Mich 69, 79, 23 NW 594 598 (1885)
4. Jones: Commentaries on the law of evidence (1914), vol 4 §753, p 516 et seq
5. See Matthews v Hoagland, supra
6. A psychotherapist treating a homosexual presumably would have no duty to report his patient's contemplated act of sodomy even where such is a crime, although he would have such a duty to report contemplated rape. We decline to hazard an opinion regarding contemplated incest. Likewise we assume there would be no duty to report to the police the plans of a compulsive gambler even though gambling is illegal, but that if the gambler revealed plans for embezzling funds for the particular gamble, there would be a duty to report the latter.
7. Jones, supra, in discussing the duty to disclose says that there must be some independent proof of the wrongful purpose and that the mere suggestion of fraud (or crime) does not set aside the general rule. See also, US v Bob, 106 F 2d 37, 125 ALR 502 (CA 2, 1939), cert den'd, 308 US 589 (1939), where it is said that the mere assertion of an intended fraud or crime is not enough to release the attorney from his general duty to maintain confidentiality.
8. See Louisell and Williams: Medical Malpractice §11 20 (1970)
9. See Freezer: Intervening crime and liability for negligence, 24 Minn L Rev 635 (1940), but compare Austin W. Jones Co v State, 122 Me 214, 119 A 577 (1923), and Higgins v State, 43 Misc 2d 793, 252 NYS 2d 163 (1964)
10. The New York Times article, *op. cit. supra* n. 1, quotes Dr. David Allen as saying "If it's publicly known that psychiatrists are required to report these things, then the patient will be less likely to talk about it." *Sed quaere.* Dr. Morris Grossman is quoted as having said "The soundest practice is to try to defuse a person's homicidal urges through treatment. The minute you report them, they drop out of therapy." Although we are all for defusing, demolition experts are careful to pick the right place when possible.
11. An article I have misplaced reported some years ago that a substantial number of Chicago psychiatrists responding to a questionnaire stated that they would take no action if a patient revealed his intention to place a bomb on an airplane. *Res ipsa loquitur.*
12. For example, it is deplorable that proposed Rule 504 was eliminated from the proposed Federal Rules of Evidence. Leading proponents for the psychotherapist-patient privilege include: Louisell and Sinclair, in 59 Calif L Rev 30, 53–54 (1971); Slovenko, in 6 Wayne L Rev 175, 186–187 (1960); Slovenko and Usdin, 4 Archives of General Psychiatry 431–432; Goldstein and Katz, 118 Am J Psychiatry 733 (1962); and Beigler, 129 Am J Psychiatry 311 (1972). In general, see Slovenko: Psychiatry and Law (1973), Chap. 4, but be skeptical about Slovenko's claim that the legal requirement of relevance tends to resolve the problem. Finally, In re Lifschutz, 2 Cal 3d 415, 467 P 2d 557, 85 Cal Rptr 829 (1970), is one of the most comprehensive opinions on confidentiality and privilege.