The Misperceived Duty to Report Patients' Past Crimes

Marcus J. Goldman, MD, and Thomas G. Gutheil, MD

A questionnaire survey revealed that a number of mental health professionals believed that they had a duty to report a hypothetical patient's past criminal act. The authors examine the legal context of this misperceived reporting duty and discuss its implications for training and practice.

The interaction between psychiatry and the law, once thought to fall exclusively within the domain of the forensic psychiatrist, has grown both more complex and inescapable. The increasing obligations on clinicians are burdensome enough without the addition of misconceptions about the law that lead to unnecessary legalistic confusion and misunderstanding.

By introducing what amounted to novel duties to third parties, the *Tarasoff* case[1] set in motion a number of changes in clinicians' perceptions of the limits of the confidentiality they were expected to observe. These changed perceptions not uncommonly produced confusion; for example, in the notorious case of *Hopewell v. Adibempe*,[2] a clinician grossly misunderstood his mandate under the *Tarasoff* principle and paid the price in a confidentiality suit.

A current perception that may represent an offshoot of "*Tarasoff* confusion" is clinicians' belief that they have some sort of duty to take action (for example, by report to the authorities) when they hear in the treatment setting about a patient's *past* crimes. Indeed, this is perhaps the most frequently asked question from the audience at risk management seminars around the country. This article attempts to clarify this issue.

The Legal Context

Appelbaum and Meisel analyzed the issue of a therapist's obligation to report a patient's *past* criminal behavior,[3] a notion termed "misprision of a felony" (or the presumed obligation of citizens to report felonies that come to their attention). The authors found that under federal statutes, a therapist's simple knowledge of a patient's past felony is not sufficient to convict the therapist of misprision.[3] For example, the case of *Neal v. U.S.*[4] held, *inter alia*, that liabil-

Drs. Goldman and Gutheil are affiliated with the Program in Psychiatry and the Law, Massachusetts Mental Health Center, Harvard Medical School. Dr. Goldman is also Associate Chief of Psychiatry, St. Vincent Hospital, Worcester, and is a psychiatrist at The Boston Road Clinic. Address correspondence to Dr. Marcus Goldman, Boston Road Clinic, 108 Belmont Street, Worcester, MA 01605

ity would require that a therapist take "*an affirmative step to conceal the crime* [emphasis added]." This requirement appears to remove most therapists from liability unless, for example, a therapist hospitalizes a patient known to have committed a felony for the specific purpose of helping him escape detection.[3] Another example of concealment, the authors found, would include lying to authorities about the patient's alleged offense (although a physician is under no obligation to reveal details because such a revelation would constitute a breach of confidentiality). Most states had actually repealed such laws[3]; interest in prosecuting such cases appears minimal.

Since no obligation to report a patient's past felony existed, Appelbaum and Meisel further noted that such reporting could constitute a breach of confidentiality that could itself be subject to civil suit.[3] They conclude, however, that a suit would be unlikely if, in fact, the patient had committed the crime.

Empirical Study

An empirical study was undertaken to document the perception (or misperception) of the issue in a large sample of mental health professionals.

Methods

Four different versions of a clinical vignette were randomly circulated to audiences of a variety of mental health professionals (including nurses, psychiatrists, psychologists, and social workers) in a series of law and psychiatry seminars given around the country. Subjects filled out answers to two questions about the vignette, addressing legal and ethical reporting obligations (see appendix). The form variations were: male vs. female perpetrator, embezzlement vs. murder as a crime. *No* reporting requirements actually existed in any of the variations; notwithstanding this fact, we hypothesized that respondents would answer as though a reporting requirement existed, most often for a male murderer and least often for a female embezzler.

Results

Out of an n = 149, 17 (11%) subjects believed they had a reporting duty (an analysis of the reasoning used will be reported elsewhere). Of the 17 would-be reporters, none would have reported the female embezzler, confirming this element of the hypothesis; one would have reported the male embezzler; and eight each, the male and female murderers.

Discussion

Clearly, the imagined duty to report past crimes continues to have some hold over the imaginations of clinicians. There are several reasons why this may be so.

Many consultants on medical/legal issues have been impressed by the manner in which the duty imposed by the well known Tarasoff case is perceived as a "duty to warn" rather than a "duty to protect" victims from possible violent acts of individuals one is treating. At times, even relatively experienced forensic experts appear to lapse into this misperception (note that the duty to warn was raised by the initial Tarasoff case in 1974, but this was superseded by more general duty to protect in the re-hearing

of the Tarasoff case in 1976).[1] We speculate that this inaccuracy is based in part on the fact that the notion of warning a potential victim of one's patients' violent propensities is so non-clinical a task and so much at odds with the therapist's agency on behalf of his or her patient, that it becomes stuck in clinicians' minds, as it were, and stands out as a kind of false memory.

In a broader sense, flowing from the notion that one might have duties to others, which was the unprecedented holding of the final Tarasoff cases and their progeny,[5] clinicians may have lost a clear sense of the boundaries of their responsibility and appear to reason subliminally: "If I have duties to break confidentiality regarding my patient's potential future violent propensities, perhaps I have the similar duties for the patient's past criminal behavior."

At a far deeper level, clinicians appear to be motivated to report past activity on the basis of anxiety arising in the countertransference. This impression is provided by multiple consultations when this issue is brought up as it is with high frequency, as noted above. The notion that one's patient might be "getting away with murder" or, at least, getting away with some forbidden activity, appears to stir clinicians' superego concerns so that the idea of "doing nothing" (although more accurately, pursuing the issue in therapeutic terms alone) feels to clinicians like a form of condoning the illegal behavior. Thus, the anxiety mobilized by this concern stimulates the clinician to "do something" along the vector provided by the *Tarasoff* conceptualization of reporting.

Insofar as a past violent crime might be predictive of future violence, of course, a clinician would clearly be free to use the past crime as *clinical* data in deciding about commitment. In this future-oriented context, the past crime serves only to indicate that this particular patient once turned impulses into action. As always, hospitalization of the potentially violent patient may be a feasible alternative to either breaching confidentiality or reporting past criminal behavior.[3]

What implications do these possibilities have? Clearly, there is an educational burden on teachers and consultants on medical/legal issues to attempt to clarify this matter. Their task is rendered all the more difficult because, like issues of sexuality, which pose similar reporting anxieties,[6] aggression is a fundamental human drive and one that carries and stimulates irrational thinking as well as rational. As always, cognitive efforts must be rallied to the struggle, coupled with the perennial resources of education, consultation, and documentation.

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Appendix

It is your first session with a patient who has called for an appointment saying [he/she] has something urgent to discuss. [He/She] shifts in [his/her] chair uncomfortably for the initial half-hour,

responding to your questions with only vague generalities. Finally, [he/she] exclaims, "I can't take this anymore. I [used to work as an accountant for a supermarket chain, and last week before I left my job, I embezzled $10,000. I fixed the books so no one will ever find out that the money is missing] [killed my ex-husband's/ex-wife's lover last week. The body is hidden where no one will find it and the police don't even know he's/she's missing yet]. You are the only person I've told. I don't want you to tell anyone else."

For the rest of the session, you barely listen to the patient, as you try to figure out how to handle this. The patient is adamant about your not revealing the [embezzlement/murder] and says firmly that [he/she] has no intention of turning [himself/herself] in. At last, the session ends.

Questions:

1a. Do you have a legal obligation to report the information that you have obtained about the [embezzlement/murder] to the police? (Circle Number)

Yes No

1 2 3 4

1b. Why or why not?

2. Taking into account whatever legal obligations you might or might not have, along with your ethical obligations as a mental health professional, how would you respond to this situation?

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