Substance Abuse and the Duty to Protect

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The *Tarasoff* case provided some legal guidance for handling the situation where a patient threatens deliberate violence against an identifiable individual. But what about the situation where a patient's substance abuse impairs safe driving of a large commercial vehicle such as an airplane, clearly endangering a class of individuals (passengers)? Some legal restrictions on confidentiality, if followed literally, would not even permit the therapist to take preventive measures advocated by the *Tarasoff* court when deliberate violence is threatened, let alone more specific measures to prevent a tragic accident with loss of many lives. Review of literature on the relationship between alcohol and operator safety leads to the conclusion that therapists must have some latitude in which to exercise judgment free of professional liability. The dilemma posed by contrasting duties to maintain confidentiality and to make preventive disclosures is too rigid to govern all situations, especially a worsening risk of substance-induced accidents by drivers of public carriers.

On August 28, 1991, an IRT Lexington Avenue Train going to Brooklyn, New York, derailed in a subway tunnel. Most of the front car, separated from the rest of the train, was split lengthwise in half. The next four cars also derailed. "Cars jumped into the air and were crushed together in a tangled mass."[1] The accident left over 200 passengers injured, some critically, and killed five. Police reported the motorman was intoxicated when he ran the train across a switch at a high rate of speed. An alcohol test confirmed the driver was legally intoxicated. After the accident a vial of crack cocaine was found in his cab. One year later the motorman was found guilty of five counts of second degree manslaughter, five counts of criminally negligent homicide, and 26 counts of second degree assault, and he was found not guilty of five counts of second degree murder.[2]

Now suppose this man had been evaluated by a health professional earlier on that same day. Careful history and assessment disclosed that this subway motorman abused cocaine and alcohol and was occasionally intoxicated or withdrawing from drugs even while operating the train. Adding at this point hypothetically to our example, the man's substance abuse was worsening, he recently had several automobile accidents while intoxicated, and his ability to safely operate a train was becoming increasingly compromised.

If the professional had notified the Transit Authority and the man was re-

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lieved from his work assignment, the motorman might have been angry at the professional for breaking confidentiality, causing loss of income, and possibly costing him his job. If after notification the Transit Authority took action and prevented the accident; no one would know for certain that without intervention a disastrous accident would occur leaving five dead and over 200 injured. On the other hand, imagine how the injured and the survivors of the deceased would have felt about this professional, if he had done nothing. There is little cause for gratitude without knowing what has been saved, but much reason for scorn when people are faced with what they have, in fact, unnecessarily lost.

The focus of this analysis pertains to the mental health professional who evaluates a driver of a large commercial or public vehicle and who is not employed by the same company or branch of government as the evaluee. Industrial and military clinicians typically have permissible procedures for dealing with a substance abusing driver. For example, a military physician who evaluates a substance abusing pilot can refer the individual to a flight surgeon. The flight surgeon can, in turn, temporarily "down" the at-risk evaluee for a period of evaluation. The safety-minded physician who initiated the intervention does not incur legal liability. Neither will this discussion concern preventive measures already taken within companies and governmental organizations such as periodic physical examinations, mandatory drug testing, and medical certification (e.g., the new physical and psychiatric requirements of the Federal Highway Administration concerning commercial truck drivers (3)). Neither does this analysis address the matter of prescription drugs wherein legal and clinical aspects can be quite different.

Confidentiality and Public Service

State and federal statutes governing confidentiality and privileged communication do not provide the clinician with guidance in dealing with this issue. In Texas, for example, the clinician concerned about violence can notify medical professionals or law enforcement officials,[4] but the law is mute about the commercial vehicle operator who presents an increasing risk of a fatal accident. Federal regulations that provide confidentiality for patients of federally funded substance abuse rehabilitation programs are even more restrictive,[5] not even permitting the clinician to take protective action in a classical Tarasoff-like situation, let alone a foreseeable vehicular accident caused by substance abuse.

Even in the face of statutes protective of confidentiality and privileged communication, well-reasoned protective disclosures may be justified to prevent serious harm to others. At the time of *Tarasoff*, California had statutory law to guard confidentiality. Although the California Supreme Court was divided as to whether this statutory protection pertained to the instant case, the court nonetheless formulated a now well-recognized dictum:

"[P]ublic policy favoring protection of the confidential character of patient-

psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others since the protective privilege ends where the public peril begins."[6] But under what circumstances is public peril sufficiently compelling to warrant disclosure? And to whom should protective disclosures be made? Most of the courts that addressed this issue would permit disclosure to law enforcement officials or the identifiable victim, if a patient makes a serious threat against another. But a patient can present a foreseeable risk of violence to others without expressing a threat against particular individuals. Moreover, the agency with the key to prevention may not invariably be the police or "nameable" victims.

The Supreme Court of Alabama has held that a physician can be liable in damages to a patient for disclosing confidential medical information to the patient's employer.[7] Unfortunately, information about the case is so scant, the ruling provides little help to the clinician in search of guidance. What if the patient has a grudge against his employer and intends to shoot his employer and other coworkers? Or what if the patient, employed as an air traffic controller, is consuming increasing amounts of alcohol and his judgment and ability to process information is worsening? The Alabama court allowed for an exception to the duty not to make extra-judicial disclosures, "[w]here the physician's duty of nondisclosure is subject to exceptions prompted by supervening interests of society or private interests of patient himself."[7]

Several courts, in duty to protect cases, offered that physicians may be in violation of the law if they inform the Department of Motor Vehicles of a patient's increased risk, though reporting epileptic drivers is legally compelled in several states. This, even though many more accidents are caused by drivers under the influence of alcohol than drivers momentarily incapacitated by an epileptic seizure.

The Tarasoff Principle and Accidents

The California Supreme Court's Tarasoff Principle in 1976 permitted a psychotherapist to be liable, under some circumstances, when the therapist's patient harmed another person. When patient Prosenjit Poddor told his therapist, Dr. Lawrence Moore, that he intended to kill Tatiana Tarasoff, a specific threat was made against a reasonably identifiable individual. Other courts considered the therapist's duty to protect other persons from the violent acts of one's patients. Though no single principle has been uniformly adopted by courts,[8] the original Tarasoff Principle did not explicitly require a threat for the duty to arise, only that the therapist determined, or, pursuant to the standards of his profession, should have determined, that the patient presented a serious danger of violence to another. In some other Tarasoff-like cases the potential victim need not be identifiable for the duty to protect to arise.[9,10] Neither is the type of violence specified in these other court decisions. In the Tarasoff Principle, the potential victim is "intended," which

implies the violence is deliberate or preplanned, but then other courts, citing *Tarasoff*, have supported liability where the violence was accidental and the identity of the victim(s) could not have been known in advance.[10-13]

Protective measures mentioned in the Tarasoff Principle include warning the victim or someone else who can warn the victim, notifying the police, or taking "whatever other steps are reasonable under the circumstances." But consider our hypothetical patient who is a substance-abusing motorman of New York City's subway trains and who drives the trains while intoxicated or withdrawing from alcohol or other substance with resultant substantially compromised driving performance. The most reasonable preventative measure may be to notify the Transit Authority of the risk. This measure becomes especially compelling if the risky behavior is worsening and detoxification and rehabilitative treatment have been recommended, but the patient has rejected all attempts at helpful intervention.

When a health professional can take a reasonable measure to prevent a patient from seriously endangering others, there is a moral basis for doing so. If the impending violence would endanger a class of individuals (e.g., train passengers), rather than an individual identifiable by name, these individuals are nonetheless deserving of protection. If the foreseeable violence would be accidental, rather than deliberate and preplanned, reasonable attempts at prevention should just as well apply. Whether the action, morally justified, ought to be legally compelled is wholly another question.

Alcohol and Aircraft Accidents

A task force commissioned by the Federal Highway Administration recently prepared a report on all psychiatric disorders that may compromise safe driving of truck drivers.[3] Recommendations in this report will serve clinicians who evaluate truck drivers for their medical certification. Although this report does not include procedures or guidelines for the clinician who evaluates or treats a truck driver in an unofficial, independent capacity, it is a useful resource document regarding how a variety of disorders may possibly affect safe driving. Together with a considerable body of research,[14-26] this report establishes the unquestionably deleterious effect that alcohol in particular can have on abilities needed for driving vehicles safely, including large trucks.[3] Perhaps more than any other disorder, alcohol abuse contributes substantially to a large number of vehicular accidents.

Since alcohol appears to be a contributing factor in 40 percent of all automobile accidents,[26] it is remarkable that alcohol is not implicated in more aircraft accidents. Alcohol has not been found to be a causative factor in any fatal accidents recorded by the United States commercial airline system.[26-28] Outside of the American system, a Japanese Airline aircraft crashed in Alaska in 1977. An autopsy of the pilot resulted in a measured blood alcohol concentration of 210 mg/dl.[29] Various factors may contribute to the low incidence of fatal

accidents of commercial aircraft where the pilot was intoxicated with alcohol. Commercial airline crashes, though of great publicity, are unusual occurrences.

The role of alcohol as a factor contributing to fatal aircraft accidents is, in contrast, more pronounced for pilots of general aviation aircraft. Of those fatal aircraft accidents involving general aviation pilots, where the accident was due to pilot error, about 10 to 30 percent of these pilots had measurable concentrations of blood and tissue alcohol on autopsy.[27, 30–43]

Piloting an aircraft is a demanding process requiring heightened attention, concentration, orientation, vigilance, and psychomotor coordination. The pilot must be capable of making quick adjustments to changes in the operation of the aircraft and its movement through a three-dimensional environment.[44] Even a relatively low level of blood alcohol can affect the ability to ably accomplish specific tasks required to pilot an aircraft safely.[43] Results of surveys indicate pilots may underestimate or deny the compromising effect alcohol has on their flying performance.[45] Even less well appreciated are the adverse effects of hangover on piloting performance 12 to 14 hours after drinking.[27] Studies on the effect of alcohol consumption on driving performance provide a scientific basis for attempting to control the alcohol factor in promoting safe piloting.

Recognizing the importance of reducing the risk of alcohol-related aircraft accidents, the Federal Aviation Administration implemented revised regulations. According to these regulations, crew members of civil aircraft are prohibited from acting as crew members within eight hours of alcohol consumption, "while under the influence of alcohol, or a drug that compromises a person's faculties to function safely *or* while having 0.04 percent by weight [8.7 μg] or more alcohol in the blood."[46] Though it is argued that these measures do not go far enough,[45] together with mandatory drug testing, they may have helped to maintain the low rate of substance related fatal crashes involving commercial airlines. Commercial pilots, who are financially well compensated, have far more motivation to adhere to these guidelines than the average drinking motorist.

A commercial airline pilot, who is alcoholic, may, by the same token, have every reason to deny any relationship between his drinking and piloting. Denial and lack of insight are common for alcoholics generally, not just pilots. Thus, a clinician could evaluate a pilot who has a significant problem with alcohol abuse, but who denies drinking just before flying and who denies that alcohol has diminished his ability to pilot a plane safely.

What should the clinician do in this case? Alcohol rehabilitation and possibly detoxification should be recommended certainly, but recommendations are not always accepted and civil commitment for alcoholism alone, even when the danger extends to others, i.e., passengers, is not always practical or possible. In such cases, the clinician should feel legally free to notify the airline or the

FAA, out of concern for the safety of passengers who travel on planes piloted by this alcoholic person. Such discretionary action ought to be allowed when the alcoholic operates aircraft, trains, buses, or large trucks.

Conclusions and Recommendations for Public Policy

In several states mental health professionals have a duty to take preventive or protective action where a patient's dangerousness is manifested by a specific threat against a reasonably identifiable victim. Some courts find a duty to protect if the violence is foreseeable, even violence in the form of an automobile accident. Where the therapist has no duty to make preventive disclosures, law governing confidentiality and privileged communication may seem to create a duty not to disclose. Ethical codes, such as that of the American Psychiatric Association, prohibit disclosure except under compulsion of legal duty.[47] Protective disclosure, it seems, is either legally compelled and ethical or not legally compelled and unethical. According to the APA ethical code, protective disclosure is not ethical where a legal duty does not mandate disclosure. The clinician, then, teeters on a fence, facing two liabilities, yet the fence itself changes in position depending upon which legal rules are enforced.

Law pertaining to the role of health care providers in preventing accidents is comparatively underdeveloped. Yet fatal accidents are more firmly related to alcohol misuse than deliberate acts of violence are to verbal threats, where the law promises liability in many jurisdictions. When the alcoholic patient is a pilot or driver of a vehicle providing public transportation, the risk of harm to others is vastly increased. Since law has not addressed these issues, potential liabilities exist for the clinician.

Should mental health professionals serve as "watchdogs" for society? Where legal duties to protect third persons have been created, clinicians already have some sentinel responsibilities. Even though not compelled by law in the United States, a moral basis exists for any citizen to take responsible action to prevent one person from killing another. Unlike the ordinary citizen, however, the clinician faces potential liability for making unauthorized disclosures in violation of confidentiality and liability for failing to make disclosures that could have prevented deaths. At issue here is whether, where lives of many are at stake, a clinician can be unmuzzled and allowed to make a protective intervention without incurring a duty to do so.

A well-reasoned protective disclosure can be morally justified without having to be legally compelled. The APA's Ethical Code, however, allows protective disclosure only when legally required,[47] yet the laws governing disclosure and reporting requirements vary between states; thus, no underlying moral principle guides psychiatrists. The ethical principle should be amended with a clause allowing for disclosure to key individuals who could reasonably be expected to present the view of the psychiatrist when the patient presents a sub-

stantial risk of causing a mass casualty unless such disclosure is made (e.g., alcoholic pilot or operator of a large commercial or public vehicle). Note that this would create no new ethical duty; it would merely ethically permit disclosure when justified.

Second, statutory laws governing confidentiality should be amended to permit disclosure to key individual(s) who could reasonably be expected to prevent tragedy; if, in the view of the psychiatrist, the patient presents a substantial risk of causing mass casualty unless such disclosure is made. This would not create another legal duty; it would merely alter the exception to confidentiality for such rare but eminently justifiable occasions. Beyond state laws, if protective disclosures are morally justified, it makes little sense to prohibit substance abuse programs from making such disclosures as federal law has done.[5]

Protective disclosure statues ("duty to warn laws") that now exist in several states provide greater clarity regarding the clinician's responsibilities than the courts have done. On the other hand, such laws have reaffirmed the principle that confidence can be violated for protective purposes *only* where a legal duty to warn or report exists. Thus, these laws neglect the possible "gray area" wherein protective disclosures can be morally justified without legal compulsion. Similar to the suggestion for improving law on confidentiality, these laws too should allow for the very real possibility that a preventable peril can occur without a specific threat, without a victim whose identity is knowable in advance, and for which the most useful disclosure would not be to the police.

Finally, until legal guidance reflecting public policy is clarified and codified, courts must allow clinicians to make well-reasoned, discretionary decisions about whether to report a substance abuse problem, with foreseeable risk to public safety, to the management of the carrier system or an appropriate governmental regulating body, such as the FAA, in the case of airline pilots.

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