To protect and serve: Psychiatrists' duty to patients

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Patient discharged from group therapy kills psychiatrist, patient, and himself

Oakland County (MI) Circuit Court

The plaintiff, age 57, attended regular group therapy with a psychiatrist. Another patient, Mr. B, was dismissed from group therapy by the psychiatrist, but returned to the office with a gun during one of the regular sessions. Mr. B shot and killed the psychiatrist then entered the group meeting room and discharged his gun, fatally injuring another patient and wounding the plaintiff. Mr. B then turned the gun on himself and committed suicide. The plaintiff suffered gunshot wounds to the lower leg, foot, and hand and was away from work for 6 weeks.

The plaintiff alleged that the psychiatrist, his associates, and his daughter—who is also a psychiatrist at the office—knew Mr. B was dangerous and should not have been included in group therapy. The plaintiff claimed that Mr. B had a history of questionable psychotic behavior and other patients should not have been exposed to him. The psychiatrist's associates contended that they had no way to anticipate this event and had used due care and caution in their practice.

- **A $2 million verdict was returned**

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Dr. Grant's observations

WARN AND PROTECT

In this case, several unavailable facts may have supported the successful negligence claim. For example, why was Mr. B dismissed from the group? Did he threaten someone in the group? Did he tell the group or the group leader about thoughts of violence or homicide? If so, perhaps a violent event was foreseeable.

Was Mr. B dismissed because of delusional or paranoid thoughts? What was done to help him, and were appropriate referrals in place? Instituting the right interventions requires clinicians to walk a fine line between preserving doctor-patient confidentiality and protecting other patients and the general public.

Doctor-patient confidentiality is deeply rooted in medical ethics and protected by law—in various forms—in all jurisdictions. Directives requiring a physician to reveal information without a patient's consent are either legislated—and tend to be

Box 1

"Warn and protect" statutes by state

Require clinicians to warn potential victims

Arizona	Massachusetts	Ohio
California	Mississippi	Oklahoma
Colorado	Minnesota	Pennsylvania
Delaware	Michigan	South Carolina
Idaho	Missouri	Tennessee
Indiana	Montana	Vermont
Kentucky	Nebraska	Washington
Louisiana	New Hampshire	Wisconsin
Maryland	New Jersey	Utah

Allow clinicians to warn potential victims but do not require it

Alaska	Florida	Rhode Island
Connecticut	Illinois	Texas
District of Columbia	New York	West Virginia
	Oregon	

No definitive law on a clinician's duty to warn and protect

Alabama	Kansas	North Dakota
Arkansas	Maine	South Dakota
Georgia	Nevada	Virginia*
Hawaii	New Mexico	Wyoming
Iowa	North Carolina	

*Rejected the "warn and protect" provisions of the Tarasoff rulings

Source: Herbert PB, Young KA. Tarasoff at twenty-five. *J Am Acad Psychiatry Law* 2002;30:275-81.

clear—or are based on court precedent, which is more open to interpretation. These mandated exceptions are purpose-specific and intended to preserve overall doctor-patient confidentiality.[1,2]

Tarasoff. Two cases—called Tarasoff I and II—set the precedent for a physician's duty to warn and protect others from potentially violent patients.[3] The cases involve a psychologist who believed his patient would kill a university student. The therapist notified the campus police, who apprehended and then released the patient. Two months later the patient murdered the student.

In Tarasoff I, the court ruled that when a clinician has information from a patient that an identified victim is at risk, he or she has a duty to warn the victim, even if it violates doctor-patient confidentiality. In fact, not breaking confidentiality may be illegal and against the profession's standards of practice.

Tarasoff II extended the first case and established the clinician's duty to protect—not simply to warn—a potential victim. The ruling states that a clinician must "exercise reasonable care to protect the foreseeable victim." This means that warning the intended victim might not be enough and may not be necessary if the clinician takes reasonable care to protect the potential victim by admitting the patient to a secure psychiatric facility, for example.

Although the duty to warn often is standard among jurisdictions, not all states have adopted the protection standard. Clinicians should be familiar with laws in their jurisdictions (*Box 1*).

PROTECTING POTENTIAL VICTIMS

In general, clinicians should exercise their duty to warn and protect when:

- a clearly identifiable person or group is at risk
- risk of harm includes severe bodily injury, death, or psychological harm
- danger is imminent and creates a sense of urgency.[2]

The clinician must first identify if a potential victim is at risk (*Box 2, page 152*). Predicting risk requires assessing several factors including:

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Box 2

Risk factors for patient violence

- **History of violence** is the single most predictive factor
- **Gender.** Men are 10 times more likely to be violent than women
- **Substance abuse** increases the likelihood of violence by reducing inhibitions
- **Mental incapacity** interferes with judgment
- **Having an organized plan;** look for a clear plan of how the violence will be perpetrated
- **Unavailability of support group;** patients with more support are less likely to be violent
- **A violent environment,** such as within a family or circle of friends, increases the likelihood of violence

Source: Reference 7

- likelihood of injury
- nature of potential harm
- when it may occur.

This boils down to probability assessment and determining if harm is foreseeable and imminent.

Clinicians should be aware that the term "imminent" injury could be based on the patient's potential for violence, not passage of time. In some cases a psychiatrist has been found negligent for not preventing violence that occurred 5 months to 2 years after a threat was made.[4,5]

The therapist's opinion must be based on clinical judgment using all available information, such as a history of violent acts, evidence of weapons possession, or substance abuse. By itself, a mere mention of a threat to harm someone may not be reasonable justification to breach confidentiality. For example, a patient might talk about frustrations without any intent of acting on these thoughts. When documenting your clinical decision, be sure to include:

- what the patient said
- an assessment of the seriousness of the threat
- the patient's history as it pertains to the threat
- your actions in response such as calling the police or detaining the patient.

ASSESSING RISK

Look to a patient's past, present, and future actions when assessing his or her potential for violence.

Past. A history of violence is the most predictive factor for violence.

Present. Three variables affecting the patient's present potential for violence are:

- situational, such as use of weapons, stressors, and other criminal activity
- interpersonal, which includes the patient's relationship to the victim and third parties that may be involved with the victim
- mental status, such as mood or cognitive issues, hallucinations, paranoia, delusions, medication, or substance abuse.[6]

Future. Assess the patient's insight into his behavior. For example, is he aware that his anger is out of proportion to inciting events? If the patient knows he is just venting anger and doesn't intend harm, the clinician can help him work through these feelings. Otherwise, the clinician might have to detain the patient against his will.

A clinician's obligation to take reasonable precautions to prevent harm threatened by a patient is fulfilled when the clinician:

- communicates the threat to the identified victim or victims
- notifies a law enforcement agency where the patient or any potential victim resides
- arranges for the patient to be hospitalized voluntarily
- or takes legally appropriate steps to initiate

proceedings for involuntary hospitalization.[7]

Potentially violent patients might remain under your care after you fulfill your duty to warn and protect. When treating these patients:

- conduct competent suicide and violence risk assessments to direct clinical interventions
- perform risk-benefit assessments before discharging suicidal or potentially violent patients
- observe basic safety precautions and procedures.[6]

GROUP THERAPY GUIDELINES

Often negligence that occurs during group therapy is caused by the group leader's failure to render proper services; in other words, the leader did not follow standard practices (*Box 3*). If you use group therapy techniques that are not consistent with those used by other group leaders, you need to justify your practices in your notes to protect yourself from a possible malpractice claim.

In group therapy, the therapist works for the good of the group. Therefore, duties to warn and protect also apply to the group. The leader must take reasonable action and inform authorities when a group member's condition indicates a clear and imminent danger to other members of the group.[8]

A safe and trusting environment is essential to the group therapy process. The American Counseling Association's ethical guidelines for group counselors[9] state that group leaders need to protect members against physical threats, intimidation, coercion, and undue peer pressure as is reasonably possible. Part of this protection may occur at the selection process. Counselors should screen participants and select individuals whose needs and goals are compatible with those of the group and will not impede the therapeutic process.[8] Group leaders can also create policies—such as prohibiting personal or sexual relationships between group members—at the start of therapy, which would be grounds for dismissal if violated.

Box 3

Group therapy standards of care

- **Techniques** should be congruent with the group's goals and purposes
- **Group leaders** must recognize their competencies and work only with groups they are trained and experienced to work with; collaborating with an experienced co-leader may reduce potential risks
- **Give potential group members** enough information to make informed choices about participating in the group; this might include discussing the inclusion of emotionally disturbed individuals in the group
- **Adequately screen**, select, and prepare members for the group
- **Keep specific treatment notes** for each group member
- **Use written contracts** for members to comply with group rules regarding harm to other members; contracts will not discharge Tarasoff I or II responsibilities but will document that members' rights and safety were considered
- **When a person poses a threat**, document any intervention and its basis

Source: References 8 and 9

DISMISSAL FROM A GROUP

Therapists also can protect patients during the dismissal stage of group therapy, an issue involved in this case.

Be alert for signs and symptoms of decompensation such as tardiness or increased absences from the group, depression, or a noticeable decrease in a patient's ability to function or care for himself. Make provisions to help a group

member leave, such as providing pretermination counseling and arranging for continuing care.[8]

References

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For more information on this topic, see the November 2006 issue of CURRENT PSYCHIATRY for "Is this patient dangerous?" (p. 25-32) by John Battaglia, MD, and "Protect yourself from patient assault" (p. 15-24), an interview between Dr. Battaglia and Lois E. Krahn, MD.