When Duties Collide: Medical Privacy v Public Safety

The following material was presented by Dr. G. in modified form at a panel on ethics in a meeting of the American Psychiatric Association. The matter concerned the troublesome conflict we face as psychiatrists between protecting the society and protecting the patient—a Tarasoff-related litigation.

About thirty years ago, a married 2nd year resident in psychiatry, fully licensed to practice medicine, and a candidate in the medical school's psychoanalytic training program sought Dr. G. as his training analyst. The medical school had a psychoanalytic training institute and candidates-in-training needed a personal analyst, a so-called training analyst. This candidate was also aiming for a child fellowship after his residency. He reported that he had been in treatment with another training analyst, but they did not get along. Later, Dr. G. would find out it was more complicated.

In one session six months into their 3-times-weekly analytic work together, his patient disclosed that he had strong erotic interests in young boys. Dr. G. was astounded. His patient said that he was at peace with this erotic desire. It was entirely ego-syntonic for him. It was also politically colored. He believed that he and others like himself were wrongly regarded. Pedophiles, he believed, should have a right to pursue their interests as they do in certain other cultures. He sought what the gay community had achieved years earlier: to overthrow the pathologizing of what he called his sexual orientation.

In that session, Dr. G. said something simple like, "We will talk about this, but

you must not act on these desires." The patient assured the doctor that he never did act on these desires and that he would not so long as it was widely regarded as immoral and illegal. Within hours of his patient's disclosure, Dr. G. began seeking advice. He phoned an outstanding forensic psychiatrist of his acquaintance. In their brief call, the forensic psychiatrist ruefully joked that the doctor's only option was to put a bullet through his patient's head. The forensic psychiatrist lived in another state and did not know the law in Dr. G.'s state. There was no further help he could offer. Why not speak to the Chair of Ethics of the local district branch? That person, on hearing Dr. G.'s first words, said he should get a lawyer and abruptly hung up. Fortunately, the medical society lawyer Dr. G. then consulted considered the matter. The lawyer researched the state law code and found that reporting a threat to potential victims and to law enforcement required that the threat be imminent and against an identifiable individual. Furthermore, the lawyer said, the doctor had a responsibility to inform his patient that he would report him if such a threat arose. This followed the legal theory on which the *Miranda* principle is based, he said.

Dr. G. recognized that his psychiatric colleagues did not want to enter what might be a pit of quicksand. He was surprised and dismayed at this limit to what collegial consultation can offer. But on reflection, he realized, they had legitimate reason to stay away. When he spoke the next day over lunch to a colleague, he placed the issue in the form, "I have a friend who . . ." This colleague, like the others, said nothing and advised him to speak with an esteemed psychiatrist, a colleague in the psychoanalytic institute

associated with the medical school. This colleague was a senior clinician and an expert in the paraphilias.

The senior clinician graciously invited Dr. G. to dinner to discuss his "friend's dilemma." He listened carefully and said that the patient needs to withdraw from the analytic school. The direction of therapy must be supportive and prescriptive, not psychoanalytic. "Your colleague is going to have hard time with this next point," he told the doctor. "Your colleague will need to stand by this patient indefinitely regardless of whether fees are paid, regardless of scheduling difficulties all in order to contain this matter of his patient's pedophilic fantasies. Only if the patient explicitly abandons the therapy should your colleague take further action, which we can discuss if that should happen. The patient should stay in the residency and not lose his sense of identity as a psychiatrist and as a child psychiatrist." The consultant said that he would appear in court if it came to that.

With halting determination, Dr. G. followed this advice. He recalled feeling some pride in doing the 'hard thing' heightened in its drama by the privacy it required. From time to time, Dr. G. occasionally contacted his senior colleague. When the patient rotated through out-of-state hospitals, sessions which were now once weekly, were by phone. The general strategy was to maintain the dialogue, to seek to contain anxiety that could erupt in pedophilic enactment, to emphasize that the patient must not act on his desires, and to recommend that he choose work with adults to reduce the temptation that children stimulated.

About three months after the disclosure, Dr. G.'s patient molested two boys in an out-of-state hospital and was arrested. He lost his medical license and served years in prison.

Then, several years later, Dr. G. received the formal legal complaint: he had failed to do something to protect a child from this predator. He immediately contacted the insurance company. A discussion of settlement ensued. Dr. G. was confident in his position. He had done what he could, consulting the best in the field and following through conscientiously. If the insurance company wanted to take this to trial, he was secure that he had done what was ethically, legally, and clinically correct. After review, the insurance company agreed. A modest settlement was offered and the plaintiff refused.

Five years later, a jury trial was scheduled in federal court. Newspapers, television news shows, and psychiatric trade papers picked up the story. The immediate impact on Dr. G.'s personal and professional life was intense. Though his family, friends and colleagues commiserated and supported him, hate calls spewed venom into his answering machine. Ironically, he also received requests from people seeking to consult with such a discreet psychiatrist.

The jury trial lasted a month. The state law on which the doctor depended was effectively interpreted in the light of law in the state where the crime was committed. The law was different. In this state, the threat to an identifiable individual could be regarded as a threat to an identifiable "class of persons." That is, the threat expanded from an identifiable child to the entire class of children. This greatly increased liability. In court, also, Dr. G.'s advising his patient about his need to report him if he proved an imminent

threat—the *Miranda* principle—was frankly ridiculed by the plaintiff's attorney. What he was really doing, she said, is telling his patient not to speak about reportable activities. Meanwhile, the doctor was the sole witness who presented the facts of the case. The experts, three on each side, offered their views pro and con concerning his liability. Also, in the 13 years the senior colleague on whose counsel Dr. G. relied had died. And, finally, it was learned that the patient's first training analyst had dropped the patient when he disclosed his pedophilic interests. That analyst had shut the door on him. She said nothing to anyone and just discontinued treatment. She, too, had died.

After three days of jury deliberation, Dr. G. was found liable. The jury seemed to believe he should have figured out a course that would have protected children. The medical school was not found liable. The matter was duly reported in the local newspaper and the out-of-state papers. The insurer and the plaintiff settled within the bounds of the insurance coverage. Subsequently, the insurer denied Dr. G. malpractice insurance. He found insurance elsewhere. The amount of the settlement triggered a state department of health investigation for professional misconduct. Three years later, the department closed the case without comment. There were no other ethical or administrative inquiries. During these few years, Dr. G.'s academic position at the medical school was advanced. His clinical and scholarly work progressed without adverse impact. Years later, a representative of the original insurance carrier phoned and offered once again to cover his professional liability needs at the advantageous premiums accorded psychoanalysts. The statute of limitations for child abuse—17 years after the age of majority—had run its course. The doctor accepted the insurance company offer.

At the time of the disclosure and in the ensuing years through the trial and after, Dr. G. maintained that his actions were consistent with clinical, ethical and legal behavior. He believed that his senior colleague's recommendations were correct. Yet, now, he says, he is no longer sanguine about it. Perhaps the senior colleague was wrong. These days, decades after his patient disclosed his pedophilic desires, Dr. G. sometimes still plays out different scenarios and traces their possible consequences. The expert witnesses who opposed him in court said he was wrong, but could not offer any alternatives. Standing by his patient and trying to contain the impulse to act on his desires was not sufficient for them. What should Dr. G. have done? Perhaps that previous training analyst who had discharged the patient on hearing his proclivities and said nothing—perhaps she chose the best path. Drop the patient and never look back. Perhaps Dr. G. might have denied the patient ever raised the matter of pedophilic desire and simply perjure himself. There was no one other than his compromised patient who could gainsay that lie. Perhaps the ego-syntonic nature of his patient's desire and his wish to change society's view of pedophilia were a sufficient trigger to report the matter immediately. But to whom? On a couple of occasions, when the patient failed to call for his appointment, should that have been a line bright enough for Dr. G. to blow the whistle? But how, and to whom, and what might be the unintended consequences of that? What is the basis for breaching confidentiality and destroying the doctor-patient alliance when no crime had been committed and was not imminently threatened? How well can we predict dangerousness? What criteria need to be present to act? Act how?

What if we are wrong? Was Dr. G. a coward as at least one caller insisted? Was he courageous as some psychoanalytic colleagues said? And what about the children who might be molested? Did Dr. G. care enough about them? Did he suffer from a failure of imagination in failing to find a solution? Did the jury believe him? To what extent was he self-deceiving?

Dr. G. says these possibilities and questions remain open for him, at least somewhat. About this case, he finds that his earlier complacent self-assurance, a self-assurance that rose at times to self-congratulatory righteousness, has faded. The matter has not come to rest, not fully. In moments of idle thought, it all may come back as a shadowy revisited awareness.

In idle thoughts, he occasionally finds himself wondering about the case. To the extent he can, and out of a belief in the value of skeptical self-review, he prefers to keep the questions raised by his experience open rather than bury them beneath what might be a convenient denial.

COMMENT:

This case illustrates the value of establishing a service that would provide for psychoanalysts' direct consultation with forensic psychiatrists. Though we have no data, it seems likely that questions like those set forth in this case arise with some frequency in the course of psychotherapy. About this specific case, my view is that that the senior analyst who was consulted was wrong. The author is hesitant to acknowledge it. The author of the narrative faces two important matters. First, he needs to relinquish any

shame still associated with challenging the senior analyst, or failing to do so. Second, he needs to neutralize any guilt associated with activating a Tarasoff matter. Tarasoff matters do create a collision of duties.

Paulina Riess, MD
Chief Resident
Department of Psychiatry
Bronx Care Health System