

## The Duty to Protect

Gary Chaimowitz, MB, ChB, FRCPC <sup>1</sup>, Graham Glancy, MB, ChB, FRCPsych, FRCPC <sup>2</sup>

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### Introduction

Privilege and confidentiality are central to the physician–patient relationship. These concepts are protected by law in almost all jurisdictions (1,2). Breaches of confidentiality have long been considered unethical and, in many situations, actionable. In this regard, physicians have been governed by their standards of practice, by the regulations of their professional colleges, and in many jurisdictions, by legislation.

In general, there are some circumstances wherein it may be acceptable to breach confidentiality, and in some circumstances, not breaching confidentiality may be illegal or contrary to established standards of practice. Some of the circumstances in which therapists may disclose information obtained in confidence are defined by precedent or law (3,4). The mandated breaches of responsibility are purpose-specific, and the overall confidentiality of the physician–patient interaction should, as much as possible, be preserved. However, there now exists the concept of a “duty to protect” when third parties may be at risk (5–8).

Legal precedent has established the concept of “duty to protect and warn,” the continued development of which has impacted practice incrementally (9–13). The concept has been variously interpreted using case law, legislation, and guidelines—often borrowed from outside jurisdictions. The issue has been clarified for Canadian practitioners: in Canada, a Supreme Court decision has provided guidance regarding the legal obligations of physicians when patients pose a risk to others (11). In light of these developments, the Canadian Psychiatric Association (CPA) has produced this position paper.

### Discussion

Although the Supreme Court has now clearly indicated what the obligations are, there exists a healthy debate regarding the conflicting duties. Confidentiality and trust between physician and patient have traditionally been considered essential to successful treatment (14,15). The Hippocratic oath states, “Whatsoever things I see or hear concerning the life of men, in my attendance on the sick ... I will keep silence thereon, counting such things to be as sacred secrets” (16). Physicians have long had a fiduciary duty to their patients and can and should protect their patients’ privacy, refusing inappropriate access to their files. However, beginning with Tarasoff in 1974 and 1976 (9,12), the idea that physicians may have a duty to breach confidentiality when third parties are at risk began to influence the practice of medicine, especially psychiatry.

The concept of a duty to warn, inform, or protect has now permeated the practice of psychiatry in North America. Although the Tarasoff decision and its progeny have often been misunderstood (17), the concept of protecting potential victims of patients appears to have become a standard of practice in many areas. Twenty US states have enshrined the duty to protect within law (PS Appelbaum, personal communication, October 2000). In Britain, the Royal College of Psychiatrists states that a duty of care may be owed to a third party if there is a “proximity” between the patient and a potential identifiable or identified victim (18).

The concept of a duty to warn and protect achieved widespread exposure following Tarasoff I and Tarasoff II (9,12). In Tarasoff I, the clinician had obtained information from his patient that an identified victim was at risk, and the courts held that there existed a duty on the part of the clinician to warn the intended victim, even if that meant breaking confidentiality.

Tarasoff II extended the concept, with the result that the duty to protect supersedes the duty to warn. The implication here is that warning in itself may not ultimately be sufficient to protect the victim. Despite this critical development, some jurisdictions have nonetheless focused on the Tarasoff I duty to warn, rather than on the subsequent Tarasoff II duty to protect, as the key element of legislation. This distinction is important with respect to the psychiatric discharge of responsibility.

Some issues pertaining to the duty to protect complicate the picture. To initiate protective action, the physician must have determined that there is a victim or victims at risk. This risk may have several parameters: the likelihood of injury, the nature of the potential harm to the victim, and how soon might it happen (19). Predicting

risk is notoriously difficult, however (2,20,21). In general, it has until now been necessary for the risk to be foreseeable, of serious harm to an identifiable victim or group, and imminent. These parameters continue to be redefined in law. The base assumption that psychiatrists can and should predict violence underpins the responsibility and consequent potential liability that we face in the duty to protect. Harm and injury have qualitative elements, and the decision is based on probability (5). As prediction tools become more reliable, the expectations related to foreseeability may shift. In law, opinions already differ on whether a potential victim needs to be identified, either singly or as part of a group, although some jurisdictions do clarify this (18). "Imminence" is a vague term that the courts have extended to more than 1 month in some cases (12) and that, in fact, could be interpreted as 3 years in the definitive Canadian case (11). Felthous makes the pragmatic point that, to clinicians, the question is whether patients will do harm before their next appointment or without protective intervention (5).

As a result of the growing body of law respecting them, duties to warn, inform, or protect may be invoked when there is possible risk to third parties. Discharging the duty to warn implies letting the victim or others know of the risk. (While this may reduce risk, in certain situations it may very well increase it.) The duty to inform implies a similar action, but it has been used in the context of an obligation to inform the potential victim, the police, or the courts. As a result, it appears that this is a duty to be discharged by the physician.

The duty to protect carries broader implications and encompasses actions that lead to protecting potential victims. Unlike the duty to warn or inform, the duty to protect may be discharged without breaching confidentiality (for example, by detaining a threatening patient with mental illness under a mental health act). It also requires a strategic decision about the specific actions needed to protect victims. With the duty to protect, we now have duties both to our patients and, flowing through them, to third parties (12). Our obligations to care for our patients remain, including the expectation that we will preserve confidentiality wherever possible. When we determine risk to third parties, however, an obligation to society is created through our patients. We are then required to act.

In Canada, one provincial medical licensing organization adopted a standard for the duty to inform and asked the government to pass regulations regarding it (6). In this case, the standard duty to inform was summarized as "where a physician forms the opinion, based on clinical judgement in all the facts available, that threats of serious violence or death made by a patient are more likely than not to be carried out, the doctor has an obligation to notify the police, or, in appropriate circumstances, the intended victim of the danger" (6).

Underlying recommending mandatory standards rather than guidelines is the belief that a merely discretionary duty will not adequately protect either potential victims or physicians. Assuming that potential victims deserve the opportunity to take measures to protect themselves, a discretionary duty may be insufficient to warn all potential victims equally. Further, a mandatory duty may make it easier to defend physicians who report patient threats in good faith, because otherwise, professional liability could be found either for reporting or for not reporting such threats. This epitomizes the physician's dilemma: even if it exists as a practice standard, physicians' discretion to report such information may not protect them from charges of professional misconduct. The existence of standards provides a defense for physicians but in no way assures them of protection from litigation or censure (14,22).

### **The Duty to Protect**

In light of the Supreme Court of Canada decision in *Smith v Jones* (11), the CPA takes the position that its members have a legal duty to protect intended victims of their patients. This duty to protect may include informing intended victims or the police, or both, but may more easily be addressed in some circumstances by detaining and possibly treating the patient. The CPA recognizes that informing the intended victim may be insufficient action to prevent harm in certain circumstances.

In Canada, several cases have provided some guidance since *Tarasoff* and before *Smith v Jones*. In *Wenden v Trikha*, a duty to protect a third party or parties was indicated if a requisite proximity of relationship existed (10). The physician's liability hinged on the risk posed, the predictability of future dangerous behaviour, and the ability to identify the person or persons at risk. An analogous case implied that there may be a duty to inform potential partners of HIV-positive individuals (23).

However, it is the Supreme Court of Canada decision in *Smith v Jones* that has guided physician actions in this regard. In *Smith v Jones*, the court identifies privileged relationships but describes a public safety exception. The highest court in the land has clearly articulated a duty to warn and protect—laying to rest any doubt whether public safety outweighs doctor–patient confidentiality. There are now practical implications for psychiatrists. The CPA makes the following recommendations, based on the *Smith v Jones* Supreme Court decision:

1 . As part of the informed consent process, patients need to be warned of limits to confidentiality.

This should be done at the beginning and at junctures during treatment. A written contract may assist but does not replace the explanation. There is a potential risk of steering certain patients away from therapy or of restricting the content of the therapy to noncontentious issues. Past arguments about these restrictions have been overshadowed by *Smith v Jones*.

2. A duty to protect (warn, or inform) exists

- I in the event that risk to a clearly identifiable person or group of persons is determined
- I when the risk of harm includes severe bodily injury, death, or serious psychological harm
- I when there is an element of imminence, creating a sense of urgency

It is by reviewing these 3 elements that the risk is evaluated. If the review of these 3 elements points to the risk being real, the psychiatrist is encouraged to take action to protect the potential victim or victims. Although the Supreme Court declined to outline the exact steps to take in discharging this duty, the steps could include detaining the patient, treating the patient, or breaching confidentiality and informing the target(s) or the police. In the event of informing, the information disclosed should be limited to that which would provide protection.

Although the CPA position is clear in light of the legal precedents, cautions exist. There is a risk of degrading the usefulness of psychotherapy and the physician–patient relationship if confidentiality is diminished (4,24–26). As goes confidentiality, so follows psychotherapeutic efficacy. In 1996, the US Supreme Court held that

effective psychotherapy depends upon an atmosphere of confidence and trust, and therefore the mere possibility of disclosure of confidential communications may impede development of the relationship necessary for successful treatment. The privilege also serves the public interest, since the mental health of the nation's citizenry, no less than its physical health is a public good of transcendent importance (27).

How can risk be assessed if the patient will not discuss violent thoughts, fantasies, or behaviours? Paranoid patients may have their persecutory ideas reinforced by notification, and potential victims may be left with little protection beyond their own newfound fear. The concept of protection has not always been served by informing the victim or police and occasionally may exacerbate risk. The opinions and actions of the psychiatrist need to be based on clinical judgement and all the information available. The psychiatrist should address threats of serious violence or death and assess whether they are more likely to be carried out than not. The mere mention of a threat to harm someone, when made within the physician–patient relationship, is in itself not a justifiable reason to breach confidentiality (5,28,29). It is the physician's assessment that the patient is more likely than not to carry out these threats that raises the issue of breaching confidentiality, with the additional element that physicians have at their disposal the power to detain and treat patients who are seriously mentally ill and dangerous.

At this stage, the psychiatrist should decide upon a course of action that is based upon sound professional judgement and a clear sense of legal precedents. The use of an algorithm (5,29) and consultation may guide the psychiatrist though this minefield.

### **Conclusion**

The CPA recommends that its members become familiar with the current regulations and standards within the practice of their profession (professional governing bodies), as well as with case law and any legislation pertaining to the duty to protect third parties. Specifically, the highest court in the land has spoken on this issue, and its decision will serve to guide action. The concepts, law, and standards will likely continue to endure. Risk assessment and management, and an understanding of the implications and enactment of the duty to protect (as well as the duty to warn or inform), need to be part of psychiatrist training.

The CPA recognizes the duty to protect as a public safety, common-law obligation that is often in conflict with the principle of confidentiality. Informing and warning are but 2 options, and these may not serve to protect. We should seek to protect potential victims of our patients while also attempting to protect our patients' rights. Because the duty to protect partly originates in case law, the CPA advises its membership to take the position articulated by the Supreme Court of Canada in *Smith v Jones* as a professional standard of practice. To assist physicians to balance their professional responsibilities, the CPA encourages increased awareness of any obligations with respect both to the duty to protect and to confidentiality. This can be promoted by offering

residents specialty training in risk assessment, in the medicolegal aspects of psychiatry, in accurate documentation procedures, and in ethics. Physicians are required to recognize the limitations of confidentiality as well as their obligations to patients and the consequences of breaching this confidentiality.

Ultimately, legislation and case law will define the liability a physician faces. Foreseeability, imminency, serious harm, and whether the target is identified have been defined in law, yet these concepts may continue to be refined. As the area continues to evolve, an awareness of pertinent case law, civil commitment laws, confidentiality statutes, and privilege is essential to maintaining acceptable practice standards.

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### Authors

1 Assistant Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, Ontario, Canada.

2 Assistant Clinical Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, Ontario, Canada.

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