Dimensions of Third Party Protection

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Although we psychiatrists have preferred to think of ourselves as having concern only for the welfare of our patients, participation in the protection of third parties from the actions of our patients** is not new. We have reported to the secret service when our hospitalized patients made threatening remarks toward the President even when no imminent danger was foreseen. We have filled out forms for departments of motor vehicles to help insure safety on the highways. We have responded to employers' requests for information not only to protect the employees from health threatening jobs, but also to protect the companies from possible subsequent compensation actions. Insurance companies have obtained our aid in protecting themselves against poor insurance risks. We have taken part in legal proceedings concerned with competency, custody, criminality, and compensation, where the issues were not only the interests of our patients but the protection of the personal and property rights of others.

There has been little uniformity in third party protection; different psychiatrists in various settings participate to greater or lesser degrees. If there be a pattern at all, it is an informal one, often left to the discretion of the individual psychiatrist or the vigor of the agency demanding that we fulfill the protector role.

Recent events, however, have challenged this informality as legislation and litigation have increasingly demanded our participation as society's agents in protecting the safety and property of others. Child abuse laws covering both physical and emotional harm require us to report to social agencies; as Derdeyn[1] has noted, the concept of abuse has broadened to that of the "more nebulous" neglect. Virginia has enacted a law[2] mandating similar reporting for "abused, neglected, or exploited" adults. *Tarasoff*[3] has raised the possibility that we might be required to warn potential victims of our patients. The demands of third party payers for ever more information, whether justified or not, requires us to protect property rights, as does the patient-litigant exception tested in Lifschutz.[4] The Virginia requirement[5] that practitioners report the treatment of other practitioners for "mental, emotional, or personality disorders . . . drug addiction or chronic alcoholism" unless the treating physician deems the patient competent to continue practice, draws us further into the area of protecting the public health and safety.

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**For the purposes of this paper, the word "patients" refers to those who consult us for treatment and excludes those whom we see in evaluation as agents for third parties.

The trends are clear. The areas of third party protection are expanding. The decisions to participate reside less and less with the psychiatrist; even the passive role of waiting until one is asked is being replaced by the active duty to report. And, as in the Virginia practitioner law, there is some movement away from considering the third party protection as an exception to the psychiatrist-patient relationship and toward requiring the psychiatrist to justify why he/she should *not* report. The rhetoric of *Tarasoff*[3] signals the conflict: ". . . the protective privilege ends where the public peril begins." Thus, as Gurevitz[6] has warned, we psychiatrists must quickly become aware of the dimensions of this complex problem in order that we may actively and thoughtfully participate in its resolution.

Types of Protection

We may consider four types of third party protection:

1. *Patient Warning:* We warn our patients about possible consequences of their actions and rely on them to exercise reasonable control. This occurs, for example, when we caution patients against driving automobiles if they should feel sedated by the medications we prescribe.

2. *Notification:* We may notify the appropriate authorities that our patient poses an imminent threat to a third party. In a sense, this is what happens when physicians report patients with communicable diseases to Departments of Health; in many instances, such third party protection is mandated by law. Of greater interest is the issue of notifying the police when our patient threatens to harm physically a third party. Our obligations here do not stem from the fact that we are psychiatrists. Common law doctrine dictates that "any citizen, regardless of relationships, (has the duty) to communicate to law enforcement officials the imminent commission of a serious crime."[7] Unless we psychiatrists are to be given special exemption, we also have this duty – not particularly as psychiatrists but as citizens. Where common law prevails, neither lawyers, nor ministers, nor psychiatrists may exercise any presumed right of confidentiality when the imminent commission of a serious crime comes to light. The third party must be protected.

3. *Third Party Warning:* The most celebrated of this type of third party protection is found in the decision of the California Supreme Court in *Tarasoff.*[3] Here the California Court said that the potential victim must be warned if there is no other reasonable way to control the patient. This situation is quite different from notification (number 2 above); whereas all citizens have the duty to notify in dangerous situations, there is no general duty to control the actions of others. As citizens, we are not "our brothers' keepers." According to the California view (and it is only the California view), as physicians and as psychotherapists we have a "special relationship" with our patients which requires us to control their actions and may make us liable for injuries they cause if we reasonably knew their actions were imminent. Warning the third party is seen as one of the control mechanisms.

4. *Restraining the Patient:* This is another control mechanism that arises from the "special relationship." Again, the average citizen, while having the duty to notify, does not have the duty to restrain. Psychiatrists, on the other hand, may be liable for injuries caused by patients who escape from locked

wards, or by patients who have been discharged despite a reasonable assessment that they are dangerous.

Although these several types of third party protection may overlap, *Tarasoff* makes it clear that they are often separable. Thus, the psychotherapists involved did notify (although the police took no restraining action); the therapists were held immune from the suit on the grounds that they, themselves, failed to restrain the patient; and they were held subject to suit on the grounds that they failed to warn the third party.

Special Relationship

What is the nature of the special relationship which may, in certain instances, demand more in the way of third party protection from the psychiatrist than from the average citizen? Starting with the statement, "the relationship between the defendant and the person threatening harm to the third person may be such as to require the defendant to control the other's conduct." Harper and Kime[8] outlined some conditions (relationships) under which the control should be required: 1. Parents must control their minor children. 2. People must exercise control over those who use their property or be liable for injuries to third parties (*e.g.*, in the case of lending your automobile to a known intoxicated person who injures another person). The reasoning here is that we can choose to let others use our property or decide that it is too dangerous. 3. One may be professionally associated with someone who acts dangerously and whose actions we should be able to influence (*e.g.*, we may be liable for injury to our patient caused by the doctor who covers for us when we are on vacation).

Fleming and Maximov[9] feel that the special relationship between physician and patient exists "not only by reason and a mature sense of social responsibility" (an expression more of their bias than their logic) but also by a host of legal analogies and precedents, such as a hospital's obligation to admit and not to prematurely release dangerous mental patients. *Tarasoff*[3] made explicit the notion that the special relationship may exist between psychotherapist and patient, whether hospitalized or outpatient.

But what do we mean by a special relationship in this context? Special relationships in which respects? The fact that we are licensed and enjoy some special privileges and immunities does not, in and of itself, satisfy reasonable criteria of "specialness" in the sense of duty to protect third parties. If there be principles underlying this concept, they must be tightly drawn. Following Harper and Kime,[8] one such principle might be our right and ability to control the actions of the other person. Parents or those *in loco parentis* may have this power. According to the 1965 Restatement of the Law of Torts,[10] the "special relationship" applies to parent and child, master and servant (employer and employee), owner and licensee, person "in charge" of the dangerous person, and person having custody of another.

What should concern us as psychiatrists is the meaning and implications of the phrase "in charge". Are we in charge of our patients? Even with respect to voluntarily hospitalized patients, do we take total charge, or are we in charge of some aspects of our patients and not others? If patients have the right to refuse certain treatment modalities, does this weaken the concept of "in charge" and thus the concept of special relationship? Conversely, if we

insist on conformity with our prescriptions, are we strengthening the special relationship? We must bear in mind that when we assume greater control over the lives of our patients we may be broadening the area of special relationship and our potential liability for injury to third parties. And when our power to control patients is eroded by court decision or statute, we should examine whether we can reasonably be said to be "in charge."

When we deal with involuntarily hospitalized patients, we are often in greater charge, but here too, laws or good practice may weaken our ability to control. We must stringently define the boundaries of the special relationship in terms of delineating the circumstances when we act in *loco parentis*, and we must vigorously assert the areas in which we cannot or do not assume or even refuse such parental and controlling powers. Further, we must be wary of too great an eagerness to be "in charge" because of the nature of the special relationship and its attendant liability for injury to third parties.

Harper and Kime[8] wisely assert that the nature of the relationship which renders it special in the sense which we are considering here is not subject to exact principles. It is elastic, and it requires that we psychiatrists examine the assumptions of the relationships with our patients in order that the word "special" be not stretched beyond reason.

Parens Patriae

The concept of the special relationship based on parenting brings up another dimension: The minor child is not expected to have the judgment of the more mature parent. In society, this relation is reflected in the concept of *parens patriae*, which in this country refers to the power of the legislatures or their delegates to care for those who are not competent to care for themselves. Despite its noble and humane intent, *parens patriae* power can be abused, and the decision to place someone under its protection is subject to due process.[11] The threshold consideration is the incapacity to make reasonable decisions.[12] Once we determine a patient's incapacity, we or others may assume the parental role, and a reasonable case might be made for the existence of the special relationship. In terms of commitment, this might (but need not) occur if we dropped the criterion of dangerousness and used the criterion of competence as advocated by Peszke.[13] While Peszke states that our only concern should be the patient's and not society's welfare, this *parens patriae* situation might make us even more vulnerable to protecting third parties.

There are other situations in which the issue of competence arises. If we believe, for example, that our hypomanic patient lacks the competence reasonably to make a contract, are we sufficiently "in charge" following the concept of *parens patriae* that we might be held liable if a third party sustains property loss? I believe not, but issues such as these must be considered and defined.

A further dimension which requires considerable thought and definition is the question of the standards of incompetence. With increasingly broad interpretation of the insanity defense standard, we might see similarly broad standards of incompetence finding their way into the civil area which would strengthen the concept of special relationship and require wider third party protection. We must bear in mind that the definitions of incompetence

which we support in one area may come back to haunt us in another.

There are two issues needing scrutiny and definition here: 1. What constitutes incompetence? 2. In any area, when does the label of patient incompetence evoke the *parens patriae* role and with it liability for third party injury?

Police Power

Another vehicle for understanding a possible special relationship between a psychiatrist and patient might be through government police power. The states may promulgate laws and regulations to "protect the public health, safety, welfare and morals".[12] Here we must distinguish between the regulations placed on psychiatrists, themselves, and the regulations placed on the patients for whom the psychiatrist then becomes the government's enforcer. Third party protection puts the psychiatrists in the latter role.

The states do not have unbridled power to issue regulations; it must be balanced against whatever rights are abridged. When a fundamental right, protected by the constitution, is taken away, the state must have a "compelling" reason. Rights which are not fundamental require less stringent justification. We might conceptualize two graded series.[14] First is the degree of importance of the rights which are abridged. Commitment is a deprivation of liberty and infringes on a fundamental right.[12] Confidentiality seems to be constitutionally protected in *Lifschutz*,[4] a position somewhat stronger than that taken by earlier writers[15] who treated it as the exception to the need to testify instead of the other way around. However, as Foster[7] indicates, psychiatric confidentiality is not absolute. For example, as we have indicated above, psychiatrists have the duty to notify authorities about an impending serious crime.

The right to make contracts or to handle one's own property perhaps might be seen as less compelling than the right to liberty.

The "right to treatment" has yet to be delineated in terms of its degree of importance. And within this "right" does one have a right to choose a form of treatment which depends on and guarantees confidentiality? How compelling would such a right be?

With respect to treatments requiring confidentiality, we must define which modalities require which degrees of confidentiality. Plaut[16] has made an attempt at such a delineation. To put all psychiatric treatment in one confidentiality bundle is as misleading as to argue that since we breach confidentiality in some situations, we can reasonably breach it in all situations.

The second continuum is that of the degree to which the social need to protect a third party is compelling. One might consider the relative importance of physical danger (and to how many persons?), emotional danger, danger to the President or from a presidential candidate with a psychiatric history, likelihood of fraud, stealing, etc., etc. If, and I stress the word "if", one uses police power to justify the duty to protect third parties, protecting them from what type of danger becomes important to define.

Under the police power, the action of the state must be reasonably related to a legitimate state purpose.[14] While protection of the populace is a noble and legitimate aim, it remains to be demonstrated that invoking the third

party protection duty will result in increased safety or protection of society. Dangerous people may learn to avoid psychiatrists or learn to withhold information from them. As Stone[17] has commented in another context, the social deterence function of the criminal justice system has not had sufficient success to recommend that it be grafted onto the psychiatric system.

When we balance the importance of right being abridged against the importance of a social need, we weight the balance with the social climate. In periods of social turmoil, the outcry for expansion of police action increases. At other times, especially with better economic conditions, the humane *parens patriae* functions are promoted. Still other social forces push for the expansion of individual rights and liberties. The social context is thus an important dimension of third party protection, and it will influence our judgment of how fundamental or compelling is any particular or any felt societal need.

Equal Protection

Even if we invoke the police power concept, why should psychiatrists be singled out as a class of people having a duty to protect third parties? I submit that as yet it has not been convincingly demonstrated that all our relationships with patients qualify as special. While we may reasonably be seen as agents of public policy in promoting health, we may not be reasonably singled out as public agents in promoting safety in the sense of policemen. Indeed, our record of predicting danger has, with some justification, been called into question.[18]

Another approach seems to be to identify not psychiatrists, but mentally ill patients as the class to be singled out. Their rights to confidentiality cannot be abrogated on the grounds that as a class they are more dangerous, because there is little evidence to support this view.[19] It has been stated[12] that dangerous mental patients comprise a special class by virtue of having "diminished responsibility." Somehow, this is not incompetence but is an inability to appreciate or utilize the potential deterrent function of arrest and conviction. This concept certainly must be examined in terms of psychiatric reality. Further, we are not really talking about the class of mentally ill patients; the class most often dealt with in actuality is "those people who go to psychiatrists." Do all of them have the same type or degree of mental illness or "diminished responsibility?" We may deny many of our patients the Constitutional right of equal protection by lumping them all together in the same classification.[14] On the other hand, are we unduly widening the meaning of incapacity or "diminished responsibility" by the concepts employed in the insanity defense standards?

Special Third Parties

Another dimension of third party protection relates to the question of who the particular third party is. Harper and Kime[8] indicate that one might have a special relationship to third parties which mandates their protection. The "custody" provision of the 1965 Restatement of the Law of Torts[10] refers to the special relationship of those in custody who might be injured by others. Here again, the relationship is with the third party rather than the

potential wrongdoer. Pertinent to the present issue is the dictum that we must protect such people as our children or wards, or perhaps patients in our hospitals from attacks by other patients. However, even with people in our custody, we must define limits to the degree to which we may reasonably afford protection. We must not unwittingly accept the implication that all people in our mental hospitals are incompetent in all respects and at all times and thus are either subject to our control or render us liable for injury to them.

Informed Consent

If after a consideration of such dimensions as these, it is concluded that at least in some instances, we do have a duty to protect third parties by notification, third party warning, or restraint, do we have a *Miranda*-like[20] duty to warn new patients that they may have rights or reasonable expectations abridged under certain circumstances? Fleming and Maximov[9] and Noll[21] answer in the affirmative. Roth and Meisel[22] advocate a limited type of warning. While this may afford us subsequent legal protection against charges that we failed to warn our patients, are we in some instances also telling our patients not to disclose certain dangerous information to us?

Impact on Psychiatry

One cannot predict with accuracy the impact of the ever-broadening third party protection on our profession. While it may not have a chilling effect on all potential patients, it may deter some from seeking or participating freely in treatment. If *Miranda*-like warnings are required, patients increasingly will be made aware of the risks. Such warning, while appropriate for the adversary police situation, does not do much for inducing the non-adversarial aura of cooperation and collaboration desirable in our professional activity.

Will we increasingly practice defensively? Will we tend further to overpredict danger which may result in more and longer hospitalization and more frequent divulgences? Will we, in self defense, find ourselves volunteering information about, say, the incompetence of our patient, perhaps very loosely defined, when we learn that he/she is making a will, because we are concerned that the persons left out of the will might accuse us of having not afforded them protection? It is true that we will not be held liable for "honest errors in judgment" about danger to third parties, but what is often overlooked is our defensive desire not to want our judgment called into question.

It is possible that we may find ourselves trapped in unusual third party protection situations because the definitions and procedures we have developed with reference to certain psychiatric situations are subsequently applied by attorneys in litigation with reference to other psychiatric situations.

We must also consider the implications of the first type of protection mentioned earlier – that of warning the patient and depending on him/her to exercise control. When we affirmatively give the patient medications we would seem to fall into the same type of special relationship, at least with regard to the consequences of medication, as the barkeeper serving alcoholic beverages.[9] We must assess reasonably that the patient is able to monitor and

control the consequences, and, again, we will not be liable for "honest errors in judgment" provided that our assessment has been based on an adequate standard of psychiatric practice. But what about potential injury (not necessarily physical) to third parties which are not consequences of our *affirmative* actions? In the course of treatment, patients frequently act out their conflicts and their transferences, sometimes in such a manner that they harm other people. For example, a professor-patient may treat a student in a grossly unfair and possibly illegal fashion having unfortunate consequences on the student's career. If we, as the professor's psychiatrist, foresee this, can we be required to warn the student, and if we assess that the professor's unconscious conflicts may prevent him/her from avoiding the action, will we have a duty to move to other means of protecting the student? At present, this degree of duty seems inconceivable; it would cripple psychotherapy. Yet, it might be developed as a logical extension of the concept of special relationship on the one hand and an insanity defense criterion of the patient's being "incapable of controlling his/her conduct . . ." on the other.

One further impact on psychiatry in both its practice and its scholarly aspects must be mentioned. I have already noted the tendency to practice defensively. As we alter our practices to protect ourselves, we rope ourselves in with ever more stringent standards of practice. Thus, it is possible that what we now *elect* to do defensively, we will be *forced* to do when enough of us have chosen this or that procedure that it becomes standard. In the scholarly area, what we write may be cited in subsequent litigation. I have already encountered discussion among our colleagues about "defensive writing." The threat of an increasing scope of third party protection duty can have a chilling effect on scholarly inquiry. In this regard, I feel impelled in the present instance to state that the conjectures and possibilities presented in this paper do not in any way represent endorsements or opinions about what our legal liability or our practice procedures should be. Rather, they are illustrations of third party protection – issues – which must be faced and carefully considered.

The law is elastic, and it can stretch along several dimensions. And the law, in this respect, is not a matter strictly for lawyers to evolve; it is an instrument which shapes social policy, and it, in turn, must be shaped by all those who have a stake and some expertise in such policy. For this reason, psychiatrists must carefully scrutinize the various dimensions of third party protection. Equally carefully, we must define boundaries and examine our concepts and working assumptions with respect to these dimensions.

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