# Legal Duties of Psychiatric Patients

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**Psychiatric practice involves an implied contract in which each party fulfills a specialized role and incurs corresponding duties and obligations to be discharged as best able. Patients incur duties at three levels. First are *specific* duties that arise from patients' specialized role in their own health care: (1) to provide accurate and complete information, and (2) to cooperate with treatment within the bounds of informed consent. Second are *general* duties that apply to all citizens, but are especially relevant within the mental health context: (1) to respect the physical integrity of self, others, and property, and (2) to obey the law. The controversial "duty to protect" is at a third level, a *transcendent* duty that is specific to the context at hand, but in principle can apply to more than one party. Advantages of enforcing patients' duties include better care by treating professionals, optimum level of functioning of patients, and improved systems-wide morale and safety. Breach of patients' duty has many potential consequences in the forensic sphere: termination of care, malpractice defense, criminal prosecution, and tort liability. Complicating factors include the degree and effect of patients' psychiatric impairment, patients' legal status, and the role played by psychotherapeutic transference.**

Legal duties are enforceable obligations that arise from widely shared societal role expectations, as well as from specific contractual and quasi-contractual elements in interpersonal transactions. Patients incur well defined duties from both sources. Health care roles are generally well known. In addition, an implied contract arises whenever a professional accepts a prospective patient's request for help in fulfilling those life responsibilities in which that person feels impaired. This process cements a mutual agreement, first, that a complaint exists and, second, that the professional has assumed the duty to employ the reasonable standard of care toward its resolution. It satisfies the essential elements of contract: an offer by one party, an acceptance by another, and a consideration that lends substance to the transactions.[1]

Health care contracts are often *implied* in fact or "manifested by conduct" of the respective parties. In general contract law, where fees are not stated but assumed, the recipient of services must pay the provider a "reasonable commission."[2] "Implied in law" refers to an obligation "to do justice" even when no promise was made. For example, when necessary medical services are rendered over a guardian's objection, the guardian

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can still be held obligated by "quasi-contract."[3] This can apply to involuntary treatment rendered in good faith.

When specific intentions of the contracting parties are unclear, the "reasonable person" test of common law applies: "a party's intention will be held to be what a reasonable man in the position of the other party would conclude his manifestation to mean."[1] When usual and customary practice is sufficiently well known to most reasonable people, well defined legal duties arise, e.g., the legal standards of practice for psychiatrists that have become increasingly consolidated.[4]

A "reasonable person" will hold different individuals to different standards of responsibility. A party with "special knowledge," is held responsible for what a reasonable person *with that special knowledge* would do. As noted by an appellate court, ruling against a physician defendant in *Morrison v. MacNamara* and citing the vast body of extant case law, "it is this notion of specialized knowledge and skill which animates law of professional negligence."[5] In addition, the limited experience, maturity, and knowledge of patients (relative impairment) "negates the critical elements of the defense, i.e., (patient's) knowledge and appreciation of the risk." Together with the interest of all citizens in quality of medical care, these twin presumptions, special knowledge of professionals and relative impairment of patients, support the ever higher duties of care charged to treating professionals.[6]

There is, however, another domain of special knowledge and competence that imposes high duties of standard care on the patients themselves. Only a patient, for example, can directly experience his or her inner state of being: thoughts, feelings, sensations, goals, value priorities, conflicts, and incongruities. The treating professional can know only what is conveyed by patients' words, behavior, and in some cases physical and laboratory findings. Whenever patients enter a health care contract, because of this special knowledge and reasonable self interest, they incur a binding duty to provide accurate and complete information.[7]

In addition, self-interest mandates that a "reasonable person" in the patient role will also maximally cooperate with the processes of diagnosis and treatment. Right to informed consent supports this active patient participation. From this arises a second binding patient duty: to cooperate with diagnosis and treatment as best able.[8]

Extending this domain, only patients can activate their skeletal musculature to institute outward actions, or refrain from such. From this arise common law duties charged to all citizens: to guarantee physical safety from destructive actions to self, others and property; and to obey the law. Their breach or threatened breach occurs all too often in psychiatric practice, which to date has not been successful in applying remedies that common law already provides.

Patients' duties parallel corresponding duties of treating professionals. The duty to provide information parallels physicians' duty to provide informed consent.

Each obligates that party with special knowledge to impart this information to the other for mutually informed assessment and decision-making. Similarly, patients' duty to cooperate parallels the composite duty of physicians to provide diagnosis and treatment at or above the prevailing standard of care.

## Case Law: Legal Duties of Patients—Specific Duties of Psychiatric Patients

***1. Duty to Provide Accurate and Complete Information*** That medical patients should provide treating professionals with whatever data about themselves is relevant to diagnosis and treatment is explicitly defined as a duty by a 1983 Indiana appellate court in *Fall v. White.*[7] Although a patient can reasonably expect the physician to ask the proper questions, "failure of patient to disclose complete and accurate information can, under certain factual circumstances, prevent finding of negligence on part of the doctor."

This duty was defined more broadly in a 1979 Kentucky appellate decision, *Mackey v. Greenview Hospital, Inc.*[9] Although a patient is under no general duty to volunteer information, such a duty *does* arise if the information is known to be relevant, and omission to be risky.

> If patient is aware that the treating physician has failed to ascertain some aspect of the patient's medical history which patient knows involves a risk of harm to patient during the course of future medical treatment. . . ordinary care may dictate that the patient volunteer the additional information to the treating physician. Otherwise, the patient may be deemed to have voluntarily and unreasonably encountered a known risk.[9]

The patient is contributorily negligent if a reasonable person would "know that the history was false and misleading, and his failure to inform the physician of the condition is unreasonable under the circumstances."

Other courts have affirmed the duty to give accurate and complete information. In *Ray v. Wagner*[10] and *Somma v. United States,*[11] failure of patients to give accurate identifying data nullified physicians' attempts to notify them of adverse medical findings, thus absolving the physicians of responsibility for tragedies that ensued. *Stager v. Schneider* further noted that "a patient cannot, by her conduct, make it virtually impossible to communicate . . . yet charge the doctor with damages for his inability to communicate . . . with her."[12]

A strong precedent also exists for holding actively psychotic patients to this duty. In *Skar v. City of Lincoln, Neb.*, a U.S. Court of Appeals absolved a defendant psychiatrist and his institution accused of failing to restrain a psychotic patient, who despite reasonable inquiry had failed to disclose a history of paranoid schizophrenia.[13] Though actively psychotic, the patient was contributorily negligent by his "failure to give information requested of him . . . [though able to do so] and the giving of allegedly false, incomplete, and misleading information.'

***2. Duty to Cooperate with Diagnosis and Treatment*** The *Skar* court also ruled that even when psychotic, "a pa-

tient has a duty to cooperate with a treating physician, at least to the extent he is able."[13] In fact, the duty to provide information can be seen as a specific aspect of a more general duty of patient to cooperate with the treating professional in both diagnosis and treatment.[7, 9-13] Affirming an earlier appellate decision, the Nebraska Supreme Court ruled in *Mecham v. McLeay* that: "It is the duty of the patient to cooperate with his professional advisor . . . but if he will not, or under the pressure of pain cannot, his neglect is his own wrong or misfortune, for which he has no right to hold his surgeon responsible."[14] Even when impaired by the pain of illness, the patient must still cooperate.

It should be noted that a patients's duty to cooperate does not in any way obviate one's fundamental rights to informed consent or to refuse treatment. It does mean, however, that if one exercises the latter right, he or she voluntarily assumes some of the responsibility otherwise charged to the treater. Reversing a decision for plaintiff in *Newell v. Corres*, an Illinois appellate court stated a basic rule:

> Refusal of 'standard' treatment by a competent adult patient fully cognizant of the potential consequences of his refusal, after the physician's reasonable explanation of the necessity of the preferred treatment, is a complete defense to a charge of malpractice resulting from the physician's failure to give the treatment; whether the treatment was offered and refused is a question of fact.[8]

Other cases address the question of to what extent treatment refusal is a knowledgeable and voluntary act, a condition for patient liability. Presented with a passively controlling patient whose obstructive behavior contributed to subsequent injury, the 1972 Oregon Supreme Court concluded by material evidence that "plaintiff's conduct was volitional, that is, . . . was not completely out of the control of her will."[15] Another court had ruled against a grossly impaired psychotic patient in *DeMartini v. Alexander Sanitarium, Inc.*, noting that "the question . . . [of voluntariness is] still an open one . . . in which reasonable minds might differ."[16]

## General Duties of Psychiatric Patients

***1. Duty to Respect the Physical Integrity of Self/Others/Property*** Patients share a societal duty to protect person and property, affirmed by the universal presence of statutory law for involuntary commitment of those who, because of a mental disorder, either can or will not respect this duty.[17] The act of court commitment can be seen as an *ipso facto* recognition that, first, a duty for protection exists and, second, that the patient either can not or will not fulfill this duty. Conversely, if treating personnel unsuccessfully attempt to commit a patient, a court's dismissal equally affirms that patient's competence to fulfill the duty—assuming that the court has been provided with adequate information.

Of particular legal as well as therapeutic import are behavioral *contracts for safety* made by patients in treatment. Patients' agreeing to voluntarily guarantee safety from destructive actions, is a *sine qua non* of treatment for potentially violent individuals.[18] Contracts for

safety are paradoxical in that they are *unilateral*, not contingent on the actions of any significant other; yet implications for therapists and treatment institutions are *implied in fact* by the conduct of the relevant parties. Inasmuch as they are so often the ultimate criterion for release from confinement or a psychiatrist's decision not to commit, their legal enforcement must be granted high priority in mental health law.

*2. **Duty to Obey the Law*** All citizens also share an obligation to respect statutory law, including criminal statutes. Appellate decisions in *State v. Grimsley*,[19] *Kirkland v. State*,[20] and *U.S. v. Hearst*[21] affirm criminal accountability even for patients with severely impaired consciousness and volition,[22] or subject to severe duress.[23] Recent Iowa Supreme Court decisions further illustrate the scope of this duty within the health care context. In *Cole v. Taylor*, the court established

> that a person cannot maintain an action if, in order to establish his cause of action, he must rely, in whole or in part, on an illegal or immoral act or transaction to which he is a party, or to maintain a claim for damages based on his own wrong or causes by his own neglect . . . or . . . base his cause of action, in whole or in part, on a violation by himself of the criminal or penal laws. . . .,[24]

and affirmed this ruling in *Veverka v. Cash*.[25]

***"Duty to Protect" Transcends the Health Care Contract*** It must be emphasized that patients' liability for their own actions does not absolve professionals of potential liability for patients' injury to third parties. In the landmark *Tarasoff* decision, neither the patient/killer's guilt nor the quality of his care were at issue. The treater and institution were held at fault at another level: *knowing* of the patient's intended breach imposed a *new* duty of common law, to warn an intended victim of known identity,[26] later expanded to the broad "duty to protect" third parties[27] that has resulted in the wide but problematic use of "preventive detention" in current practice.[28] While in *Tarasoff* and its progeny it was the "special relationship" inherent in mental health practice that determined the professional context of the tort actions,[29-31] the cardinal principle is that responsibility for protection is *not either-or:* i.e., it does not fall on one party *or* the other. If several individuals are privy to a dangerous situation and have the means by which a "reasonable person" would mitigate it, all potentially incur the duty to protect.[32] That another person shares this duty, and may breach it, in no way abrogates this responsibility.

***Advantages of Enforcing Patients' Duties*** The most likely consequence of enforcing patients' duties will be to improve the overall quality of care. Patients' duty to provide information, along with their right to informed consent, allows access by both parties to the information needed for competent decision-making. Collaboration and informed trust are reinforced in both parties. This reciprocal process enhances supervisory elements at both ends of the relationship: patients are held to a higher standard of communication and cooperation, and professionals are faced with

an informed and active participant who may stimulate quality treatment as well as peer review.

To reinforce patients' competence may also stimulate the more healthy coping strategies in their repertoire, avoiding the regressive effects of reinforcing the impairments alone.[33] Halleck notes that even when defined as "sick," undesirable behavior is "most likely to change . . . when its perpetrator is held fully responsible for using all of his capacities to control it."[34] Beahrs and colleagues are finding that a "strategic self-therapy" paradigm in which patients voluntarily assume full responsibility for their safety and treatment direction, partly achieves this goal in regressive patients like borderline personalities.[35,36] In over 50 such patients, regressive dependency and acting out were minimal, and therapeutic progress correlated highly with the degree of patients' self-therapeutic activity. The enforcement of patients' duties should have a comparably salutory effect.

Additional observations show the extent to which both therapeutic results and safety can improve, when positive expectations of patients are conveyed and limits enforced. First, an order of civil commitment can often lead to patient relief with improved rapport and therapeutic participation.[37,38] Second, criminal probation or its equivalent may motivate normally noncompliant patients with behavior disorders to follow through with treatments that permit an increasingly optimistic prognosis.[39-41] Finally, abstinence from alcohol or drug use can well be viewed as a *precondition* for treatment of chemical dependency, as opposed to its desired end result,[42-44] whose value is further shown by improved results in many community programs utilizing disulfiram,[45] and the sometimes salutory effect of legal probation.[46]

Abstinence from destructive problem-maintaining behavior as a condition for treatment merits special emphasis because it counters the reasonable common-sense view that only after successful treatment can a symptom be expected to resolve. When the "symptom" is voluntary behavior, however, this is a "cart before the horse" error. Behavior control as a precondition for treatment can apply as well to a variety of offender groups.[47,48] Also, if van der Kolk and Greenberg are correct that posttraumatic reenactment behavior relieves symptoms of withdrawal from endogenous opiates heavily secreted during trauma, abstinence from destructive behavior may be literally analogous to abstinence from drugs, and equally essential for recovery of normal brain function.[49] With this information in mind, the law can help foster a more therapeutic outcome by enforcing limits against behavior that is clearly out of line; insisting that it not only must but can be brought under voluntary control, despite many patients' initial subjective experience otherwise.

Improved staff morale and more therapeutic milieu may also follow successful prosecution of an assaultive patient.[50,51] Despite concerns that this could hamper the therapeutic alliance,[52] further studies confirm the enhanced

system-wide morale.[53, 54] Sparr and colleagues present additional data on the efficacy of interdicting violent incidents at a system-wide level; besides clear expectations of and consequences for patients, they keep a data base on violent incidents, "flag" dangerous patients, and maintain an ongoing behavioral emergency committee.[55] This has reduced patients violence by over 90 percent.[56]

## Breach of Patients' Duties: Forensic Implications

***Termination of Treatment Versus Abandonment*** When faced with an uncooperative or abusive patient, termination of care is often the most appropriate recourse. Courts respect a physician's right to withdraw from a case; if need for services persists, he or she is bound only to give notice to the patient, and to afford ample opportunity for securing other medical attendance of choice.[57] Unilateral termination is actionable "abandonment" only when these duties to provide notice and alternative treatment options are breached.

***Patient Negligence as Malpractice Defense*** Patients' negligence and assumption of risk are increasingly recognized as a valid defense in professional malpractice actions.[58] In pure contributory negligence, a plaintiff's recovery may be barred even when defendant was also at fault. Relevant rules are set forth in *Santoni v. Schaerf*: patient's negligence "must be concurrent" with, not subsequent to, the physician's; the burden is on the defendant; key elements are patient's appreciation of risk and failure to do what a person of "ordinary prudence" would.[59] Assumption of risk shares the two elements of "knowledge of the danger and . . voluntary exposure to that known danger."[5] Contributory negligence of patients has been affirmed as a complete defense to malpractice claims, by many appellate courts in decisions already reviewed under the duties to provide information and to cooperate.[7–11, 13–16]

Many states have adopted some form of "comparative negligence," with degrees of negligence measured in terms of percentage instead of either-or. An Illinois appellate court defined the relevance of comparative negligence to malpractice actions in *Newell v. Corres*, noting that a patient's refusal of recommended treatment put a physician in a dilemma of giving suboptimal treatment or abandoning patient.[8] The court charged the jury to consider the nature of the treatment provided, whether this and the preferred treatment were fully explained to the plaintiff, and whether plaintiff knowingly refused the preferred treatment. It noted that comparative negligence is "particularly suited for such a broad-based fact-finding." Some limits are stated in *Bellier v. Bazan*: patients' fault must be concurrent to defendant's, subsequent fault can still mitigate damages, but any reduction in recovery can be negated by physician's failure to give informed consent.[60]

***Recommendations for Malpractice Defense and Prevention*** To evaluate whether patient negligence is likely to be affirmed as a valid defense in a given action, and if so how to best proceed,

requires that the attorney answer the following questions: (1) what specific duties were charged to this particular patient, (2) whether and how these were breached, (3) the degree to which the breach was knowledgeable and voluntary, (4) the degree to which these factors were documented in advance of the injury, (5) whether the breach materially contributed to the injury, (6) whether the breach was concurrent with or subsequent to any alleged act of professional negligence, and (7) whether independent evidence supports a level of knowledge and volition that would hold the patient accountable for his or her actions in other areas of law. When all or most of these questions are answered affirmatively, a court is likely to rule for the defendant. As in most malpractice law, the dominating factor will often be the degree to which answers to the relevant questions were documented in the record. Mental health professionals are therefore advised to bring their record keeping into line with these guidelines.

As a qualifying caution, patients' negligence will rarely prevent an adverse judgment against a professional who was clearly negligent with resulting damage; i.e., it is not a legal panacea for bad medicine. The New Jersey Supreme Court recently ruled not even to admit arguments for contributory negligence when a patient's actions (negligent or not) were "subsumed within the duty of care defendants owed to her."[61] The subsequent plaintiff, hospitalized following a suicide attempt, had injured herself by jumping from a hospital window while inadequately attended. Despite expert testimony that her behavior was voluntary and manipulative, this was deemed irrelevant: "Simply stated, ... [the] plaintiff committed the very act that defendants were under a duty to prevent."

***Criminal Prosecution of Psychiatric Patients*** Most literature of the prosecution of psychiatric patients deals with assault—usually against treatment personnel, occasionally third parties or property. Not only do criminal authorities often resist prosecuting patients,[50] mental health professional also hesitate to press such actions. Guthiel succinctly stated the usual concerns; to press charges might hamper the therapeutic alliance, or incite patients to bring more suits against treatment staffs for physical restraint.[52] Hoge and Guthiel advise a cautious multidimensional approach to deciding whether to press charges;[53] Miller and Maier also urge caution.[54] Phelan and colleagues reply that a therapeutic alliance is not always feasible, and point out the destructive impact of licensed patient violence on staff morale.[51] Reluctance to prosecute is generally limited to offenses that arise in treatment. Outside this protective sanctuary, courts usually hold disturbed individuals guilty for criminal actions, except in the relatively few cases of legal insanity. Also, an otherwise valid insanity plea may be denied when patients' offenses arose from knowing and willful noncompliance with essential treatment.[62]

"Harassment" is a petty misdemeanor that occurs when with ill intent one (1) makes a telephone call without purpose of legitimate communication; (2) insults, taunts, or challenges another in a

manner likely to provoke violent or disorderly response; (3) makes repeated communications anonymously or at extremely inconvenient hours, or in offensively coarse language; (4) subjects another to offensive touching; (5) engages in any other course of alarming conduct serving no legitimate purpose of the actor.[63] "Terroristic threats" are similar, but of sufficiently greater severity and grave social implications to merit the status of a felony.[64] Few therapists have escaped such abuse by patients in the course of the occupational duties. Miller reports that nearly half of forensic psychiatrists have experienced harassment that would approach the felony level.[65] Rarely does one even think of criminal prosecution until a pattern of harassment becomes entrenched, invading the far corners of a therapist's life, or causing fear for life, family, or property. By granting felony status to the offense, the law now provides a remedy. Implementing this remedy remains an open area.

***Tort Liability of Psychiatric Patients*** That a professional might sue a patient or former patients for damages arising from breach of duty rarely occurs to professionals in either mental health or the law. Therapists rarely institute tort action unless malicious litigation motivates them to fight back; hence, counterclaims are the most common type of litigation in this category.[66] These are rarely affirmed; e.g., although noting violation of physician's privacy as a legitimate cause for action, an appellate court in *Wolfe v. Arroyo* still ruled that "communications in judicial proceedings are absolutely privileged and are immune from an action for invasion of privacy."[67] Thus, the invasive effects of litigation *per se* are not an actionable violation of privacy; only if such violations occurred independently of the malpractice suit, can the physician's cause be heard.

It is common for dissatisfied patients to "bad mouth" former therapists, which can significantly harm the latter's reputation in the community, hence economic survival. This opens another area: civil suit against a patient for defamation: libel or slander. Although no relevant case law exists for defamation of therapists by patients, similar actions have been affirmed for defamed attorneys,[68] with issues that should be transferable. "Intentional infliction of emotional distress" is another tort, closely related to the crimes of harassment and terroristic threats.[69] As with defamation, judgments have been affirmed for other professionals by criteria that should be transferable to the mental health context: for a teacher,[70] and a real estate agent.[71] Again, the issue is open.

## Discussion: Complexities and Complications

***Psychiatric Impairment*** The most obvious limit to enforcing patients' duties is the question of whether the patients are too impaired—either to understand their duties or to voluntarily conform their actions to them. This corresponds to the cognitive and volitional arms of the insanity defense in criminal law, which is likely to excuse only the most severely disordered patients from culpability. The issues discussed in this

paper are more likely to be relevant to what Halleck terms "disorders of will":[34] personality disorders, dissociative disorders like multiple personality, substance abuse and eating disorders, and many posttraumatic conditions. Such patients present a true paradox to health care providers. On the one hand, few question their level of distress, potential for violence to self or others, or their perceived lack of control—all of which call professionals toward assuming an active therapeutic role. On the other hand, this is often regressive and may actually increase the risk, inasmuch as patients do better when retaining a high level of responsibility for their actions.[33-36, 56, 72]

Multiple personality (MPD) epitomizes the dilemma, a disorder in which conflicted currents of consciousness and volition manifest as separate entities or alter-personalities.[73] One may be a conscientious law-abiding citizen in one's usual state, yet beyond either awareness or apparent control "switch" into another personality state that commits some violent crime, subsequently reporting neither recollection, control, nor the existence of a rational motive. Can such a person be held responsible for his actions? By concretizing issues common to most psychopathology, this provides an opportunity for a definitive legal test of to what degree patients in general are accountable for their actions.

Two state appellate decisions provide a legal foundation for such a test, both affirming the reality and severity of the underlying disorder yet refusing to accept an insanity plea.[22] In *State v. Grimsley*, a 1982 Ohio appellate court noted that "it is immaterial whether she was in one state of consciousness or another, *so long as in the personality then controlling her behavior, she was conscious and her actions were a product of her own volition*" (emphasis added).[19] In *Kirkland v. State*, a 1983 Geogria appellate court affirmed conviction for a crime committed in a fugue state: "the personality (be she Phyllis or Sharon, or both) who robbed the banks did so with rational, purposeful criminal intent and with knowledge that it was wrong."[20]

These rulings cut to the heart of the matter. Despite gross overall impairment in both conscious awareness and voluntary control, not disputed by either court, *at another level* each patient *did* know what she was doing and why, and *it was only this level that was relevant to the determination of criminal responsibility.* Similar reasoning applies to crimes committed under duress.[23]

The key to the dilemma is to recognize that impairment is only partial, accompanied by healthier coping in other areas of personality. Whether one emphasizes biological, developmental, or posttraumatic etiology, most practitioners agree that to get well, patients must actively employ their healthier sectors to bolster impaired ones, contain destructive impulses, and work through relevant issues.[33-36, 72-78] Even when actions are carried out only at a neurotic level, *this level* is still conscious and acting voluntarily, and is a vital part of one's basic being for which he or she must remain fundamentally accountable.

***Transference of Responsibility*** Another unresolved issue is to what extent

patients' responsibility is lessened by transferential factors. Responsibility can be shifted from patient to professional in two ways. First is the implied contract, in which a therapist assumes the duty to provide the prevailing standard of care, one that may vary significantly with a patient's legal status. Second, "transference" also denotes a patient's experiencing a therapist not as an objective reasonable person would, but instead as he or she once experienced significant others early in life, often with emergence of regressive thoughts and feelings like those of child toward parent. These will be discussed in turn, with forensic implications.

***Patients' Legal Status*** When patients are encumbered by legal hold, e.g., illness-related criminal probation or involuntary commitment, this may alter the balance of duties between them and their professionals in ways that are extraordinarily complex, evolving, and not yet consolidated in legal doctrine. In principle, patients' duties are retained and should be enforced, for reasons already discussed. Recent trends toward preserving committed patients' civil rights and legal competency[17] further support the retention of these duties as well.

In practice, however, two factors will variably place a higher burden on treating professionals in the involuntary arena. First, all else being equal, a reasonable person is likely to hold a committed patient to a lower standard of responsibility, though this will vary considerably with the reason for commitment and the particular legal arena in which patients' duties are relevant. Correspondingly, psychiatrists may be expected to make greater efforts to obtain information from collateral sources, and use more coercive methods to counter noncooperation. Second, and most important, the greater degree of fiduciary control permitted and charged to the psychiatrist in such settings, along with the dominance of dangerousness as a criterion for commitment,[17] will lower the threshold for professionals' duties to warn and protect third parties, regardless of what duties are also charged to the patients.

In *Perreira v. State*, a psychotic patient had killed a third party after discharge from involuntary commitment, and the bereaved spouse sued the state hospital and psychiatrist for wrongful death.[79] District court had ruled for the plaintiff, appeals court for the defendant, and the Colorado Supreme Court again for the plaintiff. When the patient refused medication, the psychiatrist, knowing the need for antipsychotic medication, also "realized that *he could have sought a court order for the administration of the medicine . . . but declined to do so*" (emphasis added), differentiating this case from those in which the right to refuse remains inviolate and thus beyond the physician's prerogative or control.

***Psychotherapeutic Transference*** Two components of psychological transference are "parataxis," transferential feelings evoked immediately in any situation of authority,[80] and "transference neuroses" in which intensive psychotherapy patients extensively merge their

experience of the therapist with unresolved early life issues.[74]

Transference supports a new professional duty, to exert unusual and special care to protect patients at levels where they would normally be responsible for themselves but are now highly vulnerable; e.g., therapists' duties to refrain from sex with patients[81] or patients' intimates,[82] or abuse of transference for personal gain.[83] Transferential factors may also heighten the risk of liability for failing to prevent a patient's suicide.[84]

This increase in the potential liability of therapists is not accompanied by a parallel decrease in patients' responsibility, however. The law not only holds patients accountable for criminal actions, it also draws a solid line against their benefiting from these at their therapists' expense. Actions have been pressed against professionals for patients' conviction of crime, for example, alleging that the former either "caused" or failed to prevent the offense; outside of the duty to protect third parties, such actions are uniformly denied.[24, 25, 85]

In summary, patients retain the specific duties to provide accurate and complete information to their care providers, and to cooperate with diagnosis and treatment within the bounds of informed consent. They also share with all citizens the duty to respect the integrity of self, others, and property, and to obey the law. Better enforcement of these duties is likely to improve the overall quality of patient care, to promote an optimum level of functioning by patients, and finally, to foster a systems-wide climate for patient care with improved morale and safety.

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